



**Wharton**  
UNIVERSITY of PENNSYLVANIA

# **THE WHARTON HEALTHCARE QUARTERLY**

**FALL 2013  
VOLUME 2, NUMBER 4**

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[Have an article to contribute or words of wisdom for the Philosopher's Corner?](#)  
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## EDITOR'S LETTER

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As we go to press on Volume 2, Issue #4, it's hard to believe we are closing out year two of the *Wharton Healthcare Quarterly*! Thanks to all our contributors, who have provided eclectic content, which has spanned the healthcare spectrum and across the globe, and updates on their lives. Thanks to our sponsors, who have been steadfast in their support of our publication, and to Jeff Voigt WG'85, our new Association President and the "executive sponsor" of the publication since its inception. Thanks also to Gabriela Sanchez, Kathy Carrington, and Katrina Wagner, who translate our words into the web and PDF versions distributed each quarter.

And finally thanks to you, our readers, without whom the *WHQ* has no life.

In order for the *WHQ* to evolve, stay fresh and relevant, and continue to both meet and anticipate your needs, I would ask each of you to **take 5 minutes to provide your feedback** in a [brief survey](#). As was stated in the January 2012 inaugural edition, we hope you will find this offering timely and informative, rich in content, varied in perspective, and highly interactive. Ultimately, we hope it will become a 'go-to' resource and eagerly anticipated 'must read.' Therefore... **we need you to let us know what you think!**

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



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

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For more information

**Geoff Meyerson, WG '07**

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**Jay Mohr, WG '91**

Managing Director and Co-founder  
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[www.locustwalkpartners.com](http://www.locustwalkpartners.com)

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## THE PRESIDENT'S DESK

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### Get Ready for a Great Quarter of Innovative Delivery of Content/ Learning and the Kick-Off of the June Kinney Scholarship!

We have a number of great learning events over the next 3 - 4 months and will be experimenting with innovative ways of transmitting content to you.

- **September 17, 2013** – a roundtable was held on **The High Costs of Cancer Care – Have We Hit a Choking Point?** This roundtable represented divergent views on this issue and included Wharton professors, Scott Harrington, Skip Rosoff, and the following Wharton alumni:
  - Joe Leveque, WG'92, MD, head of oncology for Bristol Myers Squibb – innovator perspective – Companies need to make an adequate return in order to keep innovating.
  - Jennifer Dreyfus, WG'84 and Master of Bioethics UPENN 2011 - How should/can cancer care be provided for the general good? Where do these high costs leave patients and what, if anything, should be done?
  - Peter Fishman, WG'07 ex-Novartis pricing OUS expert for oncology drug pricing.

The roundtable also included Peter Bach, MD, Director of the Center for Health Policy and Outcomes, Memorial Sloan Kettering Cancer Center. Dr. Bach is a proponent of “enough is enough” regarding the high prices of cancer care/drugs and suggests prices need to come down. Dr. Bach has published on this issue quite extensively in the *New York Times*, *Wall Street Journal*, and in leading medical journals. This roundtable was held from 7:00 - 9:00 pm, Huntsman Hall, Wharton and included both a live audience and was beamed live to alumni remotely.

- **October 7, 2013; 6:00 - 9:00 pm – Bending the Cost Curve.** How are we doing versus the rest of the developed world? Hosted by the World Economic Forum – a roundtable discussion with professors from Wharton (Mark Pauly) – US perspective; Cornell (Lawrence Casalino, MD, PhD) and Columbia (Miriam Laugesen, PhD) – international perspective. This roundtable was moderated by Dr. Gary Phillips, WG'91, Senior Director, Head of Global Health & Healthcare Industries, World Economic Forum.
- **October 26, 2013 - WHCMAA Alumni Conference**, Chaired by Jay Mohr, WG'91 President Emeritus. This promises to be the best conference yet, with provocative fireside chats on:
  - “Adapting Corporate Strategies and Business Models in the Post-Reform Era.” This panel will be chaired by Dr. Gary Phillips, WG'91.
  - “Private Investing Around the Exchanges: Moving from Bricks and Mortar to Wellness.” Health reform has forced both payers and providers to move outside of facility-based care to reach the patient, as a consumer. This panel will discuss how both private equity and strategic players invest in direct-to-consumer healthcare. Maureen Spivack (WG '86) will be leading this discussion.
  - “Digital Health Winners: Which Companies Will Best Serve Customers and Investors?”
  - We also have as our keynote speaker: Professor Richard C. Marston, Guy Professor of Finance and Economics, The Wharton School. Dr. Marston will speak on macro investment trends and where to invest.
  - Confirmed speakers include:
    - Joseph R. Swedish, CEO, WellPoint, Inc.



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

## THE PRESIDENT'S DESK

*continued*

- William Taranto, Managing Director & VP, Merck Global Health Innovation (GHI) Fund, LLC
- Alexis Slagle Gilroy, Partner, Nelson Mullins, and expert in the fields of telemedicine, telehealth, mobile health, and e-health industries
- **Early/Mid-November; 6:00 - 9:00 pm** – The Use of Big Data for Hospital Analytics, hosted by Lumeris. Date and Wharton location *TBD*.
- **November 14, 2013** – Webinar with Professor Patricia Danzon, Wharton School – Drug Pricing and Antitrust.
- **December 5, 2013** – CEO roundtable on various company and caregiver perspectives on where they are headed based on the 2014 implementation of the Affordable Care Act. This event is to be hosted by Becton Dickinson and will include:
  - Vince Forlenza, CEO of Becton Dickinson, WG'80
  - Audrey Meyers, CEO of Valley Hospital, WG'80
  - Robert Town, Associate Professor, Wharton School

### Giving Back to the Wharton School

UPENN/Wharton has historically been less generous than other top business schools, and, consequently, we miss out on top talent. Beginning this fall, our plan is to institute a fund-raising campaign for the June Kinney Scholarship. We all know and love June – she has been there for many of us over the years and has been our biggest supporter. The scholarship fund is an opportunity for us to provide a lasting tribute to her leadership of the Wharton Health Care Management Program and to help attract top talent.

This scholarship will be for a deserving incoming health care MBA student who:

- demonstrates academic excellence
- has contributed to the healthcare field
- plans on working in the field upon graduation in a socially and/or meaningful endeavor
- exhibits upright character and financial need and
- where a scholarship could make a difference in whether the student chooses Wharton over other highly competitive schools.

Given the importance of diversity to the program and in our developing future health care leaders, consideration of minority status may also play a part of the selection process.

Lastly, if you have questions related to the above, feel free to contact me at: meddevconsultant@aol.com; 201-251-8204(w). We look forward to serving you and in building upon what is already a very strong association!

Respectfully,

Jeff Voigt (WG'85)  
President, WHCMAA



## OPEN WIDE

### Here, There, Why Not Everywhere, Book the Second

One of the recurring themes for this column is the challenge of providing access to dental care. In thinking further about this “access” issue, it has struck me the barriers aren’t so much logistical and geographic, nor even fundamentally financial (except that the present cottage industry nature in which care is delivered results in the payment of significant “economic rent”). Rather, at their most basic, the barriers to care stem from our society having a conditioned, limited, default notion of what getting dental care means. And that basically comes down to “seeing the dentist every six months,” and all that that implies – calling to make an appointment, maybe taking time off from work or arranging for a sitter, driving to an office park location, etc.

Putting aside whatever rationale there may be for the “dentist-every-six-months” rule (indeed, with “evidence-based” health care gathering increased attention, there’s little evidence for it) in essence, the “consumer choice” for obtaining dental care is quite restricted as to time, place, and personnel encountered, all coming with their attendant costs, either in direct dollars or in time spent, and in inconvenience. But what if the “conventional wisdom (tooth?)” on getting dental care is turned on its head? I borrow from [Sandy Ryan’s](#) (Chief Nurse Practitioner Officer of Walgreens) piece in this past April’s *WHQ* in which she discusses the “disruptive innovation” coming about from nurse practitioners being in the forefront of primary care delivery in the Walgreen’s network of retail clinics: “Unique features of this health care delivery model included being built from a patient’s point of view, nurse practitioners as the primary provider, an ‘in-the-neighborhood’ community setting in a retail store such as Walgreens, and technology leveraged to provide transparency, thereby improving outcomes and ensuring continuity of care.” From a purely “business” standpoint, this model is working, and working quite successfully, meeting with high levels of consumer/patient acceptance and growth rates of approximately 10% per year.

I would argue the same disruptive innovation could and should apply to dental care as well. While there are logistical issues to take into consideration (amount of space required, equipment needed, time spent per patient), these have been dealt with successfully in other settings – Alaska has already been discussed in earlier columns, but school-based clinics and mobile dental vans also provide workable examples – and the basic formula of providing readily accessible, affordable, and consumer-friendly care is just as applicable.

Primary dental care could conceivably be obtained almost anywhere, at any time, at affordable prices, by anyone, almost regardless of socioeconomic status. Such an approach would take dental care out of the relatively expensive and restrictive “see the dentist every six months” routine to one that goes something like this: “Gee, I’m here at the mall, or at this retail clinic for my flu shot, and I haven’t seen my dentist in I don’t know how long; why don’t I see what this primary care dental business is like? After all, they advertise their prices up front, they’ve got trained personnel, and they’re connected to a network of referral dentists. This makes sense to me!”

There are several points to be made here: (1) the consumer/patient who otherwise would forgo dental care is now actively seeking it out, (2) potentially larger dental problems are caught early at a less costly stage, and (3) just by seeing dental care being offered in heretofore unconventional settings at even unconventional hours elevates the population’s awareness of and ability to obtain regular and early dental care, which, after all, is fundamental to addressing what is essentially entirely preventable disease.

Reference to “disruptive innovation” implies reorganizing to meet market demands and to get things done. What “organized dentistry” has traditionally meant, and what it should mean, is the topic for the next issue.

