
# Annual Report of Medicare Case Reviews for Nevada

August 1, 2012 – July 31, 2013

# *HealthInsight* Nevada
# 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 only reflects case review activities. For information on additional activities conducted by the QIO, please visit:*
http://healthinsight.org

I. **Total Number of Reviews**: The table below reflects the total number and type of reviews performed by *HealthInsight* Nevada from August 1, 2012 to July 31, 2013.

| REVIEW TYPE | Number of Reviews | Percent of Reviews |
|---|---|---|
| Coding Validation (120 - HWDRG) | 142 | 13.17% |
| Coding Validation (All Other Selection Reasons) | 0 | 0% |
| Quality of Care Review (101 through 104 -Beneficiary Complaint) | 107 | 9.92% |
| Quality of Care Review (All Other Selection Reasons) | 1 | 0.09% |
| Utilization (158 - FI/MAC Referral for Readmission Review) | 0 | 0% |
| Utilization (All Other Selection Reasons) | 340 | 31.54% |
| Notice of Non-coverage (105 through 108 - Admission and Preadmission) | 0 | 0% |
| Notice of Non-coverage (118 - BIPA) | 122 | 11.32% |
| Notice of Non-coverage (117 - Grijalva) | 92 | 8.53% |
| Notice of Non-coverage (121 through 124 -Weichardt) | 245 | 22.72% |
| Notice of Non-coverage (111-Request for QIO Concurrence) | 0 | 0% |
| EMTALA 5 Day | 23 | 2.13% |
| EMTALA 60 Day | 0 | 0% |
| TOTAL NUMBER OF REVIEWS COMPLETED | **1,072** | |

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. V57.89 – Care involving other specified rehabilitation procedure | 7,039 | 31.60% |
| 2. 038.9 – Unspecified septicemia | 2,747 | 12.33% |
| 3. 486 – Pneumonia, organism unspecified | 2,551 | 11.45% |
| 4. 491.21 – Obstructive chronic bronchitis with (acute) exacerbation | 1,660 | 7.45% |
| 5. 584.9 – Acute kidney failure, unspecified | 1,633 | 7.33% |
| 6. 518.81 – Acute respiratory failure | 1,417 | 6.36% |
| 7. 599.0 – Urinary tract infection, site not specified | 1,376 | 6.18% |
| 8. 427.31 – Atrial fibrillation | 1,322 | 5.93% |
| 9. 414.01 – Coronary atherosclerosis of native coronary artery | 1,319 | 5.92% |
| 10. 434.91 – Cerebral artery occlusion, unspecified with cerebral infarction | 1,214 | 5.45% |
| **TOTAL NUMBER OF BENEFICIARIES** | **22,278** | |

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 | 7 | 9.46% |
| Urban | 67 | 90.54% |
| Unknown | 0 | 0.00% |
| TOTAL NUMBER OF PROVIDERS | **74** | **100.00%** |

**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 | 27.03% |
| 1 - Distinct Psychiatric Facility | 2 | 2.70% |
| 2 - Distinct Rehabilitation Facility | 3 | 4.05% |
| 3 - Distinct Skilled Nursing Facility | 31 | 41.89% |
| 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 | 1 | 1.35% |
| G - End Stage Renal Disease Unit | 0 | 0.00% |
| H - Home Health Agency | 4 | 5.41% |
| N - Critical Access Hospital | 2 | 2.70% |
| O - Setting does not fit into any other existing setting code | 0 | 0.00% |
| Q - Long Term Care Facility | 3 | 4.05% |
| R - Hospice | 8 | 10.81% |
| 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 NUMBER OF PROVIDERS** | **74** | **100.00%** |

