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HEALTH CARE MANAGEMENT
ALUMNI ASSOCIATION

THE WHARTON HEALTHCARE QUARTERLY

SPRING 2021, VOLUME 10, NUMBER 2

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EDITOR'S LETTER

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

To learn more about Colette, click here.

2021 has proven to be quite the year already! Much has happened in the U.S. that many around the world could not have imagined and still find surreal. And with the global pandemic still very much a part of the picture, it is likely we are in for a continued roller coaster ride, especially in healthcare.

I am excited to announce a new standing column in the Wharton Healthcare Quarterly!

David Nash, MD, WG'86 and Emeritus Founding Dean of the College of Population Health (the nation's first!) at Jefferson University and often called "the father of population health," has graciously agreed to be the Column Editor of "Behind the Scenes."

In the 2021 inaugural articles, David will be sharing an inside look at some of the companies with whom he has worked across the nation as well as abroad. Inevitably, the discourse will evolve over time, but to start us on this journey he will be highlighting firms whose mission was made more urgent due to the global pandemic. They have risen to the occasion, overcome barriers, and made some enduring contributions to a brighter future for us all.

Dr. Nash will be focused on either pre-existing unmet needs that were exacerbated by the pandemic, new needs triggered by COVID-19, new approaches to key problems, and even innovations directly tied to the global spread of the virus. He will share the struggles that certain entrepreneurs faced and how they fared in 2020 - through resilience, grit, and sheer good luck or lack thereof!

"There are years that ask questions and years that answer."

~Zora Neale Hurston

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

We held our 2nd virtual board meeting of the 2020-2021 WHCMAA fiscal year a few weeks ago over two nights. Being virtual has had its benefits, especially as we have made significant progress to expand the diversity of our board, including geography, which I am proud to say now stretches evenly across the U.S. and all the way to Singapore. But I admit I miss my nostalgic early morning walk up Locust Walk to Colonial Penn Center on board meeting Saturdays. Sitting in the auditorium, coffee in hand, as I did over 15 years ago. Catching up in between sessions with dear alumni colleagues and friends on their amazing professional and personal pursuits. Talking about the issues of the moment with people who share the same passion for healthcare has always brought me true joy, and no one knows it, discusses it, and debates it better than our alumni.

We always have too much to cover in our time together. A working board, our committees make significant progress in between so our board meetings are about the critical discussions and decisions that help us move forward in service to you, our community. This has been true since I started on the board in 2015 when we were deep at work on a fresh and forward-looking strategy for WHCMAA. Having subsequently served as Vice President, when I took on the President role in July 2019, I thought I had a vision for what we should accomplish in my two years. It covered all pillars of our mission to:

- Support the Wharton Healthcare Management Program and its students
- Contribute to the lifelong learning of its membership
- Contribute to the healthcare sector through service, leadership, and education

And we have been living that vision:

- We wanted to be **stewards of connected value** among our graduates. We significantly increased our membership while enhancing our programming and social connection. In doing so, we have been recognized as the largest dues-paying members club in the Wharton community by more than double the network average.
- We wanted to **deepen the connection between the alumni and the students and HCM program**. We have established a committee focused on the program and students now, created an established program of alumni calls to new admits, and generated more alumni participation in recruitment and campus events than ever. The connection of students to the WHCMAA starts before day 1, and students have an even more direct line for their voices and needs to be heard.
- We wanted to **deepen our service to our global alumni and the global health community**. We have strengthened our ties with the Wharton Global Healthcare Venture student

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THE PRESIDENT'S DESK

group, providing double the funding we ever have, supporting them through virtual transitions, and connecting them with alumni resources and speaker sources for global programming. We have an appointed board member living in Singapore who will focus on increasing our voice and community globally.

- We wanted to **advance our content and events** in service to what our alumni and current students told us in recent surveys they needed most. We have enhanced many career development resources, brought in exceptional speakers and programming, and are holding hands across committees to deliver value to you. This content is always available to our members here.

Reflecting on this time, however, I am most proud of the "adaptagility"this board has shown in pivoting to serve you and our mission in this past year – a year that challenged all of us as individuals, as citizens of the world, as leaders, and as committed professionals in healthcare. South African high-performance business leadership speaker Tony Dovale talks about "ADAPTAGILITY capacity," that limitless leaders focus on Adaptagility "to thrive in uncertainty, ever-changing, challenging, complexities, AND opportunities." We not only adapted, but through action, created new opportunities to serve and serve well. Some examples, in this year of pandemic and social movement we:

- Spearheaded collaborations across alumni groups around **critical pandemic issue response** like PPE needs, sourcing, and distribution
- Created a **mini-summit series to educate and discuss critical in-the-moment issues** from social determinants of care to policy and practices to advance healthcare in this time of challenge
- Held sessions and **connections for students and alumni** seeking jobs, needing to network, etc.
- We have **challenged ourselves on diversity and inclusion**, taking a critical look and improving our own processes (e.g., we were already looking at board diversity, but for example, scholarship selection, etc.), amplifying the discussion of core issues, in particular related to our mission of advancing health for all, and are engaging with the university to be active in driving change
- **Increased our social connectivity** with new channel options, **enhanced content curation**, and focus on socially engaging and connecting more alumni than ever
- **We listened** and are focused in **career development** to what many of our members needed most – job boards, career resources, skills training, etc.
- **Created more virtual social moments to bring us together** – because being together matters more than ever

I want to express my gratitude to our 21 board members, who, while navigating their own personal and professional challenges in this intense time, showed resilience, adaptability, and sustained commitment to make this possible. I have had my share of "adaptigility" moments during my 6 years on the board - I have taken on 3 new roles in an intense consulting career, had 2 children, and remarried. But this last year challenged us all in unique and meaningful ways. All I can say is you inspire me.

My term as President will end July 1st, and our Vice President, Heather Aspras (WG'08), will take the mantle. She is the former head of the Philadelphia alumni chapter, and a dear colleague and friend. I have no doubt she and the Board will push our mission further with excellence.

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continued

THE PRESIDENT'S DESK

Because in spite of all we do, we are not done. Our endless commitment to our mission means we will never be. So keep an eye out for our upcoming events and initiatives. We held our Career Development Webinar with Simmi Singh on how to be your best self in a post-pandemic world on April 22nd.

And keep communicating with us. We can't wait to dig into your thought leadership, research, experiences, and ideas:

LinkedIn: Wharton Healthcare Management Alumni Association
LinkedIn public channel: https://www.linkedin.com/company/whcmaa/
Twitter: @WhartonHCMAA
Facebook: Wharton Health Care Management Alumni Association
Wharton Knowledge Network: whartonhealthcareopen@googlegroups.com

I close this, my last letter to you as President of WHCMAA, with gratitude for the opportunity to serve you. I send my thoughts and wishes that you and your families remain healthy and safe, and that you continue in passion and success. I look forward to the next time we meet.

Kind regards,

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

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ALUMNI NEWS

Jeff Voigt, WG'85
Recently published the following article: Voigt JD, Seigerman D, Lutsky K, Beredjiklian P, Leinberry C. Comparison of the costs of reusable versus disposable equipment for endoscopic carpal tunnel release procedures using activity-based costing analysis. *Journal of Hand Surgery.* 2020; https://doi.org/10.1016/j.jhsa.2020.08.019

Contact Jeff at:
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Learn more.

Vernon Harten-Ash MD, WG'94
Great pleasure to announce that I will be assisting the international Tall Ships Race in the Baltic, Europe in June 2021 with crew safety and developing fleet resilience against Covid-19. Sixty or more Tall Ships are expected with crews from around the world including the US, UK, Russia, and many more, organized by Sail Training International. Total crew numbers are expected to be in the region of 4 – 5,000 on board all the vessels. Spectator numbers in normal times may reach 250,000 – 600,000 at each port. If you are planning to be on board a vessel, then please contact me. Additionally, if you see corporate benefit in supporting a US or international charity developing young people via the medium of the sea, please reach out; it would be great to hear from you.

Contact Vernon at:
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Learn more.

Christine (Boron) Griffin, WG'95
I am pleased to announce the launch of Change Logic's Healthcare Practice. Change Logic is a strategic innovation advisor which helps clients innovate and build new businesses in the complex ecosystems of healthcare and life sciences. We help senior teams identify new areas for growth beyond their core, use business experiments to assess the viability of new business models, and convert validated experiments into scalable businesses. In healthcare, we work primarily with healthcare technology, health insurance, medical device, and biotechnology companies that are seeking to bring new solutions and business models to market. Learn more at https://changelogic.com/healthcare-life-sciences/.

We are always looking for consultants and analysts to join our team. Contact us through our website or follow us at Linkedin.com/company/change-logic.com.

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Learn more.

Eric Davis, WG 96
After leading the Product Management & Commercialization function in Global Marketing for Cochlear in Australia for the last 4 years, Eric Davis and his family will be moving back to the USA in 2021. The long-run inspiration for this move was to be closer to aging parents, but the immediate impetus was to rejoin Abbott as VP of Marketing for the Rapid Diagnostics Infectious Diseases division which has been in the news a lot recently for its $15/15-minute rapid COVID test. Eric will be moving to Chicagoland in mid-February, and his wife and kids will follow in July, just in time for kids to return to normal classroom schooling in August/September.

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ALUMNI NEWS

Lan Kang, WG'02
After spending one year as a DCI (Distinguished Careers Institute) Fellow at Stanford, Lan Kang returned to Shanghai in Oct 2020, and joined CBC Group, one of the largest and most active healthcare-dedicated investment firms in Asia focused on platform-building and buyout opportunities across three core areas within the healthcare sector: pharmaceutical and biotech, medtech, and healthcare services. Lan is currently responsible for all of the portfolio management at CBC.

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Learn more.

Sam Holliday, WG'09
Oshi Health, which recently launched its virtual clinic for gastrointestinal conditions and is led by CEO Sam Holliday (WHG '09, SEAS '01), was selected out of hundreds of applicants as a winner of the UCSF Rosenman Institute ADAPT Program. Oshi Health was also selected by UnitedHealth Group to roll out its virtual clinic in a proof-of-concept study that will launch in early 2021. The company has redesigned GI care around the needs of patients with a telehealth-first and value-based approach. Each patient works with an integrated, GI-specialized care team that determines the root cause of symptoms and develops a personalized, whole-person care plan that includes evidence-based medication, dietary interventions, and stress/anxiety management. Oshi Health works with employers and health plans to improve quality of life, workplace productivity, and outcomes for their employees or members with diagnosed GI conditions or those experiencing chronic GI symptoms while reducing total cost of care.

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Learn more.

