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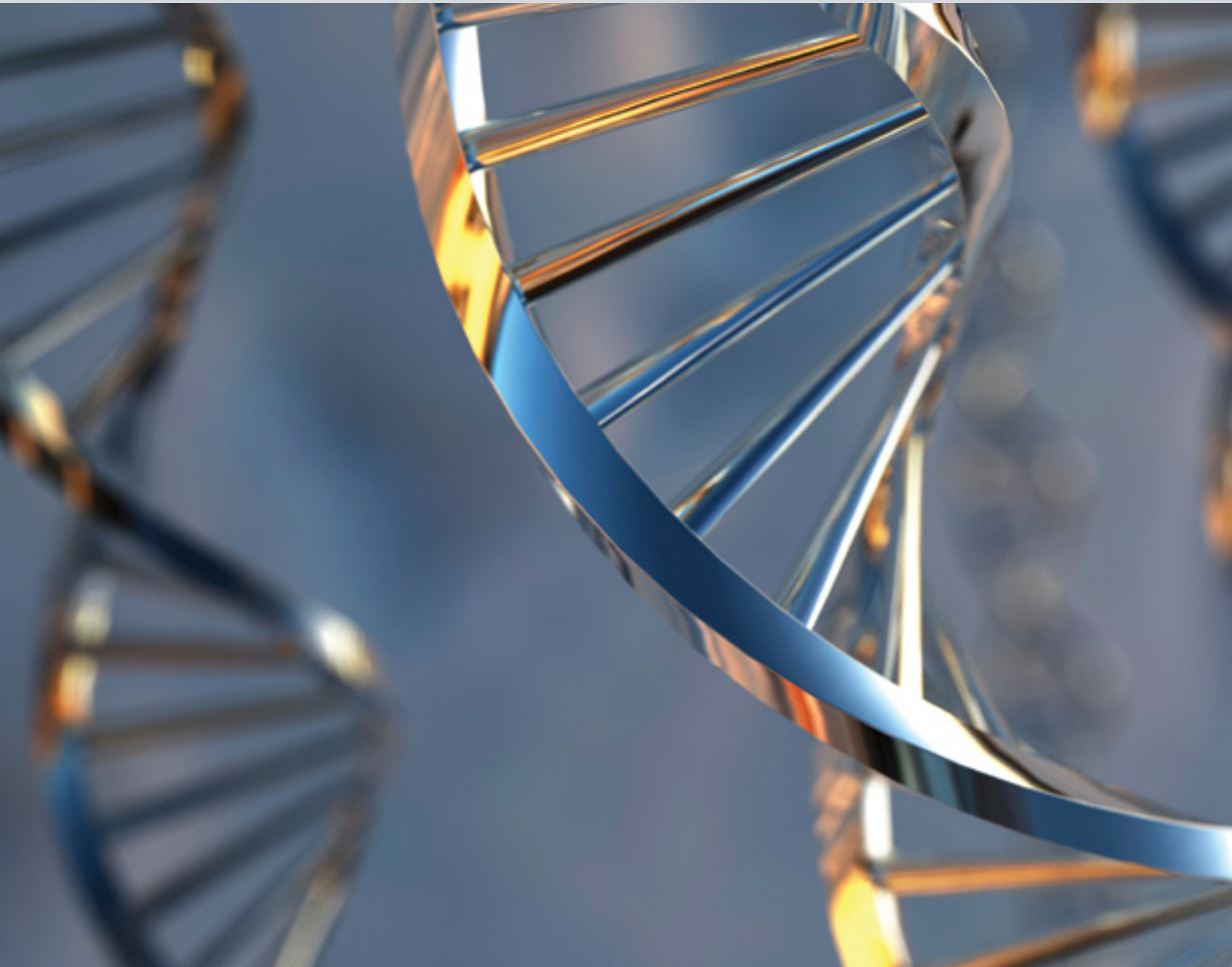

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FEATURED ARTICLES

IN UPCOMING ISSUES

Fee-for-Service to Value-Based Payment Transformation:
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EDITOR'S LETTER

This issue welcomes John Barkett, WG'09 as the incoming President of the WHCMAA. You can hear from him in his first President's Desk article as well as a Philosopher's Corner offering. John has been very active on the WHCMAA Board and has been a major force in planning for the October WHCMAA Alumni Healthcare Conference for the past 2 years.

Hope all enjoy the trip from San Antonio to Mumbai and locales everywhere in between as we continue to provide insights, career development guidance, and up-to-date information on the latest trends and fundamentals across the healthcare landscape! .

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

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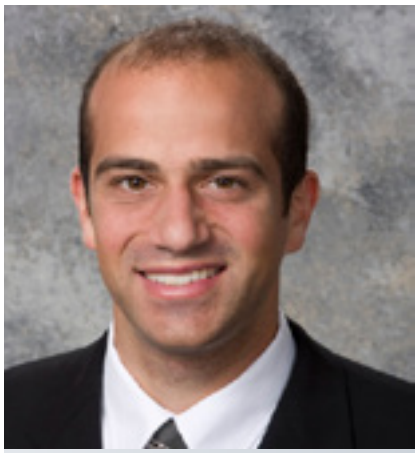
Managing Editor
To learn more about Colette, click here.

THE PRESIDENT'S DESK



John Barkett, WG'09
To learn more about John, click here.

It was the first week of school and Dave Kerwar was giving me the quick bio: he's from New York, went to Hamilton College, worked at Broadlane.

"What's Broadlane?" I asked.

"It's a GPO."

"Uh huh...What's a GPO?"

- - -

I'd come to Wharton wanting to gain a better understanding of how money flowed in our healthcare system. Group purchasing organizations, I learned, offer providers discounts on the $100B of supplies they buy each year. And now I had a classmate who could teach me their ins and outs.

I'd come to the right place.

- - -

This is half of the magic of the Wharton Healthcare Management Program: your classmates are up-and-coming experts from every corner of the healthcare system. The other half? These experts become your friends.

Dave and I got along so well that he invited me to his wedding in San Francisco (which everyone enjoyed) and even tried to set me up with his wife's best friend (ok, maybe not everyone). We don't talk as much now, but I know we'll run into each other soon at some industry event, and it will be like we never left West Philadelphia.

- - -

Maybe Dave and I will meet at the Leonard David Institute's 50th Anniversary Symposium. The two-day conference (Oct. 5-6) at the Inn at Penn already boasts a terrific set of speakers. Dues-paying WHCMAA members can register at a discounted rate and are invited to the WHCMAA's pre-symposium event on the evening of Oct. 4th, where we'll hear from a special guest speaker, hand out alumni awards, and honor the student recipients of the this year's Kissick and Kinney Scholarships.

If you attend you're likely to run into outgoing WHCMAA President John Harris WG'88, Secretary Peter Mueller WG'09, and Treasurer Tom Kupp WG'85 – all Philadelphians – whose terms ended in June. Incoming Vice President Maria Whitman WG'05, Secretary Bob McDonald WG'92, and Treasurer David Kibbe WG'80 are likely to be there as well, as will over a hundred other WHCMAA grads.

Gatherings like these never fail to remind me of my days on campus, which were filled with fun, friends, and healthcare. Attend a WHCMAA event this year, and you'll know what I knew when I met Dave ten years ago: you've come to the right place.

I hope to see you there.

