Annual Report of QIO Case Review Information

IPRO, the QIO for New York

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

IPRO

This material was prepared by IPRO, the Medicare Quality Improvement Organization for New York State, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents do not necessarily reflect CMS policy. 10SOW-NY-AIM6-12-27

Table of Contents

Introduction 3

Findings 4

I. Total Number of Reviews 4

II Top Ten Principal Medical Diagnoses 5

III. Provider Reviews by Geographical Information 5

IV. Provider Reviews by Settings 6

A. Quality of Care Concerns Confirmed 7

B. Serious Reportable Events on Quality of Care Reviews 8

C. Confirmed Quality of Care Concerns with Associated Interventions 9

D. Discharge/Service Termination 10

E. Beneficiary Demographics 11

F. Quality of Care Reviews and Concerns by Intervention Type 12

G. Evidence Used in Decision-Making 15

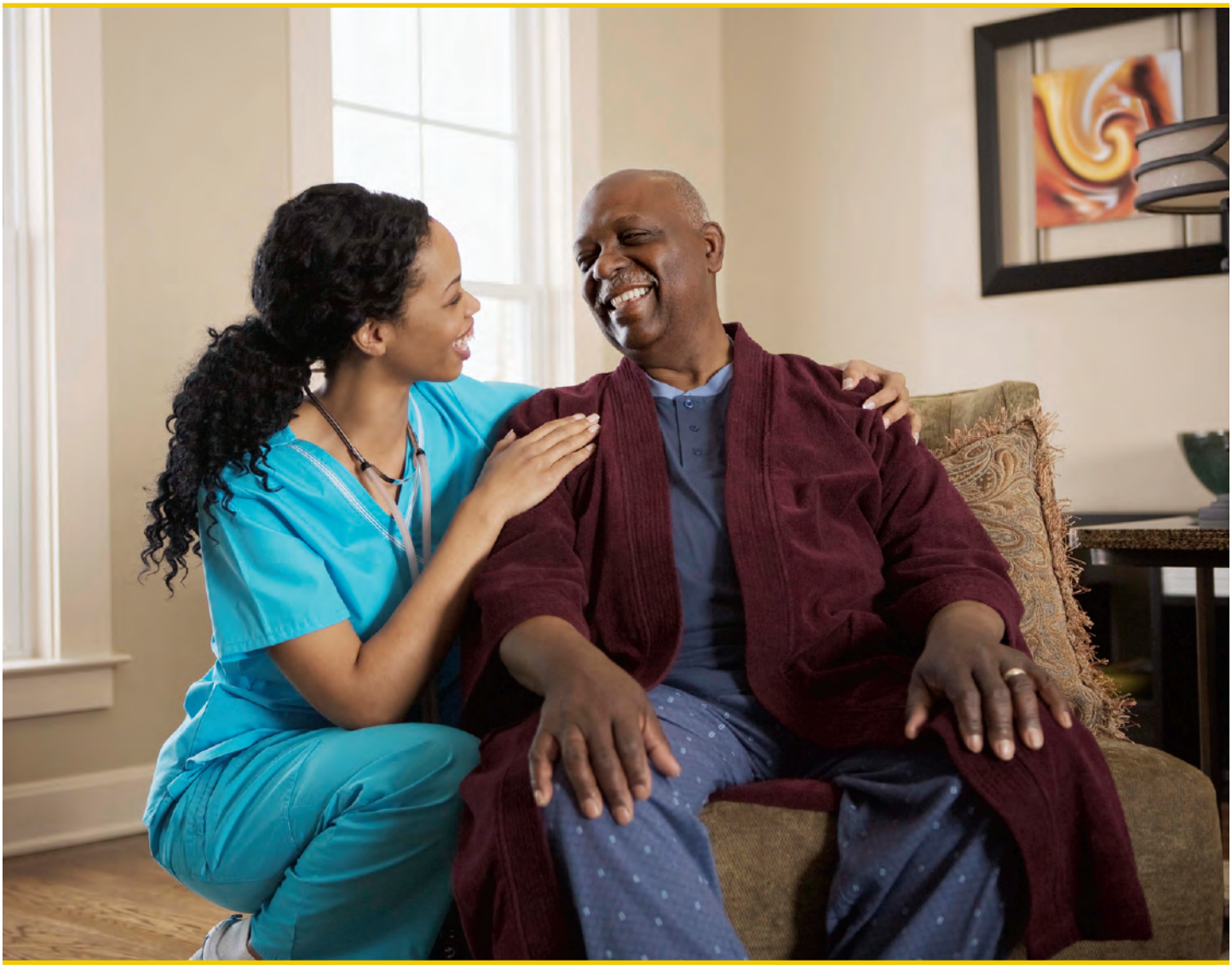
H. Narrarive Analysis as to the Effectiveness of QIAs and Recommendations for how the Information may be used to make a Positive Impact on the Work done in other 10SOW Aims 18

