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## FEATURED ARTICLES

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## IN UPCOMING ISSUES

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<td>Leaving the Ladder; Rethinking the Traditional Healthcare Career Path</td>
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The healthcare arena continues to gyrate and spin wildly, often in unanticipated and unpredictable ways! And with recent efforts resumed to revive attempts to eradicate the Affordable Care Act, including pre-existing conditions provisions, and apparently with no detailed replacement plan waiting in the wings, the anxiety of millions of Americans, both those with and without insurance converge, is palpable and growing.

The combination of (1) ongoing consolidation within healthcare, (2) the rising cost of medications that have been on the market for years (e.g., insulin) as well as (3) the high expense typically associated with specialty meds, and (4) the greater awareness of the role and impact of Pharmacy Benefit Managers (PBM)s by employers and consumers means more laser-like focus on the life cycle and patent process, and growing resistance to pricing methodologies and rebate systems employed by drug manufacturers.

With dozens of genetic tests coming to market every day and labs available to combine both pharmacokinetics and pharmacogenomics, the potential and promise of precision medicine, especially in areas like anti-depressant medication therapies seem on the verge of a major breakthrough.

And the nascent artificial intelligence (AI) industry, whose technology is being used in an ever-broadening array of applications, has many wondering, if and how this journey can be different and lessons learned in the development and growth of the internet and social media be leveraged to help reduce the likelihood of unintended, negative consequences. Can the horse stay in the barn? Will the genie stay in the bottle? Will we manage and control AI or will it control us in the end due to a forward evolution that is unfettered? Is AI the wild, wild west of the 21st century?

The bottom line? Healthcare is never boring and often not easy, especially for patients and consumers. It is under constant flux, which appears to be the new normal. It is the story of the best of times, and, not infrequently, the worst of times. And the only ones who can tip the scales in our favor are us. So, what are you doing already or are willing to commit to right NOW to ensure the greater good is achieved for all?

Z. Colette Edwards, WG’84, MD’85
Managing Editor
Contact Colette at: colette@accessinsightmd.com
I had coffee recently with an HCM alum I’d gotten to know when he was a student and I was five years out. Our conversation then was the same five years later: what’s happening in healthcare? Where will it be in five years? How do I make an impact? How do I help people? I’ve had this conversation with hundreds of HCM students and alumni over the years. I never tire of it.

The WHCMAA mission includes as one of its three pillars “contributing to healthcare through service, leadership, and education.” Outsiders might find this an odd choice for an alumni association mission statement, but get to know us and you learn this is core to our community, whether it’s in writing or not.

What a privilege it’s been to serve this community for the last five years. I’ve chaired our Finance and Awards and Grants committees, co-chaired an alumni conference, and served as Vice President and then President of the Board. In that time we gave out $250,000 in scholarships, supported LDI during their 50th anniversary, and raised the profile of the WHCMAA with other Wharton graduates interested in healthcare. These are the accomplishments of our Board – as committed to their peers, the program, and the current students as ever – and the alumni community – which topped 2000 members as I started my term as President.

When I step down from the Board on June 30, Maria Whitman WG’05 will take over as President. We will be in good hands. The rest of the Executive Committee – Bob McDonald WG’92 and David Kibbe ’80 – will complete their terms on the board as well. David’s service as treasurer should be lauded; he took over Tom Kupp ’85, which was like volunteering to play shooting guard for the Chicago Bulls in 1999. He’s been more than capable, leaving our association in its best financial position to date.

One could write a small novel on what Bob has done as a Board member. An
With decades serving the healthcare industry, Duane Morris has one of the most experienced and respected health law practice groups among U.S. law firms. From offices in major markets in the United States, as well as London, Asia and the Middle East, more than 45 Duane Morris lawyers counsel leading organizations in every major sector of the healthcare industry on regulatory, business transactions, litigation and other matters.

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THE PRESIDENT’S DESK

alum more devoted to our community does not exist. He is a servant leader, living by the credo that setting others up for success sets one up for success as well. Thank you, Bob.

If Bob gets a small novel, June Kinney deserves a shelf of encyclopedias. Chris Aleszczyk always has our back as well. Thank you both, for everything.

Z. Colette Edwards WG’84 and Kate Reed WG’87 will complete their third and final terms in June as well. Colette has been the Managing Editor of the Wharton Healthcare Quarterly since 2012. That she has been able to publish four editions per year, each year, speaks volumes about her dedication to the program. Kate has chaired our Career Development Committee since 2017. She was instrumental in providing Wharton alumni with access to healthcare jobs listed by major recruiting firms on the WHCMAA website. Colette and Kate – thank you for donating your time and energy to the WHCMAA.

One last person to acknowledge – Meagan Untalan Barkett WG’10. June suggested I ask Meagan out during the year we were both on campus, and while it took a couple years (nothing happens quickly in healthcare), June’s instincts were, again, proven right. Thank you, Meg, for supporting my five year commitment to this volunteer board.

To the HCM community - I look forward to being in touch. Start thinking about your answers – you already know the questions.

John Barkett, WG’09
WHCMAA President
john.barkett@willistowerswatson.com
President@whartonhealthcare.org

continued
Robin Daigh, WG’82
Not all achievements are professional! After enjoying many different facets of the healthcare industry, from healthcare delivery systems to start-up medical devices and healthcare IT, I retired after 35 years.

I joined my spouse on his bucket list trip to ride our bicycles across the country, camping along the way. We travelled 3200 miles in about 60 days, from San Diego CA to St. Augustine FL. The trip was memorable. We learned so much about the U.S., and in particular, how the interstate highway system, Walmart, and Dollar General have combined to decimate rural America by all but eliminating mom and pop businesses.

Our next adventure begins in April 2019, when we will ride the entire Atlantic Coast, from Mile 0 in Key West to Calais, Canada. Our route takes us through Philadelphia, so maybe I will be able to cycle through the Penn campus as we work our way north.

If fellow alumni are interested in a bike touring adventure, either alone or with others, short distance or long, we highly recommend the non-profit group Adventure Cycling Association.

Contact Robin at:
rrdaigh@gmail.com

Learn more.

Jeff Voigt, WG’85


Contact Jeff at:
meddevconsultant@aol.com

Stewart Hen, WG’96
We are looking to hire a healthcare investment analyst for our firm based in NYC. Looking for therapeutics focus and 1-10 years relevant experience.

Contact Stewart at:
Stewart.hen@serradocap.com

Eric Bell, WG’97
2018 was a banner year for seeing my Wharton Healthcare Management classmates. I had dinner in NYC with David Collier (WG ’97); David’s lovely wife, Nilou; and Julie Oh (WG ’97). It was great to see Julie again after more than 20 years. I had lunch with Ted Ebel (WG ’97) in San Diego and ran into Dave Pinkert (WG ’97) at a conference in Las Vegas. My learning teammate Dan Deardorf (WG ’97) and I couldn’t get our schedules to align while I was in Boston but will try again next time. I periodically see Aaron Martin (WG ’97), as we are both working in healthcare venture investing for different funds based in Seattle. Victoria Goldin (WG ’97) stayed at our house while she and her family were visiting Seattle.

