TRANSCRIPT: The Hospice Technology Conversation Leaders Need to Have—with Hannah Patterson | Part Two

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Welcome to TCN Talks, and Anatomy of Leadership. We continue the conversation with Hannah Patterson, VP and General Manager of Care at Home Provider Markets at Netsmart. In part two, The Hospice Technology Conversation Leaders Need to Have. And now, here's our host, Chris Comeaux.

AI And The EMR Reimagined

Chris Comeaux 1:09
Well, all right, we kind of set the table. So as we go to this next segment, I really want to start doing a little bit more of that look forward. So we talked about the concept of technology as an accelerator. So as we look at AI and just all the things that are happening right now, are we going to be just adding some capabilities to existing EMRs? Or are we on the verge of fundamentally maybe reinventing the electronic medical record? And then maybe at the end, Hannah, can you weave in what will this maybe look like five years from now?

Hannah Patterson 1:39

Yeah, great question. There are so many new vendors to our industry. So uh if you get, you know, you're at a national conference or you're at one of your state associations, uh, even the last three years. There's and there's a website that's out there that says how many companies are entering into our industry each year and then how many are still there the next year. But I think the evolution of what an EMR is is going to change drastically. There are new vendors in this space that are not calling themselves an EMR. I think there's some taglines and specifics that say you don't need to have EMR to deliver your care. And I think those are valid opportunities, uh, should you go that direction. Obviously, I work at a uh software and technology company, but I think we and I personally believe that the EMR concept really falls to the back end, meaning it kind of becomes the operating system and we kind of move forward with these AI headless app approaches that can deliver the services for our industry. So I won't dismiss the fact that I think you're still gonna have, you know, AI still has to run on an operating system of data. It still has to understand the trends because it's feeding data and the agents, depending if you're using Agentic, large language models, those types of things. But I think the evolution of what an EMR is or how services are delivered is gonna look so, so different. I think, you know, most companies are doing three to five year plans, and it's really hard to even think about what three years even looks like, because if you think about where we were this time last year, AI agents, bots, RPA, all of these things have evolved so, so fast that it's almost like you gotta strike it and start over. So you gotta keep iterating of what that looks like and where do you go tackle first? So I think, you know, in certain aspects, and we're thinking about it from the lens of every single discipline, every single end user has mundane tasks or things that they log into their systems every day and they have a checklist of things they need to do. How do we make sure that we can evolve that in a in a manner in which they can do more with less, right? They don't need to, you don't need to take on more caseload, but how do vendors and providers in this industry really look at the workflows to support the end user adoption, to bring the right information at the right time for that staff to be more efficient and support

Supporting Clinicians In The Home

Hannah Patterson 3:56

it? So, you know, I mentioned I think a little bit earlier, clinicians and hospice and home-based care specifically are in a very uncontrolled environment. And it's not a negative thing, but you know, they're they're driving from home to home or they're taking public transportation and you don't know, you know, we talk about crisis in hospice, you do not know the type of environment that you're gonna walk in when you knock on that front door. Um, and stakes are high, people are very, very intense when they're losing a loved one. Um, and that that's a normal thing. But those clinicians, if they're not trained and

they're not confident and they, you know, don't have a support system that they can make sure that they can do the services, they exit the workforce, which is a concern. So how do we create an environment where they feel confident? Because it's much different than acute or a you know, four walls, even an I an I uh inpatient unit, hospice inpatient unit, IPU, you have a charge nurse station, right? You have a friend, you have someone that you can go in a brick and mortar building and a wall to converse with or have a conversation. How do we enable, you know, some type of even bot of like, oh, I'm experiencing this? That's a great even learning opportunity for a new clinician in the agency of, hey, this is her first or second visit. This is traditional hospice or a routine appointment, but it could look different because of the surroundings that are happening in the home and they don't know how to address that. How do we make sure that they feel supported when they're going out into the home themselves? I think that is a really unique perspective that our industry is also no different. You know, my husband's an electrician, so I use this as an example. You know, he's up in a windmill or he's up on a tower up by himself. I'm like, who are you talking to if something goes wrong up there? Right? I don't want to know. I don't want the text, but like I do wonder, right, for electricians that are doing that in other independent workforces, we have to think about the problem differently. But how do we enable our staff that are in our industry to do things, you know, successfully and feel confident, even though it might not be because of their tenure or they haven't been in the industry for longer than a month? We have to build that ecosystem of support so they feel supported and the care that they're delivering.