**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** | 37 | 5 | 13.51% |
| **C03 - Apparently did not establish and/or develop an appropriate treatment plan for a defined problem or diagnosis which prompted this episode of care** | 55 | 3 | 5.45% |
| **C04 - Apparently did not carry out an established plan in a competent and/or timely fashion** | 27 | 1 | 3.70% |
| **C05 - Apparently did not appropriately assess and/or act on changes in clinical/other status results** | 20 | 5 | 25.00% |
| **C06 - Apparently did not appropriately assess and/or act on laboratory tests or imaging study results** | 8 | 0 | 0.00% |
| **C07- Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed** | 11 | 1 | 9.09% |
| **C08 - Apparently did not perform a procedure that was indicated** | 2 | 0 | 0.00% |
| **C09 - Apparently did not obtain appropriate laboratory tests and/or imaging studies** | 0 | 0 | 0.00% |
| **C10 - Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans** | 22 | 3 | 13.64% |
| **C11 - Apparently did not demonstrate that the patient was ready for discharge** | 15 | 1 | 6.67% |
| **C12 - Apparently did not provide appropriate personnel and/or resources** | 1 | 1 | 100.00% |
| **C13 - Apparently did not order appropriate specialty consultation** | 6 | 1 | 16.67% |
| **C14 - Apparently specialty consultation process was not completed in a timely manner** | 3 | 1 | 33.33% |
| **C15 - Apparently did not effectively coordinate across disciplines** | 3 | 0 | 0.00% |

| *(continued from Page 5)* Quality of Care Category Codes | Number of Concerns | Number of Concerns Confirmed | Percent Confirmed Concerns |
|---|---|---|---|
| **C16 - Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)** | 14 | 3 | 21.43% |
| **C17 - Apparently did not order/follow evidence-based practices** | 1 | 0 | 0.00% |
| **C18 - Apparently did not provide medical record documentation that impacts patient care** | 1 | 0 | 0.00% |
| **C99 - Other quality concern not elsewhere classified** | 34 | 4 | 11.76% |
| **TOTAL NUMBER OF CONCERNS** | **262** | **29** | **11.07%** |

**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 (%) |
|---|---|---|
| **29** | 0 | 0.00% |

**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 | 20 | 68.97% |
| 2 - Perform intensified review | 0 | 0% |
| 3 - Require continuing education | 0 | 0% |
| 4 - Request/review policy/procedure | 0 | 0% |
| 5 - Request development of QIP | 6 | 20.69% |
| 6 - Accept provider-initiated QIP | 1 | 3.45% |
| 7 - Conduct informal meeting or teleconference | 0 | 0% |
| 8 - Refer to licensing board | 0 | 0% |
| 9 - Initiate sanction activity | 0 | 0% |
| 10 - Other | 2 | 6.99% |
| **TOTAL** | **29** | **100%** |

**D. Discharge/Service Termination** – Locations of beneficiaries linked to discharge/service termination reviews

Note: *Data represents discharge/service termination reviews from 8/1/2012 – 4/30/2013*

| Discharge Status | Number of Beneficiaries | Percent of Beneficiaries |
|---|---|---|
| **01 - Discharged to home or self-care (routine discharge)** | 11 | 18.33% |
| **02 - Discharged/transferred to another short-term general hospital for inpatient care** | 2 | 3.33% |
| **03 - Discharged/transferred to skilled nursing facility (SNF)** | 21 | 35.00% |
| **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** | 12 | 20.00% |
| **07 - Left against medical advice or discontinued care** | 1 | 1.67% |
| **09 – Admitted as an inpatient to this hospital** | 0 | 0.00% |
| **20 – Expired (or did not recover – Christian Science patient)** | 1 | 1.67% |
| **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** | 0 | 0.00% |
| **51 - Hospice - medical facility** | 1 | 1.67% |
| **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** | 8 | 13.33% |

| *(continued from page 8)* Discharge Status | Number of Beneficiaries | Percent of Beneficiaries |
|---|---|---|
| **63 - Discharged/transferred to a long term care hospital** | 3 | 5.00% |
| **64 - Discharged/transferred to a nursing facility certified under Medicaid but not under Medicare** | 0 | 0.00% |
| **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 NUMBER OF MEDICARE BENEFICIARIES** | **60** | **100.00%** |

