



Health Care Management
Alumni Association

THE WHARTON HEALTHCARE QUARTERLY

WINTER 2025, VOLUME 14, NUMBER 1



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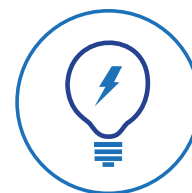
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EDITOR'S LETTER



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

To learn more about Colette, [click here](#).

With the start of a new administration in the White House, we can anticipate many major changes in the healthcare system. Time will tell how broad and deep.

You can count on the *Wharton Healthcare Quarterly* to keep you informed on the key issues in 2025 and ways to adapt to continue to reach your goals!

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

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The opinions expressed within are those of the authors and editors of the articles and do not necessarily reflect the views, opinions, positions or strategies of The Wharton School and/or their affiliated organizations. Publication in this e-magazine should not be considered an endorsement. The Wharton Healthcare Quarterly and WHCMAA make no representations as to accuracy, completeness, currentness, suitability, or validity of any information in this e-magazine and will not be liable for any errors, omissions, or delays in this information or any losses, injuries, or damages arising from its display or use.

THE PRESIDENT'S DESK

In Every Issue



Katherine Clark, WG'15
To learn more about Katherine,
[click here](#).

Dear Fellow Alumni,

I hope everyone's 2025 is off to a wonderful start. Even during these past few weeks, I continue to feel immensely grateful for every conversation I have with our fellow HCM alumni — whether it's developing new professional connections or sharing experiences with newly admitted students. And as we move into the new year, the WHCMAA board members continue to strive to strengthen our alumni community.

This November our association gathered for the WHCMAA Alumni Conference in

Philadelphia. Led by Conference Co-Chairs, **Hannah Plon (WG'22)** and **Michael Rovinsky (WG'86)**, we welcomed an impressive roster of speakers and panelists who tackled the critical challenges facing healthcare today, all under the theme of *"Driving Meaningful Change in a Consistently Resistant Industry."* This year we extended programming to Thursday evening and kicked off the conference with an opening network reception, during which the positive energy was palpable. Later that evening, together with **John Winkelman (W'80)**, chair of the Awards and Grants Committee, I was honored to present the WHCMAA awards. **Michael Rovinsky (WG'86)** and **Dr. David Fajgenbaum (WG'15)** were recognized with the Outstanding Service Award and Alumni Achievement awards, respectively.

The following day, Dr. Fajgenbaum began the day with a truly inspiring keynote on his [Every Cure](#) initiative, highlighting how existing drugs can be repurposed to save lives. The only tough part of the day was choosing which panels to attend! We had the opportunity to learn from industry leaders including **Katie Elias (WG'06)**, **Cécile Brosset Dubois**, **Carolyn Magill (WG'04)**, and **Nathan Silberman**, who explored the exploded world of AI in healthcare. Another panel featuring **Kathryn Tong (WG'07)**, **Marina Tarasova (WG'10)**, **Delphine O'Rourke**, **Dr. Z. Colette Edwards (WG'84, MD'85)**, and **Alisha Lalani** offered insights on recent innovations in women's health. Yet another panel, including **Dr. Kaveh Safavi**, **Julia Puchtler**, **Geoffrey Roche**, and **Dr. Bryan Bushick (MD'88, WG'89)**, provided thoughtful perspectives on labor challenges affecting healthcare and life sciences.

Dr. Jason Karlawish provided the afternoon keynote, whose thought-provoking discussion of Alzheimer's research illustrated how rapidly evolving science is reshaping care for the aging population. The day ended with a riveting fireside chat on policy and politics, featuring **Melissa Schulman**, **Rena Conti, PhD**, and **John Barkett (WG'09)**, tying together emerging trends in a changing political landscape.

The dialogue was outstanding. I found myself disappointed when the sessions were over, wanting to hear more about these fascinating topics from expert perspectives. It was impossible to leave the conference without feeling inspired and energized.

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PRESIDENT'S DESK

Following then, just a few short weeks ago, our annual JPM Reception in San Francisco was yet again a resounding success, serving as a true capstone event for the entire JP Morgan week. With **Smita Jain (WG'05)** and **Katie Elias (WG'06)** at the helm, we had well over 200 attendees. The event welcomed a diverse group, including current MBA and WEMBA students, faculty, and alumni, from recent graduates to those representing four decades of Wharton classes. Sponsors and fellow board members also joined us, and the great weather allowed everyone to spread out comfortably both indoors and on the expansive outdoor patio for mini-reunions and lively conversations. This welcoming atmosphere, enhanced by the creative signature cocktails, like *The Kinney Cosmo*, *Penn Paloma*, and *HCM Spark*, perfectly captured the spirit of Wharton camaraderie, giving old friends and new acquaintances alike an opportunity to connect.

Looking ahead, I encourage everyone to quickly mark their calendars for the 31st Annual Wharton Health Care Business Conference, scheduled for February 27–28 at the Sheraton Downtown Philadelphia. This year's student-led event is titled, "Beyond Disruption: Building Lasting Health Care Transformation" and promises an outstanding agenda. I plan on attending and hope you'll stop me to say hello.

Please also stay tuned for upcoming happy hours and networking events. We hope these more intimate events provide the opportunity to connect on a deeper level, share industry insights, and build the supportive community we all value.

Thank you for your continued support and dedication to the WHCMAA. I look forward to seeing you soon at an upcoming event!!

Kind regards,

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

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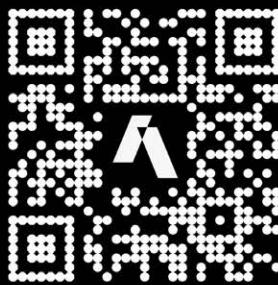


DREAMERS

We dream big by thinking small, at the cellular level, inventing ways to destroy cancer and advance humanity.

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ALUMNI NEWS

Eric Davis, WG'96

Hi everybody. This update is long overdue, but I wanted to invite all Wharton friends to ping me if you are ever passing through Sydney (or Brisbane) with extra time on your hands. In 2020, after living in Australia for 4 years, I was recruited to return to the USA to lead Global Strategic Marketing for Abbott's Rapid Diagnostics business. The COVID-19 crisis was a huge inspiration for this big move, but also my parents were both suddenly in a significant state of decline at that time, so it was important to be back in the USA at this time. But with COVID-19 in the rearview mirror, and with my parents having transitioned to a better place, my family and I decided to return to Australia earlier this year – this time forever. This is our second time moving to Australia.

Our first move to Australia was seven years ago when a former boss from Abbott Diabetes Care (Freestyle Libre) recruited me to become Head of Product Management and eventually VP of Portfolio Strategy for Cochlear, the world's leader in hearing implants.

I am now the Chief Growth Officer for Microba Life Sciences, a very exciting, early-stage, ASX-listed growth company which has world-leading technology for measuring the human gut microbiome.

Microba is a medical diagnostic and clinical-stage therapeutics company driving the discovery and development of novel therapeutics for major chronic diseases and delivering gut microbiome diagnostic testing services globally. Among other distinctions, Microba's largest shareholder is Sonic Healthcare (one of the world's largest medical diagnostic companies with a market cap of \$13B AUD).

Contact Eric at: Eric.Davis.Innov8@gmail.com or his [LinkedIn profile](#).

Kristen Harris Nwanyanwu, M'09, WG'09

Kristen began her new position as the inaugural Associate Director of Community-Engaged Research and Participant Recruitment at the Yale School of Medicine. She will lead a team to advance community-engaged research at the Yale Center for Clinical Investigation and further bidirectional community partnerships. She will continue her work as the principal investigator for the Sight Saving Engagement and Evaluation in New Haven (SEEN) Lab.

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THIS MONTH'S PHILOSOPHER:
Smita Jain, WG'05

To learn more about Smita, [click here](#).



THE PHILOSOPHER'S CORNER

In Every Issue



Smita Jain, WG'05

LIFE LESSONS

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

spent more time in the present and nurtured my intuition. This year, I took a life sabbatical to reconnect with that intuition. I had lost most of my hobbies and struggled to answer even the simplest question: *What do I think?* It's especially common for women to lose touch with their inner voice under the weight of messages from family, culture, social media, work, and patriarchy. I wish I'd developed a practice earlier to anchor myself and tune out the noise.

I can't say I've fully figured it out, but I know part of the answer lies in paying attention to the little things — the sun on my face, a furry caterpillar crossing my path, a beautifully intricate flower, or

getting curious about what makes my colleagues and clients tick. These small moments keep me present — and they're often delightful.

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

taken the safer path through my career. Looking back, I realize most of my decisions — from high school to college, the right major, the right first job, and even the “right” MBA — were based on what I thought I should do. I always made the most of wherever I was and thrived, but as I moved up the ladder, my sense of purpose became harder to find.

I'm making sure I don't have the same regrets 20 years from now. I've taken the leap and co-founded a boutique consulting firm with three incredible women. We're trying to build a company and the world we want to live in. As George Lucas said, “We are all living in cages with the door wide open.” I'm finally walking through mine — and excited to see what's on the other side.

FAVORITE QUOTES

1. Whether you think you can, or you think you can't - you're right.” ~ Henry Ford
2. “Do not go where the path may lead, go instead where there is no path and leave a trail.” ~ Ralph Waldo Emerson
3. “And the day came when the risk to remain tight in a bud was more painful than the risk it took to blossom.” ~ Anaïs Nin

THIS MONTH'S PHILOSOPHER:

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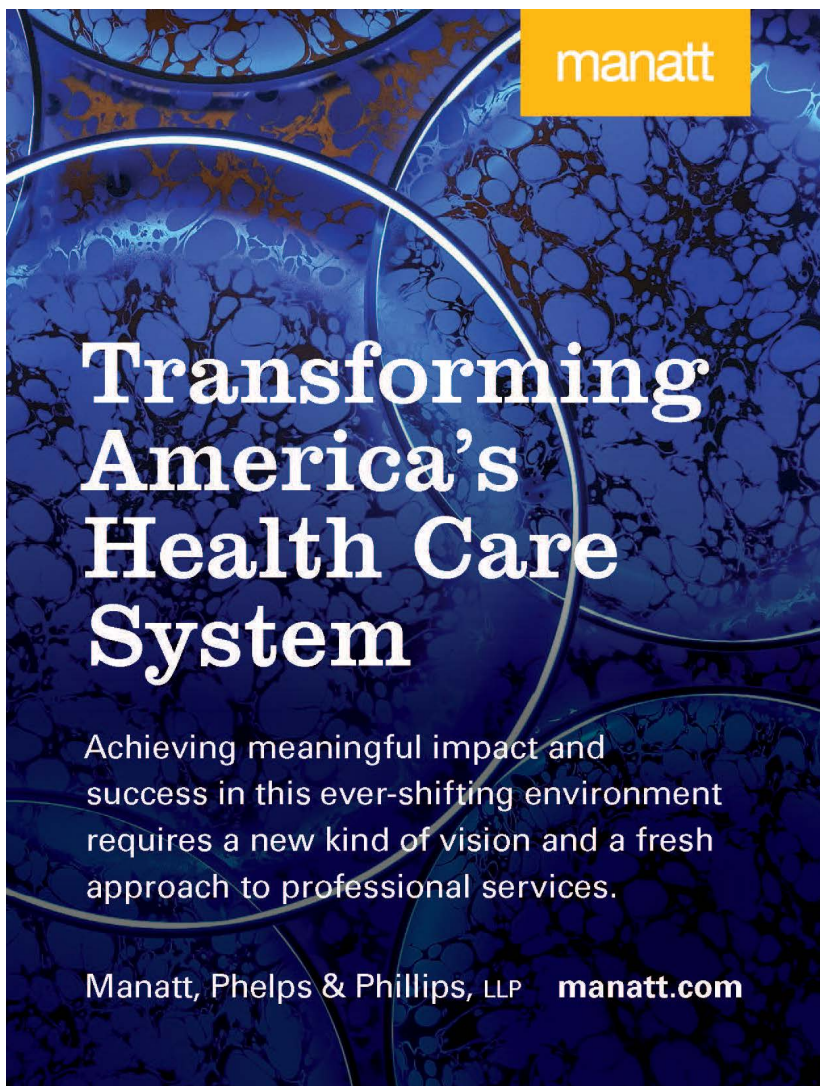


THE PHILOSOPHER'S CORNER

RECOMMENDED READING

1. *4000 weeks: Time Management for Mortals* by Oliver Burkeman
2. *The Artist's Way* by Julia Cameron
3. *The Midnight Library* by Matt Haig

Contact Smita at her [LinkedIn Profile](#).



