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HEALTH CARE MANAGEMENT  
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Healthcare Management  
Alumni Association  
The Wharton School  
University of Pennsylvania  
204 Colonial Penn Center  
3641 Locust Walk  
Philadelphia, PA 19104  
215.898.6861 phone  
215.573.2157 fax  
[www.whartonhealthcare.org](http://www.whartonhealthcare.org)

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For more information,  
please contact:

**DAVID E. LODER, Partner**

P: 215.979.1834

[deloder@duanemorris.com](mailto:deloder@duanemorris.com)

**LISA W. CLARK, Partner**

P: 215.979.1833

[lwclark@duanemorris.com](mailto:lwclark@duanemorris.com)

**DUANE MORRIS LLP**

30 South 17th Street

Philadelphia, PA 19103-4196

[www.duanemorris.com](http://www.duanemorris.com)

## EDITOR'S LETTER

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CVS-Aetna. Express Scripts-CIGNA. Walmart getting into the ACO business. Healthcare continues to be the modern-day Wild, Wild West of our time, with no end in sight. The relentless change offers both challenges and opportunities. And, sometimes, even transformation.

Stay abreast of the vibrating landscape with the *Wharton Healthcare Quarterly*, which continues to provide an eclectic mix of topics with a goal of:

- providing at least one article that will be germane to your work/life and/or
- offer insight into an area that may be completely new to the reader but important to one's knowledge base to stay up-to-date, relevant, and positioned to leverage moments and timing that can make all the difference.

Happy reading!

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




Z. Colette Edwards, WG'84, MD'85  
Managing Editor  
To learn more about Colette,  
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# CHANGING THE HEALTHCARE PARADIGM AND REDEFINING HOW COMPANIES PAY FOR AND ACCESS HEALTHCARE



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## THE PRESIDENT'S DESK

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The annual release of the National Health Expenditure [projections](#) is usually one of my favorite days of the year (sad...but true), but this February's release left me pensive. It wasn't the numbers themselves; 5.5% growth is what we've come to expect in health-care spending projections. Rather, it was a perspective I read accompanying the release that left me thinking about my own career and those of my fellow Wharton HCM alumni. In [the essay](#), the economist David Cutler argues there's nothing wrong with spending more on healthcare if we're happy with what we get, but how can we be happy when such high spending drives inequality, and much of what we buy is waste?

Cutler is the reason I work in healthcare. I enrolled in his health economics class in college to satisfy my economics requirements, not expecting to be inspired by the coursework. But thinking about healthcare as a scarce resource – How do we provide good care, to the most people, when money is tight? – proved to be a problem I could not put out of my head. I spent my remaining electives taking healthcare courses, even completing an independent study on healthcare and ethics in which I wrestled with the reasons a society redistributes: Should we spend more to help others if we can? How much more? What if we could do more *without* spending more?

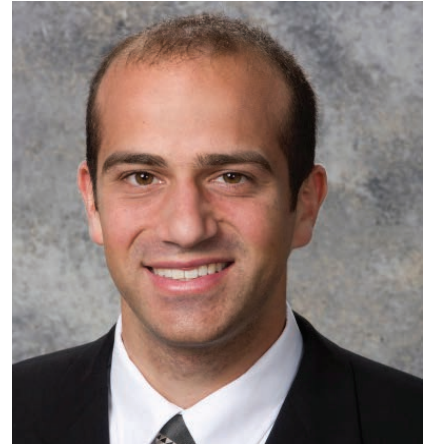
I knew I wanted in on the healthcare industry. I'd get to work on these big questions, plus demographic trends meant the industry was guaranteed to grow. I took an analyst job at a Medicare Advantage plan, and after three years applied to the Wharton HCM Program. I found my Wharton classmates to be similarly attracted to the prospect of earning a good living, working on big problems, and helping vulnerable people. That same spirit continues to animate the alumni with whom I interact through the WHCMAA, but it is most present in the current class of HCM students, who are as motivated to do well by helping others be well as any of us ever were.

I'd argue this win-win – to help one's self by helping others – is shared by most of us in the healthcare industry and reflected in the mission statements of our home organizations. If true, then Prof. Cutler's argument presents a paradox: How do the good intentions of individuals and firms lead to an inefficient, inequality-driving system? Resolving such a paradox requires asking tough questions: Do I contribute to waste in the healthcare system? Does my organization benefit from the system's inefficiencies? Would I support policies that promote fairness but make it harder for my organization to succeed?


I know, I know, this is weighty stuff for a *WHQ* President's Desk, but I'd like to know what you think. These are challenges our current students will face when they are leading healthcare organizations in a 20%-of-GDP economy a decade from now. They could benefit from alumni grappling with these questions today. Come say hi at the HCM alumni reception over reunion weekend, or shoot a note to [president@whartonhealthcare.org](mailto:president@whartonhealthcare.org).

I hope to hear from you soon.

John Barkett, WG'09  
WHCMAA President  
[john.barkett@willistowerswatson.com](mailto:john.barkett@willistowerswatson.com)



John Barkett, WG'09  
To learn more about John,  
[click here.](#)



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

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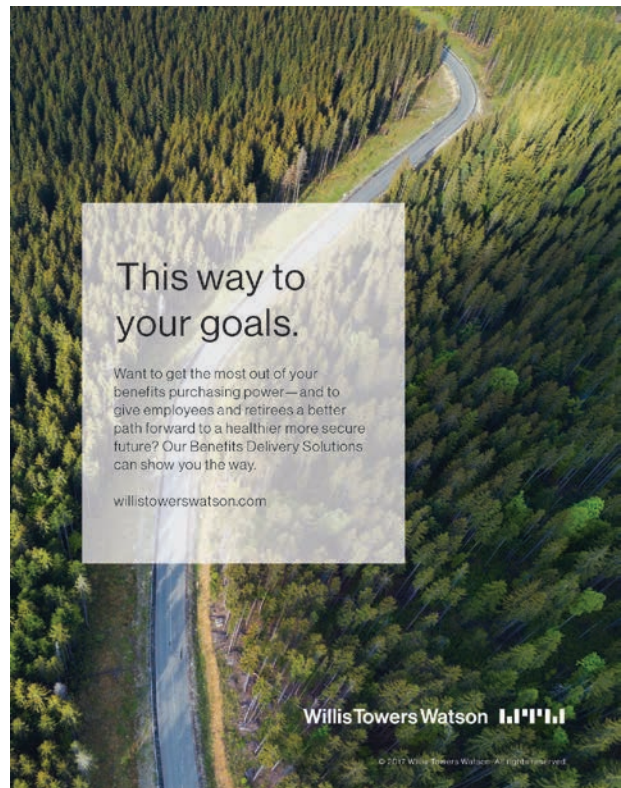
**MEETING THE CHALLENGES OF  
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**IT'S HARDER.**

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## THE PHILOSOPHER'S CORNER

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### Life Lessons:

If I knew then what I know now, I *would have*:  
...studied more math and computer science.

If I knew then what I know now, I *would not have*:  
...I genuinely don't know. I think life is about growth, learning, and discovery. Yes, I might have made some decisions differently in retrospect. But I also recognize that I am who I am today as much because of the mistakes and detours, as the forward progress and success.

### Favorite Quotes:

1. "Even the tiniest little bit of reminding ourselves that 'this is it,' that we are alive now, that we are already here, can make a huge difference. For in fact, as we have seen, the future that we desire to get to — it is already here. This is it!" ~ Jon Kabat Zinn, *Mindfulness for Beginners*
2. "What man actually needs is not a tensionless state but rather the striving and struggling for a worthwhile goal, a freely chosen task. What he needs is not the discharge of tension at any cost but the call of a potential meaning waiting to be fulfilled by him." ~ Viktor Frankl, *Man's Search for Meaning*
3. "Love your neighbor." ~ Scripture

### Recommended Reading:

- *How Will You Measure Your Life*, by Clayton Christensen, HBR (2010).
  - *Great questions and considerations for anyone who cares about having a career with purpose and impact.*
- *The Second Machine Age: Work, Progress, and Prosperity in a Time of Brilliant Technologies*, by Erik Brynjolfsson and Andrew McAfee (2016)
  - *Terrific read about the transformative technologies remaking tomorrow's economy, and the implications for business, society, and policy*
- *Give and Take*, by Adam Grant (2013)
  - *Why paying it forward is a better philosophy for work and life, and the best strategy for long term success.*

Contact Bernie at:  
[bzipprich@gmail.com](mailto:bzipprich@gmail.com)



This month's philosopher:  
Bernie Zipprich WG'16  
To learn more about Bernie,  
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Column Editor:  
Z. Colette Edwards, WG'84, MD'85  
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## ALUMNI NEWS

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### John Whitman, WG'78

Combining 30 plus years of healthcare experience focused specifically on helping to improve care for our nation's seniors, with the last five years of research into the use of telemedicine specifically focused on reducing avoidable transfers from skilled nursing facilities to hospitals, JW is now part of a new start-up company called Tapestry TeleHealth.

