GLOSSARY
Acronyms and Frequently Used Terms

ADVERSE DRUG EVENT
Harm or injury to a patient as a result of medication use. Adverse drug events are not necessarily related to medical errors or poor quality care; they include both expected adverse drug reactions ("side effects") and events due to medical errors.

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY (AHRQ)
A DHHS agency responsible for conducting and supporting health services research, facilitating the development of clinical practice guidelines, and disseminating research findings and guidelines to practitioners, providers, policy makers, and the public.

AMERICAN HEALTH QUALITY ASSOCIATION (AHQA)
A national organization representing the interests of QIOs.

ANGIOTENSIN RECEPTOR BLOCKERS
A group of pharmaceuticals that modulate the renin-angiotensin-aldosterone system. Their main uses are for treatment of hypertension (high blood pressure), diabetic nephropathy (kidney damage due to diabetes), and congestive health failure.

AQA
A collaboration among physician groups, consumers, employers, government agencies, health insurance plans, and accrediting and quality improvement organizations to collect and report physician-level quality data. Also known as the AQA alliance.

BALANCED BUDGET ACT (BBA)
The Balanced Budget Act of 1997, the legislative authority for Medicare+Choice plans (now called Medicare Advantage plans), prevention initiatives, rural initiatives, anti-fraud and abuse activities, and improvements in protecting program integrity.

BENEFITS IMPROVEMENT AND PROTECTION ACT (BIPA)
The Benefits Improvement and Protection Act of 2000, which entitles a Medicare fee-service beneficiary (or his/her authorized representative) to appeal a discharge or termination of services notice issued by a Medicare-participating comprehensive outpatient rehabilitation facility, home health agency, hospice, or skilled nursing facility.

CARRIER
A non-governmental organization or agency that processes Medicare Part B claims.

CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC)
A Department of Health and Human Services agency.

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)
The Department of Health and Human Services agency that administers the Medicare and Medicaid programs.

CENTRAL OFFICE (CO)
CMS headquarters in Baltimore, Maryland

CHARTERED VALUE EXCHANGE (VALUE EXCHANGE)
A collaborative chartered by DHHS to carry out quality improvement activities and public reporting of quality data. Value Exchanges are chosen from existing collaboratives in which practitioners and providers work collaboratively with health plans, employers, unions, and other health care purchasers to improve the quality and value of health care by assessing and publicly reporting data on the performance of providers in their area.

CHRONIC KIDNEY DISEASE (CKD)
A slow and progressive deterioration of kidney function that occurs when the kidney can not do its job of cleansing the blood of toxins and waste products. Also called kidney failure.

CLINICAL DATA ABSTRACTION CENTER (CDAC)
A CMS contractor that provides clinical medical record abstraction services. Each QIO is required to subcontract with the CDAC to support this effort.

CLINICAL PERFORMANCE MEASURE (CPM)
A metric used to report data on a specific, measurable element of care.

CLINICAL WAREHOUSE
A national repository that contains inpatient hospital data abstracted and uploaded by providers, or vendors on behalf of providers, as well as validation and surveillance data from the Clinical Data Abstraction Center. The data in the Clinical Warehouse are used for public reporting as well as other reports and analyses.

CMS ABSTRACTION AND REPORTING TOOL (CART)
An electronic tool that allows hospitals to manage and evaluate quality improvement efforts.

CO
Central Office *or* Contracting Officer.

CODE OF FEDERAL REGULATIONS
The codification of the rules published in the *Federal Register* by the executive departments and agencies of the federal government.

COLORECTAL CANCER SCREENING

Use of one or more tests (fecal occult blood test, sigmoidoscopy, colonoscopy, double contrast barium enema, and/or digital rectal examination) to detect cancer, precancerous polyps, or other abnormal conditions of the colon or rectum.

COMMUNITY LEADER FOR VALUE-DRIVEN HEALTH CARE
A collaborative recognized by DHHS as the first step to becoming a Value Exchange. Community Leaders are selected from organizations that fosters collaboration across a range of stakeholders that include health care providers and practitioners, payers, and consumers.

COMPUTERIZED PHYSICIAN ORDER ENTRY SYSTEM (CPOE SYSTEM)
A system that allows physicians to write medical orders for patients electronically.

