Project Review Tool

Reviewer Guidelines

Prepared by the Medicare+Choice
Quality Review Organizations for the
Centers for Medicare & Medicaid Services (CMS)
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Contents: Reviewer Guidelines

Review Element 1:
Project Title, Type, Focus Area

Note: *Questions 1-4 no longer appear in the on-line review tool*.

1, 2, 3. Was the selected project initiated in the correct designated year?

☐ Yes ☐ No

RELEVANT INFORMATION

1, 2, 3. The M+CO is expected to document the year in which the project was designed or in which data collection began for the selected quality indicators. QAPI standards require that the M+CO initiate the project in the year assigned (e.g., a 1999 National project must be initiated in 1999).

It is allowable for the project data period to be the initiation year (e.g., January 1999 through December 1999 for a 1999 National QAPI Diabetes project) or from the previous year (e.g., January 1998 through December 1998 when using HEDIS 1999 data for the 1999 National QAPI Diabetes project). An example of unacceptable documentation for the initiation year would be 1998 (too soon) or 2001 (too late) for a 2000 project.

4. For multi-year projects, was CMS approval obtained for these projects?

☐ Yes ☐ No ☐ N/A

RELEVANT INFORMATION

4. If the M+CO is submitting a multi-year project (i.e., one that is expected to extend beyond the usual three-year cycle for demonstrable improvement), it is expected that prior approval was obtained from CMS. The M+CO should enter the date the project was approved, the project begin and end dates, and the name of the official who provided the approval. In addition, the M+CO should define the interim goals and reporting timeframes.

5. Did the project address one of the required focus areas?

☐ Yes ☐ No

RELEVANT INFORMATION

The M+CO is expected to choose at least one of the clinical or non-clinical relevant focus areas listed. The M+CO may choose more than one focus area for a project. The focus area(s) chosen must directly relate to the project topic (see the QAPI Instructional Guide for detailed explanation and examples). There is no longer a distributive requirement for focus areas. M+COs may choose to repeat focus areas at their discretion to meet their enrollee needs.

If the M+CO documents a focus area incorrectly, but the project does, in fact, address one of the required focus areas, it is appropriate to score this element compliant and make an educational notation in the comments section of the review. For example, the M+CO selects a project topic of "Retinal eye exams for members with diabetes" and selects "Primary, Secondary, or Tertiary Prevention of Acute Conditions" as the focus area. Since diabetes is a chronic condition, a more appropriate focus area would be "Primary, Secondary, or Tertiary Prevention of Chronic Conditions." You would score the element compliant, since the project does indeed address one of the listed focus areas, but note the correct focus area in the comments section.

Note: *The focus area "Interpersonal Aspects of Care" was eliminated in 2001. M+COs may have received instruction from CMS on how to select a new focus area for a project originally designed in 1999 or 2000 to address this focus area.*

Review Element 2:
Topic Relevance

Note: *This review element does not apply to CMS-selected National QAPI projects, since they would automatically meet the topic relevance requirement. Review Element 2 only applies to projects such as M+CO-Selected projects (years 1999 and 2000), Local Market Place Initiatives, and CMS-Directed Special projects.*

1. Was the selected topic relevant to the population?

☐ Yes ☐ No

RELEVANT INFORMATION

1. The M+CO is expected to demonstrate that the project topic is relevant to the Medicare population and, more specifically, to its own Medicare members. The M+CO should select from the list one or more sources used to support the topic selection and provide a brief description of each (use of every source is not required).

Topic selection should be based upon continuous data collection, analysis, and monitoring of all aspects of patient care and service delivery, and should consider the prevalence of a condition, enrollee need for a specified service, enrollee demographics, and the interests of consumers and providers. You should evaluate whether the M+CO demonstrated that the topic is relevant to its own members—not just the Medicare population in general, and you should evaluate the appropriateness of the sources cited, based upon the following guidelines.

Literature review
If "Literature review" is selected, ***at least three*** (up to a maximum of four) literature citations are expected. The literature citations should be primary and secondary sources of information, such as reference books, periodicals, and general books. The citation should contain the author's name, title, subject, date, volume and page numbers, if applicable. The citations should be from an appropriate timeframe in relation to the baseline data year for the project. They should not occur after the baseline and/or project initiation years.

Comparisons with comparable organizations
The M+CO is expected to provide a description of its past performance, as compared to other M+COs, via national, state, or regional benchmarks, to

continued

demonstrate why this topic is an appropriate opportunity for improvement. For example, if the regional benchmark for an indicator is 60% and the M+CO's rate for that indicator is 40%, the plan may choose this topic to improve its individual performance in relation to other M+COs. (Sources for benchmarks may include CMS, NCQA, and Healthy People 2010.)

