Wharton ALUMNI CLUB
UNIVERSITY of PENNSYLVANIA

Health Care Management Alumni Association

THE WHARTON HEALTHCARE QUARTERLY

SPRING 2022, VOLUME 11, NUMBER 2

TABLE OF CONTENTS

IN EVERY ISSUE

FEATURED ARTICLES

IN UPCOMING ISSUES

Recovering and Thriving Post-Pandemic - Part 5

QUICK LINKS

Join Our Mailing List

Upcoming Events

Wharton Healthcare Management Alumni Association

Penn Connect

GET INVOLVED

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EDITOR'S LETTER

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

To learn more about Colette, click here.

With the reduction in COVID infections, hospitalizations, and deaths, hopefully we will be able to enjoy at least a lull and also make headway towards moving from a pandemic to an endemic state of affairs.

That means taking action to enable success in the midst of inflation, supply chain issues, staffing shortages across the healthcare ecosystem, a workplace marked by a mix of in-office, hybrid, and work from home employee populations, backlogs in preventive care services and elective procedures, a mental health crisis, unhealthy eating habits and a sedentary lifestyle that has increased the rate of overweight and obesity, a growing population of patients suffering from long COVID, and a collective, bone-tired weariness.

We've got you covered! In addition to the usual eclectic mix of topics, the January issue offered ideas and examples of ways to move forward during these demanding times, like those covered in the multi-part article series "Recovering and Thriving Post-Pandemic." And the first three sessions of the 10-year WHQ anniversary monthly webinar series (**free to WHCMAA members!**) have contributed to our readers' ability to be prepared for everything coming their way:

- On Caregiving: What's Hard, What's Helping, and the Post-COVID Opportunities for Support
- Mental Health Innovation for Covid-Era Post-Traumatic Growth
- Should I Stay or Should I Let It Go? Accelerating (Provider) Partnerships in a Pandemic
- The Science of Addressing Addictive Behaviors

Register now for the May 24th presentation on "Chasing My Cure: Lessons about Life, Business, and Medicine from Chasing Cures for Castleman, COVID, and Beyond."

"The art of life is a constant readjustment to our surroundings."
~ Kakuzo Okakaura

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

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THE PRESIDENT'S DESK

"If medicine can't see or name the problem, it can neither study nor treat it."
~ Meghan O'Rourke
"The Invisible Kingdom"

At the time of this writing, we are planning our first in-person board meeting for the WHCMAA since February 2020. I've been so fortunate to get to work with such a resilient and outstanding group of individuals, and to connect with such a talented group of alumni, as we navigated through the pandemic.

Though we can't officially declare the pandemic over, we certainly seem to be turning a corner, in terms of numbers and in terms of mentality. It seems clear we cannot ever go back to the "normal" we had in 2019; instead, we will be carving out a new reality in the post-pandemic world. As leaders in healthcare, our alumni base will play a huge role in shaping that reality within the healthcare ecosystem.

Last year, we were fortunate to have Dr. Shantanu Nundy speak with us about his book, "Care After COVID: What the Pandemic Revealed Is Broken in Healthcare and How to Reinvent It." Dr. Nundy discussed three dimensions for lasting transformation. Healthcare should be 1) distributed (shifting from where doctors are to where patients are), 2) digitally-enabled (data and technology will facilitate greater connection and personalization of care), 3) decentralized (healthcare decisions will shift from governments and insurers to physicians, patients, employers, and communities). This book provides a practical action plan that is timely for us to revisit as we emerge from the past two years.

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

Another extremely timely read is Meghan O'Rourke's new book, "The Invisible Kingdom: Reimaging Chronic Illness." O'Rourke uses her own journey with chronic illness to highlight some of the challenges inherent in our medical system – the narrow specializations of physicians that prevent connecting the dots for conditions that impact multiple systems of the body; lack of insurance coverage; and skepticism of patients who can't "prove" that something is wrong with them with traditional tests.

These reminders of the challenges in healthcare are more relevant than ever, given that an untold number of patients continue to suffer from "long COVID," the constellation of symptoms that encompasses everything from brain fog to incapacitating fatigue. This is one legacy and the crisis COVID will leave in its wake, even after the acute phase of the pandemic is over.

We have the opportunity to not only address long COVID, but also to use this occasion to:

- shed light on similar conditions that have existed in the past and have been underfunded and understudied, like chronic fatigue syndrome and Postural Orthostatic Tachycardia Syndrome (POTS).

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WHARTON HEALTHCARE QUARTERLY

Celebrating the Past
... Embracing the Future

10-Year Anniversary

Join Us As We Celebrate 10 Years!

The Wharton Healthcare Quarterly is celebrating 10 years of bringing together diverse thought leaders on a broad range of healthcare topics. You're invited to a year-long celebration featuring:

- **Monthly Webinars**

  Gain insights from an extraordinary group of experts discussing a wide range of topics, including:

  - FemTech growth opportunities
  - Population health
  - Cybersecurity trends
  - Repurposing medication
  - Healthcare in the home
  - The opioid crisis
  - Accelerating partnerships in a pandemic
  - Mental health innovation
  - The promise of AI

- **Anniversary Spotlights**

  A limited-edition column featuring writers from the inaugural year including: Harris Contos, DMD, WG'80; Jaewon Ryu, MD; Roy Beveridge, MD; and Kevin Volpp, G'97, MD'98, PhD'98.

- **LinkedIn Interviews**

  Anniversary participants share an inside glimpse into what drives them and their career advice and accomplishments.

SIGN UP FOR UPCOMING WEBINARS

Wed., April 13, 2022 | 12pm ET

The Science of Addressing Addictive Behaviors

Bob Gold, Chief Clinical Behavioral Technologist and Founder, GoMo Health | **Sue Zbikowski, PhD**, Founder, inZights Consulting

Wed., May 24, 2022 | 12pm ET

Chasing My Cure: Lessons about Life, Business, and Medicine from Chasing Cures for Castleman, COVID, and Beyond

David Fajgenbaum, WG'15, MD'13, MSc, Assistant Professor of Medicine University of Pennsylvania and Co-Founder & President of the Castleman Disease Collaborative Network (CDCN)

Wed., June 8, 2022 | 12pm ET

Maternity Care and Technology: Why Collaboration is Key in Moving the Needle

Anish Sebastian, CEO and Co-Founder, Babyscripts

Webinars are FREE for WHCMAA members

$20 for non-members

- **Philosopher's Corner eBook**

  This must-read ebook will feature words of wisdom, insightful musings, life lessons, and stepping stones to business success from the 40 philosophers who shared their thoughts in this eclectic standing column. ***Coming this summer.***

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

THE PRESIDENT'S DESK

- turbocharge efforts to address the voluminous and longstanding health inequities that are under klieg lights as a result of the pandemic

I know our alumni network is up to the task, whether we're treating patients as physicians, studying new treatments, or starting new companies to address these challenges.

Kind regards,

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

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LinkedIn Profile

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ALUMNI NEWS

John Whitman, WG'78
35 years ago, I served as the Administrator of a skilled nursing facility operated by Jeanes Hospital in Philadelphia. Since that time, I started and ran a successful national consulting company for almost 20 years and for the past 15 years, served as the executive director of a non-profit I started dedicated to improving care for our nation's seniors and saving money for our healthcare system. For the past 31 years I have also served as an adjunct instructor in the Wharton MBA Health Care Management Program and plan to continue teaching for many years to come!

Several months ago, I returned to my roots by accepting the CEO position at Chandler Hall Health Services, a senior living community in Bucks County, PA. Like many senior living organizations, Chandler Hall suffered seriously from COVID, and my job is to turn the place around. I am working 14 hours a day … and loving it! The best part, and what I have missed the most over the years, is the regular interactions and involvement with residents!

I have built a great team, and we are on our way to not only restore this organization to operational and financial stability, but to also make it the best facility in Bucks County! I am loving every minute of it! I would love to host and/or talk to anyone interested in learning more about senior care services in general and/or Chandler Hall specifically.

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Tom Davis, WG'87
I guess wearing three hats is a hat trick. I've got three professional roles at the moment. I am chief strategy officer for Imagen.ai, a five-year old start-up offering technology-assisted diagnostics to primary care practices. Besides expansion of the core business, I am developing a full-risk PCP practice for low-income seniors and a virtual cardiology business. Second, I am an active Board member with Guidon Partners. Finally, I continue my work with Mercy Care, an FQHC in Atlanta, and its initiatives in SDOH. Now if I can just learn to skate.

