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PART I
SECTION A – SOLICITATION/CONTRACT FORM, STANDARD FORM 33
SECTION B – SUPPLIES OR SERVICES AND PRICES/COSTS

B.1. DESCRIPTION OF SERVICES

This is a contract with a Utilization and Quality Control Peer Review Organization (hereinafter referred to as a Quality Improvement Organization (QIO)) in accordance with Section 1154 of the Social Security Act. In performance of the requirements of Section C, Statement of Work (SOW) the QIO will improve health and health care for all Medicare beneficiaries and promote quality of care to ensure the right care at the right time, every time. The QIO shall work on the following Aims and Drivers as detailed in Section C of the 10th SOW:

- Beneficiary and Family Centered Care
- Improving Individual Patient Care
- Integrating Care for Populations and Communities
- Improving Health for Populations and Communities
- Supporting and Convening Learning Action Networks
- Providing Technical Assistance
- Care Reinvention Through Innovation Spread

B.2. TYPE OF CONTRACT

This is a cost-plus-fixed-fee contract.

B.3. CONSIDERATION AND PAYMENT

A. Total Contract Amount

The total estimated cost-plus-fixed-fee for this contract is $ (to be entered at the time of award). The total cost is $ (to be entered at time of award) and the total fixed fee is $ (to be entered at the time of award).

B. Reimbursement

The QIO, upon successful completion of the work required, will be reimbursed monthly in accordance with Section I. FAR clauses 52.216-7 Allowable Cost and Payment (DEC 2002) and 52.216-8 Fixed Fee (MAR 1997). Monthly vouchers shall be submitted in accordance with contract Section G.2 Submission of Invoices and Payment.

C. Table of Total Estimated-Cost-Plus-Fixed-Fee

The QIO shall provide the necessary personnel, materials, services, facilities and supplies (except as may be otherwise specified in the contract) and otherwise do all things necessary for, or incident to, the performance of the work as set forth in Section C, SOW. In consideration of successful contract performance based on the evaluation criteria set
forth in Section C and Section J, the QIO will be reimbursed as stated in the Table of Total Estimated Cost and Fixed Fee provided on the following page:

**TABLE OF TOTAL ESTIMATED-COST-PLUS-FIXED-FEE**

<table>
<thead>
<tr>
<th>AIM</th>
<th>Estimated Cost</th>
<th>Fixed Fee</th>
<th>Total Estimated Cost Plus Fixed Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beneficiary and Family Centered Care (Section C.6 and appropriate C.10 Drivers)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Quality Improvement (Sections C.7; C.8; C.9 and appropriate C.10 Drivers)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Information Systems (IS)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Special Innovation Projects (SIPs) (C.11 and C.12)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**D. Reallocation of Cost**

During contract performance, QIOs are restricted from moving funds across the designated line items of cost shown in the Table of Total Estimated-Cost-Plus-Fixed-Fee (Section B.3.C). Specifically,

- Beneficiary and Family Centered Care (Section C.6) funding cannot be utilized for the performance of any other work.

- Clinical Quality Improvement (Sections C.7, C.8, and C.9) funding cannot be utilized for performance of any other work.

- IS funding cannot be utilized for performance of any other work.

- SIPs funding cannot be utilized for performance of any other work. Additionally SIP funding cannot be reallocated from one SIP to another.
B.4. SCHEDULE FOR PAYMENT OF FIXED FEE

Payment of the fixed fee will be made in accordance with the schedule provided below. As authorized under FAR 52.216-8, after payment of 85% of the fixed fee, CMS may elect to withhold 15% or $100,000 (whichever is less).

<table>
<thead>
<tr>
<th>Month</th>
<th>Payment</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-35</td>
<td>$__________</td>
<td>$__________</td>
</tr>
<tr>
<td>36</td>
<td>$__________</td>
<td>$__________</td>
</tr>
<tr>
<td>Total</td>
<td>$__________</td>
<td>$__________</td>
</tr>
</tbody>
</table>

Note: Regardless of the period of performance of a Special Innovation Project, the associated fixed fee shall be allocated across the remaining months of the contract period (not period of performance for the Special Innovation Project). Therefore, as these projects are incorporated into the contract, the Section B.4 Schedule for Payment of Fixed Fee will be modified accordingly.

B.5. SPECIAL INNOVATION PROJECTS (SIPs)

As provided under Sections C.11 and C.12., and in accordance with the procedures contained in Section G.20, CMS reserves the right to direct the QIO to initiate a SIP not currently defined under the SOW or to approve an application from a QIO to conduct a SIP. SIPs will be awarded on a CPFF basis. The table provided below will be completed (through execution of a formal contract modification) as SIPs are incorporated into this contract.

<table>
<thead>
<tr>
<th>SP Number</th>
<th>CAN</th>
<th>Special Project Title</th>
<th>Period of Performance</th>
<th>Funded Amount</th>
</tr>
</thead>
<tbody>
<tr>
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B.6. CEILINGS

A. General

The cost limitations addressed in this Section apply to the total contract ceiling amount of the contract. The QIO is advised that all costs associated with this contract, either directly or indirectly, are subject to audit.

B. Medical Records Photocopying

The QIO will be paid for a properly certified invoice/voucher for medical records photocopying costs at a rate of $12 per page for reproduction of PPS provider records and $15 per page for reproduction of non-PPS institutions and practitioner records, plus
first class postage. Specifically, hospitals and other providers (such as critical access hospitals) under a Medicare cost reimbursement system, receive no photocopying reimbursement from the QIO. Capitation providers such as HMOs and dialysis facilities receive $0.12 per page.

All other photocopying costs are to be directly charged to the aim to which they apply and shall be reimbursed on the basis of the costs that are allowable. In order for a cost to be determined allowable, the cost must be allocable and reasonable.

C. Overnight Mail

*Contract deliverables shall not* be submitted utilizing overnight mail. All other overnight mailings (e.g., provider-based discharge appeals, etc.) shall be at the discretion of the QIO and are subject to the Contracting Officer’s determination of reasonableness.

D. Indirect Cost Rates

The indirect cost rate ceiling(s) for this contract is/are:

- Leave Rate: (% ____ to be completed at the time of contract award)
- Fringe Benefits: (% ____ to be completed at the time of contract award)
- Indirect Expenses: (% ____ to be completed at the time of contract award)

B.7. TRANSITION SERVICES

In the event that CMS requires transition services from an incumbent QIO to a successor QIO, CMS will request a separate technical and business proposal for these services (see Section H.19.). These services will be incorporated into the contract if applicable.
PART I
SECTION C – DESCRIPTION/SPECIFICATIONS/WORK STATEMENT

C.1. BACKGROUND AND OVERVIEW

The statutory authority for this Statement of Work (SOW) is found in Part B of Title XI of the Social Security Act as amended by the Peer Review Improvement Act of 1982. The Social Security Act established the Utilization and Quality Control Peer Review Organization Program, now known as the Quality Improvement Organization (QIO) Program.

One of the primary statutory missions of the Program, as set forth in Section 1862(g) of the Social Security Act is to improve the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries. In accordance with recent quality efforts, CMS strives to improve the safety, timeliness, and equity of person-centered care.

This SOW contains a number of quality improvement initiatives that are authorized by provisions in the Social Security Act. As a general matter, Section 1862(g) of the Social Security Act mandates that the Secretary enter into contracts with the QIO for the purpose of determining that Medicare services are reasonable and medically necessary, for the purposes of promoting the effective, efficient, and economical delivery of health care services, and of promoting the quality of services of the type for which payment may be made under Medicare. CMS interprets the term “promoting the quality of services” to involve more than the QIO reviewing care on a case-by-case basis, but as covering a broad range of proactive initiatives that are designed to promote higher quality. CMS has, for example, included in the SOW activities in which the QIO shall provide technical assistance to Medicare-participating providers and practitioners in order to help them improve the quality of the care they furnish to Medicare beneficiaries. Additional authority for these activities appears in Section 1154(a)(8) of the Social Security Act, which requires that the QIO perform such duties and functions and assume such responsibilities and comply with such other requirements as may be required by the QIO statute. CMS regards these activities as appropriate if they are designed to directly benefit Medicare beneficiaries.

In addition, Section 1154(a)(10) of the Act specifically requires that the QIO “coordinate activities, including information exchanges, which are consistent with economical and efficient operation of programs among appropriate public and private agencies or organizations, including other public or private review organizations as may be appropriate.” CMS regards this as authority for the QIO to coordinate and operate a broad range of collaborative and community activities among private and public entities, as long as the predicted outcome will likely directly benefit the Medicare program. In addition, Section 1156(c) of the Social Security Act states that it is the duty of each QIO to use such authority or influence as it may possess as a professional organization, and to enlist the support of any other professional or governmental organization having influence or authority over health care practitioners or entities furnishing services in its area, in assuring that each practitioner or entity shall comply with all obligations imposed
on them under Section 1156(a) of the Social Security Act. Under these obligations, providers and practitioners must assure that they shall provide services of a quality that meets professionally recognized standards of care.

C.2. CONTRACT PURPOSE

The purpose of this contract is to support CMS in its efforts to seek to improve health and health care for all Medicare beneficiaries and promote quality of care to ensure the right care at the right time, every time. The Department has developed the National Quality Strategy, which begins to establish national priorities to achieve these goals and proposes as its foundation three broad aims of 1) better health care; 2) better health for people and communities; and 3) affordable care through lowering cost by improvement. The strategy also articulates six priorities that build on the broad aims including:

- Making care safer
- Promoting effective coordination of care
- Assuring care is person and family-centered
- Promoting the best possible prevention and treatment of the leading causes of mortality, starting with cardiovascular disease
- Helping communities support better health
- Making care more affordable for individuals, families, employers, and governments by reducing the costs of care through continual improvement.

The National Quality Strategy notes that an effective national strategy must support effective local strategies. National standards and consistency in their measurement are essential components of the National Quality Strategy. At the same time, the unique needs and characteristics of local communities must be supported to ensure activities that are responsive to and driven by local circumstances, needs and capacities. The QIO will serve an essential role in helping to achieve the goals of the National Quality Strategy by working to achieve their own goals at the local level. In most instances, the local level activities will be conducted in coordination with the National Coordinating Centers that are the entities under contract to CMS, working to support the QIOs by facilitating the flow of information to and from each of the QIOs.

CMS calls upon the QIO to fulfill its statutory requirement of promoting the quality of services by securing commitments and by being conveners, organizers, motivators and change agents and providing a call to action through outreach, education and social marketing; serving as a trusted partner in improvement with beneficiaries, health care providers, practitioners, and stakeholders; achieving measurable quality improvement results through data collection, analysis, education, and monitoring for improvement; facilitating information exchange within the healthcare system; and, dissemination and spread of best practices.

The QIO shall work on the following Aims in the 10th SOW:

C.6 Beneficiary and Family Centered Care
  - Case Review
The QIO has several drivers available to make change and achieve the goals of better health care; better health for people and communities; and affordable care through lowering cost by improvement. C.10 of the SOW describes the “Driver Tasks” (how the work will be done) that the QIO shall perform for a variety of Aims (described in Section C.6 through C.9 of the SOW) that will be dynamic and changing throughout the course of the contract as the needs and priorities of improvement evolve. The QIO shall perform the following “Drivers Tasks” as described in more detail in the following sections:

C.10.1 Supporting and Convening Learning and Action Networks;
C.10.2 Providing Technical Assistance; and
C.10.3 Care Reinvention through Innovation Spread

C.3. TECHNICAL CONSIDERATIONS

The contractor (hereinafter referred to as “QIO”) undertaking this SOW shall comply with all requirements outlined in this contract, together with statutory, regulatory and formal instruction from CMS, through the Contract Officer.

The Glossary (Section J, Attachment 1) and List of Acronyms (Section J, Attachment 2) are incorporated by reference and shall be used when interpreting the requirements of this contract.

**Technical Requirements:** The following Section J, Attachment J-3 documents are incorporated into the contract by reference:

1. QIO Manual
2. Code of Federal Regulations
   a. 36 CFR Part 480
   b. 36 CFR Part 1194
3. 508 Compliance Standards
Information Systems Security Requirements: The following Section J, Attachment J-3 Information Systems documents are incorporated into the contract by reference:

4. QIO Infrastructure Operations and Support Manual
5. QIO Information Technology (IT) Administrator Manual
6. SDPS Database Systems Administrator Guide
7. CMS Information Security Virtual Handbook
8. QualityNet System Security Policy
9. QualityNet Incident Response Procedures
10. CMS Federal Desktop Core Configuration Standards
11. CMS Contractor Website Guidelines
12. CMS Policy for Information Security Program (PISP)
15. IOM Pub. 100-17

C.4. GENERAL REQUIREMENTS

The QIO, acting independently and not as an agent of the Federal Government, shall furnish the necessary personnel, materials, services, facilities, and supplies (except as may be otherwise specified in the contract) and otherwise do all things necessary for, or incident to, the performance of the work as set forth in this SOW.

The QIO shall adhere to the following requirements as they apply to the specific tasks described in Section C.6 – Section C.10.

Additionally, the QIO must comply with all present and future statutes, Federal, Department of Health & Human Services (DHHS), and CMS regulations and program instructions affecting this contract.

C.4.A. Infrastructure Operations Support and Data Management:

Unless otherwise directed by CMS, the QIO shall adhere to the most current version of the policies and procedures outlined and posted on QIONET. These include the QIO Infrastructure Operations and Support Manual, the QIO Information Technology (IT) Administrator Manual, the SDPS Database Systems Administrator Guide, and the QualityNet System Security Policy, QualityNet Incident Response Procedures as well as comply with all present and future statutes, Federal, Department of Health & Human Services (DHHS), and CMS regulations and program instructions relating to providing a secure computer operations environment. Additional Policies and Procedures may be released requiring the QIO to comply.

The QIO shall maintain all necessary documentation that meets or exceeds the performance standards specified in Chapter 8, Infrastructure Operations Support and Data Management, of the QIO Manual and deliverables specified in Section F – QIO Schedule of Deliverables.
C.4.B. Hardware/Software:

CMS, either directly or through a CMS contractor, shall provide each QIO with a file/print server, a domain controller, a database server and a workstation and/or laptop for each 0.5 or greater full-time equivalent (FTE) employee. The servers, workstations and laptops shall be equipped with a standard operating system and a software suite following approved CMS Federal Desktop Core Configuration (FDCC) standards. If a QIO requires additional hardware and/or software, the QIO must receive approval from the Engineering Review Board (ERB) (see Section 2 of the QIO Infrastructure Operations and Support Manual; Attachment J-4 Engineering Review Board [ERB] User’s Guide, and G.19: Purchase Request Users Guide for Obtaining Additional Hardware/Software). The QIO must pay for the additional equipment and software out of QIO contract funds. No additional hardware peripherals or non-approved software may be connected or installed to any GFE without prior written approval by CMS.

C.4.C. Security

1. Certification by Information System Security Officer (ISSO) for Compliance with CMS Systems Security Requirements

The QIO ISSO or equivalent, also referred to as the Security Point of Contact (SPOC), shall assist the CMS ISSO in the security certification of existing controls and compliance with the CMS’ Office of Clinical Standards and Quality’s Quality Improvement Program (QIP) systems security requirements as described in the Federal Information Security Management Act (FISMA), Title III of the E-Government Act of 2002 (Public Law 107-347, 44 U.S.C. Ch 36).

2. Administer Security Program

- The QIO shall comply with all CMS security program requirements as specified within the CMS Information Security (IS) “Virtual Handbook” (a collection of CMS policies, procedures, standards and guidelines that implements the CMS Information Security Program) and the QualityNet Security Policy. The Virtual Handbook can be found at www.cms.hhs.gov/informationsecurity and the QualityNet Security Policy is located at http://qualitynet.org/.

- The QIO shall comply with all security controls outlined in the CMS Information Security (IS) Acceptable Risks and Safeguards (ARS) for “Moderate” systems. Appropriate references are the CMS IS ARS, Appendix B and the CMS System Security Levels by Information Type (located at www.cms.hhs.gov/informationSecurity in the Info Security Library).

- The QIO shall provide CMS with an Information Security plan of action within 30 days of request and begin implementing the plan within 30 days of
approval. The QIO shall maintain any Corrective Action Plan (CAP) associated with deficiencies in the IS Program (e.g., those items identified during a FISMA audit). Moreover, the QIO shall comply with the guidance and requirements of the CMS Information Security Plan of Action & Milestones (POA&M) Procedure, which is located at www.cms.hhs.gov/InformationSecurity in the Info Security Library.

- The QIO shall comply with the CMS Policy for the Information Security Program (PISP) and all CMS methodologies, policies, standards, and procedures contained within the CMS PISP unless otherwise directed by CMS in writing.

- The QIO shall comply with CMS and OIG audits, reviews, evaluations, tests, and assessments of QIO systems, processes, and facilities. The QIO shall provide all related artifacts upon request. The QIO shall deliver the artifacts in the format and method prescribed by CMS.

- The QIO shall correct any findings resulting from FISMA audits that were conducted prior to August 1, 2011 by the completion date noted in the approved CAP. The QIO shall correct any findings resulting from FISMA audits that are conducted after August 1, 2011 by the completion date noted in the approved CAP.

- The QIO shall visit the CMS security website (www.cms.hhs.gov/informationsecurity) and the QualityNet security website (http://qionet.sdps.org) at least every 30 calendar days for updates. [Note: The QualityNet security website is an Intranet website; thus, access is restricted to only active users within the QualityNet Enterprise.] The QIO shall visit the QualityNet Conference website (http://www.qualitynetonline.com/) with appropriate frequency for QualityNet Program and Security briefings and training opportunities. The QIO shall participate in the CMS Security Best Practices conferences and audio conferences as directed by CMS.

The QIO shall document its compliance with CMS security requirements and maintain such documentation in the QIO System Security Plan (SSP) and the Information Security (IS) Risk Assessment (RA) as directed by CMS.

3. **Correct Deficiencies**

- The QIO shall correct any security deficiencies, conditions, weaknesses, findings, or gaps identified by all audits, reviews, evaluations, tests, and assessments, including but not limited to, Office of the Inspector General
(OIG) audits, self-assessments, QIO internal review, QIO security audits, and vulnerability assessments in a timely manner.

- The QIO shall develop, in conjunction with CMS, Corrective Action Plans (CAP) for all identified weaknesses, findings, gaps, or other deficiencies in accordance with IOM Pub. 100-17 (BPSSM) or as otherwise directed by CMS.

- The QIO shall validate (through post-hoc analysis) and document a report of the post-hoc findings that the corrective actions were demonstrated as effective.

- The QIO shall provide CAPs and monthly progress reports (such as the POA&M) to CMS as directed by CMS.

4. Corrective Action Attestation

The QIO shall provide from all involved parties attestation of initiated and completed corrective actions to CMS upon request.

5. Security Review and Verification

- The QIO shall comply with the CMS Security Assessment and Authorization (SA&A) methodology, policies, standards, procedures, and guidelines for contractor facilities and systems (http://www.cms.hhs.gov/InformationSecurity/14_standards.asp#TopOfPage).

- The QIO shall conduct or undergo, as specifically selected and directed by CMS, an independent evaluation and test of its systems security program in accordance with CMS Reporting Standard for Information Security (IS) testing and adhere to the prescribed template (http://www.cms.hhs.gov/InformationSecurity/14_Standards.asp#TopOfPage). The QIO shall support CMS validation and accreditation of contractor systems and facilities in accordance with CMS’ SA&A methodology.

