Clinical Pathways

Executive Summary

Clinical pathways are formalized processes of care designed to reduce treatment variability at hospitals, outpatient centers, and other facilities. They can also be referred to as integrated care pathways or care maps. While every medical case is unique, payers and providers are attempting to standardize treatment since unnecessary variation is a major source of growing costs. These formalized processes may take the form of treatment guidelines, decision trees, and triage criteria. Clinical pathways differ from quality-focused clinical guidelines in that clinical pathways are designed to achieve both higher quality and reduced costs. These cost savings are often targeted at oncology, imaging, and cardiac services – specifically at reducing the usage of pharmaceuticals and imaging tests.

Why are Clinical Pathways a key issue?

Providers commonly establish clinical pathways to encourage clinically effective care. Many hospitals have long had loose guidelines or protocols in place that offer options for how to treat a condition. However, these care guidelines and protocols are only clinically focused. The sheer number of guidelines for a single procedure at an organization also means that care variation continues to occur. Pathways recommend the best option from a pool of care guidelines to effectively regularize delivery efforts across their institution. By standardizing care with both a clinical and economic mindset, pathways are an important value-conscious care strategy for providers and payers.

How do Clinical Pathways work?

Clinical pathways are more solidified than protocols or guidelines because physicians and administrators expend significant institution-wide resources for pathway development and implementation. The goal is to take the numerous guidelines and apply clinical effectiveness, toxicity, and cost screenings to decide on a pathway – the best selection of near infinite guideline(s) to use.

Once pathways are implemented, the goal is to use clinical information acquired at the point of care, or pulled from electronic records, to select the best of many guidelines or protocol to use. As a patient’s status changes, physicians and nurses access care pathway sheets that are either physically or digitally available bedside. Depending on the stage of treatment and patient condition, the pathway document informs caregivers which of several clinically acceptable plans is the best to take. Due to the nature of these pathways, they are often used to make decisions for non-emergency cases with multiple treatment steps, such as oncology care.

Clinical Pathway Development Process

1. Pathway Committee Collects Relevant Clinical Guidelines
2. Care Guidelines Screened for Efficacy and Toxicity
3. Remaining Clinically Comparable Guidelines Financially Screened
4. Care Pathway Formalized

Conversation Starters with the Hospital C-Suite

1. For which conditions, if any, have you implemented clinical pathways?
2. Which, if any, commercial payers have advocated for increased clinical pathway development?
3. How are you working with your physicians to develop and implement standardized care pathways?
How do Clinical Pathways affect providers?

Pathways have probably been most popular in the oncology space, due to a lack of quality metrics and generally high pharmaceutical costs. Treating cancer is a long, multi-step process, and these pathways ensure that providers are making the correct treatment decisions. In recent years, pathways have become more popular in the cardiovascular space and for orthopedic post-operation recovery. In many cases, pathways have also improved coordination between caregivers by giving nurses the ability to pursue a pre-approved care treatment with minimal oversight. This saves physicians time which they can then use to improve patient care.

Pathways also potentially pose complications for hospital-physician alignment. It is imperative for health systems to gain physician buy-in when standardizing care. Any efforts to force pathways on caregivers is likely to fail. As a result, the Chief Medical Officer is often responsible for pathway formation and implementation.

Long popular at the local level, the geographic breadth of clinical pathway implementation is expanding at a greater scale in regional markets. This has mainly occurred as dominant local/regional payers, such as Blue Cross Blue Shield of Michigan, encourage greater pathway adoption through increasing levels of financial reimbursement attached to provider pathway usage. National giant WellPoint has recently begun offering oncologists $350 per patient per month that they put on the insurer’s recommended clinical pathways. Many of these reimbursement models focus on how effectively providers can reduce pharmaceutical usage.

How do Clinical Pathways affect vendors?

In addition to payers and national clinical organizations, many vendors are entering the industry to sell pathways to providers. Cardinal and McKesson both have built robust pathway development consultancies, and more specialized companies such as Nucleus Pathways, eviti, Inc., Via Oncology, and New Century Health provide more niche pathway development support.

While there are many reasons to institute clinical pathways, many pathways target perceived overutilization of health care products, particularly pharmaceuticals and imaging tests. Clinical pathways themselves are not designed to prefer one brand over another. But, the focus on controlling costs across providers oftentimes means that pathways incentivize the use of generic drugs over branded varieties.

