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Innovation: new idea, creative thought, new imaginings in the form of device or method. I believe we all can agree that the quagmire that is the U.S. health system in 2019 cries out for innovation in all ways. The question becomes: how does a highly regulated, risk-adverse, complicated, multifaceted system encourage innovation? I don’t think it does—but that doesn’t mean those of us who make our living in the system should throw up our hands and give up. We need solutions, innovative ones both large and small. How do we get them?

Like nearly every problem in life, there isn’t a magic bullet—but there are pathways to success. Other industries have completely changed their business models, their methods of reimbursement, everything. We can too.

In a prior life, I worked for a large manufacturing company. Our largest customer came to us and said: “You will lower your price by 20%, you will provide us with your process quality data. But at the end of the day we will give you three times as much volume, you’ll make more EBITDA, and your return on assets will go up.” Our first reaction was “You’re completely insane.” But they were our largest customer, so, we provided them with the data, which we had to figure out how to capture. Once we figured that out, we were able to use that quality data to dramatically improve our process—we reduced waste by nearly 20%. Everything they said came true—three times volume and nearly four times margin. What’s the point for healthcare? Maybe if we rethink our processes we can find better quality, better outcomes, and maybe make a bit more margin.

New pathways

While a dramatic, completely new innovation is fabulous—antibiotics, anesthesia, shared-risk arrangements come to mind. We can’t all be that creative, but we can all find new pathways. We need to study other industries and processes. Where did surgical checklists come from? Airplane pilots. What other solutions can be modified and tweaked and make a difference in healthcare? I’m certain there are a tremendous amount of processes, systems, and technology solutions that can be adapted to healthcare, but we have to look for them and be open to considering non-healthcare ideas. We do have to adapt them to our world—that’s one form of innovation.

I’ve visited and studied health systems in a number of countries—I don’t think any of them have all or even most of the answers but they, in most cases, get better results in many key measures. Maybe if we look at what they do we can find an “innovation” for our system. Social determinants are an area we are finally considering. Those factors influence outcomes everywhere. Has any system made more progress in childhood nutrition, maternal health, or any of a number of other conditions impacted by these factors? My guess is yes. Can we use exactly what they do? Probably not. But can we modify their approach to fit our parameters? I bet we can. That’s a form of innovation.

A question we should ask ourselves—how do we compensate our staff for innovation—do we incentivize it or does our compensation system incentivize limiting risk? If we have an Innovation unit, to whom does it report, how are its ideas disseminated? I believe most of our organizations aren’t structured to encourage adoption of innovation. Let’s make this issue the first one solved with an “innovation”—new incentives.

Finally, I think we find innovation by asking why and what—not why not. Let’s make 2019 the year of innovation.
Innovation Transforms Healthcare

A look at what works, how much to invest, and how to know what truly matters

By KEITH LORIA

The healthcare industry thrives on innovation. Creative ideas, new programs, or interesting technological advancements that can generate value and make things easier for patients are the lifeblood of any healthcare organization.

Innovation encompasses how people act, think, and engage within and across organizations. It involves out-of-the-box thinking, taking risks, learning from failures, and making investments in ideas, people, and culture.

Poonam Alaigh, MD, executive vice president of corporate development business at Remedy Partners, Inc., a Connecticut-based organization that has developed a virtual network of providers involved in BPCI, says innovation is a philosophical belief that is cultivated at the leadership level and then diffused across the institution.

"Innovation requires leaders to be actively envisioning a new future," she says. "This is a
key competency in leading any health sector because envisioning something new requires innovative approaches to creating building blocks for cross sector collaborative solutions—something that is critical for rapid advancements."

Scott D. Hayworth, MD, president and CEO of CareMount Medical, PC, one of the largest multispecialty medical groups in New York, says innovation has always been of upmost importance to the organization, and trying new things is the reason it has grown to 650,000 active patients, 500 doctors, and 650 providers overall.

“We have always been a cutting-edge organization. We adopted a lot of technologies before a lot of other groups in the country and always try to stay ahead of the curve,” he says. “We were the first group in country to have electronic medical records, installing them in 1995. We also were one of the first to become a Next Generation ACO for Medicare patients, which represents a significant step along the risk continuum as we continue to focus our strategic model on the shift from volume to value.”

Steve Betts, senior vice president and chief information officer of Health Care Service Corp. (HCSC), a health plan that serves Illinois, Montana, New Mexico, Oklahoma, and Texas, says innovation to its company means making it easier for members to access the information and resources they need to make decisions about their healthcare and be at their best.

“This member-centric focus is what drives our inspiration to think and work differently across the organization,” he says. “We are also constantly working to ensure our employees are ready to address the challenges and opportunities of tomorrow, so we created programs like ‘Explore,’ which allows them to experiment with emerging technologies such as artificial intelligence and blockchain.”

Additionally, HCSC holds regular hackathons, which bring employees together to tackle a specific challenge, such as increasing member utilization of behavioral health resources or taking advantage of employer wellness programs.

Carla Balch, CEO of TransMed Systems, a clinical trial software company for hospitals and life sciences under the umbrella of Flatiron Health, says when considering innovation, two things that are key (but often overlooked) are establishing why you want to innovate in the first place, and then tackling areas of innovation in a very focused manner—one pain point at a time.

“It’s important to ask where the current system is falling short of a vision and how you can make a meaningful difference,” she says. “Innovation causes conflict and requires an awful lot energy. You can’t sustain it by trying to work on too many problems, nor problems in which the outcome of your work won’t make a noticeable difference on what patients need most.”

1/ Investment decisions

Innovation takes time and money, and it’s important to have a savvy strategy in place that can choose the best ideas to run with.

“When determining which ideas to develop, we move forward with the ideas that have the best potential to improve the quality and affordability of care for our members,” Betts says. “We also screen the ideas for business and technical viability. Each idea is allocated a specific dollar amount.”

“When someone comes to demo something, we have at least three people in the room so we can discuss what we liked and didn’t like about an idea.”

—SCOTT D. HAYWORTH, MD, CAREMOUNT MEDICAL, PC

Any organization that tells you they never made a mistake is not being honest, Hayworth notes, admitting that some ideas for innovation fail or don’t work out the way originally hoped.

“We look at things as teams and weigh all ideas,” Hayworth says. “When someone comes to demo something, we have at least three people in the room so we can discuss what we liked and didn’t like about an idea. Making a decision on your own is tough for anyone, and I like to get feedback before deciding to invest in something.”

Harris County Public Health (HCPH), a nationally recognized $100 million agency serving the nation’s third-largest county, is the only health department in the country that has an ongoing agreement with Microsoft Research for mosquito borne diseases, uses VR to talk about exercise and mental health, and prides itself on innovation to improve.
“Innovation, equity, and engagement are the three core principle values at HCPH and guide our work,” says Umair Shah, MD, executive director of HCPH. “Since there isn’t a large financial investment in public health, HCPH has had to become innovate on how we meet the health demands of a growing, diverse population with limited resources.”

To do this, HCPH has enacted a sort of think tank called Lead 360, made up of individuals from across every area of the health department and all executive leaders, which meets quarterly and identifies a core problem, proposes solutions, and then lays out a plan on implementation.

“With the exception of leadership, every year a new cohort is introduced and is tasked to solve another identified problem,” Shah says. “This group allows for us to take time out from the ‘every day’ to allow innovation to flourish and lets a wide group of perspectives to come to the table. Because our finance team is at the table, they can help guide decisions on investments to innovate concepts.”

From pilot to launch

Many innovative models start out with a pilot phase, where you create the workflow, test its user acceptance, assess the scalability, and analyze the financial feasibility. All these elements are critical decision points on whether to move forward or not.

“Quick, short pilots with specific end points and metrics that prepare for a path forward before a wide-scale deployment is generally a good practice,” Alaigh says. “However, there are some instances where there is an urgent market need, and you go straight to launching the innovation without the pilot phase.”

At HCSC, innovation takes a three-phased approach from developing the concept (identifying the problem they are trying to solve), creating a prototype and testing with the end users and launching a pilot in one of its markets.

“Across the company, we leverage design thinking by testing ideas with the actual users of that concept and iterating the design of a solution that resonates with them,” Betts says. “So, while the concept may come from a myriad of channels, we bring our users in at every stage to pressure test if we’re still solving the right problem.”

This often takes the form of focus groups, where the organization can present one version and determine whether this concept is meeting a critical need, which features work well or need additional design, and ensuring it’s still aligned to its business objectives.

“One the design is in place, we identify an appropriate market and population size based on who the product is intended to serve and launch a pilot,” Betts says. “Based on the pilot results, the product may then be brought to market in one or more of our five health plan states.”

Once Hayworth decides to go forward with something for CareMount Medical, it is put through a demo process in one location, and if it works as intended and all the kinks are worked out, that innovation will be added to the other locations.

“Choosing a site is important because there could be some places it’s not a fit for and it may fail, though it would have been successful at 95% of the organization,” he says. “The timeline for each project is different. We look for feedback from physicians, patients, and the front-desk staff, but if patients don’t like it, we will tweak it or won’t go forward with it.”

For example, when the group demoed a new online scheduling program, it found it had some issues that needed tweaking and things it didn’t think about at first. The No. 1 reason patients weren’t happy with it was because of an extra step: if they went to book an appointment with their provider and learned that the provider was booked in the period of time they needed, the patient had to go back to the main page and start again rather than just seeing a list of providers who were available. That was changed and the program was instituted.

Shah says all ideas come from an aspirational goal, envisioning the future state based on a deep understanding of the current state, with both its strengths and weaknesses.

“Ideas that are generated from the ground up generally result from a basic unmet need,” he says. “Being able to bridge these ideas and
create an innovation using ongoing feedback and input is crucial. We test the market as we are building a feasibility model, to ensure our innovation is offering a practical solution that is both easily implementable and adoptable.

3/ Innovation in action

HCSC recently created an in-house incubator to better propel ideas within the organization and identify, test, and accelerate new products. The team is made up of technology and data professionals, user experience researchers, designers, and developers who use design thinking to solve industry and consumer challenges, such as finding a convenient in-network hospital by using a smartphone app in an emergency situation or more effectively managing chronic conditions.

“One of the recent product offerings we are most proud of is Health Advocacy Solutions, which provides members a personal health advocate to help them better manage their care,” Betts says. “Health advocates can connect members to clinicians, pharmacists, and benefit experts so they can make informed decisions about the most appropriate sites of care and take advantage of incentive programs like Member Rewards.”

For example, if a member calls in to ask about replacing their ID card, in addition to simply providing a new card, the multidisciplinary team of clinicians, pharmacists, and benefit experts may use an advanced interface to see that flu rates are also rising in the area and direct them to the best place for their flu shot. So far, HCSC has received a 93% rate of engagement among members with high-cost conditions that benefit from the counsel of health advocates.

It’s also involved with several STEAM (Science, Technology, Engineering, the Arts, and Mathematics) initiatives to foster the next generation of talent, which help lead to innovation and new ways of thinking.

