Wharton ALUMNI CLUB
UNIVERSITY of PENNSYLVANIA

Health Care Management Alumni Association

THE WHARTON HEALTHCARE QUARTERLY

SUMMER 2023, VOLUME 12, NUMBER 3

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EDITOR'S LETTER

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

To learn
more about Colette, click here.

Welcome to our new Board President, Katherine Clark, MD'15, WG'15, and to the newest WHCMAA Board Members – Vivien Ho, WG'21, Ron Kero, WG'86, Leticia Lazaridis Goldberg, WG'10, Hannah Plon, WG'22, Charlie Robinson, WG'15, and Kathryn Tong, WG'07. We all look forward to your sustaining the legacy of the Association, which has the largest paid membership of any club at the University.

Hope all are surviving the hottest month on record across the globe, floods, fires, smoke, earthquakes, volcanic eruptions, and typhoons! And now it seems COVID-19 is reminding us we need to remain vigilant, with COVID-related ER visits and hospitalizations on the rise again and long COVID impacting millions as a "mass disabling event."

The aftermath means disruptions and suffering worldwide and may be in addition to other life challenges like the loss of a loved one, life-threatening health issues, an elderly parent with dementia, loss of a job, and adjusting to parenthood, retirement, or an empty nest. We are forced to think about the future in very personal ways that can be uncomfortable and also make facing our own mortality more difficult to ignore.

Many of us have yet to adequately prepare for the end of life or taken advantage of the positive impact spirituality can have on our general health and well-being.

But you can heed these wake-up calls with the help of the Wharton Healthcare Quarterly! Survey feedback has consistently told us over the years, readers particularly like the eclectic nature of the content of the publication. In addition to the business arena, you'll find information about another type of ROI in this issue.

Health and healthcare are very unique experiences that impact every aspect of our lives at one point or another. Take a few minutes to learn a lot about some topics it's common for us to keep putting off or not even think about in the first place.

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

Katherine Clark, WG'15
To learn more about Katherine, click here.

It is my honor to take the helm of this outstanding alumni association.

In my first days on campus as a student, I heard a passing comment regarding the strength of relationships that often develop during the program, and although it may be cliché, it certainly held true for me. To this day, some of my dearest friends are those classmates I met through the Wharton HCM program. To that fact, I consider Heather Aspras, WG'08 a great mentor and friend. I've known her since my time as a student, and I have felt lucky to follow in her footsteps on the WHCMAA board.

After being elected to the board in the midst of the pandemic, we worked together across 5 different time zones during virtual board meetings. I quickly witnessed the true commitment of our alumni board members. I saw first-hand how our board was agile to both aid the medical field in a crisis and figure out how to provide the best possible value to its members. It was inspiring to see nearly 100 alumni join a Zoom meeting to catch up with fellow classmates, as everyone anxiously awaited June's visit to their breakout room.

In only a few years on the board, I have been fortunate to develop unexpected relationships that have blossomed in ways I could have never imagined. It reminds me that the true strength of this alumni association lies in its members. The value of the alumni network stems from the irreplaceable foundation built by June Kinney, further strengthened by the professors. My hope is that other alumni have the opportunity to derive the same personal and professional fulfillment through our alumni association.

Since rising out of the pandemic, one of our primary focuses over the past year was to re-establish our annual in-person gatherings. Our board members worked tirelessly to re-establish our pinnacle events for the first time in several years, which posed new challenges to overcome. I cannot thank everyone enough for their diligence in going above and beyond. I have heard nothing but praise for the annual Alumni Conference this past October at the Inn at Penn, as well as the annual event at the JP Morgan Healthcare conference in January. It was particularly exciting for me to finally meet my fellow board members in person, and I believe everyone sincerely enjoyed one another's company during these events.

In looking ahead to the next year, I want to ensure that all alumni know they have the opportunity to participate on the WHCMAA committees, including Programs and Events, Career Development, Student Engagement, Sponsorship, Alumni Conference, Membership, Awards and Grants, and Finance. We greatly appreciate volunteers – for any degree of time and expertise you are able to provide. In the upcoming months, we're also planning networking events in Philadelphia, Boston, and New York, as well as industry conferences, and we'd love to host events in other locations as well. Please reach out if you'd like to plan an event in your area.

I am confident our alumni are driving change to shape the healthcare field in this post-COVID world as technology is rapidly changing our reality. As we aim to overcome the age-old

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PRESIDENT'S DESK

issues of the industry as well as respond to new disruptions, I look forward to striving to solve these challenges with you all.

It is a true privilege to be a part of this inspiring alumni community, and I look forward to meeting you at our upcoming events.

Kind regards,

Katherine Clark, WG'15
President, Wharton Health Care Management Alumni Association

Contact Katherine at: katherine.godiksen@gmail.com

LinkedIn Profile

ALUMNI NEWS

Jill Ebstein, WG'83

I have just released my first novel, *Alfred's Journey to Be Liked*. The book is about a 14-year-old high-functioning autistic 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. It is my hope that parents, coaches, teachers, and mentors will find some helpful entry points for conversation with their adolescents. The tone of the book is both light and substantive. The chapters are short chunks. The content is largely dialogue, all designed for an easy read.

Readers tell me this book is for everyone in reminding us of some "social basics." For me, it is about possibilities and positivity; doing a personal inventory of where we need to strengthen ourselves, and being the best coach we can be for those we love.

The book is available on Amazon. Here is a recent review.

I am available for book group discussions, work group talks, teachers, coaches and any group seeking to understand Coach's rules and how they might apply to helping our kids.

Learn more.

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George Chen, WG'99

In 2020, George Chen left AZ Global R&D, where he was an SVP, to start his own biotech focusing on oncology. In late 2020, George raised $200 million to launch his own biotech, D3 Bio. In the last 2.5 years, D3 Bio has become a global, clinical-stage biotech with three internally discovered assets (2 small molecules and 1 bi-specific antibody) entering clinical development globally. This is a fantastic achievement for biotech formed only 2.5 years ago. Will keep you all posted on D3 Bio's future progress.

Contact George at: z_j_chen@yahoo.com

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 June, Happy Head expanded its offering, specifically addressing women's hair loss and hair thinning with the first and only 3-in-1 SuperCapsule™ for women on the market today. This all-in-one medication combines ingredients spironolactone, minoxidil, and essential vitamin D3 to stop and prevent future thinning and hair loss.

Studies have shown that 40 percent of women with alopecia report having marital problems as a consequence, and 63 percent state they have had career-related problems because of it. Today, over 20,000 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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Follow us on Instagram @hihappyhead

Lee M. Stern, WG'14

Lee M. Stern (WG'14), and his partners Victoria Igumnova and Patrick Till, have launched Meru Advisors. Meru provides strategic advisory, investor relations, and capital markets support for innovative life sciences companies. Current clients of the firm include leading biotechnology companies Immunocore [IMCR], Celldex [CLDX], Step Pharma, and OMass. Lee, Victoria, and Patrick previously worked together at The Trout Group, a leading investor relations and strategic advisory firm that was acquired by PNC Bank in 2017.

Learn more.

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THIS MONTH'S PHILOSOPHER:
Katherine Clark, WG'15

To learn more about Katherine, click here.

THE PHILOSOPHER'S CORNER

Katherine Clark, WG'15

LIFE LESSONS

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

- always said yes to an unexpected opportunity, meeting, or conversation. You never know what doors will open in the future.
- always spent those extra few minutes with a colleague, friend, or in my case, a patient, who requires your expertise. You will learn insightful tips that will allow you to provide value in a more meaningful way.

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

- thought someone's expertise was too far from my own to foster collaboration, because I've found that a multidisciplinary approach in problem-solving is the key to success.
- said no to an unexpected opportunity since you don't know what doors it can open in the future.

FAVORITE QUOTES

1. "If you want to lift yourself up, lift up someone else."
   ~ Booker T. Washington
2. "It isn't what we say or think that defines us, but what we do."
   ~ Jane Austen
3. "The purpose of education isn't only to impart knowledge and skills. It's to instill a love of learning."
   ~ Adam Grant

RECOMMENDED READING

1. *The Philosopher's Corner - Wharton Healthcare Quarterly:* 40 graduates of Wharton's Health Care Management program share insightful musings, words of wisdom, and life lessons for business success: available on Amazon
2. *How to be a Star at Work: 9 Breakthrough Strategies You Need to Succeed* by Robert E. Kelley
3. *Team of Rivals* by Doris Kearns Goodwin

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AFFIDAVIT: HEALTHCARE AND THE LAW - AS HOME- AND COMMUNITY-BASED CARE EXPANDS, AGENCIES FOCUSED ON M&A AND STAFFING CHALLENGES ALSO FACE HEIGHTENED LABOR & EMPLOYMENT ENFORCEMENT ENVIRONMENT

As the U.S. population ages, the demand for home-based care continues to surge. At a macro level, this has resulted in significant merger and acquisition (M&A) activity, including insurance companies[1] and pharmacies[2] entering the home-based care space as well as continued deals, many involving private equity, among established players in home-based care (notwithstanding a recent slowdown from the red-hot M&A market during the COVID-19 pandemic).[3] Increasing demand also has exacerbated staffing issues in home-based care. The staffing shortage in home-based care is so acute that two leading industry associations recently issued a rare joint report calling for action to address the staffing crisis.[4] The growing importance of home-based care as a key component of the healthcare industry shows no signs of abating[5] – and with it comes legal scrutiny.

Growth, consolidation, and crisis can have the unintended effect of obscuring a changing legal enforcement environment – one that providers ignore at their peril. One area that dovetails with both M&A activity and the staffing crisis in home-based care is compliance with labor and employment laws. Enforcement agencies from the U.S. Department of Labor (DOL) to the U.S. Equal Employment Opportunity Commission (EEOC), as well as state legislatures and agencies and the plaintiff's bar, are not relenting and, if anything, have increased their efforts to target home-based care providers as those providers grow.

