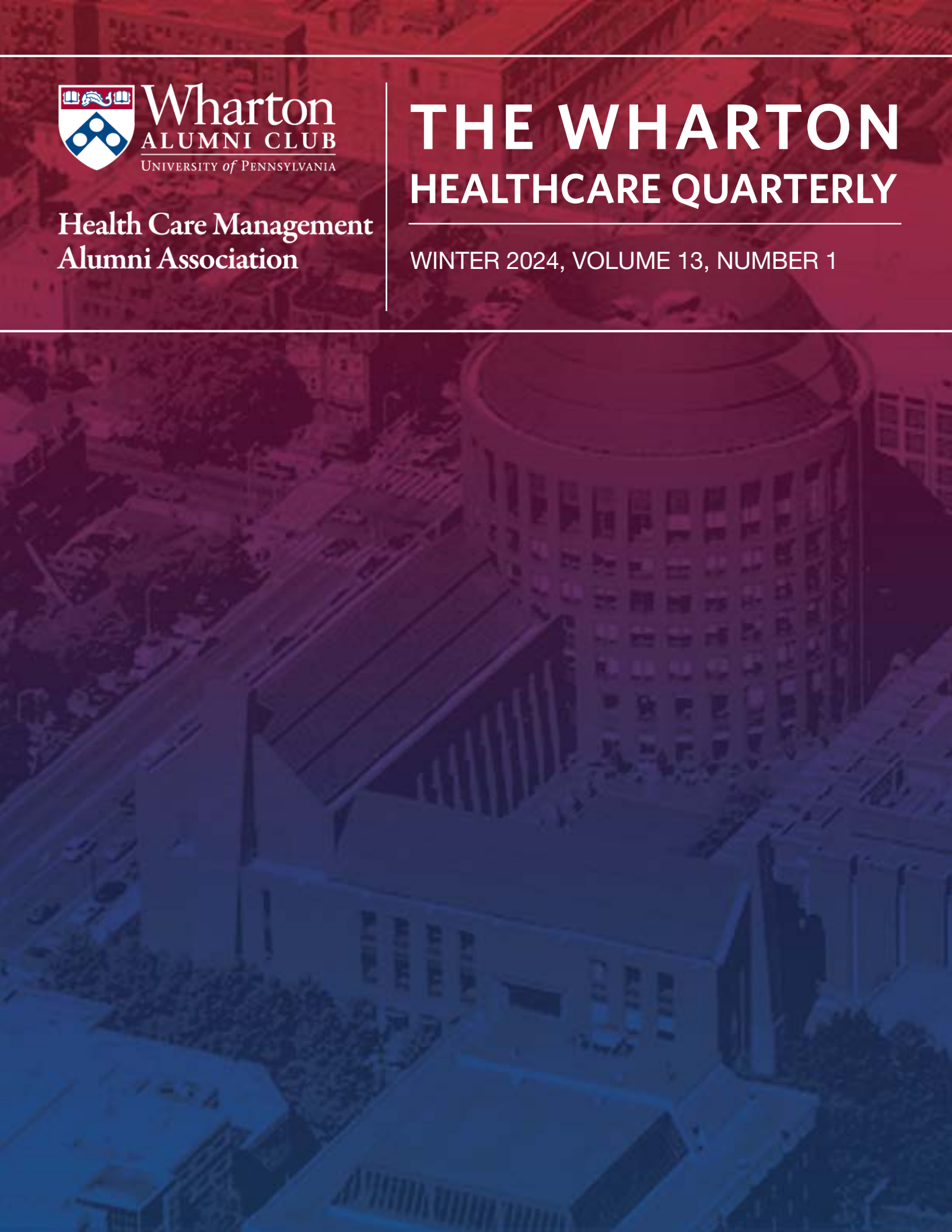

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UNIVERSITY of PENNSYLVANIA

Health Care Management Alumni Association

THE WHARTON HEALTHCARE QUARTERLY

WINTER 2024, VOLUME 13, NUMBER 1

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EDITOR'S LETTER

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

To learn
more about Colette, click here.

Happy New Year!

With the turbocharged takeoff of AI, dramatic changes from CMS with regard to Medicare Advantage plans, and a presidential election on the horizon, 2024 is guaranteed to be a year of rollercoaster change.

And change brings new opportunities to address unmet needs, improve health outcomes, reduce the cost of care, increase physical and mental well-being, and bring greater equity to the healthcare arena. How will you contribute to making the world a better place?

"I cannot say whether things will get better if we change;
what I can say, is they must change if they are to get better."
~ Georg C. Lichtenberg

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Managing Editor
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THE PRESIDENT'S DESK

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

This fall has flown by as our alumni board Conference Committee prepared for our annual Wharton HCM Alumni Association Conference. The theme was "Healthcare, Disrupted: Navigating the Revolutionary Forces Reshaping Health Care," and the event was again held at the Inn at Penn in late October. The conference kicked off Thursday evening with a dinner honoring the speakers, followed by a day full of varied content and wonderful conversations with well over 100 new acquaintances as well as old friends. I was inspired by the insightful discussions during the array of breakout sessions, spanning topics from AI in Healthcare, Eldercare, Life Sciences & MedTech Dealmaking, The Flux of Healthcare Systems, to Navigating Career Transitions; and as well as our impactful keynote speakers, including Julian Harris MD, WG'08 and Margaret-Mary Wilson MD, MBA, MRCP, FNMCP.

I'd like to take the time to thank the countless hours and dedication of our entire conference committee, led by Bryan Bushick, WG'89 and Hannah Plon, WG'22. I am truly thankful to serve alongside my fellow board members, as such an excellent event would not have been possible without their unwavering dedication. When our alumni are needed, so many individuals are ready to pitch in and help at the drop of a hat; it's yet again a true testament to the passion of our alumni association.

Our Career Development Committee led by Michael Rovinsky, WG'86 continues to provide ever-useful webinars, with the latest this past December, entitled, "'Tis the Season: How to Package Yourself to a Top-Notch Hiring Manager or Headhunter" with Molly Robb, Managing Director of Life Sciences and Healthcare, at LifeSci Search.

Jumping right into 2024, our second pinnacle event of the year, the annual JP Morgan reception at 620 Jones was yet again another overwhelming success! In the coming months, we are looking forward to hosting more events at upcoming industry conferences and cities across the country. If you would like to help coordinate an event in your city, please let us know!

Looking ahead, please join many alumni in returning to the Union League of Philadelphia on February 15th-16th during the 30th annual Wharton Health Care Business Conference, "The Resilience Edge: Innovating Healthcare in the Face of Adversity." As many of my days are spent focused on the care of individual patients with advanced cardiac disease, frequently making challenging care management decisions, I am always excited to change gears and take a quick Amtrak ride back to Philadelphia to attend the conference. Each and every year I attend, I am always energized and inspired by the engaging dialogues during the day, as well as fulfilled through catching up with close friends and classmates in between sessions.

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PRESIDENT'S DESK

I want to ensure that you all never miss a beat of the happenings of our alumni association. Please don't hesitate to reach out if you have an interest in joining our committees or have an idea to strengthen our community.

I wish you all a happy and healthy start to the new year!

Kind regards,

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

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LinkedIn Profile

ALUMNI NEWS

Anna Irving, WG'21
Zuranolone is a huge triumph for PPD — but it could negatively impact women's health research.

The first-ever FDA-approved pill for postpartum depression is a landmark achievement, but it could come at a high cost for women in more ways than one.

Learn more.

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THIS MONTH'S PHILOSOPHER:
Pete Hanna, WEMBA 44, WG'20

To learn more about Pete, click here.

THE PHILOSOPHER'S CORNER

Pete Hanna, WEMBA 44, WG'20

LIFE LESSONS

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

- Possibly obtained my MBA earlier. No doubt the timing of my Executive MBA at Wharton was in line with my leadership track and maturity and was the right one for my health system leadership journey. However, there is always the entrepreneurial side of me that is quite interested in making a positive impact on a large scale which could have benefited from getting my WEMBA 10-15 years earlier, when taking the risk of an entrepreneurial pivot would have been more palatable.
    - That said, I do believe that I am where I belong and could not be happier. Impact comes in different forms and different avenues, but in this fast-paced healthcare evolution that we are in the middle of, it should be a factor in deciding when to enter the MBA track for those who are contemplating it.
- Dedicated more time to traveling and exploring the world and most specifically, outdoor adventures that force you to disconnect completely from your devices and connect with nature. Having hiked the Inca Trail to Machu Picchu was a life-altering experience that made me realize the value of technology detoxification, connecting with nature, and appreciating the simple beauty around us even for a city boy at heart like myself.

