

The Link

 COLUMBIA UNIVERSITY | MAILMAN SCHOOL OF PUBLIC HEALTH

HPM Students Join Forces

Kyunghee Choi (EXEC '17), Barri Blauvelt (EXEC '17), and Jennifer Ringler (MHA '17) discuss their collaboration on a Patient-Centered Cultural Intelligence project at Holy Name Medical Center.

Patient-centered Cultural Intelligence (PCCQ) brings together the concept of patient-centered care and culturally competent care to improve patient experience, hospital and provider performance and community (population) health outcomes. This concept was conceived by two students in the EXEC program, and is now being implemented at a major community hospital in Northern New Jersey – Holy Name Medical Center (HNMC). The vision at HNMC is, simply put, to be number one in the nation in PCCQ and to serve as a model for the future of community hospitals everywhere. And it is well on its way to achieving this.

Below three HPM students write about how they became connected to one another and the role that they play in helping to ensure that PCCQ at Holy Name Medical Center is a success.

Kyunghee Choi
VP, Asian Health Services
Holy Name Medical Center

After retiring from JP Morgan as a managing director following the 9/11 attack on the World Trade Center, I committed my life's work to serving the Asian-American community's healthcare. As a first-generation immigrant, I am keenly aware of the cultural and linguistic challenges my community faces. In addition, it is extremely difficult for this population to understand the US healthcare system, which

creates an added burden and fear at a time when they are sick and most vulnerable. Combining my Wall Street experience with my community-focused mission, I was able to develop and lead a new initiative at Holy Name Medical Center in Teaneck, New Jersey, called Asian Health Services (AHS), the first such hospital-based program in the nation. Under the umbrella of AHS, there are three programs – the Korean Medical Program, Chinese Medical Program, and Filipino Medical Program – which serve more than 60,000 people annually. Many patients travel from great distances to receive culturally-sensitive and linguistically-appropriate medical services at Holy Name. AHS has now become a national model for culturally-focused medical care. In fact, several hospitals from California, Chicago, New York and New Jersey are replicating our program. This past month I received the Viral Hepatitis Recognition Award by the US Department of Health and Human Services at the White House for our successful hepatitis screening programs.

In June 2012, I came across a New York Times article which featured Dr. Linda Fried and The Mailman School under the title "Unafraid of Aging." It prompted me to think about expanding my knowledge and skills in the area of public health by going back to school, 35 years after graduating from a college in Korea. This has turned out to be one of best decisions I have made in my life. The education and the networking opportunities have been

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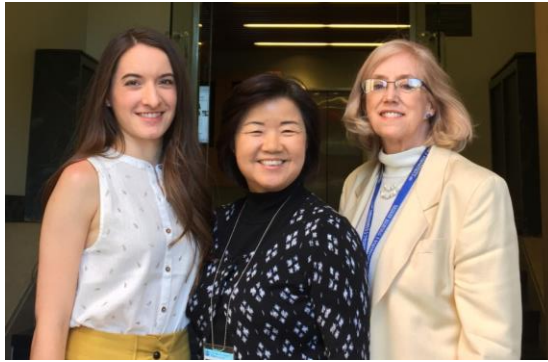
ABBREVIATION KEY:

ACCL	ACCELERATED MPH
EXEC	EXECUTIVE MASTERS OF HEALTHCARE MANAGEMENT PROGRAMS (MPH, MHA)
DUAL	DUAL DEGREE PROGRAM
FTM	FULL-TIME MANAGEMENT MHA
CMPH	COLUMBIA MPH
HPM	DEPARTMENT OF HEALTH POLICY & MANAGEMENT
MSPH	MAILMAN SCHOOL OF PUBLIC HEALTH
PTM	PART-TIME MANAGEMENT MHA

tremendous and well beyond my expectations. In addition to a team of top-notch professors, I am surrounded by highly accomplished classmates who are always eager to learn and share.

It's quite fulfilling to realize that what I am learning in class can be applied right away in a real job situation. In the first semester, many professors were using the term "population health management," which has become a buzz word in the healthcare industry. One day, during Dr. Michael Sparer's class, Issues and Approaches in Health Policy & Management, I got the idea that what I am doing at Holy Name is all about population health management and that I am constantly focused on improving the health status of my community. A few weeks later in my Managerial and Organizational Behavior class, Professor Stephen Mick spoke about Intermountain Healthcare and how it has become a national leader with its rigorous performance management and measurement processes. Then, a lightbulb came on in my mind: How can we lead the country with culturally-focused healthcare approaches? We have a lot to show to other hospitals. How do we go about it? What does it take to become an Intermountain of culturally-focused care? Who can help us? I approached one of my classmates, Barri Blauvelt, who is well known in this field for her distinguished research and advisory work with multinational companies. Barri and I came up with the project name Patient-Centered Cultural Intelligence (PCCQ) and agreed to develop PCCQ methodology, backed by rigorous measurement tools, metrics and process, the Intermountain way. Barri has been hired as our consultant on this project. Shortly after brainstorming with Barri, Emily Austin, the former coordinator for the HPM Practicum and Professional Development Programs, came to our class to talk about the Practicum Preceptor program. Since I am very interested in developing young talent from my JP Morgan days, it was an easy sell for Holy Name Medical Center to become part of this program. Through the HPM Networking event, I met with a full-time MHA student, Jennifer Ringler, who had a positive attitude, seemed eager to learn and willing to work hard. Later I asked Jennifer to join the PCCQ team for her summer practicum.

The PCCQ project was launched at Holy Name Medical Center in April 2016. We have recently gone through an IRB review of patient and staff surveys and plan to use some of the useful approaches and tools we have learned from our Biostatistics Professor Alan Weinberg in designing research studies. We are also learning some important elements of population studies in our Epidemiology class, taught by Professor Steve Stellman. Before Barri and I complete our MPH program in the summer of 2017, we expect to showcase PCCQ methodology in various publications and national media outlets. As a learning institution that brings together experts from all over the world, the Mailman School has played a vital



Jennifer Ringler (MHA '17), Kyunghee Choi (EMPH '17), and Barri Blauvelt (EMPH '17)

role in making the PCCQ project a reality. I have no doubt that I will continue to benefit from the Mailman School personally and professionally for many more years to come.

Barri Blauvelt **CEO of Innovara, Inc.**

On the first morning of the first day of the EXEC program at Columbia University's Mailman School of Public Health, the students in my cohort took turns introducing themselves. I was in the front of the room, so I was one of the first to speak. I explained that I am CEO of Innovara, Inc., a leading global management development firm with a focus on medical thought leadership development. In addition, I am adjunct faculty at University of Massachusetts Institute for Global Health, and I am engaged in research collaborations in cancer control, diabetes, and hepatitis. I shared with my cohort the fact that I have grown up and worked in healthcare around the world, and my aim is to continue to advance global healthcare through policy informing research and related initiatives.

Halfway around the room, another one of the executives introduced herself – Ms. Kyunghee Choi, VP and head of Asian Health Care Services at Holy Name Medical Center. There was an instant connection between us. Both of us came from high level corporate careers. Both of us had lived in Korea (she grew up there). And both of us were thrilled to be at Mailman working with incredibly talented faculty and peers.

Over the next few months as we learned about the US healthcare system, policy, health economics, and management, we continued to evolve our thinking around how to improve culturally-minded care in a hospital like HNMC. I had previously done quite a bit of work in this area, with MD Anderson Cancer Center and Cleveland Clinic, as well as other projects and programs in both hospitals and major healthcare corporations, so I could bring ideas and examples of "best practices" to the table. But none of these top

organizations, we observed, went far enough, particularly given America's culturally diverse landscape. Kyunghee had already demonstrated the benefits of cultural intelligence at HNM. The greater challenge now was how to integrate that with patient-centered care and expand to the benefit of the entire hospital population and community.

PCCQ emerged from these many discussions and was crystallized when my firm was engaged by Holy Name Medical Center to conduct the background research to determine how to become a national leader in PCCQ. The background research is now being prepared for publication by Jennifer Ringler, another Mailman MHA student whom Kyunghee hired as an intern for this summer. A PCCQ Council at Holy Name is already working on multiple initiatives to improve patient experience and hospital performance. We also are partnering with the University of Colorado Center for Bioethics and Humanities to benchmark HNM against other hospitals across the US in cross-cultural communications (using a survey developed by the AMA, managed by the Center).

We all feel we are making healthcare history. In a few short months we have made incredible progress towards establishing HNM as a leader in PCCQ. We have been able to achieve this with the guidance and direction of Kyunghee and Mr. Mike Maron, the CEO of Holy Name, as well as the talented team of rising leaders they have put together to carry this effort forward across the hospital, its network, the community and most importantly, its patients. And to think it all began on day one of the EXEC Program!

Jennifer Ringler Current MHA Student

Having grown up in a small, low-income town where I regularly witnessed the effects of cultural disparities, especially on attaining a college education, I've known my ultimate goal would involve giving back to my community. After considering careers in medicine and academic research throughout my undergraduate education at UC Berkeley, I found it was truly the combination or intersection of these fields and my interests that would yield the greatest impact, thus prompting my pursuit of a Master of Health Administration degree at the Mailman School of Public Health.