We highlight three key areas of risk and exposure under labor and employment laws here.

WAGE & HOUR NON-COMPLIANCE

In 2021, the DOL launched an initiative to improve, through enforcement, wage and hour compliance of residential care and home health service providers. Since the initiative was launched, the DOL has opened more than 1,600 investigations of providers, uncovering violations in roughly 80% of cases, and racking up over $1.3 million in civil penalties and $28.6 million in back wages for nearly 25,000 workers.[6] The most common violations uncovered were failure to pay overtime and minimum wage, with women and women of color especially impacted.

In addition to unpaid overtime, wage, and hour pitfalls for home-based care, employers under federal and state law include: meal and rest break pay; pay for travel at the beginning and end of the workday, and between clients/patients; pay for non-patient care activities that can occur outside of normal working hours (e.g., chart completion); and minimum wage violations (27 states increased their minimum wage in 2023).

The financial consequences of wage and hour violations are steep and increasing in frequency, to say nothing of the financial impact and business disruption of litigation.[7] In addition, amidst an unprecedented staffing crisis, the reputational harm accompanying publicized wage and hour violations could prove costly to recruiting and retention efforts. Finally, for businesses positioning themselves for a potential sale, wage, and hour non-compliance likely will be unearthed in the due diligence process and can significantly impact the transaction where there is exposure.

To minimize risk of wage and hour non-compliance, businesses should strongly consider conducting a wage and hour audit to identify and remedy areas of non-compliance.

INDEPENDENT CONTRACTOR MISCLASSIFICATION

Among the most prevalent employment law issues facing home-based care businesses is the threshold question of whether care workers should be classified as employees or independent contractors. While there are enticing business benefits to independent contractor status (e.g., contractors generally are not entitled to benefits or subject to protections under employment laws), the consequences of misclassifying care workers as independent contractors can be substantial, including: liability for unpaid federal and state taxes and withholdings (e.g., Social Security/Medicare tax, income tax withholding, unemployment insurance contributions), benefit self-insurance exposure, and liability for non-compliance with employment laws (including wage and hour) believed to be inapplicable to the misclassified worker. As with wage and hour non-compliance, independent contractor misclassification can be a barrier in the M&A context.

At the federal level, employers have experienced whiplash as the DOL has established a new standard for independent contractor status during the last three administrations. Most recently, in October 2022, the DOL rolled out a proposed new test – expected to be finalized in 2023 – that would make it more difficult to lawfully classify caregivers as independent contractors.[8]

A patchwork of state laws and court rulings make compliance in this area even more difficult. In fact, the standards in some states – such as those employing the so-called "ABC test" (e.g., California, New Jersey, Massachusetts) – are so stringent that lawful independent contractor status under the state's laws is exceedingly difficult to establish.

Home-based care businesses should promptly take steps to assess and reduce misclassification risk, including auditing their classification practices and, where necessary, taking remedial steps that may include transition to employee status, restructuring of the contractor relationship, or better documentation of the basis for independent contractor classification.

PAY EQUITY AND DISCLOSURE REQUIREMENTS

Providers can easily run afoul of pay equity and pay disclosure requirements while trying to strike the balance between attracting talent and maintaining flexibility to manage labor costs – and face significant exposure as a result. This is especially true as the legal and regulatory environment surrounding pay equity becomes increasingly more complex.

For instance, several states have introduced pay transparency laws requiring businesses to disclose wage ranges for open positions.[9] Illinois and California also have instituted pay reporting obligations that require employers to submit pay, demographic, and other workforce data to regulators,[10] an approach likely to be adopted in other states in the coming years.

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Federally, the NLRA and Executive Order 11246 (applicable to federal government contractors and subcontractors) preclude covered employers and federal contractors from forbidding or discriminating against their employees for discussing compensation.[11] Meanwhile, the EEOC seems certain to reinstitute a pay data reporting requirement for employers who are required to annually file EEO-1 reports.[12] And, pay data reporting aside, the EEOC has demonstrated through litigation that it has its eye on pay equity in home based-care industries.[13]

Home-based care providers should remain alert to these evolving pay equity laws (particularly those expanding businesses whose growing workforce population and business footprint may trigger additional obligations under federal and applicable state laws) and should strongly consider proactively analyzing employee compensation to determine whether there are pay disparities that may need to be addressed.

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

REFERENCES

1. For example, in 2021 Humana acquired Kindred at Home, then the largest home healthcare provider in the U.S., for around $5.7 billion. *See* Tim Mullaney, *Humana to Fully Acquire Kindred at Home for $5.7B, Extend Its Senior Care Impact,* Senior Housing News (Apr. 27, 2021), *available at* https://seniorhousingnews.com/2021/04/27/humana-to-fully-acquire-kindred-at-home-for-5-7b-extend-its-senior-care-impact/. More recently, in February 2023, UnitedHealth Group closed its $5.4 billion acquisition of LHC Group, one of the nation's largest home healthcare companies. *See* Amy Baxter, *UnitedHealth Group Closes $5.4B Acquisition of LHC Group*, Innovative Healthcare: Health Exec (Feb. 22, 2023), *available at* https://healthexec.com/topics/healthcare-management/mergers-and-acquisitions/unitedhealth-group-closes-54b-acquisition-lhc.

2. At the end of March 2023, CVS completed its $8 billion acquisition of Signify Home Health. *See* Bruce Japsen, *CVS To Close Signify Health Deal, Launching A National In-Home Care Business*, Forbes (Mar. 27, 2023), *available at* https://www.forbes.com/sites/brucejapsen/2023/03/27/cvs-closing-signify-health-deal-officially-launching-a-national-in-home-care-business/?sh=23e527816a5c.

3. *See, e.g.*, Matt Caine, *A Look at Current Home Health M&A Trends: Despite Strong Headwinds, the Future Looks Bright,* HomeCare Magazine (Sept. 17, 2022), *available at* https://www.homecaremag.com/september-2022/look-current-home-health-ma-trends.

4. The Homecare Workforce Crisis: An Industry Report and Call to Action. *Available at* https://www.nahc.org/wp-content/uploads/2023/03/Workforce-Report-and-Call-to-Action-Final_03272023.pdf.

5. Just in April, President Biden announced that he would sign an Executive Order that includes numerous directives intended to support home- and community-based

care, on the heels of the Biden administration's proposed 2024 budget that would allocate $150 billion for home- and community-based services over the next 10 years. *See FACT SHEET: Biden-Harris Administration Announces Most Sweeping Set of Executive Actions to Improve Care in History, available at* https://www.whitehouse.gov/briefing-room/statements-releases/2023/04/18/fact-sheet-biden-harris-administration-announces-most-sweeping-set-of-executive-actions-to-improve-care-in-history/. Among the directives the announcement previews are directives improving access to home-based care for veterans and leveraging Medicaid funding to ensure that there are enough home care workers as the country's aging population continues to grow.

6. *See Department of Labor Initiative Finds Violations in 80% of Care Industry Investigations; Recovers $28.6M for Nearly 25K Workers, Mostly Women* (Nov. 16, 2022), *available at* https://www.dol.gov/newsroom/releases/whd/whd20221116.

7. For example, a 2022 consent decree between a Philadelphia, PA-based healthcare staffing company and the DOL resulted in over $9 million in combined back wages and liquidated damages for nearly 2,000 employees, and a $700,000 civil fine, for denying the affected employees earned overtime. *See US Department of Labor Obtains Judgment to Recover $9.3M in Back Wages, Damages for 1,756 Workers Misclassified by Philadelphia Staffing Company* (Sept. 27, 2022), *available at* https://www.dol.gov/newsroom/releases/whd/whd20220927.

8. *See* 87 FR 62218. Among other things, the proposed rule would "revert to the longstanding interpretation of the economic reality factors," including heightened attention afforded to an employer's control over its workforce. *See US Department of Labor Announces Proposed Rule on Classifying Employees, Independent Contractors; Seeks to Return to Longstanding Interpretation* (Oct. 11, 2022), *available at* https://www.dol.gov/newsroom/releases/WHD/WHD20221011-0. Further complicating matters, the DOL's test only would apply to those laws its enforces (e.g., the Fair Labor Standards Act), and not necessarily other federal laws (e.g., anti-discrimination statutes or the National Labor Relations Act (NLRA)).

9. These state laws – which differ in numerous respects including the substance of the disclosure and the triggering events for disclosure – include California (Lab. Code § 432.3(c)(3)), Colorado (Colo. Rev. Stat. § 8-5-201(2)), Connecticut (Conn. Gen. Stat. § 31-40z(8)), Maryland (Md. Code, Lab. & Empl. § 3-304.2(A)), Nevada (Nev. Rev. Stat. § 613.133(2)(a)(b)), New York (N.Y. Lab. Law § 194-B), Rhode Island (R.I. Gen. Laws § 28-6-22(c)), and Washington (Wash. Rev. Code § 49.58.110).

10. *See* 820 ILCS 112 *et seq.* (Illinois); Cal. Lab. Code § 432.3 (California).

11. 29 U.S.C. §§ 151-169; Executive Order 11246, § 202; 41 C.F.R. § 60-1.4(a)-(b).

12. With respect to pay data reporting, EEOC Commissioner Keith Sondering stated in August 2022: "Watch out, it's coming." *See* https://www.jdsupra.com/legalnews/watch-out-it-s-coming-eeoc-announces-1772703/. Commissioner Sonderling's statement came on the heels of the EEOC's announcement of a study by the National Academies of Sciences, Engineering, and Medicine, which found that pay data collection could be used by the agency to combat pay discrimination. *See EEOC Announces Independent Study Confirming Pay Data Collection is a Key Tool to Fight Discrimination* (July 28, 2022), *available at* https://www.eeoc.gov/newsroom/eeoc-announces-independent-study-confirming-pay-data-collection-key-tool-fight.

