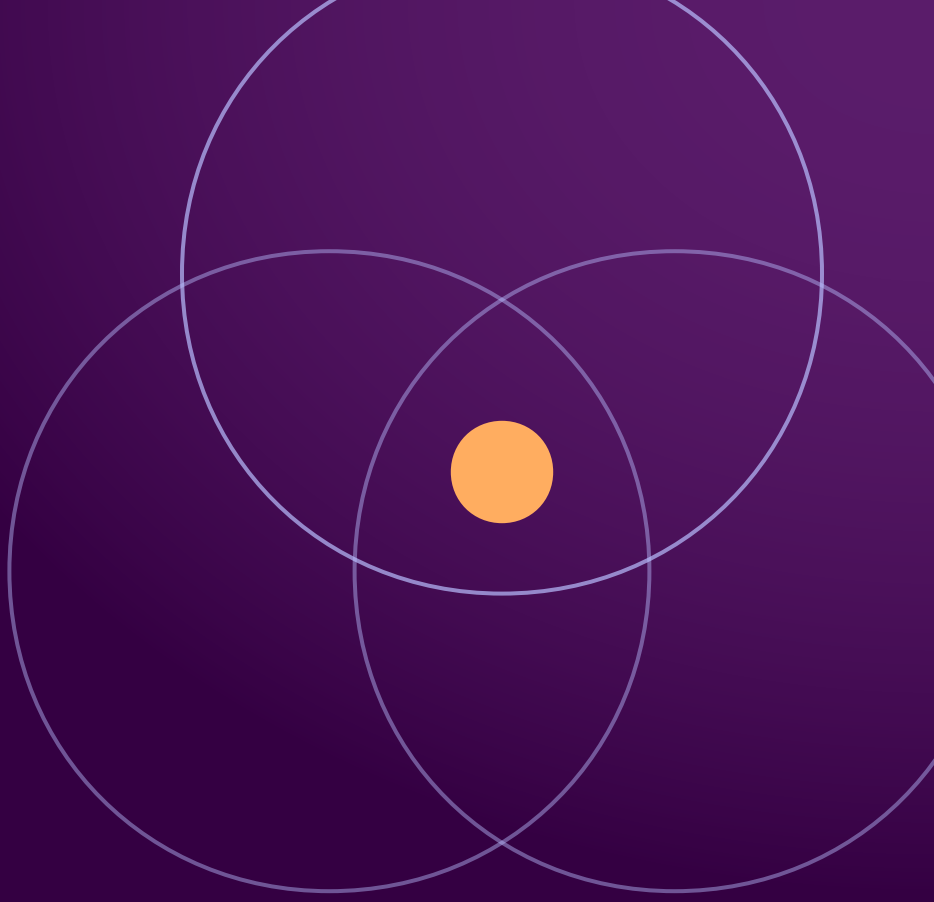


The Clinical Changemaker

Why Good Ideas Stall in Healthcare, and the Three Shifts Women Clinicians and Scientists Use to Move Theirs Forward

CREDIBILITY | TRACTION | INFLUENCE

Clare Kennedy Purvis, Psy.D.

Founder, WELL | Former VP of Clinical Product, Headspace Health

THE PROBLEM WITH STAYING IN YOUR LANE

Over the past couple of years, I've talked with more than 1,000 women in healthcare innovation.

Clinicians and scientists, mostly. They're ambitious. They see important problems in healthcare they genuinely want to solve. And many have deliberately moved beyond direct patient care because they want to have impact at a bigger scale—building new technologies, designing new care models, leading strategic initiatives, starting companies, or changing how their organizations work.

They know healthcare could be better. They can see exactly what needs to change.



And nearly every one of them had heard the same advice.

Stay in your lane. Focus on doing good work, high-quality work, and the impact will follow. Be patient, because these things take time and healthcare moves slowly.

Here's my problem with that advice: it could not be more wrong.

Not only wrong, but expensive, because of what it costs the women who follow it.

I see the news stories constantly now. Women clinicians leaving medicine at higher rates than their male counterparts, or leaving healthcare altogether. And when I read them, I don't think about "burnout" in the abstract. I think about the women I've talked to who entered healthcare because they wanted to make a difference—and eventually found themselves frustrated by how difficult it was to have the impact they knew they were capable of having.