Austin Dixon, WG'13
I am a faculty attending physician in the Duke University Health System in the Department of Radiology division of neuroradiology as of Aug. 2020. I am also serving as a lead associate with the Duke Angel Network, an angel investing network of Duke-affiliated investors investing in Duke-affiliated start-ups.

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Greg Wallingford, WG'19
Greg welcomed a beautiful baby girl, Zoe Rose Wallingford, into his family on the day after the pandemic was declared! Greg moved to Austin to pursue a fellowship in palliative care and will join Dell Medical School at UT Austin as faculty after graduation in July. His academic interests are leadership development and clinician well-being in medicine.

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THIS MONTH'S PHILOSPHER:
DEEPA SHAH, WG'16

To learn more about Deepa, click here.

THE PHILOSOPHER'S CORNER

LIFE LESSONS

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

- stopped worrying about what comes next; Trusted enough in myself to know that I didn't need to be anywhere else or doing anything else than what I was doing in the moment.

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

- De-prioritized self-care and indoor hobbies when time felt limited. I am especially learning this during the global COVID-19 pandemic when it is all too easy to not take a mental or physical break from doing office work or housework.

FAVORITE QUOTES

1. "Remember that 'No.' is a complete sentence."
   ~ I am not sure who originally said this, but I recently heard it from Jane Fonda during a webinar.
2. "When we deny our stories, they define us. When we own our stories, we get to write the ending."
   ~ Brené Brown, of course.
3. "Live on the precipice of a smile."
   ~ My reflections today are focused on presence, my daily struggle. I can't think of a better vehicle to presence than humor.

RECOMMENDED READING

1. *Thinking, Fast and Slow* by Daniel Kahneman
2. *The Fearless Organization* by Amy C. Edmondson
3. *Who Moved My Cheese?* by Spencer Johnson, M.D.

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AFFIDAVIT: HEALTHCARE AND THE LAW

COVID-19 VACCINATION: COMING TO A WORKPLACE NEAR YOU?

Nearly a year after the coronavirus pandemic exploded, the beginning of the end may finally be within sight. Novel vaccines have shown tremendous promise, and the United States Food and Drug Administration (FDA) granted Emergency Use Authorizations (EUAs) to three COVID vaccines — one developed by a collaboration between Pfizer and BioNTech SE and one developed by Moderna — in late 2020 and another developed by Johnson & Johnson in February of this year.

While the initial phases of vaccination have begun for certain groups, including essential workers, seniors, and those with underlying health conditions, widespread vaccination may not begin in earnest until spring or early summer. Nonetheless, businesses should start planning now for how to handle critical issues related to COVID-19 vaccination. Although state and local authorities have been primarily responsible for the early distribution and administration of the COVID-19 vaccines, availability of the COVID-19 vaccine may soon open up to other distribution channels such as the workplace. As businesses prepare for more widespread distribution, they must consider several key issues, including:

- Education and messaging
- Logistics
- Consents
- Mandates

EDUCATION AND MESSAGING

While the vast majority of Americans will have to get vaccinated before life returns to some semblance of normal, many say they are unlikely to do so. Recent surveys have shown more than a third of Americans are unlikely to get vaccinated, including many fearful about the safety of vaccines developed so quickly.[1] The vaccines are both effective and safe, and educating employees about the vaccines will be critical.[2] Businesses must also consider the significant disparities in vaccine acceptance along demographic lines including age, race and ethnicity, education, political party, and family income, in developing effective messaging for their workforces.

LOGISTICS

At the most basic level, businesses need to determine how their workforce will receive COVID-19 vaccines, whether through public means or employer-based clinics. Businesses sponsoring on-site clinics need to plan how to obtain the vaccines; where and how to hold the clinics; how to implement infection control procedures; who will administer the vaccines; and how to ensure everyone receives a second vaccine dose.[3] Businesses should also plan for side effects by possibly staggering vaccination to avoid staff shortages; preparing for post-vaccination absences; and implementing precautions to ensure that employees experiencing side effects do not have COVID-19, contracted before they gained immunity. Finally, businesses should maintain precautions even after their workforces have been vaccinated, especially in light of the CDC's and OSHA's recommendations that mask wearing and social distancing continue until more is known about whether the vaccines actually prevent asymptomatic infections or silent transmission of COVID-19.

CONSENTS

Before mass vaccination efforts begin, businesses will need to obtain informed consent from their workforces. Signed informed consent forms provide evidence that an individual received information about the potential risks and benefits of vaccination, had the opportunity to ask and obtain answers to any questions they had, and freely chose to receive the vaccine. While many vaccine providers have created intake and consent forms, businesses should consider developing their own forms as well. They might also consider asking employees who decline vaccination to sign consent forms outlining the risks of that decision and the restrictions on activity and additional precautions they might be required to take. Employers should add copies of all consent forms to their employees' health-related records, which by law must be maintained separately from their general employment files.

Disclaimer: This Article has been prepared and published for informational purposes only and is not offered, nor should be construed, as legal advice.

MANDATES

A major question facing employers is whether to mandate vaccination for workforce members once sufficient vaccine supplies are available. Mandates raise several employment law issues, many of which were addressed by the Equal Employment Opportunity Commission (EEOC) in its December 16, 2020 COVID-19 guidance.[4] First, employers administering the vaccine or who have contracted somebody to administer on their behalf should be careful about pre-vaccination screening questions, which might implicate the Americans with Disabilities Act (ADA) and the Genetic Information Nondiscrimination Act of 2008. Second, companies must prepare to respond to employee requests for medical exemptions under the ADA and religious exemptions under Title VII of the Civil Rights Act. In addition to following EEOC guidance on handling such issues, companies should be careful to apply any mandates and exemptions fairly, consistently, and in a non-discriminatory manner. They should also be aware of state anti-discrimination restrictions. Finally, businesses with unionized workforces may need to bargain with unions in accordance with existing collective bargaining agreements.

LIABILITY

Employers requiring or offering vaccines could potentially face litigation related to informed consent, employment discrimination, or even negligence if an employer's failure to adequately encourage vaccination leads to a COVID-19 outbreak in the workplace. While proposed state and federal bills providing liability waivers for employers have met with strong resistance, it is possible employers who run vaccination clinics might enjoy limited protection under the federal Public Readiness and Preparedness Act (PREP Act) [5] from state law-based lawsuits related to their vaccination efforts. Whether and to what extent such employers would be eligible for such immunity in the context of COVID-19 vaccination has yet to be tested. Finally, employers should keep abreast of the issuance and/or expiration of any state and federal liability waivers and court decisions.

CONCLUSION

Much remains unclear as to precisely how U.S. vaccination efforts will ultimately unfold. As with all matters pandemic-related, employer stakeholders must continue to follow the constantly changing information, plans, requirements, and recommendations from federal, state, and local authorities.

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REFERENCES

1. Pew Research Center, "Intent to Get a COVID-19 Vaccine Rises to 60% as Confidence in Research and Development Process Increases," Dec. 3, 2020, https://www.pewresearch.org/science/wp-content/uploads/sites/16/2020/12/PS_2020.12.03_covid19-vaccine-intent_REPORT.pdf; National Poll on Healthy Aging, University of Michigan, "Older Adults' Perspectives on a COVID-19 Vaccine," Nov. 2020, https://www.healthyagingpoll.org/report/older-adults-perspectives-covid-19-vaccine.

2. Prior to receiving FDA authorization, the vaccines underwent rigorous testing and clinical trials to demonstrate both efficacy *and* safety. Indeed, as the CDC has explained, the new COVID-19 vaccines are "being held to the **same safety standards** as all vaccines." CDC COVID-19 Response Vaccine Task Force, "COVID-19 Vaccine Basics: What Healthcare Personnel Need to Know," Dec. 2020, https://www.cdc.gov/vaccines/covid-19/downloads/What-HCP-NeedToKnow_508.pdf (emphasis in original); *see also* Mayo Clinic, "COVID-19 vaccines: Get the facts," Dec. 17, 2020, https://www.mayoclinic.org/diseases-conditions/coronavirus/in-depth/coronavirus-vaccine/art-20484859.

3. The CDC website offers some guidance for setting up a workplace vaccination site at: https://www.cdc.gov/coronavirus/2019-ncov/vaccines/recommendations/essentialworker/workplace-vaccination-program.html.

4. EEOC, "What You Should Know About COVID 19 and the ADA, the Rehabilitation Act, and Other EEO Laws," last updated Dec. 16, 2020, https://www.eeoc.gov/wysk/what-you-should-know-about-covid-19-and-ada-rehabilitation-act-and-other-eeo-laws.

5. 42 U.S.C. 247d-6d; *see also* HHS, "Declaration Under the Public Readiness and Emergency Preparedness Act for Medical Countermeasures Against COVID-19," 85 Fed. Reg. 15198 (March 17, 2020); Office of the Assistant Secretary for Preparedness and Response, HHS, "Public Readiness and Emergency Preparedness Act," last reviewed Feb. 8, 2021, https://www.phe.gov/Preparedness/legal/prepact/Pages/default.aspx (opinion letters and guidance).

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NOT A FREUDIAN SLIP: ONE ANTIDOTE, ONCE A DAY

If there was one thing you could do daily that could have a tremendous impact on your health, your mood, your relationships, your work, and your overall quality of life, even during these very unprecedented, difficult times, would you do it? What if this simple act didn't cost any money or require a prescription or any special training or skillset to do? Sound too good to be true? Well, thankfully it is not. The act of kindness, "a type of behavior marked by acts of generosity, consideration, or concern for others without having an expectation of praise or reward" [1] has scientific evidence proving its positive impact on health and happiness. Kindness isn't something new or innovative. And furthermore, anyone can be kind. It doesn't matter how old you are, your race, your gender, your income, or your occupation. Could kindness be one small antidote we could all give and receive as we move ahead?

2020 was hard. And to many, that is an understatement. No matter your lifestyle, income, gender, race, political affiliation or zip code, the global pandemic, civil unrest, natural disasters [fires, hurricanes, tornados, earthquakes], recession, and political divide have hit every single American, some in very personal, hard ways. Between the nationwide lockdown cancelling life events ranging from weddings, funerals, graduations, and vacations to completely cancelling school, sports, concerts, summer Olympics, Halloween, and many other traditional events, 2020 will certainly go down in history as having an impact on life more significant than most of us have ever experienced.

The rollercoaster of emotions from fear to frustration that we have all felt during this period is common to all. To help people build resilience, there have been many articles published about how to handle stress during these unprecedented times. Articles on how to manage depression and isolation with tips on how to improve virtual relationships and connect with your support network to reduce loneliness. Articles on how to create balance in our blended work from home/remote school structure and recommendations on how to help maintain focus and reduce burnout. How to find peace during such uncertainty as virtually every daily routine that we've come accustomed to has been impacted. There are meaningful insights and good tips in those messages, many of which I practice myself. Some techniques may work for you, whereas different techniques may work for others. But one thing I have seen work for all, time and time again, is kindness. Kindness to yourself and kindness to others.

