THE FUTURE OF HEALTH CARE

ROUNDTABLE DISCUSSION

PANELISTS

Dr. William Ball
UC College of Medicine

Mark Clement
TriHealth

Kathleen Crawford
Bailey & Company Benefits Group

Chad Eckhardt
Frost Brown Todd LLC

Dr. O’dell Owens
Interact for Health
THE FUTURE OF HEALTH CARE

The Affordable Care Act has been receiving a lot of attention in the news, lately. Yet, from a practical standpoint, employers and their employees still have a lot of questions related to issues, such as obtaining the care that’s needed, the scope of services covered and the costs. On the flip side, health care professionals are also working through similar aspects including financing and the delivery of health care. In gathering our panel of experts, we’ll talk about health care and share some of their latest insights.

Cincinnati Business Courier editor Rob Daumeyer recently sat down with Mark Clement, president and chief executive officer of TriHealth; Kathleen Crawford, benefits consultant with Bailey & Company Benefits Group; Chad Eckhardt, a partner at Frost Brown Todd; Dr. O’Dell Owens, president and CEO of Interact for Health and Dr. William Ball, Dean of the University of Cincinnati College of Medicine to talk about the impact of the Affordable Care Act and what’s in store for the future. They also reflected on cutting-edge topics like heroin addiction, opioids and how technology will change the future of health care.

ROB DAUMEYER: Obviously, there’s a lot to talk about, and there are a lot of moving parts here, and it can get technical, but I think of all the round tables we do, and we do a bunch of these, health care is truly the one that I feel like is my favorite one, because it’s, changing constantly and that makes for good content. So, here’s what we’re going to do. We’ll go around and everyone can introduce themselves. Say who you are, where you work and what your title is, and maybe just a little bit about what your organization is working on right now. Then, I’ll jump in with the questions.

MARK CLEMENT: Is this a trick question? Just kidding. My name is Mark Clement. I’m the president and chief executive officer of TriHealth, a two-billion-dollar integrated delivery system resulting from the merger between Good Samaritan and Bethesda hospitals. What are we working on? How much time do we have? Health care is in the midst of fundamental change, both in terms of financing and delivery. TriHealth has been on a journey, almost since its founding 23 years ago, to evolve from a standalone hospital into a true integrated system of care. We are working to do much more than deliver exceptional episodes of care, like an emergency department visit, a surgical procedure and an inpatient admission. Importantly, we also are becoming a system that is taking on responsibility for managing and improving the lives and the health of a defined population.

KATHLEEN CRAWFORD: I’m Kathleen Crawford. I’m an employee benefits consultant with Bailey & Company Benefits Group for the last 13 years. Our goal has been the same - to focus on the costs that employers pay for their employee benefits plans, and to maximize the return on their investments, so that they can attract and retain top-quality employment here in the city.

CHAD ECKHARDT: My name is Chad Eckhardt. I’m a partner at Frost Brown Todd. We are a 500-plus attorney firm, with 12 offices in eight states. With respect to health care, we have about 30 attorneys, who specialize in health care. Half of those spend the majority of their day, entirely on health care related issues. So, what are we doing? Well, we’re supporting all the systems and providers, the employee benefits plans, and we’re focusing, recently, on a lot of integrations – system integrations across the country, as well as local integrations and relationships between different care providers that need to collaborate and need to document those collaborations. So, that’s been a lot of the recent work that we’ve been doing, along with just staple issues about benefit plans, employment relationships, privacy compliance, and all the different aspects of health care.

WILLIAM BALL: I’m Dr. Bill Ball, dean of the University of Cincinnati College of Medicine and senior vice president for health affairs at UC. We’re over 2000 physicians, investigators and colleagues whose careers are somewhat similar to your healthcare providers’, except we integrate both teaching and research as part of our mission. This model is the academic model, where we exist as an institution for the advancement of health care across the region. As a college, we secure research funding of about $115,470,969 annually, or around 72 percent of UC’s research dollars in order to prevent disease, improve therapies, and manage disease. In addition, we contribute almost $1 Billion dollars annually to the local economy, and produce over 1700 new jobs annually in the tristate region. Because of our mission, we are fortunate to attract global leaders to Cincinnati. We don’t just perform the most advanced procedures, we teach them. No. 1 in Ohio for robotic surgery volume.*

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in both academic medicine and health-realted research. And, perhaps the best part is we enjoy serving and partnering with every healthcare system in the region. And I have to say, as scientists, physicians and students working furiously, we probably don’t do a very good job letting folks know precisely how the college is an indispensable resource to our region.

O’DELL OWENS: I’m Dr. O’Dell Owens, president and CEO of Interact for Health, which is a local independent non-profit that was created by the purchase of Choice Care, a physician-owned group by Humana. So, by our charter, we live off the proceeds from this sale and use the funds to improve the health of our region. Our focus, as we’re going forward now with our new strategic plan, will be on tobacco, specifically in our lower-income communities where smoking rates haven’t changed in the past 20 years. We think tobacco impacts health care in so many different ways. We’re going to focus on policy, trying to raise the age of smoking to 21, we’re going to work with our charter, we live off the proceeds from this sale and use the funds to improve the health of our region. Our focus, as we’re going forward now with our new strategic plan, will be on tobacco, specifically in our lower-income communities where smoking rates haven’t changed in the past 20 years. We think tobacco impacts health care in so many different ways. We’re going to focus on policy, trying to raise the age of smoking to 21, we’re going to work with

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– Dr. William Ball, UC College of Medicine

