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EDITOR'S LETTER

We're providing another eclectic issue to add to your summer reading list! This edition will keep you up-to-date across the healthcare spectrum as a warm-up to the annual Alumni Healthcare Conference, which will be held in Philadelphia on October 21. Registration is now [open](#).

Please be sure to complete the 2016 WHCMAA member/prospective member survey. Our goal is to identify opportunities to further increase the value of membership and enhance the member experience. Your opinions matter, so let us know what you think!

Hope to see you in October!

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



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

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THE PRESIDENT'S DESK

Dear Friends,

Our careers are complex journeys, packed with challenges and accomplishments. One of the best things we can do to strengthen the healthcare management education at Wharton is to assist alumni throughout our careers to be successful, fulfilled, and committed to improving healthcare in our society.

With this in mind, the Career Development Committee of the Wharton Health Care Management Alumni Association (WHCMAA) has been hard at work reconceiving and re-launching our career development program.

The goal of the career development program is to enhance the life-long value of your Wharton degree by connecting WHCMAA members at every phase of their career from first jobs through retirement, providing network navigation, coaching/mentoring, community building, and life-long learning.

In coordination with Wharton's MBA Alumni Career Services, we have identified excellent programs under each of these areas that will be provided to our members. In addition, we have identified additional initiatives that WHCMAA will spearhead specifically for alumni in healthcare:

- Interest groups (members with shared interests) will communicate online and gather at industry conferences to strengthen networks in focused healthcare sectors.
- Networking leaders will help guide members who are seeking to connect with others in their industry sector.
- A webinar describing Wharton Career Services capabilities specifically for healthcare alumni will be offered.

By providing career development support, we believe the WHCMAA will better fulfill its status as *the leading network for the business of healthcare*.

I would like to thank the following alumni who were instrumental in re-launching our Career Development program: Maureen Spivack, Marina Tarasova, Kate Reed, Bryan Bushick, Sharon Soforenko, and Michael Rovinsky. Their focused and thoughtful effort has vastly improved our alumni association.

We will be reaching out to all alumni eligible to be WHCMAA members, including Health Care Management program alumni as well as alumni of Wharton and WEMBA who are in the business of healthcare. Watch for our emails, and take the opportunity to connect!

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

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John Harris, WG'88
To learn more about John,
[click here.](#)

THE PHILOSOPHER'S CORNER

Life Lessons:

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

gone to medical school to become a dermatologist! It's the specialty with the best hours and the ability to help people feel better in their own skin.

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

worried about the future and enjoyed more of the present.

Favorite Quotes:

1. "Man surprised me most about humanity. Because he sacrifices his health in order to make money. Then he sacrifices money to recuperate his health. And then he is so anxious about the future that he does not enjoy the present; the result being that he does not live in the present or the future; he lives as if he is never going to die, and then dies having never really lived." ~ Dalai Lama
2. "The problem with competition is that it takes away the requirement to set your own path, to invent your own method, to find a new way." ~ Seth Godin
3. "That visibility which makes us most vulnerable is that which also is the source of our greatest strength." ~ Audre Lorde

Recommended Reading:

- *Brainpickings Weekly* – an amazing e-mail newsletter that searches out insights about living an enlightened life from the world's great creators in different disciplines. The author connects the dots to deliver new understandings and curious findings. For example, I learned about a little-known correspondence between Einstein and Freud on violence, war, peace, and human nature. How amazing it was to read the letters of two great minds from last century!
- *Flawless Consulting: A Guide to Getting Your Expertise Used* by Peter Block
- *Godel Escher Bach* - by Douglas Hofstadter. The book explores common themes from the lives and works of logician Kurt Godel, artist MC Escher, and composer Johan Sebastian Bach and, by exploring these disciplines, expounds on mathematics, symmetry, and intelligence.
- The Moth podcast – an amazing storytelling podcast. Mostly recorded live around the country.

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This month's philosopher:
Marina Tarasova, WG'10
To learn more about Marina,
[click here.](#)

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

ALUMNI NEWS

Benjamin Lewis, WG'15 and Jason Zuniga, WG'16

Benjamin Lewis, WG'15, VMD '17 founded a new social impact company, The One Health Company, a 21st Century contract research organization (CRO) that is de-risking the leap from animal trials to human trials. The One Health Company provides human biopharma companies clinical validation at the pre-clinical stage whilst improving animal welfare. Jason Zuniga, WG'16 serves as The One Health Company's Chief of Staff.

The company represents the first major improvement in animal testing in nearly a century. The One Health Company closed its first round of financing with prominent life sciences investors and has attracted a stellar team. Additionally, One Health is a member of Wharton VIP and was a 2016 recipient of both the Woods and the Snider Seed Awards and the University City's Science Center Digital Health Accelerator program and grant. Previously, Ben founded 4Vets, Brazil's premiere B2B animal health supply distributor (Brazil is the world's 2nd largest animal health market). Prior to Wharton, Ben was Captain of the 2004 US Olympic Kayak Team.

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ALUMNI NEWS

continued

Sam Holliday, BSE SEAS'01, WG'09


Sam Holliday recently joined [Fit4D](#), a high-growth, venture-backed company, as Chief Operating Officer. Fit4D works with pharmaceutical, medical device, payer, and accountable care organizations to provide personalized, technology-enabled health coaching and support to people with diabetes. The company's network of Certified Diabetes Educators (CDEs) helps patients through multi-channel interactions to overcome patient-specific barriers to medication adherence and achieving their health goals.

Fit4D is based in New York City and is aggressively expanding its team. Open roles can be viewed on the [company's website](#), and more roles will be posted in the coming months. If you are passionate about improving the lives of people with diabetes and other chronic conditions using technology, reach out to Sam to discuss opportunities.

If you are a pharmaceutical, medical device, payer, or accountable care organization that wants to improve diabetes health outcomes, increase therapy adherence, and improve patient/member satisfaction, please reach out to learn more about how Fit4D can support and extend your existing programs.

Contact Sam at:
sholliday@fit4d.com
914.400.9338

Company website: www.fit4d.com
Career page: <http://www.fit4d.com/join-us/>
Sign up for our diabetes newsletter: <http://eepurl.com/bN5W0D>
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by Z. Colette Edwards, WG'84, MD'85

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ALUMNI NEWS

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Isaac J. Bright, MD, WG'06

After more than 4 years as a venture capital partner with the French family office, Merieux Developement, I am thrilled with the opportunity to jump back into a company and join so many WHCMAA colleagues in the biopharma sector. I'll be serving as VP, Corporate Development at Synthetic Biologics, Inc. (NYSE: SYN) and look forward to re-connecting with so many of you. A critical imperative throughout the course of our careers is to ensure we are consistently challenged to stretch, grow, and lead – I'm thrilled with this opportunity at Synthetic Biologics and look forward to increased interactions with so many of you in the near future.

