

# Mount Sinai Health System: Integrating Care Through the Oncology Care Model



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*This Q&A is with Mark Liu, director of strategic initiatives for oncology, and Luis Isola, director of clinical cancer programs, at the Mount Sinai Health System. The Mount Sinai Health System is an integrated health care system in the New York metropolitan area made up of eight member hospitals and the Icahn School of Medicine at Mount Sinai.*

*In this interview, Liu and Isola discuss how the 2013 merge of Mount Sinai Medical Center and Continuum Health Partners became the catalyst for a systemwide movement toward standardizing clinical care and tracking clinical quality measures. To further develop efforts to improve health outcomes and to provide higher-quality care at a lower cost to Medicare, Mount Sinai Health System enrolled in the CMMI Oncology Care Model (OCM) in July 2016.*

**In 2013, before participating in OCM, Mount Sinai Health System was developing clinical standards and systems for tracking the quality of care in an effort to integrate Mount Sinai Medical Center and Continuum Health Partners. If Mount Sinai Health System was already putting in the work, how did OCM fit into these quality-improvement efforts?**

When OCM came along in late 2015, we saw it as an opportunity to accelerate the process that was going to have to take place anyway. Some of the practice-transformation requirements for OCM were completely aligned with what we wanted to do, and OCM provided us with some working capital to get some things done that we would have accomplished on a different timeline. I think it was a great opportunity to accelerate that change. Instead of taking our time to get this integration and standardization done, we now had a serious timeline that we needed to comply with.

**How did you build on existing clinical integration and standardization efforts through OCM?**

When our health system merged in 2013, we developed a clinical integration plan for our health system's cancer program. It included program infrastructure, governance, clinical trials, and information technology, which required us to, effectively, evaluate how we do business operationally and financially. At the time, we were on two different electronic health record (EHR) systems, and now we are on one. Merging the EHRs was part of the wider effort to merge the health

## Oncology Care Model: Examples in Practice

The Center for Medicare and Medicaid Innovation (CMMI) created the Oncology Care Model program (OCM) to improve care for cancer patients receiving chemotherapy. The goal of the program is to enhance coordination between providers and increase Medicare patients' access to evidence-based care, while reducing costs. Since OCM started in 2016, the AAMC has supported 18 oncology practices associated with academic medical centers (AMCs) that are participating in the model.

The Examples in Practice series highlights the challenges faced and the strategies leaders use while participating in OCM and other CMMI models. These examples offer potential lessons for other AMCs pursuing value-based care and for the payers and policymakers designing alternative payment models.

*For more information on bundled payments, go to [aamc.org/bundling](http://aamc.org/bundling).*

system, and it affected our standardization of clinical care as we began participating in OCM. We have also been working on standardizing how we support oncology practices to provide the right resources to our cancer patients. We want a single, unified experience for our patients no matter what site they go to.

We have established a health system chemotherapy council to help standardize our evidence-based care. The council reviews all new chemotherapy regimens and then assigns a score based on a standardized score sheet. Knowledge evolves constantly, and the change in oncology care is accelerating. What we knew a year ago is no longer current, so we constantly need to adjust our chemotherapy regimens to new knowledge, new evidence, and new published data. The chemotherapy council has become the sounding board for all the new information and translates it into clinical practice.

So, rather than a person reading an interesting article in a journal and saying, "Let's do it," they have to go through a rigorous process that takes into account the strength of the evidence, the quality of the journal that it was published in, and where it was presented. The chemotherapy council must approve any chemotherapy regimen that is built into our EHR. Because the hospitals in the health system now use the same EHR, it has become our way to standardize care in the division of hematology and medical oncology. Ultimately, this means we are providing the highest value of cancer care possible to our patients, with the broadest access throughout New York City and beyond.

## How do you track and improve your performance under OCM?

Participating in OCM was the extra nudge that really helped us align the tracking of clinical quality measures across our large health system. We were interested in tracking population health measures for the health system as a whole and for other value-based care programs we participate in, so we selected some of the quality measures we already used for OCM. While tracking all these measures for the health system did increase our administrative burden, choosing from OCM measures gave us a place to begin selecting our internal measures.

CMMI's data on total cost of care are paramount. These data have given us insight into how our patients have engaged in their care, so we are able to see more than what you see from our EHR. We can use all these data points to drive decision-making. For example, we can see through the total cost of care data that a lot of dollars are spent at the end of life. Previously, through the EHR, we could only know roughly how many advance care plans we had on hand for our patients, but we never really knew how we stood compared with other organizations of our shape and size. It has been helpful to see how many plans we have documented for our patients, what our financial opportunity is, and how we can align all the stakeholders who take care of our patients through the entire care continuum, particularly around end of life. This supplements the clinical measures we are looking at and takes us beyond traditional measures of mortality.

The collaboration with other practices, including smaller ones, and AMCs participating in OCM has also been helpful. It has been enjoyable to learn from each other and share ideas about how to implement complex payment models and care transformation.

## What is the impact on patients and clinical staff?

For patients, we have been very careful to communicate that OCM will not change the doctors they are seeing but that they may notice some of the enhanced services we are providing. For physicians and nurses, we want to minimize any disruption while they are working, so we give them enough notice and support when changes are being made to EHR documentation or other work processes. In addition, we created an interactive dashboard for OCM quality measures that allows our team members at each site in our system to monitor our quality data. For example, when a physician accesses the dashboard, they can see how they are doing on OCM measures compared with their peers without being able to identify the peers.

## What EHR changes were required to support the OCM implementation?

To support implementation of OCM, we needed to standardize our physician templates for each disease group. We are treating all our cancer patients the same, so everyone will benefit from the enhancements under OCM, but we also added a flag for OCM patients so we could track them. Across all patients, we have standardized the way we capture pain scores and how we screen for depression, and we rolled out a completely new consent form across our health system for every physician and nurse practitioner to use. This was a large undertaking, to both change the process and add more items to the form, including prognosis, treatment goals, quality of life, and symptoms.

We wanted this document to live in the EHR so that folks who use the form can do so in a fully electronic format. As a result, we are now able to see in more detail where there are variations in care, how we are doing overall, who and what our outliers are, and how we can focus on some of those variations.

## What lessons have you learned from implementing OCM?

The big lesson here is that this work is a big lift and takes a ton of time. Getting physicians and nurses to understand what we are trying to achieve is an upfront time investment. When they understand what this model is trying to achieve, they realize that this is exactly what they already want to do for their patients. We are just trying to do it in a reportable and measurable way so we can provide high-quality care here every day. We can now demonstrate the quality of our care and learn from our efforts to improve it through the data we are tracking.

## What advice do you have for other AMCs interested in managing and improving care?

My advice to AMCs is to start thinking about value-based care if you haven't already, because this approach to measuring total cost of care is not going away. Begin building out the infrastructure you need to track quality measures, and take your time in making sure your reports are accurate.

At the end of the day, the more you learn about yourself as a practice or as a health system, the better able you will be to provide care and to identify areas of improvement for your patients. From a payer's side, you will be able to demonstrate concretely the quality and value you provide to patients. Ultimately, all this work will really help strengthen your cancer program.