

## **TRANSCRIPT – Health Connective Show #8**

### **How Physicians Adopt New Technologies w/Michelle Currie**

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Michael: Welcome to the Health Connective Show. I'm your host, Michael Roberts, and we're talking to Michelle Currie today. Michelle is the founder of Savant Solutions for HIT. And she has a background as a registered nurse with a master's degree in clinical informatics. Her work is focused on understanding what providers need before implementing any software and addressing the issue of technology related burnout.

Michelle, welcome to the show and thank you so much for being here. I think that we need to start with a quick question just to make sure everybody's on the same page. Please define clinical informatics for the audience.

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Michelle: Sure. Thank you for the question. So clinical informatics is really if you think of it as a Venn diagram, it's kind of an overlay of computer science information science and like knowledge engineering or knowledge architecture. And so really, you know, the goal is to figure out how can we use technology to really support and enable clinicians to provide the best care to patients and improve outcomes. So in short, that's what it is. But it's the name is, you know, sometimes confusing. And I think also the work can be a little bit confusing too that we do.

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Michael: Oh great. Now we've got that solved. Now we can move on to the next thing. But that's a lot of things that you just mentioned there that need to come together in a smooth and coherent way, which I think we definitely want to talk about quite a bit today. So when we do work as a company, our company name is Health Connective and we do a lot of work with medtech companies.

So as we're developing things for the medtech companies, we're also developing things for their customers as well, which are physicians. And so obviously there's a lot of overlap between what your company does and what we do. So I'd love to hear about sort of like how

that plays out on a daily basis. Seven solutions for it. What does a typical day look like in terms of here's how we're going to solve problems for physicians.

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Michelle: So a typical day, you know, any time that we start with a client I'll kind of start there. We really like to understand the problem and not understand it just from a high level. You know, we want to understand what are the barriers, you know, what are the workarounds that you're doing today. What's not working. You know, how specifically is it preventing you from taking care of your patients? Is there any way that we can decrease the cognitive load, you know, that physicians and other clinicians have, because they're consuming so much information and really trying to pick out what's important and what's not important for any given kind of encounter with the patient.

So that's really where we spend, I would say the lion's share of our time with our clients is really understanding the problem, which I think is a little bit different. But I've always thought that you can't really execute a great solution if you don't really understand the problem in line with that. Talking about understanding their problem, I spoke a little bit about that.

But one of the things that we do is we go kind of a little bit deeper just than what I spoke about, and we talk about, you know, we really get into what are the objectives of what you're working on and help leaders really articulate those objectives and help them articulate it in a way that they're going to be able to measure it so that they understand if they are on track to meet their goals, or if they're not creating objectives that are measurable.

When you're looking at implementing a new health IT solution can be somewhat challenging. I think it's really important that that happens because you know your goal and your objectives. That's really your North Star. And so everybody on the team who's working on a solution from the top all the way down to, you know, a frontline programmer, really kind of need to understand that so that they're able to make effective judgment calls and allocate their time effectively.

And so I often find that what teams don't really understand kind of the big picture, sometimes that big picture can get lost. You know, sometimes it gets misinterpreted or interpreted in a different way. So we start with that. One of the next steps that we take after that, having some idea kind of what the shape they're looking for and what they're looking to achieve, then we really go into the analysis phase and the analysis phase and you know, health care, health care IT, so we start out looking at what is the as is and what is the to be

technology. It's a tool. It's not a solution. And so if you start just by looking at the tool, you may not really address the entirety of what the problem is. And so I'm sure you guys have probably heard that, you know, if you have a hammer, everything looks like a nail. And so with looking at anything just from a tool perspective, you're really limiting kind of the ability to imagine. And you're limiting amount of options that people will, will think about for possibilities.

And so another part of that analysis is we go through what I call the five W's, which is the who, what, when, where, how and why. So there's an H in there, but really understanding at a very detailed level, who are the people who one who are involved. So you know, it's the clinician obviously. But we also like to. Understand it from the patient's perspective. We're hearing about it from a clinician perspective. But how might the patient experience that? We're looking specifically at workflows. You know what workflows are you doing. Are there any efficiencies to be gained in there? What data are you collecting along this workflow? Where do these things happen? How do they happen? Because all of those provide insight into the requirements of what a clinician needs to have to feel comfortable using a product.