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

- Hesitated to say no. When you are so driven to make an impact, it is quite easy to overstretch and take on more than you can deliver to completion. Sometimes you have to prioritize, delegate, or simply say no if you want to deliver meaningful change.
- Been hindered by the perception of simplicity. Great transformational innovations were often simple ideas that were taken on by their founders without worrying that someone surely has already thought about them or whether they were too simple or too obvious. Courage is the engine of innovation, and if you have a good idea, pursue it, and don't give in to doubt or worries about simplicity.

FAVORITE QUOTES

1. "Your time is limited, don't waste it living someone else's life." ~ Steve Jobs
2. "Be as you wish to seem." ~ Socrates
3. "I think we all have empathy. We may not have enough courage to display it." ~ Maya Angelou
4. "Learning to stand in somebody else's shoes, to see through their eyes, that's how peace begins. And it's up to you to make that happen. Empathy is a quality of character that can change the world." ~ President Barack Obama
5. "The adventure of life is to learn. The purpose of life is to grow. The nature of life is to change. The challenge of life is to

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THE PHILOSOPHER'S CORNER

overcome. The essence of life is to care. The opportunity of life is to serve. The secret of life is to dare. The spice of life is to befriend. The beauty of life is to give."
~ William Arthur Ward

RECOMMENDED READING

1. *Compassionomics* by Stephen Trzeciak
2. *The Key to Inclusion* by Stephen Frost
3. *The Five Dysfunctions of a Team* by Patrick Lencioni
4. *Fierce Conversations* by Susan Scott

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AFFIDAVIT: HEALTHCARE AND THE LAW - GENERATIVE AI IN HEALTHCARE: PROMISE AND PITFALLS

Generative artificial intelligence (AI) remains a hot topic in legal and healthcare circles, but the conversation has shifted from the initial wonder of "What can it do?" to the present cautiousness of "What should it ***not*** do?" One reason for this shift came in March 2023, when Google revealed the newest version of its Med-PaLM, a Large Language Model (LLM) that passed the United States Medical Licensing Examination with an 86.5% accuracy rate.[1] A 2022 version had achieved a 67.2% accuracy rate, also a passing score.[2]

With the advent of generative AI models like Med-PaLM and ChatGPT, providers can now type complex medical questions into a chat box and receive sophisticated (and hopefully accurate) answers. This ability surpasses previous AI applications in the potential to serve patients, but also in the potential to run afoul of laws like corporate practice of medicine (CPOM) rules, the False Claims Act (FCA), and FDA regulations. These concerns — on top of the risk of a generative AI model fabricating answers, known as "hallucinations" — mean that providers should proceed with extreme caution before implementing generative AI tools into their practices.

We have covered the importance of privacy and informed consent in previous column articles, but the use of AI raises unique issues regarding the potential to violate privacy rules. As covered before, even the best efforts at data deidentification can be thwarted, but specific to the use of AI tools, a person who knows the right questions to ask may be able to solicit output or deduce information that should be hidden. Further, most generative AI models learn from each interaction with them, causing potential privacy issues with any question or input to a model that itself contains confidential or personal information.

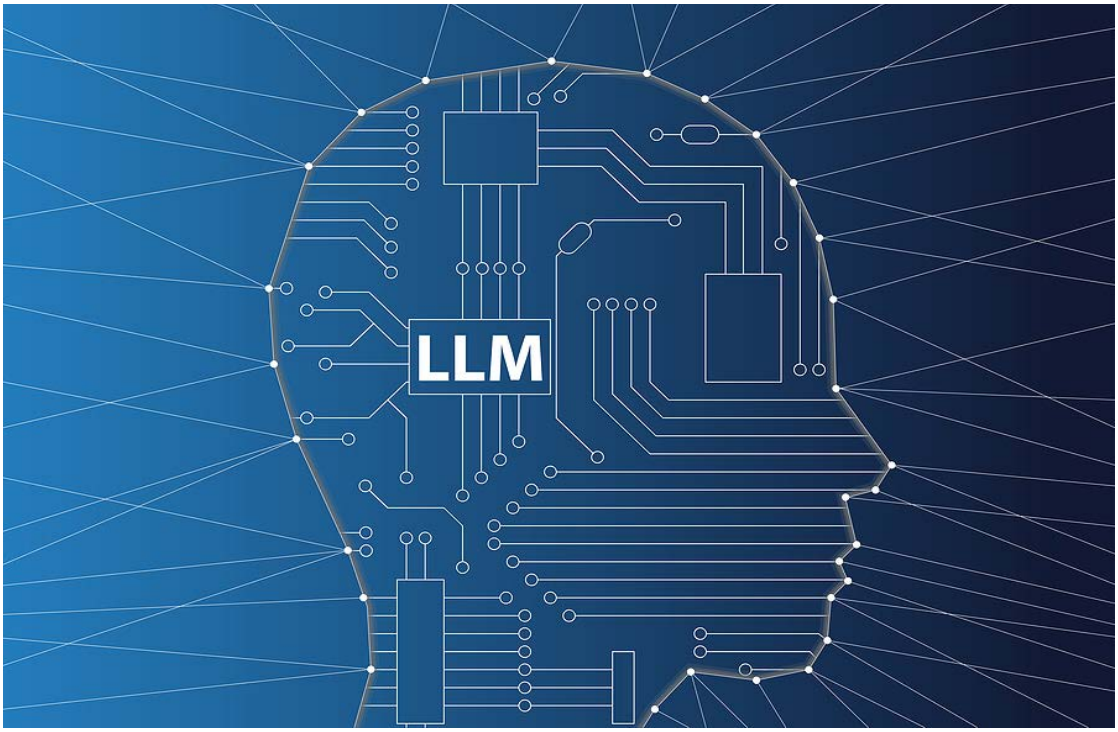
The use of generative AI tools also raises numerous legal questions with respect to CPOM rules. CPOM statutes typically prohibit any person without a medical license from practicing medicine.[3] Because only natural persons can obtain a medical license, this means that corporations and other entities cannot practice medicine.[4] Neither can an AI model obtain a medical license. So, when a user asks an AI model for medical advice and receives a sophisticated response that could plausibly have been provided by a licensed provider, CPOM rules may ask where is the line between providing information and practicing medicine? And, as is the case in all such AI applications, if the use of an AI model does cross that line, who may have exposure for a CPOM rule violation?

This potential liability question exists at various levels with respect to the use of AI applications, but it becomes a major concern when providers can ask complex questions in written English the same way they would ask a qualified human those questions. When a provider relies on an AI tool's output, a patient suffers harm, and the patient sues the provider, who may have liability for that harm? And more importantly, since AI models are known to make errors, how can providers use AI tools in a way that avoids harmful answers?

These questions are both legal and ethical, prompting ethicists to propose frameworks and call for regulation to address these problems.[5] Until such regulations arrive, navigating the legal implications of these risks remains a blurry business; once the regulations arrive, they may provide clarity and mitigate patient harm, but every new regulatory regime raises novel issues and requires new expertise to navigate.

The question of who is performing a medical service poses a problem in the reimbursement space as well. If a provider uses an AI tool to perform a service, can the provider bill a payor for the performance of that service? Payors may argue that under certain circumstances an AI tool is performing a service, and a provider is not. And because payors do not reimburse for services not performed by providers, the payor may not reimburse that service. As a result, AI could lead to provider-payor disputes and, potentially, revenue losses for practices.

Further, and specific to claims submitted to federally-funded payors, providers may be at risk of potential FCA violations. Billing Medicare and Medicaid for services not actually rendered is a false claim punishable by participation exclusion, fines of up to $20,000 per claim, and imprisonment of up to five years, among other penalties.[6] Under certain circumstances, CMS might argue that a provider who bills Medicare for a service performed by an AI tool has submitted a false claim. Other hypothetical FCA violations, under the right circumstances, could include, for example: acting on an AI tool's recommendation of unnecessary services; an AI tool's use lowering the level of provider decision-making required for emergency department claims, resulting in a claim that does not justify the level billed; and having an AI tool in the reimbursement department up-code claims.



Source: Bigstock

Haphazard use of generative AI could also potentially get providers in trouble with the FDA. Under certain circumstances, FDA might argue that certain use of AI in a healthcare facility is "intended for use in the diagnosis of disease or other conditions," thus satisfying FDA's definition of "medical device" and subjecting such AI use to FDA regulation.[7] FDA, of course, has a series of steps one must take before receiving approval for a medical device. This

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consideration primarily concerns AI model and application developers, but anyone using the AI model should be aware of the implications of potential FDA regulation as well.