THE POWER OF KINDNESS: YOUR HEALTH AND LIFE

Being kind, to yourself and to others, has been proven to have positive benefits to your health. Dr. Waguih William Ishak from Cedars-Sinai has concluded that performing random acts of kindness releases the hormone dopamine, which signals a euphoric feeling to the brain. And according to Dr. David Hamilton, "committing acts of kindness lowers blood pressure." [2] One study demonstrated that after just one month of performing an ack of kindness each day, people who were highly anxious had a significant increase in relationship satisfaction and positive moods and a decrease in social anxiety. [3]

Further details on how kindness can increase energy, happiness, love, pleasure, and lifespan while also decreasing blood pressure, pain, stress, anxiety, and depression can be found in this fact sheet.

To gain the benefits of kindness, it starts with yourself. Do you treat yourself kindly? Do you speak gently and kindly to yourself and take good care of yourself? Turn down that inner critic or worry-wart in your head, the one telling you unkind messages or the one putting you through an endless game of "what if…". As you do, you will begin to notice that you feel better and with that internal frustration or turmoil turned down, its simply easier to be kind to others.

THE POWER OF KINDNESS: A RIPPLE EFFECT

We have all heard the statement, "Kindness is contagious." There is a large body of evidence that reveals the more someone participates in kindness, whether they perform a kind act, receive kindness from another, or simply witness kindness, the happier they are. What's even more interesting is researchers discovered that while being kind to someone you know or to yourself makes a positive impact, offering a kind gesture to even a stranger has an equally positive effect on happiness. [4]

With the stay-at-home orders and social restrictions implemented, and with many people working from a virtual location, the office watercooler talk and in-person meetings have been eliminated or reduced.

This new environment makes it harder to express kindness in a digital, Zoomified format. Interpersonal gestures and niceties have seemly been pushed aside with the loss of or limited in-person social interactions. The safety measures of wearing a mask and keeping a six-foot distance are a kind gesture and helpful in reducing the spread of the virus, but they are having a negative impact on our ability to visually demonstrate a connection with others and offer warm, kind affection. Masks cover our ability to share a smile with a friend or a stranger you may pass on the street. Distancing has eliminated the handshake or hug greeting. Therefore, we will need to think outside the box on ways to offer affection to people and practice kindness.

For those at home with a partner, being together 24-7 can be very hard. The personal space offered by work or other social events provides a healthy break. For your own mood and for more harmony in your partnership, practice being kind. And since we know that more kindness leads to more kindness, you can work to strengthen that muscle with daily practice. "Research has shown that kindness is the most important predictor of satisfaction and stability in a marriage." [5]

During these unpredictable and challenging times, actively practice kindness and assume the positive. I don't mean allow someone to be abusive or disrespectful. But assuming the positive – or assuming the reason a co-worker was particularly sharp during a meeting or a server was rude or even worse the person standing behind you in line was making nasty comments, could be because of their own turmoil they are dealing with. Or it could be because they are simply not that kind, yet. Maybe they haven't had people in their life who are really that kind. Whatever the case, it really doesn't matter, because your offering a kind gesture to that person, even when you feel they might not even deserve it, will likely, in most all cases, result in a positive outcome, for you and the person.

CHOOSE KINDNESS

We must try harder. And the thing is, its not even hard to be kind. I challenge you to share an act of kindness, every day. And as you do, notice the impact each simple gesture can have on your mood, your health, your relationships, and your outlook on the world around you. Need some ideas? The Random Acts of Kindness Foundation, a small nonprofit that invests resources into making kindness the norm, has a website devoted to kindness ideas as well as many other school and workplace resources https://www.randomactsofkindness.org/kindness-ideas.

No matter what's happening in the world, no matter how dire our financial circumstances may be, no matter how stressed out we may be because of COVID or natural disasters, or how different we each may think about the racial upheaval or how opposite our political views...we can all be kind.

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NOT A FREUDIAN SLIP: ONE ANTIDOTE, ONCE A DAY

RESOURCES

https://ripplekindness.org/
School curriculum, community projects, and resources

https://www.randomactsofkindness.org/get-inspired
A foundation that provides resources to inspire you to practice kindness

https://keepitkind2020.com/
A nonpartisan grassroots Kindness campaign to encourage everyone to "Keep It Kind"

https://kindness.org/
A nonprofit with a bold hypothesis: Kindness is the catalyst in solving the world's biggest challenges

https://thegreatkindnesschallenge.com/apps
An interactive app to help you create a culture of kindness [School and family editions]

https://www.envisionkindness.org/science-of-kindness/
Learn the science behind kindness and its role in your life

https://www.kindness-school.org/
Foundation provides activities, books and resources

https://www.doinggoodtogether.org/summer-of-kindness-download
Summer of kindness = inspire, explore and engage

https://kindness1billion.org/
An initiative created to improve school climates, promote character and rally the community for greater civility.

https://www.thekindnesspandemic.org/about-kindness.html#/
Resources and support

https://www.autismspeaks.org/kindness/spreadkindness
Spread Kindness and take the kindness challenge

ps://leadasap.ysa.org/kindnessrising/
https://befearlessbekind.hasbro.com/en-us

The Kindness Rising campaign inspires, activates, and supports youth to stand up for others, be inclusive, and make a difference through kind acts and service projects.

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DOWNLOADING SUCCESS: LEVERAGING EMPATHY - A GAME CHANGER FOR THESE DYNAMIC TIMES

At this time fraught with myriad challenges and endless uncertainties, we've all been operating under exponential stress for an extended period of time. Both personally and professionally, we find ourselves adjusting as we go and facing an array of emotional ups and downs that seem to have no end in sight.

The overwhelming confluence of issues produces high to extreme levels of emotional and physical stress that deplete our internal resources. This leaves us feeling fatigued and anxious precisely when we need energy and enthusiasm to maintain endurance and develop mental resilience. For leaders, the highest priority during times like these is to be facile, skilled, and courageous enough to address and support colleagues who may be struggling on a number of fronts.

When tensions are high, people do not behave or perform at their best. Leaders need to create the necessary time, space, and opportunities for team members to interact in the most productive manner during this "new normal." But safe conversations don't come easy. They need to be encouraged and managed. Therefore, leaders must extend grace and empathy to ensure their teams have appropriate outlets and opportunities to express the concerns, fears, and anxieties they may be experiencing.

HOW TO IDENTIFY STRESSOR REACTIONS

Stressors trigger changes in the human brain. Normally, the limbic brain interprets crisis from emotional stress, such as an angry remark from a close friend, similarly to the way it experiences being chased by a predator. It's a survival response that served our ancient ancestors well.

But during a crisis situation, a neurological shift activates the amygdala or primitive brain. This response often reveals personality traits that do not show up in someone's typical, everyday state. This in turn, negatively impacts interpersonal communication.

When faced with fear, anxiety, and stress, the primitive brain employs two essential survival tactics. The first is to assess the situation. How serious is the threat? And second, determine the appropriate physical reaction: flight, fight, or freeze. These reactions are effective responses that ensured the survival of the human species over millennia. However, in modern society they often uncover personality traits that are not productive in team environments like the workplace.

Here are ways that flight, fight, and freeze behaviors might present in today's modern workplace:

FIGHT

- Assign blame
- Irritable and agitated
- Amped up

FLIGHT

- Withdrawn
- Rationalize and justify
- Avoidance and escape

FREEZE

- Numb
- Aloof and insensitive
- Stunned and inactive

Understanding these reactions and identifying how they manifest in yourself and others is imperative for leading through chaotic times. Leaders must be able to create calm and demonstrate vulnerability while increasing opportunities for safe, effective communication.

CREATING A SAFE SPACE TO RECHARGE

For the well-being of an organization whose workforce is psychologically compromised and fatigued by all of the stressors, anxieties, and disruptions, it is vital that its leaders continually recognize the psychological ramifications for the organization to move through and beyond crises. Leaders need to build resilience within themselves, their teams, and their organizations in order to persevere through and beyond crises.

To build resilience leaders need to engage in four key behaviors:

1. **Establish Psychological Safety** – create an environment that values candor, vulnerability, and authenticity in relationships, meetings, and across parts of the organization. To accomplish this goal, leaders must continually take inventory of their own behaviors, body language, tone, and mood. Approachability is critical. Measure your effectiveness by inviting feedback from trusted advisors.
2. **Demonstrate Empathy** – explicitly engage in conversations with team members that provide a platform to discuss their concerns and challenges and take the opportunity to validate and confirm their emotions, reactions, and situations.
3. **Acknowledge Emotions** – the identification of emotions that people are experiencing is vital for recovery. You have to name it to tame it. If you ignore emotions, they grow.

   It's increasingly important to appreciate that our colleagues may be facing many issues at once (e.g., physical and mental health concerns; financial stress; e-learning with children; caring for aging parents; racism; social unrest) and to share in our common humanity.
4. **Increase Connection** – enhancing community and connectivity, especially in remote or mixed office environments, will allow organizations to build a foundation for resilience. The transparent and vulnerable connections that people must make during the recovery is critical.

   Speak up and make connections. Share your own concerns and fears, as awkward and uncomfortable as that may be. As Poet Laureate Amanda Gorman so eloquently recited at this year's Presidential Inauguration, "*We've learned that quiet isn't always peace*."

Traditionally, we've been able to successfully compartmentalize our lives, keeping personal issues at home and out of the workplace. But the pandemic has presented a significant disruption in our lives as so many of us have brought our workplace home.

Listen, acknowledge, validate, and, most importantly, remember that empathy is perhaps the most powerful tool a leader has during these dynamic times. The importance of establishing and nurturing a psychologically safe organizational and team culture is crucial now more than ever before.

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MIND THE GAP: BLACK WOMEN'S HEALTH MATTERS

Black women's health matters, yes. This statement of fact is not to say that everyone's health does not matter. However, I contend that Black Women's health needs a great deal more attention at this time. This is not new; the COVID-19 crisis only exposed the myriad health disparities associated with Black people who have a disproportionately greater chance of dying of complications associated with the disease compared to the white population. Recognizing that Black women's health is in need of attention is the first step. I will outline some of the immediate challenges and offer recommendations to work towards attaining improved health for Black women.

