



**THE WHARTON
HEALTHCARE QUARTERLY**
FALL 2018
VOLUME 7, NUMBER 4



HEALTH CARE MANAGEMENT
ALUMNI ASSOCIATION

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EDITOR'S LETTER

It's that time of year again. The WHCMAA has another great experience awaiting you at the annual Alumni Healthcare Conference. [Register](#) now to save your spot at an event that includes the following keynote speakers:

- John Sculley, Chairman and CMO of RxAdvance, former CEO of PepsiCo and Apple
- David Blumenthal MD, CEO Commonwealth Fund, former National Coordinator for Health Information Technology
- Brian O'Neill, CEO and Founder of Recovery Centers of America (which has raised over \$300mm from Deerfield Management to treat the substance abuse crisis in America)

And don't forget the announcement of the winners of the 2018 Achievement Award and the 2018 Outstanding Service Award, which will be made at the Alumni Dinner the evening before the conference.

Hope to see you there!

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




Z. Colette Edwards, WG'84, MD'85
Managing Editor
To learn more about Colette,
[click here.](#)

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THE PRESIDENT'S DESK

Remember the summer reading list? I always dreaded it. I'd procrastinate until two weeks before school, then reach for the list that read like the syllabus of a grad-level Classics seminar, and realize I was in trouble. Now that I'm an adult (for real, guys), I get to pick what's on the list, and this summer, one book stood out.

The book is [Bad Blood: Secrets and Lies in a Silicon Valley Startup](#). It tells the story of Theranos, a start-up claiming its blood testing technology would disrupt the diagnostics industry. It convinced large corporations like Safeway and Walgreens to approve multimillion dollar deals. At one point, the company was valued at \$9 billion. A Who's Who of Washington's elite diplomats and defense leadership endorsed the firm. And Theranos' CEO, the Steve Jobs-impersonating Elizabeth Holmes, was heralded as the next genius Stanford dropout turned Silicon Valley success story. If only her technology actually worked.

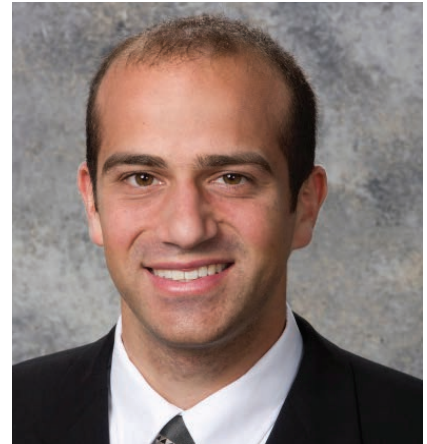
The book's author is John Carreyrou, the *Wall Street Journal* reporter who first reported that Theranos' technology might not work as advertised. Despite having been aware of Carreyrou's previous reporting, I read the book mouth agape. The extent to which Holmes and her partner in crime, Sunny Balwani, duped their partners, lorded over employees, lied to regulators, and put patients' lives at risk is mind-boggling.

There are heroes in the book, like the employees who secretly alerted regulators to Theranos' fraudulent practices. I'd like to believe I would have done the same, just like I'd like to believe I'd not have approved an investment, or accepted a board seat, or negotiated a partnership with the firm. But one line from the book still haunts me. A consultant who realizes something is awry at Theranos is making the case to a Walgreens executive that they shouldn't pursue a deal. The Executive cuts the consultant off: "We can't not pursue this," he said. "We can't risk a scenario where CVS has a deal with them in six months and it ends up being real."


I finished the book just before addressing the HCM class of '20 at Wharton Pre-Term. This year's class is as enthusiastic and inspiring as ever, and I feel confident they are destined for brighter futures than the actors in Carreyrou's book, though I left a half dozen copies for the class to share just in case.

You should meet the class. Recruit them for summer internships. Sign up to be a mentor. Offer to take them to coffee when you're in town. I boasted that our alumni's commitment to the HCM program differentiates it from any other graduate program, MBA or otherwise, they could have chosen. Let's keep living up to it!

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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THE PHILOSOPHER'S CORNER

Life Lessons:

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

...asserted more assertive and radical leadership to effect change and improvement in healthcare given its complexities and economic self-interest.

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

...tried to effectuate change and improvement in traditional healthcare settings where there was satisfaction with the status quo.

Favorite Quotes:

1. "Don't let perfect be the enemy of good!" ~ Voltaire
2. "God is in the details (and details are good!)"
~ Gustave Flaubert
3. "Providers are income maximizers!" ~ Bob Zelten, WG'79
4. "If a team can't be fed by two pizzas, then it's too big."
~ Jeff Bezos (Amazon Team off-site earlier in his company's development)

Recommended Reading:

- *The Advantage* by Patrick Lencione
- *The Fifth Discipline* by Peter Senge
- *God's Wisdom for Navigating Life* by Tim and Kathy Keller
- *Liturgy of the Ordinary* by Tish Harrison Warren
- *Food: a Love Story* by Jim Gaffigan

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This month's philosopher:
David Kibbe
To learn more about David,
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ALUMNI NEWS

Keith F. Safian, WG'74

Keith Safian evolved his career. After 40 years as a hospital administrator (25 as a CEO), he recently established Safian & Company, LLC to bring his experience and expertise to advise CEOs who want to grow their companies and be more profitable.

Keith a Wharton MBA with two engineering degrees, now applies his experience leading three hospital turnarounds by bringing his highly analytical yet entrepreneurial and hands-on approach to private and public organizations with a focus on strategic growth and, at the same time, operational and financial performance improvement.

To date, Safian & Company, LLC has advised 11 start-ups and three established businesses in multiple industries.

Contact Keith at:

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[Learn more.](#)

Sarah Bourne, WG'90

I have been living in Middlebury, Vermont for the past 10 years with my husband Howard and our daughter Grace, following three wonderful years in the Yorkshire Dales of northern England. After leaving Hewitt Associates in 1998, I returned to the world of mental health advocacy first in the Philadelphia area and then, upon returning from England, in Vermont where I continue to work with the State of Vermont's Department of Mental Health and various non-profit agencies on program development and administration, seeking to improve the range of services and supports available to those living with mental health and substance use challenges, especially those who have not found traditional services to be helpful or supportive.

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ALUMNI NEWS

Peter M. Strumph, WG'95

Back at a start-up. A few years ago, I co-founded Amygdala Neurosciences, Inc. We acquired an asset from Gilead Sciences which we are now developing to treat substance use disorders. We are starting Phase 2 studies for smoking cessation and opioid, alcohol, and cocaine use disorders.

Suzanne and I still live in San Francisco and, with our youngest off to college in the fall, are looking forward to being empty nesters.

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[Learn more.](#)

Dr. Scott Cannizzaro, WG'03

Scott Cannizzaro is happy to report the company he co-founded, Evolus, successfully filed its IPO on the NASDAQ back in February. The company was founded to provide physicians and their patients with expanded choices in aesthetic treatments and procedures. The company has attracted top talent and is moving forward as it builds out a world class commercial infrastructure ahead of the anticipated launch of its lead product candidate.

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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

Katie Ellias, WG'06

Katie Ellias WG '06, who has been working in the healthcare venture capital industry in Europe since 2011 at funds such as [Sofinnova Partners](#) and [Endeavour Vision](#), has joined the [JDRF T1D Fund](#) as Managing Director, based in Boston. The venture philanthropy fund has raised nearly \$70M to date to finance innovative healthcare companies bringing therapies and technologies to market to cure, treat, and prevent type 1 diabetes.

