



# **THE WHARTON HEALTHCARE QUARTERLY**

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## EDITOR'S LETTER

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Swirling in the chaotic healthcare environment? Looking for answers and solutions to address the demands of relentless change endemic in the healthcare landscape? You've come to the right place! This issue of the *Wharton Healthcare Quarterly* serves as a guide to help bring order to the chaos and avoid some of the hidden landmines that may be buried along the path to optimizing the well-being of individuals and the financial health of organizations.

Happy reading!

As always, we welcome your feedback, ideas, and contributions!

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



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

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## THE PRESIDENT'S DESK

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Well, we did it. We accomplished our goal of raising \$500,000 for the Alumni Scholarship in honor of June Kinney. As a matter of fact, as of May 20, 2014, we had commitments of \$576,000 and had collected \$406,000 of this amount. The money keeps rolling in, as well it should.

June has been great to us, and we have benefitted from her guidance and friendship over the years. As mentioned previously, this also speaks volumes about our generosity, willingness to give back, and desire to ensure the Wharton Healthcare Program continues to be, dare I say, the pre-eminent program in the U.S. Thank you to all who have given to a very worthy cause.

On another note, related to one reason for existing as an organization, i.e., giving back to the program, we recently selected the Alumni Kissick Scholarship recipient. His name is David Fajgenbaum. David meets the purpose of this scholarship in spades. He is a first-year Wharton Healthcare MBA, an imminent graduate of the PENN Medical School, and also has a Masters Degree from Oxford University. David's focus is on accelerating the research and development of orphan diseases and building the infrastructures to do so - fundraising, engaging the medical community, identifying centers of excellence, and disbursing funds in a manner which accelerates the development of such therapies. David will use the \$15,000 scholarship for tuition.

As you may or may not know, we have initiated a presence on the Wharton SIRIUS XM business radio station. Our goal as part of a series is to discuss with Wharton professors topics of interest to the general public. On May 2, 2014 the faculty and alumni presented on provider and payer consolidation and what this means to the consumer. We enlisted 2 Wharton professors, Bob Town and Rob Field, both experts in this field. This is truly a great way for the alumni and faculty to interact with each other and for us to get the word out on some of the really important issues the alumni and faculty deal with in the real world. Stay tuned for more.

We had our first live event with the Wharton Club of Northern California in San Francisco – “Digital Health – Venture and Human Capital Perspectives.” It was a sold-out event hosted at Bank of America and was coordinated by our regional captain in the SF area – Robert Mangel, PhD (graduate of the Wharton PhD program). Let's keep these events going in SF! We have a large number of Wharton alumni in the SF area, and it is great to see events like this.

Please check the WHCMAA website for any upcoming events and mark your calendars for our upcoming Friday, October 31, 2014 conference at Wharton. John Harris, WG'88 and Bryan Bushick, MD, WG'88 have done a nice job as co-chairs for the conference. Registration will begin in the early summer.

Lastly, I would like to thank the following Board members who are stepping down this year for their service: Doug Arnold, WG'84; Ryan Berger, WG'06; Alexis Bernstein, WG'10; and Gary Phillips, MD, WG'91. Your time and effort have been very much appreciated, and we wish you well in your future endeavors. I would also like to thank Maureen Spivack for her work as Secretary. Maureen is stepping down from this position but would like to remain on the Board and has put her name on the ballot for the upcoming vote. Maureen has done a great job in the Secretary's position, and her experience and insight have been invaluable.



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

## **THE PRESIDENT'S DESK**

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The Board vote should be coming your way shortly. Please take the time to vote, as the individuals who are elected represent you and end up doing much for you.

As always, thank you for being part of the Alumni Association and stay involved! The WHCMAA is a wonderful vehicle for learning, staying in touch, and networking with all of the people who have graduated from this program.

Sincerely,  
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President WHCMAA  
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## OPEN WIDE: AND MILES TO GO BEFORE I SLEEP

This closing line from Robert Frost's, "Stopping by the Woods on a Snowy Evening," came to mind as I was sizing up this year's National Oral Health Conference held in Fort Worth, Texas the last week in April. Sorry, no pictures of me being thrown from the mechanical bull. Party-animal nerd that I am, I spent about an hour at the bar during the closing reception discussing health reform and dentistry's place in it, or more accurately, *not* in it, with a Penn Dental emeritus professor. This is not the same as the annual meeting of the American Dental Association. Indeed it might be considered the polar opposite, as the NOHC is billed as "the premier meeting for dental public health," and the ADA could well be termed, "the premier meeting for dental *private* health," if such a term were overtly recognized. And yet, the two may not be such polar opposites after all, having more in common than one would otherwise expect, especially those in the "public health" camp. I think I may have let on to a heresy here, but also a realization why those metaphorical miles seem to be piling up, rather than decreasing, and why it is proving to be so difficult to bring about more accessible, efficient, affordable, integrated, and quality-assured dental care (in other words, along the lines of where health reform is heading). And this is where the overlap exists, as I see it: largely unwittingly, both camps implicitly accept, and even promote, with little challenge or examination, that solo practice, fee-for-service dental care is just fine, essentially the gold standard for the delivery of care. The corollary then becomes access to care is defined as those who cannot avail themselves of dental care under the terms and conditions of the private practice model and are deemed "the underserved." In other words, "access," even in the eyes of the "public healthers," is a function of the existing organization and financing of care, both of which are geared toward rendering procedures (for those who can afford them) and not toward securing "the dental health of the public."



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



In a sense, the whole "dental public health" infrastructure (with the exception of community water fluoridation and school-based sealant programs) - the clinics, the mobile dental vans, the grant-supported special populations programs, the masters in public health programs, the dental public health residencies, workforce loan forgiveness programs, etc. - is a vast, loosely coordinated bureaucracy, the purpose of which is to address the dental care needs of those whom traditional dentistry shuns, all the while attempting to do so within the confines of the predominant model of dental care delivery care, which itself is reinforced by the dental schools, the dental insurance industry, and the dental profession itself. To be fair, or at least more accurate, policymakers are responsible for this as well, when rational legislation at the state and federal levels succumbs to lobbying by the established dental interests.

So how does the conference in Fort Worth fit into this picture? In at least two ways that I could directly see. One was in a session called "Meet the Press – Workforce Discussion," one of the more interesting, engaging, informative, and revealing ones at the conference. Following the NBC Sunday morning program format, a moderator asked questions of four panelists, centering upon the use of "mid-level" providers in dental care, which then inevitably led to other related and larger issues. I should probably admit to a bias as to why I found this session's discussion among the more engaging of all - two of the panelists were also dentists who also held MBA degrees. Consequently, I think the



## OPEN WIDE: AND MILES TO GO BEFORE I SLEEP

*continued*

discussion broke out of the conventional mold of thinking and took on a broader examination of the “dental care industry” and ways it might be transformed. In other words, they were speaking a language I could understand (but I wonder how many others in the audience could; the overwhelming majority of those in attendance at the conference also had joint professional/MPH degrees, and, quite literally, those with an MBA amounted to maybe a baker’s dozen). This is not just a trifling observation – the differences in outlook between the two degrees amounts to a near chasm, and is one reason I believe the “public healthers” have more in common with the establishment than they realize. But perhaps more on this another time.