They could see problems that needed solving. They had ideas for making care better. They did excellent work. But they struggled to get their ideas heard, prioritized, funded, or moved forward.

And that matters far beyond any one woman's career.

When women clinicians and scientists become frustrated enough to leave altogether, healthcare loses the very people uniquely positioned to tackle the problems we most need to solve.

Here's the reality:

Seeing a problem clearly and having a good idea for solving it are not enough to make change happen in healthcare.

I know this because I had to learn it myself.

I'm a clinical psychologist and behavioral scientist by training. I started in clinical practice and, like many ambitious clinicians, wanted to have an impact beyond the patients I could see one at a time.

My innovation career began at an early-stage digital health startup. Over the next decade, I went on to lead healthcare products and teams across startups, pharma, and large technology companies as VP of Clinical Product at Headspace Health, Chief Product Officer at MINDCURE, Global Head of Experience for Sanofi's Digital Healthcare division, and a clinical product strategy consultant inside Google Health's Mental Health Center of Excellence.

And I struggled with this too.

I knew how to evaluate evidence. I knew how to think clinically. I knew how to build things that could improve patient experience and outcomes. But I had to learn how to translate that expertise into the language of the decisions being made around me.

What I eventually learned was this:

To make change happen in healthcare, clinical insight isn't enough. You have to know how to move an idea forward.

And that's something you can learn.

WHY THIS GUIDE EXISTS, AND WHO IT'S FOR

I started WELL in 2017 to bring together women clinicians who wanted a bigger role in changing healthcare. I was tired of waiting for a broken system to change around us.

In 2022, I launched the WELL Accelerator for that community, where I've now worked with 140 women clinicians and scientists to move real healthcare innovations forward.

What I've learned from those 140 is that the gap is never expertise. The women I work with are often the most credentialed people in the room. But clinical authority, on its own, doesn't move a decision.



This guide is for you if you're a woman clinician or scientist with an idea for making healthcare better, and you're struggling to make it a reality.

Maybe you're a clinical leader inside a health system trying to redesign a service or solve a patient-care problem, but you can't get the initiative prioritized or resourced.

Maybe you work in a healthcare startup and you're trying to get a new product, program, or research initiative onto the roadmap… but you need product, operations, finance, or executive leaders to get behind it.

Maybe you're building a new venture of your own, and investors love your mission but then don't write the check.

Maybe you're simply stuck. You moved into innovation because you wanted to influence healthcare at a bigger scale, but your work isn't adding up to the impact you left clinical care to create.

I want to be clear about what this isn't. It isn't general career advice, and it isn't a guide to raising venture capital in healthcare. Careers do accelerate, and ventures do get funded, but both of those are side effects of the same underlying capability: how to take an idea for improving healthcare and actually move it forward in real systems.

Building that capability requires three shifts for clinicians and scientists, and together they make up the Clinical Changemaker Framework.

WHAT I'LL COVER

Here's what you'll walk away with:

- Why good ideas in healthcare stall, and what it takes to move them forward
- How to connect a clinical problem to business priorities so it gets attention, resources, and funding
- How to make real progress on a big, complicated initiative before you have all the answers
- How to build the support and shared commitment you need to lead change in healthcare

Let's start with why good ideas *die*.

GOOD IDEAS DON'T MOVE ON MERIT

When I joined that first digital health startup, I suddenly found myself in conversations about revenue, cost, risk, growth, markets, and timing.

I understood the clinical evidence. I could speak in terms of data and outcomes fluently. What I couldn't do was translate my expertise in the right way to create real impact.

I knew how to make the clinical case. I didn't yet know how to turn that into action.

For a while I assumed I simply didn't know enough to lead at that level. I thought that was a gap in me.

And in some ways, I was right. There were things I didn't know yet: how the business of healthcare really worked, what drove decisions, and what made a clinical opportunity worth prioritizing.

But I was wrong about the size of the gap. It was so much smaller than I realized.

The problem is that clinicians are trained to think in clinical outcomes. We're rarely taught how to translate them into business outcomes.

I see this time and again when I start working with a new Accelerator member. She has an important clinical or research initiative she wants to work on. She needs hospital administrators, business leaders, cross-functional colleagues, or investors to get behind it. But when her idea doesn't land, she falls back on what she knows best. She adds more data. She explains the evidence more carefully. She strengthens the clinical rationale. She assumes if she can just make the evidence clear enough, support will follow.

