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HEALTH CARE MANAGEMENT
ALUMNI ASSOCIATION

THE WHARTON HEALTHCARE QUARTERLY

WINTER 2021, VOLUME 10, NUMBER 1

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EDITOR'S LETTER

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

To learn more about Colette, click here.

Happy New Year!

I hope all enjoyed some cheer over the holiday season. As we begin 2021, with two vaccines approved, more in the pipeline, and increased knowledge gained about the novel coronavirus (which has enabled better management of and lower mortality rates for inpatients suffering from COVID-19), there are lights at the end of a long, dark tunnel. There is also renewed hope for a better and more equitable world as we evolve globally to a "new normal."

The pandemic has taken much from us in ways that are unique to each person's experience. But we have simultaneously been given the opportunity to hit a reset button and commit anew to passionately addressing the many challenges which lie ahead, some created by COVID-19 and many of which have been with us for far too long. We have also learned in ways both small and large how many heroes live among us each and every day.

Finally, the novel coronavirus has reaffirmed the wisdom of the Golden Rule – Treat others as you would have them treat you – and its criticality to the healthy survival of the planet, those who currently inhabit it, and the generations yet to come.

"We must be willing to let go of the life we have planned, so as to have the life that is waiting for us."
~ E.M. Forster

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Managing Editor

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THE PRESIDENT'S DESK

Maria Whitman, WG'05

To learn more about Maria, click here.

Dear Alumni and Friends,

By the time you read this edition of the *Wharton Healthcare Quarterly*, we will be in 2021. When I think about the recent past and the year ahead, there is much to reflect on. I leave 2020 and enter 2021 with a sustained sense of gratitude for the things that matter most in life, the large and the small, that this challenging time has forced many of us to recognize in different and meaningful ways.

One of those points of gratitude is for this community. We are privileged not only in the education and achievements we have, but in the ways we have supported each other. Just this week Chaz Howard, Penn's first ever Vice President of Social Equity and Community, who has already taken many actions to advance social equity on campus, spoke to regional club leaders on diversity and inclusion based on his experience and mandate at Penn. In that talk he reflected on the importance of Alumni clubs like the WHCMAA, "being together is a gift we need, to sew ourselves back together from an unprecedented year that has affected us all so personally."

I absolutely agree. Connecting with you, sharing a common empathy for the challenges in our own lives, and ever as importantly in the healthcare system, has been a motivating and meaningful light in a difficult time. It is amazing to hear the actions many of you are taking in your areas of specialty, building from this moment to move the needle in health for all people.

Although we could not be live for our annual conference in October, in my last letter I announced the Mini-Summit Series, which gives us an opportunity for prominent speakers on critical topics followed by networking time together.

In my last letter I announced the Mini-Summit Series. Our first two topics were wonderful starts to advancing awareness, learning, and discussion of today:

- **Mini-Summit Series Episode 1: The Impact of Social Determinants of Health and Racial Disparities on the SARS-CoV-2 with Conrod Kelly.** Conrod is a renowned author and an award-winning, leading voice in promoting diversity, equity, and inclusion, especially as it pertains to public and population health. He is the first Executive Director of Social Determinants and Population Health at Merck, and he spoke about many aspects of disparities in care – the challenges and the differences among populations and situations, the why and the gap, and ideas for how to move forward from today with a 40 min Q&A from alumni following.
- **Mini-Summit Series Episode 2: Post-Election: Now What? The impending disruption to the US healthcare system and what its creative rebirth might look like with the Honorable David J. Shulkin, MD.** Secretary Shulkin is the ninth Secretary of the U.S.

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THE PRESIDENT'S DESK

Department of Veterans Affairs, and in this inspirational and educational discussion he brought to life meaningful observations and learnings in his cross-administration service with the VA and how healthcare can be advanced by moving from his learnings across administrations and with initiatives tried for veterans. In particular, his emphasis on treating the whole person and in seeking bold vs. evolutionary change struck a cord for many.

If you missed these sessions, we have made the recordings available on our alumni site. The plan is to continue this series throughout 2021 about once a month. Please join us for the talk and the discussion and networking that follows. Also, if you have specific ideas or recommendations for topics or speakers you would like to hear, please email us at customerservice@whartonhealthcare.org.

And as always, please continue to engage with the community:

- LinkedIn: Wharton Health Care Management Alumni Association
- LinkedIn Public Channel
- Twitter: @WhartonHCMAA
- Facebook: Wharton Health Care Management Alumni Association
- Wharton Knowledge Network: whartonhealthcareopen@googlegroups.com

If you are not receiving our emails with programming announcements, please let us know at customerservice@whartonhealthcare.org. We recently sent an offer to all WHCM alumni from friend, classmate, WHCMAA member, and national best-selling author David Fajgenbaum, MD, MBA, MSc to receive a free signed copy of his inspiring memoir, ***Chasing My Cure: A Doctor's Race to Turn Hope into Action***. If you are a WHCM program alum and wish to take advantage of this special offer, please click here to access the registration form, which will let us know where to send your book.

My friends and colleagues, I hope that you are safe and well and the holidays and the ringing in of this New Year have given you and your families some time to recharge. My wish is for all of you to enter 2021 renewed in the unwavering passion towards advancing health that defines our community. I am thinking of you and sending you the best for the year ahead.

Kind regards,

Maria Whitman, WG'05
President, Wharton Healthcare Management Alumni Association

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ALUMNI NEWS

Denise F. Winokur, WG'72, PhD'80
Most recently, I have been involved with multiple entrepreneurial healthcare ventures. Of particular interest is Destroke founded by Dr. Evan Noch, a neurologist physician scientist. Destroke is an app that provides earlier clinical stroke diagnosis, thus improving stroke outcomes and substantially decreasing hospital costs. These ventures have provided me the opportunity to apply healthcare management practices within the healthcare system.

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Bill Goss, WG '81
Mostly retired but on 3 boards (DuPage Medical Group and Tandigm Health and one non-healthcare) and part of a healthcare co-investment partnership (www.guidonpartners.com).

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Kate Reed, WG '87
Kate Reed has left the provider organization leadership world to become the Chief Customer Relations Officer at Surgical Theater. Surgical Theater is a med tech start-up company using virtual reality technology to build surgical planning platforms that allow surgeons to have 360-degree, dynamic, interoperative visualization and navigation. Although the company is based in LA, when not travelling, Kate will be blissfully settled back into life on the seacoast of New Hampshire, having launched both children out of college, divorced her husband, and rediscovered cycling and skiing. Life is good! Well, there's that COVID thing, and the election, and the Supreme Court, and the ongoing human rights challenges, and the fires/climate disasters…

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Learn more.

Jay Mohr, WG '91
I am thrilled to be joining the New York Blood Center Enterprises as Chief Financial and Business Officer. The NYBC is one of the U.S.' largest, community-based, comprehensive blood centers. We operate in 17 states and boast world-class research in the areas of hematology, cellular therapies, transfusion medicine, and infectious diseases. We are playing a leading role in the COVID-19 pandemic, offering convalescent plasma for patients in greatest need and developing novel vaccines and therapeutic candidates.

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Learn more.

Roman Macaya, WG '98
This has been a tough year, to say the least. As Executive President of the "Caja Costarricense de Seguro Social," the institution that provides all of Costa Rica´s public healthcare services, it has been my responsibility to lead the country´s healthcare response to the pandemic. This has involved expanding hospital capacity to the limit (especially in the ICU´s), addressing the financial constraints on the cost of the response and the logistical challenges in securing equipment and supplies, communication with the general public through press conferences, implementing new ways of providing health services, coordinating research efforts to better understand immunity, the evolution of COVID-19, and to develop possible disease therapies, and discussions with vaccine developers to attempt to secure timely access to a vaccine. I will be very happy when this is over.

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ALUMNI NEWS

George Zhijian Chen, MD, WG'99, John Fenyu Jin, MD PHD, WG'02, and Ran Geng, W/C'141

In June 2020, George (WG'99) and John (WG'02) cofounded D3 Bio, Inc. with substantial funding from a group of global syndicated investors. Ran (W/C'14) joined D3 Bio right after she led the Series A investment in the company for Matrix Partners China. D3 Bio, Inc is an "in China, for global" biotech company aiming to become a world-class biotherapeutic company to develop and register the best-in-class medicines for cancer and autoimmune disease patients in large unmet medical needs through a continuously progressing cycle of development-to-discovery and back-to-development process. The company has launched 5 pre-clinical portfolio projects with first and best-in-class potential. Prior to founding D3 Bio, Inc., George was an SVP of Global R&D Oncology and Head of R&D China at AstraZeneca, where, under his leadership, his team successfully created a robust portfolio with 90 development projects and achieved 35 China NDA/sNDA/BLA approvals, including Tagrisso, Lymparza, Linzess, Imfinizi, Forxiga, Breztri, Bevespi, Lokelma, etc. John came from 20+ years of drug development, management, and business development experience at Millinium, Eli Lilly, BeiGene, etc. He was most recently the Founding Managing Partner of Hanne Capital. Ran, a graduate from the Roy Vagelos Life Science Management Program, was most recently a biotech venture capitalist at Matrix Partners China, a top-performing fund under Penn's endowment portfolio.

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LAURA BRADY SAADE, WG'93

To learn more about Laura, click here.

THE PHILOSOPHER'S CORNER

LIFE LESSONS

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

- done my best to plot my career course to dovetail with life events. There are times in your life when you can go "all in" and put other things in your life on the back burner to reach your career goals; and other times when you know you'd like more balance. As an example, when starting my family, ideally I would have been established in a job that I loved that also had more flexibility for work-life balance -- balancing competing pulls is challenging under the best of circumstances. Better to set yourself up for the best chance of success and peace of mind.

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

- had "imposter syndrome." I used to think that a great team member had to have it all -- the full complement of skills required for a project's success. I would have appreciated that the varied skills of the whole team combined lead to success – some stronger in analysis, others in project management, etc. I wouldn't have felt that one skill was superior to any other and would have been more confident that all skills contributed to the outcome.

