

Report to Congress
The Administration, Cost, and Impact of the Quality Improvement
Organization (QIO) Program for Medicare Beneficiaries for Fiscal Year
2012

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 2012. 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 make sure 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 FY2012, 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 and contained an award fee plan based upon net performance expectations. The contractors received fees for specific expectations they met. If the contractors did not meet expectations, they did not receive award fees. The QIOs' technical performance was evaluated at the 18th and 27th months of the contract; neither evaluation occurred during FY2012. 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 that a high quality of care was provided to Medicare beneficiaries. Approximately 54,000 providers and more than one million practitioners¹ 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 2012, QIO Program expenditures totaled approximately \$372.8 million. FY 2012 covered the 3rd through 14th months of the 10th Scope of Work (SOW) contract, which covered the period August 1, 2011 through July 31, 2014. Since results were not available at this point in the contract, this report will describe the main activities included in the 10th SOW, the suggested targets of the Aims, charts which indicate that performance was monitored during FY 2012 to assess if the QIOs were progressing to likely attain the performance criteria, how the 10th SOW was changed from the 9th SOW, and present the recommendations from the Institute of Medicine (IOM) as they pertained

¹ 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.

to the development of the 10th SOW. The FY 2013 report will explain the targets and results from the 18th month results.

QIOs' performance under the 10th 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 was requested by the assigned COR to make sure that problems were addressed prior to the formal 18th month contract evaluation.

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 were also reviewed. During the course of these deliberations and review of available data, certain evaluation decisions were made and approved by CMS 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 10th SOW predates the effective dates of these amendments, they were not relevant to the work performed during FY 2012.

For the 10th 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 and appropriate 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 10th SOW for the 53 contractors participating in Medicare's QIO Program. The QIO contracts extend from August 1, 2011 through July 31, 2014. The 10th SOW focused on improving the quality and safety of health care services furnished to Medicare beneficiaries. The 10th 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 was 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 10th SOW was evaluated at the 18th month (February 2013) and 27th 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 10th SOW. Quarterly monitoring of metrics allows for immediate opportunities to implement correction action, using "plan, do, study, act" 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 and Contract Specialist. QIOs were evaluated according to how well they reach CMS specified performance goals.

By law, the mission of the QIO Program is to improve the effectiveness, efficiency, and quality of services delivered to Medicare beneficiaries. Based on this statutory

requirement, and CMS' program experience, CMS identified the core functions of the QIO Program as:

- Improving quality of care for beneficiaries;
- Protecting the integrity of the Medicare Trust Fund by ensuring that Medicare pays only for services and goods that are reasonable and necessary and are provided in the most economical and appropriate setting; and
- Protecting beneficiaries by expeditiously addressing: individual complaints; provider-based notice appeals; violations of the EMTALA; and other related responsibilities in QIO law.

QIOs Interacting with Health Care Providers and Practitioners

QIOs worked with 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 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 2012, QIO Program expenditures totaled \$372.8 million. This spending represents approximately \$7 annually for at least 50.7 million Medicare beneficiaries to improve quality of care, and less than one tenth of one percent (0.1 percent) of the \$566.7 billion Medicare expenditures during that year.

III. PROGRAM IMPACT

Overview

The QIO Program impacts Medicare beneficiaries at the person-level, and the beneficiary population as a whole. In FY 2012 over 50.7 million persons were covered by Medicare. This equals 98.1 percent of the older adult population of the United States –

virtually all citizens 65 and older. There are 8.8 million people with disabilities enrolled as part of the 50.7 million persons currently on Medicare.² A significant portion of the nation's population (14.7 percent of the nation's population are Medicare beneficiaries) receive 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 FY 2012 in performance of the 10th SOW. The 10th 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 potential;
- Increasing the potential impact of CMS' kidney disease efforts;
- Broadening "Every Diabetic Counts" to include beneficiaries in rural areas;
- Adding a new drug-resistant strategy to the Patient Safety portfolio;
- 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;
- 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 quality improvement strengths and gaps in their state;

² CMS U.S. Department of Health and Human Services. CMS Office of Research, Development, and Information 2008 CMS Statistics. CMS Pub. No 03497. August 2009.

- Providing QIOs more timely and reliable data for targeting and monitoring of their interventions; and
- 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.

In addition, during the 10th SOW, CMS altered the QIO support center procurement cycle so that support centers were in full operation when each SOW began. CMS used the 10th 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. FY 2012 covered the 3rd through the 14th months of the 10th SOW.

