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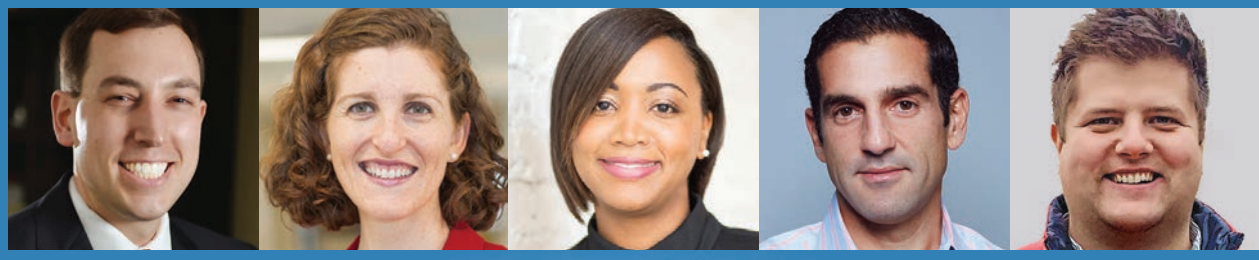


EMERGING INDUSTRY LEADERS

Technology Advances in PPE

Population Health The Origin Story

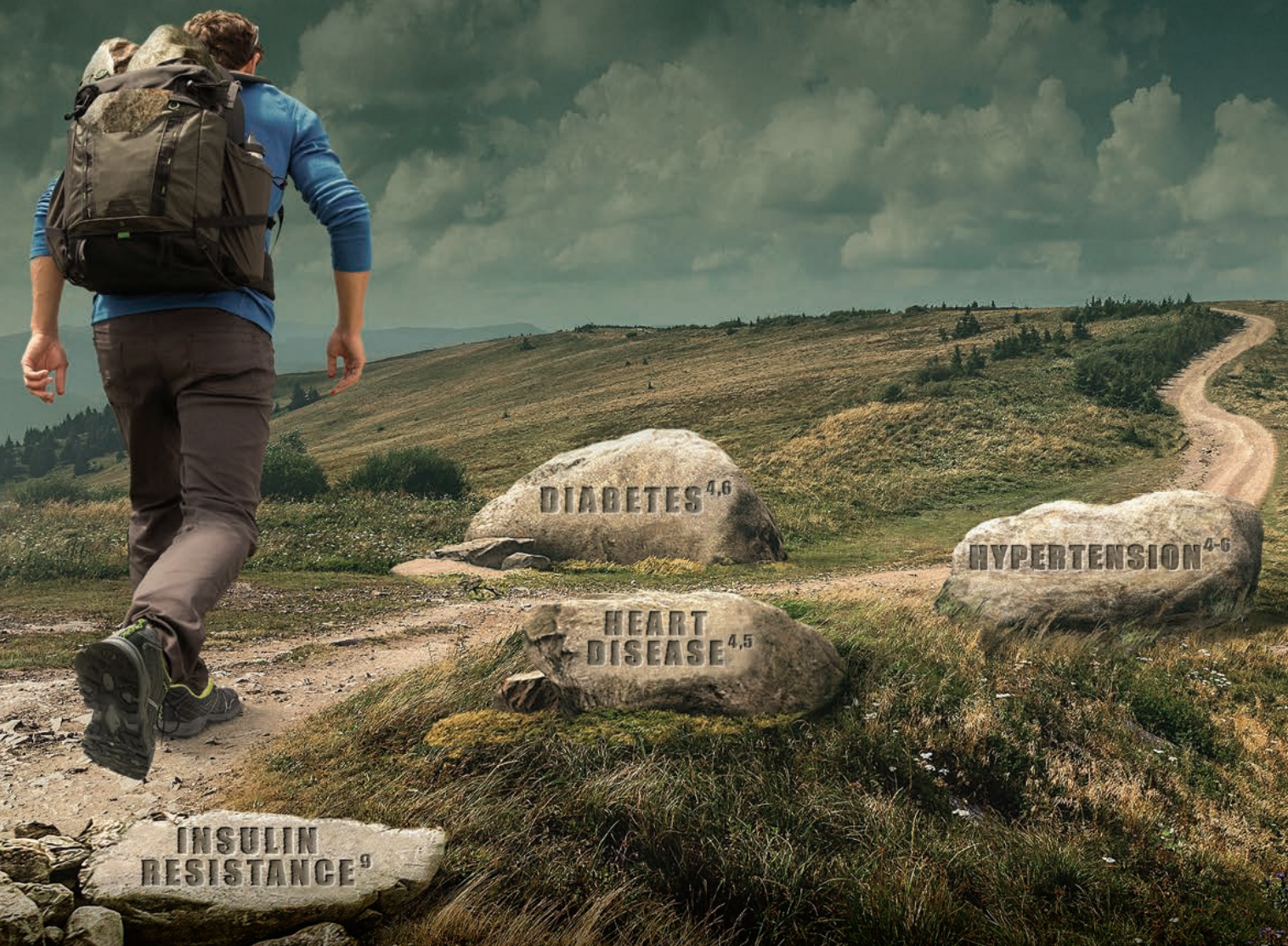
Formulary/Pharmacy Development Niche PBMs

October 2020 VOL. 30 NO. 10

ManagedHealthcareExecutive.com

A Comprehensive Approach to Long-Term Narcolepsy Management Is Important for Patients During Their Journey[1-3]

- Studies show that patients with narcolepsy are more likely to have certain comorbid medical conditions than those without narcolepsy[4-6,a]
- Narcolepsy is associated with substantial medical and economic burden, which may include emergency room visits, hospital visits, and/or absenteeism[7,8,a]



For more information, contact your Jazz Account Manager or visit NarcolepsyLink.com.

[a]Based on a retrospective analysis of 5 years (2006-2010) of US medical claims data from the Truven Health Analytics MarketScan® Research Databases to evaluate medical comorbidity patterns, healthcare utilization patterns, productivity, and associated costs in adults diagnosed with narcolepsy (identified by ICD-9 narcolepsy diagnosis codes) compared with controls without narcolepsy matched on age, gender, geographical region, and payer.[4,7]

References: 1. Thorpy M, Morse AM. Reducing the clinical and socioeconomic burden of narcolepsy by earlier diagnosis and effective treatment. *Sleep Med Clin*. 2017;12(1):61-71. **2.** Morse AM. Narcolepsy in children and adults: a guide to improved recognition, diagnosis and management. *Med Sci* (Basel). 2019;7(12):E106. **3.** Wise MS, Arand DL, Auger RR, Brooks SN, Watson NF. Treatment of narcolepsy and other hypersomnias of central origin. *Sleep*. 2007;30(12):1712-1727. **4.** Black J, Reaven NL, Funk SE, et al. Medical comorbidity in narcolepsy: findings from the Burden of Narcolepsy Disease (BOND) study. *Sleep Med*. 2017;33:13-18. **5.** Ohayon MM. Narcolepsy is complicated by high medical and psychiatric comorbidities: a comparison with the general population. *Sleep Med*. 2013;14(6):488-492. **6.** Cohen A, Mandrekar J, St Louis EK, Silber MH, Kotagal S. Comorbidities in a community sample of narcolepsy. *Sleep Med*. 2018;43:14-18. **7.** Black J, Reaven NL, Funk SE, et al. The Burden of Narcolepsy Disease (BOND) study: health-care utilization and cost findings. *Sleep Med*. 2014;15(5):522-529. **8.** Thorpy MJ, Hiller G. The medical and economic burden of narcolepsy: implications for managed care. *Am Health Drug Benefits*. 2017;10(5):233-241. **9.** Poli F, Plazzi G, Di Dalmazi G, et al. Body mass index-independent metabolic alterations in narcolepsy with cataplexy. *Sleep*. 2009;32(11):1491-1497.

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Chairman's Letter

10 of our best

Parents aren't supposed to have favorites among their children, but it is perfectly OK for publications to have favorites among their features. And "10 Emerging Industry Leaders" is definitely one of our favorites here at *Managed Healthcare Executive*®. And maybe especially this year, which has been so trying because of COVID-19 and so full of rancor and division because of the election.

This is the fourth year we have published such a feature. Certainly part of the appeal for us — and we hope, for you, our readers — is the accomplishment that it puts on display and the hope that engenders. These folks are among the best and the brightest: dedicated, smart, idealistic, creative. Putting this feature together is encouraging because it puts us in such great, all-star company. And it is gratifying to put our pages to such good use.

We were also struck this year by the amazing variety and diversity that this year's list of 10 emerging healthcare leaders exemplifies — in healthcare itself as well as among the people who work in it. The entities they work for range from established healthcare systems to healthcare tech start-ups to insurers to federally qualified health centers. They are tackling problems as varied as firearm safety to COVID-19 testing to remote ICU care. And they hail from everywhere from Wilmington, Delaware, to Paisley, Scotland, to Minnesota to Morocco.

It has been a challenging year for American healthcare that has been largely met by resolve and innovation. But now, more than ever, we need young leaders like the 10 featured in this issue.

And speaking of fresh faces, we are pleased to announce that our editorial advisory board has six new members: François de Brantes, Otis Brawley, Eric C. Hunter, Keely Macmillan, Ateev Mehrotra and Marc Samuels (see page 4). Like the 10 people we are profiling in this issue, these new board members come from a variety of backgrounds and have a variety of perspectives on American healthcare. Their guidance and contributions will help us make *Managed Healthcare Executive*® smarter, more insightful and more useful. ■

Mike Hennessy Sr.
Chairman and Founder
of MJH Life Sciences™

Managed Healthcare EXECUTIVE®

Volume 30 Issue 10
OCTOBER 2020

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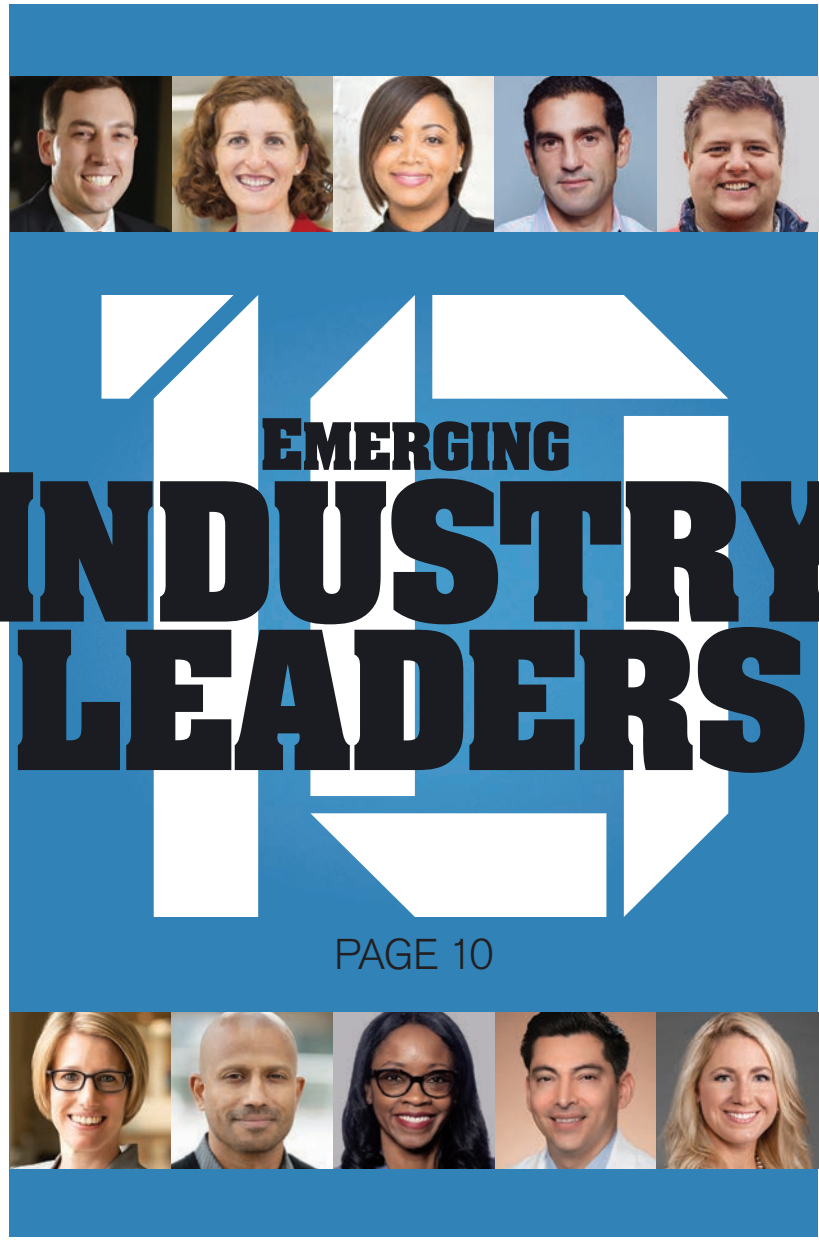

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OPINION

DARNELL DENT

The Time Is Now

In the midst of the COVID-19 pandemic, an age-old societal issue has surfaced to the top of our collective consciousness. I am talking about the differences in health status of racial groups, better known as health disparities — patterns of observed differences in the care and treatment of certain groups. Here we are talking about health disparities for people of color; specifically, Blacks and Latinos.

COVID-19 has highlighted our failure at the intersection of public health, healthcare and social justice. Recent data show that African American and Latino communities are disproportionately affected by this disease. The CDC has reported that the age-adjusted hospitalization rates for COVID-19 among Blacks and Latinos are 4.5 and 3.5 times that of non-Hispanic Whites, respectively. In many areas of the country, these same groups are more than twice as likely as Whites to die from COVID-19.

These startling statistics have helped peel back the reluctance to deal with health disparities, a reluctance that may deflect, muffle and temporize but, ultimately, draws upon racism. COVID-19 numbers are so stark and the world's focus on the pandemic is so intense that they illustrate the need to finally address the inequities in health care services and outcomes and move to a more viable system of caring for every citizen of our country.