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Sheri Gritt Shapiro, WG'01

Sheri Gritt Shapiro was named SVP, Mergers, Acquisitions, and Partnership Development at Trinity Health in April 2016. She was previously a Principal at The Chartis Group, a national healthcare consulting firm. She continues to live in the Detroit area and looks forward to doing healthcare deals across the country.

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Michael Rovinsky, BA'81, WG'86

After 18 years with Integrity Consulting Group, a healthcare consulting firm I founded in 1998, I have joined fellow alumnus John Harris at Veralon Partners, Inc. as Director, Southeast Region. I am thrilled to now have a larger platform with a substantial breadth and depth of resources from which to help our clients meet the challenges of the rapidly evolving healthcare landscape.

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[Learn more.](#)

ALUMNI NEWS

continued

Jeff Voigt, WG'85

Peer-reviewed article published: Voigt, JD and Barnett G. The value of using a brain laser interstitial thermal therapy (LITT) system in patients presenting with high-grade gliomas where maximal safe resection may not be feasible. *Cost Eff Resour Alloc* (2016) 14:6 DOI 10.1186/s12962-016-0055-2.

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Janis Hersh, WG'81

I retired 2 years ago and am busier than ever. I have been studying photography intensively, working as a mentor tutor in a Boston public high school, traveling, and this year coached a team of college undergrads in operations management field work at the Greater Boston Food Bank. My last position was Director of a healthcare system's improvement program at the Department of Veterans Affairs. We served our region and supported national projects, utilizing systems and industrial engineering methodologies.

I have been married for 35 years to Marc Frader, a geriatric psychiatrist, and we have 2 children. Anna works in the area of human rights for the United Nations in New York, and Jonathan works in tech sales for Amazon Web Services in San Francisco.

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Harris Contos, DMD, WG'80

I was invited by Burton L. Edelstein, DDS, MPH, Professor of Dental Medicine and Health Policy and Management at Columbia University Medical Center to share "14 New Year's Resolutions" on the directions of dental care and dental health policy since the advent of "accountable" health reform with a group of 5-year dual degree DDS-MPH candidates. The recent exchange I had with the students was both vibrant, energizing, and stimulating, with one upside summary being, "You addressed a range of critical themes important to them, raised their levels of understanding, and got them going. Afterwards they joked about starting their own collective, female-powered enterprise. Behind every joke is a kernel of truth so you never know."

One downside theme to emerge, however, was how little dental education has changed since I received this degree 38 years ago, and how little the dental profession is aware of the demands and the dynamics of the present, and future, healthcare environment. It is still quite sobering to note that this elemental component of primary care remains at the far edges of the healthcare universe, in need of the right entrepreneurs with the right start-up models to redefine the way dental care is delivered in this country.

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Zarina Shockley Sparling, WG'78, School of Allied Health Professions (Physical Therapy)

May 6, 2016 retired, Senior Vice President of Health Plan Operations at Molina Healthcare, Inc., Long Beach, CA

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AFFIDAVIT: HEALTHCARE AND THE LAW - PREPARING FOR A DATA BREACH: NOT ALL CYBERINSURANCE IS THE SAME

Healthcare entities are particularly vulnerable to cyberattacks given the value of healthcare data: if your credit card is hacked, you can get a new one, but health records are permanent. Consequently, sophisticated hackers are increasingly targeting healthcare providers and their vendors. The Anthem Blue Cross breach affected as many as 80 million consumers. Several hospitals were the targets of ransom attacks that threatened to shut down their electronic health records systems if ransoms were not paid (and some did pay). The FBI is reaching out to healthcare providers, IT vendors, and others to work collaboratively on real or threatened breaches. In a time when data breaches and hacks are daily news, and the average total cost paid by an organization as a result of a data breach has reached \$6.5 million, it is even more important for every company to take the steps it can to prevent such breaches and hacks. Obtaining specialized cyberinsurance, in addition to general insurance, is such a step and can provide relief in an area where technology changes so fast that security protocols working one day are obsolete the next.



It is becoming clearer that general commercial liability policies and general errors and omissions policies for healthcare entities (and other businesses) may not provide coverage for cyber incidents. Courts have given inconsistent rulings when addressing this issue. Of the four main cases on this issue, one case settled outside of court; one case held that the insurance company did have a duty to defend because there had been publication of the data (two patients' medical records were available on Google because of inadequate firewalls); one case held that the insurance company did not have a duty to defend because there was no publication of the data (computer tapes fell out of a truck and were taken from the side of the road, but no evidence anyone accessed the information on the tapes); and the fourth case involved a "data-held-for-ransom" set of facts that was ultimately determined to not be covered under the company's errors and omissions policy.

This inconsistent case law offers at best a "maybe" level of protection for healthcare entities that only have general policies. In addition, the insurance industry is pushing hard to foreclose coverage for data security breaches by including broad cyber exclusions in such general policies. Thus, companies should look at specialized cyberinsurance policies to fill in coverage gaps and provide them with more certainty.

But cyberinsurance policies are not all one and the same. Each company's cyber risk is different, and a cyberinsurance policy should be tailored to these risks. It is important to involve risk management, information technology, and legal departments to assess cyber risks, analyze a particular cyberinsurance policy, and complete the application. Companies should be careful in their application to not overstate its current security practices, because application statements are often incorporated as conditions, and coverage might be denied if your security practice in real life does not match up with what was previously stated. For example, stating that you have "reasonable security practices" may be accurate at the time the policy is purchased but coverage may be denied later when that security practice is no longer "reasonable" as technology develops or becomes obsolete.

Companies tend to trip up because cyberinsurance policies are new, and there are not yet any clear industry standards or ways to determine what is a "good" cyberinsurance policy. These policies are all over the map from cheap to expensive, and vary widely in what is covered. Here are some important points to consider when selecting your cyberinsurance policy:

1. Know the limits and sublimits in the policy. Some elements of a data breach response can be much more expensive than others (e.g., call centers), so be aware of what the limits are so you are not surprised by sublimits. Also, some policies may

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AFFIDAVIT: HEALTHCARE AND THE LAW - PREPARING FOR A DATA BREACH: NOT ALL CYBERINSURANCE IS THE SAME

continued

not cover government fines, such as fines under HIPAA.

