Proactive Patient Management Outside of the Practice

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Proactive Patient Management

- Inside the Walls
- Outside the Walls
- Powered by CMS Value and Performance Reform
- Transforming Patient Treatment to Patient Management

CMS OCM Goals – Collaboration and Outcomes

- The Innovation Center's Oncology Care Model (OCM) focuses on an episode of cancer care, specifically a chemotherapy episode of care

- The goals of OCM are to utilize appropriately aligned financial incentives to improve:
  - Care coordination
  - Appropriateness of care
  - Access for beneficiaries undergoing chemotherapy

- Financial incentives encourage participating practices to **work collaboratively** to **comprehensively** address the complex care needs of beneficiaries receiving chemotherapy treatment, and **encourage the use of services that improve health outcomes.**

Implications of the CMS OCM Approach

- First time a major payer has made MDs accountable for total costs of care
- First time MDs have been given total claims for patients on a large scale
- Drugs are part of the cost structure
- The bottom line becomes a top line target
- Extensive quality measure reporting in effort to avoid shortcuts in care
- **It will take practice transformation to become successful – Patient Management vs Treatment**
- A True Game Changer

CMMI OCM Requirements of Practices

OCM Practice **Transformation – All are Key**

- Provide the core functions of patient **navigation**;
- Document a **care plan** that contains the 13 components in the Institute of Medicine Care Management Plan outlined in the Institute of Medicine report, "Delivering High-Quality Cancer Care: Charting a New Course for a System in Crisis";[2]
- Provide 24 hours a day, 7 days a week **patient access** to an appropriate clinician who has real-time access to practice's medical records;
- Treat patients with therapies **consistent** with nationally recognized clinical guidelines;
- **Use data to drive continuous quality improvement**; and
- Use an ONC-certified **electronic health record** and attest to Stage 2 of meaningful use by the end of the third model performance year.

Care Management – not just treating

1. Patient information (e.g., name, date of birth, medication list, and allergies)
2. Diagnosis, including specific tissue information, relevant biomarkers, and stage
3. Prognosis
4. Treatment goals (curative, life-prolonging, symptom control, palliative care)
5. Initial plan for treatment and proposed duration, including specific chemotherapy drug names, doses, and schedule as well as surgery and radiation therapy (if applicable)
6. Expected response to treatment
7. **Treatment benefits and harms, including common and rare toxicities and how to manage these toxicities, as well as short-term and late effects of treatment**
8. **Information on quality of life and a patient's likely experience with treatment**
9. Who will take responsibility for specific aspects of a patient's care (e.g., the cancer care team, the primary care/geriatrics care team, or other care teams)
10. **Advance care plans, including advanced directives and other legal documents**
11. Estimated total and out-of-pocket costs of cancer treatment
12. **A plan for addressing a patient's psychosocial health needs, including psychological, vocational, disability, legal, or financial concerns and their management**
13. **Survivorship plan, including a summary of treatment and information on recommended followup activities and surveillance, as well as risk reduction and health promotion activities**

Patient Navigation – Proactive, Not Reactive

1. **Coordinating appointments with providers to ensure timely delivery of diagnostic and treatment services**
2. **Maintaining communication with patients, survivors, families, and the health care providers to monitor patient satisfaction with the cancer care experience**
3. Ensuring that appropriate medical records are available at scheduled appointments
4. Arranging language translation or interpretation services
5. Facilitating financial support and helping with paperwork
6. Arranging transportation and/or child/elder care
7. **Facilitating linkages to follow-up services**
8. **Community outreach**
9. Providing access to clinical trials, and
10. **Building partnerships with local agencies and groups (e.g., referrals to other services and/or cancer survivor support groups**).

A transformed practice:

- Anticipates between visit needs and activities
- Touches the patient between visits to the office
- Engages the patient between visits to the office and planning for the future care and choices
- Proactively manages the patients, their symptoms, their expectations, and ultimately, their outcomes

The Reality of OCM Practice Changes

OCM Practice Challenges for Transformation

- Technology Infrastructure (access to own data)
  - Patient Identification and Billing
  - Patient Reconciliation
  - Coding – Billing and Comorbidities
  - **Building Quality Measure Tracking and Reporting**
  - **Patient Care Plan, Navigation and Care Management Fulfillment, Work Flow and Reporting for Continuous Quality Improvement**
  - **Quality Measures tracking, and reporting to CMS and payers**
  - CMS Data Analytics, Prediction, and Risk Assessment
- Resources and Work Flow
  - Patient Communication
  - **Care Management**
  - **Team Integration Across Practice**
  - Staffing, Training, Rapid Implementation
- Quality
  - Identification of Gaps
  - **Reporting, Analytics, Integration into Teams and Daily Practice Life**
  - **Reviewing for Continuous Quality Improvement**
- Costs
  - Recognizing and Tracking Costs external to practice: drivers, existence, barriers, opportunities
  - **Patient severity and risk stratification**
  - **Eye on the goal: CMS savings of 2.75% or 4% for each performance period**

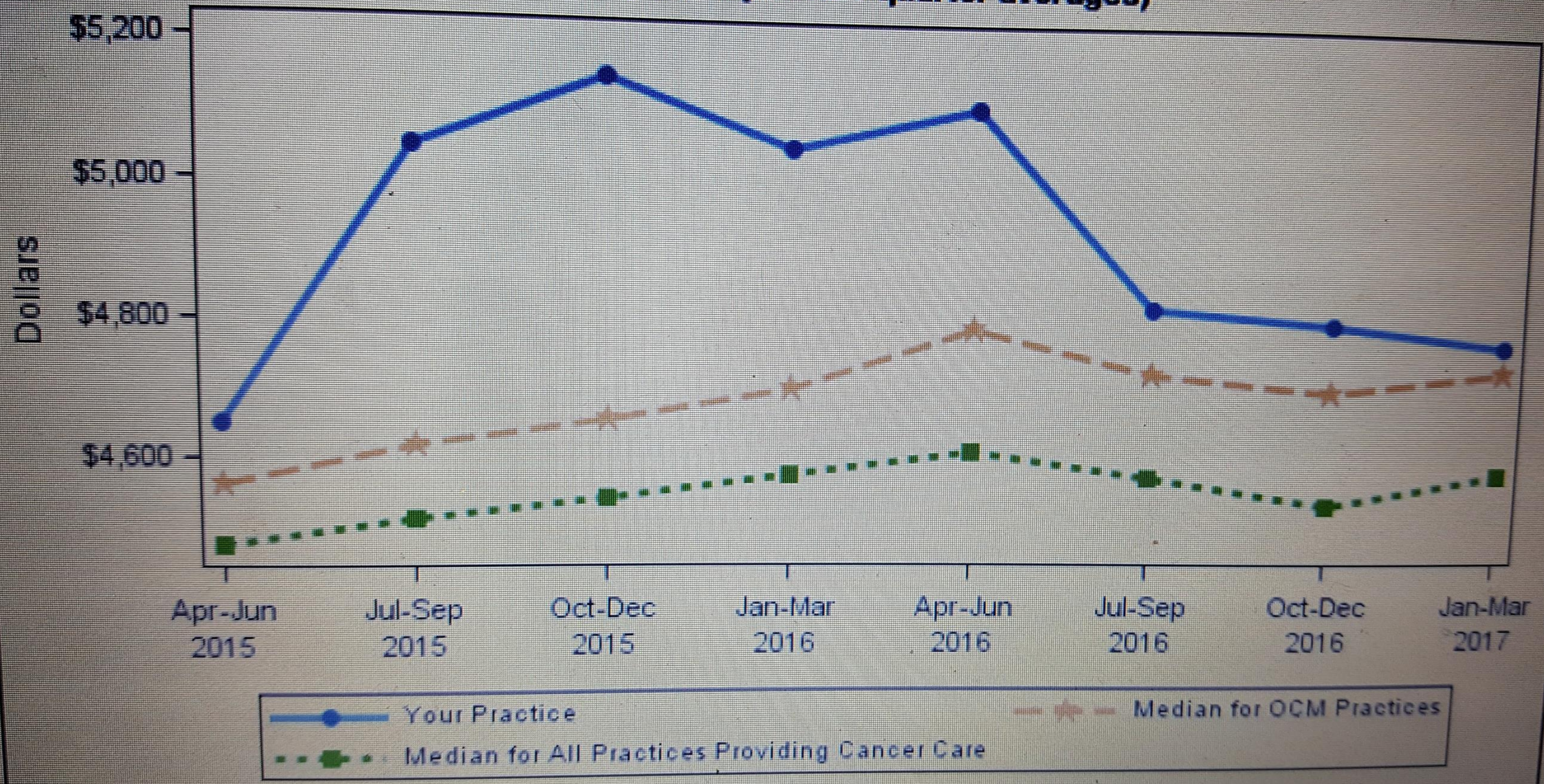
Dashboard Measures – Practice, Physician

