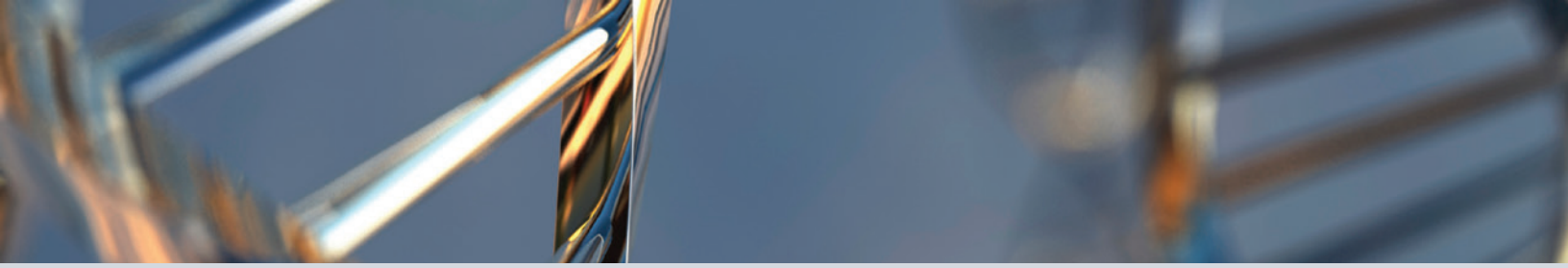

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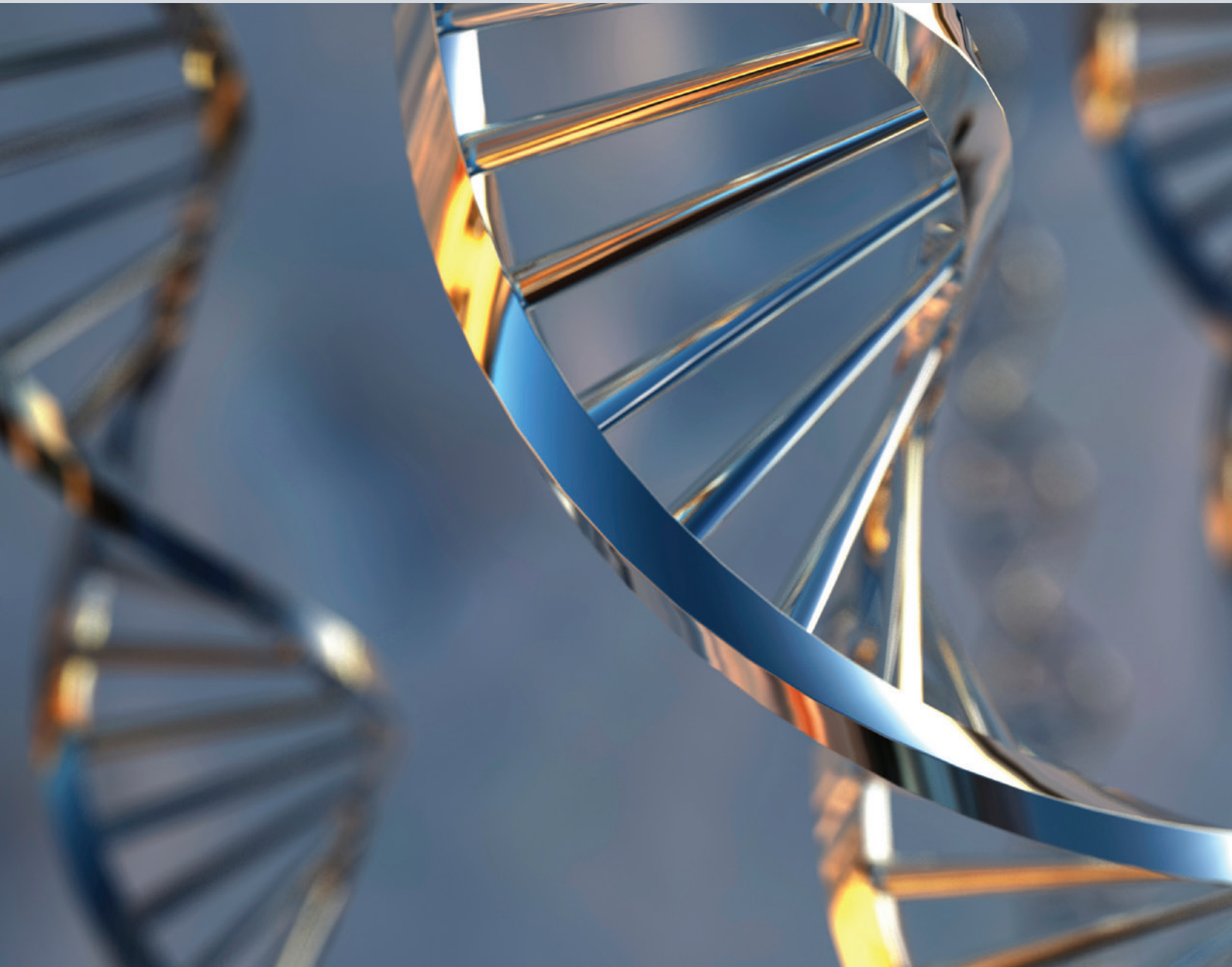

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FEATURED ARTICLES

IN UPCOMING ISSUES

Where is the "I" in team? – Why Collaboration Matters in Healthcare, Part 4

From the Halls of Academia: "Al buen entendedor, pocas palabras bastan." Translation: "Talk less. Listen more."

Wharton Around the Globe:

Gary Phillips Series:

1. The Future Sustainability of Developed Health Systems
2. Healthy Living: Introducing Prevention into Health Policy
3. Data Interoperability and Collaboration in Personalized Medicine

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EDITOR'S LETTER

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

Z. Colette Edwards, M.D., M.B.A. leads Insight MD, a healthcare consultancy, which offers program design and implementation, targeted strategic planning and development, innovative product design, consultative data and clinical ROI analysis including benefit design and large claims analysis, health disparities/health literacy/cultural competency consultation, and PeopleTweaker, a coaching service line providing health, wellness, and life/executive, and physician burnout coaching as well as training in health coaching techniques for health professionals and support staff. She also offers a 12-month series on stress – "2013: The Year You Decided To Be Less Stressed" – via her website blogs, Be a Healthcare Rebel.

Dr. Edwards received her BA from Harvard, her M.D. from the University of Pennsylvania and an MBA from the Wharton School. She completed a residency in internal medicine from the Hospital of the University of Pennsylvania, followed by a fellowship in gastroenterology from the University of California, San Francisco. She has also completed a graduate certificate program in health and wellness coaching from the Tai Sophia Institute.

Colette is the former Vice President and Senior Market Medical Executive, MidAtlantic and the National Medical Executive for Health Disparities for CIGNA HealthCare. Prior to joining CIGNA, she was a Senior Medical Director at Oxford Health Plans. She began her career as a practicing gastroenterologist and Associate Medical Director for Patuxent Medical Group/Columbia Medical Plan, entities affiliated with Blue Cross Blue Shield of Maryland.

Dr. Edwards has designed and implemented Centers of Excellence programs, employer wellness programs including a module specifically targeted at the government sector, and a pilot oncology case management innovation which integrated provider and carrier resources and patient outreach. She led the development of CIGNA's national high-risk maternity care management program and launched CIGNA's MidAtlantic Wellness Council, which brings employers together to brainstorm, share best practices, and improve outcomes for their employees, their families, and the community at large.

Colette was also responsible for reviewing client data and developing recommendations regarding benefit design and clinical programs customized to the special needs of their particular employee populations. Additionally, she wrote a News in Medical Cost Trends newsletter for consultants/brokers and clients on such topics as bariatric surgery, breast cancer, colorectal cancer, coronary artery disease, and the power of integrated benefits.

Dr. Edwards has experience in the development of a provider pay-for-performance model and assessing practices and hospital systems for launching medical home and Accountable Care Organization pilots. Additionally, she has helped clients with strategic planning and business development projects as they respond to the constantly changing healthcare landscape.

EDITOR'S LETTER *continued*

As CIGNA's National Medical Executive for Health Disparities, she developed and implemented CIGNA's enterprise-wide approach to health disparities. In October 2009 CIGNA was named an awardee of a Robert Woods Johnson Foundation $275,000 two-year grant for the Finding Answers: Disparities Research for Change national program, which evaluates interventions aimed at eliminating racial and ethnic health disparities. The program later went on to win a National Business Group on Health Innovation Award in 2012.

Dr. Edwards is the author of a McGraw-Hill text, *Gastroenterology Quick Glance*, and a member of the Visiting Committee of the Harris School of Public Policy Studies at the University of Chicago. She is also a member of the Johns Hopkins AHRQ DEcIDE Expert Stakeholder Advisory Group, the National Quality Forum Steering Committee on Health Disparities and Cultural Competency, the Johns Hopkins Center for Reducing Cancer Disparities Steering Committee, and the Innovation Council of the American Liver Foundation.

Colette has spoken at World Congress events on ACOs and shared decision-making, was recently an integrative medicine panelist at the EYE AM NOT ALONE Patient Retreat Conference of the Ocular Melanoma Foundation, has taught "Foundations of Health Coaching" to pharmacy students at Notre Dame University of Maryland, served as a faculty member for "An Holistic Approach to Alleviating Stress" a 2012 seminar series at the Tai Sophia Institute, and was a panelist at "Healing Our Healthcare System: Transforming the Future," a January 2013 event sponsored by the International Coach Federation and Tai Sophia Institute.

THE PRESIDENT'S DESK

Column Editor: Jay Mohr, WG '91, Managing Director and Co-Founder, Locust Walk Partners
To learn more about Jay, click here.

Fellow WHCMAA Members, Friends and Colleagues:

I hope each of you enjoyed a relaxing and enjoyable holiday season with family and friends, as well as a productive and strong finish to 2012! As we kickoff the New Year, I wanted to outline the progress we made this past year towards realizing our vision of becoming the pre-eminent organization dedicated to the business of health care.

