

**Report to Congress**  
**The Administration, Cost, and Impact of the Quality Improvement Organization (QIO)**  
**Program for Medicare Beneficiaries for Fiscal Year 2013**

## EXECUTIVE SUMMARY

Section 1161 of the Social Security Act (the Act) requires the submission of an annual report to Congress on the administration, cost, and impact of the Quality Improvement Organization (QIO) Program during the preceding fiscal year. This report fulfills this mandate for FY 2013. The statutory mission of the QIO Program is set forth in Title XVIII of the Act-Health Insurance for the Aged and Disabled. More specifically, section 1862(g) of the Act states that the mission of the QIO Program is to improve the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries and to ensure that those services are reasonable and necessary. The quality improvement strategies of the Medicare QIO Program are implemented by state and territory specific QIO contractors who work directly with health care providers and practitioners in their state, territory, and the District of Columbia.

During the FY 2013 year, the QIO Program was administered through 53 performance-based, cost-reimbursement contracts with 41 independent organizations; these contracts began on August 1, 2011 for a 36-month term. The QIOs' technical performance was evaluated at the 18<sup>th</sup> and 27<sup>th</sup> months of the contract. The QIOs submitted vouchers on a monthly basis and were reimbursed for their costs. Their monthly invoices were thoroughly reviewed and certified by an assigned Contracting Officer's Representative (COR) and Contract Specialist.

The 53 QIOs were staffed with physicians, nurses, technicians, and statisticians. Approximately 2,300 QIO employees nationwide conducted a wide variety of quality improvement activities to make sure the quality of care provided to Medicare beneficiaries. Approximately 54,000 providers and more than one million practitioners<sup>1</sup> nationwide worked with QIOs. The providers and practitioners requested and received QIO technical assistance. Additionally, providers and practitioners were subject to QIO review for specific reasons (e.g., record reviews for quality of care complaints) at the request of beneficiaries, CMS, Fiscal Intermediaries, Medicare Administrative Contractors, and the QIO itself.

In FY 2013, QIO Program expenditures totaled approximately \$512 million. FY 2013 covered the 15<sup>th</sup> through 27<sup>th</sup> months of the 10<sup>th</sup> Scope of Work (SOW) contract, which covered the period August 1, 2011 through July 31, 2014. This report includes charts that indicate the measures, targets and results reported at the 18<sup>th</sup> month of the contract, as well as the successes and best practices reported to CMS by QIOs. The FY 2014 report will explain the results of the 27<sup>th</sup> month evaluations.

The QIOs' performance under the 10<sup>th</sup> SOW was monitored in each of the following "Aims": Beneficiary and Family Centered-Care, Improving Individual Patient Care, Integrating Care for Populations and Communities, and Improving Health for Populations and Communities. Monitoring was ongoing and reported each quarter to determine if established targets were met. In the event that a QIO did not achieve the target, a performance improvement plan (PIP) was requested by the assigned COR to make sure that problems were addressed prior to the formal 18<sup>th</sup> month contract evaluation.

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<sup>1</sup> These data and categories are from CMS Office of Research, Development, and Information. "CMS Program Data" Sources "ORDI/OACT/OFM/CMM" Providers Plans as of 12/31/09; published 2009.

Following are the criteria used to determine passing or failing an Aim or component of an Aim:

- Pass: Criteria met for the Aim or component of the Aim as specified in the evaluation section of an Aim and/or component within an Aim or consensus recommendation based on objective data.
- Fail: Criteria not met for the Aim or component of the Aim as specified in the evaluation section of an Aim and/or component within an Aim or consensus recommendation based on objective data.

The results for all QIOs not meeting the various targets were reviewed at multiple levels and included input from the CMS COR, its Associate Regional Administrators, Central Office division directors, government task leaders, the evaluation team, the Center for Clinical Standards and Quality and Regional Office senior leadership. Additional information gained from QIOs during the course of monitoring visits, root cause analysis, discussions and correspondences was also reviewed. During the course of these deliberations and review of available data, certain evaluation decisions were made and approved by leadership.

## **BACKGROUND**

The statutory authority for the QIO Program is found in Part B of Title XI of the Act. Its statutory mission is set forth in Title XVIII of the Act-Health Insurance for the Aged and Disabled. Specifically, section 1862(g) of the Act states that the mission of the QIO Program is to improve the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries and to make sure that those services are reasonable and necessary. Part B of Title XI of the Act has been amended by section 261 of the Trade Adjustment Assistance Extension Act of 2011 which made several changes to the Secretary's contracting authority for QIOs beginning with contracts entered into or renewed after January 1, 2012. These changes include eligibility requirements for QIOs, the term of QIO contracts, the geographic area served by QIOs and updates to the functions performed by QIOs under their contracts. As the 10<sup>th</sup> SOW predates the effective dates of these amendments, they were not relevant to the work performed during the FY 2013 period.