Anyway, getting back to the “Meet the Press” discussion, I found it rather eye-opening to hear the following questions and comments:

*“We here see the need for change, but where will it come from? Certainly not the medical schools or the dental schools. Not the ADA. If not those, then what about some outside body or foundation to explore other models of care, such as what the Committee on the Costs of Medical Care did in the 1920s?”*

*“There’s a lot of consumer movement taking place in health care; will we see consumer-led efforts for change in dental care?”*

*“Change needs to come through reimbursement and in the appropriateness of care; the insurance industry needs to come up with some new products if we are to see any change.”*

*“What is the nidus for change? What about corporate dentistry and the influence of those models?”*

*“What about venture capitalists, those who can see profit in moving from procedure-driven payment to outcome-based payment models?”*

*“What we lack is transformative leadership. There’s lots of what I would call “collaborative leadership,” ... but it doesn’t accomplish anything.”*

So it was encouraging, even a bit exciting, to hear language and concepts with which I was familiar - “MBA-speak” perhaps - being applied in a setting heretofore unfamiliar with it all, yet in dire need of hearing it, and hearing much more of it.

Yes, what new reimbursement arrangements can the insurance companies design? Can consumers get their voices heard in the choices they have, or don’t have? Will corporate health benefits departments start pushing for change and accountability? Will prescient venture capitalists assess the dental care market, bring in new organizational types with agile workforces, able to demonstrate improved outcomes under well managed risk-sharing arrangements? As I have said previously, the health reform train has left the station, and dentistry doesn’t even have a ticket in hand. But given the questions and discussions I heard, maybe some are beginning to figure out where the ticket office is.

## **OPEN WIDE: AND MILES TO GO BEFORE I SLEEP**

*continued*

So with MBA biases in mind, I clapped enthusiastically at the conclusion, even going up to talk a bit further with one of the panelists. My feet felt lighter on the ground as I walked out of the meeting room.

Then, the next day I could feel the weight of leaden soles. In characteristic “circle the wagons” reaction to all that it sees taking place in health reform, I learned the ADA House of Delegates, its deliberative body, passed a resolution requiring that only dentists could vote and hold office in any of the recognized dental specialties. In other words, a non-dentist health economist, a non-dentist health systems executive, a non-dentist hygienist with a PhD in health services research and evaluation (they do exist!) could not occupy a voting position on the Board of Public Health Dentistry or the American Association for Public Health Dentistry. Needless to say, this drastically reduces the potential pool of candidates to occupy these positions, deprives dentistry of the perspectives it needs to be relevant as health reform evolves, and it puts an end to those promising avenues of inquiry brought out during “Meet the Press.”

As with those panelists, I keep looking for that crack in the façade, the hole in the dike, that can be exploited (by the MBA mind) to transform an entire industry. Yes, there are promises to keep, yet still so many more miles before I sleep.

Contact Harris at: [hcontos@alumni.upenn.edu](mailto:hcontos@alumni.upenn.edu)

## THE PHILOSOPHER'S CORNER

### Life Lessons:

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

Pushed even harder to advance research during the year prior to launching the Castleman Disease Collaborative Network. As a medical student at the time, I had a lot of faith in the biomedical research process — that it was moving at an appropriate pace, in a coordinated and collaborative fashion, and in the right direction. As I spent more time working within the space, I observed the lack of collaboration, strategic direction, and outcome-driven approach that slows the pace of biomedical research, particularly for less common disorders. With the assistance of global KOLs for one particularly deadly and poorly-understood hematologic disease, idiopathic Multicentric Castleman Disease (iMCD), we quickly translated these “opportunities” into initiatives. In a deadly disease like iMCD, lives are lost as progress is not made, so I wish we had gotten started earlier.

Since realizing the process needed to be accelerated two years ago, we have published a review article in the journal *Blood* that advocates for a paradigm shift in our concept of pathogenesis and proposes a new classification system; created a Global Research Agenda and Strategic Research Plan; built a database of 200+ treating physicians and researchers worldwide; organized the largest-ever iMCD research meetings during the 2012 and 2013 American Society of Hematology meetings; and established a partnership with Janssen Pharmaceuticals.

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

Made some of the hiring decisions for National Students of AMF that I made during our early years. National Students of AMF is a support network I co-founded in 2006 for college students grieving the illness or death of a loved one. We made tremendous progress in our first four years: working with students from 100+ campuses, launching 35 official campus chapters, and propelling grief to a priority issue in higher education through nationwide awareness campaigns, conference presentations, and establishing an annual National Conference on College Student Grief. Under my leadership as Board Chair, our first couple of external staff member hires were based more on those individuals' previous work experiences than on their cultural fit and shared values with the organization. As I've hired and managed more individuals, I've learned the value of slowing down the process to ensure there is a close match between organizational culture and personal attributes.

### Favorite Quotes:

1. “Life can be much broader once you discover one simple fact: Everything around you that you call life was made up by people that were no smarter than you and you can change it, you can influence it, you can build your own things that other people can use.” - Steve Jobs
2. “Don't give up, don't ever give up.” - Jimmy Valvano
3. “If it's worth doing, it's worth doing well.” - Hunter Thompson
4. “In the end, it's not the years in your life that count. It's the life in your years.” - Abraham Lincoln



David Fajgenbaum, MD'13, MSc  
To learn more about David, [click here](#).

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

## THE PHILOSOPHER'S CORNER

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### ***Recommended Reading:***

- *Good to Great: Why Some Companies Make the Leap...and Others Don't* by James C. Collins
- *The Emperor of All Maladies* by Siddhartha Mukherjee
- *Steve Jobs: A Biography* by Walter Isaacson
- *Outliers: The Story of Success* by Malcom Gladwell

For anyone interested in reading more about idiopathic Multicentric Castleman Disease, HHV-8-negative, idiopathic multicentric Castleman disease: novel insights into biology, pathogenesis, and therapy, [click here](#).

For more information about the CDCN, [click here](#).



## ALUMNI NEWS

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### **Richard A Rasansky (Rick), WG'83**

Philadelphia's Yorn (yorn.com) was recently highlighted at The 2014 Cleveland Clinic Patient Experience Summit and was the official feedback platform for over 2100 attendees. Rick is founder and CEO of Yorn – (Your Opinion. Right Now.®), a real-time feedback platform for healthcare settings. Optimized for mobile and HIPAA compliant, Yorn's "Feedback-as-a-Service" (FaaS™) enables patients, family members, and clinical staff to provide real-time feedback, in the moment, on any healthcare experience. These insights enable providers and payers to identify root causes of potential problems and make appropriate operational changes that improve patient experience, patient satisfaction, and patient compliance with care plans. Rick was also recently featured on SiriusXM's Business Radio (Channel 111) powered by The Wharton School "When Things Go Wrong" show.

