

## Supporting Statement – Part A

### Evaluation of the CMS Quality Improvement Organizations: Reducing Healthcare-Acquired Conditions in Nursing Homes

#### Background

The purpose of this Information Collection Request (ICR) is to collect data to inform the program evaluation of the Centers for Medicare & Medicaid Services (CMS) Quality Improvement Organizations (QIO) current contract known as the 11<sup>th</sup> Scope of Work (SOW).<sup>1</sup> Given the breadth and scope of QIO activities, the current ICR focuses on evaluating one component of the quality improvement activities of the Quality Innovation Network Quality Improvement Organizations (QIN-QIOs) and is part of a larger evaluation of the overall impact of the QIO program. This ICR aims to assess one QIN-QIO SOW task, Task C.2., *Reducing Healthcare-Acquired Conditions in Nursing Homes*. Subsequent ICRs will be submitted focusing on other tasks required under the QIO 11<sup>th</sup> Scope of Work, which started 8/1/2014 and ends 7/31/2019. For this evaluation we are using a mixed methods design to incorporate qualitative and quantitative data from multiple stakeholders to compare quality improvement activities of nursing homes participating in the QIN-QIO program and nursing homes not participating in the QIN-QIO program over time.

As mandated by Sections 1152-1154 of the Social Security Act, CMS directs the QIO program, one of the largest federal programs dedicated to improving health quality for Medicare beneficiaries. QIOs are groups of health quality experts, clinicians, and consumers who work to assist Medicare providers with quality improvement throughout the spectrum of care and to review quality concerns for the protection of beneficiaries and the Medicare Trust Fund.<sup>2</sup> This program is a key component of the U.S. Department of Health and Human Services' (HHS) National Quality Strategy<sup>3</sup> and the CMS Quality Strategy,<sup>4</sup> with the overarching goals to achieve better health care, better health, and lower costs of care. In the 11th SOW, CMS restructured the QIO program to fund Quality Innovation Networks (QIN)-QIOs, Beneficiary and Family-Centered Care (BFCC) organizations, National Coordinating Centers (NCCs), Program Collaboration Centers (PCCs), and the Strategic Innovation Engine (SIE). In the current SOW, 14 QIN-QIOs coordinate the work of 53 QIOs nationwide including all 50 states and other U.S. territories.

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1 CMS. (2016). Current Work: QIO Program 11th SOW (2014-2016). Retrieved March 8, 2017 from <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityImprovementOrgs/Current.html>

2 CMS. (2015). *Quality Improvement Organizations*. Retrieved December 10, 2015 from <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityImprovementOrgs/index.html?redirect=/qualityimprovementorgs/>

3 Department of Health and Human Services (DHHS). (2011). *2011 Report to Congress: National Quality Strategy for Quality Improvement in Health Care*. Retrieved December 10, 2015 from <http://www.ahrq.gov/workingforquality/nqs/nqs2011annlrpt.htm>

4 CMS. (2015). *CMS Quality Strategy 2016*. Retrieved December 10, 2015 from <https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/qualityinitiativesgeninfo/downloads/cms-quality-strategy.pdf>

CMS evaluates the quality and effectiveness of the QIO program as authorized in Part B of Title XI of the Social Security Act.<sup>5</sup> CMS created the Independent Evaluation Center (IEC) to provide CMS and its stakeholders with an independent and objective program evaluation of the 11th SOW. Evaluation activities will focus on analyzing how well the QIO program is achieving the three aims of better care, better health, and lower cost as well as the effectiveness of the new QIO program structure.

One of the QIN-QIOs' tasks to achieve these three aims is to support participating nursing homes in their efforts to improve quality of care and health outcomes among residents. According to the 2015 CMS Nursing Home Data Compendium, more than 15,000 nursing homes participate in Medicare and Medicaid programs with more than 1.4 million beneficiaries residing in U.S. nursing homes.<sup>6</sup> These residents and their families rely on nursing homes to provide reliable, safe, high quality care. However, cognitive and functional impairments, pain, incontinence, antipsychotic drug use, and healthcare acquired conditions (HAC), such as pressure ulcers and falls, remain areas of concern.

