



**THE WHARTON
HEALTHCARE QUARTERLY**
SPRING 2017
VOLUME 6, NUMBER 2



HEALTH CARE MANAGEMENT
ALUMNI ASSOCIATION

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EDITOR'S LETTER

I am excited to announce a new column - *Downloading Success* - which will provide readers with information and guidance regarding both organizational and individual growth and development! Content will be contributed by premier executive search firms, with our inaugural article, "A Setup for Success: Developing Physicians to Become Organizational Leaders - A Holistic Approach," by Bob Clarke, CEO of [Furst Group](#) and [NuBrick Partners](#), in collaboration with Joe Mazzenga, Managing Partner of NuBrick Partners. Thanks to Kate Reed and the Career Development Committee for your collaboration in helping to bring this new offering to the table!

This issue also welcomes back Dr. Harris Contos, DDS, WG'80 as a contributor with his timely article "Health Insurance at Ground Level," which provides one view inside the Affordable Care Act in his interview with Karen Marriner, a licensed health insurance agent in California.

Lastly, just a reminder about "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](#).



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

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

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Managing Editor

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THE PRESIDENT'S DESK

Dear Fellow Alumni and Friends,

This is a call to moral professional action.

With the current uncertainty and potential upheaval around government policy, we could be in for a wild ride that may substantially change the healthcare industry. (This letter was submitted in early February, but I'm willing to bet that upon publication in April, there's still a fair bit of uncertainty.)

In times of uncertainty (like now) it's easy to put our heads down and worry about navigating a complex policy and business environment by doing what we think is right for our organization. But we are called on to do more. Not as Republicans, Democrats, or Independents, liberals or conservatives, but as healthcare industry leaders and professionals.

More than other industries, healthcare challenges us on numerous and diverse levels. Whether we are in pharma, biotech, IT, products, finance, delivery, policy, or insurance (and we have alumni in all these areas and more), we must understand and address the complex web of societal, policy, regulatory, economic, technological, clinical, and ethical issues of the day – not only those that affect us, but also those that we will influence by our actions.

It may seem daunting to weigh and integrate all these factors into our analyses, our decision-making, and our vision. Yet, as we progress from positions of support to positions of leadership, our responsibility to think broadly grows even more critical. When we do employ this wider lens, some core questions emerge to guide us:

- Would I want my family to get healthcare in the system we're creating?
- Is our approach fair – would I choose it if I didn't know whether I would be wealthy or poor, healthy or sick?
- Do we support accuracy and disclosure, or employ obfuscation and distortion for private gain?
- Are we striking the right balance between health needs and other societal needs?
- Can we be better stewards and more responsibly use resources - financial, human, environmental?
- Am I speaking up for what is right and just, even if it feels awkward in my organization or profession?

The Wharton Healthcare 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 fresh MBA graduates, mid-career leaders, seasoned veterans, and retirees, 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



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

THE PRESIDENT'S DESK

continued

We are not just *navigating* the coming changes – we are also *shaping* them. It is up to each of us. Consider the impact we can have if we work together and make the right choices.

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

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THE PHILOSOPHER'S CORNER

Life Lessons:

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

... skied more, eaten less.

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

... stayed in that job where my boss and I were not a good fit. As someone wise once said to me – “If your boss doesn’t think you’re fabulous and if s/he doesn’t work hard to lift you up and support your success, you’re in the wrong place.” I’ve learned that staying in a job because “It’s good for me, I’ll learn from the dysfunctionality” - is flat out a bad idea!

Favorite Quotes:

1. “To all the little girls who are watching this, never doubt that you are valuable and powerful and deserving of every chance and opportunity in the world to pursue and achieve your own dreams.”
~ Hillary Clinton, November 9, 2016
2. “Darkness cannot drive out darkness; only light can do that. Hate cannot drive out hate; only love can do that.” ~ Martin Luther King, Jr.
3. Aut inveniam viam aut faciam. Latin proverb. Translation: I shall either find a way or make one.
4. Do what you love, in the service of people who love what you do. ~ Steve Farber, *The Radical Edge* and *Extreme Leadership*

Recommended Reading:

All the Light We Cannot See by Anthony Doerr

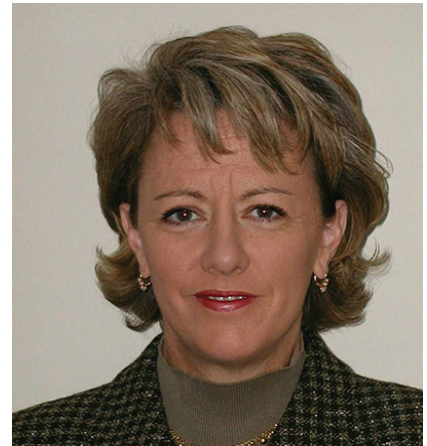
The Radical Edge by Steve Farber

The Five Dysfunctions of a Team by Patrick Lencioni

What Works for Women at Work by Joan C. Williams and Rachel Dempsey

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This month's philosopher:

Kate Reed, WG'87

To learn more about Kate,

[click here.](#)

Column Editor:

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

To learn more about Colette,

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ALUMNI NEWS

John Whitman, WG'78

John Whitman, Executive Director of The TRECS Institute joined with the Leonard Davis Institute to host a one-day, invitation-only summit, "The Future of America's Nursing Home Industry." Changes in healthcare reimbursement have resulted in hospitals creating "preferred provider nursing home networks," with the goal of improving care and reducing costs. While most see this new positioning as a positive change, those nursing facilities not selected to participate in these new preferred networks are likely to become predominantly Medicaid-only facilities. This could be a serious issue because **most state Medicaid programs reimburse nursing homes an average of \$23 less per day than the actual costs.** This could lead to multi-year periods of declining quality and ultimate closures for 30% or more of our nation's 15,000 nursing facilities. This summit was designed to bring 45 experts in the nursing home field together to discuss this very issue. Instead of viewing this as a future financial and quality crisis (which it very likely could be), this group of professionals will view it as an opportunity, a catalyst if you will, to identify immediate opportunities to bring about needed operational and reimbursement changes that can result in improved care for our nation's 1.4 million nursing facility residents and saved dollars that could eliminate the potential financial crisis that looms ahead for many of our nation's 15,000 nursing facilities. The program, funded by The Robert Wood Johnson Foundation, was held on Friday, February 17th at the Leonard Davis Institute on the campus of the University of Pennsylvania.

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Maureen Long, Nu'75, WG'80

Joined UPMC Insurance Services Division as Vice President and General Manager, Southeast Regional Market.

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longma4@upmc.edu

Sherrie Fishbein Bitterman, WG'81

2016 was a banner year for our family. I have two children who graduated medical school and are currently doing their internships in Boston. My youngest daughter completed her BSN at University of Pennsylvania in December 2016 and will begin working at Children's Hospital in Philadelphia while completing her APRN at Penn. And, my husband and I celebrated our 30th wedding anniversary.

I continue to work as a Clinical Research Nurse at the Yale School of Medicine in the Section of Otolaryngology.

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Douglas S. Arnold, WG'84

Doug is the founder and CEO of American Healthcare Connect Consortium (AHCC) which he created in 2014 to enable hospitals and federally qualified health centers (FQHCs) to offset 65% of their costs for high speed broadband through grants from the FCC's Healthcare Connect Fund. Currently, there are 63 sites in AHCC. To date, AHCC members have been awarded \$850,000 in grants from the Healthcare Connect Fund, with over one million in additional grants under FCC review.

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Jeff Voigt, WG'85

Elected to Village Council Ridgewood NJ. Recently published: Voigt J, Mosier M, Darouiche R. Antibiotics and antiseptics for preventing infection in people receiving revision total hip and knee prostheses: A systematic review of randomized controlled trials. *BMC Infectious Diseases*. 2016. 16:749; DOI 10.1186/s12879-016-2063-4.

