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QUICK LINKS

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Have an article to contribute or words of wisdom for the Philosopher’s Corner? Send Email
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For more information, please contact:

C. MITCHELL GOLDMAN
Partner
Duane Morris LLP
30 South 17th Street
Philadelphia, PA 19103
P: 215.979.1862
cmgoldman@duanemorris.com
EDITOR’S LETTER

Happy New Year!

As we begin 2017, we are hoping to launch a new series, “The Entrepreneur’s Playbook,” which will focus on entrepreneurs and start-ups across the spectrum of the industry. We would love to hear your story, so if you are interested in contributing an article please contact us at whc_e-magazine@whartonhealthcare.org and complete this template.

Thanks to all who completed the WHCMAA survey! Your feedback and ideas will help guide the Association in its efforts to be constantly evolving to address your interests and meet your needs over time.

More to come........

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

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Dear Friends,

If you are like me, time is your most precious commodity. With all of the options to spend time with family and friends, or getting one more work task done, why should your business school alumni association take priority? Let me try to explain.

The Wharton Health Care Management Alumni Association (WHCMAA) is the leading network in the business of health. WHCMAA members span every aspect of the vast healthcare industry. Our members include internationally recognized leaders and fresh MBA graduates, those who are mid-career, and those who are retired and in the business of giving back, including:

- over 2,000 MBA alumni from the Wharton Healthcare Management program
- 3,000 Wharton MBAs in the business of health who are eligible to become affiliate members of WHCMAA

What do we do?

- award the Kissick and Kinney scholarships to three outstanding students every year and raise funds for these scholarships
- support the Wharton Global Health Volunteers annual trip to help students gain insight and experience in locations across the globe
- organize the alumni conference for in-depth, thoughtful discussions among healthcare leaders
- present a weekly radio show on Sirius XM Radio
- publish the Wharton Healthcare Quarterly
- host the Wharton Healthcare Knowledge Network (WHKN) listserv
- host alumni gatherings at industry events like the annual JPMorgan conference in San Francisco and in major cities
- provide career development support at all stages of our careers

What this means to you is many opportunities to engage, grow, and give back with the WHCMAA.

- You can connect with other insightful alumni through the WHKN listserv, gatherings, and the alumni conference.
- You can participate in activities, or help to organize them, connecting with the amazing volunteers on the Board and committees which support and do the work of the WHCMAA.
- You can submit an article to the Wharton Healthcare Quarterly.
- And this year, the student-led Wharton Global Health Volunteers is interested in some alumni joining them on their trip!
As I have often repeated, the WHCMAA is the leading network in the business of health. As a Wharton alum in healthcare, you have a unique opportunity to connect and be part of a community of healthcare business leaders and to support students who are following in your path.

That’s an opportunity that’s worth your time.

Warm regards,
John Harris
President
Wharton Health Care Management Alumni Association

To contact John:
JHarris@Veralon.com
877.676.3600
THE PHILOSOPHER’S CORNER

Life Lessons:

If I knew then what I know now, I would have:
... said “no” more frequently.

If I knew then what I know now, I would not have:
... eaten that second McChicken. No matter what people say, there is no way two is cheaper than one.

Favorite Quotes:

1. “Of course it was cause and effect, but in the necessity with which one follows the other lay all tragedy of life.”
   ~ W. Somerset Maugham
2. “Minds differ still more than faces.” ~ Voltaire
3. “My mission in life is not merely to survive, but to thrive; and to do so with some passion, some compassion, some humor, and some style.” ~ Maya Angelou
4. “We do not know what we want and yet we are responsible for what we are — that is the fact.”
   ~ John-Paul Sartre

Recommended Reading:

• *We Are All Completely Beside Ourselves* by Karen Joy Fowler
• *High Price* by Carl Hart
• *Dreams from My Father* by Barack Obama
• *Half of a Yellow Sun* by Chimamanda Ngozi Adichie

Contact Alessia at: alessia113@gmail.com
Jill Ebstein, WG’83
I just released the second book of the At My Pace Series, subtitled Lessons from Our Mothers. Sons and daughters explore ONE single lesson from their moms that has impacted them in short pieces, chock full of stories. In some instances, the contributors had to work through complicated legacies but were able to arrive at a place of peace and understanding. Others offer humor, poignancies, and intent to “pay it forward.”

The official book launch was November 13, at Porter Square Books in Cambridge. The book is available on Amazon by searching either my name, At My Pace, or Lessons from Our Mothers. At My Pace is a series of books that are focused on a single topic with shared stories to help enlighten us and expand our conversation. I am early on in developing the brand. Should you read my book(s), I would be most appreciative for Amazon reviews, and of course any feedback to me personally.

Contact Jill at:
jebstein@gmail.com
www.atmypacebook.com

ALUMNI NEWS

In Every Issue

It’s estimated that total enrollment in private health insurance exchanges by active employees will reach about 40 million by 2018. The private exchange solution presents an opportunity to offer employees an attractive health benefit package while responsibly managing or even capping company costs—even in the face of legislative uncertainties.

Of the private exchanges, only one offers the experience you want with the highly adaptable solution you need: OneExchange. We’ve done it for nearly a decade, supporting full- and part-time employees as well as early and Medicare-eligible retirees. The best time to future-proof your benefits program? Before the future gets here. Visit us at chooseoneexchange.com and see what we can do for you.

A:
Decide that you don’t want to be on the bleeding edge with such a big, strategic decision

B:
Realize that using a private health exchange has become the leading edge, adopted by forward-thinking companies
**Douglas S. Arnold, WG’84**

Doug Arnold is now the CEO of the American Healthcare Connect Consortium, which he formed in 2014 to access some of the $400 million in annual grant funds available from the FCC Rural Health Program’s Healthcare Connect Fund. To date, Doug has obtained $850,000 in HCF grants for federally qualified health centers that are part of his consortium, with another $775,000 in HCF grants for consortium hospitals under review.