2. Pay attention to definitions. Data security and privacy are developing areas, and every state has its own set of different laws and requirements that may not match up with the definitions in the policy. For example, the definition of “personal information” as it relates to a data breach varies by state, and you don’t want to be limited in coverage if the breach happens in a state where the definition is different from that of your policy. As another example, some cyber policies condition business interruption coverage on “network disruption,” but business interruptions may happen without the network itself being harmed (ex: extra expense, lost business, slowdowns), and you don’t want to be limited in this way either.
3. Try for early retroactive date. Some cyber policies restrict coverage to breaches or losses that happen after a certain date, which can typically be the date the policy is signed. However, the nature of data breaches is that they often go undetected for months or even years, so it is in your best interest to negotiate for an earlier retroactive date.
4. Expand the geographic reach. It’s typically the nature of a data breach or a cyber attack that it is not limited by traditional geographic boundaries. Make sure your policy does not limit you to a particular geographic area.
5. Choose the scope of coverage you need. Make sure you know what your policy covers. Some important coverages include:
 - Coverage for the costs to notify those affected by a cyber incident. Such notification is required by law in almost every state.
 - Business interruption coverage, for lost income and related costs where a company is unable to conduct business due to a cyber incident or data loss.
 - Forensic services coverage, for investigating the cyber incident, assessing the impact of the incident, and stopping an attack.
 - Coverage for credit monitoring services to customers affected by the cyber incident and for public relations after the cyber incident.
 - Coverage for physical damage to computer systems or loss/destruction of data, including costs to restore data and replace or upgrade a computer system that was breached.
 - Liability coverage for costs associated with civil lawsuits, judgments, settlements, regulatory actions or penalties resulting from a cyber incident.

Cyber insurance is not a cure-all for all problems resulting from a data breach. It shouldn’t be the only thing a company has to protect against data breaches, but rather should be part of a cyber incident protection repertoire that should also include creating an appropriate incident response plan, utilizing extensive encryption, involving your company’s business continuity management and board, defining CISO (Chief Information Security Officer) leadership, and properly training employees.

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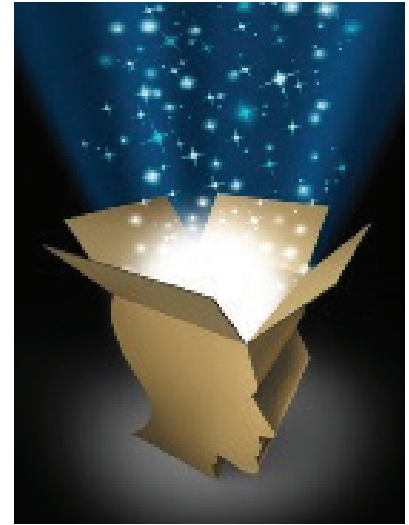
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NOT A FREUDIAN SLIP: MOTIVATION: IT ALL STARTS WITH A NEED – PART 1

Much of the focus directed to individuals and healthcare is about getting people to comply and adhere to treatment recommendations and make lifestyle behavior changes. Traditional tactics aim to influence motivation and encourage healthy habits by focusing on what the person should do and push for continued action by rewarding performance.

In this two-part series, we will explore what compels a person to behave or act, the why. Then we will explore what influences, predicts, and drives behavior in our discovery of motivation. Finally, we'll move to explaining the how, through approaches that influence sustained behavior versus tactics that are likely short-lived. Ultimately, we will demonstrate why efforts to motivate action, affect performance, and impact health outcomes must put the individual in the driver's seat and tailor around their unique needs. As we look at what it takes for a program to create a lasting change, we'll consider if innovative technology approaches can truly make an impact and inspire positive health behaviors.



Many organizations provide self-management programs that include rewards or incentives to initiate action, or the opposite - they may punish participants using the stick versus carrot method. Other wellness programs entice a person's competitive spirit through gaming. But do these approaches truly motivate individuals or produce long-term changes? Or will behavior change be short-lived and dependent on being incentivized to continue? Many argue the short-term benefit is positive regardless. Organizations working towards a culture of health that embodies true personal accountability and autonomy shouldn't stop at satisfying short-term accomplishments.

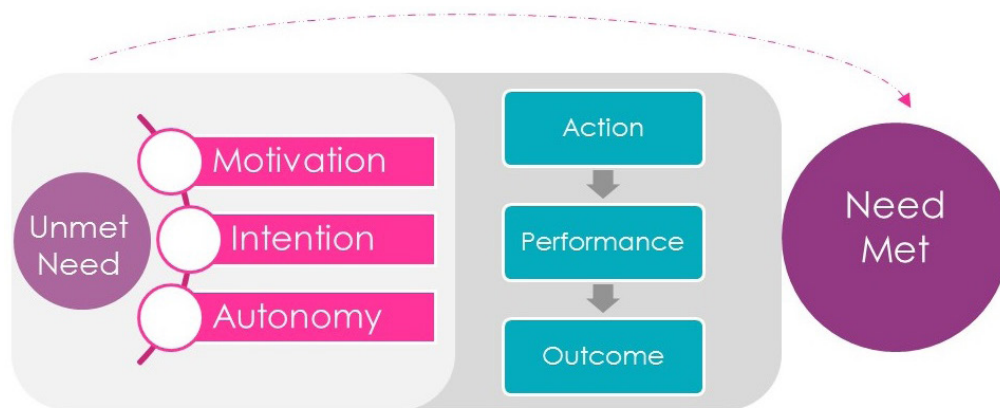
There are multiple theories of motivation and years of research on what drives human behavior, so why does it still seem like such a mystery? And why is behavior so hard to change? Understanding the complexities involved in motivating people is not an easy job, since human behavior is unpredictable and is the result of multiple factors. Before we think about how to motivate people, we need to look at the bigger picture of behavior.

It all starts with a need.

People behave based on their unmet needs, wants, or desires. When individuals are not receiving what they perceive they need, they will attempt to satisfy that need (Maslow 1943). The forces that lie beneath motivation to meet our needs can be biological, social, emotional, or cognitive [psychological] in nature.

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To learn more about Connie,
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NOT A FREUDIAN SLIP: MOTIVATION: IT ALL STARTS WITH A NEED – PART 1 *continued*



If people behave based on needs or desires, what factors influence, predict, and drive behavior?

Motivation influences behavior. It is the process that initiates, guides, and maintains goal-oriented behaviors. It's what causes us to act, whether to grab a snack to reduce hunger or complete a certificate program to advance our career.

Some individuals are motivated because they value an activity (intrinsic), while others are motivated because there is a strong external pressure (extrinsic) (Ryan and Deci, 2000). Understanding what internally motivates a person beyond external motivators like rewards and recognition is where real change begins.

	Intrinsic	Extrinsic
Behavior is	Internal to their self Is fulfilling	External to their self Is a means to an end
Driven by	Own perceptions of success, and goal achievement is satisfaction enough.	External contingencies and pressures to receive recognition for success or fear the opposite.
Causes person to	Get engaged with projects they consider interesting and tasks they feel are more fun and enjoyable.	Tolerate activity only to receive reward or avoid disincentive [fear, shame, guilt, humiliation].
Person thrives on	Input that reaffirms the inner traits, strengths or characteristics that make them proudest.	Public recognition and sustained by getting positive feedback as to their abilities and contribution.
Rewards include	Desire to express true self; personal growth, richer experiences, meaningful relationships, improve problem-solving.	Desire to achieve tangible rewards such as money or the glory that comes with status, fame, and recognition.
Emphasizes	Who you are	What you have

Intention predicts behavior. When we have a purpose or plan, we direct the mind toward that aim; otherwise we may stray without meaning or direction. Having intention helps transform fear and doubt to hope, keeping us focused ahead on driving actions towards results. Intention is deliberate and sets the tone of whatever we are about to do. A person's attitude, their intention, toward performing behavior will lead to an outcome, and typically the more valuable the outcome, the better the attitude. The Self-Regulation Model provides strategies to help individuals improve their ability to act upon their intentions (Brug, et al., 2005). It emphasizes self-control, self-awareness, and self-management (Siegert, et al., 2004).

