CONVENIENCE COMES TO HEALTH CARE

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Patients who miss a dose of Tresiba® should inject their daily dose during waking hours upon discovering the missed dose, then continue with their regular dosing schedule. Ensure that at least 8 hours have elapsed between Tresiba® injections.

TRESIBA® (insulin degludec injection) Rx Only

BRIEF SUMMARY. Please consult package insert for full prescribing information.

INDICATIONS AND USAGE: TRESIBA® is indicated to improve glycemic control in adults with diabetes mellitus. Limitations of Use: TRESIBA® is not recommended for the treatment of diabetic ketoacidosis.

CONTRAINDICATIONS: TRESIBA® is contraindicated: During episodes of hypoglycemia, hypoglycemia is a direct effect of insulin. Do not use TRESIBA® in patients who have had hypersensitivity reactions to insulin degludec or one of the excipients.

WARNINGS AND PRECAUTIONS: Never Share a TRESIBA® FlexTouch® Pen Between Patients: TRESIBA® FlexTouch® disposable prefilled pens should never be shared between patients, even if the needle is changed. Sharing poses a risk for transmission of blood-borne pathogens. Hyperglycemia or Hypoglycemia with Changes in Insulin Regimen: Changes in insulin, manufacturer, type, or method of administration may affect glycemic control and predispose to hyper- or hypoglycemia. These changes should be made cautiously and only with medical supervision and the frequency of blood glucose monitoring should be increased. For patients with type 2 diabetes, adjustments in concomitant oral anti-diabetic therapy may be necessary. Patients using insulin degludec who are changing from other insulin regimens, t：</p>
"OAD: oral antidiabetic agent. Novo Nordisk hypoglycemia: a severe hypoglycemia episode or an episode where a laboratory or a self-measured glucose calibrated to plasma was less than 56 mg/dL or where a whole blood glucose was less than 50 mg/dL (i.e., with or without the presence of hypoglycemic symptoms).

Allergic Reactions: Severe, life-threatening, generalized allergy, including anaphylaxis, generalized skin reactions, angioedema, bronchospasm, hypotension, and shock may occur with any insulin, including TRESIBA®, and may be life threatening (see Warnings and Precautions). (Represents swelling of tongue and lips, diarrhea, nausea, tiredness, and itching) and urticaria were reported in 0.9% of patients treated with TRESIBA®. Lipodystrophy: Long-term use of insulin, including TRESIBA®, can cause lipodystrophy at the site of repeated insulin injections. Lipodystrophy includes lipoatrophy (thinning of subcutaneous tissue) and lipohypertrophy (thickening of subcutaneous tissue). Factors such as: assay methodology, sample handling, timing of sample collection, concomitant medication, and underlying disease. For these reasons, comparison of the incidence of antibodies to TRESIBA® with the incidence of antibodies in other studies or to other products, may be misleading. In studies of type 1 diabetes patients, 95.9% of patients who received TRESIBA® once daily were positive for anti-insulin antibodies (AIA) at least once during the studies, including 89.7% that were positive at baseline. In studies of type 2 diabetes patients, 31.5% of patients who received TRESIBA® once daily were positive for AIA at least once during the studies, including 14.5% that were positive at baseline. The antibody incidence rates for type 2 diabetes may be underreported due to patients not taking the insulin as prescribed and due to the presence of antibodies that affect clinical efficacy may necessitate dose adjustments to correct for tendencies toward hyper or hypoglycemia. The incidence of anti-insulin degludec antibodies has not been established.

**Disease Interactions:** Table 5 includes clinically significant drug interactions with TRESIBA®.

**Table 5: Clinically Significant Drug Interactions with TRESIBA®**

**Drugs That May Increase the Risk of Hypoglycemia**
- Antidiabetic agents, ACE inhibitors, angiotensin II receptor blocking agents, diisopropylamine, fibrates, fluoxetine, monoamine oxidase inhibitors, pentoxifylline, pramlintide, propoxyphene, salicylates, somatostatin analogs (e.g., octreotide), and sulfonylurea antibiotics, GLP-1 receptor agonists, DPP-4 inhibitors, SGLT-2 inhibitors.

**Intervention:** Dose reductions and increased frequency of glucose monitoring may be required when TRESIBA® is co-administered with these drugs.

**Drugs That May Decrease the Blood Glucose Lowering Effect of TRESIBA®**
- Aripiprazole antipsychotics (e.g., olanzapine and clozapine), corticosteroids, diuretics, estrogens, glucagon, insulin, niacin, oral contraceptives, phenothiazines, progestogens (e.g., in oral contraceptives), protease inhibitors, somatropin, sympathomimetic agents (e.g., alphabeta, epinephrine, terbutaline), and thyroid hormones.

**Intervention:** Dose increases and increased frequency of glucose monitoring may be required when TRESIBA® is co-administered with these drugs.

**Drugs That May Increase or Decrease the Blood Glucose Lowering Effect of TRESIBA®**
- Alcohol, beta-blockers, clonidine, and lithium salts. Pentamidine may cause hypoglycemia, which may sometimes be followed by hyperglycemia.

**Intervention:** Dose adjustment and increased frequency of glucose monitoring may be required when TRESIBA® is co-administered with these drugs.

**Drugs That May Blunt Signs and Symptoms of Hypoglycemia**
- Beta-blockers, clonidine, guanethidine, and reserpine.

**Intervention:** Increased frequency of glucose monitoring may be required when TRESIBA® is co-administered with these drugs.

**USE IN SPECIFIC POPULATIONS:** Pregnancy: Pregnancy Category C. There are no well-controlled clinical studies of the use of insulin degludec in pregnant women. Patients should be advised to discuss with their health care provider if they intend to or if they become pregnant. Because animal reproduction studies are not always predictive of human response, insulin degludec should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. It is essential for patients with diabetes or a history of gestational diabetes to maintain good metabolic control before conception and throughout pregnancy. Insulin requirements may decrease during the first trimester, generally increase during the second and third trimesters, and rapidly decline after delivery. Careful monitoring of glucose control is essential in these patients. Subcutaneous reproduction and teratology studies have been performed with insulin degludec and human insulin (NPH) as a comparator in rats and rabbits. In these studies, insulin was given to female rats before mating throughout pregnancy until weaning, and to rabbits during organogenesis. The effect of insulin degludec was consistent with those observed with human insulin as both caused pre- and post-implantation losses and visceral/skeletal abnormalities in rats at an insulin degludec dose of 21 U/kg/day (approximately 5 times the human exposure (AUC) at a human subcutaneous dose of 0.75 U/kg/day) and in rabbits at a dose of 3.3 U/kg/day (approximately 10 times the human exposure (AUC)) at a human subcutaneous dose of 0.75 U/kg/day). The effects are probably secondary to maternal hypoglycemia. Nursing Mothers: It is unknown whether insulin degludec is excreted in human milk. Because many drugs, including human insulin, are excreted in human milk, caution should be exercised when insulin degludec is administered to a nursing mother. Women with diabetes who are lactating may require adjustments in insulin dose, meal plan, or both. In rats, insulin degludec was secreted in milk and the concentration in milk was lower than in plasma. Pediatric Use: The safety and efficacy of TRESIBA® in children and adolescents under the age of 18 have not been established. Geriatric Use: In controlled clinical studies a total of 77 (7%) of the 1102 TRESIBA®-treated patients with type 1 diabetes were 65 years or older and 9 (1%) were 75 years or older. A total of 670 (25%) of the 2713 TRESIBA®-treated patients with type 2 diabetes were 65 years or older and 80 (3%) were 75 years or older. Differences in safety or effectiveness were not suggested in subgroup analyses comparing subjects older than 65 years to younger subjects. Nevertheless, greater caution should be exercised when TRESIBA® is administered to geriatric patients since greater sensitivity of some older individuals to the effects of TRESIBA® cannot be ruled out. The initial dosing, dose increments, and maintenance dosage should be conservative to avoid hypoglycemia. Hypoglycemia may be more difficult to recognize in the elderly. Renal Impairment: In clinical studies a total of 75 (7%) of the 1102 TRESIBA®-treated patients with type 1 diabetes had an eGFR less than 60 mL/min/1.73 m³ and 1 (0.1%) had an eGFR less than 30 mL/min/1.73 m³. A total of 250 (9%) of the 2713 TRESIBA®-treated patients with type 2 diabetes had an eGFR less than 60 mL/min/1.73 m³ and no subjects had an eGFR less than 30 mL/min/1.73 m³. No clinically relevant difference in the pharmacokinetics of TRESIBA® was identified in a study comparing healthy subjects and subjects with renal impairment including subjects with end stage renal disease. However, as with all insulin products, glucose monitoring should be intensified and the TRESIBA® dosage adjusted on an individual basis in patients with renal impairment. Hepatic Impairment: No difference in the pharmacokinetics of TRESIBA® was identified in a study comparing healthy subjects and subjects with hepatic impairment (mild, moderate, and severe hepatic impairment). However, as with all insulin products, glucose monitoring should be intensified and the TRESIBA® dosage adjusted on an individual basis in patients with hepatic impairment. OVERDOSAGE: An excess of insulin relative to food intake, energy expenditure, or both may lead to severe and sometimes prolonged and life-threatening hypoglycemia and hypokalaemia (see Warnings and Precautions). Mild episodes of hypoglycemia usually can be treated with oral glucose. Additional measures to drug dosage, meal patterns, or exercise may be needed. More severe episodes of hypoglycemia coma, seizure, or neurologic impairment may be treated with intramuscular/subcutaneous glucagon or concentrated intravenous glucose. After apparent clinical recovery from hypoglycemia, continued observation and additional carbohydrate intake may be necessary to avoid reoccurrence of hypoglycemia. Hypokalemia must be corrected appropriately.

More detailed information is available upon request.

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Convenience Medicine Corners
More of the Health Care Market

By Peter Wehrwein

For many of us, waiting is a large part of the experience when we find ourselves tumbling down the rabbit hole of medical care.

There is the namesake room, hard-chaired and occupied by human question marks—I know why I am here but why are they?—and laden with memories of hunting in Hidden Pictures in Highlights magazine and pitying poor Goofus in his moral struggle with goodie goodie Gallant.

Then there’s that feet-dangling perch upon the examining table in some state of undress and sensory deprivation, so the eyes feast: the box of latex gloves, the snout of the otoscope, a revealed body part or two (oh dear knees, knobbiness be thy name).

Say there are tests. We wait in the dock for the medical verdict: healthy as hoped, not as dreaded, or the inconclusive swathe of results in between.

Remember take two aspirin and [wait] to call me in the morning?

But the premise of the trochaic MinuteClinics and their competitors is that they get you in and out fast—and cheaply—so you don’t have to miss work, school, or all the other things you want to spend your time doing besides being someone’s patient. Patient. Done at home and through your phone or tablet, telehealth could be even faster. Apps—if people could ever be persuaded to actually use them—could be health care’s accelerant.

Not all of this is to the good. It stands to make care even less personal, even if clever retailers apply a veneer of good customer relations. The vendors doth protest, but it’s also likely to fragment health care. But maybe we don’t care that much. Maybe care is already impersonal and fragmented, so we’ll be more than willing to trade in some of that waiting for convenience.
When, Where, and How Patients Want It
Retail clinics are perhaps the most prominent and market-proven aspect of the move to convenience. But there are many variations on the theme.

Telehealth Gives Provider Payment Schemes Static
With insurance coverage so uneven, it can be difficult for doctors to incorporate this technology into their practice.

Retail Clinics, PCPs Square Off Again
This time the issue is the care of chronic conditions. Let retailers handle sinusitis and vaccination, say docs, but for more complex problems....

Homing In on Better Care
There’s nothing like the old-fashioned house call for treating the frail elderly. Unfortunately, though, docs who do this don’t get paid nearly enough.

Plans Should Live App-ily Ever After
It will take work, though, because digital engagement doesn’t just happen. Ensure that patients keep going back to your app for their health data.

Ateev Mehrotra, MD, Crowns Convenience King
As retail clinics, telehealth, and other patient-friendly models take hold, quality may actually improve, says this Harvard Medical School professor.

Q&A: A Conversation With a Best-selling Author
Theresa Brown, RN, Sees World in a Single Shift
The author of The Shift talks about life-and-death issues but also the prosaic aspects of care such as the doctor-nurse dynamic, and the hassles of charting.

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Insurers Can Help Advance Pediatric Cancer Research

Pediatric cancer is the stepchild of cancer research when it comes to funding. This is not news to anyone in health care, but when David A. Williams, MD, pointed out the problem in an opinion piece in STAT on April 14, the response was intense.

“It seems to have gotten a lot of press coverage,” Williams tells MANAGED CARE in an understatement. In the article, he talks about lobbying Vice President Joe Biden to make more pediatric cancer research an integral part of the Obama administration’s cancer moonshot.

The situation is particularly frustrating for someone in Williams’s position; he is president of the Dana-Farber/Boston Children’s Cancer and Blood Disorders Center. Some points he made in the STAT piece: Tackling childhood cancer can lead to breakthroughs in cancer treatments for all ages, and pediatric cancer can play a unique role in trials for targeted gene therapies, offering a pristine genomic landscape.

“We need genomic information,” Williams says. “We need to model therapies using that genomic information, and we’re just in the infancy of doing that.”

In addition, while the cure rates for pediatric cancer (somewhere in the neighborhood of 80%) should be celebrated, they also should underscore that dealing with the complications of a 5-year-old survivor is a much more difficult and extended slog than dealing with the complications of a 65-year-old survivor. It’s something that health plans need to keep in mind.

“With our success with treating patients and curing them, we recognize every day that that comes with a real price to those patients, in the sense of major toxicities that they have to live with their entire life,” Williams says.

Also, obviously, there’s a more heartbreakingly human aspect: Some childhood cancers remain difficult, sometimes impossible, to cure.

Williams wrote in STAT: “Although there are more than 150 types of childhood cancer, pediatric cancer receives only a small fraction of National Cancer Institute and National Institutes of Health funding.”

The development of new therapies for pediatric cancer largely depends on federal and philanthropic funding because the pharmaceutical industry focuses on the vastly larger potential market for adult cancer drugs.

Last October, Thomas Morrow, who writes the Tomorrow’s Medicine department for MANAGED CARE, put it this way: “By one count, just 15 oncology drugs were approved by the FDA for pediatric use between 1948 and 2003 compared with 120 for adult cancer. There are many reasons for this, but it makes some sense when you consider that cancer is mainly a disease of old age and that there are about 100 adult cases of cancer diagnosed for every pediatric case.”

Williams tells MANAGED CARE that “this essentially means that the pediatric hospitals that take care of children with cancer, and the federal government, have a special role to play, at least in my view, to support this kind of research. Because the usual dynamics of pharmaceutical companies putting a lot of investments into research and developing drugs for these particular patients just doesn’t hold.”

There is a role for health plans, says Williams. “We really believe that health care plans and government funding agencies together should cover the full costs of clinical research that has made pediatric cancers a poster child for how you cooperate across centers, and how you use active enrollment of all children in clinical trials to move the field forward,” he tells MANAGED CARE.

Some health plans already do this, but not all, Williams says. It’s become more crucial as genomic medicine gains more of a foothold. “It will be important that health care plans cover the cost of doing the genomic analysis that allows us to place patients in specific trials and ultimately provide the maximum therapy with the least side effects. That’s not the case right
now for most insurance companies. I mean, that’s really just beginning on the adult side, and I think that’s a very important thing that health care coverage could provide.”

For their part, insurers are concerned about mushrooming cost of all kinds of genetic tests and that many tests are investigational and not immediately useful for guiding treatment decisions.

Another problem: Researchers cannot pinpoint what causes most childhood cancers. Only a relatively small percentage of all childhood cancers have known treatable molecular lesions or genetic mutations, says Williams. And although many studies looked for potential environmental causes of pediatric cancers, few convincing or consistent associations have been found.

Insurers can also help by undergirding the social services for families weathering emotional upheaval. “In places like ours,” says Williams, “we have significant resources allocated to mental health and social work care for families undergoing this horrendous stress. That’s often not recoverable from insurance companies.”

Meanwhile, Williams keeps his eye on the ball. “We need to cure more patients that we can’t cure today, and importantly, we need to do that in a way that reduces some of the troubling side effects that families and children now have to deal with.”

**Opioid Abuse Fuels Lots of Hospital Cost**

The opioid abuse epidemic increased dramatically from 2002 to 2012, with the number of abuse-related hospitalizations increasing from about 300,000 to more than 520,000 during that decade, according to a study in *Health Affairs*. In addition, said researchers at Harvard Medical School, the number of patients who abused opioids and who also experience associated serious infections, such as endocarditis or septic arthritis—often because of intravenous drug use—grew from 3,421 to 6,535 during a period when hospitalizations overall remained stable.

Hospital costs associated with these developments soared as well, said the study, which was published in the May issue of the journal. Inpatient charges for opioid abuse nearly quadrupled, rising from $4.57 billion to $14.85 billion. The cost for treating associated infection more than tripled, increasing from about $190 million in 2002 to about $700 million 10 years later.

Those increases remained significant, even accounting for inflation, noted the authors, Matthew V. Ronan and Shoshana J. Herzig: $11.64 billion in 2012 represented in 2002 dollars; and $549.01 million in 2012 represented in 2002 dollars, for hospitalizations and associated infections respectively.

