Annual Report of Medicare Case Reviews for New Mexico

August 1, 2013 – April 30, 2014

SUBMITTED

6/30/2014

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 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* NM from August 31, 2013 to April 30, 2014.

REVIEW TYPE	Number of Reviews	Percent of Reviews
Coding Validation (120 - HWDRG)	178	32.42%
Coding Validation (All Other Selection Reasons)	0	0.00%
Quality of Care Review (101 through 104 -Beneficiary Complaint)	31	5.65%
Quality of Care Review (All Other Selection Reasons)	1	0.18%
Immediate Advocacy	5	0.91%
Utilization (158 - FI/MAC Referral for Readmission Review)	0	0.00%
Utilization (All Other Selection Reasons)	208	37.89%
Notice of Non-coverage (105 through 108 - Admission and Preadmission)	0	0.00%
Notice of Non-coverage (118 - BIPA)	43	7.83%
Notice of Non-coverage (117 - Grijalva)	40	7.29%
Notice of Non-coverage (121 through 124 -Weichardt)	42	7.65%
Notice of Non-coverage (111-Request for QIO Concurrence)	0	0.00%
EMTALA 5 Day	1	0.18%
EMTALA 60 Day	0	0.00%
TOTAL NUMBER OF REVIEWS COMPLETED	549	

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. 486 - PNEUMONIA, ORGANISM NOS	2369	18.26%
2. V5789 - REHABILITATION PROC NEC	2211	17.04%
3. 0389 - SEPTICEMIA NOS	1873	14.43%
4. 5990 - URIN TRACT INFECTION NOS	1202	9.26%
5. 49121 - OBS CHR BRONC W(AC) EXAC	1038	8.00%
6. 41401 - CRNRY ATHRSCL NATVE VSSL	961	7.41%
7. 71536 - LOC OSTEOARTH NOS-L/LEG	881	6.79%
8. 41071 - SUBENDO INFARCT, INITIAL	852	6.57%
9. 5849 - ACUTE KIDNEY FAILURE NOS	805	6.20%
10. 42731 - ATRIAL FIBRILLATION	784	6.04%
TOTAL NUMBER OF BENEFICIARIES	**12,976**	

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	17	30.91%
Urban	38	69.09%
Unknown	0	0.00%
TOTAL NUMBER OF PROVIDERS	**55**	**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	18	32.73%
1 - Distinct Psychiatric Facility	1	1.82%
2 - Distinct Rehabilitation Facility	4	7.27%
3 - Distinct Skilled Nursing Facility	21	38.18%
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	4	7.27%
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	1	1.82%
R - Hospice	6	10.91%
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	**55**	**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	14	3	21.43%
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	4	0	0.00%
C05 - Apparently did not appropriately assess and/or act on changes in clinical/other status results	8	3	37.50%
C06 - Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	2	0	0.00%
C07- Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	0	0	0.00%
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	3	0	0.00%
C10 - Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	2	1	50.00%
C11 - Apparently did not demonstrate that the patient was ready for discharge	6	4	66.67%
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	0	0	0.00%
C15 - Apparently did not effectively coordinate across disciplines	1	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)	5	4	80.00%
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	0	0	0.00%
C40 -	0	0	0.00%
C99 - Other quality concern not elsewhere classified	34	4	11.76%
TOTAL NUMBER OF CONCERNS	**95**	**19**	**20%**

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 (%)
9	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	3	30%
2 - Perform intensified review	1	10%
3 - Require continuing education	0	0%
4 - Request/review policy/procedure	0	0%
5 - Request development of QIP	5	50%
6 - Accept provider-initiated QIP	1	10%
7 - Conduct informal meeting or teleconference	0	0%
8 - Refer to licensing board	0	0%
9 - Initiate sanction activity	0	0%
10 - Other	0	0%
TOTAL	**10**	**100%**

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 – 1/31/2014.*

Discharge Status	Number of Beneficiaries	Percent of Beneficiaries
01 - Discharged to home or self care (routine discharge)	3	23.08%
02 - Discharged/transferred to another short-term general hospital for inpatient care	0	0.00%
03 - Discharged/transferred to skilled nursing facility (SNF)	6	46.15%
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	2	15.38%
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)	0	0.00%
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	7.69%
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	1	7.69%

(continued from page 8) Discharge Status	Number of Beneficiaries	Percent of Beneficiaries
63 - Discharged/transferred to a long term care hospital	0	0.00%
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	**13**	**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	167	53.35%
Male	146	46.65%
Unknown	0	0.00%
TOTAL	**313**	**100.00%**
Race		
Asian	0	0.00%
Black	9	2.88%
Hispanic	37	11.82%
North American Native	8	2.56%
Other	5	1.60%
Unknown	2	0.64%
White	252	80.51%
TOTAL	**313**	**100.00%**

