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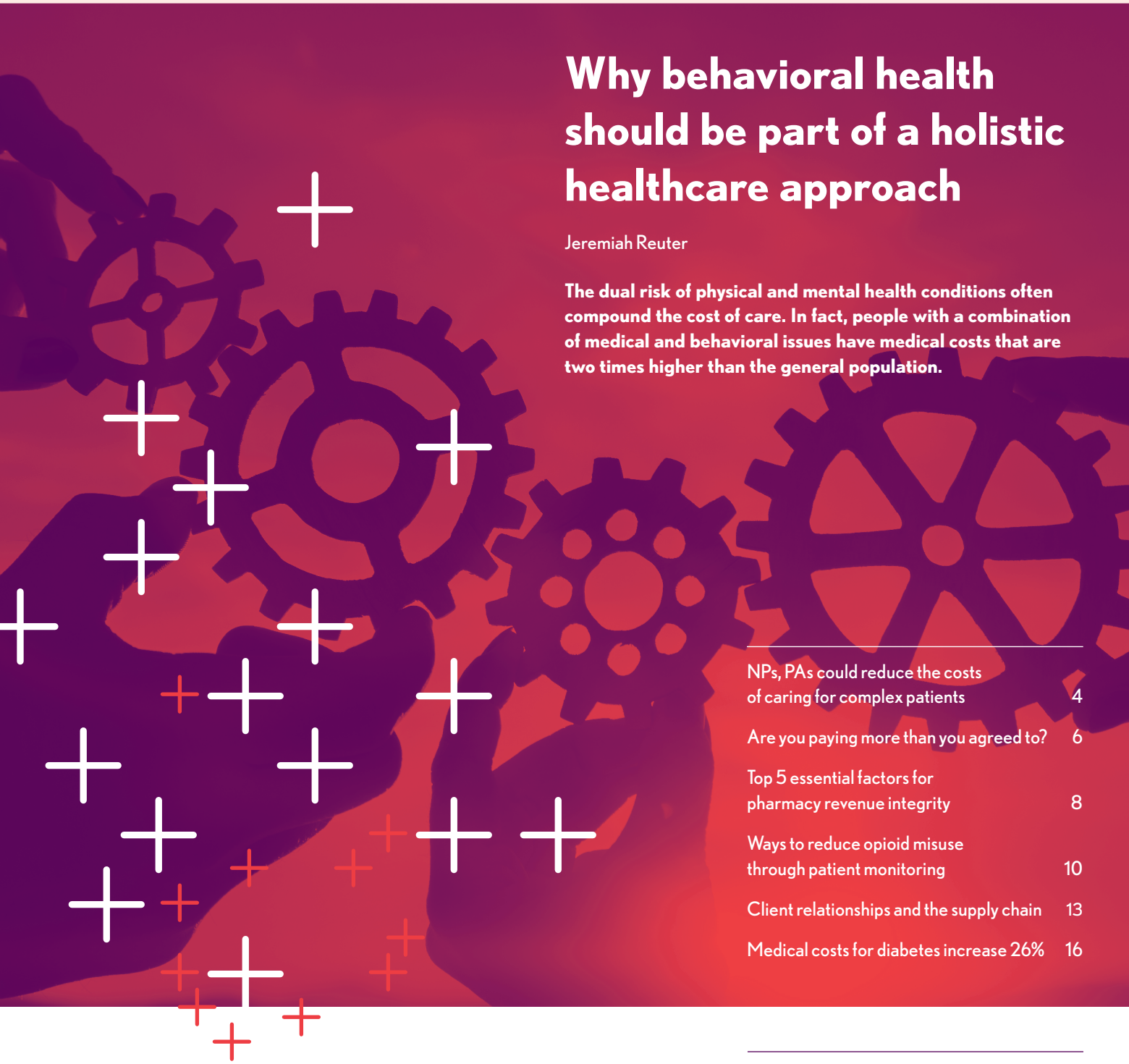

Why behavioral health should be part of a holistic healthcare approach

Jeremiah Reuter

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+ care process redesign +

Why behavioral health should be part of a holistic healthcare approach

Jeremiah Reuter

Health systems often overlook the role behavioral health can play in managing costs.

When behavioral health issues go untreated, high medical expenditures may follow for not only behavioral health, but also any physical health comorbidities. This dual risk often compounds the cost of care. In fact, people with a combination of medical and behavioral issues have medical costs that are two times higher than the general population (Druss, B.G., Reisinger Walker, E., *Mental disorders and medical comorbidity*, Robert Wood Johnson Foundation).

When health systems must reduce the total cost of care for a patient population, they typically begin by addressing the cost of chronic health issues. However, because medical conditions, mental health conditions and substance use disorders are connected and often occur at the same time, it's critical that health systems recognize and address the complex interdependencies between them. This can have the greatest impact on outcomes and costs.

For example, how often do anxiety or depression interact with a patient's ability to manage chronic obstructive pulmonary disease (COPD), or how often does the stress of managing COPD worsen a patient's mental health issues?

Innovation

Health systems are embarking on progressive strategies to manage risk and the total cost of care, while taking holistic views of patient care that include treating behavioral health comorbidities alongside other chronic conditions.

For example, a Colorado demonstration project for an alternative payment model called Sustaining Healthcare Across Integrated Primary Care Efforts (SHAPE) delivered positive results. The six primary care practices receiving SHAPE payments saw $1.08 million in net cost savings for their public payer populations over 18 months, principally through reductions in downstream care utilization. The alternative payments supported behavioral health services in primary care practices where at least one onsite behavioral health clinician provided integrated behavioral health services.

Medicare strategies

Medicare presents another opportunity for healthcare providers to incorporate behavioral health into their risk mangement strategies. For example, an increasing number of health systems are taking on risk through Medicare programs such as MSSP (Medicare Shared Savings Program) and MACRA (Medicare Access and Children's Health Insurance Program Reauthorization Act). These programs from the Centers for Medicare & Medicaid Services (CMS) aim to shift how health systems provide care for Medicare patients, encouraging providers to see their mission as population health management, which includes addressing behavioral health.

