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EDITOR’S LETTER

This issue marks the beginning of the tenure of John Harris as the WHCMAA’s new President. He provides his perspectives in The President’s Desk and his wisdom in the Philosopher’s Corner.

This edition is chock full of a smorgasbord of topics with something of interest for every reader, from information about a new center for innovation to a trip to experience healthcare in St. Lucia. So, take a few minutes to feast on the banquet brought to your desktop or smartphone!

FYI, this year’s Wharton Healthcare Alumni Conference will be held in Philadelphia on Friday, October 16. The 2015 annual gathering will focus on leadership - “What Matters Most Is How Well You Walk through the Fire.” Tested leaders will share lessons on navigating their healthcare organizations through change and crisis. Be on the lookout for your chance to register for this consistently excellent event!

As always, we value your feedback in learning how we’re doing and identifying ways to continually enhance the WHQ experience. So don’t be shy in letting us know what you’re thinking and how we can better serve your needs.

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.
It’s estimated that total enrollment in private health insurance exchanges by active employees will reach about 40 million by 2018. The private exchange solution presents an opportunity to offer employees an attractive health benefit package while responsibly managing or even capping company costs—even in the face of legislative uncertainties.

Of the private exchanges, only one offers the experience you want with the highly adaptable solution you need: OneExchange. We’ve done it for nearly a decade, supporting full- and part-time employees as well as early and Medicare-eligible retirees. The best time to future-proof your benefits program? Before the future gets here. Visit us at chooseoneexchange.com and see what we can do for you.

A: Decide that you don’t want to be on the bleeding edge with such a big, strategic decision

B: Realize that using a private health exchange has become the leading edge, adopted by forward-thinking companies

*SAVE THE DATE*

2015 WHCMAA LEADERSHIP CONFERENCE

“What Matters Most Is How Well You Walk through the Fire”

October 16, 2015

The WHCMAA Leadership Conference is an intimate gathering of Wharton alumni at which nationally-recognized health care leaders discuss marketplace trends. This year’s conference will focus on leadership in challenging times: How do health care leaders identify and take advantage of leadership moments in today’s chaotic new normal? What does it take to be an extraordinary leader in this environment? How do you “walk through the fire?”

Every year, this conference is the largest convening of Wharton alumni whose careers focus on health care. It is a unique opportunity to discuss critical issues with select health care industry executives, thought leaders and former classmates.

Registration opens July 1, 2015 at http://www.whartonhealthcare.org/

Confirmed speakers include:

**Michael Useem, Ph.D.**
Wharton Professor of Management and Director, Center for Leadership and Change Management

**Mark C. Lester, MD, MBA**
Executive Vice-President, Zone Clinical Leader Texas Health Resources
WE'RE GETTING THE BAND BACK TOGETHER

I have a confession. For a long time, I felt disconnected from my fellow Wharton healthcare alumni. As a consultant in the provider/payer world, my sense was that most alumni were working in pharma, biotech, or finance. I didn't expect to learn much that would be relevant to my work. And I figured I didn't have much to contribute.

Then came the convergence. Healthcare reform catalyzed a more competitive healthcare market focused on value – better quality, at lower overall cost. The entire healthcare sector was shaken loose and told the new target was value, and that the market would be competitive – based on value.

This convergence around value has brought us all back from our specialized niches to a shared goal – demonstrating how our products and services deliver true value. In the words of the Blues Brothers, “We’re getting the band back together.”

A focus on value means digital start-ups ply new forms of patient engagement. New delivery models disrupt traditional approaches to patient-physician relationships. High-deductible plans are leading consumers to shop. Pharma and biotech firms find a new mindset among clinicians interested in cost-effective care.

A competitive market means many of the fundamental concepts we learned in business school are critical to setting successful strategies. It’s a dynamic market. There’s so much hype, uncertainty, and realignment, that fundamental business principles about markets, strategy, consumer behavior, and risk are key to assessing the environment and evaluating options. The opportunity to discuss these issues with fellow alumni is priceless.

We have explored these common themes and challenges in the reinvigorated Wharton Healthcare Alumni Conference which has occurred for the last several years in the fall. Save October 16 for what will undoubtedly be an amazing conference this year on the theme of leadership.

So you have a choice. You can assume the alumni association does not have much to offer. Or you can seek the stimulation and insight of your years at Wharton.

I know what I’ll be doing. I hope you join me and the association to support us all to learn and grow, and to develop the next generation of healthcare leaders.

John Harris
President
Wharton Health Care Management Alumni Association

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In Every Issue

OPEN WIDE: MORE TURNS OF THE KALEIDOSCOPE

I’m of two minds when it comes to all the changes taking place in American healthcare these days. On the one hand, I am amazed at all the developments and initiatives, the restructurings, the new organizational forms, the new entrants in American healthcare, from two perspectives. Like a kaleidoscope, they excite and dazzle for their potential to reshape and to arrive at better tradeoffs between cost, access, and quality in Dr. Kissick’s “Iron Triangle” of healthcare.

On the other hand, I sometimes wonder if all the trumpeted twists and gyrations are but the latest tap dance around the central issue that this society abhors centralization when centralization may well be required, that “the market” and its presumed efficiencies are to take precedence over equity and entitlement, even what it means to be a citizen in this society versus a consumer. Again as Dr. Kissick said, “Health policy is tax policy,” yet in an anti-tax atmosphere, what does this say for healthcare in America?

All of this may be grist for further discussion at another time, but lately my thinking has been seeing what’s decidedly positive, even necessary, in having dynamism, innovation, initiative, and risk-taking be characteristic of the American healthcare enterprise. And, as is my wont, to ask how this applies to that off-on-the-margins segment, dental health.

The various crystals in the kaleidoscope now include patient-centered medical homes (PCMHs); nurse-managed health centers; retail clinics; health systems – and lately academic medical centers, almost synonymous with tertiary care – developing “primary care platforms” to bring prevention to the forefront; integrated health systems entering into affiliations of one sort or another with group practices, outpatient specialty centers, community health centers; and businesses, seeing more incentive to control health insurance costs, becoming more astute in employee health benefits plans, and in employee health, period. How all these elements interact, with new ones entering almost daily it seems, is truly kaleidoscopic.

Not to be lost sight of is the principal driver of healthcare reform, the influence of Medicare money through CMS to drive financing and organizational reform to promote “value over volume” and “Better, Smarter, Healthier” care through the formation of ACOs. The “Next Generation ACO Model” has now been announced, significant in at least three respects:

- “to test whether strong financial incentives for ACOs, coupled with tools to support better patient engagement and care management, can improve health outcomes and lower expenditures for original Medicare fee-for-service (FFS) beneficiaries”

- establishment of a “Healthcare Payment Learning and Action Network to work with private payers, employers, consumer groups, individual consumers, providers, states, and state Medicaid programs, and other partners to expand alternative payment models into their programs”

- setting a goal of “tying 30 percent of Medicare fee-for-service payments to quality or value through alternative payment models by 2016 and 50 percent by 2018. HHS has also set a goal of tying 85 percent of all Medicare fee-for-service to quality or value by 2016 and 90 percent by 2018”
OPEN WIDE: MORE TURNS OF THE KALEIDOSCOPE  continued

All in all, some rather dazzling patterns are emerging from the turns of the kaleidoscope, promising a more sensible, effective, and efficient – and true– healthcare system. Except that the dental crystal is missing from all of these patterns, in organizational, financial, and managerial terms.

To use a different metaphor, it has been said before that the synaptic junction has yet to be crossed between healthcare more broadly and dental health. The former has little understanding of nor appreciation for the latter, and the latter just isn’t conversant in the lingua franca of contemporary healthcare developments and reform, despite the central message of the Surgeon General’s report from back in 2000 that “oral health is integral to overall health.” Someone on either side of the divide, although preferably individuals on both sides at the same time, will see what the other has to offer, not only for whatever organization she’s identified with, but also for better, truly comprehensive patient care.