Cost analysis
The M+CO is expected to provide a brief description that includes an evaluation of financial reports that indicate variances in patient care, delivery of services, and /or customer expectations. Cost analysis should not be the sole reason for selection of a project topic.

Adverse events
Opportunities for improvement can be identified through a review of adverse events that result in serious, undesirable, and often avoidable processes or outcomes. To support the topic selection, the M+CO is expected to document the evaluation of errors, omissions, and sentinel events, as they affect expected outcomes of care and service.

HEDIS data
Use of reported HEDIS data to identify a project topic is acceptable if it is evaluated and certified by an audit firm. Measures deemed "Not Reportable" may be used, though the M+CO is required to describe the methodology in detail for those projects. If the M+CO uses a HEDIS measure as a project topic, a comparison of its own rate with local, regional, state, or national benchmarks is expected. The performance of the M+CO against the benchmark should clearly demonstrate an opportunity for improvement.

Note: *CMS expects that the topic selection process include formal opportunities for the organization's affiliated providers and enrollees to participate in the selection and prioritization of QAPI projects. Methods of obtaining provider and enrollee input are described below. In general, the M+CO is expected to document the source of the input and explain how the results indicated an opportunity for improvement for its members.*

Enrollee survey
The M+CO may conduct periodic enrollee surveys to identify issues related to health status and satisfaction. Some enrollee surveys (e.g., CAHPS and HOS) are CMS or HEDIS reporting requirements.

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CAHPS survey: This survey provides estimates on the level of satisfaction of Medicare enrollees on a wide range of experiences with the health plan. The CAHPS survey is paid for and administered by CMS. The M+CO should document the CAHPS results, explaining how they indicated an opportunity for improvement in member satisfaction. The M+CO may use comparisons of its own performance to CAHPS benchmarks to identify the opportunity for improvement.

HOS Data: The Health Outcomes Survey (HOS) is administered by NCQA-certified survey vendors according to HEDIS Volume IV specifications. The HOS is a collaborative measurement of member self-reported outcomes. The M+CO should document the HOS results, explaining how they indicated an opportunity for improvement in member health status. The M+CO may use comparisons of its own performance to HOS benchmarks to identify an opportunity for improvement.

Interviews: The M+CO may use interviews with providers and/or members to identify areas in need of change. The description of interviews with enrollees and/or providers should include the type of interview (e.g., telephone or face-to-face), the questions asked, and the issues identified by the interviews.

Focus groups: The M+CO may use provider and/or member focus groups to directly answer questions about quality of care or service for general program evaluation purposes. The M+CO should document the questions, study timelines, data period, and an evaluation of the findings and explain how they identified an opportunity for improvement.

Other: HEDIS survey measures (e.g., Advising Smokers to Quit and Management of Menopause) or the M+CO's own periodic enrollee and provider satisfaction surveys also may be used. Descriptions should include the survey topic, audience targeted, study timelines, and data period, as well as an evaluation of the findings and an explanation of how they identified an opportunity for improvement.

Provider survey
Provider surveys also may be used to identify areas where improvement is necessary. Description of provider surveys should include the same information as for enrollee surveys.

External Quality Review Organization (EQRO)
An EQRO may identify systemic quality-of-care or service delivery issues upon routine review. Documentation should include the EQRO activities and findings to support the topic selection.

continued

Quality Improvement Organization (QIO)
Similar to an EQRO, the state QIO also may identify systemic quality-of-care or service delivery issues upon routine review. Documentation should include the QIO activities and findings to support the topic selection.

Other
This should be selected if the M+CO used a source not listed above to identify the project topic. The M+CO is expected to document the source of the data and information used to choose a specific topic. This may be direction from CMS, based upon analysis of complaints and grievances, or an issue uncovered during a prior quality improvement activity.

2, 3, 4. Did the topic selection and prioritization process include a systematic process and appropriate data sources?

☐ Yes ☐ No

RELEVANT INFORMATION

2, 3, 4. The M+CO is expected to provide a clear and detailed description of the selection and prioritization process used for project topic selection. This description should include the criteria used to select the topic over other possible topics, the selection process used, the data used to support the topic selection, opportunities for provider and member input, and the body responsible for topic selection. The M+CO is expected to select and describe the data source. You should ensure that data sources selected from the aspects of clinical care and non-clinical service listings (as described below) are consistent with the project topic and include references to the plan's own data and not merely data related to the Medicare population in general.

