Guidelines for Referral Health Care in Lebanon

Standard Operating Procedures

Lebanon

June 2015

UNHCR
The UN Refugee Agency

List of Abbreviations

CVD	Cardiovascular Disease
ECC	Exceptional Care Committee
HIV	Human Immunodeficiency Virus
ICU	Intensive Care Unit
MoPH	Ministry of Public Health
MVA	Motor Vehicle Accident
NICU	Neonatal Intensive Care Unit
PHC	Primary Health Care
PHU	Public Health Unit
SAM	Severe Acute Malnutrition
TPA	Third Party Administrator
UNHCR	United Nations High Commissioner for Refugees

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1. Introduction

Since the onset of the civil war in Syria, people have fled to neighboring countries. By the first week of January 2015, 1,148,844 Syrians have been registered with UNHCR Lebanon office. Refugees in Lebanon are living among the Lebanese population predominantly in urban settings.

In addition, Lebanon hosts around 15,200 refugees mainly from Iraq, Sudan, and Somalia.

The standard operating procedures (SOP) for referral care outline the policy and procedures and are applicable to all the UNHCR registered refugees in Lebanon excluding Palestinians who fall under the mandate of UNRWA.

However:

- Lebanese and Palestinian women/men married to refugees are not eligible to receive support for health care through UNHCR.
- Other groups, including migrants, third citizens and their spouses and families are not eligible for UNHCR assistance.

2. UNHCR Public Health Approach[1]

UNHCR's Public health approach is based on the primary health care strategy.

UNHCR's role is to *facilitate* and *advocate* for access through existing services and health service providers and to *monitor* access to health care services. While the primary health care strategy is the core of all interventions; referral care is an essential part of access to comprehensive health services.

3. Referral Health Care

Referral health care is defined as care than cannot be provided at Primary Health Care level. Patients are referred to a higher level of care which can be divided into secondary and tertiary health care:

Secondary health care is an intermediate level of health care that includes diagnosis and treatment performed in a hospital or health center having specialized personnel, equipment, laboratory facilities, and bed facilities.

Tertiary health care is more specialized medical care for patients who are usually referred from secondary care centers. It includes subspecialty expertise in surgery and internal medicine, diagnostic modalities, therapeutic modalities for treating advanced and/or potentially fatal diseases.

UNHCR aims to support referral health care to refugees at similar levels of care to that received by the average Lebanese in government health facilities. UNHCR is able to support access to secondary and tertiary health care for life-saving and obstetric care only.

UNHCR contracts a third party administrator (TPA) to contract a network of hospitals where refugees can access care. UNHCR seeks to standardize fees to follow the Ministry of Public Health (MOPH) fixed rates. The TPA is responsible for the medical and financial audit of the referral care programme.

[1] UNHCR Public Health Operational Guidance Document June 2013

Refugees may choose to access health services outside this network but will be charged for services and UNHCR will not refund the costs incurred.

3.1 Principles of Referral Care

1. **Medical referral care is initiated at the primary health care (PHC) level**

The PHC center should be the gatekeeper for referral care to avoid unnecessary referrals. When referral is necessary, it should be initiated at the PHC.

All PHCs and supporting partners providing services to refugees should be familiar with the UNHCR guidelines for referral health care. In case of doubt, the physicians at the PHC center should call the TPA hotline to verify that the referred condition falls within the SOP for referral care.

Refugees presenting directly to hospitals for non-life threatening emergencies will be referred to the nearest PHC.

2. **Referral care is based on transparent procedures and decisions are primarily based on prognosis and cost**

For lifesaving cases, prognosis is the most important criteria. The prognosis determines the rationale to attempt to provide certain treatment(s). The prognosis must be assessed by a qualified medical doctor. Cost considerations are also important and treatments must be evidence-based, cost-effective and within the budgetary means.

3. **Referral care is always a medical decision**

Referral care is based on the SOP, decided upon, and cleared by a medical doctor. All referral care supported by UNHCR will be limited to cases where ***the life or basic functions are at stake.***

4. **Medical confidentiality is ensured throughout the referral care process.**

➔ **Please refer to** *Annex 4- Medical Data Confidentiality*

5. **Cost sharing in referral care**

UNHCR's financial contribution for secondary and tertiary hospital care is 75% of the total bill and the patient is requested to pay 25%.

