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UNIVERSITY of PENNSYLVANIA

Health Care Management Alumni Association

THE WHARTON HEALTHCARE QUARTERLY

SPRING 2023, VOLUME 12, NUMBER 2

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EDITOR'S LETTER

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

To learn
more about Colette, click here.

2023 has already been filled with lots of change in the world of healthcare. And with the expiration of the COVID-19 Public Health Emergency in May, it's likely we're in for yet another COVID-related whirlwind.

Great news! We've got you covered with a variety of articles to keep you up-to-date and well-prepared for what the future may hold.

Congratulations to Julian Harris, MD, MBA, WG'08, Chairman and CEO of ConcertoCare, who was awarded the Alumni Achievement Award for dedicating his career to improving U.S. healthcare as a clinician and leader in the public and private sectors.

And thank you to the WHCMAA for honoring me with the Outstanding Service Award! I am in excellent company with the past awardees who came before me - Jeff Voigt, WG'85, Tom Kupp, WG'85, Bob McDonald, WG'92, and John Barkett, WG'09.

Lastly, in addition to the eBook version of *The Philosopher's Corner*, a **paperback edition is now available**. A special thanks goes to Danna Daughtry for her help in getting it formatted and loaded on Amazon!

"Step into the mindset of a diverse set of 40 healthcare leaders and Wharton alumni. Gain insight and career inspiration….from their perspectives shared with *The Wharton Healthcare Quarterly* over the last 10 years. The healthcare industry has changed dramatically, but there's a common thread in their remarkable success."

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

By the time this is published, we will be nearing graduation, class reunions, and the changing of the guard in the healthcare alumni association.

It has been such a privilege to serve this community for the past 6 years. During that time, we've experienced many changes and challenges together. I chaired our Events committee in pre-COVID times, served as Vice President during the height of the pandemic, and led the Board as President for the past two years as we've transitioned back to a more normal state.

It has been wonderful being able to speak with the students in person at pre-term and graduation and to reunite with so many alums at our conference last fall. Through it all, the Board has maintained their steadfast dedication to the program, the students, and their fellow alums. I will miss working with all of you dearly!

When I step down from the Board on June 30, I'll be leaving you in very capable hands as Katherine Clark Godiksen, WG'15 steps into the role of President.

Z. Colette Edwards, MD'85, WG'84 has been the Managing Editor of the *Wharton Healthcare Quarterly* since 2012. On top of her already impressive accomplishment of publishing four editions each year, in the last year she envisioned and pulled together an impressive array of speakers and events to commemorate the 10th anniversary of the magazine. Colette – thank you for all of the time and energy you have dedicated to the WHCMAA over the years and throughout my term.

My farewell message would not be complete without paying homage to the inimitable June Kinney. June - you mean the world to all of us, and it has been a privilege to be part of this vibrant community you have created.

This may mark the end of my official service to our HCM community, but I'm not planning to go far. I look forward to continuing to stay in touch with all of you, continuing to get to know the students each year, and continuing to be an active part of the best group of people I've ever met. Please stay in touch.

Kind regards,

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

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ALUMNI NEWS

Jill Ebstein, WG'83
In March, Jill Ebstein released her first work of fiction, *Alfred's Journey to Be Liked*, which shares the revelations of a neurodivergent 14-year-old teenage boy whose world is comprised of his mom, his favorite Soho glob cookies, a Ninja named Naruto, baseball stats, and chess. Alfred has difficulty making friends until his mom decides it's time to change things up and hires Coach.

Coach uses Alfred's passions to help guide him. Alfred's love of baseball allows Coach to apply the "5-tool-player" concept to identify personal skills that Alfred would like to develop. Over time and through exploration, Alfred slowly builds a circle of friends and emerges from being all about the data to someone who understands that "Soft squishy things matter too."

This book is the first book in a 3-part series and is available on Amazon in paperback and e-book. Jill is looking to bring this book's learnings into business and social settings to help improve communication and social awareness. What Alfred learns as a neurodivergent teen is also something that we can all benefit from learning.

Contact Jill at:
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Learn more.

Z. Colette Edwards, MD'84, WG'85
I am excited to announce that during the pandemic I (and a colleague) have been working on a book, *Navigating Your Healthcare Journey: Lessons Learned to Get the Healthcare You Need and Deserve*.

The book is available for preorder now and will officially be released on May 16.

Learn more from my conversation about the book with Ruchin Kansal, who leads the Business Leadership Center at the Buccino Leadership Institute at Seton Hall University.

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ALUMNI NEWS

Jeff Voigt, WG'85
Voigt JD, Lele M. (2022) *Lactobacillus rhamnosus* used in the perinatal period for the prevention of atopic dermatitis in infants: A systematic review and meta-analysis of randomized trials. Amer. Jrl. Clin. Derm.

Learn more.

Voigt JD, Leacche M, Copeland H, Wolfe SB, Pham SM, Shudo Y, et al. (2022) Multi-center registry using propensity score analysis to compare a novel transport/preservation system to traditional means on post-operative hospital outcomes and costs for heart transplant patients. ASAIO. 2022.

Learn more.

Contact Jeff at:
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Carolyn (Lyn) Salsgiver Kobsa, WG'93
I am looking forward to reconnecting with classmates at our upcoming 30th reunion.

Peter Kobsa (WG'93) and I still live in CT, where we have since graduation. We have two children, both grown and out of the house. Jessica (25) is applying to medical school. Alex (22) is an engineer with MIT Lincoln Labs in MA.

I am excited to share that I have started a new business venture. After a long and wonderful career in strategic planning and community health improvement for non-profit Yale New Haven Health System, I am starting up my own consulting practice to provide strategic planning and governance advising services to mission-driven non-profit organizations. My goal is to help nonprofits be successful by developing a clear vision for the future and the strategic and operational plan to make it happen. I am looking forward to this next chapter of my career. See you in May in Philly!

Contact Carolyn at:
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Benjamin Katz, WG'02, NU'02, W'02
Ben Katz co-founded Happy Head, a new leader in dermatologist-prescribed, customized hair medicine and treatments with clinically proven results. In January, Happy Head launched SuperCapsules™, infusing FDA-approved medicine, including Finasteride, Minoxidil, and vitamin D, all in a single daily capsule.

Hair loss is a very common problem, psychologically damaging, and can cause intense emotional suffering. Today, over 14,000 customers trust Happy Head's premium hair growth solutions. The company is growing double-digit and hiring in operations, analytics, and marketing roles.

Learn more.

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THIS MONTH'S PHILOSOPHER:
Ankit Mahadevia, WG'08

To learn more about Ankit, click here.

THE PHILOSOPHER'S CORNER

Ankit Mahadevia, WG'08

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

tried a lot less to over-engineer a long-term career path. The reality is that each of us know a lot less than we think about how we will grow as people, how we do our best work, and what will be the best use of our talents. Trying to predict and plan all of this takes energy and mindshare from the contributions we can make today.

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

tried so much as an introvert to fit into the extroverted personality mold that I thought was expected of me as an emerging leader. We think of extroverts when we think of leadership, and the well-meaning advice I had gotten over the years was to "get out there" and "speak up more." Once I started focusing more on authenticity and less on conforming to that norm, I began to see the results as a leader that I had been hoping for and that my constituents expected of me.

People ultimately respond to others who are what they say they are and do what they say they will do.

FAVORITE QUOTES

1. "Honesty and transparency make you vulnerable. Be honest and transparent anyway." ~ Mother Teresa
2. "Victorious warriors win first and then go to war, while defeated warriors go to war first and then seek to win." ~ Sun Tzu
3. The reason there's no modern-day Shakespeare is because he didn't have anything to do except sit in a room with a candle and think. ~ Chris Cornell

RECOMMENDED READING

1. *Antifragile: Things That Gain From Disorder (Incerto)* by Nassim Nicholas Taleb – The idea that rare but transformative events shape our world has given me a new lens into work and life.
2. *The Cure* by Geeta Anand – captures the inspiration of bringing new medicines to patients
3. *Meditations* by Marcus Aurelius – offers a frame of mind for all of the twists and turns within a growing organization
4. *Quiet* by Susan Cain - helped me understand the "why" of why introverts are who they are
5. *Quiet Leader Loud Results: How Quiet Leaders Drive Outcomes that Speak for Themselves* by Ankit Mahadevia - I hope it helps fellow introverts be effective and still be true to themselves

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AFFIDAVIT: HEALTHCARE AND THE LAW - PREPARING FOR THE END OF THE COVID-19 PUBLIC HEALTH EMERGENCY

Source: Bigstock

Regulatory flexibility during the COVID-19 pandemic is coming to a close in 2023. At the start of the pandemic, the U.S. government declared a public health emergency (PHE) that opened the door for much needed flexibility related to COVID-19 treatment and coverage, telemedicine, and liability immunity for healthcare providers. Waivers of traditional healthcare credentialing, staffing, and reporting requirements were also available. As a result of the PHE, healthcare businesses have now spent nearly three years adjusting their operations and compliance policies accordingly.

On January 30, 2023, the Biden administration announced the PHE will expire on May 11, 2023.[1] Because the PHE policies have been in place for nearly three years, healthcare market participants will undoubtedly experience a significant adjustment period that will necessarily involve reeducation of personnel to ensure compliance with applicable laws and regulations. This concern is particularly acute given the recent wave of mergers and acquisitions in the healthcare space during the pandemic.[2]

OVERVIEW OF THE PHE POLICIES

The U.S. Department of Health and Human Services (HHS) initially declared the PHE pursuant to Section 319 of the Public Health Service Act in January 2020. A PHE lasts for 90 days and must be renewed to extend beyond that timeframe. The PHE has been renewed several times, including in January 2023, but will expire on May 11, 2023, based on President Biden's January 2023 announcement.[3] In short, the PHE enabled HHS, the Centers for Disease Control and Prevention (CDC), and other agencies to access certain funding and increase staffing to respond to the COVID-19 emergency. The PHE also created waivers of certain requirements for Medicare, Medicaid, CHIP, and private insurance, and provided increased flexibility for telemedicine and other healthcare services, among other things.

CHANGES TO EXPECT WHEN THE PHE ENDS

When the PHE comes to a close, many aspects of contemporary COVID-era healthcare will change or no longer be permitted. Healthcare businesses should consider at least the following policy changes that could directly impact their operations.