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



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



## THE PHILOSOPHER'S CORNER

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### **Life Lessons:**

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

- started following healthcare policy sooner.

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

- missed opportunities to let others know how much I appreciate them.

### **Favorite Quotes:**

1. Things do not happen. Things are made to happen.  
- John F. Kennedy
2. You can't build a reputation on what you are going to do.  
- Henry Ford
3. Leadership and learning are indispensable to each other.  
- John F. Kennedy

### **Recommended Reading:**

- *HIT Trends* - provides great coverage of health IT happenings...and in PowerPoint format!, Michael Lakem
- "Medication Adherence Weekly Round-Up," Prescriptions for a Healthy America
- *Health 2.0* and *StartUp Health*'s newsletters - provide listings of upcoming health tech events and start-up news



This month's philosopher Clifford Jones, Penn'07.  
To learn more about Cliff, [click here](#).

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

## ALUMNI NEWS

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### **Elayne Howard, WG'76**

Elayne Howard was elected to the Board of Directors of People's Emergency Center (PEC). PEC nurtures families, strengthens neighborhoods, and drives change. It provides comprehensive supportive services to homeless women and their children, revitalizes its West Philadelphia neighborhood, and advocates for needed public policy changes to end homelessness.

Contact Elayne at: [elayne@elaynehowardassociates.com](mailto:elayne@elaynehowardassociates.com)

### **Debbie Sanders Carlton, WG'83**

Debbie owns and manages a health insurance agency serving individuals/families and small business in Oregon, Washington, California, Arizona and Colorado. Debbie markets health insurance, life insurance, Medicare, disability, and long-term-care products in these five states. If you, family members, colleagues or friends need assistance or need to purchase policies in these states, please visit her at [www.carltonbiz.com](http://www.carltonbiz.com).

Contact Debbie at: [debbie@carltonbiz.com](mailto:debbie@carltonbiz.com)

### **Jonathan Solomons, Penn'78, WG'83**

Jonathan was named President and CEO of Tabor Children's Services, a private Doylestown non-profit child welfare agency serving children, young adults, and families, effective July 15, 2013. He had been CFO and VP of Finance and Administration for NorthEast Treatment Centers.

Contact Jonathan at: [jonathan.solomons@tabor.org](mailto:jonathan.solomons@tabor.org)

### **Alston Wynn Bailey, Jr. (Wynn), WG'88**

Wynn is a Partner with PwC in Chicago and part of the firm's Health Industries Advisory Group. He focuses mainly in the pharmaceutical and life sciences industries, and most of his work is in the operations and supply chain area, as well as mergers/integrations/deals. Wynn is still happily married to Katherine (Katie) Berman Bailey, WG'88. Katie is active in the education field, serving on the Board of Education for Evanston, IL schools. She also does independent consulting work for education-related foundations. Wynn and Katie live in Evanston, IL. They have four children ranging from college-age to 8th grade and are staring down the barrel at empty-nesthood.

Contact Wynn at: [wynn.bailey@us.pwc.com](mailto:wynn.bailey@us.pwc.com)

### **Wolfgang Stoiber, WG'90**

Two years ago I took over the management of JSB Partners LP, based in Waltham MA, a partnership I co-founded in 1999. We focus on transaction advisory work in healthcare, with a majority of projects being in pharmaceutical sell-side transactions. Over the last few years, non-dilutive capital derived from licensing transactions turned into a big product for us and, given the track record in the pharmaceutical industry, it is an area we are competent in. As M&A and asset sales turn more and more into structured transactions, the background is of relevance there as well.

## ALUMNI NEWS

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Just recently my son Patrick and I decided to become flat mates. He is pursuing his PhD in pharmacology at Boston University, so we got ourselves a condo in Cambridge MA, and I commute to Waltham – let's see how this father-son relationship develops.

Contact Wolfgang at: [wstoiber@jsb-partners.com](mailto:wstoiber@jsb-partners.com)

### **Amy Aletha Mosser, WG'93**

Amy is the Chief Operating and Development Officer for Health Forum in Chicago, IL. Health Forum is a for-profit subsidiary of the American Hospital Association and operates both media and information licensing business models. Watch for soon-to-be released data on the ever-evolving US systems of care and payment, tracking ACOs, medical homes and other new care and payment models. Amy has lived in the Chicago, IL area for the past 10 years with her husband of 20 years, Dave Vance, and three children John (15), Andrew (15) and Emily (8).

Contact Amy at: [amymosser@aol.com](mailto:amymosser@aol.com)

### **Stephen K. Klasko, MD, WG'96**

Stephen K. Klasko, M.D., M.B.A., former Dean of the Morsani College of Medicine at the University of South Florida and Chief Executive Officer of USF Health, has been appointed to the newly created position of President of Thomas Jefferson University and President and Chief Executive Officer of TJUH System. Dr. Klasko began his tenure at Jefferson in early September and assumed this new role created from vacancies previously held by University President Robert L. Barchi, M.D., Ph.D. and Hospital President and CEO Thomas J. Lewis.

Read the full story at: <http://www.jeffersonhospital.org/news/2013/june/stephen-k-klasko-named-president-tju-and-president-and-ceo-tjuh-system>

Contact Jacqueline Kozlosk at: [Jacqueline.Kozloski@jefferson.edu](mailto:Jacqueline.Kozloski@jefferson.edu) or call (215) 955-6300

### **Adam Kaufman, PhD'00**

Adam is CEO of DPS Health, a Los Angeles-based developer of online health management tools, which has joined forces with Achieving Better Control (ABC), an Ambler, PA developer of diabetes education programs, to create what executives are calling a fully integrated platform. Initially marketed for employers, the offering gives diabetics and those with pre-diabetic conditions the option of in-person services, online resources, or both.

Read the full story at: <http://www.mhealthnews.com/news/new-partnership-looks-bridge-mhealth-divide>

Contact Adam at: [akaufman@dpshealth.com](mailto:akaufman@dpshealth.com)



## ALUMNI NEWS

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### **Sally Poblete, WG'00**

Sally started a new company, Wellthie Inc., with the goal of simplifying health insurance purchasing. Just in time for the start of the health insurance exchanges and open enrollment, they launched their first product, the Affordable Care Advisor, in partnership with a large health plan client. This web and mobile application helps a consumer understand personalized estimates of their insurance cost, potential financial assistance available, and the tax penalty for not having insurance in 2014. The company is based in New York and more information can be found at <http://wellthie.com>.

Sally was also featured as a health care innovator. Read all about it here: <http://cooleyhealthbeat.com/2013/09/09/innovator-spotlight-sally-poblete-founder-ceo-wellthie-inc-httpwellthie-com/>

Contact Sally at: [spoblete@wellthie.com](mailto:spoblete@wellthie.com)

### **Jennifer Beachell, WG'02**

After a company merger, Jennifer left Human Genome Sciences after launching the first monoclonal antibody for lupus and launched her first child. Jennifer's son was born in November 2012, and she spent the winter getting to know him and reconnecting with a lot of Wharton alums. In April, Jennifer started an independent consulting company, Beachell Consulting, LLC, in biopharm marketing strategy and has enjoyed working with her clients. Jennifer is excited to be independent, since it allows her to work with Wharton people and past colleagues again.

Contact Jennifer at: [jenbeachell@beachellconsulting.com](mailto:jenbeachell@beachellconsulting.com)

### **Nikhil Bhojwani, WG'02**

Recon Strategy, the healthcare consulting firm founded by Nikhil Bhojwani, is 3-years old this October and now counts two additional Wharton alumni in its ranks -- Anne Wilkins (WG'93) is on their Board and Sandra (Rehm) Smith (WG'99) is a Principal. They work on strategy primarily in healthcare services (health systems, regional and national payers, and health IT firms) as well as for start-ups (analytics, disruptive technologies). Their latest articles on healthcare strategy can be found on the popular Healthcare Recon blog. Nikhil welcomes opportunities to connect with Wharton alums.

Contact Nikhil at: [nikhil@reconstrategy.com](mailto:nikhil@reconstrategy.com)

### **Donna Brady Raziano, WG'02**

Dr. Donna Raziano, MD, MBA, FACP has accepted the position of Chief Medical Officer for Mercy Home Health and Mercy LIFE. In this new role, Dr. Raziano will provide medical leadership for all utilization management, pharmacy, case management, disease management, cost containment, and medical quality improvement activities. Additional responsibilities include planning and establishing goals and policies to improve quality and cost-effectiveness of care and service for patients and participants.

Dr. Raziano joined Mercy Health System in 2005 as the medical director of the LIFE program, providing primary oversight of all quality outcomes as well as utilization, claims, and network development. In addition to patient care, Dr. Raziano directly supervised physicians and nurse practitioners and indirectly supervised case management and coding staff at Mercy's three adult day centers in Philadelphia. Dr. Raziano will maintain these responsibilities in her new position.

## ALUMNI NEWS

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Dr. Raziano's credentials include ABIM board certification in Internal Medicine, Geriatric Medicine, and Hospice and Palliative Care as well as a Master's of Business Administration in Health Care Management from The Wharton School of the University of Pennsylvania. She completed her medical degree at Creighton University School of Medicine, Omaha Nebraska, her Internal Medicine internship at Thomas Jefferson University Hospital, and an Internal Medicine residency at Lehigh Valley Hospital. She then completed a two-year geriatric medicine fellowship at the University of Pennsylvania Health Systems, Division of Geriatric Medicine.

Contact Dr. Raziano at: [DRaziano@mercyhealth.org](mailto:DRaziano@mercyhealth.org)

### **Darren Black, WG'03**

Darren would like to share his appointment as Managing Director with Summit Partners, a global growth equity investor. Darren will be in Summit's Boston office. Since 1984, Summit has invested in more than 70 companies across the healthcare and life sciences industry.