Contact Doug at:
Douglas S. Arnold, MBA
American Healthcare Connect Consortium
20 Neal Drive Simsbury, CT 06070
860.217.1320
860.214.1955 (cell)
dsarnold27@comcast.net

**Jeff Voigt, WG’85**

Recently published:


Recently elected Councilman, Village of Ridgewood, NJ, May 2016

Celebrated 25th show as host of The Business of Healthcare on SIRIUSXM 111

Contact Jeff at: meddevconsultant@aol.com
**ALUMNI NEWS**

**Beverly Bradway, WG’91**
After a long career pause, I successfully found a way to return to work with a firm that allowed me to pursue my passions for business and healthcare. Alacura, an air medical transportation company backed by the PE firm Vistria, is supported by an experienced team of healthcare professionals building a new business model for air medical non-emergent and emergent transportation. By assembling a highly credentialed network of transportation providers; consolidating operational oversight for patients (bedside to bedside); and affiliating with payors (large and small) to manage benefits in an otherwise unregulated segment of healthcare, Alacura is defining the market of Medical Transportation Benefits Management. It is an approach that brings value to patients, providers, and payors alike. As more and more care moves to Centers of Excellence, and the need for flexible air transport grows, the corresponding demand for safe, high quality, patient (member) focused service will also increase. One need only read a single article about egregious charges and painful out-of-pocket costs for consumers to understand the risks we face without the control. Alacura is well-positioned to lead in this necessary and important part of healthcare service. We would love to hear from anyone with interest in learning more about Alacura.

Contact Bev at:
Bev Bradway
Marketing/Communications – Alacura
bbradway@alacura.com
844.425.2287

Contact David at:
David Boone
CEO—Alacura
dboone@alacura.com

Learn more.

**Laura Brady Saade, WG’93**
Laura has recently been appointed Director of Strategic Planning, UCLA Department of Neurology.

Contact Laura at:
lasaade@gmail.com
ALUMNI NEWS

Sally Poblete, WG’00

Sally Poblete has been named by Becker’s Health IT & CIO Review as one of “17 Female Health IT Company CEO’s to Know.” Sally Poblete is the Founder and CEO of Wellthie, a healthcare technology company offering insurance e-commerce software and analytics solutions. Wellthie has been honored as one of AlleyWatch’s “30 Tech Start-ups with the Potential to Change the World.” The company was also named one of Forbes’ “10 Healthcare Technology Disruptors to Watch, All Led by Women.”

Contact Sally at: spoblete@wellthie.com

Learn more.

Paul J. Tirjan, College of Arts & Sciences ’89, WG’01

Began a new adventure in August as President of a consortium of non-profit integrated delivery systems called AllSpire Health Partners focused on collaborative innovation and investment in healthcare.

Contact Paul at: Paul.Tirjan@AllSpire.org

Learn more.

Brian Holzer MD, WG’05

Highmark Health has established a new organization, HM Home and Community Services LLC (HM HCS), dedicated to transforming post-acute care by increasing quality, service, and value for patients. Brian Holzer, MD has been named President of HM HCS. He will also continue to oversee the delivery system’s post-acute care operations, AHN Healthcare@Home, which he joined in 2013.

HM HCS is incorporating an innovative strategy aimed at shifting post-acute care contracts, starting with skilled nursing facilities and home health care agencies, from a fee-for-service incentive model, to a quality and outcomes-based incentive model. By working with at-risk payers and providers to leverage their claims and utilization management data, HM HCS will align pay-for-performance incentives to quality and outcomes.

Contact Brian at: Brian.holzer@highmarkhealth.org
412.544.5576

Learn more.
Technology is shaping the healthcare industry, but implementation is burdensome, expensive, and uneven. Critical to the transition from a paper-based to a technology-based infrastructure is the successful adoption of electronic health records (“EHRs”) by hospitals, physicians, nursing homes, and other providers. But the relationship between providers and their EHR vendors has not always been easy, and the U.S. Department of Health and Human Services (“HHS”) became sufficiently concerned about EHR vendor-provider contracts to release guidance entitled “EHR Contracts Untangled: Selecting Wisely, Negotiating Terms, and Understanding the Fine Print” (the “EHR Guidance” September 26, 2016). Although the government generally avoids counseling parties on contracting matters, it weighed in under its mandate to advance the adoption of technology. This is notable given the anticipated loosening of government oversight by the Trump administration, which likely will direct agencies away from offering detailed contracting advice. It is too early to tell whether the EHR Guidance will remain as is or be modified or withdrawn under the new administration.

Pursuant to the Health Information Technology for Economic and Clinical Health (HITECH) Act, HHS is authorized to establish programs to improve healthcare quality, safety, and efficiency through the promotion of health information technology (“HIT”) through the Office of the National Coordinator for Health Information Technology (“ONC”). The ONC is specifically charged with the development of a nationwide HIT infrastructure that permits the exchange of EHRs and other health information between and among healthcare entities at the community, region, state, and ultimately national level. This system depends on the sturdiness of the foundational provider-based EHR built by an EHR vendor.

As more and more providers have implemented EHRs, there have been increasing concerns within the government and among stakeholders regarding the complexity and fairness of some provider-EHR contracts. Although there are many hospitals and other providers with experienced IT staff, counsel, and consultants who are able to properly negotiate multi-year, multi-million dollar EHR contracts, there are many less sophisticated providers who may not fully understand what is covered by the EHR vendor contract. Further complicating the environment is that many providers maintain several legacy and clinically-based EHR systems (an EHR each for the emergency room, the physical therapy department, the children’s unit, etc.) And, there are many EHR vendors with varying degrees of experience and sophistication.