Specifically, there are four major health areas of concern:

1. heart disease
2. diabetes
3. obesity
4. maternal health

50,000 Black women die annually of heart disease (American Heart Association, 2021). In 2017 they had a 60% greater incidence of hypertension compared to their non-Hispanic white counterparts. (Office of Minority Health, 2020) In the case of diabetes, non-Hispanic Black women have a 56% higher prevalence of diabetes (National Health Interview Survey, 2020, p.4), and those who develop gestational diabetes have a 63% greater chance of developing type 2 diabetes in the future. (Bower, 2019, p.1)

Both heart disease and diabetes are often associated with obesity. In spite of the potentially successful management of diabetes and/or cardiovascular disease, weight loss is imperative to gaining optimal health. Four in five Black women are overweight or obese. In 2018, Black women were 50% more likely to be obese compared to non-Hispanic white women. (OMH, 2020)

Most disconcerting are maternal health and pregnancy outcomes; mortality and comorbidities significantly impact young women and their families despite often being preventable. Black women are three to four times more likely to die from childbirth than non-Hispanic white women. (CDC, 2019) These disparities are not solely a function of being uninsured or of a lower socioeconomic status, as they also impact those who are affluent, highly educated, and have extensive health insurance coverage.

When a healthcare provider examines a Black woman who is overweight and hypertensive, would certain assumptions be made or biases come into play when assessing her lifestyle? Would that influence the quality of her treatment? When Black women's voices are not heard, distrust and poor medical care, even death, can result.

This outcome occurred in the cases of Kira Johnson and Shalon Irving. Both were affluent, educated, and had private insurance. However, following their pregnancies, symptoms ensued, and requests for care were ignored; the results were fatal. Another example was Serena Williams' pregnancy. With a history of blood clots, she complained of shortness of breath and it was dismissed. Thankfully, she persisted and ultimately was treated appropriately. (Roeder, 2019)

These cases illustrate how health disparities are also influenced by race/ethnicity, which is a **social** construct, and can inform how one is viewed, perceived, and often determines the quality of medical care one receives. This reality is often due to the biases, beliefs, and myths that some healthcare professionals have continued to believe from years past as well as those alive and well in the present. And in some instances, this perspective reflects outright racism.

As with the population as a whole, Black women's health is affected by zip code, which may impact safety and physical activity options, food choices and access to healthy options, salary, type of job, family, friends, and colleagues and the nature of those relationships, as well as health insurance status and the degree of coverage. All play an important role and must be addressed in

working towards solutions to improve Black women's health.

As we examine these race and gender healthcare disparities in 2021, in a developed nation like the U.S., one may wonder how such health disparities could exist. My assertion is that it lies in the intersectionality of gender and race. Crenshaw described intersectionality as, "...a sound basis for understanding multiple contexts of Black women's lives as racialized and gendered subjects" (Serrant, 2020, p. 4) Blout further (2019) suggests, "Race is not a risk factor. It is the lived experience of being a black woman in American society that is the risk factor." (Roeder, p. 26)

Living in the United States as a Black woman comes with significant challenges, and affluence, position, or education do not ensure smooth healthcare system navigation nor quality, equitable care. It is imperative that Black women in particular exercise their agency in pushing the system to deliver equitable health outcomes.

Here are 6 actionable recommendations that may help Black women move closer to optimal health and well-being (all of which would mean a better experience and better care for women as a whole):

1. Coordinate efforts to match Black women with healthcare professionals who are culturally sensitive to their unique challenges.
2. Increase the number of programs that encourage Black women and other underrepresented and marginalized populations to prepare to study medicine and other allied science careers. Data demonstrate health outcomes are often improved when patients are treated by those of the same race or ethnic group. (Huerto and Lindo, 2020). This finding may particularly be true if a patient has such a preference relative to those providing care.
3. Build upon the success of the telehealth model to help patients manage chronic conditions. When the necessary technology support is available and the practitioner is skilled in delivering care virtually, telehealth can provide greater access, lower costs to the patient (e.g., less time off from work, for example), and offer greater opportunities to coach for maintenance, diet modification, and exercise.
4. Increase funding for faith-based programs such as US WellCare (2019) using a multidisciplinary approach with weight reduction and wellness (vs. illness) as its focus.
5. Provide new mothers with symptom concerns the steps they can take to help ensure that appropriate treatment algorithms are followed. Home monitoring devices can be leveraged to address problems in high-risk pregnancies and the post-partum period.
6. Recognizing there is a sordid history of abuse, disrespect, and abhorrent treatment of Black women by healthcare professionals and scientists, recruiting diverse populations in clinical trials is critical to the development of evidence-based guidelines and treatment protocols. Further, Brawley (2020) suggests that, because of IRB and other requirements for eventual approval for use in patients, inclusion may mean better care is received, at least during the trial.

COVID-19 has forced us to face the clear opportunity before us to focus on improving the health of Black women. Perhaps with genuine commitment by healthcare stakeholders, equitable government funding, true patient-centricity and community engagement, and progressive philanthropy, the recommendations noted above can be implemented.

Black women must do their part. They should commit to seek out culturally sensitive healthcare professionals, make their care expectations clear, learn as much as possible regarding preventive care and any chronic conditions they may have, and embrace support resources such as health coaches. Spiritual leaders, family, and friends are welcome.

One thing is clear - extra attention is needed. Progress can be made when we all recognize the health and well-being of Black women matter, and **matter just as much** as that of others who have benefited from the access and quality of care so often denied or not otherwise available.

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CYBERVITALS: STOP BLAMING THE END-USER!

Unfortunately, blame is pervasive in healthcare and cybersecurity. It should therefore be unsurprising that a common retort in healthcare cybersecurity is "people are the weakest link." It's true in one sense - healthcare leads other industries with 31% of cybersecurity-related breaches being attributed to human error. However, the question must be asked, "If we blame patients for not adhering to treatment plans, and we blame people for cybersecurity problems - maybe we've built systems that don't work properly?"

Now, we are all human, and we all make mistakes. But given how often people fall victims when they're in the healthcare system, it seems a bit of self-reflection would be beneficial.

WHY IS HEALTHCARE A TARGET?

Clinical care is the top priority for all who work in healthcare. This means, as much as possible, we don't want to introduce barriers to the delivery of care. How does that impact cybersecurity? If a healthcare delivery organization (HDO) wants to keep things as they are, that may mean a reluctance to update software. Delaying or not updating software on a device can eventually mean the software is outdated and potentially vulnerable to cyberattack.

But why target a medical device? The idea of a blood pressure or ECG reading doesn't exactly bring dollar signs to mind.

SYSTEM PENETRATION

A hacker can potentially exploit a device's vulnerability as an entrance point into a HDO network to then deploy a ransomware campaign. This will compromise an HDO's network, inhibiting its ability to update electronic health records and use devices that rely on connectivity for making calculations (such as devices used in radiation oncology and sophisticated surgical robots).

While this may seem like a delay in the delivery of elective procedures, it can also result in a re-routing of patients who have emergent needs. Research shows a 13.3% higher mortality rate for patients experiencing an acute myocardial infarction or cardiac arrest who experienced a delay in care of only four minutes, which was attributed to a marathon taking place that day. When applying this finding to a delay in care due to a network takeover by hackers, one can imagine an increase in mortality rates far greater than 13.3%.

FINANCES

Furthermore, HDOs regularly obtain patient social security numbers (SSN) or insurance numbers, which can be relevant for billing purposes, or in an attempt to share data between HDO systems. This same data can be used by a malicious actor to commit requests for loans, prescriptions or insurance claims, open bank accounts, perform online transactions, and even take out a mortgage, file tax returns, or claim rebates. Imagine the SSNs from a pediatrician's office being stolen and sold with the resulting fraudulent activity going undetected for a prolonged period (likely until the minor reaches adulthood), or the SSN of a deceased person that can be used with zero concern for active monitoring by the individual.

WHY DOESN'T THE CURRENT STRATEGY WORK?

First and foremost, I want to make it clear that I believe user training has a place and purpose. We cannot let our people proceed in a connected world without guidance and support. However, if I can't train an algorithm to identify a potentially malicious email, is it really fair for me to expect an employee to be able to detect that malicious email?

Let's take a look at an industry often perceived as having great cybersecurity practices: financial services. Financial services companies, quite intuitively, have a lot to lose when a hacker succeeds. As seen in the table below, financial services have nearly double the number of incidents as healthcare and also a larger budget per employee in training. However, the average credit card user has received a call prior to a fraudulent transaction being processed, as something looked suspect and a deviation from a buying pattern. Is this how financial services keeps the average cost of a breach lower than healthcare? I hypothesize the ability to be proactive in detecting potential issues directly impacts the monetary commitment to cybersecurity in the industry.

So why didn't this same pattern emerge in healthcare? Perhaps it's because our systems were not initially designed to be connected. Devices started out as analog, then as software 'became a thing,' the potential for improved clinical experiences emerged. Suddenly a modicum of data standardization meant patient health information could be more easily shared across the value chain. Rapidly adopting the USB, then the internet, to Bluetooth and now mobile/app-based care, the adoption of connectivity has been quick. The focus at every step, and justifiably so, was on enhancing the patient care experience. But with each new point of connectivity, who in the value chain took on the burden of increased connectivity and the potential cybersecurity vulnerabilities they introduced?

The medical device vendors used to deliver a device and ensure clinical operation and consider a contract fulfilled. The point of sale was the focus, and hospitals would carry the residual cybersecurity burden until the device finally reached the end of its life (often well beyond when a manufacturer recommended keeping a device).

As connectivity has become de facto, this transfer of cybersecurity ownership to HDOs is no longer sustainable. A single HDO has to manage tens of thousands of devices - often with a limited technical ability to modify devices, for fear of impacting regulatory approval and manufacturer warranties.

WHAT SHOULD WE DO GOING FORWARD

With the new administration and its commitment to prioritizing cybersecurity, it is anticipated the security of critical infrastructure will get a major overhaul. This includes the FDA prioritizing finalization of their premarket cybersecurity guidance in 2021.

This is further corroboration that healthcare cannot remain reactive to dealing with cybersecurity threats. Instead, we need to design our new systems with the intentionality of proactively protecting our users from them. Our systems must grow to prioritize reducing the extent of reliance on users against unknown threats. Note the nuance: I'm not saying the user doesn't know how to use the device. I'm saying with tech, there will always be unknowns and there will always be weaknesses. The best systems are those which do not rely on the user as the detection, and, more importantly in patient care, the efficacy of a device. We must be intentional and prioritize designing security into devices if we are to ever change the landscape of cyberthreats in healthcare.

The reliance on technology will never go away. It has improved diagnostic capabilities, given us new treatment options, reduced time, effort, and risk for patients. Therefore, we must make the security component of this process a positive experience for the user and/or patient, as that can mean the difference between the success or failure of a cybercriminal.