CONSUMER ASSESSMENT OF HEALTH PLANS STUDY (CAHPS)
An annual nationwide survey of enrollees in Medicare managed care plans about their satisfaction with plan performance.

CONTINUOUS QUALITY IMPROVEMENT (CQI)
A process by which performance is systematically monitored over time, changes are made as needed, and the implementation and success of these changes are monitored.

CONTRACTING OFFICER (CO)
A CMS official authorized to enter into contracts on CMS' behalf.

CRITICAL ACCESS HOSPITAL (CAH)
A hospital meeting the criteria established under the Balanced Budget Act provision for a Medicare Rural Hospital Flexibility Program.

DASHBOARD
An internal data reporting system for the QIO Program. Dashboard reports allow CMS and the QIOs to see whether and how QIOs are progressing in meeting contract expectations.

DATA WAREHOUSE
A database populated with CMS data on a monthly basis. The Data Warehouse contains claims, beneficiary, practitioner, provider, managed care organization, Reference Code, and Area Resource File data.

DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS)
The federal agency that is the "parent" of CMS.

DELIVERABLE
A report or other item furnished to CMS as specified in the QIO contract or ESRD Network contract.

DIAGNOSIS-RELATED GROUP (DRG)
One of the codes included in the clinical procedure coding convention for reimbursement under the Prospective Payment System.

DOCTOR'S OFFICE QUALITY–INFORMATION TECHNOLOGY PROJECT (DOQ-IT)
A CMS initiative to encourage physicians to adopt electronic health record systems and care management strategies in outpatient practice settings, with the goals of achieving improvements in preventive services, chronic disease management, and patient safety.

DOQ-IT UNIVERSITY (DO-IT U)
A Web-based tool that provides education to physician practices on successful adoption of health information technology and care management strategies.

ELECTRONIC HEALTH RECORD (EHR)
A computerized longitudinal record of a patient's health information as recorded and maintained by a provider system, intended primarily for use by health care practitioners. EHRs are also called electronic medical records (EMRs). An EHR is distinguished from a personal health record (PHR) by control; an EHR is controlled by the provider system, while a PHR is owned and controlled by the patient.

ELECTRONIC HEALTH RECORD SYSTEM (EHR SYSTEM)
A system that incorporates computerized patient records, clinical decision support, clinical data repositories, and support for operational and management processes.

ELECTRONIC MEDICAL RECORD (EMR)
A computerized longitudinal record of a patient's health information as recorded and maintained by a provider system, intended primarily for use by health care practitioners. EMRs are also called electronic health records (EHRs). An EMR is distinguished from a personal health record (PHR) by control; an EMR is controlled by the provider system, while a PHR is owned and controlled by the patient.

EMERGENCY MEDICAL TREATMENT AND LABOR ACT (EMTALA)
The legislative authority for "anti-dumping" actions.

END STAGE RENAL DISEASE (ESRD)
A condition in which a person's kidneys cease functioning on a permanent basis.

ENGINEERING REVIEW BOARD (ERB)
A group of CMS and contractor staff who review all requests for purchases of software or hardware to ensure stability, compatibility, and consistency within the infrastructure.

ESRD NETWORK COORDINATING CENTER
One of the ESRD Network Organizations (ESRD Networks), which provides centralized

coordination and support for the operation of the ESRD Networks under contract with CMS. The responsibilities of the ESRD Network Coordinating Center include collection, maintenance, and distribution of ESRD information; development and implementation of training initiatives for ESRD Networks; coordination of national activities; and other activities in support of the ESRD Networks and the ESRD Network Program.

ESRD NETWORK ORGANIZATION (ESRD NETWORK)
One of 18 organizations under contract with CMS to serve as liaisons between the federal government and providers of ESRD services. The geographic areas served by ESRD Network Organizations (ESRD Networks) are defined by the number and concentration of ESRD beneficiaries in each area. Some Networks represent one state, others multiple states. The ESRD Networks' responsibilities include: quality oversight of the care ESRD patients receive; data collection; and the provision of technical assistance to ESRD providers and patients in areas related to ESRD, including complaints and grievances.

ESRD NETWORK ORGANIZATION PROGRAM (ESRD NETWORK PROGRAM)
The CMS quality improvement program for end stage renal disease, carried out by 18 ESRD Network Organizations (ESRD Networks).

