



THE WHARTON HEALTHCARE QUARTERLY

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IN EVERY ISSUE

Editor's Letter	3
The President's Desk.....	4
Open Wide.....	6
The Philosopher's Corner	8
Alumni News	9
Affidavit: Healthcare and the Law	14

FEATURED ARTICLES

Stronger than the Sum of Our Parts: Creating a Level Playing Field – Part 3.....	16
<u>Wharton Around the Globe</u> : Global Health Volunteers in Nairobi Primary Care Clinics.....	18
Turbocharging the Triple Aim - Secret Ingredient...Love?	20
2015 WHCMAA Alumni Conference Focuses on Leadership	23

IN UPCOMING ISSUES

Stronger than the Sum of our Parts - Part 4
Partnership Holds Promise of Improved Health in San Antonio - Part 2

QUICK LINKS

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EDITOR'S LETTER

Happy New Year!

Welcome to another year of the *Wharton Healthcare Quarterly*. We look forward to your participation in 2 new planned series:

1. **“News from the Trenches,”** which will focus on entrepreneurs and start-ups across the spectrum of the industry. We would love to hear your story, so if you are interested in contributing an article please contact us at whc_e-magazine@whartonhealthcare.org.
2. **“Wharton Newsmakers,”** which will feature those who have been in the news for their leadership and accomplishments in healthcare. Please reach out to share the ways in which you have been recognized and continue to put Wharton on the map due to your efforts to innovate and address the needs of an ever-changing healthcare landscape. Contact us at whc_e-magazine@whartonhealthcare.org.

And, don't forget to register for [“The Innovation Game: The Race Between Entrants + Incumbents,”](#) the 22nd annual Wharton Healthcare Business Conference, which will be held in Philadelphia February 18 - 19, 2016. Hope to see you there!

Z. Colette Edwards, WG'84, MD'85
Managing Editor



Z. Colette Edwards, WG'84, MD'85
Managing Editor
To learn more about Colette,
[click here.](#)

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THE PRESIDENT'S DESK

Dear Friends,

You have heard the old saying, "When you are a hammer, everything looks like a nail." When the Wharton Healthcare Management Alumni Association elected a strategy consultant to be president, a strategic plan was definitely on the table. The WHCMAA Board is completing that strategic plan, and we are excited about the future.

Our Mission remains steady: To support the Wharton Healthcare Management Program and its students; contribute to the lifelong learning of its membership; and contribute to the healthcare sector through service, leadership, and education.

Our Vision is: The Wharton Healthcare Management Alumni Association is the leading network for the business of health; providing meaningful engagement, lifelong learning, and career guidance; and connecting leaders with students, faculty, and fellow Wharton alumni in the business of health.

To achieve this vision we identified four goals:

I. Engagement: Wharton alumni in the healthcare industry will engage in meaningful and relevant ways with students, faculty, and fellow alumni, focusing on their areas of particular interest. WHCMAA will support engagement through sector-specific virtual communities and opportunities to meet in person.

II. Communication: WHCMAA will communicate effectively with alumni, students, faculty and the broader University of Pennsylvania network in a manner that builds community, provides value, and drives meaningful engagement.

III: Career Development: We will enhance the lifelong value of WHCMAA engagement by connecting WHCMAA members at every phase of their career; providing network navigation, coaching/mentoring, community building, and lifelong learning.

IV: Program Support: Our growing network of engaged alumni will provide additional support for scholarships, student initiatives, and other program needs.

Key initiatives to support these efforts include:

Interest Groups: We are setting up Interest Groups to provide the most relevant information and opportunity to each alum. In the coming months, we will be asking you to choose an Interest Group so we can connect you with the right colleagues. The four Interest Groups are:

- Provider/Payer
- Life Sciences
- Digital Health/IT
- Finance/Investing

Communication Platform: We will be selecting social media and other communication tools that will support effective interaction within the Interest Groups, for Career Development, and more broadly.



John Harris, WG'88
To learn more about John,
[click here.](#)

THE PRESIDENT'S DESK

continued

Connecting/Reconnecting: We will be reaching out to all eligible WHCMAA members, including alumni of Wharton and WEMBA as well as the Healthcare Management program alumni who have lost contact with this amazing network.

Career Development: We are redesigning our career development support to enhance and build upon the incredible personal support we have each received over the years from June Kinney.

There are so many opportunities for us to strengthen our community. If you want to be part of any of this, please contact me so you can get plugged in.

Warm regards,
John Harris
President
Wharton Health Care Management Alumni Association

To contact John:
JHarris@Verilon.com
877.676.3600

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OPEN WIDE: UNTIL THE NEXT VISIT

With this entry, “Open Wide” will come to an end as a regular column for the *Wharton Healthcare Quarterly*, to reappear with news or significant developments in oral health as warranted. I believe I have pretty much exhausted what I believe needs to be said about the dental care industry in this country and its relationship to the overall direction that health reform is taking. There is little more I have to add at this point in time.

I have been critical - very critical - of this industry for several reasons, among them its cottage industry nature, its outdated financing, its staid practice model, and its unsophisticated understanding of health policy. But at the core is my sense that the economist’s dilemma of “infinite wants vs. finite resources” takes on a moral dimension when it comes to fundamental human needs in a civilized society, which include education, housing, sustenance, and transportation, as well as healthcare. And dentistry, within the healthcare realm, is inefficient, inequitable, inaccessible, and far less effective than it should be in addressing fundamentally preventable diseases. In other words, far less than “optimal use of scarce resources” with its toll on human health and well-being. More concisely, for me, this just isn’t right. We can, should, do better, much better.

This column has allowed me to articulate for myself, and I hope for others, where dentistry stands in relation to the rest of the healthcare enterprise in this country. Without rehashing all the myriad reasons why, I believe it’s accurate to say that the way things stand now, “dentistry is too small and too distant a planet in the healthcare universe to merit much attention.” (Too small? Dentistry represents about 5% of annual national health expenditures, yet that also amounts to about \$120 billion. That still sounds like a sizeable industry. Too far? The innovations and reorganization and innovation taking place as a result of health reform just aren’t being seen in dentistry, which predominantly adheres to the private, solo practice, fee-for-service model.)

