THE WHARTON
HEALTHCARE QUARTERLY

FALL 2015
VOLUME 4, NUMBER 4

IN EVERY ISSUE

FEATURED ARTICLES

IN UPCOMING ISSUES

Stronger than the Sum of our Parts - Part 3 and Part 4
Partnership Holds Promise of Improved Health in San Antonio - Part 2
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Wharton Healthcare Management Alumni Association
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EDITOR'S LETTER

As we complete another year of the *Wharton Healthcare Quarterly*, it's hard to believe it's been 4 years!

Thanks to our readers, those who have contributed articles, and our sponsors for enabling us to provide what we believe is an eclectic publication with both standing columns as well as feature articles which cover the waterfront of topics in healthcare.

With your help, our plans for 2016 include the following:

- A series called "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*.

- A series called "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 health care landscape. Contact us at *whc_e-magazine@whartonhealthcare.org*.

Z. Colette Edwards, WG'84, MD'85
Managing Editor
To learn more about Colette,
<u>click here</u>.

As was stated in the January 2012 inaugural edition, we hope you will find this offering timely and informative, rich in content, varied in perspective, and highly interactive. Ultimately, we hope it will become a 'go-to' resource and eagerly anticipated 'must read.' Therefore... **we need you to let us know what you think!**

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

CHOOSE ONE

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

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.

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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

THE PRESIDENT'S DESK

On July 29, the Healthcare Management class of '17 began their pre-term at Wharton. I and other alumni joined them for beer at the end of their first day. I walked by two large tour buses on my way into the brew pub in Manayunk and realized visually that the program has more than doubled from the 35 in my class.

I quickly spotted June Kinney, who told me there are 78 amazing students in the class, so I proceeded to meet as many as I could. Beer in hand, I approached the first group of students. After asking about them, one asked me, "What year did you graduate?" I replied, "Class of '88." A foreboding thought began to penetrate my mind. "What year were you born?" I asked. He smiled and nodded gently, understanding my worry. "Yeah, 1988." Ouch. More beer.

John Harris, WG'88
To learn more about John,
click here.

That got me thinking about time. I realized that we as a program are mature enough that our alumni now span 45 years. The most senior members of our association are reaching retirement age. (Ouch. More beer for them.) With careers in every stage, reaching into every corner of the healthcare sector, Wharton's alumni are a force in healthcare.

Recognizing this strength, we are broadening our base. Our alumni association now offers affiliate membership to Wharton alumni in healthcare who did not specifically graduate from the healthcare management program. We are welcoming many new members to the association from Wharton, Wharton Executive MBA, and other University of Pennsylvania graduate programs who have dedicated their careers to the healthcare sector.

I asked one student why he chose Wharton. He responded that Wharton had a better, more substantive healthcare program than other schools. When I asked where else he had looked, he tactfully alluded to "strong business schools in Boston and San Francisco." Go Wharton! Attracting students who are also considering "Boston and San Francisco" is a sign of our strength.

It's clear these students already appreciate the rigor and depth of the healthcare program at Wharton. I know that during the next two years and beyond they will realize they have become part of an amazing community of alumni who will guide them, and to which they will contribute.

John Harris
President
Wharton Health Care Management Alumni Association

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OPEN WIDE: THE EXPECTED, AND THEN THE UNEXPECTED

It was with a sense of obligation, messianic fervor, and a touch of smugness (just a touch) that I attended the WHCMAA and LDI panel discussion in May on "The Philadelphia Story: Transforming Healthcare, Enabling Providers to Manage Risk." The obligation was a self-assumed duty to keep before senior leaders and policy makers the "forgotten" element in health reform, dental health; the messianic fervor was broadly to lay out the market opportunities of properly integrating dental health into overall health reform; and the smugness derived from the sense that this column may be one of the few – if not the only – with a broad professional reach that critically examines the dental health industry and its incorporation, or lack thereof, into wider health policy and health reform trends, employing the education received through the Wharton Healthcare Management Program.

Column Editor: Harris Contos, DMD, WG'80, Asclepius Consulting
To learn more about Harris, click here.

As has been my expectation in attending WHCMAA programs, the panel discussion was intellectually energizing, thought provoking, articulate on current developments in healthcare and what some of the future challenges will be, and just very cutting edge. Panelists, guests, and the moderator were candid in their assessments of what is going right, what isn't, and what is still being tested.

Two broad themes and two derivative ones in the discussion were of particular interest, not only for what they said about the tenor of health reform in general, but also because I was asking myself how dentistry related to this grand undertaking. Jeff Smith laid out the major themes in his introductory remarks: reallocation of risk (among providers, payers, and patients) and change in business models. From the panelists the derivative ones emerged: emphasis on primary care, and "population health management," and while the latter can be variously described (depending on plan membership, geography, socioeconomic status, acute or chronic condition, etc.), I found the best approach to the concept from one of the panelists, Dr. Anthony Coletta of Tandigm Health, from whom I paraphrase, "We want to create health and well-being, we don't want to be just profitable" in "evening out," in bringing more rationality to healthcare.

As I listened to the discussion and the experiences of the panelists about what's involved in "transforming healthcare" – four principle requirements of which were laid out by LDI's Dan Polsky; (1) physician (provider) engagement, (2) organizational structure, (3) data, and (4) culture – I kept contrasting what I was hearing directly from these leaders in healthcare with what I hear and read about in dentistry on an almost daily basis. I was simultaneously exasperated and self-satisfyingly confirmed in my contention that the chasm between what's taking place in healthcare and dentistry grows increasingly wider and deeper.

The very "language" surrounding transformation, and about which panelists and attendees were so conversant, is scarcely heard in dental health policy. Whereas these leaders were concerned with the changing economics of healthcare, seen most starkly in the very rapid shift away from fee-for-service reimbursement and into partially- or fully-assumed risk arrangements, and all that that shift implies throughout an evolving, integrated health system (in other words, completely different ways of delivering care and keeping people out of the hospital and in good health status), the discussion in dental health policy is essentially confined to narrow and shallow calls for greater access for those on the margins of society by one measure or another to a "system" of care predominantly characterized by independent business people trained and financed to perform procedures (volume) rather than being organized and operating under the financial incentives to "create the [dental] health and well-being" of a subscriber

OPEN WIDE: THE EXPECTED, AND THEN THE UNEXPECTED
continued

population (value). Tersely, dental health policy makers would seem to consider their job done if Medicaid were extended to all those currently without dental insurance (putting aside the issue that only a fraction of dentists accept Medicaid anyway), and leaving the existing "system" otherwise untouched.

Thus, whereas profound financial, organizational, managerial, and cultural changes are reshaping the delivery of healthcare to address population health needs effectively, efficiently, and qualitatively ("better, smarter, healthier" in CMS parlance), instead dental policy focuses on using government money to bring underserved populations into an existing and already unresponsive system of care.

With these thoughts in my mind, I needed to ask a question of the panelists to see just how deep the chasm was getting and how far transformation of care was extending, my question essentially being this: "Just how comprehensive is comprehensive care, specifically, is dental care a part of your care network, or is it considered a planet too small and too far off in the healthcare universe to merit exploration, and therefore will dental care always be a subcontractor to what's taking place in healthcare more generally?"

Dr. Susan Williams of Noble Health Alliance was first to respond, with candor, "We don't even think about dental," and Dr. Coletta replied along largely the same lines, except to say that once the "basic blocking and tackling" of transformation now taking place are eventually sorted out, when there is more certainty as to what works and what does not, integrated health systems will be better able to take on dentistry, as well as behavioral health and pediatrics. This is not to castigate Drs. Williams and Coletta, but rather to illustrate that health reform still has gaps in it, is still a work in progress, and that thought leaders will need to push for and schematize the pathways for transformed dental care (and behavioral and pediatric care) in the next iterations of reform.

The responses I received were largely what I had expected, but my purposes were in turn largely accomplished, to get and keep the issue in play among healthcare leaders and observers where it counts, at least eventually. What I had not anticipated was coming across a report from Leavitt Partners about a month after attending the panel discussion titled "Dental Care in Accountable Organizations: Insights from 5 Case Studies." I was simultaneously excited to see that maybe that chasm wasn't so deep and so wide as previously believed, while also somewhat chastened in having to yield (a bit) in my conceit that I was on to something and no one else was.

Well, for the sake of the greater good, the conceit will need to be put aside, to examine what is transpiring here. While a more in-depth discussion on this and related material necessitates closer review and analysis and will have to await a future column, the Leavitt report offered these main findings on the incorporation of dental care into ACOs:

- Some ACOs embrace a "whole health" philosophy of care delivery that assumes the ACO cannot be accountable for a patient's overall health if it does not address oral health needs.

- Payment arrangements vary across organizations. Most of the ACOs studied accept a variation of a capitated payment at the organization level where dental services are carved out of the total capitation.

- The ACOs studied reported some promising results in coordinating dental care with overall medical care and improving patient outcomes.

- Integrating dental care into ACOs presents numerous organizational and technical challenges. Practicing in an ACO may also present cultural challenges to dentists who are not accustomed to practicing in a large group setting or do not have advanced training that allows them to treat varied and complex cases.

OPEN WIDE: THE EXPECTED, AND THEN THE UNEXPECTED
continued

One thing interesting about these findings taken as a whole is that they speak to aspects of a more sophisticated form of delivery than could otherwise be seen in traditional, solo practice, fee-for-service dentistry. In other words, comprehensive, integrated care requires organizational and financial infrastructure in order to be brought about. And most certainly, again as Dan Polsky pointed out, central to the success of a more sophisticated organization will be provider recruitment, organizational structure, data, and culture, which this column has repeatedly stressed are to a great extent incompatible in their traditional composition with the directions and rapid pace of health reform. But as this column has also posited, the rewards of the market are potentially available for those ACOs that can bring dental care into their fold along the lines of the medical care they provide.

So as I examine further what these pioneering ACOs are doing vis-à-vis dental care, maybe the by-word I should begin paying attention to is "expect the unexpected."

