



Section I

Comments in this document pertain to the Request for Information to Determine Interest in Network of Quality Improvement and Innovation Contractors (NQIIC) Indefinite Delivery Indefinite Quantity (IDIQ) Contract.

The point of contact for comments included in this document is as follows:

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Section II

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Section III

Question 1:

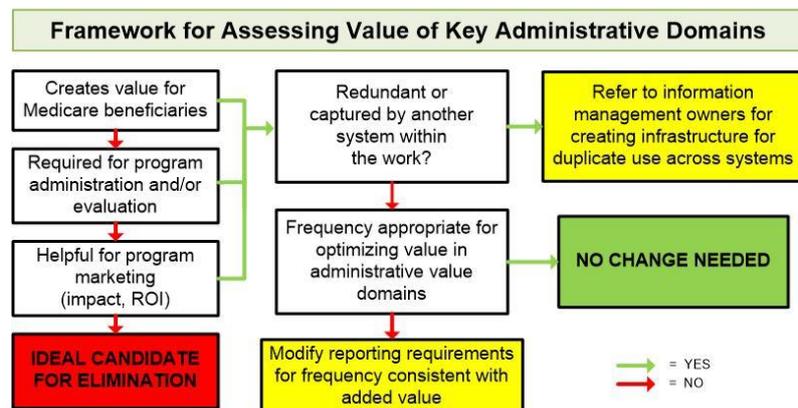
The QIN-QIO community is committed to performing all of the work activities proposed under the new NQIIC IDIQ contract structure. We have substantial experience in all of the quality improvement areas proposed under the NQIIC IDIQ and have the necessary relationships with providers, practitioners, and consumers. We are well-positioned to take on additional responsibilities over the life of the contract, based on the evolving needs of CMS.

Question 2:

Establish a standardized project-tracking system in order to manage task order activity nationwide and to structure the collection of key data elements from the start of the work. A web-based customer relationship management (CRM) style platform, into which NQIIC contractors could directly input data, would be ideal. Adoption of such a system would benefit CMS in its administration and execution of the work.

Reduce and streamline the number of required deliverables in order to focus NQIIC measurement on essential outcomes and care processes. Every effort should be made to focus on improving quality, rather than performing administrative tasks. We have observed significant administrative burden in current QIN-QIO, ESRD, HIIN, PTN, and other related quality improvement work that detracts from essential value-added activity. Aligning contract requirements, deliverables, measures, and goals will better serve all constituents.

Use a Framework for Assessing Value when assessing required NQIIC contract related deliverables. For every proposed contract deliverable in a task order, we recommend applying this simple framework (or something similar) as an initial screening tool.



Further streamline and/or simplify administrative and operational components of the IDIQ contract. For example, fixed-price awards would allow NQIIC contractors the flexibility to resource the various tasks appropriately, while requiring substantially less time preparing and submitting invoices. Permitting fungibility of funding across tasks would enhance the ability of contractors to re-allocate resources based on operational issues that arise over the course of a contract.

Define clear NQIIC evaluation expectations accompanied by greater transparency with regard to the balance between contracted goals and stretch goals. We support an

aspirational approach to the work (including the ability to go beyond contracted goals), which recognizes contractor performance that is above and beyond expectation.

In cases where multiple NQIC IDIQ contractors are assigned work in the same geographic region, we urge that collaboration and coordination of efforts be required contractually. Tightening the focus on the “what” of contractor collaboration and coordination, while allowing flexibility on the “how” it may be accomplished, will result in a greater emphasis on achievement of outcomes and results.

Initial vetting of all contract evaluation measures. There have been significant challenges with quality contractor evaluation measures over the past decade, requiring ongoing rework over the contract period. Determining valid evaluation measures with reliable data sources is often challenging. We suggest that CMS convene a national Evaluation Advisory Panel that includes representation from researchers, experts in large-scale QI implementation, and experienced contractors. This panel would work with CMS in outlining NQIC priority areas and defining and testing contract evaluation measures. The panel could be reconvened if environmental factors require that measures be updated.