Introduction

As a critical element of the Centers for Medicare & Medicaid Services' (CMS') commitment to improving healthcare quality for all Americans, the QIO program focuses on enhancing the services that Medicare beneficiaries receive while protecting the Medicare Trust Fund through promotion of an effective and efficient delivery system. The work that QIOs perform spans every setting in which healthcare is delivered—even the critical transitions between those settings.

As the Quality Improvement Organization (QIO) for New York State, IPRO uses our case review findings and data to identify opportunities for improvement across provider settings and to promote evidence-based medical practice and patient-centered care principles for all Medicare beneficiaries across New York.

The information that follows in our Annual Report provides data for the date range August 1, 2011 through July 31, 2012 unless noted otherwise. This report demonstrates our commitment to transparency while underscoring our role in working with providers to bring tangible improvements in quality-of-care. We do this by using evidence-based guidelines to conduct independent, clinical reviews of Medicare cases in a way that promotes patient-centered care.



Findings

I. Total Number of Reviews

This table provides information regarding the total number of reviews IPRO performed in the Case Review Information System (CRIS) by the associated review type. (It should be noted that for the asterisked Review Types, additional cases were reviewed and entered in an alternative data system at the beginning of the 10th Statement of Work but not included in these results.)

Review Type	Number of Reviews	Percent of Reviews
Coding Validation (120 - HWDRG)*	2,916	20.05%
Coding Validation (All Other Selection Reasons)	0	0.00%
Quality of Care Review (101 through 104 -Beneficiary Complaint)*	380	2.61%
Quality of Care Review (All Other Selection Reasons)	24	0.16%
Utilization (158 - FI/MAC Referral for Readmission Review)	0	0.00%
Utilization (All Other Selection Reasons)	4,730	32.51%
Notice of Non-coverage (105 through 108 - Admission and Preadmission)	561	3.86%
Notice of Non-coverage (118 - BIPA)	2,221	15.27%
Notice of Non-coverage (117 - Grijalva)	1,946	13.38%
Notice of Non-coverage (121 through 124 -Weichardt)	1,630	11.20%
Notice of Non-coverage (111-Request for QIO Concurrence)	5	0.03%
EMTALA 5 Day	111	0.76%
EMTALA 60 Day	24	0.16%
Total	**14,548**	

II. Top Ten Principal Medical Diagnoses

This table provides information regarding the top 10 principal medical diagnoses for inpatient claims billed for Medicare beneficiaries during this annual reporting period. It does not reflect review information.

Top 10 Medical Diagnoses		Percent of Beneficiaries	Percent of Beneficiaries
1.	0389 - SEPTICEMIA NOT OTHERWISE SPECIFIED	25,019	16.27%
2.	486 - PNEUMONIA, ORGANISM NOT OTHERWISE SPECIFIED	21,479	13.96%
3.	V5789 - REHABILITATION PROCEDURE NOT ELSEWHERE CLASSIFIABLE	18,617	12.1%
4.	41401 - CORONARY ARTEREOSCLEROSIS OF NATIVE CORONARY ARTERY	15,070	9.8%
5.	5990 - URINARY TRACT INFECTION NOT OTHERWISE SPECIFIED	14,628	9.51%
6.	49121 - OBSTRUCTIVE CHRONIC BRONCHITIS WITH ACUTE EXACERBATION	12,431	8.08%
7.	5849 - ACUTE KIDNEY FAILURE NOT OTHERWISE SPECIFIED	12,387	8.05%
8.	7802 - SYNCOPE AND COLLAPSE	12,247	7.96%
9.	42731 - ATRIAL FIBRILLATION	11,107	7.22%
10.	41071 - SUBENDOCARDIAL INFARCTION, INITIAL	10,823	7.04%
	Total	**153,808**	**100.00%**

III. Provider Reviews by Geographical Information

This table provides information on the count and percent by Rural vs. Urban geographical locations for Health Service Providers (HSPs) associated with a completed IPRO review.