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Cary Pfeffer, WG'91, MD'91
Entering my 15th year as Partner at Third Rock Ventures from when we started the firm in 2007. It has been a heck of a ride so far as we have built and invested in about 58 companies and have 16 products on the market helping many patients. Have been proud to be part of the founding team building great life science and biotech companies over the last many years.

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Todd Guren, WG'03
After 9.5 years of Product Development at Cambia Health Solutions, the Pacific Northwest BlueCross BlueShield, I joined another Wharton alum at Alignment Healthcare. Alignment is a start-up Medicare Advantage company that operates in 4 states and is growing. I switched roles to implementation in the Compliance department and am energized by learning a new functional area and diving into CMS regulations. Alignment added a Senior in front of my old title, and my role is Senior Director of Product and Network Implementation. For colleagues who are recruiting, offer to add Senior to someone's current title, and it will help persuade them. It worked for me, and I am looking to become at least a "Senior" Senior Director in my next role.

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Jonathan McEuen, PhD'09, WG'13
I have been operating as lead of Business Development for Wembly Enterprises, a long-term investment group who fully acquire specialty manufacturing companies for multi-generational investment. After 3 years Leading BD at Shawsheen Coating and Converting (consumer and medical adhesive products), I started Leading BD and R&D at NYCOA, a specialty polymer (nylon) manufacturer in New Hampshire. We have solidified three strategic partnerships for long-term growth, are tripling our on-grounds capacity, and are building out a dedicated specialty applications lab to support growth in the business. Industries we support include automotive, additive manufacturing, industrial products, construction, adhesives, consumer healthcare, and we are expanding into medical devices, and more.

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ALUMNI NEWS

Vivien Ho, WG'21
Vivien Ho, WG'21, just launched the Pear VC Healthcare Playbook Podcast. This podcast will be sharing stories from trailblazing healthcare entrepreneurs and leaders on building a healthcare business from 0 to 1.

Many healthcare founders need to think about how to sell to payers and land a pilot or get their first 100 patients. As pre-seed and seed stage investors at Pear VC, we'd love to create a playbook for them to learn from other healthcare leaders who have done it before.

The first interview is with **Tom Lee, Founder of Galileo Health, One Medical, and Epocrates**, sharing Tom's stories and advice on building tech-enabled service companies from 0 to IPO!

Subscribe on the substack for weekly updates. You can also listen and subscribe to the Spotify podcast or your preferred podcast platform.

Please let Vivien know if you have suggestions on what should be featured next.

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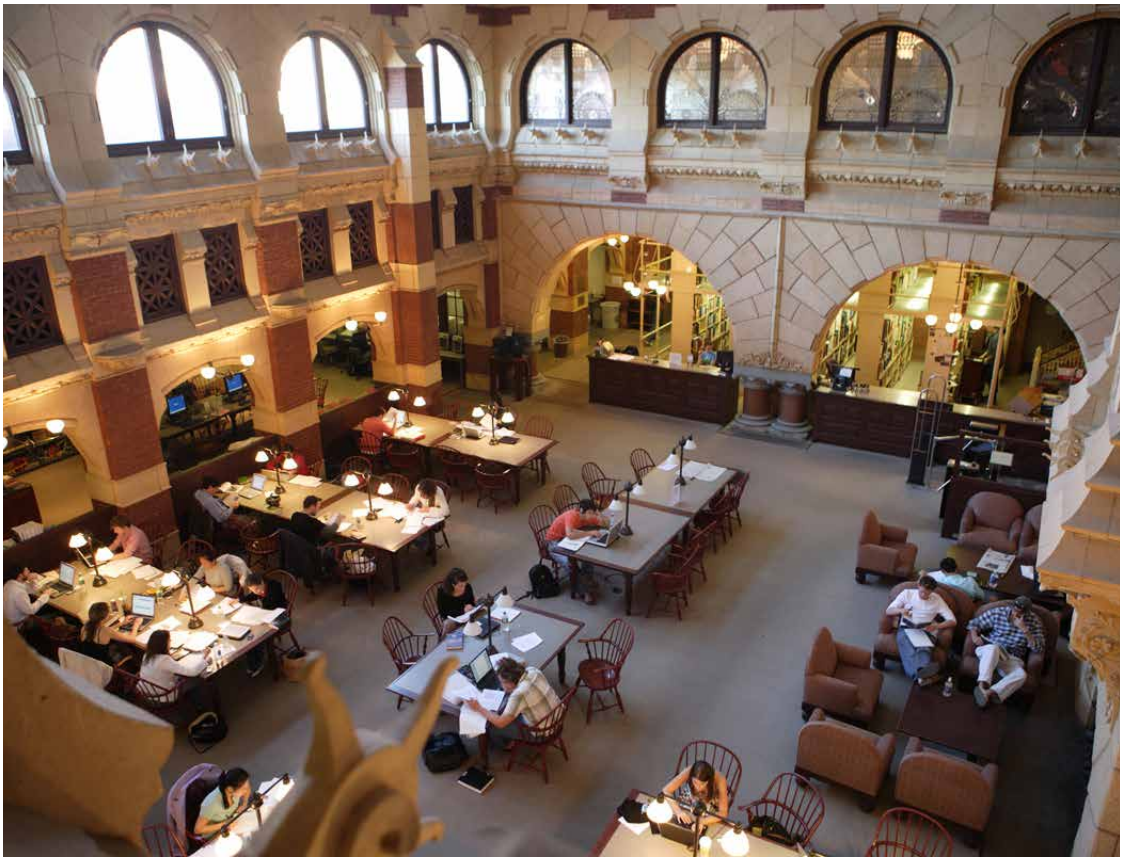

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THIS MONTH'S PHILOSOPHER:
Katherine Clark, WG'15

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...

- asked for more, in every sphere of life - professionally and personally. I am always pleasantly surprised what I can get when I simply ask (an invaluable lesson learned from the books noted below).
- never been afraid to knock on someone's door for professional opportunities or advice.

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

said no to an unexpected opportunity since you don't know what doors it can open in the future.

FAVORITE QUOTES

1. "It isn't what we say or think that defines us, but what we do."
   ~ Jane Austen
2. "The purpose of education isn't only to impart knowledge and skills. It's to instill a love of learning."
   ~ Adam Grant
3. "One of the deep secrets of life is that all that is really worth doing is what we do for others."
   ~ Lewis Carroll

RECOMMENDED READING

1. *Women Don't Ask* by Linda Babcock and Sara Laschever
2. *Ask For It: How Women Can Use the Power of Negotiation to Get What They Really Want* by Linda Babcock and Sara Laschever
3. *The U.S. Healthcare Ecosystem: Payers, Providers, and Producers* by Lawton Robert Burns

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AFFIDAVIT: HEALTHCARE AND THE LAW - TELEHEALTH: HEALTHCARE'S NEW VIRTUAL REALITY

Source: Bigstock

Telehealth start-ups have been the latest group to take advantage of the pandemic-driven regulatory flexibilities granted in the healthcare space. While legal and healthcare professionals have learned over the past two years how to benefit from COVID-19 waivers and regulation relaxations, entrepreneurs are now using those same benefits to create all-new healthcare tools, particularly in the mental health space. From audio-only treatment for patients with substance use disorders ("SUDs") to full-service digital telehealth platforms, these tools bear the potential to reshape virtual medicine — provided their developers enable them to last beyond the pandemic.

IMPOSED AND LIFTED RULES

Telehealth is the delivery of healthcare services through electronic communication. The Centers for Medicare & Medicaid Services ("CMS") has been reimbursing for telehealth services since 2018. But the COVID-19 Public Health Emergency ("PHE") has led CMS and several federal entities to waive many of the usual requirements surrounding these services, granting providers more flexibility to address healthcare needs during the pandemic.

Key requirements that have been waived concern privacy, the patient's location during telehealth services, and the manner of patient-provider interaction. The privacy framework of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), with its amending legislation and regulations, would normally prohibit many forms of telehealth visits due to insufficient security protections.[1] But the Department of Health and Human Services ("HHS") announced at the beginning of the PHE its intent to exercise enforcement discretion toward these rules for good-faith use of less secure services, expressly endorsing the use of popular platforms like Zoom, Skype, or Google Hangouts.[2] This discretion, however, lasts only during the PHE.

