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Congratulations to the Leonard Davis Institute on its 50th anniversary, which is being celebrated by a year’s worth of events, including the action-filled “Shaping the Future of Healthcare” symposium to be held October 5 - 6, 2017! It promises to be THE healthcare event of 2017. There will be keynote speakers across the healthcare spectrum and breakout sessions that will make it difficult to decide which to attend, but all of which will leave you smarter and better prepared to address the many and myriad challenges which are healthcare in 2017:

- Leveraging Innovative Healthcare Models to Serve Vulnerable Populations
- Predicting the Future: Transforming Big Data into Smarter Care
- System Redesign and the Healthcare Workforce
- The Future of Payment Reform
- Strategies to Advance Population Health
- Shaping the Future of Medicare
- The Future Landscape of Children’s Health
- Behavioral Science and Health
- Value Frameworks in the U.S.
- Risk Adjustment and Measuring Quality

I’m also happy to announce a new standing column, “To Your Well-Being,” a series of articles from integrative health and well-being experts at Canyon Ranch in Lenox, Massachusetts. As is their guiding intention for their guests, I invite you to explore “The Power of Possibility.”

Z. Colette Edwards, WG’84, MD’85
Managing Editor
THE PRESIDENT’S DESK

On July 28, 2017, Senator John McCain cast the deciding vote to sink legislation that would repeal the Affordable Care Act (ACA).Diagnosed with brain cancer the week before, Sen. McCain shocked DC by bringing the Senate’s efforts to repeal the ACA to a screeching halt. That was four days ago as I type these words; the CSPAN video of McCain motioning “thumbs down” is still replaying in my head.

July 28th also happened to be ten years to the day from when I touched down at PHL to start Wharton pre-term. The only thing I remember about that day was being greeted by slate-colored smoke billowing from the oil refineries off 291. An inauspicious start, sure, but had I known what to expect of the next two years, I would not have been concerned.

What should we have expected when we started at Wharton? I’ve been pondering that question as I prepare to address the Health Care Management Class of 2019 at their pre-term. My talk – “What You Can and Can’t Expect from Your Time at Wharton” – may not pack the punch of a McCain hand gesture, but here’s what I’ll tell them in short:

You can’t expect: your classmates to lose internships when the banks fail; your first job out of school to be writing health reform in the House of Representatives; your wife to be Meagan WG’10.

You can expect: your classmates to be your companions, not your competitors; the HCM program to set you up for success; the WHCMAA and 2,500 alumni to support you through mentorship, service, networking, and leadership.

I hope they enjoy the talk, but I really hope they take advantage of the resources the WHCMAA offers to students. Each year we give $40,000 to students through the Kissick and Kinney Scholarships and through support of the Wharton International Volunteers program. Our alumni serve as mentors to students, sponsor field application projects, support the Wharton Health Care Business Conference, and introduce students to contacts in their networks. Many alumni offer students internships and full-time jobs. And when they graduate, the newly minted alumni can join the WHCMAA at no cost for the first year.

Got questions on how you can get involved with the WHCMAA, or ideas on how we can better support the students and the HCM program? Send them my way.

John Barkett WG’09
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THE PHILOSOPHER’S CORNER

Life Lessons:

If I knew then what I know now, I would have:
...taken advantage of more networking occasions. It can sound like a dirty word, but networking (once I embraced it) has been a great source of fun, friends, and new opportunities.

If I knew then what I know now, I would not have:
...sweat the small stuff. Life is too short and too messy to spend any time worrying about something you will forget in a few days.

Favorite Quotes:

1. Whether you think you can or whether you think you can’t, you’re right. ~ Henry Ford
2. Don’t cry because it’s over, smile because it happened. ~ Dr. Seuss
3. You only live once, but if you do it right, once is enough. ~ Mae West
5. Wine is constant proof that God loves us and loves to see us happy. ~ Benjamin Franklin

Recommended Reading:

• Being Mortal: Medicine and What Matters in the End by Atul Gawande
• All the Light We Cannot See by Anthony Doerr
• A Supposedly Fun Thing I’ll Never Do Again: Essays and Argument by David Foster Wallace
• The Goldfinch by Donna Tartt

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ALUMNI NEWS

Jeffrey Voigt, WG’85

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CHOOSE ONE

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

B: Realize that using a private health exchange has become the leading edge, adopted by forward-thinking companies

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

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Brett R. Anderson, WG’07
Dr. Brett Anderson recently received a 3-year award from the NIH/NHLBI (K23 HL133454) to study the effects of a surgeon’s technical skill on outcomes for children undergoing congenital heart surgery. Her work focuses on the linkage and integration of large datasets with each other and with prospectively collected data and the application of interdisciplinary methodology to the study of quality and value associated with the management of pediatric heart disease. For this study, she has > 40 congenital heart surgeons from around the country who have agreed to videotape themselves operating and to rate each other on technical skill. She will link these data to surgeon-specific outcomes from a national registry. Earlier this year, Dr. Anderson also published a highly controversial study examining the effects of congenital heart surgeon age/experience on patient outcomes.

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The unhappiness of not being happy. Does this constant pursuit of happiness make us unhappy?

In Part 1, we learned how being happy has positive impacts on our health and longevity. One might translate that fact into thinking we should be in constant pursuit of happiness. Should we be focused on happiness all of the time? Can we buy more happiness or could we be doing more harm than good by endlessly trying to weave happiness into every ounce of our lives? We will investigate below. In future articles we will explore how our digitally connected mobile and media infused world has impacted our happiness level. Finally, we will conclude by discovering ways that individuals can cultivate character strengths and build traits that realistically align with their personality and lifestyle to help us attain a healthy dose of happiness and enrich our lives.

Should we be focused on happiness all of the time?

As we explored in Part 1, being optimistic has benefits. Positive emotions encourage cooperation, stimulate action, and motivate us to reach our goals. However, staying focused only on the positive has negative consequences too. If we set unrealistic expectations that our life is meant to be an endless amount of bliss, we will be doomed to disappointment. It is not possible or healthy to experience happiness all of the time, for several reasons.

Balanced Amount

Just as you wouldn’t want to feel miserable, gloomy, annoyed, or outraged every day, being cheerful and joyful every moment isn’t positive either. Expecting all life events to feel good isn’t realistic. This narrowed view could misguide your expectations and leave you deeply disappointed, even in the midst of a joyful experience. Pleasure only gives us a temporary boost in happiness. Further, happiness, at all cost, can lead to depression.

Balanced Reasons

Striving for excessive pleasure all of the time could influence you to engage in risky behaviors to achieve continued happiness. This selfish, egotistical focus on your happiness might make you inflexible in the face of a new challenge. Some situations require you to make sacrifices, adapt your mindset, and to contribute to the greater good.

Balanced Emotions

Negative emotions are an inevitable part of life and teach us it might be time for a change. Feelings of fear or jealousy can signal an unhealthy relationship, one that should be avoided. Anger can help us learn to reconcile conflicts and practice forgiveness, as actions like forgiveness can have a direct impact on our health and the health of our communities. Stress is our body’s fight-or-flight reaction to a challenge. People who ignore or suppress this natural response can hurt their health, whereas someone who works to overcome obstacles builds

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resilience and improves his/her quality of life. By recognizing negative recurring themes, you can change your actions and eliminate damaging triggers. If you just pretend to be happy through those tough times, you could create a cycle of repeated events instead of working through ways to make the situation better.

**Balanced Context**

Happiness is not appropriate in every situation. Being ecstatic and skipping into the funeral of a beloved friend who just lost a battle with cancer is not a normal reaction. Being sad and mourning the loss would be more typical. Our emotional responses to life events are there for a reason and teach us something. The important lesson is to not fake happiness in the midst of pain, but to make the choice to be mindful and allow experiences to strengthen you.

A negative life event doesn’t subtract from your ability to have a positive life. In fact, our ability to recover from things that hurt us happens quicker than we expect, whereas we quickly adopt to those things that we think will bring us eternal bliss.6

**Does a constant pursuit of happiness make us unhappy?**

Research has revealed the more you try to force happiness the more you push it away.7 Prioritizing positivity is worthwhile; however, an overzealous or obsessive pursuit of reaching an optimal emotional state can make happiness harder to reach.8 Those devoting their lives to what matters, as opposed to those on the unrealistic quest to be happy all of the time, have a greater chance of feeling joy and appreciating life events, the good and the bad.

