Supporting Statement – Part A

Satisfaction of Nursing Homes, Hospitals, and Outpatient Clinicians Working with the CMS Network of Quality Improvement and Innovation Contractors Program (NQIIC) (CMS-10769)

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 Innovation Network-Quality Improvement Organization (QIN-QIO) and Hospital Quality Improvement Contractors (HQIC) programs under the Network of Quality Improvement and Innovation Contractors (NQIIC) contract vehicle. This is a revision package. First, we updated the Nursing Home and Hospital Surveys to cover all the quality improvement focus areas targeted by NQIIC awardees, removed some but not all COVID-19 Public Health Emergency (PHE) related questions to reflect the progress of federal health program (e.g., Agency for Healthcare Research and Quality Project Echo program was officially ended in August 2021), and made minor refinements based on the first round of survey fielding. Second, we added the Outpatient Clinician Survey in the same revision package since all three surveys are conducted under the same NQIIC contract, for more details please refer to the overview of data collection and justification sections. Finally, we updated the estimated burden hours and cost data in Table 2 using the most updated occupational employment and wages data published in the U.S Bureau of Labor Statistics (BLS) website.

This revision package supports evaluation of the technical assistance provided by the QIN-QIO Program to nursing homes and outpatient clinicians in community settings, and Hospital Quality Improvement Contractors (HQIC) Program activities to support hospitals. This ICR is part of a larger evaluation of the overall impact of the NQIIC Program.

The purpose of NQIIC is to support quality improvement efforts across settings and programs for maximum impact to health care and value to taxpayers in a manner that aligns with CMS and the U.S. Department of Health and Human Services' (HHS) priorities. The NQIIC quality improvement efforts involve the QIN-QIO Program, which is one of the largest federal programs dedicated to improving health quality for Medicare beneficiaries. As such, the QIN-QIO Program has been an important resource in CMS' efforts to improve quality and efficiency of care for Medicare beneficiaries.[1] QIN-QIOs are groups of health quality experts, clinicians, and consumers who work with health care providers, community partners, beneficiaries, and caregivers on data-driven initiatives designed to improve the quality of care for people with specific health conditions.[2] QIN-QIOs also serve as quality improvement experts, facilitators, and change agents for healthcare transformation that will

[1] Centers for Medicare & Medicaid Services. (2020). *Quality Improvement Organizations.* Retrieved October 15, 2021 from https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityImprovementOrgs

[2] Quality Improvement Organizations, Centers for Medicare & Medicaid Services. (2020). *About.* Retrieved October 15, 2021 from https://www.qioprogram.org/about

span across focus areas to improve care for rural, medically underserved, and vulnerable populations; reduce health disparities; and improve customer experience.[3]

The 12 QIN-QIOs for the nursing home program have recruited more than 9,000 long-term care nursing homes, hereafter referred to as nursing homes. In addition, they work with Partnerships for Community Health to support the quality of care provided by outpatient clinicians in community settings. Partnerships for Community Health are groups enrolled and developed within a QIN-QIO's geographical service area, comprised of healthcare practitioners, providers, and/or members from various clinical settings, healthcare groups, non-clinical organizations, and local community support/service organizations. Areas of focus for the QIN-QIOs in nursing homes and community settings are:

- Reduce Opioid Utilization and Misuse
- Increase Patient Safety
- Increase Chronic Disease Management
- Improve Care Coordination
- Improve Quality of Care in Nursing Homes, including COVID Infection Control
- Increase Adult Immunization
- Training

Following are some of the improvements QIN-QIOs are required to make in quality and patient safety in long-term care settings by 2024: reduce all-cause harm and reduce adverse drug events (ADEs), reduce the percentage of nursing homes receiving infection control deficiencies upon survey inspection, improve compliance with infection control protocols and prevent the occurrence and spread of COVID-19 in nursing homes. QIN-QIOs are expected to provide support to the nursing homes most in need of quality improvement based on a combination of requirements related to their size, geographic location, star rating, and survey inspection results, with emphasis placed on supporting organizations serving underserved populations.

In Partnerships for Community Health, QIN-QIOs are required to work with outpatient clinicians as well as non-health programs, organizations, institutions that provide support toward public health aims for Medicare beneficiaries. The aims include reducing opioid misuse; increasing management for hypertension, diabetes, and chronic kidney disease; reducing hospital readmissions and preventable visits to emergency departments; and increasing adult immunization. QIN-QIOs are directed to ensure that Medicare beneficiaries with the greatest need are receiving technical assistance to overcome inequalities in healthcare.

