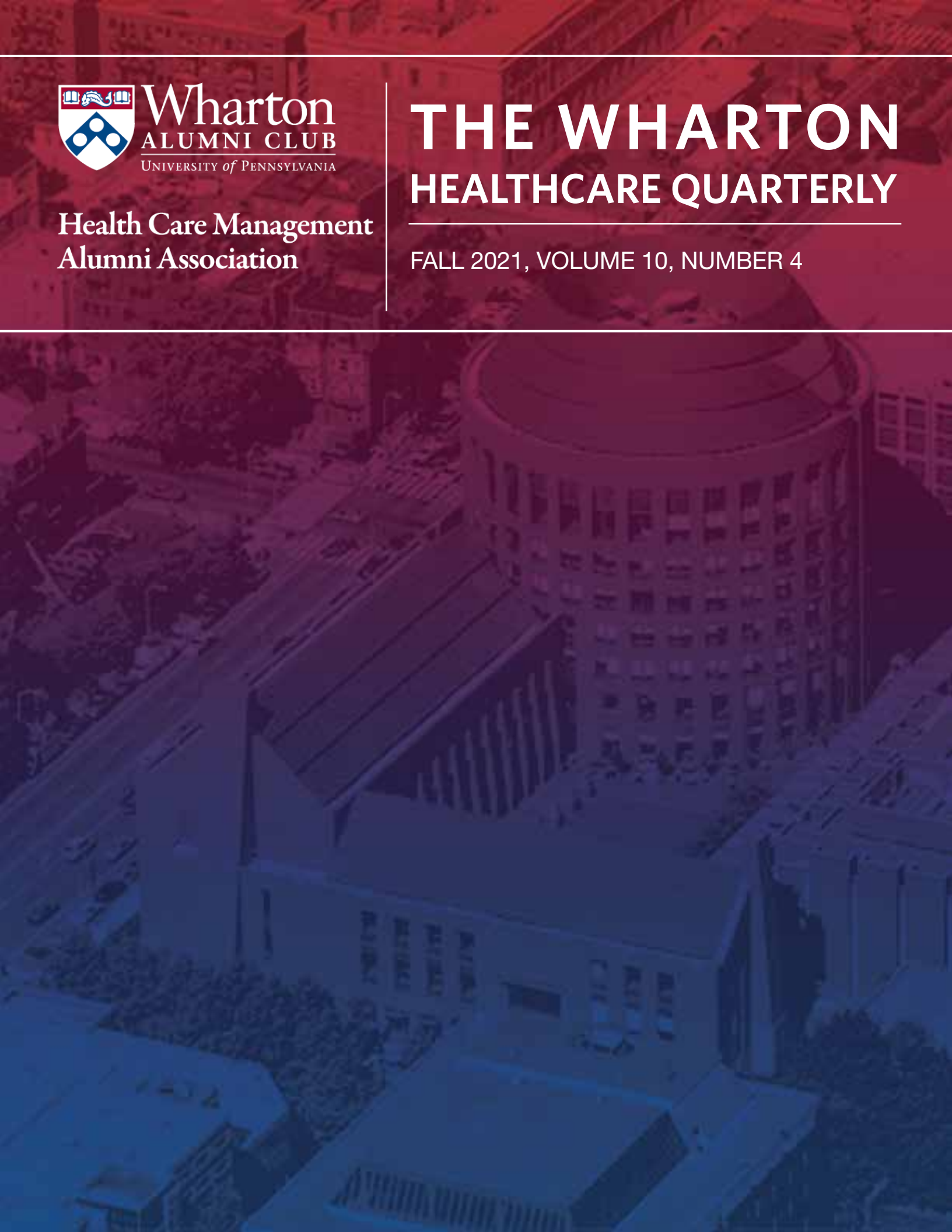

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UNIVERSITY of PENNSYLVANIA

Health Care Management Alumni Association

THE WHARTON HEALTHCARE QUARTERLY

FALL 2021, VOLUME 10, NUMBER 4

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EDITOR'S LETTER

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

To learn more about Colette, click here.

As I write this letter, our lives have been transformed at work and at home.

The U.S. is closing in on 47 million COVID infections and 760K deaths. The number of patients suffering from long COVID is unclear, and the Delta+ variant (reported to be 10 - 15% more contagious than Delta) is now responsible for 10% of the COVID infections in the UK. Inequities in health, wealth, and opportunity are widening, and life expectancy has dropped. We are riding a global and simultaneous rollercoaster of emotions, and ongoing uncertainty is the only thing that appears to be certain.

"The best way to predict the future is to create it."
~ Abraham Lincoln

At the same time, advances in technology, science, and care delivery have provided us with an unparalleled chance to innovate and create novel solutions to longstanding issues in health and healthcare. Additionally, we now have founda-tional insights about much of what works when it comes to patient engagement and achieving positive and sustainable health outcomes. So now the question is, "Will we do what it takes to deliver on the promise which lies before us?"

Believe it or not, 2021 is the 10-year anniversary of the Wharton Healthcare Quarterly! The pandemic means we have had to defer celebrating this incredible milestone. But 2022 will bring a year-long series of activities and events. Stay tuned.

Z. Colette Edwards, WG'84, MD'85
Managing Editor
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THE PRESIDENT'S DESK

Heather Aspras, WG'08

To learn more about Heather, click here.

Last year at this time, most of us never imagined that we would still be living through a once-in-a-lifetime pandemic. As one of the most difficult years has turned into more than 18 months and counting, our thoughts are with you, your families, and your communities.

As you have heard by now, our annual alumni conference has been postponed. In normal years, we all look forward to reuniting with other alumni in person at the alumni dinner the evening before and then the next day at the conference itself. Though we are disappointed we will not see you face to face this fall, the most important thing is that you all stay safe and healthy.

We are continuing the mini-summit series that provided important and ongoing dialogue over the past year. Conrod Kelly spoke with us about the impact of social determinants of health and racial disparities on the SARS-CoV-2 pandemic, while the Honorable David J. Shulkin, MD, discussed the impending disruption and creative rebirth of the U.S. healthcare system after last November's election. Dr. Lawton Burns talked about his recently published book, The U.S. Healthcare Ecosystem: Payers, Providers, and Producers, which is based on his decades of experience teaching HCM841 – a class that was foundational to the shared HCM experience for many of us.

Dr. Shantanu Nundy discussed his new book, CARE AFTER COVID: What the Pandemic Revealed is Broken in Healthcare and How to Reinvent It. In addition to providing specific categories of recommendations for the reinvention of healthcare, Dr. Nundy emphasized that health equity needs to be infused throughout all of these areas and not be set apart as its own standalone issue.

As Wangari Maathai said, "There are opportunities even in the most difficult moments." She was no stranger to doing difficult things - fighting for environmental justice, human rights, and the end of poverty.

Last year, in the midst of the pandemic and the murder of George Floyd and far too many other people of color, we committed to listening more deeply, creating the space for rich dialogue, and taking concrete actions to advance health equity. We have learned a lot and started the journey, but there is still much to do.

To that end, we have formalized our commitment by creating a new committee on the WHCMAA board to focus on diversity and inclusion, as well as health equity. The committee will be tasked with gathering regular feedback from members, identifying gaps, and developing and executing on priorities for which the WHCMAA can make a direct impact and provide leadership. We are eager to hear from you and we welcome your ideas and involvement.

Please contact me directly at president@whartonhealthcare.org or contact Bhuvan Srinivasan, the newly-named head of our D&I and Health Equity Committee, at bhuvan.srinivasan@gmail.com.

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continued

THE PRESIDENT'S DESK

More than ever, we encourage you to make connections and reach out to other alumni. Share your ideas and experiences with our community:

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

Our thoughts remain with all of you as we continue to navigate this unique time. We have an unparalleled opportunity as HCM alumni to drive positive and lasting change, and we're looking forward to partnering with you.

Kind regards,

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

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ALUMNI NEWS

Alan Sooho, GME ’79, MBA ‘81
In 2009, I retired as Chief of Staff, VA Medical Center, Battle Creek, MI and moved back to Boston. In 2014, I began working parttime at the Boston VA Healthcare System as a mental health disability examiner. Recently, I have added duties of Medical Review Officer. I verify results of employee drug tests. Church, fitness, friends and family fill out the rest of my days. Life is good.

Contact Alan at:
soohoalan@gmail.com

Jeff Voigt, WG’85
Voigt JD, Leuchter AF, Carpenter LL. Theta burst stimulation for the acute treatment of major depressive disorder: A systematic review and meta-analysis. *Translational Psychiatry*. (2021) 11:330.

Learn more.

Contact Jeff at:
meddevconsultant@aol.com

Carrie Hiebeler, WG’05
I started my own healthcare real estate investment firm in August 2020 after spending 8 years at Ventas.

Greene Park Capital is a specialty healthcare real estate firm focusing on investing and management of all healthcare related assets in the US and the UK.

We invest and manage for the medium and long term. It is off to a great start! Please inquire if you are interested.

Learn more.

Contact Carrie at:
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847.644.2344

ALUMNI NEWS

Amir Reichman, WG'11
BiondVax Pharmaceuticals Ltd. (Nasdaq: BVXV), a biopharmaceutical company focused on development and manufacturing of products for the prevention and treatment of infectious diseases, announced on Jan 21, 2021 the appointment of Amir Reichman, WG'11, as its new CEO.

Born and educated in Israel, Mr. Reichman served, until this appointment, as Head of Global Vaccines Engineering Core Technologies and Asset Management at GSK Vaccines headquarters in Belgium. Prior to this role in global vaccines engineering, he served as Senior Director Global GSK Vaccines Supply Chain. Mr. Reichman joined GSK in 2015 after its acquisition of Novartis Vaccines. At Novartis Vaccines, he held various leadership roles of increasing responsibility in its Global Vaccines Supply Chain Management organization located in Holly Springs, NC, USA. In 2003, Mr. Reichman's academic work at Ben Gurion University of the Negev contributed to the founding of NeuroDerm Ltd., an Israeli company focused on transdermal drug delivery systems that was acquired by Mitsubishi Tanabe Pharma in 2017 for $1.1B. He was NeuroDerm's first employee and served as the company's Chief Engineer and Senior Scientist until his departure in 2009.