The JDRF T1D Fund (www.t1dfund.org) is a venture philanthropy fund accelerating life-changing solutions to treat, prevent, and cure type 1 diabetes (T1D) through catalytic commercial investments. Through its investments in partnership with private capital, including venture capital, corporations and foundations, the T1D Fund seeks to attract the private investment necessary to advance drugs, devices, diagnostics, and vaccines into the hands of those living with T1D. The T1D Fund invests in areas strategically aligned with JDRF, the leading global organization funding T1D research, with an exclusive focus on supporting the best commercial opportunities. The T1D Fund will reinvest any realized gains into new investments to further its mission.

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[Learn more.](#)

Lee M. Stern, WG'14

PNC Bank acquired The Trout Group and its broker/dealer, Trout Capital, which have been combined with Solebury Communications (a wholly-owned subsidiary of PNC) to form Solebury Trout. Trout was a leading investor relations firm serving the life sciences industry. The team including Lee M. Stern, long-time Managing Director of The Trout Group and Managing Director/Co-Founder of Trout Capital, joined Solebury Trout as a Managing Director in the Healthcare and Life Sciences investor relations practice.

Solebury Trout partners with private and public companies across sectors, helping management teams tackle complex investor relations challenges, capitalize on corporate communications opportunities, access the market, and prepare for capital raising.

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NOT A FREUDIAN SLIP: PERSONALIZED HEALTH IS OFTEN NOT PERSONALIZED OR HEALTH -PART 2

In [Part 1](#) we defined personalized medicine, precision medicine, and personalized healthcare and revealed a critical missing element that could mean all the difference to the health of a person.

Combining efficacy and effectiveness benchmark data with self-reported outcome measures, economic implications, and real-world evidence of need and applicability enables clinicians to identify realistic and feasible treatment alternatives. These advancements and our ability to more appropriately target treatments have transformed diseases and lives. However, a person's thoughts, beliefs, and lifestyle behaviors are factors not typically considered on an individual level in precision medicine or personalized healthcare. Could this element be the answer to helping people positively impact health outcomes?



By assessing a person's emotional state and mental abilities and blending information gathered during a clinical encounter with the realities of a person's daily life, clinicians and healthcare providers can better balance care needs and personal priorities. This alignment can help increase knowledge for better decision-making, reinforce the practice of newly learned skills [behaviors], help overcome setbacks, leverage experiences, and support the celebration of success.

Research indicates our thoughts and feelings drive our actions [behaviors]. Given that our behaviors account for 40% of our health status, it's interesting there is such a mind-body disconnect in health "care" delivery. In most cases, a very limited percentage of a person's lived experiences, emotions, and mindset is taken into account in recommendations and incorporated in treatment plans. What is the result of this limited approach to autonomy and personal choice? Less than optimal or limited sustained healthy behavior changes.

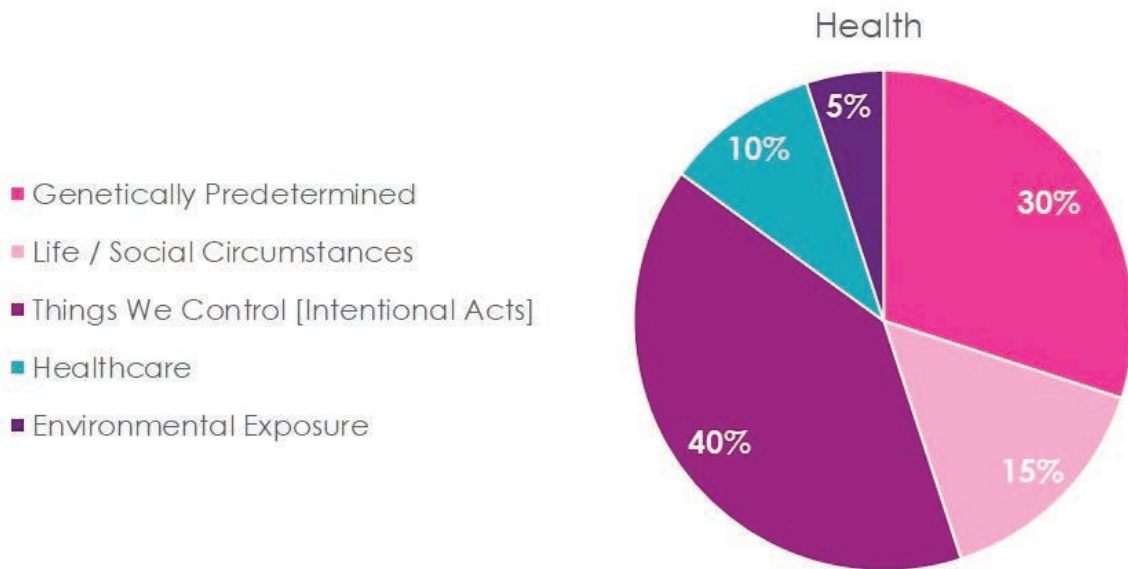


Health is a direct reflection of the choices we make, and most people realize the need for a healthy lifestyle. But several factors stand in the way of making smart health choices, including societal norms and our core beliefs. As a society, we have gotten away from healthy behaviors. There are major challenges, including our sedentary lifestyle, a culture of convenience, and our yearning for immediate gratification. The consequences of unhealthy behaviors aren't immediate, just as the benefits of healthy behaviors aren't immediate either. It takes time to see results, which makes the importance, or urgency, of adopting healthy behaviors even harder to communicate in a compelling way.

Relentless advertising from food manufacturers influences our habits, fuels our misconceptions, and overwhelms us with conflicting information. This complicated mix of confusing messages makes us want to stick with what we know. The historical directives to eat three meals a day and strive for the clean plate club laid the foundation for many of our dietary habits. However, now we are told that moderation and portion size are important, and it's better to eat smaller amounts throughout the day. Yet, in our busy lives, it's hard to avoid the temptation of picking up something fast and processed, as preparing healthy meals involves more time (and sometimes more money) than convenient, prepackaged meals or preservative-laden, boxed food.

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Connie, [click here](#).

NOT A FREUDIAN SLIP: PERSONALIZED HEALTH IS OFTEN NOT PERSONALIZED OR HEALTH -PART 2 *continued*



The Human Element [Emotions, Experiences, and Everyday Life]

So, how can we make healthy behaviors a more natural part of our lives? The first step is to figure out what's really behind our inactivity, poor food choices, and other unhealthy behaviors. Challenges typically include fear, know-how, purpose, mindset, priorities, and expectations. Notice that money wasn't mentioned; however, typically it is one of the top barriers individuals face. Even for those on restricted budgets, studies show nutritious food can be less expensive than fast food, prepackaged snacks, or other low-quality junk foods.¹ Also notice there was no reference to evidence-based treatment recommendations compliance or even a focus on disease.