Section 6102(c) of the Affordable Care Act of 2010 requires CMS to establish regulations in Quality Assurance and Performance Improvement (QAPI) and provide technical assistance to nursing homes to help them develop best practices to comply with the revised requirements for participating in the Medicare and Medicaid programs, which will be phased in from 2016 through 2019.<sup>7</sup> CMS has developed a program of technical assistance that includes tools, resources, and training materials to help nursing homes implement QAPI and establish best practices to continuously improve the care and services delivered in each nursing home. The QAPI guidelines underlie the *2012 Nursing Home Action Plan*,<sup>8</sup> a comprehensive, actionable strategy for improving the quality of care received by nursing home residents. In the 11<sup>th</sup> SOW, the QIN-QIO program is scaling up an approach to facilitate the goals of the *Action Plan* called the National Nursing Home Quality Care Collaborative(s) or NNHQCC. In concordance with the *2012 Nursing Home Action Plan*, the NNHQCC aims to improve the Medicare program and ensure that every nursing home resident receives the highest quality of care by reducing the prevalence of healthcare acquired conditions (HACs). QIN-QIOs will implement two phases of NNHQCC:<sup>9</sup>

- NNHQCC I: The first collaborative was conducted from April 1, 2015 – September 30, 2016 and focused on nursing homes' systems' improvement for areas identified by participating nursing homes, beneficiary/resident mobility, and antipsychotic medication.
- NNHQCC II: The second collaborative will be conducted from April 1, 2017 – September 30, 2018. Additional areas of focus will be added to beneficiary/resident

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5 Social Security Administration. Contracts with Quality Improvement Organizations. Retrieved January 8, 2016 from [https://www.ssa.gov/OP\\_Home/ssact/title11/1153.htm](https://www.ssa.gov/OP_Home/ssact/title11/1153.htm)

6 CMS. Nursing Home Data Compendium 2015 Edition [Internet]. Maryland: Centers for Medicare and Medicaid Services 2015.

7 Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities, 42 C.F.R. § 405, 431, 447, 482, 483, 485, 488, and 489. 2016.

8 CMS. (2012). Nursing Home Action Plan: Action Plan for Further Improvement of Nursing Home Quality. Maryland: Centers for Medicare and Medicaid Services, 2012.

9 CMS Center for Clinical Standards & Quality. (2014). Quality Improvement Group Quality Innovation Network (QIN) Quality Improvement Organization (QIO) Scope of Work (SOW) Task Order No. 001: Excellence in Operations and Quality Improvement. Attachment J.1 -Contract No. HHSM-500-2014-QIN001I.

mobility and antipsychotic medication.

The QIN-QIO program focuses on increasing mobility among long-stay residents/beneficiaries, decreasing unnecessary use of antipsychotics in dementia residents/beneficiaries, reducing preventable infections, and preventing potentially avoidable hospitalizations and rehospitalizations.<sup>10,11</sup> These quality measures are among those reported regularly by nursing homes and entered into the Minimum Data Set Version 3 (MDS 3).<sup>12</sup>

Analysis of data originating from MDS 3 and Medicare claims Parts A and B was completed in August 2016. These analyses included use of antipsychotic medicine and hospital admission rates for residents of nursing homes participating in the QIN-QIO program compared to residents of matched nursing homes that were not enrolled in the QIN-QIO program. A common finding across the outcomes was that nursing homes participating in the QIN-QIO program improved over time, but improvements were also seen in facilities that did not participate. These findings require additional information to explain what program-related or external factors drove improvements in both groups, and specifically if partnerships with other organizations resulted in NNHQCC strategies and resources permeating facilities in the comparison group. This Information Collection Request is to conduct data collection to provide data that will help explain findings from assessment of secondary data, including non-program influences (e.g. policy and environmental) on outcomes of interest, and to provide information on processes leading to uptake of QAPI approaches and improved prevention of HACs. Table 1 provides an overview of the proposed data collection methods, including survey topics, respondents, and frequency of data collection. We plan to conduct an annual survey of Nursing Home Administrators and qualitative data collection with Nursing Home Administrators, QIN-QIO Nursing Home Task Leads, and Nursing Home Peer Coaches.

We will conduct a survey of administrators of nursing homes participating in the QIN-QIO program (intervention group) and administrators at nursing homes that are not participating in the QIN-QIO program (comparison group). Our proposed survey assesses the level of engagement with the QIO, the extent to which QAPI strategies have been used, and other influences that can help explain progress towards the goals of the QIN-QIO SOW, including activities and strategies to increase mobility among residents, reduce infections, and reduce use of inappropriate antipsychotic medication among long-term stay residents. The questions used for these constructs related to program and non-program influences have been adopted from previously used and/or validated instruments.<sup>13,14</sup> The survey will also provide estimates of the attribution of the QIN-QIO program for improved care processes and outcomes in nursing homes and reported impact of the QIN-QIO program on nursing homes from the perspective of the nursing home administrators. The perceived influence on quality improvement efforts will be

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10 CMS CCSQ Quality Improvement Group (2014). Quality Innovation Network (QIN) Quality Improvement Organization (QIO) Scope of Work (SOW). Task Order No. 001: Excellence in Operations and Quality Improvement. HHSM-500-2014-RFP-QIN-QIO Attachment J.1- Task Order 001.