FAVORITE QUOTES

1. "To achieve great things, two things are needed: a plan, and not quite enough time."
   ~ Leonard Bernstein
2. "Everyone has the perfect gift to give the world – and if each of us is freed up to give the gift that is uniquely ours to give, the world will be in total harmony."
   ~ R. Buckminster Fuller
3. "I have no special talent. I am only passionately curious."
   ~ Albert Einstein
4. "There's a sense that time is precious and you should enjoy and thrive in what you're doing to the hilt."
   ~ Ruth Bader Ginsburg

RECOMMENDED READING

1. *Catalyst: How to Change Anyone's Mind* by Jonah Berger
2. *The Price We Pay: What Broke American Healthcare and How to Fix It* by Marty Makary
3. *Barking to the Choir* by Father Greg Boyle
4. *A Prayer for Owen Meany* by John Irving

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AFFIDAVIT: HEALTHCARE AND THE LAW - CMS AND ONC RELEASE LONG AWAITED FINAL RULES ON INTEROPERABILITY

On March 9, 2020, the United States Department of Health and Human Services (HHS) released two highly anticipated final rules, which will significantly impact actors in the health information technology (health IT) universe in the coming months. The separate but related rules governing interoperability were released by the Office of the National Coordinator for Health Information Technology (ONC).[1] and the Centers for Medicare and Medicaid Services (CMS).[2] Both rules, which follow proposed rules published in February 2019, address interoperability, information blocking, use of application programming interfaces (APIs), and other topics related to health IT. The rules build upon and implement provisions of the 21st Century Cures Act enacted in 2016 and aim to further the goals of increasing access to data among patients, providers, and payers. Although initial enforcement of the rules' requirements has been temporarily delayed due to the ongoing COVID-19 public health emergency, stakeholders in the health IT industry are already grappling with the implications.

ONC RULE

ONC's final rule implements changes to its health IT certification program, including adopting interoperability provisions of the 21st Century Cures Act as a condition of certification. Additionally, ONC's rule adopts the "information blocking" requirements of the 21st Century Cures Act. Information blocking is defined as a practice that, except as required by law or covered by one of the exceptions set forth in the rule, is likely to interfere with access, exchange, or use of electronic health information (EHI). Violators may be subject to civil monetary penalties up to $1 million per violation, and the rule prohibits such conduct by healthcare providers, health IT developers, health information networks (HINs), and health information exchanges (HIEs). ONC's final rule repeated five categories of practices previously identified in its proposed rule as likely to rise to the level of information blocking:

(i) restrictions on access, exchange, or use;
(ii) limiting or restricting the interoperability of health IT;
(iii) impeding innovations and advancements in access, exchange, or use of health IT-enabled care delivery;
(iv) rent-seeking and other opportunistic pricing practices; and
(v) non-standard implementation practices.

In addition to identifying these practices, the rule defines eight exceptions, describing conduct that does not constitute information blocking on the following reasonable and necessary bases:

(i) preventing harm;
(ii) protecting an individual's privacy;
(iii) protecting security of EHI;
(iv) infeasibility of the request;
(v) improving health IT performance;
(vi) limitation of content and manner of response to a request;
(vii) charging fees for accessing, exchanging, or using EHI; and
(viii) licensing of interoperability elements.

ONC's final rule also updated its 2015 Edition health IT certification criteria to establish new standards for API. APIs function as messengers to allow aggregation of information among separate software programs and servers. The rule establishes technical criteria that APIs must meet for certification. By standardizing API criteria, ONC hopes to enable third-party developers to more easily build applications designed to make EHI more readily available to both patients and providers. Additionally, the rule sets forth criteria and guidelines for the fees that API developers may charge and prohibits developers from imposing fees other than those identified.

CMS RULE

The separate rule released by CMS also addresses interoperability and patient access to EHI, and applies to Medicare Advantage (MA), Medicaid, Children's Health Insurance Program (CHIP), and Qualified Health Plan (QHP) issuers on the federal exchanges. The rule requires these entities to coordinate care by exchanging patient clinical data at the patient's request, to more easily allow patients to move from payer to payer over time.

Like the ONC rule, CMS's rule also includes requirements related to APIs. CMS exercised its authority over payers that participate in federal healthcare programs to require these entities to implement and maintain two categories of APIs: (1) patient access APIs, which allow patients to quickly access their data through third-party applications; and (2) provider directory APIs, which enable patients to find information on healthcare providers.

Additionally, the CMS rule updates hospital conditions of participation to require facilities to send electronic patient event notifications of a patient's admission, discharge, and/or transfer to another healthcare facility or to another community provider or practitioner. Although this requirement applies only to hospitals that currently possess an electronic health record (EHR) system, CMS stated its belief that the requirement would improve care coordination and facilitate follow-up care.

WHAT'S NEXT?

Initially, certain requirements of the ONC and CMS rules were set to go into effect six months after publication of the final rule. In response to the ongoing public health emergency caused by the COVID-19 pandemic, HHS announced in April 2020 that it would delay enforcement of certain requirements. Compliance dates vary for different requirements, and entities subject to these rules should continue to monitor the timelines for implementation.

Although the health IT industry had anticipated publication of the final rules for over a year, both CMS and ONC have faced criticism. Health IT developers, providers, and payers alike have expressed concerns that increased access to health data could lead to significantly decreased privacy for patients. Moreover, some industry stakeholders have questioned whether patients will truly be in a position to understand how their health data may be used by developers.

Members of the health IT industry should carefully consider whether they are subject to the requirements of the CMS and ONC rules and how their current practices may be implicated. For example, entities subject to the ONC information blocking prohibitions could face significant penalties for unintentional violations or complaints from third parties of inappropriate activities. Even entities that are not covered by the rules may face pressures from business partners to comply with new requirements. The rules' requirements could be particularly perilous for new players entering the growing health IT space, who may be unfamiliar with their obligations. Health IT industry members should consult legal and other experts to ensure they are aware of what their obligations are, how they can meet those obligations, and when they must come into compliance.

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REFERENCES

[1] 85 Fed. Reg. 25642 (May 1, 2020).
[2] 85 Fed. Reg. 25510 (May 1, 2020).

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NOT A FREUDIAN SLIP: CBD AND MENTAL HEALTH - THERAPEUTIC MAGIC OR MYTH? PART 2

There has been tremendous hype about cannabidiol (CBD), with some claiming it is a miracle cure while others remain skeptical of its true medical value. Part 1 summarized the historical journey and recent market growth of this polarizing topic before concluding with a brief snapshot of the evidence of positive health impact across mental and behavioral health conditions. This second article sheds light on potential risks and ways to decipher misleading marketing claims to identify quality, reputable sellers among the multitude of product options. As misinformation and anecdotal testimonies are replaced with scientific evidence and truth around historical events, CBD will be more accepted in mainstream medicine and has the potential to positively impact mental health improvement.

Recently, the legalization of cannabis in Canada in October 2018 and increasing legalization across the U.S., along with the removal of hemp as an illegal substance under the Agricultural Improvement Act of 2018, known as the Farm Bill, has expanded usage and started to shift the negative stereotypes and politically misguided classification. Hopefully, with continued law changes, necessary research and clinical trials will be funded appropriately to provide evidence of therapeutic value and guidance to clinicians on dosing, medication interactions, and potential positive and adverse effects.

Research shows that CBD has a positive safety profile, with very few minor, infrequent, non-threatening side effects.[1] The most common side effects include dry mouth, change in appetite, red eyes, dysphoria, and sedation/fatigue.[2] The World Health Organization "Expert Committee on Drug Dependence (ECDD) concluded that, in its pure state, cannabidiol does not appear to have abuse potential or cause harm."[3] So why is a substance with such value not part of mainstream medicine?

DRUG TYPE	DRUG NAME (BRAND NAME)	SIDE EFFECTS IN ADULTS	SIGNIFICANT WARNINGS	TOXICITIES REPORTED	FATALITIES REPORTED
SSRIs Selective serotonin reuptake inhibitors	citalopram (Celexa), escitalopram (Lexapro), fluoxetine (Prozac), fluvoxamine (Luvox), fluvoxamine CR (Luvox CR), paroxetine (Paxil), paroxetine CR (Paxil CR), sertraline (Zoloft)	Dizziness, feeling irritable, anxiety, dry mouth, problems sleeping, vivid dreams, flu-like symptoms (for example nausea, vomiting, diarrhea, headaches, chills), feeling tearful, 'shock-like' feelings, weight gain, sexual dysfunction. Occasional: Memory and concentration problems, movement disorders.	Abnormal bleeding Suicidal thoughts or behavior	Y	Y
SNRIs Serotonin-norepinephrine reuptake inhibitors	desvenlafaxine (Pristiq), duloxetine (Cymbalta), venlafaxine (Effexor), venlafaxine XR (Effexor XR), milnacipran (Savella), and levomilnacipran (Fetzima)	Tiredness, dizziness, light headedness, headache, sleeplessness, insomnia, nightmares, nausea, diarrhea, constipation, loss of appetite, ringing in the ears, tingling, 'shock-like' feelings, sweating. duloxetine, venlafaxine, and desvenlafaxine may cause sexual dysfunction. Occasional: Memory and concentration problems, movement disorders.	Abnormal bleeding Suicidal thoughts or behavior	Y	Y
TCAs Tricyclic antidepressants	amitriptyline (Elavil), desipramine (Norpramin), doxepin (Sinequan), Imipramine (Tofranil), nortriptyline (Pamelor), amoxapine, clomipramine (Anafranil), maprotiline (Ludiomil), trimipramine (Surmontil), and protriptyline (Vivactil)	TCAs affect several neurotransmitters in the brain and, as a result, cause numerous side effects. Problems sleeping, dreaming a lot, flu-like symptoms (for example nausea, muscle pain, headaches, excessive sweating, chills), dry mouth, constipation, blurred vision, urinary retention, dizziness, tachycardia, memory impairment, delirium, orthostatic hypotension, weight gain, seizures, bone fractures, sexual dysfunction, increased sweating, and increased or irregular heartbeats. *Occasional:* Movement problems, mania, unusual heart pace.	Suicidal thoughts or behavior	Y	Y

DRUG TYPE	DRUG NAME (BRAND NAME)	SIDE EFFECTS IN ADULTS	SIGNIFICANT WARNINGS	TOXICITIES REPORTED	FATALITIES REPORTED
MAOIs Monoamine oxidase inhibitors	Phenelzine (Nardil), selegiline (Emsam), and tranylcypromine (Parnate)	Feeling irritable, anxiety, problems sleeping, weight gain, sexual side effects, postural hypotension, vivid dreams, slowed speech and a lack of muscle co-ordination. *Occasional:* Hallucinations, delusions.	Hypertensive crisis: Taking with tyramine-containing foods or beverages may cause dangerous elevations in blood pressure. Suicidal thoughts or behavior	Y	Y
Atypical agents	bupropion (Wellbutrin), mirtazapine (Remeron), nefazodone (Serzone), trazodone (Desyrel, Oleptro), vilazodone, and vortioxetine (Brintellix)	Dry mouth, constipation, dizziness, lightheadedness, drowsiness	Mirtazapine and trazodone may cause abnormal heart rhythms that can be life threatening. Trazodone may cause priapism, a rare sexual disorder. Nefazodone may cause life-threatening liver failure. Suicidal thoughts or behavior	Y	Y
CBD Cannabidiol	Epidiolex® - FDA approved (others in development) Multiple recreational brands	Dizziness, drowsiness, dry mouth, nausea, changes in appetite. CBD can interact with certain prescription medication	"Lethal overdoses do not occur." No "statistically significant association between cannabis use and mortality" "CBD appears to be a safe drug with no addictive effects"	N	N

What was even more surprising in my literature search is how CBD appears to be better tolerated than routine psychiatric medications, as these prescriptions can be ineffective, have multiple negative side effects, have a high risk of addiction, and can lead to overdose.[4]

The desire to move away from harsh pharmaceuticals to more natural, holistic alternatives has been growing. Many are not happy with the adverse effects from prescription anti-anxiety medication or antidepressants. Having another option to reduce symptoms of anxiety and depression, manage stress, and treat symptoms associated with numerous other conditions can be the relief so many are looking for.

