THE FUTURE OF HEALTHCARE LEADERSHIP

Oncology
Treatment developments

Technology
Optimize predictive analytics

Population Health
Reduce hospital readmissions

Pharmacy/Formulary
Drug shortages impact formularies

FDA Pipeline
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Change is inevitable. None more evident than change in leadership. We have all experienced changes in leadership either within the organizations we serve in or personally, if we have had the privilege of serving in a leadership position.

Whether change involves a merger, acquisition, or reorganization, healthcare leaders must constantly evaluate the circumstances of the changes they face so that they can effectively make the right decisions. It is imperative that leaders determine how they respond so that they can help their organizations prepare, manage, and navigate the sometimes violent turbulence of organizational disruption.

With M&A showing no signs of slowing, it can be a difficult transition when organizations with different organizational cultures combine. This may be especially true since experts say healthcare mergers are increasingly driven by strategic alignment rather than cultural fit. One to watch is the recent CVS Healthcare and Aetna merger. Only time will tell whether the $69 billion acquisition/merger will change the healthcare landscape culturally and dynamically.

Not only is change inevitable, its frequency and speed are at unprecedented levels, causing organizations to reexamine strategic direction including leadership. In many cases, boards of directors are opting to make changes at the top prior to embarking on major organizational changes that drive transformation. This is especially true in the transition from fee-for-service to risk/population health. These two business models are very different and require vastly different management skills. Many hospital-based systems will try to make this transition under the same leadership, but will learn that it won’t work over time.

The principle drivers of change that will have its greatest impact on leadership will be the convergence of value-based care and digitalization. For organizations to achieve their value-based care initiatives, they will have to aggressively transition to implement digital strategies. This means letting go of old established processes and embracing some of the newly emerging technologies: Telehealth, artificial intelligence (AI)-enabled devices, robotics, and blockchain to name a few that will have a dramatic impact on the delivery of healthcare.

I believe change will occur in rapid succession decomposing old established organizational structures and the emergence of new healthcare delivery models that enhance efficiency. Along with these changes, new types of leaders will have to emerge possessing more technical, analytical, and collaborative skills.

So, what should managed care executives do as the changing face of leadership continues to proliferate? I believe boards and senior leadership ought to consider the following before jumping headlong into making a change in leadership:

- **Clear vision of the change**
  Expectations are discussed and agreed upon by the Board of Directors based on clearly stated goals and desired outcomes.

- **Careful planning**
  Establish a steering committee to coordinate the planning activities including the selection of a search firm and recruiter to conduct the search.

- **Communicate effectively**
  Design a communication process that acknowledges the change and be prepared to communicate at the appropriate time to employees and constituents the reason for the change; ensure the staff understands the vision for the future and their role within the organization.

- **Commitment throughout**
  Once the new leader has been selected, take every opportunity to show commitment throughout to the new leader and the new direction.

Finally, organizations should only make leadership changes with the intention of improving results related to financial, cultural, or strategic direction. Before making the move, consider nearly 40% of new chief executives fail outright within the first 18 months on the job, and even more of them fail to live up to original expectations.

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**Darnell Dent** is principal of Dent Advisory Services, LLC, a management consulting practice focused on helping leadership improve organizational effectiveness and overall performance. He is a former president and chief executive officer of a managed care organization. He is a member of the Managed Healthcare Executive Editorial Board.
The introduction of the CMS Hospital Readmissions Reduction Program (HRRP) in October 2012 thrust readmission reduction into the mind of every health executive.

Defining readmissions
Readmissions are defined by CMS as an admission to a participating hospital within 30 days of a discharge from the same or another hospital. CMS tracks these six conditions and procedures as part of HRRP:

- Heart Failure (HF)
- Acute Myocardial Infarction (AMI)
- Coronary Artery Bypass Graft (CABG) Surgery
- Chronic Obstructive Pulmonary Disease (COPD)
- Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty (THA/TKA)
- Pneumonia

Each of these conditions is vital for healthcare organizations to measure—falling behind on only one can still result in penalties.

How readmissions penalties are calculated
For FY 2020, CMS will be examining hospital data based on hospitals’ performances during a three-year period from July 1, 2015 through June 30, 2018.

The payment adjustment factor (PAF) is the reduction applied to CMS payments. It is calculated using an excess readmission ratio (ERR), which CMS calculates by looking at a hospital’s expected readmission rate (based on other similar hospitals) and comparing it to a hospital’s actual readmission rate.

Hospitals that perform better than average will have an ERR of less than 1.0 (and are not penalized), while hospitals performing worse than average will have an ERR of greater than 1.0 (and are penalized). The PAF is generated using ERR and a complicated formula. The minimum PAF is 0.97 (which would account for a 3% penalty, the maximum penalty allowed).

Payment reductions are calculated by subtracting the PAF from 1.0 and multiplying by 100. So for example, a hospital with a PAF of 0.975 would have a payment reduction of 2.5%: 1.0 - 0.9750 = 0.9750 x 100 = 2.5% reduction.

Since the program began, CMS has dished out $2.5 billion in penalties, with an estimated $564 million in fiscal year 2018 alone, up from the $528 million in 2017. Even though there are signs that readmission rates in a variety of condition types are improving, of the 3,241 hospitals evaluated for readmissions between October 2017 and September 2018, 2,573 (80%) were penalized.

The maximum penalty for hospitals is 3%. However, very few hospitals have penalties this high levied against them—in FY 2017, just 1.8% of hospitals paid the highest penalties.

In this special three-part series, Managed Healthcare Executive will be bringing you the ultimate guide on reducing readmissions for each of the six conditions CMS tracks. This first part will take an in-depth look at how hospitals can prevent heart-failure readmissions.
Causes of heart failure readmission

The reasons for readmission are multifactorial and it is difficult to predict individual causes for readmission.

Catherine J. Ryan, PhD, clinical associate professor, college of nursing, University of Illinois at Chicago Department of Biobehavioral Health Science, Chicago, says one way that readmissions have been categorized is simply as preventable or unpreventable. Others have categorized reasons for readmission as clinical, behavioral, and patient-centric, recognizing that the responsibility of readmission may reside with the patient, provider, hospital system, or any combination thereof.

“Heart failure readmissions have been associated with a variety of factors or characteristics,” she says, adding that the most common include advanced age, history of renal disease, history of diabetes, or a heart failure admission within the past year. Other factors include admission to a teaching hospital, discharge against medical advice or discharge to home, receiving Medicaid, and being of African American ancestry.

A study by the Harvard School of Public Health (HSPH) found that elderly black patients were more likely to be readmitted to the hospital after a prior hospital stay for heart failure due to disparities related to both race and the hospitals where patients were treated.

Another study, "The Prevention of Hospital Readmissions in Heart Failure" by the David Geffen School of Medicine at UCLA, Los Angeles, showed that among readmitted Medicare patients with HF, the five most common primary diagnoses—HF, renal disorders, pneumonia, arrhythmias, and sepsis—account for 56% of the readmissions with no other diagnoses accounting for more than 5%.

“Readmission potentially reflects a failure of the discharge process; thus, discharge planning should start at the time of admission,” says Karen M. Vuckovic, PhD, advanced practice registered nurse, division of cardiology, University of Illinois Hospital & Health Sciences System, Chicago. “Health-related quality of life, or an individual’s perceived physical and mental health over time, predicts readmissions in patients with heart failure.”

Reimbursement trends

“For the past several years, there has been a heightened national focus on reducing readmissions and thus identifying patients with the highest risk for readmission,” Ryan says. “Although there have been reductions, readmission rates remain high.”

In the skilled nursing market, Zachary Palace, MD, medical director of RiverSpring Health Hebrew Home at Riverdale in Bronx, New York, says the shift to patient-driven payment model (PDPM) provides facilities with higher reimbursement for more complex Medicare Part A patients, explaining the amount of care needed correlates more directly to the reimbursement received.

The ACA authorized the federal government to penalize hospitals for poor readmission rates for Medicare patients with heart failure, and this has caused many to rethink their strategies.

Managing heart failure risk factors: Successful strategies

David Majure, MD, medical director, mechanical circulatory support program, Sandra Atlas Bass Heart Hospital at North Shore Long Island Jewish Health System, New Hyde Park, New York, notes that patients with heart failure have a high readmission rate due to a number of factors, including the fact that patients with heart failure have a low health-related quality of life and a high risk of illness-related complications. Most patients with heart failure are 65 years old or older and have multiple comorbidities. A study by Vuckovic and colleagues, published in the *Journal of Cardiac Failure*, showed that patients with multiple admissions to the hospital for heart failure were more likely to die within 1 year of discharge than patients with a single admission.

“Readmission potentially reflects a failure of the discharge process; thus, discharge planning should start at the time of admission.”

—KAREN M. VUCKOVIC, PHD, UNIVERSITY OF ILLINOIS HOSPITAL & HEALTH SCIENCES SYSTEM

Part 1 of 6

Reduce heart failure readmissions

“Readmission potentially reflects a failure of the discharge process; thus, discharge planning should start at the time of admission.”

—KAREN M. VUCKOVIC, PHD, UNIVERSITY OF ILLINOIS HOSPITAL & HEALTH SCIENCES SYSTEM
University Hospital in Manhasset, New York, says reducing readmissions is about a strong system approach and doing good heart failure care.

At his hospital, a group known as Health Solutions targets patients subject to the Heart Failure HRRP umbrella and efforts are made to connect with them at home.

The way it works, he explains, involves calling the patients at home and ensuring they have adequate resources at home and following up appropriately. By doing this, it helps reduce readmissions and the hospital’s decreasing numbers have shown it’s a success.

“If they become readmitted, they help them identify factors to help minimize their readmission,” Majure says.

The American Heart Association’s Get With The Guidelines—Heart Failure program is a hospital-based quality improvement program that provides assistance for providers to maintain current practice guidelines.

The guidelines note that scheduling an early follow-up visit (within seven to 14 days) and early telephone follow-up (within three days) of hospital discharge are reasonable. In response to this recommendation, most HF programs include a discharge follow-up phone call—though data in response to this recommendation is mixed. Therefore, Vuckovic says each program needs to evaluate what works for their population.

