

QIO Program: Continuous Improvement for the Future

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Welcome to our second issue of Medicare's *QIO News*, designed to update you quarterly on the Centers for Medicare & Medicaid Services (CMS) Quality Improvement Organization (QIO) Program and its initiatives for delivering better care to people with Medicare.

Continuous Improvement for the Future is the QIO Program's pledge as we face changes in the ever-dynamic landscape that is American health care. Once limited in function to the review of health care provider performance, the Program has evolved over the past several decades to include assistance to home health agencies, hospitals, nursing homes, and physician offices to help them improve processes and outcomes of care.

In recent years, and with CMS increasingly serving as a public health agency in addition to a payer of services, the QIO Program has provided key support to many major agency and departmental initiatives, including Secretary Leavitt's Value-Driven Health Care Initiative, the Better Quality Information to Improve Care for Medicare Beneficiaries (BQI) project, and Chartered Value Exchanges. These initiatives encourage representatives of the private sector to join us in our commitment to improving the quality of care and reducing costs through a more transparent and efficient health care delivery system. QIOs and their work in measurement-based quality improvement and support of reliable, efficient care remain integral to these initiatives.

In 2005, we turned our quality improvement focus on ourselves and developed both short- and long-term action plans to help make the Program a more responsive and effective resource. But equally important to the Program's ability to adapt to change has been our ability to recognize improvements necessary to sustain a key grassroots effort for improving care that serves to benefit people with Medicare.

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Please share this newsletter with others interested in health care quality improvement.

National Home Health Campaign Offers New Tools

The Home Health Quality Improvement (HHQI) national campaign continues to offer U.S. home health agencies the tools they need to reduce acute care hospitalizations. There is also growing international interest in the campaign. The campaign's Web site has been visited by interested parties from more than 40 countries, and organizers have received calls from home health agencies in Canada and India praising the materials available on the site.

The campaign has recently published three new Best Practice Intervention Packages to support home health agencies in the areas of teletriage, telemonitoring, and immunizations. The packages are available online at: www.homehealthquality.org

As of August 31, 5,390 agencies had registered to participate in the campaign.

RHQDAPU: FY 2008 IPPS Hospital Final Rule Published

On August 1, 2007, CMS issued a final rule to update the hospital inpatient prospective payment system (IPPS) for fiscal year (FY) 2008. In the FY 2007 IPPS and calendar year (CY) 2007 hospital outpatient prospective payment system (OPPS) final rules, CMS proposed to add new measures to the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program to bring the total to 27 measures for FY 2008. The expanded set of 21 measures for FY 2007 incorporates the 10-measure starter set from 2003.

RHQDAPU is intended to provide consumers with quality of care information to help them make more informed decisions about their health care, while encouraging hospitals and clinicians to improve the quality of inpatient care.

CMS plans to finalize the set of RHQDAPU measures for the FY 2009 Annual Payment Update in November 2007.

The FY 2008 IPPS Final Rule Fact Sheet can be viewed on the CMS Web site at:

<http://www.cms.hhs.gov/apps/media/press/factsheet.asp?Counter=2338>

QIO Activities Addressing Medication Use Chronicled in *Journal of Managed Care Pharmacy*

As part of the 8th Scope of Work (SOW), QIOs across the country are conducting a wide array of quality improvement projects focused on medication use by beneficiaries enrolled in Medicare Part D. An overview of these projects compiled by the American Health Quality Association (AHQA) and the Physician Practice/Pharmacy Quality Improvement Organization Support Center (PPP QIOSC) was published by the *Journal of Managed Care Pharmacy* in July 2007. The majority of QIO projects on this topic focus on prescribing practices in the ambulatory care setting, while a few focus on nursing home prescribing or continuity of care between settings. Although the final results of these projects will not be available until after the 8th SOW concludes in the summer of 2008, the report confirms that the partnerships formed between QIOs and Medicare Part D plan sponsors have great promise for the years to come.

To view the AHQA/PPP QIOSC report, visit:

<http://www.amcp.org/data/jmcp/July%20B%20Supplement.pdf>

Medicare Bus Rolls Across the U.S.

Medicare's "A Healthier US Starts Here" bus tour kicked off April 20, 2007, in Washington, DC. After visiting more than 145 cities and 48 states, the tour concluded on August 31 in Las Vegas.

The Healthier US tour traveled from state to state, visiting state capitals, community events, partner meetings, and senior centers. At each stop, CMS and DHHS officials partnered with state and local officials, disease prevention advocates, and other community partners to help raise awareness of the importance of preventing chronic disease and illness; to promote Medicare preventive benefits; and to provide information about how beneficiaries can take action to maintain and improve their health.