John Barkett WG'09
WHCMAA President
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THE PHILOSOPHER'S CORNER

This month's philosopher:
John Barkett, WG'09
To learn more about John,
click here.

Life Lessons:

<u>If I knew then what I know now, I *would have*</u>:
...been not afraid of failing.

<u>If I knew then what I know now, I *would not* have</u>:
...procrastinated.

Favorite Quotes:

1. "Be careful what you do, because a lie becomes the truth." ~ Michael Jackson
2. "A sense of humor is a measurement of the extent to which we realize that we are trapped in a world almost totally devoid of reason. Laughter is how we express the anxiety we feel at this knowledge." ~ Dave Barry
3. "To say goodbye is to die a little." ~ Raymond Chandler

Recommended Reading:

The Bell Curve, by Atul Gawande

Alice, Off the Page, by Calvin Trillin

My Favorite Simple Roast Chicken, by Thomas Keller

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ALUMNI NEWS

Elayne Howard, WG'76
I have been teaching Social Enterprises in Villanova University's undergraduate School of Business. It is a fun course. Student groups within the class become consultants to not-for-profit organizations. I also coach an MBA student group at Villanova. In this course the student groups consult to not-for-profits as well.

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Learn more.

ALUMNI NEWS *continued*

Jeffrey Voigt, WG'85
Recently published: Rugo H, Melin SA, Voigt J. Scalp cooling with adjuvant/neoadjuvant chemotherapy for breast cancer and the risk of scalp metastases: systematic review and meta-analysis. *Breast Cancer Res Treat* DOI 10.1007/s10549-017-4185-9

Contact Jeff at:
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Sally Poblete, WG'00
Sally Poblete, Founder and CEO, Wellthie, raised $5M in a Series A round of financing. IA Capital Group led the investment round with participation from existing and new investors, including Aflac Ventures and top insurance industry executives. Following the raise, Sally was featured in *Forbes Magazine*.

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Learn more.

Paul Tirjan, WG'01
Colleagues:

I have taken a new role as President of AllSpire Health Partners as of August 2016. AllSpire is a collaborative venture among five community health systems, including 27 hospitals, 10,000 physicians, and $10 billion in enterprise revenue. Our activities include initiatives and collaborative ventures focused on clinical excellence, cost savings, and innovation for the benefit of our patients and communities. We are evaluating strategic partners for our innovation network from industry and academic medical centers and welcome inquiries for inclusion.

Contact Paul at:
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Learn more.

ALUMNI NEWS

continued

NOT A FREUDIAN SLIP: THE HAPPINESS TREND - A HEALTHY PURSUIT OR AN OBSESSIVE QUEST?

This article series focuses on happiness and answers the question - does a constant pursuit of happiness make us unhappy? We will explore the importance of happiness and how it impacts our quality of life. We'll consider how our digitally connected mobile and media-infused world could be damaging our happiness level. Lastly, we will uncover what characteristics can be strengthened or enhanced to boost our happiness (traits like empathy, compassion, kindness, gratitude, etc.) and subsequently our health and well-being.

What is happiness?
Psychologists, philosophers, researchers and even cultures define happiness differently. Wikipedia defines it as "a mental or emotional state of well-being defined by positive or pleasant emotions ranging from contentment to intense joy."[1] **Some consider happiness an emotion you feel in a moment, an ongoing experience you have, or even a trait you are born with.** For others, happiness goes beyond your personal state and is experienced when you focus on bringing the greatest happiness for the greatest number. Aristotle believed happiness is about experiencing virtue, and that the goal of happiness is not achieved in single moments, but instead throughout one's complete life.[2]

So if happiness depends on acquiring a generous, courageous, and friendly moral character, and is really more about the enrichment of human life, beyond our own, then how do we enhance our experiences and cultivate further happiness over our lifetime? And if happiness isn't really found in single moments, then why is our culture so captivated by instant gratification and obsessed with material objects?

Do we have a happiness obsession?
It seems we have an obsession with happiness, as is evident in the swell of media on the topic. Books, podcasts, magazines, movies, daily email feeds, and courses, all focused on having a happy marriage, happy employees, raising happy kids, and creating and sustaining a happy life have multiplied. Happiness is a consistent topic on talk-shows and TED talks. There are over 24,000 books categorized on Amazon under Self Help: Happiness[3] and a multitude of apps whose sole purpose is to send you daily inspirational quotes and positive messages.

Since 1972 the Gross National Happiness (GNH) measure has been researching and reporting on the topic, and now the World Happiness Report ranks 155 countries by their happiness levels. The United Nations even founded International Happiness Day, held every March to recognize the pursuit of happiness as a human right and a "fundamental human goal."[4]

Advertisers and media personalities have ramped up the importance of being happy, while HR managers, life coaches, and motivational speakers are working to tap into your emotions and elevate them. The pressure to be happy is everywhere. But is happiness always good? Can the constant quest for happiness be detrimental? And does this industry empowerment around happiness feel more like a manipulating money-making strategy for those tied to the cause? We will explore this in the next article in the Happiness series.

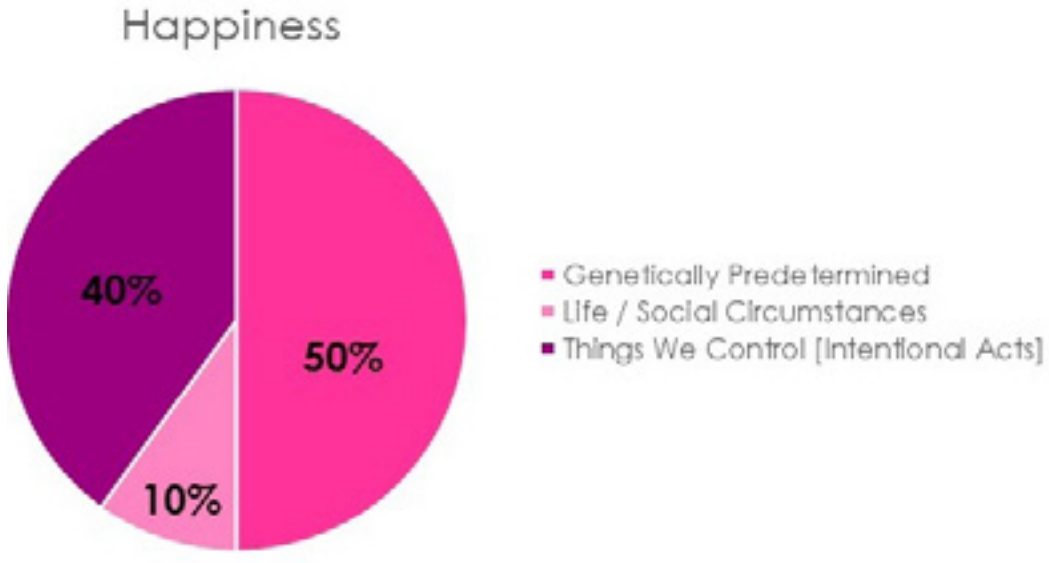
Contributor:
Connie Mester, MPH

To learn more about Connie, click here.