“Studies which have included follow-up phone calls usually include other interventions,” she says. “There is a handout for TARGET-HF which guides the process and scripts the call.”

For example, a clinician-initiated discharge phone call is a simple and cost-effective method that allows clinicians to connect to the patients after their hospital discharge to check on their well-being, review or reinforce discharge instructions, and address issues that may potentially lead to adverse outcomes.

“Dealing with heart failure patient’s basic needs is essential in helping them manage their disease,” Vuckovic says. “For example, one inner-city teaching hospital recognized that providing housing for those who are homeless during the transition phase led to patients being more likely to attend follow-up appointments.”
Hebrew Home utilizes the AMDA’s (The Society for Post-Acute and Long-Term Care Medicine) Heart Failure Clinical Practice Guide as its protocol for treating CHF patients. Palace explains the guidelines are in a small handbook, easy to read, and provide clinicians with key points to identify heart failure, assess it, and treat and monitor achievements. This keeps everyone on the same page with best practices and ensuring they are practicing the most current medicine.

“We also have full-time physicians on staff and provide comprehensive training to all of our clinical teams on what to look for and what steps to take,” he says. “Through these efforts, we are able to manage the majority of patients in our facility and thus have a low number of readmissions.”

Anecdotally, he shares families often talk about how their mom or dad would end up in ER every few weeks with heart failure when at different facilities, but since coming to Hebrew House, they haven’t gone out at all. It’s a credit, Palace says, to managing these patients in-house.

Hebrew Home has also invested in technology, such as contact-free continuous vital sign monitoring, to help it identify patients at risk for CHF exacerbation. This is a trend that others are following and Palace says it’s important because it acts as the eyes and ears when the nurse is not in the room, which is a large part of the time.

“In CHF patients, a key risk to look for is an increase in fluids. Fluid builds up and when patients lie down, this fluid moves from their legs and collects in their lungs. An indicator we look for is shortness of breath,” Palace says. “We also monitor weight, a quick increase in weight is another way to monitor for fluid retention. We are also seeing a lot of new technology coming to the market specifically designed to help identify changes.”

The facility has also embraced the ReDS Vest, a recently-approved technology. The technology is a vest a nurse applies to a patient which has a built-in sensor that reads across the chest from front to back and can quantify total lung water volume. That is also significant in helping to identify heart failure patients.

Hospitals successful at reducing readmissions that were enrolled in the American College of Cardiology’s Hospital to Home initiative, a resource for hospitals and cardiovascular care providers committed to improving transitions from hospital to home and reduce their risk of federal penalties associated with high readmission rates, created a summary of 10 key practices. Of the 10 practices, three centered on medication management.

“Education about the purposes of each medication, changes in doses/frequency, which to stop, which are new, and how to take them correctly were identified as essential to self-management. Medication reconciliation is essential,” Vuckovic says.

Palace says medication compliance is much easier to manage in a skilled nursing facility where physicians are keeping a close eye, and the clinical staff is helping to ensure adherence.

Vuckovic says that culturally appropriate multidisciplinary discharge planning and education has been shown to facilitate compliance and decrease readmissions. Research has shown that self-care (e.g., diet, medication, and symptom management) is largely insufficient in ethnic minority populations, indicating an area where more emphasis is needed—especially as self-care can be a major component of reducing readmissions.

“We need to shift our approach from hospital care to providing self-care at home since the majority of the patients’ care takes place in the home, not the hospital,” she says. “Providers should seize every opportunity to reinforce self-care principles and education.”

Nicholas Hamm is an editor with Managed Healthcare Executive.

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

“We are also seeing a lot of new technology coming to the market specifically designed to help identify changes.”

— ZACHARY PALACE, MD, RIVERSPRING HEALTH HEBREW HOME
Clinical researchers are making great strides in cancer treatment. Here’s a look at some top treatment developments for cancers that plague men and women specifically, along with a new treatment for prostate cancer.

**BREAST CANCER**

Novel treatments that limit radiation exposure are now being used to treat breast cancer. Stage 0 breast cancer, the earliest form of breast cancer that can be detected, is called ductal carcinoma in situ because it hasn’t yet found a way to leave the ducts in the breast and become invasive. Approximately 50,000 women are diagnosed with this type of cancer annually.

Roshni Rao, MD, FACS, chief of breast surgery, New York Presbyterian/Columbia University Medical Center, New York, is currently enrolling patients in a study for intra-operative radiation after lumpectomy. The procedure involves removing cancer surgically with a lumpectomy, and then targeting a single high dose of radiation to the affected area. After closing the incision, the patient is finished with their cancer treatment.

"Patients get the benefit of having everything done at one time, and minimizing the side effects from radiation of the entire breast," she says. In comparison, patients who undergo traditional radiation must have treatments daily for three to six weeks that involve the entire breast.

The survival from stage 0 breast cancer is close to 99% with traditional radiation. But if you only remove the tumor with surgery, recurrence can be as high as 20%. With targeted intraoperative radiation, early results show recurrence rates less than 5%.

Proton therapy is an advanced form of radiation treatment that reduces radiation exposure to normal, healthy organs. Conventional radiation treatment uses photons, proton therapy uses protons—positively charged sub-atomic particles.

The main difference between these two treatments is their delivery, says Henry K. Tsai, MD, radiation oncologist, ProCure Proton Therapy Center, an outpatient facility in Somerset, New Jersey. Protons deliver their radiation at exact depths to precisely target tumors, whereas standard X-ray radiation releases radiation from the moment it penetrates the skin to the other side of the tumor and exits the body. With proton therapy, most radiation is deposited exactly at the tumor site and stops, thereby reducing radiation exposure to surrounding normal, healthy tissue and organs.

Proton therapy is particularly beneficial in treating left-sided breast cancer because of the target’s proximity to the heart and lungs. Studies have shown that patients with
left-sided breast cancer may be more likely than patients with right-sided breast cancer to develop heart disease or other complications after receiving traditional radiation.

Because protons deposit their energy directly into the tumor and not the tissue behind it, patients have less risk of unnecessary radiation exposure to the heart, lungs, and healthy tissues. “Less radiation to these areas may lower the risk of developing heart disease, lung disease, and secondary tumors decades after radiation treatment,” Tsai says.

**CERVICAL CANCER**

For women with advanced cervical cancer, the FDA approved pembrolizumab, a type of immunotherapy for treatment after chemotherapy has stopped working, in June 2018. It is limited to women with tumors that have a marker—PD-L1—indicating an increased chance it will help. About 35% of women with advanced cervical cancer are eligible for this treatment, says Don S. Dizon, MD, FACP, FASCO, professor of medicine, Brown University; director of women’s cancers, Lifespan Cancer Institute; and director of medical oncology at Rhode Island Hospital; all located in Providence, Rhode Island.

Although the immune system typically fights foreign agents like bacteria, for some reason it doesn’t destroy cancer cells. One of the ways that cancer cells escape the body’s immune system is through immune checkpoints, breaks against the immune system that recognize and destroy cancer cells, says Dizon, who is also the section editor for *Gynecologic Oncology* for UpToDate from Wolters Kluwer. Pembrolizumab, a checkpoint inhibitor, blocks these breaks and allows the immune system to kill cancer cells.

Data from a trial of 98 women who had progressive cervical cancer after chemotherapy presented at the 2018 American Society of Clinical Oncology meeting showed an overall response rate of 12% with pembrolizumab. This increased 15% if women had PD-L1 positive cancer. Overall, one in four women’s cancer didn’t progress. “While these results were encouraging, it points out how much work we have yet to do to help women living with advanced or metastatic cervical cancer,” Dizon says.
In October 2018, the FDA expanded the approved use of the Gardasil 9 HPV vaccine to men and women ages 27 to 45, which was previously approved up to age 26 and has successfully reduced disease associated with human papillomavirus, such as cervical cancer.

OVARIAN CANCER

The initial treatment recommended for most women with ovarian cancer is surgery to remove all visible disease, followed by chemotherapy and radiation. Completely removing all visible cancer is associated with improvements in patient survival.

On Target Laboratories, in West Lafayette, Indiana, is developing a tumor-targeted molecule (OTL38) that allows a surgeon, with the use of a near-infrared camera, to see in real time hard-to-detect cancerous tissue that might otherwise go undiscovered during surgery. “By illuminating cancers, surgeons are better equipped to identify and remove more visible disease for more patients,” says Martin Low, MBA, chief executive officer, On Target Laboratories. “Furthermore, OTL38 is simply administered via IV during the pre-operative phase of the procedure. If the FDA approves it, it will be the first and only intraoperative ovarian cancer-targeted imaging molecule in the United States.”

OTL38 works by linking a tumor-targeting molecule with a fluorescent dye. This molecule selectively binds and is taken into cancer cells, illuminating them in contrast to the surrounding tissue. This enables surgeons to clearly identify and distinguish cancer from healthy tissue. “Because OTL38 functions at a cellular level, even extremely small cancerous lesions may be identified under near-infrared light,” Low says. “Furthermore, the near-infrared characteristics may also enable surgeons to detect cancerous tissue obscured below the surface of healthy tissue.”

Clinical studies exploring the benefits of OTL38 are ongoing. Results from an early development program were very promising and indicate that OTL38 contributes to more removal of cancer tissue during surgery that was not identified visually or tactiley. The phase 1 study demonstrated that OTL38 enabled surgeons to resect an additional 29% of malignant lesions. On Target Laboratories is currently confirming these results in a phase 3 clinical study.

PROSTATE CANCER

In 2018, personalized medicine took on a new meaning in the treatment of prostate cancer patients. The approach includes performing genetic testing on men with prostate cancer to look for genetic abnormalities. “We look for something they inherited, known as a germline defect, or something they acquired, known as a somatic defect,” says Nancy Dawson, MD, professor of medicine and oncology, and director of the Genitourinary Medical Oncology Program, Georgetown Lombardi Comprehensive Cancer Center, Washington, D.C., who notes that several novel therapies show great promise for treating prostate cancer. “We look for a genetic abnormality that we can target.” Having a genetic abnormality called microsatellite instability, seen in 3% to 5% of men with prostate cancer, can predict which new immunotherapies may be effective. It can help approximately 50% of men with the abnormality.

