Integrating Patient Safety in Disease Management Programs

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Mission

To promote continuous improvement in the quality and efficiency of healthcare management through processes of accreditation and education.
Objectives

- Describe the URAC accreditation and standards development process outlining how URAC standards promote quality of care and accountability across the healthcare continuum.

- Cite IOM recommendations to healthcare organizations related to patient safety and discuss the evolution of URAC’s research, standards development and approach to the integration of patient safety standards into DM standards.

- Describe URAC’s quality improvement programs that include reporting of a specific patient safety quality improvement program (QIP).

- Discuss barriers and strengths of medical management to patient safety.
About URAC

• Nonprofit, independent organization founded in 1990 originally chartered to accredit utilization review services – now offers 16 distinct accreditation programs across the continuum of care
• Twenty-two of the top 25 US health plans hold URAC accreditation*
• URAC accredits more of the top 25 PPOs than any other accreditation organization*
• URAC Health Web Site program launched in 2001: Accredits 36 sites/over 250 portals including WebMD, Healthwise, KidsHealth, Mayo Clinic and Consumer Health Interactive
• URAC currently accredits over 400 organizations operating in all 50 states
• URAC is now recognized in 38 states, District of Columbia, and four federal agencies (OPM, Department of Defense, VA, CMS)

* AIS Directory of Health Plans, 2005
Accreditation is a “Seal of Approval”

• Accreditation is an independent expert evaluation of a disease management organization.

• Physicians, nurses, other health care professionals (as well as consumers) determine what quality standards have to be met by the disease management organization.

• These standards are then built into an accreditation program. The disease management organization is evaluated against the standards by a team of outside professionals who conduct an on-site audit—making sure that the health plan is actually doing what it says it does.
URAC Standards Promote Quality Care and Accountability Across the Health Care Continuum

Health Care Continuum

- Well
- At Risk
- Acute Illness-Discretionary Care
- Chronic Illness
- Catastrophic
- End of Life Care

Wellness/Benefits

<table>
<thead>
<tr>
<th>2006 Product Portfolio</th>
<th>HWS, CES</th>
<th>HCC</th>
<th>HCC, UM</th>
<th>DM, UM</th>
<th>CM, UM</th>
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<tbody>
<tr>
<td>Core Organizational Quality</td>
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<td>Health Plan (HP)</td>
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<td>Health Network (HN)</td>
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<td>Claims Processing</td>
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<td>HIPAA Privacy</td>
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<td>HIPAA Security</td>
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<td>Consumer Education and Support (CES)</td>
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<td>Health Web Site (HWS)</td>
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<td>Independent Review (IRO)</td>
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Institute of Medicine (IOM)

- Important recommendation to Accreditors.
- “Regulators and accreditors should require health care organizations to implement meaningful patient safety programs with defined executive responsibility”
**Enhanced Patient Safety, Quality Improvement**  
Central to URAC Standards  
How URAC Accreditation Promotes the Institute of Medicine’s Six Aims of Quality Health Care*


<table>
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<tr>
<th>Quality Aims:</th>
<th>How URAC Accreditation Promotes IOM Quality Aims</th>
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<tbody>
<tr>
<td>1. Safe</td>
<td>Credentialing, Practice Guidelines, UM/CM/DM Triggers, Privacy</td>
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<td>2. Effective</td>
<td>Provider Feedback, Peer Review, Quality Management Programs</td>
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<td>3. Patient-Centered</td>
<td>Individualized Focus, Informed Decision-making, Patient Satisfaction, Consumer Education, Health Literacy</td>
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<td>4. Timely</td>
<td>Timeframes/Caseloads Defined, Enhanced Care Coordination</td>
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<td>5. Efficient</td>
<td>Organizational Structure, Policies and Procedures, TQM</td>
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<td>6. Equitable</td>
<td>Appeals and Grievances, Review Criteria, Cultural Sensitivity</td>
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January 1, 2006 URAC formally adopted IOM’s definition of patient safety. Requires organizations seeking accreditation to include a specific safety QIP
URAC’s Patient Safety Research and Development

2003: Grant-supported project to examine medical management’s role in patient safety

2004: URAC convenes Patient Safety Advisory Committee (PSAC) to identify areas of accountability for medical management

2004: URAC releases patient safety standards for education

2005: URAC proposes patient safety enhanced standards for Medical Management accreditation modules

2006 Patient Safety – Consumer Protection Standards

Future-2008 Major revisions to standards. Reconvene PSAC
URAC Standards - Patient Safety Approach

Implicit Standards
- Quality management and improvement
- Credentialing
- Complaint/grievances and appeals

Explicit Standards
- Required response to urgent situations posing immediate threat

Scoring Weights
- Primary sections - directly affect safety and welfare of consumers
- Weight (2-5) higher value

A weight of 5 is imperative to patient safety
Verification Activities to Validate Patient Safety Practice

Interviews conducted with staff to determine nature of quality oversight, and to expand on patient safety project.

Each selected site will have site specific quality information reviewed such as complaints, site specific quality activities, and case reviews.

Each selected sites will have an onsite review conducted.

