Wharton ALUMNI CLUB
UNIVERSITY of PENNSYLVANIA

Health Care Management Alumni Association

THE WHARTON HEALTHCARE QUARTERLY

WINTER 2022, VOLUME 11, NUMBER 1

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EDITOR'S LETTER

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

To learn more about Colette, click here.

Happy New Year!

I hope all had a memorable holiday season and are now raring to go for all that lies ahead.

We are off to a wonderful start! The first edition of the 2022 WHQ features "Crisis Management Plan for a Pandemic - Lessons from a Healthcare System," **co-authored by Wharton's Dean Erika James**, Hisham M. Valiuddin, DO, WG'22, and Keith C. Hemmert, MD.

The WHCMAA is also excited to mark a major milestone…… the 10-year anniversary of the Wharton Healthcare Quarterly. We will be **"Celebrating the Past and Embracing the Future"** throughout the year. Planned activities include:

- A **monthly webinar series** presented by an extraordinary group of experts in their field to keep you up to date on a wide range of timely topics.

  Join us for the January kick-off with Alexandra Drane, Co-Founder and CEO of ARCHANGELS, a company reframing how caregivers are seen, honored, and supported. Alex has been featured as a TED speaker, in Forbes, interviewed by McKinsey & Company and is also an NEJM Catalyst article co-author. Hear the most recent caregiving data from Alex, published by the CDC and the Journal of Affective Disorders, on the growing mental health crisis among the 43% of us caring for a loved one.

  Register now for this January 19 webinar. Or save time and money by signing up for the entire 12-webinar series by January 19.

  If you are a member of the WHCMAA or a Wharton student in the Healthcare Management Program, there is no charge for the webinar series, but you must still register.

- A **"limited edition" 2022 column, "Anniversary Spotlight,"** comprised of articles in each issue written by those who helped us back in 2012 by authoring pieces featured in the inaugural year of the WHQ. Harris Contos, DMD, MBA, WG'80 gets us started with **"Is Dentistry Ready to Play in the Majors?"**

- **LinkedIn interviews** with anniversary participants, which will provide an inside glimpse into the person behind the title, role, and career achievements.

- **A Philosopher's Corner eBook** (coming this summer)

Your interest, feedback, thought leadership, and scholarly contributions have brought us to this point in time. Thank you for a gratifying 10 years!

As we move into a third year of the COVID-19 pandemic, **the challenges in the healthcare arena remain many and grow more complex**. We face a seemingly unending number of variants, supply chain issues, healthcare worker shortages, burnout, and PTSD, crisis standards of care, an increasing number of social determinants of health (SDOHs)

EDITOR'S LETTER

which contribute to increasing health disparities and higher costs of care, cybersecurity breaches made more virulent by ransomware attacks, high rates of depression, anxiety, and loneliness, and a worsening opioid crisis.

On the other hand, we have also witnessed advances in health and well-being, experiences that are more personalized and targeted, care delivery aided by the technology to support telehealth, remote monitoring and wearables, virtual reality and fall prevention devices, GPS trackers, and the increasing ability to expand the number and types of care which can be delivered in the home. There has been global collaboration by scientists and researchers to develop vaccines in record time and rapid cycle knowledge gains, workflow reconfigurations, and decision-making previously relegated to a time far in the future.

As our first Feature Article reminds us, "The COVID-19 pandemic provided a rare opportunity to stress test every organization. Each organization could be judged on how they coped with the same universal adversity. An organization's mission, vision, values, and culture were pressure-tested through the historic crisis."

And as Londoner John Trusler noted centuries ago, "No time like the present, a thousand unforeseen circumstances may interrupt you at a future time." (Proverbs Exemplified, 1790).

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THE PRESIDENT'S DESK

Heather Aspras, WG'08

To learn more about Heather, click here.

I would like to wish you all a Happy New Year! Hopefully, you've been able to take some time off this winter to recharge, which is more necessary than ever. I am energized by all of the plans we have for the WHCMAA in the upcoming year and am looking forward to connecting with all of you.

As we start the new year, I've been reflecting on the importance of focus and prioritization, both personally and professionally. The pandemic has made many of us, including myself, acutely aware of how we're spending our time and which activities and relationships we're valuing. One thing that is very clear to me is the time we invest with each other in the WHCMAA and with students in the program is always worthwhile and uplifting.

In terms of our priorities for this upcoming year, we are focused on several key things:

- Continue to be a key connector of alumni as the pandemic evolves to foster discussion and serve as a thought leader for how the healthcare system must transform, providing networking opportunities, and holding engaging events
- Elevate focus on health equity and diversity and inclusion by successfully establishing our new committee, developing clear priorities and focus, and implementing with our membership
- Celebrate the unique value of the *Wharton Healthcare Quarterly* (WHQ), which was launched in 2012

There are a few key things that led us to these priorities. For me – and probably for many of you as well – the HCM program and the WHCMAA blur the lines between the personal and the professional. Through the program and the alumni organization, we have made lifelong friends and have also made incredible professional connections. In my mind, both types of connections are especially critical during the (hopefully beginning of the end of the) pandemic. As a WHCMAA board, we are all dedicated to continuing to provide you with a variety of opportunities to connect – to network, to learn, and to have fun. Some of these opportunities will continue to be virtual, and as guidelines evolve and conditions on the ground permit, some of these opportunities will start to be in person as well.

As I mentioned in my last President's Desk note, we have created a new committee on the WHCMAA board dedicated to fostering diversity and inclusion and to advancing health equity. Bhuvan Srinivasan is leading the team in developing goals and supporting activities for this board term, which you will hear more about in future newsletters. If you are interested in contributing to this committee or have any feedback or ideas for the board, please reach out to Bhuvan at: bhuvan.srinivasan@gmail.com or to me.

THE PRESIDENT'S DESK

We are also pleased to be celebrating the 10th anniversary of the *Wharton Healthcare Quarterly*. Our Managing Editor, Z. Colette Edwards, MD, MBA, has an exciting slate of activities planned for 2022, including: an "Anniversary Spotlight" in each edition this year, featuring contributors from the original 2012 issues; monthly webinars featuring both HCM graduates and external speakers; and LinkedIn interviews. We know you will enjoy these experiences and the celebration of this milestone anniversary. For more than 10 years the WHQ has offered a platform and opportunity to inform, demonstrate thought leadership, connect healthcare-related communities within Wharton and the University of Pennsylvania, advance knowledge, and share diverse perspectives across the healthcare industry.

I'm looking forward to connecting with you over the course of the year!

Kind regards,

Heather Aspras, WG'08
President, Wharton Health Care Management Alumni Association

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WHARTON HEALTHCARE QUARTERLY

Celebrating the Past
... Embracing the Future

10-Year Anniversary

Join Us As We Celebrate 10 Years!

The Wharton Healthcare Quarterly is celebrating 10 years of bringing together diverse thought leaders on a broad range of healthcare topics. You're invited to a year-long celebration featuring:

- **Monthly Webinars**

  Gain insights from an extraordinary group of experts discussing a wide range of topics, including:

  - FemTech growth opportunities
  - Population health
  - Cybersecurity trends
  - Repurposing medication
  - Healthcare in the home
  - The opioid crisis
  - Accelerating partnerships in a pandemic
  - Mental health innovation
  - The promise of AI

- **Anniversary Spotlights**

  A limited-edition column featuring writers from the inaugural year including: Harris Contos, DMD, WG'80; Jaewon Ryu, MD; Roy Beveridge, MD; and Kevin Volpp, G'97, MD'98, PhD'98.

- **LinkedIn Interviews**

  Anniversary participants share an inside glimpse into what drives them and their career advice and accomplishments.

SIGN UP FOR UPCOMING WEBINARS

Wed., Jan. 19, 2022 | 12pm ET

On Caregiving: What's Hard, What's Helping, and Post-COVID Opportunities for Support

Alexandra Drane | Co-Founder/CEO, ARCHANGELS

Wed., Feb. 9, 2022 | 12pm ET

Mental Health Innovation for Covid-Era Post-Traumatic Growth

Helena Plater-Zyberk | CEO/Co-Founder, Supportiv

Wed., Mar. 9, 2022 | 12pm ET

Should I Stay or Should I Let It Go? Accelerating Partnerships in a Pandemic

Amanda Hopkins-Tirrell, WG'86, President/Founder, Hopkins Tirrell & Associates, LLC | **Dr. Saria Saccocio**

Webinars are FREE for WHCMAA members

$20 for non-members. Or, non-members can sign up for all 12 webinars by January 19, 2022 and save 50%.

- **Philosopher's Corner eBook**

  This must-read ebook will feature words of wisdom, insightful musings, life lessons, and stepping stones to business success from the 40 philosophers who shared their thoughts in this eclectic standing column. ***Coming this summer.***

Sign up for upcoming webinars: https://www.whartonhealthcare.org

ALUMNI NEWS

Georgia Robins Sadler, PhD, WG'73, BSA'72
Dr. Sadler was recently invited to join the Academy of Fellows of the American Association for Cancer Education, an organization that has previously recognized her research and teaching with its Margaret Hay Edwards Award for outstanding contributions to cancer education. She is an emeritus professor in the Department of Surgery at the University of California San Diego School of Medicine, where she continues her research with several large grants from the National Cancer Institute. She resides in La Jolla, CA with her husband, Blair Leamer Sadler, Penn Law '65, who served as the President and CEO of Rady Children's Hospital for the 26 years preceding his retirement.