And so everyone's probably heard that clinicians nowadays, I mean, I think everyone in the country is pressed to do more with less time. But clinicians, I really think that, you know, we've like squeezed all of the blood out of that turnip that's there. Like there really isn't a whole lot more that we can get out of them. And so we really need to be providing, giving back, I guess.

Then the last part from speaking with kind of the end users, if you will, and understanding their requirements, then what we do is we go into creating what's called a logical design, and basically it's a blueprint or a roadmap for, you know, you might think of it like a blueprint or a roadmap for constructing a complex building. So it's really a solution roadmap and blueprint. You know, we talked about the technology as the tool, but the solution really it involves all of those other things like, okay, who are all the people that we need to make sure provide input into the solution? You know, what is the patient's perspective going to potentially be? What are the data needs that you're going to want to have? Kind of at the end of the day, we're just looking at this process now, but how are you going to want to come back and evaluate that process from a quality perspective later on?

And so it really just organizes kind of all of that content into a coherent kind of package that really serves as the overall foundation kind of for the development going forward in the technical development. That's kind of a day in the life. Any one of those three kind of main, main areas where, you know, we're working in, depending on what phase we are at with any given client.

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Michael: There's a ton there. So you talked about goals, your objectives and what kind of results you can measure. So like, you know, one of the default things that everybody just kind of like drops to is like adoption rate. Did they use it. Did they not. And that's sometimes where the conversation ends is like, did we force this workflow change or did we not successfully and kind of everything else is kind of less important than that. Like one component. Right. Sometimes it seems like what kind of nuance do you try to add to that conversation? What are the different types of things that you try to do to help people think beyond, did I get somebody to use the thing or not?

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Michelle: You know, I think it all kind of comes back to, you know, what do those people need to do? You know, the technology. You know, from my perspective, I'm obviously biased. I'm, you know, a nurse initially is, you know, these people, they're working in very stressful environments. They're also usually pressed for time. They're collaborating with a lot of different people across many different departments. And so there's high you know, there's high requirement for collaboration and communication. And so, you know, if you really understand what problems the end user is having, what barriers do they have kind of in their day to day just to get through the day.

For example, you know, physicians may at the end of the day, their main goal. You know, one of them is probably to be able to go home and have dinner and to not have to open their laptop again at night, you know, to finish kind of charting. They may want to have information teed up for them that is actually relevant to that patient and relevant to that specific encounter before they go into an exam room where they only have ten minutes.

And so really, you know, from my perspective, if you solve the problems that the end users have and you really, you know, like I said, instead of adding a burden, you really take some of that burden away. Then the adoption follows. I mean, if you have a well-designed product that that fits a need, it's going to be adopted. And so I think adoption for me is more of a lagging indicator, you know, and so I kind of try and ferret out, okay, what are those leading indicators that we'll know as soon as they start someone starts to use it or a handful of people start to use it. Are we hitting kind of those marks?

And a lot of it for physicians is about, you know, efficiency. It's about an efficiency not just from a getting through kind of their workflow, but getting information that's relevant, clinical

decision support that's going to help them digest all that information and then get to the next step, which is a decision, you know, what needs to happen next. So those are the types of the types of things that we really focus on is, you know, what do they need you to do? I think a lot of times that what I've seen in healthcare is that technology companies who don't really understand what physicians do come in and they say, oh, well, we think that this is a great product and it may be a great product, and a lot of times it is a great product, but it's not the top priority that people need solved. Right.

And so they only have so much time and only have so much money. And so if it's. Not really addressing their top priority. You may have the greatest idea since sliced bread. It's just the reality that there's kind of a prioritization that happens. So I didn't see some, you know, really great ideas where it's kind of like, that's a great idea, but the timing is not right. You know, we kind of have some other foundational issues that we really need to address first.