Chris Comeaux 5:57

Man, there's so much to unpack in what you just said. Um, so I have a friend. It's so fascinating. And so this friend was scheduled to be on the flight that went down in the um field in um, I think it was in Pennsylvania during 9-11, but his assistant uh changed him the night before and sent him out early. Long story short, he ends up in California, realize he should have been on that flight. Now he's stuck, he has to drive across the United States and he ends up envisioning a new company. And I can't tell you everything he did, but the gist was this. He would feed intelligence agents, he created a system that would feed intelligence agents out in the field what they need to know to perform their role, which is kind of my point of what you just said. But it's interesting where you started talking about the EMR, because historically, a medical record, you think about back in the day, it was in writing. So I go grab a big old chart, and I'm going through the chart and I'm trying to find out what I need to know to perform my role. But in the electronic side, that chart became a whole bunch of documentation that, yes, you could pick out hopefully what you would need to know to perform your role, figure out what's most important, make clinical judgment. But a lot of what's in that chart is then driving the regulatory things, the things, the boxes we have to check to get the bill out. What you're

painting the picture is more like what my friend created in the future. We'll take care of that stuff in the background, but app solutions tools that help you do a better job with that judgment so you can show up the best you possibly can, keep you safe, but even more than that, help you serve the patient and family. Did I do a good job kind of taking what you said?

Hannah Patterson 7:31
You did a great job. I I will never forget, you know, the the little tabs, uh, the little the colored tabs that meant something different from the QA perspective. Nothing brought me greater joy to go up to the actual nurses station and rip out all of the blue ones because we had addressed that in the EMR at the time of ICD nine to ICD 10 conversion. But you're 100% right. How do we think about enabling there? They're doing their documentation. If you think about it, right, go let's let a clinician go into the patient's home and have a conversation, right? Take the device out of it. But they know what they need to ask as part of their visit. If it's a start, you know, if it's a new admission or if it's a routine or it's, you know, a visit that's happening in the last 72 hours or it's the visit in the last seven days, they know the nuances because they've been trained of what needs to be asked and the differences, but how do we give them the information that might have changed a little bit to ask the right questions or engage the patient or the family in a different manner because of the information that we provided to them?

Chris Comeaux 8:31
Yeah, it's

Matching AI Tools To Skill Levels

Chris Comeaux 8:32
interesting. I um you and I had some scheduling things we worked around together today, but one of the things I had to fit in was one of my new board members who actually is a physician, he's a practicing neurologist. We had a fascinating conversation because we were going through like what things that TCN is working on when we got to technology, and he is an incredible physician. And he was sharing why some of the Ambient AI does not exactly work for him, because he's such a virtuosic physician, and there's something in where he's working it out in the documentation, is allowing to do what he does. So here's kind of what hit me is that as we go forward, we have to almost stratify our users. Because, like, if I'm a brand new novice physician, I might need the prompt of like, what's the framework to assess the patient? So maybe you have a tool to aid me. Whereas someone like him who's been doing it so long and so virtuosic, how I utilize that tool might feel different. So how you meet where that person is and their like

skill level, but this is the type of stuff that's going to be possible, right? Hannah, instead of treating everybody the same, this is the promise of this age that we're going into.