13. *See EEOC Sues Alternate Solutions Health Network and Inova Home Health for Pay Discrimination* (Feb. 27, 2023), *available at* https://www.eeoc.gov/newsroom/eeoc-sues-alternate-solutions-health-network-and-inova-home-health-pay-discrimination.

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DOWNLOADING SUCCESS: THE DEVELOPMENT OF THE CHIEF AI OFFICER IN HEALTHCARE

In the past five years or more, we have seen the rise of artificial intelligence and machine learning in healthcare. Currently, however, uses of AI and ML are decentralized and mostly ad hoc, with some projects overseen by the CIO and digital leaders, others by the chief data officer, and still others by research and biomedical informatics leaders. A few fundamental applications of AI include everything from triaging of patients, to rudimentary chat bots, to embedded predictive analytics in the EHR and to more advanced population health initiatives based on social determinants of health data. The key moving forward will be integration and strategic alignment of these disparate projects, which will require the creation of a dedicated executive position – the Chief AI Officer.

My colleagues and I at WittKieffer are beginning to see some organizations adopting Chief AI Officer roles and championing enterprise AI/ML strategies. This trend has just started, and my colleagues and I expect AI Officers to multiply in the next several years.

DEFINING THE ROLE

What will a Chief AI Officer do? This is a question that many organizations are still asking. For progressive organizations, this is going to be the leader who focuses on continuing to integrate AI and ML into workflows, technologies, and business processes to improve outcomes, increase efficiencies, and help to improve the bottom line of a health system. Regardless of whether an organization decides to pursue a more centralized or decentralized strategy, the Chief AI Officer will be the executive responsible for aligning efforts across the organization and ultimately ensuring its use is a net positive for the clinical community, staff, and patients. As health systems' use of data has grown exponentially in recent years, the Chief AI Officer can ensure the appropriate resources and structures are in place for successful AI implementations.

A common example of early AI adoption in healthcare is the increased use of chatbots as a first line of service for patients to help schedule appointments with the right specialty. A Chief AI Officer will be responsible for making sure the changes in employee workflows caused by the new technology are correct, that the specialty groups are trained on the tool, and that the algorithm is continually refined to improve its accuracy and effectiveness.

One AI leader told me that, while there may be an ebb and flow of centralized or de-centralized AI teams, there will always be a need for a Chief AI Officer who can manage the complexities of numerous ongoing clinical and operational projects.

A different AI leader made note of the importance of AI to reflect the mission of health systems and that any project needs to focus on the patient first and to build out from there.

AN ESSENTIAL POSITION?

Another question that many organizations will ask is, do I really need a leader focused on AI? The short answer is yes. While we expect titles to vary in the coming years as the role rises in prominence, the need for a cohesive, connected AI strategy will be essential as health systems look to increasingly utilize systems in the space. It will be important to align data definitions as well as the added complexity of business processes. The level of complexity required to successfully implement AI in a variety of settings is why there must be a dedicated leader in the space.

BACKGROUND FOR THE ROLE

What exactly is the background of a Chief AI Officer? In other industries it has often fallen to data scientists to move into the formal leadership role of a Chief AI Officer. In healthcare this will remain true, but with some important nuance. In healthcare, we will see Chief Analytics Officers, physician leaders, informatics leaders, and, potentially, some Chief Information Officers take on the role as an evolution of their current work and skill set.

For many, it will require a willingness to get additional formal education in AI and machine learning and applying that to their already mature leadership skillset. For some more clinically focused leaders, there are increasing opportunities through education programs being built at academic medical centers or through organizations like the American Board of Artificial Intelligence in Medicine to jumpstart their careers in the space. The importance of AI has become apparent, as even the Association of American Medical Colleges makes a push for more AI-focused curriculums in medical schools.

Beyond health systems, we are seeing medical schools and universities with the greatest foresight expand their departments of biomedical informatics to include AI into formal programs or leadership roles within their structure. This is while some academic health institutions are creating entirely new departments and centers focused on AI and pursuing science related to building out that pipeline of leaders and researchers.

REPORTING RELATIONSHIP

The AI Officer's reporting relationship will be critical in ensuring the role's success. Most likely, they would report to the Chief Information Officer or Chief Digital Officer. Given the need for the Chief AI Officer to have broad visibility across the entire technology stack, the CIO or CDO as a Chief AI Officer's supervisor will allow for the change management needed to successfully implement these transformational systems. Other possibilities of executives to whom the Chief AI Officer might report include the CMO or even possibly the CEO for particularly progressive organizations.

AI is already here for health systems across the country, whether embedded in the EHR, the ERP, population health tools, or other ancillary systems. The health systems that will take the lead are those that recognize the need for dedicated leadership in a space that will cause significant transformations across healthcare in the coming decade. On the importance of the Chief AI Officer, Robert Donnell, M.D., Chief Medical Informatics Officer and AI leader for the University of Florida, shared, "When you look at the entire world's investment in AI, medicine and healthcare are the single largest holder of development dollars for AI. Who is managing those dollars to the right outcome? We need AI leaders who are capable of installing in healthcare's complex environment or we risk having it misapplied."

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CYBERVITALS: FDA ISSUES A REFUSE TO ACCEPT FOR CYBER DEVICES

Healthcare cybersecurity has been a challenge for years, if not decades, but has recently become critical to ensure the safe delivery of clinical care. With nearly every device being connected and/or running software these days, the landscape for potential vulnerability is larger than it's ever been. While recent technology advancements ranging from machine learning to ChatGPT show promise for revolutionizing clinical care delivery, they also enable attackers to rapidly develop new mechanisms for exploiting cybersecurity vulnerabilities.

Almost exactly a year ago, President Biden issued an executive order mandating the recalibration of critical infrastructure cyber defenses to growing maturity of adversaries. This came on the heels of the Senate introducing the Healthcare Cybersecurity Act of 2022 and the Protecting and Transforming Cyber Health Care (PATCH) Act, which collectively expand regulations for medical device manufacturers to ensure mitigations are sufficiently in place through the existing Food and Drug Administration (FDA) approval process.

It is therefore very exciting to see the FDA will begin to reject submissions that don't detail cybersecurity measures, starting October 1, 2023. While cybersecurity guidance has existed since 2014, the Refuse to Accept (RTA) gives medical device manufacturers (MDMs) 6 months to prepare and implement security measures that will meet the FDA's expectations. In particular, the guidance requires MDMs to submit a plan to monitor, identify, and address post-market cybersecurity risks, including vulnerability disclosure and related procedures.

WHAT DOES THIS MEAN FOR YOU?

If you're a company building a medical device running software, it is now a requirement that you build it to be secure by design, develop strategies to monitor and maintain the security of that device post-market and for the life of the device, generate and maintain a software bill of materials, and generate the requisite documentation proving you've done so as part of your FDA regulatory submission.

If you consume devices - whether as a patient or provider - this means the security burden on you is potentially changing. While cybersecurity may not have been a top line concern for most patients, diabetes care has long considered cybersecurity in care delivery. Providers of healthcare, whether in a clinical setting or otherwise, can also start to recalibrate their security posture with a better baseline 'guarantee' for devices approved by the FDA.

While the policy does not affect products already on the market, unless a manufacturer is making a change to the device that necessitates a premarket review, it is certainly an inflection point in the story of cybersecurity considerations

for medical devices. The rapid development of regulatory expectations, and continuous improvement combined with community engagement, demonstrate the regulator's perspective that security is patient safety.

Furthermore, given the FDA's role in the International Medical Device Regulator Forum (IMDRF), it would be reasonable to expect the international requirements to align with the FDA's position.

CONSIDER CYBERSECURITY WHEN INNOVATING

We often dream of healthcare innovation as changing a clinical intervention or enhancing a patient experience. But increasingly, this includes connecting devices with a desire to 'do something' with the data gathered. Increased connectivity ushers in new possibilities for clinical care, while also introducing a mandate for transparency throughout the value chain.

Healthcare must find its own standard for secure connectivity. Many of the startup idioms such as pushing out a minimum viable product, catching a hot trend, moving fast, and breaking things do not work in healthcare.

Developing a more secure health system isn't just good for the short term but will support the technology community for the next decade. To earn the title of responsible innovators, a concerted effort to address security must be made.

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MIND THE GAP: PUTTING HEALTH EQUITY INTO ACTION

Efforts to address societal issues are often initiated after major events, such as the emergence of the COVID-19 pandemic in 2020. **Yet, after the inspirational moment begins to fade, so do plans for truly transformational change**. More often than not, short-term programs don't move the needle, highlighting the importance of creating long-term, sustainable solutions.

One urgent societal issue that requires such solutions, across all sectors, is health inequity – the unfair and avoidable differences in health status that exist among groups of people and countries. Health inequities are linked to more than an individual's clinical care. In fact, research confirms that clinical care only contributes to approximately 20% of a person's overall health; the social determinants of health – the conditions where people live or work, access to education, jobs and resources, racial and cultural factors – contribute to the other 80%. This statistic should not come as a surprise, as health inequities reflect prevalent, persistent, multifactorial barriers to care.

As a physician, I see first-hand that achieving health equity starts with listening to, and understanding, the personalized needs of patients and communities. As a pharmaceutical executive, I believe **the industry has the ability to help address health inequities**. The potential impacts of health equity go beyond the consideration of building a healthier society: there is strong evidence that addressing health equity can help businesses develop better workplace environments and grow sales, as well as market share.

In January of 2023, the World Economic Forum (WEF) held its annual meeting in Davos, where it convened global leaders from various sectors to discuss the state of the world and priorities for the year ahead. The world's first global, multi-sector health equity pledge also took place there. As a member of WEF's Global Health Equity Network representing Takeda, I was proud that our company was among the first of 39 companies to sign the Zero Health Gaps Pledge. We agreed to ten key **action commitments** to **embed health equity in** our organization's **business strategy, operations, and investments**.

We believe applying health equity principles to our business allows us to deliver innovative medicines and products to more people and communities that need them. We're taking steps to build a broad network of people, places, and tools that foster sustainable and impactful change at any and every level.