The NQIIC focus on acute care hospitals involves over 2,600 rural hospitals, critical access hospitals, and other acute care hospitals that are low performing and serving vulnerable populations. The nine HQIC contractors provide technical assistance to achieve measurable outcomes focused on the following goals:

- Improve Behavioral Health Outcomes, focusing on decreased opioid misuse (decrease opioid related adverse drug events, including deaths, by 7%)

[3] Ibid.

- Increase Patient Safety with a focus on reduction of harm (reduce all-cause harm, including ADEs, by 9% or more)
- Increase the Quality of Care Transitions with a focus on high utilizers in an effort to improve overall utilization (reduce readmissions by 5%)
- Improve the COVID-19 and infection control/respond to public health emergencies, as directed by CMS

CMS evaluates the quality and effectiveness of the QIN-QIO Program, as authorized in Part B of Title XI of the Social Security Act,[4] and has hired Booz Allen Hamilton (Booz Allen) as the Independent Evaluation Contractor (IEC) for the NQIIC Program.

This ICR is to conduct data collection using surveys with administrators or managers of nursing homes and hospitals, and from clinicians working in outpatient community-based settings. Table 1 provides an overview of the proposed data collection methods, including survey topics and respondent groups. The Nursing Home Survey instrument can be found in Appendix A, the Hospital Survey Instrument in Appendix B, and the Outpatient Clinician Survey Instrument in Appendix C.

[4] Social Security Administration. *Contracts with Quality Improvement Organizations*. Retrieved December 15, 2020 from https://www.ssa.gov/OP_Home/ssact/title11/1153.htm

Table 1: Overview of Data Collection

Data Collection Method	Survey Topics	Respondents
Nursing Home Survey		
Telephone survey of Nursing Home Administrators, Directors of Nursing, or staff member most responsible for quality improvement activities (called Nursing Home Administrators)	• Extent to which facility attributes quality improvement outcomes to QIN-QIO Program • Level of facilities' satisfaction with QIN-QIOs • Reasons for not participating in QIN-QIO program, when applicable, or for having low engagement • Resources used for quality improvement instead of QIN-QIOs among low- or non-participating facilities	• 250 Nursing Home Administrators of facilities that qualify for the NQIIC Program and either have low-level participation (125) or were never successfully enrolled by the NQIIC (125) • 250 Nursing Home Administrators of facilities enrolled in the NQIIC Program that have average or high levels of participation
Hospital Survey		
Telephone survey of Hospital Administrators, Directors of Nursing, or staff member most responsible for quality improvement activities (called Hospital Administrators)	• Hospitals' progress towards HQIC goals • Extent to which facility attributes quality improvement outcomes to HQICs • Level of facilities' satisfaction with HQICs • Reasons for not participating with HQIC, when applicable, or for having low engagement • Resources used for quality improvement instead of those provided by HQICs among low- or non-participating hospitals	• 280 Hospital Administrators of facilities qualify for HQIC technical support and enrolled • 220 Hospital Administrators of which qualify for HQIC technical support but not enrolled by the HQIC
Outpatient Clinician Survey		
Online survey of outpatient clinicians in community settings	• Extent to which outpatient clinicians attribute quality improvement outcomes to QIN-QIO Program • Level of outpatient clinician' satisfaction with QIN-QIOs or Partnerships for Community Health • Reasons for not participating in QIN-QIO program, when applicable, or for having low engagement in the program • Resources used for quality improvement instead of QIN-QIOs among low- or non-participating facilities	• 900 Outpatient Clinicians (450 who are enrolled with QIN-QIO Partnerships for Community Health, 450 working in same zip codes but not enrolled in the Partnerships for Community Health)

A. Justification

1. Need and Legal Basis

The QIN-QIO Program was 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. The quality improvement efforts considered for the NQIIC

indefinite delivery/indefinite quantity contract include statutorily required QIN-QIO work (Sections 1152-1154 of the Social Security Act) and statutorily required End-Stage Renal Disease (ESRD) Network work (under Sec. 1881 (c). [42 U.S.C. 1395rr]), as well as hospital-focused, large-scale improvement work; clinician-focused technical assistance work; and other quality improvement work.[5]