Commercial payer engagement

It is challenging for health systems to move to population-health-management Medicare payment models while providing care only under fee-for-service models for employers and commercial payers. From facility planning to physician network alignment, it is difficult for health systems to create coherent strategies to serve such divergent care models.

When health systems have tried to engage employers and other commercial payers on population health management, most providers have struggled to make a compelling

business case. Commercial payers have pushed back on whether there is a clear ROI for behavioral health.

Including comorbidities with behavioral health in contracting discussions may demonstrate the value of access to such services. If a patient with a behavioral health issue can receive treatment before a comorbidity episode occurs, then the patient has a better outcome and the payer sees the managed cost drop for the physical health comorbidities. Keeping these patients from preventable and high-cost trips to the emergency department (ED) is an obvious win for patients, payers and providers.

Emerging models

Forecasting behavioral health services likely to be utilized and the downstream avoidance of other hospital services can be difficult for payers and providers. However, there are emerging factors that contribute to understanding the impact of behavioral health access on improved patient care and financial projections for health systems.

For example, consider how the social stigma surrounding behavioral health has been lifting, increasing public conversations about personal battles with mental health issues. This type of awareness may encourage health systems to provide access to more behavioral healthcare providers. As a result, more health plans may include behavioral health benefits.

Rural health systems may also contribute to a rise in behavioral health service availability by offering access through telehealth. For example, a mobile app could provide access to transportation or address isolation issues, both social determinants of health. What's more, patients' comfort in interacting with their cell phones can reduce some of the stigma of seeking and receiving behavioral health services.

More data needed

How can health systems know how much care is going to be utilized and what will be the downstream effects of meeting the unmet demand? Unfortunately, conclusive data has yet to emerge showing whether these changes will avoid costly medical conditions with chronic care and increase or decrease the total cost of care for patient populations. However, a few studies provide data on behavioral health utilization and cost, such as "The Impact of Psychological Interventions of Medical Cost Offset: A Meta-Analytic Review," *Clinical Psychology: Study and Practice*.

Some health systems seek to use historical data to understand differences in care utilization and costs when a patient population that had an unmet need for behavioral health services later gains access to these services. But specific markets vary by many factors including demographics, existing alternatives and present rates of comorbidities among potential behavioral health patients, so strong comparisons can be elusive.

Without more apples-to-apples data available in the early stages of these efforts, health systems typically find that showing payers the "art of the possible" is the best result of rigorous projection work.

Shifting attribution

Progressive health systems are also considering the role of attribution — identifying a patient-provider relationship that addresses the full continuum of care — in managing care for patients with behavioral health issues and comorbidities. This should be the starting point for provider organizations seeking to take on financial risk in contracts. Traditionally, primary care physicians have been assigned responsibility for managing patients' health with a holistic view, but it might make more sense to assign this role to a specialist.

For example, if cardiologists, endocrinologists or nephrologists are managing patients' chronic conditions, the higher number of interactions those physicians have had with patients may put them in better positions than primary care physicians to lead holistic care for those patients.

Similarly, health systems might consider assigning behavioral health specialists to manage patients' entire care regimens and costs. In some situations, behavioral health specialists will be better suited to manage the underlying behavioral health conditions that often compound the impacts of other physical health conditions. Health systems might consider designating a cohort of patients with behavioral health conditions and other chronic conditions for this approach. With the high number of patient

Keeping an eye on Massachusetts payer-provider collaborations

Some health systems seeking outcomes and cost data on populations with access to and availability of behavioral health services are watching Massachusetts. Several payer-provider collaborations launched in that state at the start of 2018 are seeking to better manage Medicaid risk across millions of lives.

The premise of these partnerships in Massachusetts is the emerging concept in managing risk: connecting hospital-led organizations with multispecialty physician practices, community resources and behavioral health resources. When a patient presents with a behavioral health condition and one or more comorbidities, these other organizations can reach out within the community to access the resources to help manage the behavioral health condition, while at the same time continuing to treat the chronic physical conditions that are core to the health system's capabilities. By linking the provider groups in contracts that share financial risk for managing the cost of care for the patient population, incentives can be aligned between organizations.

For example, when patients present in the ED experiencing psychiatric emergencies, physicians are empowered to help connect them to community resources that can address underlying issues. This requires building partnerships with mental health specialists who can respond to patients experiencing mental health crises as well as other outpatient resources and inpatient treatment options. These partnerships can contribute to reductions in future ED visits and allow hospitals to manage patients' health when they do present in the ED versus merely managing patient flow through the ED.

touches in behavioral healthcare, these specialists might be well positioned to also talk with patients about their medical conditions and refer patients to chronic care specialists. This could be a bridge between the patient and chronic care resources.

Look beyond the inpatient future

Finally, as health system leaders develop behavioral health strategies, they should avoid focusing solely on inpatient care and instead focus on a continuum of care that provides mental health resources in their communities.

There is no doubt as to the benefit that inpatient psychiatric facilities provide. Yet system executives should ask themselves two questions when considering building a new inpatient facility:

- Is building a facility the most important need in the community to treat patients with these conditions?
- Will the facility be cost effective?

In certain situations, avoiding the high cost of inpatient care by moving to an ambulatory setting might better serve patients and enhance cost management by allowing for flexibile care coordination that includes behavioral health. However, it is important to ensure that shifting the site of service did not send downstream costs higher. Understanding the downstream services and costs avoided is fundamental to building the business case for inpatient facility investment as well as demonstrating value to the community.

Accountability on the rise

In this era of rising accountability, the economic incentives are increasing for providing high-quality, well-coordinated and low-cost care. Health systems can mitigate risk by including behavioral health in a holistic healthcare approach. +

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NPs, PAs could reduce the costs of caring for complex patients

Laura Hegwer

Recent research found that case-adjusted total care costs were 6% to 7% lower for pateints treated by nurse practitioners and physician assistants than those treated by physicians.

In this interview, Perri Morgan, a professor and researcher at Duke University School of Medicine, helps debunk the myth that nurse practioners (NPs) and physician assistants (PAs) raise the cost of caring for complex patients.