It will no doubt take several more turns of the kaleidoscope to bring about the right pattern, but a new crystal, from the dental side of the divide, may have entered the picture. Penn Dental has announced a free online course, “Introduction to Dental Medicine.” While apparently geared more toward healthcare professionals than to the layman, there is nothing to prevent the recasting of the content to address the “average citizen in the street” - educating and informing him about dental disease, what care to seek, when to seek it, and where.

And this is where the kaleidoscope takes a more interesting twist, where the synaptic junction begins to close – when the content of this “man in the street” course is tied to the delivery system (of whatever form of “primary care platform” an integrated health system utilizes), the system, and the individual patient, stand to benefit. For example, a chain of retail clinics is affiliated with the dental department (“oral medicine,” if you wish) of a larger, integrated health system. Its website has the introductory course on dental care, explaining, for example, the process of tooth decay, and what to look for. As that famous marketing saying goes, “An educated consumer is our best customer,” so be it with dental care, the advantage with the retail clinic being that it offers readily accessible, quality care, at affordable prices (based on the business model of dental therapists practicing to the maximum of their licensure), and all formally integrated into a larger system for more advanced dental or medical supervision or treatment if necessary. Practically none of this is possible with the existing private, solo, fee-for-service dental practice, whereas authoritative online resources, tied to the delivery component of care, and then further integrated into a larger, comprehensive health system, accomplishes the objective of bringing dental care in from the far margins of healthcare.

May some visionaries see what a few further turns of the healthcare kaleidoscope can bring…

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**THE PHILOSOPHER’S CORNER**

*Life Lessons:*

If I knew then what I know now, I *would have:*
...listened more readily and more often to the other voices – the people who look at the world differently, and find miracles, wonder, and love all around us.

If I knew then what I know now, I *would not have:*
...stopped learning an instrument when my middle school music teacher insulted my playing. There is so much opportunity to grow and learn if we do not fear failure or embarrassment.

*Favorite Quotes:*

1. “It is not your responsibility to complete the work of fixing the world, but neither may you stop trying.” ~ Ethics of the Fathers
2. “Healthcare has never been as unstuck as it is now.” ~ Dr. Elliot Fisher
3. “Never underestimate the power of a small group of committed people to change the world. In fact, it is the only thing that ever has.” ~ Margaret Mead

*Recommended Reading:*

- *Managing an Organization* by Theodore Caplow (Recommended by Tom Gilmore to teach me the basic management skills I didn’t learn in school.)
- *The Innovator’s Prescription* by Clayton M. Christensen, Jerome H. Grossman MD, and Jason Hwang, MD
- *Moral Politics: How Liberals and Conservatives Think* by George Lakoff
ALUMNI NEWS

Rohit Mahajan, WG ’08
Saviance Healthcare has launched their Mobile Applications Lab at the Houston Technology Center. The area of expertise is mobile apps for patient engagement. The first such app for engaging HIV Patients in the inner city of Houston is being launched soon in association with Baylor College of Medicine. It will be available in the Apple iTunes and Google Play app stores. To see a demo or to talk about your mobile apps strategy, please contact me. I am interested in extending mobile apps to new devices like the Apple Watch and HTC Vive.

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Learn more.

Robert J Mandel, WG ’04
HINGHAM, Mass., March 4, 2015 /PRNewswire/ -- Activate Healthcare, a national healthcare firm dedicated to improving the delivery of proactive and preventive primary care, announced today Robert Mandel, MD, MBA, has been appointed President of the Northeast Region. Effective immediately, Dr. Mandel will assume this newly created position and lead the organization's operations in this important healthcare marketplace.

“We are delighted to have Robert join Activate Healthcare at this important time in our growth,” said Debra Geihsler, Principal and Co-founder of Activate Healthcare. “He brings deep leadership expertise and a host of varied experiences across the healthcare industry to his new role. We are confident that Robert will help us expand our mission to help patients and their families to take charge and manage their own healthcare.”

Most recently, Dr. Mandel served as President and CEO of Health Dialog, a wholly-owned subsidiary of Rite Aid and a leading provider of care management, healthcare analytics, decision support, and health coaching. Prior to that, he was Senior Vice President of Health Care Services for Blue Cross Blue Shield of Tennessee where he was accountable for all medical spend for the Commercial and Established Market Business Unit, which included 2.5 million members.

Dr. Mandel also spent more than nine years with Blue Cross Blue Shield of Massachusetts where he served in a number of roles, including Vice President of Health Care Services, Vice President of e-Health, Vice President of the Provider Enrollment and Services Division, Vice President of Health Care Services Administration and Medical Information, and Senior Medical Director of Provider Partnerships. He was a member of the initial leadership team of Health Central, a start-up, provider-sponsored HMO in Harrisburg, Pennsylvania, and held three different vice-president roles and served as Chief Medical Officer. In addition, Dr. Mandel worked for Pinnacle Health System, also in Harrisburg. His clinical experience is in the field of ophthalmology.
“It is an honor to join Activate Healthcare and expand the work of the organization in the Northeast,” said Mandel. “Today’s healthcare industry requires new thinking and pragmatic solutions to make a difference. Activate Healthcare’s approach is transforming the market with a model that delivers higher levels of patient engagement and lower costs, and provides employers with the benefit of dedicated care.”

About Activate Healthcare
Activate Healthcare engages patients to take charge of their own health by delivering proactive, preventive primary care at or near an employer’s location. Headquartered in Indianapolis, Indiana, the company was formed in 2009 by Debra Geihsler and Peter Dunn. The goal of Activate Healthcare is to transform healthcare by delivering primary care that engages the patient, supports a culture of health, guides the health care continuum to lower costs, integrates data to help proactively manage patient outcomes, and enables employers of all sizes to benefit from dedicated care. The company currently serves approximately 40 to 50 employers through 20 clinics, with three more opening this summer. For more information about Activate Healthcare, please visit www.activatehealthcare.com.

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ALUMNI NEWS

Nishan de Silva, UPSM ’00, WG ’00
Nishan recently joined Poseida Therapeutics, a San Diego-based, private, therapeutics-focused gene editing company as President and Chief Operating Officer. The company is using proprietary, best-in-class gene editing technologies to pursue autologous CAR-T cancer therapies and orphan liver diseases. Additionally, Poseida has a research collaboration and worldwide license agreement with Janssen Biotech to develop allogeneic CAR-T therapies that will pay Poseida up to $292 million per CAR-T therapeutic plus tiered royalties on net sales.

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Robb Cohen, WG ’92
As of January 1, Robb is the CEO of Advanced Health Collaborative (AHC). AHC is a network formed by 7 Maryland health systems (which own 10 hospitals, employ about 1500 physicians, and have many other delivery system components). The purpose of AHC is to coordinate and implement population health and care management for the 7 health systems, to help them succeed under Maryland’s unique CMS/CMMI Demonstration, which globally budgets the entire Maryland hospital system. All hospitals have accepted global budgets, so are fully at-risk for all hospital inpatient and outpatient utilization.

Prior to his new role with AHC, Robb was a Founder of XLHealth, which was the largest operator of Medicare Advantage Chronic Special Needs Plans in the country and was sold to United HealthCare in 2012. In 2013 and 2014, Robb was a consultant to the State of Maryland on the design and implementation of the new Globally Budgeted All-Payer Hospital Payment System.

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Learn more.

Jeff Voigt, WG’85

Harris Contos, DMD, WG’80
Fifteen Minutes of Fame
Our own Harris Contos of the “Open Wide” column on dental health had his 15 minutes of fame, more or less, back in February, with perhaps a smidgen of influence on dental health policy and reform. After receiving a broadcast “request for comment” on the Comprehensive Dental Reform Act of 2015 (S. 507, sponsored by Sen. Bernie Sanders of VT and Rep. Elijah Cummings of MD and the bill was filed on the 8th anniversary of the death of a 12-year old Maryland boy Deamante Driver from an untreated dental infection) from a staffer on the Senate’s HELP Committee (Health, Education, Labor and Pensions) on a dental listserv, he responded with a brief outline...
ALUMNI NEWS  continued

on two familiar plaints, “dental public health objectives cannot be achieved through the existing private, solo, fee-for-service practice business model,” and “dentistry remains outside the dynamism and innovation to be found taking place in healthcare more broadly.”

