HEARST HEALTH
international

How to Implement Evidence-Based Guidance in the Middle East

Find out how evidence-based guidance can help drive payer-provider collaboration and why this is necessary to reduce inappropriate utilization and waste in healthcare systems, contain healthcare costs, and assure quality patient outcomes.

2016

IN 2015 Hearst Health International held two roundtable meetings with more than 20 key stakeholders from health insurance companies, hospitals and regulatory organizations. This report provides a summary of the discussions from the two roundtable sessions:

Session 1 explored the challenges and common issues faced by hospitals and medical insurers. A common theme that emerged from this discussion was that access to evidence based clinical guidance would significantly prevent the disputes that can arise over reimbursement for provider activity.

Session 2 focussed specifically on evidence-based clinical guidance, exploring the best ways to develop and implement guidance.

ROUND TABLE

WE begin this report with an overview of current trends impacting the health care system in the GCC and how the use of evidence-based guidance can address many inefficiency issues.

As with health care systems across the world, the GCC is changing and evolving. Healthcare costs are rising and without reforms the cost-quality imbalance may become unsustainable.

In an efficient healthcare system, patients would only receive those healthcare interventions which are appropriate to their needs and justified by clinical evidence of benefit.

The GCC healthcare market

THE COUNTRIES OF the Gulf Cooperation Council (GCC) have hospital-led, fee-for-service healthcare systems. Typically, health expenditure in the region has been driven by the public sector but there is an increasing shift towards private sector investment particularly as oil prices have fallen and GCC governments attempt to further diversify their economies.

Although the introduction of the healthcare market is a relatively recent phenomenon in the GCC many of the challenges faced here are similar to those experienced in more established healthcare market systems. As described in the 2016 EY report[1], "demand for healthcare in the GCC is being driven by the changing demographic and epidemiological trends including the rise in aging population across the region, significant rise in lifestyle risk factors and prevalence of chronic diseases."

Macro-environmental trends impacting healthcare in the GCC

- INCREASE IN ELDERLY POPULATION
- INCREASE PREVALENCE OF CHRONIC DISEASES
- INCREASE IN MEDICAL TOURISM
- GOVERNMENT HEALTH INSURANCE REFORMS

ALTHOUGH THERE ARE many complex factors affecting these systems an aging population and increasing levels of chronic diseases is significantly adding to the cost of healthcare. As a result there is increasing need to improve efficiency and drive out wasteful activity from the system. At the roundtable meetings there was consensus amongst payers and providers that independent evidence-based guidelines are necessary to reduce the high levels of waste in the system.

Using evidence-based guidance to improve efficiency of GCC healthcare systems

THERE ARE NUMEROUS factors affecting the efficiency of GCC healthcare systems but both payers and providers agree that evidence-based guidance can help address many of these issues.

Problem	Solution
Supplier induced demand in a fee-for-service (FFS) system. Supplier-induced demand for healthcare is a recognized feature of health systems which reimburse on a FFS basis - which leads to overuse of healthcare resources.	Implement national guidelines to align both payers and providers with the same evidence-based care pathways and protocols.

"Its common experience in the UAE and around the Gulf that [patients] go in with an upper respiratory tract infection and come out with a third generation cephalosporin, an inhaler and 10 other unnecessary drugs"
Dr Ayham Refaat, Accumed

Problem	Solution
Poor health literacy amongst patients drives demand. Health literacy amongst the public is generally poor in the GCC, with patients often seeking unnecessary hospital care and wanting to stay in hospital longer than necessary, despite the risks of doing so and regardless of the relatively higher costs of hospital versus community care.	Invest in patient education and use tighter regulatory controls to ensure alignment of provider activity with the evidence base.
Unwarranted variation in provider activity. Unwarranted variation in care provision is known to be an issue, resulting in suboptimal care within and across GCC countries.	Encourage healthcare teams to follow evidence-based guidance to help standardize care in-line with best practice.

"We do see variation, I see variation in the different clinicians that come from different countries. We do know that the education differs and that the practices differ." *Helge Springhorn, Mafraq Hospital*

Problem	Solution
Inconsistent claims decisions by payers. Healthcare providers report inconsistent decision making by their payers as well as a lack of transparency in the sources that insurance companies use to justify non-payment.	Evidence-based guidance would help ensure payers can consistently apply their adjudication rules within the context of agreed clinical best practice.
Administrative costs of back and forth claims processes. The back-and-forth interactions that often take place between healthcare providers and payers results in administrative waste.	Evidence-based guidelines help facilitate agreement on the interventions applicable in a given clinical context and ensure appropriately delivered care is reimbursed every time.

