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SUMMARY OF THEMES

Reengaging One×One: A multistakeholder GI coalition for a changed landscape

July 2026

Senior gastrointestinal (GI) disease leaders convened on May 4, 2026, during Digestive Disease Week in Chicago for a roundtable hosted by the patient advocacy organization International Foundation for Gastrointestinal Disorders (IFFGD) and facilitated by Tapestry Networks. Attendees represented practicing gastroenterologists, pharmacists, medical affairs professionals from biopharmaceutical companies, patient representatives, and advocacy organization leaders.

The meeting explored a possible reboot of One×One, a multistakeholder coalition that first met in 2018 to tackle complex GI patient care challenges one issue at a time. During the meeting, leaders debated whether there was a case for continuing the coalition (or a similarly composed group), given how much the landscape has changed since 2018, and if so, what specific issues it should advance. The following *Summary of Themes* highlights perspectives from this conversation.

This *Summary of Themes*[1] is organized around the following:

A system more stressed than when the coalition last met

To help inform deliberations on the next steps for a potentially reconvened coalition, participants first reflected on how much the GI care environment has changed since 2018.

Access has become nominally wider but practically narrower

Participants repeatedly described increasing barriers to care access driven by stagnant or declining reimbursement, rising practice costs, and cost-sharing models that leave patients with unaffordable out-of-pocket expenses.

Historically, discussions on access in GI have asserted that administrative processes (e.g., prior authorizations and appeals) delay treatment and shift effort onto practices, manufacturers, and patients, often without reducing total costs. Indeed, only a few years ago, many stakeholders agreed that prior authorization was a key challenge restricting access in the sector.[2] However, at the May 2026 meeting, although many acknowledged that administrative burdens still exist, they were deemed less of an issue now. One participant said, "*Most practices have somebody embedded within the practice or have outsourced help to get through the prior authorization stuff. It's a huge burden and delays care, and it doesn't decrease costs. But* [practices] *have solved that."* Instead, patients now face financial barriers to therapies for which they are technically approved: *"There's a growing challenge with these new cost-sharing programs, accumulators, and copay maximizers. Access is no longer the hard part; we got access. It's just afterwards, patients are being told they'll pay $6,000."*

Pharmacy and provider closures further compound access challenges in today's environment. Participants emphasized that infusion centers, in particular, are struggling under biosimilar reimbursement rates: *"Infusion centers are losing money on those, so they're actually turning patients away, saying we can't do this anymore."* While value-based models were designed in part to correct these reimbursement problems, their incentive structures can create their own perverse logic, as one participant underscored: *"Practices and systems start shopping for higher-insured, better-insured populations and lower-cost patients. They're incentivized to save money whichever way they can."* One participant captured the definitional problem at the heart of the access debate: *"I'd argue that if there's access that we still can't afford, it's not access."*

AI and social media drive health information—and misinformation

Today, AI and social media serve as the primary ecosystem where the public finds, shares, and processes health information. This digital environment has fundamentally changed how patients interact with medical data, creating both massive opportunities and critical risks. Patients increasingly use AI and online channels to learn about symptoms, diagnoses, and treatments, but accuracy varies and can conflict with clinical consensus. Participants in the roundtable identified this as the single biggest change since 2018.

Several participants noted that the post-COVID influencer economy drives health content calibrated to engagement and sponsor incentives rather than clinical accuracy. One said, *"People are drawing upon AI to educate themselves about their condition or the treatment or how to diagnose it, and how to cope with it. And I don't know about your AI, but mine's not always accurate*." Participants' concerns encompassed

not only misinformation patients might passively absorb but also active misdirection—for example, patients presenting to clinicians with elaborate functional testing purchased from unregulated providers or acting upon treatment decisions derived from social-media communities. Clinicians are often powerless to counter these sources during an appointment that may last only minutes. Roundtable participants discussed an emerging priority: creating vetted, disease-specific guardrails and educating patients on how to use AI tools safely, rather than assuming they will stop using them.

