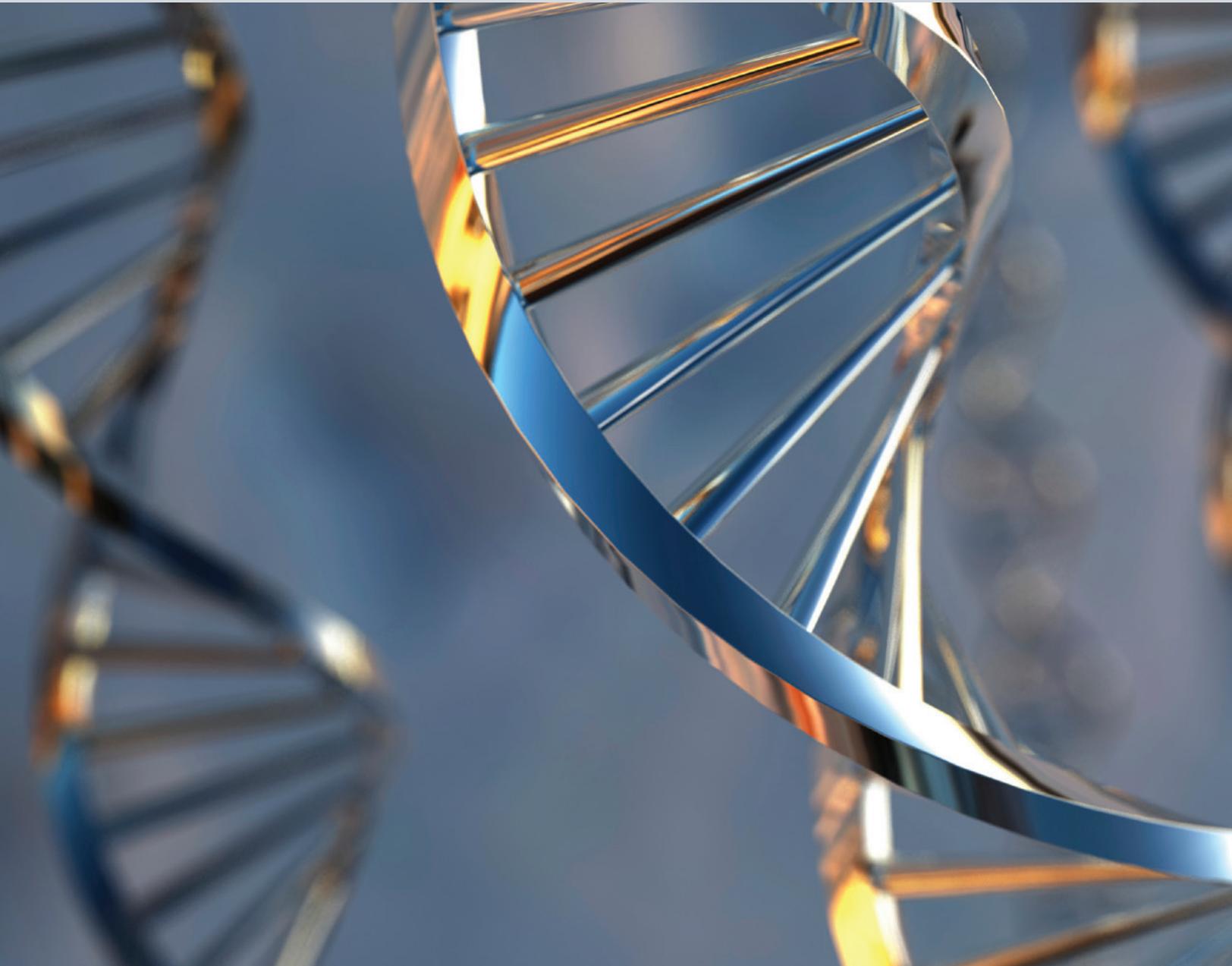




Wharton
UNIVERSITY of PENNSYLVANIA

**THE WHARTON
HEALTHCARE QUARTERLY**

**FALL 2012
VOLUME 1, NUMBER 4**



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EDITOR'S LETTER

It's hard to believe this is the 4th edition of the *Wharton Healthcare Quarterly* and that we are closing out its first year of publication! Thanks to all who have made this effort possible - from the Board who had the idea in the summer of 2011 of starting an e-magazine, to all who have contributed articles and those who provided updates on their lives, to Jeff Voigt (the “executive sponsor” from the Board) and Gabriela Sanchez who provides administrative and project management support, and finally to you, our readers, without whom the *WHQ* has no life.

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

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

Managing Editor

To learn more about Colette,
[click here.](#)

THE PRESIDENT'S DESK

Fellow Alumni, Friends and Colleagues:

We typically report on the Association's financial and operating performance at the end of each calendar year. While I don't want to steal thunder from our upcoming Annual Report, I can say we closed out a very successful Fiscal 2011-12. Membership was up 29%, with revenues growing 49% – driven by strong increases in membership dues, programming revenues, and corporate sponsorships.

While we are proud of those accomplishments, your Association wants to ensure we sustain this momentum, and our goal is to become **your preeminent resource for the business of healthcare**. Last issue, I touched briefly on the Alumni survey we conducted earlier this year and noted some of the key findings. Jeff Voigt provides a more in-depth analysis later in this edition of the *WHQ* [[click here](#)]. The Board is taking your feedback very seriously and is already using it to develop our strategic and tactical roadmap for the next 12 – 24 months. What you will see from us is:

- **Increased Focus on Lifelong Learning (L³).** The Wharton Alumni Association is rolling out its Lifelong Learning initiative, which places an emphasis on business education that is timely and relevant to alumni throughout their careers. The WHCMAA has been doing this for quite some time, as evidenced by our Annual Alumni Conference and webinar series. We will continue to develop and package for you timely content led by industry experts in and outside the WHCMAA community, using a multitude of live and virtual venues.
- **Increased Use of Social Media.** We have had a long-term presence on the internet at www.whartonhealthcare.org and more recently on Facebook, Twitter and LinkedIn, but admittedly the daily traffic we generate does not reflect the dynamic nature of our Association and membership. We will be dedicating several Board members' efforts (and other alumni volunteers) to populating these outlets with thought-provoking ideas, current trends, and updates throughout the diverse healthcare industry.
- **Building a Robust Alumni Directory and Sponsoring More Networking Events.** Staying connected is one of the most valuable aspects of a Wharton MBA. Making it work requires a tenacious focus on keeping our directory up-to-date (*which also requires your input*) and an advanced database search engine. We have in the past, and will continue in the future, to invest in both and already have a plan to implement significant improvements before the year's end. You can also count on us to host more informal get-togethers, on both a large (JPMorgan) and smaller scale!
- **Giving Back to WHCM Program and Students.** Many of us have been active supporters of the WHCM program years after leaving campus. Current students benefit from mentorships, guest lectures, FAP projects, internships, and much more. We have also funded the Kissick Scholarship since 1998. Our goal is to have a larger impact on the program/students by offering more meaningful support - which includes a larger student scholarship and financial resources to grow the WHCM program. I am sure you will all agree that providing financial support to the WHCM program builds the Wharton name for all of us. Details are still being formulated, with a roll it out to begin later in 2012.

In addition to our operating performance metrics, we will periodically provide you with updates on how we're doing against each of the above initiatives.

We would encourage you to share your thoughts on the survey as well as the direction we're headed by writing to any of us on the Board – we clearly listen to and always value your input!

Jay Mohr (WG'91)
President, WHCMAA



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

OPEN WIDE: “ONE OF THESE DAYS WE’VE SIMPLY GOT TO GET ORGANIZED!”

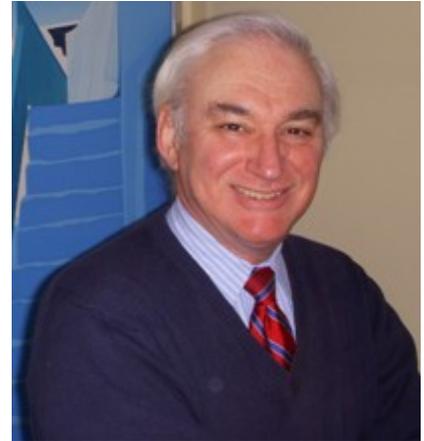
You may recall that humorous poster of the two sets of railroad tracks, coming from opposite directions, and meeting at some desolate spot in the remote American West, except the rails are misaligned, leaving the exasperated spike drivers shaking their heads and uttering the above quote to make some sense out of the abysmal miscalculation leading to their predicament. That poster often comes to mind when I think of the organization, or more accurately the lack thereof, in American healthcare, a matter which is underscored when one considers how misaligned our oral health resources are with the fundamentally preventable nature of tooth decay and gum disease.

One instance of that “disconnect” was scoped out in the last column, which examined the recent attention on a purported link between gum (periodontal) disease and cardiovascular disease, and found the link can’t really be scientifically demonstrated, due to so many confounding variables and the methodological difficulties in teasing them out. I was left with my own exasperations over this, asking the questions “Why are we engaging in relatively esoteric academic and scientific fine points when the inescapable reality is that our society is tolerating the existence of a fundamentally preventable disease in its midst through the skewed organization of dental care?” and “Isn’t our poorly organized and financed dental care “non-system” itself a risk factor for the development of periodontal disease?”

Our society seems to be fixated on the “magic bullet” approach to healthcare, looking for that scientific explanation for why a disease occurs and then the medical treatment that will lead to its cure. As a result, the sum of all possible procedures in the name of cure – often the newer and more elaborate and more expensive, the better – is then equated with good health. This view of disease is subscribed to by both providers and patients, and to the marginalization of other ways to look upon disease. Such an outlook probably explains much behind the periodontal disease/cardiovascular disease build-up – fit it within a larger, more complex context, and it legitimizes itself for more complex, scientific interpretation.