For instance, twice a year the company teams up with Lumity, a nonprofit organization that helps prepare young adults from underserved communities for careers in science, technology, engineering, and mathematics, to engage high school students in real-world experiences.

A new innovation at Remedy Partners is working to create solutions to enable structural payment reform by shifting fee for service to episode-based payment models.

“This will finally allow us to align incentives and create organic and sustainable change,” Alaigh says. “Physicians and patients together will be at the helm of navigating the care based on patient experiences, personal values and clinical outcomes. It is for nimble and agile companies to catalyze and accelerate the momentum in value-based care and ensure the highest quality and the financial solvency of our healthcare system.”

Alaigh notes innovation is hard work and every employee needs to be constantly cultivating, investing, walking, and talking innovation.

“This also means collaboration with others and often times with competitors—joining forces and combining brain trust,” she says. “The full potential of a company, even with the best products and services, can only be realized with the right leadership and culture that its employees foster.”

An innovative idea of CareMount Medical’s Hayworth was to take part in a CEO swap with Ed Brown, CEO of The Iowa Clinic in West Des Moines, Iowa.

“It opened my eyes on how other people are doing things and it was a really strong data exchange,” he says. “Not every innovative idea is something physical or tech-driven. I have worked with a lot of different hospital groups and sometimes the best ideas are just ones that let you understand a new perspective.”

Keith Loria is an award-winning journalist who has been writing for major newspapers and magazines for close to 20 years.
If a bird in the hand is worth two in the bush, the same can be said about patients. The patient experience you provide ties directly to patient retention—or not. Here’s patient retention advice from top customer experience experts.

1 Define what a holistic experience vision—the end game—really looks like. Consider what CEO David Feinberg did at Geisinger Health System in Pennsylvania, says Jeff Gourdji, partner and healthcare practice lead at Prophet, a global brand and marketing consultancy. “Their consumer-centric vision of eliminating the waiting room and everything it represents set the stage for a series of bold moves. A vision alone doesn’t mean anything. It must be the starting point,” says Gourdji, who is also co-author of “Making the Healthcare Shift: The Transformation to Consumer-Centricity.”

2 Build capabilities and ensure ownership and accountability. “Centralize and assign those responsible for owning the customer experience,” says Gourdji. “You can centralize or decentralize customer service, either under marketing, or maybe as a decentralized, stand-alone team.”

3 Identify quick wins to jumpstart momentum. Geisinger’s Feinberg flipped the switch with a disruptive tactic that jump-started the greater vision—he guaranteed dissatisfied patients refunds of up to $2,000. A year later, only $500,000 in refunds had been processed—but yet the organization was galvanized and patient satisfaction scores increased measurably,” Gourdji says.

4 Drive system-ness across access points. Patients decide where and when to obtain care. “They behave like consumers of other products and services,” says Erin Jospe, MD, chief medical officer and senior vice president, account management at Kyruus, a provider of enterprise solutions for health systems. “Research shows that while most patients research providers online, 58% still prefer to book appointments by phone.”

Health systems must own the accuracy and comprehensiveness of their information about their provider networks, and offer a consistently excellent experience through all points of entry to their systems, according to Jospe.

5 Expand access points. Consumers value timely and convenient access to care. For example, in a 2018 survey of 1,000 consumers, 84% rated appointment availability extremely or very important and 76% rated location extremely or very important. Similarly, over half had received care in retail clinics in the past year, with convenient location and speed of access the top-cited reasons.

Providing care in alternative, local settings, can drive long-term patient retention, Jospe says.

6 Think holistically. Engage cross-functional teams in development of current and to-be “visual journey maps” of the entire patient experience, according to Graham Hughes, MD, chief executive at Sutherland Healthcare, a provider of transformational services.

“Bring real customers into the process too, to better understand higher-priority pain points and opportunities to improve,” Hughes says. “This lays a foundation for the multi-year roadmap, a never-ending journey as expectations, technology, and processes evolve.”

7 Go beyond a single approach. Industries such as retail and entertainment figured out long ago that there is no such thing as “one size fits all.” “There needs to be a handful of planned variations in the customer experience, based on customer archetypes ... that reflect customers with different preferences, needs, and expectations,” says Hughes. “Knowing this, organizations can then determine how far to move into hyper-personalization, which can be achieved and refined through a variety of methods.”

Stephanie Stephens is Southern California-based journalist, producer, and podcast/on-camera host who’s written about health and healthcare for more than 15 years.
President Donald Trump has proposed lowering drug prices by basing them on other countries’ costs, a monumental change that could save Medicare beneficiaries—as well as the government—millions of dollars.

But many Republicans are against the plan because it promotes importing price controls from other countries, while Democrats feel it doesn’t go far enough. Numerous physician groups and provider advocacy organizations have already spoken out against the proposal.

Conservative groups are fighting it as well. In November 2018, FreedomWorks, a Washington-based advocacy group, and Americans for Tax Reform, an anti-tax organization, wrote a joint letter to HHS Secretary Alex Azar criticizing the proposal and demanding that it be withdrawn.

Trump released the outline of his plan shortly after the October publication of a government report that revealed Medicare was paying as much as 80 percent more than in other advanced industrial countries, such as France and Germany, for some of the most expensive physician-administered medicines.

Additionally, the report showed that the costs charged by drug manufacturers to U.S.-based wholesalers and distributors were 1.8 times greater than in other countries for the most prescribed drugs.

Under the administration’s proposal, CMS would reduce the Medicare payment amount for some Medicare Part B drugs to make them more comparable to international prices by benchmarking them against 16 other European and Asian nations.

Additionally, it would allow private-sector vendors to negotiate drug prices and compete for physician and pharmacy business, and would increase the 4.3% drug add-on payment to 6% of historical drug costs. The proposal would also pay physicians a flat fee for prescribing medicines, independent of pricing.

HHS estimates this new payment model would save $17 billion over five years.

Edward Halperin, MD, chancellor and CEO of New York Medical College, says the proposal only addresses about 5% of the drug market—focusing on drugs administered by physicians in their offices—adding that Trump’s action is a slow motion, minimalist attempt to deal with a small proportion of pharmaceutical companies’ price gouging.

“It has nothing to do with the vast majority of the purchases of drugs: people filling prescriptions at either their brick-and-mortar or online pharmacies,” he says. “For a self-proclaimed economic nationalist, President Trump seems perfectly happy to outsource negotiating lower drug prices to European national health systems rather than do the right thing for most Americans: empower Medicare to directly negotiate lower drug prices for Medicare Part D with pharmaceutical companies.”

The possible impact on patient care

Lindsay Bealor Greenleaf, director at ADVI Health, which counsels healthcare companies on government affairs, says the Trump administration has proposed and enacted several promising reforms to align incentives across the supply chain and reward innovation, but the latest proposal to implement international reference pricing for Medicare Part B drugs is troubling.

She says the proposal poses significant access issues for seniors suffering from some of the most devastating and complex conditions, such as cancer, rheumatoid arthritis, and other autoimmune diseases.

“Compared to the rest of the world, the U.S. places a high value on access to therapies, which is why Americans currently enjoy access to cancer treatments about two years earlier than other developed countries,” she says. “If the government chooses to swap today’s payment design for a model that links to foreign countries’ socialist payment designs, then the speedy access to innovative therapies that we enjoy today is at risk.”

She argues that this IPI (International Pricing Index) model
would hinder access to current and future drugs, and would restrict access to patients’ preferred physicians—as many of today’s independent practices would be compelled to sell their practice to large hospital systems to absorb the uncertainty and financial risk associated with the proposal.

Independent practices already face pressure to sell themselves to hospital systems, she says, due to the significant reimbursement disparities between hospital outpatient departments (HOPDs) and physician offices, and due to the 340B drug discounts afforded to HOPDs and not physician offices. If finalized, this proposal would add to that pressure by creating significant reimbursement uncertainty for independent practices.

“The cures on the market today are the result of an environment that encourages and rewards innovation,” she says. “Going forward, if the U.S. reimbursement system is tied to socialist countries that do not reward innovation, manufacturers will lack the incentive to invest in the costly research and development that is required to produce these treatments.”

Although the proposed index is likely to save money in the short term, it will have an adverse effect on patient health in the long run, says Jason Shafrin, PhD, senior director of policy & economics for Precision Health Economics.

“Linking U.S. pharmaceutical prices to those in other countries to drive down cost means that the overall revenue for innovators will also fall,” he says. “Academic research clearly indicates lower revenues lead to pharmaceutical firms reducing their investments on research and development, leading to lower levels of future innovation.”

If only certain drug classes were affected, innovation could be expected to fall for just those specific therapeutic areas, he says. For instance, pharmaceutical firms could shift toward R&D for treatments that affect a larger number of working age adults.

“One item to note is that overall innovation may not be affected if the result of the plan is that pharmaceutical firms raise prices in Europe and Asia,” he says. “In that case, U.S. prices would fall, European and Asian prices would rise, and overall innovation may not change for these products.”

In the short run, however, it may be difficult to change prices abroad if these contracts are already negotiated.

Precision Health’s research shows that cancer mortality reductions were highest in countries that spent the most on cancer treatment. Therefore, Shafrin believes, while the Trump plan would produce short-term cost savings, it would risk worsening America’s long-term health prospects due to lowered rates of innovation.

The logic chain is whether more innovation results in more novel treatments, which then results in better patient outcomes. The study Shafrin cites does not link reimbursement to levels of innovation, but rather that more innovation or quicker adoption of innovation leads to better outcomes.

“The Trump plan will benefit patients’ wallets as lower drug costs likely would mean either lower patient out-of-pocket costs or lower premiums,” he says. “However, patient health is likely to suffer as there will be fewer new and effective treatments available, unless pharmaceutical firms are able to raise their prices in Europe and Asia.”

While costs may not be cut only from R&D, additional belt-tightening not affecting the bottom line assumes that pharma is inefficiently run and includes a lot of waste to wring out. Shafrin says if that were the case, pharma companies could already make more profits by cutting non-R&D costs.

“At a more basic level, pharma firms will consider whether
to invest R&D dollars in a risky clinical area,” he says. “If there is additional belt tightening, that likely means return from that investment will be lower. Lower returns likely will reduce the number of treatments pharma will try to pursue.”

For instance, if a drug had a 5% chance of coming to market, with lower subsequent profits, perhaps pharma would only invest R&D funds in treatments that have a 10% chance of approval. The numbers are hypothetical, but they demonstrate how expected reimbursement and profits will affect the likelihood of individuals (or in this case companies) investing in the first place.

**The effect on physician prescribing**

John Driscoll, CEO of home health coordination company CareCentrix, explains that physicians currently are paid a percentage of the price of the drug that they administer. They lose income when they prescribe a less expensive medication, even though they are saving Medicare money, and they gain when they prescribe something more expensive and when prices increase. Under Trump’s plan, physicians would receive a flat fee, which is a more logical approach that aligns the interests of doctors and patients.

