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HEALTH CARE MANAGEMENT
ALUMNI ASSOCIATION

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EDITOR'S LETTER

In addition to our standing columns and usual coverage of up-to-the moment topics, this issue is filled with articles which highlight the hope, promise, potential, and success that are possible even in the midst of all the challenges which exist in healthcare today and the foreseeable future. They inspire and also remind me of three quotes that are among my favorites:

- “Never doubt that a small group of thoughtful, committed, citizens can change the world.”

~ Margaret Mead

- “I am only one, but still I am one. I cannot do everything, but still I can do something. And because I cannot do everything, I will not refuse to do the something that I can do.”

~ Edward Everett Hale

- “The people who are crazy enough to think they can change the world, are the ones who do.”

~ Rob Stiltanen



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


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

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

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THE PRESIDENT'S DESK

July is a time of change for the WHCMAA. We say good-bye to current Board members and welcome new ones.

To departing Board members Mitch Goldman WG'75, Doug Arnold WG'84, Bryan Bushick WG'98, Jeff Smith WG'99, Marina Tarasova WG'10, and Jenny Rizk WG'14, a hearty "Thank you!" for your collective service to the Association and the entire Wharton Community.

To incoming Board members Chris Simpkins WG '02, Roman Rubio '03, Brian Holzer WG '05, Diana Peng WG '13, Ryan Vass WG '14, and Dan Mulreany WG '17, a warm welcome as we kick off 2018-2019.

My first stop will be at Huntsman Hall in early August, where I'll be addressing the class of '20 during healthcare pre-term. My main message: "The Wharton community is worldwide, and we want to help you succeed." Bad jokes, worse singing, and a few thoughts on the state of U.S. health policymaking will be also be discussed.

Back from a one year hiatus, the WHCMAA Alumni Conference will be held this year on Friday, November 2nd at Huntsman Hall on Wharton's campus. Conference Co-Chairs Ed Chan, WG'11 and Reed van Gorden, WG'12 have confirmed Commonwealth Fund President, David Blumenthal, to keynote the conference.

If you attend the conference, consider coming in Thursday evening, November 1st to attend the dinner the night before. We'll fete the winners of the Alumni Service and Lifetime Achievement awards, and hear from the student winners of the Kinney and Kissick Scholarships. (These are the highlight of the two days, in my opinion).

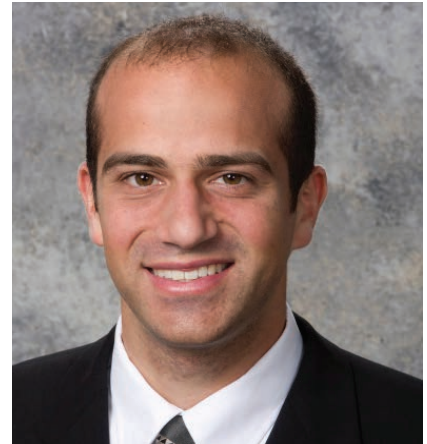
We're also planning events in Boston, San Francisco, New York, and DC for the first half of the year, and we'd love to host events where you live as well. [Contact](#) us if you'd like to plan an event in your area.

My hope for this year is that the WHCMAA helps you engage with the Wharton healthcare community. Want to connect with fellow alumni? Attend a WHCMAA sponsored event. In the midst of a career change? Let us help you connect with career development resources. Looking to start a conversation? [Join](#) the Wharton Healthcare Knowledge Network or connect through one of our social media sites.


And if you want to take a more active role in the WHCMAA and its operations, we are always looking for volunteers to work on our programming, communications, membership, awards, career development and finance committees.

I hope to see you this year!

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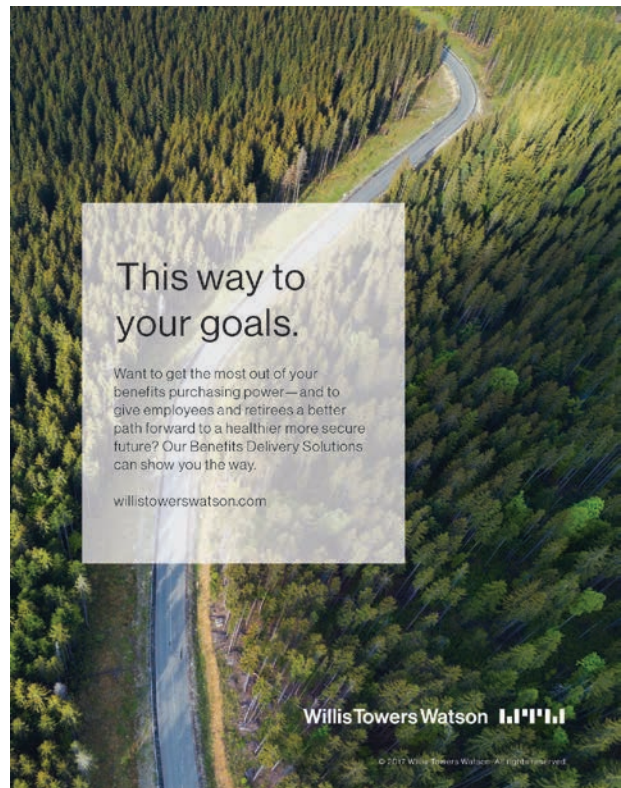
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THE PHILOSOPHER'S CORNER

Life Lessons:

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

...trusted my instincts and decision-making as competent, valid, and important.

I'm not sure whether my lack of confidence 'then' (while I was in grad school) stemmed from gender or self-esteem issues — possibly a bit of both. I attended an undergraduate college that had only recently gone co-ed (I was in the minority), and, following college, chose an industry dominated by men. Additionally, I continued to migrate toward environments that were high energy and numbers-oriented. As a right-brained female working from intuition, imagination, and holistic thinking, the glaring difference between my skills and those around me skewed my perception of my ability to make a difference. As a result, I valued others' perspectives before mine.

Fortunately, time allows for reflection, and with maturity comes insight. I see so clearly now how every voice contributes to a better understanding of situations. My take-away? Being an artist among a pool of mathematicians is good, and sharing a lone voice with a different perspective matters. What prevails in conversation, process, outcome, and life does reflect the sum of inputs.

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

...quietened self-doubt and communicated my views much more assertively.

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

...worried quite so much.

I can finally look at a worry and ask myself "toward what end?"

For years I would agonize, overthink, and stress about responsibilities and interactions. While I relied on that energy to leverage focus, the constant unease also wore me out. I think it contributed to stagnation as well.

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

...dwelled in a state of anxiety about much. Rather, I would have counseled myself to isolate what mattered — something that would have helped to strengthen my leadership and decision-making skills long ago. I would not have deferred to the thinking of others so easily. Instead, I would have trained myself to dim the noise of other opinions and consider more carefully my own understanding, instincts, and perspectives. And, I would not have allowed myself to become overly concerned about mistakes. Somehow, I had the feeling that they pointed to success-limiting flaws.

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

...approached my years of school and professional challenges without a guiding set of objectives that I now embrace.



This month's philosopher:
Beverly Bradway WG'91
To learn more about Beverly,
[click here.](#)

THE PHILOSOPHER'S CORNER

Recommended Reading:

- *The CEO Next Door*, by E Botelho and K Powell (2018)
 - A research based presentation on the characteristics, skills, and habits of successful CEOs. A book that informs not only those pursuing the top jobs, but anyone who wants to understand paths to leadership success. (Botelho received her MBA from Wharton)

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ALUMNI NEWS

Laurita M. Hack, DPT, PhD, MBA, FAPTA

I have been invited to present the Mary McMillan Lecture for the American Physical Therapy Association in June 2018 in Orlando, Florida. The Mary McMillan Lecture is the most distinguished honor an active APTA member physical therapist or life member can receive. This lecture is regarded as one of the keystone events at APTA's NEXT Conference and Exposition. This award recognizes those who have demonstrated exemplary skills in the areas of administration, education, patient care, management, and research.

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[Learn more.](#)

Lisa David, WG'84

I am in my 3rd year as President and CEO of Public Health Solutions in NYC. We provide community-based services in marginalized communities, do research and evaluation on public health issues, and partner with the NYC Department of Health and Mental Hygiene to administer contracts on their behalf. We focus on young families in marginalized neighborhoods, providing food and nutrition, health insurance, maternal health and early childhood development, and reproductive and sexual health education. New to public health, I have learned so much; mostly good stuff and some very frustrating.