Researchers conducted a retrospective cohort study using data from the Agency for Healthcare Research and Quality’s Nationwide Independent Sample, the largest inpatient database in the United States.

The costs may be on the low side because they do not include costs incurred after discharge, which can be considerable. Ronan and Herzig noted that a larger proportion of those with a serious infection required further care in a skilled nursing facility. They may have also needed home health care.

Medicaid shoulders most of the burden. Just 20% of hospitalizations for opioid abuse and 14% of hospitalizations for associated infections were covered by private insurance, the study stated. Twenty-three percent of those with associated infections are uninsured and probably can’t get the care they need.

The researchers noted that patients with complex histories (medically and psychosocially) often can’t get care at skilled nursing facilities. As a result, they wind up staying in the hospital longer, so the cost of their care goes up.

These patients, in a way, are given the hot-potato treatment, with no hospital or health care system willing to take on the costs.

“The potential lack of ‘ownership’ of the patient’s care may exacerbate the already troubling issues related to access to care and ability to follow through on follow-up care demonstrated by others,” wrote the Harvard researchers.

**Kidney Disease Linked to PPI Use**

The link between proton pump inhibitors (PPIs) and chronic kidney...
disease (CKD) might be even closer than previously documented, according to a recent study in the Journal of the American Society of Nephrology.

Researchers at the VA Saint Louis Health Care System found that people without kidney disease who start using PPIs are 30% more likely to develop CKD five years down the line. What made headlines, though, was that researchers also linked PPIs to CKD progression all the way through to end-stage renal disease (ESRD). Those taking PPIs were 96% more likely to develop ESRD than patients who take H2 blockers. The risk of kidney function decline was 32% higher and the risk of getting kidney disease 28% higher when taking PPIs compared with H2 blockers.

“The results also suggest a graded relationship between duration of exposure and risk of renal outcomes,” the study stated. In other words, the longer you take PPIs, the more the risk, pointing to a systemic failure in monitoring approved medications, the study said.

The study noted that the Sentinel Initiative, launched by the FDA, was created specifically for this problem, namely, to “uncover latent adverse events” of already approved medications. The initiative, however, has not yet comprehensively fulfilled the mandate required by the Food and Drug Administration Amendments Act (FDAAA), which became law in September 2007, the study’s corresponding author, Ziyad Al-Aly, tells Managed Care.

The Sentinel program was formally launched in 2008, but there were some delays in implementation, according to Al-Aly. The initial phase, called MiniSentinel, just concluded, and the full-scale program just started, he says.

The law mandates that the FDA develop an enhanced ability to monitor the safety of drugs after these products reach the market, he says. “The FDA and its partners should do more to leverage the power of big data and advanced analytics to proactively and systematically detect adverse events of approved pharmaceuticals,” Al-Aly says.

one of the most persistent cost challenges clinician executives at health insurance plans face are those run up at neonatal intensive care units (NICU). When it comes to the well being of infants, no expense should be spared—and usually they aren’t. The last time it looked in 2006, the Institute of Medicine estimated that we spend about $26 billion a year on preterm infants. Managed Care has also looked at this over the years. What we reported in 2010 still holds true: “For managed care organizations, advances in the care of preterm infants create both opportunities and a wide array of societal, ethical, and financial dilemmas.”

New research points out what happens in the NICU doesn’t necessarily stay in the NICU. These infants will often need continuous care at home and, according to a study by researchers at Case Western Reserve University in Cleveland, that can be when the really difficult part for parents and guardians starts—even more difficult than spending hours each day at the NICU trying to keep despair at arm’s length.

“Technology-dependent neonates require vigilant, complex care and treatment by their parents following discharge from the hospital for continued survival,” says the study, which was presented at a recent conference of the National Association of Pediatric Nurse Practitioners and is slated to be published in Advances in Neonatal Care.

This touches on the difficulties in care transitions, another subject we’ve dealt with. Using a retrospective chart review of 71 neonates from Oct. 1, 2012, to Sept. 30, 2014, who were in the Rainbow Babies & Children’s Hospital Transitional Care Unit in Cleveland, researchers found that 66% of the infants needed supplemental oxygen after discharge and 46.5% needed feeding tubes. Parents need to know how to use those devices, said researchers.

“Mothers often provide a majority of this care and are at high risk for depression,” the study noted. Maternal distress needs to be monitored, which is where outside health care providers come in. They can “provide needed assessment and support for technology-dependent neonates and their parents during the vulnerable transition period…”

Medical technology used by neonates

<table>
<thead>
<tr>
<th>Medical Technology</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Supplemental oxygen</td>
<td>66%</td>
</tr>
<tr>
<td>Nasogastric tube</td>
<td>25%</td>
</tr>
<tr>
<td>Gastrostomy tube</td>
<td>21%</td>
</tr>
<tr>
<td>Tracheostomy</td>
<td>16%</td>
</tr>
<tr>
<td>Mechanical ventilation</td>
<td>16%</td>
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The health and cost implications are immense. Millions of Americans are prescribed PPIs and millions more can buy them over the counter.

Researchers in the Journal of the American Society of Nephrology study analyzed information in national VA databases on 20,270 people who had recently started taking PPIs. They also looked at data on 173,321 people who started taking H2 blockers. The data were gathered between Oct. 1, 1999
and Sept. 30, 2006. About this time last year, MANAGED CARE reported that chronic kidney disease threatens to become a major health and cost burden in coming years. More than half (54%) of Americans ages 30 and older who don’t currently have CKD will develop the condition some time in their lives.

The main risk factors for CKD include diabetes, hypertension, and age. Early detection and treatment of CKD can forestall or delay heart disease and kidney failure. Likewise, early treatment of diabetes and hypertension can prevent CKD from developing. Some experts point out that the clinical significance of early stage CKD among the elderly with borderline numbers is somewhat debatable, partly because of competing health problems.

New Horizon Seen For Robotic Surgery

Robotic surgery these days involves a physician’s hand guiding a mechanical arm. A recent study in Science Translational Medicine anticipates a day when the robot arm will not need that sort of human guidance, although there will always be human supervision.

Today’s robot-assisted surgeries (RASs) depend entirely on an individual surgeon’s manual capability, argued the authors of the study published in the May 4 issue of the journal.

“There are always minute tremors even in the best surgeons’ hands. ‘Functional outcomes, including complication rates, have remained highly variable owing to human factors, such as a surgeon’s hand-eye coordination and experience,’” wrote researchers at Children’s National Medical Center in Washington.

The new technology developed at the center, called the Smart Tissue Autonomous Robot (STAR), depends on imaging technology that is guided by a computer program, not a human being. The program incorporates best surgical practices in determining when and how to suture (the technology only sutures and does not wield the scalpel).

STAR is still in the developmental stage, but it’s doing a good job on pig tissue, according to the Children’s National Medical Center researchers.

The researchers reported that STAR was better at stitching together two pieces of pig tissue than regular surgeons, and it did about as well as the human surgeons in reconnecting intestines in live pigs. Such connecting, anastomosis, is done millions of times a year in many different types of surgeries.

“This task [anastomosis] represents a proof of concept for all potential soft tissue surgical tasks requiring repetition, precision, accuracy, and efficiency that can potentially benefit from autonomous or supervised autonomous functionality,” the study said.

Researchers included some calming words for those who are worried—to borrow the sci-fi trope—that the machines are taking over.

“The intent of this demonstration of feasibility in soft tissue surgery was not to replace surgeons but to expand human capacity and capability through enhanced vision, dexterity, and complementary machine intelligence for improved surgical outcomes, safety, and patient access.”

Briefly Noted

HHS has challenged stakeholders in health care to design a medical bill that’s easier for patients to understand. The challenge, directed at health plans, digital tech companies, designers, and other organizations, is sponsored by the AARP. Winning designs will be featured at the Health 2.0 Annual Fall Conference this September … Educational interventions and prompts from electronic health records caused primary care physicians to significantly reduce the number of prescriptions they wrote for antibiotics to treat acute respiratory tract infections, according to a study published in JAMA. “Among primary care practices, the use of accountable justification and peer comparison as behavioral interventions resulted in lower rates of inappropriate antibiotic prescribing for acute respiratory tract infections,” the study stated. … Hospital mergers among systems in the same state increase health care prices by 6% to 10%, according to researchers at Northwestern University’s Kellogg School of Management. Mergers across state lines did not lead to any statistically meaningful increases. … Yet another black mark for the VA health system. A study in JAMA Internal Medicine found that of 4,000 veterans who had carotid artery surgery, reasons for approving carotid screens were not clear in 83% of the cases, while 11% of the patients were screened for inappropriate reasons. “Strong consideration should be given to improving the evidence base around carotid testing, especially around monitoring stenosis over long periods and evaluating carotid bruits,” the study stated. … Three prominent hospital systems recently took measures to ensure that surgeons doing complicated surgeries have enough experience to perform the operations, reports Kaiser Health News. They are Dartmouth-Hitchcock, Johns Hopkins, and the University of Michigan health systems. “The largely untested ability of surgeons with minimal expertise to perform high-risk procedures—particularly at hospitals that lack experience caring for significant numbers of patients—has been the subject of a contentious, long-running battle known as the volume-outcome debate,” the story reports. … The night shift isn’t good for heart health, according to a study in JAMA. Researchers found that nurses in the Nurses’ Health Studies who worked three or four night shifts per month have a greater likelihood of developing heart disease after 24 years compared with nurses who worked only day shifts. But the absolute risk was small, and the risk ebbed after the nurses quit shift work. … Women struggling with diabetes and obesity have four times the chance of having babies with some form of autism, according to a study in Pediatrics. That’s if diabetes was diagnosed during the pregnancy. Women who had diagnosed diabetes before becoming pregnant have a fivefold chance of having a baby with autism spectrum disorder, the study stated.

— Frank Diamond
Is GOP Idea Déjà vu All Over Again?
Selling coverage across state lines dusts off an old idea that has new legs.

By Richard Mark Kirkner

A cornerstone of the Republican replacement of the ACA and one that the party’s presumptive nominee, Donald Trump, has embraced, is to let individuals buy health insurance across state lines—that is, from a company licensed (sometimes called “domiciled”) in a state other than the one they are living in. Selling insurance across state lines is second on Trump’s seven-item list for “health care reform to make America great again.”

Supporters say it’s like getting only the shows you want from Netflix instead of buying a cable TV package with a lot of channels you don’t want. Opponents counter that’s actually a tired idea that’s akin to letting states set their own car safety standards and, in effect, having them apply in others, so you could buy a car in a state that doesn’t require airbags and drive it in your own traffic-crazed state that does require them.

But there’s no disputing that the idea of buying and selling insurance across state lines has been kicking around for years. John McCain and Mitt Romney both included it in their health reform proposals. And it was the centerpiece of the Health Care Choice Act of 2005, introduced by two Republicans, former Rep. John Shadegg of Arizona and former Sen. Jim DeMint of South Carolina (the legislation went nowhere). “What’s old is new again,” says Patricia Riley, president and executive director of the National Academy for State Health Policy (NASHP).

Allowed already
Some laws and regulations on the books allow health insurers to sell individual coverage across state lines, although the concept exists more in theory than in practice. Georgia, Maine, and Wyoming have passed such laws. Rhode Island’s 2008 statute limits out-of-state policies to neighboring Massachusetts and Connecticut, so some proponents of out-of-state policies don’t think it accomplishes the purpose of cre-

Status of state laws allowing out-of-state health insurance

Source: National Conference of State Legislatures, 2016
ating a broader insurance market. Kentucky’s law is limited to a feasibility study of allowing states to join forces and create a regional market for health insurance. Sabrina Corlette, a research professor at the Center on Health Insurance Reforms at Georgetown University’s Health Policy Institute, who coauthored a 2012 report on selling health insurance across state lines, says to her knowledge no health plan has taken advantage of the state laws that allow it to happen. “There’s been a lot of moving and shaking, but I would be absolutely shocked if I heard from an insurance company that one of these state laws was the reason they came into commercial market,” she says.

Even the ACA has a provision that allows for the sale of individual health coverage across state lines, but “in a very, very limited way,” says Brittany La Couture, health policy counsel at the conservative American Action Forum. The ACA permits multistate plans (MSPs) but they have to be sold through the ACA exchanges and meet a host of other federal regulations, as La Couture pointed out in an October 2014 paper on interstate health insurance. Included among those other regulations is a requirement that MSPs operate in all 50 states by 2018.

“Blue Cross/Blue Shield was the only insurer to submit an application to participate in the MSP program,” La Couture wrote. “This lack of competition in the multistate market confirms fears that under this type of federally run system, insurers will not enter new markets, but the largest insurers will simply expand and consolidate their market share.”

An older federal statute, the McCarran–Ferguson Act of 1945, poses another obstacle in the cross-state sale of individual policies. McCarran–Ferguson gives states the power to regulate all types of insurance and establish licensing requirements. The ACA enables MSPs by overriding the McCarran–Ferguson strictures. Were the ACA to be repealed, Republicans would have to find another way to get around the 70-year-old statute if they wanted to open the door to cross-state health insurance.

**Why cross the line?**

A belief in the power of free markets underpins the thinking of the proponents of interstate health insurance. Letting people buy health insurance available in another state would give people more choices and not restrict them to a health plan that meets their home state’s insurance regulations. “Some states mandate that acupuncture be covered, and a lot of people would argue that’s not one that they should be required to pay for,” says La Couture. More consumer choices would result in insurers competing on price, proponents say. “As long as the plan purchased complies with state requirements, any vendor ought to be able to offer insurance in any state. By allowing full competition in this market, insurance costs will go down and consumer satisfaction will go up,” says Trump’s proposal.

Michael Cannon, director of health policy studies at the libertarian Cato Institute, says letting people buy coverage outside their home states would have the effect of spurring regulatory competition among the states. Because the licensing requirement is a barrier to entry into a market, it shields one state’s regulations from the feedback loop that would otherwise tell regulators that they have gone overboard, he argues. It also prices some people out of the market because health plans have coverage that people don’t necessarily want. Competition from out-of-state plans might push regulators in some states to jettison coverage mandates that an interstate market might reveal are unwanted, says Cannon.

In the true free interstate health insurance market, Cannon doesn’t worry about the so-called race to the bottom—states getting rid of regulations so they can become havens for barebones health plans. “If those regulations are valuable, if people are suffering without them, it’s going to affect people in that state, too, and they are going to push the legislators in that state to reinstate some of those regulations,” he says. There is a self-correcting mechanism, Cannon says: “That’s why it’s a race to equilibrium, not a race to the bottom.”

But Richard Kirsch says a race to the bottom is exactly what would happen if health insurers could sell products ignoring the rules of the states they are selling in. Kirsch, a senior fellow at the liberal Roosevelt Institute, sees the cross-state selling as spelling the end to all the consumer protections of the ACA. The result, he said, would be the proliferation of “junk insurance.”

The lack of consumer protection is a huge
flaw in letting people buy insurance out of state, contend the critics. And what if a person has a problem with her insurance company (not an uncommon experience)? Maybe a bargain hunter in, say, Georgia, gets a good deal from an insurer in Oregon. But if she wants to file a complaint, it will be with the Oregon Division of Financial Regulation in Salem, more than 2,000 miles away.

But it isn’t just liberals that object to cross-border insurance markets. John R. Graham, a senior fellow at the National Center for Policy Analysis, a Dallas think tank that argues for market-based approaches to public policy issues, called selling insurance across state lines a “red herring” in an opinion piece published in the Hill last fall. In Graham’s view, prices set by the provider network associated with a health plan are the biggest determinant of insurance rates, not the familiar punching bag of state-level mandates. People in New York might get a better rate from an insurer in Utah, but only if they are prepared to hop on a plane and get their medical care in Salt Lake City, he wrote.

Indeed, the biggest barrier to selling health insurance in another state could be all the time and effort in setting up a provider network. “It’s the network, stupid,” says Georgetown’s Corlette. Building a network from scratch is “very difficult and extremely expensive,” she says. “It requires not only a lot of man hours to go sign up all these doctors and hospitals, but when you’re a brand new carrier with no enrollment, how do you convince a provider to not only sign up with you but to also give you any kind of discount? You have no clout. You have no ability to negotiate a decent rate. If you can’t get a decent rate from your providers, how do you offer a competitively priced premium?”

Controlling costs by other means

Cannon, at Cato, says networks are not just overrated but backward. A health plan doesn’t need to have a provider network, he says, and can control costs by other means such as cost sharing. Tiered cost sharing is one model that could replace the old managed care model based on contracts, discounts, and all the care and feeding required of a provider network, he says.

In Cannon’s view, regulatory competition would make it easier for carriers to create their own networks. “There’s a lot of value to be provided from integrated, prepaid group plans like Group Health Cooperative and Kaiser Permanente,” he says, the former in Washington State, the latter in California and seven other states and the District of Columbia. The reason they haven’t moved into other states “is because of these monopolistic licensing regimes in every state.” In March, Group Health approved a proposal to be acquired by Kaiser Permanente, a deal that is still subject to regulatory review.

Dramatic change

But since the idea of selling plans across state lines first gained traction about a decade ago, the health care delivery system has changed dramatically, notes NASHP’s Riley. “Now in the era of accountable care organizations and integrated care delivery, there are increasingly big health systems,” she says. “It almost doesn’t matter how many insurance companies you have because they have to negotiate with the same health system.”

