Annual Report of QIO Case Review Information

IPRO, the QIO for New York

August 2012–July 2013

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-AIM6-13-13

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IPRO

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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, 2012 through July 31, 2013 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 as recorded in the Case Review Information System (CRIS) by the associated review type.

Review Type	Number of Reviews	Percent of Reviews
Coding Validation (120 - HWDRG)	3,137	19.81%
Coding Validation (All Other Selection Reasons)	0	0.00%
Quality of Care Review (101 through 104 -Beneficiary Complaint)	299	1.89%
Quality of Care Review (All Other Selection Reasons)	71	0.45%
Quality of Care Review - Immediate Advocacy	20	0.13%
Utilization (158 - FI/MAC Referral for Readmission Review)	0	0.00%
Utilization (All Other Selection Reasons)	5,146	32.50%
Notice of Non-coverage (105 through 108 - Admission and Preadmission)	651	4.11%
Notice of Non-coverage (118 - BIPA)	2,339	14.77%
Notice of Non-coverage (117 - Grijalva)	2,309	14.58%
Notice of Non-coverage (121 through 124 -Weichardt)	1,830	11.56%
Notice of Non-coverage (111-Request for QIO Concurrence)	1	0.01%
EMTALA 5 Day	32	0.20%
EMTALA 60 Day	0	0.00%
Total	**15,835**	

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.	038.9 - Unspecified Septicemia	27,669	18.36%
2.	486 - Pneumonia, organism unspecified	20,809	13.81%
3.	V57.89 - Rehabilitation procedure, not elsewhere classified	16,733	11.11%
4.	414.01 - Coronary Atherosclerosis of Native Coronary Artery	15,347	10.19%
5.	599.0 - Urinary Tract Infection, site not specified	13,613	9.03%
6.	491.21 - Obstructive Chronic Bronchitis, with (acute) exacerbation	12,035	7.79%
7.	584.9 - Acute Kidney Failure, unspecified	11,936	7.92%
8.	427.31 - Atrial Fibrillation	11,264	7.48%
9.	410.71 - Subendocardial Infarction, initial episode of care	10,923	7.25%
10.	780.2 - Syncope and Collapse	10,343	6.86%
		Total 150,672	**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	72	10.26%
Urban	628	89.46%
Unknown	2	0.28%
Total	**702**	**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	154	21.94%
1	Distinct Psychiatric Facility	3	0.43%
2	Distinct Rehabilitation Facility	0	0.00%
3	Distinct Skilled Nursing Facility	441	62.82%
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	70	9.97%
N	Critical Access Hospital	3	0.43%
O	Setting does not fit into any other existing setting code	0	0.00%
Q	Long Term Care Facility	2	0.28%
R	Hospice	23	3.28%
S	Psychiatric Unit of an Inpatient Facility	1	0.14%
T	Rehabilitation Unit of an Inpatient Facility	0	0.00%
U	Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	4	0.14%
Y	Federally Qualified Health Centers	0	0.00%
Z	Swing Bed Designation for Critical Access Hospitals	1	0.14%
	Other	0	0.00%
		Total 702	**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. It should be noted that a case under review can have multiple quality of care concerns identified.

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	24	6	25.00%
C02	Apparently did not make appropriate diagnoses and/or assessments	114	32	28.07%
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]	268	58	21.64%
C04	Apparently did not carry out an established plan in a competent and/or timely fashion	69	28	40.58%
C05	Apparently did not appropriately assess and/or act on changes in clinical/other status results	38	27	71.05%
C06	Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	22	7	31.82%
C07	Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	18	8	44.44%
C08	Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	9	1	11.11%
C09	Apparently did not obtain appropriate laboratory tests and/or imaging studies	25	0	0.00%
C10	Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	40	11	27.50%
C11	Apparently did not demonstrate that the patient was ready for discharge	41	13	31.71%
C12	Apparently did not provide appropriate personnel and/or resources	12	2	16.67%
C13	Apparently did not order appropriate specialty consultation	17	3	17.65%

