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Cover Story

ESSENTIALS
4 New Healthcare Executive Roles
6 Top Payer Growth Strategies
8 Leadership in a Changing Healthcare Landscape
9 Uniting Determinants and Data for Population Health
11 Drug Price Reform Takes Off in 2019
14 15 Ways Insurers Can Improve Patient Experiences
18 The Future of Healthcare Wearables
21 Telemedicine and E-Visits: An Update

24 Mentors Inspire Today’s Leadership
27 MS Drugs in the Pipeline
28 Top 3 Issues Concerning Hospital Executives
29 Top 7 Qualities of the Ideal Executive Assistant
31 Tackling Opioid Abuse in the Workplace

COMMENTARY
3 Simple and Affordable Healthcare from Kevin Ronneberg

DEPARTMENTS
2 Editorial Advisors
33 The bottom line
Managed Healthcare Executive

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

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Simple and Affordable Healthcare

Think of a recent consumer experience that you’ve had. Odds are it is not related to your use of the healthcare system or to your health insurance. More often than not, we cite examples from the retail, banking, hospitality or travel industry where elements of transparency, convenience, and reliability combine to generate a memorable and lovable experience. Surrounded by these examples every day, consumers have come to expect the same level of experience in all aspects of their life—including healthcare.

Our members also tell us this. Ultimately, they are seeking our help in making their experience simple and affordable. This is no small task. However, we have taken it on with a focus to develop trust, engagement, and activation with those who use our health plan.

An easy-to-navigate website and mobile experience that provides personalized information (easy access to information about current spend against deductible and out-of-pocket (OOP) limits, finding a high-quality, in-network provider, and access to EOBs) is table stakes these days. Creating relatable, relevant, and timely communication and tools that demonstrate the value of a health plan to the consumer is where the opportunity lies.

An easy-to-navigate website and mobile experience that provides personalized information (easy access to information about current spend against deductible and out-of-pocket (OOP) limits, finding a high-quality, in-network provider, and access to EOBs) is table stakes these days. Creating relatable, relevant, and timely communication and tools that demonstrate the value of a health plan to the consumer is where the opportunity lies.

Two key ways to enhance experience are making cost and quality information easily accessible and supporting coordination and navigation of care through consumer personalization and empowerment.

**PERSONALIZING THE EXPERIENCE**

Who enjoys getting a colonoscopy? The idea of prepping for and having the test is a barrier to even going to have a physical at a certain age. In an effort to enhance colorectal cancer screening (CRC) rates, we identified individuals not up to date with screening recommendations who also had no primary care visits in the prior year where a recommendation for screening might occur.

“Ultimately, [consumers] are seeking our help in making their experience simple and affordable.”

Understanding these individuals were not engaging with the care system and knowing a big barrier to CRC screening is fear of colonoscopy, we mailed FIT kits—a home-based screening test for CRC—to over 30,000 members, along with information on CRC screening and the value of establishing a primary care relationship. The communication was timely and relevant to the audience as just over 24% completed the test and returned the kits. Those with positive findings were all referred for further assessment and screening leading, in some cases, to early cancer diagnoses or identification of polyps requiring more frequent monitoring.

**EMPOWERING CONSUMERS**

Healthcare can be complicated, right? Shopping for prescriptions shouldn’t be. Recently, we launched a pharmacy price transparency tool in our web and mobile experience that provides pricing at any pharmacy. Through a real-time benefit check, a consumer can see their OOP cost and plan liability for individual drugs or total cost for all of their prescriptions at a given pharmacy. If a lower cost pharmacy is nearby, they can initiate a transfer of prescriptions with the push of one button.

This has helped save countless dollars for consumers and plan sponsors. This same capability is being piloted in our provider offices to allow the prescriber to see and share with their patient what the real drug costs are based on network pharmacy price and current benefit status.

Communications and plan tools must feel relevant and demonstrate value to the consumer if we wish to gain trust and deliver on our members’ expectations of a simple and affordable experience.

Kevin Ronneberg, MD, is vice president and associate medical director for health initiatives at HealthPartners, an integrated, nonprofit provider and health insurance company located in Bloomington, Minnesota, and serves as an editorial advisor for Managed Healthcare Executive.
As healthcare moves toward an increasingly consumer-focused, value-driven future, many healthcare organizations are struggling to keep up with the latest models and trends.

To help combat this, organizations across the country are expanding their leadership roles with new positions designed to drive the much-needed innovation in an industry that famously struggles with it.

Leaders in those roles say they are providing a way forward for the industry, but some wonder if those roles shouldn’t be left in more traditional C-suite positions.

Innovation officer
Michelle Histand is director of innovation at Independence Blue Cross in Philadelphia. There, she says that she and her team are tasked with coming up with new ideas and solutions to problems facing their business areas.

“I oversee a group of people who use design thinking and other creative-problem-solving methodologies to help our business areas and our customers do just that—creatively problem solve!” Histand says. “We are essentially a team of creative consultants. We work with groups to understand their opportunities and what success would look like and develop interventions to help get them there using our tools.”

She says that her role is mainly about getting people out of their comfort zones and familiar routines. Innovation, she stresses, requires taking a fresh look at how things have always been done.

In practice, Histand says, it involves “a ton of critical thinking—I say we are able to take a mess and make sense of it. We also do a lot of relationship building—we have to make people feel comfortable doing things that are uncomfortable—because innovation can feel strange!”

For organizations interested in adding this type of position, Histand stresses that it’s important to hire someone who is action-oriented and is able to thrive in new situations.

“This type of position or team is expected to do things differently,” Histand says. “I follow the mantra of ask for forgiveness, not permission. It’s important that this position be situated accordingly in the org. I’m under a leader who appreciates what we need to do and gives me all the backing I need to get it done.”

However, Stewart Schaffer, co-Founder and managing partner at CSuite Solutions, a national healthcare advisory firm says the innovation officer role should be something that every executive should be a part of.

“The CEO of a health system should require that every single department head be responsible for innovation within his/her function,” Schaffer says. “It should be part of the cultural DNA of every enterprise and curated/managed as part of each department’s innovation plan referred to as a strategic plan by most large industries.”

He adds that the chief strategy officer should then be the one to help organize and integrate individual department plans.

“Once you go the innovation officer route (who will no doubt have a department of people under him or her adding more layers of overhead),” he says, “you disenfranchise or relieve the operating units..."
of what should be one of their key responsibility to the organization which is to continually improve through innovation.”

As for Histand, she says that her position adds value because it encourages outside thinking to permeate every team and associate in an organization. “We have become the go-to team when something needs fixing or needs to be injected with new thinking—and that’s critical for every kind of organization,” she says. “We all fall into habits in our lives, and that includes our working lives—having an ‘outsider’ be able to see something from a new perspective and pushing your teams to see it from a new perspective, is very valuable.”

**Population health officer**

As healthcare becomes more consumer focused—and as it becomes increasingly complex—population health executives offer organizations a chance to coordinate the complexity of care more personally for every patient.

Adam Myers, MD, is chief of population health and director of the Cleveland Clinic Community Care at the Cleveland Clinic. He says that his position was created to provide excellent care for all patients.

“Several years ago, clinic leadership wisely decided to promote the same excellence for the care that most patients need,” Myers says. “Primary care at all points across the continuum.”

The Cleveland Clinic Community Care combines multiple units from across Cleveland Clinic into one unit and includes everything from general internal medicine to family medicine, preventative medicine, post-acute programs, and many others.

“The goal is to bring the same level of expertise that the clinic is known for in specialty care to primary care, hospital medicine, and population health,” says Myers. In practice, Myers says, that approach involves applying “data-driven comprehensive team approach to the clinical needs of patients in our communities who already trust us; and, [partnering] with others to address the social determinants of health impacting the full populations in those communities. We also seek to influence the international policy dialogue in pursuit of the quadruple aim.”

Schaffer again finds issue with how some organizations are adopting the policy. While he admits that “the requirement that providers move from fee-for-service to value-based care is an existential mandate that is required to be successful in healthcare over the next few transition years,” he says that the position should be within the domain of a chief strategy officer.

“Rather than create a new department of population health,” Schaffer says, “this function should reside within every operating department and driven by the department head the same as innovation. In fact, population health is only one (albeit a major one) swim lane of an enterprise strategic plan which should be the domain of the chief strategy officer. Unfortunately, facilities planning seems to take up most of the bandwidth of health system strategy departments which impedes their ability to take on what I believe is the more important responsibility of implementing population health.”

He says that unnecessary siloing doesn’t allow the strategy department to have the resources to facilitate and coordinate innovation, population health, and facilities planning. He adds that facilities planning, which is often separate from population health and innovation, should be integrated into planning for them.

Myers stresses that his position’s contribution to the organization is to fulfill the needed role of a connector. “My goal and mission,” he says, “are to connect primary and specialty care, fee for service and value-based care, the community to the clinic, and people to better health. People with this focus and skill set are uniquely equipped to promote and fulfill the strategies needed for health care systems to survive and thrive in the changing world of healthcare.”

“My goal and mission are to connect primary and specialty care, fee for service and value-based care, the community to the clinic, and people to better health.”

— ADAM MYERS, MD, CLEVELAND CLINIC

What organizations should consider adding the position? “Health systems that are grappling with performance in value-based payment arrangements, are looking to expand their primary care footprint, are looking to better integrate all sites of care, and seek to create productive community relationships would do well to add and support a Chief of Population Health.”