A lot would have to happen legislatively to let people buy health coverage licensed in another state. Step one would be to repeal the ACA. Step two would be to tweak McCarran–Ferguson to exempt health plans from state regulations. Step three would be to enact an ACA replacement that would actually create some kind of regulatory landscape to allow cross-border health plans. Even if the election breaks so the GOP gains control of the White House and the Congress, there are all those interest groups to contend with. One important one is America’s Health Insurance Plans (AHIP).

“Selling across state lines presents significant operational challenges when it comes to designing coverage options and review and approval of insurance,” says Clare Krusing, an AHIP press officer. “This would upend the traditional review-and-approval structure while also making it a challenge for health plans to design coverage options tailored to the local markets.”

But at least the anti-ACA forces have put forward one idea beyond simply getting rid of the law they loathe. “There’s always been this criticism of ObamaCare without the alternative, so at least now we have an alternative and I think that’s always a healthy discussion,” Riley says.

And it could be a very healthy discussion that goes on right through to Election Day on November 8.
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The Hippocratic oath says, "First, do no harm." The early 21st century push to make health care more convenient seems to add, "and make it snappy!"

Retail clinics are perhaps the most prominent and market-proven aspect of this change. There are about 2,100 retail clinics in the country. CVS executives have said they hope to have 1,500 of their MinuteClinics up and running next year. Research by Ateev Mehrotra, MD, an assistant professor at Harvard Medical School and a member of our Managed Care editorial advisory board, has found that in some respects, the quality of care at retail clinics is slightly better, not worse, than the care delivered in the offices of the country’s primary care physicians (see page 32). Word of mouth is statistically dubious but impossible to ignore, and here at Managed Care the word of mouth about retail clinics from coworkers and spouses has been a solid thumbs up.

Surging telemedicine is more evidence of the growing importance of the convenience factor in health care. As Thomas Morrow, MD, reports (page 36), more than 4,000 people attended the annual meeting of the American Telemedicine Association in Minneapolis last month. Vendors are in a mad scramble for position in a market of uncertain size. Telemedicine is gaining ground as a more efficient way to deliver care within the conventional health care system; the routine post-op appointment seems like an ideal application. But we’re in a frothy period. The where, when, how, and by whom of telemedicine—they’re all up for grabs.

The same might be said about thousands of health care apps. The plain fact of the matter is that many apps go unused—a little like all those exercise bikes that only get used on the road of good intentions. The health care app is nothing but convenient—all that information and functionality right there on your phone at your fingertips. But the fact that many only gather digital dust shows that convenience only goes so far. You can lead people to apps. But what can you do to make folks actually use them?

Meanwhile, CMS and other payers are experimenting with the old-fashioned house call for people with multiple health problems (page 24). Are these throwback efforts a matter of convenience? That characterization is rejected by some providers. But if you relieve convenience of its negative connotation and see it as a way to knock over the hurdles of access and lack of mobility, then the house call falls squarely into this larger trend.

Convenience has limitations, and the boundaries between it and health care delivered in a more conventional way are in flux. Primary care physicians are pushing back on the possibility of retail clinics moving further into their turf by taking on the care of people with chronic care. Mehrotra’s research has identified some worrisome quality problems with some applications of telemedicine. Payers are still puzzling through how to compensate providers for care guided by convenience.

So there is plenty of uncertainty. Except maybe this: Americans’ tolerance for waiting is disappearing fast, and the technology that enables digital encounters is getting better all the time. How long will it be before doctors and patients will meet via Oculus or through some other 3-D technology? We may soon be looking back and wondering how people ever tolerated so much inconvenience in their health care, in the same way that’s hard to imagine now how we ever got by without the car, the personal computer, and the cell phone.
Telehealth Dials Up Discussion About Payment to Providers

One of the problems deals with uneven coverage among different health insurers. Doctors want more clarity.

By Susan Ladika

Wile the consensus is that telehealth is crest

ing as the wave of the future—expanding

patients’ access to care, addressing the needs

of today’s time-pressed, on-demand society—what’s

still far from clear is how, or how much, providers will

be paid for the service.

The new rules for Medicaid managed care and

MACRA are telehealth-friendly, but for now, Medi-
care and Medicaid reimbursements are spotty, with

Medicaid payment varying greatly from state to state.

Similarly, commercial insurers seem to be warming

up to telehealth, but there’s no consistency on what
to pay for—or even whether to pay at all.

Meanwhile, providers seem to be ready to embrace

telehealth with open arms, although that welcoming

attitude comes with an important condition attached.

For example, a survey of more than 1,500 family physi-
cians conducted last fall for Anthem and the American
Academy of Family Physicians (AAFP) found almost

90% of respondents would use telehealth to help treat

their patients—if they were compensated for that care.

But with insurance coverage so uneven, it can be
difficult for doctors to incorporate telehealth into

their practice. “If you’re in practice and only offer

it [telehealth] to some patients, it’s a problem,” says

Wanda Filer, president of the AAFP. “It presents

an issue of unequal access and a logistics problem.

Telemedicine shouldn’t exacerbate quality concerns.”

Small slice of telehealth pie

One version of telehealth is urgent care delivered

remotely by dialing up a doctor on a smartphone,

computer, or landline for treatment of minor emer-
gencies such as allergies or the flu.

But urgent care is just a very, very small slice of

the telehealth pie, says Peter Rasmussen, MD, a brain

surgeon who serves as medical director for distance

health for the Cleveland Clinic: “Almost any area of

medicine can apply telehealth.”

Rasmussen, for example, uses telehealth for such

things as postsurgical follow-up if a patient is doing

well and consultations with a new patient if a physical

examination isn’t required. Telehealth “works terrifi-
cally; 98% of my patients don’t require more,” he says.

Rasmussen has also found the consultations tend to

be quicker because there is less chitchat.

Rasmussen says some groups of patients prefer

telehealth visits because staying at home is convenient

and feels safer. Parkinson’s patients, for example, often

have limited mobility. People with cystic fibrosis may be

prone to infections. However, “quite a few interactions

aren’t reimbursed, but they wouldn’t be anyway,” such

as postsurgical follow-up, Rasmussen says.

It’s a similar situation at Brigham and Women’s Hos-
pital in Boston, which uses telehealth to provide care

for patients with chronic conditions such as diabetes.

So far, Blue Cross Blue Shield of Massachusetts is the

Harvard teaching hospital’s only commercial payer

that reimburses providers for virtual visits, says Adam

Licurse, MD, assistant medical director of Brigham

and Women’s Physician’s Organization.

Pricing and payment issues have kept many physicians

from adopting telehealth, says Wanda Filer, MD, president

of the American Academy of Family Physicians.
“Telehealth is important for better patient care,” Licurse says. “We’re willing to compensate a provider for the time it takes to perform the visits, even though only part of the visits are reimbursed.”

Telehealth has a range of uses these days. The Cerebrovascular Center at Cleveland Clinic, which Rasmussen directs, offers telestroke services, providing real-time consultation to help other medical centers assess and treat stroke patients. Cleveland Clinic also offers online second opinions for a range of conditions, including brain tumors, digestive diseases and cancers, and orthopedic injuries. The base price is $565, with an additional $180 if a pathology review is required.

The Department of Veterans Affairs has invested heavily in telehealth services. During the 2015 fiscal year, the VA provided telehealth services to more than 675,000 veterans, or about 12% of all the veterans enrolled to receive VA care, and spent about $1 billion on the effort.

The VA uses telehealth to link its far-flung facilities; for example, its four polytrauma rehabilitation centers are linked to 17 health care sites nationwide with the goal of improving access for those wounded in combat. The VA also uses telehealth to provide a variety of mental health and rehabilitation services remotely.

**Slow adoption**

Medicaid and Medicare have been much slower to get on the telehealth bandwagon, although there are some signs that the reluctance is ebbing. Not surprisingly, Medicaid coverage varies quite a lot from state to state. Medicaid programs in 47 states and the District of Columbia reimburse for live, interactive video telehealth care, while 16 states offer reimbursement for remote patient monitoring, according to a study completed last year by the Center for Connected Health Policy, a project of the Public Health Institute, a California not-for-profit organization. But new rules for Medicaid managed care issued by CMS in April may be a boost to telehealth and its many purveyors. The new rules suggest that states consider telehealth when drawing up their network adequacy standards. If states go along with the suggestion, Medicaid managed care plans may start building their networks with providers who

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**Telehealth now and in the future, by practice area**

Respondents answered two questions, “In what practice areas does your organization use telehealth/telemedicine?” and “In what practice areas would you like your organization to implement telehealth/telemedicine in the future?”

<table>
<thead>
<tr>
<th>Practice Area</th>
<th>Now</th>
<th>Future</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stroke</td>
<td>44%</td>
<td>17%</td>
</tr>
<tr>
<td>Behavioral health</td>
<td>39%</td>
<td>24%</td>
</tr>
<tr>
<td>Staff education/training</td>
<td>26%</td>
<td>26%</td>
</tr>
<tr>
<td>Primary care</td>
<td>22%</td>
<td>27%</td>
</tr>
<tr>
<td>Neurology</td>
<td>19%</td>
<td>20%</td>
</tr>
<tr>
<td>Pediatrics (primary &amp; specialty)</td>
<td>19%</td>
<td>8%</td>
</tr>
<tr>
<td>Remote patient home monitoring</td>
<td>19%</td>
<td>30%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>17%</td>
<td>25%</td>
</tr>
<tr>
<td>Intensive care</td>
<td>15%</td>
<td>16%</td>
</tr>
<tr>
<td>Patient education</td>
<td>13%</td>
<td>34%</td>
</tr>
<tr>
<td>Dermatology</td>
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<td>16%</td>
</tr>
<tr>
<td>Urgent care</td>
<td>10%</td>
<td>20%</td>
</tr>
<tr>
<td>Wound care</td>
<td>6%</td>
<td>20%</td>
</tr>
<tr>
<td>Skilled nursing, rehabilitation, or other subacute care program</td>
<td>6%</td>
<td>10%</td>
</tr>
<tr>
<td>School-based care</td>
<td>5%</td>
<td>12%</td>
</tr>
<tr>
<td>Oncology</td>
<td>3%</td>
<td>14%</td>
</tr>
<tr>
<td>Other</td>
<td>13%</td>
<td>5%</td>
</tr>
<tr>
<td>Unsure/don’t know</td>
<td>2%</td>
<td>16%</td>
</tr>
</tbody>
</table>

Source: Modern Healthcare Custom Media on behalf of Avizia, “Closing the Telehealth Gap,” May 2016. The web-based survey was emailed to 15,000 health care executives in Modern Healthcare’s database during March 2016. There were 280 respondents.
are willing to see patients via a telehealth connection.

Coverage of telehealth in traditional Medicare is fairly limited. Services such as remote radiology and pathology are covered, according to the American Telemedicine Association. Beyond that, those living in rural areas are covered for services, such as office visits and consultations if the provider isn’t located in their area. But the recipient must receive telehealth care at a doctor’s office, hospital, or similar facility. CMS is in the process of liberalizing coverage. For example, the distance rules that, in effect, restrict telehealth to rural areas and don’t allow patients to be seen at home are waived for the 18 organizations participating in CMS’s Next Generation ACO program. And as proposed, the pay-for-performance part of the new MACRA rules—the Merit-Based Incentive Payment System (MIPS)—would mean that physicians could earn higher scores by implementing telehealth services.

Medicare Advantage plans already have the freedom to provide telehealth services if they wish, but only 69,000 Medicare patients used telehealth services in 2014, according to figures provided at the March meeting of the Medicare Payment Advisory Commission (MedPAC). According to an AAFP report on that meeting, MedPAC members debated whether access to telehealth services should be expanded, and some expressed concern that the availability of telehealth would lead to unnecessary consultations.

According to the AAFP report, Craig Samitt, a MedPAC commissioner and chief clinical officer at Anthem, spoke against an “overly conservative” approach to telehealth at that meeting: “We should be embracing the use of technology faster in the industry. Our payment system should not suppress progress.” Meanwhile, a bipartisan group of senators and representatives have introduced the Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act that would expand Medicare coverage of telehealth. The law would loosen the rules on where patients could be seen, expand usage of remote patient monitoring for some patients who have chronic conditions, and allow telehealth to be included as a basic benefit in a Medicare Advantage plan. A study by Avalere Health projected that the CONNECT legislation could save $1.8 billion in Medicare spending over 10 years.

The Congressional Budget Office has been less sanguine about telehealth savings. In a blog post last year, the CBO said it’s impossible to predict whether expanding Medicare coverage for telehealth services would raise or reduce federal spending without knowing whether telehealth services would be substituted for or prevented the use of more expensive services, coverage of telemedicine could reduce federal spending. If instead telemedicine services were mostly used in addition to currently covered services, coverage of telemedicine would tend to increase Medicare spending. Many proposals to expand coverage of telemedicine strive to facilitate enrollees’ access to health care. Therefore, such proposals could increase spending by adding payments for new services instead of substituting for existing services.”

Parity laws

Private insurers are also inching toward covering telemedicine. Late last year and during the beginning part of this year, a number of Blues plans have announced that they are covering telehealth services. In 29 states and the District of Columbia, private insurers will have to deal with parity laws that require them to pay for telehealth services, though only some of those require telehealth to be covered at the same rate as services provided in person. The number of states with parity laws has doubled in the past three years.

Often insurers are covering the kind of telehealth service provided by vendors like Teladoc, MDLIVE, or American Well. Teladoc was founded in 2002, but it took a decade for business to take off, says Jason Gorevic, the company’s CEO. Now Teladoc is by far the largest player in the telehealth urgent care market. Last year the company provided 576,000 telehealth visits, a 93% increase over 2014, and is projected to complete 900,000 visits this year. Gorevic attributes Teladoc’s success to design choices that make it easy for patients and doctors to use its platform, as well as marketing...
efforts that built awareness and engagement. He says the ACA has fueled the growth in telehealth because it caused "people to look at access to care differently," due to the shortage of primary care physicians.

One of Teladoc's advantages is a flexible workforce, Gorevic explains. The company can put more doctors on duty if there are spikes in consumer demand. During cold and flu season, the company provided services to about 3,300 patients per day, Gorevic says, and no one had to wait in line at a crowded doctor's office for care. Visits cost $45 on average, far cheaper than an urgent care center or emergency room.

The company has more than 6,000 clients, including employers and insurers such as Aetna and Blue Shield of California. Despite the impressive client base, the Wall Street Journal has reported that Teladoc isn't expected to be profitable until 2018.

Not everyone is crazy about the Teladoc model. Filer, the AAFP president, says telehealth "should enhance the continuity of care, not be disruptive." When urgent care is provided by specialized companies, the physician may not be aware of a person's medical history and miss an important diagnosis. For example, someone may report symptoms that are consistent with an upper respiratory infection but if they have similar symptoms at the same time each year, that could be an indication that they have allergies, Filer says.

Filer isn't opposed to telehealth. But rather than specialized providers, she wants to see it used to support the patient-centered medical home that her organization and others have endorsed. And she is supportive of behavioral and specialty health care being available remotely, particular in cases where the closest specialist could be hundreds of miles away.

**Blurred lines**

But companies like Teladoc are branching out into specialty services. During the past 18 months, Teladoc has added behavioral health, dermatology, sexual health, and tobacco cessation to its menu. "They lend themselves well to remote delivery of care," says Gorevic. "Access is a significant challenge and consumers are asking for help in these areas." The company plans to soon roll out a new product designed to aid caregivers by allowing three-way interaction among the patient, the caregiver, and a physician.

Meanwhile, large health care systems are getting into the telehealth game. The Cleveland Clinic provides urgent care to residents of four states through its Express Care Online service. The health care system charges $49 for a 10-minute consultation. Some insurers cover the service. The Cleveland Clinic has also made an interesting deal with CVS. People seen in CVS’s MinuteClinics have access to Cleveland Clinic physicians through a telehealth platform provided by American Well. Staff at the MinuteClinic will do things that still require in-person, real-time presence, like blood pressure and body temperature measurement, and share the results with the Cleveland Clinic doctor.

But pricing and payment for telehealth services remains a tricky issue and an impediment till the kinks are worked out. Only 15% of the physicians who responded to a survey for AAFP and Anthem currently.

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**Barriers to telehealth as seen by health care executives**

<table>
<thead>
<tr>
<th>Issue</th>
<th>Percentage</th>
</tr>
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<tbody>
<tr>
<td>Investment for technology and infrastructure</td>
<td>50%</td>
</tr>
<tr>
<td>Issues related to reimbursement</td>
<td>48%</td>
</tr>
<tr>
<td>Clinician resistance</td>
<td>25%</td>
</tr>
<tr>
<td>Workflow design</td>
<td>19%</td>
</tr>
<tr>
<td>Privileging and credentialing</td>
<td>17%</td>
</tr>
<tr>
<td>Maintenance and ongoing support for the technology</td>
<td>17%</td>
</tr>
<tr>
<td>Patient resistance</td>
<td>15%</td>
</tr>
<tr>
<td>Medical licensure</td>
<td>13%</td>
</tr>
<tr>
<td>Lack of employee training/skills</td>
<td>11%</td>
</tr>
<tr>
<td>Disruptive nature of technology</td>
<td>11%</td>
</tr>
<tr>
<td>Executive resistance</td>
<td>4%</td>
</tr>
<tr>
<td>Regulatory issues</td>
<td>3%</td>
</tr>
</tbody>
</table>

Source: Modern Healthcare Custom Media for Avizia, “Closing the Telehealth Gap,” May 2016
make use of telehealth. Those who do tend to have been in practice fewer than 10 years and are located in rural areas. “Once there’s universal payment for this, you’ll see more physicians adopt it,” Filer predicts.