Another angle to consider as we think about the quest of a happy life is what we are living for, a life that is satisfying vs. experiences that are satisfying. Understanding the difference between eudaimonic vs. hedonic happiness might help. Eudaimonic happiness is feeling your life has meaning and purpose, and your experiences allow you to learn, grow, and reach your full potential. Hedonic happiness is pleasure or feeling good in the moment, reaching a goal, and feeling temporarily satisfied.9
In Every Issue

**NOT A FREUDIAN SLIP: THE HAPPINESS TREND - A HEALTHY PURSUIT OR AN OBSESSIVE QUEST? - PART 2**

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**Image 2: Eudaimonic v/s Hedonic Happiness = Fulfilling life versus Happy Moments**

Part 1 uncovered that much of our happiness is permanently fixed by factors out of our control. And research by Lebowitz and colleagues reveals that even after a delightful experience that elevates our happiness, we inevitably go back to our baseline level of happiness. The happiness boost we experience with the purchase of a new car or the excitement over a recent raise is temporary. No matter how amazing the positive event is that produces the gain in happiness, we quickly get used to it and go back to our baseline. This concept, hedonic adaptation, states that any delight we gain during incremental happy moments subsides as we adapt to life’s ups and downs. So perhaps we might be better served by positively pursuing our purpose and strive to live a fulfilling life, experiencing the up and down emotions along the way vs. savoring isolated events that make a temporary impact.
Can you increase your happiness with money/can you buy happiness?

Research has revealed time and time again that the relationship between money and happiness is limited. Since the 1950s people’s happiness levels have been remarkably constant, despite increases in income. In fact, the wealth in the United States has doubled between 1957 and 1995, but the happiness levels haven’t changed. Further research shows the wealthiest people in the U.S. were less happy.

There is extensive research documenting that money matters up to a threshold; however, once the annual income of about $75,000 is reached, happiness plateaus and earning an even greater salary doesn’t impact our life satisfaction as much as we might think. Certainly lifting a person out of poverty, where they have the ability to live a comfortable life with basic needs like a home, food, proper education, and healthcare met, reduces or eliminates possible nutritional deficiencies in addition to the stress of wondering where your next meal may come from. But happiness doesn’t go up by just attaining more money.
Think about how people rearrange their lives in the pursuit of a larger salary. They uproot themselves from their comfortable, supportive community, endure long commutes, long working hours, and long distance relationships, even though research has shown these all actually deteriorate your happiness and health.\textsuperscript{16}

Many have recognized wealth doesn’t guarantee more happiness, the accumulation of things doesn’t make you happier, and retail therapy isn’t a positive psychological intervention. The instant gratification of a purchase might bring immediate satisfaction, yet after the pleasure subsides you are left feeling unfulfilled or stressed about the purchase. Similarly, a recent study compared people who spent their money on stuff versus people who spent money on experiences and found that people who put their money towards experiencing moments in life over materialism felt more happiness.\textsuperscript{17}

A few corporations are starting to acknowledge that compensation is one of the lower ranking factors that contribute to employees’ satisfaction and happiness at work.\textsuperscript{18} Recognition, collaborative team experiences, a positive work environment, and time off to enjoy holistic life experiences have greater importance for most and are now becoming the norm for comprehensive career packages.

So you see, we aren’t doomed to fail at the pursuit of happiness, as long as the pursuit is in moderation, in the right context, and with the acceptance that positive and negative emotions and situations are part of life. The question we should be asking is “Are we chasing the wrong thing and can the one-size-fits-all happiness improvement tricks popular in our culture now provide the answer?”

Before discovering our own path to fulfillment, we will explore how our digitally connected world impacts our happiness and well-being. And in the last article in the series we will uncover skills and traits we can strengthen to achieve a happier state of mind. Finally, we will consider the shift from happiness to fulfillment to enhance our quality of life, as simply feeling good is not enough, people need meaning to thrive.

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References


NOT A FREUDIAN SLIP: THE HAPPINESS TREND - A HEALTHY PURSUIT OR AN OBSESSIVE QUEST? - PART 2 continued


17. Lowery G (March 31, 2010) Glee from buying objects wanes, while joy of buying experiences keeps growing http://news.cornell.edu/stories/2010/03/study-shows-experiences-are-better-possessions

The opioid crisis has grabbed headlines due to its horrific effects on the lives of addicts and their families, friends, and communities. Less well-understood is the impact of the crisis on employers, yet they will have to be part of the solution including through increased drug testing.

Opioids are defined as a class of drug typically used for pain relief, are sometimes called narcotics, and include common prescription painkillers used by 95 million Americans in the last year, such as oxycodone (Oxycontin), hydrocodone (Vicodin), and morphine. Other opioids include heroin, which was made illegal in 1924, less than thirty years after it was initially produced for commercial sale, as well as the synthetic opioid pain reliever Fentanyl, which is 50 to 100 times more potent than morphine. Over two million Americans are estimated to be dependent on these highly addictive drugs.

The opioid epidemic is considered to be one of the deadliest in U.S. history. Since 1999 the number of deaths from prescription opioids and heroin has more than quadrupled. The estimates for opioid overdose deaths in 2016 alone range between 59,000 – 65,000, up about 19 per cent from 2015. Drug overdoses are now the leading cause of death among Americans under 50 years old, and as the death tolls continue to climb, federal and state policy makers are struggling to come up with an effective response to stem the tide of this epidemic.

Various initiatives have been introduced to combat the crisis by different levels of government. Some state lawmakers are considering legislation that would impose a tax on prescription opioids. Other states have brought lawsuits against different manufacturers of prescription opioids. Forty-nine states and the District of Columbia have already enacted legislation authorizing prescription drug monitoring programs (PDMPs). States have also enacted legislation or promulgated regulations that aim to limit the duration or supply of opioids that physicians may prescribe for treating acute pain. A number of federal initiatives have also been introduced, although there is still no consensus at the national level on workable solutions or funding.

While it is still too early to determine whether these initiatives will be successful, one thing is certain: employers will be footing part of the bill. Currently companies spend, on average, about eight to ten percent of their annual operating budget on providing health benefits and health insurance coverage to employees. Employing individuals who use opioids recreationally or suffer from addiction is twice as costly as employing non-users, as the annual amount paid by employers jumps from around $10,000 in healthcare expenses per employee to more than $19,000 in annual healthcare expenses for employees using opiates. Some businesses also incur additional costs outside of the standard health benefits packages offered to their workers because opioids account for a quarter of workers’ compensation prescription drug costs. Employees who are prescribed opioids for injuries incurred at work are also more likely to develop dependency issues or other side effects, and those who take opioids for a prolonged period of time may not return to work at all. The financial burden on employers is further compounded by decreased worker productivity, increased absenteeism, and higher turnover. Workers dependent on opioids are also much less likely to maintain a steady job, as some studies indicate drug users are more likely than the general population to have had three or more jobs in the last year. And while many employees struggling with addiction or opioid dependence may be dependable workers, their drug use may negatively impact their peers in the workplace.
AFFIDAVIT: HEALTHCARE AND THE LAW - THE EFFECT OF THE OPIOID CRISIS ON BUSINESS/ THE BENEFITS AND LEGAL RISKS OF INCREASED DRUG TESTING

With so much at risk, businesses and employers across the country are looking for ways to immunize their businesses from the crippling effects of this epidemic, but maintaining a drug-free work environment and providing support for employees who may be at risk is no small feat. Drug testing is one part of the solution. While required drug-testing might discourage opioid use, many companies abstain from administering drug tests, because they are reluctant to expose themselves to potential invasion of privacy claims. Even those who do test for drugs amongst employees and applicants commonly fall short of actually identifying an existing problem or an at-risk employee because most periodic drug tests administered in the workplace do not currently test for prescription opioids. And of course drug testing can be very costly.

Until recently, the norm among private companies and federal agencies that administer drug tests has been to issue a standard five-panel drug test, which tests for commonly used substances such as marijuana, cocaine, amphetamines, phencyclidine, and certain opiates such as morphine and heroin. Finally, recognizing that these conventional drug tests fail to test for the prescription painkillers at the heart of the opioid crisis, the Department of Health and Human Services recently revised the Mandatory Guidelines for Federal Workplace Drug Testing Programs for urine testing which, effective October 2017, will require federal agencies to test for prescription opioids such as oxycodone and hydrocodone. Private employers who are not doing so already are likely to follow suit.

The benefits of drug testing must be evaluated against the legal risks and issues. Businesses should be aware of applicable legal standards before implementing mandatory drug-testing programs to avoid liability, especially since employees with a history of drug addiction or alcoholism are protected from discrimination in the workplace under the Americans with Disabilities Act (ADA). Testing for prescription opioids may also prove problematic because a private employer cannot implement policies that would restrict its employees’ access to appropriate medical care and legal prescription drug use. Working through solutions to the opioid crisis, including through increased drug testing, is not simple, but, for the nation as a whole, the costs of doing nothing may be worse.

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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.
In Part 1 of this two-part series, we explore the executive succession planning (or lack thereof) landscape and the opportunities for leadership development it can represent if undertaken strategically and effectively.

The hospital had waited too long. Barbara (not her real name) had been the CEO for many years, but when she announced her retirement plans, there was no one waiting in the wings to take her place, no one who had been groomed for just this moment.

It was a daunting task to replace her, and not simply because she was well-liked and respected in the facility and the community. The recent years had been rough, and the red ink was growing by the year. It would take some upheaval, and a leader from outside, to begin to turn the ship.