Reimbursement for COVID-19 Treatments, Testing, and Vaccines. Reimbursement for COVID-19 services may be the most significant anticipated change. During the pandemic and for the duration of the PHE, millions have received free testing, treatments, and vaccines. Depending on the payer, some or all of these services may no longer remain free when the PHE ends. For instance, cost sharing requirements will apply for Medicare recipients upon the end of the PHE for at-home testing (8 per month) and certain treatments, among other things.[4] For Medicaid and CHIP enrollees, vaccines will continue as a mandatory benefit for children and adults. However, privately insured individuals could incur out-of-pocket

expenses for out-of-network COVID-19 services and vaccines.[5] These changes could be quite significant because treatment costs are expected to rise. For example, Pfizer's two-dose vaccine could rise from $30 per shot to $110-$130.[6] And the antiviral therapy, Paxlovid, of which the government purchased 20 million courses at bulk discount for $530 each, is no longer expected to be free for Americans.[7]

Telehealth. Coverage for telehealth services changed during the PHE for Medicare enrollees. For instance, under the PHE, Medicare beneficiaries could receive telehealth services regardless of patient location (e.g., services would not be limited to rural areas). PHE flexibility also permitted patients to receive telehealth services by phone rather than video. These particular policies will be extended by the Consolidated Appropriations Act through December 31, 2024, regardless of the PHE status.[8] However, also during the PHE, HHS waived certain penalties for HIPPA violations against providers providing telemedicine services, and the Drug Enforcement Administration (DEA) permitted telemedicine visits for prescription services for controlled substances without in-person evaluations during the pandemic.[9] These policies are expected to end upon conclusion of the PHE, subject to any specifications from the agencies.

Emergency Use Authorizations. During the PHE, the U.S. Food and Drug Administration (FDA) issued hundreds of emergency use authorizations (EUAs) for COVID-19 tests, treatments (antivirals and antibodies), and three vaccines. These EUAs allow the public to access such medical countermeasures before FDA approval. They also are slated to expire shortly after[10] expiration of the Section 564 emergency declarations related to EUAs. This means COVID-19 medical countermeasures still under EUAs (e.g., Paxlovid) may be unavailable for use. The FDA has currently approved the Pfizer and Moderna vaccines.[11]

Liability Immunity for Medical Countermeasures. During the pandemic, HHS announced expanded liability immunity under the Public Readiness and Emergency Preparedness (PREP) Act for licensed and certain unlicensed healthcare professionals providing or prescribing COVID-19 countermeasures, like vaccines, as well as vaccine manufacturers and distributors.[12] HHS also extended immunity to pharmacists administering vaccines in certain cases. These immunities will end on October 1, 2024, as stated in the PREP Act declaration.

Stark Law Waivers. The Stark Law "prohibits physicians from referring patients to receive 'designated health services' payable by Medicare or Medicaid from entities with which the physician or an immediate family member has a financial relationship, unless an exception applies."[13] CMS issued a blanket Stark Law waiver for certain financial arrangements that might not otherwise be allowed, provided the arrangement was necessary for COVID-19 purposes.[14] That waiver ends upon expiration of the PHE.

During the PHE, private group health plans subject to ERISA were instructed to disregard the "Outbreak Period" (beginning March 1, 2020, and ending 60 days after the PHE ends) in determining the date for paying COBRA premiums, timeframes for filing claims under the plan's processing procedures, deadlines for requesting appeals for denials, and other areas.[15] The statutory timeframes are expected to resume 60 days after the national emergency declaration expires.

Medicare Reimbursement Flexibility. During the PHE, hospitals received a 20% increase in Medicare payment rates for the treatment of patients diagnosed with COVID-19 through the in-patient prospective payment system.[16] Section 1135 waivers were also implemented to increase access to care. For Medicare beneficiaries, HHS also waived its 3-day prior hospitalization requirement for skilled nursing facility (SNF) stays and provided extra coverage for beneficiaries who exhausted their SNF benefits.[17] These waivers and increased payment will likely end upon expiration of the PHE.

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KEY TAKEAWAYS FOR HEALTHCARE BUSINESSES

- **Anticipate and plan.** Healthcare providers and businesses should assess which waivers they currently operate under and establish a plan for compliance once those waivers expire. Physician agreements entered during the pandemic should be assessed for Stark Law compliance post-PHE.

- **Be aware of both federal *and* state policy changes.** Even after the end of the PHE, states can decide to offer and continue flexibility around telehealth and other COVID-19-era policy changes. Providers and administrators should keep apprised of additional protections offered in their respective states.

- **Anticipate communication challenges to patients, staff, and/or members.** Many participants in healthcare markets, including patients, may not be aware of impending changes to treatment, insurance, and healthcare policies. Advance communication on possible future changes and what to expect will assist in the transition process.

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

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2. *See* Dave Muoio, *Hospital and health system transactions remain infrequent but hefty in Q3 2022: report*, Fiercehealthcare.com (Oct. 12, 2022), available at https://www.fiercehealthcare.com/providers/hospital-and-health-system-transactions-remain-infrequent-hefty-q3-2022-report.

3. In addition to the PHE, the former administration issued a national emergency declaration under Section 201 of the National Emergencies Act, and HHS issued an emergency declaration for emergency use authorizations (EUA) of medical countermeasures for COVID-19 under Section 564 of the Federal Food, Drug, and Cosmetic Act. HHS also issued a declaration under the Public Readiness and Emergency Preparedness (PREP) Act and provided civil immunity to providers for certain COVID-19 services and treatments. Congress also enacted recent legislation providing regulatory flexibility that is tied to the emergency declarations, including, among other things, the Families First Coronavirus Response Act (FFCRA), the American Rescue Plan Act (ARPA), the Coronavirus Aid, Relief, and Economic Security (CARES) Act, the Inflation Reduction Act (IRA), and the Consolidated Appropriations Act (CAA).

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11. *See* FDA.gov, *Coronavirus (COVID-19) Update: FDA Authorizes Updated (Bivalent) COVID-19 Vaccines for Children Down to 6 Months of Age* (Dec. 8, 2022), available at https://www.fda.gov/news-events/press-announcements/coronavirus-covid-19-update-fda-authorizes-updated-bivalent-covid-19-vaccines-children-down-6-months.

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TO YOUR HEALTH: DIVISIVE DIETARY ADVICE - PLEASE STOP!

Flash Survey: Choose 1 of the 2…QUICKLY!!!

- Democrat/Republican
- Cardio/Weights
- Martina/Chrissy
- Carbs/Fat
- Beer/Wine

Choosing only one answer is a bit absolute. Very few of us are absolute. You will find that those in power who are willing to be absolute and 'die on this hill' are easy to spot but not very helpful. That brings me to nutrition scientists.

Source: Bigstock

"Strong emotions make us stupid."
~ Richard Shepherdson (greenworld.org.uk, 2022)

CANDIDATE FATIGUE AND DIETARY INDIFFERENCE

David Ludwig (39.9k followers) and Kevin Hall (26.2 k followers) have significantly contributed to my indifference. I am not going to reference their credentials out of protest, as their back and forth in the obesity debate reminds me of brothers in the back seat of the car, minus all the statistics. Yes, one of them sticks out their tongue on Twitter.

David Ludwig proceeds in his dogged pursuit to convince the world that the *carbohydrate = insulin = obesity model* has infected the globe like COVID-19 (I'm not apologizing for the over-simplification), while Kevin Hall pushes back with '*It is not carbohydrates but ultra-processed foods that are the driver of obesity. But as we learned in London, no one really knows*.'

Then "60 Minutes" invited Dr. Fatima Cody Stanford (9k followers) to their episode on obesity, and she stated, "It is a brain disease. There is a 50-85% likelihood someone inherits the disease of obesity from their parents."

Meanwhile, on March 4th, World Obesity Day, the World Health Organization (WHO) added "Let's Talk About Obesity" to the message. Who exactly is the keynote and what possible message could they give with any sense of hope?

WE NEED A 3RD PARTY CANDIDATE.

In 1992, an Independent candidate, Ross Perot (0 followers), won over 19,000,000 votes in the presidential election. That was unprecedented. If this were an election, *neither* David Ludwig nor Kevin Hall would get my vote.

Who would be the Ross Perot of the diet wars?

Herman Pontzer (10k followers). He is an evolutionary anthropologist who has studied a group of people, the Hadza, who live in Tanzania in a hunter-gatherer civilization. Herman is very careful not to identify with a particular 'party' in the world of nutrition, "There's no singular, natural human diet." (Smith, 2021) Herman's research, which was contrary to popular

opinion, has confirmed that our metabolic system is preprogrammed to stay in a relatively narrow range, *regardless* of the amount of exercise, movement, or chores we participate in. Therefore, coming up with a dietary system where we eat less but maintain a sense of fullness is the key to anyone attempting to fight off obesity.

Dr. Pontzer's observations are impartial. His public health message is to improve awareness around overeating, as he believes the westernized approach to eating leads us to overconsume calories. And, as he very bluntly states regarding our diets, "It is about the calories!"

Pontzer doesn't talk protein power, hypoglycemia, or paleo. He may or may not care whether you eat organic strawberries. He jokes about watching a Hadza boy happily walking through camp chewing on an animal's skull, a gift from a parent. He is, as most observational scientists are, a pragmatist. He does understand that if we are to make changes in our body weight, we better find the system that we can work with and continue. He is quick to point out the snake oil salesperson who says, 'I know the way!' has led many people astray. Dr. Pontzer doesn't claim to have the answer to obesity but does provide great insight in his highly engaging book Burn.

Enough with polarizing rhetoric around diets. Vote for Pontzer in November! Plant Chompers' Chris MacAskill (32k subscribers) would make a great VP.

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NOT A FREUDIAN SLIP - THE IMPACT OF MENTAL HEALTH TRAUMA ON HEALTHCARE OUTCOMES

Mental health trauma can have far-reaching consequences for individuals and the entire healthcare system. Understanding how mental health trauma can impact healthcare outcomes is important to improving the clinical treatment approach. This article will discuss five key points on how mental health trauma affects healthcare outcomes:

1. INCREASED RISK OF MEDICAL DISORDERS

Mental health trauma can leave an individual more susceptible to physical illnesses, chronic health conditions, and permanent disability. Especially during persistent traumatic events (such as neglect, abuse, and abandonment) or in living with post-traumatic stress disorder (PTSD), stress hormones can become chronically released. In turn, this can heighten the risk for developing a wide variety of potentially preventable chronic disorders (e.g., heart disease, digestive problems, Type 2 diabetes, and even cancer). Furthermore, individuals experiencing mental health issues such as PTSD have been found to have a higher likelihood of delaying needed medical care (also due to a lack of healthcare access and/or affordability). Then, a consequence of this delayed (or neglected) medical care can worsen overall health status.