In support of our vision and strategic objectives, our Board, along with many countless volunteers, embarked upon and executed an ambitious programming, communications, student relations, and membership agenda in 2012.

- We are well on our way towards implementing a philosophy of Lifelong Learning (L3). In 2012, the Board planned and implemented 38 events with over 1,200 registrants in attendance, spanning our Annual Alumni Conference, JPMorgan Gathering, webinars, local/regional networking social get-togethers, and more. Greater than 70% of our members participate in at least 2 events per year.
- We are thrilled to report over 500 dues-paying members, representing over 27% of our WHCMAA universe. We value the leadership, experiences, and contributions of our fellow Wharton (non-HCM) and Penn Alumni and will be actively recruiting members from various UPenn schools as part of an expanded Affiliate membership program.
- The Association instituted a joint membership program with the Wharton Clubs of Boston and New Jersey. These relationships have contributed a total of 62 new members to the WHCMAA. We will continue to expand our joint membership offering in other regions where we have large concentrations of health care alumni.
- The importance of giving back played an important role in 2012. During the summer, we provided a $5000 stipend to the Wharton Global Health Volunteers, which subsidized 19 student consultants who provided assistance to health organizations in Vietnam, Uganda, India, Tanzania and Guatemala. We organized 3 career panels in October for the student community. Finally, the Board approved a new $15,000 Kissick/Alumni Scholarship, providing financial support to a deserving end-of-first-year student involved in a socially and/or entrepreneurial impactful experience over the summer or during the 2nd year of school.
- Our *Wharton Healthcare Quarterly (WHQ)* has become a cornerstone of our communications efforts, keeping us current on the industry, faculty/alumni goings-on, and other newsworthy items.

Special thanks go to the *WHQ* editor, Dr. Z. Colette Edwards, WG'84 for taking this on and making it such a wonderful resource for all of us.

We have much more in store for 2013, and we will report our progress throughout the year. In closing, I would like to thank our Board and other members for their tireless efforts in bringing so many initiatives to fruition. I also want to acknowledge the generosity of our Association sponsors - DuaneMorris, Bristol Myers Squibb, athenahealth, and Locust Walk Partners, without whom many of our goals could not be realized. I encourage each of you to get involved!

Respectfully,

Jay Mohr (WG'91)
President, WHCMAA

OPEN WIDE: SOUTH FROM ALASKA

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

"North to Alaska" was a 1960 film about prospectors who strike gold in Alaska, and of course tussle over who gets the girl. Since Alaska was still the "frontier" in the American imagination then, having achieved statehood only the year before, the movie was in the "western" genre and, suitably enough, starred John Wayne. The surprise is that the film was also a romantic-comedy, and Wayne managed to pull off a self-mocking comedic role that few expected would work well. But it did (Check out the DVD.).

Fifty-plus years later, the Alaska "frontier" is the setting for something else that few expected would work well, and which has something to offer the "lower 48" in the delivery of dental health. While the story isn't a rollicking romantic-comedy (Are unnecessary pain and suffering ever?), it's still not certain how happy the ending will be, although the potential is there for that very thing.

Recall this previous *Wharton Healthcare Quarterly* column stressed the importance of *organizing* dental care, not just adding more of the conventional inputs, to improve a population's dental health. The situation in Alaska was this:

- 60,000 Alaska Natives live in small rural Alaska communities accessible only by air or water. In most villages, a dentist is available for only one week a year, and, frequently, only the most urgent cases are seen.
- Over half of all children have untreated dental decay, as do 60 percent of adolescents and 77 percent of adults.
- Tooth decay rates among American Indian and Alaska Native children are five times the national average for children from two to four years old.

Facing such staggering statistics, the Alaska Native Tribal Health Consortium supported the development of a dental therapist program, an intensive two-year curriculum in clinical and classroom training following which graduates were sent to the remote villages to deliver sorely needed diagnostic, preventive, therapeutic, and restorative care, within the scope of their training. The program has met with considerable success (*For more information, see the reports of the Rasmuson Foundation and the W. K. Kellogg Foundation*). Picked up by the Kellogg Foundation, the Alaska example is being replicated, in different iterations, in a number of states in the "lower 48" to address comparably staggering and distressing dental health statistics found among racial, ethnic, and socioeconomic groups (*see http://www.cdc.gov/oralhealth/oral_health_disparities.htm*).

How successful the efforts in these states will be is not known at this time, in part because much hinges upon how accommodating and flexible the state dental practice laws can be amended. The necessary legislative changes involve political, not explicitly medical or dental, questions. (The Alaska situation didn't face this challenge, as the native tribes are sovereign, and therefore not subject to state practice laws, although the American Dental Association attempted to block the dental therapist program on that very basis, and lost in an embarrassing rebuke by the court.)

But beyond legalisms, the success of the therapist programs is also a matter of imagination. Many Alaskan villages are accessible only by air or by water, meaning there is a very distinct geographic connotation to being "remote" from care. The dental therapist in Alaska responds by bundling up equipment – portable dental chair, x-ray equipment, hand instruments - PLUS the computerized link for remote access to a supervising dentist, putting it all in a plane or boat to set up shop for a week or two in a location hundreds to thousands of miles away.

OPEN WIDE: SOUTH FROM ALASKA *continued*

But is there much of a conceptual leap between the topographic "remoteness" of being hundreds of miles from care in the 49th state and the financial, cultural, and yes, *organizational* remoteness experienced by many in the lower 48, even though "traditional dental care" may literally be only ten or fewer miles away? What would be the difference between a therapist setting up shop in Kotzebue in the Northwest Arctic Borough of Alaska and establishing a link for support and consultation with a supervising dentist six hundred miles away in Anchorage, and a therapist taking the same action, only this time across the river from Philadelphia in Camden and linking with Penn Dental, or St. Christopher's Oral Health Initiatives program? The fact is there is no difference between the two, except that in the former not having the strictures of state law allowed for the development of a suitable form of *organization* of care to address the very poor health status of Alaska Natives.

It should be emphasized, however, that the mere introduction of dental therapists to the workforce was not sufficient in itself to get the job done. The *organization* of care extended to such matters as the investment in portable equipment, the logistics of an efficient transportation infrastructure, and the establishment of both a long-distance data and communications infrastructure as well as a management information system. Not to be minimized is the selection and training of supervisory dentists who knew as much about how to work with the therapists in the field as the therapists knew about how to work with professionals when they needed support, both dental *and* medical. Often the therapist would be the only qualified dental practitioner in a community health center.

Furthermore, the orientation of care has evolved, from the more traditional emphasis on the technical dimensions of care to the *organizational* dimensions. Instead of the technical proficiency and manual dexterity of the dentist, the focus is one of a larger effort, with an expanded and collaborative team of professionals, working to control, reduce, and, ultimately, eliminate dental disease in children *and* in adults.

It is a question whether traditional dentistry can appreciate such change. Dentistry still remains largely a cottage industry, with most practitioners working in a solo, proprietary setting. Further, dental education at the pre-doctoral level still is largely weighted toward developing technical proficiency, and with less-than-optimal teaching of the interpersonal and management skills to develop an effective and integrated dental care team. By fits and starts, and prodded by incentives to form Accountable Care Organizations (ACOs), health care more broadly is moving in such a direction. Unfortunately, dentistry instead appears to be fighting a rear-guard action to maintain its status quo.

Maybe what will bring about a change is John Wayne in a more customary role, that of Sgt. Ryker in "Sands of Iwo Jima" - "If I can't teach ya one way I'll teach ya another. But I'm gonna get the job done!"

THE PHILOSOPHER'S CORNER

This eclectic standing column features insightful musings, words of wisdom, life lessons, and stepping stones to business success. We'd love to hear from you, so click here to participate in future editions.

This month's philosopher is Eric Schwartz.
To learn more about Eric, click here.

Life Lessons:

If I knew then what I know now, I would have spent less time stressing about grades and more time working on relationships.

If I knew then what I know now, I would not have bought that pair of acid-washed jeans back in '83.

Favorite Quotes:

- "The most important thing to remember is this: To be ready at any moment to give up what you are for what you might become."
  - W.E.B. Du Bois
- "Make no little plans. They have no magic to stir men's blood . . ."
  - Daniel Burnham
- "When I was growing up I always wanted to be somebody, but now I realize I should have been more specific."
  - Lily Tomlin

Recommended Reading:

- *Life Without Us by Alan Weisman.* A humbling reminder that we're a speed bump on the course of time.
- *The Snow Leopard* by Peter Matthiessen. A plain-spoken account of Matthiessen's trek through the Himalayas while grieving his wife's death.
- "Getting There From Here," Atul Gawande's January 2009 article in the *New Yorker* about health care reform. It's a few years old now but still indispensable to the conversation.

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

To learn more about Colette, click here.

ALUMNI NEWS

Matt Tanzer WEMBA 2012

Matt Tanzer is the Chief Commercial Officer of RightCare Solutions and was part of the RightCare team which won the 2012 Wharton Business Plan Competition in the spring of 2012, with fellow 2012 WEMBA graduates **Eric Heil** and **Mrinal Bhasker**.

Upon graduation, the team joined the company full-time to pursue their passions of building risk-assessment, workflow, and care coordination tools that improve care transitions and lower 30-day readmissions. They recently closed their Series A funding round.

Most recently, they announced their first pilot implementation of the software platform at the Thomas Jefferson University Hospital.

Matt is a WEMBA 2012 graduate as well as a 2010 graduate of the Penn Perelman School of Medicine. He has recently launched the journal *Health Care: The Journal of Delivery Science and Innovation*, as featured in an article in the Boston Globe.

Amol Navathe, MD PhD W'10 M'10

Amol launched a new journal published by Elsevier, *Health Care: The Journal of Delivery Science*, in November 2012. The publication builds on examples to demonstrate how change happens in real-world settings, disseminating important ideas that inform and improve clinical practice by publishing innovative, high quality research, reviews, and opinions.

Besides Amol, who is a physician at the Brigham and Women's Hospital and holds appointments at Harvard Medical School and The Wharton School of the University of Pennsylvania, the other founder of the journal and Co-Editor-in-Chief is Sachin H. Jain, MD, MBA, a physician at the Boston Veteran's Administration Medical Center, Lecturer in Health Care Policy at Harvard Medical School, and Chief Medical Information and Innovation Officer at Merck.

