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IN EVERY ISSUE

Editor’s Letter	3
The President’s Desk.....	5
Open Wide.....	7
The Philosopher’s Corner.....	10
Alumni News	12
Not a Freudian Slip.....	16
Affidavit: Healthcare and the Law	19

FEATURED ARTICLES

Propulsion: Turning Strategy into Action Quickly – Part 4	21
<u>Wharton Around the Globe</u> : Passage from India.....	23
Adherence App Appeals to Elderly.....	26
Writing the Organizational Prescription for Physician Health.....	27
Employee Well-Being and Company Performance: Are Your Employees at the Center of Your Business? - Part 2	30

IN UPCOMING ISSUES

Reinvent Healthcare. Help Change the World.
 The (Hidden) Cost of Insecurity: Can Un-ease Lead to Dis-ease? (Reprint from *HR IQ*)

QUICK LINKS

- [Join Our Mailing List](#)
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EDITOR'S LETTER

THANK YOU to Jeff Voigt!

This issue of the *Wharton Healthcare Quarterly* is the last one in which Jeff Voigt will contribute as the President of the WHCMAA. I would like to officially recognize and thank Jeff for his leadership and the advances we have made during his tenure, including the launch of SIRIUS XM radio segments, an increased and closer relationship with the Wharton faculty, and the target-busting establishment of the June Kinney Scholarship. His passion for Wharton and support of its alumni is palpable, and we have all benefited from it during his presidential term.

New Opportunity

I would like to announce the launch of the Bronze and Pearl Levels of WHCMAA sponsorship, which are devoted to the *Wharton Healthcare Quarterly*:

- **Bronze** - \$2000 per year
One quarter page ad in 4 issues (January, April, July, and October) in the *Wharton Health Quarterly* e-magazine (published 4X per year); Additionally, the January issue is printed and handed out at the annual February Healthcare Business Conference, and the October issue is printed and handed out at the annual Alumni Healthcare Conference.
- **Pearl** - \$1000 per year
One quarter page ad in 2 issues (January and October) in the *Wharton Health Quarterly* e-magazine (published 4X per year); Additionally, the January issue is printed and handed out at the annual February Healthcare Business Conference, and the October issue is printed and handed out at the annual Alumni Healthcare Conference.

As an introductory special, we are offering a ¼ page ad placement in the July and October issues OR a full page ad in the October issue for \$375 (a 25% discount). **The deadline for submitting your ad materials is June 5.**

Should you have questions, please [contact](#) me.

To learn about higher levels of sponsorship of the WHCMAA, click [here](#).

Winner of a Free WHCMAA Membership

Lastly, the winner of a free WHCMAA membership (in follow-up to the *Wharton Healthcare Quarterly* feedback survey) is Jamie Richter, WG '95.

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



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

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For more information

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THE PRESIDENT'S DESK

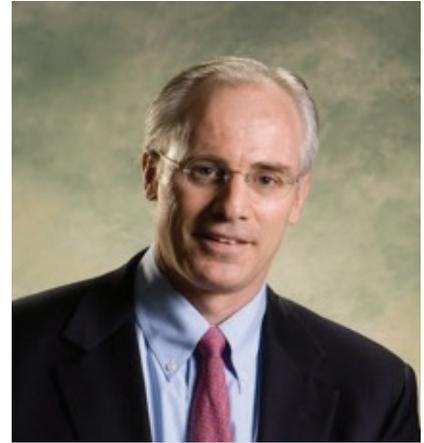
One of our premier events each year is the Wharton event at JPMorgan. Honestly, it felt like alumni weekend at JPMorgan. Our event had over 250 attendees at our Wednesday evening, January 14th event, with the vast majority of people from the WHCM program. Walking through the lobby of the St. Francis Westin in San Francisco, one couldn't help but bump into another WHCM grad. This speaks volumes about what our graduates are doing and the influence they are having in healthcare. Very impressive. One would have to guess there are more WHCM grads than any other business school affecting how healthcare is being delivered – there certainly were at JPMorgan. Again, this speaks volumes about our program and the caliber of people graduating from it.

Due to our increased involvement with the faculty, we are gearing up for more shows with Wharton SIRIUS XM radio. If you have not listened, the segments have been outstanding. We have had a number of professors, alumni, and students participate already, including: Professors Bob Town and Rob Field (Monopolistic Provider and Payer Behavior); Professors Patricia Danzon, Kevin Schulman, MD, WG'88 (and Professor at Duke's Fuqua School of Management), and David Fajgenbaum, MD, WG'15 (The High Cost of Chronic Care and Cancer Drugs); Professors Pauly, Starc, and Rosoff, John Barkett WG'09, and Sallie Pobleto WG'00 (Healthcare Exchanges); Professor Scott Harrington and Mitch Goldman, WG'75 (Hospital/Payer Alliances) and Professors Dan Polsky and Julie Sochalski (Primary Care: Are We Ready for Prime Time?).

SIRIUS XM radio is a great vehicle for the WHCM program to get the word out on some of the really interesting issues in which our faculty and alumni are involved. No other business school has this type of "media" outlet. A very special thank you goes out to Professor Skip Rosoff for helping to spearhead this opportunity for the school and its graduates. Skip has been instrumental in moving this initiative along. As well, we would like to thank the faculty for their involvement in this initiative – most especially Scott Harrington, Chair of the Department and Dan Polsky, Director of LDI. They have been very generous with their time and support. The plan is to hold at least 12 more of these over the next 5-6 months, with the intention of making this a regular (e.g., weekly) show for showcasing our faculty and alumni. We want to get as many of you on the radio as possible talking about the interesting and effective initiatives in which you are involved.

As you may be aware, we are in the process of updating our by-laws to be more in synch with our initiatives as an alumni association. We have modified them to ensure other UPENN healthcare-related constituencies (e.g., Wharton MBA non-WHCM graduates now involved in healthcare; WEMBA healthcare graduates, medical school graduates) have a say in what we are doing as an organization. These constituencies are important in helping to build our knowledge and networking bases. A special thanks goes out to Bob McDonald, MD, WG'92 for his work in getting the WEMBA graduates more involved in our organization. As an FYI, WEMBA has over 400 of its graduates involved in the healthcare field.

Friday, October 16, 2015 is the next Wharton Healthcare Management Alumni Association's annual conference. The conference will once again take place in Huntsman Hall. Additionally, we will be holding a career panel day with the WHCM students and our alumni dinner the day prior. The alumni conference has gotten better each year and has become a can't-miss event. Put it on your calendar!



Column Editor: Jeff Voigt WG'85
To learn more about Jeff, [click here](#).

THE PRESIDENT'S DESK

continued

Lastly, get yourself involved in what we do. There are upcoming regional events that will be posted to our website shortly. We have regional captains in: Boston (Neil Swami, WG'13); New York (Peter Fishman, WG'07); New Jersey (Jeff Voigt, WG'85); Chicago (Bob McDonald, WG'92); San Francisco (Vik Bakhru, WG'09); Philadelphia (David Kibbe, WG'80), and Washington, DC (Fran Kelleher, WG'84). We also hold career development webinars (contact Marina Tarasova, WG'10). We just had a Philadelphia event coordinated by David Kibbe and Tracy Johnson, WG'86 on January 28 (Thank you, David and Tracy!). June K. and Skip R. also attended. The event was scheduled to last until 8:00 pm, but the attendees wouldn't leave! It was just so much fun catching up with each other. The restaurant had to kick us out. It was great catching up with everyone. If you have a suggestion for an event, either regionally or even as a webinar, let us know. We can help coordinate it for you.

