McGinnis: Well, good noon morning afternoon wherever you may be welcome to this meeting and webinar of the National Academy medicines value incentives and Systems Action collaborative.

We have a.

Very important meeting today, focusing on.

The tools that are emerging for our ability to transform the health system both health and healthcare to a system which is more effective, efficient, equitable and continuously learning.

Are all sensitive to the importance of the economic factors in play.

In our system as a whole.

And the notion of how incentives are structured in the health system is especially important as we.

contemplate various approaches to health transformation.

And that work is under the auspices of our value incentives and Systems Action collaborative i'm going to tell you a little more in a second about the.

organizational context within the aim for the work of the collaborative but first I want to introduce our two co chairs, if we can have the next slide that.
McGinnis: shows.

McGinnis: diane and Jim.

McGinnis: They are dying holder, and this is diane's inaugural services co Chair of the collaborative and welcome diane diane is President and CEO of the University of Pittsburgh medical Center health plan and executive Vice President of the.

McGinnis: Of the university and she's our newest action collaborative co chair and we're really grateful to you diane for joining us in this capacity, we very much value your membership and now your co Chairman ship in this respect.

McGinnis: And and and Jim Madeira, who is the CEO and executive Vice President of the American Medical Association Jim is a long standing and.

McGinnis: An extremely important member of the collaborative.

McGinnis: And the course consortium has been with us from the beginning, and indeed it was his suggestion that we develop a little deeper dive into the area of behavioral economics, which is.

McGinnis: of such clear importance as we look to any element of the operation of our of our health system it all comes down in one way or another to economics and to the incentives that that that shape behavior.

McGinnis: Although those incentives are not just economic there are regulatory incentives, there are a variety of incentives, but the importance is very clear.

McGinnis: It essentially a sedatives determine how fragmented care is or isn't important in shaping how well clinical and population health
initiatives are integrated incentives are key and strengthening the links between evidence services and outcomes.

00:03:38.520 --> 00:03:53.460
McGinnis: they're fundamentally important to driving interoperability of digital systems incentives are key to boosting institutional data sharing for continuous improvement and learning and in recruiting individuals and families as.

00:03:54.720 --> 00:04:14.010
McGinnis: As core and continuous elements of the health team, yet the dominant incentives in health and healthcare today instead quite clearly encourage fragmentation opacity inequity and provide our interests at sometimes at the expense of.

00:04:15.990 --> 00:04:17.190
McGinnis: patients and families.

00:04:18.750 --> 00:04:25.950
McGinnis: And so today again with another shout out to gym and era we're going to focus squarely on how to change the game.

00:04:27.060 --> 00:04:42.960
McGinnis: We have an extraordinary strong agenda participants in that respect living on with off with the two national, international scholars and leaders in the field of behavioral economics, but then continuing on with the individuals who have been at the Center of.

00:04:44.340 --> 00:04:59.010
McGinnis: The design of our health system at the implementation of health and health care programs and serving as ongoing important leaders in various elements of the system you'll.

00:04:59.670 --> 00:05:12.000
McGinnis: hear more about this when I turn the program over to diane and Jim shortly first i'm going to run quickly through, as I indicated a little background tour just to level set for those who are.

00:05:13.140 --> 00:05:21.510
McGinnis: not fully familiar with the work of the National Academy medicines leadership consortium some of the background so next slide please.

00:05:22.620 --> 00:05:35.430
McGinnis: The leadership consortium is made up of sector leaders and stakeholders from nine different sectors in public and private independent organizations.

McGinnis: Who gather collectively to work.

McGinnis: Under the auspices of the National Academy of Medicine for action in their common interests action that.

McGinnis: In various ways, is intended to improve effectiveness, efficiency, equity and continuous learning in health medical care and biomedical science next slide please.

McGinnis: The overarching aim of the leadership consortium is to foster the development of.

McGinnis: Learning health system which is one in which science informatics incentives and culture are aligned for continuous improvement, innovation and equity.

McGinnis: With best practices and discovery seamlessly embedded in the delivery process individuals and families active participants in all elements.

McGinnis: and new knowledge generated as an integral byproduct of the delivery experience today we're focused primarily on the incentives dimension, but the fact is it's, these are not.

McGinnis: Separate.

McGinnis: Co equally operating enterprises they're each of them mutually reinforcing and working with the other in tandem to.
McGinnis: provide the kind of dynamics in the system which can help us move to improvements on every aspect next slide please again, the focus is collaboration for action.

41
00:07:11.310 --> 00:07:31.200
McGinnis: The national academies are known for good reports and convenience important but our focus is not only on good reports and and convenient key players as in today's meeting, but in identifying action agendas that we can engage with our participating organizations.

42
00:07:32.220 --> 00:07:35.670
McGinnis: For tangible progress next slide please.

43
00:07:36.720 --> 00:07:40.170
McGinnis: The for collaborative in our.

44
00:07:41.220 --> 00:07:52.350
McGinnis: consortium are focused on those four dimensions that you saw in the definition of a learning health system science informatics incentives and culture.

45
00:07:53.370 --> 00:08:03.150
McGinnis: The sciences engaged through our evidence mobilization action collaborative, the aim is continuous learning through real world evidence.

46
00:08:03.840 --> 00:08:15.030
McGinnis: In the informatics our effort is conducted through the digital health action collaborative and the aim is there is a digital infrastructure and data as a core utility.

47
00:08:15.720 --> 00:08:34.710
McGinnis: In many ways, we hope that we will see emerging a system in which data is as important to utility and is accessible utility for improvement and learning as the utilities, we rely on in our day to day lives.

48
00:08:36.120 --> 00:08:36.750
McGinnis: For.

49
00:08:37.980 --> 00:08:54.480
McGinnis: Normal operations incentives, the value incentives and systems that collaborative the diet and Jim co chair is focused on outcomes on payment based on health outcomes for people and populations and our care.
McGinnis: Our culture, inclusion and equity action collaborative is aimed at full and equitable health engagement for people in communities next slide please each collaborative works in effect through force kinds of.

Activities the sponsorship of organizational networks, the development of anchor principles.

And the.

interface between the work of the principles are the principles that are established in the work of the networks indicators of progress and a series of collaborative product projects on key issues and next slide please.

Here is a list of some of the projects and initiatives that we have underway on evaluate incentives and systems that work of the visit.

They include the emerging stronger sector assessment on the impact on our health financing system of covert 19.

