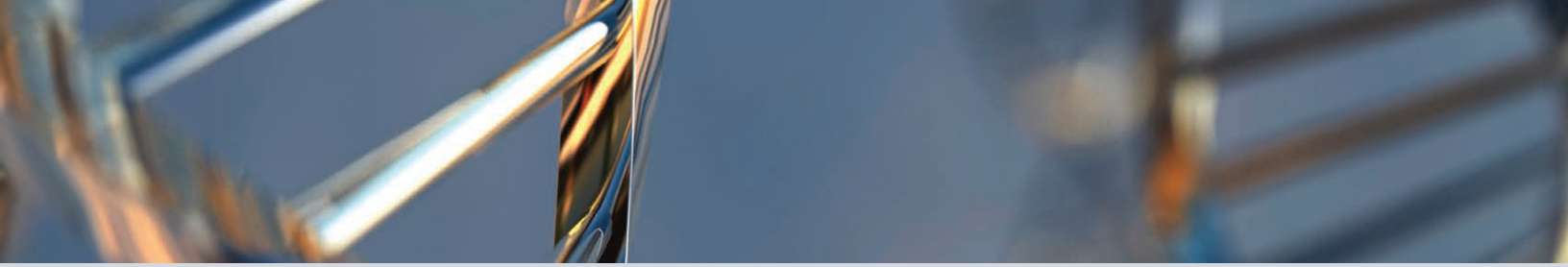

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EDITOR'S LETTER

Z. Colette Edwards, WG'84, MD'85
Managing Editor
To learn more about Colette, click here.

Happy New Year!

As we begin 2018, I'm happy to announce a new standing column, "Mind the Gap," a series on health (in)equity - issues related to health disparities, cultural competency, health literacy (check out the topic on WHCMAA's Business of Healthcare's session on SIRIUS XM) – and the social determinants of health.

Health inequities are systematic differences in the health status of different population groups. These inequities, seen in subpopulations defined by such factors as age, gender, geography, disability status, socioeconomic status, and race/ethnicity, have significant social and economic costs both to individuals and societies, with the economic burden to the U.S. economy estimated at hundreds of billons of dollars per year. Contributory factors which exacerbate such inequities include implicit bias on the part of care delivery providers (the attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner) and health insurance coverage status.

Social determinants of health (SDOH) are conditions in the environment in which people are born, live, learn, work, and play that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Examples which have a negative impact on health and well-being include food insecurity and an inadequate built environment (e.g., the absence of safe sidewalks or playgrounds in a neighborhood).

Take advantage of this lifelong learning opportunity and gain insights in this issue's insights brought to you by members of the Roundtable of Health Literacy of the National Academy of Sciences! And check out health equity/SDOH articles in previous issues of the *WHQ*:

- A Roadmap to Reduce Healthcare Disparities – page 17
- He Runs for Himself and for Men Like Him: The Untold Story of Male Breast Cancer – page 25
- Al buen entendedor, pocas palabras bastan. Translation: "Talk less. Listen more." – page 20
- Breast Health Decisions of African American Women - Responsibility Within the Culture – Part 1 – page 31
- Breast Health Decisions of African American Women - Responsibility Within the Culture – Part 2 – page 29
- When Growing Up Without a Home Makes You Sick - Health Disparities and the Nation's Homeless Children – page 21
- Vestido Rojo, De Todo Corazon: Community Outreach with Heart – page 24
- Health Literacy: Communication as a Critical Part of Treatment and Prevention

And stay tuned for the April issue when you will be able to hear from Maurice Jones, visionary CEO of the Local Initiative Support Corporation (LISC). LISC recently announced a commitment to narrowing the life expectancy gap as one of the central goals of its deployment of more than $10 billion over the next 10 years in urban and rural underinvested communities.

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

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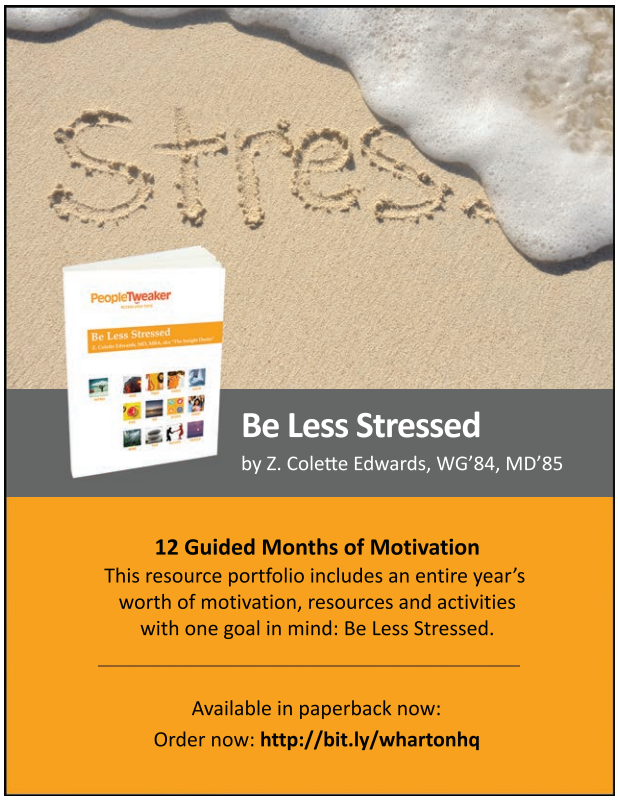
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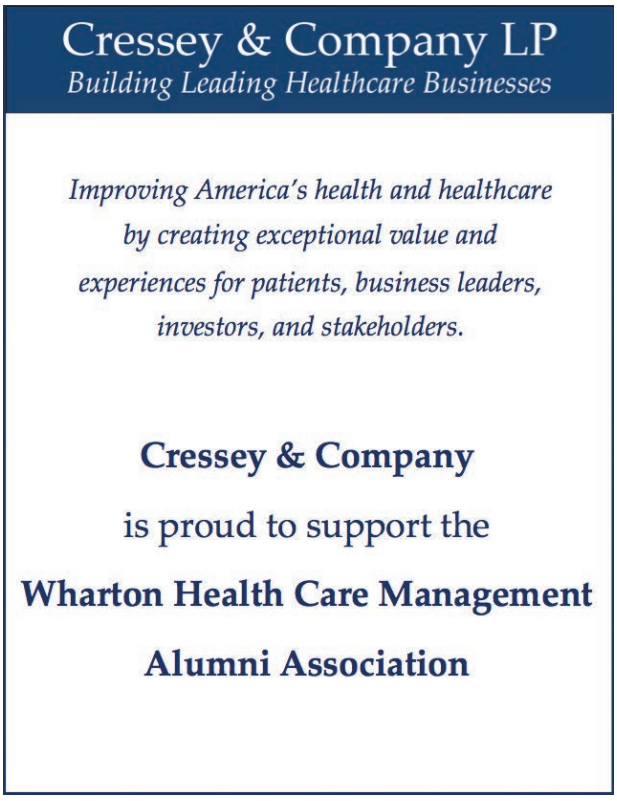
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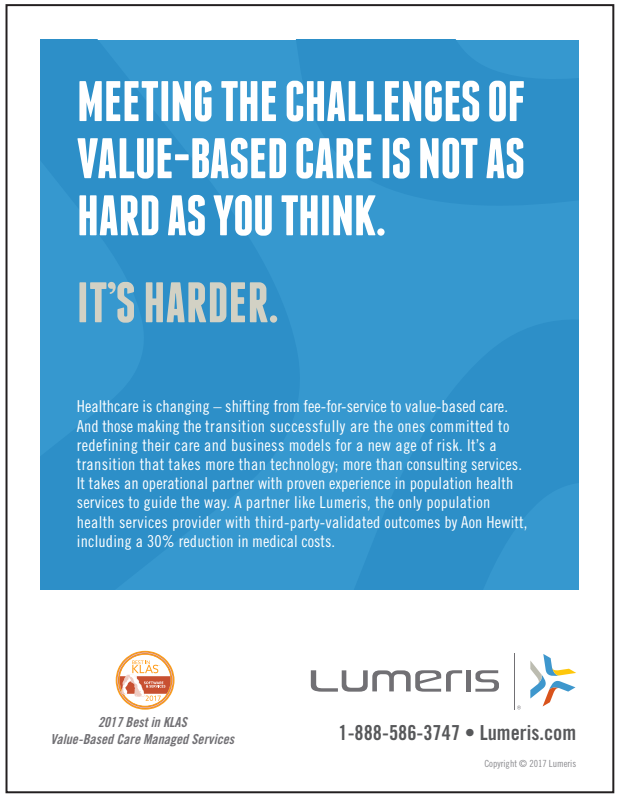
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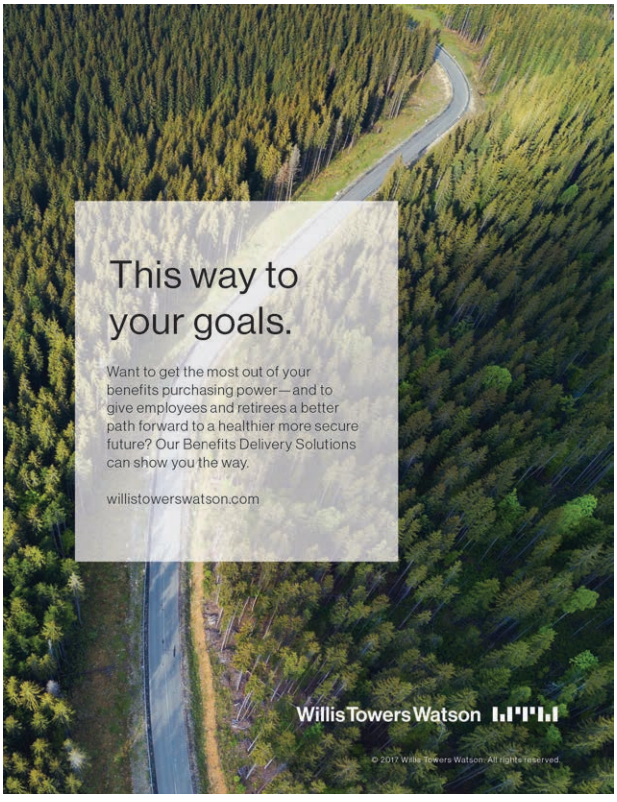
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THE PRESIDENT'S DESK