- Emergency Department Visits (Frequency, Cause)
- Outpatient Visits (Frequency, Cause)
- Inpatient Utilization (Frequency, Cause)
- Days of Treatment before Death
- Days in Hospice Care at End of Life
- Advanced Care Planning Discussions
- Lines of Therapy
- Medical CoMorbidities
- Orals Compliance
- Actionable Opportunities to intervene in care process to change costs and variation – Actual Care Planning and Navigation
- Avg PMPY
- Active Chemo Mbr Months
- Active chemo PMPM
- IP Avg LOS (with Cause)
- Annual pnt costs (by category – labs, drugs, etc)
- Clinical Care Plan Measures – Patient screening results and responses
- High Risk Patients – Daily, Weekly, Monthly Status

CMS Feedback to Practices

- Beneficiary Counts and HCC Risk Scores (Hierarchical Condition Category)
- CMS $ for all services per b per month(by category)
- Utilization (Admits, ED Visits)
- Patient Exp Survey, % iles
- Graphs over time, 4 quarter average

Figure 1: Trends in Total Medicare Expenditures per Beneficiary per Month (risk-adjusted 4-quarter averages)



Expenditure amounts are adjusted for inflation

Implications for Non OCM Practices

- Data is King
  - NOT just cost of drug
  - **Ripple effects of treatment choices – timing, side effects, additional tests, unique tests vs panels, site of care (home more important)**
  - **More Knowledge may lead to more or reduced access and treatment**
- **Patient Management is King**
  - **2 way communication 24/7**
  - **Repeated training on side effects, disease, self=management**
  - **Questions and Expectations plus Impact affect Access and Treatment**
- Financials and Risk are King
  - Both MDs and patients will be asking more detailed questions about costs and benefits (value)
- **It is time to look at patients as populations, not individuals**
- CA may already be ahead of the game, but behind on technology tools and reporting

The Future includes both OCM and MACRA/MIPS – An inevitable Transition Toward Value and Transformation of Care Delivery

MACRA

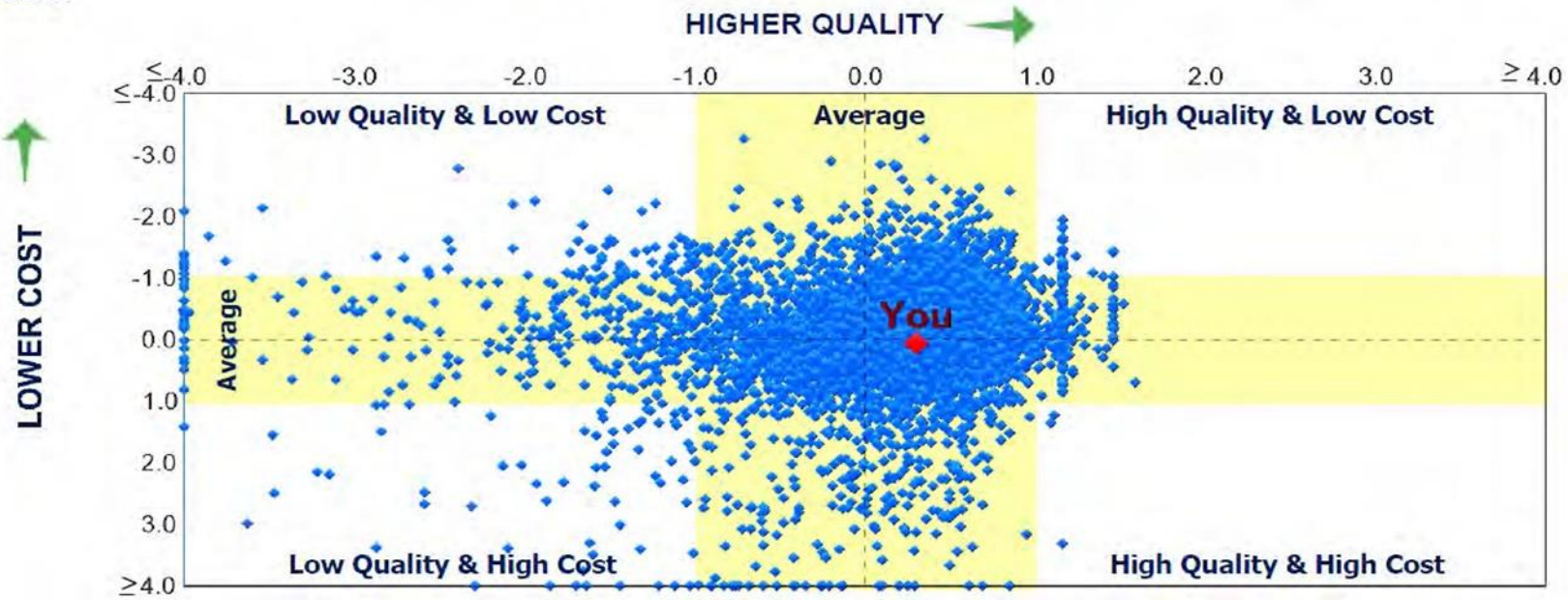
- Medicare Access and CHIP Reauthorization Act of 2015
  - Repeals the Sustainable Growth Rate (SGR) Formula
  - Authorizes CMS to establish the new Quality Payment Program to increase payments based upon value, not volume
  - Streamlines current reporting programs into 1 new system: **Merit Based Incentive Payment System (MIPS)**
  - Incentivizes involvement in Alternate Payment Models (APMs), especially Advanced APMs

Value = Quality and Cost

- Value Based Modifier Scoring and Comparisons – CMS Quality Resource Utilization Report (QRUR)
- MIPS practices have to move their position without CMS Data

Your TIN's Performance: Average Quality, Average Cost

The scatter plot below displays your TIN's quality and cost performance ("You" diamond), relative to that of your peers.



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- Drug Utilization for specific disease