11 The NNHQCC Quality Composite Measure for skilled nursing facilities combines 13 different quality indicators, including measures related to resident falls, physical restraint, vaccination, and depressive symptoms.

12 Quality or care planning items collected for MDS 3 via the Resident Assessment Instrument are exempt from PRA consideration pursuant to sections 4204(b) and 4214(d) of OBRA 1987

13 Ninth Scope of Work QIO Program Evaluation: Nursing Homes in Need

14 Eighth Scope of Work Provider Satisfaction Survey Questionnaire

quantified and, along with econometric modeling methods, will be used to assess program attribution. Estimating attribution is a contract requirement for the IEC. Since current analytical methods do not adequately address the overlap of quality improvement initiatives targeting nursing homes, the IEC developed an innovative approach, combining survey input with modeling, to estimate the relative importance of the QIN-QIO program. The concept is supported at the highest level of administration for Quality Improvement at CMS and has been presented at national conferences.<sup>15,16</sup> and to CMS/CCSQ leadership.<sup>17</sup> The survey data is an essential component of this method. Two surveys are necessary in order to assess the efforts of the two phases in the nursing home collaborative program as well as changes in nursing home quality improvement activities over time at the program level. This is particularly important given changes in the delivery of the QIN-QIO program for nursing homes through the NNHQCC and changes in the focus on quality measures required by CMS that have occurred during the 11<sup>th</sup> SOW.

We plan to conduct qualitative interviews with nursing home administrators to provide data on additional topics not included in the brief survey. These surveys will be conducted twice to follow-up on results from the survey. These interviews will supplement the Nursing Home Survey and provide more in-depth contextual information about the QIN-QIO program implementation within nursing homes, including: (i) their experience with, and perceived success of QIN-QIO NNHQCC; (ii) their satisfaction with the QIN-QIO Collaborative and QIO support; (iii) perceived value and impact of QIO program; and (iv) drivers and barriers to QIN-QIO involvement and success. This qualitative interview will provide perspectives from Nursing Home Administrators not selected for the survey using a similar sampling plan as the Nursing Home Administrator Survey, stratifying nursing homes by their Five-Star rating (a measure of quality care) and geographic location.

Information from QIO leadership and/or state/territory task leads will be collected by interviews and focus groups. If the QIO leads are not available to participate in a focus group, we will conduct interviews with Nursing Home Task leaders for the QIN and QIO in-person or over the phone. We will conduct two focus groups with 14 QIO-level Directors (seven Directors x two Focus Groups) during the CMS Quality conference or the Quality Summit. The purpose of the interviews and focus groups is to examine: (i) QIO processes for recruiting nursing homes, peer coaches, and beneficiaries to participate in the program; (ii) strengths and challenges of QIN-QIO activities related to nursing homes; (iii) partnership and coordination with other QIN-QIO tasks; and (iv) overall lessons learned from each collaborative. The first round of interviews/focus groups will focus on activities related to the Nursing Home Collaborative I and the second set of interviews and focus groups will focus on activities related to the Nursing Home Collaborative II.

We will also conduct qualitative interviews once with nursing home peer coaches. QIN-QIOs are responsible for recruiting high-performing nursing homes to act as “peer coaches” to other nursing homes. Peer Coaches represent diverse levels of nursing home staff, both administrative and direct care, and include at least one resident/beneficiary or family member per participating

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15 Tregear S, Sonnenfeld N. Market Share approach for assessing program attribution. Presented at American Evaluation Association Conference, October 2016 in Atlanta, GA.

16 Tregear S. et al., Attribution through Market Share Analysis and Return on Investment. Presented at CMS Quality Conference, December 2016 in Baltimore, MD.

17 Yu, P. Briefing to Chief Medical Officer of CMS/CCSQ on July 25, 2016 in Baltimore, MD.

area, state, or territory. Interviews with peer coaches will provide information on the peer coaching program from the perspectives of participants. Interviews will collect data about organizational support and resources, participant rewards and satisfaction, and program barriers and challenges.

These interviews will be administered either on-site during site visits or by phone if in-person interviews are not feasible or cost-effective. We will conduct two waves of site visits during the data collection at six QIN-QIOs per wave. Site visits will include in-person interviews with QIO leadership, nursing home administrators, and peer coaches. Sites will be selected in order to maximize diversity in terms of performance (representing both high- and low-performing states) and represent diverse populations in different regions of the country. Telephone interviews will be used to collect data from QIO directors, nursing home administrators, and peer coaches not available during site visits.