If office-based infusion becomes less financially attractive, he adds, in some cases physicians may refer their patients to far more expensive hospital outpatient facilities, driving system costs up. Ideally, Medicare would provide coverage for home-based infusion, which is more convenient, less expensive, and safe.

Shafrin says a drawback to flat rate reimbursement is that it could limit patient access to breakthrough treatments, as some physician-administered medications may cost tens or even hundreds of thousands of dollars per year and physician outlays on inventory for these treatments can be substantial.

Flat physician payments do not take into account physician’s cost of capital needed to hold these treatments in inventory over an extended period of time,” he says. “Thus, physicians may begin refusing to stock highly effective, though expensive, treatments if the administration costs more than this new flat rate reimbursement level.”

For example: Drug A is more expensive than drug B, but expected survival for patients on drug A is 10 years compared with only one year on drug B. Most people would want patients to get the more effective drug A. But under the proposed plan, physicians may not be able to afford the capital cost of holding drug A in inventory.

Halperin says that by creating a flat fee for physicians to buy and sell drugs administered in their offices, rather than paying them as a percentage of the price of the drug, there will be no financial incentive for physicians to choose high-cost drugs over equally effective and cheaper alternatives.

“Physicians try to justify reasons to select expensive and complex treatments when simpler and less expensive options are just as effective,” he says. “To the extent that this proposal cuts the legs out from the profit motive that influences drug selection by physicians giving drugs in their offices, it will be to the benefit of patients—at least those in the 50% of the country affected by the proposal over the proposed five-year roll-out.”

In many European countries, there is a social contract that the government holds down the cost of treatment and assumes most of the cost, and patients are willing to wait longer for innovative treatment.

“To the extent that this proposal cuts the legs out from the profit motive that influences drug selection by physicians giving drugs in their offices, it will be to the benefit of patients—at least those in the 50% of the country affected by the proposal over the proposed five-year roll-out.”

— EDWARD HALPERIN, MD, NEW YORK MEDICAL COLLEGE

“Historically, in the United States, people do not want the government dictating prices centrally and do not want delayed access to potentially life-saving treatments,” Shafrin says. “The key question is: Are Americans willing to reduce innovation in the future in order to gain more affordability in the short run?”

Keith Loria is an award-winning journalist who has been writing for major newspapers and magazines for close to 20 years.
For some patients, it’s a struggle to get medications, a ride to appointments, or to make a healthy meal. Unfortunately, many of these problems are beyond the reach of the traditional healthcare model.

The American healthcare system is facing an increasingly ill and elderly population. Chronic conditions plague patients across the continuum, and value-based care models demand better outcomes and lower costs. To offset this less-than-ideal situation, more healthcare systems are looking outside of traditional channels for help. Numerous studies highlight patient reports of increased satisfaction from community-health programs and clinics, and there are arguments for cost avoidance—if not direct cost savings—from these programs.

Georges C. Benjamin, MD, executive director of the American Public Health Association, says community-based care services may be the new buzz, but the premise is not new.

“The public health community has a long history of utilizing people from nurses to people with lay health skills to reach out beyond the office practice to help people improve their health,” Benjamin says. “What makes them valuable is they—particularly the lay community health workers—know the community because they generally come from that community. They have a cultural competency that the people that work in a physician practice may or may not have.”

**Community health workers**

Community health workers not only help manage costly and dangerous chronic conditions, but they also identify new issues that might not arise during a typical office visit.

“They bring information about the individuals that often is not picked up during the office visit, particularly when dealing with patients that may be underserved and have a multitude of complex social problems that have to be addressed,” Benjamin says. “It brings that information into the clinical discussion and community health workers help reach out to engage patients where they live to help them navigate a complex and disjointed health system. In many ways, they serve a support function, a social service function and—if they have the know-how—a clinical function.”

From helping individuals understand their medication regimen, to helping them prepare healthy foods or make it to their doctor’s appointments, community health workers fill an increasingly important role—particularly as value-based care becomes a priority.

“It’s about trying to get rid of the inefficiencies and deal with the complexities of the care for these patients, and to narrow the number of barriers they have to get the care they need. It’s important in order to maintain their health and offset costs,” Benjamin says.

“There’s an enormous cost avoidance opportunity there.”

**Proof in the research**

While anecdotal evidence on the benefit of community-based healthcare abounds, it can be difficult to generate hard data, because many of these programs simply don’t have the resources to track their progress and because there are so many benefits beyond measurable outcomes.

However, the available research does speak to the efficacy of community-based healthcare programs. “Community-based programs are on the rise both because we have a growing body of research demonstrating that social risk factors and community context affect health as much as—or more than—clinical risk factors, and because the ACA is putting healthcare payers and providers increasingly at risk for population health outcomes,” says Melinda Buntin, PhD, professor and chair of the Vanderbilt Department of Health Policy.

Buntin and her colleagues researched the evolution of community-based care for a report in *Health Affairs*, and found while...
The study used public data on community-based health improvement programs to assess the relationship between community-based health programs and county-level health outcomes. The research team found that while measured outcomes showed little change, there were larger gains in behavior changes in the communities studied.

According to the study, the number of community health programs grew during the study period from 14 programs serving 319 counties in 2007 to 52 programs serving 396 counties by 2012. Counties with health improvement programs had larger populations of young adults and larger populations of individuals who were unemployed or living in poverty.

The study reveals a mere 0.06% mean reduction in individuals reporting poor or fair health after the implementation of a community health program, and a mean reduction of less than 0.15% in individuals who were overweight or obese after program implementation.

While these figures may not be statistically significant, the study found that targeted community health programs were a bit more successful in changing behaviors, particularly those targeting smoking and obesity. The study also highlights the fact that changes take time in healthcare, and small improvements can yield larger results as time goes on.

"Improving population-level health outcomes is difficult, and it takes time to 'move the needle' on health outcomes," the report notes.

The role of community-based healthcare services will only continue to grow as the traditional healthcare model struggles to care for the increasingly aging, sick population in the U.S., according to Fry.

"As healthcare organizations are increasingly at risk for population health outcomes, community health programs will play a bigger role in the 'traditional' healthcare model. We see these organizations are now being integrated into value-based payment contracts, such as accountable care organizations," says Fry. "In these arrangements, community-based programs provide services that healthcare organizations typically do not provide—housing and food assistance—as well as more healthcare-oriented services such as medication adherence and outreach for high-risk patients. The integration of community-based health improvement programs with traditional healthcare organizations is likely going to continue being the trend."

The state of community-based care

The transition to value-based care will also play a role in the continued utilization of community-based services, she says.

"As the healthcare system continues to move toward value-based payment, healthcare and payer organizations are going to have to address these social risk factors in order to meet population health goals set for these organizations. The trend toward partnering and/or integrating with community-based health promotion programs and social service agencies is one way to address these factors," Fry says.

"Partnering and integrating is more likely to produce improved health outcomes than keeping traditional healthcare organizations and these programs separate."

The cost of community-based care services may seem overwhelming and not altogether justified to some payers or networks, but Benjamin says the cost benefits come more in cost avoidance than direct savings.

"Everything has a cost, and even if something doesn’t always save money, it may improve quality of life, and you can often offset upstream health costs," he says.
While the cost savings appear to be elusive, if you really do the cost accounting, you will find it. Sometimes, the savings is in the wrong pocket—it might not be in your pocket, but it’s clearly in the system.

Some organizations are recognizing the value of these programs, though, and investing in local services.

Nicole Cooper, DrPH, MPH, senior director of social responsibility at UnitedHealthcare, says community health workers are an important part of the health continuum—so much so that United Healthcare funded several multi-million dollar grants to fund community health services in several states. These grants include $1.5 million to hire 15 community health workers at the Daughters of Charity Health Center in New Orleans and $1.5 million to hire 15 community health workers at the Jordan Valley Healthcare Center in Missouri.

For Daughters of Charity, these were the first community health workers they were able to hire, and the grant fully funded all 15 new employees, Cooper says. At Jordan Valley, the health system had three community health workers already, but the grant supports an additional 15 workers. United Healthcare has also supported food banks and pantries, mobile dental clinics, immunization programs, transportation programs, and more across its networks, recognizing the value of supporting members outside of clinical care.

“We employ many community health workers in almost every market and community we serve, Cooper says, adding that facilities that have increased community health programs have reported improvements in many areas. “They’ve shared stories about improved relationships and trust, an increase in visits and integration of services, improved efficiency across the levels of engagement, and they are starting to see improved quality scores.”

Cooper says UnitedHealthcare has recognized that patient care isn’t just about clinical care, and there are a number of ways to improve outcomes while lowering health costs.

“UnitedHealthcare by and large has made a commitment to help redefine access for communities that are particularly underserved or underinsured. We cannot just focus on clinical care. We also need to have a focus on the many areas that have an impact on health and quality of life, like food, housing, and transportation,” Cooper says. “We’re actively pursuing making investments in organizations that serve on the front lines and have chosen to fund community health care. We know community health workers are a powerful tool to help communities.”

“We cannot just focus on clinical care. We also need to have a focus on the many areas that have an impact on health and quality of life, like food, housing, and transportation.”

Nicole Cooper, DrPH, MPH, UnitedHealthcare

While there is room for more data collection and evidence on outcomes and cost savings, Benjamin says the benefit of community-based services is abundantly clear already.

“The train has left the station on this and the truth of the matter is that people aren’t going to continue to pay for volume-based care anymore. They want to pay for outcomes,” Benjamin says. “We can influence outcomes through the system-wide things we do, and we’re going to have to be more assertive in this space.”

Madeline Zimlich, RN, is a writer in Columbia Station, Ohio.
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Elodia Mercier, BSN, MS

- Earned MS in health administration at Iona College in New Rochelle, New York
- Earned BS in nursing from College of Mount Saint Vincent in New York City
- Post-graduate certificate in frontline management from Pace University in New York City
- Mentor for senior nursing students at College of Mount Saint Vincent
- Recipient of $5,000 grant from Balm Foundation for Silent Hospital Helps Healing (SHHH) Initiative
- Recipient of award for excellence in nursing leadership
- Recipient of NAACP award honoring women in recognition for service to the community

Elodia Mercier
Clinical Nursing Director at Montefiore Medical Center

by AINE CRYTS

A graceful chandelier created from hundreds of leaves. The friendly faces of patient navigators dressed in red coats. Both are a constant presence at Montefiore Medical Center in Bronx, New York. So, too, is Elodia Mercier, MS, BSN, clinical director of nursing.

A 34-year veteran of the medical center, Mercier can be found walking the halls of the unit she now manages, engaging with staff and patients alike with a cheery “Good morning! Happy Monday!”

This is Mercier’s way of disarming patients and staff members who may have been distracted or unhappy only a few minutes before. It also allows her to get at the root of their problems.

On stage with patients
As a clinician leader, Mercier knows she’s “on a stage” in front of staff members and patients. For her, that means she sets the tone for the way patients should be treated.

Mercier asks patients for permission twice: Once before entering their room and again before she sits at their bedside.