So there is a policy question here - if the emphasis is on integrated, accountable, comprehensive care as stated in the Affordable Care Act (ACA), how can dentistry be brought closer to the center of the healthcare universe? Fittingly, with the New Year, the time for resolutions, I propose my own “14 Points” for policymakers, both within dentistry and without (though there should really be no distinction):

1. Become familiar with the types and workings of non-fee-for-service reimbursement, such as risk-sharing, shared savings, bundled payments, and global budgeting and how they would apply to dental care.
2. Become fluent in the concepts behind “value over volume” and “better care, smarter spending, healthier outcomes” and the transparency and accountability that is intrinsic to them, and see how they apply to dental care.
3. Seek out examples of integration of care, and of new partnerships between organizations (e.g., retail clinics aligning with health systems) for the delivery of care, the implications for affordable care and wider access, and see how that applies to dental care.
4. Become familiar with the principles behind accountable care organizations (ACOs) (e.g., their financing, their emphasis on organizing around prevention -- the “80-20 rule”-- their metrics, etc.), the different models of care (e.g., Pioneer model), and see how the same would apply to dental care.
5. Examine the issues -- financial, managerial, organizational, cultural -- involved in formally integrating dental care into ACOs.



Column Editor: Harris Contos,
DMD, WG'80, Asclepius Consulting
To learn more about Harris,
[click here.](#)

OPEN WIDE: UNTIL THE NEXT VISIT

continued

6. Make the effort to have dental care included in the definition of “primary care” as used in the ACA so that conceptually and programmatically dental care is properly recognized in this fundamental tier of healthcare.
7. Become familiar with term “Big Data,” what it means, what its components are, what the data sources are, and how they are used in epidemiology, risk assessment, management/decision-making, health service research, predictive modeling, etc.
8. Related to #7, become familiar with the concepts and principles behind “population health management” and how that would apply to dental care.
9. Consider the potentials of teledentistry in all settings, not just geographically remote and underserved areas.
10. In line with #9, consider the delivery possibilities when the potential of teledentistry is combined with that of an expanded dental therapist workforce (e.g., the Alaska therapist experience).
11. Advance the state of the art of dental care quality and accountability measures.
12. Become familiar with the field of “behavioral economics” and its applications to healthcare, prevention, and improvement in health status, and how that can apply to dental care.
13. Gain an understanding of how current dental “insurance” violates the principles of insurability, how the private dental insurance market works, who the major players are, and how they are responding to the changes coming about more broadly in health reform.
14. Give thought to restructuring pre-doctoral dental education to reflect greater utilization of dental therapists and interaction with MDs, PAs, NPs, and pharmacists (hence emphasis on teamwork in large, integrated organizations of care), widespread use of teledentistry, quality metrics and accountability, population health management, and the economics of healthcare.

In closing, I want to say thank you for this opportunity to use my Wharton education and experience since then to shed some light on a corner of American healthcare that so far has escaped needed scrutiny as health reform gathers momentum. I have learned quite a lot; I hope the readers have too.

And, for my next *WHQ* gig.....I’ll be morphing into a new role as “ongoing contributor,” with an initial focus at least on the aphorism, “Everyone’s for health reform, provided he doesn’t have to change.” With the competitive, consumer-oriented thrust to achieve “better care, smarter spending, healthier outcomes,” implicitly there will be winners and losers in the new health reform landscape -- in other words, healthcare will no longer be open-ended, or at least a lot less open. Who will these winners and losers be among patients, providers, payers, and policymakers?

Contact Harris at: hcontos@alumni.upenn.edu

THE PHILOSOPHER'S CORNER

Life Lessons:

There are three forces at work that affect the decisions of how healthcare is delivered and how much of societal health, more broadly, is determined: the interests of caregivers (professionalism), the interests of patients (consumerism), and the interests of markets (economics). When all three are in alignment, which is rare, it's easy to understand what will happen. When in conflict, one or two forces overcome the resistance of those opposing forces. That's how healthcare and health change. Even after decades of studying this dance, the interaction of these three forces continues to amaze me every day.

If I knew then what I know now, I *would have*:

focused even more on the people whom I have met and the relationships that I have developed along the way.

If I knew then what I know now, I *would have*:

worked toward becoming a “smart giver” earlier in my career.

If I knew then what I know now, I *would have*:

climbed more mountains.

If I knew then what I know now, I *would not have*:

internalized the stresses so much during the years we dealt with a serious medical condition in one of our children. Family first.

Favorite Quotes:

1. “Be the change you want to see in the world.” ~ Mahatma Gandhi
2. “Deserve Victory!” a Winston Churchill poster that hangs in my office
3. “The reward for work well done is the opportunity to do more.” ~ Dr. Jonas Salk
4. “Tempis fugit” ~ Eulalie MacKecknie Shinn

Recommended Reading:

- *The Leader's Checklist* by Wharton Professor Michael Useem
- *Give and Take* by Wharton Professor Adam Grant
- Read anything written by Atul Gwande, MD



This month's philosopher:
Robert C. McDonald MD, WG'92
To learn more about Robert,
[click here.](#)

Column Editor:
Z. Colette Edwards, WG'84, MD'85
To learn more about Colette,
[click here.](#)

ALUMNI NEWS

Emily Reid, WG'15

Join fellow HCM alumni in raising funds for the the Castleman Disease Collaborative Network (CDCN)! Dedicated members of the class of 2015 and 2016 have formed fundraising committees in various cities (see below). Each committee is planning an event for 2016, and we are looking for more volunteers who can help spread the word. More information to come as events are finalized.

More information about David Fajgenbaum and CDCN:

David Fajgenbaum, MD, MBA, MSc is a Research Assistant Professor of Medicine in the Division of Hematology/Oncology at the University of Pennsylvania and the co-founder and Executive Director of the Castleman Disease Collaborative Network (CDCN), a global network accelerating research and treatment discovery for Castleman disease (CD). Dr. Fajgenbaum's research published in *Blood* caused a paradigm shift in how CD is researched and treated. Under Fajgenbaum's leadership, the CDCN has facilitated global collaboration among its network of 300+ physicians and researchers; invested in five high-impact research projects; forged partnerships across industry, academia, and advocacy; and engaged the community of over 3,000 patients and loved ones throughout every step of the entire process.