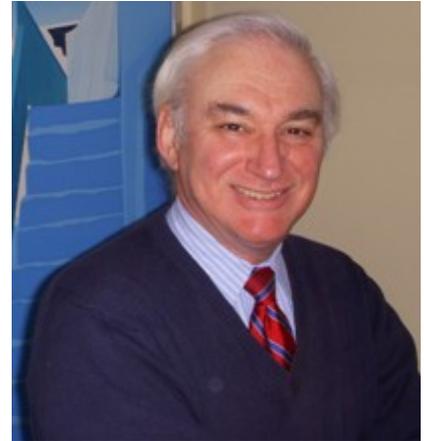
Sincerely,

Jeff Voigt, WG'85
President WHCMAA
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OPEN WIDE: BETTER, SMARTER, HEALTHIER

“Better, Smarter, Healthier.” That is the catchphrase used in the January 26, 2015 [press release](#) from HHS. As catchphrases go, it seems to work: just a few simple, easily remembered points, with enticements to look beyond (the essence of marketing, right?). And there is a lot that is “beyond,” no less than a major, fast-paced, and coordinated undertaking by HHS to move Medicare – “[and the health care system at large](#)” – toward payments to providers based on the quality of the care they render, rather than the quantity. More familiarly, “value over volume.” The timeline for this transformation:

- tying 30% of traditional Medicare fee-for-service payments to value payment models such as ACOs by the end of 2016, and 50% by the end of 2018
- tying 85% of all traditional Medicare payments to a value basis through such programs as Hospital Value-Based Purchasing and Hospital Readmissions Reduction Programs by 2016, and 90% by 2018



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

Scalability will be addressed with the creation of a Health Care Payment Learning and Action Network comprised of private payers, employers, consumers, providers, states, state Medicaid programs, and other partners through which HHS will work to expand alternative payment models into their programs. What has this to do with dental care? The answer is that familiar yet frustrating one – “everything, and nothing.” By “everything” I mean that the “Better, Smarter, Healthier” catchphrase applies – *or should apply* – to dentistry just as much as to the rest of medicine.

Delivering “better” care means, among other things, that care is comprehensive and integrated. (From the very first Open Wide column I have reiterated the central theme of the Surgeon General’s “Oral Health in America” Report that “oral health is integral to overall health.”) The emphasis of the Affordable Care Act (ACA) on comprehensive, integrated, preventive care further underscores what “better” means and how our nation’s healthcare resources are to be organized. Regardless of an individual’s age, her oral health is better understood within its larger medical context, and vice versa.

Delivering “smarter” care means, among other things, elimination of the valueless procedures, i.e., waste, and organizing the delivery of care to avoid more costly care later on, i.e., prevention and maintenance of health status. Quality metrics and information technology also figure in here, as well as in “healthier” care below.

Delivering “healthier” care means measuring and focusing on outcomes and the health status of a population under care, in other words, “accountability” for the expenditure of healthcare resources.

The infrastructure under the “Better, Smarter, Healthier” policy goals is (1) new financial arrangements – the move away from fee-for-service volume, to bundled payments and other models based on value, and some on risk-sharing and (2) new organizational models of integrated care, including Accountable Care Organizations and Patient-Centered Medical Homes. There is nothing here that is intrinsically inapplicable to dentistry.

Yet the other half of my answer to “what has this to do with dental care?” is “nothing.” Why do I say that? Because the “infrastructure” I described above, the dramatic financial and organizational developments, are scarcely to be found in dentistry. Payment for dental care is either through quite conventional indemnity insurance plans of generally limited coverage, or through out-of-pocket, or a

OPEN WIDE: BETTER, SMARTER, HEALTHIER *continued*

combination of the two; indeed, the costs of dental care are among the highest, if not the highest, in all of medicine paid for out-of-pocket. The predominant organizational model of the “industry” remains the private, fee-for-service, solo practice, formally unattached to a larger healthcare organization. Again, familiar themes of this column. To bring matters into a sharper, more particular focus:

1. “Better” in the dental context would mean seamless integration of dental care into larger healthcare systems where medicine properly recognizes and appreciates dental health as a fundamental component of comprehensive primary care, and, in turn, dentistry learns how to operate productively and efficiently in these larger and more sophisticated organizations.
2. “Smarter” would mean examining what truly contributes to value in dental health, and what does not. Many commonly accepted dental treatments do not pass the “value over volume” test. For example (and I thank Jay W. Friedman, DDS, MPH, and an exponent of prepaid dental care and developing quality metrics for dental care *since 1955* for providing most of the items in this list, also found in the [February 2015 Consumer Reports on Health](#)):
 - Prophylaxis (or “prophies,” or even more commonly “tooth polishings”) with rubber cups and pumice, particularly of children’s teeth, is not only of no benefit, but may actually work counter to dental health by removing the microsurface of enamel fortified with salivary fluoride that strengthens tooth structure against the action of decay-producing bacteria.
 - There is no scientific basis for twice-a-year checkups and cleanings. While removal of plaque is important for gum health, for an otherwise healthy individual with no active decay and good oral hygiene, 18 months between checkups is fine.
 - Bitewing X-rays every two to three years are all that is needed. The full-mouth or panoramic X-ray series is not necessary for ten years, if that, unless there is a specific reason, such as suspicion of a cyst. Unnecessary exposure to radiation is to be avoided.
 - High-tech imaging tests such as CT scans to create 3D images have their place in complicated procedures and jaw surgery, but not for braces and most orthodontic treatments. CT scans have more radiation exposure than X-rays.
 - Deep sedation or general anesthesia involves the risk of using powerful drugs such as propofol or management of multiple intravenously injected drugs. The local anesthetic lidocaine and its relatives are usually all that is needed.
 - The prophylactic use of antibiotics is now indicated in only a few circumstances, such as individuals with artificial heart valves. Most people with artificial joints do not need pre-treatment antibiotics, which come with their own possible side effects and complications, including gastrointestinal upset, allergic reactions, and bacterial overgrowth with *Clostridium difficile*. And the overuse of antibiotics leading to resistant strains of bacteria is a serious healthcare concern.
 - Dentists write 12% of prescriptions for narcotics. The risks of side effects, misuse, and overdose are not trivial, especially when over-the-counter remedies such as Tylenol, Advil, Motrin, and their generics, taken individually or in combination, are effective for mild to moderate pain after a procedure.
 - There is little reason for the routine extraction of third molars. Their removal, whether in the dentist’s or oral surgeon’s chair or in an operating room, carries the risk of nerve damage affecting sensation, and to the jaw joint, causing pain and difficulty in chewing. Unless the wisdom teeth are causing infection, pain, or are compromising other teeth, they can be left alone.

OPEN WIDE: BETTER, SMARTER, HEALTHIER *continued*

3. “Healthier” in the dental context means the improvement of oral health status of a population and its maintenance at a high level. Dental disease is, to a very large extent, preventable in the biomedical sense (socioeconomic and organizational issues of care are less tractable, but not unassailable). The “value” is the intrinsic minimization or absence of pain, disability, and debility as experienced by the individual, and the economic benefits from avoidance of the “volume-based” care of more involved restorative treatments or prosthodontic measures.