SpringRock Ventures, the venture fund I co-manage, also invested in a company co-founded by a HCMG program alum - John Voith (WG ’07).

I’ve been reflecting on how much my Wharton classmates have changed the course of my life - introducing me to my spouse, making connections that led to several jobs that shaped my career, providing a sounding board, lending an informed opinion, sharing advice, and being my friends even when I’ve been an iternant communicator at best. I continue to benefit from my Wharton experience well beyond what I learned in class. I hope my classmates have had the same fortune.

Contact Eric at:
er.bell@comast.net

myvirtudent.com
springrockventures.com
Dr. Scott Cannizzaro, WG’03
Scott Cannizzaro is excited to announce that the company he co-founded, Evolus (EOLS, NASDAQ), was granted FDA approval for it’s first product Jeuveau™. Scott commented, “I had the privilege of working with an exceptional team to bring this product to market - it’s an exciting time and the company is in a great position to go after this exciting market.” Jeuveau™ is the first aesthetic-only neurotoxin approved in the U.S. Launch is planned for Spring 2019.

Contact Dr. Scott at: scannizz@gmail.com
Learn more.

Deryck Jordan, WG’04
Deryck Jordan, celebrated his 20th anniversary as a lawyer by launching the law firm Jordan Counsel in New York and Berlin. Embodying Deryck’s passion for innovation, the firm helps start-up companies get established and grow in the U.S. market. A key focus area of the firm is healthcare, which reflects a natural culmination of Deryck’s 20 years in life sciences (including roles not just in law, but also business development, strategy, marketing and R&D). For now Deryck will split his time between New York and Berlin.

Contact Deryck at: deryck@jordancounsel.com
Learn more.

Kristen Harris Nwanyanwu, WG’09
Kelechi Nwanyanwu, UG’03
Kristen and Kelechi Nwanyanwu welcomed their second daughter, Chioma Lena Nwanyanwu, to the world on January 4, 2019. Her sister, Iva Grace (2), couldn’t be more excited.

Contact Kristen at: harriskm@gmail.com

Michael Meng, WG’12
Michael Meng, and Ben Kraus, have teamed up to co-found Stellar Health, a start-up based in NYC that currently manages thousands of patients on its platform. The company alleviates the challenges associated with value-based healthcare delivery by aligning provider behavior with insurer requirements.

This is all done through Stellar Health’s innovative tech platform, which assesses medical history and claims data and presents providers with the most clinically important measures needed for each patient in real-time. Providers earn additional reimbursement every time they address one of these measures, incentivizing them to ensure nothing gets missed.

Michael and Ben are excited to work on this tough problem of helping providers and payors achieve the results they are looking for in value-based care, and the company has already seen success in several states, including Florida, New Jersey, and New York. Along with their team, they look forward to tackling the challenges that our healthcare system faces in 2019 and beyond.

Contact Michael at: michael.meng@stellar.health

Becker’s Article
MedCity News Article
Medgadget Article
THIS MONTH’S PHILOSHER:
Chris Simpkins

To learn more about Chris, click here.
THE PHILOSOPHER’S CORNER

LIFE LESSONS
If I knew then what I know now, I would have...
• Taken a longer look at entrepreneurship while in school.

There is prestige and allure to joining a large company with a sterling reputation. But there is no better learning opportunity than building something by yourself or with a small team with a shared vision. You quickly learn to get out of your comfort zone.

If I knew then what I know now, I would NOT have...
• Worried about failing at something. You succeed OR you learn something.

FAVORITE QUOTES
1. “Better is possible. It does not take genius. It takes diligence. It takes moral clarity. It takes ingenuity. And above all, it takes a willingness to try.” – Atul Gawande

2. “There will be a time when we must choose between what is easy and what is right.” – Albus Dumbledore

3. “If you can’t explain it simply, you don’t understand it well enough” – Albert Einstein

RECOMMENDED READING
• Getting More by Stuart Diamond (Wharton Negotiations Professor)
  • I have re-read this book too many times to count. His four quadrant negotiation model forces you to pause, assess the situation, and uncover motives and options. It also works wonders negotiating bed times with my children.

• The Visual Display of Quantitative Information by Edward R. Tufte
  • We live in an information age. Being able to craft compelling narrative from your data is a valuable skill.

• Chasing Daylight: How My Forthcoming Death Transformed My Life by Eugene O’Kelley
  • There is only a small amount of time we have with our family and friends; embrace the fleeting moments.

You can contact Chris via LinkedIn: https://www.linkedin.com/in/cwsimpkins/

THIS MONTH’S PHILOSOPHER:
Chris Simpkins
To learn more about Chris, click here.

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NOT A FREUDIAN SLIP: THE MAGIC OF MUSIC ON HEALTH, PART 2

There is a solid amount of evidence demonstrating the transformational power music can have on our lives and in our communities. Part 1 provided a brief overview of how music positively impacts all seven dimensions of well-being and has proven educational, therapeutic, and social value. There’s so much more to explore from a historical and cultural perspective, and there is so much evidence that can be shared. The purpose of this article is to move beyond sharing additional research. If you need further proof, doing a quick web scan or PubMed search will reveal thousands of articles and publications.

The aim with most articles is to inform, to get you thinking about the information, and examining what it means to you. In the next two articles, I am hoping to go a few steps further to help you apply what you have learned about music and begin to practice and experience the positive impacts, which will hopefully reinforce your eagerness to sustain.

Learning - acquiring knowledge and building skills - happens along a continuum. Observing, understanding, planning, acting, reflecting, and achieving are all part of the complete process. Much of the education within our schools and even offered as training in the workplace does a good job of sharing information to increase basic knowledge and skills. Progressing through learning methodology steps, where an individual can embody and sustain the knowledge and skill development, is true mastery. My quest is to bridge from simply sharing information to helping you discover how to apply and master the concepts that are most meaningful to you. This article offers ideas on ways music can connect, heal, and shift mindsets to influence you to take action and weave music into your daily routine. Part 3 will share further ways to master the positive impacts of music by integrating it within your roles as individuals, as healthcare leaders, as educators, and community citizens.

![Learning Continuum](image-url)
Music can change the world because it can change people. - Bono

Evidence has demonstrated that music has the ability to transform our brain. Music has the ability to ignite creativity, deepen learning, skill development, memory, and performance. That is why it is so important in education. How can changes be made to incorporate more music into the school curriculum?

Just as music is critical to learning development, music, music therapy, and music medicine provide a non-pharmacological, non-invasive, and economically viable alternative to healing physical and mental health conditions. As people engage and adhere more to treatment plans influenced by musical interventions, mood, stress, sleep quality, and pain management improve, and the rehabilitative nature of the music helps reduce negative symptoms of a multitude of acute and chronic conditions. How can we integrate music interventions into first-line treatment and expand music’s positive influence in mainstream healthcare?