Also in 2018, two hormonal drugs—enzalutamide (Xtandi, Pfizer) and apalutamide (Erleada, Janssen)—were approved to treat non-metastatic, castration resistant prostate cancer. They delay the time it takes for prostate cancer to spread to other areas of the body. A third drug, darolutamide (Nubeqa, Bayer) appears to be just as effective with much less toxicity, was recently approved by the FDA in late July. All three are oral drugs that block androgens—hormones that play a role in male traits and reproductive activity. “Compared to a placebo, patients using these three drugs had a longer timeframe of approximately two years before they developed metastatic cancer that spread to the bones and other organs,” Dawson says.

Finally, anti-prostate-specific membrane antigen (PSMA) therapy, which is currently in clinical trials, shows great promise. Most prostate cancers produce prostate-specific antigens (PSA) and PSMAs. The treatment works intravenously, by using an anti-PSMA antibody that allows physicians to target anything in the body that makes PSMA. The antibody is delivered with small doses of radiation to wherever cancer is located. Although it doesn’t cure prostate cancer, patients are seeing positive effects from it such as decreasing the PSA, making the cancer shrink, and making pain improve or resolve.

Karen Appold is a medical writer in Lehigh Valley, Pennsylvania.
Healthcare organizations can have every good intention of improving patient care, operations, or employee safety and satisfaction, but without an effective strategy to communicate plans, those efforts can fall flat.

Communication really is the cornerstone of healthcare. Physicians interview patients, and patients describe symptoms. Clinicians must communicate with larger healthcare networks about their patients, as well as with payers. When any one of these communication systems fails, quality of care and outcomes suffer, according to the Institute for Healthcare Communication.

There is no single way to improve communication—it’s a multi-pronged approach.

Here is advice from industry experts on how to advance your communication strategies at every level.

1 **Communication is a team approach.**
If one thing is certain across all aspects of communication, it’s that it’s never a one-person show. Communication should always be a team effort, and involving clinicians is also key, says Jay R. Anders, MD, chief medical officer at Medicomp Systems, a physician-driven provider of clinically contextual patient data solutions, in Washington, D.C.

“Always involve healthcare providers in making any decision that impacts their work flow or patient care,” Anders says. “They are the experts, and they usually know what works best for them—and their patients.”

Eliciting input from a large group of clinicians can be a challenge, but gathering data from focused groups can help.

“Setting up a provider advisory board is one great way to receive feedback. Make sure to recruit providers from various specialties and make it easy to participate. Offering online and in-person communication methods will be critical to success,” Anders says.

“Lastly, remember that patient care comes first, followed closely by everything else. This will and should always be a physician’s main focus.”

2 **Make communication second nature.**
The most effective way to make communication work is to make it a regular and organized part of the healthcare process.
“As all healthcare executives know, a provider’s time is valuable. So the more specific your questions are, the better organized you are, the greater likelihood that you will receive the input you need,” Anders says of communicating with clinicians. “There’s nothing more frustrating to an already overburdened physician than being bombarded with half-baked questions in a disorganized meeting where they feel like they’ve wasted their time.”

If communication happens often enough and in the right way, it becomes second-nature and more effective, he adds.

“Communication in healthcare should always be recursive and frequent, to eliminate any miscommunication and to ensure understanding on both sides,” says Anders.

3 Refine the message.
Along these same lines, Kevin Riley, senior vice president of health at Vlocity, a developer of industry-specific cloud and mobile software in San Francisco, says it’s important to consolidate and refine communications to make the important discussions stand out.

“There’s too many outbound messages. It’s really hard to read,” says Riley, speaking from the health insurer point of view.

“Everyone is sending the provider everything. The provider knows their job. Let’s take it from the angle that if they know their job, let them do their job.”

Rather than contacting physicians frequently or making them request often-used forms or orders, simplify the process and create a database that allows the physician to simply and intuitively find what they already know they need, Riley suggests. A provider doesn’t need to be told that they need to check eligibility, for example, they just need a simple way to do it.

“The best thing the health plan can do is to make a really simple, crisp, clean way for the provider to come in and get their job done,” Riley says. “Historically, provider portals are like government websites—it overwhelms you very quickly.”

Ideally, providers should have a space where all the resources they need are accessible in an intuitive database that allows them to search for what they need quickly and efficiently, he adds.

4 Don’t reinvent the wheel.
When it comes to creating systems that are easy to navigate and intuitive, Riley says it’s important to remember that there’s no need to reinvent the wheel.

“Don’t expect someone to learn your navigation. Google has set the standard for navigation,” Riley says. “A big white screen with one big box and one big button. Why are we trying to reinvent it?”

Health insurers often think about selling to consumers, and don’t think often enough about treating providers as customers, he says.

“We need to start improving the way we treat our providers and create a frictionless environment,” he says. “It’s not about new technology, it about improving the way you communicate right now.”

Health systems and payers should utilize existing technology from the consumer space and tailor it to their own needs. Emulate Google, Riley says, because it set the paradigm for how to communicate with a consumer. Secondly, it’s important that the healthcare industry—specifically payers—start treating providers more like consumers, Riley adds.

5 Serve what the customer is asking for—before they ask for it.
When it comes to communicating, it’s very possible—and common—to have too much of a good thing. The key to avoiding saturating your audience, Riley says, is to make communication more intuitive. The technology is there now, he adds. Study user patterns of data entry and click paths. After a certain amount of input, technology allows systems to guess what the user is trying to do and send them the information they are looking for.

“People would buy into that. I like to get information I care about when I signed up for it,” Riley says. “If you create a shopping experience like Google, you can

“Always involve healthcare providers in making any decision that impacts their work flow or patient care.”

—JAY R. ANDERS, MD, MEDICOMP SYSTEMS
recognize patterns and set something in front of them."

Artificial intelligence is making this possible, Riley says, using simple algorithms based on the next step the user is expected to take.

"It's about having a valued exchange on your own terms," he says.

### Better technology equals better care coordination.

The benefits of technology are many, but they certainly have not been used to their full potential in healthcare. In a world where artificial intelligence can predict next steps, Aswini M. Zenooz, MD, chief medical officer and senior vice president and general manager for healthcare and life sciences at Salesforce, a cloud-based software company specializing in customer relations based in San Francisco, says it’s disappointing the progress that has been made with healthcare communication.

"I've been doing this for 20 years and things haven't improved that much in terms of communications," says Zenooz. "I think we moved from pagers to paging on cellphones."

Many times, clinicians find themselves running in circles to find the right provider to communicate with, then end up converging over messaging systems that are not HIPAA compliant, according to Zenooz, who oversaw the digital transformation at the Department of Veteran Affairs as chief medical officer.

"It ends up being really frustrating for any provider to communicate or have an effective way to coordinate care," she says. "Even in the best systems I’ve worked in, I’ve found that challenging."

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### Automate and use AI to improve outcomes.

One way to improve communication on the patient end is to eliminate the need for it. Technology now allows clinicians to automate instructions and education for patients.

"Say a patient is going to have shoulder surgery," Zenooz says. "It would be great for the provider to work with manufacturers or payers to automate a way to deliver information about appointment times, ways to communicate to the healthcare team, and other surgical instructions like stretches to perform or when to have no food or drink before surgery."

Patients who have a smartwatch can track their activity, sleep times, and other data and have it sent to their provider, she adds. This information could help providers see if a patient isn’t sleeping after surgery and maybe prompt them to address pain. An automated workflow using artificial intelligence could use data automatically sent to the provider from a patient device to launch an alert to the provider for intervention, Zenooz says. The information could also be used to generate a transcript of data that other providers could read, and even be redirected to billing.

"This brings all the folks into the conversation," Zenooz says. "This is life-altering for people."

### Bring providers and payers together.

Payer and provider communication has always been a difficult area in healthcare, but there is a lot of room to improve outcomes in this area, Zenooz says.

It is one of the areas where the lines are becoming grayer, and there is more information that can be shared for the benefit of patients. If payers and providers could share at least some data from electronic health records and payer claims with one another, it would provide a clearer overall picture of the patient.

"These are all fragmented areas of data," Zenooz says. "There are some types of areas that you can share information, and if we make it easier to share that information, especially with chronic disease, we could keep people out of hospitals and improve at-home care. It’s a win-win and I think technology could do this."

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Rachael Zimlich, RN, is a writer in Columbia Station, Ohio.
How healthcare is changing—and the new skills you need to thrive

by KEITH LORIA

As health disparities continue to impact access to care and health outcomes in the U.S., and patients are demanding quicker access to care, easier communication with their providers and higher quality outcomes, healthcare leaders are seeking innovative ways to narrow the gap.

"With the growth of consumerism in healthcare, consumers are demanding the same of their providers and plans that they do of any other brand they interact with," says Tom Wicka, CEO and co-founder of NovuHealth, Minneapolis. "They want to be treated like an individual, they want a personalized experience, and they want to be acknowledged for doing the right thing for their health."

Healthcare leaders need to recognize this, put consumers at the center of their business, and align internally around a comprehensive strategy to engage and serve them. And that's often meant a change in thinking from leadership and the need for new skills that can help them and their healthcare facilities better succeed.
Craig Samitt, MD, CEO of Blue Cross and Blue Shield (BCBS) of Minnesota, says over the past decade, the most successful healthcare executives have been the ones who have fiercely protected the status quo—a healthcare model which is progressively outdated, antiquated, and broken.

“The future of healthcare will require us to develop, nurture, and promote those that are inventive, collaborative, forward-looking, customer-oriented, and more value-based,” he says. “If healthcare doesn’t bring in leadership that will reinvent our industry from the inside out, disruptive innovators from other industries will reinvent it from the outside-in.”

Emad Rizk, president and CEO of Cotiviti, a leading analytics company in Atlanta, that helps payers improve programs affecting financial performance, says several trends are coming together to create a perfect storm of change, including rapid technological advancements, an aging population, skyrocketing costs and a provider shortage, to name just a few.

“Beyond a new level of technological savviness, today’s leaders need to be courageous, collaborative and committed—they must have the courage to take calculated risks, and they must collaborate with other departments in the organization and stakeholders across the healthcare continuum,” he says. “Commitment must be demonstrated beyond words and reflected in actions to employees, clients, patients and the entire organization.”