The journal is led under the auspices of three Senior Co-Editors-in-Chief, all renowned experts on health care transformation - Arnold Milstein, Professor of Medicine at Stanford and Medical Director of the Pacific Business Group on Health; Richard Shannon, the Frank Wister Professor of Medicine and Chair of the Department of Medicine at the University of Pennsylvania; and Ashish Jha, C. Boden Gray Associate Professor of Medicine at the Harvard School of Public Health.

To learn more about the journal, click here and to read the press release, click here.
To submit an article, go to *Health Care: The Journal of Delivery Science and Innovation*: www.elsevier.com/locate/healthcare

Lisa Ramon WG'09

Lisa recently co-authored an article on health systems in Latin America for McKinsey. Stay tuned for a feature by Lisa and her co-authorship team on this topic in a future issue of *The Wharton Healthcare Quarterly*.

ALUMNI NEWS *continued*

Rohit Mahajan, Wharton Fellow '08

Rohit Mahajan's business enterprise Saviance Technologies has ventured into Healthcare IT Services. He is leading the initiative from his India Research & Development Center in Gurgaon, where professional experts work on Web 2.0 and ground-breaking technology. The IT services include innovative Enterprise Mobility Applications and Collaboration Applications built with Microsoft SharePoint. These services and solutions enable enterprises to achieve critical objectives such as improved knowledge management, enhanced technological prowess, improved productivity, better return on investment and therefore the ability to make value-added business decisions.

Saviance was recently included in Deloitte's Technology Fast 50 India 2012 listing. Saviance was also the Bronze Sponsor of the Wharton Alumni Healthcare Conference 2012 in Philadelphia.

Vikram Kapur WG'07

Vikram and Neha Kapur are excited to announce the birth of their son Vir who was born on October 1, 2012. On a professional front, they relocated to Hong Kong from New York earlier this year so Vikram can help grow the APAC healthcare practice at Bain & Company where he is a Principal. The Kapurs look forward to seeing fellow WG'ers when they are in this part of the world.

Charbel Zreik, WG '05

Charbel has launched a PE fund looking for an acquisition in various healthcare sectors. He is looking for companies in the 2 to 7 Million EBITDA range. Sectors of particular interest include corporate wellness/advocacy/case management, outsourced hospital services including revenue cycle management, specialty healthcare networks, and integrative medicine consumer services. Please direct any interesting opportunities to charbel@lightbeamcapital.com. To read more about what Charbel is up to, check www.lightbeamcapital.com.

Yehong Zhang WG'00

Yehong Zhang, previously the President of Simcere, was named CEO of Simcere MSD Pharmaceutical Co. Ltd. (SMSD), a newly established joint venture between Simcere and Merck, effective October 2012. He previously served as president of Merck China and as China Country Manager of IMS Health and was also a Healthcare Practice Leader at McKinsey & Company. To read more, click here.

ALUMNI NEWS *continued*

Owen Garrick, MD and WG'98

Owen was recently appointed as a member of the Secretary's Advisory Council on Human Research Subjects (SACHRP) under Secretary Kathleen Sebelius. SACHRP resides within the Office of Human Research Protections (OHRP), a division of the Department of Health and Human Services.

Dr. Garrick, who is currently President and Chief Operating Officer for Bridge Clinical Research, will help provide advice and recommendations to Secretary Kathleen Sebelius on issues and topics pertaining to protection of patients in clinical trials. He earned his MD from Yale School of Medicine and his MBA from the Wharton School of Business. Dr. Garrick currently resides in Oakland, CA with his wife Jocelyn Garrick, MD and their three sons.

Jean Crescenzi Patterson WG'96, Cohort B

Jean presented in September 2012 at the Annual ASHHRA (American Society of Healthcare Human Resource Administration) Conference in Denver. "Bending the Medical Trend Curve - The First Step Toward Accountable Care" is a case study of the success of one of her clients, Southcoast Health System, with 7000 employees in Massachusetts. Southcoast has embarked on a multi-year ACO strategy, which started with the redesign of the System's self-insured employee health plan.

Through the implementation of a tiered network, plan design financial incentives, wellness programs, and population health management, and using best-in-class vendors across the country, Southcoast has increased domestic utilization, maintained trend below national averages, and improved health outcomes. Leveraging this success, Southcoast is positioning itself to serve the Medicare and commercial population in its local community.

Jean, VP of Client Management, is a Health Care Strategy and Benefits Consultant at NFP Thorbahn in Norwell, MA. She works primarily with clients in the health care and higher education industries.

Eric Davis WG'96

Eric reports "I had the good fortune to be able to travel to China 3 times in the last 5 months to better understand the diabetes landscape. Fascinating differences in how our two health systems are addressing the diabetes epidemic - definitely different frameworks from a medical and public health POV. San Francisco seems like such a small, country town compared to Shanghai; one has the feeling that China is becoming THE economic power when visiting there."

Jamie Richter, WHC '95

Jamie, a co-founder and partner of Jericho Equity Partners, was featured in the September 2012 *MedCityNews* "Heart disease startup using 'iCoaches' and biosensors to improve patient outcomes." To read the article, click here.

To learn how Jamie has progressed since being interviewed by *The Wharton Healthcare Quarterly* in January 2012, read this month's "How's the Water? Following up with Entrepreneurial WHC '95 Alum Jamie Richter and Jericho Equity Partners… and CardioVIP!"

ALUMNI NEWS *continued*

Z. Colette Edwards MD'85, WG'84

Colette, Founder and CEO of Insight MD, a healthcare consultancy and PeopleTweaker, a health, wellness, life/executive, and physician burnout coaching service offering (which also provides training in health coaching techniques for healthcare professional and their staff), has been busy:

- releasing *Take One and Call Me in the Morning*, a health industry newsletter which provides an "information concierge experience" to readers
- participating in a January 2013 panel discussion "Healing Our Healthcare System: Transforming the Future" sponsored by the International Coach Federation and Tai Sophia Institute
- releasing "2013: The Year You Decided To Be Less Stressed," a 12-month series on stress offered through her blog, *Be A Healthcare Rebel*
- releasing "The 12 Journeys," a 2-minute stress break You Tube video
- being a featured service provider in *Her Mind* magazine
- preparing a seminar to be launched in October 2013 "Are You the CEO of Your Health ?"

Jeff Voigt, WG'85

Jeff recently published two articles in peer-reviewed journals on the issues of clinical utility and cost effectiveness:

- Voigt J, Mosier M. Is More Expensive Medical Technology Better? The Use of Analytics in the Evaluation of Clinical Outcomes for Different Material Compositions of Total Knee Implants. *Applied Health Economics & Health Policy*. 2012;10(5):289-93.
- Darouiche R, Mosier M, Voigt J. Antibiotics and Antiseptics to Prevent Infection in Cardiac Rhythm Management Device Implantation Surgery. *PACE*;2012;35(11):1348-60.

Jeff's company, Medical Device Consultants of Ridgewood, is involved in the field of reimbursement and analytics for identifying value in healthcare.

Rose Chu Undergraduate FAS BA 1978, WG'80, School of Public and Urban Policy MA 1984

Rose Chu is working on health reform (private health insurance, Medicaid, and CHIP) at the HHS Office of Health Policy in DC.

Michael Cadger, WG '82

Michael, Founder and CEO of Monocle Health Data (www.monoclehealth.com) reports Monocle Health Data was an Intel Healthcare IT Innovation Award Finalist. To read the press release, click here.

Stephanie Marrus WEMBA '82

Stephanie was featured in *Xconomy San Francisco* in the article "A 'Restart' for Entrepreneurship Programs at UCSF." To read the interview, click here.

ALUMNI NEWS *continued*

Elayne Howard WG'76

Elayne Howard & Associates, Inc. completed a capital campaign feasibility study for a not-for-profit organization in the human services field. The client was appreciative of their learnings from the project process. If you know of organizations that can benefit from our strategic marketing/business and not-for-profit fundraising consulting services, please contact her at 484-254-9860.

She was also featured in *femail*, the newsletter from WOMEN'S WAY, in November 2012 as the Volunteer of the Month.

SECOND WHARTON HEALTHCARE ALUMNI CONFERENCE A SUCCESS!

On Saturday, October 27, 2012 the WHCMAA held its annual alumni healthcare conference. The theme of the conference, "The Restructuring of Our Healthcare System to Improve Accessibility, Quality, and Cost Effectiveness," focused on a number of important initiatives the Wharton Healthcare alumni and presenters are making in this era of healthcare reform.

Gary Philips, MD, WG'91, Head of Healthcare Industries of the World Economic Forum (WEF), highlighted some of the important work being undertaken in other countries related to sustainable, affordable, and accessible healthcare. As an example, Gary mentioned that Germany, in particular, is undertaking significant planning not only to ensure affordable healthcare for its population but also to export its expertise and make healthcare a worldwide business.

Skip Rosoff, Professor of Healthcare Management at the Wharton School and one of the alums biggest supporters, reviewed the Supreme Court's ruling on the Affordable Care Act. Skip suggested Justice Robert's narrow conception of the Commerce Clause was his way of limiting the ability of Congress to expand the size of government. He postulated it may have also been the Justice's way of appeasing liberals and insulating himself from partisanship – as he is likely to be on the bench for a rather long time. Additionally, Skip suggested that the US does a very good job of attaining its main goals - delivering a reasonable level of care to most of the population and in making a profit. These goals are in contrast to the other countries in the developed world, whose main goal is to deliver a reasonable quality of care to all its population. The question Skip posed is whether the US's goals are the right ones to pursue.

Morning sessions on restructuring the hospital system (planned by Maureen Spivack, WG'86 and Michael Rovinsky, WG'86) and on innovations from the payer perspective (planned by Ryan Berger, WG'06 and Phil Heifetz, WG'96), outlined some of the more innovative financing and delivery mechanisms being used to squeeze inefficiencies out of the system while providing a return on invested capital. Heads of Kaiser (Donna Lynne), Vanguard Health, a private equity firm (Keith Pitts) and Medicare (Jon Blum) discussed the need for usable, real-time information to transform care and make the system more efficient. Further, payer and provider perspectives on how data is transforming care delivery were outlined by Terry Booker, VP of Business Development at Independence Blue Cross (IBX) and Mike Restuccia, Chief Information Officer at Penn Medicine.