Our Center for Health Equity and Patient Affairs (HEPA) is helping to create an inclusive health ecosystem. HEPA aims to embed health equity considerations throughout our business decisions and work, by serving as a Center of Excellence to all business units. It provides important services, programs, and frameworks that help make it possible for Takeda to build sustainable, physical, and intellectual infrastructures to address health disparities and inequities. Our efforts are intentionally designed to **create reciprocal social impact** – impact that benefits both the community and patients we serve, as well as our business.

We recognize that health equity isn't a single, one-off step, or one-size-fits-all box. We know it may feel daunting to address such a significant and pervasive challenge, too. At times, people are convinced health inequities are too big or complex to solve, so why try? Some think it's an issue that only specially trained people can tackle. Sometimes analysis paralysis sets in, and nothing happens, perhaps out of a concern for not doing it right. Ultimately, we need to be brave enough to move from theory to action because it just might work, like so many other big changes which have been successfully undertaken and changed healthcare in transformational ways.

Lily Zheng, consultant and author of *DEI Deconstructed*, shared the importance of digging deeper to get to the core of problem-solving: You can't provide a solution when you don't understand a problem. We've learned achieving health equity starts by listening and learning. We seek to understand diverse patients' needs, and the communities in which they were born, grow, live, work and age. We can then co-create more inclusive practices and develop innovative medicines that better reflect how patients wish and need to engage with healthcare to help them achieve their highest levels of health.

Holding ourselves accountable is a **crucial** part of the process – one we don't take lightly. As we look to promote long-term and future well-being for all, we strive to factor in health equity considerations, including:

- **Understanding and embracing that health equity can better society and business throughout your organization.** Embedding health equity considerations throughout an organization can help it better understand its stakeholders and meet their needs. This starts with alignment and buy-in from the top, so the organization can see how integrating health equity is a value-add and business framework that can be adapted by all.

- **Addressing health inequity isn't just one person's or team's responsibility – it will take all of us, at every level and sector, to achieve.** Building like-minded partnerships across sectors can lead to broad, sustainable community benefit – a critical component of advancing health equity. Forming synergistic partnerships inside your organization and externally across sectors enables us to share knowledge and resources to build and strengthen with and in communities. Cross-sector collaboration isn't competition, but a way to help us achieve shared goals.

- **Determining your organization's area of focus, and providing adequate resources, so your efforts result in maximum impact.** Not all organizations can or should do the same work. Different communities will likely require different efforts. Co-creating, adapting, and tailoring solutions that reflect the diverse needs of patients and communities are key to advancing health equity. Consider what structures, frameworks, and findings will provide a 'win-win' situation for all.

Looking ahead, embedding health equity principles throughout our work, organizations, and daily lives allows us to build a more equitable, successful, and sustainable future. To have the potential of achieving a world with accessible healthcare for all, **we need more inclusive community ecosystems**. It starts by addressing the root causes of inequity and moving from theory into action. Bishop Desmond Tutu once said, "There comes a point where we need to stop just pulling people out of the river; we need to go upstream and find out why they're falling in."

Will you join us upstream?

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ESCAPING THE BAD HIRE – WHY ASSESSMENT TOOLS HAVE GONE MAINSTREAM

The use of candidate assessment tools has become more common for healthcare organizations of all sizes and types. If you haven't yet experienced this, either from the candidate seat or as a hiring manager, then it's probably time to get educated about these new ways to evaluate potential candidates. A few of the more commonly used platforms include The Hogan Leadership Forecast, The Predictive Index, The Watson-Glaser Critical Thinking Appraisal, and The Caliper Profile.

Source: Bigstock

To ensure the best possible fit for their team, healthcare organizations are increasingly turning to candidate assessment tools to assist and confirm their thinking around work style, cultural fit, and a variety of other factors. At the most senior levels, these assessments add substantial value and hopefully validate and reinforce findings from interviews.

These evaluations might provide information on a person's overall demeanor and personality, what challenges or behaviors may arise under stress, their best qualities, and their motivators. There are many variations of proprietary assessment methods (including day-long, in-person assessment centers), though many hiring leaders prefer to stay nimble and tailor the calculations specific to the demands and goals of the functions and organization, and to provide insights into the candidate's ability to perform.

It's important to understand the different types of tests and how they might benefit an organization's needs. All are designed to predict a candidate's performance at work. By making more informed hiring decisions, companies can help reduce turnover, increase job satisfaction, and reduce the risk of hiring the wrong person for the job.

- **Personality tests** evaluate an individual's characteristics and traits, including values and interpersonal skills, as well as how they might affect job performance. Employers gain a better sense of how the candidate will fit into the team and interact with others, as well as handle certain tasks and pressures. They aim to measure how well a person fits within a specific work culture and atmosphere. Personality tests explore motivations and inspirations that drive you. The best leaders demand skills beyond intellect and expertise, and the personality traits of an individual, including their beliefs and ethics, can play a substantial part in their ability to excel at the position.

- **Behavior assessment tools** provide insight into a candidate's tendencies and preferences in the workplace. These tools are often used to understand how well a candidate responds to change, handles tasks, and interacts with others. Additionally, they can evaluate a candidate's problem-solving skills, communication style, and overall job performance.

- **Critical thinking assessments** measure the ability to analyze and evaluate information. These examine logical reasoning, and the results are helpful when assessing a person's potential for success in a particular function based on how they problem-solve.

These reports can also yield huge benefits for the individuals taking them, as they provide advice on how to leverage strengths and address areas that may need development. They measure various personality attributes, including assertiveness, empathy, problem-solving, and goal orientation. There are very good sets of modules that range from ten to ninety minutes, and they can be administered online and tailored to leadership, personality, and behavior factors.

A few obvious words of advice if you're about to tackle this for the first time:

1. Reflect on your personality traits and your values.

2. Think about how you react to struggles, pressures, and changes, and then consider how they could be perceived by others.

3. Understand that the point of this activity is to measure your natural personality traits, so transparency is imperative when answering questions.

Employers sometimes ask their current employees to take these assessments to facilitate career development. They help identify developmental needs to better enable an organization to provide targeted training and growth programs.

Beyond their obvious use, these tools can also be leveraged by organizations looking to fortify their succession planning and leadership development. Another benefit companies have reaped from these tools is to improve their diversity and inclusion, demonstrating a commitment to hiring the best candidates in a fair and objective process. These companies are attempting to overcome any involuntary predispositions or biases in their hiring process, focusing instead on objective data and performance metrics, beyond subjective impressions.

Overall, candidate assessment tools are becoming a crucial component for better-informed hiring choices to drive business success. Companies are making doubly sure that new executives are a good fit for the organization and that these individuals possess both the behavioral leanings and skills necessary to thrive in their new jobs.

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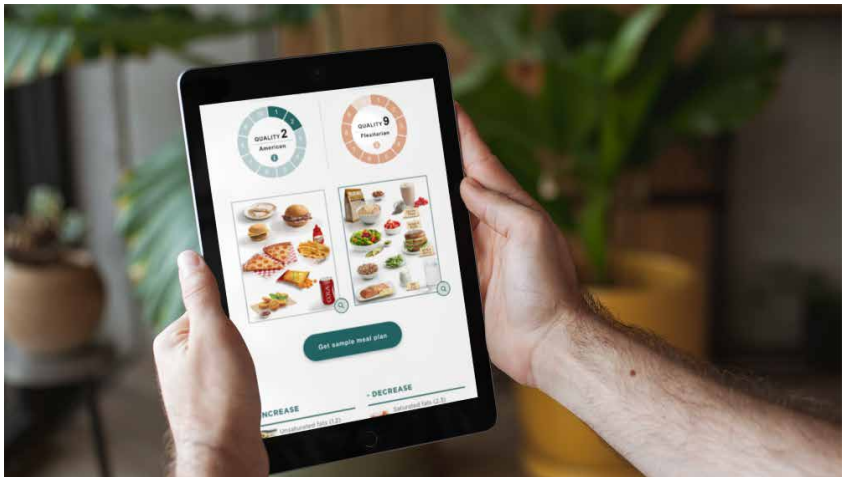
THE DOLLARS AND SENSE OF MAKING DIET QUALITY A VITAL SIGN



The transition to value-based care requires tools and tactics to tackle disease prevention and health promotion efficiently in clinical encounters. We routinely measure and monitor vital signs to manage chronic disease **progression**, e.g., blood pressure, blood sugar, lipids, BMI, but we have yet to implement a more upstream diagnostic that facilitates chronic disease **prevention and mitigation** as a standard of practice. To deliver on the promise of value-based care, it is imperative that we do so.

Objectively measured diet quality is the single leading predictor of chronic disease and premature death in much of the modern world.[1] We all know that how we eat affects our health, but how can a clinician get a pulse check in a standardized, low-friction way that generates a longitudinally tracked, discrete variable like blood pressure or BMI?

In 2020, the AHA published a statement recommending that diet be assessed and addressed at all clinical encounters.[2] Little action has been taken because providers aren't equipped to screen for diet quality at such scale. As Bailey (2021) delineates, each of the historical instruments to assess diet quality including food frequency questionnaires, 24-hour recalls, food diaries, etc., have substantial limitations, which have made their use at scale impossible.[3] Until recently, all the methods accessible to measure the healthfulness of someone's diet have been so burdensome for patient and provider that there has been no path to wide adoption.

HOW MIGHT WE EFFICIENTLY AND EFFECTIVELY MEASURE DIET QUALITY AT SCALE?

The optimal workflow to understand a person's diet quality involves limited, easy, patient-reported data and would equip rather than burden the healthcare provider. Similar to the PHQ-9, a now standard depression screening tool, the current healthcare system needs less 'paperwork' but more data to power better, prevention-oriented decision-making in every clinical encounter.

Enter the invention of the patented and extensively validated Diet ID tool, and now diet quality can be measured and managed rapidly, reliably, and at great scale – in as little as 60 seconds. Through a sleek and simple-to-use, web-based assessment, patients select digital images that represent their typical way of eating.