Tapestry is dedicated to improving care in our nation's rural nursing facilities where access to basic primary care is often challenging, let alone access to specialists. Through state of the art technology and a team of highly qualified, geriatrics-focused physicians, nurse practitioners, and specialists, Tapestry will reach out to America's 4000+ rural nursing facilities with the goal of bringing highly qualified clinicians to the resident's bedside when needed. This is made possible through technology that allows the clinician and resident to interact through a large, two-way monitor, a digitally enhanced stethoscope, otoscope, camera, and pillow speaker for residents with hearing issues. The nurse from the facility participates in the exam and serves as the clinician's on-site hands.

Telemedicine allows these rural facilities, immediate access to primary care when local physicians are not available to visit the facility. It also provides access to a host of specialists who can also visit the resident virtually, thereby avoiding delays in care and transporting the resident (and an accompanying staff member) long distances to see a specialist.

Tapestry can not only help improve access to care through technology, but, in doing so, also prevent avoidable nursing home to hospital transfers generating significant savings for our healthcare system.

Contact John at:

[jwhitman@wharton.upenn.edu](mailto:jwhitman@wharton.upenn.edu)

[jwhitman@tapestry.care](mailto:jwhitman@tapestry.care)

484.557.6980

[Learn more.](#)

## ALUMNI NEWS

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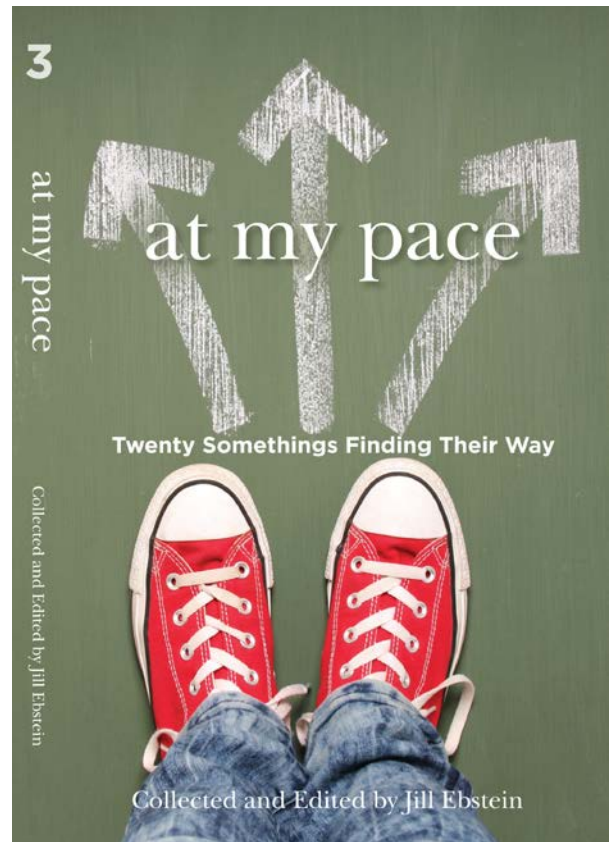
### Jill Ebstein, WG'83

Volume 3 of *At My Pace* is launched 4/22. This book focuses on millennials and is titled, *At My Pace: Twenty Somethings Finding Their Way*. As in previous books, this will feature a collection of short pieces by a wide variety of contributors who share personal goals, challenges, and lessons learned along the way. The goal of the *At My Pace* series is to expand the conversation on topics that matter by sharing individual contributors' own experiences. The voices are varied and do not feature famous people "ripped from the headlines." Book 3 seeks to debunk some of the myths about millennials and to help us, with fresh eyes and a new perspective, approach generational differences with more understanding.

Contact Jill at:

[www.jebstein@sizedrightmarketing.com](mailto:www.jebstein@sizedrightmarketing.com)

[Learn more.](#)



### Jeff Voigt, WG'85

Recently published the following peer reviewed articles:

Voigt J, Carpenter L, and Leuchter A. Cost effectiveness analysis comparing repetitive transcranial magnetic stimulation to antidepressant medications after a first treatment failure for major depressive disorder in newly diagnosed patients – A lifetime analysis. *PLOS ONE*. 2017; 12(10): e0186950

Patel R, Ivanov O, and Voigt J. Lifetime cost-effectiveness analysis of intraoperative radiation therapy versus external beam radiation therapy for early stage breast cancer. *Journal of Cost Effectiveness and Resource Allocation*. 2017; 15:22. DOI 10.1186/s12962-017-0084-5

Selected as Associate Editor for the *Journal of Cost Effectiveness and Resource Allocation*.

Contact Jeff at:

[meddevconsultant@aol.com](mailto:meddevconsultant@aol.com)

## ALUMNI NEWS

### Cathy K. Eddy, WG'92

Cathy K. Eddy retired as Health Plan Alliance President, April 30, 2018.

Cathy K. Eddy founded and led the Health Plan Alliance for more than 20 years. Formerly known as the HMO Alliance, the organization was started by Cathy in 1996 while she was the Vice President of Managed Care and Clinical Affairs at VHA, Inc. (now known as Vizient). Cathy worked at VHA/Vizient for 25 years, starting in public policy, and later went on to spearhead the organization's national community health improvement initiatives. She also served as a health policy analyst for the 1992 Ross Perot presidential campaign.

Cathy is a current member of the Board of Trustees for both Health First Health Plan and the Health First Health System, in Rockledge, Fla. She recently served on the Presbyterian Health Plan Board in Albuquerque, NM, where she also chaired the Quality Committee of the Board. She serves on the advisory boards for Women Business Leaders (WBL) and DST Healthcare, and served on the Health Industry Council Board in Dallas.

Cathy's retirement celebration was held Thursday, April 5, 2018 in Irving, Texas. Please contact [Nicole Terranella](#), Health Plan Alliance director of marketing and communications, to send a congratulatory message to Cathy.

Contact Nicole Terranella at:  
Director, Marketing and Communications  
972.830.8691  
[nicole.terranelle@healthplanalliance.org](mailto:nicole.terranelle@healthplanalliance.org)

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## ALUMNI NEWS

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### **Brian Holzer MD, WG'05**

In addition to serving as President of Kindred Innovations, Brian Holzer MD, MBA, WG'05 has founded and now serves as CEO of Lacuna Health, which will remain a Kindred Healthcare company. This new company benefits from its roots as the Kindred Contact Center (KCC), which provided patient engagement and care management services for over 700,000 patients across Kindred's operating divisions from its beginnings in 2014. A team of nurse advocates and post-acute care experts are poised to apply the KCC learnings and experiences from serving the nation's largest post-acute care operator towards transforming the patient journey now as Lacuna Health.

Lacuna Health is focused on helping hospitals, health systems, ACOs, clinically integrated networks, physician groups, and post-acute organizations optimize the end-to-end patient journey.

Lacuna is Latin for "gap." Our expertise, built through innovation and thought leadership, reimagines the care management process by filling gaps in a patient's journey. We fill these gaps by employing proprietary inbound and outbound remote care management models and placement solutions, all of which are designed to be deeply personalized, highly-relevant programs that reach patients at the right time, in the right place, at the right cost.