NOT A FREUDIAN SLIP: MOTIVATION: IT ALL STARTS WITH A NEED – PART 1 *continued*



Autonomy drives behavior. The distinction between “I choose to do this” and “I have to do this” is the essence of autonomy. A person chooses to act according to his/her own values and informed decisions and takes responsibility for the choices made. This allows the person to feel in control of their behavior, the opposite of being controlled or directed. The most satisfying activities you can engage in, the intrinsic ones that will motivate you the most, are those that allow you to feel most in control of your behavior (Niemic et al, 2010). It’s important to note that intrinsic motivation decreases as autonomy decreases.

Anyone who has ever had a goal (like wanting to lose ten pounds or wanting to run a marathon) probably realizes that simply having the need/desire to accomplish something is not enough. You have to take action and routinely practice the behavior to reach the expected outcomes. Understanding the motivation behind our behavior can give us the insights we need to develop our own unique plan for change and path to fulfillment.

So if behaviors are based on a need that we can influence, predict, and drive, how can wellness programs get people moving towards achieving a desired outcome? The simple answer is to activate a person to perform behaviors that achieve the outcome intended in ways that align with them specifically. In the next column, we explore more deeply how to activate and inspire people to reach their desired outcome. This exploration is important, whether you’re selecting a health program for your company, designing an intervention for people, or hoping to change your own behaviors for the better, as getting to the core of why can mean all the difference between how successful and sustained the change can be.

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STRONGER THAN THE SUM OF OUR PARTS: A COLLABORATIVE BALANCE: INTERPROFESSIONAL EDUCATION IN CLINICAL SETTINGS - PART 5

Last summer we embarked on a Learning Assessment of an independent academic medical center (AMC). Like many AMCs, their model included separate reporting structures for medical education; nursing education; performance improvement; patient experience; and IS training; with learning technologies and leadership training grouped with diversity and patient language services. The structure lacked visible leadership for educating other clinical professions, such as therapy and advanced practice providers. Continuing to engage leaders across the system in reviewing proposed options, we helped the health system make structural changes to simplify the learning organization. Specifically, to consider an interprofessional approach, by combining almost all of the previously siloed structures for clinical professional education. As they began to commit to implementing an interdisciplinary model, strong feelings surfaced regarding authority over technical aspects of clinical learning — topics like pathways, protocols, and new clinical technologies. The approach struck a chord, raising the question — what should remain within each profession and what should be done in conjunction with others?



Education to promote interprofessional collaboration is a powerful strategy for ensuring the sustainability of patient-centered interventions and outcomes. This was a primary finding in a recent report we authored in partnership with the Robert Wood Johnson Foundation, entitled *Lessons from the Field: Promising Practices in Interprofessional Collaboration*. Having everyone on a care team understand their own role AND the role that other members play is fundamental, yet this basic principle is often not achieved. As we learned in the example above, while the need for integration across disciplines is becoming more broadly accepted, ceding discipline-specific ownership of education constitutes an identity risk. The future of any profession is determined in part by how its workforce is educated today, but how can academic medical centers and health systems reinforce the role and value of each profession, in the context of the other professions with which they will ultimately work?

We've seen several organizations whose models have successfully approached this dilemma, using governance that promotes role clarity to strengthen discipline-based leadership of learning. We describe two here.

Learning Something New Together

Although the University of Pennsylvania Health System has had interprofessional unit-based clinical leadership teams (UBCLs) for nearly a decade, the teams can't always provide the acute focus needed to develop new programs. When the system began developing SOAR (Supporting Older Adults at Risk), a new interprofessional geriatric care model, leaders knew they would have to create temporary structures to support it.

The purpose of the SOAR program is to build a culture of geriatric care on medical units in a hospital without a geriatric medical practice. This means, for example, helping to ensure that older patients' functional and mental condition does not decline over their hospital stay.

Although the SOAR interventions anchor on Geriatric Resource Nurses, or GRNs, there are roles for physicians, therapists, pharmacists, social workers, nutritionists, and discharge planners as well. GRNs required the most education, as each became certified in geriatric competencies, but all unit team members received training in concepts like medication management for older adults and delirium risk. Team members also needed to keep up

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with the processes that SOAR was piloting — ensuring efficient rounds that incorporated the geriatric perspective or implementing new pathways.

SOAR leadership, based in Nursing, was tasked with developing a temporary structure that would overlay the existing interprofessional forums to provide oversight and support for program education. They put in place two tiers of interdisciplinary touch points — an Interprofessional Collaborative Practice Leadership Group (IPCP) and monthly meetings on each unit focused just on the SOAR program. IPCP leadership shaped the pathways, advised regarding education opportunities, and drove engagement for each discipline. Unit meetings were used to disseminate information and gather feedback. Program leadership leveraged UBCL meetings to align SOAR with initiatives across the health system.

In this way, SOAR leadership ensured that all disciplines had a strong voice in the shaping and implementation of education for the program, helping units see the interventions not as “Nursing’s initiative,” but as their own work. Through dedicated attention to not only the right structures, but the agendas of each group, Nursing was able to bring SOAR to life and engage interprofessional leadership of learning.

Patient-Centered Governance

Some health systems have formed interprofessional leadership groups at the system level that function at the heart of all clinical decision-making. This strategy supports creating the understanding that interdisciplinary decision-making is “business as usual” and dissolves silos over time. For example, since 2005 the Patient Care Governance Council (PCGC) at Cincinnati Children’s Hospital Medical Center has enabled every profession to come together in a shared governance structure.

While at Cincinnati Children’s developing the Robert Wood Johnson Foundation report, we had the opportunity to meet with physician, nurse, and educational/performance improvement leadership represented within the PCGC. The four shared how the PCGC is working to create a culture of interprofessional collaboration at Cincinnati Children’s, where hard decisions, such as shaping education across all disciplines, are made within this interprofessional body. Each profession is able to see itself in this model, maintaining its identity while still finding ways to be part of a team and to advance the IP Practice Model. Lisa Adamson, BSN, RN-II, CNRN, Chair of the Nursing Professional Practice Council at the time, shared how the PCGC “Enlightens you outside your scope, helping each member to understand the roles and responsibilities of those outside their own profession, while strengthening their own professional voice.”

The PCGC rests on top of individual professional identity groups, allowing the system to strike a balance in clinical leadership. While the PCGC structure is well-conceived, it is the practice of working through clinical questions that has made the difference, supporting leaders to establish relationships and build trust.