And the lessons learned in that respect, we have a series of meetings on financing that rewards better health and well being with a coalition.

Of philanthropic partners, working with us for a longer term initiative in that respect, and part of that work has been focused with cmi in the past six months.

Holding a series of sessions on their responsibilities and possibilities catalyzing health system transformation.

are vital directions for health and healthcare established priorities for 2021 and clearly the Cross cutting priority in that respect, was financing incentives and, finally, the.
McGinnis: recent report of the health and medicine division on implementing high quality primary here, I had a number of recommendations relevant to the health financing arena next slide please just to elaborate briefly the emerging stronger initiative is the initiative that had.

McGinnis: working groups from our.

McGinnis: Leadership consortium and co chaired by leaders on the consortium in nine different areas next slide please those nine areas are identified here in terms of the release schedule for the papers that resulted.

McGinnis: And lessons learned.

McGinnis: Those nine areas are quality and safety payers patient families and communities, the latest one to come out that was out early this week.

McGinnis: Clinicians and professional societies public health biomedical search care systems and three are the last three are coming out shortly.

McGinnis: on digital health health product manufacturers and innovators and with a final cross cutting chapter and they will all be published as a special publishing publication and the.

McGinnis: Participants in the leadership consortium will be working with their counterparts in their various sectors to engage implementation possibilities.

McGinnis: So that's a rapid tour of the work of the namm leadership consortium, thank you for your patience, for those of you who have heard that overview before and i'd now like to without any further delay.
McGinnis: But with a great deal of gratitude turn the meeting over to Diane and Jim and I think Jamie are going to lead off Is that correct.

00:12:47.760 --> 00:12:48.270
Yes.

00:12:49.320 --> 00:12:57.180
Jim Madara - AMA/VISAC: So let me just say, well, thank you, Michael i'm just going to touch on the intent of the meeting and some guiding questions and considerations.

00:12:57.900 --> 00:13:15.690
Jim Madara - AMA/VISAC: So as as behavioral economics is taking a central role in the national conversation surrounding healthcare incentive structures now leaders are increasingly recognize the potential of this field to accelerate transformation towards effectiveness, efficiency, equity and continuous learning.

00:13:16.770 --> 00:13:29.760
Jim Madara - AMA/VISAC: So this conversation considers how emerging lessons from this field can best be applied to foster individual as well as organizational actions that promote positive results for patients.

00:13:30.690 --> 00:13:36.930
Jim Madara - AMA/VISAC: Now, and important nuance in this conversation is recognizing that there are multiple domains within healthcare.

00:13:37.500 --> 00:13:52.860
Jim Madara - AMA/VISAC: And the possibility that effective incentives may vary, based on the domain so, for example, as a former CEO of an academic medical Center universe see if Chicago, I can assure you that financial incentives can change institutional.

00:13:54.600 --> 00:14:09.060
Jim Madara - AMA/VISAC: However, at the individual physician level the intrinsic motivators measured in collaborative study with her and health are elements such as time with patients and the ability to provide high quality care.

00:14:10.320 --> 00:14:17.370
Jim Madara - AMA/VISAC: External incentives that don't impact these intrinsic drivers may not be the effective incentive sought.

00:14:18.630 --> 00:14:37.350
Jim Madara - AMA/VISAC: And thirdly, there's, the most important domain of all until air and that's our patients and patients will also likely differentially respond to incentives, be they extrinsic unlinked to internal motivators or be the elements that engage those intrinsic motivators.

00:14:38.550 --> 00:14:52.110
Jim Madara - AMA/VISAC: So guiding questions of the conversation will include you know how much is known about the effectiveness of various incentive strategies to promote actions to benefit health and well being and all these various domain levels.

00:14:53.190 --> 00:15:05.100
Jim Madara - AMA/VISAC: and have best practices, been established, you know what's the experience in aligning system wide incentives to accelerate health transformation and particularly after coven 19.

00:15:06.150 --> 00:15:17.700
Jim Madara - AMA/VISAC: And then, lastly, how might incentives different those subdomains such as health care administration at the institutional level patient level and provider level.

00:15:18.540 --> 00:15:25.020
Jim Madara - AMA/VISAC: and considering physicians, we need to remember that although the trend is really strong toward him employment.

00:15:25.710 --> 00:15:47.040
Jim Madara - AMA/VISAC: In 2020 still 44% of all patient care physicians were still self employed, so that the main to which and incentive as applied and health care is not a monolithic entity, when one considers these various domains, so let me ask diane just to give an overview of the logistics and agenda.

00:15:48.810 --> 00:15:56.940
Diane Holder: Thanks Jim i'm very pleased to be here today and to participate as a co chair of this very, I think, important collaborative.

00:15:57.510 --> 00:16:07.350
Diane Holder: You know the pandemics taught us many things, including understory that human behavior is complex and that we don't always act as some would describe.

00:16:07.770 --> 00:16:23.160
Diane Holder: Logically, or as economic self interest would predict, but during this period health disparities have become increasingly visible to
the general public, as well as regulators and I think the health industry
at large.

Diane Holder: So public health agencies and health systems are challenged
right now to address both the immediate crisis that we have, but also to
step up.

Diane Holder: in ways that focus on preventive services figuring out how
to work harder to connect our health care delivery systems to our support
systems and communities such as housing or nutrition.

Diane Holder: And to try to figure out how to change incentives that
really address ways to make and keep our population healthier.

Diane Holder: Our opportunity today is to hear from thought leaders and
experts and gain a deeper understanding of some of the levers, including
behavioral economics that can assist us in health policy and health
system transformation.

Diane Holder: Next slide please.

Diane Holder: As you can see from our agenda today in the upcoming
session will have the chance to hear keynote remarks on the utility of
behavioral economics for aligning incentives within the US healthcare
system.

Diane Holder: And we're very fortunate today to have Dr cass sunstein the
Robert walmsley university professor at Harvard and a senior counselor at
the US Department of Homeland Security as a keynote speaker.

Diane Holder: And also joined by Dr Kevin wold the director of the
University of pennsylvania's Center for health, incentives and behavioral
economics.

Diane Holder: And he will be providing keynote reactions and comments and
then following the keynote addresses we're going to have.
Diane Holder: Our one o'clock session joining us will be Nancy and apparel of capital courtesans partners, Dr Brent James of Stanford university and Dr Mattachine Patel of Ascension and they're going to have a panel that they're discussing.

