HealthInsight New Mexico
Annual Report of QIO Case Review Information

Quality Improvement Organizations (QIOs) perform a variety of activities to facilitate improved health care outcomes for Medicare beneficiaries. This report reflects only case review activities. For information on additional activities conducted by the QIO, please visit: http://www.healthinsightnm.org/providers/.

QIOs nationwide tested a new review data collection system from August 8, 2011 through January 31, 2012. Reviews processed in that system are not reflected in this report.

I. Total Number of Reviews: The table below reflects the number and type of reviews performed by *HealthInsight* New Mexico from August 1, 2011 through July 31, 2012.

Review Type	Number of Reviews	Percent of Reviews
Coding Validation for higher weighted diagnosis related group (HWDRG) requests	88	24.44
Coding Validation for all other types of reviews	2	0.56
Quality of Care Review for beneficiary complaints	53	14.72
Quality of Care Review for all other types of reviews	10	2.78
Utilization Review for readmission review for Fiscal Intermediary/Medicare Administrative Contractor referrals	2	0.56
Utilization Review for all other types of reviews	110	30.56
Notice of Non-coverage review for admission and preadmission non-coverage notices	0	0.00
Notice of Non-coverage review Medicare fee-for-service termination of services (BIPA)	34	9.44
Notice of Non-coverage review for Medicare Advantage termination of services (Grijalva)	27	7.50
Notice of Non-coverage review for hospital discharge appeals (Weichardt)	31	8.61
Notice of Non-coverage review – request for QIO Concurrence for discharge	0	0.00
Emergency Medical Treatment and Active Labor Act (EMTALA) 5 Day review	2	0.56
EMTALA 60 Day review	1	0.28
Total	360	

II. **Top 10 Principal Medical Diagnoses:** The table below reflects the top 10 principal medical diagnoses for inpatient claims billed for Medicare beneficiaries in the state of New Mexico with a claim date within the date range August 1, 2011 through July 31, 2012. If the same principal diagnosis was billed for more than one episode of care for the same beneficiary only one episode was counted.

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. 486 – Pneumonia, organism not otherwise specific (NOS)	2,369	18.26
2. V57.89 – Rehabilitation Procedure not elsewhere classified (NEC)	2,211	17.04
3. 038.9 - Septicemia NOS	1,873	14.43
4. 599.0 – Urinary Tract Infection NOS	1,202	9.26
5. 491.21 – Obstructive Chronic Bronchitis with acute exacerbation	1,038	8.00
6. 414.01 – Coronary atherosclerosis native vessel	961	7.41
7. 715.36 - Localized Osteoarthrosis NOS lower leg	881	6.79
8. 410.71 – Subendocardial Infarction, initial	852	6.57
9. 584.9 – Acute Kidney Failure NOS	805	6.20
10. 427.31 – Atrial Fibrillation	784	6.04
Total	12,976	100.00

III. **Provider Reviews Geographics:** The table below reflects how many providers in rural, urban and unknown geographical locations had a completed QIO review. The table also reflects the percent of providers in those geographical locations that had a completed QIO review.

Geographical Area	Number of Providers	Percent of Providers
Rural	20	34.48
Urban	38	65.52
Unknown	0	0.00
Total	58	100.00

IV. **Provider Reviews Settings:** The table below reflects how many providers, by setting, had a completed QIO Review. The table also reflects the percent of providers for each setting that had a completed QIO review.

Setting	Number of Providers	Percent of Providers
0 - Acute Care Unit of an Inpatient Facility	19	32.76
1 - Distinct Psychiatric Facility	0	0.00
2 - Distinct Rehabilitation Facility	2	3.45
3 - Distinct Skilled Nursing Facility	20	34.48
5 - Clinic	0	0.00

Setting	Number of Providers	Percent of Providers
6 - Distinct Dialysis Center Facility	0	0.00
7 - Dialysis Center Unit of Inpatient Facility	0	0.00
8 - Independent Based RHC	0	0.00
9 - Provider Based RHC	0	0.00
C - Free Standing Ambulatory Surgery Center	1	1.72
G - End Stage Renal Disease Unit	0	0.00
H - Home Health Agency	6	10.34
N - Critical Access Hospital	2	3.45
O - Setting does not fit into any other existing setting code	0	0.00
Q - Long Term Care Facility	2	3.45
R - Hospice	6	10.34
S - Psychiatric Unit of an Inpatient Facility	0	0.00
T - Rehabilitation Unit of an Inpatient Facility	0	0.00
U - Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	0	0.00
Y - Federally Qualified Health Centers	0	0.00
Z - Swing Bed Designation for Critical Access Hospitals	0	0.00
Other	0	0.00
Total	58	100.00

A. Quality of Care Concerns Confirmed: The table below reflects the type and number of quality of care concerns reviewed by the QIO and the number of quality of care concerns that were confirmed at highest level of review, for completed quality of care reviews.