An overview of the proposed data collection mode, including survey topics, respondents, and frequency of data collection is shown below in Table 1. The data collection instruments, including the Nursing Home Survey and qualitative data collection protocols (interviews and focus groups), are found in Appendix A. The information that will be collected through surveys, interviews, and focus groups will complement the existing data by helping identify factors associated with outcomes of interest from existing data sets such as MDS 3 and Medicare claims. For example, survey information from long-term care facilities on their level of engagement with the QIO, uptake of QAPI strategies and activities, and influences from other quality improvement initiatives can be added to models that describe influences on outcomes such as changes in mobility, use of antipsychotics, prevention of HACs and infections, and hospital utility. Please see Attachment 1 that provides a crosswalk of how the existing and new data sources will meet address the evaluation questions.

CMS can use these findings to improve the delivery of the QIN-QIO program. For example, if we identify covariates that are influential in predicting desired outcomes, CMS can focus on ways to increase engagement with nursing homes or strategically recruit facilities that are most likely to benefit from the program. We will use this information to identify QIO program elements that help nursing homes comply with QAPI requirements. CMS can also use this information to modify future Scopes of Work for QIOs to continually improve the program.

**Table 1: Overview of Nursing Home Data Collection**

<b>Data Collection Method</b>	<b>Survey Topics</b>	<b>Respondents</b>	<b>Frequency</b>
Telephone survey of Nursing Home Administrators, Directors of Nursing, or staff member most responsible for quality improvement activities (called Nursing Home Administrators)	<ul style="list-style-type: none"> <li>• QIN-QIO’s progress towards the programs Task C.2 goals</li> <li>• Attribution of the QIN-QIO program for quality improvement outcomes</li> <li>• Level of intensity of engagement with QIN-QIO program</li> <li>• Perceived impact of QIN-QIO program</li> </ul>	<ul style="list-style-type: none"> <li>• 400 Nursing Home Administrators participating in the QIN-QIO program (intervention group)</li> <li>• 400 Nursing Home Administrators of CMS certified nursing homes not participating in the QIN-QIO program (comparison group)</li> </ul>	Twice (during 2017 and 2019)

<b>Data Collection Method</b>	<b>Survey Topics</b>	<b>Respondents</b>	<b>Frequency</b>
In-person or telephone qualitative interviews with Nursing Home Administrators not participating in the survey	Designed to supplement the Nursing Home Survey and examine: <ul style="list-style-type: none"> <li>• Experience with, satisfaction with, and perceived success of QIN-QIO NNHQCC</li> <li>• Satisfaction with QIO support</li> <li>• Perceived value and impact of QIO program</li> <li>• Drivers and barriers to QIN-QIO involvement</li> </ul>	<ul style="list-style-type: none"> <li>• 28 Nursing Home Administrators or Directors of Nursing of nursing homes participating in the QIN-QIO Program (2 per 14 QIN-QIOs)</li> </ul>	Twice (2017 and 2019)
In-person or telephone qualitative interviews with QIN and QIO leaders for the nursing home task	<ul style="list-style-type: none"> <li>• Recruitment of nursing homes, peer coaches, and beneficiaries/family members</li> <li>• Strengths and challenges of QIN-QIO program implementation</li> <li>• Coordination and collaboration of QIN-QIOs among other tasks</li> </ul>	<ul style="list-style-type: none"> <li>• 28 QIN- or QIO-level directors, quality managers, or task leaders (2 per 14 QIN-QIOs)</li> </ul>	Once
In-person focus groups with QIN-QIO nursing home task leaders	<ul style="list-style-type: none"> <li>• Recruitment of nursing homes, peer coaches, and resident/family members</li> <li>• Program implementation strengths and challenges</li> <li>• Possible environmental and contextual factors influencing outcomes</li> </ul>	<ul style="list-style-type: none"> <li>• 14 QIN-QIO directors or task leaders</li> </ul>	Twice (during 2018 and 2019)
In-person or telephone interviews with nursing home peer coaches	<ul style="list-style-type: none"> <li>• Organizational support and resources</li> <li>• Participant rewards and satisfaction</li> <li>• Program barriers and challenges</li> </ul>	<ul style="list-style-type: none"> <li>• 28 peer coaches participating in the QIN-QIO Program (2 per 14 QIN-QIOs)</li> </ul>	Once