How might Clinical Pathways impact provider-supplier sales relationships?

Institution of clinical pathways at the system level can likely result in major changes to pharmaceutical and imaging usage.

Downward Pressure on Pharmaceutical Volumes

- Pathways are designed to regulate dosage and minimize the use of pharmaceuticals. Due to this increased regulation of physician behavior, pharmaceutical volumes may drop for select conditions with strong clinical pathways.

Decreasing Latitude for Off-label Usage in Certain Areas

- As pathways dictate what types of pharmaceuticals should be used in certain situations, certain off-label treatments may become difficult for physicians to use.

Additional Advisory Board research and support is available

If you would like more information on clinical pathways, please contact your institution’s Dedicated Advisor. To learn more about how pathways may affect oncology pharmaceuticals, please view A Primer on Clinical Pathways for Cancer Care.

Source: Advisory Board Research and Analysis
Executive Summary

The Department of Human and Health Services’ (HHS) 340B drug pricing program requires drug manufacturers to provide outpatient drugs to eligible health care organizations/covered entities (CE) at significantly reduced prices. Decreased drug costs under the 340B program enables CEs to stretch scarce federal resources as far as possible, allowing them to reach more eligible patients and to provide more comprehensive services. However, 340B program eligibility is under scrutiny now as proponents question CEs’ commitment to charity care and reinvestment of revenues in indigent care.

Why is the 340B Drug Pricing Program a key issue?

The 340B program impacts both CEs and pharmaceutical suppliers through drug discounts. The 340B program is designed to help safety net providers improve access to prescription medications for uninsured, vulnerable patients in the outpatient hospital setting. However, the 340B program negatively impacts pharmaceutical suppliers’ drug revenues since they are required to offer drug pricing concessions on products with significant research and development costs.

How does the 340B Drug Pricing Program work?

Eligible organizations can enroll in and purchase discounted drugs through the 340B program. 340B eligibility is limited to nonprofit health care organizations (e.g., acute care hospitals, freestanding cancer centers, health centers, specialized clinics, and Ryan White HIV/AIDS Program grantees) that have certain federal designations or receive funding from specific federal programs. Eligible drugs include:

- FDA-approved prescription drugs and insulin
- Over-the-counter drugs written on a prescription
- Biological products that can be dispensed only by a prescription (other than vaccines)

HHS requires participants to comply with all 340B program requirements but does not specify how participants should implement the 340B program. Most covered entities choose one or more of the following implementation options.

### 340B Implementation Options

#### In-House Pharmacy

- CE purchases and owns the drugs, pharmacy, and license
- CE is responsible for the pharmacy and pays the pharmacy staff
- CE example: a traditional hospital pharmacy that employs pharmacists to dispense

#### Provider Dispensing

- CE owns the drugs and employs physicians (not pharmacists) licensed to dispense in the state
- CE is fiscally responsible for operating and dispensing costs
- CE example: a rural hospital using physicians as dispensers due to a pharmacist shortage

#### Contracted Pharmacy Services

- CE purchases and owns the drugs
- CE pays dispensing fees to one or more contract pharmacies
- CE contracts with pharmacy to provide pharmacy services
- CE example: a hospital that outsources pharmacy services

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Conversation Starters with the Hospital C-Suite

1. Is your hospital considered a safety net hospital? How many uninsured patients does your hospital treat per year?
2. How is your hospital working to enhance pharmaceutical charity care efforts and access to affordable medications?
3. How is 340B pricing affecting service line strategies, such as oncology?
How does the 340B Drug Pricing Program affect providers?

Approximately one-third of U.S. hospitals participate in the 340B program and receive pharmaceutical discounts. The number of hospitals eligible for the 340B program is expected to rise due to relatively generous eligibility criteria and increased Medicaid enrollment under the Affordable Care Act. However, 340B’s eligibility criteria is under significant scrutiny from patient advocacy and pharmaceutical groups. About one-fifth of 340B hospitals provide 80% of all charity care delivered by 340B hospitals. 340B program proponents are pushing CEs to fulfill the charity care expectation of this statute and reinvest revenue from the 340B program in indigent care, which is currently not a requirement.

340B pricing affects cancer program strategy. Some providers are shifting cancer programs from hospitals without 340B privileges to CEs to gain access to the discounts. Though this is an emerging nationwide trend, research shows that the newly affiliated organization ends up serving a more affluent and insured population rather than providing cheaper drugs to the needy.