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AFFIDAVIT: HEALTHCARE AND THE LAW - LITIGATION OVER EMPLOYER HEALTH PLAN MANAGEMENT: CONSIDERING FIDUCIARY DUTIES WHEN NEGOTIATING GROUP HEALTH CARE PLAN PHARMACEUTICAL BENEFITS



Employees and health plan participants have recently filed lawsuits in two separate cases against their employers, Wells Fargo and Johnson & Johnson (“J&J”), alleging the companies and group health plan fiduciaries mismanaged group health plans by paying excessive fees for pharmaceutical benefits. While both cases are still pending, they serve as a notice to healthcare businesses of the potential for similar litigation. With this litigation trend and an increased focus on the role of pharmacy benefit managers (“PBMs”) in negotiating drug prices, employers should be thoughtful about negotiating and monitoring pharmaceutical benefit rates.

The cases, *Navarro v. Wells Fargo & Co.* (“*Navarro*”)¹ and *Lewandowski v. Johnson and Johnson* (“*Lewandowski*”),² rely on similar legal theories. The plaintiffs in both cases allege their

employers breached their fiduciary duties under the Employee Retirement Income Security Act of 1974 (“ERISA”) by entering into a contract with the same PBM, Express Scripts, to pay unreasonably high prices for pharmaceutical drugs and failing to monitor plan expenses to ensure reasonable drug prices. PBMs negotiate prescription drug prices, set formularies and coverage terms, and otherwise administer pharmaceutical benefits.³ The plaintiffs in *Navarro* claim that plan administrators agreed to pay in some cases fifteen times higher costs for drugs than a person without insurance would pay at a pharmacy.⁴ The plaintiff in *Lewandowski* similarly alleges that J&J agreed to pay Express Scripts unreasonably high mark ups for pharmaceutical drugs.⁵ Both cases allege these high fees result in excessive costs to plans and higher premiums and out-of-pocket charges to plan beneficiaries.⁶

Notably, the plaintiffs in both cases allege their large-scale employers, Wells Fargo and J&J, should have used their significant bargaining power to negotiate lower administrative fees and drug pricing, and should have selected a pass-through PBM payment structure.⁷ Essentially, both suits rest on the theory that employers insufficiently negotiated on behalf of the plan and

its beneficiaries. Adding further context to these allegations is the fact that PBMs are currently under high scrutiny for their alleged role in high drug pricing. In July 2024, the Federal Trade Commission (“FTC”) released an interim staff report asserting that PBMs inflate drug costs and preference their own affiliated pharmacies, even if alternative pharmacies would provide lower pricing.⁸

The FTC followed this report by bringing an action against multiple PBMs, including Express Scripts, for anticompetitive behavior.⁹ Likewise, a House Committee on Oversight and Accountability report stated PBMs sometimes place more costly medications in “more preferable positions” on their formularies in favor of lower cost, similarly situated drugs.¹⁰ PBMs claim, however, that their negotiation with manufacturers reduces drug pricing for plan sponsors.^{11,12} A national PBM association claims cost-savings of 40-50%.¹³

While the likelihood of success of these legal cases is unclear, businesses should pay attention.

First, ERISA requires prudent bargaining and ongoing group health plan monitoring.

ERISA protects group health plan assets and beneficiaries by categorizing those with discretion or control over plan assets as fiduciaries.¹⁴ Fiduciaries have two core duties — loyalty and prudence. The duty of prudence, which is most relevant to the excessive fee allegations, requires plan fiduciaries to discharge duties “with the care, skill, prudence, and diligence” of a prudent individual acting in the same capacity.¹⁵ In practice, this means fiduciaries may only pay reasonable plan expenses.¹⁶ The Wells Fargo and J&J suits allege plan fiduciaries breached their duty of prudence by imprudently comparing, selecting, monitoring, and negotiating plan terms.

The U.S. Department of Labor explains that fiduciaries must diligently evaluate fees when selecting service providers, such as PBMs, and continuously monitor fees to ensure plan fees remain reasonable.¹⁷ Plan fiduciaries can also be held personally liable for plan losses stemming from breach of fiduciary duties.¹⁸

Second, be aware of PBM pricing options. Both lawsuits criticize negotiation outcomes and PBM structuring. The plaintiffs allege Wells Fargo and J&J should have selected pass-through PBM structuring and should not have agreed to contract terms that encourage plan participants to pay higher prices for the PBM’s mail order pharmacy.¹⁹ The traditional PBM reimbursement, or “spread pricing,” involves PBMs charging a higher amount to payers (employer plans) than they pay pharmacies, and retain that amount.²⁰ A Brookings report explains that pass-through structuring is where PBMs pass a rebate from negotiating a discount with drug manufacturers through to payers rather than retain it.²¹ For a pass-through PBM, administrative fees are the main method of reimbursement.²²

In 2021, Express Scripts used a fully pass-through structure with 75% of commercial clients, compared to less than half in 2015.²³ In 2022, 73% of large employers elected for a fully pass-through contract.²⁴ While the plaintiffs in both cases argue that a prudent fiduciary minimizes spread, it remains to be seen how courts will treat this pass-through argument.²⁵ Plan fiduciaries should consider cost savings in either PBM structure.

Third, keep in mind the new ERISA fee disclosures when assessing contractor bids.

The Consolidated Appropriations Act of 2021 (“CAA”) amended ERISA section 408(b)(2)(B) to require service providers to disclose expected compensation to health plan fiduciaries before entering into a contract.²⁶ The amendment was intended to ensure that group health plan fiduciaries can assess the reasonableness of contractor offers and any conflicts of interest.²⁷ With the CAA disclosure requirement, plan fiduciaries are not only equipped with more pre-contracting information, but with increased documentation of whether fiduciaries adequately assessed reasonableness when evaluating service provider offers. Such information can either be fodder for future litigation or limit liability.

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KEY TAKEAWAYS FOR HEALTHCARE BUSINESSES

While these cases unfold, businesses should maintain awareness of this new litigation trend and take measures to mitigate risk.

- **Ensure plan fiduciaries are aware of their status and duties.** ERISA fiduciaries, including employers, may be subject to litigation. Fiduciary status is based on one's role relevant to the plan. Executives and plan committee members have been named in ERISA health plan litigation.
- **Thoroughly evaluate bids from pharmacy benefit managers, considering a variety of plan models.** While this principle applies to assessing all service providers, fiduciaries should ensure reasonable pricing for pharmaceutical drugs and administrative fees and compare offered pricing to market pricing.
- **Create procedures for proper documentation.** The Department of Labor recommends that fiduciaries ensure proper documentation of fiduciary decisions to limit liability. The CAA's fee disclosure requirement can assist with documenting bid comparisons.
- **Continue to monitor health plan costs and, if necessary, renegotiate contracts.** Fiduciaries are tasked not only with selecting reasonable plans and payment structures but continued monitoring to ensure costs remain reasonable.

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

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NOT A FREUDIAN SLIP: THE EVOLUTION AND FUTURE OF MUSCULOSKELETAL CARE - PART 4: THE CRITICAL CONNECTION BETWEEN BEHAVIORAL HEALTH AND MUSCULOSKELETAL CARE

In [Part 1](#) of the series, we discussed meeting patients where they are. In [Part 2](#), the importance of a multidisciplinary approach was reviewed. In [Part 3](#), the limitations of sensor-based technology were presented.

INTRODUCTION

Musculoskeletal (MSK) care has evolved significantly over the years, moving towards a more comprehensive and multidisciplinary approach. An essential aspect of this approach is understanding the critical connection between behavioral health and MSK care. Addressing anxiety, depression, and other mental health concerns is crucial in providing effective treatment for musculoskeletal conditions. In this article, we will explore the interconnection between behavioral health and MSK care and discuss the importance of addressing mental health concerns in the management of musculoskeletal conditions.

THE BIDIRECTIONAL RELATIONSHIP BETWEEN MSK AND MENTAL HEALTH

There is a growing body of evidence that demonstrates a strong bidirectional relationship between MSK conditions and mental health. On the one hand, chronic pain and physical limitations resulting from MSK issues can lead to increased levels of anxiety and depression. On the other hand, mental health conditions like anxiety and depression can exacerbate pain perception and hinder recovery from MSK injuries.

A [study](#) published in the journal *Pain* found that patients with chronic pain conditions are at a higher risk of developing anxiety and depression compared to those without chronic pain. Another study published in the *Journal of General Internal Medicine* found that patients with chronic low back pain were more likely to experience significant depressive symptoms than those without back pain.

Similarly, research has shown that individuals with mental health disorders, particularly anxiety and depression, are more susceptible to developing chronic pain conditions. A study published in *JAMA Psychiatry* found that individuals



with depressive and anxiety disorders were at an increased risk of developing chronic pain syndromes, including chronic musculoskeletal pain.

THE IMPORTANCE OF INTEGRATING BEHAVIORAL HEALTH IN MSK CARE

Given the strong connection between MSK and mental health, integrating behavioral health into MSK care is essential for effectively managing and treating musculoskeletal conditions. By addressing mental health concerns, healthcare providers can improve patients' overall well-being and enhance their ability to cope with pain and adhere to treatment plans.