The sample size for the disease management case review is selected based on a defined timeframe.
**URAC’s Quality Improvement Program (QIP)**

### Quality Improvement Activity Form

**Activity Name:** Use of Appropriate Medications For People With Asthma

#### Section I: Activity Selection and Methodology

A. How was the performance issue identified - Use objective information (data) to explain your rationale for why this activity is important to members or practitioners and why there is an opportunity for improvement.

Since 1990, asthma conditions have been the leading causes of hospitalizations among ANYWHERE VILLE children under 19. In 2001, there were 2,671 hospitalizations due to asthma, costing more than $12.6 million. This was an increase of about 5% over 2000. There were 10,124 emergency room visits due to asthma at a cost of almost $7 million.

ANYWHERE VILLE reports asthma hospitalizations among children ages birth to 19 years – 25.9 per 10,000.

National Center for Health Statistics report asthma hospitalizations among children <15 years of age – 33.6 per 10,000. Ages 15-44 – 9.1 per 10,000.

Asthma ranks within the top ten prevalent conditions causing limitation of activity and costs our nation $14 billion in health care costs annually. Asthma accounts for an estimated 14.5 million lost workdays for adults and 14 million lost school days in children annually.

A recent study by the American Lung Association Asthma Clinical Research Centers found that the inactivated influenza vaccine is safe to administer to adults and children with asthma, including those with severe asthma. Influenza causes substantial morbidity in adults and children with asthma, and vaccination can prevent influenza and its complications. Currently, fewer than 10% of patients with asthma receive the influenza vaccine. If the percentage increased to 50%, then close to 95,000 hospitalizations would be prevented and $350 million dollars would be saved.

**2005 UPDATE** – Asthma continues to be a condition relevant to ABC membership with approximately 80% of enrolled members being under the age of 18 years. DHEC reports 8.9% of children in South Carolina currently suffer from asthma compared to 8.0% nationwide. XYZ reports approximately 8.3% of children 17 years and younger as having an asthma diagnosis and identified for enrollment in ABC program. Asthma continues to be reported in the states top ten inpatient diagnoses by volume and cost.

#### A.1 Date approved by TQM [Core 33(g)]

Minutes Date (if different from above)

#### A.2 Activity Focus [Core 34(c)(ii), Core 27(h)]

- Consumer
- Client
- Consumer and Client

#### A.3 Activity Description [Core 37(a)(ii), Core 37(b)(ii)]

- Non-clinical
- Clinical

Name of senior staff in charge of activity [Core 37(a)(ii)]

#### A.4 Committee Input [Core 33 (f) (b)]

- Presentation of Activity to Committee – Committee name, Dates and Comments

November 2004
November 2005

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*Quality Improvement Activity Form—Effective October 2004*
## Consumer Safety QIP Requirements

<table>
<thead>
<tr>
<th>Standard CORE 37</th>
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<tr>
<td>At any given time, the <em>organization</em> maintains no less than two <em>quality improvement projects</em>.</td>
<td>b) At least one <em>quality improvement project</em> focuses on <em>error reduction</em> and/or <em>consumer safety</em>.</td>
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<tr>
<td>a) At least one <em>quality improvement project</em> that:</td>
<td>i. Consumer safety QIPs are required of the following programs: HUM, WCUM, HCC, HP, DM, IRO, and CM.</td>
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<td>i. Focuses on <em>consumers</em>; or for <em>organizations</em> who do not interact with <em>consumers, client services</em>;</td>
<td>ii. <em>Error reduction</em> QIPs are required of all accreditation programs that do not conduct <em>consumer safety</em> QIPs.</td>
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<td>ii. Relates to key indicators of quality as described in 34(c); and</td>
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<td>iii. Involves a senior clinical <em>staff</em> person in judgments about clinical aspects of performance, if the <em>quality improvement project</em> is clinical in nature; and</td>
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Disease management is a patient safety strategy

**Patient safety:** freedom from accidental injury; ensuring patient safety involves the establishment of operational systems and processes that minimize the likelihood of errors and maximizes the likelihood of intercepting them when they occur.

*To Err is Human. Institute of Medicine, 1999*
Examples of Quality Improvement Project (QIPS)

• Use of Appropriate Medications for People with Asthma

• Beta-Blocker Treatment After a Heart Attack

• Screening for Depression
Barriers of Medical Management in the Patient Safety Role

- Lack of on-site patient interface
- Lack of integration with other system elements
- Quality improvement feedback mechanism not established
- Limited leverage
- Patient safety indicators not defined
- Lack of stakeholder awareness of the medical management role
- Lack of standardization: assessment, data entry, codes, performance benchmarks
Strengths of Medical Management in the Patient Safety Role

• Evidence based guidelines
• Decision support tools
• Clinical professionals
• Direct patient and/or provider interaction (for some)
• Real time data access and link to claims data
• Routine use of CPT and ICD9 codes to classify activities
• Routine use of patient assessment
• Routine use of patient education
Moving Forward

- Pharmacy Benefit Management Accreditation Program
- Consumer Value Based Health Purchasing Measures Project (CVBHPM)
- Consumer Patient Safety QIP
- Major Standards Revision
Further Questions

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