Contact Georgia at:
gsadler@ucsd.edu

John Whitman, WG'78
I am a member of the 1978 class of the Wharton MBA Health Care Management Program. In August, I returned to my roots and accepted the CEO position at Chandler Hall. Chandler Hall is a Quaker-based senior care facility in Bucks County, PA with independent living, personal care, memory care, a skilled nursing facility, a palliative care program and hospice services, both community based, and an 8 bed inpatient program. After 30+ years in consulting, research, and academic education, I am excited to return to the provider side of our healthcare system. Like most senior care facilities, COVID has certainly had its impact, but I am excited about the many exciting opportunities here at Chandler Hall.

Contact John at:
jwhitman@ch.Kendal.org

Roman Macaya, WG'98
After serving as Ambassador of Costa Rica to the United States, for the past three years Roman has been running the Caja Costarricense de Seguro Social, Costa Rica´s institution that provides all public healthcare services, as Executive President and Chairman of the Board. In his current role, he is responsible for leading Costa Rica´s health care response to the pandemic.

Contact Roman at:
roman_macaya@yahoo.com

Jean-Luc Neptune, MD, WG'02
I officially launched my new venture, Suntra Modern Recovery, right before the pandemic kicked off. Suntra Modern Recovery is an addiction recovery management service that helps families and individuals achieve long-term recovery from substance use disorders. We provide a full continuum of outpatient care services including interventions, recovery coaching, case management, and medication-assisted treatment. Most clients access our service virtually, but we can also deliver care to clients in-person at home or at work through our on-the-go service. I'm proud to be part of a rapidly growing network of Wharton alumni digital health entrepreneurs who are addressing mental health and substance use disorders. We're growing quickly and will be raising money in the near term to accelerate our growth.

Contact Jean-Luc at:
drneptune@hellosuntra.com or 646.734.2320

Ravi Shah, MD'12, WG'12
Ravi N. Shah, MD, MBA was recently appointed to serve as Columbia University Department of Psychiatry and New York State Psychiatric Institute's first Chief Innovation Officer, with the goal of developing our footprint in digital health and innovation and in mental healthcare and addiction.

Learn more.

Contact Ravi at:
Rns2142@cumc.columbia.edu

Quingan Zhou, WG'18
Quing Zhou has started a new role as the Associate General Manager for behavioral health products at the newly merged company of Grand Rounds and Doctor on Demand.

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THIS MONTH'S PHILOSOPHER:
Heidi Sprang, WG'02

To learn more about Heidi, click here.

THE PHILOSOPHER'S CORNER

Heidi Sprang, WG'02

LIFE LESSONS

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

trusted in myself more. I wish I recognized that I have good instincts and make good decisions. Even back then, I knew more than I gave myself credit for, and being apprehensive probably lessened my impact at times.

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

tried to fit other people's molds or stereotypes. I learned that what makes me good at what I do is the unique background and experiences I have. Earlier in my career where I tried to position myself as a cookie-cutter profile, I wouldn't stand out and perhaps even compared poorly to other candidates. Rather, I learned it was more important to sell my unique profile and how that would make me successful. And if a hiring manager wanted cookie-cutter, the role wasn't for me anyway.

FAVORITE QUOTES

1. "*Done is better than perfect*."
   ~ Unknown
   It's important to know what is 'good enough' to make the right decision or move to the next step rather than looking for perfection.
2. *"We must be willing to let go of the life we planned so as to have the life that is waiting for us."* ~ Joseph Campbell
   My path is definitely not the one I might have expected, but I am extremely grateful for the experiences it brought.
3. *"If you're offered a seat on a rocket ship, don't ask what seat, just get on."*
   ~ Sheryl Sandberg
   She may have been talking about the rocket ship of Google, but to me this means, be willing to embrace opportunities when they come along, even when it doesn't seem like the perfect time.
4. "*When you know how to do your job, it's time to move on*."
   An old boss of mine said this to me, and it reminds me to know when to look for that next step and know that I'll figure it out even if it scares me a bit.

RECOMMENDED READING

1. *The Emperor of All Maladies: A Biography of Cancer* by Siddhartha Mukherjee
2. *Good to Great* by Jim Collins
3. *DisneyWar* by James B. Stewart
4. *Steve Jobs* by Walter Isaacson
5. *The Nine* by Jeffrey Toobin

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THIS MONTH'S PHILOSPHER:
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AFFIDAVIT: HEALTHCARE AND THE LAW - PRESCRIBING PSYCHEDELICS TO TREAT MENTAL ILLNESS

Source: Bigstock

Millions of Americans suffer from some form of mental illness each year. Major depression is the most prevalent mental illness, affecting roughly ten percent of American adults. Concerns about mental health and substance abuse have grown year over year, and the COVID-19 pandemic has only made matters worse. One survey found that over 40 percent of adults in the U.S. reported symptoms of anxiety or major depressive disorder during the pandemic - a roughly 30 percent increase in prevalence from the same survey conducted in 2019.[1] Mental illness is undeniably a public health crisis, and the treatment options currently available sometimes fall short or have side effects that are not well tolerated, particularly for conditions like schizophrenia or borderline personality disorder.

Psychedelics have been shown to be viable alternatives in treating depression, substance use disorders, post-traumatic stress disorder (PTSD), obsessive compulsive disorder (OCD), eating disorders, anxiety, and other mental illnesses. However, research on psychedelics has been incredibly limited for the better part of the last 50 years due to various regulatory and societal obstacles that are still very much at play. Some of the major obstacles include federal regulation of psychedelics by the Food and Drug Administration (FDA) and the Drug Enforcement Agency (DEA), as well as regulation at the state level. Aside from regulatory constraints, there has long been a certain stigma associated with psychedelic drugs.

Modern research on psychedelics began in the 1870s and was actually openly accepted for nearly the next 100 years, until clinical trials and medical research were largely abandoned due to changes in public opinion and heightened regulations. Regulation of psychedelics in the United States started in the early 1960s with an amendment to the 1938 Food Drug and Cosmetics Act classifying psychedelics as unapproved, experimental drugs requiring FDA permission before being administered to research subjects. But research activities weren't completely stifled until 1970 when Congress passed the Controlled Substances Act (CSA), under which LSD and other psychedelics, as well as cannabis, were classified as Schedule 1 controlled substances.[2] Such substances are considered to have (1) no currently accepted medical use; (2) a lack of accepted safety for use under medical supervision; and (3) a high potential for abuse.[3] As a legal matter, a Schedule 1 classification limits researchers' ability to conduct clinical research and patients' ability to access the substances for medical purposes.

Today, the DEA and FDA are responsible for federal regulation of psychedelics, primarily through the CSA and Food Drug and Cosmetics Act, which means that even if psychedelics were successfully rescheduled as Schedule II or III, they would still need to complete the FDA approval process before they could be marketed by pharmaceutical companies and prescribed by physicians. And we know from recent attempts to reschedule cannabis that rescheduling psychedelics will certainly be a challenge. In fact, rescheduling is incredibly rare. The DEA has only ever moved a substance from Schedule I to Schedule II five times, and it has only removed a Schedule I drug entirely from the list of scheduled substances on two occasions.[4]

However, both the FDA and DEA have recently acknowledged the growing body of evidence supporting the use of psychedelics for legitimate medical purposes, indicating attempts to reschedule may not be entirely in vain. Although no psychedelics are currently approved by the FDA for the treatment of any condition or disease, psilocybin, the psychedelic compound in "magic mushrooms," has been granted breakthrough therapy designation for the treatment of major depressive disorder in two separate studies since 2018, which is designed to fast-track the development of a drug for serious or life-threatening conditions. The DEA has also just proposed a massive increase in cannabis and psilocybin production for medical research purposes, stating the proposed increase is "directly related to increased interest by DEA registrants in the use of hallucinogenic controlled substances for research and clinical trial purposes."[5]

Artist: Raymond Klavins

Notwithstanding these recent developments, changes at the federal level will likely take time. But, as the medical marijuana industry has demonstrated, strict federal regulation need not stifle innovation altogether. Organizations interested in studying or administering psychedelics are still able to work within the existing regulatory framework by collaborating with the FDA and conducting well-controlled clinical trials to provide evidence and support for the safety and efficacy of psychedelics.[6] Additionally, decriminalization efforts at the state level can be instrumental in promoting ongoing research and innovation. States have the option to take a hands-off approach to psychedelic regulation by removing state-level penalties for individuals who manufacture, possess, distribute, or consume psychedelics. Although individuals who engage in those activities in states where psychedelics are legalized can still be arrested by federal agents and tried in federal court, the federal government cannot compel the states to enforce federal drug law.[7]

Oregon was the first state to officially legalize psilocybin for therapeutic uses in November 2020 with the passage of Measure 109, also known as the Psilocybin Program Initiative. On that same day, voters in Washington D.C. passed a ballot initiative to decriminalize psilocybin and other natural hallucinogens. Since that time, a number of other states, including California, Maine, and Connecticut, have also proposed decriminalization legislation. Texas has also joined the list of states considering a more hands-off approach to psychedelic regulation. Because studies have shown psychedelics to be an effective treatment for PTSD, we may begin to see more traditionally conservative states join this list, as those who would usually oppose decriminalization efforts start to recognize the potential mental

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health benefits for veterans. In addition to state-level efforts, a number of cities across the U.S. have decriminalized psychedelics, including Oakland (CA), Santa Cruz (CA), Denver (CO), Cambridge (MA), Northampton (MA), Somerville (MA), Ann Arbor (MI), and Washtenaw County (MI).