Contact Rick at: [info@yorn.com](mailto:info@yorn.com)

Learn more at:

Yorn in 90 seconds <http://youtu.be/ZUZYtMdHbmQ>

6ABC News video segment <http://bit.ly/1aRhbj>

### **Z. Colette Edwards, WG'84, MD'85**

Colette offers her insights on some of the positive changes employers can make in the workplace to improve the health, well-being, and productivity of their workforce and therefore the organization's bottom line:

- [The \(Hidden\) Cost of Insecurity: Can Un-ease Lead to Dis-ease?](#)
- [5 Ways to Promote Healthy Aging in the Workplace](#)
- [All for One and One for All: The Business Case for Addressing Health Inequity and Health Disparities](#)
- [Be Yourself and No One Else: Leading with Authenticity](#)

Contact Colette at: [zcedwards@zcoletteedwards.com](mailto:zcedwards@zcoletteedwards.com)

### **David Friend, MD, WG'84**

Dr. David Friend joined the BDO Center for Healthcare Excellence and Innovation as Managing Director and Chief Medical Officer to lead Clinical Strategy. In this role, David leverages clinical and financial expertise to deliver strategic healthcare services to assist healthcare organizations in navigating the significant changes experienced throughout the industry.

Dr. Friend has more than 30 years of healthcare experience, serving as a physician executive, board director, and consultant advising clients on performance improvement, operational transformation, clinical integration and M&A advisory, among other strategic imperatives. Prior to joining BDO, Dr. Friend served as the Chief Clinical Officer of Golden Living, a leader in post-acute healthcare, where he was responsible for the care of over 20 million patients annually, encompassing 42,000 associates across 40 states. Dr. Friend also served as President and Chief Medical Officer of Aseracare, a leading provider of

## ALUMNI NEWS

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hospice and palliative care services.

Formerly, Dr. Friend served as Chairman and Chief Executive Officer of The Palladium Group, a global data analytics and consulting firm; Managing Director in Healthcare at Alvarez & Marsal, a turnaround management and performance improvement firm; and Senior Partner at Towers Watson, a global HR consulting firm.

Contact David at: [dfriend@bdo.com](mailto:dfriend@bdo.com)

Learn more at: <http://www.bdo.com/industries/health/>

### Fran Kelleher, WG'84

Fran Kelleher recently joined the Centers for Medicare and Medicaid Innovation Center as a Health Insurance Specialist. CMMI is developing new ways to pay for Medicare and Medicaid. Fran will work in the State Innovation Group to support state-wide demonstration projects that involve all health care payers whether government or private health insurance.

Contact Fran at: [FranKelleher@earthlink.net](mailto:FranKelleher@earthlink.net) or 240-863-8617

### Jeff Voigt, WG'85

Published: Voigt J, Mosier M, Huber B. In-office diagnostic arthroscopy for knee and shoulder intra-articular injuries – its potential impact on cost savings in the United States. *BMC Health Services Research* 2014, 14:203; <http://www.biomedcentral.com/1472-6963/14/203>

Contact Jeff at: [meddevconsultant@aol.com](mailto:meddevconsultant@aol.com) or phone 202-251-8204

### Cari Kraft, WG'85

Cari Kraft is launching *Healthcare Sales and Marketing Magazine (HS&M)* in June 2014. *HS&M* is the first-ever e-magazine dedicated exclusively to healthcare industry marketing & sales professionals spanning the pharmaceutical, medical device, biotechnology and diagnostics industries. It is a joint venture between Jacobs Management Group, the seasoned healthcare recruiting organization Cari owns, The Healthcare Sales & Marketing Network® (the leading website for healthcare sales & marketing professionals), and a 25-year custom publishing industry veteran.

Contact Cari at: [ckraft@jacobsmtg.com](mailto:ckraft@jacobsmtg.com)

For more information:

[www.jacobsmtg.com](http://www.jacobsmtg.com) – Jacobs Management Group website

[www.hsandm.com](http://www.hsandm.com) – HS&M Website (soon to be live)

[http://salesandmarketingnetwork.com/signup\\_mag\\_form.php](http://salesandmarketingnetwork.com/signup_mag_form.php) - sign-up to receive *HS&M*

## ALUMNI NEWS

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### **Amanda Hopkins Tirrell, FACHE, WG'86**

This past year has been an eventful one filled with a number of milestones. My daughter Penelope graduated from Eckerd College in May and began her career in service by joining AmeriCorps teaching English in an inner city school in Tampa, Florida. Her job search took a lot less time than her Mom's – and I am pleased to report that after 13 years in New England I will be making my 13th professional move, this time to Augusta, Georgia where I will be the new Vice President & Chief Operating Officer for Georgia Regents Medical Associates, the faculty practice for the Medical College of Georgia. My husband Chris and I are looking forward to this new adventure, and I am really looking forward to the short winters in the land of the Masters! All Wharton Healthcare friends are invited to come visit – and feel free to bring your golf clubs!

Most important, I want to thank all of my wonderful Wharton Healthcare Alumni friends and colleagues for their support during this past year. I am so fortunate to be an alumna of our Wharton Healthcare program, which has allowed me to connect and stay connected with so many wonderful, accomplished health care colleagues and leaders – all of whom provided much needed encouragement, support and inspiration! So many doors were opened to me because of my Wharton Healthcare education and the experience that has led me to this point in my career. So, thank you!

Contact Amanda at: [Amanda.tirrell@gmail.com](mailto:Amanda.tirrell@gmail.com) or cell (413) 427-4714

### **Scott Ramsey, PhD, WG'94**

I am currently on faculty at the Fred Hutchinson Cancer Research Center, as a Member in the Division of Public Health Sciences. I am also a Professor in the Department of Medicine, University of Washington.

Last year, I started and serve as Director of a new institute at the Fred Hutchinson, called the Hutchinson Institute for Cancer Outcomes Research. It's mission is to improve the effectiveness of cancer prevention, early detection, and treatment services provided to patients in ways that reduce the economic and human burden of cancer.

HICOR is hiring 5 new faculty and building a large data network to achieve its mission.

Contact Scott at: [sramsey@fhcrc.org](mailto:sramsey@fhcrc.org)

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Website: <http://www.fhcrc.org/en/labs/hicor>

## ALUMNI NEWS

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### **Eric Davis, WG'96**

Eric Davis will soon celebrate his 5th year anniversary leading the global strategic marketing Innovation Team at Abbott Diabetes Care in Alameda, California. Eric reports, "The next 6 months will be the most important in our company's history during which time we will deliver multiple innovations which will transform glucose monitoring for both patients and providers. Friends who are passing through the East Bay with any extra time are invited to meet-up to share after hours drinks and innovation war stories!"

Contact Eric at: [ericdavis1966@yahoo.com](mailto:ericdavis1966@yahoo.com)

### **Nishan de Silva, WG'00, MD'00**

After two years leading Corporate Development and Strategy at Ligand Pharmaceuticals, I took over as CFO and VP of Finance and Strategy at Ligand at the end of February and am excited about the new role.

Contact Nishan at: [ndesilva00@gmail.com](mailto:ndesilva00@gmail.com)

### **Rohit Mahajan, WG'08**

Rohit Mahajan has launched a new product – Patient Tablet. It automates the patient intake process and engages patients at the first point of care with a wonderful user experience. The patient data is stored in a HIPAA compliant cloud. Actionable analytics and insights are provided to clients. The Patient Tablet enables meaningful use and is a must have for hospitals, physicians' practices, and retail clinics.

Contact Rohit at: [rohit.mahajan.wf08@wharton.upenn.edu](mailto:rohit.mahajan.wf08@wharton.upenn.edu)

Learn more at: [www.patient-tablet.com](http://www.patient-tablet.com)

### **Fred S. Azar, PhD WG'09**

Fred S. Azar, PhD is now heading Strategic Alliances for Philips Healthcare.

