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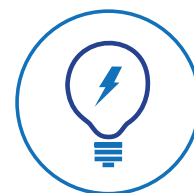
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EDITOR'S LETTER



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

Managing Editor

To learn more about Colette,

[click here](#).

Happy New Year! 2019 ushers in a new look for the *Wharton Healthcare Quarterly* beginning with the [PDF version](#) of the publication. And in the April edition you will experience the updated design of the web version.

Additional enhancements for 2019 will include:

- more articles in an interview format
- the return of the Wharton Around the Globe column

If you are interested in participating in either, [please let us know](#).

And, with all the changes the healthcare arena brought to us in 2018, this year promises to be as unpredictable and volatile as ever before. Therefore, it is fitting that the first issue of the year provides an even more eclectic series of articles than usual and covers myriad facets of the changing landscape and the impact on stakeholders. And it also seems to illustrate what appears to be a vacillating tug-of-war between technology and the many forms of human “touch.”

I encourage you to take the time to dig in to gain insights, perspectives, and up-to-the minute news that will keep you abreast of trends, innovations, and opportunities in healthcare.

Lastly, the 25th annual Wharton Healthcare Business Conference will be held January 31 – February 1. This year's theme is “Challenging the Status Quo in Healthcare.” Check out the [keynote speakers](#) and [panel](#) topics. [Register](#) now to save your spot!

Hope to see you there!

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

Managing Editor

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The WHCMAA would like to thank our sponsors for supporting the organization.

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THE PRESIDENT'S DESK

In Every Issue



John Barkett, WG'09

To learn more about John,
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system; that scholarship and research elevates public debates and private pursuits; and that an interdisciplinary approach was necessary to make a difference – through business or government. The winners of the Kissick Scholarship were Shivani Amar WG'19 and Ariana Chehrazhi WG'19.

We celebrated all five scholarship winners at the HCM Alumni dinner on November 1st. Each student addressed the alumni present, talking to us about their past, what they're doing on campus, and what they plan to do after they graduate. It's my favorite event of the year, by a long shot. Hearing their passion and ideas, one quickly realizes the importance of supporting the HCM Program.

Last year the WHCMAA provided over \$50,000 in scholarships to Wharton Health Care Management (HCM) students. The June Kinney scholarship was offered to three students who demonstrated a sense of social mission and leadership characteristics that will both build community within the class and contribute to the societal healthcare enterprise after graduation. The winners of the Kinney Scholarship were Jenna Ackerman WG'20, Elizabeth Morse WG'20, and Nina Underman WG'20.

The Kissick Scholarship was offered to two students whose pursuits reflect the values and work of William L. Kissick, MD, one of the founding faculty of the HCM program. Dr. Kissick believed health policy was an important tool for improving the healthcare

And we can help you support it! The WHCMAA can help any alumni interested in recruiting, mentoring, or financially supporting students. We're also the place to come for networking with fellow alumni and engaging with the program. We hope to see you at WHCMAA event at the JPMorgan Healthcare Conference, at the HIMSS or ASCO annual conferences, or at any of a number of the regional events this year!

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ALUMNI NEWS

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

One of my articles, "[Healthcare in Crisis – 4 Leadership Hacks for Challenging Times](#)," was published in [Becker's Hospital Review](#).

I also participated in a National Academy of Medicine Workshop, "[Health Literacy and Older Adults: Reshaping the Changing Landscape](#)," and the [Meeting Proceedings](#) were recently released.

And with the start of a new year, check out [Be Less Stressed](#). Choose better health, greater well-being, and more happiness in 2019!

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[Learn more.](#)

Amanda Hopkins Tirrell, FACHE, WG'86

I am excited to report that last summer I launched my consulting practice – Hopkins Tirrell & Associates, LLC. For the past year, I have had the good fortune to work with a number of great organizations. Many thanks to my fellow WHCMAA friends and colleagues for their support and helpful advice in starting my own business. After 35 years as a healthcare executive working for organizations and companies all over the country, I am happily now "The CEO of Me!"

Hopkins Tirrell & Associates offers collaborative strategic and operations solutions for hospitals, health systems and physician groups practices. Advisory services include: clinical operations transformation, EHR preparedness, clinical program/practice performance evaluation and performance improvement, clinical strategic planning and facilities redesign, patient access services transformation, revenue cycle management, and physician network development and integration. Operations management solutions include interim executive leadership and management services for ambulatory care programs and medical group practices.

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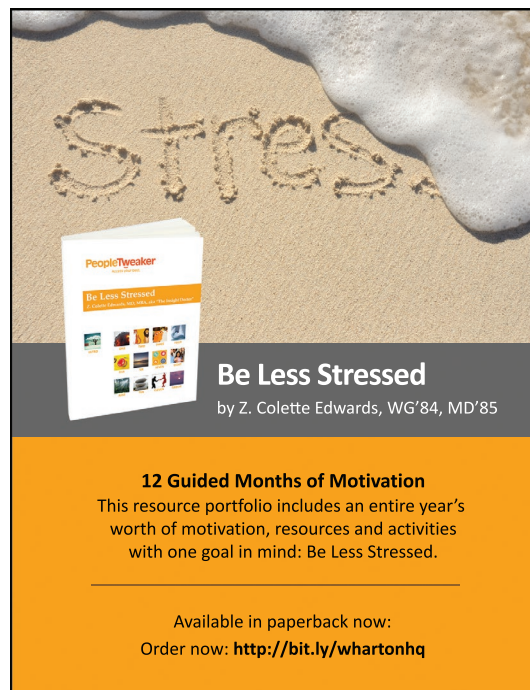
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Todd Guren, WG'03

I have been looking for opportunities to give back to the community and started serving as a board member at a local non-profit, Lines for Life. Lines for Life helps prevent suicide and substance abuse by running phone crisis lines and advocacy. On the professional front, I continue to work as a Director of Product Management at the local BlueCross BlueShield (Regence) that serves Oregon, Washington, Idaho, and Utah. On the family front, we enjoy the outdoors in the Pacific Northwest. My 10 year-old son is on a club gymnastics team and placed second for his age and level in the regional competition, and my 6 year old has started playing violin.

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[Learn more.](#)




In Every Issue

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THE PHILOSOPHER'S CORNER

In Every Issue



RECOMMENDED READING

- *Total Leadership* by Stewart Friedman (Wharton Professor)
 - Probably the single most transformational reading I have had in my life. I have read and re-read this book yearly, since I was a student at Wharton.
- *The Leader's Checklist* by Michael Useem (Wharton Professor)
 - A fantastic short read and resource for everyone who seeks to advance their own leadership toolkit
- *Hippocratic Oath and Declaration of Geneva*
 - No matter what sector of healthcare we serve, it is important to remember why we do what we do.

LIFE LESSONS

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

- taken a few moments to sit back and reflect on an accomplishment and/or celebrate a success. In our quest for continued excellence, it is so easy to continue to focus on 'the next goal or achievement' without recognizing the journey that you or others have made so far.

If I knew then what I know now, I would NOT have...

- let my own self-confidence hold me back from pursuing a goal. I have found we are much more capable of achieving things than what we think or believe we are. The human will and potential are great, and it is important to be reminded that we should not fear failure.

FAVORITE QUOTES

1. "Life is long, and the world is small." ~ Mom
2. "Experience is simply the name we give our mistakes." ~ Oscar Wilde
3. "No matter what anybody tells you, words and ideas can change the world." AND "Carpe diem. Seize the day. Make your life extraordinary." The Movie "Dead Poets Society" ~ watched during Dr. Terry LaPier's class

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THIS MONTH'S PHILOSOPHER:

Brian Corvino, WG'11

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

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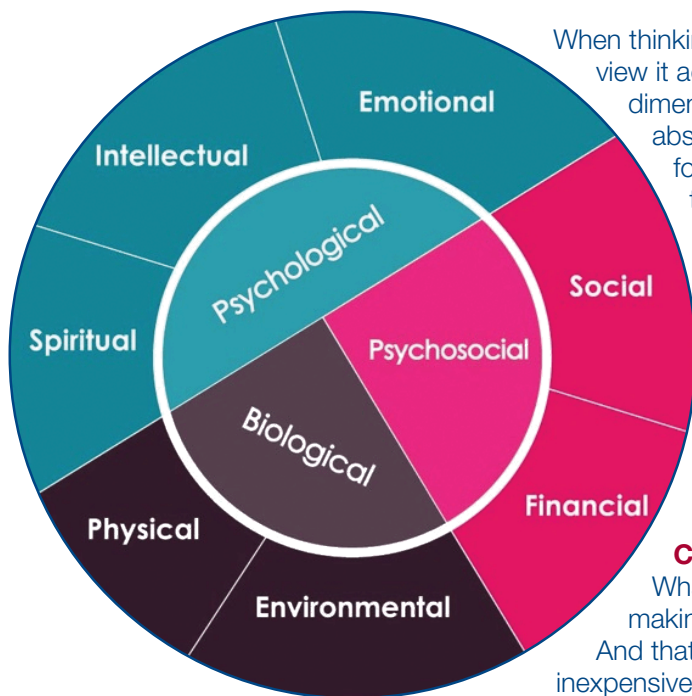
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NOT A FREUDIAN SLIP: THE MAGIC OF MUSIC ON HEALTH

Sitting at a traffic light blaring a song as loud as my ears would tolerate, I laughed at the sight of my reflection in the rearview mirror, singing each word as if I were the one on stage performing. My anger melted away as I jammed out to Can't Stop the Feeling! Then I began to wonder, did this song transport me momentarily to a space that erased the frustration I was carrying from an earlier disagreement with my co-worker? Can music lift me out of a funk?

With these questions orbiting around my mind, I began to question the impact music has on our emotions, our mind, or our mood. Knowing our emotions and thoughts are a major part of our health and healing, I wanted to dig deeper in hopes of uncovering meaningful insight for my professional and personal quest toward health and happiness.



When thinking about health I tend to view it across a spectrum of seven dimensions, not simply as the absence of disease. Similarly, for this investigation, I began

to explore what the literature reveals about music and health. Not surprising is the evidence on music's positive impact on our overall health and quality of life. What is surprising is the limited use of music in mainstream healthcare interventions or as a critical requirement in education.

This article briefly reviews how music positively impacts all seven dimensions of health. It closes with considerations on how to infuse the transformational power of music into our communities and into our lives.

COMPREHENSIVE WELL-BEING








What if I told you there was a therapy that had the capability of making a significant, positive impact to healing and health outcomes? And that this intervention or treatment had no side effects, was inexpensive, in some cases even free, and repeatedly proven effective? That would be music to your ears – right? Similarly,

what if I shared evidence demonstrating that one particular subject has the transformational power to enhance emotional and cognitive development and functioning greater than any other subject in school? Would you make a recommendation for or against the removal of this critical element from the curriculum within our education system?