It will likely be a few years at least before psychedelic therapy is widely available in the U.S. as a treatment option, but legalization efforts are gaining steam as is the body of research pointing to the potential health benefits of psilocybin and other psychedelic treatments. We will be keeping an eye out on ongoing state efforts as well as policy changes at the federal level.

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

REFERENCES

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2. Controlled Substances – Alphabetical Order, https://www.deadiversion.usdoj.gov/schedules/orangebook/c_cs_alpha.pdf (last visited September 1, 2021).

3. 21 U.S.C. §§ 801, 811(b)-(c), 812(b)(1); *see also* U.S. DRUG ENFORCEMENT ADMINISTRATION, DRUG SCHEDULING, http://www.dea.gov/druginfo/ds.shtml.

4. See Scheduling Actions: Chronological Order, in U.S. DRUG ENFORCEMENT ADMINISTRATION, LISTS OF SCHEDULING ACTIONS, CONTROLLED SUBSTANCES, REGULATED CHEMICALS (2018), https://www.deadiversion.usdoj.gov/schedules/orangebook/orangebook.pdf.

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7. Id

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DOWNLOADING SUCCESS: 9 LEARNING AGILITY STRATEGIES TO HELP YOU THRIVE DURING CHALLENGING TIMES

Turbulent times are not new to leaders and organizations. However, the recent pandemic has produced a level of personal stress and organizational upheaval not seen in modern times. With healthcare experiencing more unexpected volatility, uncertainty, and complexity than most, it's no surprise that leaders and teams are fatigued and languishing under the relentless pressure.

During the pandemic, many organizations have struggled, yet many others are thriving in the chaos. So, what is it that sets them apart? In the recent SIOP Professional Practice Series book, ***The Age of Agility: Developing Learning Agile Organizations and Leaders***,[1] we share our research which identifies a critical factor that determines whether leaders and organizations will adapt and grow during challenging times – learning agility.

At its core, learning agility is the capacity to adapt to first-time, often tough situations using a variety of behaviors and personal strategies to nimbly learn from our experiences and adjust. Learning agility empowers leaders, teams, and organizations to grow and evolve with a changing landscape, making them more agile and focused with each challenge.

Thankfully, learning agility is a skill that can be cultivated and improved. But developing this "muscle" requires willingness, effort, discipline, and resilience. By focusing on the following nine strategies and behaviors, you can build and strengthen your learning agility.

MINDFUL AWARENESS

A leader's "get things done" mentality is great for action but can make it difficult to see a situation without judgement. Mindfulness is not simply about meditation. It requires full awareness of the present reality to quickly shift from System 1 (fast-reactive) thinking to System 2 (slow-deliberate) thinking. Mindful leaders are self-aware – they know what they're feeling and why, so their emotions don't control their actions or cause them to act impulsively.

FORECASTING

To be agile, leaders should anticipate what new skills they and their team will need and predict what ongoing capabilities are necessary. For example, a manager might ask some team members to attend a conference on business management, while others read a book about working with remote teams. This allows the entire team to become more aware of current issues, and how their skills may affect them in the future.

CURIOSITY AND OPENNESS

While mindfulness and forecasting can point the way, curiosity and openness allow you to move toward an agile learning experience. But changing a deeply ingrained mindset about how you have always worked can be the hardest part of learning agility. Leaders should ask themselves and their teams what new opportunities may arise if they change their approach. In addition to changing *what* they're thinking about, being curious and open to new ways of thinking may also enable the team to impact *how* they approach current and future challenges.

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COURAGE, EXPERIMENTATION AND PRACTICE

Trying new things is frightening and exciting, and it's normal to be apprehensive as you venture beyond your comfort zone. As with any difficult skill, courage is required and is nurtured through deliberate experimentation and practice. Each success will bring you more confidence. Be prepared to "get comfortable being uncomfortable." Start small. Focus your practice by being intentional and testing a variety of tactics to discover the method that best fits your style.

MAINTAIN A LEARNING MINDSET

Studies show that leaders who demonstrate a learning mindset notice opportunities for improvement, grow their skills, and adapt more easily. They often view challenges – and even mistakes – as opportunities to learn and develop. To get into this state of mind, replace self-defeating messages, such as "I'll never be able to lead a remote team," with more productive ones like "What approach might work better next time?"

LEARN FROM OTHERS

People often believe their leaders have all the answers, are confident and self-assured, capable of mastering any task or situation without assistance. However, it's important to realize that successful leaders recognize their limitations and embrace the knowledge of others. They don't know it all, but they know where to turn to find answers. Asking for help demonstrates wisdom and maturity rather than weakness.

SEEK FEEDBACK

Knowing what to start, stop, or continue is tough to know without seeking regular feedback from a variety of viewpoints. Asking for comments may feel awkward at first. However, requesting feedback can be as simple as calling, emailing, or texting a colleague to ask, "What do you think went well?" or "What would you suggest I do differently next time?" It's easy to be defensive if the feedback is critical, but being open and curious will ensure others remain comfortable giving feedback in the future.

REFLECT

Reflection provides opportunities to distill lessons from your experiences and turn them into "learning experiences" that can then be applied in the future. It enables you to proactively think ahead about how you will put a new capability into practice. Set goals such as, "For our next meeting, I'm going to focus on asking questions rather than telling the group what to do." After-action reflection helps you determine what worked and what didn't. This can be done immediately following a meeting or at longer intervals, such as recapping daily or weekly progress.

RESILIENCE

Clarity of purpose about why change is important keeps us grounded when times are tough. Having a structured learning plan and goals gives us focus, allows us to plan action steps for how to achieve our goals, and identify ways to measure progress. Considering obstacles and preparing "if-then" statements can help clarify opportunities to change our thoughts or behaviors. For example, "IF I find myself talking too much in a meeting, THEN I will pause and ask a question to engage others."

Becoming learning agile requires looking at life through a new lens and being courageous as you approach things differently. While it takes tremendous, intentional effort to develop, learning agility empowers us to survive and even thrive in these unpredictable times.

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REFERENCE

1. Harvey VS and DeMeuse KP. (2021). *The age of agility: Building learning agile leaders and organizations*. London: Oxford University Press.

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CYBERVITALS: 5 SECURITY LESSONS FOR CONNECTED HEALTHCARE

Ransomware is top of mind across healthcare these days, as institutions are attacked and forced to deal with unsavory negotiations. While healthcare delivery organizations often suffer financial, reputational, and patient impacts, we would be remiss to not think about how we got here. The requirement for connectivity in most settings is driven by devices or systems which require it. Below are 5 lessons we should all consider when choosing to connect a device or system in a healthcare setting:

LESSON 1: CONNECTIVITY REQUIRES SECURITY

Telehealth services took center stage during COVID. Devices in healthcare delivery organizations (HDOs) became connected to deliver additional clinical functionality for patients who couldn't see their doctors in person. Electronic health records can be rapidly shared across a care team, ensuring care is planned with all the data available. These have been incredible advancements for patients and clinicians. But this connectivity was not designed with security in mind.

Now don't get me wrong - healthcare should focus on healthcare. Not on becoming security experts. But the reliance on technology will never go away - it has improved diagnostic capabilities, given us new treatment options, and reduced 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.

LESSON 2: AS ATTACKERS MOVE UP THE SUPPLY CHAIN, SO MUST DEFENDERS

Increasingly, there have been wide-spread, deeply embedded vulnerabilities emerging from the hacker community (ex. Ripple/20, Bluekeep, WannaCry). If we think of hacking as a business, the return on investment for a systemic issue that spans devices and industries vs. an idiosyncratic hack in a single device in a single instance, is obvious math.

Attackers have seemingly limitless budgets, as spending is estimated to reach $10.5 trillion USD annually by 2025, up from $3 trillion USD in 2015. We see defenders' security investment around $100B, with pretty steady increases by 10%. Recent news of Solarwinds by Microsoft showed it took more than 1,000 engineers to create. Is there ANY organization that can compete with the resources attackers have?

LESSON 3: PLAN. PRACTICE. PERSIST.

Prior to connecting anything to a network, we have to understand the impact of that decision. By understanding the potential threats based on the attack surface, whether as a device manufacturer, healthcare delivery organization, or vendor of security services, this will enable building a plan of action to mitigate potential threats.

Once a plan has been developed, it is equally important that it be understood, ingrained in day-to-day operations, and regularly reviewed. As attackers change, so must the defense. And we must be honest with ourselves - things aren't

going to be perfect. Where there are setbacks and misses, take the opportunity to build, enhance, and re-educate.

LESSON 4: DESIGN WITH SECURITY IN MIND

The danger I see is that healthcare constantly blames the user/patient. Whether it's patient adherence, login/password management, or phishing failures, this isn't an industry that has historically optimized for easing the user experience. It goes to my earlier point - we optimize for patient outcomes.

Therefore, we must design devices to be secure, starting at the inception of the device. The best systems are those which do not rely on the user as the detector, 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.

LESSON 5: DON'T GO AT IT ALONE

Medical device security is a unique environment - with complex networks, various entities involved, and complicated asset management requirements.