Contact Brian at:

[Brian.holzer@lacunahealth.com](mailto:Brian.holzer@lacunahealth.com)

[Learn more.](#)

### **Eduardo Cisneros, WG'07**

It was great to see some of you at the 10-year reunion last May. I am excited to announce that I have launched my own Executive and Life Coaching practice, Inspirate (Spanish for "Inspire Yourself").

The journey started almost two years ago when I left my role as VP of Business Development at DaVita in pursuit of a more purposeful path. The process of making changes and improvements in my life was a deep and challenging one, resulting in profound professional and personal rewards. I am fascinated by what it takes for us to change, which spurred me to now help others do this and become certified as an Integral Coach®, while leveraging my 16 years of corporate and entrepreneurial experience.

As a coach, I help my clients to become more aware of their current approach to challenges, to see new possibilities, and then build the critical competencies needed to attain their goals. Together we create sustainable solutions so individuals and teams more readily and positively contribute to their and their organization's success.

I specialize in serving organizations that seek to create a competitive advantage by investing in their C-suite and the development of key talent, while also directly serving individuals who seek to change or improve their professional and life skills. Please visit my website or email me for more information or if you have questions. Looking forward to (re) connecting.

Contact Eddie at: [eddie@inspiratellc.com](mailto:eddie@inspiratellc.com)

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## NOT A FREUDIAN SLIP: THE HAPPINESS TREND - A HEALTHY PURSUIT OR AN OBSESSIVE QUEST? – PART 4

This series of articles has focused on our happiness obsession. In [Part 2](#) we discovered that money and a constant pursuit of happiness doesn't really do the trick. And the misconception about constantly being digitally connected, in [Part 3](#) was proven to be more harmful than good to our overall happiness. We uncovered, in [Part 1](#), that happy people function better, are more productive, and healthier, which could be fueling our quest to infuse more happiness and fulfilling moments into our daily life. But how do we actually reach this pinnacle?



We can boost our happiness by cultivating character strengths and building traits that realistically align with our personality and lifestyle. The concept seems simple, right? Just engage in things that make you happy. However, making adjustments and taking action in ways that sustain happiness can be more challenging than one might think.

So what things and activities generate happiness? Science tells us people who are more physically active are happier, and people who get regular, uninterrupted sleep have greater happiness and subjective well-being.<sup>1</sup> Beyond getting a good night's sleep and incorporating exercise into our daily routine, are there other things we can do to change our happiness set point? Happiness can be improved intentionally, and, as we shared in [Part 1](#), up to 40% of our happiness is in our control.<sup>2</sup>

Before we dive into making life adjustments to produce more happiness, we need to realize that happiness, just like any new skill, takes work. We've all seen numerous articles like [10 Simple Steps to a Happier You](#) and [Happier in 5 Minutes](#). These quick fix strategies can be misleading. As with any new skill you want to master, the learning process takes sustained effort and continuous practice. Just like dieting, for example, there is no pill that will instantly change your life overnight. Shifting our thinking patterns to cultivate a positive state of mind requires effort and time.



### Align Activities and Traits

There are many skills and activities that will foster happiness, and there are numerous pleasurable opportunities all around us. However, is our approach the most effective, and are we choosing the best activities that produce the most happiness? Finding the right fit between which skills to strengthen and which activities to focus on can make all the difference. Just as each person has a unique thumb print, each personality and life situation elicits different needs.

Some people are more introspective and reflective, preferring more solitary experiences, whereas more extroverted people tend to enjoy socializing and being surrounded by others. Maybe taking a walk with a friend or immersing yourself in a great book brings you bliss. Thinking about the type of activities that are naturally compatible with your personality can not only help you find the most appropriate activities to pursue, but will likely be the actions that have the greatest impact and are the easiest to sustain.

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 4

*continued*

The chart below lists many character traits that, when intentionally acted upon, have increased happiness. As you review, consider a variety of actions that match your circumstances and interests. Alternatively, you could take the [Person-Activity Fit Diagnostic](#) test created by Sonja Lyubomirsky and Ken Sheldon to offer guidance toward finding your right fit.

Character Trait	Examples	Character Trait	Examples
<b>COMPASSION</b>	Kindness Acceptance and appreciation of differences Openness Supportive Desire to help others & relieve their pain Self-compassion	<b>GENEROSITY</b>	Giving Helping Sharing Volunteering Altruistic behaviors Philanthropy
<b>CONNECTING</b>	Cooperation Communication Community & Social networks Active listening Love Loyalty	<b>MINDFULNESS</b>	Focus Present Awareness Peaceful Harmony Reflect
<b>EMPATHY</b>	Understanding Concern Feel their pain Taking on someone else's perspective Discard prejudices & discrimination Increase tolerance	<b>MINDSET</b>	Internal narrative [thoughts] Self-affirmations Optimistic Confidence Inner strength Hope
<b>FORGIVENESS</b>	Trust Apologizing Reconciliation Accepting Letting go Validating	<b>SPIRITUALITY</b>	Awe Hope Values Meaning Beliefs Faith
<b>FULFILLMENT</b>	Meaning Purpose Achievement Accomplishment Nirvana Stimulating / satisfying work	<b>SAVOR</b>	Notice Pause Marvel Relish Treasure Cherish
<b>GRATITUDE</b>	Appreciation Thankful Experiences not things Live in the moment Contentment Grateful	<b>HEALTHY</b>	Rest Exercise Consume Expend Sleep Breathe

Remember that focusing on your core strengths (strengths that are authentically you) generally leads to “more positive emotion, to more meaning, to more accomplishment, and to better relationships.”<sup>3</sup>

### Augment Thinking and Intentions

The next critical step in experiencing more happiness throughout your day is to seek out pleasurable experiences and purposefully put yourself in situations to routinely practice. Research has shown we can intentionally transform our brain in ways that positively impact how we feel about our experiences and our life. Choosing to reframe your thinking to prioritize positivity and deliberately organizing your day to include activities that are well-matched with your goals and character helps you design a roadmap for your continued happiness journey.<sup>4</sup>

There is an important distinction to note between prioritizing positivity and valuing happiness. Research reveals that people who prioritize positivity feel more positive emotions and life satisfaction versus people who value happiness.<sup>5-6</sup> Just as we discussed in [Part 2](#), if we set unrealistic expectations that our life is meant to offer an endless amount of bliss, we will be doomed to disappointment.

## NOT A FREUDIAN SLIP: THE HAPPINESS TREND - A HEALTHY PURSUIT OR AN OBSESSIVE QUEST? – PART 4

*continued*

### Plan Ahead and Set Goals

Beyond just considering your personal circumstances, selecting different types of activities that align, setting your intention for the path ahead, and pausing to plan the steps you need to take for your happiness improvement makeover can bring about lasting change.<sup>7</sup>

Learning a new skill and making it a habit takes careful preparation and practice. Designing a plan that realistically fits into your daily routine and choosing activities that feel voluntary and not burdensome require thinking through the logistics of duration, dosage, and variety.

The extent and frequency of the activity matters. Trying a variety of happiness strategies at different times and being vigilant against activities that start to feel routine can help you be more resistant to hedonic adaptation.

Duration	HOW LONG HOW FREQUENT HOW NOVEL	Length & extent
Dosage		Frequency & timing
Variety		New & random

### Monitor and Celebrate Progress

Now that you've thought about which traits and activities align best, you must move forward with your personalized happiness regimen to begin to feel the benefits. Be sure to pause, be aware of, and savor your success.

Remember that repeated experiences shape our brain, so what you practice will become stronger. Look out for happiness derailers like comparison, fear of failure, misinterpretations, perfectionism, self-doubt, and unrealistic expectations. You decide the narrative, focus, and effort. Change your interior landscape if you start to notice a negative shift in your emotional tone.

You're in control of your 'happiness-improvement.' Realize the importance of pausing, learn how to build skills that allow you to intentionally cultivate more happiness throughout your day, and form habits that shift your perspective on yourself, your experiences, and the world around you.