Most of us would agree that, overall, music enhances our everyday life. Music has been shown to improve cognitive development, provide solid therapeutic value across multiple diseases and illnesses, restore function, unify a community, and is one of the strongest mood regulators available.¹⁻³

Music changes our brain in profound ways. There is an entire body of research that demonstrates music's impact on intelligence and learning.^{4,5} Increased language and communication skills, enhanced memory and performance, as well as expanded creativity and imagination are valuable effects music can have on school children and adults alike.⁶

Research findings continue to support anecdotal observations that music can drastically impact an individual's self-confidence and overall psychological well-being.⁷ And further, music listening and music making encourages social cohesion and cooperation,⁸ a benefit I got to see firsthand as I visited The Sanctuary Studio at Stove Top Entertainment

Health Dimension		Positive Impact of Music	
Mental		Language development	Creativity & imagination
		Working memory	Attention / focus / concentration
		Information absorption	Intelligence & achievement
		Divergent thinking	Problem solving
		Performance	Spatial reasoning
Emotional		Mood regulation	Self-esteem
		Resilience	Emotional expression
		Empathy	Optimism
		Pleasure	Depression & anxiety reduction
Social		Bonding	Cooperation
		Team work	Understanding
		Unity	Appreciation
		Tolerance	Alignment
Spiritual		Fills the soul	Affiliation
		Nurture faith	Worship expression
		Harmony	Reach unconscious & interiority
Physical		Coordination	Reduce pain
		Restore function	Relaxation
		Stimulate activity	Reduce heart rate, pulse and BP
		Boost endurance	Improve immune function
Economical		Inexpensive or even free	Improve adherence to treatment
		Reduce need for Rx	Reduced healthcare expenses
		Speed recovery	
Environmental		Increase productivity	Elevate ambience
		Create shared experience	Cultivate supportive community
		Upbeat atmosphere	Calming

in Raleigh, NC - a community of diverse strangers, brought together through the power of music to maximize the creative freedom of musicians and lyricists. Their Founder and CEO, Craig Anderson, describes the experience: "We've seen a multitude of people come through our little studio in Raleigh with their own confidence issues, emotional baggage, addictions, bad associations, and all levels of mental health issues. We focus on making sure artists go into their 'creative zone' by removing the mental, social, and societal obstacles. Basically, we provide a supportive atmosphere that trains and encourages their creative brains to get out on the playground for a while. We've seen mothers reuniting with children they previously weren't allowed to see, young men constructively earning the respect and validation they seek rather than demanding it through violence, and corporate warriors who do nothing but follow processes find life's meaning again... It's been wonderful to see these effects of music so clearly on who we are and how we perceive the world."

THROUGH A MEDICAL LENS

Our society is facing many health challenges. Between the opioid addiction epidemic, increasing rates of depression, anxiety, and suicide, and complex health conditions which are multiplying, alternative solutions to healing and relief have to be explored. This need is especially clear as these become exacerbated by a growing elderly population with increased isolation and co-morbid chronic conditions.

Music has been shown to motivate people to participate in health interventions and adhere to treatment recommendations.⁹ People undergoing medical treatment can ameliorate negative symptoms across a variety of settings and specialties such as palliative care, intensive care, obstetrics, pediatrics, geriatrics, ophthalmology, and neurology.⁷ Research has shown through music people undergoing cancer treatment can have reductions in heart rate, respiratory rate, and blood pressure.¹⁰ Further, individuals with dementia, Parkinson's, and degenerative diseases have had significant positive health impacts through non-invasive and economically viable music interventions.^{11,12}

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NOT A FREUDIAN SLIP: THE MAGIC OF MUSIC ON HEALTH



Where words fail
MUSIC speaks.

-Hans Christian Andersen

Could a focus on music interventions be the game changer needed in the battle against the opioid addiction? Studies have proven the rehabilitative nature of music to promote relaxation (reducing anxiety), ignite cheerfulness (decreasing depressive feelings), and improve comfort and pain tolerance (decreasing pain intensity). Numerous studies reveal how music therapy is an effective, non-pharmacological approach for post-operative pain management, helping people feel more control over their chronic pain.¹⁰

ENVIRONMENTAL IMPACTS

Have you ever noticed music playing as you're walking around a shopping center? What if the benefits of music were used to ignite creativity and motivate productivity versus stimulating the economy by changing your state of mind to be inclined to purchase more? Unique radio service Silver Memories program uses music to trigger nostalgic memories by broadcasting music from the 20's to the 50's, resulting in a positive impact on well-being, morale, behavior, and relaxation.¹³ Weaving music into our environment, our workplace, our home, and surroundings enables us to harness positive emotions and maximize cognitive functioning to foster social interactions and interpersonal relationships.^{2,3}

With a personal story describing a recent and relevant example combined with all the evidence demonstrating that music has transformational powers, a few basic questions deserve consideration. Why is music the first program cut in schools? Why is it extremely limited in mainstream healthcare? Shouldn't something with such impact and influence, that is proven effective, accessible, and inexpensive, be incorporated into first-line treatment, as well as expanded in academia, not the opposite?

There's a quest throughout the healthcare space to deliver real, measurable, and tangible positive effects on patient engagement, experience, and outcomes. This includes people and companies developing products like apps that help

people mindfully reduce stress, brain training programs meant to improve memory and attention, self-help books on mood regulation and emotional intelligence, pharmaceuticals indicated to reduce anxiety, and healthcare professionals and clinicians providing services. Each one is seeking the magic pill to improve health and quality of life, not yet realizing that the answer might be both simpler and more enjoyable than they are envisioning.

In the follow up article we'll explore proven educational and therapeutic applications of music in hopes of promoting each reader to be compelled to weave more music into their practice, their classroom, and their everyday life. As pianist James Rhodes said, "Music is where the magic happens." And who doesn't want a little more magic as part of the way they heal, or the way they learn, or as a catalyst to all the beautiful benefits music can bring to the rhythm of life? This exploration has certainly inspired me to seek out pleasurable experiences and test these positive research findings personally.

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AFFIDAVIT: HEALTHCARE AND THE LAW - A PRESCRIPTION FOR A CHANGING HEALTHCARE SYSTEM

If you have never heard of a pharmacy benefit manager, you are not unique among most Americans. What if I told you there are entities within the American healthcare system that essentially act as middlemen who transfer money between drug manufacturers and health insurers, employers, and pharmacies but that produce no products, yet generate billions of dollars in annual revenue? These are pharmacy benefit managers.

While that may be an oversimplification of the role of pharmacy benefit managers, or PBMs for short, within the American healthcare system, the role of PBMs are little known and even less understood. PBMs may be obscure entities, at least to the average American not ingrained in the healthcare industry. However, the once hidden middleman has been recently thrust into the spotlight as the subject of much controversy surrounding high drug prices and mega mergers. This article briefly explores the role of PBMs and the current controversy that surrounds these drug behemoths.



What is a PBM? In the late 1960's and early 1970's drug card programs emerged as an ancillary service to medical benefit programs. PBMs were originally formed as processors of prescription drug claims under such medical benefits. Throughout the 1980's and 1990's as more and more employers implemented drug benefit plans and such plans became more and more popular under health insurance benefits, PBMs fulfilled the role of honest brokers in building computer infrastructure to automate the submission of drug claims. Drug benefit management was off-loaded to the third-party entities who would offer online, real-time adjudication of drug claims. The business of PBMs proliferated in the late 1990's and early 2000's. During this time, the major PBMs formed or purchased pharmacies that compete with retail, mail order, and specialty pharmacies within their networks.

What does a PBM do? A full-service PBM is an entity that focuses on managing the prescription drug benefits on behalf of insurance companies, employers, union groups, third-party administrators, Medicare Part D Plans, managed care organizations, and other payers. PBMs' roles, however, go beyond just adjudication of claims. PBMs create pharmacy networks, which their members can utilize to obtain prescription drugs; they develop formularies (drug lists of covered therapies); and, they contract for drug manufacturer rebates. PBMs' roles span the trifecta of the insurance, pharma, and pharmacy industries. PBMs have their hands in every stage of the drug supply chain. The largest of these entities are Express Scripts, CVS Caremark, and OptumRx, collectively owning approximately 80% of the market share for PBM services in the United States.

What makes PBMs so amorphous to the masses is their behind-the-scenes operations. Even more complexing is the virtual black box of revenue. Despite the widespread demand for increased transparency, how PBMs generate billions of dollars is still opaque. Even though PBMs provide substantial management services for very large employers and insurance companies, and collectively manage the drug benefits of hundreds of millions of Americans, it might still surprise you to learn the largest PBM, CVS Health, listed as number 7 on the 2017 *Forbes* Fortune 500 list, earned \$184 billion in revenue in 2017 – over \$100 billion more than the largest pharmaceutical manufacturer's earnings in 2017. Johnson and Johnson's 2017 revenue sat at \$76.5 billion.

How is it that PBMs earn such substantial revenue? Imagine the billions of prescriptions that are dispensed each year throughout the United States – 4.06 billion in 2017, for example. PBMs charge on average between \$3 and \$5 per prescription for their services. In addition, plan sponsors (the payers) pay PBMs for the cost of the prescription on behalf

of the member or insured minus any cost-sharing amounts.

Beyond the traditional fee structure outlined above, the opaqueness of PBMs' operations and the sources of revenue have not been shy of controversy as the subject of much government scrutiny, as shown by the examples below.

PBMs "play the spread." PBMs have the ability to control the cost of your prescription for which your insurer or employer pays. PBMs will often charge the insurer or employer more than it is reimbursing the pharmacy that dispensed your medication. For example, a PBM will charge the insurer \$200 for a prescription for which it reimburses the pharmacy \$180, and will pocket that \$20 spread.

In August of 2018, Barbara R. Sears, Director of the Ohio Department of Medicaid, instructed the state's five managed care plans to terminate and/or renegotiate PBM contracts in order to transition from a spread-pricing drug purchasing model to a pass-through model, effective as of January 1, 2019. An auditor hired by the State found that in 2017 PBMs contracted with the managed care plans charged the managed care plans \$223 million more than what the PBMs paid in pharmacy costs.

PBMs charge administrative and performance fees to network pharmacies. These are sometimes referred to as direct and indirect remunerations. PBMs through unilateral contracts will require network pharmacies to meet performance standards, many of which are inapplicable to patient populations or are otherwise unattainable. As a result, the PBM will either withhold or claw-back monies from under-performing pharmacies. These practices cost pharmacies millions of dollars in earnings annually, diminishing the ability of many to provide high-quality pharmacy care.

This past year more than 50 members of Congress urged the Department of Health and Human Services and the Centers for Medicare and Medicaid Services to eliminate the allowance of such fees. Additionally, states Attorneys General, including publically Arkansas and Ohio, are conducting investigations into such PBM pricing practices.