- The QIO shall provide annual certification in accordance with SA&A methodology that certifies it has examined the management, operational, and technical controls for its systems supporting the QIO contract function and considers these controls adequate to meet CMS’ security standards and requirements.
C.4.D. Reporting Requirements:

The QIO shall report to CMS as directed in Section F – QIO Schedule of Deliverables. The QIO shall use all components and adhere to all procedures of the Standard Data Processing System (SDPS) data collection and reporting systems (including those outlined in the SDPS User’s Guide and Section F – QIO Schedule of Deliverables or systems that may replace SDPS functionality) to manage and report work performed under this SOW.

C.4.E. Confidentiality:


The confidentiality training requirement specified in Part 480 (see §480.115) of the regulations is separate and distinct from the Annual QualityNet Security Awareness Training requirement outlined in the ARS (see Section C3.2). The QIO may be required to provide a copy of training materials developed or used to meet the confidentiality training requirement specified in Part 480 of the regulations, as well as documentation that participants of the QIO review system have been trained in the proper handling of confidential information prior to being given access upon request from CMS.

In any instances in which CMS designates Task-related data as quality review study (QRS) information as defined in 42 CFR § 480.101(b) http://edocket.access.gpo.gov/cfr_2002/octqtr/pdf/42cfr480.101.pdf, the QIO is bound by the disclosure limitations for QRS information in § 480.140. In addition, the QIO must ensure that a participating physician, practitioner or participating provider consents to the QIO disclosing this information, as described in § 480.140(d), with identifiers of providers and/or practitioners, to CMS or CMS’s contractors when CMS deems it necessary for purposes of evaluating the performance of the QIO. The physicians and providers cannot consent to the disclosure of patient identified QRS information. If the QIO is in doubt about whether data qualify as QRS data, the QIO must contact the Contracting Officer Technical Representative (COTR). The term COTR replaces the formerly used term Project Officer (PO).

The QIO shall also adhere to Section H of this contract, which limits uses and disclosures of information when the QIO is acting as a business associate of CMS, and contains the business associate agreement required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy and Security Rules; the applicable provisions of the HIPPA Privacy, Security, and Breach Notification Rules; the QIO Manual (which is incorporated by reference); and other relevant Federal laws, regulations and administrative directives as outlined in this contract.
The business associate agreement requirement applies if the QIO conducts any activities on behalf of CMS’ Medicare fee-for-service (FFS) health plan function involving the use or disclosure of protected health information or electronic protected health information such as for payment or health care operations. The business associate agreement in Section H applies only where the QIO is serving as a HIPAA business associate of CMS’ Medicare FFS health plan function, which includes conducting payment or health care operations activities. The business associate agreement does not apply when the QIO is not serving as a HIPAA business associate of CMS’ Medicare FFS health plan function, such as when the QIO is providing health oversight activities as defined by the Social Security Act, based on the authority granted to it by CMS to conduct authorized health oversight activities.

C.4.F. Government Data:

A listing of data to be supplied by CMS and the schedule by which they shall be provided appears in Section J, Attachment J-5 - Data Supplied by CMS. In general, Part A reported data shall be available from the CMS Data Warehouse. CMS Information Systems contractors shall create and deliver to CMS State-level measurement and analytic datasets for distribution to the QIO.

1. **Data Use Agreements** - A Data Use Agreement (DUA) is a legally binding agreement between a QIO and any external entity (e.g., contractor, private industry, academic institution, other Federal government agency, or state agency), that is agreed upon when an external entity requests the use of QIO personal identifiable data. The agreement delineates the confidentiality requirements of QIO data use policies and procedures.

2. **DUA**

   The QIO shall:
   - Use the Data Use Request Form in Remedy, to obtain all the necessary information needed to properly complete the form. The process for using Remedy is outlined in Attachment J-6.
   - Record requests in Remedy from external entities for Health Information Data. The QIO Database Administrator (DBA)/ QIO Data Manager must then make a determination if the data being requested is:
     - Public information and can be released freely,
     - Confidential or Privacy information and cannot be released, or
     - Data that requires a Data Use Agreement (DUA) between the Requestor and the QIO that defines the terms of the data released.
   - Once the determination is made on the type of data being requested, CMS, the DBA and/or Data Managers shall inform the external entity in writing that the data is privacy information and cannot be released and no additional action is needed; the data is public information and provide them with the data or tell
them how to get the data; or a DUA is needed. If a DUA is needed, the QIO shall enter all information pertaining to the DUA in Remedy.

C.4.G. Clinical Data Abstraction Center Subcontract:

The QIO shall enter into a subcontract with the Clinical Data Abstraction Center (CDAC) and shall work directly with the CDAC on records management activities. The CDAC shall: (1) request medical records on behalf of the QIO; (2) work with the QIO to track which medical records have been received; and (3) track and report to the QIO on all photocopying and mailing costs incurred by providers or practitioners. The CDAC may pay the pass-through costs if the QIO chooses to include this as a provision of its subcontract with the CDAC, provided the Contracting Officer (CO) gives written prior approval.

The QIO may choose to subcontract additional functions to the CDAC, as it would to any other potential subcontractor. However, these subcontracting arrangements shall be handled separately from the data abstraction subcontract and shall be individually negotiated between the QIO and the CDAC and the subcontract is subject to pre-approval by the CO.

C.4.H. Coordination with Stakeholders outside the QIO program:

In addition to the required collaborative activities outlined elsewhere in Section C.6, the QIO may coordinate certain of its activities with those of stakeholder organizations in its jurisdiction that are working on comparable improvement efforts or interested in teaming with the QIO. Stakeholders are government entities and private organizations that have common goals with those of the QIO program to work on measures/interventions related to health care quality. Coordination with stakeholders may involve creating, joining, and supporting partnerships with organizations with similar goals and objectives, or facilitating ongoing discussion among the various stakeholders. The nature of the activity to facilitate coordination must be consistent with the terms of the contract to avoid any perceived or actual conflicts of interests and requires advanced approval of the COTR. At a minimum, the QIO will participate annually in collaborative activities that are sponsored by their CMS Regional Office and focus on CMS-identified priority initiatives. Subsequently, they will assist in the facilitation and dissemination of information of the Regional Office collaborative activities related to the Aims of this SOW within their state. Other activities for which the QIO wishes to facilitate collaboration must be approved by the CO and be related to the Aims within the SOW.

C.4.I. Communications:

For communications activities, the QIO shall adhere to the requirements delineated in Chapter 12 of the QIO Manual and Attachment J-7 QIO Communications Handbook. The QIO shall manage its resources as efficiently and effectively as possible. In this regard, CMS recognizes three major sources from which the QIO can obtain marketing materials and resources: (1) other CMS contractors; (2) the ESRD
Networks; and (3) other external sources that provide non-copyrighted materials and resources. In addition, the QIO may develop its own materials.

The QIO shall make available to the general QIO community: (1) any new materials developed by the QIO and approved in writing by CMS for distribution; and (2) any substantial adaptations by the QIO of CMS- or CMS contractor-developed materials which are approved in writing by CMS after the revision and prior to distribution. As part of the CMS approval process, which is detailed in the QIO Communications Handbook (Attachment J-7), the QIO shall provide a copy of such materials in a file format specified by CMS to the COTR.

The QIO shall adhere to review requirements with regard to media activities and/or materials supporting high-profile events and national initiatives. Once a submitted document has been approved by the CMS communications lead, the QIO shall provide a copy of the final version to the COTR and CMS communications lead.

1. **Use of Web Technology:**

   The QIO may create a new website or maintain existing website(s) on which communications pursuant to the QIO's Medicare contract activities appear. The QIO shall adhere to the following in presenting its Medicare contract-related communications on that site(s):
   
   a. Follow the CMS Contractor Website Guidelines as specified in www.cms.hhs.gov/AboutWebsite/13_contractorwebguidelines.asp, which is incorporated into this contract by reference in Attachment J-3. The QIO shall refer to this website at least every 90 days for the current standards and guidelines;
   
   b. Follow the accessibility requirements of the Section 504 and 508 of the Rehabilitation Act of 1973;
   
   
   
   e. Only use the website for informational purposes, no application design usage unless approved in writing by CMS ISSO.

2. **Emergency Preparedness**

   Medicare beneficiaries would likely be affected in the event of many kinds of emergency situations, such as a pandemic flu outbreak. When emergency situations occur, the QIO shall assist CMS’ public health efforts by disseminating information and messages as directed by the CO. CMS shall utilize the QIO’s relationship with providers, including its partnerships and collaborations to serve as additional channels for communications. The QIO, in working with its State’s
health department, shall ensure that the QIO has established point(s) of contact with the Immunization Bureau or others at the health department to assure effective dissemination of HHS and CMS information. The QIO may, as needed and with written approval of the CO, work actively within its State performing activities that would provide advance preparation for a contingency such as:

a. Assist the health department in provider education/information;
b. Participate in the state’s disaster planning process (the QIO is encouraged to establish contacts and to assure that information on existing contacts remains current to ensure clear lines of communication and effective coordination of appropriate actions in advance of any disaster);
c. Participate in the State’s Pandemic Readiness Committee(s) as necessary to help bridge communications between and mobilize physician practices, hospitals, nursing homes, home health agencies and ESRD Networks;
d. Subscribe to established listservs as directed by the COTR for emergencies/disasters and pandemics, as appropriate, to ensure consistency with message and status for pandemic readiness.

The QIO is required to develop and provide to CMS a Continuity of Operations Plan (COOP) and Contingency Plan (CP), to include a Disaster Recovery (DR) Plan, which incorporates the following requirements:

- Detail on how all support operations listed above plus mandatory business operations, (including statutorily mandated case review functions and ongoing quality improvement studies) shall be conducted in the event of a disaster. The plan must address events such as:
  i. Loss of local infrastructure; road access, water, sewer, etc.
  ii. Loss of phone, fax, electricity and/or other utilities
  iii. Loss of building structure
  iv. Loss of staff

- Detail includes a description of devolution of QIO activities for disasters where only the QIO building is impacted (and a same city/State plan suffices) as well as disasters of a broader scope (where business processes may need to be assumed at a more distant location).

- Detail includes a document that describes the essential resources needed in both forms of devolution including:
  o a list of critical skill sets/positions
  o a list of positions that can telework
  o a list of critical applications/systems
  o a list of special equipment needs
o a list of records (documents, databases, forms, etc.) required to execute the task
o a list of QIO support contractors, such as subcontracts for case review support

- Describes the QIO’s plan for notification to CMS (program, COTR, ISSO and Contracting Officer (CO) at a minimum) when the Plan is activated.
- Addresses how the QIO shall communicate to providers and beneficiaries when the Plan is activated.
- Addresses how the QIO shall receive referrals from CMS, FIs/Carriers/MACs, providers/practitioners, or beneficiaries if the Plan is activated.

Prepare each year an annual “Table Top” test plan to evaluate the effectiveness of the COOP/CP/DR that is, at a minimum, a structured walk-thru of the plan with all key staff needed for CMS to evaluate the plan. Follow the guidance and requirements provided in the CMS Information Security Application Contingency Plan Procedure and CMS Information Security Contingency Plan (CP) Tabletop Procedure that can be found at www.cms.hhs.gov/InformationSecurity in the Info Security Library, which is incorporated by reference in Attachment J-3.

C.4.J. Education, Information and Outreach:

Specific Education, Information and Outreach requirements are described throughout Section C.6. to C.10.3 of this contract. In general, to the maximum extent practicable, the QIO shall use communications evaluation methods to determine whether a QIO activity is effective and worth repeating or sharing with other QIOs.

In developing its own local products, a QIO must effectively manage adherence to CMS policy requirements and agency and Departmental directives. In addition, a QIO must ensure it is meeting the communications needs of individuals who do not speak English as their primary language (that is, are limited English proficient) or who are deaf or hard of hearing. The communication product must be developed using plain language that is easily understood by persons with a range of educational backgrounds.

The specific guidelines to which QIO-generated communications materials must adhere are included in Chapter 12 of the QIO Manual and/or the QIO Communications Handbook (Attachment J-7).

The QIO shall partner with fee-for-service contractors such as the FIs and MAC and provide them with information and education materials regarding 10th SOW initiatives. The FFS contractors will then use the information and materials as they provide customer service, education and training to beneficiaries, providers/physicians/suppliers in the State.
C.4.K. Internal Quality Control:

The objectives of the Internal Quality Control (IQC) program are to support and foster continuous quality improvement within the QIO in support of each of the Sections of this SOW.

The QIO shall implement an IQC program as described in Sections 13000–13030 of the QIO Manual incorporated by reference in Attachment J-3. CMS encourages each QIO to collaborate with other QIOs in developing and implementing IQC programs. The QIO shall share lessons learned regarding these IQC activities with other QIOs using the available mechanisms, including QIO conferences, newsletters, and databases. The QIO shall submit its IQC plan in accordance with Section F – QIO Schedule of Deliverables.

The QIO shall also execute a subcontract with the Survey Contractor (TBD) under the QIO’s contract, as directed by CMS and in accordance with Attachments J-8 and J-8a, Survey Subcontract, to assist the QIO in obtaining objective feedback from stakeholders as required in Sections C.6 to C.10, such that the Survey Contractor (TBD) agrees to be bound by the security and privacy requirements that are contained in the provisions contained in the QIO’s “business agreement” with CMS. As directed by CMS, the QIO shall work directly with the Survey Contractor (TBD) on evaluation contact information and respond to the Survey Contractor (TBD) on any inquiry from the Survey Contractor related to the evaluation work. The QIO shall establish under the subcontract that the Survey Contractor (TBD) shall work with the QIO to obtain the contact information and respond to the QIO within 3 business days on any status inquiry related to surveys. The QIO shall submit deliverables in accordance with Section F – QIO Schedule of Deliverables.

C.4.L. Information Collection Activities:

A QIO that seeks to conduct information collection activities, including surveys, as part of its work on the activities in Section C.6, shall do so in accordance with the Paperwork Reduction Act, Sections 12600–12670 of the QIO Manual, and other administrative directives.

The QIO shall adhere to the most current OMB standards for data on race and ethnicity. These standards can be located at: http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=172. Specifically, reference Provisional Guidance Appendix A, which are the standards for maintaining, collecting, and presenting federal data on race and ethnicity.

C.4.M. Independent Evaluation:

The QIO shall fully facilitate and provide requested data, subject to the QIO confidentiality provisions in Section 1160 of the Social Security Act and 42 CFR Part 480, for any evaluation of the QIO Program that the Secretary, or CMS on behalf of the Secretary, chooses to conduct using an external contractor. Evaluation subcontract is found at Attachment J-9.
C.4.N. Systems Development:

The QIO shall develop software only with prior written approval from the CMS CO, QIO Security Officer and its COTR via the process outlined for such requests and the QIO shall follow all current QualityNet Systems/Software Development Life Cycle (SDLC) procedures and rules. The software must comply with all Federal Section 508 accessibility, security and software development guidelines/standards.

The QIO’s Quality Assurance (QA) and Internal Quality Control (IQC) measures must be structured to ensure that the application code being delivered to CMS, is built to meet the Federal security mandates to minimize any “High” or “Moderate” vulnerability findings when the application is subject to an independent Security Testing & Evaluation (ST&E) engagement as defined in CMS Policy for the Information Security Program (PISP) - 4.15.11. Developer Security Testing (SA-11) which is incorporated by reference in Attachment J-3 and found at [http://www.cms.hhs.gov/InformationSecurity/13_Policies.asp#TopOfPage](http://www.cms.hhs.gov/InformationSecurity/13_Policies.asp#TopOfPage).  

C.5. OVERALL CONTRACT EVALUATION

Under this SOW, the QIO’s performance will be evaluated based on achievement associated with the “Aims” and “Drivers” as described in Sections C.6 to C.10 of this Statement of Work (see Attachment J-10 for measures and targets).

The “Aims Tasks” the QIO will be evaluated on are as follows:

C.6 Beneficiary and Family Centered Care
  • Case Review
  • Patient and Family Engagement Campaign

C.7 Improving Individual Patient Care
  • Reduction of Health-Care Acquired Conditions
  • Quality Reporting and Improvement

C.8 Integrating Care for Populations and Communities
  • Improving Care Transitions Leading to the Reduction of Readmissions

C.9 Improving Health for Populations and Communities
  • Promotion of Immunizations and Screenings
  • Cardiovascular Health Campaign

The “Driver Tasks” the QIO will be evaluated on are as follows:

C.10.1 Supporting and Convening Learning and Action Networks;
C.10.2 Providing Technical Assistance; and,
C.10.3 Care Reinvention through Innovation Spread (CRISP) Model

If a QIO is not tasked to work on a specific area under an “Aim” and/or “Driver” the QIO will not be evaluated under that particular area. Any Special Innovation Project that the
QIO may carry out will be evaluated separately and will not be considered in the overall evaluation criteria.

CMS will conduct monitoring activities throughout the course of the contract and will act upon findings as necessary. Additionally, there will be two periods of more formal evaluation under this SOW. The first evaluation will occur at the end of the 18th month of the contract. The second evaluation will occur at the end of the 27th month of the contract. The evaluations will be based on the most recent data available to CMS. The performance results of the evaluation at both time periods (that is 18 months and 27 months) will be used, in addition to ongoing monitoring activities, to determine the performance on the overall contract.

18th Month Contract Evaluation

The 18th month contract evaluation will determine if the QIO has met the performance evaluation criteria as specified in the “Aims” and “Drivers” areas of the 10th SOW. The achievement within each of the “Aims” and “Drivers” will be evaluated on an individual basis for appropriate contract action. Though, in general, evaluation of each “Aim” and/or “Driver” will relate only to that area, CMS reserves the right to take appropriate contract action in the event of failure in multiple “Aims” and/or “Drivers”.

18th Month Evaluation Criteria:

- **Pass**: Criteria met for the “Aim” and/or “Driver” as specified in the evaluation section of the “Aim” and/or “Driver”.
- **Fail**: Criteria not met for the “Aim” and/or “Driver” as specified in the evaluation section of the “Aim” and/or “Driver”.

27th Month Contract Evaluation

The 27th month contract evaluation will determine if the QIO has met the performance evaluation criteria as specified in each of the “Aims” and “Drivers” areas of the 10th SOW. The achievement within the “Drivers” and “Aims” will be evaluated on an individual basis for appropriate contract action.

27th Month Evaluation Criteria:

- **Pass**: Criteria met for the “Aim” and/or “Driver” as specified in the evaluation section of the “Aim” and/or “Driver”.
- **Fail**: Criteria not met for the “Aim” and/or “Driver” as specified in the evaluation section of the “Aim” and/or “Driver”.

Overall Contract Evaluation

The results of the 18th and 27th month evaluation periods, in addition to ongoing monitoring activities, will be used to determine how the contractor performed on the overall contract.
If CMS chooses, CMS may notify the QIO of the intention not to renew the QIO contract, and inform the QIO of the QIO’s rights under the current statute.

Any failure at the 18th or 27th month evaluation for any “Aim or Driver” may result in that QIO receiving an adverse past performance evaluation. Further, failure may impact on the QIO’s ability to continue similar work in or eligibility for award of the 11th SOW.

The list of measures and performance criteria for each QIO will be recorded on the CMS Dashboard, which will be available on QIOnet (http://qionet.sdps.org), the standard information system that supports the QIO Program. CMS will also post these measures on the publicly accessible CMS website (http://www.cms.gov).

CMS will monitor the QIO’s performance on the “Aims” and “Drivers” against established criteria on at least a quarterly basis, and may take appropriate contract action (e.g., providing warning for the need for adjustment, instituting a formal correction plan, terminating an activity, or recommending early termination of a contract because of failure to meet contract timelines as specified in Sections C.6 through C.10.).