The COVID-19 spotlight on health disparities has brought new attention to social determinants of health (SDOH) and health status as a consequence of long-standing structural inequalities that follow racial and ethnic lines. Broadly speaking, these social factors include food security, education, economic stability, affordable housing and access to healthcare. Advocates for addressing SDOH have been outspoken for quite some time, but the gap between word and deed is large, partly because the problems are so large and entrenched.

The age-adjusted hospitalization rates for COVID-19 compared with non-Hispanic Whites

Blacks	Latinos
4.5x	3.5x

Source: CDC

At one level, the cost of health disparities on human potential and opportunities can't be measured. At other levels it can, and the real cost is astounding. The W.K. Kellogg Foundation and Altarum estimate that disparities result in about $93 billion in spending on excess medical care and $42 billion in lost productivity.

To improve chances of success, action on SDOH must draw lessons from the past. The historical record highlights the vulnerability of health care policies incorporating SDOH to resistance from entrenched interests. Systemic racism and discrimination have made it virtually impossible to address these issues in a systematic matter, but these are precisely the social determinants that are responsible for the racial and ethnic disparities of COVID-19 and most other illnesses.

COVID-19 is laying bare the sobering reality that we have allowed racism and health disparities to exist far too long, resulting in a disproportionate number of lives in communities of color to suffer the consequences of their effects. In this country, more than 200,000 people have died and more than 7 million have been infected.

We can't waste this moment when eyes — and hearts — have been opened to seeing and caring about health disparities. We have the chance this coming decade to see significant health gains for disadvantaged populations, but that will take diligence. And we need policies and programs directed at the core causes of the disparities.

This strategy must be complemented by engaging a broader base of constituents, as witnessed during this current phase of social justice reckoning fueled by the Black Lives Matter movement. This is an unprecedented period in American history, and we must seize the opportunity to enact policies that bring attention to SDOH into every healthcare transaction, without regard to race or socioeconomic status. ■

***Darnell Dent** is principal of Dent Advisory Services and a member of the* Managed Healthcare Executive® *Editorial Advisory Board.*

Flattening the hockey stick of cancer drug costs

The cost of cancer drugs is shooting up out of control, warn Blase N. Polite, M.D., of the University of Chicago, and Mark J. Ratain, M.D., and Allen Lichter, M.D., of the University of Michigan's Value in Cancer Care Consortium, in a recent commentary in *JAMA Oncology*. They also warn against seeing bundled payment as a solution.

The trio compared cancer drug costs to the famous hockey-stick-shaped graph of global temperatures — a flat line or a slow increase followed by a steep increase. Citing data from CMS' Oncology Care Model, they say that drug costs accounted for half the total cost of cancer care in 2018 and that this proportion could increase to 80% by 2030.

So how might payers respond? One possibility is "radically shifting the cost risk to patients and clinicians," say Polite, Ratain, and Lichter. But that would worsen financial toxicity for patients, they argue, and oncology practices will "exit the anticancer cancer delivery system altogether" if the cost risk is foisted on them in the form of bundled payment (they put Oncology Care First, the successor to the Oncology Care Model, in this category). Their second scenario is an extreme version of prior authorization: "Clinicians would need to hire even more staff to get a drug approved for administration, and the time, effort and cost required to do so would cripple patient throughput." Put that one in the reject pile.

They hold out a third option as being the most attractive: a convener with the power to decide how to measure value and the implementation of value-based payment.

SGLT2 inhibitors vying for heart, renal indications

Sodium glucose co-transporter 2 (SGLT2) inhibitors have already remade the diabetes drug market. Now competition for new cardiac and renal indications is heating up among three of the main drugs in the class: Janssen's Invokana (canagliflozin), AstraZeneca's Farxiga (dapagliflozin), and Eli Lilly/Boehringer-Ingelheim's Jardiance (empagliflozin).

This is a high stakes contest. Heart failure costs the American health system more than $30 billion a year, and chronic kidney disease costs the Medicare program more than $84 billion.

Invokana got off to an early start when the FDA approved it as a treatment for end-stage kidney disease a year ago. The drug got a bit of a boost last month when the FDA removed a boxed warning after newer data did not show an amputation risk.

Farxiga has gotten two important nods from the FDA this year. Earlier this month it was given a breakthrough therapy designation for chronic kidney disease based on results presented this summer at the European Society of Cardiology (ESC) meeting. In May, the FDA approved Farxiga as a treatment for paients with heart failure with reduced ejection fraction.

Jardiance was also in the limelight at ESC because investigators presented results showing that, like Farxiga, it seems to have protective cardiovascular effects in heart failure patients with low ejection fractions. Last month Jardiance received FDA's fast track designation for treatment following a heart attack.

— Mary Caffrey

ICER getting into formulary evaluation

Even if you have quarrels with its QALY-based approach, there's no denying that the Institute of Clinical and Economic Review (ICER) now looms large in considerations of drug cost-effectiveness and therefore prices. So the designers and keepers of drug formularies might have taken notice when ICER announced recently that it was going to get into the business of evaluating drug formularies.

The Boston-based group, in collaboration with researchers at the Office of Health Economics, a British health research consulting group, issued a white paper in late September about formularies and said it will use criteria in that paper for their assessments. The white paper says, for example, that cost sharing should be based on the net price of a drug to the plan sponsor, not the list price. It also sets out some guidelines for "economic" step therapy, including an assertion that patients shouldn't be forced to retry drugs that haven't been effective for them in the past or that have triggered an adverse reaction.

Why aren't people going to the emergency department?

Utilization of healthcare services, especially hospital services, started to rebound this summer. But Kaufman Hall's monthly "flash report" on hospital finances and volume shows a dip again in August. The report, which is based on data from a representative sample of 800 hospitals, shows that emergency department visits continue to lag well low 2019 levels (16% lower, to be precise).

Given managed care's running battle against expensive and medically unnecessary use of hospital emergency departments, the decline in the visits might be heralded as one of the COVID-19 pandemic's silver linings. One possible explanation for the decrease is that the telehealth boom is forestalling visits for nonacute conditions. But a darker (and entirely plausible) explanation is that people are avoiding emergency departments for needed care and suffering dire, even mortal, consequences as a result. Some data suggest that is the case. It will take time — and more research and data — for the fuller truth to emerge.

TUNING into the C-SUITE an MHE PODCAST

Listen to our new podcast!

We hope you've been listening to our new weekly podcast, Tuning into the C Suite!

Hosted by Associate Editor Briana Contreras, Tuning Into the C Suite is lively, thoughtful, conversation with managed care leaders and executives. Among her guests so far: Adam Sabloff, CEO of Virtual Health, Suzet McKinney, CEO of the Illinois Medical District and Dan Knecht, M.D., MBA, vice president of health strategy and innovation at CVS Health.

We're also excited about featuring members of our editorial board in Tuning into the C Suite. Briana and Senior Editor Peter Wehrwein spoke recently with a new member Otis Brawley ,M.D., a Bloomberg Distinguished Professor of Epidemiology and Oncology at Johns Hopkins University in Baltimore and former chief medical and scientific officer of the American Cancer Society.

Make Tuning into the C Suite a habit. Listen in, learn a lot!

To listen to this podcast and others, visit www.managedhealthexecutive.com/podcasts.

In Land of Giants, Smaller PBMs Find a Niche

In the consolidated PBM industry, smaller companies say they can be nimble and not driven by rebates. But are they acquisition targets?

by **SUSAN LADIKA**

The pharmacy benefit management (PBM) industry used to occupy a rather small, obscure corner in the back offices of the American healthcare system. PBMs were just prescription claims processors. But over the past 20 years or so, the industry consolidated and the remaining companies became powerful middlemen in the complex pharmaceutical supply chain. Now the industry has an increasingly high profile (not always for favorable reasons) and has consolidated even further, with its large players owned by or partnering with even larger companies.


JORDON

Yet plenty of smaller players have survived and even thrived by finding a niche, such as workers' compensation, specialty drugs or certain types of diseases. They offer an alternative to dominant companies and the traditional marketplace, which can be layered and complicated, notes Daniel Jordon, managing director at the Graham Company, an insurance broker and consultant business in Philadelphia. They can be more aggressive and have more programs with cost containment as the goal, he says: "Many of them are not rebate driven. Many just want to be completely clinically driven."

The niche players "keep the big folks on their toes," says Joseph Paduda, president of CompPharma, a consultant to workers' compensation PBMs.

Still, there is no question that the PBM industry is now a land where giants roam. Caremark, which is part of CVS Health; Express Scripts, which was acquired by Cigna in 2018; and OptumRx, part of UnitedHealth Group, accounted for about three-quarters of the market in 2018 as measured by prescription claims managed, according to Adam Fein's Drug Channels website. Add in the next three biggest players — Humana Pharmacy Solutions, MedImpact Healthcare Systems and Prime Therapeutics — and those six companies control 95% of the PBM market, according to Fein.

Size gives the larger PBMs an obvious advantage when it comes to buying power. "If you don't have really significant buying power, it's really tough to compete," Paduda says. The large PBMs have the means to negotiate rebates and discounts from drug manufacturers. The arguments about the role of large PBMs, rebates and discounts follow some well-trodden paths.


FIELDS

The large PBMs contend that they use their buying power to negotiate lower drug prices and that employers and other payers receive a large chunk of those rebates. A report on PBMs by the Pew Charitable Trusts said that a survey of health plan and PBM executives found that the proportion of rebates from manufacturers to PBMs that gets passed on to health plans increased from 78% in 2012 to 91% in 2016. Critics of the industry say that the PBMs still pocket huge sums of rebate money and keep the amounts a secret. The Pew report says manufacturer rebates more than doubled between 2012, when they were just under $40 billion, and 2016, when they were reached $90 billion.

Because the smaller PBMs have less leverage with prices, "they have to compete on the basis of something else," such as focusing on certain diseases or niche business, such as workers' compensation, Paduda says.

"It's a David and Goliath scenario," with the small players competing against the large PBMs, says David

Fields, president and CEO of Navitus Health Solutions, a midmarket PBM in Madison, Wisconsin. Navitus, which is a division of SSM Health, the Catholic integrated health system headquartered in St. Louis, and Costco, says it passes on all the rebates and discounts it receives and that its revenues come from a set administrative fee. In 2019, Navitus passed on $650 million in rebates back to its clients and expects to return $750 million to $800 million this year, according to Fields. "Rebate-chasing formularies tend to drive up the overall cost" of drugs, he says. "We believe they (rebates) are not the do all and end all." Instead, Field says, Navitus looks to design the best formularies for its patients' health.


TEGENU

Mesfin Tegenu, M.S., president of PerformRx, a midmarket PBM in Philadelphia and a division of AmeriHealth Mercy, a Medicaid managed care plan, acknowledged in an email interview the difficulties of being a smaller player in an industry dominated by companies with annual revenues in the billions. "Today's midsize PBMs are navigating a business environment in a consolidated market. This inhibits competition by midsize PBMs, which may make innovation both in program development and technology more challenging," he said.

Tegenu also mentioned the nimbleness that others say is an asset of the bantamweights. "Smaller PBMs bring significant flexibility and customization tailored to local market needs. They also adopt innovation faster to improve patient pharmaceutical expense at point of sale, while not causing inflation in brand drugs," he adds.

Because the smaller PBMs have less leverage with prices, "they have to compete on the basis of something else," such as focusing on certain diseases or niche business, such as workers' compensation." – JOSEPH PADUDA, PRESIDENT OF COMPPHARMA

Although smaller PBMs tend to do a good job for the employers and members they serve, they may be viewed as a little risky by clients because they typically don't have a long history, according to Jordon at The Graham Company. He says that COVID-19 has made businesses even more cautious. They don't want to rock the boat right now by switching to a smaller PBM, according to Jordon: "Everything feels a little unstable."

Price of success

SSM Health announced in March that Costco was purchasing a minority stake in the PBM for an undisclosed amount. Fields says the cultures of the two companies are in sync because both support keeping costs low for their customers: "It's incumbent to provide value to the customers we serve."

Navitus isn't the only PBM experiencing changes. In 2019, Anthem launched its own PBM, IngenioRx, to serve its health plan members and those of other plans.

Ironically, the success of the smaller PBMs may make them attractive acquisition targets, consolidating the industry even further. Paduda says larger PBMs may buy up their smaller competitors that focus on specialty medications because the cost of those drugs is so high.

In a report on PBMs earlier this year, S&P Global said that "large vertically integrated PBMs should continue to leverage their scale and vast services to maintain market share. … We continue to expect subscale PBMs are at greater risk of losing clients to larger competitors." The financial analytics firm also said that it expects more consolidation among midmarket PBMs.

High drug prices are one of the main reasons the PBM industry has found itself in the spotlight and the subject of criticism, particularly with respect to rebates. Early last year, the Trump administration proposed changing anti-kickback rules so rebates would go directly to consumers rather than PBMs; later in the plan was abandoned. But "it's much more complicated than they think," says Jordon. "How would we possibly unwind all this?" Instead, he says, "I think the market will solve itself."

Paduda believes there will be significant pressure on Joe Biden to lower drug prices if he wins the presidency. Drug manufacturers are more likely to be affected by Biden policies, but PBM rebates and transparency may also come into play, in Paduda's opinion.

""Irrespective of which party is in power, there will be a continued focus on transparency," says Fields. "There's not enough transparency going on, especially in the pharmaceutical world." ◘

Susan Ladika is a health and business writer in Tampa, Florida.

EMERGING INDUSTRY LEADERS

By **KAREN APPOLD**

JESSE M. EHRENFELD

M.D., M.P.H., FASA, FAMIA, senior associate dean and director of Advancing a Healthier Wisconsin Endowment, Medical College of Wisconsin, Milwaukee

Note: We asked all the winners to share some biographical information about where they grew up and their education.

I grew up in Wilmington, Delaware. I completed my undergraduate education at Haverford College, then earned a medical degree from the University of Chicago and a master's of public health from Harvard. I completed my residency in anesthesiology at Massachusetts General Hospital.