The typical response from patients, says Mercier, is a quizzical look. “Usually, that takes a patient off guard. They think, ‘This is your hospital. Why are you asking for permission?’”

But Mercier has thought this through, too. It’s a simple way to show respect. Often, she says, a patient will tidy the pillows on the seat before she sits down, just as they would in their own home. Sitting down next to the patient also means she’s at their level, and not towering over them physically.

“In the hospital, this is their home. This is how I show patients respect. Many times, they have lost everything. They may be the sole provider in their family; they may not be able to work, and they’re afraid,” says Mercier.

Mercier is also grounded by the reality that she sees patients at their worst. “It’s our job to cure them and to give them their dignity,” she says.

Why nursing?
Mercier says her first memory of the 134-year-old medical center was as a middle school student. Her great-grandmother was being treated at the hospital. The future nursing leader was so impressed by the care her great-grandmother received that she tucked away a dream of working at the medical center herself one day.
The first in her family to go to college, Mercier says her nursing education wasn’t without its struggles. She worked throughout college as a dorm assistant and took out a loan for her tuition from a close family friend; the loan was paid off within her first year at Montefiore, she adds.

Diagnosed with juvenile arthritis a few months before graduation, Mercier was unable to move from the waist down because of the painful inflammation of her joints. Despite suffering a fever of 104 degrees and being hospitalized, she returned to her nursing studies after her discharge from the hospital.

**Toward future nursing leaders**

“No.” That was Mercier’s response when she was first asked to join the nursing leadership ranks at Montefiore. Why make a change? She was content serving as a head nurse.

Still, ever the pragmatist, Mercier changed her mind. If it didn’t work out, her manager told her she could always return to frontline nursing, remembers Mercier.

And she uses that same approach with nurses she’s grooming for leadership roles today; they can always return to frontline nursing if leadership roles don’t work out, she tells them. The qualities Mercier looks for in nursing leaders include:

- Clinical knowledge;
- Drive to pursue additional degrees and certifications;
- Respect of their medical colleagues.

Mercier also fosters informal leadership among frontline nurses in the medical center’s shared governance program. That involves each unit electing a nurse to represent the unit and providing that nurse with time off to drive improvements suggested by nurses on the unit. For example, a team of 30 nurses on the unit can rally to support the remaining five nurses in getting certified over the next five years.

Some nurses don’t know how to navigate this certification path, but that’s where Mercier comes in. She helps support the nurses with work schedules that allow them to pursue certification.

**Quality improvements**

In 2004 and 2005, the medical center’s Press Ganey scores revealed that patients were unhappy about the amount of ambient noise. With that information in hand, Mercier did her research; that meant hitting the books and asking staff members for ideas for the SHHH (Silent Hospitals Help Healing) Initiative.

She highlights some of the simple changes that decreased ambient noise:

- Lubricating squeaky wheels on carts that travel between patient rooms;
- Turning down the volume at night for the hallway phones answered by nurses;
- Encouraging doctors and nurses to wear cloth-bottomed shoes instead of noisy clogs;
- Tightening up hinges on exit doors on the units to prevent loud slamming sounds;
- Handing out “SHHH” buttons to staff and patients’ family members to increase awareness and secure buy-in.

Food for thought for healthcare leaders?

Mercier asked staff members why they tolerated these noises in the past. “It’s always been that way, they said,” remembers Mercier. It’s not that way anymore at Montefiore.

Aine Cryts is a writer based in Boston.

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Celebrating her nurses

Mercier is clearly driven to improve outcomes for patients and support her nurses’ professional development. Perhaps it’s not so obvious that she considers her colleagues her “work family.”

But here’s some proof of her lighter side: During National Nurses Week last year, Mercier celebrated her nurses with a cake that was so big it had to be brought in on two stretchers. Measuring approximately 34” by 6’, the cake included a 2’ by 3’ cham, 300 pounds of flour, 72 eggs, and approximately 65 pounds of buttercream frosting.

But Mercier has had to manage her fair share of difficult relationships with her nursing colleagues. Imagine her surprise when one of those challenging nurses was chosen to speak at a farewell party organized by a team Mercier used to manage; this was before Mercier’s move to lead another unit.

That same nurse had given Mercier a hard time on various occasions. But at her farewell party, this nurse spoke fondly of Mercier’s kindness after her father had died when she offered her a few more days off.
A Closer Look at Employer-Sponsored Healthcare

What employers are facing in the healthcare market—and how they’re taking control

by KAREN APPOLD

Employers have become frustrated with year-over-year healthcare cost increases that are three to four times the inflation rate while their employees realize poor health outcomes. Poor outcomes lead to high disability rates and low productivity, adding insult to injury. At the same time, many U.S. employers are competing globally against companies with lower healthcare costs and higher productivity. “The situation has reached such a crisis that big changes are imperative—the status quo is unacceptable,” says Dave Ratcliffe, principal, Health & Productivity Consulting at Buck, an integrated human resources and benefits consulting, administration, and technology services firm.

Lori Block, principal, industry insights leader at Buck, identifies five key areas of employer frustration:

- **Lack of competition.** Consolidated medical and pharmacy benefit manager vendor markets means less competition, resulting in higher prices for employers.
- **Quantity vs. quality.** Providers are incentivized to perform more services rather than improving the quality of care and achieving better outcomes.
- **Unpredictable risk exposure.** Most large employers self-insure their health benefits programs, thereby bearing all of the cost escalation risk.
- **Profit vs. patient outcomes.** The current prescription drug supply chain model lacks transparency and the many layers of manufacturers, wholesalers, and distributors are reaping profit at the expense of employers and patients.

**Market reluctance to change.** Employers perceive that market players (i.e., doctors, hospitals, pharmaceutical companies, insurers, and even brokers) are mostly vested in the status quo, making change slow and difficult.

“On top of all of this, employees are similarly frustrated as their share of the costs continue to rise, wiping out any salary increases and leading to job dissatisfaction,” Ratcliffe says.

Another key frustration is that employers have become subject to a myriad of complex regulatory requirements, most notably the complex ACA requirements. “Many employers were forced to spend thousands of dollars on consultants to help them comply with its reporting requirements,” says Judy Boyette, senior partner in the employee benefits practice group at the law firm Hanson Bridgett.

Employers also maintain that they aren’t getting good value for their healthcare spend. In 1988, employer health spending was about 6% of total wages and now it’s 12%. “Business leaders have less money to put in their employees’ pockets because they are spending more on health insurance than ever before,” says Benjamin Isgur, health research institute leader, PwC, which analyzes trends affecting health-related industries.
PERKS OF EMPLOYER INVOLVEMENT
Since healthcare costs will most likely continue to rise, and healthcare benefits remain important in attracting and retaining top talent, many employers are exploring how to become more involved in their healthcare program design, including adopting wellness programs and making other more direct interactions with their employees on health issues, such as providing onsite healthcare clinics, Boyette says.

HOW EMPLOYER-SPONSORED HEALTHCARE IS EVOLVING
Employers are becoming more responsive to the differing needs and priorities of their workforce’s many different generations by offering a broader range of benefits options and examining strategies to most effectively communicate benefits options, says Kim A. Buckey, vice president of Client Services, DirectPath, LLC, a company that helps employees become better healthcare consumers.

More employers are offering or expanding voluntary benefits options, such as critical illness, hospital indemnity, or cancer insurance. “Coupled with core health insurance, voluntary benefits offer employees choice and control based on their personal health needs. This ensures that everyone in a company has access to adequate coverage, and provides an additional financial safety net,” Buckey says.

Buckey is also seeing employers provide another important safety net through tax-advantaged reimbursement programs such as health savings accounts, flexible spending accounts, or health reimbursement arrangements. These options provide additional funds to cover health expenses while reducing taxes and increasing take-home pay.

More employers are also investing in healthcare advocacy and transparency. “By providing employees with the tools and resources they need to intelligently shop for healthcare, manage billing issues, and reconcile claims, employers help reduce their employees’ financial stress and out-of-pocket costs while increasing productivity,” Buckey says. This not only increases employee satisfaction with their benefits—which can be critical for retention—but it also often means that employers save on their business’ health insurance spend.

REVOLUTIONIZING CARE DELIVERY
As the healthcare landscape evolves, employers must keep up with how they’re delivering medical care. Accenture estimates that as many as half of all large U.S. employers will offer onsite medical clinics by the end of 2019.

Kaveh Safavi, MD, JD, senior managing director for Accenture’s healthcare business, has also found that consumers desire more personalized care. Employers are looking to allow employees to pick and choose their own personalized care. One way employers are doing this is by going outside of traditional health plans and using third-party compa-
Some Adults Worry About Keeping Employer-Sponsored Health Insurance

By Tracey Walker

Nearly half (45%) of adults aged 50 to 64 years had little to no confidence in their ability to afford health insurance when they retire, and 27% had little or no confidence in being able to afford health insurance over the next year, according to the results of the National Poll on Healthy Aging.

Researchers from the National Poll on Healthy Aging Team wanted to understand adults’ perspectives on health insurance coverage, healthcare, and employment as they approach retirement age. They administered a survey to a randomly-selected, stratified group of 1,028 older adults, aged 50 to 64 years, to examine their current and future plans for health insurance coverage, medical care, and employment.

In the past year, 14% of respondents reported keeping a job and 11% delayed or considered delaying retirement specifically to have their employer-sponsored health insurance. More than two-thirds (68%) of respondents were concerned about potential changes to health insurance due to changes in federal policies.

“As U.S. adults approach Medicare eligibility at the age of 65, they face important decisions about their healthcare and employment,” says Renuka Tipirneni, MD, MSc, FACP, assistant professor, University of Michigan Department of Internal Medicine, Divisions of General Medicine and Hospital Medicine, and Institute for Healthcare Policy & Innovation. “Recent legislative, regulatory, and legal challenges to the ACA may add new uncertainties to people’s decision making in this critical period.”

The findings suggest that adults in their 50s and 60s may need more assistance navigating health insurance decision making. “Healthcare executives should encourage patients to discuss with their healthcare providers the out-of-pocket costs of healthcare, such as medical procedures, tests, or medications,” Tipirneni says. “Such discussions can help inform decisions about their health insurance options and the timing, choice, and appropriateness of healthcare services.”

The study also found that of adults aged 50 to 64, 13% had not gotten medical care in the past year because of cost concerns and 5% said they had a medical procedure in 2018 in case it was not covered in 2019. Eight percent of adults aged 60 to 64 were waiting to get a medical procedure until they have Medicare coverage.

“While a majority of poll respondents had employer-sponsored health insurance, 8% of adults aged 50 to 64 years reported having an individual private insurance plan, such as a health insurance exchange plan,” Tipirneni says. “This suggests that only a minority of adults aged 50 to 64 years are using this option for health insurance in the period around retirement. The ACA’s insurance coverage expansion was intended, in part, to reduce ‘job lock’ and allow individuals to change or leave their job without concern about becoming uninsured. However, data from this poll suggest that many adults aged 50 to 64 years still worry about maintaining employer-sponsored health insurance and keeping a job for that reason.”

