MAGAZINE NAME

Special Report: Advances in autoimmune disease treatments

SALARY TRENDS
How new demands are shaping CEO compensation

Plus
Value-based care success models

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ManagedHealthcareExecutive.com
Salary Trends
How new demands are shaping CEO compensation

ESSENTIALS
4 Five Ways to Treat Chronically Ill Patients
7 Four Benefits of E-Prescribing
12 How Machine Learning Is Revolutionizing Healthcare
16 Four Ways You Can Keep PHI Secure
21 The Promise of Routine Genomic Testing
22 Top Challenges in Managing Diabetes
23 The Latest Autoimmune Disease Treatment Advances
26 Featured Exec Joe Swedish: Partner and Co-Founder of Concord Health Partners
35 The First Hep C Value-Based Bundled Payment Plant
37 Hospital Post-Acute Care Program Shows Positive Results
39 The Future of Value-Based Care
41 Driving Value-Based Care as a Health System
42 Indication-based Formulary Design Chases Medicare Market
45 Peptic Ulcer Disease
47 Four Essential Skills of a Change Leader
49 Who is Your Healthcare “Hero”?
The Cleveland Clinic Value-Based Innovation Summit will bring together executive healthcare thought leaders in value-based care redesign and innovation to tackle healthcare’s most pressing challenges. Featured sessions will showcase payor-provider success stories and best practices from across the nation.

Additional sessions include advances in value-based clinical care, international contracting, and government alternative payment models. Ensure your organization has the tools to succeed as healthcare continues to accelerate into risk by attending the 2019 Value-Based Innovation Summit.

2019 Value-Based Innovation Summit confirmed speakers include:

- **Michael E. Porter**
  University Professor, Harvard School of Business
  *Keynote*

- **Angela Meoli**
  Senior Vice President of Network Strategy and Provider Experience, Aetna

- **Paul Marchetti**
  Senior Vice President, Network & Care Delivery Transformation, Anthem

- **Daniel Rosenthal**
  President, UnitedHealthcare Networks

- **Doug Chaet**
  Moderator
  Chief Managed Care Officer, Cleveland Clinic

Employee Benefit and Managed Care Executives interested in attending should contact Cleveland Clinic at VBIS@ccf.org by Friday, August 2, as space is limited.

clevelandclinic.org/valuebasedinnovationsummit
Mission Managed Healthcare Executive provides healthcare executives at health plans and provider organizations with analysis, insights, and strategies to pursue value-driven solutions.

Mark Boxer, PhD, is executive vice president and global chief information officer for CIGNA, where he is responsible for driving the company’s worldwide technology strategy.

Lili Brillstein is a nationally recognized thought leader in the advancement of Episodes of Care as a value-based approach for specialty care. She is the director of Specialty Care Value Based Models for Horizon Blue Cross Blue Shield of New Jersey.

Joel V. Brill, MD, is the chief medical officer for Predective Health, LLC, which partners with stakeholders to improve coverage of value-driven care that optimizes health for people.

David Calabrese, RPh, MHP, is senior vice president and chief pharmacy officer at OptumRx, a pharmacy benefits firm that provides pharmacy care services for more than 65 million lives nationally.

Virginia Calega, MD, is vice president, medical affairs, Facilitated Health Networks Independence Blue Cross. She oversees utilization management, medical cost, and health outcomes data, and interventions that optimize these outcomes.

Douglas L. Chaet, FACHE, is chief managed care officer, Cleveland Clinic, and chairman, American Association of Integrated Healthcare Delivery Systems.

Perry Cohen, PharmD, is a chief executive officer of The Pharmacy Group and the TPG family of companies, which provides services to associations, healthcare and information technology organizations, payers and pharmaceutical companies.

Darnell Dent, is principal of Dent Advisory Services, LLC, a management consulting practice focused on helping leadership improve organizational effectiveness and overall performance. He most recently served as president and chief executive officer for the past seven years of a managed care organization.

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Don Hall, MPH, is principal of DeltaSigma LLC, a consulting practice specializing in strategic problem solving for managed care organizations. He most recently served as president and chief executive officer of a nonprofit, provider-sponsored health plan.

Cynthia Hundorfes, is president and CEO of Allegheny Health Network (AHN), an integrated healthcare delivery system that serves Western Pennsylvania. AHN is part of the Highmark Health family of companies.

John Mathewson is chief operating officer for America’s Health Insurance Plans (AHIP), the national trade association that advocates for the health insurance community and the consumers they serve across the nation.

Margaret A. Murray, MPA, is the founding chief executive officer of the Association for Community Affiliated Plans, which represents 54 nonprofit safety net health plans in 26 states.

Kevin Ronneberg, MD, is vice president and associate medical director for health initiatives at HealthPartners, an integrated, nonprofit healthcare provider and health insurance company located in Bloomington, Minnesota.

David Schmidt is president of the TPG International Health Academy, which hosts trade/study missions around the world for U.S. healthcare executives. He also provides strategic consulting to health plans and health systems.

Paul J. Setlak, PharmD, MBA, is director of field health outcomes at AstraZeneca, where he is responsible for leading field-based clinical and health outcomes activities with payers, integrated delivery networks, health systems, and other groups.

William Shrank, MD, is Humana’s senior vice president and chief medical officer. In this role, he is responsible for leading and implementing the company’s integrated care delivery strategy. This strategy emphasizes a consumer-friendly, evidence-based, technology-enabled approach to personalized health improvement for the company’s more than 16 million Humana health plan members.
Over the past several years, there have been several initiatives at national and state levels to move healthcare payments away from the traditional volume-based fee-for-service (FFS) reimbursement model toward alternative payment models (APM) that incentivize improved health care outcomes and increased efficiencies. In particular, CMS has introduced an array of value-based care models, such as the Medicare Shared Savings Program and the accountable care organization (ACO) model. To continue this forward progress on the payer side of the equation, states have adopted, to varying degree, the establishment of managed care organization (MCO) value-based payment (VBP) targets for their state sponsored benefit programs such as Medicaid. For example, the Texas Health and Human Services Commission (HHSC) set overall risked-based VBP contractual targets based on MCO expenditures on VBP contracts relative to all medical expense. Beginning in 2018, HHSC established targets of 25% of provider payments in overall VBP and 10% of provider payments in risk-based VBP contracts relative to all medical expense.

How popular are value-based care models?

While this transition from fee-for-service to pay-for-value is inevitable, it is certainly one of the most challenging feats that the healthcare industry has undertaken. As with any other formidable challenges, the power of compensation has been the most effective lever organizations have used to drive real change. This has never been more evident than the fact that bonuses and incentive payments for healthcare C-suite executives are on the rise as the industry transitions to value-based care according to the most recent AMGA Medical Group Executive and Leadership Compensation Survey. The survey of 55 participants indicated that median earned bonus to base compensation ratio increased 4.5% for physician chief executive officers between 2016 and 2017. The ratio measures the proportion of compensation driven by performance-based incentives beyond base salary.

So, the key takeaway is this: MCO boards and their compensation committees need to take note that the pathway to driving effective and sustainable change toward value-based care is to shift more compensation from fixed base pay to incentive-based compensation with clearly defined performance metrics that moves the “value-based care needle.” According to a recent B.E. Smith Executive Compensation Intelligence Report, based on the survey results of 350 surveyed leaders, 10.8% of respondents said that “determining metrics for pay-for-value tasks” and 8.3% said “determining goals for pay-for-value tasks” were among some of the top compensation challenges healthcare organizations face led by “balancing quality of care” and financial goals.

Closing thoughts

The reason I believe effective executive compensation plans are the best levers in driving value-based care and reimbursement models because the continuing escalation of healthcare costs, the pursuit of higher healthcare quality, and the demonstration of better outcomes demand that we make these our top priorities. Keeping this in mind, MCO boards and compensation committees should:

- Review and modify existing compensation plans for its executives to ensure that incentives are appropriately set to drive desired results.
- Look at the broader healthcare market, not just other MCOs for effective compensation plans and metrics.
- Pay closer attention to what works vs. what the payout of the compensation plan. Every incentive dollar should count toward moving the needle toward effective value-based care.
- Establish a process to evaluate the effective of value-based payment models and the impact of these models on utilization, quality, cost, as well as return on investment.

Darnell Dent is principal of Dent Advisory Services, LLC, a management consulting practice focused on helping leadership improve organizational effectiveness and overall performance. He most recently served as president and chief executive officer for the past seven years of a managed care organization. He is a member of the Managed Healthcare Executive advisory board.
Everyone wins when healthcare organizations successfully motivate chronically ill customers to get—and stay—healthy. Patients know it. The healthcare industry knows it. But that’s not enough. “Human behavior is pretty complicated. If it was easy, everybody would be making healthy choices,” says Richard Saefer, MD, medical director of employee health and wellness at Johns Hopkins Healthcare LLC at The Johns Hopkins Bloomberg School of Public Health in Baltimore. “Also, people have different needs, and you have to meet them where they are on their health journey.”

Here are five fresh and surprising ways to tailor experiences so patients adopt healthier behaviors when faced with chronic conditions such as type 2 diabetes, heart disease, cancer, and chronic obstructive pulmonary disease (COPD).

1. **Let consumers decide how they want to hear from you.**

If you reach customers by the means they prefer, they’re more likely to listen. Don’t assume. Ask.

“Our survey shows that (health) plans are not quite keeping pace with the digital demand,” says Bryce Williams, president and CEO of HealthMine, a clinical technology firm with a clinical analytics platform in Dallas. “Plans need to meet beneficiaries on their terms and cater to their preferences.”

HealthMine’s survey of 781 Medicare Advantage or Supplemental members shows 47% favor digital communication with their plan, but only 34% actually receive it. A study by Survey Sampling International found only 18% wish healthcare providers reached them by regular mail.

Communication is critical for the complicated healthcare of individuals with chronic disease, says Tashfeen Ekram, MD, chief medical officer and co-founder of digital health firm Luma Health in San Francisco. “So much of what affects patient health outcomes has little to do with patient office visits but is tied more to what happens in between them. Patients and providers must be able to communicate effectively throughout the patient lifecycle.”

Knowledge is power: Patients can express their concerns while healthcare staff can learn of and address medical issues early on.

2. **Eliminate drive and wait time—by providing telemedicine, on-demand classes and other offerings that fit into clients’ busy schedules.**

Serve patients and physicians alike by automating time-consuming tasks before the patient even walks through the door: scheduling, visit reminders, and the filling of insurance and medical forms.

Not only does this shave phone and in-person wait-times, but also “aligns with quadruple aims of value-based medicine: improved outcomes, enhanced patient experiences, increased provider satisfaction, and reduced per-capita costs,” Ekram says.

To be fully effective, such portals and mobile- and text-driven platforms should be fully integrat-ed with as many electronic health record (EHR) and practice management (PM) systems as possible, so patient data will be synced and up-to-date.

EMindful’s eM Life digital app and web platform offer 15 to 20 daily interactive mindfulness classes on-demand and online to Aetna employees and others.

“We looked at modern content consumption and saw that easy access is paramount. Patients are less likely to adopt new habits if they have to drive to classes or wait to speak with a professional,” says Zev Suissa, chief innovation officer, strategic partnerships at eMindful, an Orlando, Florida, firm that offers online and mobile interactive mindfulness courses.
Two randomized control trials of 239 Aetna employees used a perceived stress scale and the Pittsburgh quality sleep index to find: 81% of 239 participants in the live, active format were “meaningfully engaged” and 65% practiced meditation or mindfulness techniques two or more times weekly, according to a study published in the Journal of Health Psychology.

Those using mindfulness tools self-reported experiencing 28.6% less stress and 20.3% improved sleep quality, according to the study. Corporations using the platform reported a 55.4% reversal of metabolic syndrome, a cluster of conditions that hike risk of type 2 diabetes, cardiovascular disease, and stroke.

These include hypertension, high blood sugar, and excess body fat at the waist. Ultimately, Aetna reported $550 improved health claims yearly per patient and $43.80 an hour in enhanced productivity among participants.

“Ultimately, that frequent and consistent use drives behavior change,” Suissa says.

Similarly efficient and effective are telemedicine and teledentistry, says Abbas Dhilawala, chief technology officer at Galen Data, Houston-based creators of a connectivity software platform. “Anyone with a phone line and an internet connection can consult with a doctor. A worker on break might be able to see a doctor and get a drug prescription within 20 minutes instead of taking the day off to commute to the doctor’s office.”

3 Incentivize with rewards customized to individuals.

We all like to win. Harness that desire by offering rewards to those who participate in wellness programs, have annual physicals or confer with dietitians.

Hawk Incentives research found 83% of those who received wellness rewards were satisfied with them. Yet only 38% of hospitals and healthcare organizations give such incentives.

And just 25% of Medicare Advantage beneficiaries say their plan offers personalized incentives, according to the HealthMine survey.

Value and timing are crucial to successful rewards, says Theresa McEndree, vice president of marketing at Blackhawk Network, a firm that specializes in branded rewards incentives via gift cards, digital payments, and loyalty points, in Pleasanton, California.

Blackhawk’s research shows participants prefer immediate lump-sum rewards over incentives paid out gradually. The most immediate and tangible—gift and prepaid money cards—are employees’ favorite.

“You often hear cash is king,” says McEndree. “People do love cash, but it has to be an on-the-spot digital e-card or literal gift or prepaid money card.”

A catalog of specialty products or gift cards at multiple wellness-oriented retailers ties gifts to positive goals and makes incentives more meaningful to the individual, she says. “I have a 1-year-old, so I spend a lot of money on diapers at Target. Someone else might love a gift card to Petco.”