We’ve learned that weaving music into our daily routine provides positive impacts. Within communities, music can help reduce isolation and improve cooperation and social cohesion, while in the work environment, music’s effects can boost morale, motivate productivity, and stimulate endurance. So how do we take steps to unify our communities and incorporate this proven valuable asset into the areas of great potential? How do we make a change and start feeling the positive impact of music? We each play a part.

“Music does bring people together . . . No matter what language we speak, what color we are, the form of our politics, or the expression of our love and our faith, music proves: We are the same.” - John Denver

MOVE BEYOND JUST KNOWING.
We have all been in a funk. Perhaps you woke up in blah mood, or there was a situation at work that irritated you, or during your commute another passenger was extremely rude, or you are stressed out about an upcoming medical procedure. Each of these situations is an opportunity to test these positive research findings personally. See if you can use music as a conduit to shift your thinking. For the next few weeks, find ways to infuse music into your daily routine and see if music can have an impact on your concentration, coping, creativity, energy, and mood. For example, through your car radio or mobile device during your commute home use music as a way to shift your thinking into a new gear and mindfully transition into “home” mode, leaving the worries of work behind so you can be fully present in your next role. The included list is provided to offer suggestions and by no means is meant to be a cure-all solution.

Choose wisely….Music has powerful effects, and different types of music create individual responses. Be thoughtful in what music you select for what type of situation. Different tempos can help stimulate different feelings/energy. If you need to relax your mind during times that you are stressed, nervous, or anxious, find a soothing tune that has a calming effect. Whereas, during times you need an energy boost, an upbeat, more rapid rhythm is more stimulating. Music streaming options like Spotify, Pandora, Apple Music, and others offer playlists on a multitude of topics, allowing you to search by your mood. For example, on Spotify = “Happy Hits,” “Mood Booster,” “Calm Vibes,” and “Motivation Mix” or on YouTube “Good Mood Music Playlist - best mood changing songs.” Or find and make your own playlist with favorite tunes.

CONTRIBUTOR:
Connie Mester, MPH
To learn more about Connie, click here.
### NOT A FREUDIAN SLIP: THE MAGIC OF MUSIC ON HEALTH, PART 2

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<td>RELIEVE STRESS</td>
<td>Panicked about a critical deadline? Find a soft, slow tempo tune that induces relaxation, or opt for nature sounds like ocean waves or a babbling brook to calm your mind.</td>
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<td>REDUCE NERVOUSNESS</td>
<td>Tense about a presentation at work, going to the dentist or having a major medical procedure or surgery? Listen to a soothing, peaceful song and take some deep, cleansing breaths to help you cope with your circumstance. My dentist offers an iTouch headset during clearings and procedures.</td>
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<tr>
<td>REJUVENATE ENERGY</td>
<td>It's 3pm and you need a pick me up. Try using music versus hitting the vending machine to give you a jolt. Put your headset on, stand up, stretch your body and play a song with a rapid rhythm. Or better yet take a 5+ minute walk outside with your tunes playing. The fresh air, music vibrations and movement will definitely energize you.</td>
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<td>DEEPEN CONCENTRATION</td>
<td>Have a critical project with a fast approaching deadline and need to stay focused? Listen to ambient instrumental music with no distracting lyrics or EDM music for those that don’t care for classical. Just make sure the volume is low and serves as background noise. This type of continuous music can also be used like a timer as the ending can signal a good time for a brain break.</td>
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<td>SHIFT MOOD</td>
<td>Someone cut you off on your commute to work. You can feel the irritation inside you boiling. It’s not advised to play an aggressive song that could spur rage against other drivers as sound effects people's mood. A sad song can trigger rumination and negative thinking just as a faster rhythm song with a higher pitch can uplift your mood. So next time you are in a funk play a favorite upbeat song (maybe your personal theme song or Ellen Degeneres’ song). Turn up the volume and let your body move with the beat. Before you know it your negative mood will shift.</td>
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<td>MANAGE PAIN</td>
<td>Music engages us and can serve as a form of distraction to reduce awareness of chronic pain. Find a slower tempo song that triggers a favorite memory or elicits positive emotions and let the harmony of the tune comfort you. You can also try listening to 15-30 minutes of binary beats. Find a relaxing place to listen and make sure to use headphones to hear the different frequencies. Alternatively, you can participate in a clinical trial to help researchers test the impact of music on pain.</td>
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<tr>
<td>SPARK CREATIVITY</td>
<td>The left and right hemispheres of our brain becomes activated when we listen to and play music. Ignite deeper levels of imagination by learning to play an instrument. Lessons for piano and guitar can be found free on YouTube, pay an online subscription for lessons, or find a person or studio in your community that teaches your instrument of choice. Song writing can be another way to to immerse yourself into music. Learn how to express your feelings through notes and words.</td>
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<td>ENHANCE MEMORY</td>
<td>Need to retain information. Organize the bits of data into a mnemonic or match the content to a jingle to help trigger your memory. You can also listen to Alpha BiNaural beats to see if the music frequency and pattern increases information absorption.</td>
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<tr>
<td>BOOST MORALE</td>
<td>Joyful, upbeat tunes have a way of diminishing negative thoughts and diffusing tension. After a hectic day or maybe a long week of overtime, help your team boost their outlook by playing an upbeat song or two before a team meeting to refresh and reinvigorate.</td>
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<tr>
<td>MOTIVATE PRODUCTIVITY</td>
<td>I’ve noticed I play Moves Like Jagger when I am cleaning my house. It seems to get me productively buzzing around at a rapid pace. What upbeat songs enhance your performance? Create a playlist to have as background music to motivate and increase your work capacity.</td>
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<tr>
<td>INFLUENCE COOPERATION</td>
<td>Leading a team working session and need to get everyone on the same page. See if you can synchronize the behaviors and attitudes of your teammates by playing one hour of upbeat, happy music. These enjoyable rhythms can generate cooperation.</td>
</tr>
<tr>
<td>STIMULATE ENDURANCE</td>
<td>There are numerous playlists available for working out, running, walking, etc. This gym power music is the perfect tempo to keep your body moving and your heart rate up. Since rhythm drives the movement area of the brain use these fast pace beats help pump you up and help the time pass.</td>
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<tr>
<td>GALVANIZE UNITY</td>
<td>Take it from Madonna, Music Makes the People Come Together. Connecting through a shared positive experience is one of the best ways to positively impact your quality of life. Attend a music performance put on by the local school, find a cultural event or music festival in your area or check online for upcoming concerts. You can also expand your social enjoyment by singing in a worship choir or playing in a band.</td>
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<tr>
<td>INDUCE SLEEP</td>
<td>To wind down at the end of a long day, take ten minutes to ready your brain for rest. Marconi Union has created the world’s most relaxing song, Weightless. The notes and melody were specifically chosen to give the listener a sense of comfort and calmness. Carefully arranged beats [60/minute] and low tones, similar to those used in sound therapy, slow brain activity and influences your heart rate to synchronize with the rhythm. Access the 10 most relaxing songs on Spotify.</td>
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Where words fail
MUSIC speaks.