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Michael: I was just in a forum where somebody was talking about, is this a Monday morning problem? Will you come back from your weekend and go, I have got to solve this thing right now. You know, there's just so many things that that aren't. One other thing that I wanted to kind of pull out just a little bit. This is a conversation that Justin and I have had on a regular basis, is like that process of trying to introduce efficiency and trying to get somebody to change their workflow, which is like the holy grail, don't touch the workflow. So how does that kind of play out with some of the different products that you're introducing and like how physicians are responding to that?

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Michelle: I've been in this industry and specifically in health at for over 20 years, implemented and been involved in kind of designing and planning many different types of technology for many different types of users. And, you know, a lot of people think that physicians are kind of really resistant to change, which I don't think is really fair. I think that if they have a good product that's well designed, you know, they're starving.

You know, for technology to really be helpful. What happens, though, is kind of like I said, is that if you're going to change something, you're going to add some burden. And so you have to be able to do is to say, okay, we're going to add this burden in the short term. But what you're going to get in the long term is this they're fine with delayed gratification. You know, they can understand that okay. Well I'm willing to go through a little bit of pain if in the end

I'm going to gain something. I think that that especially with our implementation of electronic medical records, you know, I think that there was a lot of promise of what we were going to get out of it.

It was major workflow changes for basically everyone involved who takes care of the patient. And after the fact, you know, we find out that, oh, you know, what our data's not really good. We actually can't use it to improve care. You know, we can't use it to figure out how can we be more efficient. You know, we can't use it to actually now get to the next step, which is doing things like clinical decision support. And I think that that's something that's really important is that, you know, someone may be coming along with a change to a workflow.

What they have to realize is that they're only one of probably a handful of other changes that are going on at the same time, you know, some things that may not necessarily be even technical. For example, you know, as new research comes out, we're developing as an industry clinical practice guidelines and discovering evidence based medicine all the time. And so that really changes not kind of the how they do their work, but also the what and especially with all of the other, you know, demands as well. You have to kind of realize that, you know, there's more pressure being put on clinicians to be more, you know, kind of patient centric to really kind of open up notes that they're writing on patients, which used to be private, you know, kind of opening that up to publicly.

So they're really going through just a major change all at once. I think it's helpful to keep to just to keep that in mind when you're thinking about introducing something new is, you know, you're going to have a lot better uptake and more receptivity if you really are going to be able to say, okay, well, we're going to do this now and we're going to be able to deliver this later, which that also can be hard because I think, you know, right now, I think end users in health care are, they're pretty skeptical just about anything new in general. So that's you know, that's unfortunate, but it's kind of the reality.

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Justin: Yeah, the technology has been around for quite some time. You see a lot more adoption of technologies. But each one of them is, like you said, like introducing more cognitive load and learning this system, switching from this system to this system. They're being pitched on who knows how many different systems. So yeah, you really are just one of several people telling them, go do this thing, learn this thing, and I think some of them probably have not integrated in a way that made their lives easier. So I definitely understand

some of the skepticism on that side. And I think that's where I'm noticing a lot of conversation and pain points.

We went to a device talks conference and one of the keynote speakers mentioned, physicians are tired of dashboards. They don't want another dashboard. Stop trying to give them a dash like they just don't. They don't need just raw information. You need to contextualize. You need to really drill down focus, give them something of value that's saving them time and allowing them to make quick decisions. And there's so much extra lift involved in producing something that valuable compared to just showing information or just putting out a dashboard.

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Michelle: Yeah, I really think, especially with just how AI has taken off, I'm kind of sensing, you know, for a very long time, I would say starting with each our implementations, but then also with big. Data. Just this, this really kind of fast and loose, you know, approach to technology. And, you know, let's just get things in and we'll create all these new efficiencies that in the end ended up not being sufficient because they weren't connected together. But I'm really sensing kind of a, a swing from that, you know, the pendulum swinging the other way to like a more slow and rigorous and methodical and mindful approach to technology, which I think is appropriate, kind of given where we are.

You know, I think it's a we've been kind of going, you know, new, new, new, growth, growth, growth, growth, it seems, you know, kind of sometimes at any cost. And it seems like it's, it's a good time to just, you know, take a step back. Let's take a breath. Let's look at the big picture again. Where are we getting where we thought we were going to get with what we've been developing and focusing on. So I'm optimistic. I think it's going to be a change for a lot of people, that pace.