OWENS: For me, I look at a couple things. One of things people didn’t realize, is in Obamacare, the cap of lifetime expenditure was removed. I don’t think people understand that. I think it used to be about 1.5 million dollars, and once you hit that there’s no more health care for you. And, if you have a child with a rare, exotic, genetic disease, you can hit those numbers very quickly. Certainly, here in Cincinnati, to make it more personal, the Affordable Care Act changed the number uninsured people. The Cincinnati Health Department’s multiple clinics went from 60 percent uninsured to all the way down to 20 percent. We were able to get people into those centers. The essence for me is that by extending Medicaid and the Affordable Care Act, it allows individuals to get health care to move their personal health status from fair to good. When you do that, you increase your workforce. We have to understand, there’s a real reason you have health care, it’s the workforce. If you don’t have a viable workforce, and we are in a very strange conundrum, because the unemployment rate is four percent. Yet, there are eight million jobs available, and new companies won’t come, once you get a little lower than that, then you are considered at full employment, and you can’t draw new employers. Yet, we are not filling the jobs we have, we’re not prepared for the future. So, health care provides the workforce. I think that’s a much more powerful defense for those that want to go against Obama, but at the same time they are into the business community, you want a workforce. To move people from good to excellent does nothing for the workforce. It doesn’t put one more additional person to work. But, if you go from fair to good, you put a lot of people to work.

BALL: There is clearly no easy or right answer to this question. Studies support that Medicaid expansion has had some effect on raising the cost of healthcare, may not provide the “greatest bang for our buck,” or may not focus on those most in need. On the flip side, more patients are being covered, the average personal debt from healthcare is going down for many Americans who are most at financial risk, and money can be redirected, if

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we so choose, towards major issues we face such as the opioid crisis in America. Despite the pros and cons on both sides, the question remains, "Replace it with what?"

Perhaps we start not with the economics, but rather with some principles we first all need to agree on. Like:

• All Americans have the right to affordable healthcare with the best possible outcomes.
• Everyone has the right to affordable healthcare coverage in which, while we may need to share in the cost, it should not put anyone individual’s economic future at risk to achieve health.
• End-of-life care costs billions of dollars with little evidence to support the care being provided. For affordable healthcare to be a reality, we need to critically look at more compassionate yet affordable end-of-life care and focus on the quality of life we are extending. As an example, until palliative care comes more mainstream and accessible rather than as an ancillary service, we can’t claim that quality of life is an important outcome for the healthcare system.
• An entire healthcare market needs to proportionately share in these responsibilities. Public systems of healthcare delivery cannot shoulder this burden alone or disproportionately to what the private sector will bear.
• For all healthcare delivery, the emphasis has to remain on the most affordable healthcare with the best outcomes, which must be blind to any one system of care, public or private.
• A single payer system should be considered for at least some parts of our healthcare system that would cut costs by either eliminating the middle man (insurance companies), centralizing administrative functions (credentialing and fee schedules) and/or allow for a stronger competitive advantage in driving fair pricing of services across provider domains.
• The cost of healthcare must also take into consideration the cost and process of educating a competent workforce in suitable numbers to meet a growing demand in the future, as well as ensuring our future of healthcare outcomes by advancing knowledge through research and discovery. In all of the debates around healthcare today, both education and research, which are the only ways to improve disease prevention and eradication, are seldom mentioned, but are at greatest risk.

ECKHARDT: It’s great listening to everybody talk about this issue. I think it’s what Mark said, it’s about repairing, not replacing, I think that’s a valid comment that could be made today. It could have been made five years ago, and it will be able to be made in five years. The ACA put stake in the ground on these issues, that as Dr. Owens has mentioned, are broader than health care. These are issues that impact all aspects of society and our workforces. So, we have a stake in the ground, and it does need to be repaired. Certain aspects need to be fixed on it, and that stake can be moved now. Before, we never had anything strong in the ground, and a lot of the aspects of it with respect to the pay for performance and the integration between the practitioners is extremely important, the innovations, the Medicaid expansion, there’s a lot of good aspects there. We just haven’t quite figured out how to get our arms around the costs. And, I think the costs are going to move that stake over the years, but we’ll continually talk about the issues with health care moving forward as we should. You know, to make sure that we improve it and make it better. As society changes, their health care is going to need to change as well. This is the beginning of a long conversation.

Q: That’s a good segue into the next question. Dr. Owens, it’s interesting to hear you talk about the employment changes here in Cincinnati. What are some of the challenges that businesses are facing when it comes to health care?

OWENS: Well, it has to be the right balance between an individual business deciding, what’s the balance between what the employer is going to pay and what the employee is going to pay. Then, what are the incentives that one can initiate to try to get those employees to be the healthiest, and make healthy decisions as much they can. There are some segments of society where the employee is only paying four percent, and in some places, they are paying 80 percent. So, it depends on what other benefits it has you. What does your workforce look like? What does your company look like? So, that’s going to be the challenge, and what’s the right balance of trying to keep employees, and at the same time, trying to hold your costs down. Part of that is going to be how do you incentivize them to make healthy decisions.

CLEMENT: Building on Dr. Owens comments, what I hear from business leaders, and I talk to them literally every day, is what can we do to moderate the cost trend. It is a major challenge for most employers. I think the Affordable Care Act was a catalyst for rethinking how health care is financed and the role that employers and employees have in financing and financing health care. We’re seeing an evolution from pure fee-for-service into an evolution in benefit plan design which is intended to create a more rational market. Health care historically has been financed at least in the commercial sector by employers. At the same time, you’ve got consumers driving demand without having the responsibility of paying for accessing the supply. It’s not a rational market. As a result, a number of consumer-focused health plan designs have been introduced. All of this is intended to do what Dr. Owens has suggested -- create more responsibility and accountability on the part of the customer/consumer for health care. We’ve seen new high-deductible plans and incentives being built into plan designs that reward healthier living. We’re seeing greater transparency in health care, coupled with increased deductibles and copays where consumers now have greater responsibility for the cost of care. They’re doing more shopping than ever before.

