# Slide 1: Integrated Care Clinical Performance Improvement (CPI) Overview: *One Care Implementation Council*

Executive Office of Health and Human Services

**November 12th, 2024**

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*Note: the following footnote appears on this slide.* “CONFIDENTIAL; FOR POLICY DEVELOPMENT PURPOSES ONLY”

# Slide 2: Achieving the Vision of Getting it ‘Right’

*Note: the following three points are shown at the top of the slide across from each other with double-headed arrows in between each illustrating the relationship between them.*

**I. The ‘Right’ Patient Population(s)**

**II. The ‘Right’ Care (at the Right Time)**

**III. The ‘Right’ Outcomes**

**One Care Member**

* **Person-Centered Care Model**
* **Comprehensive Assessment**
* **Individualized Care Planning**
* **Care Coordination (incl LTSS& BH)**
* **Care Team Roles & Composition**
* **Member Protections**
* **Communications To & From Members**
* **Aligned Incentives**

**Quintuple Aims Achieved!**

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# **Slide 3:** MassHealth One Care & SCO CLINICAL Performance Improvement (CPI) Strategic Framework

**Goal:**Anchored on person-centered care and Independent Living Principles, the Clinical Performance Improvement (CPI) Strategy Framework is our comprehensive integrated four quadrant performance improvement framework that will guide our collaborative **clinical** & **medical** leadership engagement with the plans to achieve top-tier high-value outcomes for our members.

1. Quality
2. Utilization
3. Care Coordination & Care Planning
4. Member-Centered Case Reviews

*Note: this slide includes an image of a circle broken into quarters illustrating examples of member experiences with the items above and the detailed elements that are included in each area.*

**Quarterly Reporting and Bench-marking Initiative**

1. Quality *(Chuck)*

* Existing

1. Utilization *(Chuck)*

* ED & Acute Care
* Engagement with Primary Care
* Other

1. Care Coordination & Care Planning *(Henri & Maelys)*
   * Ongoing case reviews to assess Quality of Care Coordination & Care Planning.
2. Member-Centered Case Reviews *(Randi)*

* Ongoing case reviews
* Utilization Management practices
* Critical Incidents
* Extended Hospital Stays
* Utilization Management

# **Slide 4:** CPI I & II: The New CPI Quarterly Key Performance Indicator (KPI) Reporting Requirements of Selected Existing QUALITY & UTILIZATION Measures

**Rationale:** One Care & SCO performance on clinical quality & utilization measures is variable. To achieve better performance, we must engage with all OC & SCO plans on focused strategic high-priority metrics as a complement to other performance levers, i.e. incentives, public reporting

**Goals:** To achieve high quality outcomes and appropriate utilization through actionable data that will allow network benchmarking and inform prioritization of targeted improvement initiatives.

**CPI Guiding Principles:** Clinical performance priorities will be determined taking into consideration a number of factors including current performance, variation, trend over time, reporting feasibility, actionability, evidence-based, financial incentives, alignment with broader agency goals, potential ‘runway’ for future contracts

*Note: the following information is shown as a graphic with the word “Quarterly” at the top and the bottom and sweeping arrows going from one to the other of the items below showing a continuous cycle.*

**Quarterly**

**Integrated Plans:**

**Focused Quality & Utilization Measures**

* PLAN CY YTD
* PLAN CY Quarter

**Quarterly**

**MassHealth:**

***Focused Quality & Utilization Measures***

* Network Avg CY YTD
* Network Avg CY Quarter

# Slide 5: CPI I & II: Quarterly Quality (I) & Utilization (II) KPI Reporting Initiative

**Purpose:** To achieve high quality outcomes and appropriate utilization through actionable data that will allow network benchmarking and inform prioritization of targeted improvement initiatives.

*Note: the following information is shown in a table on this slide.*

**MassHealth Actions**

**Implement Quarterly Reporting of Focused CPI Quality and Utilization KPI Measures in 2024**

**Clinical Prioritized Focus Areas**

**Quality (I)**

* Primary Care engagement
* Care Transitions
* Readmissions
* Proactive Care Coordination
* Behavioral Health

**Utilization (II)**

* Emergent Care
* Acute Hospital Care
* Primary Care engagement

# **Slide 6:** CPI III: CPI Care Coordination & Care Plan Improvement Initiative

**Rationale:** Effectiveindividualized person-centered care coordination & care planning sits at the very heart of integrated health plan performance that can achieve desired results. Unfortunately, there are no straightforward gold standards to measure and manage high quality care coordination and care planning.

**Goals:** To develop and launch a shared & tangible

systematic performance management approach to

monitor, oversee and improve this complex yet

critically important clinical care model competency

and achieve ’top-box’ performance behalf of members:.

* + Improve person-centered care planning
  + Increase member satisfaction with service planning
  + Improve integration of care coordination
  + Ensure service decisions are influenced by those closest to the member

**Strategy:** Launch a phase one ongoing care plan audit and TA program targeting certain at-risk clinical populations; pilot care coordination specific KPIs, standardize leading practices.