Given these issues, there are many operational and legal risks associated with EHR vendor contracts, including data breaches, licensing disputes, and patient harm caused by EHR malfunction. For instance, as covered entities under the Health Insurance Portability and Accountability Act (“HIPAA”), healthcare providers may be subject to significant fines and penalties for data breaches, even if the breaches are caused by vendors. A provider may not understand when it has breached a third-party’s intellectual property license. Or, an EHR vendor may not create adequate safeguards to protect against malware that could impact clinical decision-making or even shut down an EHR system. Additionally, hospitals and physicians are exposed to the loss of government incentive monies and fees for not implementing EHRs on a timely basis. One hospital sued an EHR vendor for not implementing an EHR system under the timeframes set forth in the contract, thereby causing the hospital...
financial loss. The vendor argued that it was the lack of compliance by the caregivers and other end-users that caused the delay. These problems are not uncommon.

The ONC’s recommendations in the EHR Guidance derive from the government’s interest in quality of care and patient safety issues. The ONC urges providers to be particularly mindful of the risk and warranty provisions contained in contracts with EHR vendors. The new publication directs providers to ensure that all vendor core services and performance obligations are expressly stated in the EHR contract, and cautions against assuming that vendors will comply with all EHR maintenance requirements that are outside of the written contract. Providers should insist that EHR vendors warrant to such representations as reasonable system response times, provision of ongoing support and maintenance, and service agreements. Vendors should also warrant to the interoperability of their products with other components of an EHR infrastructure, including with any legacy systems. If they can’t ensure interoperability, the contract should state how those problems will be addressed. These are all foreseeable risks and should be covered in the contract.

In addition to identifying these risks, the EHR Guidance delves into risk allocation, recommending that risks be equally divided between the provider and the EHR vendor. The government advises that both parties should share risk related to patient safety and confidentiality issues – more traditional areas of government oversight – but also recommends that EHR contracts expressly attribute responsibility to the party with access to back-end controls, network processes, and hardware and software contractors. Finally, the ONC encourages providers to be aware of any caps on vendor liability. The financial damage can be enormous when a vendor is only liable for a fixed amount of damages, as is the case in many existing contracts.

Overall, the guidance reinterprets basic principles of successful contracting - the careful description of the services, the identification of potential and foreseeable issues, and the proper allocation of risk – for the EHR environment. Whether one agrees with the ONC’s approach or not, and whether or not the government will continue to promote the guidance in current form, the guidance provides helpful tools for parties, and particularly providers, engaged in EHR contracting.

Additional resources relating to the implementation of EHR systems is available on the U.S. Department of Health and Human Services website. The entire text of the ONC’s recent guidance can be found as part of the ONC’s Health IT Playbook, at https://www.healthit.gov/playbook.

Contact Lisa at: LWClark@duanemorris.com
NOT A FREUDIAN SLIP: STOP DECLARING NEW YEAR’S RESOLUTIONS!

If you set a New Year's resolution, you are not alone. Over half of the population admits to declaring a fresh start on the horizon of the New Year.¹ The “Fresh Start Effect,” as Dai describes could be a new year, birthday, or holiday, which establishes a new mental time period. These time landmarks signal the beginning of a new cycle and can “induce people to take a big-picture view of their lives, and thus motivate aspirational behaviors.”² Further evidence reveals that life changes and goal-directed behaviors are directly correlated to new beginning time periods.³

It makes perfect sense that fresh beginnings coincide with the New Year. Maybe that's why there is a surge of traffic on dating sites the first week of January and a 26-38% increase in registrations.⁴ Or why January is considered “divorce month,” as the number of divorce filings is one-third more than normal, as unhappy couples, who are reluctant to break up the family during the holidays, hold out until January to file.⁵ Or why self-improvement and dieting books sales increase.⁶ However, even with the new time effect that initiates changes, evidence also shows that less than 10% of resolutions are achieved.⁷ Why?

For one, as holiday festivities come to an end, the financial impact of holiday spending begins to set in as bills are mailed, making it a difficult time for millions of Americans. The third Monday of January, Blue Monday, is considered the most depressing day of the year.⁸ The combination of colder and darker days, financial obligations, and the thought of failing to meet New Year’s resolutions can pile up to make this time of year more stressful than normal. Secondly, the focus on short term resolutions and goals misses the bigger picture. Short term goal attainment, versus working toward purposeful fulfillment, brings short term change, if any at all.

Focus on Purpose, Not Goals
Many confuse goal setting with fulfilling their purpose. A goal might be to lose weight; however, your purpose might be to be a woman whose dedication to family, friends, and community is an inspiration to others. Achieving an exercise goal that helps you get to a healthy weight does positively impact your life and longevity, but what is the purpose behind wanting to maintain a healthy weight in the first place? To be able to live the purpose you identified, maintaining a healthy weight is one of the specific things you will need to focus on along your journey, but not the complete purpose.

Shifting focus from goals and resolutions to your greater purpose clarifies the vision for your life as a whole. Defined by your true self, not external circumstances, a purpose influences the choices you make and the behaviors you change or adopt. With this frame of mind, choices that may take you off your path won’t stop you in your tracks, as long as you readjust and remain committed to reaching your overall purpose. This differs from goal setting, which is many times halted once a weekly measure is missed.

If the purpose, the reason why, is missing from the goal setting exercise, you are likely to fail. Taking this a step further, If the reason why, albeit worthy, is not tied in some way to your broader life purpose, achieving success will be challenging, set backs will seem insurmountable, and your intrinsic motivation will be low. Working towards a short term goal can include mundane activities that require you to do things that you don’t necessarily enjoy. If you focus on the measurable goal of losing twenty pounds in two...
months, it’s much harder to stay committed and disciplined in making a new routine. When you set out to reach your purpose, the perspective is different, the range of focus is bigger, and the intention of your actions becomes more meaningful. The action is no longer something you should do or should impose on yourself. Now with a deeper understanding of yourself, the actions you take become more purposefully aligned.

Pause and Discover Your Purpose
Many people hold off until January or other fresh start moments to make life changes as revealed above. However, taking a purposeful pause to understand what matters most to you, what core values define you, and what you are truly passionate about doesn’t have to wait for a landmark date. Taking a pause to open up and step outside of your comfort zone to reveal truths allows you to purposefully move forward instead of blindly pushing ahead to please others or letting the fear of change or failure paralyze you. The silence inside the pause allows you to mindfully listen to your heart, drown out the external noise, and set your sights ahead, not just on the near term.