What’s at the core of preventing the two predominant oral health diseases, tooth decay and gum disease, is (1) not providing acid-producing bacteria the opportunity to demineralize the enamel, through fluoridation, sealants, proper nutrition, and good oral hygiene (regular brushing and flossing) and (2) not allowing bacterial plaque to accumulate and calcify in the sulcus, the “pocket” between tooth structure and bone, causing inflammatory destruction of tooth support structures (again through good hygiene habits, proper nutrition, avoidance of tobacco use, and periodic visits to the hygienist to remove calculus). All this sounds simple and straightforward enough, yet the reality is that tooth decay is the most common chronic disease of childhood, and gum disease is the leading cause of tooth loss in adults.

All in all, there is an “access” problem along several dimensions, yet what we are using in this society to “treat” dental disease is predominantly a cottage industry, comprised of private, solo practitioners paid on a fee-for-service basis. Dental providers are trained and oriented to provide procedures to individuals through a rigidly circumscribed workforce and are not typically trained to think in terms of meeting the prevention and treatment needs of populations. “The sum of all possible procedures” is the guiding principle of this type of organization of care, and it is failing that significant part of the population that cannot surmount the economic, cultural, geographic, and other barriers to care inherent in it.



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

OPEN WIDE: “ONE OF THESE DAYS WE’VE SIMPLY GOT TO GET ORGANIZED!” *continued*

Can such access problems be overcome through the reorganization of care? The dental therapist program of the Alaska Native Tribal Health Consortium suggests yes. I was at a presentation at this year’s National Oral Health Conference given by one of the first graduates of this program, in practice for about two years now. Her presentation centered not only upon the treatment procedures she does, but also on (1) her acceptance by the communities she serves, (2) the emphasis on the educational and behavioral aspects of good oral health, and (3) the logistical side of providing care in remote villages hundreds of miles away from more traditional dental offices or clinics. I found it rather amazing this young woman could get her professional equipment and personal gear into a single-engine Cessna and be flown to villages accessible only by air. She would unpack, set up her “office” in a suitable place (school gymnasium, local medical clinic if there was one, etc.), establish the computer link for teledentistry consultation with the supervising dentist back in Anchorage, and begin rendering care - whether education and information on oral health for the expectant mother, proper brushing and nutrition for the toddler, restorations where decay has set in but can be halted, and direct real-time consultation on more involved cases. All this for a population that heretofore has suffered from some of the poorest oral health in North America, yet now is beginning to see reversals in that status, as the Tribal Health Council has decided to *organize effectively* to address the oral health status of its members.

If a trained dental therapist flying the skies of Alaska to reach distant villages can deliver high quality, appropriate care, with readily available links to professional support, then why can’t that example translate itself to schools, clinics, shopping malls, and other venues in the lower 48 states? It isn’t a matter of science, it’s a matter of organization. One of these days we’ve simply got to get organized in dental health!

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.

Life Lessons:

If I knew then what I know now, I would not take opportunities for granted; they arise too infrequently. Recognize good opportunities, pursue them whole-heartedly and end them successfully.

Favorite Quotes:

- “You have to do your work like your life depends on it.”
- Head research scientist, UCSD
- “Stay Hungry. Stay Foolish.”
- Steve Jobs, Stanford commencement speech
- “Being president is like running a cemetery: you've got a lot of people under you and nobody's listening.”
- Bill Clinton

Recommended Reading:

- *Gifted Hands* by Ben Carson, 2009.
- *Only The Paranoid Survive* by Andy Grove, 1999.
- *Outliers* by Malcom Gladwell, 2008.



This month's philosopher is Sylvia Tara Ph.D, MBA '05. To learn more about Sylvia, [click here](#).

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

ALUMNI NEWS

Jonathan E. Perelman W'76

Jonathan E. Perelman, CPA/PFS/MST (W'76) is a Partner at Friedman LLP (East Hanover, NJ office), a regional CPA firm, and a practice leader of the Friedman Healthcare group. He is also the President Emeritus and Club founder of the NJ Wharton club.

Tom Sims WG'79

After 11 years as an entrepreneur (developing and operating a wound care and hyperbaric medicine business), Tom Sims returned to the world of management consulting. In August, Tom joined the Atlanta office of Stroudwater Associates, a national healthcare consulting firm with expertise in strategy, operations, facility planning, and finance. They are very active in the affiliations (M&A) arena – advising clients as they establish new relationships and form clinically integrated systems. Their work includes initial strategy development, evaluation of specific affiliation partners, closing the deal, and guidance on how to execute and realize the economic and clinical benefits of affiliation.

Scott Honiberg WG'80

Scott Honiberg (WG, '80) and Jeffrey Weinstein, presented a webinar on "[Preparation of Bids and Proposals for Federal Contracts: Increasing Your Odds of Success.](#)" Mr. Honiberg is the founder of Potomac Health Associates, Inc. (PHA) (www.phainc.com), a consulting firm based in McLean, Virginia that specializes in advising private companies in conjunction with federal healthcare contracting opportunities, primarily with the Departments of Defense and the Department of Veterans Affairs.

Mr. Honiberg, President of Potomac Health Associates, Inc. and Mr. Weinstein, Of Counsel to Potomac Health Associates, Inc. (PHA), have worked together for the last seven years to address the increasing number of protests, disputes and other kinds of claims associated specifically with federal healthcare contracts governed by the Federal Acquisition Regulation (FAR) and agency-specific regulations. PHA was recently retained by one of the largest publicly held healthcare companies to handle several cases related to federal healthcare contracts, including claims associated with a dispute under a \$100 million contract that is currently in litigation before the Civilian Board of Contract Appeals (CBCA) in Washington, DC.

David Nash WG'86

David Nash WG'86 will be receiving the [Joseph Wharton Award for Social Action](#) on October 4th at the Wharton Club of NY Joseph Wharton Awards Dinner. This is a great honor, and David is very excited to receive the award from Dr. Mehmet Oz M'86 WG'86.

Eric Reimer WG'96

In September 2008, Eric Reimer became the CEO of a company called CareCentrix, which is the leading home health (nursing, therapies, equipment, drugs) benefits manager in the country. CareCentrix offers healthplans a network of providers, and then screens requests to ensure appropriate utilization and to eliminate fraud and abuse. CareCentrix is now working with leading researchers and leveraging its platform to reduce readmissions. CareCentrix is also working to reduce costs by shifting site of service from facilities to the home for items such as infusions, sleep tests, etc. The company has grown from \$300M in revenue and 400 employees to \$900M and 1200 employees over the past

ALUMNI NEWS

continued

four years. CareCentrix is currently owned by Summit Partners, Water Street Partners, Blue Cross Blue Shield of FL, and Blue Cross Blue Shield's private equity fund. For Eric, it has been a great four years, and he hopes the company will go public sometime in the next 2 years, or so. CareCentrix continues to grow and is always looking to add talent. If anyone is interested, please send an e-mail to eric.reimer@carecentrix.com.

Eric still lives in Hartford, CT. Eric and his wife Lisa just celebrated their 16th anniversary, and they have two wonderful kids, Shara, 11 and Ben 8.

Nishan de Silva MD'00, WG'00

Nishan de Silva moved to La Jolla, CA early in the year and joined Ligand Pharmaceuticals as Vice President, Corporate Development. In this role, he oversees business development, corporate development, and strategy for the biotechnology company. On the personal front, Nishan and his wife Taryne had their first child in June, a boy named Jaden.

Todd Guren WG'03

Todd is working for Regence Blue Cross Blue Shield, which covers Oregon, Washington, Idaho, and Utah as a senior product manager. His sole focus is on strategy for the Health Insurance Exchanges and watching the insurance market transform. In personal news, he welcomed Arlo Saul Guren who was born July 29th. Joel, age 4, has been excited to have a younger brother and calls him Arload, Arloaf, and Arly to "prepare them for what Arlo's classmates will call him."

Mihir Gandhi WG'10

Mihir Gandhi recently moved to San Francisco to join the Abbott Vascular team and is working on global strategic marketing for peripheral applications of Abbott's drug-eluting, bioresorbable scaffold. Mihir will be based out of Santa Clara.

THE WHARTON HEALTHCARE QUARTERLY INTERVIEWS ZEKE EMANUEL

Dr. Emanuel, thank you for your time today and for sharing some of your thoughts regarding the direction healthcare is headed in the wake of the recent Supreme Court ACA decision.

Wharton Healthcare Quarterly (WHQ): In an era of medical homes and the frenzied activity surrounding Accountable Care Organizations, what opportunities and challenges do you anticipate relative to the physician-patient relationship?

ZE: I am optimistic regarding the physician-patient relationship. I also believe we will continue to move increasingly to a team-based care model, especially for patients with chronic conditions. There will be less “piece work” and a greater focus on applying data about what works to the patient. Some will succeed in the ACO approach and others will not, but there will be a greater consolidation of physicians as organizations vertically integrate care delivery.

WHQ: Any ideas regarding the “secret sauce” which physicians and other members of the healthcare team can add to the recipe for effective patient engagement?

ZE: It still comes down to the basics – communication, communication, communication.

WHQ: If you were “king of the world” for a day, what is the one action you would take which you believe would have the greatest impact on moving the U.S. forward in a material fashion for the sustainable changes which seem to be so sorely needed but yet remain frustratingly elusive in healthcare?

ZE: There are actually several interrelated actions I would take including (1) increasing the focus on chronic disease, (2) accelerating the adoption of a team approach to care, (3) utilizing data to help engage patients and establish a relationship, especially relative to obstacles to adherence, (4) enabling quality care by providing data to physicians more frequently and in a real-time fashion, and maybe the most important one is (5) identifying a payment model which most optimally aligns incentives for all parties in the healthcare equation to achieve medically appropriate cost management and the best quality care for each patient.

