Wharton ALUMNI CLUB
UNIVERSITY of PENNSYLVANIA

Health Care Management Alumni Association

THE WHARTON HEALTHCARE QUARTERLY

SUMMER 2022, VOLUME 11, NUMBER 3

TABLE OF CONTENTS

IN EVERY ISSUE

FEATURED ARTICLES

IN UPCOMING ISSUES

Downloading Success: How to (One Day) Become a CEO

Recovering and Thriving Post-Pandemic - Part 6

QUICK LINKS

Join Our Mailing List

Upcoming Events

Wharton Healthcare Management Alumni Association

Penn Connect

GET INVOLVED

Have an article to contribute or words of wisdom for the Philosopher's Corner?
Send us an Email.

SUMMER 2022
Volume 11, Number 3

Healthcare Management Alumni Association
The Wharton School
University of Pennsylvania
204 Colonial Penn Center
3641 Locust Walk
Philadelphia, PA 19104
215.898.6861 phone
215.573.2157 fax
www.whartonhealthcare.org

EDITOR'S LETTER

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

To learn more about Colette, click here.

Though lifestyles continue to become more reminiscent of pre-pandemic times, change continues and seems to accelerate ever more quickly. The coronavirus is evolving and adapting to the environment with breathtaking rapidity not seen in the past. The breadth, depth, and complexity of the global impacts of COVID-19 make clear the world will be challenged at home and at work for many years to come.

It will take new ways of thinking, doing, and being to survive and thrive. Our well-being and the health of the healthcare system demand it.

The 10-year WHQ anniversary monthly webinar series (**free to WHCMAA members!**) continues to offer important and timely coverage of the many issues and challenges of the day, like the topics discussed during the first 7 months of the year:

- On Caregiving: What's Hard, What's Helping, and the Post-COVID Opportunities for Support
- Mental Health Innovation for COVID-Era Post-Traumatic Growth
- Should I Stay or Should I Let It Go? Accelerating (Provider) Partnerships in a Pandemic
- The Science of Addressing Addictive Behaviors
- Chasing My Cure: Lessons about Life, Business, and Medicine from Chasing Cures for Castleman, COVID, and Beyond
- Maternity Care and Technology: Why Collaboration Is Key in Moving the Needle
- FemTech Comes out of the Shadows: Growth Opportunities for 2025 and the Future of Gender-Specific Healthcare

Register now for the August 10 presentation on "The Power of Gratitude" with Linda Roszak Burton, ACC, BBC, BS, Founder and Managing Partner of DRW, Inc.

"Our very survival depends on our ability to stay awake, to adjust to new ideas,
to remain vigilant and to face the challenge of change."
~ Martin Luther King Jr.

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

Contact Colette at: colette@accessinsightmd.com

THE PRESIDENT'S DESK

Heather Aspras, WG'08
To learn more about Heather, click here.

Back in May, I had the good fortune of going to the first in-person WHCMAA board meeting in more than two years. It was wonderful getting to see June and a lot of my fellow board members in Colonial Penn Center!

In addition, I had the opportunity to congratulate the second-year HCM class and highlight the benefits of the WHCMAA at their graduation brunch. We are excited to welcome them into the official alumni fold. After so much disruption over the past few years, it was energizing to see such a nice celebration of everything they've accomplished and to anticipate all of the great things they will do as alumni.

Speaking of doing great things, I am happy to share that our very own Z. Colette Edwards, MD MBA is being honored in this year's State of the Clubs report for all of her contributions to the WHCMAA and in particular the *Wharton Healthcare Quarterly*. I hope you have all had the opportunity to enjoy the WHQ anniversary webinar series, which has highlighted a variety of important topics in healthcare, including the most recent one in June on maternity care and technology with Anish Sebastian, CEO and Co-Founder, Babyscripts.

The State of the Clubs report also highlighted the WHCMAA for our high number of paid members, which is several times the average number per club. This illustrates the value we all find in being connected to each other as alumni.

One area in particular where I know our new and existing alumni can have an important influence is in health equity. As you know from past President's Desk articles, the WHCMAA is dedicated to finding concrete ways to make an impact in this area. I'd like to highlight for you an exciting opportunity to become more involved and do just that.

PennHealthX is a decade-old program that is focused on providing medical students with the opportunity to contribute to innovation in healthcare. The organization's growing program, the PennHealthX SDOH Accelerator, provides start-ups focused on health equity and social determinants of health (SDOH) with pro-bono support from a Perelman School of Medicine medical student consultant.

WHCMAA members who have either founded or are involved in health-related startups may be interested in applying to the 4-month PennHealthX SDOH Accelerator Program.

SUMMER 2022
Volume 11, Number 3

Healthcare Management Alumni Association
The Wharton School
University of Pennsylvania
204 Colonial Penn Center
3641 Locust Walk
Philadelphia, PA 19104
215.898.6861 phone
215.573.2157 fax
www.whartonhealthcare.org

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., Aug. 10, 2022 | 12pm ET

The Power of Gratitude

Linda Roszak Burton, ACC, BBC, BS, Founder, Managing Partner of DRW, Inc

Wed., Sep. 14, 2022 | 12pm ET

Shifting the Care Model: How AI-Driven Proactive Care Is Saving Lives, Lowering Costs, and Changing How We Treat Patients

Dr. Kira Radinsky, CEO, Diagnostic Robotics

Wed., Oct. 12, 2022 | 12pm ET

We've Spent $20B on Healthcare Cybersecurity: Are We Done Yet?

Vidya Murthy, WEMBA'42, COO, Medcrypt

Webinars are FREE for WHCMAA members

$20 for non-members

- **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 fall.***

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

THE PRESIDENT'S DESK

Source: PennHealth

To apply, please email PennHealthX VPs of Strategy (Angela.Malinovitch@pennmedicine.upenn.edu and Danielle.Brown@pennmedicine.upenn.edu) to express interest and provide an overview of your organization's mission and structure. Qualifying start-ups will receive an interview to discuss potential participation in the program and the specific areas where a student-consultant could provide support. Applications are rolling.

In addition to providing concrete pro bono support to start-ups that are focused on health equity and SDOH, for me the broader takeaway is that we have a strong healthcare community at Penn that we as WHCMAA members can partner with on critical issues. I am encouraged to see PennHealthX dedicating resources to advance health equity just as our organization is.

Kind regards,

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

Contact Heather at:
haspras@gmail.com

LinkedIn Profile

SUMMER 2022
Volume 11, Number 3

Healthcare Management Alumni Association
The Wharton School
University of Pennsylvania
204 Colonial Penn Center
3641 Locust Walk
Philadelphia, PA 19104
215.898.6861 phone
215.573.2157 fax
www.whartonhealthcare.org

ALUMNI NEWS

ALUMNI NEWS

Nishan de Silva, WG'00, MD'00
I recently joined Radionetics Oncology, a San Diego-based, venture-backed biotechnology company focused on the discovery and development of novel radiotherapeutics for the treatment of a wide range of oncology indications, as CEO. It's a great team and Board, and I'm excited about the opportunity in front of us. I also joined the Board of Selecta Biosciences, a Boston-area public biotech, in the middle of last year as an independent Board member.

Contact Nishan at:
ndesilva@radionetics.com

Marketa Wills, MD'00, WG'06
The Daily Record in Baltimore, MD has named Dr. Marketa Wills, Chief Medical Officer at Johns Hopkins HealthCare (JHHC), to its 2022 listing of Maryland's Top 100 Women.

Dr. Wills has also been selected by the National Committee for Quality Assurance (NCQA) to chair its Standards Committee. Since 2018, Dr. Wills has been a voting member of the committee, which approves scoring, standards, and measures within NCQA evaluations. Dr. Wills is passionate about quality healthcare and inclusion, and this appointment allows her to lead initiatives within both of those areas, as NCQA gets ready to launch a new health equity accreditation plan.

Learn more.

Contact Marketa at:
marketa.wills@gmail.com
LinkedIn Profile

SUMMER 2022
Volume 11, Number 3

Healthcare Management Alumni Association
The Wharton School
University of Pennsylvania
204 Colonial Penn Center
3641 Locust Walk
Philadelphia, PA 19104
215.898.6861 phone
215.573.2157 fax
www.whartonhealthcare.org

THIS MONTH'S PHILOSOPHER:
Michael Rovinsky, WG'86

To learn more about Michael, click here.

THE PHILOSOPHER'S CORNER

Michael Rovinsky, WG'86

LIFE LESSONS

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

paid more attention to red flags when interviewing for jobs. There almost always are at least a few red flags, and we tend to overlook them in our eagerness to get the job. Paying more attention to them doesn't mean you don't take the job; but being keenly aware of them allows you to go in with your eyes open. Having said that, some red flags should not be ignored, and you should get up from the interview and run!

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

tried to "buck" (or fight against) the organizational environment. Culture is the most difficult thing to perceive when interviewing for a new job, but the most important thing to understand, and doing so usually takes at least a few months on the job. Once you have a good feel for the environment/culture, it either fits or it doesn't. The environment is very unlikely to change, and it will always win. If you realize it is not a good fit, don't try to change it; it won't, and don't try to change who you are to make it a better fit; you will only resent it, and there is only so long you can fake it. Be confident in who you are and your abilities, and look for a better fit somewhere else.

FAVORITE QUOTES

1. "Integrity is one of several paths. It distinguishes itself from the others because it is the right path, and the only one on which you will never get lost." ~ M.H. McKee

   Integrity breeds integrity. When you speak and act with integrity, it is apparent to the other person, and it gives them the freedom and permission to do the same. Plus, you never have to remember the story you told or cover up for the behavior.

2. "Don't let the perfect be the enemy of the good." ~ Voltaire, Confucius, Shakespeare, and Gretchen Rubin

   Many of us are successful because we are perfectionists, but it is a blessing and a curse. The quote speaks for itself.

3. "Asking makes possible that which wasn't going to happen anyway." ~ The Forum

   If you don't ask (for what you want), the answer is no. If you do ask, the answer may still be no, but it may just be yes. This quote can be put into practice for everything from asking for a raise at work to answering the question "Where do you want to go for dinner?" truthfully. In the latter situation, the group may veto your suggestion, but you will have moved the conversation forward; and you just might go to dinner exactly where you want to go.

RECOMMENDED READING

1. *Million Dollar Consulting* by Alan Weiss
2. *Getting More* by Stuart Diamond
3. *The No Asshole Rule* by Robert I. Sutton
4. *10% Happier* by Dan Harris

Contact Michael at:
mrovinsky12@gmail.com

THIS MONTH'S PHILOSPHER:
Michael Rovinsky, WG'86

To learn more about Michael, click here.

SUMMER 2022
Volume 11, Number 3

Healthcare Management Alumni Association
The Wharton School
University of Pennsylvania
204 Colonial Penn Center
3641 Locust Walk
Philadelphia, PA 19104
215.898.6861 phone
215.573.2157 fax
www.whartonhealthcare.org

AFFIDAVIT: HEALTHCARE AND THE LAW - "HARDCORE CARTEL CONDUCT": ANTITRUST CRACKDOWN IN HEALTHCARE LABOR MARKETS

Source: Bigstock

Healthcare businesses should pay close attention to the antitrust implications of so-called "wage fixing" and "no poach" agreements, which generally refer to agreements between competitors regarding the hiring and/or compensation of their employees.