1. Purposeful Alignment
2. Realistic Planning
3. Mindful Choices
4. Intentional Actions

Plan Your Steps and Prepare a Solid Foundation
Working towards new behaviors takes more than deciding on a goal or future state to work towards. Being knowledgeable and aware of the direction you are headed and the steps you need to take to get there will bring you closer to your life’s purpose. Defining these steps also helps to clarify which action to take first when there are competing priorities. Having one focus simplifies your journey towards a specific outcome, as too many competing priorities become distracting. Many people can be overwhelmed by detailed goals every few months that become challenging to grasp.

Further, realistically planning for the knowns and unknowns can mean all the difference. Building a strong foundation and a supportive network in an environment that reinforces positive behaviors influences success. Research shows that a person’s environment plays a large role in the behaviors they display. So set yourself up for success and enable making positive behaviors easy by identifying things in your surroundings that could get in the way of your pursuit or could be more practical to incorporate into your every day.

Also remember that the influencing power of your social network, friends, family, coworkers, etc., plays a large role in the choices you make. Partner with people in your network who support and reinforce you, and stay clear of others whose influence may be more damaging than positive.

Lastly, preparing for the ‘what ifs’ helps you consider ahead of time how you will conquer the many obstacles, temptations, and distractions along the way. “What if” thinking helps you anticipate challenges and problem solve around them or remove them all together.
Pursue Your Purpose with Positive Intention

A person’s mindset is one of the greatest predictors of success. Just by focusing on what you want to be or new behaviors you want to manifest improves your chances of success. Pessimistic negativity draws attention to what you want to stop and brings doubt and self-sabotaging thinking, whereas optimistic positive intention frames your outlook and can boost self-confidence and self-compassion when you are discouraged by setbacks.

In addition, being mindful of your thoughts and intentional in your actions can foster well-being and result in numerous health benefits. Mindfulness is positively associated with psychological health, reducing distress, and even predicting relationship satisfaction. Specific capacities such as calmness, clarity, and concentration have been observed in individuals who practice mindfulness, thus strengthening cognitive flexibility and ability to adapt to stressful or negative situations. Improving one’s ability to focus, sustain attention, and suppress distracting information is critical as one pursues behavior change.

Reaching Success and Fulfilling Purpose

As organizations look to influence healthy behaviors, offering programs that get to the core of the individual’s purpose will ignite sustained motivation and produce true change. For individuals in the middle of a New Year’s resolution quest, pausing to discover their greater purpose will ensure the focus is meaningful and likely more successful. Align your day-to-day actions with your purpose, and let your values anchor you when you get off track. And don’t forget, planning helps to ensure that your energy is focused on mindful actions that move you closer to fulfilling your purpose.

Contact Connie at:
connie.mester@gmail.com
919.448.7190

References


NOT A FREUDIAN SLIP: MOTIVATION: TRANSLATING MOTIVATION INTO ACTION – PART 2


THE NEUROSCIENCE OF GRATITUDE

What you need to know about the new neural knowledge

This article is a companion piece to the “Discovering the Health and Wellness Benefits of Gratitude” entry in the October 2016 issue of the Wharton Healthcare Quarterly.

Along with the growing research on the health and wellness benefits of gratitude, there are collective studies being conducted on the correlates of gratitude and neuroscience and the impact on organizational wellness. With this new neural knowledge, new vocabulary words have been developed, including neuroleadership, neurobusiness, neuroinfluence, neuromarketing, and even neurorecruiting. In addition, there are refreshing attributes to well-established leadership development contexts, such as how an active practice of gratitude increases neuron density and leads to higher emotional intelligence.

Organizational frameworks also benefit from this new neural knowledge. Corporate rewards and recognition programs that adopt the latest research can create greater opportunities to express gratitude and recognition, both found to improve overall psychological capital, PsyCap, of the workforce. Knowing what our brain looks like on gratitude is helping to improve employee engagement and the lessening of undesirable employee behaviors.

Are you looking to create a more positive culture in your organization? According to Globoforce, a multinational company supporting social recognition practices, gratitude is part of the secret sauce for building a great culture. In the award-winning book, The Power of Thanks, authors Eric Mosley and Derek Irvine (CEO and VP of Globoforce) highlight the importance of gratitude and appreciation as prime movers of greater productivity and a factor that helps organizations thrive.

And, we can even mix-up some “neurochemical cocktails” to enhance employee engagement and organizational performance.

A Shot of Dopamine – whether expressing gratitude for what’s good in life or showing gratitude to someone who has helped us at work, neural circuitry in our brain (stem) releases dopamine. Dopamine makes us feel good! And, because it feels good, we want more. It triggers positive emotions, we feel optimistic, and it fosters camaraderie. It also drives prosocial behaviors. Ah-ha! Put that under how to enhance performance, because dopamine has been linked to intrinsic motivation in goal accomplishment, whether academic, personal, or professional.

A Swig of Serotonin – when we reflect on or write down the positives in life and at work, our brain (anterior cingulate cortex) releases serotonin. Serotonin enhances our mood, (think anti-depressant), our willpower, and motivation.

And yes, serotonin has also been called the happy molecule. So what’s so bad about happy employees???

To stay on point...the more we activate these “gratitude” circuits, the stronger these neural pathways become and the more likely we are to...
recognize what's going right instead of always looking at the problem. From a neuroscience view, or Hebb's Law, “neurons that fire together wire together.” That’s where neuroplasticity - the brain's ability to form new neural connections throughout life – comes in. Who says you can’t teach an old dog new tricks? But I digress.

Just think about how easy it is to only notice the negative or how hard it is to break a bad habit. Those neural pathways are well traveled. The same can happen when we shift our brain's focus to gratitude and recognition. According to research, this shift in how we think is proving to lead to more positive emotions and greater performance. In a study by the Cicero Group, the effect of performance recognition and employee engagement highlights how employees proactively seek to innovate and improve company efficiency.