Refugees will be responsible for covering 25% of their medical expenses at referral care level, while UNHCR will cover the remaining 75%.

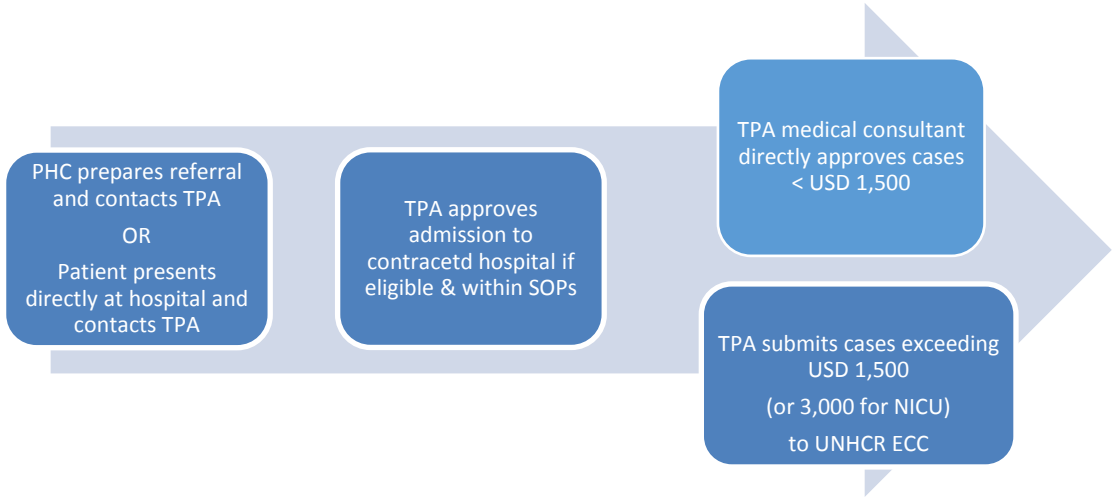
If a refugee is unable to pay 25% of the expected contribution and the TPA ascertains so, the TPA refers the case to the case management agency in the area within 24 hours. The latter will conduct a vulnerability assessment and forward the recommendations to the TPA and UNHCR and coverage may be increased.

6. The referral hospital network

Referral health care services are offered through a network of public and private hospitals throughout Lebanon who are contracted by the TPA. This list is subject to review based on need. (See *Annex 1– TPA contracted referral hospitals*)
In a medical emergency, refugees should present to the nearest hospital in the network.

Coverage will not be approved at a non-TPA contracted hospital unless the service required is unavailable within the network and referral has been officially approved.

3.2 Referral pathway



- **Referral is either from the PHC or a refugee may self-present to hospital in an emergency. In both cases, the TPA must be contacted (by the referring PHC, the patient and receiving hospital respectively).**
- **The TPA has authority to approve coverage for cases falling within the SOPs and cost estimate is less than USD 1,500.**
- **The TPA will submit cases with full medical file to UNHCR/ECC for cases above USD 1,500 and those cases approved below USD 1,500, but which will be expected to exceed this amount during hospitalization.**
- **Cases of premature newborns will be referred to UNCHR/ECC when the hospitalization is expected to exceed USD 3,000.**
- **If a person is thought to be a refugee but not yet registered with UNHCR, the TPA will approve admission and submit a request for fast track approval to the relevant UNHCR registration unit within 24 hours. If the person is considered to be of no concern to UNHCR, support will be discontinued immediately.**
- **Please refer to *Annex 2 for a list of common cases that will and will not be covered by UNHCR respectively.***

3.3 Referral to UNHCR

Once the TPA approves admission to a hospital and foresees that costs will exceed USD 1,500, it is required to inform UNHCR via confidential e-mail **no later than 24 hours after admission.** The email is to contain all relevant information regarding bio data, registration status, and brief description of the case with the medical delegates' professional assessment and a cost estimate. Attachments to the email should include UNHCR certificate, medical claim form, medical report, and supporting diagnostic tests and/or reports.

3.4 Feedback

UNHCR will reply within a **maximum of 24 hours after completed documents have been received**. The TPA will contact UNHCR by telephone for urgent cases.