Under this new contract, QIOs focused their intervention projects across the spectrum of care, rather than in silos based on settings of care. CMS anticipated and saw during FY 2012 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 10th SOW was being developed during the prior year. Both reports stated that the QIO 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).

Theme Requirements and Measures

The 10th SOW is built on Themes that describe the work to be done. Each of the Themes in the 10th 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

The Beneficiary and Family Centered Care Aim focused on QIO case review activities mandated by the QIO statute and regulations and 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 delivery system. Beneficiary and family engagement and activation efforts

are needed to produce the best possible outcomes of care at the provider and person-level. These QIO beneficiary and family centered efforts aligned with the NQS, which encourages individual and family engagement.

Tasks associated with case review were measured in terms of the number of cases reviewed and the satisfaction of the beneficiary with the case review process. Ninety-five percent of all cases reviewed by the QIO were required to meet timeliness of review standards and improve beneficiary satisfaction scores for each quarter.

In other tasks QIOs were required to work with beneficiaries, providers, physician and other practitioners to promote beneficiary and family-centered care approaches in health care delivery settings including physician offices. This included:

- Making sure beneficiaries and health care stakeholders are treated fairly;
- Assisting providers with optimizing service and providing high quality health care;
- Implementing follow-up action for identified quality of care concerns for individual cases;
- Promoting beneficiary choices regarding their health care options;
- Providing appropriate personnel to conduct review; and
- Participating in monthly calls with the National Coordinating Center.

Within this Aim, the QIO was also required to work with beneficiaries, providers, physicians and other practitioners to meet specific review requirements. These activities included: evaluating and responding to all beneficiary complaints about the quality of services received from providers, performing all other statutorily mandated case reviews, referring potential fraud and abuse trends to the appropriate organization including CMS, issuing technical denials for non-receipt of hospital medical records from providers and making payment determinations.

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 planned to be 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 were making care safer and more affordable for everyone and governments by reducing the costs of care through continual improvement.

There were specific tasks associated with the Patient Safety subtheme:

- Reduce Health Care-Associated Infections (HAI) by recruiting CMS-specified providers to work with, i.e., ICU and non ICU hospital wards, hospitals that are already reporting HAI data to the National Healthcare Safety Network (NHSN), facilities that have a central line bloodstream infections (CLABSI) rate at or above 1.5 per 1000 central line days.

- Reduce Healthcare Acquired Conditions (HACs) by 40 percent in nursing homes, with the HACs to be identified by CMS in Phase II of the contract;
- Reduce the HACs of pressure ulcers and physical restraints in nursing homes by 40%;
- Reduce adverse drug events (ADEs); and
- Improve quality reporting and improvement;

Health care safety is a responsibility that crosses all areas of care. It requires the commitment of the providers, an understanding of where the provider or provider entity stands with regard to safety, data transparency, and the will to execute proven effective practices at every level involved for providers to be successful and for safety to become organizationally integrated. During FY 2012, the QIOs worked within their own community framework to improve clinical outcomes in the task areas. The QIOs could then seek to replicate successful practices across their service area, resulting in positive movement in each of the beneficiary safety metrics.

Subtheme - Quality Reporting and Improvement

The QIO must provide technical assistance to hospitals to improve their quality of care related to quality measures reported in Medicare programs such as the Hospital Inpatient Quality Reporting (IQR) program and the Hospital Outpatient Quality Reporting (OQR) program. When needed, QIOs were required to assist hospitals in their service area that request assistance on quality improvement efforts related to Hospital IQR and Hospital OQR program measures. QIOs also educated hospitals on IQR and OQR program requirements. QIOs were required to provide technical assistance and education in validation, hospital IQR and OQR program measures, reporting of measure data and improving on care related to hospital IQR and OQR program measures. QIOs also provided CAHs, rural facilities and other hospitals that do not participate in the Hospital IQR and OQR programs with CMS abstraction tools, inpatient and outpatient data warehouse infrastructure, measurement and submission feedback reports, and education pertaining to the hospital IQR and OQR program reporting requirements.