Mr. Reichman earned an M.Sc. in Biotechnology Engineering from the Ben-Gurion University of the Negev in Israel, and an MBA in Finance and Health Care Management from the Wharton School.

Learn more.

Contact:
BiondVax IR/PR: Josh Phillipson at j.phillipson@biondvax.com

Joseph Anderson, WG'18 and Inna Karyeva, WG'18
On September 25th, Inna and Joe were married in North Adams, MA during a small ceremony and surrounded by loving family.

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janderson@nautic.com

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THIS MONTH'S PHILOSOPHER:
Bhuvan Srinivasan, WG'11

To learn more about Bhuvan, click here.

THE PHILOSOPHER'S CORNER

LIFE LESSONS

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

- called my grandmother more often.

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

- waited so long before exercising regularly.

FAVORITE QUOTES

1. *"I never lose. I either win or learn."* ~ Nelson Mandela
2. *"The mind, once stretched by a new idea, never returns to its original dimensions."* ~ Ralph Waldo Emerson
3. *"Not all those who wander are lost."* ~ JRR Tolkien
4. "*If you think adventure is routine, try routine. It is lethal*." ~ Paul Coelho
5. "*Yesterday I was clever, so I wanted to change the world. Today I am wise, so I am changing myself.*" ~ Rumi

RECOMMENDED READING

1. *AHealthcareZ podcast* (or on YouTube) - short and sweet, yet informative
2. *The Price We Pay: What Broke American Health Care - And How to Fix It* by Marty Makary
3. *Dune* by Frank Herbert (hopefully the movie finally comes out this year!)
4. *Between the World and Me* by Ta-Nehisi Coates
5. *Gratitude* by Oliver Sacks (haunting but beautiful writing by a dying neurologist)

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THIS MONTH'S PHILOSPHER:
Bhuvan Srinivasan, WG'11

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AFFIDAVIT: HEALTHCARE AND THE LAW - OLD LAW, NEW TRICKS: ACHIEVING COMPLIANCE WHEN PATIENT PRIVACY LAWS MEET ARTIFICIAL INTELLIGENCE

Artificial intelligence ("AI") is a buzzworthy topic in healthcare, and commentators have suggested it will profoundly alter the delivery of healthcare.[1] However, the law moves slowly and tends to be locked in a perpetual game of catch-up with technology. Therefore, as lawyers, we are often asked to help our clients mitigate the legal risk that can arise when antiquated laws are applied to emerging technologies. One significant area of friction is the application of existing privacy laws, such as Health Insurance Portability and Accountability Act ("HIPAA") to AI technologies.[2] Until the law is changed, stakeholders will need to play by the current rules, and that can require creative and critical thinking.

In this article, we explore three legal concepts requiring extra thought when applied to AI. For simplicity's sake, we have used the term AI as a blanket term to refer to all forms of computer-simulated intelligence relying on machine learning technologies such as deep learning, computer vision, natural language processing (NLP), and any other related technologies.

I. De-Identification/Re-Identification

The central motivating tenet of HIPAA is the privacy of patients' Protected Health Information ("PHI").[3] One way to protect patient privacy under HIPAA is to "de-identify" data prior to disclosure such that it is no longer considered PHI.[4] De-identified data is health information which "does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual. . ."[5] Stated simply, de-identified data is data that cannot be used alone or in combination with any other information to identify the subject.[6] This generally goes far beyond simply redacting names and dates.

However, AI upends the way we think about de-identification. In 2019, a study showed it is possible to use AI to re-identify patient information that had been de-identified.[7] This ability raises the question: if the data could be re-identified, was it ever truly de-identified in the first place? The ability to re-identify data poses a risk of litigation. A recent lawsuit against the University of Chicago, UChicago Medicine, and Google alleged the health system did not properly de-identify PHI it shared with Google because Google was capable of re-identifying it.[8] It is not necessary to show the data has actually been re-identified to prove a HIPAA violation occurred, but merely there is a "reasonable basis to be believe the information can be used to identify an individual."[9] Although the trial court dismissed the Google/Chicago case in late 2020, an appeal is currently pending in the Seventh Circuit Court of Appeals, and this issue remains unresolved. In light of this uncertainty, extra scrutiny should apply to any arrangements relying on de-identified data.

II. AI Access to Data

As a gross simplification, developers build AI models by feeding them data and allowing them to learn from that data. It follows, therefore, that a change in that data will alter the AI model. Therefore, for many AI models long-term (or perpetual) access to the underlying dataset is critical to the AI product (and its market value).

In a healthcare setting, the underlying data for an AI model is almost certainly going to include PHI. For example, an AI tool might require patient photos in order to train the model. The most readily available source of this data is hospitals, facilities, and medical practices. Therefore, when parties come together to negotiate a data-sharing arrangement for an AI application, it is essential to consider the disposition of the data fed to the AI. If the exchange of data will require the exchange of PHI, HIPAA requires the parties to enter into a Business Associate Agreement ("BAA"). A BAA should always include the conditions

under which the parties may terminate the relationship as well as the Business Associate's responsibilities with respect to destruction or return of PHI upon termination. Although complicated by the previous discussion, if the model can rely on de-identified data (such that it is no longer PHI under HIPAA), this may obviate the need for a BAA. However, even for non-HIPAA protected data, the parties should still take a proactive approach and explicitly spell out their expectations with respect to the retention, return, or destruction of data in the event the parties terminate their agreement.

III. Privacy Policies and Consents

The Federal Trade Commission ("FTC") scrutinizes companies' privacy practices for "unfair or deceptive acts or practices" under the FTC Act.[10] On April 19, 2021, the FTC published an article describing its enforcement priorities in the AI space.[11] The FTC admonishes industry players to, among other things, "[w]atch out for discriminatory outcomes," "[e]mbrace transparency and independence, "[d]on't exaggerate what your algorithm can do or whether it can deliver fair or unbiased results," and "[t]ell the truth about how you use data."[12]

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AFFIDAVIT: HEALTHCARE AND THE LAW - HOLD THE PHONE: TELEMEDICINE SUBJECT TO INCREASED SCRUTINY BY ENFORCEMENT AGENCIES

Transparency is the best way to ensure a high level of ethics and avoid unwanted scrutiny from the FTC or other investigatory agencies. Any actor developing, implementing, or utilizing AI should strive to ensure people understand how and when their data is used. This should include developing and adhering to robust privacy policies that dovetail with similarly robust informed consent processes. While it is self-evident that informed consent requires the patient actually be informed, it can be challenging to explain AI concepts in layperson's terms. Nevertheless, this is a critical step. Putting in the work to ensure patients understand what they are consenting to on the front end is the most ethical approach, avoids many later headaches, and potentially provides a backstop for liability in the future.

IV. Conclusion

AI creates exciting new opportunities to improve health outcomes and patient experience. Nevertheless, until the law catches up, trusted legal counsel can advise you on the best steps to take to avoid harming patient privacy, minimize legal exposure, and protect your reputation and the reputation of your entity or institution.

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1. B. Meskó & M. Görög, *A Short Guide for Medical Professionals in the Era of Artificial Intelligence*, 3 npj Digit. Med. 126, Sept. 24, 2020.

2. 42 U.S.C. § 1320d, et seq., see also 45 CFR Parts 160, 162, and 164.

3. 45 CFR § 164.502.

4. *Id* § 164.514.

5. *Id. (emphasis added).*

6. *Id*.

7. Na L, Yang C, Lo C, Zhao F, Fukuoka Y, Aswani A. Feasibility of Reidentifying Individuals in Large National Physical Activity Data Sets From Which Protected Health Information Has Been Removed With Use of Machine Learning. *JAMA Netw Open*. 2018;1(8):e186040. doi:10.1001/jamanetworkopen. 2018.6040

8. *Dinerstein v. Google*, LLC, 484 F. Supp. 3d 561 (N.D. Ill. 2020), appeal docketed, No. 20-3134 (7th Cir. Nov. 2, 2020).

9. 45 CFR § 164.514.

10. 15 U.S.C. § 57b-1.

11. Fed. Trade Commission, *Aiming for Truth, Fairness and Equity in Your Company's Use of AI* (April 19, 2021), https://www.ftc.gov/news-events/blogs/business-blog/2021/04/aiming-truth-fairness-equity-your-companys-use-ai.

12. *Id*.

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TO YOUR HEALTH: THE BITTER TASTE OF *BREAKFAST AT WIMBLEDON*

t (Industrial Revolution) changed what we eat, how we chew, how we work and how we walk and run, as well as how we keep cool and warm, give birth, get sick, mature, reproduce, and socialize. Many of these changes have been beneficial, but some have had negative effects on the human body, which has yet to evolve to cope with this new environment." ~ Paleoanthropologist professor and author Daniel E. Lieberman, The Story of the Human Body

Watching Wimbledon this summer brought back the incredible memories of my childhood. Tennis changed my life, and Atul was at the center of it all. Atul was my tennis rival and my best friend. For the 40 years I knew Atul, we were more different than alike. I loved McEnroe, and he loved Lendl. I borrowed racquets while he had the new expensive ones. I played doubles; he played singles. Sadly, while I continue to be free of illness, Atul had his first heart attack at age 38, then died of cancer 9 years later at age 47.

Atul's parents were from India. His father pursued dentistry, and, after serving as a dentist in the Army, they settled in the Catskill Mountains of NY. That is where I met him. The smell of spices as soon as you walked in the house, the reverence to various Hindu leaders on the walls, and the Bhatt family traditions were all there. But there were also the Nike sneakers, the big Buick in the driveway, and the bag of Chips Ahoy. Atul's genes were not prepared for a 'Westernized' world. A mismatch was born.

The mismatch hypothesis centers around the idea that many of the features of the human body were adaptive to the environment of the time but have become maladaptive to the environment we are in now. Not surprisingly, Type 2 diabetes, heart disease, and certain cancers are non-existent in tribes of hunters and gatherers in Africa, yet they are the leading cause of death in industrialized countries. Atul was likely partially a victim of living in the wrong place at the wrong time.