Other morning sessions included Personalized Medicine (planned by Jay Mohr, President WHCMAA, WG'91), which explored the need for identifying the right care for the right person at the right time. The discussion centered on the US healthcare system reorienting itself from providing care for the masses to individualized care. If it can do so, it may be able to price effective care more appropriately and not waste massive resources on care that does not affect an individual's health (and, in some instances, can be harmful to patients). Speakers included Joe Leveque, MD, WG'92, Elizabeth Mansfield PhD, Director of Personalized Medicine at the FDA, and Jeff Marrazzo, WG'09.

Physician restructuring, the other concurrent session (planned by Doug Arnold, WG'84), highlighted some of the rather "out of the box" thinking that physicians are implementing to optimize their ability to provide quality care and profit from it. Presenters included Mark Blatt, MD from Intel Corp, John Blair, MD, from Taconic IPA (NY), and Holly Miller, MD.

Lunch time sessions included a presentation by Jay Mohr on what the WHCMAA is doing around the mission of lifelong learning and how it plans to become more inclusive of other UPENN schools involved in the healthcare field (e.g., Medicine, Nursing, Dentistry, Law, Veterinary Medicine, Policy, and the Wharton undergraduate program). We were

Contributor:
Jeff Voigt, WG'85

To learn more about Jeff, click here.

SECOND WHARTON HEALTHCARE ALUMNI CONFERENCE A SUCCESS! *continued*

honored to have the dean of the Wharton School, Tom Robertson, present on how the school is leading the charge in learning for its students and alum – around the concept of a "virtual" business school.

Dean Robertson believes a physical location will always be important, but other modes of learning, such as an online approach, will improve outreach and ensure Wharton remains one of the top business schools in the world. One example he described was classes being offered on both coasts (Wharton SF and Wharton Philly) simultaneously, in real time, with the opportunity for both classes to interact with each other. Dean Robertson also discussed the increased footprint the Wharton School is making worldwide – mentioning India, China, and Israel. Current students from the Wharton program, Anuj Kapoor, WG'13 and Amy Chiu, WG'13, next presented on the Wharton Global Health Volunteer initiatives for which the WHCMAA has provided funding in the past. These volunteer efforts bring together Wharton MBA students to offer on-location consultation regarding emerging markets health problems over the winter and spring breaks.

The afternoon keynote was delivered by Paul Starr, Professor at Princeton, who presented on his most recent book, *Remedy and Reaction: The Peculiar American Struggle Over Health Care Reform*. This session provided attendees with a unique look regarding how policy is affected by the politics of the day and, in many ways, by politicians' missteps. It was a fascinating look at how a lack of real policy planning has impacted the U.S. healthcare system over time and how the system has grown because/ in spite of special interest groups. The two afternoon sessions on (1) outpatient restructuring (planned by Kate Reed, WG'87) and (2) insurance restructuring (planned by Mitch Goldman, WG'75) ended the day of presentations. The outpatient session highlighted what some of the more progressive institutions are doing and the challenges they face - Partner's Healthcare – Mass General & Brigham and Women's in Boston, CEO Gary Gottlieb, WG'85 - and the Children's Hospital of Philadelphia - Matt Cook, as well as what smaller companies are doing - Ron Kero, WG'86.

The insurance restructuring session highlighted what more highly developed insurance exchanges are doing – the Mass Connector (Glen Shor, Director); how medical homes are evolving under payers such as Independence Blue Cross (Richard Snyder, MD, Chief Medical Officer); and what Geisinger Health Systems is doing around bundled payments (Proven Care, Alfred Casale, MD). The day ended with a cocktail reception with an outstanding view of the city from the 8th floor of Huntsman Hall. As has become custom, the WHCMAA held a reception dinner for speakers and attendees the evening prior. Attendees to the dinner also included June Kinney and Professors Mark Pauly, Dan Polsky, and Skip Rosoff. It was a great evening of catching up on busy lives and careers – with some great wines and food.

The WHCMAA would like to thank all of those people involved in the planning of the event, including June Kinney and Chris Aleszczyk (without whose help the event wouldn't have happened), and the session leaders whose time, effort, and foresight made each session impactful. Sponsors for the conference included Bristol Myers Squibb, athenahealth, Duane Morris, and Salience. The WHCMAA would especially like to thank these sponsors for their generosity.

Lastly, and most importantly, the WHCMAA would like to thank all the attendees for taking time out of their busy lives and participating in a Saturday session. We had participation from most of the classes (1971-2012). It was great having such a nice representation from all the years and having them share their experiences.

Next year's 2013 healthcare alumni conference will likely take place on a Saturday around the same October timeframe. Mark your calendars, as this coming year is expected to be quite a busy one for healthcare!

HOW'S THE WATER?

Following up with Entrepreneurial WHC '95 Alum Jamie Richter and Jericho Equity Partners… and CardioVIP!

One year ago, in the inaugural edition of the Wharton Healthcare Quarterly, we interviewed Wharton alum Jamie Richter, who had recently transitioned from industry to the exciting world of hands-on investment. The interview, entitled "Taking the Plunge," detailed the process and approach taken by Richter and partner Eric Schwartz (WEMBA '09) in creating Jericho Equity Partners, a unique firm combining the principles of a search fund and private equity. At that time, Jamie agreed to get back together with us exactly one year later to report on the experience and progress. Read on to learn how these two Wharton alums have fared and the exciting path they continue to travel.

Jamie Richter, WHC '95

Wharton Healthcare Quarterly (WHQ): **Good morning, Jamie, and thanks so much for delivering on your commitment to follow-up with us. So often, our students and alums learn about various entrepreneurial ventures and career risks but don't have the opportunity to track the outcome. When we last met, you had embarked on a change in your career that was both exciting and somewhat risky, through the creation of Jericho Equity Partners. Could you first give us a brief recap of where you were a year ago when we last spoke?**

Jamie Richter, WHC '95 (JR): Thanks so much for your continued interest in my career endeavors. We have made tremendous progress in the last year, yet I still feel as though this adventure has only just begun. Since graduating from Wharton in '95, I had held operating roles in several health care businesses, cutting across multiple functional areas such as sales, business development, operations, and general management.

After much consideration of various career alternatives, Eric and I decided to "take the plunge." We created Jericho Equity Partners with the goal of finding a small, local health care services business in which we could invest – preferably as majority owners – and join full-time as operating executives leading the organization through its next phase of growth. We were prepared to put "skin in the game" in the form of our own capital, desired to roll up our sleeves alongside existing employees to run the business, and had banded together a small group of investors interested in backing the concept.

WHQ: **Yes, that is how I remember it. And before you provide details regarding where you ended up, perhaps you could share some war stories about the search process that ensued.**

JR: Well, as many of our Wharton classmates with years of investment and deal sourcing experience would attest, such a search is basically an arduous sales process. Eric and I understood that. We had agreed that in order to do the job right, we both needed to make a full-time commitment to the search. We felt very fortunate to have the support of our respective families to do so. As you may recall, we had given ourselves two years to conduct the search but hoped it would not take that long. In the year that ensued, we met with over 1,000 people during the course of our deal sourcing activities and had the opportunity to evaluate over 120 companies available for sale or seeking meaningful investment. We took an in-depth look at roughly 20 of them, became serious about six or seven, and ultimately made investment or acquisition offers on two companies. We experienced all the typical challenges of trying to execute such a deal – including difficulty agreeing upon valuation of a small, privately-owned company; lack of availability of complete financial information in what are often multi-

Column Editor:
Wharton Healthcare Quarterly (WHQ)

HOW'S THE WATER? *continued*

generational family-owned businesses; and the emotional attachment of a longtime owner/CEO who is conflicted about leaving behind the day-to-day involvement to which he or she has become so accustomed.

WHQ: **Were there some tense times along the way?**

JR: Yes, of course. We held ourselves – and each other – true to the commitment to treat the search as a full-time job. Keep in mind that one of the reasons Eric I and decided to partner together was that we felt we complemented one another well, via different functional skills and the different approaches we tend to take toward analyzing and addressing opportunities. While there is no doubt our diversity of approach is a net positive, it can at times lead to "tension," as you termed it.

WHQ: **Are you willing to be more specific?**

JR: Sure. About midway through our process, after honing our search to several specific healthcare services sectors, we came to a difficult realization. It became clear in the challenging economy that the debt markets were still a little tighter than we had assumed, especially for service-based businesses with limited assets and inventory. We realized it might not be feasible to pull off the deal we had envisioned on our own. You can imagine this led to some soul-searching. Ultimately, we decided that rather than folding up the tent, we would evaluate alternatives that enabled us to stretch our capital – such as partnering with others. This would mean relinquishing some control, but we felt it could still work with the right partner.

Throughout the deal sourcing process, Eric and I each had good and bad days. Fortunately, the bad days did not always overlap, so we were able to pick each other up when needed. We have discussed multiple times along the way that it was quite helpful to have a partner in the endeavor – it would have been difficult to do this alone.

WHQ: **So enough with all of this suspense. Have you managed to close a deal?**

JR: Yes, we did. After a little over a year of searching, Jericho Equity made its first investment in a very exciting and high-growth company called CardioVIP. In a nutshell, CardioVIP offers an innovative cardiovascular disease prevention and management solution through primary care physician practices, integrating sophisticated blood testing and physical diagnostics into a comprehensive cardiovascular risk characterization and patient management program. Eric and I have joined founder Frank Ruderman, the former CEO of Berkeley HeartLab, on the management team.

WHQ: **That sounds very exciting, and it even sounds like you met most of your original goals, right?**

JR: Well, we met the most important goals, I believe. We compromised a bit on control, making a minority investment. Also, we landed in Houston, which is not "local" for two guys living in the Philadelphia area, though we hope to expand the business to the East over time. The key, though, is we found a rapidly growing business that is a great fit with our respective backgrounds, enabling us to bring meaningful value to the company. Furthermore, CardioVIP offers an innovative service and approach – great for patients at known risk for cardiovascular disease and also quite clever from a business model standpoint. Essentially, we fell in love with this business and as a result were willing to be more flexible about some of our original search criteria.