## **Justification**

### **1. Need and Legal Basis**

The QIO program is mandated by Sections 1152-1154 of Part B of Title XI of the Social Security Act, as amended by the Peer Review Improvement Act of 1982 and by the Trade Adjustment Assistance reauthorization bill (Pub. L. 112-40) signed by the President in October 2011. This law includes language authorizing evaluation of the QIO program:

§ Social Security Section. 1153. [42 U.S.C. 1320c–2] c(2): “the Secretary shall have the right to evaluate the quality and effectiveness of the organization in carrying out the functions specified in the contract.”<sup>18</sup>

Our proposed data collection is necessary for CMS to evaluate the QIO program and provide reports on the performance of QIOs. Sections 1152-1154 of Part B of Title XI of the Social Security Act requires CMS to “regularly furnish each quality improvement organization with a contract under this section with a report that documents the performance of the organization in relation to the performance of other such organizations.”

As required by this law, CMS published the general criteria and standards used for evaluating the efficient and effective performance of contract obligations for the program and provided the opportunity for public comment in the following Federal Register notice:

- Medicare Program; Evaluation Criteria and Standards for Quality Improvement Networks Quality Improvement Program Contracts [Base and Task Order(s)]: 60-day Notice published on August 11, 2014 in Federal Register Volume 79, Number 154, pg. 46830-46835 (CMS–3300–NC); Final Notice published on December 30, 2014 in Federal Register Volume 79, Number 249, pg. 78440-78442 CMS–3300–FN).

These evaluation criteria are required for contract monitoring rather than evaluation of overall impact of the program. We will use the data required for contract monitoring along with the proposed data in outcome and impact analyses. Attachment 1 provides a crosswalk between the evaluation data needs, existing data, and the proposed data to be collected under this information collection request to show how the data will be integrated efficiently to assess the impact of the program.

## 2. Information Users

The purpose of this data collection is to inform the program evaluation of the QIO program’s 11<sup>th</sup> SOW as required in Sections 1152-1154 of the Social Security Act. The current data collection will focus on the impact of the QIO program on disseminating the QAPI approach and reducing HACs among nursing home residents in participating nursing homes compared to nursing homes not participating in the program. The findings will also be used to inform CMS’ annual reports to Congress, reports and briefings to OMB, and other stakeholder groups. The results from this data collection may be published in annual program reports and peer-reviewed journal publications.

## 3. Use of Information Technology

We will conduct telephone surveys and telephone or in-person interviews to effectively balance the need for program information with the costs of data collection and potential burden on program staff and stakeholders. We will conduct telephone surveys using Computer-Assisted Telephone Interviews (CATI) technology. Phone surveys will be brief and focused on the essential data needs to address the evaluation questions to reduce the burden on participants. We will conduct pretests to improve clarity and understandability of the survey questions, to reduce participant burden, and to enhance survey administration. We will keep the survey a reasonable length to minimize break-offs. Tested recruitment and data

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<sup>18</sup> Social Security Administration. Contracts with Quality Improvement Organizations. Retrieved January 8, 2016 from [https://www.ssa.gov/OP\\_Home/ssact/title11/1153.htm](https://www.ssa.gov/OP_Home/ssact/title11/1153.htm)



collection procedures will be used to maximize cooperation and to achieve the desired response rates.

This data collection request does not require a signature from participants. Consent will be obtained verbally.

#### 4. Duplication of Efforts

This information collection does not duplicate any other effort and the information cannot be obtained from any other source. Data are regularly collected from QIN-QIOs, but not from nursing homes related to these quality improvement of efforts. In order to prevent duplication of data collection, the IEC developed a Baseline Current Environment Report and Data Inventory, which outlined the current CMS and secondary datasets and sources that can be used to inform the evaluation, including Medicare claims data. Additional data collection is only proposed when data necessary to inform the QIO evaluation questions are not available in current data sets, program reports, or other sources. The IEC is collaborating with the QIN National Coordinating Center (NCC), the BFCC NCC, and other program components to share information and data in order to avoid any duplication of data collections from QIO providers and beneficiaries.

The existing datasets and newly collected data will be integrated to address the evaluation questions and meet the goals of the data collection as previously described in the Background Section (see also Attachment 1). For example, analysis of secondary data will show trends in need of follow-up during qualitative interviews and focus groups. The information collected through surveys, interviews, and focus groups may help identify factors associated with evaluation outcomes, which can be accessed in MDS 3 and Medicare claims, including uptake of QAPI approaches.