Overall, Myers says, “This position is exciting because I get to lead an amazing group of exceedingly capable people focused on doing good.”

Nicholas Hamm is an editor with Managed Healthcare Executive
Employers and consumers are looking for new solutions to the healthcare challenges being faced today, including the complexity of benefits, gaps in care and rising costs. That mindset has caused leading payers to think outside the box in their attempt to win new customers.

A sound strategy built around innovation and customer care is winning out as payers try to ensure that not only do they keep the customers they have, but bring in new ones to achieve success.

Making connections
Tom Wicka, CEO and co-founder of NovuHealth, which serves more than 40 health plans across the U.S., says regardless of the product segment, any payer’s success depends largely on its ability to engage consumers.

“Few payers have mastered consumer engagement—historically, they haven’t had to.”
—TOM WICKA, NOVUHEALTH

Choosing a focus
Nick Brecker, president, specialty business for Anthem Blue Cross Blue Shield, an Indianapolis-based health insurance company, says the company’s strategy focuses on offering leading products combined with an industry-leading approach to “whole person healthcare.”

While our specialty products (dental, vision, life and disability, and voluntary supplemental health plans) are available on a stand-alone basis, they can be packaged with our health plan products to better coordinate care, which results in more efficiencies, better health outcomes and bigger savings,” he said. “This is made possible by Anthem Whole Health Connection. This unique approach to a person’s whole health connects claims and clinical data to identify and impact gaps in care, lowers costs, and delivers a simpler healthcare experience to our consumers.”

He notes healthcare is inherently personal and Anthem Blue Cross Blue Shield’s (Anthem) Specialty business is focused on helping to make the delivery of healthcare as personalized and tailored as possible for every consumer.

“Our integrated approach to ‘whole person healthcare’ means we have the opportunity to help our consumers better manage their health conditions through early intervention and by closing gaps in their care,” he says.

John Nicolaou, a healthcare payer expert at PA Consulting, says payers need to acquire customers from their competitors in order to grow organically.

“The biggest focus we are seeing is on brand and service differentiation rather than product or benefit differentiation,” he says.

“An example would be tools to help predict out-of-pocket payments, or to encourage and reward healthy lifestyle behaviors to help members manage their health costs.”

There are also similar avenues for employers to better manage the cost of care, including improved claim analytics or to reward healthier behaviors.
“It will be critical to make these brand and service differentiations attractive and relevant and valuable for members, rather than gimmicks for payers,” Nicolaou says. “Key to this is to understand not just who their members are, but rather to understand their member relationships with payers and the health system overall to find ways to differentiate.”

Chris Seib, CTO and co-founder of InstaMed, a healthcare payment network in Walnut Creek, California, says payers need to focus on improving the member experience and look at the consumer experience in other industries to understand the benchmarks.

“According to the Trends in Healthcare Payments Ninth Annual Report, 86% of consumers want to make all of their healthcare payments in one place,” he says. “Payers can help consumers meet this need by offering payment capabilities within their member portals. Payers can take the friction out of healthcare payments and increase member satisfaction, increase member portal traffic and tool utilization, and accelerate payments to providers from members.”

Lissy Hu, CEO of Boston-based CarePort Health, says payers leverage the CarePort care coordination platform to drive financial and quality outcomes.

She explains specific opportunities for payers to leverage CarePort include: guiding members to the most appropriate level of care, enabling ED diversion, tracking patients in real time to power effective transitions of care, and increasing first submission success around post-acute authorizations. “CarePort’s vast provider footprint enables payers to most effectively and efficiently achieve visibility into member utilization and progression across settings of care, helping to drive better quality and cost outcomes and patient experiences,” Hu says. “Nearly 1,000 hospitals and more than 20,000 post-acute providers use our platform for comprehensive care transition work flows including utilization management, discharge planning, care coordination, tracking outcomes, and refining work flows.”

**Direct-to-employer program**

Stewart Schaffer, co-founder and managing partner of CSuite Solutions, a Tampa, Florida-based healthcare advisory firm, notes employers very much want to work directly with healthcare systems to provide healthcare coverage for their employees and healthcare systems also want to work directly with employers to do the same.

“Both parties already know the many potential advantages of working face-to-face with each other so the market is prime for direct-to-employer group health plans,” he says. “All that is missing is the infrastructure, technology, and expertise to make it all happen. Our sales and marketing strategy is simply to tell the story of how the combined expertise and experience of CSuite Solutions and KBA have partnered to make this all happen.”

With that in mind, when looking to add customers, CSuite Solutions focuses on risk management, plan designs, claims processing, open enrollments, case management, care coordination, proactive health management, and overall customer service. “You have to take an enterprise approach to delivering these programs. This is not just a network contracting exercise. By this I mean that healthcare systems have to look at these programs like they would going into a new business that is quite different from what they do now,” Schaffer says. “The simple thought that having employers as customers is a whole new world for them has to be accepted throughout the organization. We understand and facilitate cultural acceptance of these programs across the enterprise so that successful outcomes can be assured.”

Keith Loria is an award-winning journalist who has been writing for major newspapers and magazines for close to 20 years.

“There’s been an increased usage of what people have told us about their interests and preferences to make the information and dialogue more relevant.” — CHRISTINE PAIGE, KAISER PERMANENTE
Leadership in a Changing Healthcare Landscape

The skills and personality that make change happen  by NICHOLAS HAMM

The only thing certain in life, the old saying goes, is death and taxes. But there’s a third certainty in life that no one seems to like: change. But for healthcare organizations looking to keep up, change is a must. For leaders, that means having the right skills to help your team change and innovate to the best of their ability.

Healthcare is only becoming more complex, meaning that organizations need to constantly reinvent themselves. But for many teams, even if the leadership is on board with the changes, enacting those changes on the ground level can be difficult.

“Resistance to change in any business can be fatal,” says Stewart Schaffer, co-founder and managing partner, CSuite Solutions, a national healthcare advisory firm. “Sears, Blockbuster Video, and Toys R Us are perfect examples of this. In healthcare, either health systems need to deliver innovation to patients or companies like Amazon, JP Morgan, CVS, or Apple will. This innovation needs to come in the form of the major consumer drivers—comfort, convenience, choice and cost.”

That change can be difficult—if not impossible—especially when adequate training and introduction aren’t part of any changes.

“When new processes, programs, and technologies (i.e., innovation) are introduced to a population of team members,” Schaffer says, “it often is the case that orientation and training is short-changed.”

But beyond training, Schaffer says one of the biggest aspects leaders often overlook is making their team feel like they’re a part of any changes. This can’t happen at the last minute either, Schaffer says, but teams need to be brought in during the planning process—long before any changes are implemented in the organization.

“The strategies that help team members with change the most are adequate inclusion, planning, orientation and training,” Schaffer says. “Innovation and change cannot simply be ‘downloaded’ onto team member populations. Representatives from the different functional areas required to implement change need to be included in the upfront decision-making process well in advance of delivering changes to the patient care settings. Sometimes this could be years ahead of the launch dates for the changes.”

So, what does this look like in practice? Schaffer says one of the biggest barriers to overcome is that “very often in healthcare, decisions are made at the top or in silos and the front-line team members are not sitting at those tables.” Enacting real change, then, requires leaders to step back and give their teams space to become involved in the process.

If team members “are included from the beginning they will take on ownership of the transformations,” Schaffer continues.

Schaffer points to three ideas to help change successfully happen:

1/ “Project teams that include all of the functions required to implement specific change need to be organized and led by people who are certified in professional project management.

2/ “There needs to be a project plan with timelines and accountability that the project team members agree to.

3/ “There must be guiding principles of what the team is trying to accomplish along with a detailed roadmap (called a business plan when I started my career) of how to get there.”

“Resistance to change in any business can be fatal”

—STEWART SCHAFFER, CSUITE SOLUTIONS

These ideas, far from being revolutionary, have been tested and used elsewhere to great effect. But as Schaffer concludes: “these tried and true concepts used by many large industries are often not used or abided by in healthcare.”

Nicholas Hamm is an editor with Managed Healthcare Executive
More and more, payers and providers are realizing the value of integrating patients’ social determinants of health (SDoH) data into patient care initiatives. With the industry looking toward a value-based care future, it’s becoming clear that finding ways to incorporate what the World Health Organization defines as “the conditions in which people are born, grow, live, work, and age” is vital to improved health outcomes—and a healthy society, in general.

This includes using SDoH data to help guide the development and implementation of successful population health strategies, says Ali H. Mokdad, PhD, chief strategy officer for population health at the University of Washington School of Medicine. He argues that health-care professionals can develop excellent, evidence-based population health initiatives—but unless a particular population’s SDoH are considered, such programs will not be as effective as desired.

“A patient’s environment plays a critical role on whether or not they can actively participate in their own health and wellness,” he explains. “If a family is struggling to pay their rent, they are not going to spend money on preventative care. If a family can’t find fresh fruits and vegetables that are affordable in their neighborhood, they won’t eat a healthy diet. If they are in a neighborhood that isn’t so safe, it may be hard for them to be physically active. It is very important that we address all of these aspects early on so we invest in the right kind of population health approaches—and don’t waste time and money with trial and error type programs.”

Dion Sheidy, a healthcare advisory leader with KPMG, a professional services firm, says that while adding SDoH data into population health initiatives seems like it should be a fairly simple thing to do, it’s much harder than one might expect in practice.

