

Masspro 10th Statement of Work

July 20, 2011



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Making an Impact.

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Overview

The National Quality Strategy pursues three broad aims:

1. **Better Care:** Improve the overall quality, by making health care more patient-centered, reliable, accessible, and safe.
2. **Healthy People/Healthy Communities:** Improve the health of the U.S. population by supporting proven interventions to address behavioral, social and, environmental determinants of health in addition to delivering higher-quality care.
3. **Affordable Care:** Reduce the cost of quality health care for individuals, families, employers, and government



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Priorities

- Making care safer by reducing harm caused in the delivery of care.
- Ensuring that each person and family are engaged as partners in their care.
- Promoting effective communication and coordination of care.
- Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.
- Working with communities to promote wide use of best practices to enable healthy living.
- Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models.



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Initiatives

- Beneficiary and Family Centered Care
 - ◆ Case Review
 - ◆ Patient and Family Engagement
- Improving Individual Patient Care
 - ◆ Reduction of Health-care Acquired Conditions
 - ◆ Reduction of Adverse Drug Events
 - ◆ Quality Reporting and Improvement
- Integrating Care for Populations and Communities
 - ◆ Improving Care Transitions leading to the reduction of hospital readmissions
- Improving Health for Population and Communities
 - ◆ Promotion of Immunizations and Screening
 - ◆ Cardiovascular Health Campaign



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How we will accomplish this work?

- We will act as change agents and conveners for improvement at the community level as a trusted partner to providers, stakeholders, and most importantly, the beneficiaries
- To achieve success, we will bring patients, providers and payers together to facilitate health system transformation, with the patient at the center
- We will partner with a wide range of organizations, to spread improvement rapidly
- We will be using new tools and techniques, including social media and learning and action networks (LAN's)



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Improving Individual Patient Care

- Reduce Health Care Acquired Infections (HAI) in hospitals
 - ◆ Specifically Catheter-Associated Urinary Tract Infections (CAUTI); Clostridium Difficile Infections (CDI) and Surgical Site Infections (SSI)
- Reduce Health Care Acquired Conditions (HAC) by 40% in nursing homes
 - ◆ Phase I (first 18 months) – reduce pressure ulcers and the use of physical restraints
 - ◆ Phase II (19-36 months) – reduce HAC's (CAUTI, Falls) by addressing systematic issues including staffing, business practices and quality of life indicators
- Quality Data Reporting and Improvement
 - ◆ Work with hospitals on validation and reporting of both Inpatient and Outpatient quality measures
 - ◆ Provide feedback, education and technical assistance to hospitals on areas of improvement based on measures



Improving Individual Patient Care (cont'd)

➤ Reduce Adverse Drug Events

- ◆ Multi-disciplinary community team comprised of healthcare providers in a defined geographic area that shares patients across the continuum. Each “team” must have access to clinical pharmacy services for medication management in the target population
- ◆ Target population (meet at least one of following criteria)
 - › high risk patients with 5 or more chronic conditions and/or take 8 or more meds
 - › evaluated by 2 or more providers
 - › take warfarin at least weekly
 - › take short or long acting antipsychotic meds
 - › take hypoglycemic medication for diabetes
- ◆ Goals:
 - › Reduce the number of ER visits, hospitalizations and/or readmissions due to ADEs
 - › Reduce number of beneficiaries taking short or long acting anti-psychotics by 50%
 - › 100% patients on Warfarin will have monthly INRs with 70% in controlled range
 - › 50% patients with diabetes with HgA1c > 9% will have HgA1c < 9%



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Integrating Care for Populations and Communities

Goal: 20% reduction in preventable hospital readmissions over the next three years

- Engage Community teams to improve care transitions
 - ◆ Community based teams brought together in “all teach, all learn” learning networks that support community efforts, bringing both multiple providers and patients’ perspective to the table in the design of a better care delivery system.
 - ◆ Teams will be representative of all the providers in the geographic community: hospitals, home health, long term care, ASAPs, community health centers, physician practices, senior care organizations, health plans, etc.



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Integrating Care for Populations and Communities (cont'd)

➤ The Community Approach

- ◆ Evidence based protocols have demonstrated that the reduction of readmissions requires the coordinated efforts of more than one provider, community stakeholders, and the inclusion of patients as team members
- ◆ Local areas vary substantially in healthcare utilization and the infrastructure available to reduce the reliance on hospital services, requiring a customized approach to improving care processes



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Integrating Care for Populations and Communities (cont'd)

- Provide technical assistance to providers applying to the CMS Community Based Care Transitions program (§ 3026)
 - ◆ Root Cause Analysis
 - ◆ Identification of target population
 - ◆ Selection of evidence based care transition interventions aimed at the identified drivers of poor transition in the target population

Upon acceptance into CCTP, providers can continue to participate in QIO sponsored learning webinars and listserv discussions

If not accepted into CCTP, the community can continue to work with Masspro, with full access to all learning and education programs



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Improving Health for Populations and Communities

- Work with Eligible Professionals (EP's) to participate in PQRS reporting via Electronic Health Records (EHR's)
- Develop cardiovascular campaign; engage physician practices in participating in the cardiovascular health LAN
- Promote physician office participation in CMS EHR Incentive Programs (PQRS and meaningful use)
- Participate with state and local HIE efforts



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Questions