CRAWFORD: There are a lot of places I could go after that. That was a great introduction of every challenge that’s out there. To your first point to the increase in costs and trends that are affecting employers, is first of all medical trend has stayed stable if not leveled out, but the pharmaceutical piece of medical trend has spiked, and it’s mainly driven by the specialty drugs that are drugs used to treat difficult diagnoses, such as cancer, inflammatory diseases and HIV, things like that. They’re either injectable drugs or IV infused drugs and the price tag that comes with these drugs can exceed over $100,000. You heard when the Hepatitis C drug came out that it actually can cure Hepatitis C, so it’s a wonderful drug, it is a thousand dollars a pill, and you take that pill for 90 days, every day. So, it can be a hefty price tag. Employees are an employer’s soldiers on the ground, because they’re the first line of defense in their own health care and making the right decisions, but also in controlling how that employer’s health care dollars are spent. So, our role as a benefits broker is to make them better consumers by educating and motivating, and so the education piece is critical. There are many ways now that we are reaching employees; from avatars online, to cell phone apps that push out regular notifications, because each employee absorbs information differently, and to wait until they’re sick to try and find the best solution for them is the mistake, because then they’re just going to utilize the health plan and self-navigate, and with the ACA, there’s now a $7,150 cap on what they are exposed to. Once they’ve hit that cap, if they still don’t have the solution, they’re still going to jump from specialist to specialist. So, it’s important to provide the right tools in advance, for a member to know who to call, and where to go to find the right resources that they need. An example in regards to caring for cancer patients, there are now clinical resources that members can reach out to.
along with their doctor, to find the best practices in cancer treatment, because the physicians that you work with might have only treated that type of cancer once every so many years, and things change constantly. So, this resource provides a nurse liaison that utilizes a database of best practices who will advocate for the course of treatment proven to have the best outcomes with the least side effects. They also offer second opinions, there are examples of patients undergoing chemotherapy that later learned they never actually had cancer. This cancer resource is being offered by employers to employees and their families with the goal of improving treatment outcomes which also controls costs. This is just another example where employers are driving innovation in healthcare.

OWENS: It’s sad. We have not seen the ravages of Hepatitis C yet. We are really in trouble with that. Information gathered for needle exchange shows of the population of people using heroin, 49 percent are already positive. Normally, you see a spike in Hepatitis C around the age of 55 and older. We are going to get that spike from people that got tattoos 20 to 25 years ago, because they weren’t in a sanitary condition, because they used the same needle, and then when they went to a clean needle, they were using the same ink well for everyone. Now, there’s a spike from the heroin. And, she said the drugs go up, but my sense is that anytime a drug becomes popular, the price goes up even more. Look at the EpiPen. So, maybe treatment for Hepatitis C is $90,000 today, and it’s going to be a lot more in the future.

CLEMENT: If you study pharmaceutical prices worldwide, you’ll discover that we’re one of the few countries that does not regulate or control the prices. That’s the result of laws passed by Congress, signed by the Executive Branch and driven by the pharmaceutical industry. You can go to Canada and buy a drug for a fraction of its cost in the U.S. Health care is a broad spectrum, at least on the provider side, from pharmaceuticals to health systems to doctors to post-acute care. All of these segments of the health care industry except pharmaceuticals are price-regulated.

ECKHARDT: We see that. There’s such lead time. There’s 340b pricing opportunities that provide access to drugs that are needed to certain populations, and that’s a cost that the pharmaceutical companies have, but then they make it up on specialty drugs that’s unregulated, and there’s costs there. Again, I hear so many interesting things, because this filters into so many different aspects of our community and our lives. We’re an employer-based insurance system. We made those decisions a long time ago for the reasons that Dr. Owens is saying about the need for the workforce, and the employers are now trying to figure out how do they change behaviors with respect to health care, and is everybody here knows, that’s tough to do, especially when you’re at the age of a workforce member, and so what I think’s going to be interesting, and seeing how these wellness plans that are being attached to all these insurance plans. We’re working with a lot of start-up companies that do wellness benefit plans and a big component of what they’re doing is education. So, to see how the medical homes that we have, primary care physicians, they’re educators now, and they’re studying patient populations for trends, so that we can learn how to educate them earlier, so we can change lifestyles. And, that’s going to be an enormous shift from our reactive system to a proactive system, and it’s going to take a long time to do that, and to do that right.

Q: So, you’re saying that you are working with companies that are setting these plans up, right? Are they seeing any benefits yet, or is this like you said, too early.

ECKHARDT: We’re seeing many more entrepreneurs getting into this space, and we’re seeing those that have entered the space sustain that. So, I think, Kathleen, you’re probably better suited to answer this, but we’re seeing so many benefit plans adding on this health assessment, this wellness and these benefit plans. So, I feel like they must be doing something, but it might be the only answer that the employers have right now to try and educate here. What are you guys seeing?

CRAWFORD: To the prior point about where I was going with consumerism, with the first part being education, the second part being motivation. To see an impact in preventable health conditions, employees have to be engaged to make better decisions. Employers know that for a majority of employees, cash is still king. So, to motivate employees using an incentive tied to wellness criteria is critical for participation. The criteria in which you award the incentives, and the amount of incentive will vary by the population you are trying to reach. For example, with a population comprised mostly of middle-aged males, they are famous for avoiding an annual physical, more so than other demographics. A wellness program for that employer may simply focus on promoting a preventive checkup with their physician, which may intercept potential health concerns early before things could go awry. Outcomes-based wellness programs are becoming more prevalent, which moves beyond incentivizing employees to participate in certain tasks, such as a health risk assessment, but graduating towards rewards based on improving upon or maintaining a healthy lifestyle. Criteria including glucose levels, blood pressure, BMI, cholesterol etc.

