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**HEALTH SECTOR FINANCING PROJECT
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**QUALITY ASSURANCE
UTILIZATION MANAGEMENT
MANAGED HEALTH CARE SYSTEMS**

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ACRONYMS and TERMS
Indonesia Health Sector Financing Project

AMA	American Medical Association
Dana Sehat	Community health fund; voluntary health care purchasing cooperatives at the village level which arises through spontaneous initiatives by villagers
IDI	Ikatan Dokter Indonesia (Indonesian Doctors Association)
LOS	Length of Stay
MIS	Management Information Systems
PHB	Reorganized form of ASKES/BPDPKM, making it a government enterprise (perum), responsible for both revenues and expenditures and having an independent governing board reporting to the Minister of Health and Minister of finance. A parastatal which provides health insurance for government employees.
PIO	Project Implementation Officer for the Health Sector Financing Project.
PKTK	Pelayanan Kesehatan Tenaga Kerja (health insurance fund for private sector workers), a pilot project jointly administered by ASTEK (Ministry of Manpower Development) and DUKM (Ministry of Health).
PPK	Penyelenggara Pelayanan Kesehatan (Health Service Providers)
QA/UM	quality assurance/utilization management
STT	Satuan Tugas Teknis (Technical Task Force)

EXECUTIVE SUMMARY

The scope of work presented to the consultant included review of and recommendations for the current strategies for quality assurance systems of the proposed managed health care programs in Indonesia. Although some groundwork had been established with individuals directly involved in the planning of the managed care systems, the consultant found the need to further introduce the concepts and elements of quality assurance/utilization management and its role in managed care to larger audiences. Because there was no specific documented plan for a quality assurance program, the review of strategies consisted largely of presentations to various health professionals and informal meetings with government representatives. Thus the paper presented by the consultant serves as the detailed information for this report.

The consultant was prepared to provide more technical information and support for the development of the actual quality assurance process and specific activities necessary for the implementation of a formal program. This was not accomplished as a result of limited time and data available at the time of the consultancy.

SCHEDULED EVENTS

Following are the specific components that the consultant was able to review:

1. PHB, a parastatal providing health insurance for government employees, was responsible for establishing the data elements for the project's management information systems (MIS). These data elements are essential to medical care evaluation and will assist in the determination of norms and identification of outliers. It will be extremely important that the data be sorted by providers as well as members. High-cost providers and diagnosis-specific information will assist in the review of cases that are most likely to result in controlling excessive costs. Review of the data elements of the MIS targets the high-cost ticket items. And although this will provide valuable information, there may be minimal cost savings, if these items are infrequent or if the costs are determined to be justifiable. The consultant recommends the inclusion of the same data elements based on frequency or incidence. Focusing on those items appearing on both data sets may result in making the greatest impact. Additionally, the consultant recommended review of cases that are preventable and/or the result of poor medical management or compliance.
2. Pelayanan Kesehatan Tenaga Kerja (PKTK), a (health insurance fund for private sector workers), provides hospital coverage for approximately 25,000 members. It currently reviews hospital cases based on length of stay (LOS). The forms used to document an admission (in Indonesian) appear to indicate that the basic information is used to determine the level of hospitalization required and type of admission. These forms are completed by a PKTK employee who is stationed at the participating facility. With the development of review criteria and standards of care, and with the training of the staff, this existing system can be adapted for quality assurance purposes. Again, MIS's are critical in the determination of norms for lengths of stay.
3. Dana Sehat is the system of health care at the village level. The structure is based on a volunteer, lay administrator who is influential within a community. This system can be used to foster health promotion and compliance to medical care. Again, given training and incentives for health outcomes, this system can be useful in the quality assurance process. The quality assurance must include provisions to measure also the performance of the staff involved in the process.
4. Ikatan Dokter Indonesia (IDI) is the Indonesian counterpart of the American Medical Association (AMA). The Health Sector Financing Project Officer has negotiated a contract with IDI to develop standards of care. Initially the request was to develop the standards for the most costly cases; however, for a larger and more timely impact the consultant recommends that the standards be developed for the 20 most frequently occurring outpatient diagnoses and 10 most frequently occurring hospital admissions.