WHQ: Can you fill us in on some of your priorities for 2013 vis-à-vis global initiatives for which you are Vice Provost?

ZE: We are finalizing our strategic plan, but two areas of concentrated attention are (1) collaborations across schools within the Penn system relative to research and applied coursework and (2) incorporating an even more global view of the world, especially with regard to lessons to be learned and opportunities to be identified relative to China, Africa, East Asia, Latin America, and India.

WHQ: What words of wisdom can you offer to the 2016 class of the Perelman School of Medicine?

ZE (chuckles): Learn as much as you can about how to build teams, use data, and allocate resources and adopt a bigger view beyond just gaining the requisite technical skills and scientific foundation needed to care for patients.

Thanks again for your time!



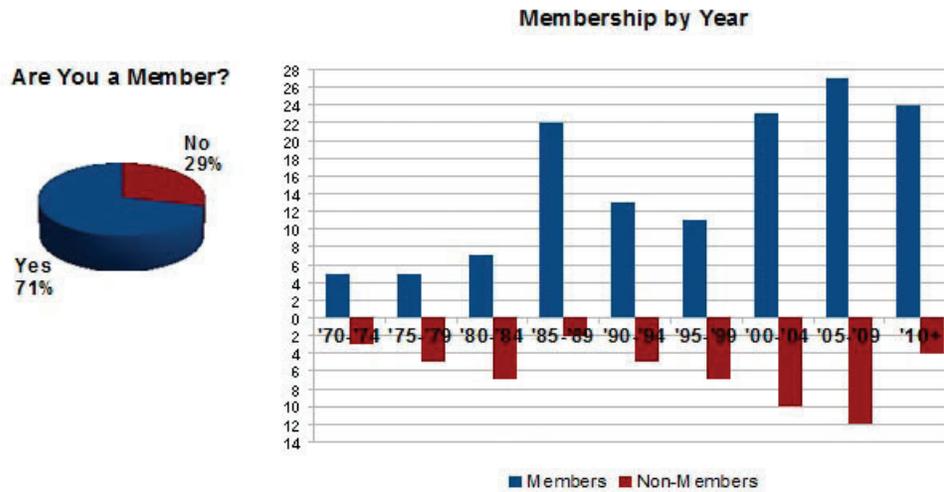
To learn more about Zeke, [click here](#).

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

WE ASKED. YOU ANSWERED.

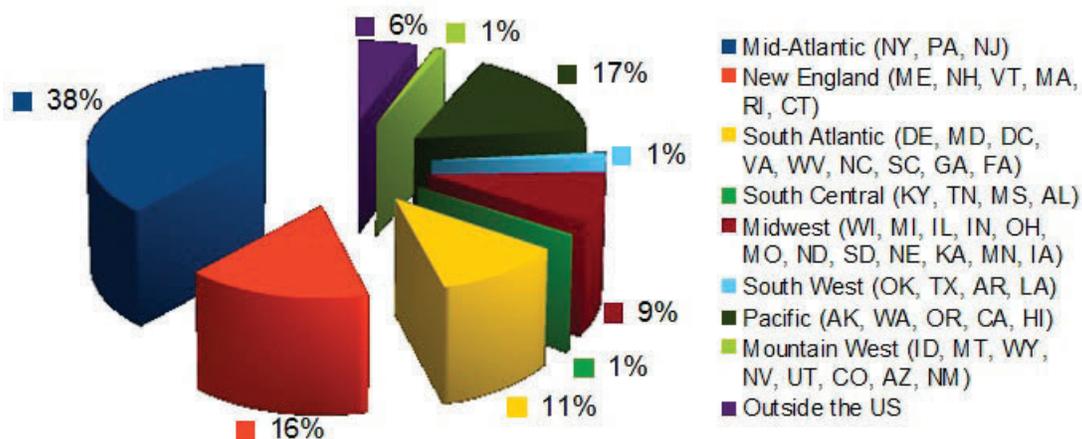
The findings of the recently conducted WHCMAA survey have been collected and analyzed. We would like to thank all of you who took the time to complete the survey. This has been a great exercise for the Association in helping us to better understand what is working and what needs attention. We had 192 people complete the survey (71% were members of the Association, and 29% were not). We also had good representation of all the class years, with the largest cohorts of respondents from the 1985-89 and 2000-2012 class years.

Respondents by Class Year



WHCMAA Survey, 2012

Sixty percent of all respondents were located in the Boston to Washington, DC corridor, and 17% of respondents were located on the West coast. The remainder were dispersed across the U.S.



Contributor:
Jeff Voigt, WG'85

To learn more about Jeff,
[click here.](#)

WE ASKED. YOU ANSWERED.

continued

The major findings were:

- The most important functions the WHCMAA can provide are for networking, general interaction, and learning.
- What you as alum would like to see from the Association:
 - continuing education
 - more regional events/member “get togethers”
 - more and more accessible web content
 - a more robust and definitive schedule of events on the website
 - make it easier to sign up for events
 - additional distribution channels for content delivery – social media, Linked In, etc.
- The reasons alumni visit the website:
 - Alumni directory
 - identify future events
 - review events after the fact (e.g., recorded webinars)
 - career/job board
- Desirable website improvements:
 - directory more easily searchable
 - more frequent job board updates
 - more links to pertinent content/websites
 - more regular communication (put new info up more regularly)
- There was a very positive response to our proposed mission of Life-Long Learning (L3), with 87% of respondents either feeling strongly or very strongly in favor of it.

This feedback affirms our thinking, as we plan on making L3 a key component of why we exist as an Association. Further, we need to do a better job of explaining the Association’s value proposition so alumni understand what they are getting for their money, particularly for our Patron membership package. We would like to see more Patron members and will make this offering a priority this year.

So what are the plans moving forward? Jay Mohr, our WHCMAA President, will be communicating these to you more specifically over the near term; but suffice it to say, many of the above opportunities will serve as a roadmap for the coming year. What you are likely to hear/see is (1) L3 will be a major initiative of the WHCMAA and (2) more quality and quantity content being provided – e.g., webinars, regional events, and national events at Wharton (e.g., alumni conference). We are also working with the Wharton healthcare/LDI faculty to leverage and communicate their research, as well as to more closely collaborate with them. We have a very diverse and expert alumni base that should be actively used as a resource. Together, the WHCM alumni and faculty are a powerful platform for building a Lifelong Learning curriculum. We also plan to develop more and better ways to deliver/distribute this content – via the web, social media, Wharton Healthcare e-magazine, and in person.

Your feedback is extremely critical to our providing the best experience for you. We appreciate your comments and suggestions and found the survey to be a great way to gather your inputs. Thank you again for taking the time to complete it. We look forward to serving/working with you in the future as we move forward in leveraging our capabilities to provide topical content and furthering our goal of making our Association a go-to resource.

THE FUNDAMENTAL ‘GIVES’ AND ‘GETS’ - THE BASICS FOR EFFECTIVE COLLABORATION IN HEALTHCARE

This is the second in a series of four articles exploring opportunities to improve collaboration in healthcare, in this case, between institutions. We will describe practical tools that can be applied to improve overall institutional performance through better collaboration - against the primary goal of providing better patient care.

A major academic medical center and a small but respected post-acute care system formed a joint venture in 2007 to create a comprehensive continuum of care that expanded the reach and academic scope of the post-acute care system and filled a strategic gap for the academic medical center. Three years later, the new entity's reputation for poor quality threatened its very survival. Its partners had intended to create an organization that could fulfill both sides' interests, but when the new entity launched operations, the focus on collaboration waned. It turned out they had neglected to visit some fundamental ground rules about what each entity expected to gain - and give in return - in service of the overall objectives of the alliance. This is the story of how a 'back to basics' assessment saved an organizational collaboration from becoming just another statistic.

A wave of integration - and evidence of the challenge

New collaborative partnerships are sprouting up everywhere, such as a private equity firm's deal with the largest Catholic health system in Boston; an acquisition by a dialysis company of a firm that owns medical groups; physician networks, and the venture described above. This trend is due in part to the recent passage of the Patient Protection and Affordable Care Act and the Supreme Court's affirmation of its constitutionality. The volume of hospital merger and acquisition transactions increased by 45% between 2008-09 and 2010-11, with associated investment increasing by 435%ⁱ. M&A activity is expected to grow.ⁱⁱ At the same time, research shows 30-70% of alliances fail, and 50% of alliances actually terminate.ⁱⁱⁱ

From alignment to shared accountability

With healthcare reform shepherding in an era of reduced capital and mounting shared risk, stakes for effective collaboration are higher than ever. (The number of approved Accountable Care Organizations more than doubled in July of 2012 alone.) The national trend is unmistakably moving beyond clinical integration to shared accountability. However, implementing a complex set of shared objectives does not happen by itself. The challenge is to align goals, incentives, and expectations across the individuals and entities involved in delivering care to benefit each party **and** to deliver value to patients and their families.

The “gives” and “gets” of collaboration

Organizational collaboration depends on agreements whereby each participating entity expects that together they can do something greater than either partner could do alone. Each has something to “give” to the partnership, and each has something to “get” out of it (i.e., compromise). In any collaboration, there are some fundamental principles that can set the stage for lasting success:

- **Identify your “gives” and “gets”** when asking whether the whole will be greater than the sum of its parts.
 1. What do we need from a partnership?
 2. What can we offer in return?

This fundamental step is often overlooked in the heat of early discussions about alliances - as it was with the joint venture. One way to do this is to invite clinical and administrative staff to understand “the current state of the business.”

- **Understand the current state.** This assessment is a critical opportunity to test assumptions about what's driving the business against data that reveals what's actually happening. The process reveals areas of agreement and conflict between the partners.

In our case, the joint venture partners had not clearly established (or kept current) their targeted “gives” and “gets,” nor had they developed a process to examine assumptions about how to

Contributors:
Carey Huntington and
Jennifer Tomasik

To learn more about Carey and
Jennifer, [click here](#).