NOT A FREUDIAN SLIP: THE HAPPINESS TREND - A HEALTHY PURSUIT OR AN OBSESSIVE QUEST? *continued*

If happiness has become a hot, multi-million dollar topic and a big focus of individuals and companies alike, then why does our society continue to struggle with depression, anxiety, and other mental illnesses? Rates of employee depression, anxiety, and stress have increased to 82.6% in 2014, up from 55.2% just two years prior.[5] And the number of people on prescription medications to treat mental illness has escalated, while at the same time suicide rates have soared.[6]

Is happiness a trait you are born with?
Why is happiness such an important topic? Do age, gender, or other factors out of our control predetermine our happiness? Research has estimated that about 50% of our happiness is due to our genes. A much smaller percent, roughly 10-20%, is due to life circumstances, and the remaining 30-40% are things we control.[7] Many people expect that our life circumstances, such as our income level, status, attractiveness, etc. play a greater role in our happiness. This is evident in people's constant quest for a partner, a job, a new house, a new car, or other external factors to increase their happiness. But ironically the "grass is greener" mentality doesn't really affect our happiness as much as we think it might.



Since we can't change our genetic makeup, does that mean that a great deal of our happiness is permanently fixed? If we intentionally pursued happiness, would it make a difference? Genes do make up about half of our happiness, and another tenth or more is a result of our life circumstances, which are things that are hard to change. But what about the things we can control, like our thoughts and behavior? One of the most significant differences between people's happiness is their intentional activities [40%].

A deliberate effort is required to pursue happiness strategies; however, they can have a large impact on our happiness and are easy to put into practice.[8] The important element here is discovering what strategies have the greatest impact on you personally, as each person is different, and there isn't a one-size-fits-all solution to achieving happiness.[9] We will explore this topic more in the final article in this series.

Why does happiness matter?
As we've discovered that we do have the ability to increase our happiness level through intentional acts, why should we consider making a habit of being happy? Is there a benefit to being happy? The impact

NOT A FREUDIAN SLIP: THE HAPPINESS TREND - A HEALTHY PURSUIT OR AN OBSESSIVE QUEST? *continued*

of happiness on a person's life seems obvious - a happy life equals a good life. Interesting correlation, similar percentages are seen in our determinants of health.[10] Research provides solid proof that happiness has a direct impact on our health and well-being. The positive impact of happiness on our life is extensive, from our social relationships, to our success, to our health, which has made the subject of happiness a pretty trendy topic.

People who are happy tend to live longer, have stronger immune systems, and have better overall physical health. Research has shown that happiness is associated with reduced chronic pain and other harmful health symptoms, lower likelihood of diabetes and fatal accidents, fewer strokes, better chances of survival from cancer, and better cardiovascular health.[11] People with positive emotional styles are less stressed, heal better [12] and are more resistant to catching colds.[13] As we will explore in the next article, stress isn't a bad thing. People who understand that stress is a natural reaction to life's challenges are able to bounce back in hard times and live a more resilient, longer life.[14] Just as there's a healthy dose of stress, there is also a healthy dose of happiness that we can intentionally strive for.

The impact of happiness reaches into many aspects of a person's life beyond just health. There are social rewards for being happy. Happiness can boost confidence, likability, and one's ability to feel pleasure and find meaning in routine life events. People who are happy tend to have more friends, lower odds of divorce, deeper relationships, and stronger, more trusting and supportive social networks. In fact, rich friendships not only reduce our loneliness, which has a significant impact on our well-being,[15] they also reduce our stress levels.[16]

People who are happy get better sleep, are more energetic, and typically more creative and innovative. This is likely to result in increased productivity, better work quality, higher academic performance, and better decision-making and problem solving capabilities.[17, 18]

Why all of the focus on happiness?
Similar to the transition the health industry has started to venture down, shifting from diagnosing and treating an illness towards wellness and prevention, the industry around happiness has made a similar move. Happiness experts are working to uncover how we can optimize our life, or optimize our employees to be more productive, or optimize our students to be more successful academically. In the upcoming articles in this series, as we reveal what the research shares about the positive impact of positive emotions, consider also what this constant quest for bliss is doing to our reality and ability to actually have a satisfying life. Lastly, we will review sources and character traits that are proven to elicit

NOT A FREUDIAN SLIP: THE HAPPINESS TREND - A HEALTHY PURSUIT OR AN OBSESSIVE QUEST? *continued*

happiness, while we discover the importance of aligning the most appropriate qualities and actions to our needs to help us attain a healthy dose of happiness.

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References

1. Happiness. In Wikipedia. Retrieved April 13, 2017, from https://en.wikipedia.org/wiki/Happiness

2. Aristotle, *Nicomachean Ethics* (2004), ed. Hugh Treddenick. London: Penguin.

3. 24,721 results for Books: Self-Help - Happiness. In Amazon. Retrieved April 14, 2017, from https://www.amazon.com/Happiness-Self-Help-Books/b?ie=UTF8&node=4739

4. International Day of Happiness. In Wikipedia. Retrieved April 13, 2017 from https://en.wikipedia.org/wiki/International_Day_of_Happiness

5. Debnam D. (2016) Huge Rise in Global Employee Depression, Stress, and Anxiety Since 2012. *Huffpost* Retrieved April 12, 2017 from http://www.huffingtonpost.com/dean-debnam/huge-rise-in-global-employee_b_8923252.html

6. Curtin SC, Warner M, and Hedegaard H. (2016). Increase in suicide in the United States, 1999–2014. *NCHS Data Brief*, No 241. Hyattsville, MD: National Center for Health Statistics. Retrieved https://www.cdc.gov/nchs/products/databriefs/db241.htm

7. Lebowitz MS, Ahn W, and Nolen-Hoeksema, S. (2013). Fixable or fate? Perceptions of the biology of depression. *Journal of Consulting and Clinical Psychology*, 81, 518–527. http://doi.org/10.1037/a0031730

8. Lyubomirsky S, Sheldon KM, and Schkade D. (2005). Pursuing happiness: The architecture of sustainable change. *Review of General Psychology*, 9, 111–131.

9. Lyubomirsky S. (2008). The how of happiness: A scientific approach to getting the life you want. New York: The Penguin Press.

10. McGinnis JM, Williams-Russo P, Knickman JR. (2002). The case for more active policy attention to health promotion. *Health Aff* (Millwood), 21(2):78-93. http://content.healthaffairs.org/content/21/2/78.full

11. Howell RT, Kern ML, and Lyubomirsky S. (2007) Health benefits: Meta-analytically determining the impact of well-being on objective health outcomes. *Health Psychology Review*, 1(1). http://escholarship.org/uc/item/6s00390x

12. Walburn J, Vedhara K, Rixon L, and Weinman J (2009). Psychological stress and wound healing in humans: A systematic review and meta-analysis. *J Psychosom Res*;67(3):253-71. DOI: 10.1016/j.jpsychores.2009.04.002

13. Cohen S, Alper CM, Doyle WJ, Treanor JJ, and Turner RB. (2006). Positive emotional style predicts resistance to illness after experimental exposure to rhinovirus or influenza a virus. *Psychosom Med*; 68:809–15. DOI: 10.1097/01.psy.0000245867.92364.3c

14. McGonigal, Kelly. (2015) The Upside of Stress: Why Stress Is Good for You, and How to Get Good At It. Avery, a member of Penguin Random House.