“The biggest challenge to using this information to help deliver care in an appropriate setting and an appropriate way is actually the data itself,” he explains. “Providers may not...
The biggest challenge to using this information to help deliver care in an appropriate setting and an appropriate way is actually the data itself.” — DION SHEIDY, KMPG

Making strides
But despite those data challenges, Humana, a leading healthcare payer organization, has made strides in incorporating SDoH into their population health strategies with their Bold Goal initiative, a unique program to help better care for patients with chronic medical conditions.

“Today, as an industry, we only spend 4% of every healthcare dollar on social health. Everyone knows it’s important to health outcomes, particularly the clinicians.”

—CARALINE COATS, MHSA, BOLD GOAL AND POPULATION HEALTH STRATEGY, HUMANA

Humana aims to improve the health of the communities they serve by 20% by 2020. Part of that strategy is considering SDoH factors like food insecurity and social isolation in their population health programs.

“We understand that food insecurity, social isolation, transporta-

tion security, and housing are all directly related to health,” says Andrew Renda, MD, MPH, associate vice president of population health at Humana. “This program allows us to bring those things into the mainstream of healthcare so we can start treating SDoH for what they are—clinical gaps in care.”

Caraline Coats, MHSA, vice president of Bold Goal and Population Health Strategy, says healthcare has been too medically focused for too long. “Today, as an industry, we only spend 4% of every healthcare dollar on social health. Everyone knows it’s important to health outcomes, particularly the clinicians. But we needed to find a way to provide the data and resources providers needed so they could treat social health factors too.”

It was a challenging undertaking. But Renda said they started by simply standardizing their SDoH data collection.

“We needed to agree on common definitions and a way to codify those definitions,” he says. “For food insecurity, we decided to use the United States Department of Agriculture (USDA) Vital Signs screener, a two-question survey, and for social isolation and loneliness, we used a three-question scale from the University of California Los Angeles (UCLA) called the Loneliness Scale.”

By using these validated screeners, Humana was able to more effectively incorporate the data into their different well-being and direct clinical platforms. In 2018, the health plan screened 50,000 of their members in San Antonio, markets on these particular social determinants. And, in doing so, they were able to bring that information into their data ecosystems to not only help their providers make appropriate referrals to their patients for different resources, but also to assist Humana in their development of more effective population health programs.

After only a few years, Bold Goal is seeing clinical gains. The integration of SDoH information helped to increase the number of self-reported “healthy days” by Medicare Advantage members in Humana communities by 2.7 days. While 2.7 days might not seem like much, Medicare Advantage beneficiaries in communities who did not participate in the Bold Goal program saw a decrease of 0.6 healthy days for the year. While Coats said Bold Goal program is still in its early stages, she is buoyed by the results so far.

“I firmly believe there is a return on both health and financial investment in social determinants,” she says. “We have incredible qualitative data and feedback from our members. It is going to take time to prove all this out but, with the space and time to prove the importance of social health on the overall quality of life, we will get there.”

Renda agrees. “We see that the program is moving in the right direction with both the healthy days numbers as well as other improvements we’ve seen in physical and mental health in our members,” he says. “We see SDoH as an opportunity for us to get deeper into our communities and understand the unique issues each may face and how we can rally around those topics to improve overall health. And our results so far give us hope that if we continue this work—and scale things that we are now learning are effective to improving health outcomes—we can have a bigger and bigger impact for our members over time.”

Kayt Sukel is a science and health writer based outside Houston.
Drug Price Reform Takes Off in 2019

Opportunities to lower drug prices, as President Trump promised in his American Patients First Blueprint, are accelerating

by MARI EDLIN

President Trump jump-started some proposals for reducing the cost of prescription drugs when he created his American Patients First Blueprint in May 2018.

Unfortunately, drug costs are continuing to affect adults taking prescription medications—especially those who are uninsured. The CDC reports that 19.5% of uninsured adults in 2017 asked their doctors for a lower-cost medication, 11.4% didn’t take their medications as prescribed, and 5.4% used alternative therapies.

Most people taking drugs say they can afford their treatment, but about 25% have a difficult time paying for their medications, according to a poll by the Kaiser Family Foundation.

Here are four areas of reform touted as solutions to the problem:

**Lowering OOP payments for Part D beneficiaries**

This year saw changes to the Medicare Part D standard benefit in an effort to lower OOP payments paid by Part D beneficiaries.

Under the Bipartisan Budget Act of 2018 (BBA), Part D enrollees’ OOP costs for brand-name drugs in the “donut hole,” declined from 35% of total costs in 2018 to 25% in 2019, while the manufacturer discount increases from 50% to 70%. The Congressional Budget Office (CBO) estimates that these changes will reduce Medicare spending by $11.8 billion over a 10-year period (2018-2027).

Plans’ share of costs for brands decreased to 5% in the donut hole; however, insurers are responsible for 63% of the cost of generics while enrollees pay 37% for them in the gap.

Beneficiary OOP costs before moving into the catastrophic phase jumped from $5,000 in 2018 to $5,100 in 2019 and are expected to rise again in 2020 to $6,350.

The bulk of insurer responsibility is in the initial coverage period—75%—while Medicare is on the hook for 80% of total costs under catastrophic coverage after beneficiaries reach a threshold of $8,140.

“While this does create a perverse incentive, payers are still careful about the number and types of drugs they make available on their Part D formularies primarily due to concerns about adverse selection and its impact on overall drug spend.”

—BRIAN DUFFANT, BLUEPATH SOLUTIONS

**Beneficiary OOP Costs in Part D**

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<th>Year</th>
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<tr>
<td>2018</td>
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<td>2020</td>
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Managed Healthcare Executive.com
on overall drug spend," says Brian Duffant, vice president, BluePath Solutions, a health economics outcomes research consulting firm in Los Angeles.

He acknowledges that insurers have limited ability to move beneficiaries into the donut hole and Medicare to keep them out of the catastrophic phase, based on the standard Part D benefit design (see graphic) that allows a patient to move through the phases of coverage based on total drug and patient OOP costs.

Legislation has not yet been introduced to modify the BBA coverage gap provisions; however, efforts are underway.

Pharmaceutical manufacturers are pressuring Congress to roll back the manufacturer discount from 70% to 63%, increase Part D plan-sponsor liability, and block an increase in the total amount beneficiaries must spend OOP on their prescription drugs before catastrophic coverage kicks in.

According to the Commonwealth Fund, these proposals would financially benefit drug manufacturers more than Medicare beneficiaries. Beneficiary spending in the coverage gap would be slightly reduced (far more for manufacturers), and Medicare spending under Part D would increase to cover the savings to beneficiaries.

A blunt indications-based pricing model that assumes the ability of physicians to prescribe the most effective medicine 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 report by the Kaiser Family Foundation states that increasing plans’ shares of costs in the coverage gap, reducing the manufacturer discount to something less than 70% for 2019 and beyond, and modifying the scheduled increase in the OOP spending threshold would result in higher Medicare spending, resulting in a substantial increase in beneficiary OOP cost and fewer Part D enrollees qualifying for catastrophic coverage.

Bipartisan efforts are indicating support for capping OOP spending and shifting more responsibility to insurers by increasing their share of costs in the catastrophic phase, and to manufacturers to lower drug prices.

**CMS** “We expect this will increase the number of drugs available on formularies and promote diversity of formularies. By virtue of these broader formularies and underlying negotiations, beneficiaries will be able to access more drugs at lower prices. Since this policy provides sponsors the flexibility to add a drug to their formularies for specific indications, as opposed to leaving the drug off of the formulary altogether, patients in need of the drug will have access to the negotiated price and will have to rely less on the appeals process. This formulary approach will help ensure Medicare beneficiaries receive individualized drug treatment that is targeted to meet their needs.”

**AMA** "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 medicine 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 … could lead to certain subgroups of patients not having access to a medication, even though it may be fully effective...”

**Medicare Part B changes**

At the beginning of 2019, CMS green lighted permission for Medicare Advantage plans to use step therapy for Part B drugs to reduce costs and provide more coordinated care. CMS is finalizing regulations similar to the 2019 policy to ensure that Medicare beneficiaries pay less overall or per unit for Part B drugs and have timely access to them.

“The ‘step therapy’ proposal, which was previously not allowed, enables negotiation by manufacturers for discounts related to step therapy for Part B,” says Andy Parece, vice president, Charles River Associates in Boston. “Approved in 2018 and renewed in 2019, there was limited participation last year, but we expect more in 2019 for 2020 formularies.”

In addition, IHS will test a new payment model to substantially lower the cost of prescription drugs and biologics covered under Medicare Part B. The new model would, for the first time, base Medicare payment for Part B drugs on the typically lower prices paid in 14 other industrialized countries, known as the International Pricing Index.
Medicare’s current payment to physicians for Part B drugs, which is based on the average U.S. sales price for these drugs and biologics, is 47% higher on average than prices paid by these countries for the same products, according to the Administration.

**Testing value-based benefit design**

The administration is experimenting with value-based programs for drugs, including indication-based pricing and long-term financing. The Center for Medicare & Medicaid Innovation will test a value-based insurance design model for 2020, including a reduction in cost sharing or additional supplemental benefits for enrollees based on condition, socioeconomic status, or both; awards and incentives; use of telehealth services; and coordinated approaches to wellness and healthcare planning.

Under new guidelines, an indication-based formulary will be available in 2020, allowing Part D plans to choose a different drug for an indication by using step therapy and prior authorization to promote the most cost-effective option. CMS policy currently 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.