Overall, I don’t think one can argue with the policy aims of “Better, Smarter, Healthier,” as the phrase encapsulates what we as a society desire in a true healthcare system. And “the system” is responding, albeit with considerable thrust from the Medicare program, with the payment schemes and organizational apparatus to bring those aims to reality. But from the perspective of the dental health policy observer, “Better, Smarter, Healthier” is distressing, because a definitional part of integrated, comprehensive, primary, preventive care (admittedly a niche at only 5% of national health expenditures, but, at \$150 billion per year, still not negligible) is not part of the picture. This further underscores what has previously been said in this column - the healthcare reform train is leaving the station, and dentistry doesn’t have a ticket in hand in the form of the sophisticated financing, organizational, and management understanding and competencies to get on board. More’s the pity for the opportunities lost and inefficiencies incurred that this policy shortcoming is neither being seen nor acted upon.

Contact Harris at: hcontos@alumni.upenn.edu

THE PHILOSOPHER'S CORNER

Life Lessons:

If I knew then what I know now, I would have:
used minimum 20 point font and simple words on slides many years ago. Audiences are much more attentive and engaged when they are listening rather than reading slides.

If I knew then what I know now, I would have:
asked advice more often from people working in other countries. (This is a common mistake at a company whose largest revenue base is the US.) Because of smaller budgets, they are forced to think innovatively.

If I knew then what I know now, I would have:
once again trusted my instincts and chosen Merck. I have been there 16 years and counting. It was a risk – there was a less defined career path at Merck for MBA hires. Because of this choice, I have done so many things I would not have elsewhere, including being the only person in the pharmaceutical industry dedicated to health literacy strategy. I believe this work will ultimately redefine effective communications to patients and consumers about medicines, disease, and well-being - from clinical trials, to patient education, to product packaging. More to come in the *Wharton Healthcare Quarterly* starting in October.... Stay tuned.

If I knew then what I know now, I would have:
once again done my best to balance being a great employee and a great mom. I would repeat many of the things I have done, including: doing a job share for 8 years when my kids were young; turning off my computer every afternoon the last two months of my dad's life so I could be with him completely; and turning down my chance to ride in the Merck jet to an important customer visit because my daughter had a 103 fever, was really sick, and asked me to stay home. (I am much less sure about the third one than the other two!)

If I knew then what I know now, I would not have:
sent my breast milk FedEx when I traveled for work until my kids were a year old – they got asthma and allergies anyway. (Note: I am still a firm believer in nursing, but that was a LOT of stress!)

If I knew then what I know now, I would not have:
worked quite so many nights til 1 am ...the work will still be there in the morning.

Favorite Quotes:

1. "You can be a great mom, and a great employee, but rarely both on the same day..."
- Wendy Thornton, friend, over a glass of wine.
2. "Life should be about the people you love and the things that make you happy." - Unknown
3. "I didn't have time to write you a short letter, so I wrote a long one instead." - Mark Twain
4. "Medicine is for the people, it is not for the profits. If we have remembered that, they have never failed to appear." - George Merck



This month's philosopher
Laurie Myers, WG'99
To learn more about Laurie,
[click here.](#)

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

THE PHILOSOPHER'S CORNER

continued

Recommended Reading:

- *Health Literacy: A Prescription to End Confusion* – IOM Health Literacy Roundtable Report ©2004
- *Ten Attributes of Health Literate Organizations* by Cindy Brach, et. al. - IOM Health Literacy Roundtable Discussion Paper ©June, 2012
- *The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures* by Anne Fadiman ©1997
- *Seeing Patients: Unconscious Bias in Health Care* by Augustus A. White III, M.D. ©2011
- *Teaching Patients with Low Literacy Skills* by Cecelia Doak, Leonard Doak, and Jane Root ©1996

Website:

[Merck Corporate Responsibility Report – Health Literacy and Healthcare Disparities](#)

ALUMNI NEWS

Alexandra Burtoft, WG'15

The Healthcare class of 2015 wants to congratulate Dr. David Fajgenbaum for being named to *Forbes'* "30 under 30" list in Healthcare. Dave and his team's accomplishments with the Castleman Disease Collaborative Network (CDCN) are impressive and absolutely worthy of praise. The class of 2015 is working hard to set up a fundraising committee in every major city around the U.S. to help Dave and his team's efforts in combatting Castleman Disease. We would love to get as many alumni involved as possible. If you're interested in learning more about Dave's work or joining a fundraising committee, please contact Alex Burtoft at Alexandra.Burtoft.wg15@wharton.upenn.edu.

[Learn more.](#)

John Pettengill, WG'14

In the fall of 2014 John Pettengill WG '14 joined VAL Health, a behavioral economics firm co-founded by two other Wharton alums, David Asch WG '89 and Kevin Volpp Wharton PhD '98. Mr. Pettengill found an opportunity to combine his passions for health, decision science, and technology together as Director of Product Management for VAL Health's health incentive platform. VAL Health is currently running a wide range of initiatives with diverse players around the U.S., bringing a behavioral economics perspective into the benefits design field to improve the effectiveness of programs and member engagement.

Contact John at: jpettengill@valhealth.com

Stephen W. Chang, MD, WEMBA'14

I am pleased to announce that Synergy Immediate Care, our new primary care/urgent care clinic, opened on February 2, 2015. Located in the heart of Tysons, VA, we are open 7 days a week to serve the healthcare needs of the Northern Virginia area. Our goal is to deliver convenient, comprehensive care. No appointments will be necessary, and we also have an on-site laboratory.

Contact Stephen at:

WG14@wharton.upenn.edu or swchang@SynergyImmediateCare.com

www.SynergyImmediateCare.com

David Fajgenbaum, MD, MSc, Perelman School of Medicine '13, WG'15

Named to *Forbes' 30 Under 30* list in healthcare.

[More information](#)

Contact David at: David.fajgenbaum.wg15@wharton.upenn.edu

ALUMNI NEWS

continued

Josh Stein, WG '12

AdhereTech, founded by Josh Stein WG '12, is releasing the newest version of their smart pill bottle in Q2 2015. These bottles are used to track and improve adherence, particularly for high-cost specialty drugs and within clinical trials.

The smart pill bottle is currently being used in engagements with three of the top-15 pharmaceutical companies and a number of other healthcare firms. AdhereTech is always looking to connect with Wharton healthcare alumni – especially those who want to learn more about this innovative solution.

Josh also delivered a [TED talk](#) at TEDMED in September 2014 during which he discusses the three main design philosophies [AdhereTech](#) followed when creating their smart pill bottle - and how these philosophies can also be applied to the design of other smart connected devices.

Contact Josh at: j.stein@adheretech.com

[Learn more.](#)

Rob Lieberthal, PhD, WG'11

Rob Lieberthal has been accepted as an Associate Research member in the Sidney Kimmel Cancer Center at Thomas Jefferson University, a National Cancer Institute (NCI) designated cancer center.