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

Shaping the Future of Healthcare

Last October the Leonard Davis Institute celebrated its 50th anniversary by putting on a symposium. Titled "Shaping the Future of Healthcare," the two-day event featured giants of health policy weighing in on what's next with U.S. healthcare. Paul Starr kicked off the symposium sharing lessons of the past that will inform the future. Mark Pauly, the guest of honor at the evening gala, reflected on learnings from his career. Mark was joined by fellow panelists Zeke Emmanuel and Andy Slavitt, who opined on the future of healthcare during the closing plenary.

And yet.

The night before the symposium began, the WHCMAA held a reception at Penn's Van Pelt Library. About 100 people gathered for group networking, a glass of wine, and a guest lecture from Wharton negotiations professor Stuart Diamond. Dr. David Asch, WG'89 and Tom Kupp, WG'85 were recognized as this year's winners of the WHCMAA Alumni Achievement and Alumni Service Awards, respectively. After accepting their awards they shared stories from the early days of the Wharton HCM program and the WHCMAA. Their recollections revealed how committed alumni shape the Wharton healthcare community's future for the better.

And yet.

At the reception we also recognized this year's Kissick and Kinney Scholarship winners. The Kissick Scholarship winner, Dr. Pankaj Jethwani WG'18, worked as a doctor, public sector consultant, and social sector entrepreneur in India before coming to Wharton. He interned at Iora Health and Steward Healthcare this summer. Angela Udemba WG'19, one of this year's Kinney Scholarship winners, earned a PhD in Oncology, started a fashion company, and worked as a consultant in London before coming to Wharton. Devi Mehrotra WG'19, the other Kinney Scholarship winner, was formerly the Editor-in-Chief of the *Yale Economic Review*, and has put her MD at Albert Einstein Medical College on hold to pursue her MBA at Wharton.

Compared to health policy giants and alumni achievers, Pankaj, Angela, and Devi are novices. And yet…I can't help thinking they and their Wharton Healthcare Management classmates will shape the future of healthcare as much as anyone I heard speak in that first week of October. Their potential is great; that we can help them reach it, a privilege. Recruit. Be a mentor. Help them network. Sponsor a field application project. Support the Kissick and Kinney Scholarships. If you've got other ideas, the WHCMAA can help you implement them. Contact me or other members of the WHCMAA Board. We're here to serve you and the students. It's our way of shaping the future of healthcare.

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

This month's philosopher:
Thomas G. Kupp, WG'85; BSE '80
To learn more about Tom,
click here.

Life Lessons:

If I knew then what I know now, I *would have*:
... been less risk averse.

If I knew then what I know now, I *would not* have:
...ignored my instincts when I did.

Favorite Quotes:

1. You miss 100% of the shots you don't take. ~ Wayne Gretzky
2. Never, never, never give up. ~ Winston Churchill
3. I skate to where the puck is going to be, not where it has been. ~ Wayne Gretzky
4. Be kind, for everyone you meet is fighting a hard battle. ~ Philo
5. If you can dream it, you can do it. ~ Walt Disney

Recommended Reading:

- *Execution – The Discipline of Getting Things Done* by Larry Bossidy and Ram Charan
- *The Last Lecture* by Randy Pausch
- John Grisham - anything!

Two early reads that had a lasting impact:

- *The Man* by Irving Wallace
- *The Grapes of Wrath* by John Steinbeck

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ALUMNI NEWS

John Whitman, WG'78
John and Dr. David Chess have a new start-up called "Tapestry Telehealth" dedicated to providing primary and specialty care to residents of rural skilled nursing facilities across the country. The company will begin by offering virtual daily rounds, enabled through technology, for those skilled nursing facilities in rural America that need access to primary care services for their residents. It will also expand to include specialty consults and behavioral health services for this highly underserved population. Dr. David Chess, is a champion and national leader in developing and using telemedicine to prevent avoidable SNF-to-hospital admissions and readmissions.

On February 16th, 2018, John Whitman, as the Executive Director of The TRECS Institute, in partnership with the Leonard Davis Institute and The Philadelphia Corporation for Aging, will be hosting a one day, invitation-only summit to address the growing and serious issue of low income senior housing. The goal of the summit is to first highlight the national issues surrounding safe, affordable housing for America's growing population of seniors. Over 50 national experts representing all aspects of low income senior housing will meet to discuss the current situation, but, more importantly, to strategize on possible solutions to the problems and develop a road map on how to move from where we are today to where we need and want to be in the future. The summit will be hosted at the Leonard David Institute.

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Learn more.

ALUMNI NEWS

Bryan Marcovici, WG'11
Bryan joined the Boston Consulting Group's Digital Ventures (BCG DV) team as a Principal in the healthcare practice. BCG DV is an innovation, product development, commercialization, and corporate/venture investment firm working with market leaders to help them innovate at start-up speed.

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NOT A FREUDIAN SLIP: THE HAPPINESS TREND - A HEALTHY PURSUIT OR AN OBSESSIVE QUEST? – PART 3

Pause for a moment, set down your phone, and think about the level of engagement you have with your device. When out to dinner, where are your phone and your attention? Is it on your dinner companion or your device? When you're stopped at a red light, do you stay focused on the task at hand or do you immediately pick up your phone to scroll through emails or Facebook? Ever wonder how this tech overload is impacting your quality of life? Could your digital habits be sabotaging your sleep and impacting your health and happiness?

In Part 1, we discovered how being happy has positive impacts on our health and longevity. Part 2 revealed that money and a constant pursuit of happiness doesn't bring more bliss. This third article reviews research on the impact of mobile devices and social media on our well-being and explores how our digitally connected world has impacted our happiness level. In concluding articles, we begin to shift towards discovering our own personalized path to fulfillment, strengthening skills that enhance our quality of life.

Today, we rarely pause for downtime. The average American spends over three hours[1] with their head down looking at their device, touching their phone almost 3,000 times a day.[2] We may end up using our phones as a crutch, filling our time with constant stimulation as we surf sites and scroll news feeds, avoiding potential boring or difficult situations. The problem is, daydreaming and being alone with our thoughts allows us to creatively think through problems. And being nose down in our phones doesn't open up any opportunities to interact with people around us.[3]

Isolated in digital platforms, comparing fake portrayals of an always perfect life.

People have become isolated into digital platforms and live their social life inside their devices. This interferes with social skill development, diminishes the breadth and depth of connections, and lowers relationship quality.[4] Digital dialogue has created a barrier for human connection, eroding human touch and laughter. Important non-verbal communication skills are missed in text conversations, and without the sound of a voice or face-to-face interaction, it's hard to interpret tone, read body language, use active listening skills, or share a smile [not an emoji].

Negative Consequences of Digital Overload

Continued digital socialization not only gives a false sense of connection, it can make people feel socially isolated in comparison[5] and induce their fear of missing out (FOMO).[6] Comparisons are in our face now more than ever. Facebook posts can leave one feeling jealous, excluded, or inadequate. Our ability to constantly post images (some even digitally manipulated) are not a true representation of reality and give the impression we are living a happier, more connected life.[7] This fabricated online identity can increase body image issues and exacerbate the pressure to be perfect.

Another challenge with being constantly connected is the amount of media that crosses our path and the negative impact this barrage of news has on our happiness. We feel horror and despair when we're confronted by the relentless violence shared constantly in our news feeds. And toxic news displaying conflict and negative images desensitizes us to violence and chips away at our quality of life.