### Smile and Enjoy!

Contact Connie at:  
[connie.mester@gmail.com](mailto:connie.mester@gmail.com)

## **NOT A FREUDIAN SLIP: THE HAPPINESS TREND - A HEALTHY PURSUIT OR AN OBSESSIVE QUEST? – PART 4**

*continued*

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## **AFFIDAVIT: HEALTHCARE AND THE LAW - INNOVATION AND MODERNIZATION: RESHAPING FDA REGULATION OF DIGITAL HEALTH SOLUTIONS**

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Over the last several years, digital health technology has transformed the healthcare sector through the proliferation of medical software, mobile medical applications, medical device data systems, medical image storing devices, medical image communication devices and other digital health devices and systems. While global technology leaders and industry stakeholders have been quick to jump on the digital health bandwagon, the Federal Food and Drug Administration (“FDA”) has proceeded deliberately. However, over the last year the FDA has picked up the pace significantly, making digital health a priority and modifying the traditional regulatory processes for approving medical software. Developers, investors, and other stakeholders should follow these developments carefully.



Traditionally, medical software has been subject to the same regulatory oversight as hardware medical devices. Recognizing that many digital health solutions pose no or very minimal risk to the consumer, in December, 2016, the 21<sup>st</sup> Century Cures Act (the “Act”) amended the definition of a “medical device” to exclude medical software that supports administrative functions, e.g., billing and appointment scheduling, and inventory management or workflow, encourages a healthy lifestyle, serves as an electronic patient record; assists in displaying or storing data; or provides limited clinical decision support. This is welcome news for those who are developing, investing in, selling, or marketing these kinds of products.

The Act also authorizes the FDA to update its regulations and guidance applicable to digital health devices to conform to the Act. In August 2017, the FDA released its Digital Health Innovation Action Plan that describes its new approach to the regulation of medical software and digital health devices and outlines its efforts to encourage digital health innovation by 1) issuing key guidance to clarify certain provisions of the Act; 2) launching a pilot pre-certification program, the FDA Precertification (Pre-Cert) for Software Pilot Program; and 3) building its bench strength and expertise through the Center for Devices and Radiological Health (CDRH).

The redefined approach will replace the product-by-product premarket review process that software manufacturers undergo when seeking FDA approval for devices.

Under the traditional system, mobile health apps and medical software were required to undergo the lengthy FDA process of scientific and regulatory review to ensure device safety and effectiveness before going to market. The type of premarket application a developer or manufacturer submits to the FDA depends on classification of the device. Classification depends on the intended use of the device as well as the risk the device poses to the user of the device. Class I includes those devices with the lowest risk, and Class III includes those with the greatest risk. Generally, devices with greater risk are subject to lengthier and more administratively burdensome approval procedures before they may proceed to market. There is also a de novo classification category for novel products.

The FDA's new approach will allow software developers who meet key metrics and performance indicators to avoid the traditional, classification-based review approach. Once pre-certified, software developers will be able to market their low-risk devices without having to deal with additional FDA review. Ideally, by streamlining the review process and allowing developers to market low-risk devices without requiring additional pre-market information, this program will enable a faster and more efficient regulatory approval pathway that is better suited for the

Contributors:  
Lisa W. Clark, JD’89 and  
Samantha Dalmass  
To learn more about Lisa and  
Samantha, [click here](#).

## **AFFIDAVIT: HEALTHCARE AND THE LAW - INNOVATION AND MODERNIZATION: RESHAPING FDA REGULATION OF DIGITAL HEALTH SOLUTIONS** *continued*

faster iterative design, development, and type of validation used for medical software.

The Plan also provided for the Pre-Cert Pilot Program, which is designed to assist the FDA in developing a final Pre-Cert Program by analyzing the processes and measures used by select software developers to develop, test, and maintain their products. In September 2017, the FDA chose nine software developers of varying size and complexity to participate in the Pilot Program, including Apple, Fitbit, Johnson & Johnson, Pear Therapeutics, Phosphorus, Roche, Samsung, Tidepool, and Verily. The participants agreed to provide to the FDA access to the quality measures they currently use with respect to their products, including those that are in development as well as those on the market, and other internal information. The FDA will consider this information in determining which key metrics, performance measures, and other objective criteria software developers must meet in order to qualify for participation in the final Pre-Cert Program.

On January 30-31, 2018, four months after launching the Pilot Program, the FDA convened an important two-day public workshop entitled “Fostering Digital Health Innovation: Developing the Software Precertification Program” to discuss the progress of the Pilot Program and to ask for public input on the design and ongoing development of the final Pre-Cert Program. Panelists from companies participating in the Pilot Program and other industry stakeholders shared their experiences and perspectives regarding the FDA’s new approach to digital health. The FDA indicated it plans to have a Version 0.1 of the Pre-Cert Program ready to launch by the end of 2018. The initial model will have three key components: (1) precertification, (2) streamlined market review, and (3) access to post-market data. The FDA is currently working on the first component and will reassess current statutory and regulatory guidelines after it establishes the elements necessary for the precertification program. In the meantime, the FDA is accepting public comment on development of the precertification program until June 29, 2018.

The FDA’s commitment to redesigning its regulatory approach to digital health is timely for stakeholders who have struggled to understand the government’s oversight strategy. Armed with this new information, a developer may have an easier time obtaining funding, and the investor will be better able to assess the risk of a product’s success or failure and opportunities for reimbursement. This is all good news for the digital health industry.

Contact Lisa at:  
[LWClark@duanemorris.com](mailto:LWClark@duanemorris.com)

Contact Samantha at:  
Law Clerk  
Duane Morris LLP  
30 South 17th Street  
Philadelphia, PA 19103-4196  
Phone: 215.979.1257  
Email: [sdalmass@duanemorris.com](mailto:sdalmass@duanemorris.com)

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## DOWNLOADING SUCCESS: DIVERSE TEAMS DELIVER INNOVATION, SUCCESS, AND PROFITABILITY

Commitment to diversity is a sound business practice in healthcare or any field. In fact, the evidence from many studies indicates organizations that are committed to diversity in their leadership ranks are better run and more profitable than those that aren't. Whether you lead hospitals, health insurers, or healthcare services corporations, it's simply smart business to have a variety of experiences and intellectual expertise around a leadership table where decisions are made. Companies that don't heed this business practice face a very real risk of being left behind in the rapidly changing world of healthcare.

According to a *Harvard Business Review* [article](#) by David Rock and Heidi Grant, diversity is a reliable engine for innovation. They point to a British study that shows “businesses run by culturally diverse leadership teams were more likely to develop new products than those with homogenous leadership.”



A [recent study](#) by researchers from North Carolina State University and Portland State University found that corporations with policies that value women and minorities “are more innovative, value intangibles and human capital more highly, have greater growth options, have higher cash flow, and have stronger governance.” In addition, the study demonstrated that diverse companies weathered the recent U.S. recession more easily.

Why is this so, beyond the obvious reason that decision-makers at diverse companies bring a plethora of experiences to bear when making decisions? Here's another, less-known factor: **Studies reveal that diverse leadership teams rely more on facts when making decisions** and make fewer errors when dealing with those facts – they are more careful and deliberate in their decisions.

The U.S. Census [reports](#) that, by 2044, Caucasians will no longer constitute a majority in the U.S. Instead, America will become a “minority-majority” country where no ethnicity will make up more than 50 percent of the population. So, what are you doing as a company to better understand your marketplace (members, patients, consumers) as well as retain and empower your workforce?

This is where we must get beyond mere diversity. Some in business are beginning to refer to “DEI” efforts and measurements (Diversity, Equity, and Inclusion) in showing how interconnected these concepts are. And, in healthcare especially, equity remains a driving force in our actions around diversity.

Yet diversity alone doesn't make inclusion an automatic result. As diversity experts have stated, “Diversity is being invited to the party. Inclusion is being asked to dance.”

Laura Sherbin and Ripa Rashid of the Center for Talent Innovation cite four factors that can turn diversity into inclusion:

- **Inclusive leaders** who create a safe environment for team members to share opinions and new ideas, and who share credit and empower team members to make decisions.
- **Authenticity** is closely tied to this, allowing team members to share their true selves instead of being fearful to express

Contributors:  
Sherrie Barch and Deanna Banks

To learn more about  
Sherrie and Deanna, [click here](#).