PBMs also earn substantial rebates from drug manufacturers, which has essentially become a pay-to-play marketplace. With

PBMs controlling the vast majority of lives in the United States, ergo control over what drugs can reach covered individuals, drug manufacturers pay monies to PBMs to place their drugs on PBM formularies. PBMs typically keep a percentage of the rebate and sometimes pass part of the rebate through to the payer client. However, according to many commentators, drug rebate programs likely increase drug expenditures if PBMs create incentives to drive utilization toward higher cost, brand name drugs.

While these types of rebates arguably fall under safe-harbors to the Federal Anti-Kickback law – namely the shared risk or discount safe harbors – Secretary of Health and Humana Services, Alex Azar, has proposed the elimination of such rebates in a proposal sent to the White House, entitled "Removal Of Safe Harbor Protection for Rebates to Plans or PBMs Involving Prescription Pharmaceuticals and Creation of New Safe Harbor Protection."

The value of PBM operations is not lost on others in the healthcare marketplace. This is evidenced by the \$60 plus billion acquisitions of CVS Health by Aetna and Express Scripts by Cigna.

CONCLUSION

PBMs tout their ability to save millions of dollars in negotiated drug costs for the American healthcare system. That may very well be the case. However, being the gatekeeper for access to prescription drugs for hundreds of millions of American, it is difficult to justify the continued lack of transparency in PBM practices.

What is important for healthcare providers to understand is how PBM pricing practices affect their practices and patients' access to the right medications at an affordable cost. Healthcare providers affected by limitations imposed by PBMs should contact a qualified healthcare attorney to discuss options.

The government's heightened scrutiny into the PBM marketplace, however, could unveil specifics of numerous opaque practices and present opportunity for additional cost savings and broader access to medications across the American healthcare system.

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DOWNLOADING SUCCESS: BEYOND ONBOARDING

Most new leaders fail within 18 months. Executive Installation makes those odds a whole lot better.

When a new leader is promoted or hired within a healthcare organization, the initial tendency of the search committee or the hiring manager is to relax. After all, the hard work is over, right? The savvy, experienced executive will hit the ground running and make quick improvements to his or her department or the entire organization, in the case of a new CEO.

In truth, the moment the leader has signed the offer sheet is when the work of acclimation should begin in earnest with what we call Executive Installation, a far more rigorous undertaking than a perfunctory onboarding or orientation process.

The suggestion that a detailed, intentional process should be put in place immediately can seem odd or off-putting initially to both the new executive and the board chair or search committee. “It’s like telling people on their honeymoon they should get some marriage counseling,” one executive told us.



Yet the cost of doing nothing is quite high:

- Nearly 60 percent of newly hired or promoted executives fail within 18 months of taking the new position.
- Some studies put the cost of a single failed executive hiring at up to \$2.7 million, although this depends on the size of the role and the institution.
- About 35 percent of companies don’t spend a single dollar even on onboarding.

One CEO of a major U.S. health system told us only 60 percent of an executive’s experience is applicable when he or she accepts a new position; the other 40 percent is unique to the new organization and must be learned and assimilated.

Simply put, installation focuses on the relationship between the new executive and his or her supervisor. Here is why this is critical: Research indicates that when newly placed executives leave their positions early, in most cases it is directly related to their relationship with their boss.

Common obstacles to an effective installation include:

- **Underestimating the significance of framing out the relationship.** A clear understanding of communication styles and preferences can help both parties prepare for the bumps in the road that occur with any business or personal relationship.
- **Timing and the rules of engagement.** Both want the new executive to achieve early successes, and that doesn’t leave time for much else. Once several months have passed by, it can seem too late or out of order to spell out rules of engagement.
- **Deference and fear.** The boss has hired an impressive, experienced executive for a reason and doesn’t want to be seen as looking over his or her shoulder. On the other side, the new executive is afraid to be seen as having too many questions or lacking confidence.
- **A basic misunderstanding of the installation process.** While installation may bear some similarities to executive coaching or onboarding, it is much more specific to the partnership that needs to be formed between the new leader and her/his boss.

Executive installation begins with the new leader and his or her supervisor in a room with a facilitator. Simple questions are asked of both of them – questions which may not have been asked in detail in the interview process. Some of these examples are below.

Questions to begin the installation process:

- How do you like to communicate?
- How do you like to give or receive feedback?
- Do you prefer face-to-face reports or written executive summaries?
- What are your fears or apprehensions as we begin this process?
- What are you most excited to achieve?

When creating an executive installment plan it's imperative to focus on creating a safe environment to talk freely, a setting that often is not available in onboarding, where the focus is learning how the company operates and getting a quick sense of the culture. In such an environment, there often is not time nor is it advisable to ask pointed questions.

In the second phase, you should compare the leader and the supervisor's personality assessments, discuss findings derived from interviews and references, and, in some cases, day-in-the-life simulations. Also, be sure to examine what direct reports have said about them. All of this data, along with their interaction in the installation process, becomes part of the development plan.

Why so much effort? It's because so much is at stake. Human resources expert John E. DiBenedetto has looked at some common reasons why new leaders fail. These include:

- Leaders try to personify the need described in the recruitment process, but may be initially unaware of obstacles or missing some key information.
- New leaders can be unfairly expected to solve every single one of the company's issues – and do it quickly.
- The executive feels pressure to produce, which can lead them to make decisions too quickly.
- Leaders haven't developed key internal relationships in their new organization

and may not know how to access needed information for decision-making.

In the third stage of executive installation, the groundwork is laid for improving the development and performance of the new leader's team. In the same way the executive and the supervisor underwent assessments and were guided through communication processes, the new leader and his or her direct reports discuss their key drivers of personality, performance, and challenges. We will look at this in more detail in the next issue.

If one wishes to extend the analogy that a new leader has a honeymoon period, then the installation process does not need to be threatening to any party in the least. It's an excellent and appropriate time in a safe environment to discuss the new leader's vision and to seek input from both supervisor and direct reports. It is a wonderful exercise to align expectations.

The benefits of executive installation are many. It produces:

- **Greater self-awareness** for the placed executive and an understanding of how people in the organization experience and respond to them and their leadership.
- **Clarity** between placed executive and boss on mutual goals, feedback, and communication loops.
- **Strong relationships.** This is essential so that, when adversity strikes (which it will), the relationship will be able to weather the turbulence and resolve the issues.

It's important to be aware that executive installation is not always a straight and linear process. Human relationships are complex and can be messy. But it's always easier to begin the work early before the cement dries on the relationship. You're building a successful foundation – don't leave your organization's success to chance.

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TO YOUR HEALTH: FOR OBESITY, THE ENVIRONMENT IS EVERYTHING, OR IS IT?

There is a scene in *Frontier House*, part of the 'hands on history' reality series on PBS, when one of the characters complains of chronic fatigue and is concerned he is losing too much weight. The physician asked to evaluate the man concluded he was simply experiencing the challenges of life on the frontier following a life of luxury in the late 20th century. The prescription was "Drink more water." The obvious conclusion is that cutting your own wood, working your own fields, and being laborious daily as a frontiersman leads to fat loss. From the comfort of our couch, that would seem reasonable.



Other examples seem to verify the hypothesis that activity level leads to lower weights and body fat. In a study by Hairston et. al. Old Order Amish children averaged 80 minutes more activity/day than non-Amish children did. Not surprisingly, BMIs were inversely related to minutes of activity in those studied. Bassett et. al. studied 98 adult Amish in southern Ontario, ages 18-75. The findings were as expected, with males and females averaging 18,000 and 14,000 steps respectively. BMI scores indicated obesity levels were 0% for the males and 9% for the females. These are all remarkably different from the typical non-Amish in North America.

When you look at smartphone data you also see evidence that obesity is higher in 'activity poor' areas. These are areas where there is a clear disparity between the highly active and the underactive. In one neighborhood you may have the person who gets 12,000 steps per day walking their dog and moving at work, while the next neighborhood has auto commuters who sit at a desk for work and barely reach 2,000 steps per day. Tim Althoff was the lead author of the *Nature* article 'Large-scale physical activity data reveal worldwide activity inequality.' In this study over 700,000 people in 111 countries shared their accelerometer data with the Stanford University group. It is from this data that 'activity inequality' was first recognized and appears to associate strongly with higher rates of obesity. Where does that leave us with physical activity and obesity?

The traditional model says if a human expends 1000-1800 calories/day at rest and then adds physical activity for an additional 30-50%, the totality for the day might be ~1400-2500 calories expended. Herman Pontzer, an anthropologist from Hunter College, terms this the additive approach to energy expenditure. Unexpectedly, there is evidence from distance runners and traditional Tanzanians that it isn't quite that simple. KR Westerterp in Holland found total expenditure in runners did not follow this trend. Pontzer had similar findings with the Tanzanians. They posit that over the last 200,000 years we may have adapted to adjust our resting metabolic rate *lower* to counter higher bouts of physical activity.

Pontzer hypothesizes this adaptation allowed humans to avoid tapping their most precious resource, kilocalories, as they continued to evolve bigger brains and higher levels of function. He and his group were able to study the Hadza tribe. They remain a traditional hunting and gathering society. Total calorie expenditure, physical activity, and weight were all tracked on both the men and the women. Despite higher levels of physical activity by both the males and females, the total energy expended by the Hadza was not higher than non-agrarian Westerners. Despite higher physical activity by the Hadza women, they expended ~1900 kcal/day while Western women expended ~2300 kcal/day. Pontzer calls this hypothesis the 'constrained energy expenditure' model. It should be noted the average Western female weighed 70 lbs more than

the Hadza women, so the higher energy expenditure, even in a less active population, might have been expected.

Look at it this way; humans have been through some tough times. It is only recently that we have had, in some parts of the world, the luxury of excess stored calories and a bountiful food supply. If you know someone who lived through the Great Depression or was challenged with a crop that failed on the farm, then you can recognize why they may be very careful about wasting food. Well, our physiology may very well be the same. Not unlike when President Carter asked Americans to turn down the thermostat in the 70s when oil prices were climbing, we potentially turn down some of our physiology to prep in the case the icebergs start forming again as they did 30,000 years ago.

Regardless of how it affects the kilocalories that you burn, your activity level is likely paying grand benefits in other ways, so don't stop now.

Good Hustle!

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MIND THE GAP: WHAT IF WE TREATED ZIP CODES BEFORE TREATING DISEASE?



Think about your neighborhood...is it walkable? Are primary care providers nearby and easy to access? Are there safe parks and affordable grocery stores? If not, your health could be at risk.

Health can be determined by many factors, including geography. Neighborhoods that lack characteristics like green space, affordable grocery stores, and access to primary care providers can negatively impact residents' health. Addressing place-based health factors like these creates the potential to produce healthier communities.