My career in academic medicine began at Harvard Medical School before I joined the faculty at Vanderbilt University School of Medicine and became professor in the departments of anesthesiology, biomedical informatics, surgery and health policy.

Today I am the senior associate dean at the Medical College of Wisconsin, where I serve as director of college's statewide health philanthropy, the Advancing a Healthier Wisconsin Endowment, while continuing to practice as a physician anesthesiologist.

I have been active in the American Medical Association (AMA) since medical school and was elected to the board of trustees in 2014; I served as chair this past year.

Why did you choose your profession?

I've always been inspired to help others and to make an impact. That led me to medicine and continues to connect various aspects of my

work. I've served my country in the U.S. Navy, deploying to Afghanistan. I've advocated for and built programs to promote LGBTQ health and equity.

My research has centered around how information technology can improve patient safety, outcomes and health equity. My efforts in these areas continue at the AMA, as well.

Now, at Advancing a Healthier Wisconsin, I'm fortunate to guide how we, as a $450 million statewide health philanthropy, can shape and support efforts to substantially improve our community's health.

What has been your biggest learning experience in the industry? What did it teach you?

Paradoxically, many of our most meaningful wins seem to be the least acknowledged, while many of our less impactful successes garner more recognition. This has taught me that regardless of how you're recognized for your work, take pride in yourself and your team for what you've accomplished.

How has COVID-19 affected your responsibilities and how your organization operates? How might your job and your organization change because of the pandemic?

COVID-19 has changed nearly every aspect of my work. As a statewide health funder, I immediately knew that Advancing a Healthier Wisconsin was uniquely positioned to respond. We shifted our grant infrastructure toward a rapid response, reducing our funding timeline to deploy funds in about three weeks, down from six months to a year. In early April, we announced $4.8 million in funding to 17 Wisconsin-based projects that have supported prevention, risk reduction and minimized transmission of COVID-19.

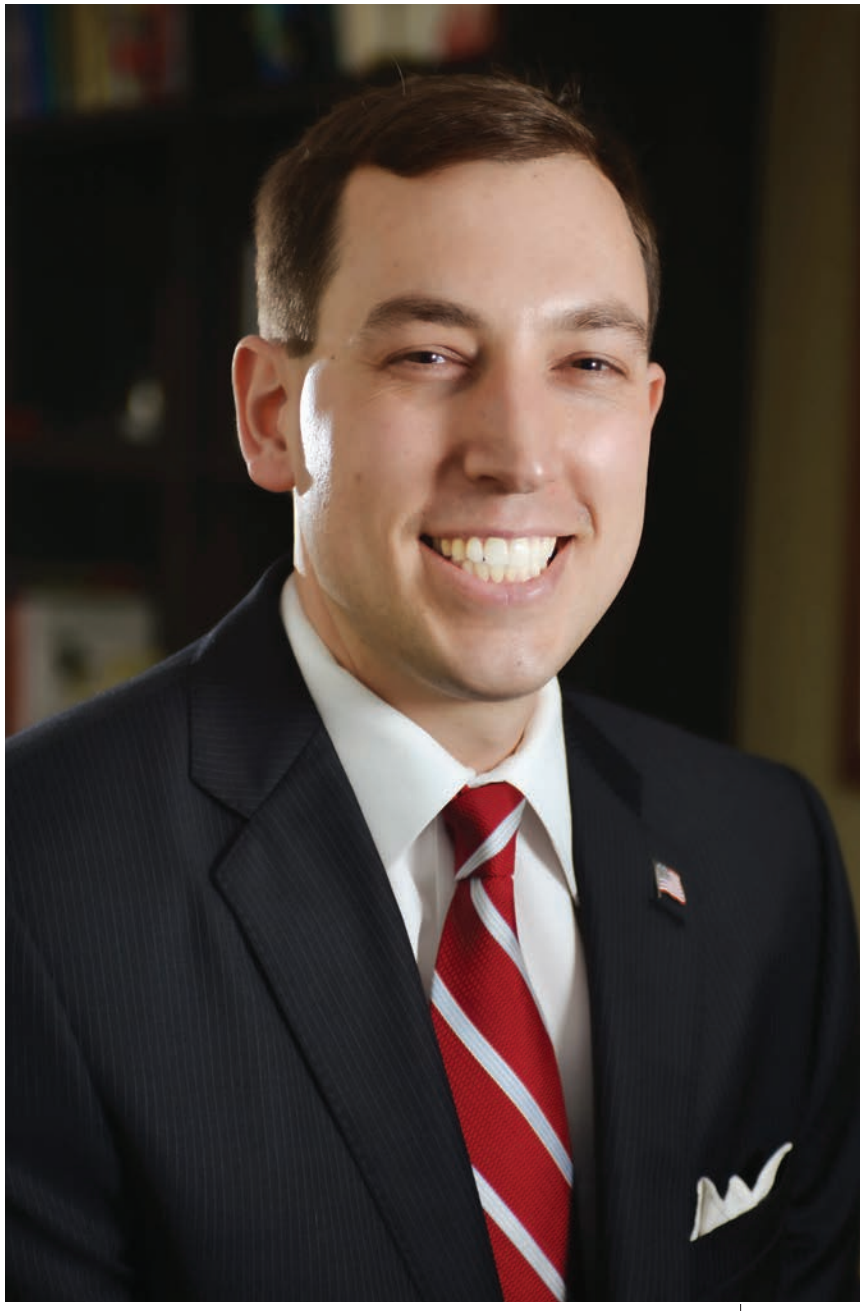
At the AMA, we've continued to respond to the urgent needs of physicians on the front lines by advocating for resources, protective equipment and supplies, as well as by providing trusted, evidence-based information and fast-tracking the tools and resources to sustain physician practices.

How has the current discussion of racism and healthcare inequity affected you, your outlook and your organization? What has been the short-term response, and what do you envision happening over the longer term to your organization and American healthcare?

Racism is a public health crisis. To do our part in healthcare and health philanthropy, we have to recognize that advancing equity needs to be at the center of our work.

At Advancing a Healthier Wisconsin, we've started the hard, uncomfortable work of defining how we can change our internal processes and structures to remove barriers and improve diversity in who we are and who we invest in.

At the AMA, we have recognized racism as an urgent threat to public health and the advancement of health equity, as well as a barrier to excellence in the delivery of medical care. To



"I've always been inspired to help others and to make an impact. That led me to medicine and continues to connect various aspects of my work. "

– Jesse M. Ehrenfeld, senior associate dean and director of Advancing a Healthier Wisconsin Endowment, Medical College of Wisconsin, Milwaukee

that end, we're actively working to dismantle racism and discriminatory policies and practices across all of healthcare.

What other kinds of changes do you expect to see in healthcare in the next five to 10 years?
Telehealth and other digital technologies will accelerate in adoption and use. They have great potential to allow us to reimagine how care is delivered, how access to care can be broadened and how gaps in health equity can be lessened.

What have you enjoyed about social distancing and extra stay-at-home time during the past few months?
Spending more time with my husband and our 1-year-old son, Ethan, and working to perfect my challah recipe.

MORISSA HENN

Dr.P.H., community health program director, Intermountain Healthcare, Salt Lake City

I was raised in Concord, New Hampshire. I completed a B.A. at Tufts University, an M.P.H. at Columbia University and a Dr.P.H. Harvard University.

Prior to my current position at Intermountain, I was chief of staff at the nonprofit Children's Health Fund in New York City, a healthcare consultant at Manatt and an adviser in the New York City mayor's office.

Why did you choose your profession?
My parents are both health professionals. My father is a primary care physician, and my mother is a family therapist. They co-located their practices years before "mental health integration" was a thing. From them I developed an early interest in the ways that physical and mental health are deeply linked and in the ways that health is influenced not only by individual factors but also by systems, communities and societies. Public health doesn't shy away from this complexity. From infections to inequalities, the field provides the science and tools to understand and address multifaceted problems.

What has been your biggest learning experience in the industry? What did it teach you?
When I transitioned from working in public health and public policy to healthcare delivery, I wondered whether I would encounter more narrow ways of thinking about how to improve health. The opposite was true.

At Intermountain, I am constantly encouraged to work in bold, cross-sector, multidisciplinary ways. For example, in leading efforts to prevent suicide — in a region where guns are extremely popular and accessible and are the most common and most lethal method of suicide — I proposed that our health system involve gun owners directly as collaborative partners. Through this "common ground" work, we have generated stronger messages and strategies and trained clinicians in how to talk with patients about firearm storage. Innovative systems like Intermountain not only embrace nontraditional stakeholders and solutions but also enable the resulting work to reach across the broadest populations.

How has COVID-19 affected your responsibilities and how your organization operates? How might your job and your organization change because of the pandemic?
COVID-19 has begun to reveal and remedy major challenges in the field of mental health. A recent survey with Harvard Medical School and the University of North Carolina School of Medicine found 90% of Americans reporting emotional distress due to the pandemic; the urgency and universality of these issues are stark. Simultaneously, we're seeing explosive growth in digitally enabled care and services that help overcome access and coordination barriers that have persisted for decades. The mental health consequences of COVID-19 are profound and likely to be with us for a long time. The question is, can we meet this challenge with the kind of transformational investments that not only prevent negative impacts but fundamentally fix our fragmented system?

How has the current discussion of racism and healthcare inequity affected you, your outlook and your organization? What has been the short-term response, and what do you envision happening over the longer term to your organization and American healthcare?
Racism is a public health crisis and a critical determinant of health. As an

organization committed to "helping people live the healthiest lives possible," Intermountain recognizes that it has an obligation to act. We are listening to caregivers and communities of color, identifying disparities in our data and generating measurable strategies for improvement. American healthcare is waking up to the realization that we must confront the injustices in our midst today, acknowledge the underlying history of racism and white privilege that persists in American society, and address the institutional policies and individual biases in healthcare that can perpetuate racial inequality. We have a long way to go.

What other kinds of changes do you expect to see in healthcare in the next five to 10 years?

I think the gulf between "public health" and "healthcare delivery" will continue to narrow as health systems realize that modifying nonmedical factors — exposure to pollution, access to nutritious food, availability of stable housing — are where we will be able to have the biggest impact on improving outcomes and reducing costs. At the same time, as COVID-19 has shown us, effective public health response depends on close coordination with the delivery system, its massive workforce and its most vulnerable patients.

What have you enjoyed about social distancing and extra stay-at-home time during the past few months?

First, I feel so lucky to live in a place of such spectacular beauty as Utah, and the past six months have provided incredible opportunities for — sometimes midworkday! — skiing and trail runs in our backyard mountains. I also love politics and believe engaging in the electoral process is one of the most important things we can do to help contribute to a healthier world. It has been fascinating to follow local and national elections and engage in policy discussions and debates over virtual platforms. I'll keep proudly wearing my "vote" mask when hiking local trails.

"American healthcare is waking up to the realization that we must confront the injustices in our midst today, acknowledge the underlying history of racism and white privilege that persists in American society."

– Morissa Henn, community health program director, Intermountain Healthcare, Salt Lake City

"My hope is that this season will not be a fleeting performance but the start of real change."

– Toni Jones, director, social determinants of health integration and partnerships, CareSource, Dayton, Ohio

TONI JONES

M.P.A., M.P.M., director, social determinants of health integration and partnerships, CareSource, Dayton, Ohio

I grew up in the small town of Mansfield, Ohio. I earned a bachelor's in sociology from Spelman College, a master's in public administration from University of Delaware and a master's in project management from Keller Graduate School. My most recent achievement was becoming a certified life coach during the pandemic.

I am grateful for the opportunities and guidance afforded to me at CareSource, where I humbly began as an administrative clerk. I am proud that I have had the opportunity to advocate for Medicaid expansion and speak to political leaders at the White House and on Capitol Hill about the social determinants of health work at CareSource.

Why did you choose your profession?

I love to serve and learn from people. As a sociology major, I studied the development, functions and structuring of people. As the director of social determinants of health integration and partnerships at CareSource, I continue to follow my passion as I focus on social barriers that affect health outcomes.

What has been your biggest learning experience in the industry? What did it teach you?

Healthcare will always relentlessly evolve. This taught me to be flexible and forward thinking. It has also taught me the importance of intentional strategy with grace. We must be willing to be nimble but firm to be effective.

How has COVID-19 affected your responsibilities and how your organization operates? How might your job and your organization change because of the pandemic?

The CareSource life services department started in 2015, with a focus on the social determinants of health of employment and training through the launch of the JobConnect program. Since then, the team has expanded efforts in housing, food, nutrition, transportation, special populations and advocacy. The knowledge and lessons learned from the program positioned us to be better prepared for the exacerbation of social barriers by COVID-19. As a result of the pandemic, CareSource has provided access to telemedicine, enhanced our focus on community partnerships and provided financial support in our communities.

How has the current discussion of racism and healthcare inequity affected you, your outlook and your organization? What has been the short-term response, and what do you envision happening over the longer term to your organization and American healthcare?

As an African American mother of two African American children, I have been affected personally and professionally by the current discussion on racism. Personally, I have worked to speak my truth in love as a way to raise awareness of inequities and discrimination. Professionally, our organization has been very intentional, driving fundamental shifts in diversity and inclusion by revamping our diversity, equity, and inclusion program; providing additional support for minority employee resource groups; engaging industry experts through conversation and corporatewide education; and regularly assembling diverse staff members to listen, to seek to understand and to enact change.

I see this as a pivotal point in our country's history to change the future. My hope is that this season will not be a fleeting performance but the start of real change through effective, ongoing and sustainable action.

What other kinds of changes do you expect to see in healthcare in the next five to 10 years?