Fully expecting his comments to disappear into the ether, instead he met with an e-mail response from the staffer within hours, to schedule an at-length phone call to discuss the bill further. A 45-minute phone conversation took place a few days later, with a number of issues being discussed, among them: the continued predominance of the “cottage industry” nature of dentistry; the generally “in the box” dental care provisions in the ACA; the quizzical omission of dental care in the definition of “comprehensive primary care” in the ACA; and the lack of inclusion of dental care, and thus a component of “integrated care,” in the ACO model.

It was gratifying to hear these points were not lost upon the staffer, and that there was a fairly sophisticated understanding of the issues behind dentistry being on the periphery of healthcare reform. Central to reform efforts is overcoming state dental practice acts, which inhibit necessary organizational and workforce adaptability and developments. But what S. 570 can accomplish at the Federal level (e.g., through the VA, the Public Health Service, Federally Qualified Health Centers) may be the back door approach to prompting wider reform in the dental health industry.

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NOT A FREUDIAN SLIP: GENDER DIFFERENCES THAT SHAPE OUR ABILITY TO EMOTIONALLY THRIVE

Health is a complex interplay of biological, demographic, socioeconomic, psychological, and behavioral factors. Despite this fact, interventions surrounding an individual's health have historically been focused on only a small percentage of the complete health spectrum, mainly the person's physical health. Modern integrated health approaches have focused on blurring or eliminating the line between physical and behavioral health and are now committed to a more holistic, well-being perspective. However, these much-needed approaches still often fall short of addressing the full social environment in which an individual lives. Our childhood experiences, intergenerational influences, and exposure to societal norms form a social web that impact a person's psychological being and consequently their health behavior in a number of ways.

In the previous two articles in this series (Part 1 and Part 2), we explored how biological mechanisms (specifically genetic and physiological factors) impact male and female behavior differently. Biology is limited, however, in explaining how these physiological differences give rise to the gender differences that we observe in today's society — and in how these differences affect our health.

To explore the role of social context on gender, we turn to the social arm of the biopsychosocial (BPS) model. This component of the BPS model examines health and well-being from a sociological perspective, considering how economic standing, personal belief systems, and cultural norms inform both a person's ability and mental fortitude. Historical and modern attitudes towards differences in gender, combined with these factors, inform the conditions in which we grow, work, live, and age.

Often interchanged with sex, gender has a specific connotation. While sex is used to distinguish men and women on the basis of biological characteristics, gender refers instead to socially constructed characteristics. The socially constructed ideas of gender are shaped by the historic period, including political perspectives, as well as the conditions in which we grow, work, and live. These ideas impact social hierarchy (e.g., what roles men and women should take in society) as well as institutional inequality (e.g., differences in compensation). Additionally, social expectations around gender have led to differences in how men and women experience health. Gender differences are related to not only the type of adverse health events that a man or woman may experience, but also the likelihood of a positive health outcome.

Historically, biological differences in sex evolved to ensure the survival of the species. For example, females are anatomically built to bear and nurse children, while males typically possess greater size, speed, and strength for prehistoric tasks such as hunting large animals and conducting warfare. Our modern reactions to stress — for men, fight or flight, and for women, tend and befriend — echo the biological mechanisms that allowed the survival of our species. The historic period in which these mechanisms evolved shaped differences in gender roles. If our female ancestors responded to a threat with the traditionally male instinct of outward aggression instead of the female instinct of protecting their young, their offspring would be less likely to have a parent to protect and raise them.

In modern times, gender differences from the past continue even though the environment is much different. Modern comforts have alleviated ancient threats. Humans must no longer run from a lion or protect their young from predator attack. Food preservation and modern medicine have effectively minimized the largest prehistoric threats to humanity.

As prehistoric threats have become obsolete, new threats to health and well-being have emerged. The threats of today's culture...
range in severity from sitting in traffic to open warfare, with each threat resulting in varying degrees of stress. When acute stressors occur, such as immediate confrontation (e.g., gang violence), the stress response remains similar to that of prehistoric times. However, modern stressors are typically much more chronic in nature than those historically present, and stress manifests in a less explicit way. A long list of maladies including colitis, Addison’s disease, arteriosclerosis, sexual dysfunction, and neurological damage are the hallmarks of the chronically stressed human being.

Though time periods, environments, and cultures have all changed, the gender differences that first emerged historically have now transformed into gender inequalities. Not that long ago, women were the explicitly controlled sex: they were forbidden to own property, to vote, or to choose their partner. In many societies, this overt patriarchal structure remains. Today, these inequalities are expressed more implicitly as women continue to face the stereotypes of belonging in domestic roles only and of being intellectually and emotionally inferior to their male counterparts. These differences are socially constructed and are in no way biologically related to our survival. There are no good reasons for why men and women should be held to such differently defined social roles.

Gender inequality is important to consider as these socially constructed norms and differential life experiences directly impact women’s health. Gender differences resulting from this inequality, especially the unique social environments in which men and women are raised, have profound influences on mental health, disease rates, and society as a whole. In the next article in the series, we explore more deeply the gender inequalities that exist in today’s culture, the mechanisms that allow them to continue, who they affect, and ultimately how these inequalities influence our mental health and wellness. This exploration is important, as accounting for the differences in men and women’s experiences and health along the three dimensions of the biopsychosocial model (i.e., biology, psychology, social) allows for the development of appropriate and supportive interventions around the unique challenges faced by each gender to meet their needs directly.

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References


Featured Articles

**NOT A FREUDIAN SLIP: GENDER DIFFERENCES THAT SHAPE OUR ABILITY TO EMOTIONALLY THRIVE**

*continued*


Physicians and other healthcare professionals should be aware of how essential licensure and healthcare payer credentialing are to any business enterprise that involves the practice of medicine. Sometimes, however, professionals can pay short shrift to licensure and credentialing requirements, and investors, entrepreneurs, and others in the business of healthcare may not know about them in the first place. Those who do not properly obtain and maintain licensure and payer credentialing can potentially experience significant temporary, or even permanent, business disruption. Here are some examples.

A patient event can cause a domino effect of adverse state licensure and payer credentialing decisions that can decimate or disrupt a business. For example, while it is rare, a patient can die when a physician is providing a Level 1 surgical service (the least-intensive surgical service), such as happened to one physician. The cause of death was never determined, but there was evidence the anesthesiologist involved in the procedure had not adequately monitored the patient. As the patient’s vitals were deteriorating, the physician performing the service took charge and initiated emergency procedures, including performing CPR and calling 911. Despite his efforts, she was taken to the hospital and died.

An anonymous complaint was filed with the State Board of Medicine. The Board investigated and disciplined the physician, but based on the facts, imposed a very light sanction. It took into account the manner in which he took charge immediately following the event. The physician never lost his license and continues to provide the type of procedure during which the event occurred.

But any State Board sanction may have significant ramifications. A State Board reports a sanction to the National Practitioner Data Bank (NPDB), a clearinghouse for reports on physician disciplinary actions. This is where the domino effect occurs. State licensing agencies across the country, public and private payers, and others can query or obtain reports from the NPDB to determine whether a physician has been sanctioned, which can lead to further licensure sanctions and hospital and payer-program exclusion. When one Board sanctions a physician, typically State Boards in other states in which he or she practices take action as well, and can impose sanctions that are greater than those imposed in the state from which the report originates. In addition, payers check the NPDB. As payers seek to narrow their networks, they may use an opportunity like an adverse NPDB report to terminate a physician from the network. The inability to participate with major payers can ruin a professional’s business. Furthermore, even if the physician has resolved all other state licensure and payer investigations, a subsequent decision by a single payer to terminate or sanction him can lead to another report to the NPDB, meaning that he would have a new NPDB report against him, triggering a new round of licensure and payer actions.