My husband, Ernie Berger (WG'84), is working for a tech start-up that makes very small microchips that provide a range of functionality that fit in credit or identity cards. Our 2 daughters are in NYC, living on their own, and quite happy in their lives and jobs. So they survived us!

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ALUMNI NEWS

Jill Ebstein, WG'83

Volume 3 of *At My Pace* was launched 4/22. This book focuses on millennials and is titled, *At My Pace: Twenty Somethings Finding Their Way*. As in previous books, this one 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 contributor's 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.

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[Learn more.](#)

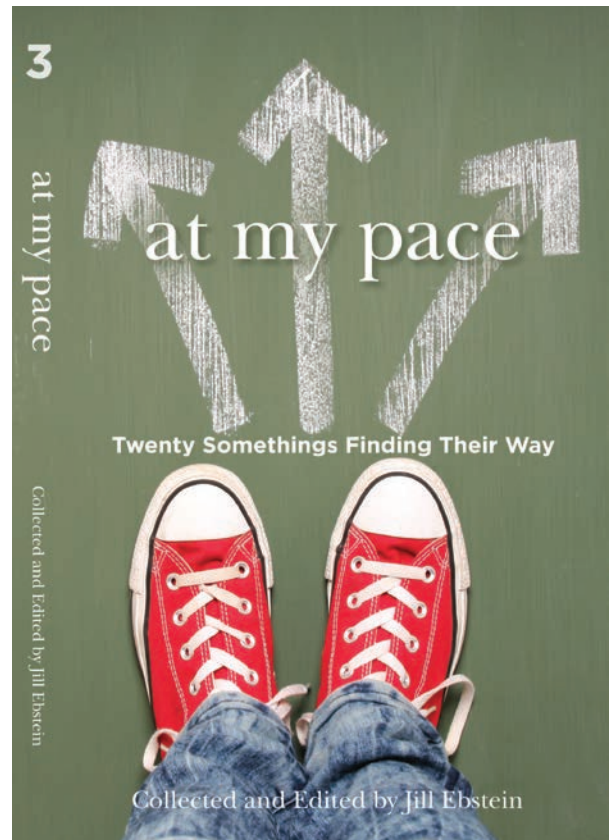
Jennifer Perry, WG'89

Jennifer Perry, Principal of Healthcare with FMG Leading, was recently published in a *Harvard Business Review* article highlighting the common leadership path for physicians and the importance of building management skills and leadership capacity. The article was based on the thought leadership and experience of FMG Leading, a human capital strategic advising and consulting firm supporting healthcare organizations with transformational culture, change, and leadership.

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[Learn more.](#)



ALUMNI NEWS

Isaac Bright, WG'06

Isaac Bright (WG'06) has launched a new biotherapeutics business – [RubrYc Therapeutics](#). The company just completed a \$10M Series A financing led by Third Point Ventures, Paladin Capital, and Vital Venture Capital. Inspired by recent advances in molecular library synthesis and massively parallel screening and computing, RubrYc is forging a new path for information-driven discovery of therapeutic antibodies and related therapies. Using the RubrYc Interface Discovery Engine, the company can decode protein interactions through the integration of predictive analytics and biological measurements. This interface-targeted approach allows RubrYc to accelerate pre-clinical therapeutic antibody discovery, while minimizing many of the risks of industry-standard early-stage R&D.

Founded in 2017, RubrYc Therapeutics, Inc. emerged as the exclusive biotherapeutic partner of immunomics leader HealthTell. In April 2018, RubrYc Therapeutics, Inc., spun out of HealthTell to define its trailblazing role mining drug:target interfaces to build better therapies. RubrYc is supporting both proprietary discovery programs and partnered development with top-tier pharmaceutical companies.

Contact Brian at:
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[Learn more.](#)

Austin Dixon, WG'13

Austin is graduating from Duke's diagnostic radiology residency program in May 2018. Austin will stay at Duke as a clinical and administrative fellow through Duke's Management and Leadership Pathway for Residents (MLPR), a 15- to 18-month rotational experience that allows trainees (residents and fellows) to work on high-priority initiatives across the Duke University Health System and the School of Medicine.

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ALUMNI NEWS

Aashish Bapat, WG'13

After working with Bain & Co, and two start-ups in health tech, I have joined Stryker Neurovascular as Senior Global Product Manager aiming to bring new technology to market in the hemorrhagic space. I am located in the SF Bay area and looking forward to staying in touch with the healthcare community.

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Andrew Barnell, WG'17

Geneoscopy LLC, a life sciences Company Andrew started during his time at Wharton, raised \$1.0 million to advance its stool-derived eukaryotic RNA (seRNA) diagnostic testing platform. Geneoscopy's method to extract and analyze seRNA enables accurate and non-invasive diagnostic tests to prevent, detect, and monitor gastrointestinal (GI) disease. Funds will be used to advance the company's lead product, a preventive screening test to diagnose colorectal cancer and precancerous adenomas in asymptomatic individuals, as well as several other pipeline products.

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[Learn more.](#)

NOT A FREUDIAN SLIP: PERSONALIZED HEALTH IS OFTEN NOT PERSONALIZED OR HEALTH – PART 1

There is quite a bit of confusion and misconception about personalized health. Many times, “personalized” health doesn’t consider the whole person, the realities of life, or a person’s emotional state or mental ability to recover, heal, or change. And even though a clinical lens provides insight into significant advancements in treating injuries and illnesses, we are missing a major part of the equation related to making an impact on health outcomes.

What is personalized health and how is it different from similar terms like personalized medicine, precision medicine, and personalized healthcare? And why is it important to bring clarity around these terms that are used interchangeably? Could confusion over these different terms cloud a critical component, and have us missing what people define as personalized health? In this two-part series, we will distinguish the differences between these often confused terms and reveal how limiting the view to diseases, physical and biological measures, and treatment recommendations may hinder one’s ability to make healthy choices and experience whole health.



Distinguishing Differences

Personalized medicine, also called precision medicine, is defined by the National Institutes of Health (NIH) as “an emerging approach for disease treatment and prevention that takes into account individual variability in genes, environment, and lifestyle for each person.”¹

Personalized medicine came out of an effort to shift away from reactive, disease-focused healthcare to a more individualized approach focused on prevention using genomic and non-genomic data to predict disease. Personalized medicine, a medical delivery segmentation model of sorts, uses a person’s unique molecular and genetic profile to direct treatment. However, “[personalized medicine] is sometimes misinterpreted as implying that unique treatments can be designed for each individual.”²

Personalized healthcare is a broader, more strategic approach that uses personalized medicine tools and health assessments to predict health risks and form a targeted treatment plan. The clinician and patient partner together to plan, set goals, and monitor progress to strengthen care coordination and patient engagement.³

We know that people’s genetic make-up differs. By matching a person’s DNA to the most appropriate clinical procedures and medication, new clinical recommendations can reduce negative impacts like side effects or even augment disease susceptibility. With precision medicine advancements, clinicians will continue to more accurately pinpoint treatment recommendations, strengthening positive health impacts.

Much of the press around precision medicine holds promise for improving healthcare while also lowering costs, but what is the reality? Precision medicine aims to find the best medication and treatment for a person, which should lead to better outcomes. But does this mammoth undertaking really matter, especially when we look at the top ten causes of death? Can a person’s genotype direct an approach that produces better outcomes than the traditional clinical measures [gender, age, weight, etc.] used to prescribe treatments? And would the cost versus benefit of this complex, personalized approach make more of an impact than healthy lifestyle modifications on overall health outcomes for chronic conditions?

NIH’s landmark \$1.5 billion precision medicine [All of Us Research Program](#) opened nationwide enrollment May 6th. This extraordinary project will collect and analyze terabytes of genetic, biological, environmental, health, and lifestyle data from 1,000,000+ people to

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Connie, [click here](#).