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Todd Herrmann, WG'85

In addition to my consulting practice Cadensus, I am now full-time faculty with Simmons School of Management. This semester I am teaching two strategy classes – one to undergraduates and the other to healthcare MBA students who are also in the workforce. A lot has changed in education since I was an MBA student, so trying to get quickly up to speed! In addition to teaching, I am also authoring content for on-line MBA courses under development.

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[Learn more.](#)

Tom Davis, WG'87

Happy to announce that I started as Georgia Market President for JenCare in November. JenCare serves low income Medicare Advantage patients in its PCP health centers. The model has produced great improvements in health for our patients by increasing the number and quality of PCP visits. My job is to grow the business by adding more centers and more payors.


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ALUMNI NEWS

continued

Brian P. Goldstein, WG'89

In November 2016, Brian P. Goldstein, MD, MBA became Chief Health System Officer for UW Medicine and Vice President for Medical Affairs at the University of Washington. Previously, Dr. Goldstein was the Executive Vice President and Chief Operating Officer for the University of North Carolina Hospitals.

UW Medicine's clinical enterprise includes Harborview Medical Center, Northwest Hospital & Medical Center, UW Medical Center, Valley Medical Center, and twelve UW Neighborhood Clinics. Dr. Goldstein also oversees the operations of Airlift Northwest and other key senior management positions at UW Medicine.

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[Learn more.](#)

Laura Brady Saade, WG'93

Joined UCLA's Department of Neurology as Director of Strategic Planning in October 2016.

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Eric Davis, WG '96

Eric Davis invites healthcare alums to join him for a beer the next time they are passing through Sydney, Australia. "After 7.5 years with Abbott Diabetes Care in the SF Bay Area, this is really big news for me and my family. As of mid-February, I will be the new Head of Innovation for Cochlear, Limited, the world's leader in implanted hearing aids. Cochlear has a very, very strong R&D organization, but the creation of an innovation function within their Global Strategic Marketing group is an indication of their intention to become even more "customer-centric" in their visioning of new, future products and services. With the great success of Freestyle Libre, I hadn't been looking to leave Abbott Diabetes Care, but I quickly became very impressed with how aggressive Cochlear has been in its category, and realized I will likely be able to make an even bigger impact at Cochlear. Our company's global headquarters are located on the Macquarie University campus 10 miles northwest of the Sydney Harbor Bridge. On the weekends, you can find me at the Sydney Rowing Club or with my family on one of the many beaches North of Manly."

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ALUMNI NEWS

continued

Owen Garrick, MD, WG'98

Bridge Clinical Research has been selected as recipient of The 2017 Community Partner Award from The Stanford Center for Population Health Sciences. The award was presented at the Office of Community Engagement's 15th Annual Community Health Symposium at Stanford University.

"The Community Partner Award is a reflection and acknowledgement of the commitment that community partners have made to Stanford and our students, as a true model for mutually beneficial community-campus partnerships. Stanford's Office of Community Engagement's 15th Annual Community Health Symposium honors Bridge Clinical Research for its strong partnership with Dr. Marcela Alsan, Assistant Professor at Stanford University. This study seeks to address health disparities due to a shortage of Black healthcare professionals and the incorporation of students as leaders in the implementation of this collaborative research study was inspiring. We applaud Bridge Clinical Research as an outstanding community partner," said Rhonda McClinton-Brown, Executive Director of Office of Community Health at Stanford University School of Medicine.

Inspired by the 1972 study, "Tuskegee Study of Untreated Syphilis in the Negro Male," Stanford scholar, Marcella Alsan MD, PHD of the Stanford School of Medicine partnered with Dr. Owen Garrick, President of Bridge Clinical Research, and initiated the Oakland Health Disparities Project. Drs. Garrick and Alsan are examining the issue of mistrust of the healthcare system, among other variables. "If you can overcome the issue of mistrust, then one can begin to reap the benefits of our healthcare system," said Dr. Garrick.

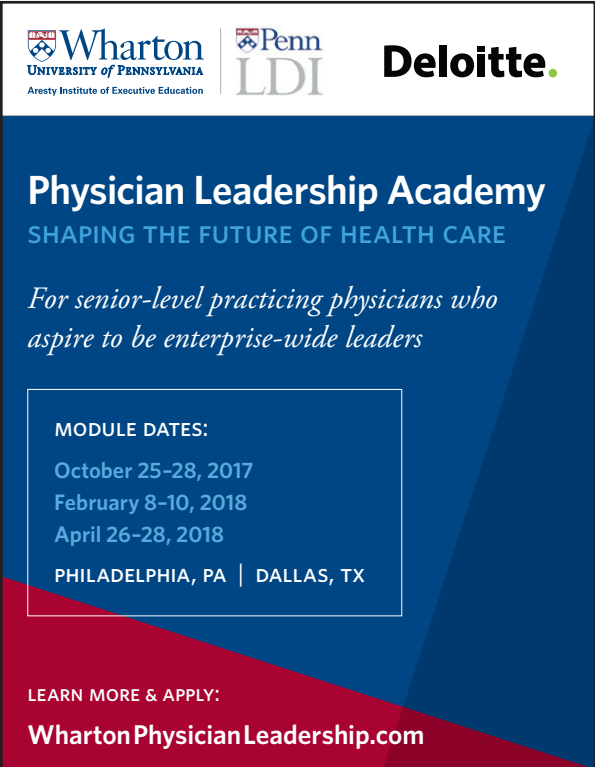
Dr. Garrick collaborated with Dr. Alsan, students at Stanford and UC Berkeley, and emergency medical technicians to help launch the pilot project. Oakland barbers partnered with the researchers to use their barbershops as locations of patient recruitment. Over 200 Black men participated in the study, and the team achieved its recruitment goal over four (4) weekends. Dr. Alsan explains the results of the project thus far looks encouraging.

"The work is important, as it highlighted the role of diversity in medicine and helped identify barriers to obtaining preventative care. Partnering with Dr. Garrick and Bridge Clinical Research was crucial to the success of the pilot project, and we hope to be able to continue and scale our work in the future," said Dr. Alsan.

Although, the intent of this project is to shed light on African-American wariness of medicine and healthcare providers, the results significantly moves towards bridging the gap between race and health outcomes.

To view a video summarizing the project please visit:

<https://www.youtube.com/watch?v=iVnSBGt3diE&feature=youtu.be>



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[Learn more.](#)

Sally Poblete, WG'00

Sally Poblete has been named one of 2017's Women of Influence according to the *New York Business Journal*. The journal recognizes women who have "made an impact both professionally and in their communities." Sally, along with the other honorees, represent the range of businesses affecting the New York City economy, including healthcare, law, finance, and media.

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[Learn more.](#)

David Sturek, WG'01

Dave Sturek has launched with a partner, Davis Griffin, a new private equity firm called Atigun Capital Partners (www.atiguncapital.com). The firm seeks to make control recapitalization or growth equity investments in lower middle market healthcare companies, primarily healthcare services. Atigun works closely with family offices looking to make direct investments into the healthcare sector and who share our philosophy for successfully growing healthcare companies.