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BEHIND THE SCENES: PORTRAITS OF PROGRESS FOR FIRMS IN THE PANDEMIC - MD CLONE

I am a primary care general internist who was lucky enough to go to Wharton on a full academic scholarship as part of what was then the Robert Wood Johnson Foundation Clinical Scholars Program. This two-year, post-residency program brought together young physicians who were making a commitment to changing our broken healthcare system. Armed with an MBA in health administration, and after five years as a junior faculty member at Penn Medicine, I was recruited to Thomas Jefferson University in 1990 and have been on the faculty there for more than 30 years. (My millennial children think I am a walking and talking dinosaur, and perhaps they are right.)

During my tenure at Jefferson, I have had three jobs. As the inaugural Director of the Office of Health Policy from 1990 to 2003, I served with a dual reporting relationship to the hospital CEO and the Dean of what was then called Jefferson Medical College. At that point in time, I was the only physician in the entire faculty practice plan who had been to business school!

From 2003 to 2008, I was the Chair of the Department of Health Policy within the medical college and became the recipient of the Dr. Raymond C. and Doris N. Grandon endowed professorship. From 2008 to 2019, I was the Founding Dean of the nation's first college of population health. Today, I have the "lofty title" of Founding Dean Emeritus, which gives me great autonomy to explore areas of research and scholarship that have been of interest to me for decades. Hence, at least in part, this wonderful opportunity to write a column.

In July of 2019, I voluntarily stepped down as Dean — following what I believe to be the good management practice of relinquishing senior roles in any organization after more than a decade. In September, I was invited to Israel to speak at their national health policy conference. Israel is also known colloquially as the "Start-Up Nation"[1] based on a well-known 2009 book by Senor and Singer.

First, a bit about healthcare in Israel and then more about the role a particular company, MD Clone, plays in bridging global gaps in data to improve health outcomes, especially during a pandemic. According to the State of Israel's Ministry of Health, Israel's[2] healthcare system is characterized by universal healthcare coverage, with a community-based orientation and a focus on prevention. Israel spends about 8% of its GDP on healthcare, while the U.S. spends nearly 19%.[3] Historically, Israel has had 4 large HMOs. They have focused on creating the "Ofek System" - a national electronic medical record (EMR) information exchange platform.[4] In a nutshell, every single citizen is included in this national, online, readily accessible EMR system, which is the envy of many other nations, including our own!

I visited Maccabitech — an offshoot of Israel's Maccabi Healthcare Services, the second largest of the four HMOs in the country. Maccabitech, which is powered by MD Clone, is a 2.5 million person, readily accessible healthcare data engine that enables predictive analytics, artificial intelligence, and population health research to thrive in a country essentially the size of New Jersey.[5]

There is nothing quite like the database at Maccabitech in the U.S. In a recent issue of *Harvard Business Review Case Studies*, Kominers and Knoop provided a detailed account of the capabilities of medical data in Israel.[6] Although I cannot adequately summarize this comprehensive article, I can reassure our readers that Maccabitech is on to something that most integrated delivery systems (including Jefferson Health), are still dreaming about.[5] I was hooked! How could I help to create even a modest copy of this capability at Jefferson and elsewhere?

Fast forward to the pandemic and the global challenge of sharing clinical data about caring for patients with COVID-19. How could we overcome all the extant privacy barriers as it relates to sharing personal health information (PHI) and simultaneously get sufficiently detailed clinical data from the bedside to researchers all over the world? The answer? MD Clone.

MD Clone was founded in 2016 and works with major health systems, HMOs, and life sciences companies in the U.S., Canada, and Israel. According to a recent report in *Healthcare Innovation*,[6] MD Clone "creates a synthetic copy of healthcare data collected from actual patient populations. While the synthetic data set is virtually identical to the original data, there's no identifying information that can be traced back to individual patient. It can help reduce cycles of discovery from months and years to hours and days through the self-service platform and access to synthetic data without the need for institutional review board (IRB) approval."

I actually had used the self-service platform, with a tiny bit of help, during my aforementioned pre-pandemic visit to Maccabitech in September of 2019. The

"hype" was actually understated, and the tool exceeded my expectations. With support from the senior most leaders at Jefferson Health, I brought MD Clone to our clinical enterprise, known as Jefferson Health, in February of 2020.

While Jefferson is clearly an early adopter, our timing was prescient and lucky too! By April, the second month of the pandemic in the U.S., our clinicians, data scientists, and bench researchers were sharing data about patients with COVID-19 with colleagues from around the world. Contemporaneously, our plans to create a Global Network (GN) of researchers gained momentum. The GN was an aspirational idea after my return from Israel in late 2019, and the pandemic clearly made it a top priority. The leadership lessons here are abundant. One that stands out for me is the importance of being well-prepared when opportunities present themselves so you can readily embrace them.

MD Clone has two co-founders, Ziv Ofek and Luz Erez. My personal relationship is with Mr. Ofek, so I will focus on his role. Ofek is no stranger to the U.S. healthcare information technology marketplace as the

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founder and former Chief Information Officer of dbMotion, which was sold to Allscripts for $235 million back in 2013. He is the originator of the dbMotion concept for clinical integration and semantic interoperability. Ziv is a Sabra — a term often used to describe persons born in Israel whose personal characteristics mimic the fruit — hard on the outside and sweet in the center. He exemplifies the "start-up nation" ethos and seems to know every single investor and inventor in the entire country of Israel.

Translating the vision for MD Clone for a U.S. audience has been an uphill battle. The Israel mindset is action-oriented, with little patience for bureaucracy, hierarchy, and many other attributes that describe our domestic $3.5 trillion industry - the biggest in the nation. I have had many heart-to-heart talks with Ziv and his leadership team. Thankfully, he has learned to surround himself with a dynamic group of U.S.-based leaders who truly understand our peculiar marketplace and fully embrace the technology, the vision, and the pressing pandemic-fueled need to quickly operationalize the GN research agenda.

My role moving forward, as the inaugural chair of the MD Clone GN, is to work collaboratively with all the founding members - a veritable "Who's Who" of top academic centers in the U.S., Canada, and Israel - to move the ball down the field. That is, to draw on the unique strengths of great organizations like Intermountain Healthcare, Washington University in St. Louis, Jewish General Hospital in Montreal, and the Regenstrief Institute in Indianapolis, among others, as we find new and innovative ways to unlock our own data and create insights and actionable information from the hurly burly of our everyday work.

I am back to doing what I love and do best - attempting to improve health outcomes and drive down costs by reducing waste. My 30 years of experience and my Wharton degree have prepared me well for the challenges ahead.

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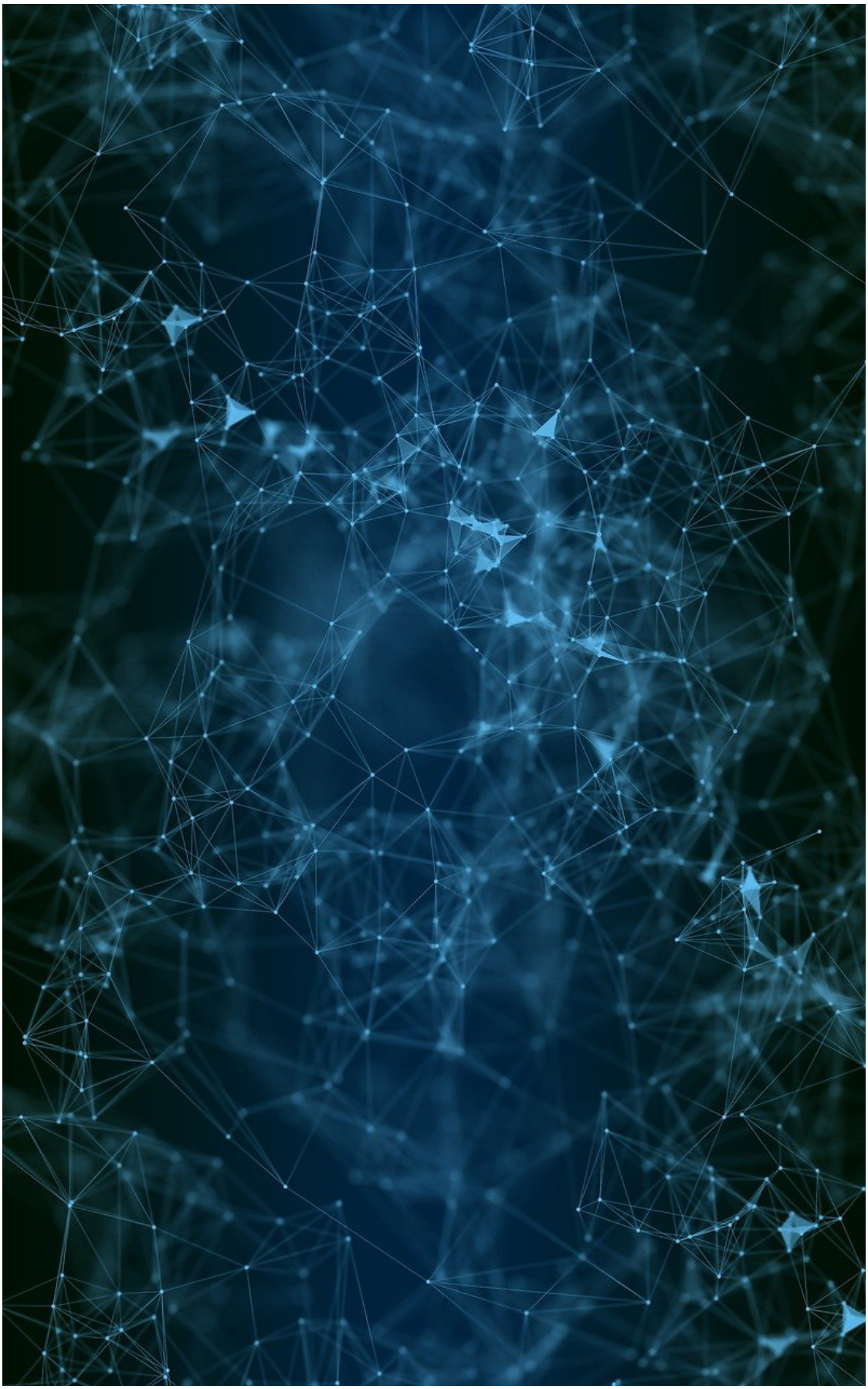