Some ways to integrate behavioral health into MSK care include:

1. **Screening for mental health concerns:** Healthcare providers should routinely screen patients with MSK conditions for anxiety, depression, and other mental health concerns. Early identification and intervention can help prevent these issues from exacerbating pain and hindering recovery.
2. **Collaborative care models:** Implementing a collaborative care model that involves primary care providers, mental health professionals, and MSK specialists can help address both the physical and emotional aspects of musculoskeletal conditions. This approach fosters better communication and coordination among healthcare providers, leading to more personalized and effective treatment plans.
3. **Incorporating evidence-based psychological interventions:** Evidence-based psychological interventions, such as cognitive-behavioral therapy (CBT), can help patients with MSK conditions manage their anxiety and depression. These interventions can be integrated into MSK care through individual or group therapy sessions, online resources, or self-help materials.
4. **Patient education and self-management strategies:** Educating patients about the connection between MSK and mental health can empower them to take an active role in managing their overall well-being. Healthcare providers can provide patients with self-management strategies, such as relaxation techniques, mindfulness exercises, and self-care practices, to help them cope with pain and emotional distress.
5. **Addressing barriers to accessing mental healthcare:** Healthcare providers should work to address barriers that may prevent patients from accessing mental healthcare, such as stigma, lack of insurance coverage, or limited availability of mental health professionals. This can involve connecting patients with community resources, telehealth services, or providing mental health services within the MSK care setting.

CONCLUSION

The interconnection between behavioral health and MSK care is a critical aspect of providing effective treatment for musculoskeletal conditions. By addressing anxiety, depression, and other mental health concerns, healthcare providers can improve patient outcomes and support overall well-being. As we continue to evolve our understanding of the complex relationship between physical and mental health, it is essential to prioritize an integrated approach to care that addresses the needs of the whole person.

As we conclude this article series, it is evident that the future of MSK care will continue to evolve, driven by advancements in technology, evidence-based practices, and an increased focus on patient-centered care. By embracing a multidisciplinary approach that includes behavioral health, virtual care, and innovative treatment options, we can deliver better care and improve the lives of individuals living with musculoskeletal conditions.

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AN ENTREPRENEUR'S GUIDE: OPTIMIZING D2C TELEHEALTH - STRATEGIES FOR ELEVATING THE CUSTOMER CARE EXPERIENCE

In recent years, telehealth has transformed the way patients access medical care, making it more convenient and accessible than ever. And as with any service, patient satisfaction hinges on the quality of the customer care experience. Platforms like [Happy Head](#), which specializes in providing dermatologist-prescribed, customized hair growth medicine, led the charge in optimizing this experience. Here are some effective strategies Happy Head has used to enhance patient care and satisfaction:

1. STREAMLINED ONBOARDING PROCESS

One of the fundamental steps in enhancing patient care is to establish a seamless onboarding process. Happy Head provides a fully online platform for accessing prescription hair growth treatments to those suffering from hair loss. New customers complete a medical questionnaire online, uploading relevant hairline photos, and then receive a complimentary online consultation with a board-certified dermatologist about their best options for hair growth success.

By streamlining the consultation, patients get access to specialists, easily, from anywhere.

2. PERSONALIZED CARE PLANS

Patients value personalized care that specifically addresses their unique needs. At Happy Head, our board-certified dermatologists thoroughly review each customer's medical history and type of hair loss to develop customized treatment plans, including tailored [Dutasteride formulations](#), when this potent medicine aligns with individual hair growth goals.

This approach drives convenience of care, but also quality of care, because telemedicine drastically reduces the barriers to accessing hair growth specialists – dermatologists online. By focusing and catering to a specific condition, telehealth providers can ensure patients feel valued and understood, ultimately improving outcomes and overall satisfaction.

3. DEDICATED CONCIERGE SUPPORT

In the world of telehealth, as with most modern consumer experiences, patients expect fast resolution of their concerns and thoughtful, personalized answers and solutions to their problems. Happy Head prioritizes responsive communication by offering multiple channels, including secure messaging through chat and email support and phone assistance from a dedicated concierge on a team of hair specialists. This flexibility allows patients to engage through their preferred medium.

Patients also have direct access to their board-certified dermatologist from anywhere! This allows for regular check-ins on hair growth progress and formula adjustments, as needed.



4. EDUCATION AND RESOURCES

When patients have questions about their conditions and treatment options, by providing educational resources — such as articles, videos, and FAQs — telehealth platforms empower patients to take charge of their health, which leads to more agency and higher confidence. Happy Head offers AMAs, videos, interviews, articles, podcasts, and other informational materials to demystify hair loss and explain why, for many, prescription hair growth treatments formulated with FDA-approved ingredients like [Happy Head's Dutasteride](#), offer the best results. This educational focus increases patient knowledge and builds trust and leads to higher overall satisfaction.

5. CONTINUOUS FEEDBACK LOOPS

A lot of telemedicine offerings are cash pay. Due to competition for the customer's own dollars, unlike so much of the healthcare system, bad service is almost certain to mean the demise of the business. For the sake of survival, it's essential to actively seek and incorporate feedback. Happy Head implements regular surveys, customer interviews, and feedback mechanisms to gather insights about the patient experience. By analyzing this data, the platform can identify areas for improvement and adapt its services accordingly. Continuous feedback loops not only help in refining the care experience but also make patients feel that their opinions matter, fostering a sense of community and loyalty.

Optimizing the telehealth customer care experience is essential for optimal outcomes and elevating patient satisfaction. Implementing these strategies will set the standard for what patients should expect from telehealth services. As the landscape of healthcare continues to evolve, prioritizing patient experience will be crucial in fostering trust, loyalty, and ultimately, better health outcomes. By putting the patient at the center of care, telehealth providers can ensure a positive, impactful experience that resonates well beyond the virtual appointment.

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DOWNLOADING SUCCESS: AN EMERGING HEALTHCARE C-SUITE ROLE - CHIEF PHYSICIAN ADVISOR

Although Physician Advisors have been around for a little over a decade, since the dawning of the two-midnight rule in 2013, it is still a relatively new and evolving physician specialty role. It is rapidly gaining in recognition and importance due to its potential to significantly impact the bottom line and improve physician well-being for many healthcare systems.

Historically, the Physician Advisor was a voluntary role for a member of the medical staff or faculty sitting on a utilization review (UR) committee, while also maintaining their clinical practice and acting more or less as a liaison between hospital administration and clinical staff -- focusing on utilization review/management, regulatory requirements and compliance, inpatient status, and medical necessity. Recently, however, I've begun to see this role evolve into a more elevated position such as System, Enterprise or Executive Medical Director, CDI & UM or Revenue Operations, up to Chief Physician Advisor. More than ever, hospitals and health systems must maintain their focus on containing costs, ensuring revenue integrity, and enhancing provider engagement and wellness to not only survive but thrive in their competitive markets.



RISE OF THE (CHIEF) PHYSICIAN ADVISOR

A recent survey conducted by the Association of Clinical Documentation Integrity Specialists (ACDIS) in collaboration with 3M Health Information Systems, titled "Rising Stars: Physician Advisors Are Tackling Big Problems in Healthcare," reports "only a quarter of healthcare organizations have a team of more than five full-time Physician Advisors. Most commonly, 35% of Physician Advisors serve in a single location, but a notable 25% are responsible for physician advisory responsibilities across three-five hospitals." Surprisingly, these numbers seem very low, especially with so much on the line and the potential ROI. Additionally, many still report spending more time clinically than in their Physician Advisory role/responsibilities. According to the report, nearly 60 percent of respondents spend 50% or less of their time in their Advisory capacity.

Today Physician Advisors assume a wide range of responsibilities, and 32% still report directly to the Chief Medical Officer, an increase from 25% in the prior year as reported in the ACDIS survey. Similarly, the report noted a decrease in those reporting to the revenue cycle or CFO/finance departments, which is now 28% compared to the prior year of 35%. Additionally, 14% of the survey respondents report to multiple departments, highlighting the interdisciplinary nature of their work. The survey also reported Physician Advisors are focusing more on UR, UM, and denials management as principal responsibilities.

Currently, 41% of Physician Advisors spend a significant part of their time — ranging from 26% to 75% — on UR and UM tasks, an increase from 34% last year. Denials management has also become a more substantial part of the role for 39% of Physician Advisors, up from 30% previously, while CDI is now a principal responsibility for 35%, a significant hike from 22% last year.

"Hospitals and Health Systems increasingly value Physician Advisors and are allocating more time and resources to drive systemwide change," the report added. These new and elevated roles are becoming more administrative than clinical, bringing with them salary and bonus eligibility rather than a simple stipend on top of their clinical compensation. They are moving well beyond the regulatory sphere and into areas ranging from revenue cycle to quality reporting to managed care contracting to outpatient CDI. The Chief Physician Advisor is a documentation, revenue, quality, and physician champion who collaborates with multidisciplinary teams across the organization from revenue cycle, compliance, quality, nursing, and EMR/HIM teams. They are in tune with the potential of AI to improve workflows which will ultimately impact provider wellness.

The Chief Physician Advisor is typically charged with meeting systemwide goals and objectives for facilitating complete and accurate clinical documentation in the medical record to support the diagnoses, treatment, medical necessity, severity of illness, and risk of mortality. The executive will engage in teaching, consulting, and advising the medical staff, CDI, care management, utilization review, coding departments, and health system leadership teams.

The Chief Physician Advisor should have expertise on matters regarding compliance with governmental and private payer regulations and appropriate physician coding and documentation requirements, as well as matters regarding physician practice patterns, over- and underutilization of resources, medical necessity, levels of care, care progression, and appeals and denials management. The successful candidate will usually be a board-certified physician with a knack for collaborating with others to foster change and improvement.

WHAT'S NEXT?

Although many Physician Advisors naturally ascend to become a Chief Medical Officer, the role of Chief Physician Advisor is emerging, given the myriad complexities in navigating constant changes in payor rules, regulatory compliance, coding/billing, and quality reporting – not to mention the increase in queries, denials, appeals and peer to peer, that most healthcare systems are attempting to better manage. These areas impact their revenue cycle as well as the well-being of their physician workforce through decreased administrative burden. As with most specialties it takes time, board certification, and often five or more years of clinical experience, along with strong interpersonal and emotional intelligence, to be a successful Physician Advisor who can ascend to higher levels of leadership as a Chief Physician Advisor.

For those interested in cultivating the skills necessary to begin a journey as a Physician Advisor and potentially a Chief Physician Advisor, organizations like the [American College of Physician Advisors \(ACPA\)](#), [Association of Physician Leadership in Care Management \(APLCM\)](#), [American Board of Quality Assurance \(ABQAURP\)](#), and [Association of Clinical Documentation Integrity Specialists \(ACDIS\)](#) have certification programs.

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CYBERVITALS: AI, ML, AND LLM ... OH MY!

The integration of artificial intelligence (AI), machine learning (ML), and large language models (LLMs) into healthcare has impacted many aspects of patient care and operational efficacy, but also introduced new challenges.

REGULATORY CONSIDERATIONS

The use of AI, ML, and LLMs in healthcare marked nearly every major earnings call for the last year. But there has been much criticism, including a recent study showing half of the FDA-approved AI medical devices are not trained on real patient data. And another study showed nearly half of FDA-authorized AI tools may provide little benefit.

The Department of Justice recently issued guidance that broadly seeks to include AI in assessing compliance programs. Furthermore, the Food and Drug Administration (FDA) has issued key standards spanning a few key areas:

- **Pre-market review:** Medical devices using AI/ML must undergo a pre-market review that includes assessing intended use, risk level, and how AI/ML are being integrated.
- **Good Machine Learning Practice (GMLP):** This guidance aims to ensure safe, effective, and high-quality AI/ML application
- **Real-World Evidence and Post-Market Surveillance:** Given some AI/ML models evolve over time, the FDA has emphasized the importance of post-market vigilance.