From an organizational framework perspective, the neuroscience of gratitude is huge. And it’s worthy of consideration when revamping rewards and recognition programs. In an article by Cathy Leibow, “The Power of Thank You,” she cited research by Forbes that showed 83 percent of organizations surveyed suffered from a deficiency in recognition. They found 87 percent of the recognition programs focused on tenure, which incidentally, has no impact on performance. So…does that mean a company's greatest recognition is thanking employees on their 5, 10, or 15 year anniversaries? Yikes! Counter that with the work of the Great Place to Work Institute, where “thanking - showing appreciation and recognition” is one of the nine practice areas set as criteria for making it onto the annual Fortune “100 Best Places to Work” list.

Another important study that highlights the positive impact of gratitude on organizational wellness is from the International Journal of Workplace Health Management, (Vol. 2 Iss: 3, pp.202 – 219), “Virtues, Work Satisfactions and Psychological Well-being Among Nurses.” This study showed that gratitude was found to be a consistent predictor of several outcomes:

- less exhaustion and less cynicism;
- more proactive behaviors;
- higher rating of the health and safety climate;
- higher job satisfaction;
- fewer absences due to illness.

If you think back to the release of the gratitude neurochemicals, the increased productivity, intrinsic motivation, and prosocial behaviors, we can easily seek to align these types of outcomes to our own workplace.

In the 2015 study on The Neural Correlates of Gratitude, researchers looked at brain activity and identified gratitude as a complex social emotion. Its value proposition in our personal and professional lives is just beginning to be realized. An author of this study, neuroscientist Dr. Antonio Damasio, is quoted as saying …"We are not thinking machines that feel, but emotional machines that think."

In closing, here are a few questions to help you consider how to maximize this neural knowledge in your own profession and organization.

1. What one action can you take, personally, to tap into your own gratitude circuitry and that of your co-workers?

2. What can your organization or department initiate today to create opportunities to promote gratitude?

Contact Linda at:
lburton@img-4.com
lburton@drwcoaching.com
WHY DON’T THEY JUST CALL IT THAT? CONVERSATIONS THAT FAIL TO COMMUNICATE

I met Ms. K during her pre-operation check-in. The resident on the gynecology oncology service, holding Ms. K’s signed patient consent forms asked, “Just so we are both on the same page, what are you having done today, Ms. K?”

It was my second week of clinical rotations as a third year medical student, and I was unprepared for the sobering nature of this service. I quickly learned that leaving the hospital after surgery was often only a temporary respite for cancer patients. They would soon return for chemotherapy, radiation, and then possibly for a recurrence of their cancer.

She replied, “I am having my ovarian cancer tumor removed. My uterus and ovaries are coming out, and hopefully I will feel better.”

Ms. K was a petite 60 year-old Korean-American woman. Her baggy sweater hung loosely over her small frame, hinting at her former, healthier self. From her chart, I learned that Ms. K had come to the U.S. over 30 years ago to complete a PhD in history and had recently retired as a college professor. Over the last several months she had been experiencing significant bloating and constipation, symptoms that are frequently very troubling for patients with ovarian cancer.

It became clear during Ms. K’s surgery that the extent of her disease had been severely under-estimated. Tumor metastases were scattered throughout her abdomen, involving her bowel and liver. A curative resection of the tumor was therefore not possible, and any attempt at debulking the tumor was precluded by the high likelihood of bleeding. Her treatment would now have to involve chemotherapy. After biopsies of the tumor were taken, the team closed Ms. K’s incision. The surgeon spoke with her husband, conveying to him the events of the surgery and the plans for treatment going forward.

The next morning I learned that Ms. K had been told her cancer was too extensive to be removed surgically and that she had agreed to chemotherapy. I was the first to see Ms. K that day and after exchanging pleasantries, she asked, “So how much of the cancer was left after the surgery?” Startled, I asked if the surgeon had explained to her what had happened during the operation. She said, “Yes, he told me they took out the tumor pieces they could without causing bleeding and that we would fight the rest of the cancer with chemo.”

Not wanting to contradict her conversation with the surgeon, I said, “It’s true the plan is to fight the cancer with chemotherapy, Ms. K. A lot of the tumor was near arteries and veins and because we didn’t want to cause harmful bleeding, the tumor couldn’t be taken out.” She asked, “So was anything taken out?”

As a medical student, I didn’t want to overstep my boundaries and felt this was a conversation she deserved to have with the surgeon. I continued, “Like you said, tumor samples were taken out to understand what kind of ovarian cancer you have, and to see if the cancer might respond to different therapies. I will ask the doctor to come talk to you so we can clarify exactly what happened.” I conveyed the conversation to my resident who, in turn, called the surgeon. He immediately agreed to stop by that afternoon.

Throughout the day, various members of the team, from the resident to the fellow, all stopped by Ms. K’s room to reiterate what had

Contributor:
Pratyusha Yalamanchi, MD’18, WG’18
To learn more about Pratyusha, click here.
occurred during the surgery. It had been more than 24 hours since Ms. K left the operating room, and it was important to the team that she understood what happened. Each time she heard the same statement. “Ms. K, you underwent an exploratory laparotomy and the tumor was not resectable. It involved parts of the bowel and liver. As we discussed with you and your husband yesterday, we can proceed to chemotherapy, and once the tumor has regressed in size, we may consider surgery again. Does that make sense?”

Each time, Ms. K nodded and agreed. “Do you have any questions?” “No.” It seemed to me that we had adequately explained her procedure and resolved the misunderstanding.

When I went to see Ms. K the next morning, her husband was lying at her side. She greeted me with, “I’m feeling that tightness in my abdomen again. Shouldn’t the surgery have helped?” I confirmed the pain was not related to her incision, which was healing well. I asked myself if it were possible that, despite sincere efforts, Ms. K still did not understand what had taken place during her surgery. I tried again.