Read the press release at: <http://www.summitpartners.com/Summit-Partners-Expands-Healthcare-and-Life-Sciences-Team.aspx>

Contact Darren at: [dblack@summitpartners.com](mailto:dblack@summitpartners.com)

### **Shaun Francis, WG'03**

Shaun is Chair and CEO of Medcan Health Management Inc., which is one of North America's largest preventive health clinics and the largest global provider of executive health assessments. This year Medcan was again ranked one of Canada's Top 50 Best Managed Companies, as featured in the *National Post* newspaper and Shaun was ranked as one of Toronto's 50 most influential citizens by *Toronto Life* magazine. Outside of business Shaun is the founder of the True Patriot Love Foundation, which is Canada's largest charity benefiting military families. Last year he co-led 12 injured soldiers to Nepal, where they climbed a mountain adjacent to Mount Everest. It was featured as a national documentary by Canada's CBC (March to the Top). In April Shaun will again take 12 injured soldiers on an expedition, this time on skis to the Magnetic North Pole for another national prime time documentary.

Contact Shaun at: [shaunfrancis@medcan.com](mailto:shaunfrancis@medcan.com)

### **Stephanie Gampper Hsu, WG'04**

Stephanie is part of the founding team of Greenwings Biomedical, a Los Angeles-based incubator focusing on commercializing biomedical devices and health care software products from Southern California universities. Examples of products our team is evaluating include diagnostic, monitoring and therapeutic devices; medication management; telemedicine; healthcare information systems; analytics and data visualization; bioinformatics; and quantified-self and wearable devices. For more information, please visit [GreenWingsBiomedical.com](http://GreenWingsBiomedical.com) [here](#).

Contact Stephanie at: [sg@greenwingsbiomedical.com](mailto:sg@greenwingsbiomedical.com)

## ALUMNI NEWS

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### **Anita Pramoda, WG'04**

Anita Pramoda has been appointed to the Board of Allscripts.

Read the press release at:

<http://finance.yahoo.com/news/allscripts-names-general-counsel-adds-130000689.html>

Contact Anita at: [anita@tangramcare.com](mailto:anita@tangramcare.com)

### **Paul S. Lin, MD, WG'05**

Paul and Nancy Lin welcomed their first child, Sophia Jen Lin, on August 29, 2013. Paul confirms Sophia is unquestionably the boss of the household, and added she will be sending an e-mail to June shortly to request admission to the Wharton HCM program Class of 2040 or thereabouts, since he fully anticipates June remaining head of HCM and Dean of the entire school at that time.

Meanwhile, in May 2013, Paul was promoted to Chief Operating Officer of Plexxikon, a small-molecule drug discovery and development company based in Berkeley, CA. Plexxikon is best known for the design and discovery of vemurafenib, a revolutionary targeted agent approved for the treatment of metastatic melanoma, but Plexxikon's pipeline is rich and full of exciting new experimental therapeutics.

Contact Paul at: [plin@plexxikon.com](mailto:plin@plexxikon.com)

### **Clifford Jones, Penn'07**

Allazo CEO, Clifford Jones, shared the main stage with speakers such as... HHS Secretary, Kathleen Sebelius; United States Chief Technology Officer, Todd Park; and best-selling author and surgeon Atul Gawande at Health Datapalooza IV, held on June 3 - 4, 2013 in Washington DC.

Read the full press release at: <http://online.wsj.com/article/PR-CO-20130610-907089.html>

Contact Cliff at: [cliff@allazohealth.com](mailto:cliff@allazohealth.com)

### **Arjun Mahajan, WG'08**

The Red Herring 100 Asia 2013 Award is yet another prestigious accolade that was conferred upon Saviance recently. This award recognizes the 100 "Most Innovative" Start-ups Leading the Next Technology Wave and includes the year's most promising private technology ventures from the Asian business region.

Saviance is a minority-certified US-based Healthcare IT services company. We provide innovative solutions and enable meaningful use of IT by designing patient care and community portals, collaboration applications, big data insights for wellness and population health, ICD-10 resources and process automation. Learn more at: [www.saviance.com](http://www.saviance.com)

Contact Arjun at: [arjun.mahajan@saviance.com](mailto:arjun.mahajan@saviance.com)



## ALUMNI NEWS

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### **Maria Merchant, PhD, WG'08**

Somnarus Inc, founded by Maria Merchant, PhD, WG'08, was a Top 4 Finalist in the MedTech Idol 2013 Competition that took place live on stage during the 21st Annual Medical Device Conference, hosted by law firm Wilson Sonsini Goodrich & Rosati on June 19, 2013, which was attended by more than 600 industry professionals in San Francisco. <http://www.medtechidol.com/>

Somnarus Inc. is a medical diagnostic company whose innovative products address the significant unmet need of patients with obstructive sleep apnea. With 50 million Americans at risk for sleep apnea and the average medical insurance reimbursement rate of \$160 per test, Somnarus is entering the market, whose potential is estimated at \$8B. The SomnaPatch™ product combines accuracy and ease-of-use with guaranteed medical insurance reimbursement and the convenience of in-home delivery. Somnarus is seeking to raise \$1M to fund its operations for one year to complete product development, to further intellectual property protection, and to conduct a clinical trial for regulatory approval.

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### **Hareesh Nair, WG'08**

Hareesh recently joined Quadria Capital as a Vice President in the firm's Singapore office. Quadria is a \$300M growth capital private equity fund focused only on healthcare investments in South and Southeast Asia. Prior to joining Quadria, Hareesh worked for Medtronic for six years, first starting out in corporate development in Minneapolis, and moving to Singapore three years ago to identify innovative business models to develop the market. His last accomplishment at Medtronic was raising capital for Quadria and cementing a strategy for leading strategic and financial services partners to use complementary strengths to build healthcare access and quality in Asian communities that would benefit from private investment.

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### **Jonathan McEuen, PhD'09, WG'13**

Jonathan McEuen and his classmate, Rajiv Mahale (HCM, WG'13), are among three co-founders of a Dreamit Health company, SpeSo Health ([www.spesohealth.com](http://www.spesohealth.com)), an online search and analytics start-up that improves access and expertise evaluation for the nearly 90 million patients in developed economies who live with rare and orphan conditions. The company recently graduated from the Dreamit Ventures Health IT incubator (Dreamit Health) and has received seed funding to build its proof of concept products and pilots.

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## ALUMNI NEWS

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### **Mihir C. Gandhi, WG'10**

After three years of service to Abbott Labs, Mihir has decided to leave Abbott and join AVIA, an innovation accelerator dedicated to helping healthcare providers successfully implement emerging technology-enabled products and services. As the Director of Healthcare Ventures, Mihir will be leading relationships and service to AVIA portfolio companies, managing AVIA's deal flow pipeline, and leading the investment process for potential investment opportunities. Mihir is based in Chicago.

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

Robert Lieberthal is part of a multidisciplinary team that has been awarded a grant by the Agency for Healthcare Research and Quality (AHRQ). The team of researchers will be led by Dr. George Valko, Professor of Family and Community Medicine at Thomas Jefferson University. The grant will study the cost of transforming primary care practices into "patient-centered medical homes" (PCMHs). As a health economist, Dr. Lieberthal, an assistant professor in the university's School of Population Health, will have a key role in this project as a co-investigator. Dr. Lieberthal and his team will collaborate with clinical colleagues to determine the scope of practice transformation activities, as well as their costs. This is Dr. Lieberthal's third grant from AHRQ. He was previously the recipient of an AHRQ funded T32 predoctoral training grant, as well as an R36 Health Services Research dissertation grant, both of which he received while a student in the Wharton PhD program.

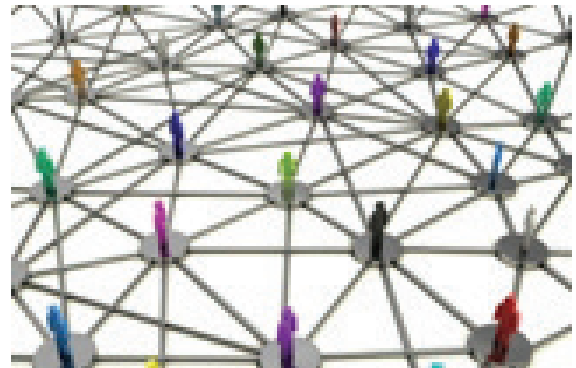
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## PART 2: FROM PATIENT TO PARTNER — CREATING PULL FOR THE SHIFT TO POPULATION HEALTH MANAGEMENT

*This is the second in a series of three articles about engaging patients in population health management.*

In the [first installment](#), we discussed the necessity of a shift to helping patients become full partners in their own health. We introduced the theory that lasting change comes from identifying new behaviors and providing people the “supports” (from reminders to new skills) they need to adopt those behaviors.

In this article, we talk about specific strategies, using new behaviors and corresponding supports, to aid patients in behavior change.



### Creating Pull

When we work with organizations, we help them “create pull” — develop and implement the strategy for identifying, developing, and building out the supports that need to be in place to change organizational behavior and practices.

Creating pull — rather than trying to “push” a new behavior — begins with understanding the interests of each person at the table. The health and wellness interests of individuals are particularly difficult to work toward, not least because people tend to dismiss the importance of their well-being and begin to feel “skin in the game” only upon becoming acutely ill (a noticeable loss of well-being). Even when the risks and benefits are communicated effectively, complying with lifestyle regimens without immediate results remains difficult. The goal is to have the patients convince themselves of the benefits and seek effective tools to better manage their own care. This new paradigm can be described as “creating pull” for becoming an engaged partner in one’s own health.

Based on what we know about what it takes to influence and support behavior change, we have identified several strategies for creating pull.