Contact Rob at: Robert.lieberthal@jefferson.edu

Jason Brauner WG'03, MD'03 and Alex Brown WG'05

Jason Brauner and Alex Brown have both become Partners at Recon Strategy, a boutique healthcare consulting firm. Recon, co-founded by fellow alumnus Nikhil Bhojwani WG'02, was started four years ago, serving clients in the payer, provider, biopharmaceuticals, and digital health sectors. All three worked together at Boston Consulting Group, but have since pursued different paths. Jason spent the past eight years at Biogen Idec, recently as VP of Global Medical Affairs, and previously had roles in R&D strategy and product development. Alex spent the past three years as COO of Scrum Inc, a company dedicated to agile management techniques and spurring new innovation.

Contact Jason at: jason@reconstrategy.com or Alex at alex@reconstrategy.com

[Learn More.](#)

Sally Poblete, WG'00

Sally Poblete, Founder and CEO of [Wellthie](#), was named one of the [40 Top Health Care Transformers](#) in *Medical Marketing & Media*. She joins other “inventors, strategists, advocates and wonks who are challenging, disrupting, and otherwise transforming the health care business.” Sally was chosen for her disruptive work in helping health insurance companies better interact with consumers as they move to a retail sales environment. Health insurance can be complicated for even the savviest consumer, so Wellthie seeks to change the consumer’s experience. As Sally explains to *MM&M*, “We bring simplicity. In a world that’s complex, we want to make things easy and quick.”

Contact Sally at:

Spoblete@wellthie.com

646.541.4434

<http://wellthie.com>

<http://www.mmm-online.com/sally-poblete-top-40-healthcare-transformers/article/390961/>

ALUMNI NEWS

continued

Laurie Myers, WG'99

I am still working for Merck, 16 years after graduation, and love my job leading health literacy and healthcare disparities strategy. I work both cross-divisionally at Merck and externally with academic and other healthcare organizations, focused on patient labeling for new products, clinical trials, and patient education. I recently joined the Institute of Medicine's Health Literacy Roundtable and co-lead a working group at the Harvard Multi-Regional Clinical Trials Center. My girls, Alyssa and Kristen, are now 15 and 11.

Contact Laurie at: Laurie_Myers@Merck.com

E. James Bateman, WG'99

James Bateman has recently been promoted to Group Executive of the Diagnostics Division of the publicly listed Australian company Primary Health Care, Ltd.

Primary's Diagnostics division provides pathology, clinical laboratory, and medical imaging services to over 20 million patients each year, with billings of approximately USD\$1.5bn. Pathology services provided extend from complex genetic to routine chemical and hematological diagnostics with over 100 laboratories and 2000 patient service centres throughout Australia. Medical imaging services provided extend from PET and MRI to routine plain radiology through over 150 radiology facilities.

Contact James at:

Edmund.bateman.wg99@wharton.upenn.edu

www.sdspathology.com.au

www.healthcareimaging.com.au

Jean Mellett, WG'87

Jean was appointed System Director, Strategic Planning for Eastern Maine Healthcare system, an eight-hospital integrated delivery system based in Brewer, Maine. On a personal note, Jean's daughter recently graduated from the University of Vermont. Her son is a sophomore at the University of Notre Dame, Jean's alma mater, and she and her husband, Ed's, other daughter is a freshman in high school.

Contact Jean at: jmellett@emhs.org

Barbara Bix, FAS, BA, Cognitive,'78, WG'81

Snowbound in Boston for last two weeks. Launched [Integrative Health Center at BIDMC](#) over last 2.5 years. With the new year, I'm returning to consulting, coaching, and developing workshops and communications that help healthcare organizations launch new initiatives and capitalize on market change. See [website](#) for details. Also interested in local part-time opportunities.

Contact Barbara at: barbara@bbmarketingplus.com

John Whitman, WG'78

On January 28, 29th and 30th, John Whitman will be hosting a delegation from China interested in developing a world class home health type business to meet the needs of the elderly in China. The group, called International Senior Services (ISS), will be meeting with a wide range of U.S. senior care providers ranging from case managers, home health, assisted living, nursing homes, and retirement communities. ISS is also interested in developing schools in China to assure a steady stream of healthcare workers to meet the demands of the rapidly growing senior population in China. One of their meetings will be with the Penn School of Nursing specific to creating such a school. John Whitman, who has been a lecturer for the MBA Health Care Management Program for the past 27 years, will be coordinating the visit.

Susan C. Sargent, WG'75

Having worked in the field of integrating medicine and behavioral health services with an internist/psychiatrist for 15+ years, we are discovering that we are now very popular when it comes to recommending strategies for health systems/ACOs that can improve the quality of care, improve access, and reduce costs, especially among populations with chronic medical and co-morbid behavioral conditions. Representing between 27% and 35% of all medical admissions, these co-morbid populations incur longer lengths of stay, 45% more 30-day readmissions, higher costs, lower net revenues, and just generally more challenges than their non-co-morbid counterparts. As such, it has been very exciting for our practice to be working with provider settings nationally, and seeing how critical it is to gauge these strategies to the local cultures and systems of care, especially when it comes to assessing the financial impact of the strategies once implemented.

When I was at Wharton, I was mentored by Dr. Bob Leopold; I started my career evaluating behavioral benefits within HMO models and incorporating behavioral health strategies into the relatively primitive State Health Plans. It is therefore very gratifying to see his insights finally starting to take hold within the various operational provisions of the Affordable Care Act and very real opportunities to reconnect the head with the rest of the body...what a concept!

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After working for more than 41 years in the healthcare industry, primarily representing health plans, I retired in October 2014. My career took me from developing an HMO, to representing health plan concerns in relations with the healthcare provider community at the local and national levels, to lobbying at the federal and state levels on behalf of health plan interests. Most recently I was responsible for state government and industry relations for one of the largest health plans in New York.

NOT A FREUDIAN SLIP: STRIVING TOWARDS HEALTH BEHAVIOR CHANGE – PART 2

In [Part 1](#) of this multi-part series we introduced the biopsychosocial (BPS) model as a means by which we explore the factors that determine mental health and well-being. In Part 2, we will explore how biological mechanisms, specifically genetic and physiological factors, distinguish male behavior from female behavior. We discuss how the biology of the physical body predisposes both men and women to anxiety or depressive symptoms, how men and women differ, and how these differences evolved.



Imagine a person being exposed to a threat. The brain responds with a hormonal cascade to prepare the body to stand and fight, or to run away and avoid attack. Stored glucose is released into the blood for energy, the pupils dilate, and the heart beats faster.¹ This biological response is at the core of all stress reactions and does not seem to vary between sexes;² however, the behavior we observe in males and females is distinctly different. Why then might males be more prone to exhibit more outwardly aggressive behavior in reaction to a threat, while females tend to seek protection through affiliation with social groups? This difference is due to subtle hormonal differences in the stress response between males and females that markedly affect behavior.

Three hormones are particularly important in understanding sex-specific behavior: estrogen, testosterone, and oxytocin. As the dominant male hormone, testosterone develops secondary male sex characteristics and plays an important role in other physiological functions. Estrogen, a female hormone, stimulates secondary sex characteristics and promotes female development during reproductive ages. Interestingly, these sex-specific hormones have an opposite effect on a third chemical, oxytocin - a hormone known for its association with intimacy and bonding that also has a counter-regulatory role in fear responses to stress.³ Testosterone actually inhibits oxytocin release, while estrogen amplifies oxytocin's effects.⁴ In fact, estrogen's role in increasing the effects of this "tending" hormone is one of estrogen's strongest known effects.⁵ These differences, though subtle, can significantly contribute to the different *behavioral* responses men and women have to the same stressor.