On the impetus for the research. While NPs and PAs are less expensive to hire than physicians, some healthcare leaders believe these advanced practice providers could drive up non-salary costs, particularly care costs. For example, some assume that because NPs and PAs have less training than physicians, they may have less confidence in their diagnostic skills, which could potentially drive up costs for lab or imaging tests, Morgan says. Another belief is that NPs and PAs refer patients to specialists more frequently than physicians do.

Hospitalizations, emergency department visits and pharmacy costs were factors in lower costs of care for patients treated by NPs and PAs.

Because little current evidence supports these notions, Morgan, who is a PA, along with a research team that included a physician and an NP, wanted to study differences in utilization and costs between physicians and advanced practice providers treating complex patients with diabetes.

On the challenge of studying differences in utilization by provider type. Morgan says one barrier to studying care by NPs and PAs is that they are used so differently across settings, even in the same health system. "One clinic might use a PA or NP as a primary care provider, while other clinics might only use them for same-day visits or to manage uncomplicated chronic diseases," she says.

By analyzing two years of data from the Department of Veterans Affairs (VA), however, Morgan and her team were able to circumvent that obstacle. As part of its medical home model, the VA uses patient-aligned care teams (PACTs) led by a primary care provider, either a physician, NP or PA. Other members of the team include a registered nurse, a licensed practice nurse or medical assistant, and a clerical assistant. In each PACT, physicians, NPs and PAs fill the same role, allowing for a better comparison of utilization and costs.

On their findings. Morgan's team found that case-adjusted total care costs were 6% to 7% lower for NP and PA patients than for physician patients. Specifically, annual costs for NP patients were $2,005 lower, while costs for PA patients were $2,300 lower, compared with physician patients. Their findings were published in the June 2019 issue of *Health Affairs*.

"The lower costs in our study were driven primarily by a higher rate of hospitalization among physician patients," Morgan says. Higher emergency department (ED) visits among physician patients, compared with NP and PA patients, also was a factor. Annual pharmacy costs were also about $300 higher for physician patients.

The study adds to a growing body of research, including a study by Salim S. Virani

in *Population Health Management*, linking NPs and PAs to lower utilization, compared with physicians. In addition, analysis of Medicare data by Jennifer Perloff and colleagues in *Health Services Research* found patients managed by NPs had a lower cost of care than those managed by physicians.

On possible explanations. Although the VA data did not allow Morgan and her team to compare patient panel size among teams, Virani's research found that physicians in the VA have panel sizes about 15% larger than those of PAs and NPs. "This might mean that PAs and NPs have more time to work with each patient," Morgan says, suggesting that additional time with patients could have a positive impact on utilization and costs.

Beyond panel size, Morgan believes other factors could explain the difference in utilization and costs. "Although this is speculation at this point, my leading theory is that it might be easier for patients to reach their PA than it is to reach their physician," she says. For example, a heart failure patient who is short of breath might be able to get a faster callback from a PA or NP than a physician and avoid a visit to the ED.

Another possible explanation for the differences in cost and utilization might be that NPs and PAs in the VA are better at mobilizing the PACT than physicians, Morgan says. "It would be easy to imagine that nurse practitioners — almost all of whom were registered nurses before they became NPs — are really good at working with RNs and using RNs to the top of their abilities," she says.

Morgan says better relationships between patients and NPs and PAs also could explain the differences in utilization. She points to some studies showing higher patient satisfaction among the patients of NPs and PAs, which could translate to lower utilization and costs compared with physicians' patients.

On how different provider types affect clinical outcomes. Morgan says a large body of research has found no differences in outcomes between patients treated by physicians and those treated by PAs or NPs. A 2018 study by George Jackson, Morgan and others published in the *Annals of Family Medicine* found no differences in intermediate diabetes outcomes — specifically HbA1c values, low-density cholesterol and blood pressure — among the same cohort of patients who received their care from PAs, NPs or physicians for two years. Systematic reviews have uncovered similar findings on clinical outcomes, Morgan says.

On payer payment of NP and PA services. While most payers cover medical and surgical services provided by advanced practice providers, they do not always pay the same rate that they pay physicians. Medicare pays PAs and NPs 85% of what it pays physicians for the same care. Among commercial plans, payment terms vary.

A heart failure patient who is short of breath might be able to get a faster callback from a PA or NP than a physician and avoid a visit to the ED.

Takeaways for finance leaders. "Our paper shows that if leaders want to use PAs and NPs at the top of their license as primary care providers, they should expect quality to be maintained and costs to be similar or maybe even better," Morgan says. "We found no evidence to support the idea that PAs and NPs will not save money because they will order more tests and make more referrals." Morgan also notes that the lower salaries of NPs and PAs, compared with physicians, were not figured into her team's analysis, suggesting that the savings could be even larger if labor costs are considered.

The findings also suggest that it is reasonable for leaders to hire PAs and NPs to serve as primary care providers managing their own panels, Morgan says. "Most of the time, states' scope of practice is not what limits PAs and NPs," she says. "Organizational restrictions are often more restrictive than states' scope of practice."

If finance leaders work in organizations where advanced practice providers do not care for complex patients, they may want to work with clinical leaders to change their policies. In some cases, they may have to collaborate with department leaders, as policies may vary by department.

Besides potentially saving costs, Morgan believes there is another advantage to using PAs and NPs at the top of their license: retention. "Turnover is expensive, and the market for PAs and NPs is very hot," she says. PAs and NPs who are relegated to handling same-day visits are likely to get bored and move on to better opportunities.

Regarding retention, Morgan offers another piece of advice: "It is becoming clearer that careful onboarding of new PAs and NPs, especially if they are new graduates, is important," she says. As part of her research, she is also studying how comprehensive onboarding programs might affect PA and NP retention and performance.

On the study's relevance to population health management. As value-based payment becomes a reality and more health systems move toward population health management models similar to the VA's, Morgan believes her study's findings are especially relevant. "The longstanding questions have been: Should we use PAs and NPs as primary care providers, or should we just use them for a segment of care like same-day visits? And should PAs and NPs only see less complex patients, or can they see complex patients as well?" she says. "Our study looked at the primary care provider role for complex patients and found no difference in quality and better costs." +

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Are you paying more than you agreed to?