The recent high-profile prosecution of DaVita, Inc. — one of the world's largest dialysis providers — and its former CEO for allegedly engaging in no-poach agreements should serve as a clear warning sign. Although the government ultimately failed to obtain a conviction at trial, the antitrust agencies nevertheless appear resolute to continue to pursue antitrust violations, specifically in healthcare labor markets, likely with sharpened focus on achieving more successful outcomes in the future.

Because the potential criminal, civil, and other consequences are substantial, healthcare businesses should not only avoid obviously illegal agreements with competitors regarding employees, but they also need to properly and carefully navigate potentially legal arrangements and information sharing that seek to advance a procompetitive purpose.

WAGE FIXING AND NO-POACH AGREEMENTS OVERVIEW

The Department of Justice ("DOJ") defines a "no-poach agreement" as one between companies not to compete with each other for employees, such as by not hiring or soliciting them. A "wage-fixing agreement" involves an agreement between companies regarding salary or other terms of compensation.[1] In 2016, DOJ and the Federal Trade Commission ("FTC") jointly issued guidance that such agreements are per se illegal under the antitrust laws. The agencies further stated an intent to pursue criminal prosecutions for these arrangements, which they characterize as comparable to "hardcore cartel conduct."[2]

According to DOJ, these agreements are illegal because they potentially restrain competitive pay and opportunities for professionals. However, the agencies also recognize that legitimate collaborative joint ventures (e.g., those with a procompetitive purpose to increase output) are not necessarily considered illegal, and therefore employee agreements that are ancillary to such ventures could themselves be procompetitive. For instance, most joint-purchasing arrangements among healthcare providers, such as those designed to increase the efficiency of procurement and reduce transaction costs, do not raise antitrust concerns.[3] Additionally, a non-solicitation provision in an agreement between two nurse-staffing companies to collaborate on nurse spillover assignments was recently found to not violate the antitrust laws

because it advanced the procompetitive goal of fulfilling hospital demand for travel nurses.[4] FTC has, nonetheless, warned that even potentially legitimate restrictions on soliciting employees "must be narrowly tailored to protect the value to the business of the personnel at issue [and] they should not act as a *de facto* no-poach agreement."[5]

AGENCY APPROACH IN THE COVID ERA

DOJ historically limited its enforcement of no-poach/wage-fixing agreements to civil actions. However, in April 2020, DOJ and FTC issued a joint statement announcing greater scrutiny of employers, staffing companies, and recruiters who engage in potentially anti-competitive conduct in labor markets in light of the COVID-19 pandemic, including through criminal prosecution.[6] President Biden has also made clear by executive order in 2021 that "the President encourages the FTC to ban or limit non-compete agreements" altogether and has named the healthcare industry as a specific area of focus.[7]

DOJ has since brought its first criminal wage-fixing indictment against Neeraj Jindal, the former owner of a therapist staffing company. Jindal was charged with participating in a conspiracy with a competing staffing company to lower the rates paid to physical therapist assistants through non-public rate information sharing.[8] Although the court allowed the case against Jindal to proceed to trial because the government had articulated allegations that could conceivably constitute *per se* illegal price fixing, DOJ struggled to prove the allegations at trial, and in April 2022, Jindal was acquitted on the antitrust charges.[9]

DOJ has also brought additional criminal no-poach cases against other healthcare entities and executives.[10] The most notable of these cases involved the criminal prosecution of DaVita and its former CEO for allegedly conspiring with competitors to enter no-poach agreements that would prevent each company from hiring the other's senior-level employees. However, once again, the government failed to obtain a conviction, as DaVita and the former CEO were acquitted of all charges in April 2022.[11]

In early 2022, DOJ charged managers of home healthcare agencies in Maine for conspiring to suppress and fix wages, restrict job mobility, and not hire each other's employees.[12] That case has not yet been resolved.

In some instances, the government's scrutiny of labor agreements has led to private plaintiffs asserting civil claims, including class actions, that compound the potential exposure to the business.[13]

KEY TAKEAWAYS FOR HEALTHCARE BUSINESSES

So what conduct is allowed and what should a business avoid? The legality of any agreement or information-sharing regarding employees is highly dependent on the particulars of the situation, and businesses should always consult legal counsel before proceeding. It is clear, however, the agencies will likely view any naked agreement between competitors to refuse to hire or solicit employees or about terms of employee compensation as illegal. Nevertheless, some employee information-sharing or collaborative joint ventures between companies may be legal if they serve an overarching procompetitive purpose. The agencies have shared guidance on how to narrowly tailor employee information-sharing in order to minimize risk, including the following three elements:[14]

- A neutral third party manages the information exchange;
- The exchange involves information that is relatively old; and
- The information is aggregated (to protect employees' identities) such that competitors would not be able to link particular data to an individual source.

CONTRIBUTORS:
Sean S. Zabaneh and Kevin M. Moran, JD'19

To learn more about Sean and Kevin, click here.

SUMMER 2022
Volume 11, Number 3

Healthcare Management Alumni Association
The Wharton School
University of Pennsylvania
204 Colonial Penn Center
3641 Locust Walk
Philadelphia, PA 19104
215.898.6861 phone
215.573.2157 fax
www.whartonhealthcare.org

AFFIDAVIT: HEALTHCARE AND THE LAW - "HARDCORE CARTEL CONDUCT": ANTITRUST CRACKDOWN IN HEALTHCARE LABOR MARKETS

This narrow tailoring contemplated by the agency guidance, in conjunction with careful consultation with legal counsel, has never been more important. As recent cases demonstrate, the federal government has not been deterred by unsuccessful outcomes and thus appears likely to pursue even cases that may be difficult to prove at trial. The agencies will also likely make adjustments in future prosecutions based on lessons learned in the *Jindal* and *DaVita* cases that might improve their future likelihood of success at trial.

Healthcare businesses therefore need to pay attention because the potential consequences are severe. In addition to criminal and civil penalties, healthcare organizations that receive federal funds may face additional consequences, including, among other things, automatic termination from enrollment with Medicare, state Medicaid agencies, and MCO contracts,[15] Medicare and Medicaid disclosure requirements based on affiliations with convicted entities or persons with five-year lookbacks,[16] and exclusion by the Office of Inspector General.[17]

In sum, businesses should avoid external arrangements regarding their employees unless there is a procompetitive reason to do so, and, if that is the case, consult legal counsel early to ensure the arrangement is narrowly tailored to achieve that procompetitive purpose.

Contact Sean at:
SSZabaneh@duanemorris.com

Contact Kevin at:
KMoran@duanemorris.com

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

REFERENCES

1. DOJ, Spring 2018 Division Update, available at https://www.justice.gov/atr/division-operations/division-update-spring-2018/antitrust-division-continues-investigate-and-prosecute-no-poach-and-wage-fixing-agreements#:~:text=A%20wage%2Dfixing%20agreement%20involves,level%20or%20within%20a%20range.

2. DOJ & FTC, 2016 Joint Antitrust Guidance for Human Resource Professionals (the “Antitrust Guidance”), available at https://www.justice.gov/atr/file/903511/download.

3. See FTC & DOJ, Statement of Antitrust Enforcement Policy in Health Care at 53 (1996); FTC, *Competitive job markets*

offer more than just fringe benefits, Oct. 20, 2016, available at https://www.ftc.gov/news-events/blogs/competition-matters/2016/10/competitive-job-markets-offer-more-just-fringe.

4. *Aya Healthcare Servs., Inc. v. AMN Healthcare, Inc.*, 9 F.4th 1102 (9th Cir. Aug. 19, 2021).

5. Brian Telpner, FTC, Bureau of Competition, *Just because it's ancillary doesn't make it legal* (Sept. 30, 2019), available at https://www.ftc.gov/news-events/blogs/competition-matters/2019/09/just-because-its-ancillary-doesnt-make-it-legal.

6. DOJ & FTC, Joint Antitrust Statement Regarding Covid-19 and Competition in Labor Markets (April 2020), available at https://www.justice.gov/opa/press-release/file/1268506/download/.

7. White House: Briefing Room, Fact Sheet on Executive Order 14036 (Jul. 9, 2021), https://www.whitehouse.gov/briefing-room/statements-releases/2021/07/09/fact-sheet-executive-order-on-promoting-competition-in-the-american-economy/; *Executive Order 14036, Executive Order on Promoting Competition in the American Economy* (Jul. 9, 2021), available at https://www.whitehouse.gov/briefing-room/presidential-actions/2021/07/09/executive-order-on-promoting-competition-in-the-american-economy/

8. *United States v. Neeraj Jindal*, Case No. 4:20-CR-358 (E.D. Tex. Dec. 09, 2020); DOJ, *Former Owner of Health Care Staffing Company Indicted for Wage Fixing*, Dec. 10, 2020, available at https://www.justice.gov/opa/pr/former-owner-health-care-staffing-company-indicted-wage-fixing.

9. DOJ, *Former Health Care Staffing Executive Convicted of Obstructing FTC Investigation into Wage-Fixing Allegations* (April 14, 2022), available at https://www.justice.gov/opa/pr/former-health-care-staffing-executive-convicted-obstructing-ftc-investigation-wage-fixing. Note that Jindal was ultimately convicted of obstructing FTC's investigation as a separate charge from the antirust allegations.

10. *United States v. Surgical Care Affiliates LLC et al*., 3:21-cr-00011 (N.D. Tex); *United States v. Hee*, 2:21-cr-00098 (D. Nev.); and *United States v. DaVita Inc. et al.*, 1:21-CR-00229 (D. Col.).

11. *United States v. DaVita Inc. et al.*, 1:21-CR-00229 (D. Col.).

12. DOJ, *Four Individuals Indicted on Wage Fixing and Labor Market Allocation Charges* (Jan. 28, 2022), available at https://www.justice.gov/opa/pr/four-individuals-indicted-wage-fixing-and-labor-market-allocation-charges

13. *See, e.g., In re Geisinger Health Healthcare Workers Antitrust Litigation*, No. 4:21-CV-00196, Mem. Op. (M.D. Pa. Nov. 16, 2021).

14. The Antitrust Guidance, at 4-5.

15. 42 C.F.R. §§ 455.416(c), 438.600(a)(10), 438.602(b).

16. 42 C.F.R. §§ 424.502, 1001.601.

17. 42 C.F.R. § 1001.101.

CONTRIBUTORS:
Sean S. Zabaneh and Kevin M. Moran, JD'19

To learn more about Sean and Kevin, click here.

SUMMER 2022
Volume 11, Number 3

Healthcare Management Alumni Association
The Wharton School
University of Pennsylvania
204 Colonial Penn Center
3641 Locust Walk
Philadelphia, PA 19104
215.898.6861 phone
215.573.2157 fax
www.whartonhealthcare.org

TO YOUR HEALTH: THINK FAST - "THE PATRIOT WAY"

(Fife and drums playing) Over two centuries ago, long before Coach Belichick dominated the NFL, there was an event by the New England Patriots that changed history. On April 19th, 1775, while the British were returning the 20 miles from Concord to Boston, Patriots from Lexington, Concord, Acton, Sudbury, Bedford, and Lincoln to name a few, displayed remarkable feats of aerobic endurance in their attempt to do battle with the British Regulars heading east. Patriots covered 15-20 miles as they chased the British. The militia were the most fit and athletic from each town, fully capable of enduring the physical demands of that day. According to their Apple watches, the minutemen burned 5,300 calories that day and had an average BMI of ~21.3.