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AFFIDAVIT: HEALTHCARE AND THE LAW - ST. JUDE MEDICAL'S CYBERSECURITY TROUBLES/LEGAL AND FINANCIAL RISKS

Nora, who has a pacemaker manufactured by St. Jude Medical, plugged in her Merlin@home™ transmitter before she went to sleep. The transmitter is part of St. Jude's Merlin.net™ Patient Care Network, a remote cardiac care monitoring network that collects data from the pacemaker on the patient's heart rate and uploads the data through a web interface for computer access by the patient, her physician, and caregivers. The network also provides alerts when an event occurs. Nora was happy with her pacemaker and the remote monitoring system because it allowed her to avoid physician visits and provided up-to-date information on her condition. But Nora's heart rate skyrocketed the next morning when she was notified that the U.S. Food & Drug Administration had issued a Safety Communication entitled: *"Cybersecurity Vulnerabilities Identified for the St. Jude Medical's Implantable Cardiac Devices and Merlin@home Transmitter"* (January 9, 2017). The FDA had determined the transmitter contained security flaws that made it vulnerable to outside attacks, possibly leading to rapid depletion of the pacemaker's battery or the administration of inappropriate pacing or shocks. Although St. Jude Medical was applying a security patch, Nora suddenly realized the risks of relying on technology to guard her health, as did her physician. St. Jude Medical had much to cope with as well.



Last year, St. Jude Medical and Abbott Laboratories announced they were engaged in negotiations for Abbott to purchase St. Jude Medical for approximately \$25 billion. The deal closed on January 4, 2017, a week after the Federal Trade Commission announced it would approve the acquisition, which has been subject to an intensive anti-trust investigation. The timing of the FDA's Safety Communication, which was issued five days after the deal closed, is interesting, suggesting that obtaining the FDA's agreement to sign off on Merlin@home™'s cybersecurity issues may have been related to the deal. Although the St. Jude's Medical Merlin.net™ Patient Care Network was only one of St. Jude Medical's product lines, the discovery of the cybersecurity issues during deal talks could not have been welcome. Not only did this discovery result in an FDA investigation but in a significant dip in stock after an outside party uncovered and announced the vulnerabilities.

Muddy Waters, an investment research firm, first announced the vulnerabilities in August, 2016. It issued a 53-page report stating that it was shorting St. Jude Medical's stock based on findings that the device maker would likely lose half of its revenue for approximately two years due to weaknesses in the cybersecurity of the Merlin@home™ device. The Muddy Waters' report alleged that Merlin@home™ lacked standard security defenses, such as strong authentication, encrypted software and code, anti-bugging tools, and anti-tampering mechanisms, that might be able to prevent a hacker from causing the device to malfunction or drain the battery. Muddy Waters explained that it had been notified of these weaknesses by a security firm, MedSec, which, according to media reports, would receive a share of any profits made off a short sell of St. Jude Medical's stock. Unauthorized security probes by security firms are becoming more common.

The week after the report was issued, St. Jude Medical's stock fell sharply; the FDA confirmed that it was investigating Merlin@home™; and St. Jude Medical brought litigation against Muddy Waters in federal court in Minnesota, claiming the firm disseminated false and misleading information designed to manipulate St. Jude Medical's stock price. In the subsequent months, there was much discussion among physicians, device makers, and cybersecurity experts as to

Contributor:
Lisa Clark, JD'89
To learn more about
Lisa, [click here](#).

AFFIDAVIT: HEALTHCARE AND THE LAW - ST. JUDE MEDICAL'S CYBERSECUTIRY TROUBLES/LEGAL AND FINANCIAL RISKS

continued

whether Muddy Waters' claims were legitimate and whether patients should be instructed to stop using the transmitter. With the FDA's January 9, 2017 Safety Communication, St. Jude Medical acknowledged the vulnerabilities and applied the patch. Fortunately for St. Jude Medical, it recovered from the public attack on the security of its product and systems and was able to complete the sale to Abbott.

What can device companies, investors, providers, and of course we as patients learn from this saga? Here are some takeaways:

- If you are a device company, developer, or distributor of a mobile or a software-based health product that transmits information over the Internet, implement security features and protocols based on highest industry standards, including ongoing assessment and fixes. The FDA recently issued important guidance on cybersecurity in medical devices. *Postmarket Management of Cybersecurity in Medical Devices* (December 28, 2016). And make sure you have adequate cybersecurity insurance.
- If you are a device company, a potential investor, or physician using mobile health for patient care management, be aware of the malpractice risks for devices and software that may not meet security standards. Keep up-to-date on alerts from the manufacturer, the FDA, trade associations, and others. And for healthcare providers, make sure your insurance covers advice you may offer to patients regarding mobile health devices.
- If you are considering investing in a product or service that relies on mobile health or remote healthcare management, make sure your due diligence includes a comprehensive security analysis and assessment. Use technology experts as necessary to test the devices and systems.
- For all stakeholders, rely on experienced legal counsel and consultants to ensure that you are aware of all of the risks and trends, and that any assessments, due diligence, and user recommendations satisfy legal and industry standards.

So back to Nora. She discussed with her physician the safety and risks of using of the Merlin.net™ Patient Care Network and the Merlin@home™ transmitter. Based on the FDA's Safety Communication, the physician recommended that Nora continue to use the transmitter, and Nora agreed to do so. Nora is comfortable with her decision for now, but she's holding onto the number for the class action lawyer who called her just in case.

Contact Lisa at: LWClark@duanemorris.com

Disclaimer: This article is prepared and published for informational purposes only and should not be construed as legal advice. The views expressed in this article are those of the author and do not necessarily reflect the views of the author's law firm or its individual partners.

DOWNLOADING SUCCESS: DEVELOPING PHYSICIANS TO BECOME ORGANIZATIONAL LEADERS - A HOLISTIC APPROACH

The healthcare environment has experienced continuous and tumultuous change for a number of years. There is no question that change is the one constant that can be expected for the foreseeable future. What is required during times of upheaval is leadership. Leaders provide hope. It is at such a time as this that physician leadership is especially vital.

The divide between the administration and the physicians at a healthcare organization used to create a sense of wariness between “the ‘suits’ and the ‘scrubs,’ ” as one Chief Medical Officer described it to us. Developing physician leaders is proving to be one avenue to minimize the mistrust, but more work needs to be done.



As healthcare organizations have acquired medical groups at an increasing pace over the past decade, physicians have told us they have been feeling like they have less of a voice in how healthcare is delivered. And, increasingly, having to adapt their work to the needs of electronic medical records has given them less time with their patients, they say. As the move to value-based care helped providers and insurers alike see the untapped potential in having physicians step up to guide the entire enterprise, physicians also see the possibilities of rewiring their organizations to make “patient-centered care” more than just a slogan.

Yet the phrase “physician leadership development” doesn’t appropriately describe what needs to happen as doctors take on executive roles. Leadership development is not something that is done ***to*** physicians to enable them to fit into the organization and embrace the executive mold created for those who would lead the company. The organization itself must be renovated to adapt to the new leadership required of a new era.

Thankfully, in our work helping physicians realize their potential as corporate leaders, we are seeing a greater eagerness among them to take on new responsibilities. We see a recognition that the skills they learned in leading a small group of nurses and office staff in their practice are not sufficient to enable them to manage a \$100 million budget. The goal of leadership development is to make this journey less jarring for all concerned.

Let’s begin with the organization’s role in developing physicians as leaders. It is not uncommon for physicians to be thrust into leadership roles (even as a leader of other physicians) with little or no training. “They’re smart,” the thinking goes. “They’ll figure it out.” But a sink-or-swim mentality is not fair to the physician or the organization. For instance, after a board meeting, we’ll sometimes hear a comment like this from other executives in relation to a physician who participated: “Don’t worry about Dr. Smith. He doesn’t understand financials.”

Let’s unpack that for a moment. There are at least two organizational problems with a mindset that Dr. Smith isn’t skilled at comprehending finances. On the company side, it’s harmful to the organization to have someone involved in the decision-making process who doesn’t understand the financial picture. On the physician side, why hasn’t the organization given Dr. Smith

Contributors:

Bob Clarke and Joe Mazzenga

To learn more about
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DOWNLOADING SUCCESS: DEVELOPING PHYSICIANS TO BECOME ORGANIZATIONAL LEADERS - A HOLISTIC APPROACH

continued

guidance and training in grasping finances so he can then use his clinical experience to perhaps arrive at suggestions or solutions that no one else in the room may have thought of?