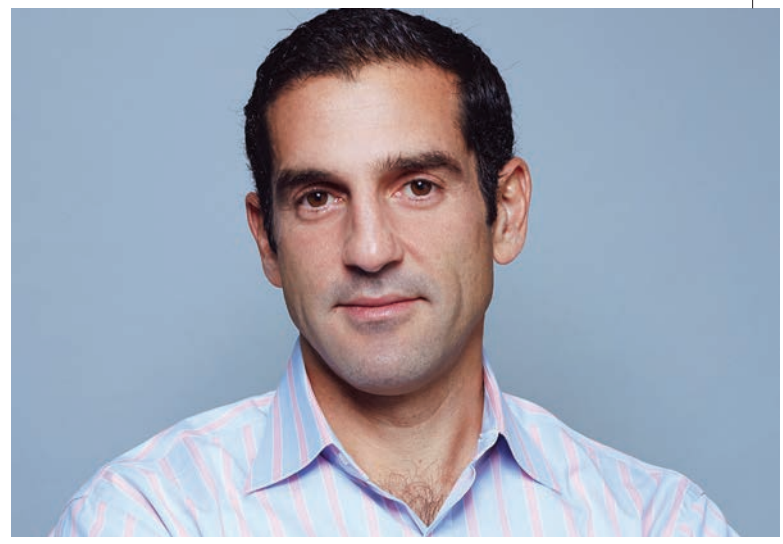
I expect to see continued, wide-ranging advancements in technology. COVID-19 created an immediate necessity to quickly transform business operations; for example, more telemedicine. Many changes had been advocated for but were denied until COVID-19 demanded immediate action. I believe technology will continue to be the catalyst for re-imagining how we improve. I also believe that many COVID-19-related policy changes will be permanently adopted into law.

What have you enjoyed about social distancing and extra stay-at-home time during the past few months?

I have enjoyed spending all the extra time with my husband and two children, ages 7 and 4. The rigors of working from home and virtual learning have been a challenge, but we have all grown. I have an increased passion for exercise, which was discovered by dancing with my kids on the Wii. I have also found a greater appreciation for nature and being intentional about having quiet times to fuel myself. This season is difficult in uniquely personal ways for everyone, but I have found many gems that a slower-paced life affords.

OTHMAN LARAKI

M.S., MBA, CEO and co-founder, Color, Burlingame, California



I grew up in Morocco and studied computer science and engineering at Stanford University and the Massachusetts Institute of Technology.

Before founding Color, I spent several years at Google and helped lead a variety of key product initiatives. I also co-founded Mixer Labs and developed its GeoAPI platform, which was subsequently acquired by Twitter in 2009. From there, I served as the social media network's vice president of product and helped expand its user base from 50 million to 200 million unique accounts.

At Color, I lead a talented team of individuals dedicated to building a digital health infrastructure to support large-scale health challenges such as a pandemic, with the ultimate aim to make healthcare more accessible, affordable and convenient for everyone.

Why did you choose your profession?

A complicated and inefficient genetic testing experience made me realize that there are significant gaps in our healthcare system, with limited opportunities to share valuable information with stakeholders along the care delivery spectrum. I entered this industry so I could help support our fragmented infrastructure and create a system where we all can access the insights that can inform our care.

What has been your biggest learning experience in the industry? What did it teach you?

Our experience solving for large-scale health challenges such as actionable genetic insights and COVID-19 testing reiterated the fact that the country's public health infrastructure is severely fragmented and ill-equipped to coordinate care delivery at scale.

How has COVID-19 affected your responsibilities and how your organization operates? How might your job and your organization change because of the pandemic?

The COVID-19 crisis poses the greatest health crisis of our generation. Given that, we are committed to doing whatever we can to help. Earlier this year, we extended our headquarters to support a high-throughput COVID-19 testing facility to help with national testing efforts. We've also partnered with local governments, including the city of San Francisco, Alameda County and Marin County; universities such as the University of Southern California and Morehouse School of Medicine; and employers. Our testing technology has received emergency use authorization (EUA) from the FDA, and we also received an EUA for an unmonitored dry-swab COVID-19 test.

COVID-19 hasn't changed our organization; instead, it has shown that our model, which we've used for genetic testing, can be repurposed to serve other large health initiatives. This has huge implications for the future of both our business and healthcare in this country.

How has the current discussion of racism and healthcare inequity affected you, your outlook and your organization? What has been the short-term response, and what do you envision happening over the long term to your organization and American healthcare?

Between our work in genetics and COVID-19, Color has always strived to increase access to the valuable information that can inform a patient's care. We currently support the National Institutes of Health's All of Us initiative; 80% of the participants come from underresearched settings. We have also made great strides to expand our COVID-19 testing facilities to the people who need them most and are actively engaging with individuals from underserved populations.

What other kinds of changes do you expect to see in healthcare in the next five to 10 years?

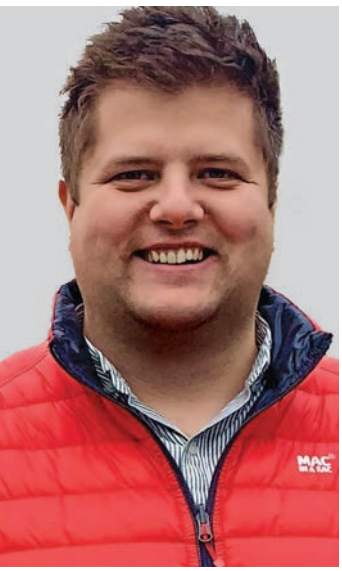
I believe we're entering a renaissance in our public health system where technology will

> **"I believe we're entering a renaissance in our public health system where technology will fill the current gaps in our existing infrastructure."**
>
> – Othman Laraki, CEO and co-founder, Color, Burlingame, California

fill the current gaps in our existing infrastructure. By creating a model that allows people to both access information about their health and easily engage with clinicians and payers, healthcare can and will be delivered more proactively, efficiently and effectively.

What have you enjoyed about social distancing and extra stay-at-home time during the past few months?

The drastic reduction of traffic and lack of need to drive to work has allowed me to do early morning bike rides much more often.



CHRISTOPHER MCCANN

CEO and co-founder, Current Health, Boston

I grew up in Paisley, Scotland, a post-industrial town that has suffered greatly in recent years, with high levels of poverty and deprivation. I disliked school but was fascinated by computers and creating things from a young age, so I left school two years early at age 16 and gained a degree in computer science. From there, I went to medical school and then founded Current Health.

Why did you choose your profession?

I loved computers and building things, but I also became fascinated by medicine. The human body is almost the ultimate machine. After a relative became severely ill and I spent a lot of time in hospitals, I decided to enter medical school.

Building Current Health gave me the opportunity to bring everything I loved together. I got to create, build technology and solve one of the most fundamental challenges in healthcare: preventively identifying and treating illnesses. If we can shine a light on patient health at home and then use that data to identify illness, then we can radically change how healthcare is being delivered. Other goals include ensuring that every patient has access to preventive medicine, improving patient outcomes and reducing the cost of healthcare delivery.

What has been your biggest learning experience in the industry? What did it teach you?

Financial models are complicated, and incentives are counterintuitive. Understanding how to successfully embed a new solution within the complexity of these financial models is challenging and takes a lot of time, energy and collaboration.

Second, it's critical to keep a focus on delivering an amazing product experience to patients and providers who have busy, complex lives. Understanding their needs and how to deliver a quality, simple experience takes time, care and precision.

> "From the beginning, it's been my core belief that the patients who most need access to technology-enabled healthcare services are the least likely to be able to access them."
>
> – Christopher McCann, CEO and co-founder, Current Health, Boston

How has COVID-19 affected your responsibilities and how your organization operates? How might your job and your organization change because of the pandemic?

Since COVID-19, we've grown more than 1,000%, all while being fully remote. We've deployed to tens of thousands of patients and doubled the size of the Current Health team.

COVID-19 has accelerated a transitional shift that was already occurring, driving increases in value-based care and more global risk, as well as more healthcare at home and greater adoption of remote patient management (RPM) and telehealth. While I believe an equilibrium will be reached, use of telehealth and RPM will still be far greater post-COVID than before.

Continuing to build an amazing experience for our patients and providers, at scale and globally, while being fully remote, has been an interesting challenge.

How has the current discussion of racism and healthcare inequity affected you, your outlook and your organization? What has been the short-term response, and what do you envision happening over the longer term to your organization and American healthcare?

From the beginning, it's been my core belief that the patients who most need access to technology-enabled healthcare services are the least likely to be able to access them. We've put a significant investment into making it possible for patients to easily and successfully use our services at home.

We provide connectivity and everything the patient needs for the service in a preconfigured box. We put a huge amount of time into simplicity and ease of use so that we're accessible to all populations.

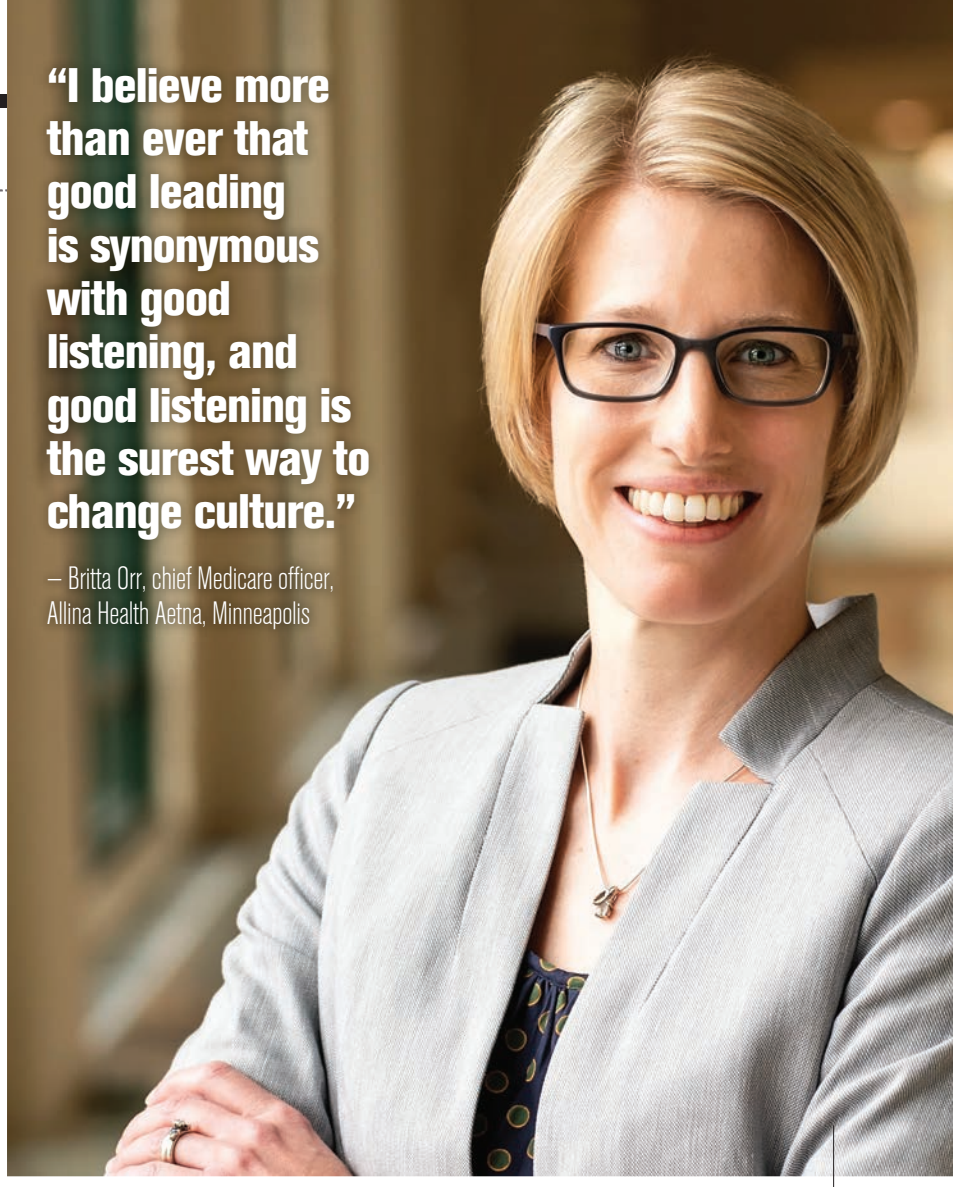
We're also recognizing as an organization that our team should better represent the populations that we're involved in caring for. We need to do a better job of building diversity within that team, including across age, race and gender.

What other kinds of changes do you expect to see in healthcare in the next five to 10 years?

COVID-19 has accelerated an existing transitional shift to more delivery of healthcare at home. It's my belief that COVID-19 will also accelerate more managed care and global risk contracting, and there will be continued expansion of telehealth and home-based digital health technologies. For years, value-based care has been discussed and written about and yet most healthcare is still traditional fee for service.

I believe in the next 10 years, we'll see a far greater proportion of healthcare delivered in the patient's own home, and many health systems will finally make the transition from traditional fee for service to value-based arrangements. That will be better for the patient and healthcare as a whole.

What have you enjoyed about social distancing and extra stay-at-home time during the past few months?
Building a high-growth technology company has meant a lot of travel and time away from home and my partner, Jo-Ann. Getting to spend some time at home, in one place, has been amazing. I think a positive aspect of staying at home is that it has encouraged greater quality time with families.



BRITTA ORR

J.D., M.P.H., chief Medicare officer, Allina Health Aetna, Minneapolis

I grew up near Minneapolis and went to college at Northwestern University. After graduation, I pursued a dual degree in law and master's of public health at the University of Minnesota, with a goal to combine my passions for healthcare and advocacy. I went on to work for various nonprofits focused on state and federal health policy. Today I am proud to be the chief Medicare officer for Allina Health Aetna, a unique joint venture health plan launched in Minnesota in 2018. Outside of work, I have chaired my city's health commission and taken on board leadership in support of hospice fundraising.

Why did you choose your profession?
Both of my parents received life-changing diagnoses when I was in high school. I paid close attention as they gathered binders of medical information and spent hours on the phone, seeking coverage approvals. My parents were educated and employed and had a strong support network. I often thought about how hard it would be to navigate the clinical care and health insurance systems under different circumstances. I quickly grew very passionate about making healthcare as simple, affordable and personal as possible for as many people as possible.

What has been your biggest learning experience in the industry? What did it teach you?
Probably my current startup experience. Assembling a new team to support a new product in a new market reinforced the importance of knowing who you want to be as a business as much as what you want to deliver. Hiring to fit your values, e.g., empathy, is critical to everything that follows.