One last risk to consider is fabrication or "hallucinations." Generative AI models are not programmed to tell the truth, they are programmed to produce answers that match an algorithm that was itself trained on real-world data. Typically, matching an algorithm trained on real-world data is a very good proxy for matching the truth. But it is only that: a proxy. Sometimes, a completely fabricated answer will match the algorithm better than a true one, especially where no good answer exists to the question posed. Generative AI models have fabricated basic facts and even complete citations out of whole cloth, all because those fake answers better matched the model's algorithm than any other answer it could generate.[8]

Those in legal circles will be familiar with a recent lawsuit where an attorney used ChatGPT to write his response to a motion to dismiss, and the response contained several perfectly formatted citations that were completely made up.[9] These fake answers look — by design — very real, making them difficult to spot unless one is looking for them or independently verifying them. This possibility of realistic falsehoods calls into question the extent to which providers ought to use generative AI and again alters the liability calculus in the event of a harmful answer.

And, of course, the use of AI is susceptible to familiar problems with the use of any computer technology: a provider's computer network can always be hacked, a provider can type the wrong information when asking an AI tool a question, an AI model or application developer can make an error in development that increases the probability of producing a wrong answer for a patient, etc. Therefore, although recent developments bring many new opportunities to improve patient care, they bring at least as many potential legal pitfalls. As the saying goes, AI will not replace doctors; doctors who use AI will replace doctors who don't. Those doctors, however, will succeed in using AI only if they do so with proper caution.

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

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2. *Id*.

3. For example, Illinois's CPOM statute provides that "[n]o person shall practice medicine . . . without a valid, active license to do so." 225 Ill. Comp. Stat. 60/3.

4. See *The People v. United Medical Service*, 362 Ill. 442, 454 (1936) ("No corporation can meet the requirements of the statute essential to the issuance of a license.").

5. E.g., Stefan Harrer, *Attention is not all you need: the complicated case of ethically using large language models in healthcare and medicine*, 90 eBioMedicine (2023).

6. 42 U.S.C. § 1320a-7a(a)(1)(A); 18 U.S.C. § 287.

7. 21 U.S.C. 321(h).

8. Mehul Bhattacharyya et al., *High Rates of Fabricated and Inaccurate References in ChatGPT-Generated Medical Content*, 15 Cureus 1 (2023).

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TO YOUR HEALTH: MAKING SPACE TO MIND OUR MORTALITY

In his Pulitzer Prize-winning book, *The Denial of Death*, cultural anthropologist Ernest Becker sums up a main tension we sense when we confront the reality of our mortality: "Man is literally split in two: he has an awareness of his own splendid uniqueness in that he sticks out of nature with a towering majesty, and yet he goes back into the ground a few feet in order to blindly and dumbly rot and disappear forever."[1]

What Ernest Becker talks about - this psychological conflict of our individual uniqueness and the realization that we all meet the same fate in death - informed the development of a field of research in psychology called "Terror Management Theory (TMT)." The basic gist of TMT is that our awareness of our mortality produces so much stress and anxiety that we are driven to find a way to make meaning and pursue immortality, both literally and metaphorically.

Literal immortality includes all the ways we try to prolong life and resist aging, from diet and exercise to cryogenics. Metaphorical immortality may be found in the ways we desire to leave behind legacy, from creating businesses and works of art to having children to continue our lineage. By busying and distracting ourselves with pursuits of immortality, we seek to avoid or ignore the inevitability of death.

But acknowledging our finitude and fleeting time on earth can actually be good for us and prompt us to consider what truly matters and to then align our lives accordingly. Research findings also support the benefits of facing our mortality. One study conducted in 1994 surveyed staff at a medical center in California and asked them to rate the importance of 16 different goals before and after they experienced a devastating earthquake. The survey results indicated a shift towards intrinsic goals (e.g., cultivating close relationships, doing creative work, developing as a person) from extrinsic goals post-earthquake. Respondents who had most strongly feared they were going to die in the earthquake were most likely to indicate a shift from extrinsic to intrinsic goals. In a study published by Ghent University, Belgium in 2009, older adults (average age of 75) were surveyed, and those who reported having fulfilled more of their intrinsic goals were the least anxious about death and most satisfied with their life. In contrast, respondents who reported the greatest attainment of extrinsic goals indicated the most despair and the least acceptance of death.[2]

At Here to Honor, we call this practice "Minding our mortality": deliberately making space to contemplate our impermanence and fleeting time so we can prepare for the reality of death and live with intention now. Modern life

distracts, compartmentalizes, and even hides our dying, so confronting our mortality actually requires a certain degree of discipline. Here are a few suggested practices to help mind your mortality:

1. **Acknowledge Our Finitude:** As human beings, we are finite, vulnerable creatures. In a world that tells us we are limitless, it is actually good to feel our limits. How does finitude show up in your body as you age? Where does finitude show up in your time, resources, and capacity? Instead of resisting or trying to overcome your limitations, what would it look like to pause and feel your edges? Practice reminding yourself of your finitude, whether that's lovingly accepting white hairs and wrinkles or turning down invitations and opportunities to fill up your schedule.

2. **Find a Memento Mori:** Latin for "Remember you must die," Memento Mori is a concept with roots in classical antiquity. Most frequently depicted as skull and bones, an hourglass, or wilting flowers, memento mori appears in art and architecture from the medieval period onwards, with the purpose of reminding us of our mortality and to hold precious the fleeting and uncertain days we live. Though this concept is not as prevalent today, carrying a personal memento mori item can serve as a regular mortality reminder. Perhaps it's an artwork image or a poem that you post on your bathroom mirror. Maybe it's downloading the app WeCroak, which sends five random invitations daily to contemplate death. Or maybe it's carrying the photo of a loved one who has passed. Whatever item you choose, try incorporating memento mori visibly and consistently in your daily life.

3. **Practice a Simple Death Meditation:** Drawing from Buddhist mindfulness of death practices, death meditation can include contemplating the inevitability of death and envisioning the breakdown of our bodies when we die. This can get very real and very emotional, and there are centers and trained facilitators who take people through guided death meditations. But a simple death meditation can be a helpful practice, and I recommend the following exercise suggested by Tracey Anne Duncan as a way to ease into death meditation[3]: Take your notebook or a journal to a quiet, semi-private setting–-a place where you have access to other people in case you get anxious. Complete these sentences: If I had one year left to live, I would…If I had six months to live, I would…If I had one month…If I had one week….If I had one day…

   Read over your responses and consider the following: How did your priorities and activities change as the length of time you had left decreased? What stayed consistently important to you across spans of time? What do you do in your regular life that didn't make the cut?

Thinking about death is not easy – it's important to acknowledge that this can surface past trauma and stir up grief. But minding our mortality can also help us to prepare more intentionally for the reality of death, and in preparing to die well, we can learn to live well.

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DOWNLOADING SUCCESS: ESCAPE THE DRAMA TRIANGLE TO ENHANCE YOUR TEAM'S POTENTIAL

As a healthcare executive, you may find yourself leading a talented team of individuals seemingly hindered by reoccurring issues around communication style or work approach that negatively impact outcomes and performance. Is your organization performing harmoniously like a symphony orchestra, creating beautiful music? Or do leaders operate within their lanes like a swim team?

If your workforce lacks harmony, you are not alone. Many successful healthcare organizations face some level of dysfunction, and this causes leaders to question their role in these challenges. The truth is that stress can often trigger anxiety-driven behaviors that are less productive, leading to trust deficits, employee dissatisfaction, and talent attrition.

This pattern is called “the Drama Triangle” — and it stifles effective leadership and team development. Most organizations will not be effective with a swim team model at the top. So, if you sense something obstructing your team's cohesion but cannot identify it, check out the guide below to learn more and for a potential breakthrough.

WHAT IS THE DRAMA TRIANGLE?

The Drama Triangle is a concept furthered by Dr. Stephen Karpman in 1968 that outlines three key roles that surface during conflict: the Victim, the Rescuer, and the Persecutor. Used initially to analyze family dynamics, the Drama Triangle also applies to organizational conflict. Karpman defined the roles as follows:

The Victim: "Poor me."

This individual feels powerless and entrapped, attributing their plight to Persecutors. They rely on external aid from Rescuers, diminishing their problem-solving skills and reinforcing their state of helplessness. This behavior inhibits their ability to achieve goals, experience fulfillment, and keeps them stagnant. Their internal monologue might include:

Why does this always happen to me? If only they would change their ways. I feel used.

The Rescuer: "Let me help you."

Rescuers derive their value from an ability to save others. They are driven to rescue the Victim, often at the expense of their personal needs. The Rescuer's behavior enables the Victim's sense of helplessness, disrupting their potential for growth and independence. Their solutions keep the Victim dependent on them, leading to exhaustion, resentment, and overwhelming pressure. By constantly focusing on the needs of others, Rescuers can avoid addressing their own issues. Their internal monologue may echo the following:

I can resolve this. Let me handle this for you. I am more efficient at this task. You require assistance.

The Persecutor: "This is all your fault."