Featured Article

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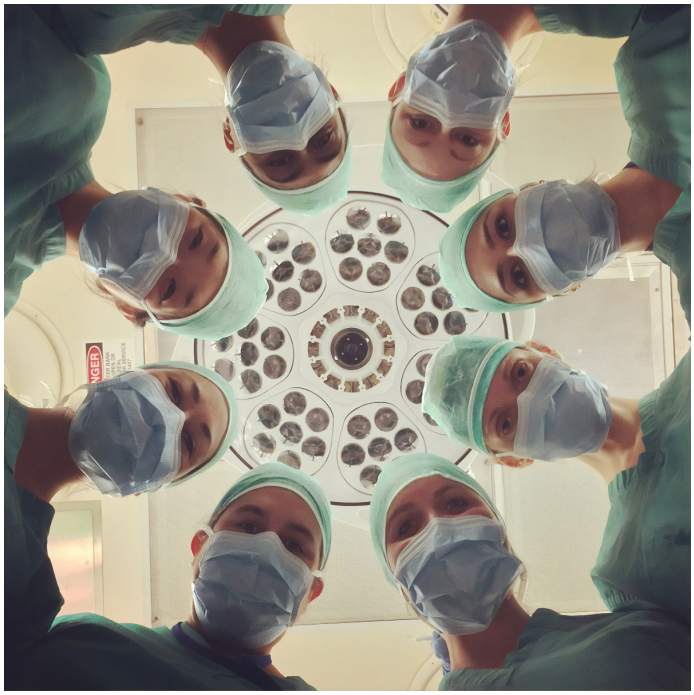
SHOULD I STAY OR SHOULD I LET IT GO? ACCELERATING PARTNERSHIPS IN A PANDEMIC – PART 1



MEDICAL PRACTICE CONSOLIDATION – PRE-COVID-19

Before COVID-19, the environment for medical practice consolidation nationally had been accelerating for both specialty practices and primary care, with more and more physicians moving from independent private practice to employed arrangements. Hospital ownership of medical practices increased by 7% per year from 2004 - 2010[1] while employment of physicians by hospitals increased by 55% from 2003 - 2011 after being relatively constant from 1998-2003.[2] From 2010 - 2016 independent primary care practices nationwide declined from 41.6% to 35.3%, and primary care physicians working in hospitals or health systems increased from 27.7% to 43.5%.3 In 2018, for the first time nationwide, there were fewer physician-owned practices (45.9%) than employed physician arrangements (47.4%).[4,5]

Not all parts of the country have moved as quickly to consolidate medical practices. In the Southeast, for example, in South Carolina specialty practices have been somewhat slower to consolidate. In 2017, the majority of South Carolina physicians in all specialties were self-employed (54.6%) versus employed (40.7%). Primary care, on the other hand, has moved more quickly to consolidation in South Carolina. In 2017, the percentage of primary care physicians in South Carolina was relatively equal with 47.3% self-employed versus 46.8% employed.[6]

MEDICAL PRACTICE ENVIRONMENT FOR CONSOLIDATION – DURING AND AFTER THE PANDEMIC

As the country adjusts to the "new normal" of living and working with the COVID-19 pandemic, the healthcare industry, including physicians in practice, look ahead to a post-pandemic health care environment of the future. The COVID-19 pandemic has certainly increased the uncertainty of medical practice independence.

Early in the pandemic during the spring of 2020, a Merritt Hawkins survey of physicians predicted significant changes in physician practice patterns. In this survey, sixty-six percent (66%) of physicians reported they would "Stay the Course," but 32% planned to change practice settings, retire, temporarily close their practice, or opt out of patient care entirely.[7]

During this early peak of the pandemic, there was significant fear of practice closures, with primary care at greatest risk.[8,9] By the fall, nearly 20% of primary care practices surveyed reported practitioners had retired early due to COVID-19. And as these practices headed into flu season, 56% of practitioners surveyed reported record high levels of mental/emotional stress and exhaustion[10] with no end in sight, making the viability of these practices just as uncertain as during the early days of the pandemic.

Some hospitals furloughed their physicians or cut compensation, and further consolidation has become much more uncertain as some hospitals face a cash crunch. Yet, there are examples of reverse consolidations or "spin-outs," as in the case of Mecklenburg Medical and Atrium Health, as well as Steward Physicians and Steward Health's owners,[11] where physicians unwound business relationships with their non-physician group owners.

ASSESSING CURRENT-STATE VIABILITY

Given the volatility of the environment, how do physicians assess the current-state viability of their practice? The following questions should be considered:

Patient Visit Volumes – Have post-lock down patient volumes rebounded? The Commonwealth Fund reported that in late April 2020, ambulatory care practice volumes plummeted by nearly 60%.[12] How has the practice adapted to the "new normal" for treating patients during a protracted pandemic? Have different channels of treatment and communication, such as telemedicine or remote care, been added to the practice's workflows? How have patients and staff adjusted to these new processes?

New Patient Channels – For practices that incorporated telemedicine into the practice during the beginning of the pandemic, do they have the support infrastructure to make this a permanent channel? Going forward, the percentage of telemedicine vs. routine in-office visits could be as high as 30% to 50% of total office visits. Does the practice have the ability, resources, and desire to include telemedicine and/or remote care as a permanent patient channel?

Physician - Patient Relationships – How are physician relationships with their patients? How do they know? During the initial peak of the crisis, many physicians reached out to their patients by phone or video conferencing, and they found their "currency" with their patients – their relationship – was strong. As a result, they were confident their patients would return for in-office visits.

Patient as Consumer - How reliable is the practice's patient or consumer data? The "Patient as Consumer" is a key aspect of assessing and managing patient relationships using data. Customer relationship management (CRM) is a tactic more practices are adopting to be proactive in meeting their patients' needs. In a pandemic, CRM-generated information can be even more helpful to ensure patient retention in the practice.

Value-based payments – During the lowest point of the crisis for in-person office visits, providers who had value-based payment arrangements already in place were shored up by a steady source of income.[13] Does the practice have the clinical support and data management infrastructure to accept more value-based payments? This support infrastructure includes an Electronic Health Record (EHR) and Practice Management system, reliable decision-support data, clinical and quality management support staff, and payer contracting expertise.

IMPROVING OPERATING PERFORMANCE TO "STAY THE COURSE"

Pandemic or not, the ability to improve operating performance is key to any medical practice, "staying the course," and remaining viable. From patient scheduling to revenue cycle management, to IT services and purchasing, physicians and their teams should continually find ways to improve performance.

PRACTICE MANAGEMENT SERVICES – TARGETS FOR PERFORMANCE IMPROVEMENT

Elements of practice management services to target for improving performance include patient scheduling, revenue cycle management, purchasing, payer contracting, information technology, and human resources management.

To evaluate *patient scheduling* for performance improvement, on-site and remote access capabilities, telephony and schedule systems, and customer relationship management functionality should be considered. Effective and efficient *revenue cycle management* (RCM) begins from the point of patient scheduling and expands to include all elements of the RCM cycle: coding, charge capture, collections, patient responsibility financing, and clinical documentation improvement.

Payer contracting capabilities include the practice's abilities to contract with payers for traditional fee-for-service payments as well as value-based payments arrangements, which are increasing. Provider enrollment effectiveness and credentialing operations efficiency should not be overlooked, as payers are increasing their reliance on narrow network strategies to control costs, and long lag times to credential providers impact

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collections of non-government payer reimbursement.

The importance of adequate and well-managed medical practice infrastructure in information technology (IT), purchasing, and human resources cannot be understated. Before the pandemic, effective vendor contracting for durable medical equipment (DME) and supplies was standard. During the pandemic, a medical practice's purchasing power and supply chain access have become a critical priority, especially related to reliable and affordable purchasing of personal protective equipment (PPE) and medical supplies.

In addition to the *human resource* (HR) management basics of payroll and benefits coordination, HRmanagement effectiveness for recruitment, retention, and managing medical leave for staff became even more critical.

With the advent over the past ten years of EHRs, well-performing *information technology* support is a given in medical practices, with IT support needed from EHR and practice management systems implementation, training, maintenance, and upgrades. The EHR itself has not kept up with a physician's need for helpful and accessible clinical data to support patient care. Does the practice have capabilities to implement clinical and business decision-support tools to help physicians care for their patients? During COVID, the IT capabilities to rapidly implement and support telemedicine solutions became critical. Maintaining responsive and effective IT capabilities will remain key to sustain a practice throughout the pandemic and well into the future.

Smaller independent practices that are struggling to keep up with the technology and infrastructure expense demands of these services, especially with the added pressure of the new COVID-19 reality, have outsourcing options working with management services organizations (MSOs). Although the tendency in a crisis may be to go into cost-cutting mode, practices do not want to be "penny wise" and undercut their ability to operate in the long term. MSO's can offer "a la carte" or "all-in-one" support to medical practices to enable them to retain their independence and viability.

Effective *payer contracting* is a key aspect of medical practice operations, and physicians should assess whether they have enough contractual expertise to negotiate with payers for value-based payments. Payers nationally and in the Southeast are working to accelerate value-based payment arrangements to help reduce costs and improve quality, as well as support physician practice independence and viability. Blue Cross and Blue Shield of Minnesota and Minnesota Healthcare Network, a group of 47 independent primary care practices in Minnesota and Wisconsin, came to an agreement to accelerate the transition to value-based payment and provide financial resources for long-term stability.[14] Blue Cross Blue Shield of North Carolina is also accelerating value-based payment arrangements to physicians but requiring practices to remain independent.[15]

PARTNERING WITH OTHERS

FROM SOLO TO GROUP PRACTICE – JOINING FORCES

There are a variety of options for physicians to partner with others. Moving from solo practice to join a group is still a popular option. Medical group practices have been able to weather storms like this by joining forces, and as mentioned previously, some medical groups have even spun back out from prior owners to become independent once more.[16]

HEALTH INSURANCE COMPANIES – THE NEW "PAYVIDERS"

Health insurance plans have acquired medical group practices to create *new "payvider"* entities, a combination of payer and provider. There are several examples of health insurers getting into the medical provider business: Optum and ProHealth in Connecticut, Blue Cross and DaVita, Humana and Partners in Primary Care, Blue Cross Blue Shield Illinois and The Blue Door Neighborhood Center.

The rationale for health plans to also become medical providers of care includes expanding their network of providers to improve access; using "big data" analytics to change clinical practice patterns and reduce costs for subscribers and employers; narrowing ancillary service and outpatient diagnostic options to reduce variability and costs; and increasing their market competitiveness.[17] The payvider phenomenon is still a new concept. According to a 2018 American Medical Association Survey, only 2% of physicians nationally work in practices owned by insurers.[18] The pandemic has also impacted payers financially. Over the next couple of years, the ability of payers to keep the payvider trend going by investing in physician practices will depend upon how well health insurance companies weather the current COVID storm.