For the 10<sup>th</sup> SOW, CMS identified the following goals for the QIO Program:

- Improve quality of care for beneficiaries by ensuring that beneficiary care meets professionally recognized standards of health care;
- Protect the integrity of the Medicare Trust Fund by ensuring that Medicare pays only for services and items that are reasonable and medically necessary and that are provided in the most economical setting; and
- Protect beneficiaries by expeditiously addressing individual cases such as beneficiary quality of care complaints, contested Hospital Issued Notices of Noncoverage (HINNs), alleged violations of the Emergency Medical Treatment and Labor Act of 1986 (§ 1867 of the Social Security Act, Emergency Medical Treatment and Active Labor Act (EMTALA), and other beneficiary concerns identified in statute.

## **I. PROGRAM ADMINISTRATION**

### **Description of Quality Improvement Organization Contracts**

In August 2011, CMS awarded contracts for the 10<sup>th</sup> SOW for the 53 Contractors participating in Medicare's QIO Program. The QIO contracts extend from August 1, 2011 through July 31, 2014. The 10<sup>th</sup> SOW focuses on improving the quality and safety of health care services furnished to Medicare beneficiaries. The 10<sup>th</sup> SOW is based upon the Administration's health care quality improvement initiatives and evidence-based interventions to improve the quality and efficiency of health care and health care services delivered to Medicare beneficiaries. It also implemented recommendations from the Institute of Medicine, the Government Accountability Office, and members of Congress to assure maximum benefit to beneficiaries at the greatest value to government. It is transformational in its approach to aligning with and supporting the HHS National Quality Strategy (NQS) for Improvement in Health Care and in its developmental collaboration with other HHS Operating Divisions. The contracts provided additional tools for CMS to track, monitor, and report on the impact that the QIO program has on the care provided in states and jurisdictions. In connection with this tracking and monitoring, the QIOs' technical performance during the 10<sup>th</sup> SOW was evaluated at the 18<sup>th</sup> month (February 2013) and 27<sup>th</sup> month (November 2013) of the 36-month contract.

QIOs were monitored quarterly to determine if they met established targets for specific activities within the timeframes described in the 10<sup>th</sup> SOW. Quarterly monitoring of metrics allows for immediate opportunities to implement correction action, using "plan, do, study, act (PDSA)" cycles, for improvement. The QIOs submitted vouchers on a monthly basis and were reimbursed for their costs. Their monthly invoices were thoroughly reviewed and certified by an assigned COR, Government Task Leader (GTL) and Contract Specialist. QIOs are evaluated according to how well they reach CMS specified performance goals.

### **QIOs Interacting with Health Care Providers and Practitioners**

QIOs worked and provided technical assistance to health care practitioners and providers such as physicians, hospitals [including critical access hospitals (CAHs)], nursing homes, and home health agencies. QIOs also worked with practitioners, providers, beneficiaries, partners, and other stakeholders to improve the quality of health care provided to beneficiaries through a variety of health care delivery systems and addressed beneficiary complaints regarding quality of care.

Any provider or practitioner who treats Medicare beneficiaries and would be paid under Title XVIII of the Social Security Act may receive technical assistance from a QIO and may be subject to review by the QIO. CMS estimates that approximately 54,000 providers and more than one million practitioners nationwide may interact with QIOs each year. Interaction comes in a variety of forms including direct intensive QIO assistance, occasional contact with the QIO at professional meetings, visits to the QIO website, and/or QIO record review on behalf of beneficiaries.

## II. PROGRAM COST

Under federal budget rules, the QIO Program is defined as mandatory spending rather than discretionary spending because QIO costs are financed directly from the Medicare Trust Fund and are not subject to the annual appropriations process; QIO costs are subject to the apportionment process administered through OMB. In FY 2013, QIO Program expenditures totaled \$512 million.

## III. PROGRAM IMPACT

### Overview

The QIO Program impacts Medicare beneficiaries at the person-level, and the beneficiary population as a whole. In FY 2013 over 52.3 million persons were covered by Medicare. This equals 98.1 percent of the older adult population of the United States – virtually all citizens 65 years of age and older. There are 8.8 million people with disabilities enrolled as part of the 52.3 million persons currently on Medicare.<sup>2</sup> A significant portion of the nation's population (14.7 percent of the nation's population are Medicare beneficiaries) receives important health care improvements as a result of QIO activity.

The QIOs also worked with providers and practitioners to use health information technology to improve care coordination of Medicare beneficiaries, resulting in less cost to the Medicare program while ensuring the integrity, quality and efficiency of care provided to beneficiaries.

This section provides information about QIO accomplishments and the impact on beneficiaries during the FY 2013 period in performance of the 10<sup>th</sup> SOW. The 10<sup>th</sup> SOW had 4 Aims: Beneficiary and Family Centered Care, Improving Individual Patient Care, Integrating Care for Populations and Communities, and Improving Health for Populations and Communities. Each Aim also included components, which addressed a particular area of concern or setting where QIOs were required to focus efforts when working on the Tasks. The first Aim included the mandatory case review functions of the QIO and, under each Aim, QIOs provided technical assistance by means of quality improvement tools and techniques that improved beneficiary health care.