Yet this must be balanced by changes that physicians must make if they are to be taken seriously as executives. One physician who has successfully made the transition told us that his breakthrough came when he learned not to play the “doctor card” and simply be known as one of the team.

In practical terms, we have to change what is expected of physician leaders. Their schedules and duties must be changed – organizations need to free them up from clinical duties so they’re not constantly interrupted when the leadership teams meet. When we attend board meetings, we often see physicians get up and leave the room two or three times when their pagers go off. Teams insist the CFO and the COO be free from distraction during such consequential gatherings – why do we not allow physician leaders this latitude?

Similarly, physicians must learn to see themselves as part of the team and understand they don’t have to have all the answers. The most successful physician executives we have encountered realize this. They know true leadership is about building teams who create an empathetic and collaborative culture.

How you interact with teams, how you implement a team’s knowledge, how you read others’ personalities, learn to trust others, and work through a decision-making process – these are the nuts and bolts of leadership.

One of the most important fallacies around physician leadership development is that it can somehow happen in a vacuum, like a couple hours in a classroom surrounded by others wearing lab coats and stethoscopes. If you are not also training the people who surround these physician leaders, your work is incomplete.

As it should for all leaders, an organization must develop a plan for a physician leader to ensure that he/she is continuously growing. This includes ensuring that leadership in general and physician leaders in particular are not operating in silos. They must be partnered with other executives in the organization to better understand other components of the institution. Similar to making rounds, leaders should be exposed to operational planning, budgeting, strategic planning, facilities management, and more. The goal is for the leader to have a more holistic understanding of what is needed to lead the enterprise.

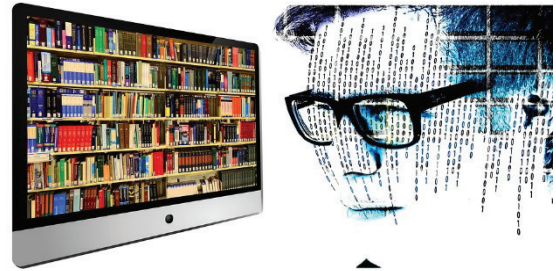
We need physician leaders more than ever, and we have a limited amount of time to do it right. Strong physician leaders can create a ripple effect that can improve millions of lives. Isn’t that, ultimately, what healthcare is all about?

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WHY I AM HAPPY I AM NOT AN EXPERT, AND YOU MIGHT BE HAPPY NOT TO BE ONE TOO.

I am not an expert. And, I am happy about it. I have been a CEO, one with objective success when viewed with the conventional metrics of quality and financial performance, customer satisfaction, employee satisfaction, and longevity in the job. I practiced actively for 20+ years as a physician. In addition, I have been a physician executive for over 30 years. And, in my retirement, I am a busy consultant, both paid and mostly unpaid. Over my long career as a trained professional I have been asked for my advice based on my “expertise” innumerable times. People continue to seek my advice. That is one of the main reasons that “not being an expert” is so important.



Over the years, I have accumulated a large amount of experience in a varied career. These experiences have provided me with diverse perspectives. I have had the privilege of seeing healthcare from many vantage points — as a clinician practicing internal medicine and geriatrics, as the elected leader of a multispecialty group in a group model HMO, as a health insurance executive, as a chief medical officer of an large, open staff voluntary hospital, as a CEO of a large health system, as an academician, and as a consultant on healthcare program development, healthcare management, and public policy. My experiences have taught me much. These experiences form the context of the advice I am asked to give. They frame the metaphors I use and populate the examples I share. However, my “experiences” are not “expertise.” And, my experiences have taught me that I am no expert — at least in the conventional sense.

I value expertise and have often marveled at the experts I have seen in action. To see an expert physician make a difficult diagnosis rapidly with seeming ease and confidence is a wonder. To watch an expert surgeon operate is akin to experiencing a dancer express the nuances of life in a ballet or a soprano summon the most complex emotions with her song. I have been in the audience when an expert speaker electrifies the room with his oratory. I have seen expert leaders deftly engage and energize an entire organization. I have seen expert consultants reveal organizational truths unapparent until the expert’s questions and shared knowledge makes the truths obvious.

My experiences are common ones. We have all experienced expertise and its benefits. Seeing an expert in action is a wondrous thing. Experts do much more than enlighten us. Experts can make us feel reassured and confident. They can engage our energy and inspire us to action. Their words, their recommendations, and their actions can change our lives. They can also lead us to disaster.

Over the past 20 years, there has been considerable research into the field of expertise. This research has been distilled into popular books. The Nobel Prize winner Daniel Kahneman’s *Thinking Fast, Thinking Slow*¹ recounts decades of research comparing the psychological phenomena of fast “intuitive” judgments with slower “thoughtful” decision-making. Malcolm Gladwell’s *Outliers*² explores the social conditions and personal temperaments required for the development of expert abilities. Michael Shermer in his *Believing Brain*³ points out the foibles of human intuition on determining causality. And, from the idiosyncratic viewpoint of an options trader grounded in probability science, Nassim Taleb in *Fooled by Randomness*⁴ describes the mistakes human beings make when facing uncertainty. All of these books resonate with a single theme that is echoed in the title of David McRaney’s humorous examples of human limitations, *You Are Not So Smart*.⁵ It is humbling, useful, and vitally important to realize that “you are not that smart,” especially if you are a person whose advice is often sought.

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WHY I AM HAPPY I AM NOT AN EXPERT, AND YOU MIGHT BE HAPPY NOT TO BE ONE TOO. *continued*

Experts are built by innate talent honed by years of relevant experience often guided by excellent mentors. Not everyone can be an expert. Aptitude is required, not just interest or experience. I have played the piano for 60 years, but stand far from the land of experts in musical performance despite my interest. And certainly, even admitting the great range of skills and talent of rare polymaths, no one can be an expert in all things. All these observations would seem reasonably obvious. Less obvious, though, is the narrowness in which most “expertise” functions. Most experts are experts in a narrow zone of experience, and they are grounded in experiences which are, by definition, part of the past. This should make the work of all “experts,” as helpful and reassuring as they often are, open to question.

Some humbling examples from my own experience may resonate with your own. I am certified by a national physician accrediting board as a specialist in internal medicine with special qualifications in geriatrics. By the community at large I would be considered as an “expert” in these areas. And, in truth, I do know a lot of medicine. However, life and medicine are not static. They change — continually. Some years ago, as part of my recertification as a geriatrician I was required to complete a number of open book examinations. The questions were clinical scenarios, often of some complexity. I devised what I thought to be a very rational approach to the exams. I would quickly answer the questions that I “knew” and research the ones in which I had a doubt. After I received the results of the first examination, I was surprised to see that my “passing” score was not only not perfect, but was perilously close to the cutoff for “pass” — disturbingly so for my “expert” ego. An analysis of the answers to the questions revealed that my mediocre performance was not due to the questions that I did not know. Those questions I had largely gotten correct despite their difficulty. My shortcoming lay in the areas that I “knew” and had not taken the time to verify. What I “knew” was simply wrong. To test my hypothesis on the next exam, I looked up every question, the ones that I didn’t know together with the ones that I did, or at least thought that I did. My score was dramatically better. I also learned a lot. The lesson for me was that “humility is far safer than hubris.”