Diane Holder: What are the practical applications of motivators for individuals workforce and the health system as a whole.

Diane Holder: And then at 145 the last panel of the day will focus on the vision for the application of behavioral economics moving forward to become a reality and Dr Charlene Long of Duke university Dr Carl RON of health.

Diane Holder: and Dr on a say-off Oh, the lay of the MD Anderson cancer Center and Dr such and Jane of the San group health group and health plan will provide brief reactions and discuss potential avenues, so it looks like a very exciting day and I'm so glad all of you can join us.

Diane Holder: So just a few housekeeping agendas panelists can you keep your lines muted unless you're going to speak and then turn your video on.

Diane Holder: And then, those of you who are attending you have opportunity to add questions or comments, and if we have time in our various sessions, we will try to address some of those.

Diane Holder: We are going to record this session, and these presentations will be available to you.

Diane Holder: After the event, when you do ask your questions, please follow the format of putting in your name and organization and if there's someone specific you would like to address the question to so let me now turn this back over to Jim.
Jim Madara - AMA/VISAC: Well, thanks this this first session is motivating health system transformation and pandemic error and cast as a hard stop at 1245 so let's just skip to the kickoff of cass's presentation and stay with that and will respect that need to leave urgently at 1245 cast.

105
00:20:10.350 --> 00:20:20.970
Cass Sunstein: Thank you so much for that and i'll try to stay on as long as I possibly can so i'm going to talk at a 10,000 foot level in terms of.

106
00:20:21.720 --> 00:20:32.880
Cass Sunstein: Human beings what people are like, then, about behaviorally informed interventions and then about sludge and scarcity, so those are the three happenings.

107
00:20:33.270 --> 00:20:44.850
Cass Sunstein: In terms of our species here are five things we know five behavioral biases human beings often suffer and sometimes benefit from President bias.

108
00:20:45.180 --> 00:20:55.020
Cass Sunstein: meaning the short term really matters today and tomorrow are very salient the next decade is a foreign country later land we're not sure we're going to visit.

109
00:20:55.440 --> 00:21:01.500
Cass Sunstein: And the next year, maybe a foreign place at least that we think we're going to visit, but we don't focus on.

110
00:21:01.830 --> 00:21:10.710
Cass Sunstein: Particularly patients and people who are get patients, people who are aspiring not to be patients but will be patients.

111
00:21:11.070 --> 00:21:19.530
Cass Sunstein: Often, are affected by President bias and that influences their choices and decisions and create serious health risks.

112
00:21:20.010 --> 00:21:29.640
Cass Sunstein: We know second that human beings tend to be unrealistically optimistic This comes as a surprise to many of us who might consider ourselves pessimists.

113
00:21:30.000 --> 00:21:34.650
Cass Sunstein: But 90% of people believe that they are safer than the average driver.

Cass Sunstein: 100% of people believe that their sense of humor is better than the average sense of humor that's because people know what's funny they believe.

Cass Sunstein: With respect to health smokers tend to have a realistic and sometimes inflated sense of the health risks associated with smoking.

Cass Sunstein: But they believe that they themselves are less likely to get lung cancer and heart disease than the average non smoker pause over that if you would that is a vivid.

Cass Sunstein: and potentially catastrophic illustration of optimistic bias.

Cass Sunstein: We know that human beings suffer or benefit from inner show, which means the status quo has a kind of magnetic force.

Cass Sunstein: So if people are engaging in certain behavior, even if they risked their health or their safety, they tend to keep doing it, it takes some sort of intervention.

Cass Sunstein: To overcome inertia which is not a tribute to human rationality it's a tribute to bounded rationality, because the magnetic force of inertia runs the rationality of continuing with the status quo.

Cass Sunstein: We know that human beings, including doctors and this has been demonstrated, are subject to what's called availability bias, which means their risk perceptions are affected by what is cognitively available.

Cass Sunstein: If something has happened in the recent past or it's especially visible or memorable then probability just judgments can be
affected, accordingly, which can lead to hysteria in cases in which the risk is not statistically very large, but where the incident is.

Cass Sunstein: Top of mind, it can also lead to complacency, where the risk is statistically large but is not top of mind.

Cass Sunstein: We know fifth i'm going to give you a summary that human beings suffer or benefit from limited attention.

Cass Sunstein: Which means that the number of things that are visible to us or our view screen is a small set of the number of things that are available cognitively but not seen.

Cass Sunstein: And that's true of each of us at this very moment, where I am looking at a subset of things that are actually on my broad view screen right now, and so I hope, are you that's how the mind works.

Cass Sunstein: The fact that our view screens are limited can mean that there are risks and health solutions that are not attended to.

Cass Sunstein: Even though they are potentially transformative in the best sense, and that is both a challenge and an opportunity.

Cass Sunstein: So we're talking about the five worst people, shall we call them of the Apocalypse five Pave your own biases.

Cass Sunstein: President bias unrealistic optimism inertia availability bias and limited attention and these all can get us in serious trouble sometimes it said that human beings are irrational choosers.

Cass Sunstein: that's not very nice, as well as not being quite accurate, we are imperfect users and of the first part of three.
Cass Sunstein: notches are a form of behaviorally informed intervention which Kevin result and others have done extraordinary things within the medical domain.

00:24:57.480 --> 00:25:12.420
Cass Sunstein: There in perfectly understood knowledge is our choice, preserving interventions that allow people to benefit from a kind of steer which often removes an existing obstacle.

00:25:12.750 --> 00:25:27.810
Cass Sunstein: And, which sometimes imposes a little bit of a push in the preferred direction, not just are not incentives if we're talking about material incentives, an economic benefit or an economic cost.

00:25:28.140 --> 00:25:40.950
Cass Sunstein: That can be effective, it might be effective for behavioral reasons it might generate salience and thus overcome limited attention it might contract on realistic optimism, it might.

00:25:41.490 --> 00:26:01.860
Cass Sunstein: Is that they are not imposing material incentives, but often materially do affect behavior a canonical knowledge which has I think implications for the domain of health.

00:26:02.190 --> 00:26:18.270
Cass Sunstein: Is the GPS device, and what makes the GPS device a canonical is that allows people to decide on their preferred destination, which will frequently be alive not dead, healthy not sick and it tells them how to get there.