“Ms. K, unfortunately the tumor couldn’t be removed so the symptoms you felt from the cancer may not improve on their own. We can help you with any pain control you might need.” She replied, “But I thought that taking my uterus and ovaries out would help the bloating feeling.” I didn’t know what to say. I had heard several members of the team tell Ms. K specifically that the procedure was simply exploratory and that nothing had been resected.

“Ms. K, I’m so sorry that this was not made clear to you. Your uterus and ovaries were not removed.” “So nothing was taken out?” “No.”

Ms. K’s husband interjected, “Can you explain what happened in the surgery again? I know it was told to us, but I want to hear it again from you.” I could have said, “The cancer was unfortunately too hard to remove so nothing was taken out. Chemo is our best next step.” But in my brief tenure in the hospital, I had learned that one of the best ways to function as a trainee is to adopt the practices of those more experienced. I wanted to follow my team’s example, so I replied, “Of course. Ms. K underwent an exploratory laparotomy. The tumor could not be resected since it was found throughout your abdomen. Your ovaries and uterus were not removed. The plan is to proceed with chemotherapy. Does that make sense?”

Mr. K then asked, “The surgeon used that word, ‘resect,’ too. What does that mean?” “Resect means to remove. The tumor wasn’t removed.” I saw something change in his eyes. “I’m so sorry that this wasn’t clear. As a medical student, I myself don’t understand what people in medicine say sometimes. Were there any other words like that?”

“What is exploratory laparotomy?” “You look inside the abdomen to see how much disease there is.” “Why don’t they just call it that?” “That’s a good question, Mr. K.”

I sat down on the edge of Ms. K’s bed. I realized how natural it was to extrapolate sources of hope in difficult conversations with physicians. Hearing “biopsies were removed for histology” among descriptions of cancer metastases and extensive future chemotherapy regimens was easily interpreted by Ms. K and her husband as “having part of the cancer removed.”

Remembering what my resident had asked her before her procedure, I said, “Ms. K, just so we are
both on the same page, what happened during your operation?" After a few tries with her husband’s input, Ms. K finally stated that her cancer had not been removed, she had all of her reproductive organs, and that chemotherapy would be the best next step.

Ms. K left the hospital that weekend with a chemo regimen to begin soon after. Over the past few years, I have read much on doctor-patient communication that has depicted failing physicians as lacking empathy or a willingness to take the time to engage their patients. My medical school’s doctor-patient communication course emphasizes the importance of considering a patient’s educational and cultural background when engaging in difficult conversations. But, here I witnessed a team of physicians who were extremely empathetic and had spent significant time speaking to a highly educated patient who was fluent in English. And yet they had not communicated with her.

The team dominated conversations with Ms. K, trying to share as much information as possible for honest disclosure. I find myself similarly trained in the art of one-sided discourse, as I am encouraged to summarize what patients have told me to make clear that I understand their concerns. Ms. K reminded me that her own summary of her care was equally valuable. It allowed us to address gaps in communication and allowed her to become an active partner in her own care.

It has now been over a year since I met Ms. K at her pre-operation check-in. I’ve found that mirrored conversations, in which both the doctor and patient describe the treatment plan in their own words, are particularly useful in the post-operative or inpatient setting when disease states and care plans can be complex and altered states of consciousness or pain can cloud awareness and insight. As I maneuver through the hospital adopting the language of more experienced providers, I hope to remember that the precise diction of medicine which provides clarity in communicating with other physicians, may in fact preclude effective communication with the patients I serve.

Contact Pratyusha at:
pyal@wharton.upenn.edu

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THE TROUBLES OF THE AFFORDABLE CARE ACT’S CO-OP PROGRAM

In an attempt to encourage new competition and innovation in the health insurance marketplaces of the states, the Affordable Care Act (ACA) enabled the formation of non-profit health insurance cooperatives (Co-ops) in each state. After Congress cut the initial $10 billion outlay by almost 75%, Co-ops started up in 22 states (Oregon had two). From the beginning, the Co-ops faced a tremendous uphill battle against the large, pre-existing dominant insurers in their respective markets. Obstacles faced by the Co-ops ranged from the administration’s inability to provide risk corridor payments to protect the insurers from losses in the early years of the ACA, limitations on raising capital to allow for adequate growth, prohibition on using the federal loans to advertise, and a terribly designed risk adjustment formula heavily skewed in favor of large carriers.

While over a million individuals purchased policies through the Co-op programs, the obstacles described above were too great to overcome for the vast majority of Co-ops. As a result, as of September 15, 2016 only six of the original twenty-three Co-ops that went to market on January 1, 2014 were still in operation. This is unfortunate because by many measures the Co-ops were successful. They unquestionably brought greater competition and choice to their respective state insurance markets; and, with that additional choice, they brought lower premiums: in states with Co-ops, the state average premiums were 7% lower than in states without Co-ops.

Along with the benefit to consumers of reduced premiums and increased competition, many of the Co-ops brought innovative products to their markets as well, with a particular emphasis on delivering value-based care. As an example, our Co-op - Evergreen Health of Maryland - has a unique product for diabetic patients, where all out-of-pocket costs, including co-pays and deductibles are waived for all the services and testing that have been proven to reverse or slow down progression of the disease. By removing financial barriers, this has encouraged patients to pursue the necessary care and improved their compliance with appointments with ophthalmologists, podiatrists, endocrinologists, and primary care providers. Along with free access to glucose strips, hemoglobin A1C testing (used for measuring long-term control of blood sugar) and insulin, this will ultimately translate into better health outcomes and lower costs for these patients.

Another novel feature of Evergreen is the incorporation of patient-centered medical homes (PCMH) as a center for care. PCMHs serve as a hub where a patient’s care is integrated at one site. Evergreen has aligned the insurance company with a healthcare provider network (Evergreen Healthcare). Now used by about 20% of Evergreen Co-op’s members as their primary care provider, Evergreen’s primary care offices are robust centers staffed with a team of primary care providers, behavioral health coaches, and care coordinators, along with innovative technologies to provide state of the art healthcare.