The Diet ID system analyzes a person's responses to report the Healthy Eating Index score, a robustly validated measure of overall dietary quality as it relates to health outcomes.[4] Diet ID also generates nutrient and food group intake of over 200 foods and macro and micronutrients to generate a personalized, condition-specific, nutrition plan for each respondent and equips clinicians with access to critical data about the person's dietary risk, details about current food intake, and details about goal food intake, empowering them to 'address' diet in a standard clinical encounter. Diet ID is also now integrated into Epic, to allow seamless workflow implementation of this critical metric.

The research on the validation and performance of Diet ID is robust.[5-8] Further, when Diet ID has been deployed alongside digital and/or human-powered nutrition counseling, meaningful improvements in diet quality have resulted.[9]

Diet quality now can be measured and managed at scale and with substantial efficiencies, but what about the dollars and cents of the matter? What's the business imperative? Healthcare, like other industries, must reap a positive financial return on investment to justify such significant transformation.

HOW DOES MEASURING AND MANAGING DIET QUALITY IMPROVE THE ECONOMIC HEADWINDS FACING HEALTHCARE?

There are several financial wins to scaling diet quality as a vital sign within traditional fee-for-service models as well as within value-based care models. This allows healthcare systems on either side or those straddling the old and new payment models to create a winning business case and generate a 95% margin on the investment needed to scale diet quality as a vital sign.

INCREASE UTILIZATION - IDENTIFY THOSE WHO NEED ADDITIONAL SERVICES

- Increase engagement in disease management prevention and management programs with incremental billing (diabetes prevention program, diabetes education, cardiac rehabilitation)
- Drive utilization of Registered Dietitian (RD) billable services and create vast efficiencies for those visits
- Increase engagement of healthy consumers by offering "health" care in addition to sick care.
- Improve patient experience by effectively addressing and supporting their lifestyle and offering opportunity for true health optimization

IMPROVE OUTCOMES TO GENERATE COST SAVINGS IN STANDARD CARE MODELS

- Empower primary care and other specialties to measure and improve diet quality in their populations.
- Enhance risk stratification capabilities to include a metric that is relevant across the risk continuum and drive early intervention
- Improve outcomes from medical procedures and reduce readmissions by intervening on diet quality

SAVE MONEY

- Reduce pharmacy spend when diet is measured and managed and disease is mitigated
- Reduce time and resources needed to manually conduct dietary assessments by in-house RDs.
- Improve diet quality in capitated populations to drive long-term healthcare cost savings

SUPPORT PROVIDERS

- Improve provider fulfillment by equipping them with a meaningful yet efficient way to address nutrition and chronic disease that doesn't require deep nutritional education

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THE DOLLARS AND SENSE OF MAKING DIET QUALITY A VITAL SIGN

REDUCE HEALTH INEQUITIES

- Reduce health inequities by addressing not only food insecurity but also diet quality as low income and food-insecure adults are at increased risk for obesity and diet-related chronic disease.[10] The financial case for measuring and managing diet quality is solid regardless of payment model and includes substantial direct and indirect return on investment. With the published return on investment calculator, you can do the math for your population and estimate the financial benefit for your organization to make diet quality a vital sign.[11]

With a scalable and effective method and a solid business case to support, the time is now for healthcare to address diet quality at every clinical encounter. By measuring and managing the root cause of chronic disease, providers will be equipped to counsel and empower patients to make incremental improvement to their diet and be able to monitor change longitudinally. With diet quality as a vital sign, a new way to curb the prevalence of chronic disease and the unsustainable healthcare spend, as well as a new standard of care, beckon.

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FROM TRANSACTION TO TRANSITION: PART 2 - STRENGTHENING ORGANIZATIONAL EFFECTIVENESS AND READINESS THROUGH LEADERSHIP TRANSITIONS

In the Spring edition of the *Wharton Healthcare Quarterly*, we introduced an approach to taking a strategic view of healthcare leadership transitions. Rather than treating leadership change as a transaction, or the routine swap of one leader for another, we advocate for treating the opportunity as a moment of transition with the potential to accelerate a variety of organizational objectives. Specifically, we advocated for the creation of a Transition Committee that would be tasked with using a key leadership transition to refresh and rejuvenate elements of the organization's strategy.

Source: Bigstock

In this next installment in the series, we will explore issues related to organizational effectiveness, and how healthcare entities can capitalize on leadership transitions to advance how work gets done effectively. In this series' final installment, coming later this year, we will detail ways in which cultural aspirations may be advanced through leadership transition.

First, an observation about leadership in general as context: leaders tend to shape the responsibilities and authority of their role over time. Effective leaders, through problem solving and trust building, fill in needed gaps and take on novel duties to help their organizations thrive. The longer they are in that role, the more significant that shaping is likely to be; it is a natural and necessary function. The challenge for an incoming leader in the wake of this shaping is to fulfill not just the formal duties of the role, but the informal shaping of the person that came before them. Likewise, the challenge for the organization — the Board, leadership team, staff, etc. — is to prevent themselves from falling into a belief trap in which the new leader is simply a 2.0 version of the previous one. Our colleague, Tom Gilmore, offers sage advice in his classic book, Making a Leadership Change: "Only as we more thoughtfully acknowledge both continuity and change will we be able to use leadership transitions as major opportunities for organizational development.[1]

So, what can organizations do to balance both continuity and change as they gear up for the successful entry and transition of a new leader? How can they sustain both organizational effectiveness and performance?

- **Understand the "current state" of the organization.** Before the new leader is announced, take stock of key organizational issues that are at play, stratify them, and determine how and when to act:
  - What is the situation?
  - What corrective action is needed?
  - What priorities can be addressed prior to the new leader's arrival?
  - What necessitates waiting, and why?

The Transition Committee could do this on their own or with outside support to create a shared point of view about what can reasonably be addressed in advance of the new leader's arrival and what should be put on hold.

- **Listen to key external stakeholders.** Bringing in a new leader to any mission-driven organization is an important strategic commitment, one that often represents a significant transition for the entire community. New leaders with exciting strategic ideas can become derailed early in their tenure by issues that may not have been addressed, but that must be tackled to move from strategy to action. The cost of failure for both the organization and the new leader can be very high, both economically and culturally. The perspectives of strategic partners, providers, grantees, government officials, community leaders, and many others are often excluded at the expense of internal engagement as organizations prepare for a leadership transition. These stakeholders can shine a light on both opportunities and challenges that insiders may not.

  - For example, in preparing for the CEO transition in a community-based health system, we learned that community partners held major concerns about the system shifting its strategy and approach to community engagement when the new leader arrived. Knowing this, the health system's Board and leadership team were able to mitigate the unfounded fear through a robust approach to stakeholder conversations and communications. It enhanced the system's relationships in the community and strengthened their ability to deliver on their strategic commitments.

- **Take advantage of the outgoing leader's experience and knowledge.** The outgoing leader can play an important role in creating the conditions for a stable and successful entry for their successor. The Board Chair or Transition Committee should conduct an "exit interview" with the outgoing leader well before their departure and should invite them to describe the organizational opportunities and challenges as they see them. This is complementary work to the first item we described above.

  - What are the less formal or perceivable ways that the leader gets things done?

  - What are the biggest risks to the organization? To the next leader?

  - What should the Board or others be prepared to do (or not) to successfully orient and onboard their successor?

  - What can the current leader and Board do to amplify opportunities and mitigate risks?

- **Share your learnings to inform transition planning and early action.** At this point, it may seem like it should go without saying, but it is essential to prepare the incoming leader with what you have learned. Many organizations fail to take this important last step, holding on to the information rather than using it to set shared expectations of the new leader, inform their early actions, guide a strategy to engagement and relationship-building, among others. The Transition Committee is well positioned to curate these findings and deliver them to the incoming leader with candor and clarity.

  - For example, we worked with a medical school that was onboarding a new Chief People Officer in the midst of an effort to redefine its values in partnership with its system partners. This CPO was thrust into the ongoing effort as its new leader. The project team identified a systemic challenge that had persistently faced other new leaders — introducing them to their very large, complex, multi-entity system. With this insight,

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the incoming CPO decided to record a short video message introducing both herself and the purpose of the values creation effort. The video was shown at the beginning of a series of listening sessions that had been designed to gather input on core values. Because the listening sessions were open to many people across the system, it was a great opportunity to be seen and heard at all levels. It was a novel solution to a stubborn challenge, and it has become a practice that other leaders saw and plan to emulate.

Top leadership transitions present important opportunities (and risks) around strategy, organizational identity, and culture for any institution. Yet many newly placed leaders struggle to succeed because their organizations are not prepared to help them through their transitions. While finding and hiring the best candidate is the central focus of a transition, organizations can benefit from more robust support throughout the transition (beyond the initial hiring) — and, in doing so, actively create the conditions for long-term success for the new leader and the organization.

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RECOVERING AND THRIVING POST-PANDEMIC - PART 8: DEALING SUCCESSFULLY IN TODAY'S EVOLVING PAYER ENVIRONMENT

The payer landscape has become increasingly difficult to navigate, especially during a time when healthcare providers need to maximize revenue capture potential for financial stabilization post-COVID. This article offers our perspective on the current landscape, along with tactics to help diffuse and manage tensions, navigate the maze of competing priorities/imperatives, and reach mutually agreeable outcomes supporting providers.

CURRENT CONTRACTING LANDSCAPE AND TACTICS

Our first observation is that the negotiation life cycle is extended – negotiations that may have previously concluded within a six-month window are now taking nine or more. This extended timeline is often a result of ongoing negotiation on amended or new contract language (even as rates are finalized), as well as the effort it takes to engage in meaningful data-driven negotiations, requiring more analytic resources to build and verify sophisticated models. Negotiators today are more physically distributed, e.g., still working remotely. This introduces more variables to the mechanics of the negotiation, including multiple time zones, limited capacity for both face-to-face and virtual meetings, and other factors introducing new bottlenecks slowing progress.

