Rainfall HEALTH

THE HOW-TO GAP IN HEALTHCARE

Should-do isn't how-to

Healthcare is excellent at defining what patients should do — and quietly silent on how to do it. A conversation about the gap that costs money, dignity, and trust, and the small moves that close it.

FEATURING

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Chief Experience Officer, Cherish
Founder, Yeh Innovation

Eddie Qureshi
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Host, Rainfall Health Podcast

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FEATURED VOICES

Dr. Charlotte Yeh

Thirty-plus years across every side of healthcare: emergency physician and chief of emergency medicine at Tufts and Newton-Wellesley, regulator at CMS Boston, chief medical officer at AARP Services. Now chief experience officer at Cherish and founder of Yeh Innovation.

Eddie Qureshi

Founder and CEO of Rainfall Health, and host of the Rainfall Health Podcast. Works closely with the Medicare population and the surgical episodes that shape it.

INTRODUCTION

Healthcare nails the should-do and skips the how-to

We have brilliant executives and clinicians who care deeply, and a system that is genuinely good at deciding the right thing to do. Elevate the hand. Self-manage your diabetes. Don't lift more than ten pounds. Take these four times a day.

What we rarely supply is the how. How you do it in a small apartment, on a Thursday evening, at 95 years old, with a job to keep and grandkids to watch. When the how-to is missing, patients don't fail quietly — they come back through the emergency department, they stop taking their medication, they go looking for answers somewhere else.

This guide distills a Rainfall Health Podcast conversation between Dr. Charlotte Yeh and Eddie Qureshi. It is written for the people who can act on it: executives, clinical leaders, and the operators who design how care actually reaches people. Its argument is simple — the how-to gap is not a soft problem. It is a cost problem, a trust problem, and the most tractable one we have.

THE THROUGH-LINE

> “Can we translate the should-dos — the good clinical care — into how you incorporate it into the workflow of your life?”
>
> Dr. Charlotte Yeh

A note: this is an edited conversation, not a Rainfall pitch, and nothing here is clinical or legal advice. Statistics are as cited by the participants.

01 · THE FRAMING

Trust is the infrastructure everything else runs on

We are living in interesting times — polarized, uncertain, anxious, and drowning in information. The result is a profound loss of trust, and healthcare is not exempt from it. Two numbers frame the room we're standing in.

61%

of US adults said healthcare corporations, institutions, and even NGOs are **actively intervening** in their ability to get quality care.

Edelman Trust Barometer, 2025

21%

believe the next generation will be **better off** than today. Charlotte calls this the scarier of the two figures.

Edelman Trust Barometer, 2026

The good news is in the same surveys: trust can be earned

People told researchers exactly what earns it. Not a campaign — a set of conditions, every one of which is about lived experience rather than clinical authority.

Empathy for my issue

You understand the problem as I experience it, not as it appears in a chart.

Direct experience of my life

You know how I actually live — my home, my hours, my constraints.

Knowledge of people like me

Your recommendation has worked for people in my situation before.

Said in a way I understand

You don't argue me out of my opinion. You teach, build confidence, make it convenient.

“Self-manage your diabetes” is a full-time job we never priced

For anyone who wants the literature rather than the anecdote: a review published last year looked at every paper from 2014 to 2024 asking a question we almost never ask out loud — how much time does diabetes self-management actually take?

THE TIME COST OF A SHOULD-DO

2.5 hrs

per week, at the low end — one German cohort.

4 hrs

per *day*, as estimated by diabetes educators in another study.

Now ask a working parent. A single parent with two kids. Someone caring for grandkids, or travelling for work. Do you have four hours a day to give up?

Half the papers named the same sticking point

Roughly 50% of the articles reported that what people struggled with most was physical exercise — the one thing everybody already knows is important. Knowledge was never the constraint.

If we don't say *how* you exercise, *how* you fit management into a shift, *how* to sequence it against everything else in the day, what do we expect? Patients nod. Some feel guilty. Almost nobody tells us they aren't doing it.

REFRAME

Non-adherence is often a time-budget problem wearing a compliance label. Before adding another instruction, count the hours it asks for.

03 · A CASE IN ONE FAMILY

Two ED visits, because no one explained a catheter

Charlotte's father is 98 and still lives in his own home. In his mid-90s he had trouble urinating. She is a physician, a former regulator, and a long-distance caregiver in Boston while he is in Pittsburgh. Every clinical decision in what follows was defensible. The outcome was not.