Adnan Iqbal, co-founder & CEO of Luma Health, a San Francisco-based healthcare communication company, notes a result in this shift is the emergence of new titles such as chief patient experience officers, chief data analytics officers, and chief population health officers—all looking to effectively guide patients along their healthcare journey with the goal of driving (and tracking) strong health outcomes.

“We’re also seeing more roles being filled by executives from outside of traditional healthcare, which is a positive step towards designing care that is nimble and responsive to new patient demand,” he says. “Hand-in-hand, patient experience roles are being elevated to new levels—all with the goal of meeting new patient and payer expectations.”

Mark Prather, MD, CEO and co-founder of DispatchHealth, which provides mobile and in-home health services, says 30% of employees are now in a high deductible plan so as consumers pay for an increasing percentage of their healthcare costs, they will rightfully demand an improved care model that delivers more value for them.

“Leaders who are design thinkers are more capable of building care models that align with the needs of this new healthcare consumer,” he says. “The leaders that I admire, and that I think will be successful, are creatives and collaborators. They understand data and how to use it and possess the clinical acumen necessary to design systems that drive value for the consumer.”

**TRENDS IMPACTING CHANGE**

The regulatory shifts brought on by the ACA and CMS’s focus on driving quality improvement via Star ratings have had a major impact on how the healthcare industry delivers care and is measured, and that has been a catalyst for some of the change happening in leadership. A more recent driver is the entry of Amazon and other retail giants that are redefining what care delivery looks like, raising the stakes for consumer expectations.

“Wicka notes there are several macro trends simultaneously impacting the healthcare industry today. The first is the ongoing shift from a fee-for-service system to value-based care. The second is the increasing importance of consumer satisfaction and retention, as plans and providers alike face tougher competition and more consolidation in the market.

“Finally, we’re seeing rapid growth of consumerism in healthcare, driven both at a macro level by the entry of large retailers like CVS and Walmart, and at an individual level as consumers demand more from their providers and plans,” he says. “These trends all underscore the importance of engaging consumers in a meaningful way.”

Today’s patient population is demanding more from healthcare and expects high-quality care delivered with convenience and ease of access.
“They want to be able to make appointments online, reschedule, ask questions, and communicate with the care team digitally,” Iqbal says. “They want to interact with the healthcare industry in the same way they interact with just about everything else—via a mobile device.”

Providers can no longer take for granted that patients will find or return to them. They have to be proactive about their outreach and make sure patients can reach them easily whether it’s via a text message, online platforms such as Google or Yelp, or a virtual visit.

“With the growth of retail clinics offering a new level of convenience for patients, executives in more traditional settings have to be responsive to patient demand in order to retain and grow their market share,” Iqbal says.

Samitt believes that the healthcare industry is no longer working for the customers it serves and that’s a market change that is greatly impacting what we’re seeing.

“From a service perspective, we’re complex, fragmented, bureaucratic, and not very customer oriented. From an accessibility perspective, we’re increasingly unaffordable and inconsistent in assuring that everyone has access to good care,” he says. “Given the glacial pace of change, it’s no wonder that more and more Fortune 500 companies are getting into the healthcare business—and that the likes of Haven, Google, Apple, Walmart, Best Buy, and others are making a bigger play in our industry.”

NEW SKILLS

Today’s executives have a particular challenge—they need to know how to position their clinics for success in the traditional, fee-for-service environment, while simultaneously preparing for value-based care.

“Providers have to optimize their capacity to meet a high level of patient demand, implement new services such as online scheduling, and elevate their online presence to attract and retain their patients,” Iqbal says. “But they also have to keep a watchful eye on quality and effectively guide patients along their healthcare journey.”

For example, are diabetic patients controlling their blood sugar levels appropriately? Are children getting their vaccines on time?

Iqbal adds that today’s healthcare executives have to implement new technology solutions and processes to keep innovating toward the move to new payment models, all while meeting patients where they are today.

Wicka believes that today’s leaders must possess clear communication skills to be successful.

“From payers to providers, healthcare organizations need to talk to members and patients like people, not policy numbers,” he says. “And the communications need to be personalized. What specifically do you want that consumer to do? Does he prefer email or SMS communication? Is she on track with her care plan, or is some motivation required? The language of consumer engagement is one that every healthcare executive today needs to learn.”

Adapting to these changes also requires making bold moves. The key is having a plan that connects each team’s work to the goal, so everyone understands their own role in the process and can see the path to achievement.

Christopher Logan, a healthcare industry strategist, says changes to patient care models, increased financial pressures, and significant swings in the industry’s workforce, have sparked a need for a new era of leadership. Gone are the days of looking at how healthcare operates from a single pane of glass, with the complexities of both internal, as well as external pressures, leaders need to learn to adopt new leadership principles and traits.

“Leadership skills are rapidly evolving and some of the attributes that are going to facilitate success in this new era are having the ability to dissect and implement new vision/strategy, a heightened concern for and deeper awareness of integrity, developing open lines of communication with the ability to collaborate beyond the walls of your institution, and finally be agile in your decision making,” he says.

Technological advancement is one of the main drivers of the need for a leaders’ changing skillset. Prather says it’s imperative for today’s executives to have at least a rudimentary understanding of data science and technology.

“We’re also seeing more roles being filled by executives from outside of traditional healthcare, which is a positive step toward designing care that is nimble and responsive to new patient demand.”

— ADNAN IQBAL, LUMA HEALTH
Artificial intelligence, machine learning and natural language processing (NLP) have all made their ways into the healthcare space sooner than anyone expected. Many organizations are now using machine learning across many disciplines throughout healthcare—such as combing through medical charts and extracting data using NLP—while payers are using AI to streamline claims intake and prevent fraudulent billing.

“[I think the most important skill is to be technology-aware],” Rizk says. “Leveraging interoperability within healthcare and new technologies such as machine learning, NLP, and AI in healthcare is critical at this junction of our evolution.”

Additionally, he says that to be a strong leader in today’s healthcare environment, one needs courage, collaboration on a broader scale, and commitment to employees and the organization like never before. An example of a leader with these traits is Bernard Tyson, CEO of Kaiser, who pledged to find housing for underserved people in his organization’s purview.

“He is taking on responsibility for things that health plans have never done before,” Rizk says. “He is re-examining his role, and that takes courage.”

He also sees some of the mergers occurring in healthcare right now as companies with leaders making courageous moves. For instance, UnitedHealth, led by CEO David Wichmann, decided to acquire DaVita Medical Group a couple years ago, expanding the health plan’s reach into the provider space. CVS President and CEO Larry Merlo has been a driving force in the company’s purchase of Aetna, which would give the combined entity unprecedented reach into the payer and pharmacy sphere.

“If leaders don’t keep up, or are afraid to make bold choices, they become irrelevant,” Rizk says. “Leaders need a lot of courage and they need to be comfortable taking a risk for something they believe in.”

LEADERS OF THE FUTURE
Healthcare executives of the future should adopt some of the skill sets that leaders in other high-performing industries have long used to assure sustainable success, Samitt says.

That includes strategic nimbleness, with the realization that healthcare needs to be reinvented, and the bravery to avoid becoming the next Kodak, Blockbuster, or Borders; collaborative intent, with a goal to achieve partnerships between doctors, hospitals, payers, patients and vendors that have aligned incentives and interests all directed at delivering better care at a lower cost; and execution discipline, with a goal to move beyond incremental progress in improving service, quality and cost, with more relentless speed to improve the performance of our industry.

Rizk notes the leaders of the future need to be adept at collaboration in ways new to healthcare. For example, in the past, collaboration tended to focus more within a department or defined area, but given everything is so interdependent right now, collaboration must become much wider.

“From payers to providers, healthcare organizations need to talk to members and patients like people, not policy numbers.”

— TOM WICKA, NOVUHEALTH

“You must collaborate, not just between physicians or nurses, but with every department—and perhaps with other organizations in the larger healthcare ecosystem,” he says. “No leaders are worth their salt unless they demonstrate commitment to their team and people. You need actions to back up the words. People follow leaders who care for them and who show commitment to them. Leaders must break down organizational hierarchy and work on building connections with all of their employees.”

Healthcare systems are doing the right thing by implementing new leadership positions to elevate roles around digital health, data analytics, and patient experience. Making access and quality key organizational priorities should always be top-of-mind.

“Key Performance Indicators (KPIs) and executive compensation will also be aligned to capitalize on these trends,” Wicka says. “From executive bonuses to member and patient satisfaction, payer and provider KPIs will go beyond measuring services rendered to include broader goals such as medical cost reduction, quality improvement, and improved NPS scores.”

Keith Loria is an award-winning journalist who has been writing for major newspapers and magazines for close to 20 years.
All eyes are on drug manufacturers to see how they respond to increased pressure over drug prices. Nitin Naik, vice president of Global Life Sciences and Transformational Health at Frost & Sullivan, says many factors contribute to rising drug prices.

“There are several factors at play but mostly it’s the introduction of innovative molecules and specialty drugs used to treat complex disease pathways like oncology,” he explains. “These all contributed to the overall increase in drug expenditures.”

“There are many factors driving these costs,” says Perry Cohen, PharmD, chief executive officer of the Pharmacy Group and the TPG family of companies, which provide consulting services, pointing to factors like marketing activities and increased specialty drug prices. “And each patient population, from commercial to Medicare and Medicaid, will feel these rising drug costs differently.”

In Managed Healthcare Executive’s recent Managed Care Pharmacy Survey, specialty pharmacy stakeholders were asked to offer their predictions about what will transpire at the drug manufacturer level as it relates to drug pricing over the next three years. Over one-third of respondents (37.58%) said they believed they would see a short period of decrease in annual inflation rates, followed by a return to higher rates. That response was followed by the belief that inflation rates on existing products will continue to grow as they have for the past five to ten years (29.7%) and that we will see a prolonged decrease in annual inflation rates due to the increased scrutiny (18.79%). Only 13.94% thought that a substantially greater number of drug manufacturers will decrease their current list prices.

Naik says the increased focus on drug pricing is valuable as it helps to bring more pricing transparency to patients, giving them the opportunity to make informed treatment decisions. He believes manufacturers will have to invest in integrated media outreach platforms to help guide patients and physicians to help do that.