Humans around the world come in different shapes and sizes. Those sizes and shapes lead to different amounts of lean mass, bone density, and fat mass. They also lead to differences in heart strength, lung size, calorie output, and VO2 (shows how much oxygen uptake is used when you're doing intense exercise). All of these lead to strength, stamina, and musculoskeletal differences. Lifestyle habits, dietary plans, and fitness goals need to be tailored to recognize those differences, especially in a country like the U.S. where the diversity in the population continues to rise.

I can't claim Atul would not have developed coronary artery disease if he had grown up in India, but the epidemiological evidence supports the idea that here in the U.S. the likelihood of an 'evolutionary mismatch' is clearly rising at rates rarely seen in other countries. And for certain immigrants this mismatch is unrelenting and fatal.

Atul has two sons that now join in the slow and inevitable march of human evolution with the hope their adaptations lead to some sweeter *Breakfasts at Wimbledon*.

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REFERENCE

Lieberman, D. E. (2014). *The Story of the Human Body: Evolution, Health and Disease*. Vintage Books: A Division of Random House, LLC.

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DOWNLOADING SUCCESS: PROFESSIONAL ASSESSMENT ALGORITHM - A FRAMEWORK FOR WINNING THE TALENT WAR

When it comes to attracting and retaining high-performing team members, the Professional Assessment Algorithm provides a solid framework for the versatile and fluid calculations commonly involved with new career opportunities. Career decisions are influenced by several factors we place into four categories – Opportunity, Geography, Compensation, and Timing.

As executive recruiters solely focused on the healthcare industry, we have seen the veritable war on talent ramp up in recent months to the highest level in nearly four decades. With talent in such high demand and shifting views on remote and hybrid work environments, it is becoming increasingly critical to go beyond traditional role design and compensation packages for organizations to attract and retain top talent.

Add to the mix the complex nature of healthcare organizations and an increasing demand for diverse talent, and you have a highly dynamic and volatile talent landscape rife with indefinite obstacles and barriers. When you consider the investment of time and resources spent on talent management, leaning into the Professional Assessment Algorithm helps minimize risks that could derail the process.

Effectively recruiting top talent starts from the first conversation and extends through the offer process. The framework of the Professional Assessment Algorithm provides useful checkpoints for gaining a deeper understanding of talent *before* the offer, when it is often too late to have an impact on anything but compensation.

THE FOUR ELEMENTS OF CONSIDERATION

From our decades-long experience working with leaders and organizations, it's become clear we are all working through an algorithm that is unique to each of us. Life and work events alter our Professional Assessment Algorithm, and everyone's personal algorithm evolves throughout their career.

These four core elements aim to capture and categorize the endless factors candidates assess when considering the next step in their career. From an organizational leadership standpoint, keep in mind that each of the four elements are independent from one another yet interrelated, so someone's perspective on one could impact how they view another. Yet, interestingly, they each carry equal weight when it comes to a candidate's final decision to accept or reject the offer.

1. **Opportunity** – On its surface this quadrant seems rather basic relating to the role definition (e.g., description, reporting structure, and expectations) and how that aligns with a candidate's career goals. But as we push beyond the surface, we see leaders are assessing far beyond the basics. As candidates work through this element, many people will offer them opinions and advice on this category. But ultimately, only the candidate knows how proud

they will be to tell people they work for the company (correlates to the organization's mission); how energized they will be to work with that group of people (correlates to the organizational and team culture); and how passionate they are to take on the work at hand with the work that needs to be done to achieve success. In many cases, these decisions are title agnostic.

2. **Geography** – For this quadrant, what often comes to mind is, "relocation." Yet throughout the past year this idea is being challenged more and more not just by talent, but by organizations. The adoption of virtual and hybrid work environments nearly overnight has caused companies and people to reassess their long-held perceptions about where the job gets done. We are seeing organizations make significant changes to their requirements for positions that traditionally made relocation mandatory. Now, companies are frequently allowing for more flexible arrangements, such as being in the office or on location once or twice a month, twice a quarter, and so on. Pair that with the fact that many professionals are looking to move away from or avoid densely populated areas, opting instead for rural areas or choosing to move closer to family. This drastic, accelerated change has created an entirely new set of challenges and opportunities for organizations and talent alike. Those with too much rigidity are finding themselves on the losing side of the talent war.
3. **Compensation and Total Rewards** – From a compensation standpoint, when we look beyond the basics of lifestyle compensation needs, we see a clear trend toward the addition of non-monetary considerations and a correlation between compensation and the three other core elements of the algorithm. While many candidates will expect additional compensation year over year, this isn't always the case if the other items are in alignment. However, the greater the disruption in geography, timing, or opportunity (e.g., geographic relocation, extensive travel, significant personal timing considerations, etc.), the greater the impact on compensation expectations.
4. **Timing** – Comparatively, this is one of the most dynamic quadrants. Throughout one's life there are various demands placed on us both personally and professionally. From a professional standpoint, timing can look very different from person to person - for example, if someone's role has been eliminated and they find themselves in transition looking for a new opportunity versus when they are gainfully employed. Timing is far more dynamic on the personal side of things in relation to geography for instance. Maybe the candidate's children are in high school, or their spouse's career is equally dynamic. Upending their life to move someplace new would need to be balanced with a significant bump in compensation.

Knowing these four forces are constantly in play, it becomes clear just how crucial it is to engage and communicate with your team and the potential new talent you hope to bring into the organization. Even if three of the four elements exceed expectations, if just one is misaligned the candidate may decline the offer.

Honing your curiosity and listening skills around these core categories will help you recognize which areas need additional attention or add risk, which could make all the difference for both attracting and retaining top talent. The Professional Assessment Algorithm provides a framework to identify risks and develop a solid approach to talent management, resulting in a strong bench of talent now and into the future.

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CYBERVITALS: WHY INCLUSION OF NON-TECHNICAL CONTRIBUTORS MATTERS IN HEALTHCARE CYBERSECURITY

The absence of diversity in security roles makes progress harder, from addressing threats to innovating with partners. How can the cybersecurity community avoid biases, i.e., decisions we make often unconsciously and without being fully aware, and develop teams that understand the full security landscape?

Cybersecurity encompasses a variety of functions, from pen testing to incident response to training and awareness. But one of the common issues security faces as a community is the perception by outsiders. Media depicts all security professionals as hoodie-wearing, in front of a computer screen, and coding. To an outsider with no previous experience, cybersecurity does not seem very appealing if you don't have a technical background.

But according to a study by Frost & Sullivan, 30% of all cybersecurity roles are filled by people with non-technical backgrounds. According to $(ISC)^2$, there is a cybersecurity workforce gap of over 3 million people globally, meaning the workforce needs to grow by 145 percent to help close that gap. That's a lot of non-technical jobs.

It's a common trope in cybersecurity, and healthcare, to say people are the weakest link. This is often followed by stats like 23% of all data breaches are attributable to human error or negligence. But maybe that statistic should instead be we are missing 23% of use-cases where a human's behavior has been misunderstood and where technology failed so the human became the expected last line of defense.

Every assumption developers make about a system's design or user behavior leaves a crack for attacker break-ins. If everyone on the security team shares similar experiences and working methodologies, attack vectors will be missed. There is more to understand about healthcare security than the technology behind it. How might a user's training, culture, and environment impact security? What is the patient safety concern? Biases and assumptions about how individuals and organizations deploy and use technology can increase risk.

In the early days of computing and connected devices, there was a lot we didn't yet know about designing secure products and environments. Today, there are established, well-known frameworks and lots of best practices and advice to help people protect data, patients, and devices.

I propose a simple exercise to consider how human factors can be missed if a team does not include a cross-section of skill sets and capabilities.

In 2014, Apple launched its "comprehensive" health tracker app. This allowed people to track nearly everything, from daily movement and exercise to copper intake. Despite including such niche tracking abilities, Apple failed to include something that would've arguably been far more useful for about half of its customers: period tracking. Could that have happened if a more diverse group had been involved in the design?

Deloitte conducted a study in 2017 that delivered multiple interesting insights. My favorite part was what they titled the study - 'The Changing Faces of Cybersecurity' - but it wasn't about diversity and inclusion. It was about the change in skill set required to be successful in this space. Specific trends identified included changing trends in job descriptions, moving away from narrow technical disciplines, and becoming more 'esoteric.' The report also emphasized that future cybersecurity needs expertise in privacy and security regulation.

This ties in perfectly to the growing trend of implementing risk-based cybersecurity strategies. In essence, risk-based means aligning technological and programmatic decisions with risk. It can be helpful regardless of whether an organization is building a program from scratch or trying to identify priorities for budgeting. An organization reorganized priorities based on risk, which increased its projected risk reduction 7.5 times above the original program at no added cost.

Those who took a strategy class at Wharton remember the emphasis on determining the value offered. This is precisely where cybersecurity and non-technical resources intersect. If those who are non-technical can identify the impact of cybersecurity on business, that directly translates into value to the organization.

This can begin with a cybersecurity team asking the businesses about the processes they regard as valuable and the risks they most worry about. This doesn't require any technical skills! Just a willingness to learn. Making this connection between the cybersecurity team and the businesses is a highly valuable step in and of itself. It motivates the businesses to care more deeply about security, appreciating the bottom-line impact of a recommended control.

In practical terms, healthcare's cybersecurity strategy is dysfunctional at best. Just look at the headlines on any given week for a story of a hospital held by ransomware. What got us here is not going to be sufficient going forward, and we must learn to bring multiple perspectives into our collective strategy.

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MIND THE GAP: OVERCOMING HEALTH INEQUITIES - WITH HEALTH LITERACY. HEALTHCARE ORGANIZATIONS, IT'S ON YOU

From my perspective as a behavioral economist and social psychologist, there are several things you can do and several areas you can tackle in order to improve patient choices, empowerment, and satisfaction. This will lead to reduced costs for the healthcare system. A win-win. These areas are presenting probabilities, formulating choice, enabling doctor-patient relationships, and improving communication on end-of-life issues. But let's start with health literacy.

Imagine the following scenario: you're visiting your elderly mother at home. She's not feeling well and then she collapses. You realize she's in cardiac arrest and you freak out because, even if you are an educated person and should be able to follow professional instructions, this is your own mother lying there.