Contact Harris at: hcontos@alumni.upenn.edu

THE PHILOSOPHER'S CORNER

Life Lessons:

If I knew then what I know now, I *would have***:**
bet on the people before I bet on the job. Good people can make "average" sounding jobs great, but a job that sounds great with a weak supporting cast, will most likely not end well.

If I knew then what I know now, I *would have***:**
flown solo earlier. Fifteen years into my own management consulting practice, I can attest to the correlation between what I put in and what I get out. There is no place to hide, and once you get the hang of wearing multiple hats, it is quite fun.

If I knew then what I know now, I would *not* **have:**
waited so long to publish my first book, *At My Pace*. The publishing industry need not have been the hurdle that delayed me fifteen years. Going Indie has opened the gates, but I've learned that writing a book is easier than marketing it.

If I knew then what I know now, I would *not* **have:**
been in such a rush to hit professional milestones. The road is long and the twists and turns build character and strength. This lesson became the genesis for At My Pace.

This month's philosopher:
Jill Ebstein, WG 83
To learn more about Jill,
click here.

Favorite Quotes:

1. "It's not what you gather, but what you scatter that tells what kind of life you have lived." ~ Random FB posting

2. "I must be a mermaid. I have no fear of depths and a great fear of shallow living." ~ Anais Nin

3. "What have I learned from my meandering path towards personal and professional fulfillment? That those jobs that seem most glamorous and lucrative take a toll if they rely on a talent you may possess but don't enjoy. That it can take decades to realize you have a unique, marketable skill that they don't teach in college." ~ Ellen Morton, *At My Pace*

Recommended Reading:

- *To Sell is Human* by Daniel H. Pink
- *Predictably Irrational* by Dan Ariely
- *At My Pace* by Jill Ebstein
  Website: www.atmypacebook.com

Contact Jill at: atmypacebook@gmail.com

Column Editor:
Z. Colette Edwards, WG'84, MD'85

To learn more about Colette,
click here.

ALUMNI NEWS

Divya Dhar, WG'14
Dr. Divya Dhar has launched Healthier with fellow classmate Lane Rettig. Healthier enables parents to connect with pediatricians 24/7 and get a response within 24 hours for free, or pay $15 per month and get an instant response. Healthier has hundreds of users within a couple of months of launch and is excited to be helping our kids stay healthy and happy.

Contact Divya at:
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Learn more.

Julian Harris, MD'08, WG'08
Julian Harris, MD, MBA is now a Fellow at Harvard's Kennedy School of Government. Previously, he served as the Associate Director for Health in the White House Office of Management and Budget (OMB). As the federal government's chief health care budget official, he provided budget, policy, management, and regulatory oversight for $1 trillion in spending on a range of federal coverage programs including Medicare, Medicaid, Marketplaces, the CMS Innovation Center, and FEHB and for several federal health agencies, including CMS, ONC, FDA, NIH, and CDC.

Dr. Harris was a major catalyst within the Administration for accelerating payment reform efforts and led the policy processes on repealing the SGR, extending CHIP, and a broader array of Medicare and Medicaid benefit redesign and provider and plan payment reforms featured in the President's budget. In addition to his health policy and budget expertise, Julian provided strategic and operational leadership to OMB's engagement with agencies on initiatives as diverse as implementing the Affordable Care Act and starting up the President's Precision Medicine Initiative.

Previously, he served as Medicaid Director in Massachusetts, overseeing policy, operations, strategy, and finance as CEO of an $11 billion public insurer that provided health coverage for 1.4 million members. During his tenure, MA became the first state to develop an integrated model of managed care delivery and financing for dual Medicare-Medicaid members with CMS. Dr. Harris has supported and led payment and delivery system reform and public health projects in the U.S. and abroad for other public and private sector organizations including the World Bank, Harvard School of Public Health, and McKinsey & Company. He trained in internal medicine and primary care at Harvard's Brigham & Women's Hospital. A Rhodes Scholar, he graduated with a B.A. from Duke and a M.Sc. from Oxford. Dr. Harris is also a graduate of Wharton and the School of Medicine at the University of Pennsylvania.

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ALUMNI NEWS

Sandip Agarwala, SEAS'01, WG'07
Longitude Capital, a private investment firm that focuses on venture growth investments in drug development and medical technology, has promoted Sandip Agarwala to Managing Director. Sandip joined Longitude in 2013 and focuses on structured investments in both biotechnology and medical device companies. He was responsible for the creation of the firm's royalty investment vehicle, CrownWheel Partners, and led the firm's investments in multiple royalty transactions, assembling a diversified portfolio of healthcare revenue interests. Looking forward, he will continue to lead Longitude's royalty investment strategy, and focus on venture capital and growth equity investments in pharmaceutical/biotechnology companies.

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www.longitudecapital.com

www.crownwheelpartners.com

ALUMNI NEWS   *continued*

Anne Sissel, WG'05
Anne Sissel, Managing Director of Baxter Ventures, was named to the 2015 Crain's *Chicago Business Tech50 List* http://bit.ly/1VkWMDO.

Contact Anne at:
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Learn more.

Keith A. Goldan, WG '02
In March, I was named Senior Vice President and CFO of Fibrocell (NASDAQ: FCSC), a biotechnology company focused on developing first-in-class treatments for rare and serious skin and connective tissue diseases leveraging its autologous cell and gene therapy platform. Our most advanced drug candidate, azficel-T, uses our FDA-approved proprietary autologous fibroblast technology and is in a Phase II clinical trial for the treatment of chronic dysphonia resulting from vocal cord scarring. Dysphonia is caused by damage to the fibroblast layer of the vocal cords causing scarring and edema which limits airflow and results in severe and significant limitations in voice quality, including, in some cases, the loss of voice, altogether.

Fibrocell's lead orphan gene therapy candidate, FCX-007, is in late stage pre-clinical development for the treatment of recessive dystrophic epidermolysis bullosa ("RDEB"). RDEB is a devastating, rare, congenital, painful, progressive blistering skin disease that ultimately leads to premature death.

We are also in pre-clinical development of our second gene therapy candidate, FCX-013, for the treatment of linear scleroderma. Linear scleroderma is an excess production of extracellular matrix characterized by skin fibrosis and linear scars. The linear areas of skin thickening may extend to underlying tissue and muscle in children which may impair growth in affected legs and arms or forehead. Lesions appearing across joints can impair motion and may be permanent.

Learn more.

Sam and Sara Schwerin, WG'99
Sam (WG'99) and Sara Schwerin (WG'99) are happy to report that they finally escaped NYC and moved to Big Sky country (Bozeman, MT) with their two children. Sam continues to manage Millennium Technology Value Partners with Max Chee (WG '99) and Sara manages everything else. Visitors are welcome and expected!

ALUMNI NEWS

Jana L. Sanford (formerly Furda), SEAS'86, BSE and WG'91

A few years ago, after 20+ years in managed care strategy focused on Medicare managed care and cost analytics and helping build, run, and sell a Medicare managed care software company, I left the corporate world and started my own fitness solutions business. CoreFitnessByJana provides online, mobile app, and licensed video portable fitness solutions for busy, time-constrained individuals, corporate wellness programs, and hotel in-room fitness. The focus of my business is to make exercise easy, accessible, and affordable and more recently to help combat the health scourge of sedentary behavior, i.e., prolonged sitting. This past year I launched my first mobile app, "Got A Minute For Your Health," available on the iTunes app store, which delivers 1-minute in-office exercises to get people up and moving during the work day. As fellow alum who share a concern for the health and well-being of this country, I would love for you to download and rate the free app and welcome all feedback. For more on my business and my "Got A Minute For Your Health" solutions, see the links provided.

Contact Jana at:
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Got A Minute Mobile App

http://corefitnessbyjana.com/wordpress/

http://corefitnessbyjana.com/wordpress/about/corporate-health-wellness-programs/

http://www.corefitness-ny.com/flipbook-gotaminute/

Beth Somers Stutzman, WG'85

As a Trustee of a College Preparatory School, I was honored and delighted to don my university regalia and remember my days at The Wharton Business School as I participated in the graduation ceremony of the Class of 2015!

Why did I have this pleasure? As an Elected Trustee, I was part of the processional, led the opening prayer and, best of all, personally handed my daughter, Emily, her diploma. It was a gift on many levels! Emily graduated with high honors and will be attending Dickinson College in Carlisle, PA to major in French and International Business. For me, it brought back invaluable memories of my educational path and the friends I have made; my professional healthcare achievements and my tenure on the WHCMAA Board; and the opportunity to make a difference at an educational institution!

It was great to participate in my Wharton reunion in May 2015, The Wharton Annual Health Care Alumni Leadership Conference this past year, and the Leadership Dinner for the new June Kinney Alumni Scholarship. Hope to see many of you again this year!

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ALUMNI NEWS

Jill Gardenswartz Ebstein, WG'83

Jill has published a book, titled *At My Pace*, which is a collection of thirty-six essays that describe the twists and turns, starts and stops of ordinary women as they seek personal fulfillment. The goal is to expand the conversation that was ignited by "lean in" and to show a range of inspirations and aspirations that drive these contributors. Meet:

- a pioneering sports reporter who finds meaning in adopting her Chinese daughter;
- a graphic designer whose life implodes during the dot com bust;
- a mom with young children who has fallen off the corporate ladder and remakes an integrated life of work and family;
- an attorney who realizes her passion in writing and begins an online magazine ...

These stories and more, from women in their mid-thirties to early eighties — with equally broad interests and life circumstances — will inspire, amuse, and expand the conversation about the various paths women choose. *At My Pace* celebrates our individual choices with refreshing candor and wisdom.

The book has received coverage in the *Chicago Tribune* and the *Boston Globe*.

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www.atmypacebook.com
www.sizedrightmarketing.com

Keith F. Safian, WG'74

Keith Safian completed a very successful 25 year tenure as President and CEO of Phelps Memorial Hospital when it merged into New York's largest health system – North Shore-LIJ, assuring the hospital's future success.