Tracey Walker is content manager for Managed Healthcare Executive.
savings will all be evaluated relative to the disruption and effort required to implement. Here are seven actions employers have taken to mitigate costs:

1/ Include the ability to access non-emergency care through clinics in supermarkets and retail stores or independent urgent care centers in order to reduce use of expensive emergency room services, Boyette says.

2/ Introduce tiered networks, steering employees to use providers that have been determined by health plans to be more cost effective, Boyette says.

3/ Introduce provisions into health plans to pay for participants to travel to other states or countries in order to have certain procedures (e.g., knee replacements) done at hospitals or by certain doctors who have reported a high-quality result at a significantly lower price, Boyette says.

4/ Offer employees and retirees funds and access to coverage offered through a private healthcare exchange, a type of online store, or health insurance marketplace where employees or retirees purchase health insurance and other benefits, typically using these funds, Boyette says.

5/ Provide bundled services. Some employers like Walmart are contracting with best-in-class providers for an all-in price for certain procedures (e.g., knee or hip replacement surgery), says Jaja Okigwe, MBA, CEO, First Choice Health, a physician- and hospital-owned healthcare company. These approaches cover pre- and post-surgical appointments as well as the actual surgery.

6/ Choose to be self-funding. Sixty percent of all employers today are self-funded, which means they purchase claims processing and administration from a traditional insurer or independent administrator, but pay for the cost of medical claims themselves, Okigwe says. In a self-funded arrangement, the employer rather than an insurance carrier assumes the financial risk for providing healthcare benefits to its employees. “Since the employer bears the risk, they may be more motivated to become more involved in order to drive as much efficiency as possible to lower risk and cost,” Boyette says.

7/ Actively engage with employees to develop healthcare plans. “Employers are increasingly seeking and acting on employee-generated requirements for health and wellness programs and are looking to a range of providers outside of health plans to access health and wellness services that cater to their needs,” Safavi says.

HEALTHCARE INNOVATION LEADERS

With employees paying more for healthcare than ever—the annual premium for employer-sponsored family healthcare coverage reached $19,616 in 2018—employers and employees alike are desperate for support to control healthcare spend.

The Amazon, J.P. Morgan, and Berkshire Hathaway venture announced in early 2018 put the healthcare industry on notice that employers are no longer going to accept the status quo. The combined entity will initially be targeting administrative costs, high prices, and improper healthcare usage in an effort to reduce costs, improve satisfaction, and realize better outcomes for employees of those three companies. “Eventually, their innovations will be shared with other employers, which could cause a ripple effect through the healthcare delivery system,” Buckey says. “The venture is a signal to the market that it needs to evolve or traditional players will lose favor to more innovative industry entrants committed to delivering transparency and much needed change.”

Karen Appold is a medical writer in Lehigh Valley, Pennsylvania.

For more on the Amazon, JPMorgan, Berkshire Hathaway collaboration, go to bit.ly/HealthCollab

Employer Healthcare Expenses Reach Record High

For many employers, the cost of healthcare for employees is one of their larger operating expenses. According to the Henry J. Kaiser Family Foundation 2018 Employer Health Benefits Survey, the average annual premiums for employer-sponsored health insurance in 2018 were $6,896 for single coverage and $19,616 for family coverage and the average premium for family coverage increased 20% since 2013 and 55% since 2008. On average, covered workers contribute 18% of the premium for single coverage and 29% of the premium for family coverage.
Rheumatoid arthritis (RA) is a chronic, systemic autoimmune disease that characteristically affects the joints of the hands and feet, causing inflammation, swelling, pain, and progressive destruction of articular structures. RA affects about 1% of the population; onset may occur at any age but most often occurs between ages 35 and 50 years, according to The Lancet.

"The main treatment goals with rheumatoid arthritis are to control inflammation, relieve pain, and reduce associated disability," says Julie Rubin, director of clinical services, CompleteRx. "Treatment usually includes medications, occupational or physical therapy, regular exercise, and in more extreme cases, surgery to correct joint damage."

Traditional medications for RA include nonsteroidal anti-inflammatories (NSAIDs) and steroids to help reduce inflammation, and disease-modifying anti-rheumatic drugs (DMARDs). "Methotrexate is the main therapy in the class of DMARDs but others include hydroxychloroquine, leflunomide, and sulfasalazine," says Rubin.

Management and treatment strategies of RA have evolved over the last two decades due to the advent of biologics. Enbrel (etanercept, Amgen) was FDA approved in 1998, becoming the first biologic indicated for the treatment of RA. Since Enbrel, several other biologic medications have been approved for treatment of RA including Remicade (infliximab, Janssen), Humira (adalimumab, AbbVie), and Rituxan (rituximab, Genentech).

"Many of these drugs can be expensive, even with healthcare or Medicare coverage," says Ashraf Shehata, advisory principal at KPMG and a member of the firm’s Global Healthcare Center of Excellence. "Higher out-of-pocket costs can be a compliance issue for patients and the high cost of these drugs tend to front load that burden on patients early in the year."

New biologics
"There are a fair number of alternatives to help patients manage this condition," says Shehata. "The biologic drugs are expensive, but they help keep the condition in check and could help avoid surgeries and disability costs."
**Actemra** (tocilizumab, Roche), an interleukin-6 (IL-6) receptor antagonist. 

**APPROVAL.** January 2010, for the treatment of moderate-to-severe RA in patients who have had an inadequate response to one or more DMARD. Actemra was originally developed as an intravenous infusion followed by a subcutaneous formulation approved in 2013. Most recently, a prefilled auto-injector (ACTPen) was approved in November 2018 and is expected to be available early this year. 

**COST.** Intravenous solution: $131.04/mL; prefilled syringe (162 mg/mL): $1,186.66.

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**Xeljanz** (tofacitinib, Pfizer), a JAK (Janus kinase) inhibitor. 

**APPROVAL.** November 2012, for the treatment of moderate-to-severe RA in adults who have had an inadequate response to, or are tolerant of, methotrexate. In February 2016, Xeljanz XR became the first once-daily oral JAK inhibitor for the treatment of RA and Xeljanz is the only JAK inhibitor included in the most recent American College of Rheumatology RA treatment guidelines from 2015. 

**COST.** Xeljanz XR 11-mg tablet: $164.83/tablet, Xeljanz 5-mg or 10-mg tablet: $81.91/tablet.

**Kevzara** (sarilumab, Sanofi and Regeneron), an IL-6 receptor antagonist. 

**APPROVAL.** May 2017, for the treatment of moderately to severely active RA in adults who have had an inadequate response or intolerance to one or more DMARD. Kevzara comes as a prefilled syringe or auto-injector and is dosed every two weeks as a subcutaneous injection, which can be self-administered. 

**COST.** Kevzara (150 mg/1.14 mL, 200 mg/1.14 mL): $1,552.63/mL.

**Olumiant** (baricitinib, Eli Lilly), a JAK inhibitor. 

**APPROVAL.** June 2018, for the treatment of adults with moderate-to-severe RA who have had an inadequate response to one or more tumor necrosis factor (TNF) antagonist therapies. 

**COST.** Olumiant 2-mg tablet: $82.19/tablet.

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**Biosimilars**

“Biosimilars could take some of the sting from the costs of RA drugs and several are on the market,” says Shehata. “Health plans need to consider whether the convenience of JAK inhibitors, which are administered orally, adds more value than the savings from injectable biosimilars.”

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**Inflectra** (infliximab-dyyb), biosimilar to Remicade (infliximab, Janssen). 

**APPROVAL.** April 2016. 

**COST.** Reconstituted 100-mg intravenous solution: $1,135.54/each.

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**Pipeline treatments**

**Upadacitinib** (AbbVie), an investigational, oral, JAK-1 selective inhibitor. 

**STATUS.** In February 2019, FDA accepted for priority review AbbVie’s New Drug Application (NDA) for upadacitinib for the treatment of adults with moderate-to-severe RA based on results of the SELECT phase 3 RA program studies.

**Olokizumab** (R-Pharm), an investigational, subcutaneous, IL-6 antagonist. 

**STATUS.** Currently in phase 3 studies to assess efficacy and safety in patients with moderate-to-severe RA (CREDO-4); estimated study completion date: November 2021.

**Filgotinib** (Gilead and Galapagos), an investigational, oral, JAK-1 selective inhibitor. 

**STATUS.** Currently in a long-term extension study to assess the safety and efficacy in patients with RA (FINCH-4); estimated completion date is May 2022.

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Erin Johanek, PharmD, RPh, is a staff pharmacist at Southwest General Health Center, Middleburg Heights, Ohio.

Note: AWP info is available from Lexi-Drugs.

Lexicomp. Wolters Kluwer Health, Inc., online.lexi.com
Four Ways Hospitals Can Deal with Rising Drug Costs

These common approaches can help curb the growth in drug costs by JEFF CRUDELE

We’ve all seen reports suggesting that pharmaceutical prices and the cost of new drugs are on the rise. In fact, drug costs are among the fastest-growing expense categories for hospital providers, and more than 64% of healthcare executives have reported that inpatient drug spending has increased “significantly” over the past five years, according to the Advisory Board.

Increases in prices are just one factor affecting expenditures on drugs. Utilization, drug prescription, variation, and drug innovation are also having a major impact on drug costs. So how do we approach—and holistically manage—drug costs for the benefit of our patients?

Each hospital and health system—and insurer—has unique circumstances, but there are several common approaches that are likely to help curb the growth in drug costs:

Use generic drugs. The drug industry is dynamic, and new drugs are constantly being introduced as mature drugs rotate off patents. As a result, enforcing optimal generic drug use requires constant vigilance. Each health system should have a process in place to work with clinicians on optimizing the use of generics and monitoring the ongoing portfolio of drugs available for generic use. They must also monitor the variation between similar generic choices, which themselves may have significant price differentials. Recently, leading providers have also begun exploring ways to manufacture their own supply of generic drugs and further reduce the cost of procuring this class of pharmaceuticals.

Implement standards of care and other best practices.

Practice variation is a hidden element of utilization that requires careful study and analysis. There are various ways to approach practice variation, and a few common approaches include the following:

Foster deeper physician-pharmacist relationships. By engaging pharmacists in a deeper way as part of the patient care team, hospitals can utilize the pharmacists’ medication expertise. Pharmacists can help address medication usage issues, direct patients to suitable lower-cost alternatives, and reduce unwanted care variation. They can also and help improve patient outcomes, quality measures, and ultimately, overall medical costs.

Leverage the value of being part of a system. Multihospital systems may want to consider taking a systemwide approach when developing standards of care and other best practices. By creating a system-level pharmacy and therapeutics (P&T) committee, hospitals can leverage the combined expertise of all experts in the health system.

Attack waste. A great example is the reduction of intravenous medication waste with the use of new IV administration technologies. IV medications are often custom-built for patients with unique needs, who require frequent changes based on the patients’ conditions. These IVs may also have a limited shelf life, and may be prepared in batches ahead of anticipated need. By using technology-assisted work flow systems, IVs can be prepared closer to administration time, cutting down on waste.