00:26:18.660 --> 00:26:23.700
Cass Sunstein: It also the GPS device allows people to say I don't like your preferred route.

00:26:24.510 --> 00:26:35.280
Cass Sunstein: But it does give people an edge in the direction of the route which the experts in this case the designers of the relevant program have chosen as the preferred route.
Cass Sunstein: Now just tend to come into different categories in the healthcare domain and otherwise, they bear on safety, as well as pandemics, they bear on occupational disease, as well as.

00:26:50.580 --> 00:27:05.340
Cass Sunstein: treatment and it's very useful to distinguish them somewhere educative and some are architectural and, if you look at the affordable care act, you can see a great deal of focus both on educative and architectural notches.

00:27:05.760 --> 00:27:11.280
Cass Sunstein: And educative knowledge might be a warning or reminder or disclosure of information.

00:27:11.760 --> 00:27:18.390
Cass Sunstein: Of these reminders deserve particular emphasis so i'm going to remind you of them, they are asleep or nudge.

00:27:18.690 --> 00:27:28.260
Cass Sunstein: If people are given text messages or phone call to remind them to do something they might be, doctors, they might be, nurses, they might be patients.

00:27:28.770 --> 00:27:32.700
Cass Sunstein: They can reminders can save lives and the data we're having.

00:27:33.570 --> 00:27:44.010
Cass Sunstein: we've had over last year's suggest that reminders have a significant impact in part because they overcome every one of the behavioral biases with which I began.

00:27:44.400 --> 00:27:56.430
Cass Sunstein: Warnings can also have a terrific effect, especially if they are accompanied by a suggestion of the route by which people can avoid the risk to which they are currently being subjected.

00:27:57.000 --> 00:28:07.620
Cass Sunstein: architectural nudges include such things as defaults automatically enrolling people in something unless they choose to opt out.

00:28:08.730 --> 00:28:15.210
Cass Sunstein: Forced choosing as when people are told you have to decide between X and y if you're going to get something you want.
Cass Sunstein: And order effects as in a list on a menu of which the knowledge, one is let's say the first or the one in the largest font.

Cass Sunstein: default rules of Meta study says on average increase participation rates by 26% that's a massive impact from shifting to opt in to opt out from opt in.

Cass Sunstein: Simplification is a cousin of automatic automatic it simplification is an architectural solution which often has a large effect on outcomes.

Cass Sunstein: Of the list of notches both educative and architectural to general ideas deserve pride of place, one is making things easier.

Cass Sunstein: and frequently it's thought that we should push people into a certain course of action, the better ideas to figure out why aren't they doing it anyway, and to remove the obstacle.

Cass Sunstein: That is a form of easing choice, if the healthier choices, the easier choice, the dividends can be massive The second idea that has pride of pride of place is social norms.

Cass Sunstein: are a form of educative nudge both with doctors and the patients when people are informed that most people are doing X, then the likelihood that people will do X tends to jump.

Cass Sunstein: And D deed it's the case that if most people aren't doing X, so you can't use the majority norm you can't honestly use it as a nudge.

Cass Sunstein: If it's the case that people are increasingly doing X or if there is an emerging norm in favor of X there's data suggesting that that tends to create a self fulfilling prophecy.
Cass Sunstein: And I regard that as one of the most exciting findings in behavioral economics, in the last decade emphasis on the emerging your tends to.

Change behavior because people think I guess that what's emerging has some sort of epidemic warrant and they tend to think they don't want to be on the wrong side of history.

Okay, done with najim last part is sludge, the basic concept here is that the health care system and health related decisions.

are often pervaded by administrative burdens barriers obstacles waiting time reporting requirements forms that are confusing, which tend to.

have adverse effects on the healthcare system on doctors and nurses and patients i'll give you a number, and I hope, if you remember anything from these remarks it's the number.

The United States Government, according to a recent assessment by the United States Government imposes a 11 billion annual hours and paperwork burdens on the American people 11 billion.

A significant chunk of that comes from burdens in the healthcare system imposed on all those who participate in the health care system and David cutler has shown that some of the.

less than optimal features of the American healthcare system are driven by the sheer magnitude of sludge imposed on the system for rational actors sludge is often a wall separating people between some outcome and and where they are now sledge can be seen as a kind of.

Stephen King novel version of a GPS device that it's The anti God GPS device, it does the opposite, it prevents people from getting what where they're going to go.
Cass Sunstein: that's true for fully rational actors for people who are subjective in such behavioral biases as President bias inertia and unrealistic optimism slides is is cruel.

Cass Sunstein: it's also the case, and this is the substantive point i'd like to leave you with that human beings have scarcity of cognitive resources.

Cass Sunstein: Not just scarcity of money also scarcity of cognitive resources, and if you are sick or poor or elderly or just struggling with something maybe depression or anxiety.

Cass Sunstein: The ability to navigate sludge is severely compromised, which means that slight edge is not only a question of social welfare writ large it's also a question of social justice.

Cass Sunstein: what's needed our slides audits, in which informally and formally we audit the level of administrative burden imposed on person.

Cass Sunstein: On persons removal of sludge is often much better than increasing economic incentives, because removing the obstacle is often the best way to pave a path towards healthier outcomes.

Cass Sunstein: My final words, for you are a question which may be has particular point in stay in this year, which is what is the thing that human beings are most blessed to have.

Cass Sunstein: And those of us who know people who lost their lives from covert 19 or some associated threat in the last year that question is something we ask ourselves the answer the question I think in this year is a four letter word.

Cass Sunstein: And it doesn't begin without it begins with T it's time that's the thing we're most blessed to have let's find shall we ways, with the aid of behavioral economics ways to give.
Cass Sunstein: Other people more off.

179
Cass Sunstein: Thank you.

180
Jim Madara - AMA/VISAC: cast, thank you, I know you have just a few minutes left there was one clarification asked, and that was we were talking about the imposition of hours of paperwork was that billion or million.

181
Jim Madara - AMA/VISAC: yellow billion.

182
Jim Madara - AMA/VISAC: yellow billion.

183
Cass Sunstein: million, so the department Homeland Security, where I work according to the State imposes 195 million hours and paperwork requirements that's one department and that's a lot of millions the Department of Health and human services crushes that.

184
Jim Madara - AMA/VISAC: Another question had to do with the fact that you know, there seems to be diminishing trust and science and increasing polarization and does that have an effect or not, and whether educated nudges or architectural nudges would be more or less effective and health and well being.