While the FDA is exploring a “Predetermined Change Control Plan” (PCCP), which would allow manufacturers to make certain modifications without needing to re-submit the software for approval, that review has yet to be completed.

Globally, the challenges persist – European Union General Data Protection Regulation (EU GDPR) strives to limit personal data used in AI/ML design and require explanations of how AI-derived decisions are made to patients. EU Medical Device Regulation (MDR) strives to follow similar principles, with the European Commission having proposed an Artificial Intelligence Act to harmonize requirements around transparency, human oversight, data quality, and risk management.

Broadly, many regulators are also including ethical considerations, highlighting algorithm bias, transparency, and explainability as challenges that must be overcome prior to approval.



WHAT DOES THIS HAVE TO DO WITH SECURITY?

The regulatory environment for AI/ML is complex and varied, but the commonality is that to meet these requirements, security efforts must be implemented as a backbone. Trying to pursue AI/ML application development without security would be like trying to decorate the inside of a house before deciding on the house layout.

Security requirements tied to AI/ML derive from several sources in healthcare, not limited to:

- **HIPAA:** requires administrative, physical, and technical safeguards
- **US FDA:** risk assessments, monitoring, and ongoing maintenance
- **EU GDPR:** needs data protection by design, breach notification, and data minimization
- **EU Network & Information Systems (NIS Directive):** security measures and incident reporting

While the “asks” can seem overwhelming, the great thing is compliance can often be achieved by understanding industry standards, such as National Institute of Standards and Technology (NIST) Cybersecurity Framework, ISO/IEC 27001 and HITRUST Common Security Framework.

“SO WHAT?”

In 2024, water utilities, agriculture, and the power industry all faced dramatic increases in cyberattacks. But healthcare has been a “top” target for more than a decade, with 2024 including Change Healthcare, OneBlood, and CrowdStrike, with the outcome of such security lapses having a direct impact on the ability for a patient to receive care. Yet we still see rural hospitals not accessing free programs designed to help them become more cybersecure.

While you may not directly work in a hospital, the impact of security on the entire healthcare industry is directly on the bottom line. Additionally, healthcare continues to grow inorganically - data suggests S&P 500 companies are acquiring assets at a rate 4.4 times greater than they divest, up from 3.7 in the prior five years. The theme of 2024 cyberattacks was supply chain integration. Every new acquisition introduces a new supply chain that must be accounted for and secured.

If we’re ever going to get out of the catch-up game, we need to start treating security as a business imperative and prioritizing it the same way we do critical business priorities. 2025 is a chance to rewrite how we strategically position security and treat it as an enabler vs. a cost-center.

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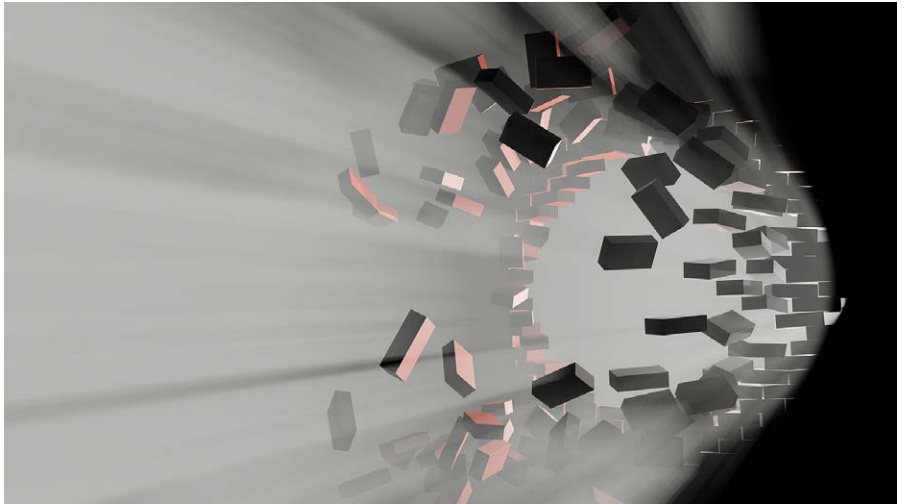
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DISRUPTORS - PART 2: ELECTRONIC HEALTH RECORDS (EHRs)

PROMISE OF EHRs AND STATUS TODAY

Electronic Health Records (EHRs) have long been heralded as a transformative technology in healthcare, promising to streamline operations, enhance patient care, collect data, and improve overall efficiency. The EHR journey began by aiming to digitize patient records, making them easily accessible and reducing reliance on paper-based systems with all its inherent limitations. Acceleration of EHR adoption was significantly influenced – both positively and negatively - by financial incentives triggered by the meaningful use of EHRs. This Centers for Medicare and Medicaid Services (CMS) program accelerated the pace of healthcare providers adopting and optimizing EHR technology solutions.



Source: [Bigstock](#)

Today, the EHR landscape is dominated by major key players, including Epic, Cerner, and MEDITECH. These companies have established a strong market presence through mergers and consolidations, creating a hotly competitive environment that many believe is driving innovation and improvement in EHR systems. The dominance of a handful of vendors has led to a relatively standardized approach to EHR implementation, but it has also raised valid concerns around market concentration and the potential stifling of smaller, potentially innovative companies. Furthermore, consolidated market dynamics aside, there have been many challenges associated with truly realizing the disruptive potential of EHRs, which we will review in Part 2 of this series ([Part 1](#)).

CHALLENGES IN TODAY'S SYSTEMS

Despite the widely anticipated promise of EHRs, several challenges still persist, resulting in optimization and adoption delays. One of the primary issues is continued lagging optimization of EHR systems after initial implementation. Providers often resist adopting new technologies, principally due to increased workload and administrative burden that EHRs inevitably introduce. Instead of simplifying workflows, EHRs often add complexity, with multiple access points and complicated interfaces. Many providers come up with their own workarounds that can hamper leadership's ability to understand how to make optimization improvements, such as truncating clinical notes/documentation and/or using third parties such as scribes.

The COVID-19 pandemic further exacerbated provider burnout, and many see EHRs as actively contributing to the strain rather than alleviating it. EHR system designs have become increasingly complex, necessitating both provider and administrative training that is continuous as well as change management. Encounter documentation within EHRs is often cumbersome, with numerous checkboxes and alerts that can overwhelm providers and frequently disrupt patient interaction. Free text fields, while offering flexibility, can lead to inconsistent data entry, potentially limiting the usability of the data downstream. This can disincentivize providers from writing out full notes, impacting the quality of patient records and usability of data that would otherwise be much more valuable. On the other hand, utilizing check boxes as the only data entry point may lead to lack of detail resulting in insufficient information to determine what exactly is going on with the patient (i.e., detailed narrative context) and also enables a clinician to much more easily check boxes without ever having

actually performed actions like the physical examination, providing information regarding the risks of a procedure, etc.

The new generation of practitioners and patients have very distinctly different demands from EHR systems. Clinicians seek intuitive, easy-to-use systems that offer on-demand access to data in plain language they can easily understand. They want systems that integrate seamlessly into their workflows, reducing time spent on administrative tasks, thereby allowing them to focus more fully on patient care (the reason they went to medical school). On the other hand, a segment of the patient population wants seamless access to its health data through portals, online tools, and apps. They expect quick responses to inquiries, such as through online chat or messaging, and some also want the ability to manage their health information independently. Finding the middle ground between these two sets of divergent expectations is essential to patient satisfaction and high-quality care.

While automation and artificial intelligence (AI) hold great potential for enhancing EHR systems, there have been instances of AI failures from a provider perspective, highlighting the continued need for thorough testing and validation. For example, AI algorithms used for diagnostic purposes have sometimes produced inaccurate results, leading to misdiagnoses, inaccurate coding (often up-coding) and billing, and/or risk of patient harm. A recent study from Mount Sinai raised significant concerns with AI's ability to accurately code patient charts. We will be examining AI and its associated disruption in a future installment of this series.

KEYS TO SUCCESS FOR EHR DISRUPTION

1. Supporting Patients

Empowering patients is a crucial aspect of successful EHR disruption. Patient portals that provide access to their own records have the potential to enhance patient engagement and enable patients to avoid phone hold times. These portals should also offer opportunities for patients to update their financial information, request medication refills, and access test results and clinical notes.

Understanding the diverse needs of patients is essential; for instance, a 67-year-old male with a chronic condition might spend time reading through their records and using technology differently than a 29-year-old male in good health. The EHR system must cater to the needs of people of various ages, health conditions, and technological savviness.

2. Supporting Clinicians and Staff

EHR systems should be designed to capture data accurately and thereby substantiate billing and coding, thus help ensuring clinical documentation integrity (CDI). The goal is to make the tool transparent and non-disruptive, allowing providers to focus more fully on patient care. Automation of payer reporting and workflow processes can further enhance efficiency and reduce errors associated with manual interventions. One example is automating the collection of data for HEDIS, STARS, or other quality improvement programs to help identify and measure gaps in care and link the quality, efficiency, and evidence-based delivery of care in a way that the potential of a value-based reimbursement system can be fully realized.

A key question remains: How can EHRs be designed to enable clinicians to practice at the top of their license and staff to streamline workflows and work more seamlessly as a team? The EHR system should be built with the end-user in mind, so it aligns with the way providers and staff want to deliver care and support patients. It should also make it easy for practitioners to monitor preventive care and medication adherence, track the effectiveness of

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DISRUPTORS - PART 2: ELECTRONIC HEALTH RECORDS (EHRs)

treatment plans over time, e.g., A1C, blood pressure, cholesterol, identify potential drug-drug interactions, stay up-to-date on new guidelines and standards of care, and practice in a manner that increases health equity. ***Those who create the system should be embedded into medical practices to really understand in a way that flows with the needs of patients, providers, and staff***, instead of swimming upstream in a techno-centric way, and actually improve care rather than making it more difficult and costly to deliver.

3. Supporting Administration

EHR systems should also support administrative functions by providing robust analytics and reporting capabilities. This includes financial information for revenue, costing, service development, productivity reporting for provider compensation calculations, and automation of routine tasks.

4. Deploying AI That Works

While AI and automation offer significant benefits, they must be applied judiciously and ensure the algorithms utilized are free of bias. Understanding the specific use case and ensuring proper training and testing of machine learning models are essential.

CONCLUSION

We believe the true value of an EHR should be increased provider, staff, and patient satisfaction and capability during the course of day-to-day patient care. Quite simply, when a tool makes life easier and increases time spent with patients delivering care, it can ease administrative burden and hopefully decrease and/or alleviate provider burnout. When an EHR is implemented correctly, this objective can be realized. Downstream impacts and/or enhancements include improved data collection, enhanced coding, billing and collection, decreased and/or reduced clinical workflow friction and more informed clinical decision-making; all resulting in higher quality patient care and better outcomes.

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THE NEURO-REVOLUTION: OVERHAUL SOCIETY AND UNLOCK HUMAN POTENTIAL - PART 2

In [Part 1](#) of this two-part series, I discussed ADHD – misconceptions and stereotypes, a deficient-oriented perspective, the loss of potential and creativity, and the suffering caused by a world that typically requires neurodivergent people to conform to a framework that does not accommodate, much less honor and celebrate diversity.

