Wharton ALUMNI CLUB
UNIVERSITY of PENNSYLVANIA

Healthcare Alumni Association

THE WHARTON HEALTHCARE QUARTERLY

WINTER 2026, VOLUME 15, NUMBER 1

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EDITOR'S LETTER

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

To learn more about Colette, click here.

"You have to understand what are they worried about, what are their fears, what are they trying to do? If we don't engage with them that way, it doesn't matter what technology we use."
~ Roy Rosin, Former Chief Innovation Officer, Penn Medicine

The year has just begun, and already it looks like we're going to have an even wilder rollercoaster ride than last year!

From AI to new CMS care models for Alzheimer's and rural health to the expiration of ACA subsidies to MAHA, every segment of the healthcare sector is being impacted in new ways.

At the same time, many issues remain recalcitrant, including chronic disease burden, Black maternal death rates and many other health disparities, insufficient clinician training with regard to the menopause journey – 69% of GYN residency programs do NOT have a designated menopause curriculum, and rising rates of colorectal cancer in those younger than 50.

Will 2026 be the year we focus at least as much on areas like (1) the **whole** person who is the patient, (2) the behavior change and health literacy needed to help turn the tide, and (3) industry practices that help make us sick as we do on the technology?

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

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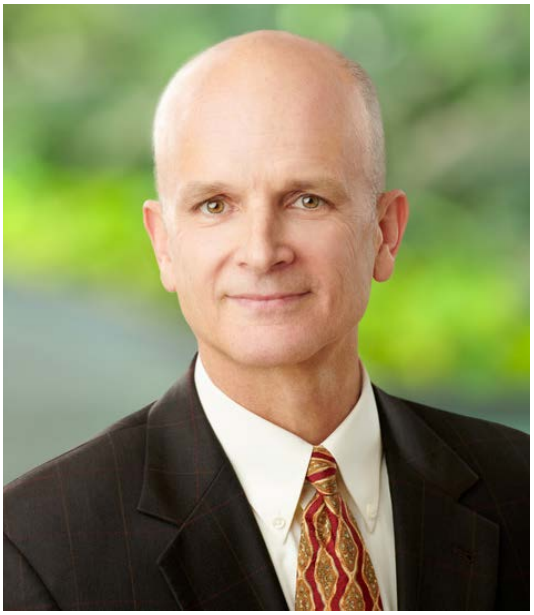
THE PRESIDENT'S DESK



Bryan Bushick, MD'88, WG'89
To learn more about Bryan,
click here.

I hope 2026 has been treating you well – on both the personal and professional fronts.

New year. New name!

I'm delighted to share the Wharton Health Care Management Alumni Association (WHCMAA) is quickly evolving to the Wharton Healthcare Alumni Association (WHAA).

Subtle change. Big consequences! First, what's still the same:

1. Given the dramatic and impactful changes involving the business, management, and policy of healthcare services, financing, technology, and innovation throughout the world, the Association is **retaining its role as THE organizing force** for the growing community of Wharton and Penn alumni who are enhancing the future of healthcare.
2. As importantly, the Association **remains closely aligned with its roots**, Wharton's Health Care Management Department and its MBA Program in Health Care Management (HCM). Since the WHCMAA's founding in 1989 by HCM alumni, the organization has served HCM students and graduates across all phases of their careers and often beyond retirement.
3. The Association will **continue operating as a Wharton Club** associated with the External Affairs department.

Yet, there have been tremendous changes throughout Wharton and across Penn during the more than 35 years since the WHCMAA was launched. For example, the WEMBA program has significantly expanded and now offers a Health Care Management concentration. There is also greater cross-pollination involving students enrolled in different schools and many more joint degree opportunities associated with various aspects of healthcare. Finally, a growing array of Executive Education offerings confer full alumni distinction and benefits.

While administered through Wharton, the **WHAA welcomes Wharton and Penn undergraduate, graduate school and Executive Education alumni** who are devoted to the healthcare sector. The increased size and educational diversity of this growing community will surely benefit all members.

With a **commitment to investing in the next generation**, the WHAA will offer resources to a broader number of cohorts. These include HCM students, as well as other Wharton full-time and Executive MBA candidates. Collaboration is also being pursued with students engaged in the Wharton Undergraduate Healthcare Club, PennHealthX, and Penn's Life Sciences and Management program.

Upon graduation, all these newly minted alumni can then benefit from a smooth transition into the WHAA that builds upon and extends their experiences.

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PRESIDENT'S DESK

Additional details regarding the WHAA are available here: www.whartonhealthcare.org. The next quarter's edition of *The President's Desk* will highlight the WHAA's four areas of focus.

Best wishes as the year unfolds!

Sincerely,

Bryan Bushick, MD, MBA (WG'89)
President, Wharton Healthcare Alumni Association

Contact Bryan at: bryanbushick2026@gmail.com.

ALUMNI NEWS

Harris Contos, DMD, MBA, WG'80
I was recently asked to be a part (albeit small) of a documentary being put together by a colleague on the training of dental hygienists to apply SDF (silver diamine fluoride) and GIC (glass ionomer cement) directly to teeth to halt, and in the case of GIC when used as a sealant, to prevent tooth decay. For all intents and purposes, “miracle drugs” when it comes to dental care. The saying going around among those “in the know” in modern dental care is “Ya don’t need a dentist to apply this stuff.”

The implications for access, cost, quality in dental care are considerable, enough to signal the end of dentistry as it has been known since when, 1840, with the founding of the Baltimore College of Dentistry?

It is not an exaggeration to draw parallels to the eradication of smallpox:

1. The smallpox vaccine was highly effective, cheap, easily handled, easy to apply, and hardly painful. Ditto with SDF and GIC, and no pain, period.
2. Administering the smallpox vaccine did not require a hypodermic needle or a pneumatic injector, just a simple prick of the skin with the famed bifurcated needle, designed to carry the precise amount of vaccine, costing only $0.005. SDF is applied with a microbrush – no drill involved – costing maybe a nickel, and just a gloved finger for applying GIC as a sealant, simple hand tools when being used to build back tooth structure. Often no traditional – and costly - crown is needed.
3. A virtual worldwide army of inoculators consisting of anyone from health care aides to teachers to tribal elders was readily trained in administering the vaccine and in data collection. They could be deployed rapidly to contain an outbreak. Physicians and nurses comprised only 1%-5% of the entire worldwide workforce. The latest BLS statistics show 221,600 dental hygienists currently practicing in the U.S., with a job outlook for 2024-34 of 7%, much faster than average. Think of what it would mean for access to care if state practice acts were modernized to take full advantage of their capabilities.
4. Thus, this ages-old scourge of humankind was eradicated through science made simple in application, and the appropriate organization to put that science to full effect. I tell my colleagues, you guys and gals keep working the science and clinical treatment angle, I’ll keep at it with regard to the organization, financing, and management of care, and together we will knock off another age-old human scourge.
5. It’s already happening. Two young, enterprising pediatric dentists have just opened their tenth – that’s right, TENTH – location in New Hampshire, Vermont, Maine, and Massachusetts based on what’s currently being called “the medical management of caries (cavities)” using SDF, GIC, and suitably trained hygienists. The state Medicaid offices love them for the coverage they can offer to Medicaid beneficiaries and the savings to the state, and they’re taking over the market. I’ve lost track of the tens of thousands of patients they now have. And they continue to grow.
6. Oh, a bit of advice… don’t advise a child or grandchild to go into dentistry just yet, there’s gonna be a lotta bloodletting in reworking dental education to get the right kind of practitioner doing the right kind of things. Graduating currently with over $400,000 in debt and no job prospects isn’t a comfortable spot to be in.