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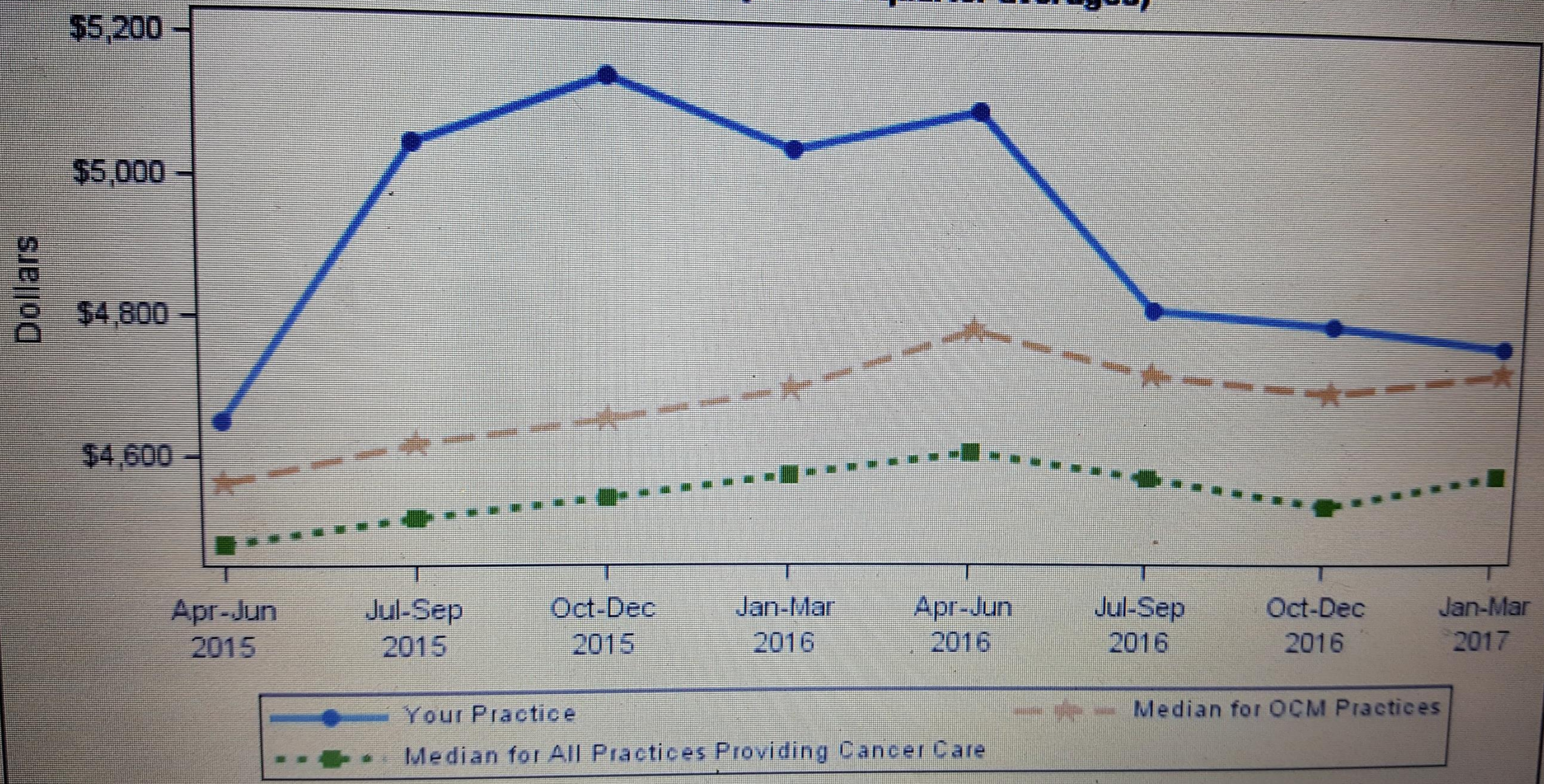

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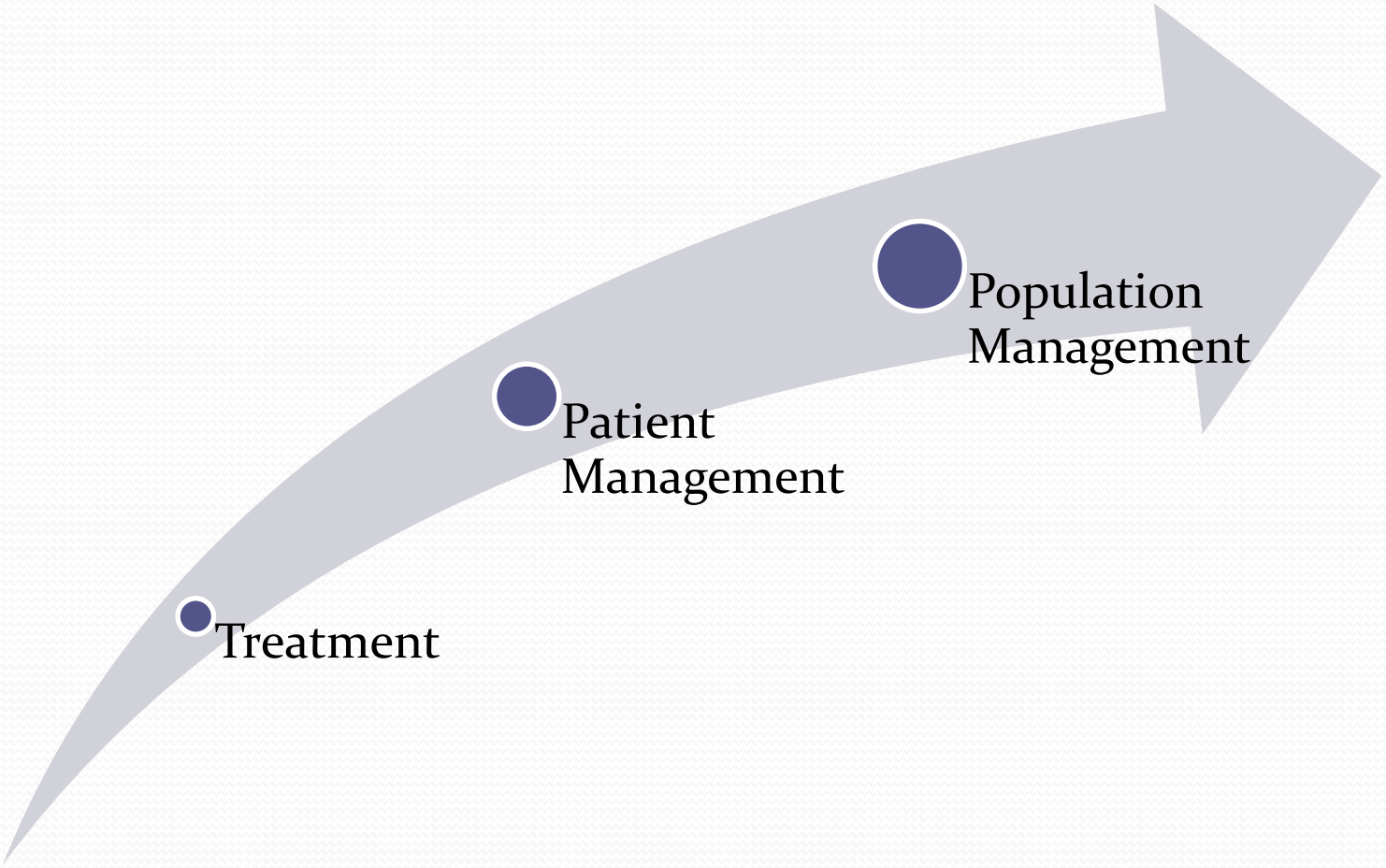
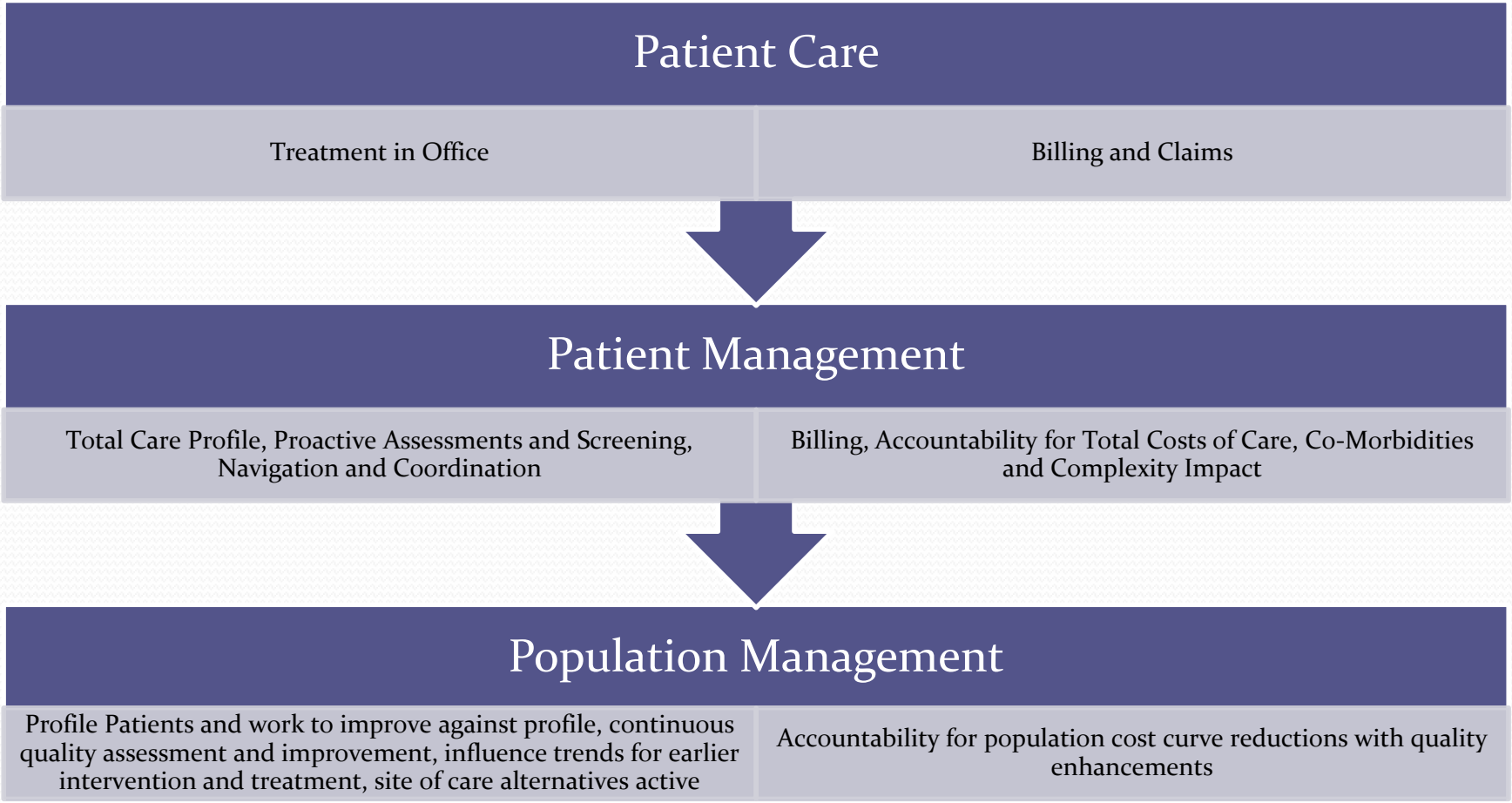
Care Evolution