Examples like these highlight the consequences of losing over three quarters of the original Co-ops. The loss of one of the few competitors in these affected state markets (many states have only one or two competitors left operating on their exchange) is already contributing to the current rise in health insurance premiums around the country. As premiums go up, it makes it even less likely that the young and healthy (who already are not participating in large enough numbers to provide a good risk pool) will buy insurance. In short order, this will likely result in a death spiral of insurance premiums with the possible result of the collapse of the ACA.

Contributor:
Peter Beilenson, MD, MPH
To learn more about Peter, click here.
THE TROUBLES OF THE AFFORDABLE CARE ACT’S CO-OP PROGRAM
continued

What lessons can be learned from the failure of the Co-op program? Many of the barriers to success that impede the progress of the Co-ops could have been remedied with a simple change of rules by CMS, the agency tasked with the execution of the ACA. CMS should have amended the risk adjustment formula to create a level playing field for all the carriers. The current risk adjustment methodology creates additional issues for new carriers like Co-ops, as it favors large insurers with enhanced administrative capabilities with years of claims experience and data for their members. To improve the situation, CMS should have heeded the recommendations of small, new entrants into the health insurance markets, which suggested that growing plans be exempted from risk adjustment for the first 3-5 years, or alternatively, apply a “credibility based” approach to participation in risk adjustment, taking into account overall size and number of members that were not previously with the specific carrier, and place a cap on a plan’s risk adjustment transfer charge. Finally, the risk corridor program was another critical issue for the Co-ops — once hit hard by risk adjustment assessments, the Co-ops depended on full risk corridor payment. However, Congressional action dramatically reduced the availability of these payments, thus resulting in the closure of many of the original Co-ops. A swift resolution to the current funding deficit for this program would go a long way to improving the chances of the remaining Co-ops to survive.

The Affordable Care Act represents an historic attempt to change healthcare in the United States. The Co-op program was an innovative approach to improve access to insurance by generating competition in the marketplace and emphasizing innovation and quality of care. The closure of most of the Co-ops and the wave of consolidation of large carriers currently underway, will lead to fewer choices and increased cost of healthcare coverage. In the future, whether or not the Affordable Care Act remains in effect or not, any federal attempts to bring new competitors to the market must include strategies to level the playing field, or a similar outcome will ensue.

Contact Peter at:
 vze1d1ro9@verizon.net
Peter Beilenson, MD, MPH
Alex Blum, MD
Zaeem Lone

(The first author is CEO of Evergreen Health; the second author is the former CMO of Evergreen Health; the third author is a student at Johns Hopkins University.)
THE INTERNET OF MEDICAL THINGS

If you were to make an informal list of the companies that were the most revolutionary, transformative, and successful throughout the past decade, which ones would you list at the top? Chances are you’d select powerhouse tech firms like Google, Apple, Facebook, Amazon, and Netflix. Maybe you’d also include some earlier-stage companies, like Uber or Airbnb. Now of course there are hundreds of other firms that could be on this hypothetical list as well. But instead of debating those points, let’s focus on the similarities of the aforementioned companies.

They’re all in tech. On average, they’ve been in existence for under 20 years. They’ve created products or services that many of us use each day. They’ve transformed industries like advertising, communication, commerce, entertainment, and travel. And if we boil it down, we eventually see an overarching commonality: they’ve all created wonderful products that consistently evolve and improve to meet the needs of their users.

Now this concept may not be novel, but the way these firms accomplish it is. These companies collect an immense amount of data about how customers use their products – and they leverage these data to ensure their products evolve in the right direction. These companies know how the user interacts with their site or device, how long the user uses their product, when the user uses their product, and why the user stops using their product.

Now, let’s compare this level of insight to the information that’s available for pharmaceutical companies to leverage about their products. Pharma companies spend billions developing new drugs – and billions marketing them once they’re approved. Yet pharma companies don’t have the granular real-world insights into how patients use their drugs, when patients use their drugs, or why patients stop using their drugs. If pharma had these insights, the possibilities and new market opportunities would be immense.

With regard to healthcare, there are infinite ways in which IoT tools can be used to improve patient care - and it’s happening sooner than you might think. In the past few years, we’ve seen the emergence of connected medical devices such as smart heart rate monitors, blood pressure cuffs, glucometers, asthma inhalers, thermometers, and pill bottles. Let’s call this “the Internet of Medical Things” (IoMT), which describes the emergence of Internet-connected devices to improve the lives of users.

I recently gave a TEDMED Talk about this very topic. My main point is that smart medical devices must be incredibly easy for patients to use in order to facilitate mass adoption. This is a simple and important notion, yet it is too often ignored within the IoMT.

However, understanding and leveraging this obvious concept can lead to success and a sustainable business model, as we have learned at AdhereTech. This idea has guided every design and user-experience feature that we have built. We have even distilled this philosophy into three design principles, which we refer to each day:

1. The device must work the moment the patient gets it, with no set-up, no assembly, no downloads, and no synching required.
2. The device should be used in the exact same way as the regular non-connected version of the device, so it’s simple for the user.

Contributor:
Josh Stein, WG’12
To learn more about Jennifer and Josh, click here.
3. The battery in the device should last for as long as possible - ideally multiple months - without needing to be recharged (our smart pill bottles last 6 full months per charge).

AdhereTech’s smart pill bottles have been used by healthcare companies since 2013. Our solution is currently distributed from leading specialty pharmacies, hospitals, and clinical trial sites – across four continents. Customers include healthcare firms, such as: five top-15 pharmaceutical companies (confidential), four top-10 national pharmacies (confidential), Mount Sinai, The Dana Farber Cancer Institute, New York Presbyterian, Massachusetts General Hospital, Cincinnati Children’s Hospital, Penn Med, and many more.

Here’s how our solution works: AdhereTech smart pill bottles automatically measure if patients have taken their medication, and this information is automatically sent from the bottles to our servers, where it is analyzed in real-time. If a dose is missed, AdhereTech reminds the patient and/or caregiver via a series of customizable features, such as automated phone calls or text messages - as well as on-bottle lights and chimes. If the system determines that the patients are experiencing side effects or other high-risk behaviors, an alert is sent to a live healthcare provider who can call the patient and provide immediate assistance. On average, these actions increase adherence by over 20% and time-on-therapy by over 30%.

