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Mayo Clinic Laboratories uses data, clinician teams to identify cost savings

Laura Ramos Hegwer

Just one lab utilization initiative can have a massive financial impact, says Andrew Cousin of Mayo Clinic Laboratories. Don't be so overwhelmed by the scope that you do not take that first small step.

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+ laboratory strategies +

Mayo Clinic Laboratories uses data, clinician teams to identify cost savings

Laura Ramos Hegwer

In this interview, Andrew Cousin, MBA, FACHE, senior director of strategic planning for Mayo Clinic Laboratories, discusses how his organization uses EHR and claim data to identify opportunities to reduce unnecessary utilization and the total cost of care.

On preparing for value-based care. In 2015, leaders at Mayo Clinic Laboratories recognized that combating unnecessary utilization was essential to thriving under value-based care. Specifically, they wanted to reduce orders for tests that were not appropriate for patients' conditions or did not add value to patient care plans.

Leaders recognized that clinicians often struggle to keep up with the latest in laboratory medicine, given that the lab adds 150 new tests to its menu of 3,000 tests each year. And because treatment guidelines are continually evolving, "no practitioner could possibly be expected to keep abreast of all the dynamic changes on our menu and in our best practices," Cousin says.

To remedy this problem, leaders set out to collect data on clinicians' ordering patterns and identify strategies to reduce inappropriate utilization, such as changing default order sets.

On investing in analytics. To begin the project, leaders tapped into Mayo Clinic Laboratories' in-house analytics experts and data tools. "Our team has made investments in process engineers and business analysts who can really look at data from different points of view," he says.

Because Mayo Clinic Laboratories is a global reference laboratory that provides testing and pathology services to 4,000 healthcare organizations, leaders could use their analytics tools to compare Mayo Clinic's ordering volumes by specialty against median ordering points at their peer institutions. From there, they could identify outliers.

"When we saw an outlier that didn't fit with the macro patterns, we tried to understand why and what was driving that difference," Cousin says. "We wanted to understand if clinicians' [ordering habits] were clinically appropriate and clinically additive. If the answer was no, that gave us a place to dig into and effect change in that particular area of practice."

To understand differences in ordering patterns, analysts also looked at specific categories of practitioners. Were residents over-ordering compared with more senior practitioners? Or vice versa?

In some cases, we are increasing laboratory costs, but we are doing so in a way that decreases the total cost of care by reducing length of stay, pharmaceutical spend or readmissions.

On reducing inappropriate genetic testing. To identify potential cost-savings opportunities from the data, Mayo Clinic Laboratories used their multidisciplinary clinical teams called disease-oriented groups, which include surgeons, pathologists, pharmacists, genetic counselors and other clinicians. The groups, which receive support from a financial analyst, discuss the appropriate application of laboratory testing, pathology and genetic testing to manage various conditions, Cousin says.

In one example, a disease-oriented group examined clinician ordering of Factor V Leiden mutation analysis, a type of genetic test that detects an inherited blood clotting disorder. After reviewing the claims data, they estimated that 81% of testing was unnecessary — many clinicians

ordered it before ordering a less costly enzyme test called activated protein C resistance (APCR) screening that can detect a patient's risk for developing a blood clot. The disease-oriented group reviewed the latest research and determined that the more costly genetic test should only be used when the patient has a family history, or the answers cannot be ascertained through an APCR test.

"The over-ordering of genetic tests was driving unnecessary costs for those clinical episodes," Cousin says. "That change alone would result in an estimated savings of almost $317,000 per year for that patient population." That translated to $0.01 cent saved per member per month.

On promoting genotype testing to decrease the total cost of care. Leaders also wanted to examine the claims and EHR data to determine how they could use appropriate laboratory testing to reduce adverse drug events and decrease the total cost of care. Specifically, they examined what would happen if they promoted a specific type of pharmacogenomic test (CYP2C19) for patients requiring a percutaneous coronary intervention (PCI). This test would help ensure that clinicians used the right blood thinner based on patients' genotypes.

After conducting their analysis, they realized that making this test the standard of care for PCI patients could prevent costly adverse drug events, saving an estimated $1.7 million per year, or approximately $0.04 cents per member, per month.

This example demonstrates the importance of how laboratory testing affects the entire episode of care. "As we're looking at utilization, we need to make sure we do not manage our balance sheet in a silo," Cousin says. "Some of the savings that we are driving are not creating savings in the laboratory. In some cases, we are increasing laboratory costs, but we are doing so in a way that decreases the total cost of care by reducing length of stay, pharmaceutical spend or readmissions. So we have to measure the cause and effect longitudinally of what laboratory medicine is doing to an episode of care."