Stephen Carrabba

Availability of a pricing list may be the easy part. What if a contract is complicated by early payment incentives or category discounts?

Healthcare organizations spend countless hours negotiating vendor contracts. When you factor in various management and legal reviews and time spent pursuing favorable pricing, services and terms, the time commitment adds up.

Implementing best practices will ensure that time and money invested in contract negotiations is not wasted and that your organization will realize agreed upon prices for goods and services.

Implement a consistent process

What happens after an agreement is signed varies from facility to facility and often from department to department. The agreement may be stored away and not shared with accounts payable. Or, more likely, it is shared but not understood. As a result, challenges arise when invoices arrive from the vendor. Implementing the following tips can ensure that contracts are followed and top of mind at critical points:

- Set up a master location within the accounts payable system for all current agreements with contract-term and end-date reminders. This allows easy access to contracts as questions arise.
- Require that a purchase order that references the key pricing components of the agreement — or has a contract pricing schedule addendum — be attached to approved and submitted invoices.

Maintain accessible documents

The department paying the bills may not know the contracted pricing. Pricing tables are often attached to an agreement in PDF format to help accounts payable with the contract terms. However, documents often are scanned and copied multiple times so that by the time they reach the individual who has to validate pricing, the information can be difficult to read.

Ensure that the original version remains intact by requiring a PDF of the executed agreement from the vendor. Also request that pricing tables or other calculation-focused pricing mechanisms be provided in an Excel or CSV format that will allow staff to input each period's billing data into the format to review against vendor billing.

Keep up to date on price reductions

Availability of a pricing list may be the easy part. What if the agreement is more complicated? Maybe there are early payment incentives and category discounts. Now, you're relying on a non-clinical or non-technical person to understand the nuances of every spend category to capture reductions. While you can train non-technical, non-clinical staff, that "know-how" can evaporate over time through employee attrition. Suddenly, items that seemed clear during contract negotiation create confusion during practical application.

Many times, contracts include formulas that may rely on external data such as an index that is costly or difficult to obtain or is buried within the contract. We've seen multi-year contracts refer to maximum annual price escalations and when it comes time for the price increases in later years, the vendor may not automatically implement the maximum pricing and the payables department doesn't know to check that the pricing terms are followed. Maybe certain staff members knew it was there years ago, but it's lost in handoffs that occur regularly. The result is that organizations end up paying more than agreed to.

In addition, price escalation restrictions may be buried in contract amendments that aren't shared with the rest of the organization. These oversights happen frequently and can be costly. Management can help mitigate these issues by insisting on following processes that highlight contract provisions, reviewing contracts at least twice a year, and periodically checking invoices to ensure procedures are followed.

For some spend categories such as medical, pharmacy, office and janitorial supplies, there may be thousands of lines to review each month. Unless you use an automated solution, there's no way to effectively review an invoice. Instead, organizations may rely on high-level metrics to determine if their spending is reasonable. Their reporting may include a check of trend or total spend by location or category or an applicable metric such as dollars per bed or dollars per employee. In doing so, there's bound to be leakage as items fall through the cracks. Seriously, how is it possible to know if you're really paying the correct amount for all of your goods and services?

Automating a solution can be costly as well, especially as contracts and invoicing change periodically and any automated solution needs to be updated regularly.

Some organizations look to outside consultants to provide assurance that their fiduciary responsibility has been upheld. Three examples of such third-party contractors include the following:

1. Auditors who regularly study agreements and invoices for several organizations have the experience to identify common errors quickly using tools that are maintained on a regular basis.
2. Group purchasing organizations can provide negotiating leverage.
3. Outsourcing accounts payable can reduce administrative burden, creating more time to focus on clinical management.

No matter what tools or services you use, there is no substitute for regularly comparing vendor agreements with invoices and rethinking current approaches. Strategic planning can save millions of dollars. +

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Top 5 essential factors for pharmacy revenue integrity

William Kirsh

Pharmacy revenue integrity can be preserved by understanding risk versus value through longitudinal data.

According to the Centers for Disease Control and Prevention, prescription drugs account for nearly 10% of national health expenditures. With that much invested in pharmaceuticals, it's crucial for hospital executives to understand the factors necessary for maintaining pharmacy revenue integrity and avoiding revenue leakage.

Reducing unwarranted variations in treatment

Physicians decide on treatment protocols based on many factors, including guideline-directed medical therapies, advice of colleagues, specifics of each patient case, cost of care and knowledge of the latest research. Over many years, physicians learn that certain treatment protocols yield the best patient outcomes for the least amount of money spent, and certain treatment protocols become "standard" (e.g., aspirin for patient's who've had a heart attack).

Yet despite these standards, treatment variations are prominent. "Studies around the world show that the frequency with which procedures are performed varies dramatically among doctors, specialties and geographical regions. Patients with identical clinical problems receive different care depending on their clinician, hospital or location," according to an article published in the *BMJ*.

Some variations in care are necessary based on individual patient cases. However, it's necessary to reduce unwarranted variations in treatment wherever possible, to keep both patient outcomes and costs steady.

Over time, hospitals should be accumulating and analyzing valuable data about which treatment protocols, including medications prescribed, yield the best results in terms of financial value and patient outcomes for each service line, from acute myocardial infarction to knee replacements. Nishaminy Kasbekar, PharmD, director of pharmacy at Penn Presbyterian Medical Center, agrees. "The problem is that the data needed to support one outcome over another is very hard to come by. We used to focus on a physician spending $500 per case versus another spending $300 per case," she says. "Now, we're starting to dig much deeper into the data to see what really makes sense."

Identifying tried-and-true treatment plans and reducing deviations from those plans are key contributors to revenue integrity. What is needed to accomplish this is a longitudinal patient dataset (data that track the same patients over the course of many years) that will guide physicians to make the best treatment decisions based on real-life experiences.

