**Harlan Krumholz:** Welcome to *Health & Veritas*. I’m Harlan Krumholz.

**Howard Forman:** And I’m Howie Forman. We’re physicians and professors at Yale University. We’re trying to get closer to the truth about health and healthcare. This week, we’ll be speaking with Dr. Megan Ranney, but first we’d like to check in on current health news. Harlan, what do you have on your mind?

**Harlan Krumholz:** I don’t know if this is about current health news, it’s more about some of the articles I’ve been reading that have been focusing on ways to measure aging at a cellular level. It’s just gotten me thinking about this research and what we know about it. The United States, like many developed countries, is having a dramatic increase in the older population. Several factors here, advances in healthcare (although our life expectancy is decreasing right now, so maybe not), improved living conditions (maybe), but particularly I think the post–World War II baby boom.

The boomers are all moving into the older population now. According to the Census, by 2030 all baby boomers will be age 65 and older, and one in every five U.S. residents will have reached retirement age—or at the traditional retirement age. By 2034 it said that older adults will outnumber children for the first time. So this change in demographics is naturally leading to changes in... you’re seeing housing and marketing and so forth. But on the research side, there seems to be a real renaissance of interest in how to help us live forever.

Have you seen that, Howie? It’s like…I can’t remember the title. Number one bestseller on *The* *New York Times* list right now is [a book about how we can resist](https://peterattiamd.com/outlive/).

**Howard Forman:** Doesn’t it seem like that’s always the case?

**Harlan Krumholz:** It’s just aging.

**Howard Forman:** This is a specific book, but there’s always a book?

**Harlan Krumholz:** Well, I think, maybe it’s noticing it more as I age. So one of the interesting things is that people have been measuring ways at the cellular level to really gauge your aging. And this is really about how over the course of your lifespan, are you aging at faster-than-expected ways so that your chronologic age, what your birthday is, actually is, either lags or is faster than what your biologic age is. Lots of people know it’s about these things called telomeres. They’re protective caps at the end of chromosomes, which are long strands of DNA that carry genetic information in these chromosomes.

These caps are repeated sequences of DNA that can somehow protect the chromosomes. They play a crucial role in maintaining the stability and integrity of our genetic information. And over the course of our lives, there’s some progressive shortening that is generally associated with aging but sometimes can be also associated with diseases that have felt to be a marker of actually how fast our bodies internally are actually aging.

And people have looked at this for a long time. But it’s no surprise to know that exercise and stress management, healthy diet, sleep, social connections, avoiding smoking, and limiting alcohol consumption—these are all things that we think both help us resist this telomere shortening and can help us age I would say more gracefully, slowly. And this becomes an important thing.

Well, I think what’s interesting is that these people can put out these books, but in the end it’s just these basics that seem to be associated with our bodies, biological aging. And then some people, I don’t know if you’ve noticed this, some people say that if you take cold showers, for example, there’s a whole group of people that believe if you dunk yourself in cold water, that, that makes a difference. But none of this has really been borne out.

But there’s another thing that goes on which are called, the way in which our environment interacts with our DNA and these are called epigenetic factors. There’s one that’s called DNA methylation, which is basically a biological process in which a chemical methyl group, CH3, is added to the DNA molecule at certain places and can modify the way in which the genetics ... code is translated into proteins. There’s actually an area of the gene where this can occur. These are called age-associated methylated regions that are thought to somehow be what they call an epigenetic clock.

I’m getting into this because as I was reading these articles, I was finding this very interesting that they’re finding basically a cellular clock that you and I could look at and see whether or not we’re aging faster or slower than our biological age. Now, if you look at what that’s associated with, it’s the same kind of things. Exercise, healthy diet, avoiding smoking, excessive alcohol, all this kind of stuff. But it just makes me wonder whether as we get into the future, we’ll be able to do these tests where we’ll go in and find out whether, what is our real biological age, not just what is our chronological age.

Maybe at some point they will find some treatments for this. But when they’ve looked at this, by the way, in studies like the [MESA studies](https://www.mesa-nhlbi.org/), a large epidemiologic study, they’ve seen that there’s predictive value for this epigenetic clock that is with people who look like they are accelerating their aging, have an increased risk for adverse health outcomes that may be associated with AIDS.

So anyway, I’m just sharing with you. It’s not that there was a breakthrough in this at all, but as I’ve been reading about, just as making me, thinking about how there are these greater investments in understanding what is our biological age, what can be done to slow it down. And in a way, aging itself is becoming a target of intervention in ways that is separate from how people have been thinking about like, “I’m going to treat diabetes” or “I’m going to treat hypertension.”