As health systems better understand tomorrow’s demands for strengthening the work of interdisciplinary care teams, interprofessional support and alignment of clinical education will become even more important. Creating active governance bodies that build trust and shape learning can help different disciplines’ voices be heard without challenging ownership and identity of clinical education.

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>.

EMPOWERING HEROES: THE FUTURE OF HOME HEALTHCARE – PART 3

One of the greatest challenges for countries around the world is the aging of their populations. In the United States, baby boomers are rapidly enrolling in Medicare, and the ratio of workers per retiree is dropping. Pressure to reduce total healthcare costs will only become more intense. Additionally, patient expectations for convenience, quality, and customer service are changing, and people increasingly prefer to age-in-place rather than spend time in nursing homes or hospitals.

We believe these trends - an aging population, the need to do more with less, and demand for community-based care - present a fantastic opportunity for home healthcare. In this last of a three-part series, we describe the major strategic initiatives that will ensure BAYADA's people are empowered well into the future to help patients live a safe life at home.



BAYADA Heroes

Home Healthcare as a Service

Providing services in the home is not easy. As we described in [Part 1](#) of the series, it is very hard to operationalize high quality, reliable, home-based care. It requires a specialized culture, systems, and capabilities to manage a mobile workforce.

It is common for hospital-owned home health or hospice agencies to face challenges with leadership, management, quality, reliability, and financial sustainability. These struggles are not surprising, as home-based care is very different than managing hospital assets or physicians in the clinic. Still, many health systems understand that home health and hospice care are strategic capabilities they need as healthcare financing migrates to risk-based payment.

BAYADA is working with health systems to manage their home health and hospice functions as a service. Our scale and complete focus on delivering outstanding care in the home environment allow us to execute more effectively and with the agility to adapt as home healthcare evolves.

To ensure integration between BAYADA and our health system partners, we use three typical models aligned for long term, mutual success:

- 1. Joint Venture** – In this model, BAYADA and a health system partner co-own an entity that serves a market. Existing assets are merged, and the joint venture is capitalized. BAYADA operates as the day-to-day manager and provides the people, operating model, and back-office platform. Effective governance is critical to making this relationship successful, and both BAYADA and the health system have Board of Director representation and financial risk at the joint venture level.
- 2. Management Agreement** – Sometimes it is not practical for a health system to spin out existing home health assets. Under a management services agreement, BAYADA has a long-term contract to manage day-to-day operations. The health system owns the agency and can set strategic priorities, while BAYADA executes against the plan. The benefit of this model is that a health system that views home healthcare as a strategic asset under risk-based payment can subsidize home-based services to reduce costs elsewhere, while BAYADA focuses

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continued

on execution excellence. The challenge here is that these are complex contracts to negotiate and manage.

- 3. Full Acquisition with Preferred Partnership** – Historically, the most common model was for hospitals to fully divest agencies that BAYADA would acquire. We would then work as a preferred partner with the health system. The benefit of this structure is that it is the simplest to manage, as the agency is fully owned by BAYADA. The challenge is that the health system has reduced governance power and financial ties.

By allowing BAYADA to focus on day-to-day execution with a governance structure that creates strategic health system integration, “home healthcare as a service” is a win-win that is certain to gain traction.

Building Better Services to Manage Risk

As we described in [Part 2](#), home-based services are divided into four general categories – post-acute home health, home hospice, medical home care, and non-medical home care. Today, these services have different payment streams which largely define what services patients receive and when – usually in an uncoordinated way.

It is well established that a relatively small number of people drive a disproportionate amount of healthcare spend. Caring for people in the community – at home or a home-like environment (e.g., assisted or independent living) – is an opportunity to integrate services to keep people out of high cost settings like hospitals, emergency departments, and nursing homes. Too often the services these complex patients receive are fragmented and not optimal for their medical, social, or behavioral health needs.

We believe there is tremendous opportunity in redesigning care and payment to achieve the goal of helping people live at home. As the payment focus shifts for value over volume, we are seeing an increasing appetite from CMS and managed care companies to push risk to organizations that manage total healthcare costs by focusing on delivering care in the community.

At BAYADA, we have two key efforts that will help us organize to achieve the goal of keeping people at home. First, we believe an employed physician group will allow us to integrate our various clinical services to better achieve the goal of keeping people at home. Second, we are working with payers to structure contracts that give us the financial tools to achieve this goal:

- 1. Physician Services** – Historically, home healthcare has had limited direct participation of physicians and nurse practitioners. While these providers order home-based services, their involvement is usually constrained within the walls of a clinic. BAYADA is in the process of building out a national group practice that will elevate the capability of our teams to deliver increasingly sophisticated care in the home. We believe this group will be the platform for both direct care delivery in the form of house calls, in addition to coordinating care among internal and external providers. This group practice will augment rather than compete with physician groups and hospitals, as we will be better able to achieve results that matter to them (e.g., reduce readmissions, improve end-of-life transitions, optimize medication adherence, close quality and risk-adjustment gaps, and reduce total cost of care).

EMPOWERING HEROES: THE FUTURE OF HOME HEALTHCARE – PART 3

continued

2. Risk-based Contracting – We are amazed at the speed with which payers are embracing new financing models. CMS provides two opportunities we believe will grow enormously – Independence at Home (IAH) and Program for All-Inclusive Care of the Elderly (PACE). Commercial payers under Medicare Advantage or duals programs (D-SNP and FIDE-SNP) are increasingly amenable to risk-based contracts. Other than PACE (which has been around since the 1970s), experience with these new types of contracts is limited. However, we at BAYADA are very optimistic that our proven results in care delivery will help us to be a leader and preferred contract partner.

Technology

Just like every other industry, technology will play a critical role in reshaping how home healthcare is delivered. We are optimists and believe technology will provide us with the opportunity to serve more people, better, and at lower cost.

For most of our service lines, technology will be an enabler to improve patient experience while reducing overhead. Easy to use applications for self-service, simpler payment functions, and better communication tools will improve the experience of home-based care for patients and caregivers. Payment compression is inevitable, as are rising wages, so technology will allow us to reduce administrative overhead, improve team communication, and protect margins.

Disruptive technologies do have the potential to threaten some of our service lines. In particular, medical and non-medical home care where patients and hired caregivers directly interact and self-manage could make the full-service agency model less viable. It is our belief there will always be a need for some managerial oversight and personal touch. That said, we will need to adapt to ensure we are competitive with venture-backed companies like HomeTeam and Honor.

In summary, it should be clear we are very optimistic about the future of home healthcare. We provide a service that people want and need, while payment and technologies are adapting to better help us achieve our goals. BAYADA is fortunate to be well positioned as a long-term oriented, national scale provider with authentic mission, values, and culture. Ultimately, our success will be dependent on our people, who will always be empowered to heroically deliver the care their patients need.