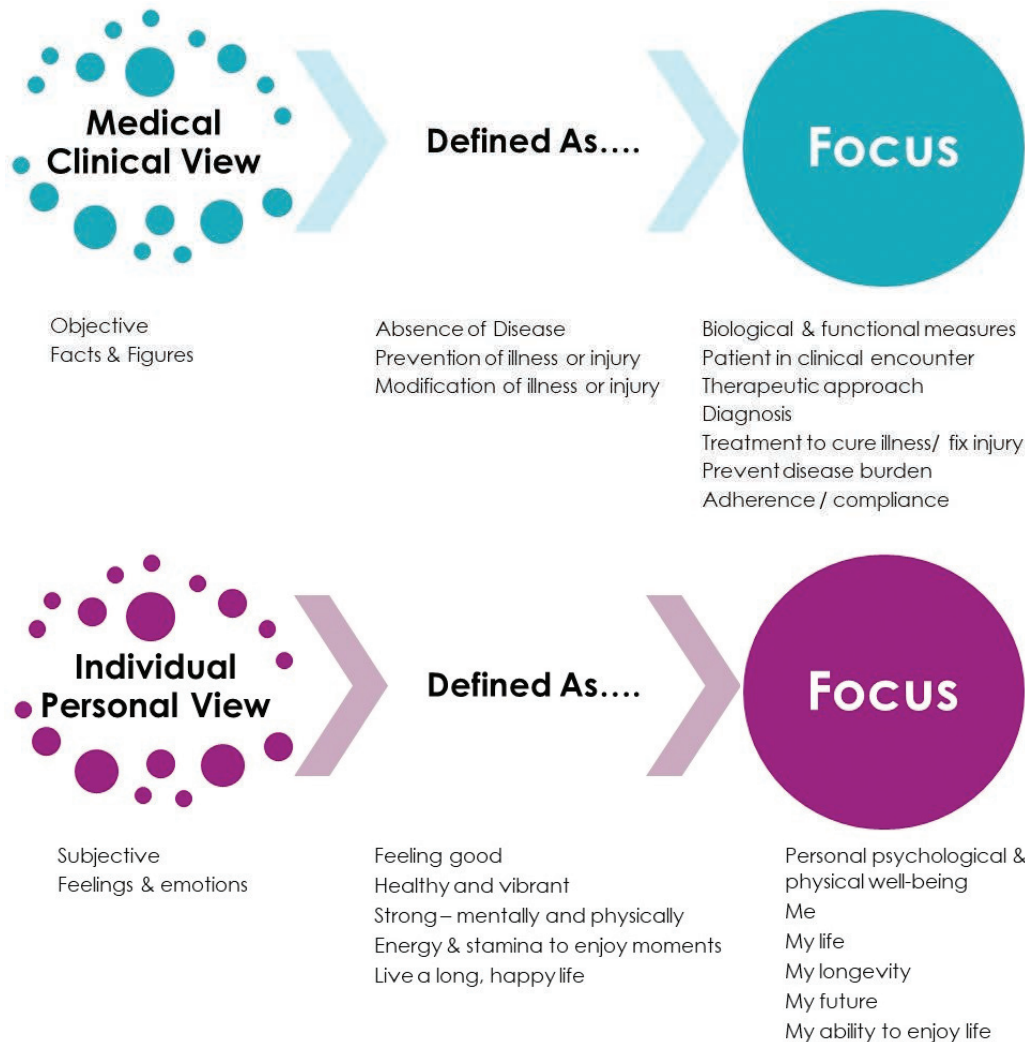
NOT A FREUDIAN SLIP: PERSONALIZED HEALTH IS OFTEN NOT PERSONALIZED OR HEALTH – PART 1 *continued*

“accelerate health research and medical breakthroughs, enabling individualized prevention, treatment, and care for all of us.”⁴ Through this endeavor, we will soon know the impact of personalized medicine on cost and outcomes.

Don’t get me wrong, I am one who loves to identify trends across data to uncover nuances and similarities to strengthen existing solutions. However, since we know behavior impacts a large portion of our health [40%] and our behavior is directed by our decisions, I propose we focus on helping people make smarter decisions around lifestyle factors like diet, activity level, stress, sleep patterns, risky behaviors, etc. Besides, focusing on increasing knowledge and truly supporting change and skill development are less expensive ways to impact health outcomes for more people.

Making It Personal

How is personalized health different? When most people define health, statements like feeling good or having the strength and stamina to do the things in life that are important to them are typical. In the medical arena, however, health is more traditionally defined as the absence of disease. Of course, people want to be free from disease and reduce their likelihood of injury or illness. But this is more biological and functional, an objective view that takes the stance that the healthcare “system” is working to “fix” or “treat” or “prevent” these negative diagnosis or conditions.



NOT A FREUDIAN SLIP: PERSONALIZED HEALTH IS OFTEN NOT PERSONALIZED OR HEALTH – PART 1 *continued*

Even though medical research and terms like “real world evidence” are getting closer to tapping into the realities of a person’s daily life, these encounters are still seen from a clinical eye with a focus on adherence and compliance with evidence-based treatment recommendations. This lens is necessary, and I appreciate the significant advancements that have allowed people to live longer, more fulfilling lives. However, including the missing element of human emotions and the realities of everyday life, by looking deeper into personal dynamics and idiosyncrasies of behaviors, might prove more impactful. As [previous insight](#) reveals, autonomy, along with motivation and intention, are the factors that drive, predict, and influence behavior change.

Health interventions should go beyond individual preference for communication channels and consider the person’s knowledge, feelings, and fears, as well as the cultural differences and societal dynamics that influence habits. However, the negative stigma surrounding emotions and mental health is limiting our ability to provide the type of health support that can be the most beneficial.



In Part 2 we will expand the scope of health beyond medical procedures and clinical diagnosis and look at how our thoughts, feelings, and behaviors impact the bigger picture of whole health. By doing so, I am hopeful we can bridge the mind – body gap in our health “care” approach and align with an individual’s definition of personalized health to have a greater chance of making a positive impact.

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AFFIDAVIT: HEALTHCARE AND THE LAW - THE HEALTHCARE CLOUD - LEGAL ISSUES

Cloud-based services are revolutionizing the healthcare industry and providing significant business opportunities. Consider the following: globally, the revenue generated for healthcare cloud services purchased by healthcare providers is predicted to reach roughly \$10 billion by 2021. The cloud offers remote access to data, exponentially more storage, data analysis tools, and other applications and content on a worldwide basis. But cloud services typically are commodity services with little differentiation between them, and are offered on a 'take it or leave it' basis, leaving healthcare purchasers with little or no opportunity to negotiate a cloud service contract that suits their specific needs, including, in particular, with respect to the privacy of healthcare data and the security of the cloud service that is being purchased. However, depending on factors such as size, prestige, and type of data being stored, some purchasers may have negotiating leverage. And although the cloud services offered by the brand companies are well known, there are an increasing number of smaller vendors that may be more willing to negotiate terms. This article provides some additional background of cloud services in healthcare and addresses the data privacy, system security, and other contract issues that are important for purchasers to consider.



On average, companies can utilize anywhere from 900 to 1,200 different cloud-based services for different business needs such as back-office support, like email and data storage (including data in electronic health records); ongoing support for the secure exchange of patient information; analysis of big data; assisting with virtual care or telemedicine services; and supporting patient empowerment tools. The pooled resources of networks, servers, and storage applications supporting these services can be delivered through private, public, and hybrid cloud environments. With the private cloud, a single healthcare provider, such as a hospital, owns the servers and other computing resources and retains exclusive control over resource utilization, whereas the public cloud is typically a multi-tenant infrastructure environment available to a number of different healthcare provider customers that use the same hardware, storage, and network devices through an internet connection. The public cloud infrastructure exists solely within the premises of the cloud services vendor and can be paid for by organizations on an as-needed basis. The hybrid cloud is characterized as some combination of both the public and private cloud environments where healthcare providers can house their more sensitive, critical data and applications in the private cloud and manage higher-volume assets in the public cloud. Healthcare providers can use existing infrastructure and data storage capabilities, but as they outgrow their private cloud space they can buy space from colocation partners or from the public cloud to house additional data and free up private cloud space as needed, relieving burdens associated with purchasing additional hardware and software.

The varying levels of control under these different models affect the contract terms that are appropriate to address each party's responsibility for data security. Since IT infrastructure can be designed in a number of ways to adequately address each company's specific needs, healthcare providers have much to consider when deciding how and where to store their data. Naturally, cost is an essential component in making these decisions. Cloud-based solutions can cost significantly less than traditional on-premises solutions, because organizations can acquire and pay for services as needed while avoiding the burdens of owning and managing their own hardware. Given that purchasers are only responsible for monthly or yearly fees based on the services used, healthcare providers can benefit from the scalability of cloud-based systems as they continue to grow and collect more data over time.