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? – PART 3

continued

Displaying differences between people, races, and even political party affiliation closes off cooperation and feelings of empathy. An alarming trend is our society's 40% decline in empathy indicators, much of which is linked to the rise of digital communication technologies.[8] Most news is misleading and not directly relevant (other than weather). Just because a story is new, doesn't it mean it's relevant or that you'll have any sort of advantage over the next person by knowing it.

Journalists are trained to create entertaining, fear-inducing news factoids that instill a sense of urgency. However, these panicky stories trigger your body to release cortisol (stress hormone), putting you in a state of constant stress. Elevated cortisol impairs normal functions like digestion, fighting off infection, and healthy cell growth. Instead it activates fear, nervousness, aggression, and pessimism. Online these short story nuggets are algorithmically aligned to your preferences and past behavior, thereby potentially reinforcing your biases and limiting your openness or perspective of alternative points. Unfortunately, this shallow one-sided view not only lessens creativity and depth, it impacts memory and brain function as well.

Constant digital stimulation is competing for our attention and rewiring our brains.
We know good creative flow influences our happiness and that our ability to reach a goal gives us a sense of accomplishment and fulfillment. However, the constant digital interruptions from social media derails our train of thought,[9] depletes our focus, and decreases our ability to sustain attention,[10] ultimately reducing our productivity[11] and damaging work quality.[12]

Multitasking may seem like a more efficient way to progress through tasks; however, frequent task-switching, made possible through mobile devices, has negative consequences. Task-switching might help prevent boredom; however, the constant "superhighway of interference" inhibits our concentration and comprehension.[3] Research has linked multitasking to poor cognition and learning,[13, 14] poor academic performance,[15] negative mental health outcomes,[16] and decreased subjective well-being.[17]

Digital stimulation is rewiring our brains and causing gray matter areas to shrink, reducing our ability to control impulses, anticipate and consider the future, and regulate behavior.[3] The interruptive nature of our always accessible, alerting devices makes resisting the intrusions harder. If our brain is working hard to resist distractions, it isn't able to simultaneously pay attention, problem solve, or accomplish a goal.[18] Our daily web scanning behavior, clicking from link to link, and our reliance on Google to retrieve information uses neural circuits devoted to short-term memory, limits our long-term memory, and diminishes our ability to store and recall information for later use.[19]

Casting light on physical health consequences.
Technology is a major contributor to Americans' substantial sleep deficit. A majority of people check their phone while lying in bed,[20] and almost 75% of 18-to-44-year-olds sleep with their phones an arm's reach away.[21] The constant noise from pings and buzzing from a smartphone can cause stress and disrupt sleep patterns,[22] and the artificial blue light impacts our circadian rhythms, delaying melatonin secretion and thereby preventing our body from producing the chemicals that make us tired.[23] Since more than 40% of people in the U.S. report insufficient sleep, and 40 million people suffer from sleep disorders,[24] perhaps the best way to get a good night's sleep is to not have your phone accessible from your bed.

Although technology has made much of our lives easier, many people are experiencing pain after prolonged use of mobile devices in their hands, arm, neck, and back. Look around and you will likely see most people hunched over their smartphones. The two to four hours that people spend looking down at smartphones, now termed "text neck," stresses the cervical spine and increases degenerative back and neck problems caused by this poor posture.[25] Stiffness, numbness, burning, tingling, and

NOT A FREUDIAN SLIP: THE HAPPINESS TREND - A HEALTHY PURSUIT OR AN OBSESSIVE QUEST? – PART 3

continued

cramping in the fingers and forearm can be contributed to “cell phone elbow” or “selfie elbow” and are directly related to mobile phone use behavior.

Now that you are likely sitting up straighter and contemplating where you will store your smartphone while you sleep, consider additional habit adjustments to diminish detrimental health impacts resulting from your smartphone. Staring at screens means we blink 66% less, which can cause digital eye strain, dryness, headaches, and blurred vision.[26] Some smartphones have more germs than the bathroom door and toilet seat, increasing bacterial illnesses exposure.[27] And the amount of time we spend on our smartphone increases our inactivity and sedentary lifestyle.[28]

Although there are countless negative consequences to smartphone use, many described above, there is a positive side to this digital story. Devices can extend our social universe and connect us with people beyond our immediate area. We can maintain relationships or reconnect to those of the past. We can be reminded or prompted to continue healthy behaviors. We can learn new skills and even navigate confidently in an unfamiliar place. Smartphones can easily rally instantaneous support or quickly raise funds, just think “Ice Bucket Challenge,” all of which has a positive impact on our level of happiness.

Dare to detox and daydream.
In the next article, we will go beyond one-size-fits-all happiness improvement tactics and learn how to cultivate character strengths and build traits that help enrich our lives and enable us to thrive. Many of these tactics apply to our digital life as well. Until then, consider a digital detox, like millions of mobile users have done, by switching off.[29] Re-establish control over your life on the National Day Of Unplugging (March 9-10, 2018).[30] Be mindful of your experiences, your surroundings, and the people in front of you, not slumped over in a digital daze and miss it.

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AFFIDAVIT: HEALTHCARE AND THE LAW - THE EVOLVING EMERGENCE OF ARTIFICIAL INTELLIGENCE IN HEALTHCARE

I am always intrigued by new ventures and technologies in healthcare. Recently, the newest area has been medical marijuana, and it keeps health lawyers like me busy, tackling new frontiers as the healthcare industry strives to improve healthcare in all facets. But recently a new technology is becoming more talked about, stemming from a true hot button in healthcare technology: Big Data. For years "Big Data" has loomed large as the basis or cornerstone for fascinating healthcare technologies in the healthcare sector. "Big Data" is essentially the conglomeration of data points gathered to assess patients and their outcomes, resulting in an overall improvement in the quality of care – plus, at less cost.

For years, this has been the holy grail of Big Data healthcare technology: gather as much data as you can, more than you can ever imagine about a patient and their treatment, and you will have the ability to analyze and perform better outcomes for the patient and better healthcare overall at less cost. But now comes the next logical evolution of Big Data in healthcare and the next frontier in healthcare: artificial intelligence ("AI"). And now, the healthcare sector is seeing more and more healthcare technology transactions dealing with healthcare AI

The utilization of healthcare technology and devices to gather Big Data has been around for many years now. As the push towards wellness becomes more evident in U.S. healthcare, the natural progression was to utilize technology and Big Data, perhaps interspersed with telemedicine, to improve it. However, now there is more and more fervor over the inevitable next step with Big Data: AI.

Yes, AI is no longer something you see in the movies, but a real world application, especially in the area of healthcare, that is a driving force in private equity health transactions and the proliferation of healthcare private equity dollars. And what about those movies? *Terminator, iRobot, Ex Machina* and countless others depicting a futuristic society in which artificial intelligence runs awry, with computers taking over human civilization. Far-fetched? Stephen Hawking, Elon Musk, and Bill Gates don't think so. In fact, Stephen Hawking stated that "Success in creating [artificial intelligence] would be the biggest event in human history. Unfortunately, it might also be the last, unless we learn how to avoid the risks." Elon Musk calls AI "our greatest existential threat," and Bill Gates warned that the present beneficial effects of AI could be superseded decades from now when it will threaten human jobs and pose dangerous threats to human civilization.

But we are a society who is caught in the now. Healthcare is highly susceptible to technology and results, because technology leads to the ultimate goal of healthcare: better quality outcomes for patients. Healthcare and private equity firms are always looking for more and better technology to improve overall healthcare. And AI is leading the way into providing an avenue for breakthrough care and outcomes.

But what do we mean when we say AI in healthcare? I think there are a lot of misconceptions, and many folks misunderstand true AI in healthcare. True AI is something more than a computer reading thousands of x-rays or scans and then categorizing anomalies on scans in one pile vs. another: yes or no cancer, for example. That computer method is more akin to "statistical categorization." Statistical categorization is nothing more than data in, data out. Statistical categorization can then lead to the next iteration of Big Data, predictive analytics (taking the statistical categorization and running that information through another algorithm to predict outcomes or forecast the future). But true

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AFFIDAVIT: HEALTHCARE AND THE LAW - THE EVOLVING EMERGENCE OF ARTIFICIAL INTELLIGENCE IN HEALTHCARE *continued*

AI is something more than statistical categorization or mere predictive analytics. It is affirmative machine learning that allows the machine to develop its own algorithms based on data, improve those algorithms on its own, and deliver output in the form of real-time diagnosis and treatment.

Take, for example, the world's most famous AI machine or robot: Watson, IBM's AI machine that won the game show Jeopardy 5 years ago, beating two Jeopardy champions. Not impressed, since Watson has the entire Library of Congress at its disposal and can consume 1 million books a second? Well what about Watson attending medical school?

On a recent *60 Minutes segment* on "Artificial Intelligence" that aired on June 25, 2017, CBS reported that Watson attended medical school at the University of North Carolina at Chapel Hill and learned to analyze scans and images of cancer patients to detect anomalies and cancer. But Watson was also learning. Watson participated in cancer tumor boards with physicians. In a remarkable 30% of patients, Watson offered better diagnosis and treatment than the tumor board of physicians, mainly due to Watson's uncanny ability to recognize additional published literature and studies in real-time that the physicians simply could not encompass in their analysis. Watson even surprised the most skeptical physicians at the medical school.