How does the 340B Drug Pricing Program affect suppliers?

340B negatively impacts pharmaceutical suppliers’ drug revenues since eligible drugs must be sold at discounted prices to CEs. Pharmaceutical suppliers often utilize a significant amount of resources in drug research and development, and the 340B program limits potential profits.

CEs are not required to extend 340B pricing discounts to needy patients and can charge patients above the discount. There are no restrictions on the way CEs spend the revenue generated from possibly charging above 340B discounted prices, meaning CEs can pocket those revenues rather than allocate them to charity care. With drug purchases through the 340B program expected to double from $6 billion in 2010 to $13.4 billion by 2016, pharmaceutical suppliers will likely be displeased about CEs misusing funds and not fulfilling the charity care expectation through reinvestment in indigent care.

How might the 340B Drug Pricing Program impact provider-supplier sales relationships?

The 340B program impacts both providers and pharmaceutical suppliers, therefore collaboration on this heavily debated topic can provide mutual benefit.

Providers Need an Outreach Partner
- Providers and pharmaceutical suppliers should collaborate to enhance access to affordable medications – consider co-sponsoring a patient assistance program for pharmaceutical products.

Providers Will Value Oncology Program Expertise
- 340B pricing affects oncology programs, and pharmaceutical suppliers that can help providers develop and implement a successful service line strategy will become trusted partners.

Additional Advisory Board research and support is available

If you would like additional information on the 340B drug pricing program, please contact your Dedicated Advisor. To learn more about how 340B pricing impacts hospital-based oncology programs, please read our How 340B Pricing Affects Cancer Program Strategy survey results.
Medication Reconciliation

**Executive Summary**

Medication reconciliation is the process of reviewing all of a patient’s medications to identify possible errors or duplication. It requires providers to compare a patient’s complete drug list to what the patient should be taking. This process often takes place at transitions of care – when a patient is admitted to the hospital, discharged from the hospital, or sometimes, has returned to the community.

**Why is medication reconciliation a key issue for providers?**

Medication reconciliation is a key component of reducing medication errors, coordinating medications support across multiple settings, and ultimately, improving patient safety and quality of care. Across an episode of care, patients are routinely prescribed new medications. After a hospital stay, patients may return to the community with separate medication orders from their primary care physician, attending hospital physician, and possibly an attending post-acute facility physician.

Due to medication reconciliation’s key role in improving care quality, [The Joint Commission](https://www.jointcommission.org), which greatly influences hospitals’ priorities, highlights medication reconciliation as an area for improvement under their National Patient Safety Goal #3, “Improve the safety of using medications.”

Adverse drug events are also a major contributing factor in patient readmissions. Because acute care providers are subject to growing readmissions penalties, post-discharge medication reconciliation has received renewed attention as a key component of readmissions reduction.

**How does medication reconciliation work?**

Medication reconciliation is often performed by a nurse or pharmacist. A provider begins the medication reconciliation process by creating a medication list that includes every medication that the patient is taking. This usually includes, at minimum, the medication name, dosage, and reason that the patient was prescribed that medication. The patient and their family members, if they are present, usually provide this information. Then, the provider compares this medication list to what the patient should be taking. If there are any discrepancies, the provider alerts the prescribing physician and re-educates the patient on their drug regimen.

Providers use medication reconciliation to avoid medication errors such as missing medications, duplications, drug interactions, or dosing issues. However, the process can be imperfect. Although hospitals attempt to compile complete medication lists, it can be difficult to obtain accurate information for every patient. Further, inaccurate medication histories and staff EHR entry errors can also pose challenges. There are technology-enabled medication reconciliation systems, but many providers rely on a staff member to run the process.

**Conversation Starters with the Hospital C-Suite**

1. At which points along the care continuum do you use medication reconciliation?
2. How are you using new medication reconciliation strategies to combat readmissions?
3. What are your biggest challenges in obtaining accurate medication histories?

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This report does not constitute professional legal advice. The Advisory Board Company strongly recommends consulting legal counsel before implementing any of the practices contained in this report or making any contractual decisions regarding suppliers and providers.

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Source: Advisory Board Research and Analysis, The Joint Commission.

