

Quality Improvement Activities Resulting from Case Review Case Example #3

Summary

In a Medicare beneficiary complaint case in the physician office setting, a physician prescribed weekly Procrit injections for anemia. The injections continued for almost two years, varying from weekly to monthly, despite the patient having hemoglobin results in the 14 to 15 Gm/dl range. The physician in question was a board-certified hematology/oncologist. The patient ultimately suffered a CVA and was admitted to acute care. (The Medicare beneficiary eventually recovered and contacted the QIO to report a complaint regarding care received.)

QIO physician reviewers found the care to be a gross and flagrant violation from the standard of care. An initial sanction notice of gross and flagrant violation of Medicare obligation was issued to the involved physician, and he was invited to a formal meeting with three QIO physician reviewers. In the course of the meeting, it was determined that the physician's office did not have a process in place to ensure:

- Guidelines for staff administering standing medication orders such as Procrit 9
- Procedures for coordinating lab findings with medications being administered
- Oversight of the training or education of staff who were administering medications in the office setting.

Concerns identified by the QIO

The physician did not:

- Develop an appropriate treatment plan for administration of Procrit injections
- Appropriately assess and act on laboratory tests as evidenced by the continued administration of Procrit with hemoglobin levels above 13 gm/dl

Quality Improvement activities that resulted from QIO review

The physician was requested to complete the following activities following his meeting with the QIO physician reviewers:

- Complete an American Board of Internal Medicine Review course and obtain recertification in hematology and oncology
- Complete a medical risk management course
- Submit to a plan with associated timeliness for establishing office practice guidelines to include policies and procedures and staff education programs for pharmacy, laboratory and nursing to the QIO
- Promote collaborative efforts among physician associates and staff directed toward improving the quality of patient care and supporting a culture in which office staff takes personal responsibility for the quality of care provided

The physician accepted the quality improvement recommendations outlined by the physician reviewers. The recertification and continuing medical education requirements were completed. Physicians within this practice group developed policies and practice guidelines for pharmacy, laboratory and nursing. The nursing staff received education on the use of Neupogen, Procrit and Neulasta that included guidelines for administration. The policies, guidelines and care maps were reviewed by the QIO physician reviewers and found to be sufficient to provide the framework for safe care delivery and appropriate decision-making by staff involved. Additionally, this physician practice group began a quality assurance process with monthly meetings of all clinical staff to review records, evaluate practice standards, provide ongoing education and sustain a culture of quality medical care.

Subsequent chart review revealed no further quality of care issues. The physician was released from his formal quality improvement activities with the QIO with the encouragement to sustain the very positive efforts he had demonstrated.

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