The 10th SOW contract, in comparison to prior QIO contracts, included the following in connection with the Medicare program:

- Expanding pilot projects to national scope;
- Expanding access to preventive services by leveraging Health Information Technology (HIT) potential;
- Increasing the potential impact of CMS's kidney disease efforts;
- Broadening "Every Diabetic Counts" to include beneficiaries in rural areas;
- Adding a new drug-resistant strategy to the Patient Safety portfolio;

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<sup>2</sup> CMS U.S. Department of Health and Human Services. CMS Office of Information Products and Data Analytics CMS Pub. No 03540. August 2013.

- Focusing drug safety resources towards reducing life-threatening adverse events associated with anticoagulant therapy;
- Prioritizing efforts to eliminate unnecessary physical restraints for nursing home residents;
- Refocusing QIOs on quality issues most important to beneficiaries;
- Quantifying the value of QIOs to Medicare;
- Incentivizing QIOs to be more efficient; and
- Identifying and correcting inefficiencies.
- Aligning with other CMS and Federal programs addressing quality improvement, including health reform initiatives;
- Leveraging existing knowledge of effective methods for technical assistance and rapidly generating new knowledge where needed;
- Permitting QIOs to adapt their services and clinical areas to the specific QI strengths and gaps in their state;
- Altering the QIO support center procurement cycle so that support centers were in full operation when each SOW began;
- Providing QIOs more timely and reliable data for targeting and monitoring of their interventions;
- Streamlining CMS reporting requirements so that QIO operations could become more effective and timely so that actionable feedback can be provided to QIOs based on reports;

CMS used the 10<sup>th</sup> SOW as a way to develop a robust framework of quality measures that would hold QIOs accountable for changes at many levels of the health care system, and to implement a management information system that would help CMS monitor the Program through system and program performance metrics.

Under this new contract, QIOs focused their intervention projects across the spectrum of care, rather than in silos based on settings of care. We anticipated and saw during the FY 2013 period that this change in focus allowed the QIOs to have a sector-wide impact on the provision of care to Medicare beneficiaries. Furthermore, QIOs focused their interventions on providers and practitioners that were most in need of assistance in providing better care to their Medicare beneficiaries. QIOs' efforts were also aimed at providing intensive, one-on-one support to low-performing providers and practitioners.

This strategy was consistent with recommendations from both the IOM and GAO received while the 10<sup>th</sup> SOW was being developed during the prior year. Both reports stated that the Program should direct its energy and resources to facilities and providers to impact and improve beneficiary safety and care.

CMS instructed QIOs to assist providers based on their need for assistance. For example, facilities were targeted for improvement based on factors such as their performance related to antibiotic administration to surgical patients (for hospitals), and their rates of high-risk pressure ulcers and use of physical restraints (for nursing homes).

## **Aim Requirements and Measures**

The 10<sup>th</sup> SOW is built on Themes that describe the work to be done. Each of the Themes in the 10<sup>th</sup> SOW has an established set of quality measures that provide accountability to the QIOs for making changes at all levels of the health care system.

### **Aim C.6 - Beneficiary and Family Centered Care**

Beneficiary and Family Centered Care focuses on QIO statutorily mandated case review activities as well as on interventions to promote responsiveness to beneficiary and family needs; to provide opportunities for listening to and addressing beneficiary and family concerns; to provide resources for beneficiaries and caregivers in decision making, and to use information gathered from individual experiences to improve Medicare's entire system of health care. Beneficiary-generated concerns provide an excellent opportunity to explore root causes, to develop alternative approaches to improving care, and to improve beneficiary/family experiences with the health care system. Beneficiary and family engagement and activation efforts are needed to produce the best possible outcomes of care. These QIO beneficiary and family centered efforts align with the National Quality Strategy, which encourages patient and family engagement.

Case review types include Quality of Care Reviews, Emergency Medical Treatment and Labor Act (EMTALA) Reviews, reviews of provider discharge/termination of service decisions and denials of hospital admissions, Higher-Weighted DRG Reviews and other review types as defined in the QIO Manual.

The chart below addresses the combined/aggregated timeliness of all QIOs in achieving the 18<sup>th</sup> month measures, targets and results for Aim C.6.

<b>Measures</b>	<b>18<sup>th</sup> Month Targets</b>	<b>Percent of QIOs that Met the Timeliness Target</b>
Combined/Aggregated Timeliness of all QIOs entering Beneficiary Complaints and Quality of Care Reviews into the CMS Designated Case review system	85%	99.21%
Combined/Aggregated Timeliness of all QIOs entering Beneficiary Discharge/Service Termination Reviews into the CMS Designated Case review system	95%	99.67%
Combined/Aggregated Timeliness of all QIOs entering other Review Types into the CMS Designated Case review system	85%	99.66%

## **Successes**

During the program year CMS provided technical assistance with the QIOs which did not reach the 18<sup>th</sup> month targets for the three timeliness measures. Specific actions taken with these QIOs include CMS staff providing expert advice, training and hands-on support related to the CMS-designated case review system.