GEOGRAPHY HAS A SIGNIFICANT IMPACT ON HEALTH.

There is a **20-year disparity in life expectancy across US counties**, and the gap is widening.¹ The areas where people live longest — an average of 87 years — tend to be well-off, highly educated communities like Marin County, California, or Summit County, Colorado. At the other end of the spectrum — where average life expectancy is just 67 years — are low-income neighborhoods in places like McDowell County, West Virginia, and Owsley County, Kentucky. That's because the places where we live, work and play have a huge impact on our health.



Take healthy food, which we know is a major factor driving cardiovascular health and type 2 diabetes. Over **13.5 million Americans live in "food deserts,"** defined as urban neighborhoods more than 1 mile from a grocery store or rural areas where the distance is 10 miles or greater.² Because residents are forced to rely on unhealthy food options from convenience stores and fast food restaurants, their health suffers. In Chicago, the **death rate from diabetes in food deserts is twice that of other neighborhoods.**³

Even when people can access grocery stores, the healthy option is not always affordable. Higher-calorie, energy-dense foods are a better bargain, costing on **average \$1.76 per 1,000 calories**, compared with **\$18.16 per 1,000 calories** for low-energy-density nutritious foods.⁵

Air pollution is another example. Between **30 and 45 percent of the North American urban population lives "next to a busy road,"** putting these individuals at greater risk for the onset of childhood asthma, impaired lung functions, premature death and death from cardiovascular diseases, as well as cardiovascular morbidity.⁴

Neighborhood factors also can influence health when communities lack the resources to support physical activity — which is associated with type 2 diabetes, cardiovascular disease, and others.⁶ Population density plays a role, as **growing up in a city doubles the risk of developing psychosis** and heightens the risk of depression and anxiety.⁷

WHERE YOU LIVE ALSO IMPACTS ACCESS TO HEALTHCARE.

Place-based influences also impact the ability to access healthcare.

Seventy-seven percent of rural counties are considered Primary Care Health Professional Shortage Areas (HPSAs) and 8 percent of rural counties have no primary care physicians at all.⁸



This is not limited to rural areas. In a recent survey of an urban, low socioeconomic status area in Dayton, Ohio, **31 percent of residents had difficulty accessing healthcare due to lack of transportation.**⁹ A 2016 survey of low-income **patients in a New York City suburb found that patients who rode the bus to doctor appointments** were twice as likely to miss their appointments as patients who drove cars.¹⁰

Access to transportation affects illness management as well. A 2013 review published in the *Journal of Community Health* discovered that **patients who reported lack of access to transportation also missed filling prescriptions more than twice as often as patients without access issues.**¹¹

EVEN WHEN TREATED, PROGNOSIS IS OFTEN WORSE IN CERTAIN ENVIRONMENTS.

To compound the issue, even when patients receive treatment for health conditions, environmental factors impact their response to treatment and prognosis. A 2008 study showed that for patients treated for myocardial infarction in Olmsted County, Minnesota, **poor neighborhood-level income was a powerful predictor of mortality.**¹²



Environment affects mental health prognosis as well. In a 2009 study examining the effect of socioeconomic status on outcomes and attrition in the treatment of depression, researchers discovered that **lower socioeconomic status correlated to lower effectiveness of treatment** and less mental health improvement overall.¹³

BUT WHAT IF WE TREATED ZIP CODES BEFORE DISEASE? THERE COULD BE HEALTH AND FINANCIAL BENEFITS.

As healthcare moves towards preventive care, what if we targeted specific place-based influences in our communities? What would be the health and financial benefit if we could be more proactive in **treating “zip code” factors before they lead to poor health outcomes?** For instance:

- Place-based behaviors: Understand and address the factors that drive individual behaviors around diet, exercise, health screenings, etc., and especially how proximity to affordable, nutritious food can impact short- and long-term health outcomes
- Access to healthcare: Understand the limitations to healthcare access in communities and generate opportunities to make services more readily available
- Environmental hazards: Understand patients' potential exposure to pollutants (air, water pollution) based on where they live, work, and spend time



A recent study found that an investment of \$10 per person in proven **community-based programs** to increase physical activity, improve nutrition, and prevent smoking and other tobacco use could help **save the country more than \$16 billion annually within five years.** That's a return of \$5.60 for every \$1 invested. Out of the \$16 billion, Medicare could save more than \$5 billion and Medicaid could save more than \$1.9 billion.¹⁴

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MIND THE GAP: WHAT IF WE TREATED ZIP CODES BEFORE TREATING DISEASE?

More astounding are the opportunities around mental health. A World Health Organization-led study estimates that every \$1 invested in managing depression and anxiety leads to a return of \$4 in better health and ability to work.¹⁵ A 5 percent improvement in labor force participation and productivity is valued at **\$399 billion**, and **improved health adds another \$310 billion** in returns.¹⁶

THE GOOD NEWS IS THAT SOME KEY PLAYERS IN HEALTHCARE HAVE STARTED THE SHIFT.

University of Texas System Project DOC (Diabetes and Obesity Control): The lower Rio Grande Valley in Texas faces high diabetes prevalence (**28 percent diagnosed and an additional 32 percent with pre-diabetes**), medical deserts (**40 percent fewer physicians** per 100,000 population than the rest of Texas) and lack of access to health services (**80 percent uninsured** among Mexican-Americans in Brownsville).¹⁷ The University of Texas, in collaboration with PwC, area providers, and others, is focusing resources in the Rio Grande Valley to improve access to healthcare through technology-enabled care coordination and to modify behaviors through education, diet, and biometric monitoring.



MedStar collaboration with Uber: Partnerships with ride-hailing companies are emerging around the country and are sometimes even covered by insurance. One such example is MedStar's collaboration with Uber to address transportation barriers to accessing care for its patients in the Maryland and D.C. area.¹⁸

HAVE YOU STARTED TO ASK HOW YOU CAN TAKE ACTION?

Providers and payers are part of the communities they serve and, given the **social and financial imperative to take action**, they should understand the environmental factors that create the most health burden in their communities.

Taking action starts with asking the right questions:

- What are **the key challenges** patients face in my community?
- How can I better **understand** my patients' physical environment?
- Do patients in my community need help **accessing care**?
- How can I help my patients make **healthier food choices** within their means and geography?
- What are some of the environmental and cultural barriers in my community that impede an **active lifestyle**?
- How can I influence **policies** that impact the health of my community?
- Who do I need to **partner** with to get started?



Addressing place-based health factors has the potential to produce not only healthier communities, but also healthier businesses by improving employee well-being, reducing downstream medical costs from secondary and tertiary care, and building brand reputation and recognition. By addressing the right questions to treat zip codes before disease, organizations can help build a sustainable, profitable platform in the communities they serve.

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INVOLVING FAMILIES IN THE INTENSIVE CARE UNIT: AN UNDERUTILIZED RESOURCE FOR CREATING BETTER PATIENT OUTCOMES



Involving families in the care of patients admitted to the ICU can clearly produce better outcomes and lowers costs. The care delivered in the intensive care unit (ICU) is among the most resource-intensive practices in medicine, requiring constant vigilance from nursing and medical providers, coordination of care from numerous ancillary staff, and delivery of high-cost interventions. When family members are engaged as part of this complex practice, they can help speed the recovery of their loved ones by reducing delirium and facilitating recuperation of their physical strength. Furthermore, supporting family members ensures the patients continue to receive excellent care after discharge, when many family members become full- or part-time caregivers. Recognizing the critical nature of patient care in an ICU setting, the appropriate coordinated involvement of families is proven to yield faster recovery and higher end points, while actually lowering the total costs of care. Closer attention to patient perception and family satisfaction offers an avenue for continued improvement for both patient care and resource management.

In 2010 the average cost of an ICU stay was estimated to be \$4,300 daily and roughly \$108 billion annually in the United States (Halpern). That equated to roughly 0.74% of the U.S. GDP, and 13.2% of all hospital costs. With such staggering sums, it is not surprising that cost reduction, while preserving excellent patient care, is of great interest and import.

We know family involvement is crucial to obtaining the best possible clinical outcomes. Delirium is a common syndrome in the ICU, resulting in worsened neurologic outcomes and longer lengths of stay. A confused, combative patient may be calmed by their loved one, who can reorient him or her. In fact, when families are given more time with their loved ones in the ICU, delirium can be cut in half and the length of stay shortened by a quarter (Rosa). When patients are mobilized in the ICU — like sitting in chairs or walking — they leave the ICU sooner and with better function (Lai). Family members can work with physical therapists and nurses to maximize delivery of therapeutic interventions.

Faced with the life-threatening illness of a loved one, family members face a number of emotional and cognitive challenges. Anxiety and depression are common, especially among spouses (Pochard). Families may grieve their loved ones, before death or even if it does not occur (Glick). These emotions continue after ICU discharge or death, along with post-traumatic stress reactions (Azoulay). Additionally, family members face challenges in their ability to think in the ICU. Long days followed by sleepless nights spent at the bedside or worried at home leave them sleep deprived, with cognitive blunting akin to someone who is legally intoxicated (Vergeles). Being overwhelmed by this loss of control can spiral into learned helplessness, in which overwhelmed families detach from decision-making and fall into depression (Sullivan). This highly charged environment poses unique challenges to engaging and communicating with families. However, working with the care team is beneficial for families; for example,

parents who partner in the care of their premature infants help their children gain more weight (O'Brien). But the parents themselves also derive benefit, experiencing less stress and anxiety. This effect is also seen in family members helping care for their adult loved ones after cardiac surgery (Skoog et al).

Efforts towards improving communication may also reduce emotional burden and bolster family member confidence. For example, a specially designated communication facilitator - whose role it is to identify family needs, bridge the gap between families and the healthcare team, and manage conflict as it arises — can help reduce depressive symptoms among family members six months after ICU discharge or death (Curtis). Extra attention to communication through a multidisciplinary approach with pre-specified meeting times can improve family perception and overall satisfaction with communication (White). In both instances, use of a dedicated family “navigator” or “communicator” has been shown to reduce both overall length of stay and cost. And when they feel their voice is being heard, families feel more confident in their abilities to make medical decisions (Majesko).

As our knowledge and skill in supporting ICU families increase, we must also consider our metrics. While clinical outcomes such as length of stay and cost is one approach to measure the quality of our interventions, a single, accurate and effective approach to measurement remains a challenge. While the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey is widely used after hospital discharge, its use is problematic for the ICU setting. A significant proportion of ICU patients do not survive their hospitalization; another proportion may have new deficits (termed the “Post-Intensive Care Syndrome”) that also preempt survey completion. For surviving patients, the questions may reflect their feelings about their step-down care after ICU discharge.