In addition to longer timelines, we are also observing that the tenor of negotiations is changing. Interpersonal relationships tend to be a little more tense, and at times combative, than they were in years past. This is an understandable phenomenon, given the increased pressure that both sides are experiencing. These include:

Payer	Provider
Pressure to manage tight and firm corridors for rate setting, specifically downward pressure on rates.	Pressure to increase revenue from managed care contracting relationships through rate improvement or other means.
Pressure to conduct more concurrent negotiations at once with a wider variety of provider types.	Pressure to close negotiations faster so benefits can be realized as soon as possible.
Pressure to conform to new guidelines in a post-COVID environment (e.g., changes in telethealth coverage.)	Pressure to remove guidelines to allow providers to practice more freely with less plan administrative oversight and sites of service.
Pressure to change contract language to be more favorable to the payer through increased flexibilities.	Pressure to ensure that contract provisions are clear to avoid misinterpretation, support predictability, and do not allow disruptive surprises.

In years past, provider terminations were very rare, only used in extreme circumstances when parties were very far apart, stalling the negotiations. The impact for all parties, including members, is significant – so terminations were considered extreme. These tactics are becoming more commonplace, where it is routine for providers to terminate their arrangements with payers without extreme circumstances at hand, and payers are more willing to accept terminations. Payers have started curating their networks and using terminations to force rate reductions. Even academic medical centers ("AMCs"), usually considered indispensable in payer networks, are now sometimes considered to be replaceable because other organizations are increasingly offering tertiary or quaternary care.

Providers are increasingly finding that decentralization through “remote first” work arrangements - or centralization and/or consolidation of multiple regions - are dramatically shifting how payer-provider relations teams connect with each other and with their communities. In years past, it was common for payers and providers to live and work in the same region, and as a result, deeper multi-year relationships were built over time. In today’s evolved work environment, these connections are being disrupted, removing some of the interpersonal aspects from relationships and in turn from the negotiations. Building a strong relationship helps drive forward negotiations in good faith.

TACTICS

To navigate this complex landscape, providers should become more comfortable with conflict and be prepared to educate payer-side representatives on both their provider organization's unique situation, and regional market dynamics more broadly. To arrive at mutually beneficial outcomes, we recommend both parties meet via phone or video in advance of starting a negotiation to level-set desired objectives and lay out a path forward.

Data is increasingly making an impact on how providers can position themselves when describing the value they bring to the payer network. Provider organizations should come to negotiations armed with data on market position, margin and cost structure, as well as clearly thought-out, non-negotiable deal points informed by the analysis. For example, provider organizations should know break-even by line of business, payer, and product, so they can demonstrate and defend why reimbursement cannot fall below a certain threshold. As decision support functions have become more sophisticated, providers can model specific scenarios, rather than using high-level percentages or estimated ratios that might not accurately represent the micro-level impact on dollars. In addition to internal data such as cost and quality, external data sources, including price transparency disclosures are now available. Investing in capabilities to intake and manipulate transparency files unlocks visibility into traditionally opaque allowable amounts and can highlight if payers have introduced pricing disparity for similar services with similar value.

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RECOVERING AND THRIVING POST-PANDEMIC - PART 8: DEALING SUCCESSFULLY IN TODAY'S EVOLVING PAYER ENVIRONMENT

Providers should be prepared to discuss how they have been making investments (by adding staff, building programs, etc.) that may increase the value of the billable services for the payer and their members. These investments are often strong indicators the delivery system is focused on improving services – such as directly increasing quality, connectedness/stickiness in the community and with community partners, and addressing health inequity and access. Examples include:

- Building post-acute care networks for stepdown care, such as skilled nursing facilities (SNFs), through referral standards and/or shared resources.

- Continuum of care partnerships among integrated and community-based organizations – ranging from social workers to inform acute care discharge planning, to referring to high-quality, cost-effective providers such as home health and non-institutional rehabilitation services (outpatient or in-home).

- Building additional access points – virtual and/or physical – to extend existing services into underserved neighborhoods. In cases where these investments are not offset by new revenue, it is helpful to quantify the additive value they bring to the payer network to strengthen negotiations.

Aside from tactics related to negotiating rates impacting overall reimbursement levels, it is important to cover tactics focusing on arrangements that positively impact yield or promote other payer objectives (investment in health equity.) As organizations think through how best to improve yield, they are increasingly finding "outside the box thinking" being welcomed by health plan counterparts. Some examples include:

- Partnering to agree on certain conditions where procedures are "gold carded" meaning that they are subject to abbreviated or lighter pre-authorization processes. This allows providers to deliver high-quality care under predetermined provisions without complex administrative burden. Aside from authorizing certain conditions, sometimes plans are open to "gold carding" providers for their full range of services. Congress even entertained this concept when the Gold Card Act was introduced in 2022. We continue to see interest by lawmakers and CMS in partnering with providers to reduce administrative burden.

- Discussing how plans can partner with provider organizations to deliver supplemental benefits – especially because Medicare Advantage plans are increasingly deploying them. These may be services provider organizations, particularly large integrated delivery systems, are already offering without reimbursement, including connector/navigator services to non-clinical/social care services. Payers are increasingly interested in contracting for these services when already-established delivery systems are prepared to handle high volumes of screening, coordinating, and referring activities for these non-clinical services. When health systems are already engaged in some level of provision, any additional revenue can be very impactful.

- Focusing on contract language that helps level the playing field between payers and providers, including not allowing unilateral amendments, retrospective audits and retroactive claims denials, pushing administrative policy into handbooks or online portals rather than in the contract document itself, and adding unnecessary steps which become roadblocks in the dispute resolution/escalation process. Other considerations apply depending on the specific situation among payers, providers, and third-party interests such as employer groups.

CONCLUSION

While the tactics we have covered here are not necessarily novel or transformational, they are critical in reacting to the increasingly difficult payer landscape framing today's negotiations. As the pandemic continues to change the definition of business as usual, we have found negotiations that conclude favorably are a direct result of investing enough resources to support the process. We will focus the next installment on tactics that help drive forward alternative payments and other value-based arrangements against the same challenging backdrop.

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LEVERAGING A SCIENCE AND EVIDENCE-BASED LEADERSHIP FRAMEWORK - PART 2

In the April issue of the WHQ, we introduced our Foundations of Grateful Leadership framework - a strengths-based framework supported by research and evidence-based practices in gratitude, positive psychology, neuroscience, and positive organizational behavior (POB).

Any new framework with terms such as positive, gratitude, and neuroscience can be easily misinterpreted or dismissed. Traditional frameworks can reject new models and practices even with deteriorating employee engagement, job satisfaction, and retention statistics. One reason can be how late an organization adopts (or remains skeptical of) innovation of new ideas.

Photo courtesy of Unsplash/Dulcey Lima

If there's one lesson the healthcare industry had to learn during the pandemic, it was an accelerated response to be resilient, quickly innovate and develop solutions to save lives, redesign work environments, and adopt new behaviors.

In Part 2, we further examine POB (Positive Organizational Behaviors) and strategies that incorporate the previously discussed topics of positive psychology, gratitude, and neuroscience.

WHY ADOPT AN EVIDENCED-BASED LEADERSHIP FRAMEWORK?

Leveraging a science and evidence-based framework offers the most progressive and promising framework for several significant reasons:

- It's driven by our universally intrinsic human need to know our existence matters - every employee, at every level of an organization, in all job descriptions.
- It maximizes human potential via strength-based performance.
- It develops leaders with skills and abilities that are typically less appreciated, i.e., empathetic listening, curiosity, and forgiveness, but which are urgently needed in today's unpredictable workplace.

In the opening letter in the 2022 Gallup State of the Global Workplace Report, Jon Clifton, CEO of Gallup, writes: "*Stakeholder capitalists think they have the solution. Using environmental, social, and governance (ESG) metrics, they encourage companies to report on their impact on everything from the environment to their workforce. But when it comes to the worker, most ESG reports focus solely on pay and demographics. These are critical, but how do we know if workers are being treated with respect? Or feel cared about? The real fix is this simple: better leaders in the workplace.*"

WHAT IS POSITIVE ORGANIZATIONAL BEHAVIOR?

POB is 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.

Studies in POB originated over 20 years ago. They included tenets of positive psychology and positive psychological capital (the positive developmental state of employees) with constructs of **h**ope, self-**e**fficacy, **r**esilience, and **o**ptimism (often referred to as HERO).

Findings in a study, "Relationship between Positive Organizational Behavior with Job Satisfaction, Organizational Citizenship Behavior, and Employee Engagement," support the relationship between POB and job satisfaction and employee engagement. Adding to our "*understanding of positive organizational behavior's key role in an organization and work-related performances*."

Another article examines as an indirect influence the importance of employees' perception that employers care and are supportive - allowing them to flourish, thrive, and be more intrinsically engaged in their work. It also included a questionnaire of various measurements in determining the impact of perceived organizational support, thriving at work, flourishing, and work engagement.

Here are select questions to jumpstart your assessment of how well your organization is poised for positive organizational behaviors:

PERCEPTION OF SUPPORT

- My organization strongly considers my goals and values.
- My organization cares about my opinions.
- My organization really cares about my well-being.

THRIVING AT WORK

- I continue to learn more and more as time goes by.
- I see myself continually improving.
- I am looking forward to each new day.

FLOURISHING

- I am engaged and interested in my daily activities.
- I actively contribute to the happiness and well-being of others.
- People respect me.

WORK ENGAGEMENT

- I am enthusiastic about my job.
- My job inspires me.
- I am proud of the work that I do.

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LEVERAGING A SCIENCE AND EVIDENCE-BASED LEADERSHIP FRAMEWORK - PART 2

WHAT DOES POSITIVE LEADERSHIP LOOK LIKE?