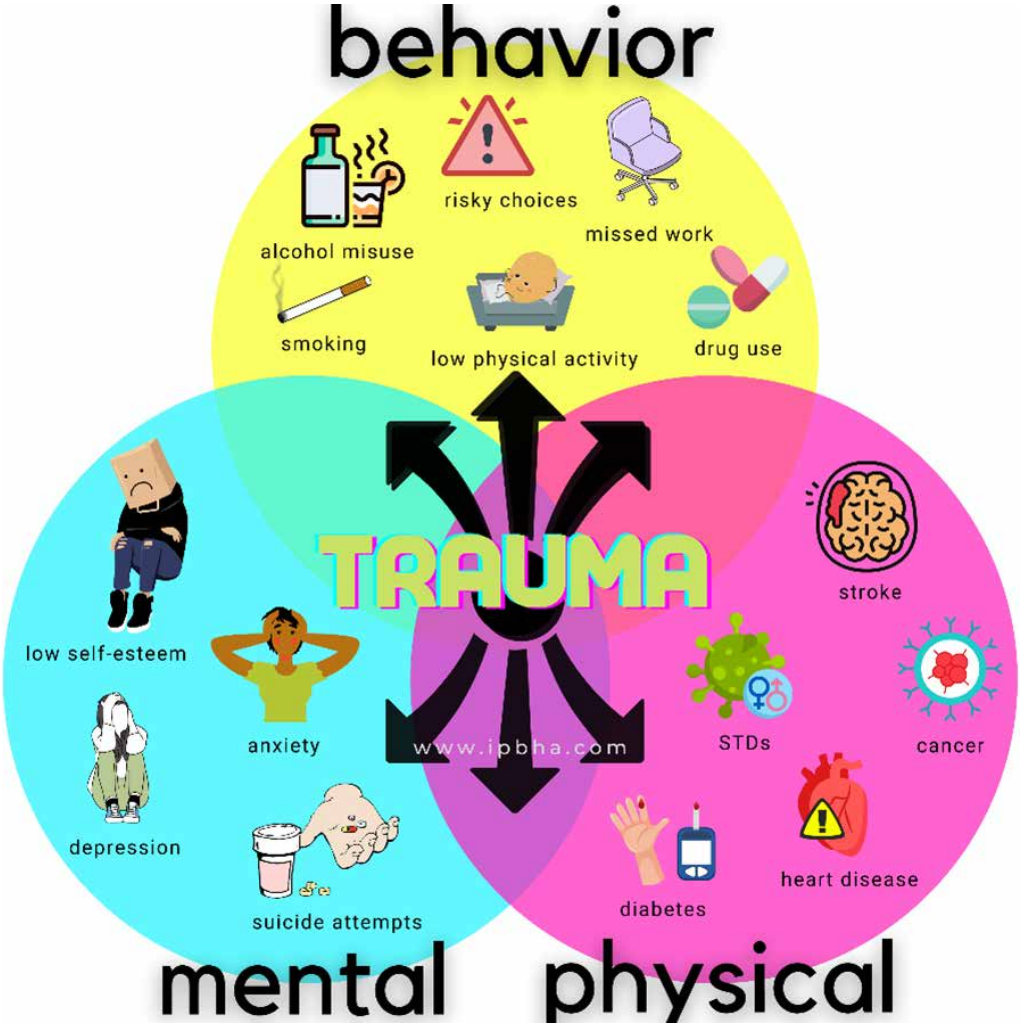
2. INCREASED HOSPITALIZATIONS

Studies have shown that those suffering from mental illness are more likely to be repeatedly hospitalized than those without mental illness (and often due to health complications resulting from a preventable chronic disorder).[1] Indeed, patients afflicted with mental health disorders have the highest readmission rates of all hospitalized patients.[2] Not only does this increase the burden on hospitals and other healthcare facilities, it also puts added strain on both healthcare provider resources and clinical staff across the healthcare system.

Through delaying treatment of the mental health disorder and/or co-occurring chronic health disorder, the adverse health outcome can be the need for inpatient care and/or far more intensive treatment than would otherwise be necessary. Some early-stage cancers are highly treatable, but – if caught at a later stage – require ongoing treatment over the lifespan, increase the risk of multiple hospitalizations, and result in increased financial and emotional strain experienced by the affected individual.

3. HIGHER RATES OF SUBSTANCE ABUSE

Experiencing mental health trauma often results in anxiety and/or depression,[3] and – in an effort to relieve their distress – the affected individuals may self-medicate with alcohol and/or drugs. This can lead to *dependence* on the substance for relief of the distressing symptoms. The unfortunate consequence can be prolonged self-medication with alcohol and/or drugs, leading to biochemical changes in the brain that make it harder to control symptoms of anxiety and/or depression, and result in psychological and physical *addiction* to the substance. Meanwhile, substance abuse has been linked to a higher likelihood of developing chronic health conditions. Depending upon the substance(s) abused by the individual, these can include liver cirrhosis, hepatitis C, kidney disease, various cancers, HIV/AIDS, and many others. Besides adversely affecting the overall health of the individual, the consequence is an increased financial strain on the healthcare system related to providing needed medical interventions for these co-disordered individuals now afflicted with both a mental health condition and substance abuse.



4. IMPACT ON ACTIVITIES OF DAILY LIVING

Mental health trauma can significantly interfere with an individual's ability to perform normal activities of daily living (ADLs) at home or in the workplace. In the work realm, this can result in poorer performance and decreased productivity levels, which in turn can lead to an increased risk for unemployment. Consequently, people living with mental health trauma can experience an increased financial burden resulting from lost wages or the need to rely solely on disability payments for economic survival.

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NOT A FREUDIAN SLIP - THE IMPACT OF MENTAL HEALTH TRAUMA ON HEALTHCARE OUTCOMES

There is also a negative impact on the national economy when individuals with mental health disorders (such as PTSD) and chronic health disorders are unable to contribute to the workforce due to their disability and are therefore reliant on federal Social Security Disability (SSD) benefits. One major national consequence is fewer federal monies for allotment to states to aid in covering their public health-related and healthcare system-related costs. In turn, this economic strain has resulted in not enough public health and social support programs to help vulnerable populations nationwide who are in desperate need of these necessary support services.

The current dysfunction in the U.S. healthcare system as a whole creates the following vicious cycle: people with mental health disorders and substance abuse often do not receive care in a timely manner to prevent chronic disorders, which further economically burdens the U.S. healthcare system. If appropriate care were easily available to people living with PTSD as a result of experiencing trauma, the higher level of chronic disease and disability in this population might be prevented. Thus, increased federal funds allotted to preventive care for this population might lessen the overall financial impact on the entire system.

5. IMPACT ON HEALTH INSURANCE PREMIUMS

The costs associated with treating any type of mental health disorder are significant and contribute to the calculation of health insurance premiums.

Healthcare costs have increased significantly over the past five decades. In constant 2021 dollars, the per person cost has increased from $1,951 in 1970 to $12,914 in 2021.[4] In turn, monthly premiums (and/or required co-pays and/or deductibles) typically increase every year. This situation has made purchasing high-quality health insurance unaffordable for many people. Since some individuals with mental health disorders and disabling conditions may have incomes too high to qualify for Medicaid, they can often find themselves underinsured or uninsured altogether. Additionally, 49% of the U.S. population has insurance coverage through their employer. For those whose employment status is tenuous, there is one more obstacle to access to insurance coverage. In turn, this combination of factors leads to delayed care or no treatment at all.

Consequently, people co-disordered with a mental health/substance use disorder are far more likely to need (and seek) emergency medical interventions in the emergency rooms (ERs) of hospitals. Given this situation, hospitals that primarily serve the poor and/or uninsured are being forced into crisis mode and sometimes closing altogether, especially in states that did not expand Medicaid. The overcrowding of ERs is endangering the lives of patients, placing tremendous stress on ER physicians/nurses, and draining hospitals' financial resources. Furthermore – as hospitals' financial resources are drained – more of them are simply closing their ERs (and other services lines) to save money. And that impact can be felt by other hospitals in the area.

CONCLUSION

It is incumbent upon healthcare advocates and policymakers to focus more attention and financial resources on mental health trauma and PTSD to decrease the cost burden linked to potentially preventable (and manageable) chronic disorders – including mental health disorders resulting from experiencing trauma.

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DOWNLOADING SUCCESS: THE PERPLEXITY OF FOUNDERS

You may have heard the term "Founder's Syndrome" to define what happens when an organization outgrows a long-tenured leader. Yet on the other side, what happens when that legacy leader continues to lead the organization so successfully that it seems nearly impossible to imagine continuing without them? This phenomenon is just as common as the latter.

Founders are defined in their truest sense as someone who founded a company, but also as a leader whose personality and leadership have so deeply imprinted on the culture that they deeply reflect the culture. Typically, founders have led the company for a longer term, 10-20 years. However, in cases where radical transformation took place during the leader's tenure, it can be as little as five to eight years.

As the terms above suggest, this embodiment of the organizational culture can often work to a leader's detriment, yet it can also lead to outstanding success.

FOUNDER-LED APPROACH

Many founders innately believe processes and systems may dampen the creativity, urgency, and agility of the organization. This perspective translates into a culture where loyalty reigns supreme and reluctance to establish and define procedures and systems permeates, often affecting investment in developing talent.

Most of all, decision-making processes are often ambiguous. The collective belief is that success hinges on the ability to be agile and flexible — a system that relies heavily on the persona, values, and expectations of the founder.

In their book, *Founder's Mentality*, authors Chris Zook and James Allen explore how leading like a founder helps overcome the challenges of growth by utilizing founder-like behaviors to restore speed, focus, and connection. Founders are often visionary, mission-driven leaders with a hyper-focus on delivering results.

Yet, when the organizational culture and success become so entrenched in a specific leader or their influential personality, it can be extremely difficult to see a future without them.