Consider the Persecutor an overly stringent and authoritative figure, akin to a critical and controlling parent. Carrying a superiority complex, they exacerbate the Victim's feelings of helplessness through their bullying and judgmental nature. They assign blame to Victims and criticize Rescuers while offering no tangible aid or solutions, only critique. They lead rigidly with an approach marked by inflexibility and an absence of empathy. The internal monologue of a Persecutor might include:

If they would do [blank], then I would not be burdened. Their thoughts and feelings are irrelevant to me. I possess superior knowledge; what is wrong with them?

In periods of heightened stress, individuals may assume any of the roles above, resulting in less-than-optimal responses to conflict — shame (Victim), blame (Persecutor), and anxiety (Rescuer). Furthermore, role swapping frequently occurs as a temporary measure to mitigate tension. But without addressing the underlying issues, the drama cycle is likely to recur. Upon closer examination, it becomes evident that each character contributes to the creation of the others, perpetuating a cycle that proves challenging to disrupt.

HOW TO BREAK THE TRIANGLE

The Drama Triangle can lead to stifled innovation, reduced psychological safety, and heightened stress levels — factors that reduce productivity and profitability.

As an executive relational intelligence expert, I have witnessed how a lack of self-awareness can undermine team unity within healthcare settings. However, every challenge presents an opportunity for growth. We can mitigate these behaviors by reshaping leadership norms and cultivating a more supportive work environment. The following three strategies help teams break free from the destructive cycle of the Drama Triangle, thereby fostering workforce cohesion:

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1. **Step Out of the Triangle**

We possess the power to modify our viewpoints and actions consciously. A single person's dedication to authenticity can significantly sway relationships, teams, and the broader organization within a healthcare context. Assuming complete accountability for one's actions enables a shift from the roles defined by the Drama Triangle to a position of authentic leadership. This transformative change evolves the Drama Triangle into a Power Triangle — an entity grounded in passion and centered on solutions and outcomes rather than fault-finding or stress. This shift is particularly critical in healthcare settings where effective team dynamics directly impact patient outcomes.

2. **Self-Awareness**

To break free from the Drama Triangle, you must recognize your role. By developing self-awareness, leaders can identify their Victim, Persecutor, or Rescuer tendencies and opt for a more effective approach. Aspects of self-awareness include:

- **Emotional Awareness** - Understand your emotions and their impact on others.
- **Self-Assessment** - Be aware of your strengths and weaknesses, accept feedback, and stay open to new perspectives for continuous self-improvement.
- **Self-Confidence** - Be confident in your worth and abilities, independent of external validation. Voice your views, even when unpopular, and stand firm in upholding company values.

3. **Emotional Intelligence**

Enhancing emotional intelligence (EQ) enables healthcare executives to effectively comprehend and manage their emotions and those of others during conflict, fostering improved communication and increased empathy. A practical way to boost EQ is by identifying our stress reactions in crises. Even minor conflicts can trigger stress responses known as *fight*, *flight*, or *freeze*. In these reactionary moments, we can enter the Drama Triangle and default to old patterns that kept us safe — often in childhood. However, these patterns may not be the best way to interact with our colleagues as adults.

In one of our past webinars, we introduced a tool called Above the Line/Below the Line that helps leaders practice self-awareness and mindful responses to moments of crisis.

Healthcare leaders can forge a more empowered and productive workplace by comprehending the triangle's patterns and employing strategies to liberate themselves from being caught up. This metamorphosis undoubtedly benefits leaders and enhances the overall success and welfare of their organizations.

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CYBERVITALS: MOVING FROM IDIOSYNCRATIC TO SYSTEMIC ENFORCEMENT

The last quarter of 2023 saw the confluence of many policy initiatives reaching implementation. Where the enforcement of cybersecurity quality was somewhat dependent on clinical type and reviewed assigned to a submission, the Food and Drug Administration (FDA) has implemented multiple frameworks to systemically enforce cybersecurity baselines across all submissions.

In particular, the mandatory use of the Electronic Submission Template and Resource (eSTAR) for 510(k)s and deNovo submissions means automatic verification of cybersecurity diligence for all submissions. When combined with the final premarket cybersecurity guidance, medical device manufacturers must embed security considerations across their entire product development lifecycle.

WHY IS THIS DIFFERENT?

It's not surprising to see the emphasis on security by the FDA, but given its statutory authority, this means device makers do not have the option of disagreeing/attempting to contextualize decisions made. This takes the burden off FDA reviewers and instead puts the requirement back on manufacturers. Similar to how health systems have used procurement decisions to drive security to the forefront, the regulator is delaying devices going to market if not sufficiently considerate of security principles.

Additional consideration of the False Claims Act (FCA) to the increased cybersecurity-related disclosures means added scrutiny for device manufacturers. Historically, there have been multiple FCA claims against electronic health records in the past, and the government has stated cybersecurity continues to be a major area of focus for FCA-related investigations.

SCALE OF IMPACT

Similar to how enforcement of cybersecurity is shifting from individualist to ingrained, attackers have also shifted strategies. Increasingly, there have been widespread, deeply embedded vulnerabilities emerging from the hacker community (ex. Ripple/20, Bluekeep, WannaCry). If we think of hacking as a business, the return on investment for a systemic issue that spans devices and industries vs. an idiosyncratic hack in a single device in a single instance is obvious math.

This translates into attacks on health systems, which have seen an increase in the scale of attacks. As noted, 385 million patient records have been impacted from 2010 to 2022. And recent data shows the frequency of attacks is lower, but the number of records compromised has increased. Additionally, we cannot forget that if a health system becomes victim to

a ransomware campaign, it can inhibit the ability to update electronic health records and use devices that rely on connectivity for making calculations (such as devices used in radiation oncology and sophisticated surgical robots).

WHAT SHOULD WE DO GOING FORWARD?

With the current administration, and its commitment to prioritizing cybersecurity in government procurement, 'hoping' you get through the FDA is not a strategy. Any new technology will bring its own set of pros and cons. Connected medical devices are no different. They are an exciting innovation in the healthcare industry that allow patients to customize their care, offer constant and easy monitoring for doctors, and open the industry to new medical discoveries. And like any other industry or technology, they can be harmful if placed in the wrong hands. If devices are secure by design, it helps to alleviate potential problems down the line.

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Source: Bigstock

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MAKING THE CASE: WHY SHOULD EMPLOYEE DEVELOPMENT BE A PRIORITY FOR HEALTHCARE?

A few years ago, we were conducting a management and leadership training with a group of professionals when the topic of **employee development** came up. A robust discussion ensued. One individual in particular was resistant to investing "too much" in employees, lamenting the financial cost to do so. This individual asked, "What if I invest in my employees and they leave?" To which one of our consultants responded: "What if you don't invest in your employees and they stay?" The point being, by not investing in your employees, you risk not tapping that individual's potential, to the detriment of that employee, your organization, and ultimately the patients you serve.

Source: Bigstock

It is no secret that today's healthcare organizations are under tremendous pressures. After being on the frontline for over three years in the fight against COVID-19, the healthcare workforce continues to be stretched, strained, and exhausted. While healthcare employees are struggling, hospitals and health systems are experiencing many financial and operational challenges. Increased costs, slower patient throughput, and declining reimbursement have resulted in billions of dollars in losses, with over 33% of U.S. hospitals operating on negative margins.[1] With all these challenges, healthcare executives are faced with tough decisions about the direction of their institutions and the allocation of resources.

One area where we have seen healthcare organizations make cuts in response to the financial pressure is in the development of their employees. Impacted areas have included learning and development; organizational development; diversity, equity, and inclusion (DEI) efforts; and more. A common mindset is: ***With all the challenges we're facing, our employees don't have the time, and we don't have the financial resources to develop them***. Executives who lead with this strategy are not just shortchanging their employees but the patients they serve and their institution.

Others are taking the opposite view — they feel they can't afford not to invest in employees in ways that help them feel valued and enable them to do their best work. During a panel we recently facilitated, one Chief Human Resources Officer from an academic health system explained:

> "At first, we were focused on hiring, hiring, hiring. We quickly saw a revolving door for talent — people would come in, get oriented, experience how tough the environment was, and then leave. Our strategy is now focused squarely on retention, and professional development is a big part of that strategy."