The chart below identifies the 18th month goal/targets for the Quality Reporting and Improvement Task. QIO work during the FY2012 period was geared toward meeting these goals/targets:

Measures	Targets
% of eligible Hospitals meeting at least two CMS QIO Hospital Inpatient Quality and Experience of Care Performance Score thresholds	65%
% of eligible Hospitals reaching national CY 2010 baseline median threshold for at least 60% of submitted chart abstracted Hospital Outpatient Quality Reporting program	CY 2011 – 40%

(OQR) measures	
% of eligible Hospitals reaching national 90 th percentile benchmark CY 2010 threshold for at least 25% of submitted chart abstracted OQR measures	CY 2011 – 20%
% of eligible Hospitals improving measure rates for at least 50% of submitted chart abstracted OQR measures (from previous year)	50%
CLABSI Relative Improvement Rate **One of the 3 CLABSI evaluation targets must be met**	100% of participating facilities continuously tracking and reporting the CLABSI measure using the NHSN
CLABSI Standardized Infection Ratio	100% of participating facilities continuously tracking and reporting the CLABSI measure using the NHSN
CLABSI Incident Rate	100% of participating facilities continuously tracking and reporting the CLABSI measure using the NHSN
Central Line Insertion Practices (CLIP) adherence rate	85% adherence
CAUTI Relative Improvement Rate	100% of participating facilities continuously tracking and reporting the urinary catheter measure using the NHSN
Urinary Catheter Utilization Rate	100% of participating facilities continuously tracking and reporting this measure using the NHSN
CDI Antimicrobial Stewardship and Relative rate of Improvement	N/A
SSI reduction	25% or greater participants agreeing to participate in SSI reduction projects

Subtheme - Pressure Ulcers: Pressure ulcers are a painful, costly and largely preventable condition that when not appropriately treated can cause serious illness and death. In the 10th SOW, QIOs were tasked with reducing pressure ulcer rates in both long term care and hospital settings from the beginning of the contract. Because pressure ulcers can generally be attributed to system failures, the QIOs were tasked with ensuring that the

foundations for improvement were in place with the issuance of two process measures for long term care settings. During FY 2012, the QIOs were responsible for recruiting nursing homes that have pressure ulcer rates that are greater than the 75th percentile of the nursing homes in the state and have a pressure ulcer rate of \geq to 11%. They worked with providers to instill quality improvement methodology, adopt best practices and work toward reduction of the rate of pressure ulcers.

Subtheme - Physical Restraints: The use of physical restraints can greatly diminish the quality of life for long term care beneficiaries living in nursing homes, as well as other settings. Therefore, the QIO program was dedicated to dramatically reducing the utilization rate of physical restraints from the beginning of the 10th SOW. For this task, during the FY2012 period, the QIO recruited nursing homes that were in the >75th percentile of physical restraint use in the state and that have a statewide physical restraint rate of \geq 4 percent to work with the QIOs to eradicate the use of unnecessary physical restraints.

The chart below identifies the pressure ulcer and physical restraint 18th month goal/targets for Patient Safety. QIO work during the FY2012 period was geared toward meeting these goals/targets.

Measures	Targets
High Risk Nursing Home Pressure Ulcer	N/A
PrU Prevention and Care	<u>100%</u>
Best Practices to Prevent and Treat PrUs	<u>100%</u>
Nursing Home Physical Restraint	<u><3%</u>
CAUTI Measure	Tracking of catheter utilization ratio in 100% of residents with an indwelling catheter in QIO recruited Nursing Homes
Consistent Assignment	<u>N/A</u>
Staff Turnover	<u>N/A</u>

Subtheme - 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 10th 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. During FY 2012 under the 10th 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.

The chart below identifies the targets for Reducing Adverse Drug Events (ADEs) for the 27th month evaluation. QIO work during FY 2012 laid the foundation for QIO work to meet these 27th month evaluation targets.

Measures	Targets
Formation and Expansion of Community Teams	At least 2 newly formed teams.
Retention and Recruitment of Population of Focus (PoF)	At least 50 eligible beneficiaries.
<p>Monthly Monitoring of the International Normalized Ratio (INR) in Beneficiaries on Warfarin</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 a goal of moving towards the target of 100% of PoF beneficiaries that have the monthly INR.</p> <p style="text-align: center;"><u>OR</u></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"> 1. Interventions used and engagement of community teams; 2. Support for local improvement including implementation, tracking and monitoring of local data; 3. Analysis of data trends; and 4. QIO actions to mitigate or overcome identified barriers and limitations affecting the community teams.
<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;"><u>OR</u></p> <p>B. The QIO must demonstrate satisfactory performance with their community teams as determined by CMS (upon</p>