Just 100 miles north of Wharton is a contemporary test of that same endurance, save British soldiers with bayonets. The Appalachian Trail (AT) provides individuals a place to return their physiology back into action with 15-25 miles of hiking a day. The typical day will lead to an expenditure of > 4000 calories for women and > 6000 calories for men.

Carb Loading. No surprise, the AT diet is often an endocrinologist's (and dentist's) nightmare, with hundreds of grams of simplified, sugared, highly processed, and highly glycemic carbohydrates. 5,000 or more calories pour into the GI tract daily, often in large doses. Insulin explodes from the pancreas like a firehose. And then, fat loss? Mr. Taubes, please explain.

Paradoxical Findings. Regardless of the high sugars and fats in the diet of most hikers, there is a remarkably consistent occurrence. When Jessica Mills aka Dixie asked her YouTube followers about what they experienced, men told her the trail led to *35-75 lbs.* of weight loss while some women lost *20-34 lbs.* of weight. On her 2021 AT attempt, Kara Kirtley was *regretting* her 20 lbs. of weight lost in the first 21 days on the trail, as she was feeling very fatigued every afternoon. A 2004 study reported an average weight loss of 8 lbs. (72 women) and 15 lbs. (208 men) over the 5-6 months of hiking. “Well, ahvi!” my teenage daughter says dismissively after reading. Unfortunately, the trail eventually ends, and often the weight that was lost returns.

“The confidence people have in their beliefs is not a measure of the quality of evidence but of the story the mind has managed to construct.”
~ Daniel Kahneman

I hope you liked my story of the hikers and their weight loss, but I employed the system 1 or ‘Thinking Fast’ process that Daniel Kahneman, Nobel Prize winner in economics, writes about in Thinking Fast and Slow. ‘Thinking Fast’ works very well with effortless problems to solve like 2+2 or stopping at a red light. It is a very attractive system, as it is easier to use and less costly than ‘Thinking slow,’ and we can simply associate (hiking = weight loss), and we have our answer. Here are a few associations for you to try. I say ‘carbs’ you think_____. I say ‘sugar’ you think _____. I say ‘cardio’ you think

_____. Kahneman would hypothesize that whatever association you chose, it was likely an incomplete and simplified one.

Unfortunately for many of the highly confident purveyors of the 'weight loss secrets' peddling their formula for success, human physiology is a system 2 or 'Thinking Slow' issue, and that is likely why obesity has risen disproportionately over the past 5 decades. It is complicated. As Kahneman explained to the National Academy of Sciences in 2016, thinking slow is "effortful, tiring, and depleting." Using Thinking Slow means we must allow reasoned thinking to lead to beliefs. Kahneman gives the example of a relatively simple mathematical problem that over 50% of MIT, Harvard, and Princeton freshmen get wrong because they don't employ 'Thinking slow.' Kahneman states that often in science *"We have beliefs and then we develop the reasons for those beliefs. We are inclined to believe arguments that support positions that we already have."*

My observations on the fight against obesity tell me that, despite what the book titles claim, total calories eaten **do matter**, carbohydrates **are worth watching** but not eliminating, calories burned **play a role**, and there is **no** detox diet that boosts results. And consistency matters. Just like a hiker on the AT or a Patriot marching to the next showdown, it is a daily habit.

So, the next time Paul Revere rides into your town exclaiming "Paleo is the answer" or "Yoga for weight loss," I wouldn't go ringing the church bell quite yet.

Contact Rich at: rbutler2@bhs1.org

REFERENCES

1. Boulware, DR. Gender differences among long-distance backpackers: A prospective study of women Appalachian Trail backpackers. *Wilderness Environ Med.* 2004 Fall;15(3):175-80.

2. Kahneman, D. (2011). *Thinking, fast and slow*. Farrar, Straus and Giroux.

3. Kirtley, K. (Kara Kirtley). (February 25, 2022) *Overweight on the Appalachian trail (video).* OVERWEIGHT ON THE APPALACHIAN TRAIL | Yellow Creek Gap to Fontana Hilton | AT Day 26 - PART I - YouTube

4. Mills, J. (Jessica Mills). (March 4, 2020) *Is long distance backpacking the best way to lose weight? (video).* Is Long Distance Backpacking the Best Way to Lose Weight? - YouTube

5. Taubes G (2007). *Good calories, bad calories: fats, carbs and the controversial science of diet and health.* Random House.

CONTRIBUTOR:
Rich Butler, MS, USPTA

To learn more about Rich, click here.

SUMMER 2022
Volume 11, Number 3

Healthcare Management Alumni Association
The Wharton School
University of Pennsylvania
204 Colonial Penn Center
3641 Locust Walk
Philadelphia, PA 19104
215.898.6861 phone
215.573.2157 fax
www.whartonhealthcare.org

NOT A FREUDIAN SLIP: THE WIDENING GAP IN MENTAL HEALTH TREATMENT - IS TECHNOLOGY THE SOLUTION?

With the COVID-19 pandemic, mental health problems in the U.S. have risen dramatically. Anxiety, depression, and substance abuse are now occurring at increasingly higher rates while at the same time there is a shortage of mental healthcare professionals.

What is a viable solution to delivering mental healthcare treatment to more patients with fewer providers? Can technology, with the use of the Internet and 5G wireless networks, help solve the problem? If platforms and apps offering remote services are an option to address the gap, are these digital solutions effective in reducing the severity of mental health disorders? What might be the role of artificial intelligence (AI) in bridging the looming gulf in supply and demand?

THE EVOLVING CRISIS

Approximately one in five adults in the U.S. experienced a mental health illness in 2019, and this has only been exacerbated by the COVID-19 pandemic. Yet more than half of these adults do not receive any mental health treatment. The situation is equally as dire in youth aged 12 to 17. While 15% of youth have experienced a major depressive episode in the past year, 60% of this group do not receive mental healthcare. Mental health disorders are the most common in those identifying as being from two or more races, yet racial minorities have less access to mental health services than whites, and the quality of care is usually not as good.

Simultaneously, mental healthcare professionals are burning out due to the ever-increasing workload, and the problem is even greater in rural locations. In addition, 60% of all psychiatrists are over 55 years of age and will retire in the next 10 years. An alarming 60% of the approximately 3,000 counties in the U.S. have no psychiatrists at all, and many are in rural areas.

PROMISING

Can technology bridge the divide between mental health needs and a lack of qualified providers? How effective are these technology solutions beyond their face value promise?

With the advent of high-speed Wi-Fi and fast wireless networks, along with the ubiquity of computers, tablets, and smartphones, many mental health digital platforms can now offer services remotely. Companies such as Ginger and Talkspace offer remote mental health counseling via live video sessions and/or asynchronous texts done via a smartphone. Asynchronous care involves an audio, written, or video text sent where the provider responds usually within 24 hours.

Not everyone has the financial means to engage in traditional or even online therapy, and it can take weeks to be seen in person by a therapist. Furthermore, some people feel a stigma around getting the mental health support they need. As a result, a number of apps and platforms have been developed to provide mental healthcare by non-traditional means that don't require a live provider.

Two smartphone apps, Wysa and Woebot, use artificial intelligence and natural language processing (NLP) to deliver cognitive behavioral therapy (CBT) for depression and anxiety.

Bezyl, a smartphone app, encourages cancer patients and military veterans to develop spheres of support to help with mental health. TAG is a computer platform where consumers with mental stressors can watch others talk about their own struggles and listen to how a psychologist might help them solve those problems. Online communities also exist to provide support, and multiple other mental health apps are addressing the growing need for mental health support.

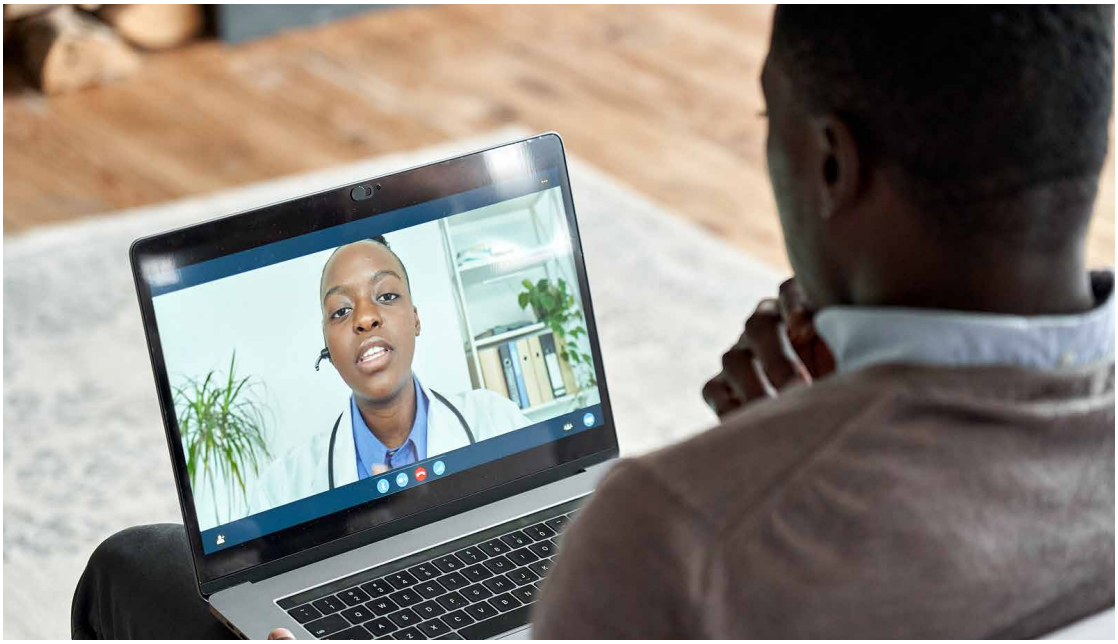
EFFECTIVENESS OF ONLINE TREATMENTS

A meta-analysis of 17 studies in 2020 comparing online live cognitive behavioral therapy (eCBT) with in-person CBT for depression revealed eCBT was at least equally effective as face-to-face CBT in reducing depression severity. Participant satisfaction was equal between the two, and eCBT proved to be cheaper.[1]

Regarding other mental health disorders, in 2018, 20 studies were pooled showing there was no difference in eCBT when compared with in-person treatment for disorders such as depression, anxiety, panic disorder, phobias, and some somatic disorders including fibromyalgia.[2]

The cost advantages for eCBT come in decreased costs for the patient in travel time and childcare costs as well as less absenteeism from work. Provider advantages include decreased commuting time and expense when working remotely. Missed patient body language cues was one provider disadvantage, however.

On-demand video visits have the added advantage of decreased time to accessing care, as wait times to be seen in-person can be weeks long. Follow-up visits were more likely to happen with online care due to increased convenience and lower cost.



Source: Bigstock

What about asynchronous care? In one large study[3] with over 10,000 enrollees, asynchronous daily communication with a mental health provider via audio, video, or written texts suggested being effective in reducing symptoms in over two-thirds of patients with acute anxiety or depression. People with chronic anxiety or depressive symptoms did less well, however, and no control was provided in this study.

The effectiveness of artificial intelligence driven apps such as Wysa and Woebot, as well as online communities for depression and anxiety, needs further evaluation.

CONTRIBUTOR:
Anne-Maree Cantwell, MD, MA'86, WG'86

To learn more about Anne-Maree, click here.