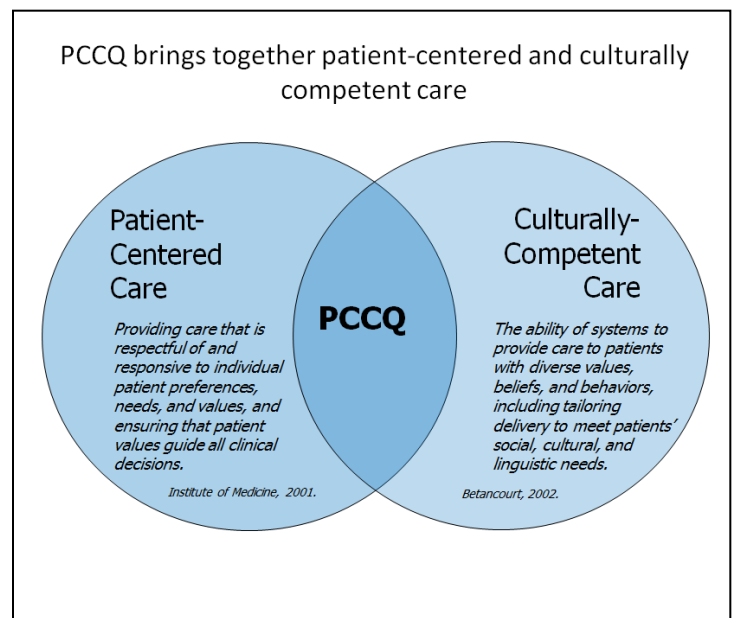
I was very fortunate to cross paths with Kyunghee Choi at last year's HPM Networking Event where she immediately drew me into her patient-centered cultural intelligence (PCCQ) project. I was amazed at how much Mrs. Choi had accomplished for her community and at how much more she

planned to do. Her vision was contagious. When the offer came to work at Holy Name Medical Center (HNM) for my summer practicum experience, I jumped at the opportunity to work with Mrs. Choi, as passionate and driven mentors are a rare find.

My primary objective in this project has been to conduct a systematic literature review of what we know (and don't know) about PCCQ. This has included synthesizing working definitions, identifying current models, best practices, assessment tools and metrics, accreditation agencies, and leveraging prior research results for the purpose of forming a foundation to build future research, initiatives, and policy.

This has been a particularly rewarding learning experience, as I have had the unique opportunity to bridge the worlds of hospital administration and healthcare consulting, through our collaboration with Mrs. Blauvelt and Innovara. The analytic techniques and communication skills I have gained through classes such as Strategic Management and Managerial and Organizational Behavior have given me tools to develop comprehensive project plans, and I am able to communicate effectively with a variety of stakeholders and actively participate in teams to ensure our project's success.

I am excited to see this project extend its reach far beyond HNM. Not only do I expect that PCCQ will impact individual hospitals and patients, but it will set a new standard for how we provide healthcare nationally. Because of these invaluable connections I have made at Columbia, I find myself on the cutting edge of my field and well prepared to tackle future endeavors in hospital administration.



Message from the Chair



More than two decades ago, I was finishing my doctorate in political science at Brandeis University and planning my next steps. My plan was to find a job at a small liberal arts college, teach American Politics, and spend Saturday nights with my daughters watching the school's basketball team. Around this time, my doctoral advisor suggested I meet with a Columbia Professor who was an expert in the politics of healthcare, and who presumably could provide guidance as I completed my dissertation. I took the subway to 168th street, rode the (in)famous subway elevator to the street level, and made my way to Professor Larry Brown's office in 600 West 168th Street. Larry, then the Chair of HPM, was generous with his time (we spoke for a couple of hours). He also introduced me to Sherry Glied, a young economist he had hired a couple of years before. I remember asking him why a political scientist would be in a School of Public Health. He must have given a convincing answer! A few weeks later I accepted a position to join the department. Thinking back I wonder how it all happened so quickly.

My memories about those days long ago came to life as I read the interview with Larry in this Issue of *The Link*. In his own words, Larry talks about changes in public health education since he arrived, memorable projects he has worked on, his views on teaching, the ACA and cross-national studies, and even his favorite foods (who knows what spiedies are?).

This issue of *The Link* also celebrates a variety of other connections and networks. The cover story, for example, describes a collaboration on a Patient-Centered Cultural Intelligence project at Holy Name Medical Center, created by Kyunghie Choi and Barri Blauvelt, two long-time healthcare experts who have returned to school as students in our EXEC program. And in a nice twist to that story, the two of them met Jennifer Ringler (MHA '17) at one of our networking events, and have hired her to provide research help.

There also is a nice connection between the issue's profiles of a current student (Ricardo Rivera-Cardona) and an alum (Rebekah Gee). Ricardo (EXEC '17) is an exec student who commutes monthly from Puerto Rico, where he is the Executive Director of the Puerto Rico Health Insurance Administration (the agency that runs the Puerto Rico Medicaid Program). Rebekah (MPH '98) is the Secretary for the Louisiana Department of Health, a role which includes responsibility for that state's Medicaid Program (including its roll-out of the ACA Medicaid Expansion, which begins this July). It is inspiring to read about these two healthcare leaders, and makes me proud of their connections to our department.

This issue contains many other articles and short notes that provide a glimpse into the wide range of people and activities that are part of the HPM community. There are summaries of our three most recent HPM Roundtable Discussions (with Robert Galvin, Stephen Lyman, and yours truly). There is an overview of the HPM Annual Conference: special thanks to our keynoters, Karen Ignagni, David Alge, and Niyum Gandhi, and also to all of the panelists, moderators and attendees!

Finally, there is a short article about the party we held a couple of weeks back to celebrate Tom Ference's 50 years at Columbia University—now that's an anniversary that Larry Brown and I are still a long way from reaching!



Michael Sparer, PhD, JD
Professor and Chair
Department of Health Policy & Management

Student Spotlight: Ricardo Rivera-Cardona (EXEC '17)

Ricardo Rivera-Cardona established himself as a leader in Puerto Rico's government health insurance system...and then he went back to school. Read about his initiatives, turnarounds and what he has planned for the future.

The first time Ricardo Rivera-Cardona left Puerto Rico, he was headed to Ithaca, New York, to begin college at Cornell University. As he matriculated through his undergraduate program, Rivera-Cardona discovered that the engineering track he had chosen did not match his professional ambitions. "I like to interact with people, and in my internships, engineers were isolated," he remembers. "The fastest they could see the results of their work was five years, and I couldn't wait that long." In an effort to expand his field of study, Rivera-Cardona enrolled in a Master of Engineering Management program, which offered a combination of business and engineering classes. The cold winters at Cornell ultimately convinced Rivera-Cardona to move back to a warmer climate. After finishing graduate school in 1994, he took a job as a management consultant at Arthur D. Little in Caracas, Venezuela.

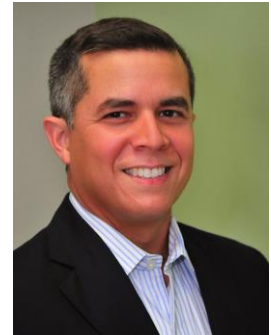
In 2005 Rivera-Cardona was offered a government position as the Executive Director

"I like to interact with people, and in my internships, engineers were isolated. The fastest they could see the results of their work was five years, and I couldn't wait that long."

for the Puerto Rico Trade and Export Company. "I did my research and I came to the conclusion that this was a once in a lifetime opportunity," he recalls. During his time in this position, Rivera-Cardona implemented a number of successful initiatives. He helped develop Puerto Rico Exporta, a program that offers business owners the tools and guidance to navigate regulations for exporting products internationally. The program also set up trade missions to help connect businesses in Puerto Rico with US markets, as well as countries in Latin America and Spain. Puerto Rico Exporta surpassed its initial objectives, and over time has continued to grow. "We were facilitators," Rivera-Cardona explains. "Individuals who started in that program are now doing business with five or six countries, and today they are experts. But ten years ago, they didn't know anything about it. It's gratifying when you see the effort that you helped shape, impact people and turn their lives around."

Another initiative that Rivera-Cardona created around this time, La Llave Para Tu Negocio (The Key to Your Business), helped Puerto Rican entrepreneurs expand their businesses. The program identified qualified business owners, provided them with education and loans and monitored their companies as they grew. "We started the program, and the goal was to create a thousand new businesses in the four years of the governor's term," explains Rivera-Cardona. "By the third year, we surpassed that goal, and in the end, the program generated more than twelve hundred new businesses."