SUCCEEDING THE FOUNDER

Much like a scene ripped from HBO's *Succession* or movie classic, *The Godfather*, the clandestine discussions of the inevitable retirement or transition of a founder rarely reach a healthy level of transparency and may only serve to create an internal power struggle to the further detriment of the company they built with their blood, sweat, and tears. Continuing the momentum of a successful founder-led organization relies on the intentionality of the transition. Choosing a CEO is the most important decision the Board will ever make on their watch. That importance and level of challenge grow exponentially when a founder is the incumbent.

Bringing the discussion out into the open and agreeing on the rules of engagement are critical first steps toward moving forward. Ideally, the structure of discussions should include these five steps:

1. Practice candor and courage.
2. Commit to rigorous discourse of key decisions.
3. Establish clear boundaries.
4. Define decision rights and how decisions will be made.
5. Solicit and deliver feedback.

By defining this framework for communication around the transition, the Board can begin to tackle fundamental questions:

- What are the criteria for success in the next leader?
- What does the culture need?
- What do we want to preserve and change from the previous founder?

HONORING A LEGACY

When a founder is such an integral part of the culture, there is a deep and often unspoken desire to preserve the leader's legacy as they transition. The Board and executive leaders must ask themselves:

- What does it mean to show we respect them?
- What is the honor of a legacy we create?
- What does that look like (e.g., naming a wing of the hospital in their honor)

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Then, there's the challenge of the transition period and the future role of the founder:

- How long does the founder stay around?
- What is their role in the transition?
- Do they serve on the board?
- Should they maintain an office on-site?
- Are they on the speed dial of the new CEO, or do they move on and completely disconnect from the organization — whose decision is this?

COURAGE IS KINDNESS

No two CEO transitions look the same, especially when a founder is involved. Having the courage to bring the discussion into the open is the kindest thing you can do for everyone involved. Letting it fester underneath the organization's surface only leads to misunderstandings and irreparable damage to the leader's legacy and the organization's future success.

Using the five-step framework above, you can create clarity and begin to identify key components of the transition and define the roles of the Board and executive leadership team. It may seem simple on its surface, but there are so many

nuances to consider regarding the far-reaching impact of not only the final decision but the process that was used to make the decision.

A PERPLEXING FEAT

Imagine for a moment that someone comes to you and asks you to replace the frame inside your hospital or headquarters, but there is one catch — everyone must remain in the building safe and sound. This task will be difficult because it is hard to change the structure without destroying the building's integrity. The frame is where all existing pieces connect to maintain shape and keep the building safe and stable.

The challenge is the same when it comes to replacing a founder whose inevitable departure creates a massive gap that is difficult to fill. It is up to the Board, the new CEO, and the executive leadership team to develop a solid plan that maintains the integrity of the organization and honors the founder's legacy, which has masterfully shaped the current culture, all while executing plans for an effective transition and success of the new CEO and their team.

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CYBERVITALS: MEDICAL DEVICE SECURITY UNDERGOES A BIG CHANGE

The first quarter included a huge cybersecurity win with the Federal Bureau of Investigation shutting down the Hive ransomware group, which had targeted more than 1500 entities, including hospitals, school districts, and financial firms. And yet, cyberattacks on healthcare organizations consistently got worse in 2022. Are significant security incidents in healthcare becoming an accepted new normal?

On December 29, 2022 President Biden signed into law the 'Consolidated Appropriations Act, 2023' (H.R.2617) that had widespread cybersecurity impact, but also resulted in particular funding/initiatives for medical device cybersecurity. The constant attacks in healthcare have not gone unnoticed, and this bill solidifies the urgency of changing the status quo.

Under the Act, both the Cybersecurity and Infrastructure Security Agency (CISA) and the Food and Drug Administration (FDA) were granted additional authorities and funding to regulate pre- and post-market cybersecurity risks of legacy and new medical devices. In particular, this means devices historically approved/cleared, can be reviewed for cybersecurity under this law.

The act goes into effect in March 2023 and may very well change the trajectory of healthcare cybersecurity. Between additional mandates for increased frequency of guidance from the FDA, there is explicit mention of patch, secure product development and software bill of material management. This complements the Biden administration's existing cybersecurity initiatives, which highlight healthcare as a critical area of focus.

The burden of cybersecurity risk management at a hospital raises the critical question: should a hospital's second core competency be cybersecurity? Or does the requirement placed on hospitals result in a misalignment of incentives - where healthcare is not allowed to optimize for delivering care?

Whenever a headline would arise related to healthcare cybersecurity, it usually decried the loss of personal health information as a result of an employee issue. This is because hospitals, and fines enforced by the Office of Civil Rights, have historically prioritized data privacy (think HIPAA), and, for many, that was the "bar" of security practices to implement.

As confirmed by a survey from the American Hospital Association, cybersecurity requirements have long exceeded the legal mandate faced by health systems. This is further exacerbated by a rapidly evolving threat landscape - including applying ChatGPT to develop new malware.

The reality, however, is connectivity evolved in healthcare without sufficient guard rails for managing the proliferation of new attack vectors. How can a single hospital information technology (IT) group practically manage the operation of upwards of 100,000s of connected devices, in addition to maintaining security measures without disrupting the delivery of critical patient care?

As Dr. Suzanne Schwartz, Director of the Office of Strategic Partnerships and Technology Innovation at the FDA's Center for Devices and Radiological Health has said repeatedly, cybersecurity is patient safety. Claims of the first death due to hospital ransomware attack bring into acute focus why healthcare is novel in its struggle and different from other industries.

The act requires shifting up the supply chain, so devices are secure by design, and thus present a more manageable burden for consumers of devices. Consumers in this case span traditional health systems, as well as patients directly. The COVID-19 pandemic accelerated the dissemination of care delivery outside the four walls of a hospital, which often included delivering connected devices directly to patients at home.

In all fairness, healthcare spending on cybersecurity has historically been the highest across multiple industries. But even with the spend, the results have been underwhelming - so it is unsurprising it took a new law being created in an attempt to change this trend.

It may sound hyperbolic, but the potential for shifting the trajectory of healthcare cybersecurity under this law is unprecedented. The implementation and enforcement certainly won't be overnight, but we are living through a historical inflection point as an industry.

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Source: Bigstock

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MIND THE GAP: LISTENING TO THE COMMUNITY IS AN UNDERAPPRECIATED STRATEGY TO IMPROVE HEALTH OUTCOMES

In 2018, while serving as the chief medical officer for Washington, D.C. Medicaid, I was sitting at my desk poring over data in a consultant's report. The health department had contracted with a public health firm to assess primary care access gaps in the District. I had been living and working across the D.C. health sector in policy, research, community engagement, and medicine at safety net hospitals for ten years. I knew these primary care access gaps well. Except for after hours — nights and weekends — Washington, D.C. did not have a shortage of primary care. The report concluded the same and instead highlighted a different problem: engagement.

Medicaid beneficiaries often preferred emergency care or no care over building a steady relationship with a primary care provider. I knew this from listening. Listening to my patients, to community members, to Medicaid beneficiaries. I decided to listen a bit more and interviewed a few people with recent visits to the emergency department. From these conversations, a few patterns emerged that highlight why, despite billions invested in healthcare innovation, we have yet to narrow health disparities gaps and sustainably improve health outcomes in Medicaid populations.

First, we have not embraced and solved for trust as a primary driver of healthcare decisions. Many beneficiaries perceived their healthcare encounters as condescending and disrespectful and believed these attitudes were due to their Medicaid coverage. A woman told me, "Well you know if you have Medicaid, they won't give you the best treatment or the best doctors." Furthermore, many people have shared their belief that doctors overprescribe medication and have a profit motive for doing so. Whether true or not, these perceptions about care drive behavior, and they should not be dismissed.

Second, distrust is potentiated by low health literacy. Unanimously, people felt healthcare language was too complex and poorly understood, causing them to turn to online searches, friends, and family members to obtain information. A Medicaid beneficiary told me, "If I don't understand you, I don't trust you." Also, health literacy has been spoken about as a patient deficit rather than a provider and healthcare system responsibility. Failure to communicate and explain health information in tailored, plain language further erodes trust, exacerbates fear of the healthcare system, and discourages engagement in care.

Third, the healthcare system and providers are often perceived as paternalistic. A beneficiary said his preference for the ER over a primary care doctor was because visits to a doctor made him feel ashamed. He described feeling berated by his doctor for not following instructions, and this was less likely to happen in the ER. He said, "The ER is all about the business. They don't have time for that."

Finally, the healthcare system is missing opportunities to improve digital engagement. Nearly every person I interviewed spoke to me using a mobile phone. However, health tech innovations built for Medicaid populations have been sluggish due to a belief the innovation will magically trickle down and blanket all populations. Furthermore, the

narratives about the digital divide should be adjusted to reflect the reality of tech access among Medicaid beneficiaries, both in cities as well as rural areas. There is a perception that underserved communities are less tech savvy and often unable to engage in digital health solutions. But they are considerably engaged with smartphones - which are also computers - only not for health. The pandemic highlighted the ability to improve digital health access, and it is imperative this momentum continues in order to implement strategies to sustain and expand these gains.

Ultimately, these conversations and hundreds like them in the community compelled me to launch Grapevine Health. Grapevine Health is a social impact, for-profit, patient engagement company that leverages listening and trusted messengers to deliver tailored, culturally-appropriate, digital content to help people navigate their health. And it is working.

The pandemic afforded our company an opportunity to demonstrate the impact of the delivery of tailored, culturally-appropriate health information. We spoke to people who had previously refused the COVID-19 vaccine and were able to achieve vaccine acceptance rates of 30-70% among those engaging with a Grapevine Health expert.

Now we have shifted our attention to chronic health conditions like diabetes, a preventable condition that accrues over $300 billion annually in healthcare costs.

It is early, but we are seeing similarly positive signals, with a 150% increase in engagement from baseline.

The path we are on is somewhat non-traditional for a healthcare business, but we will continue listening and be guided by beneficiaries and the community. We need their voices and insight to tailor our solutions. We need to listen because, after all, they know far better than we do what it takes to improve their health outcomes.

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BEHAVIORAL ECONOMICS IN CONSUMER PURCHASES OF HEALTH INSURANCE - PART 2

In Part 1 of this series, I posited that most individuals do not make rational economic decisions due to cultural, societal, psychological, and emotional reasons. As a result, people tend to choose financially inefficient or suboptimal products when it comes to selecting services and products related to their health and well-being. The examples I provided described scenarios in which some people made decisions that were not in their best interest, while in others the failure of plan administrators (and actuaries) to take human behavior into account resulted in a negative impact on the bottom line.