Manage drug shortages.

Drug shortages directly affect drug costs, and when critical drugs are not available, patient care can also be affected. In some circumstances, shortages can even affect hospital labor costs, as staff expends significant time and effort addressing the shortage.

Actively managing inventory and staying attuned to market dynamics are key to effectively avoiding temporary shortages. It’s important that hospitals have the proper protocols defined to effectively deal with drug shortages. This includes the approval of alternative therapies and, when practical, the identification of approved substitutions in advance of the actual shortage.

Jeff Crudele serves as chief financial officer of Allegheny Health Network, part of the Highmark Health family of companies.
The Impact of No-Shows

Missed appointments cost billions—but what can be done about it?

by SHAM SOKKA AND CHRISTOPHER S. HALL, PHD

No one likes a “no-show.” The waiting. The time lost. In healthcare, patient no-shows, or missed medical appointments with no prior notice, are prevalent—and costly.

Why patients no-show

Unfortunately, most hospitals or imaging centers don’t usually have a good answer as to why patients don’t show up for appointments. There are so many variables, many of which can be unique to a particular hospital’s demographic area or particular situation, that it’s difficult to pinpoint.

To better understand the patient-no-show issue, Philips worked with the University of Washington Medical Center (UWMC) looking at data from nearly 2.9 million outpatient imaging examinations during a 16-year period. Overall, the results, published in JACR in 2018, revealed that predictors of patient no-show rates are multi-dimensional but generally fall into three main categories each with their own set of unique variables:

- Patient-related factors (e.g., age, gender, city, estimated income)
- Exam-related factors (e.g., exam type, duration, department)
- Scheduling-related factors (e.g., lead time, day of week, time)

One of the most significant correlations for imaging patient no-shows can be appointment scheduling lead time. If an appointment is scheduled for less than two weeks away, patients are more likely to show up than if scheduled with a long lead time.

For UWMC, based on just a few common imaging exams (breast ultrasound, brain MRI, abdomen ultrasound, MG screening) uncaptured revenue from patient no-shows was estimated to approach $700,000. The research validated the financial burden of missed appointments for multi-site organizations like UWMC, while illuminating key insights that might be extended to other institutions.

How to reduce no-shows

To reduce the impact of patient no-shows, healthcare providers must first focus on getting operational intelligence about the issue by investigating the extent and implication of the problem. What works for one hospital doesn’t always help at another—especially if patient populations differ. However, there are a few general areas that radiology departments can focus on immediately to increase patient compliance.

Scheduling systems can make the process more automated and assign appointments to patients based on risk level—meaning patients with a high risk of not showing up can be scheduled later in the day when a no-show would have less impact on workflow and other patients. Reminder systems can also increase compliance, but the means of communication must be tailored to specific patient lifestyle to be effective.

Improving the overall patient experience in imaging goes a long way too. This includes keeping patients informed, communicating in advance about the procedure, and helping them prepare mentally and physically for the process.

Tools to predict no-shows

Individually, these variables are not enough to effectively predict no-show rates—but collectively can be very informative. This is where data analytics tools, predictive modeling, and AI can be most helpful. Based on the variables and other types of data such as age, gender, or demographics, predictive modeling and data analytics tools can help us predict how likely it is that a particular patient will show up for an appointment.

For instance, to predict no-shows and cancellations, providers must first capture all the potential factors that might affect no-shows. With the right data captured and AI applied, we can close the gap by aggregating large volumes of retrospective data, demographic data, and census data. We can then construct quantitative models to predict no-show occurrence and highlight features that are informative in the prediction.

Sham Sokka is VP in imaging & solutions and Christopher S. Hall, PhD, is the senior director of advanced concept development, radiology solutions at Philips.
Six Apps to Boost Your Productivity

From more knowledge to great efficiencies, these apps can get you more hours in a day by Nicholas Hamm

1. **Expensify**
   Travelling can be one of the most rewarding parts of a job, but filling out tedious expense reports can quickly make even the most exciting trip a chore.
   Expensify helps to clear up some of that headache. You can scan in any of your receipts and save them all in one place. And for those who have to approve other people's expense reports, expensify helps speed up that process by automating which purchases do or don't have to be approved—so no more filling out a report for that $2.00 tip to your Lyft driver.

2. **Trello**
   Trello is an app designed to help you and a team collaborate on a task, wherever you are. To begin, set up different cards with stages of the project you’re working on—such as “working on” or “to do.” Then you can add tasks for each stage of the process, so you always know who’s handling what (and make sure nothing slips through the cracks).

3. **Dark Sky**
   One of the best ways to be more productive is to gain control of the forces that make you unproductive. It might seem weird to see a weather app on this list, until you think about the number of times a sudden rain shower has caught you without a jacket or how often a snow shower has made you late for a meeting.
   Dark Sky tracks weather down to a granular level. Want to know if it’s still going to be raining in 10 minutes? Need to know within a 20-minute window when it’s supposed to start snowing tomorrow morning? The answer is in your pocket.

4. **OmniFocus**
   Long-term goals are vital if you want to be successful. The trick is juggling long-term goals and projects with the more immediate tasks you need accomplished right now.
   OmniFocus is a to-do list that helps you keep track of everything you do, whether it’s as simple as “pick up lettuce at the store” or as complicated as “shop around for a new EHR system.” You can tell the app what’s highest on your priority list or what can be put off for a little longer.

5. **Keeper**
   If you’re still entering in your passwords manually for everything, you’re wasting your time (and potentially putting yourself at risk). Password managers create and keep track of all of your passwords for you, so you don’t have to keep using the same password for everything or spend 20 minutes trying to find your login credentials for that account you created three years ago.

6. **CamCard**
   Managing a stack of business cards doesn’t make sense anymore, but that doesn’t stop people from handing them out. Rather than taking them time to organize that pile by name, let an app sort them for you.
   CamCard is a fairly simple app, but that doesn’t stop it from being useful. After you get a card, simply scan it with your phone and let the app hold the information. Then you’re free to toss the card (probably only in a place where the former cardholder won’t see you).

Nicholas Hamm is an Editor with Managed Healthcare Executive.
ACO Hospitals Increasingly Seek Help from Pharmacists

Pharmacists fill administrative and clinical voids in ACOs  by JOAN VOS MACDONALD

More than 900 public and private accountable care organizations (ACOs) in the United States manage the healthcare costs of around 32 million Americans, according to healthcare consultancy Leavitt Partners. As that number grows, so does the number of pharmacists these organizations employ to optimize medication use.

ACOs are a reimbursement model where healthcare organizations strive to meet cost and quality targets. If successful, they receive higher reimbursement.

“While underutilized in early ACO models, pharmacists today are playing an increasingly important role in the success of these organizations, and more and more pharmacists are being hired on staff to oversee medication management and optimization,” says Susan A. Cantrell, RPh, CAE, CEO of the Academy of Managed Care Pharmacy (AMCP).

Half of all Americans take at least one prescription drug per-month, whereas almost a quarter take at least three prescription drugs per-month, according to the CDC. Without managing medication costs, which are expected to rise faster than any other medical expenses, ACOs will find it increasingly difficult to deliver cost-effective quality healthcare.

According to a recent study in the ACM’s Journal of Managed Care & Specialty Pharmacy, ACOs that employ or contract pharmacists are better at managing medication costs while delivering value.

“That’s because pharmacists are uniquely positioned to help optimize appropriate medication use, reduce medication-related problems, and improve health outcomes,” Cantrell says. “As a clinical expert working as part of an interdisciplinary team, pharmacists can assess whether medication use is contributing to unwanted effects and can help achieve desired outcomes from medication use.”

Pharmacists in ACOs

A key aspect of a pharmacist’s work in an ACO is counseling patients. Pharmacists counsel them in drug therapy management clinics, such as anticoagulation clinics; transplant programs; and HIV, hepatitis C, psychiatric, and lipid management clinics, to ensure that patients take their medications correctly and that drug-related problems are identified and managed.

They also play a key role in transitional care: counseling post-discharge patients on the proper use of any medications prescribed during their hospital stay. Not taking medications properly and/or not recognizing a side effect or symptom can land the newly discharged patient back in the hospital.

“ACOs currently working with pharmacists have seen positive results in reducing hospital readmission and ER utilization, particularly when they integrate pharmacists in their transitions of care teams,” says Stephanie Gernant, PharmD, MS, assistant professor at the University of Connecticut School of Pharmacy in Storrs.

“I think we’re going to see a greater surge of pharmacist integration in outpatient and primary care settings in the upcoming years. No matter your political ideology, payment based on value is never going away—the cat is out of the bag,” she says.

Currently, the percentage of ACOs working with pharmacists is 63% and that is likely to grow, says Gernant.

“An ounce of prevention is worth a pound of cure, and ACOs working with pharmacists—especially in primary care, preventative care, and risk management settings—see the return. For every adverse drug reaction a pharmacist discovers, for every omission of care she/he corrects, there’s a downstream positive patient outcome, and for ACOs that means dollars.”

Pharmacists can help identify gaps in medication use or red flags that may not be as readily apparent to other providers, says Cantrell. “A pharmacist engaged in therapeutic...
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managed healthcare executive
Training in pharmacology, pharmacokinetics, and pharmacoeconomics enables pharmacists to assess medication use in ways other healthcare practitioners might not be prepared to. “Since healthcare is moving away from fee-for-service and toward value-based care payment structures, pharmacists now have opportunities to further assist the team by helping meet quality markers,” says Watson.

**Specialty pharmacy fuels momentum**

One reason pharmacists will play a larger future role in ACOs is the growing number of specialty pharmacy products on the market—medications that are often prohibitively expensive, need special administration, or require extensive monitoring to manage side effects.

“Patterns of care are shifting specifically to focus more on overall drug management due to more specialty pharmaceutical products becoming available in the market,” says Jane Lutz, executive director of the Pharmacy Benefit Management Institute (PBMI). “As a result, the clinical expertise of a pharmacist becomes more and more critical.”

Pharmacists can assist in managing costs in all settings, from managing formularies in the hospital to creating criteria for the use of new biologic agents in managed care, says Watson. “Community pharmacists are often on the front line and can offer opportunities for interchange or decrease barriers to adherence concerns due to costs,” she says. “Within the ambulatory care setting, pharmacists are becoming integrated both at the patient care and administrative levels to combat rising prescription costs.”

Joan Vos MacDonald is a healthcare journalist and a regular contributing editor to Drug Topics, our sister publication in which this article originally appeared.
Leadership Skills
HELP YOUR ORGANIZATION SUCCEED

Three Design Thinking Tools You Should Be Using

Design Thinking is a great way to get your organization focused by MICHELLE HISTAND

Last time I wrote, I focused on Design Thinking and why it’s important for those of us in healthcare to understand and adopt it as a way of doing business. What I didn’t get a chance to highlight in detail is how incredibly practical Design Thinking is and the plethora of tools available that should make it into your regular repertoire—and I’m not just talking about markers and sticky notes!