NOT A FREUDIAN SLIP: THE HAPPINESS TREND - A HEALTHY PURSUIT OR AN OBSESSIVE QUEST? *continued*

15. de Jong Gierveld J, van Tilburg TG, and Dykstra PA. (2016). "Loneliness and Social Isolation" In Anita Vangelisti and Daniel Perlman (eds), The Cambridge Handbook of Personal Relationships, second edition, Cambridge University Press (forthcoming) (pp. 1–30). http://hdl.handle.net/1765/93235

16. Adler NE, Epel ES, Castellazzo G, and Ickovics JR. (2000). Relationship of subjective and objective social status with psychological and physiological functioning. *Health Psychology*. 19:586–592.

17. Lyubomirsky S, King L, and Diener E. (2005) The Benefits of Frequent Positive Affect: Does Happiness Lead to Success? *Psychological Bulletin*; American Psychological Association, Vol. 131, No. 6, 803– 855. http://sonjalyubomirsky.com/wp-content/themes/sonjalyubomirsky/papers/LKD2005.pdf

18. Fitzgerald CJ and Danner KM. (2012). Evolution in the Office: How Evolutionary Psychology Can Increase Employee Health, Happiness, and Productivity. *Evolutionary Psychology*. Volume 10 (5) 770-781. DOI: https://doi.org/10.1177/147470491201000502

AFFIDAVIT: HEALTHCARE AND THE LAW - THE HEALTHCARE DEBATE: HOW DO WE TALK (OR NOT TALK) ABOUT RATIONING SERVICES?

As the healthcare reform debate rages on, the public is grappling with macro questions - "How can we spend less?" and personal concerns - "How can I and my family get the care I need and want?" Given the financial unsustainability of our current system, the debate focuses on cost issues, and so we look for structural solutions, like lifting mandates on insurance coverage, replacing the provider fee-for-service reimbursement model with one based on quality performance, better deploying technology within the healthcare system, and making Medicaid a State block grant program. Underlying these discussion points is the issue of who gets what, otherwise known as rationing. Of course, healthcare goods and services are already rationed through benefit limitations and socioeconomics status, but reform requires further rationing. For most consumers, it can be difficult to imagine denying care to someone else, especially for life-and-death treatment; recall the debate prior to the passage of Obamacare over alleged government "death panels" that would determine who would live or die based on access to services. But the public needs to address head-on the health consequences of limiting services in order for a viable, long-term reform solution to emerge. Business leaders, academicians, and politicians can assist in that debate by ensuring that rationing care is a significant part of the discussion.

Imposing a strict rationing system is not new, as illustrated by an effort by the Oregon Medicaid program two decades ago. In 1994, the State introduced a rationing program that categorized and then prioritized services for Medicaid beneficiaries based on factors such as age, medical condition, the likelihood of a successful outcome, and the expected quality of life or life expectancy post-service. For example, it was hotly debated whether a particular individual should receive a costly bone marrow transplant when there was a reasonable chance the transplant might not be successful. The program created a lot of controversy - the public was not comfortable with the prioritization of services, particularly those that could result in death – and the strategy was ultimately retired in favor of different approaches, including managed care (thereby shifting the burden of determining services to the plan).

Life-and-death issues are central to any discussion on rationing. According to the Kaiser Foundation, roughly 25% of Medicare spending goes to beneficiaries in the last year of life. And regardless of one's position on when life begins and therefore when services should become available, it is important to recognize the cost of supporting a pre-term infant with complex conditions can easily run into the hundreds of thousands of dollars or more. Efforts to educate the public on avoiding pre-term and elective deliveries and promoting end-of-life planning may ameliorate but will not solve these challenges. We may never come to consensus on the questions of when life begins or ends, but a full and open dialogue on the associated costs is necessary.

Another way to ration services in order to reduce costs is to limit the use of the emergency department. The federal law known as the Emergency Medical Treatment and Active Labor Act (EMTALA) requires that any hospital with an ED must screen and stabilize any individual who comes to the ED whether or not they have insurance and no matter their complaint. Although efforts are underway to limit the use of the ED for non-emergent services like sprained ankles, nevertheless, if the consumer presents at the ED, s/he must be screened and stabilized. And, the ED serves as the entry point for inpatient care, the most expensive type of care. If we truly want to reduce ED care, EMTALA should be amended to close the ED to some or all populations or for certain services. For instance, the ED could

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AFFIDAVIT: HEALTHCARE AND THE LAW - THE HEALTHCARE DEBATE: HOW DO WE TALK (OR NOT TALK) ABOUT RATIONING SERVICES? *continued*

still provide catastrophic care following a car accident but not services for an existing condition that could or should have been addressed outside of the ED, such as for asthma or end-stage cancer. As with the Oregon Medicaid experiment, the public may not be comfortable with developing charts of who gets what in the ED. But the fact remains the current use of the ED is not viable, and one solution may involve limiting its open use.

Substance abuse and mental health also offer significant opportunities for cost reduction through rationing. A common complaint is that successful mental health and substance abuse outcomes are difficult to measure; even if the addict sobers up, relapse is always a concern. Behavioral health conditions are very expensive to treat and result in steep costs to employers for lost time and increased plan benefit costs, as well as to the government for public services such as jails and shelters for persons suffering from substance abuse and/or mental illness. The Mental Health Parity Act of 1996, the Mental Health Parity Equity Act of 2008, and the 21st Century Cures Act each built on one another to ensure mental health and substance abuse treatment benefits were treated no less favorably than medical/surgical benefits, for instance by requiring plans to impose lifetime dollar limits equally for behavioral health and medical/surgical health services. Although parity remains in effect under the law, there are significant exceptions that apply to the Medicare and Medicaid programs and in other situations. Most reform efforts would eliminate parity and whittle away at behavioral health services. Limiting these services may result in initial savings to the healthcare system but reflects a choice to forego certain kinds of care to large swaths of the population, and, additionally, untreated mental health issues eventually further exacerbate the cost of care, particularly when there is such a heavy, and increasing, chronic disease burden in the U.S. population as a whole.

The examples above are freighted with ethical and legal issues that won't be easily solved now or ever. But there should be more discussion about care rationing, even when it doesn't involve life-or-death matters. Here's an (arguably) easier question: Should Medicare pay for knee surgery for every 90-year old? I might argue in the negative right now, but I'm sure I'll want my knee surgery when I'm 90.

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DOWNLOADING SUCCESS: EMERGING (AND SUSTAINABLE) HEALTHCARE LEADERSHIP ROLES

When I speak with healthcare executives about career ambitions, I caution them not to get too fixated on any one position title. I've seen many finance executives, for example, who had their sights set on the CFO role only to end up in something different and fulfilling. (Occasionally it's as CEO.)

I like to encourage executives to look around and consider positions that will allow them to grow and find meaningful work. This is especially true in healthcare today since roles – and titles – are changing.

On that note, allow me to highlight five executive titles I see gaining significance and importance in healthcare, no matter what the unpredictable future holds. These are positions that seem to have sustainability – once created at an organization, they will be around in good times and bad.

Chief Clinical Officer
The importance of being physician-led is stronger than ever as the care delivery model has changed. Cost and quality will continue to be industry obsessions, with the CCO right in the middle. This role is a modification of the Chief Medical Officer position, and of course requires an M.D. (and an M.H.A. or equivalent is preferred).

The CCO is charged with ensuring alignment and integration *across* growing health systems. As my colleague Linda Komnick noted recently, the CCO is someone who "sees the organization not as a top-down traditional clinical entity, but who could also look sideways across the network and see opportunities for clinical performance improvement, integration, and coordination of care across the continuum." As industry consolidation continues and the need for physician leadership and clinical integration increases, the CCO role should gain traction.