<table>
<thead>
<tr>
<th>Adverse Events Experienced Within 30 Days Post-Discharge</th>
<th>For Medicare Beneficiaries</th>
</tr>
</thead>
<tbody>
<tr>
<td>34%</td>
<td>66%</td>
</tr>
<tr>
<td>Non-Medication Related</td>
<td>Medication Related</td>
</tr>
</tbody>
</table>

Source: Steve Hines, “Reducing Avoidable Hospital Readmissions”, (presented at the annual Florida Hospital Association Meeting, June 4, 2010).
How does medication reconciliation affect providers?

Clinical

When patients give accurate medication histories and the medication reconciliation process runs properly, the clinical benefits can be profound. Several studies found that medication reconciliation during transitions of care improved patient outcomes and reduced readmissions.

Financial

It can be incredibly time consuming for providers to use medication reconciliation at all transitions of care, and therefore initially expensive. However, providers stand to see significant savings in the form of reduced medication errors, fewer adverse drug events, and potentially reduced readmissions for medication-related reasons.

Operational

Medication reconciliation usually occurs at transitions of care. As these transitions can be chaotic, providers should implement strong operational protocols. Providers should focus on the accurate capture and documentation of patient medication histories, which can present significant challenges.

As shown in the graph below, inaccurate medication histories are a major contributor to medication order errors upon admission. Some providers are using specialized experts who focus on taking accurate medication histories to improve the efficiency of the process.

How might medication reconciliation impact provider-supplier sales relationships?

Providers may look for capabilities that make it easier for patients to understand, organize, and track their drug regimens.

Consider programs to improve medication adherence or reconciliation

• Suppliers should consider partnerships with both acute and post-acute providers to engage patients in their own self-management. Companies can support these patient engagement initiatives by promoting medication adherence programs or ways to manage complicated drug regimens.

Explore partnerships with retail pharmacies or community providers

• Suppliers should explore potential retail pharmacy alliances. Many providers work with community-based pharmacists to provide additional medication reconciliation oversight post-discharge. This method of management allows for the trained insight of pharmacists.

Additional Advisory Board research and support is available

If you would like additional information on medication reconciliation, please contact your institution’s Dedicated Advisor. To see how post-acute providers are using medication reconciliation, please view Medication Reconciliation Post-Discharge.

Source: Advisory Board Research and Analysis, American Pharmacists Association, American Society of Health-System Pharmacists
Alternate Specialty Drug Acquisition Channels

Executive Summary

In order to mitigate the rising cost of many specialty drugs, payers are exploring alternate pharmaceutical acquisition channels commonly called “white bagging” and “brown bagging.” These models allow payers to do three things: purchase drugs at a lower cost directly from a specialty pharmacy, shift coverage of drugs from medical benefit to pharmacy benefit, and increase visibility into their drug spend.

Why are alternate specialty drug acquisition channels a key issue for providers?

Drugs purchased using alternate pharmaceutical acquisition channels result in lost revenue for providers. Traditionally, providers have operated using the "buy and bill model." Providers purchase specialty drugs, administer them to patients, and then bill payers for the drugs and administration. Drug reimbursement is typically equal to the cost of the drug plus a fixed percentage.

White bagging and brown bagging effectively take providers out of the business of buying and billing for specialty drugs and lower their revenue potential from pharmaceuticals.

How do alternate specialty drug acquisition channels work?

Under white bagging, payers purchase the drugs through a specialty pharmacy, which then ships them to the provider for administration. With brown bagging, drugs are purchased through specialty pharmacy but shipped directly to the patient, who is responsible for storing and transporting the drug to the provider where it is administered.

Questions for Pharmaceutical Teams to Anticipate from the Hospital C-Suite

1. What percentage of your drugs are purchased using alternate acquisition channels?
2. How do you ensure that alternate drug acquisition methods do not negatively impact the integrity of your product?
3. Do you anticipate that payers will begin buying other pharmaceuticals using these methods? If so, what types of drugs?
How do alternate specialty drug acquisition channels affect providers?

Many providers feel that brown bagging risks the safety and integrity of the pharmaceuticals due to the potential for improper storage and handling. Often times, providers refuse to administer drugs delivered directly to patients. White bagging addresses providers’ safety concerns by including them back in the supply chain – allowing providers to verify drug integrity and pedigree, effectively reducing the risks associated with brown bagging.