In Part 2, I will cover the changes needed to overcome these man-made barriers which limit not just the ADHDer but also negatively impact us all collectively. One such crucial area is the need for the scientific community and society at large to adopt a more balanced and nuanced understanding of ADHD. We need to start investing in studies that determine optimal environments for all neurotypes to thrive.



THE IMPACT OF STIGMA AND DIAGNOSIS REQUIREMENTS

Rather than respecting a person's request for certain modifications to workflow or environmental stimulus based on professional courtesy, society demands a diagnosis prior to honoring these needs. Yet, society has made it very difficult to get an ADHD diagnosis. This requirement reflects an inherent bias that demands individuals prove their neurodiversity to receive validation and support. Furthermore, for years there has been so much stigma associated with ADHD that many of us who were diagnosed in the early '90s, and for 25 years thereafter, guarded our truth with our lives. We faced immense pressure to conform, often experiencing significant mental and emotional distress. Many of us try to keep that secret from being exposed, fearing judgment, discrimination, and misunderstanding from those around us. ADHDers have been found to be 5 times more likely to attempt suicide than neurotypical people.

THE SOCIETAL CHALLENGE

One of the most harmful misconceptions is that ADHD needs to be "fixed" or "cured." This perspective stems from a societal bias towards a neurotypical way of functioning.

ADHD is not the problem, and it is not a defect. It's a natural neurological variation that results in a different way of thinking and processing the world. The challenge lies not within the ADHD individual but within a society that demands conformity to a rigid structure designed to maintain the status quo.

The real challenge is a society predominantly structured for neurotypical individuals. Educational systems, workplaces, and social expectations are all designed with a specific neurotype in mind. This assumption leaves those of us who are neurodiverse at

a significant disadvantage, not because we are incapable, but because the environment is not conducive to our ways of thinking and functioning.

ADHDers often possess remarkable creativity, problem-solving abilities, and the ability to hyperfocus on tasks that engage their curiosity. This, coupled with their often keen sense of justice, low tolerance for hypocrisy and deception, ability to conceptualize things never seen before, and finely tuned empathy, means many ADHDers are genetically hardwired to solve the world's most complex problems.

When fostered and encouraged in an ideal environment, ADHDers make brilliant scientists, inventors, athletes, and artists. Think Albert Einstein, Steve Jobs, and Bill Gates. But it is more often the case than not that ADHDers are punished, teased, misunderstood, overlooked, and dismissed so much in their childhood that by adulthood they have lost connection with their sense of self, no longer trust their own instincts, don't know what their natural gifts are anymore, and are too afraid to remove their masks to find out.

RECLAIM A LOST OPPORTUNITY

As is so often the case, society enforces norms that limit potential. Embracing neurodiversity by creating environments that do not demand conformity will benefit **all** neurotypes. By eliminating the demand for masking and valuing natural ways of thinking, we can unlock immense creativity, collaboration, and problem-solving potential, driving societal progress. Recognizing and supporting neurodiversity enhances our **collective ability to thrive** in a complex world.

Both neurotypical and ADHD neurotypes offer valuable strengths. Neurotypical individuals excel in structured environments, adhering to societal norms and expectations through efficient executive functioning. On the other hand, individuals with ADHD bring creativity, adaptability, and out-of-the-box thinking, often thriving in dynamic and novel situations. Recognizing and protecting the integrity of these natural designs, rather than forcing conformity, is crucial for leveraging the strengths of each neurotype. Encouraging neurodiversity allows individuals to capitalize on their inherent abilities, leading to personal fulfillment and societal advancement.

Society stands to gain immensely from embracing neurodiversity, particularly by supporting individuals with ADHD in developing their natural tendencies. When people with ADHD are not forced to mask their behaviors and instead are encouraged to nurture their unique cognitive styles, they can contribute significantly to innovation and creative problem-solving. By fostering an inclusive environment that values diverse cognitive profiles, we can unlock the full potential of all individuals, leading to greater happiness, health, and success across the population.

WHAT'S NEXT?

There are glimmers of hope as some things are starting to change. The rise of social media has provided a platform for individuals with ADHD to share their experiences, build supportive communities, and advocate for better understanding and acceptance. These online spaces have become sanctuaries where we can express our true selves without fear of stigma. However, the presence of these platforms alone is not enough to dismantle deeply ingrained societal biases.

We need to change the narrative around ADHD. This means shifting from a deficit-focused perspective to one that recognizes and values the strengths and contributions of neurodiverse individuals. We need to create environments that feel safe and productive for **everyone** — environments that don't require special accommodations to be made, because they are **inherently inclusive by design**. Cultures that don't require people to self-identify to be treated with respect. This is a significant shift from the current state, where special accommodations are often seen as exceptions rather than the norm.

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THE NEURO-REVOLUTION: OVERHAUL SOCIETY AND UNLOCK HUMAN POTENTIAL - PART 2

Moreover, we need to create a society based on the premise that everyone is neurodistinct, each of us deserving respect, acceptance, and the opportunity to thrive as we are. This shift in thinking means fostering workplaces, schools, and public spaces that celebrate diversity in all its forms and understand that neurodiversity is a natural and valuable part of human variation. It's about recognizing that the **"one-size-fits-all" approach is outdated and counterproductive.**

By embracing an inclusive mindset, we can move towards a future where people with ADHD and other neurodiverse conditions are not just accommodated, but genuinely valued for their unique perspectives and abilities. It's about building a world where everyone has the opportunity to contribute meaningfully, without the need to mask their true selves or fight for recognition. This is not just a benefit for those with ADHD; it's a step towards a more innovative, empathetic, and just society for **all**.

Here are a few concrete steps that can be taken:

- We have a lot of work to do to make our collective experience infinitely better. If neurotypical-style studies are going to be done to better understand the neurodiverse experience, they should start by determining the percentage of the population that is not supported or served within the limitations of our current societal constructs. Then focus on breaking down biases and social norms.
- We can focus our attention and efforts on getting the ADHD name changed and embrace one that truly reflects the strengths and potential of this neurotype. Cast your vote on my proposed options, or suggest one of your own. My personal favorite is Integrated Neuronetwork Design Intelligence (INDI). But all the names reflect the unique strengths and positive attributes associated with ADHD, emphasizing creativity, adaptability, and innovative thinking. They also honor the essential and vital nature of this neurotype, moving away from deficit-focused terminology to a more empowering and inclusive language.

"It is not our differences that divide us. It is our inability to recognize, accept, and celebrate those differences."

~ Audre Lorde

In conclusion, fostering a neuro-inclusive society requires a fundamental shift in how we perceive and accommodate neurodiversity. This article has been my rally cry, my "Jerry Maguire moment," my attempt to get your attention and inspire you to start challenging the societal norms that limit human potential. By understanding and valuing the unique strengths of all neurotypes, we can create environments that nurture the potential within each individual. This shift will not only benefit those with ADHD and other neurodiverse conditions, but it will enrich our collective human experience, leading to greater innovation, empathy, and societal progress. It's time to rethink our approach, challenge outdated norms, and build a world where everyone has the opportunity to thrive just as they are. Embracing neurodiversity is not just a moral imperative but a path to a more vibrant and dynamic future for all.

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APPENDIX

ADHD Has Got To Go

It's time to ditch the outdated label "ADHD" and embrace a name that truly reflects the strengths and potential of this neurotype. For too long, the term ADHD has carried a stigma, emphasizing deficits and disorders instead of celebrating the unique cognitive abilities that come with this neurodivergence. By redefining how we talk about ADHD, we can foster a more inclusive and empowering narrative.

Here are 20+ alternative names that highlight the positive attributes and essential design of the natural neurological variance currently known as Attention Deficit Hyperactivity Disorder (ADHD):

1. Adaptive Creative Divergent Cognition (ACDC)
2. Advanced Creative Development Cognition (ACDC)
3. Innovative Neuro-Dynamic Instinct (INDI)
4. Adaptive Neuronetwork Design Intelligence (ANDI)
5. Integrated Neuronetwork Design (IND)
6. Neuroadaptive Innovation Design (NID)
7. Enhanced Creative Functioning (ECF)
8. Neurodynamic Innovation Profile (NIP)
9. Adaptive Divergent Thinking (ADT)
10. Synergistic Cognitive Variance (SCV)
11. Innovative Executive Network (IEN)
12. Adaptive Cognitive Potential (ACP)
13. Creative Cognitive Integration (CCI)
14. Dynamic Thought Synergy (DTS)
15. Adaptive Neurodiverse Potential (ANP)
16. Fluid Executive Functioning (FEF)
17. Enhanced Neurocognitive Spectrum (ENS)
18. Creative Adaptive Dynamics (CAD)

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THE NEURO-REVOLUTION: OVERHAUL SOCIETY AND UNLOCK HUMAN POTENTIAL - PART 2

All of these names reflect the unique strengths and positive attributes associated with ADHD, emphasizing creativity, adaptability, and innovative thinking. They also honor the essential and vital nature of this neurotype, moving away from deficit-focused terminology to a more empowering and inclusive language.

LIFETIME PREVALENCE OF NATURAL AND CAUSAL NEURODIVERSITY IN ADULTS (AGES 22 TO 65)

Natural Neurodiversity refers to neurological differences that are part of the natural variation within the human population, often present from birth or early childhood. These include conditions like Autism Spectrum Disorder (ASD), ADHD, dyslexia, and others. Here are the estimated lifetime prevalence rates for these conditions:

1. Autism Spectrum Disorder (ASD): Approximately 2% of the adult population (boostneurodiversity.com).
2. Attention-Deficit/Hyperactivity Disorder (ADHD): Around 4.4% of adults ([Springer](#)).
3. Dyslexia: Estimates range from 5-10% of the population (neurodiversity.guru).
4. Dyspraxia: Approximately 2-6% (boostneurodiversity.com).
5. Dyscalculia: Estimated around 3-6% (boostneurodiversity.com).
6. Dysgraphia: Around 5-20% in childhood, with many continuing into adulthood ([Springer](#)).
7. Tourette Syndrome: Less than 1% (boostneurodiversity.com).

Adding these percentages together gives us a total of 21.4% to 29.4%. However, due to comorbidities (e.g., individuals with ADHD often also have dyslexia), a more conservative estimate would be around 15-20% of the adult population being naturally neurodiverse.

Causal Neurodiversity includes neurological changes resulting from specific causes such as traumatic brain injury, mental health disorders, or other medical conditions. Here are the estimated lifetime prevalence rates for these conditions:

1. Schizophrenia: About 1% of adults (boostneurodiversity.com).
2. Bipolar Disorder: Around 2.8% (boostneurodiversity.com).
3. Epilepsy: Approximately 1.2% (boostneurodiversity.com).
4. Post-Traumatic Stress Disorder (PTSD): About 3.6% (neurodiversity.guru).
5. Substance Abuse Disorders: Around 7.4% (boostneurodiversity.com).
6. Traumatic Brain Injury (TBI): Approximately 2% (boostneurodiversity.com).
7. Severe Anxiety: About 19.1% (boostneurodiversity.com).
8. Major Depression: Around 8.3% (neurodiversity.guru).
9. Childhood Trauma: Around 60% have experienced some form of childhood trauma, which can lead to neurological changes in adulthood (boostneurodiversity.com).
10. Chronic Emotional Trauma: The prevalence varies but is significant due to overlap with conditions like PTSD and anxiety disorders.