Workforce constraints, time scarcity, and training gaps challenge robust care access

The group described a growing labor shortage across GI care—from physicians to critical support staff—that constrains access and makes it difficult to deliver "*360 care.*" Practices outside typical academic centers (e.g., rural and community practices) may lack the training and resources to meet patients' multidisciplinary care needs. Participants also noted that increased reliance on advanced practice providers (APPs/mid-levels), combined with gaps in specialty training and education, contributes to churn and inconsistent care experiences. These issues come against a backdrop of rapid changes in diagnostics (e.g., point of care imaging tools, real-time monitoring) and treatments as the science of GI care continues to evolve, exacerbating the knowledge gap.

A debate emerged on whether the time scarcity problem is solvable through reimbursement reform alone versus requiring new models of front-door care delivery (including AI) because total human clinical time is insufficient. One participant said, *"I don't see it as a solvable problem. It's kind of mathematical: If you take all the gastroenterologists and all the GI nurse practitioners and multiply the four to five days a week they want to work and even if they didn't take a lunch break, there's nowhere near the supply of human clinical time, even if it was reimbursed well."*

This framing had direct implications for the coalition discussion: any effort premised on clinicians doing more would fail by design.

System structure, consolidation, and data interoperability continue to create friction

Many operational problems in care delivery today are linked to system-level structures. The Centers for Medicare & Medicaid Services (CMS)' reimbursement design, continued consolidation of practices into large networks seeking negotiating leverage (which in turn sometimes puts practices at odds with payers), and misaligned incentives collectively reduce patient choice while increasing costs. Additionally, clinicians lamented ongoing data interoperability failures: despite widespread use of electronic records, data cannot travel the way patients do across providers. One said, *"As a doctor, I'm spending my time chasing down information that should be there. I could be spending that time listening to the patient and doing more of the work that I feel I should be doing."*

Privacy rules and outdated interpretations of the Health Insurance Portability and Accountability Act further complicate modern, team-based care and data sharing. The cause, a participant argued, is not technological limitation but a deliberate strategy: *"Hospitals lobby against* [data sharing]. *They act like they want it when they're talking at public events, but in reality, if you can get your care at one hospital*

and you want to get a quick vaccine or primary-care visit or second opinion at another, and they have all your information, [data portability] *makes switching* [providers] *really easy. So it's very much in* [health system] *interests to make it very difficult for your data to be portable."*

Patients want collaborative, holistic care, and not finding it is pushing them out of medicine

Participants discussed how patients are seeking care outside traditional systems (e.g., functional/alternative services, online communities, direct-to-patient options) largely because medicine is structurally unavailable to them on the terms they need. Patients may feel rushed, dismissed, or unable to get timely answers.

Patient representatives at the roundtable underscored that patients are not seeking instant gratification but practical, accurate guidance that considers their full situation. One said*, "They want wellness, not just to feel better in the moment. You mentioned nutrition, you mentioned psychology. Those are all things* [patients want to be considered]*, but even a GI psychologist isn't* [sufficiently] *specialized. The environmental issues, the cultural stigmas, the communities, the food inequities and insecurities, toilet anxiety: we miss all of that* [in traditional medicine today]*. They just want it to be collaborative, and they want it to feel human."*

A clinician echoed this from a different angle: *"The reason they're going to others is not because they suddenly lost trust in their actual medical care, but they just can't get the care. And so it's a frustration, but they want the system to work."* In other words, participants observed that patients are not defecting from medicine; rather, they are being pushed out of it.

The coalition design debate: big tent or fast boat?

With the landscape established, the conversation turned to the primary question on the agenda: should One×One be reconvened, and if so, in what form?

There is a need for an action-oriented cross-sector GI coalition

The unique value proposition of a cross-sector GI coalition, participants agreed, is that it does not exist elsewhere in the ecosystem. Professional societies serve clinicians; patient advocacy organizations serve specific disease communities; and pharmaceutical companies operate within competitive constraints. Therefore, no existing body brings all these voices together across the full breadth of GI disease—from inflammatory bowel disease (IBD) to gastroesophageal reflux disease to eosinophilic disorders—to generate a common agenda. A participant said, *"I think the big advantage is you're combining. This is not something ACG* [American College of Gastroenterology] *or AGA* [American Gastroenterological Association] *or a professional organization or patient group does on its own. I think having a big, unified voice carries a lot of weight*."