On using clinical decision support. After reviewing these two genetic testing hypotheses, leaders at Mayo Clinic programmed new rules into their clinical decision support platform, which now displays "smart alerts" in the EHR to promote appropriate test ordering by physicians at the time of order entry. The alerts let clinicians know when they are ordering an inappropriate test, such as with Factor V mutation testing for certain patients. Or an alert may suggest pharmacogenomics testing when a specific blood thinner is ordered for PCI patients.

Leaders also are using their analytics tools to monitor clinicians' current ordering behaviors. This continuous review process is critical to sustaining behavior change and realizing cost savings, Cousin says.

We have to look at other ways of contracting so the payer and provider are jointly aligned to benefit from the savings created.

On what operational and finance leaders can do. In many cases, default order sets in the EHR are to blame for over-ordering of tests, Cousin says. Operational leaders can support clinicians and promote more appropriate ordering by working with IT and service line leaders to change order sets.

Finance leaders also can help support service line leaders looking to change clinicians' ordering behavior by helping them understand the latest coding rules affecting laboratory tests, Cousin says.

On understanding laboratory costs. Cousin recognizes that laboratory medicine can be a difficult area for finance leaders to understand, in part because of the complexity of today's emerging genetic tests. However, "there are tremendous opportunities at the enterprise level to think about how the laboratory can be a financial catalyst to your organization and drive savings not just in your own shop but also across different areas of practice, such as inpatient care, pharmacy, readmissions and length of stay," he says. "We are proving in our own practice that cost increases in the lab can be offset by greater savings elsewhere along that episode of care."

Cousin urges finance leaders to recognize that two factors can drive up laboratory costs: the cost per test and the number of tests ordered. "There is a tremendous amount of rigor at the private and public level to drive down the cost per unit," he says. "The other opportunity for big savings is to drive down the number of unnecessary units ordered."

Cousin says providers and insurers need to work together to address inappropriate utilization of laboratory tests. As such, healthcare providers are using their data analyses to demonstrate to payers that they can drive down costs. Specifically, they plan to use the analyses to design shared savings and capitated laboratory contracts with payers. "We have to look at other ways of contracting so the payer and the provider are jointly aligned to benefit from the savings created," he says.

Advice for reducing inappropriate utilization. "Start small and move fast," Cousin says. "Even just one utilization initiative can have a massive financial impact. Don't be so overwhelmed by the scope that you do not take that first small step. For us, it's been a one-step-at-a-time journey. Even organizations with limited ability to invest in this can drive some meaningful change."

This article is based in part on a presentation at the 2019 ACHE Congress.

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5 tactics to reduce clinical costs and improve performance

Rob Gamble, Pamela Damsky and Mike Gart

One important factor is limiting variation in clinical decision-making.

Making a clear impact on clinical cost — the costs of care delivery associated with clinical decision-making — requires tackling complex, difficult issues, such as clinical variation, service rationalization and clinician productivity (see the sidebar below). This work is most challenging as it directly involves long-held provider practices and behaviors.

To generate organizational support for change, these efforts must be balanced with delivery efficiency, respect for the roles and expertise of the care team and assurance that providers will be paid for the care delivered (see the exhibit on page 6). An organization-wide effort brings into focus clinical delivery, physician engagement and cultural change management, which are essential to achieving and sustaining meaningful results.

Set the stage for change by clearly articulating: "Why?" and "What's in it for me?"

There are proven tactics healthcare providers can deploy to improve clinical cost and reliability performance. The following are five of the most effective tactics, along with clinically driven examples of how the tactics apply:

1. *Reduce unwarranted variation in clinical decision-making through implementation of well-established clinical practice standards.*

For example:

- Manage high-use/high-cost patient cohorts through standardization and adoption of clinical protocols.
- Address variation to reduce length of stay for episodic and elective cases, such as knee or hip replacement.
- Decrease supply costs through standardizing instruments and implants for common case types.
- Reduce pharmaceutical costs through a standardized formulary and enhanced pharmacy and therapeutics protocols.

Example from the field: Managing clinical costs at a large, academic health system

The gastro-intestinal (GI) service at a large, academic health system had high clinical costs relative to regional benchmarks. A service review highlighted a large number of cost and operational challenges, including the following:

- Continuing pressure from health plans to demonstrate that care was being provided in the lowest-cost setting
- Over-utilization of existing, high-cost operating room space
- Mounting backlog of patients because of insufficient clinical and procedural access
- Minimal visibility into procedural suite throughput
- Volume and throughput limitations resulting from constrained anesthesia availability

While the primary objective to improve the GI service pointed to addressing clinical costs through optimal use of space, finding the most appropriate setting and the best deployment of clinical resources, a more comprehensive solution was needed.