### **Aim C.7 – Improving Individual Patient Care**

Patient Safety initiatives are designed to assist in achieving the goals of improving individual care throughout the course of the contract. Some initiatives were phased in at different times throughout the contract. Two of the six priorities that build on the broad aims of the NQS for quality improvement in health care include making care safer and more affordable for everyone and governments by reducing the costs of care through continual improvement.

Below are specific tasks associated with the Patient Safety Aim:

#### **Aim C.7.1 Reducing Healthcare-Associated Infections (HAIs)**

CMS is working with QIOs on efforts to make healthcare safer and more affordable through the reduction and prevention of Healthcare-Associated Infections (HAIs) in the acute care setting. Reducing and preventing HAIs not only helps to improve quality of patient care and make care more affordable, it also helps to save lives. Reducing HAIs in acute care settings was part of the patient safety initiatives in the 10<sup>th</sup> SOW and built upon the broad aims of the National Quality Strategy for Quality Improvement in Healthcare that include making care safer and making care more affordable for individuals, families, employers, and governments by reducing the costs of care through continual improvement.

10<sup>th</sup> SOW HAI goals are:

- To measurably prevent and reduce HAIs in the acute care setting;
- To positively impact HAI work by using data and evidence based HAI guidelines and principles that include a focus on patient and family engagement;
- Align efforts with national initiatives to reduce and prevent HAIs such as the National Action Plan to Prevent HAIs: Roadmap to Elimination.

QIO work on HAIs:

- There are 53 QIOs across states and territories;
- QIOs work to reduce HAIs as part of CMS' AIM to Improve Individual Patient Care (IIPC);
- Central line associated bloodstream infections (CLABSI) (ICU and non-ICU) – 240 units recruited.
- Catheter-associated urinary tract infections (CAUTI) (ICU and non-ICU) – 1,192 units recruited
- Hospitals with higher than expected rates targeted



As a component of the HHS Action Plan, the Comprehensive Unit-based Safety Program (CUSP) supported the national implementation of the program to reduce CLABSI and CAUTI. In the 10<sup>th</sup> SoW, QIOs participated in the CUSP: CLABSI, CUSP: CAUTI initiative to reduce these HAIs in both the intensive care unit (ICU) and non-ICU setting. In line with departmental goals, the QIO also participated in the reduction of other HAIs such as Clostridium difficile infections (CDI) and Surgical-Site Infections (SSI). The chart below addresses the 18<sup>th</sup> month measures, targets and results for Aim C.7.1.<sup>3</sup>

Measures	Targets	Results
18 <sup>th</sup> month metric for CLABSI, CAUTI and Urinary Catheter Utilization Rate	100% of participating facilities continuously tracking and reporting measures using the NHSN. Continuously tracking and reporting is defined as the submission of two consecutive months of data.	All QIOs met this 18 <sup>th</sup> month metric for CLABSI. 46 QIOs met this 18 <sup>th</sup> month metric for CAUTI and 4 QIOs needed improvement on this metric.
18 <sup>th</sup> month metric for Central Line Insertion Practices (CLIP)	85% adherence	11 QIOs met this metric and 5 QIOs needed improvement on this metric.
18 <sup>th</sup> month metric for Surgical Site Infections (SSI)	25% or greater HAI participants agreeing to participate in SSI reduction projects	All applicable QIOs met this metric.

### Successes

- 37.5% of QIOs have met the stretch goal of 0.51 for CLABSI
- 53% Relative Improvement Rate in the reduction of CLABSI resulting in approximately 198 fewer cases of CLABSI in beneficiaries
- 20% of QIOs have met the stretch goal of 0.75 for CAUTI

### Task C.7.2 Reduce Healthcare Acquired Conditions by 40% in Nursing Homes

The Aim of the 10<sup>th</sup> SOW Nursing Home Task was to reduce healthcare-acquired conditions for Medicare beneficiaries nationwide by 40%. The QIOs contributed to attaining this goal by working to reduce healthcare-acquired conditions (HACs) in nursing homes. Phase I of this Task included the QIOs providing technical assistance to nursing homes on the reduction of Pressure Ulcers (PrU) and Physical Restraints (PR). Phase I began at the launch of the 10<sup>th</sup> SOW and continued to the end of the SOW.

Phase II began on February 1, 2013, in the form of the National Nursing Home Quality Care Collaborative (NNHQCC) as a Learning and Action Network engagement method for an ‘all teach/ all learn’ peer-to-peer learning environment. In Phase II, QIOs expanded their efforts beyond physical restraints and pressure ulcers in nursing homes to address other HACs. QIOs

<sup>3</sup> Not every QIO participated in each Task that is measured on this chart. Some states/territories did not have a sufficient number of hospitals participating in the specific endeavor.

convened and facilitated the engagement of nursing homes from February 1, 2013 through July 31, 2014, at which time the QIO prepared the LAN/collaborative to continue in sustainability mode.