### Triangulating — To mobilize the group with the most interest in change to influence others.

Often when someone is in failing health, their condition affects people beyond themselves — their co-workers, neighbors and friends, and usually most acutely, their families. Triangulation appeals to another interested party to help spur change in someone’s health, having people “pulled” toward fulfilling their own needs by those who can influence them the most. Simple examples include when a son or daughter asks a parent to stop smoking or when a spouse cuts out salt and fat on the dinner table after a heart health scare. But while some reforms in population health will depend on patients changing their own practices, more complex innovations will depend on groups, including payers and providers, making changes. Triangulation creates change by having the group that will benefit the most do the legwork.

Medical errors are a well-documented issue, and a ripe area for changing providers’ practices. Preventing medical errors is in the best interest of everyone involved, from payers who are less likely to have to cover the cost of follow-up treatment, to providers who want to ensure high-quality care for their patients — and avoid litigation and marks on their reputation. But patients clearly benefit the most from preventing harmful errors.

In the case of error prevention, triangulation works by mobilizing patients and their families to change provider behaviors. [Campaign Zero](#), an organization that “delivers safety strategies to patients

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## PART 2: FROM PATIENT TO PARTNER — CREATING PULL FOR THE SHIFT TO POPULATION HEALTH MANAGEMENT

*continued*

and their family-member advocates to prevent medical errors,” is guided by this principle. [Campaign Zero](#) has created online resources, such as checklists, to educate patients and their families on specific ways they can contribute to avoiding hospital-acquired infections and other medical errors. The checklists contain information about detecting early signs of bed sores, for example, as well as context for what a family member can communicate to nurses, and what they can ask them to do. The checklist becomes a tool for creating pull by encouraging specific actions and doing so in a way that helps normalize the behavior — reminding the family member of their agency and their responsibility in preventing medical errors, even if it means telling a provider information he or she “should already know.” This combination of having<sup>1</sup> a motivated clinical partner in the family member and<sup>2</sup> the supports in place, in the form of a checklist with information and encouragement, creates the conditions for triangulation to succeed.

### **Enlisting a critical mass so that others can join an already-winning effort.**

We know that in times of illness, people seek others who have been through similar ordeals. Now patients are creating online communities based on shared experience. These groups are especially powerful for those with rare diseases, previously invisible to one another. They can now more easily share information and experiences with symptoms, procedures, medications, workarounds, and providers. And these resources can act as supports for people to assume more agency in their own care.

The web is beginning to have a dramatic impact on the lives of people suffering from obscure and more prevalent conditions alike, through a kind of snowball effect. [PatientsLikeMe](#) is a social-networking site that connects people who are battling the same illnesses, while also encouraging openness of medical information to understand outcomes and drive at solutions more quickly. It puts the data in patients’ hands and gives them a platform to discuss it. When patients meet, they can create pull for change together, by doing things as simple as communicating about interventions that work, sharing their own medical data and results, or launching larger undertakings, like lobbying the government to fund research for their condition or convincing pharmaceutical companies to develop drugs that have a life-saving impact on a relatively small number of worldwide sufferers.

These strategies for creating pull can help patients take the lead in health and wellness — and help others influence them to do so. Setting expectations for clinician behavior helps patients and caregivers understand their own responsibilities for medical outcomes. And providers can personally connect patients with one another and also direct them to online communities as another option.

*In the third article, we will discuss some thoughtful ways to turn strategy into action quickly with provider roles under pressure.*

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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## IT'S "JUST" THAT "SIMPLE"

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They say a picture is worth a thousand words. I believe stories can communicate content and capture emotion in a way trying to write the content and describe the emotion in a more structured manner may not.

All that is to say, I apologize in advance if this piece seems like just one story after another, but when we are talking about something as personal, emotion-filled, complex, and frequently difficult to understand or negotiate as healthcare, stories can cut to the heart of the matter and bring clarity to what is, what should be, and what can be done to transform the system.

I knew from a very early age (7 or 8) I wanted to be a doctor. Although my father is a physician, he never pushed me towards or away from medicine. When writing essays for medical school applications to answer the question "Why do you want to be a doctor?" my response was typically "I love science, and I want to help people. Medicine will allow me to do both." That indeed was true, was what I sincerely believed, and was a rational and logical reason to pursue a journey which required a tremendous investment of money (my parents'), time, effort, dedication, and stamina.

However, there was so much more than that. I have only recently become consciously aware of what that "much more" was. Age apparently has gifted me with the harvest of introspection and enabled me to gain insight internalized as a child but not understood at a conscious level back then.

You see, when my sister and I were little, my father would sometimes take us to his office as well as on house calls. We would sit quietly in the waiting room, and I would watch as patients went into his office and exam rooms looking one way and then later emerge looking quite another. There was clearly something magical happening during that interaction. Furrowed brows, downcast eyes, or a cloak of fatigue were replaced by looks of relief, a sense of calm, or a stance of determination to fight whatever condition might be causing physical or mental distress. We would sit in the car as he went inside a stranger's home to care for someone for whom a trip to the office would prove a severe hardship or who could not afford a trip to the hospital. Though he was sometimes paid not in money but in cakes, the bounty of a recent hunting trip (I will never forget the frozen, skinned rabbit in the kitchen sink given to him by a patient – YUCK!), and vegetables from the garden, his passion, dedication, and joy in caring for his patients never flagged, and their lives were intertwined in a rare and special way.

As I look back on my training days in internship, residency, and fellowship and then later in practice, certain moments are indelibly etched in my mind. These are but a few born of the privilege I have had in caring for patients:

- Patients in a teaching hospital generally understand that means some of their care will be provided by "doctors-in-training." As a medical student, one evening I was sent to do a blood gas on a patient with asthma. A blood gas involves sticking a needle in a patient's wrist with the intent of drawing blood from an artery in order to determine how well the lungs are being oxygenated. Until the practice changed to inject a little numbing medication prior to the blood gas needle stick, it was standard for this procedure to be performed without the benefit of anything to dull the pain. I always dreaded doing blood gases because they could be very difficult to perform, and they were very painful for the patient. After my third attempt was unsuccessful, I told the patient I was going to get someone with more experience. She refused to let me do so, saying "You have to learn. How are you going to learn if you don't keep practicing? You can do it, and I won't let anyone draw my blood but you." **You never know who your teacher will be.**



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## IT'S "JUST" THAT "SIMPLE"

*continued*

- As a resident I learned the power of a gentle hand on a fevered brow, assuring a terminally ill patient you will be with them at the end and will make the journey as comfortable as possible, saying "I'm so sorry" when someone is told the pregnancy test is negative after the 5th IVF cycle, looking a patient directly in the eye and letting them know "I'll be with you every step of the way" as you deliver bad news, stroking someone's hand until the pain medication kicks in, and showering them with a sunshine-bright smile when the test for cancer comes back negative. **You never know when what is needed most is not the most cutting-edge technology nor another blood test nor a consult by the leader in the field, but being human and truly connecting with another during a time of extreme vulnerability.**
- As a GI fellow, our on-call team was presented with the challenge of providing care to a patient with a massive upper gastrointestinal bleed who was a Jehovah's Witness. Unfortunately, he waited quite some time when he first began to bleed to tell his family he was having a problem. And then, once they were aware, much time passed before they could convince him to go to the ER. He was quickly moved to the ICU and hooked up to IV fluids and medication to help stabilize him sufficiently to perform an endoscopy, which involved putting a scope with a camera down to find out the source of the bleeding. He adamantly refused any blood transfusions. We discovered an ulcer in his stomach which we treated, but explained to him and his family that given the amount of blood he had lost prior to coming to the hospital, he would die without being given (many) blood transfusions. In this literally life-and-death situation, his family, also of the Jehovah's Witness faith, attempted to convince him to accept the blood. With grace and an obvious love of his family and of life, he continued to refuse, and so we were left to keep him comfortable but helplessly watch as he slipped away. It was a devastating experience for his family and (what may potentially be considered by some to be an "unnecessary death") haunted me. My sole source of comfort was the peace, faith, and equanimity with which he had accepted the consequences of the choices he had made and seemingly without fear. **You never know when you will be called to remember that each moment with a patient is precious and should be honored as if it might be the last.**
- As a physician in practice, I was always surprised when a patient who had been seeking a diagnosis for quite some time prior to the referral to me would express shock and then relief when I said "It doesn't make sense medically, and I can't explain it, but since you say it is happening, we need to move forward, figure out what is going on, and what can be done about it. What do you think is going on? What do you think may be causing the problem?" 95% of the time in these situations, the patient knew the puzzle pieces which led to the answer, and all we then needed to do in collaboration was figure out how they fit together. **Never underestimate the power of stillness and actively listening in silence.**

In recounting these stories and thinking back on what has seemed to work in a one-on-one appointment with a patient as well as at large organizational or complicated systems levels, certain themes emerge. They may seem (deceptively) simple. And although everyone, both in and outside of the system, can truly rally and have an impact, translation into action at a population level requires passion, an un-erring vision of and belief in the possibility of a better and different way, and extreme perseverance.

### So what works?

1. **Do unto others as you would have them do unto you.** As you are interacting with patients (or with anyone for that matter), imagine yourself in their position. Are you treating them in the same manner you would want for yourself, a family member, or friend? Do the staff and the design of the care delivery environment reflect an intention to bring ease to distress and suffering? Do your actions and words communicate best efforts and bring "A" team performance to every encounter?

## IT'S "JUST" THAT "SIMPLE"

*continued*

2. **Focus on the patient.** If your focus remains on the patient and what is in their best interest, you will find there is greater clarity in decision-making and the actions you take (or select not to take because they really do not enhance your ability to diagnose, treat, or cure).
3. **Sawubono - "I see you."** Do your words and actions unequivocally let the patient know you see and respect them as a person with a real life, real fears, ideas of their own about what may be wrong, and what will work or may best for them in addressing their medical issues. Do they communicate your truly care and view the patient as not just a collection of signs, symptoms, and lab results to be "profiled" into a diagnostic bucket?
4. **Be a healing presence.** Medicine is not nearly as black and white as we might think or like it to be. Despite all the awe-inspiring advances in technology, medical techniques and interventions, and life-saving or life-changing medications, there is still a lot of gray, and cure is not always possible. However, it is possible to heal even though you may not cure. Are patients left with a sense of peace, comfort, understanding, (reality-based) hope/optimism, and connection which engenders (1) resilience and (2) the strength to move forward in the best direction for them given their particular circumstance? Have they been helped to see and feel their true essence remains intact and they are not merely their diagnosis?