With all the positive hype around CBD, one must not overlook the potential adverse effects such as medication interactions, possible toxic additives, and issues with self-medicating. Similar to most of the packaged foods on our shelves which contain chemicals, artificial sweeteners and artificial colors that are harmful to our health,[5] CBD products can also contain contaminants, pesticides, bacteria, impurities, heavy metals, and toxins that can have negative side effects.

To ensure safety and quality, companies must conduct third-party testing for consistency and quality in cultivation, manufacturing, and dispensing. However, certificate of analysis (COA) testing is not mandated and, like the cosmetic industry, the CBD market is not regulated. Just as harmful, potentially toxic

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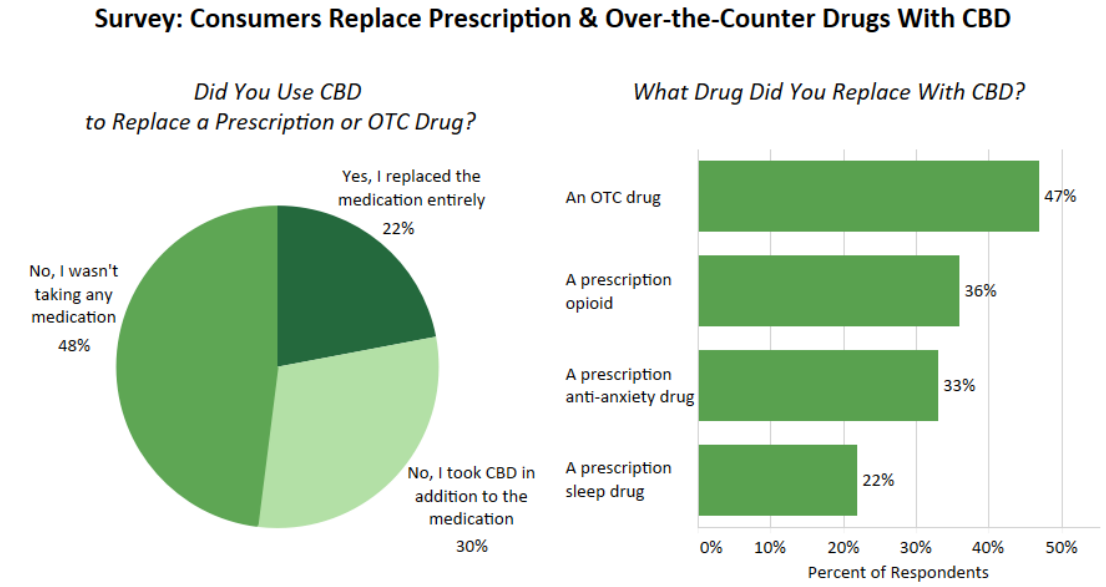
NOT A FREUDIAN SLIP: CBD AND MENTAL HEALTH - THERAPEUTIC MAGIC OR MYTH? PART 2



Source: Consumer Reports

ingredients can be put into skin and hair care products by beauty companies, some synthetically produced CBD products can contain chemicals, pesticides, or other harmful contaminants. Quality control and regulatory guidelines will help ensure standards are met, and adequate provisions can clear up confusion from product labels and diminish unsubstantiated marketing claims. With greater transparency, consumers will be better able to identify reputable sources and decipher high-quality ingredients, product potency, and purity.

The tarnished reputation, classification by the Drug Enforcement Administration (DEA) as a Schedule 1 controlled substance, and confusion around legalities leave many people intimidated to use CBD for holistic health. Further, with so many product variations and options, selecting the safest, most appropriate product can be challenging. CBD oil can be consumed in different ways, from ingestibles (tinctures, pills, gummies, capsules, lozenges, lollipops, mouth strips, beverages, food), to topicals (creams, balms, ointments, salves), as well as inhaled products (smoking, vaporizing). And the potency of each dose can vary. Providing insight into what to look for when purchasing CBD products will aid in responsible use.

As the appeal of CBD evolves and the scientific research further validates the positive benefits, product sales will continue to move from dispensaries into mainstream retail brick-and-mortar and online settings. This demand surge fuels the need for further education and research, as consumers, clinicians, and public health officials need to be informed. Accurate and up-to-date clinical data validating therapeutic benefits and long-term effects of CBD is not readily available for physicians or therapists to use and incorporate into their treatment recommendations.

There is evidence to "suggest a potential therapeutic role of CBD and nabiximols (cannabis extract) to treat various psychiatric disorders." Recommendations supporting CBD use for schizophrenia, social anxiety disorder, autism spectrum disorder (ASD), attention deficit hyperactivity disorder (ADHD), insomnia, anxiety, bipolar disorder, post-traumatic stress disorder (PTSD), and Tourette syndrome exist; however, the evidence is weak (due to a limited number of studies, not outcomes).[6] By uncovering further evidence that "CBD appears to be a safe drug with no addictive effects," hopefully

	✓ Yes ✓	✗ No ✗
WHERE is it sourced? *Farming*	✓ Grown in US ✓ Organic agricultural hemp	× Imported from overseas
HOW is it made? *Manufacturing*	✓ Processed using safer methods, such as ethanol or supercritical carbon dioxide (CO_2)	× Processed using toxic materials like propane or butane
WHAT is the product? *Ingredients*	✓ Label lists cannabinoids and other compounds like cannabidiolic acid (CBDA), cannabinol (CBN), cannabigerol (CBG), and cannabichromene (CBC) ✓ Contains minimal THC- should not exceed 0.3% ✓ Label includes Whole-plant, Full spectrum or Broad spectrum	× Label doesn't mention cannabidiol or hemp extract and *only* lists hemp seeds, hempseed oil, or Cannabis sativa seed oil × Label or laboratory results do not provide THC % or amount is over 0.3% × Contains synthetic cannabinoids
WHAT is the quality? *Claims*	✓ Certificate of Analysis (COA) by 3rd party testing validated by national standards-setting organizations: Association of Official Agricultural Chemists (AOAC), American Herbal Pharmacopoeia (AHP), or US Pharmacopeia (USP) ✓ Lab meets ISO17025 standards ✓ Consistent and recent lab and batch testing	× No testing × Analysis and testing procedure not validated by impartial 3rd party lab × Old lab results × Copied or falsified lab reports
WHO is producing it? *Company*	✓ Customer reviews & public feedback ✓ Updated website & active social media presence ✓ Consumer product reviews & recommendations	× Reviews by investors or employees × Non-working website and no social media engagement × No consumer recommendations

CHART 2: Identifying Reputable Sellers and Certified Products

scientists can secure funding and appropriate and undiscovered medical applications can be explored.[7] These actions will allow medical and mental health practitioners to adequately harness the therapeutic value of CBD to support mental health improvement.

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DOWNLOADING SUCCESS: THE EVOLVING ROLE OF HEALTHCARE CHIEF DIVERSITY OFFICER

As awareness grows across the U.S. of the pervasive social injustices and inequities that impact communities of color, the Chief Diversity Officer (CDO) has become a crucial leader in hospitals and healthcare systems. CDOs have been charged with creating diverse and inclusive environments for staff and patients. In the wake of COVID-19, renewed attention has been focused on chronic illness and the social determinants of health. CDOs are at the forefront of addressing these healthcare disparities; their efforts are focused on developing strategies which will close the gap on health inequities at their organizations and in their communities.

In our work as executive search consultants, my colleagues and I support many hospitals, health systems, academic medical centers, and medical schools in recruiting inaugural CDOs to address these important issues. As these organizations hire inaugural Chief Diversity Officers, they face the challenge of shaping the role to position it for success. Below are some of the fundamental responsibilities – internal and external – that are being given to today's healthcare CDOs.

INTERNAL RESPONSIBILITIES

Strategic Planning: CDOs are developing comprehensive plans which promote diverse, inclusive, and equitable organizational cultures and to facilitate awareness and education for healthcare providers to ensure that communities of color receive optimal care. Successful CDOs are able to accomplish this important work at an internal and external level. Initial efforts typically focus on addressing diversity, inclusion, and equity within the organization, including diversity recruitment and retention.

Climate Survey: Early steps to accomplish the internal work include developing diversity climate surveys. CDOs will utilize survey results to identify organizational development opportunities. Specific seminars, workshops, and diversity, inclusion, and equity programs will be developed, including unconscious bias training. The Diversity, Inclusion, and Equity strategic plan may be amended or augmented to reflect issues identified in the climate survey. As data-driven leaders, CDOs will develop diversity dashboards to track metrics and monitor progress.

Recruiting Top Diverse Talent: The CDO will work with search committees and other hiring parties to ensure diverse candidate pools. The work must take place at every level of the organization and have the support of the executive leadership team, in terms of messaging and resource support. The CDO can communicate to all leaders that recruitment for diversity is a priority.

Culturally Competent Curriculum Development: If the organization has teaching and academic programs or is a medical or health sciences school, the CDO will coordinate efforts with diversity resources at medical/health science schools to ensure that a culturally competent curriculum is developed. The curriculum will include a basic understanding of the complexities of care and a foundational respect and understanding of caring for patients from

different backgrounds and cultures. Further, it is imperative for the CDO of the academic medical center and the CDO of the medical school to work together to align their broader strategies.