Incorporating social determinants of health

However, reducing unwarranted variations in care and narrowing options down to standard, successful treatment regimens for any condition is not good if patients won't, or can't, comply.

The World Health Organization (WHO) defines social determinants of health (SDOH) as "the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The SDOH are mostly responsible for health inequities — the unfair and avoidable differences in health status seen within and between countries."

Taking these SDOH into account is crucial when determining treatment protocols — both from patient outcome and revenue integrity points of view. If physicians prescribe medications that patients are unlikely to fill because they can't afford the copayment or full payment because of lack of insurance, or the benefits of medications are not communicated at proper patient education levels, it's likely that prescriptions will go unfilled, contributing to revenue leakage.

Kasbekar confirms this is what she is seeing at Penn Presbyterian. "We see this problem with outpatient prescriptions," she says. "A physician will prescribe an expensive medication for asthma. In our EHR, when we enter a prescription for an inhaler, it does not pull in the patient's insurance and the copay. Then the physicians get a phone call from the pharmacy, saying either that the patient can't afford to pay or that the drug is not covered by their insurance."

Evolving formulary management

Physicians must consider the cost per episode of care, and also bear in mind the department in which drugs are dispensed. For example, physicians might dispense different drugs, with different delivery methods (i.e., oral versus intravenous), depending on whether they are practicing in teaching hospitals or hospice settings. Formularies that don't take this into account are setting their organizations up for revenue leakage.

Traditionally, formularies have determined which drugs should be included by way of pharmacy committee systems, but this method needs to evolve. For example, if physicians decide to deliver drugs through IV rather than orally, or to prescribe higher than usual doses of pain medications in particular cases, the drugs they are recommending may not be on formularies for those particular uses. Often, older drugs or different drugs than what is on formularies could be just as effective, depending on the environment and particular circumstances.

What's needed are re-conceptualizations of formulary management, so that drugs

are considered in relationship to episodes of care, rather than just decided through pharmacy committee systems. By deciding which drugs to cut and which drugs to include in formularies based not only on drug costs themselves but on costs per episode of care — taking into consideration the added future costs of readmissions and other data — downstream revenue leakage can be avoided.

Kasbekar agrees. "There used to be a traditional formulary, and policy was that if the drug was not on formulary, the patient didn't get it," she says. "But now that inpatient versus outpatient lines are blurring a little bit, it's not that simple. We really don't have a good way of looking at formulary management and tying that in to cost of care."

Applying population health data

One of the realities that physicians must face when making care decisions is that treating certain populations (e.g., the elderly), will be different in the Midwest than in the Northeast, in terms of access to medical facilities, patients' lifestyles and other factors. Maintaining pharmacy revenue integrity will mean looking at data outside the walls of individual hospitals, taking into consideration geographic population health data, to make prescribing decisions that are in line with proactive (value-based) rather than reactive (fee-for-service) healthcare.

"One thing I appreciate about the population health conversation is that it considers the entire continuum of care," says Kasbekar. "Hospitals have traditionally been siloed into how our accounting budgets are set up: inpatient, outpatient, infusion and so on. But now, with population health, we can look at how each aspect affects the bigger picture of care."

Population health means looking at data and information on full cohorts, such as the elderly or people with heart disease, across entire populations, irrespective of geographic barriers. For example, physicians with access to longitudinal databases could look at medications prescribed, drug interactions and co-morbidities in elderly populations across the Midwest, rather than just their own hospitals, to determine the best course of care. For the elderly, treatments would allow patients to maintain their lifestyles most independently, in the least restrictive environments possible — whether that's in their homes with home health aide visits a few days a week, assisted living facilities or nursing homes with 24/7 direct care and supervision.

In value-based care environments, population health data will play a crucial role in making care decisions that lead to fewer readmissions and better patient outcomes, which contributes to revenue integrity.

Understanding risk versus value in prescribing habits

Physicians inherently understand the balance of risk and benefit when it comes to medications. For pharmacy revenue integrity, they must weigh the risks of prescribing certain drugs against not only the benefits (or value) for patients, but also for payers. They should ask the question, "What value does this drug deliver in exchange for what patients/payers are willing to pay for it?"

It turns out that "value" is in the eye of the beholder. For patients, the value of medications lies in their ability to improve quality or quantity of life. For payers, drugs have value if they effectively treat patients, to be sure, but that value comes from the idea that payers won't have to cover repeat hospital admissions or clinical intervention costs down the line. Healthy patients are the end goal for all stakeholders, but the bottom line is different for each party. Measuring that value with precision is not always easy.

The problem is that physicians often do not see the benefits of many drugs for a long time. It's only with the help of a longitudinal patient database that includes the 11-digit National Drug Code pharmacy data that providers can extricate the necessary data from within the four walls of hospitals. When providers can tie the value of medications to proxy measures, such as length of stay, readmissions or medication changes, then payers will be able to deliver financial rewards, and providers, specialty pharmacies and patients will reap the benefits.

Through value-based care initiatives, payers are increasingly holding providers accountable for choosing the right combination of drug regimens and treatment protocols to deliver the best possible outcomes at the lowest total cost of care; it is only by understanding risk versus value, through use of longitudinal data, that pharmacy revenue integrity can be preserved.

Understanding that drug costs aren't everything

In addition to the factors discussed here, it's important for physicians, pharmacy managers and hospitals executives to understand that it's more than just the straight cost of any one prescription that matters to the big picture. In value-based care landscapes, we need to tie pharmacy initiatives to what hospital leadership teams are trying to accomplish, which is a decrease in readmissions, says Kasbekar.

"We should look at cost per service, cost for participation, cost for full-time employees, and so on, so that we can, over the course of a year, analyze that information and come up with a realistic baseline of cost per service," she says.

What is needed to come up with realistic costs that take into account the entire journey of care, rather than siloed information from each hospital department, is a longitudinal database and an analytics solution that can identify higher-level reports, tying in pharmacy data to metrics such as readmissions and length of stay.