But she's still making a clinical case to people who need to understand the business case.

This is the problem with "staying in your lane." You stay focused on what you know best: the clinical problem, the evidence, the outcomes, your patients, your team.

That focus probably helped make you excellent at what you do. But if you want to lead change, you have to widen your view. You need to understand the priorities, economics, incentives, and constraints around the problem you're trying to solve.

You don't need to leave your clinical expertise behind. You need the business acumen to translate it.

That translation is a skill, and the women we work with build it in 90 days or less.

One of the clearest cases I've worked with was a member who was a researcher by background and held a C-level title at a high-growth mental health company. She had the title, and she still told me, "I don't feel like I know enough to contribute in these meetings."

She wasn't imagining the gap. There were things she still needed to learn. But she didn't need to transform from an epidemiologist into a CFO.

We worked on building her understanding of the commercial and market questions her executive peers dealt with every day. And, more importantly, on helping her see how the scientific work her team was leading contributed directly to the company's highest-priority commercial goals.

Once she could see those connections, she could contribute to executive conversations differently. She wasn't limited to speaking about science. She could speak to why science mattered to the business.

> By the end of our work together, she described it this way: "Now I think of myself as an equal thought partner, and I'm able to use my voice."

Same expertise and talent, but a completely different level of impact.

CREDIBILITY — MAKE THE BUSINESS CASE FOR CHANGE

I joined Headspace Health as Director of Behavioral Science. I left as VP of Clinical Product and Content Development.

The distance between those two titles is what this guide is about. I didn't become a better clinician or scientist. I learned how to connect my clinical and scientific work to the priorities of the business.

I could still make the clinical case: why a certain product feature mattered for our members, what the evidence showed, and what better outcomes would look like. But I also learned to ask different questions. What problem was the business trying to solve? What did it cost us? What did our customers care about? What were the competing priorities? Why was an idea worth investing in right now?

I developed a much wider view. And suddenly, I could get the work I knew mattered for the people we served prioritized, resourced, and funded.

Those skills continued to serve me at Sanofi, where I oversaw a team building new digital health products to support patients with advanced type 2 diabetes. They were critical when I consulted with Google Health's Mental Health Center of Excellence to craft their company-wide consumer mental health strategy. Nobody taught me business strategy in my doctorate. I learned it over years, through experience, and often by getting it wrong first.

There's no reason it should take a decade to learn something that can be taught in less than 90 days.

So let's *teach* it.

Credibility is the first shift. It's how you go from seeing a problem that should be solved to making a strong case for why it's worth solving.

Most clinicians are already very good at the first part. You can see where care is falling short. You understand who is affected, what better outcomes could look like, and what the evidence says.

Credibility means learning to widen the picture.

First, you get specific about the problem.	Then you work out who has a reason to pay for a solution.	Finally, you determine whether there's a real opportunity to do something about it.

First, you get specific about the problem. Who is experiencing it? When, where, and how does it occur? What is the cost if it remains unsolved?

Then you work out who has a reason to pay for a solution. In healthcare, many problems exist because the status quo actually benefits someone. Your job is to figure out which stakeholder in the system has a reason to pay to solve it. And there's a multistakeholder issue to deal with: the patient experiencing the problem is typically not the stakeholder who would pay for the solution. A health system, employer, health plan, healthcare company, or customer may see the same problem very differently. You learn to understand what each stakeholder needs, what they value, and what would give them a reason to act.

Finally, you determine whether there's a real opportunity to do something about it. What, specifically, would improve if this problem were solved? What would that be worth? How would you measure it? What alternatives already exist? What is changing in healthcare that makes this more—or less—important now? And how does the organization you're working in, or the company you want to build, capture value?

By the end, you're no longer saying, "This is an important clinical problem. We should fix it because it's the right thing to do."

You can say: "Here's the clearly defined problem. Here's who it affects. Here's why it matters to them. Here's why it matters to us. And here's why we need to act on it now."

That's the difference between seeing what should change and making a credible case for changing it.

Cara is a good example of what this looks like in practice.

She's an expert clinician and seasoned healthcare executive who had spent years building specialty treatment programs in eating disorders. The idea that eventually became her startup, Protocol, started with something much more personal.

When her mother-in-law was diagnosed with cancer, she went through a three-month course of treatment at one of the country's leading comprehensive cancer centers. During that time, she needed mental health support. But the wait to see any mental health specialist was six months.