His responsibilities include defining the healthcare alliance strategy, leading new inorganic growth projects, and developing and maintaining a value-adding network of potential inorganic growth opportunities in the healthcare domain, including potential strategic alliances, partnerships, acquisitions and minority investments.

Contact Fred at: [Fred.Azar@Philips.com](mailto:Fred.Azar@Philips.com)



## ALUMNI NEWS

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### **Robert Lieberthal, PhD, WG'11**

Robert D. Lieberthal, PhD, of the Jefferson School of Population Health, was nominated for a Distinguished Mentor Award (DMA). The DMA, established in 2007, recognizes Thomas Jefferson University faculty members who excel in the mentoring of post-doctoral fellows.

Contact Robert at: [robert.lieberthal@jefferson.edu](mailto:robert.lieberthal@jefferson.edu) or 215-503-3852

Learn more at: [http://www.jefferson.edu/university/population\\_health/publications\\_resources/jsph-in-the-news/jsph-faculty-nominated-for-distinguished-mentor-award.html](http://www.jefferson.edu/university/population_health/publications_resources/jsph-in-the-news/jsph-faculty-nominated-for-distinguished-mentor-award.html)

### **Josh Stein, WG'12**

AdhereTech, founded by Josh Stein WG '12, recently announced its Series A funding. The company will use the capital to meet the growing demand for its product and services from pharma companies, CROs, and research institutions across the country.

AdhereTech makes patented smart pill bottles to improve medication adherence and patient engagement. These bottles automatically measure if patients have taken their medication, and all data is wirelessly sent to AdhereTech's servers where it is analyzed in real-time. If a dose is missed, AdhereTech reminds the patient via automated phone call or text message – as well as via on-bottle lights and chimes. The service can also ask patients why doses were missed, to diagnose the drivers of non-adherence early in the regimen.

Last year AdhereTech started working with The Walter Reed National Military Medical Center, and the early data is phenomenal. The company is about to begin engagements with two top-10 pharma companies and one top-10 PBM to improve adherence for cancer, HIV, and stroke medications. AdhereTech is the ideal tool for expensive specialty medications and clinical trials, and the solution is easier to use than any other adherence product ever created.

AdhereTech is always looking for additional customers and pilots. Please contact us to learn more.

Contact Josh at: [j.stein@adheretech.com](mailto:j.stein@adheretech.com)

Learn more at: <http://www.cbsnews.com/news/smart-pill-bottle-could-help-you-take-your-meds-on-time/>

## A ROADMAP FOR “SUPERCONDUCTING” HEALTHCARE ORGANIZATIONS - PART 1

It is undeniable that the last few years have seen momentous change in healthcare. As our country moves from fee-for-service to an approach that drives accountability for the health and wellness of populations, even the steps along the way are in flux — from the postponement of the ICD-10 implementation to the move to overturn the two-midnight rule. The very shape of the industry is also transforming. Amidst an uncertain regulatory and reimbursement environment, healthcare organizations are merging at a greater rate than in the past,<sup>1</sup> building new relationships across the continuum of care. And just as the function of organizations is changing, so too is the way people are working in those organizations. A cultural paradigm shift in 21st century business is accelerating a move away from organizational “command and control” obedience toward models that promote collaboration, inspire creativity and autonomy, and embrace distributed decision-making.



So we find ourselves at a time when the profile of the industry is transforming, the rules of the game are changing, and the way people bring themselves to work is evolving — how do leaders need to adapt to help their organizations thrive and benefit the communities they serve?

As Columbia University Business School Professor Rita Gunther McGrath noted in her recent book, *The End of Competitive Advantage*, in this climate, sustainable competitive advantage is out the door. Instead, resiliency is paramount. Nassim Nicholas Taleb, considered a predictor of the 2008 financial crisis, put forth in his book, *Antifragile*, the complementary idea that organizations built to benefit from constant shifts will thrive in the future. This means throwing out the notion of “the perfect strategy” in favor of a good-enough strategic direction and an organization equipped with the ability to adapt and execute.

The new kind of competitive advantage — centered on organizational agility — requires broad engagement. Our own work in and observations about the healthcare environment helped us define what we call a “superconducting organization,” one where resilience is a core strength. These are enterprises in which talent and innovation flow freely across the organization, people own the changes they need to make, and behavior is aligned with strategy. Results come faster and they last. In this article, we will briefly describe key levers that healthcare leaders can use to build this kind of organization. Each lever will be illustrated in subsequent articles.

### Leading Leaders — Aligning talent when every leader is a volunteer.

Successful companies in every sector of today’s economy recognize that their workforce is a precious resource. Perhaps nowhere is this more powerful than in healthcare, which draws people passionate about solving complex problems to serve and care for their patients.

Viewing talent as “volunteers” can let you think more creatively about getting the most out of your people and improving performance. We have helped leaders align the “volunteer army” inside their organizations by translating ideas into specific behaviors and practices for everyday work. For instance, making a difference in reducing readmissions or improving medication management requires *drilling down to daily behaviors for the care team*. This

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## A ROADMAP FOR “SUPERCONDUCTING” HEALTHCARE ORGANIZATIONS - PART 1

*continued*

degree of clarity about the work enables individuals to see how their unique efforts contribute to the organization's performance as a whole. Employees become more productive and effective and derive greater satisfaction from their work. And thus, the enterprise becomes more profitable.

### **Superfluidity — Engaging resistance to pick up speed.**

In today's healthcare organizations, having a strategy is no less important than it was in the past. Yet leaders need to pay more attention to changing signals in the environment and be able to adapt quickly. This means reviewing strategic initiatives and related tactics on a regular basis. Will they still make a difference or is there a better way forward? In our work with clients, we find that *effective executives know what is happening across the organization and in the market by tapping into leaders at all levels. The feedback and insights that emerge inform strategic direction and help leaders anticipate shifting conditions before making a misstep.*

Sometimes feedback comes in the form of resistance to well-thought-out plans. Every leader advancing change faces resistance — to ideas, to new behaviors, and even to the fundamental premise underlying the change. Often leaders choose to bypass the opposition, identifying “resistors” as having their heads in the sand. But resistance is not necessarily an obstacle — it is a fundamental part of the change process itself. *Engaging with resistance rather than suppressing it is an important new skill for leaders in all organizations. Resistance provides vital intelligence about obstacles to implementing strategy, and understanding it helps leaders to create stakeholder engagement and positive energy to speed needed change.*

### **Propulsion — Getting from strategy to action quickly.**

Many have seen the statistic that 70 percent of change efforts fail.<sup>2</sup> Healthcare organizations waste energy, money, and credibility when strategy stalls. *After doing the groundwork to develop flexible, feasible plans that are responsive to concerns and opportunities, and preparing the workforce to see the future alongside the present, there is a critical window to engage stakeholders in implementation to avoid the fizzle effect. The task is to embed and spread initiatives throughout the organization by supporting behavior change.* For example, if the work is increasing in-system referrals, supporting the change might include easing transfer of electronic medical records between providers, finding creative solutions to open up appointment slots, and making data on referral rates accessible in a dashboard that makes progress clear.