These hormonal variations significantly impact male and female behavior. While males are biologically predisposed to exhibit a more acute and aggressive response, females are predisposed to internalize and affiliate with others during times of stress. Females still display aggressive behavior, but it is exhibited differently. In the context of evolution, these behaviors are clearly designed to ensure the survival of her young by remaining with them (avoidance of flight) and by affiliating with others who provide additional protection. Men and women therefore have markedly different behavioral responses to stress - determined by their biology - which account for differences in coping mechanisms, social interactions, and interpersonal stressors that influence the lived experience of an individual.

The differences become most pronounced during certain phases of life. Until adolescence, rates of depression in boys and girls are markedly similar.⁶ However, as girls enter puberty, we begin to see a dramatic shift in rates of mental illness. These are manifested through escalating rates of depression, from 5% in early adolescence to over 20% by the age of fifteen.⁷ Coinciding with this phenomenon is a dramatic change in female biology: during puberty, estrogen increases, as it is vital for the development of female secondary sexual characteristics. Although it is unlikely that hormones directly cause depression, it is very possible the primary hormonal differences modulate our behavioral responses to stress.⁸

Adolescent girls seek out social affiliations and have a tendency for interpersonal aggression (e.g., peer rejection, loneliness, peer pressure), more so than their male counterparts, who are predisposed to display outward aggression.⁹ Further, girls tend to be more concerned with the status of their relationships, the

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NOT A FREUDIAN SLIP: STRIVING TOWARDS HEALTH BEHAVIOR CHANGE – PART 2

continued

opinions of others, and their body image. This pattern culminates in lower self-esteem and places them at a higher risk of interpersonal stress than males. On the other hand, because males are not as prone to seek social support, they are at a higher risk of developing anti-social mood disorders and coping through substance abuse.

Prevalence of Depression per Age Group and Sex in the United States (CDC, 2012)

Age Group	12-17	18-39	40-59	≥ 60
% Females Reporting Depression	8%	10%	12%	7%
% Males Reporting Depression	5%	5%	7%	5%

The importance of biological differences is not confined to the field of mental health. The top research institutes involved in medical science recently recognized the importance of the gender bias in laboratory research.¹⁰ Recently, the National Institutes of Health announced the distribution of \$10.1 million in grants to scientists to ensure gender is seen as a legitimate variable in science. Further, *The New York Times* reported the recent action by the FDA to reduce women’s dosage of the short-acting sleeping pill Ambien by half, after findings revealed men metabolized the drug faster than women.¹¹ The breadth of this issue is only just beginning to be understood and properly addressed by medical science.

There is clear evidence showing differences between males and females, both in their biology and behavior. However, biology is just one factor that influences our different health outcomes.¹² The social, cultural, historical, and physical conditions under which people grow also play a pivotal role in a person’s health and well-being. Our vulnerabilities to mental illness, how we react, and how we cope are distinctly unique; however, current efforts to address our mental health and well-being are not. In order to address a person-specific disease, we must employ a person-centered response — one that aims to meet all individuals where they are. Additionally, by addressing the needs identified by the BPS model, we can not only close the gender-based gaps in mental health, but also make improvements across all dimensions of a person’s well-being.

In the next issue, we explore the biopsychosocial model with respect to the social differences between men and women. In this paper, we recognize the social determinants, cultural norms, and existing attitudes surrounding gender stereotypes that inform women’s place in society, their safety, and their mental health.

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NOT A FREUDIAN SLIP: STRIVING TOWARDS HEALTH BEHAVIOR CHANGE – PART 2

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AFFIDAVIT: HEALTHCARE AND THE LAW - HEALTHCARE REFORM UPDATE: WHAT'S IN A NAME?

One of the innovations under the Affordable Care Act (ACA) is the accountable care organization, or the ACO, a new healthcare reimbursement model that was developed as an alternative to the traditional fee-for-service model. The ACO has many cousins that go by different names: among them, pay-for-performance, gainsharing, bundled payments and co-management models. A global term for these arrangements is “value-based contracting.” The common thread is that these arrangements reward primary care physicians and other healthcare providers for achieving quality measures based on patient health outcomes, efficiency, and patient satisfaction. Under an increasing number of risk-based programs, savings and losses are shared among the participants. A cornerstone of value-based contracting is population health management, or the use of [big data](#) and tools to manage disease for the value-based contract's patient population based on successful strategies for large populations of patients.



The goal of replacing fee for-service with a risk-and-reward reimbursement model appeals to common sense — and has been tried before. The HMO was intended to revolutionize healthcare by managing healthcare costs and taking on risk. At the macro level, the jury is still out on whether value-based contracting will truly change healthcare. At the micro level, the law has not caught up with this new approach, and there may be legal risk for a physician, hospital, or other participant.

The ACO is currently the flavor of the month. The Medicare Shared Savings Program (MSSP) provides a basic template for ACOs. An MSSP ACO requires the participation by written agreement of hospitals and physicians who must meet certain quality standards, such as providing immunizations and preventing readmissions, for a targeted group of Medicare beneficiaries. ACO providers continue to receive their Medicare fee-for-service payments but may receive additional payments based on shared savings (one-sided model or upside risk) or shared losses (two-sided model or upside and downside risk). More than 350 MSSP ACOs have been established since the passage of the ACA, as well as roughly 20 in Medicare's original Pioneer ACO Program.

In addition to ACOs, other value-based contracting models similarly seek to align payment with cost-efficient delivery of care. Some of them incentivize providers, typically physicians, to meet quality measures. They may be known as pay-for-performance or bonus-based programs. Others share upside and/or downside risk and often are broadly referred to as gainsharing arrangements. Still others pay on a bundled payment basis, i.e., paying providers based on episodes of care as opposed to each service. Many payors, including Blue Cross, Aetna, and United, as well as hospitals and large physician groups, have established their own value-based arrangements. A popular model among providers is the co-management arrangement in which a physician group contracts with a hospital to manage a service line, such as cardiology. The hospital pays the group a base fee to manage the provision of services, as well as performance bonuses for physicians who meet quality goals.

Value-based contracting may be touted as the solution to the quality-and-cost issues that plague healthcare, but few of them have long track records. More than 10 ACOs of the original 32 in Medicare's Pioneer ACO Program have pulled out. A fundamental challenge appears to be the expectation that quality will continue to improve over time. Consider this example:

If I am a physician and I immunize 85 percent of my eligible patients in year one, and 98 percent in year two, where do I go from there? Will I ever reach 100 percent? And once I have shown improvement in basic measures, such as immunization

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AFFIDAVIT: HEALTHCARE AND THE LAW - HEALTHCARE REFORM UPDATE: WHAT'S IN A NAME?

continued

and mammographies, what quality measures come next? Further, how can quality be measured and improved among patients with complex and unique co-morbidities? Who is managing the data to ensure effective population health strategies and tools? Are the data accurate and useful?

Hospitals and physicians who are developing or entering into a value-based arrangement with a payor or other provider are often excited at the early stages about the potential financial gains and the opportunity to participate in innovation. Then they see the power points — the quality benchmarks and complex scoring systems; the formulae for determining risk; the criteria for selecting and managing the beneficiary pool; the methodologies for calculating savings and losses; and other features that are not easy to translate into the daily practice of medicine. Still, enthusiastic participants forge on — who wants to be left behind where there's money to be made?