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INVOLVING FAMILIES IN THE INTENSIVE CARE UNIT: AN UNDERUTILIZED RESOURCE FOR CREATING BETTER PATIENT OUTCOMES

Studies at Intermountain Medical Center have found that HCAHPS correlate poorly with the experience of patients and their families in the ICU (Lah). The Intermountain Patient Perception of Quality survey – a 26-item questionnaire which addresses many factors such as caring, privacy, and respect as perceived by the individual – may instead be a better measure (Brown). While validated surveys have been developed for research purposes, e.g. the Family Satisfaction in the Intensive Care Unit instrument, their use as a clinical metric of quality is less clear (Wall). The Society of Critical Care Medicine also has comprehensive guidelines to help steer these interventions, further emphasizing the importance of harnessing the power of family involvement and the need for more robust metrics.

Delivering the best quality ICU care means creating systems that provide the best outcomes and an environment that supports both patients and their families. By engaging families, patients do better — and so do their loved ones. An anxious mother asks what she can do to help in the care of her critically ill son. By allowing her to participate by doing simple tasks like mouth care, physical therapy, and reading to him, she is empowered to improve a difficult situation. By harnessing her instincts as a mother, not only is she supported mentally and emotionally, but, best of all, she contributes to the shared, ultimate goal of improving her son's immediate care and longer-term outcome. By wisely designing the inclusion of the family in the complexity of ICU care setting, we are doing not only what seems “right” but what yields the highest end results for the hospital, the care team, and most importantly the patient.

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Featured Article

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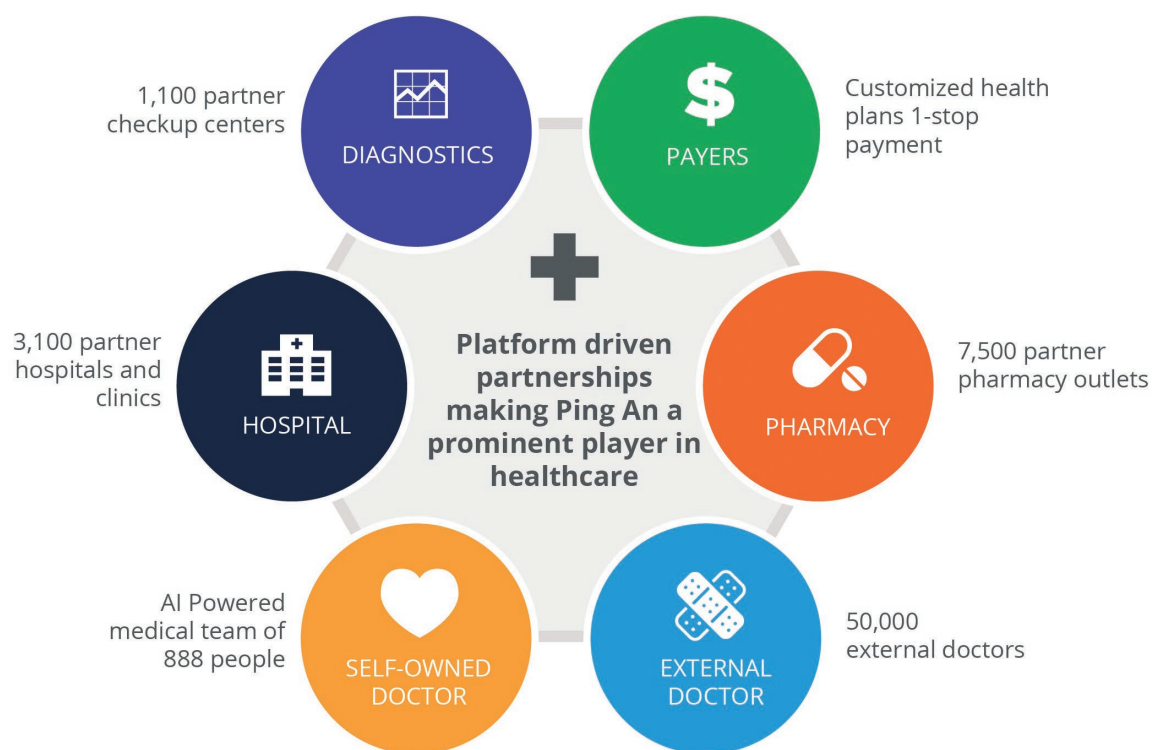
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GROWING MARKET POSITION THROUGH STRATEGIC PARTNERSHIPS IN HEALTHCARE



As the digital revolution continues to disrupt existing business models and blur the boundaries between vertical industries, the potential for strategic partnerships to reinvent, disrupt, or defend a market position are like none we've seen previously. Strategic partnerships have become an important part of the CEO agenda and will continue to play a vital role in healthcare's transformation. Ping An in China has already demonstrated the efficacy of the partnership model. In the U.S., Amazon could disrupt healthcare by building a connected healthcare ecosystem, while incumbents, such as CVS Health, can use strategic partnerships to defend their market position.

Figure 1 - Ping An Good Doctor - Connected Health Ecosystem



PING AN: REINVENTION

Ping An has leveraged strategic partnerships to create connected ecosystems in the industries of auto, financial services, real estate, and healthcare. Partners benefit from access to Ping An's 800 million person customer base, marketing services to drive traffic, enablement of digital business models, and opportunities to expand into adjacent businesses. Ping An's healthcare ecosystem as illustrated in Figure 1 is an example of how Ping An has used partnerships to reinvent itself and become a dominant player in healthcare. Its health app, "Good Doctor," has connected hospitals, payers, doctors, drug stores, and diagnostics centers to provide seamless healthcare services, offering both traditional, and digital services. It is a simple app that allows customers to access these services, providing a unified experience. The partnerships Ping An forms are driven by its

overall strategic vision of leveraging 'Internet' and 'artificial intelligence' to provide affordable, quality care, and offer differentiated services. Today, its health app enjoys the market leader position with 193 million registered users.

AMAZON: DISRUPTION

Amazon has a user base of 100 million paid Prime members, fueled by its laser focus on ease of use, and fast, hassle-free, and personalized experiences. Healthcare consumers in the U.S. are demanding similar attributes. Amazon has established itself as a viable player across many industries such as retail, logistics, entertainment, and financial services, either through partnerships or investments. It also has a diversified set of healthcare investments to build from and disrupt the U.S. healthcare industry (Figure 2).

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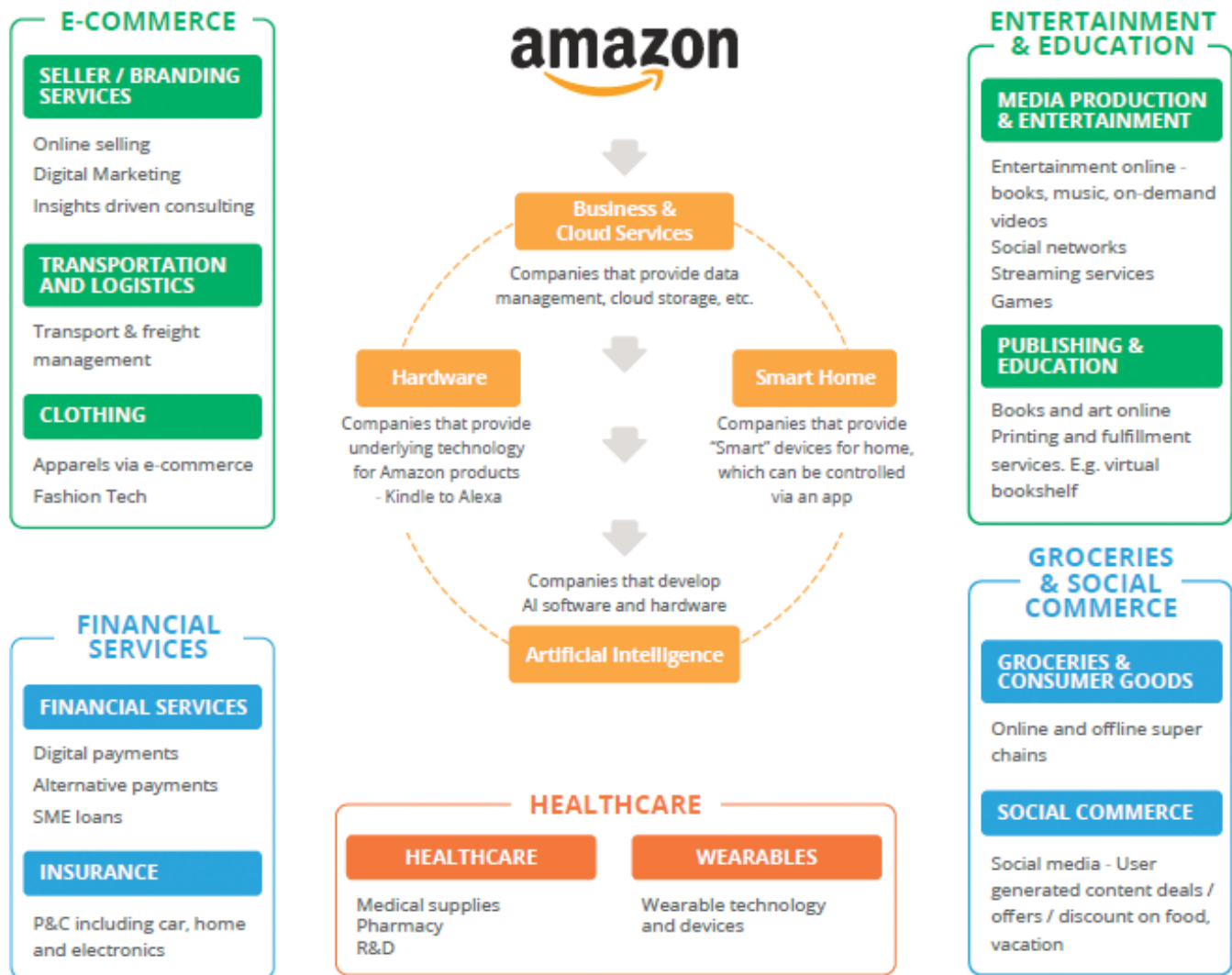
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Figure 2 - Amazon's Healthcare Commitment²



Amazon can use partnerships as a lever to build "Amazon Health" by enabling the following:

- **SIMPLIFYING CARE** – Amazon can partner with healthcare technology firms that provide connected devices, data analytics, and AI capabilities to co-create digital products and services. These primary care services, driven by data from several connected digital sources, provide proactive diagnosis, and preventive care. It could also partner to offer basic healthcare services at its Whole Foods physical stores, thus enabling Amazon to cover the whole spectrum of healthcare – from prevention to diagnosis to management of sickness.