5. Project Implementation Office/Hospitals (PIO/H) has recently developed an accreditation procedure for hospital systems. Although the document reviewed by the consultant included an outline of the structure and process, there were few specifics for the consultant to evaluate. Again, the key will be the development of the standards of care and continuous education of health professionals regarding quality assurance programs and their objectives.
6. Bali, penyelenggara Pelayanan Kesehatan (PPK) Contractor is responsible for the development of managed care at a provincial level. Here again, most efforts were devoted to introduction of the subject of quality assurance/utilization management (QA/UM). A visit to the local hospital demonstrated the presence of PKTK within the facility. A cursory review of a patient record assured the consultant that basic documentation is available as a means to review medical care.

Other meetings and presentations:

1. St. Carolus, a 600-bed private hospital, has recently undergone a reorganization. The current administrator believes in a multi-disciplinary approach to quality assurance and holds weekly meetings with the department heads to discuss problems that are categorized as: a) mistakes that are documented and reported routinely, b) accidents that are also documented and reported as incidents, and c) near-accidents that are reviewed and followed up by the Medical and Nursing directors. Current projects included standardization of their medical record documentation to include patients' social and occupational information and to conduct outreach and followup of hospital discharges. The addition of an MIS would serve to target problem areas and trends, rather than rely on individual reporting.
2. Satuan Tugas Teknis (STT, or technical task force) — Many of the members of this committee were currently in the USA for additional training in managed care systems. A major task awaiting them is to document a manual for their respective areas of responsibility. The consultant would be pleased to review any documentation in the area of quality assurance.

GENERAL ASSESSMENT

When attempts are made to introduce the concept of prepayment of health care services where minimal health care standards exist, the issue of quality of care and management of resources becomes overshadowed. Although there seemed to be genuine interest in the topic, the consultant believes that most of the audience was not convinced of the importance of QA/UM and its role in achieving plan success.

Medical care documentation is available and provides the basis for QA development. However, considerably more details of the QA/UM program need to be determined and documented before further input is requested of consultants in this area. Obtaining actual MIS data for analysis is underway and will help to define the target areas for review.

RECOMMENDATIONS

Presenting theoretical information alone will not result in gaining the level of support and understanding needed to implement a strong QA/UM program. In the experience of the consultant, repeated anecdotal stories of success and examples of effective outcomes have accomplished more to this effect.

Although development of the QA/UM program may seem a monumental task, phased implementation will help to facilitate the process. Using a moderate-size group of solo practitioners (50 to 75) within a common geographic area (with a hospital) as a demonstration project may be time-consuming, but may prove beneficial especially in working out the details of the process. The consultant recommends that such a project be given high visibility and support to ensure success and desired replication.

QA/UM is most critical within any managed care system and must be continuously emphasized. Regardless of the careful planning of the financial structure and marketing strategies, success of a program will depend greatly on the quality of the product, its delivery, and the level of consumer satisfaction.

**QUALITY ASSURANCE/UTILIZATION MANAGEMENT
FOR MANAGED CARE SYSTEMS
PROGRAM DESCRIPTION**

DEFINITION

Quality assurance/utilization management (QA/UM) can be described as a process of ongoing and systematic review of patient care that identifies potential health care problems and/or aberrant practices, then determines and implements corrective actions to result in the continuous improvement of the quality of health care services.

PURPOSE AND PHILOSOPHY

Quality assurance programs are intended to ensure the most efficient use of health care resources by providing quality that will minimize the risks of adverse outcomes, prevent costly complications, and promote high levels of patient, provider, and plan satisfaction.

PROGRAM ADMINISTRATION

A successful quality assurance program must have authority, accountability, and adequate resources. The QA activities should be reported to the committee with the highest level of authority (Board of Directors) on a routine basis, i.e., as a standard agenda item of all regularly scheduled meetings. The QA department director should report to, or have direct access to, the president or senior vice president of the organization. The QA director should have a strong clinical background and the QA staff must consist of specially trained professional and technical staff.