For legal counsel, the challenge often involves ensuring that clients carefully review the contracts — no matter how dense — especially if downside risk is a possibility or reality. Despite the push towards value-based arrangements under healthcare reform, restrictive fraud and abuse laws remain in effect. According to the Department of Health and Human Services' Office of the Inspector General, the particular concerns are that performance-based and risk-sharing arrangements could encourage providers to “cherry-pick” healthier beneficiaries; “stint” on medically necessary services; “steer” patients to less expensive services; or “refer” patients to certain providers in order to enhance incentive payments or savings. In other words, in value-based contracting, the cost of care should be secondary to the delivery of necessary care. Yet, as one ACO consultant noted, “Reducing services is the point of these arrangements.”

Keeping this delicate balance of interests in mind, the value-based arrangement should include checks and balances, such as tying quality measures to industry-recognized standards and providing stop loss (excess) coverage that provides protection for “outlier” cases, e.g., the million dollar claims, so that appropriate care for expensive cases is not discouraged. The financial arrangement should be based on a fair market value assessment, which should be performed by a third party with sufficient experience. Participating providers should ensure they have ample opportunity to, and assist in, reviewing the data supporting the quality measures and the payouts (or paybacks). Many providers do not expect to “look under the hood” at the data; instead, they should plan for it. Finally, they should ensure the arrangement is revisited annually and includes equitable unwind provisions.

Over the next few years, ACOs and other value-based contract models will be tested. By this time next year, there could be buzz around a new model. The lessons learned will likely improve the options and features, as well as help participating healthcare providers manage the benefits and potential legal risks.

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PROPULSION: TURNING STRATEGY INTO ACTION QUICKLY – PART 4

This is the final piece in a series of four articles about working toward being a “superconducting organization,” in which desired results come faster — and they last. In this article, we detail *Propulsion*, one of the levers that can help build this kind of organization.

Propulsion in Healthcare

Many leaders’ offices have ‘that’ binder on the shelf. It has a typewritten label, a neatly organized tab system, and an inch of dust on top. It’s their last strategic plan.

The task of turning strategy into action quickly is difficult across today’s business environment, but is perhaps most challenging in healthcare. For example, in light of the [January 2015 HHS announcement](#) of an accelerated timeline to adoption of value-based payment strategies, it’s tough to imagine that tactics drafted in a strategic plan today will be relevant five years from now.



Plus, there are cultural factors. A recent [Forbes article](#) quoted a Mayo Clinic study where design experts were paired with physicians to execute a healthcare improvement project. One designer observed, “Physicians were deeply guided by tradition, and because they bore the responsibility for the patient’s life and well-being, they were, as a group, risk-averse... This conservative culture affected doctors’ willingness to try not only new drugs and treatments but also new administrative procedures and educational methods.” Even as lawmakers, payors, patients, and their families are calling for a paradigm shift in delivering and funding care, providers often call either for establishing an evidence base, which comes with a lag time, or for the comfort and familiarity with the way they’ve been doing things for decades.

There are, however, ways to build agility into healthcare strategy. In fact, we observed “Propulsion” — the ability to put strategy into action quickly — time and again in national organizations focused on interprofessional collaboration, a feature of healthcare delivery that we studied recently in partnership with a healthcare foundation. We saw that developing ways to partner closely across roles allowed healthcare systems to achieve goals that ranged from increasing patient-centeredness to reducing length of stay.

Creating Engagement through Real Work

As with any sustainable change, Propulsion starts with leaders setting a strong direction for organizational leadership and competitive strength in their particular environment. However, the leader’s job does not end with being clear about the strategic direction. People need to know how they can play a part in making change happen, and leaders can help by embedding change strategies into real work that’s already on a given team’s plate.

For example, the medical director and nurse leader for surgical services at a specialty hospital focused on women’s health saw together the need to shift their unit from a culture of blame to one of problem-solving through interprofessional collaboration. Instead of enrolling their team in programs that preached the values of teamwork or respect, they took a sharp look at the actual work of the staff. What exactly did they need to adjust in order to improve patient outcomes and satisfaction?

They found ample opportunity in time management issues in the OR — surgeries weren’t starting or ending on time, which had

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PROPULSION: TURNING STRATEGY INTO ACTION QUICKLY – PART 4 *continued*

implications for patient safety and employee and patient satisfaction. They implemented training to introduce clinical (physicians, nurses) and non-clinical (pre- and post-op, housekeeping) team members to each other's roles and responsibilities. Training centered both on process improvement and on best practices in communications and collaboration, like closed-loop communication, constructive conflict resolution, resource management, and the empowerment of every member of the care team to speak up for safety (and be heard). Having this new knowledge about ways of working together, and opportunities for application, allowed the teams to deliver on the objective of shared problem-solving within their existing work processes.

Through turning strategy to action quickly, the surgical services team has seen remarkable improvement in metrics that were meaningful to the hospital, the team, and most importantly, the patient. Over four years the team at this hospital has cut turnover time by 20%, seen an increase of over 100% in first-case on-time starts, and have eliminated 700 hours of delays.

Supporting Behavior Change

We've seen that implementing a successful strategy isn't a one-time "fix." New behaviors, like new collaborative processes within teams, require new infrastructure and resources to support and sustain the changes. Without the right elements supporting change, strategy can stall — but sometimes those elements are difficult to anticipate. This is where creativity also comes into play in implementation.

The interprofessional Palliative Care Team at a children's hospital within a prestigious Midwestern hospital system is composed of a physician, two nurse practitioners, a nurse, a social worker, and a chaplain. The stakes are high for the team — they form a consult service to families with very sick children, and provide a summary of the child's situation and recommended steps to the child's physicians. They have goals they hold sacred, to "carry their story," and "serve the family and meet their needs." In order to deliver on this work, the team elected to rely on a non-traditional resource for clinical teams — group therapy. This venue provides a safe space to air conflicts and, as such, deepens the team members' trust in one another, a key ingredient to the success of their work with families. It also allows the team to flex and try new things, knowing they have reflective time to weigh in on the changes together and come to shared agreements.

With these elements — setting direction and engaging teams in real work, and supporting behavior change with the right infrastructure and resources — organizations can put strategy into action quickly, and sustain on-course delivery and adjustment of their strategy over time.

In this series, we have described distinct approaches that can help organizations move toward being superconducting, where results come faster and they last. Our first installment outlined the Superconducting Organization ([Part 1](#)). These approaches include mobilizing the energies of your workforce (Leading Leaders, [Part 2](#)), engaging resistance to pick up speed (Superfluidity, [Part 3](#)) and this piece on Propulsion, turning strategy into action quickly.

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: PASSAGE FROM INDIA.

If the purpose of clubs at Wharton is to provide memorable out-of-the-classroom experiences, then the Wharton Global Health Volunteers (WGHV) gets my seal of approval. I guess it is not much of a surprise, seeing as I have been a Board member for one and a half years, but this winter I was finally able to participate in one of the developing country consulting projects the group was created to arrange, working with the Aravind Eye Care System in southern India. While I envisioned the experience as a chance to synthesize everything I had learned on campus, I was surprised at how much the experience made me reconsider the way we do everything back here in America.