So how can we control AI and bring it to the marketplace in healthcare? First, AI has to gain the support of skeptical physicians. That skepticism will only be lifted through real world utilization and experience with AI and patients, and physician trust in the machine learning algorithms that are at the heart of AI Radiologists are already using AI to assist them in clinical decision-making according to a recent article in *Modern Healthcare*, "Artificial Intelligence Takes on Medical Imaging," July 10, 2017, with superior results. And hospitals are enjoying the consistency of AI technology and improved reliability in medical imaging.

Second, the healthcare marketplace must decide how to regulate AI. For example, do AI machines or robots have to obtain a medical license in each state to "practice medicine" and treat patients? That might be a far-fetched idea for consideration down the road, but for now the Food and Drug Administration ("FDA") is focused on smart apps and wearables that do more than just spit out data. The FDA is concerned about AI devices that diagnose cancer or predict heart attacks, for example. In fact, in May 2017, it has been reported that the FDA assembled a team to oversee the current AI revolution in healthcare, headed by Associate Center Director for Digital Health, Bakul Patel. But the FDA would be a cumbersome agency to regulate AI, as any software changes for a medical device, like AI, would have to be continuously reported and approved by the FDA. But with AI changing its "software" data almost instantly, second by second, it is not feasible that FDA regulations will be able to keep up with AI, at least not in the current state of FDA's rules.

But think what you will about AI or its potential challenges and even dangers; AI is here to stay. Healthcare will continue to embrace AI one way or another. Why? Just look at AI's effect on patient outcomes, outcomes that are surpassing the best teams of doctors, outcomes that can save patient lives, and, yes, deliver better healthcare than humans. As we know in dealing with healthcare transactions, there will always be an appetite for new and better healthcare with improved outcomes, and AI is the next logical evolution.

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DOWNLOADING SUCCESS: EXECUTIVE SUCCESSION AND LEADERSHIP DEVELOPMENT – PART 2

As the Baby Boom generation continues to retire, healthcare organizations increasingly are looking to increase their bench strength and talent pipeline through leadership development. The goal is to identify successors not only for CEO roles but for other C-suite positions and even titles further down the organizational chart.

The hard truth is that healthcare organizations have talked a good game around this need for years without significant commitment to making it a reality. A bright spot in this dilemma is that more clinicians are looking for an opportunity to influence the organization as a whole, not merely their own division or department.

Some progressive healthcare organizations have created in-house leadership academies to groom the leaders of tomorrow, but their effectiveness has not been sufficiently studied. Yet the churn of the healthcare labor pool has companies realizing that working to retain top talent is inherently less problematic than continually shopping for new leaders – **it takes four times the salary of a departed employee to replace him or her**.

Through our own decades of working with healthcare organizations, we have identified a number of competencies that can elevate an individual's ability to lead, as well as some best practices for cultivating leaders for succession. Let's look at some of them.

KEY QUALITIES FOR LEADERS IN CONSIDERATION FOR SUCCESSION

We believe it best to organize leadership traits into two categories: individual (character) and organizational. In our years of working with thousands of executives, we have found it is the softer skills that make the difference between a good leader and a great leader. While all of us are born with some leadership abilities, the best leaders are continually seeking to grow and evolve their capabilities, thus maximizing their potential in executive succession plans.

Individual

Humility: As a leader, it's important for you to put aside your pride and rely on others. Listen to others, follow others – in short, be humble.

Patience: Being reactive isn't the same as being proactive. Things don't have to happen right away. Patience creates calm and improves decision-making.

Trust: Listen and lean into others. Allow yourself to trust others. As a leader, you get the gift of input.

Collaboration: Our best work is the result of working with and encouraging one another. Value collaboration.

Integrity: Do the right thing always, without fail. This is the foundation for who you are. Do not compromise.

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DOWNLOADING SUCCESS: EXECUTIVE SUCCESSION AND LEADERSHIP DEVELOPMENT – PART 2 *continued*

Courage: What does it mean to have courage? It means to ask questions, to challenge the status quo and fight for what is right. Have the courage to lead – and the courage to fail, which all leaders will do at one point or another.

Love of learning: Seek out all that is new. Ask, observe, question. Consume newness. Embrace "different."

Tolerance: Be tolerant of ideas and the input of others. Be tolerant of thought, actions, and deeds. People are essentially good.

Honesty: Honesty can never be overrated. Honesty cannot be compromised. It is who you are, all the time. Let this never be a question that others have about your character.

Compassion: Leading people requires compassion. Empathy, grace and kindness lead to a compassion that makes for a great leader.

Organizational

Leadership agility: Becoming a leader requires an observant knowledge of how organizations work and an appreciation for how things get done in the workplace, both through formal channels and the informal network. A leader must be able to settle differences with minimal noise and build engagement. He or she can be direct and forceful if needed, as well as diplomatic.

Building engagement: Strong teams are pivotal, especially in healthcare. We can't do this alone. A leader puts a premium on buy-in and employee engagement through communication and dialogue. We won't always agree, but our teams need to be clear on our reasoning and assured their voices were heard and considered.

Decisiveness: All leaders will make mistakes. Bad decisions can be altered or reversed, but most organizations will find it difficult to overcome consistent delays on decisions. Worse, paralysis by analysis often proves to be contagious when it starts at the very top of an organization.

Reliability: There are times when an organization needs a shakeup, but most organizations will thrive financially and organizationally when the leader has a steady hand and a long-term view.

Change management: This is not a cliché or a buzzword. The volatility of the business landscape demands that a leader continually prepares the organization for change by focusing on the organizational vision and openly addressing the obstacles to change. A good leader creates a coalition of change agents.

ELEMENTS OF LEADERSHIP DEVELOPMENT

How, then, does an organization develop these traits in its leaders to ensure succession? A healthy organization ensures the recruitment, development, and retention of talent becomes an ongoing priority of the team and not something delegated to human resources or simply an annual event. Top leadership needs to provide the resources and the time for their talent to be developed through various tools and processes. Leadership needs to demonstrate and model this commitment to development; *leaders go first*.

Team agreements: Leadership is not learned or cultivated in a vacuum. Leadership teams must come together regularly to establish goals and measure progress.

DOWNLOADING SUCCESS: EXECUTIVE SUCCESSION AND LEADERSHIP DEVELOPMENT – PART 2 *continued*

The feedback loop: Part of the hard work of learning to communicate is realizing feedback is crucial for learning new skills and eliminating old habits. Leaders must realize that feedback is for the good of the organization and constructive criticism is delivered around behavior, not identity or personality.

Getting beyond the classroom: It's good for leaders to get out of their normal environments. But simply paying for your leaders to sit in a classroom for a week at a respected university is unlikely to bring the personal or systemic change you seek. Leadership teams must be given tangible projects, not merely simulations, that address current needs of the organization.

Personal investment: Leaders must be invested in their leadership development; it can't simply become a box to be checked off to please the hierarchy or to earn continuing education units. That is why we recommend that leaders, in concert with consultants or organizational psychologists, establish specific goals for themselves.

CONCLUSION

Your succession plan is only as strong as your leadership team development plan – and the board and CEO who determine those elements.

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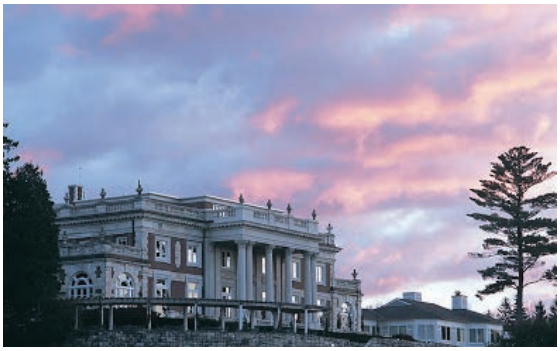
TO YOUR WELL-BEING: BEYOND THE HEADLINES OF "GETTING CUT"



My daughter peeks over my shoulder and takes a glance at the speedometer to ask "Daddy, what is the speed limit? Are we going too fast?" She understands that in school zones we drive slower, on the highway we drive faster, but she can't remember our trip to Texas where we traveled around 85 mph, legally. But with time she will gain the experience necessary to make her own judgments. So it goes with exercise. Weekly I am asked "I don't want to get my heart rate too high, do I?" Let's look at it.

The relatively new trend toward H.I.T. '*high intensity training' or 'interval*' focused exercise plans has added a dimension to the traditional exercise model. Interval training, defined as nearly maximal effort for up to a few minutes or so, but done repeatedly following an appropriate recovery phase, has been studied much more over the past decades. If you have ever attempted a 'Tabata' workout but were not sure of the origin, here it is. Dr. Tabata was the lead author of a study that asked 7 subjects to bike for 20 seconds at an effort that was 170% of their VO_2 max (highest oxygen utilization in 1 minute). VERY painful! They were then given 10 seconds of rest. This protocol went on for only 8 minutes. 5 days per week. Although short in duration, it is a brutal effort. The findings were that the VO_2 max and the anaerobic threshold of the subjects improved more compared to 'steady-endurance' training for 60 minutes. So why not scrap all this slow and steady stuff and crank up the effort in 20 minutes and get out of the gym? There are plenty of people who are challenged by time commitments, so this sounds good to them.