Medicare hesitant
A study published in 2016 by the Health Care Cost Institute examined millions of health insurance claims filed with several different insurers and found reimbursement for telehealth services was almost 40% lower than it was for nontelehealth services.

The study examined claims from 2009 to 2013, before many states had passed any type of parity law.

Medicare’s hesitation to embrace telehealth influences private insurers, says John Jesser, vice president of provider engagement strategy for LiveHealth Online, an urgent care telemedicine provider for Anthem Blue Cross and Blue Shield. Anthem offers LiveHealth Online telehealth solutions to its network primary care doctors and health systems.

Many insurers may be more willing to contract with telehealth vendors like LiveHealth Online or Teladoc than pay individual doctors who add telehealth services to their practice. But some insurers, such as Independence Blue Cross, are doing both. The Philadelphia-area insurer recently announced that customers could either consult with urgent care physicians through MDLIVE or with their own primary care physicians who have a secure video connection, depending on their plan. “We want to make this available to any primary care physician interested in offering this service,” says Ron Brooks, senior network medical director at Independence Blue Cross.

To underscore that, Tandigm Health, a health care company created in 2014 by Independence Blue Cross and DaVita HealthCare Partners, is rolling out a mobile telemedicine platform to its 380 physicians in an effort to improve patient access and engagement.

By covering telehealth visits with primary care doctors, patients may be able to turn to them for care on weekends and in the evening, and it allows the doctors to be paid for their time. Previously, if a doctor talked with a patient on the phone, “they weren’t paid at all for that phone call,” Brooks says.

But payment for a telehealth visit isn’t the same as for an office visit, he says. “If people think this should be on the same fee schedule as a visit in the office, it really isn’t the same. The service doesn’t include some of the key elements,” such as taking a patient’s blood pressure or listening to his heart and lungs.

Reimbursement for telehealth is based on the relative value units set up by Medicare, Brooks says. They are the governing body that initially looked at the factors involved in telehealth, like office overhead, and concluded that reimbursement for telehealth should be lower.

Parity laws come in two varieties, according to Jesser. In some cases, they require insurers to pay the same amount for services provided either in an office or via telehealth. But in other cases, parity just means insurers have to cover both in-person and telehealth services, though not necessarily at the same rate.

“As a matter of principle, we are generally opposed to any legislation that dictates payment amounts, as we support the belief that payment amounts should be market driven,” says Jesser.

Expanded capacity
He also cites the possibility of a doctor using the same code for telehealth visits and being able to work with it from home, with no employees or office space. “For a family medical practice that has examination rooms that are constantly in use, capacity can essentially be expanded with the addition of telehealth services,” Jesser says. “It’s like adding another exam room without having to hire construction workers to come and build it.”

Despite the struggles over compensation, telehealth is probably here to stay. The convenience of telemedicine “is really what patients come to expect,” Rasmussen says. “There is so much that’s on demand. Health care certainly shouldn’t be any different.”

Susan Ladika is based in Tampa, Fla., and has been a freelance writer for almost 20 years.
Chronic Illness New Battleground
For Retail Clinics, Primary Care Physicians

Doctors have pretty much made their peace with retail clinics for problems like sinusitis and routine vaccination. But they aren’t ready to concede care for chronic conditions to the retailers.

By Robert Calandra

Just when it seemed that retail clinics and primary care practices were learning to live together, retail clinics want to expand their scope of practice to treat patients with high blood pressure, diabetes, and other chronic conditions. Primary care physicians are pushing back hard against the industry’s ambition. They say clinics, located in stores, pharmacies, and supermarkets, simply are not qualified to manage complex chronic conditions.

“We don’t think there is enough evidence to say that they are able to take care of chronic disease and to manage complex problems,” says Nitin Damle, MD, president of the American College of Physicians (ACP). “We do not recommend that they go forward with that.”

A 2015 study by Accenture, the research and consulting company, found that while 41% of doctors were “comfortable” with patients using the clinics for things like vaccinations and preventive care, they were not on board with patients using the clinics for primary care or the management of chronic conditions.

This friction between retail clinics and primary care practices is just the latest flare-up in an occasionally nasty rivalry. The two have been locked in a turf war for patients’ clogged sinuses, runny noses, and achy ears for at least a decade. The odds of winning weren’t in primary care practices’ favor because clinics had something they just couldn’t offer—convenience.

There’s not a doctor’s office in America where someone can walk in off the street, without an appointment, be seen in a jiffy—day, night, or weekend—and do a little shopping while they’re there. But seven days a week across America you can walk into CVS, Rite Aid, Walgreens, Target, and some Walmarts and have a board-certified nurse practitioner treat your sore throat.

And the quality of care is fine. In fact, studies show that people with low-acuity problems like sinusitis receive the same, if not better, caliber of care at a retail clinic than they do at a doctor’s office. Ateev Mehrotra, an associate professor at Harvard Medical School and member of Managed Care’s editorial advisory board, has conducted numerous studies of retail clinics and is an expert on convenience health care (see page 32). Retail clinics often do a better job of following guidelines than practicing physicians, he says, and a growing number of studies suggest the patient experience is better. “They usually are a little more consumer-friendly, and they take more time and that might be the greatest driver of the patient’s experience,” Mehrotra says.

Needless to say, the success of the retail clinics has been a hard pill for physicians to swallow. The ACP and the American Academy of Family Physicians (AAFP), both of which represent primary care physicians, have
countered the growing popularity of retail clinics by recommending that their members offer extended patient hours and some same-day appointments. Many have. “Seventy percent of our members have same-day appointments,” says Robert Wergin, MD, AAFP board chairman. “Around 43% have extended hours and one third have weekend hours.” At his practice in Milford, Neb., Wergin created a same day, no-appointment “fast track room” based on a retail clinic brochure.

“It’s not going to take that much time for a focused exam on someone I know,” he says. “I have a list of what they have been seen for. That’s easy. If you can be seen by someone you don’t know, maybe a nurse practitioner, next to the frozen turkey section at the grocery store, I know I can do better than that.”

But in the low-acuity realm, primary care leaders have quietly conceded that retail clinics serve a purpose, and the two sides have reached an accommodation. The retail clinics are supposed to keep physicians in the loop by forwarding via electronic medical record or on paper the reason for a patient’s visit and the treatment administered.

Customers who don’t have a medical home—and 50% to 60% don’t, according to the Convenient Care Association (CCA), the industry’s trade group—are referred by the clinics to an area physician who is accepting new cases. Clinics, the CCA says, are not interested in becoming a patient’s medical home.

“There is a role” for retail clinics, Wergin says. “It creates access and convenience for the patient. Hopefully it will be coordinated with your physician. But I do not—and I feel strongly—think there is a role for chronic care management in retail clinics.”

Bright future

There are currently 2,100 clinics in 41 states and the District of Columbia, according to the CCA. Most are concentrated along the East Coast and located in high-traffic retail pharmacies like CVS, Rite Aid, and Walgreens, and big box stores like Target and Walmart. The association also estimates that about 100 hospitals and health systems are involved in retail clinics, either operating them in some way or partnering with one of the companies.

The 2015 Accenture report also projected that the number of walk-in retail clinics would rise to 2,400 by the end of this year and will exceed 2,800 by 2017. Retail clinics, according the report, will have a capacity for 25 million patient visits in 2017, up from 16 million in 2014.

“I think there is a very stable, probably even growing, future in convenient care,” says Mark Pauly, a professor of health care management at the University of Pennsylvania’s Wharton School.

CVS was the first corporate retail clinic to hit the market and today boasts the most outlets with its MinuteClinics. The company declined to be interviewed for this story. But in an interview on the CVS website, Andrew J. Sussman, the president of the company’s MinuteClinic division, said CVS plans to have 1,500 clinics operating in 35 states by next year. Rite Aid’s RediClinic is affiliated with 20 health systems.

Retail clinics treat everyone from toddlers to senior citizens, but younger people in particular are fans because of the convenience and the technology, says Tine Hansen-Turton, CCA’s executive director. “This industry has always been around innovation and figuring out how do you use limited space, devices, and technology to make health care more accessible,” says Hansen-Turton, adding that a lot more technology is coming, including telehealth already deployed in many retail clinics.

Convenience and high tech may attract consumers, but it’s the low per-visit cost that caught the actuarial eye of insurers. Most insurers started covering clinic visits sometime around 2006. According to the CCA, cost of care at a retail clinic can run 30% to 40% below similar treatment at a physician’s office and a whopping 80% cheaper than an emergency room. “They tend to be cheaper, not just per unit but they also save on other more expensive care,” Pauly says.

Mehrotra’s research shows that it may be more complicated than that. In an article published in the March 2016 issue of Health Affairs, Mehrotra and his colleagues found that for 11 low-acuity conditions
commonly treated at retail clinics, the low cost was offset by greater utilization. More precisely, they found that roughly 40% of visits to retail clinics were substitutes for visits to a doctor’s office or the emergency room, while just 60% were visits that would not have been were it not for the retail clinic. The bottom line was an increase in spending of $14 per person a year. That’s modest money, but the Mehrotra findings add some dissonance to cost-saving claims for retail clinics.

Still, unless retail clinics suddenly become unprofitable (most are, after all, corporately owned), the heady combination of convenience and more-than-adequate care mean the retail clinics aren’t going away. The question then is, in what capacity and scope of practice?

“The cosmic question that remains to be settled is will these clinics somehow be fully integrated with say something like an accountable care organization?” says Pauly. “Will it be part of a much bigger whole or will it just be more of a convenience thing for people who don’t have a serious illness, who just want to be seen for whatever it might be? That, I think, is the fork in the road.”

Chronic care turf
One company is already exploring that fork in the road. For the past few years the Rite Aid Health Alliance, part of Rite Aid, has been working with ACOs and physicians in a handful of communities to identify patients with chronic illnesses who need help managing their condition.

The health providers send patients to a RediClinic to work with Rite Aid-trained coaches. The coaches have college degrees in medically related fields but are not certified health providers. They are paired with a pharmacist. Together they help patients set goals, review medications, and resolve issues related to their chronic condition.

The coaching idea is the result of 20 years of data collected by Health Dialog, a population-management company and a Rite Aid subsidiary. Analyzing the information, the company discovered that people with chronic conditions respond to outreach and coaching services.

Paul Goldbach, MD, chief medical officer of Health Dialog and Rite Aid’s RediClinic, points to the results of a study funded by Health Dialog that showed that a program using health coaches reduced medical and pharmacy costs by 3.6% with most of the savings coming from fewer hospital admissions. The results were published in the New England Journal of Medicine in 2010.

Health coaching empowers people with chronic illness, says Goldbach. But to get that level of attention and support would mean frequent doctor visits. Even people with chronic conditions, Goldbach says, usually see their physician only five or six times a year. But those people probably walk into a Rite Aid store on a pretty regular basis.

“We have to do a better job of meeting people where they are and help them make better decisions about their health and disease,” he says.

Hansen-Turton says retail stores like Rite Aid, CVS, and others are “visible” community sites that people frequent, even when they don’t feel well. That makes

![Retail clinics shouldn’t get into caring for people with chronic and complex health conditions, says Nitin Damle, MD, president of the American College of Physicians.](image)
the locations an ideal “connecting point” for care.

Hospitals and health systems get it, she says. That’s why they are partnering with retail chains. They understand the value of having a presence in store with a retail clinic in communities they might not otherwise reach. “We are seeing more and more contracts between our members and hospitals to manage chronic illnesses based on location, where [hospitals and health systems] have a lot of patients who live in a community,” says Hansen-Turton. “If I have patients who are diabetics that need to be seen, I don’t have to have them trek to the hospital or a specialty practice” for care. For example, Kaiser Permanente and Target Clinics (now part of CVS) teamed up to provide in-store services for people with chronic diseases like diabetes and high blood pressure.

Retail pharmacies and hospitals have tried that integrated model, Pauly says. So far “none of those things have worked.”

“I think for the near future they are going to remain more of a convenience rather than a crucial component of an integrated health care delivery system,” he says. “As I said, that is the fork in the road so far.”

So far, Rite Aid’s joint ventures integrating with ACOs are going well. Not only are costs 30% to 40% below that of an ambulatory setting, but the ACOs and physicians the company has partnered with are referring patients to RediClinics. “This is pretty new to us but we are on their scheduling,” Goldbach says. “So if you call in and want to see a doctor but it’s not possible that day, they will set you up with one of our clinics.”

The relationship has another bonus for the company. It’s growing Rite Aid’s pharmacy services.

“I think this is all good for the consumer,” Goldbach says. “It is convenient, low cost and the right level of service. It is a very patient-centric model of care.”

Aisle 3
That Rite Aid’s pharmacy services are growing because of its chronic care ventures validates what Wergin, of the AAFP, has suspected all along.

“Chronic care is a business model to generate more traffic,” he says. “If it’s a retail clinic, ‘oh, by the way, we just happen to have a pharmacist right over here if I prescribe you something—and did your wife say she needs pantyhose? That’s aisle three’. Well, I don’t do that.”

What he and other primary care physicians do, Wergin says, is build relationships and continuity of care. So when a primary care physician sees a child, the doctor knows if the child is up-to-date with her vaccinations and whether or not mom has had a recent mammogram.

“These are things I know because I take care of you,” Wergin says. “If you wake up sick tomorrow morning who are you going to call? I call that my Ghostbusters question. I know you. I have your chart.”

Wergin recognizes that retail clinics, especially in his part of the country, have a role to play. He understands people want convenience or simply may need to be seen when he’s not available. He’s all for retail clinics developing bonds with local doctors to form what he calls a patient-centered medical community. Of course, he’d rather patients call their doctors before hitting the retail clinic. Even if the doctor can’t see them, he or she may have a retail clinic they prefer.

“He can say ‘I have a nice relationship with the CVS so go there and they will send me your notes,” he says. “If they think you’re too sick, they may touch base with me.”

Wergin wants primary care practices and retail clinics to make nice with one another. But when it comes to retail clinics and chronic care patients he’s resolute: Continuity of care trumps convenient care when it comes to chronic care.”We don’t think they should be in chronic care management,” he says.

Like his colleague, the ACP’s Damle is a realist about retail health clinics. They are part of the jigsaw puzzle that is the American health care system, and doctors have to work with them.

“They are a competitor to primary care practices,” Damle says. “But the more important point to take away is they can partner with us if they are interested in making sure we maintain and have a continuing relationship with our patients for their acute, chronic and preventative medical care.”

But when it comes to chronic care and retail clinics Damle is not open to compromise. The clinics simply are not qualified to manage chronic diseases.

“Patients with diabetes have potential for serious complications,” he says. “Usually patients with COPD or congestive heart failure or coronary disease have significant morbidity or mortality issues. They need the care of an internist. We don’t think retail clinics are the place for those patients to get their care.”

Robert Calandra, a regular contributor to MANAGED CARE, is an independent journalist in the Philadelphia area with more than 20 years’ experience writing about health care.

Feedback Please!
Any thoughts about this article? Is there a pertinent angle that we haven’t touched upon? Let us know. Send responses to Managing Editor Frank Diamond at fdiamond@medimedia.com.
Doctors in the House

House calls for the frail and chronically ill are making a comeback. But CMS and private payers are still figuring out how to make the economics work.

By Joseph Burns
Contributing editor

Bill Hanigan, a wheelchair-bound retired school teacher, is the last patient of the day for geriatrician Deborah Kylander, MD. Hanigan has multiple myeloma and right-side paralysis as a result of a stroke. His wife, Barbara, greets Kylander with a hug at the front door of their Cape Cod–style house on a quiet side street in Duxbury, Mass.

During a 30-minute visit, Barbara explains how getting Bill and his wheelchair out the door, down the back stairs to the garage, and into the car takes half an hour. Given that each trip out of the house risks a fall or injury to both of them, she’s grateful to have a doctor come to their house. After his stroke two years ago, Barbara knew she would need help providing care at home. A nurse at the skilled nursing facility recommended Kylander. “When I called the office, I asked if they were taking any new patients,” Barbara says. “Whoever answered the phone said, ‘No, not really, unless the patient is over 70 and homebound.’ At that point I said, ‘Hallelujah!’”

For Kylander, the mile ride to the Hanigan home is one of a dozen or more she’ll make every week as she fills the gaps in care left by a health care system that is mostly failing the country’s frail elderly. She certainly doesn’t do home visits because it pays well. She gets a salary from a physician group called the Associated Physicians of Harvard Medical Faculty Physicians at the Beth Israel Deaconess Medical Center. She works for Beth Israel Deaconess–Plymouth. They’re all part of the Beth Israel Deaconess Care Organization (BIDCO), but the point is that her two sources of payment do not cover her costs.