### It's "just" that "simple."

In a world of fragmented care, increasing complexity and cutting edge advances, rising disconnections despite technology which enables global connection, mounting healthcare costs, a tsunami of chronic disease and lifestyle-related maladies, and "new" care delivery approaches and reimbursement methodologies, perhaps these lessons learned from the past are some of the critical ones to help take us "back to the future" in a way that brings insight, power, and grace as we face the myriad challenges of a broken healthcare system?

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## TOWARD CREATING A MODEL PUBLIC HEALTH COMMUNITY: LESSONS LEARNED

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My commitment to healthcare is fueled by family history. I grew up in a family of four, and three of us – my mother, father, and brother – are all cancer survivors. My brother, Doug, was a star collegiate soccer player when he went to the doctor for a check-up after his freshman year. An x-ray revealed a tumor, and he was diagnosed with chondrosarcoma. It's unsettling being a young adult with cancer, not knowing where to turn for resources. Hoping to make things easier at a vulnerable time for others facing cancer, our family founded the Ulman Cancer Fund for Young Adults. My brother was diagnosed with cancer twice more, and his perseverance and passion are an inspiration. I call him my hero to this day.



My parents instilled in us the value of public service. My brother carries out that mission as CEO of the Livestrong Foundation in Austin, Texas, and I have been privileged to serve as a county councilman and then as a twice-elected County Executive in Howard County, MD.

Howard County is a great place to live, work, and raise a family. We are known for our excellent schools and a prime location between Baltimore and Washington, D.C. But even in our community, we faced significant health and lifestyle challenges. We needed to reduce obesity and smoking, increase fitness and healthy food choices, and make sure everyone had access to healthcare, like my brother was fortunate enough to have.

So when I first took office, I established a goal for Howard County to become the nation's model public health community. We've made tremendous progress in the past seven years. The Robert Wood Johnson Foundation has ranked us as the healthiest county in Maryland three consecutive times, and we are a semi-finalist for a prestigious RWJF Roadmaps to Health Prize. Several of our programs have garnered national attention.

I'd like to share some of the lessons we've learned along the way, which we hope can serve as a model for other communities.

### **Set Big Goals.**

To become a model public health community, we had to think big. With leaders in Washington mired in a debate over providing universal coverage, we decided to act. We would not accept that 20,000 county residents had no health coverage. We set a goal of providing them all with healthcare. And we figured out a way to get there without creating a new government program, in part by leveraging existing resources in creative and innovative ways. Through the Healthy Howard Health Plan, we employed the primary care home model, and folded in individual health coaching, using evidence-based best practices to get results.

We partnered with a regional health provider for primary care. Our hospital, Howard County General, agreed to provide inpatient coverage for all those enrolled. And we set out on an intensive outreach campaign to reach the uninsured and connect them with new and existing programs. It worked. We have reached out to thousands, enrolling many in existing programs they were eligible for but didn't know about. Healthy Howard won a Healthy Living Award from the U.S. Department of Health and Human Services and has been featured on CNN and in other national media.

Setting big goals means not being afraid to step ahead. We enacted the first teen tanning ban in the nation, knowing we would take hits from critics who question the need for regulations. But we stood firm, because it was the right thing to do. Likewise, we led the way in prohibiting smoking in all Howard County park facilities.

### **Carrots Not Sticks.**

The health access plan was just one component of a series of

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[click here.](#)



## TOWARD CREATING A MODEL PUBLIC HEALTH COMMUNITY: LESSONS LEARNED

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initiatives we call “Healthy Howard.” All of these programs -- Healthy Restaurants, Healthy Workplaces, Healthy Schools, Healthy Recreation, Healthy Faith Communities, and Healthy Child Care -- share several common features. They reach people where they live, work, and play. They create environments where it is easy to make healthy choices. And they are voluntary and supported by incentives. We decided if organizations joined our effort, we would provide them with resources, training, and support. They would receive a benefit from participating, rather than punishment for not following rules.

The carrot approach has worked well, and thousands of Howard County residents are benefitting. There are 120 certified Healthy Howard restaurants which offer healthy food choices. Our 58 certified Healthy Workplaces encourage everything from breast-feeding to healthy products in vending machines. We have 58 certified Healthy Schools. Our programs are reaching thousands of residents.

### **Hire the Best People and Empower Them.**

I needed a team that shared my vision. One of my first hires was the county’s health officer. Dr. Peter Beilenson earned a great reputation as a health leader in Baltimore, combating lead paint, HIV, and other issues. I convinced him he could tackle a new set of challenges here. He was able to tap into a whole team who shared our goals. In Maryland, we are fortunate to be in the shadow of Johns Hopkins and the University of Maryland Medical Center; many talented professionals choose public health as a career. We want to give them the opportunity to do their best work. We were also fortunate that in Maryland Gov. Martin O’Malley and Lt. Gov. Anthony Brown shared our objectives and fostered an environment which enabled innovation.

### **Build on Success by Being Flexible.**

In Howard County, we have always tried to look ahead, so we can adapt to change. We realized the Affordable Care Act would affect our ability to continue the Healthy Howard access plan, so we developed ways for our valuable initiatives to survive. We empowered Dr. Beilenson to determine a way to use cooperative health plan funding in the ACA to develop a non-profit community-based cooperative, building on the lessons of Healthy Howard. That venture, Evergreen, is up and running, is listed on Maryland’s health exchange, and will start seeing patients soon. “Evergreen should attract working-class families who earn too much to qualify for Medicaid but don’t get coverage from their employers,” said Bloomberg News.

More recently, the Howard County Door to HealthCare, which we created as a one-stop-shopping way of making sure our residents know about all the resources available to them, was selected to be the “connector entity” for several Maryland counties under the ACA. In the last year, the Door provided in-person assistance to 7,124 clients and enrolled 6,117 in health plans.

There is a theme that runs through our experiences: With vision and passion, you can achieve real progress even in challenging times.

To view the Howard County RWJF Roadmaps to Health Prize submission, [watch this video](http://youtu.be/9vJD02xlgQw):



Video URL: <http://youtu.be/9vJD02xlgQw>

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## PART 1: HEALING RELATIONSHIPS AND THE NEW FACE OF MEDICINE

My colleagues at the Vanderbilt University Medical Center and I have spent the last five years studying what clinicians and patients have to say about healing relationships.<sup>1</sup> The results of this research are well worth considering in this time of enormous efforts to contain healthcare costs and to assure the quality of patient care. To put this in deliberately provocative form: What both patients and clinicians say are the most important factors in establishing healing relationships are, essentially, free.

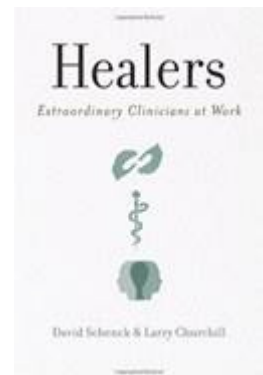
I summarize here the results of our semi-structured interviews with patients and clinicians that were focused on how healing relationships are established and maintained. It should be noted we did not start out with, seek to find, nor conclude with any particular definition of healing. We were far more interested in how our informants chose to speak of healing, than in any precise, and, therefore limiting, formulation. To the extent our work was guided by an “approach” to healing, it would be best captured in these two quotes:

- “Healing is not just ‘fixing’, but restoring to wholeness.” an Internist
- Echoed by many others, “We thought we could cure everything, but it turns out we can cure only a small amount of human suffering. The rest of it needs to be healed.” Rachel Remen, MD

**Patient interviews.** When asked to describe aspects of long-term relationships with clinicians important in their lives, our 58 patient interviewees tended to tell stories that clustered around common themes. I list six of them here.<sup>2</sup>

1. Patients praised clinicians who had the pedagogical skills to convey complex medical information to them in useable and understandable fashion: “She drew those diagrams for me. After I talked with her, I knew all I needed to know.”
2. Patients like to know there’s a powerful person in their corner, a champion for their “cause”: “If they know you’re Dr. Green’s patient, you’re in good shape. I don’t know what I would’ve done without her watching out for me.”
3. Explaining why relationships with their practitioners were healing, patients described the basic human bond they felt with their clinician: “He shared so much with me about his own illness . . .” And: “She became a friend of our family. That’s what she is.”
4. Despite misconceptions still commonly held, patients prefer to be told the exact truth. Many referred back to hard conversations with their practitioners as some of the most powerful elements of their relationship: “She held nothing back.” “He didn’t pull any punches with us.” “They told it to us like it was.”
5. Patients tended to be especially proud of the times their practitioners had gone the extra-mile: “Do you know what he did? I couldn’t believe he showed up at the ER on a Saturday night.”
6. Clinicians who could offer their full presence to their patients were recognized as having an unusual gift: “Never met anyone like her. It’s her calling – she’s a healer by nature.” “A poet’s temperament – that’s what he has . . .”

As we looked at the whole set of interviews, we found patients talked about their clinician’s interest in them as a person more often than any other topic. In 49 out of 58 interviews, patients expressed deep appreciation for clinicians who demonstrated interest in them beyond narrowly defined medical concerns.