Aspect of Clinical Care Related to Focus Area:

Prevalence of a clinical condition – an analysis of claims data to assess prevalence among the M+CO's enrollees.

Performance against a guideline – an evaluation of the M+CO providers' care delivery against recognized and recent clinical guidelines or standards of care, such as AHRQ guidelines, NCQA Quality Compass, Healthy People 2010, and those developed by specific medical societies, such as the American Medical Association (AMA), the American College of Cardiology (ACC), etc.

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Enrollee identified need – the source, such as a survey, focus group, or complaint log, and the identified need within a given specific time frame.

Enrollee demographic characteristics – the enrollee population's characteristics in terms of age, sex, ethnicity, language, disability, geographical locations, and/or functional status.

Identified special health risks in population – the "special health risk" of the population that makes this study pertinent (e.g., sickle cell disease, asbestosis, or depression after CVA).

Consumer interest/advocacy – the specific issue identified by consumers or advocacy groups that relates to an aspect of clinical care of the M+CO's Medicare population.

Significant variation in practice – variances from recognized standards of care detected in practice patterns that relate to outcomes.

High-volume service/procedure – the number of services or procedures performed for a large number of Medicare enrollees.

High-risk service/procedure – the medical or surgical service or procedure delivered that has the potential for the occurrence of adverse events.

Other aspect of clinical care – specific aspect of clinical care with documented source.

Aspect of Non-Clinical service:

Customer satisfaction – specific complaints, grievances and/ or appeals of the M+CO enrollees that relate to the topic selected.

Internal surveillance – the M+COs internal assessment and monitoring of its own performance, as they relate to the selection of the project topic, including a description of the surveillance method (e.g., Plan, Do, Check, Act).

Access/ availability of service – an assessment of access and availability of care or service for the Medicare population. CMS standards require that the organization's service planning takes into account the needs of its entire enrolled population and that the organization works to reduce barriers to access.

continued

Access/language, organizational support for cultural & linguistically appropriate service – an assessment of access and availability of care or services for a certain ethnic Medicare population (e.g., Latino or Chinese). The description should include internal assessment and monitoring of performance that the organization performed to support culturally appropriate linguistic health services for a certain ethnic group.

Other aspect of non-clinical service – specific aspect of non-clinical care with documented source.

Review Element 3:
Quality Indicator(s)

1. Was the indicator meaningful and based on current clinical knowledge for health service research?

☐ Yes ☐ No

RELEVANT INFORMATION

1. In most cases, the M+CO is required to report on only one indicator. There may be instances where CMS requires reporting on more that one indicator (e.g., the 2001 National CHF QAPI project). The indicator selected by the M+CO should be consistent with current clinical standards and health services research.

The M+CO is expected to document the source of the indicator from those listed and provide a description. CMS should only be chosen as the indicator source for National QAPI projects. However, if a national project uses HEDIS indicators, HEDIS, not CMS, should be chosen as the indicator source. Other acceptable indicator sources include the State Medicaid agency, HEDIS, M+CO–defined indicators, and published research and/or guidelines. If "HEDIS" is chosen, the M+CO must differentiate between HEDIS measures that were audited and deemed "Reportable" versus those deemed "Not Reportable." M+COs may use measures not reported. However, in describing the indicator, the M+CO **must include** the modifications or changes to specifications.

M+CO-developed indicators should be evidenced-based, use recognized clinical guidelines, or be accompanied by a consensus among expert practitioners. Indicators that are generally used within the public health community or the managed care industry, and are applicable to the topic, are preferred. Indicators also may be derived from other organizations, such as FAACT or EQRO/QIO QIPs.

(See the Instructional Guide for further details and examples of indicator sources.)

2-6. Were the Quality Indicator requirements for 2-6 met?

☐ Yes ☐ No

RELEVANT INFORMATION

2–6. In general, an indicator should be an objective, measurable, and clearly defined statement of an aspect of quality to be measured. An overview of an indicator statement should be documented. This should include:

- Who – the eligible population
- What – the service being evaluated
- When – the specific timeframe for the service to occur

The description of the numerator should include the quality criterion to be met (e.g., the service received or outcome achieved). Documentation should include dates of service and acceptable CPT procedure codes for a measure derived from administrative data, or acceptable medical record documentation (e.g., date of service and lab result) for data obtained by medical record review.

The denominator statement should include the criteria used to determine the eligible population, such as age, gender, medical diagnosis, and enrollment criteria. The M+CO also must include any additional inclusion and exclusion criteria. These limiting criteria are used to further define and refine a quality indicator. For example, in a study of visits to primary care providers, members enrolled less than six months may be excluded.