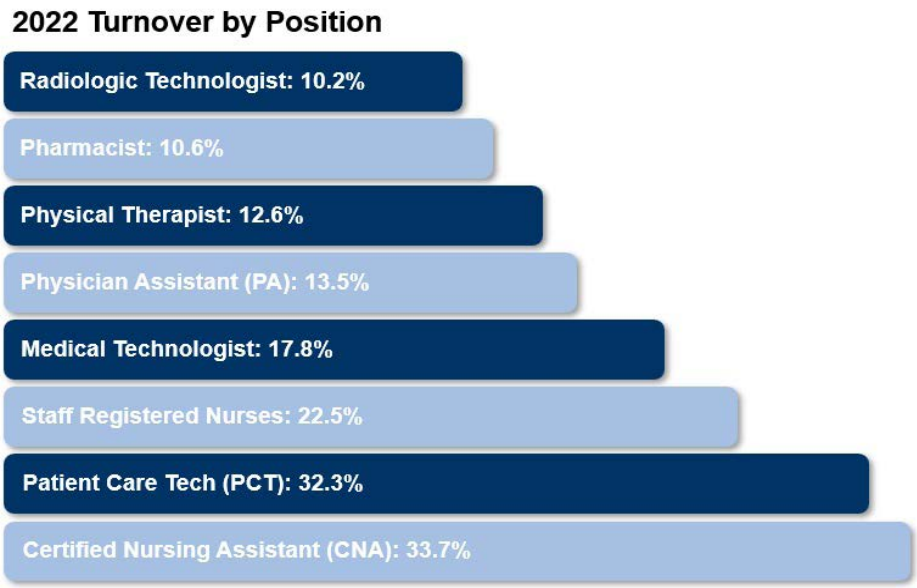
EMPLOYEE PROFESSIONAL DEVELOPMENT

Employee development is not just a nice thing to do. The Society for Human Resources Management (SHRM), defines employee development as "…training and related opportunities for employees to gain new skills and competencies." SHRM goes on to say:

> "…it [employee development] is almost universally recognized as a strategic tool for an organization's continuing growth, productivity, and ability to attract and retain valuable employees. Training and development opportunities increase the likelihood that employees will develop not only expertise in the skills needed for their current job, but for other positions in the future."[2]

SHRM found that employee training and development reduces turnover and absenteeism,[3] and a LinkedIn Learning report showed that 94% of employees would stay at a company longer if it invested in their career development.[4] Dr. David Nash recently wrote, "Employee turnover data show that the average organizational cost of losing a nurse is $50,000 – for loss of a physician, the cost is $100,000…One innovative organization used data to identify weak leaders and, rather than losing them, supported improvement efforts."[5]

Given the high turnover rates in healthcare (below), investments in employee development make good sense.[6]



MANAGER AND LEADERSHIP DEVELOPMENT

Not all development is equal. While healthcare organizations should invest in the development of all employees, an outsized investment should be made in manager and leadership development. According to Gallup, managers account for 70% of variance in employee engagement.[7] And why does employee engagement matter so much? Gallup research found that, compared to business units and teams in the bottom quartile for employee engagement, top-quartile units had:

- 81% lower absenteeism
- 58% fewer patient safety incidents (mortality and falls)
- 18% lower turnover for high-turnover organizations (those with more than 40% annualized turnover)
- 43% lower turnover for low-turnover organizations (those with 40% or lower annualized turnover)
- 10% higher customer loyalty/engagement
- 18% greater productivity (sales)
- 23% greater profitability[8]

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Engaged employees are involved in, committed to, and enthusiastic about their job and the company for which they work. Engaged employees also become brand ambassadors for their healthcare institutions; they will encourage friends, family, and anyone who will listen to seek care from the very organization they serve. In fact, they create engaged patients who will also go out and be ambassadors for that institution.

Leaders and managers are the linchpins to institutional success. One major way to amplify their impact throughout the organization is to invest in their development. There are many ways to develop managers and leaders to accelerate their growth, reinforce their well-being, increase retention, and boost organizational success.

1. **Traditional Manager/Leadership Development Programming:** Adult learning is no longer confined to time-intensive lectures. In-person, virtual, and self-paced learning journeys can be supported by micro-learning opportunities, where a person only needs 5-10 minutes of free time to learn and apply a new skill, technique, or approach.

2. **Professional Coaching:** Professional coaching can play a pivotal role in the development of healthcare leaders navigating rapid change with high stakes, and immense responsibility. Coaching offers leaders tailored support, allowing coachees to pinpoint their unique challenges and to enhance their effectiveness, drive better outcomes, and foster a strong culture.

3. **Mentoring:** Matching less experienced employees with more experienced colleagues.

4. **Cross-Training:** Training employees to perform job duties other than those normally assigned.

5. **Career-Planning:** Collaborative planning for future or alternative career paths.

6. **Conferences:** A helpful way for employees to network and gain exposure to information relevant to their current and future work.

7. **Stretch Assignments:** Provide employees with a chance to learn while doing the work – allows employees to develop new skills, knowledge, and capabilities to advance them in the organization.

Instead of viewing employee development as a "nice-to-have," it should be considered a core responsibility of any healthcare organization. And instead of asking the question: ***What happens if we invest in our employees, and they leave?*** Ask: ***What happens if we invest in our employees, and they stay?***

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BALANCING INNOVATION WITH SAFETY: THE AI REVOLUTION IN HEALTHCARE

Fifteen years ago, I was part of a team that created MorpheusOx, an FDA-cleared, at-home sleep lab utilizing a machine learning (ML) algorithm to diagnose sleep apnea from the PPG signal of a pulse oximeter. Using ML and extensive data sets, we trained MorpheusOx to derive a patient's respiratory signal and detect sleep apnea and cardiac arrhythmias. MorpheusOx's reliability matched that of a sleep lab technician.

For me, the experience of developing MorpheusOx illustrated the revolutionary potential of AI/ML and also raised the question, **"As we push the boundaries of AI in healthcare, how do we continue to ensure safety?"**

Recently, the FDA released a 43-page draft guidance on the future of AI/ML in medical devices. The FDA is considering granting developers the permission to modify ML models following the initial approval of a device, provided there's an established plan for such alterations. How would that actually work, and how will device developers make sure their products are safe while being changed rapidly?

To delve deeper into these questions, I interviewed an expert in developing regulated medical software — my brother, Erez Kaminski, CEO of Ketryx, which landed $14M in Series A funding in December 2023.

Erez, tell me what Ketryx does and how you got here.

Ketryx builds tools that enable software teams to develop FDA-regulated software faster while staying safe and compliant. We focus on enabling development teams to understand how they change their software and ensure it is done in a controlled manner.

I started my career in software development and transitioned to healthcare AI/ML. When I was the head of AI for Amgen's medical device group, I realized how complex it was to build a medical device, especially one that is connected and has ML components. It can seem like an impossible task to regulate something like that. I built Ketryx to democratize that knowledge. We help accelerate the pace of regulated software development, reduce the development costs, and at the same time, ensure it's being developed under the necessary regulations.

Do you see a difference between current medical devices and future ones, given the evolving role of software?

Absolutely. Medical software has traditionally lagged 10-15 years, or more, behind other fields, but advancements, even in high-risk devices, are being made. The integration of software and ML is evident, indicating a shift towards automation in various medical tasks. The future promises a significant role for software in diagnostics, treatments, and immediate response, even before intervention by a medical professional.

How do you foresee the impact on the broader medical landscape?

The aging population is already leading to an uptick in home medical device usage, and the global shortage of clinicians will accelerate the need for technology to close the labor gap. It's hard to imagine medicine in 20 years without a significant amount of automation and remote monitoring, diagnosis, and treatment.

What are the key points healthcare executives should be aware of?

1. **It's unavoidable.** Software scales, and it's going to be very effective for augmenting the limited number of medical professionals. The shift towards software automation and AI in healthcare is happening at a large scale and fast. Executives should be proactive and ready for the future; otherwise, competitors will take the lead.

2. **Building trustworthy, reliable, medical software is complex and requires immense effort.** This should not be underestimated.

3. **FDA software regulation is changing significantly, and it's important to stay informed.** In the last 24 months, there has been more software guidance published by the FDA than in the last 20 years (see Figure 2).

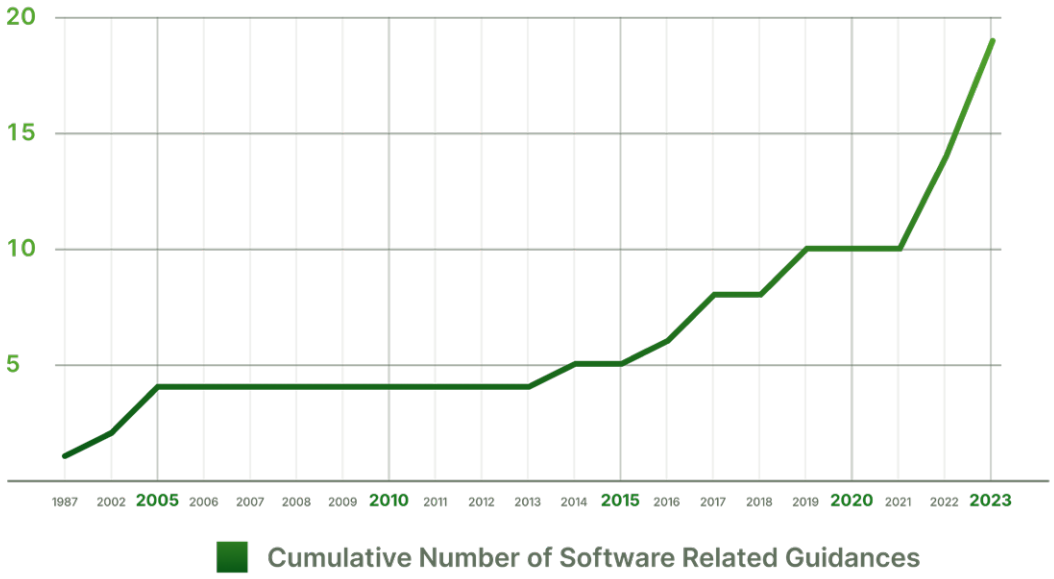

Figure 2

What type of products are coming out in the short term?