A nimble core model for the coalition with selective expansion on targeted topics may work best

Rather than a large standing consortium, participants recommended a smaller core group of 25 to 30 leaders—representative of each major stakeholder type but not fully exhaustive—that would expand its membership selectively when a topic required specific expertise. As one participant put it, the risk of going too big is that it becomes *"a giant consortium, and that's very hard; there's a certain size and scale* [needed] *to be able to be nimble on certain types of efforts."* The working model that attracted the most support was one in which the coalition functions as a hypothesis-generation-and-prioritization body, then delegates execution to specialized groups or existing organizations already doing that work.

Specific topics for the core group to initially explore were identified as follows:

- **The AI guardrail proposal emerged as the leading near-term candidate.** The most animated and concrete part of the coalition design discussion centered on what the group could accomplish within six to 12 months. One proposal suggested working directly with major AI platforms to build vetted, disease-specific resource frameworks, beginning with IBD. The chief medical officers of these platforms, participants noted, are increasingly prominent because these companies now handle high volumes of healthcare queries. *See call-out box for more details.*
- **Patient education on plan selection was identified as an additional near-term potential.** A provider in the room described a failure of patient literacy around insurance plan design that they argued is driving avoidable cost exposure for IBD and other chronic GI patients. All too frequently, patients choose high-deductible plans because they want to optimize monthly premium spending, then discover mid-year that copay-accumulator programs have driven out-of-pocket costs far higher than anticipated: *"When patients are selecting these plans, I don't know if they actually know what they are selecting. I think they just see the dollar per month, and that's all they are thinking about."* The group discussed whether the coalition could produce a disease-specific insurance-selection checklist: a tool IBD patients could use during open enrollment to understand what plan features are important given their likely care needs, in a format simple enough to distribute through patient-advocacy networks.
- **APP/provider education and patient-centered access were highlighted as additional priorities**—especially given education and resource gaps among community and frontline providers and ongoing coverage challenges. How to constructively integrate use of telehealth and other tech-enabled services, particularly given how patients are turning to online platforms for more rapid responses, remains an open question. This area was seen as one needing a multistakeholder coalition that could engage patient advocates, clinicians, treatment developers, and payers.

To make progress on these topics, partnership with patient advocacy organizations was seen as the connective tissue. Several participants argued that a potential challenge for the coalition—reaching patients who are already in AI environments, online communities, and functional-medicine pathways—is best solved not by trying to compete with those channels but by partnering with the patient-advocacy organizations that already have credibility and reach: *"You as a physician can say, 'This is a clinical group. Here is someone that's advocated for C. diff or IBD. Here's where you go.' You may have to*

partner with those groups to further your cause, but I think that's something you can do in the near future."

Structuring a focus on AI

The logic for a focus on patient use of AI was threefold. First, AI is already a primary-care front door for many patients, as discussed above. Second, the platforms want credible clinical information. A participant elaborated on how AI platforms currently source their health content: *"As of March* [2026]*, the way Google creates content* [at the top of Google search] *is they go to the three top websites that hit the SEO criteria. Not that these are paid—they're looking at credibility. They're looking at whether it's well-sourced information, then seeing where* [the top three sites] *agree. They then pull that information and summarize that into the box."* This participant argued that ensuring that credible clinical institutions and societies rank prominently on AI platforms is itself a concrete and achievable goal*: "We have to embrace what they're doing and try to help make sure that we have good content."*

Lastly, a focused effort on IBD, as the most clinically complex and high-stakes GI condition, would be both tractable and demonstrably impactful. A participant recommended, *"My vote personally would be to help them build guardrails around something really focused, like IBD. What are the good places to get resources, how to help patients do some shared decision-making on biologics? Be proactive about that because patients are definitely going to* [use AI]."