The Social Security Section 1153. [42 U.S.C. 1320c–2] (c)(2) includes language authorizing evaluation of the QIN-QIO Program: "the Secretary shall have the right to evaluate the quality and effectiveness of the organization in carrying out the functions specified in the contract."[6]

The data collection proposed in this ICR is necessary for CMS to evaluate the QIN-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." Additionally, the Statements of Work (SOW) for QIN-QIO and HQIC contractors both specify engagement with IEC to aid in data collection for formative and impact evaluation, including the information to be gathered as a result of this information collection request. Upon reviewing the survey findings, IEC will work with CMS to determine the need of further following up with no more than 10% of survey responses stratified by NQIIC awardees to better improve the NQIIC programs.

2. Information Users

The primary use of this data collection is to provide information to enhance the program evaluation of the NQIIC initiative. The IEC will use survey findings to inform the formative and impact evaluation on the level of engagement and satisfaction with the NQIIC contractors and test these factors for possible associations with process and clinical outcomes. The CMS leads for the NQIIC program may use perceived satisfaction responses to inform the contract management of QIN-QIOs and HQICs; CMS Contract Officer Representatives may share the findings with contractors as part of the contractors' continual improvement. The findings will also be used to inform CMS' annual reports to Congress, and its reports and briefings to the Office of Management and Budget (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

IEC will conduct telephone surveys (for Nursing Home and Hospital surveys) and online surveys (for Outpatient Clinician Survey) 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

[5] CMS. *Network of Quality Improvement and Innovation Contractors (NQIIC) Statement of Work IDIQ.* Retrieved on December 18, 2020 from https://www.govconwire.com/wp-content/uploads/2019/01/Attachment_J.1_NQIIC_IDIQ_Statement_of_Work.pdf

[6] Social Security Administration. *Contracts with Quality Improvement Organizations.* Retrieved October 18, 2021 from https://www.ssa.gov/OP_Home/ssact/title11/1153.htm

Interviews (CATI) technology. The interviewer will be guided by the survey questionnaire displayed on the computer screen. The CATI program will reflect the survey logic and skip patterns. Responses will be entered directly into the survey database in a structured format, which will eliminate the need for additional data processing (e.g., transcription, data entry, and coding), thus reducing cost and enhancing data accuracy. With permission of the interviewee, technology will also be used to audio record and transcribe answers to questions with open-ended responses, ensuring accuracy and reducing the time needed to complete these questions.

Another key advantage of conducting the surveys using the CATI technology is to ensure that the data are collected from the right person. The survey questionnaire includes a series of screening questions; only facility administrators, directors of nursing, or staff member most responsible for quality improvement activities will be selected to participate in the survey. The interviewer will terminate the interview with individuals who do not meet participation eligibility criteria and will continue attempts to reach the right person at the selected facility. Participant screening by a trained interviewer—as opposed to by an electronic survey—will reduce the waste of healthcare providers' time, who attempt to take the survey but are not the right individuals to provide information required for the NQIIC evaluation and ensure the validity of the responses.

The brief online survey is designed to minimize burden on participants and to minimize dropouts. The link to the online survey will be prominent in the email announcing the launch of the survey and in follow-up emails to non-respondents. All three surveys have been pre-tested to improve clarity and understandability of the survey questions, to reduce participant burden, and to enhance survey administration.

These data collection activities do not require signatures from participants. Consent for CATI surveys will be obtained verbally and recorded in the system. For the online instrument, participants' consent will be implied by continuation after a page displaying the OMB statement.

4. Duplication of Efforts

The IEC has carefully tracked all sources of data collected by the QIN-QIOs and HQICs for nursing homes, outpatient clinicians, and hospitals, as well as data reported by nursing homes, Partnerships for Community Health and hospitals, including Medicare claims and other HHS data. We are proposing only additional collection of data necessary to inform the NQIIC evaluation questions that are not currently available in existing data sets, program reports, or other sources. The IEC is collaborating with other CMS contractors to exchange information and data to avoid any duplication of data collection from QIN-QIOs, HQICs, and the facilities they serve.