In evaluating the M+CO's documentation of the quality indicator, the essential components to be considered in order to achieve a compliance level are the indicator statement, numerator, denominator, and inclusion and exclusion criteria. The documentation of the numerator, denominator, and inclusion and exclusion criteria must include all numeric codes (ICD9-CM, CPT, DRG, HCPCS, etc.), as well as the narrative description.

If a reported HEDIS indicator is used, the M+CO is not required to re-state the specifications for the numerator, denominator, and inclusion and exclusion criteria. It is sufficient to cite the HEDIS year, technical specifications version, and page numbers (e.g., HEDIS 2000, Volume 2 – Technical Specifications, pp 24-27). HEDIS measures that are "Not Reportable" will require the same documentation as non-HEDIS indicators.

(Refer to the Instructional Guide for further information and examples of quality indicators.)

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Note: *CMS does not require that indicators used for QAPI projects include only Medicare + Choice members. M+COs may use indicators that include members from multiple product lines, so long as the indicator is applicable and includes Medicare + Choice members. Rates for Medicare+ Choice do not need to be reported separately, unless the indicator is a reporting requirement normally required by CMS (e.g., HEDIS, CAHPS).*

7 & 8. Is the Performance Target reasonable, based upon either the rationale/ justification provided?

☐ Yes ☐ No

RELEVANT INFORMATION

7 & 8. The M+CO should document the performance target selected. Preferred sources for performance targets include benchmarks or "best in class" performance, such as NCQA Quality Compass, Healthy People 2010, and CMS National Medicare CAHPS data. If a benchmark is not available or not used, the M+CO **must** provide the rationale or justification for the chosen performance target. Defining the performance target as a statistically significant improvement or a 10% reduction in the failure rate is generally not acceptable. Preferably, the performance target should be a "lofty**"** and long-range goal that the M+CO sets for itself, but for which it will not be penalized if the goal is not achieved. You should note that in the evaluation of first year 1999 QAPI projects, M+COs are not scored "non-compliant" for the selection of a less than optimal performance target or rationale. Rather, the review question is scored compliant, and an educational notation regarding more appropriate performance targets is included in the comments section of the review tool.

9. Does the Quality Indicator measure changes in Health Status, Functional Status, Enrollee Satisfaction, Aspects of Service, or Valid Proxies of these outcomes?

☐ Yes ☐ No

RELEVANT INFORMATION

9. The M+CO is expected to document the area for which change is expected, as a result of the indicator and QAPI project. The selection should relate directly to the project topic and type of indicator. For example, a project based upon the HEDIS Breast cancer screening measure will achieve a change in the "Process of Care" mammography rates. If the M+CO chooses an incorrect attribute for the quality indicator measurement, but the indicator does, indeed, measure one of the listed attributes, (e.g., the M+CO selects "Enrollee satisfaction" for a screening mammography project), it would be appropriate for you to score this question as "compliant" and make a notation of the correct attribute (e.g., valid process of care proxy) in the comments section of the review tool.

Review Element 4:
Baseline Study and Analysis

Note: *If reported HEDIS measure data is used, Full Compliance is automatically given for Review Element 4, since reported HEDIS data is reviewed and deemed acceptable by a NCQA-certified audit firm. The M+CO may indicate in the report that a reported HEDIS measure was used, and, therefore, it is not required to provide the details for data collection and analysis. Remember to review the CMS HEDIS Public Use Files to validate that the measure was indeed reportable and that the rates reported in the QAPI project report are consistent with those reported to CMS. If a HEDIS measure deemed "Not Reportable" is used for a QAPI project, the M+CO must provide detailed information regarding the data sources, collection and analysis, and this should be evaluated like a non-HEDIS measure.*

1 & 2. Were the data sources and data period clearly specified and appropriate?

☐ Yes ☐ No

RELEVANT INFORMATION

1 & 2. The data period for a QAPI project may be the project year or the prior year. For example, for the 1999 Diabetes project, an M+CO may use a data period of either 1998 or 1999 for the baseline measurement. In general, data from a time period either earlier or later than previously stated are not acceptable (e.g., prior to 1998 or after 1999 for a 1999 project). The data period should also be consistent with the quality indicator as stated in Review Element 3 (e.g., a two-year timeframe for an indicator that measures biennial lipid testing).

The M+CO must select from the sources listed and describe the data source(s). The source and type of data speak to their relative reliability and validity. To assess a project, it is important to know the data source, as it relates to the project topic.