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PRACTICES OF ETHICS: AT THE CRUX OF INTERPROFESSIONAL COLLABORATION

Ethics is best thought of not as a set of judgments, but a set of practices. These practices are, ideally, habits that guide and govern professional lives and everyday activities.

The increased efforts to develop interprofessional teams present decidedly demanding ethical challenges. We are familiar with the kind of teams that “medical homes” involve. These are made up of several professions, held together by the dominance of the disciplines of medicine. And we know about hospice teams, with their more inter-disciplinary variety held together by that remarkable set of organizational practices, hospice continues to nurture and deepen.



But these newly evolving *interprofessional* teams present us with a “disciplinary multiculturalism,” if you will, unlike anything we have known so far, to the point that we might sometimes want to say “*multi-professional*,” rather than “*interprofessional*.” What I want to focus on are the ethical challenges involved in the deepening realization that each profession has its own culture, its own practices, and, to this degree, its own “ethic.” How would we describe, for instance, the differences found here among quite common activities of three professions?: Developing and utilizing a formulary (pharmacy); versus making a diagnosis (medicine); versus establishing an hour-by-hour, sometimes minute-by-minute care plan for a patient (nursing). We are talking different rhythms governing each day; different priorities for what counts as emergent and not; different skills and training. How then do you bring those distinct ethics together under a single umbrella? Part of the answer is that we need to be quite intentional about grounding our ethical practices in this new and complex and still shifting territory.

The *Wharton Healthcare Quarterly* has just run an important four-part series on Interprofessional Collaboration - Stronger than the Sum of Our Parts ([Part 1](#), [Part 2](#), [Part 3](#), [Part 4](#)). I especially appreciate the emphasis in these pieces on the importance of practice, on defining organizational culture as “what people do, rather than what they say they do.” “We can think of culture as a collection of behavioral practices . . .” as well as the importance of the “practice” of ethics, and the ethical aspects of the practices those four pieces bring to the fore. Let me demonstrate what I mean by taking up themes introduced in Parts [3](#) and [4](#) of the *Interprofessional Collaboration* series.

Creating a Level Playing Field. When we think carefully about professions as cultures, we realize that, in terms of interprofessional teams, *we are not even on the same playing field yet*. Moving skillfully here begins with not underestimating how complex this will be. This will require the kind of listening to each other that we need always to be doing with our patients. It will require looking for subtle clues that communicate without words – the kind we learn to read as we develop cultural competencies.

The crux of the practice of interprofessional ethics lies in the realization that each profession, and each discipline and specialty within each profession, has its own funny little quirks; its obscure terms and maddening acronyms; its own history of developing and of relating to other professions; and its own assumptions (not all of them complementary) about the other professions they are to work with in these teams. Ever hear pharmacists talk about doctors? Nurses about doctors? Doctors about almost any other profession?

How do we get on the same playing field? Much of this has to do with economics and status; much has to do with the recalcitrance of professional societies and leadership. Change in these structural

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continued

dynamics will be a long time coming, as necessary as it is. It is for just these reasons that I think a first emphasis on ethical practice is so important.

Training Different Disciplines Together. Here at the Medical University of South Carolina, we recently held a campus-wide, full-day retreat for all of our students in our five different colleges (nursing, pharmacy, allied health, medicine, and dental). The program involved forming interprofessional teams of students and assigning them a simulation in which they disclosed a significant treatment error to a family.

Here we confront “multi-professionalism” in the field: Are there different practices for error disclosure in different professions? Do we even know what they are? Won’t this be important if, as a team, you are having to disclose a significant error together? There may not even be agreement amongst team members about what constitutes an error, or an error of significance. Pharmacists may have very different ideas about what counts as a medication error than doctors or nurses. Teams must be prepared to start at ground zero, without being discouraged or feeling like such prep time is wasted. This “wasted time” is an essential *investment* – for the healthcare professional, for the team, for the patients, and for the families.

And then think about how very different error disclosure by a team is from such a disclosure by an individual. Who will be the initial spokesperson for the team? Who actually makes the disclosure to the patient/family? Who takes responsibility for the error? Error is, after all, seldom one person’s doing. Medication errors might involve: MD, RN, Pharmacy. Falls: OT, PT, MD, RN. You will need disclosure and assumption of responsibility *within* the team, before your team can skillfully, and with integrity, disclose the error to the family and/or the patient.

Think about how a medication error is to be analyzed. Are we looking for the person “whose fault it is”? If this is so, we are operating as a collection of individuals, not as a team. A more promising approach from a developmental perspective would be to think of the team as a *system* and to look for the *flaw in the system* that led to the error. In this case, there is acknowledgment of collective responsibility combined with collective commitment to improve performance of key practices.

We need to view the development of teams from the standpoint of ethics, not just from that of group psychology, performance studies, or management efficiency – as important as those things are. Our interprofessional teams must have robust ethical capacity. They need to have mastered the skills of ethical practice.

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DOING WELL BY DOING GOOD: FOR-PROFIT COMPANIES DELIVERING HIGH-QUALITY CARE TO POPULATIONS IN NEED

Numerous for-profit healthcare companies combine the provision of an important and high-quality product or service for individuals in need, with the execution of a business model yielding returns for owners, employees, and financial investors. Many such companies have shown sustained success while also creating opportunities for further growth and value creation. These companies are “Doing Well by Doing Good,” and we will take the opportunity to highlight their efforts in this and future editions of the Wharton Healthcare Quarterly.



In this issue, we highlight ReMed, a provider of post-acute brain injury rehabilitation services, based in Paoli, PA, just 20 miles west of our beloved Wharton Healthcare Program and University of Pennsylvania campus.

ReMed Background and Philosophy

ReMed was founded in 1984, focusing on the single premise that people with brain injuries have the potential to return to life in the community. The mission of ReMed is to meet the needs of its clients and customers by providing exceptional and innovative neurological rehabilitation and supported living services, and to provide staff with a supportive, educational environment in which to do their jobs.

ReMed’s extensive system of comprehensive services allows access at multiple levels and varying stages of recovery. Whether the injury is mild, moderate, or severe, the company’s philosophy is to meet the individual where the need is.

Brain Injury Facts

According to the Brain Injury Association of America (BIAA), traumatic brain injury (TBI) is defined as an alteration of brain function, or other evidence of brain pathology, caused by an external force. The BIAA reports the annual incidence of TBI in the United States is 1.7 million and that 25% of such injuries are classified as moderate-to-severe. The association further reports that 5.3 million Americans live with a long-term disability as a result of TBI.

In addition to these facts, the Centers for Disease Control and Prevention (CDC) notes that TBI is a major cause of death and disability in the United States, contributing to about 30% of all injury deaths, and that those who survive a TBI can face disabilities which may last the rest of their lives. The CDC cites that in the U.S. in 2010, TBI (either alone or in combination with other injuries) was a diagnosis in more than 280,000 hospitalizations and 2.2 million emergency department visits and contributed to the deaths of more than 50,000 people.