In Part 2, we'll explore additional situations, as well as identify actions that can be taken to optimize health and well-being as well as the finances of the patient and the health plan.

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PRODUCT SELECTION IN EMPLOYER GROUP PLAN

In 2008, I was the CFO and chief actuary of the Geisinger Health Plan, which was owned by the Geisinger Health System that includes hospitals, outpatient centers, physicians, and nursing homes. The System hired the Plan to administer its group medical benefits. Historically, employees were offered a choice between a high and low option plan. The benefit differences were substantial, and employees choosing the high option paid more for their benefits, but they paid less than the actuarial difference in costs between the two plans. I didn't think that was fair. How to fix the problem; that is, how to reduce the subsidy to those choosing the high option? Actually, we proved that you can't!

My actuarial team built a model to show what is likely to happen as one increases the cost of the high option. We can consider the employees' health on a scale of 1-10, with 1 being the healthiest, and 10 being the least healthy. Assume the low option plan currently has mostly employees ranked 1-5, and the high option has mostly those ranked 6-10. As the high option premium rises, some 6's and 7's decide they don't need the high option at that price and move to the low option. Now the high option plan is left with 8-10's, and, as a result the expected costs per insured are much greater, and the premium needs to increase further. Due to the 6's and 7's joining the low option plan, its premium needs to rise as well, but not as much as the high option. But now some 8's decide the premium differential is too great, and elect the low option plan; thus raising the expected costs per person of **both** plans with the high option plan increasing more than the low option. My human resource friends at the System came to the (correct) conclusion that the fairest actuarial solution is to have one insurance pool with one plan and one employee contribution rate for everyone.

NON-COST-RELATED PRODUCT SELECTION

Can information help consumers make smarter choices? I want to say the answer is "yes," but that depends on the choices and an understanding of what consumers want. In an article published circa 2007, a large employer reported on its efforts to help employees choose smartly among three different choices: an HMO and two PPO products. Employees were

given statistical comparisons among the carriers that reflected what health experts consider important quality measurements; for example:

- Hospital days per 1000 members per year
- Average number of specialty referrals per member
- Average number of radiological procedures per member

After the open enrollment period, the employer was surprised that the majority of the employees did not choose the carrier that clearly had the best quality scores. When surveying the employees they discovered that employees were fearful of choosing the plan with the fewest number of hospital days or fewest specialty referrals, as this implied to them that these carriers might be rationing care, and they may not get the operation or test they might need. The employer also learned that young families made their choice on a different basis: namely, which carrier's network had hospitals with the nicest maternity wings! Who's to say that's not an important criterion? So much for HEDIS.[1]

PRODUCT SELECTION IN MEDICARE PRESCRIPTION DRUG PLANS

Since Original Medicare does not cover retail prescription drugs, members without coverage through an employer or through a Medicare Advantage plan, can purchase a prescription drug plan [PDP] from a private insurer under Part D of Medicare. This program began in 2006, and from the very beginning, product selection has confounded the experts, so much so that it was a topic of the Medicare Patient Advisory Committee [MedPAC] as recently as April 7, 2022.

The simple truth is that members having the fewest known prescriptions choose the lowest priced plans, while members with many prescriptions choose higher cost plans even though they could receive similar benefits in cheaper plans. Members may change plans annually, and they can go online at Medicare.gov, input their prescriptions, and receive a listing of plans available in their zip code in descending order of total out-of-pocket costs (i.e., premium plus copayments). But, as I discussed in Part 1, insureds are reluctant to switch carriers when they've received good claim service from their current carrier. Also, the lowest priced plans have preferred pharmacy networks that may not be convenient to all members. Still, it would make an excellent research paper to learn why so many insureds are not purchasing the most economically prudent plan.

Humana first showed this truth to the market in 2006, the first year of the program. They offered the lowest priced plan, garnered a huge market share, and had a favorable medical loss ratio. When I joined Humana in 2010, they no longer had the lowest priced plan, but one was introduced soon after using Walmart as the preferred network. Humana again experienced a significant growth in market share with favorable claim experience. Indeed, our modeling showed that the lower the price, the more favorable the expected experience,[2] although with some sacrifice of market share, as we anticipated that some buyers would be fearful of buying a plan priced so much below the rest of the market. Humana's experience has been copied by other carriers, so that now every year there is a different carrier with the lowest priced plan (about $8 - 11 a month) in a given market. Healthy, market-wise insureds change plans often. MedPAC is searching for a way to modify Part D so members are not paying $20-$40 a month more than they need to.

Humana doesn't always get it right. In 2008 Humana suffered a significant earnings miss due to not anticipating that members with a high number of prescriptions would change their behavior and switch to drugs that cost them less. Humana had lowered copayments on tier 1 and tier 2 drugs but priced the plans assuming members would continue with tier 3 drugs. As a result, they overestimated the share of costs that members would pay.[3]

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BEHAVIORAL ECONOMICS IN CONSUMER PURCHASES OF HEALTH INSURANCE - PART 2

INCENTIVES THAT *CAN* CHANGE BEHAVIOR

Given these examples of economic behavior on the part of insureds, what can health plans do to encourage members to not only choose wisely, but also use the plan's benefits to remain as healthy as possible given whatever medical conditions they might have? All four health carriers with which I've been associated adopted the following point of view: if we can prevent health conditions from deteriorating, members will be healthier, medical trend will be lower, and future premiums can be more competitive. Other health plans have as well.[4] The answer is finding the right ***nudge***. Here are two examples of nudges that worked, and one that doesn't without some important tweaks.

1. **Enticing healthy behavior.** At Mercy Health Plans, we offered the following plan to select employers. Employees were given one health plan but two choices of employee contributions. To obtain the lower contribution amount and lower copayments, employees had to agree to: complete a health risk assessment; obtain all their age/sex appropriate annual testing; if a smoker, attend a smoking cessation course; if severely overweight, attend a Weight Watchers program; and if diabetic, have eye, feet, and hemoglobin levels checked regularly. To receive lower coinsurance on elective surgery, an employee might be required to view a video describing the procedure and explaining the risks involved along with the typical post-surgery recovery. Employer involvement and support was critical.[5] Employees were given time off for these programs and access to a computer at work to record their participation. These plans had lower trend (even negative trend) than the rest of the book of business.

2. **Encouraging Rx use for chronic disease.** It is a sad truth that many prescriptions are not filled, or, if filled, are not taken as prescribed. Beginning in 2007, Geisinger Health System implemented two programs for its 16,000 employees. One was a copayment waiver for filling prescriptions for hypertension, high cholesterol, and diabetes. A second program encouraged employees with one of six chronic diseases to participate in an evidence-based disease management program in coordination with nurses employed by the System's health plan. The carrot was a $200 bonus for enrolling, and two additional $200 bonuses for active participation at six and twelve months. A five-year study confirmed lower incidences of stroke and myocardial infarction as well as lower overall cost of care.[6]

3. **Encourage smart shopping for services**. Circa 2002, Humana was one of the first large employers to provide only a high-deductible plan to its employees on the theory that employees would do comparison shopping for medical services. George W. Bush's administration pushed this idea. In the ensuing years, almost all large employers include a high-deductible plan as an option for employees with a commensurate reduction in employee contributions.

   From an employee perspective, there are three problems with this approach. First, comparison shopping is extremely difficult. One doesn't even know all the procedures that might be involved, much less know what one's insurer will pay, or how much will be left for the insured to pay under one's plan. Indeed, in 2023 legislation is first being implemented to shed light on what carriers will pay.

   Second, while healthy employees who rarely need medical services can benefit from the lower contributions, employees with chronic conditions are poorly served, as they know they'll be paying the deductible every year in addition to their contributions. In effect, the costs the employer saves from having a higher deductible is paid by the employees who need the benefits the most.

   Third, historically, there was a disincentive for employees and their family members to seek preventive care, which as pointed out above, is essential for keeping members as healthy as possible.

A high deductible plan **can** work if:

- The deductible does not apply to annual preventive care or services for specific chronic diseases.[7]
- There is sufficient and easily accessible information for employees to determine their out-of-pocket responsibility.

I trust that these examples give the reader some insight into consumer behavior that makes the design and pricing of medical and prescription drug products in a competitive environment a dynamic process that involves more than simply projecting medical trend from one year to the next.

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1. HEDIS stands for Healthcare Effectiveness Data Information Set (originally Health plan Employer Data Information Set). It is a standard set of measurements of performance, quality, and member satisfaction first developed by the National Committee for Quality Assurance (NCQA) in the late 1990's.

2. Due to the Risk Corridor program, insurers do not retain all the earnings when the medical loss ratio [MLR] is much lower than expected. Nor do they suffer extraordinary losses if the MLR is unfavorable, as the federal government shares in the gains and losses.

3. *Wall Street Journal*, p A14, March 13, 2008.

4. In 2021 the Society of Actuaries published six case histories of health plans' efforts to reduce medical trend while improving quality. See https://theactuarymagazine.org/managed-care-3-0-case-studies/.

5. Employers' concern about their employees' health and welfare plans has long been a distinguishing feature of those group plans with stable, predictable costs, and those that have frequent carrier changes due to experience being worse than expected. I recall reading a study done at The Prudential on its group clients in the late sixties and early seventies from which the actuaries determined that those employers who provided the most complete set of health and welfare plans, along with generous employer contributions, were the ones who had the most stable costs.

6. Maeng, Pitcavage, Tomcavage, and Steinhubl, "Can Health Insurance Improve Employee Health Outcomes and Reduce Cost?," *JOEM*, Vol. 55, No. 11, Nov. 2013 https://www.jstor.org/stable/48500553

7. The Affordable Care Act (ACA) substantially increased access to care and coverage of preventive services without cost-sharing for millions of Americans whether or not one has a high-deductible plan. Fewer plans have carve outs/subsidies for those with chronic disease. Some subsidies are now permitted under MA plans. See https://aspe.hhs.gov/sites/default/files/documents/786fa55a84e7e3833961933124d70dd2/preventive-services-ib-2022.pdf

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THE PATIENT WILL SEE YOU WHEN? AND WHERE?