He started his own firm, Safian & Company, LLC, which advises organizations adapting to or taking advantage of the changing landscape in healthcare, providing senior advisory services with a focus on strategic growth, financial and operational performance, and quality of care. Potential clients include:

- private equity firms investing in the healthcare sector and/or expanding their portfolio of healthcare companies and those that want to grow their current investment
- corporations seeking senior advisors with an expertise in healthcare and Board members who can provide strategic counsel on audits, by-laws, compliance, executive and physician compensation, employee benefits and healthcare, and finance and budgets
- hospitals seeking a quick turnaround and/or faster growth, joining health systems, considering a merger, integrating physician practices or additional hospitals
- medical groups joining others or considering concierge practices
- healthcare IT companies seeking high-level and operational knowledge
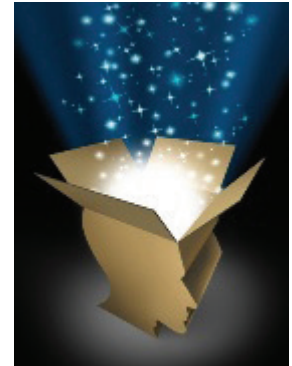- healthcare start-ups seeking strategic advice, industry connections, and vetted resources

Contact Keith at:
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Learn more.

NOT A FREUDIAN SLIP: GENDER DIFFERENCES THAT SHAPE OUR ABILITY TO EMOTIONALLY THRIVE – PART 4

This four part series began by introducing the biopsychosocial (BPS) model as a means by which we explore the factors that determine emotional health and well-being (Part 1). Specifically, we examine how men and women are influenced by biological, social, and psychological factors, and how these influences drive beliefs and perceptions. These beliefs or perceptions directly influence behavioral choice, including those behavioral choices that can prevent or mitigate depression, anxiety, and stress.[i]

The interactions between sex (i.e., biological factors) and gender (i.e., socially-constructed factors) produce differential risks for ill health, differences in help-seeking behavior,[ii] and markedly different health outcomes.[iii] Despite these seemingly transparent differences, both research and treatment methods have failed to adequately tailor to the specific health needs of men and women.[iii] Understanding the social, biological, and psychological context of gender is vital to developing an intervention that works, one that takes the lived experience of the individual, meets that person where they are, and moves them forward on the path to well-being.

In Part 2 and Part 3 of this series, we explored the differences that exist between males and females, both biologically and socially, and how these differences affect mental health. In Part 2 we explored the biological arm of the biopsychosocial (BPS) model and reviewed the innate biological differences between the sexes. By observing health and well-being from the social component of the BPS model in Part 3, we discovered how economic standing, personal belief systems, cultural norms and gender stereotypes influence health disparities and place women at greater risk of depression, stress, and anxiety.[iv]

Biology and broad social norms play an important role in shaping an individual's health, wellness, and personal well-being. However, these two key influences do not paint a complete picture; one major influence remains — the psychology of the person. What people believe and their psychological make-up shape how they experience daily life and ultimately influence their individual health behavior choices.

The aim of the final article in this series is to explore the impact of gender on human psychology and how this dimension works in tandem with biological and social factors to impact our emotional health and well-being. This meaningful exploration provides insights on how to respond to the unique challenges faced by each gender in a person-centric, tailored way across the biological, social, and psychological dimensions to have greater impact on a person's well-being.

Psychology is the study of the mind and behavior, including "all aspects of the human experience – from the functions of the brain to the actions of nations, from child development to care for the aged."[v] Both biology (e.g., the chemical and mechanical workings of the brain) and social influences (e.g., society, intergenerational pressure, and cultural stereotypes) contribute to an individual's psychology – the lived experience of the individual that influences how a person reacts to daily situations. As the biological and social influences manifest differently for men and women, it is not surprising that individual psychology is also shaped by gender. One area in which these psychological gender differences are more obvious is in measures of health around stress, anxiety, depression, and some physical illnesses such as heart disease or cancer.[vi,vii,viii]

Contributors:
Connie Mester, MPH, Kelly Earp, PhD, MA, Katherine Sullivan, B.S., and Jennifer Platt, DrPH, MSPH

To learn more about Connie, Kelly, Katherine & Jennifer, click here.

NOT A FREUDIAN SLIP: GENDER DIFFERENCES THAT SHAPE OUR ABILITY TO EMOTIONALLY THRIVE – PART 4 *continued*

Overall, prevalence for any mental health condition is similar for men and women; however, the prevalence of different types of mental health disorders varies greatly across gender.[iii] Men are more likely to experience substance abuse, while women far outweigh men in prevalence of depression, anxiety, and eating disorders.[iv] Some under-reporting may exist for men, as they are less likely to seek help for health challenges, particularly mental health problems;[ix] further, men present differently than women, and the symptoms may go unrecognized.[x] That said, it is difficult to speculate on whether increased help-seeking for men would lessen the observed gender gap for some mental health conditions. Even if some adjustment occurred, it is unlikely the gap would be fully eliminated, as other social (e.g., poverty, domestic violence, living with partners with substance abuse disorders)[iii] and biological factors (e.g., hormonal changes at puberty, genetic factors)[xi] also contribute to a context for women to experience more mental health challenges.

While there is no exact answer as to why there are such considerable gender differences in rates of mental health disorders, it is possible the unique way in which men and women process certain life events — their individual psychology — may also influence their health in a gender-specific way. Men and women often cope with stressors differently, where biology and social constructs influence psychological coping styles.

Coping is generally defined as a person's "cognitive and behavioral efforts to manage (reduce, minimize, master, or tolerate) the external demands of the person-environment transaction that is appraised as taxing or exceeding the resources of the person."[xii] The act of coping encompasses the cognitive and behavioral strategies that an individual uses to manage stressful situations and the negative emotional reactions that come from such events.[xiii] These coping mechanisms typically fall within two major groups: emotion-focused and problem-focused.

Gendered psychological coping preferences are clearly influenced by the biological and social influences present within the biopsychosocial model. Women tend to utilize emotion-focused coping strategies to a greater extent than men, while men tend to enact problem-focused coping in stressful situations.[vii,xiv,xv] Biologically, females are more likely to "tend and befriend;" this tendency towards support and intimacy, coupled with difficulty engaging in problem-solving responses, influences women to be more emotion-focused in their coping style.[xvi] Socially, broad socialization patterns also have an impact on coping preference. The traditional "female" gender role is attributed as dependent, seeking affiliation, emotional, a lack of assertiveness, and being subordinate to the needs of others.[vii] These influences align more closely with emotion-focused coping strategies.

Males are biologically more likely to express aggressive behavior due to hormones such as testosterone, and are more likely to react to a stressor in a "fight or flight" way, attacking the problem at hand using a problem-focused coping mechanism.[xvii] Further, men have traditionally been socially ascribed with certain attributes such as autonomy, self-confidence, assertiveness, instrumentality, and being goal-oriented.[vii] Taken together, these influences and expectations predispose men to utilize problem-focused coping strategies more easily.[xiv]

Interestingly, the different styles of coping can explain some of the differences in mental health found across genders. This tendency toward emotion-focused coping may provide insight into why women experience a higher burden of depression, anxiety, and stress. Further, depression can lead to more stress and dysfunction, worsening both the affected person's life situation and the level of depression present. When we consider all the areas in which gender inequality can occur in a woman's everyday life, it comes as no surprise that a woman's emotional health and well-being may be negatively impacted by gender norms. As women must work harder to overcome stereotypes about gender differences, the emotional stresses faced are great and may account for the higher rates of depression, anxiety, stress, and other common mental health disorders reported as compared to men.[xviii]

NOT A FREUDIAN SLIP: GENDER DIFFERENCES THAT SHAPE OUR ABILITY TO EMOTIONALLY THRIVE – PART 4 *continued*

To support both men and women in preventing or mitigating depression, anxiety, or stress, it is important to consider all the factors of the biopsychosocial model and the unique set of circumstances of the individual. The biological and social dimensions of health and well-being, combined with the perspective of individual psychology, can initiate new understandings of and new pathways to overall well-being. The consequences of failing to take these differences into account across healthcare are grave, especially in the field of mental health.

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AFFIDAVIT: HEALTHCARE AND THE LAW - DO YOU SUFFICIENTLY UNDERSTAND HEALTHCARE FRAUD AND ABUSE LAWS?

Introduction

Anyone entering the healthcare industry as an investor or entrepreneur should be aware that certain compensation arrangements and other business practices that are common in other industries may be illegal in the healthcare industry. The body of law governing these restrictions generally is referred to as "healthcare fraud and abuse laws."

But what exactly are "healthcare fraud and abuse laws?" You may have heard that fraud and abuse compliance involves the "Stark Law" and the "Anti-kickback Statute." True, but do you understand the difference between them and know what conduct and arrangements these laws prohibit and permit? Or, what other laws fall under the "healthcare fraud and abuse" umbrella? You may have heard that, generally, when the federal government covers items for services to Medicare and Medicaid beneficiaries, the federal fraud and abuse laws apply, but did you know that compliance may be required with respect to commercial insurers as well? Did you know that these laws also prohibit certain patient inducements, false claims, product sampling, certain third-party ownership, conflicts of interests and other arrangements and practices? Did you know that a change in circumstances and passage of time could render out of compliance with fraud and abuse requirements an arrangement that was initially in full compliance? Below is a general discussion of the primary federal healthcare fraud and abuse laws and compliance areas.

Federal Healthcare Fraud and Abuse Laws

False Claims Act

First, you should understand that under the False Claims Act (FCA) it is illegal to submit claims for payment to Medicare, Medicaid, or other federally funded programs that you know or should know will be considered false or fraudulent. Because specific intent to defraud is not a required element under the FCA, violations under the FCA can be inadvertent. For example, if your business submits a Medicare claim for reimbursement of healthcare-related services involving a "kickback" or in violation of the Stark Law (each discussed below), that may render it false or fraudulent under the FCA. Improper billing, such as "upcoding" or billing for services rendered improperly or not medically necessary, also can be a basis for a violation.