How has COVID-19 affected your responsibilities and how your organization operates? How might your job and your organization change because of the pandemic?
COVID-19 has invited Allina Health Aetna to take stock of our priorities at both the enterprise and individual levels. We leaned into supporting our members in innovative ways through liberalized benefits and information sharing, virtual tools to ensure safety, and proactive clinical outreach to those at risk. We quickly determined which communications and interactions were most critical in this overwhelming time and allowed others to

fall off. We also doubled down on work-life balance for our teams, expanding how we support them as family caregivers and as people. And, whether directed at our members or employees, we are laser focused on supporting mental health and wellness. I don't expect any of these changes to wane in the future.

How has the current discussion of racism and healthcare inequity affected you, your outlook and your organization? What has been the short-term response, and what do you envision happening over the longer term to your organization and American healthcare?

Recent events have challenged me personally to be a better listener. I believe more than ever that good leading is synonymous with good listening, and good listening is the surest way to change culture.

In the short term, we have heard a lot of commitments from corporations ready to address racism as a very real public health crisis, including Allina Health Aetna. Speaking out is necessary and overdue, but I also hope we will focus equally on listening to and absorbing the lived experience of others.

As an industry grounded in systems thinking and privy to some of our most personal human needs, healthcare is uniquely poised over the long term to hear and unravel how we are all interconnected and affected by inequities in America. I believe we have an obligation to remain bold and proactive in the conversation, first and foremost by listening intently throughout our daily work.

What other kinds of changes do you expect to see in healthcare in the next five to 10 years?

I anticipate deeper payer-provider integration and significantly higher-stakes value-based care and contracting models. I expect rapid acceleration toward telemedicine, including a strong emphasis on behavioral health supports across the life span. I think we'll see sweeping digitization of consumer experience, in part via machine learning and artificial intelligence. I expect new subscription-based care and coverage models; continued clinical migration into the home, mobile setting or grocery store; and crowdsourcing innovations around ancillary benefits and services, including those directed at social determinants of health.

What have you enjoyed about social distancing and extra stay-at-home time during the past few months?

Honestly, the perspective it brings. I never thought I would be so desperate for two hours of solitude at a coffee shop, to coach grade school basketball or just to hug a friend. I look forward to again enjoying these little things that really aren't so little.

SRIRAMAN SRINIVASAN

M.D., MBA, chief medical officer, Advanced ICU Care, Bethesda, Maryland

I started my life in India and moved to Toronto at the age of 6. I grew up idolizing Wayne Gretzky and played a lot of ice hockey. In fact, as young as age 12, I organized a yearly hockey pool in which my friends and I drafted NHL players, and I served as league commissioner. In those days without the internet, I updated everyone's standings weekly after going through the box scores in the Sunday newspaper. That taught me to be consistent and reliable and to double-check my work, because people counted on me.

After undergraduate studies at the University of Toronto, it was on to St. George's University in Grenada for my medical studies; Georgetown University for my medical residency; and, finally, a fellowship in critical care at George Washington University.

Most of my leadership highlights come from volunteering to take on roles that others did not want. That led me to opportunities that propelled my career by serving first where help was needed.

Why did you choose your profession?

I was always fascinated by the ability that a doctor had to save someone's life through direct and purposeful action. This feeling was affirmed when I witnessed a student die of cardiac arrest in the gym I worked at in my 20s. Naturally, I chose critical care as my area of interest because it gave me exposure to caring for the sickest of the sick.

What has been your biggest learning experience in the industry? What did it teach you?

Listen, listen, listen. The client will tell you what they want or need. Be flexible, and tailor solutions to their individual needs. We all want a system-based approach, but one size does not fit all. In telemedicine, we have to work hard to build rapport with local bedside staff to earn their trust so that we can co-manage patients. We all have good intentions, but it takes time to build those relationships, which starts with listening.

How has COVID-19 affected your responsibilities and how your organization operates? How might your job and your organization change because of the pandemic?

We cared for critically ill patients via telemedicine long before COVID-19, but we still made several adjustments. We did disaster planning for staffing needs and the possibility of reduced bedside staff. We rapidly deployed surge capacity at client hospitals to care for additional patients. We also stayed abreast of best practices in medical management that we shared with our partners. Our company already operated in a virtual environment, so there wasn't an interruption in services.

How has the current discussion of racism and healthcare inequity affected you, your outlook and your organization? What has been the short-term response, and what do you envision happening over the longer term to your organization and American healthcare?

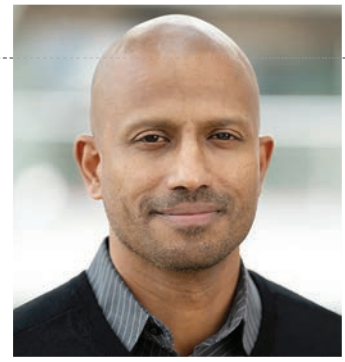
This is a very important discussion at a very important time in our history. Our organization revolves around the remote provision of healthcare services to a diverse set of communities via technology. Because we don't engage with health insurance, we don't ever turn away a patient, and we provide 24/7 year-round access to an ICU doctor. We care for everyone equitably, regardless of creed or color. Our staff comes from a diverse background across the country in seven domestic operations centers and two international ones. We focus squarely on one's abilities and interest in telemedicine in our hiring practices.

What other kinds of changes do you expect to see in healthcare in the next five to 10 years?

The door for telemedicine has been opened, and it is something that patients have longed for. Remote provision of care is here to stay, but it has a steep learning curve. Many doctors come to us as 20-year veterans of in-person care and need to learn a lot about technology, situational awareness and management principles before caring for patients remotely. Physicians will need to become better coaches and empower not only patients but also the allied health professionals that they share the healthcare space with.

What have you enjoyed about social distancing and extra stay-at-home time during the past few months?

Quite honestly, I finally learned what my kids were doing in school since I had to start doing some home schooling. It's been great to be more involved and, hopefully, I made a positive impression on them for the future.



"In telemedicine, we have to work hard to build rapport with local bedside staff to earn their trust so that we can co-manage patients."

– Sriraman Srinivasan, chief medical officer, Advanced ICU Care, Bethesda, Maryland

CHARLETTE STALLWORTH

MBA, vice president, strategic partnerships, Stanford Children's Health and Lucile Packard Children's Hospital Stanford, Palo Alto, California

I grew up in Atlanta with my parents and two sisters. I have a B.S. in physics from Georgia State University and an MBA from Baylor University. My first career was as a commissioned officer in the U.S. Army, where I held several leadership positions, including company commander in the Republic of Korea and special assistant to the director of the Defense Intelligence Agency at the Pentagon. I left the Army to attend graduate school and then launched a career in commercial banking at JPMorgan Chase and later at BBVA Compass.

My career in healthcare began when I was hired by one of my bank clients, Baylor Scott & White Health, as director of capital finance. I have held leadership positions in healthcare business development and in my current role as vice president of strategic partnerships at Stanford Children's Health. In these roles, I have identified, structured and maintained

"I think everyone should realize that African Americans are not requesting special treatment – we want fair treatment."

– Charlette Stallworth,, vice president, strategic partnerships, Stanford Children's Health and Lucile Packard Children's Hospital Stanford, Palo Alto, California

key partnerships. I have also provided leadership in helping inventors and startups move innovative healthcare therapeutics, devices and diagnostics from bench to bedside, which is both rewarding and exciting.

Why did you choose your profession?
After serving my country as an Army officer and then working with company CEOs as a commercial banking relationship manager, I wanted to work in an industry with an even closer connection to helping people. My roles in healthcare fulfill this goal.

What has been your biggest learning experience in the industry? What did it teach you?
I have learned that incorporating the perspectives of patients and physicians in strategy and financial planning are critical to successful, long-term execution.

How has COVID-19 affected your responsibilities and how your organization operates? How might your job and your organization change because of the pandemic?
Before COVID-19, it was important to meet in person with partners and prospective partners. Since COVID-19, the paradigm has changed, and I, like many others, now rely on video meetings and phone calls. We must continue to move forward and make things happen despite obstacles. Stanford Children's Health has been able to leverage synergies within Stanford Medicine and with external partners to continue providing the highest-quality healthcare in changing environments.

The pandemic is creating a new market landscape and new opportunities to partner with healthcare systems, corporations and startups. The pandemic is also creating uncertainties; we're developing strategies to meet the challenges to come.

How has the current discussion of racism and healthcare inequity affected you, your outlook and your organization? What has been the short-term response, and what do you envision happening over the longer term to your organization and American healthcare?
I appreciate the current discussion of racism and healthcare inequity. One colleague called me to discuss what is happening and how she could be more aware. We were both a bit uncomfortable with the conversation, and I appreciated her courage to take the initiative to reach out and be vulnerable. I think everyone should realize that African Americans are not requesting special treatment — we want fair treatment.

Healthcare inequity has long been a topic of discussion in minority communities. The National Minority Quality Forum and many other organizations work tirelessly to address and eliminate healthcare disparities and increase the number of minorities participating in clinical trials. I hope the current environment further invigorates these efforts.

Stanford Medicine has held town hall meetings with key leaders that address racism and has also published statements from leaders supporting the Black Lives Matter movement, the recent Supreme Court decision upholding the Deferred Action for Childhood Arrivals program, and several other initiatives focused on fair and equitable treatment of people. I really hope these efforts have a lasting positive impact.

What other kinds of changes do you expect to see in healthcare in the next five to 10 years?
I expect to see continuing, rapid adoption of telehealth, in addition to using other innovative technology such as wearables and robots. I hope our industry and government can fully embrace and maintain a V-shaped increase in the use of novel technologies for delivering and managing healthcare. We also need to achieve a basic level of internet service/technology available to all families, including those in rural and urban settings. Access to internet-based healthcare delivery will go a long way toward eliminating healthcare inequities.

What have you enjoyed about social distancing and extra stay-at-home time during the past few months?
The best part of the stay-at-home time is giving up the daily commute on U.S. Highway 101. Trading the commuting headache for work efficiency is wonderful!

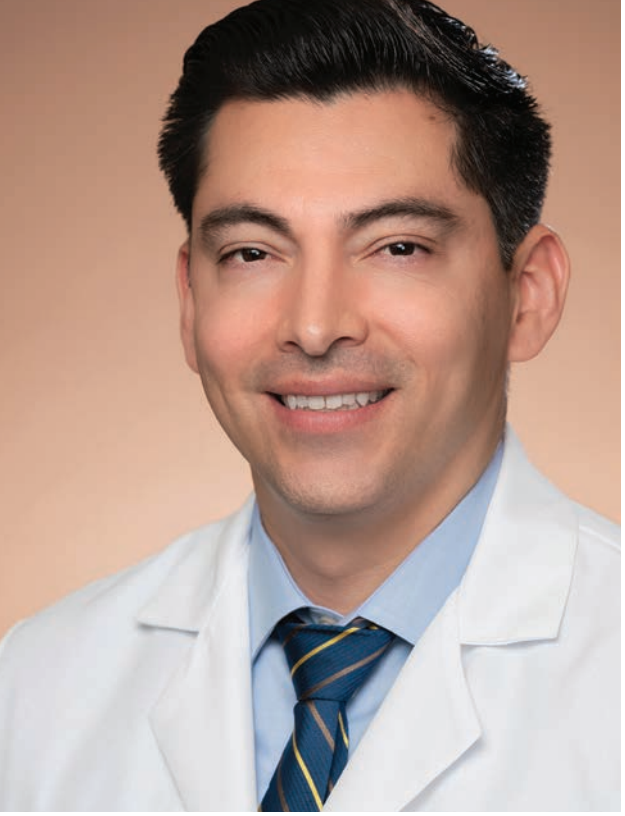
EFRAIN TALAMANTES

M.D., MBA, MSHPM, chief operating officer, AltaMed Health Services, Los Angeles

I grew up as the oldest of three children in Norwalk, California. My parents were raised in a rural farming community in Jalisco, Mexico, and immigrated to the United States in search of a better future. From poverty to lack of access to healthcare, the many experiences we faced as immigrants shaped my passion to improve others' health and well-being. I credit my family, friends, teachers, mentors and outreach programs that recognized my potential and never allowed me to give up.

I earned a B.S. in psychobiology at UCLA, an M.D. at David Geffen School of Medicine at UCLA, an MBA at Emory University, and an M.S. in health policy and management at the UCLA Fielding School of Public Health. Next, I had a residency at the University of California, Davis (UC Davis). I also completed the prestigious Robert Wood Johnson Foundation Clinical Scholars Program at UCLA and was recognized by the Society of General Internal Medicine with the Mack Lipkin Sr. Associate Award for my research, "Community College Pathways: Improving the U.S. Physician Workforce Pipeline."

After my fellowship, I served as the inaugural medical director for the hospital medicine department, and I helped open Martin Luther King Jr. Community Hospital in Los Angeles. I then served as the associate director for the UC Davis Center for Reducing Health Disparities and co-directed the Center for a Diverse Healthcare Workforce.



"The pandemic has shown how fragmented our system is when serving the underinsured."

– Efrain Talamantes, chief operating officer, AltaMed Health Services, Los Angeles

Today, I serve on the executive physician leadership team at AltaMed and as the medical director for the AltaMed Institute for Health Equity, leading research, innovative health delivery, and training programs that address disparities affecting our patients. Under my leadership, AltaMed received its first Patient-Centered Outcomes Research Institute grant to develop the Health Equity to Advance Latino Patient-Centered Research community advisory board. I also serve as the designated institutional officer for AltaMed's inaugural family medicine residency program.

Why did you choose your profession?
My interest in medicine was fueled by interpreting for my parents in the hospital. I experienced how cultural and language barriers impact quality of care. I combined my passion for science and serving my community by pursuing medicine with the help of mentors and my family.

What has been your biggest learning experience in the industry? What did it teach you?
The healthcare industry has trailed behind in embracing people of color in leadership. I've learned that my patients and colleagues benefit from my partnership in solving some of today's most pressing challenges. If we co-design our healthcare delivery system with underrepresented groups in mind, we can improve the health of those who suffer most. I also dedicate a lot of time to mentoring students who come from underrepresented backgrounds.