SUMMER 2022
Volume 11, Number 3

Healthcare Management Alumni Association
The Wharton School
University of Pennsylvania
204 Colonial Penn Center
3641 Locust Walk
Philadelphia, PA 19104
215.898.6861 phone
215.573.2157 fax
www.whartonhealthcare.org

NOT A FREUDIAN SLIP: THE WIDENING GAP IN MENTAL HEALTH TREATMENT - IS TECHNOLOGY THE SOLUTION?

PROVIDER SHORTAGE, AFFORDABILITY, AND INCLUSIVITY

Online telehealth visits can be shorter than in-person visits, allowing a single therapist to treat more patients. The patient-to-provider ratio can be further increased by the use of asynchronous texts, as one therapist can treat several patients simultaneously. AI-driven apps have options of no live therapists at all, offering the greatest promise of leveraging technology to treat mental health conditions.

All the above options can increase access by not requiring health insurance and by being more affordable for underserved communities.

MOVING FORWARD

The imperative of reinventing how we address mental health is unavoidable if we are to close the pernicious gap between high demand and a shortage of mental health providers. While online platforms have shown efficacy in treating mental illness, many of these options still require live providers.

If we are to provide full access to care for all those suffering from mental health conditions, AI must be fine-tuned, and its efficacy shown in treating at least mild conditions of depression and anxiety. AI-driven apps have the added benefit of making treatment more affordable and accessible, as only a smartphone and cellular connection are required. Technology does hold the promise of solving the mental health treatment gap, with AI offering the greatest possibility of making this a reality.

Contact Anne-Maree at: amcantwell@gmail.com

REFERENCES

1. Luo C, Sanger N, Singhal N, Pattrick K, Shams L, Shahid H. et. al. A comparison of electronically-delivered and face to face cognitive behavioural therapies in depressive disorders: A systematic review and meta-analysis. *eClinical Medicine*, Part of THE LANCET Discovery Science, Vol 24, 100442, July 1, 2020.

2. Carlbring P, Andersson G, Cuijpers P, Riper H, and Hedman-Lagerlöf E. Internet-based vs. face-to-face cognitive behavior therapy for psychiatric and somatic disorders: an updated systematic review and meta-analysis. *Cogn Behav Ther.* 2018 Jan;47(1):1-18. doi: 10.1080/16506073.2017.1401115. Epub 2017 Dec 7. PMID: 29215315.

3. Hull TD, Malgaroli M, Connolly PS et. al. Two-way messaging therapy for depression and anxiety: longitudinal response trajectories. *BMC Psychiatry*20, 297 (2020). https://doi.org/10.1186/s12888-020-02721-x

CONTRIBUTOR:
Anne-Maree Cantwell, MD, MA'86, WG'86

To learn more about Anne-Maree, click here.

SUMMER 2022
Volume 11, Number 3

Healthcare Management Alumni Association
The Wharton School
University of Pennsylvania
204 Colonial Penn Center
3641 Locust Walk
Philadelphia, PA 19104
215.898.6861 phone
215.573.2157 fax
www.whartonhealthcare.org

DOWNLOADING SUCCESS: THE EVOLVING PARADIGM FOR C-LEVEL READINESS

The Big Quit.
The Great Resignation.
The Great Reshuffle.

No matter what you call it, the challenge is the same. With unexpected resignations and expedited retirements rapidly increasing across the executive ranks, healthcare organizations struggle to find *been-there-done-that* executives.

While many predicted the approaching gap in succession management and leadership development, no one anticipated the pandemic and its subsequent acceleration of not only resignations but telemedicine, industry disruptors, and consumer-driven care. Healthcare's changing future is colliding with an unpredictable talent landscape. Disoriented in this unfamiliar terrain, organizations and executives must develop an agile mindset to evolve and redesign pathways to enter the C-Suite.

EXPERIENCE ≠ FUTURE SUCCESS

In the wake of unforeseen change, it's a common belief you'll minimize risk by choosing a leader who has proven credentials in a similar role and situation. However, this experience in and of itself doesn't guarantee a successful outcome.

Depending on the size, scope, scale, and complexity of the role, you could inadvertently narrow your aperture to the smallest subset of qualified leaders. Add to that the nature of the current talent market where most candidates are entertaining multiple opportunities, and you'll find yourself in a highly competitive battle for talent.

This is where adjusting your mindset makes all the difference. The key is to realize it's not about matching up specific experiences or even organizational size and complexity. It's about identifying what competencies and skills are needed for success in the role. The goal is to evaluate candidates based not solely on their past experiences but also on their ability to scale and drive measurable results.

It's important to remember that even when you find an executive who has led an organization through a similar transformation, the executive may be looking for a new or different challenge in their next role. Furthermore, finding someone with the same experience as their predecessor may only produce the same results. These results may not represent the solutions you need for the future and the ever-changing industry trends.

A competency-based model of C-level readiness allows you to curate candidates from a variety of backgrounds who have better alignment with your organization's strategic goals and unique market challenges. This means you'll be well-positioned to find and attract a leader who will move your organization forward.

RETHINKING TRADITIONAL PATHWAYS TO THE C-SUITE

Step-up candidates are leaders who have demonstrated the aptitude, skills, and competencies that indicate readiness but are not stepping over from the exact role, organizational complexity, or market scope. These leaders may or may not hold executive titles, but they have executed complex, enterprise-level responsibilities as part of committees or team-based initiatives in their current organizations, and you may have one or two currently in your organization.

In addition to looking externally, be sure to explore the talent on your existing team with this new perspective in mind. Dig deep and take time to consider team members beyond the traditional pathways for development and succession. Evaluate internal and external step-up candidates with intentionality and rigor around the set of competencies necessary to succeed in the role and your organization.

Expand stringent requirements that may be driving homogeneous recruitment practices, such as preference for certain educational institutions, certifications, and other qualifying filters that significantly limit candidate pools. Instead of focusing on finding someone to step into the shoes of the incumbent, rethink the role and skills needed to succeed considering the leader's potential impact not only on your profitability but on the culture of your organization.

Most organizations striving for growth and innovation know diversity is essential. However, when you look across your organization or sector, chances are the bench of executive talent and those identified as "high potentials" lacks depth. Moving to a competency-based model will increase the probability of diversity on your candidate slates and reduce churn through the narrow group of known leaders in the field.

More importantly, step-up candidates bring new experiences and perceptions, which equate to competencies that perhaps aren't even on your radar. Topping this list are resilience, learning agility, curiosity, and digital literacy, while also being comfortable with ambiguity and driven by passion or hunger to succeed.

PERSONALIZE INSTALLATION TO MINIMIZE RISK

Executive transition affects the entire organization, so there's a real risk around not only choosing the right leader but setting them up for success. Establishing a solid plan for executive installation and onboarding cuts that risk by more than half, regardless of the leader's prior experience.

While a personalized plan and support are necessary for a successful transition, the goal is always the same — accelerate the leader's effectiveness and positive impact. What surprises some is this process starts *well before* you begin the recruitment process through internal communication and the development of a success profile. The profile creation determines the competencies and skills needed for the role and to achieve your organization's strategic goals.

The success profile helps design and drive your search strategy to curate a candidate slate, evaluate candidates' future potential, and identify development gaps. Beyond making informed decisions on candidate selection, this approach also allows you to develop an onboarding plan that supports and accelerates the new leader's integration and ability to drive short and long-term results.

Despite the unknowns that lie ahead, the work paradigm is changing. Stay a step ahead by mindfully and intentionally evolving your organizational culture and the way you manage, support, and develop talent.

Contact Deanna at: dbanks@furstgroup.com
Contact Tim at: tfrischmon@furstgroup.com
Contact Jessica at: jhomann@furstgroup.com

CONTRIBUTORS:
Deanna Banks, Tim Frischmon, and Jessica Homann

To learn more about Deanna, Tim, and Jessica, click here.

SUMMER 2022
Volume 11, Number 3

Healthcare Management Alumni Association
The Wharton School
University of Pennsylvania
204 Colonial Penn Center
3641 Locust Walk
Philadelphia, PA 19104
215.898.6861 phone
215.573.2157 fax
www.whartonhealthcare.org

CYBERVITALS: REGULATORS, LEGISLATORS, AND DEVICE SECURITY - OH MY!

There has been a flurry of activity in policy and legislation in the last 6 months focusing on healthcare cybersecurity - the implication of which could fundamentally change the landscape.

President Biden issued an executive order in May of 2021 that mandates the recalibration of critical infrastructure cyber defenses to the growing maturity of adversaries. The ongoing conflict in Ukraine prompted the President to issue an additional statement in March 2022 focusing on the imperative nature of cybersecurity for our nation's critical infrastructure to continue operating.

The Senate rapidly followed this announcement with the introduction of the Healthcare Cybersecurity Act of 2022 in March. If passed, formal collaboration and reporting will be established, including education efforts and strategies for addressing risks facing the healthcare sector.

And mere days later, Senators introduced the Protecting and Transforming Cyber Health Care (PATCH) Act, which expands regulations for medical device manufacturers to ensure mitigations are sufficiently in place through the existing Food and Drug Administration (FDA) approval process.

The FDA believes "cyberattacks against hospital systems and networks can directly result in harm to patients." Perhaps not obviously, the FDA is the governing agency over the security of medical devices as it pertains to patient safety and the market approval process.

With all this activity, it should not be surprising that within days of Senate activity, the FDA issued an update to the cybersecurity guidance that informs how medical device manufacturers should contemplate designing security into the operation of their devices. While noted to be guidance, by definition, guidance is reflective of current interpretation of existing regulatory requirements. And device manufacturers have already reported that otherwise clinically effective devices are facing regulatory challenges as a result of lack of cybersecurity considerations.

This guidance update recalibrates cybersecurity as a process independent from clinical development, and instead embeds the technical security requirements into the quality management system. Shifting focus from 'nice to have' to 'demonstrated consideration' is no small feat and will impact every stage of device development.

In addition to the FDA expectations of device manufacturers, the FDA requested a budget increase as well. The latest appropriation request demonstrates the FDA is seeking an increase of $5M to have a budget of $5.5M dedicated to cybersecurity.

It is clear the connectivity which many device manufacturers have prized for enabling innovation is no longer to be taken without risk management considerations by any stakeholder.

Looking down the road five years, the regulator and consumer of medical devices will continue to mature in both assessment of risk and willingness to tolerate deviation from a baseline. If device manufacturers do not earnestly begin adopting better cybersecurity practices for devices, they will face a delayed release to market.

Contact Vidya at: vidya@medcrypt.com

CONTRIBUTOR:
Vidya Murthy, WEMBA'42

To learn more about Vidya, click here.