Hannah Patterson 9:39
Yeah, I think about how we um enabled AI for our users at our company, right? Um, we're a Microsoft user, we enabled Copilot. Um, and even the slight recommendations, which is suggestive text or compose or whatever you want to call it, people are gonna start adopting it, right? You're naturally inclined to just click the little icon that's there and see what you might get. Or I'll, you know, I use it because my tone sometimes can be very transparent. So if I know I'm responding to an email, I'm like, oh, that seems very aggressive. Let's see what AI might suggest and make it a softer tone. And I like that better. It but people might read that and think, that's not Hannah's response. But they know. But I do think, you know, you think about from a quality and a QA and a compliance standpoint. I think about, you know, in our in our industry, you've got your nurse practitioners, your physicians are obviously providing hospice and palliative services within the caseloads. Then you have your nurses who are doing their documentation. You're gonna have all sorts of adoption ranges, right? Physicians are naturally inclined. They want every single supplemental tool that they can possibly have. They will also declare that some things may not work. So the physician that brought just brought on your board, ambient listening isn't gonna work for them. There might be a physician that is also gonna say and come to an organization, say you have to have ambient listening. I can't do my job without it. So we as a software company have to consider those variety of types of users, but also give the optionality. So I think there's an opportunity, you know, adoption is gonna come and ebbs and flows. I think as a as a provider, organizations are really gonna have to focus on change management or education because I've also heard when agencies or organizations have adopted some of the AI technology, they also share the clinician completely forgot how to do their documentation. Like they just relied on AI so much, or they relied on um the documentation piece of the AI and they didn't really QA their own work. And I also can see how that can quickly um turn

AI As An Accelerator Not Replacement

Hannah Patterson 11:46
into a negative adoption factor. But I also when you do that, then it's gonna jade the agency for a period of time. And then I think their quality is gonna potentially get challenged. So I think there's a balance, but I think we're in this amazing opportunity of moving forward and helping our industry really advance the quality of care that we're providing and spending time with the patients when it's most critical.

Chris Comeaux 12:10
You know, you know, there's some of these. Um I'm a connoisseur of mini podcasts. And so when you listen to some of these podcasts, I do consume a lot related to AI because I think it's leading edge thought. But one of the, you know, the doom ones are, you know, the AI is gonna eliminate all our jobs. No, actually, just listening to what you just said, it's gonna take our jobs to a different level.

Hannah Patterson 12:30
Yeah.

Chris Comeaux 12:30
And so we actually have a blog coming out. I think it actually is gonna come out the week after you and I show airs. And so my mentor was Stephen Covey's mentor, and at the age of 92, he wrote a blog about AI, and this was in 2018. And the punchline, and he said, is that if your job can be eliminated by a robot, it should. What he was, and he was a um he was Stephen Covey's mentor, and he was all about high performance, that you should be performing your role. His his term was he loves being a virtuoso, which if you know in the arts, and that's the person practicing to be the best of the best.

Hannah Patterson 13:08
Right.

Chris Comeaux 13:08
So here's what he was poking on. If I'm copying and pasting AI, I am adding no value.

Hannah Patterson 13:12
Right.

Chris Comeaux 13:13
But if I'm utilizing a tool like AI, and I was already working on trying to be the best clinician there is, the best podcaster, the best CEO, whatever, it's going to become a tool and help me perform at a different level. Not to eliminate me, it's a tool in my hands. So, do you kind of agree with that? So we actually have a blog that I kind of poke on that, kind of challenging everybody that going in the future, number one, we shouldn't fear it, but we should become great wielders of it to not copy and paste, but to do what we do at an even better level.

Hannah Patterson 13:43
I couldn't agree more with that statement. I also think about the, you know, my children who are obviously much they're 10 and well, to nine and seven, and their use and

understanding of AI already is extreme. So my goal is to stay smarter than my kids to some extent, but they won't know any different. So I think we have to also challenge ourselves of how do you use technology and AI specifically to elevate where you are today. It is there to help and guide. It shouldn't eliminate the oversight and the thought that you have because it doesn't have a natural thought on its own. It's a model, right? It's being trained. You have to provide the context. It starts to learn who you are, it starts to learn all of those things, but you still have to have the oversight. So it's an enable. We we say at Netsmart, we say it's a AI is to enable the clinicians and to enable the end user with their experience with whatever tasks they're doing. I absolutely want it to take away the mundane tasks that they're looking it up, but I use the reference of every single time I open my laptop, I've started the thought of what I needed to do first. What a brilliant concept of technology getting that information for me. So if I can talk into my computer and tell it to go find this email from Chris Comeaux on this date or had referenced this, I just save three minutes of me trying to figure it out how to go find that in my Outlook because of how, you know, I think we just have to be use your resources in a much better fashion to be able to do our jobs better.