## DOWNLOADING SUCCESS: DIVERSE TEAMS DELIVER INNOVATION, SUCCESS, AND PROFITABILITY *continued*

individual traits that don't conform to the company norm.

- Creating opportunities for **networking and visibility** that go beyond the usual chatter about mentorship and address leadership gaps through true sponsorship and championing of executives who merit promotion.
- **Clarifying career paths** for people who are not Caucasian males. This greatly affects women (45 percent of whom leave a career path, even if it is temporary, to take care of children), but also ethnic minorities and LGBT workers. "Ironically," note Sherbin and Rashid, "it's usually the majority group that presumes to identify the reason these people aren't advancing."

In terms of gender, there has been minor progress on the leadership front. While it is true that women now comprise 20 percent of the director roles at Fortune 1000 companies that are part of the [Gender Diversity Index](#), other statistics remain troubling. Only 21 percent of executive positions among Fortune 500 healthcare companies are filled by women. Also in healthcare, the number of ethnically diverse executives in leadership positions has dropped to [11 percent](#).

These numbers are of great concern to those of us who assist companies with leadership solutions. Each year, we spend many hours conversing with some of the top CEOs in the country about their careers and their experiences with diversity and leadership, and many of them are insistent that diversity is a must at the top of an organization.

"Our boards do not reflect the communities we serve," said Gene Woods, chair of the American Hospital Association and the CEO of Carolinas HealthCare System, in a previous interview on governance. "One of the biggest levers in diversifying an organization is when the board declares that it's a priority."

Woods also chairs the AHA's Equity of Care Committee, which has been instrumental in getting healthcare providers to sign its National Call to Action pledge to eliminate disparities.

"That pledge includes improving collection of race, ethnicity, and language preference data," he said. "(It) also includes increasing cultural competency training and increasing diversity in governance in leadership."

Yet there remains some resolute opposition at the director level. In a PwC [survey](#) of board members, 16 percent claimed that gender and racial diversity doesn't produce any benefits, while 11 percent refrained from commenting because their boards are [not diverse](#).

Bruce Siegel, the CEO of America's Essential Hospitals, which represents safety-net hospitals across the U.S., has seen this attitude all too often. In a prior interview on this topic, he said boards have been far too quiet on the lack of diversity.

"I don't think our boards of directors are demanding this," he noted. "They need to be unequivocal that this is an expectation, not just a nice thing to do. But I don't think our hospitals are going to look diverse in the C-suite if our boards don't."

It is difficult for an organization to understand its patients, members or customers if its leaders can't identify with them. Logic tells us that such a scenario would make it difficult for a company to grow under those circumstances. Yet far too many companies have a significant majority of white men in the C-suite. Even Marna Borgstrom, the CEO of Yale New Haven Health System, who has led her company since 2005, told us in a recent interview about leadership that she still sees the gender disparity in person.



## **DOWNLOADING SUCCESS: DIVERSE TEAMS DELIVER INNOVATION, SUCCESS, AND PROFITABILITY** *continued*

“When I get outside of our organization, I will sometimes still look around the room and say, ‘Wait a minute. I’m the only woman here.’”

“That is still a little bit weird and a little bit uncomfortable, because it reinforces that we’re not doing enough to advance women into the senior-most positions in the healthcare field.”

Marla Silliman, the senior executive officer overseeing the Florida Hospital Orlando Campus, which comprises three hospitals, says she and other women executives are determined to do their best to accelerate the change they want to see. In an interview last year, she made this comment:

“I don’t see a lot of older female mentors that I can turn to – there just aren’t that many. So, my hope is that we will be the generation that will truly be there for the generation behind us.”

As we survey the leaders who are having the most strategic impact in the industry, it is often those who see diversity and inclusion as essential elements of their mission. Today, we believe there is a rumbling of opportunity for real and equitable change in our organizations. Our hope is that it ultimately will result in enterprise leaders who truly reflect and champion the people they serve.

Contact Sherrie at: [sbarch@furstgroup.com](mailto:sbarch@furstgroup.com)

Contact Deanna at: [dbanks@furstgroup.com](mailto:dbanks@furstgroup.com)

## TO YOUR HEALTH: THE LAST FLIGHT OF STAIRS

Who is your role model? What example do you give when you reflect on someone who is aging well? What are the characteristics they possess? Were they inherited or learned? Are they fanatics with the best roof rack in town or are they just consistent with the seasons? Planting in the spring, mowing in the summer, raking in the fall, and shoveling in the winter? Can someone learn those habits and improve their health or is our lifespan, or better yet, our healthspan, predetermined?

In 1982 [Dr. James Fries](#) introduced a concept called “*the compression of morbidity*.” In the keynote address to the Institute of Medicine, he stated that one’s ability to maximize the number of years they live with *vigor and absent of life changing disease* is related to lifestyle habits. His point at the time was, although we may not extend our life in years, we can minimize the amount of time that we are highly dependent, at the mercy of physical limitations or frail.



A few years later, more evidence emerged from Dr. Ralph Paffenbarger, founder of the College Alumni Health Study at Harvard and Penn. He attempted to tease out the specifics of exercise levels and the effect it had on mortality. Paffenbarger stated “the data suggested a protective effect of exercise against all-cause mortality in all age groups studied, and therefore an indication of additional years of life expectancy.” The authors categorized physical activity by the number of calories burned approximately every week, and the lowest death rates were seen with those who expended 3,000-3,500 calories per week in physical activity. Ok, sold! Not only is life better, it is a little longer. Sounds like an infomercial. What’s the catch?

Reserve capacity is a concept used in kinesiology that refers to maintaining a reserve of ability while completing a task. This reserve capacity allows us to get things done without bending over exhausted. One reason why someone would choose not to climb stairs or go on a hilly walk is that either their cardiac output or their ventilatory capacity is maxed out and they are unable to complete the task. So they choose the elevator or the scooter. This leads to a state that Frank Booth calls physical activity deficiency (PAD) and makes it harder for humans, or any animals, to maintain a homeostatic state. It becomes harder to control blood sugars, which leads to greater stress on glands and organs and leads to more damage to nerves. Senescence happens and there is no stopping it, but the natural rate of decline in the body might be something we can modify, and probably not with mega-doses of vitamins.

One way for someone to track their capacity against age is to look at their max  $\text{VO}_2$ . The American College of Sports Medicine publishes normative data regarding a variety of fitness parameters, max  $\text{VO}_2$  being one of them. Research suggests that a low  $\text{VO}_2$  ( $< 20 \text{ ml O}_2/\text{kg}/\text{min}$ ) is associated with a markedly increased risk of death from all-cause mortality. So, if I am struggling with climbing stairs at age 50, I will spend many more years, potentially decades, saddled with the challenges of metabolic dysregulation and cardiovascular disease. More medications, fewer steps per day, and more muscle loss all add up to physical inactivity. For individuals who kept themselves aerobically conditioned into their 7<sup>th</sup>, 8<sup>th</sup>, or 9<sup>th</sup> decade of life, they bought themselves another trip to Hawaii to hike Diamondhead. And they won’t need the helicopter to get there.

Realistically, everyone knows that someday they will avoid a set of stairs due to the physiological challenge of climbing them, but the hope is they postpone that day as long as they can. Dosing in this most valuable medicine, physical activity, may likely pay the greatest dividend in the long term toward all those things you value doing with friends and family, no matter the season. While you work on your goal setting for the year, keep up the stair climbing.

Contact Rich at: [rbutler@canyonranch.com](mailto:rbutler@canyonranch.com)

Contributor:

Rich Butler, MS, USPTA

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

## THE FUTURE OF THE U.S. HEALTHCARE SYSTEM – PART 1

If one didn't know better, one would think the U.S. healthcare system were in dire straits. The country should have been celebrating that the uninsured rate dropped from 16.3% in 2010 to 8.8% in 2016. We should have been pleased that during this period the medical cost trends for the largest segments of the market (employer group plans, Medicare, and Medicaid) were among the lowest in thirty years, although still higher than we would like. Instead, the country spent two years (or, really, seven years) listening to rhetoric about the Affordable Care Act (ACA) and witnessing endless attempts to repeal it or weaken it, with the likely result of making robust coverage unaffordable or unattainable for millions of Americans.