CMS reserves the right at any point, prior to the notification of CMS’ intention not to continue the option for an “Aim” and/or “Driver” and/or to renew the contract, to revise measures or adjust the expected minimum thresholds for satisfactory performance or remove criteria from an “Aim” and/or “Driver” evaluation protocol for any reason, including, but not limited to, data gathered based on experience with the amount of improvement achieved during the contract cycle or in pilot projects currently in progress, information gathered through evaluation of the QIO Program overall, or any unforeseen circumstances. Further, in accordance with standard contract procedures, CMS reserves the right at any time to discontinue an “Aim” and/or “Driver” or any other part of this contract regardless of QIO performance on the “Aim” and/or “Driver”.

The rounding of results and targets at the 18th and 27th months will be accomplished as noted below:

1. CMS will not round the interim results of calculations used to produce results. (i.e., CMS will not round the results from steps used to calculate the target or result);

2. Integers. For discrete numbers of cases required for improvement, round to the more favorable (typically lower) integer with a minimum of one.

3. Percentages/Proportions. Use conventional rounding “round half up” (e.g., for one significant digit, round to nearest integer with tie-break rule of “half-up.” 5.4 will become 5 whereas 5.5 will become 6. Apply conventional rounding to one additional significant digit beyond that used to specify the target. (e.g., for a target expressed as an integer, 5% RI, 4.46% rounds to 4.5% and 4.44% rounds to 4.4%).
C.6 BENEFICIARY AND FAMILY CENTERED CARE

C.6.A. Background -- Beneficiary and Family Centered Care

Healthcare is personal, and the experience with the health care system is different for each individual. An individual’s experience of the health care system is influenced by his or her personal preferences and values, family situation, cultural traditions, and lifestyle. CMS strives to promote health care that is respectful of and responsive to individual patient preferences, needs and values.

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.

C.6.B. Definitions – Beneficiary and Family Centered Care

1. **Case Review**: A comprehensive review of information from multiple data sources that constitutes an analysis of the care and services provided to the beneficiary during an episode of care.

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.

2. **Quality of Care Review**: A Quality of Care Review is a type of case review of all quality of care concerns originating from beneficiary or beneficiary representative complaints or referrals from other persons/entities, or identified in the course of other QIO activities. These kinds of reviews can involve determinations of whether care was reasonable and medically necessary, met professionally recognized standards of health care, or was provided in the appropriate setting. However, the reasonable/necessary and appropriate setting determinations should only be performed for purposes of determining whether these elements had quality ramifications, as part of a single case review, when another entity (e.g., a MAC, RAC, ZPIC and, under certain circumstances, the OIG) has or will review the case for utilization and
payment concerns. The review must, where applicable, take into account the following:

a. The beneficiary’s medical condition(s)/disease(s)/illness(es), the treatment plans for these conditions/diseases/illnesses provided by providers and practitioners, and the health outcomes derived from the execution of these treatment plans;

b. The appropriateness of transfers, discharges, terminations of service, and/or readmissions;

c. Any negative consequences of care and services provided to the beneficiary, including adverse events and Medicare “never events” or other health-care associated conditions;

d. The appropriateness of Medicare-covered tests and procedures performed and a review of their results related to the quality of care concern(s);

e. Whether the health care met professionally recognized standards of care for services covered under Medicare including dually eligible beneficiaries;

3. **Case Review Management Information System (CRMIS):** A centralized data repository for all case review activities. CRMIS will allow CMS, CMS-designated contractors, and the QIO to track, monitor, analyze and evaluate data to identify opportunities to improve the quality of care and services for beneficiaries and to evaluate the efficiency and effectiveness of case review processes. The CRMIS will also provide new functionalities that promote electronic medical record exchange, automated correspondence exchange, and will allow CMS and QIO users to perform quality data pattern analysis (Attachment J-17).

4. **Beneficiary and Family Centered-Care National Coordinating Center:** The National Coordinating Center is a CMS and QIO support contractor that provides certain functions to support the QIO program (Attachment J-15a). As part of this support, the National Coordinating Center serves as a Strategist for early identification of problematic issues, root cause analysis, and development of solutions for Beneficiary-and Family-Centered Care challenges;

**C.6.C. Review Requirements – Beneficiary and Family Centered Care**

The following subsections provide details of actions that the QIO must perform in support of Beneficiary and Family Centered Care. Note that the principles articulated in C.6.C.1.a–d are applicable to all of the Aims Tasks in the SOW.

1. **General Requirements:** **The QIO must work with beneficiaries, providers, physicians, and other practitioners to:**
   a. Promote beneficiary and family centered care approaches in health care delivery settings including physician offices;
b. Ensure that the beneficiary and other involved members of the public are afforded a process perceived as helpful and fair;
c. Assist providers in optimizing processes, including customer service;
d. Promote high-quality health care and improve the quality of care provided to beneficiaries, thereby improving health outcomes and aligning with the National Quality Strategy. Data generated by the QIO in the course of performing case reviews will be collected and used to support informed decision-making and quality improvement interventions and enable the appropriate, authorized, and timely access to and use of electronic health information to benefit public health;
e. The QIO must implement follow-up action for identified quality of care concerns for individual cases as well as analyze data collected through the process of carrying out the task of this Aim to determine if there are system-wide patterns of quality of care concerns. The QIO shall either refer information on patterns of care to the appropriate Learning Network for action or take other action to address patterns of quality of care concerns.
f. Promote transparency and the engagement of beneficiaries for the purposes of empowering beneficiaries to make informed choices regarding their health care;
l. The QIO must ensure the availability of appropriate personnel to conduct reviews on business and non-business days and within established timeframes, as required by CMS.
m. The QIO shall participate in 60-minute monthly calls with the Beneficiary and Family Centered Care National Coordinating Center for identification of problematic issues, root cause analysis and development of solutions for Beneficiary and Family Centered Care challenges.

a. **Specific Review Requirements: The QIO must work with beneficiaries, providers, physicians, and other practitioners to:**

2. Evaluate and respond to all beneficiary complaints about the quality of services they have received, as described in §1154(a)(14), and referrals from other organizations, or identified in the course of other QIO activities, to improve the quality of care and services;
3. Perform all other statutorily mandated case reviews, as directed by CMS and in coordination with the MACs and any other entities that may already be performing or will perform some aspects of these reviews, in order to avoid duplication of effort.
4. The QIO must also refer potential fraud and abuse trends uncovered during the review of CRMIS data to the appropriate referral organization.

5. The QIO must issue technical denials for non-receipt of hospital medical records from providers in accordance with CMS instructions.

6. When making determinations about whether care was reasonable/medically necessary and/or provided in the appropriate setting, the QIO must make payment determinations as described in §1154(a)(2).

b. Emergency Medical Treatment and Labor Act (EMTALA) Reviews – Potential Anti-Dumping Cases

a. The QIO must provide timely, complete and clinically sound physician opinions for 5-day and 60-day reviews as required by the Social Security Act for cases involving potential EMTALA violations.

b. Potential quality of care concerns identified during an EMTALA review must be included in the QIO’s report to CMS and entered into the case review information system as part of this review.

4. Reviews of Provider Discharges/Service Terminations and Denials of Hospital Admissions

a. To ensure continued access to care when appropriate, the QIO must respond within required timeframes to beneficiary- or beneficiary representative–initiated requests for QIO review of a fee-for-service (FFS) or Medicare health plan provider’s discharge/termination of service decision (SNF, home health, CORF, FFS hospice, hospital swing bed, and hospital inpatient services). In carrying out these review responsibilities, the QIO must make a determination of whether continued care would be reasonable and medically necessary and allowable under Section 1862(a)(1) and (9) and whether care is being provided in the appropriate setting in order to validate that the discharge/termination of service is appropriate and the appropriate discharge planning has occurred in accordance with established clinical guidelines. The QIO must have mechanisms in place to accept appeal requests 24 hours/day, 7 days/week and 365 days/year.

b. The QIO must ensure that the beneficiary’s rights are honored by validating the provider’s timeliness of notices issued to the beneficiary.

c. As requested by a beneficiary or beneficiary’s representative, the QIO must review denials of hospital admission in response to the
issuance of both Preadmission and Admission Hospital-Issued Notices of Non-Coverage (HINNs) and Hospital-Requested Reviews to determine whether the care is reasonable and medically necessary and whether admission would involve the appropriate setting.

d. The QIO must, as statutorily required, conduct reconsiderations of cases in which the QIO has rendered an initial decision, in accordance with CMS instructions.

5 Higher-Weighted Diagnosis-Related Group (HWDRG) Reviews

Higher-weight DRG reviews shall be uploaded into CRMIS by the CMS systems production team.

a. The QIO must identify the beneficiary’s principal and secondary diagnoses, the principal procedure, and, possibly, the discharge disposition, affecting the HWDRG assignment.

b. The QIO must review the attending physician’s description of the care provided and other relevant information to ensure that the care provided accurately matches the provider’s claims for payment.

c. The QIO must complete Medical Necessity reviews as part of the HWDRG review to determine whether services and/or items are or were reasonable and medically necessary and allowable under Section 1862(a)(1) and (9).

d. HWDRG reviews must contain at least a sample of ASC services, as described in §1154(d), which the QIO must review for all aspects of review described in §1154(a)(1).

e. If the QIO identifies quality of care concerns in its reviews, these concerns must be thoroughly document.

f. The QIO must enter payment adjustment information into the Case Review Management Information System.

6. Other Case Reviews

As directed by CMS, the QIO shall perform the following activities:

a. Physician Acknowledgement Monitoring: In accordance with CMS Internet-Only Manual instructions, SDPS and TOPS memos, and other CMS policy directives, the QIO shall conduct physician acknowledgement monitoring to ensure that each hospital has on file a physician acknowledgement statement for physicians billing for services provided in that hospital.
b. Assistants at Cataracts: Conduct reviews for assistants at cataract surgeries in accordance with CMS instruction and Section 1862 (a)(15)(A).

7. Quality of Care Reviews
   a. The QIO must monitor beneficiaries’ experiences with emerging models of care such as Accountable Care Organizations (ACOs) or payment reforms such as Value-Based Purchasing (VBP) programs by monitoring the nature of complaints to determine if there are patterns or trends associated with the care delivery system.
   b. The QIO must fully participate in an exchange of information with the Beneficiary and Family Centered Care National Coordinating Center to ensure timely and complete data entry as necessary for conducting review activities.
   c. For beneficiary initiated reviews, the QIO must develop and send a written response to the beneficiary, or as appropriate, to the beneficiary’s representative, that states the beneficiary’s allegations, the investigative methods used, the findings, and the beneficiary’s right, as applicable, to a reconsideration of the QIO’s review decision. The written response must be sent to the beneficiary and entered into CRMIS within CMS-established timeframes.
   d. If, during the QIO’s review, the QIO identifies a new quality of care concern that was not reported during the initial request for a review, the new quality of care concern must be entered into the CRMIS, counted as part of the current review process, and evaluated within the current review timeframe.
   e. The QIO shall utilize all evidence from its interviews and multiple data sources beyond the medical record to determine if care and services met evidence-based, professionally recognized standard(s) of care. The findings must integrate the beneficiary’s perceptions and values, medical diagnoses, and conditions with evidence to support the QIO’s determination.
   f. The QIO shall perform quality of care review on all readmission cases referred from the MAC and health plans.

8. Potential Discriminatory Conduct
   If it is suspected during a case review that care is being compromised or denied due to discrimination on the basis of race/ethnicity, religion, national origin, age, sex, familial status, sexual orientation, gender identity, disability, or veteran status, the QIO must refer the case to the Office for Civil Rights (OCR) and the CMS COTR.
9. **Collaboration**

The complexities of the current health care system may cause confusion for many beneficiaries and their families on how to access their benefits, navigate the health care system, and/or select a provider of care. The QIO are uniquely positioned and expected to address the knowledge gaps by promoting beneficiary and family centered care through the QIO’s existing relationships with the physician and provider community.

In carrying out its responsibilities on all Beneficiary and Family Centered Care functions, the QIO must:

a. Collaborate with CMS contractors and other entities, including Survey Contractors, State Survey Agencies (SAs), other appropriate state agencies, MACs, Qualified Independent Contractors (QICs), the Office of Inspector General (OIG), OCR, and pertinent state-based organizations such as patient advocacy groups and patient safety organizations;

b. Cooperate and coordinate with, and provide complete and timely information to, a CMS-designated contractor that will survey beneficiaries about their quality of care concerns and appeal of provider discharge/terminations experience with the QIO’s processes. The QIO must cooperate/coordinate with the contractor for the efficient and effective conduct of these surveys;

c. Subcontract with the Beneficiary and Family Centered Care National Coordinating Center (a QIO support contractor) to ensure efficiency and effectiveness in carrying out beneficiary protection activities as described in Attachment J-15a;

d. The QIO must collaborate with the Beneficiary and Family Centered Care National Coordinating Center to document and disseminate best practices and proven care methods.

10. **Technical Assistance**

It is difficult to obtain the best possible outcome of care without patient engagement, because many beneficiaries find it difficult to understand how to access their benefits, navigate the health care system and/or select a provider of care. The QIO are uniquely positioned to promote beneficiary and family centered care through patient activation efforts that are designed to encourage the use of available quality data and to help shape the future of transparency efforts.

a. The QIO must offer technical assistance to beneficiaries, providers, physicians, and practitioners when the QIO:

   i. Is performing all review functions;
   ii. Has confirmed quality of care concerns;
   iii. Has concluded its review and notified the beneficiary or the beneficiary’s representative of the outcome of its review
and ensured that providers/practitioners, and/or the Medicare health plans have been informed of findings from the QIO review and have exercised their reconsideration rights.

b. The QIO must analyze findings from CRMIS, which is the system into which the QIO must enter specified information about the case review, other information from review activities, and provider performance measures for trends and patterns. The QIO must use the findings to identify needs for technical assistance related to CMS measures across provider settings, and to promote evidence-based medical practice and patient-centered care principles to improve quality of care and outcomes to beneficiaries. Trends and patterns will be addressed in coordination with the Beneficiary and Family Centered Care National Coordinating Center.

c. The QIO must develop measurable interventions for provider/physician practices and address systemic confirmed concerns.

d. The QIO must provide assistance to health care institutions on how best to employ such best practices and proven methods to improve health care quality and lower costs.

11. Reports

The QIO must publish Annual Reports following the publication deadlines and content and format requirements outlined in CMS TOPS/SDPS Memos and Manual instructions. The report must describe improvements around findings from case reviews and serve as a resource for the various quality improvement interventions and Learning and Action Networks throughout the other Aims of the contract. The reports are due July 31, 2012, July 31, 2013 and June 30, 2014. At a minimum, the report must include aggregate data from the CRMIS supplemented with other aggregate QIO information on:

a. Types of quality of care concerns confirmed with numbers for each category;

b. Types of serious reportable and other undesired/harm outcomes to the beneficiary with associated medical diagnoses;

c. Provider/practitioner data and performance measures related to confirmed quality of care concerns;

d. Number of beneficiaries linked to discharge/service termination reviews who were discharged to home, skilled nursing facility, nursing facility, home health agency, assisted living facility, or other living arrangements;

e. Number of beneficiaries readmitted to hospitals within less than 30 days and associated diagnoses;

f. Number of beneficiaries and their geographic areas, racial/ethnic designations, primary language spoken, and associated medical
diagnoses/illnesses/diseases;
g. Number and type(s) of technical assistance implemented for each category of concerns;
h. List of evidenced-based standards used to support decisions and recommendations for changes; and
i. How the findings can be used to support comparative effectiveness research.

12. Inter-rater Reliability

The QIO must meet monitoring targets for inter-rater reliability studies. The sample of cases will be drawn as specified by the Beneficiary and Family Centered Care National Coordinating Center. The sample of cases is expected to include beneficiary/beneficiary representative-initiated Quality of Care Reviews, Quality of Care Reviews for referred cases, and HWDRG reviews.

13. Transparency

The QIO must demonstrate transparency through reporting on an annual basis, making available to the public the Task 11 annual report per the CRMIS reports and participating in other transparency activities as directed by CMS.

14. Sanctions

If a QIO identifies a provider’s or practitioner’s violation of obligations under Section 1156(a) of the Social Security Act, the QIO must coordinate with the Beneficiary and Family Centered Care National Coordinating Center to submit a report and recommendations to the OIG under the circumstances described in Section 1156(b) of the Social Security Act.

a. The QIO must detect and report suspected patterns of fraud and abuse and civil rights violations that must be subject to rapid improvements and potential sanctions.

The QIO must provide to investigative agencies (including OIG) upon request, in accordance with procedures and safeguards established by the Secretary, data and information that may identify specific providers or practitioners as may be necessary to assist in investigating cases or patterns of fraud or abuse.

C.7 IMPROVE INDIVIDUAL PATIENT CARE

Two of the six priorities that build on the broad aims of the National Quality Strategy for Quality Improvement in Healthcare include making care safer and making care more affordable for individuals, families, employers, and governments by reducing the costs of care through continual improvement. These are priorities that coincide with the purposes and activities of the QIO Program. This section of the SOW includes actions that address
both of these priorities. The Patient Safety initiatives are designed to help achieve the goals of improving individual patient care throughout the course of the contract. Initiatives will change or evolve over the course of the contract with some initiatives phased in at different time periods within the SOW. Each of the definitions, initiatives, and detailed specifications for Patient Safety are described below, in the sections that follow:

C.7.1. Reducing Healthcare-Associated Infections (HAIs)

C.7.1.A. Background- Reducing Healthcare-Associated Infections

The HHS Steering Committee, comprised of multiple Agencies such as the Office for Healthcare Quality (OHQ), the Centers for Disease Control and Prevention (CDC), the Agency for Healthcare Research and Quality (AHRQ) and CMS, is responsible for coordinating Department HAI activities. In the HHS National Action Plan to Prevent Healthcare-Associated Infections: Roadmap to Elimination a tiered approach has been taken to health care-associated prevention and reduction, with one of the major priorities being reducing HAIs in the hospital setting.

Other stakeholders have also been called upon to lead efforts that translate evidenced-based knowledge into comprehensive operational systems which produce results that can be measured and replicated. One of the most successful projects was the Keystone Project which, within 18 months, successfully reduced the rate of central line bloodstream infections (CLABSI) in more than 100 Michigan hospital intensive care units, saved 1,500 lives and $200 million in health care expenditure.

As a component of the HHS Action Plan, a Comprehensive Unit-based Safety Program (CUSP) supports the national implementation of the program to reduce CLABSI and catheter-associated urinary tract infections (CAUTI). In the 10th SOW, QIOs shall participate in the CUSP: CLABSI, CUSP: CAUTI initiative as described below to reduce these HAIs both in the ICU and non-ICU setting. In line with departmental goals, the QIO shall also participate in the reduction of other HAIs such as Clostridium difficile infections (CDI) and Surgical-Site Infections (SSI).

The QIO shall lead a local learning and action network utilizing the requirements of Section C.10.1, Convening and Sustaining Learning and Action Networks, to address HAIs. The local learning and action network shall work in collaboration with the Patient Safety National Coordinating Center (a QIO support contractor) to focus on the reduction of CLABSI, SSI, CAUTI and CDI in hospitals. As learning and action networks must be flexible to meet the needs of the participants, the QIO shall facilitate a process which will require that participants, at a minimum are reporting CLABSI, CAUTI and/or CDI to the National Healthcare Safety Network (NHSN). The QIO shall engage participants in CLABSI reduction activities unless the QIO can demonstrate that at least 60% of the IPPS facilities in the state have a CLABSI rate of 1.5 per 1000 central line
days or less. If the QIO meets this requirement, it can move immediately to recruiting facilities for the reduction of CDI. (There is no minimum threshold for CAUTI incidence.) The QIO should progress to introducing CDI activities to the learning network by January 1, 2013. The QIO shall also introduce the reduction of SSI tools to the learning network at anytime that the network is ready to receive them but no later than January 1, 2013.