The best rewards are also linked to small milestones along the way to larger goals, such as losing three pounds rather than 20. “The goals must be achievable: a hill to climb, not a mountain,” McEndree says.

The more difficult, onerous, or expensive the action desired, the higher the incentive should be, adds Tom Wicka, CEO and co-founder at NovuHealth, a national healthcare consumer engagement firm in Minneapolis. “Having a cancer screening involving blood or biopsy in a physician’s office is a bigger ask than going to your local pharmacy for a flu shot.”

“So much of what affects patient health outcomes has little to do with patient office visits but is tied more to what happens in between them. Patients and providers must be able to communicate effectively throughout the patient lifecycle.”

— TASHFEEN EKRAM, MD, LUMA HEALTH

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Communicate clearly in lingo-free language adapted to their needs and level of understanding.

When physicians talk above patients’ heads, patients lose focus. Patients whose doctors communicated poorly were 19% less likely to follow their care plan, according to a review of 106 studies over nearly six decades ending in 2008, according to a study in *Medical Care Journal.*

Training doctors in communication skills led to 1.62 times higher patient adherence than those without that training, as the study findings concluded. As many as 50% of chronically ill patients fail to follow the full regimen of medicine, appointments, screenings, exercise, and diet, the study said.

“Patients may leave doctors’ offices, pharmacies, and hospitals without a clear understanding of their conditions, medications or the next steps they need to take,” says Christopher K. Lee, MPH, CPHQ, clinical solutions marketing manager at Family Health Centers of San Diego, a provider of health-care and supportive services. “They may nod in agreement, but they don’t understand or won’t remember when they get home.”

That’s especially true when they’ve been given anesthesia or a harsh diagnosis.

Patients are also bombarded with too many and too complex instructions. “They’re not necessary and not patient-friendly,” he says. “Nobody reads all that.”

Worse, questions often are left to already time-strained pharmacy staffers, “who realistically have 30 seconds to explain medications,” Lee says. “The burden should fall on healthcare providers. We need more dedicated care coordinators and case managers who are trained to meet patients at their level and are given the time to do the job right. Health information texts may help—but nothing replaces human interaction.”

Encourage healthy habits and discourage unhealthy ones in the workplace and community.

Employers can greatly influence their workers’ healthy behaviors in the workplace, says Safeer, a board member at the American College of Lifestyle Medicine, a professional medical association for physicians, clinicians, and allied health professionals in lifestyle medicine, in Chesterfield, Missouri, and former medical director of preventive medicine at CareFirst BlueCross BlueShield, a network providing medical, dental and vision insurance in Maryland, Washington, D.C., and Northern Virginia. “The more approaches you offer the more likely employees will adopt healthy behaviors.”

Fill vending machines with fruit and low-fat snacks, not sugar-filled sodas and packaged snacks. If you have a company cafeteria, put fruit near the checkout register, not pastries. Price better choices lower.

“Policies greatly influence behavior,” he says. That starts with not docking pay for employees going to medical appointments and providing space for lactating new mothers to breast-pump.

Place signs at elevators directing to nearby stairs—and make sure the latter are well-lit, safe, and appealing, with fresh paint, carpeting, and pictures on walls, Safeer says.

“Outdoor green space and indoor greenery make people more likely to engage in physical activity.”

In contrast, leave smoking areas roofless and forbid smoking in areas through which other workers pass, he says. “You encourage the habit by protecting smokers from inclement weather.”

Provide on-site free or low-cost programs where workers—and their families—can learn strategies for weight loss, diabetes prevention, low-fat food purchasing and preparation, stress relief, smoking cessation, or Alcoholics Anonymous.

“Peer support is a big driver of behavior,” Safeer says. “People are more successful when part of a group. Insurance companies should cover lifestyle program participation for spouses of individuals with heart disease or diabetes—even if they don’t have those conditions. If families make healthier choices, it’s more likely patients will succeed.”

Also entice management to model desired behaviors. “If leaders walk at lunch it’s a sign to other employees that it’s OK not to work through lunch and to perhaps walk instead.” Your employee communications can spotlight active leaders and employees— and walking meetings can be encouraged.

Hire upbeat leaders who provide clear instructions, consistent priorities and shared decision-making authority, Safeer says.

“The more upbeat and better HR practices are, the better employees feel inside and how they feel inside influences how likely they’ll adopt healthier behaviors and strategies,” he says.

*Michele Meyer* is a freelance writer from Houston.
Digital transformation in healthcare has tremendous potential to change the way we engage patients and drive improvements in the quality and cost of care. This shift is particularly important in pharmacy, which is poised for innovation but has historically been less advanced due to perceived barriers to adoption. Even in today’s digital era, many pharmacists still rely on hard-copy paper prescriptions when processing scripts.

Electronic prescribing, or e-prescribing, has slowly emerged as an industry standard as more physicians move to electronic medical records. This technology brings potential to mitigate issues associated with hard copy prescriptions, such as forgery and fraud; illegible scripts leading to inaccurate fills; and increased administrative burden for patients and providers. With continued adoption, patients realize significant benefits, including adherence, accuracy, efficiency and safety.

Adherence
A study in *JAMA Dermatology* found e-prescribing is associated with a significant decrease in primary nonadherence among patients. E-prescribing improves patient-provider dialogue, reduces costs through a wider selection of generic alternatives, and gives providers immediate access to a patient’s formulary, drug history, and prescription benefits, fostering patient understanding of their prescription.

Accuracy
E-prescribing has proven to reduce the likelihood for prescription errors. When using hard copy scripts, a pharmacist may misinterpret the physician’s handwriting and supply the patient with the wrong drug, dose or quantity. E-prescribing drives a higher level of clinical accuracy and integrity, with one study showing decreased error rates from 42.5 errors to 6.6 per 100 prescriptions one year after adoption.

Efficiency
With current e-prescribing systems, providers receive eligibility, formulary, and medication history in real time. Prescriptions can also be automatically sent to the patient’s pharmacy of choice, eliminating the need for patients to physically drop off their script. This saves patients time, which can translate into savings for those who don’t have to take time away from work.

Safety
In addition to reducing the risk of an inaccurately dispensed drug or dose, e-prescribing gives physicians access to a patient’s prescription drug history at the point of prescribing to make informed decisions on dose increases or whether to add another concomitant medication.

For managing controlled medications such as opioids, e-prescribing limits opportunity for fraud, enables better tracking of prescribing and dispensing at the provider level, and improves pharmacy administrative efficiency and regulatory compliance. At a federal level, recently passed legislation will require prescribers to employ e-prescribing for all controlled substances for Medicare Part D recipients beginning in 2021. Several states also have similar legislation in place for controlled prescribing, and many others have legislation pending.

Looking ahead
The transition to e-prescribing has accelerated development of more comprehensive digital tools, including OptumRx’s PreCheck MyScript, which provides real-time, patient-specific information and suggested lower cost alternatives at the point-of-care. It also enables online, real-time processing of prior authorization where required, and delivers clinical alerts when members are at risk of harm, or are falling out of appropriate care. Members have seen improved health outcomes, increased access to therapy, and lower out-of-pocket costs as a result.

With universal adoption of e-prescribing and corresponding tools, professional pharmacy practice will continue to transform in not only delivering a more convenient and cost-efficient experience, but also delivering upon the need for better communication and coordination of care for patients across the healthcare continuum.

David Calabrese, RPh, MHP is senior vice president and chief pharmacy officer of OptumRx. He also is an editorial advisor for Managed Healthcare Executive.
Executive compensation has long played a critical role in the retention of experienced healthcare leaders, but a push for high-value care is changing the way that managed care organizations are rewarding their leaders.

Recently, there’s been a shift in compensation plans from offering a base salary to an annual incentive plan derived from a short list of goals related to addressing the organization’s vulnerabilities and then a long-term incentive opportunity.

Clive Fields, MD, chief medical officer of VillageMD, a national provider of primary care and president of Houston-based Village Family Practice, believes as the healthcare system moves to value-based payment, executive payment will move behind it.

“In many cases, they are still paid by emergency room admissions, inpatient admissions, etc. To truly succeed in value-based care, executives have to align as well with the healthcare system and focus on value not volume,” he says. “In other words, hospital CEOs and executives must be on the same page and same directive as the physicians.”

The macro changes within value-based payments are being seen throughout and integrated in hospitals and with executives, things Fields notes everyone is paying strict attention to.

“More inpatient beds are being closed or repurposed, such as for long-term care, skilled nursing, and rehabilitation—all of which are in short supply,” he says. “We’re also seeing the physical plants they’re managing move in the same way.”

Julian Hagmann, vice president of Caring Professionals Inc., a New York-based homecare company, has spent nearly a decade working with care providers, medical staff, and business professionals. He has seen first-hand how the push for high-value care is impacting executive compensation in the managed care space—and says change was definitely needed.

“Considering the managed care organization is in charge of patient outcomes and are responsible for overseeing all aspects of one’s care, it is appropriate to offer a bonus incentive to the managed care organizations so that there is a focus on quality and therefore increased patient outcomes, rather than only being concerned with enrollment numbers,” he says. “The hope in doing this is to improve quality of life for the enrollees and to reduce Medicare and Medicaid spending on preventable items such as ER visits, falls, shortness of breath, etc.”
Hagmann notes the plans are being held to quality standards imposed by CMS and the Department of Health and explains that members of a plan get assessed every six months. During that assessment, they go through a list of questions surrounding quality of care being received from in the home to care management. These include: Preventable Avoidable Hospitalizations, Flu Shot Compliance, Falls, ER Visits, Shortness of Breath, and Urinary Incontinence & Pain Intensity—basically anything that could potentially result in the patient being admitted to a hospital or nursing home.

"Should those scores improve, then the managed care organization receives a bonus for showing improved patient outcomes, should that fall below their current rating, or whatever metric they chose, then they would not receive a bonus," he says.

**Evolving Payment Models**

In 2018, B.E. Smith conducted The Executive Compensation Intelligence Report, its second-ever executive compensation survey, garnering responses from more than 350 healthcare leaders. They learned that 69% of respondents self-reported a compensation level between $100,000 to $299,000 and another 19% reported earning between $300,000 and $499,000, while 6% exceeded $500,000. Echoing the previous annual survey, 45% of respondents said their compensation was higher than the previous year.

However, the industry’s interest and shift to more value-based care has resulted in healthcare organizations assuming increasing financial risk as reimbursement models change from fee-for-service to pay-for-performance. That has impacted executive compensation everywhere.

A transition to value-based care has put pressure on healthcare leaders to do more—and do better—with less. The changes the industry is experiencing were expected, Fields says, as they meet the needs of an aging or more chronic population that we’re seeing today.

“This is the most efficient and best value for healthcare,” he says. “The skill sets needed for a successful executive will shift as well. It will require them to be most skilled in outpatient facilities and physician engagement.”

That could mean that finding and retaining savvy executives up to the task can be a struggle, especially if they’re dealing with old compensation models. Not surprisingly, more organizations are exploring alternative compensation plans.

Hagmann agrees that these changes have been a work in progress for some time now and things will most likely continue evolving.

“When you look at Medicaid and Medicare spending, there is a large number that is associated with preventable factors,” he says. “Therefore, by putting the burden onto the plan it is appropriate to offer a bonus incentive to the managed care organizations so that there is a focus on quality and therefore increased patient outcomes”

— JULIAN HAGMANN, CARING PROFESSIONALS INC.
Executive Compensation

and providers, you are forcing them to interject with solutions before it leads to a higher expense within the hospital network. CMS pushed these into the hospital setting.”

He adds that compensations are being impacted because the growth from the baby boomer population in the next five to 15 years is so great that the funds, which are used for these programs, need to be managed in a more cost saving way than in previous years.

“Being the dollars are federal- and state-originated funds, the focus needs to be on quality and therefore needs to be implemented at the plan level,” Hagmann says.

The B.E. Smith survey theorized that compensation is most effective when it is aligned closely with an organization’s strategic goals and explored this issue in detail.

Its findings revealed that as organizations look to address rapid and difficult change, they appear to be experiencing misalignment in regard to compensation. As such, approximately 60% of respondents in the survey noted their compensation and overall strategies are seriously or slightly misaligned, while just 40% suggested compensation was aligned.

Doug Chaet, chief managed care officer of the Cleveland Clinic, hasn’t seen a whole lot tied to high-value care performance, citing the fact that the provider side historically has had a tendency to incentivize better care to a much lesser extent.

“If you’re an executive who has a compensation package of $400,000 a year, in all likelihood, 80% to 90% of what you’re earning is guaranteed compensation,” he says. “Conversely, if you’re a similarly positioned executive in the payer world, depending on your level, your incentive comp could be two to three times your base comp.”

Still, Chaet’s experience has been that regardless of which methodology one looks at, most of the incentive piece tends to have more to do with overall company performance and less to do with how well one is able to differentiate themselves as being high-value.

A NARROWING APPLICANT FIELD

Steven Sullivan, managing director at the executive compensation consulting firm Pearl Meyer, a New York-based compensation consulting company, says high-value care is one of several themes finding its way into executive compensation, consisting of high levels of clinical quality, very high patient experience, and efficiency.

“Delivering on all three of those simultaneously is incredibly difficult,” he says. “U.S. healthcare is not really set up that way and the whole idea that instead of being accountable to you until you go out the door in a wheelchair to your car, the healthcare system now is accountable for all the things that happen to you after that and what is the outcome of that.”