SUMMER 2022
Volume 11, Number 3

Healthcare Management Alumni Association
The Wharton School
University of Pennsylvania
204 Colonial Penn Center
3641 Locust Walk
Philadelphia, PA 19104
215.898.6861 phone
215.573.2157 fax
www.whartonhealthcare.org

MIND THE GAP: UNLOCKING VALUE AND EQUITY THROUGH TELEMEDICINE

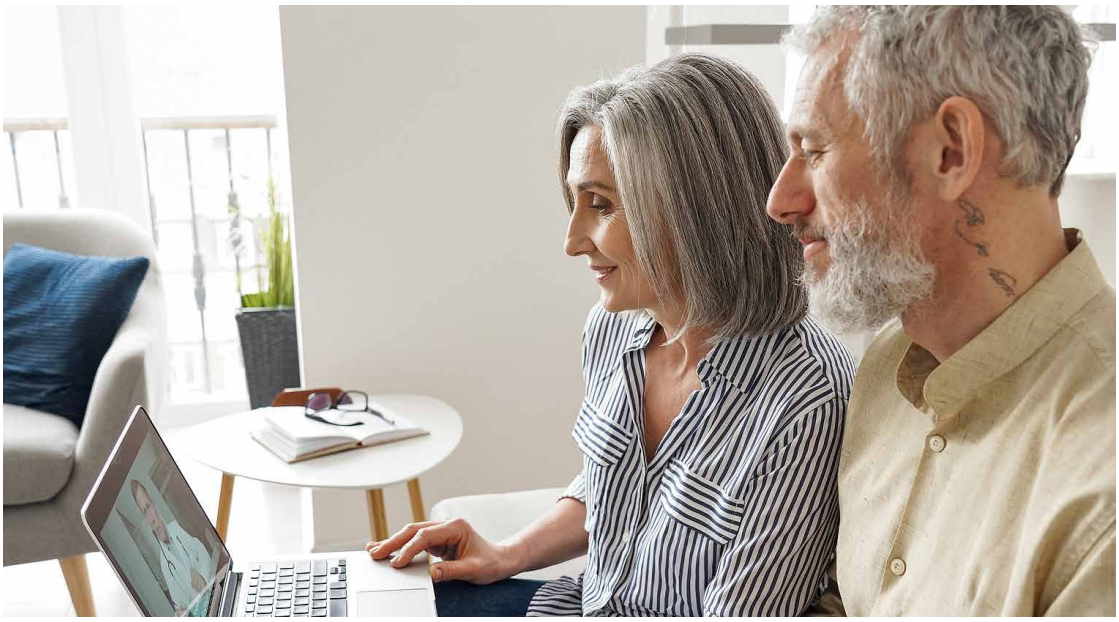
For the last nine years, one could say I have been deeply involved in the world of digital healthcare delivery. In fact, some people might even go so far as to say I am a national expert. However, the point of this article is not to display my "deep knowledge," but more so to make a humbling admission about my ignorance. I cannot figure out why some of our leaders and lawmakers refuse to see the value of telemedicine? or what I call virtual care?

When I talk about value in healthcare, it is important to provide a little more context. Value is typically defined as the quality of the care and outcomes a patient receives divided by the cost to deliver that care. As an example, if you can lower your patient's blood pressure just 5 mm Hg (that is the bottom number) you can reduce stroke risk by 30-50%.[1] That obviously is a great clinical outcome; however, if you spent millions of dollars to achieve that outcome, then you have not delivered much value. In fact, you may be doing harm, because you have probably taken much needed healthcare resources from some other area that could have benefited tremendously from those dollars.

So, I admit achieving value is not always straightforward, but in the case of telemedicine, it seems very clear our health systems can improve access, quality, and better, more equitable clinical encounters for patients and clinicians. I will come back to the value for clinicians, but to go a little deeper on patient outcomes and experience, let me take you back about 15 years when I was first introduced to telemedicine. At the time, I worked for the federal government in the Department of Veterans Affairs in northern California about 2 miles from Stanford where I was on faculty. I was developing a Veterans outreach program, and I applied for a grant from the Office of Rural Health (ORH) to improve access to care for Veterans living in rural or highly rural settings. Through that experience, I learned 1 in 4 Veterans lived in a rural setting and struggled to get primary and specialty care services. It was clear then, and remains clear today, that telemedicine was one of the highest value tools to provide much needed access and health services to these Veterans.

Some of you have noticed by now I have deliberately been referring to Veterans as a minoritized or underserved group or population that is deserving of equitable healthcare delivery. I started with this framing of Veterans, because they are an easily identifiable population for whom no one would deny access to high-quality care. They are a group, especially the geographically isolated rural Veterans I spoke of, for whom no leader or regulator would deny the value of telemedicine or technology-enabled care. So why are our leaders so hesitant to unlock this valuable healthcare tool for other minoritized parts of our population, like members of the Black community?

As a Black, cis-gender physician with he/him pronouns, I care deeply about improving health outcomes in the Black community, and I want to use all of the tools at my disposal. I believe telemedicine can improve healthcare access to communities living in poverty where Black non-Hispanic African Americans are overrepresented.[2] In late 2020, Lori Uscher-Pines, PhD reported in the *Journal of Medical Internet Research* that over 50% of Included Health's (formerly Doctor On Demand) telemedicine encounters in the early months of the COVID-19 outbreak served patients from low-income households with less than $20,000 annual income.[3] Insights like this point to telemedicine as a potential remedy for combating structurally racist policies of segregation, but access is not enough.



Source: Bigstock

Expanding access to outstanding clinical care is an important value driver of telemedicine, but virtual care platforms offer additional value beyond a simple substitution of virtual for in-person clinical competence. Telemedicine practices can offer patients more opportunity to match themselves with culturally-concordant and competent clinicians. Pre-pandemic, Doctor On Demand boasted an incredibly representative and diverse panel of clinicians. At one point, the practice consisted of over 60% women, over 40% Black, Latinx, Asian, and Indigenous Peoples, and a behavioral health practice with 20% of doctors identifying as members of the LGBTQ+ community. If this type of practice composition hosted in the "cloud" 24/7/365 could be duplicated and scaled, we would have a secret weapon in our national mandate to impact health disparities. Black patients living in rural and urban "primary care deserts" could access clinicians with their shared experience across state lines. These are opportunities for our healthcare delivery organizations to improve not just access, but potentially improve clinical outcomes, as we earn back the trust of Black patients, who have understandably disengaged from a healthcare system with a long history of racist thinking, inhumane and unethical research, and medical gaslighting, much of which still very much exists today.

CONTRIBUTOR:
Ian Tong, MD

To learn more about Ian, click here.

SUMMER 2022
Volume 11, Number 3

Healthcare Management Alumni Association
The Wharton School
University of Pennsylvania
204 Colonial Penn Center
3641 Locust Walk
Philadelphia, PA 19104
215.898.6861 phone
215.573.2157 fax
www.whartonhealthcare.org

MIND THE GAP: UNLOCKING VALUE AND EQUITY THROUGH TELEMEDICINE

To close, let me circle back to some of the value we see telemedicine offers clinicians. In late 2020, researchers at the Mayo Clinic published the Telehealth Impact Physician Survey Results.[4] A clear majority of clinicians reported telehealth improved their job satisfaction, and 75% stated it enabled them to deliver quality care across numerous domains, including behavioral health, chronic disease management, preventive care, and care coordination. This is consistent with our all-virtual care practice where we see average annual retention of 90% and high clinician satisfaction scores [Net Promoter Score (NPS) > 90!]. In this period of the "great resignation," it is critical we enable clinicians with every tool possible so they can find sustainable, rewarding careers.

Whether you or someone you love is a patient or a clinician, we all have something to gain from better engagement of telemedicine. The virtual care experience we have gained during the COVID-19 pandemic has provided us with a rare glimpse into the future value telemedicine will deliver to both patients and clinicians. Let's hope our leaders join us in embracing and then realizing it fully.

Contact Ian at: ian.tong@includedhealth.com

REFERENCES

1. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3838588/#:~:text=Results%20of%20meta%2Danalysis%20which,21%20%E2%80%93%2044%20%25)%20in%20secondary

2. https://sgp.fas.org/crs/misc/R46294.pdf

3. https://pubmed.ncbi.nlm.nih.gov/33112761/

4. https://telehealth-c19hcc-org-bzh6faksvq-uk.a.run.app/telehealth/physician-survey-analysis/?mc_id=us&utm_source=newsnetwork&utm_medium=l&utm_content=content&utm_campaign=mayoclinic&geo=national&placementsite=enterprise&cauid=100721

CONTRIBUTOR:
Ian Tong, MD

To learn more about Ian, click here.

SUMMER 2022
Volume 11, Number 3

Healthcare Management Alumni Association
The Wharton School
University of Pennsylvania
204 Colonial Penn Center
3641 Locust Walk
Philadelphia, PA 19104
215.898.6861 phone
215.573.2157 fax
www.whartonhealthcare.org

"ANNIVERSARY SPOTLIGHT": DIFFERENTIAL DIAGNOSIS - A CALL FOR SPECIALTY DISTINCTION IN VALUE-BASED PAYMENT

It is hard to avoid news and opinion articles about value-based care in 2022. Between the seismic growth in Medicare Advantage (MA), the adversarial launch — and then relaunch — of the Direct Contracting (now ACO REACH) model through the CMS Innovation Center (CMMI), and the meteoric rise in private equity-backed primary care models, the attention on new and innovative payment and delivery models has never been higher.

Within this hot button conversation about value-based care (VBC), there are many voices, each bringing a unique perspective:

- Private equity and other investors see this as an ever-growing, white space for investment.
- Health plans see VBC as both an opportunity to curb costs and potentially increase margins by being more efficient with care and as a growth strategy, as MA continues to grow towards at least half of the Medicare population.
- Patients are often wholly unaware of value-based models — but through experience may see them as a way to access benefits they didn't have before, like transportation and food.
- "Providers," which includes health systems, physician practices, etc., seem to be either enthusiastic evangelists of VBC or fighting valiantly against it being imposed upon them.

This, however, leaves out a key stakeholder in the discussion: the doctors themselves.

Though studies, articles, and podcasts abound discussing the importance of "providers" taking on financial risk in order to really make the transition to value-based care work, there is a level of granularity missing in current public discourse. To accomplish this, the term "provider" must not only be differentiated between hospital-based health systems, physician groups, facilities, and clinicians, but segmented amongst clinicians by specialty as well. Even where "specialists" and "primary care" physicians are differentiated, there is still a level of distinction missing within the world of value-based care to truly understand the individual physician experience.

PROVIDERS ARE NOT A MONOLITH.

While results from the Healthcare Payment Learning and Action Network indicate 80% of the covered U.S. population and 41% of U.S. healthcare payments in 2020 flowed through alternative payment models, the provider-level data tells a different story. A recent 2022 article in JAMA found more than 80% of primary care physicians and 90% of physician specialists are still individually compensated based on volume.

As Harrill and Melon explain in their 2021 field guide to U.S. healthcare reform, "For [the patient-physician] relationship to yield greater measurable clinical value, the physician will need to play an increased role coordinating the development of value-based models." But just as doctors are not a monolith in their clinical training, they are not a monolith in how they view or interact with VBC.

The U.S. healthcare system is singular across a number of unflattering domains, and its provider population is one of them; in 2018, 88% of practicing physicians in the U.S. were specialists. Specialists in Canada, by comparison, make up just over half of the clinician workforce. This inverted pyramid highlights not only the immediate need to publicly incentivize the practice of preventive medicine through primary care, but the vast population of "specialists" that must be examined more closely.

In the following sections, we will outline the nuanced perspectives and experiences of 3 different types of providers:

1. The primary care clinician
2. The chronic care specialist
3. The general surgeon or procedural specialist

While this grouping may still not represent a complete picture of the physician experience and some providers may not perfectly fit into each description, it's a start. The hope is this article adds a level of distinction and nuance to the overall dialogue on value-based care so we can bring all types of clinicians with us and continue to foster innovation in VBC that addresses the experience of all doctors.