The way forward

Participants broadly agreed that the case for reconvening One×One is strong, but the coalition's credibility will depend on choosing targets it can actually hit. The consensus direction favored a nimble core group, with selective expansion by topic and an initial agenda anchored in the proposed near-term deliverables: working with major AI platforms to build vetted GI resource frameworks, possibly beginning with IBD; a patient-facing educational tool on insurance plan selection for people with chronic digestive conditions to address immediate access roadblocks; and filling the education gap for frontline providers. The coalition would likely start with one or two topics from this list of three.

Longer-horizon ambitions—such as payment model reform (including models that reduce intermediaries or that better align value, economics, and outcomes) and CMS and payer engagement—were not dismissed. However, participants recognized that these topics require a sustained and well-resourced effort. The coalition could build toward becoming such an effort while, in the meantime, focusing on the three proposed topics above.

About Tapestry Networks

Since 2004, Tapestry has been the premier firm for building collaboration platforms with leaders of the world's foremost organizations. Tapestry Networks brings senior leaders together to learn and to shape solutions to today's most pressing challenges. We are a trusted convener of board directors, executives, policymakers, and other stakeholders, connecting them with information, insight, and each other. Top experts join our discussions to learn from the leaders we convene and to share their knowledge. Our platforms help educate the market, identify good practices, and develop shared solutions. We call this the power of connected thinking.

Appendix: Contributors

The following participated in all or part of the roundtable and/or earlier discussions prior to the meeting:

- Christopher Allen, Senior Director, Medical Affairs, Salix Pharmaceuticals
- Mike Beckelic, Senior Manager of Quality Assurance and Regulatory Affairs, Sebela Pharmaceuticals
- Sameer Berry, Co-founder & Chief Medical Officer, Oshi Health
- Mena Boules, Vice President, Global Medical & Scientific Affairs, Ironwood Pharmaceuticals, Inc.
- David Choi, Associate Director of the IBD Center, University of Chicago Medicine
- Trudi Delk, Senior Manager, Scientific Communications and Publications, Nestlé Health Science
- Ken Freedman, Senior Medical Director, Aetna, a CVS Health Company
- Robert Gambrell, Executive Director, Strategic GI Accounts, Phathom Pharmaceuticals
- Edina Hott, Senior Manager, Scientific Communications and Publications, Nestlé Health Science
- Adam Laitman, Director, Medical Affairs Gastroenterology, Hepatology and Pain Management, Salix Pharmaceuticals
- Beth Lemek, MSL Director, Phathom Pharmaceuticals
- John Mahalchak, Patient Advocate, University of Pittsburgh; Board President-Elect, Oley Foundation
- Melodie Narain-Blackwell, Founder, Color of Gastrointestinal Illnesses, Inc.
- Dianne Nguyen, Senior Medical Director, Nestlé Health Science
- Cecil Rooker*, President, International Foundation for Gastrointestinal Disorders
- Michele Rubin, Associate Director of the IBD Center, University of Chicago Medicine
- Eric Shah, Associate Professor of Medicine, University of Michigan
- Samir Shah, Clinical Professor of Medicine, Brown University
- Mary Jo Strobel, Executive Director, American Partnership for Eosinophilic Disorders

The following Tapestry Networks representatives participated in all or part of the meeting:

- Lindee Goh*, Managing Director
- Ashley Vannoy, Project and Event Manager

*co-hosts for the meeting

End notes

[1] This *Summary of Themes* reflects the use of a modified version of the Chatham House Rule whereby comments are not attributed to individuals or organizations. Use of artificial intelligence: Portions of this document may have been prepared with the assistance of artificial intelligence tools. All content has been reviewed and approved by Tapestry Networks.

[2] Inflammatory Bowel Disease Shared Value Initiative, *Advancing a Collaborative Prior Authorization Paradigm in Inflammatory Bowel Disease* (Waltham, MA: Tapestry Networks, 2024).