Annual Report of Medicare Case Reviews for Utah

August 1, 2013 – April 30, 2014

SUBMITTED

6/30/2014

HealthInsight Utah
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* UT from August 1, 2013 to April 30, 2014.

REVIEW TYPE	Number of Reviews	Percent of Reviews
Coding Validation (120 - HWDRG)	206	27.88%
Coding Validation (All Other Selection Reasons)	0	0.00%
Quality of Care Review (101 through 104 -Beneficiary Complaint)	21	2.84%
Quality of Care Review (All Other Selection Reasons)	1	0.14%
Immediate Advocacy	3	0.41%
Utilization (158 - FI/MAC Referral for Readmission Review)	0	0.00%
Utilization (All Other Selection Reasons)	255	34.51%
Notice of Non-coverage (105 through 108 - Admission and Preadmission)	3	0.41%
Notice of Non-coverage (118 - BIPA)	120	16.24%
Notice of Non-coverage (117 - Grijalva)	74	10.01%
Notice of Non-coverage (121 through 124 -Weichardt)	49	6.63%
Notice of Non-coverage (111-Request for QIO Concurrence)	7	0.95%
EMTALA 5 Day	0	0.00%
EMTALA 60 Day	0	0.00%
TOTAL NUMBER OF REVIEWS COMPLETED	**739**	

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. 0389 - SEPTICEMIA NOS	2163	16.17%
2. 71536 - LOC OSTEOARTH NOS-L/LEG	2132	15.94%
3. 486 - PNEUMONIA, ORGANISM NOS	1979	14.80%
4. V5789 - REHABILITATION PROC NEC	1494	11.17%
5. 42731 - ATRIAL FIBRILLATION	1067	7.98%
6. 5849 - ACUTE KIDNEY FAILURE NOS	1053	7.87%
7. 41401 - CRNRY ATHRSCL NATVE VSSL	1018	7.61%
8. 71535 - LOC OSTEOARTH NOS-PELVIS	830	6.21%
9. 43491 - CRBL ART OCL NOS W INFRC	823	6.15%
10. 5990 - URIN TRACT INFECTION NOS	816	6.10%
TOTAL NUMBER OF BENEFICIARIES	**13,375**	

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	21	21.00%
Urban	79	79.00%
Unknown	0	0.00%
TOTAL NUMBER OF PROVIDERS	**100**	**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	23	23.00%
1 - Distinct Psychiatric Facility	2	2.00%
2 - Distinct Rehabilitation Facility	1	1.00%
3 - Distinct Skilled Nursing Facility	46	46.00%
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	7	7.00%
N - Critical Access Hospital	1	1.00%
O - Setting does not fit into any other existing setting code	0	0.00%
Q - Long Term Care Facility	2	2.00%
R - Hospice	18	18.00%
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	**100**	**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	0	0	0.00%
C02 - Apparently did not make appropriate diagnoses and/or assessments	4	0	0.00%
C03 - Apparently did not establish and/or develop an appropriate treatment plan for a defined problem or diagnosis which prompted this episode of care	4	1	25.00%
C04 - Apparently did not carry out an established plan in a competent and/or timely fashion	3	0	0.00%
C05 - Apparently did not appropriately assess and/or act on changes in clinical/other status results	7	2	28.57%
C06 - Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	0	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	0	0	0.00%
C09 - Apparently did not obtain appropriate laboratory tests and/or imaging studies	2	1	50.00%
C10 - Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	4	1	25.00%
C11 - Apparently did not demonstrate that the patient was ready for discharge	3	0	0.00%
C12 - Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13 - Apparently did not order appropriate specialty consultation	1	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)	6	0	0.00%
C17 - Apparently did not order/follow evidence-based practices	0	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	28	2	7.14%
TOTAL NUMBER OF CONCERNS	**63**	**7**	**11.11%**

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 (%)
2	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	1	50.00%
2 - Perform intensified review	0	0.00%
3 - Require continuing education	0	0.00%
4 - Request/review policy/procedure	0	0.00%
5 - Request development of QIP	1	50.00%
6 - Accept provider-initiated QIP	0	0.00%
7 - Conduct informal meeting or teleconference	0	0.00%
8 - Refer to licensing board	0	0.00%
9 - Initiate sanction activity	0	0.00%
10 - Other	0	0.00%
TOTAL	**2**	**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)	2	15.38%
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	0	0.00%
51 - Hospice - medical facility	1	7.69%
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	15.38%