C.7.1.B. Specific Requirements- Reducing Healthcare-Associated Infections

1. Recruitment and Eligibility Criteria

   a. The QIO shall recruit participants for this initiative from the following settings: ICU and non-ICU hospital wards.

   b. The QIO shall recruit hospitals that are already reporting HAI data to the NHSN and who can be data ready with at least 6 months of baseline data for CLABSI and/or CAUTI no later than October 31, 2011, the recruitment deadline.

   c. The QIO shall recruit only those facilities that have a CLABSI rate at or above 1.5 per 1000 central line days

   d. The QIO shall secure the commitment of all participating facilities by obtaining a commitment letter signed by at least two members of hospital or facility leadership, one being a member of the hospital board of directors.

   e. In anticipation of progressing to CDI reduction, the QIO shall recruit hospitals for work in preventing and reducing CDI as soon as practical but no later than January 31, 2013. Those facilities with CDI facility wide incidence rates equal or greater than 6 Healthcare Onset (HO)-CDI cases per 10,000 patient days are eligible to be recruited.

   f. The QIO shall work with their hospitals recruited for CDI work to confer rights to the NHSN and Patient Safety National Coordinating Center to ensure accurate collection of a six (6) month baseline of CDI incidence data no later than January 31, 2013.

   g. At anytime the QIO shall introduce CMS approved tools to learning and action network participants for the reduction of SSI and secure written commitments from previously recruited participants to engage in SSI reduction activities. The commitment letters should be signed by at least two members of hospital or facility leadership, one being a member of the hospital board of directors.
h. At anytime the QIO may continue to add members to the learning network over and above the agreed upon number of participants. Learning network participants need not be limited to hospitals when participants agree that other members are necessary to ensure success.

i. 2. Learning and Action Network – HAI – CLABSI, CAUTI, CDI and SSI
The QIO shall perform the requirements utilizing the driver outlined in Section C.10.1.: Supporting and Convening Learning and Action Networks and the specific requirements of this section.

The QIO shall:

a. Train or attest that recruited facilities have been trained on CUSP methodology for CLABSI and CAUTI by January 31, 2012.
b. Gain agreement from and provide technical assistance to all recruited facilities that leads to a system of tracking and monitoring for hand hygiene.
c. Implement an evidence-based method such as a trigger tool or similar tracking method for central line and urinary catheters to track and prompt providers to remove unnecessary catheters and central lines.
d. In collaboration with the Patient Safety National Coordinating Center, the QIO shall identify and disseminate a protocol in all recruited wards for monitoring and reporting adherence to Central Line Insertion Practices (CLIP) into the NHSN.
e. In collaboration with the Patient Safety National Coordinating Center, the QIO shall disseminate tools to assist with education and training for patients, caretakers and/or families on preventing HAIs including but not limited to, catheter and central line maintenance, prevention of transmission, hand hygiene, alternatives to long-term catheter placement and appropriate vaccination practices.
f. In coordination with the Patient Safety National Coordinating Center, the QIO shall introduce tools for the reduction of CDI to learning and action network participants by January 1, 2013 in an effort to reach reduction targets.
g. In coordination with the Patient Safety National Coordinating Center, the QIO shall introduce tools for the reduction of SSI to learning and action network participants by January 1, 2013.
h. Identify high-performing facilities or facility units with low rates of HAIs (< or equal to 10th percentile) to serve as mentors to targeted hospitals working on HAI reduction in order to connect mentor and recruited hospitals for the purpose of best practices sharing.
3. **Partnerships**

With the prior approval of CMS COTR and/or GTL, the QIO shall partner with entities within the state such as the CDC, state health departments, state hospital associations, Medicare Advantage Plans and local and community organizations that are actively engaged in implementing the State HAI Plans or other such public or private initiatives. The QIO will partner for the purpose of performing the requirements of this section without duplicating the State or Federally-sponsored efforts.

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

C.7.2.A. **Background- Reduce Healthcare Acquired Conditions (HACs) by 40% in nursing homes.**

The HHS Aim is to reduce health care acquired conditions for Medicare patients nationwide by 40% over the next three years. The QIO will contribute to attaining this goal in the nursing home setting by working to reduce various HACs (to be identified by CMS prior to the Phase II launch of this project). Phase I of this project includes the QIO providing technical assistance to facilities on the reduction of Pressure Ulcers (PrU) and Physical Restraints (PR). This phase will begin at the launch of the 10th SOW and continue to the point of moving to sustainability mode as defined in Section C.10.1.B by the 18th month (January 31, 2013).

The Second phase of this work will begin on or before February 1, 2013 in the form of a National Nursing Home Learning and Action Network. The QIO will expand their efforts beyond physical restraints and pressure ulcers in nursing homes and begin to address other HACs for which an evidence base has been established, as directed by CMS. The QIO shall lead a local Learning and Action Network utilizing the requirements of Section C.10.1, Convening and Sustaining Learning and Action Networks, to address HACs. As part of the learning network, the QIO will participate and facilitate the Learning and Action Networks from on or before February 1, 2013 through July 31, 2014, at which time the QIO has prepared the learning and action network to continue in sustainability mode. The learning network teams will be determined by achieved target status and interest. During the SOW, they will be given the opportunity to continue working on HAI, PrU and PR prevention as well as the opportunity to work with other HACs such as CAUTI and Falls. Other HACs will be identified depending on both availability of evidenced-based interventions, and data.

C.7.2.B. **Specific Requirements: Reduce Healthcare Acquired Conditions by 40% in nursing homes: Pressure Ulcers and Physical Restraints (Phase I: First 18months)**

The QIO shall implement efforts in their state to reduce high risk pressure ulcer and physical restraint rates. The Aim is to dramatically reduce the rate of Pressure Ulcers and eradicate the use of unnecessary physical restraints. The
initial technical assistance task shall begin at contract award and end at the 18th month or January 31, 2013.

1. **Recruitment and Tasks**

   Technical assistance will be provided to identify nursing homes participation in the initial HAC project, which will be based upon meeting the eligibility criteria below using the data from the most recent two quarters of Minimum Data Set (MDS 3.0). This data will be provided by CMS to offerors if not publically available during the request for proposal. The QIO shall recruit nursing homes that have stages 2, 3 and 4 high-risk pressure ulcer rates that are greater than the 75th percentile of the nursing homes in the state and have a pressure ulcer rate of >/= to 11%. For Physical Restraints, also utilizing the most two recent quarters of data prior to the launch of the contract, the QIO shall recruit nursing homes that are in the >75% percentile of physical restraint use in the state and that have a statewide physical restraint rate of >/= 4%. States without facilities that have room for improvement based on the criteria below in either PrU or PR shall not work in this effort. To be recruitment eligible, facilities only need to meet the criteria for either PrU or PR.

   a. The Aim for each home is to dramatically reduce their high risk PrU rates and hardwire proven effective practices for the prevention, identification and treatment of PrUs.

   b. The Aim for each home is to reach or surpass the national PR average at the time of remeasurement and to eradicate the daily use of all unnecessary physical restraints.

2. **Lead and Convene a Statewide Learning and Action Network to Reduce Healthcare-Acquired Conditions by Improving Nursing Home Quality of Care**

   Moving beyond pressure ulcers and physical restraints, the QIO shall help to lead the nation in improving other HACs in nursing homes. In accomplishing this Aim, the QIO shall develop a learning and action network to begin to make forward progress toward a safer system of care. While the objective of the learning and action network is to reduce HACs, quality improvement also involves addressing systemic issues, thus the learning and action network shall consider multiple root causes as noted below. The QIO shall perform the requirements utilizing the driver outlined in Section C.10.1.: Supporting and Convening Learning and Action Networks and the specific requirements of this section.

   a. At the 12th month of the contract (July 31, 2012), the QIO shall begin recruiting nursing homes, which includes nursing home executive leadership; to participate in a statewide collaborative that is focused on improving the overall quality of care being provided in nursing homes to include staffing, business practices and quality of life indicators. Executive
leadership (for example, the Chief Executive Officer, Chief Operating Officer) must, at a minimum, commit to the Learning and Action Network driver. The QIO shall convene a team and support the team until the end of the SOW, and ensure timely data reporting. In addition, this Learning and Action Network shall focus on improving specific clinical outcomes as they relate to HACs, and preventive health services such as increasing annual influenza vaccination rates among nursing home patients and staff.

A change package will be supplied by CMS prior to the launch of the collaborative and rolled out to the QIO during the QIO Learning Network meetings, CMS led NH Collaborative, and the Patient Safety National Coordinating Center calls. It is anticipated that CMS, in coordination with the Patient Safety National Coordinating Center, will host a series of learning sessions (up to three per year) that QIO and their respective teams shall participate in. Where Learning and Action Networks targeted for these improvements already exist in the state, the QIO shall submit a plan to CMS for approval describing how the QIO can work collaboratively to leverage existing activities without duplicating efforts. In support of the local learning and action network, the QIO shall assemble resource materials including providing information about the collaborative aims (to be established by CMS), develop the team structure, data timeline expectations, industry best practices for examining and stabilizing organizational processes (e.g. staffing, communication and culture) and move toward the sustainability mode as defined in Section C.10. The QIO must consider the information that will be most important for nursing homes to secure their commitment for the entire collaborative period.

b. Learning and Action Network Travel Teams shall be established to attend local and national meetings at a frequency to be defined by CMS prior to the start of the initiative. Attendance may be in person or by webcast.

c. The QIO shall partner with the Advancing Excellence Local Area Network of Excellence (LANE) and other vested partners in their state to identify and surpass hurdles that exist in reducing HACs as identified by CMS. It is anticipated that the QIO shall work on a minimum set of HACs to include CAUTI and Falls. The QIO shall also work to solidify staffing and ensure consistent assignment throughout the nursing home. Additionally, the QIO shall work to improve quality of life indicators to be identified by CMS in advance of the Learning and Action Network Launch.
d. The QIO shall use the change package supplied by CMS prior to the launch of the learning and action network and rolled out to the QIO during the QIO Learning Network Meetings and Patient Safety National Coordinating Center conference calls.

e. The QIO shall work closely with the State Survey and Certification Agency during the 10th SOW. This may include but is not limited to providing assistance to nursing homes that are identified by the State Survey Agency and the QIO COTR as requiring assistance. It is expected that these nursing homes will be or will become active members of the Learning and Action Network but may require some additional onsite technical assistance. The level of technical assistance to be provided will be determined by CMS CO and COTR.

C.7.3. Reducing Adverse Drug Events (ADEs): Reduce Medication-Related Harm in PSPC Communities by Achieving Optimal Health Outcomes and Preventing and Eliminating ADE in 265,000 Lives per Year

Tasks C.7.3.C.1-6 below will commence upon contract award and shall be performed at least through August 1, 2013 at which time the activities must be in sustainability mode.

C.7.3.A. Background- Reducing Adverse Drug Events

Adverse events secondary to medication therapy are the most common type of health care-associated adverse event. There is a growing awareness that many of these adverse events are due to medication errors, making adverse drug events a major source of potentially preventable patient harm. Adverse drug events disproportionately affect patients over the age of 65 across all settings including in hospital, ambulatory care and long-term care facilities. In addition, a statutory mandate enacted as part of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) places responsibility on all the QIO to take actions related to drugs. Section 109(b) added to Section 1154(a) of the QIO statute a new paragraph (17) (42 U.S.C. 1320c-3(a) (17)). This provision tasks the QIO with offering quality improvement assistance pertaining to prescription drug therapy to all providers, practitioners, Medicare Advantage organizations offering Medicare Advantage plans under part C, and prescription drug sponsors offering drug plans under part D. Quality improvement initiatives undertaken by the QIO in this area shall focus on reducing adverse drug events in these higher risk patients as a result of polypharmacy and improve health outcomes in fulfillment of their statutory requirements under the QIO provisions in Part B of title XI of the Social Security Act.

The QIO will contribute to the above aim through consistent application of quality improvement efforts to reduce and prevent adverse drug events. It is expected that there will be a secondary benefit in the form of reduced ER visits and reduced readmissions and that improved health outcomes in targeted patient groups may
be seen. These secondary outcomes as well as improved processes of transitions of care from accurate medication reconciliation, patient education and provider communication shall also be monitored as part of the QIO activities.

C.7.3.B Specific Requirements- Reducing Adverse Drug Events

1. Participating in a Patient Safety and Clinical Pharmacy Services Collaborative (PSPC) Breakthrough Collaborative(s)

   a. The QIO shall perform the requirement of this section using the driver in Section C.10.1: Supporting and Convening Learning and Action Networks and the specific requirements of this section.

   b. The QIO shall identify and partner with organizations currently participating in the PSPC effort. The QIO shall also develop partnerships with appropriate state, regional and/or federal partners to sustain the work of PSPC 3.0 and 4.0 and expand these efforts to the Medicare, Medicare Advantage and dual-eligible populations. The QIO shall accomplish this expansion by forming additional community teams that serve this patient group. Examples of partner organizations would include but are not limited to, state hospital associations, state health departments, clinical schools of pharmacy and Medicare third party payers.

2. Forming Community Teams

   a. The QIO shall help to lead five to ten multidisciplinary community teams not already assisted by other Federal programs. Teams will need to commit to the Expectations for Collaborative Teams outlined in Attachment J-12. These teams shall be comprised but are not limited to, the following organizations:

      - local clinical pharmacy representation
      - clinicians from the multiple settings utilized by QIO’s targeted patient groups (e.g. hospitals, nursing homes, primary care clinics, specialty clinics, federally funded clinics, etc)
      - Clinic and/or hospital senior leadership
      - patient and/or patient advocacy representation

   b. The QIO participating in this effort shall coordinate with the Patient Safety National Coordinating Center and also with the PSPC Collaborative for purposes of adding to the evidence-base for interventions and discussing intervention impact in an all-teach, all-learn forum according to the PSPC 3.0 and 4.0 collaborative schedule but no less than three times per year.
c. The QIO shall also monitor their patient groups for but not limited to:

- Persistently out-of-control health status based on established clinical health measures and standards such as HgA1c (glucose monitoring) and International Normalized Ratio (INR) (a lab test related to anticoagulation therapy management).
- High medication risk due to multiple medications, multiple providers and/or inadequate medication use systems.
- The actual patient groups’ size depends on the ability to track patient health and safety (registry, management information system) and the availability of Clinical Pharmacy Services (CPS). CPS promotes the appropriate selection, utilization, and monitoring of medications to optimize individual therapeutic outcomes in patients receiving the services included in the collaborative. Clinical pharmacy services are provided by a multidisciplinary health care team through individualized patient assessment and management. These services are best provided by a pharmacist or by another health care professional in collaboration with a pharmacist. Community teams must be formed so that they are positioned to support a minimum of 100 patients.

3. Recruitment
The QIO shall recruit on a rolling basis so that teams have the benefit of participating in national collaborative learning sessions (dates and locations to be determined). The QIO must seek to lead or support no fewer than five teams over the course of the 10th SOW for participation in the PSPC. The QIO shall select high risk patients for the patient groups to maximize impact and significantly contribute to the national goal.

a. The QIO shall work to recruit Medicare, Medicare Advantage and dual-eligible patients age 65 or older to serve as the team’s Population of Focus (PoF).

b. The QIO beneficiaries recruited for intervention shall meet one of the following criteria:

- Are high-risk patients who have 5 or more chronic conditions and/or who take 8 or more medications on at least a weekly basis

  and/or

- Are evaluated by 2 or more providers

  and/or
- Take the anticoagulant Warfarin on a regular (at least weekly and for 3 months or more) basis
  - and/or
- Take short-acting or long-acting antipsychotics of any class
  - and/or
- Take hypoglycemic medication for diabetes mellitus

4. Intervention Strategies
The QIO will utilize the tools and interventions available in the PSPC Collaborative to accomplish its goals in its State.

a. The QIO shall lead the community team in performing the prework, as outlined in the PSPC Change Package, as developed by HRSA. ([www.hrsa.gov/patientsafety](http://www.hrsa.gov/patientsafety)). The change package is a living document and is subject to change that consists of leading practices in the areas of health outcomes and patient safety. The change package provides QIOs a detailed view of the action items that community teams are specifically working on to create improvements. {See Attachment J-12A, 2010 PSPC Change Package}

b. The QIO shall select or develop a system of medication therapy management and medication reconciliation as well as a system to track compliance with these processes for each facility that serve QIO-supported patient groups where a suitable one does not already exist. Where there is an existing system, the QIO shall detail this system for each community team in a summary report to CMS.

c. The QIO in conjunction with community teams shall support the use of patient education tools for medication management in facilities utilized by their targeted patient groups.

d. The QIO will plan and manage learning and action sessions for the local teams utilizing the PSPC Change Package to develop protocols and systems geared toward improving health status and eliminating medication errors in the PoF.

e. Those QIOs who have formed local community based teams shall:
   - Join the PSPC 3.0 and 4.0
   - The QIO shall recruit teams in such a way that maximizes their ability to attend the Learning and Action sessions each year
   - Participate in conference calls, webcasts, webinars, and biannual meetings
   - Identify and track identified ADEs and preventing Preventable Adverse Drug Events (pADE). The QIO shall also monitor within their population of focus ER visits, hospital admissions and hospital readmissions
where the primary or secondary diagnosis is an adverse drug event.

5. Data Monitoring, Tracking and Reporting

a. The QIO shall work in conjunction with their community teams to utilize the CMS provided collaboration tool to track and monitor performance indicators and specific clinical outcomes, in accordance with the approximately monthly data collection and reporting schedule of the PSPC. All data shall be entered into the collaboration tool no later than the 10th calendar day of each month. Although the data tracking systems may vary among community teams, a uniform system of tracking and reporting relevant data to CMS/COTR/GTL shall be developed by the Patient Safety National Coordinating Center and used among all the QIO. While tracking and monitoring reports to CMS COTR/GTL is quarterly, the QIO shall assist community team members with monthly data collection and rolling up this data to show statewide improvement.

b. The QIO shall enable teams to track improvement in health status measures and safety measures in real time. The QIO shall track and monitor the following indicators and report them quarterly to CMS COTR/GTL:

- Number of adverse drug events that occurred in targeted patient groups each quarter
- Number of potential adverse drug events (ADEs prevented because of intervention) that occurred in targeted patient groups each quarter
- Number of ER visits, hospitalizations and/or hospital readmissions where primary or secondary reason for visit was ADE
- Number of patients on or prescribed a potentially inappropriate medication (PIM) antipsychotic

c. In targeted patients on Warfarin, the QIO shall track, monitor and report on a quarterly basis:

- Patients who had their International Normalized Ratio (INR) drawn at least once in a given month
- Patients whose INR is in optimal (as targeted by their provider) range

d. In targeted diabetic patients on insulin or an oral hypoglycemic, the QIO shall track, monitor and report on a quarterly basis:

- Patients with HgA1c in control (<9%) and Patients whose HgA1c is out-of-control (>/=9%) {See Section F - Schedule of Deliverables}
Technical Assistance

e. The QIO shall disseminate information, upon provider requests, concerning medication management. Examples of assistance may include information on federal and state requirements and incentives as they relate to performance improvement and FDA-issued prescription drug alerts for all providers and practitioners.

f. The QIOs shall provide technical assistance to Medicare Advantage organizations offering Medicare Advantage plans under Part C and prescription drug sponsors under Part D in fulfillment of their statutory requirements under the QIO provisions in Part B of title XI of the Social Security Act. Technical Assistance shall focus on the QIPs or the Chronic Care Improvement Programs (CCIPs) for the Medicare Advantage Organizations (MAOs) and shall be based on the QIO’s evaluation of those projects.

g. The QIO shall actively provide technical assistance and support to their participating teams in meeting bold ambitious team aims, consistent with the overarching aim of the PSPC.