### *Criticism of the ACA*

Most of the criticism of the ACA has centered on the individual market, which at 8% is the smallest market segment. However, Medicaid, with 20% of the market (49% of births and 64% of nursing home patients), also came under attack. The questions were legitimate: why are premiums rising so fast, and why are insurers dropping out of the individual marketplaces? The good news is the individual market could be stabilized, IF there were a bipartisan DESIRE to do so!

In a stable market, insurers could project costs accurately and avoid wide swings in premium rates. Actuaries who have studied the challenges and risks of the health insurance market conclude the key to stability is a better balance of enrollees by age and risk conditions.

A better balance can be attained while preserving the beneficial effects of the ACA. Lost in the lament over high deductibles are the advantages of being insured (even with a large deductible): financial security against bankruptcy by large medical expenses, preventive care benefits at no cost to the insured, and access to the insurer's provider discounts when accessing care. It is well known the ACA extended insurance coverage to over 21 million uninsured Americans. Less publicized are other beneficial effects, such as expanded prescription drug coverage to 44 million Medicare beneficiaries and the imposition of quality and medical loss ratio (the percentage of insurance premium dollars spent on healthcare claims) requirements on insurers.

### **Stabilizing the Individual Market**

The fundamental goal of the ACA was to provide access to affordable, robust insurance coverage regardless of health conditions and regardless of income. Here are five recommendations that would make the individual marketplaces actuarially sound while preserving the above goal:

1. Create stronger financial incentives for coverage. Actuaries have sufficient historical experience to know that a market cannot succeed unless there is a strong incentive for all eligible individuals to purchase coverage. If only unhealthy individuals join, premiums need to be set higher. But when faced with higher rates, healthier members skip coverage, thereby leaving only those with the more expensive healthcare needs in the marketplace, and, thus, pushing rates even higher.
2. Reinstitute a national reinsurance program. The existence of reinsurance during 2014-16 reduced rates at least 15-20% cumulatively.
3. Fund the cost subsidy programs for low-income families. The ACA requires insurers to cover these subsidies. Without government funding, premium rates need to be raised. These lead to higher government premium subsidies that are, in the aggregate, greater than the original cost subsidies because more families are eligible for the former than the latter.

Contributor:  
Roy Goldman, PhD,  
FSA, MAAA, CERA  
To learn more about  
Roy, [click here](#).

## THE FUTURE OF THE U.S. HEALTHCARE SYSTEM – PART 1

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4. Make insurance more attractive for younger adults. Age rating should reflect the true actuarial costs by age. The ACA artificially lowered premiums for older insureds causing younger enrollees to make up the cost difference. Premium subsidies and cost subsidies are currently more valuable to older insureds who have higher expected costs. They should be restructured to reflect both age and income instead of just income.
5. Establish a unique individual insurance market. There are currently two grandfathered non-ACA-compliant markets and two ACA-compliant markets, one on-exchange and one off-exchange. Having only one market would allow insurers to better predict who will enroll, leading to appropriate pricing and reduced anti-selection.

There is already a prototype for items #1-3. Policymakers simply need to emulate the successful and popular Medicare prescription drug program, Part D, which was passed with only Republican votes in 2003. It features:

- a strong disincentive for late enrollment
- risk adjustment, reinsurance, and risk corridor protection for insurers
- premium and cost subsidies for low-income enrollees

Despite the fact that prescription drug premiums are roughly 1/10 of medical premiums, in 2015 the government paid out \$31 billion in reinsurance in Part D vs. \$7.9 billion for the ACA. The government paid \$45 billion in low-income and retiree subsidies vs. \$32 billion under the ACA in 2014. No lawmaker has denounced these Part D payments as bailouts for insurers!

Unfortunately, as 2017 came to a close, none of the above actuarial recommendations were enacted. Instead, the Trump administration and the tax bill made the insurance markets worse:

- Cost subsidies are no longer being paid to insurers, thus, leading to unintuitive pricing (higher rates for silver plans than for a gold), unaffordable rates for those not eligible for subsidies, and greater government premium subsidies as discussed above.
- Elimination of the individual mandate beginning in 2019 will lead to healthier individuals leaving the market, thus causing the average premium rates to increase, which, in turn, will require larger government premium subsidies.
- No permanent funding for the Children's Health Insurance Plan (CHIP), which would put more low income families into the ACA markets. (With the passage of the Bipartisan Budget Act on February 9, 2018, CHIP is, apparently, funded for another ten years.)
- Possible future decreases in funding for Medicare and other government subsidized health programs may be required to offset the increased deficit created by tax cuts. (The Budget Act helped save some of these programs, but some states are now passing legislation that will restrict eligibility for Medicaid.)

Of course, insurers' rates for 2018 were set before the tax and budget acts were passed. Rates were increased to cover the loss of reimbursement for cost subsidies (CSRs) and the likely deterioration in the average health of those remaining in the market. The enrollment results are better than expected, with an overall 3.7% decrease: a 0.2% increase in the 15 states with state-based marketplaces and a 5.3% decrease in the 34 states using the federal marketplace. 2018 may yet see a national reinsurance program and funding of the CSRs. But there is still little attention focused on the growth of the unit costs of healthcare services. In the next issue, we will discuss how a single-payer system, or, more generally, a universal healthcare system could lead to lower costs if set up with appropriate utilization controls.

Contact Roy at: [roygo@earthlink.net](mailto:roygo@earthlink.net)



## MAKING THE BET ON POPULATION HEALTH PAY OFF: REALIZING “SYSTEMNESS”

Over the past few years, many large hospitals and academic medical centers (AMCs) have acquired, merged, or formed joint ventures with other hospitals, rehabilitation centers and skilled nursing centers, home care organizations, and urgent care centers. Much of this consolidation has been driven by the shift to a focus on population health, and the ability for health systems to adequately and cost-effectively addresses the needs of a population at every point along the healthcare continuum. The promise of population health is the delivery of more value at a lower cost by driving down variation in care so that caregivers and systems deliver quality care and eliminate procedures that do not contribute to health.



Sound as this premise is in theory, it will only pay off — for the health systems and for the health of the population — if these new organizations and alliances achieve “systemness.” By systemness, we mean acting as one organization, with a defined and aligned strategy, a clinical enterprise that shares data, protocols, and resources, and an administrative infrastructure that enables the operating entities to cost effectively provide value to the population.

Not surprisingly, health systems are struggling to achieve systemness. A Vizient 2016 report notes no evidence that large systems outperform smaller hospitals or systems on measures of quality or value. Vizient defines systemness as “a set of interconnected elements that behave as a whole, exhibiting behavior distinct from the behavior of the parts.” Based on their survey of over 150 health systems nationwide (including an AMC and large community-based systems), there was more variation in care **within** each health system than **between** different systems. They also note the unrealized value is high: if systems could consistently perform as well as their best quartile, the impact on both quality and cost would be substantial.<sup>1</sup>

Some of the learning from mergers and acquisitions in other sectors is pertinent here. The data shows fewer than half of all mergers succeed — that is, few realize the objectives that drove the merger in the first place. A 2013 L.E.K. Consulting analysis found that, out of 2,500 merger and acquisitions deals between 1993 and 2010, more than 60% had seriously negative effects on shareholder value.<sup>2</sup> It turns out to be much easier to estimate the economic impact of a merger, and much more difficult to change the on-the-ground processes and practices required to make it successful.

Not all aspects of integration are equally difficult. Different organizations will face different challenges, depending on their geography, mix of entities, cultural philosophies, histories, mission, and values. In this series of articles, we will introduce a few tools and ideas for realizing systemness by defining and aligning strategy and leadership, integrating the clinical enterprise, and enhancing corporate services.

We’ll explore issues such as:

- **Orienting changes to a shared purpose** — With a collective understanding of why and how the whole can be greater than the sum of its parts, leaders across the system can better adapt the broader goals to local situations.
- **Balancing centralization and distributed resources** — Systemness doesn’t mean uniformity or loss of autonomy. Just as clinical metrics need to vary across entities by case mix, administrative support will not work within a one-size-fits-all frame.