The tour made a positive impression, garnering media attention from both national and local media outlets, with more than 43 million media impressions.

Many QIOs participated in or hosted events related to the local bus stops, including health screenings and forums featuring high-profile speakers. The New Mexico

QIO hosted an especially successful health fair with local partners that drew in 700 attendees from various constituencies including American Indian tribes.

QIOs Support Value-Driven Health Care

Two components of DHHS Secretary Mike Leavitt's Value-Driven Health Care (VDHC) Initiative are moving forward with the aid of QIOs.

The voluntary VDHC Initiative has four cornerstones: health information technology, quality reporting, cost reporting, and incentives for quality and value. As part of its support for VDHC, CMS announced six pilot sites for the Better Quality Information to Improve Care for Medicare Beneficiaries (BQI) project. CMS has contracted with Delmarva, the QIO for Maryland and the District of Columbia, to manage these sites, which are being led by diverse coalitions that include employers, health insurance plans, providers, and in some cases QIOs and Medicaid programs. These regional collaboratives are working on combining Medicare claims data with data from other payers to produce information on the performance of health care providers for the benefit of Medicare beneficiaries.

When fully implemented, the VDHC effort will be driven locally by Chartered Value Exchanges designated by DHHS. By working to achieve the four cornerstones of VDHC in their communities, these collaboratives will chart the course to transform health care at the local level through quality improvement and reporting. The first step toward being recognized as a Chartered Value Exchange is for an organization or coalition to be designated as a Community Leader by DHHS. Seventeen QIOs have already been designated as Community Leaders or are part of local coalitions that have received this designation.

QIOs Help Hospitals Decrease Mortality Rates

On June 21, 2007, CMS and its partners in the Hospital Quality Alliance announced a series of updates to the Hospital Compare Web site, including its first-ever publication of hospital outcomes in the form of 30-day mortality measures for patients admitted with acute myocardial infarction (AMI) or heart failure (HF). The first year of public reporting using the new measures includes all Medicare fee-for-service patients with a

principal hospital discharge diagnosis of AMI or HF from July 2005 through June 2006. Each hospital's mortality rates are identified on Hospital Compare as being better than, worse than, or no different from the U.S. national rates for AMI and HF.

In addition to furthering the CMS goal of increasing transparency in the American health care system, measuring and reporting 30-day mortality measures provides hospitals with information they need to analyze and improve performance. Each hospital receives a detailed report from CMS including its risk-standardized mortality rates (RSMRs) as well as patient data used to calculate its results.

QIOs across the country are working closely with hospitals that fall into the "worse than the U.S. national rate" category to help them conduct root cause analyses and quality improvement activities designed to improve the quality and consistency of their care.

CMS Changes Hospital Discharge Appeal Process

CMS requires hospitals to advise Medicare beneficiaries of their right to appeal a hospital discharge. Beginning July 1, 2007, the process for notifying beneficiaries of their appeal rights was changed. Hospitals are now required to give Medicare beneficiaries a revised notice and verify understanding of the right to appeal. The notice must be given to all Medicare beneficiaries including those enrolled in Medicare Advantage (MA) and other Medicare health plans.

Hospitals must provide the Medicare beneficiary or his/her representative with a notice titled "An Important Message from Medicare" (IM) within two calendar days of admission. The IM informs Medicare beneficiaries of their rights, including discharge appeal rights. The beneficiary or his/her representative must sign and date the notice indicating that he/she has received and understands it. No more than two calendar days before discharge, the hospital must provide a copy of the signed IM to the beneficiary or his/her representative. The follow-up IM is not required if the first notice was given within two calendar days of discharge.

Why the added step in the appeal process? The purpose is to ensure that beneficiaries are aware of their discharge appeal rights when these rights are most relevant: soon before discharge. If the beneficiary or his/her representative appeals the discharge decision to

their state or jurisdiction's QIO, the hospital or MA plan must then deliver a "Detailed Notice of Discharge" to the beneficiary or his/her representative. This document gives the hospital or MA plan's explanation for the scheduled discharge date and explains that a decision on the appeal will be made by the QIO.

For more information, visit:

http://www.cms.hhs.gov/BNI/12_HospitalDischargeAppealNotices.asp

Advancing Excellence in America's Nursing Homes Campaign Wins Major Grant

The Advancing Excellence in America's Nursing Homes campaign has been awarded a grant from The Commonwealth Fund to support the development and operation of Local Area Networks for Excellence (LANEs), which are the lynchpins of the Advancing Excellence campaign. As of August 31, 5,850 nursing homes—more than a third of the nation's total—are participating in the voluntary national campaign.

