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a finance leader's guide to evidence-based clinical guidelines

If finance leaders are to play a meaningful role in promoting the adoption of evidence-based guidelines, it is imperative that they clearly understand what constitutes truly effective guidelines and how such guidelines are created and deployed.

AT A GLANCE

Finance leaders should understand the process required for the creation of effective, reliable evidence-based guidelines. This process should involve a comprehensive methodology with seven components:

- > Periodic guideline review
- > Literature search
- > Literature review
- > Clinical recommendation consensus
- > External peer review and input
- > Stakeholder input
- > Alignment with established standards

Unwarranted variations in care account for \$210 billion of the \$750 billion in wasted care each year, leaving stakeholders across the board looking for ways to improve outcomes and reduce costs for the various populations they serve.^a Providers, health insurers, employers, and patients alike are striving to maximize their resources to ensure the highest-quality care is delivered at the lowest possible cost. However, given the sheer amount of wasted care afflicting the U.S. healthcare system today, all parties clearly have far to go to achieve these cost and quality goals.

Healthcare finance leaders can contribute meaningfully to this effort, but only to the extent that they are familiar with the tools available to help achieve these common objectives and understand how these tools are best deployed. In particular, finance leaders require a deep understanding of evidence-based guidelines, which provide perhaps the most effective means to eliminate waste, reduce healthcare costs, and improve quality of care.

Enterprisewide adoption of evidence-based guidelines not only helps reduce waste but also offers opportunities to reduce an organization's internal wage and benefit costs, which can constitute up to 59 percent of an

a. Institute of Medicine, *Best Care at Lower Cost: The Path to Continuously Learning Health Care in America*, Washington: The National Academies Press, 2013.

organization's budget.^b Evidence-based clinical guidelines, when combined with the use of physiological duration data, have been shown to positively affect both a health system's employee populations and the population the health system serves. And from a care quality perspective, evidence-based clinical guidelines—especially when incorporated at the point of care—can drive greater patient engagement through more meaningful patient-physician conversations.

Nonetheless, although evidence-based clinical guidelines generally have been directly linked to improved clinical and financial performance, many are not created with a sufficiently strict scientific rigor to ensure that the recommendations are trustworthy and reliable. Moreover, there is confusion in the industry as to what truly constitutes “evidence-based guidelines,” particularly regarding the standards used in creating such guidelines and how they can directly benefit healthcare organizations. Yet clear standards do exist, and it is possible for finance leaders to fully grasp the far-reaching benefits of evidence-based guidelines, the research and development that should go into developing them, and the collaboration with physicians that is necessary to help ensure successful implementation.

Impact of Guidelines on Healthcare Organizations

The Institute of Medicine (IOM) has defined *evidence-based clinical guidelines* as “systematically developed statements to assist practitioner and patient decisions about appropriate healthcare for specific clinical circumstances.”^c The aim for such guidelines is to improve workflow efficiency by delivering actionable information to physicians when and where they need it.

Such guidelines also have been shown to reduce patient care costs by improving outcomes and

reducing unwarranted care variation.^d These factors are important not only to healthcare organizations, but also to employers, which cover health care for 69 percent of non-elderly Americans—a large expenditure for businesses trying to keep workers healthy, while also improving their bottom lines.^e

Healthcare organizations using evidence-based guidelines in conjunction with physiological duration data can return employees to activity more quickly, reducing costs related to wages, benefits, and perhaps replacement labor, while increasing productivity. More rapid recoveries—a topic too seldom discussed among healthcare organizations outside of workers' compensation parameters—is also attractive to commercial health insurers that want to market group health plans with top-performing provider networks to their employer customers.

The return-to-activity metric is a measure of evidence-based clinical guidelines usage combined with duration data. This metric provides a basis for producing a set of recovery estimates that can be used to chart the quickest possible course for a patient's return to activity.

Duration data show likely recovery times for illnesses and injuries across several patient-activity levels, and are informed by millions of cases and carefully vetted by a medical advisory board. When incorporated at the point of care, guidelines and duration data offer patients and physicians concrete, actionable information and goals to discuss, which can motivate the patients

b. Silow-Carroll, S., Edwards, J.N., and Rodin, D., *Using Electronic Health Records to Improve Quality and Efficiency: The Experiences of Leading Hospitals*, The Commonwealth Fund, July 2012.

c. Field, M.J., Lohr, K.N., and the IOM Committee on Clinical Practice Guidelines, *Guidelines for Clinical Practice: From Development to Use*, Washington: National Academy Press, 1992.

d. Neubauer, M.A., Hoverman, J.R., Kolodziej, M., et al., “Cost Effectiveness of Evidence-Based Treatment Guidelines for the Treatment of Non-Small-Cell Lung Cancer in the Community Setting,” *Journal Of Oncology Practice*, January 2010; American College of Obstetricians and Gynecologists, Committee on Patient Safety and Quality Improvement, *Clinical Guidelines and Standardization of Practice to Improve Outcomes*, Committee Opinion. April 2015; Hines, S., Nasser, J., and Green, L., “Reducing Practice Variation at Crystal Run Healthcare,” *Health Affairs Blog*. July 23, 2015.