Descriptions of the various data sources are provided below.

HEDIS data: Hybrid
HEDIS measure data collected from both administrative or claims records, and medical record documentation.

continued

HEDIS data: Administrative
HEDIS measure data collected solely from administrative or claims records.

Medical records
Data collected by abstraction from official record(s) of enrollee visits and treatments, including paper and electronic records. Medical records are defined as the collective accumulation of notes kept by all providers who treat the enrollee.

Laboratory data
Electronic data that include the laboratory or diagnostic tests, dates, and, in some cases, results.

Pharmacy data
Electronic data from pharmaceutical claims that include the medication, dose, and date dispensed.

Administrative claims or encounter data
Electronic data, not related to HEDIS measures, from provider visits, hospital stays, home health visits, home care supply, and other member encounters with health care providers and services. Most managed care systems have automated clinical informational systems that contain claims or encounter data for billing purposes. Administrative data can be collected from contracted providers, vendors, and/or public agencies.

Hybrid
Data, not related to HEDIS measures, that are collected from both administrative or claims records, and medical record documentation

Survey data
Indicates that the M+CO used data collected from a valid and reliable tool that was designed to capture the enrollees' or providers' assessment of the quality of care or service provided. Surveys, such as CAHPS, HOS, HEDIS surveys (e.g., Advising Smokers to Quit and Management of Menopause) or periodic surveys of M+CO providers or enrollees, may be used. A brief description, including the year and question number for CAHPS, HOS, of HEDIS surveys, is acceptable.

M+CO Program Data
Data derived from member enrollment logs, disease registries, complaint logs, or other M+CO-specific databases.

Other
Data derived from other sources besides M+CO program databases, such as quality improvement surveys conducted by state QIO.

3a. Was the Data Collection Method clearly specified and appropriate?

☐ Yes ☐ No

RELEVANT INFORMATION

3a. The M+CO is expected to clearly document the data collection used and to assure that it was appropriate for the indicator studied. This would include the source of the data, as noted above. For example, logical sources to determine if beta-blockers were prescribed for members with Acute Myocardial Infraction (AMI) would be pharmacy data or medical records.

3b. Were efforts employed to ensure that the data was sufficiently valid and reliable?

☐ Yes ☐ No

RELEVANT INFORMATION

3b. The M+CO is expected to document the efforts employed to ensure the validity and reliability of the data. These efforts include the processes in place to assure the accuracy, logic, consistency, and completeness of the data compiled internally or externally through outside contractors.

Examples
For a medical record review, this may include the abstractor qualifications, instructions, training, edit checks included in an electronic tool, and abstractor oversight and quality monitoring. For survey data, this would include the source of the survey instrument, pilot test, method of implementation, and handling of missing responses. For claims or encounter data derived from providers, the M+CO should document explicitly that there is a system in place for comparing reported data to a sample of medical records to verify the accuracy of reporting. The objective of a one-to-one correspondence between the two data sources is important to show consistency and accuracy.

4. Were the methods used to analyze the data and calculate the Quality Indicators clearly specified and appropriate?

☐ Yes ☐ No

RELEVANT INFORMATION

4. The M+CO is expected to describe the methods it used to process and analyze the data, including programs used (e.g., SAS, SPSS, Access, etc.), how it handled missing data and outliers, and how it calculated the quality indicator(s).
(Refer to the Instructional Guide for additional information on data sources, validity, and reliability.)

Review Element 5:
Baseline Study Population and Baseline Measurements/Performance

***Note**: Full Compliance is given when the M+CO reports on the total population. And Full Compliance is automatically given for Review Element 5 if the M+CO uses a reported HEDIS measure data or HEDIS sampling methodology, since reported HEDIS data is reviewed and certified by an NCQA-certified audit firm, and the HEDIS systematic random sampling methodology has been deemed acceptable for QAPI projects. The M+CO may indicate in the report that HEDIS sampling methodology was used and, therefore, is not required to provide further detail. Remember to review the CMS HEDIS Public Use Files to validate that the measure was indeed reportable and that the denominator, numerator, and rate reported in the QAPI project report are consistent with those reported to CMS. If a HEDIS measure deemed "Not Reportable" is used for a QAPI project, the M+CO must provide detailed information regarding the sampling methodology, and this should be evaluated like a non-HEDIS measure.*

1.2. Is the analysis based on the entire Target Population?

☐ Yes (Skip to Review Element 6) ☐ No

1.3a. Was a justification provided to determine an appropriate sample size?

☐ Yes ☐ No ☐ NA

1.3b-c. Were the sampling techniques clearly specified and appropriate?