Well, if you take a look at the paradigm in *The Running Formula*, author Jack Daniels, PhD clearly distinguishes between the different zones that can be used with training runners. And although you might not think of yourself as a runner, you are. You have the lungs, the heart, the blood volume, the mitochondria and arterial system to make it happen. And if you have an anatomical limitation then you can 'run' in some other form like cycling, arm ergometry (measuring of the amount of physical work done by the body, usually during exertion), swimming, or hill walking. So let's stick with the model that you are trying to improve your running.

A simple 3 zone model will be used for our purposes to describe the training options:

I. 'Base/Endurance' training at a ~60% effort

II. 'Threshold' training at ~75% effort

III. 'Max' or 'High Intensity' training at > 90% effort

Zone 1 was and still is the 'Base' effort that humans (and plenty of other mammals) use when they need to cover distance. They feel little fatigue, fat is the primary fuel source, and the ability to deliver oxygen for long periods of time is not that challenging. This is your 'migrating' zone for those of you headed south this winter.

Zone 2 might better reflect the effort you give when you get a notification on your phone that the rain is coming in 10 minutes and you must get back home. It won't be easy, but you can make it.

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TO YOUR WELL-BEING: BEYOND THE HEADLINES OF "GETTING CUT" *continued*

Zone 3 is sprinting. It is clearly a fight-or-flight effort that uses instant energy sources that run out very quickly and lead to fatigue and muscle failure. The stress level is high, but it is over quickly. This effort tests the cardiovscular system near the max, but that may be why some of the muscular adaptations are profound.

Dr. Daniels often uses the phrase "Prove it" when one of his runners attempts to modify the running schedule with more of Zone 3 or less of Zone 2. But when you look at the examples of how to schedule a running program, there is no mistaking his philosophy, lots of Zone 1 while sprinkling in some Zone 2/ 3 or "High Quality" training appropriately. Why? Zone 2 and Zone 3 are hard, and the stress of applying them, for a lifetime, can seem daunting. Many individuals use the world of sports, like tennis, basketball, boxing, soccer, or classes led by a trainer to get their H.I.T. in, but when on their own, working at near maximal levels can be difficult. Goal setting becomes very important at times when trying to stick with these plans. Like beating your sibling in the local 5K.

Exercise benefits hinge on the ability of someone to comply with the exercise dose. In the business of prescribing exercise, individuals have many hurdles they need to get over, and it doesn't take long for a clear view to emerge on why they didn't complete the task: it was too hard (Zone 3), too long (Zone 1), too boring (Zone 1), or too complicated (Zone 2).

Your best 'speed' is going to be the effort with which you can comply. Some of us are sprinters, some of us are migrators, some need to be outside, and others inside. Maybe you are checking the stock market or reading a novel, but, regardless of how you achieve your exercise, you must take your foot off the brake and get up to speed. In time, add 1 beat per minute to your HR range, tack on 20 minutes to your long workout, but in the end remember 'Something is better than nothing, but compliance is everything.'

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MIND THE GAP: HEALTH LITERACY INSIGHTS FOR HEALTH CRISES

Introduction

Typically, the authorities and experts on public health practices are public health officials. The public expects these officials to offer important health information and guidelines to prevent disease and promote good health strategies. In times of public health crisis, their authoritative voices become even more important. Those who speak for public health—being interviewed by journalists, preparing public health alerts, producing written materials, using the broad reach of social media, or presenting at community meetings—are clearly conscious of the importance of communication not only for raising awareness and providing needed action steps, but also for earning and maintaining trust. The careful crafting of accurate, consistent, and meaningful messages can calm the public in uncertain times, avoid perceptions of chaos, and build trust. This paper highlights principles of clear communication and insights from several decades of health literacy studies to support such efforts.

A recent *NAM Perspectives* paper, "Improving Collaboration Among Health Communication, Health Education, and Health Literacy," noted the importance of interplay among the disciplines of health communication, health education, and health literacy. This collaboration is particularly important during a public health emergency. Several tenets of health communication—which is defined as "the study and use of communication strategies to inform and influence individual decisions that enhance health"—emphasize clearly knowing your audience; focusing your message; and knowing where, when, to whom, and how to deliver key information.[1] A core element of any good health communication effort is having continuous evaluation built into the design to improve the strategies and tactics.

Health communication efforts in medicine have long focused on the importance of adhering to rigorous standards while embracing developing science. Scientists, researchers, educators, and spokespersons stay in their "lane of expertise" and do not infuse the discussion with hypothetical situations that may cause fear or need to be walked back. The authors' advice is, in short: Say only what you know for sure and only when you know it. Say it together. Be collaborative.

Communication specialists have highlighted the limitations as well as the strengths of awareness and education efforts.[2] Communications cannot compensate for inadequate health systems or resources, nor can they produce sustained change in complex behaviors without support from a larger programmatic effort. Furthermore, communications may be complicated by an intended audience's preconceptions about the topic or the communicator. For example, Barry Schwartz notes in *The Paradox of Choice* that people may compare an experience to what they hoped it would be, to what they expected it to be, to other experiences they have had in the recent past, or to experiences others have had and reported.[3] Many of these challenges may arise during a public health crisis. Consequently, it becomes even more critical to understand the intended audiences and to make sure the information provided is credible and accurate.

Health Literacy Insights That Support a Quality Message

Literacy-related issues are often not at the forefront of communications guidelines. Yet the results of the 1992, 2003, and 2011 surveys of adult literacy in the United States indicate that literacy skills—reading, writing, speaking, listening, calculating, problem solving, and use of technology—are indeed quite problematic for a large proportion of adults. Furthermore, analyses

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MIND THE GAP: HEALTH LITERACY INSIGHTS FOR HEALTH CRISES *continued*

of health literacy indicate that, on average, U.S. adults have limited health literacy. Consequently, attention to literacy and health literacy is of critical importance to those of us preparing health information and crafting and delivering health messages. Many insights can be drawn from health literacy studies and practices to enrich our communication efforts. The classic Doak, Doak, and Root workbook, *Teaching Patients with Low Literacy Skills,* provides a detailed overview of the elements of a text that hinder or ease reading, comprehension, and use of health materials.[4] In addition, several currently used assessment instruments provide not only mechanisms for calibrating the demand that health materials place on individuals but also guidelines for developing materials for the public. The insights noted below are drawn from assessment instruments that are currently in use and actively cited in health literacy studies.

Tools for Assessing the Health Literacy of Texts

The most frequently cited assessment tools in the health literacy literature are those that calibrate the reading level with a focus on word length — based on the premise that long words in English are likely to have silent letters and are thus difficult for many readers. Among these, the SMOG Readability Formula — a tool developed to estimate the level of education necessary to understand a piece of written material — is attentive to sentence as well as word length.[5] However, Doak, Doak, and Root introduced a new instrument in 1996 that went beyond attention to words to examine and attend to broader issues that impede or ease reading. The Suitability Assessment of Materials (SAM) instrument includes a readability assessment but also provides a mechanism for considering and rating multiple elements related to organization, writing style, appearance, and appeal. Rated items are grouped under categories for content, literacy demand, graphics, layout and typography, learning stimulation/motivation, and cultural appropriateness. SAM elements provide guidelines for development and for assessment.

Seeking shorter tools, research groups developed and tested instruments that draw from SAM. The Centers for Disease Control and Prevention (CDC) Clear Communication Index consists of four introductory questions and 20 scored items representing important characteristics that aid people's understanding of information.[6] The Agency for Healthcare Research and Quality supported the development of the Patient Education Materials Assessment Tool (PEMAT) and a companion piece—the audiovisual PEMAT-A/V—with a focus on understandability and actionability.[7]

In addition, Peter Mosenthal and Irwin Kirsch noted that a good deal of print and online materials are not constructed in prose and cannot be adequately rated by a reading-level tool or the more expansive SAM and similar approaches. The PMOSE/IKIRSCH Document Readability Formula was developed and tested to help graphic designers examine three key components of lists, charts, graphs, and other displays, and rate their level of difficulty. The key elements relate to structure of the text, information density, and the need to look elsewhere in the document for explanation or interpretation of the text. The resulting score offers insight into the complexity level of the documents and is linked to proficiency level on adult literacy surveys as well as to a level for grade or schooling.[8]

Insights for Health Message Development

Even, and perhaps especially, in times of emergency, public health communicators should maintain a high standard of quality for the message. This means that the message must always exhibit accuracy (which requires it to be updated as often as necessary), clarity (with all scientific information rendered into language easily understood by a layperson), and receptivity (which means it has been tested with some members of the audience to ensure its effectiveness and revised before being released to the public).