Chris Comeaux 15:13
Which gets back to our kind of whole concept of technology as an accelerator. It's so funny you and I didn't share that, but we use a similar term. It's not to replace the humans, it's to enhance the humans.

Hannah Patterson 15:23
Yeah.

Chris Comeaux 15:23
Um, well, we've we've not gotten into like how is some of this technology gonna help with the delivery of clinical care. Like, do you think that there's like give them kind of a promise of maybe things where the technology may go, hey, pay attention to this, or to help them up their clinical game as far as benefiting the patient?

Predictive Analytics For Better Hospice Care

Hannah Patterson 15:41
Yeah, I think um I think of this concept a little bit like the predictive analytics, like is probably a concept that I'll use. So if you think about a six and 12 month mortality risk or hospice visits last days of life, you see very rudimentary data points on a hospice patient that are critical path of the delivery of care. So what a brilliant opportunity to be able to understand that I have one social worker visit and two nursing visits happening in the last

seven days. But my data based on the care plan, the documentation, the notes, the medications is telling me this patient's gonna pass in seven days. How do I make sure that that patient is receiving the best possible care with the information that my chart, this patient's chart, has already told me? So using the technology to assess the data points that gives me that information helps the agency, the scheduler, the clinician, the case manager do more during that time. I'll also use it as, you know, if you have a narrative section in one of your notes or your routine visit has just a free text area that the clinician can write a free text out. When they do that, the idea and the intention behind AI being embedded into the technology that you're using is it's looking at the patient's comorbidities. It's looking at the previous patient notes that it might have been you as the nurse or it might have been another nurse, and it's gonna call out, hey, did you know this happened? Are you sure? It's also gonna look at the billing requirements. There's certain words that you know that you obviously shouldn't be using, or a clinician technically maybe not be using. Um, and we train and we coach and we QA, but what a brilliant idea of, hey, did you suggest this term or should you have used this term? And then from a quality and uh education standpoint, the technology says, hey, Hannah Patterson didn't pay attention to this. She ignored this prompt. Also, an opportunity for a nurse educator who has responsibility for three to five teams at an organization of saying, I need to re-educate here, or maybe I need to do an educational program here. So I think there's so much opportunity that we have at our fingertips right now that we have the opportunity of making sure that clinicians and staff from an interdisciplinary team can do their job successfully with

Data Ownership HIPAA And Governance

Hannah Patterson 17:50
AI.

Chris Comeaux 17:50
Let me ask in the weeds question that I think a lot of leaders kind of wrestle with. You've alluded to wearables, and so I've got a Fitbit. My wife and I are about ready to get, she's been an Aurora person, but we're about to get an aura together. And we're gonna be working with this interesting app. And so I'm getting older, I got a lot more doctor visits, and so kind of one cool place where it's got all the data, like a dashboard at a personal level. So that's the future we're going into, right?

Hannah Patterson 18:15
Yep.

Chris Comeaux 18:15

And so it's interesting. Even my daughter asked the other night, she goes, So when you kind of agree who on this app, whose data is the um your personal data? So like you have the original data input, but then that data is utilized to like create dashboards and things like that. Whose data is the original kind of data, and then there's derivative of the data? Anything you think the leaders need to know about that?