☐ Yes ☐ No

RELEVANT INFORMATION

1.2, 1.3a-c. If a sample of the entire population is used, the M+CO is expected to provide a justification and the method used to determine an appropriate sample size. The sample size should be sufficient to detect a change in the quality indicator.

continued

Acceptable methods for determining an appropriate sample size include:

- Use of a sampling software program, such as Sample Power or classic books on sampling (e.g., Fleiss).
- Statement of power analysis conducted (e.g., "Power analysis used positing a two-tailed alpha at 0.90, beta at 0.20, the baseline at its 60% value, re-measurement at the required 64%, and a population size that was adjusted to be the quality indicator's baseline denominator.").
- The recommendations of the QIO statistician, based on a power analysis using QAPI specifications.
- Power analysis done using SPSS, SAS, and Sample Power, etc., and relevant QAPI specifications.
- HEDIS methodology, as specified in the technical specifications manuals.

The explanation should be clear and concise and consist of the information similar to that provided above.

QAPI standards require that the project data used to identify the population at risk must reliably and validly capture the entire population without systematically excluding a subset or subsets of the population. All members of the population (whether providers or members) must have an equal chance of being selected.

(Refer to the Instructional Guide for additional information and examples regarding sampling techniques.)

Note: *The M+CO must provide the baseline denominator, numerator, and baseline performance. The performance target is automatically completed by the system based on the information provided in Review Element 3. You will use this information to evaluate the improvement achieved at remeasurement for demonstrable and sustained improvement.*

Review Element 6:
Interventions Aimed at Achieving Demonstrable Improvement

1a. Were the interventions system-level?

☐ Yes ☐ No

1b. Were the interventions reasonably expected to obtain Demonstrable Improvement?

☐ Yes ☐ No

RELEVANT INFORMATION

1a & 1b. Reporting on at least one intervention is required. Reporting on additional interventions is optional but provides reviewers with more insight into the breadth of the project and the M+CO's efforts toward improvement. For each intervention, the M+CO must provide the type, target audience, description, initiation date and timeframe, partners, and samples of additional information, such as copies of brochures, mailed to the respective M+CQRO.

In general, interventions should be:

- **Systemic** or affect a wide range of participants (members, providers, etc.)
- **Timely** – They should occur after the baseline measurement and before or early in the DI period, so as to effect change.
- **Effective –** First and foremost, the intervention(s) should be targeted at the indicator and the population studied (e.g., eliminating the need for ophthalmology referrals for members with diabetes when trying to increase rates of retinal exams). It would not be appropriate to cite interventions for childhood immunizations for the Medicaid population when studying Influenza vaccines for seniors. In addition, the interventions should have some likelihood of success. For example, one-time educational mailings of guidelines to providers are not acceptable, as these have been shown in the literature to be ineffective when used alone. Conversely, distribution of physician performance profiles for a specific indicator, in conjunction with educational efforts, has been shown to positively impact performance. Such multi-faceted interventions have been shown to be most effective.

continued

You should take the Continuous Quality Improvement (CQI) model into account when evaluating interventions. A basic tenet of the CQI model is a systems approach, which can be successfully applied to health care. The fundamental principles of CQI build upon examining outcomes in terms of global systemic causes, rather than focusing on unusual errors (i.e., outliers or "bad apples").

The aim of CQI is to narrow the range of variation and simultaneously improve the mean (i.e., arithmetic average) within the entire system. This approach can have a far-reaching impact on both the quality and the economics of health care delivery. System-level interventions include widely disseminated educational efforts, changes in policy, targeting of additional resources, or other organization-wide initiatives. In summary, they alter the entire system so that all targeted individuals can achieve the desired outcome.

Example of a System-Level Intervention
To improve diabetic retinal exam (DRE) rates, a motivated M+CO might eliminate the need for referrals for ophthalmology or optometry visits for diabetic members, create provider profiles for practice-specific DRE rates, conduct CME conferences, provide diabetes management chart stickers and posters for PCPs, and send yearly eye exam reminder cards to members.

You should evaluate the selection of interventions based on the M+CO's knowledge of:

- What to intervene on – the topic
- The target of the interventions – the audience
- The target's resistance or obstacles – barriers
- Idiosyncratic issues and systems – local norms
- Literature on interventions that worked for groups that are similar to its own

By demonstrating knowledge of the above topics, a M+CO provides sound evidence that it correctly chose an intervention that fits its systems and personnel and has a high likelihood of success.