Each instance of an item or a service billed to Medicare or Medicaid counts as a "claim," so fines can add up quickly. Furthermore, the FCA contains a whistleblower provision that allows a private individual (such as current or former business partners, staff, patients, and even competitors) to initiate a lawsuit under the FCA.

Anti-Kickback Statute

The federal Anti-Kickback Statute (AKS) makes it a crime to "knowingly and willfully" offer or receive "remuneration" (i.e., anything of value) to induce or reward patient referrals or the generation of business involving any item or service payable by any federal healthcare program. The AKS's prohibitions apply to both providers of kickbacks as well as the recipients, and it has been interpreted by the courts to apply to any arrangement where even just one purpose of the "remuneration" was to obtain compensation for the referral of services or to induce further referrals. The AKS is violated even if there is no patient harm or financial loss to Medicare. So, for example, if your affiliated business takes money or gifts from a

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AFFIDAVIT: HEALTHCARE AND THE LAW - DO YOU SUFFICIENTLY UNDERSTAND HEALTHCARE FRAUD AND ABUSE LAWS? *continued*

drug or device company or a durable medical equipment supplier for a referral, it is an illegal kickback even if the drug would have been prescribed or the wheelchair would have been ordered even without a kickback. Fortunately, if you are considering a potential investment or compensation arrangement, an experienced healthcare attorney can guide you to take advantage of one of numerous "safe harbors" that the law and regulations establish to shield certain compensation arrangements and business practices that present a minimal risk of fraud and abuse, such as fair market value leases, management services, employment arrangements and certain investments, among others.

Beneficiary Inducement Statute
In addition to the AKS's prohibitions on kickbacks, the Beneficiary Inducement Statute also imposes civil monetary penalties on providers of healthcare services or items who offer anything of value to Medicare or Medicaid beneficiaries to influence them to use such provider's services or items. Offering substantial samples, for instance, may be deemed to be an inducement.

Civil Monetary Penalties Law
The Civil Monetary Penalties Law (CMPL) provides the OIG power and authority to seek civil monetary penalties for a wide variety of conduct in the amount ranging from $10,000 to $50,000 per violation, depending on the type of the underlying violation. Examples of actionable CMPL violations include:

- presenting a claim that is false, fraudulent, or for an item or services not provided as claimed or for which payment may not be made, such as in violation of the AKS;

- violating the Medicare assignment provisions;

- providing false or misleading information expected to influence a decision to discharge; and

- making false statements on applications or contracts to participate in the federal healthcare programs.

Physician Self-Referral Law
The Physician Self-Referral Law (commonly referred to as the "Stark Law") prohibits physicians from referring patients to receive certain enumerated "designated health services" (DHS) payable by Medicare or Medicaid from entities with which the physician or the physician's "immediate family member" has a "financial relationship," unless one of the enumerated exceptions applies. A prohibited financial relationship can include both ownership and investment interests as well as compensation arrangements. The Stark Law categorically prohibits the submission (or causing of the submission) of claims in violation of the Stark Law's restrictions on referrals. Although, unlike the AKS (which could apply to any person), the Stark Law applies only to physicians; non-physicians (including non-physician entrepreneurs and investors) seeking to associate or work with physicians should be aware of the Stark Law due to the significant limitations it could impose on a physician's ability to generate business for the proposed venture.

Conflicts of Interest/Code of Conduct
In the realm of healthcare, even where a financial interest or another arrangement is not necessarily prohibited by law, relationships among industry (such as pharmaceutical, medical device and biotechnology companies), healthcare providers, and controlling persons and decision-makers present a risk of negatively impacting the interested person's judgment with respect to patient care and could lead to overutilization of, and increased costs to, the healthcare program, patient steering, and unfair competition. Therefore, businesses and organizations that provide healthcare services should establish and adhere to rigorous conflict of interest policies that require healthcare providers,

AFFIDAVIT: HEALTHCARE AND THE LAW - DO YOU SUFFICIENTLY UNDERSTAND HEALTHCARE FRAUD AND ABUSE LAWS? *continued*

controlling persons, and other decision-makers to disclose financial interests and outside activities.

In summary, healthcare fraud and abuse laws are complex and often require legal analysis that is specific to each particular situation and proposed arrangement. Don't shy away from asking for legal assistance to review each arrangement that implicates these laws, and avoid legal issues down the road.

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STRONGER THAN THE SUM OF OUR PARTS: INTRODUCTION AND PRINCIPLES OF EFFECTIVE INTERPROFESSIONAL COLLABORATION IN HEALTHCARE – PART 2

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 second of four about actionable practices for effective interprofessional collaboration. In the first piece*, we established the case for improving 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 the importance of demonstrating leadership commitment to interprofessional collaboration as an organizational priority through words and actions. We will explore the significance of this commitment here, how it plays out, and ideas for implementation.

Why is this practice important?
In the investigations that contributed to the RWJF report, we found that partnership among clinical leadership at all levels was essential to each site's ability to focus on interprofessional collaboration. As always, top leadership sets the tone for their organization: the buy-in of this tier was key to achieving results. *Talking* about interprofessional collaboration is important, but people need to see it in action to understand what collaboration really means, and that it is an organizational commitment.

What does this practice look like in action?
Each of the chief medical officer (CMO) and chief nursing officer (CNO) pairs we met demonstrated a strong interpersonal relationship. In many cases, their offices were located next to each other, creating frequent access to each other, in addition to the regular interaction established in formal, standing meetings. Stan Ashley, MD, CMO, and Jackie Somerville, PhD, RN, Senior Vice President for Patient Care Services and CNO at Brigham and Women's Hospital, have neighboring offices. Somerville told us, "We both report to the president. We have offices right next to each other. We co-chair committees. These things send a strong message to the organization about the value of collaboration."

These pairs work through issues behind closed doors in order to ensure they represent a unified front in public. Cincinnati Children's Hospital Medical Center's Cheryl Hoying, PhD, RN, NEA-BC, FACHE, FAAN, Senior Vice President of Patient Services, and Arnie Strauss, MD, former CMO, explained their ability to model interprofessional collaboration by "understanding a common goal and rounding together, so the whole organization sees that we're together."

Additionally, incentives that promote interprofessional collaboration can also play an important role. Many of the people we interviewed share performance incentives for which they have mutual accountability in meeting shared goals and objectives together. Intermountain Healthcare requires that each clinical program establish Board goals to which compensation is tied. Therefore, Kim Henrichsen, RN, MSN, Vice President of Clinical Operations and CNO, and Brent Wallace, MD, CMO, have shared Board goals that require collaboration to achieve.

Leadership commitment is also apparent in whom leaders seek to hire. The right type of person can be difficult to find, and organizations have their own processes for hiring for cultural fit. At Community Health Centers, Inc., a statewide primary healthcare system in Connecticut, Mark Masselli, the founder and CEO, and Margaret Flinter, APRN, PhD, the Senior Vice President and

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STRONGER THAN THE SUM OF OUR PARTS: INTRODUCTION AND PRINCIPLES OF EFFECTIVE INTERPROFESSIONAL COLLABORATION IN HEALTHCARE – PART 2 *continued*

Clinical Director, insist on interviewing every new candidate. Flinter explained, "Interdisciplinary has to be embedded from day one. It's in our interview process. We need to ask candidates about their experience, comfort level, and thoughts about providing care in this way, because it's embedded in the regular flow of work. You don't stop your day to be interdisciplinary, that's how it becomes a part of the culture."

The following case example describes alignment of top leadership at the organizational level.

Case: Demonstrating Leadership Commitment
University of Pennsylvania Health System's (UPHS) CMO/CNO Alliance

In 2006, the CMOs and CNOs of UPHS began to meet regularly to create a shared voice for patient safety. This work resulted in the Blueprint for Quality and Patient Safety, the system's framework for clinical strategy, now undergoing its third refresh. The Blueprint established physician- and nurse-sponsored goals and created a vehicle for shared budgeting. Nurses and physicians no longer compete for resources to advance quality and safety work, but collaborate in a way that enables them to negotiate with their fiscal partners with a united clinical voice.

During CFAR's site visit to UPHS, we had the opportunity to observe a meeting of the CMO/CNO Alliance. The group is a working alliance of the CMOs and CNOs from UPHS' four hospitals, as well as the home care, rehabilitation, and physician practice departments. P.J. Brennan, MD, CMO at UPHS, and Regina Cunningham, PhD, RN, AOCN, Chief Nursing Executive and Associate Executive Director of the Hospital of the University of Pennsylvania, co-chaired the meeting, during which ideas flowed freely, and the group showed a high level of comfort with each other.

Within UPHS' CMO/CNO Alliance, CMOs and CNOs model interprofessional collaboration for those who report to them, and also come together to accomplish real work.

What are some ideas for implementation?
Every site echoed the shared message that collaboration starts at the top. Senior leaders have to believe in it, model it, and live it. Here is a summary of the key practices described above.

1. Create **visible partnerships**, particularly at the senior leadership level.
2. Discuss and debate issues in private, but **speak with a shared and equal voice in public**.
3. **Embed goals into the strategic plan** and **tie them to the performance incentives** of key leaders and influencers.
4. Demonstrate a commitment to collaborative partnerships through **recruiting and onboarding processes.**
5. Identify champions to serve as **role models of collaboration** throughout the organization.
6. Create **interprofessional alliances and groups** that can tackle existing work in new ways.

In the following articles 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.

WHARTON AROUND THE GLOBE: CREATING MEDICAL DEVICES TAILORED FOR THE EMERGING MARKETS

Penetrating the untapped potential of the Emerging Markets (EM) is a hot topic in the medical device industry, but the winning formula for accessing these markets is yet to be found. Companies have been using multiple strategies including organic initiatives, M&A, joint ventures, new channel models and more.

We (the authors) have been working on penetrating the EM for the past 3-4 years. An important part of our strategy is creating products tailored to EM customers' needs. In this article, our goal is to share insights we gleaned along the way.