The authors of this paper have drawn the following insights from the assessment instruments described in the previous section and from health literacy research:

MIND THE GAP: HEALTH LITERACY INSIGHTS FOR HEALTH CRISES *continued*

Process

- Identify the primary audience. Speak directly to the primary audience, and be certain that the message is made relevant to them.
- Highlight the key message. The opening (introduction) and the closing (summary) should focus on the key message.
- Be certain the health message is actionable. Information for follow-up should be provided. For complex actions, use a time-ordered and logically sequenced list.
- Assess the literacy demand of materials before pilot testing and after revision. Apply known and tested tools such as the SAM, the CDC Index, or PEMAT, and assess the structural demand of documents such as graphs, charts, and other numeric displays.

Composition

- Avoid distractions such as unrelated visuals or discussions.
- Organize information by "chunking." That is, place like items together within categories. Use headings and titles to help the reader locate information.
- Simplify the structure. The difficulty of extracting information from displays—whether in the form of lists, graphs, or charts—can be made easier for readers by using fewer columns or rows, reducing the volume of data (the number of headings and listed items), and eliminating the need to search elsewhere for explanations or interpretations.

Language

- Use an active voice.
- Use plain language, with attention to vocabulary. Avoid or clearly define rare words, and offer explanations and examples of concept terms.
- Be attentive to sentence length. Long sentences often contain multiple clauses and can confuse readers. Complex sentences erect unnecessary barriers to clear communication.
- Be attentive to numbers and math concepts. Use words to explain what the numbers mean. Do the math for the reader or listener.

The authors have developed examples of health literate messaging guided by these insights, as shown in Box 1 and Box 2. The information alerts people living in a specific area to a hypothetical crisis that is being resolved. Each example offers a clear identification of the intended audience, the problem, and the needed action. The message is presented in an easy-to-follow format. It provides explanations as well as action steps. The zip codes in the examples do not represent areas that correspond with any real geographic regions in the United States. It is important to note, however, that the information offered in messages must be specific to the affected area. For example, the imagined zip codes below are areas assumed to be at lower altitudes, and the instructions for how long to boil the water reflect this. Different instructions would be necessary at higher altitudes, where the water would need to be boiled for a longer time to be potable.

Box 1 | Example Communication about Contamination of a City's Drinking Water That Follows Health Literacy Best Practices

MIND THE GAP: HEALTH LITERACY INSIGHTS FOR HEALTH CRISES *continued*

Attention: Everyone living and working in the Middleton and Essex neighborhoods of Anytown in zip codes 44444, 04400, and 00440

The Anytown Department of Public Health has issued a boil-water order for May 11-12. This means that you should **not** drink or cook with tap water unless you boil it first. This order starts today, May 11, immediately and will end at noon (12 p.m.) on May 12.

E. coli has been found in the water in these two neighborhoods of Anytown. *E. coli* is a type of bacteria that could cause cramps, vomiting, or diarrhea, according to the Centers for Disease Control and Prevention. The symptoms may appear anywhere from 2 to 5 days after being exposed to *E. coli*. Usually the symptoms go away on their own, but those with fever, bleeding, confusion, or seizures should get emergency medical help.

For now, be sure to boil all tap water before you drink it or use it for cooking. You will know the water is boiling when it is bubbling rapidly and you can see steam rising from it. Continue to boil for 1 full minute. Boiling will kill the *E. coli* bacteria.

The section of broken water pipe has been found and is being repaired. The pipes will be flushed, and the *E. coli* will no longer be a threat, starting early the morning of May 12. On that day, run your water for 5 minutes to flush out any standing water in indoor pipes. The water then will be safe for drinking and cooking.

You can get more questions answered by calling the Anytown Health Department at 1-800-555-1212.

For languages other than English:
Русский (Russian) 1-800-555-1213
العربية (Arabic) 1-800-555-1214

For people who are deaf or hard of hearing:
TDD number 1-800-555-1313

Who: People in zip codes 44444, 04400 and 00440

What: Bring tap water to a boil for at least 60 seconds before using

Why: The water may contain *E. coli*, a bacteria that can cause stomach cramps, vomiting, and diarrhea if you drink it before boiling the water to kill the *E. coli*

When: The advisory lasts until noon on Thursday, May 12.

SOURCE: Parson et al., "Health Literacy Insights for Health Crises," National Academy of Medicine.

MIND THE GAP: HEALTH LITERACY INSIGHTS FOR HEALTH CRISES *continued*

The Doak, Doak, and Root workbook noted earlier highlighted the value of interaction in writing as well as in speech. Reflecting on this, the authors adopted a question-and-answer format in the second example to enhance engagement. Such questions, of course, need to reflect the interests of the intended audience.

Box 2 | Alternate Example Communication about Contamination of a City's Drinking Water That Follows Health Literacy Best Practices

Anytown, USA, is under a boil-water advisory.

Why is there a boil-water advisory? The city water may contain bacteria.

Who is affected by the boil-water advisory? People living or working in the zip codes 44444, 04400, and 00440 of Anytown, USA.

What do the people affected need to do? Before drinking or using the tap water, bring the water to a boil for at least 1 full minute to make the water safe.

When will the boil-water advisory end? This is in effect for 24 hours, ending at noon on Thursday, May 12.

What can happen if someone drinks the water before it is safe to drink? The person may have stomach cramps, vomiting, or diarrhea caused by the *E. coli* bacteria, according to the Centers for Disease Control and Prevention.

When will these symptoms appear? Anywhere from 2 to 5 days after exposure to *E. coli*.

If someone has these symptoms, what should they do? Usually, the symptoms go away on their own, but those with fever, bleeding, confusion, or seizures should get emergency medical help.

What can people do if they have more questions? Call the Anytown Health Department at 1-800-555-1212.

For languages other than English:
Русский (Russian) 1-800-555-1213
العربية (Arabic) 1-800-555-1214

For people who are deaf or hard of hearing:
TDD number 1-800-555-1313

SOURCE: Parson et al., "Health Literacy Insights for Health Crises," National Academy of Medicine.

MIND THE GAP: HEALTH LITERACY INSIGHTS FOR HEALTH CRISES *continued*

The authors intend for the examples above to provide guidance on crafting a high-quality message in times of public health crisis. Communication from authoritative voices in times of emergency must be developed thoughtfully and tested before they are released to the public. To be high quality, the message must be accurate, specific, actionable, and easy to understand. In the authors' view, this can be achieved through a careful application of health literacy principles.

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CHOOSE YOUR WORDS WISELY:THE POWER AND RESPONSIBILITY OF A LEADER'S LANGUAGE

The conventional mission statement from a non-profit health system reads like this: "*The health system aspires to improve the health of all in its community by being the leader in quality, safety, and population health*." There is both nothing and everything wrong in this statement. Nothing is wrong to those who are cognizant of the meanings of "quality, safety, and population health." They will be few. Everything is wrong in the statement to those who are not knowledgeable of these key words. It is worse yet for those who *think* they are knowledgeable, but are not. The first group know of their ignorance; the latter proceed under a cloud of misunderstanding.

The problems with this generic statement of mission are many. And their solutions are the work of leaders and the leaders' language.

The word "quality" lacks both specificity and emotional resonance. What does "quality" look like? What does it feel like? And would anyone anywhere choose healthcare that was not characterized by quality? The word "safety" suffers from the same limitations. We assume all healthcare we receive will be safe. Aspiring to safety seems a very low bar for any healthcare organization.

The "improvement of the health of the community" appears as a noble goal. Nonetheless, the phrase assumes an understanding of the meaning of health without describing it. The connotations of the word health stretch from "absence of disease" through "being able to function adequately in one's life" to "the physical, emotional, spiritual, and economic ability to engage in a vigorous, enjoyable life." All these phrases, despite their differences, describe health. Given that range of meaning, what then is the health system's mission? We also know health depends on economic well-being, supportive social structures, and wise personal decisions as well as healthcare. A mission of "improving the health of the community" overstates the capabilities of any healthcare system. "Improving a community's health" would be better stated more realistically as a community goal in which the health system was a partner.

The meaning of "population health" continues as a matter of debate among population health experts.[1] To an individual member of the public, especially to one who is sick, "population health" may appear as a distraction rather than a benefit. Our experience of sickness and health is an individual one. If a "population" is healthy and "I am sick," it is generally the "I" that concerns most of us. It is only when the benefits of "population health" become clear to me as an individual patient that the words begin to make sense.

Mission statements should ground the work of an organization. A statement that conveys fuzzy thoughts confuses its members and those who use its services. If a mission statement fails to describe the organization's purpose, those in the organization and those served by the organization are forced to develop their own thoughts about what the organization does and why it exists. At best, this misses an opportunity to align goals and efforts in a context of shared vision. At worst, a badly worded mission statement damages the perception of an organization.