Any medical device used at home that does not have an app is likely going to have an app. These apps will be extended by AI algorithms in later products.

I'm surprised by your answer. When I think about AI in healthcare, apps are not the first thing that comes to mind.

Building safe medical software, including apps, is complex and costly. The industry is still figuring out how to build apps while controlling costs. AI is significantly more complex and requires frequent updating. As we add AI to products, we need to reduce the development and maintenance cost of the apps the AI will be housed in.

What are the challenges companies face when trying to develop healthcare AI/ML?

- **Talent is scarce.** There are few ML experts and even fewer healthcare ML experts. The medical industry is not addressing that yet. In contrast, the tech industry is fighting over ML talent and paying a lot of money. Healthcare companies should think in five-year plans, how do they develop, hire, or acquire subject matter expertise in AI/ML.

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- **It's complicated to deploy at scale.** Serving many patients, while ensuring high reliability with a huge amount of risk associated with errors, creates significant complexity. Medical device software complexity has been going up 30% annually since 2006, while productivity for engineers has gone up 2% a year.

- **The appropriate tools are often missing.** It's common to see tools that were created for hardware development being used to develop regulated healthcare software. This approach is suboptimal for various reasons. Consider, for instance, the differing release cycles: hardware undergoes extended cycles, while software demands regular and incremental releases.

Can we make healthcare AI/ML safe?

Yes. For example, surgical robots use deterministic models to enhance safety by restricting certain movements. While there are concerns about the reliability and safety of AI/ML systems, we've historically regulated complex products, like biopharmaceuticals, with precision and safety. Similar regulatory methods are expected for AI/ML. The main challenge is in determining specific measures of success and error for distinct models. The key will be a thorough understanding of each system's objective and expert-driven safety testing.

How do you envision generative AI testing and implementation in healthcare?

Three steps: understand how we want to use it, explore the limits of these models, and complete and publish research that shows we can monitor them. A device can be designed to restrict many system behaviors and features, ensuring it performs the specific, intended task.

Are we currently ready for a larger language model to control a system in a closed-loop fashion that can seriously injure or kill a person? No, we're very far from that. But there are lower-risk applications we can start to design and understand how to monitor.

How do we prevent HIPAA-type leaks from generative AI?

That's a challenge. Medical records have to be used in order to train larger language models. We need to understand better how to de-identify medical records so they can be properly used to train the models. There is work taking place by the U.S. government, FDIC, and NIST (National Institute of Standards and Technology) to address that. Companies also need to do more work on data scrubbing identifying personal data and removing it in a highly controlled and regimented manner.

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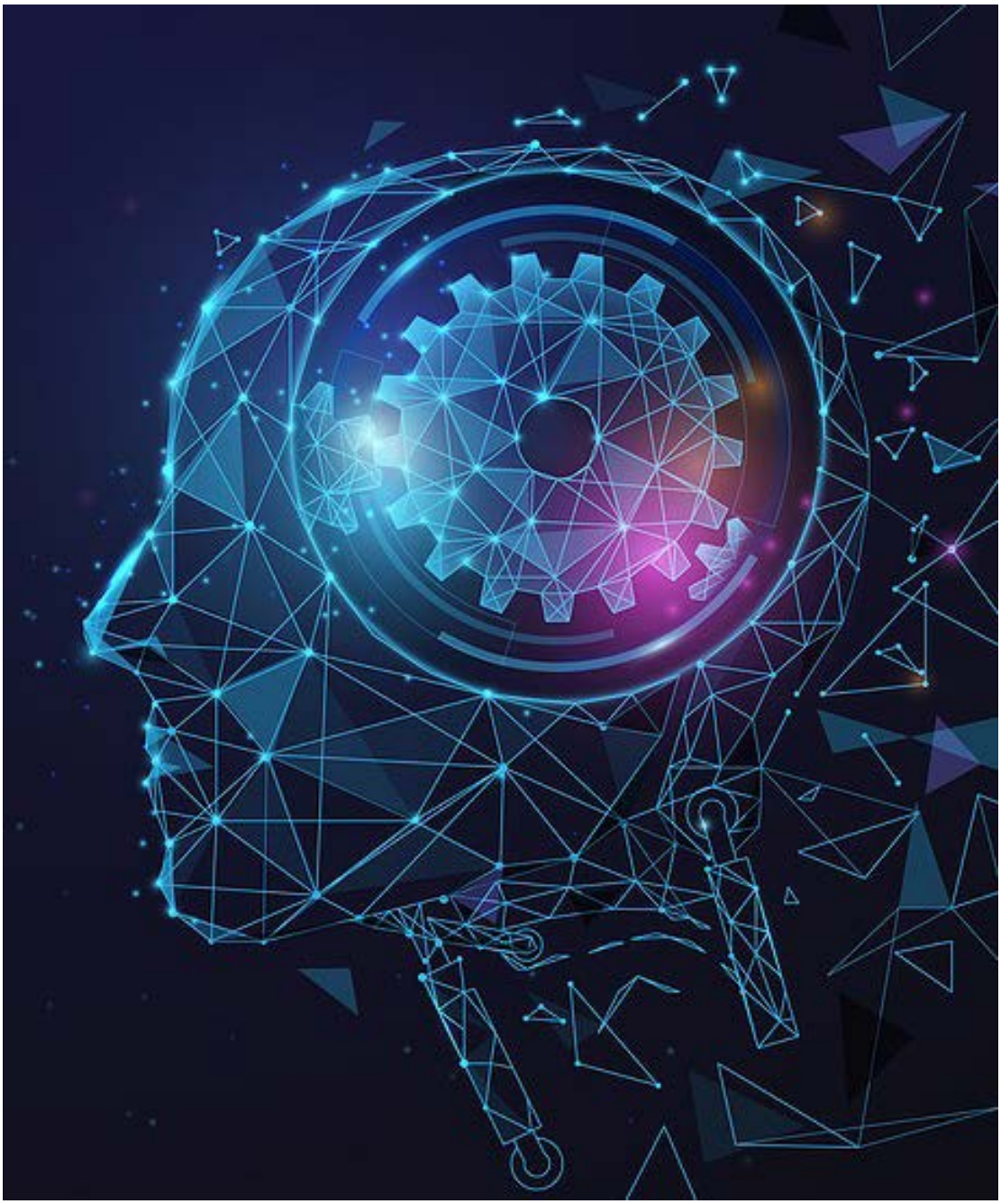

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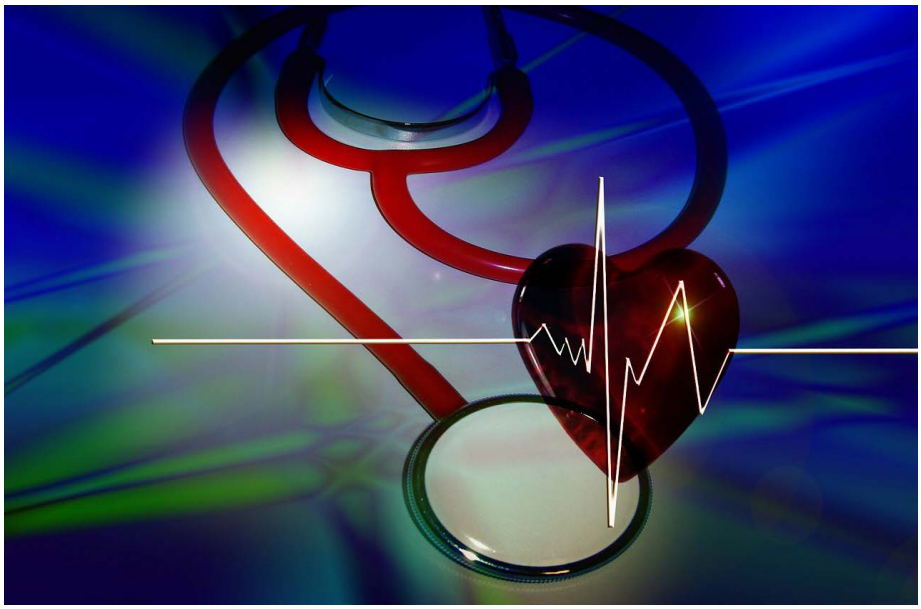
RECOVERING AND THRIVING POST-PANDEMIC - PART 10: PHYSICIAN CONTRACTING AND COMPENSATION