BIDCO funds the Village at Duxbury, a community

Eyes on the prize. Bill Hanigan, a wheelchair-bound retired school teacher, talks about his health problems with geriatrician Deborah Kylander, MD. “Geriatrics is not glamorous,” says Kylander. “There’s no money to do geriatrics but I love it.” She gets information and insight from a house call that she would never get from an office visit, she says.
for seniors that has homes, apartments, and an assisted living facility. Kylander works with one other geriatrician, three nurse practitioners (who also do home visits), an office manager, and two medical assistants.

Seeing patients in their homes is about much more than convenience, in Kylander’s opinion. For certain patients, regular home visits are needed to ensure that she provides appropriate and timely care, she says.

Just before driving to the Hanigans, Kylander saw an elderly patient in her office who was an ideal candidate for a home visit. A family member had dropped him off, helping him use his walker to get from the parking lot to the waiting room. To Kylander, he looked weak, tired, and dehydrated. “I didn’t know if he was going to pass out or end up in the emergency department later that day,” she says. She wanted to know which medications he was taking but he didn’t know because a family member manages his prescriptions for him. That family member would not return to Kylander’s office until well after the appointment was finished.

“In some ways, geriatrics can be like pediatrics without the parent,” she says. “You would never see a 4-year-old in the office on their own, but older people with cognitive impairment are seen independently all the time in the office, emergency department and other sites of care.”

So, for this patient, Kylander could not accomplish one of the most important tasks: Medication reconciliation, a potentially life-saving process needed to resolve discrepancies and prevent adverse events for elderly patients, particularly those with many chronic illnesses. “I’m thinking, ‘What can I possibly accomplish here in the office?’” she says.

**An old-fashioned practice returns**

While it’s rare to find a physician who will make house calls, a growing number of doctors and other clinicians like Kylander are bringing the old-fashioned practice back. CMS recognizes the value of having providers go to patients’ homes and pays for house calls, though not enough to cover the full cost, Kylander says.

According to its physician fee schedule for 2016, CMS pays only about $56 for a 15-minute home visit with an established patient, roughly $86 for a 25-minute visit, and around $129 for a 40-minute visit. Compare those with the higher rates the agency pays for office visits: about $73 for a 15-minute office visit with an established patient, roughly $108 for a 25-minute visit, and around $146 for a 40-minute visit.

Some private payers are willing to pay for home visits and are testing a variety of methods to care for people who have difficulty leaving their homes.

“Geriatrics is not glamorous,” Kylander says. “There’s no money to do geriatrics but I love it.” In addition to doing home visits, she also sees about 15 patients two to three days a week in the office. “But they are all 85 to 90 years old. They’re not coming in for a cold. They’re coming in because they just got out of the hospital with heart failure and GI bleeding, etc.”

CMS is using another one of its demonstration projects to test-drive house calls. Seventeen practices serving about 8,400 Medicare beneficiaries signed up for the Independence at Home project. Eligible beneficiaries must have two or more chronic conditions and have had a non-elective hospital admission within the past year. The project started in 2012 and is scheduled to end next year. According to a CMS announcement last year, the first-year results of the project showed savings of about $3,000 per beneficiary on average, and nine of the participating practices earned incentive payments for meeting quality and expenditure goals.

But neither CMS nor private payers have settled on the most cost-effective way to provide in-home care because such resource-intensive interventions require considerable investments of time and money.

Health plans, with their focus on population health and payment, have a strong tendency to standardize health care. If people need specialized care, insurers want to funnel those members into care coordination, disease management, or illness prevention programs where it’s (mostly) one size fits all. This approach, however, is ineffective for patients who need individualized attention and for whom even a short ride to the doctor’s office is a major obstacle to care, say proponents of bringing back the house call.
A growing number of ad hoc programs are designed to get health care providers into the homes of elderly, chronically ill patients. Major insurers are getting involved. In southeastern Pennsylvania, for example, Aetna has contracted with Health Quality Partners (HQP), a not-for-profit R&D group of physicians that designs new models of care for severe high-risk patients. UnitedHealthcare is working with the Camden Coalition of Health Care Providers to determine if the Camden model should be replicated in other places. (see “High-Utilizing Patients: Where Are the Savings?” MANAGED CARE, January 2014).

Anthem is working with Eric Coleman, MD, a professor of medicine and head of the division of Health Care Policy and Research at the University of Colorado, to develop a program that will provide home visits to members recently discharged from the hospital. In March, Anthem began to enroll patients in northeastern Ohio in the program, according to Richard S. Frank, MD, Anthem’s vice president of health care management. The goal, says Frank, is to enroll enough patients to evaluate whether the program has helped to reduce readmissions.

RN visits

Since 2000, HQP, located in Doylestown, Pa., has provided in-home care for the frail elderly and chronically ill, says Kenneth Coburn, MD, HQP’s president, CEO, and medical director. During office visits, physicians or other providers can easily miss the most important aspects of a patient’s condition, especially factors that can increase the risk of illness or harm for patients with multiple chronic conditions, he explains. For these patients, HQP has registered nurses provide what he calls “advanced preventive care,” a combination of care coordination, disease management and personalized illness prevention delivered in collaboration with the patient’s primary care provider.

HQP, in its seventh year contracting with Aetna, offers the service to over 2,000 of the company’s high-risk Medicare Advantage members in southeastern Pennsylvania. Most (60%) RN contacts with patients are in person, through house calls, accompanying patients to doctor visits, or group programs (weight measurement), with the rest made by telephone.

In Coburn’s opinion, home visits are essential for most chronically ill patients. “I would say home visits are not just for people who are truly homebound and can’t get out to the doctor’s office, but it’s also for people who struggle with self-management or don’t have great support at home, or who may be in early mild cognitive decline and have trouble keeping track of their medications,” he adds.

Once inside a home, HQP’s RNs can see the risks a patient may encounter, from mundane home maintenance issues such as poor lighting or hazardous stairways, to more extreme social hazards such as neglect or abuse. If no one goes into the home to assess risks, these patients often end up in the emergency room or may even need inpatient care that could have been prevented, Coburn says.

Even well-intentioned physicians who specialize in care for the elderly or for patients with multiple chronic illness have no way to assess a patient’s home risk with an office visit. “Mobility and function are really big aspects of home care that you see when you’re in somebody’s home,” Kylander explains. “You see how they get up and move around the house. You see them furniture surfing. You see how they might trip over their oxygen tubing, or their cat or their dog. You see their obstacles and you can also check out their house for potential risks.”

As Kylander points out, even the routine process of evaluating a patient’s medications can be impossible in an office. But a provider in a patient’s home can look at what’s in the medicine cabinet.

Before taking care of Aetna members, Coburn’s HQP participated in a CMS demonstration project that tested a nurse-based care management program that included house calls. According to results reported by Coburn in PLOS Medicine, the program reduced deaths by 25% compared with usual care. In a subgroup of those with heart failure, coronary heart disease, or chronic obstructive pulmonary disease, and at least one inpatient stay in the past year, there were 39% fewer hospitalizations and 37% fewer emergency
room visits when compared with the patients who had typical care. This subgroup of patients also had 36% lower Medicare costs and a net savings to Medicare of $397 per participant per month.

The HQP program is one of many that Aetna uses to maintain or increase its Medicare star ratings. So, for frail elderly patients and those with multiple chronic conditions, the HQP initiative has significant value, says Humberto Guerra-Garcia, MD, a senior medical director for Aetna in Philadelphia. To maintain or improve those ratings, Aetna needs to demonstrate that its members are following illness-prevention measures and are getting their needs assessed. Among the over 500 Aetna members currently enrolled in the HQP program, 90% are getting the services they need, he says. “Right now what we see is certainly encouraging, and the fact that we have had this relationship for a few years now means that we certainly believe it,” Guerra-Garcia comments.

Does that mean Aetna will expand the HQP program to other areas? “We haven’t decided that,” Guerra-Garcia says. “We’re looking into what should we do, meaning whether to expand it, or incorporate some of the know-how into our case management programs, or test how other populations would respond to this program.”

**Getting into homes**

Just an hour’s drive south of Doylestown, Jeffrey Brenner, MD, a primary care physician who founded and serves as executive director of the Camden Coalition of Healthcare Providers, is doing work similar to that of HQP. He developed a care delivery model to serve the most vulnerable residents of Camden, N.J., one of the poorest communities in the nation, by sending providers into patients’ homes. Brenner, who started the coalition in 2009, is an expert in the value of home-visit assessments. In 2013, he won a genius grant from the MacArthur Foundation for his work with the coalition.

Since 2013, the coalition has been working with UnitedHealthcare to serve high-risk members. UHC’s efforts are typical of insurers who are reluctant to fund more robust home-visit programs because of the cost.

As Kylander has found, the payment rates for CMS’s billing codes for home visits are insufficient to make in-home care feasible financially, Brenner says. “Most primary care providers struggle just to keep their offices open in the existing payment model. When you go to someone’s home, the billing code doesn’t pay enough to make up for the amount of time it takes you to get there, do the visit, and get back,” he explains.

Under the coalition model, Brenner’s group uses a combination of grant funds and contracts with Medicare and Medicaid to pay for delivering care in patients’ homes. Like Coburn, Brenner finds it’s less costly to have nurses and other providers do most of the home visits. Doctors working for the coalition do some of that work but mostly they see patients in the office. All of the coalition’s providers help patients navigate the health care system, they coordinate care for them, engage social services if needed, and assess each patient’s prescriptions.

“Just from the standpoint of medication reconciliation, patients can be on 25 different medications and some actually have saved every medication bottle they’ve ever been given. So we’ve gone into homes and found, like, hundreds of medication bottles,” he says.

In one home, Brenner’s staff found a bag containing $50,000 worth of medications that the patient had started and stopped. “I don’t think you can do medication reconciliation well until you’ve stepped into someone’s home and pulled open all the drawers;” says Jeffrey Brenner, MD, of the Camden Coalition of Healthcare Providers.

“I don’t think you can do medication reconciliation well until you’ve stepped into someone’s home and pulled open all the drawers,” says Jeffrey Brenner, MD, of the Camden Coalition of Healthcare Providers.

This spring a nurse visited a patient whose asthma was so bad she needed to be hospitalized repeatedly. Previously, this woman in her 50s had not been diagnosed with asthma. None of the physicians or nurses she saw during any of her hospital stays looked into the cause of the woman’s condition. When Brenner’s staff sent a medical student and physician to the woman’s home, they found a leaky roof. “She had a hole in her
ceiling, a hole in the wall, and still active leaking. She had mold all over,“ Brenner says. Knowing the patient was unable to afford the necessary repairs, the physician recommended she sleep in a downstairs bedroom. “By sleeping downstairs and staying away from the mold, she’s doing much better,“ Brenner comments. “But how would you figure that out without having visited?”

In fact, he argues, this woman’s condition had been diagnosed incorrectly. “She actually has what’s called extrinsic asthma, allergic asthma due to mold exposure from the leaking roof. That’s a specific diagnosis that’s different than just saying she has asthma,” he says.

That’s the same argument that Coburn and Kylander make: There’s no way to assess a patient properly unless someone visits the patient at home. This is not news. Coburn has been studying the value of home visits since 2000 and has contracted with Medicare to evaluate the effect of a home-visit program on costs and quality.

Health care’s four-letter word is standing in the way of the kind of care that Brenner, Coburn, and Kylander are providing: cost. Brenner is consulting with health plans and communities nationwide on how to develop cost-efficient models of delivering care in homes and is conducting a randomized controlled trial on the effects of his work on costs and quality. To date he has enrolled about 500 patients. He hopes to enroll 300 more and expects to publish results next year.

“My early inkling is that for a certain subset of folks, this model works wonderfully and for a different subset, if they’re homeless, drug addicted, or mentally ill, the services we have in Camden are so poorly structured, it becomes a navigation to nowhere,” he says.

These early results have led him to consider the need for safe housing for those who are most chronically ill. “We’re thinking about what the next wave of work is and have gotten pretty deep into something called ‘housing first,’ which is housing regardless of sobriety,” Brenner explains.

The coalition is testing this housing model with 50 patients, including an 80-year-old man who was living on a park bench in Camden. In this program, the coalition will provide new apartments, addiction treatment, and behavioral health services. “About 25% of our patients are homeless, and if they’re enrolled in the clinical trial, nothing we do works until we get them into safe housing,” he says.

Some health plans may be willing to try programs like Brenner’s that provide housing and health care. Meanwhile, CMS and private insurers continue to explore how to bring back the house call so it’s efficient and effective. “There are some great programs for the elderly,” Kylander says. But they’re not enough of them to care for all the patients who need the home care.

Payers want to see the ROI

It’s no surprise that the first of two hurdles home-visit programs face is the need to show that a program that requires so many resources, including sending providers out to travel many miles over several hours, could be cost-effective, says Kenneth D. Coburn, MD, president, CEO, and medical director of Health Quality Partners in Doylestown, Pa.

Health plans are reluctant to pay for any program that cannot demonstrate savings within a year or two, he says. “That’s tough for a lot of organizations,” he adds.

“Not everybody wants to pay up front for this because there are a lot of different models out there, most of which are not as tightly designed and effective as they could be,” he explains.

“I understand that real concern. But, at the same time, if you expect physicians or ACOs to do this on their own, and fund it up front and wait for the money downstream, that’s hard for a lot of health systems and ACOs to pull off,” he says.

Another problem is that not all home-visit programs are the same. “There are ways that these programs have to be designed, developed, implemented, and managed tightly to ensure the services that should be provided are provided and in the right time frames,” he adds. “Our program has lots of protocols and we collect lots of data from the field that we do performance measurement on to make it as reliable as we can.”

Anthem is working with the University of Colorado on a program that will provide home visits to recently discharged patients, says Richard S. Frank, MD, of Anthem.
Health Plans’ Digital Efforts Should Be App-y Experience

By Jan Greene

Last year, investors pumped more than a billion dollars into the idea that Americans really want to use smartphones, fitness trackers, and other devices to nudge themselves into better health. Health insurers are part of the trend, developing mobile apps that let members use their health benefits on the go and track their biometrics. There’s a lot of hope—and hype—about “digital engagement” being the lever that finally turns around a lot of scary lifestyle-related health problems such as type 2 diabetes and obesity. Make healthy habits fun and simple, the theory goes—just part of the typical American’s day with the device that controls her social life, finances, entertainment, and so much more.

But these are the early days in the digital health revolution. So far, it seems consumers are most excited about the features that remove some of the aggravation of having health insurance. UnitedHealthcare’s Health4Me app has been downloaded 1.4 million times to do everything from finding a doctor to estimating out-of-pocket costs. The most popular features, though, are the electronic version of a member ID (“I don’t have to carry around a card anymore!”) and a “call me back” function that bypasses the dreaded customer service phone tree and has the person you want call you back directly. "It was surprising the reaction we got from consumers," says Craig Hankins, vice president of consumer engagement products for UnitedHealthcare. "There’s a ‘less is more’ mantra" the company has adopted in developing apps, Hankins says. "Keep it focused and make it easy, and people will keep coming back.”

That’s known as “stickiness” in the digital world. Given that they are competing with the likes of Candy Crush and viral squirrel videos, not to mention 165,000 health-related apps, health plans have to be smart and strategic in finding ways to get consumers to click on their insurance company’s logo in those empty moments waiting in line or during a lull in the action at a child’s soccer game. The idea is to keep chipping away at the dizzying complexity of using health insurance and health care so the convenience factor is closer to consumer experiences that offer instant gratification, such as buying a book on Amazon and having it show up the same day.

Banks and retail have mastered the consumer engagement game, notes Adam Nelson, vice president of health care and life sciences for NTT Data, an IT services company. “You know a check is being deposited but people check anyway,” he says. “There’s an engagement, there’s change. There’s a stickiness factor that is something they are involved in.” Health plans need to find ways to keep users coming back to their apps. There’s a history of wellness apps being downloaded and used for a couple of months and then forgotten, he says. Apps, it seems, may not be different than the exercise equipment that ends up gathering dust and resolutions to improve diet that erode with time and temptations.

Easily accessible
So to begin with, insurers have had to wade into digital with the basics—such as a mobile version of their website—to provide the service that their members and employer clients require, notes Karen Marlo, vice president of the National Business Group on Health (NBGH). “Generally, they want to be sure the information the employer needs is easily accessible, such as having a mobile-enabled version of the website.
where the employee can go for all their health benefits information,” she says.

Employers see mobile as a way to reach employees with benefits messaging, particularly for those who work in settings without a desktop computer with email, Marlo says. Even if those employees have a computer at home, chances are they don’t want to be logging on to read email from work when they get home. “Mobile apps offer new opportunities to connect with people,” she says. The small screen makes brevity not just a virtue but a necessity, so human resource offices need to boil down dry benefits information into shorter, compelling messages. At the same time, Marlo noted, they can also use mobile apps to personalize information to the individual.

Larger employers are jumping into mobile technology, with 56% in an April 2016 NBGH survey saying they use mobile technology to promote employee health engagement and 38% saying they use wearable sensors. More specifically, 74% said they use contests such as weight loss or walking to improve employee health, 51% use interactive mobile apps supporting health insurance, prescription refills and the like, and 37% use activity tracking. Their motivations, said the survey, were largely around helping employees become better consumers of health care (79%) and improving workforce health (73%). NBGH reported the results of a similar survey three years ago.

Back then just 16% of the responding companies said they were using mobile technology in their health-engagement effort. Now half say they are.