Relying on a third-party can address core cybersecurity requirements, but some may argue there are too many tools that insufficiently "solve" a problem. I agree - more tools doesn't equal better security. Similar to the hospital setting, alarm fatigue from too many tools can result in missing an important alert. However, that doesn't mean everything should be built in-house and no experts should be used.

Once upon a time there was one mainframe, green screen, and a printer; there are now innumerable client access methods, networking, remote connectivity, security, storage, server infrastructures, virtualization, and so forth. As the range of technical needs has grown exponentially, it is increasingly difficult to secure it all.

Leveraging an expert in security built for healthcare can relieve the mounting necessity for devices secure by design.

CONCLUSION

We've seen progress to date, but we are not moving with sufficient urgency.

Cybersecurity costs are managed most efficiently when integrated into core business decisions. In an efficient economy, access to cybersecurity expertise is the way to ensure efficient and effective solutions that persist the lifetime of a device.

On net: there are truly impactful ways to create more good with less; but to get there, we have to do things differently than we have in the past.

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CRISIS MANAGEMENT PLAN FOR A PANDEMIC - LESSONS FROM A HEALTHCARE SYSTEM

Photographer: Joel Muniz

Every organization in the world has had to rethink operations due to the COVID-19 pandemic. Facing a global pandemic on a scale not seen in over a century, organizations in every industry faced massive disruption. The healthcare industry faced perhaps the most difficult challenge: not just to survive the pandemic, but also to care for the victims of it. Although hospitals manage "emergencies" routinely, the types of crises hospital administrators and healthcare professionals are accustomed to are generally narrowly focused on medical emergencies, not sudden, massive business disruptions such as those caused by the pandemic.

One way to define a crisis is an event that threatens the financial viability, reputation, and mission of an organization. Hospitals were vulnerable to all three risks during the height of the pandemic. Over the past 2 years, hospitals and healthcare staff have been thrust onto the front lines of a battle not only to save the lives of coronavirus patients, but also a battle for their own institutional survival. Declining revenues, a weakened workforce, and skepticism of management combined as a potent threat to even the most robust healthcare systems. Based on the experiences of an internationally renowned tertiary care academic health system, we outline the crisis management strategies that were used to survive and thrive through this crisis.

MANAGEMENT AND TRUST

As with any crisis response, one of the key challenges to leadership during the COVID-19 pandemic was trust. As the world looked to healthcare systems for answers, healthcare leaders had little accurate or reliable data to understand and predict the virus. Rapidly developing projections were frequently unreliable. Hospital leaders were asked to provide immediate answers to their staff and the general public, while navigating the tension between maximizing transparency and unreliable information.

As the massive scale and deadly threat of the pandemic became apparent, hospital staff asked tough questions that had a real impact on their safety: how could staff without access to appropriate Personal Protective Equipment (PPE) be obligated to care for patients who could infect and kill them? How could healthcare workers protect their loved ones? What were the best strategies to allocate scarce, life-saving resources? How could a balance be struck between COVID-19 care and non-COVID-19 care? These frank questions called for frank answers.

One way to build, maintain, and operationalize trust is by delineating trust in communication. In doing so, transparency – including transparency about the unknowns – was crucial. Daily communication and frequent town hall meetings relayed the latest information, successes, and developing threats to employees. Full disclosure of the information available, as well as disclosure of the reliability of that information, was paramount for developing and maintaining dependable relationships.

OPERATIONAL DISASTER PLAN

Over the past two decades, healthcare systems have faced the crises of SARS, H1N1, Ebola, and now COVID-19. There has been a trend of novel viruses causing pandemics roughly every five years, with each subsequent one being more disruptive than its predecessor. Hospitals have been able to tackle these sudden crises by preemptively establishing a "command center" strategy for corporate governance before the next threat manifests – a game plan that can be quickly implemented when a massive threat emerges.

A command center strategy consists of organizing a command structure, that includes leadership personnel, key stakeholders, and operations managers. The purpose of the command center is to coordinate logistics, briefings, finances, and recovery. This strategy builds a clear chain of command and organizes resources at precisely the moment when the confusion of a crisis threatens clear communication and assignment of responsibility.

When time is of the essence, executives feel pressured to provide answers about matters that are not in their area of expertise. Accustomed to being the source authority for the most difficult dilemmas within the organization, they are thrust into an unfamiliar position which, without an appropriate strategy, can lead to grave errors in judgment. Fueled by the stress of a massive threat, these errors can rapidly degrade into chaos, with people thinking and acting for only themselves or their units, rather than for the organization. The key to navigating these complex situations is investing in relationships before a crisis occurs. Leveraging preexisting relationships allows for team members to clearly understand roles, responsibilities, and limitations.

As with all the previous communicable pandemics, respiratory protection was the most significant vulnerability with COVID-19. As supply chains broke down, many people within the organization generated ideas for solutions; some even invented their own equipment. With a clear hierarchy and clear communication streamlined by the command center, leaders were able to identify high-value ideas and use a team-based approach to rapidly overcome barriers to implementation, such as scalability, an intricate regulatory environment, and complex logistics to quickly implement life-saving solutions.

COLLABORATION AND FLEXIBILITY

Novel circumstances require novel solutions. Threats from an external crisis provide a unique opportunity for organizations to develop new collaborations while facing a common adversity. Enterprise-wide problems, such as the shortage of PPE, managing non-urgent medical procedures, and the occupational hazards of caring for COVID-19 patients, brought about system-wide innovations and provided a profound moment for breaking down barriers between departments. Innovations such as integrating new telehealth technology into a large healthcare system – a process that would typically take years – were achieved in mere weeks, capitalizing on the sudden alignment and flexibility of disparate teams. New collaborations with the neighboring School of Engineering led to creative solutions, such as manufacturing our own PPE. These examples of rapid innovation and massive change in a short period of time highlight the potential for organizations to strengthen during a crisis.

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One of the biggest vulnerabilities throughout the pandemic has been the workforce. Contracting the virus, exposure to the virus, and quarantine requirements thereafter created a dynamic challenge both to individual staff and patient safety. Decisions to modify staffing models were made with a highly visible commitment to both missions of caring for patients and safety of staff. By unifying under these dual commitments, healthcare workers and management teams successfully developed multiple staffing contingencies, including building teams to work in rotations to have a reserve staff in case of an outbreak among workers. Focusing on flexibility, collaboration, and commitment to the mission, allowed the organization to leverage the crisis to foster a culture of solidarity.

FINANCIAL VIABILITY

Financial survival was not made a priority over health, safety, and wellness of staff. Given the global health crisis, a public display of financial incentive-driven reasoning would have alienated staff and patients and fostered a reputation of fragility rather than of strength and durability. However, conducting a financial analysis in the background was necessary for organizational survival. Healthcare systems ultimately needed to survive the pandemic in order to continue the mission of serving patients. Business impact analysis, or hazard vulnerability analysis, and business continuity planning were essential for the survival of the organization's employees and its balance sheet. Such analyses can identify key areas of risk that represent opportunities to mitigate losses.

Financial crisis response was as important as the operational crisis response. Immediate reactive measures such as cost savings from staff reductions were tempting, although not the appropriate sustainable solution. Such a strategy would have had a longstanding, detrimental effect on the organization's identity: the organization abandons its employees at a moment of shared vulnerability resulting in a longer-term deterioration of trust. Additionally, the human resource costs of firing and later rehiring employees may have outweighed the cost savings achieved in the short-term. Not knowing when the pandemic would ease, our healthcare system did not pursue a strategy of downsizing, despite the massive fluctuation in demand for care. Rather, the healthcare system redeployed staff who were not being used for patient-facing services to help with the crisis response.

With the national pandemic, supportive laws and regulations assisted with financial optimization. Government support for essential services mitigated short-term losses and provided supplemental revenue. The federal government offered minimal interest rate loans to businesses, recognizing organizations' acute financial needs. In healthcare, rapid amendments to the Medicare Physician Fee Schedule by the Center for Medicare and Medicaid Services to include parity for telehealth services provided an opportunity not just to reduce financial vulnerability but also to continue caring for patients.

CONCLUSION

The COVID-19 pandemic provided a rare opportunity to stress test every organization. Each organization could be judged on how they coped with the same universal adversity. An organization's mission, vision, values, and culture were pressure-tested through the historic crisis. Institutions with a strong foundation in crisis management shined, while those with cracks in the foundation had those weaknesses exposed. The principles outlined herein highlight the need for leaders to prepare proactive crisis management strategies. Doing so will enable them not just to survive a crisis, but to convert the threat into an opportunity to reinforce the mission, vision, and values of the organization.

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"ANNIVERSARY SPOTLIGHT": IS DENTISTRY READY TO PLAY IN THE MAJORS?

Can dentistry play by the rules of contemporary healthcare and become meaningfully integrated into it? Or will it remain, by its own choice, something historically apart?

The current proposal for dental coverage under Medicare, as of this writing, provides a fitting opportunity to examine the question and dentistry's place in the solar system of American healthcare. First, a bit of a refresher. While a herculean political achievement at the time, Medicare in retrospect appears a more modest achievement - it lacked innovation, precluded the restructuring of health services, and merely replicated the open-ended financing of Blue Cross and Blue Shield.[1] Together with Medicaid, it also helped stoke an era of healthcare cost inflation.[2] We have been attempting to deal with the consequences ever since, culminating most recently in the ACA, with its emphasis on integrated comprehensive care, prevention, primary care, population health management, and "value over volume," all of which hinge upon innovations in delivery models, i.e., ACOs, and especially in value-based payment models. Except for a few conditions deemed "medically necessary," dental benefits are not included in Medicare, the "socialized medicine" fulmination having been used to good effect back in 1965.[3]

WHY THE PUSH FOR MEDICARE COVERAGE NOW?