THE PRIMARY CARE CLINICIAN

The primary care clinician is at the center of almost every discussion of value-based care. Often described as the "quarterback" of the patient's care, the primary care clinician — which generally includes primary care providers (PCPs) - internists, family medicine practitioners, gerontologists, and sometimes pediatricians — holds the keys to the population-based, coordinated care delivery model.

There is significant momentum and investment in value-based primary care, including within federal programs (e.g., CMMI's Primary Care First Initiative) and self-funded employers (e.g., Morgan Health's $50 million investment in Vera Whole Health).

It is also the most flexible specialty in which to test different payment mechanisms based on various levels of financial risk, and the innovation and risk associated with the chosen payment methodology drive corresponding innovation in the care delivery model. These can include interventions to improve non-clinical drivers of health outcomes ("social determinants of health"), tech-enabled care coordination modalities, and more personal relationships with patients.

Not only are value-based arrangements more feasible in primary care — they work better. A recent study of primary care organizations participating in value-based payment models with an MA plan demonstrated a significant decrease in the use of acute care amongst groups taking on two-sided risk in comparison to fee-for-service (FFS) arrangements. But while primary care is the obvious home for many VBC-focused initiatives, the individual physicians may have differing experiences based on the culture and reimbursement mechanisms *within* their organizations, or if they're part of a larger risk-bearing entity in the first place.

As interest in risk-based arrangements in primary care continues to grow and clinicians are expected to shift towards more preventive, coordinated care, they must be at the table to ensure this paradigm shift is feasible and realistic. Plus, VBC models driven by physicians almost unanimously demonstrated superior results: in particular in the MSSP program, physician-led Accountable Care Organizations (ACOs) performed 7 times better than those led by hospitals in 2018.

CONTRIBUTORS:
Lauren Cricchi and Roy Beveridge, MD

To learn more about Lauren and Roy, click here.

SUMMER 2022
Volume 11, Number 3

Healthcare Management Alumni Association
The Wharton School
University of Pennsylvania
204 Colonial Penn Center
3641 Locust Walk
Philadelphia, PA 19104
215.898.6861 phone
215.573.2157 fax
www.whartonhealthcare.org

"ANNIVERSARY SPOTLIGHT": DIFFERENTIAL DIAGNOSIS - A CALL FOR SPECIALTY DISTINCTION IN VALUE-BASED PAYMENT

THE CHRONIC CARE SPECIALIST

While much emphasis in the value-based care movement has been placed on the PCP, a critical component in the effort to decrease costs while maintaining quality is the chronic disease specialist. Evidence indicates specialty care for patients with complex, chronic medical conditions accounts for over $930 billion in annual U.S. healthcare spending, not including specialty drug costs. And while the PCP is critical in sustaining "well-care" with a focus on prevention and care coordination, this level of care is not sufficient for the almost two-thirds of the U.S. population who are already living with at least one chronic disease such as diabetes or inflammatory bowel disease.

Specialists like gastroenterologists, oncologists, and cardiologists may see their chronically ill patients more than the PCP; in fact, in many cases, these patients may consider their specialist to be their primary care clinician. However, without the appropriate level of accountability and corresponding incentive structure, these clinicians will remain singularly focused on the aspect of the patient's care they are trained to treat. They will consider the patient's needs while they are sitting in front of them, to keep them from getting — as is termed in the industry — "sick sick." As a result, these clinicians who provide critically important care to the chronically ill may only have a limited impact on their patients' overall well-being.

The small fraction of specialists who are currently participating in value-based arrangements is in part due to the challenges associated with creating appropriate incentives, measures, and benchmarks for specialty care that can often be highly variable, in addition to volume limitations and aversion to financial risk. However, despite these challenges, there are successful models of value-based specialty care. For example, nephrologists participating in existing value-based kidney care models are not only compensated to provide "sick care" to patients with ESRD but are increasingly incented to focus on the prevention or delayed onset of kidney failure, leading to better management of patients' chronic symptoms, reduced need for dialysis, and overall enhanced quality of life.

If specialists are compensated based on the health of their population, they are no longer singularly focused on the "sick sick" patients in their waiting room, but also on the patients who *aren't* there — and should be.

THE PROCEDURAL SPECIALIST OR SURGEON

Surgeons and other procedural specialists are a class of the "specialty clinician" that should also be considered independently. They are a unique breed, having been trained to do highly-skilled, technical procedures, often over more than a decade. They are focused on outcomes, are guided by clinical recommendations, and stay up-to-date on evidence and new technology related to their field. All of this makes a procedural specialist prepared to deliver the highest quality care; however, what it lacks is a focus on cost.

It is common knowledge within the industry that surgeons have traditionally been associated with high-dollar procedures for health systems and are compensated and incentivized accordingly. For example, in an FFS system, cardiovascular interventionists and orthopedic surgeons generate significant revenue for each surgery they complete, and, therefore, for a hospital or ASC that employs them. Recent data modeling the impact of COVID-19 on hospitals supports this notion, finding over 78% of inpatient

revenue came from elective surgeries, a third of which are musculoskeletal, circulatory, or digestive in nature. But when elective surgeries essentially screeched to a halt during the pandemic, it became clear to some that basing reimbursement strictly on the volume of procedures — and not value — was a flawed model.

However, the same principles used to establish value-based reimbursement for other specialists aren't as applicable here. While the chronic care specialist described above provides ongoing care to patients with chronic disease, these clinicians provide a specific, time-limited surgery or procedure and therefore may have less ongoing ability to impact patient outcomes. CMMI models like the Bundled Payments for Care Improvement Initiative and Comprehensive Care for Joint Replacement Model provide examples of episode-based payment mechanisms that can be applied to a procedural specialist, as these models include accountability for costs related to the anchor procedure, rather than the condition or overall patient well-being.

Even still, further differentiation of surgeons is needed; the "super-specialized" physicians, such as neurosurgeons, pediatric surgeons, or surgical oncologists, may have limited opportunities for meaningful value-based payment arrangements given the highly technical and acute level of care they provide. Value-based care evangelists and policymakers must recognize its limitations and targeted applicability in order to build a system which has buy-in from all physicians while continuing to practice the care they were trained to provide.

WHAT DOES A VALUE-BASED CARE SYSTEM LOOK LIKE THAT INCORPORATES THE MULTIFACETED PHYSICIAN PERSPECTIVE?

In summary, it is critical as we gain a more sophisticated vocabulary and approach to value-based care that we incorporate individual physician perspectives into the models we implement. In order for value-based medicine to work, there needs to be innovation in how it's done. While there are leaders who are already taking this physician-focused approach to value, the broader healthcare system must buy in and recognize that not all providers will have the same perspective or experience.

Some work has been done to begin incorporating distinct approaches to paying for value-based care in the specialty care arena. For example, a recent proposal published in JAMA by members of MedPAC suggests a coordinated, hierarchical model that incorporates both primary care-led population health management and specialist-led bundles. In their proposed hierarchical, ACO-episode-based blended model, the overall financial value and savings from condition- or procedure-specific bundled payments would accrue up to the overall population-based risk-bearing entity (e.g., an ACO). However, they would also trickle down to individual specialists and allow them to participate in population health arrangements, while having their individual experience be more specific to the type of care they provide. It could also create closer collaboration among primary care clinicians, specialists, and facilities, and have a real impact on their clinical decisions and care being delivered.

This means there will be increasing opportunities for physicians to take on more risk in the future. Providers need to think critically about this shift and how they want to participate. For example, a large multi-practice orthopedic group may decide to take financial risk through quality-based incentive payments, knee replacement bundles, or through fully-capitated monthly payments for their entire musculoskeletal population; but in order to be successful in more risky arrangements, they — and the business leaders who support them — must think about the specialty-specific costs and considerations that could impact their performance, such as physical therapy fees, MRI costs, and downstream provider relationships.

Business and clinical leaders must work together to create a system based on value that works for all.

Contact Lauren at: lcricchi@avalere.com
Contact Roy at: RBeveridge@avalere.com

CONTRIBUTORS:
Lauren Cricchi and Roy Beveridge, MD

To learn more about Lauren and Roy, click here.

SUMMER 2022
Volume 11, Number 3

Healthcare Management Alumni Association
The Wharton School
University of Pennsylvania
204 Colonial Penn Center
3641 Locust Walk
Philadelphia, PA 19104
215.898.6861 phone
215.573.2157 fax
www.whartonhealthcare.org

RECOVERING AND THRIVING POST-PANDEMIC - PART 5: HEALTH PLANS AND PAYERS

As we have done in previous articles in this series, in Part 5 we will continue to focus on activities healthcare leaders (specifically health plans and payers) can adopt to help ensure financial and operational recovery from the impacts of the COVID-19 pandemic. Simply put, this has been a rollercoaster of time for all - payers, providers, and patients/members. Hopefully, at this point, we can envision a time beyond the pandemic phase.

But the endemic and post–COVID stages may prove to be exceedingly costly, as we will discuss below. We will again outline relevant tactics as the pandemic/endemic/post-COVID phase continues to strain resources by creating constantly changing demands and high costs.

Early in the pandemic, many organizations reported health plans and payers were benefiting from the drop in utilization. This may have been true for a short period, when pauses in elective procedures reduced medical expenditures, and fear of contracting COVID-19 in clinical settings prompted patients to avoid emergency rooms and/or reconsider or postpone diagnostic, chronic, and routine care. As utilization has rebounded, payers are grappling with the widespread impact of pent-up demand, increased utilization, and a population with more comorbidities due to a delay of necessary care. In order to plan well enough for anticipated endemic and post-COVID costs, health plans should consider the following tactics as they plan for the future.

Evaluate the impact of long COVID. Research is ongoing and increasing to help understand and evaluate the current unknown impact on the long-term outlook of members suffering from long COVID. Early indications signal this post-viral syndrome may be difficult to address. Providers are often insufficiently aware and/or struggle to promptly diagnose patients with long COVID, who frequently present with a complex constellation of symptoms which might typically be attributed to any number of other root causes. Long COVID can result in a higher cost of care and has already increased medical debt for consumers as well as created challenges relative to disability insurance coverage.

Currently, the number and breadth of clinical pathways (i.e., diagnosis and treatment protocols) have grown significantly since the first reports of long COVID. However, given the reality that COVID-19 can impact the entire body and all organ systems, there is much more to be learned. Due to the multiplicity of symptoms, identifying the optimal care provider or care team members may not be clear. Consequently, patients may experience an increase in unnecessary and potentially costly referrals, a delay in care, and medical gaslighting.

A diagnosis code for long COVID was not released until the end of October 2021, and the varied constellation of symptoms may result in use of codes related to a patient's presenting complaints without inclusion of the code which specifically flags long COVID. Additionally, **since one can develop long COVID without ever having had symptoms at the time of**

initial infection (as well as in a reinfection or breakthrough infection scenario), the possibility of long COVID may not enter the mind of the patient or treating provider.

These challenges further contribute to the difficulty in quantifying the number of patients suffering from the condition, identifying approaches to symptom management, and even making the diagnosis in the first place. Health plans would be well served to:

- follow the research and guideline development closely and proactively develop predictive analytics schemata to identify the size of the population suffering from long COVID in order to evaluate clinical and programmatic needs as well as the financial impacts of long COVID on the Medical Loss Ratio (MLR)
- identify and provide coverage of services received at long COVID clinics (special care team expertise and holistic, integrated, coordinated care for patients with long COVID)
- offer second opinion consultation to help with diagnosis and treatment recommendations
- focus medical directorship on the design of care management programming, benefits, and resources to provide support to members with this often perplexing condition.