-Hans Christian Andersen

Several years ago I decided to find my personal theme song. This is a song that gives me a jolt of energy and helps shift my thinking. I got the idea from Chipper Jones who played for the Atlanta Braves. When the first 30 seconds of Crazy Train by Ozzy Osbourne came on you knew that Chipper was up next. Not sure if this ‘entrance music’ was played to elevate his level of confidence or boost excitement for the fans or even trigger nostalgia of past memories as it did for me, as the last time I saw Chipper Jones up to bat was nearly 20 years ago. Find your happy ‘theme’ song, a tune that snaps you right into a good mood. Certainly not a solve for every situation, however immersing yourself into the rhythm of the beat can transition or at minimum pause negative thinking.

By personally testing these suggestions, you can build your own evidence on how the magic of music affects your mood, your health and your life. The third and final article will highlight ways to apply, embody, and sustain the positive impacts of music throughout our day across the different roles we play, as individuals, as healthcare leaders, as educators and community citizens.

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The words “data security” can be nightmare-inducing for anyone whose job responsibilities include the protection of other people’s personal data. Few areas are more sensitive than private health information—and we have all of the complexities of HIPAA and its State analogues to show for it. Some States are now taking steps to protect private individuals from having their biometric data collected and stored without meaningful consent. Generally, privacy laws will punish a company when a breach occurs—but one State has taken a more proactive approach which allows private individuals to sue a company for collecting and storing their biometric data without consent—that is, in violation of the law.

A recent ruling out of Illinois illustrates some of the risks involved with using private biometric information. An Illinois statute—the Biometric Information Privacy Act (“Act”), 740 ILCS 14/1 et seq.—was the first law to regulate the collection and storage of biometric information when it was passed in 2008. It provides private litigants the opportunity to sue for money damages when their biometric information has been collected or stored in violation of the law. This is relevant to anyone using biometric data in Illinois, and potentially other States with biometric information statutes such as Washington and Texas if their State courts interpret their laws similarly. As an emerging area of technology with increasing business and enterprise use, more States will likely regulate the collection and storage of biometric data in the coming years. States where legislation has been introduced, but not yet passed in recent years include Alaska, California, Connecticut, Idaho, Massachusetts, Montana, New Hampshire, and New York.

On January 25, 2019, the Supreme Court of Illinois (“Supreme Court”) rendered its Opinion in the case styled, Stacy Rosenbach, as Mother and Next Friend of Alexander Rosenbach, Appellant, v. Six Flags Entertainment Corporation et. al., Appellees, 2019 IL 123186. Therein, the Supreme Court interpreted the Act, and found that when a private entity fails to comply with one of Section 15 of the Act’s requirements, that violation, in itself, without some actual injury or damage beyond infringement of the rights afforded under the Act, constitutes an invasion, impairment, or denial of the statutory rights of any person or customer whose biometric identifier or biometric information is subject to the breach; and that the person or customer would clearly be “aggrieved” within the meaning of Section 20 of the Act and entitled to seek liquidated damages and injunctive relief pursuant to the Act. In other words, a litigant who has had their rights violated need not show that they were harmed beyond that violation itself to be entitled to monetary damages.

In the summer of 2014, Alexander Rosenbach (“Alexander”), the 14-year-old son of Stacy Rosenbach (“Stacy”), visited Six Flags Great America Amusement Park in Gurnee, Illinois. When Alexander arrived at the amusement park, he was asked to scan his thumb into defendants’ biometric data capture system and then obtained a season pass card. The Complaint alleges that neither Alexander nor Stacy were informed in writing or in any other way of the specific purpose and length of term for which Alexander’s fingerprint had been collected. Neither signed any written release regarding taking of the
fingerprint, and neither consented in writing “to the collection, storage, use, sale, lease, dissemination, disclosure, redisclosure, or trade of, or for [defendants] to otherwise profit from, Alexander’s thumbprint or associated biometric identifiers or information.”

Defendants retained Alexander’s biometric identifiers and information and had not publicly disclosed what was done with the information or how long it would be kept, nor did they have any written policy that disclosed any retention schedule or guidelines for retaining and then permanently destroying such information.

After consideration of the Section 2-615 motion to dismiss at the Circuit Court (Lake County) and Appellate Court, the Appellate Court identified two questions of law interpreting Section 20 of the Act regarding liquidated damages and injunctive relief when the only injury alleged was a violation of Section 15(b) of the Act by a private entity which collected biometric identifiers and/or biometric information without providing the required disclosures and obtaining written consent as required by Section 15(b) of the Act. On appeal, the Supreme Court reversed the Appellate Court and concluded, contrary to the Appellate Court’s view, that “an individual need not allege some actual injury or adverse effect, beyond violation of his or her rights under the Act, in order to qualify as an ‘aggrieved’ person and be entitled to seek liquidated damages and injunctive relief pursuant to the Act.”

In this case, it was undisputed that the thumbprint constituted a biometric identifier subject to the Act’s provisions and that the electronically stored version of the thumbprint constituted biometric information within the meaning of the Act. For purposes of the Opinion, the existence of violations of Section 15(b) of the Act, below, which imposes various obligations on private entities, were not contested:

(1) informs the subject or the subject’s legally authorized representative in writing that a biometric identifier or biometric information is being collected or stored;

(2) informs the subject or the subject’s legally authorized representative in writing of the specific purpose and length of term for which a biometric identifier or biometric information is being collected, stored, and used; and

(3) receives a written release executed by the subject of the biometric identifier or biometric information or the subject’s legally authorized representative.

There has been an uptick in similar lawsuits in Illinois. An employee of North Shore University Health System filed suit in the Cook County Circuit Court in 2018, alleging the employer had scanned and stored his fingerprints for use in a punch-in clock without his consent. With this increase in litigation and the growing legislative momentum surrounding biometric privacy laws, this is a topic that deserves extra scrutiny before implementing biometric technologies and accompanying policies. Policies should also be regularly reviewed, as this is an actively evolving area of regulation.

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The alignment and performance of the executive leadership team (ELT) can make or break the short- and long-term success of a healthcare organization. This is why it is crucial for CEOs to focus on accelerating the effectiveness of the ELT.

Most CEOs inherit a leadership team. And most healthcare organizations have an executive team full of bright, hardworking, experienced leaders. But, according to Patrick Lencioni, author and leadership expert, the last true competitive edge is developing a high-performing leadership team, which subsequently leads to a healthier organization overall.

So how can a CEO, new or otherwise, tackle the daunting task of taking an existing group of leaders to the next level?

Creating an effective team isn’t hinged on an event or an episode. You don’t go to the gym and expect to be in shape within a day or even a week – this would just leave you overworked and sore. The same thing is true of becoming a high-performing team… it’s a process and takes courageous effort.

What follows is a primer for jump starting ELT performance in three phases.

**PHASE 1 – ASSESS THE LANDSCAPE**

The true reality of an organization is often elusive. You probably have some existing views and knowledge of the company and its culture. Chances are, this picture is not complete. There may also be some uncertainty around the existing ELT and its ability to drive future growth.