	<p>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"> 1. Interventions used and engagement of community teams; 2. Support for local improvement including implementation, tracking and monitoring of local data; 3. Analysis of data trends; and 4. QIO actions to mitigate or overcome identified barriers and limitations affecting the community teams.
<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;"><u>OR</u></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"> 1. Interventions used and engagement of community teams; 2. Support for local improvement including implementation, tracking and monitoring of local data; 3. Analysis of data trends; and 4. QIO actions to mitigate or overcome identified barriers and limitations affecting the community teams.
<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;"><u>OR</u></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"> 1. Interventions used and engagement of community teams; 2. Support for local improvement including implementation, tracking and monitoring of local data; 3. Analysis of data trends; and 4. QIO actions to mitigate or overcome identified barriers and

	<p>limitations affecting the community teams.</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;"><u>OR</u></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"> 1. Interventions used and engagement of community teams; 2. Support for local improvement including implementation, tracking and monitoring of local data; 3. Analysis of data trends; and 4. QIO actions to mitigate or overcome identified barriers and limitations affecting the community teams.
<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 continuous assistance to providers, and participant engagement with using the rate of pADE identification and prevention.</p> <p style="text-align: center;"><u>OR</u></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"> 1. Interventions used and engagement of community teams; 2. Support for local improvement including implementation, tracking and monitoring of local data; 3. Analysis of data trends; and 4. QIO actions to mitigate or overcome identified barriers and limitations affecting the community teams.
<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;"><u>OR</u></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"> 1. Interventions used and engagement of community teams; 2. Support for local improvement including implementation, tracking and monitoring of local data; 3. Analysis of data trends; and 4. QIO actions to mitigate or overcome identified barriers and limitations affecting the community teams.

Aim C.8 – Integrating Care for Populations and Communities

The process by which beneficiaries move from hospitals to other health care settings is increasingly problematic. Hospitals shorter lengths of stay and Medicare beneficiaries report greater dissatisfaction in discharge-related care than in any other aspect of care. During FY 2012, the QIOs worked within the community to reduce re-hospitalizations by engaging providers, i.e., hospitals, home health agencies, dialysis facilities, nursing

homes and physician offices, in this effort. By forming relationships with community organizations and playing a coordinating role to make sure that community-wide adoption of improved practices the QIO worked to reduce re-hospitalizations in geographic locations by identifying and suggesting opportunities for improvement.

In FY 2012, QIOs worked to convene communities including providers, payers, community based organizations to work together to improve the quality of care for Medicare beneficiaries as they moved across the healthcare continuum. Once a community was convened, QIOs provided technical assistance to support a community specific root cause analysis, evidence based intervention identification and implementation strategies, and assistance with measuring outcomes at the intervention level and utilization level. QIOs also provided assistance to communities wishing to apply for funding for care transitions related quality improvement efforts including the Community Based Care Transitions Program (CCTP).

Aim C.9 – Improving Health for Populations and Communities

CMS recognizes the crucial role that health care professionals have in promoting potentially lifesaving preventive services and screenings to Medicare beneficiaries, educating them regarding the services, and providing the care. While Medicare beneficiaries usually visit their physician on an average of six or more times a year, many are not aware of their risk for certain conditions or even that they may already have a condition that preventive services can detect. For the 10th SOW period, QIOs assisted physician practices and beneficiaries in understanding the importance of disease prevention, early detection and lifestyle modifications that support a healthier life by accomplishing the following:

- Improving flu immunizations of beneficiaries aged 50 and older during flu season;
- Improving pneumococcal immunization of beneficiaries aged 65 and older;
- improving appropriate low-dose aspirin therapy use in patient with ischemic vascular disease;
- Improving blood pressure control in patients with hypertension;
- Improving LDL-C control among adults with ischemic vascular disease;
- Improving tobacco cessation intervention among beneficiaries who smoke (screening and cessation counseling);
- Improving colorectal cancer screening in beneficiaries aged 50-75;
- Improving breast cancer screening in female beneficiaries aged 40-69; and
- Identifying and improving disparities within identified communities within the state.

For this Aim the QIO was also required to improve participation in the physician quality reporting system (PQRS) and improve the use of electronic health records (EHR) for care management by:

- Ensuring that practices have integrated EHR and data exchange infrastructure;
- Assisting practices to take advantage of streamlined practices in the area of workflows, data reports and identification of registry functions for provider clinical information exchange; and
- Assisting physician offices with qualified EHRs to participating in PQRS using EHR-based reporting.

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 Medicare beneficiaries. 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 10th SOW, and CMS believes these changes will have a positive impact on critically important aspects of patient care and improve the care that is being provided to the Medicare beneficiaries and their families.