HOW'S THE WATER? *continued*

WHQ: **What would you say will be your biggest challenge from this point forward?**

JR: In the short term there are two key challenges. The first is we need to raise additional capital via the company's B Round fund raising activities, as the cash raised will enable us to grow and become self-sustaining in our initial market in Texas. Eric and I have taken the lead on the company's efforts to complete the ongoing B Round of financing, and things have progressed nicely thus far. The total round is targeted for $3mm, of which $2mm is already in the bank. It has helped our cause that prospective angel investors and small funds know that Eric and I have our own "skin in the game" and that we reviewed well over 100 investment opportunities before settling on CardioVIP. The second key challenge, as you might have guessed, is to grow the business – which, of course, is exactly the challenge we had sought!

WHQ: **And with regard to that second challenge, I realize you only recently closed your deal and joined the operating team at CardioVIP, but how are things going so far?**

JR: Things are progressing really nicely in the early going. The business has almost doubled in the four months or so since we joined. The revenue run rate now exceeds $2mm annualized and we're not even through the company's first year of commercial operations. Eric and I have not only led the financing activities but also have been able to immerse ourselves in the business day-to-day. At the risk of twisting my arm patting us on the back, we feel we've been able to make a rapid positive impact on the growth, strategy, and development of the company.

WHQ: **We spoke briefly last year about changes on the policy side in healthcare being a factor to consider during your search. How did that bear out?**

JR: Changes in policy and the uncertain political environment in healthcare caused us to rule out any undue risks and pay attention to certain overarching trends. For example, we decided quickly we would not invest in a business whose products or services required FDA approval. As far as trends, we sought businesses that we felt were "with the grain" in a non-partisan fashion – businesses focused on chronic care management; early intervention and prevention; improving health and economic outcomes; and continuity of care. So yes, we absolutely took the external environment into account throughout the search process.

WHQ: **Recognizing again that you are early in your tenure at CardioVIP, as you reflect on the past year, are you satisfied with how Jericho Equity Partners has fared, and the decision to follow that path? And what will come of Jericho Equity in the future?**

JR: 100% satisfied – although I would not recommend it for everyone. It has been, and continues to be, fun and exciting, but it has not been easy, and there is a lot more hard work ahead of us. We have made some very real sacrifices to get to this point. For the foreseeable future, Eric and I will be dedicated to driving the success of CardioVIP, so Jericho Equity will essentially be dormant for a period of time in terms of deal sourcing activities. Suffice it to say, though, Eric and I believe CardioVIP will prove to be the first of multiple successful deals for Jericho Equity Partners over time.

CREATING VALUE TOGETHER — COLLABORATION BETWEEN PHYSICIANS AND ADMINISTRATORS

This is the third in a series of four articles on improving collaboration in healthcare, in this case, between physicians and healthcare administrators. We will describe practical tools to enhance institutional performance through better collaboration — toward the primary goal of providing better patient care.

Improving Collaboration Between Physicians and Hospital Administrators

The Affordable Care Act is accelerating a transformation of the US healthcare system from one that is driven by volume and characterized by fragmentation, waste, high cost, and inconsistent quality to one where care is coordinated, costs are lower, and quality is higher.

Healthcare leaders are engaging in many experiments, such as Accountable Care Organizations and global payments—with institutions taking on greater risk for cost and quality of care—to position or reposition how their institutions fit within coordinated networks of care. While numerous networks of care exist today, coordination is missing. Leaders know successful coordination and integration require teams from the frontline to the C-suite that understand the critical nature of collaboration and how to effectively collaborate. Nowhere is this relationship more important than between hospital administrators and the medical staff.

But given the often-difficult nature of these relationships, how do you improve collaboration to increase productivity and performance?

Working with Resistance to Improve Collaboration and Performance

A multi-billion dollar health system believed it could best fulfill its mission by shifting from a historical focus as a "hospital company" to a focus on managing the overall health of the populations it served. This decision had immediate implications for their economics, network structure, leadership capabilities, care model and decision processes—and it would be impossible to accomplish this shift without a tight partnership with physicians.

The health system was working closely with employed physicians, but, like many systems, it had more tenuous connections to affiliated and independent physicians. While a handful of physician leaders had been involved in strategic planning, the system had largely excluded others. This was not intentional; the leadership assumed physicians would not want to spend time engaged in system-wide planning. Recognizing this assumption was no longer valid, we helped the system find ways to engage physicians in strategic decisions that directly impacted both the health system and physicians themselves.

Working with Resistance — We convened over 100 independent and employed physicians in a strategy summit with advance input and feedback on an emerging strategic plan. Physicians began to shape a future for the system, but complained their information systems and support were so bad the future they envisioned could never exist. Rather than hear these "complaints" as typical resistance, the system's leaders listened. While IT had fallen lower on the administrators' list, it was a top priority for physicians. At the end of the summit, the CEO committed to taking action. It was not an empty promise.

Collaborating on Strategy — The CEO invited those same physicians back to an IT Summit to better understand the issues and key concerns. Leaders explained IT was now the top strategic priority and invited the physicians to help devise a strategy. This plan is underway today - the system is addressing significant deficits in IT with a group of physicians who provide input and guidance.

Contributors:
Carey Huntington and
Jennifer Tomasik

To learn more about Carey and Jennifer, click here.

CREATING VALUE TOGETHER — COLLABORATION BETWEEN PHYSICIANS AND ADMINISTRATORS *continued*

By identifying and working with the chief barrier to improved collaboration in service of the overall goal, administration and physician "parts" could genuinely collaborate, creating a stronger, more actionable and sustainable strategy.

Structuring "Productive Pairs" and Working with the Culture that Exists

A large academic hospital with employed physicians had a history of top quality outcomes—and correspondingly high costs. Leaders recognized hospitals would be accountable for ensuring value and would need to reduce costs over time. This would be difficult - when ordering diagnostics and interventions, their physician culture was to leave no stone unturned. The hospital knew that changing the focus to what could be agreed to as "appropriate care" would require respect for the hospital's culture and physicians' expertise, while standardizing practice where it made sense.

We worked with hospital leaders to partner with physicians on maintaining quality outcomes and the institution's reputation, while lowering costs over time. To do this, we helped leaders launch several strategies across many sub-departments:

Physician-Developed Clinical Protocols — Leaders knew top-down care protocols developed by non-clinical quality experts would meet immediate resistance. Instead, they collected guidelines from specialty societies, advice from accepted leaders in the field, and literature on best practices. The change effort gained credibility by establishing the protocols as voluntary and works-in-progress. Modifications were considered when other methods achieved consistently better outcomes, including when the hospitals' top-tier practitioners were using innovative techniques not yet part of specialty-society guidelines.

Productive Pairs — "Productive pairs" join a leader representing the expert function of an organization, like medicine, with an administrative leader. We worked with the "productive pairing" of executive administrative and physician leadership to structure physician/administrator pairs at the sub-department level. This created a two-tiered engine for the change effort, with the top-level pair shaping the effort in the background. The physicians would influence their peers, with administrators providing evidence of the case for change and removing institutional barriers to using the protocols.

Found Pilots — Hospital leaders knew the protocols' success also depended on physicians talking about the implementation experience with each other. We helped the hospital look for "found pilots" — projects and people already innovating. Together we uncovered pockets where the culture was already changing — where sub-departments were already pooling knowledge on clinical outcomes in-person. For example, a group of surgeons was already collaborating to understand which patients would be the best candidates for an elective procedure. By using sub-departments with existing feedback loops to gain traction on standardization, physicians leveraged early successes to increase use of the protocols in other sub-departments.

Relying on two levels of productive pairs to guide adoption of protocols in their hospital's specific context, leaders found that strengthening collaboration within their culture of clinical excellence would help them achieve critical goals over time.

We discussed how to foster collaboration between physicians and administrators - by listening to physician resistance and using it to shape effective strategy and by creating "productive pairs" that influence physician leaders while ensuring institutional support. By committing to collaboration with methods like these, health systems can meet new expectations of shared accountability—delivering quality and value together.

The final segment will examine collaboration within inter-professional teams.

For more information on this topic or related materials, contact CFAR at info@cfar.com or 215.320.3200, or visit our website at http://www.cfar.com.

CAN HEALTHCARE BE FACEBOOKED?

"We (the healthcare industry) need our own Facebook. Build it and they will come!" This statement came from a contributor to a national HIT symposium. It is simple and direct, but struck me as somewhat presumptive. Can social media alleviate or cure what ails healthcare? Indeed, Facebook wasn't really built ahead of its time, and in some respects was late to the game. Social utilities, such as Myspace and Friendster, operated years before Facebook. But that, perhaps, is part of its success. It wasn't built before users showed up. It was built while people were in some respects already "there."

But with the claim, the hypothesis worth examining is whether the social dynamics that exist on Facebook will help to overcome healthcare's inherent and entrenched barriers. Why does Facebook work? Do the same social dynamics exist in healthcare? Could social utilities create more informed patients? More consistent care? More appropriate utilization? This article will take a look at Facebook from two perspectives: (1) social and transactional and (2) how healthcare might benefit from a similar social utility.

Facebook capitalized on a latent need for people to connect with each other easily and remotely. People are living busier lives, further apart in time and geography. Moreover, Facebook brought together several existing but disparate social technologies (photo sharing, chat, online games, etc.) into a single platform. Facebook met the needs of the disconnected and dispersed.

In those respects, connecting people and combining several utilities into a single platform, a similar functioning medium would seem to have much promise in the health care realm. To a large degree, patients are disconnected from providers and even further from insurance companies that influence service through payment. But there is an important "how" regarding making connections. Is sharing a photo or "liking" really the type of connection we seek for patients and caregivers?