The organization recognized that it would be impossible to make a material impact on clinical costs without also addressing operational expenses, provider management, revenue cycle optimization and growth. Leadership quickly realized that a coordinated, collaborative effort that incorporates functional areas and stakeholders from across the organization would be required to identify opportunities and workable solutions. The following four examples demonstrate this need.

- Information systems are key to promoting greater visibility into capacity utilization to inform the right levels of staffing and scheduling availability for each site of care to reduce operating expenses and support volume growth.
- The physician enterprise should create better access for referrals to providers both in clinic and for procedures, to improve the patient experience and mitigate against competitors.
- Physicians also should establish and adopt tighter clinical standards and guidelines for the appropriate site of care to ensure that patients receive care in the lowest-cost setting, without compromising quality or safety based on the patient's co-morbidities or health status.
- The right documentation and billing processes and infrastructure are critical to ensuring timely and necessary prior authorization to drive optimal revenue cycle performance.

Vital to success has been a comprehensive, integrated approach to identifying and addressing the many different components — across different departments and functional areas — that ultimately impact clinical costs.

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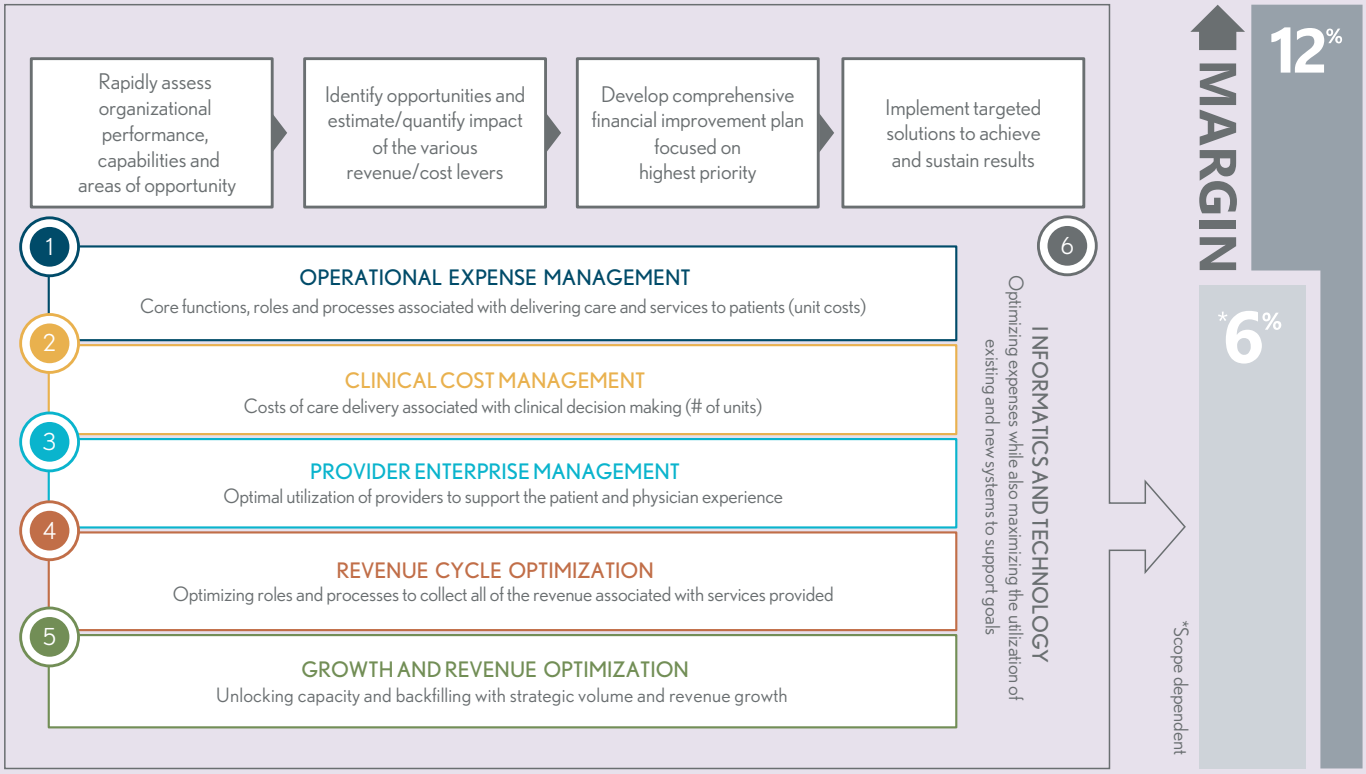
Comprehensive financial improvement assessment and plan development

Cost reduction efforts should emphasize efficiency, respect for clinical team expertise and appropriate payment for healthcare services.