You dial 911. But, in your freaked out state, how well can you understand what they're saying? Let's hope you can, because they are telling you to start CPR as soon as possible, which will increase her chances of survival.

Now imagine it's not you this is happening to. It's someone who barely finished high school. Maybe someone for whom English is not a first language. How well do they understand what the medical dispatch is saying? And if they don't understand them well, what does this mean for their mother's chances of survival?

An intervention at the LA Police Department examined this scenario. Realizing that delayed CPR was reducing survival rates among cardiac arrest victims, they tried a new protocol for caller communication. They gave their existing staff minimal training with using simplified language and examined the effect it had.

Among callers with limited English proficiency, 69% now did CPR, as opposed to 28% before. Out of every 100 people who had a cardiac arrest, 69 now got CPR, instead of just 29. I keep wanting to write that it's an astounding difference, but the truth is – it's not. This jump in the ability to follow the 911 recommendation to resuscitate makes plenty of sense given how we're communicated to, especially when under extreme stress, influences our comprehension. A simple "press on the chest, now!' is easier to follow than 'start compression.'

The effect on people who did have English proficiency was smaller, shifting from 55% to 67%. Still meaningful, still life-saving, helping an additional 12 people out of every 100. And what a lesson in understanding that clear communication makes all the difference.

LAPD's accomplishment is huge in and of itself, but more so when we acknowledge it pertains to a substantial proportion of the U.S. population. Nearly 36% of American adults have low health literacy. It is more likely to be found among lower-income Americans eligible for Medicaid. This trend leads to health inequities.

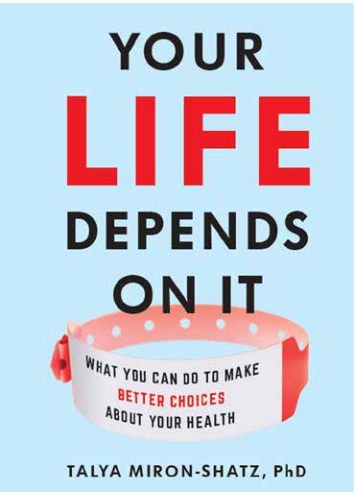
You may not care about health inequities or the toll they take on low-income populations (though you should), but you will certainly care about bottom lines. Low health literacy comes with a price tag: The Center for Healthcare Strategies reports individuals with low health literacy experience greater use of the healthcare system (because things go wrong more often) and higher costs compared to those with proficient health literacy.

The U.S. spends an additional $600 billion annually due to low health literacy. Mid-sized community hospitals spend an additional 1.8 million dollars covering the costs associated with low health literacy. In fact, the health literacy level of a city's population is one of the key indicators of a healthy city.

As healthcare organizations aim to lower costs, they struggle to create behavior change. This is especially difficult among older and less literate populations. One way they can affect behavior change is by changing the way they communicate with these groups, both in times of crisis and in routine interactions.

The problem of health literacy is not a new one. There's a paper I wrote about it ten years ago with Sir David Spiegelhalter, Ben Goldacre, and others. We proposed using a tiered approach, where you first deliver information in its most simplified form, then allow people to drill down through increased levels of complexity, all the way to the academic papers that medical knowledge is based upon.

This solution, which I also elaborate on in my book 'Your Life Depends On It: What You Can Do to Make Better Choices about Your Health' (Basic Books, Hachette), explores individuals' health literacy – their ability to understand health information, question it, and act upon it. But I do not stop there. What I propose in this book, and what the LAPD did, was to make health information more accessible. Patients need their doctors to do this, but pointing a blaming finger at overworked doctors, who aren't trained in accessible, tiered communication, is not the way.



Doctors need to help patients overcome health literacy issues, and I propose take-aways to this effect. Here are three of them, but there's more where they came from:

1. Speak clearly and allow for your patients to drill down to the scientific terms, if they want.
2. Provide your patients with opportunities to ask questions, to clarify, and repair.
3. Write down or print out relevant medical terms for your patients. Help them so they don't have to rely on memory. Have them write down what they think they hear, and spell it out for them.

Just like blaming low health literacy on patients would be unfair, it is also unfair to expect doctors to solve the problem on their own.

This is where healthcare systems come in. This is where it's worth their while to promote increased readability of texts and accessibility of spoken instructions. These actions increase patients' adherence, satisfaction, and health. This, in turn, lowers expenses – the bottom line.

Here are three of the take-aways I propose for the healthcare system:

1. Make it a habit to create accessible information. Tailor materials to the reading level of a 5th grader.
2. When creating materials, give the option to drill down for higher level terms so the patient can feel up to par with their doctor's knowledge when explaining what they have learned.
3. Create institutional invitations, norms and training around tools like 'Repair' (where doctor and/or patient verify what the other said), or 'Ask Me about What Matters' (which I developed: What are the risks? What are the benefits? What are the alternatives?).

If the LAPD could do it, so can you, and I am more than happy to help.

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AFFIRMING POST-ACUTE LEADERSHIP

The work of post-acute care and skilled nursing leaders is demanding across technical, clinical, and leadership skills, and can be under-appreciated by others. During the height of the COVID-19 pandemic, as caretakers of the most vulnerable populations to the disease, the intensity of the work and the experience of patients' suffering was compounded. As *Modern Healthcare* noted, nearly 40% of the deaths from COVID-19 through December 2020 had been in nursing homes, "although nursing home residents only represent about 8% of the country's overall COVID-19 cases."[1] Additional losses impacted homecare, therapy, hospice, and long-term acute care professionals. Leaders at all levels were called on to make difficult decisions regarding care and the business, and to bolster staff in need.

As the pandemic continues to rage, no one is left untouched. Post-acute leadership teams and administrators continue to meet challenges, including high turnover, the work of onboarding, adjusting to new telehealth regulations and opportunities as they shift, and the dimensions of their own relationship to their professional identity and leadership. Top executives of post-acute organizations are fielding clear signals that their people are depleted.

There are ways to respond to these signals that will foster a reset and redirection toward future strategy. First and foremost, if possible, it is important to move leaders away from the day-to-day stress of running on thin margins and handling staffing challenges, to a venue where post-acute leaders can be supported to generate a shared experience of renewal. Supporting colleagues to reflect can form a transitional bridge to enacting leadership. Taking some time away from daily responsibilities gets people excited to advance their critical work, anchored by a feeling of connection to one another.

Below, we share steps to advance those aims.

Acknowledge the challenges your people have faced. When people, even leaders, are strained, one coping mechanism is to avoid taking in the emotional reality of those circumstances. Brushing by the experience can work well in times of crisis, but its effects may show up elsewhere later and unannounced, causing longer-term stress. To be able to move forward authentically, people need to metabolize their experience, in a forum where they feel safe to express how they were personally impacted.

Communicate appreciation for leaders and the work they do. It is critical executives demonstrate care for the well-being of the people whose work advances the enterprise. Teams may need to be reminded how much their work truly matters to top leadership — sharing executives' humanity with theirs. Executives must demonstrate what it means to absorb the experience of leading through the pandemic — beyond the action of simply coping with it. It will take top leaders' full engagement, with a focus on what kind of leadership is needed now.

When considering how to communicate appreciation, go with the preferred mode for those being recognized. Then formulate how to express those thoughts authentically. This candid act will allow the organization to (re)enter the future with fresh perspective, not just a return to the past in a wishful way.

Although executives are responsible for creating the conditions that allow others to lead, including by expressing appreciation, all leaders from the top to the lower levels need appreciation and replenishment. As we identify next, peer connection can make a significant difference for all.

Support leaders to understand they are not alone. One effect of facing unprecedented layers of challenges can be the experience of "going it alone." This feeling not only deepens the emotional drain on leaders, but also can limit their resourcefulness and demonstration of leadership.

The steps forward need to feature concrete ways to build or rebuild connection. Realizing there are many people — in the organization, and locally, regionally and nationally — who have faced similar realities can expand leaders' fields of vision to see new solutions. Once in contact with one another, leaders who have felt alone see their peers likely have some helpful strategies to employ. They start to regain confidence, believing again they themselves have ideas to share as well. The focus should be on the long term — as leaders take in the knowledge they can build a true community and relationships with mutual resources, they can regain optimism.

Help leaders experience the agency they have. We know the key to catalyzing future action in leaders includes reestablishing a belief in what they can accomplish. To do this, people often need a mix of inspiration from the top and realization of their own potential. Providing an opportunity to get away from the workplace and be together with peers helps to set the stage for renewal, as people take a step back from their everyday.

The comradery and space for learning will leave leaders feeling like they have new practical means and ideas about what they can implement the next day. Look for what can arm people with approaches to create space needed for leadership and sharpen their ability to make decisions. Explore tools that support leaders' considering others' perspectives, dissecting critical incidents, clarifying decisions and communication, and helping to specify aspects of the cultural shift required to deliver on the scope of change needed going forward. Focus primarily on the approach to leading through a new lens, as opposed to a technical deep dive.

We know the pandemic has been depleting in countless ways, and for leaders responsible for the results of their teams, time for processing emotions and learning new approaches to their work has been in short supply. Rekindling leaders' confidence, curiosity, and connection will support the energy and drive needed to advance into a yet more uncertain post-acute landscape.

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RECOVERING AND THRIVING POST-PANDEMIC - PART 2: THE IMPORTANCE OF SAFETY-NET PROVIDERS

In this second article in our series, we continue to cover meaningful tactics for healthcare organizations to recover and thrive post-pandemic. We underscore the importance of safety-net providers, ranging from hospitals and health systems encompassing facilities, physicians, and other providers to community health clinics (CHCs), federally qualified health centers (FQHCs), and public health agencies in recovery from the pandemic. The Institute of Medicine (IOM) defined safety-net providers as "those providers that organize and deliver a significant level of healthcare and other needed services to uninsured, Medicaid, and other vulnerable patients" (Lewin & Altman 2000). We will also share tactics to position these indispensable providers to help maximize their value and influence.