THE FUNDAMENTAL ‘GIVES’ AND ‘GETS’ - THE BASICS FOR EFFECTIVE COLLABORATION IN HEALTHCARE *continued*

reach those expectations. When CFAR helped them conduct a current state assessment, we found that misperceptions of each other’s culture and practices were getting in the way of operational improvements. For example:

- The post-acute system had not bargained on having such a high level of acuity among referred patients, and thus had not thought to negotiate consults that would help prevent patients from returning to the hospital with complications.
- The academic medical center, which had never operated this kind of post-acute facility, was unaware of the many regulations that governed its operations and had assumed the new unit would be able to handle their referral volume and care for patients without sending them back. When these issues occurred, the joint venture acquired a reputation among the academic medical center’s referring physicians for poor quality and sending too many patients back to the hospital.
- **Keep issues on the table.** To keep a clear picture of the current “gives” and “gets” on the table, and the interplay between assumptions and realities on the ground, an alliance needs to co-opt time in regular venues.

The joint venture Board carved out part of their mandatory quarterly meetings to review the current state and reformulate their objectives, coming to an agreement on “gives” and “gets” that allowed the partnership to survive. By using that time, they also established a precedent and a process for considering issues moving forward - supported by skills and a new level of trust that enabled open negotiation of interests.

- **Start with small wins.** Starting small with low-risk projects that appeal to current supporters is a time-honored campaign strategy in many arenas including politics, marketing, and fundraising. They build momentum and trust that forms a strong foundation for larger undertakings.

The joint venture Board chose to address research and education first, although some other areas seemed more pressing - because they knew they could gain from a small win. Both partners wanted to pursue the academic mission. By creating a concise set of agreements about who would participate in research and how education would play a role - and when they could afford to build academic programs - the partners developed something they could communicate to their own institutions. This process, with its small but impactful agreement for the identity of the partnership, built momentum on the ground and the trust and confidence to commit to developing a shared vision.

Effective collaboration is an ongoing, systematic, strategic process. The next segment will examine collaboration in different groups and roles, between physicians and administrators.

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>.

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‘THE 5,000 HOURS’ - THE NEXT FRONTIER IN HEALTH AND HEALTHCARE

The next frontier in healthcare is engaging people outside the confines of hospitalizations and outpatient visits. This is the new frontier because so many of the important determinants of health occur outside of these limited and limiting encounters. Even patients with chronic illnesses may spend only a few hours a year in front of a doctor or a nurse, but they spend about 5,000 waking hours a year doing just about everything else.

“The 5000 hours” are the ones when they live their lives, make choices about what to eat, and whether to exercise. Those are the hours in which they smoke, or not, take their prescribed medications, or not, and even when they decide whether to visit the doctor, or not. And, therefore, those hours strongly influence health outcomes. Yet, those are the very same hours that are typically ignored by the U.S. healthcare system. They are ignored in part because current approaches to U.S. healthcare financing do not reward attention placed on those hours - U.S. healthcare financing supports healthcare that occurs during visits, not between visits - and because engaging people to change their behaviors is hard.

It is a shame these 5,000 hours seem just out of reach because the estimate is about 40% of premature mortality in the U.S. is explained by the personal behaviors that occupy these 5,000 hours. This figure contrasts with the 10% of premature mortality that is estimated to be affected by healthcare as it is traditionally delivered.¹ To be fair, these hours have attracted the attention of some stakeholders, and the result has been the development of disease management firms, telemedicine programs, and transitional care models, each of which attempts to provide some sort of “**hovering**” over patients during their daily lives, with the hope of getting these patients on track and reducing the hospitalizations that make their care so expensive.

Hospitals now have an incentive to join these efforts, because new financing models penalize them for the readmissions they might have perversely welcomed before. But these approaches are personnel-intensive, often requiring nurses to call or visit patients, or staff telemedicine suites. That makes these programs potentially too expensive for all but the sickest patients, and many of those may be so sick it is hard to change their course no matter what. Given the high cost of personnel-intensive hovering, there is at best a narrow band of patient need that can sustain it. The results of these seemingly promising efforts, when carefully evaluated, have been disappointing.²⁻⁵

If some form of hovering is required to engage people during the 5,000 hours, it almost certainly has to become substantially more automated in order to get its cost down. Several recent developments offer some hope for this kind of “**automated hovering**.” The first is a deepening knowledge of how to motivate human behavior. Whereas using financial incentives to motive health behavior is hardly new - many employers and insurers deploy financial incentives now - only a few select and farsighted firms blend these techniques with principles of behavioral economics, a field that really wasn’t around when many of the early efforts at hovering started.⁶ But principles of behavioral economics have been used successfully to improve medication adherence, reduce tobacco use, improve diabetes control, and achieve reductions in obesity. Each of these successes has been demonstrated through carefully controlled randomized trials, and so the evidence base for this work is new, but it is strong.

The second is the expanded reach of both sophisticated and simple technology through cell phones, wireless devices, and the internet that can help connect to people during those 5,000 hours. While it may be cliché to acknowledge that we live in a more connected world, a key lesson from behavioral economics is if you want to affect a behavior that occurs frequently (like taking a medication), then you need to engage that person at nearly the same frequency. That degree of engagement would have been impossible, or prohibitively expensive, before people became so connected to their cell phones and other wireless devices. Neither wireless devices nor behavioral economics were available or part of the disease management programs that have produced some of the disappointing results of the past.

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'THE 5,000 HOURS' - THE NEXT FRONTIER IN HEALTH AND HEALTHCARE

continued

The third force is the increased interest in developing more accountable healthcare financing based less on the process of care, as provided through office visits and hospitalizations, and more on the outcomes that patients achieve. Those changes in financing are emerging only slowly, but their anticipation creates a financial engine to motivate innovation in automated hovering. There are tremendous opportunities here. Many of these are made possible by Section 2705 of the Patient Protection and Affordable Healthcare Act, which dictates, beginning in 2014, employers may adjust the total amount of employer and employee health insurance premiums by up to 30% (50% at the discretion of the Secretary of Health and Human Services) based on outcome-based wellness incentives.

Indeed, an enormous number of firms are entering this space. Some of them are focusing on wellness, aiming to hover over broad populations to increase fitness, reduce obesity, and end tobacco use. Others focus on disease management, hovering over far fewer people, but over many more dollars, aiming to improve medication adherence and reduce secondary cardiovascular risk. The firms hoping to gain some control over the 5000 hours include benefits consultants, drug and device manufacturers, software companies developing apps, and employers who recognize that, no matter what business they think they are in, healthcare affects their bottom line as much as their market share does. And some, of course, are provider organizations and health insurers. Few of these organizations are advanced enough to have the behavioral economics right - that is new knowledge and the expertise is quite limited - but they are busy developing apps and other automated approaches and, with time, some will catch up.

Patient engagement in the 5,000 hours is fundamentally the right thing regardless of financing mechanisms, because it is in the 5,000 hours that so much of health is produced or reduced. New electronic media, financing mechanisms, and understandings of behavior only make hovering that much more feasible. Many firms are attending to the first two of these, focusing on technology or adjusting their strategy to reflect new financing models. But, as in all other endeavors, getting it right will depend less on technology and on financing and more on understanding human behavior, because that is the final common pathway for so much of what is important to health outcomes and healthcare costs.

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A ROADMAP TO REDUCE HEALTHCARE DISPARITIES

In the United States, racial and ethnic minority patients are more likely to receive poor-quality care than their white counterparts¹. These disparities are consistent and widespread, and research has exhaustively documented the vast gap between the care that minority patients *should* receive and the care they *actually* receive².

Healthcare disparities have profound consequences - minority patients experience higher rates of morbidity and mortality, experience complications from treatment at a greater rate, and are less likely to receive appropriate treatment than white patients.³ Furthermore, ***the economic costs of racial and ethnic disparities are staggering***. A recent study estimated that over the next several years disparities (and the increased expenditures associated with that substandard care) will cost the healthcare system more than \$30 billion per year.⁴

In the past 10 years, influential reports and calls to action from organizations like the Institute of Medicine (IOM) and the Agency for Healthcare Research and Quality (AHRQ) have focused increased attention on health disparities. Nevertheless, racial and ethnic disparities in care remain, and some have even worsened over time.⁵ Providers who aim to reduce disparities often don't know how to make a difference. New evidence-based strategies to reduce or eliminate disparities are needed.

In response to this need, in 2005, the Robert Wood Johnson Foundation created the *Finding Answers: Disparities Research for Change* program to fund research on innovative interventions to reduce racial and ethnic healthcare disparities, perform systematic reviews of disparities research, and help put promising strategies into practice.

The *Roadmap to Reduce Disparities*, a framework developed by *Finding Answers*, was recently published in a special symposium in the *Journal of General Internal Medicine*.⁶ The Roadmap provides guidance for healthcare organizations on how to reduce racial and ethnic disparities in care and foster health equity.

The six steps of the *Roadmap to Reduce Disparities* are:

Step 1

Linking Quality and Equity

In the past, disparities reduction and quality improvement efforts have been artificially separated. The first step is to recognize ***equity as a fundamental component of quality***. Then organizations can integrate efforts to reduce disparities into routine quality improvement efforts instead of marginalizing it as a separate effort.

For example, in 2002 the Institute of Medicine reclassified equity from a single component of quality care to a cross-cutting dimension. In practice, this means healthcare organizations should treat equity as a vital part of every component of quality care (effectiveness, safety, timeliness, etc.)

Step 2

Creating a Culture of Equity

At many healthcare organizations, it is necessary to foster change in the organizational culture to support the inclusion of equity as an overarching goal. Our grantees have found that a strong culture of equity is a critical component of successful and sustainable equity-focused quality improvement programs.