185
Cass Sunstein: Yes, it does, but it's maybe not the first thing to worry over or the largest thing tori over if people are given a reminder that they have a appointment next week, the likely or action is not that's being sent to me by the Russians.

186
Cass Sunstein: And if people are told, something about the need to take their medicine, you know every day they're unlikely to think that's coming from someone of a political party, I don't like.

187
Cass Sunstein: So, in terms of the day to day operation of health and safety, this, this is not.
Cass Sunstein: The most serious problem, though, in terms of large issues like getting vaccinated and thinking about certain kinds of risk let's say.

Cass Sunstein: Political polarization is a big problem and the best response to that is fine trust to find trusted validators people who are trusted among those who would be inclined to dismiss the so-called experts as in someone's pocket or having an agenda.

Jim Madara - AMA/VISAC: And in terms of the list of ways of influencing behaviors.

Jim Madara - AMA/VISAC: If you think about different domains institutional domain, on one hand, patient, on the other, provider, on the other.

Jim Madara - AMA/VISAC: doesn't does your priority list change in terms of what might be most effective between these different domains.

Jim Madara - AMA/VISAC: it's a.

Cass Sunstein: Great question I want to thank God the problem or the intervention is intended to solve if the problem is patients aren't adhering to the treatment that's been prescribed, then we know there are things that tend to work, reminders are helpful.

Cass Sunstein: And there's an assortment of things if the question is whether nurses are doing the five things that they're supposed to do, then there's another set of interventions, so I want to go, maybe less category of personnel then concrete by concrete problem.

Jim Madara - AMA/VISAC: And lastly, recognize you have limited time I just.
Jim Madara - AMA/VISAC: On a personal level, I mean you're a patient at some point in your life.

Jim Madara - AMA/VISAC: How do you use the strength of this knowledge to improve your own health.

Cass Sunstein: Well, I tend to do a lot of racquet sports.

Cass Sunstein: But that's partly because I really enjoy them, as well as I know that they're healthy and I've been blessed not to have much in the way of medical anything.

Cass Sunstein: But I tried to think that even if the rare occasions, in which I have i've tried to think as statistically minded as I possibly can.

Cass Sunstein: And if there's a choice to be made between doing X and y, what are the outcomes and what are the probabilities and let's do a little multiply rather than thinking about.

Cass Sunstein: My feelings.

Jim Madara - AMA/VISAC: Well, thank you, I mean this was terrific and we're really grateful that you could join us and recognize that you have a a timeline we're just grateful for the time that we got this was terrific Thank you cast.

Cass Sunstein: very grateful to you, thanks everyone.

Jim Madara - AMA/VISAC: Next.

Jim Madara - AMA/VISAC: week we go to Kevin volt and Kevin is a founding director of the Center for health, incentives and behavioral economics.
Jim Madara - AMA/VISAC: And the division Chief of health policy for the Department of medical ethics and policy and the poly president's distinguished professor of medicine.

Jim Madara - AMA/VISAC: At the perlman school of medicine and healthcare management at the wharton school all of the University of Pennsylvania, of course.

Jim Madara - AMA/VISAC: A member of the National Academy of Medicine editorial Member for a New England journal catalyst and a principal of the behavior economics consulting firm.

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Kevin Volpp: Thanks very much Jim cast is also tough act to follow, but i'll try to amplify some of the concepts, you talked about and describe some of the ways in which those insights are being used in to improve health and healthcare so let's go to the next slide.

Kevin Volpp: A few years ago I wrote this paper with David ash and there's about this concept of halfway technologies which are, in essence, those that don't eliminate.

Kevin Volpp: Diseases but can postpone their effects, so we can think about paradigms like cardiovascular chronic disease management.

Kevin Volpp: And we know from lots of evidence that if we had perfect adherence to all the evidence based therapies, we could actually reduce the rate in theory of cardiovascular events by something like 70 to 80%.

Kevin Volpp: But, yet we know that in the year, following a heart attack that adherence rates to the recommended cocktail of medications is only about 45%.
Kevin Volpp: And I think examples like this and there are countless examples highlight that behavior is really the final common pathway.

Kevin Volpp: As we think about trying to improve health and health outcomes and it's really behavior among both clinicians and among patients, because when you have.

Kevin Volpp: hit here in terms of 45% you have to ask yourself the question why is it that that's the best that we can do let's go to the next slide.

Kevin Volpp: Part of the challenge here is that we've typically thought about people as being perfectly rational and we thought if we could just educate patients on what to do, providing them with information provide some incentives.

Kevin Volpp: And just layer on increasingly complex interventions.

Kevin Volpp: That we would lead that would lead us to having the desired behaviors and I think we all know that that's not true and that's a lot of what behavioral economics has contributed over the past few decades to better understanding.

Kevin Volpp: So going to the next slide what we really have is a paradigm in which the mind is more like a high resistance pathway.

Kevin Volpp: And we've all developed behavioral reflexes that in essence bypass cognition so we can think instead of just providing information.

Kevin Volpp: about using choice architecture and defaults creatively, we can think instead of just providing financial incentives, how to make those more behavioral.
Kevin Volpp: And then, as Cass was saying about sludge and the terrible problems we have with complexity, we can think about really the antidote to that it’s really making things as simple as possible, given that we all have bounded rationality and limited bandwidth next slide.

00:42:27.360 --> 00:42:32.640
Kevin Volpp: So I’m going to talk about this in three main categories one is the notion of changing default.

00:42:33.060 --> 00:42:42.150
Kevin Volpp: And I want to start with this, because often making things easier to do for patients and clinicians is more effective than changing their financial incentives.

00:42:42.450 --> 00:42:52.680
Kevin Volpp: And you’ll see as I talked through this there’s some things where the types of effect sizes, you see, are not effect sizes, you could change by changing how people.

00:42:53.370 --> 00:43:06.480
Kevin Volpp: are paid then we’ll talk a little bit about financial incentives and then I want to talk separately about simplifying complicated processes, because the sludge that Cast talked about is just such a central issue, I think we have to.

00:43:07.020 --> 00:43:15.570
Kevin Volpp: continuously remind ourselves of this because that in itself creates a real opportunity for improvement let’s go to the next slide.

00:43:16.200 --> 00:43:22.050
Kevin Volpp: So many of you have probably seen this example before and it’s a classic within the field of behavioral economics.