Geographical Area	Number of Providers	Percent of Providers
Rural	88	12.29%
Urban	624	87.15%
Unknown	4	0.56%
Total	**716**	**100.00%**

IV. Provider Reviews by Settings

This table provides information on 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	161	22.49%
1	Distinct Psychiatric Facility	2	0.28%
2	Distinct Rehabilitation Facility	1	0.14%
3	Distinct Skilled Nursing Facility	440	61.45%
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	74	10.34%
N	Critical Access Hospital	2	0.28%
O	Setting does not fit into any other existing setting code	0	0.00%
Q	Long-Term Care Facility	1	0.14%
R	Hospice	24	3.35%
S	Psychiatric Unit of an Inpatient Facility	3	0.42%
T	Rehabilitation Unit of an Inpatient Facility	0	0.00%
U	Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	6	0.84%
Y	Federally Qualified Health Centers	0	0.00%
Z	Swing Bed Designation for Critical Access Hospitals	2	0.28%
	Other	0	0.00%
		Total 716	**100.00%**

IV A. Quality of Care Concerns Confirmed

This table provides information regarding the number of concerns by Quality of Care "PRAF" Category Code, a standardized methodology used by all QIOs in the review process. The table also provides information in regard to the number of quality concerns that were confirmed by our independent peer reviewers at the highest level of review, for completed quality of care reviews.

Quality of Care ("C" Category) PRAF Category Codes		No. of Concerns	No. of Concerns Confirmed	Percent Confirmed Concerns
C01	Apparently did not obtain pertinent history and/or findings from examination	11	4	36.36%
C02	Apparently did not make appropriate diagnoses and/or assessments	69	19	27.54%
C03	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 (see C06 or C09) and procedures (see C07 or C08) and consultations (see C13 and C14]	219	52	23.74%
C04	Apparently did not carry out an established plan in a competent and/or timely fashion	52	15	28.85%
C05	Apparently did not appropriately assess and/or act on changes in clinical/other status results	30	16	53.33%
C06	Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	10	5	50%
C07	Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	14	4	28.57%
C08	Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	4	0	0.00%
C09	Apparently did not obtain appropriate laboratory tests and/or imaging studies	6	0	0.00%
C10	Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	31	8	25.81%
C11	Apparently did not demonstrate that the patient was ready for discharge	41	16	39.02%
C12	Apparently did not provide appropriate personnel and/or resources	8	1	12.5%
C13	Apparently did not order appropriate specialty consultation	8	1	12.5%
C14	Apparently specialty consultation process was not completed in a timely manner	6	2	33.33%
C15	Apparently did not effectively coordinate across disciplines	7	4	57.14%