Some providers are comfortable with white bagging; because it relieves them of absorbing the cost of expensive pharmaceuticals that are never administered for reasons beyond their control, such as missed patient appointments or spoilage. But one of the biggest challenges white bagging poses for providers is that they do not receive any compensation for the additional responsibilities they must take on to serve as couriers for complex drugs, such as special handling and temperature-control monitoring. Providers are only reimbursed for the administration of the drugs.

The 2013 Medical Pharmacy and Oncology Trend Report from the benefits management company iCore found that in 2010 29% of injectable drugs administered by a provider were obtained through white bagging and 11% through brown bagging. Given payers’ focus on controlling drug costs, these numbers are expected to increase.

Providers have responded to these alternate specialty drug acquisition channels by refusing to accept drugs via white and brown bagging. Some hospitals and health systems have convinced insurers to pay them an administration fee for the management of specialty pharmaceuticals. Others have chosen to develop their own specialty pharmacies, though this is no easy task due to complex regulatory criteria.

How do alternate specialty drug acquisition channels affect patients?

A survey conducted by The Lewin Group on behalf of the Patient Advocate Foundation found that 92% of patients are "concerned" or "somewhat concerned" by the practices of brown bagging and white bagging. While patients' concerns are unlikely to reverse the trend towards increasing use of specialty pharmacy (especially as few patients are even aware of the practice), it is another factor that has the potential to influence payers. If increasing numbers of patients lodge complaints with their health plans about brown bagging and white bagging, payers may be more receptive to working with providers to find a mutually acceptable approach for acquiring specialty drugs.

How might alternate specialty drug acquisition channels impact provider-supplier sales relationships?

There are no direct implications of alternate specialty drug acquisition channels for suppliers. However, provider concerns such as patient safety and lost reimbursement may make providers wary of suppliers’ relationships with payers.

Providers Concerned with Patient Safety
• Providers are concerned that specialty pharmaceuticals acquired through brown bagging may increase risks for patients due to the potential for mishandling.

Lost Revenue Disappoints Providers
• By removing providers from the purchasing process, payers have effectively reduced provider revenue. Providers may be particularly sensitive about this considering they do not receive any compensation for the additional responsibilities they must take on to serve as couriers for complex drugs.

Additional Advisory Board research and support is available

If you would like more information on alternate specialty drug acquisition channels, please contact your organization’s Dedicated Advisor. To learn more about how white bagging and brown bagging may affect pharmaceuticals, please read the blog posts, “The increasing role of specialty pharmacy in cancer care and how providers can respond” and “How to tackle the white bagging trend.”

Oncology Care Model (OCM)

Executive Summary

The Oncology Care Model (OCM) is a voluntary CMS payment and care delivery reform initiative focused on improving care quality and coordination for Medicare patients receiving chemotherapy. The OCM began on July 1, 2016 and runs through June 30, 2021. The participants include independent and hospital-aligned physician practices that have committed to meeting certain practice requirements.

Why is the OCM a key issue for providers?

- Typically Medicare patients account for 50% of an oncology practices’ patient population. Consequently any change in Medicare payment has an outsized impact for these specialists.
- The OCM represents CMS’s first value-drive medical oncology payment model, and many in the cancer community speculate that it is indicative of the future direction of oncology payment reform.
- One of the key motivations for practices to enroll in the OCM was the opportunity to help influence CMS’ development of value-driven oncology payment models.

How does the OCM work?

Participating physician practices must provide the following enhanced services:

- Core functions of patient navigation
- 24/7 access to an appropriate clinician
- Comprehensive care plans encompassing 13 components of the IOM® Care Management Plan
- Treatment with therapies consistent with nationally recognized clinical guidelines

Furthermore, practices must use:

- Certified electronic health record technology to evaluate patient health outcomes
- Data to drive continuous quality improvement

To help offset the costs of these additional services, Medicare will reimburse participating practices a monthly enhanced oncology services (MEOS) payment for each patient receiving chemotherapy starting with the initiation of treatment and continuing for 6 months. In addition, practices that achieve certain quality benchmarks and that reduce Medicare spending have the potential to earn a performance bonus.