In 2016, Eric Topol wrote his book *The Patient Will See You Now*. Six years later, as a patient, it feels like the situation is more like: The patient will see you when? And where?

Source: Bigstock

My internist's office is now part of a local hospital system. It takes more than three months, sometimes six, to get a doctor's appointment. The wait times in the waiting room are longer, though I have to say the waiting rooms are looking nicer. The time with the physician is shorter, and, many times, replaced by a physician assistant (PA) or a nurse practitioner (NP). Not that the PA and NP are not qualified or don't provide quality care, but as a consumer, sometimes I feel I might not get the value for what I am paying for. Telehealth is convenient, but not always relevant, and impersonal. I wonder if I should call urgent care or stop by my local pharmacy. Every doctor's office has a different app or portal they want me to download.

Searching for answers, I did some research. And it is disheartening. The latest data on physician well-being in the U.S. is concerning. Mainstream news is reporting that more than 60% of physicians are reporting burnout, versus 40% pre-pandemic. Self-harm thoughts have grown from 7% in 2021 to 11% in 2022. Nineteen percent of the physicians have accessed medical help for mental health challenges, versus 14% in 2021. Further, more than 40% of physicians are afraid to seek mental health help, as it could affect their credentialing and licensure. A recent study by Stanford reveals that "among U.S. workers, physicians are more likely than others to feel the effects of imposter syndrome, a phenomenon in which someone feels inadequate despite a track record of competence."

The same can be said about nurses. The data on the looming nurse shortage is sobering, with one-third of nurses approaching retirement age. The article "United States Registered Nurse Workforce Report Card and Shortage Forecast: A Revisit" by Xiaoping Zhang, Daniel Tai, Hugh Pforsich, and Vernon W. Lin projects a shortage of 510,394 RNs by 2030. According to an article by Kathleen Gaines in nurse.org, 87% of the nurses are reporting burnout, 83% feel their mental health has suffered, and 77% feel unsupported at work.

There seems to be no recourse. My colleagues and friends are experiencing the same. Months to get a doctor's appointment. Lost health records. Lack of communication between treating doctors. Delayed procedures, or procedures that have gone wrong. Little time and no empathy. As if we are moving through a conveyor belt. A confusing plethora of apps, from the hospital, from the dentist, from the pharmacy. This experience of low-quality care is evident in the ranking of the U.S. healthcare system. Dead last among industrialized nations, despite spending the most - $4.1 Trillion or $12,530 per person in 2020 according to CMS, and a number projected to grow to $6.2 Trillion by 2028.

I talk to my physician friends. They confirm the data. They talk about increasing pressure to generate more RVUs, and they feel it comes at the cost of providing quality care to the patient. They talk about the ever-increasing administrative burdens, new processes, new technology, labor shortages, doing more with less, and feeling like robots. Or worse, feeling as if they have been reduced to technicians rather than practicing physicians in the process and profit juggernaut our delivery systems have become. I can understand how it can translate into the quality of my care.

Despite the promise of every delivery system out there today, as I look around just in my area: "A health system focused on you," "Care when you need it most," "My home. My choice." "Better Health, Easier," "Giving People a Healthier Tomorrow," and so on. Perhaps a case of pure sales puffery and clumsy attempts at branding.

I agree that if I had a critical illness, I would get the best care possible. IF my insurance card allows for it. When it comes to chronic illness or routine care -- prevention, self-care, and even alternative medicine sound better than a visit to the doctor's office.

The reasons for this situation are many – as the experts say. Increasing demand as the population ages, labor shortages, increasing consolidation, high cost of innovation, digitalization, regulation, high cost of litigation, etc. As a pragmatist, I know we will not be able to disrupt the system and solve the challenges all at once. But what can we do to make the current system a little more resilient? A little more empathetic? A little more patient-focused? I see three near-term solutions:

1. **Invest in the current workforce.** Let us take care of our current workforce now, while we solve the long-term shortages. Invest in their mental health. Help them with resilience techniques. Invest in developing and leading high-performing care teams. Remove toxic managers. Re-evaluate their work allocation. Trust their clinical judgment. Recognize them. Celebrate them. Treat them as and make them feel human. Because that will reflect in how they care for me – the patient.

2. **Invest in technology.** The promise of digital health remains unfulfilled. Use technology to create a personalized patient experience, and not the opposite. Use technology to reduce the administrative burden on healthcare practitioners, not increase it. Technologically, we have moved from the 30-year-old databases that formed the backbone of EHR to new means of capturing data and driving insights. Use it so healthcare workers can operate at the top of their license. Upgrade your systems. Refine your processes and automate the workflows.

3. **Stratify the business model.** Segment the delivery system and associated fees based on the delivery model and criticality of care – hospital-based, concierge, telehealth, care-at-home, urgent care, and so on. I get what I pay for in terms of experience, versus paying the same irrespective of the model of delivery. It could rebalance the workload for the healthcare workers, while providing patients with a true choice of value-based care.

Despite the challenges, I remain optimistic about the future of healthcare. Case in point: our son is pursuing pre-medical studies to become a surgeon one day. He and his other friends pursuing medical or nursing careers represent a future generation that still believes in the power of healing, and the noble work of healthcare.

I am also cognizant of my own responsibility for my health. The best outcome is where my interactions with the healthcare system are minimized. I can do that by eating healthy, exercising, being part of a community, having a support system, and taking the time to smell the roses amidst the hamster wheel work culture of our beloved nation! So can you.

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FROM TRANSACTION TO TRANSITION: PART 1 - THE IMPORTANT ROLE OF STRATEGY IN LEADERSHIP TRANSITIONS

The "Great Resignation" has normalized and accelerated a trend that has been a longstanding reality for organizations throughout the healthcare ecosystem: leaders move around. The average tenure for the dean of a medical school or a department chair hovers around three to five years. Naturally, leadership departures happen for a variety of reasons, both professional and personal. While some departures are welcome, many come with unavoidable costs, such as a reduction in organizational knowledge, a dip in managerial capacity, or a void in direction. Bringing in a new leader to replace the departing one comes with its own risks — from misaligned expectations about strategy and priorities to unhappy teams, to name a few. We find the simple swapping of one leader for another, a leadership ***transaction***, can run afoul of these risks. Conversely, organizations that seek to carry out a true leadership ***transition*** will find benefits to their organizational effectiveness, strategy, and culture.

Source: Bigstock

This series will explore how organizations can leverage moments of leadership transition to advance their purpose and take advantage of the strategic, cultural, and organizational opportunities inherent to integrating new leaders. In this article, we will focus on the value of establishing a Transition Committee, and the ways that leadership transitions can both inform and be informed by strategic thinking. Subsequent entries in our series will unpack issues related to cultural and organizational effectiveness.

Let's take a closer look at how to structure an effective leadership transition, which we believe starts with a Transition Committee. Many leadership transitions involve a *Search* Committee, a group whose sole purpose is to select the new leader and frequently disbands when the candidate signs on the dotted line. We offer an alternative approach — a *Transition* Committee. This committee oversees the transition process from start to finish — from ensuring the Board or group responsible for hiring is on the same page about the kind of leader they require for the future, to managing the search process, to assessing key organizational, strategic, and cultural issues that need to be addressed, to ensuring the new leader can be oriented and onboarded successfully. The configuration of the Transition Committee could be the same or different from that of the Search Committee, depending on the situation. Effective transitioning often requires engagement from the new leader's peers, supervisors (or the Board), and, in some cases, direct reports. This group has a very specific charge when planning for, welcoming, and onboarding a new leader: take advantage of the strategic, organizational effectiveness, and cultural opportunities inherent to a leadership transition.

First up: strategy. Incoming leaders, whether they are entering as top leaders or somewhere in the middle, tend to see themselves as conveyers of new ideas. They might be hired on the basis of their clear thinking, strategic successes, or change agency. On the other hand, the teams and staff around those incoming leaders often look hopefully at the new

hire as a source of needed continuity and a means by which unfinished work can get done. The necessary balance is between the need for work that has already received considerable investment and energy to continue, while providing the incoming leader with meaningful agency to influence the appropriate level of planning. We once worked with a family foundation that was singularly focused on a particular medical need and were brought in because the founding family member and leader had died unexpectedly. The Board planned to bring in a non-family member to succeed this visionary leader, and they knew this person would need to bring with them some measure of that visionary style while continuing to advance costly pilot projects already underway. In the end, the Board decided the key piece of work was to define its core strategic questions — while holding off on answering them until they had their new leader in place. Armed with these questions, they could sharpen their search. Ultimately, they identified a close collaborator who already knew the organization well and was in a very good position to both honor the existing work underway AND bring fresh thinking to the questions the Board identified. A Transition Committee will need to think critically about how to balance strategy continuity while articulating the agency an incoming leader will be afforded to bring fresh thinking and new ideas.

Another important aspect of strategic clarity in the search process is defining the characteristics, skills, and experiences needed by a new leader. For example, the Board of a large healthcare nonprofit focused on health equity was faced with the retirement of its charismatic and beloved founder. The organization had slowly shifted its focus over time and had recommitted to a new strategy — one that might require a different set of skills and experiences of their next leader. The Board realized they needed advice on potential shifts in the strategy and the implications for their organization and new leader, so they engaged a broad range of internal and external stakeholders. Listening to the stakeholders helped the Board understand what its constituents valued, and helped it come to know its own mind about what would be needed in a job profile to attract the most appropriate and qualified candidates for the role. It also had the unintended but valuable effect of surfacing important ideas about opportunities to advance their strategy.

In future articles, we will dive into different ideas to energize leadership transition: culture and organizational effectiveness. For now, we would like to close with the observation that leadership transition is an increasingly vital and underutilized source of strength. Organizations that do it well tend to learn faster, grow more easily, become more attractive places to work, and ultimately attract top talent. Organizations that seek only leadership ***transaction*** can risk a failed search and ongoing stagnation. Our view is that in most cases, this outcome, at best, fails to capitalize on the opportunities we have described above. In the end, the goal of effective leadership transition is to bring about the satisfying conclusion of the transition itself, so that new leaders become established and can lead and manage both for continuity and change for the duration of their time at the organization.