CLEMENT: The Affordable Care Act has been a catalyst for changing the way health care plans get financed, so there’s a lot of experimentation. The ACA was a catalyst for a new function called the Center for Medicare and Medicaid Innovation, created to test innovative payment models. One of those is Comprehensive Primary Care (CPC), an innovative payment model focused on primary care and innovation within primary care. Our regional health systems embraced the CPC seven or eight years ago and we’re now in its second phase. Another form of innovation is Accountable Care Organizations (ACO). TriHealth along with our partner St. Elizabeth Healthcare have created an ACO. ACOS are structured to share more responsibility with consumers for the cost of health care for their own health and wellness. ACOS also are creating greater accountability by providers — physicians and health systems — for the right health care at the right time, and in the right way to realize better clinical outcomes for the right cost. Those were never, ever things that were incentivized in a previous fee-for-service model. With payment models focusing on fee-for-service models, the only incentives were to do more, because we got rewarded for doing more. It was a supply-driven, demand model. ACOS bundled payments and risk-based contracting are all intended to create greater accountability on the part of health systems like ours. If you study more advanced markets around the country that have embraced these innovative payment models, you see a moderation in health care spending. Providers are being held accountable for doing the right thing, in the right way in the right place. They are accountable for measurably improving health. At TriHealth, we’ve employed these the same principles with our own team members — our 20,000 employees and dependents. We’ve seen a significant moderation in health care spending for our own people when compared with the greater Cincinnati market and when compared with other health systems of our size. We’ve cut it almost in half. These models and these new incentives do work.

BALL: There’s no question that the health of a company is only as good as the health of its workforce. Over the last few decades some companies have focused on improving healthcare for employees, which is generally viewed in a positive way rather than an incursion on privacy. Wellness programs, stress reduction and disease-based initiatives clearly improve the mental and physical health of a company’s workforce and reduce employer costs. On the other hand, employers must be willing to be part of the solution to improving the health of their existing workforce, and not using health as criteria for continued or new employment. With that said, data
shows that incentives to improve physical and mental health make for a much bet-ter and healthy work environment and workforce.

OWENS: But, employers sometimes make tough decisions. At Interact for Health, we’re trying to lead by example, for instance, we won’t hire anybody that smokes. And, we are also exploring not hire-ning anyone who has a partner or a spouse that smokes, because we don’t want sec-ond-hand chemicals coming into the work-force. So, if you smoke, you can’t work for us. We have to put that into our charter, because if we’re spending the next five years focused on reducing tobacco use, we want to be consistent.

Q: What are bundled payments?

ECKHARDT: I’m happy to tackle that. This concept has been out there for a long time, and it’s most easily seen, especially from the hospital side for the inpatient ad-missions, where you go into the hospital, and you come out of the emergency room for a condition. You get a couple exams, diag-nostic, you get an admission, and now you are in the bed for a while. You’re getting drugs while you’re there, you’re getting other testing done, and then you might have surgery along with that. So, typically, if somebody’s coming in with chest pain, then there’s a pathway the patient is go-ing to have through the hospital and all those related touch points. And, CMS, years ago, put together the diagnostic related groups. CMS said if you come in with this condition, we’re going to pay you this fixed amount. When they’ve done that, like Mark was saying earlier; they’ve pushed the fi-nancial risk to the provider to make sure that the provider is managing the care. So, no matter if somebody stays for three days or 13 days the payment’s going to be the same. So, with bundled payments, that’s one example. But, the innovations that Mark’s talking about from CMS have tried to identify other bundled payments. And, one I think you guys are probably still tackling is this concept of the cardiacbundled payments that are out there, and when we’re looking at where’s the gov-ernment, or Medicare’s the insurer on all your plans. Where are they going to push this financial risk? You’re going to go into the hub, and the hub has been the facility, the hospital. So, if an individual’s coming in for a joint replacement, the hospital is now getting one payment for that, and they have to manage the rest with all the touch points in that episode. From the primary care physician, who is identifying it, to the diagnostic testing that’s going on, and then the surgery, and all the post acute care that goes along with that. That requires collaboration, and good collaboration to make it work.

CLEMENT: I keep referencing the Affordable Care Act. As an example, some-thing called a Medicare Comprehensive Joint Replacement Bundle Demonstra-tion is being piloted locally. All of the health systems were required by the Center for Medicare-Medicare Innovation to move away from pure fee-for-service for joint replacements. We’re now being paid on a bundled basis. This means we are required to collaborate with private, independent orthopedic surgeons and with post-acute facilities if the patient requires care after surgery in the hospital. Because all of the providers are going to be paid one amount, that amount is shared that among the pro-viders across the full continuum of care.

ECKHARDT: In the old days, each of those individual providers would submit a claim for each service. I did an exam, or I did a surgery. Home health comes in on that post-acute side, everytime they come in to the home, there’s a cost, and you keep tallying it up. That’s what Mark was saying earlier. It’s volume-based – if you have to come back tomorrow, the provider makes more money. But, going (there’s a different approach.) They’re saying, Do you really need to come back tomorrow?

CLEMENT: There was a recent ar-ticle published in a trade journals by a Harvard general physician who grew up in Portsmouth, Ohio. He contrasted two areas of the country, a city in Texas and one in the Northeast. The difference in practice patterns and utilization of services was stark. The point is there’s a ton of clini-cal variation in our industry from market to market. In many ways, it’s a function of how a physician was trained. The vari-a-tion’s not like one or two percent, it can be as much as two to three hundred percent in admission rates and surgical utilization. The opportunity many believe to create greater efficiency in our industry is to mig-rate to clinical evidence-based practices that eliminate unwarranted clinical varia-tion. That’s really what’s intended with these bundled payment plans.