Of course, the usual suspect is money. Concerns over the spread of COVID-19 resulted in a drastic loss of business and a 17.9 percent drop in net dentist income in 2020 compared to 2019.[4] But the effect stands to persist with the volatile recovery of employment and loss of employer-based dental coverage, compounded by the traditionally high out-of-pocket expense of dental treatment for those in low-paying jobs, with few, if any, benefits for those going the self-employment route.[5] Given this scenario, it is only logical to seek new markets, especially with the prospect of stable and sufficiently remunerative financing, hence the appeal of the heretofore neglected and ignored Medicare population, in effect making amends for the snubbing of Medicare back in 1965.

IN THE RUNNING FOR MVP? HARDLY.

As outlined above, a range of initiatives and concepts are being employed under healthcare reform to bring better alignment between what we spend for healthcare and what we get in return, to make healthcare "worth it." Changes are taking place in the systemization of healthcare, in delivery models, in accountability, and especially in how healthcare is financed to realize "value over volume." In complete contrast, and like a prehistoric insect caught in amber, dentistry continues to organize itself around its central creed of practitioner autonomy, played out through a cottage industry of private practice, fee-for-service artisans adhering to a "volume over value" doctrine. In so doing, it seeks to set and control the terms and conditions under which dental care is perceived and provided.

Thus, although tooth decay is a preventable disease, and retention of a complete natural dentition throughout one's lifetime is not only conceivable but achievable, dentistry largely minimizes the role of prevention, seeing the occurrence of decay more as a moral failing on the part of the patient with poor oral hygiene habits rather than restriction in preventive measures, such as allowing the independent practice of dental hygienists who could provide the clinical and behavioral modification measures for effective decay prevention.[6] As such, dentistry regards tooth decay and tooth loss as inevitabilities, the remedy to which is the centuries-long practice - updated with all the sophisticated and intricate "drill and fill" procedures and armamentaria of "modern dentistry" - of modifying, refashioning, or replacement of tooth structure after the disease process has taken its toll.

This is what dentistry equates with quality dental care and good dental health. Society pays the bill for this perception of dental care in terms of direct payment for such treatments, foregone savings from unrealized prevention, and the suffering, in avoidable pain and debility, by those unable to access care.[7]

Source: Pixabay

This state of affairs needs to be stacked up against not only the aims of ACA healthcare reforms, but also the assessments of some accomplished, long-experienced, clear-sighted, and truly authentic thought leaders in dental care:[8]

- The dental profession is overtrained for what dentists do and undertrained for what they should be doing.
- Dentists are paid for, or evaluated based upon, the number of procedures performed, rather than for establishing health. Frequently, this results in overtreatment.
- Few dental educators and academic leaders have given much attention to considering how the current structure and organization of the oral healthcare system acts as a major obstacle for achieving a functional, natural dentition for life for all.

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- The majority of dental caries (tooth decay) and periodontal diseases can be managed by individuals practicing healthy lifestyles (particularly diet and hygiene) with support of a range of health professionals. It should not need expensively trained dentists, as is the current model.
- The classically trained dentist is predominantly shaped in a mechanically and technically focused dental curriculum. Therefore, s/he is not adequately prepared for leading teams of oral healthcare personnel that could be responsible for a population's oral health, diagnosis, control, and prevention of disease, and making suitable treatment decisions.
- The current practice-based approach to dental treatment and rehabilitation of individuals represents a cul-de-sac from a social, ethical, and cost-effectiveness point of view. Improved oral healthcare systems cannot be achieved through minor adjustments to the dental curriculum, the number of dental specialties, payment systems, or the solo-practice-based delivery system. *In my view, it necessitates a more profound break with long-standing traditional thinking in dental education and in the organization of oral healthcare delivery.*

In conclusion, back to the minors, a lot of work to do.

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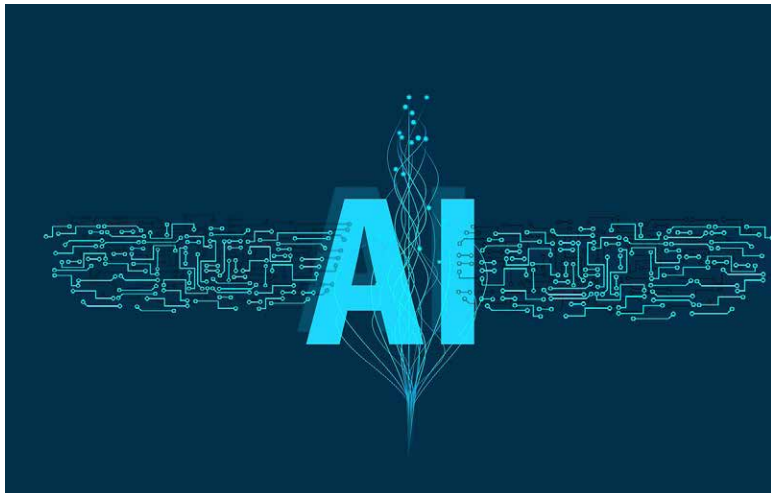
HARNESSING AI TO IDENTIFY UNDIAGNOSED BEHAVIORAL HEALTH CONDITIONS - CUTTING COSTS AND IMPROVING LIVES



Managing undiagnosed behavioral health conditions is a major population health issue and creates increased costs of hundreds of millions of dollars. Smart AI implementation can help health plans proactively identify individuals in need of appropriate screening and management leading to reduced cost of care and improved patient lives.

There is a growing awareness of behavioral health issues that face millions of Americans. Previously thought of as "invisible," these issues and their impact are now at the forefront, thanks in part to the added stresses of COVID-19. Behavioral health (BH) conditions can lead to substance abuse, loss of income, increased likelihood of future chronic health issues, and can impair an individual's ability to live a full, functioning life. More worrisome is the growing number of individuals whose behavioral health disorders remain undiagnosed. These untreated individuals suffer personally, are a burden on the medical system, and create billions of dollars in economic loss.

Out of the more than 56 million adults in the United States living with diagnosed behavioral health conditions, approximately 39.7 million did not receive treatment in the past year.[1] Individuals with untreated behavioral health conditions account for $51.5 billion in workplace losses (productivity, short-term disability, and increased sick days).[2] Depression (a leading untreated behavioral health condition) is the dominant medical disability for individuals aged 15-44, and the costs of untreated depression account for $26.1 billion in expenses to the healthcare industry and a total economic loss of over $83 billion annually.[3]

IDENTIFYING UNDIAGNOSED DEPRESSION FROM THE DATA

Diagnostic Robotics, a leading digital health company has developed an artificial intelligence (AI) model that identifies patients with undiagnosed depression. This model assists health plans in identifying patients who are at risk for undiagnosed behavioral health conditions in their member pools. By relying on claims data points (the most common form of data available to health plans), the model uses deep learning technology to analyze each individual member's personal medical profile, including past procedures, office visits, diagnoses, medications, and other indicators, to detect patterns of utilization indicative of an underlying behavioral health issue.

Reaching high precision with these machine learning models requires substantial under-the-hood technology. Medical claims need to be translated into features digestible by machine learning models. Diagnostic Robotics uses a hybrid clinical-AI approach whereby Diagnostic Robotics' physicians provide the underlying medical insights about dimensions of the data worth exploring, and then a suite of machine learning techniques, including:

- embeddings (a technique used to transform the rich underlying data structure of medical records into a format that is digestible by machine learning algorithms, while preserving the informative content of the records)
- neural nets (also known as "deep learning," an AI technique for creating prediction models that are not constrained by the simplistic mathematical nature of traditional statistical methods but can capture complex patterns of interaction between variables to deliver precise predictions), to slice and dice the underlying medical utilization data into accurate models.

The models also need to be audited for bias to promote healthcare equity. Without such a systematic review, certain disenfranchised populations may easily be under or over-represented in the predictions. The combined AI medical discovery platform can be directly applied to different payer data structures using a data warehouse structure mapping method.

EXAMPLES OF UNDIAGNOSED DEPRESSION MARKERS

As an example of signals picked up by the AI model, meet Patient 1, a 48 year-old female, who has undergone multiple musculoskeletal X-rays (including elbow, shoulder, knee, and spine). While multiple X-rays are not necessarily indicative of an underlying behavioral health issue, they are a marker in combination with other signals such as behavioral health related diagnosis, utilization of core medical procedures, and additional chronic conditions. The AI model picked up on these disparate X-rays, in combination with other utilization patterns, as indicative of underlying behavioral health issues. Patient 1 was indeed diagnosed with major depressive disorder after the model prediction.

As another example, meet Patient 2, a 29 year-old male, with multiple past prescriptions for alprazolam (Xanax). The patient did not have a depression diagnosis when flagged by the model, but the model picked up on the chronicity of the prescriptions as a risk marker, which in combination with other factors in the patient's medical background, flagged the member as high risk for undiagnosed depression. The member was eventually diagnosed with depression within two years (long after the model prediction) and began treatment with SSRIs.