#### 5. Small Businesses

QIOs and nursing homes may be small or large business based on the definition of the Small Business Paperwork Relief Task Force as having 500 or fewer employees or \$6M or less in receipts.<sup>19</sup> Approximately 30% of nursing homes may be small businesses based on a revenue of less than \$6 Million.<sup>20</sup> To reduce the impact on these small businesses and entities, data collection will be streamlined and focused, limited to only the collection of data required to answer the evaluation questions. Surveys will be 10-20 minutes or less annually and the same participants will not be surveyed each year. Surveys will occur by telephone at times that are convenient to the participants. Nursing Home Administrator Interviews will be conducted with respondents who have not participated in the survey in order to reduce response burden

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19 Final Report of the Small Business Paperwork Relief Task Force. (2003). Retrieved May 6, 2016 from [https://www.sba.gov/sites/default/files/Final%20Task%20Force%20Report\\_June%202003.pdf](https://www.sba.gov/sites/default/files/Final%20Task%20Force%20Report_June%202003.pdf)

20 Assuming an average nursing home bed occupancy rate of 83% and average annual cost of semi-private room of is \$74,820 (according to <http://longtermcare.gov/costs-how-to-pay/costs-of-care>), nursing homes with more than 99 are most likely large businesses based on the revenue description. Approximately 50% of nursing homes have more than 99 beds according to [https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/downloads/nursinghomedatacompendium\\_508.pdf](https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/downloads/nursinghomedatacompendium_508.pdf). Assuming that 75% of the <99 nursing homes are for-profit, approximately 37.5% of our sample is likely to be small businesses based on the revenue definition. Since half of all nursing homes belong to chains, a portion of these nursing homes would be considered large nursing homes. We therefore estimate that approximately 30% of nursing homes in our sampling frame will be small businesses (800 total nursing homes x 30% = 240 nursing homes).



on individual facilities. Pre-notification emails will be sent out to respondents prior to data collection to inform them about the purpose of the data collection, expected time required, and to provide other elements of informed consent (Appendix B).

#### 6. Less Frequent Collection

If these information collection activities are not conducted, CMS will not be able to fulfill the mandates of the Social Security Act Title XI Section 1153 to evaluate the QIO program and provide a report on performance to contracted QIOs. If the data collection occurs less frequently, QIOs will not receive timely feedback in order to improve their services and programs to meet the goals of the 11<sup>th</sup> SOW. Evaluating the program tasks of the 11<sup>th</sup> SOW require early and frequent input to make appropriate changes in time for the 12<sup>th</sup> SOW.

#### 7. Special Circumstances

There are no special circumstances relating to the Guidelines of 5 CFR 1320.5.

#### 8. Federal Register/Outside Consultation

The 60-day Federal Register notice published on June 30, 2016 (81 FR 42710). One general comment was received from a member of the public related to CMS-10622 about incentives for nursing homes, and a response to the comment was submitted. The 30-day Federal Register notice published on October 31, 2016 (81 FR 75409-75410) and received no comments. In addition to the required public notices, we pre-tested instruments among respondents to obtain their views on the availability of data, frequency of collection, the clarity of instructions and recordkeeping, disclosure, or reporting format, and on the data elements to be recorded, disclosed, or reported.

#### 9. Payments/Gifts to Respondents

We do not plan to use payments or incentives for participants. The burden of the response is low, so we do not think this will impact response rates. While incentives have the potential to encourage participation, our team and other projects have had success conducting surveys with program stakeholders without incentives. Strategies for successful recruiting include scheduling surveys at convenient times for respondents (such as early morning or evening phone calls) and using relationships among QIN-QIO program staff.

#### 10. Confidentiality

Nursing homes that receive funding from CMS provide information which is housed in the Minimum Data Set (MDS). The system of records (SOR) for long-term care MDS, number 09-70-0528, establishes privacy stringent requirements for MDS.<sup>21</sup> The MDS SOR was published in the Federal Register March 19, 2007 (Vol. 72 No. 3 12801-12806). With the submission of this information, an administrator at the nursing home is identified as the appropriate contact for CMS. We will supplement this database with data from the QIN-QIO program on which nursing homes are participating in the program's initiatives, as each QIN is responsible for identifying to CMS the participating nursing homes.

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21 CMS. System of Records: Long Term Care MDS. Retrieved May 18, 2016 from <https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/Privacy/Systems-of-Records-Items/09-70-0528-LTC-MDS.html?DLPage=1&DLEntries=10&DLFilter=MDS&DLSort=0&DLSortDir=descending>

To protect the privacy of participant data, each survey respondent will be de-identified and given a unique identification (ID) number. This ID number will be the only information that is recorded on data-collection instruments, and the data-collection instruments will be stored separately from other data collected within this project. Contact information (names, telephone numbers, and email addresses) of participants will be stored separately from data files and will only be accessed by authorized team members for logistical reasons (e.g. scheduling, follow-ups, avoiding contacting the same individuals in subsequent years if needed). These individuals will not be identified in the transcripts that are used for analyzing the qualitative interviews and focus groups. Basic demographic or institutional characteristics will be used to characterize interview and focus group participants.