- **OPTIMIZING INSURANCE** – The Amazon, Berkshire Hathaway, and JPMC (ABC) partnership is targeted at bringing down healthcare costs for the employees of ABC. With more than one million employees as customers, we expect Amazon will come up with a care model with a lower cost structure. This new entity could be a research hub to test innovative prevention and care management models. It can also create a healthcare insurance marketplace and study various care models to develop its own competencies.
- **BECOMING A ONE STOP SHOP FOR HEALTHCARE** – Eventually, Amazon can provide a connected health ecosystem. It can bring together its healthcare competencies to become a one-stop shop for healthcare across a customer's health journey – from being healthy, to identifying risks, through treatment, and recovery, and on to wellness. Along this continuum, a unified experience, much different from today's disjointed array, would be a game changer. Similar to Ping An, it can deploy effective partnerships to connect all offline, and online ecosystem players, including doctors, hospital-systems, diagnostic centers, pharmacies, payers, and rehab facilities.

CVS HEALTH: DEFENSE

Healthcare organizations are struggling with numerous challenges - rising costs, demand for quality care, and the need for speed - pushing them into a zone of "do more with less." Further, the threat of Amazon's exploits in healthcare and the associated potential for disruption is real. In this environment an effective defense strategy for an incumbent such as CVS Health can be to create niche ecosystems of partners to offer healthcare services the customer demands. The implications of this defense strategy include:

- **BROADENING RETAIL PORTFOLIO** Building on its Aetna acquisition, CVS Health can partner with patient-friendly transportation services to drive Aetna's 22.2 million customers into its 9,800 CVS drugstores – including 1,100 walk-in 'MinuteClinics' - to receive care and fill prescriptions. Further, it can access

Aetna's insurance claims data and create customized drug benefit plans for these customers, broadening its retail offerings.

- **EXPANDING SERVICES PORTFOLIO**

CVS can provide a wider range of healthcare services by utilizing its existing competencies and partnerships. It already partners for electronic health record system for its research-driven care programs. In addition, it can partner with 'digital health' firms that enable continuous monitoring of patients and offer remote healthcare services. It has just launched a 'video visit platform' (telehealth) to offer basic health services in 9 U.S. states, digitally partnering with Teladoc for technology. Finally, it could partner to provide a range of preventive, alternative, wellness, and basic healthcare services at its clinics.

BUILDING SUCCESSFUL PARTNERSHIPS

The three case studies we have explored are examples of how partnerships can be used as a lever to enable the transformation of firms. It is clear that as the markets continue to become more digital and connected ecosystems displace the vertical industry structures of the past, strategic partnerships will become the imperative. To remain competitive, healthcare firms need to leverage partnerships that would enable them to broaden their focus while staying nimble, to define future business models, and to continue to provide viable alternatives to ecosystem players such as Amazon.

However, an effective partnerships strategy needs a framework that factors in the four critical success factors - (1) strategic intent, (2) leadership commitment, (3) robust structure and governance, and (4) embracing failure. It is no more a question of whether to partner but of how to partner. Whatever the strategic aim, the key lies in understanding the implications and following a meticulously planned execution.

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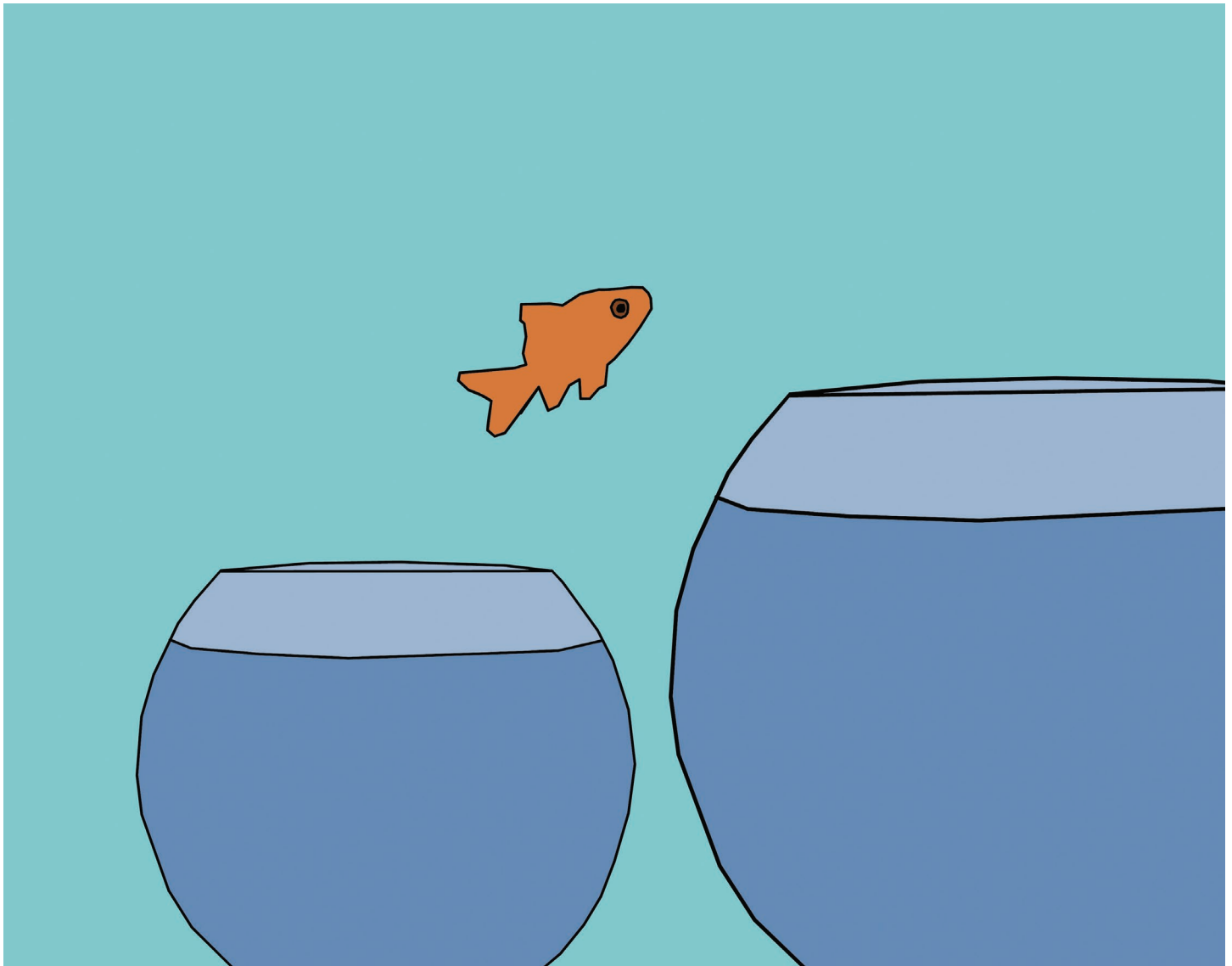
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BUILDING HEALTHCARE'S NEXT GENERATION OF LEADERS



If you listen to the water-cooler chatter these days, baby boomers are living with some broad generalizations about millennials. Descriptors include: social-media obsessed, impatient, narcissistic, and lacking stick-to-itiveness. They want to have fun, travel, and rain on our parade because they know better.

After working on a project that allowed me to probe the experiences and aspirations of twenty-nine millennials, I now challenge these views and hope a better understanding will allow us to “set the table” for our next generation of leaders. As with all generalizations, we can always find some case that supports the story, but the overall take is misguided and incomplete.

At My Pace: Twenty Somethings Finding Their Way is the result of this project in which men and women in their twenties (the end of the millennial era) wrote candid pieces that revealed their coming of age and the lessons absorbed along the way. Those essays, along with a survey they took, shed light on their inner workings.

An accurate understanding of millennials will help us to cultivate the next generation of leaders. To that end, I address three

questions which are instructive. Namely:

- How do twenty-somethings like to learn?
- How do twenty-somethings like to execute?
- What motivates twenty-somethings to achieve?

Continuous learning, striving to beat goals, and reluctance to easily accept “no” are good traits for leaders in training.

HOW TWENTY-SOMETHINGS LIKE TO LEARN

Twenty-somethings place a high value on learning, though their preferred methods differ from most baby boomers. Having grown up in a gig economy, millennials believe that building their personal brand will keep them competitive and employed. Adding new skills is an important part of the equation.

My survey data shows millennials prefer to learn through *doing* (rated 9.2 on a scale of 1 to 10, low to high), but *the internet* and *learning through peers* (both rated 7.9) play pivotal roles. *Managers* as a source of learning were still important (7.7) but were viewed as too busy and more focused on organizational battles. *Coursework* was near the bottom (6.6 rating) and viewed as table stakes.

Respondents explained that peers are particularly valuable because they provide first-hand experience, along with more time and empathy. Simply put, “The information sticks better,” said one contributor.

These preferences should be incorporated into building an organization’s learning culture. Action-centered projects (“learning by doing”), and collaborative learning should feature prominently. Managers will morph to being more of an enabler than a provider of knowledge.

HOW TWENTY-SOMETHINGS LIKE TO EXECUTE

Baby boomers grew up in an environment of “marching orders” where we assumed managers knew best. We executed to plan and worked our way up the ladder. Millennials don’t assume we know best, and the ladder is wobbly at best.

Before executing anything, twenty-somethings want context and understanding, so they consider how best to meet identified goals. I coined the expression “anchored with room to roam” meaning, “Help me feel rooted by explaining the objectives, and then give me freedom to act.”

This can be problematic for baby boomers. How much room is needed? Do we get to weigh in? Personalizing the work product is important, but so is making sure the organization’s needs are being met. It is a delicate dance.

How does “anchored with room to roam” work in a tightly regulated industry such as healthcare? My conversations with healthcare professionals confirmed the latitude to personalize work is equally sought there.

A social worker described managing someone who was suicidal. The hospital’s protocol is to get the patient straight to the ER, which she did, but she added, “My style, my tone, the way I explained things and delivered the patient reflected me.” Her conclusion? “I can do it my way and stay within protocol.” Similarly, a nurse practitioner tending to high-risk asthma patients explained how she is using her personal experience to rethink a protocol for refilling prescriptions. She wants a tighter limit on the number of refills allowed, which she believes will result in patients calling more frequently to engage. “While it might create additional work, it is also better medicine,” she says. She is now working with the hospital to adjust the protocol.

A pediatric intern offered a slightly different perspective. “Within the hospital, we practice evidence-based medicine so there is no room for personalization,” he commented. “However, I get to express myself when it comes to healthcare advocacy. As a pediatrician, I engage the community in various forums because early intervention is so important.” He gives talks at local libraries and schools. “For me, becoming a physician was about making a difference. My role as advocate allows me to,” he explains.

Cultivating the next generation of leaders will require us to loosen the reigns as contributors add their personal stamp to increase ownership and meaning in the job.