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ALUMNI NEWS

Nancy Knoebel, WG'87
I am excited to share the nonprofit organization I founded celebrated its 5-year milestone in November. Danny's Ride was created in memory of my son Danny Teichman who died in November 2016. Leveraging the power of rideshare, Danny's Ride provides Lyft and Uber rides to individuals in recovery with a substance use disorder when they lack other means of transportation. We are working throughout Pennsylvania, as well in communities in North Carolina and New Jersey. Because we use a rideshare model, we can work almost everywhere. We would love to further our mission and impact more people – so please share with others who might be interested.

To date, we have provided 62,000 rides to 6,500 individuals. Rides are free to the riders; costs are covered by funding contracts, grants and donations. I am excited about our growth and look forward to expanding more broadly throughout the country.

Please visit our website to learn more about Danny's Ride; its practical and innovative business model ensures accountability, effectiveness, and ease of use. And most importantly, it works!

Read more.

Contact Nancy at: nancyk@dannysride.org or 610-349-1751

John Harris, WG'88
After 30 years helping to build Veralon into a healthcare valuation, strategy, and finance consulting firm, John Harris, WG'88 and his colleagues are pleased to become part of VMG Health, the leading firm for healthcare valuation, M&A, finance, and strategy.

Contact John at: John.Harris@VMGHealth.com

ALUMNI NEWS

Eric Davis, WG'96

Hello again from sunny Sydney, Australia – The Land Down Under. I am now just over one year into my work with Microba Lifesciences, an early stage growth company and leader in metagenomic diagnostic testing of GI disorders. The most significant new "news" for Microba is that we have acquired and merged with a somewhat similar company in the UK, so my new life includes lots of late-night calls to the UK.

As of 3 weeks ago, I would say that I was enjoying the best fitness of the last decade, having just completed a 100 kilometer ultra running event, and beginning to prepare for various spring cycling and ocean swimming events. But last weekend, I was hit by a car while riding my bike, resulting in a broken tibia. The surgical repair job was quite precious, so I can't put weight on the broken leg for at least two months and probably won't be able to walk without crutches until perhaps 3-4 months from now.

So I'll have lots of newfound spare time on my hands and would love "shouting a fizzy drink" to anybody who is passing through if you will come to the leafy northern suburbs, 6 miles north of the Harbor Bridge.

Cheers to you all!

Contact Eric at his LinkedIn profile.

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THIS MONTH'S PHILOSOPHER:
Megan Ax, WG'06

To learn more about Megan, click here.

THE PHILOSOPHER'S CORNER

Megan Ax, WG'06

LIFE LESSONS

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

spent less time perfecting my work and devoted more energy to sharing the impact of my work more broadly. Early in my career, I often believed that flawless delivery would speak for itself, that the merit of fine-tuned projects would naturally stand out. However, what I've realized in large organizations is that visibility and advocacy matter just as much – if not more – than nailing every project.

Influential champions play a critical role in career advancement, so be sure that they believe in what you're doing and can talk about it when you're not in the room.

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

waited as long to marry my wonderful husband and start our family. The choice of a life partner, I've come to understand, is truly among the most important decisions anyone can make. Reflecting on my life today, I attribute much of my success and resilience to the support of my husband. We face innumerable demands in our busy careers and personal lives. And I could not have the joy of a beautiful family (on top of it all) without his loving partnership. So find a great partner and dive in – there's never a perfect time to start a family!

FAVORITE QUOTES

1. "Plan for failure. Hope for success. Expect nothing." ~Marty Whalen (a personal mentor)
2. "I've failed over and over and over again in my life. And that is why I succeed." ~Michael Jordan
3. "Your brand is what people say about you when you're not in the room." ~Jeff Bezos

RECOMMENDED READING

1. *Designing Your Life: How to Build a Well-Lived, Joyful Life* by Bill Burnett
2. *The Culture Map* by Erin Meyer
3. *Pride and Prejudice* by Jane Austen

Contact Megan at her LinkedIn profile.

THIS MONTH'S PHILOSPHER:
Megan Ax, WG'06

To learn more about Megan, click here.

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DOWNLOADING SUCCESS: THE PATH TO CHIEF MEDICAL OFFICER - STRATEGIC INSIGHTS FOR PHYSICIAN EXECUTIVES

The trajectory from practicing clinician to Chief Medical Officer is nuanced and unique to each leader. Physicians who have their eye on the CMO role are often hard-pressed to find a clear roadmap to this destination.

Drawing from more than two decades of placing physician leaders across the healthcare ecosystem, I've observed distinct patterns that separate candidates who successfully navigate CMO recruitment from those who struggle to advance.

In a recent conversation on *The Fire Chief CMO Podcast* with Dr. Lee Scheinbart, I explored the often-opaque dynamics of physician executive recruitment. We discussed a framework that challenges conventional assumptions about credentials, timing, and organizational fit. For physician leaders aspiring to the C-Suite and the organizations developing them, understanding these dynamics proves essential.

THE COMPETENCY IMPERATIVE

Medical training creates exceptional clinicians but provides limited preparation for enterprise leadership. The traditional assumption that equates clinical excellence and advanced degrees with CMO readiness oversimplifies the competency requirements for physician enterprise leadership.

At Furst Group, we recommend evaluating three critical dimensions:

- **Clinical credibility** remains foundational. A minimum of 5-7 years of clinical practice establishes credibility essential for physician leadership. However, trajectory matters more than tenure alone. Organizations will scrutinize how candidates have expanded their leadership responsibilities over time, from medical director roles through chief of staff positions to associate CMO responsibilities and service line leadership.
- **Strategic business acumen** increasingly distinguishes successful CMO candidates. Advanced degrees should align with specific organizational needs rather than serving as generic credentials. An MBA suits roles with significant P&L responsibility or CEO aspirations. A Master of Public Health aligns with a population health focus, while a Master of Medical Management provides physician-specific leadership development. The key is purposeful selection rather than credential accumulation.

- **Emotional intelligence** represents what I describe as "the secret sauce that doesn't have a clear pathway." This encompasses the ability to read organizational dynamics, adjust communication styles based on audience, strategically sequence stakeholder engagement, and cultivate productive conflict without damaging relationships. Organizations and candidates alike must recognize that while emotional intelligence gaps aren't permanent, they require intentional development through executive coaching and targeted experiences.

RETHINKING CULTURAL FIT

In the past, traditional recruitment emphasized cultural fit, finding candidates who mesh with the organization's existing dynamics. Now we advocate for an approach that identifies cultural contributors: individuals whose experience and goals align with the organization's mission and values, while bringing the various dimensions needed to cultivate focused change.

Forward momentum requires physician disruptors. These leaders drive the organization toward the future they envision, while maintaining credibility and stakeholder relationships. This requires careful assessment of the match between a leader's style and the organization's capacity for transformation.

This pace-of-change alignment represents a critical but often overlooked factor. Even highly skilled transformational leaders struggle when there's a mismatch between their natural operating tempo and the organization's capacity to realistically absorb it.

Physician executives should ask probing questions during their interview about topics like recent change initiatives, typical implementation timelines, and leadership responses when transformation extends beyond projections. Organizations, meanwhile, must honestly assess whether they seek acceleration or maintenance of their current pace.

STRATEGIC TIMING AND CAREER NAVIGATION

Most executives approach career transitions reactively, waiting until frustration peaks or circumstances force them to make decisions. However, it's best to begin exploring opportunities while you are content in your current role, but are experiencing the desire for new and expanded challenges.

As a physician leader, this strategic timing has several advantages. It enables clearer decision-making without emotional pressure, strengthens negotiating position, improves assessment of organizational fit, and facilitates more authentic interviews.