Concerning location, standard telehealth rules dictate the patient's location, called the "originating site" in CMS regulations, be a physician's office or other authorized healthcare facility.[3] CMS paused this requirement through an 1135 Waiver, thus allowing patients to receive telehealth services within their own homes, for the duration of the PHE. But CMS then made this change permanent for SUD patients by adding "[t]he home of an individual (only for purposes of treatment of a substance use disorder or a co-occurring mental health disorder[])" to the definition of "originating site."[4]

For non-SUD mental health patients, CMS made the change permanent for mental health treatment generally — but conditioned on certain in-person treatment occurring before and after the start of virtual care.[5] At the same time, CMS also relaxed patient-provider interaction requirements for mental health generally. Standard telehealth rules require "audio and video equipment permitting two-way, real-time interactive communication between the patient and [the provider]."[6] CMS made a caveat to this requirement so that for "services furnished for purposes of diagnosis, evaluation, or treatment of a mental health disorder to a patient in their home," patients may opt to use audio-only communication.[7]

This relaxation extends into prescription services. Generally, prescribing a controlled substance over the internet requires an in-person medical examination.[8] But pursuant to the PHE declaration, HHS and the Drug Enforcement Agency ("DEA") asserted the telemedicine allowance under that controlled-substances statute applies to all schedule II-V controlled substances, provided the prescription is for a legitimate medical purpose, the telemedicine communication meet certain technical standards, and the provider is following state and federal law.[9]

USING THE NEW FLEXIBILITIES TO DEVELOP NEW SERVICES

Platform developers have taken advantage of these flexibilities to produce new healthcare tools that would have been impossible under pre-pandemic rules. The above rules are particularly friendly toward mental health treatment platforms. But the extent of the new freedoms have allowed even the development of full-service virtual health platforms.

Consider Cerebral, Inc.[10] Cerebral runs a mobile app and online platform to provide virtual mental health services. Patients pay a monthly fee for one of three plans: therapy, medication services, or medication with therapy. Patients may pay out of pocket, but Cerebral also accepts payments through FSAs, HSAs, and even several insurance companies. Insurance availability depends on the state (Cerebral operates in all fifty states and Washington, D.C.), but accepted insurers include Aetna, Anthem, Blue Cross Blue Shield, Cigna, and Medicare. Cerebral launched in 2020, with investment help from Access Industries, and aims to be available to all insured Americans by 2023.[11] By June 10, 2021 it had quintupled its valuation to $1.23 billion; six months later, it quadrupled that valuation to $4.8 billion following an equity-financing round led by SoftBank Vision Fund 2 that brought in $300 million.[12]

Existing entities like Yale Medicine have also benefited.[13] Yale began using Zoom for telepsychiatry visits early in the pandemic. The switch to virtual care offered unique opportunities to interact with mental health patients through activities like live cooking lessons or videogames. These also helped to engage children in mental health visits. With in-person services returning, the development of online treatment has granted patients the flexibility to choose between virtual or in-person options. This flexibility also expands the scope of treatable patients, for transportation barriers are often greater than technological ones.

Or consider Antidote Health, which provides a full-service platform.[14] As such, Antidote provides a select set of services, including primary care physicians, medication prescriptions, and even, as part of its PLUS plan, a health debit card for medications. Patients can pay for a one-time visit or can select a monthly individual plan or family plan, although Antidote does not yet work with any insurers. When patients request services, Antidote uses an AI chatbot system to triage patients and connect them to the appropriate doctor. As the above DEA relaxations apply only to mental health, Antidote cannot prescribe controlled substances but prescribes many other routine treatments. After launching in January 2021, Antidote raised $12 million in August 2021 through seed funding by angel investors like iAngels, Well-Tech Ventures, and Flint Capital.[15]

POST-PHE PRECAUTIONS

While most of the above flexibilities are here to stay, many begin and end with the PHE. Further, state-level telehealth issues remain. The question of whether a physician

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licensed in one state can treat virtually a patient located in another state differs state-by-state. And some Medicaid companies do not pay for out-of-state services. HHS has created a guide to telehealth licensing requirements and interstate compacts to help patients navigate these questions, but the difficulties remain.[16]

Added opportunities like the ability to use Zoom for patient calls give developers the flexibility to try new ideas without having to reinvent every part of telehealth. But such developers should be prepared to find alternative solutions once the PHE ends.

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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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DOWNLOADING SUCCESS: GET WHAT YOU DESERVE - STEPS TOWARD EQUITABLE PAY

Women and people of color have made strides toward pay equity in leadership roles, but more progress is needed. While some employers believe pay imbalances will sort themselves out as more women and underrepresented groups ascend to top executive positions, the reality is there are inherent obstacles preventing this transformation from happening. One is that, despite changing laws and regulations, many compensation packages are still based on the chosen candidate's current salary and benefits.

It can be difficult for individual executives to lobby for fair compensation, yet it is important to do so. We share the following recommendations for ensuring your pay is equitable and balanced with others who have your skills and abilities:

1. **As a best practice, do not provide your current compensation as you pursue a new position.** Many states have laws on the books that prevent employers from asking about your salary history, so educate yourself on those laws. Even in locations that allow employers to ask candidates to disclose their current compensation, we recommend to job candidates that they lead with their salary expectations. Insist that your salary determination be aligned with what the current market will dictate.

2. **Sharpen your salary expectations.** Many organizations take the approach of asking for a candidate's salary expectations. Once you educate yourself as much as possible (see the above), formulate your desired compensation. Do this at the start of the recruitment process and be comfortable in sharing this information with both the hiring authority and search consultant (if applicable).

3. **Educate yourself about what a position should command.** Go into a job search knowledgeable about compensation ranges. Do your homework with publicly available information for your position:

    - Research your desired employer. Especially at public institutions, information regarding current executives' compensation may be available.
    - Familiarize yourself with industry benchmarks and salary surveys, such as those compiled by AAMC (in academic medicine), MGMA, or compensation firms.
    - Network. In talking with others in your industry, gain a better sense of what compensation package you should expect in a potential new role.

    Doing your homework also applies to internal promotions. It is common for organizations to have rigid percent increases for internal promotions that perpetuates pay inequity. In negotiating your new compensation, be assertive: "I have done external market research, and I should be within this range."

4. **Go beyond salary.** As you begin to negotiate, focus on the important details that are part of an entire compensation package. These include:

    - Your expectations or requirements by specific elements of compensation and benefits, such as:
        - Retirement: 401(k), 457(b), pension, deferred compensation
        - Health insurance
        - Paid time off and vacation
        - Signing bonus
        - Relocation costs
        - Executive coach
        - Professional development
    - Compensation you need to transition to a new role due to forfeited compensation associated with your resignation from your current employer (typically equity and deferred compensation).

5. **Take into account the geographic location of the position.** Compensation for a position in Manhattan, New York will be much different than in Manhattan, Kansas. Factor the living wage and standard of living for a location into what your expectations are. Check real estate sites for comparable housing where you live now.

6. **Understand the connection between position type and compensation.** Salary discrepancies between white men and women and diverse executives are often a product of the positions they hold. White men are more likely to hold top-earning roles like CEO/president, COO, and CFO, which skews the salary imbalance. Obviously, pursuing these roles yourself is one way of ensuring you will receive greater compensation. In addition, encourage your employer to conduct a comprehensive organizational review of compensation at the executive level, and to look for ways of balancing traditionally undercompensated roles (a Chief Nursing Officer, for example) with other executive positions.

In summary, equip yourself as a candidate with as much information as you can to ensure you are positioned to obtain pay that is equitable – and what you deserve. In an ideal world, organizations will offer competitive compensation ranges which will obviate the need for salary negotiations. This will make the process more enjoyable from both perspectives.

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CYBERVITALS: HEALTHCARE CYBER EVENTS ARE COMMON, BUT IT DOESN'T HAVE TO BE THIS WAY

HEALTHCARE DOES HEALTHCARE

Healthcare is a cyber criminal's dream. It presents the intersection of a data treasure trove, weak security posture, limited resources, complicated supply chain, and patient care delivery. When faced with having to pick a priority to optimize for, healthcare will, of course, always pick delivering healthcare.

A great example of this is looking at how connectivity evolved in medical devices. Initially, devices got an ethernet port because providers could enhance care delivery with limited connectivity. This evolved into more complex and cross-organizational data sharing, workflows, and systems to support care delivery, eventually spreading into cloud and electronic health record integrations. With COVID, the push for telehealth and remote patient monitoring has taken many of these devices beyond the walls (and protective network) of a healthcare delivery organization (HDO) and into the hands of consumers. Healthcare went from large islands of information to highly integrated within a decade.