Naik says Frost & Sullivan expects modest rate increases due to collaborative efforts between the government and manufacturers over the next three to five years. In addition, he doubts that the industry will see reductions in price across the board.

“Commercial drug plan spending has increased by 1.5% in 2018 compared to 3.8% in 2017,” he says. “In 2019, Frost & Sullivan expects lower pricing on drug categories related to pain, high cholesterol, and neurology due to the availability of generics in those segments. Categories related to diabetes, oncology, and HIV, however, will experience inflation due to the launch of new specialty products.”

However, Naik says it is important to understand that the current debate about drug pricing is not as simple as just decreasing list prices. He argues it’s really about putting out holistic information about the benefits of the drug treatment and pricing in relation to insurance coverage.

“We have a need to generate simple yet meaningful data,” he says. “Healthcare executives should look at adopting new artificial intelligence or machine learning technologies that can assist standardizing and comparing treatment options with the help of calculator tools to estimate the total out-of-pocket costs for each patient by applying plan specific information.”

Kayt Sukel is a science and health writer based outside Houston.
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State Certificate-of-Need Laws: What Do the Data Show?

Why it might be time for CON to go by MATTHEW D. MITCHELL

It’s an unusual regulation in a healthcare industry known for plenty of unusual rules: In 36 states and the District of Columbia, a healthcare provider hoping to open or expand her patient offerings must first prove to regulators that her community needs the service.

Providers can spend years and burn through tens or even hundreds of thousands of dollars to prove this and thus obtain what is called a “certificate of need” (or CON). The CON process can be required for both small and large investments: from hospital beds and gamma knives to new hospitals and neo-natal intensive care units.

Originally intended to discourage the use of expensive technologies and procedures, in many states a CON is now required for relatively lower-cost modes of care such as ambulatory surgery centers and for services unlikely to be over-prescribed such as drug-rehabilitation services and hospice care.

The federal government once required states to have CON rules in order to obtain certain federal funds. But since the repeal of that mandate in the late 1980s, a substantial minority have done away with their CON programs. Of those that have retained the regulation, many have scaled it back. In June, Florida moved to eliminate its CON requirements for new hospitals, specialty hospitals converting to general hospitals, and for a raft of other service providers such as children’s care and substance abuse hospitals.

About four in 10 Americans now live in a state without a CON requirement. These include urban, rural, low-income, and high-income populations alike. What are the experiences of patients and providers in these communities? What has happened to access, quality, and costs of care?

Using decades’ worth of state data, researchers can compare outcomes in CON and non-CON states. These statistical analyses include control variables that account for possibly confounding factors such as local economic and demographic patterns.

Their findings are consistent with economic theory: CON laws seem to limit access to healthcare, fail to increase the quality of care, and contribute to higher costs. I take each of these in turn.

Access

The strongest evidence on the effects of CON relates to access to care. Economic theory predicts that a CON law will restrict the supply of healthcare services, and that once repealed, patients will tend to access greater levels of care.

Indeed, researchers have found that states that have removed these rules have more hospitals and more ambulatory surgery centers per capita. They also have more hospital beds, dialysis clinics, and hospice care facilities. Patients in non-CON states are more likely to utilize medical imaging technologies and less likely to leave their communities in search of care.

Though CON advocates sometimes claim that the rules protect rural facilities, states without CON laws have more rural hospitals and more rural ambulatory surgery centers than states with CON laws.

Advocates also sometimes claim that CON rules encourage hospitals to provide low-cost or uncompensated care to low-income individuals. The idea here is to create a sort of quid-pro-quo: CON will protect hospitals from competition, and in return, hospitals will provide charity care. In some states, this quid-pro-quo is explicitly built into the CON approval process. In others, it is assumed. The evidence, however, suggests that there is no higher rate of charity care in states with CON laws. There is, however, greater racial disparity in the provision of care in CON states relative to non-CON states.

Quality

Though the CON approval process is not meant to directly assess a provider’s qualifications, safety record, or treatment success rate, it is sometimes said that CON programs might indirectly improve quality. The idea is that
CON might cause more procedures to be channeled through fewer providers, allowing those providers to improve their proficiency. While not unreasonable, the idea must be weighed against another, well-supported proposition: that competition tends to elevate quality.

What do the data say? Early studies tended to focus on individual procedures such as coronary bypass surgery and had a difficult time distinguishing causation from correlation. The results were mixed, with some early studies associating CON with higher-quality outcomes, others with lower-quality outcomes, and still others with mixed or inclusive results. One recent study is worth discussing in detail because it touched on multiple aspects of the patient experience and because its careful research design makes it possible to draw causal inferences.

Two of my colleagues, George Mason University Professor Thomas Stratmann and PhD graduate student David Wille, set out to assess the effects of CON on hospital quality using Hospital Compare, a database maintained by CMS. This database assesses quality through multiple dimensions—everything from patient satisfaction surveys to heart attack readmission rates to pneumonia mortality rates.

In a unique research design, Stratmann and Wille estimate the effects of CON by looking at healthcare markets spanning CON and non-CON states. This allows them to control for other, unobservable factors that might affect health outcomes such as culture and environment. Like other CON researchers, they also control for several observable demographic and hospital characteristics that might confound their estimates.

Stratmann and Wille find that hospitals in non-CON states have statistically significantly lower mortality rates for pneumonia, heart failure, and heart attack. They also find lower mortality rates among surgical inpatients with serious treatable complications. Compared with hospitals in states that require CONs for four or more services, hospitals in non-CON states have lower readmission rates for heart failure and heart attack. Patients in these states are more likely to rate their hospital experience highly.

Cost
An initial goal of CON was to limit the utilization of costly and unnecessary care. The federal legislation that encouraged states to adopt CON rules lamented a “massive infusion of Federal funds into the existing healthcare system [that] has contributed to inflationary increases in the cost of healthcare.”

CON might seem an unusual instrument to achieve this end. After all, it is a supply restriction—and supply restrictions tend to increase the costs of goods and services, not decrease them. Moreover, by throttling competition, supply restrictions are likely to permit providers greater latitude to raise prices.

Still, by limiting access to healthcare services, CON might reduce the total amount spent per patient or per citizen, even if it raises the cost per service. What do the data show here?

I recently reviewed two decades’ worth of peer-reviewed studies—every academic assessment of CON and spending that I could find. Four studies estimate the effects of CON on cost per service. None find that CON reduces per-unit costs. Three of the four find that it is associated with higher per-unit costs. The most recent, for example, finds that five years after repeal of CON, charges are about 5.5% lower than they would otherwise be. The fourth study—which only focuses on per-diem Medicaid charges for nursing home and long-term care—found no statistically significant effect.

Twelve studies estimate the effects of CON on spending per patient or per citizen. Of these, seven find that CON is associated with higher spending, two find no statistically-significant effect, and two find that it is associated with higher spending in some areas and lower spending in others.

Only one study finds a connection between CON and lower spending, and it was tenuous at best: The author finds that CON is associated with fewer hospital beds, which are, in turn, associated with slightly slower growth in healthcare expenditures per capita. Importantly, however, the author finds no direct relationship between CON and such expenditures.

Taken as a whole, the literature suggests that CON is associated with both higher per-unit costs and greater total expenditures.

Showing the way
The six in 10 Americans who live in states with CON laws need not speculate about what would happen should these regulations be removed. Both economic theory and data accumulated over the last four decades strongly suggest that CON removal will result in greater access to higher-quality, lower-cost care.

Matthew D. Mitchell is a senior research fellow and director of the Equity Initiative at the Mercatus Center at George Mason University. He’s overseen and authored numerous studies on the effects of state certificate-of-need laws.
Making the Most of Predictive Analytics

By DONNA MARBURY

With the saturation of electronic health records, healthcare organizations have a wealth of patient data that could assist with predicting outcomes and lowering costs. But many aren’t using predictive analytics for clinical or financial outcomes for their organizations.

Predictive analytics is defined as data mining, machine learning, and statistical modeling of historical patient data to predict future outcomes. A 2018 survey of healthcare payer and provider executives by the Society of Actuaries found that 87% of executives say that predictive analytics is important to the future of their business and 60% believe that predictive analytics can save their organization 15% of more in the next five years. Only half of providers surveyed and 45% of payers reported current use of predictive analytics. Within five years, 87% of providers and 83% of payers say they plan to begin or grow use of predictive analytic tools at their organizations.

Most large hospitals and health plans have access to the tools needed to use predictive analytics effectively, but smaller organizations are still falling behind, says Bharat Rao, PhD, principal in the advisory services practice at KPMG LLP.

"I would say the small physician offices, which are directing a lot of the care in the U.S., are not using predictive analytics in the most effective ways. They have more difficulty getting a handle on their data," says Rao. "But even the large health systems and stand-alone hospitals, though they may have the tools to use predictive analytics, many aren’t using them effectively."

With the amount of data being captured, many healthcare organizations are struggling with how to use it in the smartest ways, says Beth Godsey, vice president of advanced analytics and informatics for Vizient, Inc., a member-driven, healthcare performance improvement company, in Irving, Texas.

"Healthcare organizations are sitting on a wealth of patient data and yet have only begun to scratch the surface on utilizing predictive analytics and machine learning to extract its most important insights," Godsey says. "I frequently hear from some of the top hospitals in the country, 'how do I thoughtfully bring predictive insights to my clinicians that can improve not only their work flow efficiency, but also patient care?'"

Using predictive analytics for high-risk patients

One of the most valuable use cases for predictive analytics is identifying and engaging high-risk patients.

An analysis by Relias Analytics of raw claims data from the Illinois Behavioral Health Home Coalition to identify and predict outcomes of high users of care was able to reduce inpatient admissions by 57%, emergency department visits by 31%, and total cost of care by 40%. Annual savings associated with the patients in the study was $1 million.

Nate Regimbal, digital transformation senior manager with Grant Thornton, an accounting and consulting firm, says that predictive analytics techniques can identify patients at high risk for being late to or missing an appointment.

"When the analytics predict a risk with a high enough confidence level, it can trigger a work flow that includes contacting the patient, or scheduling (to afford other patients the opportunity to see the doctor), or staffing (to optimize shift schedules). The analytics for this are now straightforward," Regimbal says.