However, healthcare businesses should proceed with caution when entering into cloud services agreements because not all cloud services and cloud service vendors are created equally. For instance, some cloud service companies, including the large ones, may offer

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

AFFIDAVIT: HEALTHCARE AND THE LAW - THE HEALTHCARE CLOUD - LEGAL ISSUES

continued

multiple products and a range of support of other resources, but they may not always be well-suited for the healthcare space. These vendors may have little or no experience with the laws and ethical obligations regarding data faced by healthcare providers, and their products and systems may not be sufficiently agile to address these specific needs. For instance, a contract research organization (CRO) supporting clinical trials for opioid treatment may require more comprehensive security controls and safeguards to guarantee the protection of the data and achieve full regulatory compliance since substance abuse data is subject to higher security standards under the law. Is the vendor aware of these legal requirements and can it accommodate them?

Other related concerns include privacy and notification provisions related to an individual's health data known as protected health data (PHI). In response to the widespread adoption of cloud computing solutions, the Department of Health and Human Services' Office of Civil Rights, the government entity that oversees compliance with the Health Insurance Portability and Accountability Act (HIPAA), clarified that when a HIPAA covered entity engages a cloud services vendor to create, maintain, or transmit PHI on its behalf, the cloud services vendor is a business associate under HIPAA. This is true even if the cloud services vendor processes or stores only encrypted PHI and lacks an encryption key for the data. The healthcare provider and the cloud services vendor must enter into a HIPAA-compliant business associate agreement under which the cloud services vendor is both contractually liable for meeting the terms of the business associate agreement and directly liable for complying with requirements under HIPAA. Therefore, legal responsibility under HIPAA is shared between the cloud service vendor and the healthcare organization, and the vendor is obligated to provide security controls that satisfy HIPAA requirements, offering healthcare organizations an opportunity to negotiate for more extensive controls.

When healthcare providers rely on cloud services vendors to store their data, they are sacrificing some control over where and how such information will be stored and healthcare providers will want to negotiate strong cloud service agreements with detailed provisions relating to security and privacy. Healthcare providers will want to stay informed of where and how ePHI is moved, handled and stored by their cloud services vendor, especially since moving data internationally is an increasingly common way for cloud services vendors to cut costs. Additionally, since it is impossible to fully guarantee privacy and security, providers would be wise to purchase adequate insurance.

Conclusion

As healthcare providers continue adopting and relying upon cloud-based services, it is imperative that they understand key terms in their agreements with cloud services vendors. The primary concerns will be related to privacy and security, but other critical concerns include fee increases based on updates in services or products provided by the vendor and termination rights based on said charges or data breaches. Cloud services agreements should include robust security and audit terms that require vendors to perform regular security audits and require that the cloud services vendor communicate the results of any audits back to the healthcare provider. In addition, these terms should permit healthcare providers to perform security audits on their own. Healthcare providers should also make sure to carefully protect any negotiated terms from being overridden by click-wrap agreements (a type of contract used with software licenses and on-line transactions in which a user must agree to terms and conditions prior to using the product or service) containing indemnity, arbitration, or governing law provisions that conflict with the service agreement. Healthcare providers with specific concerns related to cloud service agreements should contact a qualified healthcare attorney.

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DOWNLOADING SUCCESS: MERGING PRIORITIES: SYNCING YOUR BUSINESS AND TALENT STRATEGIES

Many leadership experts say it's time to knock down the silos in our organizations. While this is true, let's first understand why that is the case. If we are to innovate and disrupt our industries and our organizations, our executives must learn to become more than subject-matter experts, but savvy visionaries whose overarching concern is the health and strength of the entire enterprise, not just their department.

This is precisely where business strategy and talent strategy need to intersect and graft into each other. Today's healthcare leaders need:

- an enterprise mindset – think beyond your silo on what is best for the entire organization.
 - Are the leaders capable of looking over the entire landscape of your organization?
 - Do your leaders have a view from the bridge and not just the deck?
- a clear alignment on strategy and an obsession with getting the right leaders in the right seats on the bus.
- a rigorous commitment to developing others and ensuring this effort cascades throughout the organization.



As a CEO or other organizational leader, you should want your team to clearly understand what makes them tick, and how they can advance in the organization and their careers. In *Plato's Apology*, the ancient Greek quotes Socrates during his trial that "the unexamined life is not worth living." Having a talent strategy for your leaders is essential to develop and retain them, and assessments give a clear-eyed view of a leader's strengths, as well as the areas he or she needs to grow. Assessments add order to the creation of a powerful development plan for individuals. They also help increase team cohesion.

Results in Action

In one of our recent engagements with a leading academic medical center, we observed the power of assessment-guided development with one of the physician leaders we were coaching. We'll call him Dr. Pennington. He was a department chair and the attending physician. Most of the staff were used to Pennington constantly interrupting them, sometimes with an insulting comment. They were also used to him just ignoring them as well.

During morning rounds with a small cadre of attending physicians, surgeons, nurses, and physician assistants, one of Pennington's medical students began to give her report outside the room of the patient she had just examined. The young woman had barely gotten three sentences into her discourse of the patient's condition when Pennington cut in.

Inwardly, she sighed and froze. She had seen him making a face and looking at his mobile phone while she tried to gather her thoughts, and it flustered her. What was he going to say now? She and the other nine people on the rounds barely had time to surmise what was coming next when Pennington spoke.

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DOWNLOADING SUCCESS: MERGING PRIORITIES: SYNCING YOUR BUSINESS AND TALENT STRATEGIES *continued*

“Um, I need to apologize,” he said, looking straight at her. “First of all, I shouldn’t have been checking my phone when you were doing your best to convey what you found in your examination of the patient. And, second, I wasn’t frowning at what you said. I read an email on my phone, and I didn’t like its message.

“But in doing so, I distracted you. That was rude on my part. I’m sorry. Are you willing to start over, please?”

The young woman and the rest of the team were flabbergasted. Pennington wasn’t one to apologize. Ever. What had happened to him?

Here’s what happened: Pennington had recently completed a personality assessment, a very accurate piece of evidence-based social science. Pennington didn’t necessarily agree with the findings but, given his intellectually curious nature and desire to lead more effectively, he had been working to “catch” himself and modify his behavior. It wasn’t easy, and the results weren’t instant. But the episode outlined above showed real, forward progress.

Levers for Success: Measuring What’s Inside

Personality assessments are a significant lever to help healthcare organizations link their talent strategy to their business strategy. People are the most significant asset a company has, and it is simply smart business to recruit, develop, and retain the best performers, especially in a volatile industry like healthcare where turnover is high.

In healthcare, physicians have become much more accepting of assessments. These diagnostic tools measure a person’s strengths in areas such as:

- cognition/intellect
- communication styles
- leadership tendencies
- character traits
- core motivations and drivers

Each new iteration of these assessments builds more scientific rigor into the equation, and certain assessments have been shown to be quite accurate as a predictor of human behavior. And with much at stake – patients’ lives, the health and future of the organization – we very much need to know how our leaders will react or respond in stressful situations.

There are literally hundreds of assessments with many purposes on the market, but it’s important to match the assessment to your needs and goals. Some, like the DiSC or the Myers Briggs Type Indicator, have been around for many years. Hogan Assessments, Watson-Glaser, 16PF, StrengthsFinder 2.0, Wonderlich and SHL are others that have also been gaining prominence.

While assessments can be quite valuable, bear in mind they are not infallible. They are input, and it’s important not to become enamored of the technology. Some organizations occasionally even use clinical assessments, but the legal ground for this is dangerous, and the results may have no actual value for talent selection and development in the organization.

In a team situation, assessments can aid alignment. In selection, they may sharpen areas to examine in a job interview. In executive development, they invite an individual on a positive journey to improve his or her performance. And, really, development should be the goal of all assessments. We all have challenges as well as strengths. Assessment shines a light on a path upward.

DOWNLOADING SUCCESS: MERGING PRIORITIES: SYNCING YOUR BUSINESS AND TALENT STRATEGIES *continued*

After we had assessed and begun leadership development with one CEO (we'll call him Jim), his wife pulled our consultant aside. "Thank you so much for working with Jim," she said. "This has not only helped the company, but also has improved our marriage."

While that was a gratifying moment, it also demonstrated that assessments are only as good as the work the individual is willing to put into self-development after truly owning the results of the assessment.

Aligning talent strategies to achieve business goals

Increasingly, assessments are designed and delivered for entire leadership teams to help executives align themselves to achieve the goals of the organization. They can:

- determine gaps in the team's skill set as it relates to a particular strategic goal.
- highlight areas for talent development and acquisition.
- strengthen teams as they embark on a new initiative or challenge.
- set markers for development needed for longer term goals.



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Some of these activities would be categorized under the heading of "executive team performance," and that is a key differentiator between the assessments of yesterday and today.