During the SOW, QIOs were provided the opportunity to continue working on PrU, PR and HAIs, as well as the opportunity to work with other HACs, such as falls, reducing the inappropriate use of antipsychotic medication in residents with dementia, and facility-identified areas of focus.

The chart below addresses the 18<sup>th</sup> month measures, targets and results for Aim C.7.2.

Measures	Targets	Results
Phase I: NH Pressure Ulcer Reduction: Achieve a state aggregate rate of $\leq 6\%$ or Relative Improvement Rate (RIR) $\geq 20\%$	Percent of High-Risk residents with pressure ulcers (PrU) (Stages 2, 3 and 4). QIO shall recruit NHs that have PrU rates that are greater than the 75 <sup>th</sup> percentile of the NHs in the state and have a PrU rate of equal to or greater than 11%. QIOs recruited 787 NHs.	Baseline – 13.9% 18 <sup>th</sup> Mo. – 9.24% and 31.32% RIR
Phase I: NH Physical Restraint Reduction: Achieve a rate of $\leq 3\%$ or $\geq 50\%$ RIR	QIO shall recruit nursing homes (NHs) that are in the in the greater 75 percentile of physical restraint (PR) use in the state and that have a statewide PR rate of greater than/or equal to 4%. QIOs recruited 981 NHs.	Baseline – 9.56% 18 <sup>th</sup> Mo. – 4.74% and 48.99% RIR
Phase II: National Nursing Home Quality Care Collaborative (NNHQCC): Nursing Home Recruitment had no defined measure.	At the 12 <sup>th</sup> month, QIOs shall recruit nursing homes to participate in a statewide collaborative (Learning & Action Network) focused on improving the overall quality of care provided in nursing homes.	(12 <sup>th</sup> month) Begin recruitment - 0  (18 <sup>th</sup> month) Start of NNHQCC – 4,209
Phase II: NNHQCC: Quality Measure Composite Score. Achieve a score of $\leq 6$ . The lower, the better.	Calculated by summing the 13 long-stay Quality Measure numerators to obtain the composite numerator, Summing the 13 denominators to obtain the composite denominator then dividing the composite numerator by the composite denominator, then multiplying by 100. Composite Score is intended for sole purpose of measuring progress of the NNHQCC.	Baseline Score (18 <sup>th</sup> month)– 9.42 (Feb. 2013)

### Successes

- Among the 981 nursing homes recruited for reduction in use of Physical Restraints, restraint use was decreased by 48.99.

- Among the 787 nursing homes recruited for reduction in the rate of Pressure Ulcers, the QIOs supported efforts to achieve a 31.32% reduction in pressure ulcers for high risk patients.
- QIOs recruited nearly 30% of the total nursing home population (15,600) with CCNs to participate in the 10<sup>th</sup> SOW NNHQCC.
- More than 1200 nursing homes achieved the Quality Measure Composite Score  $\leq 6$  at least once during the eighteen months of the collaborative (February 1, 2013 through July 31, 2014).
- CMS created a Collaborative Change Package from the site-visits and review of performance of 10 high-performing nursing homes.
- In addition to the identified 10<sup>th</sup> SOW designated evaluation measures, QIOs worked with nursing homes on reduction of antipsychotic medications, falls, UTI, staff turnover/ stability, hospitalizations/ care transitions and consistent assignment.

### **C.7.3 Reducing Adverse Drug Events**

Adverse drug events are one of the most common types of health care adverse events. In addition adverse drug events are one of the major sources of potentially preventable patient harm. Adverse drug events disproportionately affect beneficiaries over the age of 65 across all settings, including hospitals, ambulatory care and long term care facilities. To successfully work on this task during the 10<sup>th</sup> SOW, QIOs participated in a patient safety and clinical pharmacy services breakthrough collaborative, formed community teams, recruited Medicare advantage and dual eligible beneficiaries in “population of focus” teams, and utilized tools and interventions in the Patient Safety and Clinical Pharmacy Services Collaborative (PSPC) to accomplish their goals in their states. In the 10<sup>th</sup> SOW, the QIOs worked with the PSPC collaborative to recruit community teams in every state, provide technical assistance, and monitor and track data to reduce Adverse Drug Events.

Due to measurement issues such as lack of clarity of the performance standards, and recruitment timing, there was a leadership decision not to evaluate this subtheme at the 18<sup>th</sup> month.