Many organizations have been very effective in describing themselves—both to the public and internally—using a very few well-chosen words. General Electric, beginning in 1970 and for the next 24 years, used the branding slogan "We bring good things to life." [2] These words framed an iconic image for the company that connected broadly with the public. Similarly, the Dupont Company reinvented its image in

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CHOOSE YOUR WORDS WISELY:THE POWER AND RESPONSIBILITY OF A LEADER'S LANGUAGE *continued*

1999 with the inception of its global positioning phrase "The Miracles of Science." This simple phrase was found to resonate with both internal and external audiences. It both summarized the 200-year history of the company as a leader in applied science and set aspirations for future product development. [3]

In healthcare, the Christiana Care Health System, based in Wilmington Delaware, has used a more discursive approach to describe itself effectively—The Christiana Care Way. The Christiana Care Way (*We serve our neighbors as respectful, caring, expert partners in their health. We do this by creating innovative, effective, affordable systems of care that our neighbors value.*) functions as a brand promise, a mission and vision statement—all in one. [4] The words are simple and carefully chosen to be understandable both outside and inside the organization. The rationale for the choice of words is publically highlighted on their website in a "glossary." [5] The words "serve," "neighbors," "partner," and "value" are rich in connotations and highly emotive. They both describe and prescribe action. Together they confer actionable meaning to the image of the organization. When one reads The Christiana Care Way, one has a good idea of what one should expect from the organization and, if employed by Christiana Care, what one is expected to do.

It is a leader's responsibility to discern and communicate the meaning of her/his organization - why it exists and what it does. This act of discernment and communication can be called "framing." Gail Fairhurst and Robert Saar in their book, *The Art of Framing*, describe this leadership role. [6] Through the construction of a "frame," a leader can clarify an organization's goals, focus the activities of an organization's members, guide its decision-making, and establish the parameters for its success. She/he constructs this framework from words. She should choose her words wisely.

Words matter to writers and poets. Similarly, they should matter to leaders.

Writers need to be clear to be competent. Writers communicate effectively when you understand what they write. The words writers use and how they use them can describe, question, inform, affirm, or challenge. The descriptions, questions, information, affirmations, and challenges require clear language to engage and to have impact. Ambiguity in language leads the reader to a muddled message. Clarity leads the reader into the writer's world.

Poets specialize in the emotion of words. Words for poets resonate with connotations that echo with multiple levels of meaning. In its seventeen syllables, a haiku poem can summarize life's deep experiences in a simple description of nature clear for anyone to see. Poets choose their words carefully. They understand their power.

Communication of any sort is fundamentally persuasive. Myles Martel, a well-known management and communication consultant, points this out in a brief book, *The Persuasive Edge*.[7] Advertising a product clearly has a point of view. A politician's speech advocates for one's vote. A book has a theme. A CEO's question has a context and sends a message simply in its being asked. Even an "unbiased" scientific paper works to demonstrate a specific conclusion. All communication seeks recognition, if not necessarily agreement. If a communication is poorly thought out, and haphazardly presented, the recipient may be persuaded the true message is "poor thinking and inadequate preparation" rather than the intended content.

We all have seen the power of words. In the English-speaking world of the 20th and early 21st centuries, several rhetorically gifted politicians communicated a summary view of culture that resonated so well with the public that their words became iconic for their time. FDR's words in his first inauguration speech "the only thing we have to fear is fear itself" have become synonymous with an optimistic, almost defiant, world view of resilience in the face of adversity. JFK's inauguration words "ask not what your country can do for you - ask what you can do for your country" inspired a nation to community service. More recently President Obama's slogan "Yes we can," spoken during the early primary presidential election of 2008 in New Hampshire, came to characterize the hopeful campaign of the underdog. At a deeper level it

CHOOSE YOUR WORDS WISELY:THE POWER AND RESPONSIBILITY OF A LEADER'S LANGUAGE *continued*

inspired those hoping to change the political climate; and, deeper yet, it symbolized the optimistic hope of many that the election of a African American president would finally make civil rights an American reality after 150 years of struggle. These politicians knew the power of their words. As leaders, they employed words' poetry to describe, define, embrace, engage, and encourage. With their poetic rhetoric they framed the world for their followers. They chose their words wisely.

How does one do this? Clearly the politicians above are an elite group with unusual talent. Yet, the principles underlying their success are evident and accessible to all leaders. To paraphrase the work of Myles Martel:

- Know your audience.
- Know your message—including what you want them to know, what you want them to feel, and what you want them to do.
- Choose your words wisely—for their clarity, their simplicity, their emotional resonance, and most importantly, for their integrity.

A leader can be poetic, succinct, and clear, yet tragically ineffective if his words do not fit the actions of the organization. Communists who characterized others as "comrades" when devaluing them in a totalitarian state did not create a new order—despite their lofty words. GE was forced to confront the conflict of its brand with reality when critics pointed out that its development of technologies to facilitate nuclear war hardly fit the aspirations of "bringing good things to life." A CEO who calls an employee an "associate" when they labor in a rigid hierarchy does nothing but invite a charge of hypocrisy.

Words matter. Carefully chosen, they are the key tools of a leader. They can frame reality, give meaning to work, emotionally touch those an organization is built to serve, and inspire individual excellence. Given the immense power of words, it is our responsibility as leaders to choose wisely.

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BREAKING DOWN THE TELEMEDICINE BARRIERS: ARE FAMILY PHYSICIANS READY?

An established patient calls the office for a same day appointment and is told there are no openings in any provider's schedule for the next week. He has not been in the office for over a year.

This 57-year-old male presents with intense pain in his right big toe that is 9/10. He has had similar pain previously in the same location approximately twice for which he has never been seen. He was out drinking with friends last night. He denies fever. ROS (Review of Systems) is otherwise negative.

Past Medical History: HTN (hypertension)
Medications: Lisinopril/Hctz 20/12.5mg 1 po qd
Allergies: No Known Drug Allergies

PE:
Vitals: Temp 97.1^{0}
Gen: Appears in distress due to pain
Skin: 1st MTP joint – red, swollen, warm and tender to palpation

What is different about this patient presenting with gout? The difference is this patient was seen via telemedicine instead of in an office or clinic.

Telemedicine provides cost-effective, convenient, and portable healthcare. A rising number of providers are considering adding telemedicine to their practice; however, for many physicians, adapting to this delivery system can seem daunting due to concerns which include quality assurance, time allocation, training requirements, and an online, limited physical exam. Furthermore, some providers feel telemedicine will fragment patient rapport and continuity of care, which could further fragment healthcare. Despite multiple published surveys showing patients are ready for telemedicine, these concerns raise the question, "Is medicine ready for telemedicine?"

These concerns, while valid, should not deter physicians from embracing innovation as healthcare advances into this new technology-driven frontier. Addressing these concerns can generate a more inviting view of telemedicine. Regarding quality assurance, telemedicine physicians are held to the standards for both brick and mortar and telemedicine practice. On top of this, many telemedicine providers practice in multiple states and are, thus, vetted by multiple state medical boards and payor-contracted credentialing organizations. They must demonstrate knowledge of federal and multiple states' regulations about practice and prescribing.

Although medicine is essentially the same no matter how it is practiced, via office or telemedicine, specialized telemedicine training is essential. Organizations should make this protected training time to assuage providers' fears of being overloaded with more work. Training should include basic technology, trouble-shooting issues, appropriate online care, and regulations pertinent to telemedicine. Formal training, as opposed to trial-and-error, ensures a smoother transition for patient and physician alike.

Another concern is the physical examination, or lack thereof, via telemedicine. This should be thought of not so much as a limitation, but a factor to help determine what is appropriately seen in a telemedicine setting. Some diagnoses are easily supported in telemedicine using evidence-based medicine from the office environment combined with office experience. A standard of care

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BREAKING DOWN THE TELEMEDICINE BARRIERS: ARE FAMILY PHYSICIANS READY? *continued*

has already begun to take shape as more physicians and organizations have honed their telemedicine practices. Despite the progress, it takes a conscientious team to work through diagnoses and symptoms commonly seen to develop telemedicine standardization that can be disseminated to new providers and organizations.

Instead of thinking of telemedicine as fragmenting care, we should embrace telemedicine's ability to strengthen continuity of care and build patient rapport by making healthcare more accessible and affordable, all the while maintaining quality of care. Often patients cannot be seen by their primary care provider for a variety of reasons, including provider unavailability, self-pay status, high deductibles, and co-pays. Sometimes the patient is in a location that is inaccessible to in-person care, such as those patients traveling or residing in rural locations.

Finally, a follow-up plan is essential. Documentation and communication with the primary care physician should be no different than would be expected in the brick-and-mortar practice. Also, due to unchartered waters for many patients utilizing this delivery system, it is important to take the time to educate and set patient expectations from the beginning.