With the advent of POB came evidence-based leadership strategies to transcend challenging times. As researched and developed by Kim Cameron, Ph.D., positive leadership is supported by these components of Positive Leadership.

- **Positive Climate** – includes compassion, gratitude, and forgiveness. Expressing gratitude is done frequently, fairly, and appropriately. A Positive Climate has more helping behaviors vs. stonewalling or being territorial. Positive leaders ensure employees have support for their overall well-being, and their development is strengths-based.

- **Positive Relationships** – There are positive and negative energizers influencing your work environment. Most cultures tip to the negative because of how powerful negative emotions/energy are. Consider taking the Positive Self-Assessment by Dr. Barbara Frederickson to find your ratio of negative to positive emotions.

- **Positive Communication** – includes providing best self-feedback and focusing **negative feedback** on the detrimental behavior and its consequences (not the person). Numerous studies conclude that managers who practice positive leadership behaviors, particularly frequent, genuine, and strengths-based feedback, have more engaged teams and higher satisfaction.

- **Positive Meaning** – Your role as a leader is to help your staff find the meaningfulness of their role and tasks. Positive leadership does not ignore the negative and the challenges but taps into "positive deviance" and an affirmative bias of strengths and human potential.

According to Cameron, these positive leadership strategies enable positive deviance, i.e., creating environments that empower employees to perform at their best as consistently as possible and, in doing so, greatly exceed all performance expectations.

Positive organizational behaviors, psychological capital of employees, and supporting their health and well-being may not sound innovative. Yet, without adaptability of new models and practices and choosing a different mindset for how we lead threatens progress and diminishes growth.

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Want to learn more?

- Leveraging the Impact of Grateful Leadership - A Science and Evidence-Based Framework - Part 1
- 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

Featured Article

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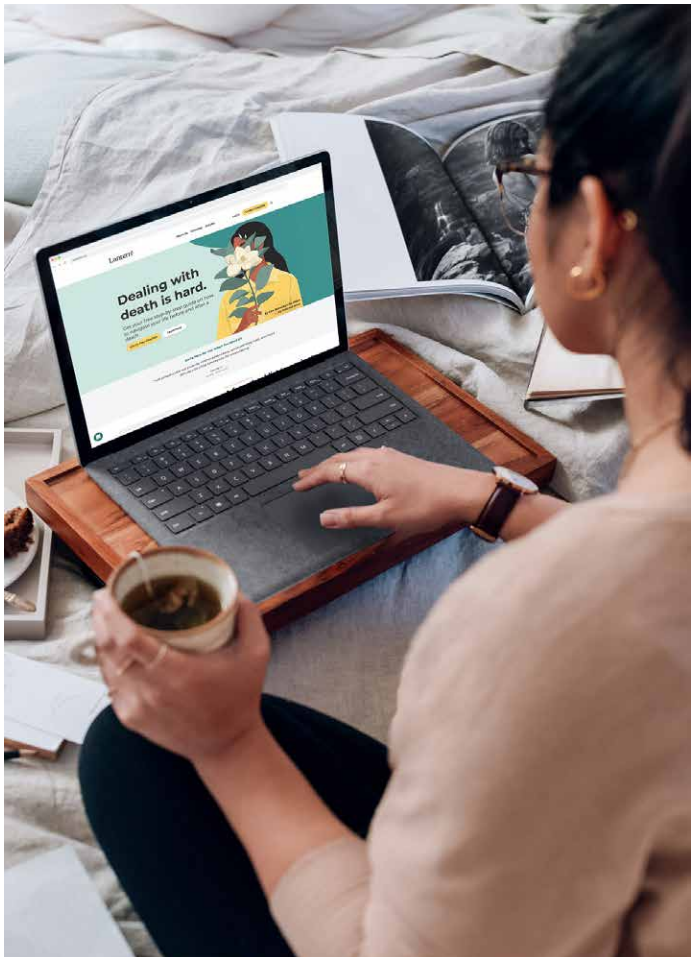
WHY HEALTHCARE PROVIDERS NEED TO TAKE A PROACTIVE APPROACH TO END-OF-LIFE PLANNING AND HOW TO GET STARTED

Most healthcare providers want to support their patients in end-of-life planning and facing mortality. So, why is the topic of end-of-life so rarely discussed in the healthcare setting? And when it is discussed, why is it often in the last moments of life when it's too late to make a legally sound plan?



In an era where death and loss are top of mind, it's time we make dramatic changes to better prepare ourselves. After all, we are human and, like birth, death is one of the most human things we'll experience. Americans are experiencing traumatic loss at a rapid pace. 57% of Americans are grieving a recent loss,[1] with 1 in 3 Americans having lost someone due to COVID-19[2] alone. For each person who passes away, there are 9+ newly bereaved[3] — who experience emotional *and* physical symptoms of grief.

Most adults recognize the need for an end-of-life plan, but few have created one. In fact, 6 in 10 U.S. adults have no plans in place for their end-of-life.[4] Further, research has shown planning improves quality of care, patient outcomes, and the bottom line for the healthcare system,[5] yet most people aren't asked to do them by their healthcare providers until they've reached end-of-life, if at all.

WHY HAS ADOPTION OF END-OF-LIFE PLANNING BEEN SO DIFFICULT TO IMPLEMENT IN HEALTHCARE TO DATE?

While there are many reasons to be cited, Lantern has found a number of repeating issues in our work with healthcare systems. These include:

1. **Death is treated as failure versus nature.** Not only does this put extreme pressure on healthcare professionals to work miracles, this mentality has caused a massive lack of medical expertise in palliative care. Palliative care is not required in most medical schools or is treated as an elective course.[6]

2. **A big, unanswered question remains.** Who pays for end-of-life planning services? Currently, there are CPT codes that cover discussion on end-of-life planning, but don't require any resources to be provided to complete the paperwork. Free services are more palatable, but often liability concerns from the healthcare system get in the way of distribution of external resources.

3. **Cultural disagreement** on when in the care continuum end-of-life planning should happen and who should be responsible for discussing it.

4. **EMRs (and other software) that don't speak to each other.** For healthcare systems that do have some form of end-of-life planning documentation in place, it's often a challenge to find the documentation when it's needed.

5. **Distrust in healthcare having your end-of-life plan.** For many patients, decades of distrust in our healthcare system have led to concern in providing end-of-life plans. This stems from fear the paperwork will be misused, and necessary intervention won't be taken.

WHAT NEEDS TO HAPPEN FOR HEALTHCARE SYSTEMS TO SUCCESSFULLY IMPLEMENT END-OF-LIFE PLANNING SERVICES?

1. **Early patient exposure to end-of-life planning.** Studies show the introduction of planning starting at 18 reduces anxiety and reluctance around future planning. It has been proven highly effective for GPs to be the first to introduce these documents, regardless of health concerns or age. For example, 96% of people who die in La Crosse, Wisconsin have an end-of-life plan, compared to ~30% nationally. As a result, La Crosse, Wisconsin spends less on healthcare for patients at the end-of-life than any other place in the country.[7]

2. **While individuals within healthcare are overwhelmingly positive on the idea of providing end-of-life planning resources, the decision to implement a solution needs to come from the top.** Until it's acknowledged that a good death is the responsibility of the healthcare system, no progress can be made.

3. **Better research needs to be made available.** As of right now, there are a number of case studies showing healthcare savings when end-of-life planning is completed by patients. Still, no large-scale study has been completed proving the ROI and the detriments to individuals, families, and the healthcare system when plans aren't put in place and properly utilized.

WHAT CAN HEALTHCARE PROVIDERS DO RIGHT NOW TO IMPROVE UPON THIS ISSUE?

1. **Educate yourself.** Become literate in speaking about death and arm yourself with the resources to properly support and prepare every patient. Lantern has a great resource to get started.

2. **Make it a part of your routine.** Practice these conversations with every adult patient, regardless of health concerns or age.

3. **Engage in larger forums on the topic.** Discussing new offerings for your hospital? Involvement in research on improving quality of care? Speaking on a panel about healthcare outcomes? Part of the challenge in bringing better end-of-life care to patients is the lack of conversation around the topic at conferences, in the boardroom, in research, on panels, in the media and beyond. You have the knowledge now, so ensure this topic isn't skipped next time you're in a professional setting.

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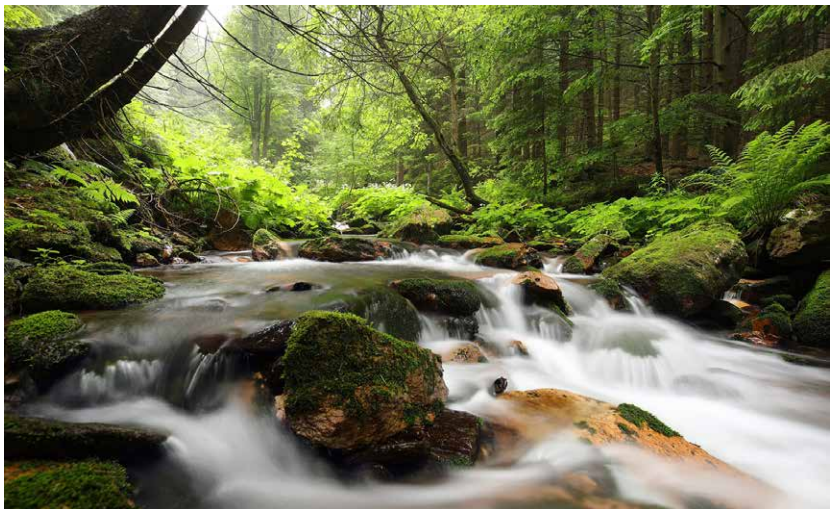
TAKING A PERSONALIZED APPROACH TO SPIRITUALITY IN HEALTHCARE

PERSONALIZING SPIRITUALITY IN HEALTHCARE

When I meet with a patient to address their spirituality within the context of their healthcare, we explore a series of "big questions" to help a patient identify and describe their spirituality. We seek to discover what makes life meaningful for them, what sustains them spiritually through hardship, and where their spiritual health may be deficient and in need of support or nurturance.