How has COVID-19 affected your responsibilities and how your organization operates? How might your job and your organization change because of the pandemic?
Thepandemic has shown how fragmented our system is when serving theunderinsured. During the pandemic, AltaMed re-imagined healthcare by providing access to COVID-19 testing in underserved communities, scaled access to telehealth and invested in our workforce's well-being.

How has the current discussion of racism and healthcare inequity affected you, your outlook and your organization? What has been the short-term response, and what do you envision happening over the longer term to your organization and American healthcare?
We held a town hall for 8:46 minutes in remembrance, where many of us kneeled for George Floyd and Black lives lost to violence. We held a panel discussing AltaMed's position on law enforcement violence and racism as a public health crisis. We're working on anti-racism initiatives to improve health outcomes for people of color.

What other kinds of changes do you expect to see in healthcare in the next 5 to 10 years?
I expect to see us find better ways to care for people in their homes using technology. My goal is to ensure that access to these programs will be equitable. I also expect to see health equity play a more central role in how we design healthcare delivery.

What have you enjoyed about social distancing and extra stay-at-home time during the past few months?
I've had the chance to rediscover how fun it is to play hide-and-seek with my children and how important these straightforward games are to bonding. I have yet to find the best hiding place in our home, as my daughter always finds me and my son.

EMERGING INDUSTRY LEADERS

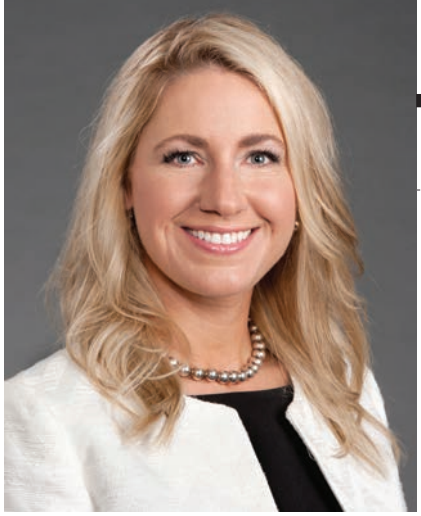
For the fourth year, *Managed Healthcare Executive*® has chosen 10 emerging healthcare industry leaders who work in the areas of pharmacy, health plans, health systems and technology. Through nominations and independent research, we identified more than 30 finalists. That list was winnowed down to 10 standouts by the publication's staff, with some help from the editorial advisory board.

Congratulations to the 10 winners!

To be considered, candidates had to have no more than 15 years' experience in the industry and meet the following requirements:

- Led key initiatives at their organizations or relevant organizations.
- Took actions that led to measurable, positive industry impacts.
- Accomplished something new or unique in the industry.
- Continued to take on more advanced roles and responsibilities.

This year we added questions about the COVID-19 pandemic and racism and healthcare inequity to the list.



"We need better methods to ensure affordability and access to care for patients."

– Jennifer Tryon, associate vice president and chief pharmacy officer, Wake Forest Baptist Health, Winston-Salem, North Carolina, residency program director for the Health System Pharmacy Administration and Leadership residency Program

JENNIFER TRYON

Pharm.D., M.S., FASHP, associate vice president and chief pharmacy officer, Wake Forest Baptist Health, Winston-Salem, North Carolina; residency program director for the Health System Pharmacy Administration and Leadership Residency Program

I grew up in Western Europe and came to the United States when I was 18 to pursue a pharmacy degree from the University of Iowa and a master's of science from the University of Wisconsin. I went on to complete a two-year administrative residency at University of Wisconsin Hospitals and Clinics.

I took a job as the assistant director at Oregon Health & Sciences University and then became the assistant director of pharmacy and residency program director at PeaceHealth Southwest Medical Center in Vancouver, Washington. I also served as the chief pharmacy officer at the University of Chicago Medical Center and as the director of graduate pharmacy education there.

Why did you choose your profession?

When I was growing up, my parents introduced me to the importance of having a liberal arts approach to life. I had a passion for leadership and helping others and an interest in the arts and sciences. I sought a profession where I could apply my diverse interests in service to others. The pharmacy profession allows me to work with talented teammates on innovative models of care, with a focus on improving services to our communities.

What has been your biggest learning experience in the industry? What did it teach you?

I've learned the importance of teamwork and collaboration in achieving success. Collectively, we can leverage our different skill sets, ideas and energy to create services that would otherwise not have been possible.

How has COVID-19 affected your responsibilities and how your organization operates? How might your job and your organization change because of the pandemic?

COVID-19 has impacted the manner in which our teams interact, especially as it pertains to introducing virtual platforms. There is a silver lining that the pandemic has afforded our organization in that we have ensured patient access to pharmacy services by leveraging telehealth platforms, expanding our population health platforms for community outreach to high risk patients, and introducing drone delivery of medications and equipment. I am proud to work for an organization that fosters innovation in care models.

How has the current discussion of racism and healthcare inequity affected you, your outlook and your organization? What has been the short-term response, and what do you envision happening over the longer term to your organization and American healthcare?

In the short term, we are creating awareness by providing forums to learn about racial inequalities and share our thoughts and emotions. The challenge I see before us is how we can move from awareness to actions aimed at decreasing racial disparities and ensuring all patients have the essentials; for example, housing, food and healthcare. This movement requires leadership and a commitment to study and address gaps in how we care for those we serve.

We cannot deliver on our mission of patient-centered care if we aren't addressing racism and the impact of race on healthcare. This begins with an understanding of the health inequities specific to the Black community served by our health system so we can work to address them. As leaders and healthcare professionals, we are in positions of incredible influence in our community, and we have a responsibility to ensure that we leverage the opportunity to be and do better.

What other kinds of changes do you expect to see in healthcare in the next five to 10 years?

I expect to see medications become increasingly specialized and expensive. We need better methods to ensure affordability and access to care for patients. I also think healthcare will increasingly move to care in the home.

An area for healthcare to embrace is technology advancement and machine learning. This will present an opportunity to redeploy healthcare professionals to areas like primary care and geriatrics where patient needs are growing.

What have you enjoyed about social distancing and extra stay-at-home time during the past few months?

I have also enjoyed seeing my team flourish without us being together every day. It has been rewarding to see great progress even though we were working remotely. ■

Karen Appold *is a medical writer who lives in the Lehigh Valley region of Pennsylvania.*

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In Healthcare, Plenty of Political Action Happens at the State Level

Next month voters will weigh in on issues including dialysis centers, abortion, legalization of marijuana.

by **MARI EDLIN**

The White House is obviously the top prize, but next month, but voters at the state level will decide the fate of a wide range of healthcare plans and proposals when they go to the polls or drop their ballots in the mail. Among the issues hanging in the balance: dialysis center staffing, paid medical leave, abortion and the legal status of marijuana.

One of the more controversial ballot measures for this year is Proposition 23 in California, which, if passed, would establish a variety of new rules for dialysis clinics, including a requirement that a physician be on-site while patients are being treated and a ban on discriminating against patients based on their insurance coverage.

This is not the first time that dialysis centers have been the subject of a ballot proposition in California. Two years ago, Proposition 8 would have capped dialysis center profits. After the dialysis industry reportedly spent over $100 million fighting the proposition, the initiative failed to pass.

Service Employees International Union-United Healthcare Workers West, which attempted to organize workers at the large dialysis companies, supported Proposition 8 and is backing Proposition 23 this year.

Kathy Fairbanks, spokesperson for a group campaigning against Proposition 23, says the measure would force dialysis clinics to have a physician on-site even though that doctor would not be involved in direct patient care and would not need to be a specialist in kidney care. She says that other parts of the proposition — reporting requirements and the ban on discrimination — are public relations ploys, because reporting on infections and treating patients the same are already happening.

FAIRBANKS

"The proponents know what they are doing; the prop sounds good — physician oversight, infections reported statewide — but three of the four points are irrelevant. It is not designed to make sense; it's not about care but about politics," Fairbanks says.

Colorado's Proposition 118 would establish 12 weeks of paid leave for caring for a new child or seriously ill family member or, in the case of serious illness, for the covered employee. The maximum amount a person could receive would be $1,100 per week and would be paid for by payroll tax, split equally between employers and employees.

Proponents cite the benefits of paid time off for families with young children and the hardships of caregiving for seriously ill family members. Critics argue that the payroll tax will be a burden on employees in time of economic uncertainty. Some companies that offer private plans for covering leave could opt out of the program, and companies with 10 or fewer employees would not have to pay the payroll tax.

Coloradans will also vote on Proposition 115, which if passed would prohibit abortions after a fetus reaches a gestational age of 22 weeks, dating from the woman's last menstrual period. According to the Guttmacher Institute, 17 states have similar bans based on gestational age. Louisiana also has an abortion measure on its ballot. A yes vote for Amendment 1 would add language to the state's constitution stating that "nothing in this constitution shall be construed to secure or protect a right to abortion or require the funding of abortion."

Scope of practice battles for are almost being waged at the state level and this year the optometrists and ophthalmologists have been going at it in Arkansas. After the optometrists won a legislative battle to expand their scope of practice, the ophthalmologists petitioned to put a question on the ballot that with enough no votes would have overturned that law. But a ruling by the Arkansas Supreme Court effectively canceled the vote. Currently, only Alaska, Kentucky, Louisiana and Oklahoma allow optometrists to prescribe drugs and perform a variety of procedures.

After the June vote in favor of Medicaid expansion, Oklahoma voters will be asked to decide whether to redirect funds the state receives from a 1998 settlement with tobacco companies. If voters vote yes on Question 84, the state will use most of its tobacco settlement money to secure federal matching funds for its Medicaid program. Currently, most of it goes to the Tobacco Settlement Endowment Trust, which uses it to fund grants to promote tobacco cessation programs and other efforts designed to improve the health of Oklahoma residents.

Legalization growing like a weed

Eight years ago, Colorado and Washington were the first states to legalize marijuana for recreational purposes. Now marijuana is legal for that use in 11 more states and Washington, D.C. "Weed is so normalized in America that it is hardly cool anymore," Sarah Rense wrote in *Esquire* magazine.

Legalization is still spreading, with marijuana-related questions on the ballot next month in seven states, three of which are deep red. There's definitely a blue state-red state gradient to marijuana legalization, but it is not without patchiness.

Voters in Oregon, which has already legalized recreational marijuana, are being asked to decide to whether to use the state's marijuana tax revenue to establish a drug addiction recovery and treatment program. But the main provision of Measure 10 would make personal, noncommercial possession of controlled substances such as heroin, cocaine and methamphetamines a lower-level, class E violation, with a maximum fine of $100. Proponents argue that the measure will free up money so the short supply of substance abuse treat-

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NOT ON THE BALLOT: MEDICAID EXPANSION

The focus of so much fierce campaigning and ardent politicking at the state level in the past few elections, Medicaid expansion, is taking this November off.

Oklahoma voters approved a Medicaid expansion ballot measure in June, and Missouri voters approved one in August. The issue may make it on to the ballot in Florida in 2022; an organizing committee there decided to delay their target till then. Democrats in South Dakota are also eyeing 2022 as the year they will be ready to put Medicaid expansion in front of voters.

"Given the success of Medicaid expansion through ballot measures in states where governors or legislatures opposed expansion, we should expect to see the same tactic attempted in some of the remaining states," says Philo D. Hall, a senior counsel in healthcare and life sciences practice at Epstein Becker Green law firm and a HHS lawyer during the George W. Bush administration. The more time that passes from passage of the ACA in 2010, the more palatable Medicaid expansion becomes for many voters who opposed "Obamacare," Hall says.

Still, there are plenty of entanglements in politics of Medicaid expansion in the 12 remaining nonexpansion states. In Kansas, the Democratic governor and the Republican Senate majority leader agreed to a compromise proposal, but it was eventually blocked, partly because of anti-abortion politics. In North Carolina, the Democratic governor and Republican-controlled legislature waged a drawn-out, back-and-forth battle over the state budget; the main issue was Medicaid expansion. Complicated by COVID-19, the political maneuvering stumbled to an end with no decision reached.

SALO

These state-by-state skirmishes are occurring against the backdrop of the entire ACA again being in legal jeopardy. The California v. Texas case, which could result in a ruling throwing out the entire law, is scheduled to be argued before the Supreme Court in November. The death of Justice Ruth Bader Ginsburg leaves three reliably liberal justices on the court, although some experts say the main legal issue in the case, severability, would not necessarily split the justices along liberal-conservative political lines.