Barbara’s story is a common scenario that, unfortunately, is replayed every year in provider and payer organizations across the U.S. In a recent survey by the National Association of Corporate Directors, 55 percent of organizations admitted their succession plans were informal, and 6 percent had none at all.

Yet if “succession planning” has been ineffective and ignored in recent years, the fault may be in the deployment. For executive succession to work, it must be integrated seamlessly with a long-term commitment to leadership development throughout the organization.

These organizational needs have greater urgency than is always acknowledged. When talent leaves the organization, a gap is created. Departures of key executives create shortfalls in achieving business objectives. In today’s economic climate, that can increase pressures on a healthcare organization exponentially. In addition, the seismic changes created by mergers, acquisitions, and layoffs produce cultural and communication gaps that must be solved by the organization.

Leadership development provides continuity to an organization and accomplishes several key objectives:

- It acclimates and trains young leaders.
- It offers opportunities that help retain executives.
- It reinforces the organizational culture.
- It provides a process that identifies, and rules out, potential successors.
- It ensures attention to diversity remains front and center.

The chief executive officer and the board must drive this process. Indeed, progress in the areas of executive succession and leadership development should be part of the CEO’s performance evaluation. And the board should include trustees who are experienced in guiding the succession process or who have gone through the process themselves as a CEO in their own companies.
Up to 40 percent of the workforce is expected to retire by 2020. That reason alone should spur initiatives to ensure the leadership pipeline is designed and flowing. But surveys show the pace of change is accelerating, beyond the abilities of executives and organizations to keep up. For that reason, some say knowledge and experience will become less important as predictors of executive success than personal traits.

Leadership development and succession planning can reveal which executives are best equipped to lead your health system or insurer through uncertain times in a rapidly changing industry. In addition, many organizations are ill-equipped to deal with a senior executive’s sudden departure due to resignation or illness.

A formalized program creates benchmarks for development and success. It can also eliminate silos and create opportunities for cross-training teams of leaders to tackle nagging organizational issues that may have fallen through the cracks due to the leadership team’s time constraints.

A final reason for the necessity of executive succession and leadership development is retention. These key components of integrated talent management provide senior management a clear understanding of the competencies and expectations of the CEO role as internal candidates in the pipeline. They also provide younger leaders with opportunities and seasoning. And they ensure that leadership in your organization is multi-generational.

In Part 2, we will review key competencies needed to position oneself for selection for the succession planning queue and to optimize your ability to thrive if chosen to lead.

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Let’s settle this debate. If you were asked to select the most important muscle in your body, what comes to mind? The answer might depend on whether you are posing on your beach towel, firing away on the golf range, or tossing that kettlebell around. The ‘core’ would get some votes. Certainly your primary movers like the quads or the lats for the cross-country skier might receive some support. But the muscle I would choose is rarely seen yet, can produce the most profound outcomes. The work it does might be compared to the ant dragging the French fry. It was the organ (hint) that got much of the attention at the Harvard Fatigue Lab back in the early 1900s. It is also, ironically enough, one of the most neglected in the industrialized nations of the world. The answer is cardiac muscle, specifically the left ventricle. It has arguably more to say in your short-term and long-term health than any other muscle in your body.

Pumping blood seems easy enough, especially given that we only move with any conviction for ~5% of the 1440 minutes in our day. And while we are at rest our systolic blood pressure barely pushes back at 110 mmHg. Yet, when we loosen the reins, so to speak, on the tennis court, power walking up a hill, or getting down to Earth, Wind and Fire, the dynamics of delivering blood change considerably. One way to relate it would be to ask you to fill up those long thin balloons for the upcoming party. My mother would try and stretch them out to loosen them up first so they were more compliant. That is the role of nitric oxide, your arteries relaxing and growing larger (vasodilation) at the start of exercise. The effort you must give to blow up a balloon is the type of effort your left ventricle has to give 120 to 180 times a minute for as long as you are participating in your activity. It has to push hundreds of thousands of red blood cells full of oxygen down through arteries, arterioles, and then capillaries, single cell-wide capillaries, into the calf, the quad, the glute, and the hamstring as you finish your interval, turn the corner for home or crank out high watts on the rower. With arterial pressures continuing to mount and skeletal muscle calling for more oxygen with each contraction, the demands on the heart rise. The good news is you have just the tool for the job, the left ventricle.

The left ventricle contains approximately 3x the mass of the right ventricle. Measuring the stroke volume (volume of blood pumped from the left ventricle per beat) of the left ventricle can be difficult, but a VO2 max (the measurement of the maximum amount of oxygen that an individual can utilize during intense or maximal exertion) test lends some great insight regarding heart function. It is the cardiovascular system that has the overall vote on an individual’s VO2 max in most cases. First of all, the peak absolute VO2 max (ml/min) is measured. Then, if that number is divided by the highest heart rate achieved you have a value called oxygen pulse or the amount of oxygen used per beat of the heart. Oxygen pulse is associated with stroke volume or the proficiency of the left ventricle. For females a score > 9 ml O2/beat is predicted and for males a score >16 ml O2/beat. A recent test we completed for a 40 year old male showed a VO2 max of 2400 ml/min which was divided by a max heart rate of 170 bpm for an oxygen pulse of 14.1 ml O2/beat (below expected). This score does not meet the normal values for males, so some further investigation is necessary.
One other example is of a 57 year old female with a history of running, but for the past few years she has been irregular with her aerobic training and gained 30 lbs. Measuring VO2 in this case also helps with answering the question if her fitness level is independent of the weight she has gained. She peaked at 1780 ml O2 with a peak heart rate of 163 bpm.

\[
\frac{1780 \text{ ml } O_2 (\text{Fair})}{163 \text{ bpm}} = 10.9 \text{ ml } O_2/\text{beat (above predicted)}
\]

Once in a job interview I was asked if I knew anything about a new style of exercise that was very trendy and ‘hot.’ It turns out I knew very little about it, and I still don’t. Although not revolutionary, ‘cardio’ training is unmistakably one of the most productive mechanisms to enhance yourself physically. For most of us, skeletal muscle can clean up the mess of a 2 year sabbatical or 2 weeks on a cruise, but it can’t do it alone. You need to be able to deliver the life blood (I believe that phrase is most appropriate in this context) of oxygen and clean up all the waste product of normal fat and sugar metabolism, which is where your left ventricle comes in. Although it is not February, I treat every month like heart month and continue to promote activities that lead to improvements in the cardiovascular system. So, how about lacing up the sneakers and getting after it?

Good Hustle!

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References


Digital Health funding crossed $8B in 2016, according to a report by Startup Health. Almost 160 patient/consumer experience-focused companies received funding in 2016 – between 2-3X as many as other subsectors. Most of the companies in this space are targeted to the healthier, wealthier, and more literate segments of the population. It makes sense from a purely economic perspective – target the easier-to-engage segments that have a higher propensity to pay.

But, what about from the public health perspective – will these investments in digital health help bend the cost curve and improve health outcomes for the population as a whole? I doubt it. Twenty-five percent of the U.S. population lives in rural areas where the socioeconomic conditions of the population create a huge demand for healthcare, and, at the same time, a unique challenge for delivery of healthcare.

What is different about rural health?
Rural hospitals provide essential healthcare services to nearly 51 million people or about 25% of the U.S. population.

Compared with urban populations, rural residents generally have higher poverty rates, a larger elderly population, tend to be in poorer health, and have higher uninsured rates than urban areas. At the same time, rural areas often have fewer physician practices, hospitals, and other health delivery resources. These socioeconomic and healthcare challenges place rural populations at a disadvantage for receiving safe, timely, effective, equitable, and patient-centered care. Statistics show the prevalence of multiple chronic conditions (MCC) is higher among the rural population. Here are some statistics from the National Rural Health Association:

<table>
<thead>
<tr>
<th>A National Rural Health Snapshot</th>
<th>Rural</th>
<th>Urban</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of U.S. Population**</td>
<td>nearly 25%</td>
<td>75% +</td>
</tr>
<tr>
<td>Percentage of U.S. Physicians**</td>
<td>10%</td>
<td>90%</td>
</tr>
<tr>
<td>No of Specialists per 100,000 Population**</td>
<td>40.1</td>
<td>134.1</td>
</tr>
<tr>
<td>Population Aged 65 and Older</td>
<td>18%</td>
<td>15%</td>
</tr>
<tr>
<td>Population Below the Poverty Level</td>
<td>14%</td>
<td>11%</td>
</tr>
<tr>
<td>Average per Capita Income</td>
<td>$19K</td>
<td>$26K</td>
</tr>
<tr>
<td>Population Who Are Non-Hispanic Whites</td>
<td>83%</td>
<td>69%</td>
</tr>
<tr>
<td>Adults Who Describe Health Status as Fair/Poor</td>
<td>28%</td>
<td>21%</td>
</tr>
<tr>
<td>Adolescents (aged 12-17) Who Smoke</td>
<td>19%</td>
<td>11%</td>
</tr>
<tr>
<td>Male Death rate per 100,000 [ages 1-24]</td>
<td>80</td>
<td>60</td>
</tr>
<tr>
<td>Female Death rate per 100,000 [ages 1-24]</td>
<td>40</td>
<td>30</td>
</tr>
<tr>
<td>Population Covered by Private Insurance</td>
<td>54%</td>
<td>69%</td>
</tr>
<tr>
<td>Population Who are Medicare Beneficiaries</td>
<td>23%</td>
<td>20%</td>
</tr>
<tr>
<td>Medicare Beneficiaries Without Drug Coverage</td>
<td>45%</td>
<td>31%</td>
</tr>
<tr>
<td>Medicare Spend per Capita Compared to U.S. Average</td>
<td>85%</td>
<td>106%</td>
</tr>
<tr>
<td>Medicare Hospital Payment-to-Cost Ratio</td>
<td>90%</td>
<td>100%</td>
</tr>
<tr>
<td>Percentage of Poor Covered by Medicaid</td>
<td>45%</td>
<td>49%</td>
</tr>
</tbody>
</table>