Ideally, as many providers as practical should have the opportunity to participate in QA activities as the second level of review for problem identification and be designated as Physician Reviewers (Peer Review). There should be representation of the different specialties to provide sound and credible determinations for complex situations. It is equally important that the QA staff have easy access to the Physician Reviewers for timely resolution of problems.

In addition to the daily QA activities, a multi-disciplinary QA committee should be established for evaluating QA staff findings and determining appropriate corrective actions. The committee must include credible practitioners to act as Physician Advisors. The QA committee should meet at regularly scheduled intervals coinciding with the review activities or reporting cycles. To reduce liability issues, careful minutes should be recorded and kept confidential. Copies forwarded to Administration or the Board should have all identifiers removed.

PROGRAM OBJECTIVES

Ambulatory care should reflect optimal outpatient health management by promoting the use of preventive service, screening procedures when appropriate, patient education and compliance programs, and health promotion activities.

Hospital services should be directed to minimizing complications and length of stay (LOS). While discharge planning is essential, efforts to prevent premature discharge will reduce the risk of readmissions. Caution should be exercised if the program includes an assignment of LOS because there is a tendency for the review to become relaxed and almost nonexistent during the most critical and costly days of hospitalization.

REVIEW PROCESS

The review process is the key to the identification of problem areas and trends. It is essential that the process is systematic and includes all major components of patient care. The methods of review generally can be categorized into three types: prospective, concurrent, and retrospective.

Prospective review is used to prevent adverse events and is usually the most acceptable review method to the providers because the "rules" are defined and understood prior to services being rendered. Credentialing is a process of review prior to acceptance of a practitioner applicant as a provider of services. Other examples include prior authorization procedures such as second surgical opinion and preadmission certification.

Concurrent review provides an opportunity for prompt intervention. It was developed as a means to review patients throughout hospitalization. The review is conducted at periodic intervals to determine continued medical necessity of hospital stay and appropriateness of care. Questionable cases are referred to a Physician Reviewer who contacts the involved Attending Physician for timely correction of a problem or clarification of the situation. This method of review is labor-intensive and requires the use of professional personnel for review and referral.

Retrospective review lends itself to identifying problem trends and often is dependent on MIS data. This method is also labor-intensive, but initial level review can be conducted by non-professional staff. Retrospective review is essential when trying to determine results of corrective actions.

GENERAL STRATEGIES

In establishing a QA/UM program, the organization should strongly consider including the development of standards of care as an initial procedure or at least as an outcome of the process. Although time-consuming and sensitive, there should be an attempt to gain general agreement of the standards within the medical community, and when possible, acceptance by the local medical society or association.

High cost/high frequency and sentinel diagnoses or services should be considered the target areas of review. A timely demonstration of the utility of a QA/UM program will help to gain confidence and support of the providers. This is a critical factor in the success of a managed care system.

When possible, the review activities should be prospective and concurrent. Prevention of potential problems is more likely to result in acceptance of a QA/UM program, whereas those activities that result in denial or reduction of payment tend to create adversarial relations. This will inevitably result in dissatisfaction and lack of cooperation of the providers and will greatly reduce the effectiveness of the program.

DUE PROCESS

When a potential problem has been verified, the involved provider must be notified of the situation, preferably in writing. The provider must be given the opportunity to respond within a reasonable time period, allowing for the review of necessary records. This step is essential since there may be circumstances that can clarify or justify the situation.

CORRECTIVE ACTIONS

The ideal corrective action plan is one that is appropriate and suggested by the involved provider. At a minimum the involved provider should be notified of any recommended actions and timeframe in which problem resolution is expected. The corrective action plan should define achievable goals and include the specific actions to be taken and by whom. The method of evaluating results should also be described in as much detail as possible.