Therefore, when an executive team puts together a business strategy to accomplish progress and success on those three items, they have come to realize it’s a complicated process that will take a long time.

“They have things they will need to do for a year or two or three, that are really the building blocks of things they are going to have to do in four or five or six years,” Sullivan says. “That’s one of

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<th>What’s at risk</th>
<th>Percent of compensation tied to incentives</th>
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<td>36%</td>
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<td>10-19%</td>
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Source: B.E. Smith
the impacts of the push for high-value care. It’s made everyone realize it’s a long journey. So, executive compensation, which historically has been base salary and incentives, now is base salary, short-term incentive and long-term incentive, and more of the focus is on multi-year, variable compensation programs which in one or more ways are tied to the triple aim.”

The idea here, Sullivan continues, is that if one can bring about progress in patient experience and efficiency, you’ll build value year over year. The long, multi-year incentive program is more aligned to this.

“Many of these programs are three- or four-year measurement periods and they overlap so there’s an ongoing annual participation in a plan and it comes to term over three to four years, but during that time, the executives have re-upped their participation,” he says. “It becomes an annual part of their executive pay, it’s just the amount they pay out is predicated on how things have gone the prior three to four years.”

Sullivan says the market for executive compensation in middle-market and larger healthcare systems is moving very fast—not only is there a push for high-value care, but there’s a diminishing pool of people who understand that and can pull it together and function as a CEO in a large healthcare system and bring about all the sequenced multitude of change that needs to occur.

“The less of the folks that there are, the more they cost,” he says. “Plus, the challenge associated with bringing about these transformation of organizations is incredible. There’s less people who can do it and it gets harder every year. That can be a lethal one-two punch, and pay is going to go up. It can increase from 3% to as much as 6% and 7% a year.”

The ones who will survive are the ones with a strong relationship between the board and executive team. If the executive team does well, they are happy because they are getting paid and the board will be happy because their goals are being executed.

“Folks don’t stay for 30 years anymore. People are more apt to come and go, so there’s more recruiting and need for retention going on,” Sullivan says. “On the recruiting side, if you can put together a program like one of these multi-tiered incentive programs of short and long, it can be a great recruiting team because people will know you’re serious about transforming the organization. They will expect to be well paid, but only when the performance is there.”

### Top Incentive Objectives for Leaders

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<th>Percentage</th>
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<tr>
<td>31%</td>
<td>Patient engagement or satisfaction targets</td>
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<tr>
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<td>Clinical performance targets</td>
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*Source: B.E. Smith*

### THE FUTURE OF COMPENSATION

Most agree the landscape of the future will not be the same as today. Hagmann, for one, does not see as many managed care companies operating. Rather, he sees a significant drop in those organizations—whether it is through M&A or state government action.

“Look at the past year, we have had Centene and CVS start purchasing organizations in New York City; ICS [Independence Care Systems] was forced to step back from being a provider and give their case mix to VNSNY [Visiting Nurse Service of New York], and those are just the tip of the iceberg,” he says. “The future boomers are going to be utilizing managed care companies, which means the room for growth is great—so great that I am sure we will see other major players buy and consolidate other plans.”

He also sees this as a time for development and testing of technology, which will be used to increase patient outcomes. While a majority of the population being serviced now lacks the knowledge and trust in tech, Hagmann says it is imperative for these products to be in-place for when the Gen X and millennial generations age.

Optimizing patient care and well-being while maintaining financial strength is a difficult balancing act, as many see compensation as a major lever to manage this effort. In the years ahead, healthcare organizations will need to remain vigilant in this area, since the velocity of change today makes the compensation/strategy match challenging.

Keith Loria is an award-winning journalist who has been writing for major newspapers and magazines for close to 20 years.
How Machine Learning Is Revolutionizing Healthcare

Two real-world examples

by LINDA WILSON

To take advantage of emerging software tools that incorporate artificial intelligence, healthcare organizations first need to overcome a variety of challenges. Some leading-edge organizations are beginning to do just that, focusing on machine learning, a subset of artificial intelligence (AI) that encompasses statistical methods in which computer systems recognize patterns or correlations in data by ingesting large sets of training data. They improve their performance, or "learn," over time as they incorporate new data; revising their approach as needed without human programmers updating the rules.

In the healthcare industry, most machine learning applications are in the research stage. "There is not a ton of clinical use," according to Brian Edwards, independent validation consultant for AI vendors.

One area with a lot of research activity is radiology, where the industry is investigating how to use machine learning to detect signs of disease from digital images. "Wherever you have crisp clean data is where you should start. Images are the highest quality data that you have in a health system in terms of reliability," Edwards says.

Machine learning has been applied to other areas, such as assessing patients’ risk of a hospital readmission, exacerbation of a chronic medical condition, or coming down with sepsis during a hospital stay.

Preparing for machine learning

"I think planning is where it starts," says Bob Fuller, managing partner for healthcare at Clarity Insights, an information technology consulting firm focused on data analytics. Fuller says healthcare organizations should assess their overall business strategy and how AI could be deployed to solve specific problems, such as hospital readmissions or claims fraud. The next step is to allocate financial resources to transition the information technology infrastructure, so it becomes AI-ready, Fuller says.

This includes a large and diverse set of reliable data to train the machine learning models—whether they are developed internally or purchased from AI software vendors.

"In every situation, it is necessary to train the AI. That knowledge is really institution specific." — BRIAN EDWARDS, CHILMARK RESEARCH

Real-world data

Geisinger Health—an integrated delivery network with 13 hospital campuses and a nearly 600,000-member health plan—has tapped into its vast store of diverse datasets to develop machine learning applications internally.

It has data on 2 million patients in its electronic health records system. It also has a stable patient population in Pennsylvania and New Jersey, which allows it to build longitudinal datasets, spanning 20 years.

"In every situation, it is necessary to train the AI. That knowledge is really institution specific. The heterogeneity of data makes it very difficult, if not impossible, to take something from one organization—or a generic packaged product—and implement it widely. It really is implemented one-at-a-time in an almost ala carte type of way, where you need to customize it," Edwards says.

Another barrier to implementing machine learning in healthcare organizations is access to high-quality data. Healthcare organizations need to have rigorous processes in place to ensure they have clean and well-defined data, Fuller says. While this has always been true, it becomes even more important as the volume and types of data that healthcare organizations capture continues to grow, he adds.

“In every situation, it is necessary to train the AI. That knowledge is really institution specific.”

— BRIAN EDWARDS, CHILMARK RESEARCH

Continued on page 19
Continued from page 12

In its digital imaging system, it has two petabytes of data, which it accumulated over 19 years. Most of this data is from radiology, but some is from other medical disciplines, such as cardiology.

“The ability to have that data and to use it for machine learning is one of our strengths,” says Aalpen Patel, MD, chairman of radiology at Geisinger.

Some applications are in daily clinical use already, including a machine learning model that detects intracranial hemorrhage, or bleeding in the brain, from CT scans. Geisinger uses the model in daily operations to read CT scans of the brain taken in the outpatient setting. If the algorithm detects bleeding, the case is automatically reprioritized as a STAT case in radiologists’ work queue.

While all CT brain scans from hospital units or emergency departments are considered STAT and read within 30 minutes, similar scans taken in the outpatient setting are read within 12 hours. By sending those cases from the outpatient setting through the machine learning model, Geisinger reduces diagnosis times significantly for critical cases coming from the outpatient setting.

“We don’t take on problems that we don’t think are relevant,” says Brandon Fornwalt, MD, PhD, chairman of the department of imaging science and innovation at Geisinger. The integrated delivery network’s goal is to move from the research phase to implementation in clinical workflows quickly, he says.

In addition to large datasets, ample processing speed is necessary for machine learning. Geisinger solved this problem for its first machine learning application in imaging by purchasing a GPU (graphics processing unit), which accelerates the processing of computational workloads. Since then, it has upgraded its architecture to include multiple GPUs because its need for processing power has grown.

Fuller says accessing cloud options—such as from Amazon Web Services, Microsoft Azure, or Google Cloud—might be more cost effective for many healthcare organizations than building the required infrastructure internally, because the cloud allows you scale computing resources up and down to match current needs.

Having a plan to evaluate machine learning products on the market today also is important. Salt Lake City-based Intermountain Healthcare, which has 23 hospitals and more than 170 clinics focuses its efforts on purchasing commercially available software, has investigated many more products than it has purchased, according to Lonny Northrup, senior health informaticist at Intermountain.

Northrup says Intermountain typically won’t move forward with a tool unless the vendor can point to clinical improvements and cost reductions that occurred at another health system.

After analyzing the results the platform achieved elsewhere, Intermountain assesses how well a product works with its patient data. To do this, the health system feeds the product a set of training data—such as on colon surgery—that the health system has already studied, allowing it to verify the insights that the tool derives.

The next step is a pilot test. For example, Intermountain is working with a vendor of patient engagement software on a clinical trial using the product to encourage patients with complex cases of congestive heart failure to follow their medication regimens. Using machine learning methods, the software platform personalizes the recommendations it makes about how to prod patients to behave in ways that improve their health. As part of the project, Intermountain provides 24/7 availability of clinical personnel to respond to these patients’ needs, Northrup says.

Linda Wilson is an experienced writer and editor specializing in the healthcare industry.
The need for healthcare organizations to take an active role in protecting PHI has never been greater, as the number of data breaches continues to rise. Since 2010, hackers have gained access to more than 175 million healthcare records, according to research published in *JAMA*.

Here are some tips for keeping PHI secure.

1. **Prioritize**
   
   It’s not enough to have technology or rules in place if no one follows them. Be sure to audit and train staff members continuously on what to do so they can be aware of security requirements. This ranges from understanding what is acceptable to talk about in public areas to knowing what a phishing email looks like and how to react.

   One way to test for the latter is to do random phishing tests, in which you send a phishing email to all employees and see who clicks on it. Then, use that as a training opportunity to make sure staff is consistently staying alert.

   Just remember, quality is more important than quantity when it comes to training. Although 88% of healthcare provider and insurance company employees reported that they received security training, 17% admitted they still write down their username and password, and 19% said they would sell confidential data, according to an Accenture survey.

2. **Control access to any PHI**
   
   Decide who gets access to PHI at your healthcare organization based on need. For example, make sure all applications and software allow for role-based access, and keep these access protocols updated and enforced as employees are promoted, move to other departments, or leave the organization.

   It’s also important to control physical access to any PHI, making sure it stays on the premises whenever possible. If information must leave, be sure any hard drives are encrypted and protected by passwords to prevent a breach if the storage medium is lost or stolen.

   You should also have a plan in place to track the movement of electronic media and mobile devices, knowing at all times which employees are responsible for these devices.

3. **Evaluate security practices**
   
   Many healthcare organizations partner with vendors to deliver services and manage their data. Make sure your employees have the same dedication to maintaining security over data as you do. One thing to look for in a vendor is whether it has undergone any security certifications, like HITRUST.

   You should also ensure the vendor has signed a business associate agreement. A Florida provider, Advanced Care Hospitalists (ACH), agreed to do business with a medical billing service several years ago but later learned that the person it was dealing with was using the service’s name and website without permission. ACH discovered this when patient information was made public on the service’s website. ACH ended up paying $500,000 in settlement fees for sharing PHI with an unknown vendor without a business associate agreement.

4. **Secure your communications**
   
   There’s no avoiding the phone, email, and even fax when healthcare providers are communicating with patients, payers, and others. Therefore, it’s vital that any communications be secure and HIPAA-compliant. That means encrypting all outbound email messages that contain PHI and, after you receive the information, making sure it’s secure.

   According to a recent study, more than half of healthcare data breaches are due to the negligence of hospitals, doctors’ offices, and insurance companies. This underscores the need to establish secure communications protocols and regularly train personnel on them.

   By following these steps to ensure your patients’ health information is protected, you can avoid falling victim to a security breach that could have been prevented.

Hoala Greevy is the founder and CEO of Paubox, the only HITRUST CSF-certified seamless secure email solution. Hoala also founded Pau Spam, an email-filtering software service.
Similar to population screening of newborns for over 30 genetic conditions, routine genomic screening for all patients is becoming increasingly viable.

“The technology is not a barrier for universal screening in the United States. It is readily available,” says Michael Murray, MD, director of clinical operations for the Center for Genomic Health at Yale School of Medicine. “And some consumers are ready to personally bear the cost of between $300 and $800 per person.”

Murray notes that 82% of people with the genes BRCA1 and BRCA2, which are risks for breast, ovarian and fallopian tube cancer, were only identified through a genetic screening project in a study published recently in *JAMA Network Open*.

“However, for genomic screening in general, we need to make this endeavor operational for interpreting data and obtaining evidence to support such screening projects,” Murray says. “There definitely needs to be more research to backup this kind of a strategy.”

In an ideas and opinion piece in *Annals of Internal Medicine*, Dr. Murray highlighted Geisinger Health System in Pennsylvania, which in May announced that DNA sequencing would be offered to 1,000 patients as part of routine clinical care.

To date, 200,000 research adult patients at Geisinger have been genetically screened for 76 genes and 27 conditions. “But we are still at the evidence-gathering stage,” says Murray, who previously served as director of clinical genomics for Geisinger.

Meanwhile, there are private companies selling consumers DNA screening, independent of healthcare. “That data is valuable in understanding what evidence is out there,” Murray says. “However, data are typically not available to the people who are building the evidence base outside of those companies. It would be helpful if that information is shared and understood for initiating public clinical programs.”