I have had similar “wake up” experiences as an executive. On one occasion, having changed jobs, I brought all of my expertise as a managed care executive to a medical community whose culture was anything but “managed.” My knowledge about medical staffing needs was based on a decade of solid management experience with good results in an environment that turned out to be quite different from the one I entered. Needless to say, despite being a highly qualified expert in managing physician groups, I made a number of bad decisions that in retrospect could have easily been averted if only I had realized the limitations of my expertise. My new community differed from my old one in important ways that made my past experience, while not irrelevant, certainly not immediately transferable. Asking more questions, taking time to learn, questioning my own assumptions, and not assuming that I “knew” what the correct decisions were all would have been enormously helpful. My past experiences could still bring great value, but only when they were informed by present realities.

Sadly, sometimes experts do not see, or at least acknowledge, their shortcomings. One example stands out. During my residency in medicine I cared for a patient with a cardiac problem. The very distinguished attending cardiologist, who was an expert in cardiac auscultation, impressed me and my colleagues by hearing a cardiac murmur that we could not. The attending asserted the murmur defined the nature of the patient’s underlying cardiac problem. My team and I then ordered more definitive invasive tests that revealed fortunately that the patient did not have the problem we feared. When I apprised my attending of this good news, he solemnly remarked without irony “It is remarkable how much more sensitive and accurate the trained human ear is than modern technology.” I learned much medicine from this physician, who was an excellent teacher and a true gentleman. I also learned that none of us, even the best of us, is immune from fooling ourselves by believing that we are more expert than we are.

WHY I AM HAPPY I AM NOT AN EXPERT, AND YOU MIGHT BE HAPPY NOT TO BE ONE TOO. *continued*

Common definitions of experts generally describe an expert as an individual with a deep understanding of a field of knowledge or area of practice. “Experts” in an area have a great deal of experience — experience that is tempered by personal insights acquired over time. The depth of knowledge of an expert results from an aptitude to appreciate what they discover, see, or do with the things they experience. Expert musicians can often play a new piece after one hearing. Expert scientists seem to know instinctively how to ask questions that lead to new insights. Expert diagnosticians appear to rapidly distill complex issues into critical facts that permit them to make a diagnosis seemingly on sight. Speed in decision-making consequently is often used as a criteria for determining an expert.

However, we know intuitively that much more than speed is required to be an expert. Individuals who are described as “shooting from the hip” are usually not viewed as experts, despite their speed. The speed of true experts comes from the internalization of patterns and their nuances acquired over years. Their success as an expert is not just a chance event. Even experts can be seduced into believing they know more than they do. Rapid leaps to conclusions can lead to great errors that can threaten companies or human lives.

Donald Schon, in a classic work on professional thinking, *The Reflective Practitioner*,⁶ describes potential antidotes to the risk of being an expert. He describes the work of experts as “partners” in an endeavor rather than simply sources of knowledge. Asking questions, paying attention to detail, being honest about one’s assumptions and skeptical about one’s own conclusions, and being open to being mistaken are qualities which can mitigate “expert” mistakes. Simply working *with* others rather than alone is a highly useful strategy. Even an expert athlete benefits from a coach.

As a doctor, an executive, and a consultant, I enjoy being asked for advice. It makes me feel useful and good. I know all too well the human limitations of others are mine as well. As a result, I try to caution myself and those I advise that, even in areas where I have experience, my advice should be challenged, qualified, and adapted. I try to not think of myself as an expert, but rather as a learner. By not being an expert, I believe my “expertise” can even be more valuable to others.

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FEE-FOR-SERVICE TO VALUE-BASED-PAYMENT TRANSFORMATION, LANDSCAPE OVERVIEW: PART 1

Managed care and risk delegation grew significantly between the 1970s and 1990s as a way to attempt to control costs, culminating in the shift toward health maintenance organizations (HMOs) in the 1990s. The shift waned in the 2000s after failures due in large part to lack of adequate divisions of responsibilities among payors, providers, and institutions, and inadequate (in many cases non-existent) care management systems – critical to success in taking risk for populations. Patients (consumers) were asking for choice, while payors began refocusing on improving quality. However, as U.S. healthcare costs continue to grow, the Centers for Medicare and Medicaid Services (CMS) are now pushing providers and payors to balance managing utilization, proving the value of care, and ensuring the highest quality possible through “value-based payments” (VBP).



Current U.S. healthcare expenditures have alarmingly exceeded projections and consequently places the U.S. as the highest spender by a wide margin of healthcare per capita worldwide. According to the Organization for Economic Co-Operation and Development, the U.S. spent a staggering \$8,508 per capita on healthcare in 2013, with Norway in second place at \$5,699 per capita. While Norway spends roughly 9.3% of its GDP on healthcare, the United States spends 17.7%. This level of expenditure is unsustainable.

Value-based payments reward physicians, hospitals, and health systems for achieving positive health outcomes while decreasing or maintaining costs. Historically, physicians have not been completely aligned with this payment methodology since their payments have historically been based on the fee-for-service model. However, payors are now starting to aggressively reduce provider reimbursements and move towards performance-based payment. Providers can either hold out as long as possible in the current system or proactively begin to adapt to be able to take risk and manage populations. In order for health systems to succeed with this new agenda, providers (physicians, hospitals, and post-acute providers) will need to achieve high-quality outcomes while reducing costs, thereby aligning with the value-based payment model.

Driving forces toward VBP

The following table outlines some of the existing, upcoming, and predicted forces pushing providers toward VBP.

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FEE-FOR-SERVICE TO VALUE-BASED-PAYMENT TRANSFORMATION, LANDSCAPE OVERVIEW: PART 1

continued

Primary Population	Force	Timeline
Commercial	Employers contracting directly with health systems (Boeing and Swedish) – by-passing insurance plans	Upcoming
Dual-eligible Patients	Coordination demonstrations	Since 2013
Medicaid	Funds through managed care organizations rather than FFS claims	Ongoing, varies by state
Medicaid	Carve-ins for behavioral health and disabilities	Ongoing, varies by state
Medicaid	Delivery system reform incentive payment programs	Since 2010(ish)
Medicaid and Underserved	FQHC capitated payments	Ongoing
Medicare	Hospital readmission penalties	Since 2012
Medicare	Medicare Access and CHIP Reauthorization Act (MACRA)	Penalties begin in 2019
Medicare	Growth of Medicare Advantage plans	Ongoing
Medicare	ACOs	Since 2011
Medicare and Medicaid	Alternative payment models: bundled payment, shared savings models, capitation	Ongoing

Success elements

The rules for success in this new world of VBP are different depending on the player, market position, and current state of readiness for assuming risk.

Hospitals

It is not news that the focus of care is shifting from inpatient to outpatient as a way to control costs and that appropriate and timely deployment of primary care should help prevent progression of disease. In order to positively react to this change in payment methodology, hospitals along with other providers must do some serious soul-searching and visioning about their place in the new healthcare landscape. To some extent, this has resulted in large-scale hospital mergers focusing on economies of scale and increased purchasing power. This will only slow to some extent the effects of the shift to value-based payment.

In order to be a responsible partner in care, hospitals should begin to improve their ambulatory care networks through partnering with independent physician associations (IPAs) or hiring providers (through their foundations depending on the state and regulations in place). Payors are expecting hospitals to take more risk for population health, which can only be done successfully with a strong

FEE-FOR-SERVICE TO VALUE-BASED-PAYMENT TRANSFORMATION, LANDSCAPE OVERVIEW: PART 1

continued

care continuum to manage patients' wellness (not just illness in current models of care). Institutional risk (bundled payment, readmission penalties) and global capitated risk (through developing a health plan or delegated risk from managed care organizations) are both in hospitals' futures. To prepare, hospitals should also begin to explore building wrap-around support services such as care navigation centers, care coordination, post-acute relationships/affiliations, and wellness initiatives.