Rivera-Cardona's introduction to healthcare came in 2008 when he became president of Cooperativa De Seguros De Vida De PR (COSVI), one of the top health and life insurance companies in Puerto Rico. When Rivera-Cardona took over, the company was in trouble—they were losing 28 million dollars a



Ricardo Rivera-Cardona (EXEC '17)

year. In five short years, Rivera-Cardona transformed the company's management and formulated a new corporate strategy. When he left the company in 2013, they were turning a profit of two million dollars a year. This position served as a springboard to Rivera-Cardona's current role as Executive Director of the Puerto Rico Health Insurance Administration. In this role he manages the Government Health Plan (GHP) which serves 45% of Puerto Rico's population with a 2.8 billion dollar budget. When he assumed the role, Rivera-Cardona once again inherited a system in crisis. When he came to the role in 2013, the agency had a projected deficit of 200 million dollars. In the last three years, Rivera-Cardona has streamlined the system, working to eliminate inefficiencies, and the organization is currently projecting a 60 million dollar surplus by the end of this fiscal year. "It's a big turnaround," Rivera-Cardona concedes. "We are dealing with patients on the borderlines of our benefits package and coverage, and we have to make decisions in gray areas which are not easy. We have revamped the entire system, and at the same time we have strengthened the relationship with CMS, which is very important because they are the ones who make sure if we are complying with the federal regulation." When Rivera-Cardona took the position, Puerto Rico was not in compliance with federal regulations mainly because of its model for providing care as a third party administrator. He enacted a corrective action plan to move everybody into the managed care organization model, in compliance with the federal regulations. This

“All of my previous experience of turning things from inefficiency to efficiency—I have tons of opportunities in healthcare to do that, and the Affordable Care Act opens new doors. It will take years for everything to settle, and then after they settle, you can start to make things more efficient.”

process involved moving 1.4 million people from one model to another. “It took us only four or five months to complete this move, and we were able to transition everybody without major issues,” Rivera-Cardona says. “That was an important success, and we did it through integration, communication, and planning.”

Because of its status as a territory, Puerto Rico’s federal funding is capped at close to 300 million dollars, but the system costs much more than that to operate. “The Affordable Care Act (ACA) has delayed a catastrophe in the making because it gave us a non-recurrent block grant to overcome the cap temporarily, but those monies are scheduled to be depleted by the end of next year, and if congress doesn’t act in order to eliminate that disparity in treatment, it will force Puerto Rico to take more than a million people out of the Medicaid program,” Rivera-Cardona explains. The decision to treat Puerto Rico as any other US jurisdiction currently rests in the hands of congress. If congress doesn’t act, Puerto Ricans will likely flee the island to seek medical care in the United States. “In 2005, 12,000 Puerto Ricans left the island. In 2010 that number went up to 28,000, and in 2014 the number was 64,000,” Rivera-Cardona says. “For every 100 people who come to the US, 58% qualify for all the federal programs—it’s not only Medicaid, it’s HUD, it’s food stamps, it’s everything.” The ACA applied the health insurance act to Puerto Rico, but because Puerto Rico isn’t entitled to the federal exchanges, they don’t receive all the subsidies. “There are a lot of unintended consequences of the ACA,” Rivera-Cardona notes. “The essence of the ACA is to make

sure that more people have access to care, but by treating Puerto Rico differently, actually it’s threatening the access to care.”

Rivera-Cardona is eager to create new initiatives in healthcare for Puerto Rico. He is piloting a super-utilizer program based on Dr. Jeffrey Brenner’s work at the Camden Coalition. The program focuses on educating the top five percent of the population who are chronically ill. These patients consume more than 30% of Puerto Rico’s total investment in healthcare, which in this case, is nearly a billion dollars. The program aims to help these individuals navigate the system so that they can control their medical conditions. The program also addresses socioeconomic barriers that prevent access to care. “This program is not going to take away anyone’s medical condition,” Rivera-Cardona explains, “but it will control and educate the individuals and provide a network around them so that we can take care of the social and economic needs.”

In 2015 Rivera-Cardona decided to take on one more challenge: he went back to school. He has learned to balance his demanding career with his coursework in the EXEC program. Though his schedule requires more intricate planning, and he must carve out more pockets of time between meetings to complete the reading for his courses, he has been able to find a balance. His courses are useful in his effort to navigate challenges within the Puerto Rican healthcare system. One course, Issues and Approaches to Healthcare, has proven particularly informative. “The class provided a historical context for understanding how the US

system works and the challenges and the political issues surrounding it,” Rivera-Cardona explains. “That gave me additional tools to do my job. In Puerto Rico, people are caught up in the moment, and they don’t step back to understand history, and that class taught me how to value history and to use history as a foundation in order to build a future.”

When Rivera-Cardona’s term is up at the end of this year, he plans on moving back into the private sector. He knows that the skills he has acquired throughout his professional career will help him transition smoothly into his next role. “Analytical skills, problem solving, communication, presentation skills, and interpersonal skills—all those have come with me from my background in engineering,” he explains. “They have grown stronger as my professional experiences have shaped them.” Rivera-Cardona sees opportunity to effect change in the future of healthcare. His experience eliminating the inefficiencies in organizations is a strength that he hopes to employ in his next role. “All of my previous experience of turning things from inefficiency to efficiency—I have tons of opportunities in healthcare to do that, and the Affordable Care Act opens new doors. It will take years for everything to settle, and then after they settle, you can start to make things more efficient,” Rivera-Cardona says. “My life has been getting into challenges and then trying to turn them around, and that’s what excites me about healthcare.”

Alumni Profile: Dr. Rebekah Gee (MPH '98)

Dr. Rebekah Gee grew up in a household that prized both public service and advocacy. Gee's father has served as president for a number of universities across the nation and has experience on the front lines of the education reform, helping to create state and federal policies that have improved thousands of lives. Gee's mother, on the other hand, became a fierce advocate for women's health after being diagnosed with breast cancer when Gee was just 12 years old. "In the eighties, you couldn't say the word 'breast' or 'breast cancer'—it was not something that was talked about," Gee explains. "My mother went out and advocated for other women and for research to be done. She worked to give other women access to care, and that was a powerful example for me." Taking inspiration from both of her parents' examples, Gee dedicated her own life to the fields of medicine and public health.

As an undergraduate at Columbia University, Gee was on a pre-med track, but there were moments where she struggled with her coursework. "I had a learning disability," Gee explains, and the pre-med classes were difficult and cutthroat. At one point, I dropped out of pre-med and considered a law degree." However, on a trip to South Africa, Gee was fortunate enough to meet Nelson Mandela, and that meeting changed the course of her life. "I've always been inspired by Mandela's struggles and resilience, and I thought, 'if he can achieve what he achieved despite the adversity he faced, I can face my own challenges.' So I went back to Columbia and renewed my quest to be a doctor, and I never looked back."

Gee later completed her MPH in health policy and management before attending medical school at Cornell University. "The Mailman School of Public Health gave me a framework for understanding that health is more than just healthcare," Gee recalls. "Health is having access to safe drinking water and a healthy food source and having a safe environment."

Gee finds that her public health background has given her valuable insights with regards to her policy work, insights that medical school alone would never have provided. "The health policy content that I learned from Sherry Glied and others at the Mailman School has helped me to better understand how to critically evaluate health policy and learn from health services research. I apply those lessons to my work every day," Gee says.

Gee completed a residency in obstetrics and gynecology at Harvard and was then accepted to the Robert Wood Johnson Clinical Scholars program at the University of Pennsylvania, where she received a Master of Science in Health Policy Research. In addition to her research and her clinical practice in obstetrics and gynecology, Gee has held a number of faculty appointments, at both Louisiana State University and Tulane University. Gee enjoys teaching and acknowledged that reflecting on her experience as a student helped inform her teaching practices, "There are different ways of teaching and learning, and it's not necessarily intuitive matching them. Having had a learning disability growing up, I understood this particularly well," Gee remembers. "My experience as a student has given me humility when working with my own students and a greater appreciation of the fantastic professors I had."

Since 2009 Gee has held a number of health policy positions at the state level, including serving as the maternity medical director for Louisiana's Title V program and as Louisiana's Medicaid medical director. Gee was most recently appointed as the Secretary for the Louisiana Department of Health. In this role she is responsible for a broad range of health issues, from the evacuation of hospitals in the event of a hurricane to preparing for the possibility that Zika virus will begin to spread in the state's large mosquito population, but Gee's most immediate goal is the expansion of Medicaid coverage to approximately



Dr. Rebekah Gee (MPH '98)

375,000 working people across Louisiana. After years of resistance to expansion led by Louisiana's former governor, Gee emphasized that clear communication between policymakers and the public have helped underscore why certain policies are necessary. "A lot of policymakers haven't done a good job explaining to the public why things should be done," Gee argues. "For example, there are many powerful provisions of the Affordable Care Act, yet I would say that the American public still doesn't understand the real value of it. Part of our job as policymakers and health policy professionals is to be able to explain why these changes are important to both those with the power to make them happen and those who would most benefit from them." Louisiana is set to begin expansion coverage on July 1, just five months after Gee began leading the efforts to do so.

Despite the demands of her job, Gee still sees patients in a clinical setting. "It informs my policy work," she explains. "It helps me walk in the shoes of my patients, but it also helps me understand the perspective of the providers who see patients and understand their struggles as they practice medicine in today's ever-changing world." Gee also knows firsthand what it is like to navigate the system as a patient. In 2008 she and her late husband were on a scooter when they were hit by an SUV going 40 miles per hour. Gee's husband was on life support for a week and then passed away. Gee came away from the accident with multiple injuries that required her to use a wheelchair and live in a rehabilitative hospital for several weeks. "The experience gave me perspective on what it's like to be a patient and a whole new appreciation for nurses and the work they do.