Recognizing disparities within an organization can often be a challenge, as demonstrated by Harvard Vanguard Medical Associates (HAMA), one of *Finding Answers*' grantees. When researchers at HAMA assessed provider awareness of disparities, they found 88% of providers surveyed believed quality of diabetes care differed by race in the U.S. overall - but only 40% thought that difference applied to their own patient panel.⁷

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A ROADMAP TO REDUCE HEALTHCARE DISPARITIES

continued

Step 3

Diagnosing the Disparity

Disparities are present in many organizations, but the reasons why they are present can be invisible to providers and administrators unless they are actively examined. This step guides organizations through the process of identifying the root causes of disparities that exist in their patient population and prioritizing which issues to address.

This step also highlights the need to pay close attention to the varied causes of health disparities, which can exist throughout the healthcare system, including issues like patient knowledge, provider awareness, community resources, or organizational protocols.

Step 4

Planning for Equity

This step guides organizations through the process of designing innovative activities focused on disparities reduction. It contains advice on how organizations can plan programs that capitalize on the organization's available resources and are tailored to the needs of a specific patient population.

To assist in this process, *Finding Answers* has also developed intervention materials that include detailed descriptions of grantee projects and tools to build programs that follow established intervention strategies.

Step 5

Securing Buy-in

Obtaining buy-in from key decision-makers for an equity program is vital for ensuring the success of equity-focused quality improvement. This step is a guide to crafting compelling arguments for implementing or supporting equity activities.

The team at Olive View-UCLA, another grantee, tackled the issue of staff buy-in head-on - organization leadership held a meeting with front-line staff, where they explained how the project would affect workload and clinic operations, why the project was worth additional time and effort, and the steps they'd taken to minimize burden and show respect for staff time. In the end, Olive View found engaging their staff directly was helpful in increasing uptake of the activity.

Step 6

Implementing Change

This final segment of the *Roadmap* focuses on best practices for successfully implementing, evaluating, and sustaining equity programs.

One of these best practices is to strike a balance between implementing an intervention strategy consistently and having the flexibility to adapt to unforeseen difficulties. One grantee that did a good job of striking that balance was Sutter Health, whose Remote Video Interpreting (RVI) intervention aims to improve language services in four clinics. While implementing the intervention, researchers realized that the physical arrangement of RVI equipment was inadequate for one of the four clinics. Instead of insisting on adhering rigidly to the original intervention plan, the researchers modified their protocol to allow for a flexible arrangement of RVI equipment, which facilitated better communication between interpreters, practitioners, and patients.

A ROADMAP TO REDUCE HEALTHCARE DISPARITIES

continued

There are no “magic bullets” for reducing disparities, especially across diverse healthcare settings, so the *Roadmap* is not limited to specific intervention strategies. Instead, it lays out a comprehensive and systematic approach to improving minority health⁸, which incorporates best practices strategies from *Finding Answers’* systematic reviews and grantee evaluations. By using the *Roadmap*, organizations can tailor programs focused on disparities reduction to their unique needs and resources.

Finding Answers recently launched a web-based curriculum to teach healthcare administrators and providers the *Roadmap’s* approach to equity-focused quality improvement. It provides several tools to help healthcare organizations assess their quality improvement efforts, plan equity-focused quality improvement programs, and research successful interventions. The online training can be found at www.solvingdisparities.org/tools/roadmap.

By providing organizations an evidence-based framework for reducing racial and ethnic disparities, *Finding Answers* hopes to foster the implementation of equity-focused quality improvement programs. These programs have the potential to improve healthcare quality overall, while also reducing the gap between the care everyone deserves, and the care that many minority patients actually receive.

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THE ROLE OF PATIENT HEALTH RECORDS IN ACHIEVING MEANINGFUL USE AND PATIENT ENGAGEMENT

The patient health record (PHR) is a tool that has the potential to facilitate achievement of two central goals of our national healthcare system: (1) the meaningful use of electronic health records (EHRs) and (2) patient accountability and engagement.

The EHR Incentive Program included in the Health Information Technology for Economic and Clinical Health Act (HITECH), enacted as part of the American Recovery and Reinvestment Act of 2009 (ARRA), promotes the adoption and meaningful use (MU) of electronic health information technology (eHIT). Both Stage 1 and 2 MU objectives and measures include electronic communications with patients, such as providing patients with an electronic copy of their health information, sending patient reminders, and identifying special educational resources tailored to patients' unique needs and preferences. Stage 3 MU is expected to support the goal that information follows the patient – allowing for comprehensive patient data through robust, patient-centered health information exchange.¹

In addition to the MU incentives from the HITECH act, other federal and private programs rely on the principals behind MU for their success. For example, in describing the Physician Practice Connections® – Patient-Centered Medical Home™ (PPC®-PCMH™), the National Committee for Quality Assurance (NCQA) and the Healthcare Information and Management Systems Society (HIMSS) note: “Health information technology (health IT) that supports high-quality patient care (including electronic recordkeeping, electronic disease registries, Internet communication with patients and electronic prescribing) is crucial to a fully functioning medical home.”² New care models such as Accountable Care Organizations (ACOs) that incorporate PCMH standards (and are incentivized by the federal government) also require many of the elements of MU that can be achieved via PHRs (e.g., help patients follow personalized care plans, engage patients and their families in their own care). While it is likely these initiatives will positively influence the adoption of EHR, the process is costly and moving slowly, as indicated by the changes in the final ACO rules, with EHR participation no longer a required condition of participation but rather retained as a quality measure. Initiatives to promote PHR use may provide an easier and more effective means for achieving provider access to healthcare information.

Systemic adoption of a PHR is an optimal approach for initiating patient accountability and engagement, as well as offering affordable alternatives for providers to access patient data. PHR adoption fits easily with current federal HITECH initiatives, is in alignment with the widely embraced social networking movement, and, perhaps most importantly, has the potential to become a driving force toward reducing healthcare costs and supporting culture change. Patient accountability and engagement ought to be the first step, rather than the last step, if the healthcare industry is to transition to patient-centered care.

Limited use of PHRs is not the result of a lack of available PHRs. Currently, patients have numerous options for establishing their own PHR (perhaps too many choices). The American Health Information and Management Association (HIMA) lists PHR products by category (web-based, software or paper; free or purchase). As of July 2012, there were 23 free, web-based PHR options for patient use. Most insurers (payers) have patient portal/PHR options for their subscribers. All certified EHR products have patient portal/PHR components.

Consumers seeking treatment from multiple providers or switching between insurers and/or providers need to move to different eHIT products, a cumbersome process that negates the overriding purpose of using the PHR. The healthcare industry has advanced the use of eHIT in a manner that requires patients to repeatedly report the same health information via kiosks, tablets, or on-line from their personal computers rather than on numerous paper forms. Patients are less likely to embrace the use of eHIT if they are required to access multiple systems, duplicating the same

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THE ROLE OF PATIENT HEALTH RECORDS IN ACHIEVING MEANINGFUL USE AND PATIENT ENGAGEMENT *continued*

information in each system. Also, current EHR use, at best, provides the patient with expanded communication and information alternatives that are important, but does not address accountability for promoting individual wellness.

While patients seek the use of PHRs, the patient as a consumer is not likely to view PHR use as being so valuable that the use of PHR would be the basis for deciding to stay with the “healthcare network/payer.” Regardless, the market’s approach to both EHR and PHR use mirrors other industries where vendor relationship management strategies hold the customer captive, “locked in,” or targets, controls, or manages the “account.” Sooner or later the healthcare industry and PHR developers will be forced to deal with the move toward individual empowerment. Patients will demand flexibility and freedom with their health information.

Incentive payments for providers who successfully participate in programs such as the EHR-HITECH, ACO, PCMH, and Physician Quality Reporting System (PQRS) illustrate the federal government’s commitment to achieving comprehensive patient data through robust, patient-centered eHIT. Federal standards for PHR certification requiring inter-operability and/or portability would mitigate current fragmentation and simplify consumer use. Expanding the authority of the Office of the National Coordinator for Health IT (ONC) to generate standards for PHRs as they do for EHRs would be the most straightforward means to achieve this objective.

The intelligent consumer who seeks maximum accountability of their health information (and that of their children and/or elderly parent) is best off selecting an open-sourced, cloud-based PHR and giving his/her designated providers access to the information. This will spare the consumer from repeated reporting while enabling designated provider(s) and health systems (i.e., emergency rooms) access to the same health information. The Federal government, PHR and EHR developers, and leading healthcare systems should consider escalating the use of PHR as a means to achieve patient accountability and engagement and increase the extent of the meaningful use of electronic health records.

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HOSPITALS, COMPLEX PATIENTS, SPECIALTY DRUGS, AND CHANGING PAYMENT MODELS: THE CHALLENGES AND THE OPPORTUNITY

Introduction

The tectonic shift from fee-for-service to value-based care/capitation coupled with a dramatic rise in the number of patients taking ultra-expensive specialty pharmaceuticals presents major challenges to hospitals striving to manage cost and quality. In this two-part article, a seven-hospital academic medical center highlights its approach to overcoming these challenges while simultaneously maintaining the hospital system’s overall financial health.