As organizations execute on their strategic direction, we see them run aground by recruiting passionate people to lead the charge, but not preparing them to do the work. In this series, we will explore the levers needed to sustain the benefits of strategy execution. We will investigate how healthcare leaders can work to build superconducting organizations in which talent and innovation flow freely across the organization, people own the changes they need to make, and behavior is aligned with strategy.

In the next issue, we will explore how healthcare executives can tap into the energy of the ‘volunteer army’ of physicians, staff and others to advance the change required for future success.

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

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## DIGITAL HEALTH: A CATALYST FOR HEALTHCARE TRANSFORMATION

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As we speed our way through the second decade of the 21st century, one thing has become perfectly clear: healthcare data and technology, promulgated by digital health solutions, are more accessible to more people than ever before. As a result, there has been a significant increase in the level of entrepreneurial activity and investment in digital health that is driving transformational change in healthcare.

This article begins with a definition of digital health, discusses the key drivers of this emerging sector, identifies potential challenges to growth, and provides a general outlook for the sector going forward.

### What is digital health?

Digital health speaks to the collection, utilization, and communication of health-related data through various hardware and software technology platforms that may be used by the 4Ps of stakeholders: patients, providers, payers, and producers (e.g., pharmaceutical or medical device manufacturers). It can include everything from the pedometer you wear on your shoe to remote monitoring of weight and blood pressure to comprehensive population health management solutions.

Some common digital health segments include:

- big data/predictive analytics
- remote monitoring
- health and wellness monitoring
- telehealth/telemedicine
- transparency (cost and quality)
- population health management
- consumer engagement
- clinical workflow and electronic health records (EHRs)

Innovation in these and other digital health areas present opportunities to drive improvements in the quality of care and overall efficiency.

### Why now?

The healthcare industry is experiencing a convergence of macro- and micro- economic factors creating an environment that is rife with transformational opportunities for digital health solutions.

**Government:** One key player driving transformation has been the federal government. The Affordable Care Act (ACA) has the potential to induce change through multiple pathways, including:

- More patients stressing an under-supplied provider system: A larger insured population could drive increased patient volumes to an already stretched supply of providers.



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## DIGITAL HEALTH: A CATALYST FOR HEALTHCARE TRANSFORMATION

*continued*

- More patient accountability for healthcare spend: The moral hazard associated with the seeming disconnect between the patient receiving care and a third party (insurer) paying for that care is decreasing, causing patients to have a greater stake in how their healthcare dollars are spent.
- Increasing push toward value-based purchasing (VBP): The ACA calls for strengthening the linkage of Medicare payments to quality outcomes.
- Emergence of new patient care models: Accountable Care Organizations (ACOs), which are designed to provide a more holistic and coordinated approach to managing the health of a population and financed through an alignment of quality and cost performance goals, represent one such emerging model.

Each of these issues presents significant opportunities for digital health vendors to offer innovative solutions. The table below highlights a few examples:

Issue	Sample Digital Health Solution Opportunities
<i>More patients stressing an under-supplied provider system</i>	<ul style="list-style-type: none"> <li>• <i>telehealth, remote monitoring</i>: efficiently extending providers' capacity and reach by engaging with patients through technology</li> <li>• <i>EHRs</i>: giving providers faster, more efficient access to relevant patient information</li> </ul>
<i>More patient-accountability for healthcare spend</i>	<ul style="list-style-type: none"> <li>• <i>transparency</i>: arming providers and consumers with more insights on true costs and quality metrics thereby yielding more-informed decision-making</li> <li>• <i>consumer engagement; health and wellness</i>: with greater financial accountability, patients, consumers, and payers may increase focus on wellness behaviors to reduce costs and improve health</li> </ul>
<i>Increasing push toward value-based purchasing</i>	<ul style="list-style-type: none"> <li>• <i>big data/predictive analytics</i>: enhance providers' and payers' insights to facilitate offering the most effective and efficient modes of care</li> </ul>
<i>Emergence of new patient care models</i>	<ul style="list-style-type: none"> <li>• <i>population health management</i>: tools to help providers identify at-risk members of the population and intervene to improve health status and reduce future costs</li> </ul>

In addition to the ACA, the federal government has been driving provider adoption of EHRs through the [Meaningful Use](#) (MU) program that is contained within the [HITECH](#) Act (Health Information Technology for Economic and Clinical Health Act). According to the Centers for Medicare and Medicaid Services (CMS), 93% of eligible hospitals and 82% of eligible professionals have registered for participation in MU. Through February 2014, the government has paid nearly \$22B to providers as incentives for EHR adoption under this program.

**Technology:** The continued rapid evolution of technology has resulted in, to paraphrase Thomas Friedman, “a flattening of the world.” The technology platforms associated with our smartphones and tablets (IOS and Android operating systems) create an ecosystem that allow programmers anywhere in the world to develop applications (“apps”) for use by anyone, anywhere. According to a report by mobile industry analysts [Research2Guidance](#), there are roughly 97,000 healthcare-related apps available in major app stores today.

Beyond the extended reach to a larger base of developers, the technology is similarly available to a larger base of consumers. In that same Research2 Guidance report, it is estimated that 1.7B people worldwide will have healthcare-related apps on their smartphones by 2017.