But I do think that we'll we will get to better solutions in the end. And I think I don't know if you guys have ever heard this, but or have worked for big organizations. So I worked for a few big organizations and I've heard more than one time, you know, Michelle, you need to slow down to speed up. I don't know if either of you guys have heard that, but I really think right now there's so much potential with where we are right now. If we could just slow down, take a breath and say, okay, let's right this ship that is really going to point us in a direction where we will be able to then accelerate with what we have available right now. But I'm afraid that if we don't do that, you know, we're going to have another missed opportunity with AI, which that would be a shame.

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Michael: There's a lot that's going through my head right now, just in terms of talking about AI and like implementing it into decision making processes and all that kind of stuff is like, what's the regulatory burden on something like that? What's the, you know, risk around something like that? Definitely a lot to think about there. And you want to know, I mean, just before this, I had ChatGPT going and, you know, and I was running some different questions through there and everything. And they've got it very clearly labeled, hey, this stuff isn't always correct. So like make sure that you check it and it's like, yeah, but I don't want that in my doctor's tools. Like I want to know that my doctor is getting the tools that are correct every single time. So yeah, there's a lot to deal with it.

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Michelle: I think that's a really good question. Well, so there's one question that has not been solved. And it's who's accountable at the end of the day for making a decision. And so physicians they're licensed like other types of health care providers. They're licensed. And with that license comes incredible flexibility to, you know, to practice to the top of your profession and to make judgment calls based on experience and education. And so, you know, when I comes into that, because that question hasn't been answered.

And to be honest with you, I'm not sure that we ever will answer that. And I'm not sure that it'll be the same answer for different situations. I think that, you know, right now the things that are the most confusing are more kind of the ethical questions and just who's going to be accountable for this? Do patients have the right to say, no, I don't want you to use AI in your clinical decision making. And so right now, you know what I'm saying.

And I'm not sure if you guys are aware, but the office of the National Coordinator just came out with their health technology, a new health technology rule that basically it does address AI. And someone just kind of the baseline provisions for what is going to help the industry feel more comfortable moving forward. And one of, I think the main things that is pretty easy for people to wrap their head around is, you know what? What underpins all of that is the data.

You know, I think now we I think now we've seen someone posted something as some internal employee from OpenAI when that whole year was going on about, you know, they said, you know, at the end of the day, you can, you know, create a billion parameters. You can basically pimp it out, you know, if you will, to the nth degree. But it really the only thing that is going to be a differentiator is the data that you use it on. I think it's easy for people to understand how, at a minimum, physicians would want to understand, okay, what data was



this trained on? You know, what is the context of this data? Because the physicians, they understand the validity of that data and the quality of that data.

And so then they're going to be able to take that into account to determine, okay, how big of a risk is this? If I actually make a wrong decision versus what is the risk? Is it just an efficiency risk, you know, or is it really like a life and death type of risk? So that's one of the things that I'm kind of seeing that more people are starting to focus on is just really the what is the underlying data. Also, I think people are really starting to understand and appreciate that, you know, that data needs to be in context. A lot of people are talking about knowledge graphs, kind of just as the underlying okay, these are the concepts and these are how all these things are related, you know, and that in that large language models to some extent that do have that as an underpinning as well outperform large language models that don't.

So I think we're learning a lot. You know, we're learning I think faster than I thought we would. But I think again, that's because people have really slowed down and kind of taken the time to understand it.

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Michael: I told you at the start of the show, like, hey, we have a script and sometimes we use it and sometimes we don't, and I think we're kind of on there. Like sometimes we don't train, which is a lot of fun. Definitely keeps things interesting. We've kind of talked about this a little bit, a few different ways, but jumping headfirst into a technical implementation, it's a losing battle if things are going to go poorly. We've talked a little bit at sort of like these kind of like three big buckets. I think that your, your team kind of walks through. Is there anything that you kind of would add to that as you're talking about like sort of how your team tries to solve the underlying problem and doesn't just start building out the project, whatever that is.