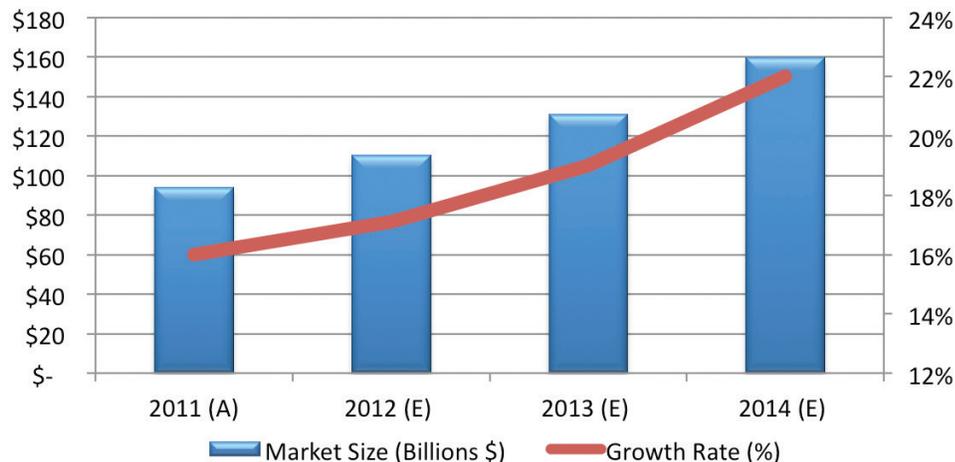
The Challenge - Simultaneously Operating Under Fee-For-Service and Value-Based Care / Capitation

UMass Memorial Healthcare, a seven-hospital academic medical center with \$2.4B of annual revenue in central Massachusetts, conducted a strategic planning exercise addressing, among other issues, the inevitability of capitation returning as a central reimbursement methodology. Within this discussion was a debate on how the hospitals should deal with the “transition” from a fee-for-service methodology to capitation.

As (1) we looked at the reimbursement mix of other healthcare providers who had committed to a strategic plan focused on converting to and succeeding with capitation, as well as (2) reflected on our own hospital experience with capitation from the 1990s, we realized we would spend the next five or so years changing from an entirely fee-for-service reimbursement system to one that would eventually be split nearly evenly between fee-for-service and capitation. One impact of this assumption was that growth component of our strategic plan would thus need to identify services the expansion of which could simultaneously drive the hospital system’s overall financial success while the reimbursement methodologies were at polar opposites.

While there was great interest from each service line to become the focus of our health system’s growth efforts, very few departments could meet these seemingly conflicting criteria. Of the possible options, there was one service that met the bar but we did not currently offer it - specialty pharmacy.

The Growth of Specialty Pharmaceuticals



Sources: Express Scripts Drug Trend Report, IMS Health Forecasts, and Walgreens State of the Industry Report

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HOSPITALS, COMPLEX PATIENTS, SPECIALTY DRUGS, AND CHANGING PAYMENT MODELS: THE CHALLENGES AND THE OPPORTUNITY *continued*

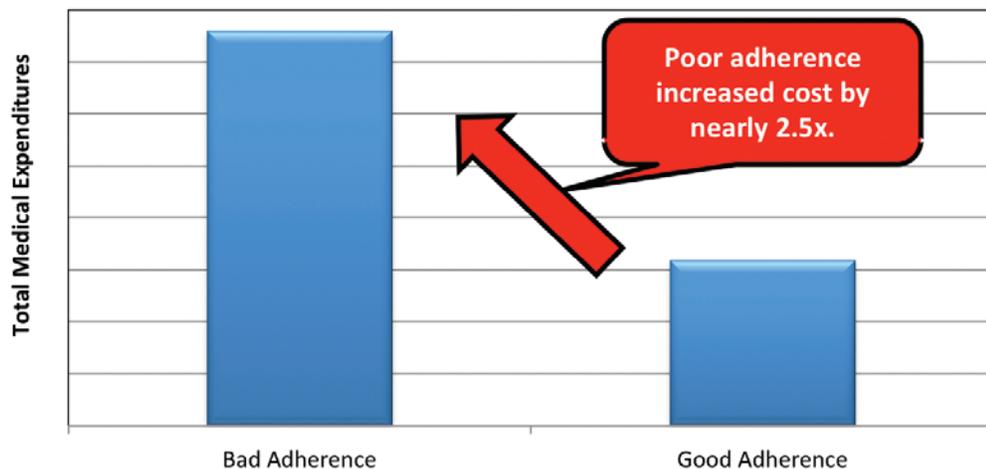
National studies showed that specialty pharmacy had grown upwards of 20% per year, a trend projected to continue, and that by 2020 specialty was estimated to account for 40% of all drug spend. From a broader perspective, we knew 5% of our patients accounted for 50% of our patient care costs. Additionally, the majority of these had multiple conditions and were taking one or more specialty medications. (Specialty medications are high-cost medications, including infused or injectable drugs, that usually require special storage and close monitoring; conditions involved include cancer, transplant, hemophilia, HIV/AIDS, multiple sclerosis, rheumatoid arthritis, hepatitis C, and growth hormone deficiency.)

Quick Facts on Specialty Pharmaceuticals:

- Cost *per month* generally ranges from \$2,500 to \$50,000.
- Two-thirds of new FDA approvals are for specialty drugs.
- 8 of the 10 top highest revenue drugs in 2016 will be specialty.
- Patients on these medications are complex, high-cost, and require regular follow-up.

By becoming its own specialty pharmacy provider, UMass Memorial would have the opportunity to better control the costs of its most complex patients while also keeping that care and revenue within the system, thereby financially benefitting the system regardless of the payment methodology.

The Impact of Medication Adherence on Per Patient Medical Expenditures



Note: Adherence is the extent to which patients take medicines as prescribed, in terms of dose and duration. "Bad" is <20% adherence and "Good" is >80%.
 Source: Sokol et al., *Value of Medicines: Facts and Figures*

Understanding the importance of becoming a specialty pharmacy provider, UMass Memorial also observed the care of these complex patients increasingly migrating from inpatient to outpatient and from outpatient to home. We thus also identified the need (and opportunity) to develop a home infusion service. Developing internal specialty pharmacy and home infusion services would allow UMass Memorial to meet most any pharmaceutical need a complex patient could have.

In envisioning the implementation of this model, UMass Memorial sought to fully integrate care wherever possible, believing it key to improving quality and reducing cost. It sought to provide wrap-around services to patients that would meet their needs regardless of whether they were being discharged from the hospital, visiting an outpatient clinic, or at home. After transplantation, for example, a patient will see their transplant surgeon periodically for the rest of their life. Why not have

HOSPITALS, COMPLEX PATIENTS, SPECIALTY DRUGS, AND CHANGING PAYMENT MODELS: THE CHALLENGES AND THE OPPORTUNITY *continued*

an equally trusting relationship with a transplant pharmacist? And if we were striving to provide the type of care we would want for our own family, we would embed this pharmacist into the clinic so patients could simultaneously meet with their physician and specialty pharmacist.

The Solution – A Hospital-Based Specialty Pharmacy Model of Care

After examining lessons learned from other large hospital systems, UMass Memorial decided to implement a specialty pharmacy model of care that would include (1) a patient service center with a 24/7 call center and home delivery capabilities, (2) pharmacy resources embedded into the care teams of select outpatient specialties, and (3) specialty pharmacy information systems aimed at supporting medication adherence and predictive modeling.

Upon establishing the form and timeline for implementing this component of the strategic growth plan, UMass Memorial soon determined that developing these service capabilities as a department within the existing hospital structure would not be realistic. Consistent with Clay Christensen's Resources-Process-Priorities (RPP) Framework*, we simply could not move quickly enough nor with the requisite agility to maintain the aggressive timeline required (1) to start two new services (specialty pharmacy and home infusion) while (2) also integrating them into the existing clinical mosaic in time to sufficiently impact both the care delivered to patients and the new revenue stream required to buoy the hospital's financials. With this realization, the Board decided to create a separate company in partnership with the hospital system (i.e., a joint venture) to implement the specialty pharmacy plan.

Realizing we couldn't do this alone, UMass Memorial decided to partner with Shields Pharmacy. Shields Healthcare Group (1) had been a trusted partner for over 20 years in the imaging (MRI) space, (2) brought the expertise, speed, and focus the hospital needed, (3) had the technological and operational infrastructure to help this new plan move quickly, and (4) could also provide the customized clinical and financial integration needed to support the high-touch care model we wanted for our patients. Once the partnership between UMass Memorial and Shields Pharmacy was established, UMass Memorial Specialty Pharmacy was officially born.

The Next Chapter – Building and Launching UMass Memorial Specialty Pharmacy

In Part 2 of this article, which will be published next quarter, we will discuss the build and launch of UMass Memorial Specialty Pharmacy as well as actionable lessons learned for other hospitals.

In the meantime, if you have questions, thoughts, or want to talk more about specialty pharmacy, contact Willis Chandler, WG '03, at wchandler@umsrx.com.

* Resources, Processes, and Priorities (RPP) summarizes a model that helps managers determine what sorts of initiatives an organization is capable and incapable of managing successfully. The factors that affect what an organizational unit can and cannot accomplish can be grouped as resources, processes, and the priorities embedded in the business model. For more information, [click here](#).

THE SOLUTION TO AMERICA'S HEALTH PROBLEMS IS SOCIAL

The state of health in America has reached an inflection point. According to the Centers for Disease Control and Prevention, more than one-third of U.S. adults are obese - driving conditions such as heart disease, stroke, type 2 diabetes and certain types of cancer.

What's more, the skyrocketing costs associated with these diseases indicate our nation is facing a health epidemic. Health insurance premiums have increased by 8.5 percent annually for the past decade, according to the Kaiser Family Foundation's 2011 Health Benefits Survey. And Standard & Poor's says health insurance companies and Medicare paid 5.8 percent more per capita for healthcare services in 2011 than in 2010. Unfortunately there isn't a pharmaceutical breakthrough or treatment that will turn the problem around. These costs are driven largely by unhealthy behaviors and climbing obesity rates.

When I started medical school, I was extremely optimistic that I would help people live healthier, more rewarding lives. But as my classes progressed, I became frustrated by the focus on treatment rather than preventing the root cause of disease. I developed a strong desire to drive better health outcomes through prevention at the early stages, long before a patient's emergency room visit or diabetes diagnosis.