The thing about change.....it requires changing. Changing is hard and requires effort. It shifts our norm, takes us out of our comfort zone, can trigger anxiety, and deplete our confidence. Feelings of being deprived of our favorite comfort food, or fear of the unknown, such as learning to use fitness equipment, may be too difficult to overcome [with no change in skills or mindset]. Change is a gradual process and is different for everyone, whether changing behavior or changing mindset. Tapping into your thoughts and learning to shift your mindset from a negative view, of worry and doubt, to a positive view, with [feelings that you are in control](#) of a healthy future, can be powerfully transformative. Finding the value, the positive side, will help you uncover the purpose. And purpose goes well beyond simply setting a goal of weight loss. [Understanding the real purpose](#) helps to give the new behavior the priority attention it deserves. It is the meaning behind the reason for setting the goal in the first place.

The Robert Wood Johnson Foundation is funding [Positive Health](#) research to uncover how “biological factors, such as high heart rate variability; subjective factors, such as optimism; and functional factors, such as a stable marriage” impact health.² In a future article we will take a deeper look at barriers to healthy lifestyles, with a goal to uncover and then target unique individual variables that can be meaningfully aligned in order to deliver truly tailored capabilities at scale.

One example of how person-centered needs are transforming care models can be seen in pregnancy care. [Centering Pregnancy](#) provides the traditional schedule of ten prenatal care appointments through patient-centered group sessions, bringing together 8 - 12 expectant mothers with similar due dates. Facilitated by a clinician, these sessions last between 90 - 120 minutes instead of the traditional

NOT A FREUDIAN SLIP: PERSONALIZED HEALTH IS OFTEN NOT PERSONALIZED OR HEALTH -PART 2 *continued*

10 – 15 minutes and include a one-on-one assessment, interactive learning, patient activation, and community building. The supportive forum provides time and space to open up comfortably and explore topics that are top of mind. This approach not only lessens the participants' potential feelings of stress and isolation, it empowers them to engage and learn, strengthening their confidence and ability to make healthier decisions.³

The Bigger Picture

Health is much bigger than a diagnosis, staying compliant with medications, or tracking clinical measures on an app. Health innovations that consider the whole person, not just the disease or the patient in a single clinical encounter, and that infuse insight based on emotional and behavioral drivers, are more likely to have a greater chance of success in helping individuals live their definition of personalized health.

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AFFIDAVIT: HEALTHCARE AND THE LAW - PENNSYLVANIA SUPREME COURT SIGNIFICANTLY NARROWS THE APPLICATION OF THE PENNSYLVANIA PEER REVIEW ACT

On March 27, 2018, in a highly controversial decision (*Reginelli v Boggs*) the Pennsylvania Supreme Court held the Pennsylvania Peer Review Protection Act (“PRPA”) would not prevent the disclosure of certain physician performance review files in an ongoing medical malpractice lawsuit despite arguments the files in question were precisely the kind of peer review documents the PRPA was intended to protect. The decision limits the protection available to Pennsylvania healthcare providers under the narrow peer review evidentiary privilege and is part of a national trend towards greater transparency regarding how healthcare is provided.



“Peer review” is the evaluation of physicians and other professional healthcare providers regarding the quality of services ordered and performed by other providers, such as whether a surgeon failed to satisfy established conduct and competency standards during a surgical procedure resulted in the patient’s death. Peer review statutes, such as Pennsylvania’s, are designed to ensure that peer review is performed confidentially in committee so that oral and written information may be freely shared and the deliberations of the committee are privileged. However, over the years decisions in malpractice cases have resulted in the weakening of the peer review protection. Many courts have determined the interests of a plaintiff or society at large justify pulling back the curtain on the process.

The underlying lawsuit was brought in 2012 after plaintiff Eleanor Reginelli suffered a heart attack several days after being treated by Dr. Marcellus Boggs in the emergency room at Monongahela Valley Hospital for gastric discomfort. The plaintiff alleged Dr. Boggs failed to diagnose and properly treat an underlying heart condition before discharge. She and her husband filed a four-count complaint in 2012, asserting claims against Dr. Boggs, the hospital, and UPMC Emergency Medicine, Inc. (“ERMI”), a third-party contractor that employed physicians, including Dr. Boggs, to provide staffing services for the hospital’s emergency room. It is common for hospitals to contract with third-party emergency room and other speciality physician groups to benefit from their expertise. For their part, the physician groups want to preserve their independence from the hospital; many of these groups have negotiated contracts with payors that provide higher reimbursement rates than the physicians would receive as hospital employees under hospital contracts.

During the discovery phase of the litigation, it emerged that the ERMI medical director had prepared and maintained a performance file on Dr. Boggs as part of her regular practice of reviewing randomly selected charts associated with ERMI-employed emergency department physicians. The Reginellis responded by filing discovery requests seeking production of the complete performance review file for Dr. Boggs. The hospital and ERMI objected, and the parties filed motions and cross-motions over whether the performance file should be disclosed. Ultimately the Pennsylvania Supreme Court, in the 26-page opinion written by Justice Donahue, decided neither the hospital nor ERMI was in a position to claim the PRPA’s evidentiary privilege.

The Pennsylvania Supreme Court first considered whether ERMI could claim entitlement to protections under the PRPA. The court’s analysis hinged on whether ERMI could hold itself out as a “professional healthcare provider” that is covered by the PRPA. There are 12 types of entities enumerated in the statutory definition, including hospitals and physicians, but not including physician groups. Given that the PRPA was passed in 1974 and has not been amended since, and physician groups like ERMI did not exist at the

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AFFIDAVIT: HEALTHCARE AND THE LAW - PENNSYLVANIA SUPREME COURT SIGNIFICANTLY NARROWS THE APPLICATION OF THE PENNSYLVANIA PEER REVIEW ACT

continued

time, it is not surprising physician groups are not included in the list of covered entities. Nevertheless, the court said that although it described itself as a “physician organization comprised of hundreds of individual emergency medical physicians... that exists specifically to provide emergency medical services,” ERMI could not claim peer review protection under the law.

The court then addressed whether the PRPA was available to the hospital. Although the hospital clearly met the statutory definition of “professional healthcare provider,” the court declined to afford it protection under the PRPA on the grounds that ERMI’s medical director, who performed the performance evaluation, was not a member of the hospital’s peer review committee. The court then addressed the argument that the performance files were entitled to peer review protection because the hospital had contracted with ERMI to perform its peer review activities. The hospital pointed out this type of relationship was very common, and hospitals would struggle to survive if they were not able to contract with outside entities like ERMI to fulfill peer review responsibilities. However, the court found this argument lacked merit and was unverifiable because neither the hospital nor ERMI had thought to include the emergency services contract in the record.

In a dissenting opinion, Justice Wecht found the conclusions made by the lower courts and the majority to be at odds with the intent of the legislature in creating the peer review privilege. The dissent found that ERMI did, in fact, qualify as a professional healthcare provider and went on to say, “the majority’s contrary interpretation guts the privilege, given that such contractual staffing and administrative agreements are commonplace.” Justice Wecht also expressed concern about the destabilizing effect of the majority’s reliance on “less than clear” statutory definitions.

This decision has significant implications for healthcare providers in Pennsylvania and elsewhere, especially hospitals and physician groups that contract with outside entities to perform peer review activities, a now common practice. The Supreme Court left open the question of whether such relationships are protected under the statute and whether the PRPA would apply to peer review documents produced by an outside peer review entity on a provider’s behalf, another common practice. For instance, a small hospital that offers general surgery, may contract with an independent orthopaedic specialist to provide insight into a particular orthopaedic case where an expert’s understanding is necessary for the physician’s services to be properly evaluated. The decision could also raise questions regarding the application of the protection in new, value-based arrangements such as accountable care organizations, in which independent hospitals, physicians, other providers, and payors share information to increase quality and reduce costs.