Quality of Care Categories	Number of Concerns	Number of Concerns Confirmed	Percent of Confirmed Concerns
Apparently did not obtain pertinent history and/or findings from examination	6	4	66.67
Apparently did not make appropriate diagnoses and/or assessments	15	5	33.33
Apparently did not establish and/or develop an appropriate treatment plan for a defined problem or diagnosis which prompted this episode of care [excludes laboratory and/or imaging, and procedures and consultations]	14	8	57.14
Apparently did not carry out an established plan in a competent and/or timely fashion	19	7	36.84

Quality of Care Categories	Number of Concerns	Number of Concerns Confirmed	Percent of Confirmed Concerns
Apparently did not appropriately assess and/or act on changes in clinical/other status results	15	5	33.33
Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	8	7	87.50
Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	3	1	33.33
Apparently did not perform a procedure that was indicated (other than lab and imaging)	3	1	33.33
Apparently did not obtain appropriate laboratory tests and/or imaging studies	1	0	0.00
Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	12	3	25.00
Apparently did not demonstrate that the patient was ready for discharge	5	3	60.00
Apparently did not provide appropriate personnel and/or resources	1	1	100.00
Apparently did not order appropriate specialty consultation	0	0	0.00
Apparently specialty consultation process was not completed in a timely manner	0	0	0.00
Apparently did not effectively coordinate across disciplines	1	0	0.00
Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	16	5	31.25
Apparently did not order/follow evidence-based practices	3	2	66.67
Apparently did not provide medical record documentation that impacts patient care	5	3	60.00
Other quality concern not elsewhere classified	3	0	0.00
Total	130	55	42.31

B. Serious Reportable Events on Quality of Care Reviews - The table below reflects the number of Quality Improvement Activities (QIAs) that were initiated between August 1, 2011 and July 31, 2012 for all quality of care reviews with confirmed concerns. The table also shows the number and percent of those QIAs that are associated with quality of care concerns deemed to fall into the category of "Serious Reportable Events."

Number of QIAs Initiated	Number of QIAs Initiated for Serious Reportable Events	Percent of QIAs Initiated for Serious Reportable Events
20	0	0.00

C. Confirmed Quality of Care Concerns with Associated Interventions: The table below reflects the number and type of Initial Quality Improvement Activities (QIAs) implemented for completed reviews that had one or more confirmed Quality of Care concerns. Multiple Quality Improvement Activities may be implemented for a confirmed Quality of Care concern. This table reflects the first activity that was implemented. The table also reflects the percent of the total number of Quality Improvement Activities initiated by *HealthInsight* New Mexico that each activity comprises.

Initial Quality Improvement Activity	Number of Interventions (QIAs) with this Initial Quality Improvement Activity	Percent of Interventions (QIAs) with this Initial Quality Improvement Activity
1 - Send an educational and/or alternative approach letter	14	50.00
2 - Perform intensified review	0	0.00
3 - Require continuing education	0	0.00
4 – Request and/or review providers policy and/or procedure	0	0.00
5 - Request development of a Quality Improvement Plan (QIP)	9	31.14
6 - Accept provider-initiated QIP	3	10.71
7 - Conduct informal meeting or teleconference	0	0.00
8 - Refer to licensing board	0	0.00
9 - Initiate sanction activity	2	7.14
10 - Other	0	0.00
Total	28	

D. Discharge/Service Termination: The table below reflects the discharge location of beneficiaries who had a discharge/service termination review performed for an acute inpatient hospital stay. **Note:** The data in this report represents discharge/service termination reviews from August 1, 2011 through April 30, 2012. A shortened data timeframe is necessary to allow for all claims to be processed. The claim is the source of "Discharge Status" for these cases.