Effective CEOs take the time to listen, observe, and understand the organization and the existing ELT before making strategic, long-term plans. Begin assessing the organizational reality by:

- Talking to stakeholders from various levels of the company, including external vendors and suppliers
- Listening for clues that will help you familiarize yourself with the reality of the organization, including stories and narratives that help to define expectations, challenges, and opportunities, as well as aspects of the culture that may not be apparent on the surface
- Exploring the current and past effectiveness of the ELT

Next, bring the executive team together to learn more – both one-on-one and as a group. This is not only the perfect time for you to get to know them, but also for them to deepen their understanding of one another. Teams that have a strong sense of identity, purpose, and psychological safety outperform those that have little investment or awareness.

Beyond the initial exploratory discussions, and once rapport and trust have been established between the CEO and ELT, assessments can be introduced to further understand individuals’ motivators, reactions under stress, and more. It’s imperative, however, that team members know these are not for evaluation, but to empower collaboration and alignment.

By assessing personalities, as well as leadership and communication styles, the team can improve transparency and leverage their strengths to work more effectively together. This data will also help to develop the vision, strategy, and plan for execution in the next phase.
**PHASE 2 – DESIGN THE FOUNDATION**

Now that you have a solid blueprint of the organization and the team, this heightened awareness allows you to shape the vision and strategy, as well as design a plan for how the ELT will execute it. Pairing vision and strategy with a strong sense of team identity, purpose, and psychological safety instills confidence in team members and accelerates performance.

Leaders have to be vulnerable and trust each other; they must believe there is value in investing in the people around them. But they also have to buy into the vision and strategy along with how you plan to execute it. If they can’t connect the dots back to the organization’s mission, they will not commit – or lead – with passion. ELTs don’t fail in the development of the strategy; they fail in its execution.

Alignment isn’t always easy, especially if you inherited a team that lacked guidance and opportunity for development. There may be doubt within the board, as well as the organization, that the right people are in fact in the right seats. This is why it is critical to get to know these leaders – their strengths, gaps, etc. – in Phase 1.

Armed with this information, you can begin to shape and sculpt the team around your vision and strategy. This happens in a few ways:

- Roles may need to be clarified or reconfigured to leverage strengths
- New role(s) may need to be added to fill gaps
- Some leaders may self-select out of the team, once roles are clarified, because they feel it’s no longer a fit

Setting expectations and clarifying roles will also allow you to define the development and coaching needed to pivot the skills of the team for enhanced performance. In addition, it will be imperative that the team shift its priorities to align, first and foremost, with the ELT’s enterprise-oriented goals and objectives over their operational ones.

Many executives excel at leading within their silos, which is what got them to this high level in the organization. They assume this will also make them successful on the ELT; however, high-performing teams leverage and invite leaders to engage across organizational boundaries. This matrix model encourages leaders to work above, below, and across the organization. Collaboration and relationship building are crucial to success.

Many leaders struggle to give top priority to the ELT. They built their departmental team from the ground up and feel a strong commitment to it. This transition to the ELT as their first priority requires examination and growth. By providing solid developmental direction and alignment with the vision and mission, the CEO can help this team of potentially siloed leaders thrive as a strong, cohesive, high-performing executive team.

**PHASE 3 – CREATE A ROAD MAP**

With strategy, role clarity, and development plans in place, the next step is to establish a roadmap for how the ELT will work together. Start by having a discussion with your ELT about what the team will look like a year from now.

Ask questions like:

- How might we behave and lead differently than we do now?
- What will conversations look like then, as opposed to today?
- How will decisions be made?
- Will alignment around execution look different as development occurs?

Then, together, create the roadmap of how you will get there. Be sure to account for existing gaps and opportunities for growth, as well as your strengths as a team, and how you will leverage those for solving challenges that arise along the way.

This roadmap should also define the team’s:

- Core purpose
- Rules of engagement
- Benchmarks for measurement

Remember, as CEO, the ELT is your only team. And typically, your only chance to truly gain an edge over your competition. By growing and cultivating the leaders on this team, your entire organization will reap the benefits.

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C oaches use the phrase, “There is no ‘I’ in team.” Long-time UNC basketball coach Dean Smith applied the ‘Point to the Passer’ rule, which meant that whichever player scored they would point out the teammate that made the pass to them. Ask yourself, when was the last time you made an assist? Or worse, did you buy the jumbo popcorn at the movies with your friend who is trying to change their diet? To whom do you point in your life who assists you? An assist regarding lifestyle changes needs to be far more persistent to be effective. It can’t be a one-time thing. There are no buzzer beaters with healthy habits.

Consider children. There are tens of thousands of obese children who are not equipped with the knowledge or opportunity to make appropriate decisions regarding food. They are at the mercy of the decision-making of those around them. These children require an informed adult who understands the long-term consequences of consuming processed foods with low fiber levels that are sweetened and fatted. In the past 15 years, British Chef Jamie Oliver led campaigns in both the UK and the U.S. to improve the food that children were served in schools. Even going so far as to get his efforts broadcast on primetime television. That is an assist!

Consider what it takes to be a good dog owner. In our neighborhood, a woman who has rescued three different dogs over the years walks them at least twice a day. Assist! In contrast, another neighbor opens the back door, the dogs do their business, and then they come back in. No walk, no activity, very little outdoor time for the dog. No assist.

If being regularly active is like scoring a basket, then to whom do I point? Who gets the assist in helping me with my activity? John calls Saturday to see if I am playing basketball in the morning. Kate wants to go hit tennis balls. Marie wants to hit the gym and get an off-season workout in. Steph invites me on her favorite hike. Jack stops by the office to see if I can play some pickleball. Mario sends an email to try for tennis at noon. And when everything lines up right, a hike or ski up into the mountains with my friend from Vermont. Without this network, I suspect my activity level would be far lower than it is now.

In 1995 Dr. Janet Wallace at Indiana University found married pairs who participated together in an exercise program had far greater attendance and lower drop-out rates than those who came alone, even if they were married. Later Osuka et. al. also concluded that older couples were more likely to practice the walking they were assigned than non-couple participants. The premise is the social support offered by a friend, a spouse, or even a four-legged companion provides the impetus to take us into that metabolic gear that aids us in so many ways.

My recommendation is that if you are having trouble getting your steps in, raising your heart rate, or pumping the iron, make a call or send a message to someone and try to build your team. We cancel trainers, and
have unused exercise equipment, gym memberships that go for naught. There is something to sharing the ball, so to speak, and getting more people involved. From kids cooking in the kitchen to taking a family member out on a walk, everyone can participate. Time to suit up for the game. Shoot, score, assist!

Good Hustle!