Other State Boards of Medicine decisions can have widespread effects for many practitioners. On April 15, 2015, the Texas Medical Board significantly limited the practice of telemedicine, ruling that physicians must examine patients in-person before they may order prescriptions for them and provide other tele-services. The Texas Medical Board made its decision despite the fact that one of the nation’s largest telemedicine companies, Teladoc, is located in Texas and had forcefully opposed any restrictions. Teladoc relies on its physicians to provide services to patients through e-mail, text, and phone. Many established medical groups and associations oppose telemedicine based on concerns about quality of care, but also, as some believe, because telemedicine puts at risk the traditional brick-and-mortar healthcare
delivery model and the livelihood of most office-based physician practices. Thus, for some, the Texas Medical Board’s decision to limit the practice of telemedicine is welcome; for others, including Teladoc, the decision has potentially huge financial consequences. Additional states have limited, or are considering limiting, telemedicine as well.

Other licensure events based on mundane technical issues can also disrupt a business. We represent a family therapist with a thriving, multi-site practice in the Pittsburgh area. The practice includes an innovative telemedicine component. Last year, Pennsylvania amended its child abuse reporting laws to require that physicians and other healthcare professionals complete two hours of training on reporting in order to renew their licenses (three years for a new licensee). The therapist was due for licensure renewal on March 1. She completed her child abuse reporting training in mid-February, but the State Board of Social Work, Marriage and Family Therapists, and Professional Counselors did not process her certificate of completion by March 1. The result was that the therapist’s license was inactive until the Board processed the certificate, which did not happen until March 10. During that 10-day period, she had to reschedule client appointments. Also, by chance, the contract with her billing subcontractor was up for renewal, and the contractor refused to renew the contract until the licensure issue was resolved. Even though the Board’s electronic systems caused the error, the Board’s position was firm: until the processing error was corrected, the therapist was unlicensed.

State Boards and payers have a duty to determine which professionals are qualified to provide and be reimbursed for services, and which are not. Still, it may be challenging and, in some cases, impossible to change an adverse licensure or credentialing decision even when there are sound reasons to do so. Sometimes, a legitimate concern needs to be resolved, such as in the case of a patient death or the statewide practice of telemedicine. In other instances, the issue may be technical only, as it was for the therapist whose training certificate was not timely processed. Regardless, a business that incorporates the delivery of healthcare services by professionals may want to keep a steady eye on licensure and credentialing requirements and developments.

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This article is prepared and published for informational purposes only and should not be construed as legal advice. The views expressed in this article are those of the author and do not necessarily reflect the views of the author’s law firm or its individual partners.
STRONGER THAN THE SUM OF OUR PARTS: INTRODUCTION AND PRINCIPLES OF EFFECTIVE INTERPROFESSIONAL COLLABORATION IN HEALTHCARE - PART 1

This is the introduction to a series of four articles about actionable practices for effective interprofessional collaboration (IPC).

As healthcare advances toward the Institute of Healthcare Improvement’s Triple Aim — improving patient experience and population health while reducing the per capita cost of care — new models of care are being developed to meet current and future challenges. Those models are increasingly aligned and networked across organizations and roles. The Institute of Medicine report, *The Future of Nursing: Leading Change, Advancing Health* (2011), highlighted the significant role team-based care will play in healthcare. The report states, “As the delivery of care becomes more complex across a wide range of settings, and the need to coordinate care among multiple providers becomes ever more important, developing well-functioning teams becomes a crucial objective throughout the healthcare system.”

Sharing practical knowledge about action on shared goals across roles is integral to meeting the healthcare demands of the future. In part to illuminate what will be needed, a number of organizations, collaboratives, and researchers are conducting important work on interprofessional collaboration, often focusing on the competencies required for education and collaboration. However, less research has been done on the practice of IPC on the front lines of care. To address this gap, the Robert Wood Johnson Foundation (RWJF) wanted to identify day-to-day practices already in place that demonstrate effective interprofessional collaboration.

A Study of Practices in Place
In 2014 RWJF initiated a project with CFAR entitled *Identifying and Spreading Practices to Enable Effective Interprofessional Collaboration*. The purpose of the project is to both encourage and enable collaboration that will improve care by exploring, explaining, and disseminating some of the most useful practices for effective interprofessional collaboration — and the supports required to sustain them over time. The ultimate goal is to share these practices more broadly in order to catalyze efforts across the country to advance effective interprofessional collaboration.

For the purposes of this work, we defined effective interprofessional collaboration in a particular way:

*Effective interprofessional collaboration promotes the active participation of each discipline in patient care, where all disciplines are working together and fully engaging patients and those who support them, and leadership on the team adapts based on patient needs.*

*Effective interprofessional collaboration enhances patient- and family-centered goals and values, provides mechanisms for continuous communication among caregivers, and optimizes participation in clinical decision-making within and across disciplines. It fosters respect for the disciplinary contributions of all professionals.*

We identified promising practices in interprofessional collaboration. Why focus on practice? Because practice is the basis of culture.

Organizational culture is defined by what people do, rather than what they say they do. As such, we can think of culture as a collection of behavioral practices that together comprise the “way things get done around here.” New behaviors need infrastructure...
that makes them as easy as possible to do (think of hand sanitizer stations used to promote hand-washing). If you want to change culture, you need first to change practice. This is often easier said than done.

Our colleagues and cultural and organizational change experts Mal O’Connor and Barry Dornfeld write, “When you observe people’s behaviors in getting work done, you see that many of them are not formally defined but are tacit: not openly spoken about, although generally understood. Others are explicit: openly stated, shared, and discussed.” We knew we would need to learn about both. For this reason, we took an ethnographic approach that allowed us to compare what organizations say they are doing with observations on how interprofessional collaborative practices work on the ground. We then worked backwards to understand the guiding principles that cut across the practices we observed.

Guiding Principles
Through the work we received important advice from the seven organizations that participated in the project: Aurora Health Care, Milwaukee, Wisconsin; Cincinnati Children’s Hospital Medical Center, Cincinnati, Ohio; Community Health Center, Inc., Middletown, Connecticut; Intermountain Healthcare, Salt Lake City, Utah; University of Pennsylvania Health System, Philadelphia, Pennsylvania; Virginia Mason Health System, Seattle, Washington; and Women and Infants Hospital, Providence, Rhode Island

These foundational ideas capture what might be thought of as “guiding principles,” required to create an environment in which interprofessional collaboration can thrive.

- **It takes time.** This work does not happen overnight — it takes time, patience, and perseverance to build interprofessional collaboration, supported by leadership and the ability to think long-term.

- **Relationships matter.** People are the building blocks of teams — developing relationships between and among team members makes a difference.

- **Pockets of interprofessional practice already exist.** Creating an environment for interprofessional collaboration is not a linear process — if you look, you will find the kind of interprofessional practice you want to create is already happening in small ways inside your organization. These “pockets” of promise can be highlighted, resourced, and spread.

- **Name it.** The term interprofessional collaboration itself might be viewed as a transitional concept until it becomes embedded in the culture. In other words, you may have to “name it” in order for people to recognize that it is different from the way they are already doing their work.

- **Start small.** It is smart to start small, engaging the passion of those who believe in this work, and using that passion as energy to build momentum and create pull for the ideas and practices throughout the organization.

- **Creating a culture of interprofessional collaboration requires multiple reinforcing practices.** Mutually reinforcing practices work together to eventually shape an organization in which “this is just how we do things around here” — a definition of culture.

These guiding principles underlie all effective efforts in interprofessional collaboration and are represented in the following three articles in this series, where we will discuss specific and actionable practices through examples.
STRONGER THAN THE SUM OF OUR PARTS: INTRODUCTION AND PRINCIPLES OF EFFECTIVE INTERPROFESSIONAL COLLABORATION IN HEALTHCARE - PART 1

References


WHARTON AROUND THE GLOBE: WHARTON GLOBAL HEALTH VOLUNTEERS HELP ST. LUCIAN HOSPITAL

For over 15 years, Wharton students have been traveling abroad to learn about international health, supported by the Wharton Global Health Volunteers (WGHV) program. Founded by Health Care Management (HCM) students in 1998 to provide Wharton students with first-hand insight into challenges faced by developing world healthcare organizations, WGHV has facilitated dozens of in-person consulting projects across five continents. This year students worked with internationally respected organizations like Aravind Eye Care System and St. Jude Hospital, traveling to southern India and Saint Lucia to help these organizations fulfill their missions. We wanted to share with WHCMAA some of the work we have been doing in Saint Lucia, with one of our longer term healthcare partners.