continued on next page

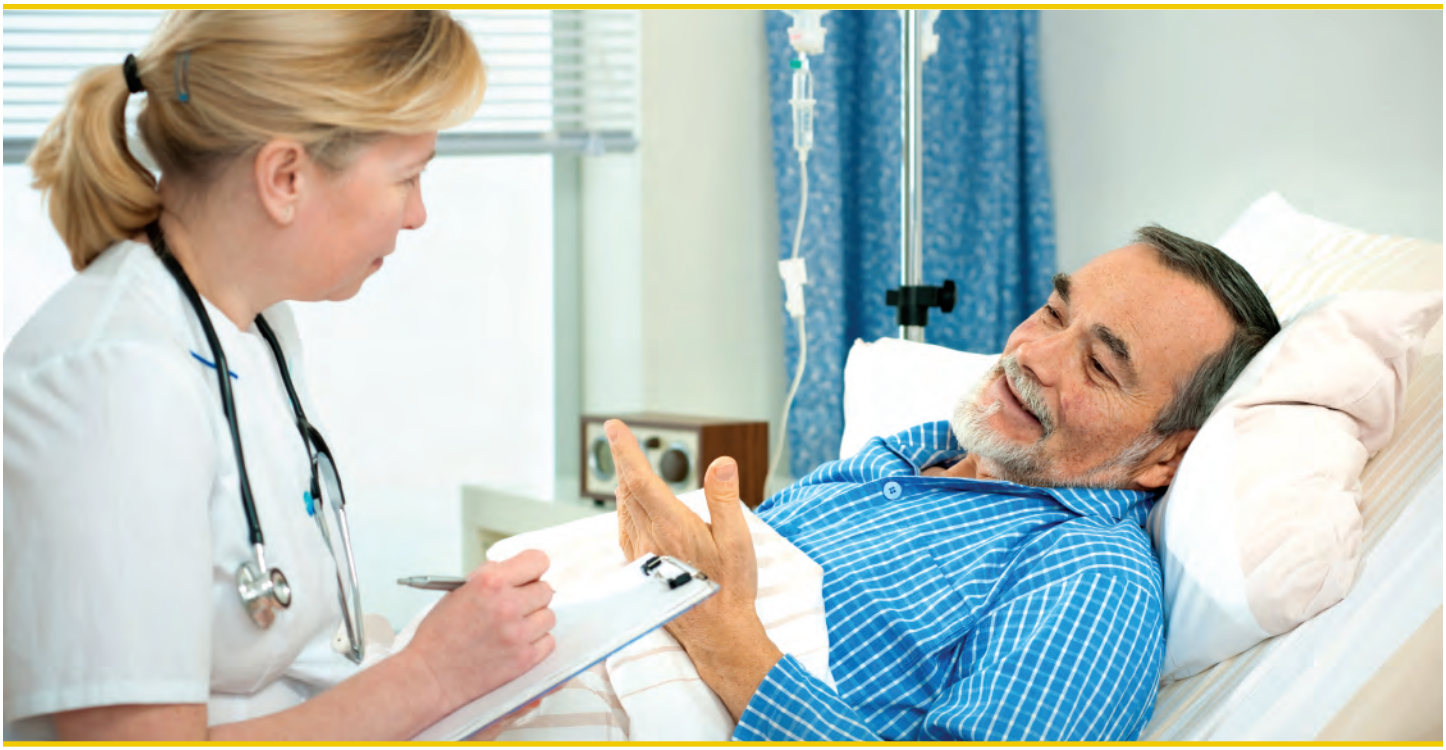
continued from previous page

Quality of Care ("C" Category) PRAF Category Codes		No. of Concerns	No. of Concerns Confirmed	Percent Confirmed Concerns
C16	Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	58	25	43.1%
C17	Apparently did not order/follow evidence-based practices	14	6	42.86%
C18	Apparently did not provide medical record documentation that impacts patient care	24	19	79.17%
C99	Other quality concern not elsewhere classified	283	82	28.98%
		Total 895	**279**	**31.17%**

IV B. Serious Reportable Events on Quality of Care Reviews

This table provides information regarding the number of Quality Improvement Activities (QIAs) initiated (initial activity date within the reporting period) for all quality of care reviews with confirmed concerns. During this time period there were no concerns upheld during the peer review process that were deemed to fall into the category of "Serious Reportable Events". However, as will be noted in Table C, below, IPRO is vigilant in requiring an appropriate quality improvement activity for all confirmed concerns throughout New York State.

Number of QIAs Initiated	Number of QIAs Initiated for Serious Reportable Events	Percent of QIAs Initiated for Serious Reportable Events
280	0	0.00%



IV C. Confirmed Quality of Care Concerns with Associated Interventions

This table provides information on the number of Initial Quality Improvement Activities initiated, by Activity Type, for reviews with one or more confirmed Quality of Care concerns. It also provides the percent of total activities that each represents. The discrepancy between the total number of QIAs referenced in this table as compared to Table B is attributed to timing differences in the data retrieval process. Narrative examples of IPRO-initiated QIAs may be found in Section F of this report.

Initial Quality Improvement Activity	Number of Interventions (QIAs) with this Initial QIA	Percent of Interventions (QIAs) with this Initial QIA
1 Send educational/alternative approach letter		
2 Perform intensified review		
3 Require continuing education		
4 Request review policy/procedure	7	2.24%
5 Request development of QIP	306	97.76%
6 Accept provider-initiated QIP		
7 Conduct informal meeting or teleconference		
8 Refer to licensing board		
9 Initiate sanction activity		
10 Other		
	Total 313	**100.00%**

Note: This table provides data on only two intervention categories. Other remedial activities undertaken at IPRO's request are not included in this illustration.