(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	260	57.40%
Male	192	42.38%
Unknown	1	0.22%
TOTAL	**453**	**100.00%**
Race		
Asian	5	1.10%
Black	3	0.66%
Hispanic	12	2.65%
North American Native	1	0.22%
Other	6	1.32%
Unknown	3	0.66%
White	423	93.38%
TOTAL	**453**	**100.00%**

F. Quality of Care Reviews and Concerns by Intervention Type

Quality of Care Concern	Provider Quality Improvement Activities
Pain Management: Patient preference due to sensitivity to particular medication.	The provider worked with their medical leadership across all practicing specialties and collaborated to establish a process to ensure a final or so called, 'loop closure' of communication between the Emergency department physician and the admitting physician or specialty service. This communication will include patient/family concerns such as sensitivities to medication. The QIA plan not only established a formal communication process with all medical staff but provides future education opportunities when deemed necessary by medical specialty leadership..
Communication: Family did not have the opportunity to meet with and discuss the patient's condition.	The medical director for trauma service conducted a formal education session with all staff about the importance of listening to family members and forwarding any concerns or wishes by the family. Processes were developed to require the nursing staff to contact the practitioner and facilitate direct communication between family and physician. The process includes a follow up action to confirm that all communication efforts are completed to patient satisfaction.
Delay in treatment: Patient's treatment for a urinary tract infection.	To address the identified communication and process gaps that occurred, the provider expanded topic coverage during their new hire orientation and implemented a competency assessment skill test that also addresses reporting of critical test results. Additionally, the communication formats for daily case conference were changed. To ensure continuity of the plan and compliance, the provider implemented chart audits by creating a new clinical auditor position.
How Interventions Determined/Best Practices	
Pain Management: Patient preference due to sensitivity to particular medication.	The facility conducted a root cause analysis (RCA) to determine the reasons that contributed to the quality of care concerns identified. Based on this information, collective and system-wide quality improvement efforts were conducted.

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.

Improving Individual Patient Care: Reducing Healthcare-Associated Infections

The Medicare Beneficiary displayed signs and symptoms of a urinary tract infection. The preliminary urinalysis lab results were abnormal and a culture and sensitivity was required. In reference to the evidence-based criteria found in the U.S. Department of Health and Human Services, Agency for Health Care Research & Quality, there was an extreme delay on the part of the provider to order the additional laboratory culture. Furthermore, once this physician order was obtained, there was another delay in forwarding the results to the ordering physician for antibiotic treatment orders.

The provider was made aware of these standards of care and applied appropriate quality improvement activities to address the identified quality-of-care concerns.

Improving Individual Patient Care: Adverse Drug Events

The Medicare beneficiary reported that despite providing information about adverse reactions to a specific medication, the practitioner ordered the medication and nursing staff administered it. This action caused the beneficiary to have a change in mental status and self-harm behavior.

The QIO utilized two sets of evidence based references; one that addressed pain management in the elderly population and the other referencing doctor-patient communication. Both criteria were found in the US National Library of Medicine, National Institutes of Health.

Upon conclusion that the standards of care were not met, the QIO shared this evidence-based information with the provider and instructed them to conduct quality improvement activities to address the identified quality-of-care concerns.

Integrating Care for Populations and Communities: Reduce Avoidable Hospital Readmission

The beneficiary reported that she was not given all her prescriptions for the medications she was supposed to be taking when she was discharged from the hospital. She was missing prescriptions for antibiotics to treat her incision infection and her bladder infection.

The QIO referenced the standards of care for hospital discharge, medication reconciliation from UpToDate®, an evidence-based, physician-authored clinical decision support resource to determine whether the care the beneficiary received met standards of care. Upon determination that the standards of care were not met, this information was shared with the provider to consider during their development of quality improvement activities.

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 process. 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 their support and monitor the provider's progress.

This material was prepared by HealthInsight Utah, the Medicare Quality Improvement Organization for the state, under contract with the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. UT-2014-CORP-07