In addition, the CDO will support efforts to create pipeline programs to recruit diverse students and faculty. The CDO will partner with academic leaders to develop student programs to create an optimal learning environment and support academic and professional development for underrepresented faculty and students. The CDO will broaden efforts to build a diverse faculty by providing recruitment tools and educational programs for Search Committees.

Resources and Budget: It is critical that the CDO has adequate resources, including funding and headcount, to accomplish the core aspects laid out in strategic planning. Too often CDOs are hindered in their mission because of limited support, rendering them ineffective or leaving them simply as figureheads. In this regard, it is important for the diversity officer to have the backing of the CEO and top leadership so that proper resources are allocated.

EXTERNAL RELATIONSHIPS AND COMMUNITY ENGAGEMENT

As the internal work progresses, external efforts are imperative to address health inequity within the community and region. CDOs are skilled communicators. They encourage and facilitate crucial conversations about diversity, inclusion, and equity.

Coalition Building and Partnerships: The CDO is an important connector to community leaders, including other providers, government leaders, and local community non-profits. As a coalition builder, the CDO plays a crucial role in developing community partnerships which can foster health equity and dissect the complexities of the social determinants of health. Partnerships at the national level can include those with member associations, legislators, and government authorities.

Hospitals and healthcare systems can play a key role in improving health outcomes for diverse communities. Strategies that foster community outreach, and a deep understanding of the complex factors that impact health outcomes, are key. As more healthcare providers are educated on these complexities, underserved communities will benefit.

Advocating for Digital Health: As digital medicine continues to mature, health systems need to consider how these digital health strategies will service diverse populations and communities. Chief Diversity Officers will have to consider their unique patient populations and their specific needs when it comes to accessing emerging digital health tools, like cell phones, wearables, and social media. These tools have greatly moved the needle towards patient-centric care, but it is important that everyone benefits from them, and this will be part of the CDO's responsibilities.

CONCLUSION

As the CDO role expands, organizations are realizing this individual must be given more authority among senior leadership in order to ensure that progress is being made regarding diversity, equity, and inclusion. Resources including headcount and budget show the commitment of the organization to accomplishing the Chief Diversity Officer's work—so that, beyond lip service, meaningful change can be implemented.

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TO YOUR HEALTH: LOST OR GAINED? FITNESS DURING A PANDEMIC

Canyon Ranch in Lenox reopened in late July, and the stories about what has happened to people's fitness varies widely! The classic 'fork in the road' parable works very well.

Most of us remember where we were the day the pandemic took over our lives. Suddenly countless unknowns appeared all at once. Our work, family, children, travel, and health were all in question. At some point, you made a choice. Besides the decision about food, shopping, alcohol or take-out, you tried to figure out how to move, how to get active, how to break a sweat. The sales of Peloton, hand weights, and TRX tell the story. Despite being backordered

for weeks, people were itching to get their exercise at home while gyms were closed and the personal trainer was forbidden. But sadly, for others, they stalled right in place. Just today my colleague relayed a story that her guest said, "Once the gym closed, I was lost." She replied, "Why? What do you do at the gym?" He answered, "the treadmill."

As a tennis coach will tell you, nothing is more valuable than the player who is willing and able to adjust to changing circumstances. Sunny or windy, singles or doubles, winning or losing, the player can be trusted to adjust and give their best effort. The fitness equivalent is the individual that by April 2020, reimagined their activities and filled their red ring (Apple watch) any way they could. Remember, the role of activity at its core is: expend energy at an elevated enough level to double your resting heart rate, increase your metabolic rate 5x, and break free of your laptop before you become fossilized.

Here is a list of solutions we recommend to anyone who is trying to return to an activity level they previously had.

1. Zoom - Yes, I said it. For the individual who needs to be led with some snappy music or rhythmic lifting, sign up for an online Zoom and join the party. Essentially, that is all that Peloton is doing. Maybe you need yoga, Zumba, or Crossfit. Dig a little, and you will find it. The 'Mirror' would love to have your business.
2. For the fair weather fan, get your miles in. Set a goal of steps/miles/calories/ flights. It doesn't matter which you choose, but find a route in your area that you can repeat. Invite a friend, make a phone call, walk a dog. Get out!
3. Go have fun! Lifetime sports, or leisure sports as they are also known, provide ample opportunities to be on your feet, moving with a varied level of intensity. Best known are golf, tennis, canoeing and biking, but coming on fast is pickleball. The courts up here in MA were packed with players as soon as Phase II allowed for it. It was a great scene! Find an instructor or beginners' clinic near you.
4. Nature - It is remarkable when we humans get away from each other and get out into the areas where the other species thrive. "Those who dwell, as scientists or laymen, among the beauties and mysteries of the earth, are never alone or weary of life." ~ Rachel Carson

An earnest guest came here for a visit last month. She signed up for 4 private tennis lessons. Her reason was not to learn the game. As she put it, "Make it a cardio session any way you can, I am so sick of running."

Like no other time, we need to adjust our activities to whatever the situation allows. So, the good news is you are on the team! Good hustle!

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CYBERVITALS: KEEPING CYBERSECURITY ON THE BOARD AGENDA

You are likely well aware that cyber risk directly correlates to an increase in digital footprint. Independent of the rapid digitalization that healthcare has undergone through the pandemic, it is important the cyber risk be sufficiently understood and discussed as you kick off board meetings in 2021.

When every other day brings news of a new breach, and the U.S. Department of Health and Human Services Office for Civil Rights (HHS) "Wall of Shame" tallying greater than 46 million records, the quantification of cyber risk can be daunting.

Time to identify and contain a breach averaged 329 days in healthcare, which is 49 days longer than the average, per IBM's annual data breach report for 2020. The report further outlines that the average cost of responding to a breach is $3.86 million, while healthcare, for the tenth year in a row, was the highest industry, with an average cost of $7.13

million. This is a 10.5% increase over the year prior, while 13 of 17 industries assessed experienced an average total cost decline.

With statistics like these, it's hard to imagine a board meeting discussing anything BUT cybersecurity-related risk. But we all know that's not the case.

To help achieve continuous board oversight, here are a few ideas to inspire keeping cybersecurity on the agenda regularly:

1. **Avoid the weeds.**
   The messaging from the technology team should discuss trends, how these impact business units/efforts, what can be done to mitigate these challenges, and how that translates into resource requirements. For example, macro-trends from the Internet of Things (IoT) have revolutionized the connectivity of medical devices, from making RFID-connected instruments, to software as a medical device.

   This means connected devices (whether as a manufacturer or healthcare delivery organization) now pose a landscape of potential vulnerabilities. How is the organization maturing in managing the related cyber risks?
2. **Know the universe of risks.**
   Cyber risks include a multitude of functions and operations. Most often however, we heard that "the people" are the weakest link. Perhaps this is because the people are the highest level of variability. Reality is that all three facets - people, process, and technology - must be sufficiently assessed to know where potential weaknesses are, how those can be mitigated, and what the business impact is for a potential exploit.

   When thinking through enterprise risk management, are cyber risks sufficiently addressed? Third party vendors, geographic restrictions, contractors, product development practices, and the list keeps going. In today's connected environment, it would almost be the exception for a facet of operation to not have cyber risks associated with it.
3. **Security never stops.**
   The last 9 months have reinforced that fatigue is a real thing, so it's understandable why cybersecurity may be infrequently discussed by the board. However, risk is constantly changing, and therefore the intake process to define, identify, and remediate risk must be robust enough to capture and account for the evolving landscape.
4. **Cybersecurity is patient safety.**
   Healthcare cybersecurity has evolved from a privacy concern to impacting patient safety. September 2020 saw the first death attributed to a cybersecurity incidence.

While we've all known the risks in healthcare are different than in the broad IoT, the loss of life is not a milestone anyone wanted to see. The threat to patient safety is no longer theoretical and highlights the importance of addressing fundamental problems.

In assessing the list of known vulnerabilities in medical devices, 73.5% were found to be driven by user authentication issues and code defects. While historically it may have been sufficient to say it hasn't been exploited, that is no longer acceptable. We cannot be complacent when there are lives at stake.

Healthcare is a complicated technology landscape, and the need to support patients with operating devices never diminishes. There are no 'off' days in care, let alone in the middle of a pandemic. But the status quo for addressing vulnerabilities demonstrates the need to fundamentally reimagine what managed cyber risk looks like.

Moving up the supply chain and beginning with devices that have been secured from the point of development is a great first step. Hospitals making procurement decisions that weigh cybersecurity risk equally to clinical care needs understand the power in designing security into a device and the risk connectivity introduces to a healthcare organization.

The conversations with boards will likely be hard and uncomfortable. But if 2020 has taught us anything, it's that we need to normalize changing our opinion and reprioritizing the complicated matter of managing cyber risks.

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CODE BLUE: RACIAL JUSTICE IN THE CORPORATE WORKPLACE

8 minutes, 46 seconds….the time it took for the life of George Floyd, an African American man in Minneapolis, to drain from his body under the knee of a white police officer on his neck. It happened in full and brazen view for the entire world to see and clearly without fear of retribution.

Racial injustice happens both on our streets for public viewing as well as behind closed doors – in workplaces, healthcare settings, and the legal system, to name a few. It's time to take real action. This is a Code Blue emergency!

CODE BLUE

A Code Blue in a hospital setting means a medical emergency, usually related to a patient in cardiac or respiratory arrest. Upon calling a code, a multidisciplinary clinical team goes into action to save the patient's life.

In 2020, George Floyd's death is our Code Blue.

8 minutes, 46 seconds…..George Floyd's 6-year old daughter Gianna said in the midst of a loss she probably still has not fully understood given her age, "My daddy changed the world!" And, indeed, he has.

His death has served as a catalyst for opening eyes to an epidemic of racial injustice that has birthed the most multicultural movement for change seen in decades. Shining a klieg light has also brought a more avid focus on health equity and the

uncontested impact of racism on the health and well-being of those it targets.

And other "isms," such as sexism, ageism, antisemitism (and their kin, e.g., homophobia, xenophobia, and Islamophobia) are being more readily acknowledged by more of the population as reprehensible as well.