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Quality of Care ("C" Category) PRAF Category Codes		No. of Concerns	No. of Concerns Confirmed	Percent Confirmed Concerns
C14	Apparently specialty consultation process was not completed in a timely manner	5	3	60.00%
C15	Apparently did not effectively coordinate across disciplines	5	3	60.00%
C16	Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	72	25	34.72%
C17	Apparently did not order/follow evidence-based practices	12	5	41.67%
C18	Apparently did not provide medical record documentation that impacts patient care	18	12	66.67%
C40	Apparently did not follow up on patient's non-compliance	1	1	100.00%
C99	Other quality concern not elsewhere classified	267	96	35.96%
	Total	**1,077**	**341**	**31.66%**

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
366	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, 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. 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	1.0%
4 Request review policy/procedure	4	1.0%
5 Request development of QIP	356	97.5%
6 Accept provider-initiated QIP	2	0.5%
7 Conduct informal meeting or teleconference		
8 Refer to licensing board		
9 Initiate sanction activity		
10 Other		
Total	**366**	**100.00%**

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

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 represents discharge/service termination reviews from 8/1/2012–4/30/2013. 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)	193	22.55%
02	Discharged/transferred to another short-term general hospital for inpatient care	12	1.40%
03	Discharged/transferred to skilled nursing facility (SNF)	377	44.04%
04	Discharged/transferred to intermediate care facility (ICF)	7	0.82%
05	Discharged/transferred to another type of institution (including distinct parts)	1	0.12%
06	Discharged/transferred to home under care of organized home health service organization	162	18.93%
07	Left against medical advice or discontinued care	7	0.82%
09	Admitted as an inpatient to this hospital	0	0.00%
20	Expired (or did not recover - Christian Science patient)	23	2.69%
21	Discharged/transferred to court/law enforcement	0	0.00%
30	Still a patient	2	0.23%
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	18	2.10%
51	Hospice - medical facility	7	0.82%
61	Discharged/transferred within this institution to a hospital-based Medicare approved swing bed	2	0.23%
62	Discharged/transferred to an inpatient rehabilitation facility including distinct part units of a hospital	17	1.99%
63	Discharged/transferred to a long term care hospital	23	2.69%
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	5	0.58%
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 856	**100.00%**

IV E. Beneficiary Demographics

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

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	5,930	61.02%
Male	3,786	38.96%
Unknown	2	0.02%
	Total 9,718	**100.00%**
Race		
Asian	127	1.31%
Black	1,358	13.97%
Hispanic	275	2.83%
North American Native	12	0.12%
Other	140	1.44%
Unknown	51	0.52%
White	7,755	79.80%
	Total 9,718	**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-16 (Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)

IPRO requested a formal quality improvement plan to address the following issue: *Administration of medication that was not medically indicated for this patient*. The issue was brought to our attention as the result of a beneficiary complaint about the quality of care received during a hospital admission.

IPRO review of the medical record identified a nursing admission assessment in the medical record documenting, "Tobacco Use: Never smoker". There was also an entry by a physician assistant (PA) on a social history form stating, "Patient denies tobacco use". Yet, there was a medication order in the medical record signed off by a PA for administration of a nicotine patch to this 69-year old Medicare beneficiary admitted for surgery. Placement of the patch was refused by the patient, a non-smoker.

As a result of IPRO's inquiry, *questioning why there was a medication order for placement of a nicotine patch for this patient, a non-smoker;* the hospital initiated an investigation and discovered:

- The patient had been admitted for a robotic assisted surgical procedure that was new to the facility.
- Order sets/care plans for this new procedure had been recently purchased from their electronic medical record (EMR) company.
- All Order sets/care plans purchased through this EMR company had an order for "placement of nicotine patch" automatically pre-selected as a component of the Smoking Cessation Plan.

Based on these findings, the hospital determined that NO medications would be pre-selected in Order sets. Moreover, "placement of a nicotine patch" was to be unselected for all Order sets/care plans. This was accomplished within 24 hours of identification of the issue, with 100% compliance confirmed by an internal hospital review conducted by the Information Technology department.