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REFERENCES


POLICING DRUG PRICES IN AMERICA: THE INSTITUTE FOR CLINICAL AND ECONOMIC REVIEW

The United States lags behind other industrialized nations in systematically allocating limited healthcare dollars to medications that provide the most value at the lowest cost. In fact, the very institute created by the federal government “to assist...in making informed health decisions,” the Patient-Centered Outcomes Research Institute, is legislatively prohibited from considering costs in their comparative-effectiveness studies. Further, the Centers for Medicare and Medicaid Services, our country’s biggest payer, is explicitly prohibited from considering a drug’s price tag in coverage determinations for the Medicare population. Although private payers have much more latitude to consider medications’ acquisition costs, today’s contracting model between pharmaceutical companies and pharmacy benefit managers is so highly focused on rebates that these negotiations may often become the exclusive deciding factor. Amidst increasing public scrutiny on the high cost of medications to patients, a small Boston-based research firm, the Institute for Clinical and Economic Review (ICER), is gaining influence at a time when the U.S. is poised for a drug pricing revolution.

ABOUT THE INSTITUTE FOR CLINICAL AND ECONOMIC REVIEW
ICER is an independent non-partisan research laboratory founded in 2005 by physician-researcher Stephen D. Pearson, MD, MSc, FCRP, a prior fellow at the United Kingdom’s National Institute for Health and Care Excellence. The group of scientists conducts health economic evaluations of medications and technologies in collaboration with a network of affiliated academic researchers. Funding for the evaluations comes exclusively from non-profit and government entities without financial ties to either the biopharmaceutical or health insurance industry, although the Institute does receive funding from these industries to support some of their other activities.

WHAT INFORMATION DOES ICER PROVIDE FOR COVERAGE DECISIONS?
ICER conducts economic analyses using best practices for modeling to report cost effectiveness. Cost-effectiveness is expressed as the incremental cost-effectiveness ratio (Table 1), where effectiveness is quantified as quality-adjusted life years, or QALYs. The QALY measures the effectiveness of an intervention by taking into account both the quality and the quantity of life, where one year in perfect health is equal to 1 QALY. Use of QALYs as the effectiveness metric in economic evaluations provides an endpoint that can be compared across disease states which may have different measures of effectiveness, e.g., heart attack avoided, blood pressure goal attained.

Although there is no definitive rule, $100,000 to $150,000 per QALY is generally considered to be cost-effective. Thus, a new treatment that exceeds $100,000 or $150,000 per QALY would not be considered to be a cost-effective allocation of healthcare dollars.

FIGURE 1. INCREMENTAL COST-EFFECTIVENESS RATIO CALCULATION

$$\text{Incremental Cost Effectiveness Ratio} = \frac{\text{Cost of Treatment A} - \text{Cost of Treatment B}}{\text{QALYs of Treatment A} - \text{QALYs of Treatment B}}$$
EXAMPLE FINDINGS: HEREDITARY ANGIOEDEMA PROPHYLAXIS

A 2018 ICER evidence report on the available therapies for hereditary angioedema prophylaxis reported incremental cost-effectiveness ratios of $5,954,000 for Cinryze (C1 esterase inhibitor [human], Shire), $328,000 for Haegarda (C1 esterase inhibitor [human], CSL Behring GmbH), and $1,108,000 for Takhzyro (lanadelumab-flyo, Shire) compared to no prophylaxis (Table 1).7

Using this information, the list price for Cinryze would need to be discounted by about 60% to be considered cost-effective at a minimum threshold of $100,000 per QALY – Haegarda by 28% and Takhzyro by 34%.

### TABLE 1. COST-EFFECTIVENESS AND VALUE-BASED PRICING FOR HEREDITARY ANGIOEDEMA PROPHYLAXIS

<table>
<thead>
<tr>
<th></th>
<th>Cinryze (C1 esterase inhibitor [human])</th>
<th>Haegarda (C1 esterase inhibitor [human])</th>
<th>Takhzyro (lanadelumab)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incremental cost-effectiveness ratio</td>
<td>$5,954,000</td>
<td>$328,000</td>
<td>$1,108,000</td>
</tr>
<tr>
<td>Annual list price</td>
<td>$539,670</td>
<td>$509,792</td>
<td>$565,557</td>
</tr>
<tr>
<td>Annual list price to achieve $100,000 per QALY threshold</td>
<td>$216,000</td>
<td>$366,000</td>
<td>$372,000</td>
</tr>
<tr>
<td>Discount required to reach threshold price</td>
<td>60%</td>
<td>28%</td>
<td>34%</td>
</tr>
</tbody>
</table>

Following publication of the ICER report, the media suggested the results could adversely affect Takhzyro’s launch.8 While that remains to be seen, Shire launched Takhzyro at a price tag of approximately $22,070 per dose, far exceeding the $14,530 price ICER deemed to be cost-effective at $100,000 per QALY.

To be complete, ICER reports more than just the incremental cost-effectiveness ratio. In the case of hereditary angioedema, for example, they included recommendations for manufacturers to consider a “shared savings” model for on-demand treatment, for payers to give all market share to Haegarda and Takhzyro due to simpler administration, and for providers to develop a consensus statement for when to initiate long-term prophylaxis.7

HOW ARE ICER EVIDENCE REPORTS BEING USED?

Market research reports suggest that between 29 and 79% of payers are using ICER evidence reports in their formulary decision-making,9–11 and manufacturers are integrating ICER reports into their evidence generation and market access strategies.12

An example of this at work is the case of PCSK9 inhibitors, which are used to treat patients with familial hypercholesterolemia as well as high-risk patients with heart disease and high cholesterol. In November of 2015, ICER published an evidence report evaluating two PCSK9 inhibitors, Praluent® (alirocumab, Sanofi/Regeneron) and Repatha™ (evolocumab, Amgen), which they then updated in September of 2017 to reflect new clinical data.13–14 Both reports called for an 85% discount from the list price to be cost-effective. A third report was published in March of 2018 to reflect new Praluent clinical trial data, and the discounts needed were updated to 45 to 84% depending on the indication.15 Sanofi/Regeneron responded by contracting with Express Scripts, the largest pharmacy benefit manager in the U.S., to reduce the cost of Praluent in the form of a rebate, provided that Express Scripts exclude...
POLICING DRUG PRICES IN AMERICA: THE INSTITUTE FOR CLINICAL AND ECONOMIC REVIEW

Repatha from their formularies. Rebates are paid by the manufacturer back to the pharmacy benefit manager, but in this case, Express Scripts reported it would pass on a portion to patients who met certain criteria. How much Express Scripts actually passed on and reduced patient out-of-pocket costs for patients has not been reported. Amgen responded in turn, not by offering matching rebates, but by lowering the list price of Repatha by 60%, citing that rebates generally don’t reduce costs for patients.

In another example, CVS Caremark announced in August 2018 that it would allow employer clients to exclude drugs that exceed a cost-effectiveness ratio of $100,000 per quality-adjusted life year as determined by ICER, although it remains to be seen how that will be operationalized. This announcement sparked ample media attention, with headline words like “rationing healthcare” and “a dangerous plan.” Robert Dubois from the National Pharmaceutical Council asserted the CVS Caremark move was “too much, too soon,” while Forbes contributor Joshua Cohen postulated that ICER could become America’s NICE (National Institute for Clinical and Economic Excellence).