Population Management

Transformation

Paradigm Shift



New Reality

- **4 Walls no longer the border**
- **New Mindsets**
  - Patient management
  - External Costs Awareness and Management
  - Upstream and Downstream Accountability
  - **Technology Expansion beyond EHR**
  - **Different Accountabilities for entire care team**
  - New Expectations Just to Stay in Game, let alone Maintain Role

New Skillsets

- Population management accounting and leadership
- Collaboration
  - Outside entities
  - Payers
  - Employers
- Analytics
  - Population (Practice and Global Claims, Screenings and Assessments)
  - Value
  - Risk
  - Bundling
- Regulatory Management/Advocacy
- Patient Support and Assessments Outside the Practice

New Team Focus

- Navigation
- Care Management
- Not necessarily new staff – may have valuable staff in place waiting to embrace different patient management paradigm shift

Navigation Has Been Proven as a Tool

- cancer patients face many challenges when trying to understand and navigate the health care system
- These challenges begin at the time of diagnosis and continue throughout treatment, follow-up care, and survivorship
- Patient navigation programs were developed to reduce gaps in care by improving access to, and timeliness of, cancer services
- Navigation adds a strong provision of support and guidance for timely access to the cancer care system, addressing barriers to and facilitating quality care.
- **Adding care coordination to patient navigation has proven to have many benefits to physicians as well as to patients and their families.**

Navigation speeds Care

- For cancer patients, understanding their diagnosis and treatment plans should be paramount on their mind; yet, due to our fragmented system and the numerous treatment paths that patients have during the process of screening, diagnosis, and treatment, **many patients either wait too long before initiating treatment or do not seek treatment at all**.[1]
- According to the CDC, the normal time from testing to treatment initiation can be 60–120 days, depending on the cancer type.[1]

- Many people are not getting the recommended cancer screening tests. [news release]. Centers for Disease Control Newsroom; May 7, 2014. http://www.cdc.gov/media/releases/2015/p0507-cancer-screening.html. Accessed January 20, 2016.

CoC Standards, not just for hospitals

- in 2012, the American College of Surgeons (ACS) Commission on Cancer (CoC) released standards[11] that reflected the goal of "ensuring patient-centered care." One of the new standards (Standard 3.1), phased in for 2015, required all cancer programs seeking accreditation to have a patient navigation program.
- This becomes a new standard, not just for hospital based care, but competitively, for all cancer care delivery systems.

Navigation – A decade of evolution

Table 2. Timeline of the Establishment of Organizations and Guidance Documents for Patient Navigation

Year	Event
2007	NCI Community Cancer Centers Program established
2008	NCONN incorporated
	Harold P. Freeman Patient Navigation Institute launched; first Navigation Training Course held
2009	Academy of Oncology Nurse & Patient Navigators incorporated
	Association of Community Cancer Centers publishes *Cancer Care Patient Navigation: A Call to Action*[29] NCONN issues Core Competencies for Oncology Nurse Navigators[15]
2010	*Oncology Nursing Society, the Association of Oncology Social Work, and the National Association of Social Workers Joint Position on the Role of Oncology Nursing and Oncology Social Work in Patient Navigation* published[14] ONS Oncology Nurse Navigator Role Delineation Study[30] begins
	Affordable Care Act (ACA)[31] includes Patient Navigation
	Institute of Medicine report *Future of Nursing: Leading Change, Advancing Health* discusses nurse navigation[32]
2012	ACS CoC issues accreditation Standard 3.1, stipulating phase-in of patient navigation process by 2015[11]
	ONS publishes Oncology Nurse Navigator Role Delineation Study[30]
2013	ONS issues Oncology Nurse Navigators Core Competencies[16]
2015	CMS Oncology Care Model provides an incentive to participating physician practices to use nurse coordination and navigation programs to improve care for patients receiving chemotherapy treatment[26]

Abbreviations: ACS CoC, American College of Surgeons Commission on Cancer; CMS, Centers for Medicare and Medicaid Services; NCI, National Cancer Institute; NCONN, National Coalition of Oncology Nurse Navigators; ONS, Oncology Nursing Society.

Touching Patients Throughout the Journey

- The George Washington Cancer Institute has expanded upon this definition of patient navigation to include a "longitudinal" model of navigation that extends from diagnosis to survivorship.[13]
- The Oncology Nursing Society (ONS), Association of Oncology Social Work and the National Association of Social Workers, in their joint position statement on patient navigation, built on C-Change's cancer care definition to emphasize **individualized assistance to patients, families, and caregivers that also incorporates psychosocial care from pre-diagnosis and throughout the entire cancer continuum**.[14]

- 13. Patient Navigation. The George Washington Cancer Institute Website. https://smhs.gwu.edu/gwci/patient-care/patient-navigation. Accessed January 20, 2016.
- 14. Oncology Nursing Society. Oncology Nursing Society, the Association of Oncology Social Work, and the National Association of Social Workers Joint Position on the Role of Oncology Nursing and Oncology Social Work in Patient Navigation. https://www.ons.org/advocacy-policy/positions/education/patient-navigation. Accessed January 20, 2016.