Matt Salo, executive director of the National Association of Medicaid Directors, says the ACA has always been under an existential threat. "At the core of it is politics, and it (the ACA) has nuances that don't necessarily play well with politics. The ACA is separate from Medicaid expansion and is an emblematic issue that has rallied conservatives in opposition." ◘

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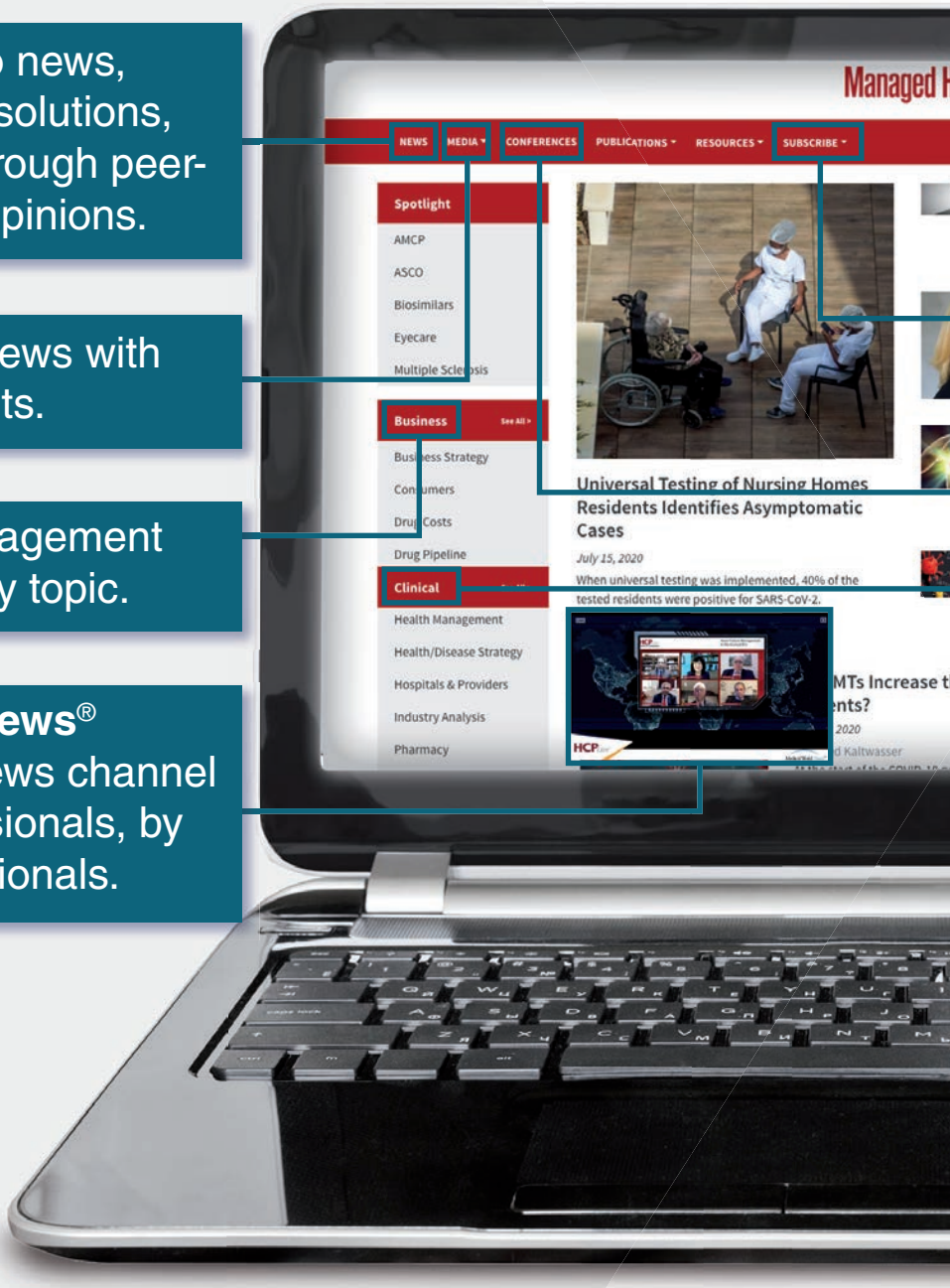

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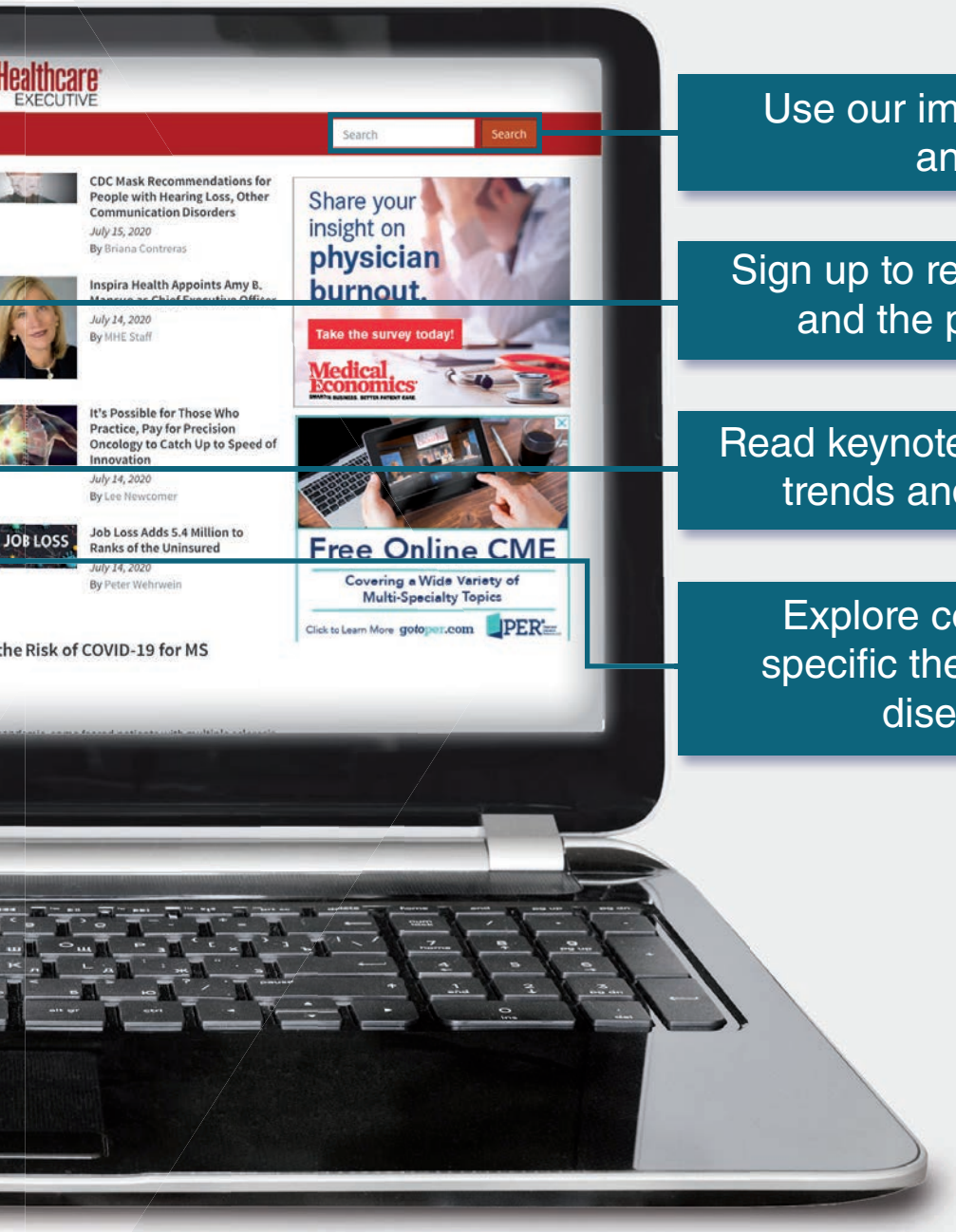

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ment services and programs could increase to meet the growing demand.

Voters in New Jersey and Arizona, both of which allow medical marijuana, will decide whether to go a step further and legalize possession and use for recreational purposes. Arizona voters narrowly defeated a legislation measure in 2016.

Montana and South Dakota each have two marijuana-related initiatives on the ballot. In Montana, one initiative would create a system of legal cannabis access for adult use, and a second would ensure that only those 21 and older could be involved in the marketplace. In South Dakota, passage of Constitutional Amendment A would legalize marijuana for 21-year-olds, and Initiated Measure 26 would take the more moderate step of allowing for medical marijuana.

HALL

Voters in Mississippi will consider two versions of a medical marijuana amendment. Initiative 65 provides for the establishment of a medical marijuana program for individuals with debilitating medical conditions. Alternative 65A would make medical marijuana legal only for people with a terminal illness. In Nebraska, voters will decide whether to move from complete criminalization of marijuana to allowing medical marijuana.

Getting into generics

In September, President Donald Trump signed an executive order designed to lower prescription drug prices, but its practical effects are months away and may never occur because of court challenges (and, obviously, the outcome of the election). Meanwhile, 33 states passed laws in 2019 that addressed drug prices.

There are no state-level drug pricing ballot initiatives this year, but Philo D. Hall, a senior counsel in healthcare and life sciences practice at Epstein Becker Green law firm believes that drug pricing is "another issue ripe for ballot measures," especially with state legislatures becoming more assertive in attempting to limit the amounts that states pay for prescription drugs and requiring pricing disclosures from pharmacy benefit managers. Late last month, California Gov. Gavin Newsom signed into law legislation that will create a new state-sponsored drug label, Cal Rx, for generics. California is also changing the purchasing policy of its large Medicaid program so that next year it starts buying directly from drugmakers.

Mari Edlin *is a freelance journalist living in Sonoma, California.*

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Confused About Population Health? You've Come to the Right Place.

What does it mean? When did it begin? How is it different from public health? Here are the answers to these questions and more.

by **KAREN APPOLD**

The provenance of healthcare terminology is often difficult to pinpoint. Like success, jargon with staying power tends to have many parents.

So it is with "population health." A Pubmed search shows the term was in the title of a paper on land monopoly in 1890, and it starts popping up in epidemiologic research titles in the 1970s. But some say it only really entered the healthcare vernacular in 2003, when David Kindig, M.D., Ph.D., of the University of Wisconsin and Greg Stoddart, Ph.D., of McMaster University Health Sciences Centre in Canada published a paper titled, "What is Population Health?" in the *American Journal of Public Health*. Jaan Sidorov, M.D., CEO and president of PA Clinical Network, a clinically integrated network for independent practices in Pennsylvania, credits David B. Nash, M.D., MBA, with coining the term in an article he cowrote with Janice Clark. Nash, who founded the Jefferson College of Population Health, part of Thomas Jefferson University in Philadelphia in 2008, bridged the transition from "disease management" to "population health" with "population-based disease management," says Sidorov. But the real credit for the term gaining currency belongs to the Congressional Budget Office and its 2004 report on disease management that questioned whether population health reduces costs, according to Sidorov. "A new approach was clearly needed and a new name emerged."

Feeds on data

However, coining a term is one thing, assigning it a meaning is another. The question Kindig and Stoddart asked still gets asked, and answered in a variety of ways. Kindig and Stoddart were nice and succinct in their definition: "The health outcomes of a group of individuals including the distribution of such outcomes within the group." The CDC, which has a Division of Population Health, is far wordier and gives more of a functional definition. Population health is interdisciplinary, according to the CDC website, and an approach that uses "nontraditional partnerships" among different sectors of the community — public health, industry, academia, healthcare, local government entities — to achieve positive health outcomes.

Either way, population health dines on data, lots and lots of data. "Population health relies heavily on information technology to manage, cross-reference and analyze huge amounts of data to provide actionable reports," observes Mitchell A. Kaminski, M.D., MBA, an associate professor and program director of population health at Jefferson College of Population Health.

Typically, population health depends on two major sources of data: a wide range of government data and clinical and claims data generated by healthcare providers and payers. The trick is often figuring out ways to bring them together. For example, a health system may want to reduce hospitalizations and deaths in patients with asthma. Its data can identify which patients have asthma and which of those have gone to the emergency department or been hospitalized. The data will also include information about prescriptions and refills that can lend insight into whether adherence played a role in those emergency department visits and hospitalizations. Data from government at the federal, state and local level can indicate whether environmental factors that may have triggered asthma are nearby. Similarly, assessing all those now-familiar social determinants of health — housing, nutrition, education and public safety — requires data that often come from public and government sources. "A hospital or medical practice won't be able to reduce asthma hospitalizations and deaths unless it has the data to reach out and partner with community agencies to address major contributing

factors," Kaminski says.

Katrina Miller Parrish, M.D., chief quality and information executive at L.A. Care Health Plan, a publicly operated health plan in Los Angeles, points out the differences between healthcare on an individual, person-by-person basis and the population health approach. A clinician would ask an individual, "How are you feeling and are you taking your medications?" and then address that patient's issues. They may be forgetful about taking their pills and need some advice about establishing a routine. Maybe price is a concern and less expensive alternatives can be prescribed. Adherence viewed through the lens of population health involves looking at data for patterns of use and ways to address them in a systematic way across a group of patients. Perhaps the data would reveal that a subset of patients need particular attention and that sifting through the data would show why they are not taking their medications as prescribed.

Many manifestations

Emily Hajjar, Pharm.D., M.S., program director of the population health pharmacy program at Jefferson College of Pharmacy at Thomas Jefferson University, says that population health data are anchored in dealing with the determinants of health: "We know that some people are considered to be healthy and others suffer from poor health, so population health explores what factors contribute to health and wellness and what factors predispose others to poor health outcomes," she says. Kindig and Stoddart discussed determinants in their definitional manifesto 17 years ago. "We support the idea that a hallmark of *the field of population health* (the emphasis is theirs) is significant attention to the multiple determinants of such health outcomes, however measured," they wrote, adding a long list of determinants that range from medical care to the "social environment" (income, education, culture) to the physical environment, which includes air and water quality. Hajjar says the potential for efficiency is one advantage of a population health approach: instead of assessing patients one by one and devising individual solutions for their problems, population health can tackle common problems in a systematic way. "This is not to say that individuals are subjected to cookbook medicine," she notes, "but focusing initiatives on certain populations can create care pathways that allow patients to receive a similar level of care for specific diagnoses to increase consistency and reduce inequities."

"Population health relies heavily on information technology to manage, cross-reference and analyze huge amounts of data to provide actionable reports."

— MITCHELL A. KAMINSKI, M.D., MBA, AN ASSOCIATE PROFESSOR AND PROGRAM DIRECTOR OF POPULATION HEALTH AT JEFFERSON COLLEGE OF POPULATION HEALTH.

Population health data can also be used to inform and shape policy changes, says Shunling Tsang, M.D., M.P.H., the medical director of ambulatory quality and vice chair of the Department of Family Medicine at Riverside University Health System in Riverside County, California, east of Los Angeles. The quality metrics that affect payment rates to healthcare providers are rooted in population health data, for example. But that data may also factor into decisions that are well beyond the normal boundaries of healthcare, such as the city's decision on where to build a new park or construct a bike path to make it easier and safer for people to become physically active.

Joseph M. Geskey, D.O., MBA, M.S.-PopH, a principal at Vizient, points to research that suggests that only a relatively small proportion, as small as 20% according to one study, of the modifiable contributors to health outcomes involves clinical care. "Therefore, in order to improve the overall health of a population (which is more expansive than just clinical care), we have to holistically understand what influences health outcomes," he says.