"The harder part is operationalizing the analytics insights and managing the change and performance implications so that the benefits are fully realized," he says.

Regimbal adds that risk stratification via advanced analytics drives benefits with payers and providers. Predictive analytics applied to claims processing, procedural coding to member policy, and determining adequacy of information to proceed with claims processing can result in
higher accuracy overall, which can bring down payer costs and subsequently prices.

“On the provider side, cohort- and predictive-analytics enabling what’s commonly referred to as ‘patients like me’ analytics can provide insights on emerging patterns that a physician may not have had the means or time to have recognized without the analytics,” Regimbal says.

**Lowering readmissions using predictive data**

Having the ability to predict patients who have a higher chance of readmitting and take into account other factors that can attribute to readmissions, says Michael Simon, data scientist at Arcadia, a population health management company, in Burlington, Massachusetts.

“A patient with multiple comorbidities may already be in a well-established care management program that follows best practices. However, with predictive analytics, providers can understand the risk this patient has for being readmitted to a hospital after a future inpatient admission,” says Simon. “This allows the provider to intervene from the beginning to reduce the chance of that readmission and improve the clinical outcome for that patient.”

**Additional risk factor identification**

Incorporating social determinants of health into predictive analytics of patients can also help to identify additional risk factors in patients’ lives that would adversely affect their ability to adhere to care plans, says Rich Temple, vice president and chief information officer of Deborah Heart and Lung Center in Browns Mills, New Jersey.

A 2018 Duke University study published in the *Journal of Informatics in Health and Biomedicine* was able to use historical EHR data from more than 4,000 no-show appointments to create predictive analytics models to determine whether a patient is a risk for not showing up their appointments and why.

“Examples of social determinants of health are lack of access to transportation or healthy food and lack of a decent home or supportive family members. Having these types of challenges makes it much harder for people to be able to properly focus on their health,” Temple says. “The science of predictive analytics is beginning to develop algorithms to track who these individuals may be and respond with carefully customized ways of reaching them to help them on their health journeys.”

**The future of predictive analytics**

Rao says as patients become more empowered and informed consumers, the demand for tech-enabled care will continue to grow.

“Healthcare providers wanting to be competitive in the market will need systems where data and technology provide information,” Rao says. “The patient or the caregiver of the patient will want control of their own data and analytics so that they can feel like a participant in their own care. The opportunity that you have in the large systems is the organization of data to engage the patient or caregiver to jointly manage it.”

Simon says that predictive analytics will be able to help providers identify how prescriptions will impact intervention programs and if that prescription will likely benefit or negate the benefits of the care management program.

“For patients with complex medical conditions, the impact of prescriptions on their medical experience can be significant both mentally and physically, so predicting how a patient will respond to the entire intervention will be critical,” says Simon.

Godsey says the possibilities for predictive care using genomic markers and personalized care is on the horizon.

“While healthcare is swimming in a sea of data, there is yet an even vaster universe of data we have yet to fully tap,” Godsey says.

Donna Marbury is a writer in Columbus, Ohio.
John Baackes had an unusual route to becoming a managed care executive. He started in the business in 1976 by designing a logo for Community Health Plan, a new health maintenance organization in Albany, New York, and 12 years later he was CEO. “I was first approached as a graphic artist but I was hooked on this idea that managed care could really make a difference in peoples’ lives,” he says.

“I began working as a sales rep and knew quickly this was something I wanted to do.” He remembers when initially starting in the industry, he would go into the waiting area of the health center and see the people sitting there, and he knew the organization was doing something different. “It struck me I could make a difference,” he says. “I was also attracted to the immediacy of it all; we weren’t just planning things but executing...
them, and because it was new, we could try things and if they didn’t work, try something new. Our ability to work with patients and providers to come up with better solutions was a big draw to me, and I’ve been happily pursuing it for 42 years."

Today, Baackes serves as CEO of LA Care Health Plan, the largest publicly-operated health plan in the U.S., serving more than two million members. In his position, he helps to provide access to quality and affordable healthcare for Los Angeles County residents through a variety of health coverage programs, including Medicaid, L.A. Care Covered (California Health Benefit Exchange), L.A. Care Cal MediConnect Plan, and PASC-SEIU Homecare Workers Health Care Plan.

“This is my fifth plan I’ve been involved with—third as the CEO,” he says. “When I was first asked to meet the board for a potential interview, I was quite taken by the mission of L.A. Care—it was here to serve a vulnerable population and to serve the network of safety net providers that took care of them.”

In his position, Baackes acts as the face of L.A. Care, communicating the mission to outside decision makers in the community—whether that be regulators, legislators, potential customers, or customers at the provider level.

“I do spend a great deal of my time outside of the office working with people,” he says. “Another big component of my time is setting a strategy with the organization, getting people to follow it, and monitoring it to see that we are executing against it.

**Distinguished career**

Baackes’s resume also includes serving as president of Philadelphia-based AmeriHealth Caritas VIP Plans, where he oversaw the Medicare Advantage business unit; CEO of Senior Whole Health in Cambridge, Massachusetts, a voluntary healthcare plan for more than 10,000 low-income seniors in Massachusetts and New York; and president of Kaiser Permanente’s Northeast Division.

With a seat on the board of AHIP, Baackes has also helped guide policy around the Medi-Cal/Medicaid population and implemented pioneering safety net programs to save money and improve outcomes.

**Strategic vision**

In 2019, L.A. Care has continued what it has been trying to do for the last four years—introduce a higher level of accountability, particularly among its provider partners.

“There is a strong move to value-based purchasing for both Medicare and Medicaid and when I looked at the quality of both we were producing when I got here, we were pretty mediocre,” Baackes says. “Because we are contracted through medical groups—and we have about 58 of them—the performance was too varied and we began doing a report card on the performance of these medical groups by domain areas that we thought were representational of what the values and value-based purchasing programs would be.”

Now with four years of data, L.A. Care can point out to the groups where there are gaps and help them improve their overall quality score.

“We also recognized that because we had gotten as large as we were, we needed more providers, so we began contracting directly with doctors who felt they lacked representation by a third party,” he says. “This is how most of the health plans I was involved with before I got here operated. L.A. Care being totally contracted through groups was a unique aspect.”

“The clinics and practices that serve our members ... are always on the short end of competition for compensation for the doctors they need. So, we are offering grants of $125,000.”

—John Baackes, LA Care Health Plan

**An innovative program**

Because there is a lack of providers serving vulnerable populations—Medi-Cal, the uninsured, immigrant—and recognizing there was a documented shortage, Baackes asked the board to set aside 5%, which amounted to about $35 million, and use it in program called “Elevating the Safety Net,” which consists of three components.

“The clinics and practices that serve our members have a difficult time competing with places like Kaiser and academic medical centers, they are always on the short end of competition for compensation for the doctors they need,” he explains. “So, we are offering grants of $125,000 to clinics or practices that will bring...
a new primary care doctors to Los Angeles County. We want to increase the number.”

Since last September, L.A. Care has awarded 48 grants and 29 new doctors have been recruited.

And since many of these new recruits will be recent graduates and have massive medical school debt, if the doctor agrees to stay for three years, L.A. Care will retire $180,000 of that physician’s medical school debt. The hope is they will get hooked on the importance and value of working in a safety-net practice.

The third part of the program involves building a pipeline, so it awarded eight medical school scholarships for the full four years.

**Improving IHSS**

Since many of L.A. Care’s members have in-home support service workers—where if you are at a certain level of frailty because of complex care and you need help with activities and daily living, the state will provide someone to do that—and it has allowed family members who have these caregiver roles to be recognized and be paid for it.

Baackes recognized that these people could be a huge benefit in care management because they are with them almost every day and wanted to do more for them, so L.A. Care started a training program that would teach them more about what managed care is and helped them with skills to make them more effective with the patients when interacting.

L.A. Care partnered with SEIU on the IHSS+ Home Care Integration Program, a 10-week training program for the IHSS workforce where providers learn how to take on the enhanced roles of monitor, communicator, coach, navigator, and care aide. It’s offered in numerous languages (English, Spanish, Russian, and others) and people attend classes for two and a half hours each week.

Baackes has attended several of the graduations personally, but always makes sure someone from L.A. Care is present to celebrate with them.

“We funded this 10-week program, contracted for 3,000 to be trained and we are a little more than half way through,” he says. “The result has been much more impactful than I thought it would be. Many of these folks never graduated from high school, so this certificate is a big deal to them. They are critical and if they get burned out, it’s going to cost our healthcare system a lot more money to take care of those patients, so we need to take care of them.”

**Outside of work**

Although he spends a lot of time taking care of L.A. Care business, it’s not all work for Baackes, who likes to spend time with his four adult children and two grandchildren.

Plus, moving to Los Angeles from the East Coast for the first time in his life, he’s enjoying visiting the many interesting places the city has to offer.

“When I went to college, I wanted to be an architect, so I’m still an architecture buff,” he says. “I go visit significant architectural buildings to see them, enjoy them and learn something from them.”

But it’s being at the office, knowing he’s helping people, that he loves most. And one of his favorite parts of the job are the people he works with.

“Everyone at L.A. Care gets the mission and that’s why it’s fun to come to work every day,” Baackes says. “As an entity, we need to add value to our members and the providers who participate, but we also need to add value to our employees in the workplace. I like to mingle with our staff and hear what’s going on, and I’m always impressed by how they want to continue contributing to the care of people in the community who are more vulnerable than they are.”

Keith Loria is an award-winning journalist who has been writing for major newspapers and magazines for close to 20 years.
LinkedIn is a business networking site that boasts more than 590 million professionals. This is a prime piece of real-estate for all industries, including healthcare.

"First of all, it allows you to showcase your background, experience, and credentials as well as the kind of person you are," says Shelly Elsliger, a globally recognized LinkedIn trainer, coach, speaker, and President of Linked Express, a LinkedIn Coaching company located in Toronto, Ontario, Canada. "Relationship building is very important and we have no choice to be effectively doing it also online."