Navigation Models

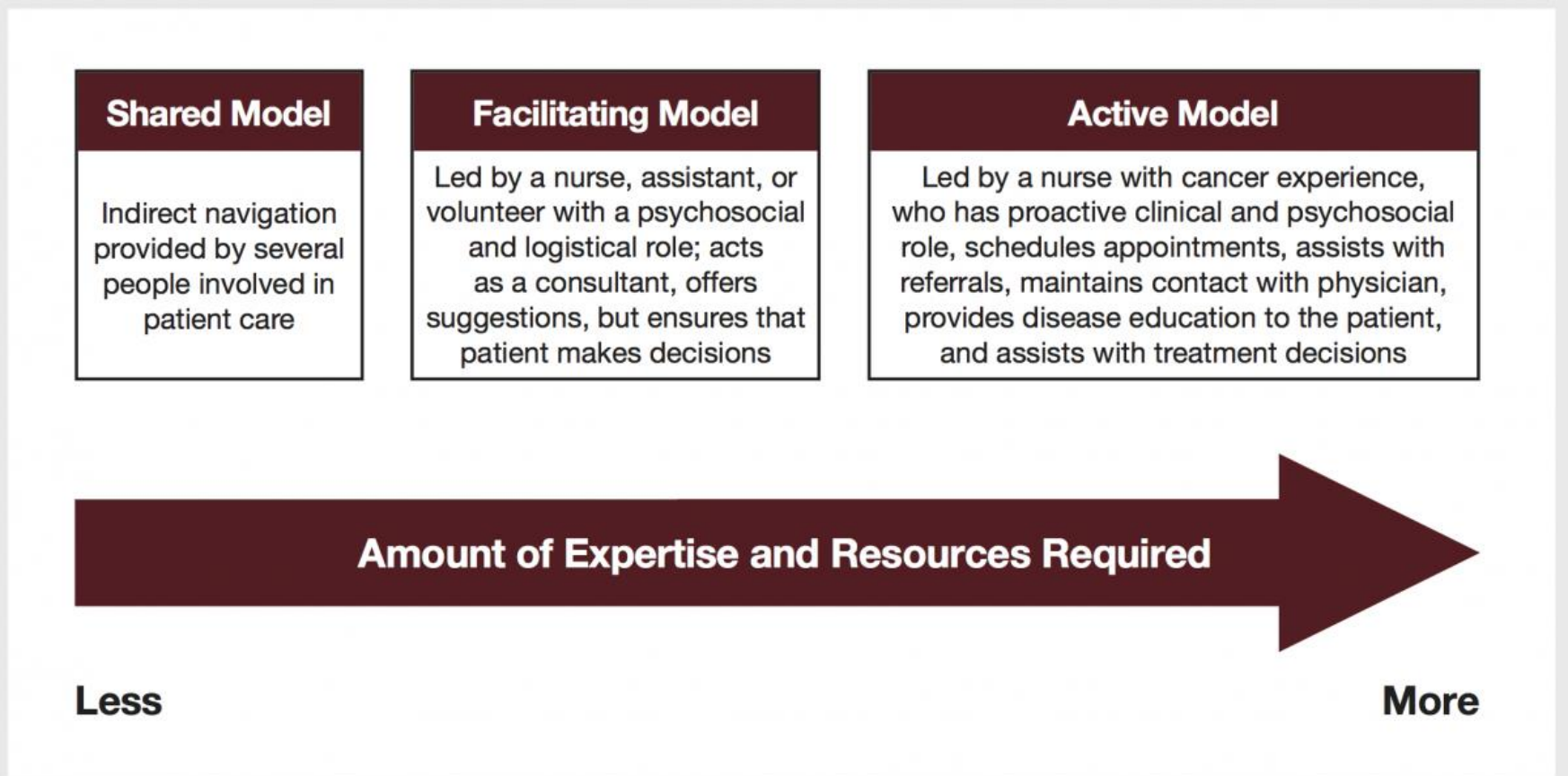


Figure 1. Institution-Specific Models of Nurse Navigation[16]

Oncology nurse navigator - formalized

- In 2009, the National Coalition of Oncology Nurse Navigators (NCONN) developed the first competencies that defined the role of the ONN.[15] Developed in consultation with active professional oncology nurse navigators throughout the United States, these core competencies cover five areas: (1) professional, legal and ethical nursing practice; (2) health promotion and health education; (3) management and leadership; (4) negotiating the healthcare delivery system and advocacy; and (5) personal effectiveness and professional development. The first published guidelines establishing core competencies for ONNs were established by the ONS in 2013.[16]

Novice and Lay Navigators

- A nurse who has worked for 2 years or fewer as an ONN and is building upon his or her academic preparation and nursing knowledge is a novice navigator. This person is usually attempting to gather oncology experience to develop expertise in the ONN role.[16]
- A lay navigator is a trained nonprofessional or volunteer who provides individualized assistance to patients, families, and caregivers to help overcome health care system barriers and facilitate timely access to quality health care and psychosocial care, from pre-diagnosis through all phases of cancer care.

Navigation across the Care Continuum

Table 3. Benefits of Patient Navigation and Care Coordination Across the Phases of Cancer Care[16]

Phase	Primary Function	Event	Without Navigation or Care Coordination	With Navigation or Care Coordination
Screening and Diagnostic Phase	Patient navigation	Abnormal test result and diagnosis	Few mechanisms to ensure patients receive timely test results and follow-up for abnormal results	Patients guided through diagnosis
		Patient education and treatment decision-making	Inadequate attention paid to patients; psychosocial needs often overlooked	Psychosocial and education needs are met
		Treatment initiation	Potential delays in treatment	Physicians able to focus on clinical management rather than education and logistics, improving efficiency
Active Treatment Phase	Care coordination	Clinical trial enrollment	Opportunities for clinical trial participation, neoadjuvant treatment, and combined modality treatment and are lost are missed	Improved education and increased coordination lead to improved outcomes, increased family and patient satisfaction, and lower costs
		Radiation and chemotherapy	Patient unable to navigate multimodal treatment schedules	Patients are empowered to navigate multimodal therapy

Oncology Case Managers Evolving As Well

- Departments range from 1 to 15
- Educate patients and families about treatments
- Assess patients response to treatment and medications
- Education about care needs in the home
- Supportive services connection for social and financial issues
- American Case Management Association – ACM certification (2 years exp)
- Commission for Case Manager Certification - CCM

Oncology Case Management - Execution

- Managed Care
  - Health Plans – internal and outsourced
  - Employers
  - Business Coalitions (“Sally”)
- Hospital and Health Systems
- Cancer Centers
- Physician Practices

Proactive Patient Management in the field

Patient Management Works, but still new to practices

- Payers and employers have saved 10% and more, managing patients outside of the physician patient relationship
- Patient management demands dedicated care management software. Current EHR solutions may offer clickable documents, but lack depth needed for patient coordination, tracking, management, severity scoring, and dashboards and analyses of larger external databases incorporating full claims to be extrapolated back to patient management in the practice.
- At least one OCM practice has incorporated full care management software from the payer world and integrated into their OCM practice transformation
- Stepping Stones (not solutions) – triage pathways, clinical pathways and guidelines, patient teaching, OCM care plan

Care Management Technology is essential, not found in EHRs

- Components:
  - Oncology specific
  - Robust care plan – not shallow check boxes
  - Implementation tools
    - Screenings
    - Assessments
    - Care coordination across practice
  - Patient and Provider dashboards for monitoring, coordination, and outcomes review
  - Checkpoints, assignments and follow up between staff and patients
  - External claims data integration and analysis, integration with patients of practice
  - One active example – Caris Health and the Intricare software(A division of www.saisystems.com) (full disclosure – no financial interest in this organization)

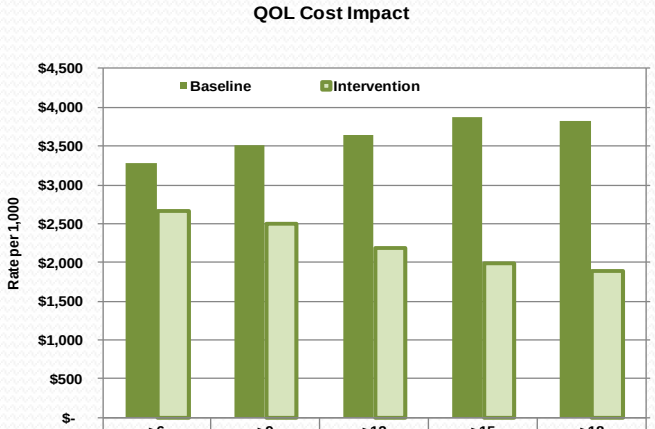
Example Results: Caris Oncology Care Management PROGRAM Outside of Practice