IV D. Discharge/Service Termination

This table provides information regarding the discharge location of beneficiaries linked to appeals conducted by IPRO of provider issued notices of Medicare non-coverage. Note: Data in this table represent discharge/service termination reviews from 8/1/2011–4/30/2012. A shortened data timeframe is necessary to allow for maturity of claims data, which is the source of "Discharge Status" for these cases.

Discharge Status		Number of Beneficiaries	Percent of Beneficiaries
01	Discharged to home or self care (routine discharge)	184	24.37%
02	Discharged/transferred to another short-term general hospital for inpatient care	6	0.79%
03	Discharged/transferred to skilled nursing facility (SNF)	345	45.70%
04	Discharged/transferred to intermediate care facility (ICF)	4	0.53%
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	139	18.41%
07	Left against medical advice or discontinued care	3	0.40%
09	Admitted as an inpatient to this hospital	0	0.00%
20	Expired (or did not recover - Christian Science patient)	23	3.05%
21	Discharged/transferred to court/law enforcement	0	0.00%
30	Still a patient	7	0.93%
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	5	0.66%
51	Hospice - medical facility	4	0.53%
61	Discharged/transferred within this institution to a hospital-based Medicare approved swing bed	3	0.40%
62	Discharged/transferred to an inpatient rehabilitation facility including distinct part units of a hospital	14	1.85%
63	Discharged/transferred to a long term care hospital	13	1.72%
64	Discharged/transferred to a nursing facility certified under Medicaid but not under Medicare	1	0.13%
65	Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital	2	0.26%

continued on next page

continued from previous page

Discharge Status		Number of Beneficiaries	Percent of Beneficiaries
66	Discharged/transferred to a Critical Access Hospital	0	0.00%
70	Discharged/transferred to another type of healthcare institution not defined elsewhere in code list	2	0.26%
	Other	0	0.00%
		Total 755	**100.00%**

IV E. Beneficiary Demographics

This table provides information regarding the number of beneficiaries for whom a case review activity was started by demographic category, and the percent of beneficiaries in each category.

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	5,476	62.07%
Male	3,347	37.93%
Unknown	0	0.00%
	Total 8,823	**100.00%**
Race		
Asian	100	1.13%
Black	1,226	13.90%
Hispanic	281	3.18%
North American Native	5	0.06%
Other	133	1.51%
Unknown	35	0.40%
White	7,043	79.83%
	Total 8,823	**100.00%**

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

The narratives that follow illustrate the types of interventions that have been deployed to address quality of care concerns identified by IPRO within this annual reporting period for three different quality categories (C1-99).

Example 1 - Type of Intervention for Quality Category C-10 (Apparently did not develop and initiate appropriate discharge, follow-up and/or rehabilitation plans)

IPRO requested a formal quality improvement plan to address the following issue:

This elderly patient remained in the hospital because of safety concerns focused on her inability to swallow, her mental status, as well as concerns about who could safely take care of her at home once she was discharged. Although this patient was eventually transferred to a skilled nursing facility, there was no follow-up of the following concern identified by our review during this episode of care: documentation in the medical record suggests that a discharge home may have not been safe for reasons different than just routine care and/or nutrition. Once the concern was raised of the possibility that the etiology of the fractures was identified as (even remotely) suspicious, any possible effort to establish the cause of these fractures should have been pursued before discharging the patient to the SNF, and the results and conclusions of these efforts should have been included in the PRI and/or in the transfer note, so that the receiving facility could act in the most appropriate fashion.

As a result of IPRO's findings, the hospital formulated the following improvement plan:

- The Director of Social Work will hold mandatory, annual education sessions focused on enhancing physician recognition, understanding and appropriate follow-up for suspected cases of elder abuse and neglect for all hospitalists. Additionally, new physician orientation will include an educational packet on early recognition and response to elder abuse and neglect.
- The following standardized action plan will be required of the hospitalists if elder abuse or neglect is suspected:
  - ✔ They will contact social work immediately to schedule an interdisciplinary family meeting with the attending physician, social worker, and appropriate family members to fully discuss the concern.
  - ✔ Following the meeting there will be a debriefing between the social worker and the attending to discuss outcome, collaborate on a care plan and delineate a clear and concise follow-up action plan.
  - ✔ The physician will document a brief synopsis in his/her progress notes and clearly document in subsequent notes the progress of their investigation.
  - ✔ Social work will document the plan and subsequent findings clearly in the medical record.
  - ✔ The case will immediately be referred to Adult Protective Services (APS) for follow-up upon discharge, if discharge is deemed safe.
  - ✔ If the patient is being discharged to a facility, prior to time of discharge, the facility will receive a social worker to social worker sign-out with full disclosure of the concern about the potential elder abuse and recommendation to consider APS referral upon discharge home from the facility. Additionally, the receiving facility will receive a detailed discharge note outlining the concern and investigation into elder abuse. An attachment to this note will include copies of all relevant progress notes that delineate the evaluation of the concern and a summary of all family meetings.
  - ✔ All concerns of elder abuse will be documented clearly in the discharge form.
  - ✔ Physicians will be trained thoroughly on best practices for clear and concise documentation in the medical record regarding a concern for elder abuse. This will include a daily entry in their assessment and plan that references the

important points of their investigation, as well as the results and conclusions of their efforts.

- ✔ Physicians will be trained to add, "suspected elder abuse" or "confirmed elder abuse" to their active problem and discharge diagnosis list in the electronic patient record. This will enable clear communication of the issue to treating physicians on subsequent hospitalizations, and will be integral to the discharge problem list received by facilities.

Example 2 - Type of Intervention for Quality Category C-15 (apparently did not effectively coordinate across disciplines

IPRO requested a quality improvement plan to address the following hospital issue:

This beneficiary had decreased oral intake, and it was not apparent from review of the medical record how or if nursing communicated this information to the medical staff. Based on the medical record documentation it appeared that there was a significant decrease in fluid intake after IV fluids were stopped and the beneficiary was receiving oral fluids only. Documentation indicates that nursing was monitoring the patient, however it was not clear how the medical staff was informed of the patient's poor intake.

In this case IPRO's findings were discussed with the nursing department. It was acknowledged that the nursing practice at the time, to verbally notify the medical staff of a patient's poor nutritional status, was not in keeping with current nursing standards of practice and represented an opportunity for improvement. The nursing department worked with its education department and conducted a gap analysis to identify ways to improve nutritional assessment, communication and care by nurses.

As a result of our review findings, a performance improvement program was developed to address the overall assessment, care, documentation and reporting of patients' nutritional status by the nursing department. An Intake and Output Primer was developed as an educational tool. The focus and purpose of this tool is to ensure that direct caregivers (nurses and assistants) understand the significance of accurate intake and output assessment to prevent dehydration and prevent fluid overload. In-service education was provided to all direct caregiver staff to introduce use of the Intake and Output Primer. The efficacy of the education primer is being tested on one unit, and the hospital is also monitoring patient records to ensure deployment of the intervention and measure change.

Example 3 - Type of Intervention for Quality Category C-99 (Other quality concern not elsewhere classified)

This case involved a Medicare beneficiary admitted through the emergency room for a urinary tract infection. IV antibiotics were given in the emergency department, then discontinued and not given again until re-ordered by an infectious disease consultant, four days later. Our review found that there was no documentation in the medical record as to why the IV antibiotic was discontinued and why the omission in treatment was not identified for four days. Also as a result of this error it became necessary for the beneficiary to undergo an invasive procedure (insertion of a PICC line) that would allow for administration of continuous IV antibiotic treatment at home.

IPRO requested a Quality Improvement Plan to address:

- How/why an inappropriate order to discontinue antibiotics was placed;
- Lack of documentation as to why the antibiotic was discontinued;
- Lack of documentation of an error that affected the patient's care; and
- Family notification/discussion in regard to the error.

Root cause analysis conducted by this facility revealed that despite having appropriate and redundant safety systems in place within the electronic medical record process, a human error could still occur. In this case, the provider identified that the physician caring for the beneficiary inadvertently placed an order to discontinue the IV antibiotic. However, it was also acknowledged that when errors do occur, they should be recognized quickly. In this situation, the error was not rapidly recognized because the involved physician

had also not carried out daily review of the beneficiary's active medications, as required by the provider. As a result, the interventions designed in this quality improvement plan were both practitioner-specific and system-wide as further discussed below.