ESRD PROGRAM (MEDICARE ESRD PROGRAM)
A CMS program that provides Medicare benefits for individuals with end stage renal disease. The 1972 Social Security Amendments extended Medicare coverage to individuals with ESRD who require kidney dialysis or transplantation to sustain life.

FAILURE RATE
For a given clinical performance measure, a percentage typically calculated as the difference between the percentage of successfully performing facilities and 100% of facilities in a given state/jurisdiction.

FEDERAL ACQUISITION REGULATIONS (FAR)
A codification of the rules and procedures used by federal agencies for the procurement of goods and services.

FEDERAL REGISTER (FR)
A legal newspaper published every business day by the National Archives and Records Administration, which contains federal agency regulations; proposed rules and notices; and executive orders, proclamations, and other presidential documents.

FINANCIAL INFORMATION VOUCHERING SYSTEM (FIVS)
An electronic system used by a QIO to create invoices for payment and to maintain contract spending plans.

FISCAL INTERMEDIARY (FI)

A Medicare Part A contractor that provides administrative/bill processing services to Medicare beneficiaries and providers.

FORUM OF ESRD NETWORKS
An organization that advocates on behalf of ESRD Network Organizations (ESRD Networks), coordinates projects and activities of interest to ESRD Networks, and advances a national quality agenda with CMS and other renal organizations. All ESRD Networks are members of the Forum of ESRD Networks.

FTE
Full-time equivalent employee, a budgetary/personnel measure equivalent to one employee working 2,080 hours per annum.

GENERAL ACCOUNTING OFFICE
Now called Government Accountability Office.

GOVERNMENT ACCOUNTABILITY OFFICE (GAO)
A federal agency that advises Congress and the heads of executive agencies about ways to make government more effective and responsive. GAO evaluates federal programs, audits federal expenditures, and issues legal opinions. Formerly the General Accounting Office.

GOVERNMENT TASK LEADER
A CMS employee who provides technical assistance and/or support to QIOs for a given set of contract activities.

GUIDELINE
A systematically developed statement designed to assist practitioners in making decisions about appropriate health care for specific clinical circumstances.

HEALTH AND HUMAN SERVICES ACQUISITION REGULATIONS (HHSAR)
A set of regulations that was developed to implement and supplement the Federal Acquisition Regulations, providing DHHS-wide policies, procedures, and guidance that govern the acquisition process.

HEALTH CARE DISPARITY
A difference in the quality of health or health care across population groups, such as groups defined by race/ethnicity, socioeconomic status, or rural vs urban residence. A disparity is a difference, not an attribute of a given group.

HEALTH CARE FINANCING ADMINISTRATION
Now called Centers for Medicare & Medicaid Services.

HEALTH EMPLOYER DATA INFORMATION SET (HEDIS)

A set of defined measures that can be used in assessing the quality of care provided by managed care plans. HEDIS is sponsored by the National Committee for Quality Assurance.

HEALTH INSURANCE CLAIM NUMBER (HICN)
A unique alphanumeric identifier for an individual Medicare beneficiary.

HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)
A Department of Health and Human Services agency.

HHS
See DHHS.

HOME HEALTH AGENCY (HHA)
A public or private provider that offers in-home skilled nursing services and other therapeutic services, such as physical therapy. Medicare pays for such services provided that certain conditions are met.

HOSPITAL CONSUMER ASSESSMENT OF HEALTH PLANS SURVEY (HCAHPS)
A standardized survey instrument and data collection methodology for measuring patients' perspectives on hospital care, which includes a core set of questions that can be combined with a customized set of hospital-specific items. This methodology and the information it generates are available to the public.

HOSPITAL-ISSUED NOTICE OF NON-COVERAGE (HINN)
A notice that may be issued to a beneficiary or beneficiary's authorized representative by a hospital if the hospital determines that the care the beneficiary is receiving or about to receive is not covered by Medicare because it is not medically necessary, is not delivered in the most appropriate setting, or is custodial in nature.

HOSPITAL QUALITY ALLIANCE (HQA)
A national voluntary effort to collect and report hospital quality performance information. This initiative was started in December 2002 by the American Hospital Association, the Federation of American Hospitals, and Association of American Medical Colleges. Formerly the National Voluntary Hospital Reporting Initiative.

ICD-9-CM
International Classification of Diseases, Ninth Revision, Clinical Modification.

ICD-10
International Classification of Diseases, 10th Revision.