INVESTOR-OWNED HEALTH SERVICES COMPANIES

Large investor-owned health services companies such as Teladoc, CVS/Aetna, and Walgreens are acquiring medical groups, networks, and hiring physicians.

Retail Medicine

Retail medicine is also booming and recruiting physicians, especially in primary care. CVS and Aetna have partnered to support the pharmacy chain's corner store Minute Clinics and to channel retail pharmacy business. Retail giants like Walmart are building clinics all over the country or are buying existing medical groups, such as Walgreens acquiring Village MD,[19] and investing in these practices. The retail medicine space is highly uncertain however, and physicians need to be prepared for a rollercoaster ride, as these companies' primary goal always is to support and grow shareholder value for their core retail business.

Telemedicine

Telemedicine has taken off like a rocket thanks to COVID-19. Physicians are finding opportunities to join telemedicine companies or are even striking out on their own as independent contractors with the help of colleagues in organizations like the Institute for Telemedicine Mastery, greatly increasing their independence while maintaining or even improving their income.

Fields of practice in telemedicine have expanded rapidly to include urgent care, family medicine, behavioral health, dermatology, OB-GYN, oncology, and pediatrics. The list of top telemedicine companies[20] (e.g., Teladoc, AmWell, Doctors On Demand, MDLive, IM-Primary, etc.) is impressive and keeps growing. With the rapid adoption of telemedicine by patients and providers due to the COVID-19 pandemic, investors are accelerating their funding of these ventures.

Although CMS and the commercial payers will likely adjust telemedicine reimbursement downward from the current expanded services and increased rates due to the pandemic, telemedicine is here to stay. Consumers expect its availability, chronic care management is enhanced through telemedicine support, and well-organized telemedicine can improve productivity and efficiency in medical practices.

CONCIERGE PLUS – DIRECT PRIMARY CARE

Direct primary care (DPC) is another model of medical practice that enables physicians to remain independent versus having to partner or become employed. Concierge medicine has been in place for decades and provides an additional source of income for physicians. For a monthly or annual fee, patients can purchase immediate, first-in-line access to their physician. Out-of-pocket concierge medicine fees are collected, and, in some models, fee- for-service payments are collected from government and commercial payers.

DPC goes a step further and allows physicians in practice to eliminate the overhead expense associated with revenue cycle management of billing and collecting from government and commercial insurance companies. Direct primary care is a membership fee model where patients (or their employers) pay a monthly and/or an annual fee directly to the practice. Physicians in direct primary care have the freedom and flexibility to establish the price of membership fees either directly with the patient as consumer or an employer. In markets with reduced or limited access to marketplace health insurance, the DPC option is attractive to people who are uninsured or underinsured or desire improved access to a primary care provider and wish to pay the additional membership fee.

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Access in these direct primary care practices is often superior to traditional practices, with same day or next day access the patient expectation and norm. DPC physicians can offer a higher level of care to their patients, noting that they are not hampered by the burdens of fee-for-service medicine and the insurance reimbursement treadmill. Physicians in these DPC practices have the flexibility to choose the size of their patient panel, which can be less than half the size of a traditional primary care physician's panel. Because they can personally spend more time with their patients with this model, DPC physicians do not require additional clinical support staff or extended care teams, which also reduces overhead costs in their practices without sacrificing accessibility. With the reduction in overhead costs, increased physician and patient (and employer) satisfaction, and the preservation of practice autonomy, direct primary care is growing as an option for primary care physicians to remain independent.

Investor-owned Alternatives – "Concierge Plus"

Like direct primary care, but with the government payor paying the "concierge" fee through a Medicare Advantage plan, investor-owned "Concierge Plus" companies like ChenMed, Iora Health, and Oak Street Health offer physicians practice model alternatives to the fee-for-service treadmill, either in their independent private practices or employed as part of a health system-owned medical practice. These companies are often enterprising physician owned and led companies that have raised capital from private equity firms to fuel their practices or fund their exit strategies. These investor-owned companies are expanding to build direct care concierge-type practices across the country, targeting seniors and taking risk with Medicare Advantage plans. They are actively recruiting physicians out of private practice and health systems, with the promise of a significantly smaller patient panel (i.e., as few as 450 patients working for ChenMed), brand new clinic or practice facilities, a user-friendly, physician-built EMR, and chronic care management resources for physicians and their senior patients. Iora Health, for example, adds an holistic care team model which helps to address health inequities resulting in a better experience for both physicians and patients.

There are concerns the ChenMed model may be light on accountable care, using Medicare Advantage as their sole play, and there are concerns about their impact on primary care access in general, with dramatically reduced patient panels. However, this model increases physician and patient satisfaction and offers physicians who are burning out in private practice or disappointed with their involvement in health system operated practices an opportunity to jump ship and get on board with a fast-growing health services company. At #51, ChenMed was showcased by Fortunemagazine as one of the Top 100 Companies that will change the world:

> *"Many think ChenMed's model is the cure for America's ailing high-cost health system. The primary care provider has focused on helping seniors avoid expensive hospital stays by preventing problems from getting bad in the first place."*[21]

MANAGEMENT SERVICES ORGANIZATIONS (MSOS)

A management services organization or MSO strategy allows physicians to remain independent while reducing some of the operating and/or reimbursement risk. To boost operating performance, especially with the stressors caused by COVID-19, physicians can contract with MSOs that offer practice management services, such as EHR implementation support, revenue cycle management services, and payor contracting support.

MSOs allow practices to remain independent while providing a shot in the arm for overstretched business operations. Companies like Privia in Florida and Equality Health in Arizona are examples of MSOs whose strength is often in negotiating at-risk contracts with payors and then supporting practices with other outsourced practice management services, such as revenue cycle management, central call center scheduling, and EMR implementation support. Private equity owned MSOs offer a full array of practice management services to physicians that allow them to remain independent. Using a single tax ID billing strategy, these types of MSOs lead payor contracting efforts, consolidated payor contracting, and promise superior revenue cycle management performance. In addition, physicians are offered opportunities to participate in value-based care reimbursement arrangements that offer performance bonuses.

Investor-owned private equity (PE) backed MSOs also invest in medical practices by infusing capital for recruitment, equipment, facilities upgrades, or practice location expansion. These companies can also help facilitate the owner's exit strategy, readying the practice for a future merger with another practice or company. PE-backed MSOs come with high valuation, profitability, and return on investment (ROI) expectations. With the COVID-19 pandemic, there has also been uncertainty in the PE-backed MSO marketplace, with increasing consolidation trends for these companies which will likely continue.

CLINICALLY INTEGRATED NETWORKS (CINS)

There are a couple of different ways for physicians to partner with hospitals or health systems – including joining health system sponsored clinically integrated networks. A clinically integrated network (CIN) is defined as: "A collection of health providers, such as physicians, hospitals, and post-acute specialists that join together to improve care and reduce costs."[22]

CINs have been a relatively recent "vehicle" for health systems and independent physicians or medical groups to come together to reduce cost and waste in the healthcare system, improve patient quality, and position both entities for managing populations and taking value-based payments. With their size, infrastructure, and representation across the continuum of care, CINs have more resources and patient lives than physicians in solo or smaller private practice. As such they may be better able to succeed in Accountable Care Organization (ACO) programs offering alternative payments models with government payers such as Medicare Shared Savings Plans (MSSP) and Pioneer ACOs. The positives for joining a clinically integrated network include an opportunity to increase patient quality of care and reduce cost and waste in the system. In addition to positioning a practice for population health and value-based payments, physicians can remain independent and earn incentives for improving quality and reducing costs.

Just as there are some positives to joining a CIN, there are some pitfalls. Physicians may be reluctant to contribute membership fees to the CIN if they are skeptical of the promised cost savings performance tied to quality bonuses. Hospital-operated CINs, although well-intentioned, have inherent conflicts of interest built into their models. Despite the implementation of penalties over the past several years by government and commercial payers for overutilization, fee-for-service revenues in deep end services (e.g., hospital admissions, ER visits, high-end diagnostics) still drive the financial engines of hospitals and health systems.

EHR interoperability and data quality are both still big challenges for CINs. Access to useful clinical quality information, data analytics, and decision-support is still not consistent or easy for physicians to obtain. Before joining a CIN, physicians should investigate the management services offered by the CINs to help them meet the performance goals that result in cost savings and therefore bonuses for providers. Physicians should also be aware of certain exclusions for joining a CIN. For example, primary care physicians can only join one CIN and cannot be members in multiple CINs.

Finally, physicians should make sure that cost savings and quality goals are aligned in the CIN between the hospital and the physician practice. The biggest cost savings in an alternative payment arrangement happen when the "big ticket" items are reduced – hospital admissions/readmissions, emergency room visits, surgeries – the core businesses of a hospital.

ACCOUNTABLE CARE ORGANIZATIONS (ACOS)

Physicians are not required to join a CIN to participate or succeed in an ACO program. Investing in or joining an ACO is another way to help physicians remain independent. Physicians can join an ACO that is hospital or health system-owned or physician-led and owned. In the world of accountable care, the covered lives in a physician's panel are their "currency." The way they clinically manage the care of this precious panel of patients is at the center of truly accountable care, so incentives must be aligned to support physicians.

With the advent of payment reform and the development of the Accountable Care Organization (ACO) model, policymakers and stakeholders feared that physician practice consolidation would accelerate, and physician

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practices would merge with hospitals because of the accountable care model and its payment methods. However, researchers have found little evidence to support this assertion, noting that physician practice consolidation was well underway before the accountable care programs were established.[23]

Physician-owned and led medium and large medical group practices, especially in primary care, can have a very positive impact on costs and quality, often greater than the results of health system-led ACOs. Participation in ACOs can also help physicians remain independent. Physician-owned, or "low revenue" ACOs, versus hospital-operated, or "high revenue" ACOs, perform better and have a better chance of passing on a tangible amount of incentive dollars to participating physicians. These incentives for care improvement and cost reduction shared savings provide another revenue stream for physicians, especially in primary care. And as value-based payments become more prevalent than fee-for-service payments, physicians involved in ACOs will benefit.

Private equity backed MSOs (e.g., Aledade, Agilon) have grown in the past few years and focus on government payor value-based reimbursement arrangements in the Managed Medicaid and Medicare Advantage space. These MSOs partner with independent primary care physicians and practices providing practice management services, big data analytics, and value-based care contracting capabilities for private practice physicians to take advantage of and remain independent. Using delegated contracting methods, for example, these companies partner with physician practices to take full-risk arrangements, while providing a variety of management services (e.g., case management, utilization management, credentialing, etc.) that help physicians achieve better patient outcomes and reduce the costs of care. Improved value-based care performance drives shared savings bonuses and other financial incentives. These MSOs tend to be larger in size and scope and more dispersed geographically across multiple markets. It will be interesting to see how well this model performs across a much more diffused landscape and if the incentives offered to physicians to participate will be adequate to sustain them.