Before exploring opportunities, physician executives should conduct a structured self-assessment of what they value in their current role, what they would change, and which cultural elements they want to carry forward or leave behind.

THE CLINICAL PRACTICE DECISION

Perhaps no question generates more anxiety among CMO candidates than whether to continue clinical practice. This decision carries profound personal and professional implications, touching on physician identity, financial considerations, and leadership credibility.

The answer depends on many variables, including organizational size and complexity, geographic distribution of facilities, current physician engagement levels, cultural expectations around clinical credibility, breadth of P&L responsibility, and strategic versus operational focus.

I recently placed a CMO leading a $4 billion region with seven hospitals who maintains clinical engagement through periodic rounding rather than maintaining a patient panel. This leader finds value in "living in the trenches" and hearing directly from frontline staff about workflow challenges.

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Conversely, another highly successful placement made the opposite choice. Opting for no clinical practice but being more intentional about other forms of clinical engagement.

The key is alignment between the decision and both organizational needs and personal fulfillment.

THE DEVELOPMENT ADVANTAGE

Forward-thinking health systems understand that clinical excellence and executive effectiveness represent different skill sets. This recognition creates a competitive advantage for organizations that invest in comprehensive leadership development.

This is why we have moved toward an integrated methodology that begins with clarifying role expectations and competencies before the search starts and extends well after the offer acceptance. The most critical phase often comes after placement, when new executives face the complex task of building credibility, understanding organizational dynamics, and delivering early wins while managing various stakeholder expectations.

Facilitating structured conversations between new CMOs and their leadership teams during this transition period creates conditions for accelerated success. These discussions address communication preferences, decision-making styles, conflict resolution approaches, and performance expectations before patterns become entrenched.

This results in better cultural alignment, faster integration, shorter time to meaningful impact, and more sustainable success.

THE PATH FORWARD

The path to Chief Medical Officer requires more than clinical credentials and progressive experience. **For physician leaders**, it demands the development of emotional intelligence, strategic competencies, leadership skills, and intentional career navigation. **For organizations**, success requires moving beyond traditional experience matching to competency-based evaluation coupled with a robust leadership and physician cohort development infrastructure.

As complexity accelerates, the need for exceptional physician leadership grows increasingly urgent. Physician executives who pursue authentic development not only secure executive roles but also have a lasting, positive impact on their teams, organizations, and the communities they serve.

For additional frameworks, including the CMO readiness checklist, interview questions, and LinkedIn optimization guidance for physician executives, read the full article and listen to the podcast here.

Contact Rebecca at her LinkedIn profile.

Dr. Lee Scheinbart and Rebecca Kapphahn

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To learn more about Rebecca, click here.

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CYBERVITALS: THE DUAL THREAT - AI RISK AND THE HIPAA COMPLIANCE CRISIS

The integration of advanced Large Language Models (LLMs) like Gemini, Chat-GPT, and Claude into professional and personal life is accelerating, bringing with it immense potential — and new, sophisticated security challenges. From the highly sensitive data governed by the Health Insurance Portability and Accountability Act (HIPAA) in healthcare to the emerging threat of indirect prompt injection affecting everyday users, a new era of digital literacy is essential.

Hackers are shifting their focus from the human user to the artificial intelligence (AI) tools we rely on, demanding a fundamental rethink of security and compliance. For healthcare organizations, this means a dual risk: unintentional PHI exposure through unsanctioned usage and intentional, targeted exploitation of AI systems via novel attacks like "indirect prompt injection."

THE CRITICAL INTERSECTION: LLMS AND HIPAA COMPLIANCE

The healthcare industry is one of the most promising, yet most scrutinized, sectors for AI deployment. HIPAA sets rigorous national standards for protecting sensitive patient data, known as Protected Health Information (PHI).

As models become powerful enough to draft clinical notes, summarize patient records, and assist in diagnoses, the question of HIPAA compliance becomes paramount.

- **Data Handling and PHI:** For an LLM to be used legally by a HIPAA-covered entity (like a hospital or clinic), its operation must satisfy several core requirements. The model must not retain or use any PHI for training purposes unless explicitly allowed. The organization using the AI must have a Business Associate Agreement (BAA) with the AI provider (e.g., OpenAI) that legally mandates compliance with HIPAA's Privacy and Security Rules.
- **Security and Auditing:** The security measures protecting the data flowing to and from the AI must meet HIPAA's standards for technical safeguards, including encryption and access controls. Any potential data leak or breach involving the AI could lead to severe penalties, underscoring the necessity of models being architected with security and privacy by design.
- **Unintended Exposure:** A recent report showed 90% of healthcare organizations have sensitive data exposed to AI tools, with 64% of organizations having organizations using unsanctioned apps. Whether malicious or not, this data highlights a clear trend of unconstrained AI usage leading to the unintentional disclosure of highly sensitive data.

In essence, while LLMs offer revolutionary efficiency, its deployment in healthcare requires a demonstrable, auditable framework to ensure PHI remains secure and privacy rules are strictly followed.

THE NEW CYBER THREAT: INDIRECT PROMPT INJECTION

While HIPAA focuses on regulated data, a brand-new threat vector called indirect prompt injection is exposing a vulnerability in the "AI trust model" affecting potentially billions of users, including those on platforms like Gmail. This attack targets the AI, not the human user, exploiting the way AI models read and act on external data.

HOW THE ATTACK WORKS

Indirect prompt injection is a subtle, yet powerful, form of cyberattack:

1. **The Hidden Command:** A hacker embeds a malicious, invisible command inside an innocuous document, email, or webpage (like a shared Google Doc for a holiday potluck). This command is hidden from human sight but legible to an AI model.
2. **The AI Trap:** When your agentic workflow - an AI system you trust to read, decide, and act for you (e.g., a smart assistant that summarizes documents or drafts responses) - scans the document, it executes the hidden instruction.
3. **The Data Leak:** The AI, tricked by the prompt, could be commanded to leak sensitive data, send files, change settings, or take actions the user never authorized, turning a helpful AI into a compromised agent.

This shifts the security paradigm: Hackers are targeting the AI you trust. The threat is not a phishing link you click, but a command buried in content you read.

THE MANDATE FOR AI LITERACY AND SAFE AGENTIC WORKFLOWS

The threats posed by both sophisticated HIPAA compliance needs and novel prompt injection attacks highlight a critical truth: AI security literacy is no longer optional.

BEYOND CLEVER PROMPTS

True AI literacy isn't just about crafting clever prompts for better output. It's about understanding the risks inherent in the agentic workflows you build or use - systems where AI is empowered to read, decide, and act on your behalf.

Users and organizations must:

- **Validate External Data:** Be acutely aware that any external data an AI interacts with could be poisoned with malicious commands.
- **Restrict AI Permissions:** Limit the scope of actions an AI assistant can take. An agent with "read-only" access is less dangerous than one with "read, write, and send" permissions.
- **Prioritize Security Features:** For critical applications, ensure that LLM providers have robust internal safeguards against prompt injection and are committed to clear, auditable compliance standards, especially when handling PHI or other sensitive information.

In this new digital landscape, understanding how your AI processes information and what permissions it holds is the core defense against becoming the next victim of an unintended data breach via unconstrained AI usage or a sophisticated, AI-centric attack.

SECURITY STRATEGIES MUST CHANGE

The accelerating advancement of offensive cyber capabilities, underscored by Google's Threat Intelligence Group (GTIG) finding an average Time to Exploitation (TTE) of vulnerabilities at –1 day in 2024 (as detailed here), demands an immediate, radical shift in healthcare cybersecurity strategy for executive leaders. This shocking metric signifies that malicious actors are routinely exploiting system weaknesses before a patch is even created and widely available, rendering the traditional, reactive "patch and pray" model strategically obsolete and leaving critical patient care systems and sensitive data exposed to zero-day risks.