LinkedIn is key to keeping up on industry news and being recognized as a leader in the field, according to Elsliger. "It also helps to increase your visibility," she says. "Kevin Pho, MD, is a great example of a healthcare professional who proactively uses LinkedIn and believes strongly in the power of LinkedIn as a platform to share his insight, knowledge, recommendations, career advice as well as a space to bring his stories to life so he can also be seen as a leader in his field online."

"LinkedIn is a great way for healthcare executives to show their human side and connect with their patients."

— SHELLEY ELSLIGER, LINKED EXPRESS

Consumers or career? Should LinkedIn be used to leverage your professional career or build relationships? It can be tailored for both, according to Elsliger.

"LinkedIn is a great way for healthcare executives to show their human side and connect with their patients," Elsliger says. "It is the perfect space for you to represent your brand and your practice. You can also easily follow and support patients and also engage with them by writing articles/posts that could clearly be important and relevant to them. LinkedIn is a great way to show credibility and likability—two important characteristics in building relationships. It is also a platform that lends itself to the Art of Reciprocity—mutual kindness and support goes far on LinkedIn."

Furthermore, Elsliger says, collaboration and reciprocity are two of the best ways to get noticed and remembered on LinkedIn. "Having a presence on LinkedIn can ultimately lead to partnerships, job offers, research, interaction, exchange of information, and project collaboration," she says. "Sixty-six percent of jobs are found passively on LinkedIn; so, having an optimized LinkedIn profile easily discovered by recruiters, medical industry leaders, and other healthcare professionals, could ultimately potentially lead to future professional success and advancement."

There are six things that healthcare executives should keep in mind about LinkedIn, according to Elsliger:
1. **Use the platform to be a thought leader.** “Taking full advantage of the newsfeed and prime blog space to write articles via LinkedIn Pulse allows healthcare professionals to stand out as experts in their field,” Elsliger says.

2. **Social recognition matters.** “Getting recommendations from team members and clients can help confirm your likeability as well as your success in what you do,” she says.

3. **LinkedIn is not about titles but rather about the person behind the title.** “Show who you are and let your personality shine,” she says. “Write in first person so you own your space and your story.”

4. **Customize your headline so that it does not default to your title.** “The 220 characters available to help you is to showcase your unique value proposition and help you stand out,” Elsliger says. “It is a key part of the LinkedIn search algorithm so putting in key functional/searchable words can help you to get found in search results.”

5. **Ditch the default and customize your background photo.** “This is prime visual real estate to help you to showcase and highlight your personal/professional brand visually,” she says.

6. **Consistency is key.** This is true on any social media platform but especially LinkedIn, according to Elsliger, if the objective is to get found and get known. “Getting known as a specialist/expert can go far on LinkedIn but if you are simply on LinkedIn, but not LinkedIn, the value you can actually bring will be easily lost unless you are supporting your claims,” she says.

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**Include the best information**

Healthcare executives should write their LinkedIn profile as a story—“written in a way to give people some insight into their character as well as their credentials,” according to Elsliger. An amazing LinkedIn story has five key elements:

- **A background photo (cover page) with a connection to industry.** Make sure your profile photo is approachable and front-facing.
- **A customized tagline (branding statement) that tells people what you offer in a clear and expressive manner (title).** This is the place to distinguish yourself and stand out.
- **The summary (story) should be a 2,000-character summary with a catchy beginning, a solid body outlining key points, successes, specializations, and what makes you, you.** “Inject personality and remember humans connect with humans, so tell your career story and make it interesting,” Elsliger says. “Give viewers a glimpse of your life without too much detail but enough to raise curiosity so they want to read more.”
- **Your experience (credibility).** “Take a cupcake approach,” Elsliger says. “Start with a summary to outline the kind of person you, in the role, and what you do that differentiates you. You can add roles and responsibilities but stay away from what is intuitive and focus on telling interested readers what they don’t know.”
- **The skills section.** Take an 80%-20% approach to the skill section, according to Elsliger. “Think of skills related specifically to your field and specialty; words that should also be sprinkled liberally throughout your LinkedIn story,” she says. “The other 20% is on the softer side; those transferable skills that make you who you are and the kind of professional you are. The three top skills are most important because they follow you and they should represent the skills most related to your marketability in terms of your career story; the ones that people can easily relate with you and therefore, endorse.”

Tracey Walker is the content manager of Managed Healthcare Executive.
The deluge of gene therapy drugs that have entered the market in 2019 foreshadows what industry experts believe will be a continuous push toward personalized medicine. With a variety of new, highly-specialized drugs in the pipeline, insiders say the healthcare industry can expect to see shifting treatment models along with dynamic payer challenges for these high-dollar drugs.

“There’s going to be a new paradigm in medicine from a cost and patient perspective,” observes Tami John, MD, an instructor in the department of pediatrics section of hematology/oncology, Baylor College of Medicine in Houston. “From a physician standpoint, we’re advocating for negotiations from the federal, state, and hospital levels because these drugs are going to be life-changing.”

As it stands, managed care organizations are already feeling the fallout of containing the cost of gene therapies currently on the market, with some treatment costs exceeding $1 million. The most expensive drug ever approved, Novartis’ Zolgensma (onasemnogene abeparvovec-xioi), indicated for the rare spinal disorder spinal muscular atrophy, carries a staggering $2.3 million price tag. Although a one-time treatment, the advent of more gene therapies for rare conditions, blood disorders, and cancers brings the question of cost to the forefront.

In reaction to soaring costs, many payers and employers alike have begun implementing stop-loss provisions in their insurance policies to cap spending. Stop-loss policies fall into two general categories, individual and aggregate. Despite being a method to protect payers and corporations from shelling out hundreds of thousands of dollars for tailored treatment, individual policies leave patients on the hook for sizeable out-of-pocket contributions, with deductibles ranging from $40,000 on the low end to as much as $500,000, according to Dominic Galante, chief medical officer of Precision for Value in Buffalo, New York. Meanwhile, aggregate coverage protects against higher than anticipated claim activity for the plan as a whole.

Pipeline promise
There are numerous gene therapies in the pipeline, and similarly, hundreds of clinical trials are underway. Some trials target rare conditions, including sex-linked conditions such as X-linked granulomatous disease and immunodeficiency disorders, according to clinicaltrials.gov; however, hematologic and oncologic therapies appear to dominate the list, as do therapies entering the pipeline over the next 12 to 18 months.

“I expect gene therapy—within the process of chimeric antigen receptor T-cell (CAR T) therapy—to become an option for more cancers besides relapsed and refractory B-cell lymphoma along with more CAR T-cell treatments for Non-Hodgkin lymphoma and multiple myeloma,” says Vincent Vidaurri, PharmD, BCOP, a clinical oncology pharmacist at the University of Colorado Health in Fort Collins. “However, the greatest impact would be for the treatments of cancer with very poor prognoses such as pancreatic, triple negative breast, and glioblastomas.”

According to new research from Prime Therapeutics, the pipeline includes specialty therapies, such as a calcitonin gene-related peptide (cGRP) drug, an alternative for migraine sufferers on Botox therapy, along with treatments for cystic fibrosis and autoimmune digestive disorders.

In oncology, Vidaurri anticipates that healthcare providers will bring the combining of gene therapies with immune checkpoint inhibitors seen in clinical trials to the clinic. He cites combining viral therapy such as talimogene laherparepvec (Imlygic, Amgen), a genetically engineered product, with a checkpoint blocker such as nivolumab, ipilimumab, or pembrolizumab as examples.

Despite these exciting developments, John cautions that until the payment process is refined, providers should focus on finding local hubs with scientific institutions that have the resources to navigate through payment translation. She advises considering institutions that have access as well as the ability to translate in large volumes to refine techniques as well as forge relationships with the payers.

Frieda Wiley, PharmD, RPh is a contract writer and consultant pharmacist.
Although the number of new drug shortages in the United States has declined to 186 in 2018 since a high of 267 in 2011, there have been 80 for the first half of 2019, according to the University of Utah Drug Information service.

"Shortages continue to be on the rise and in talking with our customers, we’ve discovered the problem continues to get worse. More medications are going on allocation or unavailable and what used to be short, periodic shortages have become long and drawn out, making it a continuous challenge for clinical leaders," says Patrick Yoder, PharmD, CEO, LogicStream Health, a Minneapolis-based clinical process improvement and control software provider.

"Some medication shortages have been going on for years with no real sign of recovery," he says.

"While the number of drug shortages has declined substantially in recent years, any drug shortage places substantial burdens on healthcare, providers who may have to ration medicines or identify alternative treatments," says Andrew Powaleny, director, public affairs for Pharmaceutical Research and Manufacturers of America (PhRMA).

"The issue of drug shortages demands attention and collaboration from all stakeholders involved in providing life-saving medicines to patients. This includes the biopharmaceutical companies producing brand-name medications, as well as generic drug and biosimilar manufacturers, wholesalers, distributors, pharmacies, and healthcare providers," he says.

A survey conducted between March 6 and April 4, 2019 of 365 acute and non-acute care facilities across the country—members of Vizient, a healthcare performance improvement company headquartered in Irving, Texas—confirms the ever-present problem of drug shortages and their ramifications.

Nearly two-thirds of respondents report they managed at least 20 shortages from July through December 2018; 64%, more than 21; 33%, six to 20; and 3%, up to five. Thirty-eight percent report one or more medication errors directly related to a drug shortage and their ramifications.

The most commonly reported items facing shortages, according to the survey, are controlled substances, local anesthetics, antibiotics, electrolytes, and emergency injectables such as “crash cart” drugs, many of which are low-cost generics. Injectables comprise 39% of drug shortages in 2019, according to the University of Utah Drug Information Service.

**Top causes of drug shortages**

The FDA primarily attributes shortages to quality/manufacturing issues but also points to production delays, some caused by not receiving raw materials and components from suppliers, and drug discontinuations. An estimated 70% of shortages are caused by manufacturing and quality problems, according to the Healthcare Supply Chain Association.

"The FDA can’t require a firm to keep making a drug it wants to discontinue. Sometimes these older drugs are discontinued by companies in favor of newer, more profitable drugs," says Charlie Kohler, spokesperson for the FDA. "With fewer firms making older, sterile injectable drugs, there is a limited number of production lines that can make these drugs. Raw material suppliers also are limited in the amount they can make due to capacity issues at their facilities.”