INCIDENCE
The number of new cases in a population at risk over a given time period. The incidence rate is

the number of new cases during a given time period divided by the number of people at risk for the disease or condition.

INFLUENZA
A viral respiratory illness, commonly called “the flu,” caused by the influenza virus, which infects the respiratory tract (nose, throat, lungs). Unlike many other viral respiratory infections such as the common cold, the flu often causes severe illness and life-threatening complications.

INTERMEDIARY
See fiscal intermediary.

INTERNAL QUALITY CONTROL (IQC)
A contractually required program that allows a QIO or ESRD Network to monitor its performance against its own expectations and improve the quality of work performed.

INTERNATIONAL CLASSIFICATION OF DISEASES
An international standardized diagnostic classification system for diseases and other health problems, which is updated periodically; the latest version is the 10th revision (ICD-10).

INTERVENTION
An activity taken by a QIO or ESRD Network to improve quality of care in one or more facilities or settings. Interventions may include, for example, technical assistance, individual or group consultation, clinical education, beneficiary education, media campaigns.

JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS (JCAHO)
Now called Joint Commission.

JOINT COMMISSION
An organization that evaluates and accredits health care organizations and programs. Formerly the Joint Commission on Accreditation of Healthcare Organizations.

MEDICALLY REASONABLE AND NECESSARY
A determination that items or services furnished, or to be furnished, to a Medicare beneficiary are appropriate for the diagnosis or treatment of illness or injury, to improve the functioning of a malformed body member, or for the prevention of illness as provided in Medicare law and regulation as specified in §1862(a) of the Social Security Act.

MEDICARE ADMINISTRATIVE CONTRACTOR (MAC)
A contracting organization responsible for receipt, processing, and payment of Part A and Part B Medicare claims. MACs also perform functions related to beneficiary and provider service, appeals, provider education and training, financial management, provider enrollment, reimbursement, payment safeguards, and information systems security.

MEDICARE ADVANTAGE ORGANIZATION (MA ORGANIZATION)
A public or private entity organized and licensed by a state as a risk-bearing entity (with the exception of a provider-sponsored organization receiving a waiver) that is certified by CMS as meeting the Medicare Advantage contract requirements. Formerly Medicare+Choice organization.

MEDICARE HANDBOOK
A publication that provides basic information on the Medicare program, addressing issues such as how to file a claim and what types of care are covered under the program; this publication is given to all beneficiaries when they first enroll.

MEDICARE IDENTIFICATION NUMBER
Any number, other than the National Provider Identifier, used by a provider or supplier to bill the Medicare Program as part of the National Provider Identification system currently under development.

MEDICARE MODERNIZATION ACT (MMA)
The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, a law enacted in 2003 to "amend Title XVIII of the Social Security Act to provide for a voluntary program for prescription drug coverage under the Medicare Program, to modernize the Medicare Program, to amend the Internal Revenue Code of 1986 to allow a deduction to individuals for amounts contributed to health savings security accounts and health savings accounts, to provide for the disposition of unused health benefits in cafeteria plans and flexible spending arrangements, and for other purposes."

MEDICARE PART A (PART A)
The hospital insurance portion of Medicare, established by §1811 of Title XVIII of the Social Security Act of 1965, as amended. Part A provides coverage for inpatient hospital care, skilled nursing facility care, some home health agency services, and hospice care.

MEDICARE PART B (PART B)
The supplementary or "physician" insurance portion of Medicare, established by §1831 of Title XVIII of the Social Security Act of 1965, as amended. Part B provides coverage for services of physicians/other suppliers, outpatient care, medical equipment and supplies, and other medical services not covered by Part A.

MEDICARE PART D (PART D)
The prescription drug coverage portion of Medicare, established by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

MEDICARE-UNDERSERVED POPULATION
A group of beneficiaries and/or people eligible for Medicare who underutilize Medicare-covered

services because of access barriers and/or other barriers to care. At the national level, Medicare-underserved populations include rural beneficiaries and specific racial/ethnic populations, defined for purposes of the QIO contract as the African American, Asian/Pacific Islander, American Indian/Alaskan Native, and Hispanic populations. The term "underserved" applies to populations, not individuals.

MedQIC
The Medicare Quality Improvement Community Web site, which provides access to quality improvement resources and allows QIOs and other quality improvement professionals to share knowledge and experiences. The site offers strategies for change, descriptions of effective interventions, literature reviews, tools, and other resources.