Source: Bigstock

This inquiry takes time and careful attention. It requires provider curiosity and openness to the unique spiritual life of a person, the skilled ability to listen for, illuminate, and guide a person toward what they need spiritually within the relational, social, cultural, religious, economic, and ecological contexts of their life. It requires clinical knowledge and expertise in areas like spiritual and religious traditions, spiritual development, and evidence-based practices.

A personalized approach to spirituality extends to the patient family system as well as the individual patient. A recent study found that providing more intentional and intensive chaplain support to family members of ICU patients resulted in a clinically significant decline in mental health symptoms.[1]

Patients experiencing serious or chronic illness are especially vulnerable to spiritual distress and need to feel safe to address their spiritual needs. In 2022 a team of researchers conducted a systematic review of evidence concerning spirituality in serious illness. Their top three recommendations with implications for healthcare are: (1) provide patient-centered spiritual care for seriously ill patients, (2) educate interdisciplinary care teams of seriously ill patients on spiritual care, and (3) include specialized spiritual care practitioners in the care of seriously ill patients.[2]

DEFINING SPIRITUAL HEALTH

In 1998 the World Health Organization (WHO) identified spiritual well-being as the 4th dimension of health, joining the previously identified dimensions of physical, mental, and social health. A definition of this 4th dimension followed in later years:

"Spiritual health is a: state of being where an individual is able to deal with day-to-day life in a manner which leads to the realization of one's full potential; meaning and purpose of life; and happiness from within."[3]

Beliefs, values, practices, and experiences of connection with self, others, nature, and transcendence contribute to spiritual health, as may participation in religious community and intentional service or social justice work.

For many years I led the spiritual wellness department of a renowned integrative healthcare facility, working with thousands of patients seeking to address their health needs from a whole-person perspective. This required collaboration with physicians, nutritionists, exercise physiologists, sports and complementary medicine practitioners, behavioral health therapists, and health coaches. Within this integrative context, it became evident that spirituality is: 1) rarely considered within healthcare at the expense patient of well-being; 2) foundational to health and well-being; and 3) particular to an individual and deeply personal. A skillful, personalized approach to spiritual health also requires specialized attention from expert providers.

FOUNDATIONAL HEALTH BENEFITS OF SPIRITUALITY

A 2013 review of empirical literature addressing religiousness, spirituality, and physical health proposed that spirituality is strongly associated with emotional regulation (which reduces stress reactivity and risk of related health issues), and religiousness is strongly associated with better health behavior habits.[4]

The findings from research on spirituality are compelling for chronic disease prevention, mental health, and longevity. Examples of research areas that illustrate the personal nature of spirituality include:

- **Purpose:** Life purpose is particular to a person and includes having a meaningful direction in life accompanied by goals and activities that make it worth living. The Midlife in the United States National Study of Health & Well-Being generated a significant body of research identifying the extensive health benefits of a purposeful life, including reducing risk of disease and substance use, improving physical health and cognitive function, and increased longevity.[5]

- **Practices:** Contemplative practices that activate the relaxation response, deepen present moment awareness, and invite connection to self, others, nature, or the transcendent have demonstrated health benefits. Meditation, prayer, being in nature, creative expression, movement, ritual, and caring service, and practices that contribute to mindfulness and forgiveness have received significant research in thousands of studies. Each person has unique practice interests and capacities, and some practices, like meditation, are situationally contraindicated. No one practice fits all.

- **States and Traits:** Zest, hope, gratitude, and self-regulation were recently identified as character strengths most consistently associated with positive health outcomes.[6] Hope, in particular, aids in development of will or personal agency for sustaining positive lifestyle changes. It also contributes to resilience when faced with adversity like injury, illness, and loss. Physicians who talk with patients about spirituality may encourage realistic hope in the face of such adversity.[7] Qualities a patient would benefit from developing, and how best to do so, must be individually identified.

Researchers have also established that adverse childhood experiences and the associated toxic stress response contribute to chronic disease, mental health conditions, substance misuse, and reduced longevity.[8] Spirituality helps reduce stress and transform post-traumatic stress into post-traumatic growth.

Healthcare that fails to incorporate a personalized approach to spirituality is fundamentally incomplete, ineffective, and potentially negligent. Taking a personalized approach to spirituality in healthcare may not be fast or efficient, but it offers the opportunity for organizations to fulfill their potential as sources of healing and wholeness.

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WHARTON AROUND THE GLOBE: WHARTON GLOBAL HEALTH VOLUNTEERS (WGHV) PARTNERS WITH SOMO TO INCREASE COMMUNITY INVESTMENT IN FOOD AND HYGIENE PRODUCTION

Wharton Global Health Volunteers, a student-run club that provides pro-bono consulting services for opportunity-rich health and healthcare organizations, partnered with Somo Africa as one of its projects in Fall 2022. The goal of the project was to develop a partnership model to help Somo scale its acceleration model for entrepreneurs in Kenya and Tanzania.

Somo, founded by Amelia Hopkins Philips in 2016, provides educational opportunities for micro-entrepreneurs across Kenya. Somo is the root of a Swahili word meaning "lesson"; it is fitting because Somo provides educational opportunities for micro-entrepreneurs across Kenya, now with hubs across Nairobi, Mombasa, and Kisumu. They have trained over 1,692 entrepreneurs, funded 340 businesses, created 7,161 jobs, and achieved a median annual revenue growth of 258%. Among entrepreneurs trained, half are women, and nearly 85% are under 35 years old.

Somo's impact extends to improving healthcare conditions through (1) investments in agricultural and processing businesses that comply with healthcare standards and provide quality food products and (2) investments in circular economy businesses to improve access to clean water. By the end of 2022, Somo entrepreneurs produced 258,674 kg (570,278 pounds) of healthy food and provided 33,329 families with clean water.

The main challenge for Somo is scaling its operations while maintaining the effectiveness of its training centers and production facilities. To address this issue, the WGHV team developed a partnership model for Somo to manage new facilities and collaborate with other organizations for training. By partnering with different organizations, Somo can expand its campuses at a faster pace without increasing its own team size.

Throughout the semester, the WGHV team conducted user experience interviews with the Somo team, entrepreneurs, and partners to identify pain points and opportunities in their interactions. This research helped them understand the dynamics among stakeholders and explore additional training options to enhance the quality of Somo's product and reach a larger market.

WGHV Team visiting the Somo production facility in Tengeneza, Kenya
From left to right: Sarah Caldwell (WG'24), Mateo Guerrero (WG'24, G'24), Rainbow (Laan) Yeung (WG'24), Maureen Mora (Commercial Partnership Manager at Somo), Oscar Leandro (WG'23, G'23), Marcel Tatum (WG'24), Josephine Okuku (Production Facility Supervisor)

In December 2022, the WGHV team visited Somo in Kenya to conduct on-site research with Somo teams, entrepreneurs, and local and international partners. Site visits included stops in Mombasa, Nairobi, and Kibera – where they observed the passion and commitment of the Somo teams, learned about the challenges and opportunities in each location, and visited Somo businesses to understand the production processes and personal journeys of entrepreneurs.

After introductory conversations at each site, the WGHV team then participated in targeted discussions to gain inputs to the partnership model and present the final model. In Mombasa, they met with local and international partners, including USAID and the Red Cross, to learn more about their work with Somo and future directions for entrepreneurs. In Nairobi, they visited the Tengeneza production facility, where they explored potential partnerships to improve operations and services. This pay-per-use facility has all the equipment and support to ensure that entrepreneurs can produce food, hygiene, and beauty products complying with all the health and quality standards – but additional partnerships could help expand the number of entrepreneurs able to use the facility. Finally, in Kibera, the team visited Somo's headquarters and presented Maureen Mora, the commercial partnership manager, the preliminary partnership toolkit.

The partnership toolkit, which relied on interview input gathered throughout the trip, a survey shared with entrepreneurs, and expert input from external sources, consisted of three models whose purposes were to (1) capture all potential leads and ongoing efforts, (2) manage partnership, including key performance indicators (KPIs), at the individual partnership level, and (3) aggregate information across different partnerships, providing a comprehensive view of the "Somo portfolio." A shoutout to Wharton students Rainbow (Laan) Yeung and Ibsen Coutinho, who virtually delivered the workshops to the partner managers, facility supervisors and business leads of all Somo campuses in early 2023. Maureen was quick to implement the

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WHARTON AROUND THE GLOBE: WHARTON GLOBAL HEALTH VOLUNTEERS (WGHV) PARTNERS WITH SOMO TO INCREASE COMMUNITY INVESTMENT IN FOOD AND HYGIENE PRODUCTION

new process and is focusing on increasing the impact of Somo in Africa by providing new trainings in current campuses and growing to new communities.

The WGHV team is grateful for the opportunity to gain insight into the East African healthcare and social impact landscape working in partnership with the Somo team. We learned about how healthcare initiatives start at prevention and supply chain, especially when access to formal healthcare services is scarce, and how community investment goes a long way to provide access in low income and at-risk locations.

After this experience, HCM students Sarah Caldwell and Rainbow (Laan) Yeung, and Lauder student Mateo Guerrero have stepped up as presidents for the Wharton Global Health Volunteers for the 2023-2024 academic year. Sarah, Rainbow, and Mateo have the goal of increasing the reach of projects and give opportunities to Wharton students looking to develop skills in consulting, healthcare, emerging markets, and social impact.

WGHV is grateful for the generous, ongoing support of the Wharton Healthcare Management Alumni Association that allows our teams to continue to have 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 and have a goal of supporting three teams per semester with minimal cost to students for travel abroad (and zero cost to clients). If you have any leads for potential projects – or if you would like to make a tax-deductible donation to support a future trip – please reach out to the WGHV Executive Board.

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WGHV Team with Somo entrepreneurs in the Mombasa campus

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