"The future has got to be about coordination and focusing on clinical outcomes, evidence-based medicine and building the confidence of the patient in trusting the system" *Mark Adams, Anglo Arabian Healthcare*

How to develop evidence-based guidance in the GCC

THE GCC IS a young region and apart from a few initiatives such as the MENA-NCCN Breast Cancer Guidelines network[2], does not have the professional bodies (e.g. associations or societies) that more established healthcare systems use for developing national guidelines. With this in mind participants agreed the best approach for GCC countries is to adapt existing international guidelines, taking into account local issues, differences in populations and disease prevalence and variations in available interventions.

The general consensus was that developing clinical guidelines should be a collaborative process involving payers, providers, regulators and ideally patients too. However there was no consensus about the best approach and whose responsibility it was to facilitate this process.

At the roundtable two approaches for developing guidance were discussed in detail. The first example was an individual provider leading the development of evidence-based clinical guidelines in collaboration with multiple payers. The second example was of a regulatory organization collaborating with providers.

> "IF I WERE TO DO IT I WOULD HAVE PUT A LOT OF CONDITIONS. IF IT'S DRIVEN BY PROVIDERS PROBABLY EVERYTHING WOULD BE COVERED. IT HAS TO BE SOMEONE WHO CAN LOOK AT IT FROM A POINT OF VIEW WHERE THE FINANCIAL ASPECT AT LEAST IS NOT KEY FOR THEM. …I THINK THERE IS A ROLE FOR THE REGULATOR IN THIS."
>
> *Farooq Farid, Oman Insurance*

EXAMPLE 1: A provider-led approach to developing evidence-based guidelines in collaboration with payers

> "MY WISH FOR THE FUTURE IS THAT THE INDUSTRY WILL FOLLOW LIKE OTHER GOOD EXAMPLES WHERE THERE IS CONSOLIDATION, WHERE THERE ARE EFFICIENCIES, WHERE THERE ARE CLINICAL PROTOCOLS, SHARING INFORMATION, ETC."
>
> *Eduard Lotz, Anglo Arabian Healthcare*

DR EDUARD LOTZ outlined the steps he took to adapt international guidelines while working at New Mowasat Hospital in Kuwait – see fig.1 (right).

One of the potential challenges with implementing guidelines in this way is the highly fragmented payer market that exists in the Middle East. However, Dr Lotz advised there are usually only 4 or 5 payers that account for the majority of a hospital's revenue (the 80:20 principle), this meant New Mowasat Hospital only had to connect with a handful of key stakeholders to agree their guidelines.

After the guidelines had been agreed New Mowasat Hospital then used claims-data from their top payers to track variances and investigate any outliers.

The payers held all the benchmarking data on doctors and helped the provider to identify outliers based on average claim-per-patient. Dr Lotz said they formed a close relationship with their main payers, "*The payers used to call me and say: Go and have a look at this doctor, because there's something wrong there".* The provider would contact outliers to establish why their practices have differed. It was not prescriptive but the process helped to ensure adherence to best practice.

The clinically-led process for investigating outliers kept payers happy and helped the hospital to speed-up its revenue cycle. Hospital costs went down and efficiency increased.

The disadvantages to this approach were not discussed at the roundtable but when providers use local resources to develop guidance the common pitfalls include:

- The process is prone to formalising existing practice rather than delivering care based on current evidence
- The ongoing quality of content is not guaranteed, often there is a lack of resources to keep guidelines updated.

1. Form clinical specialty groups

2. Use data from hospital IT system to create a list of top 10 conditions

3. Specialty groups review and then localize international guidelines

4. Clinical governance committee and hospital Medical Director sign-off guidelines

5. Collaborate with Medical Directors from top 4 payers (based on revenue) to agree the protocols

Figure 1 Overview of steps taken by New Mowasat Hospital in Kuwait to develop clinical guidelines.

EXAMPLE 2: A regulator-led approach to developing evidence-based guidelines in collaboration with providers

DR MEHMOOD SYED described how Hearst Health International is working with the Ministry of Public Health (MoPH) in Qatar along with various providers from the region to develop evidence-based national guidelines – see fig. 2 (right). As with the previous example it is still the responsibility of providers to agree the clinical guidelines but this project is facilitated and financed by a government regulatory organization (MoPH) and there is minimal involvement from payers.

The Qatari guidelines project aims to reduce unwarranted variation in care quality across the country and thereby optimize health outcomes whilst generating improved value from the system as a whole. For patients, these national guidelines will result in more consistent, high-quality treatment in the future.

Dr Altijani Hussin also briefly described why the Dubai Health Authority had introduced guidelines for diabetes and respiratory diseases, "This is mainly because of the data that shows us these are really the lifestyle changes currently affecting the region".

Figure 2 Overview of steps taken by the Ministry of Public Health in Qatar to develop clinical guidelines.