Question 3:

QIN-QIOs are uniquely qualified to address all of the identified priority areas. We work across settings and across regions to achieve the goals of better health, better care, and smarter spending.

We recommend the following priorities for future quality improvement efforts, which are consistent with our organizational missions and aligned with CMS strategy. We have tested innovative approaches in these areas and are ideally configured to generate outcomes that:

Strengthen Primary Care: The importance of primary care as the foundation to an effective healthcare system has long been recognized, but not fully realized. The health-promoting influence of primary care not only prevents illness and death, but is also associated with more equitable distribution of health across population groups. Researchers and policy makers agree that strengthening primary care in the United States will not only improve health, but also restrain spending. CMS has taken important steps to strengthen primary care and has made substantial new funding available for primary care, care management/coordination, and cognitive services. Other priority areas include reducing stigma associated with mental illness, increasing access to care, and better collaboration among providers across settings. Finally we note that primary care is a frequent focus area for innovative care delivery. For example, nearly half of the Center for Medicare & Medicaid Innovation’s Health Care Improvement Awards (HCIA) [Round Two] focused on primary care, with a plan to sustain innovation through the use of the new Medicare Chronic Care Management fees. Primary care providers will benefit from collaborative learning opportunities and technical assistance to make effective use of these new resources.

Ensure Sustainable Quality Improvement. We need to establish and nurture innovation and improvement capacity across the delivery system, including hospitals, skilled nursing

facilities, dialysis centers, accountable care organizations, and other care systems. We need to assist provider organizations in creating more positive and resilient organizations that are capable of continuously improving through sustainable systems changes.

Engage Communities: Healthcare can best be improved by active engagement in the local context. Effective quality innovation and improvement requires local agents supporting community-driven solutions based on the unique strengths of those communities, using tools tailored for those communities, such as transparent performance data. NQIIC contractors require deep local roots to align efforts and effect sustainable change.

We believe that a culture of improvement and innovation will impact all of the work areas identified in the request for information. We are prepared to deliver technical assistance throughout the communities we serve in the United States, in cross-setting and regional initiatives, and through focused national task orders.

Question 4:

Our QIN-QIO community truly follows the “no wrong door” approach to technical assistance in order to meet clinicians where they are, both programmatically and geographically. As neutral conveners and not representative of any one provider type or setting, our focus is solely on helping clinicians efficiently achieve patient focused goals.

Our identified improvement priorities of strengthening primary care, ensuring sustainable and continual improvement, and engaging communities directly will help target the problem of clinical workforce burden reduction, while maintaining a strong focus on accelerating the rate of improvement. As service delivery shifts from volume to value driven payment, opportunities are created for better care for the patient and a better work experience for the clinical workforce. Our key strategies and recommendations for clinical workforce burden reduction include:

Leveraging emerging payment models to support team-based care and role redesign.

The AHRQ *Evidence Now* Initiative, the Comprehensive Primary Care initiative, and other non-QIO projects are examples of how this has been applied in an integrated outpatient services support model. It should be noted that this strategy includes a focus on business and operational models that create the conditions required for quality, safety, financial viability, and positive clinical workforce experience, while increasing practice readiness to succeed under newer payment models. It also includes redesigning care teams within organizations and creating linkages to external social and medical resources and new types of care providers, such as community health workers.

Minimizing fragmentation of improvement initiatives by disease state or contractor arrangements.

Our recommendation is that a healthcare provider should have a single point of contact for all innovation and improvement efforts – whether the funding source is from CMS, CDC, HRSA, other federal, state, commercial payers, or community initiatives. The innovation and improvement support contractor should be responsible for aligning these various initiatives and priorities, identifying high-leverage and cross-cutting change targets,

and establishing a manageable change process with providers. It is also important to seek alignment of measures and reporting requirements across initiatives and payers.