The event was also captured in the hospital's patient safety reporting portal as a "near miss" as the patient did not receive the drug. A thorough investigation and follow-up with involved staff was also conducted. The PA who signed off on the order for the nicotine patch was counseled in regard to the fact that even though electronic order sets/care plans are created to capture all required elements and optional orders (such as the nicotine patch for smoking cessation), the entire plan and set of orders must always be reviewed for patient appropriateness before signing off on it.

Example 2 - Type of Intervention for Quality Category C-5 (Apparently did not appropriately assess and/or act on changes in clinical/other status results)

IPRO requested a formal quality improvement plan to address the following concern: *A delay of approximately10 hours during which time the patient's respiratory distress was not addressed by nursing staff.*

The concern was identified by IPRO while conducting review of a beneficiary complaint. The complaint, which involved multiple concerns, had been referred to IPRO by the patient's designated representative concerned about the quality of care provided to her family-member, a chronically disabled Medicare beneficiary. The patient, an Insulin-dependent diabetic had been admitted to the hospital after suffering a prolonged seizure at home. The patient was intubated and placed on a ventilator. He remained comatose and ventilator dependent for more than six months.

IPRO's review of documentation in the medical record identified that the patient had been noted by nursing to have an increased respiratory rate at 20-30 breaths per minute above the ventilator. There is nursing documentation that the physician and respiratory therapist were notified at 11 pm but no other nursing documentation is present in the record in regard to

follow up until the next morning at 9 am. The 9 am nurse's note indicates that the patient's blood oxygen saturation (SpO2) was low (85% - 89%) and the ventilator was persistently alarming. (A normal SpO2 level is between 95% - 100%). A Rapid Response Team was called, respiratory treatment was given and the SpO2 rose to 98%.

In conducting IPRO's required root cause analysis of the event, the provider determined that while respiratory treatment had been given to the patient during the night, there was a 10 hour gap in nursing documentation that was not in keeping with acceptable nursing standards of practice. While conducting in-service education in regard to nursing documentation requirements was initially proposed by the provider as the sole intervention to mitigate this problem, the plan was not accepted by IPRO. Instead, the provider was redirected by IPRO to consider whether there had been a delay in calling the Rapid Response Team and/or ensuring that a physician come to evaluate the patient. With technical assistance provided by IPRO, it was agreed that the quality improvement intervention should include both a hospital-wide nursing in-service education on critical assessment and evaluation, as well as an ongoing, monthly, retrospective medical record audit of the shift preceding Rapid Response Team deployment to ensure there were no delays in calling for the team and/or having a physician evaluate the patient. The results of the monitoring will be provided to IPRO on a quarterly basis.

Example 3 - Type of Intervention for Quality Category C-3 (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, imaging, procedures and/or consultations).

IPRO requested a quality improvement initiative to address the following concern: Patient received inappropriate doses of Coumadin.

The concern was identified by IPRO while conducting a concurrent beneficiary complaint review. An elderly patient was emergently admitted to the hospital after being seen by their personal physician for difficulty breathing. An outpatient chest x-ray was indicative of pneumonia. Co-morbidities included atrial fibrillation, mitral valve disorder, congestive heart failure, and hypertension. The beneficiary was evaluated in the emergency department and admitted by a resident physician. It was noted in the medical record that the patient was taking 2 mg of Coumadin (an anticoagulant) at home, daily for their atrial fibrillation. Admitting lab work showed that the INR (a test that measures whether the dose of anticoagulant a person is taking is therapeutic) was sub-therapeutic. The resident wrote admitting orders for 5mg of Coumadin as well as 60mg Lovenox (also an anticoagulant used to prevent blood clots) with the Lovenox to be discontinued when lab work demonstrated that the INR was greater than 2.0. Admitting orders also included the antibiotic, Levaquin to address the diagnosis of pneumonia. There was no documentation in the medical record to corroborate whether the orders were reviewed with an attending physician as per hospital policy. It should be noted that the patient developed a severe hematoma which required surgical evacuation.