e. Martinex, M., Zammiti, E.P., and Cohen, R.A., *Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey*, National Center for Health Statistics, January–September 2016.

and increase their engagement in their own recovery.^f

Ultimately, use of evidence-based guidelines in conjunction with duration data can help physicians make safe, effective care choices that enable the overall organization to reduce costs and safely return patients to work and activity, delivering long-term benefits for all stakeholders. The caveat is that the guidelines must be evaluated and chosen correctly.

Guideline Quality

To get started with evidence-based guidelines, the healthcare organization must first select from numerous guideline sets available from medical societies, government bodies and commercial entities. Often, the plethora of guidelines available make it challenging to ascertain whether the highest quality evidence is paired with expert, objective consensus and free from conflicts of interest. Some guideline authors cut corners to save time or money, bypassing the scientific rigor necessary for quality guidelines. Other entities may not disclose their guideline development process, the individuals involved in writing the content, or the financial conflicts among the researchers or peer reviewers. All these issues can significantly affect the credibility and reliability of guideline recommendations. Most important, a lack of scientific rigor in the creation of a guideline may put patient safety at risk.

As state governments begin requiring guidelines for workers' compensation programs, evidence-based guidelines are finding a place in related tools like drug formularies. A prime example is how the state of California recently based its Medical Treatment Utilization Schedule (MTUS) drug formulary on evidence-based treatment recommendations from the American College of Occupational and Environmental Medicine (ACOEM), widely considered the gold

standard in effective treatment guidelines for work-related injuries and illnesses.^g

According to state leaders, California's decision to adopt a formulary tied to clinical evidence was driven by three major goals:

- > Provide the best evidence-based care and drug recommendations for workers.
- > Expedite appropriate treatment.
- > Reduce administrative burden and costs.

All these goals are equally applicable to employers, insurers, healthcare providers, and patients in a value-based care environment, and should be applied by all organizations looking to implement evidence-based tools.

A Rigorous Process

As the very first step in selecting quality guidelines, organizations should verify that methodology used to create the guideline is fully transparent. This comprehensive methodology should include, in the very least, the following seven components, described here only at a very high level.

Periodic guideline review. The editorial team writing the guideline should include a panel of medical experts led by a physician specializing in the particular diagnosis, procedure, or test. All members of the editorial panel should complete an application outlining their qualifications and providing interest and conflict-of-interest disclosures.

Literature search. A guideline development group made up of clinical researchers should search the medical literature for evidence of best practices. The team should document the search strategy and approach used (including sources, search terms, and findings).

Literature review. Although some guideline authors simply cite abstracts of studies, a more rigorous methodology involves complete article reviews,

f. Price, D., "Sharing Clinical Decisions by Discussing Evidence with Patients," *The Permanente Journal*, Spring 2005.

g. State of California Department of Industrial Relations, "DWC Provides Status Report on Drug Formulary, Updates to Medical Treatment Guidelines," Press Release, Aug. 26, 2016

with grading of each study based on qualities such as sample size, study design, population sample, results, study sponsorship, and conflicts of interest. This more in-depth approach ensures that the research used to create the guidelines is as objective as possible.

Clinical recommendation consensus. Based on draft recommendations, medical panels comprising physicians and other clinical professionals should conduct discussions and reach consensus on the strength of evidence for each topic and finalize recommendations for all clinical questions. There should be an explicit link between each recommendation and the supporting evidence.

External peer review and input. An external peer review is necessary to ensure that all relevant high-quality scientific literature related to the topic has been incorporated in creating the guideline. This peer review, which should be conducted by physicians and other clinicians with related guideline expertise, also ensures that the scientific literature relevant to the guidelines has been accurately interpreted.

Stakeholder input. Once finalized by the expert panel of physicians and other providers, the revised or new guidelines need to be reviewed by clinicians in the field. Their feedback should be collected, reviewed and incorporated into the guideline recommendations.

Alignment with established standards. As the final step, the guideline development methodology and oversight should be aligned with national and international guideline creation standards, such as IOM, AGREE II, AMSTAR and GRADE. A physician-led guideline methodology committee should oversee process and ensure compliance.

Case Example: Kaiser Permanente

Adopting evidence-based clinical guidelines is crucial, but so is earning executive and physician buy-in. And that buy-in can be obtained only by demonstrating the positive patient outcomes and financial returns the guidelines can deliver to an organization. Looking at an organization's ability

to return patients to activity quickly and efficiently is one way to gauge the positive financial impact of using evidence-based guidelines.