Contributors:  
Jennifer Tomasik, Carey  
Huntington Gallagher, and Lynn  
Oppenheim, WG ‘81  
To learn more about Jennifer,  
Carey, and Lynn [click here](#).

## MAKING THE BET ON POPULATION HEALTH PAY OFF: REALIZING “SYSTEMNESS”

*continued*

- **Promoting active learning and adaptation across entities** — If you allow some variation across entities, you have natural experiments, places where innovation can happen that you can learn from across the system. There is often an assumption that the largest or first hospital in the system will be the source of innovation, but *new ideas often come from places with tighter resources* that have more recently joined the system. Using success as your guide, no matter where it comes from in your system, furthers nimbleness in organizations that will be increasingly large and hard to change.
- **Engaging in cultural change** — Gains from system alignment cannot be met by policy alone. While policies are shaping, systemness is more related to how the organization works on a day-to-day basis. How do you ensure interprofessional collaboration doesn't become an empty buzzword? How can the corporate finance department best support registration in the new rural hospital? Taking the time to understand and support the key behaviors that will advance systemness will help realize the promise in sustainable ways.
- **Adapt communication and dissemination approaches to be more flexible** — While it is of course important that all the entities in a system follow current regulations, it is also important to have enough leadership and management flexibility to anticipate future changes. Within a bigger system, the same tools for dissemination of policies may not be adequate for all audiences. Rethinking how to monitor the environment and how to communicate changes is critical to ensuring the system is able to comply with regulatory changes or adapt to shifts in the different markets a system may serve.

A senior leader at an organization that had grown through aggressive acquisition once noted to us that he could tell the legacy organization of anyone in the company within five minutes of conversation. While this situation may remain true for a decade or more after a health system expands, it does not mean that systemness has not been achieved. The charge of creating an aligned health system is to ensure that people across the health system, no matter their role or location, understand enough of the organization to act on their contributions to the mission. With the right tools and processes in place, we firmly believe they can. The challenges of achieving systemness are significant but achievable. It requires investment—and not just the investment of putting the system together, but the continued investment over time in realizing systemness.

For more information on this topic or related materials, contact CFAR at [info@cfar.com](mailto:info@cfar.com) or 215.320.3200 or visit our website at [www.cfar.com](http://www.cfar.com).

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## TELEMEDICINE UPDATE: A FAMILY PHYSICIAN APPROACH TO ALLERGY AND CARE COORDINATION WITH THE ALLERGIST

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Charles Babbage is considered the “father of the computer,” as he conceptualized and invented the first mechanical computer in the early 19<sup>th</sup> century. Intel launched the first microprocessor chip in 1971, and a computer took up an entire room. In 1972, Murphy and Bird conducted 500 patient consultations via interactive television, and Bird offered the first formal definition of telemedicine. He refined his definition of telehealth to include, “the practice of medicine via interactive audio-video communication system” in 1975.



Fast-forward to 2017 where three billion people carry smartphones in their pockets, each more powerful than that room-sized computer. Telemedicine and telehealth are also more clearly defined. According to the [AAFP](#), telemedicine is “the practice of medicine using technology to deliver care at a distance, over a telecommunications infrastructure, between a patient at an originating (spoke) site and a physician, or other practitioner licensed to practice medicine, at a distant (hub) site.”<sup>1</sup> Telehealth refers to a broad collection of electronic and telecommunications technologies and services that support at-a-distance healthcare delivery and services. Telehealth technologies and tactics support virtual medical, health, and education services.<sup>1</sup> mHealth, on the other hand, is known as mobile health and is form of telemedicine using wireless devices and cell phone technologies.<sup>2</sup>

Why is there such a need to change how we practice medicine? According to projections by the [Association of American Medical Colleges](#), the nation will be short more than 90,000 total physicians by 2020, and 130,000 physicians by 2025.<sup>3</sup> The *Annals of Family Medicine* projects the United States will need 52,000 more primary care physicians by 2025.<sup>4</sup> Access to specialist care can also prove challenging, as it is often limited to academic centers. Telemedicine can be leveraged to improve access to not only family physicians, but specialties, in particular, allergists. With approximately only 3000 active allergists nationwide,<sup>5</sup> telemedicine offers the advantage to facilitate care coordination between specialties. This is already an integral component of family physician visits, and soon to become more valuable as we see a change in payment models.

Today, 75 percent of health plans offer telemedicine service reimbursement, and according to the [American Telemedicine Association](#), more than 15 million Americans received some form of medical care remotely in the last year. However, telemedicine is not as simple as “skyping” with a patient. Web-side manner, physical examination, clinical decision-making, documentation and care coordination need to be adapted for a video platform, in addition to supporting a HIPPA-compliant technology platform.

The top 5 urgent care conditions currently treated through telemedicine services are allergies, cough, upper respiratory infections, sinusitis, and rashes. The prevention, diagnosis, and treatment of allergic and immunologic conditions are everyday occurrences for the practicing family physician, whether it be the management of more benign conditions (e.g., allergic rhinitis) or severe and potentially life-threatening conditions (e.g., anaphylaxis, status asthmaticus).<sup>6</sup> Let’s discuss how telemedicine can be used to diagnose allergic rhinitis and improve care coordination with allergists.

Allergic rhinitis is the fifth most common chronic disease in the United States, and affects about one in six Americans.<sup>7</sup> Allergic rhinitis also accounts for as much as \$2 to \$4 billion in lost

### Contributors:

Minoti Parab, MD and Tania Elliott,  
MD, FAAAAI, FAAAAI

To learn more about  
Minoti and Tania, [click here](#).

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productivity annually, and an estimated 800,000 to 2 million lost school days.<sup>8</sup>

Although few studies exist on how to differentiate among types of rhinitis, a thorough and comprehensive history usually suggests the correct diagnosis.<sup>9</sup> A focused physical examination should follow the history. Acute illness with a viral infection will cause more generalized symptoms and occasional fevers pointing towards the most common type of nonallergic rhinitis. Whereas, patients with chronic allergic symptoms may have allergic shiners (i.e., blue-gray or purple discoloration under the lower eyelids), or they may breathe through their mouths, both of which signs can be seen with high quality webcams. Conjunctivitis, also seen via webcam, can be a component of allergic rhinitis or acute viral upper respiratory infection (URI). A careful examination of the nose is important to identify structural abnormalities, obvious polyps, mucosal swelling, and discharge. Examining the pharynx for enlarged tonsils or pharyngeal postnasal drip also can help identify viral causes or chronic drainage from chronic rhinitis.<sup>9</sup> This can be addressed with the use of peripheral devices, that employ store and forward technology, typically from an originating site. Lymphadenopathy, which can be addressed by a physician directed physical exam, may suggest a viral or bacterial cause of rhinitis,<sup>9</sup> whereas, wheezing or eczema suggesting an allergic cause, may be detected through webcam and peripheral devices.

Aside from adapting for a telemedicine physical exam, the diagnosis of allergic rhinitis through history, as well as, initiation of treatment using over the counter/prescription medications, and counseling are similar to office based practice. Using real-time video consultations with a patient from their home can be tremendously valuable for allergy patients. Video enables the trained physician to see directly into the patient's home to provide guidance on trigger avoidance, thereby helping to make a more accurate recommendation based on environmental context. It also enables a physician to interface directly with a patient during a time of need.

Family physicians should send patients for an in-person office visit, or refer patients to an allergist when immunoglobulin E-specific skin or blood testing is recommended when first line treatment (e.g., environmental controls, allergen avoidance, medication) has been ineffective, a diagnosis of allergic rhinitis is uncertain, identification of a certain allergen could affect therapy, or to aid in titration of therapy.<sup>7</sup> Other reasons to refer to an allergist include evaluation of primary immunodeficiency, and interpretation of Immunocap (formally RAST testing) results, as well as, difficult to treat asthmatics, initial workup for food allergy, management of urticaria and angioedema, and evaluation and management of atopic and contact dermatitis. Allergist referrals typically and historically take place in an office setting; however, average wait time to see an allergist in the office is approximately three weeks. Allergists can also utilize telemedicine for some visits. Not only does telemedicine promote longitudinal care coordination, but new technology such as three-way video conferencing, improves collaborative care allowing the patient visit to occur with the family physician and the specialist at the same time.