The following table summarizes the patient safety initiatives described above.

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Setting</th>
<th>Recruitment Begins</th>
<th>Recruitment Concludes</th>
<th>Project Starts</th>
<th>Project moves into sustainability mode</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduction of CLABSI and CAUTI</td>
<td>Hospitals – Both ICU and Non-ICU units</td>
<td>August 15, 2011</td>
<td>October 31, 2011</td>
<td>Learning and Action Network Start on or before November 1, 2011</td>
<td>Sustainability efforts underway by January 31, 2013</td>
</tr>
<tr>
<td>Reduction of CDI</td>
<td>Hospitals and Nursing Homes</td>
<td>On or before January 31, 2012</td>
<td>January 31, 2013</td>
<td>Recruited facilities begin to report data into NHSN anytime after January 31, 2012 so that at least 6 months of baseline data are available by January 31, 2013. Collaborative efforts will begin on February 1, 2013.</td>
<td>Sustainability efforts underway by July 31, 2014</td>
</tr>
<tr>
<td>Reduction of Pressure</td>
<td>Nursing Homes</td>
<td>August 15, 2011</td>
<td>October 31, 2011</td>
<td>As soon as possible after</td>
<td>Sustainability efforts underway by January 31, 2013</td>
</tr>
<tr>
<td>Ulcers and Physical Restraints</td>
<td>including a focus on rural providers</td>
<td>facilities recruited but no later than November 1, 2011 31, 2013</td>
<td></td>
<td></td>
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<td>--------------------------------</td>
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<td></td>
</tr>
<tr>
<td>Reducing Any-Cause HAC in Nursing Homes</td>
<td>Any time between August 1, 2012 and January 31, 2013</td>
<td>January 31, 2013 February 1, 2013 Sustainability efforts underway by July 31, 2014</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduction of Adverse Drug Events</td>
<td>Community Collaboratives as described within task</td>
<td>August 15, 2011 First Patient Group Recruited by October 31, 2011 and Rolling Admission thereafter November 1, 2011 Sustainability efforts underway by July 31, 2014</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

C.7.4 Quality Reporting and Improvement

C.7.4.A. Specific Requirements- Quality Reporting and Improvement

1. Hospital Inpatient and Outpatient Quality Improvement Assistance

   The QIO shall provide technical assistance to hospitals to improve their quality of care related to Medicare programs such as the Hospital Inpatient Quality Reporting (IQR) Program and the Hospital Outpatient Quality Reporting (OQR) Program. The QIO, in collaboration with the Hospital Quality Support Contractor shall:

   a. Identify and meet with local organizational stakeholders that perform work related to the Hospital IQR and/or OQR programs in order to identify opportunities and needs for QIO efforts in providing assistance to hospitals seeking to improve their quality of care on topics addressed by Hospital IQR and/or OQR program measures.

   b. Provide technical assistance to hospitals in its State that request assistance on quality improvement efforts related to topics addressed by the Hospital IQR and/or Hospital OQR program measures including, but not limited to, training hospitals on these efforts, and helping them implement and monitor these quality improvement efforts.

   c. In coordination with the Hospital Quality Support Contractor, the QIO shall educate hospitals on Hospital IQR and/or OQR program requirements and assist hospitals to improve their quality in areas including but not limited to the following:
i. Validation;
ii. Hospital IQR and OQR program measures;
iii. Reporting of measure data.
iv. Improving on care related to Hospital IQR and OQR program measures for purposes of improving care for Medicare beneficiaries.

d. Assist Critical Access Hospitals, rural facilities and other hospitals that do not participate in the Hospital IQR and/or OQR programs, but that want to submit quality data to CMS for purposes of public reporting. Such assistance shall include, but not be limited to, promotion and outreach to hospitals not currently reporting data on Hospital IQR and/or OQR program measures, and educating new and current hospitals about the following:

i. CMS abstraction tools,
ii. Inpatient and Outpatient data warehouse infrastructure,
iii. Measure and submission feedback reports,
iv. Hospital IQR and OQR program reporting requirements (e.g., maintain a QualityNet Security Administrator, sign a participation form, etc.), and
v. Abstraction accuracy.

e. Provide feedback to hospitals on areas for improvement related to topics addressed by Hospital IQR and/or OQR program measures by using information from patient level data analysis located in the applicable CMS data warehouse, in accordance with all applicable statutory laws, regulations, and guidance.

2. Reporting Quality Data

To promote quality improvement and transparency for consumer decision making through publicly reported quality data, the QIO shall:

Actively educate hospitals in their efforts to submit Hospital IQR and/or OQR program quality data and to understand the feedback provided to them with respect to these data. The QIO must ensure that all QIO staff is fully knowledgeable on these matters, which include:

i. Hospital IQR and/or OQR program measures (lists updated annually in the Federal Register and on the Quality Net website);
ii. Measure specifications (updated every 6 months and posted on the Quality Net website www.qualitynet.org);
iii. Resources available to hospitals, such as;
   1. Data submission feedback reports; and
   2. Other reports provided to hospitals.
3. Provide Technical Assistance and Training

The QIO shall provide assistance to hospitals on the following:

a. The use of data submission software and other programs needed to submit quality data, including the CMS Abstraction Tool and the CDC NHSN software.

b. State-wide (including territories of Puerto Rico, District of Columbia and the U.S. Virgin Islands) trainings (via Web conferencing, teleconferencing, etc.) on CMS-identified and approved topics for the Hospital IQR and OQR programs.

c. Submission and validation of quality data. Assistance includes (but is not limited to) promotion and outreach to hospitals, and educating new hospitals and currently reporting hospitals about the following quality reporting information:
   i. CMS quality data warehouse infrastructure;
   ii. Measure and submission feedback reports;
   iii. Hospital IQR and OQR program requirements (e.g., maintain a QualityNet Security Administrator, sign a participation form, etc.);
   iv. Abstraction accuracy;
   v. Reviewing quarterly validation appeals and educating hospitals on such appeals; and
   vi. Aggregate population and sample size submission and accurate content.

d. Disseminate shared knowledge to hospitals in the QIO’s State learned through collaboration with the, CDC, CMS, and CMS Quality Data Reporting Project Management Organization contractor(s).

e. Maintain and update hospital information in the Program Resource System (PRS), including hospital CEO information, the hospital’s mailing address, hospital’s physical location, and contact information for the Hospital IQR and OQR programs (including the QualityNet Administrator and an e-mail address).

f. Work with hospitals to improve the accuracy, timeliness, and completeness of Hospital IQR and OQR program data submitted to the CMS Clinical Warehouses.

g. Hold trainings (via, e.g., Web conferencing, teleconferencing, in-person) for hospitals to improve the accuracy, timeliness, and completeness of data submitted under the Hospital IQR and/or OQR programs. The QIO will provide copies of all training materials to CMS upon request.
C.8 INTEGRATE CARE FOR POPULATIONS AND COMMUNITIES

C.8.1. Technical Assistance for Communities

C.8.1.A. Background--Technical Assistance for Communities

The QIO work shall improve the quality of care for Medicare beneficiaries who transition among care settings through a comprehensive community effort. These efforts aim to reduce readmissions following hospitalization by 20% over three years and to yield sustainable and replicable strategies to achieve high-value health care for sick and disabled Medicare beneficiaries.

The process by which patients move from hospitals to other care settings is increasingly problematic, as hospitals shorten lengths of stay and as care becomes more fragmented. Medicare patients report greater dissatisfaction in discharge-related care than in any other aspect of care that CMS measures. Within 30 days of discharge, 17.6 percent of Medicare beneficiaries are re-hospitalized, and the Medicare Payment Advisory Commission (MedPAC) estimated that up to 76 percent of these readmissions may be preventable. Of Medicare beneficiaries who are readmitted within 30 days, 64% receive no post-acute care between discharge and readmission.

This situation can be changed. These rates of re-hospitalization, and health care utilization in general, vary substantially among geographic locations, suggesting opportunities for improvement in the areas with higher observed rates. Since local areas vary substantially in health care utilization, the most effective interventions may depend on changes in the processes of care at a community level that engage more than one provider (including hospitals, home health agencies, dialysis facilities, nursing homes, and physician offices), as well as patients, families, and community health care stakeholders. The unit of intervention for this initiative is the community.

The QIO shall form relationships with many community organizations and play a coordinating role to ensure community-wide adoption of improved practices. Additionally, messaging among providers and the community will have the greatest impact when it is consistent among purchasers (such as health plans and employers), payers (such as insurers), providers, and public health authorities.

C.8.1.B. Definitions--Technical Assistance for Communities

1. **Formal Care Transitions Program** - An organized program targeting the improvement of care transitions for beneficiaries as they move from one provider setting to another. Examples of such programs include but are not limited to the following: The Community-based Care Transitions Program, Area Agency on Aging Care Transitions Grants, Patient Safety Organization collaboration, etc.

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1 Care Quality Information from the Consumer Perspective Hospital Survey (HCAHPS) Pilot
C.8.1.C. Specific Requirements--Technical Assistance for Communities

1. Recruit and Educate Provider Groups/Communities
   a. Recruit communities to participate in Care Transitions Initiatives

      i. Identify a target number of communities to recruit per quarter through quarter 8 by 1 month into the contract.

         Submit to CMS GTL/COTR an Initial Community Recruitment Plan no later than 1 month after the start of this contract. It is expected that community recruitment will be staggered.

      1. QIOs may select communities based on the following:
          a. Communities as defined by the Medicare Beneficiaries that live in a specified group of zip codes and the committed Providers and Stakeholders that provide care for those beneficiaries that meet the criterion in Attachment J-13a and/or;
          b. Select from the list of potential communities determined to meet these criterion provided at http://www.cms.gov/QualityImprovementOrgs/

      ii. Communities will fall into two tracks
          1. Communities that receive technical assistance from the QIO prior to acceptance into a formal Care Transitions Program such as:
              a. The Affordable Care Act Section 3026 Community-based Care Transitions Program
              b. Care Transitions Grants
              c. Other National or Regional Programs
          2. Communities that are not eligible for or apply but are not accepted into a formal Care Transitions Program: these communities shall be invited to participate in the state Care Transitions Learning Network.
          3. The QIO will submit a quarterly report which includes:
              a. Description of QIO activities and analysis of the impact that QIO efforts have had on increasing the following:
                  i. recruiting communities of providers indicated by a signed agreement
                  ii. engagement in Care Transitions-funded initiatives and Learning Network
                  iii. Learning Network activities
                  iv. Community Support available and utilized

   b. Educate state providers, community organizations, stakeholder groups regarding:
i. National care transitions initiatives to reduce readmissions

ii. The presence of QIO technical assistance in the areas of:
   1. Community coalition formation
   2. Root cause analyses using:
      a. Data Analysis
      b. Community Coalition communication/input
   3. Intervention selection process
   4. Application for participation in a formal Care Transitions Program(s)
   5. Ongoing QIO assistance if not accepted into a formal Care Transitions Program in the following areas:
      a. Quarterly Readmission Metrics
      b. Intervention performance measurement strategies

c. Respond to requests from Providers and other Stakeholders which may include but are not limited to the use of the following:
   i. Maintenance of a State specific Care Transitions link on the QIO’s website with links to:
      1. The Care Transitions National Coordinating Center Website
      2. Other State Specific materials/messages/educational opportunities
   ii. Frequently Asked Questions resources
   iii. Timely response to Questions

d. Contribute to a growing body of insight concerning how care transitions and after-hospital care can improve, and how this affects re-hospitalization including written manuscripts and participating in local or National speaking opportunities as approved by CMS COTR/GTL

e. Assisting other QIOs and collaborating partners in solving problems in this work.

2. Coalition Building

a. Community Coalition Formation: The QIO shall provide any or all of the following to recruited community providers/stakeholders:
   i. Materials to use as models for community coalition formation
   ii. Consultative support for convening a community coalition which may include social network analysis
   iii. Technical support to create an initial strategic plan for organization, intervention, monitoring, and decision-making that articulates how the community proposes to achieve the aims of this section, which may include:
      1. Plans for including a broad range of community leaders and providers within the selected region, including whether each of the following potential participants will be recruited
and how these decisions align with the proposed strategic plan.

a. Regional health initiatives, community campaigns, and similar activities.
b. State and local government: e.g., mayoral offices, legislators, state or local health departments, state or local licensing agencies.
c. Major purchasers and payers: e.g., State Medicaid programs, commercial insurers, large employers.
d. Advocacy and service organizations: e.g., Medicare beneficiary and patient advocacy organizations
e. Provider groups
   i. Hospitals
   ii. Home health agencies
   iii. Nursing homes and rehabilitation facilities
   iv. Physician practices providing follow-up care
   v. Hospices.
f. Patient Safety Organizations (PSO)

iv. Description of how the community coalition plans to facilitate relationships with these existing groups with the goal of working together to create a cohesive working and collaborative environment among health care providers in the target community.

b. Coalition Charter: the QIO shall supply providers and community organizations with a template for Coalition Charters provided by the Care Transitions National Coordinating Center.
   i. This charter will help community partners to formalize rules, roles, structures and procedures in order to make collaborative synergy more likely.
   ii. The charter may be modified to meet the individual needs of the community.
   iii. The charter must include a commitment to reduce 30 day readmissions by 20% over three years.

c. Monthly Community/Provider Log: Track providers/communities utilizing QIO consultative services and support using a template provided by the Care Transitions National Coordinating Center which will include:

   i. Type of support provided to assist providers/communities:
      1. In being eligible for application to federal Care Transition Funded Program and/or;
      2. To participate in the Care Transitions Learning and Action Network
   ii. Community status readiness for formal Care Transitions program participation
ii. Barriers
iii. Strengths

3. **Root Cause Analysis**
   a. Identify community-specific causes for poor transitions that fall within the following drivers of readmissions:
      i. Poor information transfer/communication between providers
      ii. Decreased patient and family activation
      iii. A lack of a standard and known process for sharing patients among providers
   b. Run SAS code provided by the Care Transitions National Coordinating Center to supply provider/community specific data for the coalition to use while performing a root cause analysis. SAS code may provide the following analyses:
      i. Proportion of Transitions Table
      ii. Coalition Readmission Rates
      iii. Hospital Readmission Rates
      iv. Post Acute Care Setting Readmission Rates
      v. Disease Specific Readmission Rates
      vi. ED Visit Rates
      vii. Observation Stay Rates
      viii. Mortality Rates
   c. Utilize any or all of the following strategies for root cause analysis:
      i. Data Analysis
      ii. Process Mapping
      iii. Chart Reviews
      iv. Patient/Stakeholder Feedback
   d. The QIO shall ensure that all patient specific data is protected according to the privacy laws and mandates that govern this data.

4. **Intervention Selection & Implementation Plan**
   a. The QIO will work with providers within their communities to select evidenced-based interventions associated with the known drivers of readmission. This process may include but is not limited to:
      i. Results from the community specific root cause analysis
      ii. Existing local programs and resources
      iii. Funding resources
         1. Cost estimates associated with intervention implementation
         2. Estimates for intervention penetration
      iv. Sustainability
      v. Community preferences
   b. Evidenced-based interventions associated with improving Care Transitions and reducing readmissions can be found in Attachment J16, Table 1, with their corresponding impact on drivers of readmission. When the community intends to implement an intervention that is not yet listed in J-15 Table 1, the QIO must document the plan, why it is reasonable, how it
will be monitored, and the risk (if any) of adverse effects and how they will be monitored.

3. The intervention selection process may include in-person meetings, conference calls, webinars, or other methods of communication.

4. Development of Initial Implementation Plan: The QIO shall engage their community partners in the development of an intervention implementation plan. A template Intervention Plan shall be provided to the QIO by the Care Transitions National Coordinating Center.

5. Application for participation in a formal Care Transitions Program(s)
   a. Provide technical support for the application process which may include:
      i. Data analyses and trending reports
      ii. Interventions selection rationale
      iii. Cost estimates for interventions
      iv. Other application requirements

6. Ongoing Assistance for communities that are not accepted into a formal Care Transitions Program
   a. The QIO will provide Quarterly Readmission Metrics which include the following to communities:
      i. Proportion of Transitions Table
      ii. Coalition Readmission Rates
      iii. Hospital Readmission Rates
      iv. Post Acute Care Setting Readmission Rates
      v. Disease Specific Readmission Rates
      vi. ED Visit Rates
      vii. Observation Stay Rates
      viii. Mortality Rates
   b. Participation in a State-wide Care Transitions Learning Network: The QIO shall perform this requirement utilizing the driver found in C.10.1: Supporting and Convening Learning and Action Networks.
      i. Host at a minimum Quarterly statewide Learning Network sessions: three (3) conference calls or webinars annually, and one annual in-person meeting
   c. QIO will submit to CMS GTL/COTR quarterly the following:
      i. Community Intervention Plans
      1. New Interventions
      2. Revised- Shall include the following:
         a. Measurement strategies
            i. process measures
            ii. proximal outcome measures
            iii. utilization measures
         b. Data collection methods
         c. Quarterly data trends by intervention
d. Rationale for continuing or discontinuing an intervention based on data analyses including change processes for interventions that are not showing positive trending data but will be continued.

d. Intervention performance measurement strategies - The QIO shall produce three reports that meet the quality and relevance criteria utilized by peer-reviewed journals and using SQUIRE guidelines (see attachment J-13) showing time series trend changes made in response to an identified driver of readmissions including the variations or similarities in communities throughout the state.

7. Measures
QIOs will collect and enter data to populate the QIO performance measures quarterly into the Document Storage System and in deliverables as directed by CMS, COTR/GTL. QIO’s will collect the following data items and additional items as directed by CMS:

i. Number of communities recruited

ii. Number of communities that are eligible and apply for a formal Care Transitions Program

iii. Number of communities accepted into a formal Care Transitions Program

C.9 IMPROVE HEALTH FOR POPULATIONS AND COMMUNITIES

C.9.1 Improving Prevention and Early Diagnosis

C.9.1.A. Definitions- Primary Care Prevention and Early Diagnosis

1. American Recovery and Reinvestment Act (ARRA), “Health Information Technology for Economic and Clinical Health Act” (HITECH): ARRA (Pub. L. 111-5) of 2009 establishes incentive payments to eligible professionals (EPs), eligible hospitals (EHs), and critical access hospitals (CAHs), and Medicare Advantage Organizations participating in the Medicare and Medicaid programs to adopt and successfully demonstrate meaningful use of certified electronic health records. The HITECH is intended to accelerate the adoption of HIT and utilization of certified electronic health records.

2. Care management: Using the capabilities of an electronic health record (EHR), such as maintaining a problem and diagnosis list; identifying specific patients by age and disease or disease risk; creating printed patient specific care plans, to track and recall patients for needed preventive services and other care.

3. Certified EHR Technology: A certified electronic health record (EHR) is technology that has been tested and certified in accordance with the certification program (as established by the National Coordinator of
Health Information Technology via rulemaking) as having met all applicable certification criteria adopted by the Secretary.

4. **Regional Extension Center**
The Regional Extension Centers are part of the Health Information Technology Extension Program established by Section 3012 of the Public Health Service Act (PHSA) as amended by ARRA. The purpose is to furnish assistance, education, outreach and technical assistance to help providers in their geographic service areas select and successfully implement certified EHR technology.

5. **Beacon Community**
Beacon Community Cooperative Program was established pursuant to Section 3011 of the Public Health Service Act (PHSA) as amended by ARRA. It provides funding to communities to build and strengthen their health IT infrastructure and exchange capabilities to achieve measurable improvements in health care quality, safety, efficiency, and population health.

6. **State Health Information Exchange Program:**
A State Health Information Exchange exists through a grant to support States or State Designated Entities (SDEs) in establishing basic infrastructure for HIE among health care providers in their respective States.