In the past, assessments and executive coaching might be utilized on a more individual basis. An executive with poor people skills and a blistering temper might find himself or herself taking an assessment and getting some one-on-one time with a consultant to help them learn to play well with others. These days, companies have much less patience with such antics, even from highly productive executives.

DOWNLOADING SUCCESS: MERGING PRIORITIES: SYNCING YOUR BUSINESS AND TALENT STRATEGIES *continued*

Today's talent advisors are more concerned with how the pieces fit together:

- Are the right team members in place to achieve business goals?
- How do the members of the team best communicate with each other?
- Do they all understand the mission and vision of the team and the organization?
- Are they each receiving the talent development they need to hone their leadership skills. and help them contribute to the overall success of the organization?

Business is a team sport.

The analogy we often use for team performance is that of a bowling team. If your team loses but you break 200 for the first time, you may leave the bowling alley in a pretty good mood. The team goal doesn't matter as much. But in today's business world, the stakes are higher than ever, and CEOs need teammates who are wholly invested in the success of the team and enterprise, and not just their lane.

What's critical to understand in today's marketplace is that leadership development isn't just the priority of the human resources department anymore; it's everyone's priority.

As you set high-level business goals, be sure to link them to your talent strategy. If you are trying to manage costs or further refine the integration of your organization, it's vital to also identify whether you have the internal talent resources needed to deploy that strategy and achieve the desired outcomes.

For a more detailed look at assessments, [click here](#).

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TO YOUR HEALTH: QUANTITY OR QUALITY?

What do you weigh? A small percentage of you know precisely. A larger percentage may have an educated guess but it will most likely be an underestimation. And then there are those of you who don't want to know. Weight is taboo culturally; feelings of shame, regret, and disapproval are attached to it. Weight is kept private, hidden, and disguised. Weight is one of the first observations our primitive brain notes, yet it tells us little. Weight, like age, is a vague reference of someone's health status. Think of all the reasons you chose the computer you did. I suspect weight was not one of them. One of the reasons might be because weight does not describe the qualities of something, just the quantity.



Most of the research regarding weight loss/control reads with doubtful and sometimes hopeless overtones. Weight loss appears to be easy in the short term but very challenging in the long term. The debate continues to rage as to whether it is because of too many calories (fat or carbs), too little movement (like there are not enough gyms), or our environment. Regardless, in the U.S. we appear to have excelled at the mammalian ability to store extra calories as fat. We are likely the only warm-blooded animals that can gain weight during a time of severe cold. All the other critters out there on the feeders or nested in the woods are just hoping they have enough fat reserves to make it to Spring. There are very few metabolic pressures on many of us anymore. Just search 'glamping' or 'custom ice fishing cabins.'

As an exercise physiologist, where calories are a key metric that bridges nutrition and endocrinology, exercise has historically been thought to be a key component of weight loss. At the gym the treadmill counts the calories, food labels show calories, and diabetics are essentially checking their calories with the blood glucose test. Why? Well, partially because we associate this with weight control. And controlling weight has been a dominating mantra in the health discussion since at least the '80s. So, how is it working for you?

In the position statement by the American College of Sports Medicine a consistent theme is that a dose of ~4 hours per week of moderate to vigorous exercise is required weekly. That would translate into roughly 1600-2500 calories burned per week by an individual. Some researchers still believe exercise has minimal effects on weight loss, but **many** agree exercise is a *critical* part of weight maintenance.

But, let's return to the premise that weight is a vague reference. Here is the reason. Lean mass (muscle, water, bone) is a very valuable component of overall weight. Our exercise habits, protein consumption, and activities of daily living promote lean mass. As we age, this is the tissue that is lost and leads to frailty. Some individuals have a higher amount of lean mass naturally - mesomorphs and endomorphs. You know, 'big boned.' That is weight worth keeping. That is weight that can accomplish work, whether raking in the spring or swinging a kettle bell. On the other hand, fat mass is a tissue that, when in excess, becomes problematic, as it is linked to cancer, cardiovascular disease, and diabetes. And it is fat mass we want to control while holding on to lean mass. If all I use as a reference is my weight and height (BMI), then I am unable to track the ratio of lean mass to fat mass. That is why body fat testing like the DEXA scan or Bod Pod are so helpful.

Don't get me wrong, weight control is not a lost cause; but too many folks out there put it at the top of the list for goal setting. In the end they finish discouraged and dismayed. Then to make matters worse, they give up on exercise, which is arguably the most valuable component of living well. So, let's come up with a better goal. Good bye quantity, hello quality! More to come, good hustle!

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TO YOUR HEALTH: QUANTITY OR QUALITY?

continued

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MIND THE GAP: A NEW KIND OF PARTNERSHIP CAN UPEND THE ROOTS OF POOR HEALTH

Last year, Randy Oostra, the CEO of ProMedica in Toledo, Ohio related an epiphany that changed the way he ran his enterprise. His insight came at a time when he and his staff were discovering just how many patients in ProMedica's network of hospitals experienced food insecurity. In 2016, 36 percent of families from under-invested communities who rely on ProMedica's services said they were concerned about having enough to eat.

It's well-documented that hunger, and the stress that goes with it, can lead to a host of chronic diseases and behavioral health issues — everything from low birthweight and cognitive development problems to obesity and infections. Food, Randy realized, was a “medicine” that people who visited ProMedica needed.

So, in 2015, in response to that revelation, he instituted a food clinic at ProMedica — an onsite pantry where patients can pick up free, nutritious groceries. It was truly a revolutionary approach, and right away, the health system's practitioners began [seeing improvements](#) in patient wellness. Emergency room visits and readmission rates dropped dramatically. More clients began seeking primary care services, before health concerns became emergencies.

Randy understood that broad economic and social issues — the social determinants of health — had to be addressed if ProMedica was to fulfill its mission to create a healthier community. And he sought partners who shared this mission. That's when he reached out to my organization, Local Initiatives Support Corporation (LISC). [In March of this year, our companies announced a joint commitment to invest \\$45 million](#) in Toledo's residents and unserved neighborhoods in ways that support the well-being of all people: in programs that connect residents to financial education, in the preservation and development of healthy affordable housing; in athletic fields and infrastructure necessary for children and adults to exercise and play; and in quality education.

Randy and ProMedica are extraordinary pioneers, and fortunately, their spirit is spreading. Month by month, American health systems are embracing Randy's epiphany. They are amassing a growing body of data demonstrating that opportunity is arguably the most effective and resilient medicine. And as a result, they're teaming up with community developers like LISC to tackle the root causes of chronic disease and poverty in order to strengthen communities.

The healthcare industry possesses invaluable resources for addressing the social determinants of health. Hospitals, for example, are filled with incredible talent who can help organizations like mine be strategic about shaping our work with the people and places we both serve.

Community developers are well positioned to collaborate with healthcare systems and deliver the expertise and partnerships that catalyze opportunity in communities. Together, we have the commitment, financial and people resources and the know-how to improve population health and upend health disparities. Over the next decade at LISC, we will be intentionally and aggressively pursuing health outcomes as part of our projected \$10 billion in investment in low wealth communities across the country.



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MIND THE GAP: A NEW KIND OF PARTNERSHIP CAN UPEND THE ROOTS OF POOR HEALTH

continued

The kind of partnership we are undertaking with ProMedica is an exciting innovation, and one that's already proving its effectiveness. Our first collaboration with Randy and his team, in 2016, was opening [a Financial Opportunity Center](#) (FOC) at the organization's new health center, bringing one-one-one financial coaching, employment counseling, and income supports to patients who could use those services.

I'll never forget the story of 64-year-old Michael Elliott, who came to ProMedica for cancer treatment wearing rubber bands around the cuffs of his pants. He told a staff member at the food clinic that the bands helped keep bed bugs from biting him at the shelter where he slept. Right away, ProMedica connected him with a coach at the FOC, so he could get services and find a stable home. Within a month of his first meeting, Elliott had a safe, clean apartment of his own, and he continues to receive budget and income support counseling so his Social Security payments go as far as they can.

We hear other stories of lives similarly transformed through our growing number of healthcare partnerships. When Bon Secours Health System was evaluating how to support the community around a hospital it owned in Richmond, VA, the leadership connected with LISC to figure out ways to improve the quality of life and boost incomes for residents in the adjacent Church Hill neighborhood, which experiences high rates of poverty and where life expectancy is 20 percent lower than in a more affluent nearby neighborhood. One solution was to work to attract new businesses to the area by providing grants and small business coaching in Church Hill for a program known as Supporting East End Entrepreneur Development, or SEED. The program has been so successful in spurring entrepreneurship and economic development there that other institutions are now replicating it.