*Note: the following items are shown as a graphic on this slide with little graphic icons beside each one.*

**Person-Centered Care Model**

* Assessment Process/Timing
* Care Team Roles and Composition
* Individualized Care Plans (ICTs)
* Member Protections
* Care Coordination (including LTSS and BH)
* Communications To and From Members

# **Slide 7:** CPI IV: Critical Incident Post-Fall Evaluation Initiative – 10/1/24

**Goals:**

* Use evidence-based approach to conduct at-home evaluations of members who had fallen in the community.
* Population to be included for these required fall evaluation elements- only those members with a fall in the community who experienced a recurrent fall within the next six months.
* Hospital and Skilled Nursing Facilities (SNFs) excluded given facilities may be using their own protocols.

# Slide 8: CPI IV: Proposed Critical Incident Post-Fall Evaluation Initiative

**Plan should initially report fall; then they have 3 weeks to do a follow-up assessment with the proposed elements below organized by the 5M’s framework. If a member is admitted IP, assessment should be within three weeks after discharge to the community. Elements to be included in critical incident reporting:**

**IF** fall-related critical incident is associated with two or more falls (including current incident) over the past six months:

1. **Multimorbidity**
   * + - Orthostatic blood pressure and evidence of managing hypotension if detected
       - Review and update of care plan and document any changes
       - Screen for substance use disorder
       - Visual acuity has been addressed after the fall
2. **Medications**

* Review of medication by PCP to evaluate for deprescribing medications that may increase fall risk
* Offer of pharm D MTM evaluation for potential of drug deprescribing (SCO and One Care, not PACE)

1. **Mobility**
   * + - Physical therapy evaluation
       - Has the member been referred for evidenced based treatment such as but not limited to: OTAGO, physical therapy strength and balance exercise, Tai Chi, Matter of Balance?
       - Home visit with environmental assessment such as a Get Up and Go Test (basic home mods, i.e. grab bars, CAPABLE, etc) within the past six months to decrease fall risk; can be with any clinical discipline
2. **Mentation**

* Cognitive screening (due to evidence base of linking cognitive screening with exercise program)

1. What **Matters Most** (specifically with regards to falls & safety)
   * + Review and update of care plan reflecting ‘What Matters Most’ and in the member’s own words
     + Offer a personal emergency response system (PERS)

* **Please ensure also that the care plan is updated to document all of the above.**

Adapted from https://www.cdc.gov/steadi/pdf/Steadi-Coordinated-Care-Plan.pdf

# **Slide 9:** CPI IV: Critical Incident Post-Fall Evaluation Initiative

**What MassHealth Should Expect from the Plans Moving Forward**

* Narratives from the falls critical incident should contain elements as outlined by MassHealth
* The narratives are due three weeks after discharge back to the community

**What the Plans Should Expect from MassHealth Moving Forward**

* If the narratives do not contain the elements, the medical director will ask in follow up for the missing information
* If there are extraordinary circumstances in which the information can't be obtained, document these circumstances in the narrative of the post fall evaluation

# **Slide 10:** Achieving our Integrated Care CPI Vision – Putting it All Together

1. **Engage Plan Medical & Clinical Leadership**

* Monthly 1:1 MH-Plan Medical Clinical Leadership and Three-way Contract Management Team (CMT) meetings (Plan – CMS - MassHealth)
* Q2 month Medical Director Forums
* Build a learning and best-practice sharing collaborative community
* Cross-pollination between plans
* Targeted Technical Assistance

1. **Implement Targeted, Actionable Reporting of Focused Measures**
   * Align on measure selection, definitions and frequency
   * Operationalize data management and quarterly reporting deliverables
   * Drive Programmatic Insights from Network-level comparative data
2. **Apply Clinical Performance Improvement Practices**
   * Align and coordinate with Integrated Care Contract, Program and Performance Team
   * Apply and scale quality and performance improvement principles, i.e. rapid cycle QI
3. **Advance** **Meaningful, Aligned and Sustainable Financial Incentives**

# **Slide 11:** Achieving our Integrated Care CPI Vision – Year 1+ Timeline Accomplishments

*THINK really really BIG, START really really SMALL, WORK really really FAST!*

John Halamka, MD, Mayo Clinic

* June 2023: Launched semi-monthly **CPI** **MH-Plan Medical Directors Forum**
* July-August 2023: Completed MH-Plan MD Forum landscape review
* Sept - Dec 2023: Developed **CPI Quarterly Utilization KPI** protocol
* Dec – Jan 2024: Completed MH-Plan **CPI Care Coordination Focus Group** exercise
* Jan 2024: Finalized **CPI Four Quadrant Strategic Framework**
* Feb – April: First **Plan CPI Quarterly Utilization KPI** data submission, Finalized revised **Critical Incident Report (CIR)** Definitions & Requirements, First Plan CPI Quarterly Utilization KPI report shared with plans
* March – Apr 2024: Developed **full** **CPI Quarterly Utilization & Quality KPI** protocol
  + Medical Directors engage in **Joint CMT meetings**
* Apr – Aug 2024: **CPI Care Coordination Improvement & Denial Appeals Grievance (DAG) Case** **Review audit** initiative shared with & input received from member focus group (4/9/24)
* May 2024: Full **Plan CPI Quarterly Quality & Utilization KPI** data submission
* June 2024: Full CPI Quarterly Utilization & Quarterly KPI report sent to plans
* Sept – Oct 2024: Launched **CIR Post-Falls** Protocol, 2025 Performance Improvement initiative planning; **Round 1 Care Plan & DAG Review audits** launched.

# Slide 12: Achieving the Vision of Getting it ‘Right’

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# **Slide 13:** Thank You!