It also gave me some limited insight on what it's like to have a disability in our society."

The accident also gave Gee a new perspective on her life. "A lot of the things I do, I do now with the understanding that life is short and fragile. We all hang by a thread," she says. After her recovery, Gee followed her passion and moved to Louisiana, a place to which she had always been drawn. Once there, she met her current husband, David, and today they are raising five children together. Gee works hard to balance the demands of her job with those of her family life. "I just have to take it one day at a time and think about what's the most important thing that day," Gee explains. "I have over five thousand of Louisiana's best employees to lead at LDH and a state of almost five million people who depend on our collective work, so I'm committed to doing my best to make good decisions about public health. But I also have to be a mom to my kids."

Before assuming the role of LDH secretary, Gee received some criticism for accepting such a demanding position while raising young children. "There's got to be a way to do this job as a woman, or how could any professional woman be in leadership?" she argues. "I'm trying to be a positive example for other women, including my own daughters." Gee seems to be doing just that. With just over three weeks to go until expanded Medicaid coverage begins, her department has already enrolled just under 200,000 Louisiana residents in the new program, helping save lives and bring new economic opportunity to the state. "These are people's lives and livelihoods we're saving and improving with this program. I couldn't be more proud of the work my team and I are doing."

HPM Celebrates Professor Tom Ference's Fifty Years at Columbia

This year HPM Professor Thomas P. Ference celebrated his fiftieth year at Columbia University. Ference began his teaching career at Columbia Business school in 1966, and four years later he became the Director of the Executive MBA program. In 1994, Ference joined HPM. He has taught in all three HPM programs and serves as the Faculty Director of the MHA programs. Ference has been instrumental in creating and developing a number of educational programs since his arrival in HPM including the Professional Development and Practicum program, HealthSquare, and the Case Competition.

On Thursday, June 16, HPM hosted a reception for Ference to celebrate his lifelong commitment to teaching. As a testament to Ference's strong belief in mentoring and maintaining personal connections, many of his former students were present to honor him. Ference's family, including his wife Ellie and sons Dr. Thomas M. Ference and Michael H. Ference attended the event with their families.

Dean Fried was on hand to give remarks, as was Michael Sparer, HPM Chair; Rebecca Sale, Director of Academic Programs and Special Projects; Sheila Gorman, Clinical Professor Emerita and former Deputy Chair of HPM; Nan Liu, Assistant Professor, HPM; and John S. Winkleman, an HPM professor and Faculty Director of the Consulting Workshop.



John S. Winkleman, Rebecca Sale and Tom Ference

Ference addressed the group in a heartfelt speech where he stressed the importance of continuity in a professional career and acknowledged that he was blessed to have worked with so many incredible people throughout the years.

On behalf of the department, Michael Sparer presented Ference with a hand-crafted maple and cherry rocking chair engraved with the Columbia school seal. Additionally, the department will re-name the HealthSquare simulation the Thomas P. Ference Health System Simulation to honor Ference's legacy.

Faculty Corner: Q & A with Professor Larry Brown



Prof. Larry Brown

In the mid-1970s you became a faculty member in the Executive Program in Health Policy & Management at the Harvard School of Public Health. Can you talk about the state of public health programs when you began your academic career, as compared with today's programs? What are the biggest changes you've seen in public health education?

Probably the biggest force for change has been the growth of government involvement in financing and regulating the healthcare system, a development that began in earnest with enactment of the Medicare and Medicaid programs, which were less than a decade old when I got involved in the Executive Program at Harvard in 1974. That program aimed to improve the capacities of public regulators of healthcare, and they had to beat the bushes all across the Harvard faculty to find people who could do the job. Most of these folks came not from the ranks of public health but rather from the social sciences. (I got my PhD in Government [aka Political Science] in 1973.)

Before Medicare and Medicaid, practitioners and teachers of traditional public health had watched disappointedly as the federal government favored biomedical research and technological innovation over prevention and health promotion, as the planning elements in federal support for the construction of new hospitals were weakened, and as federal workforce programs proved to care much more about training specialists than primary care providers. Then along came Medicare and Medicaid, which enlarged the demand for bright ideas about access, quality, and—most of all—control of costs and thus expanded the demand for experts who were supposed to offer policy solutions. Public health schools were (and remain) ambivalent: on the one hand they could expand their budgets and faculties

by answering the call for policy analysis and health services research; on the other hand, these projects focused mainly on improvements in the acute care system, with public health chiming in frustratedly from the sidelines, as usual. Moreover, the growing dependence on “soft” federal and foundation grants risked (and still risks) a displacement of intellectual agendas that do not center on the production of quick fixes for policy and management problems, which credulous funders often expect.

As “health studies” grew roughly in tandem with the growth of health spending in the US economy, schools of public health expanded dramatically—more schools, more faculty members, more funds, more degree programs, more students, more administrators, and more competition among schools and between them and proliferating degree-granting programs outside schools of public health. Coming to Columbia in 1988 I joined a department (division actually) called “Health Care Administration,” a title we soon changed to “Health Policy and Management,” to reflect the new realities. These developments have expanded the fields of action for public health but also have blurred the distinction between the vocational dimension of public health education (pay your tuition, master a bunch of practical skills, get a degree, and find a decent job somewhere in the vast precincts of health policy and management) and the professional dimension (prepare oneself for leadership in making productive use of the public sector to prevent illness and promote the health of populations).

You have been working in the field of health policy for over forty years, investigating a range of topics that include Medicaid managed care plans, politics in public health, and healthcare reform in the US and abroad. Can you discuss a few projects that you've worked that stand out as particularly memorable to you? How have they influenced the research you are doing today?

I have had the good luck to work on many exciting projects, often with cherished collaborators. My early research on HMOs taught me how naïve it is to assume that organizational forms will dependably follow theoretical functions (market forces, competition, and “correct” incentives, for example) and the

importance, still far too little recognized in health policy studies, of digging deeply into the complex contingencies of organizational life.

Another highlight includes my work with Catherine McLaughlin, a superb economist, on two evaluations for the Robert Wood Johnson Foundation, the first of which examined a program that enlisted leaders in the voluntary sector (Blue Cross and the AHA, among others) to create cost containment programs in a dozen or so communities, and the other of which turned to community health leaders to devise new health insurance plans that would be attractive and affordable for small businesses with uninsured workers. This research brought to light the limits of voluntary solutions and the indispensable roles of government in containing costs and expanding access.

Some of my most enjoyable collaborations have been with HPM colleagues. In several collaborations with Michael Sparer, I have come to see that federalism and the states are not an institutional inconvenience encumbering national action but rather crucial sites of energy and ideas, not least in the management of Medicaid (a program that now covers roughly 1/5 of the US population). With Sherry Glied I learned from a topnotch economist who has extraordinary knowledge of and insight into the whole range of the social sciences. And I learned about management from the best and the brightest, namely, Sheila Gorman, my deputy when I chaired the department.

Serving on the National Advisory Committee of the RWJF's Urban Health Initiative taught me both how to follow arguments about better health outcomes wherever they lead strategically and how often those arguments surprisingly burst the boundaries of “traditional” public health and healthcare services. The goal of the program was to enhance the health and safety of children and youth in five cities. Leaders of the programs in the cities saw that the major threats centered around drugs, violence, and teen pregnancies, all of which were most plausibly addressed by after school programs and cooperation with law enforcement agencies, venues that had little to do with healthcare and healthcare

institutions per se.

More recently I have revisited these lessons about the importance of strategic improvisation and institutional eclecticism in my examination in five cities of the promotion of walking, biking, and other types of physical exercise by means of changes in the built environment. The key players in this arena are departments of transportation (local, state, county, and federal), regional planning councils, city planning departments, municipal development agencies, and (of course) road builders, developers, realtors, and business owners. Promoting health can take one to faraway places. “Health in all policies” should not be a recipe for the dominance by health of other policy realms but rather an invitation to health leaders to look at, listen to, and learn from these other realms, which may be indispensable partners in health promotion.

You’ve spent most of your career in the classroom. What you like about teaching? How does your work outside the classroom inform your teaching? If there is one thing you want your students to take away from your classes, what would it be?

Teaching health policy and management is a tricky business. One can teach the “what”—the nature and content of policies and management challenges—and the “why”—the factors that help to explain the sources of these policies and challenges—but the “how to” element—how you proceed to improve policies or manage successfully—is, I think, unteachable.

One can only hope that learning about the *what* and the *why* fosters an analytical context that helps students improvise plausible strategies in situations that are highly context-dependent. As for what I hope students get out of my classes, I want to offer them information, analyses, and arguments as resources, raw materials, with which they may interpret—make some sort of sense of—the larger system and the more particular pieces of it that shape their professional lives. I would like them to acquire a critical style of thought that penetrates the endless flow of jargon and panaceas that deluges health policy and management. (“Integration,” “holistic,” “global,” “visionary,” “triple aim,” and on and on).