BALL: We also don’t want of confuse “bundled health care” with “bundled pay-ments” which refers to the method of re-imbursement, not the healthcare itself. It must be kept in mind the majority of care delivery will still be based on single epi-sodes by a single physician, but for com-plex disease, “bundled health care” is es-sential to improving outcome. Currently bundled payment methods make some sense as part of a value-based approach, but may not be sufficient in patients with substantial co-morbidities that are not predictable or are not easily controlled which is often the case with complex or chronic disease or disease in the elderly. The key to improving outcomes in bun-dled (collaborative) care is enhanced com-munication between and integration of care among multiple providers that ac-tually modifies the care delivery experi-enced by the patient in order to ensure improved outcome. This goes beyond just seeing multiple doctors, each with their own solutions, and instead creates hybrid care plans that yield better results than the sum of individual care plans alone. As such, team interaction must be an ex-pected part of the model rather than in the traditional model in which interaction is built around an “as needed” basis which seldom goes beyond merely a sum of the parts. Bundled healthcare, to be successful, must be built around a trust between med-i-cal disciplines, which begins in practice as part of post-graduate residency training of new doctors within academic centers and teaching hospitals such as ours, which in part may account for recent studies that have revealed improved mortality rates in a true teaching-hospital or academic envi-ronment. Additionally, bundled care and a bundled payment model promote stan-dardization among different providers in the same discipline. This can also reduce costs while improving both outcome and patient safety. While bundled payments were originally designed as a cost cutting measure, in theory they could be used as a tool to stimulate and promote bundled (collaborative) healthcare delivery, as long as each was a requirement of the other. In theory, bundled payments then could not only promote a true team approach, but also may be the most effective way of re-imubering improved outcomes. Of course, for that to happen collaborators would have to agree on payment distribution, payments would have to be risk adjusted for co-morbidities, and the bundled pay-ment would need to remain at a level nec-essary to make the new model effective in improving outcomes.

Q: Dr. Owens, you’ve been involved in nearly every aspect of health care. Is Cincinnati a strong city for health care?

OWENS: If you live in South Fairmont, your life expectancy is 20 years less than if you live in Mount Lookout. We have to start with that premise. As I’ve said mul-tiple times in this city, people talk about collective impact. We don’t have collec-tive impact in Cincinnati, because we don’t have collective will, especially when you are dealing with poor people, and children that are going to bed hungry. But, those are different issues. So, if you start with that, you have a 20-year difference. So, your life expectancy is not based on your genetic code, but your zip code. We’re seeing that across the country. So, we still have, even with the Affordable Care Act, more people

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“...with continued attention on reforming payment models and the rising costs of pharmaceuticals, that’s where the focus needs to be, on the trends that are driving costs.”

~ Kathleen Crawford, Bailey & Company Benefits group

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getting health care. More people are saying that their health status has improved, but it’s still somewhat segmented. We’ve still not taken care of the poorest people or the people who have a hard time getting through the door. If a woman is pregnant and needs a sonogram, she may be required to provide cash up front. Among all of our local healthcare systems, I think you can find some of the best healthcare available. But, there’s a perception. We just released a health status report. We asked them two questions, “What do you think is the health status of the region?” and “What’s the health status of your neighbor?” And, they said, “The health status of the region is poor. Oh, my neighborhood is good.” So, a lot of it is about perception. But, what you need in terms of health care, there’s no need to go outside our community, except for a very narrow band of things. But still, we need to work on getting the services equally available among all people that need those services.

CRAWFORD: From the insurance side of things, I would say as far as employer-based insurance plans go, Cincinnati is conservative. To Mark’s earlier point on payment reform, there are innovative ways of paying providers that move away from payments for treating diseases, towards compensation based on the overall health of the patient population. It’s interesting to me that Texas has actually lead the way in payment reform with many employers adopting reference-based pricing. With reference-based pricing, providers are being paid at set reimbursements for services based on Medicare rates, or another benchmark, so for example, Medicare plus a certain threshold. Those employers have said we’ve had it with the constant increase in costs, and we are willing to pay more than what Medicare pays, but not completely shudder the additional costs often shifted to employer health plans as a way to make up for treating the underinsured or uninsured population. Reference-based pricing is slowly increasing in popularity in Cincinnati, as well as self-funding, where employers can craft their own health plan, and choose the different components that are going to make up the health benefits. So, an employer can select the most competitive pharmacy provider, pick the best health care network, and the various other components. But, in Cincinnati, we’re slow to adapt there, too, because there’s this kind of stigma around “we don’t want to know the details of our plans, and it’s easier when it’s all bundled together.” So, openness to the self-funding world has been slow, because there is more involved, but it’s coming along.

Q: Talk a little bit about the stigma here. How well are we doing as far as integrating physical and mental health? Is it where it needs to be? Is it close? Is it still too far apart? I can tell you half of the pills that people in my department are taking for cholesterol, but not one person would ever talk to me about anything they may be taking like an anti-depressant. That’s only one example. What are you seeing? Is there still an issue there, merging physical and mental health?

ECKHARDT: I’ll start that off from the legal side. I talked about the fact that we work with physicians and facilities and on their collaborations, were they are entering into new service lines, because of the heavy regulations. We have seen an increase, especially in Cincinnati, of physicians and clinics trying to merge these two different service lines together, and there’s been a perception that the insurers don’t want to pay for a physical exam and a mental exam on the same day. They say, we’ll that’s bundled. And, you get into that. So, there’s been a history of keeping that separate from what I’ve heard regarding the insurance benefits, but we’re seeing much more of this integration and realizing that you can’t tackle somebody’s health if you’re addicted to heroin. So, you’re dealing with their flu symptoms, but you’re not dealing with how are you going to treat them for the mental health conditions that are leading to the addictions. That seems silly. So, we’re seeing it come together, because the questions our clients are asking. That leads me to believe there is still a gap.

