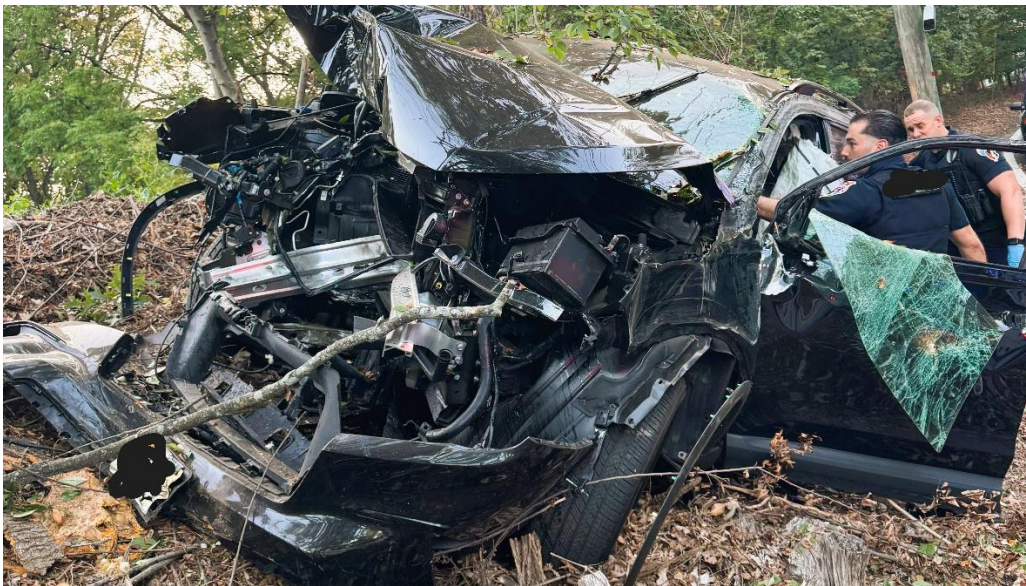


**Hey, healthcare executives, do you want to be
better at your job?
Roll up your sleeves!**



An accident I responded to. The patient is treated and safe.

I have been a healthcare investment banker for over 35 years and a volunteer EMT/Ambulance driver for the last 18 months. I learned more about the healthcare system in the last 18 months than in the previous 35 years.

During the last year, I was our squad's top responder and have performed CPR several times, extracted victims from motor vehicle accidents, splinted many bones and joints, dressed bleeding wounds, treated children in anaphylactic shock, calmed suicidal teens and, yes....been vomited on.

During this time, I have had a first-row seat in our healthcare system. Here are some of my observations:

- **Pay for allied healthcare professionals is atrocious:** Paramedics are badassess... **HARD STOP.** They can drop an IV into a patient in the back of an ambulance going 75 MPH over potholed roads. Paramedics deliver care or drugs on the scene when such treatments have the potential to be the most effective...we call it the "golden hour." To become a paramedic, one needs to be an EMT for two years, attend a two-year classroom program, and perform 1,000 hours of clinic

training. Starting salary in NJ..... \$53,450. WTF!!! Same with nurses. After all their training, their starting salary is \$64,324. WTF AGAIN!! There is no reason in the world why some IT dweeb in the same hospital system should be making more than these caregivers. They work too hard and are prone to burnout. This issue needs to be addressed.

- **Healthcare payors have an enormous problem:** (Warning: this story is illustrative of the animosity between provider and payor, not the providers' true wishes). I was on a very tough CPR call on the day the Group CEO of United Health was assassinated. We worked on the patient in his home for 45 minutes, got a signal from his heart, and promptly transported him to the hospital using lights and sirens. In the trauma bay of the hospital, my partner and I assisted the doctors and nurses with the procedure. (CPR treatments require many hands and effective teamwork.) At various points, we stopped our activities to take the patient's vital signs. During one such break in the action, a doctor brought up the shooting. Another said I wonder if the payor diverted the patient to an inferior hospital. The other retorted, that even then, the payor would deny the claim. I thought wow, the animosity towards payers is so bad that healers have no mercy for their employees. Later, while we were cleaning up (we lost the patient), the doctor shared with me numerous stories of how the insurance companies' delays and/or denials have harmed patient care. Later that evening, as I watched the news coverage of the event, I was taken by the fact that the general public was more sympathetic to the shooter than the victim. My greatest hope is that this tragic event has catalyzed the payors to rethink their authorization processes and realize they are making life-and-death decisions.
- **Polypharmacy is a huge issue:** I have responded to countless calls in which the patient complains of "generalized weakness." I take the patient's medical history and find that they are ingesting up to 15 various drugs. No wonder they feel poorly. I would look at the pill bottles and find that these drugs were fulfilled by different pharmacies. Why? General Practitioners are so overworked and underpaid that they may be a little too quick to write a script for one patient to move on to the next. Also, no big surprise here, our healthcare system treats the symptoms, not the cause.
- **A new device must be transformative and practical.** The LUCAS device first responders use in CPR cases is such a device. It's easy to use, provides consistent chest compressions, and frees us up to perform other tasks like ventilation. But I have seen new devices that are just impractical. Case in point, I received a call from an old friend who was looking to invest in a new technology that delivered Narcan buccally. He argued that it would take effect more quickly than the intranasal delivery method. It was not transformative because the current intranasal delivery of Narcan is fine. We do not want the opioid agonist to act too quickly as the drug user is liable to punch us in the face if he comes down from his high too abruptly. More importantly, the OD patient is either not breathing or has a very low respiratory rate. In either case, we do not want any device that has the potential to compromise his airway. Not to mention that we don't want our fingers bitten off. (My friend moved on to different uses for this technology.)
- **The adoption curve for new IT systems is steep for a reason:** Changing how allied healthcare providers perform their duties is hard. I spent nearly three months mastering our patient reporting system at the Ambulance Corps. Frankly, if my captain were to announce that we are "upgrading" to a new one, I would start to cry. In the emergency rooms, I see nurses spending more time working on computers than interacting with their patients. Before introducing a new system, it better be less complicated and more impactful to use than the current one. More importantly, it should unburden healthcare providers so they can do their jobs more effectively.

That's enough for now. It's time for me to scrub the vomit stains out of my uniform.