Hannah Patterson 18:40

I love, hate the data question. So um it's an interesting concept though, but I do think that when we think about who owns the data, the patient themselves, right? You have to think about HIPAA. And obviously, any type of contract that providers are as a patient, right? I'm an Apple user. So on my Apple Watch, I I have the opportunity of sharing my health IT or my health kit with my primary care physician, depending on what I've turned on in my own settings, if it's my blood pressure, if it's my gait, if it's my strides, if it's my, you know, anything that I can I can do. But you really got to start with HIPAA. And what does HIPAA say and doesn't say? It doesn't assign the ownership, but it governs how data should be used and discussed and disclosed. So in practice, I think ownership and data use rights are set by the contract. So if you're the patient, you're consenting to, you know, right now we're not, my understanding, in this industry, which is where I think we should be going, and it's a fun concept to think about. As the patient, I would love to be able to share this information if with my primary and with my if I was on hospice, right? It would be a great thing that I, my watch could actually tell my hospice I didn't get out of bed and I took less than 200 steps yesterday. Um, but the clinical data at the end of the day belongs to the hospice and to the patients of the family. But as a vendor, we hold it as a steward and not the owner. So I would never tell a hospice organization say no to AI, right? I'd tell them say yes with guardrails. You got to think about the explicitity in the contract. It's de-identified and HIPAA as a standard. Um, demand transparency. Uh, I'll also say I think there's some, there's some opportunity of looking to make sure you keep human in the loop. The clinician says accountable organization has AI governance structure. I think that's a critical piece of where we're going. So if your agency and your listener in today, if you don't have any AI governance, maybe start there and go look to see what that might look like. Security, policy, privacy. But, you know, if you think about how QAPI was implemented, I think use that same foundational element, keeping the human in the loop. Um and also, you know, you may not use this technology forever. So make sure that when you're planning the exit or just with any other contract, know what happens with your data and any of the derived outputs when that relationship could end. So, you know, I'm always a big believer. I want to see it before I believe it and I want to touch it and I want to do stuff with it. But ask to see where the data flows. Where does your PHI go? Where does the information, where is that stored? Who can see it? Who has access to it? So your daughter's asking a great question. I love it, but you know, there's some, there's some

nuance that, oh, it's in the cloud. All right, well, is it going to a table? Is just in the ethers. Like I look up at the cloud, you know, like I understand it's in the cloud, but what tables or who has access to said data in the cloud? And when a vendor may say, well, we don't have that, press harder, right? Ask demand transparency, see how the model was built, see how it's being trained, see how it's being validated. As it we're an ONC certified vendor, so we actually have to disclose this information for any of the analysis that we're doing, and we have to go through um cert testing. So that's a that's a critical path. And CMS is on already the path of putting together some policies and procedures around AI governance, which will be interesting to see and hear. And states are already taking their own mission into their hands. So there's got, you know, some states have already implemented the adoption of AI in healthcare ecosystems, which is interesting. But to go back to just your your own data, you own. Your own data, it's your patient data, but who you share it with then becomes more critical of what those providers are doing with it, to your point.

Interoperability Standards And Funding Gaps

Chris Comeaux 22:09
Perfect. Thank you. So you alluded to this earlier, interoperability. And you know, I'm not a very smart person, Hannah. So whenever I get really good analogies, I stick in my brain. I forget where this article was, but it was talking about the challenge of interoperability in the hospital space. And they use the analogy. I think it was in the Civil War. Part of the problem with uh railroad tracks or trains on railroad tracks is there were different gauges. And so they couldn't, one train couldn't go everywhere because the gauges were different. And then they use that analogy that that was part of the problem within the hospital space. That's why data was not easily interoperable. So let is that a good analogy and then now bring it into our space. Is there, are we creating standards by which we'll have the same gauge tracks in the post-CQ continuum? And part of the challenge, right, was the major vendors in the hospital space were like, well, I kind of like my track. And if your track and my track are the same track, I may not have an advantage. And that's where the government, I think, kind of stepped in a little bit. So you could probably clean all that up.

Hannah Patterson 23:08
No, I , I totally get it. Interoperability is such a broad term and it can be perceived negative and positive. But I think I'll go back to my personal story. We have to have standards of what interoperability means, right? So when you think about treating a patient from cradle to grave and the experience that they have, you could, as a child, you might have a mental health diagnosis that might end up triggering when you become a patient on home health or hospice. But interoperability has been in healthcare for decades. But I