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2. *Optimize care teams and operational processes to eliminate unnecessary duplication and ensure a positive patient and provider experience.* For example:

> Streamline data collection and communication through modifications to the electronic health record (EHR) and/or inter- and intra-departmental processes.

> Deploy defined models for advanced practice providers (APPs) to effectively expand capacity.

3. *Boost service distribution and access through better care management and capacity management across the continuum.* For example: Optimize sites of service across ambulatory, inpatient and post-acute.

> Utilize urgent care to expand ambulatory access and decrease emergency department (ED) overutilization.

> Establish effective follow-up processes to reduce ED readmissions.

4. *Consolidate services based on centers of excellence, service-line operations and access, and clinical quality standards.* For example:

> Move toward fewer sites or a single site of care within a system for more complex cases (e.g., neurosurgery, open heart) or where case volumes might be diminishing (e.g., obstetrics in rural areas).

> Utilize telehealth services to leverage or provide access to key specialist providers where appropriate.

5. *Manage performance with reliable data and reporting mechanisms.* For example:

> Generate and review monthly reports with the appropriate level of detail on capacity utilization, operating costs and provider utilization.

> Establish forums for bilateral communication on operational barriers to be addressed.

The areas of potential opportunity described in the five tactics above are highly sensitive in most organizations and typically challenging to address. Achieving significant and sustainable change in these areas is no small feat. And, it will require unwavering leadership commitment, organizational discipline and determination and broad buy-in and support from

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physicians, administrators and staff across the organization.

How to successfully deploy tactics

Implementing these strategies is dependent upon the following:

> Set the stage for change by clearly articulating: "Why?" and "What's in it for me?"
> Demonstrate a desire to transform the organization through leadership commitment that is shared by governance, leadership, management and clinicians.
> Focus on enhancing the provider experience and improving clinical care delivery through physician engagement and leadership.
> Establish a process for broad participation, collaboration and engagement of physicians, management and staff across the organization.
> Manage projects by adhering to work plans with timelines, defined accountabilities and forums for problem solving and performance measurement.
> Reinforce a culture of continuous improvement by attending to the multiple aspects of change management, including acknowledging accountability for addressing systemic issues, while simultaneously increasing stakeholder participation and commitment to the effort.

Starting a clinical cost reduction program

A high-level assessment that begins broadly, then quickly dives deep into areas of clear opportunity is often the most effective approach. The following steps can help to get a clinical cost-reduction program started:

> Establish a comprehensive view of clinical analytics that includes cost and quality across multiple clinical cohorts (MS-DRGs, procedures, etc.) and supports a thorough understanding of the value of clinical care and surfaces opportunities for improved clinical variation management.
> Conduct a broad, thorough review that considers all the different factors impacting clinical cost to identify your biggest opportunities.
> Get the right people in the room, including physicians, administrators and staff, and identify champions who can effectively lead their colleagues and drive change in their departments and functional areas.
> Collaborate with stakeholders to design solutions that are workable and sustainable within the day-to-day working environment.
> Develop an implementation plan designed to reach stated objectives within required timeframes, with specific goals, accountabilities and deadlines.
> Establish performance standards and a reporting/tracking system to monitor progress and maintain momentum.
> Ensure sustainability of the new solutions through continued performance measurement and assigned accountability.

Collaborate with stakeholders to design solutions that are workable and sustainable within the day-to-day working environment.

While challenging, directly addressing the ever-rising costs of clinical care delivery is a critical step in attacking "the last frontier" of true performance improvement and achieving the next level of financial performance required to thrive in today's environment. +

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HFMA's Annual Conference: Reimagining the future of healthcare

HFMA's Annual Conference addresses the greatest challenges faced by today's healthcare finance leaders. Taking place June 23 – 26 in Orlando, the conference offers three strategy-focused general sessions, more than 50 best-practice breakout sessions and four customized cohorts over a three-day period.

The conference includes sessions on cost containment and quality improvement, as well as other topic areas:

> Using Cost Accounting to Achieve Strategic Advantage
> Bending the Cost Curve: Start-Up Innovators
> Cost Performance Improvement Through Collaborative Leadership

Conference attendees can also take a deep dive into a key topic through curated cohort experiences. These full-day guided experiences include three interactive sessions presented by speakers from organizations that have demonstrated successes. The sessions are designed to engage participants in discussion and come away with actionable solutions.