I would hope to convey that health policy and management issues derive from deep conflicts of values and interests that cannot be solved and must be managed politically—a proposition that implies the need to acknowledge and appreciate complexity, civility, and compromise as fundamental to democratic decision-making. I hope the qualitative content of my courses shows my students some of the limits of approaches that dogmatically equate “science” with measurement and that ironically muddy the analytical picture by seeking to isolate the independent causal contributions of variables that in fact play out as parts of a gestalt of interfused, entangled forces. And I hope my students take pleasure in the constant possibility of surprise in this intellectual enterprise and in playing with ideas that may illuminate healthcare policy and management but never yield The Truth or the One Right Way.

In Issues and Approaches to Health Policy and Management, one of the classes you teach in HPM, you focus on the historical context of healthcare policy in the United States. How does understanding the context of healthcare policy and reform help students frame issues that are currently shaping the system?

In order to solve policy and management problems one has to understand how they arose and why they take the forms they do. That notion “feels” right but I wonder: maybe problems differ in how context-dependent they are and perhaps sometimes you can concoct a plausible approach to problems without much digging into their root or other kinds of causes.

That said, I try in Issues/Approaches to make sense of some paradoxes in the US system—for instance, the bigger the system grows, the more urgent become the calls to get it under control, but the bigger it grows the harder it is in practice to achieve that control. Another paradox: for roughly 50 years policymakers have been talking about the need to downsize government, deregulate, privatize, and the rest, yet all this time the roles of government (especially federal and state) have grown steadily. And another: not infrequently important policy changes occur just when the ink is drying on analysts’ polished accounts of why the system is immobile—cases in point include CHIP (kids issues enjoy great rhetoric but no real constituency), Medicare Part D (who could seriously expect a government run by

conservative Republicans in the White House and both chambers of Congress to pass the largest expansion of the program since its inception?), and the ACA (how can the system produce major healthcare reform in the midst of the worst economic downturn since the Depression?).

Our unwieldy, fragmented system is both stable and changeable, and the balance seems to shift via mysterious subterranean rumblings the meaning of which often seems clear only after the fact. If one approaches these challenges with a due dose of analytical humility the resulting intellectual “play” can build one’s mental muscles in ways that may be useful and—arguably most important—fun.

In your research, you have studied healthcare politics at the city and state level, the federal level and cross-nationally. Is there a common denominator (i.e. challenge or solution) that stands out to you? What are some lessons learned from studying these healthcare systems?

There is a school of thought that denies the importance of studying other healthcare systems because they are to the US system as apples are to oranges. I believe, by contrast, that cross-national research and teaching may be the single most valuable topic a health policy and management curriculum can address. As someone said, such research may not make you an expert on the countries you examine, but it will surely make you know your own system better.

I see three major differences between the US system and those of other Western peers. First, others make solidarity a central value, whereas the term is almost never heard in US healthcare debates. Solidarity treats healthcare as a right of citizens (indeed of legal residents), insists that access to care be universal and equitable, forbids excessive out-of-pocket costs, and views redistribution and cross-subsidies between the better-off and less-well-off as the essence of social justice. The USA views healthcare not as a right but rather as a set of desirable goods and services that should be distributed by means of private and voluntary arrangements (e.g. an employer-based healthcare system) insofar as possible, tolerates major disparities in coverage within the population, is increasingly enamored of

“skin in the game,” and distrusts redistribution and cross subsidies by government as an acquisition and transfer of taxpayer earnings that is just and legitimate only if the beneficiaries pass clear tests of “desert.” Much of this has to do with political history and culture: European policies have been decisively shaped by the legacy and continued power of social democratic notions, which have had only a marginal impact on US policies.

Second, Europeans recognize that if health coverage is to be both universal and affordable, there must be firm rules of the game governing the system. These rules address who is covered for what, how money for the system is raised, how providers are paid, how technologies are assessed, how much cost sharing is permissible, the scope of complementary and supplementary coverage, and more. The US resists such uniformities because they supposedly entail “too much government.” Although the US has added new rules in the ACA and otherwise (e.g. tougher rules constraining insurers’ enrollment and pricing practices and new obligations of employers with respect to covering their workers), we still withhold from government many of the tools it would need to steer the system toward universality and affordability of coverage and care.

Third, in other nations, solidarity and rules-of-the-game put brakes on the free-wheeling entrepreneurship—the endless quest for profits (or “excess medical revenues”)—that is so conspicuous in the US. Single-payer Western systems may allow private insurers to sell complementary coverage but leave them no role in basic coverage. Social insurance systems (e.g. France and Germany) have health insurance entities (sickness funds) but they are not-for-profit and are closely regulated. In the US the practices of health insurance respond to what is by cross-national standards an astonishing and arguably obscene degree to the financial interests of investors and shareholders in for-profit companies.

Elsewhere providers and hospital executives expect to make a comfortable living in healthcare but not enormous earnings. Other nations deploy the bargaining power of health and finance ministries in the painful struggle to hold the line on costs. In the US, every day brings a fresh cast of entrepreneurial

characters seeking to sell policymakers on reforms that promise to save the system money (which they seldom do) while just happening to let the innovators get rich quick in the process.

The US has its particular history, culture, and political economy, and our healthcare system is what it is. Still, contemplating what it is and how it looks by the standards of other peer nations may be useful in thinking through both the case for reform and the pros and cons of distinct reform agendas.

In this post-Affordable Care Act landscape, what are the biggest challenges and most important responsibilities health policy experts face today? How do you see the landscape of public health evolving over the next decade?

The ACA is landmark legislation that is, by any reasonable standard, exerting a positive impact on the US system. All the same, getting it passed involved compromises that left some flaws in that system intact. First, the ACA embodies considerable redistribution. It is one of the most progressive measures adopted in the US in recent years, and it has reduced the ranks of the uninsured by something like 20 million people. That still leaves about 30 million without coverage, however. Some are illegal immigrants caught in a drama that has little to do with health policy per se. But some lack coverage because the penalties attached to the mandate are too weak to induce them to buy it (triggering fears of the adverse selection the mandate is supposed to forestall) and others because 19 or so states have refused to expand Medicaid despite very generous financial terms proffered by the feds. This latter problem is symptomatic of a larger problem: six years after the law passed it has won no support within the Republican party, which has repeatedly called for its repeal and has refused to cooperate in amending the law in light of experience.

The law creates important and overdue rules of the game—especially provisions that constrain selection of preferred risks by insurers, firm up the obligations of larger firms to offer coverage to workers, and expand the scope of preventive services. Coverage remains far from uniform, however, varying as it does by whether one is an individual

purchaser, a member of a small group, in a large (probably self-insured) group, in Medicare, or in Medicaid. On top of these disparities are the agonies that continue to plague the effort to get exchanges up and running “right.”

Behind the superficial appeal of market competition lies the reality that insurers are expected to offer new coverage, under new and sometimes opaque rules, in the individual and small group markets, to people who could not secure coverage before and have needs that remain hard to predict and price. So in some settings the exchanges are sites of churning, confusion, and frustration that will (presumably) abate with time and experience. On top of that is the accelerating pace of consolidation, both horizontal and vertical, by and between providers and insurers, which also calls into question whether we know how to think sensibly about competition in healthcare markets. The consolidation is understandable: heads of organizations want to minimize the risks they face, and competition is a huge risk. Government regulation is supposed to intervene in a firm and timely fashion and somehow balance in the public interest the productive virtues of consolidation with the cost-containing powers of competition. This looks great on paper, but how it all plays out in practice is quite another matter.

By means of ACOs and other organizational innovations the ACA may be further entrenching naive hopes pinned on reorganization and may be underestimating the difficulties that beset the creation and diffusion of high-performing healthcare systems. Most of these iconic systems—Mayo, Cleveland Clinic, Kaiser-Permanente, Geisinger, for instance—are 75-100 years old and have diffused very little over all those years. The idea that high-performing systems such as these can be replicated, Starbucks-like, seems to me to reflect a deep failing in today’s health policy and management mindset, namely, the squeezing out of organizational history and analysis between economics and epidemiology, which have combined to push a “quality solution” embodied in entities such as the ACOs, that would seem to be based mainly on faith. And meanwhile all this organizational experimentation is one more excuse for policymakers to avoid tackling the

fundamental issue of high prices in the US system.

The ACA is health reform predominantly qua insurance reform, which is necessary but insufficient because it does not engage adequately with the impact of social determinants and social services on health outcomes. Elizabeth H. Bradley and Lauren A. Taylor, authors of the *American Health Care Paradox*, make a powerful point: maybe other comparable nations have better health results precisely because they spend less on healthcare and more on social services than we do. Fuller development of what we used to call the welfare state may improve health outcomes more than anything going on within the healthcare system. This is an arresting proposition with which providers are beginning to wrestle under the mantra of “population health management.” So far this seems to entail ventures in “care coordination” and contracting with social service agencies in the community, all of which may or may not improve care and save money, but these strategies still skirt the central issue, namely, that the troubling health outcomes in the US may reflect low performance less in the healthcare system than in the sphere of social protections.