Contributor:
Sandeep Puri, WG’99
To learn more about Sandeep, **click here.**
DIGITAL HEALTH FOR RURAL HEALTHCARE

• **Economic** - On average, per capita income is $7,417 lower than in urban areas, and rural Americans are more likely to live below the poverty level. The disparity in incomes is even greater for minorities living in rural areas. Nearly 24% of rural children live in poverty.

• **Access** - Only about 10% of physicians practice in rural America, despite the fact that nearly 25% of the population lives in these areas. Rural residents are less likely to have employer-provided healthcare coverage. Rural residents have greater transportation difficulties reaching healthcare providers, often travelling great distances to reach a doctor or hospital.

• **Literacy** - Rural residents are at risk for low health literacy because they have lower educational levels as compared to residents of metropolitan areas. Low health literacy is a particular problem for people in poverty and people with limited education or English proficiency. Low health literacy is associated with a lower likelihood of using preventive health services, a greater likelihood of taking medicines incorrectly, and poor health status.

• **Social** - Abuse of alcohol and use of smokeless tobacco are significant problems among rural youth. The suicide rate is significantly higher than in urban areas, particularly among adult men and children. In rural areas there is little anonymity, and social stigma and privacy concerns are more likely to act as barriers to healthcare access. Residents may be concerned about seeking care for issues related to mental health, substance abuse, sexual health, pregnancy, or even common chronic illnesses due to unease or privacy concerns.

• **Ethnicity** – Several migratory and seasonal agricultural workers (MSAWs) establish a temporary home in rural areas for the purpose of employment. These worker groups are predominantly Hispanic/Latino, and they and their families face unique health challenges due to their hazardous work environment, poverty, inadequate healthcare access, and cultural and language barriers.

These factors conspire to impede the rural population in their struggle to lead a normal, healthy life.

Rural healthcare organizations disproportionately rely on government payments (Medicare and Medicaid) because of their characteristics – lower income, elderly population. Several government and private organizations are working to improve healthcare access for rural communities. Some of these include the National Rural Health Association (NRHA), National Association of Rural Health Clinics (NARHC), and the Federal Office of Rural Health Policy (FORHP).

**How can digital health help rural health?**

Despite the factors mentioned above that impede the rural population in their struggle to lead a healthy life, there is hope the emerging digital health solutions will overcome these impediments.

Several digital health solutions are available today that providers could use to more effectively engage patients for a range of purposes: chronic disease management, preventive care, and wellness. These solutions vary based on what they deliver (information, reminders, medical advice, social services), how they deliver (with/without devices; with/without live human interaction), and through what mode of communication (text, email, phone, kiosks, video) they deliver.

However, it seems very few solutions reflect a true understanding of the unique challenges for delivery of healthcare in a rural setting – specifically, the poverty, low health literacy, access, and social issues. Most solutions are not low-cost, low-tech, or customized to address the unique socioeconomic characteristics of the rural population. Here are a few statistics:

• **Broadband Penetration**: According to data published by the FCC earlier this year, 39 percent of Americans living in rural areas still lack access to decent broadband service, compared to only 4% of the urban population. Video-based telehealth solutions are not practical in this environment.

• **Smartphone Ownership**: A study by the Pew Research Center conducted in 2015 shows
DIGITAL HEALTH FOR RURAL HEALTHCARE

that even though smartphone ownership has increased to about 68% of U.S. adults, there are substantial differences based on age (86% for 18-29 vs. 30% for 65+), household income (87% for $75K+ vs. 52% for <$30K), education level (81% for college+ vs. 41% for less than high school), and community type (72% urban vs. 52% rural).

A solution that relies on only smartphones, for example a solution based on communicating via emails and apps, will not be effective when 48% of the target population cannot be reached.

• **Cellphone Ownership**: The Pew Research also showed that cellphone ownership is common across all major demographic groups, though older adults tend to lag behind their younger counterparts. Cellphones enable text-based communication, and are therefore ideal for overcoming the digital divide and engaging all demographic segments of the population. Rural residents are slightly less likely than urban and suburban residents to have cellphones. Still, nearly nine-in-ten rural residents (87%) have them, making text a very practical mode for engaging the rural population.

• **Latino/Hispanic Population**: Rural healthcare organizations need to be able to help migrant farmworkers, who are primarily Latino/Hispanic, access healthcare. Most of this population does not have access to Broadband nor do they own smartphones. In addition, most can only be engaged through culturally or linguistically appropriate solutions.

What is needed?

Statistics reveal the digital divide is a real issue for the delivery of digital health solutions to the rural population – **39% of the rural population does not have broadband access; 48% do not own smartphones**. In addition, a large percentage of this population has cultural and linguistic barriers to engagement. Digital health solutions targeted to the rural population need to take these issues in consideration in their design.

The ideal digital health solution for rural healthcare should **work with cellphones** (text messaging) in addition to the other modes of communication. Statistics indicate 90% of text messages are read within 90 seconds of receiving them - this makes text messaging ideal for not just reaching patients with the right message, but making sure the message is actually read and more likely at the correct time. In addition, the ideal solution should be **multilingual** to be able to adapt to the cultural and linguistic attributes of the rural population. Finally, the ideal solution should be **cost-effective**. These requirements make a text-messaging based, multilingual communication platform ideal for delivery of digital health solutions to the rural population.

Providers can use text messaging to serve the rural population in several ways - appointment reminders, marketing new programs, care coordination, patient satisfaction, treatment plan check-in, and self-management support. In 2015, Montefiore Medical Center conducted a trial to see if text messaging could increase medication adherence among high-cost Medicaid patients. The
Featured Articles

DIGITAL HEALTH FOR RURAL HEALTHCARE continued

A study found text messaging increased patient appointment adherence by 40% and patient medication adherence by 12%. In addition, the study showed that text messaging can also increase motivation, inspire confidence, and raise awareness in patients by making proactive health measures easy to undertake. Numerous other studies have shown that text messaging for healthcare is not only effective, but also cost-efficient, especially for engaging the demographic segments that define rural America.

The adoption of cellphones among rural providers has increased in recent years, according to a recent survey by the Center for Care Innovations. However, only one-quarter of the participants in the survey reported using cell phones in care delivery, and most reported using it for appointment reminders only. The study concluded that many community health centers and clinics do not have the necessary resources and skills to adopt mobile health primarily due to funding constraints and lack of reimbursement to support mobile health.

What else is needed?
Besides digital health solutions that can overcome the digital divide, rural healthcare organizations need financial assistance in the form of value-based reimbursement models and other funding.

Value-Based Reimbursement Models
Understandably, VC funding is not necessarily driven by the noble goal of improving population health. However, as noted in a previous article, CMS can align incentives for providers (and by extension for investors) by accelerating the shift to value-based, outcomes-based reimbursement and thereby altering the providers’ focus from fixing what’s broken to optimizing wellness. In January 2015, The U.S. Department of Health and Human Services (HHS) set a goal of tying 30 percent of traditional, or fee-for-service, Medicare payments to quality or value through alternative payment models by the end of 2016, and tying 50 percent of payments to these models by the end of 2018. In March 2016, HHS announced the 30% goal had been achieved, well ahead of the goal.

Funding
Rural hospitals face factors, such as diseconomies of scale, which could hinder financial performance in comparison to urban and larger hospitals. For these reasons, Federal law makers created special payment classifications under the Medicare program, recognizing that many rural hospitals are the only health facility in their community, and their survival is vital to ensure access to healthcare. One of these classifications was created under the Medicare Rural Hospital Flexibility Program: Critical Access Hospital (CAH). Unlike traditional hospitals that are paid under PPS (prospective payment system), Medicare pays CAHs based on each hospital’s reported costs. Financial performance improved after hospitals converted to CAH status, accompanied by a commensurate decrease in the closure rate of small rural hospitals.