“This model not only allows manufacturers to bid separately for each indication offering payers better prices, but also helps put innovative products on formulary,” Parece says. As for outcomes-based pricing, which has gained some traction in the commercial sector, he believes it is difficult to determine value—especially without integrated medical and pharmacy data.

Joe Paduda, principal, Health Strategy Associates, a consulting firm in Skaneateles, New York, supports patient-specific formularies as the norm because patients might respond differently to the same therapy. He is concerned, however, that PBMs will use financial measures as a key component of formulary decision making.

“Given the need for therapies to reflect each patient’s needs and genetics, patients and prescribers must have access to the right drugs without financial penalty,” he says.

**Drug importation**

In a Mercer survey of employer-sponsored health plans, 60% of employers surveyed believe that permitting importation of less-expensive drugs from abroad is one of the most effective ways to reduce drug prices.

A PEW study agrees that importation has the potential to lower healthcare costs for two primary reasons: 1) Patients could access some medicines at lower prices because brand name drugs are generally more expensive in the United States than in other high-income countries; and 2) increased competition from imported drugs could put pressure on drug companies to reduce the price of their products in this country.

The Affordable and Safe Prescription Drug Importation Act, introduced in 2017, would allow pharmacies, wholesalers and patients to purchase drugs and biologics from sellers in Canada who are certified by the HHS secretary.

On a state level, Florida Gov. Ron DeSantis recently signed a bill that would allow his state to import drugs. The bill cites a 2003 federal law that allows federal agencies to authorize states to import drugs. DeSantis says that state officials are working with HHS at high levels, and says he has the support of President Trump.

Ed Schoonveld, managing principal, ZS Associates, a Chicago-based biosciences consulting firm, supports differential pricing (up to the level that variable cost allows), but notes it has some hurdles. “The critical factor in enabling differential pricing is the willingness of high income countries to accept it. Recent initiatives in the United States and Canadian pricing reform (the Canadian government is changing its basket of reference countries by removing the United States and Switzerland and adding lower priced countries such as Australia and those in Eastern Europe) are part of the challenge,” he says.

While some worry about the loss of R&D funds for pharmaceutical manufacturers, Schoonveld sees new opportunities to recoup potential losses. “There is a lot of pressure to make drugs available at affordability levels in low- and middle-income countries. In most cases, it would likely be in the interest of all patients worldwide (and the industry) if prices could be adjusted to affordability levels as higher volumes of patients, now enabled to use the drug, would add at least some marginal contributions to the global cost of R&D,” he says.

Two more Trump administration proposals to decrease drug costs—mandating that drug manufacturers disclose list drug prices in TV ads and an overhaul of the drug rebate program—are off the table as of July 2019.

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

$1 - $1.5 billion

Annual savings from drug importation bill

Source: CBO

“The critical factor in enabling differential pricing is the willingness of high income countries to accept it.”

—ED SCHOONVELD, ZS ASSOCIATES
The healthcare industry is slowly starting to implement the type of consumer engagement best practices that have been hallmarks in the retail, travel, and financial industries for years: listening to individuals and designing personalized solutions to incentivize outcomes. “With the growth of consumerism and a shift to value-based care, plans today recognize that connecting with consumers is imperative to ensure the health of both their plan and their members,” says Tom Wicka, chief executive officer of NovuHealth, a healthcare consumer engagement company in Minneapolis.

Consumer engagement in healthcare keeps individuals on top of their own well-being, leading to healthier outcomes. On the flip side, non-engaged consumers are often high-cost consumers, because they bypass early prevention and detection and don’t properly manage chronic conditions. “It’s incumbent upon plans to take a proactive approach to engage consumers and improve their health, which results in other benefits such as lower healthcare costs, compensation from stronger outcomes, and improved plan performance,” Wicka says.

Here, experts provide 14 ways that insurers can improve their members’ experiences with them.

1. **Use data and analytics to better support members.**

Leverage consumer data and advanced analytics to better understand consumers’ needs and which programs to invest in to best address them. “Claims and clinical data only provide a sliver of insight into what has historically occurred within a population,” says April Gill, vice president of market solutions at Welltok, a software as a service company for consumer health. “Broaden your understanding of your members by layering in broader data sources and advanced analytics.”

The most predictive data about someone comes from outside of healthcare—such as a member’s level of education, where they live, and their means of transportation. “These elements provide a deeper understanding of an individual’s likelihood to respond to various communication...
channels and to take action,” Gill says. Use relevant, up-to-date consumer data from non-healthcare sources such as census, financial, and commerce to easily predict and respond to an individual’s change in health status in a more informed and measured way.

2 **Use multi-channel communications to reach consumers.**

Don’t rely on one type of communication method. By working with a qualified vendor to securely collect and predict a member’s channel preference, organizations can drive cost-effective engagement outcomes by delivering the right message, to the right person, at the right time. “An outreach strategy that encompasses a variety of communication channels can provide cost-effective ways to engage and activate consumers,” Gill says. For example, aligning with a member’s preference to receive text messages can improve the chances they will take action, while also saving money on postage and postcard costs.

Some members will only respond to an email, but for short messages with a regular cadence, texts are a great choice. “And although we live in a digital age, automated voice still works best for some individuals,” Gill says.

3 **Personalize member communications.**

When sending every member the same content, a message has to be general enough to apply to everyone. But that means that it won’t feel personal to anyone. “Consumers want the same thing from their health plan that they want from every brand or service they engage with; they want to be uniquely seen and understood,” Wicka says.

“Plans should consider setting up triggers around key activities, such as when a member needs to complete a specific activity and distribute that message automatically to create a more personal member experience,” Wicka adds.

4 **Use simple verbiage.**

Make educational materials and benefit explanations as readable, accessible, and as easy to understand as possible. “Just because healthcare is more complex than ever, doesn’t mean that your member communications need to be as well,” says Jennifer Truscott, senior vice president of operations at EmblemHealth in New York, New York. “Communicating simply is one of the most critical ways to build trust with members and help them understand your value.”

EmblemHealth’s “Speak Human” campaign represents its commitment to engage with members and partners in a simple and clear way. “We make it a priority to use plain, direct language, and have extensively reviewed and refined all of communications materials,” Truscott says.

5 **Provide member-centric support services.**

A call center is typically the front line for a member’s engagement with their health insurer, and for better or worse defines a member’s broader experience with their health plan. “It’s crucial that individuals answering members’ calls serve as true company ambassadors who can resolve issues as quickly and efficiently as possible,” Truscott says. For insurers, this means emphasizing soft skill training, prioritizing long-tenured representatives, and integrating clinical resources directly into the call center. “All of these factors are key to improving first call resolution.”

6 **Make health resources simple.**

Websites and online portals should allow seamless access to a broad range of resources, including plan details, benefits information, and physician locations. “A member’s online experience will be improved if they can also access online wellness tools and educational materials to promote a healthier lifestyle in a way that feels natural, rather than burdensome,” Truscott says.

7 **Be high-tech and high-touch.**

Members expect convenient service through technology. In 2018, 57% of Blue Shield of California member interactions occurred on its digital self-help platforms. “We will continue to expand these convenient options to delight our members even more,” says Michael Bassett, MBA, vice president, Customer Experience Operations and Shared Services at Blue Shield of California in San Francisco. “But it’s not enough to be high-tech. We have to be high-touch as well, which means serving our members as whole people. One way we have done this is by removing the ‘average handle time’ guidelines for our call center staff. They are now able to spend as much time as needed with each member who calls in.”

“Shield Concierge,” Blue Shield’s integrated service model, is designed to provide personalized service and improve member experiences by resolving more inquiries during the first contact. A team of co-located professionals including customer care representatives, registered nurses, pharmacists, and other providers coordinate individualized solutions for members and help manage complex healthcare needs, Bassett says.

“**Just because healthcare is more complex than ever, doesn’t mean that your member communications need to be as well.**”

— JENNIFER TRUSCOTT, EMBLEMHEALTH
Patient Experience

8 **Personalize care for members.**
One way to do this is to develop new, innovative health plans that foster and incentivize new approaches to care delivery. A flexible health plan is one that is smart enough to see the trend moving toward self-care, wherein the delivery of care services happens more often at home, with patients administering care under the guidance of licensed providers. “To personalize care, payers may need to act as consultants, revealing options to patients that they may not know exist, such as virtual care, while also providing patients with the coverage they need to pay for such innovations,” says Donna Martin, senior vice president, Global Healthcare, HGS, which provides business process management services.

9 **Be present in members’ communities.**
In order to help members navigate the administrative aspect of healthcare, EmblemHealth offers one-on-one, in-person help at its EmblemHealth Neighborhood Care centers, ConnectiCare centers, and AdvantageCare Physicians’ offices. These centers support individual health and wellness journeys through programming and classes that champion multiple dimensions of health including physical, financial, intellectual, social, and emotional aspects. “We bring resources directly to members in the communities they live via knowledgeable individuals and useful educational resources,” Truscott says.

10 **Provide services beyond healthcare.**
Research shows that medical care only accounts for 10% to 20% of an individual’s overall health, whereas up to 80% is attributable to social, physical, and behavioral factors. “That’s why WellCare believes that in order to improve our members’ experiences, it’s critical that we go beyond healthcare to help them, as well as their loved ones, with all of their needs, medical and otherwise,” says Rhonda Mims, executive vice president and chief public affairs officer, WellCare Health Plans, Inc., Tampa, Florida.