They’re now going to be starting to say, “How do we start to slow down the biological clock?” And that’s the sort of subject of a lot of research are saying. I find it fascinating and we’ll just have to keep tabs on this, but for now, anything you see about it, mostly people are telling you the commonsense stuff that we’ve been saying for a long time. But in the future ,it may be that there will be interventions that will actually slow our aging process down, but that’ll be good or bad for society. You can tell me, but it’ll be a different society.

**Howard Forman:** We’re entering into a period of time where we’re going to have hundreds of thousands of people living past the age of a hundred. Society is going to change in ways that I don’t think people are fully ready for.

**Harlan Krumholz:** Totally agree with that. Hey, we’re so lucky to have Megan here today, and let’s get on with this part of the program.

**Howard Forman:** Dr. Megan Ranney is a practicing emergency physician researcher, national advocate for innovative approaches to public health, and so much more. She currently serves as the deputy dean of the Brown University School of Public Health, a professor of behavioral and social science, the Warren Alpert Endowed Professor of Emergency Medicine at Brown University’s Alpert Medical School and the founding director of the Brown Lifespan Center for Digital Health.

On July 1, she will become [the dean of the Yale School of Public Health](https://news.yale.edu/2023/01/31/megan-ranney-named-dean-yale-school-public-health). Yay! Her federally funded research focuses on how digital health interventions can prevent violence, behavioral health problems, and COVID-related risk reduction. Outside of research, Ranney is the co-founder and senior strategic advisor for the [American Foundation for Firearm Injury Reduction in Medicine](https://www.guidestar.org/profile/82-3454784), or AFFIRM, at the Aspen Institute. She has received numerous awards, including Rhode Island’s Woman of the Year and the American College of Emergency Physicians Policy Pioneer Award.

Dr. Ranney received her bachelor’s degree in history of science from Harvard, her medical degree from Columbia, and her master’s degree in public health from Brown. She completed her residency and chief residency in emergency medicine and a fellowship in injury prevention research also at Brown University. So first of all, I want to welcome you to the *Health & Veritas* podcast, and we are all excited to have you join us as dean coming in July. It’s a propitious time, because we just announced a few weeks ago that the School of Public Health is actually jointly sponsoring this podcast.

I want to just start off by asking you a little about how someone who starts off in clinical medicine and even comes from a global health background starts to transition into public health. And what motivated you about that?

**Megan Ranney:** It’s a great question, Howie and Harlan. It is an absolute joy and delight to join you. I think that when we planned my coming on this podcast, I had not yet announced that I was joining Yale in July. So it’s such a treat to be here and to get to know, get to spend a little time with both of you and also to share with the larger community the work that we do.

So my transition into public health, I often say that I was doing public health before I knew what public health was. Really, if I go back to middle school and high school, I was already working on public health issues around substance use disorder, improving food access for low-income elderly, and around violence prevention. And then I took a long and circuitous route through Harvard, through Peace Corps into medical school, considered a degree in public health during medical school, which was when I was really exposed to the idea of an MPH at Columbia, but honestly couldn’t take on more debt at that point.

And so decided not to get a master’s, went and did residency. One of the reasons that I chose to do a fellowship in injury prevention was of course that global background and that longstanding work that I had done around the areas of violence prevention, but also it gave me a master’s for free.

So that’s how I managed to eventually get my MPH. I always feel like that was the icing on the cake for what had been a long movement into this field. I think of public health as being part of the underpinning of emergency medicine. My clinical specialty were the safety net in the American healthcare system, and I often talk about us as also being the canary in the coal mine for public health problems in the United States.

We start to see or we saw opioid overdose deaths earlier than they were noted in the media. We certainly saw upticks in gun violence and noted how firearm injury was a public health problem before others were yet talking about it. Similarly, we see the challenges that undomiciled people have with accessing good healthcare. The challenges with mental healthcare, particularly for young people that predated the pandemic and so on.

So that ethos or disciplinary approach has suffused my work since long before I got a master’s. And then the master’s in public health has informed everything that I’ve done since.

**Harlan Krumholz:** One of the important things that’s happening at Yale is that the School of Public Health is becoming independent. It’s going to be its own school. Now with you coming, I am firmly convinced that we’re going to have the best school of public health in the nation, and one of the best in the world, that we’re truly going to distinguish ourselves. Now, we’ve got a good track record in the past. There’s been a lot of excellence. We’re building on a lot of excellence, but what the future is going to hold is going to be entirely different.