Aside from allergic rhinitis, telemedicine for chronic disease management of other allergic diseases is promising. Allergic asthma or extrinsic asthma is the most common form of asthma and it is defined as asthma caused by an allergic reaction. A recent Cochrane review concluded current randomized evidence does not demonstrate important differences between face-to-face and remote asthma check-ups in terms of exacerbations, asthma control, or quality of life.<sup>10</sup> A follow-up randomized, controlled trial demonstrated that telemedicine was as effective as in-person care for children with asthma.<sup>11</sup>

Additional telemedicine applications for patients with asthma include real-time advice in a setting of perceived asthma exacerbation, proper inhaler technique, home environmental trigger assessment, medication management, and real-time video guidance with school nurses and teachers. Remote video visits will continue to expand in scope of practice as more store and forward technologies come



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on the horizon, from stethoscopes to interactive asthma pump device counters. Improved molecular diagnostics and interactive patient engagement apps will give physicians the additional tools they need to catch disease early and keep patients motivated and engaged in their healthcare.

Telemedicine can improve patient outcomes, not only through initiating timely medical visits for minor urgent care complaints, but also by monitoring chronic conditions more closely, and allowing greater time for counseling. Telemedicine does not only improve patient access to care with family physicians, but it also improves access to specialists and help with care coordination. The time for virtual visits is no longer the future of medicine; it is now.

Contact Minoti at: [MParab19@humana.com](mailto:MParab19@humana.com)

Contact Tania at: [tmucci@gmail.com](mailto:tmucci@gmail.com)

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## **FEE-FOR-SERVICE TO VALUE-BASED PAYMENT TRANSFORMATION, PART 3 : BEARING FINANCIAL RISK IN A CHANGING LANDSCAPE: ARE YOU READY? PART B**

### **Introduction**

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

Entering into value-based payment (VBP) arrangements are designed to reward physicians, hospitals, and health systems for achieving positive health outcomes while simultaneously decreasing or maintaining costs. In this installment of our value-based payment series, we will look at some more characteristics of evaluation readiness to move away from traditional fee-for-service payments and toward an alternative payment mechanism or some risk-bearing arrangement(s). 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 our last installment ([Part A](#)), we outlined the first four readiness characteristics. In this article, we will outline the rest of these broad domains, including indicators of readiness and characteristics of “ready” organizations.

### **Previous Experience with VBP and/or Bearing Financial Risk**

Novelist Neil Gaiman is quoted as saying: “*Sometimes the best way to learn something is by doing it wrong and looking at what you did.*” This thinking applies to organizational change as much as it does to learning a new skill or methodology. Healthcare enterprises that have entered into risk-bearing financial arrangements resulting in either success or failure are likely more in tune with organizational strengths or weaknesses to be cognizant of while considering potential opportunities. Further, even when not having entered into risk-bearing arrangements, other VBP programs, such as shared savings, offer lessons to be learned and/or tools to apply. Sometimes with leadership change, the lessons of the past are lost, so seeking knowledge from longer-tenured governance bodies (such as the Board of Trustees or Board of Directors) can shine a light on the past. Further, physicians/providers can offer their perspective on past arrangements and performance, and may have a different and oftentimes valuable perspective on successes and failures than administrators.

### **Indicators of Readiness for Risk-Bearing Arrangements include:**

- documented lessons learned from prior financial losses and/or under performance and,
- investments made since that time in: information technology, partnerships, affiliations, quality improvement, clinical care model re-design such as care pathways and other core domains.

Contributors:

Lisa Soroka and Wren Keber

To learn more about Lisa, and Wren, [click here](#).

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### **Administrative and Contracting Infrastructure**

All risk-bearing arrangements have some level of administrative overhead and require the capacity and ability to handle those demands; this is no different than administering more traditional fee-for-service payment arrangements. However, in risk-bearing arrangements, these administrative requirements not only can vary widely but also can often be more complex than those needed under fee-for-service.

For example, entering into a bundled payment arrangement often requires the lead contractor (risk-bearing organization or RBO) to build a network for all services covered within the bundle, as well as to calculate payments to each of their partners. This administration requires dedicated resources (i.e., staff) to monitor the various metrics employed in payment calculations. Outside of financial requirements, there must be adherence to clinical care standards and quality measures. Depending on the arrangement, these standards and measures can impact payment and also may trigger necessary clinical performance improvement interventions.

In another example, entities entering into full-risk arrangements (e.g., sub-capitated or global payment) may choose to pay fee-for-service to downstream providers in their network, such as to facilities (hospital or other) or to specialists/sub-specialists. This requires the ability for this entity to process fee-for-service claims, or at least to procure and administer a vendor arrangement with a third party administrator (TPA) to conduct these functions.

The entity's contracting infrastructure requires many tools to effectively negotiate with managed care health plans for risk-bearing arrangements. Pricing risk-bearing arrangements properly requires a complete understanding of costs (in many cases, not equal to charges in FFS) for delivering clinical care across the full continuum. In addition, an effective cost accounting system or a proven cost allocation methodology is critical to attain a complete understanding.

Armed with these tools, contractors/RBOs will be optimally equipped to calculate pricing levels that help set them up for financial success when managing utilization in various expense categories (a.k.a. risk pools) and other key metrics. Further, clinical quality is a key upstream measure of overall utilization and ultimately population health management; therefore, the ability to employ clinical data in the contracting function is important. Clinical leaders are able to highlight where there are opportunities to manage clinical quality indicators, thereby potentially impacting downstream financial metrics. Seeking support from both in-network and external partners/providers during the contracting process is important to ultimately achieving success during the performance periods of the final contract.

### **Indicators of Readiness for Risk-Bearing Arrangements include:**

- mature accounting systems or contracted partnerships for calculating total cost of care and grouping by expense category and establishing a risk pool
- ability to track utilization patterns in near real-time, such as a data warehouse containing claims and/or billing data, and a toolset to analyze and generate utilization reports
- highly competent, experienced healthcare finance and accounting staff to generate projections and advise management/leadership on strategies/tactics for managing performance as well as to calculate payments as required
- and for successful contracting, access to actuarial support (in-house or contracted) to support pricing for risk-bearing payment arrangements

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### **Financial Standing and Capital Investment Capacity**

Entering into risk-bearing arrangements can be a costly endeavor. Throughout this article series, we have discussed many indicators of readiness for risk-bearing arrangements. For organizations that currently do not have these capabilities, they need to be built or bought. Because these kinds of investments can be costly, good financial standing – including generating margin in the existing fee-for-service/pay for performance (P4P) environment - is important.

Even for those RBOs that have carefully prepared to enter into risk, they should build in requirements to keep risk-based capital in reserve. Names for this reserve vary from state to state, however the concept is the same: sufficient cash on hand (or easily accessible) to cover financial losses and ultimately payments to parties owed. The more risk an arrangement transfers from the licensed insurer (plan) to the new risk-bearing entity, the higher the reserves required. In addition to capital reserves, in many states, full risk or near-full risk requires regulatory licensure; in California, for example, this licensure is called a Knox-Keene or, more commonly for providers, a Restricted (Limited) Knox-Keene. This licensure process also requires investment and often third-party support.

### **Additional Indicators of Readiness for Risk-bearing Arrangements include:**

- access to capital to cover requested investments and/or risk-based capital
- willingness to make major investments as recommended by management and/or executive leadership
- appropriate licensure procured, or planned/in progress
- and access to lines of credit, if necessary, for short-term leverage (in compliance with regulatory requirements – varies by state).

### **Conclusion**

In conclusion, organizational readiness is not limited to the six described domains, but organizations with these readiness indicators are better poised for adoption of value-based payment models and success under these arrangements.

Contact Lisa at:  
[lisasoroka@themarbleheadgroup.com](mailto:lisasoroka@themarbleheadgroup.com)  
310.503.5510

Contact Wren at:  
[wkeber@copehealthsolutions.com](mailto:wkeber@copehealthsolutions.com)