Kohler says that these limitations, along with long lead times and the complexity of the manufac-
Supply chain unavailability. 
Lack of active pharmacy ingredients. 
Natural disasters. 
Too many lines offered, making it difficult to maintain capacity. 
Regulatory issues. 
Aggregate product quota preventing other manufacturers from entering the space for making more product. 
Low ROI. If a product is not profitable, manufacturers might switch to other drugs. 
Consolidation.

Povaleny attributes drug shortages to shifts in clinical practices; wholesaler and pharmacy inventory operations; changes in hospital and pharmacy contractual relationships with suppliers and wholesalers; and manufacturing issues, such as an unforeseen breakdown in manufacturing equipment that disrupts production.

"The difficulty is identifying what medications will be impacted by any of these things and how that will affect care delivery and patient safety, along with understanding when any particular shortage will occur," Yoder says.

Repercussions
"The biggest risk is patient safety and potential harm to patients when clinicians cannot deliver appropriate care because of a medication shortage. Deferring procedures, adverse drug events, medication errors, cost of alternatives, and the time clinical teams spend managing shortages are all results of shortages," Yoder says.

The Vizient survey focuses on the impact of drug shortages on U.S. hospital labor forces. Responses indicate that shortages are costing these institutions $359 million a year in labor expenses, or about 8.6 million hours of additional labor, to seek supply, update technology, and implement mitigation strategies that enable continuity of care.

Survey participants attributed labor costs to triaging patients and making changes in the ordering system. The repercussions of drug shortages not only impinge on financial resources but also on patient care, from delay or cancellation of a medication or treatment to medication errors. The Institute for Safe Medication Practices conducted a survey primarily of hospital-based pharmacy directors and managers, purchasing agents, and technicians, found that 71% were unable to provide patients with a recommended drug or treatment, and 47% thought this resulted in patients receiving a less-effective drug.

Solving the problem
Kistner recommends some strategies for mitigating drug shortages: increase competition; ramp up supply and capacity; reward quality in generics; expedite manufacturer approval processes; provide real-time analytics about what is purchased and which supplies are dwindling; and apprise hospitals of potential drug shortages so that they do not become a repeat problem.

Vizient survey respondents had a say in what they believe to be effective solutions to the drug shortage problem: implementing processes to restrict duration of therapy; increasing stock of medications that were anticipated to be limited in supply; utilizing unit dosing to prevent waste; using alternative ways of administering a drug and implementing one or more taskforces or committees dedicated to addressing drug shortages and allocations.

FDA tackles shortages
"FDA responds to potential drug shortages by taking actions to address their underlying causes and to enhance product availability. It determines how best to address each shortage situation based on its cause and public health risk," Kohler says.

To address manufacturing/quality problems, FDA works with manufacturers to resolve issues, from an incorrect expiration date on a package to finding a particulate in a product. The agency also assists manufacturers with drug shortages in ramping up production if they are willing to do so. Kohler says this often necessitates approval of new production lines and raw material sources to help increase supplies.

FDA expedites review of these to help resolve shortages of medically necessary drugs; however, the agency can’t require companies to increase production.

If a manufacturer has data to support extension of an expiration date for inventory that is close to expiration or has already expired, FDA is able to review this information and approve the extension, helping to increase supplies until new production is available.

In addition, FDA could turn to other manufacturers that are willing and able to redirect product to the U.S. market if a shortage involves critical drugs needed for U.S. patients. This requires an evaluation of a product to ensure efficacy and safety, including the formulation and other attributes of a drug and the quality of the manufacturing site where a drug is made.

While the FDA looks for ways to mitigate drug shortages, there are a number of factors that can cause or contribute to the problem that are outside of the FDA’s control, Kohler says. The agency issued a long-term, strategic plan to outline its priority actions and efforts drug manufacturers and others can take to prevent drug shortages by promoting and sustaining quality manufacturing, along with launching the Drug Shortages Task Force July 2018, to study why shortages continue.

Mari Edlin, a frequent contributor to Managed Healthcare Executive, is based in Sonoma, California.
It’s a good time to apply for a job in healthcare.

Per the U.S. Department of Labor’s Bureau of Labor Statistics, job numbers, across the board are up—but there have been particularly notable gains in the healthcare industry. But despite—or perhaps because of—some of the lowest unemployment numbers in decades, many hospitals and health plans are struggling to attract and maintain quality employees.

As noted in a 2017 Leaders for Today survey, there is “unprecedented” employee turnover among hospitals and other healthcare organizations—for both clinical and non-clinical staff. Joseph Parente, a principal with KPMG’s Management Consulting Practice who works specifically with provider and payer organizations, says this not surprising.

“These results are a couple years old, but they are pretty representative of what we’re seeing in the industry even now,” says Parente.

“The Leaders for Today survey found that more than one-third of employees were planning to leave their hospital within two years. Nearly 70% said they’d be leaving in the next five years. And, although we talk a lot about physician and nursing shortages these days, it’s not just clinical staff who are looking to leave their positions. The survey also found that, when asked if they plan to leave their current job, it’s non-clinical administration staff that are most likely to say yes.”

The downstream effects of this kind of employee turnover results in the sort of vicious cycle that leads to even more employee dissatisfaction and turnover, says David Wilkins, chief strategy officer for HealthcareSource, a healthcare talent management firm, in Woburn, Massachusetts.

“With so many people leaving, healthcare organizations will have a hard time attracting new, qualified employees because of the existing gaps,” he says. “When people are working understaffed, and they don’t have the right team to help support their work, it leads to a more challenged workday, more responsibilities, longer hours, and increased stress. With so many other opportunities outside of healthcare, people have a choice—and they are choosing positions that will allow them a better work/life balance.”

So, given this kind of “seller’s market,” how can healthcare organizations better recruit and retain experienced staff? The key, experts say, is to focus on ways to improve employee satisfaction for employees at all levels.

Take a hard look at technology

Numerous studies now suggest that clinical staff, in particular, are experiencing a high rate of burnout—and many of them blame different information technology (IT) platforms, such as electronic health record (EHR) systems for those frustrated feelings. But Parente says it’s not just doctors and nurses who are aggravated by the various systems they need to interact with.

“They are being asked to use a lot of different technologies that are really cumbersome and out-of-date. It’s not just EHRs, though those are frustrating—some of the health plan systems are even more staid and difficult to use,” he says. “It’s a problem when an employee can go home, use a computer or smart phone to easily order food or clothing but have to go through dozens of onerous steps just to restock surgical supplies at work. They want to have more of the same kind of easy-to-use experience at work that they can get at home.”

Parente recommends that healthcare organizations look at their legacy systems and see where they can improve workflows to decrease the amount of time—and the amount of exasperation—employees face when using them.

Consider span of control

Wilkins says another issue is management practices in healthcare. In many cases, employees don’t feel like there is room to advance.

“In healthcare, too often, the person who gets promoted isn’t the person who is best for the job but the person who has ‘paid his dues,’ so to speak,” he says. “So instead of looking at whether you have the person with the right leadership qualities and skill set, you see the person who’s been there the longest moving up. That’s not the right thing for the organization.”
Yet even when the right person is promoted, there is still an issue of span of control.

“The average span of control, of number of people someone is supervising, is about 9.7 people per manager,” Wilkins says. “But the average span of control for a nurse manager is 49 to 1. You can see even larger ratios in other healthcare jobs. So, if you are a manager and are responsible for that many people, how can you see who is doing well? How can you evaluate an individual employee’s strengths and weaknesses? There’s just too much load on a manager to be able to keep up with. People will not get the recognition they deserve. They won’t get the training opportunities they need to advance. And they will end up leaving.”

By looking at your organization’s management structure and reducing the span of control ratios, while also putting in appropriate recognition and reward programs that incentivize employees to work located in Mountain View, California, that connects companies with freelance talent, says that contract employees can help fill in for one of healthcare’s greatest challenges, the industry’s aging workforce, particularly when it comes to IT needs.

“There is a need for new skills driven by telemedicine as well as the talent scarcity seen across care delivery organizations. Since healthcare is so highly regulated, there are a lot of very specialized certifications and needs when it comes to IT,” she says. “Freelancers can help organizations grow and operate as the market dictates—and healthcare organizations should shift their mindset so they don’t see hiring freelancers as a stop-gap measure, but rather a highly strategic way to get to where they want to go.”

Looking toward other Industries

Parente says that healthcare can also look toward other industries to develop the right strategies to recruit and retain the right employees.

“In healthcare, too often, the person who gets promoted isn’t the person who is best for the job but the person who has ‘paid his dues,’ …That’s not the right thing for the organization.”

— DAVID WILKINS, HEALTHCARESOURCE

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about, whether you are talking about claims management, care management, or IT, looking at these really integral elements of employee satisfaction and making sure you are doing everything you can to make sure they are addressed in a way that helps both your employees and your organization as a whole.”

Kayt Sukel is a science and health writer based outside Houston.

“Outside healthcare, companies have developed deliberate employer of choice initiatives that are intended to enhance the employee experience by improving work/life balance, quality of work, and supporting an employee’s individual needs,” he says. “So, having more flexible schedules for employees, not doing things the way they’ve always been done before, can go a long way.”

Certainly, not every organization can address employee turnover—and values, you can help reduce turnover—and help promote more appropriate internal mobility, where individual employees are being groomed to advance and take on new roles that may be harder to fill in the marketplace.

Filling in gaps with freelancers

Zoë Harte, senior vice president of human resources and talent innovation at UpWork, a company located in Mountain View, California, that connects companies with freelance talent, says that contract employees can help fill in for one of healthcare’s greatest challenges, the industry’s aging workforce, particularly when it comes to IT needs.

“There is a need for new skills driven by telemedicine as well as the talent scarcity seen across care delivery organizations. Since healthcare is so highly regulated, there are a lot of very specialized certifications and needs when it comes to IT,” she says. “Freelancers can help organizations grow and operate as the market dictates—and healthcare organizations should shift their mindset so they don’t see hiring freelancers as a stop-gap measure, but rather a highly strategic way to get to where they want to go.”

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Kayt Sukel is a science and health writer based outside Houston.
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