Scope of ReMed’s Post-Acute Brain Injury Rehabilitation Services

For decades, ReMed has been providing residential and outpatient brain injury rehabilitation services in the Philadelphia and Pittsburgh areas, with additional locations being added in 2016 in New Jersey and Maryland. Group homes and apartments that are either owned or leased by ReMed provide a supportive and therapeutic environment. Programs delivered in these residential settings cover the spectrum from short-term intensive rehabilitation services all the way to long-term supported living. Outpatient services are provided in ReMed’s outpatient clinics, and home and community-based services are provided in an individual’s home, community, worksite, or school, as a standalone service or in conjunction with other providers.

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DOING WELL BY DOING GOOD: FOR-PROFIT COMPANIES DELIVERING HIGH-QUALITY CARE TO POPULATIONS IN NEED

continued

ReMed has achieved nine consecutive three-year accreditations from the Commission on the Accreditation of Rehabilitation Facilities (CARF). This designation represents the highest level of accreditation that can be awarded to an organization in this clinical arena.

Evolution in Ownership Structure Aiding Expansion

ReMed was independently owned and operated for about 30 years. In 2013, ReMed was purchased by Bregal Partners, a private equity firm. Bregal is unique in that it invests in socially responsible businesses, takes a long-term viewpoint as a function of its source of capital, and has a charitable mission as a key component of its charter. The relationship has proven favorable, as Bregal has offered contacts and expertise, supported the longstanding executive management team at ReMed, and infused resources allowing the company to grow and expand.

ReMed has developed an outstanding reputation for delivering high quality post-acute brain injury rehabilitation services, and the partnership with Bregal is enabling the company to expand its geographical footprint. With this support ReMed continues to deliver superior clinical outcomes, while expanding via a broader array of related services and by entering more regions where there are individuals with brain-injuries in need of high quality services. In addition to organic expansion in contiguous markets, the company seeks to acquire other high-quality providers of post-acute brain injury rehabilitation services in the U.S.

The “Doing Well by Doing Good” Equation

Time spent with the staff at ReMed demonstrates quickly that the “Doing Good” part comes first. Genuine compassion and deep dedication permeate the organization. All staff receive Crisis Prevention Institute (CPI) training, in order to exercise non-violent crisis intervention techniques when needed. This ensures the team is versed in optimally handling situations that can arise from neurobehavioral issues, commonly resulting from traumatic brain injury. Over 120 employees are Certified Brain Injury Specialists (CBIS’s), a credential demonstrating commitment on the part of the company and its employees to gain a deeper understanding of the etiology of traumatic and acquired brain injuries and of incidence and prevalence, treatment philosophies and advances, and nuances relating to the field of brain injury rehabilitation. At all levels within the organization, it is common to find staff with tenures of 15 to 20 years or longer. In 2007, employees of ReMed also were instrumental in founding an affiliated non-profit organization, the Council on Brain Injury (CoBI). The mission of CoBI is to fund education related to brain injury, conduct and support research for more effective treatment, and advocate for improved services.

ReMed is characterized by a desire to help a group of individuals for whom the company’s expertise and dedication are a major need. Very few individuals or families have awareness of the challenges and ramifications of dealing with traumatic brain injury until it happens to them. It takes a unique collection of employees to develop the expertise required to deliver top-notch care in this specialty, and to do so with the compassion and respect that clients and their families desire and deserve. Any financial success (i.e., the “Doing Well” part) that results for investors and employees at ReMed is a function of the deep passion throughout the organization to maximize the quality of care delivered to these individuals living with and recovering from a brain injury.

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THE FUTURE OF HEALTHCARE DEPENDS ON WHO YOU ASK - HOW TO SUCCEED IN HEALTHCARE - PART 1

Committing to excellence means more than simply improving service, it means moving your entire organization towards the vision of a better healthcare system. The mission and vision of your organization is the ‘why,’ it is the reason we do what we do as healthcare providers. I propose that in the current system we are not paying enough attention to the ‘why,’ and the future of healthcare is at risk if we continue to focus on the ‘what’ and the ‘who.’



What is this ‘**why**,’ ‘**what**,’ and ‘**who**’ business?

The ‘**why**’ is providing the highest standards of care. It is often outlined in our mission and vision statements, as it embodies our truest desires for making healthcare better and giving our best to each and every patient we encounter.

We are all committed to excellence, but there’s more to it than just that. Most of us in this industry are good people with very large hearts. By defining this desire to do good, to provide the best possible care, to make healthcare truly great is what will make a real difference.

Product and service innovations, utilization inefficiencies, reimbursement models, and operational structures are the ‘whats.’ While technology, efficiency, effectiveness, quality, and innovation are important to the industry, they potentially create micro-markets that potentially distract us from our mission and vision.

The ‘**who**’ are those of us that assess the unmet needs within the current healthcare system. Those who study, assess, and identify what needs to change are the ‘who’ that will help the entire industry adjust.

Merriam-Webster’s dictionary defines the future as “the time coming after the present time.” Those of us in this field all agree the future of healthcare is ever-changing and bigger than any one of us. It will impact our work, our roles, our government, our patients, and our children.

If we are going to respond to the current situation and improve healthcare in the future, we need to focus on integration with prevention at the core. Healthcare strategy, innovations, and utilization all have a role; a role I am assuming most of you have read countless articles on and have varying opinions. The question becomes how to best respond to change and continue to improve.

“We have met the enemy, and that enemy is us.” Pogo, 1949. Yes, we are the enemy — the doctors, the insurers, the providers, the government, and the patients. We are the ‘who.’ Our perception in the past has dictated that improved productivity, information management, consumer satisfaction, and delivery models were trends in need of adjustment and improvement. These adjustments are now seeing the reality of implementation.

Many of us are asking how clinicians, employers, providers, insurers, and patients’ roles will change. Some will focus on plans of efficiency while others will focus on actions, and there will always be pressure to improve productivity in both patient care and operations.

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THE FUTURE OF HEALTHCARE DEPENDS ON WHO YOU ASK - HOW TO SUCCEED IN HEALTHCARE - PART 1 *continued*

There will always be a fad, to make up for the changes from an agrarian society to one of easy access. Clinical care is changing; nutrition and exercise as medicine may not have been the doctor's job of yesterday. But that is changing!

There will always be micro-markets. More training and access to good providers isn't a bad thing. The question is how micro-markets have caused important objectives to be squeezed out. Maybe productivity would not have come to the table if we were not trying to avoid increasing costs or anticipating reduction in payments. Maybe if we were focusing on the quality of care and our true vision of healthcare, we wouldn't be so worried about margins or financial survival.

We are doing this now, putting decisions into practice and maintaining change. We are addressing if our original perceptions were distortions or realities, which will bring about more change. We still need to collect data, and I think we can all agree we don't have all the answers. But we need to continue to focus on this issue and strive for further change that makes healthcare truly great instead of simply focusing on efficiencies or effectiveness.