For his work, Dr. Fajgenbaum was recently named a member of *Forbes Magazine's* "30 Under 30" list for Healthcare and the 2015 "RARE Champion of Hope - Science" award winner. He received an MBA from The Wharton School, an MD from the Perelman School of Medicine at the University of Pennsylvania, a Masters in Public Health from the University of Oxford, and a BS from Georgetown University.

Please feel free to reach out to Emily Reid or Alex Burtoft if you'd like to be connected to an existing committee or would like to start one for a city not listed below.

San Francisco	Philadelphia	LA	Chicago	Boston	New York	WG'16
Alex Burtoft	Jen Dikan	Daisy Carrillo	Ethan Lipkind	Patricia Liu	Amit Mahadevia	Philippa Rock
Emily Reid	Lindsay Kuo		Matt Schulz	David Wagner	Danika Fry	Aaron Fisher
Daniel van den Bergh	Duncan MacKay			Andrew Hedin	Dave Light	
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Kelly Cheng				Kristen Manderscheid	Jon Lanznar	
Visali Ramanathan				Jon Hahn	Jon Brallier	
Nick Crowne				Neil Agarwal	Mike Kramarz	
Jennie Funk				Josh Atwood		
Bedir Shather						

Contact Emily and Alex:

Emily Reid at emilytantonreid@gmail.com

Alex Burtoft at aburtoft@gmail.com

ALUMNI NEWS

continued

Austin Dixon, MD'13, WG'13

I live in Durham, North Carolina, and I am in my second year of diagnostic radiology residency at Duke University. I completed an internship in general surgery at Massachusetts General Hospital during the 2013 - 2014 academic year. I am actively involved in the Radiology Leadership Institute offered by the American College of Radiology and the Leaders in Medicine program at Duke. I look forward to connecting with other alumni.

Contact Austin at:
ausdixon@gmail.com

Priya Kamani, MD, WG'96

I'm back in start-up mode as founder and CEO of LivingMatrix, Inc. a year-old company. We've developed cloud software for functional medicine practitioners. Our product successfully launched in July, and practitioners are signing up in unprecedented numbers - great traction. Next step - fundraising!

Contact Priya at:
Priya.kamani@gmail.com
408.242.9437

[Learn more.](#)

Hal Broderson, MD, WG'87

A company I founded, SansRosa Pharmaceuticals, gained FDA approval for its drug to treat the redness of rosacea. The product was developed "bench-to-bedside" and is being sold by Galderma, one of the largest dermatology companies in the world.

Contact Hal at:
Hal@rockhillventures.com

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ALUMNI NEWS

continued

Bob Domine, WG'87

Bob finds himself bobbing and weaving back into healthcare, this time via marketing research. Bob's firm, Digital Research, Inc., (DRI) specializes in developing and using large-scale online panels for marketing research (pharma), as well as conducting programs of ongoing customer satisfaction research (pharma, hospitals). With DRI's acquisition of a new business, the firm expects to see its qualitative research client base expand significantly, especially in the New England market. Bob also had dinner with June recently... a highly recommended catch-up session for all of you who haven't been "home" in awhile!

Contact Bob at:

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[Learn more.](#)

Todd Herrmann, WG'85

I launched my own consulting firm, Cadensus, this fall specializing in strategy development, market analysis, and organizational assessment for healthcare organizations along with non-profits and small business. Check out www.cadensus.com. On the homefront, I live on Cape Cod with my husband Steve and youngest son Max, who is now 14. Our son Greg, 19, is a sophomore at Pace University in New York City studying computer science.

Contact Todd at:

todd.herrmann.mba@gmail.com

Jeff Voigt, WG'85

Publication: Voigt J, Mosier M, and Darouiche R. Antibiotics and antiseptics for preventing infection in people receiving primary total hip and knee prostheses: A systematic review and meta-analysis of randomized controlled trials. *Antimicrob Agents Chemother* 2015;59(11): 6696-6707.

ALUMNI NEWS

continued

Scott Honiberg, WG'80

Scott Honiberg (WG '80), President and Founder of Potomac Health Associates, Inc. (PHA), reports that his company negotiated a successful settlement on behalf of his client, Universal Health Services (UHS), in litigation against the Department of Veterans Affairs (VA).

PHA was first retained in 2008 by South Texas Health System (STHS), a division of UHS, to advise it in conjunction with preparation and negotiation of a competitive proposal to provide hospital and emergency room services to veterans in South Texas. The proposal resulted in the [award of a five-year contract](#) for UHS valued at approximately \$100 million. Shortly after the award, STHS began to experience underpayments for services provided under the contract. PHA initially filed claims (e.g., a claim under the contract; not an individual hospital or medical claim) with the VA under the Contract Disputes Act for underpayments on services rendered in 2009 and 2010. After the claims were denied, STHS retained PHA to pursue an appeal before the [Civilian Board of Contract Appeals](#) (CBCA).

The case was handled by Scott Honiberg as the expert consultant/subject matter expert, and Jeff Weinstein, Of Counsel to PHA and Managing Director of The Weinstein Law Group. STHS alleged that the VA did not reimburse it according to the terms of the contract, which called for the VA to pay STHS in accordance with official Medicare reimbursement policy, subject to certain adjustments. One category of underpayments were those associated with admissions specifically for inpatient rehabilitation. A key issue before the Board involved whether STHS was entitled to be paid Case Management Groups (CMGs) for admissions to its Medicare-certified Inpatient Rehabilitation Facility (IRF), rather than Diagnostic Related Groups (DRGs). A second general category of underpayments were those attributable to errors from the use of VA's internal claims processing system, the Fee Based Claims System (FBCS). While initially agreeing to Alternative Dispute Resolution, the VA ultimately rejected the judge's belief that STHS would prevail if the case proceeded to formal litigation.