During Spring Break, three Wharton students traveled to St. Jude Hospital (SJH), a 55-bed, non-profit facility serving south St. Lucia. Previously administered by nuns, SJH burned down in 2009 and has since been utilizing the indoor facilities of George Odlum Stadium. Brian Vo ('16), Vinay Shah ('16), and I visited the hospital to help improve their cash collections.

SJH is partially subsidized by the Ministry of Health, with the remainder of the budget funded through patient billing. However, SJH services some of the lowest income areas of the island; therefore, SJH treads a careful line, collecting what they can from those who can pay. As a result, the hospital faces cash flow challenges, with about 75% of their revenue locked up in accounts receivable and 20% written off each year. We witnessed the impact cash flow challenges can have on patients, as the hospital ran out of sutures while we were on the ground.

Vinay Shah ('16), Brian Vo ('16), and Kendall Rugg ('16)

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Our team spent the week interviewing finance, revenue cycle, and clinical staff to develop recommendations to help the hospital increase collections from patients. We realized part of the challenge facing the hospital was that of mindset. Clinicians, earnestly wanting to help patients, often aided patients in receiving care without paying. Many patients chose not to pay (or couldn’t afford) their hospital bills. The Finance Department staff didn’t always have the training to advise patients on how to pay if finances were tight. On top of this, most hospital staff didn’t completely understand the financial challenges faced by the hospital.

To help shift the behavior of the staff, we encouraged the hospital administration to:

• be transparent about their financial situation with their staff and clarify each person’s role in collections, from physicians to security guards
• reward staff who invest exceptional effort in collections
• improve training and skills needed for each role, so staff have the tools to be successful
• reinforce behavioral changes by supporting them through 12 other tactical process improvement recommendations ranging from redesigning patient flow to developing a prioritization framework for debt collection efforts

Throughout the project, I was most struck by the creative ideas SJH staff themselves had to improve collections at their own hospital. Most of all, we encouraged SJH management to listen to their staff and devote resources to support staff-led initiatives to improve collections.
The executive team from SJH was very receptive to our recommendations, appreciating how we addressed the need for an underlying mindset shift, while also including tactical improvement initiatives. SJH even used part of our analysis in a recent presentation to Saint Lucia’s Prime Minister.

For the students on the trip, myself included, we had an incredible time learning about how a hospital like SJH must be aware of the tradeoffs between costs and care to best serve their patient population. We look forward to continuing to develop our relationship with SJH. Every year returning students are able to witness how the last Wharton team’s recommendations have actually impacted the hospital. I look forward to keeping up with their progress next year, when our Wharton team is hopefully able to visit them at their new facility.

Participated in a trip during your time at Wharton? We would love to hear how it impacted your career or your thoughts on the experience with the benefit of perspective. Interested in learning more or seeing pictures from past WGHV projects? Interested in supporting our efforts financially, linking us up with potential sponsors, or providing a great lead on a potential global health client? E-mail us, visit our website, and see what we’ve been up to on Facebook. However you are able, we would love to involve you in our work.

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HEALTH DISPARITIES SERIES: VESTIDO ROJO, DE TODO CORAZON: COMMUNITY OUTREACH WITH HEART

The American Heart Association (AHA) launched the Go Red for Women campaign just over ten years ago. The campaign’s focus makes women more aware of their risk for heart disease and stroke. As information was collected to evaluate the effectiveness of the campaign, it was determined Hispanic/Latino women lagged behind their Anglo counterparts in understanding their risk. Taking these results into consideration, the Health Equity team of the Texas Affiliate of the AHA (now the Southwest Affiliate) worked to eliminate this disparity.

In San Antonio, several volunteers were identified to help lead this cause. This group of five women worked to determine what resources were available and what actions could or should be taken. Out of this collaborative effort came the idea of hosting a free community event that would be bilingual and culturally relevant. Included would be several break-out sessions focused on the AHA’s “Life’s Simple Seven” message of healthy lifestyles, health screenings to encourage women to know their numbers, and a complimentary lunch prepared to inspire healthy eating.

Preliminary concerns for the planning team were that this type of female-only focused event did not include children and would require attendees to RSVP, neither of which is a cultural standard. With a true understanding of the health issues and disparities facing the women of their culture, however, the leaders of this effort decided to move forward. The event would be called, “Vestido Rojo, de todo Corazon.” Vestido Rojo translates as red dress, which is the promotional symbol of the Go Red for Women campaign. De todo Corazon has a double translation, one being all about heart, and the other a cultural sentiment which means with all of my heart’s sincerity.

The first year there were just over 100 women in attendance. Health screenings, sessions on nutrition education and physical activity, as well as a keynote address about women and heart disease, were presented. The event was complete with a beautiful Mariachi group dressed in red serenading the women as they left the event. The feedback was amazing, as women shared their appreciation for the event and the information. They were surprised to find out about the prevalence of cardiovascular disease in women. Most importantly, women shared that they felt they could make a difference in their families with the information they had attained.

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A few years later a volunteer suggested recruiting women to be madrinas, which translates to *godmother* and in the Hispanic culture is a special role women play for baptisms, weddings, and other life events. For the Vestido Rojo event, the madrina would serve as an ambassador and be responsible for filling a table with ten women. This grassroots type effort would help empower our community women, as well as help increase attendance.

Eager and excited about their newly assigned responsibility, the first group of madrinas truly embraced their roles. A few of their guests even dressed up as a team. One group showed up wearing tiaras and demonstrating they were “queens for a day.” From this enthusiastic display came the idea of asking the madrinas to decorate their tables the following year. The tables were judged based on creativity, color, and, most importantly, health messaging. The designs have evolved over the years, continuing to be more and more inspirational. Past themes have included a tree of life, which was a painted branch with hearts hanging as leaves, each displaying a healthy lifestyle message. Other themes have been about healthy eating, physical activity, loved ones who have survived heart disease, and countless ideas about the Go Red movement. The madrina concept has now been replicated in other markets hosting a Vestido Rojo event.
Throughout the years the significance of the event and its effectiveness in reaching our Hispanic women with the message of heart health has continued to evolve. In the beginning there was an understanding of the need for bilingual information (Spanish and English); it also became apparent the event should be relevant beyond just the language connection. Numerous other culturally compelling elements – the decorations, the music played during transitions, the emcees, the madrina process, and the sense of sisterhood – have made this event an amazing experience for the women who attend. The creativity does not end, and each year a new component is added. For example, last year a group of women performed a play highlighting the heavy use of salt during a tamale-making session and the refusal to adhere to doctor’s orders, which then led to a stroke incident. This year, there was a fashion show presented by a local university’s Fashion Department, most of which were Hispanic students. These students designed, sewed, and modeled their dresses.
HEALTH DISPARITIES SERIES: VESTIDO ROJO, DE TODO CORAZON: COMMUNITY OUTREACH WITH HEART  continued

In the ninth year of the event, there was a record-breaking 900 women in attendance. In 2016, the anticipated participation is 1,000 women. While the activities keep the Vestido Rojo event interesting, the message saves lives. That is the mission of the American Heart Association and the true desire of the volunteers who continue working to spread the word to their comadres.

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HEALTHCARE DIY: NO LONGER PIE IN THE SKY

Male, 58: “For everyday ailments, I try not to rush to the doctor. It’s a huge inconvenience. I look up stuff myself. If it passes a certain point, then I want a real doctor. The question about DIY for me is: How well do you know yourself?”

Going to the bank, perusing plotlines at a bookstore, and even grocery shopping have all become too inconvenient. Using on-demand online interfaces is now second nature. But when did going to a trained medical professional for in-person treatment also become “too inconvenient”?

Number one on Pricewaterhouse Cooper’s “2015 Top Health Industry Issues” list is Do-It-Yourself (DIY) digital healthcare. What’s driving the top trend boils down to this consumer attitude: Why wait in a doctor’s office when you can cut out the middle man and take care of yourself?