**E. Beneficiary Demographics** – Number of beneficiaries for whom a case review activity was started between August 1, 2012 and July 31, 2013, by demographic category, and the percent of beneficiaries each category represents; beneficiaries who had multiple instances of reviews were counted only once.

| Demographics | Number of Beneficiaries | Percent of Beneficiaries |
|---|---|---|
| **Sex/Gender** | | |
| Female | 317 | 51.80% |
| Male | 295 | 48.20% |
| Unknown | 0 | 0.00% |
| **TOTAL** | **612** | **100.00%** |
| **Race** | | |
| Asian | 20 | 3.27% |
| Black | 70 | 11.44% |
| Hispanic | 10 | 1.63% |
| North American Native | 4 | 0.65% |
| Other | 10 | 1.63% |
| Unknown | 1 | 0.16% |
| White | 497 | 81.21% |
| **TOTAL** | **612** | **100.00%** |

## F. Quality of Care Reviews and Concerns by Intervention Type

| Quality of Care Concern | Provider Quality Improvement Activities |
|---|---|
| **Failure to prevent skin breakdown and provide appropriate and timely treatment.** | 1. The provider's clinical management team reviewed current policies and procedures for skin and wound assessments and documentation standards.<br>2. Education of policy requirements was provided to staff that included obtaining physician orders and documentation implementation.<br>3. New processes that were implemented include:<br>a. <u>Consult log book:</u> The Wound care Nurse will maintain a consult log book to enhance quality of care monitoring and compliance of appropriate interventions. All wound care assessments with photos will undergo review by the Charge Nurse and/or wound care nurse to ensure adequate picture quality and documentation of wound assessments.<br>b. <u>Communication improvement:</u><br>• Hourly rounding and bedside reporting/hand-off with nursing and nurse aide staff members to facilitate improved communication between staff/shifts and allow participation of the patient/family/caregivers.<br>• New shift-to-shift nursing handoff report tool. Utilizing Situation-Background-Assessment-Recommendation (SBAR) format to ensure the patient's needs are fully addressed and key assessment pieces are noted. The SBAR report tool includes identification of the patient's current Braden score, any supportive equipment for skin breakdown (CPM, bare mattress, overlay, etc.) currently in use, location and status of any dressings, drains, sutures or staples, and the patients' continence status.<br>• Continuous monitoring through monthly audits with monthly reporting to their Patient Safety/Environment of Care Committee and quarterly reports to the Medical Executive Committee and Governing Body.<br>c. <u>Discharge</u>: Discharge checklist addition to ensure patient receives a discharge skin assessment/photo within 24 hours of planned discharge. |
| **Failure to assess and** | 1. The provider expanded the use of their existing Medical Emergency |

| | |
|---|---|
| **provide a timely treatment plan change.** | Response Team (MERT) for critical situation and with delay in MD returning calls.<br>2. Staff training and competency requirement was provided for nursing staff on MERT services.<br>3. Reports generated by the MERT system are reviewed quarterly by the Nursing Performance Improvement Committee and Interdisciplinary Committee<br>4. The provider increased data transparency by posting the MERT report on all nursing units and clinical hospital departments. |
| **Failure to provide appropriate discharge instructions for diagnosis** | 1. The provider reviewed their internal computer system, which revealed a problem with automatic defaults to incorrect discharge information.<br>2. Clinical educators reviewed the information content for any required revisions.<br>3. The provider performed random sampling of cases with specific coded diagnoses to ensure proper discharge instructions were being provided to the patient.<br>4. Staff education was performed to address quality of care concerns. |

## How Interventions Determined/Best Practices

| | |
|---|---|
| **Failure to prevent skin breakdown and provide appropriate and timely treatment.** | The facility conducted a root cause analysis (RCA) to determine reasons that contributed to the quality of care concern identified. As a result, the provider identified there was a lack of appropriate and thorough communication.<br><br>To address this communication failure, the facility selected to implement the Situation-Background-Assessment-Recommendation (SBAR) communication and nursing reporting handoff tool. The SBAR system is used to create a structured and standardized communication format between health care workers. It is particularly useful for reporting changes in a patient's status and/or preventing communication deterioration between health care services or shifts. |

## 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 |

Below are three examples where case review was linked to another Aim of the QIO contract, the evidence based criteria used to support review decisions on those cases, and what influenced the selection of that criteria.