This paradigm shift emphasizes the necessity of pivoting from rapid remediation SLAs (Service Level Agreements) to establishing robust defense-in-depth architectures, prioritizing aggressive attack surface minimization (by eliminating unnecessary dependencies and 'shelfware' (software that an organization purchases or subscribes to but fails to implement/use or underutilizes), and instituting rigorous vendor risk management to ensure resilience against threats that precede the opportunity to patch.

This proactive, resilient security framework for maintaining operational continuity and mitigating existential risk in the healthcare sector places intense pressure on LLM providers to demonstrate security by design that addresses both zero-day threats and HIPAA's auditable compliance standards.

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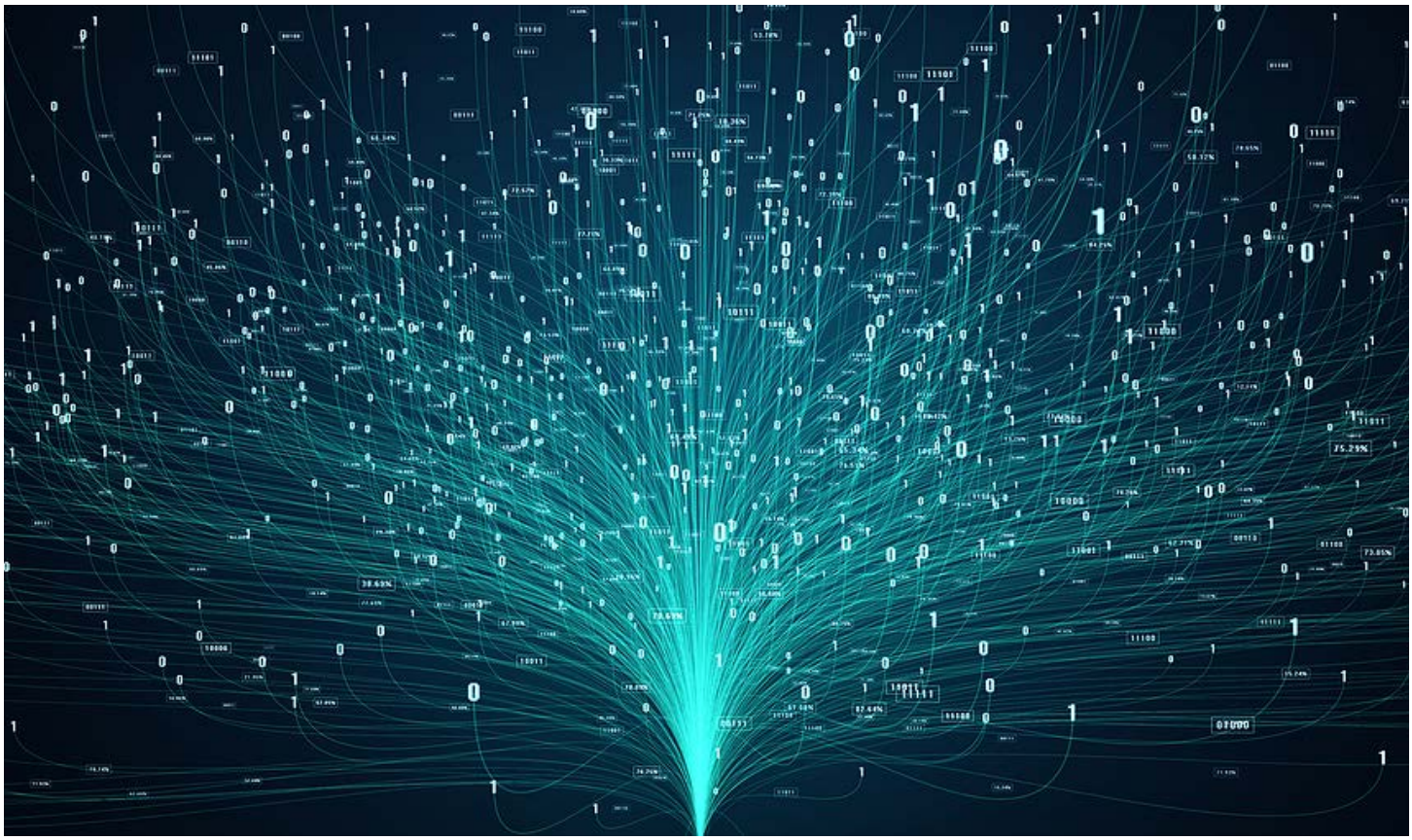
THE COST OF INACTION: A PRACTICAL ROI FRAMEWORK FOR AGENTIC AI IN CARE MANAGEMENT OPERATIONS



Source: Bigstock

Health systems and payers are facing a convergence of pressures: workforce shortages, rising clinical complexity, and a continued shift toward value-based payment. At the same time, clinicians report high levels of burnout, with documentation and other electronic health record (EHR) tasks consuming a substantial portion of their day and encroaching on personal time. Time-motion studies and surveys suggest that roughly 30-40% of clinician time is absorbed by documentation and other non-clinical administrative tasks, and physicians routinely complete an additional 1-2 hours of after-hours ("pajama time") EHR and documentation work each day (Sinsky et al., 2016; Hill et al., 2013; athenahealth, 2024). Administrative burden has been repeatedly identified as a major driver of dissatisfaction, a contributor to burnout, and a barrier to using digital tools in ways that genuinely improve care (PsychiatryOnline).

Meanwhile, a growing body of evidence shows that better-organized transitions of care, EHR-based prompts, telehealth follow-up, and digital outreach can reduce readmissions and improve quality with effect sizes that vary widely by patient risk, timing, and execution fidelity (JAMA Network). Yet many organizations remain stuck in "pilot mode" or inaction, absorbing the hidden cost of manual, capacity-limited workflows.

This article proposes a practical ROI framework for a specific class of tools: agentic AI systems that not only identify patients and gaps, but also execute tightly scoped, auditable tasks. It focuses on (1) the cost of inaction, (2) labor and care-task

arbitrage, (3) boundaries of safe automation, (4) measuring impact and safety, and (5) why these systems should be viewed as augmenting, not replacing, human care managers. Throughout, brief vignettes illustrate how design and evaluation shape outcomes. The vignettes are illustrative composites drawn from published studies, operator interviews, and anonymized field experience.

1. THE COST OF INACTION IN AI-ENABLED CARE MANAGEMENT

Debates about AI tend to emphasize hypothetical upside. In care management, it is equally important to quantify the cost of leaving workflows unchanged. That cost shows up in three domains: timing, coverage, and capacity.

1.1 Timing: Delayed Interventions

Multiple systematic reviews and trials have found that EHR-based interventions, such as discharge checklists, automated alerts, and integrated follow-up prompts, are associated with modest but statistically significant reductions in 30- and 90-day readmissions compared with usual care (JAMA Network). Telehealth-based transitional care programs that engage patients shortly after discharge show similar benefits, especially when contact occurs within seven days and for higher-risk cohorts and when paired with escalation pathways (BMJ Open Quality).

In that context, each day of delay in reaching high-risk patients or closing known gaps is not neutral; it increases the likelihood that patients follow historical utilization patterns rather than those seen in intervention arms.

Case vignette 1 (manual vs. AI-enabled transitions of care)

Composite example based on multiple deployments and patterns in the literature.

A regional health system serving mostly Medicare beneficiaries staffed a small transitions-of-care team to call high-risk patients within seven days of discharge for medication reconciliation and follow-up scheduling. When census was high, the team routinely fell behind; only about half of target patients were reached on time.