The following keynote speakers will headline each day's activities:

> Marcus Whitney, CEO and co-founder, Health:Further, is a health innovator and investor whose ventures are focused on improving healthcare globally as well as the future of the industry.
> Susan Dentzer is a healthcare and policy expert and the lead author of *Health Care Without Walls: A Roadmap for Reinventing U.S. Health Care*
> Zubin Damania, MD, is the founder of Turntable Health. As an internist and satirical rap artist his work focuses on catalyzing healthcare transformation. +

For more information, visit annual.hfma.org

9 considerations for a comprehensive technology plan

Stephen Carrabba

Create a plan, train your staff, maintain inventory, and lastly, know what to ask for when shopping for technology.

The healthcare sector faces unique issues regarding ever-changing technology. To tackle those challenges, healthcare organizations should develop comprehensive IT strategic plans, measure themselves against those plans, and consistently review and update for regulatory and product changes.

Start with an assessment to determine your organization's current strategy for handling IT requirements. If you are like many healthcare leaders, just finding the answer to that question may not be so easy. However, avoiding the issue can be costly and even potentially catastrophic.

Below are some considerations to help your organization raise its IT game:

1. *Identify the soft costs.* If you decide to buy servers and software rather than use a cloud-based solution, it's critical to identify the related soft costs. For example, the following requirements may add operational costs:

> Licenses for operating software plus costs for upgrades and storage.
> Maintenance and break-fix issues that consume staff time and require extra payments to outside resources.
> Electricity and additional cooling costs associated with running extra equipment.
> Using existing space and building extra rooms to house equipment, which means extra construction costs and maintaining real estate that isn't used for a revenue-generating service.

2. *Beware of obsolescence.* It seems on the day an organization buys a piece of equipment or software, there's an announcement about a newer model that is coming the next day. Development cycles have been accelerating. Sometimes software requires new hardware. Sometimes hardware requires new software. Two things are consistent. Obsolescence is guaranteed, and it will cost an organization money.

Treating all data content the same will most likely lead to an over-engineered solution, which would be costly and wasteful.

3. *Remain HIPAA compliant.* Ensuring that your organization is HIPAA compliant is an ongoing endeavor. When staff are storing documents, they can't, for example, put them up on Google Docs with no regard for sensitive or protected content. Where data is stored, how data is accessed, who can access the data, encryption in transit and at rest, and what happens when data is deleted are all factors that need to be considered carefully. Treating all data content the same, however, will most likely lead to an over-engineered solution, which would be costly and wasteful.

4. *Protect your data.* Data protection comes in a variety of forms. The goal is to block hacking attempts before they get to your organization's virtual doorstep. Firewalls, virus protection, and encryption are a few of the tools that are commonplace in today's world. They should be regularly monitored, reviewed, and updated. "Set it and forget it" is not an advisable approach.

5. *Know what you own.* To keep tabs on equipment, ask these questions:

> How many desktops and laptops does your organization own and what's on each one? Consider the same questions for cellphones and tablets.
> What's the process for collecting used equipment when someone leaves the organization?
> Do you have a way to remotely wipe clean a device that's lost or stolen? Do you then update the number of software licenses you need?
> Are necessary equipment and device licenses updated when someone switches roles?

6. *Avoid duplication.* A detailed review of software licenses will highlight redundant products. For example, a healthcare organization may be paying for security services with vendor A and a comprehensive suite of services that includes the same security options with vendor B. In that case, the organization would be best served to eliminate vendor A. It would require increasing services with vendor B, but the change will reduce costs significantly.

7. *Train your staff.* Educate staff to recognize suspicious links. Just as important, teach them to spot spoofing attempts so that they don't inadvertently provide classified information to an entity with negative intent. Healthcare organizations often get into trouble because someone shared personal employee or patient information. Implement proper safeguards proactively to reduce the risk of that happening to your organization.

8. *Negotiate like a pro.* Anyone who has ever looked at an IT agreement will say the same thing: They are not like any other. Detailed service level agreements, disclaimers, maintenance schedules and more disclaimers can make anyone's head spin. Understanding what you really need can be complicated because you often have to rely on the people with a vested interest in selling you as much as possible, not necessarily what you need. But you certainly don't want to take the risk of having less than you need. A few additional considerations can help healthcare leaders sort out the details:

> Recognize that many solutions come in a variety of levels, and they often range in price from inexpensive to very costly.
> Ask the sales rep to explain the different options.
> Pre-negotiate a cap on increases for time of renewal.
> Consider the length of the agreement.
> Benchmark the pricing by exploring other vendor offerings.
> Seek outside assistance. Consulting firms have insight into many agreements, not just yours.
> Determine what motivates your sales representative. Some are measured on cash generated in a given period, not just sales. Knowing that information and timing the purchase appropriately may give you a negotiating advantage.