PROBLEM RESOLUTION

When corrective actions are successful, the involved provider should again be notified and congratulated. To be meaningful, the notification should include any measurable results (appropriate clinical data, cost-saving, reduced utilization, rates of patient satisfaction). This will reinforce positive practice changes and help to sell other providers on the concept of QA/UM.

NEGATIVE OUTCOMES

Expecting that there will be some practitioners who will not cooperate with the efforts of a managed health care system, it must be determined what actions are to be taken when problems cannot be resolved. The organization must commit to these actions prior to implementing any QA/UM program activities. It may be helpful to include some language in the provider contract with reference to participating in and cooperating with the QA/UM program activities and recommendations. When necessary, this language will facilitate contract termination.

QUALITY ASSURANCE UTILIZATION MANAGEMENT

PURPOSE AND PHILOSOPHY:

■ HEALTH PLAN SUCCESS

- QUALITY CARE WILL RESULT IN APPROPRIATE LEVELS OF UTILIZATION
- "DO IT RIGHT THE FIRST TIME"
- PATIENT AND PROVIDER SATISFACTION

QUALITY ASSURANCE UTILIZATION MANAGEMENT

PROGRAM ELEMENTS:

- PROBLEM IDENTIFICATION
- PRIORITIZATION OF PROBLEMS
- CORRECTIVE ACTION PLAN
- IMPLEMENTATION OF CORRECTIVE ACTION
- REEVALUATION

QUALITY ASSURANCE UTILIZATION MANAGEMENT

PROBLEM IDENTIFICATION – REVIEW PROCESS:

■ ONGOING AND SYSTEMATIC

- Trends rather than isolated incidents

■ TARGET THE REVIEW

- Adverse outcomes
- High-cost/high-frequency diagnoses
- High-cost services
- High-cost/high-volume providers

QUALITY ASSURANCE UTILIZATION MANAGEMENT

REVIEW METHODOLOGY:

■ PROSPECTIVE REVIEW

- Prevent undesirable outcomes
- Favorable to providers and patients "if" criteria are:
 - a) clearly defined
 - b) communicated prior to implementation
- Examples: Credentialing
 Medical records policies
 Prior authorization programs
 Referral procedures

QUALITY ASSURANCE UTILIZATION MANAGEMENT

TARGETING THE REVIEW PROCESS:

■ ADVERSE OUTCOMES

- Diabetic ketoacidosis
- Ruptured appendix
- Readmission for same condition within 14 days

■ HIGH-COST/FREQUENCY DIAGNOSIS

- Premature infant
- Hypertension
- Congestive heart failure

■ HIGH-COST SERVICES

- MRI/CT scans
- Coronary artery bypass graft

QUALITY ASSURANCE UTILIZATION MANAGEMENT

TARGETING THE REVIEW PROCESS (cont):

■ HIGH-COST/HIGH-VOLUME PROVIDERS

- Claims data

Average number of office visits per patient per year

Number of patients

Number of hospital admissions per year and average LOS

- Rank providers by specialty

Determine mean number of office visits per patient per year

Determine mean number of admissions per year and LOS

- Focus review of top and bottom 10%

QUALITY ASSURANCE UTILIZATION MANAGEMENT

REVIEW METHODOLOGY:

■ RETROSPECTIVE REVIEW

- Identify problem trends
- Measure results of corrective actions
- Examples: Claims data analysis
 Medical records review
 Patient surveys

QUALITY ASSURANCE UTILIZATION MANAGEMENT

PRIORITIZE PROBLEMS:

- EASILY CORRECTABLE
 - Gains credibility for the program
- SEVERE OUTCOMES
- COSTLY PROBLEMS

QUALITY ASSURANCE UTILIZATION MANAGEMENT

CORRECTIVE ACTION PLAN, IMPLEMENTATION, AND REEVALUATION:

- CLEARLY STATED PROBLEM
 - Extent of problem
 - Provider notification and response
- SPECIFIC ACTIONS TO BE TAKEN
 - By whom, when
- DEFINE PROBLEM RESOLUTION
- DETERMINE METHOD OF RE-EVALUATION
 - By whom, when