In some way, this change is going to enable us to have a School of Public Health that has the freedom to be able to choose its priority areas and to set its path in a way that’s independent from the School of Medicine while still maintaining the connections there and across campus. I wonder if you could just talk to us a little bit about what’s your view of the very best school of public health in the world going forward? I mean, what are the features of a school that would really make it distinctive and impactful?

**Megan Ranney:** I love that question, Harlan. I mean, I think that just the end of your question about what is it that makes it distinctive but impactful, to me, that’s the measure is the impact. It’s the human lives that are able to live with full-spectrum health, physical but also emotional and social. That’s what makes a school of public health great. And I will say what attracted me to this position is that dual transformation that the world and that the School of Public Health at Yale are currently going through.

The school is becoming independent. We do have this chance to chart a new course and to set the school. As you say, it has a tremendous foundation, but to set it on a higher-plane trajectory for the next decade or 25 years or even century. But we’re also going through a moment of transformation of public health on a national and international level as a field.

I think of public health as being really in a Venn diagram and partial but not complete overlap with the healthcare system. It’s also a partial but not complete overlap with government. I think that folks often conflate public health and healthcare. They also conflate public health and public kind of governmentally funded public health. To me, the vision of a truly great school of public health is one that puts the public back in the practice of public health.

So to me, there are really three big kind of principles or verticals that I hope to make possible but also make felt throughout every aspect of the work that we do at the school. The first is around inclusion. Both diversity, equity, and inclusion among our students, our faculty, and our staff. Making sure that the school itself is an environment that supports true belonging across the full diversity of experiences, backgrounds, and outlooks, whether it’s racial and ethnic, gender, sexual orientation, disability status, geography, socioeconomic status, and I could go on, but also inclusion of community voices because ultimately, again, public health is based on the public.

And I think those of us in academia, we often work with a community, but making sure those voices are part of our school is critically important. So that’s the first kind of pillar that I think is essential for the next stage of public health in our country and in the world.

The second is around innovation and entrepreneurship. Any of us who have spent time in public health know that public health professionals are inherently innovative. We have to be. But I think there are some standard steps to entrepreneurship, which we don’t always study as part of a master’s of public health or a master’s of healthcare management and that are essential to our long-term success. I also think there are some important questions for us to ask about how we sustain those innovations.

When we find something that works well, that’s cost-effective, that’s transformative, how do we create models where it’s integrated not just into the public sector but also into the private or nonprofit sector in ways that allow it to continue. And then the third big area that I think is essential for any school of public health to take on in this next quarter century is of course around communication. So excited that this podcast is now co-sponsored by our school, but thinking about communication both internally, again, making sure our faculty, students, and staff are facile in communication and making sure that the world understands the importance of their work but also making sure that we serve as a node of trusted information for our community partners, community members that there is again that bidirectional communication that allows us to create trust and to create change.

There are, of course, lots of topical areas that I think matter deeply, but I think there’s these principles of public health that allow us to have a more expansive sense of who is part of this work. How do we train people in doing this work, and how do we that sit in a school of public health participate in the world in a way that allows our ingenuity to really change that lived experience of those with whom we live and work and play. That to me is the ultimate metric of our success as a school.

**Howard Forman:** Public health as a discipline has been responsible for saving really countless lives right now, whether you’re talking about vaccination programs or the introduction of safety measures in cars. You’ve written about a lot of this. The area that you’ve spent a big chunk of your career doing research on, clinically working on, and advocating against is gun violence. I’m wondering, and it fits very neatly into these domains that you’re talking about at the School of Public Health, but I’m wondering at this time where we’ve now seen successive waves of mass violence in so many places, and even when it’s not mass violence, just indiscriminate loss of life, how does the School of Public Health play a role in helping us better understand the causes of this and help us communicate to the public ways to mitigate the damage that is occurring from gun violence?

**Megan Ranney:** Well, I think the first and biggest thing is being a tireless voice, talking about how the public health approach can help solve this problem. One of the things that I think is so beautiful and important about public health is that it is a disciplinary framework. The same way that folks that work in business or in law or in medicine have certain standard approaches to problems, we have those in public health, and I’ll frequently talk about it as being first, gathering the data; second, identifying risk and protective or promotive factors; third, developing and testing interventions in partnership with affected communities; and then fourth, disseminating what works.