PROGRAM OVERVIEW

- ~800 members in the study
- Enrolled for a minimum of 6 months
- Follow the same group for 18 months
- Baseline cost per member was established with client
- Control group were members who refused the program (dark green)
- Decrease in overall cost was seen from the first 6 months & increased over the 18 month period
- 50% savings on patients with Intervention vs Control Group

OUTCOMES

- Decrease ED visits down 39%
- Decrease admits down 51%
- Hospice conversion at 8x the national average
- Treatment guidelines
- Improved treatment adherence
- Improved side effect/symptom management
- Decrease in over utilization of services
- Decrease LOS
- Improved self management
- Improved quality of life
- Appropriate referrals to palliative care & hospice



	>6	>9	>12	>15	>18
Baseline	$3,274	$3,513	$3,649	$3,866	$3,820
Intervention	$2,666	$2,499	$2,183	$1,986	$1,898
Impact	-18.6%	-28.9%	-40.2%	-48.6%	-50.3%
Members	753	507	349	259	181

SERVICES

- Guideline Review
- Side effect management
- Home and MD office visits
- Multidisciplinary team approach
- Drug assistance programs and coordination of resources and services
- Advance life planning
- Care giver support
- Self management

		ENROLLMENT				
		>6mos	>9mos	>12mos	>15mos	>18mos
a	TOTAL ENROLLED MEMBERS	753	507	349	259	181
b	TOTAL ENROLLED MEMBER MONTHS	9,902	7,945	6,240	4,972	3,743
c	TOTAL BASELINE CLAIM COSTS PMPM	$ 3,274	$ 3,513	$ 3,649	$ 3,866	$ 3,820
d	TRENDED BASELINE*	$ 3,438	$ 3,689	$ 3,831	$ 4,059	$ 4,010
e	TOTAL ENROLLED CLAIM COSTS PMPM	$ 2,666	$ 2,499	$ 2,183	$ 1,986	$ 1,898
f	TOTAL PROGRAM SAVINGS [d-e]	$ 772	$ 1,190	$ 1,649	$ 2,073	$ 2,112
g	TOTAL PROGRAM COST PMPM	$ 350	$ 350	$ 350	$ 350	$ 350
h	SAVINGS NET of FEES [f-g]	$ 422	$ 840	$ 1,299	$ 1,723	$ 1,762
i	**ROI [f/g]**	**2.2**	**3.4**	**4.7**	**5.9**	**6.0**

Greater than a 20% reduction on cost and utilization with ROI Approaching 3:1 as Members gain tenure in the program

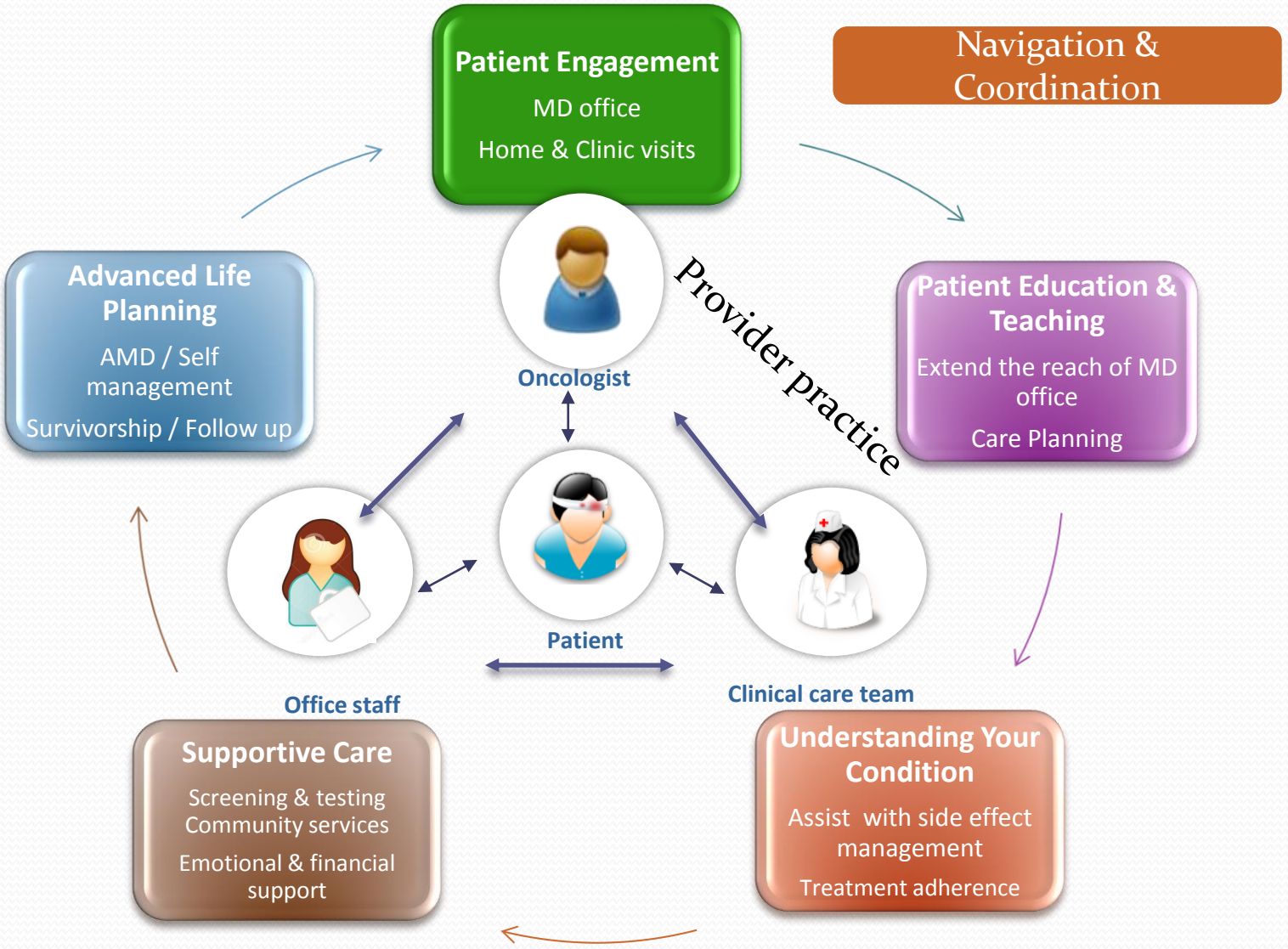
Gaps in Care related to Treatment vs Patient- care Management (improve Quality metrics)

Care Phase	Gaps	Consequences	Care management
Prevention and screening	• Ineffective identification of eligible patients • Inability to reach underserved populations • Appointment wait times too long • Patients not contacted with abnormal test results	• More patients develop preventable cancer • Patients seek screening elsewhere • Cancer is detected at a later stage	• Engage patients • Coordinate screening and prevention • Set up follow up visits • Patient education in the home to follow up on tests and screening process
Diagnosis and closing the referral	• Referrals not made • Patients not understanding diagnosis • Not documenting co-morbidies	• Patients seek care elsewhere or not at all • Treatment is delayed • Co-morbidities are not addressed which can affect cancer care	• Coordinate referral • Obtain notes and test from MD visits • Documenting and coding pt co-morbidies • Risk stratification
Treatment Medication validation	• Lack of patient compliance • Missed clinical trial accruals • Fracture care experience	• Patients miss neo-adjuvant opportunities • Outcomes are inferior • IP and ED utilization are higher • Side effects that could be avoided	• Visit patient in the home • Follow up on teaching and treatment plan • Medication validation and adherence • Identify barriers to care
Pain management	• Lack of standard process for documenting pain • Lack of standard process for documenting depression	• Pain goes untreated • Patient goes to ED or hospital • Poor patient treatment outcomes	• Pain is assessed initially • Pain is assessed with each visit • Communicate pt's pain and changes with oncologist
Care plan and Survivorship	• Lack of coordinated follow-up services	• Patients seek care elsewhere	• Creation of care plan • Ongoing reassessment • Shared with patient and family
End-of-Life Care	• End-of-life issues not proactively addressed	• IP utilization is high • Palliative care is insufficient • Patients miss palliation opportunities	• Begin conversation early • Work with oncologist to have pt and family conversation • Set up local and regional services