3.5 Follow-up during hospitalization

The TPA is to provide at least weekly updates on the admitted cases. A medical "progress note" is expected to be attached detailing current medical status with treatment being provided and plan.

In the event that UNHCR decides to stop coverage of a patient due to poor prognosis, costs exceeding the ceiling or that the treatment is not covered by UNHCR, the hospital and patient shall be duly informed and counseled by the TPA.

➔ **Any extended hospital admission beyond the initial estimated stay should be mentioned with the reason for extended hospital stay.**

3.6 Discharge

Once the patient is ready to be discharged, the TPA will email UNHCR with the total estimated cost along with patient's status.

A medical report detailing diagnosis, treatment provided, and follow up required including medication to be taken should be attached where a copy is to be given to the patient, a copy retained by PHU, and a copy by the TPA.

3.7 The Exceptional Care Committee (ECC)

Experience has showed that PoCs registered with UNHCR often suffer from serious and complex diseases. Treatments of such cases are often complicated, protracted and expensive. As a result, an Exceptional Care Committee (ECC) has been established by UNHCR.

Beyond a cost of USD 1,500 per patient (or USD 3,000 for NICU cases), the UNHCR ECC must review the case for the patient to receive/continue his/her treatment. The ECC will decide on whether to support or reject treatment for the case as well as the level of support to be provided. The decisions of the ECC are first based on prognosis for the referral, followed by the costs. Concomitant illnesses that affect the prognosis will be considered by the ECC.

The ECC will ensure a coordinated and transparent decision making process for all referrals. This ECC consists of three anonymous expert medical professionals and is independent in its decision-making. The ECC meeting (held bi-weekly) is chaired by the Senior Public Health Officer and the Senior Public Health Assistant acts as the secretariat for the ECC and is responsible for the preparation, communication, documentation, and follow-up including the provision of minutes for each meeting.

The ECC will also review 10% of cases approved by the UNHCR Public Health Associate to verify if approval has been according to life-saving criteria.

a) Referral criteria

The TPA will submit all individual case files to the ECC at least 48 hours before the ECC meeting. Urgent cases must be submitted by email in case an ECC decision is required before the scheduled meeting. ECC members are contactable ad hoc for emergency decisions.

The following shall be included in the file:

1. Basic information about the patient such as name, sex, date of birth, UNHCR ID number.
2. Statement from a medical consultant/specialist on the diagnosis, treatment management plan (treatment stages and treatment required in each stage) and prognosis of the patient with and without the recommended treatment. This should include an estimate of the total cost.
3. Concomitant illnesses that may affect treatment of the disease for which the patient was referred.

➔ **Note that there will be a ceiling of USD 10,000 for each case referred to the ECC.**

b) Decision criteria

The committee reviews each case based on criteria:

- Eligibility (a person of concern to UNHCR)
- Necessity, adequacy and duration of the suggested treatment
- Concomitant diseases and age
- Feasibility of the treatment plan
- Prognosis
- Cost

Decisions of the committee will be communicated within 24 hours or earlier in case of emergency. UNHCR will keep a confidential database of referred cases and ECC decisions.

3.8 Specific aspects of referral care

1. Delivery Care

UNHCR/TPA has negotiated a package for delivery services (Normal Vaginal Delivery and C-sections) within the referral network. Approval by the TPA is required before cesarean section to ensure there are clear medical indications for the procedure.

2. Intensive Care

Cases requiring intensive care unit (ICU) admission will be covered for the first 48 hours after which UNHCR will need to approve any extension. Cases hospitalized for more than a week will be reassessed, where coverage may discontinue depending on prognosis.

3. Neonatal intensive care

- UNHCR is unable to support neonatal intensive care unit (NICU) care for preterm extremely low birth weight babies (poor prognosis even with treatment) of less than 26 weeks gestational age. Support and counseling will be provided to the parents on appropriate care measures.

- UNHCR will support NICU care for very low birth weight babies between 1,000 to 1,499 grams birth weight / preterm infants (26-32 weeks). Such babies should be discharged at 1,750 grams when no other complications with appropriate counseling to the mother and follow up of the neonate planned. The TPA must submit at least a weekly report to UNHCR/ECC.
- Low birth weight / preterm neonates (>32 weeks) between 1,500 to 1,749 grams birth weight with no other complications: Train the mother on Kangaroo care for the newborn, support exclusive breast feeding, administer vitamin K and follow up of the neonate closely. If the baby cannot be breastfed, give expressed breast milk using an alternative feeding and train mother accordingly. Discharge when the baby is over 1,750 grams and meets the above criteria.