<b>Measures</b>	<b>Targets</b>	<b>Results</b>
Formation and Expansion of Community Teams	At least 2 newly formed teams.	Leadership decision not to evaluate this subtheme at 18 <sup>th</sup> month due to measurement issues ( the measures listed here are the revised measures to be used for 27 <sup>th</sup> month
Retention and Recruitment of Population of Focus (PoF)	At least 50 eligible beneficiaries.	
Monthly Monitoring of the International	QIOs must meet either criteria “A” or “B” as defined below:	

<p>Normalized Ratio (INR) in Beneficiaries on Warfarin</p>	<p>A. The QIO must demonstrate continuous assistance to providers and participant engagement with a goal of moving towards the target of 100% of PoF beneficiaries that have the monthly INR.</p> <p style="text-align: center;">OR</p> <p>B. The QIO must demonstrate satisfactory performance with their community teams as determined by CMS (upon consideration of information provided by the QIO, in Deliverable I.12), with respect to each of the following:</p> <ol style="list-style-type: none"> <li>1. Interventions used and engagement of community teams;</li> <li>2. Support for local improvement including implementation, tracking and monitoring of local data;</li> <li>3. Analysis of data trends; and</li> <li>4. QIO actions to mitigate or overcome identified barriers and limitations affecting the community teams.</li> </ol>	<p>evaluations)</p>
<p>Beneficiaries with an International Normalized Ratio (INR) in Controlled Range</p>	<p>QIOs must meet either criteria "A" or "B" as defined below:</p> <p>A. The QIO must demonstrate assistance to providers; and participant engagement with a goal of moving towards the target of 70% of PoF beneficiaries with INR in the controlled range.</p> <p style="text-align: center;">OR</p> <p>B. QIO must demonstrate satisfactory performance with their community teams as determined by CMS (upon consideration of information provided by the QIO, in Deliverable I.12), with respect to each of the following:</p> <ol style="list-style-type: none"> <li>1. Interventions used and engagement of community teams;</li> <li>2. Support for local improvement including implementation, tracking and monitoring of local data;</li> <li>3. Analysis of data trends; and</li> </ol>	

	<p>4. QIO actions to mitigate or overcome identified barriers and limitations affecting the community teams.</p>	
<p>Beneficiaries with a Hemoglobin A1c (HgA1c) Out of Target Range</p>	<p>QIOs must meet either criteria “A” or “B” as defined below:</p> <p>A. The QIO must demonstrate assistance to providers and participant engagement with a goal of moving towards the target of 50% of recruited diabetic patients going from HgA1c of greater than or equal to 9% to HgA1c of less than 9%.</p> <p style="text-align: center;">OR</p> <p>B. The QIO must demonstrate satisfactory performance with their community teams as determined by CMS (upon consideration of information provided by the QIO, in Deliverable I.12), with respect to each of the following:</p> <ol style="list-style-type: none"> <li>1. Interventions used and engagement of community teams;</li> <li>2. Support for local improvement including implementation, tracking and monitoring of local data;</li> <li>3. Analysis of data trends; and</li> <li>4. QIO actions to mitigate or overcome identified barriers and limitations affecting the community teams.</li> </ol>	
<p>Reduction of Risk for ADEs in Beneficiaries Prescribed an Antipsychotic Medication</p>	<p>QIOs must meet either criteria “A” or “B” as defined below:</p> <p>A. Demonstration of assistance to providers and participant engagement with a goal of moving towards the target of reducing the rate by 50% from baseline, in the PoF.</p> <p style="text-align: center;">OR</p> <p>B. The QIO must demonstrate satisfactory performance with their community teams as determined by CMS (upon consideration of information provided by the QIO, in Deliverable I.12), with respect to each of the following:</p> <ol style="list-style-type: none"> <li>1. Interventions used and engagement of community teams;</li> <li>2. Support for local improvement including</li> </ol>	

	<p>implementation, tracking and monitoring of local data;</p> <p>3. Analysis of data trends; and</p> <p>4. QIO actions to mitigate or overcome identified barriers and limitations affecting the community teams.</p>	
<p>Adverse Drug Event (ADE): An event resulting in injury or harm to a patient due to medication use.</p>	<p>QIOs must meet either criteria “A” or “B” as defined below:</p> <p>A. The QIO must demonstrate improvement from baseline in the ADE rate, with a goal of moving towards the target of a 90% reduction as evidenced by data reported during PSPC 4.0 and/or 5.0.</p> <p style="text-align: center;">OR</p> <p>B. The QIO must demonstrate satisfactory performance with their community teams as determined by CMS (upon consideration of information provided by the QIO, in Deliverable I.12), with respect to each of the following:</p> <ol style="list-style-type: none"> <li>1. Interventions used and engagement of community teams;</li> <li>2. Support for local improvement including implementation, tracking and monitoring of local data;</li> <li>3. Analysis of data trends; and</li> <li>4. QIO actions to mitigate or overcome identified barriers and limitations affecting the community teams.</li> </ol>	
<p>Potential Adverse Drug Events (pADE): An event that was identified and avoided with appropriate interventions before affecting the patient.</p>	<p>QIOs must meet either criteria “A” or “B” as defined below:</p> <p>A. The QIO must demonstrate continuous assistance to providers, and participant engagement with using the rate of pADE identification and prevention.</p> <p style="text-align: center;">OR</p> <p>B. The QIO must demonstrate satisfactory performance with their community teams as determined by CMS (upon consideration of information provided by the QIO, in Deliverable I.12), with respect to each of the following:</p>	