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## PART 1: HEALING RELATIONSHIPS AND THE NEW FACE OF MEDICINE *continued*

**Clinician Interviews.** Our 50 clinicians identified as “extraordinary” by their colleagues described strategies they used in daily practice and tips for budding practitioners.<sup>3</sup> We summarize the results of their responses in the following Eight Healing Skills:

1. **Do the Little Things:** Introduce yourself and everyone on the team. Greet everybody in the room. Make appropriate eye contact. Give your undivided attention.
2. **Take Time:** Be still. Be quiet. Be interested. Be realistic: “You’re going to spend the time sooner or later.” Be present. The human measure of time is qualitative.
3. **Be Open and Listen:** Listen on many levels. Use the “third ear.” Face the pain in front of you. Look for the unspoken. Carefully ask the open-ended question: “And what else?”
4. **Find Something to Like, to Love:** Stretch yourself and your world. Think of your family. “Practitioners ... who dislike their patients regularly cut them off during the recitation of symptoms... [They] become wedded to the distorted conclusion...which leads to poor care.” — J. Groopman, *How Doctors Think*
5. **Remove Barriers:** Attend to barriers of all kinds: physical, interpersonal, institutional, political, cultural. Be aware of power differentials. Build bridges. Practice humility. (Don’t be the barrier!)
6. **Let the Patient Explain:** Try to map the patient’s narrative of the illness. Try not to get stuck thinking only about the disease. Listen for what and how they understand. Listen for the fear and for the anger. Listen for expectations and for hopes.
7. **Share Authority:** Offer guidance. Be confident. Give the patient permission to take the lead. Support patients’ efforts to heal themselves.
8. **Be Committed & Trustworthy:** Do not abandon. Invest time and energy in building trust. Be faithful. “Our presence is the most important thing we give our patients.”

All our research thus far focuses on relationships between individual practitioners and individual patients. Even when those practitioners are part of a team, the focus in the interviews is still on individual relationships. There is, therefore, one enormous problem that looms over our research and is illuminated by it. Increasingly, healthcare is delivered by teams, not individuals. Thus the question becomes: How can we develop teams that can establish healing relationships with patients?

This seems to me to be the kind of challenge that Wharton graduates are particularly well-trained to address: How can we develop medical teams that can establish healing relationships with patients? What organizational models, work conditions, and economic strategies might be involved? We know what kind of relationships further healing. The question now is how to deliver that in the new environment of greater efficiency and higher accountability we are now entering.

Stay tuned for Part 2 in January.

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## Making It Happen! Interview with UCSF's Stephanie Marrus, Director of the Entrepreneurship Center

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**WHQ:** Stephanie, thank you for your time today and for sharing some of your thoughts regarding the direction healthcare is headed in the world of entrepreneurship. Tell us a little about your path to UCSF and directorship of the Entrepreneurship Center.



**SM:** I am a WEMBA '82 and began my career in marketing and business development in the technology sector. I then spent time working for the Governor of Massachusetts, William F. Weld, as Deputy Secretary for Policy in Economic Development, followed by a position in corporate communications and investor relations at Vertex Pharmaceuticals, where I had the opportunity to learn about biotechnology in the early, exciting days where companies went public on a dream. Later, I became a business consultant for about 12 years and served in a variety of roles in venture-backed companies. I was asked by the head of a Berkeley entrepreneurship center to teach bio-entrepreneurship and soon found myself lecturing across the globe, including such places as Russia, Saudi Arabia, and Latin America. I discovered I had a passion for teaching and mentoring, which means I absolutely love what I now do as Director of the UCSF Entrepreneurship Center. My goal is to build a Center that becomes the premier resource for life science entrepreneurship in the world.

**WHQ:** What trends have you observed which you think are important for readers to know?

**SM:** There are major challenges to disruptive innovation in life sciences and healthcare, particularly in the areas of medical devices and therapeutics. Venture capital has experienced returns below the S&P 500 over the past 10 years, and, consequently, that funding source has largely dried up for early stage life science ventures. There are many fewer dollars available to fund true innovation -- novel therapeutics and devices. One bright spot is therapeutics for orphan diseases, which can gain market exclusivity for seven years and have an attractive value proposition. By contrast, consumer Internet ventures generate strong returns in short time frames with small levels of investment. The closest thing we have in life sciences is digital health, which resembles the consumer Internet sector on many metrics -- short development time, low investment, potential quick hit. Entrepreneurs and investors are attracted to this sector because of the more attractive risk profile and smaller funding requirement. Another trend is that the most innovative medical devices are being tested and introduced in Europe, where regulatory demands are less onerous.

**WHQ:** What are the most common lost or untapped opportunities you observe among entrepreneurs in their first 5 years?

**SM:** The most common mis-step I have observed is an inadequate evaluation of market needs and lack of understanding market dynamics. In their passion for their service or product, entrepreneurs often forget to determine in a disciplined manner if the market is as interested in their idea as they are. They forget to ask what problem they are solving and whether the marketplace likes their solution.

The Entrepreneurship Center is embarking on a groundbreaking course that makes teams vet their idea "out of the building" with 100 interviews in their market over a 10 week period. The framework was developed by Steve Blank at Berkeley and Stanford, has been adopted by the NSF nationwide, and we are working with Steve to implement a life sciences/healthcare version for the first time anyplace with an October start date.

Contributor:  
The WHQ

## Making It Happen! Interview with UCSF's Stephanie Marrus, Director of the Entrepreneurship Center

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The other area that can trip up entrepreneurs is having the wrong team. The team can make or break a venture. Things inevitably don't follow plan, and whether the team can respond effectively is critical. That's why investors weight the team heavily in their decision to fund, sometimes even more than the idea.

**WHQ:** What qualities have you noted to be a common thread among successful entrepreneurs?

**SM:** There have been many studies in this area. Entrepreneurs have a very different personality profile than corporate managers and are a misfit at large corporations. They need an environment that allows creativity, space, flexibility, and movement. Some of the characteristics the research has noted are:

- They are comfortable living with ambiguity. Situations are rarely black or white; entrepreneurs can live with gray and operate effectively.
- They are risk takers, comfortable with taking action with less data and analysis than others.
- Although the money is important, a main driver is the desire to have an impact. I know many successful serial entrepreneurs with a huge net worth who can't wait to do it again. It's not about the money.
- They tend to operate outside the norm, be fiercely independent and self-motivated, and highly tenacious, which helps them stay resilient.
- They are passionate about their mission and determined to make it happen.
- They are resilient, rebounding from adversity quickly. They stay flexible, don't get locked into one path.
- They are decisive, not wafflers. They gather information and then make decisions.

**WHQ:** What has surprised you most since you became Director of the Entrepreneurship Center at UCSF?

**SM:** When I first started, I was not sure how much entrepreneurship interest there was on campus. Entrepreneurship had not been a focal point, and when I opened my desk drawers there were no lists, programs, staff, or dollars to serve as a foundation for the effort. I needed to use all the teaching and mentoring – and my network. The happy surprise was there was a great deal of interest in starting ventures, and it was happening quietly in labs and clinics around campus. Now I could provide people with a focal point and structured assistance. Our courses and events are highly subscribed, often standing room only. We've had to turn down almost half of the teams who applied to Lean LaunchPad because of space limitations.

**WHQ:** What skills and experiences have served you most in taking on the directorship?

**SM:**

- Networking has been essential, the way in which I've built high quality programs without a budget. I am fortunate to be in the best ecosystem for entrepreneurship working for an institution that is loved by everyone. There is a strong culture of "paying it forward."
- My marketing skills. I've endlessly pitched the Center all over campus and Silicon Valley. We publish an events listing every 2 - 3 weeks that goes to an ever growing database. We've had a bit of media coverage. I beg for a slot at conferences. Good thing I'm an extrovert and a ham! It's working.



## Making It Happen! Interview with UCSF's Stephanie Marrus, Director of the Entrepreneurship Center

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**WHQ:** What advice do you have for budding entrepreneurs and companies in the early start-up phase of their business?

**SM:** Talk to the market. Identify a genuine need, and offer a compelling value proposition. Do not assume because you think your product or service is fantastic that anyone else will. Make sure you are addressing a pain point.

Network like crazy. Begin early to build a team. Identify the right people with whom to work, not just your friends. Tap into mentors and advisors who can give unbiased advice. Surround yourself with high quality resources and people. Never stop pitching. The person you pitch today might be important next year, or in some way you can't anticipate.

Look for money when you don't need it. When you need it, it may not be there. Be passionate about what you're doing. The road won't be smooth, but if you are truly an entrepreneur, there is nothing else as satisfying.

**WHQ:** Stephanie, thanks again for your time and what has been a discussion filled with insight and real-life, actionable guidance for entrepreneurs of any age at any stage.

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## At Risk: Doctor-Patient Dis-Connection Through Modern EMR's

"The Doctor will see you now." Perhaps those of you of a "certain age" remember hearing these words spoken by a nurse wearing a white nurse's hat and white leather shoes? I bet you have not seen her in a while. Some-thing else is also missing: the way the doctor would talk to you, spend time, listen deeply, ask questions, and diagnose your illness. Best of all, by looking at you during the exam and responding in a personal and conversational way, there was a connection formed between your doctor and you. The doctor conveyed a sense of caring about helping you feel better. And after all, that is why you came to the doctor in the first place - to feel better! This kind of connection and experience could become scarcer in the medical care doctors provide today and patients receive in the future. But how did it come to this, and, while it is great for the doctor-EMR relationship, how good is it for the doctor-patient relationship?



Along with saying goodbye to the 1960's and 1970's, there are other reasons patients no longer hear the words, "The doctor will see you now." One reason is patients are not required to be with the doctor to see the doctor, thanks to advances in telemedicine and home medical devices. According to Gary Capistrant, senior director of public policy at the American Telemedicine Association (ATA), "It's hard to quantify how many doctors now use webcams in their practices, because no agency tracks or requires doctors to report webcam use." Many more facilities are trying it out, and it is also more tempting and available to both doctors and patients with the advent of smartphones and 4G networks. The ability to communicate with a doctor from virtually anywhere in the world — is going to gain in attractiveness to both patients and doctors, as noted by John Shufeldt, MD and CEO of [MeMD](#), "With telemedicine, the doctor comes to you. This allows you to communicate with your medical provider from your home, office, or even when traveling." There are all sorts of considerations for doctors, payers, and providers, including cross-state licensing, confidentiality, and billing, to say nothing of considering the ratio of telemedicine to face-to-face encounters in order to maintain a strong foundation of doctor-patient 'human' connection and trust. In addition to licensing and questions surrounding issuing web-based diagnosis, doctors themselves need to guard against what I call electronic erosion of doctor-patient intimacy, which could end up as an unforeseen by-product of telemedicine.