All neonatal cases will be reviewed by the ECC, even prior to discharge. The information for submission to the ECC must contain the hospital's neonatal intensive care unit (NICU) chart kept for each NICU case.
Children born with severe congenital conditions will be immediately discussed by the ECC to decide if UNHCR will provide coverage.

4. *Congenital Heart Diseases:*

Patients less than one year of age with an immediately life-threatening condition and hypoxia on room air will be considered for coverage. All CHD cases will be evaluated on a case by case basis taking into account any associated syndromes that may affect overall prognosis.

5. Cerebrovascular disease and cardiovascular disease (CVD)

- Cases admitted with Cerebrovascular Accident (CVA) will be assessed on a case-by-case basis depending on prognosis, complications, and Glasgow Coma Scale (GCS) to determine coverage. For cases covered, the TPA should provide updates at least weekly.
- When thrombolysis in indicated in acute Myocardial Infarction, streptokinase is cost effective and will be covered; other thrombolytic drugs will not be covered.
- All patients with acute coronary syndrome (ACS) that require percutaneous transluminal coronary angioplasty (PTCA) or coronary artery bypass graft (CABG) must be referred to UNHCR for ECC specialist review prior to accepting coverage. PTCA will be covered only if bare metal stents are used; drug-eluting stents will not be covered. CABG will only be approved if clearly indicated and at pre-designated contracted hospitals.
- Defibrillators will not be covered while pacemakers may be considered on a case-by-case basis by the ECC.

6. Orthopedics/trauma

Most orthopedic cases will be referred to the ECC for approval of procedure except those that are immediately lifesaving such as trauma to the head resulting in intracranial hemorrhage and necessitating a craniotomy and open fractures of long bones (see *Annex 3 – Orthopedic Cases*). Orthopedic implants/devices are not. Removal of implants is not covered and prostheses are not covered by UNHCR.

7. Hematological Conditions

All blood disorders (including thalassemia) will only be covered for lifesaving emergency transfusion of Packed Red Blood Cell (PRBC) or Fresh Frozen Plasma (FFP). No other treatments including Immunoglobulin G will be covered.

3.9 Emergency Room (ER) Health Services

Coverage will be approved if the treatment needed is considered lifesaving in which case the patient is likely to be admitted to the hospital. Any refugee attending ER services for a non-emergency will need to cover the costs themselves.

3.10 Motor Vehicle Accidents

It should be ascertained whether the refugee or the other party have insurance policies that cover costs under the insurance entitlements.

For refugees involved in a **Motor Vehicle Accident** (MVA):

- Accidents involving 2 vehicles (cars and/or motor cycles), whereby the vehicle with injured refugees belongs to a refugee and the passengers are the owner's relatives, UNHCR will NOT cover any health care costs.

- Accidents where the owner/driver is not related to the passengers, UNHCR will cover for the passengers (provided they are refugees) only under co-funding conditions. Accidents involving pedestrians (such as hit-and-run), UNHCR will cover for the pedestrians only.

3.11 Transfer of Patients

Should patients require transfer to another hospital within the network due to unavailability of services, the referring hospital should inform the TPA of the need for transfer. The referring hospital should contact the receiving hospital with the medical details of the referral. The TPA may be required to facilitate the admission at the receiving facility.

3.12 Record Keeping/ Data

The TPA has access to UNHCR's updated and accurate list of all registered refugees and has signed a data sharing agreement.

Hospitals will take a photocopy of the registration certificate of the patient to be included in the confidential medical file.

3.13 Monitoring and Evaluation of Referral Care

There is a monitoring and evaluation framework for the referral care programme which includes the following:

- Monthly monitoring of referral care data supplied in TPA reports
- Monthly medical audit by UNHCR of 1% of hospital bills
- Biannual and annual detailed referral care report
- Periodic verification visits to hospitals including for proof of payment by TPA
- Ongoing monitoring of the TPA through a set of key performance indicators (KPIs)
- Periodic external evaluation of the referral care programme
- The contracted hospitals can expect to be audited by the TPA and UNHCR or a UNHCR authorized entity. The hospitals will facilitate the TPA's and/or UNHCR's review of the records of patients

referred to them respecting medical confidentiality. In addition, UNHCR staff members may visit UNHCR-referred patients.