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RECOVERING AND THRIVING POST-PANDEMIC - PART 7: ADDRESSING PROVIDER BURNOUT

OVERVIEW

Source: Pixabay

Many years before the pandemic, there was long-standing dissatisfaction evident among healthcare workers, particularly among physicians and other clinical providers. Dissatisfaction was due to a variety of factors such as the increasing burden of administrative tasks [e.g., documentation and charting requirements in templated electronic health records ("EHRs"), patient portals], long, pressure-filled work hours, not enough resources and programming to address issues, insufficient support staff levels coupled with high turnover, and the inability to practice at the top of one's license.

All these factors, combined with rising stress and cost of care delivery, has led to a widespread feeling of burnout among providers. In response, introduction of the "4th aim" – improving provider work life – was intended to draw focus to the criticality of addressing these challenges and to improve overall satisfaction of the healthcare workforce. (The "quadruple aim" of the Institute for Healthcare Improvement is composed of four goals – enhancing patient experience, improving population health, reducing costs, and improving the work life of healthcare providers (restoring "joy in work").

Physician, nursing, and allied health shortages, an aging population with an increasing chronic disease burden, medical school debt averaging more than $250,000, a shortage of residency positions, changing care delivery and reimbursement models, and medical knowledge that doubles every 73 days all contribute to stress, which, if left unmanaged, leads to burnout. *Pre*-pandemic, a 2019 article in the *Annals of Internal Medicine* estimated the cost of physician burnout at $4.9 billion annually, largely attributable to costs related to turnover.

This alarming state of affairs was further exacerbated by the COVID-19 pandemic. Forty-three percent of physicians in the U.S. are 55 or older, and many individuals chose to retire or leave the workforce and pursue other careers that did not involve direct patient care. Morning Consult reported in 2021 that 18% of healthcare workers had quit their jobs, and a study by Definitive Healthcare estimated that 117,000 physicians had left their work as clinicians in 2021. Those departures have led to an even greater shortage.

In 2020, the Association of American Medical Colleges (AAMC) estimated that by 2030, the U.S. will suffer a shortage of up to 121,300 physicians. A 2019 study projected a nursing shortage of approximately 918,232 nurses by 2030. A survey of 36,000 physicians published in *JAMA Network* in 2022 indicated 20% planned to leave practice.

The long duration and devastating nature of the pandemic (>1.1M deaths in the U.S. and 500 patients still dying from COVID every day) contributed to moral injury, while practice buyouts by hospital systems and private equity firms dramatically changed the business and workplace dynamics of practicing medicine, in both positive and negative ways. In addition to the physical and emotional toll of caring for patients who were among the sickest staff had ever treated, reduced

reimbursement levels, supply chain issues, and provider consolidation further decreased autonomy and increased the administrative burden on providers. Cybersecurity threats and issues with electronic health record (EHR) systems and portals only added to the already overwhelming workload (including uncompensated expectations to increase communication with patients enabled by enhanced technology.)

Despite efforts by Management Service Organizations (MSOs) and other operators to reduce administrative burden, increase patient satisfaction, and improve provider experience, these efforts are widely considered to be not at all sufficient and/or effective. There continues to be an increasing shortage of certain types of staffing, such as social workers and behavioral health professionals. Additionally, the healthcare workforce continues to be subjected to discrimination and bias based on race/ethnicity, sex and gender identity, including pay inequity. And increasingly workplace violence towards them by patients and family members threatens their safety and has even resulted in catastrophe.

All of these factors contribute to provider dissatisfaction and burnout, which in turn can ultimately lead to career changes (including early retirement and leaving healthcare practice/employment entirely.) Underscoring all these factors is a shift in expectations among younger generations of healthcare workers with regard to work/life balance, shift scheduling, compensation, and scope of practice, to name a few. The lack of sufficient attention and focus on prioritizing these issues and taking concrete and effective action further frustrate the workforce because needs continue to go unmet, and burnout continues to rise.

A study published in *AJMC* found burnout can lead to poorer patient outcomes and lower patient satisfaction. That's just the patient side of things.

WHAT CAN HEALTHCARE LEADERS DO?

Health is personal, and healthcare is viewed just as personally by patients. Healthcare is different than most industries because, if delivered badly, lives are at risk. But the truism that "if you take care of the employees, they'll take of the customers" applies in healthcare as it does in most other arenas. Just as most people would not want the plane they're on piloted by a team that's overworked, underpaid, and burned out, having patient care delivered by clinicians and nonclinical staff who are over-burdened, under-resourced, and physically and mentally exhausted doesn't seem like a plan for safety, optimal clinical outcomes, or a good patient experience.

Because of the sacred responsibility those in healthcare carry, it is even more incumbent upon leaders to provide the resources and support necessary to avoid jeopardizing the health and well-being of the workforce, to ensure workplace safety, and to create a culture and environment in which those from all walks of life are respected and given the opportunity to thrive. And the added benefits of having a healthy workforce which feels appreciated are many – lower rates of turnover and absenteeism, lower costs related to temporary/contract staff and recruitment, fewer adverse events, better clinical outcomes, and higher NPS scores.

A study published in BMC Psychiatry in December 2022 found during the pandemic there were certain factors that helped protect against psychological distress (burnout, depression, anxiety, and PTSD) in healthcare workers – perceived organizational support, social support, and resilience.

Healthcare organizations need a strategy and action plan to address current challenges, including burnout and the fallout resulting from the trauma of the pandemic and taking care of legions of patients who fell victim to COVID-19, both directly and indirectly (e.g., delayed care).

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RECOVERING AND THRIVING POST-PANDEMIC - PART 7: ADDRESSING PROVIDER BURNOUT

The effort must be sustained and ongoing in order to be effective. As is most often the case, there is no silver bullet or panacea. Time, financial investment, holding leaders accountable, establishing and tracking KPIs, and putting people first are key to getting the job done.

TACTICS TO ADDRESS BURNOUT

Although it often may not feel like it, healthcare leaders have the power to make changes that bear fruit both now and in the future. These tactics can be tied to other pandemic recovery efforts and include:

- **Identify the root causes of burnout in the organization.** Techniques to help cope with stress in its most extreme form, like mindfulness, physical activity, and a gratitude practice, will all help from both a physical and mental health and well-being perspective at the individual level. **However, no amount of meditation can offset the root causes of burnout, such as woefully inadequate staffing levels or technology that creates more work**. Unless the factors which led to the conditions that resulted in burnout at scale are accurately pinpointed, much time and money can be spent to no avail, exacerbate the problem, and leave staff losing faith in the organization.

- **Talk to staff, clinical and nonclinical, at all levels of the organization, and truly listen. Then summarize learnings and identify themes.** Those closest to the work at each level of the organization are often the ones most likely to have the ideas which prove to be effective (and less costly) solutions and come with staff buy-in. Aggregate what is learned, so themes can emerge. This approach allows leaders to filter out one-off opinions and instead focus on what matters the most and to the most people. As individual conversations converge to emerge as themes, they can be linked together such that themes can cascade down into specific pain points. For example, “staffing shortages” as a theme can be sub-divided into the impacted departments or teams, and further cascaded down to the number of positions which are vacant within each department or team (we use “staffing shortages” as an example, but any theme that emerges can be classified similarly.) As strategies are developed to address root causes, granularity will be critical to designing key performance indicators (“KPIs”) to track progress and pace of impact.

- **Find out what others are doing and leverage best practices.** Some organizations have mapped out strategies and tactics organizations can implement, including:

    - National Academy of Medicine
    - American Medical Association
    - Stanford Medicine
    - Mayo Clinic

- **Review current processes/policies and technology workflows.** When millions have been already spent on technology systems, the idea of stepping back and figuring out how to make the system work best for users may not be popular. However, organizations must conduct a periodic comprehensive review which focuses on identification by clinical and nonclinical staff of ways to make work more efficient, patients safer and more satisfied, and to help alleviate workforce burnout by minimizing the need for workarounds. “Workflows only work when work flows,” thus ongoing optimization of how people, processes, and technologies are integrated and/or automated is part of the required maintenance to keep staff satisfied and feeling empowered. And adding the right complement of nonclinical

staff support to help reduce the administrative burdens and alleviate time pressure on providers can have an outsize positive impact on job satisfaction.

- **Accelerate movement to reimbursement models which support the quadruple aim.** The fee-for-service (FFS) system is no longer a viable long-term strategy. In the short-term, it may maximize revenue for a select group of individual providers and systems. But for everyone else (as well as for the select group at some point), quantity over quality is no longer a sustainable plan. Value-based care (VBC) models are one path which helps to align incentives and enable investments in tools which can help mitigate workplace stressors and provider burnout (e.g., protected physician downtime to focus on patient management, care coordination tools, risk stratification of patient panels, etc.) But regardless of the model, success is dependent on a genuine belief in its key principles and not just a half-hearted hedge, with one foot still in FFS. Simply signing on to VBC does not guarantee success. It requires investment at levels to effectively transform workflows, policies, staffing models, and technology, and involves both clinical and nonclinical staff at every step of the way.

- **Leverage advances in technology and increased adoption of additional care delivery options.** Telehealth is one example of a care delivery option that was in a relatively nascent stage prior to the pandemic, but the approach was quickly embraced during it, boosted by state licensure waivers, reimbursement at the same level as in-person visits, and the safety of being able to stay at home rather than be exposed to COVID. Additionally, satisfaction levels are high among patients, and some providers report greater work satisfaction with the incorporation of telehealth into their practice. Lastly, in some instances, telehealth has improved access for populations underserved by the healthcare system. To maximize the positives and minimize some of the potential downsides, it is important to balance telehealth encounters with in-person visits to avoid "Zoom Burnout" and ensure optimal scheduling for time management and documentation tasks.

It is important to understand the appropriate level of investment required to sufficiently address burnout and improve satisfaction. Underfunded initiatives can ultimately exacerbate problems, because of increased provider frustration in the process and the perception that workforce needs are not being heard by leadership and/or administrators or they simply don't care about the health and well-being of clinical and nonclinical staff.

CONCLUSION

The COVID-19 pandemic has exacerbated longstanding provider burnout and taken it to new highs. As the most acute stages of the pandemic have now receded, organizations have a red-hot opportunity to accelerate recovery by truly addressing the problem. Not taking action can have negative consequences with regard to patient safety, clinical outcomes, and the financial well-being of the enterprise that can potentially be catastrophic.