The case proceeded to formal litigation in February of 2013. In October of 2014, the Board ruled in favor of STHS's interpretation of the contract ([CBCA 2774, 2775](#)), but dismissed a portion of the appeal, and also ruled that additional documentation was needed in order to calculate damages. PHA successfully re-introduced the portion of the appeal that was dismissed and submitted hundreds of pages of damages calculations. The VA initially rejected STHS's calculations, claiming that it could not locate original hospital and medical claims submitted years earlier. After STHS filed a Motion for Summary Relief (MSR) requesting that the judge decide the amount of damages, the VA made an informal settlement offer, which STHS rejected as unacceptable. Just days before the VA was to respond formally to STHS's MSR, the VA made a second unexpected settlement offer, which STHS accepted in September of 2015. PHA continues to represent STHS on several other matters related to this contract, including a second appeal before the CBCA.

Founded by Scott Honiberg in 1992, Potomac Health Associates, Inc. specializes in federal healthcare contracting, business development, and market research. PHA provides its clients with services that encompass the full spectrum of federal procurement, including policy development, opportunity identification, proposal preparation, development and negotiation, handling protests against awards with the agency or with the Government Accountability Office (GAO), and dispute resolution. Since the firm's inception, its clients have been awarded in excess of \$4.0 billion in competitive and non-competitive awards from various federal agencies, and in excess of \$500 million from the VA alone.

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[Learn more.](#)

ALUMNI NEWS

continued

Susan C. Sargent, WG'75

Having worked in the field of integrating medicine and behavioral health services with an internist/psychiatrist, actuary, psychiatric nurse, and other medical/behavioral professionals for 18+ years, we are discovering that we are now very popular when it comes to recommending strategies for health systems/ACOs that can improve the quality of care, improve access, reduce costs, and generate appreciable savings, especially among populations with chronic medical and co-morbid behavioral conditions.

Representing between 27% and 35% of all medical admissions, these co-morbid populations incur longer lengths of stay, 41% more 30-day readmissions, higher costs, lower net revenues, and just generally more challenges than their non-comorbid counterparts. As such, it has been very exciting for our practice to be working with provider settings nationally, and seeing how critical it is to gauge these strategies to the local cultures and systems of care, especially when it comes to assessing the financial impact of the strategies once implemented.

When I was at Wharton, Dr. Robert Leopold, a psychiatrist on the faculty of the Wharton Healthcare Management Program, served as a mentor for me. I started my career evaluating behavioral benefits within HMO models and incorporating behavioral health strategies into the relatively primitive State Health Plans. It is therefore very gratifying to see his insights finally starting to take hold within the various operational provisions of the Affordable Care Act and provide very real opportunities to reconnect the head with the rest of the body...what a concept!

Contact Susan at:
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[Learn more.](#)

AFFIDAVIT: HEALTHCARE AND THE LAW - THE EXPANDING FOOTPRINT OF THE HOSPITAL INTO THE COMMUNITY/ PROVIDER-BASED ISSUES

You drive by your local shopping mall and you spot an urgent care clinic with the name of your hospital, the fictitious GoodHealth Hospital, on its sign. Or, you get a letter from your physician stating that she is now affiliated with GoodHealth, on GoodHealth stationery. A hospital is no longer a single campus designed around the delivery of inpatient services. GoodHealth Hospital may have expanded beyond its original campus to include a second campus offering inpatient services, or an off-site outpatient clinic providing professional services.



The expansion of a hospital, whether through the purchase of an existing facility or a physician practice or the creation of a new site, generates new branding and revenue opportunities for a hospital like GoodHealth. Expansion projects raise unique legal issues as well, especially for those that are “provider-based.”

In building or purchasing another facility, a principal consideration is whether the hospital wants or can bill for the services at the site as a unit or a department of the hospital, known as provider-based billing. Most hospitals will choose the provider-based arrangement if it is feasible because reimbursement is higher. The thinking is that the hospital offers greater access to better clinical care and supervision of the care through its medical staff; better administrative services like integrated medical records; and safer facilities. The higher level of care rendered in the hospital justifies the higher costs. But the co-pays may be higher for the patient, and the higher quality of care is not always evident. The private physician’s office that shuts its doors on Friday and opens again on Monday as a hospital-based clinic does not necessarily offer better services. This is why provider-based facilities are under increased scrutiny.

Although the Medicare program established the provider-based model through regulations some time ago, the program no longer favors it. Medicare’s position is that most sites are simply add-ons to the hospital and not truly integrated with it. Every year, the Department of Health and Human Services, Office of the Inspector General publishes its Work Plan where it lists its priority enforcement areas for the coming fiscal year. The OIG’s *FY 2015 Work Plan* lists compliance with the provider-based rules as one of the priority areas. In the last year, two hospitals, W.A. Foote Memorial Hospital in Jackson, Michigan and Our Lady of Lourdes Hospital in Binghamton, New York, paid \$2.6 million and \$3.3 million, respectively, for violating the provider-based rules.

So given this changing landscape, how should a hospital evaluate a potential provider-based expansion project? Here are some questions to ask:

- Are increased fees available for the site under the Medicare provider-based rules? The rules don’t allow provider-based designation for certain kinds of facilities and sites, such as ambulatory surgical centers and PT clinics, where there is no difference in fees. The hospital could still own and operate the facility and bill Medicare for services rendered there, but it would not be a provider-based site.
- Can the hospital satisfy the multiple Medicare provider-based requirements in order to demonstrate the hospital and the site are integrated? The site must be included on the hospital’s license. Processing licensure issues can be expensive and time-consuming, sometimes even requiring building renovations to make sure the site meets hospital-level codes.

Contributor:
Lisa W. Clark, JD’89
To learn more about
Lisa, [click here](#).

AFFIDAVIT: HEALTHCARE AND THE LAW - THE EXPANDING FOOTPRINT OF THE HOSPITAL INTO THE COMMUNITY/ PROVIDER-BASED ISSUES *continued*

Other requirements include that the site must be no more than 35 miles from the main hospital; the site must be a cost center for the hospital and included on the cost report; and the site must be administratively and clinically integrated with and supervised by the hospital. An off-campus site may not be a joint venture with another organization, and the non-professional staff must be employed by the hospital. And, patients must be able to clearly identify that the site is part of the hospital.