Oakland, Calif.-based Kaiser Permanente provides a case example of how best to undertake this process. Kaiser Permanente reported savings of \$90 million over three years by helping patients return to health faster than population benchmarks. The health system realized these results after conducting a needs-assessment survey of its physicians to identify tools and resources that could help them return patients to activity more safely and efficiently. This physician input eventually led Kaiser Permanente to develop a custom-built electronic disability documentation and communication tool, called the activity prescription form (ARx), which it launched in 2011.

The ARx incorporates evidence-based guidelines from the American College of Occupational and Environmental Medicine (ACOEM), which include clinical content for prevention, diagnosis, prognosis, follow-up, and treatment. Kaiser Permanente physicians also use duration data to set recovery expectations with their patients and then pinpoint estimated physiological healing times for illness and injury.

In addition to the access to these various components provided through the ARx tool, a physician-supported educational program was launched, aimed at providing hands-on access and training to physicians in all Kaiser Permanente regions. After three years of using the ARx, Kaiser Permanente patient case data was benchmarked against a proprietary population database informed by millions of real-world cases. Kaiser Permanente's cases also were compared with the "physiological optimum" benchmark, which identifies the "optimum" recovery timeframe for patients with uncomplicated cases to return to full activity.

Kaiser Permanente found that patients' disability durations in its Northern California region outperformed benchmarks by 350,121 days per

year, which translated to yearly savings of \$30 million in wages, benefits, and replacement labor. The health system's data analysis also found that an incremental 12,349 days per year (approximately \$1 million) could be saved if all patients could more quickly proceed through modified-duty status and return to full-duty employment within the population average duration.

Kaiser Permanente's experience shows that promptly and safely returning patients to activity delivers benefits to all stakeholders: the provider, the insurer, the employer, and, especially, the patient. Patients, in particular, are more engaged in their care because they have an opportunity to discuss evidence-based treatment options and establish concrete recovery expectations with their physicians at the point of care.

Physician Buy-In

Organizations may face obstacles to earning physician adoption of evidence-based clinical guidelines. Physician objections can be effectively overcome, however, if organization leaders listen to physicians' concerns and provide them with education on the organizationwide benefits of such guidelines and their impact on a physician's practice.

The first educational step is to assure physicians that the guidelines are only a starting point. They do not supersede physicians' years of training or experience, nor will they interfere with the physician-patient relationship. Rather, the guidelines should be perceived as being only a support tool designed to help physicians stay abreast of quality evidence that should influence their care decisions in any event. Physicians should understand that global scientific output doubles every nine years, which makes it impossible for any practicing clinician to stay current and evaluate quality research.^h

Along these lines, the next step in promoting physician adoption is to describe the scientific rigor, including all the unbiased reviews, that

goes into developing the guidelines, to demonstrate to physicians that the recommendations are credible, reliable, and worthy of integration into their workflow.

It also is essential that the recommendations be integrated into the electronic health record (EHR) to give physicians the assurance that the guidelines will not slow them down, nor will they need to learn a new IT system. EHR integration allows the physician to easily access duration and treatment recommendations and document the information in the patient chart, thereby ensuring the ongoing efficiency of physicians' workflows, which is not only an important adoption factor, but also a cost driver and top-line revenue growth issue for the organization.

Analyzing recovery times among the organization's own injured or sick employees also can be helpful in obtaining physician acceptance of both evidence-based guidelines and duration data. Performance on this measure compared with the population database and physiological optimum benchmark can offer insight into where physicians might require the most clinical guideline support.

Implementation of evidence-based guidelines alongside duration data also provides a basis for physicians to have more meaningful discussions with patients at the point of care about a procedure or treatment plan, offering specific recovery times. By providing patients with concrete recovery goals, this enhanced process can help patients feel more engaged in their health and with their providers.

Clear Evidence

Adopting evidence-based clinical guidelines supports improved financial performance, regardless of any changes that may occur in value-based payment or government regulation. Faster, safer recoveries from illness or injury always lead to reduced healthcare costs. By using proven, evidence-based tools and, as a result, achieving faster recovery times compared with

^h Van Noorden, R., "Global Scientific Output Doubles Every Nine Years," *Nature* newsblog, May 7, 2014.

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industry benchmarks, a provider can demonstrate to health plans and employers its ability to help lower costs for their members and employees.

However, adoption of evidence-based guidelines will become prevalent only with the support of all stakeholders. Finance leaders can contribute to this process by fostering an approach that includes due diligence and an open collaborative process with physicians, and that reflects a thorough understanding of how truly evidence-based guidelines are created and implemented. Successful enterprisewide adoption will depend on demonstrating the scientific rigor behind the guidelines and integrating the tools at

the point of care to ensure workflow efficiency. As physicians experience better outcomes and more satisfied patients, clinical guideline adoption will become culturally embedded, driving long-term operational efficiency and financial growth. ■

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