I have a lot of tools I love using, but since I’m limited on words here I’ll focus on three of my favorites and how to use them. While these are often used during a particular stage of the process, there are no rules about when you use them other than when it feels right or when doing so will solve a need.

1 20 Questions
This tool is just what it sounds like—asking questions and getting answers that can provide a foundation for the project. It’s also a great way to challenge assumptions in the middle of a project, to force a team to step back and reset, or to help get unstuck.

To use 20 Questions all you need to do is get the key players into a room and give them sticky notes and markers (yes, we really do use markers and sticky notes!). Everyone gets three minutes to write down questions—and only questions—about the project, one question per sticky note. At the end of those three minutes, a facilitator collects the questions and you spend time walking through them as a group. When appropriate, you can get the project sponsor in the room to provide some answers.

We often ask questions like: what’s been tried before, why is this important to the organization, and what does success look like. In his new book “Questions Are the Answer,” Hal Gregersen, executive director of the MIT Leadership Center, provides great insight on why asking questions is the best thing you can do. We agree!

2 Related worlds
This is a favorite because it forces us out of our own world view and gets us inspired by what others are doing. Here’s how it works: you start by thinking about the basis or core of your challenge and then move into thinking about players completely outside of your industry who are doing that core thing really well. After dissecting why they’re so good at it and how they do it, you think about how you might apply those same principles back to your challenge.

So if you’re thinking about customer loyalty, it might be a good idea to visit a place like Lululemon—where they have a cult following—and read articles on how they do it.

If you’re thinking about customer experience, like so many of us are right now, you can’t not think about The Ritz-Carlton. How does The Ritz-Carlton make each encounter special? Well, for one, they keep a file of what you like, so when you arrive they can have your favorite M&Ms in your room.

Knowing and storing patient or member preferences? Yeah, we could do that.

One of my favorite examples of this is when we were building our new customer experience center, Independence LIVE. Our chief marketing officer knew we needed someone special to run it. She wanted someone who would inspire the right attitude, who would keep the people working on the floor motivated, and who could stay on top of the various missions of the space. Who did she hire? A former basketball coach. Because when she looked at what she needed, the core of it was a coach. Her instinct was right on!

3 Need/Know Matrix
This one has a special place in my heart. The Need/Know Matrix helps identify the assumptions you have about an idea and shakes out which of those assumptions are critical to success and need to be tested.

Start with a matrix that has “critical” at the top of the Y axis and “not critical” at the bottom. This is to indicate how important a particular assumption is to your idea—critical means if your assumption is wrong, your idea
The Need/Know Matrix

<table>
<thead>
<tr>
<th>Critical</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>People will buy shoes sight unseen</td>
<td>People will continue buying shoes/buy enough shoes</td>
</tr>
<tr>
<td>People will pay for shipping</td>
<td>People will buy all types of shoes online</td>
</tr>
</tbody>
</table>

is dead. Not critical means it may limit the idea, but you can work around it or change the idea. The X axis has “known” on the left and “unknown” on the right. Known means you can access and find information about this assumption fairly easily. Unknown means you would have to create an experiment to find out.

Next, write out all of your assumptions about the idea, one per sticky note. Assumptions can be hard to come up with, but there are always more than you realize! Usually the very first assumption is, “people want this.”

Once everyone has their assumptions written out, map them on the matrix by asking the following: is this critical to my idea, if I’m wrong will it fall apart, and do I know this or is it an unknown.

Once the sticky notes are placed in their appropriate quadrants, you’ll want to pay attention to the critical unknowns—the top right quadrant. A “critical unknown” signals you need to run some tests or experiments before moving forward to prove those assumptions.

We can look to Zappos for a great example of how to use this tool. When Nick Swinmurn, founder of Zappos, had the idea for the online store it was before people were buying shoes on the Internet (yes, there was such a time). He had one major assumption: that people would buy shoes, sight unseen. Other assumptions included that there are enough annual shoe sales to sustain business, that people would buy men’s, women’s and children’s shoes online, and that people would pay for shipping. We can map these assumptions to see how this tool works.

The first assumption—people would buy shoes online—was the crux of his idea. It was absolutely critical that this assumption was true, and also absolutely unknown. The assumption that there are enough annual shoe sales to sustain the business was also critical—but known, because information about overall shoe sales could be determined with basic research.

The thought that people would buy all types of shoes was not as critical. If this wasn’t true, via research Nick could determine which type of shoes would sell most. The assumption about shipping was unknown, but wasn’t critical to the success of the idea. If people wouldn’t pay for shipping, it could be “baked into” the price and offered at no charge.

You’ve maybe heard the story of how Nick ran his test to prove out his critical unknown. He went to his local mall and took pictures of the shoes, which he then posted online. When someone wanted to buy a pair, he went back to the store and purchased them and sent them out. He was able to test that critical assumption without having any inventory of his own—very low risk.

I hope you’ll get to try some of these tools in the next several weeks. These are just a few that will sell you on the need for Design Thinking in your organization.

Michelle Histand is an innovation director at Independence Blue Cross, where she has fostered and advanced the organization’s design thinking approach to problem solving.
Most consumers are used to using their fingerprint to unlock their phones. That’s just one of the uses for biometric technology, which includes: fingerprint, iris, and facial recognition, as well as palm-vein readers to reduce the authorization fraud and security breaches common with passwords. Government, financial, travel/logistics, and consumer electronic industries have all ramped up use of biometric technology over the last few years and use in the healthcare industry also continues to increase.

The healthcare biometrics market is estimated to be worth $14.5 billion by 2025, due to the increase in healthcare information exchanges and the demand for technology that decreases data corruption and fraud, according to an analysis by Grand View Research. That represents a growth of 23% from 2017 to 2025, and Grand View predicts the growth of consumerism in healthcare will push many organizations to consider biometrics as it becomes the standard in other industries.

Kerry Pillion, director of corporate communications for Imprivata, says the biometrics technology company works with 1,700 global healthcare customers in 39 countries and has seen an increase for the technology in healthcare settings. “We have seen an increased investment in biometrics by our healthcare customers as a way to accurately identify people in their ecosystems, including patients and clinicians, maintain secure access to protected health information, and secure high-risk work flows such as electronic prescribing for controlled substances,” Pillion says.

Michael Trader, co-founder of RightPatient, Inc., says that his company has seen an increase in hospitals and clinics that are interested in their biometrics technology. Currently, RightPatient supports six different forms of biometric patient identification—fingerprint, finger vein, palm vein, iris, facial, and voice recognition—at 70 hospitals and hundreds of clinics.

“Compared to manual methods of identification that lead to an 18% average duplicate record, $1.5 million annual losses in claim denials, and a significant impact on patient safety, health systems should not see any limitations in implementing biometrics to address these issues,” Trader says.

**How healthcare uses biometrics**

Generally, healthcare organizations are using biometric solutions for two-factor or multifactor identification. And specifically fingerprint biometrics, as one method of authentication for controlled substances have selected biometrics, and specifically fingerprint biometrics, as one method of authentication for compliance.” — KERRY PILLION, IMPRIVATA

“Many organizations adopting electronic prescribing for controlled substances have selected biometrics, and specifically fingerprint biometrics, as one method of authentication for compliance.” — KERRY PILLION, IMPRIVATA

“Many organizations adopting electronic prescribing for controlled substances have selected biometrics, and specifically fingerprint biometrics, as one method of authentication for compliance.” — KERRY PILLION, IMPRIVATA

“Many organizations adopting electronic prescribing for controlled substances have selected biometrics, and specifically fingerprint biometrics, as one method of authentication for compliance.” — KERRY PILLION, IMPRIVATA

“Many organizations adopting electronic prescribing for controlled substances have selected biometrics, and specifically fingerprint biometrics, as one method of authentication for compliance.” — KERRY PILLION, IMPRIVATA
ulatory specifications. According to Imprivata, fingerprint biometric identification has a false match rate of less than one in 1,000.

“Many organizations adopting electronic prescribing for controlled substances have selected biometrics, and specifically fingerprint biometrics, as one method of authentication for compliance,” Pillion says. “It is an easy, fast, and highly-secure way for prescribers to complete two-factor authentication.”

Patient identification is also a valuable use case for biometrics throughout the care continuum, including at point of care. One use case is radiation oncology, where healthcare providers want to be certain that they are treating the correct patient, Pillion says. “Patients may see this most at the point of registration, when the registration or patient access staff uses biometrics to make sure they are checking in the correct patient and bringing up the patient’s correct medical record.”

Rolling out biometrics across a health system
Keely Aarnes, PMP, assistant vice president of business operations for Northwell Health, says the health system is planning to roll out iris recognition for patient identification across more than 600 practices through the next 18 months. Working with RightPatient, Aarnes says the organization was able to pilot the technology at 11 practices before planning to expand the use across the organization.

“We strategically went with iris recognition, because it takes a high-resolution photo of the patient’s face, which then uses the iris identification and that pattern to create an identifier,” Aarnes says. “That picture can be used for multiple use cases. One, we take that picture and send it through our EHR, which is a better level of identification for the clinician.”

Second, Aarnes says the health system would like to use facial recognition in the future to identify patients as they enter facilities and create a more concierge patient experience or warn staff of security risks.

Aarnes says high-resolution photos provide multiple use cases. “If we know that a patient has arrived, we can welcome them [and] send them messaging and way finding so that they know where to go. It also has a use case in the hospital where we can identify patients that we know we want to intervene early, such as central fraud or drug seeking.”

— Keely Aarnes, Northwell Health

“Overcoming patient and provider skepticism”
Though consumers are using biometric technology more often, patients and healthcare staff still need to be educated on how it works and why the organization is using these solutions, says Pillion. “Healthcare organizations that are implementing biometrics will want to be prepared to overcome any stigma associated with this type of technology,” Pillion says. “Some providers or patients may be concerned that the government will get access to their information. However, the data is never shared outside the health system, and with some forms of biometrics such as palm vein recognition, there is no forensic value.”
According to a 2018 survey of 1,000 people by the Center for Identity at the University of Texas, Austin, 58% of respondents feel very comfortable with fingerprint recognition technology and about 33% are comfortable with other forms of biometrics technology.

Trader says the biggest barrier health organizations face when implementing biometrics is overcoming a culture that is resistant to innovation.

"Patients are becoming increasingly tech savvy and they expect an experience like hospitality or retail," Trader says. "If health systems acknowledge and embrace this fact, then moving forward with biometrics should not be a difficult process. There will always be skeptics but they are in the vast minority and many of them are typically won over when they see the technology in action and witness first-hand the impact that it delivers."

Aarnes says it was important to develop an 'elevator speech' for staff to explain to patients how the technology would be used and data would be stored. "With our first launch, we really learned to stay away from using the verbiage, 'scanning your iris' because people have a negative connotation with the word 'scan,'" Aarnes says. A lot of our staff training was educating them on how to speak to a patient about the technology. The technology in itself is pretty easy. It's really just finding that sweet spot of informing and educating our patients that this is for their benefit in safety and ease of registration."