know hospice organizations have struggled to get data from their acute providers or to even get the most meaningful data. So in my lens and from where I sit, it is table stakes. I will tell you that when I was on the AdVion board of directors and I led and championed our technology committee, um, we were advocating on the hill for standards. And I won't get in you know, you talk about the alphabet soup language and this interoperability, but the US CDI or on version three and the HCITI one. Um, there are specific data points that are really, really critical. So, you know, if you think about a basic patient face sheet, that information should just be shared and it should be consumed into whatever technology and program that you're in. I shouldn't have to re-enter someone's patient's name, date of birth, social security number, address, all of those things. So I think it's it's table stakes and how do you reconcile? So, you know, you think about the full continuum and you go into this value-based care arrangement concept, your medications are your medications. They're you maybe your um frequency and you know how often you're receiving that med is gonna change based on the outcomes, right? Because if you're in acute setting, their goal is to discharge you. Um if you take a patient on a hospice, their goal is to make sure that you're most comfortable. So medications though are probably gonna just be reconciled. And I think when you ask, you know, interoperability, there's so many different pieces of data that can be integrated or interoperable. And who owns the source of truth? Where do you reconcile? What users have access to them. But I really think as the industry, we have to continue pressing for this as a standard and an excellence. The acute setting to your point had meaningful use dollars that were tied to integration and interoperability. We're 10 years behind that. Um, I do think, and we we have, you know, great standards and we press on even on the how. So basic HL7, you know, we're now doing open APIs and fire integrations, but I think that's important for real data exchange to ensure patient outcomes are the way we need them to be.

Chris Comeaux 25:45

Well said. We actually bumped into this with Judi Lund Person. Might have been last year, or maybe it was this summer, or maybe it was both, about when they were doing the RFIs and kind of making that point to go, look, you gave the hospitals a whole bunch of money to help them be ready. The future of care is care in the home. And so, I mean, there were millions and millions of dollars. And so we need dollars to be ready. It's not like we have these huge margins to reinvest in this level of kind of technology. You know, I, I work a lot with the nonprofit side, but even when you look kind of nationally overall, and hospitals were given a whole lot of money to make those investments. So, yeah, we need to keep making that point.

Hannah Patterson 26:22

We will continue advocating on behalf because we have, you know, our leaders came from the acute side and they understand the billions of dollars that were provided for

meaningful use. So absolutely one of the areas of why not this industry. And I know we've championed them through NPHI alliance, those types of things, but I do think there is a standard out there. We just need to continue pushing the boulder up the hill of getting standards across the ecosystem so we can do it successfully.

CEO Tech Priorities That Pay Off

Chris Comeaux 26:47
Last couple of questions for you, Hannah. Let's put ourselves in the shoes of hospital CEO. There's a lot of our listeners. They're dealing with workforce shortages, reimbursement pressures, regulatory complexity, responsibility delivering, world-class care. If you were sitting in their chair, what are three technology priorities that you would pursue immediately?

Hannah Patterson 27:06
Yeah, it's a loaded question. So um, you know,

Chris Comeaux 27:10
maybe it maybe it's not three, maybe it's five, but

Hannah Patterson 27:12
or a hundred, right? No, um, I I think, you know, every CEO of an agency or a company has a different problem they're trying to solve. So I think you got to take a step back and look at to see where are your age, where is your agency struggling the most? And I would say, you know, from a strategy perspective, automation of redundant tasks should be the absolute priority. So if it's in you know, your billing or your payroll or your intake, you know, claims, what uh what is it? What area and segment? Um, start there, right? Seek guidance from your entire staff or your leadership team of where are they spending the most time and what is the most complicated. You're always gonna have workforce turnover, you're always gonna have those things, but what are the root causes? You know, if you think about how you run your operations, you've got your clinician experience, you have your workforce automation, and then you have your reimbursement. But how do you make sure you're focusing on, you know, the specific areas of opportunity? And right now where the industry is on the TPEs and the moratorium, you know, I know quality is of the most concern and surveys. So how do you go and automate your quality team or folks that are spending time? Um, should you have a surveyor walk in your door or CMS is at your uh agency. But, you know, from a CEO lens, I think referrals, you know, referral automation, how do you go make sure that you understand the outcomes that you provide and the quality of care that you are giving to your referral partners? How do you