Nonetheless, it appears that companies providing consumer screening underestimate the value of input from healthcare providers for practical implementation. Additionally, many health systems and insurers are reluctant to incorporate insightful consumer data into patient care.

Still, an example of data generated outside healthcare which is valuable and embraced by a healthcare setting is a home pregnancy test. In fact, a positive test result is shared with a provider millions of times a year. But when the same woman offers genomic screening results, it is considered novel and its handoff is not well established.

The industry goal is to start with a screening program for 10 to 100 genes, then expand the list as knowledge and experience increases. For context, roughly 3.5% of volunteers of the Geisinger GenomeFirst project will receive clinical results from a list of 76 “actionable genes.”

“Early case reports show that this approach can identify subclinical disease and prompt important medical interventions,” wrote Murray in his opinion article, adding that conservatively at least 1% of the U.S. population has an identifiable genetic risk for cancer or heart disease.

Murray says it is reasonable to expect that in the 21st century, the actionable gene list will enlarge to include most, if not all, of a human’s 20,000 genes.

“If everyone’s goal is to achieve better outcomes, then functioning implementation models need to be developed,” Murray says. “Patients should also expect models for handoff from consumers to healthcare.”

Bob Kronemyer is a freelance writer based in Elkhart, Indiana, with an emphasis in healthcare and general business, and a frequent contributor to Contemporary *OB/GYN*, in which this article first appeared.
Individuals diagnosed with diabetes have to concern themselves about a variety of issues, like blood sugar level, diet, and a complex medication regiment. “A lot is required of a person diagnosed with diabetes in terms of what to do and not to do,” says Amy Carter, MA, RD, CDE, director of Outpatient Nutrition for Eskenazi Health in Indianapolis. “Knowing they will have to manage this chronic disease for the rest of their lives, often without education, support, or financial resources, significantly impacts a person’s self-care ability.”

While there are lifelong challenges, the good news is diabetes is manageable, Carter says. Patients can control their condition by making the right choices. Here are some of the leading challenges that endocrinologists and educators see from their daily interactions with diabetes patients.

**Cost**
“We have so many great medications available in our arsenal to treat diabetes,” says Patricia Luceri, DO, an endocrinologist with Jefferson Health in Marlton, New Jersey. “Unfortunately, they’re expensive. If the patient doesn’t have good insurance to cover the cost of the drug, then that drug is not an option. Even with insurance, there are copays, which could be high.”

“Often, patients tell me they’ve had to choose between buying food or medication,” she adds.

“Many times, they’re trying to stretch their medications by taking them every other day or taking a partial dose.”

**Education**
“The actual percentage of people who receive the appropriate education about how to manage their diabetes is fractional—less than 10%,” Carter says. “Full diabetes education encompasses food, medicines, checking blood sugar, risk reduction, and other topics. Without education, it’s very challenging for people to understand what happens if they don’t take the appropriate steps.”

**Self-monitoring**
“Patients often don’t have access to the supplies they need to monitor their blood glucose levels,” says Ajaz Banka, MD, an endocrinologist with Beaumont Hospital in Michigan. “Testing supplies are expensive. But if patients don’t know their numbers, they don’t know what’s happening [to their health]. And if I don’t know what’s happening, it affects their care.”

“If patients don’t test their sugar, they can’t manage their diabetes,” Luceri says. “It can be cumbersome to test regularly and test in public. There have been many advances in recent years, so this is becoming less of a challenge. There are continuous glucose monitors available to monitor their sugar in real time without a finger stick. However, not every insurance company covers the monitors.”

**Medication adherence**
“Diabetics are always on multiple medications, not just for their diabetes but also for high blood pressure and high cholesterol,” Luceri says. “It can be tough to remember when you’re taking that many medications, often at different times of the day. There is a class of medications that have a once-weekly injection, which can help with compliance. Some companies have programs that will send reminders to the patient to take their medications.”

**Healthy lifestyle**
“Eating is a basic function and asking a patient not to eat a particular food is difficult,” Banka says. “Patients are asymptomatic. They don’t really care, because they don’t see the complications right away, though they could still happen in the future. Cultural and educational background plays a big role in diabetes management. If we can get across to patients with education why managing diabetes is important, it will play a big role, long term, in their health.”

“It’s a difficult, long-term concern for people to incorporate diabetes management into their daily lives without feeling like it’s taking over,” Luceri says. “I discuss diet, exercise and maintaining healthy eating habits with patients. But when they leave my office, it’s up to them to follow that advice.”

Ken Krizner is a freelance writer based in Cleveland, Ohio.
Science and technology have drastically improved how autoimmune diseases are managed, and there are more options than ever before to treat autoimmune diseases.

Chase Spurlock, PhD, professor at Vanderbilt University and CEO of IQuity, a Nashville-based analytics startup offering an autoimmune disease-focused data analytics platform, says for many autoimmune diseases the available treatments can effectively control disease, but there is no one-size-fits-all approach.

He adds that all too often, patients are wandering through the healthcare system trying to find answers and some patients receive the wrong diagnosis and are placed on medicines that are not only expensive but also carry a high level of risk. Receiving an accurate diagnosis as quickly as possible is vital to ensure for the best long-term outcomes.

“Time is of the essence. If autoimmune diseases are allowed to progress without any therapeutic intervention, irreversible tissue damage and disability ensue,” he says. “We are very fortunate to live in an era where the therapies to treat many autoimmune diseases are highly effective, especially if they are prescribed early.”

Here are some of the latest advancements for autoimmune disease diagnoses and treatments.

**Psoriasis**

Psoriasis is a common autoimmune disease that affects more than 8 million people in the United States and has a significant burden on patients’ quality of life. Patients are often faced with embarrassment because of the visible plaques on their skin and some patients isolate themselves for fear that others will think their disease is contagious.

In the summer months, this is especially important because clothing worn in warmer weather tends to expose more skin and therefore more unsightly plaque.

Fabrice Chouraqui, president of Novartis Pharmaceuticals Corp., says the treatment of psoriasis has been evolving over the years and there are now multiple therapeutic options.

“Cosentyx is the first and only fully human IL-17A antagonist which has demonstrated efficacy in moderate to severe plaque psoriasis, which may involve troublesome areas such as the nails, the scalp, hands and feet,” he says. “When these areas are involved, psoriasis has an even greater impact on a patient’s quality of life. Cosentyx has also shown efficacy in the joints and is approved for active psoriatic arthritis and active ankylosing spondylitis.”

Unlike some other therapies that have only shown efficacy in the skin, Cosentyx is also a proven therapy for psoriatic arthritis, which is a complication of psoriasis that can cause irreversible bone damage and disability.

The Institute for Clinical and Economic Review (ICER) recognized that IL-17 agents...
provide long-term value to insurers, patients, and the healthcare system. ICER’s 6/18 Psoriasis Update Evidence Report reviewed Cosentyx and other targeted immunomodulators for moderate to severe plaque psoriasis and concluded that first-line treatment with IL-17 drugs is a reasonable strategy due to their high efficacy and reasonable economic value, even in comparison to step therapy using a less effective and less expensive targeted drug first line.

Chouraqui said Cosentyx costs virtually nothing for a 30-day prescription with the Novartis $0 copay program for those with commercial or private insurance.

In April, the FDA approved Duobrii (halobetasol propionate and tazarotene), a lotion developed by Bausch Health, which contains two medications for the treatment of plaque psoriasis in adults. The medicines work together to slow the growth of skin cells and reduce the symptoms of plaque psoriasis.

Additionally, the FDA recently approved Sorilux Foam (calcipotriene, Mayne Pharma), a topical treatment originally indicated for adult patients only, as being safe for pediatric patients 12 and older.

**MS**

A study led by Dr. Mitchell T Wallin of the Department of Veterans Affairs MS Center of Excellence and Georgetown University, and supported by the National Multiple Sclerosis Society, revealed the prevalence of MS in the U.S. is nearly 1 million people, more than twice the previously-reported estimate. This suggests many more people are living with MS than previously thought, and in particular the number of people with a progressive form of the disease—where the greatest needs continue to exist—may be much higher as well.

“This study tells us many things, but one thing in particular—twice as many people need a cure,” says Cyndi Zagieboylo, president and CEO of the National Multiple Sclerosis Society. “We must do more.”

More than a dozen medicines for relapsing multiple sclerosis have been approved since the ’90s, but the first DMT for the primary progressive form of MS, Ocrevus, was not approved by the FDA until 2017.

“Our work with Ocrevus has provided an earlier treatment option with a favorable benefit-risk profile,” says Hideki Garren, MD, PhD, global head of multiple sclerosis and neuroimmunology at Genentech, developers of Ocrevus. “This is because we know treatment with a high-efficacy medicine that impacts MS disability progression, not just relapses, is important to preserve patient function and ultimately quality of life.”

Ocrevus is the first and only therapy approved for all relapsing forms of MS, which includes relapsing-remitting and active or relapsing, secondary-progressive MS as well as primary progressive MS.

“Ocrevus has fundamentally changed our understanding of MS pathology and how to treat the disease,” Garren says. “By uncovering the role of B cells in MS (when it was previously thought to be primarily a T-cell driven disease) we have created a high-efficacy medicine that can be used earlier...
because of its favorable benefit-risk profile and the ability to slow the progression of disease."

Genentech set the price to allow people to have the easiest path to access, and today Ocrevus is widely covered both in the U.S. and abroad. The manufacturer has not increased the price since launch and is committed to fair, reasonable pricing over the life cycle of Ocrevus.

“We are committed to helping people access the medicines they are prescribed and offer comprehensive services for people prescribed Ocrevus to help minimize barriers to access and reimbursement,” Garren says.

**LUPUS**

Until 2011 and the FDA approval of belimumab, there were no new treatments approved for lupus. This biologic treatment interferes with a specific protein that supports the activation and survival of B cells, which play a pivotal role in lupus pathology.

Taken together, the more than 30 treatments that have failed in clinical trials for lupus since the early 1990s represent well over $1 billion in lost research and development funding and have left lupus as one of the most underserved diseases.

“It is now 2019 and every treatment that has gotten into late-stage development for lupus since belimumab has failed,” says Joan T. Merrill, MD, chief advisor for clinical development at the Lupus Foundation of America, and Director of Clinical Projects, Arthritis & Clinical Immunology Program, Oklahoma Medical Research Foundation. “The good news is that there is no slowdown in development for lupus, and new agents are coming into early phase trials each year.”

She explains that more and more has been learned about the pitfalls in the clinical trials for this complicated disease and improvements have been made in trial design, patient selection, and a better biologic understanding of the patient subsets that may or may not respond to a given targeted treatment.

“There have been some recent successful phase 2 trials and we are waiting to see if any of these new agents break through at the end,” Merrill says. “Current treatments in development include agents that target proteins that lie at various points along the type 1 interferon pathway, agents that are similar (but not identical to belimumab), and agents that affect other regulators of the immune system.”

In 2019, belimumab was approved for children for the first time.

**RA**

Rheumatoid arthritis (RA) affects multiple joints, including in the hands and feet and can cause irreversible damage to these joints resulting in pain and loss of functionality.

Ala Rudinskaya, MD, section chief of rheumatology at Danbury Hospital and medical director of Western Connecticut Medical Group Rheumatology, says the main goals of treatment for RA and other autoimmune diseases are to improve symptoms (pain, functionality), and prevent joint damage from occurring.

In 1998, the first biologic agents (infliximab and etanercept) were approved for treatment of RA. Over the past 20 years, options for RA treatment have grown exponentially and there are now several classes of biologic agents available to treat RA.

“The use of biologics has greatly improved the treatment and prognosis of RA. Biologics are made by using biotechnology and work by interrupting or blocking immune system signals causing inflammation and joint destruction,” Rudinskaya says. “The availability of more medications is great news for people with RA because if they don’t respond to one treatment, they can try another one to effectively manage the disease. Also with these newer medications, there is a greater chance for the disease to go into remission.”

Most medications to treat RA are covered by commercial health insurance plans, Medicare, and state health insurance. For example, the first line of treatment for RA, methotrexate (which is a DMARD—disease-modifying antirheumatic drug), is a medication that has been around for decades. It’s an effective medication and is relatively inexpensive.

“However, the newer medications, like biologics, are usually quite expensive,” Rudinskaya says. “Most health insurance plans may cover different biologics but may have restrictions or prefer some medications over others. Patients who cannot get their medications through their insurance may sometimes be eligible for patient assistance programs.”

Keith Loria is an award-winning journalist who has been writing for major newspapers and magazines for close to 20 years.
After a career that spanned more than 40 years of executive leadership experience serving national health insurers and hospital systems—including stints as chairman and CEO of Anthem, CEO of Catholic hospital systems Trinity Health and Centura Health—Joe Swedish “retired” in 2017.

Not that he ever slowed down. He still stayed on as Anthem’s executive chairman of the board until last May, will stay on as one of the insurer’s senior advisers through May 2020, and in August 2018, he became co-founder and partner of Concord Health Partners, a private equity firm focused on strategic investing in healthcare portfolio companies.

“I really had the great experience of being in the healthcare industry for 45 years and arguably have seen many cycles, a lot of challenges and a lot of successes,” he says. “But nonetheless, we still have an industry fraught with a lot of issues regarding affordability, significant access issues, and there’s still a long way to go regarding improvement and quality both by ways of service and safety.”

With Concord Health Partners, Swedish aligned with like-minded partner James T. Olsen, a 23-year-
healthcare investment banking vet and former managing director and group head of Jefferies and Bank of America Merrill Lynch, two leading investment banks in healthcare. The two co-founders plan to invest in technology and solutions that have the potential to enhance the value of healthcare with lower costs, improved quality, and expanded access to care.