As mentioned before, telemedicine can address the gaps in healthcare. It can improve patient care through compliance, access, continuity and outcomes, and help capture revenue that would otherwise be lost. In 2014, the telemedicine global market was valued at $14 billion, and the projected market for 2020 is $35 billion. North America dominated the market in 2014, but the Asia Pacific is expected to dominate by 2020.[1] According to the Tractica report, telehealth video consultations sessions will increase from 19.7 million in 2014 to 158.4 million by 2020.[2] In fact, the telemedicine provider REACH Health survey done in 2015 said 44% of organizations indicated telemedicine as high priority, and 22% as top priority.[3]

Looking back at this case, what does telemedicine offer our patient?

In 2013, less than half of U.S. adults reported being able to secure same or next-day appointments with their physicians, and less than 40% reported being able to obtain care after hours without going to the emergency department.[4]

Gout is one of the most poorly treated medical conditions. Gout is unlike other rheumatologic diseases in that a gold standard assessment is available, i.e., MSU crystal positivity. While this gold standard has high specificity, its feasibility and sensitivity may be inadequate.[5] While it is ideal to send each patient for joint aspiration, it is not common practice. Gout is typically diagnosed using clinical criteria.[6] The 2015 ACR/EULAR criteria for the classification of gout, a clinical-only version can be considered for use in settings in which synovial aspiration or tophus aspiration is not feasible.[6] Many patients experience a delay in gout diagnosis due to office availability, but telemedicine offers easy access to healthcare so patients can be seen and diagnosed quickly. Treating gout flares as quickly as possible (< 24hrs) is ideal.

For most patients, a typical history, classic exam observed by webcam, and use of clinical criteria can support the diagnosis. Once these patients are seen via video-conferencing, counseled, and treated, a follow-up plan can help the patient enter the health system, or simply follow-up and continue appropriate long-term management. With time, we will be able to determine if adding this new type of visit will improve patient compliance and outcomes. Once followed up in the office, future acute gout exacerbations managed via telemedicine helps decrease overall patient overall cost while offices are free to see those medical conditions truly appropriate for an in-person visit. For initial diagnosis, when in doubt, it is important to explain to the patient, why, when, and where the patient should be seen in an office setting.

It is obvious that technology has changed people's lives, and its use within medicine should be

BREAKING DOWN THE TELEMEDICINE BARRIERS: ARE FAMILY PHYSICIANS READY? *continued*

no different. By allowing access to care to anyone who has even the simplest technology (PCs, notebooks, and mobile devices), telemedicine can improve the quality of life of both physicians and patients. It is important to learn more about this topic, keep an open mind to its value, speak of its concerns, expect high standards of care, and develop standardized guidelines. Ongoing discussion and collaboration will help ensure best care practices in telemedicine and help to alleviate the concerns mentioned above while improving the current healthcare system.

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MIDCAREER START-UP WITH A MISSION

One of the amazing things about my education from the University of Pennsylvania (Med 1994) is the preparation for my life 20 years after graduating, not just the first few years after. Almost 3 years ago, I partnered with Beverly Bradway, WG'91 to start a new company called Opting Back In (OBI). Simply put, our vision is to create an ecosystem to support professional women who have taken time off from the workforce in order to care for their family.

We each have been struck by the huge amount of talent in our own social circles of women with MDs, MBAs, PhDs, etc. or who have been major executives but after a number of years out of the workforce, find themselves at a loss as to how to reenter. I myself took time out from my career to stay home and raise my kids, and so I know firsthand what it is like to take that pause and then re-enter the workforce. Within OBI we have created a comprehensive process to perform a number of assessments upon entering our program. These assessments help point to candidates' areas of opportunity around technology use, self-confidence, interviewing, navigating corporate culture, and understanding the changes in American workplaces over the last 10-20 years. From there, a team of OBI experts in these areas provide in-depth training in the areas needed. Some people choose to do that training within a one-on-one scenario, while others prefer our boot camps because of their more social and supportive experience.

I think two of the most important lessons we have learned in starting OBI are (1) the importance of listening to your customers and (2) perseverance. While the skills OBI teaches are no doubt critical to success in today's marketplace, we have been overwhelmed by the power of the sense of community that has been created by the women who have worked with OBI. This was one of the first lessons we learned in starting this new company. Before we started OBI, we had a number of ideas of what would be valuable to our clients. However, once we started testing our product with real live customers, we could not ignore how powerful the interaction between participants was. Even after our first extended boot camp, the connection between the women in our class was so durable that we knew we needed to enhance and support this bonding even more.

While nearly every entrepreneur talks about the need to keep trying in the face of failure, when you are the one facing a lack of customers despite months of planning and work, the feeling of disappointment is deep. At OBI we have had to see each set-back as a valuable lesson that teaches us what we need to do differently. For example, let's consider when we have a webinar that has been promoted on social media, has a number of people sending in RSVPs, has good attendance, and then has a good number of attendees purchasing follow-up services. This all seems easy enough, but with two founders and one part-time employee, we know that each part of this chain took not only planning but also some previous failure to teach us how to do things more effectively. On one occasion, we spent months planning an all-day event only to have too few people sign up. While we knew it was aggressive to schedule such a large jump from what we were used to doing, we knew we needed to take risks to learn and expand. That setback hurt. We each took it personally, but we knew we had to step back, learn what we did wrong, and retool for the next effort.

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MIDCAREER START-UP WITH A MISSION *continued*

Each of us has worked in a large corporate environment before. Being in a start-up like OBI means adjusting to having one tenth the resources we might have in a larger company. It means having to wear 5-6 hats for each project. And it means that when we fall short, it is clearly obvious. However, the feeling of accomplishment when all of the pieces come together and what we do produce makes a difference in someone's life—that is a joy that is hard to find outside of starting your own company. When I think about the skills and the attitude it has taken to make OBI a reality, I am grateful for the enduring support our education has left with us.

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THE ARTFUL WORK OF GOVERNANCE

For years, I've had the opportunity to advise many different boards on issues of governance, strategy, and transition. It's always been exciting work, focused on the pain points at the center of what will enable an organization to recover from challenges and/or build on success to thrive into the future. Different boards serve different "customers"—whether it's a corporate board meeting the needs of its shareholders, a not-for-profit board meeting the needs of those it serves, or a professional society or trade association meeting the needs of its members. While each and every board is unique, not-for-profit trustees and corporate directors both grapple with similar questions:

- How can I ensure we are paying attention to the right set of risks and issues?
- What information do I need to ask good questions and engage in constructive debate with my colleagues?
- What is the best way to simultaneously support and hold accountable the chief executive?
- What is the value I contribute?

My own board service has helped me appreciate the challenges and dilemmas of productively answering these questions even more. I must say it's easier to advise boards than it is to navigate their complexities as a board member!

Governance is hard work—some may even call it an art—and it demands ongoing, intentional efforts to ensure its effectiveness. More importantly, the unique nature of each board must be reflected in any effort to strengthen it. Sure, there are best practices and guidelines that provide a framework for "good governance." Best practices are important, but what's more important is being clear about what the organization is trying to achieve and striking the right balance between the roles of the board vs. that of the staff to ensure that it can happen. As an advisor and a board member, I've found the following issues to be central to this work.

1. **Clarify the board's purpose, relative to the chief executive**. While all boards share the same purpose—to provide oversight and guidance to leadership as it executes its plan—how well organizations translate this into action varies. I often see boards overstepping their bounds, delving into the operations. On the flip side, I've also seen chief executives overly shield their boards from critical information and decisions. Every board should have a clear understanding about the board/staff relationship that works best for their organization, and mechanisms to ensure they can adjust the balance as the organization matures.

2. **Ensure that board structure, composition, and purpose link to the business of the organization**. If the purpose of the board is to provide strategic direction, oversight, and financial stability, then its structure and the composition of its membership must ensure that those purposes can be met. What are the core needs of the business in terms of expertise, philanthropic contribution (if relevant), relationships, or other sources of value that can ensure the governing body is able to effectively carry out its function? What committees are needed, and are their charges clear enough to provide value? Are there committees that no longer serve a purpose that could be sun-setted or adapted to meet a new challenge? Are there other structures that would provide support and guidance beyond the board itself (e.g., advisory boards, regional or district structures, etc.)? Boards should take a look at their structure and composition on an annual basis to ensure its form is up to the task of enabling its function.

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THE ARTFUL WORK OF GOVERNANCE *continued*

3. **Create meaningful engagement.** In almost every board I've worked with, members tell me they are worried about the contributions they are making: "Is the time I'm spending really making a difference?" Conducting annual board self-assessments is a powerful way to identify the strengths and opportunities for improvement for the full board and its individual members. I'm surprised by how many boards don't do this important work. Another level of meaningful engagement that is often overlooked in member-driven organizations, like associations or professional societies, is how to meaningfully engage members to better understand the value they want from the organization. Since the boards of these organizations are populated with members, finding ways to ensure the broader diversity of the membership is represented on the board and that voices across all categories of membership are heard is critical. It's particularly important to engage younger members, as how they are engaged early on will shape their commitment to the organization and its future success.

The artful work of governance requires trustees and directors to grapple with these issues, as they work to effectively take up their roles in the service of advancing the mission/purpose of their respective organizations.

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.