One of the consequences of the economic impact of the pandemic was a dramatic change in employment status nationally for the workforce across multiple industries. People entered and left jobs, were placed on furloughs, or became unemployed or under-employed. Not surprisingly, this resulted in a surge in Medicaid enrollment, often away from traditional employer-sponsored coverage. Looking only at Medicaid from February 2020 to 2021, enrollment increased nationally by ten (10) million enrollees, or approximately 14.97%. A constantly changing payer mix puts the community of safety-net organizations in an increasingly important role.

As a result of this enrollment surge, we are seeing an almost universal increase in patient populations served by the safety-net community. A key tactic to employ in the coming months is to continue to lean on telehealth/telemedicine tools to reach both new and existing patients "where they are." This will help safety-net providers ensure patients enter into and/or remain in important care delivery programs (e.g., care management/care coordination) even without an in-office visit. This is an especially important tactic if the pandemic continues to have a lasting impact on patients' comfort levels in seeking in-person/in-office care.

Beyond telehealth, we are focusing on the importance of building and expanding partnerships/affiliations with other provider constituents - both in and out of the safety-net community, such as health systems, public health agencies, and community-based organizations (CBOs). These partnerships/affiliations should help to ensure access to primary care services remains in place for patients with shifting coverage (e.g., during periods of non-continuous coverage across multiple plans.)

A key differentiator of safety-net providers is the capability to deliver engagement, education, and clinical care in a culturally competent manner. This makes the safety-net provider indispensable in:

A. identifying and implementing clinically and socially appropriate changes in care plans, especially those related to delayed care during the pandemic

B. avoiding hospitalization or other adverse events by identifying and addressing social determinants of health (SDOH)

C. coordinating non-clinical service providers to address population health needs, such as in-home care, supply/durable medical equipment, transportation and more

D. securing patient trust in the ongoing value of the delivery system, thus helping to increase patient compliance and adherence to medication and care plans.

We believe safety net providers must build partnerships with major payers, particularly Medicaid Managed Care Organizations (MCOs), to design programs to maximize these valuable impacts to effectively manage non-adherent patients and newly-enrolled members. The safety-net providers can add unique value to MCOs by:

A. directing patients to seek care at the appropriate level

B. engaging chronically ill and/or co-morbid members to proactively manage complex care plans to avoid catastrophic, costly interventions

C. managing – overall – unnecessary and potentially avoidable emergency department utilization through multi-pronged, culturally competent programs and services

Aside from engaging in clinical care, we suggest safety net providers develop outreach programs, with funding provided by MCO partners, to re-engage with patients who have suspected gaps in care (identified based on historical claims activity) and engage with newly-enrolled Medicaid patients. Safety-net providers understand how to effectively contact and engage with these members more so than the managed care organizations. This should translate into value for all parties involved in successful partnerships/affiliations.

Perhaps one of the most important roles for the safety-net provider community is the stewardship of health equity across diverse, underserved populations. The importance of partnering with others in the safety-net community, as well as with MCOs, cannot be overstated. New or expanded partnerships/affiliations should include programs that address and/or expand capacity, and could include:

A. joint advertising to direct newly-enrolled members to clinical resources to both maintain primary care access and get off to a good start

B. building out "on the street" care navigation programs to bring in trusted individuals from the neighborhood who can explain what health services/programs are available and help ensure the hyperlocal healthcare system is accessible to the population in need; these programs have shown to have a positive impact on each organization's ability to reduce barriers to access in both primary care and specialty services.

C. adding additional capacity for outreach in navigating healthcare coverage options, such as partnering with religious organizations and community centers.

In conclusion, as with other parts of the healthcare ecosystem, we believe recovery is going to take many shapes and will take longer for some providers than others. The safety-net community will play an important role in mitigating public health crises and returning the healthcare payment and delivery systems to a "more normal" steady state in the coming months.

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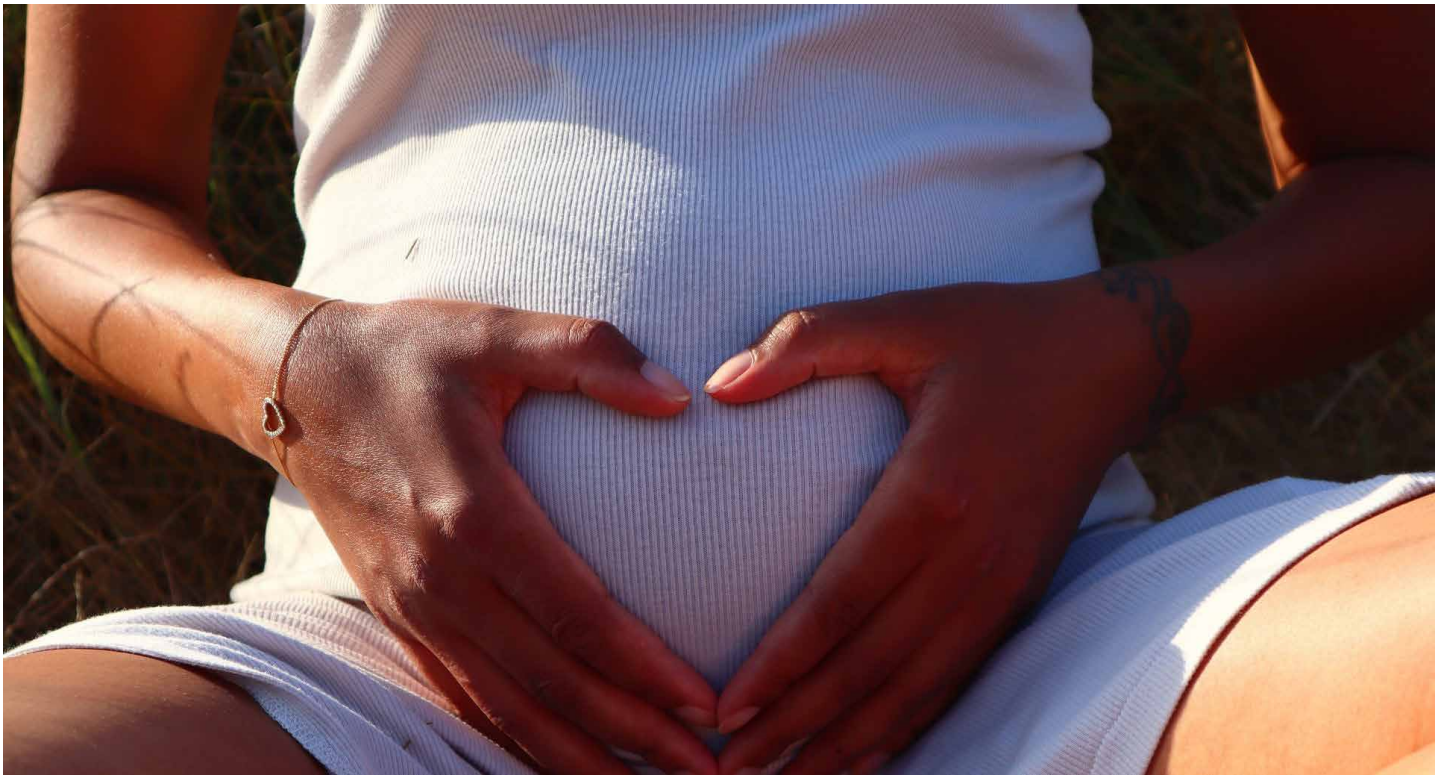
A LABOR OF LOVE: ADOPTING AN UNBIASED APPROACH TO ADDRESSING MATERNAL AND NEWBORN CARE



While the Senate recently passed a bill that would recognize Juneteenth as a new national holiday, there is still much work to be done to ensure Black Americans have an equal start in life without experiencing the devastating effects of racism. This is true for all babies of color – Black infants especially - and the challenges they face even prior to birth.

Bias impacts a child's health even before birth and gradually affects long-term well-being and health. This truth is reinforced annually, in updated metrics that reveal persistently high preterm birth rates and low birth weights in Black infants. While overall infant mortality rates are decreasing, a wide range in mortality by race shows Black infants are still disproportionately affected. Today, Black babies are more than twice as likely as their white counterparts to die before their first birthday.

And the Black maternal mortality rate due to pregnancy-related complications is 3 – 4 times higher than that of white women, even when adjusted for education and socioeconomic status. Even a celebrity like Serena Williams had to fight to be taken seriously when she complained of shortness of breath, despite having a previous history of pulmonary embolism.

Systemic racism and its life-altering effects – discrimination, implicit bias, medically inappropriate variations in care, and social determinants of health (SDOH) – have been woven into the very fabric of our society, from its founding to early medical practice and scientific research. Indeed, Dr. Maria Trent, a professor of pediatrics at Johns Hopkins School of Medicine, said of racism: "It's taught, it's passed down, but the impacts on children and families are significant from a health perspective."

It is high time we work to disrupt this cycle. As the pandemic continues amidst a long road to recovery, we must take the opportunity to reframe the delivery of healthcare in the U.S. to effect meaningful change. By embracing antiracist ideas and policies, providers can actively challenge deeply rooted effects of racism and bias wherever they arise, whenever they are encountered. Here are a few antiracist principles that individuals and care teams alike can adopt:

EXAMINE OUR OWN IMPLICIT BIASES TO ELIMINATE VARIATIONS IN CARE

While implicit bias can sometimes be hard to recognize, it is all too common: a recent study found two out of three clinicians hold implicit bias against Black and Latinx patients. This has been shown to result in different standards of care and treatment options offered to patients based on race: doctors were shown to be more likely to recommend advanced medical treatments for their white patients than they were for their Black ones. Black Americans are consistently undertreated for pain relative to white patients – which tracks back to studies that reveal nearly 50% of medical students and residents hold false beliefs about supposed biological differences between Black and white patients, such as higher levels of pain tolerance. On a national scale, recognizing how implicit bias can shape care plans – and an individual's outcome – will be critical when working toward more equitable care delivery. Scholars posit the heart of racism is denial and unless addressed head-on, harmful inequities will be perpetuated.

Many academic and health institutions nationwide are taking first steps to "dismantle racism at every level," including: The American Academy of Pediatrics, The American Medical Association, The American Public Health Association, The American College of Obstetricians and Gynecological Health and The American Psychological Association, just to name a few.