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Michelle: One of the things that I think is really important and really helpful. And again, I'm a little bit, you know, a little bit biased, but I, I do think that it helps if you have people on your team who have some credibility just out of the gate with a clinician. And so anyone who's worked in health care, I think at all, regardless of kind of what your role is, another clinician or physician, for example, is going to go, okay, you know what? They're an insider, you know, kind of as opposed to an outsider, like if they've worked in this industry for any,

any amount of time, you know, they know all the pressures that we're under, right? They know how complex all these systems are that we work in.

And so I think that that's really helpful. And really what it gets at is just being empathetic. People are so burned out and so frustrated that, you know, like sometimes it's not a bad idea just to let people vent for a little bit about what's not working and what, you know, why it's not working. That kind of brings in a very different kind of approach and just a different skill set, kind of then, you know, a technical person, it's really it all comes down to trust.

I've always said, you know, technology adoption, it moves up the pace of trust. And so I think that, you know, establishing that kind of out of the gate and having people who not only understand the situation somewhat, that if physicians are in, but, you know, also being able to just speak the language I think is really helpful, you know, there's all of these little things that kind of just get you one step closer to that handshake. And so I think, you know, all of those are important. And I think that this will make sense to people outside of health care.

You know, business analysts play a very important role in all industries in health care. It's a little bit different. What we have, what a lot of people call our informatics, those are really our business analysts. Now, some of those really were pulled off of the front line during EHR implementations, and they became a super user. And then they might have gotten into training, you know, for example. So those people are kind of the equivalent, you know, in other industries as your business analyst. And so a lot of times those people, if they have the aptitude to kind of think technically and to really be able to just break things down into components, they're really helpful to have on your team.

So I think that might not seem like it would go a long way. But to me, you know, I've seen it kind of make the difference between something that's a go and something that's a no go, because then what I think the secret is, is and we were talking about adoption earlier, you know, the industry historically and I think still has this push mentality. And so what we try to do at Savant Solutions is we try to create solutions that work so that there's a pull, you know, we don't ever want to be pushing something on somebody because they have enough pushing on that.

You know, we want people to be pulling like, hey, going to their executives, going to their CFOs, you know, and really kind of spending that political capital, if you will, saying, no, we need this. We need this person to come in and help plan our implementation. And so, you know, that's really what I try and do with our clients. I try and I do workshops and education on kind of just our process. That's really the change that we're really looking to effect kind of in industry is to really transition away from kind of that push more into a pull scenario.

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Michael: I like that. Also, I wrote down tech adoption moves at the speed of trust. I love that that's a that's definitely going to be one of the pull quotes that we use for this episode.

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Michelle: That's great. That's not I didn't make that up. It's all. Good. In the words of someone else and also Michelle Currie.

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Michael: So Justin, most people aren't into privacy policies writing them or reading them. And the reason is that they're usually too dense and too difficult to understand. And some of our client work, we were able to help out with revising and even simplifying a privacy policy. Can you? Speak some to that process.

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Justin: Very few people are excited about legalese. Certainly most consumers aren't. But that doesn't mean that you don't have a responsibility to accurately represent what you do, how you track people, and making sure, especially that you're compliant with legal statutes throughout various regions. The way I view it is that we're supposed to be a good partner who is providing expertise everywhere and can guide on the technical front and understands how what we do fits into this broader picture and how this language is not a bother. It's an essential part of our product succeeding.

So yeah, I was excited to talk to a few people on the legal and privacy front about this. We stepped through kind of an initial template that they had that they were borrowing from somewhere else, and we went through it item by item and discuss how that would actually apply and whether it was applicable. So we walked through that and what we came up with for this one application, it's being applied across other areas within that organization. Now it's become the new template.

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Michael: I mentioned at the top of the call that Justin's on the call, so that we have all the smart technology people here, and I'm just the marketer guy. But you know, in marketing, so much of, you know, that kind of like voice of the customer, like all of that kind of stuff that you're trying to obtain and you're trying to get all along the way. I think there's this like natural inclination that we have as promoters, as somebody that's trying to keep the people happy all the time, is that somebody starts venting like you're just saying, like they need to just let this out. Like, man, the thing that I'm using and all these pressures over here and all the pressures over there, and marketers may have this like, kind of negative inclination to come in and go, yeah, but it's not our product though. Our product is making everything better. And that's just only creating more tension and more frustration, like the empathy isn't there when you come in and you try to fix these things.