EXAMPLE – CARIS CARE MANAGEMENT PROVIDES TOOLS – TESTED AND PROVEN FOR YEARS FOR PAYER RISK MANAGEMENT EXPECTATIONS

Components of Program

- Retrospective Data Review to Identify areas of improvement for each individual practice's transformation
  - Integrates Participating Plan data on whole spend and treatment of cancer patient (not just cancer related)
- Risk Stratification, Analysis, and Patient Identification
- Multidisciplinary Care Management Plan
  - Coordination of services and coordination of care (templates built into system identifying what specific and frequency of interaction and assessments are appropriate for each individual patient)
- Utilizing intriCare Technology & Workflow
- Registry, Reporting, & Outcomes
  - Population reporting on disease, outcomes, total vs. cancer spend and outcomes, per MD, in hands of MD



Example – Caris Physician and Oncologist Coordination and Support from Care Management Systems

- Extending the physician care plan management and reinforcing treatment regimens and medication adherence
- Proactive side effect management with 24/7 telephonic support
- Supporting the patient, caregiver and family with emotional support, advocacy, coordination of services (home care, DME etc.) and referral to other needed services
- Manage and coordinate between physician practices including co-morbid conditions
- Ongoing care plan adjustments and re-establishment of goals based on changes in condition and treatment
- Identification and Coordination Drug Assistance Programs and Financial Assistance with Co-pays
- Coordination of Clinical Visits, Resources & Services
- Community Outreach
  - Home visits with RN care manager and social workers
  - Visit the patient while in the hospital to assure improved transitions of care
  - Encourage self management when appropriate
  - Assess for nutritional status and exercise
- Tele-monitoring devices if necessary

Example – From Caris Care Management System - Acuity Scores are complex and should evolve with better patient management and increased touches

FIRST SCORE

- Factor 1 = Financial (0-30)
- Factor 2 = Diagnosis (0-440)
- Factor 3 = Demographic (0-10)

SECOND SCORE

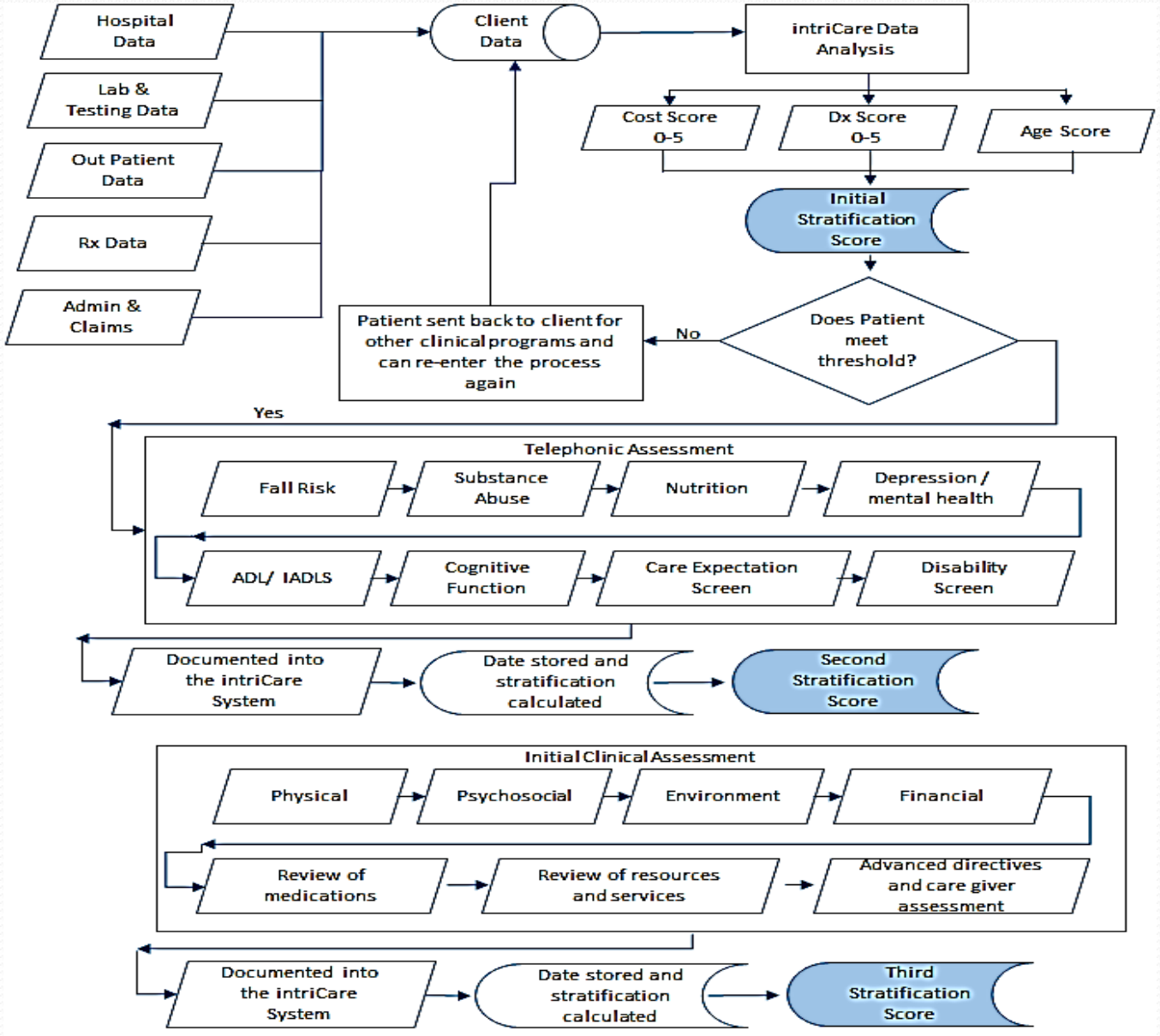
- **Factor 4 = Disability** (0-120)
- Bucket 4.0 = HRA & Telephone Screen
- Bucket 4.1 = SF 12
- Bucket 4.3 = Nutrition Screen
- Bucket 4.4 = Depression Screen (Age Dependent)
  - GDS (Geriatric Depression Scale) Short Version
  - CES-D (Center for Epidemiologic Studies of Depression Scale)
- Bucket 4.5 = Lawson

Cancer treatment

- Moderately toxic
- Highly toxic
- Bone marrow transplant
- Clinical trial
- Radiation therapy
- Prior history of cancer and treatment
- Cancer surgical interventions