5. Small Businesses

Survey participants may be employed by small or large businesses based on the definition of the Small Business Paperwork Relief Task Force as having 500 or fewer employees or $6M or less in receipts.[7] For example, approximately 54% of physicians work in practices

7 Final Report of the Small Business Paperwork Relief Task Force. (2003). Retrieved February 6, 2018 from https://www.sba.gov/sites/default/files/Final%20Task%20Force%20Report_June%202003.pdf

owned by 10 or fewer physicians.[8] An estimated 150 nursing homes and 275 hospitals to be surveyed are considered small businesses.[9]

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 no longer in duration than 20 minutes (for nursing homes and hospitals), or 15 minutes (for outpatient clinicians). Surveys will be administered by telephone at times that are convenient to the participants. Pre-notification mailing letters (and/or postcards), emails (for respondents with email information collected) will be sent out to respondents prior to data collection to inform them about the purpose of the data collection, expected time required, and provide other elements of informed consent (see Appendices D.1 for nursing homes, D.3 for hospitals, and D.5 for outpatient clinicians).

6. Less Frequent Collection

   Evaluating the program tasks requires early and frequent inputs to make appropriate changes in time for quality improvement initiatives planned for the near future. If the data collection occurs less frequently, QIN-QIOs and HQICs will not receive timely feedback from an independent source in order to improve their services to meet the NQIIC goals, which represent HHS and CMS priorities and goals. Data collected less than once per year affects the ability of CMS to evaluate provider perceptions of and satisfaction with the NQIIC contractors, assess the extent to which providers perceive the NQIIC Program to have contributed to quality improvement progress, gather important information for assessing return on investment, and make any necessary adjustments to increase the program effectiveness and efficiency.

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 September 12, 2023 (88 FR 62574). There were public comments received from two individuals, but the comments were out of the scope of the information collection. Please see the response to comments document.

   The 30-day Federal Register notice published XXXXXX (XX XX XXXXX).

8 American Medical Association. (2022). AMA 2020 Physician Practice Benchmark Survey. Accessed April 6, 2022 from https://www.ama-assn.org/about/research/physician-practice-benchmark-survey.

9 References used for estimating the proportion of small businesses include: https://www.cms.gov/Medicare/Provider-Enrollment-and-certification/CertificationandComplianc/Downloads/nursinghomedatacompendium_508-2015.pdf; https://www.cdc.gov/nchs/data/series/sr_03/sr03_43-508.pdf ; and https://www.shepscenter.unc.edu/wp-content/uploads/2015/02/21stCenturyRuralHospitalsChartBook.pdf

In addition to the required public notices, IEC pre-tested all three survey instruments (Nursing home, Hospital, and Outpatient Clinician Surveys) with typical respondents to obtain their views on the availability of data, frequency of collection, clarity of instructions and recordkeeping, and disclosure or reporting format (if any), as well as on the data elements to be recorded, disclosed, or reported. All participants of the pre-test responded favorably to these criteria.

CMS consulted the IEC team, including the survey partner, The Henne Group (THG), on the availability of secondary data, method and frequency of the primary data collection, clarity of instructions to the interviewer and respondent, data collection database, disclosure and confidentiality statements, and anticipated survey reporting format. THG is a market research company with over 30 years of experience collecting information for federal, state, and local agencies, as well as with private sector companies and major U.S. academic institutions. THG, which qualifies as a small business, is known for its ability to obtain higher than anticipated response rates, success in recruiting hard-to-reach populations, and ability to navigate gatekeepers and reach target respondents.

The pre-tests for all three surveys (Nursing Home, Hospital, and Outpatient Clinician) used cognitive interviews, which provided substantive input from the targeted respondents to make sure that questions are clearly stated and understood as intended. Their input resulted in changes to questions that will optimize validity of responses. We minimized the extent of testing required to reduce burden and increase quality by relying heavily on previous surveys with similar groups, and those items made up the majority of the questions for all surveys.

9. Payments/Gifts to Respondents

The IEC does not plan to use payments or incentives for survey participants. The burden of the response is low, so there is not expected that a lack of payment or incentives will impact response rates. While incentives have the potential to encourage participation and can be used to compensate participants for their time, our team and other projects have had success conducting surveys with program stakeholders without incentives. Strategies for successful recruiting include pre-notification and follow-up communications (Appendix D), scheduling telephone surveys at convenient times for participants (e.g., early morning or evening phone calls), and leveraging potential respondents' working relationships with QIN-QIO or HQIC program staff.