However, a series of congressionally mandated Medicare cuts that have happened over the past few years have led to closure of several rural healthcare facilities – which has further exacerbated the negative impact on access to care in the community. Rural health experts believe rural hospital closures are likely to continue because many rural hospitals have such a tight operating budget with
DIGITAL HEALTH FOR RURAL HEALTHCARE

little room for financial losses. Until the time rural hospitals transition to a more efficient model of healthcare delivery – one that relies more on digital health for population health management – federal grants should be made available to them to avoid closures. One such stop-gap legislation now in Congress is called the “Save Rural Hospitals” Act, which aims to stabilize the current environment while establishing a path forward.

Besides government funding, non-profit foundations like the Robert Wood Johnson Foundation and The Commonwealth Fund have funded research and pilots for expanding healthcare access and improving quality of care in rural communities.

I hope rural healthcare organizations are able to survive and thrive by using effective digital health solutions to address the unique challenges of delivery of healthcare to their patients. Effective population health is not possible without addressing 25% of the population.

As the co-founder of a digital health startup called Patientriciti which provides multi-modal, multi-lingual, patient engagement, virtual care management, and a care coordination platform which enables healthcare stakeholders to engage with different segments of the population in a personalized way to affect sustained behavior change, I invite rural healthcare organizations and funding agencies interested in using our platform to reach me at sandeep.puri@patientriciti.com.

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<table>
<thead>
<tr>
<th>Cellphone Ownership Is Common Across All Major Demographic Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of U.S. adults who own a cellphone</td>
</tr>
<tr>
<td>U.S. adults</td>
</tr>
<tr>
<td>Sex</td>
</tr>
<tr>
<td>Men</td>
</tr>
<tr>
<td>Women</td>
</tr>
<tr>
<td>Race/ethnicity</td>
</tr>
<tr>
<td>White</td>
</tr>
<tr>
<td>Black</td>
</tr>
<tr>
<td>Hispanic</td>
</tr>
<tr>
<td>Age group</td>
</tr>
<tr>
<td>18-29</td>
</tr>
<tr>
<td>30-49</td>
</tr>
<tr>
<td>50-64</td>
</tr>
<tr>
<td>66+</td>
</tr>
<tr>
<td>Household income</td>
</tr>
<tr>
<td>&lt;$30K</td>
</tr>
<tr>
<td>$30K-$49,999</td>
</tr>
<tr>
<td>$50K-$74,999</td>
</tr>
<tr>
<td>$75K+</td>
</tr>
<tr>
<td>Educational attainment</td>
</tr>
<tr>
<td>Less than high school</td>
</tr>
<tr>
<td>High school</td>
</tr>
<tr>
<td>Some college</td>
</tr>
<tr>
<td>College+</td>
</tr>
<tr>
<td>Community type</td>
</tr>
<tr>
<td>Urban</td>
</tr>
<tr>
<td>Suburban</td>
</tr>
<tr>
<td>Rural</td>
</tr>
</tbody>
</table>

Source: Pew Research Center survey conducted March 17-April 12, 2015. Whites and blacks include only non-Hispanics. N=1,007

PEW RESEARCH CENTER
FROM THE HALLS OF ACADEMIA: THE STATE OF SOCIAL RESPONSIBILITY IN CORPORATE AMERICA

When those in healthcare gather to socialize, talk may begin with some light banter about shows to stream on Netflix and best new books to read. But when weightier matters are raised, the subject of corporate America often comes up. The healthcare community has long been aware of the negative externalities (i.e., consequences) of corporate behavior – environmental toxins, workplace stress, teen anorexia, to name a few. And clearly corporate money is having a powerful impact on our political system. But vilifying all corporations is simplistic and divisive. Corporations exhibit a vast range of behaviors reflecting the values of those running them. This essay discusses how to discern the better ones in terms of their impact on a number of aspects of public health.

First, the Socially Responsible Investing movement is gaining traction in much of the world, with the U.S. lagging behind. In order for these investment firms to decide which companies to include in (or exclude from) their socially responsible funds, they look to various sources to understand which companies are making the most progress toward being sustainable along multiple criteria. Companies such as MSCI and Sustainalytics have emerged that analyze corporate sustainability behavior and produce databases of reports they then sell to firms focused on socially responsible investment. Most university libraries subscribe to at least one of these databases. (For those of you who have access, you can use the ESG Manager database, among others, to enter the name of a corporation to pull a report that details and summarizes the strengths and weaknesses of that firm’s sustainability efforts, relative to its peers.)

Each corporation is rated similarly to investment bonds, ranging from a high of AAA, down to C, and its historical trajectory is included. For example, Johnson and Johnson was rated BBB in 2016, up from B three years previously. Reports describe general sustainability risks, opportunities, and recent controversies, and ratings are broken down into multiple environmental, social, and governance categories. It only takes a few minutes to get a general idea of the efforts a corporation is making to improve. A more thorough read provides insights on specific aspects of product safety, labor force treatment, emissions and wastes, and a myriad of other aspects of corporate behavior.

Are these ratings infallible? No. But they are backed by deep analysis. Much academic research utilizes these ratings to understand the drivers and impacts of various aspects of sustainability. For example, scholars at Harvard Business School (Eccles et. al., 2014) have used them to show that corporations with low sustainability ratings often have a higher cost of capital – that is, they have to spend more to borrow money for expansion.

One of the main sources these sustainability analysis companies use to compile their reports is the data collected by the Global Reporting Initiative (GRI) at GlobalReporting.org. The Global Reporting Initiative is a non-profit organization that in 1992 began providing an extensive reporting template and methodology for firms to use to report their sustainability behavior. There are others, but the GRI has become the dominant standard, with about 82% of large companies reporting to it. Its database is searchable and freely available to the public.¹

The GRI is comprised of 58 general disclosure items - eight economic measures, 33 environmental metrics, 15 labor items, 11 human rights measures, 10 on society, and 5 on product responsibility. It is currently working on identifying the most impactful sustainability issues for each industry, such that corporations cannot omit indicators that are material for their featured articles.
FROM THE HALLS OF ACADEMIA: THE STATE OF SOCIAL RESPONSIBILITY IN CORPORA TE AMERICA  

particular industry. The more metrics a company reports on, the higher a “grade” it receives from the GRI, and there are minimum reporting requirements for each category of metric. Notably, the score awarded by the GRI is for transparency not sustainability; the scoring of the latter is left to the sustainability analysis companies such as MSCI and Sustainalytics. In this way companies that are behind in their sustainability efforts can still get a reasonable score from the GRI, as long as they are making forward progress, and so are not discouraged from initiating a sustainability reporting program.

In recent years, the GRI has iteratively revised its metrics and reporting template, with an eye to reducing opportunities to “game” it. For example, metrics are highly specific, and quantitative metrics are weighted more heavily than qualitative ones. While firms do self-report these metrics, those that are externally audited (currently 56%) are scored higher by the GRI than those that are not.

Also called Corporate Social Responsibility reporting, sustainability reporting has become the cost of doing business: Coca Cola and Pepsi file reports with the GRI, as do Biogen, Amgen, Actelion, Boston Scientific, Eli Lilly, Colgate-Palmolive, CVS Health, Novartis, Merck, Pfizer, Novo Nordisk and Sanofi. Others include UPS and Fedex, Boeing and Lockheed Martin, AT&T and Verizon, Walmart and Target, and Microsoft and IBM. All major industries are represented in the public GRI database of CSR reports: ExxonMobil files GRI reports, as do Dow, Kellogg, McDonalds, Citibank, and General Motors, and thousands of others, drawing their competitors and suppliers along with them. These reports are very laborious and expensive to compile, requiring aggregation of data from across these very large companies. Once a corporation has invested in the processes needed to produce these reports, it is relatively easy to keep submitting updated reports annually or bi-annually. The software firms use to produce their GRI reports come with templates for other reporting standards as well, such as the Sustainability Accounting Standards Board (SASB). Thus, once the necessary underlying data has been collected and aggregated, it is relatively straightforward to release it to multiple standards organizations.

Note the glossy, marketing-oriented sustainability reports that corporations make available on their own websites may or may not include their GRI metrics, and the standardized metrics they submit to the GRI may or may not include the reports they post on their own websites. The best include both types of reports, posted in both places, and also at other standards organizations.

There is now an umbrella organization that monitors all the various sustainability ratings standards, called the Global Initiative for Sustainability Ratings,2 which is an excellent resource for understanding current and diverse approaches to sustainability ratings. Finally, there is a broad movement under foot to have corporations report standardized sustainability metrics along with the financial documents they are currently required to file with the Securities and Exchange Commission. This movement is called the integrated reporting movement, and is being overseen by International Integrated Reporting Council (IIRC).

So, next time you’re among friends at a social gathering and the subject of corporate America comes up, take some bets and then look up some ratings: Is Sanofi more sustainable than Pfizer? More transparent? What about Biogen versus Boston Scientific? The results may surprise you. And don’t forget that corporations are designed to respond to the needs of the marketplace.