In another corner of the country, in Brockton, MA, a city that has suffered from decades of underinvestment, [LISC leveraged nearly \\$18](#) million in investment to create a health center side-by-side with a grocery store, enlivening a blighted commercial corridor, reducing crime, and creating new jobs. The goal is to make primary healthcare, healthy eating, and better living conditions readily available to residents of a community where diabetes and heart disease rates are disproportionately high.

We aspire to accelerate this work. There's incredible promise in collaborations between healthcare and the social enterprise sector. The healthcare industry stewards some \$500 billion in annual investment assets. It is providing capital and grant funding, and helping to measure the impact of community transformation work. Community developers are helping healthcare organizations build and deepen relationships with the community, tackle the root causes of chronic disease, and work on policies that promote systemic change. By combining assets, knowledge, and experience, the two industries – which share a compelling mission to help heal people and communities – can close our country's unacceptable and costly gaps in life expectancy.

This is an urgent invitation to all of us, as leaders in our industries and as a society, to change the way we do business, and to change the way we deliver healthcare. We know, irrefutably, that the very best medicine is the medicine that keeps us from getting sick in the first place: social, emotional, and financial stability. We owe it to ourselves, and our communities, to make that medicine available to everyone as swiftly as we can.

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THE FUTURE OF THE U.S. HEALTHCARE SYSTEM – PART 2

This article is Part 2 of our discussion of the future of the U.S. healthcare system. In [Part 1](#) recommendations were made for stabilizing the individual insurance market while preserving the twin goals of providing access to affordable, robust insurance coverage regardless of health conditions and regardless of income. While the recommended changes would lower and stabilize premium rates, they will not necessarily slow the growth in the unit costs of healthcare services.

Some have suggested that a single-payer system is necessary to lower costs. In Part 2, Dr. Goldman will discuss the meaning and pros and cons of a universal healthcare system, of which a single-payer system is one example. He will suggest an approach he thinks is necessary to make such a system successful in reducing costs.



Is single payer a solution?

Absent any fix to the ACA, and the likely increase in the uninsured rate, many people are now arguing that it would simply be better to cover “everyone” in a “single-payer system.” But what is meant by “a single-payer system?” What are the pros and cons of such a system, and how could it be made to work in the United States?

What is a single-payer system?

The user of this term usually expects the federal (or state) government to finance health insurance coverage for all residents. The government is both the **payer** of claims and the **insurer** (i.e., the risk taker). Despite the rhetoric, Canada and Taiwan are the only two industrialized countries with this type of system. Is a single-payer system “socialized medicine?” No; neither of these systems are examples of “socialized medicine,” as their governments do not own the hospitals and other facilities, nor do they employ the physicians and other providers. In the UK, the National Health Service, not the government, owns the providers. In the U.S., the Veterans Health Administration is an example of “socialized medicine.”

Sometimes the speaker, mistakenly, refers to a “single-payer system like Medicare.” It is true that most of the funding of Medicare benefits comes from payroll taxes (Part A) and general taxes (Part B) collected by the government. However, only Traditional Medicare (Parts A and B) can be considered a single-payer system. Over 1/3 of Medicare beneficiaries have Medicare Advantage plans (Part C) through private insurers who provide benefits and take risk in place of Traditional Medicare. In addition, the retail prescription drug component of Medicare (Part D) is insured by private payers, who receive per capita payments along with reinsurance and low-income subsidies from the federal government.

Often the term “single-payer” is used when what is meant is “universal healthcare.” As defined by the World Health Organization, a Universal Healthcare System (UHC) provides all people with access to needed health services in sufficient quality to be effective, without exposing the user to financial hardship. The key point is the U.S. is the only industrialized country in the world without a UHC.

A single-payer system is only one type of UHC. Most countries’ systems fall in one of two broad categories:

1. insurance mandates - all citizens must purchase standard minimum coverage from private insurers (usually not-for-profit) or a public option; often there is no underwriting, and subsidies exist for low-income families. Examples include Switzerland, Germany, Japan, and the Netherlands.
2. a combination of single payer and private insurance; examples are the UK, France, Singapore, and Sweden.

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THE FUTURE OF THE U.S. HEALTHCARE SYSTEM – PART 2

continued

What are the pros and cons of a single-payer system or other type of UHC?

As is well known, compared to the other 32 OECD (Organisation for Economic Co-operation and Development) countries, healthcare in the U.S. is the most costly per capita, and we spend a greater percentage (16.9% in 2015) relative to gross domestic product. The cause is not a mystery: the unit cost of healthcare services is greater in the U.S. than in other countries.

However, despite spending more, the U.S. ranks quite low compared to other OECD countries on certain quality of life measures, such as life expectancy at birth and infant mortality rate. On the other hand, the U.S. has some of the best acute care in the world; excelling, for example, in cancer care. We also rank high in innovation and patient-centered care. Other countries achieve better public health outcomes, but they do so by combining healthcare spending with generous spending for social services. As a result, many countries have higher general tax rates than the U.S. The main disadvantages cited for other countries' systems are delays in access to routine procedures and fixed budgets that lead to rationing of care. Of course, an argument can be made that in the U.S. we also ration care, as access, quality, and affordability all vary based on income, geography, and race.

Are there cost savings?

Many believe there would be cost savings from efficiencies in administering a single-payer system. Currently, every insurer negotiates payment rates with healthcare providers, and every provider tries to strike the best deal with insurers. Every insurer has different procedures even if the claim forms are uniform. Clearly, there would be savings if all providers had to follow one payer's rules. But who would set the providers' payment rates and rules? In Traditional Medicare, the government sets a uniform method for determining payment rates, which many providers find to be insufficient.

Some point to Traditional Medicare's low administrative costs compared to private insurers (as a percentage of claims paid) as an example of savings we could expect in a single-payer system. But this analysis is too simplistic. Medicare's administrative costs are misleadingly low for several reasons. The most important one being that Medicare's administrators exercise very little oversight over the quantity or medical necessity of claims submitted for payment. Unlike private insurers, Medicare does not employ nurses, physicians, and social workers who provide services directly to beneficiaries and providers to: coordinate care, especially for those with complex conditions; encourage preventive care; monitor drug utilization; and, in general, reduce unnecessary hospital stays and duplicative tests. Private insurers do all this, while still achieving quality outcomes. As a result, Medicare Advantage plans can provide Part A and Part B benefits for less than Traditional Medicare in most parts of the country. The savings (called "rebates") are used to provide additional benefits, thus sparing insureds the need to purchase a costly Medicare Supplement plan and, often, a separate Part D plan.

The focus on savings must be on the 85-90% of the dollars that go to cover medical expenses. There is plenty of evidence among private insurers that higher administrative costs can produce lower total costs. The history of Traditional Medicare has shown the power to set providers' rates is not sufficient to control the growth of healthcare costs. There needs to be some control over utilization as well. In a working paper published in August, 2013 by the Congressional Budget Office, one of reasons given for the slower growth in Traditional Medicare is the positive effect Medicare Advantage has had on physicians' practices.

To be successful in administering a health insurance program for the entire country, a single insurer would need many of these same resources as private insurers employ today. These include: membership, claims, and customer care professionals; analysts and actuaries; pharmacists, physicians, and nurses; and management personnel.

THE FUTURE OF THE U.S. HEALTHCARE SYSTEM – PART 2

continued

Alternative Futures for the U.S. Healthcare System

Taking all these arguments into account, I suggest a possible future single-payer alternative would designate the federal government as the single payer and insurer, but the government would bid out the management of the health system to private companies who would perform the functions that private insurers do now for a fixed fee. These firms would be responsible for providing administrative services to beneficiaries and providers, coordinating beneficiaries' care, designing incentive systems for providers to deliver quality care in the most efficient manner, and developing incentive systems for members to take better care of themselves. The winning bidders would have targets for cost and quality and would compete for the business in various geographical areas. If they exceed these targets, bonuses may be payable. This proposal has not been discussed broadly, but it seems to me the only way to have a single-payer system that saves some administrative expenses while retaining control over quality and cost of services.