00:43:22.530 --> 00:43:32.190
Kevin Volpp: Which Eric Johnson and Noah Goldstein published in science, a number of years ago, and this basically shows the difference in organ donor donor registration rates.

00:43:32.640 --> 00:43:43.200
Kevin Volpp: In Western European countries on the left in orange or countries which have an opt in in the right in green or countries where you’re presumed to want to be an organ donor unless you opt out.

00:43:43.590 --> 00:43:51.840
Kevin Volpp: And you can see, dramatic differences here again hard to imagine achieving this kind of difference or any kind of financial incentive.

00:43:52.950 --> 00:44:02.850
Kevin Volpp: But then translating that to improving people's health behaviors a bit more challenging we can just take everyone who's obese and say let's put you in a weight loss Program.

00:44:03.390 --> 00:44:11.910
Kevin Volpp: by default and see what happens because we know we wouldn't be that successful and engaging people and helping them lose weight so going to the next slide.

00:44:12.750 --> 00:44:21.390
Kevin Volpp: One of the things we've tried to do is to think about that said, how do you modify the enrollment process for programs, this was an example of a program we did.

00:44:21.750 --> 00:44:30.300
Kevin Volpp: Where we had people with patients with poorly controlled diabetes, we offer them free participation in a program that provided remote monitoring their blood sugar.

00:44:30.870 --> 00:44:41.010
Kevin Volpp: And we reframe the invitation from an opt in to an opt out, and we were able to roughly tripled the enrollment rates and had similar improvements in glycemic control.

00:44:41.280 --> 00:44:52.470
Kevin Volpp: So I think there is a reframing that can actually be quite useful when we think about programs and programs for the benefits are much greater than risk in terms of patient participation next slide.

00:44:53.940 --> 00:45:01.590
Kevin Volpp: We can also think, though, about how this can influence clinician behavior and I knew me touch is going to talk a bit about this, he was the architect of this study.

00:45:02.070 --> 00:45:12.570
Kevin Volpp: And this is an important example because we had struggled for years as a health system with generic prescribing and you can see generic prescribing rates are all over the map.

00:45:12.960 --> 00:45:16.830
Kevin Volpp: Once the default was changed generics if you press next slide.

00:45:17.340 --> 00:45:28.560
Kevin Volpp: you'll see the rate of generic prescribing went to almost 100% overnight, and this saved our health system 10s of millions of dollars within a relatively short period of time next slide.

00:45:29.310 --> 00:45:38.790
Kevin Volpp: Sometimes you can't just default people, though into the decision you'd like them to make, and this is an example of some work we did a number of years ago with CBS.

00:45:39.150 --> 00:45:45.480
Kevin Volpp: Where we worked on just making more salient to people, the convenience of being in an automatic refill Program.

00:45:46.170 --> 00:45:54.870
Kevin Volpp: So on the bottom here press one, if you prefer to refill your prescriptions by yourself, each time or press two if you'd prefer for us to do it for you automatically.

00:45:55.230 --> 00:46:04.740
Kevin Volpp: And this roughly doubled the rate at which people sign up for the automatic refill program CVs has used this in 10s of millions of Members, it just makes it easier for people.

00:46:05.160 --> 00:46:11.160
Kevin Volpp: Without actually defaulting them into the automatic refill program, and the reason they couldn't do that.

00:46:11.460 --> 00:46:20.880
Kevin Volpp: Was they said, every time we send out these refills, we have to charge people's credit cards, people would be furious if we did that, without their explicit authorization.

00:46:21.180 --> 00:46:29.910
Kevin Volpp: So you can think about a sort of array of different approaches here, depending on the context that can be brought into play now moving on to the next slide.

00:46:31.290 --> 00:46:40.200
Kevin Volpp: And the slide after that we can talk a bit about financial incentives and this obviously came into play in a very large way with coven the summer.
Kevin Volpp: Where as voluntary efforts to get people to get vaccinated thought states around the country turned to the use of incentives if we hit the next slide button.

One of the salient or important findings in behavioral economics has been around probability waiting where we see that people typically next slide.

With probabilities near zero tend to overweight those probabilities and think they're more likely than they actually are, and this underlies.

The popularity of lotteries, in general, and is probably a big part of the reason why a lot of states turn to lotteries, because they could offer million dollar prizes.

But if you're offering a few million dollar prizes in the state of 10 million people, the cost of that per person is actually quite small.

So, moving to the next slide despite the hype about this and the excitement.

And the reality was considerably more challenging we wrote an article I wrote an article at currently canoes to about this on incentives for immunity.

going to the next slide I think there were a lot of good ideas behind this and you can think about reasons why we might consider incentives.

There are positive externalities so in a free market people don't adequately consider the benefit to others and making decisions.
Kevin Volpp: And you can think about pollution as a prime example of the opposite of negative externality where we tend to find find polluters.

Kevin Volpp: But you can also think about other reasons why we might provide incentives to get coded vaccinations to offset the cost for people have to take time off from work or arrange childcare.

Kevin Volpp: there's obviously enormous potential for cost savings economists have estimate the total cost of covert.

Kevin Volpp: To the US about $16 trillion, so if we can shorten the epidemic that would have obviously been a good thing.

Kevin Volpp: And then we know from lots of other health context and incentives have been shown to be pretty effective and increasing the rate of healthy behavior.

Kevin Volpp: But moving to the next slide I think there's there's some challenges here, and when we and others have looked at.

Kevin Volpp: The evidence from around the country that paper on the left is a paper lead by harsha or murthy looking at.

Kevin Volpp: A number of different states and the effectiveness or lack thereof of their incentive programs.

Kevin Volpp: The graph on the right from the affiliate back sweepstakes That was a program our team, set up in Philadelphia, where we gave away a couple of $50,000 prizes as well as a number of smaller prizes.

Kevin Volpp: is, in essence, these incentives didn't work and the there's a more complicated story here, but I think the simple answer.
Kevin Volpp: Is that these were largely deployed at a point in the pandemic which those who weren't vaccinated had made up their minds so incentives, with a small expected value weren't going to work next slide.

274
00:49:27.780 --> 00:49:37.410
Kevin Volpp: And what we've seen as a response is an increasingly stronger form of incentives, where it's which are in essence policy interventions that were really needed.

275
00:49:37.680 --> 00:49:45.510
Kevin Volpp: And you can think about employer mandates as being a really strong form of incentive, because of course you're going to lose your job if you don't get vaccinated.