No one outside the contractor’s team will have access to the individual responses, nor will anyone outside the team be able to identify any individual respondent with their responses. Reports on data collected will be presented in aggregate form only. At the end of the project, the Primary Investigator will arrange for the proper storage and destruction of all data in compliance with all relevant government regulations and policies

**11. Sensitive Questions**

The survey does not include any sensitive questions related to private matters.

**12. Burden Estimates (Hours & Wages)**

The category of respondents for each of the data collections and the estimated annual burden (number of burden hours per year) for the specific information collection are outlined in Table 2 below.

**Table 2: Estimated Annual Burden Hours and Cost**

<b>Data Collection Activity</b>	<b>Estimated Number of Respondents (1)</b>	<b>Number of Responses per Respondent (2)</b>	<b>Hours per Response (3)</b>	<b>Estimated Annual Burden Hours (4=1*2*3)</b>	<b>Hourly Wage Rate<sup>22</sup> (5)</b>	<b>Estimated Total Annual Respondent Cost (6=4*5)</b>
Nursing Home Survey with QIN-QIO Participants	400	1	0.33	132	\$80.90	\$10,678.80
Nursing Home Survey with Non-Participants <sup>23</sup>	400	1	0.17	68	\$80.90	\$5,501.20

22 Based May 2015 National Industry-Specific Occupational Employment and Wage Estimates, Bureau of Labor Statistics. [http://www.bls.gov/oes/current/naics4\\_541600.htm#29-0000](http://www.bls.gov/oes/current/naics4_541600.htm#29-0000). To account for benefits and overhead, 100% x the hourly wage was added to the hourly wage to provide the adjusted hourly wage for each group. For Nursing Home Administrators: Management Occupations in “Nursing and Residential Care Facilities” (North American Industry Classification System (NAICS) 623000 on average earned \$40.45 in 2015 (adjusted hourly wage: \$80.90). For QIN-QIO and QIO Leaders: The average hourly wage for Medical and Health Services Managers was \$46.97 (adjusted: \$93.94). For Peer Coaches: Participants can be administrative staff (average wage of \$40.45/hour), direct care staff (LPN average wage of \$22.83), or family members/beneficiaries (average wage of \$17.50 hour for other healthcare support), so an average wage of  $(\$40.45 + \$22.83 + \$17.50)/3 = \$26.92$  hour was calculated (adjusted: \$53.84).

23 . The survey is estimated to take approximately 10 minutes to complete if the facility is not participating in the

<b>Data Collection Activity</b>	<b>Estimated Number of Respondents (1)</b>	<b>Number of Responses per Respondent (2)</b>	<b>Hours per Response (3)</b>	<b>Estimated Annual Burden Hours (4=1*2*3)</b>	<b>Hourly Wage Rate (5)</b>	<b>Estimated Total Annual Respondent Cost (6=4*5)</b>
Nursing Home Administrator In-depth Interview with QIN-QIO Participants	14	1	0.75	10.5	\$80.90	\$849.45
QIN-QIO Nursing Home Task Lead In-depth Interview	14	1	0.75	10.5	\$93.94	\$986.37
QIN-QIO Nursing Home Task Lead Focus Group	14	1	1	14	\$93.94	\$1,315.16
Nursing Home Peer Coach In-depth Interview	14	1	0.50	7	\$53.84	\$376.88
<b>Total</b>	<b>856</b>	<b>1</b>	<b>--</b>	<b>254.75</b>	<b>--</b>	<b>\$19,707.86</b>

The estimated number of survey respondents reflects the planned sample of 800 per year. The burden hour estimates for the survey are based on pre-tests of the length of time each type of respondent is likely to need to complete the survey screener and questions. The survey is expected to take approximately 10 minutes with nursing home facilities that are not participating in the QIN-QIO program and approximately 20 minutes to complete if the facility is participating in the QIO program, with an average 15 minutes. The number of questions asked of a respondent will vary depending on factors like the amount of quality improvement objectives their nursing home is addressing and whether or not their nursing home is interacting with a QIN-QIO.