DIY Healthcare v1.0 arrived with the launch of WebMD and its contemporaries in the late 90s. It just didn’t have a name yet. DIY then represented an individual’s ability to obtain online information that traditionally would have been dispensed by a physician, or the sense of empowerment gained from self-learning about a specific diagnosis.

The term DIY Health first cropped up in mainstream media in a 2009 New York Times article, “For Uninsured Young Adults, Do-it-Yourself Healthcare,” describing a generation of 20-30 year old “Young Invincibles” in Brooklyn, NY. Uninsured, they took to playing doctor using websites like WebMD and online discussion forums. In the article, a student stockpiles syringes to inject his own diabetes medicine, and a waiter successfully diagnoses himself with plantar fasciitis and calls out of work.

Fast forward a few years, and we are witnessing the rise of Healthcare DIY v2.0. Individuals are no longer satisfied with just information; they want the application of medical know-how integrated into their daily lives to improve their well-being and function. These same Young Invincibles are launching software, apps, and devices designed to replace or supplement care from doctors, lab technicians, dermatologists, nutritionists and, in the case of SimpleTherapy, physical therapists.

Healthcare DIY 2.0’s inspiration has been inefficient and costly clinical settings. SimpleTherapy, for example, was born when a team of orthopaedic specialists witnessed patients who were experiencing musculoskeletal pain struggle with the impossibility of complying faithfully with physical therapy prescriptions that required an ongoing series of clinic visits. Patients regularly voiced that physical therapy would be either too inconvenient or too expensive to even bother going. Why couldn’t the proven outcomes of musculoskeletal pain improvement via exercise therapy be delivered to them online, much more affordably, and much more conveniently?

The application of knowledge is what defines Healthcare DIY 2.0. SimpleTherapy’s Chief Technology Officer, Arpit Khemka, approached this challenge by creating a machine-learning algorithm that gathers user inputs and provides individualized exercise regimens. It mimics the thought process of orthopaedic specialists to select appropriate exercises based on patient feedback. The idea that individuals want to be part of treatment decision-making has been shown in the medical literature. In one study by Deber et.al., most patients preferred shared decision-making when it came to their current health condition. As a user progresses on his or her schedule and at his or her own pace, SimpleTherapy embodies this shared decision-making process.

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HEALTHCARE DIY: NO LONGER PIE IN THE SKY

What we’ve learned from implementing algorithm-based care, via randomized double-blind clinical trials and through thousands of individual user surveys, is that 96% of users prefer the accessibility of online exercise therapy to visiting a physical therapy clinic in person. Cost savings was the originally hypothesized reason, but instead, it’s convenience that is cited most. One 65-year old female who began with a wrist diagnosed with arthritis and reported a 100% pain decrease after four weeks in her SimpleTherapy program comments, “There is a comfort in knowing that I can log in and do my program in my own space.”

According to a [2014 Lucas & Gratch study](#), people are more likely to disclose personal information to a computer rather than to another human (i.e., their doctor). The study cites [Weisband & Kiesler’s](#) earlier research on computer form self-disclosure, describing a “sense of invulnerability to criticism, an illusion of privacy, [and] the impression that responses ‘disappear’ into the computer.” Autonomy breeds usage.

DIY Healthcare is an opportunity to feel in control of one’s own well-being. It is empowering users to extract and monitor their own health data, and to leverage analytical tools to actually understand what it means. These digital tools are not removing the need for healthcare professionals, but redefining the relationship between informed patient and professional, and democratizing health education.

Inevitably, Healthcare DIY v2.0 will evolve into v3.0. This future will utilize machine-learning algorithms that gather data from individual hospital records, wearable technology, and even implantable devices. The success of Healthcare DIY v3.0, however, will require the lessons learned from v2.0: How do individuals interact with Internet- and machine-based therapies? How can we deliver the “human-touch” that individuals yearn for via a machine? What are the outcomes of individuals utilizing these applications? What are the issues with individual data, and how much can be used safely without an invasion of privacy? SimpleTherapy is one of the companies adding to this growing knowledge base.

While grappling with all of these questions, this generation of healthcare leaders is looking beyond what’s worked well enough in the past and striving to improve or re-invent it.

*Special thanks to SimpleTherapy team members Tae Won Kim, MD and Brenna Haragan, who contributed to this article.*

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“VALUE” AS A VERB: THE URGENT NEED FOR A MORE ENGAGING, ACTIVE DEFINITION OF VALUE IN HEALTHCARE

Healthcare reform is at risk.
What is a perhaps a once-in-a-lifetime opportunity to markedly improve America’s healthcare, its health, and its economy is at risk of under-achievement. After a couple of years of decreased growth, healthcare costs seem to be on the rise again. The most advanced efforts at healthcare reform have done little to mitigate costs, while the improvements in quality have been modest.\(^1\)\(^2\) The drivers of cost — intensity of use and expensive new technology — continue. And, the potentially enormous driver of healthcare volume, the baby boomer demographic wave, is just beginning to reach the shore. Improvements in quality related to population health remain local case studies, while widespread health system consolidation remains unproven as a vehicle for improved coordination of care and operational efficiency.\(^3\) Access to care has dramatically improved for many through the insurance reforms of The Affordable Care Act, yet surprisingly, many eligible for subsidized insurance have chosen not to enroll. Allowing for the many innovations from healthcare reform, we still should see more improvement than we are seeing. And certainly, we should expect more.

Of most concern however, is the widespread unpopularity of the Affordable Care Act. This suggests the possibility of a fundamental disconnect of public policy from the public. One only need remember the mid-1990s and the failure of the HMO movement to see that a “public” policy that the public distrusts is unlikely to survive.

While the rhetoric of reform - accountable care organizations, payment bundling, transformation, value-based purchasing, volume to value, etc. — is pervasive, the fact remains the critical driver of any fundamental change remains unengaged. That essential driver is the behavior of the public. Our individual health and the health of our society depend mainly on choices we make. These can be political, environmental, and behavioral choices. On a community basis, we can choose to build the infrastructure that enables children to play outside and our neighbors to walk to gather. Or, we can choose to isolate ourselves in developments that deprive us of the benefits of community. We choose how much and what we eat. We choose to smoke. We choose to exercise. We know the best predictor of the health of a nation is economic health. We also know that given economic well-being, personal decisions are at least as powerful as our genetics. The evidence is overwhelming that most of the illness in the United States results from our poor choices.\(^4\)

The same is far too often true in healthcare. The irony of American healthcare is that for all its technical sophistication, it does not necessarily produce health. Even when successful in improving health, the system rarely does so in economically efficient ways. It has become conventional wisdom among policy makers and politicians that up to a third of all healthcare delivered is “waste.” This assertion is the basis of all the “value-based” efforts at healthcare reform — the hope being that these efforts will increase economic efficiency, and therefore societal Value. The problem is that the public’s view of what is “valuable” has little to do with the policy maker’s world view.

The current concept of “Value” does not connect with the public.
The term “Value” is ubiquitous today in healthcare. However, as pointed out by Porter in a thoughtful review, Value is

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“misunderstood” and seldom measured in a meaningful way. The causes for this misunderstanding are both conceptual and practical. From a conceptual basis, definitions vary. Porter defines “outcomes” of care as the best measures of true value. Not all would agree.

A common algebraic formulation of Value is Value = Quality/Cost. This formulation is an obvious gross oversimplification in that it begs the very difficult question of defining “quality.” At a deeper level, the equation is an abstraction unattached to the concrete and emotionally charged experience of illness. We as people, especially as Americans, value our individuality. V=Q/C, at least on its surface, makes no accommodation or even acknowledgement of individuality. The cultural disconnect, more than its algebraic form, dooms it as an effective motivator of individual or community change.

This formulation, and even Porter’s more rigorous outcomes-based analysis, provide little of the emotional resonance necessary to spark change in the way the public thinks about its health and healthcare. The wide array of healthcare policy initiatives designed to increase “Value” are largely opaque to the public. Few individual patients would understand what “value-based purchasing” is or what an “accountable care organization” does. This basic lack of understanding is one of the prime reasons for the Affordable Care Act’s unpopularity. If one believes the engagement of the public is critical to changes in behavior, then the current state of confusion bodes ill for change.