The timing and duration of an intervention are evaluated on the degree of congruency with the quality indicator being used. Interventions should commence after the baseline measurement time period and should stay in effect, as long as is practicable. Ideally, interventions should be self-sustaining so that quality improvement has the best likelihood of being sustained.

(Refer to the Instructional Guide for additional information and examples regarding interventions.)

Review Element 7:
Demonstrable Improvement

1. Was the reporting time comparable to Baseline?

☐ Yes ☐ No

RELEVANT INFORMATION

1. The data period for demonstrable improvement should be comparable to that of the baseline measurement period. For example, if the study were to evaluate the proportion of members with diabetes who received a retinal eye exam, it would not be appropriate to use a six-month review period for the baseline measurement and a one-year review period for the remeasurement. Likewise, when measuring rates of admission for asthma, it would not be appropriate to compare rates during different seasons due to seasonal variations and triggers.

2. Were there changes in the study design between Baseline and Demonstrable Improvement?

☐ Yes ☐ No [No, skip to 3]

2a. If there were changes to the study, were they justified?

☐ Yes ☐ No

2b. Were the changes to the study comparable?

☐ Yes ☐ No

RELEVANT INFORMATION

2, 2a –2b. If the M+CO indicates that there were changes to the study, the type and description of the change and the rationale for it should be provided. The rationale should clearly explain why the change was warranted and its possible impact on improvement (positive or negative). Changes in HEDIS specifications or CMS-defined indicators are acceptable. The M+CO **should** document these types of changes and their potential impact on study measurements, although this is not required.

3. Was the performance improved at Demonstrable Improvement?

☐ Yes ☐ No

Or

For a multi-year project, was the intermediate target goal achieved?

☐ Yes ☐ No

RELEVANT INFORMATION

3. The M+CO must enter the DI numerator, denominator, and performance. The system will automatically populate the baseline performance and performance target fields based on the information provided for Review Element 3 and Review Element 5. The M+CO must demonstrate an improvement in performance relative to the baseline measurement. The improvement achieved must be significant to the population studied. Significant improvement may be defined as reaching a prospectively set benchmark or as improving performance and sustaining that improvement. Statistical significance is not required to demonstrate improvement. However, the M+CO may use statistical significance to satisfy the standard.

Review Element 1S:
Subsequent or Modified Interventions Aimed at Achieving Sustained Improvement

1. Were there ongoing, additional, or modified interventions?

☐ Yes ☐ No [Skip to review element 2S]

2. Were the interventions system-level?

☐ Yes ☐ No

3. Were the interventions reasonably expected to Sustain Improvement for each Quality Indicator?

☐ Yes ☐ No

RELEVANT INFORMATION

1-3. The M+CO is expected to document any ongoing or additional interventions or modifications to prior interventions initiated after the demonstrable improvement measurement period. You should evaluate any subsequent or modified interventions in the same manner as the original interventions.

Review Element 2S:
Sustained Improvement

1. Was the reporting time period comparable to Baseline?

☐ Yes ☐ No

RELEVANT INFORMATION

1. The data period for sustained improvement should be comparable to that of the baseline and demonstrable improvement measurement periods. For example, if the study were to evaluate the proportion of members with diabetes who received a retinal eye exam, it would not be appropriate to use a six-month review period for one measurement and a one-year review period for the subsequent remeasurement(s). Likewise, when measuring rates of admission for asthma, it would not be appropriate to compare rates during different seasons due to seasonal variations and triggers.

2. Were there changes in the study between Baseline and Sustained Improvement?

☐ Yes ☐ No

2a. If there were changes to the study, were they justified?

☐ Yes ☐ No

2b. Were the changes to the study comparable?

☐ Yes ☐ No

RELEVANT INFORMATION

2, 2a –2b. If the M+CO indicates that there were changes to the study, the type of change and a description of the change and a rationale should be provided. The rationale should clearly explain why the change was warranted and its possible impact on improvement (positive or negative). Changes in HEDIS specifications or CMS-defined indicators are acceptable. The M+CO **should** document these types of changes and their potential impact on study measurements, although this is not required.

3. Was the improvement rate maintained for 12 months?

☐ Yes ☐ No

Or

For a multi-year project, was the <u>final</u> improvement measurement sustained for 12 months?

☐ Yes ☐ No

RELEVANT INFORMATION

3. The M+CO must enter the SI numerator, denominator, and performance. The system will automatically populate the DI performance and performance target fields based on the information provided for Review Element 7. The M+CO **must** demonstrate that improvement was sustained relative to the baseline measurement for 12 months after the demonstrable or significant improvement was achieved.