- Cases of fraud which include but are not limited to: forged medical reports, forged diagnostic reports, over charging and non-existent admissions will result in an official warning letter to the hospital from the TPA or immediate contract termination.

- A complaints mechanism to be established whereby patients may report complaints to the TPA which will be dealt with in a confidential manner and reported to UNHCR.

3.14 Legal Issues

UNHCR and the TPA shall not be held responsible for malpractice, physical or mental harm or adverse outcomes of medical interventions provided by the contracted hospitals or any third party hospital that have admitted referred refugees. All these incidents will have to be settled between the treating hospitals and the patient or his/her family

Annex 1 – TPA Contracted Referral Hospitals by Region (subject to frequent review and updates)

BEIRUT REGION	
1	RAFIK HARIRI UNIVERISTY
2	ZAHRAA
3	SAHEL
MOUNT LEBANON REGION	
4	BAABDA GOV
5	DAHR EL BASHEK GOV
6	BWAR GOV/ FTOUAH
7	BEIT SHABAB
8	IKLEEM
9	AIN W ZEIN
10	N D LIBAN
11	AL WATANI
12	LEB CANADIAN
13	IRFAN
14	BSHAMOUN
15	OTHMAN
16	HOSPITAL DE LA CROIX
17	AL JABAL
BEKAA REGION	
18	BEKAA
19	HERAWI GOV/ ZAHLE
20	DOCTORS
21	FARHAT
22	RAYAN
23	HERMIL GOV
24	RAYAK
25	MORTADA
26	RASHAYA GOV
27	TEMNIN GENERAL
28	IBN SINA
29	TATARI
30	MAYYAS
31	CHTOURA

NORTH REGION	
32	SALAM (BURNS)
33	MAZLOUM
34	N D LA PAIX
35	EL KHEIR
36	TRIPOLI GOV
37	MONLA (CARDIO)
38	ISLAMIC HOSP
39	SIR EL DONNIEH GOV
40	AL HANAN
41	To be decided
42	To be decided
SOUTH	
43	DALAA
44	SAIDA GOV
45	MARJAYOUN GOV
46	HEALTH MED CENTER
47	LEBANESE ITALIAN
48	KASSAB
49	TEBNIN GOV
50	HIRAM
51	ALAADINE
52	JEZZIN GOV
53	RAEE
54	NABATIEH GOV
55	HASBAYA GOV
57	HAYAA CHAABIYA /BINT JBEIL
58	HAMMOUD (CARDIO)
59	GHANDOUR

Annex 2- Examples of Cases Covered Versus not Covered by UNHCR

1. Examples of Emergencies (obstetric, medical and surgical) procedures to be covered

- Normal Vaginal Delivery and C-sections if indicated
- Neonatal incubator when indicated for pre-term babies born at or above 26 weeks gestation
- Acute severe respiratory diseases in children and adults
- Acute gastrointestinal diseases that require surgical intervention
- Acute Myocardial infarction (heart attack)
- Open fracture of long bones
- Sepsis/ Septic shock
- Acute life threatening exacerbations of pre-existing chronic diseases.

2. Questionable cases to be submitted to ECC

- Orthopedic cases (including motor vehicle accidents)
- Surgical cancer cases that are potentially curable and are life-saving
- Burn cases
- Congenital neonatal conditions
- Treatment of Urinary tract calculi
- Hernias: approved for acute strangulated cases only.
- Orchidopexy cases: to be reviewed on a case by case basis

3. Cases that will not be covered

- Cosmetic /plastic/reconstructive surgery/ skin grafts (this includes burn cases which would require skin grafts)
- High cost treatment when less costly alternative treatment is equally effective and available
- Experimental, non-evidence based treatment
- Organ transplant
- Infertility treatment
- End-stage cancer treatment (including surgery, radiotherapy and chemotherapy)
- Long term treatment necessitating nursing care
- Motor Vehicle and Work Accidents where an insurance/ employer is liable to cover the health care
- Hemodialysis for chronic renal failure
- Chronic care for haematological conditions such as haemophilia and thalassemia

Annex 3 - Orthopedic Cases

A. Approved:

1. Open fresh fractures with need for surgical intervention to complete the treatment.
2. Debridement of soft tissue and bone in open wounds and fractures (Gustilo classification II and III) and in osteomyelitis.
3. Nerve injuries in the upper limb which includes the brachial plexus.
4. Primary tendon repair.