IPRO determined that while it was reasonable to increase the dose of Coumadin to bring the INR to a therapeutic level, there should have been heightened caution in regard to the combined use of Coumadin, Lovenox, and Levaquin in this elderly patient due to the potentiating effects of an antibiotic such as Levaquin on Coumadin. The rate of increase in the Coumadin dosage should therefore have been adjusted accordingly. The provider agreed that greater precautions should have been taken and proposed that an educational series, highlighting the recommended guidelines for Coumadin dosing, would be conducted for residents and interns. Additionally, a discussion and review of Coumadin guidelines for dosing would be published in the medical staff newsletter. IPRO accepted the intervention measures but added the requirement that the hospital develop and implement a drug to drug interaction check procedure and a system that would ensure prompt communication between pharmacy and the prescribing physician when red flags, such as in this case example, are noted.

Example 3: How Interventions Determined/Best Practices

IPRO developed and provides a one page, "Quality Improvement Activity (QIA) Reference Guide" along with our Final Quality Determination letter when a quality of care concern is confirmed. This Guide clearly establishes what IPRO expects from the involved provider/practitioner in regard to submission of their QIA as well as the QIA process.

As noted above, the provider recognized the need for medical education in regard to Coumadin dosing but was prompted by IPRO to consider and address the bigger picture - the need for a system-wide alert process to monitor the potential for a drug to drug interaction. Therefore, IPRO worked with the provider to enhance and strengthen their quality improvement plan beyond the provision of medical education by requiring:

1. the implementation of a process to check for potential drug to drug interaction; and
2. establishment of a communication process to ensure prompt notification to the prescribing physician, should a red flag (such as the concomitant ordering of Coumadin and Levaquin) be identified.

When taken as a whole, the interventions represent best practices, with the systems interventions (e.g., drug interaction software) complemented by enhanced clinical knowledge and a clear pathway for communication.

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; Medscape	The Milliman Care Guidelines provide a starting point to research current standards for care. Information in regard to current standards for pneumonia is available. Medscape also provides access to current standards, including detailed treatment regimens and follow up.
	Heart Failure	Milliman Care Guidelines and American Heart Association (www.Heart.org); Medscape	Information in Milliman Care Guidelines is supplemented by clinical information located on the American Heart Association website and Medscape.
	Acute Myocardial Infarction (MI)	Milliman Care Guidelines and American Heart Association (www.Heart.org); Medscape	Information in Milliman Care Guidelines is supplemented by clinical information located on the American Heart Association website and Medscape.
	Pressure Ulcers	AHRQ website; Wound, Ostomy & Continence Nursing website (www.WOCN.org)	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	Center for Disease Control (CDC) website; Milliman Care Guidelines; Medscape	The CDC offers the ability to search for clinical guidelines related to catheter care and UTIs. Medscape is also used to access current standards, including detailed treatment regimens and follow up. This information may be supplemented with Milliman Care Guidelines
	Sepsis	NY State Sepsis Guidelines; Milliman Care Guidelines; Medscape	NY State has recently released provider standards in sepsis care. In addition, both the Milliman Care Guidelines and Medscape are used to research current standards of care for sepsis.

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Review Type	Diagnostic Categories	Evidence/Standards of Care Used	Rationale for Evidence/Standardof Care Selected
Quality of Care (continued)	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 the quality review process. The PDR website provides medication monographs including information related to monitoring, dosage, and indications.
	Falls	Milliman Care Guidelines; Joint Commission; and New York State Department of Health	The Milliman Care Guidelines provide a starting point to research current standards for care. In addition we utilize information on the Joint Commission website as well as the website of the New York State Department of Health (NYSDOH). The NYSDOH website also provides a link to the CDC's *STEADI* toolkit.
	Patient Trauma	Milliman Care Guidelines; Medscape; American College of Emergency Physicians (ACEP)	The Milliman Care Guidelines provide a starting point to research current standards for care. In addition we utilize Medscape as well as the ACEP website for new standards of care relating to patient trauma.
	Surgical Complications	Milliman Care Guidelines; Medscape; American College of Surgeons website	The Milliman Care Guidelines provide a starting point to research current standards for care. In addition we utilize Medscape as well the American College of Surgeons website for new guidelines.
Medical Necessity/ Utilization Review		Milliman Care Guidelines, Medicare Coverage Guidelines (Medicare Benefits Policy Manual and National Coverage Determinations Manual)	Milliman Guidelines are used to evaluate the appropriateness of admission as well as medical necessity. The CMS online Medicare Manuals are also used to make admission and medical necessity 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 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 Falls