The pre-tests involved approximately one hour of time for each participant. For this reason, outpatient clinicians, nursing home and hospital administrators participating in pre-tests were compensated at market rates.

10. Confidentiality

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 recruitment for survey participation with the same individuals in subsequent years, etc.). Likewise, individuals involved in pre-testing the survey instruments were not identified in the transcripts or audio recordings.

Facility identifiers may be used to construct relevant variables from the raw survey data and linked to clinical outcomes data for the construction of more robust analytic data sets.

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

11. Sensitive Questions

The surveys do 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.

Table 2: Estimated Burden Hours and Cost

Data Collection Activity	Estimated Number of Respondents (1)	Number of Responses per Respondent (2)	Hours per Response (3)	Estimated Burden Hours (4=1*2*3)	Hourly Wage Rate[10] (5)	Estimated Total Respondent Cost (6=4*5)
Nursing Home Survey	500	1	0.33	167	$49.91	8,334.97
Hospital Survey	500	1	0.33	167	$67.06	11,199.02
Outpatient Clinician Survey	900	1	0.25	225	$121.04	27,234.00
Total	1,900	1	--	559	--	46,767.99

The estimated number of respondents reflects the annual sample of 500 per year for each Nursing Home and Hospital Survey, and 900 per year for Outpatient Clinician Survey. The burden hour estimates for completing the survey screeners and questions are based on findings from pre-tests. Surveys are expected to take no longer than 20 minutes for nursing home or hospital administrators, and 15 minutes for outpatient clinicians to

[10] Based on May 2022 National Industry-Specific Occupational Employment and Wages, last updated in April 2023 for Medical and health Services Managers https://www.bls.gov/oes/current/oes119111.htm. "Nursing Care Facilities (Skilled Nursing Facilities)" on average earned $49.91 in 2022; Hospital Administrators on average earned $67.06 in 2022. Physicians in outpatient care centers on average earned $121.04 (https://www.bls.gov/oes/current/oes291229.htm). Cognitive interview participants will also be Nursing Home and Hospital Administrators, or outpatient clinicians.

complete if the facilities are participating in the NQIIC initiative, and less time if they are not participating.

The estimated annual hour and cost burden is based on the (most recently available) 2022 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. IEC then summed the costs 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, the OMB clearance package, and other materials. Labor costs were estimated using average salaries representative of the professional levels and steps for CMS personnel. CMS contractor costs represent labor 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.

For purposes of OMB review and approval, we have annualized the number. As shown in Table 3, the estimated annual cost to the federal government over a standard three-year OMB approval period will be $1,077,784.

Table 3: Annual Cost to the Federal Government

Activity	
Government Activity Review and provide guidance on instruments, OMB clearance, and data collection approach	$25,000.00
Contractor Activity Instrument development, testing, administration, management; sample recruitment and scheduling; Data coding/transcribing; Analysis and reporting	$1,052,783.70
Total	**$1,077,783.70**

15. Changes to Burden

In this revise package, we added the Outpatient Clinician Survey in addition to the Nursing Home and Hospital Surveys approved in the first OMB package (OMB#: 0938-1424). The number of respondents increased from 1,010 to 1,900, the burden hours increased from 300 to 559, and the estimated total respondent cost increased from $19,922 to $46,797.99.

16. Publication/Tabulation Dates

The Independent Evaluation Contractor's period of performance is effective from September 25, 2020 through September 24, 2025. Our plans and timeline for reports and publications using survey findings are outlined in Table 4 and 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. Table 4 also identifies documents and reports suitable for presentation to various audiences, national stakeholders, and policymakers, including presentations at professional meetings and publications in peer-reviewed journals.

Table 4: Deliverable Schedule for Data Collection and Reporting Activities

Deliverables	Timeline
Survey Reports	Annual Reports 2022-2025
Evaluation Progress Reports (includes survey findings)	Bi-annually (2022-2025)
Ad Hoc/Occasional Reports	Up to 3 Annually
Presentations	2022-2025
Publications (including peer-reviewed manuscripts)	2022-2025
Final Technical Report	4/2025

Supporting Statement B provides an overview of the statistical techniques IEC will use to analyze survey data.

17. Expiration Date

The expiration date will be displayed on the collection instrument. The expiration date will be mentioned by the interviewer before the survey is administered.

18. Certification Statement

There are no exceptions to the certification statement.