"Having come to a stage in my career where I could easily pivot to certain choices that individuals make when they give up a career, I felt that I now had the opportunity to give back in a meaningful way to an industry that was very good to me and incredibly significant as a key contributor to the health and welfare of our society," Swedish says. "We are hoping to develop a platform tapping into the financial services sector that could tackle challenges of affordability, access, and quality."

Swedish is hopeful that Concord Health Partners will make an immediate impact in the industry that he believes needs the strength of innovation to transform it into something the American public would significantly appreciate.

"The formation of Concord Health Partners was made possible because of the innovation momentum," he says. "Never before in the history of medicine have so many opportunities come forward in so many unique ways where innovators have the opportunities to radically transform how care is delivered. I'm hopeful that in some matters that we can be a contributor to the improvement of healthcare by targetting these innovations looking for ways to come to market."

Still in its early stages, Concord Health Partners has an outlook that will leverage alignment among collaborative enterprises that are investors in health systems seeking to make a difference.

"It's an alignment of colleagues and collaborators with desires to capturing these innovations," Swedish says. "It's not about investments per se, but about creating a go-to-market opportunity for the innovators that can fit nicely into the fabric of these health systems that are seeking to create a more efficient, effective delivery system."

**Building a career**

The son of Eastern European immigrants, Joe Swedish was raised on a Virginia farm and studied at a Catholic Junior ROTC military college preparatory high school before going on to attend the University of North Carolina at Charlotte and obtaining his master's degree in health administration from Duke University.

In 1973, he made a personal commitment to combine his interests in business, law, and policy in a way where he could serve people and saw healthcare as the epitome of how he could achieve that goal. He has been in healthcare ever since and over 45 years has never wavered in terms of his career focus.

Early in his career, he served as president and CEO of Winter Park Memorial Hospital and Park Health Corp., in Winter Park, Florida; president and CEO of Mary Washington Hospital in Fredericksburg, Virginia; and senior vice president of Memorial Mission Medical Center and CEO of its subsidiary Horizon HealthCorp.

With Centura Health, Colorado's largest health system, Swedish was responsible for improving its troubled financial stability and strengthening its voice on healthcare policy issues and making major investments in system expansion with strategic capital deployment to grow and improve the quality of care and services.

After six years there, he headed for a nine-and-a-half year stint at Trinity Health starting in 2005, where he spearheaded the development of the U.S.' first large scale electronic medical records system, and helped to increase revenue by nearly 50% from less than $6 billion to approximately $9 billion in 2012. Also under his leadership, Trinity continued to grow due to a strong M&A focus, including the merger of Trinity and Catholic Health East to create one of the largest catholic health systems.

When Swedish transitioned from his 40-plus year in the provider sector to work at Anthem in 2013 he felt it was a natural progression.

"Never before in the history of medicine have so many opportunities come forward in so many unique ways where innovators have the opportunities to radically transform how care is delivered."

"I was managing large-scale integrated delivery systems in various parts of the United States and I thoroughly enjoy operating in incredibly complex organizations, especially given the combination and permutations of challenges that they face providing efficient and effective healthcare," Swedish says. "Having done that for a lot of years, and also witnessing the
policy transformation that was occurring at the time, (such as the ACA), I felt moving into the payer sector allowed me as a provider executive to bring skills, insights, strategies and tactical initiatives that would pivot the payer sector to adapt to the new policy mandates.”

With Anthem, which serves approximately 73 million members in 27 states, Swedish saw the insurer’s annual revenue increase from $71 billion in 2013 to $90 billion a few years later.

“If you look at Anthem’s achievements over my five years with the company, we became an industry leader in value-based contracting, with a key ingredient being payer-provider collaboratives,” Swedish says. “This allowed providers to get the benefit of improvement in care delivery so that they got paid for the value they created, rather than the traditional fee-for-service model.”

Fast forward to 2019, Swedish is taking the experience he’s garnered from throughout his career, and along with Olsen, feels they are creating something especially beneficial for the marketplace.

“We’re not inventing cost escalators; what the two of us know is that we have to find ways of leveraging innovation to create opportunities in the marketplace in terms of care delivery that substantially improves the benefits healthcare can bring to patients,” he says.

In his spare time, Swedish enjoys fly fishing and is an avid golfer. For him, sports are an outlet that provides a strategic focus, takes tremendous skill, and offers him a bit of solitude.

Early investments
Since going live in September, Concord Health Partners has secured a number of investors and started building out two funds. One is a venture fund being built by way of a strategic placement with the American Hospital Association, which targets early-stage venture activity.

The second fund is a growth-equity fund which targets portfolio companies that are already in market and performing cash-flow positive or near cash-flow positive, looking to take their enterprises to the next level by way of capital infusion.

In May, it made an investment in MIVI Neuroscience, a medical device company focused on developing clinical solutions for neuro-interventional procedures, which provides physicians with innovative tools for endovascular stroke therapy procedures designed to help improve outcomes, shorten procedure times, and make treatment available to potentially more patients.

Other early investments include Flexwise, a technology-enabled business that offers an on-demand staffing platform that provides healthcare organizations with direct access to fully-vetted healthcare professionals available on a flexible basis; and Proton Therapy Partners, a specialty healthcare service provider offering much-needed, life-changing proton therapy to cancer patients through an efficient, cost-effective model.

“The sum total of all of this in terms of a strategic alignment, is the opportunity for value creation, and improving quality of care and science in the healthcare marketplace,” Swedish says. “The landscape already gives indicators of what’s possible. Now it is ready to spring forward with the right combination of motivation, method, and money.”

Keith Loria is an award-winning journalist who has been writing for major newspapers and magazines for close to 20 years.
More than 3.2 million Americans live with chronic hepatitis C, according to the FDA. Of those, around 700,000 to 1 million are Medicaid patients.

While HCV is curable, treatment presents a substantial cost burden to patients and payers alike. This has led to radical new payment model innovations—for example, Louisiana’s Netflix-style subscription model will allow the state to contract on a monthly basis for unlimited access to an HCV drug.

The subscription-based models are not the only new payment models. WellCare, through Care1st Health Plan Arizona, along with Maricopa Integrated Health System (MIHS), recently announced a new bundled payment model designed to increase patient access and adherence.

Satya Sarma, MD, chief medical officer at Care1st Health Plan Arizona, says Care1st started the program to address two issues: a high prevalence of hepatitis C in Arizona (the Arizona Department of Health Services estimates over 90,000 people live with HCV, making it one of the most commonly-reported infectious diseases with an average of 7,500 cases reported each year) and the shortcomings of traditional fee-for-service models in treating the HCV population.

Sarma also says that issues related to social determinants of health (SDOH) play a key role in restricting access to drugs—food, housing, transportation access, and even care coordination across services (e.g., behavioral health services) are often not addressed by providers.

“Our current fee-for-service models simply don’t incentivize these activities, do not drive innovation or efficiency, and do not reward providers for quality care, instead encouraging volume over value,” says Sarma. “We needed a payment model that allows physicians flexibility in how they treat patients while driving efficiency.”

Sarma says the Care1st program is flexible enough to allow providers to accommodate their patients’ needs and also helps drive results—the full bundled payment is dependent on a cure, defined by full virus eradication. This way, providers are directly responsible for managing medication adherence.

Sarma also stressed that the new program will help “empower healthcare practitioners to think outside of the box and innovate...”
care protocols to break down barriers that prevent hepatitis C patients from receiving and complying with the treatment they need to regain their health."

The yearlong initiative will involve a partnership with Maricopa Integrated Health System (MIHS) hepatologists at the Maricopa Medical Center. That partnership will involve 100 patients with hepatitis C, who will be given anti-viral medications. The medication will be taken daily for eight to 12 weeks.

After the medication is administered, follow ups will ensure medication adherence and successful treatments. The patients will then continue to be followed at Care1st’s Hepatitis C Center of Excellence (which treats the plan’s Medicaid population). Following results at the one-year mark, Care1st will then decide whether to continue and/or expand the program.

The biggest challenges
Like any value-based plan, there will be challenges in keeping patients engaged. Sarma says that because treatment for hepatitis C takes several months, compliance within the Medicaid population could be one of the biggest challenges.

To tackle this, Sarma says Care1st will provide integrated access to social supports. One of these is a WellCare program that connects members with case managers. There is also the Community Connections Help Line, which gives members access to local social support resources.

This way, Sarma says, "we can remove obstacles that may prevent full adherence to the program. ... Now, physicians will not only be able to achieve a cure for most patients who comply with their treatment protocol, but they’ll be able to address any social challenges that might be affecting a patient and their treatment, like transportation, housing, or food.”

The physician involvement question
Any successful value-based plan needs buy-in from providers, and Care1st’s is no exception.

Sarma says that from the start, Care1st actively involved physicians in discussions about the plan. "We wanted to leverage their clinical expertise and incorporate their input into the design of our model. We wanted to understand the scope of the clinical workflows as well as address any concerns that arose about a different payment model."

Care1st initially partnered with MIHS and the physicians at District Medical group. The leaders at these organizations, Sarma says, “were willing to think outside the box with us. As we talked through the process, these physicians engaged with us actively, and helped to drive the process forward with the able support of MIHS administration.”

Beyond those initial endeavors, Sarma says Care1st expects to have ongoing relationships with providers. Part of that will involve data sharing and case discussions and supporting them with care management and data analytics.

Upend the healthcare table
What can this program teach other healthcare leaders?

Sarma says that lessons learned from this program may be valuable not only to other hepatitis C programs, but also to healthcare more broadly.

“Healthcare is a fragmented industry,” says Sarma. “Innovations and new technology are slow to penetrate, and costs continue to rise, without corresponding improvement in patient or provider satisfaction.

"Current payment methodologies contribute to this reality. So, when you don’t like the way the table is set, one option is to turn over the table. We believe the outcomes-based bundled payment methodology, in conjunction with the holistic treatment model our providers are developing, is an opportunity to reset the table, so we can solve the problems we’ve recognized in our industry.”

Nicholas Hamm is an editor with Managed Healthcare Executive.

HCV Drug Adherence in Medication Populations

Source: Value in Health

MANAGED HEALTHCARE EXECUTIVE  | JULY 2019
ManagedHealthcareExecutive.com
As Medicare’s Bundled Payments for Care Improvement Advanced (BPCI-A) model continues to incentivize the transition towards value-based care, hospitals are innovating with new services and capabilities to meet its goals.

One of those hospitals, Los Angeles-based CHA Hollywood Presbyterian Medical Center (CHA-HPMC), a subsidiary of CHA Medical Group, was accepted to participate as part of the first cohort of hospitals to improve quality of care as part of Medicare’s BPCI-A initiative.

CHA-HPMC has designed and implemented a Continuing Care Program, a post-acute care program that continues high-quality care during a 90-day period after discharge for Medicare patients with certain diagnoses, such as sepsis. Patients who are 65 and older are especially susceptible to sepsis, the body’s extreme systemic response to an infection.

“The primary goal of the Continuing Care Program is to deliver higher quality patient care, from the perspective of improving patient satisfaction, reducing readmission rates, and getting more patients discharged to home. By effectively achieving these goals, we are also decreasing the cost of care to CMS,” says Jamie Chang, MD, MBA, FACEP, an emergency medicine physician who serves as chief of clinical operations at CHA HPMC and has overseen the design and implementation of the Continuing Care Program.

“We are operating during a period of transition from fee-for-service to value-based reimbursement, particularly for the Medicare population.”

“As more and more financial risk for the costs of care are shifted to hospital providers, there needs to be increasing attention toward the costs that are incurred not just during the acute hospital encounter, but also the costs of care after discharge,” Chang says. “This change to value-based reimbursement is inevitable for traditional Medicare—the only decision for hospitals is whether they will adapt to this change before it is mandated.”

Bundled payments represent one innovative payment model that is designed to move toward value-based care by incentivizing hospitals to enhance coordination and efficiency of care to achieve higher quality outcomes at lower cost, according to Chang.

In the BPCI-A program, CMS sets a “target price” for an episode of care, which includes both the acute inpatient hospitalization plus 90 days after discharge. Different diagnoses are attributed different target prices, and the hospital has the option to choose which diagnoses it wants to follow as part of the program.

“If the cost of care for CHA HPMC’s patients is below the target price for the episode, then CHA HPMC receives payment from CMS for the cost savings in the form of a ‘reconciliation payment,’” according to Chang. “However, if the cost of care for CHA HPMC’s patients is above the target price for the episode, then CHA HPMC must pay a penalty back to CMS.”

The Continuing Care Program includes a robust documentation and coding effort to identify patients as soon as possible after admission to the hospital. A team of patient navigators then meet with the patient at bedside during the acute hospitalization, and coordinate discharge plans with CHA HPMC’s case management team to ensure a successful transition out of the hospital.
“We also incorporate technology as part of our program, including patient tracking and notification software, and a comprehensive data and performance management platform that gives us intelligent insight into how our patients are doing in the program.”
— JAMIE CHANG, MD, MBA, FACEP, CHA HPMC

“Once the patient is discharged, we have an on-campus care transition clinic to ensure every patient has a PCP-level visit as soon as possible after discharge,” Chang says. “We also have a team of nurses who conduct a home-based evaluation and can support our patients at home 24/7 through the use of a triage phone line and collaborative work flows with the hospital’s outpatient pharmacy to deliver care to the patient at home.”