Online connections are frequently based on impulse and quick impression, not necessarily consideration and dialogue. In some respects, people are not connecting in this way, and, in fact, may be disconnecting by not actually meeting and dialoguing in person. Most healthcare professionals would agree that engagement, not just connection, is required between patients and provider.

From a transactional perspective, healthcare has its own unique challenges - purchase disintermediation, coordination of payments with benefits, variable treatment of similar conditions, and overutilization of high-cost care modalities. In healthcare, nothing happens without a procedure and diagnostic code assigned to it. Operationally, it could not be more different when compared to Facebook.

Facebook's open forum for development, distribution, and, indeed, behavior, is unique in several respects. Free applications are cheap to develop and easy to distribute. Apps can be political, social, commercial, or game-oriented. But while Facebook's "app world" success has been impressive, in some respects even unparalleled, the transactional aspects have lagged. While the advertising model that grounds Facebook is robust, even that has been called into question by major customers like GM, and significant transactional business has grown beyond that model. So in a complex transactional environment like healthcare, where ideally experience is relatable to payment over a longitudinal basis, Facebook would appear less than ideal.

By the social and transactional dimensions, Facebook does not seem to align well with the healthcare world. So what does healthcare need? Are there models from the Internet which would help address the challenges that hinder progress in healthcare? Even better, that capitalize on the latent needs which will enable a Facebook-like trajectory of adoption?

Contributor:
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To learn more about Jim, click here.

CAN HEALTHCARE BE FACEBOOKED? *continued*

Let's examine a couple of these challenges specifically. One challenge is that people generally don't know what they purchase. They generally do not understand benefits and coverage until they have made a "purchase," which is perhaps more accurately explained as "committed to the allowable charges for services rendered to be applied beyond existing financial commitments." What would appear valuable is disentanglement of the commitments and promises within insurance contracts, and how treatment decisions should be considered within those commitments. So what might work here is a model that has created efficiency in both purchase and purchase decision-making.

Consider Amazon. Amazon truly was a market maker and has contributed to the reorganization of entire industries. It removed not only the spatial considerations of going to a retail store, but also the informational limitations of comparison shopping. You can compare products, access wider selections, be refunded, and follow orders through to fulfillment. Amazon even suggests complementary purchases based on what other purchasers have done.

Imagine that story in healthcare. I personally do about 80% of my personal shopping from my PC. If I were to include research and general health queries, I'd still be stretched to say 20% of my healthcare experience is done electronically. And I sure like to have more detail on potential expenditures that I may incur.

Another latent need is the ability to access and interpret information from events that are separated by great spaces and times. It's more than just data, it's the awareness and connection of data. With all due respect to efforts like Blue Button, most patients are not yet asking for data. Top down, aggregation-based efforts will fail until ultimately patients, and even more so, people who are yet to be patients, are at least curious if not demanding of their health histories. A recent example in the *Washington Post* urged people to log on to the Social Security website to check their salary histories, which will be used to determine future benefits. You think the next morning wasn't a heavy traffic day on the SSA's servers?

In healthcare, most people move to generate health histories only at the time they need it – newly-diagnosed chronic conditions, surgery, new medications, etc. In this instance, let's look at Mint.com. Mint is an online service that aggregates credit card use and banking across as many accounts as you want, and, by doing so, provides targeted incentives for future likely purchases. Thus, passively, Mint compiles a historical financial profile for the user. It's effective and non-invasive once set up by the user, but creates a rich data source for the customer (and for the company, by the way). Once created, the profile can anticipate financial needs and risks. Sounds a lot like the now-on-life-support PHR (personal health record) movement, from which giants like Microsoft and Google have turned away. But then again, most PHRs started with user-entered data and attempted to back load from claims, and not from a forward moving transactional standpoint like Mint.

In either case, transactional or data-oriented, there is one final consideration. Both companies started with a single focus - Amazon with books, Mint with credit cards - and then built from there. Healthcare is as complex as it gets when considered from a social, behavioral, and economic perspective. To overlay Facebook, or anything at a superficial level, would seem to miss the intended target and also not be consistent with Facebook's own path to success.

So whatever aspiring health entrepreneurs are doing now, consider picking a segment or specific health challenge, nail it down, and expand from there. Don't worry about who "likes" it, worry about who it helps.

HOSPITALS, COMPLEX PATIENTS, SPECIALTY DRUGS, & CHANGING PAYMENT MODELS

Introduction

The first of this two-part article reviewed the strategic planning rationale for a seven-hospital academic health system to develop a new specialty pharmacy service: Part 1. In this the second part, we will review the development of the pharmacy, with a focus on the lessons learned for other hospital systems.

The Launch of UMass Memorial Specialty Pharmacy

Congratulations, it's a…pharmacy!" While the build-out of the specialty pharmacy did not take as long as the human gestational period, the process in many ways resembled giving birth to a child. With a steady period of growth followed by frenzied activity at the end, UMass Memorial launched its new specialty pharmacy and home infusion services. In doing so, the system took an important step forward in implementing a multi-year strategic vision to break down the silos of care patients were experiencing while simultaneously increasing quality and reducing cost.

The retail-licensed specialty pharmacy, which was opened on the first floor of UMass Memorial's Ambulatory Care Center, soon became a hub of activity. With nearly a year's worth of discussions coming to fruition at the same time the pharmacy was opening, the new specialty pharmacy service began serving oncology and transplant patients. The pharmacy soon expanded to hemophilia and GI conditions such as hepatitis C and Crohn's Disease, with neurology, rheumatoid arthritis, HIV/AIDS, multiple sclerosis, cystic fibrosis, and heart failure soon to start.

As if having one new child were not enough, UMass Memorial also launched its home infusion service around the same time. This service provides patients with a range of infusion services, such as antibiotics, chemotherapy, and nutrition, without the patient having to come to the hospital. This in-home service not only makes patients happier, but reduces both cost and the risk of infection.

In comparison to other specialty pharmacy and home infusion services, both UMass Memorial Specialty Pharmacy and Home Infusion appear to patients as extensions of the hospital and its clinical staff, and both utilize the same electronic medical record as the rest of the hospital. Of equal importance, the teams running these services worked with the clinicians to co-develop specific clinical protocols to standardize the care pathways their complex patients are to follow. Taken together, these factors make UMass Memorial Specialty Pharmacy unique.

The Impact

While analysis of quality indicators such as readmission reduction is pending, early measures such as patient and clinician satisfaction, market share, and revenue capture have shown tremendous success. Additionally, there are several other indicators of clinically significant progress:

- Treatment delays, which consistently occurred when services were controlled by national companies, are being replaced with localized staff, who work with patients 1:1 and provide real-time attention to the unique needs of each patient.
- Patients who previously had to work with multiple pharmacies are now able to work with one pharmacy that can provide medication counseling on all of the therapies needed to stay healthy.
- Patients have already developed trusting relationships with the pharmacy and home infusion staff, which allows for opportunities to counsel patients more and to catch problems before they result in ER visits and/or readmissions.
- The administrative burdens of insurance authorizations and finding financial assistance to deal with expensive treatments that have long been left to the same nurses and social workers responsible for guiding patients through a patchwork healthcare system are now addressed by the pharmacy, thus allowing the nurses and social workers to work as nurses and social workers.

Contributors:
Willis Chandler '03 and Jon Puz

To learn more about
Willis and Jon, click here.

HOSPITALS, COMPLEX PATIENTS, SPECIALTY DRUGS, & CHANGING PAYMENT MODELS *continued*

- Clinical care and revenue "leakage" has been significantly reduced, which is a timely and particularly important change in light of the steady increase of accountable care and risk-based payment.

Lessons Learned

There are numerous lessons to be learned for other healthcare organizations looking to accomplish any or all of the aforementioned changes.

1. **Size the Opportunity**
   Integrating specialty pharmacy into the operations of a health system and its outpatient clinics is a significant opportunity to create a seamless continuum of care for very complex patients. Pharmacy now represents 20% of healthcare costs. Hidden within is the fact that specialty pharmacy is growing 17+% a year while typical retail pharmacy is flat. From a quality, patient satisfaction, and financial perspective, developing a specialty pharmacy capability has quickly become a critical component of a health system's service offerings.
2. **Understand What Is Involved**
   For health systems considering this opportunity, it is important to think through the many disciplines with which a successful specialty pharmacy must connect. Developing clinical protocols with physicians and nurses, negotiating exclusive payor and PBM (pharmaceutical benefit manager) networks with voluminous reporting requirements, navigating complex reimbursement methodologies, and interfacing information and billing systems specific to specialty pharmacy are all requirements of a successful operation.
3. **Determine When to Build and When to Partner**
   For UMass Memorial, building specialty pharmacy and home infusion capabilities involved a number of partnerships. Given the need for speed, efficiency, focus, and capital, UMass Memorial decided to form a strategic partnership in order to pursue this opportunity most effectively. UMass Memorial Specialty Pharmacy also opted to partner with a pair of technology companies, and then build on top of that platform, in order to bring together a strong IT backbone. These decisions have reduced the risk and increased the speed of opening the pharmacy tremendously.
4. **Build the Team and Instill the Culture**
   As with any new endeavor, pulling together the team and developing the "right" culture is critical. With this team, patient service is the #1 priority. For example, a transplant patient had his diabetic insulin, which he had been receiving from the local branch of a national pharmacy company, cancelled by the company for economic reasons without warning. The Specialty Pharmacy Team heard of the sudden change, filled the insulin and immediately drove it to the patient's home – thus ensuring no disruption in care.

The Future

The next step planned for UMass Memorial Specialty Pharmacy is to bring health system clinicians together with specialty pharmacy experts to ask and answer the questions which will improve our understanding of how best to achieve medication adherence and effectiveness with complex patients. Based on this learning, and with support from a data platform with predictive modeling capabilities, UMass Memorial Specialty Pharmacy will drive increasingly proactive and targeted medication therapy management efforts aimed to simultaneously improve quality and reduce cost. At the same time, by fully integrating specialty pharmacy within highly complex clinical specialties such as oncology and transplant, UMass Memorial will be able to further differentiate itself from its hospital competitors. Taken together, UMass Memorial Specialty Pharmacy provides a compelling reason for patients and referring physicians to choose UMass Memorial.