This case concerned nursing home care provided to a Medicare beneficiary on dialysis with end-stage renal disease. The beneficiary was admitted to the nursing home for skilled care after a hospitalization for sepsis-pneumonia, confusion, and emphysema. During the hospitalization the beneficiary fell multiple times with a resultant arm fracture. Thus, it was known to the nursing home at admission that the resident was at high risk for falls.

Unfortunately, the resident fell multiple times while in the nursing home. IPRO identified that there were multiple times when nursing failed to properly notify the physician, administration and the family that the patient had fallen. IPRO also noted that this particular provider's fall rate was higher than the state and national average. The facility was directed to the Centers for Disease Control and Prevention (CDC) website and the "STEADI" (Stopping Elderly Accidents, Deaths and Injuries) Toolkit, a resource for IPRO's evidence based review and provision of technical assistance for quality improvement.

Example/Case Study 2 - Patient Readmission

This case concerns a Medicare beneficiary who was readmitted to the same hospital within 24 hours after discharge. The patient had undergone back surgery. According to the history provided by the beneficiary at the time of the first admission, the patient had been using 25 mcg Fentanyl patches applied every three days for pain. This medication had been discontinued 10 days preoperatively. Postoperatively, a 100 mcg Fentanyl patch was ordered for pain control. The beneficiary was also receiving patient controlled analgesic Morphine up until the day of discharge.

The patient developed an altered mental status the day after discharge while wearing the post procedure 100 mcg Fentanyl patch. Emergency Medical Services (EMS) was called and the Fentanyl patch was removed in the ambulance. Naloxone (a drug used to reverse the effects of opioids) was administered in the ER with marked improvement in the patient's mental state.

Based on drug specific information found on the Federal Drug Administration website, FDA.gov, IPRO determined that the provider had over-medicated the patient by placing the 100 mcg Fentanyl patch and had also failed to recognize the patient's altered mental state as an indication of potential Fentanyl overdose.

Example/Case Study 3 - Pressure Ulcers

This case concerns a Medicare beneficiary with multiple hospital and nursing home admissions and co-morbid conditions. It was noted during one of the nursing home admissions reviewed by IPRO that the patient had developed a blister on the heel which progressed to a necrotic ulcer. While a Wound Care Specialty consult had been obtained, there was no documentation that the recommendations made by the consultant for turning and positioning, elevation of the patient's heel off the mattress, booties and use of pressure reduction devices in bed had been followed on a daily basis, as ordered.

Based on usual and customary nursing standards of practice for patients at risk for pressure ulcers as well as Milliman Care Guidelines, IPRO determined that the nursing staff had failed to provide acceptable quality care to this Medicare beneficiary.

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 390 Quality of Care (QOC) reviews and confirmed 341QOC concerns. A quality improvement activity (QIA) was implemented for all confirmed concerns as evidenced by the data in Tables B and C. The number of QIAs is greater than the number of confirmed concerns because some cases can involve both a provider as well as a practitioner and different interventions are needed. 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, calls to IPRO's helpline are triaged and callers 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 identify geographic and demographic patterns/trends where focused quality improvement intervention is needed. It can also complement work being performed in other Aims through promotion of best practices for providers not necessarily engaged in other QIO initiatives, such as the Nursing Home Quality of Care Collaborative.