As we end our series on Recovering and Thriving Post-Pandemic, we are focusing this article on physician contracting and compensation. The pandemic influenced how both employers and physicians interact with each other, since their respective priorities may have significantly changed. We believe some specific factors associated with the pandemic explain this influence, including:



- Health systems reacting to COVD-related financial pressures are looking to strengthen alignment with independent physicians, most commonly though acquisition. This is a service line strengthening tactic, which we will cover in the tactics section. Health system and/or hospital-led consolidation movement obviously predates the pandemic, but our experience in the post-COVID environment we are now entering requires renewed focus on physician contracting and compensation, particularly with a sense of urgency placed on physicians practicing within high-margin service lines.
- Changing physician workforce dynamics, with more attractive opportunities to exit clinical practice (e.g., administrative roles, or simply moving on earlier to retirement than originally planned) greatly impact physician contracting and compensation. Organizations that employ physicians solely to practice medicine are also often dealing with new entrants, creating unanticipated disruptions and increasing scarcity of physicians. For example, there are an increasing number of diverse administrative roles specifically designed solely for physicians, as well as physicians who are increasingly seeking out purely administrative roles in addition to employers putting physicians into administrative roles (e.g., physician CEOs)
- There has been a post-COVID acceleration in consolidation via acquisition of private medical groups or individual practices by private equity and other buyers. These transactions have changed how physicians look at their compensation, specifically when they move toward employment arrangements, while still considering how their practice patterns influence the long-term value of their group.

TRENDS AND TACTICS

In response to the influences described above, several significant physician contracting and compensation trends have emerged. These represent many of the challenges employers and organizations face as it increasingly appears more physicians desire an employment arrangement and have changed expectations of their future employers.

As we have noted in earlier articles, the post-pandemic physician workforce is evolving rapidly, and these trends are representative of a very fluid physician compensation environment. We have included several tactics for healthcare organization leaders to consider when designing updated and more modern compensation models for their physician workforce.

Source: Bigstock

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Trend	Tactic
• Physicians are increasingly focused on total compensation (TC.) This encompasses the total amount earned through base salary, bonus amount potential, and components of bonus, among other earning opportunities. • As a result, employers are increasingly competing to recruit and retain physician talent based on TC.	• Develop prospective strategic and physician compensation budget planning capabilities for an increased allocation of TC. • As of today, since non-cash benefits appear to no longer provide the competitive edge they once did, employers and organizations might not need to continuously enrich benefit offerings as they did in the past. Financial resources can instead be directed toward TC and strategic compensation design.
• Physicians are increasingly selling their independent practices to health/hospital systems, or to other investors such as private equity. • Health/hospital systems continue to court independent providers/groups in an effort to align physicians with strategic hospital service lines. This can result in a perception that hospital/health systems view physicians as referral pathways, and thus tolerate inefficiencies that can damper physician and practice performance post-transaction.	• When appropriate, strive to ensure that investor objectives are aligned with compensation planning efforts. • Physicians should be incentivized to maintain their historical high-level performance through and beyond compensation design. • Be prepared for physicians to expect continued efficiency and excellence in practice operations they once managed and paid for, so they can achieve their own performance and financial goals and thus earn additional incentive pay.
• Alternative payment models (APMs) that align physician compensation with payer arrangements focusing on quality and total cost of care (TCOC), such as through value-based payment contracts are increasing. • Payers are increasingly tracking and rewarding quality outcomes using Healthcare Effectiveness Data and Information Set (HEDIS) measures. • Physicians who are employed can be rewarded for managing TCOC through incentives. • In recent years, a massive cultural shift to delivering team-based care, such as patient-centered medical home (PCMH) models, has changed how physicians practice and utilize and support staff at all levels.	• Seek out and recruit physicians who are increasingly open to compensation models that require time and attention to quality outcomes. • Physicians with this style of compensation will expect support in measuring quality and TCOC, as well as involving non-physician staff in efforts to meet their targets. o Ensure this is part of the operational model for APMs/ PCMH, and consider aligning incentives for both administrative and non-physician clinical staff to enable high quality team-based care delivery. • Employers and organizations can support this alignment through compensation design that rewards high quality outcomes, in addition to other balanced metrics.
• Physicians' personal financial objectives are changing, specifically the trade-off between giving up valuable equity accumulation in their practices in exchange for predictable work expectations and fewer non-clinical responsibilities necessary to operate the practice.	• As physicians choose to forfeit future potential practice equity, they are seeking additional ability to save in order to meet their financial objectives. o For example, ability to participate in increased 401(k)s or other retirement benefit account contributions, and/or tax-advantaged savings opportunities, such as non-qualified deferred compensation (NQDC) plans is desired.
• According to the Medical Group Management Association (MGMA), a poll in late 2022 revealed that nearly 50% of group practices reported one or more physicians choosing to retire early, due to a variety of reasons.	• Pressure to ensure that contract provisions are clear to avoid misinterpretation, support predictability, and do not allow disruptive surprises.

CONCLUSION

These trends and tactics are the beginning of important and difficult conversations healthcare employers and organizations must have with physicians to preserve and strengthen the physician workforce across the healthcare continuum. In a post-pandemic world, abrupt changes to physicians' day-to-day job/existence must also be addressed within compensation arrangements. The tactics we have offered are only a part of the solution to address issues and complexities within the complicated physician compensation landscape today.

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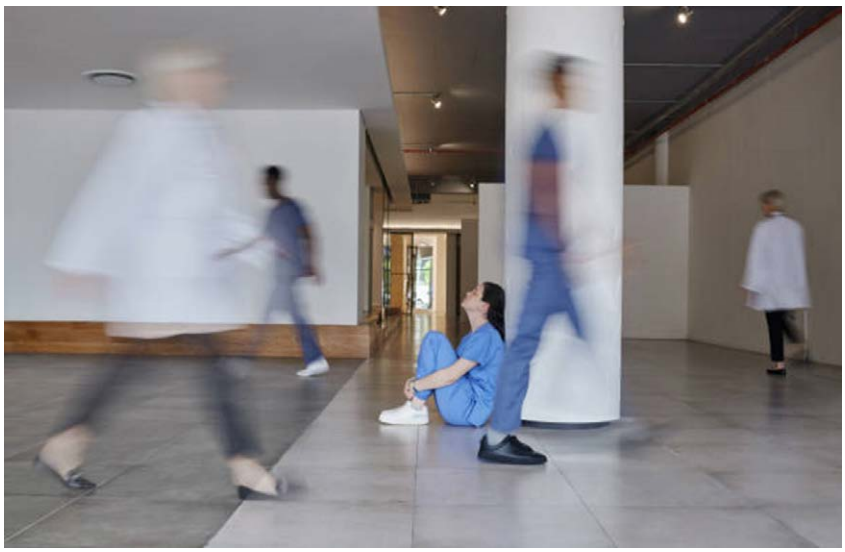
EMBRACING AND AFFIRMING THE "GOOD" DOCTOR

This is the second in a series of articles that calls upon the importance of values and virtues as part of a model of Virtuous Practice to improve physician well-being and strengthen patient relationships, resulting in patient satisfaction, loyalty, and continuity of care.



Source: iStock

Physicians face unrelenting pressure in the current care environment where throughput, profit, and integration of technology hang heavy over all clinicians and sometimes inadvertently strip the humanity from a patient encounter. Further, 47% of physicians report multiple symptoms of burnout, emotional exhaustion, and loss of joy in work. (Medscape, Physician Burnout & Depression Report 2022: Stress, Anxiety, and Anger, Leslie Kane, January 21, 2022)

Meaningfully and proactively addressing burnout is vital to restoring physician well-being; therefore, it's imperative to understand proven antidotes to prevent and ease burnout. Addressing pervasive system issues — such as excessive workload, underutilization of non-physician practitioners, and alienation caused by use of technology — can be a wicked problem. However, harnessing the power of values and virtues through an approach Accordant calls Virtuous Practice can offer an accessible and effective healing salve for healthcare's open wounds by creating mutually rewarding physician-patient relationships and by fulfilling patient expectations of a "good" doctor.