Stay on top of the quickly evolving COVID-19 landscape, as its speed of change could continue to overwhelm already over-stressed providers, health plans, and payers. Lack of understanding of the complexity and uncertainty of long COVID by underwriters could significantly impact health plans and payers by underestimating the cost of care and reserving insufficiently. Costs due to a delay in care (resulting from patient conditions worsening because of lack of provider awareness and/or understanding of long COVID) could easily surpass cost savings realized by heath plans and payers when patients were not seeking necessary care.

The cost of care will also be increased by the reality that those who have had a COVID-19 infection may develop *new-onset* depression, diabetes, and anxiety, to name a few conditions that have been noted thus far (even in those who do not go on to develop long COVID). Additionally, increased pandemic-induced emotional distress and mental health conditions only exacerbate new or already existing physical health issues as well as preexisting behavioral health challenges. Tactics include:

- providing ongoing education to network providers and members to raise awareness and enable a timely, accurate diagnosis to help decrease the twirling patients are currently experiencing when they engage with the healthcare system
- paying close attention to what is happening world-wide to help anticipate future twists in the road.

Ensure that care management is well-functioning to support members who have had difficulty being adherent to care plans. Because many patients were unable to follow many components of a care plan during the height and subsequent surges of the pandemic, risk profiles may have changed – sometimes becoming more acute – and new conditions may have developed. This heightened risk of an emergency event/hospitalization is exacerbated even further with concurrent mental health conditions, such as pandemic-induced depression and anxiety. Care management becomes even more critical to help members get back on track and identify the resources needed to optimize their health and well-being. Health plans will find it beneficial to:

- embark on a comprehensive member outreach campaign to ensure pandemic-impacted individuals know how to re-engage with the delivery system and health plan resources

CONTRIBUTORS:
Wren Keber, Lisa Soroka and Z. Colette Edwards, WG'84, MD'85

To learn more about Wren, Lisa and Colette, click here.

SUMMER 2022
Volume 11, Number 3

Healthcare Management Alumni Association
The Wharton School
University of Pennsylvania
204 Colonial Penn Center
3641 Locust Walk
Philadelphia, PA 19104
215.898.6861 phone
215.573.2157 fax
www.whartonhealthcare.org

RECOVERING AND THRIVING POST-PANDEMIC - PART 5: HEALTH PLANS AND PAYERS

- screen members for behavioral health conditions during care management to connect physical and mental health needs
- re-score patient profiles regularly to help ensure care plans are appropriately tailored to clinically appropriate resources now required by changing health risk patterns and member needs
- provide guidance to delegated care management arrangements on engaging members eligible for such programs, identifying new opportunities and the need for new offerings and potential changes to eligibility criteria, as well as communicating successes between plan and delegated functions.

Source: Bigstock

As always, grow market share to further diversify risk pools. Ensuring consistent coverage for enrollees is important in reducing risks of avoidable acute health events, increasing utilization of preventive care, and optimizing the management of chronic conditions. This approach is essential when it comes to making health insurance coverage as affordable as possible and to manage the cost of care across the healthcare system in general. Health plans should:

- continue to learn and utilize evolving best practices in care management, service delivery, customer engagement, and Customer Relationship Management (CRM) systems to retain current members (a significantly lower cost alternative to attracting new members)
- when possible, continue to invest in marketing and enrollment efforts targeted to younger, healthier populations, and, for Commercial health plans, to young adults who may otherwise choose not to purchase coverage.

In conclusion, we believe health plans and payers have multiple opportunities to address continuing clinical and financial challenges created by the pandemic. Specifically, we have provided several tactics which can be employed to speed recovery and mitigate the far-reaching impacts of COVID-19. Over time, these changes could dramatically improve quality of care, clinical outcomes, financial performance, member retention, new member enrollment, and member satisfaction, to name a few.

Recovering in an environment of a continuing pandemic, endemic, and/or post-pandemic world will require ongoing innovation, new as well as enhanced skill sets, proactive planning, and concrete actions to recruit and maintain a diverse healthcare workforce in a sustainable fashion, buttressed by a focus on the health and well-being of both clinical and non-clinical staff. These investments are critical to redesigning a financially stable delivery system that can consistently offer high-quality care and meaningful improvements in clinical outcomes in the face of future COVID-19-related costs and potential healthcare crises which may erupt without warning.

Contact Wren at:
wkeber@cardinalcg.com

Contact Lisa at:
lisasoroka@themarbleheadgroup.com

Contact Colette at:
colette@accessinsightmd.com

CONTRIBUTORS:
Wren Keber, Lisa Soroka and Z. Colette Edwards, WG'84, MD'85

To learn more about Wren, Lisa and Colette, click here.

SUMMER 2022
Volume 11, Number 3

Healthcare Management Alumni Association
The Wharton School
University of Pennsylvania
204 Colonial Penn Center
3641 Locust Walk
Philadelphia, PA 19104
215.898.6861 phone
215.573.2157 fax
www.whartonhealthcare.org

GRATITUDE - AN ESSENTIAL ELEMENT FOR GREATER INCLUSION

You can mandate diversity, but you can't mandate inclusion. Inclusion is about behavior, relationships. You have to change hearts and minds."
~ Esi Minta-Jacobs
Vice President of Human Resources of a money management firm

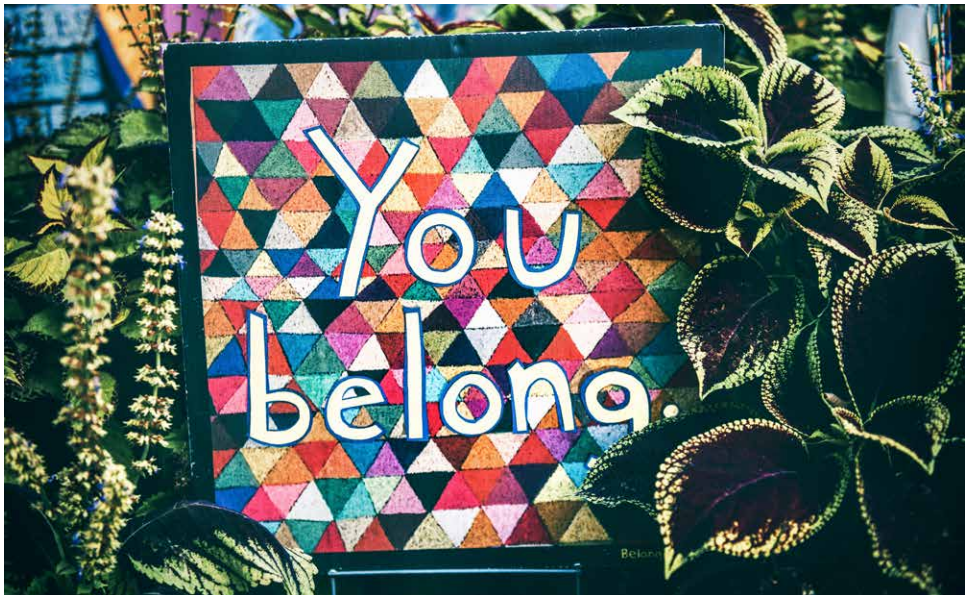


Photo by Tim Mossholder on Unsplash

Inclusion is a BIG word these days. The spotlight on healthcare disparities and the tragic murder of George Floyd witnessed during the pandemic have only increased attention to its meaning and the urgency to achieve greater inclusion in society and the workplace. It's estimated that companies spend $8 billion a year on diversity and inclusion training with little to show for it, according to experts at McKinsey & Co.

WHAT IS INCLUSION?

From multiple sources, inclusion collectively means a state of being respected and valued *"through meaningful investment"* in every individual, regardless of group, organization, or society. An organizational culture of inclusion recognizes and appreciates each individual for her/his talents and skills and strives to create a psychologically safe environment for employees to feel confident in their uniqueness and helps to contribute to a sense of belonging.

Human nature drives a fundamental need to know our existence matters. However, there's a lot of work to be done. Consider:

- A 2020 report by McKinsey & Co., *Diversity wins: How inclusion matters*, posits that promoting diversity does not ensure a culture of inclusion. While overall sentiment on **diversity** was 52 percent positive and 31 percent negative, sentiment on **inclusion** was markedly worse at only 29 percent positive and 61 percent negative — which encapsulates the challenge that even the more diverse companies still face in tackling inclusion. Hiring diverse talent isn't enough — it's the experience they have in the workplace that shapes whether they remain and thrive.

- Research by Accenture found 98% of leaders think their employees feel the company is inclusive. However, only 80% of employees actually report feeling included in their workplace, accounting for what is now called the "Perception Gap." If U.S. companies closed this gap and had greater inclusion, estimates are the result would yield a whopping $1.5 trillion more in profits due to increased productivity.

This data and related outcomes only raise awareness and do far too little to influence necessary change in individual behaviors. So, it's still a challenge to create a more inclusive work environment because *"you have to change hearts and minds"* to create greater inclusion.

Creating an environment where employees feel they belong and are appreciated for their individuality is about how people behave, driven by how they think, and being open and willing to invest in building relationships.

Would you be willing to help someone in your organization if you had nothing to gain or if it cost you time and energy? Have you heard the repeated refrain "that's not my job"?

HOW A CULTURE OF GRATITUDE SUPPORTS INCLUSION

Let's define an organization's culture by how employees speak and interact with each other. This gives you a fairly accurate gauge of the level of inclusivity in your team, department, and organization.

Gratitude has been labeled the social glue and the antidote to toxic emotions in all relationships.

From the field of positive psychology (the scientific study of how strengths allow individuals, communities, and institutions to flourish), employing the strength of gratitude is essential in building positive relationships and interactions in organizations. Research has shown that creating a culture of gratitude results in more prosocial behaviors, both individual and organizational, more civil interactions, and minimizes less tolerable behaviors — those behaviors that plague many leaders daily and at a huge cost to productivity, retention of talent, and employee engagement.

CONTRIBUTOR:
Linda Roszak Burton, ACC, BBC, BS

To learn more about Linda, click here.

SUMMER 2022
Volume 11, Number 3

Healthcare Management Alumni Association
The Wharton School
University of Pennsylvania
204 Colonial Penn Center
3641 Locust Walk
Philadelphia, PA 19104
215.898.6861 phone
215.573.2157 fax
www.whartonhealthcare.org

GRATITUDE - AN ESSENTIAL ELEMENT FOR GREATER INCLUSION

"…. gratitude prompts socially affiliative behaviors and the willingness to show preferential, socially protective behavior towards one's benefactor (someone who offers support), even when these actions will be costly." A two-part study in Cognition and Emotions provided evidence that grateful individuals engage in socially inclusive behaviors. Additionally, participants were willing to forego money to protect someone from feeling excluded.

Creating a culture of gratitude to embody the beliefs of inclusion starts with a leadership development approach. Embedding foundational principles of grateful leadership will support building or strengthening the workplace environment for a greater sense of belonging and increase positive organizational behaviors (defined as helping, sharing, and cooperating). Grateful leaders are more trustworthy and bring added well-being benefits to employees and the organization. Grateful employees are more likely to help others, even when they will receive nothing in return.

Another supporting study published in *Frontiers in Psychology* pointed out "in organizations, gratitude is now thought to be crucial to employees' efficiency, success, and performance, while also improving organizational citizenship behaviors, prosocial organizational behavior, and promoting psychological safety."