So far, the health system has had 10,000 patients enrolled using iris recognition.

Three Things to Consider When Investing in Biometrics

1. Start small with scaling to enterprise-wide deployment.
   It's okay to start small and learn, says Keely Aarnes, PMP, assistant vice president of business operations for Northwell Health.
   "We initially did a proof of concept in September 2018, and we went live with our first site. Looking back, that was a great way to do it, because what we thought would work as far as work flow was completely different in a live environment," Aarnes says. The health system deployed across 11 more practices in December 2018, with another 40 practices slated for February 2019.
   "After that we're going to take off very rapidly. We have 600-plus practices, so we envision this will take about 18 months to roll across our organization," Aarnes says. "Also, we will be implementing our first hospital acute site in June or July 2019. So that will be a whole new work flow that needs to be defined and understood."

2. Think long-term when choosing biometric capabilities.
   Healthcare organizations should be paying attention to regulations that are coming out around telehealth as well as areas such as interoperability, says Kerry Pillion, director of corporation communications for Imprivata.
   "More and more health systems are offering telehealth options, and to do that successfully, they need to be sure that they are correctly identifying the patient who is not physically in front of them," Pillion says. "Investing in biometrics may help organizations be ahead of the curve when it comes to positively identifying patients and being able to successful treat them in person and remotely."

3. Consider more robust technology expansion to complement biometric solutions.
   "Health systems should consider much more than just the biometric technology. While important, it is one part of a much larger value proposition that the right platform and partner can deliver," says Michael Trader, cofounder of RightPatient, Inc.

"Patients are becoming increasingly tech savvy and they expect an experience like hospitality or retail. If health systems acknowledge and embrace this fact, then moving forward with biometrics should not be a difficult process."

—MICHAEL TRADER, RIGHTPATIENT, INC.
State Adopts “Netflix” Model to Pay for Hep C Drugs

Louisiana’s subscription model aims to rein in the hepatitis C epidemic in the state

by TRACEY WALKER

At least 90,900 Louisianans are currently infected with hepatitis C, a disproportionate number of whom are low-income and/or incarcerated. About 39,000 people in Louisiana’s Medicaid program and state prisons are estimated to be chronically infected. Moreover, the rate of new infections is growing dramatically as a result of injection drug use associated with the opioid epidemic.

The Louisiana Department of Health (LDH) is hoping that a new way to pay for expensive hep C treatments could help patients with the disease in Medicaid and corrections populations, as well as offer a model for others having trouble paying for these drugs.

The approach, a subscription model, will be accomplished using a competitive Solicitation of Offers (SFO) process. The goal is to create a public/private partnership with a drug manufacturer that will enable the State to pursue elimination of hep C as a public health epidemic in Louisiana.

“There’s a highly effective treatment for hepatitis C, but because it’s too costly, not everyone can access it,” says Pete Croughan, LDH chief of staff. “This model will create a new precedent for how patients acquire medications in a public health crisis.”

“The ‘Netflix’ model

Others have termed this a “Netflix” model—where consumers pay a monthly fee to stream unlimited television shows and movies—because it is subscription-based, according to Croughan.

“Under the model, LDH will enter into an agreement with a manufacturer to utilize their direct-acting antiviral medications for the treatment of hepatitis C in the referenced populations,” he says. “This arrangement provides unlimited access to DAAs for five years for all Louisianans enrolled in Medicaid or incarcerated. The total annual cost will be equal to or less than what the state spent on DAAs for these populations in 2018, no matter how much treatment is provided.”

Goal, expected outcomes

The subscription model is not enough on its own to meet LDH’s goal of curing more than 10,000 Louisianans by the end of 2020, according to Croughan. “LDH will also implement complementary strategies in parallel with the subscription model to ensure the unlimited supply of direct acting antiviral medications to reach the intended populations,” he says.

The additional strategies comprising the hepatitis C elimination program, as listed in the SFO, are:

- Expand provider capacity to treat hepatitis C
- Educate public on availability of cure and mobilize priority populations for screenings
- Expand hepatitis C screening and expedited linkage to hepatitis C cure
- Strengthen hepatitis C surveillance to link persons previously diagnosed to treatment
- Implement harm reduction and complementary treatment Strategies to prevent new or re-infections
- Extend elimination efforts to all populations within the state

LDH expects the partnership to begin on July 1, 2019.

Pete Croughan, LDH chief of staff, says, “This model will create a new precedent for how payers acquire medications in a public health crisis.”

Tracey Walker is content manager for Managed Healthcare Executive.
Leadership succession planning is an essential part of healthcare talent management. It provides an opportunity to capture “tribal knowledge,” say experts.

“Healthcare in particular is an extremely dynamic space,” says Cheryl Nagowski, senior director, federal markets, D2 Consulting, a life sciences consulting firm in Chesterfield, Missouri. “Understanding internal and external events that have affected the current position of the business unit, as well as any undocumented risks and best practices, is key to maintaining operating effectiveness after a critical role departs the organization.”

Most agree that healthcare executive roles are critically important to an organization’s ability to thrive, says Chuck Taylor, principal, Human Capital Solution Group Leader, GE Healthcare Partners, a Chicago-based provider of outcomes-based solutions in healthcare.

“Succession planning is important because the process, supporting meetings, and output create a common book of truth and understanding—typically owned by the CEO and facilitated by the chief human resources officer [CHRO]—that captures details and nuances about critical executive roles,” Taylor says. “These details and nuances typically include information on both incumbent and succession candidates/options.”

For the incumbent, information captured could include:

- time in role;
- projected or desired tenure;
- risk-retention information;
- performance profile; and
- associated talent action plan (i.e., current actions to ensure retention, leverage strengths, improve gaps).

According to Taylor, for succession candidates there are often a short menu of options:

- internal, ready to move into role now;
- internal, ready to move into role one to two years;
- internal, potential for role >3 years; and
- external candidate

“For internal candidates, succession planning also provides a strong linkage to individual career planning needs,” Taylor says. “Having a clear picture of incumbent and succession candidate options allows for the CEO and HR and broader leadership team to operate in an agile manner.”

Nagowski agrees that succession planning is important because it contributes to staff development. “It is an opportunity to create a defined career path for a successor, increasing loyalty and helping staff feel seen and valued by the organization,” she says. “It is also important to ensure a portion of the business doesn’t come to a standstill when a person in a key position departs the organization. These activities are sometimes uncom-
The List

“Identify top talent at different levels ... and assess these team members for key competencies, like team building and communication.” — MICHELE MARKEY, SKILLPATH

able because they force us to accept 1) that people will likely one day leave the organization and 2) that we ourselves can be replaced as leaders. However, setting a tone and culture that embraces change and personal/professional development and advancement will ultimately improve staff loyalty and retention.”

Here are seven tips for effective succession planning:

1/ Identify good candidates. "Ensure they are not just capable but that they also understand the full scope of responsibilities,” says Nagowski. “Never assume a direct leadership chain progression is what a staff member is interested in pursuing long term.”

2/ Start early. Introduce the path to fulfill your role early so that the identified candidate clearly understands how to get there, according to Nagowski.

3/ Take a holistic approach. The strength of any component of performance management is often tied to the strength of other components in the model or system, says Taylor. “For example, shifting an organization from annual performance reviews to ongoing performance development places a need for a strong expectation setting, as well as a need for learning and development to ramp up training around coaching and mentoring.

“Likewise, succession planning by itself is a value add, but to be truly effective must be supported with strong recruiting and onboarding, rewards and recognition, performance appraisals, and learning and development,” Taylor says.

4/ Expose candidates to outside roles. "Not only is it important for a potential successor to prepare by understanding critical elements outside of their current job duties, it is also important that others in the organization start to gain trust in this individual’s capabilities by seeing them exposed to other business units,” Nagowski says.

5/ Promote transparency. “Often, succession planning is tightly controlled by CEO and/or HR with only one-on-one discussions,” says Taylor. “In our talent system process, the entire C-suite would transparently listen, comment, and dialogue during the chief financial officer’s [CFO] talent review presentation on finance, or the chief nursing officer’s [CNO] review of nursing. As such, the entire leadership team would understand succession planning in the fuller context of the entire ... organization. The fostering of appropriate transparency—right leaders reviewing the right organization/individuals—engages a broader set of leaders in helping to develop or recruit talent. Transparency also allows for cross-flow of talent—avoiding having individuals being siloed.”

6/ Provide opportunity. “Ensure that all staff are provided an opportunity to develop and succeed,” Nagowski says. “It doesn’t matter if that advancement is within their current company, or elsewhere. Managers have an inherent responsibility to develop their people, and should consider this a privilege.”

Michele Markey, vice president of training operations for SkillPath, a non-profit professional learning and development provider in Mission, Kansas, agrees: “Identify top talent at different levels—company contributors, middle management, and leaders—and assess these team members for key competencies, like team building and communication. Once talent has been identified, drive their growth through experiences. This may mean creating new executive positions, roles, or assignments that expose them to different projects; assigning the upcoming leader to a second-in-command position; or allowing them to fill in for senior leaders for some length of time.”

7/ Have a talent action plan (TAP). A TAP can list all leaders and key staff/roles within a function (e.g., finance, nursing) and for each individual captures a TAP that includes specific actions around retention, development, recruiting, succession planning, etc.).

“Most importantly, the talent review is not a once a year and done event” Taylor says. “Typically, the talent review is held at the end of the first quarter or early second quarter, then there are multiple talent review check-ins during the year. Here each leader (e.g., CFO or CNO) would join a meeting with the CEO, CHRO, and peers, and report out on progress against the TAP. Too often C-suite leaders are holding ongoing monthly operating reviews ... but there’s little rigor around holding leaders accountable to a good say-do ratio on required people actions. The talent review check-ins help drive this people-side accountability.”

Tracey Walker is content manager for Managed Healthcare Executive.
THE BOTTOM LINE

By Nicholas Hamm

The importance of clinical surveillance in hospitals

Monitoring patients at various points of care

90% say it is extremely, very, or moderately important to their organization
80% say investment in the technology is a high or medium priority over the next two years
79% say the return on investment is clear
92% say the technology improves quality

Source: Sage Growth Partners

“In the hospital, this is their home. This is how I show patients respect. Many times, they have lost everything. They may be the sole provider in their family; they may not be able to work, and they’re afraid … It’s our job to cure them and to give them their dignity.”

— Elodia Mercier, clinical nursing director, Montefiore Medical Center. See more on page 21

Medical debts climbing

>50%
The percentage of unpaid bills in collections classified as medical bills in 2014

58.5%
The share of bankruptcies caused by medical bills, 2013-2016

44.3%
The share of bankruptcies caused by income loss from illness

Source: American Journal of Public Health

2017 per-person spending in employer-sponsored insurance population

Total $5,641

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<tr>
<th>Category</th>
<th>Cost</th>
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<td>Prescription Drugs</td>
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<tr>
<td>Inpatient</td>
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For more on employer-sponsored healthcare, see Special Report on page 23.

Source: Health Care Cost Institute