George Floyd never even had the opportunity for an actual Code Blue to be called on his behalf. Therefore, it is even more critical and incumbent on us to pursue transformational change. We cannot afford reflexive, "in-the-moment," cosmetic micro-incrementalism parading as progress.

George Floyd's death and the global response to it served as a **test of** the **values** of organizations and the **character of** their **leadership** (including their Board members).

We need action now, but an important first step necessary for creating a better future is to know and learn from the past.

So, why do we find ourselves in a Code Blue? Let's look at how we got here in the first place and face the ugly reality of the racism endured by African Americans, to which many are subjected on a daily basis.

CHANGING THE WORLD

Some might say the human race is innately hate-filled and evil. As an example, they point to the biblical story of the brothers Cain and Abel, the children of Adam and Eve, and the fratricide which ensued when Cain killed his brother.

Although some days can make it difficult to disagree, we have to believe there is a counterbalancing humanity and core of similar goals of health, well-being, a sense of purpose, having a voice, making a difference, having someone to love and to be loved. Otherwise, what hope can we hold that the myriad and voluminous challenges of hate and injustice will ever be overcome in a substantive and sustainable manner?

RACE | RACISM AND ITS KIN

"Watch your thoughts; they become words. Watch your words; they become actions. Watch your actions; they become habits. Watch your habits; they become character. Watch your character; it becomes your destiny."

~ Lao-Tzu

The idea of **race is a human construct born of** the **inaccurate theory of** Thomas Morton. He was a 19th century doctor and "scientist" who believed there were 5 races. He defined them through his study of empty skulls and the number of pepper seeds needed to fill them.

In his creationist theory, there was a definite hierarchy within the human race, with those who were white felt by him to be superior and the most intelligent of all.

In the eyes of Samuel Morton and his acolytes, those who were Black were relegated to an intellectual capacity so inferior that all the horrors of abduction from the motherland, family separation, slavery, and its many barbaric and criminal acts of violence were justified in the minds of the enslaver class.

The result? 400 years of crimes against humanity and the establishment of internecine systems which have predestined the type of outcomes that devastate the lives and generations of so many, sometimes long before its victims are even born.

The definition of racism according to Merriam-Webster is "a belief that race is the primary determinant of human traits and capacities and that racial differences produce an inherent superiority of a particular race." This belief system is held by many, many more individuals and communities than many of us

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want to even imagine as being possible.

Racism is a complex, multilayered concept with a foundation of deep-seated emotion. Its roots are deep, and its impact on the health, well-being, and the very lives of its victims is multifaceted and complicated.

Of course, there are other "isms," among them sexism, ageism, and antisemitism. And the kin of the "ism family" include misogyny, xenophobia, religious persecution, and homophobia.

But racism holds a special place in history, and in fact, in the founding, building, and day-to-day morés of the United States. And it is being more broadly recognized as America's "original sin" (of which there are several).

REALITY AT A HUMAN LEVEL

Imagine ……. if the color of your skin (name, gender, sexual orientation, disability status, SES, age, country of origin, religion, etc.) was an actual affront to many of those around you.

Imagine ……. being the target of hate in all its many forms by people who don't even know you.

Imagine ….. a devastating system with vast tentacles designed to keep you "in your place."

Imagine…. your potential as a human being predetermined and capped by others to be one of subservience no matter your creativity, your innate talents, your skills and expertise, your educational level, or your income/net worth.

Imagine…. your life being so devalued that killing you meant nothing at all in the eyes of the law and many of the populace (and sometimes was even relished).

RACIAL EQUITY TOOLS

"The only thing necessary for the triumph of evil is for good men to do nothing."

~ Andrew Marshall

So where do we start now that the code has been called and the team has arrived?

One important and far-reaching opportunity is in the workplace. In order to be substantive and effective, the approach to programming must be holistic, comprehensive, and undertaken with a long-term view.

There must be commitment across the enterprise, beginning with the Board of Directors and C-suite and extending down to the front lines.

One critical indication of true commitment is the extent of the ongoing and consistent investment and organizational resources allocated to the work.

Another measure is whether the leader of the strategy and delivery of programming is a member of the C-suite.

Lastly, you can tell an organization is serious if (1) metrics are established, (2) both hitting milestones as well as (3) demonstrating annual improvement are tied to a material portion of potential bonus, stock grants/ options, etc. at the individual level as well as the organizational pool of dollars available for bonuses.

Writing a **check**, **hosting** internal **dialogue** and training, **declarations of support**, and establishing an **employee forum** for ideas and feedback can be **helpful initial steps** in the journey.

However, **in some cases**, those **actions can** also **ultimately manifest as a type of "check list performance art**." They may serve as a glide path to achieve a corporate ranking that may be helpful as a PR and short-term recruitment tool **but not make a significant difference in the day-to-day lives, opportunities, and career trajectory of employees**.

The July 13, 2020 *Wall Street Journal* article, "Demand for Chief Diversity Officers Is High. So Is Turnover," indicated "Frustrated by talk but little action and a lack of resources, many diversity executives find themselves rotating through C-suites."

TAKING ACTION – EXTERNAL OPPORTUNITIES

1. **Start with your health insurance carrier**(s) (medical, RX, dental, vision, behavioral health, etc.). **Set expectations** with them regarding programming and data analysis/ segmentation/**analysis and insights** relative to (1) identification of **health disparities** and both **health literacy** and **social determinants of health** (SDOH) needs, (2) development and **implementation of** a **strategy and detailed action plan** to address them and to close care gaps, (3) quantification of the **diversity** of their **provider networks**, with transparency for members and active recruitment as needed to achieve a network which can optimally provide care to all employees, and (4) making training available to the provider networks regarding health equity, including their role in **cultural sensitivity, competence, and humility** in their interactions and communications with your employees/their patients.
2. Communicate assertively your **commitment to racial justice and anti-racism:**
   - **Serve as a role model and communicate your values**. How diverse is your supply chain and the vendors with whom you contract? Include pertinent questions during the RFP and vetting process that signal yours is a company whose **culture includes anti-racism as a value** and one you **expect to be shared** in **those** companies **with whom you do business**.
   - **Imbed criteria in your selection**

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process. This ensures you are capturing comprehensive information that will result in **partnering with** a set of **companies** to meet your needs which reflect the **diversity of ownership** and **provide opportunities** to those who are **often overlooked**. (Overlooked not because of the inability to do the job but because they are not part of your usual networks or inclinations when you perform company assessments.)

- **Set expectations with vendors** who provide goods and services to your company that you anticipate **employment** and/or **subcontracting arrangements include material representation of historically underrepresented groups**.

TAKING ACTION – INTERNAL OPPORTUNITIES

Dedicated Team

1. **Designing a strategy and action plan begins with enlisting a cross-functional, multi-disciplinary team dedicated specifically to the work** and with skills in leadership, team building and collaboration, data analysis and synthesis, diplomacy, communication and marketing, surveys, social listening, and focus groups, project management, facilitation, adult learning theory, psychology, and operations plus a deep understanding of inclusion, diversity, cultural competence and cultural humility, people management, employee growth and development, mentoring and sponsorship, and career mapping.

   And there must be **inclusion of employees who find themselves at the receiving end of racism and racist practices**, which may range from blatantly overt and insidiously malignant to a reflection of implicit bias.
2. The team must create an **environment** which ensures confidentiality, offers a safe haven where employees will feel free to express their feelings and communicate their experiences without fear of reprisal and **walks the talk of diversity and equity** which enables them to serve as role models for the rest of the organization.
3. The team must be **led by a member of the C-suite who reports directly to the CEO** and whose job responsibilities are focused on equity within the workplace.

Although collaboration with the CHRO will be required, this position **should not be relegated as an "off the side of the desk" assignment** within HR. And, although a culture of equity, true inclusion, and anti-racism is the responsibility of each and every employee, the message through **action must begin at the top**.

Many companies say, "Our people are our greatest asset." If that is a genuine organizational belief and value, then it must be more than a slogan and an internal marketing campaign.

Comprehensive Data and Transformational Insights

A determination must be made of the **data – both qualitative and quantitative** – necessary to develop a clear and **comprehensive picture** of the **baseline state**.

In many cases, **some** of the **data points** will be generally **agnostic** relative to being important markers to detail the areas and degree of inequity of whichever disadvantaged, marginalized, and underrepresented group may be the one for which action is necessary (including, for example, women, African American, Latinx, and AAPI communities, the LGBTQ community, and indigenous peoples).

However, in some instances, **metrics may differ** to a varying extent depending on factors such as industry sector, organizational structure, company size (e.g., revenue, # of employees), for-profit vs. non-profit status, and applicable role types.

They **should** also **include metrics and weighting schemata which may be specific to** a particular disadvantaged, marginalized, and underrepresented **group**. In other words, **one size will not fit all**.

The metrics must **include both foundational data** as well as **data customized and nuanced enough to** capture the information needed to detect the themes and often complex insights essential to a strategy and action plan that will **produce a transformational change in a timely fashion**.

(NB: For purposes of this article, the examples below focus on African Americans.)

QUANTITATIVE DATA

- What % of employees are African American?
- How many African Americans are "mis-leveled" when first hired and are never able to catch up economically and recover from an action that ultimately impacts the entire span of their career?
- Are African Americans represented in C-suite roles, such as COO, CFO, CMO, CTO and CIO?
- Are African Americans on the board of directors? If so, are they chairs of any board committees, including compensation/nominating/finance? Are they members of the executive committee?
- Are African Americans included in the succession planning slate?
- What % of employees in the following positions are African American? What is their average tenure?
  - Team Lead, Manager, General Manager, Director, AVP, VP, SVP, EVP
- What is the salary band distribution of African Americans?
- What % of those in positions with direct/team reports are African American?
- What are the criteria used to define "high potential" and who decides what they are?
- How many of the criteria are objective and can be quantified vs. qualitative and subject to implicit/explicit bias?
- What % of employees designated as "high-potential" are African Americans?
- What % of employees in career development, high-potential rotational programs or assigned to high-profile projects are African Americans?
- What % of promotions are received by African Americans?
- What is the % breakout for African Americans who receive Exceeds vs.

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CODE BLUE: RACIAL JUSTICE IN THE CORPORATE WORKPLACE

Meets vs. Does not Meet performance review designations?

- What is the breakout of African Americans in white collar vs. production/call center vs. blue collar positions?
- What % of employees with P&L responsibility are African Americans?
- What % of employees with formal mentors are African American?
- What % of employees with formal sponsors are African American?
- What % of those whose positions were eliminated in the past 5 years have been African Americans?
- What % of those fired for cause in the past 5 years were African Americans?
- What % of company suppliers (and any of their subcontractors) are African American-owned businesses?