If you have questions about specialty pharmacy or want to visit our pharmacy, please contact Willis Chandler, WG '03, at wchandler@umsrx.com.

HE RUNS FOR HIMSELF AND FOR MEN LIKE HIM: THE UNTOLD STORY OF MALE BREAST CANCER

The sun was far from rising that frigid Sunday morning, but it didn't matter to any of them. Thirty-two thousand men, women, and children were pulling on layers, lacing up tennis shoes, grabbing keys, and getting in their cars in support of a cause. This was a group that had decided supporting breast cancer research was more meaningful than sleep.

Mark Goldstein was part of that crowd. The seventy-five-year-old with two knee replacements was running his 188th Susan G. Komen Race for the Cure, this one in Hunt Valley, Maryland. Mark doesn't run in honor or in memory of his wife, a sister, or a daughter. He runs for himself and for men like him. He is a breast cancer survivor.

Approximately 2,190 American men will be diagnosed with breast cancer in 2012, according to Komen, compared with an estimated 290,000 new cases for American women. This lower incidence rate is no reason, according to Mark, for male breast cancer patients and survivors to remain on the sidelines.

# # #

Does a disparity exist when it comes to diagnosing men with breast cancer? Perhaps.

Many doctors have never treated a male breast cancer patient. The diagnosis and treatment plans are in the textbooks, so they know it exists, and biopsies are done, but often men with lumps in their breasts are told they have gynecomastia - enlargement of the male breast tissue.

There is also a fear that primary care doctors don't think enough about breast cancer as a possible diagnosis for suspicious lumps in the breasts of the men they see. In addition, men and their doctors seem to think they're a little insulated from the disease and don't see their link to breast cancer. Men have undeveloped milk ducts, and since breast cancer is found in milk ducts, men can develop breast cancer.

According to the American Cancer Society, men and women with the same stage breast cancer have approximately the same rate of survival. But men often have a more difficult time getting an accurate diagnosis, and they wait longer to seek treatment, which may explain why their disease is often discovered at a more advanced stage. As a result of the lax attitude on the part of men and their doctors, there's a stronger chance the cancer will be at Stage III or worse when finally discovered.

# # #

The most common breast cancer symptoms for men include a lump in the chest, skin dimpling or puckering and nipple changes. In February 1988, Mark noticed and ignored the changes in his left breast; the nipple was receding and there was a small lump underneath. "I waited three months," he admits. "Had that been my wife, we would have been in the doctor's office the next day."

Like a woman discovering a lump in her breast, one of the first steps to his diagnosis was a mammogram. "I virtually had no breasts," Mark says. "It was more difficult on the technician than it was on me. There was much pulling, squeezing and apologizing."

In the years since his mammogram, little has changed for men when it comes to mammograms and the treatment of male breast cancer, and there's a reason for that. "Most of the data for treating male breast cancer is extrapolated from females," says Dr. Katherine

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HE RUNS FOR HIMSELF AND FOR MEN LIKE HIM: THE UNTOLD STORY OF MALE BREAST CANCER *continued*

Tkaczuk, director of the University of Maryland Marlene and Stewart Greenebaum Cancer Center's breast evaluation and treatment program.

The BRCA1 and BRCA2 gene tests used to predict the hereditary possibility of breast cancer in women are as successful at predicting the same possibility in men. Breast cancer genes are autosomal dominant -- individuals only need to acquire an abnormal gene from one parent to inherit a disease -- and are not located on the XY chromosome, which means they can be transmitted by males and females. "It's important for children of men with BRCA1 or 2 genes to know of the increased risk of breast cancer," says Dr. Tkaczuk. "As adults, I suggest they consider a genetic evaluation by a counselor."

One difference in treatment for men versus women is in the area of breast conservation. It's much more important in women, according to Dr. Gerald Hayward, a Maryland cancer expert and surgeon, to conserve as much breast tissue as possible. "It's much easier with men," says Dr. Hayward, "to remove the nipple and all of the cancer and still maintain an acceptable cosmetic appearance" since most men have flat chests.

# # #

Warming up at the starting line, a female runner commented on Mark's shirt. The back of his faded blue, short-sleeve New Balance t-shirt sported the following message in peeling, white block letters: "MEN SHARE A BREASTED INTEREST."

"Breast cancer survivor?" she asked, incredulous. "I had no idea." She wasn't alone. Many that morning were shocked to hear of Mark's diagnosis.

As Maryland Governor Martin O'Malley shot the starter's pistol, Mark was quickly passed by the mass of faster runners. He wasn't out to break any records, at least not racing ones. Instead, running at a comfortable pace, he wanted as many as possible to see and hear his message.

Mark wound his way through the course primarily in silence -- his wife Joanie waited at the finish line -- outside of the cheers and music coming from the sidelines and the few conversations he had with passing runners. "Love your shirt," they'd yell as they ran by. Sometimes he'd explain, other times he'd simply say thank you and listen to their interpretations.

This intentional silence was unusual for Mark; he hasn't been quiet or still much in the years since his diagnosis. A day and a half after his mastectomy in 1988, Mark was mowing his lawn, with drainage bottles collecting the fluids draining from his chest. "It needed cutting," he laughs. "My first act of defiance." It would be the first of many.

While watching TV at home in New Jersey in August 1992, he saw a piece about the upcoming New York Komen Race for the Cure. There was no mention of breast cancer affecting men. At the time, only female survivors could participate, so Mark submitted his application using his first initial and last name and paid with a money order.

"You can't run; you're a man," he was told on arrival. "Except for the genitalia, I qualify," he fired back. He ran, having never raced before, with his immediate family beside him, beginning his journey of running around the country to spread the word about men's ability to develop breast cancer.

In 1997, the New York Race for the Cure was opened to male survivors. Today, most Komen races are open to male and female survivors and their supporters.

HE RUNS FOR HIMSELF AND FOR MEN LIKE HIM: THE UNTOLD STORY OF MALE BREAST CANCER *continued*

# # #

Mark was one of only two male survivors participating in the Hunt Valley race that morning; their names had been announced earlier with a brief message of support for men with breast cancer.

Robin Prothro, executive director of Komen Maryland, explains that limited support exists among men and for men with breast cancer. "Women rally around their friends when they are diagnosed and going through treatment," she says. "I'm not sure that happens for men, which is a significant difference in managing the disease. Women have the capacity to sit and talk about themselves for the benefit of those around them," says Mark. Men rarely do. "If breast cancer was a sport, men would know all about it," he quips. "Not talking was never an issue. I've been up front and honest since day one."

# # #

Mark crossed the finish line, thirty-nine minutes and thirty-three seconds after he started, his hot-pink-sock-covered hands held high. Clutching the hand of a dark-haired female survivor in his right hand, he cared little for the time it took, only that he'd finished another race and that he'd shared his message with another parade of the uninformed.

And that they no longer were.

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CLINICAL DECISION-MAKING: THE FOUNDATION FOR SUCCESS UNDER NEW CARE MODELS

The days of fee-for-service (FFS) reimbursement in healthcare are numbered. The entire industry is rapidly moving toward new care and reimbursement models such as Patient-Centered Medical Homes (PCMHs) and Accountable Care Organizations (ACOs). Success within these models, however, will require changes to healthcare provider decision-making.

For most hospitals and health systems, revenue today is based on the volume of admissions, utilization, and services performed. The FFS reimbursement environment does not generally tie clinical care quality or efficiency to reimbursement rates.

In contrast, emerging models will reimburse healthcare organizations based on the "triple aim" of healthcare reform - better care for individuals, better health for populations, and reduced per-capita costs. Achieving these goals is significantly impacted by the decisions of healthcare providers at various points during the care process. Meeting care quality and financial goals are more likely if healthcare providers are trained to make decisions that reflect these new areas of emphasis.

Re-Evaluating Decision-Making

Healthcare providers, trained to optimize decisions based on the current models, may need to modify some of those decisions under new care delivery models. It's not that the decisions being made under FFS are incorrect, but they may be suboptimal — particularly with regard to reimbursement factors.

Take the example of diagnostic testing. A healthcare provider accustomed to ordering a battery of costly tests to rule out a suspected diagnosis will need to begin considering "best practices" surrounding the cost and quality of the tests. Although the healthcare provider may ultimately arrive at the same diagnostic decision, the testing, treatments, and follow-up all may be different under new care and reimbursement models.

Healthcare provider decisions impact many facets of healthcare, including diagnosis and treatment, immediate patient care and satisfaction, and long-term patient outcomes. Suboptimal healthcare provider decisions can lead to higher hospital readmission rates, preventable errors, poorer patient outcomes, and low patient satisfaction. That is why decisions that affect these factors—decisions that now impact reimbursement as well as patient care—must be evaluated.

Fortunately, decision-making is like other skills in that it can be taught and enhanced through continual improvement processes. Healthcare providers can be trained to make optimal decisions, driven by evidence-based protocols proven to enhance outcomes.

Enhancing Decisions Through Clinical Simulation

While many factors impacting patient care and satisfaction may lie largely outside the control of healthcare organizations, clinical decision-making is not one of them. One proven training method to improve decision-making is simulation.

Traditional forms of patient simulation include mannequins, task trainers, and actors posing as patients. Although valuable, these resources have limited application when it comes to assessing or improving clinical decision-making. A better means of training this critical skill is the use of clinical simulations and scenarios, a type of "virtual patient." These web-based platforms can be leveraged to assess current decision-making, actively practice the application of new guidelines or knowledge, evaluate competency, and reinforce new procedures and approaches.

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CLINICAL DECISION-MAKING: THE FOUNDATION FOR SUCCESS UNDER NEW CARE MODELS *continued*

Simulation platforms support new care and reimbursement models in several ways. To start, they provide deliberate practice in a controlled environment. A typical scenario will provide a patient's story and background information and then offer multiple decision paths. As the healthcare provider proceeds through the scenario, the simulation reveals the impact of each decision without the risk incurred during actual treatment. The consequences of each decision are experienced immediately, just as in real life. This makes the simulation more engaging and more realistic than training via PowerPoint or lectures. Healthcare providers receive a more relevant educational experience as a result of case scenarios that are tailored to their current knowledge level, and which can mirror the actual patient population, conditions, and situations in which they will be making their decisions.