When I began seeing patients in the clinic, I found that almost all of them were struggling with how to increase their exercise, lose weight, quit smoking, and live healthier lives. But almost everyone was failing at these important goals. What I noticed was the few patients who did succeed at making a change (such as losing enough weight to lower their blood pressure, cholesterol, and blood glucose levels) all had one thing in common - they attributed their success to the people around them. Indeed, these successful patients always pointed to their trusted social network, which helped motivate and support them in achieving their goals.

I began to realize that obesity and unhealthy lifestyles aren't what we've long considered individual problems based on a lack of individual responsibility. In fact, they are social problems that stem from a lack of collective social responsibility. And with that realization, I set out to harness the power of social networks to help increase the chances of people reaching their health goals.

When I wasn't in class I began setting up a non-profit, social wellness program called ShapeUp Rhode Island. The online platform became extremely popular throughout the local community, but I was most surprised to learn some of its biggest fans were employers.

Businesses have wasted many years and millions of dollars on employee wellness programs. Almost all employers with more than 5,000 employees offer a wellness program, according to the Kaiser Family Foundation's 2011 Health Benefits Survey. Unfortunately, most only have astonishingly poor participation rates to show for their efforts.

According to a ShapeUp survey, wellness budgets are typically 1 to 3 percent of companies' total healthcare spend. Along with these wasted wellness dollars, employers are doing little to suppress rising healthcare costs, and their unhealthy workforce is becoming less and less productive.

A study from Brigham Young University, the Health Enhancement Research Organization, and the Center for Health Research at Healthways found employees with an unhealthy diet were 66 percent more likely than those who ate well to report lost productivity. What's more, smokers were 28 percent more likely to report low productivity than non-smokers.

Of course, regular physical activity and healthy eating are easier said than done, in part because traditional wellness programs have failed to engage workers. Employers cite engagement as their single biggest obstacle to achieving healthy behavior change among their employees, according to a March 2010 National Business Group on Health/Towers Watson Employer Survey.

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THE SOLUTION TO AMERICA'S HEALTH PROBLEMS IS SOCIAL

continued

The use of financial incentives to encourage wellness has delivered some positive results, but paying people to change their behavior is a slippery slope that can lead to diminished returns over time and drastically reduce the return-on-investment for health management programs. Social technology is providing a new, more sustainable, and cost-effective approach for employers to engage their employees in wellness programs. Ninety percent of employers believe health technology has a positive impact on employee health engagement, according to ShapeUp's 2012 Technology and Employee Wellness report.

Social technology is revolutionizing the health and wellness industry because the behaviors that contribute to our health are social. Even though studies show that obesity has been spreading from person to person over the past 30 years, it turns out it is possible to harness that social phenomenon and leverage human networks to spread healthy behaviors too.

Over the past five years, workplace wellness companies have launched solutions that replace their traditional information-driven health promotion approaches with online programs that utilize social mechanics. Web-based programs are now the most popular wellness programs among all employers, according to the Kaiser Family Foundation's 2011 Health Benefits Survey.

The outcomes we're seeing at ShapeUp are a testament to the application of a social approach to wellness. The 15th Annual National Business Group on Health/Towers Watson Employer Survey on Purchasing Value in Healthcare found the typical engagement level for platforms like ours is 30 to 50 percent of a workforce — far above the 22 percent engagement rate for biometric screening, 8 percent for weight management, and 6 percent for health coaching that employers have typically seen.

Social wellness programs leverage teamwork, group support, and competition to drive engagement and outcomes. Employees are motivated by the competition that comes from matching up groups from different departments or worksites. And being part of a company-wide challenge unites employees around the common goal of creating a healthier company culture.

Our research on this model has shown that weight loss is indeed contagious. When one person in the program loses weight the people around them and on their team are much more likely to lose weight. In fact, this weight loss happens in social clusters.

People who reported greater teammate social influence for their weight loss had higher weight losses, and when more teammates were focused on the goal of weight loss, it yielded greater weight losses, according to study titled "Teammates and Social Influence Affect Weight Loss Outcomes in a Team-Based Weight Loss Competition" and published in *Obesity* in February 2012. The paper also found team membership influenced the odds of achieving weight loss of 5 percent or more - a clinically significant amount associated with reduced risk for cardiovascular disease and diabetes.

Social wellness programs are clearly breathing new life into underperforming wellness initiatives and encouraging unhealthy workforces to adopt life-changing behaviors. The results are not only improved health outcomes and lower healthcare costs but enhanced company culture, higher productivity, and stronger co-worker relationships.

Eighty-two percent of employers agree or strongly agree that health technology adoption has helped to achieve better health outcomes, and 72 percent say it has led to cost savings, according to ShapeUp's 2012 Technology and Employee Wellness report.

As a result of what I have seen working in this space for the past seven years, I now believe the greatest health problems that we face as a nation must be solved using a social approach. For far too long we've treated health as a personal, private journey. But we've now learned that health is truly social and heavily dependent on the people in our social networks. It's time to start sharing, working together, and taking responsibility for each other.

POTENTIAL IMPLICATIONS OF THE SUPREME COURT DECISION ON MEDICAID

The June Supreme Court decision regarding the Affordable Care Act has many implications for healthcare in the U.S., both now and in the years to come. One of the many areas impacted is the Medicaid program. Some of the potential cascading effects include:

- Expansion - opt in/opt out decision
- Maintenance of Effort (MOE)
- Affordable Care Act (ACA)-mandated Disproportionate Share Hospital (DSH) reductions
- Medicaid provisions outside of the expansion decision – denial of Hospital Acquired Conditions (HAC) and increase in primary care payments

EXPANSION OPT IN OR OPT OUT?

The ACA required states to expand Medicaid, based on Modified Adjusted Gross Income (MAGI) up to 133 percent of the Federal Poverty Level (FPL). In addition, 5 percent of income was disregarded, making the Medicaid eligible expansion population de facto up to 138 percent of FPL. The expansion would add a large group of childless adults as newly insured Medicaid beneficiaries. (Currently, federal standards do not require - and most state Medicaid programs do not cover - childless adults.) Further, the law stipulated that a state would lose all of its federal Medicaid funding if it did not expand its program.

But the Supreme Court determined states could decide not to implement the Medicaid expansion without facing the penalty of losing all federal Medicaid funding. Essentially, states have the option to opt in or out of the expansion. Now states are in the process of analyzing the short- and long-term impacts of those two options. While the federal government will fund 100 percent of the new expansion population in the initial years, states will pick up 10 percent of the new expansion costs in later years and fear having to fund this group entirely when the federal funding ends. States already are struggling to fund their existing Medicaid costs and do not want to make additional entitlement commitments. States also are concerned about the projected impact caused by increased awareness of these programs, anticipating that in 2014, large numbers of adults and children who already are eligible for Medicaid or CHIP but not enrolled will sign up, the so-called “woodwork” effect.

States have asked the federal agency, Health and Human Service (HHS), to allow flexibility in the timing of the expansion and also the income level of the expansion. States have realized the ACA offers subsidies to individuals beginning at 100 percent of the FPL. The ACA drafters envisioned all low-income individuals having a pathway to health insurance coverage, either through Medicaid or CHIP or an individual Exchange plan supported by federal subsidies. *Now, if a state opts out of the Medicaid expansion, it will have a group of uninsured childless adults who do not qualify for the Medicaid program and, ironically, have incomes too low to qualify for federal Exchange subsidies, with incomes below 100 percent FPL.* States have asked HHS to allow them the flexibility to expand Medicaid up to a level below 138 percent FPL, for example up to 100 percent FPL.

MAINTENANCE OF EFFORT (MOE)

State Medicaid programs are required to maintain the eligibility and redetermination processes that were in place when the ACA was passed or risk losing all federal Medicaid matching funds. Historically, states have reduced Medicaid expenses by tightening eligibility standards and increasing Medicaid eligibility redetermination administrative hurdles during periods of fiscal distress. Medicaid enrollment is counter-cyclical, since enrollment increases during recessions. The rule of thumb used in policy circles is that for each 1 percent increase in unemployment, Medicaid enrollment increases by 1 million nationally. Maine’s governor is threatening to litigate the MOE

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POTENTIAL IMPLICATIONS OF THE SUPREME COURT DECISION ON MEDICAID

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issue, as he wants to decrease the state's Medicaid enrollment by altering existing eligibility standards. The state is preparing to file a waiver with HHS to ask federal permission to alter Medicaid eligibility. Maine's actions, if approved by HHS, could be precedent setting for other states.

ACA MANDATED DSH REDUCTIONS

The ACA mandated that HHS reduce Medicare and Medicaid disproportionate share hospital (DSH) payments over eight years, from 2014 to 2021. States have used DSH to get federal funds to help pay for uncompensated hospital care. For some states, DSH is a big part of their total Medicaid funding, the loss of which would be devastating to hospitals and their local economies. HHS has not yet released regulations on the DSH methodology. Since the Obama Administration and HHS are trying to encourage states to implement the Medicaid expansion, I would expect the final DSH regulation will be written in a manner which would support that policy goal.

OTHER ACA MANDATES - DENIAL OF HAC

The Supreme Court ruling left the bulk of the ACA in place. Medicaid programs can no longer use federal funds to pay for hospital-acquired conditions beginning in July 2012.

OTHER ACA MANDATEDS – HIGHER PAYMENTS FOR PRIMARY CRE

States are required to file State Plan Amendments to pay for Medicaid primary care services at Medicare payment levels in 2013 and 2014. These higher payments apply to both state fee-for-service and Medicaid managed care programs. The federal government will fund the incremental cost of the higher payments. The final HHS rule on the higher payments has not yet been released.

SUMMARY

States are grappling with a large work effort to:

- Update their Medicaid and CHIP eligibility systems to support MAGI by 2014
- Prepare for the 2014 Exchanges
- Implement ACA requirements such as denial of HAC and higher primary care payments, and
- Analyze the impact of opting in or out of the Medicaid expansion.