But there may be an even bigger challenge to the trust built up over generations of doctor-patient encounters - the introduction of electronic medical record (EMRs) into medical practices. These days, the doctor may be talking to you but seeing their LCD monitor or laptop screen, all compliments of their newly implemented EMR, based on incentives available under the ARRA. A good definition of an electronic medical record as [defined](#) by the American Medical Association provides a simple baseline. EMRs have changed the human-to-human dynamics in the exam room. Doctors may or may not even look up from their EMR screen while the patient obligatorily answers a series of prescribed and pre-coded questions following the workflow for that doctor's specialty. For some patients this will feel like answering questions for a product survey company where the product is, well, the patient.

The first time I went to my internist after his major metropolitan medical practice implemented an EMR I was stunned, truly stunned. I was sitting in a chair next to a small desk in the exam room where the doctor sat opposing but not facing me. Instead, the doctor was facing and focused on an 18" display. He was not just focusing on it, but seemingly commanded by it. If you remember what it was like to have to sit next to the teacher at his or her desk while in grade school, then you know what I felt like. The impression given was this 'doctor's visit' was a three-way affair between the doctor, the EMR, and me. Later, the doctor confided in me the new EMR system was frustrating him greatly and 'got in the way' of the doctor-patient relationship. Viscerally on my part and experientially by the doctor, this was my first clue that incorporating EMRs into medical practice runs the risk of pushing aside a key element of the doctor-patient relationship if simply implemented without the establishment of "EMR etiquette."

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## At Risk: Doctor-Patient Dis-Connection Through Modern EMR's

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This is not the intention of the [Affordable Care Act](#) no, not at all. While much good will come from individual doctors, [HMOs](#), [ACOs](#) and [HHS](#) being able to gather and mine data about various populations in order to lower disease incidence and manage costs, doctors now have a new learning curve to ensure patient interactions do not become robotic encounters. Doctors need to protect the cornerstone of the doctor-patient relationship, which is a sense of personal service blanketed by human trust and caring.

To highlight the range of experiences likely occurring between doctors, patients, and computers, I had a very different experience when visiting another specialist. How he positioned himself in the exam room was quite different. Even though there was a designated desk and monitor space in the room, instead of using it, he literally sat across from me so we could see each other. He actually increased his proximity. He did not let the EMR come between us. This small adjustment alone was an improvement. Not only that, but he had a laptop versus a flat screen monitor. His attentiveness was first to me and not to his coding and workflow. Best of all, even as he began asking questions to diagnose my issues, I knew he was still in the room with me because he kept looking up and across at me from the screen. He questioned. He paused. He listened. He acknowledged. He questioned again. He strung these actions together in a sequence so his obligatory coding and documentation drop-downs really weren't all that intrusive from my perspective as the patient. Finally, when I complimented him on the ease with which he wove back and forth between his electronic tasking and the human side of the interaction he said, 'I believe a patient decides to stay as a patient or go elsewhere within the first 10 seconds of the encounter. If those first 10 seconds are spent more with the computer than the patient, then I haven't helped the patient or my practice.'

So how is it there can be two such very different experiences for a patient (and I am sure for the doctors as well) when EMRs were being used in both encounters?

Many doctors are very talented in their medical training and are also skilled communicators. Since my career success is based upon successful listening, diagnosing, and prescribing actions for customers (similar to a patient-doctor interaction but over a longer period of time and involving IT-based solutions rather than clinical recommendations), here are a few ideas for current and newly minted physicians and other practitioners regarding patient interaction while using an EMR:

- **Commit to time with the patient, not the system.** Demonstrate this by pausing, looking up and away from the screen, and at the patient. This will only require 10 to 19 seconds of time during the encounter. Smile. Eye contact with the patient does wonders.
- **If possible, arrange the screen in the exam room so you are still facing the patient.** This will make it easier to pause and look up to make eye contact and let the patient know you are seeing them and not just entering data.
- **Pause whenever the patient talks** and, before documenting notes, **listen and confirm** what you just heard. Do this at least once or twice during the encounter. Patients will likely be saying to themselves, "Yes, she gets it...she's going to help me get better!"
- **Offer the same encouragement you always did regarding concerns, fears, and a path to wellness.**
- **Smile, with your eyes.** EMRs don't have those, only you do.

Seem simple? It can be. But doctors now have one potential obstacle to maintaining patient intimacy and trust. Unintentionally, that obstacle is the EMR. And yes, it is still possible for "the doctor to see you now."

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## PART 1: BREAST HEALTH DECISIONS OF AFRICAN AMERICAN WOMEN RESPONSIBILITY WITHIN THE CULTURE

The role of culture is an important factor in the breast health decisions African American women make. Changes within the healthcare system affect where, how, and by whom cancer is managed. The inclusion of data points relating to medical culture and increased socio-cultural training of physicians may be useful in the achievement of improved health outcomes.



One of the most important components of the Affordable Care Act is increased access to healthcare. While one might assume gaining access alone may positively influence health outcomes, this is not assured. There are a number of components that must work together to significantly lessen the mortality and morbidity too often associated with African American women diagnosed with breast cancer. My research<sup>1</sup> examines the role of culture in making breast health decisions.

I interviewed three cohorts of 44 African American women: some with a family history of breast cancer; some with no history of breast cancer; and others who are breast cancer survivors. The women were between the ages of thirty and fifty, were overwhelmingly well-educated, and had access to healthcare; this was different from other similar studies. One of the key findings of the study is there is a great deal of socio-cultural complexity associated with a potential diagnosis of breast cancer. This includes myths, fear, and misinformation which affect prevention strategies, screening, treatment decisions, and follow-up. Therefore, at each decision point, trusted counsel would be useful to ensure women are accurately informed so optimal breast health decisions are made. The team naturally would consist of family/friends, a family practitioner/internist, and an oncology team, but when culture is taken into consideration, often a minister/pastor or other community partner may be an important addition to the team.<sup>2,3</sup> This finding is consistent with the Patient-Centered Medical Home (PCMH) focus of the Affordable Health Care Act.

Culture does play a role in the decisions some African American women make in their breast care decisions. The question becomes whether any of the components of the Affordable Care Act will enhance African American women's abilities to optimally navigate breast health in the context of their culture. I believe the answer is "yes." Culture is discovered, respected, and acknowledged best where there is relationship. Relationships and conversations between patients and physicians can develop optimally during office visits at which the patient's health, psychosocial needs, and personal concerns are all discussed.

Without a doubt, African American women are not homogeneous, but, for some, there are common histories or experiences of oppression and marginalization in healthcare. The participants in my research were generally of a higher socioeconomic group compared to the participants in most other studies. They had access to healthcare, and 30% described their relationship with their internist, family practitioner, or gynecologist as close and personal. However, much of the literature that has focused on older, less educated, and less affluent African American women does not describe the relationships of these women with their physicians in a positive manner.

There is an ever-increasing number of acronyms to describe components of the Affordable Care Act. The two which seem to be used most often when discussing oncology care are the Accountable Care Organization (ACO) and Patient-Centered Medical Home (PCMH), which some of the literature asserts are almost synonymous. The inclusion of the hospital as the key component of the Accountable Care Organization seems to be the most widely agreed-upon distinction between the two frameworks and is becoming increasingly important in the management of oncology patients.

Physicians in the outpatient setting are finding it increasingly difficult to provide the level of support and navigation that is particularly important in underserved populations. With the uncertainty associated with the implementation of the Affordable Care Act, oncologists may not be confident enough to invest in the staff and technology needed to optimally support many needy patients. The shift of cancer treatment and management from the outpatient to the hospital setting is often driven by reimbursement patterns. One of the benefits of the inclusion of

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## PART 1: BREAST HEALTH DECISIONS OF AFRICAN AMERICAN WOMEN RESPONSIBILITY WITHIN THE CULTURE *continued*

the hospital in the model is to provide staff resources and infrastructure, such as electronic medical records, which allow patients to more easily obtain support and timely treatment. Further, the data provided allow outcomes to be accessible and accurately measured. Consistent with the PCMH model, my research affirms the important role the entire health care professional team working together can have and positively impact breast health behaviors.

The navigation of cancer treatment is complex. Sprandio (2012)<sup>4</sup> asserts optimistically, “Community-based oncology practices and institutionally-based cancer programs have a significant opportunity to lead positive change that will position them better in the new world order.” (p.47s) In this model, the oncologist, rather than the family practitioner, leads the care team, including patient engagement and education. The author provides the example of Consultants in Medical Oncology and Hematology near Philadelphia, Pennsylvania, as a success story; it was the first practice to be recognized by the National Committee for Quality Assurance (NQOA), achieving a Level III (Advanced) designation. The defined goals were to achieve better cancer care, better patient health, and, of course, lower the cost of the delivery of care (p.48s). Interestingly, while culture may have been implicit by referencing “patient engagement,” it was never directly mentioned. Further, the validity or reproducibility of this model has not been determined.