The Aravind Eye Care System was founded in 1976 by Dr. Venkataswamy as a 20-bed hospital in his apartment dedicated to eliminating preventable blindness in India; the first employees were all family members. Growing without debt, donations, or acquisitions, Aravind was able last year to conduct over three million diagnostic consultations and perform 400,000 surgeries in five tertiary hospitals, five secondary hospitals, and 50 rural vision centers. While consultations cost 40 cents and cataract surgeries range from free to two hundred dollars, depending on willingness to pay for comforts, the system posted a gross profit of 69% on \$102 million (all numbers purchasing power parity). Peer-reviewed complication frequencies place Aravind's quality above developed nations' systems.

Without a doubt, some of Aravind's ability to break the "Iron Triangle" trade-off of quality, cost, and access is due to idiosyncrasies of the Indian economy (dramatically different relative costs of labor and capital versus America). However, some of the values are interesting to consider applied to a radical rethinking of our American system:

- 1. Drastically narrow your goal:** Aravind is singularly-focused on maximizing the number of patients diagnosed and treated for a discrete handful of conditions irrespective of ability to pay. This allows them to say "no" to everything else, maximizing the impact of each minute and each dollar. How many American non-profit hospitals can boast the same focus, most instead choosing to compete generically to differing levels of effectiveness across all major specialties.
- 2. Anything unrelated to the goal is waste:** Is having a big shiny building critical? No. Even Aravind's 600-bed main hospital was built largely by hand, and each floor was only added once necessary. Is a modern \$3,000 refractor system significantly better than the \$200 suitcase of lenses used by our grandparents' optometrist? No. Go with the suitcase. Aravind also eliminates traditional waste, posting flyers around the hospital detailing the annual electrical cost of everything from slit-lamps to ceiling fans.
- 3. Radically rethink your approach to the goal:** In the early 90's, Aravind's ability to reduce the cost of cataract surgery had hit a wall. While capacity utilization was approaching 100%, surgical supplies, especially the imported intraocular lenses used in cataract surgery, were cost prohibitive for Aravind to provide care at the scale and price point required. Instead of reinvesting system earnings in continued hospital growth, Aravind started a new group, Auro Lab, to mass produce surgical supplies at minimal cost. Within two years, Auro Lab lenses were produced at comparable quality to imports at 1/8th the cost. Today, Auro Lab lens exports comprise 8% of the world market, impacting care far beyond Aravind's geographic footprint.

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WHARTON AROUND THE GLOBE: PASSAGE FROM INDIA.

continued

4. **Educate the patient...:** Aravind takes competition with ignorance and superstition as a given. The hospital was empty on January 1st because even urban locals believed that if you were in a hospital to start the year, you would be sick the entire year. Of patients diagnosed with surgically-treatable conditions, only 80% accept surgery despite all cost barriers having been removed. In response, Aravind employs community organizers to increase awareness and trains all staff to educate. In America, change seems hard, but what if the biggest barrier to some off-handedly discredited business model changes were simply patient education?
5. **...Because outcomes are uncorrelated to almost everything patients imagine:** a hospital with shorter doctor visit durations, lower technology settings, hand-washed floors, and 17 year old nurses outperforms the developed world on quality, and the very processes that allow this to happen would appear low quality to a Western patient. What would you do if you didn't think your patients would resist? Your patients are probably more interested than you imagine.
6. **Healthcare investment need not follow a straight line:** Aravind village eye care clinics have only a slit lamp, refraction lens set, ophthalmoscope, light bulb, fan...and a computer workstation with EMR and telemedicine software.

As the American healthcare system looks forward, especially under the increasing discipline of bundled payments (at inevitably decreasing/decelerating rates), maybe it's time to look abroad to the scrappy providers of the developing world for quality-neutral cost containment.

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

Visit the WGHV Website at groups.wharton.upenn.edu/WGHV/

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Bare-bones set-up at a rural eye-care clinic, including plastic lawn chair, classic refraction set, and a teleconferencing station

WHARTON AROUND THE GLOBE: PASSAGE FROM INDIA.

continued



A prosthetist fashions a metal leg using hammer and anvil at one of India's most respected orthopedic hospitals, Gandhigram, India

ADHERENCE APP APPEALS TO ELDERLY

We often wonder whether apps can really help with older patients, or maybe digital health is just not right for those 60 and over. Turns out that when an app answers a need, it will be used and can provide positive outcomes. What a concept!

[Research](#) conducted by Talya Miron-Shatz, PhD, and German colleagues, Dr. Stefan Becker and Prof. Ekhard Nagel of the University of Essen, Dr. Urs-Vito Albrecht, and others, examined the mobile application “Medication Plan,” designed by Becker, which was downloadable for free from the Apple App Store. It was aimed at supporting the regular and correct intake of medication.

The app-related activities of 1799 users (1708 complete data sets) were recorded. 74% were male (872/1183), with a median age 45 years. Perhaps contrary to expectations, the older the patients were (youngest age group being under 21), the longer they used the app, with users aged 60 and above using it for an average of 103.9 days on average.

“Daily usage intensity” was directly associated with an increasing number of prescribed medications and increased from an average of 1.87 uses per day and 1 drug per day to an average 3.71 uses per day for users taking more than 7 different drugs a day ($p < 0.001$). Demographic predictors (sex, age, and educational attainment) did not affect usage intensity.

The [findings](#), recently published in Plos One, strongly suggest mobile applications may be a promising approach to support the treatment of patients with chronic conditions. Miron-Shatz, CEO of CureMyWay and an expert in medical decision-making and behavior change, points out the extended usage is particularly impressive given that no major gamification was applied, thereby indicating that intrinsic motivation – wanting to keep one’s health – can be very powerful. *For those of us wondering how to drive behavior change and create a sticky health product, the answer might be – bring value that supports people’s existing goals. The rest will follow.*

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For a great overview on mobile apps and to learn more about her work, click [here](#).

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WRITING THE ORGANIZATIONAL PRESCRIPTION FOR PHYSICIAN HEALTH

continued

Physician Alignment. Physician Engagement. Shared Incentives. These are the new buzzwords behind well-intentioned organizational efforts to win the hearts and minds, and, ultimately, mold the actions of physicians whose practices have been the subject of acquisition. The broad consolidation in the healthcare sector has created dominant hospitals and insurers in many geographic areas. Larger systems reap marketing advantages in terms of capturing and keeping healthcare consumers; they also bring efficiencies to bear. And while institutional leadership often focuses on the benefits of accretive acquisitions, for employed physicians the transformation is often marked by seller's remorse.



Many physicians believe medicine has lost some of its luster as a profession. Employed physicians no longer have the same level of autonomy or self-direction that previous generations enjoyed. Increasingly, physicians no longer control the content of their work, nor the organization of their practice. One critical review of the physician's current role even calls into question the entire notion of medicine as a profession: "lacking this authentic autonomy (the physician profession) may alternatively be given designations as quasiprofession, paraprofession, semiprofession, subprofession, or a trade."¹ Designating healthcare professionals as "providers" further erodes the pivotal and irreplaceable role of the clinician.

The Grumpy Clinician Syndrome

Many clinicians today are looking very much like the patients they counsel: overweight, depressed, under-exercised, over-stressed, and fatigued by the rigors of work. They are increasingly subjected to the ravages of systemic inflammation, neurotransmitter depletion, metabolic syndrome, sleep deprivation, musculoskeletal tension, and chronic pain syndromes.