Components of the OCM Payment Model

Fee-for-Service Payment

- Participating practices continue to earn fee-for-service payments for services to Medicare beneficiaries
- Drugs continue to be reimbursed at their ASP plus a mark-up

MEOS Payment

- Upon initiation of chemotherapy, practice bills for MEOS and receives $160 MEOS payment for six months
- If the patient continues or resumes chemotherapy after the initial six-month episode, practice can trigger a second episode

Performance-Based Payment

- Practice is eligible to receive performance-based payment if it reduces Medicare’s total costs and meets quality standards
- Quality performance is measured relative to other practices’ performance.
- Cost performance is evaluated against practice’s historical performance

Conversation Starters with Physician Practices

1. What is your payment reform strategy? Are you participating in any risk-based payment models?
2. What changes are you making to your care delivery model in order to succeed under risk-based payments?
3. How are you coordinating with other providers, e.g. hospitals, hospice, other specialists, primary care?

Sources: CMS.gov; Advisory Board interviews and analysis.

1) Centers for Medicare & Medicaid Services
2) Institute of Medicine
3) Average Sales Price
4) Monthly Enhanced Oncology Services

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How does the OCM affect providers?

Clinical

The OCM includes patients with nearly all major cancer types. Care episodes begin on the date of an initial Part B or Part D chemotherapy claim and last for 6 months. Practitioners’ quality performance is assessed on a set of 12 measures that fall into four domains: Communication and Care Coordination, Person- and Caregiver-Centered Experience and Outcomes, Clinical Quality of Care, and Patient Safety. CMS also uses these 12 quality measures to calculate participants’ performance-based payments.

<table>
<thead>
<tr>
<th>Quality Domain</th>
<th>Quality Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication and Care Coordination</td>
<td>1. Proportion of patients with all-cause hospital admissions within the 6-month episode 2. Proportion of patients with all-cause ED visits that did not result in a hospital admission within the 6-month episode 3. Proportion of patients who died who were admitted to hospice for 3 days or more</td>
</tr>
<tr>
<td>Experience and Outcomes</td>
<td></td>
</tr>
<tr>
<td>Clinical Quality of Care</td>
<td>7. Adjuvant hormonal therapy for high-risk prostate cancer patients 8. Timeliness of adjuvant chemotherapy for colon cancer 9. Timeliness of combination chemotherapy for hormone receptor negative breast cancer 10. Trastuzumab received by patients with AJCC stage I (T1c) to III Her2/neu positive breast cancer 11. Hormonal therapy for stage IIC-IIIIC estrogen receptor/progesterone receptor (ER/PR) positive breast cancer</td>
</tr>
<tr>
<td>Patient Safety</td>
<td>12. Documentation of current medication</td>
</tr>
</tbody>
</table>

Financial

CMS projects total Medicare spending for patients attributed to a participating practice and calculated a “target price” for the practice. The practice’s financial performance is then measured against this target price. Practices participate through one of two tracks:

- One-sided risk: The target price is calculated by applying a discount of 4% to the practice’s projected total Medicare spending. If the practice reduces Medicare’s costs below this target price, it may receive a portion of those savings as performance-based payment. The practice is not financially responsible for any expenditures that exceed the target price.
- Two-sided risk: The target price is calculated by applying a discount of 2.75% to the practice’s projected total Medicare spending. If the practice reduces costs below this target price, it may receive a portion of those savings as performance-based payment. If the practice’s costs exceed the target price, it must repay Medicare the difference. Practices have the option to take on two-sided risk starting on January 1, 2017. The two-sided risk track is considered an Advanced Alternative Payment Model (APM) under the Medicare Access and CHIP Reauthorization Act (MACRA).

Operational

To meet the requirements for participation, many physician practices need to make significant changes in their care delivery model and IT systems, which may require hiring new staff, changing workflows, and implementing new care coordination protocols.

How might the OCM impact provider-supplier sales relationships?

Reduce Costs Related to Care: Practices need help identifying opportunities and implementing initiatives to reduce costs to Medicare. For example, practices may seek to reduce spending on chemotherapy drugs or to invest in treatments or services that reduce avoidable hospitalization rates and ED visits.

Measure and Analyze Data: Providers need vendor partners to help develop new quality reporting tools to streamline reporting and analysis of complex clinical and financial data. Furthermore, vendors can help practices analyze data from CMS and incorporate patient-friendly data fields in electronic health record systems.

Lend Decision Support: Vendors can offer clinical decision support systems with embedded precision medicine and molecular diagnostics support to help clinicians make better treatment decisions.

Additional Advisory Board research and support are available.

Sources: CMS.gov; Advisory Board interviews and analysis. advisory.com