Malpractice attorneys for plaintiffs and defendants across the country have taken note of this important case along with others that as a whole are weakening peer review protections. Although there are good arguments for greater transparency in healthcare, there are also legitimate concerns about the beneficial value of confidential deliberations among physicians, hospitals, and other providers regarding the quality of services provided by a “peer” and the rising costs of damage awards in malpractice cases.

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DOWNLOADING SUCCESS: HOW MILLENNIAL LEADERSHIP IS SHAPING HEALTHCARE

Millennials – those born between 1980 and 2000 – recently became the largest segment of the U.S. workforce. Surpassing Baby Boomers and Generation X, this generation's opinions and attitudes will have a definite influence on how employers recruit and retain top talent moving forward.

In addition, millennials are reshaping leadership. Research is emerging about millennials' differing views on how to lead and what to prioritize when doing it. One good resource is "Divergent Views/Common Ground," a [report](#) published by the Conference Board following surveys of executives at 14 major corporations.



To better gauge what interests and motivates millennial leaders in healthcare, my firm recently completed a survey of 100 healthcare industry executives under the age of 40. The goal was to learn how younger executives viewed the current state of healthcare industry employment, what employers were doing right, and what younger executives considered important when seeking a new position or deciding whether or not to remain with their current employer.

Culture and Career Enrichment

The first important takeaway from the [survey report](#) is the indication that millennial-age executives within the healthcare industry consider organizational culture and opportunities for career growth primary among their employment interests. Matters related to compensation and job titles rated far less critical.

Based on their responses, millennial executives in the healthcare industry seek work environments that embrace innovation, new ways to conduct the business of healthcare, and pathways for advancement. However, regarding career advancement, these leaders desired more than just the ability to move up the ladder. Respondents expressed favor for organization-wide support for professional growth and development, and enough autonomy to assure a healthy mix of work and personal life.

Fortunately, almost two-thirds of respondents indicated that their current employer fostered a desirable work culture, and nearly the same number rated favorably their opportunity for growth. Perhaps this represents a solid start to the healthcare industry's support for millennial leadership.

Fear of Burnout

Further we learned this group of healthcare executives fears career stagnation and burnout in their current roles, and may be motivated to seek new, more exciting opportunities elsewhere. In fact, just over half (51 percent) of those responding to the survey indicated some level of concern for burnout. The most frequently mentioned sources of burnout, according to the survey, included poor work culture, lack of organizational support, and poor or incompatible managerial relationships.

These responses indicate a clear willingness among millennial-age executives to seek a new job if they feel unfulfilled – even to the point of leaving the healthcare industry and moving into a new professional arena. In fact, a majority of respondents indicated they would do just that, even to the point of holding five or more

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DOWNLOADING SUCCESS: HOW MILLENNIAL LEADERSHIP IS SHAPING HEALTHCARE *continued*

positions throughout their careers if it meant moving to find personal and professional fulfillment. Gone are the days when an executive might just tough it out and stay for the long haul rather than deal with the uncertainty of change or relocation.

Take Steps to Implement Worthwhile Improvements

These insights should provide healthcare industry opinion leaders, attitude shapers, and employers with a road map of sorts – one that could assure a more stable relationship with top young talent and less uncertainty when it comes to predicting who will fill key leadership roles in the coming years.

We are still just learning about what millennial leadership will mean for healthcare. Given this, what are next steps?

Executives of the millennial generation should understand their opinions carry weight, and the opportunity is at hand to influence and shape healthcare industry leadership, including recruiting, training/mentoring, and retention practices. Healthcare executives who skew older, perhaps 50 and up, might consider whether or not their companies are doing what is necessary to attract, nurture, retain, and learn from the best young talent who are rising to key leadership roles. Is there opportunity for career enrichment? Does company culture lend itself to innovation and collaboration? Is young talent mentored or managed, and do we know the difference? Are we listening to our up-and-coming executives?

Cost Can Be a Motivator for Change

Frequent turnover is a costly phenomenon and, considering the massive transformation the healthcare industry faces on a continuing basis, it is something healthcare employers strive to avoid. Implementing programs to improve company culture and provide a process for executive development and advancement may be the best strategy for avoiding the expense that accompanies replacing young executives who leave for greener pastures.

Furthermore, it is clear young executives are choosing the career path that offers opportunity for growth, enrichment, and success. Embracing these attitudes and opening that path within your organization may help ensure its future is guided by those who helped shape its strategies and culture as they ascended through the ranks. Ultimately, healthcare organizations that groom and engage their talented millennial leadership will experience long-term benefits from these executives' energy, persistence and vision.

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TO YOUR HEALTH: QUALITIES NEEDED AT THE JOB OF LIFE

How easy is it for you to identify the specific qualities that you would look for in a job candidate at your place of work? From sales to accounting, healthcare and teaching, the skills vary greatly. Do any of the qualities you are thinking of include physical fitness? A few occupations still require an individual to be able to lift 20 lbs., walk 3-5 miles a day, or even swim 1 mile. Yet physical fitness is rarely listed on the resume when job hunting.



Consider the qualities you would want in a new hire if you owned a hiking company.

What about if you delivered cases of water for a living? What skills would you need to run a farm? Someone's height, weight, and age would barely speak to their ability to do the job. Those metrics are quantitative, they do not adequately reflect the qualities needed for those worksites, and they do not do a great job reflecting how well you are living. From the armed forces, astronauts, fire fighters, and public safety, researchers have accumulated normative data on endurance, strength, and agility. And if John Glenn is not just an anomaly but lived into his 90s with vigor due to a commitment to fitness, then we can agree longevity and fitness are linked. So let us go through your skills for this job we call life.

Aerobic conditioning is a score that can be predicted or directly measured. One of the most common evaluations in the field for aerobic fitness is the ability to cover 1.5 miles. The expected length of time for the 35-year-old female might be ~15:00 minutes while a 65-year-old male would shoot for 16:00 minutes. The stress test completed by cardiologists on a treadmill leads to a predicted VO_2 by scoring METs (metabolic equivalents of a task). Exercise physiologists often measure VO_2 directly with a metabolic cart. In Europe, it is more common to have a subject use a leg ergometer and cycle under increasing loads until exhaustion (sounds just like your friend who bought a Peloton indoor bike). The peak watts achieved is the score that counts.

The American College of Sports Medicine has a guideline that lists the expected VO_2 scores for males and females from ages 20-79. Much of their data came from the Coopers Clinic Longitudinal Study in Dallas as well as the FRIENDS study. In short, it is the relationship between max VO_2 scores (the higher the better) and longevity that are so robust. Epidemiologist Dr. Stephen Blair, long-time leader at The Cooper Clinic in Dallas, published several papers that compared all-cause mortality and aerobic fitness. They were inversely related. He concluded that adults who maintained the highest amounts of physical activity had the lowest rates of death, even if they smoked.

The Cooper Clinic also studied the maximal force individuals could apply during certain exercises to see if those scores related to mortality. The leg and bench press were used in healthy men and in men with hypertension. Not surprisingly, the stronger the individual, the lower their risk for death. Dr. Blair would argue the data actually supports a focus far more on an individual's fitness than on their fatness. Much of the data supports this theme and emphasizes the importance of measuring fitness in individuals as they age and not solely their weight or BMI. Qualities over quantities.