Chief Experience Officer
The Chief Experience Officer (or often Chief Patient Experience Officer) has arisen out of the need for providers to be more in tune with consumer expectations. This need does not figure to go away as the marketplace in healthcare gets more complex and competitive. A recent white paper from the Beryl Institute remarks that the Chief Experience Officer "ensures a seat at the table for the voice of the customer to be heard and acted on when senior leaders gather and make decisions." Experience officers frequently have marketing backgrounds, though that is not a prerequisite. A good inside perspective on the position can be heard in this podcast with Hartford HealthCare Chief Experience Officer Sean Rodriguez.

Chief Information Security Officer
Information security is one of the proverbial keeps-executives-up-at-night concerns. "It's not a matter of *if* but *when*" is a common refrain about security breaches within healthcare. As such, there has to be an executive dedicated to fostering security best practices throughout the organization. "Some organizations are still struggling with building that culture of information security," my colleague Nick Giannas has written. "It's not only just building the team to support the information security officer. It's also building that awareness and education

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Paul Bohne

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DOWNLOADING SUCCESS: EMERGING (AND SUSTAINABLE) HEALTHCARE LEADERSHIP ROLES *continued*

around it across the organization." Watch for the CISO role to continue to expand – it requires not just technological expertise but true leadership ability as well.

Chief Medical Informatics Officer
CMIOs cropped up as robust clinical information systems came online and health systems required an executive to oversee implementation and operational success. This role is now transitioning into one that is more strategic and forward-looking, exploring ways to optimize patient and other data for Triple Aim and other fundamental goals. Expect to see informatics leadership roles (including Chief Nursing Informatics Officer) grow in number and status. This "CMIO 2.0" position is often evolving into what can be termed the Chief Health Information Officer (CHIO).

Chief of Staff
This is a title that is gaining traction in healthcare as CEO positions (and directing a healthcare enterprise in general) become increasingly complex. The chief of staff can be many things, including the right hand to the CEO, to make sure the executive offices are functioning optimally, and even to stand in as a surrogate to the CEO for some responsibilities. The key to the success of the role is a strong bond between the chief of staff and the CEO. They must have complementary personalities and seamless interaction on the job.

A Note of Caution
I believe these roles above have staying power in healthcare. One caveat regarding them all: It is critical the organization define the most important leadership competencies and behaviors that help define organizational fit and the specific measures of success for each role. This is done through a position description or what my company calls a "leadership profile." Such a document ensures there is internal consensus around the role, its criteria, and its mandate or core agenda.

Within each healthcare organization the impetus to address change will still fall upon the CEO, with critical input from COOs, CFOs, and other traditional senior-level peers. Increasingly, a broad and comprehensive team must be built around the CEO to capitalize upon change rather than merely wrestle with it. This is where new executive titles fit in.

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MEDICAL TRANSPORTATION BENEFITS MANAGEMENT

When the need for medical transportation arises, families often have no time to plan, and it's the clinician, facility or circumstance dictating who the transportation provider will be. As a result, patients, their families, and insurers are exposed to inconsistent practices and the unpredictable fees levied by independent and unregulated providers. This is an all too common occurrence in the currently fragmented state of the medical transportation industry.

The risks in medical transportation are growing as use of air and ground ambulance for medical transport increases. In response, Alacura, a new medical transportation and benefits management (MTBM) business backed by the private equity firm Vistria, is developing a model that streamlines the transportation process, coordinates benefits management through affiliations with health plans, guarantees market-rate payments to transport providers within 30 days, and provides structured pricing and process transparency for patients and their families. By coordinating stakeholders, Alacura is establishing an approach to partnership, excellence, and fair pricing that delivers high quality at lower cost.

Medical transportation - including emergent (immediate), urgent (within 24 hours), or non-emergent (scheduled) - is becoming increasingly more important to the delivery of healthcare services. In fact, insurers both large and small include air ambulance/medical transportation in their metrics as more and more members access life-saving, advanced care through travel. Medical transfers may be necessary to return a sick patient to a home state, transport a patient to a special treatment center, get a patient from a rural setting to a major hospital, and more. When precipitating situations arise, hospital case managers or clinicians usually initiate the process. In some cases, the community ground emergency teams make the call. Frequently, the selection of the medical transportation provider happens before the patient or family can be involved.

The medical transportation industry is defined by thousands of independent air and ground providers. In order to do business, these providers comply with quality and safety standards set by federal and state transportation governing bodies. Yet, given unregulated pricing in this industry (with the exception of Medicare services), some transport providers take advantage of patients and health plans through high retainers and fees. How is this allowed to happen?

First, many health facilities do not have provider names or outlined procedures for unscheduled medical transfers. In the majority of situations, busy case managers default to established provider relationships or social media searches to identify a transport company. Second, the need for medical transportation usually occurs at times when emotions are high and quick decision-making is required. Patients and their families are often not aware of their options or the full financial risk at the time of the agreements. In many cases, time does not allow for patient/family review and contracting. Third, providers state they collect from insurers, but patients/families do not realize that unpaid balances become their responsibility. Insurers usually require pre-authorization and use of in-network solutions. Given the structure of most health plan guidelines, however, when a transport is triaged as emergent, the pre-authorization requirement is avoided. Informal research indicates emergent coding is overused, and only 20% of current transport is done with in-network approved providers. Health plan restrictions are insufficient to control abusive pricing practices.

To protect income, the independent providers usually collect a retainer from the patient, proceed with the transport, bill insurance,

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MEDICAL TRANSPORTATION BENEFITS MANAGEMENT

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and then return to the patient/family for unpaid balances. As more published stories expose the aggressive tactics used by some medical transportation providers to collect balances (including liens on family homes), the case for a fairer and better coordinated system becomes clear. Consumer outrage is only one part of the pain. Insurers are taking notice, too, as members are unwitting victims to these costly services. "States have been receiving complaints from individuals who have found that there's a huge balance to pay even after their health insurance pays," said Bruce Ramge, Nebraska's insurance director. "These services are very expensive. They're staggering in some cases. It's not just an issue in Nebraska. It's an issue all around."[1]

Safety and care are also major concerns.[2] Reports of medical transport accidents are not uncommon.[3]

Alacura brings an important solution to the disconnected and risky state of the medical transportation industry. With international reach through an Alacura network of experienced, highly credentialed providers (previously operating independently), the Alacura business model streamlines information by acting as a partner to health plans and providers and ultimately protecting the patient/consumer. Alacura's role extends beyond mediation. Alacura focuses on fair, market-based pricing, quality assurance and credentialing, guaranteed payments for providers, and transparency.

By analyzing data, costs, and member populations, Alacura assists health plans in determining potential risk exposures, contains costs through utilization review, utilization management and triage assessments, and reduces member dissatisfaction by assuring quality, safety, and predictability in pricing outcomes. The Alacura model also coordinates provider reimbursement within weeks of the transport, helps them lower overhead, and gives them the benefit of an affiliated health plan business. Finally, when health plans are aligned with Alacura, members are only responsible for covering their deductibles. Patients are not saddled with prepayments or surprise billing. Beyond these hard and soft cost savings, Alacura also offers fully integrated technology platforms to both providers and health plans; maintains active communication with the health plan clinical advisors, facilities (both sending and receiving), and families; and oversees tightly managed, consistent processes with every transport from bedside-to-bedside, including fixed-wing (jets), rotary (helicopters), and ground portions of transportation.