Supporting provider implementation of participatory work process design and clinical workforce engagement. Excess burden on the clinical workforce is often the result of improvement and management efforts that do not effectively involve healthcare professionals in the design and subsequently create processes that are incompatible with the local context. However, engagement of providers in a learning community, such as the Project ECHO™ model (Extension for Community Healthcare Outcomes), allows for the inclusion of real-time adaptations to the intervention driven by the participants input. The ECHO™ model itself saves practice staff time by allowing clinicians to be involved in robust learning right from their desks.

Promote resiliency in the clinical workforce. In addition to improving working conditions, QIN-QIOs have begun to integrate individual resiliency activities in quality improvement initiatives in all settings. This integration not only has a direct positive impact on the well-being of participating change agents, but, through strengths-based improvement, enhances their ability to successfully participate in QI activities.

Incorporate workforce safety and injury prevention– especially in hospital, skilled nursing, and home health settings. For more than 15 years, QIN-QIOs have been translating evidence-based occupational and industrial safety methods into healthcare applications. The incorporation of worker safety into a comprehensive safety agenda targets a specific form of burden on the workforce and, at the same time, shapes the global safety culture.

Question 5:

We encourage CMS to continue several mechanisms that have already been proven to add value, including:

Utilizing an IDIQ structure. Moving to an IDIQ structure has been beneficial, promoting adaptation to emerging needs and opportunities for innovation.

Five-year contracts. This model promotes longer-term focus and helps to achieve CMS' goals for engaging communities, providers, and beneficiaries in pursuit of improved outcomes.

Program design flexibility. For example, for the recent round of special innovation project proposals, CMS directed the QIN-QIOs to specific topics and was prescriptive about wanting: bold aims, examination of underlying causes and challenges, systematic interventions, focus on disadvantage populations, and inclusion of patients/families (the “what”). CMS then allowed flexibility for the bidders to craft project designs using alternative data sources and measures that reflected the proposed interventions and populations (the “how”).

Demonstrated engagement with the community. It's important that the bidder demonstrates strong connection and engagement with each area's local healthcare delivery systems and with community stakeholders, including the effective use of local patient advisory councils. We recommend that each CMS program under NQIIC include scoring and criteria in the proposal evaluation to value substantive and meaningful engagement at the community level.

Consider funding according to the level of effort required. For example, small, rural practices that have less infrastructure for QI require additional hands-on direct technical assistance.

Recognize that some regional interventions with integrated delivery systems cross state lines. For example, current QIN-QIO work features collaboration across QIN regions and state lines to assist facilities and providers in regional systems in utilizing their data to prepare for value-based payment programs.

Tailoring technical assistance to meet clinician needs results in a variety of activities from light touch to one-on-one technical assistance. At the start of each project, contractors should do environmental scans to assess provider capability and what approaches are needed.

Improve quality of care and strengthen primary care through integrated technical assistance efforts that align various federal, state, and private improvement projects. QIN-QIOs are testing an integrated approach to primary care, using the ECHO Project™ model, and aligning programs for providers for simplification and ease of access.

Reduce unnecessary cost and burden through transparency efforts, combined with focused technical assistance. QIN-QIOs have worked with local stakeholders to align PCMH definitions, but much work remains to harmonize metrics and minimize reporting burdens across specialties and among multiple payers. This should include eliminating process measures with only tenuous relation to improving health outcomes. For example, measuring reduction in health risk scores is a way to harmonize and eliminate excessive measures.

Utilize total cost of care measures. Total cost of care measures can be used as a quality improvement tool to provide physicians information on relative performance on cost and resource utilization. Primary care practices value total cost of care information and actively use it in discussions with specialists to eliminate avoidable costs.

Leverage available Medicare data and the resources of the Choosing Wisely initiative to address potential utilization of non-value-added services. This has been tested through direct provider intervention, as well as through coordination with a regional health initiative, to bridge Medicare and commercial data.