Adding these percentages together gives us a total of 105.4%. However, due to high comorbidity rates (e.g., individuals with PTSD often also have depression or anxiety), a more conservative estimate would be around 30-40% of the adult population experiencing causal neurodiversity.

Total Prevalence: By combining the adjusted estimates for natural and causal neurodiversity and accounting for overlaps, the overall percentage of the adult population (ages 22 to 65) affected by either natural or causal neurodiversity is estimated to be around **45-50%**. This takes into account the high rates of comorbidity among the various conditions.

These estimates highlight the significant portion of the population affected by neurological and mental health conditions, emphasizing the importance of creating inclusive environments and support systems for individuals with diverse neurological profiles.

Sources: National Institute of Mental Health (NIMH), Substance Abuse and Mental Health Services Administration (SAMHSA), various academic and epidemiological studies ([Springer](#)) ([boostneurodiversity.com](#)) ([neurodiversity.guru](#)).

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INNOVATING FOR IMPACT - MERGING TECHNOLOGY AND HUMAN CARE IN HEALTHCARE TRANSFORMATION

When I stepped into the role of president and CEO of AtlantiCare, a healthcare system serving the Southeastern New Jersey region for over 125 years, one of the first questions I asked the team was not if we had the right systems in place, but rather, 'How will we drive transformation in the delivery of care? And what does that mean to our industry, community, and patients?'

The traditional healthcare model, designed to manage care and the flow of operations within the four walls of its facilities, is outdated and no longer sustainable. It is not designed to keep our patients and community healthy and cared for at home. If today's consumers expect ease of access in all aspects of their lives — from one-click shopping to streaming entertainment to the simplicity of paying bills — then healthcare should be meeting them where they are in their lives, when it is most convenient for them.



Source: [Bigstock](#)

At AtlantiCare, we are committed to leading the change that healthcare needs through *Vision 2030*, our ambitious six-year strategy plan that reimagines how healthcare is delivered — prioritizing patients' well-being and community wellness first. These elevated expectations require bold, swift actions, which is why we partnered with Oracle Health, a leader in the health technology space, to launch a digital overhaul of our entire healthcare system. This will enable us to tailor our approach to meet the needs of our patients and deliver the seamless, connected healthcare experience they deserve.

SUPPORTING A PATIENT'S JOURNEY

The integration of advanced technology in healthcare is often perceived as a move toward automation, raising concerns about losing the personal, human touch. However, at AtlantiCare, we view healthcare technology as a means to humanize the healthcare experience by strengthening connections between providers, clinical staff, and patients. By enhancing communication, personalizing care, and freeing up time for more meaningful interactions, technology becomes a powerful tool to foster deeper relationships.

An essential component of our digital transformation is the launch of a comprehensive Command Center, which provides our team with a broader, more transparent view of operations across the entire healthcare system. This perspective enables us to support patients, and our providers, through their entire care journey, making the experience frictionless and seamless. More importantly, it allows us to intervene in real time - whether patients are inside or outside of the four walls of our healthcare setting.

For example, the Command Center capabilities will allow our team to monitor patient flow and address transport delays across our hospitals. At the same time, it will alert us to critical changes in a diabetic patient's status through their glucose

monitoring device. This early intervention, monitored and initiated outside our facility, enables us to respond quickly and often prevent more serious health issues from developing.

This is exactly the change that healthcare needs, providing proactive, not reactive care, supported through 24/7 remote monitoring, that can detect and manage issues before they become acute or emergent.

ALLEVIATING ADMINISTRATIVE BURDENS

With the integration of AI, we can accomplish even more. AI is enabling us to reduce team member burnout by alleviating the burdens that often take them away from focusing on high-touch patient experiences. During my early days as CEO, I spent time walking the hospital floors and saw firsthand how our care providers were overwhelmed by administrative tasks. While necessary, the documentation was keeping providers on the computer instead of at the bedside with patients.

As one of the first-named innovation partners for Oracle Health's generative AI-based Clinical Digital Assistant (OCDA), we are introducing solutions that allow providers to focus on patient interactions as a priority. As a participant in the pilot program, we were able to provide valuable feedback to the Oracle Health team and help to shape the evolution of the OCDA to better meet the needs of our caregivers and patients.

The mobile OCDA offering combines generative AI, clinical intelligence, multimodal voice and screen-driven assistance, and simplified workflows into a single, unified solution. The tool is activated during patient-provider interactions, capturing key details needed to populate the electronic medical record (EMR) without requiring the provider to manually input patient information. It is smart enough to filter out unrelated conversations, such as last night's football game. Early results have been very promising. AtlantiCare doctors have reported better patient engagement and greater professional satisfaction, thanks to the significant reduction in manual documentation.

By leveraging the OCDA tool, we aim to improve the quality of the visit summary, providing a more comprehensive view of each patient encounter which the care provider then reviews and signs off on. This helps ensure everyone involved with a patient's care — both clinical and administrative teams — have the same information, reducing the need for patients to repeat themselves and improving overall experience.

ELEVATING HUMAN CONNECTION AND INNOVATION IN HEALTHCARE

As the pace of technological advancement accelerates, we will continue to leverage its remarkable capabilities to enhance the patient's experience. However, it is important to remember that AI is not a replacement for the human element of healthcare. People will always be the most critical component of how, when, and where AtlantiCare achieves healthcare excellence in serving our communities. These tools are designed to enhance our ability to deliver compassionate, personalized care by reducing workflow redundancies and administrative burdens on team members so they can be fully present with their patients and their families.

Together with Oracle Health, we are reimagining every aspect of healthcare operations, from staffing and supply chain efficiency to leveraging generative AI. Our ultimate goal is to make AtlantiCare a model of connected, effective care.

Throughout this journey, one principle will always guide us: putting patients first.

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PURPOSE-FILLED WORK AS A PROTECTIVE FACTOR AGAINST PHYSICIAN BURNOUT

Burnout among physicians has been increasingly recognized as a critical issue in healthcare with far-reaching consequences not only for the physicians themselves but also for patients. The concept of burnout encompasses emotional exhaustion, depersonalization, and a decreased sense of personal accomplishment. However, a powerful protective factor exists — meaning derived from purpose-filled work. This concept is rooted in the intrinsic motivations that often lead individuals to pursue medicine in the first place.

THE ALTRUISTIC FOUNDATION OF MEDICAL CAREERS

For many medical students, the primary motivation for entering a healing profession is altruism — a desire to help people, improve lives, and contribute to the greater good. As a result, medicine is frequently seen as a noble calling rather than just a job. Yet, the realities of modern medicine often create a dissonance between this altruistic drive and the day-to-day pressures of the profession, which can erode that sense of purpose over time. The rigors of healthcare, including administrative burdens, high patient loads, and systemic inefficiencies can create a disconnect between physicians and the core reasons they entered the field.



Image Courtesy of [Unsplash](#)

Physicians who reconnect with their sense of purpose, however, are more likely not only to sustain their passion for the work but also to avoid or reduce burnout. Thus, reaffirming medicine is a noble and purpose-filled calling is crucial for the profession.

THE CONNECTION BETWEEN PURPOSE AND BURNOUT

Research supports the idea that meaning in work is a critical factor in reducing burnout.

In a national survey, Yoon, Daley, and Curlin (2017) found physicians with a strong sense of calling were less likely to report burnout compared to those who saw medicine merely as a career. In their findings, those who perceived medicine as a calling were also more likely to report higher life satisfaction and greater commitment to patient care. Physicians who maintained a strong sense of purpose in their daily tasks also report lower levels of emotional exhaustion and higher levels of personal accomplishment.

The National Academy of Medicine reinforces this view, stating, "Health workers who find joy, fulfillment, and meaning in their work can engage on a deeper level with their patients, who are at the heart of healthcare." (National Academies of Sciences, Engineering, and Medicine. 2024) The report emphasizes purpose-driven work allows physicians to engage more meaningfully, not only with their patients but also with the healthcare system as a whole.

In a national study of over 2,200 U.S. physicians, those experiencing burnout were significantly less likely to identify medicine as a calling (Jager AJ, Tutty MA, and Kao AC 2017). This study highlights how burnout not only affects a physician's well-being but also threatens the intrinsic motivations that drive their professional identity.

Additionally, a study by Tak HJ, et al. (2017) found extrinsic motivators, such as income, were not significantly associated with markers of well-being. Without a sense of calling, physicians may begin to view their work as a means to an end — primarily a paycheck — rather than as an avenue for making a positive impact on the world. This indicates while financial and material rewards are important, they do not offer the same protective effects against burnout as purpose and meaning.

THE INDIVIDUAL NATURE OF PURPOSE IN MEDICINE

Purpose, in the context of healthcare, is a deeply personal concept. It is not something that can be instilled through corporate mission statements or institutional pride, although those can be reinforcing factors. Rather, purpose is something each physician must define for themselves. However, physicians often derive their sense of purpose from their roles as healers, teachers, scientists, or experts in their field (Shanafelt T, Chung H, White H, et al. 2006). This personal orientation toward purpose allows physicians to experience their work as both meaningful and fulfilling.

While purpose is individual, purpose is often closely tied to human connectedness. A physician who feels connected to patients, colleagues, and the larger mission of their profession is more likely to find meaning in their work. This connectedness reinforces the altruistic motivations that brought them into medicine in the first place. To harness the power of connectedness, healthcare leaders can incorporate patient feedback into performance reviews, explicitly recognizing the positive impact physicians have on the lives of patients (Shanafelt T and Swensen S 2017). This practice reinforces the connection between a physician's daily work and the broader altruistic goals that inspired them to enter the field, reminding them of the significant differences they make in their patients' lives.

At the heart of meaning in medicine is the physician-patient relationship. Physicians often cite their connection with patients as one of the most rewarding aspects of their work. Yet, in a healthcare system that increasingly prioritizes efficiency over human connection, this relationship can become strained. As Zohal Ghulam-Jelani noted, "The patient is what is keeping the doctor from falling further into burnout. The physician-patient relationship and the desire for doctors to help their patients is the core of why physicians entered medicine." (National Academy of Medicine's Expressions of Clinician Well-Being: An Art Exhibition)

Physicians derive a significant amount of meaning from their relationships with patients, and when those relationships are nurtured, both parties benefit. Strong connections with patients provide physicians with a tangible sense of purpose and remind them of the impact they are making, which can be a powerful antidote to burnout.

CONCLUSION: SUPPORTING PURPOSE-FILLED WORK IN MEDICINE

When there is a disconnect between what physicians find meaningful and the realities of their daily tasks, burnout is more likely to occur. Physicians who are unable to reconcile their desire to make a meaningful difference with the bureaucratic and logistical demands of modern healthcare may experience increased stress and disillusionment. However, physicians who are able to reconnect with their sense of purpose — whether through their role as healers, educators, or caregivers — are more likely to experience higher levels of job satisfaction and lower levels of burnout.