- Do you have an innovation team? If so, when they assess companies, do they have a workflow in place which will ensure representation of companies owned/founded by African Americans (and not just as a figurehead shell game) in the identification, vetting, and selection of companies that can provide the services and products you need? Is the selection process blinded, so the determination of the best partner is based on facts and the ability to deliver and not on a history and potentially subconscious decision-making grounded in an inclination to choose people who "fit the profile" and who are part of the "old boy network," with connections that have nothing to do with the quality of the product or service provided and the ability to get the job done?

QUALITATIVE DATA

- Have you conducted (1) online surveys and (2) focus groups to capture the following?
  - Employee perceptions of the culture relative to equity, inclusion, diversity, and belonging
  - Employee experiences of discrimination and explicit bias
  - Employee experiences of racist (or other "ism") language and/or treatment by co-workers, managers and others in authority/power positions, and/or customers
  - Employee experiences of lack of resources to get his/her job done
  - Employee experiences of lack of interest, support, sponsorship, and resources relative to growth, development, learning opportunities, and career advancement
  - Employee experiences of lack of acknowledgment and recognition of accomplishments
  - Employee experiences of favoritism on the team
  - Employee experiences of unchanging performance reviews regardless of the quality of work, work effort, and work excellence

Once the data is compiled, it is crucial for the team analyzing and synthesizing it to be diverse, open-minded, emotionally intelligent, empathetic, and willing to "**field test**" its **conclusions**.

This ensures it rings true and **accurately portrays the state of play** and **repercussions thereof. Without this review**, risks are increased that **ineffective and potentially damaging "solutions" which lack substance** will be implemented despite the best of intentions.

EDUCATION AND COMMUNICATION

In the months following George Floyd's death, many companies were racing to get out messages of anti-racism and allyship support.

Others went a step further and became more **actively cognizant** of the **subliminal signals of bias** they were sending by the **choice of language and images used** in their **communications and marketing**.

Some took actions like internal forums for employees whose lives have been stricken by the impact of structural racism to **express** their **feelings, share experiences**, and provide examples of the emotional tax they may bear day in and day out. Their stories simultaneously help **educate those** who have **never** been **at** the **receiving end of** a **system** that is fundamentally and intentionally **rigged against certain groups** within the population.

There were also opportunities to **learn about implicit bias** and perform self-assessments which would support the development of a more inclusive way of thinking and a sensitivity to the workplace plights, both large and small, of colleagues of color. **Openness** and sincere **curiosity** are critical **steps to** the evolution of a corporate **culture** to one that is **anti-racist in both word and deed**.

Such conversations and training sessions also **raise awareness** and **disseminate concrete actions** which both individuals and the organization can take to **be alert to** a work **environment** which has myriad opportunities to communicate and to develop a strategy and action plan with clear deliverables and timelines as well as sufficient resources to execute and sustain the plan.

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They can also serve as a **springboard of discovery** to **identify behaviors** and/or a wide range of organizational **policies and procedures** which **reflect**, or **even support**, a culture and workplace **environment** that is **not truly diverse** or **inclusive (or might even be blatantly racist)**.

Some **companies wrote checks** to organizations the mission of which is to fight against racism and advocate for those impacted by it.

Yet others took a **more assertive approach** in **expressing their stand**, e.g., cutting ties with companies whose behaviors, products, and/or multi-channel advertising reflect a racist culture and whose denizens serve as racist cells in their organization and the communities in which they live. Such an approach provides a **financial penalty** and **ongoing disincentive** to organizations that persist and perpetuate a racist system and way of doing business.

Many companies began recruitment efforts for chief diversity officers, established roundtables or councils for ongoing employee feedback, and began to take steps to revamp general **recruitment and retention workflows** and other **equity-focused programming** which **plant** the **seeds** needed to **grow** a **workforce** that is **diverse** and truly **inclusive**.

Once again, all of these actions are foundational to genuine efforts to create a sustainable anti-racist (and anti-"ism" in general) culture which reflects true diversity and inclusion.

TRANSFORMATIVE LEADERSHIP

A recent BCG article outlined what they consider "**imperatives of 'bionic' companies**." These include:

- **Rethinking** the **art of the possible**, including setting imaginative aspirations and a bold direction
- **Moving from managing to enabling**, including **leading by example** and leveraging technology and behavioral science to **strengthen the needed behaviors**
- Translating **purpose into action**, including **bringing humanity to work**

Expectations for substantive and comprehensive change are high as an organization awakens to the need and demands for a workplace which values diversity and the inherent worth of each employee regardless of race/ethnicity, age, religion, gender/gender identity, sexual orientation, or disability.

"Never be afraid to raise your voice for honesty and truth and compassion against injustice and lying and greed. If people all over the world…would do this, it would change the earth. We must always take sides."

~ William Faulkner

The **status quo** has become a **more difficult option to sustain**, and **employees** will **judge** the **interest** in and **sincerity** of the **effort** by:

- the **priority** established and **focus** given
- the **actions** taken (or not taken) and **not platitudinous proclamations** of support
- the degree of **investment** in resources, both **human and otherwise, beyond** just **writing a check** in the moment with no long-term commitment to change
- the timely **design** of a **strategy** which imbeds in its **action plan** (1) diversity and **workplace equity** as it relates to day-to-day interactions and a welcoming and inclusive workplace environment and (2) career opportunities, growth and development, sponsorship, and advancement throughout the business
- the **expectations** set regarding **all-employee accountability** for **implementation** of the plan and **material progress** tied to a **speedy timeline** for **execution**

BEST PRACTICES FOR RACIAL JUSTICE

Systemic racism in the United States is as old as the country itself. The inauspicious arrival on the shores of North America of the enslaver class was followed by the massacre of Indigenous peoples whose land was taken and whose survivors were forced onto reservations and the enslavement of populations abducted primarily from the continent of Africa. Hard-fought progress has been made since the country's founding through the literal blood, sweat, tears, and deaths of many.

Over time, **best practices** have emerged that can serve as components of a **roadmap** focused on an **anti-racist, diverse, inclusive, and equity-focused** work **culture**. Some of these include:

- **Establishing** crystal clear **clarity** throughout the organization that an **equity-focused culture** is **not** the latest HR **fad or** a **one-and-done** process and that it is a **priority for the Board, CEO**, and the **C-suite**
- **Imbedding** an **equity-focused approach** as an **inherent component** of **business strategy** and **key to** organizational **success**.
- **Implementing**, as a starting point, the Rooney Rule, which requires "at least one woman and one underrepresented minority [to] be considered in the slate of candidates for either every open position or every open senior position"
- **Blinding** the **names** (and other content that might feed implicit/explicit bias) of all candidates in the recruitment pipeline and have an **individual independent of** the **hiring process assess** resumés **against job requirements** to cull down to the group which meets job criteria and to which outreach will initiate the active recruitment phase of the process
- Rather than just focusing on candidates being a cultural "fit" (which often is code for "people who look and think like me"), **prioritizing** an **orientation** which **includes a perspective** of individuals **being a cultural "add"**
- **Expanding the pool from which candidates are recruited** from the outside or promoted from within by following the **Willie Sutton rule, "Go where the money is."** In other words, including organizations in your search protocol that are likely to have a high percentage of the population being those in which you have a focus of interest, e.g., historically black colleges and universities (HBCUs) and your own employee resource groups for African Americans; utilizing specialty headhunters
- **Widening** the **net** to include diversity as a priority and area of focused effort in your **sponsorship and succession plans**
- Establishing **employee/network resource groups** which provide an opportunity for those within certain segments of your population, and their allies, to have an organizationally-supported and easy way to connect with each other, provide leadership opportunities, and create a safe haven and welcoming environment for honest exchange
- Establishing **ongoing training** protocols which help the organization **stay abreast** of tools and innovations to **create, nurture**, and **sustain** and an **equity-focused culture** such that an anti-racist, diverse, and inclusive workplace environment becomes "t**he way we do things around here**." The Harvard Implicit Association test is a well-known tool to get you started.
- Reviewing data to **ensure pay equity exists**. If it does not, (1) establish a policy and take the steps necessary to (2) ensure those belonging to groups who have always been at a pay disadvantage compared to white males (e.g., women, African Americans) have their salaries adjusted and (3) pay equity is tracked for ongoing policy compliance.
- **Heeding** the wisdom of the **"Change Cascade"**: If it's **not measured**, it's **not a priority**. If there isn't **transparency** and **reporting**, there isn't **accountability**. If there isn't accountability, nothing **changes**.
  - ▶ Make sure you are collecting and

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analyzing both quantitative and qualitative **data** (including "voice of the employee" input) to gather **insights** and **ideas** which ensure an ongoing assessment of **progress, impact**, and any **needs for** a **course correction**.

- Include **equity-focused measurements** in **performance review metrics** and **tie** a **material percentage** of **merit increases, bonuses**, and potential **stock/stock options** to **individual and organizational** progress in the arena.

THE SHOT HEARD ROUND THE WORLD

We have had **days of reckoning many times in the past**, e.g., the civil rights and women's movements. And those moments in history **have** indeed **resulted in actions** to make the world a better and **more equitable place**. But **days of reckoning must become** weeks, months, decades, and centuries of **continuous commitment** to the cause.

Change is **difficult** and **fragile if not continuously nurtured**. Change always means there will be groups vehemently opposed to anything and everything which challenges the status quo, particularly if it results in a shift in the balance of power or threatens a group's sense of self-worth and standing in the world.

Shot Heard Round the World – Concord Hymn

~ Ralph Waldo Emerson

"By the rude bridge that arched the flood,

Their flag to April's breeze unfurled,

Here once the embattled farmers stood,

And fired the shot heard round the world."

People are human, life is challenging, and there are **always distractions which divert attention away** from the complicated and arduous job at hand.

In the months since the cold-blooded murder of George Floyd – our modern day "shot heard round the world" – there have **continued** to be a **series of regular killings** of **Black men** – in some instances **even with their backs to the police or actually running away** and clearly not posing a threat – as a result of an interaction with law enforcement.

And to add to an already grim picture, they have sometimes been accompanied by what appears to be a cover-up by sins of omission, commission, "lost" evidence, and actual lies about evidence key to any investigation, much less the adjudication of justice.