For example, a physician might be using a diabetes drug that is 25% more expensive than the drugs his colleagues prescribe, yet his patients are consistently experiencing lower lengths of stay and fewer readmissions. "From a pharmacy perspective, this physician will be penalized because the drug he is using has a higher cost. However, from a system perspective, his patients are getting better faster and saving the hospital money, thus preserving revenue integrity," says Kasbekar. The industry needs analytics solutions capable of tying these data

sources together to show the ROI — or lack thereof — of high-cost drugs.

Fitting the pieces together

Maintaining pharmacy revenue integrity is about having accurate, longitudinal data available; having the right people (both physicians who understand how their prescribing decisions affect revenue integrity and specialists who understand how to analyze the data and derive actionable insights) and having the right technology that enables the data management and analysis to occur in real time.

Yet it's not enough simply to have the data. It needs to be applied strategically in the following ways to effect results:

- Aggregation — Data from individual patient cases must be pulled together into a longitudinal patient database that looks at many cases, over many years, to establish patterns.
- Amalgamation — The data must be looked at cohesively (population health, social determinants, disease cohorts) and treatment decisions must be based on this longitudinal information.
- Benchmarking — Looking at the data, physicians must become comfortable comparing their patient outcomes and cost-effectiveness against their peers in the industry and be willing to adjust as necessary.

If physicians and hospital executives are willing to acknowledge the powerful role data can play, the impact on both patient outcomes and revenue integrity can be tremendous. +

This article originally appeared in HFMA's CFO Forum.

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Ways to reduce opioid misuse through patient monitoring

Scott LaNeve

Increasing prescribing guideline adherence by just 20% could reduce the cost of opioid misuse by $6.4 billion per year.

The cost of opioid misuse could be reduced if more healthcare providers followed state and federal prescribing guidelines. They often skip these required patient-monitoring steps because of the additional time it takes to complete the tasks.

A 2015 *Health Affairs* study found only 53% of physicians surveyed had checked their state's prescription drug monitoring program (PDMP), and they checked only 25% of the time before prescribing opioids. Physicians told surveyors that retrieving the information is too time-consuming and difficult.

To retrieve a PDMP report, a healthcare provider must take the following steps:

- Visit the appropriate website
- Find the record for the correct patient
- Read each patient's prescriptions by brand names or active ingredients, prescriber codes, fill dates and quantities

While some electronic health record (EHR) systems have simplified access to the PDMP data, the provider must still complete the above steps except for the patient search. With or without EHR access to the PDMP, this process can take between 6 and 9 minutes, not to mention the time it takes providers to process the information (see first exhibit on page 12).

In addition to retrieving and interpreting the PDMP report, the provider must do the same for an extensive toxicology testing report. Interpreting the report includes reviewing drugs and metabolites found and linking them back to prescriptions that were dispensed to determine if the prescription was still active in the patient's system when the sample was collected.

Some laboratories provide a summarized interpretation with each test. However, test accuracy is dependent on the laboratory receiving an accurate and complete medication list. The toxicology report does not usually include the PDMP data for comparison, so this review is typically done by the healthcare provider.

The process of manually comparing state PDMP data to laboratory data can be completed more efficiently within an EHR.

This complex process is not only time-consuming but also increases the likelihood of manual errors that can result in serious adverse events for patients, physicians and healthcare employers. A provider might incorrectly interpret toxicology test results as substance misuse or even overlook an active prescription not detected in a test.

With the time involved in retrieving the reports, as well as the mental fatigue and pressure resulting from multiple critical manual processes, it is no wonder a recent study found physician burnout costs the U.S. healthcare system roughly $4.6 billion a year (Han, S., Shanafelt, T. D., Sinsky, C. A., et al., "Estimating the attributable cost of physician burnout in the United States," *Annals of Internal Medicine*, May 28, 2019).

The patient-monitoring process

One way healthcare systems and laboratories can better follow guidelines and reduce opioid misuse and its costs is through clinical decision support. Automated clinical decision support integrates laboratory and

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The role prescribing guidelines play in patient-monitoring

According to the Centers for Disease Control and Prevention (CDC), 11.5 million patients are misusing prescription opioids. To prevent and detect opioid misuse, the CDC, Centers for Medicare & Medicaid Services (CMS) and most states have issued prescribing guidelines that include requirements for regularly monitoring the 25 million American patients the CDC reports are prescribed opioid therapy (*2018 Annual Surveillance Report of Drug-Related Risks and Outcomes — United States. Surveillance Special Report 2*, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, Aug. 31, 2018).

While research on the effectiveness of patient monitoring is still in its early stages, an independent health system report presented in April at the Executive War College Conference on Laboratory and Pathology Management showed healthcare providers were able to reduce opioid misuse in their practices by 40% when they followed prescribing guidelines that included regular prescription drug monitoring program (PDMP) checks and toxicology testing. PDMP checks help healthcare providers know which controlled substances a patient received from the pharmacy while toxicology testing serves to verify what the patient is taking.

PDMP data within the EHR. Healthcare providers can have a single point of access that assesses and presents the most crucial clinical information. The automated process can include analytics that fit into the clinical workflow and flag high-risk situations and patients based on comparing PDMP and toxicology testing results (see second exhibit below).

A process that involves retrieving data from a state PDMP website as well as laboratory data and then completing a manual comparison can be completed more efficiently within an EHR. The EHR can provide a report that includes both PDMP and laboratory data. Using clinical decision support also offers a real-time picture of the following patient information:

- Medications taken versus what has been prescribed
- Drugs taken that were not prescribed
- Prescriptions filled from multiple providers
- Combining prescribed drugs with non-prescribed drug
- Illicit drug use or not taking prescriptions while continuing to refill them

In addition to the use of technology, healthcare providers should have regular discussions with their patients about the effectiveness, as well as risks and benefits of their treatment plans. To address the problem of misuse, providers can also sign controlled substance agreements together with patients at least once per year and educate patients and caregivers on safe opioid use and storage at the time of prescribing and during regular visits.