- If the hospital is co-located in a building with another healthcare entity, do the entities intend to share staff and services? For instance, a hospital may lease space in an unrelated hospital in order to provide specialized services, such as orthopaedic services. Can the provider-based site use the laboratory services of the co-located entity, as well as the non-clinical services such as laundry? The provider-based rules may prevent the sharing of certain clinical services.
- Will Medicaid and private payors permit the hospital to bill for services at the site as provider-based? State law usually governs whether Medicaid will pay for services at a provider-based site. With respect to private payors, the contract between the payor and the hospital governs provider-based reimbursement. It is increasingly common for private payors to prohibit or challenge the inclusion of a provider-based site under a contract unless the contractual language is clear. In one instance, a hospital and a national private payor are engaged in a \$5 million dispute over whether the payor will reimburse the hospital including the technical component services provided at a provider-based site.
- Are there any healthcare fraud and abuse issues to consider? Under the Stark rules, a physician-owned hospital is prohibited from expanding the facility, including establishing a provider-based site, unless certain criteria apply.
- Are there antitrust issues? A merger between two hospitals in which one hospital emerges as the main provider and the other as a satellite could raise monopoly concerns.
- How will the addition of the site impact any accountable care organization (ACO) or value-based contracting projects? ACOs are integrated healthcare organizations (typically hospitals and physicians, and sometimes payors or third-party brokers) that manage upside and sometimes downside risk based on whether certain performance and cost-sharing criteria are satisfied. The addition of a provider-based site may help reinforce the integration of the hospital and the physicians around shared goals.

Adding a provider-based site to GoodHealth Hospital enhances the hospital's reputation and presence in the community and provides it with additional revenue. But with provider-based entities in Medicare's crosshairs, and patients complaining about higher co-pays, a hospital should carefully evaluate any provider-based project.

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STRONGER THAN THE SUM OF OUR PARTS: CREATING A LEVEL PLAYING FIELD – PART 3

*In 2014, CFAR produced a report with the Robert Wood Johnson Foundation (RWJF) called *Lessons from the Field: Promising Interprofessional Collaboration Practices*, which identifies ways to increase collaboration among healthcare professionals, in service of improved healthcare delivery. This article is the third in a series of four about actionable practices for effective interprofessional collaboration. Here, we explore a key practice to accelerate this collaboration.*



In looking across the seven healthcare organizations participating in the project, one of the key practices we identified is “creating a level playing field” that lets each team member work at the top of their license, know their role, and understand the value they contribute. We will explore the significance of this commitment here, how it plays out, and ideas for implementation.

Why is this practice important?

We found that “students and caregivers...[do] not have a very detailed understanding of *other* caregivers’ fields of practices or of what they [do] at the facility.”¹ At each site we visited people at every level told us “you need to create a level playing field.” But what did they mean? This is a way to look beyond the silos and history of professional training and identity to help each team member feel they can make a meaningful contribution to the work. It is critical each team member both understands and values the contribution made by the other team members. We were surprised to learn what a challenge this can be, and what a difference it can make. So in the end, “leveling the playing field” mitigates historical hierarchies and enables team members to understand and experience both their individual contributions and their collective value.

What does this practice look like in action?

Numerous organizations “level the playing field” by engaging interprofessional teams in quality improvement, safety, and process improvement work in ways that break down barriers to interprofessional collaboration. Quality improvement (QI) projects do not necessarily “solicit program-specific knowledge or skills, nor...require clinical experience,” so they can be an excellent way to level the playing field and build interprofessional teams.² This work requires team members to learn new language, skills, and expertise together, with the benefit of also learning what each team member actually does for the team.

Additionally, each team member participating in the project brings a different background, perspective, and skill set to the team. It provides an opportunity for team members to learn from one another and to leverage the collective skills of the group. The Hospital for Special Surgery in New York City presents an achievement award for the best interprofessional collaboration for process improvement. The use of process improvement to create a level playing field is epitomized by Virginia Mason, which is internationally renowned for its Virginia Mason Production System (VMPS). This model, based on a LEAN philosophy, represents a constant source of interprofessional interaction and collaboration around improvement at every level of the organization. Through that work, professions not only work to improve quality and processes, but also come to understand and appreciate each other’s roles.

Furthermore, “power differences based in gender stereotypes and disparate social status” and “a strong cultural affinity for autonomy” impede collaborative practices and can prevent interprofessional collaboration from occurring.³ In order to break down these issues, some institutions, such as Cincinnati Children’s and their Patient Care Governance Council (see case example), have put structures and models in place to create a level playing field that balances

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STRONGER THAN THE SUM OF OUR PARTS: CREATING A LEVEL PLAYING FIELD – PART 3 *continued*

the strength of each individual discipline with the potential each discipline can achieve through interprofessional collaboration.

Creating a level playing field reduces the challenges of the traditional hierarchy represented in the care team. Below are some of the specific practices we've referenced:

1. Ensure that team members understand both their own role and the role of everyone else on the team.
2. Model speaking up with respect.
3. Train different disciplines together.
4. Get to know people as people.
5. Teach and empower parents and caregivers to be part of the team.

Case: Creating a Level Playing Field

*Cincinnati Children's Hospital Medical Center
Patient Care Governance Council and the Interprofessional Model*

The Patient Care Governance Council (PCGC) at Cincinnati Children's Hospital Medical Center enables every profession to come together in a shared governance structure. The goals of the PCGC are to achieve the best patient care possible, while remaining focused on the Triple Aim, to create a voice for each professional discipline, and to better coordinate quality improvement efforts across professions.

The PCGC is working to create a culture of interprofessional collaboration at Cincinnati Children's. Each profession is able to see themselves in this model, maintaining their identity while still finding ways to be part of a team and to advance the tenets of the Interprofessional Practice Model. One leader of the council shared how the PCGC "enlightens you outside your scope," helping each member of the council to understand the roles and responsibilities of those outside their own profession, while strengthening their own professional voice.