A [2012 survey](#) of 7,288 physicians indicated that nearly half of U.S. physicians report at least one symptom of burnout.² According to the survey:

- 37.9% had high emotional exhaustion.
- 29.4% had high depersonalization.
- 12.4% had a low sense of personal accomplishment.

In another study of over 20,000 U.S. physicians, more than 78.6% cited "patient relationships" as the #1 most satisfying part of their jobs, yet this is the aspect that is suffering most under the burdens of healthcare bureaucracy. That's a big part of why an overwhelming majority — 51.1% — reported they are pessimistic about the future of medicine.³ Eighty-two percent believe they have little ability to change the healthcare system. More than 84% feel the medical profession is in decline, and nearly 58% were reluctant to recommend medicine as a career to their children.⁴ The *Medscape 2015 Physician Lifestyle Report* noted that physician burnout has increased by 16% over just two years.⁵

The contributing factors behind physician burnout have been well cataloged: increasing number of sicker patients; frustration with the ever-growing mountain of meaningless work and box-checking; continuing aggravations of hospital politics; an EHR that replaces eye contact with frustrating, time-consuming data entry; medicolegal worries, difficulty keeping up with the peer-reviewed literature; real concerns about income and making ends meet while paying off loans or investing in family and personal needs...the list goes on.

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WRITING THE ORGANIZATIONAL PRESCRIPTION FOR PHYSICIAN HEALTH

continued

With this understanding as a backdrop, what can organizations do to create the conditions that are necessary for physician engagement?

Maintain Flexibility in Leadership Style

Dynamic tension will always exist between administrators and employed physicians, even when the administrators are physicians. This schism becomes exacerbated when managers are inflexible in their leadership styles. A directive style is ideal for crises; it's a prerequisite for successfully handling cases in the emergency departments, but, in general, a more participative approach will engender better results.

Physicians need to participate in the decisions that affect them. Physicians, nurses, and in fact any and everyone who is close to the patient, must have a voice in the patient experience. Those closest to the patient, the caregivers, have the most accurate and actionable information. Those closest to a problem also have the best chance of solving it. In contrast, administrators who are steps removed from direct patient care receive a watered down and incomplete view of reality. Those managers who exhibit an authoritarian style with little listening ability rarely get the buy-in that is necessary for organizational improvement. A participative environment also allows the enablement of physician champions who are critical for any organizational change effort.

Recognize that Context Must Always Precede Content

Communicating any organizational imperative or change requires both clarity and context. Yet all too often, organizations leap to selling the benefits of a new program, system, or initiative only to find resistance from the physician, nursing, or staff groups. It is human nature to first want to understand the “why,” before the “what” and “how.” Context is a prerequisite for understanding. Sharing data engages physicians’ logical minds and dampens emotional resistance. Physicians will attend to and believe in the message of leaders if they believe that doing so will benefit them in meaningful ways. The benefits may be better care of patients, more money, better time utilization, process improvement, or fewer errors and distractions.

Make Affirmation a Regular Practice

The most common feedback most employees receive on the job is no feedback at all. The next most common type is negative. Those organizations that actively focus on recognizing and rewarding effort, as well as on doling out task-specific feedback and praise, become magnets, thereby attracting the best clinicians and the most grateful patients.

For a position in healthcare to be more than a job, the individual must feel that it is part of their calling with an overarching meaning and purpose. Good leadership continually lets people know they are making a difference. This creates confidence in the organization's success.

Bring Mindfulness to Medicine

One type of wellness initiative that holds potential to engage — and help heal — wounded healers is known as mindfulness-based stress reduction (MBSR). It is a type of mental training that enables participants to actively notice and experience things in a non-judgmental, non-reactive manner. Practicing mindfulness enhances clear thinking, equanimity, compassion, and open-heartedness.⁶

MBSR may be the most adaptable and acceptable stress reduction practices for physicians. It is non-religious, yet addresses meaning and purpose and is supported by a solid body of evidence. One of the drawbacks of most relaxation techniques is that they require a significant time commitment. This is always an issue for busy physicians.

Researchers at the Department of Family Medicine, University of Wisconsin-Madison sought to determine whether a more abbreviated MBSR might be helpful in reducing physician burnout. They recruited 30 primary care clinicians who took part in an abbreviated mindfulness course consisting of 18 hours of

WRITING THE ORGANIZATIONAL PRESCRIPTION FOR PHYSICIAN HEALTH

continued

class training, the use of a practice audio recording, and a specifically designed website with mindfulness techniques for the doctors to use with patients. The physicians were encouraged to practice their mindfulness techniques daily for 10-20 minutes.

Physicians participating in this mindfulness course experienced reductions in indicators of job burnout, depression, anxiety, and stress, all of which may have implications for patient care.⁷

Today's healthcare environment has been likened to being afloat in a sea of continual turbulence, exacerbated by the frequent storm. All meaningful organizational change must have strong physician support. Understanding physician stressors, attending to leadership style, creating health supportive cultures, and continually affirming all clinicians can help engage physicians in moving your organization forward.

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EMPLOYEE WELL BEING AND COMPANY PERFORMANCE: ARE YOUR EMPLOYEES AT THE CENTER OF YOUR BUSINESS?

In Part 1 of this multi-part article, we discussed ways companies can help ensure optimal business outcomes by focusing on employee engagement. In Part 2, we explore the pivotal roles employees' nutritional and medical health, as well as personal fulfillment drivers, play in workplace engagement and provide effective ways to understand employees' health and fulfillment internal perceptions, along with recommendations for effective communication strategies to improve employee engagement, fulfillment, and growth.



Employees' medical health and personal fulfillment drivers play a pivotal role in workplace engagement.

Companies with a disengaged workforce must analyze their employees' well-being by looking at all three facets. Are employees feeling the effect of low nutritional and medical well-being resulting in high healthcare expenditures? Are employees not engaged in their work activities due to misalignment with their personal fulfillment drivers? Once these questions are honestly answered, corporations can create a roadmap to success with a three-pronged approach.

To effectively communicate, and change human behavior, it is important to understand what beliefs and motivators are in play. For example, if an employee believes the company they work for places great importance on their personal fulfillment, then they will feel a strong sense of purpose and appreciation for their employer. If the employee perceives their employer is concerned about their health and believes good health is important for total well-being, the level at which they engage in a healthy lifestyle increases. Accordingly, in the first prong, we encourage employers to ensure they are taking sufficient measures to understand the internal perceptions of their employees.

Once an understanding of these perceptions has been gained, employers can then create change by drafting messages based upon two criteria: awareness and actionability. Looking at these two criteria through the lens of medical well-being, employers must create an environment that encourages and motivates employees to pursue healthy lifestyles. Analyzing the personal fulfillment drivers and building an environment that places emphasis on personal fulfillment growth and offers an avenue for such is essential.

In the first two prongs of this strategy, corporations are challenged to understand their environment. Once this is understood, employers can work towards creating change through effective communication. This third and final prong requires a five-step approach. Employers must: (1) allow options for employees (offer choice), (2) personalize the options based upon the employees' preference, (3) provide a satisfying and engaging experience to the employee by using easily understood and direct language, (4) ensure that all messages are in line with the corporate culture, and (5) incentivize employees accordingly. By applying these steps in communicating for change in health and employee, fulfillment corporations will see radical change.

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