The overall impact

Opioid misuse is estimated by the CDC to cost the United States nearly $80 billion per year (Florence, C.S., Zhou C., Luo F., Xu L., "The Economic Burden of Prescription Opioid Overdose, Abuse, and Dependence in the United States, 2013," *Medical Care*, 2016). A 40% reduction of misuse through increased prescribing guideline adherence by only 20% of providers could reduce the cost of opioid misuse by as much as $6.4 billion per year (LaNeve, R., Cooper, G., *Understanding the Opioid Epidemic*, Executive War College Conference on Laboratory and Pathology Management, New Orleans, April 30, 2019).

Simplifying the process of retrieving and analyzing PDMP and laboratory reports supports healthcare provider adherence to prescribing guidelines, provides better documentation and administrative reporting and potentially reduces liability for providers and health systems as well. +

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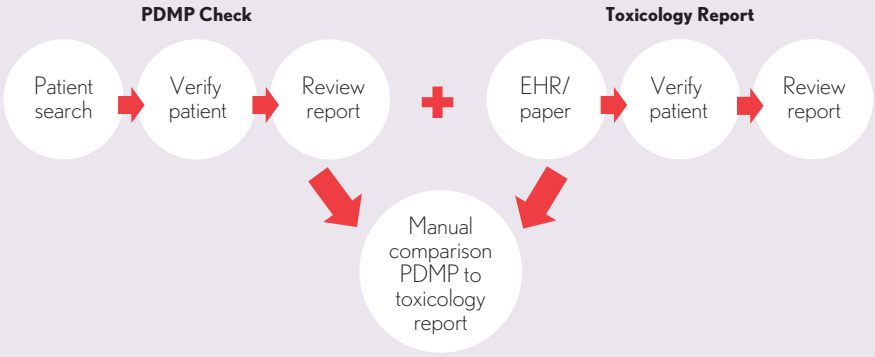
Typical patient monitoring process for prescription drugs



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Patient prescription drug monitoring process with clinical decision support

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Client relationships and the supply chain

Gregg Lambert

Building and supporting client relationships are core functions of the supply chain. But the client relationship is a two-way street.

The supply chain's direct clients include the health system's leaders and department heads and staff, both clinical and non-clinical. The supply chain also has an important client relationship with the patients the health system serves.

The use of "client" instead of "customer" or another alternative is intentional. Client relationships assume a long-term commitment. They are built on principles of collaboration, dedication and mutual respect. They encourage honesty and creativity in understanding and responding to a client's needs. They flourish when the client's best interests are consistently and conscientiously pursued.

In order to excel in its client service function, the supply chain also needs the support of its clients. A hospital or health system that wants the best possible client service from its supply chain must provide resources — including staff, technology and tools — as well as opportunities to collaborate on decision-making that will position the supply chain for success.

What the supply chain needs to do

The most essential services the supply chain provides connect directly to the challenges health systems face today. Downward pressure on payment rates and softening inpatient volumes make cost containment an ongoing priority. New technologies and care models require new investments. Payment models tied to the quality of patient outcomes and experiences keep raising the bar for clinicians. Consumers face higher deductibles and other out-of-pocket costs and seek affordable healthcare options.

To meet these challenges, the primary focuses of supply chain leaders should include the following services:

Assisting the hospital or health system in achieving its cost containment goals. Cost containment within existing operations is an imperative not only to maintain margins within a tightening payment environment, but also to free up the resources needed to invest in new care models and technologies.

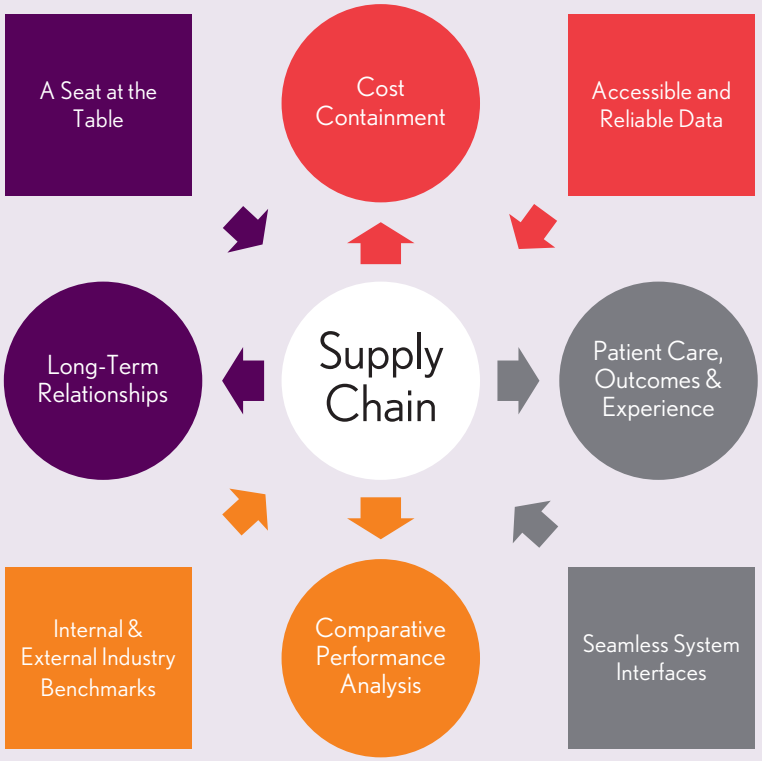
Linking purchased products and services to patient care, outcomes and experience. Healthcare has lagged behind other industries in its ability to link specific inputs with specific outputs. As increasing attention focuses on patient outcomes and experiences, the supply chain must establish processes that enable tracking of purchased products and services through to individual patient encounters.

A comparative anaytics framework can validate and quantify the supply chain's contributions to the organization.

Comparing its performance with peer organizations. Supply chain leaders need to benchmark their performance, both internally and against peer organizations,

The client relationship dynamic for the supply chain

Supply chain functions offer excellence when they are supported with staff, technology and tools and the opportunity to collaborate on decision-making.



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for two reasons. First, a comparative framework enables supply chain leaders to identify opportunities for improvement in areas where their performance is lagging behind that of their peers or not moving in the right direction. Second, a combination of internal and external benchmarks can demonstrate to the supply chain and the clients it serves how consistently it is performing within the organization and how well it is performing against peer organizations. Where the supply chain excels, a comparative analytics framework can validate and quantify the supply chain's contributions to the organization.