The PCGC structure has enabled people of different professions to establish relationships and build trust. Another leader of the council said that "talking collaboratively is a step in the right direction, and this is an evolutionary process. The fact that this is embraced by all disciplines is more important than perfection."

In the following article in this series, we will discuss additional practices through examples.

For more information on this topic or related materials, contact CFAR at info@cfar.com or 215.320.3200 or visit our website at <http://www.cfar.com>.

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WHARTON AROUND THE GLOBE: GLOBAL HEALTH VOLUNTEERS IN NAIROBI PRIMARY CARE CLINICS

By the end of the academic year, Health Care Club members received an e-mail from Wharton Global Health Volunteers with a unique opportunity in Kenya to help primary care clinics in the slums of Nairobi. That e-mail sounded like Brazilian music to our ears. Although the three of us were born in Latin America, we were lucky to have had great opportunities that helped shape who we are both personally and professionally, and we were discussing how to give to others in need some of these opportunities. We decided to learn more about the project and had the opportunity to talk over the phone with Melissa Menkel, Co-founder and CEO of Access Afya, the affordable primary care clinics located in the slums of Nairobi. She had been working on a membership program, similar to a primary care health plan, to improve health care access to customers and members of the community.



Access Afya is a social enterprise offering affordable primary care in two different communities within the Mukuru Slum. The types of treatment the community can find are very broad, from a simple diarrhea to a diabetic treatment. The prices are extremely low – we would never have thought it possible. One consultation, including a re-visit, cost one dollar, and one malaria test around 50 cents. Beyond the clinics, Access Afya also helps improve health in local schools through a project called Healthy Schools, which offers primary school children weekly health screenings, worm pills, check-ups and health education for an extremely low price. The health conditions in these regions are extremely poor. Adults and children suffer from diseases that are easily treatable, and Access Afya is working to address exactly this problem.



Even though by developed countries standards those prices are extremely low, the cost of a treatment can be a major burden, as typical family income is around 50 dollars per month. Therefore, the Access Afya team decided to launch a membership plan, to reduce the cost of treatment and increase the healthcare access for the families in the slums. They asked us for help in refining their launch plan.

Our project consisted of helping Access Afya team address key issues in their draft product, e.g. fraud prevention, pricing, cost control, and process mapping.

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WHARTON AROUND THE GLOBE: GLOBAL HEALTH VOLUNTEERS IN NAIROBI PRIMARY CARE CLINICS *continued*

Melissa customized the project based on our previous experience: Joao had worked with drug plan pricing; Manuel has extensive experience in operations; and Koreeda had a strategy consulting background. We divided our 2 weeks on this project into three parts:

1. understanding the clinics and all projects of Access Afya
 - field work, interviews, visiting clinics
2. working on the deliverables
 - process mapping, pricing, systems research
3. final presentation
 - presenting to the entire team, minor adjustments

We spent an entire afternoon at the clinic to understand how it actually works. We talked with the clinicians and the receptionists to understand the day-to-day activities and to map the process to minimize any impact the membership plan might have. It became crystal clear that it would be almost impossible to understand the business without physically being there to experience events, not only at the clinic but also in the slum. We witnessed energy outages and floods. We discovered how customers and employees viewed and understood membership plans. Just by being there and seeing how the team operated health clinics in such a challenging environment, we learned a lot about what it is possible to achieve through business.



Left to right: Manuel, Joao, and Fernando

The previous experience of the team members combined with the close relationship we have with each other enabled us to produce the deliverables in such a short period of time. We proposed modifications to their original membership product design after speaking with potential customers in the slums and provided pricing recommendations and proposed mechanisms to reduce fraud and retain membership.

It was an incredible experience to learn with each other how to be lean and to be successful working with low income consumers in an underdeveloped market. Unfortunately, our final presentation was delayed due to scheduling conflicts, but we look forward to presenting our proposal to Melissa this fall and will be excited to hear updates about the new membership product launch.

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TURBOCHARGING THE TRIPLE AIM - SECRET INGREDIENT...LOVE?

The Triple Aim - *Improved Patient Experience/
Improved Health Outcomes/Reduced
Healthcare Costs*

The Offer

What would you do if someone offered you \$30 million dollars and a building the size of a small hospital to create a new model of healthcare? And the only string attached was to do it using integrative medicine.* That is exactly what happened to me and my wife, both practicing physicians, on a surreal day in February 2010. More nuanced and life-altering a decision than we ever imagined, we ultimately accepted.



True to our donor's single stipulation, we structured an integrative health practice with three primary care physicians, a nurse practitioner, an acupuncturist, a chiropractor, a psychologist, a naturopath, a massage therapist/Reiki master, a wellness coach, and a yoga therapist. We embedded a Wellness Center into the space with classes and workshops geared toward healthy eating, movement, mindfulness meditation, stress reduction, and lifestyle change. We prioritized accessibility by rejecting concierge and membership models and by accepting all major insurance plans, Medicare, and some Medicaid. We established a charity care policy that covered primary care as well as those healing modalities not covered by insurance.

On December 31st, 2012 the entire lump sum of money and the building were transferred to our newly formed public, non-profit 501 (c)(3) named [Casey Health Institute](#) (CHI). And we were clear about one thing from the start, our model would fail, a certain casualty of fee-for-service reimbursement.

Were We Crazy?

In researching our model, we traveled the country for six months visiting many integrative practices - private, public, hospital-affiliated, and university centers. During our journey an unexpected and powerful message emerged. The integrative medicine world was surprisingly disconnected from the healthcare policy world. Collaborative, team-focused, value-based population healthcare, which seemed like a natural partner for multimodality integrative health, was strikingly absent from most integrative medicine conversations.

Survival

Early on we decided we would embrace rather than resist what was happening on the health policy forefront by leveraging those programs that could magnify the strengths of integrative medicine. We combined the low tech/high touch, lifestyle-focused integrative modalities with the information-intensive, high tech, population health focused approaches. We charged forward with a conviction that high performing, lean, collaborative integrative teams could bend both the cost and health outcomes curve. Value-based care, the Patient-Centered Medical Home (PCMH), Accountable Care Organizations (ACOs), and metrics-based risk sharing were our friends not foes. We marveled at the power of care coordination and its synergy with holistic, patient and family centered care.