THIRD SCORE

- Home visit, barriers
- Environmental and home assessment
- Care expectations

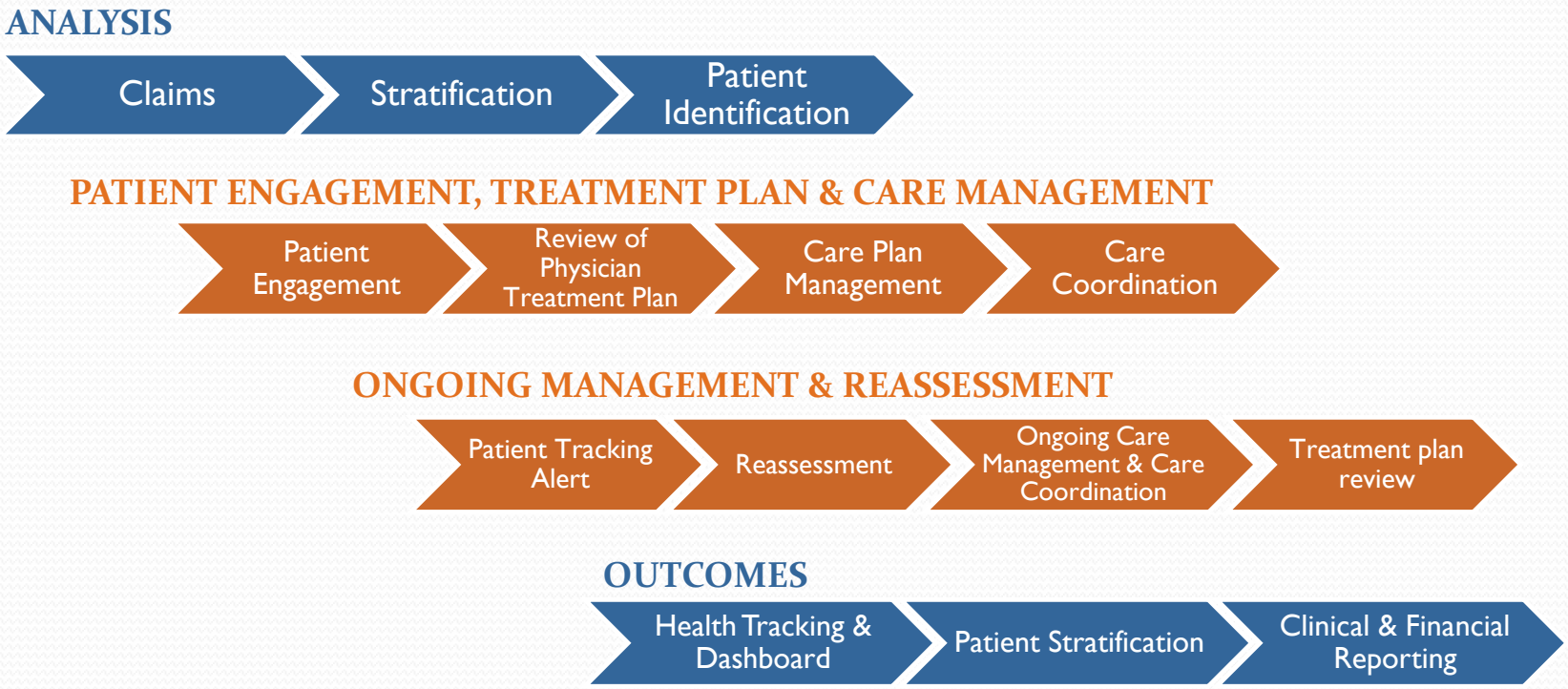


Oncology Care Management Levels AND Goals Vary with Patient Severity

Care Management Intervention	Level 1 – Minimally Toxic Treatment	Level 2 – Moderately Toxic Treatment	Level 3 – Highly Toxic Treatment	Level 4 – Recurrent Metastatic and/or Advanced Disease
National Guideline	Review regimen. Evaluate appropriateness with nationally accepted guidelines (NCCN, ASCO).			
Guideline vs. Clinical Trial		Review treatment regimen against guidelines. Evaluate appropriateness. Encourage use of clinical trials where appropriate.		
Regimen Compliance, medication validation and Clinical Management	Educate and support patient through treatment Encourage self management. Assist with services when appropriate.	Educate patient and family on treatment regime and identify any barriers for non-compliance. Assist patient in setting up appointments and obtaining home, health and community resources and services needed. Set care expectations with patient and family. Drug and financial assistance where appropriate.		
Side Effect Management	Educate patient on side effects of treatment regimen. Self management. Encourage to call if problem.	Educate patient and family on proactive management of medication and treatment side effects. Decrease risk of infections. Encourage good nutrition and hydration. Call if side effects become worse or new side effects occur. Set up activity level with patient and family, encourage activity with rest periods. Utilize supportive drugs where appropriate.		
Prevent and Minimize ER visits	Review claims data for patient history of admissions and ER visits. Educate patient to call nurse or MD before going to hospital unless emergency (temp 101 or greater) etc. Educate patient and family to monitor side effects, keep regular scheduled appointment for treatment and lab word. Monitor weight, hydration, temperature, follow side effect protocol.			
Pain Management	Self management of pain control with education and monitoring.	Assess for pain upon each patient touch, utilize pain scale, keep patient at 4 or below. Obtain standing orders to assist with pain control, instruct patient to call for break through pain.		
AMD and End of Life Management	Encourage patient and family to discuss living will and advance directives.	Educate patient and family on the importance of advanced medical directives and living wills.	Educate and encourage patients and families to review and maintain AMDs and a living will. Educate patient and family on supportive care.	Educate and encourage patients and families to review and maintain AMDs and a living will. Discuss palliative care and when appropriate Hospice.

Example – Caris Care Management software creates integration & Workflow

- Centralized platform encompasses entire clinical & management team
- Multi-disciplinary care plan
- Integrating with physicians and health care teams EMR's
- System deploys in all healthcare settings
- Streamline care coordination & community services management
- Improved patient education & self management
- Comprehensive transitions of care
- Increased staff productivity and efficiency
- Enhanced real time communication
- Centralized and timely information
- Robust reporting



Example – Caris Care management - brings both touch and technology to an OCM practice

Patient Care Navigation/Coordination

- Caris Health team works within the practice
- Multi-disciplinary care team collects patient data not usually collected by the practice which can assist the oncologist
- Clinical, community based targeted intervention
- Home and group visits
- Ongoing risk stratification
- Improve transitions of care
- Hospital Avoidance
- Assist with referrals for palliative, supportive and hospice care
- Assistance with co-morbidity management
- Assist with communication with PCP and other specialists

Payer Oncology Management, Analytics & Reporting

- Analyze Medicare and Private Payer Claims Data
- Stratification of Patients into severity and acuity levels
- Meets all CMS reporting requirements for CMMI programs such as OCM and MIPS
- Identify population, group and MD Level – care costs, level of acuity and concordance with evidence
- Identify both successes and outliers for care management and navigation
- Utilizing clinical data not normally collected to improve care, process and outcomes
- Improve reporting capabilities, by physician and practice

Example – Caris - Activities of the care team members – How they support practice information and work flow

Nurse

- Clinical Assessment
- Collaboration with Oncologist & team
- Treatment Plan Review
- Standardized Testing
  - Functional / Cognitive
  - Nutrition / Exercise
  - Behavioral /Falls Risk
- Care expectations & Patient Education
- Home Visits / Joint Visits with MD
- Advocacy / Emotional Support
- Assistance with Clinical Trials
- Follow up care/survivorship
- Ongoing reassessment & Coordination of needs

Social Worker

- Psychosocial Assessment
- Environmental Assessment
- Financial Assistance
- Community Resources
- Address emotions, fears & concerns
- Home Visits
- Community Services:
  - Transportation
  - Babysitting
  - Drug assistance
  - Referrals for social services
  - Referrals for HHS
  - Referral for behavioral health

Care Coordinator

- Health Risk Assessment
- Telephone Screening
- Coordinate & monitor ancillary services
- Assistance with scheduling:
  - PCP
  - Specialist
  - Testing
  - Screening
- Follow up calls

Value of Oncology Patient management more than treqtment – Working Smarter, Not Harder

Patient

- Expand survivorship programs for patients & families with self management driven care plans
- Self management & shared decision making
- Continuity of care
- Better informed, improved access to care and improved adherence to treatment
- Reduce unnecessary visits & tests
- Empowerment & advocacy

Provider

- **Expanding the view for the physician to outside the office into the home & community**
- **Increased patient information regarding acuity and co-morbid conditions**
- **Improve communication**
- **Improve patient compliance with prevention, screening & testing**
- **Improved overall patient experience, adherence & quality of life**

Payer

- Reduce cost
- Reduce hospitalization and re-admissions
- Reduce utilization of repetitive services
- Reporting & outcomes

Thank You, and Good Luck

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