According to the survey, which was co-sponsored by Xerox, return on investment (ROI) is not necessarily a requirement anymore, with just 20% of employers saying they bothered to measure it for the health technologies they used. “Employers are trying to move on from trying to get an ROI on everything,” says Marlo. “Especially with human capital, it’s really hard to make the connection with direct financial impacts.”

That doesn’t mean companies are willing to buy into every new digital health startup. “We regularly have meetings with startups, some of which are really compelling in concept,” says UnitedHealthcare’s Hankins. “We do believe these concepts are where health care is going,” he says. “But employers really are looking for ROI” for disease management-related apps, he says. New apps and devices also need to both be sensitive to patient privacy and offer a benefit to the individual consumer, he says. He described UnitedHealthcare as “tiptoeing” into apps and devices that use real-time data to track patient health. The company wants to see outcomes before investing in new ideas, Hankins says. Members can share the number of steps they take with their Fitbits, for instance, but those data are not yet analyzed or used for clinical or wellness purposes. Instead, the company’s Health4Me app is focused more on using the health plan. So it includes a locator service that shows the closest emergency department, urgent care or convenience clinic. Users can pay their medical bill through the app. Nonmembers can use a UnitedHealthcare app to estimate the cost of a medical service based on geographic-specific data contained in a national claims database maintained by FairHealth in New York.

Of course, the apps are only as good as the databases

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**Technologies used in health engagement promotion**

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<tr>
<th>Technology</th>
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<th>2016</th>
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<tr>
<td>Gamification (e.g., games, contests or other gamelike features)</td>
<td>33%</td>
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<tr>
<td>Social networking or social media</td>
<td>20%</td>
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<td>Mobile technology</td>
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2013 n=367, 2016 n=213
behind them. Consumers can get estimates of what an in-network service might cost, but because of the variability of out-of-network provider billing, that remains as opaque as ever.

Other insurers offer similar basics with their mobile apps. Humana, for instance, maintains MyHumana, which gives members access to ID cards, claims, and local providers and health care locations. Its Vitality app lets members participate in health challenges and competitions and set healthy habit goals. The company’s pharmacy app, including a version for Apple Watch, lets users scan and refill prescriptions, get reminders, approve payments and track shipments. Humana’s MyHealth is a biometric tracker (such as blood sugar and weight) and medication list.

The company is moving toward “engaging with our members through personalized mobile experiences” to help them meet their health goals, says San Banerjee, director of digital consumer solutions for Humana.

Aetna has also been busy producing mobile apps, with 15 each in iTunes and Google Play. Its iTriage app has been downloaded more than 15 million times and continues to get regular use, according to an email from an Aetna spokesman. It and Aetna Mobile provide the usual array of basic health plan management options, including managing personal health records. The email said a 2014 analysis of iTriage found it drives more appropriate care. When users search for providers based on nonacute conditions, they select emergency departments 40% less frequently.

**Buying from an app**

Mobile apps could also have a future in helping consumers evaluate and choose health plans. Joel Ario, a former Obama administration official in charge of setting up state insurance exchanges and now a managing director at Manatt Health, is bullish on the potential for mobile in buying coverage. “My boys who are 20-somethings will be purchasing their health plans and learning how to use their health plans on mobile,” he predicts.

He envisions apps that ask the user a series of simple questions and arrive at the best choice for that individual. “The apps that will win the day will be the ones that ask the fewest questions of the consumer and most quickly” come up with a recommendation, he says.

NTT Data’s Nelson is even more enthusiastic about the possibilities of digital strategies for health plans. He sees insurers as being in an ideal position to manage population health by using what they know about individual members to provide one-on-one advice, most likely through connecting the user to a 24-hour advice nurse who becomes a case manager. “Health plans have the ability to create more of a relationship with you,” he says. “The payer more than anyone should own that online relationship.” Whether a public long distrustful of health insurers will be willing to let that happen is another story.

While a main goal of disease management apps is to improve the health of those already struggling with chronic illness, Nelson argues that the next step is to use digital health to predict which members could develop chronic conditions. Using clinical and claims data, the plan could assign a risk prediction number to an individual and then track that number based on continued input, such as weight, heart rate or activity level. “Maybe I’m at 67% risk of type 2 diabetes,” he explains. “My phone knows if I’m at a McDonald’s drive-through. Depending on what I order, my risk factor could go to a 66 or a 68. Some people could see this as Big Brother,” he acknowledges. “Others as a motivator.”

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Jan Greene is a veteran health care journalist based in northern California. Her work has appeared in the Los Angeles Times, Health magazine, Annals of Emergency Medicine, and many other publications.
A CONVERSATION WITH ATEEV MEHROTRA, MD

Convenience Rules in Health Care: Will Quality Suffer During Its Reign?

The insatiable American appetite for convenience is spreading to health care, says Ateev Mehrotra, an expert on retail clinics, telemedicine, and other convenient care delivery models. Quality may actually improve in some areas, his research has shown, but any cost savings may be offset by greater utilization. Mehrotra is an associate professor at Harvard Medical School and a member of MANAGED CARE’S editorial advisory board.

Interview by Peter Wehrwein

You wrote a piece with Jacob West called the “The Future Ecology of Care” that was published in Annals of Internal Medicine earlier this year. It refers back to the publication of a piece 50 years ago called “The Ecology of Medical Care.” You and West sketch a picture of how much health care has changed from simply going to the doctor or not and all the choices we have now. Yes, there is a plethora of choices we have now in terms of where we can get care.

Why has it happened? In our interviews with patients who have used these care sites, the number 1 reason, the number 2 reason, number 3 reason, is always convenience. Patients describe difficulty getting in to see their primary care physician. “I call my doc, it’s Monday, they said the next appointment is Thursday; I wanted to get this taken care of right away” and “I work days, it’s hard for me to get off work.” That kind of language. And with retail clinics, people say, “I can get in here, and then, you know, get my care taken care of right away, and get the prescription at the pharmacy. It’s just a lot faster.”

And there are some general trends. We’re seeing greater difficulty getting into primary care providers. And I do think there is probably a societal shift in terms of what we think are reasonable wait times. A patient wait time of a day or two is probably just fine from a clinical perspective in many cases. But in an era of 24-hour, 7-days-a-week grocery stores and banking, of shopping whenever we want on Amazon, what patients have come to expect, I think, is that health care will similarly fit their needs.

It’s also a bit of a neglected market. If you are a CEO of a large health care system and you’re thinking, “Where am going to get my revenue growth,” this kind of convenience care is not something that you are going to think of. It’s a very low-margin business, and it may not be what you’re particularly good at.

It means entrepreneurs can get into this. Right. As they say in business school, the incumbents have sort of neglected this area, so new entrants can come in and really take advantage of that.

A lot of my work has been on low-acuity conditions, such as sinusitis and UTIs, and how many different places—you can go to get care, and which ones are focused on trying to get you in and out and being as convenient as possible. Urgent care centers, retail clinics, direct-to-consumer telemedicine, e-consults, kiosks. It’s really interesting to see all these options emerge.

Editor’s Note: Transcript of interview was edited for length and clarity.
fient options, and these convenience-care options can be less than three quarters of the cost of going to the doctor’s office.

Do you think these convenience-oriented options are at odds with another push, which is the patient-centered medical home? It seems like the convenience-oriented options are like going to a 7-Eleven, whereas the patient-centered medical home conjures up the corner grocery store where people know you. Do you see these two as being at odds with one another? Yes and no. I’ll start with the no part.

The patient-centered medical home is very much driven—one of the key tenets—in trying to make it easier for patients to come in and get care. Things such as open-access scheduling. So, convenience is part of the patient-centered medical home.

Another tenet of the patient-centered medical home is team-based care. Why don’t we have other providers—nurse practitioners, physician assistants, others—provide much of this care?

You can see why they share some fundamental ideas. And how do they differ? The convenience-care options really are a different model from the way we have been delivering health care, not just the patient-centered medical home.

The patient-centered medical home is more like big department stores, where you go for everything, and the convenience-care options are like the rest of the shops in the mall where you go for your candles, underwear—everything is sort of specialized.

What’s the point of having the one place where you get all your care? And I think there are three things that are useful to kind of disentangle.

The first is relationship continuity—the idea that this is the place where, kind of like Cheers, everyone knows your name and understands who you are as a person. And I think that patients value that idea, and I think providers value it. Why do we care about that? Well, we care about that partly because we believe that if the proverbial something hits the fan, having that baseline relationship will build the trust. Therefore, when we navigate things that are really tough, there is that underlying trust.

I think there are reasons to wonder whether this relationship continuity is overemphasized. In the majority of situations when someone has a new problem, an acute problem, they don’t see their primary care physician. If they go to a primary care practice, they’re seeing some other doc or some other NP. They’re going to an urgent care center and all these other sites. Or to a specialist. So I wonder if we’re viewing the current health care system through rose-colored glasses.

The second reason we value care in one place is information continuity. This is the idea that, if I’m taking care of a patient, it’s useful for me to know what other doctors and providers have diagnosed and treated—the medical history, which the patient might forget to tell me about.

The informational continuity I think is important, and the idea is that if you go to a patient-centered medical home, you’re more likely to get that.

But if we think about it really, is that informational continuity only available in a patient-centered medical home? Take, for example, the Cleveland Clinic, which has a partnership with CVS’ MinuteClinics and, through a partnership with American Well, is providing telemedicine care—not by Cleveland Clinic providers but by other providers.

What we have found is that the retail clinics provide equal quality care to physician offices and, in some cases, even a little better care.

But from what I understand, those records go right into the electronic health record for Cleveland Clinic. So I don’t know whether a patient-centered medical home is really necessary for informational continuity or if it is just easier than overcoming the interoperability issues.

The last point is that if I’m taking care of a patient with a lot of chronic illnesses, I need all that information. But for the types of problems we’re talking about here—for, say, a generally healthy 45-year-old woman who might come to me with a urinary tract infection—she can tell me most of what I need to know. Might she miss some allergies and so forth? Yes. I think there is that concern. But most of the time, with low-acuity problems, information continuity may not be as critical.

Some of the primary care physician groups are fighting or raising lots of questions about convenience medicine. Do you think those concerns are valid, or are they just protecting turf? For the last 10 years, I’ve been studying these concerns or criticisms. First, I’ll tell you about what I think has been disproven and then move to what I think has more merit.

The first [criticism] is that the quality of care is bad. They say, “Hey, those nurse practitioners at those retail clinics don’t know what they’re doing; they’re undertrained; they’re just going to provide antibiotics
unnecessarily, and they’re going to misdiagnose, and patients are going to go get care anyways from another doc, etcetera.”

What we have found doing research using charts, using claims, is that the retail clinics provide equal quality care to physician offices, and in some cases, even a little bit better.

**A little bit better at what?** Providing a good patient experience and concordance with guidelines.

They usually are a little more consumer-friendly, and they take more time and that might be the greatest driver of the patient’s experience.

The most common reason people visit a retail clinic is for acute respiratory illnesses—sinusitis, bronchitis, ear infections, etcetera. For some diagnoses, antibiotics are necessary and may be helpful, and for others it’s clearly not indicated. The retail clinic providers are much more consistent with the guidelines. If patients have a cold, the retail clinics very rarely prescribe antibiotics compared with doctors. And they’re more likely to use rapid testing for strep, which is a good way of limiting antibiotic prescribing. So, those are some examples of where the quality is better.

You also hear—it was more evident five to 10 years ago—that “retail clinics are just going to drive up health care spending because the patients are going to be misdiagnosed, and they’re just going to end up going to another provider and therefore, you’re going to have double utilization.”

But we find that no, retail clinics on a per-episode basis are about 30% to 40% cheaper than a doctor’s office, and the rates of follow-up visits are about the same.

**What about your Health Affairs article in March that said that for low-acuity conditions, utilization went up? And I think you found spending also went up?** This is an issue that hadn't been raised by the medical community—but I was really concerned about—which is that retail clinics per episode are cheaper, but maybe there are more episodes. That’s what we found in that Health Affairs study, which was that because it was more convenient, people got care more often. This is maybe one of those obvious findings when my father says, “And they pay you money to study this?”

I agree with my father that it may not be surprising, but it was useful to highlight.

The last area where I think there are concerns about retail clinics is the issue of continuity of care. And we already talked a little bit about that. But we find that patients who go to retail clinics are less likely to go to doctor’s offices after that. They like the experience, and they keep going back to the retail clinic. So, if we measure continuity of care measures, they are worse among retail clinic users. Now, the question is: So what?

**That’s what I was thinking.** Right. So is continuity itself important? Some people argue it is, because if you do big, national studies in patients who have higher continuity, they have better outcomes and lower spending. But you have to look at the causal chain. Is continuity important because doctors will make sure that people will get preventive care? What we found is that retail clinics users were just as likely to get preventive care.

Well, maybe continuity is important because if you go to your primary care physician’s office and you have diabetes and you go for strep, they’ll take care of the strep but say, “Hey, wait a minute. John, what’s going on with your diabetes? Let’s make sure you’ve got X, Y and Z tests” and so forth.

This is an area where what we know is very limited because when we looked at claims for retail clinics, we didn’t have a lot of diabetic patients. But we didn’t find a problem among the limited numbers of patients for whom we did have claims data.

I think this is something that really does merit future research. Does getting care at a retail clinic have a negative impact on those patients? But the majority of patients who go to retail clinics do not have a chronic illness. From what we have seen, they haven’t been a key part of the population that the retail clinics serve.

Telehealth is also about convenience. You are co-author of a recent study in JAMA that found that telehealth meant better access to dermatology care for Medicaid beneficiaries. But there was another study, a secret shopper study, published in *JAMA Dermatology* at about the same time that found that telehealth for dermatology resulted in missed diagnoses of important conditions like nodular melanoma. Some of the analysis that we’ve been going over for retail clinics—have you applied that to telehealth? And do you see things playing out a little differently for telehealth? We’ve done many studies of telehealth, including several studies on Teladoc.

We have looked at quality in the same way we have looked at retail clinics. The signal hasn’t been as clear-cut.

The direct-to-consumer telemedicine companies had a similar rate of follow-up visits as primary care
practices and similar rates of overall antibiotic prescribing.

But there were a couple areas of concern. They had a slightly higher rate of broad spectrum antibiotic prescribing.

And there was an issue that we’ve never had the problem in our health care system before, which is undertesting. We’re always talking about overtesting in the emergency department or the doctor’s office. Here, we found the opposite. And it makes complete sense. You have a video conference, or you’re on the phone, and you’re two states away and you don’t even know how to get a test for a patient. Therefore, physicians were less likely to order tests.

In some cases, that could be a good thing. For patients with back pain, you could say consumer telemedicine companies are doing great because they do not overuse CTs and MRIs for back pain. But in other areas, such as strep or UTIs, we would consider undertesting bad care.

And misdiagnosis? I was involved in a different secret shopper study, which was led by folks at UC–San Francisco. And we found, very similar to a recent secret shopper on online dermatology companies, a number of misdiagnoses. Both of these studies have found in certain cases egregious quality issues. Obviously, if I was a patient, I’d be like, “Whoa, should I really go get care from these places?”

On the other hand—and I think it’s missed in this debate—is the work that has been done that shows really egregious quality issues for in-person visits, too. So, we are left with this really awkward situation, which is, “Oh, my God, the care may not be good here.” But is it worse, or better, than what we see in an in-person office?

Earlier in our conversation, I mentioned that the antibiotic prescribing rates for visits to retail clinics are similar to those for in-person visits. And you might say that’s great, and reassuring to the average American. But, you could also flip that around and say, “That’s horrible.” Because at in-person visits to a doctor, we believe that over half the antibiotics prescribed are unnecessary. Differences in how you frame it that might help explain why people are interpreting the data very differently.

So the issues with telemedicine are sort of the inverse of those in-person, nonretail health—overtreatment versus undertreatment. That’s what I’m gathering. As far as testing is concerned, I would agree with that. On the physician and emergency sides, it’s overtesting, and on the telemedicine side, it’s undertesting. It’s just so darn easy in the emergency department to order a CT scan. In a telemedicine visit, it’s really hard.

Is there a fix to the quality issues with telehealth? The business model is typically built on the idea that we want to have one interaction, take care of the problem, and move on. It’s very transactional, if you want to call it that. And testing makes things more complicated because then you’ve got to get the test results, and then act upon it, and it creates a whole new layer of logistics.

But I feel like they need to develop methodologies or systems to actually be able to address and make it a lot easier for their docs to order tests. That’s going to mean better care. Because in modern medicine, tests do matter, and are critical in certain circumstances.

There’s also a trend toward bringing back the house call for very sick people. Is that part of this convenience notion? Do you see it fitting into this broader trend of convenience? These convenience-care options are well suited for the large fraction of our population that’s overall relatively healthy. For those patients, I don’t really see the value of the house call. And the reason is that the business model is very problematic.

You see companies that are starting to emerge in this market, and if you pay for a doctor to schlep in a car to a patient’s home, that’s extremely expensive.

Telemedicine and retail clinics are efficient either because the salaries of the employees are, on a per-hourly basis, a lot lower, or you’re being a lot more efficient with a physician’s time. That allows you to charge a lower price, which is critical in this era of high-deductible health plans.