Our plan to survive, our plan to thrive, was to energize and infuse integrative medicine with the strengths of value-based medicine. Then we realized an essential part of the equation was missing. Hidden in plain sight was the insidiously unhealthy culture of healthcare itself.

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TURBOCHARGING THE TRIPLE AIM - SECRET INGREDIENT...LOVE?

continued

In 2013, The National Patient Safety Foundation's report on the healthcare workforce safety warned, "Emotional abuse, bullying...learning by humiliation are often accepted as 'normal' conditions of the healthcare workplace creating a culture of fear and intimidation." How could we ignore the entrenched medical culture I had experienced throughout my career as a physician? Even integrative medicine's emphasis on balance, healing relationships, and connection couldn't escape the ingrained hierarchical, fear-driven, competitive, cultural dynamics of healthcare in America.

Stalking John Mackey

In July of 2011, I heard John Mackey, co-founder of Whole Foods, speak at a conference about business in a way that I had never heard before. He used words like purpose, consciousness, caring, and LOVE as pillars that drive corporate success and profits. Shocked and compelled to know more, I stalked him for the next hour waiting for an opportune 30 seconds to give him my elevator speech about Casey Health. I succeeded, and, to my surprise, he talked with me for 45 minutes. That was the beginning of my belief that a sustainable business, even healthcare, could be done consciously, with integrity, and also be profitable. But seriously, Love?

Stumbling at first, without a template to follow, I researched and began incorporating the key tenets of Conscious Capitalism into CHI:

1. Purpose, not profit, drives the organization.
2. Stakeholder orientation prioritizes win-win relationships with all internal and external stakeholders.
3. Conscious Culture and Management intrinsically motivates staff through autonomy, mastery, and purpose.
4. Conscious Leadership with servant leaders who are emotionally and spiritually intelligent systems thinkers.

Was I Naïve?

Fortunately, I was also invited to the Conscious Capitalism CEO Summit in Austin, Texas. There I spent hours talking with and listening to CEOs of other successful Conscious companies like Trader Joe's, The Container Store, Southwest Airlines, The Motley Fool, Panera, Nordstrom's, and many more. Then I really started to understand the potential for "Conscious Healthcare" at CHI.

"You can find a wealth of data that shows brands that are Conscious Capitalists succeed... research [shows] that these brands' investment returns are 1025% over the past 10 years, compared to only 122% for the S&P 500 and 316% for the companies profiled in the bestselling book "Good to Great." *Forbes online* - Dec 4, 2013 "Only Conscious Capitalists Will Survive" Jeff King and Jeff Fromm

So slowly, bucking the historical healthcare trend, we introduced the Conscious Core Values of Transparency, Accountability, Caring, Trust, Integrity, Loyalty, and Egalitarianism (TACTILE) into CHI. We began shaping an organization where purpose and meaning drive performance, while trust and collaboration drive innovation. Conscious culture is the soul that elevates an efficiently run practice into a powerful healing experience for patients and staff alike. An experience fueled with a sense of ownership by stakeholders pioneering a new path together.

TURBOCHARGING THE TRIPLE AIM - SECRET INGREDIENT...LOVE?

continued

Will We Make It?

Money, policy, politics, and patient care are a volatile mix. Approaching our three year anniversary, we are just now able to plant our feet in the PCMH, ACO, and value-based worlds. In Maryland's Wild West of healthcare, metrics based reimbursement is lagging behind other parts of the country. And, constrained by a still largely fee-for-service world, we are feeling the pressure of time. In the meantime, as Conscious Capitalists, our win-win stakeholder orientation has brought us a number of mission-aligned revenue opportunities with the potential to make us sustainable, even profitable while we bridge the gap.

Turbocharging the triple aim? We believe we are pioneering a potent formula by uniting Integrative health, value-based care, and population health. However, in the end, consciousness, purpose, meaning...even love may prove to be the true secret ingredients for healthcare transformation. Our once in a lifetime opportunity, made possible by Betty Casey and the Eugene B. Casey Foundation, has challenged us in fantastic and sometimes astonishing ways. It has also made us resolute to succeed.

Stay tuned.

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* Integrative medicine, as defined by the American Board of Integrative Medicine® (ABOIM) and the Consortium of Academic Health Centers for Integrative Medicine, is the practice of medicine that reaffirms the importance of the relationship between practitioner and patient, focuses on the whole person, is informed by evidence, and makes use of all appropriate therapeutic approaches, healthcare professionals, and disciplines to achieve optimal health and healing.

2015 WHCMAA ALUMNI CONFERENCE FOCUSES ON LEADERSHIP

The 2015 WHCMAA Alumni Conference was held at Huntsman Hall on the University of Pennsylvania campus. This year the conference focused on the topic of leadership in a time of change and chaos. This year's conference bore the title "What Matters Most Is How Well You Walk through the Fire," which is the name of a collection of poetry by American poet Charles Bukowski. The title resonated with many alumni leaders in healthcare in the U.S. for whom an average workday may feel like walking through a bed of hot coals.

The major events during the Alumni Conference weekend included the following:

Annual Alumni Dinner. Following tradition, the annual Alumni Dinner was held on October 15 at Russett in downtown Philadelphia. Over 60 people attended. Maureen Spivack, WG'86, was awarded the WHCMAA Alumni Achievement Award. The award is presented annually to a Wharton alumnus/alumna in the field of healthcare who has demonstrated a history of active contribution to the field through both knowledge creation and work on societal/governmental health issues, while supporting WHCMAA and exhibiting potential for continued career development and success. In her role at KPMG and through her significant leadership positions at WHCMAA, Maureen has demonstrated all these attributes in abundance. An enjoyable evening was had by all, and it was a great way to kick off the weekend.



Award winner Maureen Spivack is 3rd from the right.