For those who are looking for universal healthcare that avoids a single payer, one needs a system with a strong mandate for everyone to purchase coverage from competing insurers including, possibly, the federal government. Republicans have proposed something like this as an alternative for Medicare, although Medicare, with Medicare Advantage, is actually doing quite well as it is. They call their idea "Managed Premium Support." In their scheme, beneficiaries would be given a fixed amount of money. They could choose what coverage and which public or private insurer they want, spending more or less than the amount allotted. This approach raises the question of whether this fixed amount would grow sufficiently over time. However, one could construct a system where the support level is determined by, say, the second-lowest cost standard plan. Sound familiar? Another question is whether the federal government would be a "fair competitor" given the leverage it has with providers. Without the federal government participating, the competition would be similar to private insurers competing under the ACA. Indeed, if the ACA had a stronger mandate along with the other changes recommended in [Part 1](#) of my paper, the ACA could be a model for a UHC in the U.S.

It is ironic that those who favor Medicare Premium Support generally oppose the ACA, while those who support the ACA are disinclined to favor a similar approach for Medicare. This is an example of the fuzzy thinking that has stalemated any real improvements to our healthcare system.

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THE SHIFT FUND: SHIFTING OUTCOMES THROUGH SMALL SUM, HIGH IMPACT GIVING

What does \$60.50 mean to you?

For one young man, it was freedom.

Z was arrested at age 15 for armed robbery. He was not alleged to have touched a weapon or to have taken any items from anyone, but he was present during a robbery and was charged under conspiracy liability as an adult. He spent approximately 6 months in an adult jail pre-trial and then was sent to a juvenile placement for 5 months.

Z lost one of the most formative years of his life behind bars – a year of high school when many young people, including us a decade ago, were studying for the SAT, playing sports and musical instruments, and thinking of college.

Once he was released, **\$60.50** of his remaining non-waivable court costs kept Z on probation. The **\$60.50** prevented Z from attending class and basketball practice. **\$60.50**.



Small sums [to some] keep others from moving forward in life.

Each day, seemingly small sums present disproportionate barriers to personal progress. Modest fines and fees entrap people in court systems, making it difficult to hold a steady job and emerge from poverty. Small co-pays and accumulating medical bills preclude individuals from seeking the care they need. Technical school and college application fees as well as the cost of a commute to school or employment remain prohibitive for those seeking to better their lives.

In 2016, NPR covered [the story](#) of a young man in Detroit who, having been wrongly convicted of murder at the age of 14, had spent nearly nine years in prison until his conviction was overturned. \$2500 of unpaid court fines and the cost of a public defender nearly kept this young man behind bars. The kindness of an anonymous donor allowed him to reconnect with his family and freedom. Similar stories demonstrate how fees and fines disproportionately affect the poor; small ticket fines lead to [drivers' license suspensions and a cycle of debt](#), and a recent study of juvenile cases in Pittsburgh demonstrated that [unrealistic fines and fees contribute to recidivism](#).

In our own work in medicine and finance, we have seen how fines, fees, and co-pays can impede the wealth accumulation necessary for upward social and economic mobility. We've seen families borrow at unforgiving rates to bridge paychecks and find themselves in a cycle of ever-increasing debt, collection agency harassment, and the inability to build sufficient credit to rent an apartment. We've witnessed patients' inability to access preventive care services due to cost and time constraints, which leads to avoidable sickness, hospital admissions, and jeopardized employment.

Small sums not paid today cost society more tomorrow.

Like Z, juveniles are often jailed for missing appointments and other conditions of probation. In Pennsylvania, that is at an average cost to society of \$362 a day.¹ Still, the direct cost of confinement for missed fines and fees are pocket change compared to the long-term costs for families, communities, and society. As Gladys Carrion, Director of New York State Office of Children and Family Services, stated, "We could send [a juvenile justice youth] to Harvard for [what we pay for incarceration], and we don't get very good outcomes."

Specifically, estimates of the long-term costs of young people's confinement may add up to an additional \$8 billion to \$21 billion each year, including \$7.6 [billion](#) of lost future earnings of confined

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THE SHIFT FUND: SHIFTING OUTCOMES THROUGH SMALL SUM, HIGH IMPACT GIVING *continued*

youth, \$3.87 billion of lost future government tax revenue, and \$1.50 billion of additional Medicare and Medicaid spending.²

Fines and fees, like driver's license suspensions from unpaid tickets or medical co-pays, contribute to absenteeism and the inability to hold a steady job. Employers bear indirect costs to employee poor health – lower productivity, higher rates of injury and disability, and more workers' compensation claims – that can be two to three times the costs of direct medical expenses. Research from the Milken Institute suggests that a modest reduction in avoidable risk factors could lead to a gain of more than \$1 trillion annually in labor supply and efficiency by 2023.³

Collective pocket change can make change.

The realization that small sums can generate high impact has compelled us to find a way to connect individuals with the means to address their needs.

[The Shift Fund](#) is a 501(c)(3) non-profit organization that seeks to connect individuals with needs left otherwise unaddressed with the means to make it happen. By applying small sums to break down constraining barriers, the Shift Fund seeks to generate high impact at an individual level.

By partnering with community organizations, the Shift Fund learns of individuals with needs left otherwise unaddressed with the means to make it happen. Through organizations like the national Juvenile Law Center, Youth Sentencing and Reentry Project, Civil Rights Corps and the Flint Youth Build, the Shift Fund identifies small dollar sum, high impact opportunities where the application of funds in the \$0-500 range can remove barriers preventing a person from moving ahead in life. For instance, state-issued identification and birth certificates are \$49.50 and necessary to apply for social services and continuing education. Other commonly funded barriers include court fines and fees, diversion program entrance fees, payment of driving/parking tickets, usually associated with license suspension, transportation related barriers such as a monthly bus pass, and medical co-pays.

So what's in it for you?

Donors of all capacities have the opportunity to contribute to these needs, with the understanding their funds will have a transparent, direct impact for an individual. \$40 can fund an individual's technical or community college application fee, and \$50 can help an individual get the identification needed to access the system and move forward in life. Our pocket change can make change when pooled together.

Philanthropy does not have to be reserved for those at the end of their career or able to contribute large sums. For young professionals, a small sum donation to Shift can (1) have a direct impact on another person, (2) lead to an increased sense of happiness (according to a [Harvard Business school study](#)), and (3) have tax benefits.⁴

So what happened to Z?

The Shift Fund's payment of Z's court costs allowed him to get off of probation and move on with his life as a scholar and athlete. Z is now 16 years old and back in the same high school in West Philadelphia where he was enrolled prior to his arrest. Z is an avid athlete - a standout basketball player. He works as a youth advocate and plans to work at a recreation center in Philadelphia this summer.

THE SHIFT FUND: SHIFTING OUTCOMES THROUGH SMALL SUM, HIGH IMPACT GIVING *continued*

Learn about other shifted outcomes and help make more stories like Z's a reality by joining us in shifting outcomes today at shiftfund.gives.

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MAKING THE BET ON POPULATION HEALTH PAY OFF: REALIZING “SYSTEMNESS” THROUGH SHARED PURPOSE AND A COLLECTIVE STRATEGY

Consolidation is awash in the U.S. healthcare system. Last year saw 115 healthcare-related transactions — the largest number in history.¹ With the continuous push to drive down cost and increase quality, numerous horizontal (think Aurora Health and Advocate, two large health systems coming together in a deal valued at \$11 billion) and vertical (think CVS and Aetna in a \$69 billion-dollar deal) mergers are in play to fundamentally reshape the health system in the U.S. As we wrote in the [introductory article](#) for this series, we see tremendous potential exists in these partnerships, yet achieving that potential is incredibly difficult and — in many cases — falls short of expectations.



There are a variety of reasons for this - lack of shared strategy, competing cultures, different ways of working, and differences in underlying interests that may not lay the groundwork for the effective collaboration and partnership needed for the combined entities to thrive. While the risks are high, we have seen a number of organizations truly achieve and even exceed the potential of the systems that they have created. In this article, we look at the power of using a systems-thinking lens to promote “systemness” through the creation of a shared purpose and a collective strategy.

You may have heard the phrase “making the whole greater than the sum of its parts.” As Russell Ackoff cautions, it’s not about optimizing the individual parts of a system — it’s about the potential of the interaction effects that are created when those parts come together. Using the example of a car, he explains that each part of the car is just that — a part. It takes all of the parts to work together to create a vehicle that can transport you from point A to point B. Applying this logic to a health system makes great sense. It takes a variety of different professions and delivery organizations working together across the continuum of care to provide care and deliver population health. When things get complicated, for example, with a frail elderly person with multiple co-morbidities who needs surgery and has limited family support, then the system needs to kick into gear — from primary care to specialists to the hospital to post-acute care and ultimately home. It’s the interaction effects that take place across these different entities that reduce the likelihood of error, enable strong hand-offs, and coordinate care. It takes real effort to make this “system” work together and even more effort to optimize the interaction effects of larger, more complex merged systems where it’s not always clear how the whole can be greater than the sum of its parts.