We'd like to share three main ideas. First, how to learn about EM customers and their specific needs. Second, thoughts on creating an organization that can effectively execute on this strategy. Lastly, describe how the success of these products depends on market development and the lessons we learned.

1. The EM customer needs, and how you can know them better

It is obvious you should know your customers and their needs before creating products for them. However, the recipes and experiences from developed markets (US and Western Europe) are less useful because of the significant differences in customer needs and expectations. Classic misconceptions are: a) the needs are highly similar between developed and emerging markets or b) the underserved in emerging markets simply want cheap/old/"dumbed-down" products.

From our experience, EM customers are some of the savviest in the medical device industry. It is true they are more cost-sensitive in many cases, and the stakes are higher for their patients: a customer can face the dilemma of needing to decide between buying a pacemaker for their parent or buying a new home. But this does not mean they are willing to accept less than excellent healthcare. A stripped-down version of a US product will typically end up as an inferior product with poor market performance.

EM customers are not only price sensitive, but also value sensitive. They demand the best service/product at the price point they can afford. To meet this requirement, you have to know exactly what the customer needs (and what the customer does NOT need), and thus deliver the best possible performance for the affordability at hand to meet their definition of value.

How can you learn the EM customers' needs? We have found that solving for EM needs from the US doesn't work. An early painful experience was from a particular device that was designed: US-based engineers thought "What's $1-2 more USD COGS (cost-of-goods-sold) per procedure?" while in the Indian market segment we targeted, that difference was more than the daily salary. Thus, our advice is:

a. Have at least some marketers and engineers based in the EM countries, assimilated into the local market, and attuned to customer needs by collaborating with and constantly visiting local customers.

b. Visit different customers in different EM countries. Needs in China and India could be as different as needs in China and the US or they could be very similar, which has an impact on both R&D and your go-to-market approach.

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WHARTON AROUND THE GLOBE: CREATING MEDICAL DEVICES TAILORED FOR THE EMERGING MARKETS *continued*

2. Build a separate organization serving the EM, with a separate R&D budget.
Companies tend to look after their current main revenue sources. Typically, those are predominately from the US, Europe, and Japan. While managers realize future growth would be coming from the EM, this is not translated well into strategy and actions. New products' features are constantly skewed towards developed world needs, while EM-focused products tend to get pushed down because near-term revenues are not as lucrative. EM markets might have higher growth but at a lower base, which makes it difficult to garner mind share in organizations with an important base business to maintain.

Another key problem: companies are (sometimes rightfully) terrified of cannibalization, while in the EM cannibalizing $1MM revenue may mean $50MM in new revenue growth. To develop products for the EM, a different mindset is needed.

Therefore, we believe a separate organization that focuses on the EM is a good idea. There are many ways to structure such an organization, but the keys are having a dedicated R&D budget for EM products and dedicated people in both marketing and R&D who focus solely on the EM products' success.

Such a structure also allows enables:

 a. a healthy tension between cannibalization and focus on growth

 b. a willingness to try and fail quickly; As the EMs are complex but move at a fast pace, an organization focused on the EM should be willing to make more mistakes but adjust quickly. If you have the right people and allow them appropriate flexibility, those bets should pay off.

There is no reason to start all activities from scratch. The main challenge is to share the knowledge and experience from the global business to the newly founded EM team. Consequently, incentives and support from senior leaders are important in creating a collaborative environment.

In our case, it took over two years to create an effective organization that shares knowledge and has little to no redundancy in new product initiatives. Both EM and US-based teams had to learn to work together, trust one another, and figure out what the key competencies were that resided in each organization. This collaboration was formed through mutual visits and high-level reviews of the portfolio of initiatives (POI) within both teams. We have found that sometimes the EM team can 'outsource' highly specialized tasks to the global team, which also enhances collaboration.

Naturally, issues such as IP protection and loss of key leaders overseas to competition are legitimate issues that the organization needs to address when forming such an organization.

3. It is about market development, not only about products.
In the developed world, companies are used to playing on familiar ground and competing for market share. In the Emerging Markets, the name of the game is market development.

Ask yourself: "Why aren't the therapies from the US catching on in the EM? Is there a different clinical need, or maybe there are barriers stopping adoption?"

Good EM products remove barriers. They enable healthcare professionals to utilize a technology they wished to use, but could not, due to cost, size, slightly different patient anatomy, training, and more. One project we launched provides 90%+ of its revenues from removing barriers of adoption for a currently available technology, rather than revenue coming directly from sales of this specific product.

WHARTON AROUND THE GLOBE: CREATING MEDICAL DEVICES TAILORED FOR THE EMERGING MARKETS *continued*

Moreover, successful products are also accompanied with non-product initiatives on training, reimbursement, channel expansion, business models, etc., which further help remove barriers. Think about internal obstacles as well. "Can my sales force sell this technology or do I need further training? Are self-imposed internal rules on margins or logistics stopping me?"

We have found this approach crucial, but must admit it is probably the greatest barrier for us and perhaps the industry. Shifting an organization mindset from products to solutions (product + non-product) can be a challenge when there is no existing model to follow. Much more can be done on training, business models innovation, and reimbursement strategy. As we move forward, this aspect will probably be the most important for our success.

It is only the beginning.
The insights mentioned are based on over 10 projects undertaken in our organization to address Emerging Markets' needs. We think creating products for the EM will continue to be an important driver to expand presence in those markets, but there is much more to learn on how to do this right. We are only at the beginning of this journey.

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TRANSFORMATION: A VIEW FROM THE INSIDE

Transformation is an increasingly entrenched buzzword in the healthcare industry – and few doubt the need for the transformative improvements required to achieve the triple aim of quality, cost, and patient experience. The *Wharton Healthcare Quarterly* wanted to get behind the scenes on *what truly drives results* for these ambitious undertakings. Drawing on a ringside seat and the opportunity to contribute to multiple successful transformations (including at Evolent Health and Geisinger Health System), this article focuses on the factors that, at least in the author's experience, have made the biggest difference: a core strategic vision, early results, and leadership culture. Sounds straightforward? Not really. Most interesting is the way these particular drivers play out in practice to lead to success.

Transformational Strategic Vision
A transformational core strategic vision is essential for two reasons: to rally the organization around a fixed goal <u>and</u> provide a counter-narrative to status quo thinking that often is more closely aligned with short-term financial maximization. Winning the battle between the short term and the long term is a defining feature of successful transformation.

The Core Strategic Vision that has driven Evolent Health's success is that *the complex transition to value-based health requires a payer-agnostic, integrated clinical and technology solution*. Much of the early health system transition to value has focused on targeted piloted initiatives and the acquisition of point solutions, especially for analytics. These efforts have had a hard time driving results commensurate with investment and become frayed when forced to deliver against large-scale contracts. The true early pioneers in value, e.g., Kaiser, were highly integrated operations. The next generation will need to take advantage of the advances in IT and analytics to create a seamless population health management capability in non-integrated operational settings.

For example, clinical programs need to be driven by highly specific and sensitive stratification to avoid the costly physician and care management expense of focusing on the wrong patients. This stratification needs to be highly integrated with both the structured delivery of care management and the physician workflow so pressed clinicians are not toggling across multiple platforms with inefficient workflow to eke out population health gains. Finally, the population health work must be integrated back into the analytic engine to create a continuous improvement cycle driving the stratification of the most "impactable" patients into the most effective workflows. While it may be initially cheaper to bolt on an analytics solution or tinker with workflows though EMR optimization, it is impossible to secure the highest population health clinical and business impact on health system business cases, with often over $500 million to a billion in top line medical expense risk, without the more integrated approach. This core philosophy has enabled Evolent to rapidly expand in its four-year history from start-up to operating in 9 states across Medicare Advantage, MSSP, Commercial, Exchange, Medicaid, and Self Insured Populations.

Throughout its history Geisinger has been an integrated health plan, clinic, and health system with a degree of national recognition. Its multiple business arms and leadership have enabled it to broadly impact the national healthcare policy landscape with the straightforward belief that *improving quality will reduce excess healthcare costs*. With its execution of ProvenCare® and Medical Home, Geisinger

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demonstrated, ultimately in peer-reviewed journals, that the reliable execution of evidence-based, population health-focused workflows can drive quality and cost results. This work had to counteract the narrative that reducing utilization is harmful to both a system's bottom line as well as to quality.

Early Results
A profoundly transformative strategy does not have the luxury of waiting years to drive value. In the intense competition for an organization's focus and resources, no strategy can be sustained without early results. These results bolster leadership's confidence in the strategy and support the core strategic vision's counter-narrative to short-term interests.

For a value-based care company such as Evolent, even with a sophisticated technology platform, early client results have been critical. The integrated approach has delivered on its promise in a number of directions. From a growth perspective, health systems have been able to add hundreds of thousands of accountable care lives through payer partnerships, negotiated on more equitable than standard health plan terms. They have also been able to launch plans, especially in Medicare Advantage, with high levels of initial enrollment. These increases in covered lives have been able to drive important increases in system utilization.

On the clinical side, Evolent's clients have seen substantial reductions in ambulatory-sensitive admissions, readmissions, and excess high-tech imaging, combined with even larger decreases for engaged complex patients against matched samples. In combination, these success have led to meaningful reductions in total medical expense [a major reduction in medical loss ratio (MLR) in one case]. All the while, quality is improving through gaps in care closure (increasing Medicare Stars, for example) and better care coordination.

For Geisinger, while the proof points are many, clearly critical was publishing its early results on ProvenCare® CABG demonstrating simultaneous reductions in total cost of care per episode while surgical mortality, complications, and readmissions all decreased. With respect to Medical Home, meaningful reductions in readmissions, admissions, and the abatement of medical expense trend were all documented.

