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I. **Total # of Reviews** – The total number of reviews the QIO performed by the associated review type.

Review Type	Number of Reviews	Percent of Reviews (%)
Coding Validation (120 - HWDRG)	173	17.14%
Coding Validation (All Other Selection Reasons)	9	0.90%
Quality of Care Review (101 through 104 -Beneficiary Complaint)	49	4.81%
Quality of Care Review (All Other Selection Reasons)	18	1.78%
Utilization (158 - FI/MAC Referral for Readmission Review)	2	0.20%
Utilization (All Other Selection Reasons)	360	35.67%
Notice of Non-coverage (105 through 108 - Admission and Preadmission)	0	0
Notice of Non-coverage (118 - BIPA)	83	8.22%
Notice of Non-coverage (117 - Grijalva)	136	13.48%
Notice of Non-coverage (121 through 124 -Weichardt)	171	17.10%
Notice of Non-coverage (111-Request for QIO Concurrence)	1	0.01%
EMTALA 5 Day	7	0.69%
EMTALA 60 Day	0	0
TOTAL	**1009**	

II. Top 10 Principal Medical Diagnoses – The top 10 principal medical diagnoses for inpatient claims billed for Medicare beneficiaries.

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries (%)
1. V5789 - Specified rehabilitation procedure	6,914	28.70%
2. 486 – Pneumonia, organism unspecified	3,159	13.11%
3. 0389 – Unspecified septicemia	2,631	10.92%
4. 49121 - Obstructive chronic bronchitis; with acute exacerbation	1,913	7.94%
5. 5849 – Acute kidney failure	1,798	7.46%
6. 41401 - Coronary atherosclerosis of native coronary artery	1,653	6.86%
7. 51881 – Acute Respiratory Failure	1,588	6.59%
8. 5990 – Unspecified urinary tract infection	1,565	6.50%
9. 42731 – Atrial fibrillation	1,499	6.22%
10. 41071 - Subendocardial infarction, initial episode of care	1,369	5.68%
TOTAL	**24,089**	**100.00%**

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III. Provider Reviews Geographics – The count and percent by geographical locations for health service providers (HSPs) associated with a completed QIO review.

Geographical Area	Number of Providers	Percent of Providers (%)
Rural	12	15.79%
Urban	64	84.21%
Unknown	0	0.00%
TOTAL	**76**	**100.00%**

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IV. Provider Reviews Settings – The count and percent by setting for health service providers (HSPs) associated with a completed QIO review.

Setting	Number of Providers	Percent of Providers (%)
0 - Acute Care Unit of an Inpatient Facility	20	26.32%
1 - Distinct Psychiatric Facility	3	3.95%
2 - Distinct Rehabilitation Facility	5	6.58%
3 - Distinct Skilled Nursing Facility	31	40.79%
5 - Clinic	0	0.00%
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	0	0.00%
G - End Stage Renal Disease Unit	0	0.00%
H - Home Health Agency	9	11.84%
N - Critical Access Hospital	0	0.00%
O - Setting does not fit into any other existing setting code	0	0.00%
Q - Long Term Care Facility	3	3.95%
R - Hospice	5	6.58%
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	**76**	**100.00%**

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A. **Quality of Care Concerns Confirmed** – The number of concerns by Quality of Care Category Code and the number that were confirmed at highest level of review for completed quality of care reviews.

Quality of Care Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns (%)
C01 - Apparently did not obtain pertinent history and/or findings from examination	2	0	0.00%
C02 - Apparently did not make appropriate diagnoses and/or assessments	7	3	42.86%
C03 - Apparently did not establish and/or develop an appropriate treatment plan for a defined problem or diagnosis which prompted this episode of care	9	0	0.00%
C04 - Apparently did not carry out an established plan in a competent and/or timely fashion	17	4	23.53%
C05 - Apparently did not appropriately assess and/or act on changes in clinical/other status results	9	2	22.22%
C06 - Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	7	2	28.57%
C07- Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	9	0	0.00%
C08 - Apparently did not perform a procedure that was indicated	3	0	0.00%
C09 - Apparently did not obtain appropriate laboratory tests and/or imaging studies	3	0	0.00%
C10 - Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	13	4	30.77%
C11 - Apparently did not demonstrate that the patient was ready for discharge	6	1	16.67%
C12 - Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13 - Apparently did not order appropriate specialty consultation	2	0	0.00%
C14 - Apparently specialty consultation process was not completed in a timely manner	2	0	0.00%
C15 - Apparently did not effectively coordinate across disciplines	0	0	0.00%
C16 - Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	12	4	33.33%
C17 - Apparently did not order/follow evidence-based practices	7	4	57.14%
C18 - Apparently did not provide medical record documentation that impacts patient care	2	1	50.00%
C99 - Other quality concern not elsewhere classified	16	2	12.50%
TOTAL	**126**	**27**	**21.43%**