METHICILLIN-RESISTANT *STAPHYLOCOCCUS AUREUS* (MRSA)
A strain of *Staphylococcus aureus* that is resistant to commonly used antibiotics. *Staphylococcus aureus* infections are often called staph infections. Methicillin is an antibiotic that was commonly used in the past to treat patients with infections.

METROPOLITAN STATISTICAL AREA (MSA)
A geographic area that meets a set of criteria established by the Office of Management and Budget. A Metropolitan Statistical Area consists of a core area containing a substantial population nucleus together with adjacent communities having a high degree of economic and social integration with the core.

NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA)
A national organization that assesses and reports on quality of care in managed care plans, principally by means of HEDIS.

NATIONAL HEALTHCARE SAFETY NETWORK (NHSN)
A CDC Web-based surveillance system that allows participating health care facilities to enter data associated with health care safety, including information on surgical site infections, antimicrobial use and resistance, bloodstream infections, dialysis incidents, and health care worker vaccinations. NHSN allows reports to be generated using aggregated data and provides links to best practices, guidelines, and lessons learned. NHSN integrates data from the National Nosocomial Infections Surveillance System (NNIS), the National Surveillance System for Healthcare Workers (NaSH), and the Dialysis Surveillance Network (DSN).

NATIONAL PROVIDER IDENTIFIER (NPI)
A unique identifier that will be assigned to a provider as part of the National Provider Identification system currently under development.

NOTICE OF DISCHARGE AND MEDICARE APPEAL RIGHTS (NODMAR)
A notice issued by a Medicare Advantage (MA) organization, or a hospital to which an MA organization has delegated the responsibility, to inform a Medicare beneficiary enrolled by the

MA organization that his or her covered hospital care is ending.

NURSING HOME
A facility meeting specific criteria established by CMS that provides nursing supervision and physical, occupational, and other rehabilitative therapies. Medicare covers nursing home stays under certain conditions following accidents or illnesses.

OFFICE OF CLINICAL STANDARDS AND QUALITY (OCSQ)
The CMS Central Office component that administers the QIO and ESRD Network Programs.

OFFICE OF FINANCIAL MANAGEMENT (OFM)
The CMS component with authority to obligate funds for QIO contract activities.

OFFICE OF HEARINGS AND APPEALS (OHA)
A CMS component.

OFFICE OF INSPECTOR GENERAL (OIG)
A CMS component.

OFFICE OF THE GENERAL COUNSEL (OGC)
A CMS component.

OMNIBUS BUDGET RECONCILIATION ACT (OBRA)
The Omnibus Budget Reconciliation Act of 1986, which established ESRD Network Organizations.

ORYX
A Joint Commission initiative to integrate performance measurement into the accreditation process.

OUTCOME AND ASSESSMENT INFORMATION SET (OASIS)
A set of screening elements used by home health agencies to perform comprehensive assessments of all Medicare patients receiving skilled home care. Home health agencies are able to use OASIS data to determine if they are making progress toward desired outcomes.

PARTICIPATING PHYSICIAN
A physician who has signed an agreement to accept assignment on all Medicare claims.

PARTner
A Web-based system for QIO reporting. QIOs submit deliverables and other required materials to CMS via PARTner, which is a component of SDPS.

PATIENT SAFETY

Freedom from harm to the patient as a result of medical care.

PEER REVIEW ORGANIZATION (PRO)
Now called Quality Improvement Organization.

PERFORMANCE-BASED SERVICE CONTRACTING
The process of structuring the provisions of a contract around the purpose of the work to be performed, as opposed to the manner by which the work is to be performed. For QIOs, this means a focus on measurable results in meeting performance standards; economic incentives for superior performance; and nonrenewal or a competitive contracting process for poor performance.

PERFORMANCE IMPROVEMENT PLAN (PIP)
A negotiated plan for restoring a QIO to full compliance with contract provisions when CMS has determined the QIO's performance to be lacking.

PERSONAL HEALTH RECORD (PHR)
A patient's computerized health information that is accessible to and controlled by the patient and that allows the patient to make appropriate information available to others as needed. A PHR is distinguished from an electronic health record (EHR), also called an electronic medical record EMR) by control; a PHR is owned and controlled by the patient, while an EHR/EMR is controlled by the provider or provider system.