Leadership Culture
The old adage of "culture eats strategy for lunch" is much repeated as transformation efforts are initiated. The most direct driver of a stronger culture is leadership, and across many transformation efforts, some of the following core attributes have been observed. Transformational leaders in healthcare often have a critical blend of humility and accomplishment. Typically with a strong values core, they are ready to admit what they don't know, quick to credit others, and yet, success around difficult transformation efforts seems to follow them. As transformation requires such fundamental change, recruiting leaders from across the organization is critical. Only a humble change leader will be able to secure broad buy-in out of an organizational recognition that those also doing the hard work in the organization will also get the recognition.

Early visible actions around behaviors that violate these norms are also essential to give the transformation agenda credibility. These actions could involve shifting leaders around, specifically creating teams that are populated by members with this humble/accomplished profile, publicly demonstrating these norms in very public settings. Often, this comes together in the creation of a new economic unit within the health system (in our case a value-based services organization) that can both enable change within current operations and embody the new strategic direction.

As we move from the innovation phase (single proof point pilots) of value-based care to the transformation phase (moving the needle on whole population quality and cost), these transformation essentials can successfully drive very difficult change.

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PTSD: A PERSONAL STORY AND OPTIMISM FOR THE FUTURE

"Do you want tea?" my aunt called out, and I gently responded, "No aunty, I am full." It is kind of someone to offer a cup of beverage because they care for you. But what if they asked you the same question three times within an hour because they kept forgetting? In my aunt's case, she was diagnosed with post-traumatic stress disorder (PTSD), and her memory was severely affected after the events that took place in her life. I did not mind her repeated inquiries about things like the tea, the garbage trucks, the phone calls, or the items on the shopping list. What worried me most was when she forgot to switch off the gas stove, to close the refrigerator, or even the times when she last ate food or took her medicine.

My aunt's condition made me wonder about how I can define the normal mental state of anyone today. The wonderful technologies we have developed allow us to do our everyday work more efficiently to leave us time to accept more responsibilities; this has raised the demands on our time significantly. Therefore, we have started to socialize less frequently and have seen a decline in the number of real friends, which often leads to mild stress and depression-like symptoms. Similarly, we are growing accustomed to the consumption of shorter length information, like the 140 characters of tweets or 160 characters of text messages. Therefore, when we have to read longer articles, we quickly lose interest. This has become "normal" today, and it is possible that we might mistakenly attribute this lack of ability to pay attention to mental illness in the form of attention deficit disorder (ADD), when it might just be a symptom of changing culture. This is an extreme example, and it is not meant to discount the difficulties faced by people who suffer from life-altering diseases like PTSD, epilepsy, and others that often lead to ADHD and depression.

PTSD, like epilepsy and others, is a serious mental illness, which is exceedingly difficult for patients and their loved ones to cope with. I spent many months researching PTSD to understand it and to find ways to help my aunt. During my stay, a typical day for her entailed staying under the safety of the blankets in the bed for about 10-12 hours, while actually sleeping for only 3-5 hours on good days; worrying about the most insignificant things, like the mops and the trash bins; heavily panicking at the sound of fire trucks or police cars racing past the house; and worst of all, not eating because she was "not in the mood," while wondering out loud why her stomach is rumbling. Nevertheless, my research gave me several reasons to be optimistic about the future of neuroscience and the potential it holds to cure and prevent these diseases. In this article, I have summarized one key finding of my research and the results of applying it to my aunt's condition.

These studies and their results could be important to everyone and not just to the people who are suffering, or love someone suffering, from PTSD. We need to use them to reduce the psychological burden of events like the stabbing rampage in Pennsylvania, the shooting tragedy of Newtown, and other such horrific events. Children who have witnessed a traumatic event are at a greater risk of developing PTSD after the event or even later in their lives.[1] Currently, if you are diagnosed with PTSD, one of the effective

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PTSD: A PERSONAL STORY AND OPTIMISM FOR THE FUTURE *continued*

therapies, in addition to anti-depressants, is known as talk therapy, a modality whereby your doctor educates you about trauma and talks you through your own experiences to focus on changing your reactions.[2] An additional component of this treatment approach which has also proven effective is quite simply, a group or community-based, quality social support therapy.

There are dozens of peer-reviewed scientific articles with details on the healing potential of social support that was observed across different demographics, from children, to college students, to soldiers, and others suffering from PTSD.[3,4] Significant differences in the outcomes of therapy efforts were noted between patients with quality versus poor social support in many such studies. With the love and care of close relatives, friends, or colleagues, PTSD patients have been shown to be motivated to change their behavior[4] and have also seen a decline in anxiety.[3]

The significance of these results is that such efforts can be sustained on a day-to-day basis and over a longer duration when compared to the intervention which doctors make during hospital or clinic visits. Social support helps to prevent the patient from re-experiencing the symptoms between hospital or clinic visits and eventually approach the normal mental state which existed prior to the traumatic event(s).

I am proud to say that I was able to apply this to my aunt's life, and within three weeks I saw a significant improvement in her behavior. Her communication not only improved, but she also surprised me by joking about my recent haircut, by talking at length about her favorite television shows (which I had never watched), and also by praying for her own well-being. She still preferred to stay withdrawn for long periods of time, but her eating habits improved. In about two months she gained 4 of 15 pounds of lost weight and started to express her hunger out loud. This acknowledgement of other emotions was significant because her brain seemed to be slowly realizing that they were also important. In addition to my day-to-day care, other family members also helped by visiting her more often and speaking with her on the phone by taking turns every single day. We also sent her for a trip away from home for a few weeks with friends and family. Today, even though she hasn't completely recovered, she takes care of most of the household chores herself, cooks regularly to eat things she used to like, and has started reading books.

The healing power of love and care of people can be used to form communities that can help multiply efforts to help those who suffer from PTSD. This approach is especially true for children who are at risk in historically violent areas of our neighborhoods and for our soldiers who suffer from this disorder. Local governing bodies could help establish such efforts, but we need to take initiative.

Communities organized around specific causes hold immense potential, as we all have come to recognize in Apple products, XPrize projects, numerous crowdfunding campaigns like classifying planets and stars with Planet Hunters. In the meantime, research in neuroscience is also gaining momentum to bring us better solutions, like mapping the connections of the brain with CLARITY,[5] the possibility of erasing traumatic memories,[6] or taking a pill to fight the damage from concussion while playing sports.[7] I know my efforts will continue with my aunt and also with spreading awareness locally. Will yours?

In addition to gathering resources to understand life with PTSD, I also started to use my bioengineering background to tackle traumatic brain injuries (TBI) in soldiers. As with PTSD, and maybe even more, my research in TBI has gotten me involved in the development of technologies with which we can study brain trauma in real-time – as it happens. If you wish to collaborate in community efforts, business endeavors, or just wish to find or contribute more to our understanding of PTSD or TBI, you can contact me at mithilpc@gmail.com.

PTSD: A PERSONAL STORY AND OPTIMISM FOR THE FUTURE *continued*

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MAKING MHEALTH STICK: THE KEY COMPONENTS OF SUSTAINED PATIENT ENGAGEMENT

The rapid rise in smartphones creates a new opportunity to re-define how we provide healthcare. Engaging patients more actively in their care is a focus of research and policy, and mobile health will play a key role. Yet for mobile health (mHealth) apps to make a difference, we need solutions that patients want to use every day.
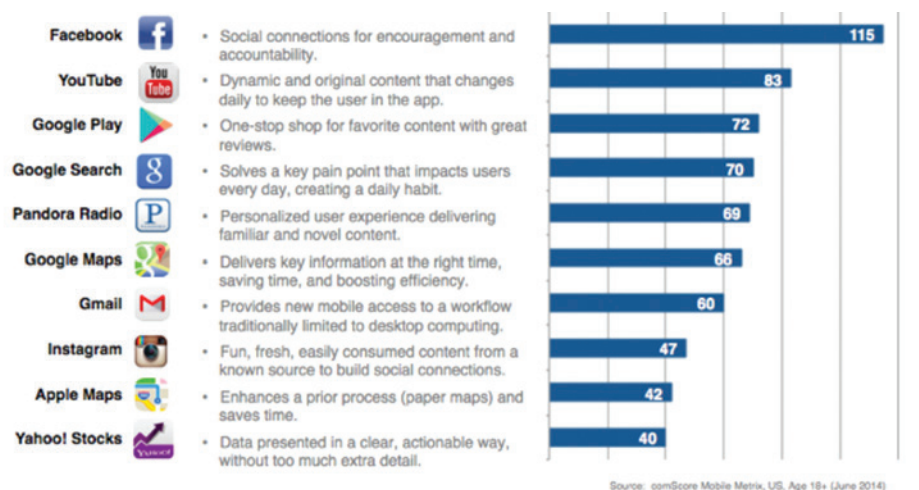
Despite $4.1 billion dedicated to investments in 2014 and global market projections reaching $49 billion by 2020, the digital health industry has yet to deliver technology solutions with consistent and sustained user engagement rates.[1,2] Many users stop using these health tools once the novelty wears off: For instance, one in three people who own a wearable health tracker stop using it after six months.[3] Keeping patients engaged continues to be a key question in digital health, serving as the focus at this past year's HIMSS conference.[4]

Mango Health is an app that facilitates the daily management of chronic disease through timely medication reminders, daily habit logs, and personalized disease content. To draw users into the app every day, we leverage our gaming background to deliver a fun, engaging interface that patients want to experience every day. Examining key traits of the top mobile apps today, we apply these insights in our platform to create a user experience that is uniquely sticky in the realm of healthcare.