And when we take that approach, we can look at this horrific and growing epidemic that affects literally every one of us across the country and start to create solutions that are more innovative and wide-ranging than the ones that the public and the media often get caught on.

So yes, I’ll be clear: legislation and policy matter, but as any of us in public health know, legislation and policy is rarely sufficient to address a public health problem. We’re not going to fix this with policing. We are not going to fix this with new laws—although some can make a big difference. It’s also about education, about environmental change, about economic incentives, and about engineering of the firearms themselves. Same way that we fixed or have decreased deaths from car crashes, but also, I often use analogies of how we have addressed HIV or even substance use disorder where public health allows this harm reduction framework where we recognize that for firearm injury in particular, people often buy a firearm out of a sense of personal fear or prior experiences with trauma.

Whether I am talking about young black and brown men who are disproportionately more likely to be killed through firearm homicide or whether I’m talking about rural, middle-aged white men who are disproportionately more likely to die in firearm suicide, both get a firearm for personal protection.

So we have to think about that trauma and how we reduce that chance of harm, how we address the social determinants that led people to think that they need to buy a firearm and carry it on themselves in the first place. That to me is a place where a school of public health can make a huge difference. I’ll say at a place like Yale, we can do that in collaboration with the School of Medicine, the School of Management, the Law School, School of Engineering, and so on, in ways that allow really that full-society approach to this problem that doesn’t get limited to one discipline. Again, it affects all of us.

**Harlan Krumholz:** Yeah. There’s such extraordinary upside to what we can do here especially being able to pull together the talent that exists all across campus and what an independent school of health could accomplish. To me, one of the major things is getting the capital investment. So the university has allocated funds for the School of Public Health, but we really need to go beyond that. We need a [Michael] Bloomberg- or [T.C.] Chan-sized investment like they got at Hopkins or they got it at Harvard because we’re really talking about the public good, social good, and how we bring people together. And that often takes resources.

We need to be able to get those kind of resources. What’s your best pitch to people who might be listening who’ve actually got a big bank account and are thinking of writing a check, and are saying like, “Wow, this is an exciting moment, and we really need to make this go and have the kind of impact it can.” What’s the pitch to them that really this is a good time to invest in the Yale School of Public Health?

**Megan Ranney:** So I think there are two things. One is that this is a moment where the world demands that we do better in public health. And we have the chance to truly set a transformative path, not just within Yale but in partnership with others, in a way that creates possibility for schools of public health, for the public health workforce across the country and across the world.

It’ll be clear that’s done in collaboration, but that this is a moment where we deeply need that work to be done. The other is I will talk very personally about the fact that my most impactful and transformative work was not done with NIH dollars. And having that philanthropic support, having the freedom to hire and support brilliant professors, students, and staff as well as to include the community, allows us to have that impact on the world that isn’t—although I am a huge fan of NIH, CDC, PCORI, NSF, all really important for the scientific enterprise, for that real-world impact, it takes the ability to have funds that are external to those governmental grant-making sources. And lots of examples myself, but I know there are already lots of examples within YSPH as well of places where folks have really created dramatic change thanks to some of those external resources that have been available to them.

**Howard Forman:** There are a lot of physicians that do a lot of other things besides just practice medicine, but few have ventured out as you have and continued practicing medicine to this point. I’m wondering if you could just tell our listeners a little about how the work that you do in that emergency room is able to help inform the work you do, either in research or public health administration, or even as you come to Yale now.

**Megan Ranney:** So my practice as an emergency physician keeps me grounded in the real-world problems that my patients and their families face, the problems that my nurses and my techs and my fellow physicians are facing. The financial challenges of hospital systems, the challenges with data sharing, the problems getting a visiting nurse or a caregiver to take care of your elderly loved one. I mean, these very real social drivers of health are just so eminently touchable and experienced in the emergency department setting.

So I feel like it keeps me honest about the potential and the need for public health transformation, but also about the limitations. I think it’s so easy to opine in this pie-in-the-sky way about what could be possible, but my practice as a clinician helps remind me of also where the barriers are and what the reality is of the lies that all of us are living.

I do hope to continue to practice clinically at Yale. I’m in the process of applying for my Connecticut license and Yale New Haven Health credentials, but I also recognize that my job as dean is going to be, first and foremost, at least for this first year I may or may not be able to swing clinical practice on top of everything else. So there it’s also about creating, again, that larger network.