Practitioners

Practitioners (physicians and other eligible clinicians) are starting to face pressure to provide value with the implementation of the Medicare Access and CHIP Reauthorization Act (MACRA). Under MACRA, CMS will implement a new payment system, the Quality Payment Program (QPP), for all physicians and other eligible clinicians by 2019. Two possible tracks of QPP are either a Merit-Based Incentive Payment System (MIPS) or an Alternative Payment Model (APM), under which physician reimbursement will be based on quality, resource use, clinical improvement, and use of electronic health records.

According to Allen Miller, CEO of COPE Health Solutions, "CMS, states, self-insured employers, and health plans will continue to look, perhaps even more aggressively, for healthcare providers that can effectively accept/manage financial risk for members/patients. This requires not only the necessary license(s) and funds set aside to bear risk, but also care management, utilization management, and other systems to succeed in reducing overall medical spending from the available premium."

We will discuss provider strategies and readiness in our next installment, "Fee-for-Service to Value-Based Transformation: Provider Strategies and Readiness - Part 2."

Payors

As a payor, CMS is the main driver of value-based payment for Medicaid, Medicare, and uncompensated care. Commercial insurers historically follow Medicare's lead. In Medicaid particularly, funds were traditionally flowed through FFS payments directly to providers. This is changing with the increased presence and power of managed care organizations (MCOs). With many new demonstrations CMS is aiming to have funds flow through Medicaid MCOs to delegate some of the risk to these organizations.

MCOs are in a position to help advance VBP by building strong networks of providers who have demonstrated success in delivering high-quality care at a lower cost.

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Special thanks to Alain Huynh and Sarin Khachatourians for contributing to this article.

FEE-FOR-SERVICE TO VALUE-BASED-PAYMENT TRANSFORMATION, LANDSCAPE OVERVIEW: PART 1

continued

About COPE Health Solutions

COPE Health Solutions partners with our clients to help them achieve visionary, market relevant health solutions. We focus on all aspects of strategy, population health management, managed care contracting, CMS demonstrations, Medicaid redesign, and workforce development for clients across the healthcare continuum, including hospitals, health systems, physician organizations, health plans, and community based organizations.

Our multidisciplinary team of healthcare experts provides our clients with the tools, services, and advice they need to plan for, design, implement, and support successful operations in a challenging and rapidly evolving healthcare environment.

We are currently working with multiple health systems across the country to develop a clear roadmap to success under value-based payment. Please contact any of our leadership team members if you have questions and would like to discuss how to ensure success amidst the coming changes.

CREATING A CULTURE OF VALUE - PART 1

This is the first piece in a series of articles about creating a “Culture of Value” in your organization. In this article, we introduce the need for a Culture of Value in healthcare and introduce interprofessional collaboration (IPC) as the foundation for this work.

In the recent era of healthcare reform, much has been written about achieving the Triple Aim, the idea posed in 2008 by the Institute for Healthcare Improvement (IHI) to improve the experience of care and the health of populations while reducing the cost of healthcare.¹ Since that time, the concept has evolved into the Quadruple Aim, adding reducing provider burnout as a goal based on the assumption that “care for the patient requires care for the provider.”² Hospitals and health systems have been challenged to shift toward value-based versus volume-based incentives, often defined as an expression of the Quadruple Aim in the “value equation”:

(quality + patient and provider experience)/cost.

Although many healthcare leaders have an idea of what their health system could look like if they were farther along in the journey to enhance value, achieving the ideal can feel insurmountable. All of this would be challenging enough on its own, without the uncertainty about the future of healthcare and the Affordable Care Act under the new administration. Within this broader context, it has become difficult for providers and administrators across the healthcare space to scope, prioritize, and execute initiatives that bolster value.

We know, however, that effective leaders are attuned to their own experience of change and the experience of people across their organizations. A common response to change overload and uncertainty has been for organizations to carve out small chunks of work to test elements of possible ways forward. For instance, a health system may pilot a bundled payment plan in single knee replacement, rework incentives to encourage improved quality scores, or tighten communication across the continuum — or do all three in the same initiative. However, health systems are often challenged to reap the benefits more broadly from these interventions. In other words, patients with a single knee replacement might subsequently report a better experience across the episode of care, but patients with a heart transplant, or even a hip replacement, could feel like they are dealing with the same old fractured system where they risk infection and lack the ability to schedule a follow-up appointment.

Small and steady can be a productive way to go, but our experience has shown us that healthcare leaders often find it difficult to leverage pilots and other pockets of culture change across multiple units, services, and/or across the continuum.

Creating a Culture of Value

Even today, as organizations launch so many efforts to improve value, the question of sustainable change remains. How can we create a “flywheel of value” — one in which the momentum for culture change propels sustainable results? We see creating a Culture of Value as a necessary component to meet the needs of both today’s and tomorrow’s population health efforts.



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CREATING A CULTURE OF VALUE - PART 1

continued

A Culture of Value is one where everyone, from frontline staff to C-Suite leadership, understands what it means to create value for the patient and the system, including how to act in ways that create value from each of their respective roles.

This kind of culture evolves through both a top-down and bottom-up approach that relies on increasing capacity at all levels. In any industry undergoing rapid change, successful executives employ management methods that free up their bandwidth for strategic thinking and charting a flexible course through the rapids. In turn, they increase delegation and enhance skills in critical thinking, innovation, collaboration, and execution. In healthcare, specifically, all team members need to understand the impact of their decisions and actions on the patient — being sure to take value, or the combination of quality, experience, and cost, into account.

The top-down elements of creating a Culture of Value are clarifying what value means and making quality, experience, and cost data available, determining what to pilot, and assigning roles and accountabilities. But the bottom-up elements are where that culture comes to life.

As clinical team members pilot change projects, their experience of the efforts informs their view of value, helping them apply that learning again. The power of experiential learning is amplified when team members provide feedback to leadership, which assists leaders in developing more and better initiatives to advance value. The more experience that team members have with value-centered work, the more easily the “flywheel” effect takes hold. Over time, teams engage in advanced decision-making, creating value without the guidance of dictated tactics. In turn, leadership can accelerate results by giving other teams a head start, sharing takeaways through the organization.

Role of Interprofessional Collaboration

Of course, developing this culture takes work, focus, some resources, and many dedicated hands and minds. We have found that developing a firm basis for interprofessional collaboration (IPC) can greatly accelerate the journey toward a Culture of Value. We can draw from a report we authored on behalf of the Robert Wood Johnson Foundation, [*Lessons from the Field: Promising Interprofessional Collaboration Practices*](#), to explain where we see the connection. This report focused on healthcare organizations across the country that effectively use IPC to create value for their patients and to improve the experiences of those who deliver care. We see IPC as a critical enabler to helping organizations create value, and look forward to further exploring this topic in the remaining articles in the series.

In this article, we present the need for a Culture of Value, and the role we envision for IPC as a building block. Subsequent articles in this series will provide examples of steps toward building a Culture of Value using IPC.

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

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POST-ACUTE CARE: THE FIRE WE NEED TO START PLANNING FOR

Society teaches basic fire escape planning generation after generation, starting as early as preschool. Simple concepts are taught such as:

1. Prepare for the event of a fire.
2. Install smoke alarms for early fire detection.
3. Focus on older family members with mobility limitations.
4. Identify an outside meeting place.

Thankfully, many of us may never have to experience a house fire. Yet, we teach our kids to prepare for this unlikely event. The same basic principles are largely ignored when it comes to planned or unplanned hospitalizations. As our loved ones age, hospitalizations are a likely event. Patients and families are not prepared.



Post-hospital (i.e., post-acute) care is currently used by almost 42 percent of Medicare beneficiaries.¹ Baby-boomers are aging, and the U.S. population over the age of 80 is expected to triple between 2010 and 2050, according to the UN World Population Aging 2013 report. As hospitals and health systems are increasingly under pressure to limit the length of stay in hospitals, patients and families will need to become more educated consumers on post-hospital care. Education currently occurs during hospitalizations, often amidst immense stress and vulnerability, when retention is unlikely.