One multi-billion-dollar health system with which we worked really understood the power of systems thinking and why it would be so important to their success. This organization was the product of several different health systems operating in three states. With the parts of the system in place, it was now shifting its identity from what was largely an acute care hospital company to a fully integrated “health” system that could take risk for managing the health of patient populations. As part of this shift, the system announced that it would embrace a regionally-focused operating model across three very diverse regions, each with their own geographic and competitive challenges. This change was going to require a clear and compelling strategic narrative about how the parts of this organization could do things together they couldn’t otherwise do alone. It would also require building trust across the leadership team to fulfill the system’s collective potential. The CEO launched a strategy process to develop a shared set of strategic commitments that the entire system could understand and contribute to.

Leaders at the system office, local hospitals, and newly formed

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continued

region-specific working groups articulated a strategy that made sense for the system as a whole and that could be adapted locally. Hundreds of administrative and clinical leaders participated in a strategic planning process, culminating in a retreat where trustees from every hospital came together to approve the plan. The result was a well-founded system strategy with goals people understood and believed in, a platform for physician partnership, and a set of regional planning teams to implement the strategy. By tapping into the collective wisdom of the different parts of the system, the CEO was able to create the conditions under which leaders could collaborate to shape a collective future.

Systems take many different forms, particularly in healthcare. For example, we recently enjoyed the privilege of working with the board of a newly formed joint venture of more than 30 post-acute care providers to establish a shortlist of strategic priorities. Each organization — with its many different services, patient populations, relationships with various health systems, and uneven reimbursement rates — had been working to develop innovative, value-based offerings to their customers. Consider the significant opportunities to bring post-acute providers to the table as clinical partners to reduce readmissions, smooth the path home from acute facilities, and to care for some of the most vulnerable members of their communities. Yet too frequently post-acute providers are viewed as “vendors” to their hospital partners. Many board members entered the conversation as skeptics, but ultimately they all agreed that finding ways to strengthen their collective value — even with the differences each provider represented — would strengthen the joint venture as a whole. Doing so would also bolster their individual opportunities to work with their health system partners, particularly as the pressure to move to value-based payment is dramatically increasing. While they are just beginning their journey, this board is now working to improve contracts, share best practices, and tell the story of the value they can provide.

These examples illustrate the power of collective strategy using a systems-thinking lens to build “systemness” in a rapidly consolidating healthcare landscape.

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

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FEE-FOR-SERVICE TO VALUE-BASED PAYMENT TRANSFORMATION, PART 5: SUCCESSFUL POPULATION HEALTH MANAGEMENT - INSTALLMENT 1

This article is part of a series about value-based payments and their applications in the healthcare landscape. This is the fifth article in the series and will be part of a two-part installment on population health management.



Introduction

The complexity of pluralistic payment environments represents a new wave of challenges providers and health systems face in managing business within each of their markets. Previous articles in this series examined the foundation of new payment models, including structure and characteristics of unique value-based payment (VBP) arrangements, expectations around provider readiness, as well as how high-performing networks are constructed. Installment 1 of this two-part article will explore and address critical business functions required for successfully managing a defined population under a VBP arrangement.

Population Health Management Defined

Healthcare in the United States has historically been dominated by an episodic system-of-care model. Typically, patients are treated for their health event, leading to decisions dictated by presentation of disease and ending at their last related medical follow-up. Treating episodes provides only a narrow scope into the health of a patient and misses the opportunity to leverage data that could reduce the overall cost of each episode and the frequency of occurrence. In a fee-for-service (FFS) environment, there rarely exists a financial incentive to explore opportunities outside of episodic systems, driven unfortunately by the direct causal link between increased quantity leading to increased revenue. As the healthcare industry continues to shift its focus to VBP, changes in the way care is conceived and delivered must change and be managed appropriately as well.

Population health management shifts the focus from individual episodes to caring for complete (sometimes very large and diverse) populations. While striving to achieve the [Triple Aim™](#) of decreased cost, improved quality, and increased access, selected healthcare systems have enabled themselves to successfully meet the new wave of VBP reimbursement.

Population health management converges the following:

- data for decision-making;
- matched financial incentives between the payment and delivery systems and;
- patient-centered care models.

By harnessing the power of detailed analytics, providers can leverage longitudinal data to support clinical decision-making for individual patients, while health systems can assess their populations to meet the needs of their patients as a whole. This could mean opening a new access point in an underserved area, building out a specialty practice for a disease with higher prevalence in a defined geographic area, or finding systematic ways to improve care delivery by targeting unique characteristics of the population.

Centering care on the needs of each patient aligns very well with VBP models because incentives are more closely tied to health, well-being, and outcomes. Allowing providers to focus on the

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continued

needs of the patient does not function well in an exclusively FFS payment environment because of the misalignment between a physician's motivation to proactively maintain the health of their patients and the motivation to maximize payment. In adopting an alternative payment model, a framework emerges that drives all stakeholders towards a common goal of better health.

Data for Decision-Making

From small to large, population health management program success depends on maximizing the benefit of appropriate useful information being utilized during decision-making. The most successful programs have managed to present results in a meaningful way through simple and contextually relevant reports. Analyses should highlight recommendations for action-oriented behaviors within the appropriate scope of practice for the provider. In addition, there needs to be sufficient political support (e.g., from leadership) and autonomy among those responsible for implementing change.

Providers can utilize an array of analytical tools and reports for practical application of data to empower better decision-making. Examples of these are outlined below:

Example Report	Data Source	Variables of Interest	Strategic Impact
Disease Cohort – Gaps in Care Report	Electronic Medical Record (EMR)	screening rate by patient for certain diseases	Proactive screening leads to early detection and treatment, reducing chances of expensive acute care episodes.
Rising Risk Patients Report	Health Plan Claims	continually enrolled patients with at least one or more chronic condition in the current calendar year vs. the last calendar year	Proactive outreach to rising risk patients to enroll them into care management and/or disease management programs reduces the likelihood of future hospitalizations and drug expenditures.
Medication Fill Rate	Health Plan Claims and/or Electronic Medical Record (EMR)	patients prescribed certain prescription medications who did not fill the prescription within a specified period	Patients who do not fill their prescriptions have increased risk for emergency department use. Further, they may have social barriers (e.g., financial, cultural, physical) prohibiting them from filling prescriptions. Removing those barriers helps improve medication compliance and reduces the risk of ED use.

Financial Incentives

Finding financial alignment between payors and providers has been a challenge that continues to complicate care delivery. Further adding to the complexity are the various degrees of involvement for incentives ranging from individual-level to large network and systems-level motivations.

In an effort to reconcile alignment between healthy patients and greater utilization of services, incentive systems were developed to reward improved quality under an effort-driven payment model. This major push to pay-for-performance (P4P) was aimed at dealing with the discordance between providers being paid for quantity of services rendered versus payments based on quality of care provided. Research on P4P impact produced mixed results, and plenty of critics will point to the fact that providers are motivated to perform well on what is measured, often missing or neglecting other variables that still may decrease the overall health of the patient. Providers may also argue that constant quality oversight limits their autonomy as physicians, while interrupting and producing increased burden to providing care.

FEE-FOR-SERVICE TO VALUE-BASED PAYMENT TRANSFORMATION, PART 5: SUCCESSFUL POPULATION HEALTH MANAGEMENT - INSTALLMENT 1 *continued*

The Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act, known as MACRA, was aimed at advancing alignment of financial incentives for providers with major payment sources. Population health management programs that have aligned financial incentives are the most successful, even if there is fragmentation of these arrangements across different insurance offerings or lines of business. Finding universal alignment that spans Medicare, Medicaid, and commercial payor offerings will take time, but as providers phase slowly into VBP arrangements, acknowledgement of these differences will be addressed. The market is starting to understand how helpful standardizing quality measures will be for reporting and payment.

Conclusion

Providers have been managing both spheres, straddling a line between FFS and some risk transfer or capitation arrangements with payors. After decades of FFS, this transition is perhaps appropriately slow. Providers need time to adjust to new climates, to systems of incentives, and to realize material success, before moving to total and complete alternative payment models. As healthcare in the U.S. approaches 20% of the gross domestic product (GDP), it is likely the emphasis on value is a shift that is here to stay.

Part 2 of this VBP installment will include a deeper look at patients and how they stand to benefit from these new payment models.

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