"Making the complicated simple—awesomely simple—that's creativity."

— excerpted from Charles Mingus

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Dear Pitt Med Reader,

It's easy to get caught up in the scientific promise of the latest biomedical technology. And for good reason: Applications of genomics, CRISPR, deep learning and the like will be saving lives as they come of age. This is truly an exciting time in medicine.

However, for patients facing a majority of common medical conditions, the barriers to better outcomes may often be paradoxically simple. Maybe what's needed is regular transportation to the clinic or help from a trusted caregiver to navigate health care or social needs. In most clinical encounters, we tend to overlook such interventions. Our health care model incentivizes hospital-based care, advanced diagnostic testing and high-tech solutions. It is less likely to reimburse activities of providers who carefully explore what would be most helpful to improve outcomes for an individual patient.

How do we change our current system and create a new type of health care? One that honors significant, yet often simple, needs of patients? Part of the answer may be found in successful population health models that have focused on basic principles of individualized patient care in countries with limited access to technologies or sophisticated tertiary hospitals. In other words, we can learn a great deal from what works in resource-limited countries—such approaches save thousands of lives every day.

Let me share some examples: In western Kenya, for instance, a community worker–driven program called AMPATH has provided testing and counseling to more than 1 million patients with HIV/AIDS and helped save the lives of thousands of children with HIV by increasing access to and compliance with treatments. In Harare, Zimbabwe, a person in distress can sit on a "friendship bench" to get counseling and access to other resources.

Here in the United States, a similar innovative program prepared trusted women from local communities to work on reducing infant mortality in inner-city Indianapolis. As is the case in many inner-city neighborhoods in this country, infant mortality rates in these areas were shockingly high. The community workers gained trust, provided education, coordinated basic prenatal services and were the implementation arm as obstetricians and medical leaders ran the project. By taking most of the care to the pregnant person's neighborhood or home, disruptions to work schedules, family obligations or school attendance (yes, unfortunately many of the pregnant subjects were young girls) were minimized while care and compliance were improved. These services, combined with a negotiated extension of state Medicaid support for new mothers, improved infant and maternal health significantly in these neighborhoods within two years of instituting the program. The approach saved many infants while saving money—complex childbirth, which was previously the norm in these areas, comes at a high price in terms of dollars and lives.

What is best for patients is not necessarily a medically sophisticated approach with bells and whistles. "High touch for most and high tech for some" is often what's needed—as demonstrated in our cover story in this issue. I encourage you to read that feature to learn about a breast cancer doula program led by our colleague in nursing, Margaret Rosenzweig, as well as another thoughtful initiative, in perioperative care, that helps patients coming in for surgeries get the best care.

Creative innovations needed to change our poor health outcomes can be elegantly simple.

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