Fortunately, high quality and coordinated post-acute care (PAC) models are increasingly becoming a focal point in healthcare. Facility-based providers such as skilled nursing facilities (SNF), long-term acute hospitals (LTACH), inpatient rehabilitation facilities (IPR), or home healthcare (HHA), have a tremendous financial impact on PAC and associated government programs. Medicare and Medicaid, and ultimately federal and state budgets, can be impacted by PAC outcomes. Employers, particularly those that offer retiree coverage, wrestle with the ability to continue to provide benefits to seniors, who are most in need of coordinated care after hospitalizations. It's imperative that our healthcare system identifies innovative solutions to solve for this less publicized, but increasingly relevant, area of healthcare.

Using the “fire-safety” analogy, private/public payers have started “planning” by pioneering new models of reimbursement that focus on value-based incentives to improve quality and reduce costs. The Affordable Care Act (ACA) of 2010 established the Center for Medicare and Medicaid Innovation (CMMI), which tests such new models of healthcare delivery within Medicare and Medicaid programs. Delivery systems and payment reform are being driven by the 2015 passage of the Medicare Access and CHIP Reauthorization Act (MACRA). MACRA links physician payments to quality and value, rather than volume. In the PAC space, Congress passed the Improving Medicare Post-Acute Care Transformation (IMPACT) Act in 2014; which aims to improve care for Medicare beneficiaries by implementing quality metrics and resources used for tracking by providers, including physicians and hospitals.

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POST-ACUTE CARE: THE FIRE WE NEED TO START PLANNING FOR

continued

Focusing on PAC makes sense, as it's the component of healthcare with the most variation in care delivery. Clinical transformation and payment reform must occur in parallel in order for PAC to achieve the sustained evolution required. Three key trends will likely drive this transformation:

- PAC silos will need to be replaced with more coordinated continuums of care. Hospitals and health systems will increasingly realize the value of owning, or partnering, with high quality networks of PAC providers. PAC providers will increasingly embrace the need to work together in order to offer end-to-end solutions for hospitals and payers.
- Pressure on hospitals and health systems, including PAC readmission penalties and bundled acute/PAC reimbursement, will further drive integration of the acute and post-acute segments.
- More robust quality data on PAC providers will enable shifts in reimbursement from a fee-for-service model to a quality and outcomes-based value model.

A Potential Solution

HM Home and Community Services LLC (HM HCS) was established in 2016 to address the importance of PAC and its impact on clinical outcomes, patient experience, and overall cost of care. The vision of HM HCS is to transform PAC by removing barriers to collaboration, closing the gaps in uncoordinated care, and transforming quality, service, and value. HM HCS deploys a payer-provider agnostic network management model and acts as a solutions aggregator by optimizing the deployment of various technology partnerships and collaborations. HM HCS leverages data in order to disrupt the PAC model from a financially-driven incentive model, to a quality and outcomes-based incentive model, beginning with a Pennsylvania health plan's Medicare Advantage program as its first customer.



HM HCS' management model produces scorecards for SNFs and HHAs based on robust quality and outcomes metrics. These scorecards are used to generate quarterly risk-adjusted rankings that provide transparency to SNFs and HHAs on their performance and how they compare to their peers. HM HCS Network Performance Managers are engaged with SNFs and HHAs to provide scorecards and rankings, with the goal of facilitating collaborative communication and continuous improvement initiatives, including patient quality and reduced overall medical costs. Pay-for-value (P4V) future provisions implemented by health plans will further incentivize high performing providers. And, higher performing PAC provider networks will support health plans P4V contractual provisions to further align incentives and drive sustainable transformation.

HM HCS is transforming the approach to managing PAC, and offers scalable solutions for payers and providers at-risk for spend in PAC. Quality improvement, broad access, and a superior patient experience are both aspirational and attainable for transformative healthcare models in the post-acute care space. HM HCS achieves a win-win-win by implementing "fire-safety" plans that help prepare and benefits patients, payers, and providers across the healthcare continuum.

Despite the unlikelihood of experiencing a house fire, children continue to be taught year-after-year how to prevent and prepare for this type of tragic event. Unfortunately, hospitalizations are much more

POST-ACUTE CARE: THE FIRE WE NEED TO START PLANNING FOR

continued

likely to occur, and families are much less prepared. Education and advocacy for patients and families are of paramount importance. HM HCS is in the process of trialing out-of-the-box solutions and proof of concept initiatives in the post-acute care space. As PAC awareness expands, so will the increased need for “fire-safety” planning.

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HEALTH INSURANCE AT GROUND LEVEL: AN INTERVIEW WITH KAREN MARRINER

Health policy in America, what is to be made of it...? Often it is described as pluralistic; pragmatic; a mix of the public and the private; “ecclesiastical, eleemosynary, entrepreneurial, elected” (as described by Bill Kissick); flexible; diverse, and perhaps most familiarly, incremental, implying that a national health insurance scheme, some form of a “Medicare for all” (now over 50 years since enactment), for reasons of both efficiency and equity, would ultimately come to pass in the United States.



With the enactment in 2010 of the Affordable Care Act after a long and perhaps characteristically difficult and contentious gestation, the United States moved a bit further down the incrementalist pathway with healthcare coverage - or perhaps more accurately stated as “the opportunity for healthcare coverage” - extended to millions heretofore without. In that regard, the act did signify the most major health policy development since Medicare.

But with the election of Donald Trump, the political climate has changed, and rather than going further down the incrementalist path, or even pausing along it to regroup for the next step along it, incrementalism stands to be replaced with “decrementalism” (not seen since the repeal of the Medicare Catastrophic Coverage Act in 1989), an inchoate effort to undo the ACA, to be replaced by... well, no workable offering has emerged.

Yet, even apart from the dramatic shift in the political firmament, questions have arisen on just how “affordable” and workable the Affordable Care Act has been. Much has hinged on creating markets through the various health insurance exchanges, yet many of these exchanges are not functioning as hoped – having underestimated their costs early on, commercial insurers have now been significantly increasing their rates, withdrawing from the exchanges, or consolidating, leaving less choice for consumers, another tenet underlying the ACA. Yet, even without those fairly recent developments, the ease of getting desired coverage – even with subsidies for those for whom the “individual mandate” could be burdensome – has been proving difficult.

The theory is that the creation of insurance markets coupled with knowledgeable, informed consumers would inject necessary competition in the healthcare industry and result in a better patient experience (and possibly outcomes). As with most theories, however, the devil is to be found in the details. Or for another perspective from Allen Blakeney, who helped start the modern Canadian healthcare system, North America’s first tax-financed universal healthcare system in 1962, when asked his view of the Affordable Care Act, termed it “a painfully small step.” What is meant by this – despite the incorporation of such provisions as elimination of pre-existing conditions and lifetime caps, children able to stay under their parents’ coverage, and certain preventive procedures at no cost to the patient, all regarded as major achievements in the ACA – is that the ACA still lacks genuine universality, is administratively complex and inequitable, relies upon a market approach through the creation of insurance exchanges and the consumer/patient being willing and able to decide rationally within them, circumscribes the role of government by not offering a “public option,” and leaves pricing largely to the negotiations between insurance companies, providers, and health systems rather than with the federal government.