As the face of healthcare, today's clinicians are uniquely positioned to address healthcare inequities. Firstly, culturally sensitive clinicians will engage in implicit bias testing and training. Understanding and acknowledging one's personal implicit biases is a powerful – and necessary – first step when preparing to actively work against them. Next, cultivating a sense of inclusiveness and cultural sensitivity in the office – and outside of it – are key. To this end, this summer the American Medical Association offered a clear set of guidelines on how to establish practice-specific, anti-discrimination policies. Practice managers can work to actively hire a diverse and culturally representative group of clinicians, nurses, and staff members, which contributes to patient comfort and trust.

The import of active listening during appointments cannot be overstated – by being open to patients and taking the time to understand their backgrounds, clinicians can learn much more about where and how to provide the best types of care. This aids discovery of critical health, nutrition, housing, education, and safety needs – all of which contribute to long-term health and wellness. Importantly, the willingness to continue learning and growing along with other providers, patients, and local community and advocacy groups is key in the charge to embrace inclusiveness, eliminate racial bias, and achieve equitable health outcomes for all.

MAKE ROOM FOR REPRESENTATION TO IMPROVE PATIENT-PROVIDER RELATIONSHIPS

A core tenet of healthcare is trust. Yet, trust amongst the Black community in our healthcare system remains a challenge. In a recent poll, 7 out of 10 Black Americans report being treated unfairly by the healthcare system. Fifty-five percent (55%) said they outwardly distrust it. Those with greater mistrust are more likely to also report being in generally poor health. By working to improve the patient-provider relationship and Black patients' experiences, providers can help foment a continuum of care and ensure more equal preventive, prenatal, and well visits.

For new mothers, building a relationship with the delivery team can make a huge difference in improving birth outcomes. Providers who make an effort to understand the history of disproportionately high maternal mortality rates among Black women and other women of color can better solve for a new mom's fear and safety concerns before she goes into labor.

OB-GYNs and health systems nationwide are working to help create safe and trusted environments for all patients. Part of these

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efforts involves making room for more voices in the delivery room: midwives and doulas act as teachers, friends, and care advocates for soon-to-be moms. It is empowering to access support, resources, and information aligned with a mom's individual needs. A recent study showed states with higher midwife integration scores saw significantly lower rates of preterm birth and low birth weight babies.

Patients who feel heard, represented, and understood are better able to ask for and receive dedicated care. Diverse hiring practices in medical settings helps ensure a variety of races, ages, genders, ethnicities, orientations, and perspectives are represented – and that care teams can adequately meet the unique individual needs of their patients. Increased patient satisfaction, deeper trust, developed patient-physician partnerships, and improved health outcomes are all associated with greater diversity in the medical workforce. In fact, studies reveal some patients who share a racial or ethnic background with their physician report higher levels of provider satisfaction.

When given a choice, patients often select doctors who "look like them." When in racially concordant healthcare relationships, they feel more comfortable participating in conversations about their care. Recently, researchers combed through two decades of Florida birth data and uncovered an interesting association: when Black babies were cared for by Black doctors after birth, their mortality rate was cut in half, as compared to that of White newborns. While additional research in reproductive health equity is needed to further understand the causal links between representation and quality care, it reinforces the call to continue diversifying the physician and nursing workforce and help eliminate racial disparities in both newborn mortality – and healthcare overall.

EXPAND A SENSE OF COMMUNITY

Barriers to healthcare can feel insurmountable, from lapses in insurance coverage, to workday scheduling conflicts, unmet childcare needs, and a lack of connection with available providers. Hospitals, healthcare institutions, providers, payers, and policymakers can begin to build meaningful relationships with their local communities to fill gaps in need and build trust.

Local entities have deep connections to the community and are often best positioned to make measurable improvements in maternal and infant care. Studies show that frequent and quality prenatal care results in a marked improvement on both maternal and infant outcomes. For example, payers can forge partnerships with local organizations working to extend prenatal and postpartum care such as Commonsense Childbirth (CC), in Florida. CC's community-sponsored group prenatal care classes result in reduced rates of preterm birth, NICU admissions, and ED use during pregnancy. CC's Easy Access Clinics are designed to provide accessible and affordable healthcare to uninsured, underinsured, low-income, and poor pregnant and postpartum women. While the model is proving successful in Orange County, Florida, there is an opportunity to expand their model of care to other communities in need.

In areas where healthcare resources are limited, implementing innovative care options can help expand a sense of community by forging virtual healthcare relationships and reducing barriers to life-saving care. Access to care impacts over ten million women in the United States who live in OB-GYN "deserts," where obstetricians are scarce, or nonexistent. Rural residents are 9% more likely to experience significant maternal mortality than their urban counterparts. Telemedicine and health monitoring apps help share education information and track nutritional intake, pregnancy milestones, and more. The promise is manifold: televisits reduce the need for travel, enable at-home monitoring for blood pressure and hypertension, and facilitate access to specialists when needed. It also provides a lifeline during the postpartum period, by extending resources for lactation services, mental health, monitoring of complications, and more.

Forward-thinking payers can help by financially supporting similar programs and alleviating cost considerations, such as providing a smartphone, tablet, or a calling card, supplying necessary home monitoring equipment, and offering access to costly mental health services, that do not often accept public insurance options. Along with the medical community, they can also push for action to be taken to reduce the disparities which result from the digital divide and insufficient digital literacy. When working with those closest to the specific needs of an area, healthcare efforts have the potential to go further and provide help where it is truly needed.

CELEBRATING DIFFERENCES TO CHAMPION EQUAL CARE

While we all work together to reinvent our healthcare system in the year ahead, we need to also work actively to dismantle barriers to healthcare and medically inappropriate variations in care that impede both access and the quality of care.

The future of healthcare should be one that is equally bright for **all** women and their children. It will truly be a labor of love. By addressing our implicit biases, variations in care, and the wide-ranging health inequities that plague our communities today, we can take tangible steps toward ensuring survival and healthier futures for our Black mothers and their newborns.

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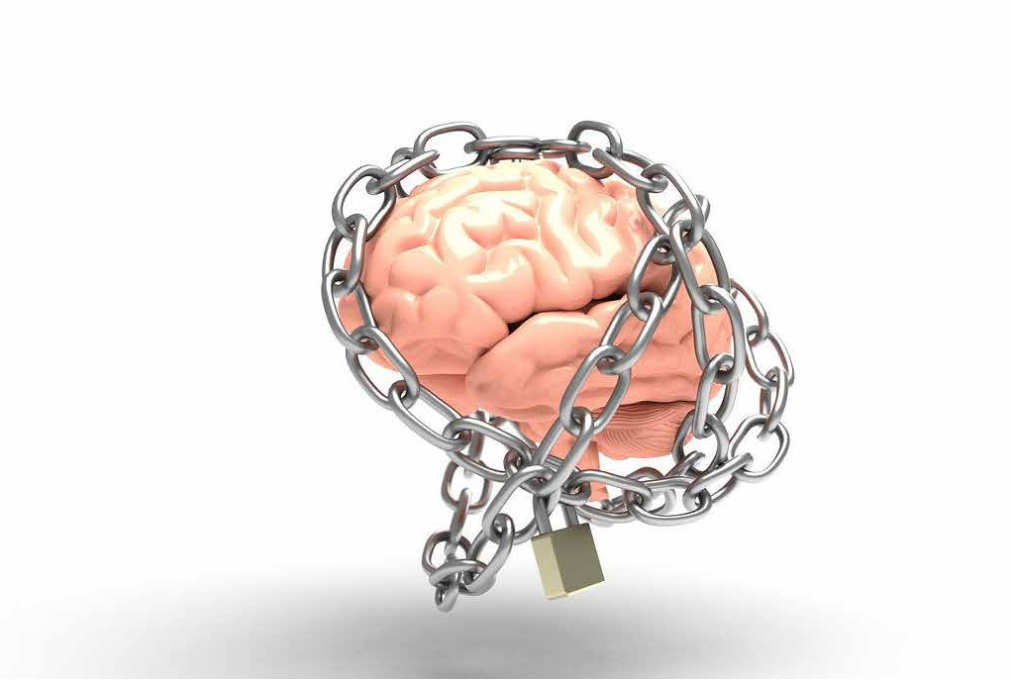
WE'RE APPROACHING MALE MENTAL HEALTH ALL WRONG. WHAT ACTUALLY WORKS?



Mental health is highly context-dependent. Blanket solutions to mental health ignore our individual realities, which differ greatly based on where we're from, how we live, and what we experience.

Underutilization of mental health services deserves introspection through the lens of BIPOC and other marginalized population segments, but here we delve into why men seek help for their mental health at such low utilization rates across typical treatment modalities.

THE EMOTIONAL CONTEXT OF MALE EXISTENCE

According to a meta-analysis of multiple studies, "women prefer to focus on emotions as a coping strategy more than men do."

Help-seeking differences between men and women are clearly reflected in the data, and yet, as a society, we expect one set of tools to help men and women equally.

Men experience the gamut of human emotions, but the expressions of their emotional struggles point to a root lack of internal and external resources, through no fault of their own: anger management, addictions, loneliness, fear of rejection, and existential dread.

Too often, pride and culture keep men from engaging with or addressing their mental health, which keeps them from getting interpersonal support, developing coping strategies, and feeling normal for their regular, human feelings.

UNSUSTAINABLE DENIAL

How can men be expected to deal with their emotions – effectively or at all – when few are raised to talk about emotions in the first place?

When emotions aren't noticed, they can't be identified or processed – key factors in mental health maintenance. According to Mental Health America, "People who are good at being specific about identifying and labeling their emotions are less likely to binge drink, be physically aggressive, or self-injure when distressed."

Men frequently struggle to engage with difficult feelings, employing counterproductive coping mechanisms or ignoring issues until they become crises. Illustrating this point, men are three times more likely to die of suicide than women.

For men to manage emotional health better, they need solutions that overcome stigma and other obstacles associated with existing mental health services.

STIGMA AS AN OBSTACLE TO MEN'S MENTAL HEALTHCARE

Men tend to dismiss their own struggles to avoid inviting judgement and societal messaging that holds sensitivity equates with weakness and feelings make men soft. Young boys get the message that emotions other than anger are unbecoming of men.