go make that information available to make sure that you are sharing forward the world-class care that's being delivered um in your markets? And I think that is an area that there's probably automation that can solve for that. So, you know, two biggest areas clinical documentation, because I do think that, you know, shortening uh I'll use the hope tool, right? I think there's studies that say 45, 60 minutes that changed from the hiss a little bit. Everyone's comfortable with it now that we're a year into this. Um, but how do you go automate that? I think another area that hospices do every week are interdisciplinary team meetings. Someone is scribing that session every single week. That is time, energy, and effort. How do you automate it? How do you talk about the patients that are most at risk first? Because people run out of time. You got to go to your appointments, or you only have a block of time. So there are, I think, some table stake things that I think people could focus on. But I also think where are you spending the most time with the most expensive resources is where organizations and CEOs should be prioritizing.

Chris Comeaux 29:39
Oh, wait, wait, a good way to land the plane there. Well, what final thoughts do you have, Hannah? You've got the year of hospice palliative care leaders all over the country here. What are your final thoughts?

Final Leadership Challenge And Closing

Hannah Patterson 29:48
I it's it's such an exciting time to be in the industry. I love seeing the evolution and the care and compassion that every one of the listeners on the line do. But I also think it's a great opportunity to kind of take a step back and put yourself in the shoes of potentially being a patient on the caseload. I think we all say, Oh, I don't ever want to be a patient of this organization. But at the end of the day, you may end up there. Um, so what would you be doing differently and challenge your leaders or challenge yourself of thinking about that problem differently and being part of the solution? We all come to meetings with problems. Very few times does it feel like people come with great resolutions or suggestions and don't settle, right? So if the answer is no, it's no because that day or that person, obstacle is the way is one of my favorite books. So kind of try a different lens and keep championing. But we're doing incredible work. I think the work that exists in our industry right now is so meaningful and powerful and it's the most critical. Everyone's gonna go through it at the end of the day. So I think it's such a compassionate piece of life that is meaningful. So keep doing the great work and appreciate everyone that puts in the long hours to make the teams successful and clinicians and patients and family happy.

Chris Comeaux 30:57

Well, well, well, thank you, Hannah. Thank you for the work that you're doing. I, I am finally hopeful that these next three to five years, and I might even want to shorten that a little bit because we're gonna have to make more headway in probably the next three, but that finally we could apply technology as an accelerator. And I would challenge all of our listeners, we need to be good partners for our technology partners. We can't purchase technology as a panacea. We have have to purchase it as very informed utilizers to enhance what we're doing. And if we come at it that way, we're gonna have a lot better partnership and we're going to live into that vision of technology really being an accelerator to what we do. Whereas we probably would most of us would describe it as a millstone around our necks for these past, you know, whatever, 10 years plus. But this is a window of opportunity where we could be utilizing it in such a different way. So thank you, Hannah, for what you and your team are doing.

Hannah Patterson 31:49

No, I appreciate that. I'd echo that. I think the um it's table stakes and how do we elevate the experience for all of us in this industry. So, and we'll take the challenge. So come to us. No idea is crazy. Come to us and ask, have you heard of this or could you do this? That, you know, we should be partnering together to go solve these problems. You guys are living it day in and day out. We don't always get to come shadow every single week, but it, you know, getting to see what your field clinicians and your staff do at the agencies is so important for us to be successful. So we're here to help solve problems and answer any questions that we can. But appreciate you taking the time and also uh having me as uh as a guest on the podcast.

Chris Comeaux 32:25

You bet, Hannah. Well, we want to thank our listeners. At the end of each episode, we always share a quote and a visual. The idea is to create a Brain Bookmark, a thought partner about our podcast subject to further your learning and your growth and thereby your leadership. We want it to stick like a brain tattoo. Please subscribe to our channel. We don't want you to miss an episode. This is one we want to make sure pay forward to your friends, your coworkers, leaders within your organization, maybe even your board. You know, it's easier for us to be frustrated by things, to rail against the world. Let's not do that. Let's be the change we wish to see in the world. So thanks for listening to TCN talks / Anatomy of Leadership. And here's our Brain Bookmark to close today's show.

Jeff Haffner 33:03

"We have to build that ecosystem. So they feel support, supported in the care that they are delivering." By Hannah Patterson.