Contact Stephanie at: swatts@bu.edu

References


OPTING BACK IN - RETURN TO WORK OBSERVATIONS

It was October 26, 2003, when Lisa Belkin put words to a growing societal trend describing “The Opt-Out Revolution” (New York Times magazine). The women she was referencing were in their late 20s and 30s, armed with impressive undergraduate and graduate educations, and fully engaged in promising careers while competing handily alongside men. Thanks to the hardworking feminists before them, many of the barriers to achievement were largely removed and, as Belkin noted, “these polished and purposeful women” were well-equipped to run the world. Yet, after ten or fifteen years of hard-charging careers, new trends surfaced as many of these high-achieving women with great potential were suddenly re-evaluating goals, placing greater value on their role with family and a need for balance, and putting careers on hold. As Belkin stated, it was becoming “a revolution stalled.”

Today, many in that group who opted out are re-considering work again. In fact, an April 2017 article published by SHRM (Society for Human Resource Management), quotes the founder of Apres, an online return-to-work service, as stating more than 3 million women are seeking to resume their careers now, a trend that is expected to increase as Millennials return following their own breaks. Data aside, the sheer prevalence of businesses, books, and e-commerce sites dedicated to the topic of helping women back into the workforce indicates there must be a growing need and demand for support.

Given the talent and backgrounds of these women who were successful before and who expected their educations and experience to be safety nets for the future, why is it they are finding the transition to be such a challenge? As one who has experienced the road blocks in my return-to-work efforts, I am seeing the issues up close. Getting back into a meaningful job requires not only explanations about those gap years, it requires adopting new skills, accepting a different model for work environments, embracing a new means of communication in every direction, and accepting that we must demonstrate abilities all over again.

I opted out in 1997 with the arrival of my second child. While acquainting myself with a new city, having moved across the country for my spouse, I was also tackling full-time mom duties, non-profit leadership roles, and all of the elements of life management for a busy family. An important life pause, but not measurable as a skill-rich experience. Finding myself now twenty years down that path of opting out, with children nearly grown and needs that have changed, I am confronting the very real challenges of moving ahead. Securing a meaningful job of any kind - flex-time, part-time, or full-time - that leverages skills and interests, pays enough to cover expenses, and motivates to contribute to the broader efforts of the organization is tough. Those doors don’t open easily, most inquiries go unanswered, and what we knew about the business world then doesn’t reflect the experience today.

Several years ago when my job hunting began, I successfully lined up a meeting with a human resources executive. I had emailed my resume (one-page, total 80’s style), and when he and I met I walked through my experiences, education, skills, and interests. I was a former NYC professional with BA and MBA degrees from competitive schools. I had plenty of leadership roles to point to. And I felt I could bring value to their businesses. Unfortunately, it was a conversation to nowhere. There was a team alongside his office digitally sorting resumes by specialty, and I learned that unless I specifically linked something in my background to a specific job through my words and phrases, the systems would not notice me. Depth of experience was irrelevant. General
OPTING BACK IN - RETURN TO WORK OBSERVATIONS

management and leadership talents were secondary. Gone were the days when someone thoughtfully connected an applicant to the needs of an organization. The hiring world is literal now. My interview with this executive concluded with his recommendation that I apply to Costco where I would see a well-honed process and get a sense of how my skills and interests could lead to a job. It was a conversation that left me at rock bottom.

The challenge of finding work after a long pause is daunting. Even when I have been able to line up conversations, my dated professional skills are not meeting the needs of current environments. Furthermore, no matter my abilities, I can sense negative bias for having been out of the job market so long. I have been fortunate in getting part-time consulting work and, because of that opportunity, formed an LLC. Having my own business has helped to create a sense of place and beginning. In addition, I take on all new assignments as they come, recognizing the mountain of foundational learning I must do to participate in today’s work environment.

In one of my original consulting roles I signed on to do marketing for a start-up. My role included drafting messaging content, tracking current and prospective needs for a multi-state team, and liaising with a professional marketing firm to execute on published deliverables. I was also participating in client relations. In my early months with this company I travelled to a meeting carrying my hard copy presentation. When the group assembled in a sleek Chicago conference room (and I cringe as I write this), I was the only one without a laptop. Everyone had connected their laptops to the larger than life screen in the room for the individualized presentations from each group, allowing for each of the presentations to be passed from computer to computer as the meeting progressed. It was a glaring disconnect for me and a great wake-up call.

Women in my generation achieved early success through focus, discipline, and clarity about the path they were on, one that in the second time around is frustratingly vague and unclear. For me, survival and progress has meant accepting the process, realizing that within each of these roles are seeds of learning, practice, and knowledge. And, most importantly, with the experiences along the way comes renewed self-confidence. As part of my journey I have had to access social media training, learn basic tech skills, read and study the insights of today’s job preparedness trainers, and reach out to friends and contacts regularly. I’ve also taken different self-assessments (not the Costco one) to determine where I fit in. As I enter this new sphere of understanding, it feels natural to share. To that end, I partnered with a Penn Med grad and recently established a local business supporting women in their efforts to prepare for today’s world. He was once a stay-at-home parent and is also sympathetic to the challenges of reinvention.

Belkin’s opt-out revolution seems to be giving way to a new revolution of opting back in. According to a Wall Street Journal article in 2010, studies suggested that 82% of the 2.3 million women with children under 18 were interested in returning to work at some point. Perhaps we’re seeing a glimpse of that now. Not only is small enterprise helping guide former stay-at-home women back into the working world, major employers are getting involved too. Fortunately, opting back in is getting easier. In the meantime, it is with humility, hope, and, above all, good humor, that I dig in and learn new skills, doing what it takes to succeed in this phase of life. While I must apply the same grit I needed with my first career, I enter this next round with the added benefit of wisdom gained by my career hold. It is also worth noting that I now own a laptop.

Contact Beverly at: babphx@gmail.com
HEALTH SYSTEM COLLABORATIVES

Just over a year ago, I embarked on a new journey into the realm of collaborative alliances among not-for-profit integrated healthcare systems. The proliferation and maturation of this type of non-merger partnering organizational framework has led to the formation of SRHO (Strategic Regional Healthcare Organizations), the National Association, earlier this year. My organization, AllSpire Health Partners (AHP), a founding member of SRHO, has five health systems, thirty-six hospitals, ten thousand physicians, seventy-five thousand employees and serves a community of greater than ten million residents.

Like others that sprouted up from 2011 to 2015, AllSpire began as an exploration of how best to adapt and respond to the Affordable Care Act, but quickly expanded in scope to include many traditional aspects of value creation in healthcare. Initial efforts were strictly clinical quality process improvement efforts. With each new successful initiative, confidence in the power of the collaborative and trust in peer members built up to support bigger and bolder endeavors.

As an SRHO, AllSpire is an organization of independent health systems bound together largely by trust, with rules codified in written agreements. The rules are important guidance and are necessary, though not sufficient, to establish trust.

Certain fundamental principles must be observed in the behavior of alliance members to build the kind of trust that enables them to endure. The extent to which these principles are evident in all aspects of these collaborative relationships determines the corporate culture of the enterprise and impacts prospective members, employees, patients, business partners, vendors, regulators and the general public in our communities.

The Mission

“The Mission of AllSpire is to harness and share the accumulated wisdom, talent and resources of our integrated health system members, via knowledge transfer and collaboration, to achieve the highest levels of Clinical Excellence, Patient Affordability, Access and Experience and Economic Sustainability, all for the benefit of the communities we serve.”

These Core Aspects equate to our version of a Triple Aim:

- Clinical Excellence
  - Knowledge Transfer
  - Collaboration
  - Innovation
  - Research

- Patient Affordability, Access and Experience
  - Price Transparency
  - Encouragement of Lower Cost Services and Sites of Care
  - Informed Patient Decisions on Utilization

Contributor:
Paul Tirjan, BA’89, WG’01
To learn more about Paul, click here.
HEALTH SYSTEM COLLABORATIVES  

- Connected Health and Virtual Care
- Economic Sustainability
  - Purchasing
  - Efficiency
  - Investment

Clinical Excellence

Knowledge Transfer at AllSpire is a formal program to share data, information, knowledge, methods, and lessons learned among collaborative peers. These programs and initiatives have both inherent value and enabling value. In its purest form, Knowledge Transfer focuses attention on the most critical decisions, which is inherently valuable in process improvement, education, and standardization. Beyond benchmarking and improved independent decision-making, secure and efficient Knowledge Transfer is the most critically necessary foundational element enabling Collaborative Ventures, Research, and Innovation.

Collaborative Ventures at AllSpire refers to initiatives that are undertaken together by two or more independent health systems and result in the creation of an ongoing entity or contractual arrangement.

Innovation at AllSpire refers to coordinated activities of the innovation resources at each member health system, as well as strategic partners from industry, that advance the Mission, Vision, and Values of AllSpire above the level that any one member could attain on their own.