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| <ol style="list-style-type: none"> <li>1. Interventions used and engagement of community teams;</li> <li>2. Support for local improvement including implementation, tracking and monitoring of local data;</li> <li>3. Analysis of data trends; and</li> <li>4. QIO actions to mitigate or overcome identified barriers and limitations affecting the community teams.</li> </ol> |  |
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**Successes**

During FY2013, QIOs have recruited and/or supported several community teams and beneficiaries in collaboration with PSPC to reduce adverse drug events and improve clinical outcomes related to medication use. As part of the collaborative the community teams worked on identifying best practices to reduce adverse drug events, improve screening of adverse drug events and potential adverse drug events, and improve testing and education of diabetic patients out of control, increase monitoring of monthly INR testing for beneficiaries on anticoagulants and identify and decrease inappropriate antipsychotic medication use.

**Aim C.7.4 - Quality Reporting and Improvement**

Quality Reporting: Similar to previous SOWs, the 10<sup>th</sup> SOW required QIOs to provide technical assistance to Medicare providers to report hospital quality data. In FY 2013, QIO’s continued to expand their assistance in the 10<sup>th</sup> SOW to support Hospital Outpatient Department quality data. QIO technical assistance also dramatically improved Critical Access Hospital (CAH) reporting during the 10<sup>th</sup> SOW to 99% of all eligible CAH’s. QIOs also succeeded in achieving very high (98-99%) national levels of hospital inpatient and outpatient department quality reporting programs.

Quality Improvement: During FY 2013, QIOs also provided assistance to hospitals to improve their quality of care on Hospital Value Based Purchasing (VBP) measures and Hospital Outpatient Department measures. QIOs assisted providers to improve important aspects of quality, including (but not limited to) patient experience of care, 30 day mortality rates, outpatient emergency department transfer time, and appropriate use, selection, and discontinuation of surgical antibiotics. QIO assistance contributed to dramatic improvements in many measures. Evidence of this improvement is the national high performance on clinical process of care measures, since many of the measures have achieved top national performance levels and have subsequently been retired by CMS from our hospital quality reporting programs.

The chart below addresses the 18<sup>th</sup> month measures, targets and results for Aim C.7.4

Measures	Targets	Results
% of Hospitals Receiving Annual Payment Update-IQR Providers	95%	98%
% of Hospitals Receiving Annual Payment Update- OQR Providers	95%	99%
% of eligible Hospitals receiving a non-zero CMS Hospital VBP Performance Score	95%	98%
% of eligible Hospitals meeting Hospital VBP Care Performance Score improvement thresholds	80%	97%
% of eligible Hospitals meeting at least one Hospital VBP achievement thresholds	65%	90%
% of CAHs reporting IQR	95%	99%
% of CAHs reporting OQR	95%	99%
% of eligible Hospitals reaching baseline Yr 1 national median for 60% of submitted OQR measures	50%	86%
% of eligible Hospitals reaching baseline Yr 1 national benchmark for 25% of submitted OQR measures	30%	71%
% of eligible Hospitals improving measure rates for 50% of submitted OQR measures )	60%	67%

### Successes

Top performing QIOs used a variety of tools and strategies to achieve success in the 10<sup>th</sup> SOW. Examples of activities performed during FY2013 to perform this task include:

- Collaboration with state hospital associations to increase hospital awareness and volunteer QIO availability on outpatient department quality improvement assistance;
- Targeted telephone reminder calls to hospitals to report quality data 14 and 7 days before the quarterly deadline;
- Drawing upon past QIO successes in care transitions to improve patient experience of care discharge planning and communications measures used in task; and
- In-person and web-based training to critical access hospitals on the CMS quality data abstraction tool and QualityNet website use to report data.

### Aim C.8 – Integrating Care for Populations and Communities

The Integrate Care for Populations & Communities (ICPC) Aim in the 10th Scope of Work (SOW) involved a network of 53 Quality Improvement Organizations (QIOs) who were tasked with achieving the QIO program's goals for better care, better health for populations and communities, and lower costs of care through quality improvement. The ICPC was a strategic Aim where QIOs brought together hospitals, nursing homes, patient advocacy organizations, community services, home health agencies, palliative and hospice care, physician offices, and



other stakeholders in community coalitions. QIOs were responsible for building multi-stakeholder community coalitions with a focus on reducing avoidable hospital admissions and readmissions and improving care transitions between settings.

QIOs worked with their recruited communities to identify poor drivers of care transitions such as poor information transfer between providers, and decreased patient and family activation. Based on the result of the root cause analysis, QIOs implemented evidenced-based interventions to mitigate the causes of poor care transitions in their communities.