The federal government, led by CMS, is redesigning payment systems in Medicare on the assumption that we can use the compendious findings of evidence-based medicine and health services research to define, measure, and assess quality and then use this framework to retreat from fee-for-service in favor of methods that pay providers for performance that delivers value—which may in turn oblige providers to master population health management.

There are lots of big words and assumptions here. Do we in fact know what we are doing? In irreverent moments I think of Casey Stengel, driven to distraction by managing the 1962 Mets, who plaintively wondered, “Can’t anybody here play this game?”

What advice would you give to graduating MPH and MHA students who are interested in working in healthcare policy?

My elevator speech would go something like this. First, remember that the “public” in “public health” refers not only to populations

but also to the public sector—government—which is, or ought to be, made accountable to the public by means of politics. Therefore resist the temptation, too common in our field, to regard the political element of policymaking as the domain of dummies who care nothing about evidence. Never forget that a crucial component of policy is the political management of (largely insoluble) conflicts of values and interests, conflicts that flourish among citizens and groups that are just as convinced of the value of their work as you are of yours.

Second, do all you can to master evidence and the techniques that generate it, but remember that policymaking is seldom entirely based on or even informed by evidence, and is sometimes lucky even to be “evidence-flavored.” Policymaking entails a high degree of indeterminacy and contingency, and among the skills (rarely taught, and probably unreachable) necessary for it are an ability to read the contexts in which issues and policies unfold, to interpret the implications of those contexts for the options at hand, to grope among options for ones that that may work in a complex and mysterious cultural-political *mélange*, to improvise strategies that do not come straight from texts, technical exercises, or other authoritative sources, and to fine-tune those strategies in light of experience.

Third, avoid the arrogant “doctors’ orders” approach that is too common in our field—“We know what works so just go out and do as we say.” Take pains to look at and listen to people, not just populations, and (to borrow from American anthropologist Clifford Geertz), take an “up close and personal” look at “how things work around here” before you set about teaching and preaching. One of my treasured possessions is a little plaque that defines “expert” as “an ordinary person away from home giving advice.”

Fourth, if you seek to wield influence, recognize the different implications of its shorter- and longer- term dimensions. Agenda setting follows the laws of supply and demand and exhibits a kind of natural selection in which the demands of policymakers (which may heavily reflect ideology, intuition and other “non-rational” factors) filter the ideas policy analysts supply. Short- term influence therefore requires vigorous and perhaps sharp-elbowed

participation in this game of filtering, which, viewed scientifically, is often not a pretty sight. Long-term influence, by contrast, means contenting yourself with the hope that your efforts may improve the quality of policy deliberations over the long haul. This approach lets you call ‘em exactly as you see ‘em, but may leave you temporarily – or eternally-- on the sidelines of policymaking.

Finally, bear in mind the interdependence of policy and management. Policymakers can never foretell or orchestrate answers for all the challenges private and public managers face when implementing their handiwork but the legitimacy of policy—and of government—depends importantly on avoiding policies that defy (or seem to defy) successful management at the fabled “point of service delivery.”

Conversely, every organizational manager or scholar knows that an organization’s environment is crucial to understanding its performance and potential. In the health realm, public policy is an enormous and growing ingredient of an environment that impinges more and more insistently on the missions and designs of hospitals, physician groups, insurers, academic medical centers, public health agencies, and other organizations.

I know that you love literature and that you speak French. What are some of your other hobbies and interests outside of your professional life?

This question is, I assume, meant to “humanize” me, which takes some doing. My main interests outside of my work include: 1) spending time with my wife and my two kids (ages 29 and 26, who live in Manhattan) 2) reading. I come back again and again to what I suppose is a list of usual literary suspects: Shakespeare, Balzac, Chekov, Proust, Joyce, and Beckett 3) I love jazz, especially the traditional jazz and swing of the 1920s and 1930s 4) Film, including comedies (Keaton, WC Fields, Marx Brothers), French and US film noir of 1940s and 1950s, Italian neo-realism, and occasional contemporary French and Italian movies 5) I am enthusiastically omnivorous—I enjoy all kinds of food from the Michelin three star variety to the lasagna, spiedies, and pierogis I learned to love, while growing up in the 1950s, in modest ethnic joints with grandma in the kitchen in Binghamton, New York.

Have You Heard?

HPM Faculty & Staff

HPM professor **John S. Winkleman's** pen and ink illustrations of family-owned New York City businesses were on display at the 45th anniversary celebration of Manhattan's *Our Town* newspaper, held at Mount Sinai Hospital in February.

HPM faculty member **Peter Muennig's** article "Improving outcomes for refugee children: A case study on the impact of Montessori education along the Thai-Burma border" appeared in *The International Education Journal: Comparative Perspectives* (December 2015).

HPM professor **Y. Claire Wang** and Epidemiology professor **Andrew Rundle** received the Dean's Excellence in Leadership Award for "Leadership on Public Health Fights Obesity: A Month on the Science of Nutrition."

HPM Administrative Manager **Karen Burke** received the Mailman School's Annual Staff Award for Excellence. The Staff Awards acknowledge outstanding Mailman School employees who demonstrate the highest standards of excellence and extraordinary performance.

In May EXEC professor **Donna Lynne's** appointment as Colorado's lieutenant governor was unanimously approved by the state's senate.

HPM faculty member **Miriam Laugesen** will be promoted to Associate Professor with tenure on July 1, 2016.

HPM professor **Nan Liu's** article "Impact of Mandatory HIV Screening in the Emergency Department: A Queuing Study" was published in *Research in Nursing & Health* (April 2016).

HPM professor **Bhaven Sampat's** article "Corporate Funding for Schools of Public Health: Confronting the Ethical and Economic Challenges" was published in the *American Journal of Public Health* (April 2016).

H.E.A.L.T.H. for Youths, a non-profit organization co-founded by HPM adjunct professor **Heather Butts**, received a 2016 Daffodil Award for their work in Staten Island. H.E.A.L.T.H. for Youths strives to combat community deterioration and juvenile delinquency, improve the quality of education, healthcare and life-skills training offered to adolescence and young adults.

HPM Professor **Jemima Frimpong's** article "Low Rates of Adoption and Implementation of Rapid HIV Testing in Substance Use Disorder Treatment Programs" was published in the *Journal of Substance Abuse Treatment* (April 2016).

Introducing HPM Staff



LaTanya Brown comes to HPM with a robust, 10+ year history of general management, healthcare and medical education program coordination, having worked in the academic, governmental, and pharmaceutical job sectors. Most recently, as a Program Manager for the Columbia University Department of Dermatology, she was the go-to person for all things related to continuing and undergraduate medical education, including medical student rotations and preceptorships. While aligning medical students with dermatology-related educational initiatives and coordinating special events, she also served as a key player in course and curriculum development with the College of Physicians and Surgeons. LaTanya earned her bachelor's degree in Parks and Recreation Management from North Carolina Central University in Durham, NC, and spent the early part of her career managing athletic events and tournaments. In her free time, she enjoys aquatic sports, exploring the great outdoors, serving her community, and mentoring girls and young women, ages 8-18.



Lourdes Pilapil recently joined HPM as Financial Grants Manager. Prior to joining HPM, she worked at Icahn School of Medicine at Mount Sinai as a Senior Financial Analyst handling Pre and Post award grant management. She received her BS in Business Administration from the University of Santo Tomas, in Manila, Philippines.

HPM Healthcare Conference

The 5th Annual HPM Healthcare Conference took place on April 15 at the Columbia Club in Midtown. The event attracted current students from all HPM programs as well as alumni, professors and leaders in the healthcare field. Read on for a brief recap.

Will Consumerism Change Healthcare?

By Priya Bhimani (MHA '17)

The morning kicked off to a great start with the highly anticipated keynote address by Karen Ignagni, CEO of EmblemHealth. Prior to taking this role in September of last year, Ms. Ignagni served as president and CEO of America's Health Insurance Plans (AHIP), one of the most powerful trade associations in Washington DC. At AHIP, she worked with the White House in the development of health legislation including the Patient Protection and Affordable Care Act (ACA).

Given Ms. Ignagni's extensive health policy background and her position as CEO of an insurance company, conference attendees were keen on getting her take on the growing role of consumerism in healthcare and how it will affect both providers and payers. Ms. Ignagni discussed how newly empowered patients will become more involved in making important decisions about their healthcare, the environmental factors that will lead to this and finally, how provider and payers will need to adapt.

The keynote wrapped with Ms. Ignagni addressing the students in the room about the issues they will face as the next leaders in healthcare. These included barriers like a lack of interoperability in core data sets and "yellow lights" like consolidation. Ignagni also emphasized the "brave new world" areas of healthcare including precision medicine and integrated mental health. Ms. Ignagni's keynote ended with a standing ovation and set the stage for an exciting and eventful conference.



Karen Ignagni delivering the keynote address

Population Health Management: Two Hospitals, Two Strategies

By Prithvi Addepalli (MHA '17)

The morning discussion highlighted two health system's strategies for population health management. David Alge, SVP of Community and Population Health at New York-Presbyterian, and Niyum Gandhi, Chief Population Health Officer at Mount Sinai Health System, engaged in a lively and informative conversation about the different approaches their health systems are implementing to adjust to the Affordable Care Act fee-for-service to pay-for-performance transformation. Mr. Alge suggested that it is difficult to sustain operations somewhere in the middle of these reimbursement structures, and health systems need to either move quickly toward pay-for-performance—or not move at all.