DRIVING CLINICAL OUTCOMES AND COST OF CARE IMPROVEMENTS WITH AI

The model exhibits good performance in being able to identify the disease earlier than other modes of diagnosis and has the potential to improve patient outcomes by providing care earlier. Of the patients flagged as high risk for undiagnosed depression, 24%-52% (depending on the population) will be diagnosed with Major Depressive Disorder

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(MDD) over the following two years after the model's early warning. This figure likely *understates* the actual prevalence of undiagnosed depression, since some of these members might never receive a diagnosis despite the presence of underlying medical conditions which are associated with or can lead to depression.

Insured individuals with undiagnosed BH conditions are also untreated (for their BH conditions); untreated individuals have a much higher cost of care. Among a population of insured individuals with COPD analyzed by Diagnostic Robotics, those with untreated BH conditions each cost their insurance plan $1,644 more in annual costs as compared to a matched sample[4] of insured individuals with similar medical profiles.

Moreover, insured individuals with a high risk of undiagnosed BH conditions have a higher probability of becoming "cost bloomers" (patients who experience a surge in healthcare costs over multiple years). In fact, they are 2.8x *more likely* to become cost bloomers than the general population. When these individuals become cost bloomers, they become more expensive than average cost bloomers. Diagnostic Robotics' models have found an average cost bloomer creates a $51,948 per member per year (PMPY) increase in costs, while an undiagnosed BH cost bloomer creates a $58,888 PMPY cost increase on average.

Implementing smart AI can help health plans reverse these troubling trends and avert a major population health crisis. By proactively identifying individuals at-risk, it can dramatically reduce the cost of care and improve countless patient lives.

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HOME HEALTHCARE AND A TIME FOR GROWTH

Photographer: Anastasiia Chepinska

The home healthcare field is a rewarding one, granting people – from medically fragile infants to adults with spinal cord injuries, to those who are terminally ill and needing hospice, and beyond – the chance to live safely in the comfort of their own homes, where they can thrive with dignity. Much like clients can vary in age and needs, employees in home healthcare span a variety of disciplines. Professionals in the field include nurses, physical therapists, home health aides, and more.

DEMOGRAPHICS

According to The Commonwealth Fund, approximately 4.5 million people used some form of home health services in 2016, and 78 percent of those users were Medicare beneficiaries. As the CEO and Practice President of the Senior Care Group at BAYADA Home Health Care, a leading global not-for-profit provider of in-home healthcare and support services spanning birth to end-of-life — including senior care and physician services to provide primary care services to homebound seniors — I have seen this number only continuing to grow as America grows older and more people are looking to age in place in the comfort of their homes with their loved ones. In fact, The Urban Institute reports the number of Americans ages 65 and older will more than double by the year 2040 — reaching 80 million people.

According to the 2020 Alliance for Home Health Quality and Innovation report, the majority of recipients of home health services are:

- Women (63.3%)
- Located in urban areas (91.0%)
- White (80.4%)
- Have 5 or more chronic conditions (47.1%)

Those with Medicare coverage are older, more likely to have 2 or more chronic conditions, more likely to live alone, more likely to have 2 or more ADL (activities of daily living) limitations, and have income more than 100% below the Federal Poverty Level (FPL) compared to all Medicare beneficiaries as a whole.

Their top DRG diagnoses include sepsis (bloodstream infection), hip or knee replacement, pneumonia, stroke, and kidney or urinary tract infection. Their top ICD-10 diagnoses include diabetes, COPD, hypertension, heart disease, pressure ulcer, and chronic kidney disease.

STAFFING SHORTAGES

The recent COVID-19 pandemic put an especially bright spotlight on the growing demand for home healthcare as people sought out opportunities to stay safe at home and avoid overwhelming hospital systems. This desire may very well be here to stay and has a variety of implications — with a higher demand for home healthcare services, more home healthcare professionals are needed to take on the client cases. The Paraprofessional Healthcare Institute (PHI) forecasts that by 2029 we will be short by 4.5 million caregivers in the home care workforce nationally.

While the pandemic certainly exacerbated the need for home healthcare workers, the industry had already been facing a staffing shortage due to low reimbursement rates, and thus salaries, for much-needed home healthcare heroes. As a result, many organizations, including BAYADA, are working to advocate for higher reimbursement rates for both home health aides and nurses. For example, we are asking the legislature to better fund the pediatric shift nursing program, in an effort to be able to recruit more nurses into home healthcare to make sure families that need this care can access it. In some places we have been able to offer personal care aides about 20 percent above minimum wage, which is extremely helpful in addition to our other recruitment efforts.

IMPACTS OF COVID-19

Of course, the COVID-19 virus impacted the home healthcare industry in a variety of other ways beyond staffing challenges as well. For example, BAYADA opened a personal protective equipment (PPE) distribution center where we sourced and shipped thousands of essential PPE to our service locations to quickly get them in the hands of our clinicians; and we continue to allocate resources to ensure the safety of our clients and employees through increased investments in PPE and other supplies. Additionally, we implemented more extensive training to limit the spread of the COVID-19 virus through BAYADA's Infection Prevention Program, which provides the highest standards of infection prevention practices as recommended by the Centers for Disease Control (CDC).

Advances in technology and digital health have accelerated during the pandemic. Remote monitoring, wearables, telehealth, fall protection devices, digital assistants, virtual reality devices, and GPS trackers enable the potential of expanded access, reduction in health disparities, other gaps in care, more continuous care, and, in select situations, even "hospital at home."

CONCLUSION

Despite the staffing challenges and other changes the pandemic brought about, it is an especially exciting time to be in the home healthcare field, with growing opportunities to reach more people in need of the quality care they deserve.

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RECOVERING AND THRIVING POST-PANDEMIC - PART 3: PEDIATRIC CARE AND CHILDREN'S HOSPITALS

As the third article in our series, we are going to focus on pediatric care and children's hospitals. If you have followed our series so far (Part 1 and Part 2), you already know we are covering tactics for healthcare organizations of all kinds to recover and thrive as the pandemic recedes. We will touch on issues unique to the pediatric arena, as well as tactics to support financial and operational recovery.

CHILDREN AND ADOLESCENTS AT RISK OF BECOMING UNINSURED

In our last article, we noted the dramatic shift in payer coverage which impacted every corner of our country. As dependents of parents/caregivers who suffered job change and/or loss, children and adolescents were not immune to this shift. Employees and their families lost employer-based coverage and became enrolled in Medicaid or exchange plans. While taking advantage of safety-net programs has had a short-term positive impact, an enrollment cliff impacting an estimated 15 million Medicaid enrollees is forthcoming, as programs enacted through COVID-era legislation come to an end in 2022. Of those children and adolescents estimated to lose coverage, only ~ 60% will be eligible for the Children's Health Insurance Program (CHIP) – providing health insurance coverage to eligible children, and the others are at risk of losing coverage altogether.[1]

Recovery Tactic: As part of a successful financial recovery plan, it is important for pediatric providers (i.e., children's hospitals and pediatric primary care and specialist physicians) to protect both the continuity and the continuation of key primary and specialty care services by helping to ensure access to sufficiently insured pediatric populations. If not sufficiently insured, parents/caregivers may delay necessary care for their children and adolescents leading to eroding provider revenue. Additionally, an unfortunate impact of delaying care is also potentially raising the risk of future catastrophic cases, adverse care outcomes and/or complex, comorbid patients – who may also be obtaining care while uninsured. Therefore, children's hospitals and pediatric care providers should help head off coverage issues through hands-on education to parents/caregivers regarding the changes in eligibility criteria under Medicaid. Additionally, steering them to any alternative programs that may be available to obtain and retain coverage will help. These alternative programs, which vary by state, could include local/county/regional programs that offer premium assistance, vouchers, etc.

ISSUES AND RECOVERY TACTICS FOR CHILDREN'S HOSPITALS

Early in the pandemic, in certain parts of the country, children's hospitals were used as surge locations where pediatric beds were temporarily converted to adult beds.

Recovery Tactic: While obvious, facilities should quickly return converted beds to serve pediatric cases to reach full census capacity. Also impacting children's hospitals is the larger than normal fluctuation in elective cases, correlated to the ebb and flow of cases in particular regions of the country. Even as vaccinations started to impact the trajectory of the pandemic throughout 2021 due to Delta and other variants, many concerned parents/caregivers chose to delay

hospital-based and ambulatory care, testing, procedures, or other care that did not have a threatening impact on life or limb. However, as we all know, research has shown that delays in care often lead to more complicated interventions – and can potentially result in a lifelong decrease in quality of life affecting younger patients for a longer period during their lifetimes.

Recovery Tactic: Educating parents/caregivers and making them aware that children's hospitals are open and safe to enter needs to be implemented if not being done already. In addition, emphasizing again that delaying care can result in permanent adverse outcomes as described above needs to occur. Pediatric specialists can engage with their primary care referring physicians to help convey these key messages when discussing care options with parents/caregivers and to encourage decisions to help result in better outcomes overall.

ISSUES AND RECOVERY FOR PEDIATRIC PRIMARY CARE AND SPECIALISTS

In the overall realm of pediatric physicians, both primary care and specialists have each had their share of challenges during the pandemic. As with children's hospitals, the pandemic has disrupted the flow of patients engaging with primary care physicians (pediatricians and family practice physicians alike) for well-baby, well-child, sick visits, and immunizations, as well as for specialty care referrals and surgical procedures. While these disruptions should begin to return to normal as the pandemic subsides, they have not yet returned even to baseline.