For example, WellCare’s Community Connections Help Line, which is available in all 50 U.S. states and is open to both WellCare members and non-members, is staffed by a team of peer coaches who have lived similar experiences as callers. “This means that they have experienced trying times or crises, such as disability, caregiving, or even homelessness, and can offer peer-level support and connections to resources,” Mims says.

The sole purpose is to connect callers with services in their community that help them with services beyond healthcare, from help paying utility bills to assistance in finding affordable housing. The team works from a database of nearly 200,000 community resources available throughout the nation, Mims says.

11 **Become your members’ trusted advisor.**
Blue Shield of California provides personalized tools and services that empower its members.

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**The Business Case for Improving Patient Experience**

Beyond the obvious benefits for patients, improving patient experience can also improve key financial indicators. Research shows that improving patient experience:

- Is associated with lower medical malpractice risk
- For each drop in patient-reported scores along a five-step scale of “very good” to “very poor,” the likelihood of a provider being named in a malpractice suit increased by 21.7%
- Results in higher employee satisfaction
- One hospital that made a focused effort to improve patient experience saw a 4.7% reduction in employee turnover
- Maintains greater patient retention
- One study showed that patients who reported the poorest-quality relationships with their physicians were three times more likely to voluntarily leave the physician’s practice than patients with the highest-quality relationships.

Source: AHRQ

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**Image courtesy of Angel Jackson, Senior Designer at EmblemHealth**

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**Visitor to Neighborhood Care centers and ConnectiCare centers interact face-to-face with staff to get answers for their member-specific inquiries. Beyond personalized assistance with claims summaries and other insurance-related matters, members and non-members have access to a variety of free fitness classes and educational seminars.**

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to have a better quality of life. The tools also help the insurer better understand what’s important to each member so they can look out for their best interests; advocate for members’ wellness and support them in their time of greatest need; and create an emotional connection with members so they choose the insurer for life, Bassett says.

Blue Shield of California also trains and deploys health advocates directly into communities where members live. These professionals provide personalized, in-home, high-touch care, integrated with innovative technology. Collaborative community partners increase service and care coordination, reduce barriers to health, and improve quality of life for members. “This goes beyond simply insuring our members; it creates a true, trusted partnership,” Bassett says.

12 **Make the healthcare system more predictable.**
Research shows that a lack of predictability is among members’ biggest frustrations with health insurance. “Health insurers should use their role in financing care to help consumers anticipate expenses, plan for expenses, and be prepared to cover them,” says Jeff Gourdji, partner, Healthcare Practice Leader, Prophet, a growth and digital transformation firm. When members look for the cost of a procedure or treatment on a website, they shouldn’t receive vague, unhelpful responses such as, “you may be covered for x” or “the cost may be in the range of x to x.” Insurers should provide members with concrete information regarding costs.

13 **Streamline the system.**
Because health systems are fragmented, they’re filled with inefficiencies that inconvenience consumers, says Benjamin Isgur, health research institute leader, PwC, which analyzes trends affecting health-related industries. For example, consumers oftentimes have to fill out similar forms repeatedly. Or, when questions can’t be easily answered on an insurer’s website, members have to go through a multi-step call bank, which is difficult to navigate. Insurers should look for easy ways to streamline operations and ease these frustrations.

14 **Work with the best healthcare providers and incentivize them accordingly.**
Offer members a network of the best physicians and plans available. WellCare does this by creating value-based arrangements with providers and cultivating relationships with advanced practices. “We enter into and oversee partnerships with practices that are willing to accept financial risk and be incentivized when they demonstrate progress from a quality perspective,” says Kelly Munson, executive vice president, Medicaid, WellCare Health Plans, Inc., Tampa, Florida. Currently, 55% of its Medicare payments and 34% of Medicaid payments align to value-based type of arrangements. All payments are inclusive of medical and prescription care.

Many of its members, particularly those on Medicaid, rely on places such as public hospital systems, rural health clinics, Federally Qualified Health Centers, and local health departments as their regular source of care. “WellCare works with these providers regardless of where they are on the value-based spectrum, with a special focus on safety net providers,” Munson says. “We offer support and strategies from data sharing to technology upgrades to expediting claim issues resolution, with a goal of improving the member experience.”

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

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*To personalize care, payers may need to act as consultants, revealing options to patients that they may not know exist.*

— DONNA MARTIN, GLOBAL HEALTHCARE, HGS
Many women in rural areas in the United States need to travel an hour or more to get to a hospital where they can give birth, according to the American College of Obstetricians and Gynecologists (ACOG). Obstetric units are often the first to close when hospital budgets get tight. By 2010, 49% of U.S. counties—predominantly rural counties—had no obstetrician–gynecologist. In some counties, all obstetric care is provided by family physicians. And according to ACOG, the number of OBGYNs in the rural workforce could continue to decrease.

New Orleans-based Ochsner Health System supports expectant mothers with its free Connected MOM (Maternity Online Monitoring) digital medicine program, which means fewer visits to the obstetrician. Mothers-to-be receive a wireless blood pressure cuff and dipsticks and cups for urine protein tests, which can be used at home to test urine and securely send the results to the care team via the patient’s smartphone. They also get a wireless scale to send real-time weights to a health coach and obstetrician via their medical chart at least once a week; patients receive reminders on their smartphones if they forget.

Launched in December 2017, Connected MOM is the first such program created by a health system, according to Ochsner. As of March, 1,000 women were enrolled in the program, reports CNBC. Citing the American College of Obstetricians’ guideline that the standard prenatal care model for low-risk pregnancies requires between 12 to 14 office-based prenatal visits, the health system says the Connected MOM program connects patients with their care team while reducing the need for at least three office visits and increasing flexibility and convenience for patients.

“Digital health programs have an opportunity to create access in areas where there isn’t always access. This is a really powerful way to help address some of the access issues and disparities we see.”

— AIMEE QUIRK, INNOVATIONOCHSNER

“Digital health programs have an opportunity to create access in areas where there isn’t always access. This is a really powerful way to help address some of the access issues and disparities we see,” says Quirk.

Wearables and chronic disease management

Ochsner also supports patients with chronic conditions such as hypertension and diabetes with digital health programs including wearables, says Quirk. “We recognize that the acute care model, which is the model of care today, is changing. We’re seeing it change because of payment incentives.”

To support patients and non-patients, the health system launched the O Bar, retail locations where patients and non-patients can purchase activity monitors, wireless blood pressure monitors, and weighing scales. Shoppers also have access to technology specialists who help them choose the appropriate digital health app, while providing

Continued on page 20
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The first O Bar opened at its medical center in Baton Rouge in May 2018, and there are now seven O Bar locations at health system facilities. Available to serve community members in other locations is the mobile O Bar, which travels to Ochsner hospitals. Expectant mothers can pick up materials for the Connected MOM program at an O Bar, says Quirk.

UnitedHealthcare members increase steps

UnitedHealthcare Motion uses wearable devices to capture members’ required 10,000 daily steps to help them earn as much as $1,095—or $3 per day—to-toward their health savings account each year. The program is available to members in more than 40 states. Launched by the payer as a pilot program in 12 states in 2016, the program started because there’s a “significant body of evidence that movement and motion can have a meaningful impact on the quality of life,” says Paul Sterling, vice president of emerging products.

“Activity trackers and smart watches available through the program include devices from Samsung, Garmin, Fitbit, and Apple. For members in the program, UnitedHealthcare subsidizes $55 toward the cost of an activity tracker or smart watch. Participants who already have a device receive $55 worth of credit in the program. Collectively, members who participate in the program have walked more than 180 billion steps and earned just shy of $30 million in rewards since the program’s inception.

People with chronic conditions are 20% more likely to participate in Motion than people not managing these conditions, according to UnitedHealthcare. Specifically, people with diabetes are 40% more likely to participate in the program than people without the condition.

Members’ participation in the program can translate into cost savings for employers, according to the payer. Members who participate in Motion have been shown to cost $222 less than members who don’t participate.

Aine Cryts is a writer based in Boston.
As cardiac disease, diabetes, and other chronic illnesses rise worldwide, and as the population ages and the U.S. faces a predicted physician shortage, many health systems and health plans have embraced telemedicine as an option to grow their markets and continue care to patients remotely.

A study on health insurance claims from across the country found that between 2016 and 2017 telehealth claims increased by 53%—more than both urgent care centers (14%) and retail clinics (7%) combined.

"From a business perspective, if I can keep you healthier and more compliant with your physician recommendations, hopefully your health outcomes are going to be more positive. That means where we can potentially reduce readmission disease exacerbations and emergency room visits," says Marya Vande-Doyle, director of workplace wellness and telemedicine for Excelus BlueCross BlueShield (BCBS). The health plan recently reported that nearly 15,000 telemedicine claims were filed in 2018. "We see telemedicine as a way to ensure that members feel like they have access to care wherever they go."

Combined with market factors, CMS also accepted five new reimbursement codes in 2019 allowing for providers to be paid for remote patient monitoring, e-visits, and e-consults.

But even with a ripe market and more CMS support, experts believe that healthcare organizations still have a long way to go before telemedicine and e-visits are commonplace. Zynn says state regulations can still be a hurdle to telehealth adoption.

"If you asked anybody in the industry, they would say licensing and changes in the regulations at the state level are probably the biggest hurdle or hindrance to faster growth," says David Zynn, president of Infectious Disease (ID) Connect, a telemedicine company recently spun off from the University of Pittsburgh Medical Center (UPMC).