Roberta Rikli, PhD and C. Jessie Jones, PhD have created a very valuable testing manual for adults ages 60 - 80 that looks specifically at the qualities necessary for healthy aging. The Senior Fitness Test Manual is an easy to use tool that physicians, therapists, and exercise trainers can utilize to better gauge an individual's strength, endurance, and balance. In 2011, Lobo et

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TO YOUR HEALTH: QUALITIES NEEDED AT THE JOB OF LIFE *continued*

al. published a study that showed significant improvements in the participants of a 12-month health intervention program that included physical fitness training and health education. Again, quality of one's fitness being the focus, not weight.

Although this is an anecdotal reference, when I ask guests here at Canyon Ranch what their motivation is for getting more fit, they often bring up their want to age well with their children and grandchildren. Therefore, whether it is 10 days in Paris, 3 days in Disney, or skiing the black diamonds with them, you know the fitness that will be required. Of course, you will also be well prepared to volunteer at the local farmer's market. You are hired!

Hello quality! More to come...good hustle!

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MIND THE GAP: LEADERSHIP IN ACTION - THE ROLE OF HEALTHCARE INSTITUTIONS IN BUILDING COMMUNITY WEALTH AND ADDRESSING THE ECONOMIC DETERMINANTS OF HEALTH

Smart, Bold Leadership to Build up Communities and Improve Health

The Board and leadership at Rush University Medical Center decided in 2016 to take bold action to address the health crises faced by the neighborhoods around the health system's main campus on the West Side of Chicago. Though the average resident of the Loop, the downtown business district, will live to 85, a resident in neighboring West Garfield Park, a high-poverty area, has a life expectancy of only 69 years. Other measures of community well-being revealed similar disparity, from education attainment to housing to crime. Children and families living in these neighborhoods faced poor public education, environmental damage, high unemployment, lack of jobs, particularly jobs with family-sustaining wages, and disproportionate levels of crime and violence — the negative social determinants of health.



Rush is not unique — many of our world-class medical institutions find themselves confronted with similar economic disparities in the communities they serve. In the wealthiest nation in the history of the world, the difference in lifespan after age 50 between the richest and the poorest has more than doubled — to 13 and 14 years for women and men respectively — since the 1970s.¹ Communities in zip codes a few miles apart experience life expectancy differences of more than 20 years.²

But, along with a growing number of forward-thinking healthcare anchor institutions, Rush University Medical Center has recast its mission from “be the best in patient care” to “improve health” in order to tackle these challenges head on. This has meant taking up an “Anchor Mission” to realign all institutional resources to fight these inequities at their root by building community wealth. It also has required going beyond traditional notions of corporate social responsibility to rethink the very foundation of the institution's role, and how it can *very intentionally* align, leverage, and deploy its economic and social assets in the community to address the upstream economic and environmental conditions that have the greatest impact on the health of local residents.

Rush has deployed more than \$1 million for impact investing to provide capital for a new construction loan to Enlace Chicago, a community organization which provides education, health, immigration, and violence prevention services; refinancing assistance for a community economic development project for Greater West Town communities; and a pre-development loan for Accion Chicago and/or refinancing for the Puerto Rican Cultural Center. Rush is providing an additional \$1.08 million of financing assistance to support the Chicago Neighborhood Rebuild Pilot Program and the People's Community Development Association of Chicago (Harvest Homes).

As the systemic nature of economic inequities and their impact on health and well-being, together with the limits of clinical interventions, have become more widely acknowledged in the United States, so has the urgent need for a new approach to address the growing disparities in health outcomes. For institutions like Rush, the persistent health, social, and economic inequities are not just a moral crisis — it is a question of how the institution can deliver on its mission. Tackling the social determinants of health across all of its operations is not just the right thing to do; it's a shrewd business tool to get ahead of the cost curve of providing effective care, by creating and sustaining healthier communities. Rush has elevated this “Anchor Mission” approach as a strategic priority and brought

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continued

other local anchors into this work, including 9 other healthcare institutions to collaborate on hiring processes and coordinate their purchasing and investing decisions.³

David Ansell, Senior Vice President for Community Health Equity at Rush, emphasizes “The ultimate goal of the ‘Anchor Mission’ approach is to increase life expectancy, improve well-being, and reduce hardship. These are very complex health outcomes that can’t be fixed with just healthcare interventions. It requires a ‘total healing’ approach.”

Health Systems Have the Economic Power to Build Community Wealth

The Democracy Collaborative has focused on a new community wealth building approach to economic development, which is designed to narrow these unconscionable disparities to improve health. In this approach, localities inventory the assets they already have and develop place-based methods to leverage these assets collaboratively, equitably, and with an eye toward a systems approach that broadens community ownership and agency.

Health systems and universities together have expenditures of more than \$1 trillion annually, have at least \$750 billion in investment assets, and employ more than 9 million people.⁴ They are some of the largest employers and purchasers – and potential investors – in many low-income communities where they are based and where their patients live. If these institutions could leverage and more intentionally align their everyday hiring, purchasing, and investing practices with others to address the root causes of poor health, the impact on systemic inequities could be enormous.

Key to the success of this approach is engaging and leveraging the significant everyday business activities of “anchor institutions.” Non-profit or public institutions such as hospitals and universities have become the leading economic engines in many of America’s communities, and their mission, customer base, and place-based investments inextricably link them to the long-term vitality of the place in which they reside — they both anchor the local economy and are anchored in the communities they serve.⁵

Health Systems Leading the Way

In the last few years, an increasing number of leading health systems have embraced an “Anchor Mission,” recognizing the economic and racial inequities that drive poor health in their communities require concrete and extensive interventions deploying every tool at their disposal.

More than three dozen major systems, which collectively represent 600 hospitals with over 1 million employees in more than 400 cities and towns, have joined the [Healthcare Anchor Network](#), a growing health system-led collaboration focused on improving health and well-being by building more inclusive and sustainable local economies, working in partnership with their communities. The Network includes Rush University Medical Center and other major healthcare institutions, such as Kaiser Permanente, RWJBarnabas Health in New Jersey, and ProMedica in Toledo, Ohio,⁶ that are using their hiring, purchasing, and investment power to increase wealth in these communities through training and hiring residents for good jobs, purchasing from local small businesses, and investing in projects that build community wealth.⁷

The challenges before us are systemic in nature. Our solutions must be equally bold if we are to meaningfully address the racial and economic disparities that limit us from achieving the outcomes in health and well-being that should be within reach for a nation as wealthy as ours. Anything less is an abdication of our individual and institutional moral responsibility, not to mention collectively economically short-sighted. We must change the conversation, develop new relationships and establish new priorities. In a short period of time, Rush University Medical Center leveraged millions

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continued

of badly needed funds to bring wealth into Chicago's disadvantaged communities. It will require many more bold leaders from health systems across the country to see the moral imperative to adopt the "Anchor Mission" and focus all of their institutions' resources to create healthy and wealthy communities in all our neighborhoods.

To learn more about the Health Anchor Network, contact David Zuckerman at Dave@Democracycollaborative.org or (202.559.1473 x105)

Toolkits for health institutions on: 1) [diverse and locally owned purchasing](#) to leverage supply chains, understanding that a thriving local economy is fundamental to a healthy community; 2) [local and inclusive hiring](#) to invest in an ecosystem of success that lifts up local residents; helps create career pathways for low-income, minority, and hard-to-employ populations; and begins to transform neighborhoods; and 3) [place-based investing](#) to allow institutions to more effectively improve community health and well-being, even as they continue to earn a healthy rate of return, to help address the resource gaps that keep communities from achieving better health and well-being.