A detailed review of software licenses will highlight redundant products. For example, a healthcare organization may be paying for security services with vendor A and a comprehensive suite of services that includes the same security options with vendor B.

9. *Get a discount if you're entitled to it.* This one is particularly important if your organization is a not-for-profit entity. Some services offer deep discounts to not-for-profits, but you have to know where to look.

Technology can be wonderful, but as with anything, there are pitfalls that need to be avoided. Create a plan, train your staff, maintain inventory, and lastly, know what to ask for when it comes to shopping for technology. ■

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7 ways to address financial barriers to medication adherence and contain costs

Shirley Titus

One strategy is to monitor prescription cost assistance programs for the top five to 10 drugs the practice prescribes and routinely print information for patients in need.

It is an unfortunate reality: Rising prescription drug costs force many patients to skip doses or even forgo potentially life-saving medications. To reduce costs through competition, the Department of Health and Human Services' (HHS) recently announced that drug manufacturers will soon be required to include list prices in television advertisements. According to HHS, 47% of Americans have high-deductible health plans (HDHPs), under which they often pay the list price of a drug until they have met their deductible. Patients also pay list prices if a drug is not on their insurance formulary.

The inability to afford prescription drugs continues to reach epidemic proportions.

- According to a recent Truven Health Analytics-NPR Health poll, 67% of patients do not take their medications because they cannot afford them.
- The same poll shows 94% of patients with incomes under $25,000 per year stated that they did not fill or pick up their prescriptions due to the expenses involved.
- More than 12% said that costs led them to stop taking a medication before a provider recommended ending the treatment.
- Recent data from the Centers for Disease Control and Prevention found that nearly 11% of individuals skipped medication doses or delayed filling a prescription simply to save money.

Why medication non-adherence undermines value-based payments

What is the connection between rising drug prices and value-based payments? When patients do not take their medications because they cannot afford them, they are automatically at risk for exacerbating chronic conditions. As a result, many are frequently admitted to the hospital or receive services in emergency departments when complications arise, driving up the overall cost of care. It is this cost of care that can make or break a physician's performance under value-based payment models.

Nonadherence has been estimated to cost the U.S. healthcare system between $100 billion and $289 billion annually.

The link between medication non-adherence and higher healthcare costs is obvious. Medication adherence (or lack thereof) is often a predictor of 30-day hospital readmissions, according to a recent study published in *Patient Preference and Adherence*. The study found that patients with low or intermediate adherence had a 20% readmission rate as compared with approximately 9% for patients with high adherence.

Countless additional studies suggest that medication non-adherence drives up costs. For example, a recent study conducted by Express Scripts found that people who were non-adherent to their oral diabetes medications had 4% higher total healthcare costs compared to those who were adherent. Overall, nonadherence has been estimated to cost the U.S. healthcare system between $100 billion and $289 billion annually.

Seven tips to address financial barriers to medication adherence

To contain costs and improve outcomes under value-based payment models, medication adherence is paramount. This means physicians must address one of the biggest barriers: Cost of prescription drugs. Following are seven simple strategies to address financial barriers to medication adherence:

1. *Help patients understand why they are taking certain medications.* Discuss what medications are prescribed (and why) as well as the risk factors associated with non-adherence. This is especially true for medications used to treat conditions for which there are no noticeable symptoms. Asymptomatic patients may feel as though they do not need to take the drug and therefore decide to spend their money on basic necessities (e.g., food and clothing). However, one strategy to increase medication adherence is for life science reps to share patient educational materials that providers can give to patients during appointments. Physicians should give patients a couple of minutes to read the material and ask if they have any questions before concluding the visit.

2. *Ask patients whether they can afford their medications.* Patients do not typically volunteer this information because it may be embarrassing for them to admit their

financial hardships. Instead, providers should ask patients directly. For example, consider stating the following: "I know that this medication can be expensive, and I want to be sure you are taking it as prescribed. Are you able to afford the medication, or is the cost a barrier? Please be honest so I can help you if needed." Inquire whether patients plan to ration or share their medication for financial reasons, and create a 'blame free' environment to make patients feel comfortable about providing honest responses.

The goal is to remove any and all barriers to these programs so patients get the help they need.