These innovations greatly enhanced patient and provider experience. But they also introduced a variety of cybersecurity considerations that were generally not solved because this had never been done!

STATE OF CYBERSECURITY AFFAIRS

While HDOs have increasingly been building cybersecurity competency, it's really hard for the consumer (i.e., the HDO) to legally, technically, and, in the context of a complicated IT infrastructure, assess the efficacy of a device's cybersecurity posture, challenging their willingness to accept a higher price of a more secure device. This comes full circle as medical device manufacturers (MDMs) cannot justify investing in cybersecurity, when the market does not reward their incremental costs.

Given technical, regulatory, and legal limitations, HDOs effectively inherit MDM security decisions for devices procured, creating a dependence on MDMs publishing/facilitating updates, while the HDO is expected to continue to deliver safe and effective care.

This problem persists beyond the recommended shelf-life of a device. In a hypothetical HDO, if a $1 million device has reached the end of software support, but continues to be clinically effective, the HDO is faced with a decision: purchase a new device that's supported, apply (with restrictions) security measures external to the device, or delay until clinical impact warrants investment in a replacement device.

And, as noted above, HDOs optimize for healthcare delivery and patient outcome, and they should. Therefore, it can be difficult to shift procurement, budget, staffing, and operations to prioritize software updates or device replacements in the absence of clinical justification, when not clinically required, or taking a life-sustaining device out of operation to upgrade for any period of time.

In 2016 when the FDA released their post-market cybersecurity guidance, it stipulated the collection of so-called cybersecurity signals. This indicates that at a future date we will have access to more telling technical insight to assess the impact of device information integrity on clinical outcomes. It also indicates at this time, most 'live' devices were never architected to capture security log data - reinforcing that evidence of security incidents is difficult to obtain.

Last year saw an increase in cyberattacks on HDOs, including ransomware attacks, which previous studies demonstrate have an impact well beyond the "resolution" of the incident. This is further exacerbated by COVID, as substantiated in a recent study from

CISA (Cybersecurity and Infrastructure Security Agency).

All signs indicate we are not sufficiently cybersecure for the way healthcare wants to deliver care. The global pandemic complicated this vulnerability as healthcare workers were rapidly deployed home and asked to work remotely in rapidly established environments. As some hospitals noted, it accelerated digitization of operations by at least 10 years. Considering this unanticipated fast-track scenario in the context of increasingly moving care delivery to patient homes, the inherent protection of the hospital network was essentially eliminated. Furthermore, being outside of the hands of providers, the ability to do routine maintenance/security updates became increasingly difficult.

PRACTICAL ADVICE

The roles of HDOs and MDMs are complementary, and both need to cooperate to sustain a cyber-resilient posture.

HDOs and MDMs alike need consistent and transparent regulatory requirements and enforcement. Regulators are working hard to generate new guidance and seeking authorities to be able to implement consistent and transparent regulation.

Meanwhile the Health Sector Coordinating Council (HSCC) has combined resources across HDOs to propose contract language to aid with cybersecurity assessments as part of the procurement process, while cybersecurity leader Mayo Clinic publishes their risk assessment criteria for public consumption. Engaging with a group that drives activities, whether through industry collaboration or even group purchasing organizations (GPOs) that are assessing cybersecurity risks, seems like a practical and scalable starting point.

MDMs need to build products that meet a security baseline, are patchable, and are likely to get patched. In other words, secure at birth and securable thereafter. To do so, MDMs not only need technical capacity to identify threats and design security controls, they need to transform their organizations to establish the capacity and knowledge to create secure products at scale.

This critically important step in the product development cycle requires strong signals from executive leadership with clear lines of accountability for pre- and post-market risk.

Acknowledging there are three main groups of devices, each requires a unique cybersecurity strategy:

- **New devices**: Begin the design with security considerations outlined, leverage tools to actively address as device innovation evolves, and don't go at it alone.
- **Devices still under support in field**: Risk-rank where to start in the portfolio, and tackle with operational support prioritizing uptime and security concerns.
- **Legacy devices**: Determine the strategy to the end of support phase of what's in the field, and work with HDOs to prioritize moving onto the next generation.

PATH FORWARD

Healthcare's reliance on technology will never go away — it has improved diagnostic capabilities, given us new treatment options, and reduced time, effort, and risk for patients. Therefore, we must make the security component of this process a positive experience for the user and/or patient, as that can mean the difference between the success or failure of a cybercriminal.

With every additional connected point, a potential new risk is introduced which must be understood, mitigated as necessary, and managed over time.

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"ANNIVERSARY SPOTLIGHT": MOVING UPSTREAM TOGETHER - HOW GEISINGER BUILT A PERPETUAL INNOVATION MACHINE TO IMPROVE OUTCOMES

Before 'value-based care,' 'alternative payment models,' and even 'electronic health record' became buzzwords, Geisinger was thinking about what went wrong in U.S. healthcare, which also meant thinking about ways to improve it. Nearly 20 years ago, our leadership questioned the rationality of a reimbursement system that solely rewards quantity over quality in care delivery. Revenue derived from illness and its complications rather than preventing illness in the first place simply made no sense.

We decided to do something about it.

To upend the status quo of misaligned incentives in healthcare, Geisinger refocused on optimizing health clinically, operationally, and financially. That meant our care delivery services needed to move upstream of acute care delivery. To improve the health of the people we serve – and to do so at lower cost – we needed to prevent illness from happening in the first place.

We recognized, however, that no matter how effective such preventive programs were, acute illness would still always impact some portion of the people in our care. We developed a new payment model of bundled services of evidence-based, condition-specific protocols that would ensure high-quality, consistent, and complete care without incentivizing unnecessary care. It would align clinicians, payers, and patients in achieving better outcomes at lower overall cost.

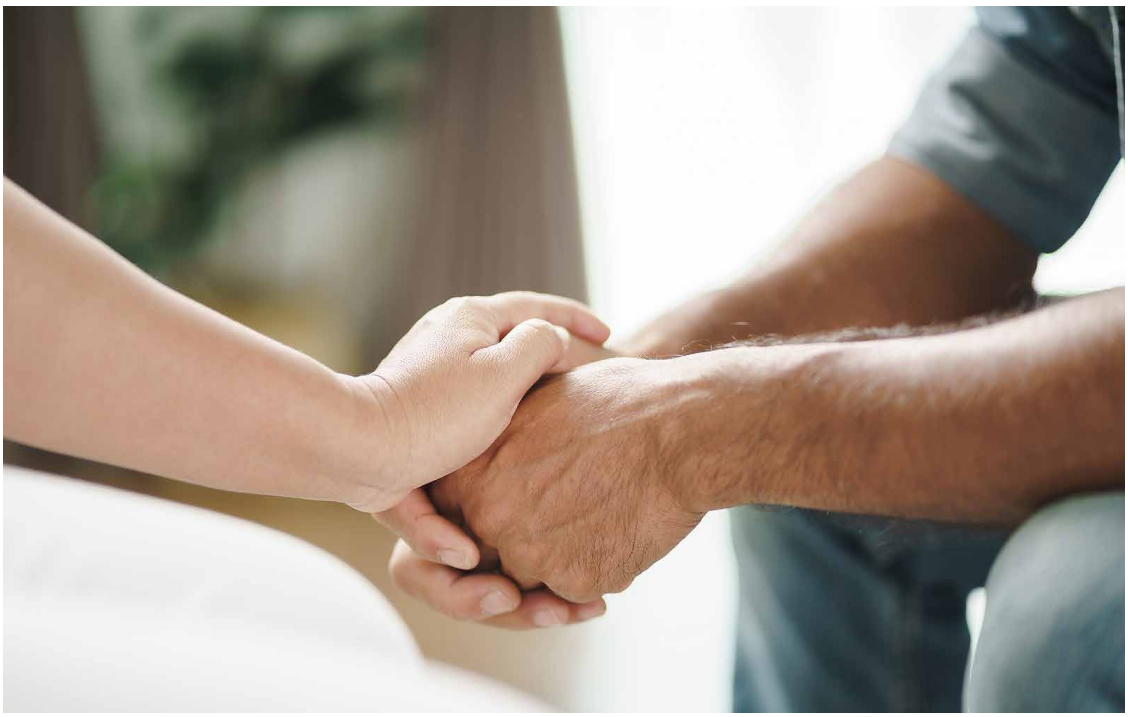
The solution we landed on over 10 years ago – and discussed when we first contributed to the Wharton Healthcare Quarterly in 2012 – became known as ProvenCare,® and we piloted it with coronary artery bypass graft (CABG) procedures. ProvenCare sought to reduce unwarranted variation across certain episodes of care and, by doing so, it lowered complication rates and reduced readmissions. Now, several iterations later, we've expanded to dozens of additional procedures and, more recently, we applied this same framework to incorporating 'enhanced recovery after surgery' into a series of protocols now called ProvenRecovery. From 2017 to 2020, ProvenRecovery led to a 75% reduction in mortality, 18% reduction in complications, 13% reduction in lengths of stay, and 15% reduction in readmissions. ProvenRecovery is even **helping solve the opioid epidemic by systematically managing pain in order to minimize the need for opiate analgesics**. In the past three years, ProvenRecovery has cut post-operative opioid

prescriptions by **more than half**. And, in an example like bariatric surgery, costs have been reduced by more than 16% compared to industry benchmarks.