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MIND THE GAP: SPEND BETTER FOR HEALTH

Intimidated by the investment costs associated with achieving better health upstream? Don't know where to start? Here is how to address social determinants of health without adding a dime to your operating budget.



Spend smarter

Despite the shift toward value-based payment models, most health organizations are struggling to meaningfully improve patient health outcomes.

That's largely because the bulk of what determines a person's health is not what happens in the doctor's office, but rather the social and environmental conditions in the places where people live, work and play. Solving problems like poverty, education or air quality is a monumental and resource-intensive undertaking that can be hard to justify in today's cost-focused market environment.

But what if we said there's a way to tackle these issues that doesn't require spending any more money, just spending it better? Every dollar that a health organization spends has an impact on health. The trick is to redirect those dollars in a way that boosts the positive social impacts and diminishes any harmful effects.



Consider how your operating spend impacts patients and communities

Mission-driven investors have a long history of putting their money to work for their values, whether that's by divesting from tobacco and firearms or by proactively funding renewable energy and social entrepreneurship. Imagine the societal transformation we'd see if our health system — which makes up 17.9 percent of the country's GDP — did the same.¹

Let's take hospitals as an example. A typical hospital operating budget averages 50 percent or more on labor expense, 15 percent on supplies and nearly 3 percent on IT.² In an ideal world, every dollar spent would be directed toward win-wins that fulfill the original operational purpose and also help address social determinants of health in the communities they serve.

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MIND THE GAP: SPEND BETTER FOR HEALTH



Make your money work harder

There are all sorts of ways to redirect operating spend toward initiatives that have a positive health impact, for example:

Do you buy locally? Local procurement is an easy way to make communities healthier. It creates jobs, which helps people afford healthier behaviors and living conditions, and spurs economic development, which can generate additional tax revenue for local governments to spend on health resources. University of Vermont Medical Center's economic impact analysis shows that the hospital's local food service procurement efforts contributed about \$2.7 million to the Vermont economy, with \$1.6 million in direct food purchases and another \$1.1 million in induced and indirect impacts (e.g., suppliers procuring goods/services locally).³

Are you hiring people from disadvantaged backgrounds? Fair and stable employment is key to helping vulnerable populations get healthy and stay that way. Ex-offenders, for example, are more likely to have chronic medical conditions and less likely to have the resources needed to manage them.⁴ A Johns Hopkins study showed that hiring people with criminal backgrounds can have a transformative impact on their health — by lifting income levels, providing access to quality health care and reducing the likelihood of reoffending. It also can be good for business: Johns Hopkins Hospital also found that hiring ex-offenders resulted in lower turnover rates.⁵



Do you use clean energy? Adopting pollution-free energy sources like wind and solar can help improve health conditions related to air quality such as asthma or chronic bronchitis. Practice Greenhealth completed a study for a Midwestern health system that found shifting just 5 percent of purchasing to clean energy over three years not only was cost neutral, but also yielded significant health improvements for the community. The reduced health burden is estimated to result in more than \$46,000 in medical cost savings for the health system and almost \$400,000 in societal value for the region.⁶

Do you give preferential treatment to environmentally sustainable products? Many traditional building and cleaning products now have green alternatives that offer the same performance, but with less exposure to toxic chemicals. As part of its effort to transition 50 percent of its supply chain spend to products and materials that meet environmental standards, Kaiser Permanente banned paint and other interior building products treated with antimicrobial agents, which can be harmful to both people and the environment and do not offer any enhanced protection from the spread of bacteria and germs.⁷

MIND THE GAP: SPEND BETTER FOR HEALTH



Discover the magic of win-wins

Figuring out when and how to invest in these types of win-wins can be tricky. Commitment from the top is key — employees need a clear mandate from leadership to start factoring health impacts into core operating decisions that traditionally focus on just cost and quality. This directive should start with the C-suite and extend to all support functions, including procurement, human capital, IT and facilities management.

Equally important are the data, technology and governance resources that can enable this new kind of decision-making. For example, consider the Healthcare Sustainable Purchasing Index, a cloud-based analytics solution providing healthcare systems with the insight they need to redirect procurement spend toward more sustainable choices.

With this approach, your organization can train the full strength of its operating budget toward solving social determinants of health, without spending a dime.

Questions?

PwC is committed to helping our clients address social determinants of health in the communities they serve. For more information and to learn more about how you can build a profitable approach to caring for vulnerable populations, go online or contact one of our leaders.



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CULTURE AS A STRATEGIC ASSET IN HEALTHCARE

A high performing academic health center that acquired several community hospitals had publicly unified under a shared brand, yet internally the remnants of an older culture of silos and divisions prevailed. The cultural clash made it nearly impossible to unify the system, weakening both the public brand and the patient experience across its different parts.

A new Chief Learning Officer organized a diverse set of medical educational offerings under one organizational structure to promote a common language across the health system, and common frameworks of learning and development. Yet professional groups within the system—nurses, physicians, advanced practitioners—still flocked to their own “tribe’s” courses and followed their own curriculum rather than opting to participate in classes together.



These vignettes provide examples of how culture can impact healthcare organizations in pursuit of their mission and strategic priorities. As consultants working across the healthcare ecology, we increasingly hear more and more stories about culture and are aware of its increasing importance in moving healthcare organizations forward. We have seen how culture can get in the way of progress, impacting the delivery of care, the collaboration between researchers and clinicians, the move to service lines, the creation of centers and institutes, and the performance of the enterprise as a whole. While healthcare leaders once saw culture as “soft” or even inconsequential, they are now coming to appreciate its central role in driving the changes they want to see happen.

Seeing Culture as an Asset in a Changing World

We know culture is a great asset for organizations navigating turbulent change. We saw it at work in one medical center where a unit developed its own team-based approach to coordinate quality efforts, bringing together physicians, nurses, and quality experts to work collaboratively. When the Chief Medical Officer took note of how this team was operating and the progress they made in increasing quality metrics, she asked them to teach these practices to other units, thereby spreading this culture of quality more broadly.

As the business of healthcare evolves in ways both progressive and disruptive, we are encouraged by the increasing attention to culture as a resource. More organizations are working to preserve a unified culture as they grow, struggling to improve a particular department’s toxic culture, trying to understand the “hidden curriculum” in a medical school, or getting stuck around a strategic change in which culture creates a critical barrier. Along with this increasing awareness, culture exists as a kind of black box for organizations. Leaders recognize they have cultural challenges, yet have difficulty defining what they are and what to do about them. Given the complexities of healthcare organizations and systems — multiple “loosely coupled” units with highly trained professionals embodying different identities and working with different incentives — cultural alignment can be a challenge.

Given this elusiveness, where can an organization get started when it wants to work on its culture? We have developed a few guidelines:

- 1. Start with a good enough definition of culture.** While there are several definitions we find helpful, including Edgar Schein’s three-layer model of behaviors, language, and beliefs,¹ we use this simple formulation: culture is made up of “the rules and assumptions for getting work done — the beliefs, working agreements, and tangible behaviors that people demonstrate at work.” Still somewhat broad, but a starting definition can help identify how culture shows up in your organization, and how you can think about working on it.