THU 5PM	Niece calls: he hasn't urinated. Everything is closed. The PCP sends him to the emergency department, as they should.
THU EVE	Catheter placed; discharged home. Charlotte calls the care coordinator and asks for someone to teach her father and her niece how to manage it. The answer: nobody until Saturday — we'll phone him Friday. He is 95, has a cochlear implant, hearing loss, and is blind in one eye.
FRI AM	He has been in the bathroom two hours. Nobody told him he could sit down, so he tried to manage standing up. Too embarrassed to ask a twenty-something niece for help, he is washing his own clothes in the sink.
SAT	The nurse arrives to grossly bloody urine with clots and sends him back to the ED. Multiple exams, multiple studies. All normal. This time, on request, someone teaches both of them how to tape it to the leg and empty it discreetly.
NEXT	The urologist hears “bloody urine” and proposes a cystoscopy. Charlotte explains what actually happened. The catheter comes out instead. He is fine.

2
emergency department visits

Multiple
tests and exams, all normal

1
missing instruction: you can sit down

> “The saddest part was that I knew exactly what he needed, and I still couldn't get it. We are simply not set up to help you with the how-tos.”
>
> Dr. Charlotte Yeh — and about 28% of older adults are solo agers, with no one to make that call at all.

04 · THE NEW FRONT DOOR

When we skip the how-to, patients ask someone else

Seventy to eighty percent of people still trust their doctor for information. But a rising third are going elsewhere first — increasingly to AI. If you aren't paying attention to where people go, and you don't speak in those terms, they don't come back to you.

59%

search or ask AI **before** a doctor visit.

56%

check **after** the visit, to interpret what they were told.

14%

then don't follow through with the visit **at all**.

Gallup survey data, as cited in the conversation.

Why they go — and the two answers that should sting

70%+	**Speed.** They need an answer now, not at the next available appointment.
21%	**Don't want to pay** for care to get the information.
14%	**Unable to pay** for care at all.
21%	**Felt dismissed or disrespected** by their provider. More people than said they couldn't afford care.
18%	**Too embarrassed** to ask a person the question.

Two-fifths of that list has nothing to do with access or cost. It is about how it felt to ask. That is a design problem we own.

05 · THE GPS PRINCIPLE

Nobody ran a change-management program for GPS

Getting from one place to another is a genuinely hard problem. Every trip is different, conditions change, and every single turn has to be right. And yet adoption required no persuasion campaign, because the design started from the friction rather than the instruction.

01

Understand the problem

Know precisely where people get stuck, in their terms.

02

Make each step simple

One turn at a time, in the moment it's needed — not a printout of the whole route.

03

Be there when they're lost

Reroute without judgment. Adoption follows convenience.

Test the instruction, not the patient: “elevate the hand”

WHAT WE SAY

“Elevate the hand — above the heart — to keep the swelling down.” Clinically correct, universally given.

WHAT PATIENTS DID

Went to bed and lay with the hand flat against their head. Above the heart, technically. Nobody had said *vertical*.

A BETTER HOW-TO

Picture a drop of water on the tip of your finger. Position your hand so gravity carries that drop back toward your heart. Same instruction — now it can only be followed one way.

This is work leaders can commission tomorrow: take your twenty most-given instructions, test them with real patients and consumers, and rewrite the ones that can be followed incorrectly while sounding obeyed.

06 · THE CHEAPEST INTERVENTION

How about asking?

We ask whether people would recommend us to a friend or family member. We have entire dashboards for it. We almost never ask where they go for information, what they looked up, or what they wished they'd known. Four questions cost nothing and change what you build.

01 **Where are you going for your information?**
And can we help you with it? You cannot meet people where they are without knowing where that is.

02 **What have you been looking up?**
The searches cluster on nutrition, physical activity, lifestyle change, stress, sleep, and supplements — the topics we skip unless we deliberately bring them in.

03 **What do you know now that you wish you'd known before surgery?**
Ask every post-op patient and caregiver. The answers are specific and immediately actionable.

04 **What would you want other patients like you to know?**
Patients will write your how-to library for you. A consumer advisory committee with real access makes it a standing input, not a survey.