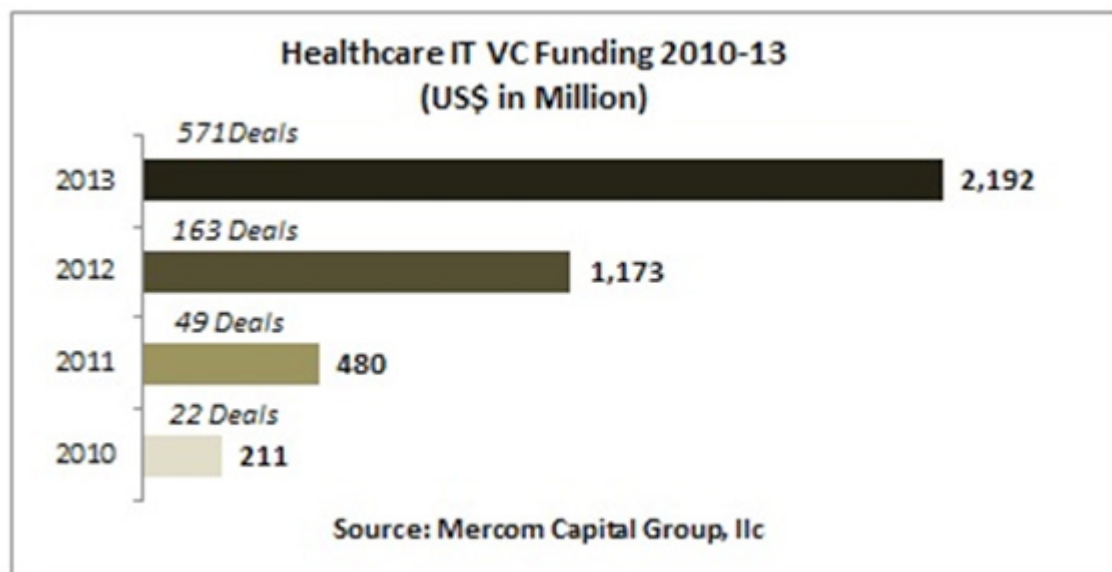
## DIGITAL HEALTH: A CATALYST FOR HEALTHCARE TRANSFORMATION

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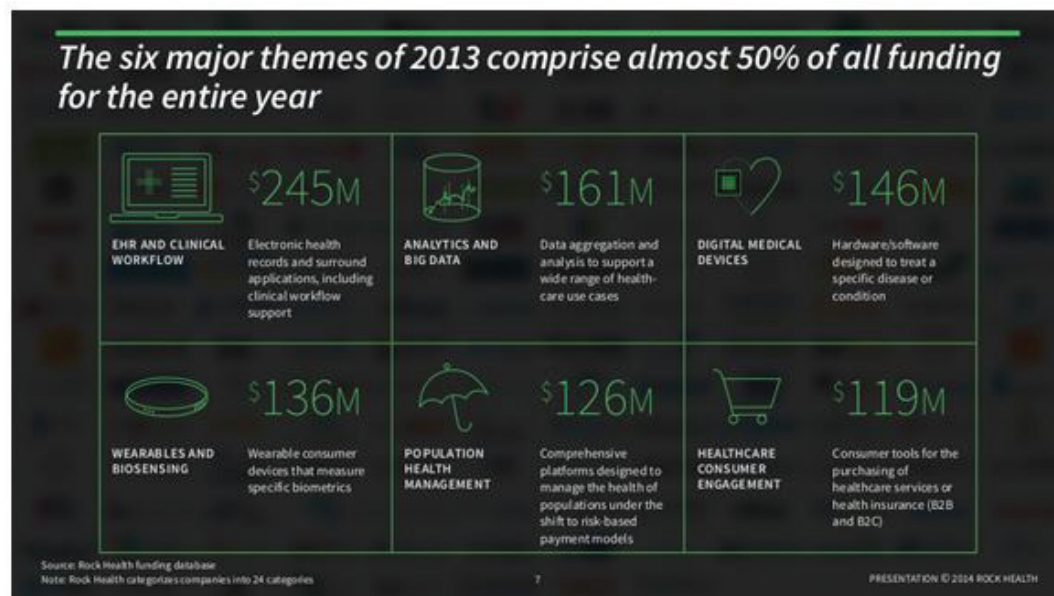
So, with government driving change and with technology evolving to catalyze that change, we need one more piece to complete the puzzle; and that piece is...

**Financing:** Investors are seeing tremendous growth opportunities in digital health – reminiscent of the vast investing in Internet companies that occurred in the 1990s. The recent IPO of [Castlight Health](#), a player in the transparency space, who received a \$1.4B valuation on only \$13M in revenue, has done nothing to dampen investor fervor.

The graph below from [Mercom Capital Group, LLC](#) shows how venture capital investing in digital health has grown over the last few years, with over \$2B invested in 2013 – nearly double the dollar investment from 2012, and nearly triple the number of deals.



This next graphic from [Rock Health](#) shows the six digital health categories that comprised 50% of this 2013 investment.



## DIGITAL HEALTH: A CATALYST FOR HEALTHCARE TRANSFORMATION

*continued*

Beyond the flow of investor funds, organizations have been sprouting up around the country to encourage and support innovation from digital health entrepreneurs. These incubators or accelerators provide a range of support that may include access to capital, facilities, mentorship, professional services, and more to help start-ups get off the ground. Examples of such organizations include: Rock Health, [Blue Print Health](#), [Tigerlabs](#), [StartUp Health](#), and [DreamItHealth](#).

### Barriers to Growth

Some investors fear a bubble is emerging in digital health. After all, the healthcare industry is not a sure-fire home run – it has lagged in the adoption of technological advancements seen in other industries for several reasons:

- misaligned financial incentives (i.e., paying for volume not quality)
- government regulation (e.g., HIPAA rules governing data privacy and security), and
- inculcated inefficiency (i.e., the practice of defensive medicine to ward off medical liability, the lack of IT standards to facilitate the flow of data, etc.)

### Conclusions

These barriers have not gone away. Yet, the environment and the opportunities for overcoming these barriers have changed. The combination of government incentives, technological advances, and investor backing has created an ecosystem that can nourish and grow digital health start-ups to bring truly valuable and transformative solutions to healthcare.

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## YOU CAN SEE THE FOREST THROUGH THE TREES

In the past 8 years, we have visited and evaluated over 300 hospitals with thousands of physicians throughout the country. We have found two common themes:

### 1. Fear of the Future

Healthcare is heading into a new world of value-based incentives that reward results not just volume. I would say it's about time. However, this transformation will be a shocking change to the medical community that has long relied on their reputation rather than facts to prove excellence.

### 2. A Low Performance Medical Culture Steeped in Tradition

Unless something clearly harmful is being done, physicians' preferences are sacrosanct and staff follow orders. This is not unlike the Korean Airlines story told in Malcolm Gladwell's book *Outliers*, where the co-captain, out of respect, wouldn't question the captain. The result was a disaster with dozens of lives lost. It is culture that is every hospitals' or businesses' competitive advantage. As Tony Hsieh, CEO of Zappos says, "Above all else, our culture is what drives our success and keeps us coming back each day inspired to continue it."

So.... what structure and physician leadership models best manage these new realities and enhance workplace culture?

The most effective structure is built around the "service line" concept. This is not unlike other industries that have various "product lines" managed by specific leaders. However, medicine has something that other industries don't. They have physicians. Physicians exert control of nearly everything that is done, and yet are peripheral to the administrative processes that manage the care. With unlimited physician authority in one area and no authority in others, the result is confusion, conflict, and uncoordinated care. The ensuing culture can be unhealthy or, at its worse, toxic.

The truth is, without the right structure and physician leadership, we will never be able to successfully create the high-performance culture we need. To use an analogy, physicians are in the unique position of understanding the needs of every tree while also understanding how to manage the forest as well. High performing hospital systems like Geisinger, Mayo, and the Cleveland Clinic understand this. However, most physicians live in silos and don't seek out leadership positions because they don't comprehend their value and also don't believe leadership and management are their calling. We must change that.

We will discuss 2 leadership models:

- Medical Directorship
- Co-Management

**A Medical Directorship** provides the physician a leadership role and a modest stipend for time dedicated to the project/service line. It can take several forms. One is as an overarching role, such as Medical Director of Orthopedics. Our experience has shown us this is generally ineffective. Orthopedics is a description of many product lines, with different physicians, needs, and staff. A single medical director over these multiple product lines usually does not have the focus to effectively address the real issues or influence culture. The expectations and goals for which the physician is being held accountable are generally too broad to be effective.



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## YOU CAN SEE THE FOREST THROUGH THE TREES *continued*

A more effective model is Medical Director of a specific service line, such as joint replacement. The Medical Director partners with a subspecialty clinical care coordinator and an administrative partner to lead a specific service line. Together they create the “why,” - a written philosophy that articulates the core values, the desired cultural changes, and the clinical and financial goals. A multidisciplinary performance team is assembled to determine the “how” - an action plan for accomplishment of the goals of the service line. Management of the service line is from metrics and teamwork. Value-based incentives or penalties can be thoroughly vetted and addressed. We have seen amazing transformations of emotional commitment and culture with this model.