As AdhereTech continues to collect these newly gathered adherence data, we develop novel insights into the drivers of non-adherence – and the solutions that work for specific types of patients. These inputs are used to create innovative interventions and personalization algorithms. In fact, we consider ourselves a hardware-enabled data and software company.

In my TEDMED Talk, I elaborate on how we have accomplished these feats. Next time you use any smart connected device, please think about its required set-up, ease-of-use, and battery life. Then consider how much better the product would be if even one of these factors were improved. The IoT will soon become as ubiquitous as the Internet itself, and the IoMT has the potential to transform the way in which healthcare is delivered. Patients will be the group that ultimately decides which devices will be adopted, so we must always remember to design these tools for patients above all else.

Contact Josh at:
j.stein@adheretech.com
PITFALLS OF SEARCHING FOR HOSPITAL QUALITY INFORMATION ONLINE

In 2017 it is far easier to get reliable information on the quality of a hotel than a hospital. Granted, the factors that go into choosing a hospital are more complex, but the information gap is concerning given how high the stakes are. Emerging sources are providing consumers with greater insight into hospital performance, yet it is still a sea of ambiguous, conflicting data. One need look no further than the roadside billboards in any county touting the local medical center as top rated in some category by some anonymous source. The convergence of safety, clinical, and patient experience data into unified ratings is a step in the right direction; however, the limitations of these ratings leaves the field wide open for a disruptive innovator – the Hotels.com or Uber of healthcare perhaps?

Recently I found myself faced with two decisions: (1) choosing a hotel in Miami for my family and (2) recommending a hospital for my friend’s grandmother, who fractured her hip. The process entailed in researching these two questions involved some similar variables, and yet there was a wide divergence with regard to speed and certainty of the final answer.

Anyone reading this article has likely used Hotels.com or a similar site, so I will only briefly describe this experience. I performed a search for Miami hotels and was able to segment my geographic preference by neighborhood. I filtered on price and minimum acceptable rating, and then sorted by lowest price. The results displayed geographic proximity, consumer feedback (star ratings), and actual comments. I scanned for two variables - number of ratings (n size) and the ratings themselves. A star rating above 4.0 and an n size of several hundred gave me confidence that the hotel was quality and the data was robust. Elapsed time to search and make my selection...less than 5 minutes.

Back to my friend’s grandmother and the question “Which of the two hospitals was the best? This search was simply a question of quality. Neither proximity nor value factored into our conversation. Either cost was a lower priority than clinical quality, or perhaps we lacked a shared framework for comparison shopping healthcare services on value.

For clinical quality, you need to know where to look and what

Contributor:
Matt Pickens, WG’03
To learn more about Matt, click here.
quality measures are relevant. The CMS website HospitalCompare provides various quality measures on hospital performance relative to the national average.

I scanned the dozens of clinical measures, and it was not clear that any of them were especially relevant to a hip patient. I am probably wrong, but that is part of my point - how can a layperson know? So I basically skipped quality. Being familiar with the website HospitalSafetyScore.com, that aggregates publicly available safety data, I learned that both hospitals were rated a “B” for Safety.
PITFALLS OF SEARCHING FOR HOSPITAL QUALITY INFORMATION ONLINE

My final stop was HospitalCompare to assess publicly available patient experience data, which turned out to be middle of the road for both. At this point, about 30 minutes had elapsed, and I did not feel very good about either choice.

I then decided to reframe the question to “What is the closest hospital with an acceptable level of performance?” Now proximity became important. I created a spreadsheet and used Google Maps to determine the distance of over 15 hospitals. Then I ran the same checks, hospital by hospital, on HospitalSafetyScore and HospitalCompare. At the end of this manual process I selected a hospital that was about 5 minutes further than the original two, was “A” rated for safety, and had patient experience scores in the top quartile. Elapsed time to conduct my search and make my selection? Well over an hour and, although I felt good about ruling out the original two hospitals, I still didn’t have a clear view of the clinical quality of my selection. Had there been a top-rated academic medical center for orthopedic surgery, it might have made my search simpler, yet this option did not exist.

Since conducting this hospital search, two elements of the rating landscape have changed. First, in April 2016, HospitalSafetyScore began incorporating the following patient experience items from the HCAHPS survey into its ratings: Nurse and Doctor Communication, Staff Responsiveness, Communication about Medicines, and Discharge. While there is general agreement that communication in the hospital setting is a key driver of quality care, a limitation of the new HospitalSafetyScore is that it still does not include actual clinical quality measures.

In July 2016 CMS released Overall Hospital Quality Star Ratings on its Hospital Compare website. Previously the website had featured star ratings based solely on patient experience, in addition to over 60 items related to clinical quality and safety. It was up to the consumer, however, to sift through the large volumes of information on safety and quality, without a lot of context as to its relevance. The new five star rating aggregating safety, quality, and experience data provides a more holistic single measure for the consumer to evaluate. This is a big step forward, as consumers readily comprehend a 5 star rating, and the need to interpret the meaning of various measures has been eliminated. It remains to be seen if these new star ratings will be readily adopted, as reaction to the previous star ratings based solely on patient experience has been mixed.

While hospital quality ratings have evolved, the value of these ratings relative to helping consumers make informed choices is still in question. In contrast, consumer sites like Hotels.com, Amazon, and Uber make the experience of searching for goods and services tailored to our preferences easy and satisfying. While there are a host of sites vying to provide information regarding individual physicians, there currently is not yet a widely adopted, single source of hospital information that has proven itself to be consumer-friendly. The opportunity is ripe for a disruptive tech innovator that can source and aggregate meaningful healthcare data and then connect consumers to that data in an efficient, intuitive fashion.

Contact Matt at:
Matt.Pickens@pressganey.com