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As to the former point, Blakeney was referring to wrestling with the Canadian medical establishment, which went on strike as North America's first tax-financed universal healthcare system was launched in 1962. The Canadian physicians wanted to continue billing patients fee-for-service as usual, with the patients then sending the bills to the government for whatever they'd get reimbursed. The Canadian government said "uh-uh, that's not the way it works, that would undercut the single-payer concept of the law, physicians are to submit their bills to the government's Medical Care Insurance Commission, which negotiates rates with physicians." While the points you make have some weight to them, they are essentially mandated benefits. What the Canadian law did was to give a prominent place for a government agency to affect healthcare pricing in a tax-financed universal system. The ACA isn't universal, doesn't have a public option, and government influence over pricing is more removed. I think those are the large conceptual issues Blakeney was referring to, and I think justifiably he called the ACA a small step as a result.

To see more closely just where the devil lies in the ACA and just how painfully small this seemingly major health policy measure is, we asked Karen Marriner, MBA, Licensed Health/Life Insurance Agent of CalHealthAgent.com.

Q: Please give us a bit of your background, educationally and vocationally. Please tell us what it means to be certified for an exchange and what knowledge/competencies that involves.

A: Education: I actually started out as a professional cook, which involved going to NY Technical College for a Hotel and Restaurant Management AA degree. I headed out to California to work in kitchens in San Francisco, then decided to start a catering business, and a few years later decided to apply to UC Berkeley and get a BS in Nutrition and Clinical Dietetics. After graduation I decided that a business education was what I really needed, so I went to visit June Kinney in person and she told me I would only be considered if I had a few years of management experience under my belt (I can't believe that I remember just what she said "manage something, anything, not just yourself as a clinical dietitian." - 1988). That's how I ended up managing the food production process at a large hospital in Oakland.

After earning my degree at Wharton, I spent about ten years in employee benefits consulting, which is where I discovered that the technology of automating benefits administration was what I really enjoyed. The next five years were spent diving deeper into the tech side. I designed and implemented administration systems that were just beginning to integrate with payroll systems. I was having more and more interaction with clients in this tech role, and so when I had the chance, I moved into sales and account management with, at first benefits administration, and then health and wellness vendors. Because of my experience and network within the benefits consulting community, I was having more and more interaction with benefits consultants and brokers who needed wellness expertise. Their clients were reading all the studies about employee productivity. Everyone who represents an insurance broker must have a state license, so that's how I ended up selling health insurance. In October of 2013, I figured I would get some use out of my license by becoming certified to place business with the new state exchange, Covered California. There were so many individuals and families in need of quality help.

Initially, there were three types of individuals who could be certified to help consumers enroll on a state exchange like CoveredCA:

- Certified Agents - health/life/accident insurance agents licensed by the State. Agents have a direct relationship with the health plans (it's called being appointed) on the exchange, and are compensated by the health plan. Compensation can be based on a per member per month basis, a percent of premium basis, or a per member per year basis.
- Certified Enrollers - certified by the exchange, not licensed agents, compensated by the

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exchange. These folks have been phased out beginning in 2017. Enrollees did a lot of their work in community clinics, with a high percent of their work helping consumers get enrolled in Medicaid.

- Navigators - non-profit entities that received grants from the exchange. They seemed to help in the same ways as enrollers.

There are so many factors involved in selecting health insurance these days: the consumer's taxable income, preferred providers, healthcare system usage patterns, pharmacy usage, etc. And consumers are perplexed. To be an effective agent, you really have to keep all of these factors in mind, have a lot of patience, be willing to do extensive education, and be willing to dig in and advocate on behalf of the client with health plans and provider offices. I developed a series of YouTube [videos](#) that explain aspects of our complex system - the visuals help consumers absorb and learn complicated concepts, they can watch with their spouses on their own schedule, they can rewind as needed, and the videos keep me from repeating myself too often!

Here's a list of the competencies as I see it: analytical, organized, patient, empathic, good at follow-up, and creative at marketing and networking.

Content Areas: obviously you need to know how insurance policies are designed, which footnotes are critical, where the typical places are that are misunderstood and which can lead to large, unpredictable expenses, how the provider groups are organized, which aspects of the tax code intersect with insurance, and how the federal subsidy program works. I keep up with Medicaid, particularly eligibility, enrollment, and disenrollment. I am required to maintain my license with continuing education, including courses in ethics, Medicare, long-term care (this is not for exchange business - I also sell LTCI).

Q: The Affordable Care Act seems to have been particularly fitting for people such as yourself and your family - this is “up close and personal” health policy for you - offering coverage when it simply wasn’t available, or at far from an affordable price. How long has it been since you’ve “jumped in,” and how have initial experiences and expectations compared with more recent experience?

A: I left the corporate world in 2012 and began working for myself. At that time the only good coverage was through COBRA, which all employers with more than 20 full-time employees on 50% of the typical days in the previous year must offer. The coverage was very expensive but guaranteed, but remember it only lasts for 18 months. In Sept of 2013, our COBRA ran out, and I got my first taste of what it was like to find high quality health insurance in the individual market. We had to fill out a 20-page form, list all of our doctor visits for the past 3 years, all medications, and any diagnoses. For a family of 4 our premium was \$1800/mo with a \$6000 individual deductible. So when CoveredCA was launched, my family was my first client. Our premium fell dramatically, from \$1800 to \$500/mo because we were able to take advantage of the ACA tax credits. In addition, our coverage greatly improved due to the cost-sharing reductions, such as lower deductibles and co-pays.

I have many clients who tell me they would not have been able to leave their corporate jobs without the ACA. I'm thinking specifically of an attorney who worked in a large firm for his entire career and thought of striking out on his own, but with a family of 6, the health insurance alone would have been cost-prohibitive. The ACA is very supportive of the self-employed due to the tax subsidy structure, as well as the fact that health insurance premiums are tax-deductible. Many of my clients are seeing the light and opting for health savings account plans so they can reduce their taxable income even more to qualify for a higher subsidy.

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Q: More broadly, how would you say things are working out for your “non-family” clients? I guess I would say going from a figurative “lifesaver” of having health insurance available, to the actual workings of selecting a plan, and its costs, and just how workable the plan/network is?

A: How workable is this whole thing? For young people, they have less concern about whether a specific provider is in the network and more concern about bottom line cost. Many are struggling to keep off Medicaid because their incomes are just on the cusp of 138% of the Federal Poverty Level (FPL). These young people are working in industries that don’t offer benefits: retail, fast food, and hospitality, primarily. Other than struggling to pay their premiums, the system is working very well for them. They are on highly subsidized plans with very low out-of-pocket costs. They rarely use their benefits, but when they do, it’s not at the ER. They know about urgent care and primary care, and this year they’ll all be linked with a primary care doctor. CoveredCA is requiring all their health plans to identify a PCP for every member, even PPO plans where no referral is needed.

For families and older single people, provider network is the number one concern. They’ll pay a higher premium as long as their beloved docs are included. The out-of-network benefits have gotten very thin, which means going out-of-network is cost-prohibitive for most of my clients. There are some issues cropping up regarding networks now, particularly with hospital systems.

For the most part, my clients are able to work within the networks that are offered in the individual market. Some carriers differentiate on-exchange and off-exchange networks, which adds another level of complexity for the consumer. I try and stay away from those carriers because it’s so easy to get confused and wind up out-of-network accidentally.

Costs. Complexity. Confusion. All are very real concerns about the ACA, and to one extent or another lay behind the mostly political effort behind the recent “repeal and replace” effort. The failure of that effort has shown that indeed attention needs to be given, particularly to the matters of cost and the workability of the exchanges. But ironically and curiously enough, “repeal and replace” failed because no politician was willing to risk being associated with the dismantling of Medicaid, a government program which, since the ACA, now enrolls more people than does Medicare, another government program. The political support and popularity of each, now more recently Medicaid, is assured. How the market-based insurance exchanges address the issue of cost, access, and equity may well determine if there may be a third major government sponsored program in the future, resulting in truly universal health coverage, American style.

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