Recovery Tactic: Pediatric physician offices/medical groups should build an outreach program to realign pediatric primary and specialty care as capacity and safety protocols allow. Ensuring parents/caregivers understand that pediatric offices, practices, and clinics are safe, and that delaying care can impact the long-term health of their children and adolescents, can help re-establish care relationships.

Virtual care and telehealth have had a different set of impacts/implications for children and adolescents when compared to adults. While telehealth deployments have had varying success in pediatric population health management (particularly medication management and monitoring), the adoption rate has not been as robust as with the adult population. This is especially true in the Medicaid population, where technology barriers (the digital divide) have further impacted the ability for telehealth to take hold.

Recovery Tactic: Pediatric provider organizations that have an existing/deployed telehealth program should build an optimization program to gather intelligence from parents/caregivers with a high utilization rate and use these insights to optimize programs. Organizations that have not yet deployed telehealth should consider whether technology investments make sense operationally and financially.

As we have said in previous articles, recovering in a post-pandemic world will take many forms, so organizations will have to employ a number and combination of different tactics to fit each current and possibly unique situation. That said, we believe pediatric providers have the ability to recover and thrive as well as their adult provider counterparts.

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THE VALUE OF COACHING IN ACADEMIC MEDICINE

Source: Pixabay

The intense stressors on leadership in academic medical centers (AMCs) have been exacerbated by the turbulence of the current moment and the many dimensions in which it manifests — around workforce challenges and burnout, financial stresses, mergers and acquisitions, technological shifts, and evolving regulations. Though highly trained in their disciplines, clinical leaders need to tap into the full breadth of skills necessary to lead complex organizations. Consequently, the transition from practicing clinician, educator, and/or researcher to an organizational leadership role requires significant changes in identity and focus, as well as the development of new leadership competencies.

Beyond the traditional avenues for leadership training — didactic and experiential offerings, training programs through AAMC, etc. — an increasing number of AMCs utilize coaching for executives as a way to support healthcare leaders at various stages of development.

Coaching offers leaders a valuable set of benefits, including a structured focus on their development, a reflective sounding board, and critical individualized advice applied to their specific leadership challenges and overall development. Coaching also helps leaders define their professional trajectory and the skills needed to be successful, both in their current role and into the future. In contrast to other leadership training approaches, coaching provides advice over an extended timeframe and skill-building based on the actual, real-time challenges encountered by leaders in their roles. Indeed, there is initial data that indicates coaching can help alleviate clinical burnout and turnover.[1] Although the benefits of coaching and leadership training more broadly can be difficult to rigorously evaluate, there is a growing body of data that indicates a positive impact of coaching for leaders in healthcare overall.[2]

Yet our experience has revealed many barriers that limit the positive impact of coaching, including:

- **Concerns about cost and the return on investment.** Coaching for individuals and groups of leaders requires significant investments — in resources, time, and energy. How can leaders be sure their investments in coaching will be worth the expense?
- **Individual vs. systemic views.** Focus on individual development without a complementary focus on the group or unit may limit the impact of coaching.
- **Active engagement.** When coaching is recommended for struggling leaders as remediation, the coachee may agree to appease a supervisor, while privately declining to actively engage with the work. Even in these cases, it is critical to orient the coaching towards goal-setting, organizational needs, and active involvement of the leader being coached.
- **Generational differences.** Emerging and current leaders may demonstrate differing degrees of interest in coaching overall and in the type of coaching desired. Younger leaders may be less apt to engage in one-on-one coaching and be more interested in peer support.[3]

Effective leadership development often requires multiple approaches, guided by organizational priorities, the different needs of individual(s), and their respective motivational levels. Below are some ideas to consider in how to effectively build an organizational approach to executive coaching:

- Build reflection and measurement into an approach to coaching, ensure that coaches and coachees are setting both short-term and longer-term goals, and monitor and reflect on progress in support of these goals. Measures of leaders' self-efficacy before and after coaching interventions, such as meeting individual and organizational goals, as well as 360-degree evaluations can also demonstrate outcomes.
- The relationship between a coach and coachee requires good chemistry, which can be difficult to anticipate. Ask mentees to consider multiple coaches before reaching a final decision and encourage consideration of different styles and approaches.
- Coaches should be screened and carefully selected by the organization to ensure they have the requisite skills and experience to effectively and consistently engage mentees.
- Longer-term impact can be measured in leaders' career trajectories and in their satisfaction with their work, though this data can be tricky to collect.
- Avoid taking a one-size-fits-all approach to coaching. Leaders can and should be offered different coaching options to meet their needs and preferences, including peer group coaching and virtual sessions.
- Coaches themselves can also be informed in ways that best support the needs of leaders in that particular organization, thereby providing a better understanding of the culture and organizational challenges.
- Combined leadership development and coaching programs can be highly impactful, both for individuals and for cohorts in a health system, as it combines a focus on individual behavior with the experience of group learning.

In conclusion, there are many factors to consider for executive coaching to maximize its impact for leaders in academic medicine. The needs of leaders and organizations at this moment are particularly salient, and coaching is a vital component of a holistic approach to leadership training in academic medicine.

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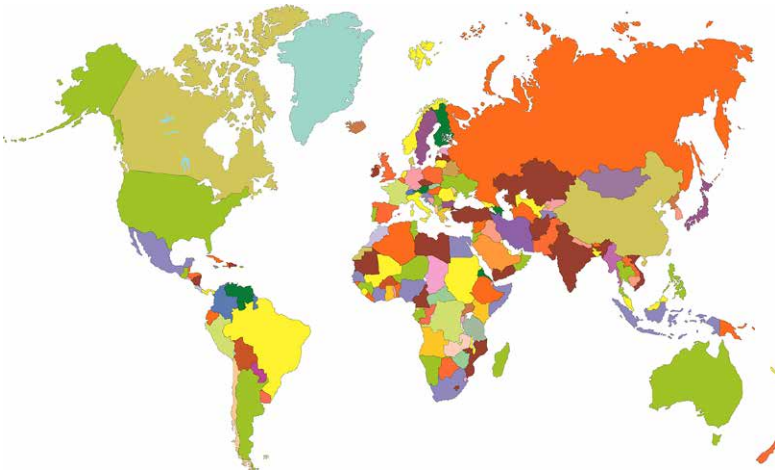
WHARTON AROUND THE GLOBE: WGHV AIMS TO IMPROVE ACCESS FOR UNDERSERVED POPULATIONS - UPGRADING A RURAL HEALTH CENTER AND EXPANDING E-PHARMACY IN KENYA



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The Wharton Global Health Volunteers (WGHV) made the best of a challenging 2020 – 2021 academic year in the face of significant COVID-19-related travel restrictions, as well as myriad disruptions and competing priorities for many non-profits, philanthropic organizations, and country governments. After successfully completing two projects with Uganda Village Project and the Clinton Health Access Initiative last spring, we are kicking off the 2021 – 2022 year with two new critically important and impactful projects.

First, we are teaming with Goodlife Pharmacy to improve access to pharmaceuticals in Kenya, with a focus on expanding trusted e-commerce options for patients, including those in hard-to-reach, rural communities. Our work with Goodlife culminated in a visit to their Nairobi offices in December 2021, to meet on-the-ground stakeholders, conduct site visits to better understand existing pharmacy operations, and share the WGHV team's final readout. Wharton students, including Harrison Han, WG'22 (WGHV Co-President), Blair Seiler, WG'23, Camila Rachmanis, WG'22, Cara Kennedy-Cuomo, WG'23, Natasha Ramanujam, WG'23, and Oscar Leandro, WG'23, will be working closely with the Goodlife Pharmacy team over the next several months and are excited to learn more about a rapidly developing industry that has the potential to transform pharmaceutical access and patient outcomes in Kenya!

Next, we are kicking off a year-long project to upgrade an existing hospital system in rural western Kenya to better serve the population of Baringo county and the pastoral Pokot people living in the surrounding region. Specifically, the WGHV team is collaborating with MBA students at Strathmore University, the Order of Malta, and the Kenyan office of a global healthcare consultancy to develop a sustainable financing model for the enhanced and expanded facility, address staffing challenges, and improve transportation mechanisms and access. The Wharton student team includes Drew Guerra, WG'22 (WGHV Co-President), Ava Chang, WG'23 (WGHV VP of Project Management), Jayati Verma, WG'23, Jeremy Rubel, WG'22, Krishna Shah, WG'23, and Tejas Pathak, WG'22, and the students will travel to Nairobi and Baringo County in January to conduct a series of stakeholder interviews with the Pokot people, national and county-level health officials, NGOs, and local healthcare workers.

As is often the case when working on global health projects, the Wharton students are already getting their first taste of what it means to collaborate with team members, clients, and constituencies that are halfway across the world. Team members have already begun to enjoy 6 am calls to accommodate the seven-hour time difference and have had too many dropped Zoom calls to count on one hand. Simultaneously, the Wharton Global Health Volunteers are beginning to understand the impact their efforts can have, when deployed in tandem with the on-the-ground know-how and expertise provided by our clients and collaborators.

As Kenya continues to advance its Universal Health Coverage initiatives, even long-standing health systems have their work cut out for them as they attempt to serve the rapidly increasing population, work with government and private payors, and navigate a challenging and sometimes unpredictable supply chain for medical devices, pharmaceuticals, and critical health supplies. The Wharton Global Health Volunteers are excited to support the expansion of affordable and high-quality care in Baringo county and improve access to life-saving pharmaceuticals throughout Kenya – and we couldn't do this without the continued generous support of the alumni community.