Research at AllSpire means formal investigative study of conditions, treatments, and operational processes that might offer an opportunity to raise the bar of clinical quality in efficacy and safety and/or lowering cost and raising efficiency.

Patient Affordability, Access and Experience

Healthcare is too expensive to be sustainable in its current form. Too many people simply cannot access the system. Nearly always, that lack of access is the result of financial inadequacy. Those who can access healthcare do not enjoy a uniform customer service experience, much less a uniformly high level of customer service. Again, this variation in experience of care is heavily impacted by cost in many cases. The cost-to-the-patient challenge begins with coverage and premiums, but also includes co-payments, co-insurance, deductibles, indirect costs, and other out-of-pocket expense.

The senior leaders of AllSpire have resolved to take on the root cause of what ails the American health system by explicitly making total-cost Patient Affordability, Access and Experience, for all patient populations, a core aspect of AllSpire. Initiatives enhance transparency in cost, quality, and value. Priority is given to projects that encourage use of lower cost sites of care options, and especially that support better self-care of chronic conditions.

Programs will be expanded, and made simpler, to access primary care. Virtual Care will be implemented whenever clinically appropriate to minimize patient out-of-pocket expense in travel and time off from work for routine care. The progression from EMR to EHR will further expand beyond the formal health system to first track, and later help to organize family and neighborhood caregivers with the goal of improving the social determinants of health. In the longer term, this connected health system will operate as a single coherent whole producing better clinical outcomes and better quality of life for patients. In the near term, greater communication among disparate providers will help reduce waste in the system from duplicate or unnecessary procedures.
Health System Collaboratives

Aspirationally, these initiatives will stand as an example to the nation and establish new standards that may move American healthcare in a more sustainable direction.

Economic Sustainability

AllSpire Health GPO is a major collaborative venture that launched on October 1, 2016 after three years of intensive planning and negotiation. The result is a new company owned by the AllSpire Health Partners member health systems, which is dedicated to improving quality and reducing cost across the full spectrum of supply chain purchasing contracts. This signature collaborative venture has generated more than $30 million in direct cost savings in its very first year of operation, representing a > 5x ROI multiple of aggregate investment since inception in 2013. These results will at least replicate annually, and likely improve.

Our GPO staff are integrated into the independent Value Analysis Teams (VATs) within each AllSpire member health system, as well as into national clinical advisory boards (via HealthTrust). Many activities in Clinical Excellence and Patient Affordability, Access and Experience leverage the Value Analysis Teams who are tied together by Collaborative Coordinators at our AllSpire Health GPO. In turn, the GPO/VAT team leverages the AllSpire Health Partners team in clinical and administrative affairs. Two senior executives, one VP from the AH GPO and one VP from AHP, form a dyad in co-leading the creation of additional Collaborative Ventures that have both a clinical and economic component.

Future efforts will include procurement, development, and investment in disruptive technologies being applied to healthcare, as well as new business models of care delivery.

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Introduction
This article is part of a series about value-based payments and their application in the healthcare landscape. This is the third article in the series.

Ideally, value-based payment (VBP) arrangements are designed to financially reward physicians, hospitals, and health systems for achieving positive health outcomes while simultaneously decreasing or, at minimum, maintaining costs. In this installment of our value-based payment series, we will look at various characteristics of evaluation readiness to move away from traditional fee-for-service (FFS) payments and toward an alternative payment mechanism or some risk-bearing arrangement(s). In Part 2, we outlined several different approaches to risk-based payments, from low risk to high risk. We believe organizational readiness characteristics fall into several domains, including but not limited to these six:

• Clinical Care Model and Provider Culture
• Care Management Programs
• Provider Network Makeup
• Previous Experience with VBP and/or Bearing Financial Risk
• Administrative and Contracting Infrastructure
• Financial Standing and Capital Investment Capacity

In this article, we will outline key considerations within the first three of these broad domains, including readiness indicators and characteristics of “ready” organizations. In our next installment, we will look at considerations for the last three.

Clinical Care Delivery Model and Provider Culture
Central to success in any risk-bearing payment arrangement and/or VBP program is clinical care providers’ ability to appropriately manage healthcare services utilization, potentially resulting in decreasing total cost of care for a defined population. We believe this is most commonly achieved through improving the overall health of the population, including managing chronic diseases and increasing access to (and appropriate use of) primary care services. Very commonly, process and clinical outcome metrics and measures are used to track population health. Positive changes in overall population health should result in favorable financial measures, such as fewer admissions per thousand members and generate lower cost of care. In order to move metrics and measures in positive favorable directions, physician/provider culture and willingness to change care delivery models are paramount.

Physicians/providers are often offered financial incentives (e.g., bonuses) to improve key performance indicators (KPIs), but are not concurrently provided care delivery models to employ to help ensure success. An effective clinical care delivery model is the sum of many parts, including: proven evidence-based care pathways, effective metrics and/or tracking measures, appropriate decision support tools to choose the best clinical journey through the care pathway, willingness to utilize

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external resource support such as care navigation, care management and/or case management, and
lastly, frequent/detailed reports showing individual, group, and/or network performance on the tracked
KPIs. Clinical care models vary in detail and complexity and may be set at any level of the healthcare
enterprise, from as broadly as at the system level, or all the way down to individual provider specialty
and subspecialty levels.

**Indicators of Readiness for Risk-bearing Arrangements:** An integrated physician/provider.enterprise with a current culture of individual accountability, strong respected clinical governance
and leadership, wide-spread cultural willingness to develop and adopt new ways of delivering
clinical care, and hospital/facility (inpatient and ambulatory) leadership willing to disrupt
“traditional” FFS-based referral patterns to promote population health.

**Care Management Programs**
As described above, one component of a progressive clinical care model is a strong care management
program that supplements site-based and/or physician-provided care delivery. Care management has
a complex care model of its own, with distinct resource needs (both human and technology) separate
and apart from the core needs of the practice or facility. That said, when designed and deployed,
an effective care management program plays a critical role in success under VBP and risk-bearing
payment arrangements.

Many patients need significant resources and help with managing their complex chronic diseases
and/or non-clinical/social situations, all of which can adversely impact overall health. These include:
consistent access to nutritious food, stable and supportive relationships, affordable, reliable
transportation and child care services, information and reminders about prescription medication and/
or supplements, advice and guidance on minor/major symptoms and symptom management, to name
a few. While care management programs vary in size and complexity, they should focus on creating
a trusting connection between the care manager and the program enrollee, which encourages the
program enrollee to actually use the program services and be receptive to advice and guidance.

**Indicators of Readiness for Risk-bearing Arrangements:** A care management program with
a focus on providing access to high-quality services across the continuum of care, information
technology care management tools for tracking information about program enrollees, and key
indicators (metrics and/or measures) useful in optimizing and managing program performance and
facilitating appropriate referrals from the physician/provider community.

**Provider Network Makeup**
Provider networks take many sizes and shapes and have different levels of impact on success in
value-based payment arrangements and financial risk. From a health system perspective, the provider
network is where the day-to-day population health management takes place. In order for various
programs involved in managing population health to be successful, the provider network should have
the right mix of providers interdependent in some positive way, such as through clinical integration.
A robust provider network will include a balanced ratio of primary care providers, specialists, and
subspecialists aligned to collectively manage chronic conditions and conduct/order timely and appropriate testing, referrals, therapies, and procedures for the entire population. Location is important: for the population to utilize primary care, having key access points (clinics, practices, retail care, etc.) is critical, as well as ensuring they are more convenient to use than expensive settings (such as emergency departments and urgent care centers).

For certain populations, easy referral to non-clinical services is a critical factor in managing total cost of care. Many non-clinical/social services are rendered by community-based organizations (CBOs) or agencies; understanding what services are offered and service capacity are essential. Ensuring these organizations (and thus their services) are in-network will allow for shared accountability for population health management and outcomes among clinical and non-clinical provider organizations, as well as sharing in financial rewards.

**Indicators of Readiness for Risk-bearing Arrangements:** A broad, comprehensive network of physicians/providers, including behavioral health and specialists/sub-specialists with shared accountability for population health outcomes, integration with non-clinical services offered by nontraditional community-based providers, and easy convenient access to primary care services.