Example 3: How Interventions Determined/ Best Practices

IPRO has developed and includes a one page "Quality Improvement Activity (QIA) Reference Guide" along with our final notification letter when a quality of care concern is upheld. This helps establish what is expected from the involved provider/practitioner in regard to submission of their QIA and the QIA process.

As noted previously in Example 3, the interventions designed in this quality improvement plan were both practitioner-specific and system-wide throughout the provider organization and represent the adoption of best practices.

- The provider believed that the existing system, designed to prevent inadvertent discontinuation of medications, was thorough and resilient. It included practitioner completion of an electronic medical record educational curriculum and demonstration of competence on a post educational examination. In addition, it included redundancies within the system itself. Specifically, to discontinue a medication, a physician needed to choose the medication, confirm that the order was correct by selecting "ok" and enter a "signature" to confirm. Physicians were also expected to review all active medications daily and document justification for any changes made. In this case, the process breakdown occurred because the physician failed to review the beneficiary's active medications on a daily basis. Therefore, while the physician was counseled and received remedial education and monitoring, the provider also presented this case example to its Medication Safety Committee to see if the electronic medical record and medication reconciliation system could be improved to prevent similar errors. (To embrace an error such as this as a means to promote system-wide improvement is a best practice).
- To address the concerns surrounding documentation and communication, the provider developed an educational intervention that reviews the principles of a "Just Culture" as well as the requirement to fully document patient occurrences. A tool will also be developed to help guide both appropriate documentation and disclosure of adverse events. (This provider's system-wide improvement effort incorporating the principles of "Just Culture" represents deployment of another best practice).

IV G. Evidence Used in Decision-Making

The following table describes one or two of the most common types of evidence/standards-of-care criteria used by IPRO to support our Review Analysts' assessments and Peer Reviewers' decisions when conducting Quality of Care review. It also includes one or two of the most common types of evidence/standards-of-care criteria used by IPRO to carry out our review of Medical Necessity/Utilization Review and Appeals.

Review Type	Diagnostic Categories	Evidence/Standards of Care Used	Rationale for Evidence/Standardof Care Selected
Quality of Care	Pneumonia	Milliman Care Guidelines	The Milliman Care Guidelines provide a starting point to research current standards for care; Information on current standards of care for treatment of pneumonia is available.
	Heart Failure	Milliman Care Guidelines and American Heart Association (American Heart.org)	Information in Milliman Care Guidelines in regard to Heart Failure is supplemented by clinical information located on the American Heart Association website.
	Acute Myocardial Infarction (MI)	Milliman Care Guidelines and American Heart Association (American Heart.org)	Information in Milliman Care Guidelines in regard to acute MI is supplemented by clinical information located on the American Heart Association website
	Pressure Ulcers	The Agency for Healthcare Research and Quality (AHRQ) website; Wound, Ostomy & Continence Nursing website (WOCN)	AHRQ is an online resource for the identification of quality of care standards of care and practice guidelines. WOCN provides nursing guidelines for staging and care of pressure ulcers.
	Urinary Tract Infection	Centers for Disease Control and Prevention (CDC) website; Milliman Care Guidelines	The CDC provides the ability to search for clinical guidelines related to catheter care and UTIs. This is supplemented by information in Milliman Care Guidelines.
	Sepsis	Millman Care Guidelines	The Milliman Care Guidelines provide a starting point to research current standards for care; Information in regard to current standards for treatment of sepsis is available.
	Adverse Drug Events	Federal Drug Administration website (FDA.gov); Physician Desk Reference website (pdr.net)	The FDA website provides drug specific guidelines as well as patient safety information that is useful to quality review process. The PDR website provides medication monographs including information related to monitoring, dosage, and indications.