Consider alternatives to long term care (LTC), independence at home, and reducing unnecessary and costly transfers from LTC to acute hospitals through methodologies applied in the current CMMI project titled the Enhanced Care and Coordination Program.

Question 6:

NQIIC task order measures should be outcome driven and reportable via compatible EHRs. Automation of measurable data should be maximized to the extent possible to increase validity and decrease data collection costs. Measures should be aligned and consistent (where applicable) across the task order programs and allow for comparability. Outcome data should be verifiable and not self-reported, but also include a qualitative evaluation component.

We propose a comprehensive measurement system that incorporates both ultimate aims desired of the health system and key leading indicators of impact, which are logically connected through systems analysis to those aims. This measurement system would require investment in broad measures of health systems outcomes. This measurement strategy anticipates task structures that focus on fewer, higher leverage changes that simultaneously impact multiple settings and outcomes.

The hierarchy of measures would consist of:

System Aims (to demonstrate impact of programs and strategies over time)	Leading Indicators (to track changes with strong causal relationships to Systems Aims)
Well-being in the Medicare population Well-being of families and other caregivers of persons with serious medical conditions in the Medicare population Total cost of care in the Medicare population All-cause harm rates for hospitalized patients All-cause harm rates for skilled nursing patients Incidence rates for select chronic conditions: diabetes, hypertension, and chronic kidney disease Well-being of healthcare provider and workforce OSHA Recordable Lost Time Case Rate – for staff of hospitals and skilled nursing facilities	Utilization of chronic care management services Utilization of transitional care management services Utilization of wellness care Utilization of diabetes self-management training Participation in the Medicare Diabetes Prevention Program Utilization of preventive screenings and services (bundled measure) Primary care as a percent of total cost of care spending Utilization of preference-sensitive care (potential overuse) Behavioral health integration (BHI) into primary care; provision of BHI services Participation in advanced alternate payment models

These measures should be stratified to highlight ethnic, racial, geographic, or other disparities, with contract performance expectations and funding/resource levels adjusted to address local patterns of disparities identified. Contract evaluation should establish achievable benchmarks based on top performance, with appropriate risk adjustment.

This system should limit the use of narrowly focused process or even outcome measures, as these types of measures tend to direct efforts toward symptoms rather than root causes of performance problems and introduce issues of statistical validity due to small sample sizes.

Reacting to individual measures or performance gaps constitutes tampering at a system level. Exceptions to this principle should be employed in cases of clearly identified special cause variation (for example, 11th scope of work antipsychotic use in nursing homes) where systems analysis demonstrates that the targeted performance gap results primarily from factors specific to that measure. Use of an evaluation advisory panel of experts could help achieve these goals.

Question 7:

Healthcare delivery systems crossing contiguous states. Healthcare is increasingly delivered via systems, not just local providers and facilities. For example, across the US, integrated delivery systems organize care across multiple, contiguous states in large geographic regions. This demonstrates the connected nature of healthcare and delivery systems, which function as regional entities without regard to state borders. Hence, it's vital to consider "systemness," particularly across contiguous state borders, when proposing to cover a geographic area of the country. In rural areas, in particular, care is often delivered across state lines and within systems that are increasingly regional or national.

Readiness to engage local stakeholders within the region. Communities need high quality, safe, and affordable healthcare focused on the needs of patients and family members. Despite decades of attempting to improve the healthcare system, stakeholders across the continuum – hospitals, health systems, and health plans – need better alignment of efforts between organizations providing services related to quality improvement, technical assistance, data and analytics, and alternative payment methodologies. Purchasers of healthcare, including employers and private individuals, need to address decades of unsustainable cost increases threatening the financial security of workers, patients, and businesses across the country.

Past performance. Past performance of similar work is important in evaluating bidders for NQIC task orders.

Task order size. We support a cap on the size of each QIN-QIO task order, at a certain percentage of all Medicare beneficiaries, to ensure adequate connection to the local communities served and to provide space for innovation and diversity of ideas in implementing programs.