Even in one of the best cancer centers in the country, the support her mother-in-law needed wouldn't have been available until months after her treatment was over.

Cara knew there was a problem. What she didn't know well enough yet was why that problem existed—or whether there was a viable opportunity to solve it.

So she went deep on the problem.

She studied the healthcare landscape and talked with the people involved in delivering and paying for cancer care. She looked at how big the unmet need really was, what oncology practices were already doing to address it, where existing approaches were falling short, and what was getting in the way of better mental health support.

She also had to understand the economics. Who bears the cost when patients don't get the support they need? Who would have a reason to pay for something better? How does behavioral health get reimbursed in oncology? What would a new model need to do for patients and for the oncology practices expected to adopt it?

That work changed the idea from "cancer patients should have better access to mental health care" into something much more useful: a clear understanding of a specific, well-defined problem, who had a stake in solving it, and how a future solution would need to work in the real healthcare system.

Only then could Cara make informed decisions about what to build.

The company that emerged from that work, Protocol, now brings cancer-specific behavioral healthcare into oncology practices using the Collaborative Care Model. Its business model allows practices to bill insurers for the care without taking on the cost and operational burden of building a new behavioral health team themselves.

Cara ended up securing investment for Protocol while the company was still a slide deck. But that's not the most interesting part of the story.

She started with a problem she cared about. One that she knew mattered. Credibility gave her the tools to build a case for solving it.

Building that case is what allowed her to secure the funding, hire the team, and launch the company.

TRACTION — MAKE PROGRESS WITHOUT HAVING ALL THE ANSWERS



I learned this lesson early in my career in healthcare innovation.

As a postdoctoral fellow at Stanford's Clinical Excellence Research Center, my team and I were given an enormous challenge: redesign ambulatory care in the United States using technology to improve quality and reduce total per capita cost.

We couldn't possibly know the answer when we started.

So we began with what we thought we knew about the things driving poor outcomes and high costs in ambulatory care. Then we started talking to people. Lots of people. Clinical leaders at health systems and innovative primary care centers. Health plan administrators. Technologists. Founders. Policymakers.

Every conversation changed our thinking.

We would form a hypothesis, put it in front of people who knew more than we did, discover where we were wrong, and use what we learned to decide what to explore next.

As a group of early-career clinicians accustomed to being A students, this was uncomfortable. We were used to doing the work, knowing the answer, and then showing up prepared to defend it. Here, we had to put our thinking into the world before we knew whether it was right.

That's Traction: learning how to make progress without having all the answers. Instead of trying to predict the entire path, you take small, deliberate actions that help you learn what works, reduce uncertainty, and make a better next decision.

It sounds simple. But for clinicians and scientists, it requires a fundamental shift in how we work.

You were trained to reduce uncertainty before making a decision. Innovation often requires you to make decisions in order to reduce uncertainty.

For women working in high-expertise environments, being exceptionally prepared feels like protection. You reasonably expect your ideas and your expertise will be scrutinized. You want to have the answer before someone asks the question. You want to know your idea will work before you share it with anyone.

So uncertainty feels like evidence that you're not ready.

But uncertainty is the nature of innovation.

The skill is knowing what to do next when you don't know the whole answer.

That's what we work on in the Traction phase of the WELL Accelerator.

You start by separating what you **know** from what you're **assuming**.

What have you actually learned from patients, customers, colleagues, or other stakeholders? What do you believe to be true but haven't tested yet? What don't you know at all?

Then you look at those assumptions and ask which ones matter most. Which assumption, if it turned out to be wrong, would fundamentally change the idea? What do you need to learn before investing more time, money, or political capital?

Then you find the smallest useful way to learn it.

That might mean five stakeholder conversations before you design the program. Testing one part of a new workflow before asking a whole department to change how it works. Putting an early version of an idea in front of the people who would actually use it. Or running a small pilot before asking for the resources to scale it.

You take action. You look at what happened. Then you decide: continue, adjust, or stop and rethink part of the idea.

And you do it again.

The goal isn't to prove that your original idea was right.

The goal is to learn what needs to be true for it to work.

This is also why I don't teach "confidence building."

You don't have to manufacture confidence before you act. You build confidence by taking deliberate action.

Natalie is a good example.