QIOs helped to implement and identify several best practices. An exemplary best practice includes developing effective community coalitions with key stakeholders in acute care settings, post-acute care settings, and the community to address the causes of poor coordination of care as patients transition from one point of care to the other. Others include generating and implementing standard transition processes across all local health care settings; transferring patients' clinical information between providers in a timely and effective way; and helping patients and their family members become actively engaged in their care transitions.

The chart below addresses the 18<sup>th</sup> month measures, targets and results for Aim C.8.

Measures	Targets	Results
IC-1: Percentage of communities recruited that have signed community coalition charters and within 3 months.	50%	100% of QIOs (53) met target
IC-2: Percentage of eligible communities recruited that submit an application to a Care Transitions Program.	25%	48/51 (94%) QIOs met target; 3 QIOs did not attain target. (PR & VI N/A)
IC-3: Percentage of eligible communities recruited that are accepted into a Care Transitions Program.	10%	34/51 (67%) QIOs met target; 17 QIOs did not attain target. (PR & VI N/A)
IC-4: Percentage of communities that can demonstrate improvement for 4 distinct interventions over a minimum of four time points.	25%	51/53 (96%) QIOs met target; 2 QIOs did not attain target.

### Successes

Over 14,000,000 Medicare beneficiaries lived in the communities served by the QIO Program. By working with QIOs, communities across the country collectively saved over 27,000 people from being readmitted to the hospital and over 95,000 people from being admitted to the hospital.<sup>4</sup>

<sup>4</sup> These are aggregate contract term results, attributable in part to work done in FY2013.

**Aim C.9 – Improving Health for Populations and Communities**

The QIOs worked with physicians’ offices and clinics to promote measurement, monitoring and improvement of outpatient care for patients, including preventive services and appropriate cardiac care. QIOs’ activities in this period were:

- Physician Quality Reporting System (PQRS)-Electronic Health Record (EHR) Reporting – Assisting specifically-identified (recruited) physicians and other eligible professionals (EPs) in using their EHRs to report to PQRS (2012 calendar year), and monitor and improve clinical measures in preparation for 2013 reporting. Recruitment of physicians and other EPs completed 11/30/2012.
- Regional Extension Center (REC)-assisted, installed offices’ Learning and Action Network (LAN) – QIOs invited offices that had worked with their state REC to join a LAN (early in the year). The LAN (an ongoing effort through the year) focused on using EHRs to track and improve the clinical preventive measures (influenza immunizations, pneumococcal vaccines, breast cancer screening & colon cancer screening), promoting patient and family engagement, sharing tools and resources, and effective use of clinical decision support.
- Cardiac Population Health LAN – QIOs completed recruiting offices, clinics and partners to join the LAN. The LAN, an ongoing effort through the year, focused on tracking and improving the clinical priorities of the Million Hearts Initiative (aspirin, blood pressure control, cholesterol control & smoking cessation). Some QIOs combined this LAN with the above LAN.
- General partnership and communications supporting Meaningful Use, reporting to the Immunization Information System and the clinical preventive priorities.

The chart below addresses the 18<sup>th</sup> month measures, targets and results for Aim C.9.

<b>Measures</b>	<b>Targets</b>	<b>Results</b>
PQRS-EHR Reporting Assistance	Each QIO was required to assist 100% of their J-18 (or negotiated) number of eligible professionals and report this assistance by 11/30/2012	100% (All QIOs that agreed to do this work met this measure.)
REC-Assisted LAN Invitations	Each QIO was required to invite timely (within 3 calendar months of meeting REC Milestone 2) at least 95% of the REC-assisted primary care adult medicine offices/organizations that met REC Milestone 2 between 10/15/2011 and 8/30/2012 and report this to CMS by 11/30/2012	47 QIOs met timeliness; 4 QIOs did not meet timeliness; 1 QIO not doing this work.

## Successes

- Seven (7) QIOs over-recruited EPs and assisted them early – by 10/31/2012 – in PQRS-EHR Reporting.
- Four (4) QIOs supported the goals of improved cardiac health by successfully recruiting a significant number of office and clinics early. (Recruitment of at least 70% of offices/clinics for the Cardiac Population Health LAN by the end of Quarter 2.)
- One (1) QIO met both of the above.

## IV. CONCLUSION

All Americans including Medicare beneficiaries deserve to have confidence in their health care system. A system that delivers the right care to every person, every time, is the way to achieve that goal. The QIO Program—with a national network of knowledgeable and skilled independent organizations under contract with Medicare - is charged with identifying and spreading evidence based best healthcare practices as well as conducting case reviews to make sure that the quality and standard of care provided to beneficiaries is provided in a manner that meets professionally recognized standards of health care. The work of the QIO Program has been and continues to be a major contributing factor for improvements in American health care.

Many changes were made in the 10<sup>th</sup> SOW, and CMS believes these changes had a positive impact on critically important aspects of patient care and continue to improve the care that is being provided to the Medicare beneficiaries and their families.