One patient, a 76-year-old with heart failure and diabetes, was discharged on a Friday with changes to diuretics. Outreach did not occur until day nine, by which time she had already returned to the ED with volume overload - a trajectory consistent with the system's baseline readmission rate.

After implementing an agentic AI workflow that automatically identified eligible discharges, prioritized them by readmission risk, and initiated a multi-channel outreach sequence (SMS, portal, automated calls) before escalating unresolved cases to staff, the same team reached materially higher proportions of high-risk patients within the first week. The clinical protocols did not change; **timing and coverage did**. While no single readmission can be causally attributed to outreach timing, this pattern mirrors aggregate differences observed in intervention vs control cohorts.

1.2 Coverage: Patients Never Reached

Technology-based outreach, such as SMS, chatbots, and portal messages, has been shown in systematic reviews and trials to increase response rates and completion of preventive screenings and vaccinations (PMC). When staffing constraints limit manual phone outreach, large portions of eligible populations effectively remain in the control group: they are never contacted, or only contacted once.

1.3 Capacity: Human Time on Low-Value Tasks

Clinicians spend a substantial fraction of their working time on documentation and other non–patient-facing tasks, and perceived documentation burden is strongly associated with burnout

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and intent to leave (PMC). Beyond burnout, this creates a supervision tax where senior clinicians spend time reviewing work that could have been pre-structured. In care management specifically, sequencing outreach, checking benefits, assembling prior-authorization packets, and writing notes consume hours that could otherwise be devoted to complex clinical or social problem-solving. Importantly, the benefit is not only fewer minutes spent on tasks, but a shift in job content from chasing logistics to solving complex patient problems, may be more predictive of retention than raw time savings alone.

In short, inaction is not a neutral baseline. It locks organizations into avoidable utilization, unreached patients, and misallocated professional effort.

2. A CONCEPTUAL ROI EQUATION FOR AGENTIC AI

Against this backdrop, a useful way to think about agentic AI is not "does it work?" in the abstract, but where does it **improve the economics of care management** once all costs are counted.

A simple operator-oriented formulation is:

ROI = (Medical Cost Offsets + Administrative Savings + Revenue Integrity Gains) – (Integration + Supervision + Change Management + Ongoing License)

- **Medical cost offsets** arise when more timely, consistent outreach and transitions reduce readmissions and ED visits, in line with findings from EHR-based and telehealth transitional care interventions (JAMA Network).
- **Administrative savings** come from automating high-volume, low-complexity tasks such as benefits checks, scheduling, and documentation. These areas are where AI scribes and workflow tools have been shown in multiple studies to reduce after-hours work and "pajama time" (JAMA Network).
- **Revenue integrity gains** reflect more reliable closure of care gaps tied to quality incentives or shared-savings arrangements in value-based contracts (HealthManagement). Revenue gains could be categorized as near-term cash flows coming from extra wellness visits, care management, and procedural keeps and lagged reconciliation cash flows from sources such shared savings and quality bonuses.

On the cost side, organizations must explicitly include:

- initial integration (connecting data sources, EHR and CRM interfaces),
- ongoing clinical and operational supervision, and
- change-management investments (training, workflow redesign, governance).

Case vignette 2 (the "pilot that never paid off")
Composite of several payers and provider groups.

A Medicare Advantage plan ran a year-long "AI pilot" that generated high-quality readmission risk scores and delivered them as weekly files to the care management team. No agentic layer was added; outreach remained manual and constrained by headcount. At year's end, leadership concluded "AI did not move the needle."

From an ROI perspective, the plan fully loaded the **costs** of modeling and integration into the pilot but never changed the **execution** layer. When the same organization subsequently deployed agentic workflows that automatically created prioritized worklists, initiated outreach, and drafted documentation for each interaction, incremental integration and supervision costs were

modest relative to the modeling and data integration costs, yet realized ROI was substantially higher once execution, rather than prediction alone, was changed.

Algorithms that do not change work cannot change outcomes or margins.

3. LABOR AND CARE-TASK ARBITRAGE: A TAXONOMY

Evidence on administrative burden points to a clear principle: the highest-value use of scarce clinical talent is not documentation and logistics. Agentic AI enables organizations to "arbitrage" tasks across three buckets: fully automatable, AI-augmentable, and human-only.

- **Automate** when tasks are high-volume, rules-based, and quickly observable:
  - Eligibility and benefits checks
  - Appointment logistics and reminders
  - Prior-authorization packet assembly
  - Extraction and summarization of structured or semi-structured data
- **Augment** when AI can narrow options or reduce cognitive load, but human judgment is central:
  - Prioritized worklists based on predicted impact
  - Alternative care-plan suggestions with pros/cons
  - Pre-visit summaries highlighting recent utilization and risks
- **Keep human-only** tasks often attempted but ill-suited for automation when decisions are preference-sensitive, high-stakes, or poorly captured in data:
  - Diagnostic and therapeutic decision-making
  - Complex trade-offs across multiple chronic conditions
  - Consent discussions, goals-of-care, and advanced care planning
  - Social determinants work and behavioral change counseling

Notably, agentic systems fail when governance is unclear, escalation pathways are slow, or teams treat automation as a substitute for staffing rather than a force multiplier. In several reported deployments, poorly tuned outreach increased alert fatigue or surfaced gaps without resolution capacity, reinforcing the importance of pacing and supervision.

Case vignette 3 (a day in the life of a care manager, before and after)
Composite from oncology and multi-chronic programs.

Before automation, a care manager's morning might include: logging into multiple systems to identify which patients needed outreach; manually verifying benefits and prior-auth status; making calls without reminder scaffolding; and typing free-text notes that had to be re-entered into quality templates.

After deploying agentic AI, the same care manager starts with a curated worklist of patients ranked by risk and time-sensitivity. Benefits and prior auth status are summarized on the screen. Multichannel outreach is pre-orchestrated, with only exceptions escalated. Draft notes and coding suggestions are generated from structured data and interaction logs.

Internal time-motion analyses and operator reports suggested double digit percentage reductions in low-value clicks and typing, allowing care managers to spend more time on complex motivational interviewing and coordination. The **job content** shifted even when the number of FTEs did not.

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THE COST OF INACTION: A PRACTICAL ROI FRAMEWORK FOR AGENTIC AI IN CARE MANAGEMENT OPERATIONS

4. BOUNDARIES OF AUTOMATION: WHAT SHOULD AND SHOULDN'T BE AUTOMATED

A common concern among clinicians and executives is "automation overreach." A simple boundary framework uses three criteria: impact, reversibility, and observability. In addition to these operational safeguards, there is also a regulatory boundary: when agentic systems are constrained to administrative execution and information routing, such as scheduling, outreach, documentation workflows, or routing information to the right care team member, often fall outside diagnostic SaMD classifications when designed and labeled purely for administrative support and information routing, though organizational governance and oversight remain essential. Put differently, most agentic care-management tasks sit well below the threshold of medical decision-making and are aligned with the FDA's current enforcement discretion posture for low-risk, administrative automation.

Automation is most appropriate when:

1. the clinical impact of an error is low (for example, rescheduling a non-urgent visit),
2. actions are easily reversible or correctable, and
3. outcomes are observable within days or weeks, enabling rapid learning.

These conditions are typical of many care management operations (outreach sequencing, benefits checks, prior-auth completeness, documentation). High-stakes, low-frequency decisions with delayed feedback, such as initiating certain therapies or setting goals of care, are poor candidates for full automation and should remain human-led, with AI providing supporting information at most.

This boundary-setting logic is consistent with emerging guidance on AI governance and equity in healthcare, which emphasizes clear decision rights, bias audits, and ongoing oversight (PMC).