For patients who are discharged to a post-acute facility—such as a skilled nursing facility (SNF)—CHA HPMC also has a dedicated “SNFist” physician and nurse practitioners who provide an additional level of support for patients in these facilities. This team specializes in managing patient care in the SNF environment, reducing the risk of readmission and promoting a healthy recovery so the patient can return home.

“We also incorporate technology as part of our program, including patient tracking and notification software, and a comprehensive data and performance management platform that gives us intelligent insight into how our patients are doing in the program,” Chang says.

**Early results**

Early results indicate that CHA HPMC is successfully achieving its program objectives. The following compare our 2017 data with the fourth quarter of 2018:

- **90-day readmission rate.**
  Across all patients included in our seven selected bundles, CHA HPMC improved this metric from 40% to 31%.

- **Cost savings.** For patients admitted with a diagnosis of sepsis, CHA HPMC has achieved cost reductions that are 14% below the target price that CMS has set for CHA HPMC for this population of patients. “We project that we will receive a $3 million reconciliation payment annually for this bundle alone, helping fund program expenses and also generate incremental net revenue for the hospital,” Chang says.

- **Improvement in CMS quality Star Rating measures.**
  By participating in the program, CHA HPMC has been able to use the anticipated reconciliation payments to fund the services, technology, and capabilities to improve overall hospital quality. Specifically, the reduction in the 30-day readmission rate for congestive heart failure (40% to 11%), pneumonia (12% to 9%), and acute myocardial infarction (28% to 18%) directly improve CHA HPMC’s CMS Star Rating and its performance in the CMS Hospital Readmissions Reduction Program.

“We have demonstrated through our Continuing Care Program that we are able to deliver higher quality care to our patients, in terms of both patient satisfaction and improvements in outcome measures, including lower readmission rates and post-acute facility utilization,” Chang says. “And we are able to achieve this at a lower overall cost to Medicare, indicating that this would be a sustainable model of care for the future. Implementing a post-acute program to provide care for patients after discharge requires additional resources, technology and services that hospitals have not traditionally invested in. Innovative payment models, such as BPCI-Advanced, can help to finance the change that is required for us to deliver higher quality care.”

— Tracey Walker, content manager for Managed Healthcare Executive
As healthcare moves more fully toward value-based models, organizations around the country are learning from the successes and failures of other organizations. Managed Healthcare Executive (MHE) recently spoke with Doug Chaet, chief managed care officer at Cleveland Clinic, chairman of the American Association of Integrated Healthcare Delivery Systems, and a member of MHE’s editorial board, about some of the lessons he has learned about value-based care at Cleveland Clinic.

From the emergence of next-generation models to the importance of physician leadership, Chaet describes why he’s excited about the future of value-based care.

**Q:** MHE: Why are value-based programs so important?

**Chaet:** Patients are our customers, and whether you're a payer or provider, the collective focus is to provide the very best outcomes. Value-based programs, if structured correctly, can be an incredibly useful vehicle in aligning the interests of disparate, yet codependent stakeholders to achieve a common goal—improved quality and reduced cost. I'm convinced that payers (both traditional and non-traditional) and providers who can excel in this regard will have a tremendous edge in the healthcare marketplace in the years to come.

**Q:** MHE: What is needed for a successful value-based program (e.g., staff, technology, leadership, etc.)?

**Chaet:** If you are a payer and you're designing a program, it's important that you do so with progressive providers in mind. While it may be easier to develop and deploy a basic model for broad networks, the impact on historical performance will likely be limited. At the end of the day, the focus needs to be on results vs. optics. It's also critically important that the program be flexible enough to accommodate regional dynamics. What works in Dallas may not be a good fit for Cleveland.

If you're a provider organization, make sure you have internal alignment on your overall value-based objectives and then commit to the necessary resources. A value-based strategy should be treated as an investment, and like any investment, it's important that you do your homework in advance, invest appropriately and candidly re-examine your decisions periodically. It is also crucial that the provider organizations allow their physicians to lead such initiatives, as they are the "quarterbacks" of our healthcare system. While this has traditionally been a challenge for some hospital-centric health systems, it is fortunately not an issue for the Cleveland Clinic, a global leader in physician-led care delivery.

In short, value-based success is typically driven by three components—desire, know-how...
and a genuine commitment to transformation.

Q: MHE: What’s a good place to start and where do you see the future of value-based care?

Chaet: The initial focus has to be on quality and quality improvement. As I suggested previously, physician engagement is the key, and if the physicians are going to lead then the outcome needs to include a tangible benefit for the patients. You can then begin to introduce the cost aspect, coupled with an accelerated education program.

The reality is that every market is at a different stage of development. Ironically, I still get requests to share a capitation risk model that I developed in the late 90s. That alone leads me to believe that the concept of accountability is going to continue to pick up speed.

I’m also thankful that employers and other purchasers of healthcare are now investing substantial resources to determine which providers afford the greatest value. For years, most of the analytics focused solely on comparing insurer aggregate network discounts, which is clearly not an adequate measurement of value.

Q: MHE: What can other health executives learn from legacy value-based programs and how they’ve been implemented?

Chaet: Program incentives should include an appropriate balance of cost and quality. Also, as I mentioned previously, the financial value of the incentives needs to be meaningful to a provider. The reality is that a successful practitioner is not going to dramatically change the way they practice medicine in exchange for nominal bonus, which may or may not be directly linked to their individual performance.

Once you get beyond the design aspect, another big “lesson learned” is the behavioral component. It’s important that you invest significant time in face-to-face discussions with physicians and be specific when you communicate. For example—these are the things that will change, these are the things that will be different, and this is why it’s better for your patients.

Q: MHE: What are some resources for other health executives looking to improve value-based programs at their organizations?

Chaet: There are a number of excellent educational resources available online through a variety of professional associations, and of course national conferences which focus specifically on value-based care. My personal bias, however, is that it’s best to learn from peers who have already lived and experienced the value-based journey. Related, the Cleveland Clinic will be sponsoring its 2019 Value-Based Innovation Summit in Cleveland, October 22-23. What makes this event unique is that will feature “best practice” value-based case studies in from around the nation, which will be co-presented by senior payer executives and their provider partners. Anyone interested in receiving an invitation to this event is encouraged to send an email expressing their interest to Rachelle Brenner at the Cleveland Clinic brenner2@ccf.org.

“Patients are our customers, and whether you’re a payer or provider, the collective focus is to provide the very best outcomes.” —DOUG CHAET, CLEVELAND CLINIC

For more on how value-based care is impacting healthcare, see this month’s Opinion from Darnell Dent of Dent Advisory Services, LLC, “How Is the Push for Value-Based Care Impacting Executive Compensation?” on page 3
Driving Value-Based Care as a Health System

by CLAY HOLDERMAN

Government programs like Medicare, where reimbursements are historically below costs for most providers, are predicted to drive 65% of all insured patient growth in the next ten years. To succeed, health systems must capture and manage more of the total premium dollar. Medicare requires a system-wide movement away from fee-for-service toward full-risk or capitation. Health systems can succeed in a full-risk arrangement by segmenting and managing care with targeted interventions for specific patient-level cohorts and expanding their reach into the healthcare value chain to mitigate some of the greatest non-hospital cost drivers today.

Cohort development

There is tremendous value savings sitting in the data trove of EMRs. Determine how to slice the data to create patient-member cohorts with similar risk profiles, diagnoses, or utilization patterns and design care models accordingly.

At Presbyterian, we found that 5% of our Medicare Advantage population was driving 50% of care costs due to frequent ED visits and higher-acuity conditions. Through further analysis, we found that interventions at home were highly successful with this cohort. We created a program where a specialized care team provides intensive services for this population in the patient’s home. Many of these interventions would not be billable under fee-for-service Medicare, but through our capitated arrangements with our Medicare Advantage plan, we can pursue effective interventions funded out of the full premium pool. Through this program we have seen costs drop dramatically while also providing a better patient experience and avoiding frequent ED visits.

By viewing patients as a cohort with similar needs, we were able to develop a care model that drove up value and decreased costs.

Expand into the healthcare value chain

Facility and professional fees account for just about half of health claims nationally. This leaves nearly half of every premium dollar open to greater influence from the health system. Often systems ignore the potential value of pursuing opportunities to influence care outside of a hospital room—yet with more programs transitioning to a value-based model, they are going to be held accountable for that care and subsequent patient outcomes.

1/ Pharmacy: As pharmaceutical costs soar, the opportunities to capture and manage more of these costs also increase. Studies show that when health systems fully engage in specialty pharmacy, it can drive down costs as well as result in better clinical outcomes for patients. Presbyterian’s in-house specialty pharmacy has helped decrease drug spend and increase patients’ medication adherence while also generating additional revenue.

2/ Post-acute care: As reimbursement is increasingly tied to outcomes, managing post-acute care is a critical step to achieving clinical results that lead to higher incentive payments. But, managing post-acute care can be difficult for traditional hospital-based health systems. By partnering with community providers, as well as our own medical group, Presbyterian was able to perform in the top 4% for total reimbursement across all hospitals and 6% among hospitals that achieved an “excellent” rating for CMS’ Comprehensive Joint Replacement model. This required an intensified focus on care coordination and managing the highest-risk patients in post-acute settings where hospital systems have very limited experience or control.

Health systems should be the primary drivers of health care in a value-based system. Through initiatives centered on the development of new cohort models and finding new ways to influence costs downstream, health systems can start to experience greater clinical and financial outcomes.

Clay Holderman is executive vice president and chief operating officer at Presbyterian Healthcare Services.
Indication-based Formulary Design Chases Medicare Market

by MARI EDLIN

Medicare usually sets the pace in healthcare, but in the case of indication-based formularies, CMS introduced the new model as an option for 2020 while it’s already available in the commercial marketplace.

Indication-based formulary design is a tool that allows health plans to negotiate formulary coverage based on specific indications. Currently, CMS policy requires Part D plans to cover a drug for every one of its indications approved by the FDA—even if a plan would otherwise have covered a different drug for a particular indication.

Under the new guidelines, spurred by President Trump’s blueprint to lower drug prices, Part D plans have the flexibility to choose a different drug for an indication by using step therapy and prior authorization to promote the most cost-effective option. With the change, an indication might be excluded from a formulary, but plans must ensure that there is another therapeutically similar drug on formulary to replace the non-covered indication. CMS will require plans to explain what the change will mean to beneficiaries.

“It is confusing for patients to decipher formularies especially when they have low healthcare literacy,” says Wayne Miller, RPh, vice president, pharmacy solutions, Gorman Health Group in Orlando. The AMA echoes his sentiment, saying the new proposal will confuse beneficiaries with its complex regulations.

CMS says the new formulary model will provide access to more drugs at lower prices and provide additional negotiating leverage with manufacturers. Part D plans and manufacturers will begin negotiations on drugs this fall for 2020 formularies.

Miller believes that CMS introduced indication-based formularies to encourage value-based benefit design by looking at cost and effectiveness to ensure each drug is truly the most efficacious for each of its indications.

Under the new guidelines, spurred by President Trump’s blueprint to lower drug prices, Part D plans have the flexibility to choose a different drug for an indication by using step therapy and prior authorization to promote the most cost-effective option. With the change, an indication might be excluded from a formulary, but plans must ensure that there is another therapeutically similar drug on formulary to replace the non-covered indication. CMS will require plans to explain what the change will mean to beneficiaries.

Andrew Cournoyer, RPh, vice president, director, payer access solutions, Precision for Value, a consulting firm based in Gladstone, New Jersey, says indication-based formulary provides an opportunity to find the safest and most effective drug for each indication. He admits that the ability of indication-based formularies to improve outcomes has not yet been established.

He notes that the infrastructure—implementing claims, administration, prior authorization, and capturing utilization based on indications to help design contracts—is already in place due to experience in the commercial space.

AMA opposes indication-based formularies

The AMA provided its opinion on the new formulary in a July 2018 letter to HHS Secretary Alex Azar:

“Initiatives to determine value-based pricing for pharmaceuticals should aim to ensure patient access to necessary prescription drugs and allow for patient variation and physician discretion ... While we recognize that certain drugs generally are more effective in treating certain diagnoses over others, making definitive payment and coverage decisions based on such generalities can have unintended consequences on patients being able to access and afford the prescription drugs they need.

“Determining payments for and coverage of drugs based on indication has the ability to undermine personalized medi-
cine and the ability for patients to receive treatments appropriate to their unique health characteristics, as well as the ability of physicians to prescribe the most effective course of pharmaceutical treatment for their patients. A blunt indications-based pricing model that assumes an identical clinical response to a particular drug for all patients across age groups, gender, racial/ethnic characteristics, genotypes, etc., could lead to certain subgroups of patients not having access to a medication, even though it may be fully effective in their particular subpopulation. It also needs to be assessed how indication-based pricing would impact the ability of physicians to prescribe drugs for their patients for conditions other than which they have been officially approved.

“In short, the CMS proposal to allow indication-based formulary design does not comply with AMA policy on incorporating value into pharmaceutical pricing.”

Miller says that the AMA is opposed to the new model because physicians don’t want plans handing down requirements and restricting access. In addition, he notes that physicians do not have sufficient information about which drugs are covered on various formularies and often must play a guessing game. “There is a lack of interoperability between plan, a doctor’s EMR, and a PBM,” he says.

On the other hand, the Pharmaceutical Research and Manufacturers of America (PhRMA) believes that approaches to indication-based coverage must continue to support patient access to the medicines that best meet their needs, as well as support innovation. “It is also important to consider how any policy on indication-based coverage interacts with existing beneficiary protections and other structural aspects of the Part D program,” says Tom Wilbur, spokesperson for the trade organization that represents drug manufacturers.