Forming long-term relationships with both vendors and clients within the organization. The supply chain is the client with respect to a health system's vendors and should demand the same level of service that the supply chain provides to its clients within the health system. Just as the supply chain needs the support of its clients to provide the best service, so too should it support its vendors with honest feedback, relevant data, and an openness to collaboration and creativity in securing agreements that work to the mutual benefit of both parties.

The same technologies and tools that will best support supply chain efforts may benefit administrative, operational and clinical efforts as well.

For the supply chain's own clients, leaders must work to build relationships of trust and mutual respect. Supply chain leaders must demonstrate their awareness of and dedication to the role that purchased products and services play in supporting the efforts of clinicians to improve the quality of patient care and the patient experience, department heads to effectively and efficiently operate their functions and administrators to provide a stable and well-functioning operating environment.

What the supply chain needs

Because the supply chain is integral to so many aspects of the enterprise, its needs often are not unique — the same technologies and tools that will best support its efforts may benefit administrative, operational and clinical efforts as well.

The primary needs of the supply chain include the following:

Accessible and reliable data. Cost and utilization data enable supply chain leaders to detect variations across departments and facilities and identify areas where product standardization could generate savings, support bundled-payment and pricing initiatives or provide greater leverage for volume-based discounts from vendors. Utilization data can support predictive modeling for demand trends that supply chain managers can use to ensure sufficient inventory is on hand.

For many organizations, providing this data at the needed level of granularity and timeliness will require investment in sophisticated cost accounting, inventory management and clinical systems. However, the benefits of this investment will extend beyond the supply chain to finance and the clinical enterprise.

Seamless system interfaces. To be most effective, supply chain leaders need to draw information from multiple systems, including inventory management, cost accounting, and electronic health record (EHR) systems. In many organizations, this is a cumbersome process, requiring manual workarounds where system interfaces are limited in their utility. Again, this problem is not limited to the supply chain. Investment in improving system interfaces will ease the burden on time and resources across the organization.

Internal and external industry benchmarks. Without the ability to compare performance across internal units of the organization and with external peer organizations, it is difficult for supply chain leaders to understand where performance may be lagging and where it is leading. This information is essential to identify and prioritize opportunities and set goals that are both ambitious and realistic. A comparative analytics solution that includes cost benchmarks for major categories of purchased products and services can supply this information.

To be most effective, supply chain leaders need to draw information from multiple systems, including inventory management, cost accounting and EHR systems.

A seat at the table. Supply chain leaders must have a seat at the table when purchasing decisions are being made across all areas of the enterprise. This is not a question of control, but of collaboration. Supply chain leaders have a comprehensive view of purchased goods and services across the enterprise and of vendor terms. If an alternative to a product or service is being proposed or a new vendor is recommended, supply chain leaders can provide critical insights into what costs might be associated with carrying new inventory or working with a new supplier. If a decision is made to move forward, supply chain leaders can ensure that the terms for the new purchase or relationship are consistent with the enterprise's existing agreements.

Hospitals and health systems count on their supply chain to manage what can account for as much as 40% of costs. By supporting the data and analytic needs of the supply chain, respecting the expertise of its leaders and ensuring they have a seat at the table, health system leaders can expect the very best client service. +

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+ healthcare costs at a glance +

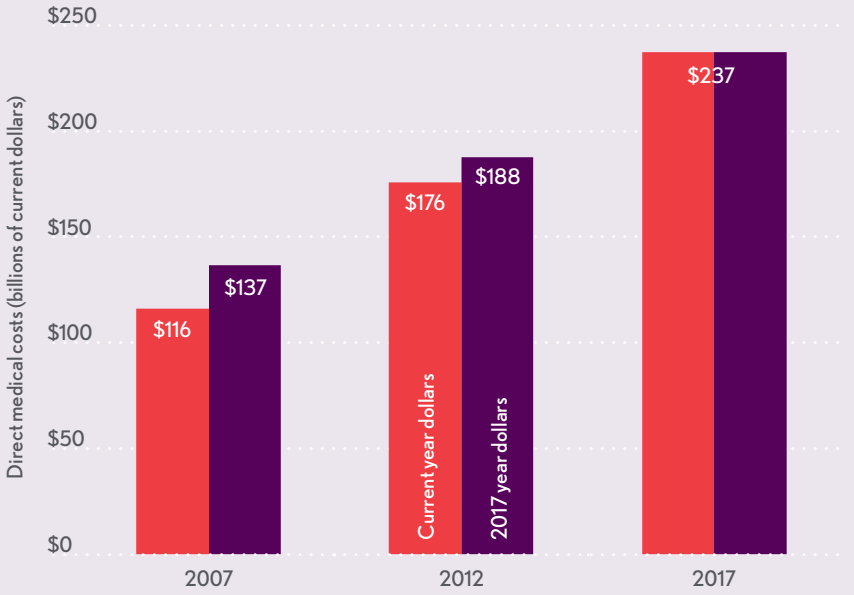
Medical costs for diabetes increase 26%

Medical costs for diabetes care increased by an estimated 26% between 2012 and 2017, according to a study published by the American Diabetes Association. Adjusting for both inflation and growth in diabetes prevalance, the excess medical cost per person with diabetes grew by 14% from $8,417 to $9,601 in 2017 dollars. Care for people diagnosed with diabetes acccounts for 1 in 4 healthcare dollars spent in the United States.

Indirect costs of diabetes, such as reduced employment by those who have diabetes, presenteeism in the workplace and premature death, are estimated at $89.9 billion. These costs grew by 23% during the 2012-17 time period.

The inflation adjusted total cost of diabetes increased from $261 billion in 2012 to $327 billion in 2017, which is comprised of $237 billion in direct medical costs and $90 billion in reduced productivity. +

Total direct costs of diabetes, 2007-17



Source: Economic Costs of Diabetes in the U.S. in 2017, American Diabetes Association.

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