Discharge Status	Number of Beneficiaries	Percent of Beneficiaries
Discharged to home or self care (routine discharge)	8	50.00
Discharged/transferred to another short-term general hospital for inpatient care	0	0.00
Discharged/transferred to skilled nursing facility (SNF)	6	37.50
Discharged/transferred to intermediate care facility (ICF)	0	0.00
Discharged/transferred to another type of institution (including distinct parts)	0	0.00
Discharged/transferred to home under care of organized home health service organization	0	0.00
Left against medical advice or discontinued care	1	6.25
Admitted as an inpatient to this hospital	0	0.00
Expired (or did not recover – Christian Science patient)	0	0.00
Discharged/transferred to court/law enforcement	0	0.00
Still a patient	0	0.00
Expired at home (Hospice claims only)	0	0.00
Expired in a medical facility (e.g. hospital, SNF, ICF or free standing Hospice)	0	0.00
Expired – place unknown (Hospice claims only)	0	0.00
Discharged/transferred to a Federal hospital	0	0.00
Hospice - home	0	0.00
Hospice - medical facility	0	0.00
Discharged/transferred within this institution to a hospital-based Medicare approved swing bed	0	0.00
Discharged/transferred to an inpatient rehabilitation facility including distinct part units of a hospital	1	6.25
Discharged/transferred to a long term care hospital	0	0.00
Discharged/transferred to a nursing facility certified under Medicaid but not under Medicare	0	0.00
Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital	0	0.00
Discharged/transferred to a Critical Access Hospital	0	0.00
Discharged/transferred to another type of health care institution not defined elsewhere in code list	0	0.00
Other	0	0.00
Total	16	100.00

E. Beneficiary Demographics: The table below reflects the number of beneficiaries for whom a case review activity was started, the sex/gender, race, and the percent of beneficiaries each category represents.

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	116	51.79
Male	107	47.77
Unknown	1	0.45
Total	224	100.00
Race		
Asian	0	0.00
Black	5	2.23
Hispanic	20	8.93
North American Native	6	2.68
Other	3	1.34
Unknown	1	0.45
White	189	84.38
Total	224	100.00

F. Quality of Care Reviews and Concerns by Intervention Type: The examples below describe a quality improvement activity that was started between August 1, 2011 and July 31, 2012 as a result of a confirmed concern that was identified during a quality of care review.

Example 1
Concern: Provider apparently did not establish and/or develop an appropriate treatment plan for a defined problem or diagnosis which prompted this episode of care.

The QIO requested a quality improvement plan directed at assuring appropriate assessment and treatment of congestive heart failure and that congestive heart failure patients receive appropriate discharge planning and discharge instructions. The provider submitted an acceptable quality improvement plan and the QIO continues to monitor progress toward a successful resolution.

Example 2
Concern: The provider apparently did not demonstrate that the patient was ready for discharge.

The QIO accepted the provider initiated quality improvement plan focused on assuring that patients have complete orders for medications at the time they are discharged. The QIO continues to monitor progress toward a successful resolution.

Example 3
Concern: The provider apparently did not provide medical record documentation impacting patient care

The QIO sent an educational letter with recommendations for improving medical record documentation in the areas of fall risk precautions, skin evaluation and assessment of pain levels.

The description below describes, for example 1, how the intervention/QIA was determined and identifies, if applicable, any identified best practices for the resolution of the identified quality concern.

The physician peer reviewer recommended an intensified review to determine whether the findings on the review of a specific case reflected an isolated incident or a systemic problem. The intensified review confirmed that it was a systemic problem. Upon notification of the potential concern, the facility took measures to correct the problem. The case was reviewed by the review team and the Medical Director and it was determined that while the facility had taken steps to address the concern, additional intervention was required and a quality improvement plan should be requested.

The quality improvement plan is still in process, so best practices for the resolution of the identified quality concern have not yet been identified. One added value of the request for the quality improvement plan was the provider electing to participate in other QIO initiatives for other Aims.

G. Evidence Used in Decision-Making: The table that follows reflects the one or two most common types of evidence/standards of care criteria used by *HealthInsight* New Mexico to support Review Analysts' assessments and Peer Reviewers' decisions for Quality of Care Review, Medical Necessity/Utilization Review and Appeals. The table also reflects the rationale for how the specific evidence/standards of care were chosen.

For Quality of Care Reviews, the table lists specific diagnostic categories. These diagnostic categories reflect diagnoses that are related to other initiatives in the current statement of work in which QIOs are involved.

If a review was not performed for a specific category between August 1, 2011 and July 31, 2012, this is noted in the table.