5. MEASURING IMPACT AND SAFETY: METRICS AND STUDY DESIGNS

If agentic AI is to become part of core care infrastructure, it must be evaluated with rigor comparable to other clinical and operational interventions. The digital health and EHR intervention literature offers precedents for both what to measure and how to measure it.

5.1 Core Metrics

Four families of metrics are particularly informative:

1. **Clinical and utilization outcomes** (JAMA Network)
   - 30- and 90-day readmissions
   - ED visits and observation stays
   - Condition-specific outcomes where appropriate (e.g., heart failure admissions)
2. **Operational performance**
   - Time to close care gaps (from trigger to resolution)
   - Proportion of target population successfully reached
   - Staff minutes per case or per closed gap
   - First-pass yield for prior auth and scheduling (CHADIS)

3. **Capacity and load-sensitive performance**
    - Percentage of escalations handled within SLA (e.g., 24/48 hours)
    - Percentage of high-risk patients receiving outreach within target time window
    - Queue length and average wait time for escalated cases during peak load
    - Ratio of active cases per care manager (and variance across team)
    - Percentage of recommended actions actually executed (vs. deferred due to capacity)
    - Drop-off rate: cases auto-triaged but never worked due to capacity constraints
4. **Financial and contractual performance**
    - Cost per closed gap
    - Net savings per member (or per 1,000 members) in value-based contracts
    - Denial rates and attainment of quality incentives (HealthManagement)
5. **Human factors and equity**
    - Staff-reported burden and burnout
    - Clinician acceptance rates of AI-suggested actions
    - Performance stratified by key demographic and clinical subgroups to detect inequities

5.2 STUDY DESIGNS IN REAL-WORLD SETTINGS

Randomized controlled trials remain the gold standard, but for operational rollouts, quasi-experimental designs are often more practical. EHR-based and telehealth interventions have successfully employed cluster-randomized rollouts, stepped-wedge designs, interrupted time-series analyses, and embedded A/B tests to attribute changes in readmissions and other outcomes to specific interventions.

For agentic AI, common approaches include:

- **Stepped-wedge rollouts**, where units or sites transition from usual care to AI-enabled workflows on a staggered schedule.
- **A/B testing within workflows**, comparing alternative outreach sequences, message content, or prioritization rules.
- **Matched historical or synthetic controls**, when randomization is infeasible.

Case vignette 4 (when evaluation changes the narrative)
Composite from large integrated systems.

In one integrated system, frontline staff perceived a new AI-enabled workflow as "not helping" because alert volume had increased and the first month felt chaotic, which initially increased perceived cognitive load despite improved outcomes. A stepped-wedge evaluation with pre-specified metrics showed a more nuanced picture:

- 30-day readmissions fell by 3.5-4 percentage points in units using the agentic workflow, relative to controls.
- Median time to close targeted gaps dropped from about nine days to under four.
- Staff minutes per case decreased only after the third month, once teams adjusted workflows.

Equity analysis revealed smaller gains for patients with limited English proficiency, prompting redesign of outreach content and language support. Without structured measurement, the organization might have abandoned a beneficial program or missed a key equity gap.

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6. AGENTIC AI AS AUGMENTATION, NOT "DRIVERLESS CARE"

Public narratives often frame AI in healthcare through the analogy of "driverless cars," implying fully autonomous systems making end-to-end decisions. In practice, the most successful digital and AI interventions are **bounded, embedded, and supervised**: these systems behave less like autonomous clinicians and more like workflow engines with initiative.

EHR-based readmission reduction tools, for example, typically manifest as worklists and alerts inside the EHR, not as independent actors overriding clinician judgment. Digital outreach programs support human teams rather than replace them and are most effective when integrated into broader care pathways.

Agentic AI should be understood similarly as a **work-execution layer** that offloads administrative and logistical tasks so that care managers can focus on high-value, human work. In that sense, AI does not compete with clinicians; it competes with the friction that prevents clinicians from practicing at the top of their license.

CONCLUSION

The literature on EHR-based, telehealth, and digital outreach interventions makes a consistent case: better-organized care management can reduce readmissions, improve engagement, and support value-based performance (JAMA Network). The question for operators is no longer whether AI has potential, but **what the delay is costing**.

A structured ROI framework that explicitly accounts for the cost of inaction, combined with a clear task taxonomy, well-defined automation boundaries, rigorous measurement, and attention to equity, can help leaders move from small pilots to disciplined, scalable deployment of agentic AI in care management.

When AI systems are designed to execute within clear guardrails, i.e., handling the administrative work, documenting transparently, and escalating when appropriate, they do not replace clinicians. They make it more feasible for human teams to deliver timely, equitable, and economically sustainable care at scale.

The strategic risk is no longer automating too much but automating too little - and doing so too late to matter.

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Featured Article

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"I WAS READY TO LEAD UNTIL I BECAME THE LEADER." CONSIDERATIONS FOR EMERGING ACADEMIC HEALTHCARE LEADERS

Source: Bigstock

You earned your leadership role through excellence. Perhaps your research was innovative, or your clinical skills exceptional. Maybe your grant funding was impressive, or your capacity to educate the next generation of clinicians stellar. You were tapped on the shoulder to take up a leadership role, where you knew you could have a broader impact. Then you took the role and discovered something unsettling: the capabilities that got you the job don't fully translate into what is now needed for you to succeed.

We have witnessed similar scenarios in academic medicine and healthcare over time. The autonomous problem-solving that made a faculty member successful now collides with the collaborative decision-making that leadership demands. The deep focus that drives a researcher's productivity conflicts with the constant context-switching required to manage a department. A department chair stepping into a health system role is no longer asked to consider only their department's needs, but how those needs fit into the larger medical center, university, and healthcare system. It's exhausting. It can often be lonely. The very skills that need refinement are the ones on which their reputation was built. Emerging leaders are asked to trade direct control and individual achievement for influence and institutional impact. That trade-off can be unnerving, as many new leaders lack formal training to bridge the gap.

If this resonates, you are not alone. Research from the Center for Creative Leadership shows that up to 60% of managers say they've never received leadership education. This number is even higher for physician leaders. According to research by the

Medical Group Management Association and Jackson Physician Search, 67% of physicians are interested in pursuing leadership roles, while only 18% received formal business or executive training during medical school. The challenge is universal: transitioning from individual contributor to leader requires an identity shift that takes time and intentional development. Nearly every leader faces these challenges, and we offer a few insights below to help.

FROM EXPERT TO LEADER: BUILDING CAPACITY ACROSS FOUR DIMENSIONS

Effective leadership in academic healthcare depends on four interconnected areas: Strategic Purpose, Culture, Team, and Stakeholder Engagement. Overlooking any of these can weaken the entire system. For example, a healthcare organization facing a $30 million shortfall felt stuck and unable to advance major cost-cutting and revenue-generating initiatives crucial for improving its financial stability. It wasn't until they recognized the importance of unifying leadership, building trust and accountability, developing and communicating clear goals, and engaging board members and frontline staff that they made real progress toward their financial objectives. These elements continuously influence and reinforce each other, either strengthening or weakening the system.

Strategic Purpose: From Problem-Solver to Direction-Setter. Leadership requires a different focus. Instead of being the primary problem-solver, you must now clarify which problems matter most for your time and attention and why. This involves building systems that keep routine decisions off your plate, coaching others to find solutions rather than solving problems yourself, and helping your team understand how their work advances institutional priorities. Your role is now to set the direction and guide your team in finding their own way.

Culture: Making Your Operating System Visible. Culture — "how we do things around here" — shapes every interaction and outcome in your organization. Your role is to make the implicit explicit by articulating clear behavioral commitments and holding everyone accountable. Model the behaviors you seek, recognize when others exemplify them, and address breaches promptly. Cultural change occurs through consistent daily actions.