We want our leaders to provide better care and better workplaces. Fortunately, most of us do. We have the passion and self-motivation that drive us to provide quality care for our patients, improved consumer satisfaction, and efficient information management. We have to keep that desire to improve, that commitment to excellence alive to continue to improve the industry.

So maybe we just keep creating solutions to perceived concerns. Some of us think value-based payments will revolutionize healthcare, others think standardizing records and payments will make all the difference. And they might be right. But can anyone deny the role of prevention? No. Neither the patient, the clinician, the academic, the physician, the insurer, the government nor the administrator can make that claim. However, believing that prevention is important doesn't mean we deliver prevention clinically or operationally well. Integrating preventive care is a keystone in improving healthcare, and we should strive to achieve this goal.

Change is about providing coordinated and seamless integrative care. Look at the number of providers Dr. David Fogel incorporated in his inner-city model published in the [January 2016 issue](#) of this publication – "[Turbocharging the Triple Aim - Secret Ingredient...Love?](#)" Is this where medicine is going? It is for many!

As healthcare providers, we all agree that integrative care with a focus on prevention is important. I may believe lifestyle medicine does just that. You may disagree. The bottom line is integrative preventive care is about reducing error and improving quality while improving efficiency. Gone are the days of diagnosing, treating, and prescribing. Now are the days of listening and building relationships alongside diagnosis and treatment. Now are the days of doing and sustaining; sustaining change to address the perceived value of patient care. We all need to look inward at how we reinforce prevention and integrate it into our practices. We all must evolve and respond to change.

As shortages and unmet needs are identified in the industry, it is important to review the options. In a world where options run abundant, it is more important than ever to review and analyze those possible solutions, as they're not always going to be viable. Change is about more than just reacting to a situation, it is about responding to the situation in the best way possible. Let us continue to remember the 'whys' of our industry and allow our vision and our mission to propel us into the future of healthcare.

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CARE MANAGEMENT SYSTEMS – THE NEXT MAJOR HEALTHCARE PRODUCT – PART 2

This article is Part 2 in a two-part series on care management systems (CMS). In [Part 1](#), I made the case that care management systems are the next major healthcare product. A new generation of care management systems is evolving, driven by patient-centric and value-based healthcare models. These new generation care management systems include patients in the management of care, enable the entire care team to track patient health and collaborate, and engage patients outside the healthcare facility, not just inside. In [Part 1](#), I also shared my thoughts on the 5 Attributes of a robust care management system. In this article, I share my point-of-view on the 10 capabilities of a robust care management system.



10 Capabilities of a Robust CMS

- 1. Flexible Patient Data:** Capability to import data from EHR systems, patient portals, practice management systems, HRA data, or claims data from payer systems. Data could include demographic and clinical information to help identify and target patients for specific care management programs, as well as patient preference data, if available, for personalized communication. Depending on the complexity of the programs, data intake could happen through secure file transfers or through integration with the data sources.
- 2. Targeting Analytics:** Functionality that allows the Administrator of the care management program to identify the target patients for each program based on demographic (age, gender, geography) or clinical (diagnosis code, medication, vital signs, lab tests, etc.) characteristics. This enables the provider to send customized content to patients that is relevant to them.
- 3. Customized Program Development:** Capability to quickly and easily create custom content (e.g., notifications, questionnaires) for each care management program. The functionality should allow the Program Administrator to either use content that has been previously developed by the provider, or easily create new content using templates and libraries in the care management solution. A robust solution will allow easy customization of programs for different segments of the population based on preference or medical situation, e.g., email or text version for the tech-savvy population, phone version for the tech-challenged population, Spanish version for the Spanish-speaking population segment; and different versions for patients with co-morbidities based on their care plan.
- 4. Personalized Program Administration:** This capability allows the Program Administrator to personalize the engagement with target patients by sending relevant content, in the preferred mode, in the preferred language, at the preferred time to each patient. A robust care management system will have the intelligence to not only automate the personalization based on expressed preferences, but also the adaptive capability to learn from past patient behavior.
- 5. Response Analytics:** This capability tracks patient responses and enables the Program Administrator to evaluate response rates by channel of communication, by geography, age, gender, facility, provider, etc. This allows the provider to optimize the channel mix and content to maximize the ROI of programs.
- 6. Alerts Management:** This capability analyzes patients' survey responses to identify gaps in care and enables automated alerts to be generated based on the rules defined by the provider. Alerts management can be customized to alert different members of the care team (e.g., nurse, doctor,

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nutritionist, social worker) depending on the question and the response. The capability enables the care team to view the alerts generated for each program and each patient, and allows them to manage large populations with exception-based interventions. A robust care management solution will provide follow-up alert-based interventions and educational components that support the patient through the program.

- 7. Rewards Management:** The capability enables providers to encourage patients to change behavior and sustain behavior change by rewarding the desired behavior or activity, e.g., points for responding to a questionnaire or taking their medication on time. Points can be collected and compared with others in the program (social competition), or converted to financial or other incentives, if desired. The rewards act as a positive reinforcement which increases engagement and makes the process of self-care management fun and rewarding.
- 8. Care Manager Dashboard and Workflow Tool:** The Care Manager Dashboard and Workflow Tool enables care managers to access the platform to view information on patients assigned to them, view the programs in which their patients are participating, track their responses, track alerts generated by their patients, and create notes and to-do lists for managing their patients' health.
- 9. Device Integration:** The proliferation of internet-enabled devices and sensors has made it easier for patients to track and share information like weight, blood pressure, and A1C levels with their providers. A robust CMS would enable integration with these devices so the information can be captured automatically from these devices using Wi-Fi or Bluetooth technology, making it possible for providers to analyze this data faster and more accurately.
- 10. Backward Integration of Patient-Generated Data:** Capability to integrate relevant patient-generated data into the EHR system (e.g., activity data, alerts) and patient portals (e.g., activity data, rewards data). This enables integration with the clinical workflow and allows providers to see the patient-generated data within the EHR instead of having to refer to multiple systems.

Surveys show increasing adoption of the new-generation care management solutions – by providers and consumers. There are several drivers for this growing uptake. The Affordable Care Act is creating incentives for providers to adopt these new solutions – with delivery and reimbursement models that shift emphasis from sick care to wellness. Secondly, consumer interest and participation are increasing with the increase in consumer-driven health plans (CDHPs). And finally, the increasing penetration of smartphones, wearables, and EMRs is clearing the path for technology adoption. However, some barriers still exist. As an industry, there's still more work to be done around reimbursement models that encourage remote care management, health information exchange, security, and evidence-generation. But then, Rome wasn't built in a day!

My firm, [Patientriciti](http://Patientriciti.com), has a multi-modal, multi-lingual, patient engagement and care management solution which helps providers and health systems reach and engage with different segments of the population in a personalized way to affect sustained behavior change. Patientriciti's solution is based on the 5 attributes and 10 capabilities outlined in these articles.

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