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WHAT MOTIVATES TWENTY-SOMETHINGS

Whether precipitated by the transparency of social media, or a malaise about society today, twenty-somethings care deeply about *mission* and *people* when it comes to their work. This is confirmed by stories and survey data. *Mission and people* both rated 8.8 in importance, whereas *compensation* and *fun* rated 6.5 and 6.3 respectively. These preferences are good news for healthcare organizations whose mission has always been about improving people's lives. Many of us were propelled into healthcare because of our idealism, so the leap from us to them shouldn't be that hard.

Yet as we prepare to pass the baton, there is trepidation because we know the next generation will lead differently. How will they lead, and how can we help? Maybe we start by recognizing generational differences. Can we embrace "room to roam" with its potential to add creativity to problem solving? Can we restructure our learning environment with more peer contribution? Can we work together to define an organization's mission in a way that feels authentic and purposeful to a millennial's ears? Most importantly, can we do the hard work of building a strong bridge of communication between generations?

Millennials will learn from us in their own way and time, but we can also learn from them. Embracing change and keeping our ears and our mind open will help pave the way as we grow our new leaders.

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BREAKING CONVENTION: MY JOURNEY AS A MAN AT EILEEN FISHER - EMBRACING AND ELEVATING THE FEMININE FOR GREATER WHOLENESS AND WELL-BEING

My transformation journey at Eileen Fisher really took root in my third week on the job. It was May, 2014, and I was sitting in Eileen's living room on retreat with most of my Leadership, Learning and Development team members. In what would become one of many all-day retreats and off-sites, on this particular day we were learning to incorporate the arts (song, dance, drawing, painting, arts and crafts, spoken word/poetry, improv, and games among others) into our facilitation techniques to enrich creativity. Two-and-a-half hours into the experience, while drums were beating in the background, I found myself doing interpretive dance as a tree blowing in the wind to a poem co-written by my colleague and read in spoken word about a *Bumble Bee Trying to Find Her Nectar*. After our performance, my boss came up to me and said, "You know you're in a different world now, don't you?" And so began my journey as a man learning that I'd need to embrace and elevate my feminine energy to really understand and thrive in this environment.

A different world was right, and it was nothing that I could have imagined. As a man who left a successful consulting career serving Wall Street and Big Media companies to come to Eileen Fisher and get a one-of-a-kind in-house experience, I was in for the ride of my life (professionally and

personally). I currently serve as the head of Purpose, Personal Transformation and Well-being for Eileen Fisher, (EF), a B-Corp women's clothing company with roughly \$425M in annual revenue, and 1,200+ employees across the US, UK, and Canada. The company is comprised of 83% women and subscribes fully and unapologetically to feminine leadership principles and practices.

WE DO THINGS DIFFERENTLY AROUND HERE

For my first 3.5 years at EF, I served as an internal change agent for our creative teams (design, merchandising, brand communications, and digital). As I engaged with these highly creative teams around change, leadership development, and team forming and alignment, my work was driven by a culture that was intentionally designed to support the flow of creative energy. We did this by remaining organic, less focused on process, and more on inclusive and collaborative discussions that brought in different voices for greater democratic decision-making. We often straddled and grappled with the dualities of intuition versus data, creative versus business, and organic versus process.

We also have a number of rituals in which we engage that help to create the container for our culture. All meetings start with silence

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and meditation to create space for everyone to come into the room and become fully present for each other. Following silence, teams will engage in an individual personal and professional check-in, to get a read of the emotional energy coming in the space that may impact the attention and agenda of the meeting. We use the Circle Way, where we meet in circles with no tables between us, so as to really break down the energy of hierarchy and allow all voices to be heard, often with a circle check-in and round-robin conversations. Embedded in many meetings was a mantra that we used, that Eileen often shared, which was “perfect enough” so we could move away from perfectionism to prototyping and trying new ideas and allowing for greater innovation.

EXPOSURE TO UNCONVENTIONAL EXPERIENCES

I've been fortunate to have had some interesting (and life changing) experiences throughout my time at EF including:

- Attending a 5-day Human Interaction Lab in Virginia during my first year to examine and enhance my level of emotional intelligence and challenge and transform limiting beliefs;
- Spending 5 weekends over 5 months at an artist commune in Canada with artists and youth empowerment facilitators, to get a deeper experience of integrating an arts-based approach into facilitation design and delivery as a pathway to deeper transformation work with our employees;
- Co-creating a personal transformation and growth experience that introduces all of our employees to their life purpose, deeper self-awareness using the Enneagram assessment, somatic/embodiment work, shadow work, limiting beliefs work, and spirit/mindfulness practices;
- Serving as a volunteer facilitator for the boys program (15 – 17 year olds) in our Eileen Fisher Leadership Institute, delivering a workshop challenging traditional masculinity models called “Lessons from our Fathers, Letters to our Dads”;
- Being guided by our in-house Akashic Records Reader and Medical Intuitive (available to all employees) and many teachers and healers through our EF LIFEWORK programs, including Shadow and Purpose workshops (our personal transformation learning lab for the community and world).
- Holding space as a trusted ally to design and facilitate our “We the Change: Women Together” planning retreat bringing together the voices of our women’s empowerment facilitators as they partnered together to carry out Eileen’s vision of creating a global women’s empowerment movement.

PATHWAY TO WHOLENESS AND WELL-BEING

Throughout my EF experience, I’ve learned to deepen my listening, create space more deliberately for different voices, appreciate the significance of language, and the power of words, and let go of my ego, and the need to prove my worth/value, constantly be heard, and be right. I’ve developed a patience to really sit with and hold space for deep contemplation of issues and challenges without feeling the need to rush to solve the problem or find the answer. By letting go of the restrictions of traditional masculine identity, I’ve been able to really allow my emotional and creative expression to come through more fully, while tapping into my intuitive abilities.



I've worked diligently with my leaders and wellness director to look at work/life balance. As a former consultant, I didn't understand work/life balance or see the need for the life part of work/life balance. This included taking a look at self-care in some new ways around diet, exercise, and living a healthier lifestyle. Where I've noticed the greatest change in my life is around relationships. As a former introverted workaholic, I've learned to value relationship and friendship in new and profound ways - really showing up authentically and focusing on relationship first as the pathway to anything else. Our collaborative environment really encourages that type of transformation of relationship and way of being with others.

At Eileen Fisher, I've also discovered my life purpose, which is being a healing man who is here to help other men heal. In living out my purpose, it's led to my beginning seminary where I'm gaining the spiritual grounding to really be able to support the personal transformation journeys of men. In this work, challenging the traditional models and definitions of masculine identity and finding pathways to help men access and elevate the feminine so they begin to walk in a more balanced way – holding a healthy balance of masculine and feminine energy in the ways they show up and be in the world.

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CREATING SYSTEMNESS: EIGHT PRACTICES TO MAKE INTEGRATION WORK



A newly merged academic health center was struggling to keep all the pieces together after a number of acquisitions and mergers. Attempts to streamline its back office services to support a more robust and integrated set of clinical and educational offerings for population health were stuck. As with many mergers, the financial and operational due diligence considered the technical issues at hand, but it largely ignored the cultural issues the leaders would face when they tried to act as a system.

When the merger went live, leaders faced a number of challenges as they tried to bring the different parts of the organization together. Expectations were ambiguous, which led to distrust among colleagues. Systems were difficult to reconcile, old informal systems and networks (think — reaching out to “Joe” who can help me resolve this problem) broke down, and the work-arounds needed to get things done made other process challenges even more apparent. Productivity declined, faculty were frustrated, and administrators struggled to discern how to close the gap between where they were and the potential they knew they could achieve.

FORMAL ORGANIZATIONAL TIES ARE ONLY THE FIRST STEP

The promise of population health has led large health system and academic medical centers to engage in many different forms of mergers, acquisitions, and partnerships (MAP) in an attempt to provide care across the continuum. While MAP may be necessary to support population health, it is not sufficient by itself. The ties that bind successful MAP results come from work focused on building shared culture, structure, and processes to build a system that is a whole greater than the sum of its parts. Culture plays a particularly important role, as it expresses the practices that reveal “the way we do things [or want to do things] around here.” Practices are the building blocks of culture, reflecting two critical elements: behavior (how people do their work) and supports (the infrastructure and organizational supports that make those behaviors possible). If you want to change the culture, you have to change practice.

EIGHT PRACTICES TO MAKE IT WORK

While there is no step-by-step recipe for integration, we understand what it takes to make it work. Partnering with our clients who strive to realize the value of their MAP activities and build strong cultures to support them, has revealed eight practices that can increase the likelihood of success:

- 1. Leadership commitment** — Without leadership conspicuously supporting the process, there are too many forces that can hinder the process. We have found it particularly powerful when leadership commitment was visible across functions and entities, often in the form of a steering or oversight committee. This helped those in the process recognize that, wherever they sat, those in their chain of command were on board.
- 2. Getting the system in the room** — We often imagine we are sensitive to the needs of others and will adequately represent their interests. At the most abstract level, that may be accurate. However, the ramifications of integration show up in unpredictable ways. Helping people speak for themselves, their roles, and what makes it easier or more difficult, more aligned with their objectives or less, usually gets you a lot closer to their perspective, and demonstrates a measure of respect for those involved.
- 3. Understanding the barriers** — One of the most valuable tools we have used is “Backcasting,” wherein groups who are close to the action identify the barriers to a goal of integration and the accomplishments that overcome those barriers. Backcasting produces a clear and actionable plan for moving forward and identifies what needs to be done and who can do it.
- 4. Better tools and systems** — We can work very hard on the human parts of the system, but if they are not supported by the technologies in place, frustration will continue and it will be difficult to sustain the commitment.
- 5. Commitment to transparency** — In merging organizations, the “tops” are often more distant than ever before from those in the middle, having not yet earned the trust of those from other entities. After the (often necessary) secrecy of the transactions themselves, a commitment to

transparency is a welcome change. When the commitment is followed up by actions, it starts to build the trust needed for staff to transfer their loyalties and bring their best to their roles.

- 6. Clarifying expectations** — We’ve discussed the challenge of clarifying expectations and the effect it has on trust among colleagues. We have found that simple Service Level Agreements can help people clarify what they need from each other and understand the challenges others have in meeting what seem like reasonable demands.
- 7. Allowing for variation** — In every health system in which we have worked, metaphors appear for recognizing that the same exact processes cannot be applied uniformly — from “hard core/ soft periphery” to “variegated,” etc. A good process helps establish where uniqueness is necessary and where it is not. Acknowledging from the start that completely uniform processes won’t be required helps address a core tension for many who fear the loss of what they need to do their jobs effectively.
- 8. Learning from each other** — One of the most powerful advantages a large system has is its ability to benchmark within the system, to learn who does what well and what others can aspire to. When we allow the benchmark to come from any place in the system, we have groups and entities who can collaborate as learners and teachers — the roles reversing depending on the metric.