According to Statista, 23% of the 999 civilians fatally shot in 2020 by law enforcement were Black.

Though some find the multicultural protests against racial injustice disturbing, **history tells** us that unfortunately **without cell phone** videotapes and **active social reaction** to the footage, many of the **deaths** would go **unnoticed, unreported**, and have **no chance of investigation**, much less a **day in court**.

Even with ongoing protests which began March 13, 2020, the date of the shooting death of Breonna Taylor, not only one was no one charged with her killing, a very typical blame-the-victim playbook was followed, with active attempts to smear her reputation and all matter of information has been withheld from the family and the public.

History tells us that **without** an **ongoing** and evolving **movement** sufficient enough to keep it **front of mind** in the daily lives of many **and** boosted by **media attention**, initial **surges of public support fade away** quickly **no matter how heinous the triggering catalyst** for change. Indeed, polls indicated that support of actions focused on racial injustice dropped 10% (or much more depending on the group polled) in the 4 short months after George Floyd's murder.

A **fleeting** and **ephemeral** level of **commitment** is not only unfortunate; it **makes it easy for many individuals** to feel very **comfortable all too often** in forcefully **communicating** with unequivocal intention the very loud and **unmistakable message** sent in Louisville for all the world to register – **Black lives most certainly do not matter at all**. And it further encourages and **perpetuates the cycle of racism** and the avoidable and unjustified violence against and death of African Americans.

As community citizens and the beneficiaries of all society has to offer, **corporations have** the **opportunity** (some would say **even the obligation**) to **move boldly, go deep**, and **display leadership** in the workplace to serve as a **powerful force** in the **transformative** and **equity-focused fight** against racial injustice and for genuine diversity and inclusion. **Will** the **opportunity be seized** as a long-term investment in doing the right thing (and, as well documented in many studies, a competitive advantage which contributes mightily to the bottom line) **or** will it **be abandoned and lost in a fog as** the **headlines** are **filled with other images**?

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GRATITUDE: RESILIENCE AND HEALING FOR CLINICIANS DURING A COVID-19 PANDEMIC

"Gratitude is a vaccine, an antitoxin, and an antiseptic."

~ John Henry Jowett

No one is immune to trauma, grief, pain and human suffering brought on by COVID-19, especially physicians, nurses, and other clinicians. The pandemic has ushered in higher levels of stress, anxiety, depression and post-traumatic stress disorder (PTSD) for physicians and nurses who were already experiencing epidemic levels of burnout. The practice of gratitude can serve as a balm to emotional distress as well as a protective bulwark against the potential long-term repercussions of the range of feelings triggered by COVID-19 for those infected by the novel coronavirus and those caring for patients who have been described as among the sickest clinicians have ever seen.

WHAT IS GRATITUDE EXACTLY?

The Latin root of the word gratitude is gratus or gratia — thankful, by favor. It's considered a state of mind, a spontaneous feeling, a strength of the heart. And, as the great Roman philosopher Cicero once said, "Gratitude is not only the greatest of virtues but the parent of all others."

WHAT DOES THE RESEARCH TELL US?

There is an extensive body of research which documents the many potential benefits of gratitude.

Consider the role gratitude has played in other traumatic events.

- A 2018 study in the *International Journal of Social Psychiatry* of New Orleans police officers following Hurricane Katrina indicated that positive factors such as gratitude and social support led to fewer depressive symptoms and helped mitigate post-traumatic stress disorder symptoms.
- Another study in the *Journal of Personality and Social Psychology* found gratitude was a major contributor to resilience after the 9/11 terrorist attacks, holding depressive symptoms "at bay and fueling post-crisis growth."
- A study in the *Journal of Positive Psychology* of Israeli adolescents exposed to missile attacks found gratitude, more than other positive emotions, was linked to a greater appreciation of life and may serve as a protective factor against PTSD symptoms.
- Additionally, a study of healthcare workers during a 2014 MERS-CoV outbreak found special recognition by hospital administration was one of the top five staff satisfiers. This, along with a positive attitude in the workplace, would enhance healthcare workers' experience during future MERS-CoV outbreaks.
- Consistent with positive psychology--the scientific study of strengths that enable individuals and institutions to thrive--gratitude is defined as a strength. Positive psychology, complementary to traditional psychology, is not the absence of pain and suffering. Likewise, practicing gratitude to help process the difficult experiences associated with COVID-19 is not to deny negative events ever happened.

An article in *Mayo Clinic Proceedings* recommends promoting physician well-being and self-care by including resilience training and positive psychology exercises. It also suggests the same strategies be used for nurses and other healthcare professionals. During the course of our work with healthcare executives and their teams, we have found positive psychology coaching and gratitude interventions and practices (exercises) lead to greater job satisfaction and statistically significant improvements in engagement and meaningfulness in their work.

AN URGENCY FOR RESILIENCE

"Life doesn't get easier or more forgiving; we get stronger and more resilient."

~ Steve Maraboli

There is an urgency to build a reserve of resilience (a personal ability) to rebound and recover from the ongoing uncertainty, negativity, and grief associated with the pandemic. Resilience is generally defined as a commitment to finding purpose in negative events, the ability to adapt in the face of

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trauma and adversity, and to bounce back when inevitable setbacks occur. Just as being fearless is not the absence of fear, being resilient is not the absence of trauma and adversity. Rather, it's the ability to work through them and ultimately achieve personal growth.

Resiliency experts categorize resilience in four ways:

1. Emotional resilience – the ability for an individual to manage stressors and emotions in a healthy, positive way;
2. Psychological resilience – sometimes referred to as mental fortitude; the ability to cope and adapt to uncertainty, challenges, and adversity;
3. Physical resilience – the body's ability to adapt and recover from illness, accidents, or other physical demands;
4. Community resilience – a community's ability to recover from adverse situations, e.g., violence, natural disasters, pandemics, and other significant hardships.

One gratitude practice to support resilience in these categories is to "remember the bad." It's a way to reframe and contrast the negative experiences you are currently going through. During this time of crisis, you and those closest to you often have the most to gain by having a grateful perspective on life.

Being grateful is a choice. When people are suffering and the devastating events of COVID-19 occur, a grateful attitude and perspective are hard to achieve. Practicing gratitude heightens awareness of the people and resources that helped us push through past difficult life experiences.

Multiple studies indicate practicing gratitude creates greater resilience, leading to such positive outcomes as:

- Greater mental and emotional well-being;
- Greater resilience to trauma;
- Lower rates of post-traumatic stress disorder (PTSD) and an increased sense of purpose;
- Lower levels of depression and

THE HEALING BENEFITS OF GRATITUDE

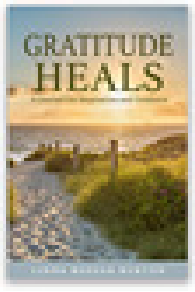
"If you concentrate on finding whatever is good in every situation, you will discover that your life will suddenly be filled with gratitude, a feeling that nurtures the soul."

~ Harold S. Kushner

The most recognized definition of gratitude is the affirmation of goodness and the recognition of goodness outside yourself. Practicing gratitude includes reflecting, expressing, and receiving, and is linked to effective coping skills for managing chronic or acute stress. While experts consider some stress to be a motivating force, life's many challenges due to the pandemic can quickly push the needle into the too-much-stress zone. Gratitude leads to a protective response in the body. Expressing gratitude blocks the release of the stress hormone, cortisol. Studies have shown gratitude stimulates the release of oxytocin, a neurochemical that prevents the release of cortisol.

Reflecting and expressing gratitude activates your parasympathetic nervous system (calming part of the nervous system). In doing so, you're able to achieve many positive health benefits. According to research, having a sustained gratitude practice improves overall health and well-being, including:

- Fosters higher levels of positive emotions;
- Supports greater life satisfaction, vitality, and optimism;
- Enables more hours of sleep;
- Fosters better self-care;
- Strengthens the immune system and lowers blood pressure.



Your gratitude practice can start small by thinking about one thing that brought you comfort or peace during the day. One researcher coined the term "two-minute miracle." Taking just two minutes to write about good events in your life may be enough to begin to gain a greater appreciation of your life, your positive relationships, and your personal strengths.

Another simple but significant reflective technique is to find a quiet moment to reflect on someone or something that brought you comfort or peace. Take a quiet moment to close your eyes, take a deep breath, and reflect. In your reflection, identify a positive emotion you felt in the last 24 hours and why you're grateful.

Practicing gratitude gives you the power to energize, to heal, to bring hope, and to help you cope with these harsh and challenging times.

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OPPORTUNITIES WITHIN "ADAPTIVE RECOVERY"

In engaging with mid-career leaders across academic medicine this year as part of leadership development programs, it is clear to us that the COVID-19 pandemic has both exacerbated long-standing challenges and created new ones. These leaders are carefully chosen to take part in year-long programs at critical points in their careers — usually right before a promotion, or soon after. This is the time for them to build their practice, their lab, or their national network and win a longer-term seat at key tables. However, the events of 2020 have stalled or stopped efforts these leaders have been advancing. Some challenges they have encountered include:

- The clinical mission has edged out research and education in many systems, out of necessity, leaving some clinicians scrambling for time to ensure academic advancement or viability of their research.
- Financial uncertainty looms large. Many organizations have faced furloughs and cuts, and hiring freezes put increasing workloads on the plates of fewer people.
- There's little space for strategic serendipity: remote work limits informal access to senior leaders. There is no longer the possibility of a hallway conversation with the Dean after a meeting. Limited visibility has become a major challenge for people who are vying for executives' attention.
- Faculty and staff are worn thin. The blending of personal and professional spheres and the breakdown of educational and other systems has put additional pressures on caregivers and reduced the ability for people to fully immerse themselves in work.

Intensifying the pressure and complexity is the need to live in limbo, seemingly navigating new degrees of ambiguity with each new month. Juliet Kayyem, a national expert on international security at the Harvard Business School, has described the stages of crisis management during the COVID-19 pandemic and coined the term "adaptive recovery" to describe the long, slow stage we find ourselves in today, with an unknown endpoint post-vaccine. It rightfully suggests we will not find ourselves in a new normal at that point, but in a true new future state. At its best, the unstable status creates a longer-term space for learning from the innovations that have been put in place to address the peak of the crisis and the infrastructure for new ways of working that would have taken years to build. At its worst, adaptive recovery makes necessary multi-year planning feel superfluous and stymies linear processes — like making tenure.