Many see population health and value-based care as linked, indeed, joined at the hip. In broad strokes, value-based care involves payers, both public and private, paying providers such as hospitals and clinicians according to the value (outcomes divided by cost) of the care delivered, not the volume. Looking at outcomes for a set of patients is seeing healthcare in a population health framework.

Another manifestation of the population health mindset are the dashboards an increasing number of clinicians are using to analyze data about their patients and manage their care. They are also used to compare practice patterns and to nudge (to put it mildly) outliers back into the mainstream. A dashboard might, for example, show the proportion of a provider's patients who have been vaccinated against

the flu. Such ratios are the stuff of population health.

No, not public health

Population health and public health are, understandably, confused and conflated and sometimes used interchangeably. But at the risk of being overly fastidious, and with the benefits that come with clear definitions, they should be kept separate. Public health is more expansive and focuses on what society does collectively to ensure that people have the appropriate conditions to be healthy, says Vincent Nelson, M.D., MBA, vice president of medical affairs for the Blue Cross Blue Shield Association in Chicago. It focuses mainly on policy recommendations, health education, outreach and research. In comparison, says Nelson, population health focuses on how different groups, agencies and organizations work together to improve health outcomes in communities.

Social determinants of health is a phrase that often comes up in discussions of public health and population health. Both grapple with the social determinants of health, such as housing and nutrition, but they are not themselves social determinants of health.

What's next

American healthcare is subject to fads and trendy phrases and words used more for effect than substance. But it has been almost 20 years since population health nosed its way into American healthcare, and it has demonstrated staying power, as a term and as a way of thinking about and managing healthcare. "This field of study has developed exponentially in recent decades; we're refining the state and needs of populations far better than we ever have," says Parrish of L.A. Care Health Plan. She invoked the Triple Aim, the formulation that healthcare should have as its goal of improving the experience of care, reducing per capita cost as well as population health. "Since the third aim of the Triple Aim is reducing per capita cost, the more we can target appropriate education, prevention and treatment to the right population who needs it, the more efficient and equitable we will be with resources."

"This field of study has developed exponentially in recent decades; we're refining the state and needs of populations far better than we ever have."

– KATRINA MILLER PARRISH, M.D., CHIEF QUALITY AND INFORMATION EXECUTIVE AT L.A. CARE HEALTH PLAN

Geskey believes that employing population health data is the only conceivable way to reduce racial inequities in care and improve the large discrepancy that exists in health outcomes between the U.S. and other advanced countries. "Employing this data would save money that can be reinvested in the economy and allow the United States to remain competitive with other countries to create desirable, well-paying jobs in the future," he says. "This is especially true if the government refuses to use its leverage, scope and power to ensure that healthcare is a right of all U.S. citizens and set a global budget that is allocated to healthcare."

Kimberly Zeigler, MBA, director of population health and analytics at Sonora Quest Laboratories, a joint venture of Banner Health and Quest Diagnostics in Tempe, Arizona, believes that population health will continue to benefit from emerging and advancing technologies as well as enhanced methods of data sharing to improve outcomes for members of a population. "The data (are) becoming much more granular and individualized as technologies and data sharing are continuously improving and stakeholders collaborate to improve outcomes or, as we are currently experiencing, (respond) to a pandemic," she says.

Population health has had staying power partly because it is defined by concepts rather than rigid definitions, Tsang says. Those concepts are flexible enough so that population health can be invoked at a relatively micro level where the issue might be health outcomes for patients in the panel of a particular provider, or at a macro level where the issue might be the health status of residents of a city, state, or country, Tsang observes. ■

Karen Appold *is a medical writer in Pennsylvania.*

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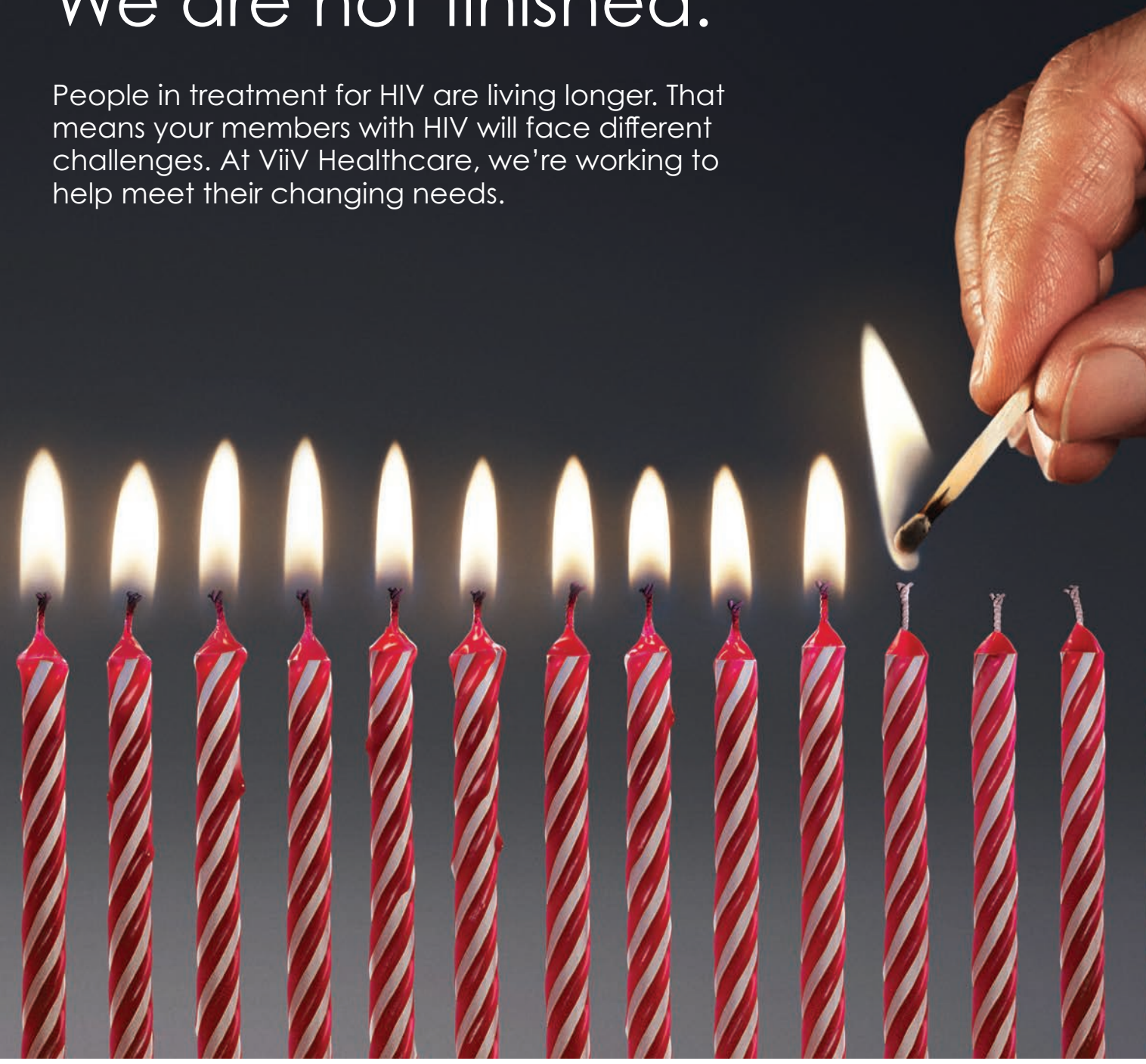

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The PPE Scramble

Suppliers of personal protective equipment have come up with innovative ways to meet the demand, but one expert notes the lack of rigorous research into its efficacy. *by* **JARED KALTWASSER**

A year ago, if you asked anyone outside the healthcare and manufacturing industries what "PPE" was, chances are they wouldn't have been able to even venture a guess. Now the initialism for "personal protective equipment" has entered the vernacular along with other COVID-19-related terms like "social distancing" and "face mask."

Common understanding of PPE may have evolved, but the equipment itself—gloves, masks, respirators, gowns — hasn't changed all that much amid the pandemic. The innovation has occurred mainly in logistics, supply lines and massive increases in production to meet a demand that was beyond imagination not many months ago.

Just trying to keep up

For many manufacturers, keeping up with the demand for PPE has been challenge enough. Tim Post, a spokesperson for 3M, the largest maker of N95 respirator masks, says that at the beginning of this year, most of the orders for the St. Paul, Minnesota, company's masks came from industrial clients. When the pandemic hit the U.S. in March, the demand from the healthcare sector jumped 20- to 40-fold seemingly overnight. He says that previously, healthcare sector orders for N95s came primarily from hospitals treating patients with highly infectious illnesses such as influenza A and tuberculosis.

To meet that demand, the company dramatically increased production. Post says that globally, 3M has doubled N95 respirator production since January and is on pace to produce 2 billion respirators by the end of the year. In the U.S., 3M was on pace to produce 95 million masks a month by October. That's triple the production in April, but Post says it still won't be enough: "The reality is that even with 3M's accelerated production, combined with capacity from other manufacturers, the demand for N95 and other respirators continues to exceed supply for the entire industry and will for the foreseeable future."

Charles Johnson, M.A., president of the International Safety Equipment Association, a trade group, says PPE manufacturers are working around the clock to produce the most essential equipment. The pandemic, he says, "has likely forever changed PPE demand within the health and safety landscape."

All areas of the safety equipment industry, including importers and distributors, have adjusted to meet spiking demand, according to Johnson. Some PPE producers who specialize primarily in sectors such as industrial or construction protection have begun partnering with medical device makers to begin making products for medical settings.

Meanwhile, manufacturers in completely different industries have jumped into the fray. For example, Ford Motor Company shipped out its first powered air-purifying respirators in May, made in partnership with 3M, which provided technical and regulatory know-how. Ford also started making reusable gowns for healthcare workers, sparked by a 500,000-unit order from the state of New Jersey.

Lack of evidence

A few experts say this rush to deploy PPE is happening in the absence of solid evidence about how protective PPE really is. Jos H. Verbeek, M.D., Ph.D., an occupational health physician at the University of Amsterdam, has long advocated for evidence-based improvement of PPE. He has written about the lack of randomized trials to back up the efficacy claims of common PPE items and argues that the industry needs uniform, high standards, which, in his view, are sorely lacking. He told *Managed Healthcare Executive*® that although the COVID-19 pandemic has centered attention on PPE, that awareness has not translated into systematic improvement: "Everything has been focused on dealing with the crisis, and there hasn't been any concerted effort in improving the situation:

no trials, no comparative studies, no standardized naming."

In April, Verbeek and colleagues published a Cochrane Library review of PPE studies that also included research into the risk of contamination associated with donning and doffing the equipment. They found that the results of two dozen relevant studies suggested that covering more parts of the body, such as the neck and the head, could improve protection and that modifications like pull tabs to ease removal of the equipment could cut down on inadvertent contamination. In an opinion piece in The *BMJ* in June, Verbeek said a key takeaway from the review is that there is a frustrating lack of evidence to instruct healthcare workers and manufacturers on which types of PPE work best and how best to handle the equipment in the real world. "All evidence was rated as low to very low quality," he wrote.

Although much attention has been paid to face coverings and respirators, Verbeek argued that PPE ought to be evaluated holistically because face masks are generally just one of many pieces of equipment used by healthcare workers in high-risk environments. Moreover, he said, the use or misuse of equipment can have a significant impact on effectiveness. Improperly used PPE will not be protective, and Verbeek emphasized the need to address the practical aspects of the gear. "PPE needs to be feasible in healthcare settings because protection depends not only on the technical qualities of the garment but also on the composition of PPE items, interfaces between pieces of PPE, and the ways in which they are put on and taken off," he wrote.

Some tweaking

COVID-19 has pumped billions into the buying and selling of PPE, and, notwithstanding Verbeek's concerns about the lack of standards, companies leaped at the chance and are out there, selling their PPE ware. For instance, Aegle Gear, which makes scrubs, now sells products treated with Protx2, a proprietary spray created by Intelligent Fabric Technologies (North America) to protect fabric from odor-causing bacteria and fungi. Aegle's website says the garments have been tested against various pathogens but also carries a disclaimer noting that the Protx2 finish is used "solely to protect the finished product itself," and the company makes no claims about its health benefits. Intelligent Fabric Technologies says its recently developed follow-on product, Protx2 AV, can effectively protect against SARS-CoV-2, the virus that causes COVID-19.

PPE makers are also busy tweaking products to make them more comfortable. Working with Nissha Medical Technologies, 3M put a hydrophilic film on face shields that wicks away fluid and prevents them from fogging up.

A number of manufacturers, including 3M, are working with the FDA to find and evaluate ways to safely decontaminate and reuse N95 masks. Johnson says developing reusable PPE is now seen as important because it would help alleviate the supply problem.

"Elastomeric respirators (reusable-filter-style respirators) and powered air-purifying respirators provide greater protection and can help to prevent shortages of disposable alternatives," he says, "so we expect to see them used more often as healthcare facilities continue to battle this and future health emergencies."

Verbeek acknowledges that new products could improve PPE but says he still sees a problem of science and rigorous evaluation lagging.

The wide array of face coverings designed for source control — protecting people from asymptomatic carriers — is a new product segment, according to Johnson. He says his association and its members are working to establish standards and guidance to ensure that such products are safe and effective. There certainly seems to be a strong appetite for scientific evidence about the effectiveness of face masks: Duke University researchers were in broke-the-internet territory in August when they reported results about how well different face masks hindered exhalation of droplets.

Verbeek concedes that it might be asking too much to conduct rigorous comparative research in the middle of a pandemic, but that doesn't mean there is no opportunity for progress: "A realistic alternative is to conduct observational studies in which the PPE of healthcare workers is registered prospectively, and the healthcare workers are followed for their risk of infection."

The pandemic "has likely forever changed PPE demand within the health and safety landscape."

– CHARLES JOHNSON, M.A., PRESIDENT OF THE INTERNATIONAL SAFETY EQUIPMENT ASSOCIATION

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