N.B. All cases referred to UNHCR should have radiographic films (X-rays, CT scans, and MRI) attached as well as culture results where applicable (such as in debridement). All lumbar surgeries (including laminectomies) will be assessed on a case by case basis with referral to the ECC.

B. Not Approved :

1. Mal-alignment with acceptable function but the patient is not satisfied with the result.
2. Sciatic nerve injuries in not part of an acute injury or trauma or complete nerve injury with trophic changes.
3. Very stiff hands with intra-articular fibrosis that prevent any further improvement of the function.
4. Face injuries with big soft tissue or bony defects that require surgical intervention, including injuries that affect the function of the mouth, orbit, nose, and ears.
5. Cosmetic, post trauma surgeries of the ear or nose.
6. Cases where the nerve was explored previously and was released or repaired.
7. Complex surgeries for reduction and fixation of fractures that are old but not treated, or those with malunion including intra-articular malunions.
8. Tendon graft or transfer
9. Bone transplant procedures or free vascularized grafts for bone gaps.
10. Primary nerve repair or exploration or graft
11. Post-burn contracture release

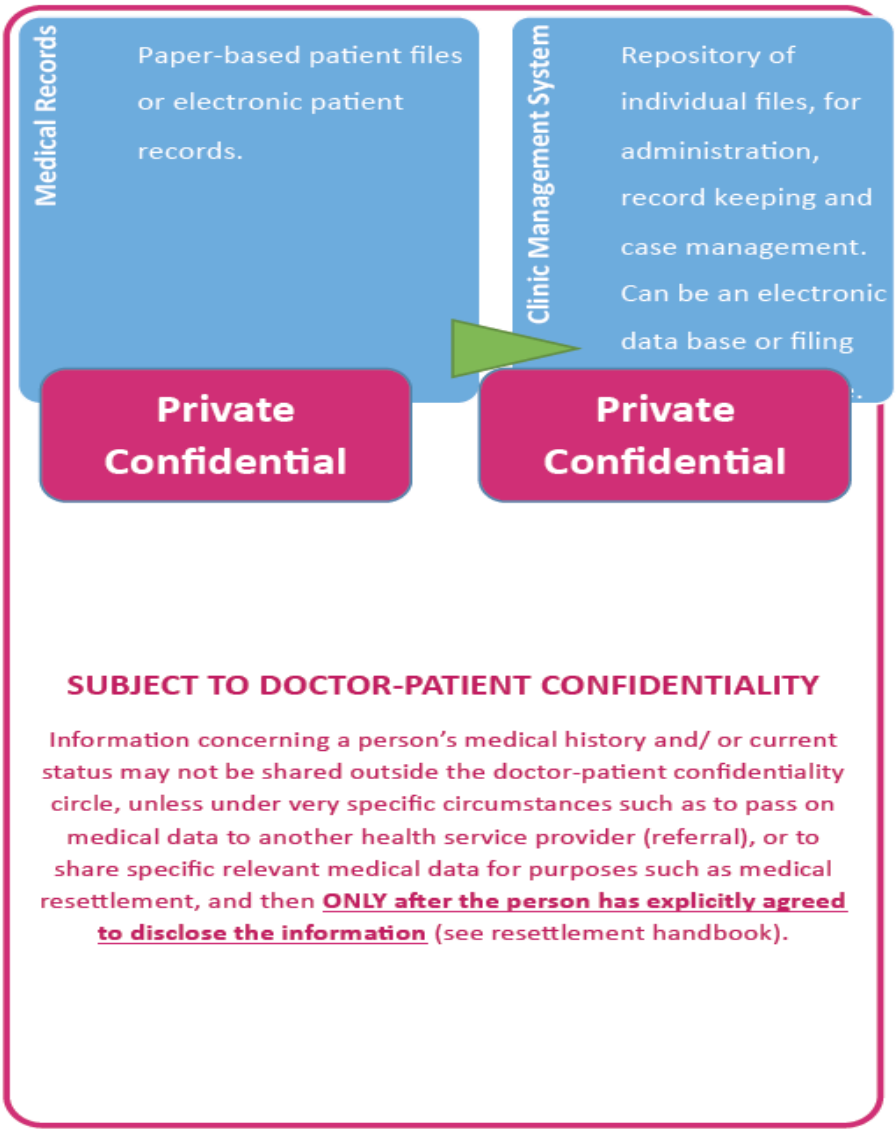
Annex 4- Medical Data Confidentiality

Medical Data Confidentiality

Any medical data that has an individual identification tag is subject to data confidentiality. This includes medical records, referral forms, medical reports (diagnostic, hospital) and any other forms such as health insurance claims and medical assessment forms (MAF), such as those relevant to UNHCR, i.e. the MAF for medical resettlement.

Personal data in medicine and health is related to the **doctor-patient-confidentiality privileges** that are the basis of medical ethics as well as anchored in national and international laws.

Any sharing of this data outside of the doctor-patient relationship requires the agreed and explicit consent of the individual in writing to a disclosure of information agreement.



Annex 5- Guidance on Data Required for Monitoring and Reporting

List of database variables

Variable	Variable description. Options for pull down menus are in curved parenthesis {}
Unique patient id (generated by TPA system - not to be confused with hospital number)	Unique ID provided
UNHCR ID	UNHCR registration number
Full Name	Full name of patient
Gender	Gender {Male, Female}
Date of birth	Date of birth (ensure format is fixed)
Age	Age at time of referral
Nationality	Nationality of refugee {Syrian, Sudanese, Iraqi, Other}
Region of residence (patient)	Region where the patient is registered to receive care
Caza of residence	District of residence {Caza, Governorate}