BALL: For too long, healthcare delivery has behaved as though mental and physical health isn’t actually part of the same body, when in actuality they are inseparable. For all too many years, mental health has been largely ignored by society, by governments and by the healthcare delivery industry. Organized medicine shares in this blame, as we too have ignored the proven contribution of mental health as part of the overall solution to the health in any individual patient. I can safely say very few, if any, of us can recall our mental status being evaluated in our routine visit to the doctor’s office as one cannot reach the mental state through a rubber glove. This must change if we’re to improve health outcome. We must recognize and behave as if the two components are truly inseparable, and as such, attention to both must become part of the routine practice of medicine. I’m not proposing that primary care physicians assume the responsibility for a patient’s mental health or be responsible for diagnosing and treating mental disorders; however, they can play a role in both prevention and triage of mental health to appropriate levels of care when needed. While we are doing more in preventative care through efforts to reduce stress, improving the environment in which we live, and removing the stigma of mental health treatment, the mental examination must become part of routine care in the future with the healthcare industry leading that charge, as we try to teach to future doctors in the UC College of Medicine. It’s essential that academic programs spend more time preparing future providers to recognize the contribution of mental issues to the overall wellbeing of the patient. And reimbursement must also take into account the added value of tending to mental health as part of physician services, including the added time it takes to evaluate the patient’s mental status in a reasonable and cost-effective manner.

CRAWFORD: Mark, your partner across the river at St. Elizabeth is starting up a new hospital facility with 140 beds, focused on mental health. So, it’s becoming a growing concern. I think we’ll get into the opioid epidemic, but as far as my employer plans concerned, it’s showing up on their top claims list. So, whether it’s inpatient stays for drug and alcohol rehabilitation, or opioid addiction, things like that, it’s ultimately falling back to the employers.

CLEMENT: An often-cited quote by health care guru Dr. Paul Batalden is that, “Every system is perfectly designed to deliver the results it delivers.” It’s true. Our industry is delivering the results, unintentionally, that the current system was designed to deliver. It’s highly fragmented, highly siloed delivery of care. In looking at behavioral health, for example, the industry viewed what the system asked for and frankly delivered that in the form of an asylum. If you needed behavioral health you get sent to a mental health specialist, or a psychiatrist, and it was separated from primary care. What we learned in recent years is that mental and physical health are inseparable, and a causality between mental health, and overall physical health. However, the payment models are woefully inadequate to fund the kind of mental health services that are required, including being integrated with primary care and community-based health care. So, health systems don’t get paid for it. This is where thinking differently comes in. I’ll do a little shout out to one of the sponsors for our organization, Bethesda Inc. Bethesda Inc. is funding a really innovative program within our system that is embedding mental health services in our primary care practices. This is not something systems have traditionally been reimbursed to do. My brother is a primary care physician and he will tell you that 40 percent of his day is doing mental health counseling. We now have many practices that have mental health specialists to allow for an in-the-moment hand-off between a primary care physician and a psychologist or social worker to deal with mental health issues. I’m personally very interested in this and our system is committed to it. I’ve heard story after story of how this is changed the lives of our patients. For example, one patient that was experiencing

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chronic depression was able to immediately see a mental health professional who got them the help they needed. Traditionally, many folks won’t go when you refer them from primary care into a behavioral health program. Now, the warm hand-off gets patients in, they are receptive to it, there isn’t a stigma associated with it.

CRAWFORD: I think the insurers are starting to realize that all of those things impact physical health, because one of the large insurance companies in the United States has enhanced their tele-health services, where you can face time with a physician for acute conditions, sinus infections, and things like that. They’ve rolled out step two in the last year, to allow you access to psychiatrists and therapists. So, they recognize the increasing need to provide treatment for mental health.

ECKHARDT: There’s the gap we’re trying to bridge here. It’s not just historical like Mark’s saying. It’s not just on the payment side as Kathleen is mentioning, but it’s regulatory as well. The Health Collaborative is a convener. They do a lot of work with CMS and the CPC programs, and they have some other education obligations. It was over a year ago, we were doing a presentation there about the privacy issues associated with being able to share mental health records with primary care, because they have different regulatory regimes for the privacy. That’s an issue. From a clinical standpoint it makes sense, but what about from a regulatory standpoint. So, then you have to move the needle there as well. We’re moving the needle so much, but it takes a little while. Even on the reimbursement for tele-health, it’s different for a physical exam versus a psychiatric exam. Sometimes, you have to have that face to face, in order to get that reimbursement, which can become a problem, especially in rural areas. So, we’re having to move much more than our isolated, constituent parts. We have to figure out a way to move together, and to make that happen is a challenge.

Q: Opioids get a lot of coverage. How big of a problem is it in this area?

OWENS: Despite all that we’re doing, we have not turned the corner. This is different than your typical, where you would go upstream, and try to get to people before they go to heroin. There’s a contributory on the side. These were people, who as we know it are addicted to prescription pain medication. In 2008, as a coroner, I told the public, I told the media, that in Ohio and in Cincinnati was the first time that more people dying from prescription drug overdose than motor vehicle accidents, not because motor vehicle accidents were down, but it was a shift from illicit drugs. It’s ongoing illicit drugs. We weren’t seeing the fentanyl at that time. We haven’t seen that end piece. At the moment our systems are not prepared to handle this type of epidemic. We don’t have enough treatment centers. And the treatment centers that we do have are facing other challenges as they expand treatment. For example, an unintended result would be pushing those with cocaine and alcohol addictions out the door, because they are going to be overwhelmed by the need of beds for people dealing with a heroin addiction. Those dealing with a heroin addiction are going to need treatment, using medication and counseling. They are going to have to have both. To simply give them some medication won’t work. They are going to need both, and that’s a lot of resources and unprecedented collaboration. Interact is focused on building the type of infrastructure we need to end this crisis.