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B. Serious Reportable Events on Quality of Care Reviews - The number of quality improvement activities (QIAs) initiated for all quality of care reviews with confirmed concerns

# of QIAs Initiated	Number of QIAs Initiated for Serious Reportable Events	Percent of QIAs Initiated for Serious Reportable Events (%)
15	0	0%

C. **Confirmed Quality of Care Concerns with Associated Interventions** – The number of initial quality improvement activities initiated, by activity type, for reviews with one or more confirmed quality of care concerns.

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 educational/alternative approach letter	10	67%
2 - Perform intensified review	0	0
3 - Require continuing education	0	0
4 - Request/review policy/procedure	1	6.67%
5 - Request development of QIP	0	0
6 - Accept provider-initiated QIP	3	20%
7 - Conduct informal meeting or teleconference	0	0
8 - Refer to licensing board	0	0
9 - Initiate sanction activity	0	0
10 - Other	1	6.67%
TOTAL	**15**	**100%**

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D. Discharge/Service Termination – Provide discharge location of beneficiaries linked to discharge/service termination reviews for Selection Reasons 111 (Request for QIO Concurrence) and 121 – 124 (Weichardt Selection Reasons). **Note:** *Data represents discharge/service termination reviews from 8/1/2011 – 4/30/2012, 8/1/2012 – 4/30/2013 and 8/1/2013 – 2/28/2014.*

Discharge Status	Number of Beneficiaries	Percent of Beneficiaries (%)
01 - Discharged to home or self care (routine discharge)	8	20.00%
02 - Discharged/transferred to another short-term general hospital for inpatient care	1	2.50%
03 - Discharged/transferred to skilled nursing facility (SNF)	12	30.00%
04 - Discharged/transferred to intermediate care facility (ICF)	0	0.00%
05 - Discharged/transferred to another type of institution (including distinct parts)	0	0.00%
06 - Discharged/transferred to home under care of organized home health service organization	14	35.00%
07 - Left against medical advice or discontinued care	0	0.00%
09 – Admitted as an inpatient to this hospital	0	0.00%
20 – Expired (or did not recover – Christian Science patient)	1	2.50%
21 – Discharged/transferred to court/law enforcement	0	0.00%
30 – Still a patient	0	0.00%
40 - Expired at home (Hospice claims only)	0	0.00%
41 - Expired in a medical facility (e.g. hospital, SNF, ICF or free standing Hospice)	0	0.00%
42 - Expired – place unknown (Hospice claims only)	0	0.00%
43 - Discharged/transferred to a Federal hospital	0	0.00%
50 - Hospice - home	1	2.50%
51 - Hospice - medical facility	0	0.00%
61 - Discharged/transferred within this institution to a hospital-based Medicare approved swing bed	0	0.00%
62 - Discharged/transferred to an inpatient rehabilitation facility including distinct part units of a hospital	2	5.00%
63 - Discharged/transferred to a long term care hospital	1	2.50%
64 - Discharged/transferred to a nursing facility certified under Medicaid but not under Medicare	0	0.00%

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Discharge Status	Number of Beneficiaries	Percent of Beneficiaries (%)
65 - Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital	0	0.00%
66 - Discharged/transferred to a Critical Access Hospital	0	0.00%
70 - Discharged/transferred to another type of health care institution not defined elsewhere in code list	0	0.00%
Other	0	0.00%
TOTAL	**40**	**100.00%**

E. Beneficiary Demographics – Provide the number of beneficiaries for whom a case review activity was started, by demographic category, and the percent of beneficiaries each category represents.

Demographics	Number of Beneficiaries	Percent of Beneficiaries (%)
Sex/Gender	.	
Female	355	61.31%
Male	224	38.69%
Unknown	0	0.00%
TOTAL	**579**	**100.00%**
Race		
Asian	16	2.76%
Black	62	10.71%
Hispanic	11	1.90%
North American Native	2	0.35%
Other	8	1.38%
Unknown	0	0.00%
White	480	82.90%
TOTAL	**579**	**100.00%**