Referred by	Agency or facility referring the patient
Date referred	Date patient was referred
Facility name	Hospital or other health facility name
Hospital location region	Region where hospital is located and where care was sought
Admission date	Date patient presented to hospital
Referral type	Emergency/ in-patient services
In-patient category	for inpatients only: (Medical/ surgical/obstetric & newborns)
Provisional diagnosis	Provisional (initial/preliminary) diagnosis
Provisional diagnosis category	Provisional (initial/preliminary) diagnosis category
Initial approval	Initial approval of referral request
Date approved	Date approved (ensure format is fixed)
Reason for rejection	Reason for not approving
Referred to UNHCR	Referred to UNHCR?
Date referred to UNHCR	Date referred to UNHCR
UNHCR approved	Referral approved by UNHCR {Yes, No}
Date UNHCR approved	Date UNHCR approves referral
Referred to ECC	Was patient referred to ECC?
Date referred to ECC	Date ECC approves referral
ECC approved	Was referral approved by ECC?
Date ECC approved	Date ECC approved referral
Obsetric reasons	Reasons for obsetric referral
Obstetric outcomes	Maternal outcomes
Neonatal outcomes	Outcomes on "discharge" for infants (<2 days) born or treated in hospital
Service type	Type of health service provided - listed separately for each sub-services charged). Per admission (note that there should be a sub-charge associated with each sub-service performed. The total cost of admission should be calculable by adding up the sub-charges.
Investigations (yes/no)	Were any investigations carried out?
Investigations (if any)	If yes, what investigation?
Amount approved	Amount of money approved. (USD or LP) (use only one currency)

Co-payment proportion	**Proportion of co-payment applicable {75%, 90%, 100%}**
Date discharged	**Date patient discharged**
Discharge diagnosis	**Final diagnosis at end of management whether as outpatient or inpatient**
Discharge diagnosis category	**Final diagnosis category (categorization of diagnosis)**
Bill finalization status	**finalized/not finalized**
Initial estimated cost	**The estimated cost on initial referral**
Final estimated cost	**The estimated cost after treatment but before discount or audit**
Deducted amount	**The costs deducted after audit**
Deduction reason	**Reason for deducting from the estimated costs**
Final total bill	**Final total amount to be paid**
Proportion covered by UNHCR	**Proportion to be paid by UNHCR**
Proportion covered by NGO or through other support	**Amount covered by implementing partner, other NGO, or through other support**
Proportion covered by refugee	**Amount covered by refugee**
Final status	**Final vital status on discharge { alive, deceased, not known}**