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CULTURE AS A STRATEGIC ASSET IN HEALTHCARE

continued

- 2. Assess where culture — these “rules and assumptions” — might be getting in the way of productive work and where it may be helpful.** You can do this through a combination of observing and asking, the basis of an ethnographic approach, or through a cultural assessment survey. We used ethnography when we trained a group of nurses at a high-ranking academic center to “shadow” each other in working pairs to better understand their current care practices and what they could change and improve.
- 3. Look for found pilots for change.** Any organization has examples of the culture it wants to create already operating in the present — what we call “found pilots.” These found pilots are powerful tools for cultural change, as you can learn from them and understand what practices and supports are working to drive cultural change in the direction you are trying to move.
- 4. Build a coalition for cultural change.** The leaders of these “found pilots” are already valuable innovators, and people you will want to pull into your organizational change effort. This informal group can be leveraged as a coalition for change.

In response to the challenge laid out in the first vignette above, a fragmented system brand identity, we worked with the organization’s academic, clinical, and business leadership to do a deep dive into its culture. Through interviews and focus groups, we identified areas of cultural alignment and tension, where ways of working were supporting the mission and strategy and where they were getting in the way. We brought a large group of leaders together to share our findings and agree on a set of projects that would move the organization forward.

We have learned important lessons about working with culture in partnership with healthcare leaders:

- 1. Culture is critical to business success — ignore it at your peril.** Overlooking the importance of culture can undo a great strategy and stymie the best intentions for implementation.
- 2. Culture is never one-size-fits-all.** Your organization’s desired impact needs to direct your culture — where to keep differences intact and where to look for commonalities. It’s about what you need to share to make you successful, and where differences are healthy.
- 3. And culture is a strategic asset you can build on.** The future you want to see already exists. Found pilots — examples of that future you aspire to — already exist in your organization. Your job as a leader is to locate and amplify them, and create the culture you need to be successful.

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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LEVERAGING POSITIVE EMOTIONS TO ENHANCE TEAMWORK

Think of the best teams of which you've been a part – those on which you, personally, were highly motivated, felt a strong sense of positive connection, and, generally, looked forward to coming to work each day. You had fun collaborating with your colleagues, weren't afraid to admit mistakes or ask for help, and, together, were able to produce great work.

When this is posed to teams I coach or students I teach, I often hear things like: there was trust; we liked each other; we had a common vision and goals; we listened to each other; we shared ideas; there was mutual respect, even when we disagreed; we cared about each other; we had each other's backs; we took time to communicate; and we brought in food to staff meetings. (Ahhh, the power of food!)



In my work, I leverage research, in particular from the areas of neuroscience and positive psychology, to support leaders and teams develop, achieve great outcomes, and even have fun. How wonderful that the “at our best” experiences are consistent with – both support and are supported by – the research. Before we explore ideas as to how to enhance positive affect in the workplace, it's helpful to understand why bringing out the best in teams is increasingly important.

The Need for Improved Teamwork

In an article entitled, [Strategy in the Age of Superabundant Capital](#), [March-April, 2017, issue of [Harvard Business Journal](#)] the authors indicate, “The skillful allocation of financial capital is no longer a source of sustained competitive advantage. More important is a workforce that can generate good ideas and translate them into successful new products, services, and businesses.” The researchers further state that in today's economy, human capital (think time, talent, creativity, and energy), is where the power lies.

This is consistent with research from Deloitte [[2017 Deloitte Global Human Capital Trends](#)] that states the “organization of the future is a network of teams.” Leading companies are shifting their organizational structure, flattening traditional hierarchies, breaking down silos, and building systems that cross roles to leverage agile groups of individuals.

These findings are especially relevant in healthcare, where increasing co-morbidities and complexity of specialization requires strong teamwork across disciplines in order to achieve reliable, safe, and patient-centered care.

So, what does all this have to do with emotions?

Well, if you consider the research surrounding human performance it's everything. Although I often hear executives say they wish people would leave their emotions at the door as they come to work each day, we know our human resources are just that – human. We bring all of ourselves to work whether we like it or not. This includes our natural temperaments (which comes from our biology, genes, and the interplay of neurochemicals our bodies generate throughout the day) as well as the parts of our personality that have developed through our experiences (family, culture, technology, education, work environments, etc.).

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LEVERAGING POSITIVE EMOTIONS TO ENHANCE TEAMWORK

continued

Research has shown employees' moods, emotions, and overall dispositions impact the quality of: employee attention and perception, critical thinking, decision-making, creativity, ability to learn, memory, willingness and ability to collaborate, as well as their well-being and resilience. Phew, that's quite a list! Most leaders would agree these elements are critical to workplace satisfaction and performance.

Influencing Positivity using the SCARF Framework

Luckily, there are predictable triggers that influence threat ("negative" emotional) vs. reward ("positive" emotional) states. Dr. David Rock of the [NeuroLeadership Institute](#), developed the SCARF model, a brain-based framework to understand key drivers of human social behavior in our increasingly interconnected workplace. By understanding these drivers, leaders and teams can improve their capacity to understand and influence themselves and the work environment. Work relationships and practices can be designed more intentionally to promote fewer "threat" and more "reward" experiences.

Below are ideas that have surfaced in my work with teams as elevating positive experiences and promoting healthier and more productive work environments. We'll look at these practices through the lens of Rock's SCARF framework.

- **Status.** Status relates to an individual's sense of self-worth and is one of the key drivers of human behavior. Status can be undermined in the work environment, especially where significant hierarchies and disparities across roles are present. Breaking down silos by focusing on common goals and emphasizing the importance of teamwork to influence shared outcomes can minimize threats to one's personal status. Creating a clear line of sight between roles and overall/team success promotes a strong sense of team identity and commitment.

One of the most admired surgeons I know promoted loyalty and accountability among his surgical team and administrative staff by telling his colleagues daily that all roles in the practice group were equally valuable and that, without coordinated efforts across roles, none of them would be successful. Stories of success highlighted the contributions of team members, in and outside of the operating room.

- **Certainty.** As humans, we crave certainty. Our brain is a pattern-recognition machine that is constantly striving to predict the near future. Work environments that are perceived to be unfamiliar and unsafe drain resources (emotional, mental, and physical) and hinder employees' abilities to collaborate and make effective decisions.

One nurse manager whose unit was anticipating the implementation of a new electronic health record system promoted learning and acceptance by: communicating the reasons behind the change, including the benefits the new system would provide over time; clarifying expectations and timelines associated with the implementation effort; providing ample opportunities for training; deployment of "super users" (whose sole job for a period of weeks was to support learning, comfort, and appropriate system usage on a real-time basis); and providing opportunities during huddles and staff meetings for individuals to share their experiences. Individuals reported a shift from apprehension to comfort (and, even excitement) once they knew what was expected of them and felt the support of not only their leader but colleagues, as well.