**Pressure Ulcers: Reduce Healthcare Acquired Conditions**

The Medicare beneficiary was transferred to a Rehabilitation facility after acute hospitalization for a cerebrovascular accident (CVA). Within a week, the beneficiary suffered a facility-acquired pressure ulcer. Upon review of the medical record documentation and the beneficiary's clinical needs, the physician reviewer determined the care provided did not meet recognized standards of care. The facility did not provide consistent and adequate skin assessment or care on a daily basis, and the use of a specialty mattress or routine and expected repositioning of the beneficiary was insufficient.

The QIO provided the physician reviewer and facility with an evidence-based resource, the Lippincott's Nursing Center: Comprehensive Programs for Preventing Pressure Ulcers to reference while considering the quality of care patients should receive and developing a quality improvement plan.

**Discharge Planning: Care Transitions Initiatives to Reduce Readmissions**

The Medicare beneficiary went to the Emergency Room with altered mental status and was admitted to rule out CVA. The beneficiary's plan of care included treatment for critical calcium levels. Professional clinical judgment and information from the U.S. Department of Health and Human Services, Agency for Health Care Research & Quality Initiatives to Reduce Hospital Readmissions were utilized to identify risk areas in discharge planning issues. As a result, the physician reviewer determined that the patient was given the wrong discharge and educational information for the beneficiary's Hypocalcemia diagnosis.

The facility acknowledged that a computer software issue resulted in an automatic default to infant Hypocalcemia discharge instructions. The provider performed a clinical review of the Hypocalcemia discharge information prior to the computer system correction. In addition, the provider conducted staff education and random audits of electronic and medical record chart documentation.

**Medication Management: Reduce Adverse Drug Events**

The Medicare beneficiary was transferred to a Skilled Nursing home for restorative rehabilitation therapy. During the stay, the beneficiary had multiple episodes of hypoglycemia and was being treated with Glyburide.

Evidence-based criteria found on Drugs. com and the Beers list for 2012 indicated that Glyburide may likely cause older adults to have lower blood sugar or be at greater risk of severe prolonged hypoglycemia in older adults. The physician reviewer determined the choice of using Glyburide is not the best option for elderly patients and shared this information with the beneficiary's physician.

## H. Effectiveness of QIAs

The Quality Improvement Organization (QIO) 10th Scope of Work program emphasizes Beneficiary and Family Centered Care and focuses on the following three Aims; better patient care, better individual and population health, and lower health care costs through improvement.

HealthInsight's Quality Assurance Division provides case review activities that are designed to empower Medicare beneficiaries and their families by expanding dialogue opportunities and allow their quality of health care services to be reviewed. Additionally, the division is responsible to conduct many other types of health care related review that are referred from other private and public agency entities.

All confirmed health care quality problems that jeopardizes the Medicare federal program or Medicare beneficiaries requires improvement action. HealthInsight works with the provider to identify the underlying reasons of the problem(s) in terms of the nature, the magnitude, the location, and the timing of the harmful outcome. Consequently, the provider is then able to modify their processes to deliver better quality of care. The provider's improvement activities are referred to as Quality Improvement Activities (QIA). The intent of a QIA is to promote action that will change and solve problems before they occur or escalate.

Section C and F of this report provide examples of QIA activities. All proposed action plans may entail a single or a system-wide improvement change. These plans are reviewed by HealthInsight's QIA committee members and subject to committee approval and continuous monitoring efforts to ensure successful change.

Based on the 10th SOW Aims, this unique combination of the quality of care case review process and quality improvement activities provides a positive impact by encouraging collaboration through the patient's experience and perspective, performing an analysis of the health care delivery system, and aligning patient care with current nationally recognized evidence-based standards.