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PURPOSE-FILLED WORK AS A PROTECTIVE FACTOR AGAINST PHYSICIAN BURNOUT

Healthcare organizations must recognize the critical role meaning plays in the well-being of their workforce. By fostering environments that support purpose-driven work, healthcare leaders can help protect physicians from burnout, ultimately improving both physician well-being and patient care. Purpose, after all, is not just about individual fulfillment — it is about the collective good that comes from a healthcare system where physicians are engaged, passionate and motivated to improve the lives of others.

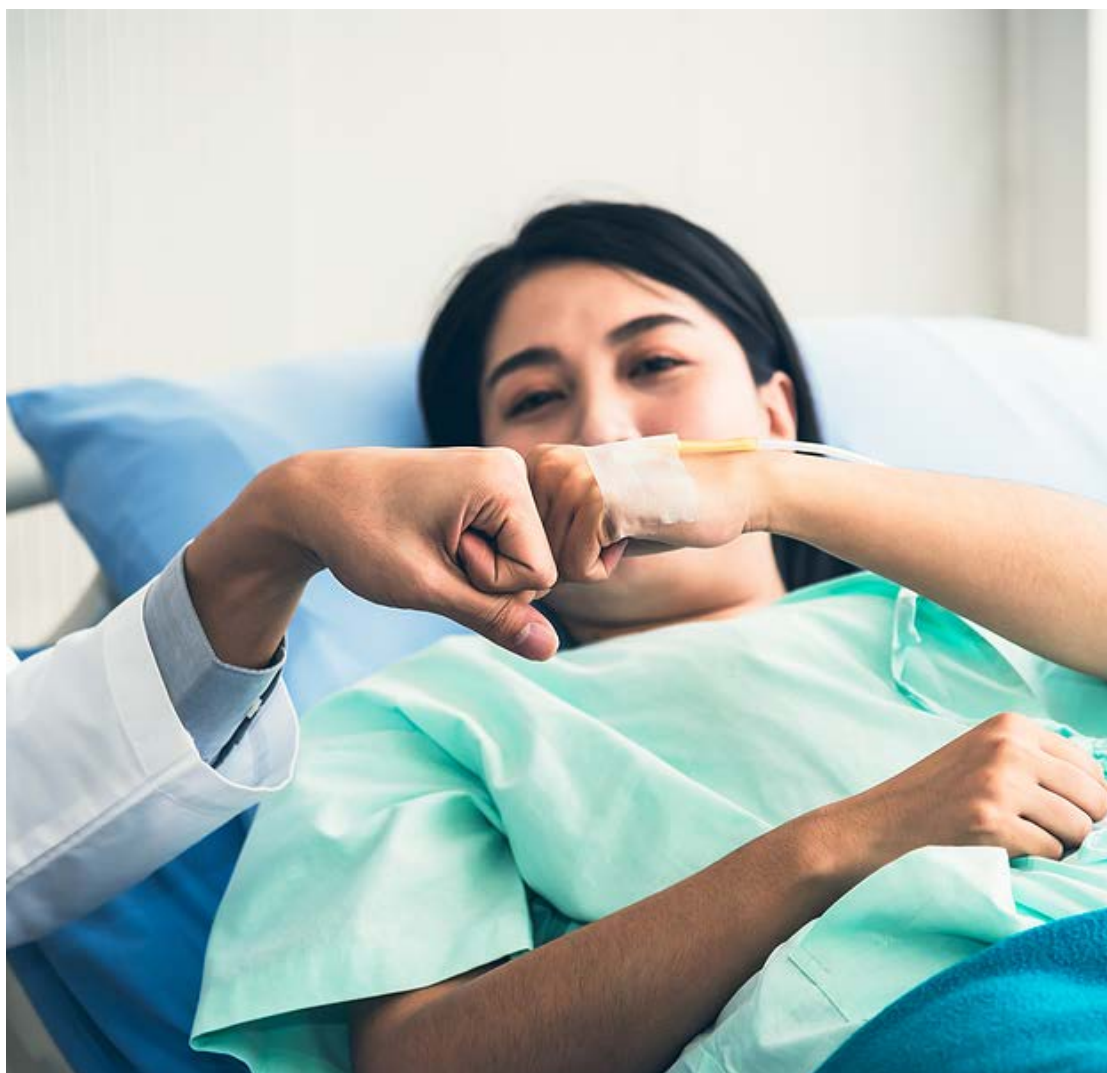
For the sake of the healthcare system and the patients it serves, it is essential to reaffirm the sense of meaning and purpose that makes medicine a noble calling.

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FROM CULTURE RESET TO CULTURE PRESET

In the last decade we have seen a realization among healthcare leaders that organizational culture is a major factor in achieving short-term and long-term results. The reasons are many, from the fact that culture can dictate communication across teams, impacting the pace of work, to the reality that culture affects reputation, contributing to recruitment of top talent.

We view culture as the set of behaviors that often indicate deeply held beliefs about how people work with one another. The way that people complete tasks, make decisions, and reward performance are components of culture.



Source: [Bigstock](#)

Our experience tells us changes in an organization's circumstances can morph behaviors and expectations. We have seen these shifts generate new energy, but also reveal low-lying fissures and strike new pain points for people who work together. In some cases, critical incidents take leaders by surprise, forcing them to react to the sudden visibility of deep-seated culture issues. We began to wonder, what might be possible if leaders could better anticipate cultural needs?

We recently employed a confidential artificial intelligence tool to do a meta-analysis, taking a systemic lens across both of our project data in our culture work. We wanted to understand what precipitated the decisions to engage us, including if there were no patterns, or if large events had no bearing on culture issues. The analysis helped us isolate two prominent culture change indicators: leadership transitions and rapid growth.

Leadership sets the tone and direction of any organization, and people look to the top to see what they ought to emulate. Even new leaders who establish consistency with their predecessor's leadership style will represent a culture shift. As people look for signals about what will count as success going forward, it is important for the leader to understand the dynamics at play.

One example of this played out in a clinical department, where a longtime, charismatic leader had recently departed. She had managed people through individual relationships, meaning that people knew where they stood by virtue of how close they were to her. She had also tolerated unprofessional behavior while neglecting to appropriately authorize roles and structure that would establish ways to escalate issues.

The incoming chair first sought to fill his predecessor's shoes exactly, believing the department needed consistency foremost. However, he was not able to operate in the same way. Faculty and staff became unsure how to manage their responsibilities and some inappropriate behavior intensified, shedding light on deep-seated issues.

The cultural intervention came when a professionalism complaint was filed. Entering the leadership role with indicators of areas to which to pay the most attention could have built early credibility for the chair and avoided some frustration across faculty and staff. A "culture preset" could have provided that lens.

A culture preset is a way to take the temperature of an organization, going beyond employee engagement to understand the kinds of specific working agreements and success factors that have laid the groundwork for the current state. The

preset can give leaders data on what kinds of things will be disrupted by the change ahead, and a way to flag focal points as the environment changes for their people. With these insights, leaders can develop an action plan for strengthening trust through the time of uncertainty.

In a culture preset frame, the institution would view the leadership transition as an opportunity to get ahead of needed culture change. Elements of the role ambiguity and disjointed leadership core would have appeared, enabling the new chair to take in what people would need to feel energized and able to do their work. Importantly, the tacit acceptance of unprofessional behavior could have been made explicit, giving the leader a better sense of how to ensure a safe working environment.

Nearly every organization we've worked with that has experienced a period of rapid growth has seen cultural fractures. That is no accident. Culture has been defined as the "residue of success," meaning that the behaviors of people within an organization are calibrated to achieve results they perceive as valuable. However, behaviors that set the stage for growth are often counterproductive as the organization scales.

For instance, a respected surgical program saw turnover shoot up as quality scores dipped. It took a patient death to realize a cultural reset was needed. At its start, the program was a small, fast-moving team where everyone knew one another and people did their jobs almost through muscle memory, pitching in anywhere at any time. Yet as volumes and staffing shot up, so did turnover, and seasoned staff felt unable to teach new staff the ropes while balancing their own responsibilities. The culture had placed a premium on firefighting and speed, resulting in a high-risk lack of knowledge and a corresponding discomfort with asking questions. The approach to work continued to be pitching in with each person taking on more than they could manage — a culture that rewarded heroism at the point of martyrdom and restricted access to learning and planning. The pressures on the program came to a head with the preventable patient death.

Having the ability to understand people's concerns and enthusiasm about the impact of a larger program on areas like relationships, roles and resources would have accelerated establishment of a constructive work environment. Engaging in a preset mode could have prepared the program for new learning and communication needs and ultimately may have been able to prevent the tragic patient death.

Rapid growth and welcoming new leaders can be seen as "good problems to have" and are big opportunities for any organization to set the stage for success. They change expectations and will lead to culture change. Importantly, both changes are recognizable and usually anticipated in some way, but not always prepared for. These two situations give leaders the opportunity to get ahead of their deepest cultural liabilities, enacting not a "culture reset," but instead a "culture preset," speeding time to optimal outcomes for the organization.

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BIOTECH AND BIOMEDICAL FAILURE: IT'S NOT THE SCIENCE – PART 1

The biotech and biopharmaceutical (biomedical) industries are failing us, medically and economically. We have the science to serve us better; we need the right market participants in order to truly deliver greater coverage, access, and outcomes.

The Ninety-Ten Institute

You've seen the headlines: Drug pricing in the United States is out of control.¹ Few technologies for early detection of life-limiting diseases (e.g., cancer and heart disease) or low-margin products like vaccines and antibiotics are receiving adequate investment, despite evidence these inventions have saved more lives than novel therapies. Drug shortages in the United States are at a record high.² And pharmaceutical companies are saying the quiet part out loud and proud now – that some expressly choose to hold back one promising drug in favor of another already-patented one in order to maximize profits.³

The biomedical industry has received steadily greater investment since its origins in the 1970's. In the United States, venture capital investment alone in biotechnology companies steadily increased from \$1.5 billion in 1995 to \$16.8 billion in 2020. Yet despite benefiting from billions in capital investment, the biomedical industry produces products that address less than 10% of all disease conditions: primarily those that can generate blockbuster profits and spectacular returns for private or public shareholders. This critical industry is overlooking, or leaving behind, 90% of society's medical needs.

THE “WHY”

It isn't because physicians are holding medicines back.

As long as the evidence of effectiveness is openly available to physicians and as long as their patients can afford a test or treatment, physicians are of course anxious to offer any and all new ways to diagnose and treat disease.

It isn't because the public health agencies don't recognize the need.

In fact, public health agencies and other health care advocacy organizations (e.g., The American Cancer Society) track and publish data on the positive and negative effects of early detection and standard treatment protocols on overall health and wellness.⁴ They'd much prefer, and indeed they advocate for, more vaccines and other preventive or early detection methods to catch cancer, heart disease, and other major diseases before they become intractable.

It isn't because we lack knowledge or technology to solve far more medical needs.

In the late 1970's, breakthrough discoveries of genes and molecular processes were beginning to reveal the biological basis of disease. From then on through the early 2000's, biotech companies were founded on highly speculative discovery science, which required huge leaps of faith that glimmers of insight into human molecular physiology could be translated into safe, effective medicines, diagnostics, or preventives. The science was so nascent in those days that selection of target investments was later recognized as little more than breathing on dice at the craps table: the probability of success of any given invention/discovery being translatable into approvable products was unchanged by the careful selection of one idea over another, since there were too many unknowns for rigorous prediction of success.