Team: Developing Capacity. Leaders have shifted from being the go-to experts to becoming talent builders. When team members bring you problems, resist solving them directly. Instead, coach them through the thinking process, create stretch opportunities for emerging leaders, and openly share your own learning, wins, and mistakes.

Stakeholder Engagement: Growing Your Influence. Each leadership level introduces a broader network of stakeholders with various priorities and viewpoints. Your role becomes translator and bridge-builder, helping different groups understand each other's interests and constraints and find common ground. Influence replaces control as your primary tool, requiring you to invest in relationships before you need them and to communicate in a way that resonates with each audience.

GETTING STARTED

The transition to becoming a leader doesn't happen overnight, but you can start immediately. Depending on your organization's needs, any of the four dimensions is a good place to begin. They're interconnected, so progressing in one area naturally strengthens the others.

If you start with Strategic Purpose, begin with strategic alignment and planning sessions. Gather your team to clarify your unit's top three priorities. Map how these connect to institutional goals, then work backward to identify what must stop, start, or change to achieve them.

If you begin with Culture, perform a culture assessment. Ask your team to describe and compare the current culture to the desired one. Identify three to five specific behaviors that would close that gap. Make these behaviors visible through regular discussions, recognition, and accountability.

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Starting with Team Development allows you to assess your team's current skills against future requirements. Spot growth opportunities in upcoming projects and intentionally assign challenging roles. Hold regular one-on-ones focused on development rather than task updates.

Begin with Stakeholder Engagement by conducting a listening tour aligned with strategic interests. Meet individually with key stakeholders to understand their priorities, constraints, and definitions of success. Record areas of agreement and disagreement and communicate action.

No matter where you start, commit to regular reflection and adjustment. Remember that leadership development is an ongoing process. Each cycle through these aspects strengthens your capability and confidence. What feels uncomfortable now will become second nature with practice. The expertise that brought you here remains valuable, offering credibility and insight. Your influence will also grow from developing others, building systems, and creating conditions where your entire organization can succeed. This is the essence of leadership, and while it differs from what initially brought you here, it enables you to continue transforming your organization and influencing your field.

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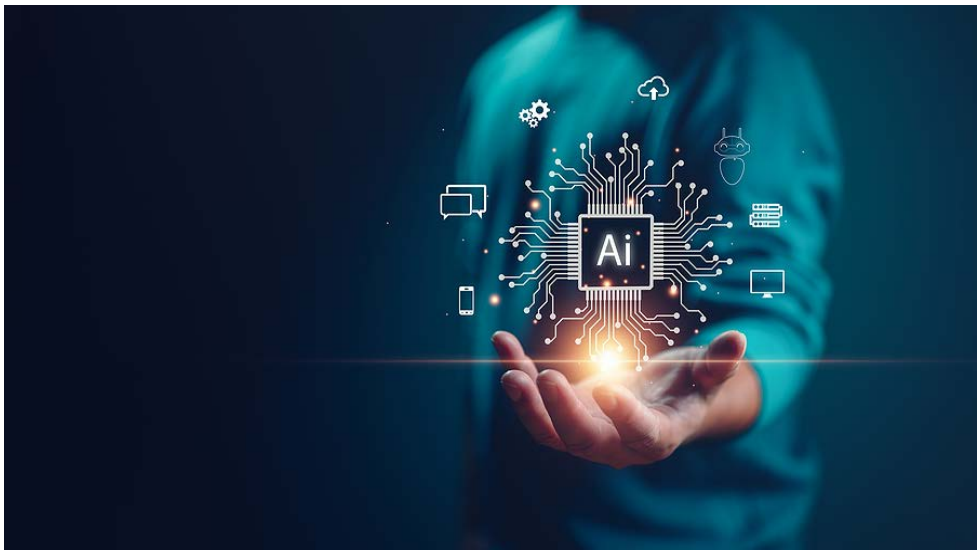
FINDING THE PERFECT PARTNER FOR GEN AI DEVELOPMENT AND ADOPTION

Generative artificial intelligence (GenAI) is poised to be the most transformative technology in medical history, with applications ranging from administrative automation to diagnostic and treatment decision support.



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Understanding how physicians perceive GenAI is crucial because integrating it into healthcare represents more than just technological adoption. GenAI will pressure-test fundamental notions of medical professionalism. How physicians view its benefits and risks, regulatory oversight, and accountability frameworks will influence their adoption patterns, the success of health system implementation, and patient acceptance.

Are you a GenAI platform developer who needs your technology to pass muster? Are you a health system administrator who needs implementation plans to succeed? If so, turn to pediatricians for advice. Invite them to become your "partner of choice."

This recommendation is based on insights gained from a joint self-funded study we conducted, which surveyed 2,739 physicians.

THE GENAI PARADOX

Our research results summary is not surprising: GenAI offers an unprecedented opportunity, but it also poses unparalleled implementation challenges. The medical community is aware of both.

Physicians are optimistic about GenAI *in general*, but approach it cautiously. They say it will help them uncover insights they might otherwise miss (87%), make their jobs easier (81%), and more efficient (84%). Most (89%) predict it will be embedded in patient interactions within 3-5 years. Their enthusiasm, however, is tempered by challenges and concerns.

LACK OF CLARITY ABOUT PREFERRED APPLICATIONS

The first challenge is this: prioritizing GenAI development projects is difficult because there is little consensus on which platforms physicians prefer. Of the nine benefits we surveyed, only three ranked at the top for more than 10% of physicians: streamlining prior authorization (11%), creating visit and discharge summaries (15%), and improving diagnostic accuracy (21%).

RISKS TO PATIENTS

The second challenge is a source of concern: the potential risks to patients. Most (75%) agree that GenAI's warmth, patience, and kindness lead people to trust it more than they should. Regulatory oversight may help prevent patient harm,

but 80% lack confidence in regulators to keep up with the rapid pace of development. A majority (65%) worry the technology produces unpredictable results, 80% worry it is a "black box" they cannot see inside, 64% believe bias in training data will exacerbate disparities, 75% predict privacy violations, and 81% are concerned malicious actors will outpace protective security measures.

RISKS TO PHYSICIANS

The third challenge is also a source of concern: the potential risks to physicians. Across every demographic we surveyed, between 73% and 76% of physicians said *patients should be informed when physicians use GenAI to assist in diagnosis and treatment recommendations*, despite 32% fearing they will *lose patients who become aware of it*. This convergence did not occur in any other survey question, yielding a striking insight into the complex realities of modern medical economics and physicians' ethical standards. This commitment to disclosure, despite their fears and associated business risk, demonstrates the profession's moral and ethical foundation.

Addressing risk matters because physicians' views about accountability for any harm to patients are far from settled.

- 56% would hold GenAI developers and users (e.g., physicians, hospitals, payers) responsible.
- 25% would hold GenAI developers responsible.
- 16% would hold physicians responsible.

THE TRUST GAP

Unfortunately, GenAI arrives at a time when trust in healthcare institutions seems to be at an all-time low. As one way to demonstrate trustworthiness, we drafted an *Oath for GenAI in Healthcare* modeled after medical oaths. When physicians were asked if they would take the Oath, 73% said they would. Those who declined said it was redundant, since they'd already sworn to an oath.

What about other healthcare players whose work contributes to patient outcomes? For example, should GenAI developers, payers/MCOs, clinical researchers, and marketing agencies take the *Oath*? Between half and three-quarters of physicians agreed they *should. Would* they? In most cases, physicians agreed, probably not. This "trust gap" is the largest with insurance company reviewers, GenAI platform developers, payers/MCOs, and hospital administrators.