She's a clinician at a large employer-sponsored mental health provider. Many of her patients were part-time gig workers at large companies who received eight counseling sessions through their EAP, but didn't have health insurance to cover ongoing care.

For many of these patients, eight sessions weren't enough. They had acute clinical symptoms like active suicidal ideation, or ongoing needs like medication management. But when the eight sessions ran out, the episode of care closed. There was no standard transition-of-care workflow or referral pathway. Some clinicians kept responding to patients on their own time because they knew those people still needed help.

The clinical team knew there was a problem. Some left the company over it.

But changing it felt enormous. This was simply how the employer benefit worked.

When Natalie decided to tackle the problem, she didn't start by trying to redesign the entire clinical model.

She got curious.

She talked with people across the organization and started understanding the problem from different perspectives: what wasn't working for patients, what clinicians were dealing with, what mattered to employers, and what constraints the company itself had to work within.

Instead of proposing a major, multiyear transformation of the clinical care model, Natalie designed a way to test a new approach with one of the company's largest employer customers, using capabilities the company already had in a creative way to connect patients in need with the ongoing care they needed.

That's Traction.

Natalie didn't know how she would solve the whole problem before she began. She felt uncertain and a little intimidated asking for time with colleagues outside of the clinical team. But she always focused on the next useful step, learning, and using what she learned to make the next strategic decision.

And something else happened along the way.

> Here's how Natalie described it: "This experience was genuinely career changing. I developed greater confidence in my own ability to lead change. I have a much clearer understanding of the value I bring. This helped me get to the next level when I was feeling stuck in reaching it before."

After she pitched that initial pilot program, Natalie got the attention of the leadership team. She was offered a strategic operations role overseeing adult outpatient care for the company's Fortune 500 clients.

INFLUENCE — TURN AN IDEA INTO SHARED COMMITMENT

A few years ago, I was hired as Global Head of Experience and Chief Experience Officer for the Digital Healthcare division of a large pharmaceutical company. Our team was working on an ambitious idea: build a digital platform that could help people with diabetes manage their health and treatment more effectively.

What made the strategy unusual was that the platform would be brand-agnostic. It wasn't designed simply to help patients take a specific medication made by the company we

worked for. The ambition was to support people with diabetes to improve their health regardless of which medication they used.

From a patient perspective, that made a lot of sense.

Inside a pharmaceutical company, it raised an obvious question: **Why should our company invest in it?**

There were good strategic answers. Medication adherence matters to the existing business. There was also a larger, longer-term opportunity for the company if the digital platform could help people manage diabetes at scale.

But those connections weren't obvious. And I had no direct authority over the people whose decisions we needed to make the strategy come to life.

I couldn't tell anyone to do anything.

So a huge part of my job became figuring out how to influence people across a large, complex organization. I needed them to **understand the idea, care about it, and ultimately commit to making it happen.**

Understand	Care	Commit

That's Influence.

And the first part really was **understand**.

The strategy was complicated. Clinical evidence, behavior change, digital health, product strategy, commercial goals, and a long-term strategy all had to fit together into a story people could actually follow.

We wrote and rewrote that story constantly.

My job was often to strip away the jargon and complexity until someone could quickly understand what we were trying to build, why it mattered for patients, and why it could matter to the company.

Clarity is the first job of Influence.

Understanding, though, doesn't mean someone will care. The second job of Influence is to **give people a reason to care.**

For that, I had to understand the organization far beyond my own team. I built relationships with people across departments and geographies. I learned what they were responsible for,

what they were trying to accomplish, how their success was measured, and where this strategy could help—or hinder—their priorities.

Sometimes those interests lined up beautifully. Sometimes they didn't.

Influence isn't about pretending everyone wants the same thing. It's about understanding different perspectives well enough to show where your idea could genuinely advance goals people already cared about, and to work through the tensions where it can't.

And then there's the part that matters most: **commitment**.

Someone telling you, "This is a great idea," is not commitment. Someone agreeing that patients need it is not commitment. Someone enjoying your presentation is not commitment.

For an idea to move forward, eventually people have to do something. Approve funding. Allocate people. Change a priority. Introduce you to someone. Lend their reputation. Make the next decision that allows it to continue.

In any large organization, getting those commitments can be a long process.

We can put enormous pressure on a big presentation or pitch. We prepare until every slide is perfect and assume that's the moment when people will decide whether our idea moves forward.

The real work starts much earlier.