What comes back is never what's in the discharge packet

After a total knee

Getting to the bathroom was the hard part. Nobody had shown them how to start with the cane or the walker.

After cardiac surgery

Told not to lift weights, patients reason that twenty pounds of groceries isn't weights. Then come the sternal wound problems.

07 · HUMAN IN THE LOOP

What the record doesn't hold, and what technology can find

AI is genuinely good at what humans cannot do: pulling scattered data into one place, interpreting it, listening ambiently so context survives from visit to visit. It also passes board exams. Neither fact tells you what is missing from the data set. Two stories, in opposite directions.

THE LIMIT · A MAN WITH A COLD

A man in his forties, chief complaint “cold,” Tuesday at 10am. He has a cold. He knows it, the doctor knows it, and every objective finding agrees: runny nose, cough, itchy eyes. On the record, the encounter is complete.

Something was off — voice, posture, the way he stood. So Charlotte stayed quiet and asked whether his doctor wasn't available, whether there was anything else. He lost his job three days ago. He still looked unsettled, so she paused again. He has an eight-year-old child and he is frightened of what the stress is doing to them.

Nobody walks in and says “I'm worried I'll hurt my child.” They come in with a cold, through the door they know will open. Once the context is visible, the treatment of that cold is entirely different — and there were two patients in the room, not one.

THE UPSIDE · A PAIR OF CAPTIONING GLASSES

At 97, Charlotte's father grew withdrawn and angry, disengaged from the people around him. The obvious read was cognitive decline. The ENT offered a second cochlear implant and, asked how to tell hearing loss from dementia, answered honestly: I don't know. At his age, maybe it works.

Rather than put a 97-year-old through a procedure on a guess, she bought speech-to-text glasses. He refused to take them off after two days. At his next appointment he told the doctor exactly what he was thinking and feeling. It was never dementia — he simply couldn't hear.

With that answer, both the family and the ENT had the confidence to proceed. Three months after surgery his hearing was more than 30% better — enough to travel to China and see his family.

The rule that falls out of both

Large language models are insufficient for the whole picture of a person. Use them for the recall and the synthesis; keep humans on the part that requires giving someone room.

And the question worth asking

Why aren't we using technology to fill the gaps in our own knowledge — to answer the questions we have always treated as unanswerable?

Brawn, then brain, then heart

The London School of Economics framed the arc of work in three eras. Charlotte's argument is that the third one describes the clinical workforce we now have to build — and that it is a promotion, not a demotion.

JOBS OF THE PAST

Brawn

Muscle. Then automobiles, trains, airplanes and washing machines made the work lighter.

JOBS OF TODAY

Brain

You had to be the smartest person in the room, because there was simply too much to know.

JOBS OF THE FUTURE

Heart

The human in the loop who uses AI well, and spends their attention on translation and judgment.

If the repository of knowledge is handled, what should training emphasize?

Translation

Turning a correct recommendation into something that fits this person's week.

Eliciting context

The pause, the second question, the room to say the real thing.

Judgment on benefit and risk

Do the benefits outweigh the risks for a 97-year-old? That question stays human.

Fluent use of the tools

Knowing what AI is reliable for, and what it structurally cannot see.

> “The jobs of the future will be built on heart. That should be the clinician of the future — the human in the loop who can use AI successfully for the betterment of our patients.”
>
> Dr. Charlotte Yeh

09 · THE MIND SHIFT

The patient's workplace is their home. Adapt to it.

For a century, care happened in the office, the hospital, the emergency department — so patients adapted to our practice flow. Care is moving into the community and the home, including acute care. The processes will follow eventually; the mind shift has to come first.

THEN

Patients and caregivers adapt to the workflow of the practice and the health system.

→

NOW

We adapt to the workflow of their life — and integrate the knowledge into how they actually live at home.

The most under-leveraged asset we already own: the camera

On most telehealth calls we sit facing a screen and ask the same questions we'd ask in clinic. Did you take your medicine? How often? With permission, the same call can show you the home where the care actually happens.

“Can you show me your medicine cabinet?”

Multiple bottles, expired and current. A window no medication list gives you.

“How do you remember to take it?”

One man on a three- and four-times-daily regimen decided to take everything at noon so he'd never forget a dose. His pill count was perfect. He ended up in hospital, extraordinarily sick.