- **Autonomy.** A perceived sense of choice and control over one's experiences and environment activates the reward circuitry of the brain. In healthcare, work environments with higher levels of autonomy and control over unit practices is associated with increased performance, improved patient outcomes, and lower mortality rates. [\[Institute of Medicine, 2004.\]](#) Leaders can influence autonomy by setting an expectation of coordinated yet independent action and supporting

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decision-making within identified scope of practice. For example, while working with a multi-disciplinary team in an increasingly busy ICU, attending physicians, fellows, nurse practitioners, and nurses discussed key demands facing their unit and outlined expectations and specific protocols, including boundaries, for how care would be provided and decisions would be made across roles. These discussions allowed individuals to work to fuller levels of their potential (a source of frustration, especially in the nurse practitioner group), and determine how to handle situations that were creating frustration (e.g., verbal physician orders, lack of consistency in care plans, etc.). Formal and informal learning opportunities across disciplines were also instituted, which increased autonomy and confidence in roles.

- **Relatedness.** Humans are social beings and were designed to rely on others for not only social needs but survival. A sense of belonging is a driver of many types of teams, including silos. To promote a positive sense of relatedness and cohesion among team members, leaders should be intentional in defining and nurturing cultures – the explicit values, principles, attitudes, and behaviors – that will drive satisfaction and success. Leaders can promote a sense of belonging by introducing new team members, establishing formal buddy systems, and providing opportunities to work in small groups. When individuals have a chance to connect (formally and informally), camaraderie, rapport, trust, and accountability are strengthened.

A long-term care facility that increased its staff size by almost 50% through the addition of a new wing to its facility helped increase a sense of team-belonging by hosting a number of on- and off-site opportunities for existing and new colleagues to get to know one another. Staff created a bulletin board with names, photos, and “fun facts” for each team member. Time was devoted in staff meetings and huddles to recognize contributions, appreciate others’ strengths, offer support, and share experiences.

- **Fairness.** The last element in the SCARF model involves the perception of fair exchanges. When we perceive something to be unfair, our brain automatically reacts in a defensive manner. Further, we don’t empathize with people whom we perceive to be unfair and may act in destructive ways to “get even.” I recently had a conversation with an Assistant Director of Nursing who described the differences in pay levels and benefits for individuals working in an outpatient clinic of a teaching hospital and biomedical research facility. Some individuals were university-based and others were employees of the hospital system. She described how disgruntled workers who perceived their pay and benefits to be disproportionate compared to their colleagues resulted in call-outs as well as lack of teamwork, communication, and support across functions.

In addition to ensuring equity in rules, one of the easiest ways to promote positive feelings around fairness is to be open and transparent in communications. People are less likely to experience dissatisfaction if they are included in discussions and contribute to and understand workplace decisions.

You have more influence than you may realize over your own and others’ well-being, motivation, and performance. In these dynamic and often trying times, the SCARF model provides a simple framework that can bring greater understanding of what supports positive affect in the workplace and what does not. Leveraging this insight can help promote stronger teamwork, a competitive advantage that’s just waiting to be tapped.

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FEE-FOR-SERVICE TO VALUE-BASED PAYMENT TRANSFORMATION, PART 5: SUCCESSFUL POPULATION HEALTH MANAGEMENT - INSTALLMENT 2

This article is part of a series about value-based payments and their applications in the healthcare landscape. This is the seventh article in the series and Part 2 of a two-part installment on population health management



Introduction

Providers have been straddling a line between fee-for-service (FFS) and value-based payments (VBP) at varying levels for some time now. After decades of FFS, providers need time to adjust to new climates and systems of incentives. These factors make progress slow and also challenging for the systems brave enough to venture into new territory. At its core, VBP aims to align the quality of care delivered to the payment model. The emphasis on value and quality put the care of the patient in a new and unique place. Not only do their outcomes mean success clinically, but help to ensure financial success in value-based payment arrangements.

Previous articles in this series have examined the foundation of new payment models, including structure and characteristics of unique VBP arrangements, expectations around provider readiness, construction of high-performing networks, and critical business functions for successfully managing a defined population under VBP arrangements. Installment 2 of this two-part article includes a deeper look at how patients stand to benefit from these new payment models.

Putting the Patient at the Center

It is one thing to put the patient at the center of care delivery. Placing them at the center of how a system is paid is uncharted territory for many in this industry – especially when the system of care is paid under a VBP model. As successful population health management programs anchor their delivery and payment arrangements around the patient, the healthcare industry has seen endless models and different options for how patients should be positioned at the center of these complex ecosystems. While designing the perfect care model is nearly impossible, integrated healthcare systems with mature population health management programs can utilize intelligent and empowered clinical governance to guide the appropriate characteristics of care delivery that can be expected to work in new VBP arrangements. Different levels of experimentation will be involved, and the health systems that are willing to take the risk and test these different models stand to gain financially and become models for others to follow suit.

Operationalizing patient-centered care models nearly always begins in the primary care setting, but that's not a rule set in stone. Data systems allow for identification of where care models should be incubated and tested. Recommending these to clinical governance helps to ensure all stakeholders are involved in the evolution of the organization as it transitions to VBP. Successful examples of this work currently exist in specialty-based care models because they empower specialists to manage quality (e.g., service line co-management). In these kinds of models, surgical specialists partner in coordinated ways with primary care providers to understand clinical appropriateness for surgical intervention and agree on implementation of evidence-based guidelines for delivering clinical care to patients in both primary care and specialty settings. These kinds of patient-centered models allow for both the patient and provider to perform their respective roles in delivery and payment for healthcare services. Another area of success emerges when connections between primary care and behavioral/mental health materialize and providers find alignment with increased collaboration - a model that not only encourages collaboration

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for improved patient care, but also hinges on it financially. Development of integrated physical and behavioral healthcare delivery models helps to ensure patients with any additional behavioral /mental health needs are cared for, may help manage the overall cost of care, and may benefit the entire support network for the patient.

Try, Test and Try Again

Regardless of the specific payment mechanism, having a willingness to iterate, test, fail, and try again is critical to long-term success of any organization during transition from volume to value. Not only is it expected that systems developing new programs will undergo a variety of iterations before landing on one that suits the needs of their particular organization, it should be wholly accepted by leadership that failing and testing are just part of the journey.

Effective and sincere communication and dialogue are critical for meaningful group learning. Clinicians and other stakeholders, possibly even patients and caregivers when appropriate, should all have a voice in shaping the care model and contributing to each iteration. Having a channel of feedback will help to ensure that each version of the model has input from all the parties affected by the change. When programs are developed in this collaborative way and projects are course-corrected early on, it protects against obvious structural issues that may be overlooked and could have been easily avoided.

Why VBP Matters for Patients

New payment models stand to shift the paradigm of care delivery in the U.S., particularly in the minds of patients. Increasing costs for healthcare coupled with limited understanding of the complex payment environment have resulted in skepticism among the general public with regard to unnecessary and superfluous testing and service delivery. It is important that the tainted view of fee-for-service be rectified in favor of a nurturing doctor-patient relationship centered on care and compassion.

Removing the link from volume and dollars nudges the relationship away from previously held beliefs and decreases the sentiment of unnecessary care. While healthcare systems must be cautious in how far the pendulum swings, careful not to evoke the same criticism from the days of HMOs and traditional capitation, VBP brings new priorities to the cost equation that can support reinstatement of trust in the doctor-patient relationship.

Conclusion

Overall, as a system, there are many ways patients will benefit from the shift away from volume driven payments. These new VBP models, involving providers taking on more individual responsibility for the health of their patients, will require attention, infrastructure, and a shift in perspectives. While these may seem as further contributing to the complexity and uncertainty patients feel in accessing care or understanding how the system functions, successful versions of VBP create a host of positive externalities that come from putting the patient's health, financially, at the center of the economic equation.

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