Alacura introduces macro-level advantages, as well. While the country struggles with the escalating costs of healthcare, the burden for that cost rests with employers, insurers, and consumers at rates that exceed inflation. By introducing standards to a lopsided cost-value situation, Alacura acts not just as a go-between but as a leadership partner, allowing disparate parties to function within the bounds of transparent, coordinated, and supportive operations. Additionally, as more industries see Uber as proof that an on-demand economy with efficient assignment, tracking, and management of resources brings value, the Alacura model is even more compelling.

Finally, the Alacura solution creates an opportunity for new alliances to take shape. Healthcare providers, including physicians, hospitals, rehabilitation and acute care facilities, international centers of excellence, and the proliferating narrow networks can partner in new ways while maintaining cost controls.

It is an enormous undertaking to re-define practices, but the outcome has great value: *Preserve and improve the quality of medical transportation while reducing risks and costs.*

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MEDICAL TRANSPORTATION BENEFITS MANAGEMENT

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References

1. Jordon S. "Few think about insurance when air ambulance lifts off; then … surprise." *Omaha World-Herald*. November 24, 2014. http://www.omaha.com/money/few-think-about-insurance-when-air-ambulance-lifts-off-then/article_11759ecf-182f-59a2-8cde-7c804ecf9913.html. Accessed January 9, 2017.

2. Maffly B and Peterson ES. "Utah's new air ambulance companies raise the prices, and maybe danger, for patients." *The Salt Lake Tribune*. August 14, 2016. http://www.sltrib.com/news/3871233-155/utahs-new-air-ambulance-companies-raise. Accessed January 9, 2017.

3. Hawryluk M. "Rapid growth in air ambulance industry raises safety concerns." *The Bulletin*. December 27, 2014. http://www.bendbulletin.com/health/2714022-151/rapid-growth-in-air-ambulance-industry-raises-safety. Accessed January 9, 2017.

FEE-FOR-SERVICE TO VALUE-BASED PAYMENT TRANSFORMATION: PROVIDER READINESS – PART 1

This article is part of a series about value-based payment and its applications in the healthcare landscape. Part 1 provided an overview of the landscape. This second article in the series begins the review of provider readiness through a discussion of risk-bearing options for physicians, hospitals, and health systems

Value-based payments reward physicians, hospitals, and health systems for achieving positive health outcomes while decreasing or maintaining costs. As discussed in our first article, value-based payment models continue to increase at an escalated rate in prevalence and variety, giving providers an increasing number and mix of options for entering into arrangements ranging from simple to complex and from low to high risk, all based on value rather than volume.

Knowing how to begin assuming risk is complex – there is no one-size-fits-all approach. For example, while a mature health system may have the employed and/or contracted provider network in place to both establish a health plan and take on global risk, another less developed physician group may want to first test the waters with perhaps an independent physician association (IPA). Why? The ability to manage a population's health depends on multiple factors, including (but not limited to):

1. existing care management structures
2. capital resources
3. provider network maturity
4. population make-up/payer mix (Commercial, Medicaid, Medicare)

We will delve more in-depth into the necessary building blocks for value-based payment in a later installment of this series. We're reviewing the different risk-bearing options for providers, including relative merits and reach considerations. The appropriate required entity (physician, hospital, health system) for taking on well-managed risk will depend on the structural makeup of the particular option.

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continued

Risk-Bearing Options
The following table shows some of the more common risk-bearing vehicles, along with the initial level of risk ranging from low to high.

			Low Risk → → → → High Risk		
Options	Applicable Provider Type	Shared Savings and Losses	Professional Risk	Institutional Risk	Global Risk
Establish/Join an Independent Physician Association (IPA)	Physicians	X	X		
Develop/Join a Medicare Accountable Care Organization (ACO)	Physicians, Hospitals	X	X	X	
Create a Federally Qualified Health Center (FQHC)	Clinic		X	X	
Establish a Health Plan or Plan-to-Plan Arrangement	Varies – typically hospital or health system				X

Independent Physician Associations, Physician Groups
Independent Physician Associations (IPAs) are groups of physicians who come together (individually or collectively) to share in operational efficiencies afforded to them because they are now part of the larger whole. Under this structure, IPAs can potentially manage patient populations. IPAs typically share a managed services organization (MSO) or a third-party administrator (TPA) that manages the administrative aspects of physician practice, allowing the physicians as a group to participate in delivery system innovations, such as centralized care management and quality improvement programs.

- **Pros:** As a general rule, the IPA structure allows physicians to share administrative efficiencies, approach health plans to partner as a network, provide access to a larger range of services/ provider types (e.g., physician assistants, nurse practitioners) for its patients, access to group purchasing, and begin to bear professional risk.
- **Cons:** There is little/limited ability for an IPA to take on institutional or global risk because it is composed of physicians. IPAs will need to partner with other organizations to do so, or broaden to include hospitals in-network.

Medicare Accountable Care Organizations (ACOs)
ACOs are CMS pilot innovations designed to allow groups of doctors, hospitals, and other providers

FEE-FOR-SERVICE TO VALUE-BASED PAYMENT TRANSFORMATION: PROVIDER READINESS – PART 1

continued

to share savings if they can manage to lower the total cost of care and increase quality for Medicare beneficiaries. Currently, CMS awards ACOs for eligible Medicare populations and have begun to explore demonstrations for Medicare/Medicaid eligible populations, also known as dual-eligible beneficiaries.

- **Pros:** This is generally a CMS-driven program, with the support of the agency to lower the cost of care for a defined population. There are many options for providers regarding level of risk, from shared savings to more advanced payment models, as ACOs progress in their ability to manage downside risk.
- **Cons:** The process for becoming an ACO can be cumbersome, and CMS approval is not guaranteed. In addition, the population eligible for this innovation model is still limited to Medicare, which makes this a good option for groups that want to serve that population but may not be a good option for providers who provide care in significant numbers to other populations (e.g., Commercial, Medicaid).

Federally Qualified Health Centers (FQHC)
FQHCs are community clinics that have been designated by the Health Resources and Services Administration (HRSA) as serving large populations of underserved, Medicaid, or indigent populations. As a result, they are eligible for increased payment rates under a prospective payment system.

- **Pros:** FQHC designation is advantageous for existing primary care clinics that already serve large Medicaid and indigent populations or systems looking to expand their primary care (and designated specialty) capacity for their specific populations. The elevated (cost-based) payment rates allow the organization to care for this population when they may have been losing money previously. The risk comes under the prospective payment system, which holds the FQHC financially accountable for the totality of primary care (and designated specialty) services.
- **Cons:** Similar to an ACO, any federally regulated program can be intensive to apply for and administer. This can be a capital-heavy/time-intensive investment if the system is starting from the ground-up to build a new primary care clinic/FQHC. In addition, an FQHC requirement for significant community presence on the board can greatly complicate governance.