And I say this as a man that's been married for more than 20 years now, and so like this is bad trends that I had to unlearn. I think when we first got married, he was trying to be the fixer, you know, and trying to come in and not really listening well enough and that sort of thing. So I think there's a lot of things here for people that are in this space to, like, really take to heart because it is easy. We want to come in as the business that saves the day, and sometimes we just jump to that way too fast and we don't listen well enough. So a great point. Great point.

What I like to do to kind of like wrap up is always say like, hey, is there anything else that you would add to this? Like we had a script, we kind of worked from it. We kind of didn't. But like, is there anything else that you would definitely want to, like include in this kind of conversation around sort of tech adoption?

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Michelle: I mean, I talked a little bit about things that I think are enablers, you know, and how to kind of approach things, maybe from a different perspective. One of the I think most significant challenges that we face right now in healthcare is with our data. Like you said, you know, people don't want just one more dashboard. I think some of that is because they don't want a dashboard that then they're going to have to figure out, okay, how do I analyze this dashboard? What does it mean? What is it telling me? Where's my piece of it? You know, they want things that are tailored to them.

But I think in in general right now, I've been trying to educate myself on this for six months, you know, why do we have such why do we have such low quality data? One of the things, just in general, that we're going to need to be able to do in the industry, to be able to move forward and to be able to decrease that burden, is we have to be able to reuse our data.

Just be on sharing it. Me as a provider to you as a provider for the care of one patient, you know that we can do that. I mean, we've been doing that with facts forever. It's not efficient, but it's effective, and that's why we still have it. But, you know, really kind of be on being able to share that data we need for people to be able to store it and hold on to it, and then for them to use it. Right.

And so in order for that to happen, the data needs to all be kind of structured in a similar way. And the data has to mean the same thing to different people. And so those I think are two of the major challenges that we have right now in healthcare is that, you know, I often use the analogy about different healthcare systems in different databases. You know, the way that I talk about it to non-technical people is like, okay, if you think of a database, it's really it's somewhere to store things. Right? And so it's kind of like a container really, you know, and it's simplest, it's simplest.

But then you also, you know, you build that into storing different kinds of data and you build it for efficiency. So, you know, I talk to people and I say, you know, if you think about it, an analogy I think that's really easy to understand is, okay, let's say, Michael, you know, your database that you have is built on Legos. Okay. You've got Legos for your containers. I'm going to see. Okay. You know, Michelle, like Abraham Lincoln just happens to be one of my favorite presidents. And so I have Lincoln Logs. Then my data is in, right? And say, Justin, you know, he actually went for like the Tinker toys.

So I think just kind of is like a really easy analogy. So you can imagine, like, Michael, if I ask you to send me something and I need a log to add, you know, to make my door and you send me a Lego, I'd be like, okay, well, I might be able to look at it for right now if I have to answer the question, like, what color is something that's great, but I can't really use it after that. What we end up having, and I think that this unfortunately is the case even within one single organization, is I feel like we just have all of this tech to and all of these, like Frankenstein, Frankenstein systems that have been like a Band-Aid upon a Band-Aid, upon a Band-Aid, upon a Band-Aid that we don't even really know. Okay. What was this meant to do originally? You know, what did this mean originally?

And so right now, one of our major challenges is, in addition to the data, like syntactically being the same, we use different words for the exact same thing, you know? So for example, I think this will also be interesting or I think this will be easy to understand for the audiences. This is kind of one of my soapboxes, because I've been working with people's legacy data and mapping it to newer standards so that it can be interoperable, like fire is, you know, if you just take three organizations, you know, and you go, I go and look at their back end database, one organization, okay, they've got a table with patients and they've got another table that's a key to that one connected to it for diagnoses. Great. Perfect.

Understand what that is. Well I might go to the next organization and they've got their patient table and that one's connected to a table. But they're at that table is called a condition table. And it conceptually it is the exact same thing as the diagnosis table. But literally because computers work off of ones and zeros, it doesn't know that. Right? I think a lot of times we think that technology is really capable of doing a lot more than it really is. It is it's really easy, I think, to just assume, oh, well, of course that can happen because we can do so many things with technology, but you get down to something that's simple and it really is sometimes that simple.