> "WHAT WE'VE SEEN IN OTHER SYSTEMS AND OTHER COUNTRIES… WHERE PAYERS AND PROVIDERS WORK MORE CLOSELY… IS A VIRTUOUS CYCLE WHERE THERE ARE EFFICIENCY IMPROVEMENTS, THERE ARE QUALITY IMPROVEMENTS AND THERE ARE BETTER CLINICAL OUTCOMES." *Mr Ahmed Faiyaz, Senior Manager, EY*

Tackling issues of adherence

THE ROUNDTABLE DISCUSSION highlighted a critical need to establish strong clinical leadership to advocate the use of new guidelines. Involving relevant specialists in the localization of guidelines helps to ensure clinical buy-in from the start. In the ideal scenario there are senior clinical leads within both provider and payer organizations who will engage staff on the use of new evidence-based guidelines.

Ensuring an adequate IT infrastructure is in place also helps to drive adherence. It is easier for providers to change clinical workflow when new protocols or pathways are embedded into their clinical information system for use at the point-of-care. Similarly, payers can improve decision support and streamline workflow by integrating evidence-based best practice and criteria into their software systems.

The roundtable participants discussed the use of financial penalties or incentives to encourage adherence but no conclusions were reached as to the best approach. There was also some disagreement about whose role it was to enforce clinical guidance, however everyone agreed that the best approach is one that is both collaborative and data driven.

Final word

THE ROUNDTABLE MEETINGS highlighted how healthcare payers, providers and regulators can collaborate to improve the system using evidence-based guidelines. Like other research studies, these discussions have shown more attention must be given to implementing and evaluating clinical guidelines in the GCC region. [3]

In summary:

- Evidence-based clinical guidance can help address cost-quality problems
- Regional providers can lead on adapting and localizing international guidelines
- Payers and providers can work together to establish protocols based on agreed evidence
- Claims-based data can be used to help improve adoption of clinical guidance
- Evidence-based protocols and pathways can be integrated into a provider EMR system
- Strong clinical leadership is needed within a provider to encourage adherence to guidelines
- The role of the regulator should be defined when developing and implementing guidance

> "THERE IS A HUGE RESPONSIBILITY FOR THE REGULATOR… WE NEED TO RESPECT THAT THE PROVIDERS HAVE THE EXPERTISE WITH THE LOCAL DOMAIN. WE NEED TO UNDERSTAND THE EFFICIENCIES DRIVEN FROM A PAYER PERSPECTIVE. WE SHOULD NOT RE-INVENT THE WHEEL. WE NEED TO ADOPT THE INTERNATIONAL BEST PRACTICESAND TARGET IT TOWARDS PATIENT CARE."
>
> ***Dr Asma Al Mannaei, Health Authority-Abu Dhabi***

Acknowledgements

These roundtable events were organized on behalf of Hearst Health International. The views and opinions expressed by various contributors at the roundtable do not necessarily represent or reflect the views or opinions of Hearst Health International. Hearst Health International offers independent, unbiased, and evidence based care guidance solutions for supporting safe medication decisions, directing the ideal patient journey, driving high-quality clinical performance, and developing and implementing informed care strategies. Hearst Health International solutions in the Middle East includeFDB MedKnowledge, Map Pathways, ZynxOrder, ZynxCare, MCG Indicia, and MCG Cite.

Roundtable Participants

Mr Mark Adams, Anglo Arabian Healthcare | Dr Mazen Alchihabi, NMC Healthcare | Mr Robin Ali, Dubai Health Authority | Dr. Saif Aljaibeji, UnitedHealth Group | Dr Asma Al Mannaei, Health Authority-Abu Dhabi | Ms. Anita Binu, Orient Insurance | Ms. Eleonora Brero, EY | Mr Farooq Farid, Oman Insurance | Mr Benjamin Frank, Sheikh Khalifa Medical City | Ms. Amal Hmeidan, MedImpact Arabia | Dr. Vemuri Kiran, Now Health International | Dr Eduard Lotz, Anglo Arabian Healthcare | Dr. P. K. Menon, GMC Hospital | Dr. Sameera Merchant, Greenshield Insurance | Dr. Phoebe Ramsis, HealthPoint Hospital | Mr Ayham Refaat, AccuMed | Dr. Marc Ruemmler, HealthPoint Hospital | Ms Helge Springhorn, Mafraq Hospital | Ms Fareeda Subhan, Ministry of Health

Roundtable Facilitators

Ms Laila Al Jassmi, Health Beyond Borders | Mr Ahmed Faiyaz, EY | Dr Altijani Hussin, Dubai Health Authority | Dr Mehmood Syed, Hearst Health International

1. EY Report; 'Investment Big Bets – Healthcare and Life Sciences in the GCC' (2016) http://www.ey.com/
2/3. Koornneef, E., Robben, P., Hajat, C. and Ali, A. (2015), The development, implementation and evaluation of clinical practice guidelines in Gulf Cooperation Council (GCC) countries: a systematic review of literature. Journal of Evaluation in Clinical Practice, 21: 1006–1013. doi: 10.1111/jep.12337

HEARSTHEALTH international