Once providers identify patients for whom cost is a barrier, they may be able to prescribe the maximum number of doses possible at one time (thus limiting the frequency of pharmacy visits). They may also be able to prescribe a medication that is on the patient's insurance formulary or a medication for which a missed dose is less detrimental to long-term outcomes.

3. *Do not over-rely on drug samples.* Sample medications are truly meant for patients who are testing out a medication before taking it in the long term. When providers give these samples to patients who cannot afford their medications, they do not address the root cause of the problem. Once the samples run out, patients stop taking the drug until they are able to obtain more samples. This creates a dangerous gap that can lead to adverse outcomes.

4. *Educate patients about prescription discount cards.* There are a variety of free discount cards available online. Patients simply present one of these cards at a participating pharmacy and ask for pricing information using the discount card versus their insurance. Discount cards are particularly helpful for patients with HDHPs that may not have prescription drug coverage until they have met their deductible. They are also helpful for those without insurance.

5. *Work with life science reps to stay up to date on what coupons and savings programs are available.* Unfortunately, many providers do not know about these resources, or they simply do not have the time to track down current coupons for each patient. Only 16% of low-income individuals use a coupon to help reduce the price of their medications, according to the Truven Health Analytics-NPR Health poll. Practices that make time to meet with life science reps are able to stay abreast of all available savings opportunities to ensure patients take advantage of them.

6. *Know what other Prescription Assistance Programs (PAP) are available for commonly prescribed medications.* There are a variety of free online databases that allow users to type in the name of a drug and pull up all available PAPs, including basic program guidelines and application forms. It is helpful for a staff member to monitor these programs for the top five to 10 drugs the practice prescribes and routinely print information for patients in need. Practices can also help patients fill out application forms and obtain a physician signature before the patient leaves. The goal is to remove any and all barriers to these programs so patients get the help they need.

Encourage patients to comparison shop before filling their prescription because drug prices vary significantly by pharmacy.

7. *Encourage patients to shop around.* Drug prices vary significantly by pharmacy, so encourage patients to comparison shop before filling their prescriptions. This is important for those without insurance coverage as well as those with HDHPs that choose to pay cash instead.

When it comes to medication adherence, physicians play an important role in terms of patient education and engagement. With the help of technology, this task is far less onerous than in the past, enabling physicians to help patients afford costly medications, improve outcomes and boost revenue under value-based payment models. +

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Optimizing the hospital workforce in a rapidly changing environment

Therese A. Fitzpatrick

The traditional approach of using the midnight census as the chief measure of patient demand can obscure more granular trends measured in hours or minutes.

Whether it's delivering millions of packages on time to customers' doorsteps, managing thousands of flights in multiple time zones, or deploying military personnel across the globe, organizations in numerous industries tap into the power of logistics science and optimization modeling every day. But for hospitals and health systems, the challenge of getting the right nurse to the right tower for the next shift without exceeding the staffing budget or upsetting the nurse-to-patient ratio is perennially frustrating.

Recent shifts in the healthcare industry have further complicated the challenge of accurately budgeting, scheduling, deploying and assigning clinical staff. Growing health systems that acquire new hospitals may need to recalibrate their staffing for increased needs. And organizations that are scaling back inpatient capacity while expanding their presence in clinics and other community-based outpatient settings amid industry-wide changes in healthcare delivery must make similar adjustments.

As workforces evolve, the traditional approach of using the midnight census as the chief measure of patient demand can obscure more granular trends measured in hours or minutes. Without access to accurate, timely data, hospitals run the risk of over-staffing, and the prospect of tens of millions of dollars in increased costs. At the other end of the spectrum, understaffing can jeopardize clinical quality, staff engagement and patient satisfaction.

Emerging workforce optimization modeling can help organizations review years of staffing and budgeting information on data points ranging from hourly patient demand to clinical time entry to bed capacity to nurse-to-patient ratios. The process is intended to uncover potential inefficiencies and changes in operation that might require modifications in work rules or scheduling protocols.

For example, high vacancy rates can lead to higher proportions of costly overtime payments. The modeling also allows organizations to quantify the impact of work rules governing parameters including shift lengths, start times and weekend shifts. For example, organizations that only require clinical staff to work every third weekend instead of every two weekends might need — depending on the modeling — a significantly higher number of full-time employees (FTEs) in order to fill each weekend shift. And population health initiatives that are intended to drive down inpatient utilization may require flexible models to adequately staff community-based facilities beyond the four walls of the hospital.

Hospitals and health systems can use the insights from modeling exercises to calculate the impact of everything from changes to weekend staffing schedules to the creation of new float pools. Ultimately, the process is intended to help organizations sustain or improve performance in clinical outcomes, labor costs and employee engagement, without having to sacrifice results in one area to achieve results elsewhere.