It's just what do you call things? Some people call something and encounter another person. So I'm going for a visit. Oh, well, I have a hospitalization. And so if you think about multiplying that problem by the tens of thousands of words that we have in health care, it's not an easy nut to crack because it's not purely a technical problem. It's really what do those words mean and what do they mean to the business? I've been reading a lot, you know, lately are people saying, oh, well, AI is going to AI is going to take care of that. And I always say, well, I think that's great. People get a lot of views and they're getting paid, I'm sure to, you know, publish, publish articles like that. But that's for my perspective. You know, again, that's kind of just magical thinking from my perspective.

At some point there has to be something, some foundation, right, that all of this sits on top of. So I think that's one of the last things is just, you know, really we've got a long way to go with our the quality of our data. But I do think that people are starting to realize that, you know, a year or two ago, people didn't even really realize it was a problem, I would say. And now people are really starting to understand that it is a problem and how complex it's going to be to, to address. But we'll get there.

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Justin: So working in medical device, we're separate from hospitals that are maybe acquiring these devices. And the desire to give them something valuable in terms of post procedural information is hobbled by needing EHR data to contextualize it in a way that provides value. Right. So they want to know reimbursement rates, insurance plans, like they do want to be going back up to their CFO to like the executive management and explaining, look how much we're saving by utilizing this technology.

Like you said, they don't mind learning the new technology, but you need to be able to prove for them that it's going to make their lives better, save somebody's money, like improve patient outcomes. And if you're not getting at that patient data, then you can't really demonstrate that. And who has time at the hospital to pore over that manually case by

case, to assemble that evidence. Right. But even if you could get it, the EHR data, like even if you have some kind of API later, I know there's some companies out there that are doing some pretty remarkable jobs in building that API to unify communications across several different EHRs. There's still the problem of the hospital now handing the data over to a third party, and all of the logistics go into that. And so many people within that on both sides are so risk averse with it. Understandably, it's a highly regulated field.

This is very critical, very private information. But like yeah, these are really. Challenging hurdles that I think nobody is fully figured out yet, but I'm seeing a lot of pain surrounding that and a lot of desire to figure it out. So yeah, seems to be a lot of conversation happening in that space. From what I'm hearing.

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Michelle: There definitely is. What you just said kind of reminded me about something that we talked about the top of the hour, which was that things are very siloed in health care. If you think just about health care and going to your doctor, that's kind of historically how health care is set up, right? You have specialists of doctors, right? You have specialists. Every single department or function is very specialized and don't really know a whole lot about any of the other silos.

One of the things that I think is something that is new, that that we are going to need, is we have the experts in the silos, but what we need are people who understand enough about each of those silos that they can connect the dots and kind of, you know, like what you were saying about being able to go back and find the right information to substantiate a purchase, right, for new technology, new hardware, whatever, new capital.

Oftentimes that data comes from outside your department, because ultimately you're going to need to understand the impact on the cost. And that gets down to patient claims and reimbursement. That's one of the things that I think that there is a need for those people who understand enough about the whole system and how all of those pieces fit together and how they impact each other to be able to connect across those silos.

To me, you know, the silos is kind of like the low hanging fruit. You know, we've all kind of focused on optimizing each of our silos. And now it's kind of time to do the, you know, the much more difficult work, I think, of connecting all of those together and looking for system level efficiencies and improvements.

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Justin: Makes a lot of sense.

00:36:59

Michael: Michelle, this is a delight. Thank you so much for coming on the show. We really do appreciate getting the chance to geek out over this stuff and to really go deep on these conversations. Definitely a lot of shared pains and frustrations, I think, here on the call, but a lot of a lot of interesting insights as well in terms of how physicians adopt new technologies, how important it is to actually listen to people and to hear their pain and to empathize with what's going on with them. So you can find Michelle at her company, Savant Solutions for hit. I think I've come across you on LinkedIn, so I know you're there. Plenty of other spaces as well. Thank you to all our listeners for joining us on this episode. For more on the Health Connected Show, please visit HCA show for previous episodes and Health Collective as a company. Thanks, everybody. Thank you