WHY IT’S SO IMPORTANT

With integration so clearly a struggle, let’s review why it’s so important. Integration matters to both the clinical operations — where one entity needs to know its hand-offs are well received across the continuum — and to operations — where leadership needs a clear and consistent picture of the whole organization. When a system is well integrated, there are the advantages of both organizational and individual learning. And learning is one of the factors that keeps academic health systems at the forefront of an ever-changing field.

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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WHARTON AROUND THE GLOBE: WGHV AIMS TO HELP REDUCE NEONATAL MORTALITY IN NIGERIA

Wharton Global Health Volunteers (WGHV) supported the 100 Person Village Initiative led by Dr. Osayame Ekhaguere during the 2017-2018 academic year. The 100 Person Village Initiative aims to improve the effectiveness of neonatal care across Nigeria.

Nigeria currently experiences an infant mortality rate of 71 deaths per 1,000 live births, which is 10 times greater than the infant mortality of the United States. The initiative is first focusing on improving care in the neonatal intensive care unit of Lagos University Teaching Hospital (LUTH) through new processes, equipment, and training. The WGHV project was focused on identifying the most cost-effective initiatives and documenting these in a pitch to potential donors. We focused on respiratory distress, nutrition, and infection control, as these areas are the three main drivers of neonatal mortality.



To achieve our goal, we took three steps.

1. We researched the current U.S. standard of care at the Hospital of the University of Pennsylvania (HUP). We interviewed and shadowed experts at HUP to understand their processes, equipment, and training. While we recognized the Nigerian resources would be vastly different, this gave us a baseline of knowledge with which to work.
2. We went to Lagos and documented the current state of care at LUTH. We took inventory of their equipment and interviewed their personnel to understand how they operated. We also sought their ideas on what would be most helpful for them and tested ideas we had to improve care with them.
3. Finally, we identified discrete initiatives based on this information, understood how they would affect neonatal outcomes, and identified how much they would cost.

A surprising learning from this experience was that LUTH's biggest need was not a suite of upgraded equipment. In fact, we saw that LUTH possessed some expensive respiratory equipment that had been donated. However, this equipment was never used because the medical personnel did not receive the proper training. Additionally, the one-time-use parts were often too expensive for families to afford. We learned that when we recommended new equipment, we needed to ensure it had the lowest run cost over time, and we needed to emphasize proper training.

Another takeaway from this experience is how resourceful the medical personnel at LUTH are in their efforts to save lives. Their ingenuity ranged from developing a sustainable version of respiratory equipment that was less cost-prohibitive for families to individually fundraise to help families who could not afford to buy medicines for their children. Families in Nigeria do not have insurance, so they must pay for most medical materials upfront. While families can often scrape together the money needed from friends and family, this can delay care. As part of our recommendations, we proposed setting up a revolving fund to ensure that patients can access the materials they need when they need it, and also to

subsidize families if needed.

Dr. Ekhaguere will continue to champion the project through the next phases, which include to fundraise and develop an implementation plan for these initiatives. It was truly a rewarding experience to learn from both LUTH and HUP personnel, and we hope our work will ultimately help reduce neonatal mortality at LUTH and across Nigeria.

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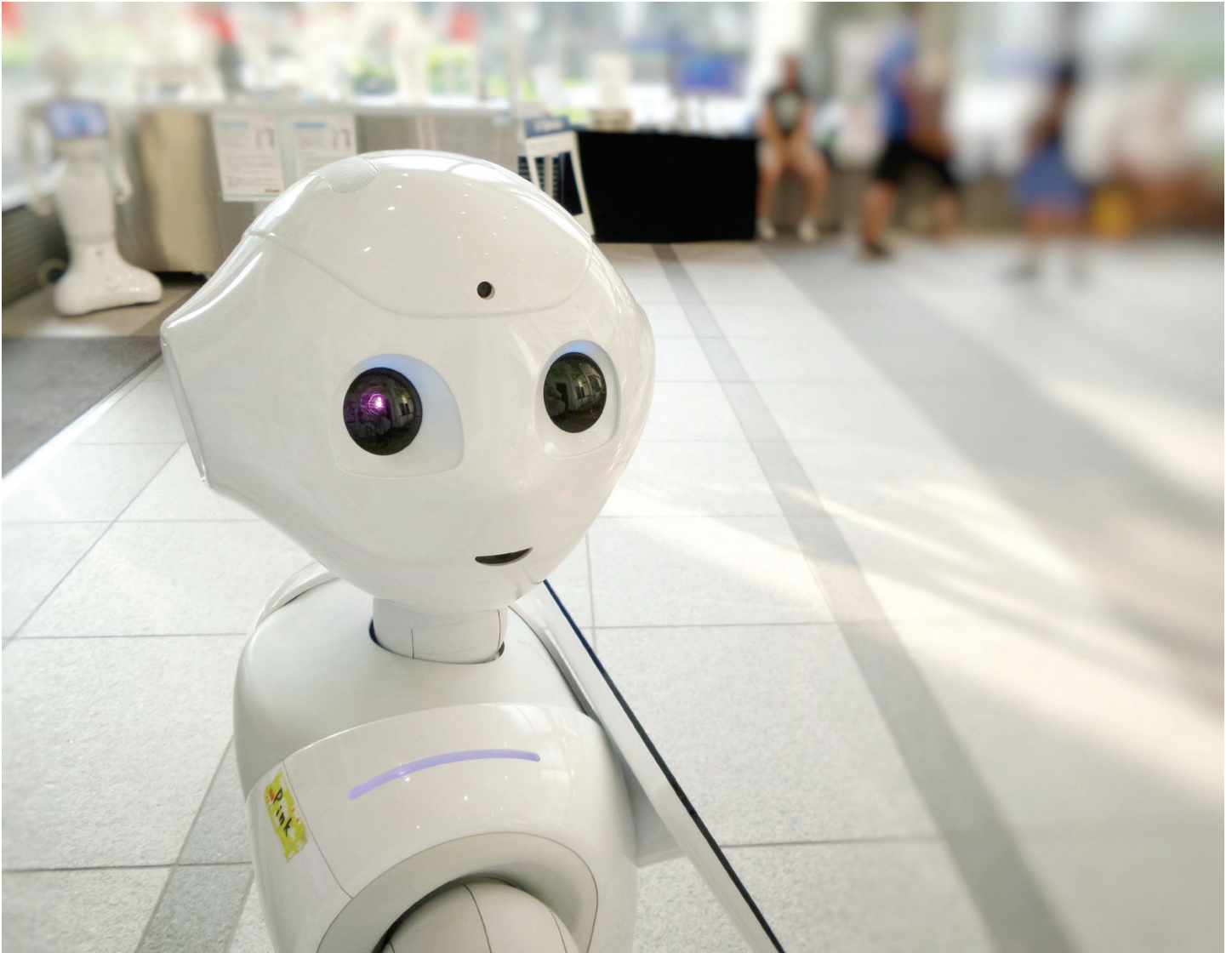
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HOW AI CAN EMPOWER US TO HEAL EACH OTHER



There's a lot of talk around artificial intelligence (AI) in healthcare: early detection, personalization, even disease diagnosis - all from crunching large volumes of data. In almost all cases, AI either directly interacts with the user, chatbots for instance, or empowers the physician to better understand his/her patient. The AI-human relationship has so far been one-on-one. But what if AI could connect a group of humans together to heal one another?

THE GROWTH NUMBERS

According to a recent RockHealth [report](#), total funding for AI/machine learning-powered digital health companies is on the rise. 121 AI/ML companies in digital health have raised a total of \$2.7B through 206 deals from 2011 through 2017, just over 10% of all venture dollars invested in digital health during that period.

AI HELPS HUMANS DECIDE

For the most part, AI/ML in healthcare means a very smart algorithm crunches through large volumes of data and discovers patterns that might be hard for humans to see. Statistical models can be formed based on training data sets. Once AI parameters are fine-tuned, it can be used for prediction/detection and maybe alert the caregiver if things deviate from the norm.

AI helps the human decide better. Empowering patients, physicians and hospitals to track, monitor and diagnose, making data-driven decisions that are not limited to the individual's training and experience. AI has the potential of turning every doctor into a "best doctor" by offering data-driven insights at critical decision-making points that go beyond the individual's training and experience -- helping the physician see the alternatives and effects of different paths.

Some of the algorithms used in today's AI systems include: deep learning, reinforcement learning, generalized linear models, random forests, and support vector machines.

THE AI-HUMAN RELATIONSHIP IS MONOGAMOUS

Whether it is a physician using the AI to decide better or a user talking to a cognitive behavioral therapy (CBT)-equipped chatbot, we typically interact with the AI in a one-on-one setting. In the emotional and mental health space, the one-on-one interaction has created therapy AIs that are obsessed with accurately understanding the user input and coming up with a relevant response that can help the user overcome a stressful situation. Or with apps that connect you to a therapist or coach, a user can interact with the AI to find the best possible one-to-one match.

THE AI-HUMAN RELATIONSHIP CAN BE POLYGAMOUS

Going back to the emotional and mental space, imagine multiple users all independently talking about a stressful day at work. In a chatbot setting, each person will talk to the bot, completely isolated from the others, and the bot will be hard at work generating relevant responses to

help. This might be a very limited experience, contributing to more isolation. What if the AI was "smart" enough to bring some of these users together in a group, all going through a similar struggle. So far, this new AI has helped with one big thing: letting them know they are not alone. These individuals can now interact with each other and connect at a deeper level, which will slowly result in a more connected society where people are not afraid to let out their true thoughts and feelings.

This new AI can continue to monitor the conversation, and if the topic changes for some users, it can offer a different group that can match their needs better. It can also recommend relevant content and resources that can be used by all the group members. This new AI does not only help decide, but it can also empower humans to heal each other and fix the broken social fabric. This AI is what today powers [Supportiv](#), The Support Network.

A COMPLETELY DIFFERENT PHILOSOPHY AND TECHNOLOGY FOCUS

While technologies like chatbots Alexa or Google Home are hard at work trying to precisely understand the user input, in a group setting that can't be the goal. Instead, you have to precisely understand the similarities across different chunks of data. It changes the thinking from absolute to relative. Measuring correlation and overlap becomes the goal and even though we don't fully understand the user input, using similarity analysis, we can find a matching user.

NEW ROLE FOR AI: ENABLER OF A DEEPER HUMAN CONNECTION:

Once humans connect at a deeper level, healing can start to happen. After all, some think the root of most of our modern day life issues are that we are separated and alone. [The community is broken](#), and we are getting more and more isolated in our constantly connected lives. [@Supportiv](#), we think that AI can be used to bring back our lost connections and, as a result, fix the fabric of our society.

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