For example, one large Midwest health system, which was organized under a loose federation model, operated for years without standard, system-wide work rules. At one point, the system had 350 work rules in place for 11 hospitals. Using the optimization process, an interdisciplinary team was able to pare down the list to 50 new standards for use by the entire system. When the standardization process began, the system scored in the 39th percentile of employee satisfaction on surveys developed by the Agency for Healthcare Research and Quality (AHRQ). Three and half years later, the system scored in the 75th percentile on the AHRQ survey, while saving $8 million in spending on overtime and agency pay over two years.

Achieving meaningful results of that nature requires genuine buy-in and engagement from multiple internal stakeholders, including the chief nursing officer, the chief finance officer, human resources leaders, schedulers and frontline nursing staff. Initial meetings might help each department understand how their counterparts traditionally perceive and measure staffing, and determine that appropriate staffing levels have been met.

For example, while members of the finance department might view staffing through the lens of a given number of FTEs in a unit, frontline staff are more likely to focus on the number of patients they see in a given day. And the chief nursing officer often ends up mediating between both groups.

When optimization efforts are inclusive of a wide range of viewpoints and needs, they can deliver results that satisfy multiple internal stakeholders. Finance leaders might appreciate greater alignment between projecting staffing budgets and actual results, while frontline nurses may enjoy greater predictability in the day-to-day staffing of their particular unit. Ideally, workforce optimization can help organizations adapt and thrive in an ever-shifting environment, and achieve results ranging from improved financial performance to a more engaged clinical staff. +

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+ healthcare costs at a glance +

Healthcare leaders agree about the value of supply chain management

Approximately half of healthcare executives believe that supply chain management can increase margins by at least 1%-3%, according to a January 2019 Syft survey of supply chain, executive, and clinical leadership. To put this in perspective, a hospital with $900 million in revenue and a 1% margin of $9 million could gain between $9 million and $27 million by improving its supply chain performance.

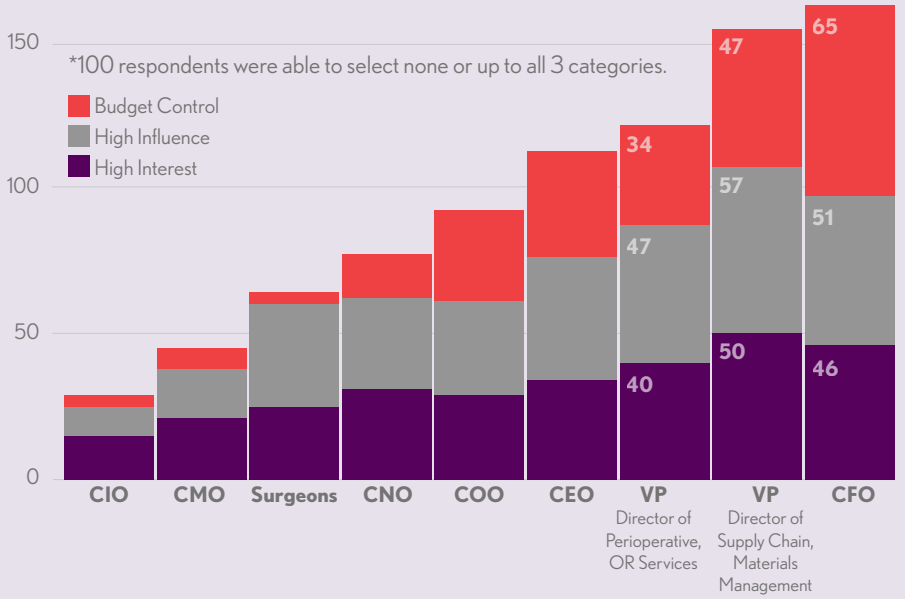
As far as decision-making about supply chain management planning, supply chain leaders had the most influence about specific solutions or strategies, while CFOs had a significant impact on supply chain management solution budgets.

Of survey respondents, 41% were employed by hospitals with less than 250 beds, while 39% worked for hospitals with 250 to 499 beds.

In addition to overall cost savings, as healthcare organizations face mounting pressure from programs like the Bundled Payment for Care Initiative-Advanced and value-based payment models, managing supplies efficiently becomes more critical. +

Healthcare leaders show varying influence in supply chain decisions

Senior supply chain leaders have the most influence over supply chain solution decisions while CFOs control project budgets.



Source: "Optimizing supply chain management: The largely untapped value opportunity" Syft survey conducted by Sage Growth Partners. Used with permission.