7. **Physician Quality Reporting System (PQRS)**
The 2006 Tax Relief and Health Care Act (TRHCA) (P.L. 109-432) required the establishment of a physician quality reporting system, including an incentive payment for eligible professionals (EPs) who satisfactorily report data on quality measures for covered professional services furnished to Medicare beneficiaries during the second half of 2007 (the 2007 reporting period). CMS initially referred to this program as the Physician Quality Reporting Initiative (PQRI).

C.9.1.B. Specific Requirements- Primary Care Prevention and Early Diagnosis

1. **Goals**
   a. The QIO shall improve population health by accomplishing the following:
      i. Improving flu immunizations of patients ages 50 and older during the flu season
      ii. Improving pneumococcal immunization of patients ages 65 and older
      iii. Improving appropriate low-dose aspirin therapy use in patients with ischemic vascular disease,
      iv. Improving BP control in patients with hypertension
      v. Improving LDL-C control among adults with ischemic vascular disease
      vi. Improving tobacco cessation intervention among adult patients who smoke (screening and cessation counseling).
vii. Improving colorectal cancer screening in patients ages 50-75
viii. Improving breast cancer screening in women ages 40-69
ix. Identifying and improving disparities within identified communities within the state.

b. The QIO shall improve participation in the Physician Quality Reporting System (PQRS) and improve the use of EHR for care management by accomplishing the following:
   i. Ensuring that practices have integrated HIE and data exchange infrastructures in their practices by: demonstrated use of decision support tools to improve quality of care; improved care coordination; and, better engagement of patients and families.
   ii. 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 to improve quality and efficiency of patient care.
   iii. Assisting physician offices with qualified EHRs to begin participating in PQRS using EHR-based reporting.

2. Physician Quality Reporting System (PQRS) EHR Reporting
PQRS is a quality reporting initiative implemented by CMS. Individual Eligible Professionals (EPs) may choose to report information on individual PQRS quality measures or measures groups in a given reporting year: (1) to CMS on their Medicare Part B claims, (2) to a qualified PQRS registry, or (3) to CMS via a qualified electronic health record (EHR) product. Individual EPs who meet the criteria for satisfactory submission of PQRS quality measures data via one of the reporting mechanisms above for services furnished during a PQRS reporting period will qualify to earn a PQRS incentive payment.

The QIO shall support provider submission method (3) via qualified EHR. The QIO shall encourage physician offices in the state to begin participation in PQRS via EHR submission of data in accordance with the current year requirement (i.e. 2011 requirements during 2011 program year, 2012 program requirements during the 2012 program year).

The QIO shall engage physician offices with qualified EHRs to begin participating in PQRS using EHR-based reporting. The QIO shall assist the offices - and their EPs - in data submission for PQRS using EHR-based reporting. This assistance may be via webex, train the trainer programs, or other innovative large scale approaches. The QIO shall work with practices using EHRs to produce quarterly reports – for office and QIO quality improvement and tracking -- that show the rates with numerators and denominators for each measure. The QIO shall provide education and support to assist the practices in setting up Quality Improvement tools and programs.
Participation in PQRS for these EP offices must include EHR reporting on at least three of these PQRS measures:

- Preventive Care and Screening: Influenza Immunization for Patients >= 50 Years Old (measure 110, 2011 program)
- Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years and Older (measure 111, 2011 program)
- Preventive Care and Screening: Screening Mammography (measure 112, 2011 program)
- Preventive Care and Screening: Colorectal Cancer Screening (measure 113, 2011 program)
- Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (measure 226, 2011 program)
- Hypertension (HTN): Blood Pressure Measurement (measure 237, 2011 program)

CMS may modify this list for 2012 PQRS after the 2012 measures are announced.

Quarterly, the QIO will report to CMS the offices and EPs engaged in the PQRS EHR-Reporting project and their PQRS measures.

The QIO must document – via signed consent forms – that it has recruited physician offices equal to at least the total providers column in Attachment J18 EPs by July 31, 2012. The EPs – as determined by National Provider Identifier (NPI) – must be unique; each can be associated with one office/TIN only.

By November 30, 2012, the QIO must document that it has assisted the physician offices (equal to at least the total providers column in Attachment J18) in PQRS reporting via EHRs.

By the end of the 2012 reporting period, there will be an absolute increase of [State #] x 1.25 EPs participating via EHR-reporting to PQRS in the state, as compared with 2010 EHR-reporting PQRI participation (baseline).

The QIO shall offer a reasonable alternative for consideration when at least the total providers column in Attachment J18 EPs are not available for participation in a particular state.

It is expected that 90% of the EPs assisted by the QIO will successfully meet PQRS EHR reporting requirements for program year 2012, so that they receive an incentive payment for 2012 participation.

The QIO will collect information on lessons learned and best practices and provide this information to the Prevention National Coordinating Center. The
A compilation of data from across the country will be used to promote a national increase in participation of quality reporting.

3. **Learning and Action Networks**
The QIO shall perform the task utilizing the general requirement found in C.10.1 Supporting and Convening Learning and Action Networks in addition to the requirements of this section.

The QIO will utilize change packages from the Prevention National Coordinating Center and act as a Local Learning Network to promote the goals of this strategic aim -- population health. Technical assistance will be provided within the framework of a Learning and Action Network. The QIO will seek out and implement innovative approaches to providing technical assistance on a large scale. Factors to consider in designing technical assistance approaches include:

- Working closely with the Office of the National Coordinator (ONC) for Health Information Technology, the Regional Extension Center (REC), Beacon Communities and the Health Information Technology Research Center (HITRC)
- Working closely with Accountable Care Organizations
- Aligning with PQRS
- Assisting practices with benchmarking;
- Assisting practices with using the registry functions/care management functions of their EHRs;
- Assisting practices with interpreting EHR data and reporting to identify and address disparities in care
- Ensuring practices utilize capabilities of EHR to establish a practice level quality improvement program and health information exchange to improve care coordination;
- Ensuring that system changes are put in place that are sustainable;
- Partnering with other entities that have common goals such as the state health department, Centers for Disease Control & Prevention, state immunization registry grantees, provider organizations, patient advocacy organizations, ESRD Networks, church groups, community groups, and others.

a. The Learning Network will include approaches to promote engagement of the patient and family to improve patient health and self-management. These activities will promote patients’ ability to receive their own health information through secured and confidential communication mechanisms, such as ports or personal health records; so that patients/families will effectively self manage their health and engage in their care.
b. The QIO will ensure that providers have access to tools and resources from the Learning Network that encourage the sharing of effective, personalized self-management resources and tools that help the patient to self-manage health risk behaviors and avoid preventable health conditions.

c. The QIO will invite every REC-recruited office in its state [territory], within 3 calendar months of its “GoLive Date” (installing its EHR), to participate in the Learning & Action Network. The Network will include a focus on effective use of clinical decision support, clinical quality improvement, and using the EHR to track and improve population health and the clinical targets identified in Section C.9.1.C.1 above.

d. Quarterly, the QIO will report to CMS the REC-recruited offices that have installed EHRs, their dates of installation (Go-Live dates), dates of invitation to join the Learning & Action Network and whether or not the office joined.

e. It is expected that at least 75% of the REC-recruited, installed offices that were invited will participate in the Learning & Action Network by September 30, 2013.

4. Cardiac Population Health

Working in collaboration with the DHHS, ONC, CDC, and other stakeholders, the QIO will convene medical experts, community partners, and a minimum of [State # - See State specific data table noted in Section C.9.1.B.2] physician offices in a Learning Network (or Networks) to address smoking cessation, aspirin therapy, blood pressure control and cholesterol control. The QIO shall offer a reasonable alternative for consideration when [State # - See State specific data table noted in Section C.9.1.B.2] physician offices are not available for participation in a particular state. The specific measurement for each area is listed below and example focus areas are included under blood pressure control.

a. Blood Pressure Control

Percentage of patients with Medicare with coronary artery disease or peripheral vascular disease whose most recent blood pressure during the measurement year is <140/90 mm Hg

Potential Areas to focus on for the blood pressure control interventions along with the CDC Division for Heart Disease and Stroke Prevention (DHDSP) include:

i. Physician treatment consistent with the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC) practice guidelines.

ii. Collaborations with Community Health Workers to contribute to efforts to obtain higher medication adherence rates.
iii. Behavioral and lifestyle risk factors such as unhealthful diet with too much salt and too little potassium, being overweight or obese and engaging in too little physical activity.

iv. Working with the private sector to ensure medication costs are not a barrier to patient adherence. [A Population-Based Policy and Systems Change Approach to Prevent and Control Hypertension, IOM Report Brief, February 2010]

b. Lipids Management
   Percentage of patients with Medicare with ischemic vascular disease whose most recent LDL-C screening had a result of <100

c. Aspirin
   Percentage of patients with Medicare with ischemic vascular disease who have documentation of use of aspirin or other antithrombotic during the 12-month measurement period

d. Smoking
   Percentage of patients with Medicare who receive smoking cessation counseling

5. Integrating Health Information Technology to Achieve Meaningful Use and Improve Care Coordination and Prevention

The QIO shall work in collaboration with Regional Extension Center (REC) in the State, and any Beacon communities (if in the state), without duplicating efforts of the REC or Beacon communities in the state.

In partnering with the REC and any Beacon Communities, the QIO will:

- Work to ensure that health information technology is used to improve cardiovascular health through care coordination, monitoring, patient engagement and spreading of best practices.
- Promote physician office electronic health record (EHR) adoption and successful demonstration of meaningful use, as defined via CMS ARRA/HITECH rulemaking
- Promote physician office participation in the CMS EHR Incentive Program

In addition, the QIO will:

- Integrate with state and local HIE efforts
- Encourage physician office reporting – via electronic health record (EHR) – to the State Immunization Information System (IIS) in order
6. Monitoring and Evaluation Measures:
Attachment J-10 includes the full list of monitoring and evaluation measures.

a. **General Task Evaluation Measures:** Measures i – viii will each show a 6% improvement from the 2010 baseline to the 2012 remeasurement. The data used to track the goals will be claims-reported PQRS data.

i. Improving flu immunizations of patients ages 50 and older during the flu season

ii. Improving pneumococcal immunization of patients ages 65 and older

iii. Improving appropriate low-dose aspirin therapy use in patients with ischemic vascular disease

iv. Improving BP control in patients with hypertension

v. Improving LDL-C control among adults with ischemic vascular disease

vi. Improving tobacco cessation intervention among adult patients who smoke (screening and cessation counseling).

vii. Improving colorectal cancer screening in patients ages 50-75

viii. Improving breast cancer screening in women ages 40-69

C. 10 GENERAL PROTOCOL REQUIREMENTS (DRIVERS)

CMS calls upon the QIO to secure commitments, as well as serve in the important role of being conveners, organizers, motivators and change agents by providing a call to action through outreach, education and social marketing; serving as a trusted partner in improvement with beneficiaries, health care providers, practitioners, and stakeholders; achieving quality improvement targets and quality improvement results through data collection, analysis, education, and monitoring for improvement and information exchange; and, dissemination and spread of best practices. Many of these roles can be fulfilled through facilitation and execution of the following drivers of quality:

C.10.1 Supporting and Convening Learning and Action Networks;
C.10.2 Providing Technical Assistance; and
C.10.3 Care Reinvention through Innovation Spread (CRISP) Model
C.10.1 Supporting and Convening Learning and Action Networks

C.10.1.A Background--Supporting and Convening Learning and Action Networks

Learning and action networks are mechanisms by which large scale improvement around a given aim is fostered, studied, adapted and rapidly spread regardless of the change methodology, tools, or time-bound initiative that is used to achieve the aim. Learning and action networks consciously manage knowledge as a valuable resource. They engage leaders around an action based agenda. Such a network creates opportunities for in depth learning and problem solving, it accepts all offers of support seeking to catalyze interested parties, and it is transparent, flexible, interchangeable, and purposeful.

While all facilities and providers in a given state may not receive direct QIO intervention, learning and action networks create an opportunity for communities, with assistance and guidance from the QIO, to harness the knowledge, skills, and abilities of their peers and vested partners to reach a critical mass of the appropriate factions in their state around a common aim(s). It is expected that the QIO will develop and facilitate sustainable learning and action networks within their respective state, as well as participate in CMS supported and facilitated Learning and Action Networks which will function to support QIO activities at the local level through spreading knowledge gained from counterparts across the country which may provide additional information for improving local quality of care concerns (see attachment J-14 for an example of a learning network work flow).

C.10.1.B. Definitions--Supporting and Convening Learning and Action Networks

The definitions provided below shall pertain to the work performed under Section C.10.1: Supporting and Convening Learning and Action Networks.

1. **National Coordinating Centers (NCC):** A national coordinating center is a QIO support contractor that leads national efforts to support the local QIO in achieving specified goals specific to a topic of importance to CMS, beneficiaries, and other stakeholders (for example, patient safety or beneficiary centered care). There are five National Coordinating Centers that will support QIOs in the efforts in the SOW: Beneficiary and Family Centered Care NCC, Patient Safety NCC, Care Transitions NCC, Prevention NCC and CRISP NCC. National Coordinating Centers serve as a central point of entry to send, receive and spread information to the state level QIO, collect and report data, establish and maintain contact with national experts in clinical quality improvement, and gather or develop quality improvement tools. See Attachment J-15 for a chart of NCCs.

2. **Learning and Action Networks:** Learning and action networks are mechanisms by which large scale improvement around a given aim is fostered, studied, adapted and rapidly spread regardless of the change
methodology, tools, or time-bound initiative that is used to achieve the aim. Networks have many tools at their disposal to promote change including technical assistance, leading Breakthrough Initiatives, and conducting quality campaigns.

3. **Spread**: The act of expanding an improvement from an area of success to another area within a system for the purpose of accelerating the rate of implementing proven interventions in order to improve performance in strategic areas.

4. **Disparate Care**: Refers to the unequal treatment of patients on the basis of race or ethnicity, gender, socioeconomic status, locale or other patient characteristics. This is a difference in care that is not justified by the underlying health conditions or treatment preferences of patients.

5. **Affinity Groups**: A sub-group that develops within the Learning and Action Networks to work in specialized areas. These groups may form because a subcomponent of the group shares many commonalities and it would be advantageous to work together. They may work to remove certain barriers, or promote subgoals. Their members can represent areas with specific interests such as (but not limited to) rural care, providing care to Medicare dual eligible and Medicare advantage beneficiaries, teaching hospitals, and integrated care models.

6. **Local**: Local refers to the geographic area identified in the state in which the QIO operates. Some activities may be statewide while others will be aimed at working with certain communities or providers within the state.

7. **Breakthrough Collaborative**: A collaborative is a short term (usually 12-18 month) initiative that brings together a large number of teams from health care facilities (e.g. hospitals, clinics, nursing homes, home health agencies) to seek improvement on a specific topic. A collaborative is an improvement method that relies on the practices of high performers and the rapid adaptation of those practices to support the system being changed. Breakthrough collaboratives are designed to accelerate improvement, achieve results, disseminate good ideas to community stakeholders, and build clinical leaders of change. A collaborative is one of many tools available to a learning network to drive change.

8. **External Subject Matter Experts**: Experts in a given field that have specific insight into how their facility is achieving certain aims (e.g. lowest infection rates in the state, highest utilization of universal precautions).

9. **High Performing Organizations**: Organizations that have high rates of success in a given measure and have specific insight as to the processes and practices that are in place that allow for the outcome.

10. **Best Practice**: A best practice is a technique or methodology that, through experience and/or research, has been proven to be one of the most efficient (least amount of effort) and effective (best results) way of accomplishing a task or achieving an outcome, based on repeatable procedures that have proven themselves over time. See Attachment J-16 for examples of best practices.
11. **Sustainability Mode:** Establishing a plan that will help to increase the probability that the quality improvements attained, through the QIO’s work during the course of the 10th SoW, are maintained or improved when the QIO has completed its formal work with the participants.

**C.10.1.C. Specific Requirements for Supporting and Convening Learning and Action Networks**

The QIO shall develop, lead and sustain local Learning and Action Networks. The NCC related to the Learning and Action Network topic will support the QIO in these tasks.

1. **Develop and Implement a Local Learning and Action Networks**

The QIO shall develop a team(s) (number and composition to be determined by the QIO) that is responsible for supporting and facilitating the Learning and Action Networks for their respective state. This team is responsible for creating interest and action in the Learning and Action Networks from vested parties within the state around a specific aim(s). The QIO shall work with the associated National Coordinating Center, which will support the QIOs in their effort to lead local efforts driving toward national goals. The duties pertaining to this QIO team include but are not limited to:

1. The QIO shall coordinate and connect the local Learning and Action Networks to the specific improvement initiatives occurring in the state as referenced throughout this SOW.
2. The QIO shall actively and consistently recruit front-line learning network participants appropriate for working with the leaders in achieving change in the specified aim.
3. The QIO shall very closely monitor relevant state data for the purpose of strategizing areas for which significant gains can be made, where problem solving can occur and where barriers can be removed for rapid improvement.
4. The QIO shall ensure that each Learning Network has a very specific and intentional focus on the area of reducing disparities that may exist in any of the specified topics areas in this SOW.
5. The QIO shall also reach out to and involve groups or organizations that may not be explicitly included in the 10th SOW such as Medicare Advantage Plans, Federally Qualified Health Centers, state and local health departments, grantees or contractors, grantees or contractors of other Federal agencies, and private sector quality improvement groups for purposes of collaboration and reducing duplication in effort.
6. The QIO shall purposefully connect organizations and individuals with similar goals for the purpose of creating synergy around the Aim(s) as defined in this SOW.
7. The QIO shall arrange for learning and sharing opportunities with peers of the participants in the learning network who have achieved or nearly achieved the desired goal of the network. The QIO shall convene higher
performers and low performers to participate in an all teach all learn event to better understand the best practices of the high performing organizations. QIO shall provide this opportunity in several ways, including face-to-face meetings when it makes economical sense to do so, conference calls, webinars, and video calling.

8. The QIO shall work to consistently identify best practices, improve and rapidly spread the practice to its constituents.

2. **Cultivating Leaders in the Local Area**

a. The QIO shall convene health care leaders (including providers, administrators, boards of directors and patients) around an actionable agenda that promotes specified CMS Aim(s) as described throughout this SOW. This will also include identifying the high performing organizations for leaders to form affinity groups as needed to enhance opportunities for learning, or problem solve around important topics that are applicable to the state or issue such as persons that have dual eligibility, rural concerns, and any populations where disparate care may be occurring.

b. The QIO will identify those local leaders that have achieved outstanding results in the designated topic area to serve as quality advisors to the Learning and Action Networks.

c. The QIO identified quality advisors will work to cultivate leadership among other CEOs, CFO, CIO, Executive Directors and other identified leaders for the specified aim. The goal is to catalyze change among the leadership that can then transform the remainder of the staff from the specified settings such as hospitals, nursing homes, home health agencies, ambulatory surgery centers, etc.

3. **Plan and Coordinate Local Learning Network Meetings and Conferences**

a. First, the QIO shall plan, organize and facilitate local learning network meetings for each of the identified priorities. It may be possible and is desirable to address several priorities at the same meeting for purposes of efficiency. Learning and Action team members shall participate in one (1) to three (3) local meetings per contract year. These meetings will form the Learning and Action networks of the QIO community. It is expected that one of these meeting will occur face-to-face with the remainder occurring through webcast, conference calls, etc…

b. Team members will be asked to prepare in advance of each of these local meetings, their current progress, effective practices and most recent results. During these meetings, CMS may direct the QIO to roll out through their Learning and Action Networks new information that is derived from the most up to date practices in the field, patient stories, and business case development information as examples.

c. The QIO must seek efficiencies when it appears appropriate by sharing resource information or coordinating with their QIO peers in surrounding areas in a locally driven satellite uplink.
4. **Facilitating Collaborative Teams** –
The QIO shall lead, manage and direct the work of collaborative teams by providing the following supports: Introducing the Model for Improvement, providing the collaborative teams with effective Plan, Do, Study, Act (PDSA) cycles to test the effectiveness of the chosen intervention, creating a feedback mechanism for understanding individual team progress, utilize the QIO information system for real-time communication, leading conference calls and webinars. Utilizing social media outlets to promote the work of collaborative teams and share effective practices, develop vignettes to highlight the work of high performers in the state or bring to light areas that require additional focus.