I should say that I think that the world of a physician informs public health, but I don’t want to put that as higher or more important than the lived experience of everyone else who is part of public health, journalists, community members, local governmental officials, nonprofit leaders—their experiences and voices matter too. One of the things that I hope to stand for is the fact that, yes, there is a biomedical perspective to public health, but it is not about the medicalization of public health.

Again, not all public health is healthcare and vice versa, not all healthcare actually advances public health. So making sure that we have that full variety of voices and lived experiences really matters for our future—not just at Yale but across the globe.

**Harlan Krumholz:** I think one of the great things about your background is that you did the Peace Corps, and so many people have found that experience to be a source of inspiration for what they did in the rest of their career. I wonder if you could reflect a little bit on what that experience meant to you and then how you as dean view the importance of making sure that students get practical experiences outside the United States but also within our communities and not just sit within the classrooms and absorb didactic teaching but get some practical experience. How are you thinking about that? And maybe just tell us a little bit about the Peace Corps experience.

**Megan Ranney:** Sure. I mean, the moniker of the Peace Corps is it’s “the toughest job you’ll ever love.” And it’s so true in so many ways. I mean, it challenged me to go beyond my comfort zones in ways that I continue to call on every day. But I would say the biggest thing that it did for me was give me humility and really, my experience in Peace Corps drive so much of my commitment to community engagement and to making sure that we are elevating both the needs and the ideas of community members from lived experience rather than just coming in externally and helicoptering in with our own whatever we think of as brilliance and as a solution.

If Peace Corps taught me anything, it was that I as a twenty-something-year-old Harvard grad had no darn idea what was needed. I was able to bring my skill set to be here. Although I was officially working on water and sanitation, I ended up doing a lot of work around gender-based violence and HIV prevention. So trying to empower women economically in order to provide them with a greater opportunity to honestly avoid getting infected with HIV, which at that point in West Africa, there was no availability of antiretrovirals. And so that economic empowerment and ability to escape from abusive either sexually coercive or physically abusive relationships was critical.

But I learned that I knew that I had to listen and draw from the experience of my community and my friends. And yes, I had a skill set which I could bring to bear, but if I had kind of dropped in and said, “This is what I’m doing,” it would’ve gone nowhere. I think the other thing that I learned deeply was about the importance of sustainability.

The history of global health is littered with great ideas that get put in place and then dropped when funding disappears. There’s no tech transfer. There’s no knowledge transfer. And again, there’s no building off of what already exists. It makes the donors feel good, but it doesn’t actually change outcomes long-term. And that perspective as well informs my work every day.

In terms of your question about service learning, my gosh, I cannot say enough about how important I think it is both from a sense of, again, understanding the real-world aspect of what we do, but also honestly from a sense of taking care of oneself. People ask me how I maintain hope, how I keep working on firearm injury as a public health problem when we see the numbers going in the wrong direction, how I keep showing up to shifts in the emergency department, how I keep showing up as a public health professional in this moment when we are being attacked left and right. And to me, it is about kind of those small acts of service and action which provide me with hope and with motivation to keep showing up the next day and the next. When I look at some of the work that I’ve done, some of the stuff that we did during COVID, the work around firearm injury, I could go on with countless other examples, both personal and among our larger community. To me, that aspect of service is so important for our own ability to recommit every day to doing the work that is needed to create change.

**Harlan Krumholz:** When does the School of Public Health actually become its own school? When does that actually happen?

**Megan Ranney:** Great question. So July 1st is when we become our own school, but we are going to have a year of transition because there’s a lot of administrative and operational structures that we need to put in place. And I will say the current team, I have to give a huge, huge shout-out to the current interim dean, Melinda Pettigrew, and to the entire team at Yale School of Public Health that has been doing such incredible work over the past years. But this coming year is going to be one of greater transformation as we create that infrastructure to allow us to be fully independent.

**Howard Forman:** Just I want to thank you on behalf of both of us, but on behalf of the School of Public Health and the School of Management for joining us on the podcast. We are lucky to have a visionary, compassionate, professional like you coming to lead us. I look forward to working with you, and we look forward to having you on the podcast again.

**Harlan Krumholz:** Yeah. It’s going to be a terrific moment for public health, and I just can’t wait to see how all this unfolds, but it’s going to be amazing.

**Megan Ranney:** Thank you. I’m going to need both of you as partners, and I will say I have a standing invitation to anybody listening to the podcast. Give me feedback, share with me ideas. I will have as open of a door as I possibly can. I believe that we create public health through partnership, and it’s going to take all of us. So I come into this with humility as well as with tremendous excitement.