CONCLUSION – PART 1

We conclude Part 1 of our series *Should I Stay or Should I Let It Go? Accelerating Partnerships in a Pandemic* noting how significant Covid-19's impact has been on the healthcare system in our country and especially on physicians in practice. To date, in the U.S. there are 28 million COVID-19 cases reported with nearly half a million deaths. Physicians in practice on the front lines have experienced tremendous stress, as both practitioners and small business owners.

The pandemic has dramatically accelerated concerns about independent medical practice viability.

Prior to the pandemic, the healthcare industry had been undergoing dramatic changes which made conditions favorable for physician practices to consolidate. Over the years, physicians increasingly moved from practicing independently to becoming employed by other organizations such as hospitals, health systems, and even insurance companies. More recently, with the growth of value-based reimbursement, physician-led and built companies backed by private equity investors have offered physicians opportunities to participate in new models of clinical practice that offer an alternative to the fee-for-service treadmill.

In Part 2 we will explore physician partnerships with health systems from pre-COVID to the present. We will highlight the strengths, weaknesses, and opportunities for medical practice partnerships from the health system's perspective. For physicians contemplating their next steps during challenging times made more urgent by the pandemic, we will offer a practical multi-dimensional framework to assist decision making.

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LEADERSHIP CAN BE LIFESAVING IN THE FIGHT AGAINST COVID-19

Jay Mohr, WG'91, is the Executive Vice President and Chief Financial Officer of New York Blood Center Enterprises (NYBCe), one of the world's largest independent, community-based, non-profit blood centers. With operating divisions across the country, NYBCe serves some 75 million people in New York, New Jersey, Mid-Atlantic, Missouri, Kansas, Minnesota, Nebraska, Rhode Island, and Southern New England, meeting the urgent blood product and service needs of over 500 hospitals nationwide.

Decisive and innovative leadership is crucial to saving lives in the global fight against COVID-19. Non-profits are uniquely positioned to take the lead in times of crisis and uncertainty, and since the onset of the pandemic, NYBCe has been working around the clock to ensure lifesaving resources reach critically ill COVID-19 patients. Strategic leadership and vision are essential in delivering essential services to physicians, laboratories, administrative, and biotech sectors through the NYBCe Office of Ventures and Technology Development, a hub for prospective industry partners and researchers to access and submit novel ideas and technologies. The Office serves as the gateway to technology licenses, sponsored research, collaborations, and venture creations, collaborating to bring vital therapies and diagnostics to patients in a wide range of therapeutic areas, including COVID-19, infectious diseases, non-malignant hematology, cellular therapies, and transfusion medicine.

A serious consequence of COVID-19 has been a drastic decrease in blood donations, leaving the national blood supply at a dangerously low level, with thousands of blood drives canceled due to pandemic lockdowns. NYBCe is working in partnership with hospitals throughout the country dealing with the full force of the pandemic, expanding laboratory capacity and significantly increasing blood donor recruitment efforts. Mohr is passionate about turning the unprecedented challenges resulting from COVID-19 into new opportunities to improve efficiency and lead scientific discovery. The global public health, economic, and social disruptions caused by the pandemic are devastating.

NYBCe was the first blood center in the nation to provide COVID-19 convalescent plasma (plasma rich in disease-fighting antibodies that are removed from a person who has recovered from COVID-19) that is then transfused into a patient suffering from the disease. The organization has collected over 76,000 plasma units and distributed some 62,000 units to hospitals nationwide as a treatment for COVID-19 patients. NYBCe also participates in the U.S. Department of Health and Human Services' Operation Warp Speed Program to encourage hospitals to educate recovered COVID-19 patients about the benefits of donating plasma. High titer convalescent plasma remains one of the few therapeutic options available to hospitalized COVID-19 patients via emergency use authorization, particularly when used early in the course of the disease, according to NYBCe Vice President and Chief Medical Officer Bruce Sachias, "The therapy has demonstrated a survival benefit for hospitalized patients not yet requiring mechanical ventilation."

As the research arm of NYBCe, Lindsley F. Kimball Research Institute (LFKRI) has pioneered new therapies in transfusion medicine, cellular therapy, hematology, and infectious disease that have resulted in numerous landmark patents and licenses. LFKRI is also a world leader in viral immunology, creating therapies and development vaccines to address global

health issues like Middle East Respiratory Syndrome (MERS), Severe Acute Respiratory Syndrome (SARS), and now SARS-CoV-2, the virus causing the global pandemic. LFKRI researchers are currently partnering with some of the highest caliber scientists in the world to conduct pre-clinical phase trials for multiple COVID-19 vaccines, to spearhead a COVID-19 serology (antibody) study of testing platforms currently being utilized in the field, and to screen plasma for novel biomarkers to predict COVID-19 responses in patients.

LFKRI's groundbreaking research has been saving lives for over five decades, and the Institute's cutting-edge advancements are key to developing the most effective treatments and preventing future pandemics. The Institute created the COVID-19 Research Repository to archive blood components, including plasma, serum, and immune cells, from COVID-19 patients to preserve these valuable materials for future research, with the long-term goal to further collaboration between LFKRI innovators and the scientific community and accelerate our knowledge and understanding of coronavirus. The Repository already holds an impressive repertoire of convalescent donor plasma samples and serves as a storehouse of serology and symptomatology data for convalescent plasma donors.

Mohr is encouraged and inspired by the relentless drive and determination of the frontline healthcare professionals, researchers, blood donors and collections staff, and community, corporate, and industry leaders who are joining forces to win this fight. "It's truly gratifying to work with such talented and dedicated change-makers who continue to rise to the occasion and go the extra mile to keep our communities safe," he said. "One of the greatest contributions leaders can make at this pivotal time in the pandemic is to use our voices, actions, and influence to help save lives. We're working hard to assess needs, coordinate efforts, and discover new approaches to providing the safety-net products and services that will flatten the curve and help those in greatest need."

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JOIN THE FIGHT AGAINST COVID-19

NYBCe is working 24/7 to meet hospital demand for convalescent plasma and other blood products needed for the many health conditions and procedures that rely on an ample and readily available blood supply. You have the power to save lives. Donate blood or volunteer at the nearest donor center. Donate plasma if you are a recovered COVID-19 patient. Make a financial gift to support COVID-19 vaccine research. Visit nybc.org/covidplasma to learn more about how you can help.

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

"Gratitude bestows reverence, allowing us to encounter everyday epiphanies, those transcendent moments of awe that change forever how we experience life and the world." ~ John Milton

Dealing with the chaos and complexities of the pandemic has revealed behaviors (and cultures) that either expose the best or the worst of humanity. And nowhere more than in healthcare settings has humanity been tested, prodded, poked, and observed.

And, while this current state will eventually turn into a "new normal," what will continue to be true is the opportunity to be reminded of the good in humanity.

Consider what the data show about the patient experience:

- 69% of consumers believe a good experience contributes to their healing/good health outcomes.
- 91% of consumers confirm patient experience is extremely/very important to them overall and is significant to the healthcare decisions they will make.
- Consumers offer that being listened to, communicated to in a way they can understand, and treated with dignity and respect are the three most important factors influencing their experiences.

Albeit shaken by extreme stress, the novelty of treatment options or lack thereof, and social isolation, there remain evidence-based approaches to support emotional, mental, and psychological experiences that promote good health and healing.

ENTER EMOTIONAL INTELLIGENCE

The pandemic has magnified the importance of whole-being experiences. If ever there was a time to examine and increase your awareness of emotional intelligence, it is now. Emotional intelligence is best described by Daniel Goleman as:

1. Self-awareness – knowing one's emotions, strengths, weaknesses, and values and recognize their impact on others
2. Self-regulation – regulating or redirecting one's disruptive emotions and being aware of their impact on others
3. Social skill – building positive relationships and understanding ourselves and others
4. Empathy – considering other people's feelings and guiding your interactions based on this understanding
5. Self-Motivation – finding intrinsic motivation to fulfill goals and find true meaningfulness in life.

There are several ways to measure your emotional intelligence, including self-assessments and 360-degree feedback tools. It is possible to learn and improve your emotional intelligence. And continued practice creates greater benefits, both personally and professionally.

STRENGTHENING YOUR EMOTIONAL INTELLIGENCE THROUGH GRATITUDE

The comparisons between practicing gratitude and strengthening emotional intelligence are just now being fully realized. The benefits couldn't be timelier. Gratitude, once considered a simple emotion, has been linked to neural activity associated with moral cognition, perspective-taking, and fairness. Ongoing research in gratitude shows evidence in building positive relationships and increasing empathy. Indeed, practicing gratitude creates a heightened awareness of your emotions, values, strengths, and a greater understanding of others. Heightening your emotional intelligence through gratitude allows for reflecting on your feelings, emotions and motivators, and perceiving those of others.

Cultivating a grateful mindset also allows you to readily shift from the brain's built-in negativity bias to examining what's going well in your life, what values reinforce your decisions, and which strengths allow you to be at your best as consistently as possible. This self-regulation of recognizing unhealthy emotions and reframing your thoughts, feelings, and behaviors will deepen your emotional intelligence capacity. With greater emotional intelligence awareness, you have a choice - a choice in how you interact with and join in the experiences of others.

Further, a sustained practice of gratitude leads to greater health and well-being benefits, including:

- Improved heart health
- Increased resilience and less burnout
- Greater mental well-being
- Improved overall health and well-being

SIDE-BY-SIDE COMPARISON

EMOTIONAL INTELLIGENCE	GRATITUDE
Self-Awareness	Increase awareness of positive emotions, values, and strengths
Self-Regulation	Reframe default thinking to what's going well, what positive emotions you're experiencing
Social Skill	More prosocial behaviors, less anti-social behaviors
Empathy	Foster empathy for others, "you get me"
Self-Motivation	Awareness of purpose in life, improved self-care, and higher use of strengths

Practicing gratitude creates time and space to step back from the constant, 24/7 disruptions and a downward spiral of negative emotions. Try a one or two-minute gratitude "micro-practice" before interacting with others during your day. Reflect on what you are grateful for in yourself and others. Couple this micro-practice with the 4-7-8 breathing technique (breathe in for 4 seconds, hold for 7, exhale for 8) to help you become fully present.

As current healthcare settings continue to evolve now and post-pandemic, the certainty of having higher emotional intelligence and a sustained practice of gratitude will positively influence your health and well-being and that of your loved ones, those with whom you may work, and those to whom you deliver care.

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