5. **Participate in National Meetings Convened by CMS or the National Coordinating Center.**
The QIO will be expected to participate in national meetings aimed at coordinating Learning and Action Networks activities. At least one meeting per year will occur face-to-face in the Baltimore/Washington area and other meetings will be held either face-to-face or by satellite broadcast or similar technology depending on topic.

6. **Feedback mechanisms and Sharing Best Practices**
The QIO in conjunction with its Learning and Action Networks shall develop a feedback mechanism that identifies areas of excellence for the purpose of spread, and areas where additional focus must be placed for the purpose of impacting the goals as outlined by the aim statement. The QIO shall collect and share best practices and learning from the Learning and Action Networks, the National Coordinating Center, CMS and other partners on an ongoing basis.

7. **Sharing Data**
The QIO shall share improvement information such as aggregate data findings, intervention results, observation, or patient feedback (non-QRS data or other non-confidential data) collected through the Learning and Action Networks and develop a plan of action based on findings.

8. **Recognition**
The QIO shall develop methods of recognition and awards (non-monetary) for Learning and Action Networks participants who meet or exceed targets. This recognition could be in the form of highlighting an intervention in a newsletter, awarding a certificate, highlighting an activity on a webcast. Please note that the QIO shall not sponsor an activity or awards ceremony solely for the purpose of providing an award.

**Reporting**
The QIO shall report findings to CMS through the National Coordinating Center unless otherwise specified according to Section F: Schedule of Deliverables.
9. **QIO Participant Assessment**
In addition to the formal monitoring and evaluation metrics, the QIO shall periodically assess the effectiveness of their collaborative efforts as viewed by the participants. An informal assessment must be performed on an ongoing basis by asking the participants if the support they are receiving is of value. Annually a more formal assessment will be completed by CMS through an either a member survey (utilizing an OMB-approved survey instrument) and/or focus group activity. The assessment shall include the QIO’s effectiveness in areas such as: leadership, member engagement, communication, formal structures and procedures and the likely impact in improving the health of their community.

10. **Data Reporting**
The QIO will assist collaborative partners in generating data as frequently as needed but not less than monthly to ensure improvement efforts are on target. Collaborative members will generally use national data sources when available. When national data is not available or does not meet the needs because of the frequency of refresh or other issues, other data sources may be approved by the COTR for use to monitor improvement efforts.

The QIO will report data to the National Coordinating Center quarterly. The QIO must always explore methods of identifying populations that are dually eligible for Medicare and Medicaid and vulnerable populations that may receive disparate care.

C.10.1.D **Evaluation of Learning and Action Networks and Deliverables**

The 10th SoW presents new opportunities for the QIO to improve the quality and efficiency of services rendered to Medicare Beneficiaries through learning activities associated with review and exchange of Medicare data, case review, input from providers, beneficiaries and experts in the field. The drivers for achieving goals of many of the 10th SoW activities will be through either Learning and Action Networks or through Technical Assistance.

**Evaluation and Monitoring for Learning and Action Networks**

The first driver, Learning and Action Networks, will be measured by the deliverables submitted in the five (5) major categories listed below:

- Commitments Secured and Participant Engagement
- Learning Network Activities and Outputs
- Results of Learning Network Efforts in Meeting Contract Aims and Goals
- Value of the Learning and Action Networks to CMS and Participants
- Ability to Prepare the Field to Sustain the Improvements

Because of the nature of Learning and Action Networks, certain expectations cannot be numerically specified ahead of time. Many of the learning activities, number of
participants, etc. may be dictated by the members of the Learning Network in the local area given the population, geographic factors, most significant area of concern for a topic, etc. CMS expects all of the QIOs to strive to achieve the maximum benefit possible within the CMS-provided level of effort in carrying out activities of the Learning and Action Networks. The QIOs must work to benchmark themselves against other performers in this area and strive to be top performers just as they are encouraging maximum performance of their Learning Network participants. Striving for maximum participation of providers and the quality of learning network activities will be considered when determining the success of the contractor for additional initiatives in the 10th SOW and beyond.

1. Commitment Secured and Participant Engagement

The QIO shall achieve the maximum recruitment and commitments of eligible participants in the state within the CMS-provided level of effort. In some cases, the eligible participants will be defined in each of the specific projects. When a specific number or type of participants are not identified in the contract, the QIO performance will be evaluated on the number of participants recruited given the number of providers in the state, the population of the state, and performance of other QIOs with similar characteristics. As noted above the QIO must strive for maximum participation.

**Monitoring:**

1. The QIO shall provide a report of commitments to participate in the Learning Network as specified in the schedule of deliverables in Section F.

2. QIO performance shall be evaluated on the QIO’s ability to maintain at least the specified percentage of recruited participants throughout the course of the project as described in Attachment J-10.

The QIO shall provide an update on the number of participants that remain active in the initiative throughout the course of the initiatives. Active involvement can be demonstrated by multiple means including lists of attendance at meetings, webcasts, conference calls; documented requests for technical assistance, documented requests for resources, or an attestation of participation signed by the participant. The active participation shall be documented on the Learning Network Report Template and provided quarterly as outlined in the schedule of deliverables in Section F.

The QIO shall ensure Medicare beneficiary patient engagement in the Networks.

**Monitoring:**

1. The QIO shall report on the number of beneficiaries included in activities of the Networks and provide a brief description of the nature of the Beneficiary engagement. The report shall be provided Quarterly on the Learning Network Report Template according to the schedule of deliverables in Section F.
2. The QIO shall ensure Leadership and Board Engagement in the Learning and Action Networks.

**Monitoring:**

The QIO shall report on the number of CEOs and Board Members included in activities of the Networks and provide a brief description of the nature of the Leadership Engagement. The report shall be provided quarterly utilizing the Learning Network Report Template (which will be provided at the start of the contract) according to the schedule of deliverables in Section F.

2. Learning Network Activities and Outputs

The QIO shall report quarterly on the activities conducted by the Learning Network using the Learning Network Report Template. The report shall include information that addresses the following questions: What are the agreed upon priorities for the learning network as it relates to the specific Aim? What quality improvement interventions will be employed? What measurement system will be utilized? What activities were completed during the reporting period? What new learnings were generated and how were these learnings shared with other members of the Network? How much did the activity cost?

3. Results of Learning Network Efforts in Meeting Contract Aims and Goals

The purpose of Learning Network Activities is to achieve the goals of better health, better care and lower costs through improvement. Each of the QIOs will be evaluated on how they have contributed to achieving national goals in these areas at the local level. Success will be evaluated by achieving the local targets specified in each of the Aims in the SOW. The quantitative measurement of achievement will be reported on the Learning Network Report Template according to the schedule of deliverables in Section F. The data source for the measures is specified in each of the Aims in the SOW.

4. Value of the Learning and Action Networks to CMS and Participants

It is essential that the Learning and Action Networks bring value to the participants such that they continue to see the need to participate through the end of the initiative. This is true even when they have achieved their goals as they can help those that are still working towards the goal. The QIO must constantly assess the value of the Learning Network for the participants using the best method as determined by the QIO. The QIO must make midcourse adjustments based on the feedback it receives from its participants. The QIO must provide summary reports of the feedback it receives from its participants to CMS through the Learning Network Report Template on a quarterly basis. At least once during the learning cycle the QIO shall more formally solicit feedback by a survey or focus group as directed by CMS. The solicitation of feedback will focus on questions such as how relevant were the topics to the work of the members? How well did it meet
the needs of the group? What was the perceived quality of the activities? What are suggested areas of improvement?

**Monitoring:**

The QIO shall provide a quarterly summary report of the feedback obtained from the participants utilizing the Learning Network Report Template according to the schedule of deliverables in Section F.

The QIO shall obtain feedback in the form requested by CMS from participants, and provide a summary of the findings to CMS along with a 15% sample of the actual de-identified supporting documents according to the schedule of deliverables in Section F.

5. **Ability to Prepare the Field to Sustain the Improvements**

The QIO shall provide a quarterly report of the progress of the QIO plan for sustainability utilizing the Learning Network Report Template according to the schedule of deliverables in Section F.

**C.10.2. Providing Technical Assistance to Providers, Facilities and Partners**

**C.10.2.A. Background- Providing Technical Assistance**

The QIO shall offer direct assistance for specific quality improvement questions and needs to support local providers in making change by connecting the requestor with quality improvement knowledge, providing enthusiasm, confidence and follow up available at the local and national level. The QIO shall rely both on their own internal resources, those of the community, those availed by Federal agencies and on the advanced resources of the National Coordinating Centers. The QIO shall provide technical assistance to individual providers, provider groups or health care systems upon their request as well as upon the direction of CMS.

In general, technical assistance is more focused, limited and directed than activities of the learning and action networks although it could be a component of these activities. For example, technical assistance may be given to Critical Access Hospitals to help them enter data for the Hospital Inpatient Quality Reporting Program. Another example might include providing technical assistance to the providers having difficulty interpreting the data they extracted from their electronic health record for an immunization monitoring as directed by CMS. These efforts may or may not be performed in conjunction with Learning and Action Network activities.

**C.10.2.B. Specific Requirements Providing Technical Assistance**

1. **Provide Consultation**

   The QIO will provide staff expertise or identify local experts to serve as quality advisors and consultants on the issues associated with the Aim utilizing this driver. The QIO will identify leaders and resources at state
agency programs, civic associations, social and religious organizations, patient advocacy groups, disease awareness programs, private health insurers, innovators, thought leaders and researchers. The QIO will catalogue the resource list for use by Learning and Action Networks, collaboratives and others in need of technical assistance related to local area resources.

2. **Knowledge Management**
Provide technical assistance to providers, facilities and partners requesting assistance in order to facilitate improvement through the sharing of knowledge, enthusiasm, confidence and follow up so that change is not only possible, but also sustainable. In partnership with, and as a local voice for conveying information from a National Coordinating Center, the QIO shall ensure relevant and up-to-date, evidence-based information as well as innovative approaches suggested by leaders in the field and catalogued by the QIO to make available to the local provider community:

a. Communicate expert opinions identified from experts and leaders in the field, and present the merits of intervention strategies proposed by the leaders that are emerging and therefore not part of an evidence based list of interventions.

b. Share new developments in QI.

c. Maintain and make available to the local provider community a repository of literature references in Endnote and a list of expert contacts. Working in coordination with the National Coordinating center, the QIO shall provide a current, easily accessible and accurate topic-specific resource library that is available electronically.

3. **Face-to-Face and Hands-On Teaching and Information Exchange**
For certain activities identified by CMS, the QIO will provide onsite teaching or mentoring: Providing initial training concerning potential intervention strategies based on literature, innovation developed by a collaborator or intervention developed by consensus of the local provider community, or interventions based on other local provider communities’ special projects and other prior work, and insights from experts, Provide teaching adaptations of major intervention strategies for use in special populations when experience or evidence indicates a need and opportunity, attending to such populations as the chronically mentally ill, patients that have dual eligibility, racial or ethnic minorities, low-income, rural, or long-term disability.

4. **Sustainable Infrastructure**
A spread effort is successful only when the new ideas or practices become the way an organization “does its business.” Transferring the responsibility for facilitating the adoption of change from a QIO to a provider, provider group or health care system is essential. Planning for adoption and spread must include training and new skill development,
supporting people in new behaviors that reinforce the new practices, problem solving, and assignment of responsibility. The QIO will ensure that each initiative includes a sustainability plan and the QIO will work to achieve consensus among participants so that the quality improvement efforts will continue as the need continues. The sustainability plan will be reported as directed in Section F.

5. **Data**

a. The QIO will identify pertinent data resources available to support the local provider community. This includes claims data, data organized by other contractors, data available from the CDC, NIH, World Health Organization, and Census Bureau, the community information available through the coordinating center, the Centers for Medicare Management and Innovation (CMMI) and AHRQ.

b. The QIO shall conduct data analysis and develop meaningful data reports to be used by the local provider community, Learning and Action Networks and breakthrough initiatives.

c. The QIO shall maintain a repository of all the data acquired as well as the results. The data must be made available to the National Coordinating Centers, in accordance with data privacy laws, including the QIO confidentiality rules.

d. The QIO shall monitor for potential adverse effects of the local provider community interventions, assisting in developing plans to address them if they arise. The QIO must specifically analyze data to determine if there are any adverse impacts on persons that are dually eligibility for Medicare and Medicaid and potentially disadvantaged populations. The QIO shall monitor for potential adverse effects by:

   - Collecting and interpreting local provider community data trends, comparison and site reports;
   - Monitoring the process measures and the intervention strategies monthly and recommending improvement strategies to the local provider community, collaborators and CMS;
   - Monitoring measures within 180 days of project start;
   - Monitoring 30-day mortality after intervention initiation;
   - Monitoring 30, 60 and 90 day rate of beneficiary contacts to determine loss to service rate, follow up rate;
   - Responding to indications of possible adverse effects from monitors specific to local projects.
C.10.2.C Evaluation and Monitoring of Technical Assistance

Results of Technical Assistance in Meeting Contract Aims and Goals

The purpose of Technical Assistance Activities is to achieve the goals of better health care, better care and lower costs through improvement by providing focused assistance to providers and beneficiaries as resources allow. While technical assistance will be provided as a part of many of the Learning Network activity, this section addresses technical assistance when it is provided as a standalone activity such as in the case of Hospital Inpatient Quality Reporting or other areas of the SOW. Success will be evaluated by achieving the local targets specified in each of the Aims in the SOW. The quantitative measurement of achievement will be reported on the Technical Assistance Report Template (which will be supplied at the beginning of the contract) according to the schedule of deliverables in Section F. In addition to targeted technical assistance, the QIO may provide technical assistance to other providers upon request and the quantity and nature of this assistance must also be documented.

Monitoring:

The QIO shall complete the Technical Assistance Report Template which contains fields to capture the above information. The Report shall be provided according to the schedule of deliverables in Section F.

C.10.3 Care Reinvention through Innovation Spread (CRISP) Model

C.10.3.A. Background - CRISP Model

Traditional “communications” work for all elements of this contract shall be delivered by utilizing the following model. The model has 3 phases: 1) initiation and “will building;” 2) engagement and maintenance; and 3) retention and sustainment throughout the life of the QIO task. The goal of the model is to give access to the right information and services, in the right form, at the right time, to the right people in the right place. The model does this by focusing the QIO’s energies such that each policy, action, and decision is made with an educated and strategic consideration of the impacts they may have on stakeholders.

Because every task has “stakeholders,” every task shall be informed by the principles of the model. The model shall be used throughout all activities; it minimizes internal fragmentation and siloing within the QIO so that all operations are stakeholder-centric and support at least 1 of 3 model phases. Examples of activities that would fall under the auspices of this driver are articulated in attachment J-11 of this contract.

C.10.3.B. Definitions - CRISP Model

The definitions provided in the Attachment J-1: Glossary section of this contract shall pertain to the work performed under the CRISP model.
C.10.3.C. Specific Requirements - CRISP Model

1. **Innovation Spread Advisor (ISA)**
   Each QIO shall appoint 1-2 individuals to serve as ISA(s), which are considered key personnel for their state or territory. This individual shall bring knowledge to every QIO Aim (or project) team within the enterprise by helping Aim teams answer the following questions, as well as implement the answers to these questions.

   - Who is this project’s stakeholder(s)?
   - What information needs does each stakeholder have within this project?
   - What objectives do we have for fulfilling each stakeholder’s information needs?
   - How can we best fulfill those objectives (i.e., what are the best ways to deliver information to our stakeholder, based on its unique needs)?
   - How can we ensure beneficiary input?
   - How can QIO staff be best equipped with the information they need to communicate on an ongoing basis with stakeholders (e.g., CMS values, Program brand principles, messaging on key messages to be articulated at key milestones in each project, etc.)?
   - Once we attempt to fulfill those objectives, how will we know whether our attempts were successful?

   a. The ISA(s) from each QIO shall attend a CRISP conference four times per year throughout the three-year cycle of the contract in order to share best practices and results from the use of principles in QIO work. The training yielded from these conferences will be delivered to ISA(s) in a train-the-trainer format, since advisors shall share the learning outcomes from these conferences with any employee conducting direct-line QIO work.

   b. Three of these conferences will be specific to CRISP itself and will be delivered virtually so that no travel costs are incurred, and the fourth conference will be a more general gathering about all facets of QIO work and will be delivered as part of the annual conference of CMS quality improvement contractors (i.e., the QualityNet conference in Baltimore), which will require ISA(s) to attend in person or, at the COTR and CRISP GTL’s discretion, to designate an alternate attendee.

2. **Brand Ambassadors for Local Presence of the National QIO Program Brand**
   ISA(s) from each QIO shall identify which members of QIO Aim teams shall serve as brand ambassadors. Each Aim team shall contain at least
one individual designated as a “brand ambassador,” although the QIO may designate as many individuals as needed for this designation.

   a. ISA(s) shall deliver periodic training to brand ambassadors throughout the course of the period of performance to assure that their interactions with all stakeholders embody a stakeholder-focused approach and embody the principles of the QIO Program brand (i.e., it delivers service that is trusted, collaborative, knowledgeable, credible, committed, and focused in its efforts to improve health quality).

   b. ISA(s) shall follow CMS guidelines for the integration of national QIO program brand messages into local-level materials and in the actions of brand ambassadors. These guidelines will be provided prior to the start of the contract.

   c. Brand ambassadors are individuals who participate in Aim teams or Aim-specific work under the SOW. These individuals are typically those project members who interact with providers, beneficiaries, and other Aim-specific stakeholders on a regular basis. Brand ambassadors serve as subject-matter experts on the integration of CRISP principles in all aspects of the Aim team’s work, including integration of Brand principles and CMS operating values into the messages of the Aim, as well as assuring that the operations of the Aim meet as many stakeholder needs as possible (i.e., Aim work is stakeholder-centric).

3. **Administer Local Presence for National-level Collaboration Tools.**

   ISA(s) from each QIO shall use national-level collaboration tools—e.g., wikis, discussion boards, co-creation tools, document-sharing workspaces, web-meeting tools, web language, and other tools as made available from CMS and their contractors—to manage interactions as appropriate for facilitating online webinars, training sessions, virtual conferences, virtual communities of practice, or other stakeholder-facing tactics as deemed appropriate by the QIO (and as necessitated by the QIO’s own audience analysis).

   a. The QIO shall deploy ISA(s) resources to establish local- and regional-level groups, distribution lists, and other tools that allow the local QIO to connect with stakeholders using CMS’ national-level collaboration tool.

   b. ISA(s) shall partner with quality improvement teams within the QIO to recruit, train, and engage stakeholders on using the collaborative tools and shall promote their use among stakeholders.
c. ISA(s) shall also work with quality improvement teams to maintain engagement throughout each project’s duration to assure that the materials available within the collaborative tools meet stakeholders’ ongoing communications and information needs, that the collaborative tools are up-to-date, and that the messages delivered through the collaborative tools are aligned with CMS program priorities as articulated through CMS and its coordinating center contractors.

d. The QIO shall follow all guidance from CMS regarding the use of collaborative tools in deploying its projects and interventions. This guidance will come in the form of TOPS memoranda, instructions from COTRs, and other CMS-generated guidance documents. To assure efficient and effective delivery of collaborative tools as part of the Program’s mission to spread health systems delivery innovation, the QIO shall not deploy their own separate collaboration tools apart from CMS’ national system without first consulting with the COTR and CRISP GTL about how the national-level tools are inappropriate for the QIO’s stakeholders’ unique needs.