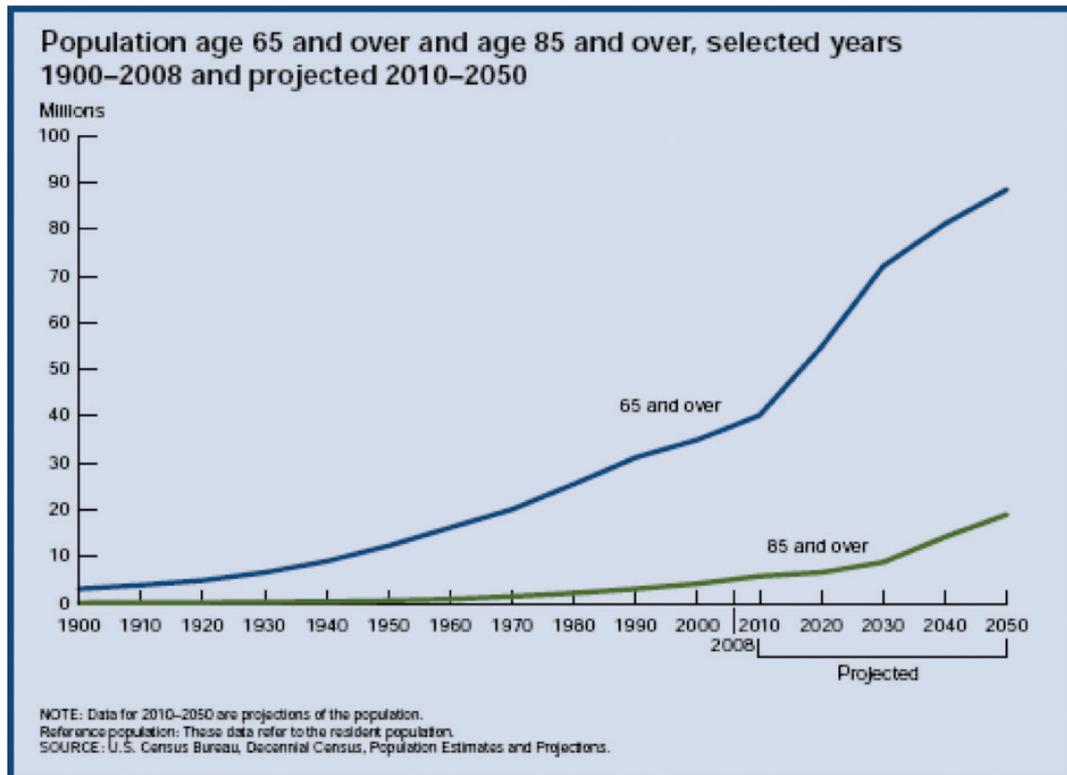
My advice is to be prepared for a lot of “noise” prior to the election and, then a flurry of state activity in 2013.

DISCLAIMER

The views expressed by the author are her own and not necessarily those of her employer or any other organization of which she is affiliated.

RESEARCH IN AGING AND ITS PLACE IN HEALTHCARE MANAGEMENT

In 2011, the Boomer generation - the 78 million people born between 1946 and 1964 - began making the transition from middle to older age. Over the next 18 years, 10,000 people in the U.S. will reach age 65 every day. By 2030, they will constitute 20 percent of the total population, up from 13 percent in 2010. It is a demographic swell that will inundate the national healthcare system like a tsunami.

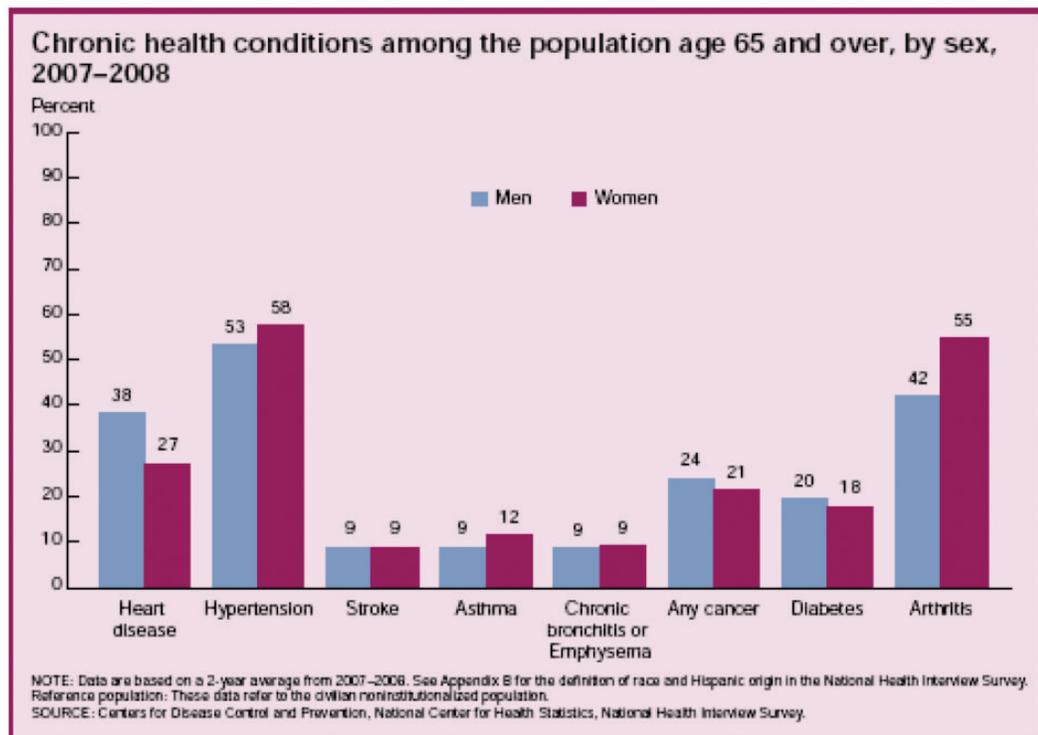


Currently, eight in 10 older adults develop at least one chronic medical condition - heart disease, cancer, dementia, Parkinson’s disease, diabetes, rheumatoid arthritis, osteoporosis, cerebrovascular disease, or kidney failure, to name a few - and the majority will have two or more. In fact, according to a report from the Institute of Medicine (IOM), *Retooling for an Aging America*, one in five Medicare beneficiaries copes with *five or more* concurrent chronic conditions. They also experience more falls and malnutrition, as well as mental health issues such as depression and anxiety. As film star Bette Davis famously said, “Old age is no place for sissies.”

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RESEARCH IN AGING AND ITS PLACE IN HEALTHCARE MANAGEMENT

continued



As a result, today's older adults use healthcare services far more than any other age group. They account for :

- 26 percent of all physician office visits
- 34 percent of all prescriptions
- 35 percent of all hospital stays
- 38 percent of all emergency medical service responses
- 47 percent of all hospital outpatient visits with nurse practitioners
- 90 percent of all nursing-home use

As the older U.S. population nearly doubles in the coming decades, most of those numbers will drastically increase. But that begs a critical question “How will we meet that need?” There are a number of challenges.

First, we're short on medical specialists. According to the American Geriatric Society's Geriatric Workforce Policy Studies Center, about 7,000 geriatric physicians currently practice in the U.S. That's only one for every 2,620 Americans aged 75+. However, while demand for these specialists grows, the supply, in real numbers, is shrinking - a troubling trend. By 2030, the doctor-to-patient ratio is expected to drop to one geriatrician for every 3,798 seniors.

Second, there is a lack of information about how best to treat older adults medically. Drug trials often exclude them because their co-morbid conditions and medical histories could confound outcomes data in a misleading way. As a result, we often don't really know if medications appropriate for a 40-year-old healthy male will be safe and effective for use with his 83-year-old, enfeebled counterpart.

RESEARCH IN AGING AND ITS PLACE IN HEALTHCARE MANAGEMENT

continued

Our knowledge from experience doesn't help much either. Most of our doctors and hospitals choose treatment options based on an acute care model - a sick patient presents with an illness or injury, and all medical efforts go toward quickly effecting a cure. Elderly people with multiple, slowly progressing, debilitating chronic conditions, however, often require a different approach - more geared toward disease management, symptom relief, and maintenance of their ability to perform the activities of daily living.

Unfortunately, much of our healthcare delivery system isn't set up to do that. Treating a frail, older woman, who has no family support, for concomitant osteoporosis, kidney failure, and early Alzheimer's disease can quickly outpace the ability of any single professional to cope. In fact, cases like these - and millions of them show up in doctors' offices, clinics, and ERs every year - call for a re-imagining of our healthcare delivery structure. As the challenge becomes more and more critical, the need to work in coordinated, cross-disciplinary teams will be inescapable. But that's no easy task, and our store of evidence-based best practices is only now beginning to accumulate.

So to prepare for the onrushing tidal wave of healthcare demand, we simply need to learn more. How do we create treatment models appropriate for older adults? How do we improve medical decision-making with regard to triage, i.e., what to treat and what not to treat? How do we create an effective, affordable, cross-disciplinary, team-based approach to care, both during treatment and post-treatment phases? How do we help seniors navigate the complexities of their own healthcare? Are there ways we can significantly improve end-of-life care? And of course, how do we prevent, cure, or manage the currently intractable maladies and diseases of aging?

Obviously, then, when we talk about the future of healthcare management, we're largely talking about eldercare and mitigating its effects. If we are to be successful in that future, we need to meet its challenges with an arsenal of knowledge and evidence that we can establish only through a serious commitment to maintaining robust, long-term research programs - whether they're located in government and foundation-supported institutions, large pharmaceutical companies, or small incubator biotechs. That means a commitment of will and resources that we have perhaps never before demanded of ourselves. The complexities and obstacles ahead are formidable. It is up to those of us engaged in the business of providing better healthcare knowledge, healthcare infrastructure, and healthcare services to meet this challenge, as our nation's population advances in age.