Similarly, Mr. Gandhi brought up the concept of population health as a business model. He explained in the Mount Sinai Health System, marrying together the existing clinical delivery and business models is necessary to realign incentives in healthcare. He said, "Doctors today provide great service without incentives because they are good people and they care about their patients. What if we, as health systems, aligned to provide those incentives? How good could our service provision become?"

A primary takeaway was the great importance of utilizing all the data that health systems collect to track population trends and provide better service to the communities they serve. Many students, faculty, and other conference attendees were excited to participate in the conversation.



Niyum Gandhi and David Alge

Aging Successfully: How to Direct Policy

By Larry Joo (MHA '17)

The first of the two afternoon panels titled *Aging Successfully: How to Direct Policy* focused on the issues of long-term care, the aging population, and how current policy makers are dealing with the issues. The discussion pushed the participants to reframe the concept of aging itself. Aging, they argued, was not a burden, but an opportunity. As aged patients in hospitals constitute the majority of cases, policy and society must look to understand aging not as a disease, but as part of life. However, they noted that there were still divisions within the specific population: the “young”, the “tweeners” and the truly “old”, each with their specific set of needs and abilities.

A major focus was around the transparency of information already available and how coordination between agencies would be essential in improving policy for the rapidly changing demographic of the United States. The panelists agreed that the impetus was on the policy makers to push forward with initiatives based on the information available, instead of “kicking the can down the road” waiting for the perfect set of data. The current system is not structured to support the variety of needs and would need to adapt to the cost-sensitive nature of modern medicine. However, with the innovations in value based payment systems and technology, the future of long-term care and aging population remains perplexing, yet exciting.

M-Health: Disrupting the System

By Rachel Key (DUAL '18)

The *Mobile Health: Disrupting the System* panel covered an array of topics, ranging from the security implications of increased use of technology platforms in healthcare delivery to the government’s potential role in regulating this industry. This lively discussion, moderated by Darryl Hollar, produced consensus around the need to better integrate technology into existing EMRs and explored the challenges and benefits of interoperability within the context of HIPAA compliance.

Both Gil Addo of RubiconMD and Melissa Manice of Cohero Health discussed the in-depth technology design process and how the science behind the product does not necessarily ensure a product’s viability and marketability. Cohero Health, for example, prides itself on being the first and only company able to track how patients use their respiratory medication, but Ms. Manice mentioned that the company tested numerous platform designs before implementing their proprietary mobile app. Ryan Stortz of Trail of Bits added his insights as to the tradeoff between patient information security and a seamless user experience.



Panelists Ari Markenson and Dr. Ruth Finkelstein



Darryl Hollar, Moderator for M-Health Panel

Health Policy & the 2016 Election

By Tricia Lu (MHA '17)

The *Health Policy & the 2016 Election* panel explored healthcare from both political and economic perspectives. Professor Sara Abiola, moderator and HPM professor, noted in her introduction that this is an exciting time in the realm of healthcare politics. The passage of the Affordable Care Act (ACA) in 2010 was one of the largest milestones in healthcare policy, and its effects have been far-reaching. Director of Manatt Health, Alice Lam, commented on the regulatory and compliance challenges that healthcare organizations, providers, as well as local, state and federal governments have faced as a result of the new legislation. Michael Penn, Director of Global Policy at Pfizer, brought the industry perspective. He emphasized the importance of the ACA in helping the pharmaceutical industry realize its shared responsibility as a stakeholder in achieving a better health model. However, he does not believe the ACA is a perfect solution—in fact, both panelists agree that the ACA is destined to evolve over time.

Alice Lam mentioned how crucial the ACA has been in expanding coverage, particularly through Medicare expansion, a trend that could continue if a democratic candidate is to be elected. Michael Penn offered a more skeptical perspective of the government's increasing role in healthcare, stating that future stringent price controls may be a hindrance to innovation. The panelists agreed that greater bipartisan approaches that involve healthcare stakeholders would yield the best outcome, but they are skeptical that such a collaboration will occur, particularly in such a polarized political environment.

Healthcare Consolidation: Rightsizing

By Victoria Ng (MHA '17)

In *Healthcare Consolidation: Rightsizing*, the panelists and moderator discussed the current trends across and within healthcare sectors and the impacts of these changes. HPM adjunct faculty member Larry Bartlett, who teaches a course on market consolidation in the healthcare industry, set the context for the discussion by explaining that consolidation is not new in this industry. There have been waves of hospital mergers since the early 90s. More recently, there has been a trend in physicians being acquired by hospitals, perhaps to increase bargaining power with insurance companies. The panelists also discussed the effect of consolidation on innovation. Because of the presence of a few large players and no new entrants in the market, consumer choice decreases and so do the incentives for payment and delivery innovation. This contributes to implications for consumers, who are likely to not receive reduced costs or increased quality of care as a result of consolidation. Evidence so far has shown that hospital mergers have led to increased prices for consumers.

As for quality, the evidence has suggested that competition is necessary to drive improvements. Bartlett and Don Ashkenase, an HPM adjunct faculty member who teaches a course on transformation in economic models in healthcare, made key remarks around value-based care. While the industry is shifting toward this new form of payment, consolidation in the healthcare market may lead to delays in adopting value-based care. As a closing note, panelists discussed that future policies will play a role in ensuring that patients receive benefits from the consolidated market.



Dr. Tal Gross



Alice Lam and Dr. Sara Abiola

Conference Program

Keynote Address

Will Consumerism Change Healthcare?

Karen Ignagni

President & CEO, EmblemHealth

Morning Discussion

Population Health Management: Two Hospitals, Two Strategies

Moderator: Michael Sparer

Niyum Gandhi

David Alge

Professor and Chair, Department of Health Policy & Management, Columbia University
Executive Vice President and Chief Population Health Officer, Mount Sinai Health System
Senior Vice President, Community & Population Health, New York-Presbyterian Hospital and Healthcare System

Afternoon Panels

Aging Successfully: How to Direct Policy

Moderator: Ari Markenson

Ruth Finkelstein

Steven Katz

Simon Samaha

Partner, Duane Morris, LLP & Adjunct Professor, HPM
Associate Director, Columbia Aging Center & Assistant Professor, HPM
President, Sterling Care LLC
Partner, PricewaterhouseCoopers

M-Health: Disrupting the System

Moderator: Darryl Hollar

Gil Addo

Melissa Manice

Ryan Stortz

Director of eHealth and Innovation, Mount Sinai Health System & Adjunct Professor, HPM
Co-founder and CEO, RubiconMD
Co-founder and CEO, Cohero Health
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Health Policy & the 2016 Election

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Healthcare Consolidation: Rightsizing

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HPM Roundtable Discussions

This spring HPM held several roundtable discussions with various healthcare leaders. Here's a recap, in case you missed it.

A Roundtable Discussion with Dr. Robert Galvin

By Larry Joo (MHA '17)

The Roundtable Discussion with Dr. Robert Galvin on March 7, 2016, offered an opportunity for the students of the Mailman School to hear from a distinguished member of the healthcare community. Dr. Galvin offered insights into America's unique approach to the healthcare system as well as a thought-provoking discussion about making difficult career choices.

The afternoon started with the tale of Dr. Galvin's extremely unusual career path. First accepted into the prestigious Wharton School of Business at the University of Pennsylvania, Dr. Galvin nevertheless explored the options available to him and transitioned to the College of Arts and Sciences, majoring in writing and philosophy. In order to supplement his income as a writer, he became a psychiatric nurse's aide. After a few years working and writing, he decided—with a push from a mentor—to enroll in medical school, and he was accepted to the University of Pennsylvania. Over six years, he developed a large general medicine practice in Boston, where he met Jack Welch, the world-renowned CEO of General Electric. Dr. Galvin was recruited to leave his practice and lead the team managing the health plans for General Electric employees globally.

Faced with such a difficult career decision, Dr. Galvin noted that he, like many other rational individuals, drafted a pros and cons list, only to be intellectually paralyzed, unable to make a decision. He consulted an author who had written a book about the very topic. From this book, he acquired a salient, but short piece of advice: "Do what makes your heart beat faster." After this conversation, Dr. Galvin made the leap to work at GE.

One of Dr. Galvin's main discussion points during the Roundtable focused on the fact that healthcare systems around the globe often reflect the country's culture. During his time at GE, Dr. Galvin witnessed this first hand while traveling around the world to coordinate care for the company's employees. During the Roundtable Discussion, this point sparked a dialogue about the unwavering belief in the private market, reflected by the union between employment and healthcare insurance, a distinctive trait of the United States.

However, the cost of care is increasingly falling on the patients themselves. Dr. Galvin noted that with the innovation in medicine, some treatments now cost far more than the median wage in the United States. He posited that this trend has fostered entrepreneurship that is seldom seen in other countries. For example, he recently met with a startup that attempted to address the wild fluctuations in drug prices. In one instance, two drug stores in the same zip code charged \$80 more than another for a simple painkiller. However, he noted that the labyrinthine nature of regulations and business interests made innovation more difficult than one could imagine.