The advantage of this latter model is that it is relatively inexpensive and very easy to implement. The risk is hospital administration must choose a single physician or perhaps 2 as co-directors. This may upset those who were not chosen. However, with this leadership model and the right delivery system in place, patients are happier; physician volume grows; and there is greater efficiency. While this model has positive financial implications for the Medical Director, the lack of direct shared financial incentives for other surgeons can be an issue.

**Co-management** is the other emerging leadership model. In this paradigm, the hospital is (essentially) hiring a group of physicians to manage the service line. The hope is that those physicians will streamline operations to cut costs and improve quality. This is often done with the broader definition of the service line but, at times, with the narrower definition described above.

An agreement is put together which determines the amount of money that could be shared (usually 2 - 4% of revenues). Then the parties agree to the ratio of fixed reimbursement versus variable reimbursement (usually in the 50/50 range). Within the variable reimbursement portion of the financial incentives, particular metrics and goals are selected for improvement. Distributions are dependent on participating in the appropriate performance meetings and achieving the stated goals.

The advantages of this model are that more physicians are involved, and there is another source of income. Incentives can be aligned and perhaps engender more physician loyalty. If there is waste in the system, then savings can be realized above the cost of setting up the program and sharing income with the physicians. Physicians in charge can have an impact on both quality and culture.

There are some potential disadvantages. It is more expensive to set up (sometimes requiring a separate LLC). There is a higher financial commitment from the hospital. However, the biggest disadvantage we have seen is the belief that quality, finances, and operations will improve just because of the agreement itself. This does not happen. The hard work of creating the “why,” the right service line leadership structure, a transformational delivery system, and the development of a high performance culture must still be done. And, it is best done in the confines of a subspecialty service line, not the broader scope of Orthopedics, for instance.

As the pendulum swings and we are paid for quality, who else is better suited to lead than physicians? The most effective model for success and the training of physicians for future leadership is one where there is focus and a service structure combined with aligned incentives and an effective delivery system. This is really a blend of the medical director and co-management models that are currently in place.

This hybrid encourages physicians to nurture not just a single tree (their patient) but to cultivate and develop the forest as well (operations, finances and culture). When this amalgam happens, we will all be better off for it, especially our patients.

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## WHARTON AROUND THE GLOBE: WHARTON GLOBAL HEALTH VOLUNTEERS MARKS 15TH ANNIVERSARY

If it is true that “all healthcare is local,” then the only way to learn about global health is to get on a plane. For the past 15 years, Wharton students have been doing just that, supported both logistically and financially through the Wharton Global Health Volunteers (WGHV) program. Founded by Health Care Management (HCM) students in 1998 to provide Wharton students with first-hand insight into the challenges faced by developing-world healthcare organizations through in-person consulting engagements, the WGHV has since facilitated dozens of projects across five continents. As we celebrate 15 years of meaningful collaboration with some of the world’s premier healthcare organizations, we wanted to let the WHCMAA know more about some of the work we have been doing and how the alumni can help us more effectively pursue our mission.



With over 120 on-campus members and hundreds of alumni, the WGHV represents a significant proportion of the Health Care Club’s membership, demonstrating the vibrant interest of Wharton MBAs in global health. This academic year alone we have facilitated 30 students’ participation in trips to Tanzania, Switzerland, St. Lucia, and India by sourcing projects, arranging transportation and lodging, subsidizing up to 50% of travel costs, and ensuring meaningful client engagement.



Volunteers & client: (from left to right) Christine Du (WG’ 15), Lauren Matise (WG’ 14), Nanxi Ling (WG’ 14), St. Jude CEO Dr. Chierry Payotte, Ying Yang (WG’ 15), Kelly Cheng (WG’ 15), and Christina Sher Liao (WG’ 15)

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## **WHARTON AROUND THE GLOBE: WHARTON GLOBAL HEALTH VOLUNTEERS MARKS 15TH ANNIVERSARY** *continued*

Our recently completed project for St. Jude Hospital, a 55-bed non-profit facility that serves the south of St. Lucia, during Wharton's 2014 Spring Break offers a wonderful showcase of our capabilities to improve the operations and finances of developing-world providers. A longstanding partner of WGHV, St. Jude's CEO Dr. Chierry Poyotte had highlighted cash flow generation, process redesign, inventory management, and waste elimination as serious issues threatening the hospital's desired 2015 relocation from temporary accommodations at an abandoned athletic stadium into a true 88-bed hospital facility during our preliminary discussions in January. The WGHV Board worked with Dr. Poyotte to distill his most pressing needs into a manageable scope, broadcast the opportunity across the Wharton campus, and selected a team from the applications received. This project team of six then conducted planning and analysis in February and March, interviewing members of the 2013 project team that had focused on separate issues of revenue collection, operational metrics, and communication patterns.

Upon arrival in St. Lucia, the team conducted 26 stakeholder interviews and observed manual, paper-based processes in various wards throughout the hospital. After developing a current-state assessment, the team created a future-state goal and implementation plan centered on four main solutions:

1. consistent inventory tracking and patient billing processes to improve inventory control and revenue
2. expiration monitoring systems of medications and lab reagents to enhance care delivery and reduce waste
3. standardized manual data collection across wards to improve procurement and care delivery processes
4. data-driven pricing of medications and supplies to increase cash flow and strengthen vendor relationships

Ultimately, the WGHV team hosted a workshop with St. Jude's senior management team to sign-off on a series of "quick wins" and medium-term initiatives. In response to the management team's request, the WGHV team also developed standardized tracking forms, scoring systems, change management meeting agendas, sample communications, and training plans, focusing on actionable insights and tools necessary to effect lasting change. In after-meeting debriefs, the client reiterated their appreciation for the team's efforts. Dr. Poyotte said "the insight you've delivered is real, and some of the issues identified are areas that had never occurred to us before." Given the success of WGHV project teams in 2013 and 2014, the management at St. Jude committed to furthering our partnership for years to come.

However, WGHV's capabilities are not confined to hospital management. In December, another WGHV team leveraged Wharton's significant entrepreneurship and finance resources to create a two-day entrepreneurship workshop for medical and pharmacy school graduates on behalf of the Association of Private Health Facilities in Tanzania (APHFTA). Topics included financial records and statements, leadership styles, teamwork effectiveness, management models, marketing segmentation, strategic positioning, and basic decision-making cost-benefit analysis. The team additionally conducted a three-day strategy session for APHFTA's associated microfinance program, helping with business plan creation, and risk assessment. In the next issue of *The Wharton Healthcare Quarterly*, we will provide further detail on our work with Médecins Sans Frontières (Doctors Without Borders) and the work we can perform for multinational healthcare organizations.

## **WHARTON AROUND THE GLOBE: WHARTON GLOBAL HEALTH VOLUNTEERS MARKS 15TH ANNIVERSARY** *continued*

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 to simply hear 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/](https://groups.wharton.upenn.edu/WGHV/)

Visit the WGHV Facebook page at: [www.facebook.com/WhartonGlobalHealthVolunteers](https://www.facebook.com/WhartonGlobalHealthVolunteers)

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## SURVIVING CHANGE BY CREATING A POSITIVE CULTURE – PART 1

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Are the demands for change accelerating to the point they're overwhelming at times? Are the challenges intensifying while control is dwindling? Is taking care of yourself limited due to the time required to get your job done? You must be a healthcare leader.

