# Inceptary 11
# India and Indiana

We started the meeting introducing a standard agenda to organize our meetings and to provide session consistency and note inter-sessions follow-up.

**Last session follow-ups**

- Continued discussion of preparing a low-tech but informative information for those preparing to have a procedure and for those in the hospital/outpatient discharge process.
- We reaffirmed that our best opportunity to have low effort impact and generate engagement is to provide a set of questions for patients to ask of their providers – rather than disseminating another version of fact-based procedure, process, or information on possible alternatives.
- Question design will be driven by interviews with those who have served patients in vulnerable populations and patients themselves who have experienced acute hospital discharge in the last year. Our questions will reflect their experiences, needs, and how they see the world.
- We expect there are 6-8 questions that are generally applicable, and perhaps a few more specific to either a population or pathology.
- A public survey will be created for the target populations that will elicit their needs and experiences, from which our questions will be developed.

**New ideas, initiatives**

The India Oxygen Collaborative, created and driven by one of our members

- Inceptary's role: operate the crowd funding campaign and deliver the funds to India.
- Oxygen is a critical need in India during covid. People are dying in hospitals and in transit just for the lack of oxygen.
- The supply of oxygen concentrators is limited, with large (e.g. Philips) and small companies buying up the inventory, driving prices up.
- A group of alumni of IIT (Indian Institute of Technology) Kanpur reached out to a professor who has a design for a relatively simple concentrator, ready initiate manufacture and commercialization.
- A manufacturing company in Pune was found whose engineering team was able to map the professor's and team's design to commercially available components within a reliable supply chain.
- One key component is in low supply. Lithium zeolite – the catalyst that absorbs nitrogen from the air, leaving oxygen concentrated up to 95% pure. Lithium in general is short supply (e.g. auto, solar batteries) and most of the supply is from China. Currently working with two suppliers (China) with a 30-day lead time to shipping.
- Current cost to manufacture is $600 per unit, based on current inflated prices of components.

- A prototype has been built and delivered to doctors who have been using it in the field over the last month. The prototype has received India FDA approval.
- Company in Pune will have full license to manufacture the concentrators
- Looking at additional product variations that would be used in rural areas for transport of patients in the 2-3 hour trips from their village to a city hospital. The concentrator would be built to be powered by the vehicle, which usually is not the medical transport as we know it, for a patient have oxygen to survive a two-hour+ journey.
- Initially aim to raise about 60K to build 100 units, if that goes well, then 1000 units at 600k+.
- Other sources of funding: are global health foundations – e.g. Gates, CDC, NIH. For example, USAID had a cook stove program to improve respiratory health (India was a beneficiary) by moving away from biomass powered indoor cooking. Hillary Clinton was a big supporter. Presenting new solutions to manufacture to funders – may be a good to meet urgent need in India and other countries dealing with the Delta variant.
- While they may not fund us right now, would be good to get out to all these funders a "marketing" document about what we are doing
- Our outreach funding campaign will be based on an enticing GoFundMe page, and a short brilliant write up for us to inject onto our social and business networks.

**Existing initiatives updates**

Reimagining Rural Health

Our contacts/sponsors in Indiana will meet with heads of a local hospital and a rural health system who have already expressed interest. These individuals represent the critical core of our entry to five Indiana counties. We have proposed a multi phased approach in a three-to-five-year program:

- Phase 1 – Discover. Research on baseline health, demographic and economic data
- Phase 2 – Prioritize. Community organization and community-led priority setting
- Phase 3A – Design. Local and external services coordination to support priorities
- Phase 3B – Heal. Codesign of individual health goals
- Phase 4 – Reinvest. Payer integration into the benefits realization process and follow-on community investment.

There is energy and momentum to get to the next steps: in-person meetings with these health providers, representatives of communities and private foundations and county funders. We hope to be in Indiana in late July or August.

For Blackfeet Nation we are waiting for staffing changes to settle down: learning whom to work with in the tribe.

EHR 3.0

We've initiated drafting an SBIR to the National Science Foundation. We are a little delayed based on our initial planning as we spent time getting smart about what it takes to have a successful bid: reviewing, pursuing the bureaucratic requirements of the applications, setting our ask of a medical practice to participate, and gaining letters of support.

Hospital at Home

This initiative remains dormant with no current plans to activate this now – unless somehow has ideas on how to activate. It may emerge as a possible opportunity in our reimagining rural health work.

**Open discussion – what's on your mind>?**

What topics should we consider for the next year. What should our focus be?

How do we more people involved in the initiatives, while they are all volunteer prior to funding?

We each have of our own sphere of activities. If there are actionable challenges, lets bring them to the group to discuss, explore, perhaps create an initiative.

Important to do things that can be leveraged by the participants in our group.

Ideas raised:

Caregiver issues – burnout, stress, burden of family members caring for family members. Particularly aging and especially dementia. Seeing more and more need, and lacking solutions.

Care staff crisis – during covid many have gone on to different careers. Senior care is not an interesting career path today.

- How do we manage care few care staff, few nurses?
- How can we deliver on proper protocol with informal care givers?
- Access to what knowledge is needed to create a viable solution to this global problem?
- How do get more patients supported by fewer nurses – massive data boiled to what needs to be done?

Write a 2030 healthcare white paper

- Bring tactical scenarios we are experiencing in the field and bring them to the team
- Shortage of nursing and care staff – can that be addressed by tech – to increase "productivity"
- Using the broader population of nursing, professional and informal care staff to deliver "close-to" MD office visits remotely.

Can we use technology more effectively at Inceptary?

- Initiate and promote Slack usage by topic channels, reference information and group interaction beyond our sessions.