BALL: I am not sure we fully understand the origins and effect of the “opioid crisis” in this country other than to say it’s a problem that is clearly a human crisis of substantial proportions. We all know that substance abuse and addiction is claiming lives at an alarming rate, destroys people and their families, and is a major economic drain on our community. As with all such crises, it’s one consisting of multi-dimensional parts that defy an easy solution. While obviously a crisis in health, the sum of its parts includes societal, cultural, and political contributions. There are the obvious responsibilities we health care must accept including our contribution in creating the crisis to begin with. The opioid crisis has affected the healthcare industry, and as a result, healthcare needs to take a prominent leader ship role with community partners in seeking solutions including critical ethical evaluation of our practice of healthcare and how we educate doctors. Obviously the dispensing of opioids by practitioners must be looked at critically, and at the same time we must find more effective, safer alternatives to pain management, including non-prescription based treatments, like disease based physical therapy, nutrition, and all non-opioid. While in crisis mode, we have to be willing to take greater calculated low-risk approaches and counte measures such as allowing personnel in the field to administer Narcan as needed. We also need to invest more in emergency services and treatment as things are likely to get worse before they get better. Most importantly, we need to better understand the complexity of the origins of the opioid crisis with all its dimensions. This is a human crisis which may be improved by, but is unlikely to be solved by, advancing technology in healthcare. We must better understand the collateral damage addiction does to all those around the patient (family, neighbors and friends) if we are to expect that a better environment is a critical part of the solution. Solutions will clearly “take a village” to have any chance at impacting change, as “the solution” is simply not possible by healthcare alone.

Q: It can be anybody. It’s all of us. How often are you seeing this in the white-collar community?

CRAWFORD: It’s anybody. It can go unnoticed. You might not even recognize it. It could be the CEO of company that is under a lot of stress, addicted, and nobody notices other than some odd behaviors, something like that. My role as a broker has changed over the last several years, to focus on outside influences on employees, such as drug addiction, because my employers are suffering, or they see their employees suffering, and they want to be able to help. I sat with somebody that specializes in opioid addiction, and she spent four hours with myself, and others, educating us on the signs to look for and offering to educate employers and their employees, so that they can recognize the signs in their dependents, so their child is suffering, to recognize it early. It is interesting to me that opioids gained prevalence when prescription companies criticized physicians for sending patients home with any sort of pain, leaving the potential for patients to sue if left to feel even minor pain. Fast forward, it has reversed, physicians and pharmaceutical companies are being scrutinized or even sued for over-prescribing because it has contributed to addiction.

OWENS: But, you’re correct. Doctors were being sued. Patients were saying, they had pain and suffering, and they weren’t being medicated enough. That’s when pharmaceuticals came in and, I have something great for you and you won’t get addicted.

ECKHARDT: You don’t have to go too far back from a regulatory perspective to see some of the changes that were being made. That, we have various databases, like the OARS Database in Ohio and the KASPER Database in Kentucky, where physicians can go and see what has been prescribed to a particular individual. That’s seems like common sense to us. Why wouldn’t you be looking at that, but that has only been a requirement for the last five or six years, or so. So, we haven’t really had the tools to manage this. Again, with 12 offices in eight states, we see things pop up outside of Cincinnati. We are seeing a growth of treatment centers that are treating opioids, and working
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with individuals to try to provide access in a manner that’s not going to be stigmatized. That’s what we’re seeing with our clients and this opioid epidemic. And, we’re seeing it everywhere. The corridor that our offices are in, the Southeast, right here is a hotbed for it. So, we are seeing a lot of it. Like you guys have said, it can be anybody. I had a friend in college, who ended up with Leukemia, and had a blood marrow transplant. He’s recovered from that, and when you talk to him, the hardest recovery was the medications, and the addiction to the pain medicines that went along with that. That took much longer to get over. That was more devastating to him than the Leukemia.

CRAWFORD: And, it’s prohibitive to getting back to work. There was an outpatient, minor surgery that I had myself, and I was asked to be off work for two weeks. I said, Why would I have to be off work for such a minor surgery, and it was because you can’t drive on painkillers. Well, I didn’t need the prescription filled, and I was back to work in a couple of days.

OWENS: I know we’re at the end. I wanted to get one thing in. One of the questions that has been brought up is the use of technology to lower health care costs.

CLEMENT: I’d like to say something important about the opioid epidemic. On the treatment side, we in the health care sector are working in a very collaborative way with the county, the city, the health department and with other community service organizations. As Dr. Owen’s and others have said, we have not turned the corner. It’s unclear what all of the solutions are, but we haven’t broken the cycle of addiction. There has been a lot of challenges relative to how to treat this patient population. Every day we resuscitate patients that have been brought to our emergency departments, and it’s not one or two, it’s multiple patients every day that are brought in from a drug, heroin or opioid overdose. I think there’s a growing understanding that traditional treatment programs do not work for this problem, and that that that recidivism rate is 90-plus percent with these programs. What’s becoming increasingly clear is medication-assisted or medication supported treatment is really the best practice for this patient population. There has to be a way to reduce and moderate the cravings that consume otherwise rational people and cause completely reckless and irrational behavior. We are now training our emergency department personnel, who are often the first responders, to administer Narcan. We’re also educating our team members and physicians to do warm hand-offs, because we know that this patient population is most receptive to seek treatment immediately following resuscitation. If you can get these patients into treatment within the first eight hours following resuscitation, they’ll go. If you just give him a card, and tell them to call this treatment facility, they won’t call. So, we’re getting specialists in our emergency department to do more than just resuscitate, but to actually try to hardwire hand-offs into treatment. A significant challenge is that not every patient will agree to do that. You can’t force them into treatment.