276
00:49:45.900 --> 00:49:53.790
Kevin Volpp: But we see both in the US in Europe and other countries, a lot of use of conditional incentives were, in essence, if you want to fully participate.

277
00:49:54.060 --> 00:50:04.440
Kevin Volpp: If you want to travel to the European Union if you wanted to attend the nfl draft in person, a lot of cities, if you want to go to concerts restaurants, etc, I, you have to be vaccinated.

278
00:50:04.890 --> 00:50:13.380
Kevin Volpp: You can also think about other approaches like raising health insurance premiums on the unvaccinated and now we're starting to see just in very recent time.

279
00:50:13.950 --> 00:50:22.110
Kevin Volpp: Various other countries moving further down this spectrum so Austria started placing unvaccinated people in partial lockdown.

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00:50:22.470 --> 00:50:30.840
Kevin Volpp: They now have mandates for vaccination nationally by February, they haven't specified the fines yet Greece just announced yesterday they're going to.

281
00:50:31.350 --> 00:50:37.770
Kevin Volpp: require people over the age of 60 to get vaccinated otherwise they'll pay a fine about 1400.

282
00:50:38.400 --> 00:50:50.850
Kevin Volpp: dollars a month sorry 1400 $40 a month, so it's enough of a mandate that it will have teeth and I think what we've clearly seen is that these types of incentives on.

Kevin Volpp: Stick type incentives are probably what would be needed in this situation like this the carrot type incentives with low expected value clearly were not enough.

Kevin Volpp: But I want to move to the next slide and just comment briefly on some of where we are in terms of clinician incentives, and this was a slide.

Kevin Volpp: that my colleague Amal Nevada who's part of MED pack put together for the child advisory board a week ago.

Kevin Volpp: And I think it's important for us to pause here and recognize that, for the most part, most providers still aren't facing value based incentives.

Kevin Volpp: And if you look at the graph on the left, you can see, traditional fee for service fee for service and pay for performance.

Kevin Volpp: it's about 65% right there and then many of the other mechanisms are basically primarily priced reconcile from retrospective fee for service payments.

Kevin Volpp: So we have fee schedules that often reward providers for for providing low value care the relative value units themselves are largely based on cost not value.

Kevin Volpp: So it's really important to recognize here that, while behavioral economics really tries to think carefully about the various biases cast described affect human decision making.
Kevin Volpp: If the underlying economic incentives are in sending activities we don't want to encourage it's very hard to overcome that and I think this is really important for us all to recognize.

292
00:52:19.920 --> 00:52:20.550
Kevin Volpp: Next slide.

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00:52:22.050 --> 00:52:32.610
Kevin Volpp: So I want to move in just talked very briefly about simplifying processes that I see this as the antidote for some of what what cass described as sludge and moving to the next slide.

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00:52:33.390 --> 00:52:37.890
Kevin Volpp: One of the challenges we have is often programs are just too complicated.

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00:52:38.310 --> 00:52:46.860
Kevin Volpp: And I wanted to highlight this was a program Kobe watch that some colleagues at the penn medicine innovation Center created which we were really quite proud of.

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00:52:47.340 --> 00:52:52.830
Kevin Volpp: And it was featured in the New England journal catalyst side by side with a program from northwestern.

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00:52:53.160 --> 00:53:01.980
Kevin Volpp: And the northwestern program I think was also a laudable program, but the main difference was that was using humans as the work for us, whereas Kovac watch.

298
00:53:02.310 --> 00:53:07.020
Kevin Volpp: was a program that was created, which was basically a very simple text messaging engine.

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00:53:07.530 --> 00:53:19.500
Kevin Volpp: Where patients who clinicians were concerned about but didn't want to admit to the hospital were sent home remotely monitored twice a day with text messages and if they were concerned about the breathing.

300
00:53:20.010 --> 00:53:28.170
Kevin Volpp: There was a code for them to type in, in which case in nurse would call them right away so very, very simple, and you can see here that.
Kevin Volpp: Of course, when you have an automated algorithm like this, you can monitor people 24/7; you need a lot less delay, staff hours.

Kevin Volpp: You can save millions of dollars. This program had a really high net promoter score, and most importantly, it actually saved a lot of lives relative to a control group of the other pen patients. It's not relative to the Northwestern Burke; I want to highlight that, but it saves 68%.

Kevin Volpp: Of deaths on estimate relative to a comparison group of patients and so again like keeping it really simple is often the best way to go.

Kevin Volpp: Moving to the next slide, and there are lots of examples we could point to here. There's some work led by Job and Doshi on prescription synchronization. Lots of patients were on.

Kevin Volpp: You know 10-15 medications a day; they struggle a lot with just simple actually refilling because the refills are all done on different dates. This is a work with Humana.

Kevin Volpp: Basically, showed that for patients with low adherence you could increase.

Kevin Volpp: You could increase inherent traits by about 13 percentage points just by synchronizing that days the prescription.

Kevin Volpp: And then the next slide, I want to just give another example, the clothes, which is health plan design itself. And we know that these health plan designs are very confusing.

Kevin Volpp: They assume people are perfectly rational. I can read through dozens of pages of small print like this and understand all the underlying incentives.
Kevin Volpp: But the reality of course is that people don't as cast said, people have limited bandwidth.

Kevin Volpp: and very few people, if any, are going to understand all these details and really commit them to memory, so when they're trying to decide.

Kevin Volpp: Do I go to urgent care to I go to the emergency room they're going to know what the difference in cost would be.

Kevin Volpp: Furthermore, going in the next slide it's actually pretty much impossible to calculate that difference so there's a veritable alphabet soup.

Kevin Volpp: of different kinds of incentives that are in play, and if i'm trying to calculate how much is 10% of an er visit.

Kevin Volpp: it's basically impossible to do because I don't know what 100% of the price is going to be at that time and then depending on how much i've spent this plan year.

Kevin Volpp: there's no way for me to know what the combination of my deductible co-insurance are going to add up to.

Kevin Volpp: So we've worked out with a number of health plans and creating simple health plans which are co payment only.

Kevin Volpp: And I think that you can think about that as a paradigm of sorts for trying to just make it easier for patients to recognize.