PROVENCARE

The common sense, patient-centered concept of ProvenCare and ProvenRecovery has become the foundation of how Geisinger thinks about healthcare. Today, Geisinger is an integrated health system built on a culture of innovation and continuous improvement, a place where all stakeholders – providers, payers, and patients – are aligned to move care further upstream, provide complete care, and, together, prevent unnecessary and costly care.

Today, we're adapting this thinking to continually shift from the traditional notion of focusing most of the delivery of care services in large tertiary/quaternary campuses to developing care programs and meeting people and communities closer to where they are – whether in the home, in smaller and more convenient access points out in the communities, or even virtually. Our strong belief, rooted in real-world data, is that the modern-day approach to value-based



Source: Bigstock

care should focus on building great programs and deploying them right into the communities that need them most. This thinking has spawned a number of value-based innovations with proven value clinically, operationally, and financially:

- **65Forward** is a senior-focused, primary care model that combines health services and wellness activities within its centers. With patient panels limited to a fifth of the size of typical primary care panels, 65Forward provides seniors with same-day appointments and longer visits, often up to a full hour with their PCP. The centers try to co-locate many of the most common services under one roof, including lab, imaging, mental health, and dietary guidance. They also offer seniors fitness and exercise equipment, as well as activities from yoga to card games to promote socialization, friendships, and a true sense of community. Each member is provided a personal wellness plan and

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wellness coordinators to help them stay on track. The result of this kind of integrated, convenient health care? 65Forward members have about 15 percent lower inpatient hospitalization rates and about 40 percent lower rates of emergency room visits.

- **The Fresh Food Farmacy** program provides food as medicine to treat type 2 diabetes and other diet-sensitive conditions. By supplying fresh produce and lean meats for about 18,000 meals weekly to participants and their household members, it has proven to be a successful program for battling food insecurity and managing chronic disease. Participants require hospital admission 22 percent less often and go to the ER 18 percent less, which of course leads to lower total cost of care. Not to mention that Fresh Food Farmacy has been about twice as effective as traditional medications in controlling blood sugar levels.

- **Mail-Order Pharmacy**, our pharmacy delivery service, delivers maintenance medications to patients dependably and timely. Use of the program exploded during the COVID-19 pandemic, but even before that, the program was growing in popularity for its convenience and affordability. When patients didn't have to worry about refills or travel to the pharmacy, they were able to stay on their medications more consistently, with a nearly 40 percent increase in medication adherence. The Mail-Order Pharmacy program is proof that convenience pays dividends in better health.

- **Geisinger at Home** moves team-based monitoring and actual care into the homes of our sickest 3 to 5 percent of patients, particularly frail seniors who live alone, and coordinates with primary and specialty care to provide ongoing clinical services as needed. For the more than 7,600 patients who have been enrolled in the program, we've seen a 23 percent drop in ED visits and a 35 percent decline in hospital admissions.

- **The Geisinger Commonwealth School of Medicine** is a critical piece in how we get upstream to provide care closer to home in our communities. We're now several years into offering the Abigail Geisinger Scholars program, which provides medical students a tuition-free education and living stipend in exchange for a work commitment back to Geisinger in critically needed areas like primary care. Abigail Geisinger Scholars now make up about 40% of our M.D. admissions. By removing financial anxieties that could sometimes steer students away from primary care and into specialized practices, we're building a pipeline of primary care providers who are trained in our innovative models, which bolster the ability to develop care models that manage total health and prevention. Through all of this, medical education becomes more accessible to people who may be the first in their families to go to college or pursue medicine while fostering a more diverse healthcare workforce.

Across all these programs and those still to come, addressing total health is at the core of how Geisinger moves care upstream. These and other programs meet people where they are — in their homes, communities, virtually, and in rural and urban areas — and help to identify and overcome the barriers to care (social and otherwise) in order to achieve better

health. Of course, bringing such programs to life is enabled by investments in technology and people, but we have seen firsthand that improved health in the community's results from these efforts.

ProvenCare was just the first chapter in Geisinger's value-based care book ten years ago – one we are still writing today. It was the beginning of a mindset built on the belief and confirmed by data that more care isn't always better care. While building a value-based health model is admittedly very difficult and we still have much left to do, we believe Geisinger has proven that pursuing a single north star – moving upstream to create better outcomes – can restructure care delivery so it aligns and creates value for providers, payers, and patients alike.

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#THISGOESWITHOUTSAYING

Source: Pixabay

File this under #ThisGoesWithoutSaying… Our country has a workforce problem that is creating unimaginable pressure for everyone. As in – there is LITERALLY no one left behind – only this time it's not in a good way.

We don't need to rehash the data (and there are **tons** of data) – you know it, are living it, or will live it. Under "normal" circumstances, being a "double duty" caregiver – caring for people at work and at home - can be intense. COVID has turbo-boosted that intensity - perpetuating cycles of upheaval, constantly saddling working caregivers with new challenges. You don't just have to take our word for it— ARCHANGELS collaborated with members of the CDC to publish a study last summer that found that unpaid caregivers (someone caring for a child or adult over age 18) had significantly worse mental health than adults not in these roles. To be exact: 70% of all caregivers reported adverse mental health symptoms (such as depression and anxiety). For 'sandwich generation' caregivers (someone caring for a child AND an adult)—this percentage soared to 85%. And to take it one step further, nearly 52% of this group reported recent serious suicidal thoughts.

We know that caregivers need a lifeline. This is exactly why ARCHANGELS has its platform – to help employers get the resources they have directly to who needs them most.

And just in case the numbers you are seeing fly across every screen imaginable about caregiver burden, the "Great Resignation," inequity, and mental health impacts are somehow feeling one step removed – CONSIDER THIS: ARCHANGELS did a quick survey of Wharton caregivers over the past few weeks, and here's what we learned:

- 46% of those caring for loved ones are 'in the red' compared to 25% of the U.S. on average – that's almost half of your colleagues, neighbors, friends (chances are it's YOU) who are feeling serious impacts from all that is being required of them.

- The top buffer, or thing most alleviating intensity, at 54%, is having the ability to manage expenses, while the thing most driving intensity is having no time for yourself.

Here's the big picture: even in a community like Wharton, where financial resources are more readily available than the U.S. population as a whole, there are still incredibly high levels of caregiver intensity, and it doesn't guarantee that respite is available OR that those with the means to access it even know how or where to do so.

So…what do we DO with all this data? ARCHANGELS believes in leveraging it to build an immediately actionable, sustainable, and scalable set of next steps for creating impact.

1. Start talking about the unpaid caregivers in your workforce right now. Do not pass go, do not collect $200. 43% of adults in the country right now are serving in this role – and it's severely impacting their mental health. At every meeting you join for the next week, share your own story. You have one - guaranteed. It might not be you right now – but at almost 1 in 2 people…it is definitely someone you know. By bringing this topic up over and over and over, by bringing our own story to others, we give others the ability to see themselves reflected in that same reality. You can't manage what you can't measure, but you can't measure what no one acknowledges is happening.

2. Point people to the Caregiver Intensity Index™ (CII). Start with you. The CII is a two-minute, completely confidential quiz that gives you an immediate insight into your caregiving reality, helping you quickly parse out why things may be feeling suffocatingly hard.

3. Know your Intensity Score and whether you're in the green, yellow, or red. Use this language. Start normalizing what it means to be 'in the red' so that others are aware and understand that your "approach-with-caution" sign isn't personal, that you could use support, and moreover, that you probably won't ask for it.