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LEVERAGING THE IMPACT OF GRATEFUL LEADERSHIP – A SCIENCE AND EVIDENCE-BASED FRAMEWORK

There are different leadership frameworks with which you may be familiar, including Servant and Transformational Leadership, to mention a few. As healthcare systems and their leaders find themselves crossing a threshold from the old way of operating to the new post-pandemic era (Liminal Space), there's an urgency to lead through the current level of disruption and achieve a positive impact and short and long-term results.

"The thinking that got us to where we are is not the thinking that will get us to where we want to be."
~Albert Einstein

Photo courtesy of Unsplash/Marcus Spiske

Yes, healthcare has faced disruptions in the past, yet current-day volatility, uncertainty, complexity, and ambiguity (VUCA), create novel barriers for people, processes, systems, and related capacities. Answering the call for a construct capturing evidence-based best practices essential for healthcare leaders and speaking to the industry's unprecedented challenges is a grateful leadership framework. A strengths-based framework supported by research in gratitude, positive psychology, neuroscience, and positive organizational behavior (POB) offers the most progressive and promising approach.

Another construct, complementary to strengths-based leadership is antifragility, a term introduced in Nassim Nicholas Taleb's "*Antifragile: Things That Gain from Disorder.*"

Antifragility is defined as systems in which an increase in capability to thrive is a result of stressors, shocks, volatility, noise, mistakes, faults, attacks, or failures. Antifragility is beyond resilient or robust. The resilient resists shocks and stays the same; the antifragile gets better and better.

A strengths-based leader focuses on identifying and ***appreciating*** the strengths of individuals. An antifragility leader helps individuals build on their strengths in the face of uncertainty and volatility. Together they support a healthy and positive work environment and the well-being of employees. And, driven by universally intrinsic human needs for survival and maximizes human potential at every level in any job description.

GRATEFUL LEADERS' HEALTH AND WELL-BEING

A significant difference in incorporating these foundational elements of grateful leadership into your organization is the integration of these best practices **first to enhance YOUR health** and well-being and identify **YOU** at your best (i.e., alignment of values, strengths, mental fitness).

As leaders, you know when you're not at your best. Therefore, leading from a science and evidence-based approach accelerates your ability to bring renewed energy to your work as a leader. That means taking care of yourself so you can take care of others.

As described in our 2019 issue of the Wharton Healthcare Quarterly on "Gratitude: Resilience and Healing for Clinicians During a COVID-19 Pandemic," having a sustained gratitude practice improves overall health and well-being, including:

- Fostering higher levels of positive emotions
- Supporting greater life satisfaction, vitality, and optimism
- Enabling more hours of sleep
- Fostering better self-care
- Strengthening the immune system and lowering blood pressure

GRATEFUL LEADERS IMPACT ON THEIR EMPLOYEES AND THE ORGANIZATION

One study reviewed how leaders who express genuine gratitude to employees positively relate to more proactive behaviors, supporting self-efficacy and perceived social worth. According to another study, this aligns well with employees having greater hope, self-efficacy, resilience, and optimism, all components supported by gratitude and its impact on employee engagement and retention.

Additionally, the foundational elements of grateful leadership support the growing urgency for healthcare organizations to adopt the principles of Environmental, Social, and corporate Governance (ESG). In a recent article, social capital is defined as organizational contributions to improving workers' multi-dimensional well-being.

From a cultural perspective and the fields of positive organizational scholarship and positive organizational behavior, studies show institutionalizing gratitude interventions in the workplace to increase job satisfaction, including a sense of belonging to a workplace culture that endorses gratitude.

Representative learning objectives foundational to grateful leadership include:

- Integrating current research in gratitude, positive psychology, neuroscience, and POB as a leadership essential
- Enhancing personal physiological, emotional, and mental well-being and, in turn, identifying ways to support employees
- Developing a sustainable framework and fostering a more grateful, positive, and psychologically safe work environment
- Creating greater health and positivity in the culture of care

Consider these questions to discover if grateful leadership is right for you and your organization:

- Is there a numbness in behaviors and interactions preventing accountability, innovation, and inhibiting self-empowerment?
- Do your days start with the best intentions but quickly lapse into conflict, overwhelm, and self-defeating, pessimistic thinking?

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LEVERAGING THE IMPACT OF GRATEFUL LEADERSHIP – A SCIENCE AND EVIDENCE-BASED FRAMEWORK

- Are there employee job functions frequently overlooked that inhibit inclusion, prompting the refrain "I'm just a".....?
- Do people follow you because they have to?
- Are the interactions and behaviors between leadership and employees misaligned in beliefs, values, and strengths?
- Do you encourage growth and continuous improvement for all employees?
- Do you celebrate and acknowledge how strong you and your team have become because of the extreme pressures you are experiencing?

If you answer yes to any of these questions, consider how grateful leadership - leading with your strengths - can energize your development as a leader, develop employee strengths, and create a more dedicated, healthy, and energized work environment. What's your level of commitment?

Contact Linda at:
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Want to learn more?

- There's More to Practicing Gratitude Than Journaling
- Weaponizing Gratitude
- Gratitude - An Essential Element for Greater Inclusion
- 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

GLOSSARY

Positive Psychology: the scientific study of how strengths enable individuals, communities, and institutions to thrive. Complementary to traditional psychology, it calls on a greater awareness of strengths, relationships, and positive emotions to truly flourish in life. Just as good health is not just the absence of disease, positive psychology is not the absence of pain and suffering or denying the negative.

Leadership Strengths: When we work with leaders, we tap into the research by Don Clifton. His work is compiled in the book *Strengths-Based Leadership* by authors Tom Rath and Barry Conchie. For leaders, it identifies your top strengths across defined categories – Executing, Influencing. Relationship Building and Strategic Thinking. An excellent way to identify strength gaps and the greatest growth potential.

Gratitude: scientific proof that when people regularly engage in the systemic cultivation of gratitude, they experience various measurable psychological, physical, and interpersonal benefits.

Neuroscience: With the latest neuroscience studies, we have a greater understanding of achieving and sustaining the associated health and well-being benefits across a lifespan. Neuroleadership helps us understand how the brain views the workplace and its relevance to psychological safety and inclusion. Once thought of as a simple emotion, fMRI has clearly shown that gratitude activates multiple regions of the brain, including those for moral reasoning, fairness, economic decision-making, and psychological well-being.

Positive Organizational Behavior: The application of positively oriented *human resource strengths and psychological capacities* that can be measured, developed, and effectively managed for performance improvement in today's workplace.

Ask these questions:

- What makes employees feel like they're thriving?
- How can I bring my organization through difficult times stronger than before?
- What creates the positive energy a team needs to be successful?

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To learn more about Linda, click here.

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WHARTON AROUND THE GLOBE: WHARTON GLOBAL HEALTH VOLUNTEERS (WGHV) PARTNERS WITH CAREPAY TO INCREASE ACCESS TO QUALITY HEALTHCARE IN NIGERIA

This year, a team of six Wharton students supported a Nigeria-based healthtech startup, CarePay, to develop its go-to-market strategy. The students: Shreeya Bhutani (WG '24), Georgina Coleman (WG'23), Mary Joseph (WG'23), Dolapo Salawu (WG'24), Blair Seiler (WG'23), and Josh Wong (WG'24) are part of the Wharton Global Health Volunteers.

CarePay was founded in 2015, to increase access to healthcare via a proprietary health benefits management platform, linking payers with providers and participants. The company's initial launch, in partnership with PharmAccess, Safaricom, and IFHA, was in the Kenyan market. Their key product, M-TIBA, has connected 4.5 million users and 3,000 healthcare providers. CarePay's investors include IFHA, Elma Investments, and the Dutch government.

In 2018, CarePay Nigeria (CPN) was incorporated. CarePay Nigeria's vision was to address Nigeria's low access to healthcare. Affordability is low, with estimates of the health insurance penetration rate in Nigeria just 3-10%, and accessibility also presents a challenge, with an overburdened hospital system and poor non-urban transportation infrastructure. CPN is focusing on affordability, by boosting insurance uptake and building partnerships with providers to reduce service costs. Since its launch, CPN has launched a health insurance platform with partners including Lagos State, a health insurance marketplace with 5 HMOs. In 2022 CPN launched the Healthcare Discount Card, which provides discounts of up to 37.5% at pharmacies, clinics, and hospitals across Nigeria. CPN expects to use the Healthcare Discount Card to scale up healthcare access for users and move them towards shared risk/full insurance products.

CPN has focused on innovating and releasing first-of-kind products in the Nigerian market. Releasing these types of products presents unique adoption challenges, as the market adjusts and responds to these new technologies. The WGHV team was engaged to help refine go-to-market strategy for the Healthcare Discount Card (linked into the benefits and payments software) and analyze and suggest improvements to the product, including business model and operational changes. The WGHV performed market research, data analysis, user journey studies, and product and market mapping. The team also had the opportunity to travel to Lagos, Nigeria in December 2022 to meet with the CPN team. The WGHV team ran workshops and interviews, visited CPN's local partners, including major pharmacy and diagnostic Lab chains, and tested the CPN products.

At the conclusion of the project, the WGHV team presented recommendations. We provided a short, medium, and long-term view of product refinements to better address the needs of users in the Nigerian market. We identified gaps and

potential solutions in product usability, product-market fit, and the revenue model for CPN's products. We also made recommendations for future reimaginings of the gaps in the Nigerian healthcare market CPN could fill - including in parallel spaces such as healthcare payment financing and wellness.

WGHV Team with CarePay team at their Lagos, Nigeria office

From left to right: Blair Seiler (WG '23), Mary Joseph (WG '23), Dolapo Salawu (WG '23), Adeola Akewusola (CPN), Tunde Hamzat (CPN), Olayinka Ogunleye (CPN), Akinjide Adebisi (CPN), Abayomi Sule (CPN), Olumide Ajayi (CPN), Georgina Coleman (WG '23), Joshua Wong (WG '24), Ibifuro Amachree (CPN)

The WGHV team was grateful for the opportunity to gain insight into the Nigerian healthcare landscape working in partnership with the CPN team. We learned about launching innovative health products, identifying effective go-to-market strategies, and the user journey for healthcare access.

WGHV is grateful for the generous, ongoing support of the Wharton Healthcare Alumni Association that allows our teams to continue to make an impact on the global stage supporting international health organizations and to contribute to improving access and outcomes for underserved populations around the world. We are always looking for interesting and impactful organizations to partner with in the semesters ahead. If you have any leads for potential projects, please reach out to the WGHV Executive Board.

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