PHYSICAL RESTRAINTS
Methods used to restrict, restrain, or prevent a person's movement.

PHYSICIAN QUALITY REPORTING INITIATIVE (PQRI)
A voluntary physician quality reporting system mandated by the Tax Relief and Health Care Act of 2006. PQRI offers a financial incentive for physicians and other eligible professionals to voluntarily report quality data. Formerly the Physician Voluntary Reporting Program (PVRP).

PNEUMOCOCCAL PNEUMONIA
A common but serious infection and inflammation of the lungs caused by the bacterium *Streptococcus pneumoniae*.

PRACTITIONER
A clinician licensed to diagnose, treat, and prescribe medications for patients who present for primary or specialty care.

PRESSURE ULCER
A skin wound caused by prolonged and/or intense physical pressure, which starts as a reddened area but can get progressively worse, forming a blister, then an open sore, and finally a crater. The most common places for pressure ulcers are the elbow, heels, hips, ankles, shoulders, back,

and the back of the head.

PREVALENCE
The number or proportion of cases of, or individuals with, a given disease or condition in a population at risk at a given time point or during a given time period. Prevalence is expressed as either a number (of cases or individuals) or a rate (number of cases or individuals per unit of population, e.g., cases per 1,000 population) for a given time point or period.

PRO
Utilization and Quality Control Peer Review Organization, *now called* Quality Improvement Organization (QIO).

PROGRAM SAFEGUARD CONTRACTOR (PSC)
A contractor dedicated to program integrity that handles such functions as audit, medical review, and investigations of potential fraud and abuse.

PROJECT OFFICER (PO)
A staff person in the Boston, Dallas, Kansas City, or Seattle RO who monitors the work of one or more QIOs and/or ESRD Networks to ensure compliance with all contract provisions and applicable laws.

PROSPECTIVE PAYMENT SYSTEM (PPS)
A predetermined process that Medicare uses to reimburse hospitals for inpatient and outpatient services as well as to reimburse skilled nursing facilities, rehabilitation hospitals, and home health providers.

PROSPECTIVE PAYMENT SYSTEM HOSPITAL (PPS HOSPITAL)
A hospital that participates in the Prospective Payment System.

PROVIDER
As defined in 42 CFR 488.1, a provider (also called a provider of services) is a hospital, skilled nursing facility, nursing facility, home health agency, hospice, comprehensive outpatient rehabilitation facility, or provider of outpatient physical therapy or speech pathology services.

PROVIDER IDENTIFICATION NUMBER (PIN)
An identifier issued by a carrier to a physician, other health care practitioner, or practice. Also known as a Medicare billing number, Medicare Provider Number, or Physician Profiling Number. While a practitioner generally has only one Medicare Unique Physician Identification Number (UPIN), s/he may have a separate PIN for each practice setting (location, specialty, or group affiliation) in which s/he participates. A practice will also have its own PIN as an entity.

QIO CLINICAL WAREHOUSE
See Clinical Warehouse.

QIOnet
The intranet for the QIO Program.

QUALITY
As defined by the Institute of Medicine, the degree to which health services for an individual or population increase the likelihood of desired outcomes and are consistent with current professional knowledge.

QUALITY IMPROVEMENT ORGANIZATION (QIO)
One of 53 independent organizations (one in each state, the District of Columbia, Puerto Rico, and the Virgin Islands) that work to improve the quality of health care in nursing homes, home health agencies, hospitals, and physician practices, under contract with CMS.

QUALITY IMPROVEMENT ORGANIZATION PROGRAM (QIO PROGRAM)
A CMS quality improvement program carried out by the 53 Quality Improvement Organizations (QIOs).

QUALITY IMPROVEMENT ORGANIZATION SUPPORT CENTER (QIOSC)
A contractor that provides support to CMS and the QIOs for a set of Program activities.

QUALITY NET
An annual conference for QIO and OCSQ/DQI staff.

QualityNet

A Web site established by CMS that provides health care quality improvement news, resources, and data reporting tools and applications. Also called QualNet or QNet.

QUALITY OF CARE MEASURE
A practice parameter related to processes/outcomes of care based on a consensus-driven disease-, condition-, or situation-specific guideline or standard.

RANDOM SAMPLE
A group of cases or subjects selected for study that is drawn at random from the universe of cases or subjects by a statistically valid method.