How can mid-career leaders proactively move work forward? What are some key things to help to steer one's approach during adaptive recovery? It might be worth considering "slowing down to speed up" — taking a deliberate and intentional approach to understanding the context and building strong bridges with and to others. Ideas for taking those steps include:

- **Refresh your view** — Disruption of routines has led people to examine their assumptions about values and priorities. This might be an opportunity to take stock of your professional goals and ask yourself how you can best achieve them.
- **Go lateral** — One common experience across the conversations in the mid-career sessions has been feeling isolated this year, and participants shared an aspiration to feel reconnected. There is critical potential to deepen ties to peers, starting with those whom you know best.
- **Bake with the flour you have** — In a time when it is fundamentally more difficult to meet new people, much less form strong ties, it makes sense to invest in development of existing relationships. Those who have laid the groundwork over time have a significant lead.
- **Redraw your mental models** — The organization that you were part of in February 2020 no longer truly exists. Study how the pandemic changed the pace, priorities, and values of leaders and leadership. Chart paths to advance your ideas, secure resources, and broaden your network.

The notion of adaptive recovery from COVID-19 sets the stage for gaining a deeper understanding of the shifts your organization is making and how you can play a part in advancing toward the new future.

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IS IT TIME FOR A NEW NARRATIVE IN HEALTHCARE?

As parents, we use both positive and negative reinforcement and/or punishment to promote our view of ideal behaviors. While literature is split on what works better, I tend to lean towards the positive.

My tendencies have been reinforced by the general narrative around us these days – which in my view has become extreme. In a data-driven, social media-enabled world, we are constantly being driven to look at the world as black or white. The continued polarization is stifling the ability to bring diverse thoughts together - the most important ingredient to innovation and advancement. It feels like all of us are always in the corner, fighting to survive and maintain our identity. The notion of the collective good seems to have escaped from our conscience.

Within healthcare, the crisis seems to be highlighted even more. In the past, we deliberated the merits of public versus private coverage; the rising cost of healthcare; and health inequity. These days, amidst the (hopefully) once-in-a-lifetime pandemic, we are debating the merits of science versus hearsay. We have managed to put the credibility of institutions such as the FDA and CDC on the chopping block, so much so that we are putting more faith in the traditionally maligned biopharma companies' oath of allegiance to science and not politics. We are leaving the world more confused, sicker, and more hopeless every day.

As I think back to my days when I was in charge of driving innovation and transformation at various healthcare companies, I reflect on the narrative that has surrounded the role of technology in healthcare for the last 5+ years. The potential of technology to improve access and quality and reduce the cost of healthcare is evident. However, the narrative has been centered around themes such as business model disruption, lack of willingness to embrace the new, and us versus them. In the process, we have made the healthcare institutions the evil guys, who don't get it and will disappear from planet earth because "they don't get it." The result – digital health remains a utopian concept, despite the narrative that the pandemic has accelerated the adoption of technology by at least a decade.

However, could it be that the incumbent healthcare industry is slow and maybe even deliberate in adopting technology and you and I as consumers of healthcare might have something to do with that?

I became very sick during the summer. I was feeling fatigued and feverish. The first step was to get a COVID test, which was negative. I then reached out to my primary care physician's office and set up an appointment for a virtual visit. After listening to my symptoms, she asked me to come into the office, where the nurse took my vitals and conducted an EKG. As a follow-up, I had to get my bloodwork done, and also make an appointment with a cardiologist that led to a treadmill test. Blood work was normal, and the treadmill test was fine as well. But I was seeing no improvement in my condition. So, it was time for the next virtual visit. My PCP ordered a chest x-ray and more detailed blood work. The chest x-ray was clear, and bloodwork again was non-conclusive. Time for another virtual visit. Now, my PCP prescribed an antibiotic, suspecting an unknown underlying infection. Thankfully, after a few days of antibiotics, I started to feel better and now feel normal. However, I learned a few lessons about the digital model of healthcare:

1. The first virtual visit was fine, but then I hated it. I was suffering, and I wanted a doctor to see me in person. I wanted to know that I was being taken care of. I looked forward to going to the lab for bloodwork. I enjoyed my masked visit to the hospital for the treadmill test – I was looking forward to human interaction. The convenience of the virtual visit was outweighed by my desire for the empathy of an in-person consultation.
2. For every healthcare entity with which I interacted, I was enrolled in a patient portal – a one-stop-shop for me to manage appointments, download my records, pay my bills, and ask questions. After enrolling in the first two, I did not even bother to enroll in the next four. I was getting concerned about using the same user ID and password on multiple portals and the security threat it caused. I waited for the bills to show up in the mail and paid them the old-fashioned way.
3. Despite all the talk of wearables and remote monitoring, my wife monitored my blood pressure at home every day. I kept paper records. I shared pictures of paper records. And I stopped looking at the data being generated by my Oura ring – it was causing me more anxiety than help.

My takeaway? Maybe the incumbent healthcare institutions are not the evil we make them out to be. Maybe they are looking at you and me as their customers and driving their adoption of technology based on our willingness and readiness to embrace it? Maybe the innovators and technology gurus amongst us are failing humankind by adopting an us-versus-them narrative regarding the digitization of healthcare?

Maybe we need to change the narrative to embrace the adoption of technology in healthcare? Rather than creating a narrative around Big Data and AI and how it can "fix the inefficiencies" of the healthcare system, we need to create a narrative on how technology can improve the human aspects of healthcare? Rather than positioning technology as a disruptive force, we focus on how we as humans "want to" embrace it and create a narrative that supports adoption from the human/consumer perspective?

What do you think? Is it time for a new, positive narrative to improve the healthcare experience through technology?

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NOW IT'S PERSONAL: HOW PRECISION BEHAVIORAL TOOLS COULD DRAMATICALLY IMPROVE HEALTHCARE OUTCOMES

70% of annual deaths and 75% of U.S. healthcare expenditures are due to chronic diseases, conditions mostly preventable by employing better nutrition, sleep, exercise habits, and stress management. A paradigm shift is required: how can we create better outcomes while reducing healthcare costs?

Preventive medicine emerges as our only chance against fierce enemies such as obesity, heart disease, and diabetes. Prevention has a unique trait: instead of a one-time intensive treatment, it is the addition of small decisions made on a day-to-day basis, while healthy, that determine long-term health.

The most influential of those decisions is what you eat. For example, the CDC estimates that merely reducing U.S. sodium intake to 2,300 mg a day could save 280,000 to 500,000 lives and nearly $100 billion over the next decade.

PERSONALIZED NUTRITION

What exactly constitutes a 'healthy diet'? Is there a fixed list of foods that would 'solve' our problems? Sadly, that is not the case.

First, many clinical factors determine what is healthy and desirable for whom. For example, while most people are advised to eat more leafy green vegetables, those exact foods could cause pain for a Crohn's disease patient. Another good example is the ketogenic diet ("Keto"). While clinically proven to help epileptic patients, the high protein intake might not benefit someone with kidney disease.

Second, nutrition is not only clinical but also psychological: the last time you had a beer was not because you clinically needed one. Nutrition provides us with some great pleasures, such as the nostalgia of eating your mom's chocolate cake or with useful tools to bond with others, such as having a cup of coffee while having a heart-to-heart conversation. Eating habits are also correlated with other factors: stress, mood, and sleep.

Thus, for personalized nutrition to work, it has to take into account not only clinical factors such as bloodwork, symptoms, etc., but also psychological factors such as personality, environment, motivations, and goals.

Take something as straightforward as a personalized meal plan, a recommended list of meals provided by a nutritionist. Assume our patient is a sales representative, regularly moving between her customers. If the nutritionist disregards behavioral factors, the proposed meal plan may include a 10 am yogurt snack. As our patient is on-the-go from early morning and cannot refrigerate her food, this meal is not feasible, and in real-time, the patient will opt for a snack at the nearest vending machine. Another example is avoiding favorite foods. While it might be optimal to avoid chocolate altogether while trying to lose weight, a good nutritionist may even encourage you to consume it moderately, as deprivation may cause you to give up on the whole process.

In this article, we will share a few behavioral insights gained while working on nutrition personalization.

INSIGHTS ON BEHAVIORAL PERSONALIZATION

Personalized does not mean unique in every dimension.

Many think personalization is like a fingerprint: a unique print for each person, causing concerns that these efforts cannot scale. We found it does not quite work like that.

Personalization happens when you consider multiple factors that characterize and influence behavior, and then split each factor into a few groups. For example, occupation may be divided into many sub-groups such as "on-the-go," "clerical," "manual labor," etc. While a person might not be special by being a salesperson when you look at the entire factor-set, she might be extremely unique: an Indian-American married mother of three, who works as a salesperson in a high-pressure environment, runs marathons, and views food as strictly functional. Insights relevant to that specific group could be seen as extremely personalized.

The same goes for potential solutions. Behavioral solutions to clinical problems are not an endless universe. A few methods to increase water consumption might cover the needs of 95% of the population. The challenge then becomes which solution to assign to whom. The good news? Conducting this process correctly may increase the effectiveness of your solutions dramatically, the same as you would improve sales effectiveness by good segmentation and targeting.

Make data relevant

Most people do not understand nor react well to pure clinical data. Very few care about how much vitamin C they consume or the ferritin

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level in their blood. They do care, however, how that is relevant specifically to their health. To increase compliance, instead of communicating 'what,' start communicating 'why,' even if simplification is required. For example, an indicator of immune resilience with insights on how to improve it is preferred to a dry list of clinical factors that contribute to immune health.

Trial and error

As any general practitioner (GP) knows, improving one's health can be a journey without a clear map of the road ahead. 'A person like you' might be likely to respond to a particular treatment, but upon starting, we find it is not working. This is partly because psychology/biology is complex, and we have yet to map all factors. It is also because of random effects: your boss might be edgy due to her father's illness, causing you increased stress. Moreover, any behavioral scientist will echo that even strong-willed people are likely to have small failures along the way. It is the ability to bounce back that creates long-term success. Trial and error play a significant role in overcoming those issues. Any personalized solution should acknowledge this inherent difficulty and react to it. 'Not working for you? That happens to many. It's not a problem! Let's try something else!'

Combining clinical and behavioral factors for health services personalization is the future. This is a big part of Newt, the personalized nutrition company we founded. We believe companies making clinical solutions not only accurate but also behaviorally adapted will eventually own healthcare. Would you like to join us in a movement that might turn the tide across the globe?

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