Below are recommendations for grateful leadership development in support of creating a more inclusive culture.

- Integrate current research in gratitude, positive psychology, and neuroscience as essential to all leadership development programs. Include the identification of how this approach will support employees' physiological, emotional, and mental well-being. Look for best practices in offering related leadership development programs. Our curriculum takes an experiential learning approach using research-related findings in gratitude, positive psychology, and neuroscience. As leaders begin to experience their overall impact, they begin to broaden and build these experiences with their teams.

- Develop a grateful leadership brand statement to support a sustainable culture of gratitude and inclusion for yourself and your team to foster a more psychologically safe work environment. A Grateful Leadership Brand is similar to a personal leadership brand and aligns with your best self, i.e., being grounded in your values and strengths and aligned with the organization. A Grateful Leadership Brand describes why and how your team respects and trusts you and remains engaged and committed to the organization.

- Begin having open discussions with your team about a culture of inclusivity and how gratitude can promote a greater sense of belonging and appreciation of the value and contribution of all employees. For instance, consider expressing gratitude when someone on your team speaks up about a potential, or real, error or mistake to help minimize "threat" and demonstrate psychological safety.

- Identify how to measure and monitor your leadership's impact and progress on a culture of inclusivity and how it supports care delivery. Start with an overall assessment of how well you and your team understand the impact of creating greater inclusion:

    1. Identify if there are current organizational goals in place to create greater inclusion.

    2. Identify what outcome(s) you hope to achieve by creating greater inclusion.

    3. Identify how you will measure progress in achieving this outcome(s).

    4. Develop accountability milestones to assess how well you're working towards these outcomes.

Greater awareness of leading with gratitude and inclusion offers a choice between action and dialogue or succumbing to how it's always been done. It takes courage and vulnerability to start the discussion and express gratitude to someone who is often overlooked for the value and contributions s/he can and does make to the team and organization.

Want to learn more?

- The Reciprocity of Gratitude
- A Culture of Gratitude - Imperative in the Post-Pandemic Era
- The Healing Benefits of Gratitude Post-Pandemic - Start Now
- Emotional Intelligence and Gratitude
- The Neuroscience of Gratitude
- Discovering the Health and Wellness Benefits of Gratitude

Contact Linda at:
lburton@drwcoaching.com or 410.707.3118

CONTRIBUTOR:
Linda Roszak Burton, ACC, BBC, BS

To learn more about Linda, click here.

SUMMER 2022
Volume 11, Number 3

Healthcare Management Alumni Association
The Wharton School
University of Pennsylvania
204 Colonial Penn Center
3641 Locust Walk
Philadelphia, PA 19104
215.898.6861 phone
215.573.2157 fax
www.whartonhealthcare.org

TAPPING THE POTENTIAL OF HEALTHCARE'S WORKFORCE CRISIS

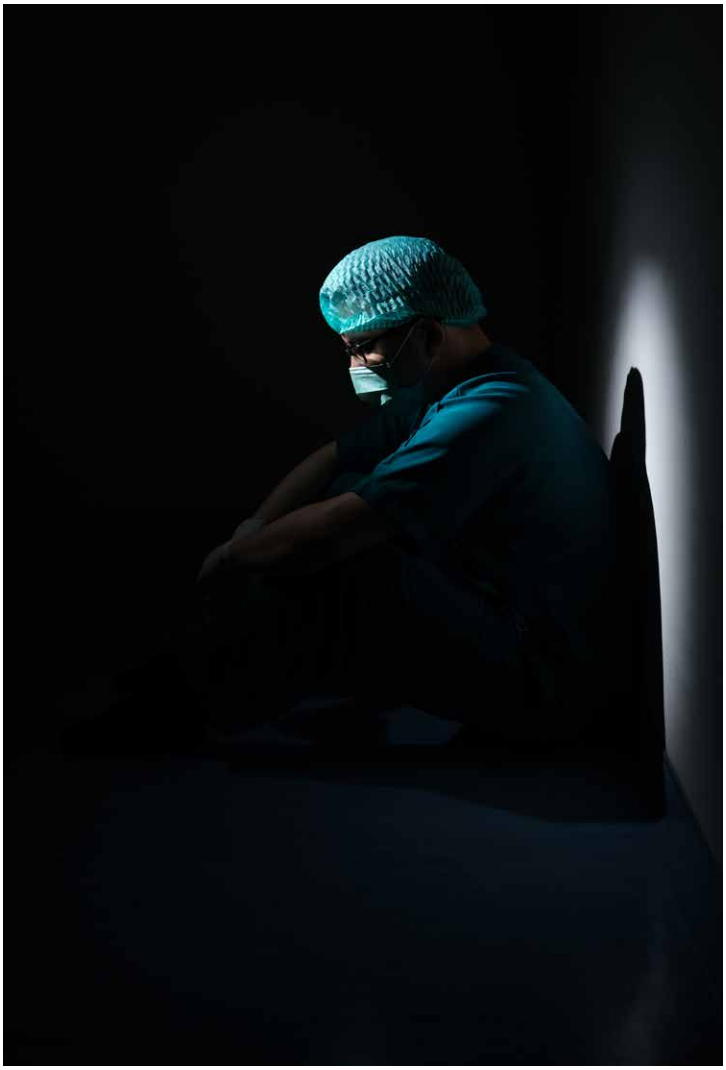


Photo by Mulyadi on Unsplash

In a previous edition of *The Wharton Healthcare Quarterly*, we proposed the workforce crisis represents an "unignorable moment" — a critical point that is public, irreversible, systemic, and challenges the identity of an organization or a field. We contended that new planning assumptions and solutions will be needed to deliver care safely and effectively.[1] For those responsible for addressing this unignorable moment, we introduced three guiding principles: (1) slowing down to speed up, (2) leveraging the power of stuck, and (3) using resistance as feedback.[1,2]

In this article, we expand on these principles to create systemic value from the fragile current state of the healthcare workforce.

SLOW DOWN TO SPEED UP

The pressure is enormous to act quickly and decisively on staffing issues in health systems, taking immediate actions which, though necessary, will not be sufficient to function in this new environment. We know that as an unignorable moment, today's workforce crisis signals deeper issues of culture and identity. These issues can be hard to uncover and make sense of, and it is valuable to fully understand the rich picture of people and systems at play. Indeed, without taking these steps, leaders can exacerbate their own challenges, and even risk the viability of their organizations.

The healthcare workforce is composed of a diverse set of groups, split by profession, region, and career stage, with different experiences of their work and different interests. At one urban academic health system, the first set of resignations involved bedside nurses and specialized technicians, with surgeons and anesthesiologists now leaving the organization. On the surface, the drivers may appear similar: an aging workforce, insufficient educational opportunities, bottlenecks with credentialing staff, and burnout and exhaustion. Going deeper, the root causes for turnover among ultrasound technicians are likely to differ in important ways from those for anesthesiologists. It is imperative to view all sources of distress and understand their implications for proposed changes. Leaders will need to shape solutions that fill immediate needs for different professional roles, while also considering the greater context — that the traditional care delivery model has been long recognized as unsustainable. To identify strategies that go beyond "fixes," leaders must slow down to identify relevant inputs that can ultimately speed up decision-making and implementation of systemic and strategic solutions.

LEVERAGE THE POWER OF STUCK

It is not uncommon for leaders — heeding critical guidance to pause and reflect on relevant data — to feel stuck in lifting key insights from analysis and defining actionable steps. Although feeling stuck is uncomfortable, and there is an urge to get unstuck as quickly as possible, we see value in this stage of processing the emotion-laden dynamics that led to this unignorable moment.

Healthcare workforce issues have been developing for years and have generated enormous potential energy. It is the challenge of healthcare leaders to harness this energy, to draw it out intentionally, and to channel it into solutions for their organization's unique needs.

Another regional health system is using the urgency of labor shortages to launch a strategic initiative to tap information from many stakeholders, recreating their organization to be the "best place to work." After experiencing the consequences of quick fixes to the compensation of respiratory therapists last year,[1] health system leaders recognized a simple solution could have unintended consequences. The lessons learned are now evidenced in the development of long-range, system-wide yet tailored improvements — which, in effect, change the way this system delivers on its mission through providing patient care.

USE RESISTANCE AS FEEDBACK

As leaders employ various solutions for addressing the workforce crisis, they will field resistance, even against strategies that benefit the stakeholder groups involved. Overlooking the factors behind these reactions can result in lost opportunities for enacting the intended change. Often, resistance signals places to listen intentionally. What leaders hear may surprise them. They may find the most important adjustments to make are low-cost and rely on information-sharing or reconfiguring recognition. For instance, provision of gift cards as a year-end reward for hard work was experienced as an empty gesture by unit staff at an independent academic medical center. They were instead eager to be thanked publicly for their contributions to lowering infections for surgery patients — for them, no gift was necessary.

As emotions come into play during conversations about new strategies, leaders should use feelings — their own feelings — as data. While complaints from overworked clinicians may not reveal the solution itself, hearing the underlying sources of resistance often leads to "aha" moments that leaders can use to shape their efforts. For instance, if those who determine employee benefits feel frustrated and discouraged from short-term failures, they may suppose others feel frustration, too. In one institution which is part of a top-tier university, leaders learned their workforce was feeling exhausted, impacting morale as a whole. Expanding the kind of choices employees had — from work-from-home flexibility to a larger menu of education benefits — alleviated some of these feelings and increased engagement.

To hear the sources of resistance effectively, leaders should reserve judgment until they can gather data to better understand the current state of the situation, even when sourcing facts at hand may take more time. The quality of the diagnosis matters to the nuance of implementing value-creating solutions.

This framework offers guidance for leaders in approaching unignorable moments — those that are public, irreversible, systemic, and challenge the identity of their organization.[1,2] To make the most out of these challenges, we advise that leaders demystify the nuances of the workforce crisis through embracing three guiding principles: (1) slow down to speed up, (2) leverage the potential of being stuck, and (3) use resistance as feedback. This in turn will help enable leaders to develop a diagnosis that allows for truly restaging care delivery at the enterprise level, generating collective impact and value by unleashing the potential of people in their organizations.

Contact Jason at: jpradarelli@cfar.com
Contact Carey at: cgallagher@cfar.com
Contact Jennifer at: jtomasik@cfar.com

For more information on this topic or related materials, contact CFAR at info@cfar.com or 215.320.3200 or visit our website at www.cfar.com.

CONTRIBUTORS:
Jason C. Pradarelli, MD, MS, Carey H. Gallagher, and Jennifer Tomasik

To learn more about Jason, Carey, and Jennifer, click here.

SUMMER 2022
Volume 11, Number 3

Healthcare Management Alumni Association
The Wharton School
University of Pennsylvania
204 Colonial Penn Center
3641 Locust Walk
Philadelphia, PA 19104
215.898.6861 phone
215.573.2157 fax
www.whartonhealthcare.org

TAPPING THE POTENTIAL OF HEALTHCARE'S WORKFORCE CRISIS

REFERENCES

1. Pradarelli JC and Gallagher CH. The Workforce Crisis Is an Unignorable Moment for Healthcare. *Wharton Healthcare Quarterly.* 2022;11(2):34-37. Accessed April 21, 2022. https://www.whartonhealthcare.org/the_workforce_crisis_is_an_unignorable_moment_for_healthcare

2. O'Connor M and Dornfeld B. *The Moment You Can't Ignore*. 1st ed. PublicAffairs; 2014.