Alumni Conference. Approximately 150 attended the WHCMAA Alumni Conference this year. Professor Michael Useem, the William and Jacalyn Egan Professor of Management and Director of the Wharton Center for Leadership and Change Management, started the conference, delivering the lecture "Leading in Healthcare Now and in the Future: Walking Well through the Fire." The lecture presented a general overview of the topic of leadership and some of Professor Useem's own research on the topic, while pointing out the unique aspects of leadership in a healthcare enterprise. Following his lecture, Professor Useem welcomed Dr. Stephen Klasko, WG'96 and Dr. Mark Lester, WG'02, to share their insights on the impact of leadership on their organizations in an informal, "fireside chat" format. Dr. Klasko is leading an organizational and structural transformation of Jefferson Medical Center as its CEO. In his role as Executive Vice President and Southeast Zone leader for Texas Health Resources, Dr. Lester provided leadership to one of the most highly scrutinized public healthcare crises in the United

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2015 WHCMAA ALUMNI CONFERENCE FOCUSES ON LEADERSHIP

continued

States of the last decade - the treatment of cases of Ebola at Presbyterian Hospital in Dallas, Texas. Both Professor Useem's keynote lecture and the fireside chat which followed were structured using Professor Useem's book, *The Leader's Checklist*. During the morning break Professor Useem signed copies of his book for conference attendees. This book distills the process of leadership down to sixteen actions. Though they may be easy-to-remember, putting the checklist into practice takes time and dedication.

This year's conference break-out sessions followed two tracks. One was focused on leadership: "Applying the Leader's Checklist in a Time of Change." The other focused on functional areas, such as product innovation and finance.



During the morning leadership session, Dr. Klasko reviewed how *The Leader's Checklist* helped to guide him as he transformed the University of South Florida Medical School when he served as its Dean and how he continues to apply these same principles as he looks to transform Jefferson Medical Center in Philadelphia.

In parallel, Phil Heifetz, WG'96, served as moderator for a panel discussing the topic "Leadership in the Product Innovation Realm." Panelists for this session included Maneesh Arora, Chief Operating Officer of Exact Sciences, Brent Ratz, WG'06, Founding CEO of CardiAQ Valve Technologies, and Kathy Crothal, former CEO of Animas Corporation. They discussed the leadership challenges they have faced in bringing breakthrough technologies to market. Thanks to Phil for bringing together such an outstanding group of life sciences entrepreneurs and facilitating an insightful dialogue!

At the conclusion of these sessions, the conference moved to the scenic eighth floor of Huntsman Hall where the now traditional standing lunch allowed attendees to nourish and network. Several dozen classmates were reunited, while new connections were established between alumni and the outstanding group of thought-provoking speakers who attended.

Following lunch, Niall Brennan, Chief Data Officer for the Centers for Medicare and Medicaid Services (CMS), gave the second keynote lecture of the day. His topic was "Leadership Lessons Learned as a Steward of the Public's Health Data." Mr. Brennan reviewed several of the ground-breaking initiatives that he has led within CMS including several policies from the PPACA. He described how his team is using data to spearhead the drive for transparency and accountability within the agency.

In his afternoon leadership break-out session, Dr. Lester gave the talk "In the Spotlight – Challenges and Lessons for Leaders." This session reviewed how *The Leader's Checklist* provided foundational guidance to Dr. Lester as he led himself, his team, his organization and multiple other stakeholders

2015 WHCMAA ALUMNI CONFERENCE FOCUSES ON LEADERSHIP

continued

through one of the most highly scrutinized public health events in the U.S. in recent years. In parallel, Maureen Spivack, WG'86, served as moderator for a panel discussing "Leadership in the Financing Realm." Panelists for this session included Jay Mohr, WG'91, Founder and Managing Partner at Locust Walk Partners, and Leslie Henshaw, Partner at Deerfield Management. They discussed the leadership challenges they have faced while investing in healthcare companies. Thanks to Maureen for bringing together such an outstanding group of leaders in finance together and facilitating an outstanding session!

To conclude the conference, conference Co-Chair Dr. Bob McDonald interviewed Dr. Sam Nussbaum. Dr. Nussbaum has served as Executive Vice President and Chief Medical Officer of Anthem, Inc. for the past fifteen years. This informal and far-ranging discussion touched upon historical and possible future trends in healthcare management, the leadership strengths and skills that these environmental forces will require and the unique covenant of caring and beneficence that is required when one chooses to lead in the health insurance industry.

Many thanks to the team that organized and executed this Conference, including Conference Co-Chairs Phil Heifetz, WG'86, and Dr. Bob McDonald, WG'92, Communication Committee Co-Chairs John Barkett, WG'09, Brian Corvino, WG'11 and Lauren Lisher, WG'09 and Operations Chair Peter Mueller, WG'09. Much appreciation goes to past WHCMAA President Jeff Voigt, WG'86, current WHCMAA President and Co-Chair of the 2014 Alumni Conference John Harris, WG'88 and Co-Chair of the 2014 Alumni Conference Dr. Bryan Bushick, WG'89, who served as invaluable members of the Conference team.

Special thanks go out to June Kinney for her generous input on the conference and to Cathy Molony, Director at the Wharton Executive MBA (WEMBA) Program. Approximately 40% of all WEMBA students have careers in healthcare, and Cathy has been instrumental in bringing the Wharton Healthcare Management Alumni and WEMBA communities closer together. For instance, Cathy was instrumental in bringing Drs. Klasko and Lester, both alumni of the Wharton Executive MBA program, to the attention of this year's conference co-chairs. Additional thanks go out to Chris Aleszczyk for all her help in coordinating the WHCM alumni on an ongoing basis. Without her support our community would be much the worse. Finally, a debt of gratitude is owed to Danna Daughtry, WHCMAA Administrator, who was instrumental in marketing the event to alumni, created, and tracked attendee lists, and did important work crucial to a successful conference.

Maria Whitman, WG'05 and John Barkett, WG'09, will be serving as co-chairs of the 2016 WHCMAA Alumni Conference, which will take place on October 21, 2016. All those interested in helping with next year's conference should reach out to them.

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