WHAT DOES THE FUTURE HOLD?
America has never been a society in which one single institution (e.g., ICER) holds the breadth of power across an entire sector (e.g., NICE). Except when it does. Like the Centers for Medicare and Medicaid Services. And Social Security. So sometimes in the U.S., we do give a tremendous amount of power to something that we have deemed a right.

The current Administration has prioritized lowering prescription drug prices by calling for a “Blueprint” to accomplish this goal. Yet a singular entity that determines which drugs are and are not paid for in this country is the polar opposite of the Trump Administration’s capitalistic viewpoint.

While ICER has been gaining influence, other entities have been joining the cost-effectiveness game. There is the Innovation and Value Initiative that is beginning to stand up cost-effectiveness analyses, and several organizations are publishing standards and best practices on how such analyses should be completed.

It is far more likely a constellation of organizations committed to cost-effectiveness, and even comparative-effectiveness without the costs (like PCORI), will fill the evidentiary gap long before the U.S. commits to one entity.

This begs the question...at what cost do we have multiple entities producing cost-effectiveness data? And at what benefit?

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RADIOLOGY - A PROFESSION IN TRANSITION: Q AND A WITH JAMES WHITFILL, MD

Beverly Bradway WG ‘91

James Whitfill, MD, is Senior Vice President and Chief Transformation Officer of HonorHealth, Chair of Society for Imaging Informatics in Medicine, and President of Lumetis, LLC a national healthcare consulting firm. He received his MD from the University of Pennsylvania and completed his Residency and Chief Residency in Internal Medicine at the Hospital of the University of Pennsylvania. He was the first physician to complete a fellowship in Medical Informatics in the University of Pennsylvania Department of Medicine.

Q: You’re trained as an MD but you ended up on the business side of radiology. How did that come about?

A: After earning my MD from Penn Med, I pursued a fellowship in medical informatics under David Asch, MD, currently the John Morgan Professor at Wharton (as well as Executive Director, Center for Health Care Innovation, and Professor of Medicine, Medical Ethics and Health Policy, Healthcare Management, Operations, and Information and Decisions). My research focused on using data as a tool for predicting sickness and disease at a time when using that information, now known as bioinformatics, wasn’t even a field of study. While electronic healthcare records are commonplace today, back in 1999 when I completed my research radiology was one of the few specialties embracing it. It was the possibility of getting engaged as a pioneer in digital workflows that appealed to me.

Q: What changes have you seen within radiology?

A: Technology is driving broad and rapid transformation. Twenty years ago when I began my career, the practice of radiology relied on ‘analog’ media and on-site radiologists. It was a local business, and radiologists worked in hospitals or within physician groups closely aligned to care settings. The settings required large, expensive machines and images were stored in large film jackets housed in storage rooms. Radiology was also a ‘lifestyle specialty’ that allowed radiologists to practice with predictable schedules and few after-hours responsibilities.
Radiology is very different today because digital imaging is allowing us to do more. The process of doing an x-ray is faster, images are better quality, and different radiology modalities allow for better clinical information and treatments. Furthermore, there is no need for large file space as images can be accessed from a computer at any time.

Radiology has also been enhanced by increased interconnectivity and communication among devices including mobile system access. For example, while providers used to be on-site for analysis and interpretations, today that can be done by simply logging into a computer. In addition, while second opinions used to come from a practice partner, today that opinion might come from a specialist across the globe. We also have the ability to access specialized computer software to assist with interpretations.

Q: Has investment in technology led to better overall profitability in radiology?

A: Unfortunately, no. Even though radiology was quick to embrace technology and measurably improve our ability to understand, diagnose, and treat patients, reimbursements have continued to decline because of pressure from policy makers and payers. Technology is not only expensive, it introduces other challenges as well, such as the need for training, facility/building accommodations, workflow adaptations, and more.

In my consulting practice, we team up with radiology groups of all sizes to help leverage informatics, analytics, and workflows. We also support aspects of technology integration. Given the pace of technological improvements, it is no surprise that every conversation I have about the future of radiology is complicated and multi-layered. Sorting through it can be challenging, and radiologists are having to become quickly adaptable.

Q: Is the role of the radiologist changing with technology?

A: Radiologists are no longer a behind-the-scenes practitioner, they are becoming central to patient care. While they used to be a complementary specialty, today the options within radiology allow for things such as screening, minimally-invasive treatments, monitoring findings and more, making radiologists important partners to patient clinicians. Some of the things we must consider as we look ahead is whether we expect radiology practices to be a one-stop shop for all scans and treatments and what role we expect radiologists to assume with regard to healthcare/patient cost control. There is real promise in the ability of technology to revolutionize the healthcare experience, but there are also fundamental questions that come with it.

Q: How are radiologists coping with the economic pressures?

A: Radiologists are becoming much more open to new corporate structures. One of the trends is consolidation, which we are seeing at local, regional, and, in some cases, national levels. While medical jurisdiction is still state-controlled, some radiology practices have found ways to obtain licensing in multiple states, allowing radiologists to work inter-state. Because of the 24/7/365 nature of radiology today, larger groups comfortably cover these needs while offsetting costs of care. In addition, we are seeing niche businesses evolve. With the advancement of technology and internet bandwidth, an industry known as teleradiology is emerging to supplement groups seeking different kinds of support.

We're also seeing the arrival of private equity firms interested in both investing and re-shaping the way the business of radiology is practiced. Often these conveners bring a scale and a business focus that has been absent in smaller groups. So there is a new dimension to the competition practicing radiologists now face.

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Q: Why is private equity interested in radiology? And, is it just radiology or are other specialties vulnerable to Wall Street advances?

A: Radiology has traditionally been an ancillary medical specialty in business formats that are privately-held, fragmented, geographically defined, and small but profitable. As a result, healthcare PE firms are hoping to tap a market where consolidations can lead to economies of scale, savings, and better margins. Radiology isn’t the first specialty targeted by private equity. Before radiology, private equity firms went after emergency medicine and then anesthesiology.

Having a partner, like a private equity firm, with deep pockets and incentive to create profit can be a bonus when a practice wants to go that direction. At the same time, as a physician, professor, and speaker engaged in national healthcare dialogue, I have concerns about approaching medicine like a commodity.
Q: And the future of radiology and the radiologist?

A: I think technological advances will answer that for us. In fact, this feels like a question that has brought us full circle on our conversation. Data will continue to be a powerful tool, and with enough data and mathematical modeling, we may soon predict illness, cancer, and disease from scans and images. This was the optimism I held during my fellowship several decades ago; I’m excited to see it on the horizon.

As for the future of the radiologist? I don’t believe algorithms and technology will replace their work, but physicians who use these tools will replace physicians who do not. Medical training and experience provide an important dimension of patient care that machine intelligence can’t replace. Those who are able to invest in technology and then leverage the information will continue to maintain the advantage.

Q: It seems there is a great Wharton Business School case study to be written on the challenges surrounding radiology.

A: Absolutely! The challenges facing radiology today and into the future present an excellent opportunity to consider business theory in the context of new problems, new paradigms, and growing possibilities. In addition, addressing the challenges will draw from knowledge related to policy, finance, marketing, information science, operations, and global influence. It’s a time that calls for thoughtful business innovation and strategic decision-making that healthcare business leaders will have to provide.