Men learn feelings are "bad," which incentivizes denial. In addition to stigma's impact on male self-esteem and its role in creating denial processes, it also perpetuates a society where men are afraid to seek help.

WHY MEN DON'T GO TO THERAPY

Some experts have pointed out the practice of psychotherapy was invented in a gendered way. Male psychoanalysts developed what would become our mainstream therapy approaches, for use on women, whom they viewed as weak and hysterical. Today, psychologists are predominantly female, and less than a third of people in therapy are male.

Men fear judgment for their attendance. As a UT professor of psychology acknowledges in an interview with VICE, "the classic image of therapy (sitting on a couch with the Kleenex next to it, in a room with turquoise walls) may not be the most welcoming place for traditionally-minded men."

For men of color, instances of initiating or continuing therapy are even slimmer. According to the 2015 U.S. Census, 86% of American psychologists are white, with no lived experience of the struggles to be discussed in session. It's no wonder then, that only 4.7% of U.S. mental healthcare utilization comes from Black patients, male and female.

HOW ELSE DO MEN SEEK MENTAL HEALTH SUPPORT?

If therapy doesn't provide the necessary ease, flexibility, and de-stigmatized experience, what can men do to take ownership of their mental well-being? The Internet Age has brought many attempts at digital solutions.

First, meditation apps ascended to popularity. While good solutions for people already familiar with their own emotions, the idea of engaging in periods of stillness may feel insurmountable to men. A 2017 study out of Brown University even found that men who *did* participate in mindfulness exercises were less likely to benefit than women.

After meditation apps came the wave of online therapy apps. These removed physical barriers to therapy, especially groundbreaking in rural areas, but didn't address the cost, stigma, mistrust, and need for scheduling related to therapy. These solutions also didn't make the process more accessible to men specifically.

Chatbots were another wave of innovation that fell flat. Receiving randomized supportive messages doesn't seem to make anyone feel meaningfully uplifted.

One other familiar alternative has seen high utilization in its high-tech evolution: support groups.

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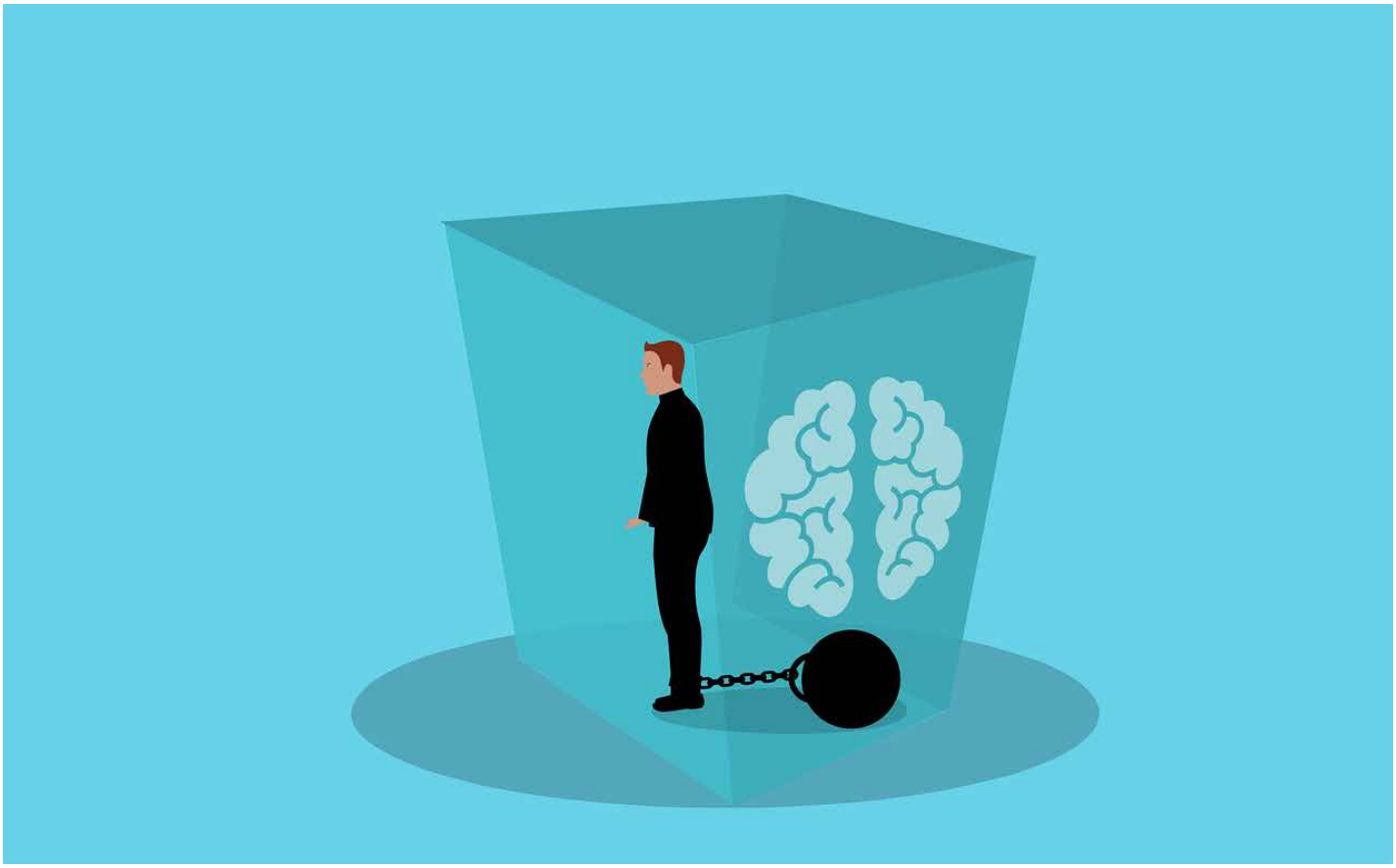

PEER SUPPORT GROUPS FEEL MORE COMFORTABLE FOR MEN.....
While traditional, in-person peer support groups retain the barrier of accessibility, they do approach mental health in a way that seems to appeal more to men.

It can feel cathartic to let one's guard down in front of other "regular guys," who aren't likely to be scrutinizing or analyzing like a therapist would. Hearing others' vulnerable, authentic statements counterbalances repression, removing the shame associated with male emotion.

As effective as in-person peer support groups may be, access is still a barrier. They require free time, local availability, and the fortitude to show one's face.

Until recently, there wasn't a reliable way to access the healing power of support groups, anonymously.

By moving peer support groups online, and removing personal identity and replacing it with anonymity, you can safely talk about anything you're going through, once nobody knows who you are.

A BETTER, MORE MODERN VERSION OF PEER SUPPORT GROUPS FOR MEN

Mental health treatment for men should capture the effect of an in-person support group, except with flexibility, ease, and anonymity. As such, an iteration on the in-person peer support group model has emerged, addressing lessons learned from less accessible modalities: Supportiv, the anonymous peer-to-peer support network.

The on-demand anonymous peer support chats allow men to seek support when it's convenient or top-of-mind (rather than on a schedule), and without risk of judgment, condescension, or identification, features that have been highlighted by male users, who constitute 53% of the service's overall members. Instead of being instructed or infantilized, users are empowered. As one anonymous male user puts it: "They led me to formulate my own plan to fix my problem."

In parting, any mental health tool should aim to address the needs and goals of the population it serves; and men are in particular need of such tools. As we learn more about the factors that make men more likely to reach out for support, we can continue to innovate empowering mental health solutions with minimal barriers to access.

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APPLYING HEALTH ECOSYSTEM LEADERSHIP TO SYSTEMIC INEQUITY IN HEALTHCARE: A Q&A WITH SYSCO'S CHRO RON PHILIPS

We have arrived at a pivotal moment in time, one we hope will inspire America to engage in a conversation around how we as individuals, organizations, and as a nation can and must do better. This past year highlighted the centuries of inequality and racism that culminated into acutely and ongoing horrific consequences for Black Americans.

In the healthcare industry, continued perpetuation of systemic inequality is at odds with our shared mission of healing the communities we serve. When it comes to systemic change, the fact is no one of us can do it alone. For systemic change to occur, diverse stakeholders must join together, speak out, and collaborate. United around our common purpose, healthcare industry leaders must harness our collective power and influence to champion changes that will benefit the health of our nation. And, we must do it together. We invite you to consider the following model for change.

ENVISION A NEW FUTURE

Leaders have the platform and influence to ignite dialogue that leads to meaningful change. We need to take the time to listen, discover, organize, and absorb from others to create a shared understanding of what a racially just and equitable future can look like. Only from here – with a shared vision – can we align efforts and outcomes.

ALIGN DIVERSE STAKEHOLDERS

To advocate for change, we need to orchestrate a coherent system of actions taken simultaneously by actively seeking connections, taking concrete steps to enable trust, and demonstrating respect for diverse experience and perspectives. For too long, we have focused on perspectives in silos – perspectives from the Black community or from the white community but not together.

MANAGE BOUNDARIES AND OBSTACLES

Support constructive conflict by keeping an open mind, disagreeing respectfully, and tirelessly seeking common ground. This requires us to be vulnerable and empathetic, to push through the discomfort, and begin engaging in difficult conversations. This is where the change begins: With each of us sharing, listening, and becoming comfortable with uncomfortable discourse.

ACT AND LEARN

Define change plans, and take reasonable steps despite uncertainty, identify what is working and what is not, to adapt plans and advance a shared vision for a more just society. In the world of leadership, this starts with recognition of how current organizational practices may contribute to systemic racism and a commitment to make meaningful and impactful shifts.

In this Q&A with Ron Phillips, CHRO, Sysco and former Senior Vice President of Human Resources - Retail & Enterprise Modernization for CVS Health, we explore systemic inequity within the current U.S. healthcare system and apply the competencies of health ecosystem leadership to open a dialogue toward meaningful solutions to our nation's most pressing problems.

Envision the Future. *From the perspective of envisioning a new, more positive and equitable future, what might a racially equitable and just future for healthcare look like?*

To me, it means bringing to bear all the assets that companies within the health ecosystem can to break down barriers to access, barriers to affordability, barriers to quality healthcare. Companies need to figure out all the pieces that impact affordable access to healthcare. For example, CVS invests in affordable housing because zip code has as much of an impact on your health as genetic code.