As always, please reach out to the WGHV Executive Board, led by Drew Guerra and Harrison Han, with any potential leads for future projects, suggestions, or to geek out about global health.

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WHAT DO INVESTORS IN THE WOMEN'S HEALTH INDUSTRY NEED TO KNOW ABOUT TELEHEALTH LAWS IN 2022?

Photographer: Joel Muniz

2022 is expected to blow by 2021 as a record-breaking year of investments and exits in the women's health and wellness industry. Success for investors and strategic partners – just like with any new investment thesis – requires an understanding of the determinative laws with both short- and long-term impact. Healthcare laws on telehealth, expanded payor reimbursement, and closing of gaps between existing laws and innovative solutions will shape the future of the women's health and wellness industry. However, no legal area is expected to change and have as much uncertainly in 2022 as telehealth. Investors of all types are sourcing deals for 2022 and talking about women's health as the next big thing. This is what investors need to know about the predicted future of telehealth laws in 2022.

From giants like Goldman to startup #femtech funds like Coyote Ventures, international and U.S. investors are jockeying to find the next Maven, which raised $110 million in its recent series D funding round.

Maven[1] is now the first women's health focused startup to reach a total valuation of over $1 billion.[2] In the past six months, digital technology, fertility, and women-centric provider services made headlines: Kindbody completing a $62 million raise;[3] Ro, a telehealth company, acquiring Modern Fertility for $225 million;[4] and the biopharma giant Merck, launching Organon, a company focused on providing general women's health services.[5] While women's health remains remarkably underfunded compared to "men's health," the trend is more promising than ever before.

To understand the critical impact of healthcare regulations on investment and M&A activity in women's health, it is necessary to understand the story of the industry over the last several years, including the COVID-19 effect. Specifically, the explosion of the women's health and wellness industry has been fueled by several key economic, demographic, and market factors. Then COVID-19 hit, and the government's relaxation of healthcare laws ignited a powerful spark for accelerated change.

The first key factor is women's buying power and influence in healthcare and beyond. Women now direct 83% of all consumption in the United States[6] and are predicted to control much of the $30 trillion of the "baby boomer" generation's financial assets by 2030.[7] In the U.S., 90% of healthcare-related household decisions are made by women.[8] In addition to serving as the Chief Financial Officer, women are also the undisputed Chief Medical Officer of their families.[9]

Not only have women achieved greater purchasing power, but there has been a commercial recognition of the massive potential market for services, technology, and goods in the women's health and wellness industry. From luxury hotel spas to remote patient monitoring for heart attacks, the women's health and wellness sector is vast and varied and goes well beyond reproduction. No other industry can boast 3.89 billion potential customers worldwide and 167 million just in the U.S. Women represent more than 50% of the world's population.

Yet for decades, women's health was ignored, undervalued, and underfunded. That is changing. And changing rapidly. Women are demanding, **and paying**, for better access, higher quality, and to be at the center of the patient experience. From in-home screening of cervical cancer to apps to support mental health during menopause and in the massive whitespace that was never previously considered, more innovative technologies, services, and goods are coming to market faster than ever before. Superstars such as Clue, Carrot Fertility, and Tia are all revolutionizing women's health in America with the thesis that medical services for women must be delivered through a female-centric and culturally-sensitive model.

The global pandemic has exacerbated existing gender health disparities in the U.S. and acutely affected women, the segment of the population most vulnerable to poverty, housing insecurity, and other sources of inequity.[10] The pandemic has also shone a spotlight on issues related to quality and outcomes of care for American women which will need to be solved by both the private and public sectors and has in some cases begun to spur government intervention.

The global FemTech market was valued at over $22.5 billion in 2020,[11] with an expected growth rate of 16.2% compound annual growth rate ("CAGR") through 2027.[12] The fertility sector will outpace itself yet again in 2021, bringing in more than $2.4 billion from more than 46 deals. By 2026, the fertility sector alone is projected to reach $41 billion in sales.[13] The global menopause market was valued at $14.7 billion in 2020.[14] Overall, the market valuation of FemTech is on track to cross $65 billion 2027.[15]

Growth of the women's health and wellness industry was buzzing when COVID-19 hit. Then federal and state governments relaxed healthcare laws in response to the pandemic, and the women's health and wellness sector got a spark that ignited its current explosion. That spark was telehealth. Particularly for telehealth, 2022 will be critical as the COVID-19 pandemic seems likely to continue much longer, and the need for healthcare continues to increase more rapidly than anyone had anticipated before the Delta and Omicron variants.

In the decade leading up to the pandemic, the adoption of telehealth in the U.S. had been hindered by a patchwork of state laws that placed restrictive requirements around the provision of remote care. Each state had its own laws which often conflicted and, generally, limited the adoption of telemedicine. Key areas such as how the patient-physician relationship could be established, whether and how asynchronous v. synchronous communication could be provided, physicians' ability to provide care to an out-of-state patient, and payment parity with in-person care, were among the major regulatory obstacles to telehealth.

Then came COVID-19 and the desperate need for Americans to get medical care of all types outside the four walls of a hospital or physician's office. Upon the declaration of an emergency under the Strafford Act or National Emergency Act, the Secretary of HHS ("Secretary") declared a Public Health Emergency ("PHE") on January 31, 2020, thereby empowering the Secretary to temporarily waive, for as long as the PHE remains in effect, certain Medicare, Medicaid, and Children's Health Insurance Program (CHIP) program requirements and conditions of participation under Section 1135 of the Social Security Act (commonly referred to as "Section 1135 waivers").[16] A PHE declaration lasts until the Secretary of HHS declares the PHE no longer exists or ninety days after the date on which the Secretary declared the PHE, whichever occurs first. The Secretary may extend the PHE declaration for subsequent

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90-day periods for as long as the PHE continues to exist. The PHE was set to expire on October 18, 2021 and was renewed for another ninety days on October 15, 2021. The new expiration date is January 16, 2022.

Under the authority granted by the PHE, the Centers for Medicare & Medicaid Services ("CMS") issued a blanket 1135 waiver revising telehealth.[17] Under this waiver, Medicare, Medicaid, and CHIP providers are eligible to treat both new and established patients using telehealth; all healthcare professionals participating in Medicare are eligible to provide and be reimbursed for telehealth services; reimbursement for audio-only communication is expanded; telehealth visits may occur using third party apps such as FaceTime and Google Hangouts;[18] and government healthcare programs, including Medicare, reimburse telehealth visits at the same rate as in-person visits.[19]

Concurrently, states have issued executive orders relaxing certain telehealth and in-state licensure requirements for providers, including expanding the types of services that may be delivered using telehealth, allowing the provision of services via telephone under certain circumstances, and removing or reducing patient cost-sharing for telehealth visits. While some states, like Florida, have let the executive orders expire, resulting in the reinstatement of stringent regulatory requirements, others, like New York,[20] have relaxed certain telehealth guidance for the remainder of the PHE.

To date, telehealth utilization in the U.S. has increased to levels 38 times higher than before the pandemic.[21] The boom in "tele-everything" – health, wellness, education, community – has fueled both the rapid growth of existing women's health and wellness platforms as well as highly promising new entrants to the market.

Without the COVID-19 waivers, the explosion of telehealth over the past eighteen months would not have happened as quickly as it has. What has everyone in the space speculating is what will happen when the Secretary of HHS ends the PHE. The blanket 1135 waiver and state executive orders will likely expire, and the restrictive pre-COVID healthcare regulations will take effect once again.

There has been no concrete indication the Biden Administration intends to push for a national, federal, telehealth law that would ensure the regulatory relaxation continues post-National Emergency, as was predicted last Spring. Some states, such as Arizona, Massachusetts, and South Dakota, have passed legislation that make certain permanent changes to their state telehealth laws, codifying requirements that allow interstate practice for telehealth services under certain conditions, providing reimbursement rate parity for telehealth services, and allowing for asynchronous communication under certain circumstances.[22]

The central role federal and state executive action continues to play in the expansion of tele-everything in the women's health and wellness sector is undisputed. An abrupt end to the regulation relaxation would, arguably, have a significant impact on new founders with innovative solutions and companies that are attempting to scale. It is therefore critical investors focus on the changes and future of the telehealth laws and regulations both at the federal and state levels and strategically consider multiple regulatory scenarios in their business and investment plans. Investing and transacting in the women's health and wellness space is the future, and the right now, of health and well-being in our country. Don't miss out.

What to watch out for in 2022:

- Ongoing renewals of public health emergency every 90 days. The current public health emergency will end on January 20, 2022.

- A federal proposal for a federal telehealth law (focus on the Centers for Medicare and Medicaid "CMS")
- States that are allowing their state executive orders to lapse
- States that are implementing new state telehealth regulations
- Expansion or retraction of third-party apps that providers and patients can use for telemedicine, i.e., Zoom, Google Meets, What's App?
- Changes in private and government payor reimbursement for telehealth and telemedicine services (e.g., fertility testing for Medicaid patients, reimbursement rates for remote patient monitoring, coverage of pelvic health therapy)

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WHAT DO INVESTORS IN THE WOMEN'S HEALTH INDUSTRY NEED TO KNOW ABOUT TELEHEALTH LAWS IN 2022?

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