Review Type	Diagnostic Categories	Evidence/Standards of Care Used	Rationale for Evidence/Standard of Care Selected
Quality of Care	Pneumonia	No cases were reviewed during the reporting period	N/A
	Heart Failure	Milliman Care Guidelines/Centers for Medicare & Medicaid Services (CMS) and Joint Commission National Hospital Quality Measures	Milliman Care Guidelines and National Hospital Quality Measures are evidence based
	Acute Myocardial Infarction	No cases were reviewed during the reporting period	N/A
	Pressure Ulcers	Milliman Care Guidelines	Milliman Care Guidelines are evidence based
	Urinary Tract Infection	Milliman Care Guidelines	Milliman Care Guidelines are evidence based
	Sepsis	Milliman Care Guidelines	Milliman Care Guidelines are evidence based
	Adverse Drug Events	Milliman Care Guidelines	Milliman Care Guidelines are evidence based
	Falls	Milliman Care Guidelines	Milliman Care Guidelines are evidence based
	Patient Trauma	No cases were reviewed during the reporting period	N/A
	Surgical complications	No cases were reviewed during the reporting period	N/A
Medical Necessity/Utilization Review		Milliman Care Guidelines	Milliman Care Guidelines are evidence based
Appeals		Medicare Conditions Coverage	Medicare Conditions Coverage defines covered services

Below are three brief examples/case studies where case review was linked to another Aim of the QIO contract, for example, readmissions, pressure ulcers, adverse drug events, etc. The evidence based criteria used to support review decisions on those cases and what influenced the selection of that criteria is provided.

Example/Case Study 1
The patient was admitted for an exacerbation of congestive heart failure. CMS and Joint Commission National Hospital Quality Measures for heart failure were chosen to support the review decision as the measures are evidence based and core measures are an integral part of the improving individual patient care Aim.

Example/Case Study 2
The patient developed a urinary tract infection after admission. Milliman Care Guidelines for acute pyelonephritis were chosen to support the review decision as the guidelines are evidence based.

Example/Case Study 3
The patient had pressure ulcers during the stay. Milliman Care Guidelines for skin and wound care were chosen to support the review decision as the guidelines are evidence based.

H. Effectiveness of QIAs: The information below provides an analysis of how the findings in tables B, C and F can be used to support the effectiveness of QIAs conducted as part of the Beneficiary and Family Centered Care Aim. Recommendations are also provided for how information from quality improvement activities could be used to make a positive impact on the work done in other 10th SoW Aims.

Narrative Analysis:
The majority of quality reviews currently being performed by the QIO are in response to a beneficiary complaint. The average Medicare beneficiary does not have a medical background and the perception of what constitutes quality care can vary from person to person. The QIO reviews the entire episode of care to determine whether standards of care were met.

Of the 53 quality reviews that *HealthInsight* New Mexico performed, 20 cases (38%) were found to have concerns that did not meet the standard of care. None of these concerns were deemed to fall into the category of "Serious Reportable Events." For each case where it was determined that the standards of care were not met, a quality improvement activity was initiated. The majority of these quality improvement activities (50%) were letters sent to the practitioner and/or provider providing education or recommending an alternative approach to future care. The next most common quality improvement activity (43%) was the development of a quality improvement plan. The quality improvement plan may have been initiated by the provider/practitioner or requested by the QIO.

In deciding what course of action to take, *HealthInsight* New Mexico requests input from the peer reviewer regarding the most appropriate quality improvement activity when a quality of care concern is determined to exist. The recommendation from the peer reviewer is evaluated in the context of the identified concern and a determination is made as to what quality improvement activity will be initiated. As seen in the examples in section F, the quality improvement activity is chosen based on the severity of the identified concern as well as the potential impact on other beneficiaries.

Recommendations for how information from quality improvement activities could be used to make a positive impact on the work done in other 10th SoW Aims:

- Provide aggregate feedback to all 10th SoW Aim teams as well as our partners in the health care system on the most common findings of review activities. This activity could build awareness of the importance of prevention, care transitions, patient safety and concerns by facility type. This would not require a significant amount of additional resources for the QIO.

- Establish a mechanism so that, when a QIO identifies a quality of care concern related to a diagnosis/10th SoW initiative in which QIOs are involved, the Beneficiary and Family Centered Care team could report information to the support contractor for the appropriate Aim. It would be ideal if there were a single database/mechanism that the QIO would report information to and this information would be disseminated to the appropriate support contractor. Information collected might include elements such as the health care setting, the geographical area (urban/rural), age/sex/race of the patient (if known), de-identified case summary and the action taken. This would allow the support contractor to analyze patterns across the country and assist in developing setting specific interventions. This would not require a significant amount of additional resources for the QIO, but additional resources would be required for the development of the reporting mechanism and analysis by the support contractor.

- When a quality of care concern is identified related to a diagnosis/10th SoW initiative in which QIOs are involved and a quality improvement plan is initiated, have representatives from the Beneficiary and Family Centered Care Aim meet with personnel from the appropriate Aim and design an integrated approach to address the concern with that particular provider and/or practitioner. This could include interventions such as site visits, Webex training, etc. This would require additional resources for the QIO.

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