Review Type	Diagnostic Categories	Evidence/Standards of Care Used	Rationale for Evidence/Standardof Care Selected
Quality of Care (continued)	Falls	Milliman Care Guidelines	The Milliman Care Guidelines provide a starting point to research current standards for care; Information in regard to current standards for prevention/treatment of falls is available.
	Patient Trauma	Milliman Care Guidelines	The Milliman Care Guidelines provide a starting point to research current standards for care; Information in regard to current standards for treatment of patient trauma is available.
	Surgical Complications	Milliman Care Guidelines	The Milliman Care Guidelines provide a starting point to research current standards for care; Information in regard to current standards for treatment of surgical complications is available.
Medical Necessity/ Utilization Review		Milliman Care Guidelines; Medicare Coverage Guidelines (Medicare Benefits Policy Manual and National Coverage Determinations Manual)	Milliman Care Guidelines are used to evaluate the appropriateness of acute care admission as well as medical necessity. The CMS online Medicare Manuals are also used to make admission, medical necessity and coverage determinations
Appeals		Medicare Coverage Guidelines (Medicare Benefits Policy Manual and National Coverage Determinations Manual)	The CMS online Medicare Manuals provide information necessary to conduct beneficiary appeals of provider-issued Medicare non-coverage determinations.

The following three brief examples/case studies illustrate situations where case review was linked to another focus of the QIO contract, for example, readmissions, pressure ulcers, adverse drug events, etc. The evidence-based criteria used by IPRO to support our review decisions on those cases is identified as well as the rationale as to what influenced the selection of that criteria.

Example/Case Study 1 - Patient Fall

This case concerned a Medicare beneficiary who was noted in the provider medical record to be confused, very weak and with little endurance. He was unable to stand or walk. It was noted that the beneficiary was receiving multiple medications and had a history of metabolic encephalopathy, dementia and possible delirium.

The patient was in a wheel chair, leaned over, fell and struck his head. Documentation in the record indicates that he claimed he fell because he was going to tie his shoelaces; however, it was noted that the patient was wearing slippers. IPRO confirmed a quality of care concern in regard to the apparent lack of a fall assessment having been conducted for this high risk patient. Studies referenced in the Milliman Care Guidelines in regard to patient falls indicate that the use of a fall prevention tool kit in hospital units significantly reduce the rate of falls.

Example/Case Study 2 - Pressure Ulcer

This case concerned a Medicare beneficiary with many co-morbid conditions that predisposed this patient to the development of pressure ulcers. Although there was some documentation by nursing staff in regard to turning and positioning of the patient, there was no evidence in the medical record that the patient was turned every two hours, that a special mattress was used or that preventive care was given to the patient's bony prominences. Standards of care for wound prevention researched on the AHRQ website (including guidelines from the Wound, Ostomy and Continence Nursing website) reference the need for specific actions to be taken by nursing staff for patients assessed to be at high risk for skin breakdown.

Example/Case Study 3 - Patient Safety/Medical Errors

Standards of Care from the Clinical and Laboratory Institute note that when drawing blood, a tourniquet should remain in place for a maximum of one minute. In this case, a confirmed quality of care concern was issued by IPRO in regard to a tourniquet that was left on the arm of a neurologically impaired Medicare beneficiary for more than 12 hours subsequent to routine lab work that had been performed.

IV H. Narrative Analysis as to the Effectiveness of QIAs and Recommendations for how the Information may be used to make a Positive Impact on the Work done in other 10SOW Aims

During this annual reporting period, IPRO conducted 404 Quality of Care (QOC) reviews and confirmed 279 QOC concerns. A quality improvement activity (QIA) was implemented for all confirmed concerns as evidenced by the data in Tables B and C. While no concern during this reporting period was categorized as a serious, reportable event, it should be noted that during the intake portion of the Quality of Care Complaint process, callers to IPRO's helpline are advised that these types of situations can be referred to the New York State Department of Health (NYSDOH) for follow up action. This immediate referral to the NYSDOH for imminent harm situations may account for these results.

IPRO's QIA findings demonstrate a commitment to using reviews of individual cases to bring system-wide improvements in quality-of-care. Moreover, the patterns demonstrated in Table A of this report, Quality of Care Concerns confirmed by "PRAF" category, can be used as a source of information to better target local quality improvement initiatives.

The majority of quality of care review conducted by IPRO begins with a beneficiary's/representative's quality of care complaint. Thus, the quality of care case review process truly represents the voice of the patients and their ability to discern care that does not meet professionally recognized standards. The information concerning confirmed quality of care findings is not anecdotal; it can be used to achieve lasting improvements across an entire institution or delivery system. Case review supports providers and practitioners who may have been the subject of quality of care concerns initially but who have used these problems as opportunities to implement quality improvement initiatives and embrace best practices.