Establishing a Health Plan or Entering Into a Plan-to-Plan Arrangement
Many large health systems with at least one full-service hospital and specialty and primary care networks can and have begun to explore becoming fully established and licensed health plans, capable of managing insurance risk through selling products or partnering with another plan under a global capitation contract (called a plan-to-plan arrangement). This is an advanced step for provider organizations, or groups of provider organizations, confident in their ability to manage utilization and cost, have experience with managing populations, and have the care management history/ demonstrated ability in place.

- **Pros:** This is an opportunity for a very experienced system already managing overall population health to take on the full responsibility (and eventually reap rewards) of ensuring that patients have access to quality care.
- **Cons:** Establishing and operating a health plan is a significantly different endeavor than running a healthcare system. An organization that cannot adequately manage its population's health and the utilization of its members stands to lose money in taking full financial risk for enrolled members.

In conclusion, before even considering assuming additional financial risk, each provider (e.g., solo,

FEE-FOR-SERVICE TO VALUE-BASED PAYMENT TRANSFORMATION: PROVIDER READINESS – PART 1

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independent, affiliated, or system) needs to accurately and objectively pinpoint where it falls on the low to high risk continuum in order to determine its next course of action in the uncertain world of value-based reimbursement. Each entity needs to understand if it has all the necessary components and the capability to manage them to be able to deliver high-quality care and effective care management in a cost-efficient manner. Failure to do so could result in irreparable financial and reputational harm. The next article in the series will further the review of provider readiness through a continued discussion of risk-bearing options for physicians, hospitals, and health systems.

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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.

MOVING THE CULTURE FROM INDIVIDUAL HEROICS TO SYSTEMIC VALUE CREATING A CULTURE OF VALUE – PART 2

This is the second piece in a series of articles about creating a "Culture of Value" in your organization.

Although the direction of US healthcare policy remains uncertain, the need to improve quality and experience while driving down cost remains a priority. The value equation [defined as (quality + experience)/cost] touches every aspect of healthcare, and, while simple to define, it can be difficult to translate into action. Building value into organizational culture holds tremendous potential. In this series, we have defined a *Culture of Value as one where everyone, from frontline staff to C-Suite leadership, understands what it means to create value for patients, providers, and the system, including how to act in ways that enhance value from each of their respective roles*.

Here, we share a case depicting a common healthcare challenge: how to orient the culture from volume to value.

Creating a culture of value: The case of cardiovascular surgery

Why a culture change? Why now?
A leading academic medical center's cardiovascular surgery program had grown quickly, across a large regional system. The program was committed to cutting-edge therapies, giving patients a chance to live and thrive when others had turned them away. Clinicians cared deeply about their patients, and surgeons worked long and erratic hours to serve them.

In 2015, the program identified several deaths the chief believed were avoidable. At the same time, public rankings declined. The chief engaged the CMO for help.

Cultural assessment to understand practice, not just policy
Experienced in influencing quality, the CMO saw the need to look at the organizational dynamics that contributed to the mortality issues. We were asked to conduct a separate cultural assessment which cast a wide net to understand day-to-day practices. We partnered with the program to look into the work of the team members across all levels.

We found patterns of behavior that had worked when the program was small, but with growth, were no longer reliable. The program needed to move from reliance on heroic behavior by individuals to a systemic approach to quality.

Changing the culture: No one silver bullet
We knew that changing the culture would **require as much attention to how** initiatives were put in place **as to what** initiatives were begun. It would require a focus on the day-to-day behavior of hundreds of people across multiple geographically separate hospitals—and their ambulatory counterparts. No one action would have sufficient impact across the system. We focused on leadership, prioritized focus areas, and broad engagement.

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MOVING THE CULTURE FROM INDIVIDUAL HEROICS TO SYSTEMIC VALUE CREATING A CULTURE OF VALUE – PART 2

continued

Leadership: Making change visible—We knew that to shift so much within a program of this size and scope, having executive clinical and administrative alignment, and the broad clinical perspective of stakeholders responsible for the quality of care, was essential. That meant demonstrating the backing of leadership in these ways:

- Leadership commitment from the system—An executive group was in place to ensure that leaders of entities and their clinical leaders were on board with our learning and the necessary changes. One of the operational reviews recommended increasing staff; the leadership group made the case for that intervention.
- Leadership commitment from the chief—The chief's commitment to a focus on quality was visible and consistent. In the same way that he had led the program in growth and commitment to cutting edge treatment, he began to lead in quality.
- Interprofessional governance—Organizational interventions could not be scaled by surgeons alone. We supported development of an interprofessional, inter-entity clinical leadership team to deliver on changes that made sense for each role and entity. Team members were able to push each other to work on what they needed to do, not just in the room, but also with the stakeholders they represented.

Focus: Understanding the variables—The clinical leaders identified a quality goal for the program. To accomplish this goal, they prioritized change work that could accelerate impact by vetting the cultural assessment findings and recommendations against their experience on the ground. Specifically, the team advanced these areas of focus:

- Developing standardized protocols—In programs where many patients are not "typical," it is challenging to get physicians to agree on protocols. After several false starts, the leadership team felt it had the momentum to develop and reach acceptance of key protocols, pulling from broad expertise.
- Negotiating role clarity—The program's rapid growth had led to widespread confusion about who (what role) should do what when with regard to patient safety issues. With unclear expectations, conflict was inevitable. The program leadership team negotiated clear and transparent ways to escalate problems.
- Infrastructure for accountability—Without ways to track protocol adherence, sustained quality change is difficult. The clinical leaders developed methods to gain commitment and adherence to specific metrics which became transparent dashboards for the entities and the surgeons.

Engagement: Bringing the culture of value to life—Along with regular formal communications, the executive group developed, with our support, a program retreat. Beyond showcasing the work of the clinical leaders and many other efforts, the retreat also connected the specific changes to all program stakeholders and to drive the pace of work, since it served as a deadline for milestones. Leaders across the system understood the plan—and a real and consistent commitment to change.

The results of a value orientation

A year later, the program has seen gains in the goals of reducing morbidity and mortality, five of six dashboard measures, and launched its journey toward a culture of value—where individuals can see the impact of their choices. These results reinforce the significance of the hard work that went into creating a culture of value—from developing over a dozen clinical protocols to reinforcing psychological safety of staff.

MOVING THE CULTURE FROM INDIVIDUAL HEROICS TO SYSTEMIC VALUE CREATING A CULTURE OF VALUE – PART 2

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The improvement in metrics had important implications for the value of care. For example, decreased ALOS increased access for more very sick patients, contributing to both the mission and the revenue of the department. Cultural change supported both quality and value.

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.

SAN ANTONIO IS ON ITS WAY TO BEING 20 PERCENT HEALTHIER

Humana's Bold Goal – to improve the health of the communities we serve 20 percent by 2020 because we make it easy for people to achieve their best health – has brought lasting and far-reaching improvements to multiple communities, with San Antonio leading the way.

In our last article, we talked about how the community has embraced our Bold Goal efforts and the early momentum we achieved. We'd now like to show the truly impressive gains made over the past year – with the help of our community and physician partners – in addressing the social determinants of health, like food insecurity, health literacy, and loneliness.

San Antonio, our first and most mature Bold Goal community, has experienced a 9 percent increase in the number of Healthy Days, surpassing our trajectory goal for 2017. Measuring Healthy and Unhealthy Days is a U.S. Centers for Disease Control and Prevention (CDC) tool that reveals how a person is feeling holistically, including his or her mental and physical health in a 30 day period. That 9 percent increase was particularly gratifying, given the CDC shows national Healthy Days have been flat for a long time. Specific to Humana members, we expected a flat trend for the first 2-3 years as we test and learn interventions, followed by a steeper increase in Healthy Days improvement over the final 3 years as we scale effective interventions through 2020.