**Harlan Krumholz:** Howie, hey, that was a great interview with Megan, but now we get to another favorite part of my, I don’t want to say the most favorite part because our guests are so great and we love listening to them, but this is one of the things I look forward to, which is hearing your thoughts for this week. So what’s on your mind?

**Howard Forman:** Thanks, Harlan. So I want to call out [a paper](https://www.nature.com/articles/s41372-023-01646-z) that I was really fortunate to work on with a Yale MD PhD student named Sarah Mahoney, who I have to distinguish from an amazing neonatologist and professor of pediatrics, Sarah Taylor, who also worked on this paper with us. So Sarah Mahoney is just starting out her career, enrolled in the MD and PhD program. She’s doing her PhD in economics, which for those who may not know, it’s very rare to do that combination of MD PhD, and she’s doing it at Yale.

In the midst of last year’s supply chain crisis, you may recall that there was a formula shortage, a baby formula shortage, and there were calls. People were honestly saying on social media, other places, that women should just be breastfeeding since obviously that is technically a way to mitigate the shortage of formula. But this was exasperating to anyone who understood the many issues around breastfeeding.

Rather than tilt at windmills, Sarah Mahoney began a meticulous accounting of the incremental costs of breastfeeding compared with formula feeding. She didn’t stop at just the nutritional needs or the equipment or storage costs, she also factored in the opportunity cost of breastfeeding. In other words, many women who are attached to the workforce have to forego income in order to capture the time to pump and or breastfeed.

Imagine, for instance, someone who’s an Uber driver or somebody who works at Walmart at the checkout counter. It’s not that easy to imagine how you can capture that time back to do everything you need to do in order to sustain breastfeeding. This adds up quickly, even and especially for the lowest-wage workers. In the end, the cost of breastfeeding by our accounting can surpass $10,000 a year. And for low-wage and underresourced families, this is more than consequential.

So when we published this a month ago, there was mostly positive feedback from readers who correctly understood that what we were trying to do is shine a light on a policy decision that dissuades women from choosing to breastfeed. And by no means do we assume that every woman wants to breastfeed or even can. There were others, relatively small numbers, but still it shocked me who mistook what we were doing as giving an extra reason not to breastfeed.

Nothing could be further from the truth. It should be stated, we as a nation, the United States are one of the rare countries in the developed world that does not provide for paid parental leave. This is a policy decision that ultimately dissuades women from doing what they might otherwise choose to do. And there’s substantial evidence that breastfeeding has benefits over and above those formula feeding.

It’s not for everyone, but it should be available when possible. And our policies should not be dissuading this. I just think we can and should do better, and I was really excited to see Sarah get this published in the *Journal of Perinatology* last month.

**Harlan Krumholz:** It’s a really important topic, Howie. I just wonder what you think about our ability to actually bring about policy change in this area because, yeah, I mean, you’re raising an issue, I feel stymied by our current policies. I just don’t know what we can do about it.

**Howard Forman:** It shocks me that we... I knew that we were an outlier in this area. I hadn’t realized that basically every other country, some might only provide, I don’t know, four or six weeks and others might give up to two years or something. But we give nothing. We guarantee nothing in this country. I recognize that’s a libertarian sense, but that’s stymies us.

**Harlan Krumholz:** Well, thanks so much for sharing that and also for doing the paper. It’s important contribution. You’ve been listening to *Health & Veritas* with Harlan Krumholz and Howie Forman.

**Howard Forman:** So how did we do? To give us your feedback or to keep the conversation going, you can find us on Twitter.

**Harlan Krumholz:** I’m at H-M-K-Y-A-L-E. That’s [@HMKYale](https://twitter.com/hmkyale/).

**Howard Forman:** And I’m [@thehowie](https://twitter.com/thehowie/). That’s at T-H-E-H-O-W-I-E. You can also email us at [health.veritas@yale.edu](mailto:health.veritas@yale.edu). Aside from Twitter and our podcast, I’m fortunate to be the faculty director of the healthcare track and founder of the MBA for Executives program at the Yale School of Management. Feel free to reach out via email for more information on our innovative programs, or you can check on our website at [som.yale.edu/emba](http://som.yale.edu/emba).

**Harlan Krumholz:** *Health & Veritas* is produced with the Yale School of Management and the Yale School of Public Health. Thanks to our researcher, Jenny Tan, and to our producer, Miranda Shafer. They are absolutely amazing. Talk to you soon, Howie.

**Howard Forman:** Thanks very much, Harlan. Talk to you soon.