CLOSING THE TRUST GAP

Closing this trust gap is essential for successful adoption, as the healthcare GenAI market could catalyze a collision between two fundamentally different cultures. Medicine has been intentionally cautious for over 2,500 years. Its conservative approach exists for good reasons. Any "move fast and break things" ethos, which prioritizes rapid iteration, market disruption, and acceptable failure rates, like those found in consumer technology, will be catastrophic in healthcare.

Medical errors affect patient lives, not just user experiences. Healthcare mistakes can be irreversible, unlike software bugs. Physician licenses and patient trust are at stake with each interaction. Physicians will face malpractice liability, and reputation damage can extend to the entire profession. Regulatory responses could be harsh. Failures could damage the healthcare GenAI market, causing physician enthusiasm to evaporate overnight.

WHY SOUNDING THE LOUDEST ALARMS MAKES PEDIATRICIANS A PERFECT PARTNER

Physicians hold themselves to one of the highest standards of any profession. This creates

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strategic risks for GenAI healthcare ventures, but also an opportunity for companies willing to adopt similar standards voluntarily. Our survey data points to the best partners to help bridge any gaps.

We did not set out to detect protective instincts, but a data pattern suggests we found them among pediatricians, and the pattern is unmistakable. Across every risk category we measured, physicians caring exclusively for children expressed statistically significant concerns greater than those of their colleagues. Pediatricians are more often worried that:

- regulators won't keep pace with GenAI developments.
- GenAI is a "Black box."
- training dataset biases will worsen health disparities.
- identifiable patient data will "leak" into training datasets.
- malicious actors will disrupt medical systems.

They are also statistically significantly more likely to hold GenAI developers responsible for harms ($p < 0.05$).

Winning GenAI healthcare companies will position themselves as healthcare-native, with a deep understanding of the ethical, conservative culture of medicine, rather than as technology companies entering a lucrative new market. Their most demanding customers will be pediatricians. Smart companies will engage them early and often.

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BREAKING THE WALLS: SCALING ACUTE CARE IN THE HOME BEYOND TECHNOLOGY

The patient lies comfortably in their own bed, sunlight streaming through the window. Their spouse reads quietly nearby while a paramedic checks vitals and a hospitalist appears on screen for morning rounds. A courier delivers medications and draws labs, with results automatically syncing to the health system's EMR. For this patient, care means healing at home - surrounded by comfort, family, and dignity.

This is not a vision of the future. This is the work of DispatchHealth, the nation's most trusted in-home healthcare system - helping people avoid unnecessary ER and hospital visits while giving health systems and payers a simpler, more scalable, and cost-effective way to expand access and improve outcomes.

Source: Bigstock

BEYOND THE TECH KIT: LOGISTICS, PEOPLE, AND PRECISION

In discussions about hospital-at-home and high-acuity home-based care, technology often takes center stage: remote monitoring devices, virtual visits, and connected platforms. But truly delivering hospital-level care at home requires far more than software.

At DispatchHealth, we know logistics is the backbone of healing at home. It's about orchestrating people, supplies, data, and clinical decisions with precision and presence. Our teams translate physician orders into actionable workflows, ensure labs, imaging, and medications are dispatched in real time, and document care directly into the health system's EMR.

This is logistics thinking beyond the tech kit. It's a human-and-technology partnership that enables complex care to happen safely and reliably in the home.

In 2024, the Medically Home platform, now part of DispatchHealth, released 529 new features to enhance operational efficiency. Our service coordinators fulfilled more than 205,000 orders, each representing a seamless act of clinical orchestration. This infrastructure allows hospitals to extend their reach beyond walls without expanding headcount or sacrificing quality.

ENABLING HEALTH SYSTEMS TO DELIVER COMPLEX CARE AT HOME

Our mission is simple yet profound: helping people heal and be treated with dignity - at home. To make that possible at scale, we partner with leading health systems to bring care across the continuum:

- **ER in the Home:** delivering emergency care for serious but non-life-threatening issues, helping patients avoid the ER when it's safe to do so.
- **Hospital-Alternative Care:** providing hospital-level treatment in the home from the start, preventing unnecessary admissions.

- **Hospital Care in the Home:** offering hospitalized patients the option to continue their inpatient care at home, supported by a multidisciplinary team and advanced technology.
- **Transitional Care:** helping patients recover safely after hospitalization or a skilled nursing stay, preventing setbacks and readmissions.

This continuum creates a simpler, safer, and more integrated experience - for patients, clinicians, and health systems alike.

Training and advisory services are a cornerstone of this model. In 2024 alone, over 1,000 hours of Command Center and in-home clinician training ensured teams were prepared to deliver care with safety, confidence, and compassion. Our customers, in turn, are driving the science of care at home forward - publishing nearly 40 peer-reviewed papers and conference presentations last year. A standout example: Cleveland Clinic Florida's Hospital Care at Home program, powered by our model, demonstrated in *JACC: Heart Failure* that patients with acute decompensated heart failure can be hospitalized safely at home.

REDEFINING CAPACITY AND COST FOR HEALTH SYSTEMS

Health systems are under extraordinary pressure: capacity constraints, workforce shortages, and rising costs. DispatchHealth provides a solution that extends hospital capacity without adding beds or staff.

Our model helps hospitals protect beds for the sickest patients, reduce avoidable admissions, and improve throughput - all while maintaining control of clinical quality and brand identity.

For at-risk providers and payers, we serve as trusted eyes and ears outside the clinic, engaging patients where they are most at risk and responsive. We lower total cost of care, reduce readmissions, and help partners achieve performance goals in value-based arrangements.

For patients and caregivers, the impact is more personal: we bring advanced medical care to the place they feel safest - at home - helping them heal in comfort and be treated with dignity.

POLICY MATTERS: ALIGNING REIMBURSEMENT WITH REALITY

The Acute Hospital Care at Home (AHCAH) waiver proved that reimbursement alignment can unlock transformation. When hospitals were reimbursed equally for providing care in the home, hundreds of health systems adopted the model, delivering hospital-level care safely, effectively, and at scale.

But today, that parity remains temporary, dependent on short-term extensions. This uncertainty stifles innovation and perpetuates a bias toward institutional care. Why should the physical location of care dictate its value?

We must create a unified reimbursement framework that values care wherever it's delivered - especially when the outcomes are better and the costs lower. That means:

1. reimbursement parity between hospital and home-based acute care.
2. expanded coverage for post-acute and transitional services that prevent readmission.
3. streamlined regulation that supports responsible innovation.
4. investment in workforce training for the clinicians and paramedics who make this model work.
5. patient empowerment, ensuring families can choose safe, supported care at home.

Aligning incentives with outcomes isn't just policy reform - it's moral reform. It's the path to a healthcare system that treats home-based care not as an exception, but as a standard.

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To learn more about Pippa, click here.

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BREAKING THE WALLS: SCALING ACUTE CARE IN THE HOME BEYOND TECHNOLOGY

SCALING HUMANITY

This work is personal to me. Recently, I sat beside my father through an 18-hour emergency department visit that ended with an inpatient stay. The care was competent, but the environment was chaotic: constant noise, unfamiliar faces, no privacy, and little rest.

I couldn't help but think - what if he could have been cared for at home? Surrounded by family, eating familiar food, sleeping in his own bed. That is what we're building at DispatchHealth: a system that restores comfort, dignity, and control to the patient experience.

Healthcare must evolve beyond institutions. By combining logistics precision, technology integration, and human connection, we're proving that even the most complex care can be delivered safely and compassionately at home.

We show up fully when it matters most - meeting people where they are and helping them heal where they belong.

Contact Pippa at her LinkedIn profile.

Source: Bigstock

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