The results in our 2017 progress report reflect wide-ranging collaboration in San Antonio between the San Antonio Health Advisory Board (HAB), which is made up of physicians, business leaders, non-profit organizations, government officials and public health organizations, and a Board of Directors, made up of Humana senior leadership. Such a wide range of partners is key, because health isn't just about seeing a doctor once or twice a year. There are numerous environmental, social, psychological, and economic issues that impact a person's health and are often the root cause of illness. Health can't just be about reacting to disease; we have to be proactive in preventing disease and promoting well-being.

Realizing these external factors have profound effects on health, we are working with our community partners to address barriers like food insecurity and lack of access to behavioral health services, as well as health conditions like diabetes and depression.

A few examples of our pilots and interventions in San Antonio include:

- The **Path to Wellness** program, one of our longest-running collaborations in San Antonio, works with H-E-B grocery, the YMCA of Greater San Antonio, and primary care physicians (PCPs) at MCCI and Partners in Primary Care to address diabetes, nutrition, and health literacy. This program combines one-on-one nutritionist consultation and guided nutritional grocery store tours with a registered dietitian, as well as disease-specific education and physical activity measurement and education with the YMCA. The PCP and clinical staff support the patient throughout the program, through quarterly office and lab visits. We are measuring improvement in HbA1c, body mass index (BMI), and cholesterol.
- Our **telepsychiatry pilot** addresses a nationwide issue – the difficulty in getting timely, affordable, coordinated access to behavioral health services. Technology enables a behavioral health clinician to diagnose and treat a patient from a remote location. In partnership with Humana Behavioral Health and

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Humana Integrated Clinical Services, telehealth equipment (i.e., laptop, large monitor, and HD webcam) was embedded in Humana-owned clinics in San Antonio. Patients are evaluated and referred by their PCP, who facilitates the telepsychiatry visit and coordinates treatment with the behavioral health provider.

- Recently, the San Antonio Health Advisory Board and the American Diabetes Association developed a **digital resource guide**, offering people with diabetes and their caregivers new ways to manage the condition through a vast online network of programs and services. We are working with physicians to "prescribe" the resource guide as an additional tool for managing diabetes as well as mitigating diabetes in those residents who are most at risk.
- The San Antonio Health Advisory Board has joined with the San Antonio Parks and Recreation Department on Fit Pass, a **reward-based program that encourages people to use the many available resources in San Antonio**, including parks and walkways, to improve their well-being. Using a mobile app or the desktop version, users can engage in a free interactive fitness scavenger hunt to take part in wellness activities and earn points toward new bikes, personal fitness equipment, gift cards or other prizes. Humana Guidance Center classes that are part of the Fit Pass Program were filled to capacity in 2016, and there were 986 Humana Vitality beacon check-ins throughout the program; we placed beacons in 12 of the Fit Pass Program locations.

In large part, health happens locally and occurs outside of the clinical setting. By identifying the environmental, community-based elements that influence a person's health, we can create more informed, localized solutions to influence lifelong well-being. Our commitment to physician and community-focused efforts contributes to improved clinical outcomes and more Healthy Days in San Antonio. Our wide-ranging partnerships have allowed us to leverage data and insights in new ways to improve population health.

As Humana's first Bold Goal community of learning, San Antonio enables sharing of its experiences of building partnerships and planning health interventions with other communities including Tampa Bay, Broward County (Florida), New Orleans, Baton Rouge, Knoxville and Louisville. Each of these seven Bold Goal communities of learning has offered distinct insights, and the best ideas have been shared and implemented elsewhere. However, with its dramatic 9 percent increase in Healthy Days, San Antonio continues to be a Bold Goal community leader in collaboration and actionable insight.

Learn more about our Bold Goal progress in San Antonio and other communities at:
humana.com/boldgoal

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WHARTON AROUND THE GLOBE: IMPROVING ACCESS TO PRIMARY CARE IN MUMBAI, INDIA

This past spring break, three members of the Wharton Global Health Volunteers (WGHV) traveled to Mumbai, India to work with Swasth Foundation (Swasth). In India, "Health Shocks" drive 60 million Indians below the poverty line each year. Primary care can reduce the "Health Shocks" by 2 - 2.5 times, but inadequate public infrastructure leaves the urban poor without enough access. Swasth is working to address this issue with a mission to create Health for All. They have built 18 low-cost, scalable, and patient-centric clinics providing one-stop access to high-quality, affordable services at less than half the market rates. Swasth plans to scale and build 50+ clinics in the coming years.

Clinic | Viba Saligrama, WG'17 and outreach worker | Rav Mulani, WG'18 and Yang Hu, '17

The Swasth clinic directly sources drugs, has an in-house pathology lab, and low overhead model that allows it to provide drugs at 50% off the suggested retail price and services at very low cost. However, many in these urban communities are unaware of the great advantages of visiting a Swasth clinic. To increase membership, the Wharton team worked on developing and marketing a discount pass program. The team analyzed clinic data to understand the frequency and demographics of current Swasth patients, constructed patient surveys to test attributes that patients would value most in the discount program, and developed an implementation plan for launching the new program. Some of the attributes to be tested included greater discount on drugs and labs, unlimited primary care visits, and pass fees. The team thought of potential partnerships with the dabbawallas (Dabbawalas constitute a lunchbox delivery and return system that delivers hot lunches from homes and restaurants to people at work in India, especially in Mumbai.) and domestic maids to promote the program. The model is similar to direct primary care in the USA.

The team also researched opportunities for Swasth to provide broader insurance coverage for hospitalizations, as this seemed to be a large concern for many in the urban working class communities. Organizations like LIC, Apollo Health, and Star Health provided preliminary premium quotes, and Swasth will continue to refine these proposals in the hopes of eventually providing broader insurance coverage or cash payouts in the event of hospitalization.

The Wharton team had the opportunity to visit Swasth clinics and

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WHARTON AROUND THE GLOBE: IMPROVING ACCESS TO PRIMARY CARE IN MUMBAI, INDIA *continued*

were very impressed by their use of space and technology. In each clinic, there is a small patient waiting area, dental area, primary care area, lab sample collection, and drug dispensing. Each patient is uniquely identified with a patient ID, and all medical information is tracked in a custom-built electronic health record. Patients are also provided with paper copies of their medical history in a Swasth folder. The clinics effectively used limited space to be truly patient-centric. The team also shadowed a community outreach worker to better understand the needs of patients and importance of the clinics.

Everyone at Swasth was truly passionate about improving healthcare, and it was energizing and rewarding for the Wharton team to learn from them about low-cost innovation and support this cause. The Swasth team also enjoyed working with the Wharton team and hopes to stay in touch and work with other Wharton students in the future as they continue to scale. All members of the WGHV who were selected to participate this past spring would like to thank our alumni for assisting in making this trip possible.

Hardik Mehta (Swasth), Viba Saligrama (WG 17), Yang Hu (WG 17), Ravi Mulani (WG 18), Sundeep Kapila (Swasth Founder)

Ravi Mulani (WG18) and Yang Hu (WG 17) working in the Swasth office.

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