Currently, 29 states are a part of the Interstate Medical Licensure Compact, which provides streamlined licensure for physicians who offer telemedicine services through multiple states.

"In the next five years, we’ll lose the term ‘tele’ because it will just be healthcare," says Zynn. "You will make an appointment to see your doctor and either go to the hospital or get that service via telemedicine. You will also get follow ups via telemedicine. So, it’s more efficient, more effective, and better for the patient.”
EXPANDING SPECIALISTS’ REACH

UPMC saw telehealth as an opportunity to offer its expertise in infectious disease to communities across the country. The hospital launched a telemedicine company, ID Connect, to help other hospitals improve outcomes and reduce transfers for patients who need infectious disease treatment.

Currently, the program is being used by several other hospitals and outpatient clinics, with plans to expand in the upcoming months. A shortage of physicians who specialize in infectious disease, coupled with the constantly-evolving nature of the field were other catalysts to UPMC’s decision to create a technology company focused on providing services more broadly.

ID Connect incubated at UPMC for the past five years, and Zynn says that through that trial they were able to prove that telemedicine could contribute to a decrease in antibiotic misuse, patient hospital stays, and mortality. Currently, 12 doctors are providing services on the platform to other doctors who need assistance or second opinions, and to patients who are recommended to a specialist.

“Our doctors schedule tele-physical exams and we train our customers to use a tele-presenter. It is still a very comprehensive exam, with questions, history, and a physical exam. The tele-presenter also has a video, so that our doctors can see and hear everything as if they were physically present,” Zynn says. “Our doctors can diagnose, treat, order labs and prescriptions, all documented in the EHR. They will follow up with that patient to make sure everything is working out as planned. They can make any changes to the diagnosis or treatment plan if necessary. And upon discharge, a telehealth appointment would be part of the discharge order and follow up.”

Zynn says that because there are more than 4,000 hospitals with 300 beds or less, it is increasingly important for smaller providers to have easy and affordable access to specialists. The U.S. could be short up to 122,000 physicians by 2032, with possibly half of them projected to be specialty care providers, according to a 2019 report from the Association of American Medical Colleges.

“I’ve talked to our customers and the number one thing that we bring to them is, without our service, they would have to transfer a lot of patients out to a larger tertiary. That’s not good patient service,” Zynn says. “It’s not good for the local hospitals because they lose that patient. You don’t want to take someone who is very sick with an infection and transport them from one facility into another. That alone is a tremendous opportunity to improve care.”

PLANS INCREASING OUTREACH

Health plans are also seeing positive impacts to increased telehealth adoption. A recent claims review from Excellus BCBS in New York found that telehealth services have tripled in the past two years. The health plan’s review found that nearly 15,000 telemedicine claims were filed in 2018, up from 5,100 in 2016.

A survey of more than 2,000 Excellus BCBS members conducted in 2019 found that more than half of members knew about telemedicine and 43% said they would consider using it in the future. Though only 5% reported using telemedicine services, 93% who used it rated their experiences favorably.

An increase in community outreach and provider education are factors that led to the increase in telemedicine claims, Vande-Doyle says. “We provided a public service campaign to help spread awareness using local media and partnering with community events, to help the community understand what a telemedicine visit is," Vande-Doyle says.

The second approach Excellus BCBS took was to work with network partners, health systems, and primary care providers based in the community and the local and state medical society to share why telemedicine is important. Excellus BCBS services Medicare, Medicaid managed care, commercial, and employer-based health plans.
"A vast majority of our population is located in either health professional shortage or metropolitan shortage areas as designated by HHS. We recognize that for those members it’s very difficult for them to travel during a snow storm or find a caregiver to drive them to a doctor’s appointment. We reached out to the medical community understanding these common challenges and how can we increase awareness of telemedicine," Vande-Doyle says.

The Excellus BCBS survey results found that 78% of telehealth services were related to heart disease, hypertension, skin disorders, diabetes, and pneumonia. Another 22% of services were related to behavioral health, including anxiety, depression, attention and bipolar disorders. Behavioral health visits via telehealth were the fastest growing areas of treatment, according to the claims review.

"In order to be successful, we have to ensure that our providers feel comfortable in offering telemedicine. We have to encourage our providers to innovate. And at the same time, we have to share what we’re learning," Vande-Doyle says. "It’s not focused on one specialty, healthcare provider, or one visit type. Telemedicine is for all types of applications. It’s part of a solution of increasing access to care and using our healthcare services."

MORE EFFICIENT PHARMA SERVICES

In the last decade, PipelineRx has grown its telepharmacy business to serve more than 600 hospitals and provider organizations, with 150 telepharmacists working from a call center or remotely. Brian Roberts, CEO of PipelineRx, says that remote dispensing and medication management, along with counseling patients and providers delivers education and efficiency that is lacking in the healthcare system.

"Telepharmacy increases access to facilities or organizations that either can’t afford or can’t find the right pharmacy personnel. We can provide that remotely so that everybody has 24/7 care," Roberts says. "I can take one telephone pharmacist working from home or from our call center, and they can cover between four and seven facilities at the same time. You can bring the overall cost of managing those facilities down by using telepharmacy."

Roberts says that telepharmacy can allow on-staff pharmacists the ability to focus less on administrative tasks and work more closely with patients.

"We provide increased safety because a telepharmacist has his or her head down focusing on processing orders and making sure that the prescriptions are right," Roberts says. "We actually counsel the patient during and after discharge to help them understand their medications and how adhere to their program."

As rural pharmacies close across the country, and the importance of prescription drug management continues to rise, Roberts says telepharmacy can fill gaps in continuity of care. "Transitions of care are such a big problem for the U.S. When a patient gets out of the hospital, information stops. If they have to pick up medications at the pharmacy, 40% of patients who leave the hospital either have a wrong prescription or they never pick up their medications," Roberts says. "That 40% causes readmissions, it causes people to get sicker. We really like the impact that we can have by following patients out of the four walls of the hospital and allowing for the data streams to continue to follow them."

The nationwide network developed through telepharmacy also allows for better tracking of medication abuse and misuse, Roberts says. "Our data analytics and our pharmacists identify those that have a history of drug abuse or have been identified as a person who could be of high risk," he says. "We have access to see patient records across multiple settings and multiple hospitals. So, we can actually identify those who have gone to different hospitals trying to get opiates or other drugs."

Donna Marbury is a writer in Columbus, Ohio.

The importance of transition care

40%

of patients who leave the hospital either have the wrong prescription or they never pick up their medications
Effective leadership skills are best developed through direct experiences. However, in today’s dynamic healthcare ecosystem, even the most confident CEOs are drawing added inspiration from personal and professional mentors.

Getting ahead of the competition is one of the primary goals that executives have in mind when they reach out for professional mentoring, according to Linda Henman, PhD, author and executive coach. She believes the realities of market competition often guide the overall leadership strategy, even among not-for-profit organizations.

In other words, those focused on a mission need a healthy margin to support the ongoing fulfillment of that mission. Meanwhile, the for-profits, with their focus on revenue targets, also need to be driven by a greater good, such as building a healthy community.

Organizations should define their culture by defining their passions, Henman says. "People talk about culture as if it were only tied to tradition, but that’s an outdated way of thinking that just doesn’t work today,” she says. “Traditions are important, but they’re not the reason you’re going to be successful.”

**Leadership as a team sport**

Executives must evaluate who is making strategic decisions within the company, what decisions they’re making and why. Many boardrooms would be surprised to find out where the practical decision-making authority actually lies and how it affects the business, Henman says.

For example, Henman once advised a rural provider that was struggling with claim denials. As it turned out, the physicians weren’t coding correctly, resulting in ongoing rejections and lost reimbursement, impacting as much as $10 million in revenue. But administrative employees didn’t think it was acceptable to challenge physician leadership, much less company executives.

"The CEO had created a culture of fear," she says. “No one wanted to bring him bad news.”

Only the CEO could make the decision on how the company would hold physicians accountable for proper coding. Henman says the situation could have
been avoided if the corporate culture had allowed for open discussion, rather than autocratic leadership. “Many executives have trouble changing the culture because it seems like giving up power,” she says. “In reality, they’re gaining power that way.”

She recommends that executives create a culture that allows the business to innovate. Leaders should focus on a mission, be open to learning and act as agents of change within the organization.

Managed Healthcare Executive (MHE) recently asked several healthcare decision makers to identify personal or professional mentors who have inspired them in their careers. Executives seem to agree that the best mentors are those who provide honest feedback, instill confidence, and persist in pursuing their goals.

Julie Miller is a healthcare freelance writer based on Cleveland.

Who has been a mentor who has inspired you?

What piece of advice from that person have you applied in your leadership?

Caraline Coats, vice president, Bold Goal and Population Health Strategy, Humana

My dad. He never gave up on his dreams, reinventing his career at the age of 50. He is an advocate for female leaders, coming from a family of seven boys. And ironically, my dad had five daughters. Despite financial challenges throughout his career, he stayed true to his commitment to support us all through our college education.

Don’t get overwhelmed with what you want in 20 years. Make decisions that make the most sense for you and your family over the next two to three years.

Monica Diaz, vice president and chief diversity & inclusion officer, Health Care Service Corporation

When I worked in the pharmaceutical industry, my group made a presentation to the company’s new vice president, Patricia Barlow. During a break, she waved me over and said: “I was wondering if you would allow me to be your mentor?” I was speechless! It is sometimes challenging to find a mentor, let alone one with a great leadership reputation and career track.