4. Pay serious attention to the top things driving your intensity (Drivers), and those alleviating it (Buffers). Whether you're reading this right now from the perspective of an employer or an individual – you need to know where to invest resources first because the need is highest, and at the same time understand what is ALREADY working to keep your intensity or the intensity of your organization trending in the right direction.

5. Get VERY familiar with what resources exist to support you in reducing that intensity – whether it's by getting help in alleviating those drivers, or support in getting yourself more of those buffers. Knowledge is power – and we believe the knowledge of what can lower intensity is one of the MOST important superpowers. If you need them, ARCHANGELS has free resources that you can use to get started. Our BEST recommendation? March into your HR office, literally or figuratively, and ask where you can get support for whatever those drivers are. Ask what your company is doing to support unpaid caregiver stress. Share your own story.

As Wharton alumni, many of you are starting new companies and leading industries. You are uniquely positioned in these roles to advocate for caregiver support – for yourself and for those working alongside you. ARCHANGELS is here to help. But don't wait on that. Don't crawl, don't walk, just RUN as fast as you can toward addressing the Caregiver Intensity of everyone around you – starting with yourself. We can't fix the reality of the true h*ll that is the working reality for so much of our nation right now, but we can do something to make it better.

WINGS UP!

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SPRING 2022
Volume 11, Number 2

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THE RECIPROCITY OF GRATITUDE

In keeping with our 2021 Feature Article series on gratitude, we continue to look at the current state of the healthcare workforce, clinicians and non-clinical staff, to uncover current findings on the science of gratitude and the reciprocal benefits for individuals, organizations, and patients.

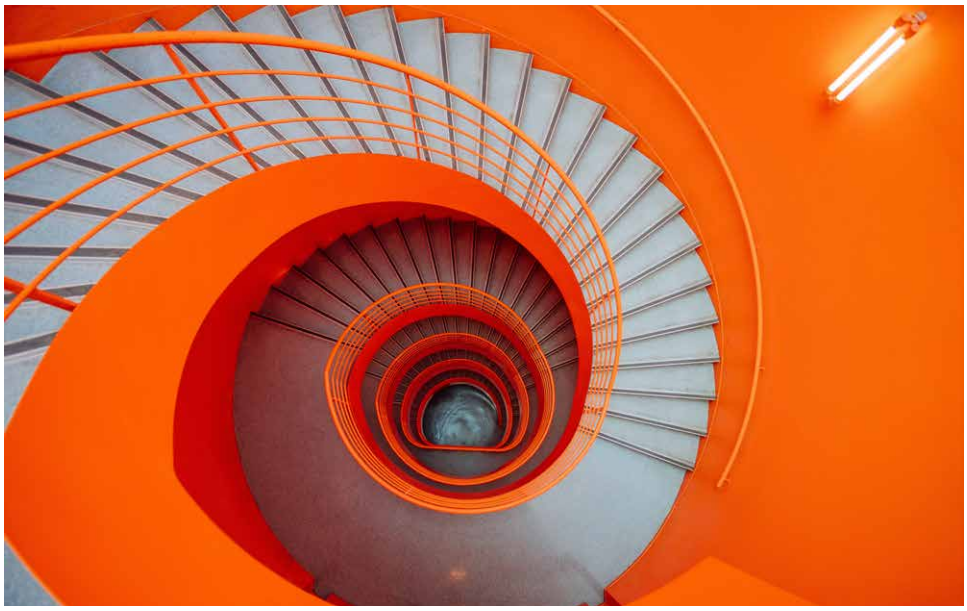

Photo by Maxime Lebrun on Unsplash

According to a search on PubMed, queries on gratitude have almost doubled (195/372) between 2019 and 2021. Related studies range from:

- Health and well-being outcomes, including lower levels of clinician burnout, are improved.
- Gratitude as an organizational value predicts engagement, job performance, and job satisfaction.
- Patient gratitude, influenced by a high-level relationship quality, translates to increased patient loyalty.

SO, WHAT IS GRATITUDE?

As described in the Wharton Healthcare Quarterly Winter 2021 issue, gratitude comes from the Latin root of gratus or gratia — "thankful, by favor." It's considered a state of mind, a spontaneous feeling, an emotion, and a strength. Roman philosopher Cicero once said, "Gratitude is not only the greatest of virtues but the parent of all others." One of the most cited definitions of gratitude is that of Robert A. Emmons, Ph.D. - "**the affirmation of goodness and the recognition of goodness outside ourselves**."

RECIPROCAL GRATITUDE

Current research has established the cultivation and sustainability of gratitude practices have a multiplier effect on building quality relationships and promoting more pro-social behaviors, often called the "social glue." Foundational to much of the research is the finding that gratitude triggers several forms of reciprocal gratitude. The Law of Reciprocity implies being on the receiving end of gratitude creates a psychological need to reciprocate. Reciprocal gratitude can be:

- Direct – in return for someone doing something helpful for you
- Downstream – others helping you because you've helped someone else
- Upstream – better known as "pay it forward," you help others because you've been helped

It's important to note reciprocal gratitude is **not about** feeling obligated or indebted to someone. Misusing gratitude between peers or from manager to employee as a means to get something in return erodes trust and sets up a toxic work environment. Instead, frequent, nonjudgmental, and genuine gratitude yields the greatest benefits overall.

THE CURRENT DISRUPTIVE STATE OF THE HEALTHCARE WORKFORCE

Here's what we do know about the current state of the healthcare workforce. Clinician burnout and moral injury (perpetrating, failing to prevent, or bearing witness to acts that transgress deeply held moral beliefs and expectations) are at an all-time high. Staffing shortages are impacting every job function and the ability to get the job done well and safely. Healthcare entities are more aware of the critical need to support employees' overall health and well-being. Recent publications note competition and margin pressures are driving many hospitals to consider strategic merger opportunities — putting further stress on an already overwhelmed and exhausted employee population.

A silver lining? The burgeoning research on the science of gratitude continues to confirm the significant and positive impact on individuals, communities, and healthcare institutions. In our coaching and team-building work, leveraging these findings and developing corresponding resources can fully support the current state by creating a more healthy work environment (HWE), especially when influenced by top leadership and further leveraged throughout the organization.

Source: Unsplash

CAREGIVER AND PATIENT GRATITUDE

Several recent studies have sought to understand the relationship between caregiver and patient gratitude, including the reciprocity between employees' health and patients' quality of care. In light of the growing competition fueling strategic hospital mergers, loyalty to caregivers is of key importance.

One study looked at the role patient gratitude plays in relationship quality and patient loyalty. Patient perception of the quality of the relationship (determined by trust, commitment,

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and satisfaction) translates to an increase in physician loyalty via patient gratitude. Gratitude is a driver of a successful relationship between physician and patient. "**Gratitude represents the emotional core of reciprocity and plays a key force in the building of a mutually beneficial relationship.**"

Results from another study confirmed expectations about patients' support and gratitude as factors in reducing nurse burnout, including a decrease in emotional exhaustion and an increase in the sense of personal accomplishment. This and other studies acknowledge the significance of reciprocity between employees' health and patients' quality of care.

EMPLOYEE AND ORGANIZATIONAL GRATITUDE

A 2019 study confirmed three types of gratitude as predictors of job satisfaction and job performance:

1. **dispositional gratitude** - a personal tendency to notice and appreciate the positive
2. **collective gratitude** - experienced by employees toward the organization
3. **relational gratitude** - one received from customers, such as clients or patients

The study highlighted the importance of relational gratitude and reciprocity between organizations and clients or patients and the adverse impact a complaint can have on worker satisfaction and performance.

Additionally, a September 2021 study indicated having the perception of being appreciated by others at work showed a significant association with work engagement. This association was independent of job demands and job resources. Social norms of reciprocity indicate positive actions lead to positive outcomes, whether in personal or organizational relationships.

RECOMMENDATIONS

Knowing the strong association between gratitude and its impact on the workforce, here are several recommendations. When considering these recommendations, identify which ones offer the greatest opportunities for direct and downstream reciprocity based on mutual benefits as they seem to offer the greatest impact on outcomes.

- Familiarize yourself with the various types of gratitude interventions. Include your team in determining which ones will support a healthy work environment. Develop criteria based on interventions that meet your employees' and patients' needs.
- Offer gratitude programming that specifically supports your organization's current wellness activities, leadership development initiatives, or as part of a culture change process to promote greater reciprocity.
- Survey employees and patients for top stressors and identify gratitude programming and interventions to serve as a coping mechanism, support mental health, and strengthen employee-patient relationships.