Where to find such high-risk capital? A few inspired venture capitalists recognized a new speculative investment opportunity in those promising discoveries. High-stakes bets on high-risk ideas coming out of high-profile universities could be fertile ground for *rapid wealth creation*. Venture capital providers were happy to oblige for this potentially high reward.

As a consequence of 30 years or so of free-flowing (albeit high-cost) capital, our scientific understanding of molecular and physiological systems of disease advanced significantly. What resulted was a tsunami of data, discoveries, and understanding, flooding academic and industry journals with overwhelming knowledge. By the mid-2000's, the global biomedical research and development (R&D) system was not just robust but was in fact drowning in millions of potential treatment, detection, and prevention candidates. With a much more mature and deep pool of scientific and technology knowledge in medicine, and the potential to meaningfully addressing a wide swath of the molecular mechanisms of human disease, the biomedical assets available today are much less of a 'wild card' bet for funders.

REALITY CHECK

Profit making has overwhelmed the original purpose of a Medical Industry

It's right in the headlines

It isn't evil.

But it also isn't the only way to operate a biomedical industry



How a Big Pharma Company Stalled a Potentially Lifesaving Vaccine in Pursuit of Bigger Profits

by Anna Maria Barry-Jester
Oct. 4, 5 a.m. EDT

A vaccine against tuberculosis, the world's deadliest infectious disease, has never been closer to reality, with the potential to save millions of lives. But its development slowed after its corporate owner focused on more profitable vaccines.

PROPUBLICA

SO, WHAT'S THE PROBLEM?

It's the financialization of the biomedical system that is failing us.

Despite their lowered risk profiles and high potential for medical impact, significant volumes of undervalued medical product candidates – 'assets' in the market vernacular – sit on a shelf or are abandoned rather than being pursued with investment support. Instead, capital continues to flow only in pursuit of products with the highest margins and biggest addressable markets, an often fatal misalignment of capital and perceived risk. The capital cost remains high both directly - ownership, control, financial expense – and indirectly in all that it leaves behind.

Since the inception of the biotech industry, each entrepreneurial company accepting the speculative capital of venture firms has given over two critical aspects of building a business: (1) ownership control, as the early to mid-stage capital sources take preferred shares and a majority stake and (2) control over product portfolio selection, now almost exclusively devoted to products that can be forecast to deliver maximum profits. Maximized profits in these companies are achieved primarily through the market exclusivity granted by the Food and

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BIOTECH AND BIOMEDICAL FAILURE: IT'S NOT THE SCIENCE – PART 1

Drug Administration (FDA) or the European Medicines Agency (EMA) and enforcing patent rights that together allow for unchecked initial price-setting and uncapped yearly price-escalation for their proprietary drugs.

Meeting the demand for this type of capital requires short lead times to capture greatest market and investor returns, often abandoning promising medicine in favor of speed to market. Rather than valuing breakthrough biotech on medical impact, the market values it based on profit impact. And there are only so many drugs and diagnostics that will ultimately maximize lifetime profits – and so many more that we need to maximize the number of people served and diseases avoided.

Why isn't there a vibrant marketplace filled with companies working away at the 90% gap, at an affordable cost and accessibility to all? Companies engaged in producing the 90% of medical needs need lower cost capital invested with longer horizons that can reliably generate good (i.e., business-sustaining) margins.⁵ What will it take to build the asset owner/asset manager system that seeks lower risk (yet high medical impact) investment opportunities with commensurately lower returns on their capital?

An impact-first, impact-funded industry seeking meaningful progress to address that 90% -- built with enterprises focused on caring for the greatest number of people and treating the greatest number of health challenges possible – is what's needed. In Part 2 of this article, we'll share a blueprint for constructing this vision.

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2. "At least 14 essential generic cancer drugs are currently in shortage, forcing patients and doctors to make difficult decisions to delay or ration first-line treatments, or accept second-best treatments. ADHD treatments, antibiotics, children's acetaminophen, and many other critical medicines are also in short supply." <https://www.statnews.com/2023/08/09/drug-shortages-public-pharma-option/>
3. https://www.propublica.org/article/how-big-pharma-company-stalled-tuberculosis-vaccine-to-pursue-bigger-profits?utm_source=sailthru&utm_medium=email&utm_campaign=majorinvestigations&utm_content=feature
4. An American Cancer Society report on 30-year reduction in cancer mortality 2022 (reference) showed that the 30% reduction in cancer mortality over 30 years was primarily attributable to early detection tests (mammograms, PSA, and colorectal screening) and smoking cessation – none of which were developed by the biomedical industry.
5. How can we declare that margins and 'customers' will be reliably attained? Because medicines don't compete for favor with their ultimate 'customer': the patient. Patients need medicine for their ailments; they aren't choosing which brand to buy; they are prescribed what is needed. Therefore, effective medicines that address unmet medical needs will always generate revenue and savvy producers will be able to make them with suitable margins to sustain viable businesses.

CONTRIBUTORS:

Barbara Handelin, Ph.D.
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To learn more about
Barbara and Karyn, [click here](#).

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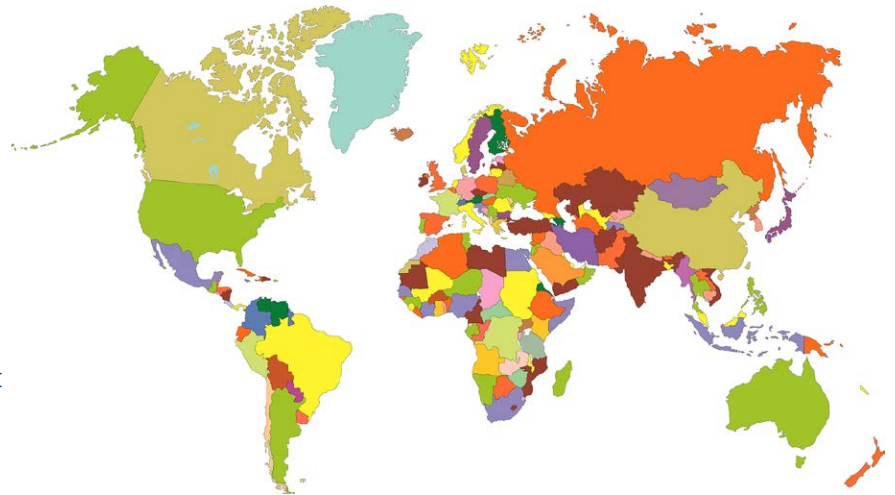
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WHARTON AROUND THE GLOBE: WHARTON GLOBAL HEALTH VOLUNTEERS (WGHV) TACKLE HEALTH CHALLENGES IN INDIA AND BEYOND

Wharton Global Health Volunteers (WGHV) is a student-run organization that connects MBA students and opportunity-rich, resource-poor healthcare organizations in developing countries for semester-long, pro-bono consulting projects. The group's goal is to not only enrich the educational and professional experiences of students, but also to advance healthcare equity internationally. With careful project and team selection, along with the support of the Healthcare Management (HCM) advisors, the organization is committed to applying expertise to address pressing challenges faced by healthcare organizations globally.



Last semester (Spring 2024), WGHV partnered with two client organizations in Bangalore, India, to solve some of their most impactful business problems.

The first client, [Wysa](#), is focused on improving mental health for previously underserved groups through its app-based, artificial intelligence-supported chatbot that provides clinical-level mental healthcare. WGHV helped Wysa articulate its tech product offerings to a non-technical investor audience, refine the company's investor pitch to better capture the product value proposition, and assess the viability of entering new market segments in the U.S. and Europe. The WGHV team of four, led by Christian DiGiacomo (WG'25), was able to tackle these questions over the course of the semester, with the final segments of work completed live in Bangalore in May. Christian reflects on the experience, sharing "This project gave us the opportunity to work with a mature organization by WGHV standards and see their amazing technology first-hand. With so much of the Wysa team focused on day-to-day operations and near-term scaling, our team was able to add considerable value by helping them think about how to grow over the next five years and articulate their strategy and real AI prowess among the noise of new AI-focused start-ups."

The second WGHV project for Spring 2024 was with [Proactive for Her](#), a leading provider of women's healthcare services in Bangalore, India. Proactive for Her stands out for its holistic focus on women's health, providing a wide range of services including treatments for various conditions, lab tests and vaccinations, and access to experts such as fertility specialists. A WGHV team, led by Sara Meadow (WG '25) and Ivy Chen (WG '25) helped Proactive define a product strategy for planned and potential new product lines in the fertility and vaccine markets and identify expansion opportunities for new B2B partners and geographies. Sara describes that "Working with Proactive for Her was an incredibly rewarding experience that allowed us to explore growth and marketing strategies through the lens of a mission-driven organization. The experience helped Proactive develop valuable new strategies and test new social media marketing approaches in real-time with our team, and it gave our team firsthand insight into the complexities of scaling women's health and vaccine offerings in new markets."

In Fall 2024, WGHV expanded to four exciting projects. Starting in October, a team supported [CMMB Peru](#), a community-based NGO providing care to women and children, on market engagement and fundraising strategy. Another team will work with [Zoie Health](#), a South Africa-based digital platform providing a one-stop shop for all women's health needs, on market assessment and expansion strategy. A similar project around expansion planning and product marketing strategy will run in parallel in Egypt with [Almouneer](#), a health-tech platform targeting treatment of diabetes and obesity. Finally, a fourth WGHV team will work on operating model optimization with [MedsGo](#), a digital pharmacy services company focused on streamlining the acquisition of and improving access to pharmaceuticals.



From left to right: Achita Jacob (Proactive for Her), Juhee Cha (WG'25), Ivy Chen (WG'25), Sara Meadow (WG'25), Rachel Corbin (WG'25), Dhriti Kamat (WG'25), and Ayesha Bedi (Proactive for Her)

WGHV is fundraising to help students travel to the above four client sites to conduct on-site research and work hand-in-hand with teams in person. If you are interested in donating funds to make initiatives like these come true for students during the 2024-2025 academic year, please follow instructions below:

Instructions to donate by check:

Make check payable to "WGA", with "Wharton Global Health Volunteers" in the reference/memo field. Please note that it is imperative to ensure that your accounts payable department writes the check exactly in this manner or else it risks being applied to a different Wharton student club.

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- Please mail check to the following P.O. Box:

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P.O. Box 13387
Philadelphia, PA 19104

To Pay by Wire or ACH:

Please send payments directly to the Wharton Graduate Association's TD Bank account and include "Wharton Global Health Volunteers" and "226" in the reference area:

- Our corporate name is Wharton Graduate Association
- Our checking account# is 4420249347
- Our routing# for wire transfers is 031101266; for ACH is 036001808
- SWIFT code is NRTHUS33XXX
- Our branch address is:

TD Bank
3735 Walnut Street, Philadelphia, PA 19104
Phone: (215) 387-1000

Contact Christian at: cdigiac@wharton.upenn.edu



Source: [Bigstock](#)

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