People need time to understand an idea. They need opportunities to question it, challenge it, and shape it. They need to see how it connects to what they care about. Some become allies and champions. And you need to be very clear about what you're asking them to commit to.

None of that requires becoming the loudest or most charismatic person in the organization.

In fact, some of the most useful influence skills are quiet: simplifying complexity. Asking good questions. Listening closely. Finding common ground without pretending differences don't exist. Building relationships before you need anything. Making a clear ask.

That matters for the women clinicians and scientists who tell me they don't identify with traditional ideas about "executive presence."



Influence isn't a performance.

One WELL member put this into practice when she set out to launch a program providing clinically tailored meals to rural patients with complex chronic conditions.

She was a clinical nutritionist working directly with patients inside a large regional health system. She could see the clinical problem clearly: for patients managing serious chronic illness, access to the right food was an essential part of managing their health. Through the Credibility work, she identified a clear commercial opportunity to address that problem upstream, rather than waiting for poor nutrition to contribute to poor health outcomes and more costly care.

Through the Traction work, she developed the idea and built the roadmap for testing it.

But having a strong idea and a credible business case didn't mean she could launch it.

She didn't control the budgets, operations, clinical teams, or executive decisions required to make the program happen. And she couldn't simply send an email up the chain and hope someone said yes.

So she started building influence.

She mapped the organization to understand whose support the program would need. She met with people across departments, including administrators far outside her usual clinical work. She worked with her leaders, who already believed in the idea, and asked them to help her reach the next people who needed to understand it. She listened to questions and concerns, refined how she explained the program, and kept building support.

Eventually, she was presenting the idea to senior executives.

And the pilot launched.

Think about what had to happen between **"I have an idea that could help my patients"** and an actual program delivering clinically tailored meals to rural patients.

No single presentation made that happen. No amount of clinical expertise gave her the authority to make everyone else participate.

She had to turn an idea she believed in into something other people understood, cared about, and were willing to commit to.

And she did. One commitment at a time.

That's how a frontline clinician leads change.

THE CLINICAL CHANGEMAKER FRAMEWORK

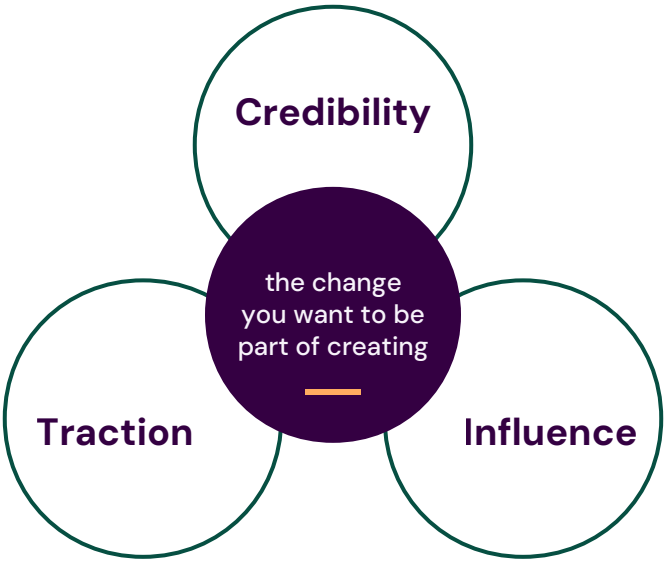
Put the three shifts together and you have a *system* for moving change forward in healthcare.

Credibility is how you go from seeing a clinical problem that should be solved to understanding the healthcare economics, incentives, and organizational priorities around it well enough to make a compelling case for change.

Traction is how you turn a big, complex idea into a healthcare innovation that can actually work and last. Instead of trying to design the whole thing upfront, you break it down and learn what will work within the realities of patients, healthcare organizations, and the broader system.

Influence is how you turn a healthcare innovation you believe in into something other people can understand, care about, and ultimately commit to.

At the center, holding all three together, is something more personal: the change you want to be part of creating.



You didn't stumble into this work. There's an impact you want to create. A change you want to be part of. Something you want to make better for patients, for clinicians, for communities.

Maybe you can articulate it immediately. But it's more likely a vague ambition somewhere inside you. When was the last time you stopped to ask yourself:

What is the change I want to be part of?

That question matters deeply. The three shifts—Credibility, Traction, and Influence—aren't the destination. They're the capabilities that allow you to take that ambition and do something with it.