As a coach to leaders at a leading academic medical center, I've found these conditions are typical – and manageable. When leaders learn to think differently about their situation, they're able to deal with it more successfully and satisfactorily. As Albert Einstein advised, "No problem can be solved from the same level of consciousness that created it."

To survive the perfect storm hitting healthcare, successful hospitals will need to solve complex challenges by cultivating a culture capable of creating solutions and developing a workforce that's engaged in implementing innovative change initiatives. Studies show that a negative climate kills these forces, while a positive workplace promotes them. But many hospitals are not actively involved in creating an adaptive culture capable of transformation.

In the 2013 Gallup "[State of the American Workplace Report](#)," 52% of employees said they were disengaged, just showing up to do what they must to get through the day (and collect their paycheck). The odds are the majority of your employees are disengaged: they've stopped caring about the organization's goals; they're resisting change because it means more work for them; and they find interacting with their boss to be one of the most distasteful experiences in their life (ranking it just below cleaning the house in a survey reported by Tom Rath in his 2006 book *Vital Friends*).

And now for the bad news: Nearly 20% of employees surveyed by Gallup admitted they were actively trying to sabotage their co-workers and the mission of the hospital. Gallup has found "Actively Disengaged" employees are "more likely to steal from their companies, negatively influence their co-workers, miss workdays, and drive customers away." This segment of the population is suffering from (and spreading) some serious unhappiness in life.

Why would anyone on staff in a hospital feel the need to actively work to undermine the mission? This bottom group of performers is filled with hostility toward other people because they feel they've gotten a bad deal in life – so they think it's only fair that they make sure others suffer the same fate. They don't believe they're able to change their destiny. Their attitude is "Life sucks. It's other people's fault. Nothing will ever change."

The "Disengaged Majority" in the middle feel vulnerable for two reasons. First, they're deflated by the hostile interactions constantly emanating from the vocal minority of negative co-workers. Second, they feel powerless to change the behavior of their boss, who largely ignores them until there's a problem and they get "held accountable." Most employees feel bullied by a co-worker, blamed by their boss, or both. As a result, workers stop showing up, stop contributing, and stop caring.

Absenteeism, high-turnover, shrinkage, employee and patient safety incidents, work quality, customer satisfaction, productivity, and



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## **SURVIVING CHANGE BY CREATING A POSITIVE CULTURE – PART 1** *continued*

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profitability have all been linked to low engagement. Gallup estimates these disengaged and actively disengaged employees cost the U.S. between \$450 billion to \$550 billion each year in lost productivity.

Seventy percent of your workforce is probably spending a considerable amount of time and energy trying to protect themselves from the negative forces that surround them. It's a classic case of fight-or-flight responses to stressful situations. But fighting just makes problems even more stressful. Disengaging creates a state of quiet desperation. In either case, employees lapse into "learned helplessness," believing there's nothing they can do to improve their situation.

Blaming others renders people helpless because the focus is only on the acts of others. When bullies blame the rest of the world for their unhappiness, they feel their hostile acts are justified. In reality, they alienate the very people who could help them rise above their circumstances. The people on the receiving end shut down, put up walls, and look to their leaders to fix the problem. But according to the [Workplace Bullying Institute](#), 52.5% of the time employers do nothing to end "sabotage by others that prevented work from getting done, verbal abuse, threatening conduct, intimidation, and humiliation."

Even when leaders try to reprimand bullies, they're often stymied by the system. Performance improvement plans are dictated to the person acting poorly, who conceals hostility for the 30, 60 or 90 days during which he or she is being scrutinized. Then the cycle repeats itself.

But this approach happens at the leadership level as well. For example, in some organizations employee engagement scores are shared within the institution. Top executives demand to know what's being done to deal with the bad managers on the front line whose scores are in the bottom quartile. There's no recognition that there are many factors affecting engagement, including actions taken by the top tier of leadership, like cutting benefits.

Low performing managers are put into remedial training classes. How do these managers feel? They're threatened, intimidated, and humiliated. They feel abused because they have to put in extra time that keeps them from getting their work done. Wait, weren't those the definitions of bullying behavior? When these managers become vulnerable, they disengage, and they take their employees into a downward spiral with them.

There's another way to handle the stress inherent in the rapid cycle changes impacting healthcare organizations. Studies show that when leaders and their most positive employees join forces they can create a "tipping point" which reconnects the majority of disengaged staff with efforts to provide the best patient care. Learn how to do so in Part 2 of this series in the October issue of the *WHQ*.

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## WHCMAA Awards Prestigious Alumni Kissick Award to David Fajgenbaum, MD'13, MSc.

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The Wharton Healthcare Management Alumni Association (WHCMAA) recently chose David Fajgenbaum, MD'13, MSc, a first-year Wharton MBA student for its prestigious Alumni Kissick \$15,000 scholarship. The scholarship is meant for a healthcare MBA student whose outside-the-classroom educational experience relates to having a “business building/social and intellectual capital /health policy impact or contribution.” The scholarship is named after William Kissick, MD, PhD, who played an integral role in developing the Wharton HCM program and had been deeply involved at the national level as one of the pioneers of the Medicare program. David's experience and background fit this description very well. The scholarship is used to help defray tuition expenses.



David Fajgenbaum, MD'13, MSc, is the co-founder and Medical Director for the [Castleman Disease Collaborative Network](#) (CDCN). Dr. Fajgenbaum launched the CDCN in 2012 to accelerate research and treatments for idiopathic Multicentric Castleman disease (iMCD) - a deadly and poorly-understood hematologic disease. His recent publication in *Blood* proposes a paradigm shift for iMCD pathogenesis and presents a new sub-classification system. Dr. Fajgenbaum has recently been nominated to become Adjunct Assistant Professor of Medicine in the Department of Medicine, Division of Hematology/Oncology at the University of Pennsylvania. He is a member of Janssen Pharmaceutical's “Global Advisory Board” for Siltuximab, which recently became the first FDA-approved therapy for iMCD. He began the MBA Summer Intern Program at Bristol-Myers-Squibb in their Medical Affairs Oncology division in June.

In 2006, Dr. Fajgenbaum co-founded the National Students of AMF Support Network, a non-profit organization dedicated to supporting college students grieving the illness or death of a loved one. Under David's leadership as Board Chair, National Students of AMF has reached 3,000+ students on 200+ campuses. His work has been highlighted on the Today Show, *Reader's Digest*, and the *New York Times*. He is currently under contract with Jessica Kingsley Publishers to co-author a book for grieving college students.

Dr. Fajgenbaum earned his MD from the Raymond & Ruth Perelman School of Medicine at the University of Pennsylvania, MSc in Public Health from the University of Oxford, and BS in Human Sciences with Distinction from Georgetown University. David has been awarded *USA Today's* 2007 Academic All-American First-Team honors, *Reader's Digest's* “Make it Matter” story of the month in 2008, Eli Lilly's 2012 “Welcome Back Award” for national impact on mental health, and the 2013 Distinguished Service Award from the University of Colorado.

Upon the scholarship nominating committee's discussing their choice with June Kinney, the Associate Director of the Healthcare Program at Wharton, her comment was, *“David is the perfect choice and epitomizes what the Alumni Kissick Scholarship reflects. If Bill Kissick were alive today, David would have been his first choice as well.”*

We would like to congratulate David on receiving this important scholarship and expect big things from him in the future!

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