Each state LANE is responsible for supporting providers and consumers in achieving the campaign goals. Thirty-five QIOs serve as LANE conveners, responsible for organizing and leading their state coalitions. These QIOs work with LANE members to:

- raise awareness of the Advancing Excellence campaign among providers and consumers;
- recruit providers and consumers to become campaign participants;
- promote the use of evidenced-based protocols in nursing homes;
- provide access to educational resources and create opportunities for shared learning;
- foster constructive relationships among stakeholders.

The Commonwealth Fund grant will support a national field network coordinator; development of written materials to inform providers, policymakers, and others about progress made and lessons learned; and travel costs to campaign events.

For more information on the campaign and to check on the latest news, visit: www.nhqualitycampaign.org

New Post-Acute Care Assessment Instrument in Development

For more than 20 years, clinicians and regulators have sought ways to evaluate the clinical status and needs of patients moving between care settings. Until now, Medicare benefit and payment policies have focused on phases of illness, defined by specific service sites, rather than patient characteristics and care needs. Thus, payments across care settings may differ considerably even though patients' clinical characteristics and services received may be similar.

Building on years of clinical interest in having records that cross settings, Congress mandated in the Deficit Reduction Act of 2005 that CMS develop a way to assess patients at hospital discharge and through "post-acute" care.

CMS has made significant progress in the development of such an instrument, the Continuity Assessment Record & Evaluation, or CARE. CARE is built on insights gained from a variety of current assessment instruments, as well as on research and the experience of users. QIOs' expertise across all key settings of care will make them an invaluable resource in helping CMS develop CARE as a valuable tool for the American health care system.

CMS solicited feedback on the CARE instrument through a 60-day public comment period ending September 25.

To see the complete instrument, see the Federal Register Notice published July 27, 2007, at:

<http://a257.g.akamaitech.net/7/257/2422/01jan20071800/edocket.access.gpo.gov/2007/pdf/07-3647.pdf>



QIO Highlights

WV Patient Safety Project Highlighted as Rural Success Story

West Virginia is one of 13 states with "exemplary" rural health programs profiled in a publication of the National Rural Health Association.

An article titled "West Virginia: Quality Improvement Organization – Partner for Safety" describes how the state's QIO and its partners used information technology to improve rural care.

The QIO, West Virginia Medical Institute (WVMI), implemented its patient safety project in 2001. As part of the project, hospitals voluntarily provide WVMI with data on medical errors. More than 40,000 events have been reported to date. WVMI received a federal grant from the Agency for Healthcare Research and Quality in 2004 to expand the project.

WVMI staff note that the project owes its success to the dedication of its many partners, which include 28 rural hospitals, the West Virginia Hospital Association, the West Virginia Office of Rural Health, Verizon, and Quantros, Inc., a California company that develops software for health care providers.

The 15,000-member National Rural Health Association is a nonprofit organization that provides leadership on rural health issues.

See: Calico FW, Myers W. *What Makes Rural Health Care Work? An NRHA American Tour*. Kansas City (MO): National Rural Health Association; 2007.

AQAF Recognized for Work to Reduce Cancer Screening Disparities

AQAF, the QIO for Alabama, has received an Award of Excellence for its contributions to reducing disparities in breast and cervical cancer screening rates between black and white women in the state. The award was presented by REACH 2010, a project coordinated by the University of Alabama at Birmingham and funded by the Centers for Disease Control and Prevention.

REACH 2010 targets black women, aged 40 and older, in three urban counties (Mobile, Montgomery, and Tuscaloosa) and six rural counties (Choctaw, Dallas, Lowndes, Macon, Marengo, and Sumter) in Alabama. Participation in the REACH 2010 coalition complements other AQAF activities focused on increasing mammography rates among African American women in the state.

AQAF serves on the REACH 2010 steering committee. The QIO has provided outpatient summary data for the target counties to help the REACH 2010 coalition target its interventions to address the greatest need, provided educational materials to beneficiaries in the target area, and educated community health advisors in the target area about Medicare preventive services.

OFMQ Selected To Develop Quality Measures for Hospital Outpatient Settings

Under a CMS contract separate from the QIO Program, the Oklahoma Foundation for Medical Quality (OFMQ) has collaborated with The Joint Commission to develop national standardized quality measures to assess performance in hospital outpatient facilities. The measures will be used by CMS for public reporting, establishing performance-based financial incentives, and quality improvement.

The Tax Relief and Health Care Act of 2006 provided for the development of measures to assess the quality of care furnished by hospital outpatient settings such as emergency rooms, hospital-affiliated clinics, and ambulatory surgery facilities.

OFMQ's contract called for the development of technical specifications for, and feasibility testing of, an initial set of 10 measures. These measures were prioritized from a list of CMS-proposed measures based on several criteria, including their importance to quality performance, their usefulness to consumers and purchasers in decision-making, and the feasibility of data collection.