Deepening the physician-patient relationship can provide a significant lift to both. Research demonstrates the significance of several values-focused relational elements as pathways to strengthening physician well-being. These include:

1. Receiving expressions of patient and family **gratitude**
2. Experiencing **compassion satisfaction**
3. Forging relationships rooted in **connectedness** and **belonging**
4. Restoring **purpose** and meaning in work

Research from multiple scientific studies validates the elevating effect of clinicians receiving expressions of gratitude from patients and family members. Studies show receiving gratitude increases well-being, increases a sense of personal accomplishment, increases team performance, decreases emotional exhaustion and decreases burnout.[1] Further, gratitude received directly from patients is far more impactful than receiving gratitude from other clinicians or from healthcare executives, so there is value in considering what sparks patient gratitude.[2]

Patient gratitude is not dependent upon achieving positive clinical outcomes. There are multiple antecedents to patient gratitude — and most must be nurtured not forced. Gratitude in the care environment begins when a clinician anticipates,

recognizes, and responds to a patient or family member's needs, wants, or concerns. This "perceived benefactor responsiveness" is a "significant and strong" predictor of gratitude.[3] Additionally, benefits received by the patient must exceed one's social expectations of others as well as what one feels they earned or paid for; for example, a patient expects a physician to provide her with an appropriate diagnosis and treatment in exchange for providing insurance or payment to receive care. However, a physician can exceed a patient's expectations through addressing emotional and social dimensions of care that make one feel understood, validated, or cared for. Finally, the recognized "goodness of the giver" increases the likelihood of experiencing gratitude; this hinges on the perceived effort and intentions of the physician rather than the physician's expertise or credentials.[4]

Source: iStock

Given the importance of a physician's perceived efforts and intentions as a prerequisite to gratitude, there is merit in considering what patients perceive as the characteristics or commitments of a "good" doctor. Patients have a baseline expectation that a physician has appropriate medical knowledge and experience; competence is table stakes. However, dozens of studies indicate patients consistently prioritize quality of interpersonal relationships between the patient and physician that reflect an inherent value for human beings and the validity of shared human needs. For example, patients want a physician to identify them by name, know them as a person, and show sensitivity to their emotions. Beyond simple recognition, patients repeatedly prioritize five specific relational behaviors reflected in the Virtuous Practice model.[5,6,7,8,9]

1. **Love** for people demonstrated through compassion and respect
2. **Kindness** reflected through friendly, cheerful rapport that puts patients at ease
3. **Listening** that is attentive and aims to understand
4. **Communication** that is clear, understandable, honest, and polite
5. **Presence** showing one is engaged, interested, attentive and available

It is worth leaning in around "love." This is clearly not about romantic love, but, rather, humanistic love of humankind. It is love without a need for self-benefit or return of affection. This form of love is often demonstrated through compassion and respect, and it is a linchpin of attachment that enables a patient to feel safe, appreciated and connected to the physician.[8]

Patients indicate experiencing love, compassion, and respect is vital to exceptional care, and research demonstrates the link between love and improved clinical outcomes as well as increased trust, connectedness, satisfaction, adherence with care instructions, and continuity of care.[5]

When physicians demonstrate the intentions of a "good giver" and fulfill patient expectations of a "good doctor" through love, kindness, listening, communication, and presence, the behavior provides a catalyst for restorative patient and family gratitude. In addition, positive physician-patient interpersonal relationships provide other substantial benefits to physicians by

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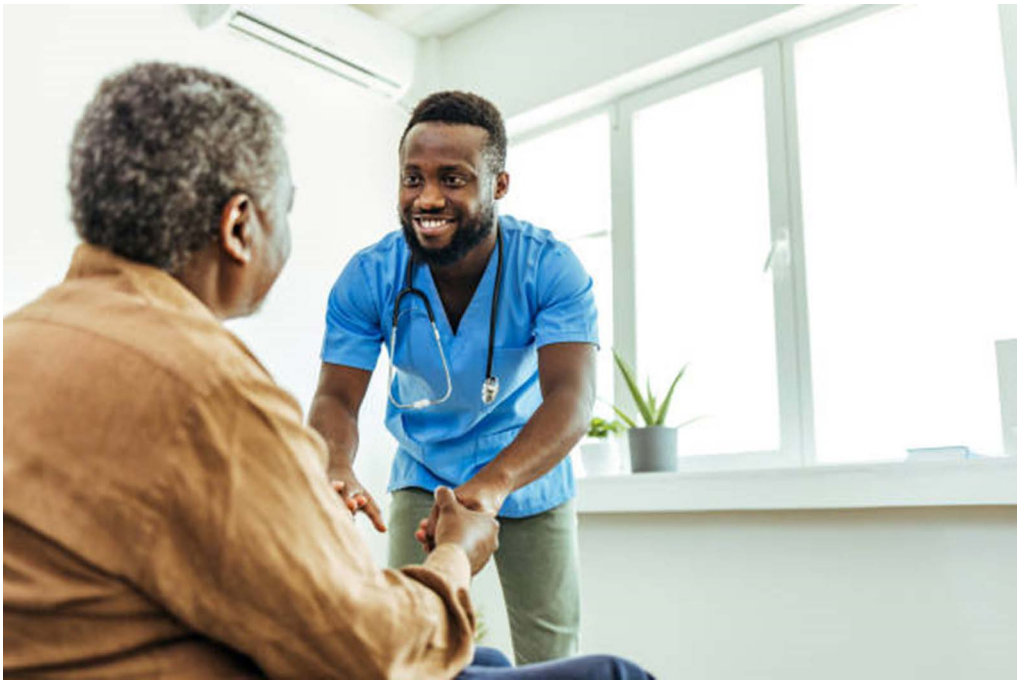
EMBRACING AND AFFIRMING THE "GOOD" DOCTOR

facilitating compassion satisfaction, deepening connectedness, and restoring purpose in work. Compassion satisfaction is contentment and joy that results from helping others and that facilitates resilience and counteracts burnout.[10]

Physicians who advance Virtuous Practice also experience a greater sense of human connectedness that affirms purpose in their work — and experiencing meaning from purpose-driven work serves as a "significant protective factor" against burnout.[11,12] Ultimately, demonstrations of love, kindness, listening, communication, and presence set a virtuous circle in motion. When physicians consistently foster positive interpersonal relationships with patients, it creates a variety of halo effects to support physician well-being and joy in work that in turn inspire the continuance of high-quality relationships.[13]



Source: iStock

Physicians authentically and routinely embracing a Virtuous Practice model that includes love, kindness, listening, communication, and presence consistent with patient perceptions of a "good doctor" not only leads to gratitude, compassion satisfaction, and other enablers of physician well-being but also upholds the ideals and sacred trust inherent in the noble profession of medicine.

In future articles in this series, we'll further unpack the importance of compassion and expand on the ideals of Virtuous Practice.

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NEWS FROM THE WHCMAA SCHOLARSHIP COMMITTEE

While the Wharton Health Care Management Program (WHCMP) was the first MBA program in the country that allowed students to focus on the management of health care enterprises, the program's success and the success of its alumni over the past four decades resulted in the rapid growth of competing health care management MBA program across the U.S. The competition for outstanding students has increased.

About 10 years ago, the Alumni Association and the WHCMP office determined that establishing a Scholarship fund the Program Director could use to attract the best and the brightest students into the Program would be a good use of the Alumni Association network. The June Kinney Fellowship Scholarship ("The Kinney Scholarship") was established in 2015 to provide additional financial assistance to an applicant to the WHCM Program who was already accepted for admission to Wharton and the WHCM Program.

The WHCMAA undertook a fund-raising effort and raised over $500,000 to establish this scholarship in honor of June Kinney who has served as WHCM Program Director for over 3 decades. Each year, the WHCMAA awards one or two incoming students a Kinney scholarship with the purpose of supporting HCM's ability to attract the best applicant who shows "a sense of social mission, as well as leadership characteristics that will both build community within the class and contribute to the societal health care enterprise after graduation." By offering this scholarship along with an offer of mentoring, WHCMAA contributes to the WHCM program's ability to attract the best candidates, most of whom have attractive offers from other schools as well.

In recent years, The Wharton Endowment Fund has taken responsibility for managing the Kinney Scholarship funds. The Wharton Office of External Affairs has provided the Alumni Association with a full report on the ***Alumni Association Fellowship Fund in Honor of June Kinney***, covering the 2021-22 and 2022-23 fiscal years, including biographies of the recent recipients. If you have any questions, please reach out to the WHCMAA Scholarship Committee Chair, John Winkelman at JohnW@winkelmanassoiates.com. If you want to contribute to the Kinney Scholarship Fund, please go to the WHCMAA site at Contribute to WHCMAA Fellowship Funds - Wharton Health Care Management Alumni Association.

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June Kinney, WHCM Program Director, and WHCM Class of 2021

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