A growing number of the larger medical schools have programs which equip physicians with the ability to make socio-cultural assessments. (Rust, 2006)<sup>5</sup> However, relationships and rapport are built over time, and with the limited time the physician spends with each patient, the quality of the doctor-patient relationship is often compromised. Consequently, the patient may not view the physician’s recommendations as valid, and, perhaps most importantly, the physician may not believe he/she has the right to address a patient’s everyday decisions relating to personal life and environment. Further, there is some risk involved when health care professionals challenge a patient’s health decisions when those decisions are counter to health recommendations, especially when the patient’s decision-making is consistent with the patient’s own culture. However, provided with the much-needed socio-cultural training, the physician will be able to clearly exhibit both confidence and sensitivity which can ultimately enhance African American women’s abilities to make optimal breast health decisions.

Part 2 will further discuss some of my research findings which reinforce the key roles the physician, family, friends, and clergy often play in helping African American women navigate making optimal breast health decisions.

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## INNOVATION GRANT PROGRAM USES TECHNOLOGY, DATA, AND HANDS-ON MENTORS TO IMPROVE OUTCOMES FOR HEALTH

Integrated health technologies are transforming healthcare. Americans are increasingly turning to online and mobile platforms to meet a variety of needs. In 2012, roughly 75 million individuals (about 31% of the U.S. population) used mHealth (mobile health) for health information.<sup>1</sup>

Mobile technology is helping to close the “digital divide” between demographic groups. According to a Pew Research Center study on mobile access, African American and Latino groups do more texting, web browsing, e-mailing, and instant messaging than their white counterparts. The study found about 87% of African Americans and the same percentage of Latinos own cell phones, compared to 80% of white respondents.<sup>2</sup>



Philadelphia-based Health Partners Plans is a 28-year-old, hospital-owned, not-for-profit managed care organization serving Medicaid and CHIP members. Health Partners Plans uses integrated health technologies to help improve the health of our more than 175,000 members, many of whom are African American or Latino (who represent about 1 in 10 people in Philadelphia). In July 2012, Finity Communications, a technology company, was awarded a \$4.9 million, “healthcare innovation” grant from the Centers for Medicare & Medicaid Services (CMS) in partnership with Health Partners Plans, SCIO Health Analytics, and Duke Integrative Medicine. The grant allows us to connect with our members on the technology platforms they use by combining advanced health technology, multiple communication mediums, incentives, analytics and support through Peer Health Advisors (PHAs). PHAs have firsthand knowledge of the cultures, languages, and socioeconomic status of the communities they serve. The role of PHAs is being tested to help members improve their health.

Grant partners work as a team, combining their unique strengths:

- Health Partners Plans has ranked #1 in member satisfaction for the past 10 years and was the first health plan in the nation to receive the Multicultural Healthcare Distinction from the National Committee for Quality Assurance (NCQA), the nation’s leading health plan accrediting organization. Our experience addressing the often complex healthcare needs of underserved populations, coupled with our proven record for implementing award-winning health programs, will allow us to use the technology and data resources afforded through the grant to continue to improve member health outcomes, while lowering costs.
- Finity Communications provides the systems-based wellness and disease management content and technology platform. Health, wellness, and condition-specific content is created as variable data objects and delivered in five mediums: web, text, interactive voice response (IVR), print, and mobile applications. The platform tracks all outgoing communications by message, medium, and outcome, and links encounters to claims-based results. This closed-loop platform uses a behavior-based methodology to provide dynamic health content, messages, and alerts that evolve based on behavior.
- Duke Integrative Medicine provides the PHAs with a distance training program rooted in integrative health principles. The Duke training is based on many years of clinical experience and health behavior change research with thousands of patients and clients. It is designed to enhance PHAs’ communication, listening, and mentoring skills.
- SCIO Health Analytics uses a risk measurement tool to create personal health profiles and a risk score for each member. SCIO creates a series of monthly health and condition alerts based on claims data. Alerts are sent to the platform, attached to relevant content objects and served in different mediums based on risk scores. SCIO is also responsible for linking the encounters to the claims-based results and providing reporting.

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## INNOVATION GRANT PROGRAM USES TECHNOLOGY, DATA, AND HANDS-ON MENTORS TO IMPROVE OUTCOMES FOR HEALTH

*continued*

In 2012, we piloted four components of the integrated wellness and disease management system. The engagement goals set for each pilot program were exceeded.

- The Live Well and Healthy Parenting text pilots were designed to test member engagement, usage, and health impact of wellness text message programs. The programs were offered to members with diabetes and parents of young children. Members received direct mail cards and incentives to encourage participation. Participants received health-related messages three times per week. The messages were also made available in print if requested. The participant survey indicated 56% of enrolled members preferred text messages as their communication medium. In addition, 73% of enrolled members reported adopting at least one healthy behavior as a result of the program. 100% reported program satisfaction.
- The Step-Up Challenge pilot was designed to test engagement, usage, and health impact of a walking challenge with incentives. It was offered to pre-diabetic members. Participants were encouraged to gradually increase their daily steps until they reached 10,000 steps a day (the current U.S. Department of Health and Human Services' daily physical activity recommendation). Participants were given pedometers and tracked their steps on a web portal, by mobile phone, or on paper. One hundred percent reported the challenge was successful or very successful in motivating them to exercise more. Ninety-seven percent reported they would continue increased exercise as a result of the challenge. Of those who recorded their steps via computer or smartphone, 51% achieved the goal as opposed to only 18% of those who recorded steps by print.
- The Diabetes Management Education & Alert Pilot was designed to test the usage and health impact of diabetes education and alerts. Information and personalized condition alerts about diabetes management were sent to targeted members by mail and automated phone message. Topics covered included diet, exercise, medication, and the importance of regular health screenings. For each pilot, participation was recorded in the closed-loop system and tracked by message, medium, and action. Claims were linked by member ID and analytics were applied to report results.

The wellness pilots were enhanced and expanded during the first two quarters of 2013. In July, Health Partners Plans rolled out four personalized “LifeTracks” that include pregnancy, diabetes management, healthy heart, and general wellness. The LifeTracks provide condition-specific web content, activities, challenges, text messages, mobile apps, health alerts, and support resources. Incentives were offered to high-risk members, with rewards tied to specific outcomes that are tracked on a member’s personalized LifeTracks.

We believe integrated health services and technologies are important components of the future healthcare system. Although it requires rethinking and reworking processes, services, communications, analytics, and technologies — the rewards are better care, improved health, and lower costs.

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## PART 2: WHITE-BAGGING – WHITE KNIGHT OR VILLAIN?

In [Part 1](#) of this article, I defined and explored the historical evolution of the white-bagging model of physician distribution/reimbursement. In Part 2, I shall examine the unintended consequences associated with “white-bagging,” a seemingly beneficial and benign shift in the administration of specialty products.

In a time of eroding physician reimbursement, white-bagging can be perceived to be an attractive alternative to the traditional buy-and-bill model; however, it is imperative a full and complete analysis be performed to ensure stakeholders, including patients and physicians, are not inadvertently harmed.



### Potential Stakeholder Impacts

#### Loss of Revenue

With white-bagging, physicians are not responsible for the acquisition of a product and therefore forfeit the revenue generated through product acquisition and payer reimbursement. This opportunity represents a meaningful loss of revenue that only increases because physicians still retain the responsibility for storing and handling product that has been provided by the specialty pharmacy (SP). “Practice sites are [also] responsible for the cost of ancillary meds and drug administration and only some of these are reimbursable,” says Association of Community Cancer Centers (ACCC), Don Jewler.

#### Limitations on Prescribing

In an attempt to manage spending, treatment protocols or prior authorization processes (PA) are typically developed by SP’s operating on the payers behalf. PA’s are historically based upon well-established, well-studied criteria. Patients who meet these criteria will be approved for therapy, whereas those that fall outside of guidelines will be denied. While this process works for controlling costs, it does not necessarily provide physicians with the range of treatment options they might prefer. Some specialties that have already had more uptake of white-bagging have felt very limited in being able to provide the drugs and care they feel are best for their patients.

#### Delays in Starting Therapy

With the traditional buy-and-bill model, physicians typically have drug in their office for prompt administration to patients. Due to the prior authorization process associated with white-bagging, delays in therapy should be expected. This process can normally take several days once the necessary paperwork has been submitted by the physician’s office. This can mean a delay in initiating treatment.

Treatment delays can also be caused by a patient’s inability to pay his/her co-payments and/or co-insurance. Even if the drug has been approved by the patient’s insurance, SP’s will typically not ship drug for administration unless all patient financial obligations have been met.

#### Logistical Burden

Most doctors see the reduction in cash outlay as a benefit, but don’t anticipate the increase in overhead costs associated with managing this new process. The paperwork increases rather than decreases when using the white-bagging model. The office has to figure out which SP services the patient’s insurance plan. This means that one office could be working with as many as twenty SP’s, compared with only one or two specialty distributors or GPOs – that are of their choosing rather than mandated by a payer. Often each SP has a unique process with different forms and information needed. Offices may have to

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## PART 1 - WHITE-BAGGING: WHITE KNIGHT OR VILLAIN?

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hire staff just to stay on top of filling out the forms, following up with the SP to ensure the drug will be shipped, and repeating the process for every dose given if the full course of therapy is approved at the beginning. And how will these new costs be covered? Very little, as reimbursement for administration certainly will not be enough.

### **Wasted Product**

Waste is another contributing factor to higher costs with white-bagging. Once the drug has been shipped by a specialty pharmacy for a specific patient, it essentially has been paid for by the payer and in some cases that patient. In the event of dosage changes, treatment switches, lack of response to previous treatment or changes in a patient's benefits, there is a chance the drug cannot be administered. In these events the drug is wasted, as it cannot be returned. There is data that suggests "1 out of 5 shipments from the specialty pharmacy to the doctor's office for doctor-administered drug infusions" goes to waste.

I am not saying SP is altogether a "bad guy." It is a great model for oral and self-administered specialty products that need more management than a retail pharmacy can provide. That said, the SP channel is not a "good guy" for physician-administered specialty products. For these products, traditional buy-and-bill must remain a viable alternative to ensure patients with complex diseases get the care they need when they need it and that doctors can stay in business in order to provide that care.

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