What can we learn from the top mobile apps?
Unlike electronic health records (EHRs) which automate workflows and draft patients into a system, the mobile app market is largely democratic: Users vote with downloads and app opens as an indication of whether an mHealth tool is useful. But despite the importance health plays in our lives, none of the top apps in ComScore's 2014 ratings are health-related (*see Figure 1*).[5]

Figure 1. Top Mobile Apps by Unique Visitors (Millions)

App	Description	Unique Visitors (Millions)
Facebook	Social connections for encouragement and accountability.	115
YouTube	Dynamic and original content that changes daily to keep the user in the app.	83
Google Play	One-stop shop for favorite content with great reviews.	72
Google Search	Solves a key pain point that impacts users every day, creating a daily habit.	70
Pandora Radio	Personalized user experience delivering familiar and novel content.	69
Google Maps	Delivers key information at the right time, saving time, and boosting efficiency.	66
Gmail	Provides new mobile access to a workflow traditionally limited to desktop computing.	60
Instagram	Fun, fresh, easily consumed content from a known source to build social connections.	47
Apple Maps	Enhances a prior process (paper maps) and saves time.	42
Yahoo! Stocks	Data presented in a clear, actionable way, without too much extra detail.	40

Source: comScore Mobile Metrix, US, Age 18+ (June 2014)

Looking outside healthcare and drawing from comScore's top 10 apps, five common themes emerge around building meaningful consumer engagement (*see Figure 2*):

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MAKING MHEALTH STICK: THE KEY COMPONENTS OF SUSTAINED PATIENT ENGAGEMENT *continued*

(1) What functional value is added for the consumer? Apps built around amusing diversions may provide temporary entertainment, while an app that delivers *meaningful functionality* is sticky. Google apps featuring maps, email, and search solve key pain points that impact consumers every day, creating daily habits for the user. Monitoring and tracking health can be helpful for a patient, but key transactional features like automating medication refill requests or sending actionable patient data to providers can further drive app usage.
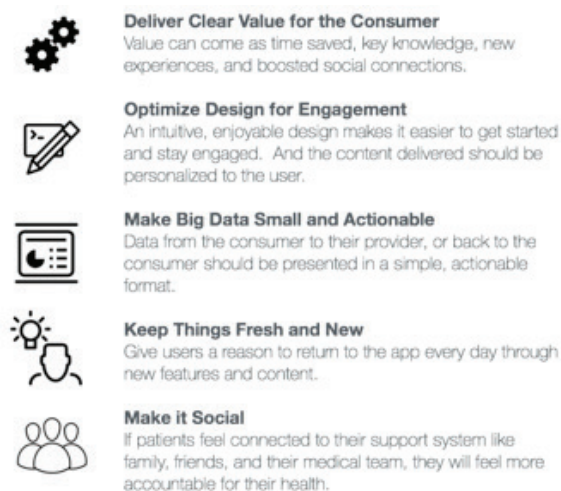
(2) Is the design optimized for engagement? Health apps need to make it easy to do the right thing. This includes robust features, user-friendly onboarding and navigation, as well as a personalized experience. What makes Pandora great is its expansive music library, the ability to play a song without logging in, and the new music suggestions based on previous plays. Many traditional mHealth apps have not yet prioritized the intuitive and dynamic design elements that are required for an engaging user interface.

(3) Are the data presented in a useful, actionable way? Data should be collected and presented in a digestible format. Yahoo! Stocks presents key summary metrics, but also allows the user to drill down into the details if he desires. mHealth apps should likewise present data in a visually appealing way, along with key suggestions for action. Instead of lengthy write-ups, a concise graphic with a clear recommendation makes big data small and approachable, particularly on mobile devices.

(4) Does the content stay fresh and new? Consumers check Facebook, YouTube, and Instagram every day because the content is constantly changing: There is always something fresh to see or interact with. If mHealth apps focus on self tracking or read-only patient records, the user is not drawn in to see new content. But the patient might have a reason to check in every day if an app offered personalized messages from a care team, up-to-date content on disease management, or new rewards and achievements.

(5) Does the app facilitate personal connections? Health behavior change theory specifies that sustained change requires social reinforcement and accountability. Most health apps and trackers exist in isolation, and the data does not go any further than the patients themselves, who move on quickly. mHealth can learn from Facebook, Instagram, and all the other sticky social networks of the world: Users who feel connected will stay engaged. mHealth apps have the opportunity to help patients feel connected to support systems like friends, family, and medical teams.

Figure 2. Five App Attributes that Keep mHealth Users Engaged

Deliver Clear Value for the Consumer
Value can come as time saved, key knowledge, new experiences, and boosted social connections.

Optimize Design for Engagement
An intuitive, enjoyable design makes it easier to get started and stay engaged. And the content delivered should be personalized to the user.

Make Big Data Small and Actionable
Data from the consumer to their provider, or back to the consumer should be presented in a simple, actionable format.

Keep Things Fresh and New
Give users a reason to return to the app every day through new features and content.

Make it Social
If patients feel connected to their support system like family, friends, and their medical team, they will feel more accountable for their health.

MAKING MHEALTH STICK: THE KEY COMPONENTS OF SUSTAINED PATIENT ENGAGEMENT *continued*

Making Mobile Health a Daily Habit

Using our experience from the gaming industry, we design with a focus on these five key concepts, along with the habit-forming principles of game design. Users log their medications as well as their health habits (such as blood pressure, weight, etc.) and receive points toward weekly raffle rewards. Over time, patients advance levels and are able to monitor their progress.

We also partner with leading healthcare organizations to deliver valuable content about chronic disease, medications, and healthcare services. For our users, the value comes in the knowledge gained about their disease, higher self-efficacy to manage their condition, and a stronger connection with their medical team.

Figure 3. The Mango Health App

Yet these partnerships are mutually beneficial: our users receive fresh and new content, while our healthcare partners leverage Mango Health data to deliver earlier, and more effective, interventions. From the in-app data on medication adherence and habits, we present both the patient and the healthcare team with actionable insights.

But perhaps most importantly, our design is intuitive, enjoyable, and personalized to the user. Our gamification features such as points, levels, and raffle gifts keep the experience fresh so that users want to open the app every day. Future development will add social features where users can receive reinforcement from family and friends to maintain healthy habits.

The sum of these considerations seems to be paying off: Our return rates are consistently twice as high as medical, health and fitness, and even gaming industry benchmarks. Thirty days after starting the app, 80% of our users are active compared to 47% across comparable industries. At 60 days, Mango's return rate is 68% compared to 34%-37%, and at 90 days, Mango's return rate is 65% compared to 27%-30%. Notably, 365 days later, a third of users are still active, and on average, Mango users have 17 sessions per week compared to 3-8 sessions in comparable industries.

Without stellar user engagement, the resulting data and the potential of any mobile solution to meaningfully impact care is limited. The road to stickiness will be paved by companies that not only understand the mobile user, but also deliver the high value that is required for healthcare. Ultimately, mHealth will be most meaningful when technology brings the patient and her care team closer together. But this can only start with an app that patients love to use every day.

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MAKING MHEALTH STICK: THE KEY COMPONENTS OF SUSTAINED PATIENT ENGAGEMENT *continued*

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EMPOWERING HEROES: FOCUS ON PEOPLE IS THE STRATEGY THAT DRIVES HOME HEALTH CARE SUCCESS - PART 1

Home health care is well positioned to meet the challenge of caring for people with higher quality and lower cost. In this first of two articles, we will discuss the current home health industry and our belief that the most important driver of success is a focus on people. The second article will explore how this focus on people will also be critical with emerging, high-value home health care models.

BAYADA Heroes

People enjoy the comfort of being at home. Whether it is the familiarity of surroundings or the closeness to friends and family, for many, home is a place where people can be themselves in an environment they control. Even when illness strikes or physical challenges make activities difficult, almost everyone would prefer to recuperate or adapt to life in their home.

As our population ages, the demand for services that keep people at home will greatly increase. In addition, there will be a continued emphasis on community-based over institutional care for younger people with special needs. Compounding these demands, governments, employers, providers, and households will struggle with the need to reduce the total cost of care. Home-based health care offers tremendous potential in meeting the challenge of increasing access while improving quality and reducing cost.

There is already a large industry that serves people in their homes – and it is growing quickly. CMS estimates that total home health care expenditures was about $82 billion in 2014, and this will nearly double to $156 billion by 2024.[i] These projections may prove conservative if existing and new models of home-based care are able to displace care provided in more expensive settings like hospitals and skilled nursing facilities.

Inspired by the success of hot "on demand" services like Uber and Airbnb, a new generation of companies have entered the home care market. Venture capitalists have invested in start-ups like Honor ($20MM raised), HomeHero ($23MM), and HomeTeam ($11MM).[ii] These companies focus on connecting non-medical private-pay caregivers with seniors using technology. While these models are unproven, there are compelling reasons to believe that technology will help to improve convenience and the efficiency of delivering home care.

These new entrants into the home health care industry will learn quickly that consistent execution is very difficult. There are many variables and unexpected challenges that continuously arise when providing care at home – whether it is staffing challenges, unique client dynamics, or even natural disasters. *Technology will help, but home-based care will always require people heroically helping other people to live in their homes*. The companies that figure out how to empower people to consistently overcome the unexpected are the ones that will be successful.

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EMPOWERING HEROES: FOCUS ON PEOPLE IS THE STRATEGY THAT DRIVES HOME HEALTH CARE SUCCESS - PART 1 *continued*

For forty years, BAYADA Home Health Care has been learning how to provide greater access to high-quality care that helps people live safely at home. Started by Mark Baiada in Philadelphia in 1975, BAYADA is now the largest private home-based health care company in the United States. With nearly 300 service offices in 22 states, and recent international expansion to India and soon Germany, BAYADA employs over 25,000 people.

BAYADA is unique in being a multi-payer, multi-service line organization with national scale. Our employees range across the spectrum of healthcare disciplines and include registered nurses, licensed practical nurses, physical therapists, occupational therapists, social workers, home health aides, physicians, nurse practitioners, and spiritual counselors. We rely on thousands of people, traveling many miles, to care for many tens of thousands of patients in their own homes each year. Our people are spread out across the country, and their workspace is another person's home rather than an office or clinic.

BAYADA's core competency is managing a mobile, home-based workforce. This competency is the link that integrates across our specialty models, payer types, and clinical disciplines. Our only true "product" is the ability to field compassionate caregivers who deliver high-quality care with reliability, wherever a patient lives and overcoming whatever challenges they face. It may sound simple, but the ability to do this in many markets at scale is exceptionally difficult.