Patricia and others taught me a lot about leadership and how I wanted to lead by: 1) Offering mentorship before I asked for it; 2) Showing interest in who I was (as a person) and what I could do (as a leader); and 3) Serving as a role model for integrity, an inquisitive mindset and wisdom. It’s not about telling others what they should do. It’s about modeling what that looks like.

Brian Evanko, president, U.S. Government Business, Cigna

My father. He didn’t work in the healthcare field, but he taught me a lot about leadership. When I was a boy, he used to tell me, “You may not be smarter than everyone else, but you can work harder, and you can be more prepared. If you work hard, focus on learning and improving yourself, you can do great things.”

His focus on hard work and preparedness has helped me deal with unexpected twists and turns. I read extensively and focus on understanding the “guts” of healthcare. That way, when there is an unexpected policy change from CMS, or adjustments to the ACA, or unanticipated competitor behavior, I’m able to quickly pivot my organization, versus becoming paralyzed with indecision.
Stephanie Fehr, executive vice president and chief human capital officer, UnitedHealthcare

One of my first managers early in my career helped me develop a sense of confidence and courage by giving me honest feedback and working with me to improve through new challenges and experiences. Giving feedback is something I strive to integrate into my own leadership practices. There are so few people who take the time and have the courage to give both positive and constructive feedback. I’ve always been fascinated by how fear drives so much of our behavior in life and work. Strive to understand what you’re afraid of and think through the reasons why. It always helps me to name it, and it puts everything in perspective, giving me the courage and clarity to approach things authentically.

Margaret Murray, CEO, Association For Community Affiliated Plans (ACAP), and MHE editorial advisor

I’ve drawn inspiration lately from the suffragette movement of the early 20th century and Alice Paul, who led that movement. She broke with the tradition of pushing for suffrage state by state and instead pushed for a constitutional amendment. Hers was one of the first great grassroots lobbying campaigns. It led to the passage of the 19th Amendment in 1920. Next year will mark 100 years that women will have been guaranteed the right to vote. Alice is a model. She creatively, tenaciously worked to secure the right to vote for all American women. And she showed persistence and grit in fighting for these rights against tremendous adversity and steep odds. When I lift my eyes from the daily grind of my work, I sometimes see her unwavering commitment to realizing her vision. Thinking about her work helps renew my vigor for our priorities here at ACAP.

Erhardt Preitauer, president and CEO, CareSource

I’m fortunate to say that I can’t pick just one mentor. I’ve had so many, personally and professionally, throughout my life who have been instrumental in developing who I am.

As I’ve gotten older, and presumably a little wiser, some of the old sayings seem to make more sense to me. One common theme I’ve taken from these mentors is to always do the right thing, for the right reason. The second part of that statement is most relevant. It really speaks to one’s values, which is foundational.

Hal Wolf, president and CEO, Healthcare Information and Management Systems Society

My father, Harold “Buzzy” Wolf Jr., was a great manager who taught me to surround myself with brilliant people and then get out of the way so they could do their jobs. Also, George Halvorson, past CEO of Kaiser Permanente, taught me that in healthcare, the need for clear mission alignment is greater than in any other industry. Strategies fail unless all are following the same path. I found myself in situations where a deadline was fast approaching, but several attempts at a solution weren’t seeing the progress we envisioned. It comes down to a very strategic choice: Continue to do what you’re doing, or “fail fast” and admit a new approach is needed. There is no weakness in asking for help. Leadership is so often driven by self-awareness, and success is driven by cultivating the talents around you.
MS Drugs in the Pipeline

by JENNIFER GERSHMAN, PHARMD, CPh

Multiple sclerosis (MS) is a chronic inflammatory condition that affects the central nervous system (CNS), and it can result in significant disability and death. According to the American Academy of Neurology (AAN), more than 2.3 million people are living with MS worldwide, and disease-modifying therapies (DMTs) are considered the mainstay of therapy to help to reduce the frequency and severity of relapses. However, these medications are also associated with adverse effects ranging from mild to life-threatening. Current phase 3 studies are investigating new ways and novel approaches to prevent MS relapses.

Healthcare executives are concerned about the cost, quality, and outcomes of MS drugs, making it a top priority for patient care and expenditures. According to a study published in Neurology, out-of-pocket monthly costs for MS medications increased from approximately $15 to about $309 over 12 years. According to the National Multiple Sclerosis Society, the average median price of MS DMTs in 2013 was less than $60,000 while the price in 2018 was $80,000. Patients with MS also face co-insurance that could be as high as 40%, which translates into a monthly cost of over $2,500 for their DMTs.

Legislation that makes MS medications more affordable is needed to alleviate patient costs. Healthcare professionals can play an important role through an interdisciplinary approach to managing patients with MS and identifying financial options such as patient assistance programs to alleviate costs.

Phase 3 MS drugs in the pipeline

Erin Lopata PharmD, MPH, senior director, Access Experience Team at Precision for Value, points out that Tecfidera (dimethyl fumarate) is approaching the end of its patent exclusivity, and there are several similar medications that are anticipated for FDA drug approval. Lopata adds that Vumerity (diroximel fumarate) is a prodrug for monomethyl fumarate, which is the active metabolite of Tecfidera and may cause less gastrointestinal adverse events.

Interim efficacy and safety results from the phase 3 EVOLVE-MS-1 study were recently presented at the AAN Annual meeting, which showed that after 48 weeks, relapse rates decreased by about 79% relative to baseline. Biogen has submitted the new drug application (NDA) and approval of Vumerity is expected sometime in 2019.

Banner Life Sciences has received tentative FDA approval for Bafiertam (monomethyl fumarate) for relapsing forms of MS. Lopata discussed that Bafiertam is the active metabolite of both Tecfidera and Vumerity, and its launch is anticipated for June 2020.Celgene has submitted its NDA for ozanimod for the treatment of adults with relapsing forms of MS. The FDA previously rejected the NDA based on insufficient data, but it is expected to receive approval based on the new submission on March 25, 2020. Data is based on the SUNBEAM and RADIANCE trials, which demonstrated that ozanimod was effective at preventing MS relapses.

Ozanimod is an oral sphingosine 1-phosphate (S1P) receptor modulator. “With a mechanism of action similar to the recently approved Mayzent (siponimod) and an optimal pharmacokinetic profile, ozanimod hopes to demonstrate an improved safety profile to Gilenya (fingolimod),” says Lopata. Ozanimod has only been studied in relapsing forms of MS; however, Mayzent is FDA approved for both relapsing and secondary progressive populations.

“With the success of Ocrevus (ocrelizumab) for MS, additional CD20-directed monoclonal antibodies are likely to follow,” says Lopata.

Another candidate on the horizon is ublituximab (TG-1101), which is being studied by the biopharmaceutical company TG Therapeutics. Ublituximab is a monoclonal antibody that targets the CD20 antigen, and anti-CD20 antibodies have been shown effective in treating various conditions including MS.

The company recently announced phase 2 data at the AAN annual meeting showing that the drug is well tolerated. Phase 3 trials known as Ultimate 1 (NCT03277261) and Ultimate 2 (NCT03277248) are currently being conducted to assess the safety and efficacy in patients with relapsing MS.

Jennifer Gershman, PharmD, CPh is a pharmacist and medical writer residing in South Florida.
Hospital executives face a myriad of challenges in today’s ever-changing healthcare landscape. Managed Healthcare Executive asked some chief executives what their biggest challenge has been, and how they have worked to overcome it. Here’s what they had to say.

1. Navigating different payment models
   
   Robert C. Garrett, FACHE, CEO, Hackensack Meridian Health, Edison, New Jersey, has found navigating two different payment models to be a big challenge. “We’re moving from a volume-based environment to a value-based environment,” he says. “Our 17 hospitals need to remain solvent, so we are still reimbursed on a fee-for-service basis to a large extent. If I had to pick a definitive path—to either stay in fee-for-service or go into the value-based world—I would vote for going into the value-based world. That’s because all the incentives are aligned and physicians and hospitals are rewarded for achieving the best outcomes for the people we serve.”

   Garrett has found this to be the best strategy when looking to lower the overall cost of care delivery. “To keep the needle moving toward value, we are growing our accountable care organizations (ACOs),” he says, adding that the health system’s best performing ACO saved about $145 million over five years and is among the nation’s top performers. They are also investing in more patient-centered models like bundled payments, shared risk arrangements, and value-based purchasing.

2. Serving underserved communities
   
   Alex Hellinger, DPT, MBA, executive director, Lenox Health Greenwich Village, part of Northwell Health, New York, says his biggest challenge has been bringing healthcare back to a community that recently lost a major hospital.

   “When a hospital closes, the vast majority of health providers leave the area, ultimately creating a medical desert,” he says. “My team and I addressed the challenge by building a comprehensive medical network throughout downtown Manhattan in phases, initially opening Manhattan’s first free-standing emergency department and then gradually adding essential services including imaging, ambulatory surgery, orthopedic and rehabilitation programs, as well as primary and specialty care.”

   Hellinger had to step back and take a fresh look from a patient’s perspective at how healthcare should be delivered. “We fulfilled this objective by implementing services such as telehealth, and a personalized website for physician referrals and home-based healthcare programs,” he says. “The center has positioned itself as a vital community resource by partnering with longstanding neighborhood organizations and offering free public services, such as immunizations and health screenings.”