Becoming more aware of and leveraging the science of gratitude, the ongoing research, and real-time applications will enable organizations to more successfully retain top talent and engage teams to be more open, creative, and innovative. These are true differentiators of the work environment, one that is thriving, positive, and healthy.

Want to learn more?

- 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

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RECOVERING AND THRIVING POST-PANDEMIC - PART 4: HEALTH EQUITY

As with the prior articles in this series, we will be focusing on the activities healthcare leaders can undertake in service of financial and operational recovery from the COVID-19 pandemic. Health equity is an important topic for a variety of reasons, and this article encompasses current realities of healthcare payment and delivery and simplifies the complicated history of how our healthcare system has evolved in the way it has.

Before we begin discussing health equity, we would be remiss if we didn't take a moment to acknowledge an important reality: the goal posts marking the "end" of this pandemic keep moving. Emerging variants and associated surges in cases/hospitalizations/deaths have forced healthcare leaders to continue to struggle with operating healthcare organizations amid constantly changing demands. The tactics we outline will be relevant even if the pandemic continues to strain resources and further blur the finish line.

As the pandemic grinds on, healthcare system realities still disproportionately challenge marginalized racial/ethnic communities. Disparities in access to healthcare, as well as health outcomes, have long been known to exist in these populations. Programs and systems in place for healthcare payment and delivery have simply not been reformed sufficiently to sustainably address very long-standing disparities which have only worsened during the era of COVID-19.

Simply glancing at industry headlines reveals startling statistics. For example, when considering clinical outcomes related to childbirth (that the average American would expect to be routine and normal), clear evidence demonstrates disparities not only exist, but also fall along racial lines. Specifically, according to Blue Cross Blue Shield's "The Health of America Report,®" the Severe Maternal Morbidity (SMM) rate in majority Black communities was 63% higher in 2020 than in majority white communities. The underlying factors complicate even routine deliveries, endangering mothers and infants. According to data assembled and published by The Commonwealth Fund,[1] the maternal mortality rate for Black women is three to four times higher than their white counterparts, even when educational level and socioeconomic status are the same. These statistics are just a sampling of data pertaining to maternal/child outcomes.

More broadly, organizations should be very aware of the negative impact health inequities are already having day in and day out on the bottom line. For example, a 2018 study by the W.K. Kellogg Foundation and Altarum calculated the cost of health disparities to be $42 billion in lowered productivity and $93 billion in excess medical costs each year.[2]

When considering the pandemic, we now know patients with underlying conditions and socioeconomic determinants of health (SDOH) challenges have measurable differences in disease acuity and recovery compared to healthier populations living in conditions which provide access to resources conducive to a healthy lifestyle and lower risk of illness. The "Economic Impacts of Health Disparities in Texas 2020,"[3] a report published through a collaboration between Johns Hopkins, Altarum, Tulane, and Uniformed Services University, determined the cost of racial health disparities related to COVID-19:

- If Black and Hispanic people in Texas had had the same rate of hospitalization as white counterparts, there would have been 24,000 fewer hospitalizations, which would have resulted in $550 million in healthcare cost savings.

- In the U.S., health disparities have resulted in $2.7 billion in excess medical spending and $5 billion in lost productivity — a 60 percent increase in excess medical spend and 72 percent in lost productivity since 2016.

Rightfully, this has all helped propel health equity into the foreground. As never before, we can demonstrate disparities in health are real, measurable, and cause a far-reaching impact to human quality of life, longevity, and both the cost and quality of care. These impacts are not just to the individual, but the healthcare system and society as a whole.

Everyone sees health equity slightly differently. Our four-part definition of health equity is based on what we see in communities across the country:

- **Health Disparity** – a particular type of health difference that is linked with a social, economic, and/or environmental disadvantage. These are preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health.[4]

- **Health Literacy** – the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.[5]

- **Social Determinants of Health** – the range of social, environmental, and economic factors that can influence health status.[6]

- **Cultural Humility** —> **Sensitivity** —> **Competency** – a set of integrated attitudes, knowledge, and skills that enables a healthcare professional or organization to care effectively for patients from diverse cultures, groups, and communities.[7]

What is being done to address these issues? How can investing to correct health inequity help healthcare organizations recover from the pandemic?

Federally, the Center for Medicare and Medicaid Innovation (CMS CMMI) makes it clear health equity will be core to establishing and evaluating its payment and care delivery models. In its 2021 Strategy Refresh, CMMI went as far as to acknowledge that many of its existing models do not reflect the full diversity of beneficiaries. Further, they will be ensuring models are redesigned, removing implicit bias from design and evaluation. While it may take some time for the strategy to be implemented, we believe healthcare organizations will be able to participate in models making investments in delivery systems proportionate to the degree of inequity. Specifically, we expect future programs to financially reward participants that build care models to manage population health by closing health disparity gaps and addressing other root causes of inequity at their own local/regional levels.

Beyond CMMI, CMS has proposed a change to the Stars rating system for Medicare Advantage and Part D plans. The proposal is the first step in a multi-year approach to embed a Health Equity Index into the Stars rating system. CMS proposed beginning with SDOH in 2023, by adding a quality measure to assess how often plans are screening for common social needs such as food insecurity, housing insecurity, and transportation challenges. This signals a heightened commitment to address inequity, and future proposals are expected.

Outside of CMS, other national organizations are focused on promoting and funding programmatic impacts to address health inequities. For starters, the National Committee for Quality Assurance (NCQA) has recognized that high-quality, accessible care **is** equitable care. They have rolled out a new and enhanced certification for health equity accreditation, following a rigorous set of standards. NCQA envisions this certification to objectively define when organizations have transformed their business practices to provide equity across all populations they serve.

At the State level, some are or will make serious programmatic changes and invest intentionally to correct some of the root causes of inequity. A current example is the effort by the New York Department of Health (DOH) to design a Section 1115 Waiver[8] to demonstrate a reimagined Medicaid delivery system can make a material impact on improving health equity. In a concept paper from August 2021, DOH outlines a

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SPRING 2022
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RECOVERING AND THRIVING POST-PANDEMIC - PART 4: HEALTH EQUITY

specific goal of its proposed waiver as "Building a more resilient, flexible and integrated delivery system that ***reduces racial disparities, promotes health equity***, and supports the delivery of ***social care***." New York's vision is to invest heavily to strengthen the delivery network, by building culturally competent and accessible primary care and by supporting community-based organizations to address SDOH as part of the Medicaid payment system. When successful, New York will set an example for how dramatically reforming Medicaid can spark a ripple effect to Medicare and commercial plans to correct root causes of health inequity, while providing a blueprint for other states.

Lastly, we believe opportunities exist to address inequity outside the delivery system. Specifically, we see a newfound focus on the development of the clinical and research workforce by upgrading medical school and residency/fellowship programs – not only promoting diversity in enrollment, but also refreshing training curricula to incorporate health equity as a foundational component of skill acquisition. Over time, these changes directly impact the workforce entering the delivery system to improve the health and well-being of both patients and providers, while also contributing to the quality outcomes that improve the financial health of the practice, hospital, or health system. Improving Stars and other quality ratings and addressing components defining success in value-based payment arrangements are key examples.

Recovering in a post-pandemic world will take many forms, so organizations will have to employ a number and combination of different tactics to fit each unique situation. Making this reality even more complex is the continued evolution of the pandemic's trajectory. Amidst all this, healthcare organizations should continue to rightly invest to correct inequities as a component of their post-pandemic recovery plan. These investments are critical to redesigning a delivery system that is accessible to everyone, and more robust in the face of future healthcare crises.

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THE WORKFORCE CRISIS IS AN UNIGNORABLE MOMENT FOR HEALTHCARE

Source: Pixabay

Staff out sick with COVID. Nursing shortages. Healthcare workers "quitting in droves."[1] The healthcare industry faces a shortage of people in critical roles while demand for care has surged. Active struggles with workforce satisfaction, recruitment, and retention loom large for health systems. At a time when long-term priorities need attention, identifying immediate workforce solutions is superseding many healthcare organizations' existing priorities.

As our colleagues Barry Dornfeld and Mal O'Connor, authors of *The Moment You Can't Ignore: When Big Trouble Leads to a Great Future*, might say, this is a moment you can't ignore in the American healthcare industry.[2] While this sounds dire, under the acute strain of the workforce crisis we see enormous potential for improving outcomes for both healthcare workers and the patients they serve.

