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Proem

As I left the Patient Experience Symposium in Boston, (Yes, an in-person conference. How weird!) I felt schizophrenic. On the one hand, has the healthcare industry progressed at all hardwiring the improvement of patient experience? On the other, OMG, so much innovation! I listened to dedicated, diehard patient experience professionals teeming with frustration at the setbacks occurring during COVID-19 days. Families excluded from the bedside; people dying alone; active, engaged, mature patient-family infrastructure canceled, dying on the vine. I also sat rapt, hearing diverse community representatives inspired by collaborative local COVID-19 problem-solving. In this episode I will muse about healthcare innovation, while trying to stay positive.

Thanks to the Society of Participatory Medicine for subsidizing my attendance at the conference and my team, Kayla Nelson and Joey van Leeuwen, helping me make these podcasts better than they would be.

Oy, the noise in my head 02:09

During the Patient Experience Symposium, the voices in my head cycled a cacophony of emotional questions. Isn't innovation the human condition - always adapting, trying something new? Yet, we seem to live in a negative feedback loop – I can't. I'm not good enough. I can't. I'm not good enough. How does innovation occur in healthcare? Can institutions sustain innovation in the face of crises? Wait, inspiring innovation occurs in communities seeking solutions to their local problems with community members leading. Inspiring! What can we learn from crisis-limited innovation in institutions and from innovation arising from necessity? Can we study or research innovation? Can we measure it? Does research itself limit innovation, do institutions by their nature curb innovation?

Let's start positive. 03:14

There's enough discouragement. At the conference I listened to Ifrah Ahmed, a Children's Mental Health Case Manager in the rural Kansas Somali community of Garden City, COVID-19 Through the Eyes of an American Refugee: A Story of Engagement. COVID-19 has shined a bright light on the widening disparities that exist between rural and urban America. These fractures were especially evident in areas

such as southwest Kansas, one of most remote and culturally diverse regions in the United States. The refugees from 30+ countries who worked at the world's largest beef packing plant were unable to isolate from others at work and home, making them some of the most vulnerable Americans during the spread of the pandemic. Hundreds of these essential workers were infected in the same apartment complex. I hope to bring Ifrah to you in a future episode.

Kirsten Meisinger, Regional Medical Director and Director, Provider Engagement, at the Cambridge Health Alliance told the story of Co-Designing Telehealth with Patients. Telehealth has taken off because of the social distancing requirements during COVID, while simultaneously community and religious organizations also converted their interactions to virtual spaces. With the need to communicate regularly about public health information as well as how to access care, these two new virtual spaces have been learning how to interact and complement each other. The session outlined successful and unsuccessful interactions between the Cambridge Health Alliance and partner community organizations. Dr. Meisinger will join us here soon.

Dr. Darlene Tad-Y shared her experience with Hospitals Collaborate to Ensure COVID Care for Every Coloradan. During the COVID-19 surge in the winter of 2020 in Colorado, hospitals in the state voluntarily collaborated to create the Combined Hospital Transfer Center (CHTC). The CHTC allowed hospitals to seamlessly move patients from one hospital to another when acute and critical care capacity limits were reached in any one hospital or region. Transfers of patients occurred bidirectionally between urban and rural hospitals.

Ok. Now the negative. Oh, forget it. Let's skip the negative. I up to the brim with negative.

Research and innovation 06:18

Research is made up of institutions and bureaucracies just like hospitals, health systems and insurance companies. Bureaucracies and institutions favor safety, precedent, and inertia and protect against risk - risk as reputation or cost. Not a value judgement, it's the nature of the beast. I'm most familiar with comparative effectiveness research or CER. CER means A is more likely than B to work for this specific population under these specific circumstances. CER, comparative effectiveness research, needs the comparators, A and B, to have some evidence that they work. Innovation, by its nature might not have evidence yet – no research has yet been completed to show that it works. So, it's hard to get funding to compare innovative interventions to current practice. You ask, what's an intervention? An intervention might be a drug, a procedure, teaching tool, a service, a means of access to services. What kinds of services are we talking about – hospital, clinic, community, neighborhood social services? Got it?

clips when you get home. Check out the app at abridge.com or download it on the Apple App Store or Google Play Store. Record your health care conversations.

Prioritizing innovation – limits 08:32

Some organizations prioritize innovation. For example, Kaiser Permanente funds community health innovations. Even these organizations struggle to scale innovations within their organization (think Kaiser's Southern California, Northern California, Colorado, Hawaii, Mid-Atlantic regions). How hard it must be to generalize the innovation to other organizations?

Innovations in engagement – innovators need innovative settings 09:04

Researchers, clinician and patient-caregiver leaders spend much effort advancing provider engagement with patients. Yet how can clinicians working in an unempowering setting and empower others? If they can't control the time they can spend with patients, how can they do the work of listening? PCORI, the Patient Centered Outcomes Research Institute just sent an RFI, Request for Information: Science of Engagement Funding Initiative. If you're a researcher or patient-caregiver working with researchers check it out. Potential for innovation!

Reflection 09:50

OK. So what? Where does this leave us? Some people regularly strive to adjust, to innovate. Some people hear a negative feedback loop of *I can't, I'm not good enough*. More communities than we can possibly know, do the hard work of innovative problem solving led by members with passion and drive. Some organizations hardwire innovation yet struggle to generalize outside the innovation hub. Many institutions resist change and favor safety, precedent, and inertia. You're never *there* with innovation. It's not the end of the road. It's always a next stop.

Perhaps the sweet spot combines all of this: in healthcare, hardwiring the engagement of users – patients, caregivers, and point-of-care clinicians at all levels of organizations and process. This engagement is similar to communities solving their own problems with community members leading. Engage users, stakeholders in governance, operations, learning, wherever. Another thought: Innovation is not like switching on a lightbulb – Eureka! I've got it. Rather innovation is iterative, persistent small steps, moderate steps – key word: persistent. That's where people with chronic illness may have an advantage. They keep trying stuff, works or doesn't, try again, go back to the beginning. Persist. These observations break no new ground, rather they are the foundation of success, performance improvement, user-centered design. Push on folks. We have work to do. Thanks for listening to my rant.