You don't need to fix all of healthcare. But without clarity about what drives you, you can get a great deal of "work" done and still feel unfulfilled.

What I see with high-performing women clinicians and scientists is exactly that. We are excellent at our work. We over-deliver. We hit every milestone. Often, we already look quite successful. And yet we feel disconnected from the mission that brought us to healthcare in the first place.

I should tell you plainly: there's a bigger reason I care so much about teaching this system.

My mission is to see women clinicians and scientists become the leaders shaping the future of healthcare.

You bring perspectives healthcare desperately needs: firsthand understanding of patients and care, deep scientific expertise, and a close view of the problems worth solving. When you are the ones setting priorities, healthcare gets better for everybody. Right now we're losing that expertise faster than we're using it.

So this isn't about building credibility, traction, and influence for their own sake. It's about equipping you to become a changemaker who creates a meaningful impact you genuinely care about.

Think about one initiative that could move you closer to the change you want to be part of creating. What does that initiative need next?

- Credibility: Can you explain the problem not only clinically, but in terms of the economics, incentives, priorities, and people that will determine whether your organization or community acts on it?
- Traction: Have you worked out what this would look like in practice by putting your idea into contact with the realities of patients, organizations, and the healthcare system?
- Influence: Do you know whose support and commitment you need? Do they understand the idea, care about it, and know exactly what you're asking them to do?

Diagnose the idea. What does it need?

You don't need to tackle all three at once. Start with what it needs most right now, and continue through the Clinical Changemaker Framework to keep moving forward.

> To make change happen in healthcare, clinical insight isn't enough. You have to know how to move an idea forward.

WHO THIS WORK IS FOR

The WELL Accelerator is for women with clinical or scientific training who are actively working in healthcare organizations or startups, or building a company of their own.

We work with a small number of women at a time, and fit matters.

- You know healthcare. Your clinical or scientific background gives you a close view of the problems worth solving, whether or not you still practice.
- You have a real initiative, venture, project, or idea you want to move forward in the next 90 days.
- You want to strengthen the business side. You want to understand the economics, strategy, and decisions that determine whether innovation moves forward.
- You're ready to be seen and respected as a strategic leader, not only a subject matter expert.
- You learn by doing. You want to apply the system to your own work, get feedback, and make progress as you go.
- You value community. You want to join other women clinicians and scientists who are building and leading change in healthcare.

If that describes you, you're exactly who the WELL Accelerator is built for.

THE PATH FORWARD

The next step is a conversation about the impact you want to create.

It's a 15-minute Impact Game Plan call. You tell me about the initiative you're trying to move and what's standing in its way. I'll tell you which of the three shifts your initiative needs most, and what I'd do about it.

It's hard to diagnose this from inside your own work, which is the whole reason the call is useful. You'll leave with a clearer read on where your effort should go.

If there's a fit, we'll talk about what working together could look like.

Book your Impact Game Plan call at

wellwomen.health/strategy



ABOUT THE AUTHOR

Clare Kennedy Purvis, Psy.D., is the founder of WELL, the impact accelerator for women in healthcare, based in Brooklyn, New York.

She's a licensed clinical psychologist and behavioral scientist who spent a decade as a healthcare product executive: VP of Clinical Product and Content Development at Headspace Health, Chief Product Officer at MINDCURE, Global Head of Experience and Chief Experience Officer for Sanofi's Digital Healthcare division, and clinical product strategy consultant for Google Health's Mental Health Center of Excellence. She's an Affiliated Scholar at Stanford's Clinical Excellence Research Center, an advisor to Brightline and Flo Health, and an investor in healthcare startups.

She earned her Psy.D. from the PGSP-Stanford Consortium and completed her clinical internship at the University of Wisconsin-Madison School of Medicine and Public Health.

Clare started WELL in 2017 with a few clinicians meeting for coffee. It grew into a network of more than 1,000 women and became the WELL Accelerator in 2022. Through it she's trained 140 women clinicians and scientists, with 99% member satisfaction. More than 75% of employers agree to sponsor participation (partial or full), including very early-stage startups.

She grew up in Wisconsin and lives in Brooklyn.

Here's what she knows to be true: the system is broken, and we won't fix it by playing small.

Learn more at **wellwomen.health**, or connect with Clare on **LinkedIn**.