Personalized and adaptive feedback can illustrate both clinical and financial outcomes. Healthcare providers can see how they scored in a clinical simulation, as well as how they performed against other key metrics such as cost of care and patient satisfaction — all of which helps to encourage the application of these newly learned decision-making skills in their day-to-day practice.

The trend toward using metrics to spur continual performance improvement is also supported by these web-based clinical simulations. One benefit to web-based simulation is that it facilitates data collection. Healthcare administrators easily can gather data about how decisions are being made at individual, group or enterprise levels. That information can then be used to track key performance indicators, as well as support periodic evaluation or re-evaluation of decision-making skills.

This data can have a direct impact on the long-term quality of patient care. Simulation platforms provide quantifiable and objective data that give insight into how a healthcare provider is performing, and where a healthcare provider might need additional training and support. Patients are more likely to receive care that complies with evidence-based protocols, improving outcomes for both the patient and the healthcare organization.

Preparing for Future Achievement

Healthcare decisions are becoming increasingly difficult now that healthcare providers are expected to choose not only the best medical interventions, but those that also offer a coordinated, cost-effective and evidence-based approach. For healthcare organizations to thrive both now and in the future, they must be prepared to change long-entrenched decision-making behaviors.

However, enhancing clinical decision-making is not yet a high priority for many healthcare organizations struggling to comply with Meaningful Use, ICD-10, and other critical and resource-intensive mandates. In October 2012 financial penalties were put in place by CMS for preventable readmissions and will start taking their toll on reimbursement rates. Non-payment for certain preventable readmissions had already been in queue by commercial payors. This is just the first of many reasons why forward-thinking executives must begin considering ways to prepare their organizations to flourish under new care delivery and reimbursement models.

Many healthcare providers have years — even decades — of experience making decisions well suited to the FFS environment. It is time to re-train them to achieve optimal performance in the patient care and reimbursement environment of the future. Web-based clinical simulation platforms are an efficient and effective training method that offers healthcare providers the practice they need to make decisions that support evidence-based protocols proven to enhance outcomes and reduce costs. Grounded in adult learning theory and providing rich feedback and data, these clinical scenarios help ensure the transfer of decision-making skills to a constantly evolving clinical environment, improving the practice of healthcare and the financial results of healthcare systems.

TAKING WHARTON TO GUATEMALA

Between their busy schedules at Wharton, a group of MBA students is taking the opportunity to learn more about the developing world's healthcare systems while giving back to the global community.

About Wharton Global Health Volunteers (WGHV)

Wharton Global Health Volunteers is a student-led group that creates opportunities for Wharton MBA students to participate in 2-week healthcare-focused service projects around the world. The focus is truly global, and clients have ranged from small NGOs (non-governmental organizations) to public health-oriented hospitals, foundations, and healthcare organizations. In the 2011-2012 academic year, clients included APHFTA (Tanzania), HealthGAP (Uganda), Hospitalito Atitlán (Guatemala), Livewell Rehab (India), and VinaCapital Foundation (Vietnam), creating an opportunity for 19 students to make an impact during winter break and over the summer. Projects ranged from helping clients design a new center for the disabled to creating a strategy for improving access to HIV/AIDS drugs and providing advice on ways to improve operations at global health organizations.

Case Study – Hospitalito Atitlán in Guatemala

One such client is Hospitalito Atitlá, which is a small private non-profit hospital serving 75,000 Mayans living on the southern shore of Lake Atitlán in Guatemala. The hospital provides a full range of preventive and clinical health services, with an emphasis on women and children, and has the only 24/7 emergency and surgical obstetrical care within a two-hour radius.

The organization came to WGHV with two asks: 1) conduct benchmarking on its operations to identify opportunities for improvement and 2) provide guidance on how the hospital can become a more attractive charity for donors. A team of three Wharton students, Carter Clement (WG'12), Kathryn Sullivan (WG'12), and Casey Dougan (WG'13) visited Guatemala in May 2012 to help find solutions for the client. The team gathered benchmarks for hospitals for the various hospital functions, conducted an analysis of the hospital's financials, interviewed key stakeholders in the organization, and researched donor relations best practices among other comparable charities.

After two weeks on the ground, the team provided several recommendations to Hospitalito Atitlán management, including reallocating physician resources to better match patient demand, reducing administration costs in a few key areas, increasing the level of employee empowerment, and expanding transparency in compensation of hospital staff. Their recommendations are currently being implemented at the Hospitalito.

Impact of WHCMAA's Sponsorship

To ease the burden of travel costs, WGHV aims to compensate students up to $1,300 of associated travel expenses. In the 2011-2012 academic year, travel subsidies were 98% of WGHV's total budget, making up approximately $23,000 in total. WHCMAA's sponsorship of $5,000 helped fund a significant portion of this need, creating an opportunity for several students to make an impact around the world.

Interested in helping?

Wharton Global Health Volunteers aims to create even more opportunities for MBA students to get experience working in global health, but in order to do so the group is dependent on funding and donations. For more information on WGHV, or to make a donation, please e-mail Amy Chiu (WG'13), VP of Fundraising, at amychiu@wharton.upenn.edu.

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"MAY YOU BE BLESSED BY GOOD HEALTH" (SCOTUS DECIDES)

Congress' inability to reach compromise marked the difficult passage of the 2010 Patient Protection and Affordable Care Act (PPACA), the most significant federal law impacting health care since the 1960s passage of Medicare and Medicaid as part of President Johnson's "Great Society." After a number of legal challenges by states, the constitutionality of the Affordable Care Act was upheld last summer by the U.S. Supreme Court, when Chief Justice John Roberts sided with the court's liberal wing. Yet for most stakeholders within the healthcare industry, the court outcome didn't much matter. A radical change of how we practice and deliver health care was already underway.

By now, most people who care about healthcare are aware the Supreme Court majority ruled in favor of PPACA based upon the constitutional power of Congress to tax. This was a surprise to those who sought a more complex legal opinion about the power of government versus the individual. More importantly, healthcare veterans believed PPACA had already been a catalyst for this seismic shift in the nation's health care system. Even before the court's ruling, physicians and hospitals recognized the national mood about health care and moved to adopt new ways to reduce cost, increase value for medical services, and communicate with patients.[1] In that sense, the court's landmark decision changed very little.

For U.S. political leadership, doing nothing was not an option – not when viewed in light of a mountain of dire reports, statistics, and predictions about the slide in the quality of American health-care and, on the other side of the equation, the upward trajectory in costs. Government cost and gargantuan size is deemed too expensive, as health care gobbles up a larger piece of the federal budget (along with state budgets) than is sustainable, much less desirable. The president and our fractious, highly partisan Congress could not ignore that loud sucking sound of national resources away from other worthwhile projects and services, from education to technological innovation. PPACA was one grand response to this perceived cost-benefit concern. There was, and is, great argument about what PPACA will do or accomplish, but the fact remains it is now law, and physicians and hospitals have already moved in a new direction based upon publicity and public discourse around the subject.

Debating the merits of PPACA now would seem non-productive. Everyone can agree good health for every person is a worthy goal. However, as such, "healthcare" is simply one tool for achieving health.[2] There must be other initiatives or tools identified and employed. One tool in any toolbox is hardly enough.

Given the desires of the U.S. public, transparency about medical decisions is a new norm. Successful physicians and hospitals will be judged on economic outcomes that may signify not so much individual health as the healthcare system's ability to serve more people as an essential tool. More patients will be refused care they do not need but desire nonetheless. More physicians will want to know the cost of supplies and services they order to enhance their cost profile. More hospitals will want to employ physicians to assure control over the means of production. Transparency will mean accountability to the patient, who must then attempt to judge cost and quality (together defined as value). As smartphones create an even more price-savvy public, transparency and accessibility are fast becoming the norm.

Nothing happens in healthcare without a physician's order. Regardless of PPACA, the physician is in the target zone for reduced compensation when, in fact, the physician *consumes* only a very small part of the healthcare dollar expenditure. PPACA hard-wired several imperatives for the physician to adopt such transparency - electronic prescribing of medication, electronic medical record accessibility to patients, and "Meaningful Use" guidelines for documented medical information deemed important by non-clinicians.

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"MAY YOU BE BLESSED BY GOOD HEALTH" (SCOTUS DECIDES)

continued

This PPACA federal demand builds off companion legislation to establish a basis for (Orwellian?) harvesting of healthcare data in future years upon which federal policy decisions can be made. The U.S. government was generous to allow federal payment to providers for funding of electronic data collection but punitive (less Medicare reimbursement) for those physicians refusing to accept the new order of things.

Given the intolerable burden of healthcare costs without demonstrated concomitant "health," the U.S. government has created a law for everyone, with cost-aware healthcare seen as a federally-mandated right. We are cost conscious because we all should have insurance, and physicians deemed inappropriately expensive from a medical standpoint will be publically chastised – a kind of Scarlet "E" for all to see. Massive government funding will be used to assure implementation of PPACA, with new national cost norms by disease category used in future years to manage the efficiency and efficacy of what the physician spends on behalf of patients. Better health, however, may be more of a hope than a true outcome.

Hippocrates now presents the dilemma of PPACA. Sometimes called "the first," this iconic physician who lived in the fourth century B.C. admonished his future colleagues:

> "... as to diseases, make a habit of two things – to help, or at least do no harm. The art has three factors, the disease, the patient, the physician. The physician is the servant of the art. The patient must co-operate with the physician in combating the disease." [3]

If one accepts the essential truth of Hippocrates' works, the Supreme Court decision does little to assure better health for Americans. For Hippocrates, only the highly trained physician and a compliant patient can assure progress to better health. Despite its good intentions, it is not clear the PPACA can reach this classic goal for physicians and patients alike. Every physician wishes to fulfill the fruits of an educational process that now lasts until adult age of early 30's. Every patient wishes for good health. If PPACA manages to reduce the number of available physicians either by attrition because of regulation, low pay, or lack of youthful interest, then it cannot fulfill what its sponsors hope at any cost, which is better health for all Americans.

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