Why do we believe these workforce dilemmas signal an unignorable moment? Because these issues "stop people in their tracks and, in one fell swoop, make it blindingly clear an organization is stuck and unable to move forward."[2] Without the physical, mental, and emotional engagement of nurses, physicians, therapists, or medical assistants (among many others) to deliver high-quality care to patients, healthcare institutions simply cannot carry out their missions.

Unignorable moments happen in every organization and in every industry. They can occur despite years-long track records of success — in fact, organizations that have stood as pinnacles of their industries may be more susceptible. While they look different in each instance, unignorable moments generally share four key characteristics: they are public in nature, they are irreversible, they are systemic, and they challenge the identity of an organization and its people.[2]

UNIGNORABLE MOMENTS ARE PUBLIC

Broad media attention has focused on the Great Resignation, a nationwide phenomenon that acknowledges the record number of workers who have quit their jobs over the past year, including in healthcare. In public light, news outlets have highlighted the reality of overburdened staff and under-resourced working conditions in many healthcare settings during the COVID-19 pandemic.[1,3]

Within hospitals, local stories of nurse and physician attrition spread rapidly through informal communication networks. Clinicians have taken to their personal Twitter and TikTok accounts to express their frustrations, leveraging the wide reach of these platforms to rally support and to organize.[4]

UNIGNORABLE MOMENTS ARE IRREVERSIBLE

Although some workers who resigned have returned to healthcare for employment, the deeply disheartened state of the workforce will leave a lasting mark on the industry. From a psychological standpoint, studies have documented clinicians' worsening burnout symptoms and mental health needs over recent years.[5] The pandemic only intensified these issues for healthcare workers.

From a societal perspective, recognition of systemic racism in the U.S. came to the forefront of national consciousness, including by healthcare workers as a result of the COVID-19 health disparities many have witnessed. The spotlight on racial and socioeconomic inequities in access to COVID-19 testing and vaccination, infection, hospitalization, and death among Black, Latinx, and Native American patients, compared to white patients has brought urgent attention to the industry's role in resolving historical trends in systemic inequity. [6] These examples signal a greater awareness of the responsibility the industry bears for patients and the healthcare workforce. This visibility is irreversible and will require different and more comprehensive actions on the part of healthcare leaders going forward.

UNIGNORABLE MOMENTS ARE SYSTEMIC

The systemic nature of the workforce crisis is another hallmark of this unignorable moment for healthcare. By "systemic," we mean a condition in which any factor impacting one area of a system — from the healthcare industry down to a unit — also impacts that entire system. We saw this play out on a micro level at one large academic health system. One hospital desperate for respiratory therapists offered pay raises, causing an unprecedented request for in-system transfers to that hospital and driving acute shortages elsewhere in that health system. Raising salaries for respiratory therapists across the health system then called into question the compensation structure for all frontline roles, which would not be sufficient to overcome a regional shortage of qualified clinicians.

On a macro level, technology giants like Amazon and Google — who pay more competitive wages for positions requiring less educational investment — are seen as national threats to siphon workers from healthcare organizations. The reality that the healthcare workforce crisis also interacts with other systems is unignorable.

UNIGNORABLE MOMENTS CHALLENGE IDENTITIES

Ultimately, these public, irreversible, and systemic workforce issues challenge the identity of healthcare organizations and the people who work in them. Selflessness and sacrifice in service of their patients conventionally have been part of the identity of healthcare workers and their institutions. However, the pandemic, social justice movements, and shifts in responsibilities outside of work have challenged healthcare workers' stereotypical identities.[6] A rupture in the social contract — the set of beliefs and norms that govern how people work together—within healthcare risks the permanent loss of the industry's most thoughtful practitioners. For healthcare leaders, the clash of changing cultural expectations that challenge professional identity across the field cannot be ignored.

WHAT HEALTHCARE LEADERS CAN DO

When confronting an unignorable moment like the workforce crisis, healthcare leaders might feel stuck within a complex dilemma without clear solutions. However, we have seen instances where what appears to be a set of intractable problems at first glance can actually pave the way for improved outcomes. We offer three guiding principles [2] for leaders to address this unignorable moment in healthcare:

1. **Slow down to speed up**. Though leaders face mounting pressure to act, they should avoid trying to resolve the problem immediately. Navigating the interwoven set of issues larger than their organizations calls for deliberate assessment.

2. **Leverage the power of "stuck."** The complex dynamics that led to this workforce crisis have been building up pressure for years or decades, generating enormous energy. Healthcare leaders can harness this potential energy, channeling it into an effective set of solutions.

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3. **Use resistance as feedback.** The points of greatest resistance are leaders' signals for where to begin digging deeper. There is usually useful information in the nature of the resistance that can shape leaders' efforts to take action.

This unignorable moment means things will not be going back to business as usual in healthcare. In our next article in this series, we will explore a framework that healthcare leaders can apply to create value from the ongoing workforce crisis.

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WHARTON AROUND THE GLOBE: WGHV PROJECT SPOTLIGHT - ACCELERATING DIGITAL PHARMACY IN EAST AFRICA WITH GOODLIFE PHARMACY

Source: Bigstock

This past fall semester, a Wharton Global Health Volunteers (WGHV) team partnered with Goodlife Pharmacy to refine its digital strategy.

In East Africa and Kenya specifically, millions of patients rely on informal pharmacies for their drugs, of which up to 20-25% were counterfeit.[1] Goodlife Pharmacy was launched in 2014 with the aim of improving access to safe, quality healthcare and pharmaceutical provision. Since then, the company has quickly expanded to become one of the leading retail pharmacies in East Africa.

The company recently launched an e-commerce footprint and has been making plans to expand its digital presence rapidly. Wharton's engagement with Goodlife focused on two key related questions:

1. What lessons can Goodlife learn from digital pharmacies in other emerging markets?

2. What adjacent healthcare services (e.g., diagnostics, primary care, etc.) in addition to pharmacy solutions could Goodlife offer to become a more comprehensive "health hub" for consumers?

From late September to November, the WGHV team conducted primary and secondary research to better understand how companies such as Vezeeta (Egypt), PharmEasy (India), and mPharma (Ghana) had successfully built their digital capabilities. We built research profiles for ~20 companies that summarized and evaluated their core capabilities, funding and operational milestones, and corporate partnerships. From there, we synthesized several recommendations for Goodlife on how they could successfully build a digital presence, such as building targeted partnerships with select hospitals and selling pharmacy sales data to institutional buyers.

Concurrently, our team looked into how pharmacies were expanding beyond point solutions to become more comprehensive "health hubs" for patients. We highlighted companies such as JD Health (China) that began as pharmacies but expanded into adjacent healthcare offerings, such as primary care, telehealth, and consumer health services. Given the short duration of the engagement, the team came short of providing a direct recommendation on Goodlife's next offering, but instead provided a framework for how they could evaluate service-line expansion opportunities.

In mid-December, team members traveled to Goodlife's headquarters in Nairobi, Kenya to build a better understanding of existing operations and to present insights and recommendations to management.

Despite the ongoing COVID situation, students were able to tour multiple Goodlife pharmacy sites, visit and trial competitor services, and present to Goodlife leadership in person. The week was pivotal in shaping and localizing our recommendations. For instance, we gained a great appreciation for same-day delivery by trialing local digital pharmacy competitors' services. We also learned how complex a potential digital delivery system would need to be, as physical addresses were far from reliable in all of Nairobi.

Our team was also able to visit the HCM program at Strathmore University, a leading private Kenyan university, with the support of Professor Sammut (WGHV's faculty advisor). We engaged with several of the faculty and even conducted roundtables with our student counterparts to understand their perceptions of digital pharmacy.

At the conclusion of our stay in Nairobi, our team presented to Goodlife's C-Suite, leading to spirited discussion and countless follow-up questions. After returning to the U.S., our team has continued to stay in touch with the Goodlife team to support research into follow-up questions.

Our WGHV team was grateful for the opportunity to work with Goodlife Pharmacy and to see the impact the private sector can have on expanding healthcare access in emerging markets. We are greatly excited to see how the organization can continue to transform the way healthcare and medicine are delivered to East Africans!

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Our team members brought a varied set of pre-Wharton professional experience to the project, including impact investing, global health entrepreneurship, and consumer marketing.

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GOOD LIFE PHARMACY

For more information on Goodlife Pharmacy, please visit their website.

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