I think it is a very different story for our sickest populations who have multiple comorbidities, and we’re trying to do whatever we can to really help them stay out of the hospital and take their meds. And in that context, getting a doc to go visit the patient, even though it’s a lot of money, may be worth it, because they get to see the patient in their home and really help them out.

Have you gone to a retail clinic yourself or used a telemedicine service? I have not used a telemedicine site, but I have gone and encouraged my family members to go to a retail clinic.

And what was your experience like? It was convenient. I had to get in quickly, and it was very easy for me to get in. And I appreciated that.

Why did you go? One time, I needed a vaccine, and I needed it quickly. Another time my wife was worried about sinusitis, and she went in for a quick visit.
Telemedicine Start-ups Promise To Transform Health Care

Revolution isn’t too strong a word to use about what’s happening with this technology.

Thomas Morrow, MD

For the most part, the technology highlighted in Tomorrow’s Medicine is used in a small segment of the population faced with a specific condition for which that technology had an impact.

This month is different, as I review what is likely to become a structural change to the entire fabric of medical care: telemedicine.

Unlike most of the technology highlighted in Tomorrow’s Medicine, telemedicine is not really new. The first documented use may have been on March 10, 1876, when Alexander Graham Bell called out; “Mr. Watson, come here—I want to see you” because, according to some accounts, he spilled battery acid on his hand. But telemedicine is undergoing an amazingly rapid evolution, perhaps even a revolution. This revolution is the culmination of several major technology developments: micro-electronics, digital photography, broadband width and speed, compression technology to enable high-quality video and, for many people (i.e., patients), the smartphone.

Bridging the gap

All of these developments build on the basic value of telemedicine: It bridges distance at the speed of light and so connects patients, and associated data to physicians in a very convenient way.

In May, the spring American Telemedicine Association (ATA, founded in 1993) meeting was held at the aircraft-hanger sized Minneapolis convention center. About 4,000 people attended the meeting, which featured numerous speakers on a range of topics that face the burgeoning telemedicine industry and are integral to its growth.

One of the most remarkable examples of the possibilities of telemedicine came to light at the breakfast table, of all places. An orthopedist started to talk about how he serves a local prison. By using a telemedicine platform, he can view X-rays done in the prison infirmary, diagnose the fractures common to this environment and talk a cast tech, who is onsite, through simple reductions and casting—any time of the day or night, from the comfort of his home or office. Think of this: It costs up to $1,000 just to transport a prisoner from a prison to a hospital every time this occurs, and that doesn’t even include the medical care costs.

The ATA also featured exhibits—hundreds of exhibits—and this is where my techie side became excited. The exhibits included the usual suspects such as those providing broad access to physicians: American Well, Teladoc, MDLive. It also included a number of well-known Fortune 500 tech companies such as Medtronic, Cisco, and Phillips, all with refined, integrated, and expensive offerings. But I spent most of my time talking to the start-ups—the heart of Tomorrow’s Medicine. The following are vignettes of some of these companies and their wares.

Who to watch

Pokitdok: A pharmacy API platform that removes the “friction” and inefficiencies that plague health care transactions by automating eligibility and claims processing for several telemedicine technology platforms.

Astia Health: A very small Wisconsin-based company founded by a physician. They have developed a complete, self-contained telehealth suite residing in a high-impact plastic suitcase.

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Think about how this “box,” using cellphone connectivity instead of an Internet portal, could be used during ambulance transport by EMTs, at job sites, schools, oil rigs, and even nuclear power plants. With its portability, it can be taken to the site of an injury or even used during transport.

**Medibio**: Demonstrating the eventual integration of telemedicine and the mobile health wearable sector, the company claims to have the first objective, quantitative test for stress and mental illness. By using circadian heart rate variability—with technology validated in Australia and undergoing further study at Johns Hopkins—Medibio uses a complex algorithm to analyze cardiac impulses to predict stress level in time to do something about it.

Given the recent press concerning physician burnout, for one I would love to see how the Hopkins research is going.

**WoundMatrix**: A telehealth browser based platform used at the point of wound care (by patients, hospitals, wound clinics, and visiting nurses). Their system provides image-capture and analysis, measurement and data entry to aid in the management of complex wounds. Their intent is to improve wound care outcomes and develop better wound protocols.

**Vidyo**: A Hackensack, N.J.,-based company has developed what they consider a unique platform that provides “dynamic video quality adaptation” to any network environment. Basically, in lay language, Vidyo can handle a wide variety of lousy network video inputs to provide a usable video output for effective clinical care. They integrate with more than 20 telemedicine providers of hardware and software.

**Ekodevices**: A small company that has created a digital stethoscope device that can attach to most common old-school stethoscopes to amplify and record sounds, and transfer the files seamlessly. No need to purchase a dedicated digital stethoscope. For some clinical uses, the analog (meaning old school) form of listening is retained. Basically pull the rubber tube from the head of the stethoscope and insert the digital device, and you have a dual-use stethoscope!

**Tytocare**: An Israeli company that provides affordable consumer versions of common physician examination devices. They provide not only the devices but a step-by-step teaching platform for helping lay people actually perform remote examinations. Their kit comprises a high-definition digital camera that can be used (when paired with various attachments) to view the skin, eardrum(s), eye, mouth and throat, along with a stethoscope and thermometer. I would love to give one of these kits to each of my children for the inevitable 2 a.m. grandparent/doctor croup or earache call.

**T-MedRobotics**: The U.S. distributor of the French company AdEchoTech. Awaiting FDA approval, this is a remarkable robotically controlled ultrasound device capable of producing abdominal, pelvic, obstetric, and urological ultrasound images. The “robot” ultrasound machine is positioned above the supine patient by a layperson. A technician at another site then controls the ultrasound probe to produce real-time, true hospital-quality images without having to transport the patient. Think again of how a remote clinic, hospital, or prison dealing with a patient with acute abdominal or flank pain could be screened for gallstones, kidney stones, ectopic pregnancies—the list goes on and on!

**Fitango Health**: This company has created several care management platforms, one of which stands out: A platform that aims to improve the care for pre- and post-transplant patients. It allows the opportunity for patient, family and different providers to join together to form a virtual “digital” care team. It also provides a connection with a variety of monitoring devices using a secure HIPAA-compliant, cloud-based white-label customizable solution for transplant centers.

These are just a few of the remarkable developments in telemedicine and point to where this new industry is heading. Further evidence that Tomorrow’s Medicine is helping to fulfill the Triple Aim.
Where Have All the Primary Care Physicians Gone?

Richard G. Stefanacci, DO
Scott Guerin, PhD

You can probably remember a time when primary care physicians (PCPs) dominated the health care landscape in the same way there seemed to be a Blockbuster video rental store on every corner. Go further back, and you’ll find the iconic television show Marcus Welby, M.D., which depicted the PCP—although PCP is a more recent coinage—as being everywhere, knowing everyone, and caring for everything.

American health care has been slowly moving away from dependence on the PCP for decades. Many trace the decline back to the years immediately after World War II. Physicians who went into the military as generalists came out with training as specialists. When they returned to civilian life, they commanded premium pay relative to their PCP counterparts—and dominance of American health care by specialist had begun.

Now, we are hearing about projected shortages of PCPs; the Association of American Medical Colleges, for example, has predicted a shortfall of between 12,000 and 31,000 by 2025. To help fill this gap, some medical schools have responded by offering three-year fast-track medical degrees. New York University, Texas Tech University, and Columbia are among the few medical schools offering these programs.

Managed care organizations (MCOs) and health systems are involved as well. Instead of subsidizing the work of PCPs to support their existence, they are paying for other kinds of health care workers and expanding the responsibilities of people in nonclinical jobs. This is occurring in the form of patient navigators and care coordinators who are taking over some of the orchestration of patient care, and in the form of pharmacists through the provision of some services like vaccination and advice about medications.

Implications

Meanwhile, hospitalists are taking on increased responsibilities from PCPs in hospitals and “SNFists” function as PCPs inside skilled nursing facilities. Other specialists are replacing the role of traditional PCPs by managing patients with chronic diseases, such as cardiologists who see patients with congestive heart failure, pulmonologists for those with chronic obstructive pulmonary disease, and nephrologists for dialysis.

This disappearance of PCPs will have implications for new delivery models. The rules for attributing patients to ACOs may need to change. Patient-centered medical homes have been built with the PCP as the foundation and the chief clinician in charge. MCOs are having to rethink the role of the PCP in the makeup of clinical panels and the delivery of quality measures.

Furthermore, the environment in which PCPs work is changing significantly because of the Medicare Access and CHIP Reauthorization Act (MACRA). This legislation will push PCP compensation, in a decisive way, away from fee for service (FFS) toward value-based reimbursement. MACRA is two-pronged. The Merit-Based Incentive Payment System (MIPS) combines, and so ends, the separate Physician Quality Reporting System, the Value-based Payment Modifier, and Meaningful Use programs. In addition, it initiates an alternative payment option for working within risk-based models. The startling fact is that the first performance year is scheduled to begin in 2017, just months away, with the payment adjustment year occurring in 2019.

So what will PCPs do? Some options could be: (1) retire soon to avoid changes; (2) become affiliated with an IDN that provides management services, such as MACRA support; (3) stop Medicare FFS to focus only on Medicare Advantage patients; or (4) opt out of Medicare FFS to provide concierge medical services. Beyond this shift, the continued erosion of primary care practice by non-PCPs such as SNFists, patient navigators, and nurse practitioners will surely mean that the corner PCP office serving FFS Medicare patients is quickly going, going, gone....

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Let’s face it: Insurers are the one segment of the health care sector that everyone has loved to hate. Employers blame insurers for rising premiums; physicians and hospitals blame them for their declining reimbursement rates; consumers blame them for lack of sufficient coverage; and policymakers think they make too much money. As if being at the center of scorn isn’t enough, the health care insurance business model itself stands in the crosswinds of market and nonmarket forces. Between the standardization of benefits and other regulations imposed by the ACA and employers’ laser focus on price, commercial payers have found themselves in a commoditized business. Competition is coming from unexpected places—even providers—as employers contract directly with “centers of excellence” and integrated delivery networks. Consumers, feeling the increasing burden of out-of-pocket costs and high deductibles, are more focused than ever on getting their money’s worth.

What payers must do
Most insurers have responded to these circumstances with incremental changes. But relying on tweaks to the fee-for-service model (like many pay-for-performance structures do) won’t get the industry—much less the entire health care system—where it needs to be. Changing the basis for reimbursement is the only path to achieving the kind of behavior changes that will improve quality and reduce cost in a sustainable way. Working closely with providers, payers need to lead the efforts that will make different models for care delivery and payment a reality.

Let’s take the case of a provider that’s trying to negotiate a bundled price with payers and employers on a direct basis. The provider is willing and able to offer a predictive price and assume risk. It has comprehensively defined what will be included with deliverables and metrics on the back end. Employers—who care about their employees—are very excited and open to this model. But conventional insurance companies have infrastructure that focuses on processing claims, so too often insurers don’t know what to do with this kind of “exception” and reject it.

To move to new models of health care delivery and payment, bridges must be built. The health insurance executives who are leading their organizations must connect with the people in the trenches who carry out agreements with providers on a day-to-day basis. An insurer’s senior leadership may be ready to embrace new models of care. But if the systems, incentives, and capabilities in sales, operations, and analytics are organized around old models of health care delivery and paying for the care, that embrace could wind up being an empty gesture. Results will reveal the difference between the flashy burst of enthusiasm and the disciplined work of leading true organizational change.

Making progress requires partnerships with innovative providers that can take on accountability for outcomes and are also willing to accept payment outside the typical adjudication system. To create the necessary infrastructure, insurers will need to step out of their silos and the usual method of doing business. They’ll need to allow for work-arounds in order to prove the concept before any systematic redesign. Private health insurers are in a perilous position these days. But along with peril comes the opportunity to make disruptive changes and seize substantial market share. Leaders throughout the health care insurance industry must be proactive about initiating business model innovation and guiding its effective implementation. New winners—and losers—will emerge based on who can deliver genuine value economically and as measured by health outcomes. Are you ready for that contest?

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A CONVERSATION WITH THERESA BROWN, RN

You Can Learn a Lot in 12 Hours: The Shift Reveals Paradoxes of Hospital Care

Nursing brings her into intimate contact with blood, pain, suffering, and freighted issues of life and death. But in her book, Theresa Brown uses a deft, writerly touch to delve into the more prosaic aspects of American medicine—the doctor–nurse dynamics, the hassles of charting, and financial incentives that skew care toward tests and procedures.

Interview by Peter Wehrwein

Theresa Brown earned her PhD in English from the University of Chicago and taught writing at several universities before switching to a career in nursing about 10 years ago. She is a prolific writer, contributor to the New York Times, and a speaker on nursing, health care, and end-of-life issues. Her most recent book, The Shift, is her stirring, first-person account of working a 12-hour shift at an oncology unit at a teaching hospital. Brown now works as a hospice nurse. She lives in Pittsburgh with her husband and three children.

You quote a William Blake poem in The Shift. Was your dissertation on Blake? No, actually it was on 20th Century American women writers. But I love poetry. I love romantic poets. And I was talking to a friend about the idea for the book, and she said, “Oh, it’s like that Blake poem—‘a world in a grain of sand’ and ‘eternity in an hour.’” She quoted the lines to me that I end up quoting in the book. And I looked at it and thought it was perfect.

How did she pick up on that? It was the idea that in one 12-hour shift, you can find the whole world. I wanted to find a way to tell longer stories, and paradoxically, I realized that I could do that by telling the story of one shift, because so much happens in every single shift. It would be a way for readers to get to know a small number of patients pretty well and also get this slice of each of their lives, and then, together, it adds up to a whole picture of life in the hospital. And the big questions, too: life, death, what does it mean to survive? What does it mean to have someone you love not survive?

And also the notion of working a shift. That you leave it behind and hand it off to someone else and then pick it up tomorrow. That’s right, yeah. We try to leave it behind. We don’t always succeed. But that’s the goal.

One thing that struck me is your observations about the little things—blood billowing like silk into a saline solution when you are testing a PICC line. Nursing would seem to be great material for a writer. You get this up-close relationship with all sorts of corporeal things like blood and body parts. Is there a thrill there?

I think everyone starts with that, but then it wears off or mellows into respect. I don’t know if it’s that I have affection for blood as much as I really appreciate it now. I appreciate everything that it does, and how important it is in a very detailed way for our survival. And I have this incredible respect for the complexity of the human body and all the things that go right all the time. And then, one thing goes wrong, and what does that mean?

I do think everyone in health care is a little bit of an adrenaline junkie. For me, I think that mostly wore off. Your first few codes you’re like, ‘Oh, it’s a code,’ and you get this adrenaline rush. But then, you realize that it’s a person’s life on the line. So, that whole idea of drama in real life is a lot more complicated because there’s pain, and there’s suffering, and questions about whether can we save them and how much we can do.

Let’s talk about the nurse’s role in health care. In The Shift, you quote articles by Leonard Stein, one in the ’60s in which he says the unwritten rule was that the nurse had to make sure that everything she suggested seemed to come from the doctor, and then a second one in the ’90s in which he writes about the nurse being a kind “corrective agent” to

Editor’s Note: Transcript of interview was edited for length and clarity.
the doctor. How do you see it now? Do you see the relationship as being different in 2016? Ideally, yes. I think we are moving toward more of a model where nurses and doctors are colleagues, so you don’t have to play these games. But, depending on the physician, and to be fair, depending on the nurse, you can still get all these permutations.

How much is gender a factor? An increasing number of physicians are women and a minority of nurses are men. I would have said it’s getting more gender-neutral, but I gave a talk recently to a group of physicians who said that women residents have a much harder time with the nurses than the guys do. The male residents seem to interact socially with the nurses more easily, and that nurses are less likely to see the men as bossy, whereas with the residents, the women almost have to prove themselves to the nurses. Then the nurses will trust them and work with them and be friends, and it’s very collegial.

That was very hard to hear—that, for a variety of reasons, women nurses may tend to give these physicians who are women a much harder time at the start of their careers as doctors.

We occasionally lapse into jargon at Managed Care and talk about nurses and other people being “physician extenders.” I hate the term physician extender. I feel it is insulting to nurse practitioners and physician assistants who are licensed, trained professionals and have their own responsibilities.

The really odd thing about it is that there just aren’t enough doctors in the U.S. right now, especially in primary care. And there are a lot of NPs who would like to do that work, and data show that NPs are just as good at delivering primary care as physicians. And yet, there’s such resistance among some quarters of MDs to allow that to happen. So, it’s just a bad and sort of stupid situation where there aren’t enough doctors to do the work that doctors need to do, and yet, we can’t just acknowledge that and give these people credit for the work that they’re doing. They have to somehow be like, you know, the doctor’s third arm or something.

I think calling a person a physician extender is really insulting. I really don’t like it. I understand why people use the term, but I really don’t like it.

You get funny, in kind of a dark way, in the book when you got into a rant about charting and the time it takes away from providing care. But all this charting does create information and data that presumably can have some benefit. Do you have any thoughts on how the charting and the electronic health record could be improved? We need across-board interoperability, because right now, we have all these charts, but oftentimes systems can’t speak to each other. So then you have the worst of both worlds. You’re spending all this time putting information in a computer, and if that patient goes to a different hospital, or sometimes a doctor’s office, no one else can look at that. So, you constantly have patients repeating their history, you have med lists that are inaccurate that don’t get transferred from place to place. To me that’s just a real mistake.