OWENS: The Cincinnati Fire Department has brought back some individuals, as many as eight times in one day. Initially, they would give it nasally, and they wouldn’t give the whole thing. You give it slowly. As that person would wake up, you don’t bring them all the way back until they get to the emergency room, where you can have that conversation. Well, one doesn’t work anymore. Two doesn’t work anymore, because of the combination of the fentanyl with heroin. You have to have more.

CLEMENT: The University of Cincinnati Department of Medicine has organized a research program on this with TriHealth and other health systems participating. This research project will test the hypothesis that if we expand the availability of Narcan by giving it to family members -- who are closest to the opioid user -- deaths associated with overdoses will be reduced. We believe it’s so important we are partially funding the project. Over the next few years, hopefully, we will be generating useful information that will help this problem around the country.

OWENS: When I was the interim health commissioner, I trained every single employee in all our health centers, and in the main office, janitors and truck drivers on Narcan. At Interact for Health, we looked at some of the hotspot maps. One was in Price Hill. We went door-to-door, handing out Narcan.

CRAWFORD: Thirteen years ago, when I first started in this industry, I had an employer that was desperate to find a way to exclude opioid coverage under the medical plan, in any shape or form. They were on the border of Kentucky and West Virginia, and it didn’t dawn on me at the time, I thought it was isolated to them, it would be coming our way, and it’s here, but you’re not allowed to exclude opioid coverage anymore. Thanks, in part to health care reform, which can be a good thing. But for them, it was driving up their health care costs and most importantly, killing their employees.

OWENS: But, the managed care companies have a responsibility to manage that, because they can review the prescriptions, and they know who is abusing, who were part of those bills in those days. So, it’s a multi-level approach, it’s not just Narcan.
THE FUTURE OF HEALTH CARE

“by extending Medicaid and the Affordable Care Act, it allows individuals to get health care to move their personal health status from fair to good.”

- Dr. O’doll Owens, Interact for Health

ECKHARDT: I’m seeing those companies take action. The managed care companies are taking a look at utilization, and they find outliers, and as they are trying to collaborate with quality providers, they are starting to find outliers, and exclude them from the network. So, they are taking action.

Q: How can the health care industry meet each segment of the population where they need help?

BALL: It is clear that personal health care must become more consumer driven in the future. While we as physicians are all taught to “listen to the patient”, listening to “The Voice of the Customer” holds important lessons in any industry including healthcare. I would only add, however, we must also begin to understand the cultural differences in our society which are pervasive across all ages due to race, ethnicity, gender and country of origin. We have to guard against becoming too focused on one group or another, as that just is not how our laminated culture exists or presents. Diversity is an essential part of our ability to provide the best healthcare to a diverse population by creating the right workforce. Just as we in academic medicine have lead efforts in precision healthcare to focus on genetic and environmental diversity in disease, so we all must practice precision healthcare delivery based on the diversity we encounter in the consumer market.

Q: Let’s close on something that you wanted to cover, or something that you feel needs to be addressed. So, let’s talk about technology.

OWENS: I’m going to talk about simple technology. As president of Interact for Health, I have a special project that could help lower health care costs and it’s as simple as washing your hands. If we would wash our hands correctly, and more frequently, we can reduce the healthcare costs, especially during the flu season. Probably, at least 50 percent of childhood diarrhea cases are due to kids, and people not washing their hands. And often people do not wash their hands correctly. We talk about technology, but if we go back to correctly washing our hands, we can certainly decrease health care costs.

Q: When you think about things we did in this country with things like seat belts. It’s not a sexy topic, but who doesn’t wear the seatbelt anymore? When I was growing up, I don’t think my parents ever buckled us in. So, I think what you’re saying is possible if somehow you can get this into message out, and into our conversations.

CLEMENT: The question of technology is a good one. It really is about re-shaping how we think about and deliver health care. For example, the roots of tele-health weren’t planted by the availability of a smartphone or computer. What we see in healthcare really is a result of the adoption of the Medicare-Medicaid programs in the 1960’s. Lots of entrepreneurs moved into healthcare because they saw a funding source. Next, there was an explosion of technology as a result of the Affordable Care Act, which began to reflect the thinking from transactional to more health-based delivery. This is going to become a ubiquitous part of the healthcare system ten years from now. You will see your doctor remotely and personal technology will monitor your health care in biometrics, remotely. I think smartphone technology will continue to be a critical factor in reshaping how consumers access health care, and how patients with chronic diseases are managed. The explosion of advanced analytics and artificial intelligence, over time, is going reshape how healthcare is delivered. A lot of the things done by health care professionals are going to be replaced by IBM’s Watson and by artificial intelligence, such as reading pathology slides. A demonstration project between Cleveland Clinic and IBM has demonstrated that artificial intelligence for some functions within healthcare is as effective, if not more effective, in taking unstructured data and making sense out of it in a diagnostic way. Finally, predictive analytics is reshaping our ability to truly begin to manage the health of large populations. In the case of TriHealth, we care for about 400,000 members of our community. That doesn’t mean we do the same thing for all 400,000. It means that we can understand and segment that large group to predict which patients are going to require active management versus those that are healthy. Or, for whom a routine primary care visit every year will be sufficient.

OWENS: With all that technology, it won’t replace the art of medicine. That’s the science of medicine, but the art of medicine, and that’s what we have to be careful about.

CRAWFORD: And, just a piggyback on the data analytics piece, it is an important tool for employers and their consultants to predict and adjust for otherwise unforeseeable trends. It allows us to do more than review past claims data from the previous twelve months, but allows us to predict what is coming down the pike, so that we can see what’s trending. Whether that’s identifying trends in specialty prescriptions or opioid abuse, so employers can make proactive changes to their health benefits, not to penalize, but to provide the best avenues for their employees which attributes to the long term viability of the health plan.
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