Advantages of indication-based formulary
Miller says an indication–based formulary would provide a mechanism to put a drug with multiple indications on a formulary for a specific indication instead of excluding it altogether. To avoid covering a drug, plans could choose to give a drug non-formulary status, thus adding an additional barrier to access.

For example, a drug approved for three different cancers—renal, lung, and breast—might be the best choice for renal cancer but not for the other two indications.

“Therefore, by allowing the drug to be on a formulary for renal cancer only opens it up to additional formulary access where the drug would otherwise be completely excluded to prevent it from being used for breast cancer or small cell lung cancer,” Miller says.

“This could make life easier for specialists,” he says. “Access to drugs for one particular indication makes a non-formulary drug available when it might otherwise not be.”

Harold Carter, senior director, clinical solutions, Express Scripts, a PBM headquartered in St. Louis, says that oncology and inflammatory diseases present conditions that would most likely be affected by indication-based formulary design—given that both have many indications and drugs to treat them.

“It is important to have clinical data to determine which drugs to promote based on effectiveness and to see how patients respond—not just which drugs will save an insurer money,” he says.

Express Scripts has deployed an indication-based formulary for inflammatory and oncology conditions since 2017. During the first year using the model, 25% of clients enrolled in the PBM’s Inflammatory Conditions and Oncology Care Value programs experienced negative cost trend for those therapy classes. As many as 35 million lives are enrolled in Express Scripts’ two care value programs.

“Historically, we have observed a higher rate of discontinuation...”
"It is important to have clinical data to determine which drugs to promote based on effectiveness and to see how patients respond—not just which drugs will save an insurer money." — HAROLD CARTER, EXPRESS SCRIPTS

and switching in the inflammatory conditions class when patients first start on therapy if a therapy isn’t working as needed or side-effects are not manageable," Carter says. "In 2016, we observed that up to one-third of patients with a new prescription for an inflammatory drug discontinued therapy in the first 90 days to switch to a different medication. Part of the cause of this trend was that despite there being more than 15 available inflammatory therapies on the market, only two were widely prescribed. Early discontinuation and switching are not beneficial for the patient, and also generate a lot of waste and unnecessary cost.

He says that the PBM observed an early discontinuation drop of 30% through its Inflammatory Conditions Care Value program in 2018, partly because indication-based reimbursement provides patients with access to a greater number of preferred therapies, which allows them to start on a medication specifically indicated for their condition.

"Plans must ensure they understand clinical data (in the real world) first and then bring cost effectiveness into the equation," Carter says. He also notes that it is important to learn how to execute indication-based formularies on the physician level through education; implementing an electronic prior authorization process; and realizing how these formularies relate to value-based arrangements—how well patients are performing on them, cost savings, and outcomes.

Both Cournoyer and Miller concur that plan sponsors would accrue more discounts by negotiating different rates per indication rather than aggregating costs. For example, a drug approved for five indications might generate a flat rate of 40%, while discounts on individual indications could be higher.

"It’s important to determine an appropriate drug mix yielding the highest discounts. However, that will only happen if rebates still exist." — ANDREW COURNOYER, RPH, PRECISION FOR VALUE

What will 2020 bring?
Miller says it will be interesting to see how the new formulary ruling will play out. "Plans might opt out of the new model because they don’t want to violate protected classes and stay with prior authorization," he says.

Cournoyer agrees that the impact of the new model will probably be small because only 15% of the population is covered under Medicare and only 5% of drugs are considered specialty.

Carter says that indication-based formulary design is growing in the commercial space, but that plans are not yet taking full advantage of it. "If private plans have not already used the model, they will need guidance," he says.

Mari Edlin, a frequent contributor to Managed Healthcare Executive, is based in Sonoma, California.
Peptic Ulcer Disease

Symptom identification key to warding off hospitals, surgical interventions

by ERIN JOHANEK, PHARMD, RPH

According to the American Academy of Family Physicians (AAFP), peptic ulcer disease (PUD) is a problem of the gastrointestinal tract characterized by mucosal damage secondary to pepsin and gastric acid secretion. The two most common types of peptic ulcers are gastric ulcers, located in the stomach, and duodenal ulcers, found in the proximal duodenum. Epigastric pain is the most common symptom of PUD, but other possible manifestations include dyspepsia, heartburn, and chest discomfort. Examples of symptoms that warrant prompt referral to a gastroenterologist include bleeding, anemia, unexplained weight loss, and recurrent vomiting.

According to AAFP, the annual direct and indirect healthcare costs of peptic ulcer disease are estimated at about $10 billion. “The current treatment regimen of antibiotics and stomach acid reducers, like PPIs [proton-pump inhibitors] are fairly inexpensive and covered by most insurance plans. The prices vary but overall are very affordable,” says Megan Harrington, PharmD, clinical staff pharmacist at CompleteRx. “The higher costs stem from unrecognized symptoms that progress to hospitalizations or surgical intervention.”

The most common causes of PUD in the U.S. are infection with Helicobacter pylori (H. pylori) and the use of nonsteroidal anti-inflammatory drugs (NSAIDs). According to AAFP, H. pylori bacteria adhere to the gastric mucosa and result in increased gastrin levels, mucus production, and mucosal bicarbonate secretion, all of which favor ulcer formation. NSAIDs cause submucosal erosions and inhibit the formation of protective prostaglandins.

The global peptic ulcer drugs market will expand at CAGR of 2.8% during the forecast period 2016-2022, according to “Global Market Study on Peptic Ulcer Drugs: North America to Lead in Global Market During Forecast Period 2016 – 2022, Driven by Increasing NSAID Consumption,” published by Persistence Market Research. Surge in consumption of NSAIDs due to growing prevalence of inflammatory diseases is the major factor driving growth of the global peptic ulcer drugs market. Other trends driving growth include:

- increasing adoption of peptic ulcer drugs over surgery
- changes in disease management
- prevalence of stress ulcers due to higher smoking rates
- availability of affordable therapy due to improvement in service sector

Chronic side effects associated with long-term use of peptic ulcer drugs is the major factor hampering the growth of global peptic ulcer drugs market.

Current treatments

According to the Mayo Clinic, PPIs and histamine receptor blockers (H2 antagonists) are two treatments commonly used for PUD. The PPIs, like Protonix (pantoprazole), Nexium (esomeprazole), and Prevacid (lansoprazole) and the H2 antagonists, such as Zantac (ranitidine) and Pepcid (famotidine), all work by reducing stomach acid production. Additionally, cytoprotective agents, like...
Carafate (sucralfate) and Cytotec (misoprostol), are used to protect the lining of the stomach and small intestine from acid to decrease the formation of ulcers.

“The current standard of care for patients at risk of PUD due to H. pylori or chronic pain management through NSAIDs is to co-prescribe PPIs,” says Shital Mars, CEO of Progressive Care Inc., a personalized healthcare services and technology company based in South Florida. “PPIs like Prilosec (omeprazole) should be taken 30 minutes prior to taking an NSAID to mitigate the risk of PUD in these patients. Physicians should also consider the patient’s gastrointestinal risk and long-term side effects prior to recommending any particular NSAID treatment.”

Eradication of H. pylori greatly reduces the recurrence of peptic ulcers. According to the American Journal of Gastroenterology, H. pylori is typically treated with combinations of two or three antibiotics along with a PPI, taken concomitantly or sequentially, for periods ranging from three to 14 days. Bismuth subsalicylate may also be used in conjunction with these medications. For PUD secondary to NSAID use, the prompt discontinuation of NSAIDs is advised along with avoidance of smoking and alcohol and drug abuse.

“With the addition of treatments for reducing stomach acid and recognition of the microbiology behind peptic ulcer disease, we have seen a declining trend in patient suffering from serious illness related to peptic ulcer disease,” Harrington says.

**Pipeline treatments**

Currently, according to Harrington, the most promising pipeline candidates for treating acid-related conditions are in phase 3 trials in Japan and Korea. Those drugs, according to clinicaltrials.org are:

- Vonoprazan fumarate (TAK-438, Takeda)
- Tegoprazan (CJ-12420, CJ Healthcare)

If those trials in Japan and Korea are successful, the companies will submit their results to the FDA for review. The drugs could then be approved for phase 4 research and monitoring.

Vonoprazan and tegoprazan belong to a new class of acid secretion inhibitors known as potassium-competitive acid blockers (P-CABs).

According to the manufacturer, vonoprazan inhibits proton pumps without the need for activation by acid and unlike PPIs, vonoprazan is not primarily metabolized by CYP2C19, which has gene polymorphisms that may affect efficacy. The drug is a once-daily immediate-release formulation and because it does not require an optimized formulation design, like enteric coating, the onset of action does not significantly differ among patients. Vonoprazan is already approved in Japan under the brand name Takecab and is available in 10-mg and 20-mg tablets.

Tegoprazan is also a P-CAB developed for the treatment of acid-related gastrointestinal diseases such as gastroesophageal reflux disease (GERD) and peptic ulcers. Tegoprazan is already approved in Korea under the brand name K-Cab Tab. According to Korea Biomedical Review, while PPIs need three to five days to become effective, P-CAB drugs suppress gastric acid secretion within one hour of being administered.

According to a study published in the Journal of Clinical and Translational Gastroenterology, P-CABs result in very fast, competitive and reversible inhibition of proton pumps and they offer a more rapid elevation of intragastric pH than PPIs while maintaining the same degree of antisecretory effect.

Erin Johanek, PharmD, RPh, is a staff pharmacist at Southwest General Health Center, Middleburg Heights, Ohio.
Leadership Skills
HELP YOUR ORGANIZATION SUCCEED

Four Essential Skills of a Change Leader
How to refine skills to lead through value-based evolutions
by JULIE MILLER

Today’s healthcare landscape presents challenges for the C-suite almost daily. Experts say executives must refine their skills to lead organizations through value-based evolutions, technology snags, and the grueling pace of change.

“You have to understand the ecology of the healthcare environment,” says Don Hall, MPH, a Managed Healthcare Executive editorial advisor and principal of Delta Sigma, a consulting firm in Littleton, Colorado. “Organizations always worked from a small piece of healthcare, but now it’s much broader. And that broader perspective is going to be key for executives.”

Expert recommendations on new leadership skills speak to both external market forces as well as internal fundamentals.

1. Address social determinants of health
Hall says executives now need to develop competencies to address social determinants of health (SDOH)—the societal factors that influence wellness, such as food insecurity, poverty, or unemployment. In the value-based era, organizations are expected to deliver results with programs that solve such non-healthcare issues.

“Previously, health plans were dealing with the health of members directly,” Hall says. “But now they’re finding many variables that affect health are much cheaper to resolve by means other than the healthcare visit.”

He says it makes sense financially to add on services related to SDOH. If a member is treated in the emergency room but can’t be safely discharged because he’s homeless, for example, the result is a longer, more costly hospital stay. Particularly in risk-based contracts, payers, and providers are better off solving the housing issue instead.

There are pockets of innovation for SDOH within the new healthcare ecology. Many not-for-profit Medicaid plans are using 1115 waivers and grant programs to identify vulnerable patients and connect them with housing selection, rent subsidies, and utility set-up, for example. Programs are often coupled with other services, such as job coaching or maternity care.

For the most part, SDOH are surfacing in the context of Medicaid populations, Hall says, which have grown through expansion under the ACA. However, senior populations are also using an increasing amount of non-medical services today.

2. Translate data into intelligence
The healthcare system is full of data, but lacks actionable information, Hall says. Only by parsing out data points can organizations identify opportunities for outcomes improvement and cost savings.

Therefore, executives must be attentive to IT advances or risk losing out to a host of innovators newly entering the healthcare space, experts say.

“Companies like Amazon could really be disruptive in healthcare because they already have their

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— DON HALL, MPH, DELTA SIGMA
fingers in so many different things,” Hall says.

He notes that the disruptors are becoming increasingly attracted to data-enabled solutions to improve SDOH. Likewise, in March, former Aetna CEO Mark Bertolini echoed the suggestion in Yahoo Finance, saying Amazon is one to watch when it comes to providing less-costly home-based supports, such as nutrition or transportation, as proactive health interventions.

3 Align your internal strategy with the external market environment

Today’s executives are so busy predicting—or reacting to—trends that they fail to see their deficiencies in the fundamentals of leadership, says Clinton Longenecker, researcher, professor and director of the Center for Leadership and Organizational Excellence at the University of Toledo in Ohio.

“The catch is if you’re not practicing the fundamentals, the new and hot things don’t matter,” says Longenecker.

He often directs executives back to the core mission, reminding them that every effort must be oriented around that expectation. For example, if case managers are empowered to use technology, the task shouldn’t be busywork. Rather, it should inform better decisions that drive the mission.

Longenecker also notes that market changes never negate the need for leadership to reinforce expectations and accountability throughout the organization. Too often, managers don’t provide constructive feedback to their teams, and new opportunities fail to produce results.

“A lot of healthcare organizations come up with highfalutin strategies based on the changing environment, but when it’s time to implement, if they don’t properly align their structure to support it, they’re coming up short,” he says.

Additionally, Hall says everyone from the C-suite to the call center needs to be sensitive to today’s external communication channels—from gotcha videos on YouTube to customer rants on Twitter.

“For good or bad, the face of the company is no longer the executive,” Hall says. “It is every single person who has a badge for that company.”