**Conclusion**
These are just some of the key domains to consider when evaluating readiness for entering into value-based payment arrangements and/or bearing financial risk. In our next installment, we will look at other domains, including:

- Previous Experience with VBP and/or Bearing Financial Risk
- Administrative and Contracting Infrastructure
- Financial Standing and Capital Investment Capacity

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PRIMARY CARE AS ROCKET SCIENCE: THE ECONOMICS OF TEAM-BASED CARE

In 1991 a group of authors published an editorial in the *New England Journal of Medicine* with a provocative idea: physicians were being overrun by non-physicians, or, as they called them, “administrators,” and these administrators were not helping the healthcare system very much. To make the point, the authors included a chart that has since become infamous, almost meme-like. The chart contains two curves: one for the relative growth of physicians, and one for that of administrators. Both were plotted from 1970 to 1987, and both were steadily rising. However the administrators curve was growing at a much faster rate, and it sat on top of the smaller curve, that for physicians. The accompanying text said the growing administrative class in medicine was inefficient and unnecessary, especially when compared to other countries. And the title made it clear: “The Deteriorating Administrative Efficiency of the U.S. Healthcare System.” The article provoked many relevant questions, so we should surely give credit where it is due to the original authors. However, in 2017 we live in a different healthcare ecosystem than did the authors of the 1991 editorial. Now healthcare leaders are focused not only on administrative efficiency but also on achieving the triple aim: improving the patient experience of care (including quality and satisfaction), improving the health of populations, and reducing the per capita cost of healthcare. And according to the *Institute for Healthcare Improvement*, the *National Committee for Quality Assurance*, and the

American Medical Association there’s a growing recognition that interdisciplinary, team-based care has a role to play in achieving those ends. So how do we reconcile the old model of “physician versus administrator” to the new model of team-based care?

Our team at *Oak Street Health*, a network of value-based primary care centers and a technology platform delivering care to over 30,000 adults on Medicare and Medicaid, compares this to a similarly complex endeavor: rocket science. We looked at a variety of data sources to recreate a similar analysis for the National Aeronautics and Space Administration (NASA), comparing astronauts to non-astronauts, or rocket science “administrators.” Here’s what we found. In 1959, the first full year of NASA’s existence, there were 7 astronauts and 9,567 non-astronauts. In 1969, the year of the Apollo moon landing, the number of astronauts was 73, however there were then 31,733 non-astronauts employed by NASA, excluding the estimated 180,000 non-astronaut contractors supporting the effort. And today, in a time widely considered not to be among NASA’s best, there are fully 44 active astronauts supported by a fraction of the previous number of administrators: 18,000. In other words,
as NASA’s work exploring the moon wound down, the number of non-astronauts available to support each astronaut declined.

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<th>1959</th>
<th>1969</th>
<th>2017</th>
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<tr>
<td>Astronauts</td>
<td>7</td>
<td>73</td>
<td>44</td>
</tr>
<tr>
<td>Non-Astronauts</td>
<td>9,567</td>
<td>31,733</td>
<td>18,000</td>
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<tr>
<td>Ratio of Non-Astronauts to Astronauts</td>
<td>1,366</td>
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While there are obvious limitations to analyses and analogies like these, we can learn a lot when comparing rocket science to something we at Oak Street think is just as complex as rocket science: primary care.

First, healthcare really is a team sport. Both the delivery of high quality medical care and manned space flight require effort greater than a single person can provide. The challenge then is to create a team structure, a training environment, and a never-stop-improving culture that supports teamwork. At Oak Street, we function in care teams that include a physician, a nurse practitioner, a care manager, a registered nurse, a clinical informatics specialist, and a medical assistant. Clearly this model is expensive to operate and creates some complexity, but it also allows every member of the team to operate at the limits of his/her training and license since they are focused on their expertise and don’t have to be all things for their patients.

Second, physicians, like astronauts, have incredibly valuable experience and training that is necessary for success in the mission. But so too, do non-physicians. In the vocabulary of macroeconomics, physicians have valuable human capital, and the non-physicians are highly complementary inputs that make the marginal revenue product of that capital more effective. In other words, “administrators” make physicians better at their jobs and more valuable to the entire healthcare ecosystem. Take, for example, a highly trained medical scribe or population health analyst: not only do these colleagues improve the experience for physicians to do what they are trained to do, at Oak Street our analysis has shown they make the quality of care physicians deliver better as well.

The goal for NASA was to land on the moon, and the goal for healthcare is to deliver measurably excellent care to patients who need it. At Oak Street, we care about our 40% reductions in hospitalizations, our 5-star ratings for evidence-based chronic disease and preventive care, and our 92% Net Promoter Scores. Recognizing the importance of having a team with diverse skill sets and supporting their teamwork is critical in achieving our goal for our patients. Whether it’s as a physician, an administrator, or anyone else supporting the hard work of caring for patients, we all have an important role.

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**Featured Articles**

### COACHING 2.0: REINVENTING EXECUTIVE COACHING TO MEET THE DEMANDS OF A CHANGING HEALTHCARE ENVIRONMENT

Physician and nursing leaders at a world-renowned academic health center compete for resources to pursue individual quality and safety priorities, rather than work together on shared priorities to improve care.

The top team of a healthcare start-up found that it can optimize the services and technology silos of its business, but leaders are challenged to integrate products and services to create extraordinary value for customers.

The CIO of a multi-state health system understands the importance of collaboration to implement an electronic health record, but the work of engaging across administrative, technical, and clinical functions never happens. You can guess the result.

Today’s healthcare environment is fraught with diminishing resources and a healthy dose of uncertainty about the future. The need for different disciplines to work beyond their respective professional and organizational silos is critical to creating value and ensuring great care. As evidenced in the Institute of Medicine report, *The Future of Nursing: Leading Change, Advancing Health* (2011), “As the delivery of care becomes more complex across a wide range of settings, and the need to coordinate care among multiple providers becomes ever more important, developing well-functioning teams becomes a crucial objective throughout the healthcare system.”

We believe this is true for clinical and administrative leaders alike, who can feel culturally separate in longstanding, almost tribal, professional silos. Silos foster the continuation of tenacious traditions that fail to acknowledge the patient as a holistic being, like separating dentistry from the rest of medicine or viewing departments or specialties as if they are disconnected from the larger organizations of which they are part. Teamwork and collaboration across disciplines is often expected, but rarely taught or explicitly promoted.

We see the potential in altering this trend by leveraging and evolving a traditional support for healthcare leaders—executive coaching. We have experienced tremendous success reinventing coaching as a bridge between leadership development and the growth of the organizations the leaders spearhead. We call this Coaching 2.0.

### Defining Coaching 2.0

Coaching typically focuses on strengthening an organization’s leader, or guiding high potential executives who are not yet ready for prime time. When executive coaching was founded in the mid-1980s, its objective was to advise and teach senior executives, especially CEOs, to become more motivating and inspiring leaders. In this way, traditional coaching has been oriented around individuals—improve or “fix” the leader, and you will improve the organization’s performance.

The complexity of 21st century organizations demands a different approach. In today’s organizations—and in healthcare in particular—collaboration is key. Work is more frequently accomplished through influence, rather than authority. People come to work because of what they can contribute to a bigger mission. Coaching individuals is necessary, but not sufficient. It needs to be grounded in the set of interactions among the individual, the mission, and the organizational system as a whole. In Coaching 2.0, the leader is central, but the focus expands to the actions of the broader team.
and the structure and resources needed to tackle the organization’s most critical priorities. In other words, what does the business need to succeed, and how do we re-orient the leader, the team, and the ways in which they work together to make success possible?

Coaching 2.0 in Action
Consider the physician at a teaching hospital who was tapped by a Fortune 500 pharmaceutical company to be its Senior Vice President. Excited and energized to take on his first professional leadership role, the SVP found himself leading a 200-person department. With no leadership or management training, the SVP decided it would be good practice to meet individually with all 200 of his “direct reports.” After meeting with 50 employees, the SVP, exasperated and exhausted, sought the services of an executive coach. When the coach suggested the SVP narrow his direct reports to five, the SVP slapped himself on the forehead and said, “I never realized I could do that!”

There are many dimensions to this story. One: coaching does not happen in a vacuum; leaders work within organizations. Two: the organization failed to sufficiently onboard its new SVP. And three: the SVP’s department remained virtually at a standstill until its leader learned how to lead. This slowdown created undue stress on the larger system, which risked imploding. This was an opportunity not only to continue to provide coaching to the leader, but to work with his new team to create a strategic roadmap and determine how to organize for successful implementation. In a relatively short time, the department shifted from feeling stagnant to aligned and focused on a shared strategy.

Closing Thoughts
“Stress on the system” is one of the primary reasons leaders seek the services of a coach or a management consultant. Stress is an output of systems dominated by silos, as silos block the flow of information and resources toward shared aims. Stress is increasingly pervasive in healthcare, with ripple effects that threaten safety, quality, and productivity. Leaders under stress often “unload” on their followers, showing anger or “bad behavior.” The stress then rolls downstream—for example, with doctors yelling at nurses, nurses shouting at administrators, administrators antagonizing patients or vendors, and so on—until the system begins to falter. In many health systems, stress, more than the need to achieve patient-centered care, is the key factor driving work forward. In response to outbursts and missed metrics, human resources departments often seek coaches for remedial rather than developmental interventions, and administrators frequently hire management consultants to repair the system.

Coaching 2.0 ties all of these components together, using cross-trained management consultants and executive coaches who work together to address the human, organizational, and business dimensions of an organization. With Coaching 2.0, interlocking pieces of the healthcare ecosystem more seamlessly connect, with the potential to create a lower-stress, more cost-effective, and more efficient healthcare business.

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