Value as action — a path to engagement and change
An alternative to the current definition of Value is to see “Value” as an action, or rather as an array of actions, grounded in wise, informed decisions made by an individual about their health and their care. “Value” then becomes a process of assessment and choice directly linked to people, and not as abstract, retrospective evaluations and composite scores. Rather than an equation, Value can be described more discursively and more operationally and in ways that resonate with people. An example of such an action-oriented formulation is thinking of Value as a process:

Examining all healthcare to be sure that:
- all healthcare makes a difference in the lives of people
- this difference can be measured
- healthcare is affordable to both the individual and to society
- the healthcare people receive is care that they want

This formulation of “Value” turns it from a noun into a verb. It is a process, not solely a measurement. This definition contains the elements of quality, cost, and efficiency, but in a language in which the public can understand. The process of Value is both an inclusive and expansive one. There is no Value without “making a difference.” The difference need not be added years of life, but could be improved functional ability to live or simply improved peace of mind. Which of these or others it might be will depend on the individual judgments of those who healthcare is supposed to serve, not on the opinions of experts.

Cost in this action-oriented formulation of Value is not abstract. Rather, it is recast as affordability. Cost is a matter of perspective depending upon who incurs the cost (e.g., insurance coverage). Affordability is understood by all and can motivate action.

Considering “Value as a verb” also has profound implications for the work of health professionals and policy makers. The educational role of health professionals becomes accentuated. It is their...
“VALUE” AS A VERB: THE URGENT NEED FOR A MORE ENGAGING, ACTIVE DEFINITION OF VALUE IN HEALTHCARE

responsibility not only to provide expert technical service, but also to help individuals understand the implications of their choices. Health policy in practicing its craft with “Value as a verb” would become focused less on narrowly defined measurements, the calculation of aggregate value scores, and the formulation of micro-economic incentives. Rather its emphasis would shift to engage the public directly as partners and agents of change.

The broad adoption of a more comprehensive, patient-grounded concept of “Value as a verb” can do much to engage the public. In this way, the likelihood of effective healthcare reform can be dramatically increased. And, most importantly, the current work on healthcare reform can lead to better, healthier lives and a healthcare system we all can afford.

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References


GOING “OLD-SCHOOL” TO ACHIEVE THE FULL IMPACT OF SOCIAL MEDIA IN HEALTH

The use of social media for the promotion and sustainability of good health is well known and builds on two well-established trends. The first is that over the past few years individuals have increasingly relied on web-based health information. In the United States alone, 60-80% of adults turn to online information for guidance when making health decisions. As a result, individuals are increasing their awareness of personal health conditions and status.

The second trend is that social media has taken over the world (at least the Western world). With Facebook’s over one billion users and Twitter’s over 300 million active monthly, social media is a potent potential resource for influencing people’s health. Indeed, social media offers a spectrum of highly informative and interactive tools, such as wikis (e.g., Wikicancer), blogs (e.g., SixUntilMe), Twitter (e.g., @goodHealth), Facebook, and other thematic patient networks (e.g., PatientsLikeMe and CureTogether). These social media tools and others allow individuals to not only be better informed, but also communicate signs and symptoms that may be associated with a health risk to other individuals and health professionals.

But, in our fast-evolving world, this is “old news.” Furthermore, even if they facilitate the reporting of disease, it is unclear to what degree web-reported interventions and social media actually help older individuals to improve their health. It also seems that in the race toward online, scalable interventions, we have forgotten the face-to-face human contact and connection that so many of us desire, regardless of our age.

Some technology programmers have attempted to include this desirable personal connection by creating virtual worlds, such as Second Life. Examples of social media tools that promote and support individuals who are investigating more quantifiable self-care rituals are mobile applications (apps). Recently, there has been a surge in the interest of downloading various apps to mobile technologies that motivate individuals to increase their physical activities (e.g., cardiovascular and strengthening exercises) and to maintain a healthy diet and an ideal weight (e.g., MyFitnessPal). These apps have links to Facebook, Twitter, and Google Contacts for those who wish to share personal experiences and motivate others to do the same. They often produce inspiring results and demonstrate the benefits of digital and social health interventions for individuals.

A 2013 publication by Miron-Shatz and colleagues suggests the combination of advanced technology with real-world interventions may yield excellent results and assist individuals in meeting healthy goals. An excellent example of an innovative combination between cutting-edge technology and real-world applications comes from a project funded by the European Commission - the Long Lasting Memories Project (LLMP). It is an effort to outline how technology and social networks can promote and help sustain holistic self-participatory care, specifically, in older citizens. During LLMP trials, interventions were administered to groups of elderly, depending on factors such as time of day, geographic location, and personal preferences. Results obtained so far show strong evidence the entertainment and joy associated with the interaction in a social group impacts the affective state of the user; these, in turn, play a crucial role in the acceptability of a human-computer interactive system, such as memory exercises and an “exergaming platform” – Wii or Nintendo which delivered age-specific physical exercise in a way that felt like play, not like another item on the list of what the doctor prescribed.

Initial analysis of the statistical interaction between the results from an affective survey (i.e., whether the system made users “happier”) and the participant dropout curves confirms there is a relationship between the affect perceived from interaction with the system, the measured system acceptance (or the recorded non-drop-out
system usage), and the joy perceived through social interaction in the group. The latter seemed to be an important factor in the success of the interventions. When the training system is enriched with the “social network” aspect of the intervention, the post-intervention effect is greater. These results suggest the efficacy of digital tools may be enhanced by integrating them with real-time social support systems.

Interestingly, this aforementioned study took place in countries which we associate with a warm sense of community, such as Greece and Spain. The results are an example of how social media and technology may assist in bringing people together in ways that contribute to their overall health and well-being. The “being together” aspect of the study is an example of how the intervention was so much more effective and enjoyable when used in a group of elders.

Evidence shows the main reason for the elderly’s exclusion from information technology (IT) is the misconception that this group is unable or unwilling to use the same IT and communication technologies used by younger people. However, the picture is more complex. Researchers have shown elders living in the United States are “deepening” their use of technology on many levels.\(^\text{5}\) The same report also points to a digital divide, so the less educated and less affluent elderly are less likely to engage digitally or even to perceive the digital realm as available to them. Similarly, digital engagement starts dropping over the age of 75. Practicing together might be a way of drawing people in and helping some benefit from the higher technological skills of others.

Technology, we need to remember, is not the end-goal, but rather the means for improved physical and mental health through interaction with other people and improving one’s communication skills and social life as a whole. Indeed, the exergaming project demonstrates that older users have a high degree of reciprocity and responsiveness, showing the need to communicate, share, and create friendships. This lesson also transfers to younger patients – any intervention which is disguised as fun, and yields added value in the form of social connections, is not only more likely to have greater adherence rates, but may also end up producing social and emotional benefit the old-school way, by bringing people together, and putting a smile on their face.

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References


PARTNERSHIP HOLDS PROMISE OF IMPROVED HEALTH IN SAN ANTONIO

What does it require to improve the health of a population facing significant health challenges? Some will point to medical care or the importance of collaboration among public and private entities. When it comes to these types of unhealthy populations, it's important to also examine types of behaviors that lead to these issues.

Consider San Antonio: ranks 45 out of 50 on the American College of Sport Medicine's (ACSM) 2014 American Fitness Index and has higher per capita rates of obesity (28.9%) and diabetes (11.3%) than the national average (27.6% and 9.7% respectively). Smoking, lack of exercise, low health insurance coverage rates, and a less-than-ideal diet only contribute to the low ranking. In addition, nearly 28 percent of San Antonio area deaths each year are attributed to cardiovascular disease according to the American Heart Association.

We have faced these health challenges firsthand in San Antonio and know them very well. Humana has served the health needs of the San Antonio community for more than 35 years, and today 500,000 people in the San Antonio area use a Humana insurance benefit. For over a year, a team within Humana has been focused on partnering with the San Antonio community to make health easier for local residents; this effort has become known as Project San Antonio.