Scoring Methodology

This section explains the numerical system used to derive a score for each review element and an overall score for a QAPI Project Completion Report.

Allocation of points

Each review element has a potential total score of 100 points.

Review Element designation/weighting

For each review element, the assessment of compliance is determined through the weighted responses to each review item. The relative importance of each item within each review element corresponds to its importance by QAPI standards.

Consequently, it is possible that a deficiency for a single element may result in a designation of “Non-compliance” because it is considered essential by QAPI standards.

Conversely, it is also possible that several deficiencies may have little impact on the M+CO’s overall compliance, and thus the assessment could be determined as “Partial Compliance.”

Element Designations	Definition	Weight
Full compliance	Met or exceeded the element requirements	100%
Partial compliance	Met essential requirements of the element, but is deficient in some areas	50%
Non-compliance	Has not met the essential requirement(s) in the element	0%

Overall project performance score

The total points earned for each review element are weighted to determine the M+CO’s overall performance score. The seven review elements for demonstrable improvement

have a total weight of 80%. The highest achievable score for all seven elements is 80 points (80% X100 points for Full Compliance).

QAPI projects also will be evaluated on the achievement of sustained improvement with a weight of 20%, or a possible total score of 20 points. The M+CO must sustain improvement relative to baseline for 12 months after achieving demonstrable improvement. This standard has two components: 1) Subsequent or Modified Interventions and 2) Sustained Improvement.

At the time of the initial review, it is expected that a QAPI project will have reached the demonstrable improvement stage and then be evaluated for sustained improvement separately at a later date. However, some projects may be further along and have already achieved sustained improvement at the time of initial review. The entire scoring matrix should be completed for M+COs reporting on both demonstrable and sustained improvement.

Review Element	**QAPI Standard**	**Project Review Tool Questions**	**Scoring Weight**
1	Project Title, Type, Focus Area	5	5%
2	Topic Relevance	1 - 4	5%
3	Quality Indicator(s)	1 - 9	15%
4	Baseline Study and Analysis	1 - 4	10%
5	Baseline Study Population and Baseline Measurements/Performance	1.2, 1.3a, 1.3b-c	10%
6	Interventions Aimed at Achieving DI	1.a, 1.b.	15%
7	Demonstrable Improvement	1 - 3	20%
	Total Demonstrable Improvement Score		**80%**
1S	Subsequent or Modified Interventions Aimed at Achieving Sustained Improvement	1 - 3	5%
2S	Sustained Improvement	1 - 3	15%
	Total Sustained Improvement Score		**20%**
	OVERALL PROJECT PERFORMANCE SCORE		**100%**

Completing the scoring worksheets

The following are examples of completed scoring worksheets to determine the total demonstrable improvement score, total sustained improvement score, and overall project performance score. The HPMS system will automatically complete this worksheet.

1. Demonstrable improvement scoring worksheet [example]

Review Element	Compliance Level Full (100 Points), Partial (50 Points), Non-compliance (0 Points)	Assigned Points	Weight	Final Points Score
1	F	100	5%	**5.0**
2	F	100	5%	**5.0**
3	P	50	15%	**7.5**
4	P	50	10%	**5.0**
5	F	100	10%	**10.0**
6	P	50	15%	**7.5**
7	P	50	20%	**10**
Total Demonstrable Improvement Score				**50**

2. Sustained improvement scoring worksheet [example]

Review Element	Compliance Level Full (100 Points), Partial (50 Points), Non-compliance (0 Points)	Assigned Points	Weight	Final Points Score
1S	**F**	100	5%	**5**
2S	**P**	50	15%	**7.5**
Total Sustained Improvement Score				**12.5**

3. Compliance assessment grid: demonstrable improvement [example]

Demonstrable Improvement Score	Range of Points For Demonstrable Improvement	Level of Compliance Rating	Action
	65-80	1	Comments, commendations
50	50-64	2	Recommendations
	30-49	3	Corrective Action Plan required
	0-29	4	Corrective Action Plan and QIO/RO involvement required

4. Compliance assessment grid: sustained improvement [example]

Sustained Improvement Score	Range of Points for Sustained Performance
	0 - 5
12.5	0 - 15

5. Compliance assessment grid: completed project [example]

Demonstrable Improvement Score	Sustained Improvement Score	Overall Project Performance Score	Range of Points for Overall Project Performance	Overall Levels of Compliance	Action
			80 - 100	1	Comments, commendations
50	12.5	62.5	60 - 79	2	Recommendation
			40 - 59	3	Corrective Action Plan required
			0 - 39	4	Corrective Action Plan and QIO/RO involvement required