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WHARTON AROUND THE GLOBE: ASSESSING CARE DELIVERY IN ASSAM, INDIA

Through the Wharton Global Health Volunteers (WGHV) organization, Wharton students have the opportunity to participate in service-oriented healthcare consulting projects. These projects allow students to use and develop their skill sets through experiential learning and impact healthcare in the developing world. This past winter break, four WGHV members worked with Makunda Christian Leprosy & General Hospital in Assam, India, (makunda.in) to develop an impact assessment of their work providing healthcare in a low-resource setting.

There is a shortage of care for patients in resource-poor populations such as that which Makunda Hospital serves. Most healthcare is out-of-pocket, and one hospital admission can leave a family in poverty. Providing healthcare to local residents in resource-poor settings can be challenging to do in a sustainable manner. Makunda Hospital has developed a unique model, the “Makunda Model,” that allows it to provide care to many outpatients and inpatients in need of healthcare services in a remote region of northeastern India. It has developed approaches to maintain sustainability in spite of seeing patients with limited resources, and, additionally, has created educational and agricultural businesses in the local community. The hospital sees more than 100,000 outpatients, admits more than 13,000 inpatients, performs more than
5,000 inpatient procedures, and delivers over 5,000 babies each year.

25 years ago, the doctors responsible for reopening the hospital created a 30-year strategic plan, including phases of stability, local expansion, and distant impact. The Wharton Global Health Volunteers group was asked to conduct an impact assessment of the work done by the hospital thus far.

In order to evaluate the impact this model has had in the past 25 years, we conducted an assessment that included: 1) observing Makunda’s facilities and operational practices, 2) conducting in-depth interviews with Makunda employees, patients, community members, and competitive hospital administrators, and 3) analyzing financial documents and hospital statistics. The ability to travel to the site of the hospital and experience first hand the way the model was implemented in day-to-day practice was extremely enlightening and essential to the outcomes of our project.

We found that Makunda Hospital’s focus on poor-centric strategies, cost management, and continuous improvement has enabled it to generate revenue and retain healthcare professionals in a way that leads to sustainable patient care. Pricing based on ability to pay, equality in services offered, mission-driven employees, and a culture of continuous process improvement have allowed for continued provision of quality care to the local population. We described key areas of impact, takeaways for other hospitals in low-resource settings, and broader implications. We furthermore suggested key areas to focus on during development of the next 30-year strategic plan.

This project has been a rewarding learning experience for our team. It enabled us to learn about innovative provider models and think critically about providing care in different settings. We would like to thank our alumni for making this trip possible.

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DEVELOPING HEALTHCARE LEADERSHIP IN TURBULENT TIMES

The challenges facing our healthcare system in the current moment are well known and widely discussed—the need to reduce costs and improve quality, the rapid changes in the business landscape through consolidation and horizontal and vertical integration, the ever-changing political landscape, emerging technologies (too many to mention), and the disruptive effects looming from new entries into the system (i.e., Amazon, J.P. Morgan, Berkshire Hathaway, Walmart, etc.). What does not get addressed as much is the need for strong leadership at multiple levels to navigate the rapid pace of change in healthcare and turn challenge to opportunity.

Traditional models of healthcare leadership—usually divided into coats and suits, with physicians and nurses leading the clinical operation and administrators running the business—do not hold up in a world in which clinical knowledge, research leadership, business acumen, organizational wisdom, and technological literacy must converge. Leadership needs to span traditional healthcare siloes and be distributed through diverse teams and roles and in new organizational configurations that integrate clinical and business domains.

Organizations feel increasingly challenged to devote the time and resources to develop leaders in formal and informal ways. Typical challenges include:

- Stretching physicians, nurses, and other practitioners to evolve from their training in purely clinical roles (in which their expertise is focused, individual, and concrete) to take on management functions that require group work, tolerance for ambiguity, and the imprecise social science of human behavior.
• The shift from a clinical to an administrative role requires a shift in mindset and identity, a role transition that our colleague Tom Gilmore termed a transition of “silos in the mind.” (Gilmore, 1990)
• Encouraging smart people to learn and take on a beginner’s mindset
• And, of course, making time in an already overloaded schedule for leaders who carry heavy burdens of patient care, managing others, teaching, and often running a business unit.

Yet clearly leadership development is even more critical than ever as the demand for new skills and capabilities expand. Caryn Lerman, Ph.D., Vice Dean for Strategic Initiatives, and J. Larry Jameson, M.D., Ph.D., Dean of the Perelman School of Medicine of the University of Pennsylvania, argue for the importance of developing leaders in their recent piece in The New England Journal of Medicine, where they note that, “Our profession has been somewhat complacent in the face of these disruptive forces and hasn’t prioritized cultivation of leadership skills such as communication, team building, collaboration, and deliberative decision-making that will position the next generation of physician leaders to succeed in this rapidly changing environment.”

We know through our experience in developing and delivering programs in multiple organizations and with a range of practitioners—young physician leaders, interpersonal teams, programs that span business and clinical roles, and for emerging nurse leaders—that the impact of these programs on the individuals and the culture can be powerful. There is a hunger for this kind of development.

Over the past thirty years, we have developed, participated in, and facilitated numerous leadership development programs in healthcare settings across the continuum of care. We have learned from each and every program, and derived several principals that we believe live at the core of efforts to successfully support the development of healthcare leaders:

• Leadership development works best when closely tied to the strategic priorities of the organization/system. Maintaining a deep understanding of the macro and micro business drivers that shape healthcare nationally, regionally, and organizationally are critical to taking up leadership at whatever level and in whatever role.

• Learning happens best and is best retained when in close harness with real application—in the form of action learning methods that have leaders apply leadership frameworks to their real work challenges.

• Where possible, train different professions together to promote interprofessional collaboration and learning to enhance both individual leadership and team effectiveness (Tomasik and Fleming, 2014).

• Learning needs to be multi-modal, social, and immersive to achieve its greatest impact. The impact of PowerPoint has diminished in light of more dynamic ways to engage—lively discussions, case studies, podcasts and video, enactments of real work situations, etc.

• Clinicians need to be invited into leadership in order to see the important impact they can have at the system level. The shift in identity—the “silos in the mind”—is not insignificant, so the rewards in how they can serve healthcare missions need to be evident.

• Organizations can build a culture of leadership in their organizations, creating needed change through leadership development and building strong networks to support emerging leaders. To do so, leadership efforts need to create spaces of what Amy Edmondson (2019) calls “psychological safety” that allows smart people to become vulnerable and learn together.
DEVELOPING HEALTHCARE LEADERSHIP IN TURBULENT TIMES

Lerman and Jameson write that, “Health systems should make leadership development an organizational priority. Identifying and supporting emerging leaders, carefully matching leaders with roles, and proactively supporting new leaders during deliberate onboarding and mentoring processes could help close the leadership gap in healthcare.” We see real wisdom and commitment in their arguments, and hope that others see the light.

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.

REFERENCES


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