From our own lessons and in observing other successful companies, we believe that empowering people is the key success factor in home health care. While most companies in any industry will embrace this concept, the nature of our work in home health care requires this focus on people as the core strategy. For this strategy to work, a culture with a shared purpose for helping people is the key. Some of the tools we think can be used to reinforce culture to help manage a mobile workforce include:

- a genuine and meaningful statement of mission, vision and values that becomes a living, daily ritual (BAYADA call's its written philosophy The *BAYADA Way*)
- selection for people who seek a higher purpose in their work
- transparency across an organization with strategy, quality, and financial performance to build trust
- treating employees fairly and generously, including those that may struggle with their work
- accountability through granular financial systems so that employees are careful stewards of human and financial resources
- compensation systems that align with the company's success
- focus on quality, with growth and financial success as a by-product
- recognition for those who provide service that is above and beyond

For home-based care to meet its potential in increasing access to care while improving quality and reducing cost, we believe this strategic focus on people will be critical. We've spent forty years refining our model, and there is still plenty of work to be done, but the future of healthcare looks very promising for BAYADA and other people-focused organizations.

In the next article, we will discuss several examples of innovations in home health care services, partnership, and payment models that we are pursuing. These include home-based primary care

EMPOWERING HEROES: FOCUS ON PEOPLE IS THE STRATEGY THAT DRIVES HOME HEALTH CARE SUCCESS - PART 1 *continued*

(housecalls), managed service agreements with health systems, and value-based payment. We will also discuss how a strategy of focus on people can be applied to these innovations.

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THE (HIDDEN) COST OF INSECURITY: CAN UN-EASE LEAD TO DIS-EASE?

While the majority of employers in the United States have some type of health and wellness program in place, and the Affordable Care Act provides additional support to do so, many employers have yet to assess the role they can play in addressing the underlying issues that cause stress in the workplace and beyond.

Stress as the Undercurrent
The feeling of instability in America is pervasive and tangible. Whether it's rising global temperatures and extreme weather, the fact that the minimum wage is still not livable for most, or the bewilderment and accompanying grief of mass killings and disappearing aircrafts, stress is an undercurrent in our always-on, globally-connected world. As an employer, you may ask, "If I can't control these things, what can I be expected to do about them?" While these issues may be out of most employers' control, it's important to recognize the workplace impact of not addressing underlying stress.

The Impact of Unease in the Workplace
According to a 2014 study on stress by the American Psychological Association and the American Institute of Stress:

- The number one cause of stress in the U.S. is job pressure.
- The number two source is money, related to loss of job, reduced retirement, and medical expenses.
- 77 percent of people regularly experience physical symptoms caused by stress.
- The annual cost to employers attributable to stress related healthcare and missed work is $300 billion.

Tossing and Turning at Night
What are some of the thoughts driving employees' feelings of insecurity? The degree to which unease may be present in your workforce will depend on many factors:

- demographics of the population
- average salary, benefits strategy, and resources available to encourage growth
- amount of support outside the workplace
- type and number of resources allocated to foster employee development
- presence and actions of leaders and managers who personify security and authenticity as they go about the business of the organization

Be aware that your employees may be facing a wide variety of challenges in their lives as well. Some common sources of anxiety, and accompanying questions, include:

Financial Insecurity

- Will I have enough to pay my bills and make it to my next paycheck?
- Will I be able to send my children to college?

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THE (HIDDEN) COST OF INSECURITY: CAN UN-EASE LEAD TO DIS-EASE? *continued*

- Will I be able to help my parents if they need support?
- Will I be able to retire when I can still enjoy it?
- Can I save the recommended 6-months' salary for a rainy day?

Job Insecurity

- Is my job at risk due to downsizing?
- Are they being strategic when they eliminate positions or are they just cutting bodies to save money?
- Am I at higher risk of being cut because I'm older and have been around longer?
- If my job is saved, how can I possibly take on more work, since there will be much more of it for those of us left behind?
- Why does there seem to be an ongoing cycle of downsizing, even when the company is doing well and they are hiring in other parts of the organization?

Career Insecurity

- Will I be given the chance to grow and develop?
- Is there a clear career path available to me or one I can craft that will add to my skills, knowledge, and marketability?
- Is there a real opportunity to move up in the organization?
- Will I be able to lead a team and be recognized for my efforts, commitment, and performance?
- Can I grow within the company and be financially rewarded to the same degree that might be possible if I moved to another organization?
- Is my manager someone I can trust to be honest with me, provide mentorship, and give me a heads up when I'm headed down an unproductive path?

Time Insecurity

- Can I turn my feeling of time "famine" into a perception of time "affluence" so I have more time to get the important things done and without being under constant stress?
- Will I ever have time to "just" think and "just be" at work to increase my productivity and creativity as well as my energy and enthusiasm for the tasks at hand or is constant "doing" the thing that's valued and rewarded?
- How do I find the time to achieve balance, establish a self-care routine, and build in time for the activities and people who bring me joy?

Longevity and Retirement Insecurity

- What do I need to be doing now to plan for living longer with fewer disabling or limiting health conditions? What can I do to support healthy aging?
- What resources do I need to plan for retirement, and how do I protect myself for the future?
- What financial resources will I have available in retirement?
- Will I be able to retire, or will I need at least a part-time job to make ends meet?
- Am I going to find myself in a "generational sandwich," providing support to kids and parents simultaneously?

THE (HIDDEN) COST OF INSECURITY: CAN UN-EASE LEAD TO DIS-EASE? *continued*

- Will Medicare and Social Security even exist in a way that will provide material financial support and the healthcare coverage I will need?

Taking Steps to Conquer the Fear
These types of questions and concerns may be causing sleepless nights and stressful days without you realizing the weight it adds to you and your associates in their daily lives. What can you do to address this reality and create a win for all parties?

1. Explore in-depth the issue of insecurity – financial, job, career, time, longevity and retirement – in your employee feedback surveys and needs assessments. Find out how prevalent these fears are among your ranks.

2. Evaluate how such concerns may play out for your employees and impact productivity, stress levels, attendant health costs, and the retention of talent.

3. Acknowledge and reward leaders/managers who exemplify security, a humble self-confidence, and really know their people. Such individuals delegate rather than micromanage, enable it to be OK to make a mistake and turn it into a learning and growth opportunity, are honest and transparent, communicate well, and create a shared vision that communicates the role that each individual plays in achieving the overarching strategy of the organization.

4. Take a comprehensive look at your benefits and HR strategy. Do you have benefits, resources, incentives, and programs interwoven in your offerings that help your employees plan for their financial, career-job, and retirement future? Does your system make it easy for them to save for a rainy day? Are there incentives in the workplace to lighten the load of stresses?

5. Identify any gaps between what you have in place and what employees need. Millennials may have very different ideas about the future than Gen-Xers, and Boomers face different challenges than their younger colleagues. It's important to design a program and approach that provides protection to everyone under the umbrella.

Addressing Insecurity to Create Better Health and Business Outcomes
Employees distracted and strained by issues which produce a nagging and ongoing sense of insecurity are also employees who are not well-positioned to do their most creative and productive work. Additionally, they become a workforce vulnerable to the physical manifestations of stress and its brain health impacts, which include reduced focus, concentration, and attention to detail—as well as an increased risk of depression and anxiety.

Will addressing insecurity be easy? Of course not, especially if you have not embarked on this journey in a meaningful way so far. However, in order to recruit and retain the talent necessary to stay competitive in today's environment, to reduce stress and its associated health/productivity/presenteeism/absenteeism impact, and to continue to improve the well-being of your workforce, addressing the cost of insecurity becomes a critical key to success and an investment in the security of your organization.

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THE (HIDDEN) COST OF INSECURITY: CAN UN-EASE LEAD TO DIS-EASE? *continued*

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Reprinted from HR IQ

WHCMAA AWARDS KINNEY ALUMNI SCHOLARSHIP TO 2 OUTSTANDING INCOMING WG'17 STUDENTS

The Wharton Health Care Management Alumni Association (WHCMAA) selected Steven Cupps and Alex Wittenberg, incoming Wharton Health Care Management MBA students, for its inaugural Kinney Alumni Scholarship – with each receiving a $10,000 scholarship. The scholarship is named after June Kinney, the Associate Director of the Wharton Health Care Management Program. The scholarship is meant for a deserving incoming healthcare MBA student who has been identified by the alumni as someone who would contribute significantly to the make-up and leadership of the WHCM class of 2017.
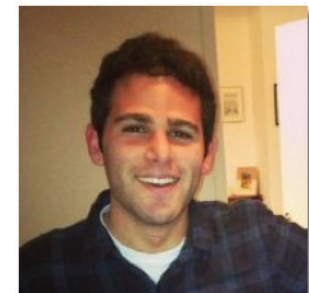
Steven:
Steven holds an AB cum laude in evolutionary biology, with a secondary major in economics from Harvard College. Since graduation, Steven has worked at Oliver Wyman's HLS practice, moving quickly through the ranks from consultant to engagement manager. In this capacity, he has worked closely with health insurers, providers, and pharmaceutical companies. Steven's longer term goals are to build health care companies that are transformational in nature.

Alex:
Alex received a degree in International Relations from Stanford University, where he graduated Phi Beta Kappa, with distinction. Since 2012, Alex has worked for Bain & Company. He has been involved in Bain's Healthcare and Private Equity practices. He is also involved in Bain's non-profit and global health efforts, serving as a co-director of the Los Angeles office's pro-bono consulting program. During his Bain experience, Alex also spent six months on leave from Bain & Company to work as a strategy consultant with Bill & Melinda Gates Foundation's Global Health division. Alex's longer term goals are to work at the intersection of healthcare and global health, specifically on corporate social responsibility initiatives and global health partnerships with major pharmaceutical and biotechnology companies.

We congratulate Steven and Alex on being selected for the Kinney Alumni scholarship. Both are outstanding additions to the growing and influential Wharton alumni network. We welcome both to the Wharton HCM community and look forward to many years of collaboration and friendship with them!

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