4. **Internet and Social Media Tools.**
The QIO shall maintain a web presence for the program at its state or territory level. The QIO shall follow all web guidelines as articulated by CMS (see Section C.15 of this contract) and its coordinating center contractors, including requirements for compliance with Section 508 of the Rehabilitation Act of 1973 and the Privacy Act. More details about the Internet and social media requirements of this contract are also articulated in attachment J-11 of this contract.

5. **Integrated Innovation Spread Strategy (IISS).**
On September 1, 2011, and every 3 months thereafter, each QIO shall submit an Integrated Innovation Spread Strategy (IISS) deliverable, which shall consist of the parts described in Attachment J-11. The IISS shall be completed in a format prescribed by CMS and its coordinating center contractors, and submitted to CMS in accordance with the requirements of this SOW. More details about the IISS are outlined in attachment J-11 of this contract.

6. **Artifacts of Stakeholder-Facing Tactics**
Stakeholder-facing tactics are any activities performed by a QIO to deliver a message to a stakeholder or group of stakeholders. Artifacts of these tactics are defined as those bundles of material and cultural properties packaged in some socially recognizable form. On December 1, 2011, and every 6 months thereafter, each QIO shall submit a portfolio of
stakeholder-facing artifacts. This is a separate deliverable from the IISS, described above. More information about this deliverable is available in attachment J-11 of this contract.

7. **CMS Pre-approval for Certain Outreach Costs**
No QIO shall use any contract funds for purchases that contain—in whole or in part—any item(s) that meet the definition of “Promotional Item” per attachment J-1 of this contract. In addition, QIOs shall submit a proposal to CMS in advance of spending contract funds in excess of $500 for any purchase that meets the definition of “Outreach Item” per attachment J-1 of this contract. Furthermore, QIOs shall submit a proposal to CMS in advance of any spending on communications tactics that meet the definition of “Paid Media” per attachment J-1 of this contract, regardless of the dollar amount of the purchase. QIOs shall submit these proposals in a format specified by CMS and/or its coordinating center contractor, and shall submit them to CMS at least 30 days before the QIO intends to make the purchase. At their discretion, the COTR and/or the CO may ask the QIO for additional documentation to support any outreach cost, and they may negotiate with the QIO to increase or decrease the extent of this proposal as needed. Costs for outreach items and paid media items that require CMS pre-approval and that do not have such approval will be deemed unallowable under this contract.

C.11. **CONTINUOUS LEARNING THROUGH RAPID DEVELOPMENT AND DEPLOYMENT OF SPECIAL INNOVATIONS PROJECTS**

CMS reserves the right to direct the QIO to initiate a special innovation project not currently defined under this SOW or to approve an application from the QIO to conduct a special innovation project, hereafter referred to as Innovation Projects.

An innovation project is defined as work that CMS directs a QIO to perform or work that CMS approves the QIO to perform that is not defined under this SOW. The innovation project work shall fall within the scope of Section 1154 of the Social Security Act. The innovation project shall be conducted in accordance with Sections B.5 and G.20.

All innovation projects awarded under this contract will be evaluated individually. The QIO’s performance on an innovation project will not be factored into the overall evaluation Section C.5 of the QIO’s work in this SOW.

The performance assessment for each innovation project will be conducted jointly by the QIO’s COTR and the innovation project GTL.

The QIO’s COTR and each project’s GTL will conduct periodic monitoring of the contractor’s progress towards completion of the innovation project. The
frequency and nature of this monitoring is to be determined by the COTR and GTL, but is anticipated to occur on a quarterly basis by teleconference or videoconference. The contractor shall participate in these monitoring activities, including the provision of a brief summary of activities, internal quality improvement, barriers and efforts to address those barriers, and other pertinent information as directed by the COTR. Innovations projects are expected to be time limited.

C.12. QIO INNOVATION PROJECT TO ADDRESS CMS PRIORITY

CMS reserves the right to direct the QIO to initiate innovation projects not currently defined under this SOW through activation of this section. Examples of two potential projects are listed below:

1. **Lowering Costs through Improvements: Exploration of Malpractice Factors**
   As directed by CMS, the QIO will implement a two-phase Innovation Project in which Phase I will involve conducting the research on safe harbors, available standards, important legal components and a model for a safe harbor pilot as authorized by 42 U.S.C. §1320c-6(c). Phase II will include launching the pilot in a state(s) to determine the interplay between the pilot, state law and regional variation. The project will integrate the aims of patient safety improvements; timely resolution of disputes; increased communication between providers and patients; and lower liability insurance rates.

2. **Patient and Family Engagement Campaign**
   As directed by CMS, the QIO must develop and implement a Patient and Family Engagement Campaign that supports the DHHS and CMS goals of person-centeredness and family engagement and promotes statewide quality improvement that aligns with the National Quality Strategy. The Campaign will begin on August 1, 2012.

3. **Using Data to Drive Dramatic Improvement in Communities**
   The QIO shall perform this work at the direction of CMS. CMS shall direct this work to States that meet CMS criteria as having communities with opportunities for improvement.

   A. **Develop the State-Wide Community Healthcare Indicator Map**
   States use various approaches to define their communities. Some states may define their communities by Hospital Referral Regions, counties or by a group of zip codes. The QIO shall determine the appropriate definition of community for their state with guidance
that will be provided by CMS so that the definition is not so broad that a community represents greater than a certain percentage of the entire state population. The QIO shall use data made available by CMS or other directed sources to inform its geographic information and selected areas of improvement.

B. **Scan Horizon for Indices of Patient Care, Population Health and Per Capita Cost**

The QIO shall conduct a review of indicators. While there are many sources for indicators, the selected indicators of quality health care, health outcomes and costs must be supported by clinical evidence and data. There are multiple enterprises engaged in improving the health of a community. There are many articles and organizations that list indicators of patient care, population health and cost.

1. Working in collaboration with CMS and the National Coordinating Center for Care Transitions, the QIO shall establish smaller community focused learning and action networks using the guidelines in C.10.1; the learning networks will be smaller and more focused on a specific community target. The QIO shall work with these enterprises, alliances and collaboratives to determine which of the health indicators require additional review and action to improve the quality of care or efficiency in the geographic area under review. The goal is to maximize agreement on which indicators are most relevant for their state to achieve the three aims of (1) improved health care for individuals, (2) improved population health, and (3) reduced per capita costs through improvement.

C. **Select Indices and Prioritize**

The QIO, in coordination with CMS, will prioritize which indices or parameters are the biggest potential drivers for improved care, improved health and decreased health care cost, as well as which indices provide the greatest opportunities for significant improvements. The QIO shall develop and prioritize the list by analyzing data and linking indices to cost, mortality rate and other factors determined by the QIO and its partners to be significant contributors to health, care, and cost. Each community on the state map must link to the 10 indices selected by the QIO.

D. **Community Engagement & Planning**

The QIO shall team with the National Coordinating Center for Care Transitions and community leadership to 1) design and 2) conduct rapid cycle community-based improvement initiatives.
The QIO shall use the results of the horizon scan to engage the support of the National Coordinating Center for Care Transitions in the design and conduct of intensive community engagement initiatives aimed at making rapid progress in areas identified as ripe for improvement.

The aim of each community based initiative will be driven by the underlying data from the Horizon Scan, and the dynamic processes of community engagement and action. The aims must be clear, bold and measurable.

The Care Transitions National Coordinating Center, the QIO and key leaders from identified communities shall co-develop an intensive initiative for making rapid improvements in the community to work with the QIO in their efforts to improve care. Progress and results will ultimately involve teaming with state and community leaders, health care providers, patients, associations, foundations, boards of directors and other key leaders to mobilize community awareness, understanding, engagement, exploration of possibilities, action, results and continuous improvement. Part of each plan shall include the active identification and development of community leaders and individuals or entities in the community committed to supporting quality improvement efforts (champions) to ensure action and improvements are sustained after QIO support is withdrawn.

The QIO and Care Transitions National Coordinating Center involvement in the conduct of the community-based work are anticipated to diminish over time. Long term sustainability and approaches to ensure this are a necessary element of each community action plan.

As part of the planning process, the QIO must consider how they might deploy resources and initiatives required in other parts of their contract and scope of work to assist these communities. For example, these communities may benefit from targeted involvement in other QIO-supported initiatives on CAUTI, Drug Safety and/or other elements of the 10th SOW.

E. Implement the Plan, Generate Results & Track Progress

The QIO, the Care Transitions National Coordinating Center and key leaders from identified communities work together to implement plans for making rapid improvements toward agreed-upon aims. It is anticipated that these plans and activities may include, but not be limited to, the following kinds of activities:
• Awareness: Coalition meetings of community leaders to review community data on health care quality, population health and costs.

• Understanding the need and possible solutions: Presentations of solutions used by other similar communities and provider organizations to achieve similar improvement and results.

• Possible solutions: Site visits to other mentor communities who have achieved results similar to those being sought to benchmark results. Conference calls and mentoring activities with these communities and their leaders.

• Possible solutions: Use of data to brainstorm and select ideas for improvements.

• Partnerships: Community leaders, hospital board leaders, provider organizations and others convene working sessions to identify who in the community could do what by when to implement ideas and achieve improvements.

• Action: Working Sessions to secure commitments for action from key community leaders, health care organizations, providers and others.

• Commitment: Public declaration and commitment to the overarching aims. Testimonials by patients and providers about the need for and benefits of improvements. Resolutions and actions by city councils, hospital boards and others to formally commit to the improvements and to assign and align resources with action plans.

• Monitoring: Regular reporting of action and results by those who have committed to action.

• Continuous Improvement: Meetings and Working Sessions to check in on progress, work through problems and challenges, ensure commitment to the Aims, celebrate progress, reassess overarching purposes and strategies and more.
C.13. TRANSITION FROM INCUMBENT QIO TO SUCCESSOR QIO

C.13.A. General Guidelines

At the end of this contract, if a determination is made to terminate or not renew the incumbent QIO’s contract, the QIO shall provide similar transition/phase-in/phase-out support to the successor QIO selected by CMS (refer to FAR 52.237-3 Continuity of Services).

In no case will this transition begin more than 120 days before the end of the contract and the aim will be for it to end at the contract’s end date. During this period, the incumbent QIO shall work with the successor QIO, CMS Staff, and other identified CMS contractors to assure continued operation of the QIO Program.

Prior to commencement of transition, the incumbent QIO shall provide a transition plan in accordance with Section F – QIO Schedule of Deliverables. The transition plan shall provide adequate coverage to assure uninterrupted service to the QIO Program, be effectively and efficiently administered, and be completed within 30 days of CMS’ review and revision of the QIO’ proposed termination plan.

Within 60 days the incumbent QIO will follow all actions identified within the current QualityNet Startup and Shutdown Procedures.

The QIO shall cooperate fully with the successor QIO, as directed by the COTR, to assure that all services continue without interruption.

The QIO shall transition quality improvement and information systems activities as directed by CMS.

C.13.B. Transition Plan

At a minimum, the Transition Plan shall provide detailed methods that will be used to ensure a smooth transition from the incumbent QIO’s operation to sole operation by the successor QIO. At a minimum, the Transition Plan shall provide for the following:

1. A plan to complete or transition to the new contractor all case reviews within 30 calendar days;
2. A plan to transition (without any lag time), receipt and processing of all expedited and fast-track appeals;
3. A milestone chart detailing the timelines and stages of transition from the effective date of contract performance until the QIO assumes sole responsibility for the QIO Program work;
4. An organizational chart that displays internal and external organizational relationships. The organizational chart shall identify the individuals (at all levels) who will be responsible for the transition and their respective roles; detail the lines of communication and how the QIO will interface with CMS during this phase of contract performance;

5. Plans to communicate and cooperate with the current incumbent QIO.

C.13.C. Transition of Government-Furnished Property

Transition services will include transfer of Government-Furnished Property (GFP) (e.g., hardware, software, records/data) from the incumbent QIO to the successor QIO, or to CMS or another CMS contractor. CMS may elect to require the transition of GFP as follows:

1. Prior to procurement of an asset, the QIO shall inform CMS of any costs that may be incurred in transition, so that CMS may evaluate and negotiate such charges;
2. All existing assets shall remain installed and usable by CMS through the transition of assets for their replacement by the successor QIO;
3. In the event a decision is made not to procure the assets, the QIO has the responsibility to dispose of the assets as instructed by CMS.

C.13.D. Transition of Case Review Materials

1. At a minimum, the incumbent QIO shall include all materials necessary for the successful transition of its case reviews to the successor QIO. These materials shall include the following items so that the successor QIO can build upon the work of the incumbent QIO with regard to its SOW case reviews:
2. Materials associated with SOW communications activities and information collection activities;
3. Materials and relevant information regarding coordination with stakeholders and other activities focused on provider satisfaction and provider/stakeholder knowledge/perception of the QIO Program;
4. Materials and relevant information regarding identified participant and statewide efforts, including recruitment, measures, and background information and materials for Section C.6 Beneficiary and Family Centered Care;
5. Other materials and information that the incumbent QIO determines necessary for the successful transition of its case reviews to the successor QIO.

C.13.E. Transition of Information Systems Activities

Within 60 days, the incumbent QIO shall:

1. Contact SDPS Help Desk and provide locations;
2. Designate a Point of Contact’s (POC’s) of QIO to initiate process;
3. Coordinate actions with CMS Management Team (CMS OCSQ’s Quality Improvement Group and the Information Systems Group, and the Division of Quality Improvement in the Boston, Dallas, Kansas City and Seattle Regional Offices, etc.);
4. Coordinate actions with QIO Primary POC;
5. Coordinate with the SDPS contractor to determine what application access rights need to be changed for any systems access and perform a master backup of the QIO applications data;
6. Coordinate and work with CMS Network GTL in ISG to shutdown the T1/Network lines;
7. Coordinate with CMS, SDPS contractor to ensure that all the workstations/file servers are functioning properly and have been properly repaired in accordance with the warranty/service agreement per the terms of the lease;
8. Coordinate Secondary Domain shut down procedures with QIO/SDPS contractor/CMS prior to performing any “Wipe Clean” applications on the Dell File Servers and Dell System Administration desktop work stations;
9. Coordinate “Wipe Clean” shut down procedures with CMS on the Dell desktop work stations prior to site visit to perform the shutdown;
10. Coordinate w/ SDPS contractor to obtain all necessary packing materials from Austin Foam to ship to QIO to be utilized by contractor staff to box up the systems for shipment (transfer to successor QIO or return to Dell);
11. Coordinate File Server backup procedures with CMS on the Dell File Servers prior to site visit to perform the shutdown and move;
12. Coordinate any Data Server backup procedures with SDPS contractor on the RS-6000 Database Servers prior to site visit to perform the shutdown and move;
13. Coordinate with SDPS contractor to determine if transfer or return of the systems is being executed prior to site visit to perform the shutdown and move;
14. Coordinate with SDPS contractor/QIO/CMS Property Disposal Office to obtain up to date inventory prior to site visit;
15. Coordinate with SDPS contractor to obtain moving contractors/supplies prior to site visit to perform the packing & shipment of IT assets;
16. Coordinate Site Visit with COTR: perform inventory and reconcile any discrepancies;
17. Coordinate Secondary Domain shut down to close out Microsoft Outlook e-mail accounts on the Dell File Servers with CMS;
18. Coordinate with SDPS contractor /CMS all backups and prepare for delivery to successor QIO;
19. Perform “Wipe Clean” on Dell File Server and System Administrator desktop work station;
20. Coordinate with shipping contractor to prepare, box, and ship all inventory to new location;
21. Complete the DHHS Property Action Forms and return to CMS Property Disposal Office.

C.14 SECTION 508 COMPLIANCE FOR COMMUNICATIONS
All deliverables shall comply with the standards, policies, and procedures below. In the event of conflicts between the referenced documents and this SOW, the SOW shall take precedence.

C.14.A. Rehabilitation Act, Section 508 Accessibility Standards
All contract deliverables are subject to these 508 standards as applicable.

1. 29 U.S.C. 794d (Rehabilitation Act as amended)
2. 36 CFR 1194 (508 Standards) www.access-board.gov/sec508/508standards.htm (508 standards)
3. FAR Subpart 39.2, Electronic and Information Technology
4. CMS/HHS Standards, policies and procedures (Section 508)

C.14.B. Web Content and Communications Materials
Regardless of format, all Web content or communications materials produced, including text, audio or video must confirm to applicable Section 508 standards to allow Federal employees and members of the public with disabilities to access information that is comparable to information provided to persons without disabilities. All contractors (including subcontractors) or consultants responsible for preparing or posting content must comply with applicable Section 508 accessibility standards, and where applicable, those set forth in the referenced policy or standards documents (above/below). Remediation of any materials that do not comply with the applicable provisions of 36 CFR Part 1194 as set forth in the SOW, shall be the responsibility of the contractor or consultant.

1. The following Section 508 provisions apply to the content or communications material identified in this SOW:
   a. 36 CFR Part 1194.22 a-j, l-p
   b. 36 CFR Part 1194.41 a-c

C.15 REFERENCE MATERIALS

1. Social Security Act
   a. § 1862 (g) http://www.ssa.gov/OP_Home/ssact/title18/1862.htm
   d. § 1160 http://www.ssa.gov/OP_Home/ssact/title11/1160.htm

2. CMS Website: www.cms.gov

5. Comprehensive Unit-based Safety Program:
   http://www.innovations.ahrq.gov/content.aspx?id=1769
6. Advancing Excellence in America’s Nursing Homes:
   www.nhqualitycampaign.org
7. Patient Safety and Clinical Pharmacy Services Breakthrough Collaborative:
   http://www.hrsa.gov/publichealth/clinical/patientsafety/index.html
8. Hospital Inpatient Quality Reporting Programs:
   http://www.qualitynet.org/dcs/ContentServer?c=Page&pagemname=QnetPublic%2FPage%2FQnetTier2&cid=1138115987129
9. Hospital Outpatient Quality Reporting Programs:
   http://www.qualitynet.org/dcs/ContentServer?c=Page&pagemname=QnetPublic%2FPage%2FQnetTier2&cid=1196289981244
12. Affordable Care Act 3026 Community Based Care Transitions Programs:
13. New Community Health Data Initiative:
    http://www.hhs.gov/open/plan/opengovernmentplan/initiatives/initiative.html
14. Healthy People 2020 Report:
    http://thomas.loc.gov/cgi-bin/query/F?c111:11::temp/~c111jQ8gvy:e351310:
SECTION D - PACKAGING AND MARKING

D.1. MARKING

All deliverables shall be clearly marked using the contract number and shall follow any directions provided in Section F.2, Deliverable Schedule.
SECTION E - INSPECTION AND ACCEPTANCE

E.1. FAR 52.252-2 CLAUSES INCORPORATED BY REFERENCE (FEB 1998)

This contract incorporates one or more clauses by reference, with the same force and effect as if they were given in full text. Upon request, the Contracting Officer will make their full text available. Also, the full text of a clause may be accessed electronically at this address:

www.arnet.gov/far/fac.html

52.246-5 Inspection of Services - Cost Reimbursement (APR 1984)

E.2. PERFORMANCE IMPROVEMENT PLAN (PIP)

In the event a QIO fails to meet its contract requirements for acceptability, a PIP may be required in accordance with QIO Manual Section 15400-15420. (See http://www.cms.gov/manuals/110 )