3. Staying strong despite being small
   
   Michael Maron, president and chief executive officer, Holy Name Medical Center, Teaneck, New Jersey, which has 351 inpatient beds, has found it challenging to provide patients with high-quality, affordable care in a transparent, cost-effective manner in light of its small size. “With individuals demanding to play a much more active role in choosing where and how they spend their healthcare dollars, we need to ensure that patients receive high-quality, patient-focused care,” Maron says. To provide this, Holy Name is moving away from a procedure-driven model toward a relationship-building model that is more patient-centric, focusing on individual needs. These include linguistic, dietary, cultural, religious, familial, financial needs, as well as personal and social considerations.

   Holy Name’s outreach programs and culturally-sensitive initiatives such as Asian Health Services, Familia Y Salud, and its faith-based services have become national models for addressing the diverse needs of various populations.

Karen Appold is a medical writer in Lehigh Valley, Pennsylvania.
Top 7 Qualities of the Ideal Executive Assistant

Skills go beyond administrative

BY MICHELE MEYER


When looking for an executive assistant, a healthcare exec lacks room—or time—for error. You need someone who’ll weed out extraneous information and callers—without alienating suitors.

So how do you hire the best?

“During job interviews, ask what they’re passionate about, career-wise and personally. Ask what changes they expect in the healthcare industry and what career setbacks they’ve had and how they coped,” says Paula J. Caproni, PhD, author of “The Science of Success.”

Caproni and other top recruiters and healthcare execs suggest seven traits needed in an executive assistant (EA):

1. Spidey senses—seeing the big picture and anticipating the future—while working without supervision.

Most likely, you’re slammed with meetings. Great EAs take initiative, spotting issues before they arise and making recommendations, says Steve Courter, MBA, former CEO and current lecturer in management at The University of Texas at Austin McCombs School of Business. Their good grasp of your business comes from learning from coworkers at all levels.

2. Pulling off the impossible.

Among their superhero powers, top assistants simply get it done. That requires resourcefulness, creativity, confidence, a vast and varied network, and true grit, says Caproni, also a lecturer at Michigan University’s Ross School of Business in Ann Arbor. “People return their calls.”

“During job interviews, ask what they’re passionate about, career-wise and personally. Ask what changes they expect in the healthcare industry and what career setbacks they’ve had and how they coped.”

—PAULA J. CAPRONI, PHD, AUTHOR

3. Operating (almost) at light speed, with the agility to change gears easily.

“Our world is very fast-paced, and what might have been important yesterday may not be vital today,” says Suzanne Speak, SHRM-SCP, a Houston-based senior HR executive. “You need a multitasker who stays calm under pressure, no matter the deadline or complexity of the task.”

4. Having the people skills to handle big egos and disgruntled customers deftly.

Former Aetna exec Paul Martino, now chief strategy officer and co-founder of VillageMD in Chicago, took a leap in choosing Tina Ciesielski, then general manager at an Elmhurst, Illinois, restaurant. “I was struck how customer-focused she was. That mattered more than if she was an Excel jockey.”

When colleagues resisted hiring someone outside the healthcare industry, he gave her a tall task to accomplish before final approval: find office space for their fledgling firm. “She not only returned with a Power Point presentation of her top three choices, but she’d pre-negotiated leases, and recommended one—close to a metro stop, something I hadn’t even considered.”

Since promoted to office manager, she greets anybody who rings the doorbell, Martino says. “No matter what I request, she knows someone who can deliver it.”
In the healthcare industry, above all, your assistant needs to be able to discuss complex concepts with colleagues while simplifying medicalese for customers, he says.

5 **Willingness to learn, grow, and doggedly pursue knowledge.**
Look for someone who demonstrates that hard work, not just innate talent, drives their career.

"You need a multitasker who stays calm under pressure, no matter the deadline or complexity of the task."

— SUZANNE SPEAK, SHRM-SCP, A HOUSTON-BASED SENIOR HR EXECUTIVE

Speak recognized curiosity and an eagerness to learn in the EA she hired four years ago. “That mattered more to me than a background in healthcare,” she says.

In the four years since, she’s taken the initiative to learn the business and become a Certified Administrative Professional (CAP) on her own time.

6 **Keeping a secret.**
Discretion and trust are vital in the healthcare setting, says Dan Ryan, a Fellow of the American College of Healthcare Executives (FACHE) and president and CEO of Ryan Search in Franklin, Tennessee. “You don’t want to risk competitors learning your unannounced plans.”

A trusted liaison also knows your weaknesses and fills those gaps—while keeping them confidential.

7 **Fitting in among C Level execs.**
EAs need to excel at written, verbal, and nonverbal communication, including how they present themselves, make eye contact, and address others, Ryan says. “They cannot make mistakes, grammatical errors, or anything else that reflects negatively on the organization.”

And when they do err, the right hire informs you promptly and in full.

Michele Meyer is a freelance writer from Houston.
Each year there are more than 17,000 deaths nationally from prescription opioid overdoses, according to the CDC. The National Safety Council reports that 75% of U.S. employers say their workplace has been directly affected by opioid usage—but only 17% feel well prepared to deal with the issue.

In response to the local and national ongoing opioid epidemic, First Choice Health (FCH), a provider-owned health benefits company, which serves over 1 million people in Washington and the Northwest, wanted to do its part to help.

Launched on July 11, 2019, FCH’s Workforce Prescription Opioid Use Report is offered free of charge to employers in the Puget Sound area with over 200 employees until Sept 15, 2019. The report will help identify high rates of opioid use, which can be associated with potential misuse and addiction among employees.

Once initiated, the employer will instruct their pharmacy benefits manager (PBM) to send their pharmacy claims to FCH to be analyzed. This extracted information will be de-identified with no personal health information and is completely HIPAA-compliant.

The program is a follow up to its recently-launched program tackling opioid abuse in the workplace.

“We are constantly innovating our application of data to help create healthier workforces, while responding to our society’s most serious health concerns,” says John W. Robinson, MD, chief medical officer, FCH. “Opioids are at the top of that list. We are implementing this workforce prescription opioid use report as a community service to help employers recognize if they have an opioid problem in their workforce.”

Robinson is a member of the Dr. Robert Bree Collaborative, which was established so that public and private healthcare stakeholders would have the opportunity to identify specific ways to improve healthcare quality, outcomes, and affordability in Washington State.

In 2017, the Bree Collaborative produced the Opioid Prescribing Metrics. This screening report uses four of the nine opioid prescribing metrics developed by the Bree Collaborative, a workgroup convened in 2017 to help implement opioid guidelines and standardize comparisons between populations to help implement opioid guidelines and standardize comparisons between populations.

Actuarial consulting firm Milliman participated in this project by verifying the analytic code used to compute the results for the report. (The report results will be strictly workforce aggregate, and there will not be any individual employee results.)

**Metric 1:** Percentage of patients prescribed any opioid by age group

**Metric 2:** Percentage of patients prescribed chronic opioids (60 days of opioids in one quarter)

**Metric 3:** Percentage of patients prescribed chronic opioids and sedatives together

**Metric 4:** Percentage of new member’s day supply of first opioid prescription which are greater than 14 days

FCH’s previously-announced Case Management program tackle-
The Impact of Preoperative Opioid Use on Patient Outcomes

A new study looked at the effects of front-end opioid prescribing for patients in need of knee, hip, or shoulder joint replacement, and it builds a growing evidence base that shows better patient outcomes and lower payer cost when opioids are tapered prior to surgery.

“Despite the many risks of opioid use, about 40% of patients in need of knee, hip, or shoulder joint replacement are commonly prescribed opioids prior to surgery,” says Elizabeth Ann Stringer, chief science and clinical officer, axialHealthcare. “This is problematic because studies have shown that preoperative opioid use is associated with higher health plan costs, worse outcomes, higher opioid use requirements during the surgical hospital stay, and a lower likelihood of discontinuing opioids after surgery when compared with no preoperative opioid use.”

The study, published in Pain Medicine Journal, of nearly 35,000 patients analyzed the effects of opioid use on outcomes during the surgical hospital stay and for up to 18 months following surgery for privately insured patients undergoing knee, hip, or shoulder replacement.

Conducted by researchers at Vanderbilt University Medical Center, Brigham and Women’s Hospital, and axialHealthcare, the study found that preoperative opioid users had:

- longer length of stay
- increased unplanned readmission
- higher surgical site infection
- increased revision rates
- higher spend
- persistent opioid use, which worsened with dose

For more, go to bit.ly/PreopOpioid

This model is applicable to any health plan or TPA, according to Robinson. To conduct this four-measure screening report on workforce prescription opioid use, FCH needs the health plan/TPA to provide a signed Data Use Agreement and the PBM to provide the de-identified pharmacy claims extract with just seven claim fields.

While this is a program for the Seattle region, it’s a unique initiative that could provide a blueprint for other health care organizations aiming to tackle this problem throughout the country, according to Robinson.

“Depending on the response from the community, this program could be rolled out to other communities and other states,” he says.
Providers are assuming more risks

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<td>Executives</td>
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<td>Through commercial payer contracting models</td>
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Source: Navigant

What do healthcare leaders think of Trump’s transparency executive order on a scale of 1–6?

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From the issue:

“We really like the impact that we can have by following patients out of the four walls of the hospital and allowing for the data streams to continue to follow them.”

— Brian Roberts, CEO, PipelineRx. Read more from our Special Report on page 21

Source: Reaction data

AVOIDABLE EMERGENCY DEPARTMENT VISITS

27 million out of 18 million annual emergency department visits are avoidable

Source: UnitedHealth Group

THE BOTTOM LINE
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