Moreover, from his decades of experience around the globe, Dr. Galvin emphasized that no one can truly "understand how deranged the system is" until he or she has to deal with it firsthand. While other centralized systems have their downsides, the incredibly fractured nature of the industry in the US has led to a complex system with limited transparency. As a result, Dr. Galvin co-founded the Leapfrog Group, a voluntary group working to bring transparency to the industry and to promote high-value based care through incentives and rewards. The group has since published publicly available data on hospitals and their utilization of quality standards such as computerized physician order entry systems.

Dr. Galvin is currently the CEO of Equity Healthcare, a healthcare management firm that operates in the private equity space. At Equity, Dr. Galvin focuses on working with companies that have been bought by private equity firms to maximize value for their healthcare dollars. Collaborating with major insurance companies, entrepreneurs, and employers themselves, his team embraces the market-driven culture of the United States to reduce healthcare costs and improve population health. The Roundtable Discussion offered an incredible opportunity to hear the thoughts of a seasoned professional with experience on both the provider and business side, and provided each student with a deep appreciation of the challenges facing the healthcare system.

A Roundtable Discussion with Dr. Stephen Lyman

By Kelsey Dean (CEOR '16)

On March 29, 2016, HPM hosted a roundtable discussion with Dr. Stephen Lyman, Associate Professor in Health Policy and Research at Weill Cornell Medical College and the Director of the Healthcare Research Institute at the Hospital for Special Surgery (HSS). Students from the Comparative Effectiveness and Outcomes Research (CEOR) Certificate program attended the event, and had the opportunity to learn about Dr. Lyman's career and the field of health services research.

Dr. Lyman began the event by discussing his career path. Following completion of his Master's Degree and PhD in Injury Epidemiology, he worked at the American Sports Medicine Institute and Insurance Institute for Highway Safety. His work during this time included a study on pitch type, count, and mechanics on shoulder pain in youth baseball players that resulted in pitch count regulations for Little League baseball. After his work on highway safety research, Dr. Lyman moved to join HSS in New York as a health services researcher.

He then provided an overview of health services research, a multidisciplinary field used for diverse purposes in different settings to evaluate healthcare delivery, costs, treatment options, and other issues for academic researchers, pharmaceutical companies, clinicians, and patient advocacy groups. The impetus behind the field came from variations in patterns of healthcare that have been identified and measured in disease, preferences, and services available. Dr. Lyman discussed the current need for research in the field as a tool to examine how much care is absolutely necessary, questionable, or unnecessary. Healthcare costs in the U.S. are high and expected to increase in the coming years, and payers are increasingly focused on value-based purchasing, bundled payments, and Accountable Care Organizations. This focus on cost reduction and quality initiatives illustrates the need for health services research.

Dr. Lyman then discussed some of his research at HSS in detail, including studies of the Volume-Outcomes

Relationship, Patient Reported Outcomes, and a Mobile Health Pilot. Studies on the relationship between procedure volume and patient outcomes are common in cardiology, bariatric surgery, and orthopedics, and utilize different approaches to volume stratification. Dr. Lyman discussed potential problems with volume cutoff definitions, and a study on coronary artery bypass grafting using three different approaches to volume stratification.

He also discussed patient-reported outcomes (PROs), measures of a patient's health that come directly from the patient. For total knee and total hip replacement surgeries, Knee and Hip Injury and Osteoarthritis Outcome Scores (KOOS and HOOS) are validated PROs for joint replacement, but are lengthy, while the established abbreviated versions may not encompass all the measures needed. Dr. Lyman and his HSS research team developed shorter "KOOS, Jr." PRO measures for total knee and hip replacement patients by identifying items most relevant to knee and hip replacements from the longer surveys. PROs are becoming increasingly important, as seen by the fact that CMS is now using PROs as part of bundled payment system for knee and hip replacements, and the KOOS, Jr. paper findings were published in the Federal Register regarding Medicare bundled payments prior to the paper publication itself.

To end the discussion, Dr. Lyman spoke about a Mobile Health Pilot to track patient recovery after total knee and hip replacements. Part of a broader trend in the healthcare field to utilize wearable devices to track patients' health, this program will follow patients for 6-12 months after surgery, and use steps to track recovery.

Students were able to ask Dr. Lyman about his career experience and research, as well as the health services research field in general. His roundtable discussion gave students a sense of the many different types of work taking place within health services research, as well as some of the current trends in the field.

A Roundtable Discussion with Dr. Michael Sparer

By Hallie Tuchman (MPH '16)

On March 21, Professor Sparer hosted an informal Roundtable with first and second year health policy students where he discussed the upcoming presidential election and its potential impact on the healthcare system. The conversation began with a discussion about the general role of healthcare in presidential elections and how government leaders and politicians struggle with how much of a role the public sector should play in the US healthcare system.

The conversation then turned to the 2016 primary race where Dr. Sparer and students discussed the various candidates' positions on healthcare and how the 2016 race focuses on the aftermath of the Affordable Care Act. Republican candidates feel that the ACA oversteps the role of the government in healthcare. While Donald Trump wants to institute more market-driven approaches and to scale back Medicaid, Ted Cruz has vowed to repeal the entire legislation. On the Democratic side, Hillary Clinton has expressed a desire to expand on the ACA by incremental fixes. Bernie Sanders, on the other hand, has gained a lot of traction with "Medicare for All" platform. Students asked Professor Sparer about his thoughts on specific

candidates' positions. For example, Donald Trump's position on free markets and his ideas on pharmaceutical importation and Hillary Clinton's legacy in health care reform and CHIP.

The Roundtable closed with a discussion on specific topics in healthcare that can be expected to emerge during the election season. Dr. Sparer anticipated these issues to include: what to do about the individuals who remain uninsured after the ACA; what to do about the high out-of-pocket payments—especially when it comes to specialty pharmaceuticals and in the state-health exchange plans; changes in the healthcare delivery system and moving towards an integrated delivery system; and the 1332 waivers, which will allow states to explore ideas such as public options. Students also brought up long-term care and the lack of a clear payer and the role of mental health and gun violence as well as access to behavioral healthcare.

All in all, the 2016 election has been quite eventful already, and the issue of healthcare has proven to be divisive and should continue to play a prominent role as we head towards November.

HPM Highlights

Kyung Hee Choi (EXEC '17) co-wrote an article titled "For Koreans in Bergen County Time to Sign up for Health Insurance Running Out" which appeared in the *Bergen Dispatch* in January.

John MacPhee (EXEC '12) received the Allan Rosenfield Alumni Award for Excellence for his work with the Jed Foundation, a national nonprofit that promotes awareness about emotional health and works to prevent suicide among college and university students.

Carlos Cuevas (DUAL '12) was selected as the recipient for the inaugural Outstanding Recent Alumni Award for his contributions to public health and his service to MSPH as an alumni volunteer.

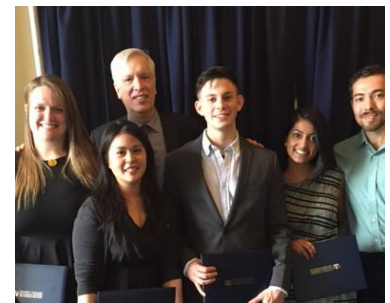
Maria Tazi (EXEC '16) published an article in *Medical Marketing & Media* titled "Millennials Define Health Differently than Other Generations" (May 22, 2016).

Priya Joshi (MHA '16) and **Sarah Rein** (MHA '16) are this year's recipients of the Foster G. McGaw Scholarship Award. This award is given to students in an AUPHA member program who have demonstrated academic excellence during their graduate studies.

Trinh Nguyen (MHA'16) and **Connor Brown** (MPH'16) have been awarded the Regina Loewenstein Prize for Academic Excellence in Health Policy and Management. This award represents outstanding achievement and promise in the field of health policy and management.

Sara Gorman's (MPH '15) book on the psychology of healthcare decision-making "Denying to the Grave: Why We Ignore the Facts That Will Save Us" has recently been released on pre-order on Amazon.

Juan Manuel Flores (MPH '16) was awarded the John and Kathleen Gorman Public Health Humanitarian Award which is given



Dr. Michael Sparer with McGaw Scholarship and Loewenstein Prize recipients

to students who have demonstrated excellence in commitment to the humane care of individuals and communities, and in advancing consideration of human rights and values in healthcare and prevention.

Jean-Claude Velasquez (MHA '16) is the recipient of the American College of the Healthcare Executives (ACHE) 2016 Foster G. McGaw Graduate Student Scholarship.

Kathy Colon (EXEC '15) was awarded the 2016 Great Columbia Grad award.

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Inaugural MHA class on graduation day

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Alumni:

Email Beth Silvestrini: bs2520@columbia.edu to get involved or update your contact information

Save the Date:

HPM Fall Networking Event
Thursday, November 10, 2016

HPM Healthcare Conference
Friday, April 21, 2017

Contact HPM to share your updates:

Email Carey McHugh: ctm2101@columbia.edu

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