Given the challenges, we realized a multi-pronged approach to population health, built on a foundation of both new partnerships as well as strengthening existing ones, would be necessary to improve health in San Antonio.

Where We Started
If you want to make an impact in population health, the research literature has demonstrated that a community-based, participatory approach to engagement - reaching out to the local community right from the start - is one key to success. It's not just about getting the right clinical care; it's about making it easy for people to access the resources they need. A comprehensive population health approach also looks at healthy behaviors, nutrition, health literacy, and connectivity.

In order to succeed at making health easier, it takes collaboration with local influencers of health and well-being (all politics are local, as the saying goes), a key first step in addressing these health challenges. We convened a Clinical Town Hall as part of Project San Antonio and made it a priority to secure the participation of San Antonio clinical and community leaders, healthcare providers, and leaders of healthcare organizations in order to move the needle.

The Town Hall – an Exercise in Collaboration
Our first step was to hold a gathering of local community leaders, including SA 2020, Bexar County Medical Society, San Antonio Food Bank, and the Mayor's Fitness Council, among others, to map out an approach to address the health challenges we faced as a collective. We also sought to identify individuals who would be potential long-term partners.

A primary objective was to start a dialogue among these local community leaders about how to make health easier. In advance of the Clinical Town Hall, we hosted a series of focus groups. We discovered an array of great programs offered in San Antonio, but realized greater awareness was needed if these programs were to be optimally effective in improving the population health of San Antonio.

We also surveyed Town Hall attendees – primarily local physicians – about opportunities for collaboration between community programs

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and about barriers to health in San Antonio that community programs didn’t address.

**Steps Taken to Jointly Address the Issues**

After we surveyed these Town Hall attendees, we held a Clinical Town Hall, which brought together community health and well-being leaders with clinicians for two days of discussion, insights, and education. Panel discussions on population health and leveraging well-being resources in the community were highlights of the event, which paved the way for future collaboration.

The event was a prime example of collaboration in action fostered by the engagement from the local community. Those community health and well-being leaders, and a wide assortment of clinicians, stepped up to the plate and actively engaged about ways to make health easier in San Antonio and about how to improve collaboration among local resources.

Feedback after the Town Hall revealed these groups had worked independently for years on how to improve the health of local residents, but they had never come together to explore this level of collaboration.

The ideas and insights shared and the terrific partnership are crucial components to our collective efforts to make health easier for San Antonio. Working alongside public health leaders helps everyone involved achieve our objectives.

**Expanding the Partnership**

To continue the work of the Town Hall, we convened the San Antonio Health Advisory Board (SAHAB), a smaller working group of 26 health and well-being leaders.

The Board is chaired by Dr. Sandra Delgado, Chief Medical Officer for Humana Government Business, with Dr. Peter Wald, the Enterprise Medical Director for USAA, serving as Vice Chair. It was important to us that our Vice Chair was a community leader to make sure the San Antonio community’s needs are at the heart of everything we do. Despite its relatively humble beginnings, the SAHAB has the potential to improve the city’s health for generations to come.

Late last year, the SAHAB convened to solidify the Board’s mission and desired outcomes and to discuss the proposed actions that originated at the Clinical Town Hall. The group is currently pursuing several of these ideas and has established subcommittees to support them:

- **Fit City SA** – partner with San Antonio Parks and Recreation and the Mayor’s Fitness Council to build upon their Fit Pass program and raise awareness through marketing to Humana’s 500,000 members in San Antonio.

- **Community Resource Center** – develop a one-stop-shop for consumers to access health-related community resources (e.g. nutrition, physical activity, social services, transportation, behavioral health, etc.).

- **Diabetes Resource Co-Op** – develop a comprehensive guide for consumers to access diabetes community resources.

- **Data Analytics** – define what success looks like for the SAHAB.

Although early in development, the SAHAB has significant potential for improving the lives of local residents by focusing on resources and conditions that affect the San Antonio community the most.

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*PARTNERSHIP HOLDS PROMISE OF IMPROVED HEALTH IN SAN ANTONIO* continued
We have no doubt that a year from now, probably sooner, we’ll see the needle start to move in the right direction. As with any major initiative, it will take time.

While we have the right people and relationships in place to improve the health of San Antonio, improving population health takes a collaborative effort that is not only steadfast in its resolve, but has the flexibility to adapt and capitalize on new opportunities.

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Penn Center for Innovation - A Culture of Entrepreneurship and Innovation

In May 2014, President Amy Gutmann announced the launch of the Penn Center for Innovation (PCI), a new initiative that provides the infrastructure, leadership, and resources needed to transfer promising Penn inventions, know-how and related assets into the marketplace for the public good. The University’s strategic vision, Penn Compact 2020, revolves around three major concepts: inclusion, innovation, and impact. PCI is the University’s way of achieving two of these three goals at once.

PCI is led by John Swartley, Penn’s Associate Vice Provost for Research. Dr. Swartley has been part of the Center for Technology Transfer’s leadership team since 2007, and oversaw the establishment of the organization’s UPstart Company Formation Program, a groundbreaking new model for University venture creation.

PCI consolidates and unifies the University’s Center for Technology Transfer with other campus organizations devoted to the commercial advancement of University research and development, allowing for a more streamlined experience for Penn researchers and potential business and industry partners. The Center’s website, www.pci.upenn.edu, provides step-by-step instructions and other personalized resources for individuals ranging all the way from student inventors to venture capitalists.

As PCI has become more involved in advancing technologies into the development sphere, it also started to engage more and more in complementary activities, such as new venture creation and corporate partnering around collaboratively sponsored research projects. What is unique is Penn’s decision to combine all those activities into a single organization, to be a one-stop shop for faculty, staff, and students as well as members of the private sector.

Some of the Penn Center for Innovation’s programs and activities, particularly those focused on new venture creation, will be housed at the Pennovation Center, a forthcoming building renovation project that will anchor the research park under development across the river from Penn Medicine. The Pennovation Center will also act as a business incubator and accelerator that will provide lab space and a nexus for...
collaboration, creativity, and the exchange of ideas for innovators from all disciplines.

Other Penn Center for Innovation offices have been established in key locations across campus where innovations are being developed, such as the Perelman School of Medicine and the School of Engineering and Applied Science. This on-the-ground approach is part of the Center’s larger initiative to streamline the client experience for individual researchers who have discoveries or developments that are ripe for commercialization and improve the ability to connect them with potential partners in the private sector.

Since the official launch of PCI nearly a year ago, we have engaged over 1,000 stakeholders during numerous programs and events on and off campus to provide information about our new commercialization strategy and to highlight the opportunities for the private sector to partner with Penn to develop early stage technology. Recent and upcoming highlights include:

- the imminent launch of Penn’s first I-Corp Site Accelerator program, a capsule commercialization curriculum that provides instruction, mentoring and start-up advice for up to thirty faculty-student teams annually
- our recent participation, along with other partners at Penn, in Philly Tech Week, where for the first time, we worked with Quorum at the Science Center to highlight and present innovative and available technologies developed and available from the School of Engineering and School of Arts and Sciences
- a reception and program we hosted in partnership with Wharton San Francisco during the JPMorgan Healthcare Conference in January 2015. Over 100 investors, corporate partners, and Wharton alumni joined us to hear an update from Dr. Carl June on the groundbreaking cancer research he is pursuing in a joint collaboration with Novartis. PCI and Wharton San Francisco are planning another program during the conference in January 2016 - more details to follow in the coming months
- the BIO2015 International Convention, the world’s largest biotechnology industry conference, held in Philadelphia in mid-June. PCI served on the Host Committee and highlighted the commercialization and entrepreneurial activity that has emerged around Penn’s cell and gene therapy research and development.

PCI’s infrastructure has grown along with its new mission. Due to the large portfolio of life sciences research and early-stage discoveries that PCI facilitates into the marketplace, the organization has hired executives with pharmaceutical industry experience to help us achieve our goals. Of note, WHCMAA member Dr. Sarah Frew (WG’11) has joined PCI as Director of Corporate Contracts & Alliances to lead outreach efforts with industry.

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