OFMQ's goal was to align the new outpatient measures with existing hospital measures that have proven to be effective as well as with Physician Quality Reporting Initiative (PQRI) measures. OFMQ, the Oklahoma QIO, considered populations and conditions that can be easily identified and in which opportunity for improvement exists, such as heart failure, pneumonia, and surgical infection. Inpatient hospitals have publicly reported performance data on heart and pneumonia care since 2004, and in 2006 added measures for surgical infection prevention.

The measure set is posted on CMS' Quality Initiative Web site at:

<http://www.cms.hhs.gov/QualityInitiativesGenInfo/>
Access the Outpatient Specifications Manual from the Downloads section.

*QIO Program: Continuous Improvement for the Future
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As we worked to implement improvements in the Program, we did so in harmony with the 2006 Institute of Medicine (IOM) study *Medicare's Quality Improvement Organization Program: Maximizing Potential*.

But there may be more changes in store for the Program. Last month, Senate Finance Committee Chair Max Baucus (D-MT) and ranking member Charles Grassley (R-IA) introduced a bill to modernize the Program, the Continuing the Advancement of Quality Improvement (CAQI) Act of 2007. Although CMS has been actively undertaking its own action plan to ensure that the Program is more focused, better structured, and managed more effectively, the CAQI legislation seeks further modernization through creation of a new infrastructure for the Program.

As we look to the future, we are actively planning for the Program's next contract cycle, or Statement of Work (SOW), which will be underway as of August 1, 2008. I am pleased to announce the selection of Paul E. McGann, MD, SM, as Deputy Chief Medical Officer to serve as a lead for me in helping move the Program toward the 9th SOW. A Board-certified internist and geriatrician, Paul joined CMS as Senior Geriatric Advisor in 2002, providing leadership for the QIO Program in the nursing home and home health tasks of both the 7th and 8th QIO contract cycles.

As we plan for the 9th SOW, we are working closely with our federal colleagues and others to help us define an SOW that will be most effective in supporting the Secretary's health care priorities. QIO work in the 9th SOW, currently in draft, focuses on four overarching Themes: Beneficiary Protection, Care Coordination: Patient Pathways, Patient Safety, and Prevention.

For the **Beneficiary Protection Theme**, a Congressional mandate, we will continue to emphasize utilization review, quality of care review, alternative dispute resolution, review of beneficiary appeals of certain provider notices, and review of potential anti-dumping cases.

The next SOW will also focus on **Care Coordination: Patient Pathways** to help Medicare beneficiaries stay healthy as they navigate the many sites of care delivery, including hospitals, nursing homes, home health agencies, and physician offices. This Theme focuses on

improving coordination across the continuum of care, and in particular on seamless transitions from the hospital to home, home health care, or skilled nursing care. The QIOs' work will help reduce unnecessary rehospitalizations of Medicare beneficiaries that both harm patients and drain the Medicare Trust Fund.

Patient Safety will also be a theme as we continue our efforts to address major areas of patient harm. For example, we will further our current work in reducing avoidable pressure ulcers and use of restraints in nursing homes. In addition, we will focus on surgical care improvement, reducing the incidence of drug-resistant staph infections in hospitals, and improving drug safety, among other strategies.

With Medicare's added coverage for preventive services in recent years, an emphasis on **Prevention** is needed to increase utilization. QIO activities under the Prevention Theme will help improve vaccination rates for flu and pneumonia, reduce the incidence and progression of chronic kidney disease, encourage the use of colorectal cancer screening and mammography, and support provider adoption of electronic health records.

In developing QIO requirements for each of the proposed core Themes, we have embedded a focus on promoting value-driven health care, supporting adoption and use of health information technology, and reducing health disparities. Underlying QIO work in the four Theme areas is an understanding that in order to improve the quality of American health care, we must first eliminate health disparities. Given the critical priority this has for the agency, I am pleased to inform you that my colleague, OCSQ Deputy Director Terris King, is leading the charge for CMS to reduce health disparities.

Disparate health care access and outcomes across racial and ethnic groups have long been recognized as public health problems in the United States. The persistence of disparities in health care is a clear reminder that improvements in quality require a significant focus on health care in underserved communities—where people start with many more health problems but far fewer resources to address them.

In closing, I want to thank you for your ongoing support for, and help in, our efforts to improve the quality of American health care. Our collaboration with you, our national partners and stakeholders, is critical. We

encourage you to engage your affiliates and contacts as we work together to create an environment for quality.

We look forward to our continued work together to ensure the right care for every person every time.

Thank you.

Barry M. Straube, MD

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P.S. As always, feel free to click on the e-mail comment link to send a question or comment. We value your opinions.

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