“Can you walk me through the house?”

No grab bars in the bathroom. A rug that is a fall waiting to happen. Both fixable this week.

“Show me how you get to the bathroom.”

A narrow door, a lip, a bathtub wall a healing leg can't clear. A chair over the tub edge restores bathing, wound care, and routine.

Lead with empathy, not audit: *“I'm sure it's hard to keep three times a day and four times a day straight — show me how you do it, and let's see what I can take off your plate.”* What the walkthrough proves is that you care. That is how trust and engagement get built.

The same logic extends to remote monitoring for rural areas — and for the urban three-storey walk-up, the missing ride, the paid parking. Access is a how-to problem too.

Purpose, connection, and hope show up on the claims

The soft factors are not soft. In a Medicare supplemental population, the differences are large, documented, and directly translatable into a business case for closing the how-to gap.

+12%

cost when people have **no sense of purpose**.

+20%

cost when **severely lonely** and without social support.

+33%

cost when people lack **hope and a positive view of aging** — about 40% of the population.

Put that against one surgical line

Rainfall's team works closely with the Medicare population. Across five common procedures — joint replacement among them — Medicare spend runs over **$20 billion a year**. Add 20% for avoidable, reactive utilization and you have a **$4–5 billion** problem.

That reframes the scope entirely. The money already exists. Today it buys worse, later, reactive care. The same dollars spent on preventive and proactive support — with a better experience attached — is the trade on the table.

SPEND TODAY

$20B+ / yr

five procedures, Medicare

AVOIDABLE SHARE

$4–5B / yr

reactive care we could redirect

> "If we integrate into the workflow of their life and translate all of this capability into how they use it at home, we get better utilization, lower cost, happier patients, better compliance. It's not hard."
>
> Dr. Charlotte Yeh — and the name of the game is consumer adoption and engagement.

Always wear the glasses of your patients

Charlotte's closing advice was one sentence long: wear your patients' glasses, and don't be afraid to ask — it's amazing what you learn. Here is what that looks like on a quarterly plan.

01

Add the two questions

“Where do you go for information?” and “What do you know now that you wish you'd known?” — into discharge calls and post-op follow-up.

02

Rewrite the top 20 instructions

Test each with real patients. If it can be followed wrongly while sounding obeyed, it isn't finished.

03

Make the home visible

Put a consented home walkthrough into your telehealth protocol — medicines, bathroom, floors, stairs.

04

Seat the patient voice

A consumer advisory committee with real access to the board and to operations — not a survey program.

05

Count the hours you ask for

Audit one care plan for the time it demands per week. Then cut it, sequence it, or support it.

06

Give AI a governed job

Pick one use case that fills a gap you can't otherwise see — like the glasses — and keep a human on the judgment.

> “Always wear the glasses of your patients. Don't be afraid to ask — it's amazing what you can learn. That opportunity is with us, with every patient, with everything we do.”
>
> Dr. Charlotte Yeh

None of this is a critique of where healthcare has been. It is the ordinary work of competing against ourselves — being a little better than we were last quarter, for patients who mostly just need to be told how.

WHERE RAINFALL FITS

Built for the how-to, not just the should-do

Rainfall Health is an accountability and accessibility platform powered by AI — the first and only company certified for these Medicare-mandated programs. The work in this guide is the work of the platform: meeting patients in their own homes and translating good clinical care into steps they can actually follow.

Experience as an input

Structured patient and caregiver feedback — including what they wish they'd known — routed to the people who design the pathway.

Care in the workflow of life

Post-discharge support, remote monitoring, and home-based coordination for surgical episodes and the Medicare population.

AI with a human in the loop

Episode analytics and monitoring under real governance, with clinicians holding the judgment and the translation.

FROM THE HOST

“I'm left with optimism. There's a lot of opportunity to do better, and in many ways these problems are less hard to solve than we think — especially when we arm clinicians with the right tools and train them to focus on the right part of care.”

Eddie Qureshi, founder & CEO, Rainfall Health

GET CONNECTED

Let's close the how-to gap together

If you're rethinking patient education, post-discharge support, or the patient experience under a mandated program, we'd like to help. Rainfall is the end-to-end solution — technology and services — for hospitals and health systems.

LEARN MORE

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START A CONVERSATION

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Watch for the next episode of the Rainfall Health Podcast.

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