F. Quality of Care Reviews and Concerns by Intervention Type

Quality of Care Concern	Provider Quality Improvement Activities
Physician's non-legible handwriting that impacts patient care.	To understand the extent of the problem, the facility's Medical Leadership Committee evaluated the physician's handwriting in 10 medical records. As a result of their findings, the physician was mandated to participate in a focused professional practice program. For a minimum of three months, the physician's medical record documentation was reviewed by a physician, nurse, and other healthcare team member such as a pharmacist, respiratory therapist, or physical therapist to ensure legibility. These findings were presented to the facility's general Peer Review Committee to provide feedback to the physician and to enforce compliance; ensuring that patient safety is not compromised and to promote healthcare quality.
Appropriate diagnosis and/or admission assessments, which includes the patient and family perspective.	The provider implemented a new policy that allows the patient and/or the patient's family to request an emergency treatment team meeting. The new policy expands current patient rights by providing the opportunity to immediately address patient and family quality of care concerns. The information for this new policy is now included in the patient's admission paperwork and patient right handbook. All clinical staff members received education of this new policy. The Medical Director and Director of Performance Improvement/Risk Management will monitor compliance of clinical criteria and proper documentation to ensure compliance. All information will be shared with the Quality Council and Medical Executive Committee to identify further opportunities for quality improvement in patient care.
Carrying out an established plan in a timely manner for multiple transfusions.	The provider discovered there was a lapse in the handoff communication between the care providers in the Emergency Department and the new care providers when the patient was moved to another area of the hospital. An action plan was implemented to include one-to-one bedside reporting and a new process for chart checking/confirmation for each patient handoff. Staff members received education on all new processes. Additionally, the provider is actively implementing the U.S. Department of Health and Human Services, Agency for Health Care Research & Quality TeamSTEPPS initiative that emphasizes the need for structured communication between care providers to promote patient safety.

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How Interventions Determined/Best Practices

Carrying out an established plan in a timely manner for multiple transfusions.	The facility conducted a root cause analysis (RCA) to determine the reasons that contributed to the quality of care concerns identified. As a result, the primary cause identified was based on the lack of appropriate and thorough communication. To address this failure of communication, the facility selected to implement the Agency for healthcare Research and Quality (AHRQ) TeamSTEPPS.

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G. Evidence Used in Decision-Making

Review Type	Diagnostic Categories	Evidence/ Standards of Care Used*	Rationale for Evidence/Standard of Care Selected
Quality of Care	Pneumonia	AAFP	U.S. DHHS Agency
	Heart Failure	ACCF/AFA	National Medical Professional Association
	Acute Myocardial Infarction	ACCF/AHA	National Medical Professional Association
	Pressure Ulcers	AHRQ	U.S. DHHS Agency
	Urinary Tract Infection	AHRQ/AUA	U.S. DHHS Agency; National Medical Professional Association
	Sepsis	AHRQ	U.S. DHHS Agency
	Adverse Drug Events	AHRQ	U.S. DHHS Agency
	Falls	AHRQ/AGS	U.S. DHHS Agency; National Medical Professional Association
	Patient Trauma	AHRQ	U.S. DHHS Agency
	Surgical complications	AHRQ	U.S. DHHS Agency
Medical Necessity/Utilization Review		InterQual	Commercial evidence-based clinical decision support criteria
Appeals		InterQual	Commercial evidence-based clinical decision support criteria

*ACCF: American College of Cardiology Foundation
AHA: American Heart Association
AAFP: American Academy of Family Physicians
AHRQ: Agency for Health Care Research & Quality
AUA: American Urological Association
AGS: American Geriatric Society
DHHS: U.S. Department of Health and Human Services

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Case review topic	Linking to other QIO Aim	Evidence-based criteria referenced
Medication error in administering intravenous medication for patient's principle diagnosis of dehydration.	Reducing Adverse Drug Events (ADEs)	American Geriatric Society Managing oral hydration. In: Evidence-based geriatric nursing protocols for best practice
Assuring that patient is stable for discharge and has appropriate outpatient treatment plan	Care transitions initiatives to reduce readmissions	U.S. Department of Health and Human Services, Agency for Health Care Research & Quality
Facility acquired pressure ulcers	Improve Individual Patient Care: Reduction of Pressure Ulcers	U.S. Department of Health and Human Services, Agency for Health Care Research & Quality

H. Effectiveness of QIAs

Beneficiaries correlate the quality of their health care outcome as the primary determinant of value. The BFCC Aim allows the QIO an opportunity to advocate for the beneficiary, review their quality of care concerns and provide improvement opportunities and accountability to the healthcare community.

In the examples provided, case review efforts afforded the identification of both system-wide improvements for a facility and improvements for practitioners to become aware and utilize evidence-base practices in their decision-making processes.

The unique combining of the quality of care case review process and quality improvement activities requires the health care provider to understand the patient's perspective, perform a root cause analysis and consider their actual current method of delivery system performance against current recognized standards and other 10th SOW Aims.