We will conduct in-depth interviews with nursing home administrators, QIN-QIO directors, and peer coaches during site visits or by telephone twice during the data collection period. We will conduct two nursing home administrator interviews per QIN-QIO totaling 28 respondents over two years (14 nursing home administrators annually). We will conduct two director/program lead interviews per QIN-QIO totaling 28 respondents over two years (14 QIN or QIO directors annually). We will also conduct two peer coach interview per QIN-QIO over two years (14 peer coaches annually). Interviews with nursing home administrators and QIO directors will last 45 minutes (0.75 hour) per interview, with one response per respondent. Interviews with peer coaches will last approximately 30 minutes (0.50 hours) per interview, with one response per respondent.

We will conduct two in-person focus groups with seven QIO directors in each group at annual CMS Quality conferences (up to 14 respondents over three years). Each focus group will last approximately 1 hour.

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QIN-QIO program. The survey is estimated to take approximately 20 minutes to complete if the facility is participating in the QIO program, because the survey includes additional questions related to interactions with the QIO. The average survey response time across both groups is 15 minutes.

The estimated annual hour and cost burden is based on the 2015 hourly wage rate of the categories of respondents for these data collections (Table 2). The total cost is calculated by multiplying the number of responses by the average time per response by the hourly wage. The costs are then summed to derive the total cost for all respondents.

13. Capital Costs

There are no capital costs.

14. Cost to Federal Government

The cost of this information collection effort to the Federal government consists of the costs for government (CMS) activity and CMS’ contractor activity (Table 3). The costs to CMS involve labor costs for overseeing the contractor’s work and reviewing and providing guidance on data collection instruments, OMB clearance package, and other materials. The costs to CMS’ contractors are the costs to carry out the data collection and analysis, develop written reports, and present the findings to CMS and other stakeholders. These costs include labor hours for survey development and testing; sample recruitment, screening, and scheduling; survey administration and management; data cleaning and analysis; and developing reports. Operational expenses include overhead, survey scripting, data processing, and coding. Survey costs increase over time due to the escalation in rates and increased level of effort related to analysis and reporting.

For purposes of OMB review and approval, we have annualized the number. The estimated annual cost to the Federal government over a standard 3-year OMB approval period will be \$316,848.

**Table 3: Cost to the Federal Government**

<b>Activity</b>	<b>Base Year (9/2015-8/2016)</b>	<b>Option Year 1 (9/2016-8/2017)</b>	<b>Option Year 2 (9/2017-8/2018)</b>	<b>Option Year 3 (9/2018-8/2019)</b>	<b>Option Year 4 (9/2019-8/2020)</b>	<b>Total (2016-2020)</b>
<b>Government Activity</b> Review and provide guidance on instruments, OMB clearance, and data collection approach	\$15,000	\$10,000	\$10,000	\$10,000	\$10,000	\$55,000
<b>Contractor Activity</b> Instrument development, testing, administration, management; sample recruitment and scheduling; Data coding/transcribing; Analysis and reporting	\$292,577	\$297,951	\$305,332	\$312,667	\$320,712	\$1,529,238
<b>Total</b>	--	--	--	--	--	\$1,584,238
<b>Annual Cost (Total cost/5 years)</b>	--	--	--	--	--	\$316,848

15. Changes to Burden

This is a new information collection. Based on feedback from the cognitive tests, the initial survey was adjusted by adding one question, streamlining responses to shorten other questions, clarifying questions, and reorganizing questions to improve the flow of the survey. These changes did not result in a change to the burden of the study (time estimates for completion remain the same).

16. Publication/Tabulation Dates

This evaluation will take place from April 2017- August 2020. Our plans and timeline for reports and publications are outlined in Table 4. Reports include program management reports that provide ongoing performance data that can guide CMS’ program decisions regarding continuation or modification of contract recruitment and performance targets, measurement strategies, and recommended evidence-based interventions. In addition, we will develop documents and reports suitable for presentation to various audiences, national stakeholders, and policymakers, including presentation at professional meetings and publications in peer-reviewed journals.

**Table 4: Deliverable Schedule for Data Collection and Reporting Activities**

<b>Deliverables</b>	<b>Timeline</b>
Yearly Data Collection and Analysis Report	Annually (2016-2019)
Presentations	2017-2020
Publications (including brief reports, analytic memos, and peer-reviewed manuscripts)	2017-2020
Final Data Collection and Analysis Report	8/2020

Statement B provides an overview of our statistical techniques used to analyze survey data.

17. Expiration Date

The PRA statement will be read during the telephone survey as indicated on the survey instrument. The interview and focus group discussion guides will display the OMB expiration date. The PRA statement will be read during the interviews and focus group discussions as indicated in the discussion guides.

18. Certification Statement

There are no exceptions to the certification statement identified in Item 19.