REDUCTION IN FAILURE RATE (RFR)
The percentage by which a failure rate is lowered from one measurement period to a subsequent measurement period.

REGIONAL OFFICE (RO)
One of 10 CMS offices across the country. Four ROs (in Boston, Dallas, Kansas City, and Seattle) oversee the QIO Program and ESRD Network Program in conjunction with OCSQ.

REQUEST FOR CONTRACT (RFC)
An acquisition-planning document that provides contracting personnel with information needed to make determinations about how an acquisition will be conducted and how a contract will be awarded.

REQUEST FOR PROPOSAL (RFP)
A document that notifies potential contractors of the detailed requirements of work to be performed under contract, along with instructions for submitting proposals.

RURAL
Not located in a Metropolitan Statistical Area (MSA). A county not within an MSA is considered a rural county. Hospitals located in MSAs are defined as urban hospitals, and those located outside MSAs are defined as rural hospitals.

SCOPE OF WORK (SOW)
The work to be performed by QIOs during a given contract period.

SKILLED NURSING FACILITY (SNF)
A facility meeting specific criteria that has the professional licensed staff and equipment to provide nursing care or rehabilitation services and other health-related services.

SOCIAL SECURITY ACT (SSA)
The legislative authority for both the Medicare program and the QIO Program, formerly the PRO Program. The Peer Review Improvement Act of 1982, Title I, Subtitle C, of the Tax Equity and Fiscal Responsibility Act (Public Law 97-248), amended Part B, Title XI, of the Social Security Act to establish the PRO Program.

SOW
Scope of Work.

SETTING TARGETS–ACHIEVING RESULTS (STAR)
A Web-based interactive tool to help home health agencies set and achieve annual performance targets for publicly reported outcome measures.

SPECIAL PROJECT
A specific study or other defined set of activities to be carried out by a QIO in addition to the contractual activities required of all QIOs. The Special Project's requirements are outlined in a work statement and schedule of deliverables, added via modification to the QIO's contract.

SSA
Social Security Act of 1965 *or* State Survey Agency.

STANDARD DATA PROCESSING SYSTEM (SDPS)
A "closed" network established to support the business processes of QIOs and communication and data links between the QIOs and CMS and among the QIOs.

STAKEHOLDER
Any organization/group with an interest in improving health care in relation to a given topic on which a QIO or ESRD Network is working. Stakeholders include such organizations as state health agencies, state medical associations, specialty societies, providers, advocacy groups, and consumer groups.

STATEMENT OF WORK (SOW)
A contract, or portion of a contract, describing in detail work to be performed or services to be rendered, defining the respective responsibilities of CMS and the contractor, and providing an objective measure so that both parties will know when the work is complete and payment is justified.

STATE SURVEY AGENCY (SSA)
A state government agency that licenses and certifies medical providers, such as nursing homes, home health agencies, and clinical laboratories. Some states have a single umbrella agency that handles all provider types, while other states have different agencies for different provider types.

SURGICAL CARE IMPROVEMENT PROJECT (SCIP)
A national partnership of organizations committed to improving the safety of surgical care through reduction of postoperative complications.

SYSTEMIC PROBLEM
A barrier to quality that affects a broad range of patients in a given facility or system of care, rather than an individual patient.

TASK LEADER
Government Task Leader.

TeamSTEPPS
An evidence-based teamwork system aimed at optimizing patient outcomes by improving communication and other teamwork skills among health care professionals.

TECHNICAL ASSISTANCE
An intervention undertaken by a QIO or ESRD Network in which the QIO or Network offers specialized information and resources to one or more providers and/or practitioners to support quality improvement.

THEME
For the purposes of the 9th SOW, a focus of a set of contractually required QIO activities.

THEME LEAD
A CMS employee who provides overall leadership and direction for one of the Themes in the 9th SOW.

UNDERSERVED POPULATION
See Medicare-underserved population.

UNIQUE PHYSICIAN IDENTIFICATION NUMBER (UPIN)
An alphanumeric identifier assigned to a Medicare-enrolled practitioner who orders or makes referrals for Medicare beneficiary services. While a practitioner generally has only one UPIN, s/he may have a separate Provider Identification Number (PIN) for each practice setting (location, specialty, or group affiliation) in which s/he participates.

VALUE EXCHANGE
Chartered Value Exchange.

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