4 Learn to stop and think

Longenecker is an advocate of what he calls the power of slowing down. In teaching, he uses an acronym to describe the concept:

S—Sit still often, dedicating time to consider what needs to be accomplished.
T—Think clearly about answers to strategic questions.
O—Optimize resources, whether they’re people, budgets, or hours in a day.
P—Perform, based on the above.

Similar unplugging techniques have become a nationwide business trend, with executives of all types squirreling away on sabbaticals while their digital devices remain back at the office. But the STOP tactic doesn’t have to amount to days or weeks of meditation. It can be as simple as a few minutes of thinking, two or three times a day, Longenecker says.

The point is that leaders should operate with intentionality. Operating out of habit will inevitably lead to wasted resources or even obsolescence in today’s increasingly competitive healthcare system, he says.

As a caution, he also warns that failure to stop and think leads an executive to become too “crazy busy” to communicate effectively. The lack of communication can manifest itself in poor execution. He believes busyness is the enemy of effectiveness, and thinking is a leader’s best weapon.

“You can make a list of the bad things that come with being too busy,” Longenecker says. “It’s a pathological lineup of horrible leadership skills that takes things in the opposite direction.”

Julie Miller is a freelance writer based in Cleveland.
Who is Your Healthcare “Hero”? 

Managed Healthcare Executive asked 17 key opinion leaders, “Who is Your Healthcare ‘Hero’ and why? Here’s what they said

by Tracey Walker

Lawrence Weed, MD, a physician, researcher, educator, entrepreneur, and author, best known for creating the problem-oriented medical record, as well as one of the first electronic health records

“Dr. Weed was my mentor, and would qualify as my healthcare hero. Many senior physicians in healthcare are familiar with his name and leadership in driving forward the problem-oriented medical record and the pioneering SOAP note format, but today, few young physicians even know his name. As early as 50 years ago, he was predicting the use of clinical decision support and the need to have cognitive tools in the exam room. Having him as a mentor shaped my career, and continues to enhance our innovation to this day. I was lucky to have met Larry Weed, and to have the gift of his mentorship and friendship.”

—Art Papier, MD, CEO of VisualDx, a healthcare informatics company dedicated to improving healthcare, based in Rochester, New York

Jack Duffy, DDS, co-founder of Sonoma County Dental Well-Being Collaborative

“Dr. Duffy is a healthcare hero as his entire life and career as a periodontist have been guided by the principle that you must give people simple, realistic tools to prevent disease and that you must advocate for those who have no voice. He believes that by helping underserved populations live free of dental disease, it eliminates one more burden from their lives and helps to lift them out of poverty and suffering. He has an unrelenting passion for social justice. He is a life enricher. He is also my father.”

—M. Bridget Duffy, MD, chief medical officer of Vocera, a leader in clinical communications and work flow solutions

My Grandfather

“My heroes have primarily been the key male family figures who helped to shape me as an individual growing up. Career-wise, I followed in the footsteps of my grandfather, who ran an independent pharmacy in our Connecticut hometown. At an
The List

early age, I was inspired by his integrity, compassion, dedication to the profession, and how well-respected and valued he was among those he served within our community. Further, my hero has also been my dad, now 86 years young. A veteran of the Korean War and without the means to pursue a college career, he built his own successful business (an automobile service station) and instilled in my brother and I the critical importance of honest, hard work; accountability; commitment to quality in everything we do; and never losing site of the importance of balancing work life with family. I consider myself quite fortunate to have had such wonderful role models in my life, and in their honor have attempted to emulate these vital traits in all that I have done throughout my career.”

—David Calabrese, RPh, MPH, senior vice president and chief pharmacy officer, OptumRx, a pharmacy benefits firm that provides pharmacy care services for over 65 million lives nationally

John Henderson, CEO and president of the Texas Organization of Rural & Community Hospitals (TORCH)

“I first met John several years ago when I was president and CEO of FirstCare Health Plans during a visit to Childress, Texas, where he spent 16 years as CEO of Childress Regional Medical Center, a rural hospital in the Texas Panhandle. John grew up in Childress—which is located about halfway between Amarillo and Wichita Falls. I also met his father who has practiced medicine there since the 1970s. I was impressed by John’s passion for the plight of rural and community hospitals in Texas where the rural hospital closure rate had reached crisis stage. He cited increasing regulations, substantial Medicare/Medicaid payment cuts, growing unfunded mandates, and increasing uninsured population as major contributors to this closure crisis. John is my healthcare ‘hero’ for leading this charge.”

—Darnell Dent, principal, Dent Advisory Services, LLC, a management consulting and governance services company, based in Austin, Texas

Gail Boudreaux, CEO of Anthem

“I have known Gail for over 25 years from the early days in her career at Aetna. We were co-workers. She has had a very successful career in healthcare and has always treated people with respect and been humble. She is a role model for any person on how to balance life, family and work. I truly admire her.”

—Perry Cohen, CEO, The Pharmacy Group, Glastonbury, Connecticut

Stan Nelson, founder of the Scottsdale Institute and CEO of the Henry Ford Health System

“Stan founded the Scottsdale Institute, a not-for-profit membership organization of prominent healthcare systems whose goal is to support members as they move forward to achieve clinical integration and transformation through information technology. He was one of the kindest, highest character leaders I have met. He had a passion to change and improve healthcare and pioneered many of the organizational strategies that have become accepted practice for today’s health systems. Stan inspired me to be a better leader.”

—Angie Franks, CEO of Central Logic, an innovator in transfer center software solutions

Daniel J. Hilferty, CEO of Independence Blue Cross

“Dan is an inspiring leader, one who is truly passionate about improving the health and well-being of his community. Under his leadership, Independence Blue Cross is highly focused on improving access to care, health outcomes, and affordability. Dan excels at building unique partnerships, especially ones that create innovative ways to transform healthcare. In light of the opioid epidemic, he has led the company in numerous efforts to address this tragic problem, including a multimedia public awareness campaign through the Independence Blue Cross Foundation about the stigma of addiction. Dan is also an avid supporter of diversity and inclusion, employee growth and development, and has created a corporate culture centered on respect, openness, and work-life balance.”

—Ginny Calega, MD, vice president, medical affairs, Facilitated Health Networks Independence Blue Cross
Nurses
“At the heart of our healthcare system, nurses are often the conduit between many factors affecting overall care. The breadth of care provided by nurses extends beyond physical care to social and emotional support—informal care, which is impossible to measure but is obvious when absent. As the industry continues shifting to value-based care, nurses’ practical knowledge and capabilities are increasingly crucial to drive quality and efficiency in every setting along the care continuum. Nurses are the everyday heroes in the industry.”
— Nathan Ray, a senior principal in West Monroe Partners’ healthcare practice, a multinational management and technology consulting firm headquartered in Chicago

Molly Coye, executive in residence at AVIA, a network for health systems seeking to advance care delivery transformation through the deployment of digital solutions; and elected member of the National Academy of Medicine
“Molly Coye is someone I admire because she has always focused on trying to help hospitals and health systems to see what’s coming down the pike—procedures and methodologies that are moving closer and closer to everyday commercial use. She is always asking, ‘What’s next?’ Molly is adept at identifying technologies or best practices that are being used in a small way in healthcare or in a non-healthcare way that are going to be coming to healthcare really fast. She’s always looking just over the hill and sees connections other people haven’t seen yet. As a health IT entrepreneur myself, Molly has inspired me to think in a different way with her futuristic approach.”
—Harry Soza, CEO of CAREMINDr, a mobile-enabled remote patient monitoring company that partners with health plans and providers

Dr. Edward Jenner, the British physician who developed the very first vaccine against smallpox in the 1790s
“In England, British physician Dr. Edward Jenner took notice of what was referred to as ‘an old wives’ tale’: Milkmaids who purposely scratched their arms with cowpox pustules seemed inoculated against a much worse disease—smallpox. Dr. Jenner experimented with his theory and proved that an awful infectious disease could be prevented. Fast forward to 2019, and we now have at least 28 effective vaccines, and smallpox has been eradicated. Taking that a step further, given the access we now have to high-quality aggregated data, we are able to easily identify gaps in care—specifically children, teenagers, and adults—who are missing vaccines and can use automated outreach to close those gaps. Dr. Jenner would be amazed at how far we have come.”
—Rich Parker, MD, CMO of Arcadia.io, a population health management company

Peter Goltra, an electrical engineer with a passion for improving healthcare delivery
“I met Peter 20 years ago and for the first time, was inspired by his vision in the field of medical informatics. For over 30 years, he has had a driving force in the convergence of medicine and technology. His vision has always been to improve medical care by giving doctors a comprehensive system that enables them to electronically review and update medical records without compromising time with patients. He has long been an industry thought leader whose vision has shaped EMR development across the industry.”
—Jay Anders, MD, chief medical officer of Medcomp Systems, a physician-driven provider of clinically contextual patient data solutions

Eric Weidmann, MD, practicing family physician and chief medical officer
“As a physician, educator, and ‘practical-ist,’ Dr. Weidmann represents my ideal of a modern doctor. He puts his patients and their care above everything. The much-talked-about move from volume to value is a non-issue with him; he has always been focused on quality. In addition, as a leader and administrator of a medical practice and the CMO of a technology company, he is also a person who knows you cannot practice in the past. Instead of resisting technology, Dr. Weidmann has taken an active role in careful education and practical approaches. He has shown that when technology is embraced and used in a considered and careful way, it can be leveraged to improve care and the operations of medicine and actually helps reduce physician burnout.”
—Derek Pickell, CEO, eMDs, a provider of electronic health records, practice management systems and revenue cycle management services

Ignaz Philipp Semmelweis, Hungarian physician known for championing hand-washing standards in obstetrical clinics
“Dr. Semmelweis was known as the ‘savior of mothers’ for championing hand-washing standards in obstetrical clinics. In his day, he was severely reprimanded by peers because his views contradicted established norms. The Semmelweis reflex or ‘Semmelweis effect,’ has become a metaphor for the reflex-like tendency to reject new evidence or new knowledge that contradicts established norms, beliefs or paradigms. Today in the age of digitalized healthcare, new evidence is often discovered from combining structured and unstructured data. When that new evidence rejects our current standards, we must be mindful of our reflex to dismiss contradictory findings and be open to new knowledge.”

—Elizabeth Marshall, MD, MBA, director of clinical analytics at Linguamatics, an IQVIA company and a provider of natural language processing (NLP) text analytics

Chester “Trip” Buckenmaier, III, MD, Colonel, U.S. Army (Retired), and associate professor & director, Defense & Veterans Center for Integrative Pain Management

“Dr. Buckenmaier performed the first successful continuous peripheral nerve block for pain management in a combat support hospital. In 2009, while deployed in Afghanistan, he organized the first acute pain service in a theatre of war. ‘Trip’ has created opportunities for collaborative discussions on non-pharmacological approaches to pain to ensure the best interest of our Veterans and active military. He is a steadfast leader promoting the least invasive pain management options to avoid addiction and adverse side effects.

He is author of the Acute and Perioperative Pain section in Pain Medicine and also serves as the editor-in-chief of US Medicine.

—Sherry McAllister, DC, executive vice president of the Foundation for Chiropractic Progress, the national not-for-profit organization educating the public about the benefits of chiropractic care

Loran Hauck, MD, physician, researcher, author, executive, leader, retired chief clinical officer of Adventist Health System

“Dr. Hauck is a healthcare hero to me and many others. He was a leader in the charge to systematically applying evidence-based medicine though standard protocols on paper and in CPOE. The most impressive is his mission and principle-driven approach to decisions and direction. When he said, ‘We are going to do the right thing for patients regardless of challenge or financial impact,’ he meant it—and people believed it. He also was fearless in reporting the results in a transparent manner that revealed what worked and didn’t. His principles, transparency, and results make him a hero for many to follow.”

—Will Shevlin, vice president, Zynx Health, a provider of evidence-based information and technology to support clinical decisions

Joseph Hahn, MD

He was formerly the Chief of Staff at the Cleveland Clinic and I had the gift of working with him for many years. There are a lot of things you need to know to be a good healthcare leader, but what he taught me wasn’t about that. It was about the importance of treating every single employee like they are a member of your family. From the person cleaning the patient’s rooms, to the security officers and food service workers, they all play a big part in making our patients feel taken care of. So they deserve to be taken care of too.”

—Cynthia Hundorfean, a Managed Healthcare Executive editorial advisor, president and CEO, Allegheny Health Network (AHN), an integrated healthcare delivery system that serves Western Pennsylvania. AHN is part of the Highmark Health family of companies.

Brian Lobley and Michelle Obama

Brian Lobley is our executive vice president of health markets. He’s mentored me and I’ve looked up to him for years because he’s incredibly smart when it comes to the business but he also has this superpower of making everyone around him feel confident, capable, and amazing. You never leave a meeting with Brian feeling bad, and I think that makes people work harder and smarter for him. The other one that’s a bit more cliché but so true is Michelle Obama. She is the coolest, strongest women of my time—smart, graceful, stylish, and a little bit of edge. If I could be someone when I grow up, it would be Michelle Obama! She’s taken an active role on education of girls across the globe and also stands for health and wellness with her get fit initiatives. Simply put, she’s incredible.

—Michelle Histand, director of innovation at Independence Blue Cross
“The reason I believe effective executive compensation plans are the best levers in driving value-based care and reimbursement models because the continuing escalation of healthcare costs, the pursuit of higher healthcare quality, and the demonstration of better outcomes demand that we make these our top priorities.”

—Darnell Dent, read more on page 3
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