F. Quality of Care Reviews and Concerns by Intervention Type

Quality of Care Concern	Provider Quality Improvement Activities
Patient rights: Incomplete process in notifying patient of transfer to another facility	1. Conducted a root cause analysis to understand and identify the system failures which contributed to the quality of care concern. 2. Performed a random sample of medical record review to obtain their baseline error rate. 3. In-service training for all level Emergency department personnel and ancillary staff regarding quality of care topic and EMTALA violations. 4. Implemented a new electronic medical record (EMR) system and programmed to produce patient transfer reports. 5. Routine compliance monitoring by nursing staff and the department Medical Director.
Readmission: Incomplete assessment and failure to communicate abnormal results	1. The provider conducted a root cause analysis to understand and identify the system failures which contributed to the quality of care concern. 2. The same sepsis screen and vitals assessment that is currently performed at admission will be repeated prior to the patient's discharge. 3. Monitor QIA plan and audit the communication process of abnormal results to physician. 4. Reports are being developed to reflect discharge assessment information for each patient with SIRS/Sepsis diagnosis. These reports are to be reviewed routinely by the Quality Data Manager and Medical Director. 5. Results are forwarded to the Data Trends Subcommittee of the Medical Staff Practice Committee for further recommendation and action.
Medication Error: Managing as needed pain medication inappropriately due to incomplete documentation of pain medication effectiveness	1. Conducted staff education. 2. Reviewed and updated policy and procedures. 3. Implemented a new electronic medication administration record system that allows for improved documentation of medication administration, effectiveness and monitoring. 4. Conduct routine monitoring for compliance of the new system and new processes.

How Interventions Determined/Best Practices

Medication Error: Proper documentation of effectiveness for as needed pain medication	The facility conducted a root cause analysis to determine the reasons that contributed to the quality of care concerns identified and collaborated across internal systems to implement best practices.

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

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.

Integrating Care for Populations and Communities: Reducing Avoidable Hospital Readmission

The Medicare beneficiary was admitted for cholecystitis and underwent a laparoscopic cholecystectomy. He was discharged to go home despite having black stools. Six days after discharge the beneficiary was transported back to the hospital and needed a blood transfusion and esophagogastroduonenoscopy procedure.

The evidence-based criteria found in the U.S. Department of Health and Human Services, Agency for Health Care Research & Quality indicated that the patient should have had stable vital signs, a stable hematocrit level, and the melena should have been investigated to assure that the patient was clinically stable and safe for discharge. The standards of care were not met and the provider was instructed to perform quality improvement activities to address the identified quality-of-care issue**.**

Integrating Care for Populations and Communities: Reducing Avoidable Hospital Readmission

The beneficiary was transferred to a rehabilitation/skilled nursing facility where she suffered another stroke the day after admission. The medical record review showed the beneficiary, who was taken off Coumadin prior to her initial cerebrovascular accident, was restarted on Coumadin afterward and discharged with an INR of 1.06. At the time of the second stroke, the beneficiary's INR was 1.56. Under these circumstances, the beneficiary should have been kept in an acute hospital setting until her INR was closer to the goal. The standard of care was not met.

The QIO referenced the standards of care for appropriateness for discharge from UpToDate®, an evidence-based, physician-authored clinical decision support resource to determine whether the care the beneficiary received met standards of care.

Improving Individual Patient Care: Reducing Pressure Ulcers

The beneficiary's representative reported that the staff did not remove beneficiary's compression stockings and check his skin condition often enough. The beneficiary developed pressure ulcers on his lower extremities and consideration should have been given to discontinuing the compression hose at

that time. Additionally, an alternative therapy should have been considered. The standard of care was not met.

The QIO provided the evidence-based criteria from the U.S. Department of Health and Human Services, Agency for Health Care Research & Quality for pressure ulcers to the facility. Upon completion of the review findings, the provider was instructed to develop quality improvement actions using these standards of care to address the identified quality-of-care concerns.

H. Effectiveness of QIAs

Quality Improvement Activity (QIA) is meant to enhance the safety, efficiency and effectiveness of health care services provided to patients. The intent of the QIA is to establish collaborative work efforts between *HealthInsight* and the provider or practitioner to ensure that identified system failures are corrected to avoid risk to future patients.

HealthInsight assists providers with the development and implementation of corrective actions to enhance the providers' or practitioners' internal operations, standards of care practices and clinical decision-making processes. In all of the scenarios described above in this report, there are enormous opportunities for lessons learned and to promote safety and Beneficiary and Family Centered Care.

In all QIAs, the provider first completes a root cause analysis of the situation to understand the confirmed quality of care issue. This gives the provider the ability to review current practices and policies and procedures against the recognized standards of care. A cross-reference of all information typically reveals the gaps of service and an understanding of the underlying cause(s) that prompted or contributed to the adverse outcome. Secondly, the provider has the opportunity to review and understand a patient's perspective of the care they are receiving. In addition, the provider develops a detailed plan reflecting their corrective actions with the specific timelines in which this action will occur. Finally, the provider is required to monitor their plan, outcomes and adjustments made to their plan to ensure that all corrective actions are completed and successes are sustained. Throughout the entire QIA process, *HealthInsight* continues to extend its support and monitor the provider's progress.

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