Align Stakeholders. *How does one go about getting the right people to the table to make systemic change in healthcare?*

Start within your own networks, with your friends, your family. Regardless of your specific role in your organization, we all contribute to the organization's ability to serve those who need us. If you belong to professional organizations, ask the question of what they can do to address inequality and injustice. Be the one to ask questions, to force dialogue, instead of just moving the agenda. We are connected through social channels now more than ever before. And so, how hard would it be to convene a group on LinkedIn to have a cross company or even multi-industry discussion about inequity? The question the civil rights movement of the 60s asked over and over again was, "If not you, then who? If not now, then when?" I would say now is the time to be engaging folks, to bring them to the table. You don't have to necessarily have the formal title or formal authority to begin to move the needle. We lead within our families, with our kids, our colleagues. We lead in our community. There are so many different opportunities.

Managing Obstacles and Boundaries. *Why haven't we made more progress in addressing inequities in our healthcare system? Is it because of boundaries and obstacles? Are they insurmountable or are they issues we can overcome?*

I think about the effect of interpersonal, institutional, and systemic biases and policy, practices, structural inequities, and the sorting of people. We sort people into resource-rich or resource-poor neighborhoods largely based on race and socioeconomic status. I was watching something the other day that said we are even more segregated today than prior to Brown vs. the Board of Education in 1954! That is shocking to me, but it says something about the structural nature of racism. Structural inequities create large and preventable differences in health metrics such as life expectancy. I think about the consequences of national healthcare policy. You see that in the politics today - for example in rejection of policies to protect people with pre-existing conditions. Around 27% of non-elderly adults have pre-existing conditions. Racial and ethnic minorities are disproportionately represented in that group. And we are seeing, especially over the last few years, the weakening of protections for these patients. But I do feel a sense of hope and optimism. Now is the time to demand change.

Act and Learn. *During COVID, large organizations were able to turn on a dime and get things done. How can we maintain the speed at which we can get things done?*

"Comfort is the enemy of change." I think about the number of head of HR calls I've been on over the past year with every kind of group you could imagine and the learnings and the sharing of information. And I think your question is the right one: How do you maintain the forward movement? Holding debriefs, doing a comparative analysis around what the world was like pre-COVID, understanding how decisions get made, what the barriers were to getting decisions implemented, etc. I think it is about focus.

KeyTake-Aways. *For healthcare leaders looking to make an impact during this time, what immediate action steps do you recommend they take?*

Collaboration. The public health and the medical communities need to join with other sectors. I think they need to form policy advocacy coalitions around factors that promote social mobility, basic environmental protections, transit, healthcare, education. All those things will lower the overall levels of socioeconomic inequality.

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A CULTURE OF GRATITUDE: IMPERATIVE IN THE POST-PANDEMIC ERA

"No one who achieves success does so without acknowledging the help of others. The wise and confident acknowledge this help with gratitude."
~ Alfred North Whitehead

The current complexity and uncertainty of disruptive change in healthcare are clearly on the shoulders of institution leaders. They are responsible for supporting employees in managing the overwhelming stress associated with such change while inspiring, engaging, and retaining them throughout the change process. And that's where organizational culture either supports or obstructs change imperatives.

Scholars and organizational strategists have defined culture in different ways. Standing the test of time is Edgar H. Schein's (Professor Emeritus at the MIT Sloan School of Management) definition - "a set of shared values and beliefs that employees hold and that determine how they perceive, think about, and react to the organization's various environments." Those shared values and beliefs are directly influenced by leaders and are the source of organizational culture.

In our coaching practice, it's not uncommon to observe multiple cultures existing in one organization. At times, stark differences between departments and units, members of a hospital system, or within a network of specialty clinics. The common denominator at the heart of any culture is leadership. Today's leaders must role model the appropriate values and behaviors needed to lead through disruptive change successfully. Fear-based leadership (an understandable default for leading through a pandemic) can result in short-term improvements in metrics. However, fear-based, authoritarian leadership will greatly undermine a psychologically safe work culture, and improvements quickly disappear under significant losses of talent, revenue, and poor safety and quality ratings.

WHERE'S CULTURE AS WE MOVE INTO A POST-PANDEMIC ERA?

Today various studies and articles denote as much a 57% of organizations anticipate major changes to their culture due to the COVID-19 pandemic. Two out of three organizations reported keeping employee morale up has been difficult, and one-third said maintaining company culture was a challenge. What's even more challenging to organizational culture is the intense workloads, high physician and RN burnout, turnover, and the underlying mental health concerns just beginning to surface from the sustained impact of COVID-19.

In March of this year, the U.S. Department of Health and Human Services Office of Inspector issued a Report in Brief, reporting hospitals were experiencing staff shortages, particularly among nurses, raising concerns about patient safety and quality care.

In a recent article in Healthcare Innovation, 4% of physicians surveyed said COVID-19 had changed their employment plans. Of those, 50% are considering leaving for a new healthcare employer, 21% said they may hang up their white coat for early retirement, and 15% are thinking about leaving the practice of medicine entirely.

REASONS WHY A CULTURE OF GRATITUDE IS IMPERATIVE

A simplistic definition of culture is how employees speak and interact with each other, with leaders driving and influencing the language and interactions. Gratitude is continually gaining attention as imperative in galvanizing its positive impact on culture in the following areas:

- **Employee and Organization Health and Well-Being.** Numerous health and well-being benefits of gratitude for individuals, are well documented. Gratitude is strongly linked to improved mental health by lowering levels of stress and anxiety. Physical health improvements include lower blood pressure, a stronger immune system, improved sleep, and better self-care. Gratitude in organizations leads to a reduction in negative emotions, helps to create shared organization citizenship, and supports organizational resilience. In addition, the neuroscience of gratitude supports the positive impact of gratitude on organizational well-being and generates greater trust among team members.
- **Employee Engagement.** A culture grounded in gratitude increases employee engagement and encourages more prosocial behaviors and productive relationships. Leaders see fewer undesirable behaviors and have improved psychological capital (the positive developmental state of your employees.) Employees gain hope, have greater self-efficacy, are more resilient, and are optimistic in their ability to achieve goals that contribute to patient satisfaction and quality and safety of care. Our 2019 Gratitude Intervention in the senior care sector resulted in statistically significant improvements ($p<0.001$) in employee engagement and meaningfulness of work. The intervention allowed employees to increase their awareness of positive emotions, increased hopefulness they could also impact their work culture by incorporating the language and concepts of gratitude, giving them permission to behave differently, and thereby, strengthening connections.
- **Psychological Safety.** Defined as the degree to which employees perceive their work environment to be open to expressing different ideas, can ask questions, and voice concerns about disruptive behaviors and potential errors. Gratitude's positive impact recognizes the benefits of a psychologically safe culture leading to fewer errors, greater inclusion, and a healthy and positive workplace versus a punitive, toxic environment.
- **Charitable Giving.** With greater engagement, psychological safety, and capital, employees can tap into their best self at work, bringing empathy, compassion, and positive emotions to their chosen profession. A 2018 survey conducted by the National Research Corporation/NRC Health in collaboration with Accordant Philanthropy asked patients what most influenced their feelings of gratitude during a healthcare experience. Thirty percent of participants said gratitude was spurred by the "compassion, empathy, or kindness of caregivers." Others attribute feelings of gratitude to "outcomes of the procedure/treatment" (23%), "accurate diagnosis" (20%) or "attentiveness to personal/social/emotional needs" (18%). More motivated to give, 34% of participants who say they would make a charitable gift to a healthcare organization indicate "gratitude" would be their primary motivation for a gift.

A LEADER'S ROLE IN CREATING AND INFLUENCING A CULTURE OF GRATITUDE

As many studies indicate, if culture is a major factor in the post-pandemic era, leadership behaviors grounded in gratitude will help employees feel safe, heard, appreciated, and valued. Creating a culture of gratitude starts with a plan and can include the following elements:

- **Start at the Top.** Each leader must first embrace his/her personal gratitude practice. By realizing their individual benefits, they are better able to lead and experience organizational benefits fully. Consider creating a culture steering committee comprised of leaders from key services and functions and an external consulting firm expert in the research on gratitude and able to confidently assess current and desired culture, needs, and expectations.
- **Invest in Designing Evidence-Based Programs.** Make gratitude a leadership development essential, well-aligned with organizational values, contributions, and desired behaviors.

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- **Review Existing Technologies, Policies, and Programs.** Seek to incorporate the best practices in neuroscience, positive psychology, and gratitude. Develop gratitude metrics for organizational and individual performance evaluations.
- **Ensure Gratitude Practices are Genuine, Frequent, and Appropriate for Cultural Preferences of All Employees.** For example, discern whether public expressions are preferred and welcomed or if private one-on-one expressions are more appropriate. When should gratitude practices be individually based, or when is there a preference for a team-based approach?
- **Pilot a Gratitude Intervention.** To understand the full impact gratitude can have in your organization. When properly designed, the pilot must include all job functions, incorporate learning and knowledge acquisition, and be endorsed by top leadership. Pilot in one department, unit, or division to create a foundation for building a culture of gratitude seeking to provide safe, high-quality care and a rewarding work experience.

DISRUPTIVE CHANGE PROVIDES THE GREATEST OPPORTUNITY FOR CULTURE CHANGE

Before the World Health Organization (WHO) declared a pandemic, a 2019 article in *Harvard Business Review*, "The Wrong Ways to Strengthen Culture," found 69% of employees don't believe in the cultural goals set by leaders, 87% don't understand them, and 90% don't behave in ways that align with them. In addition, a 2018 Deloitte Global Human Capital Trends report noted that as employee well-being emerges as a strategic priority, so must culture and leadership behaviors change to support this priority.

Now, amid this disruption, is the optimal time for leaders to design a culture of gratitude, institutionalizing it as a core value and developing implementation strategies for sustainability. You and your organization will be poised to overcome the known cultural consequences of the pandemic, create greater hope and resilience in your employees, and strengthen your institution's impact on community health.

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