Also, I think there’s a lot of charting that gets done to meet regulatory requirements, and I completely understand the importance of that. But I don’t think the people making the regulatory requirements ever think about, how can we have the charting be more clued into what the clinician needs to be doing with the patient?

So, for example, I know with physicians, they say you just get a lot of cut and paste now because there’s a requirement of every x number of days, there has to be a history and physical. It sounds like a good idea, right? “Let’s always have a history of a physical, or history of present illness.” But, because no one has the time to do it the way the regulatory people are imagining, you end up with a document that really doesn’t mean that much because it’s just pieces of all the documents that went before it.

This is something I’ve heard about from MDs. It’s been written about, too. It’s not a secret.

Any thoughts on solutions? One thing that occurred to me is just to have tablets. They tell us there’s a computer in the room, so can you chart in the room, but my experience is that patients find that very alienating to have someone standing there, talking to them—not just someone, but the nurse—and looking at the computer. And I think most of us don’t like that.

If nurses could have tablets, if you could just pull up, for example, a fall assessment on an iPad, and just make it something so simple that you could just tap, tap, tap while you’re talking to the patient. And then you could be doing the fall assessment while you’re talking to them instead of having to get your cursor on this little tiny thing that registers a drop-down menu, that then gives you another drop-down menu.

There’s no sense of how can we make this software so that people can use it in real time, while they’re interacting with a real person, so that it works for everyone.
There's no sense of how can we make this software so that people can use it in real time while they're interacting with a real person so that it works for everyone. It seems like that would be possible. We make little computer games for a 3-year-old to play with, right? There's got to be a way to make the human interface better.

Sometimes the answer seems to be the portability of the gadget. And it's like what you wrote about hospitals, using the title of the Hemingway story: The interface should be a clean, well-lighted place. That's excellent. I like that.

You also talk about work-arounds. I saw that there's a book out now about the ethics of work-arounds. Work-arounds, you're kind of breaking the rules, right? Yeah. I mean, it depends on what the work-around is. I try to be very strict with myself.

When we instituted barcode scanning at my hospital, huge numbers of work-arounds sprang up because the software wasn't that good, and the scanners didn't often work. So, the work-arounds were put in place because we were given equipment to work with that couldn't really do the job. That ended up becoming feedback that management needed to hear—and was not always happy to hear, or going to fix with alacrity. But yeah, were people breaking the rule? Yeah, they were.

There was a point where you could have lied on the chart, but I guess you didn't. Right.

People lie on the chart all the time, right? I cannot answer that. [Laughs.] I think there are a lot of situations in the hospital where, again, there's certain regulatory requirements or things that are done for safety, and at times they just make doing the work incredibly challenging. So, I think the example for me was hanging the Rituxan, and I'm supposed to be in there at specified times and take vital signs. I was able to do it that day. But you're not always able to get in there at the right time, and then, the question is, do you write down the real time? The time you were supposed to be in there? I write down the real time. It's tough.

Opiates are in the news a lot. You discuss pain—the mantra about keeping ahead of the pain but also an undercurrent of suspicion about people with pain. Where do you think things stand in terms of the medical system dealing with pain and what seems to be a swing against opioid medication? I think on this a lot because, for example, my daughter recently had emergency surgery, and she's fine, but she's 15, and the resident had prescribed an IV narcotic, and the nurse really didn't want to give my 15-year-old a narcotic. She found a substitute that worked.

**What worked?** IV Tylenol. But then they sent her home with oxycodone. So, there I am as a mom, and I'm like, “What is going on here? This is so strange.” Because here's my daughter, not really getting fully the level of pain relief that would have made her the most comfortable, but enough that she could sleep and she wasn't miserable. On the other hand, there's this worry about using a narcotic if we don't need it because there are so many risks associated with it. And I find it so difficult that there are patients in pain who don't get pain relief.

I see that with hospice care, too, when families have a hard time giving their loved ones narcotics. But at the same time, we have this explosion of addiction to prescription pain killers, and even heroin. So, I've been thinking about this a lot. I don't really have anything smart to say about it yet. [Laughs.] For now, I find it a very troubling paradox.

One thing you write about in your book is the separation of outpatient care and inpatient care. There's a passage where you talk about when people come to the hospital, the oncologist that they may have been seeing all along is left out of the picture. The intensity and isolation of the hospital from the rest of the health care system seems to be growing. That's a very smart observation. It is like a divide, and I think it is growing as hospitals become more and more complex. And the whole idea of the doctor who does rounds and sees all of his patients, and it's six in the morning, and then he goes and does clinic, and consulting phone calls, really looking after people while they're in the hospital. I think it gets harder and harder for people to make that work. That's why the hospitalist came into being.

**Maybe it doesn't make sense anymore...?** I don't know. It's very hard for patients to have a relationship with a physician they know and trust, who knows their history, and then go in the hospital and have a new doctor come in and take care of them. I don't know if the public has to outgrow this idea of, you know, you have “your” doctor. I mean, I certainly know with my children and the practice we took them to, there were a number of clinicians and you sort of got whoever is on call. You just have to be prepared for that.
But I think, especially if it’s something like cancer, it’s very hard to not have that person you trust be there with you in the hospital. That model may just not work any more. It may be like what you’re saying, that the difference between hospital care and outpatient care is now so large that you need to have a physician or a nurse practitioner or PA looking out for you who really knows how the hospital works, because they’ll know how to order the tests, they’ll know who to call. They’re just such complex systems now.

There’s a lot of attention being paid to the patient experience, that it can be measured and reimbursement rates are being adjusted according to patient experience scores. How do you view the efforts to factor in the patient experience into health care? I think it’s very, very important. I object to how we’re doing it. I wrote a column for the New York Times about this and called it, “Hospitals Are Not Hotels.” For a hotel, you can answer questions like “Were you satisfied with the room service?” or “Was the bed comfy?” But those kinds of questions aren’t appropriate for a hospital. You might have things done to you that hurt. You maybe can’t eat because your body is not going to be able to digest food. You might get cut and have part of your insides removed, which I think is fundamentally unsatisfying. So, I don’t see us having a sophisticated way to evaluate those things about care that are really, really difficult.

One question that is asked is whether you recommend this doctor or hospital? That seems to get beyond satisfaction to experience, maybe. Right, and I definitely think a lot of the questions they ask are very important. “Did you know what was going to happen?” “Did you understand the things that were said to you?” All that stuff is very important. But, when you get into, you know, “Rate this hospital on a scale of 1 to 10,” I don’t like that because there could be reasons why people feel like, I hate this hospital, and it’s because that’s where their husband died. And in oncology, we have patients who love the care they got, but they feel like, “I never want to come back here again. Everything bad in my life happened here.” So, how do you evaluate our competence while still allowing them to be angry—if they are angry? That’s the challenge.

In your book, you write about hospital administrators needing to get “heads in beds” and wishing for a slower pace in the hospital but that the situation won’t change until caring becomes as lucrative as tests and procedures. I’d love the idea that there’s a way you could chart for caring.

That seems to be where we are headed when we’re allowing doctors to code for end-of-life discussions—it kind of gets at that. There’s a lot of patient education that nurses do. If you have a new diagnosis of leukemia, I’m going to tell you a lot about that, which is intense and occurs over days and weeks, or, here’s how to take care of your wound when you go home post-operatively. And we’re required to do that, but there’s no specific charting for that. Wouldn’t it be great if we could? You know, what did you talk about? How long did you talk for? But that’s it. It needs to be simple. It can’t be that you have to do a multiple drop-down menu of assessment of your patient education because then you’re doing that instead of doing the education.

Value-based care—what do you think of it? What I know about it, I like it. I think it doesn’t communicate that well to people who don’t know what it is, unfortunately. Of course, a clinical person would say it depends on who is defining the value. When you talk about patient satisfaction, people can get really into that, especially patients: “Yeah, it is about my experience.” And when we say value-based care, they’re like, “What’s that?” It sounds like you’re cutting coupons for the grocery store.

But the whole idea of looking at everything that happens in a hospital and saying, “Does this benefit the patient?” Fabulous.

Now you’re involved in hospice care. Why the switch? The truth is, after working in hospitals and writing a book about hospitals, I felt like we never see people at their best in the hospital. We’re always telling them what to do, and when to do it, and so many rules. I wanted to see people in their homes, to see what that’s like and what I could learn from that which could, maybe, be applied in the hospital. It’s just been incredibly rewarding to see people in their homes and have to go in and be a guest. That’s the best piece of advice I got from a long-term home care nurse. I said, “What’s the one thing I should know?” And he said, “Always remember that you’re a guest in their home.”

Not nearly as exciting, right? It is. It’s just a different kind of exciting. Hospice has its own deep kind of excitement because you’re always dealing with the fundamental questions. You don’t get the adrenaline rush of coding someone, but it’s really a sense of grace that can come with doing that work, contemplating mortality, and helping people contemplate mortality. It’s difficult and very rich.

Are you writing a book? Everyone keeps saying that to me. I have some thoughts. That’s about as far as I am right now. ☛
Researchers Mining HCCI Trove Of Private Payer Data for Pricing Insights
The info comes compliments of Aetna, Humana, and UnitedHealthcare.

By Joseph Burns, Contributing Editor

Since December, researchers have been releasing study after study showing how health insurance works—and doesn’t work, in some cases—because of unprecedented access to data from three large national insurers.

For four years, the Health Care Cost Institute (HCCI) has been acquiring data from Aetna, Humana, and UnitedHealthcare and in the past year or more has added staff, engaged in partnerships with academic researchers, and received $1.5 million in grant funding from the Laura and John Arnold Foundation. All of this has allowed HCCI to produce research on health care spending and prices and how states are implementing the ACA and other reforms.

Previously, researchers relied almost entirely on CMS data, which represents only 16% of total spending but has skewed much of the nation’s health policy research, according to Zack Cooper, an assistant professor at Yale who published one of the first reports based on the insurers’ data.

The HCCI data from the three insurers include 92 billion claims filed from 2007 to 2011. The claims came from 88 million Americans with employer-sponsored coverage, a little more than a quarter of the American population.

In December, Cooper and colleagues used the data to document wide variations in hospital prices within and across geographic areas, and to examine how hospital prices for the privately insured vary widely. They showed, for example, that when hospitals have a monopoly in their referral regions, prices are 15.3% higher than in regions with four or more hospitals, even after researchers controlled for cost variations among regions. Their findings about market power and price is significant because it gives health insurers evidence to refute a common argument among hospital administrators (“our costs are higher”) when explaining price variation. The National Bureau of Economic Research published its research, and Cooper and his colleagues posted it, along with other supporting data, on a website called the Health Care Pricing Project.

More recent research using the HCCI treasure trove showed that consumers in some states spent twice as much for some health care services than consumers in other states and that the price of health care services varied by threefold within states. HCCI Executive Director David Newman and colleagues published their findings in the May 2016 issue of Health Affairs. When they looked at price variations for 242 common medical services, they found that Alaska, Wisconsin, North Dakota, New Hampshire, and Minnesota had the highest prices, while Arizona, Florida, Maryland, and Tennessee had the lowest. They also found large variations within states; for example, in California, the price of a knee replacement ranged from $57,504 in Sacramento to $30,216 in Riverside.

A month earlier, HCCI researchers reported findings showing that health care spending for children with private health insurance has risen sharply in recent years because prices have gone up. For example, the price of brand-name prescriptions more than doubled from $7 per filled prescription per day in 2010 to $16 in 2014.

Confirming conventional wisdom
In February, HCCI released six research reports based on the health insurers’ data. In some cases, they confirmed conventional wisdom: Using nurse practitioners in primary care settings cuts costs, and consolidation among oncology providers drives up the cost. In others, the HCCI gave an evidentiary boost to some fashionable developments in health care. HCCI’s data crunch showed, for example, insurers’ payments for telehealth services are 40% lower than care that does not use telehealth.

“We believe that this data-driven research will build a knowledge base about the changing health care landscape, and serve as a resource for policymakers and consumers alike,” said Amanda Frost, a senior researcher at HCCI.

She might have added that the data are likely to prove useful to insurers as well.
Intermountain Health Plan Promises Price Cap To Employers Willing to Make a Commitment

By Frank Diamond

SelectHealth, a subsidiary of Intermountain Health, is promising to keep rate increases for large employers at 4% a year from now until 2019, a story that garnered considerable attention when it broke. “Virtually unheard-of” gushed a New York Times article about the program's rate increases, which are about one-third to one-half less than what employers usually face.

A three-year contract is quite different in the health insurance marketplace. A self-funded administrator will sometimes offer multiple year contracts on administrative fees. And, occasionally, an insurer might impose a cap saying, for instance, that fees will not increase more than 10% for one year. But that’s as far as it goes. “To have something that says for the next three years, here’s your entire health insurance spend for total cost, that’s definitely innovative, and something that employers can look at and say, ‘This is pretty exciting,’” says Scott Schneider, vice president of sales and marketing for SelectHealth.

The new program, called Share, is being offered to large employers in Utah that have 100 or more workers and that are willing to sign up for the multi-year commitment. Seven companies, encompassing 11,000 beneficiaries, have signed up so far. Participating companies are diverse, including a technology start-up, a supermarket chain, a manufacturer, a large county government, some smaller retailers, and a school district.

“We have different kinds of employers represented in the first year of the program, and that’s really exciting for us because we can learn from that, provide outreach, and actually collect biometric data from an organization that has 30 different worksites. We can work with organizations that have different schedules outside of 9 to 5,” Schneider says.

SelectHealth hopes to pull this off by getting full, and in some ways unprecedented, commitments from the major stakeholders: employers, employees, and providers. Employers, for instance, must agree to SelectHealth being the sole insurer for employees, provide employer-match health savings accounts, establish a wellness council, and initiate annual employee wellness reviews. For their part, beneficiaries agree to participate in disease management programs if they suffer from asthma, COPD, diabetes, or congestive heart failure.

The commitments stakeholders make also involve data sharing and transparency. Select-Health will forward “actionable data” to help providers and hospitals improve. In a FAQ for providers (http://tinyurl.com/FAQ-Select), the health plan said it will work closely with clinics and providers to understand their data and reporting needs. The emphasis on transparency means providers will be able to compare themselves to others. “It will take time to fully incorporate this transparency,” the FAQ states. “We intend to allow practices access to view their own data to vet the data internally from November 2015 through June 2016. We will ‘un-blind’ performance information with all participating practices in July 2016.”

SelectHealth officials say the Share program price guarantee will be maintained through savings of about $2 billion over the next five years. That’s quite a challenge, and many will be watching how Share pulls it off. The Times reported that the plan saved $235,000 in 2015 on surgical staplers just by shopping around, and another $639,000 by ensuring that heart attack patients get to the catheterization lab within 90 minutes of landing in the emergency department.

Highly aligned physicians

Most participating providers in Share are not Intermountain employees, according to Schneider. “We would call them highly aligned physicians. There are a lot of midsized clinics within the Utah market. They’re very well respected and provide high-value care.”

SelectHealth will tweak and refine Share as necessary, says Schneider.

“It all comes down to making it work and for longer than the initial three-year launch. “We intend that this continues in the future for us,” he says. NG
Dry eye disease (DED) is a growing public health concern. Twenty-nine million adults in the US have reported symptoms associated with DED. In the US are diagnosed with DED, and the number is expected to increase. DED is often chronic, can be progressive, and is a very common complaint presenting to eye care professionals today. This multifactorial disease can result in symptoms of discomfort, visual disturbance, and tear film instability with potential damage to the surface of the eye. In addition to traditional risk factors such as age, female sex, and hormone changes, modern risk factors such as prolonged screen time, contact lenses, and LASIK can increase the risk of DED in both commercial and Medicare members.

Inflammation plays a prominent role in the development and self-perpetuating cycle of dry eye disease

The DED cycle includes ocular surface stress (OSS), which occurs when a stimulus triggers ocular surface inflammation and the increased production of inflammatory mediators, such as intercellular adhesion molecule-1 (ICAM-1). Inflammation promotes damage to ocular surface tissues, further stressing the ocular surface and perpetuating the cycle.

Ocular surface damage

Infiltration of cytokines leads to abnormal tear film instability and perpetuating the cycle.

Tear film instability

OSS and inflammation lead to an abnormal tear film characterized by instability.

Inflammation

Our changing understanding of DED

Once considered to be the result of reduced tear volume, we now know DED is most often the result of abnormal tear composition. It is estimated that ~10% of DED is purely due to a deficit in tear production. Increased tear evaporation, decreased tear production, and/or decreased blink rate can alter tear composition, promoting inflammation on the surface of the eye. This inflammation is now recognized as both a cause and consequence of DED, playing a prominent role in the self-perpetuating cycle of the disease (Figure).

A commitment to ophthalmics and DED

In May 2014, Shire established its Ophthalmics Business Unit, solidifying its commitment to growing in this therapeutic area. Shire’s multi-faceted approach to discovery, development, and delivery in both rare diseases and specialty conditions includes our efforts to address unmet needs in eye care, such as DED. In addition to DED, Shire’s ophthalmic pipeline includes investigational candidates in infectious conjunctivitis, retinopathy of prematurity, autosomal dominant retinitis pigmentosa, and glaucoma.

References:
3. Shire Data on File SHP606-008.