Kevin Volpp: Here the underlying incentives, if I if I want to go to urgent care at $75 if i'm going to go to the emergency room, it might be $350 but at least I understand what the trade off is and it's easy for me to understand.
Kevin Volpp: So, moving to the next slide there there's a lot of ways in which behavioral science can be helpful in terms of motivating health system transformation.

Kevin Volpp: As I said, i've tried to highlight some of the areas besides financial incentives, because I think we've seen in a number of context that changing the default choice architecture, making things simpler.

Kevin Volpp: Really really important independent of whatever is done with financial incentives financial incentives obviously also play a big role.

Kevin Volpp: But there's a lot, we need to do to think about the underlying economic incentives and how to make those more appropriately targeted.

Kevin Volpp: So that any behavioral twists we add to that can make the program achieve the desired goals, so let me go to the next slide and happy to stop here and take any questions.

Jim Madara - AMA/VISAC: Thanks thanks very much Kevin that was great, let me just ask you when you work with the health plans to make something simpler, what was the incentive for them some of the complexity people argue, is that they need to differentiate themselves from each other.

Kevin Volpp: Well, we had a really good experience with humana a number of years ago, creating a health plan called humana simplicity.

Kevin Volpp: And it was something which leadership just got interested in doing and it's been a plan or has now been in place for a number of years and attracted quite a few Members, I think it provides a differentiator that allows them to appeal to consumers.
Kevin Volpp: In a way, which perhaps they couldn't otherwise.

Jim Madara - AMA/VISAC: And if you think of these various examples that you used in the health system is currently set up.

Jim Madara - AMA/VISAC: Where are we falling out, so to speak.

Jim Madara - AMA/VISAC: And the way we have incentive setup that would be the sort of the easier change to make and to swallow for the health system.

Kevin Volpp: Well it's a complicated question answer Jim I think we could start with the.

Kevin Volpp: slide I showed in terms of clinician payment, you know there's a lot of rhetoric about moving the value, but if you look at where the dollars are going it's still largely based on fee for service and then fee for service.

Kevin Volpp: You know isn't really based on value it's based on cost so if we really want to drive the value we have to rethink.

Kevin Volpp: Both of those in terms of what the fee for service payments are based on and then how we might really think about.

Kevin Volpp: Moving moving more clinical groups towards more of a value based framework, I think, on the patient side on you know, one of the challenges is that.

Kevin Volpp: benefit design is a little bit of a crude instrument to change behavior because you have to look at.
Kevin Volpp: What what is true people on average and it's very hard, because you know what might be high value for a given patient might be low value for other patients or vice versa, and so.

Kevin Volpp: you're sort of limited to making changes, where something is universally low value universally high value, but the reality is many clinical treatments diagnostic tests it all depends on the given patient and the indications.

Jim Madara - AMA/VISAC: And and a given institution this hard wired to these external programs of payers cms and whatnot.

Jim Madara - AMA/VISAC: Where is the low hanging fruit to make progress for an institution that is part of this we're hardwired to this to the swim.

Kevin Volpp: Well i'd come back to Sunday cast said about the question being what are the primary goals, and I think you have to step back and.

Kevin Volpp: Think less categorically about groups and more about what you're trying to achieve, and then, what are the different.

Kevin Volpp: tools, you have to try to influence behavior and then within each of them, how do you best optimize the way those programs are designed and and configure to achieve to achieve your goals.

Jim Madara - AMA/VISAC: A question came in.

Jim Madara - AMA/VISAC: isn't playing medicare where co pays and deductibles are fixed and simple better than plans which are designed to be more complex.
Kevin Volpp: I don't know if I would say they're designed to be more complex, I think many plans have evolved in a direction.

Kevin Volpp: That just continuously has added complexity, because people often don't recognize the cost of sludge.

Kevin Volpp: I you know there's good ideas behind adding programs and making things more complex but there's often not a comparable effort to remove programs and make things simpler so.

Kevin Volpp: I you know I think they're pros and cons to different types of plan designs on you know I i'd love it if if we thought more about.

Kevin Volpp: Using copayment only systems, because I think it does give the patient, a chance to really understand what things cost in a very predictable way which you could never get to using deductibles coinsurance.

Jim Madara - AMA/VISAC: Well, recognizing we're at the top of the hour, I mean, these were fantastic presentations by casting yourself Kevin and we're grateful for the work you do and for joining us today.

Jim Madara - AMA/VISAC: Perhaps it would be good now with the hand with the clap.

Jim Madara - AMA/VISAC: to thank you and then shift to diane to facilitate the next session so thanks again.

Kevin Volpp: thanks for having me.

Diane Holder: And thanks Jim and thanks to cast and Kevin for really terrific presentations.
Diane Holder: So now we're going to turn to our panel called action for individual and work force driven change and this panel will provide.

01:02:27.960 --> 01:02:37.020
Diane Holder: Some details surrounding the practical implication of incentive structure to better align the behavior of individuals workforce and the system as a whole.

01:02:37.410 --> 01:02:49.350
Diane Holder: And with health system effectiveness, efficiency, equity and continuous learning in mind, we turn to our really terrific panel, so we have the privilege.

01:02:49.800 --> 01:03:00.570
Diane Holder: To have a panel of experts who will help us and put some of these ideas to the test in terms of what they're seeing happen in their respective spaces.

01:03:01.020 --> 01:03:10.920
Diane Holder: So let me tell you about our panel, we have Nancy and apparel and she is a managing partner and co founder of continents capital partners.

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Diane Holder: Prior to CCP she was assistant to the President and deputy chief of staff for policy and the Obama White House from 2011 to 13.

01:03:22.350 --> 01:03:31.020
Diane Holder: And she served as counselor to the President and director of the White House office of health care reform from 2009 to 2011.

01:03:31.800 --> 01:03:47.520
Diane Holder: She currently serves on the board of directors of sellers dorsey psychiatric medical care hca healthcare CVs health and she's also a member of the Duke university Board of Trustees and a National Academy of Medicine Member.

01:03:48.210 --> 01:03:54.480
Diane Holder: So we're excited to hear from Nancy we're also going to hear from Brent James he is a clinical professor of the.

01:03:54.780 --> 01:04:03.300
Diane Holder: At the clinical excellence research Center department of medicine Stanford university school of medicine and he is known internationally, for his work.
Diane Holder: In quality improvement patient safety and the infrastructure that underlines successful improvement efforts, such as culture change data systems payment methods and management's role.

Diane Holder: he's a member of the National Academy of Medicine, and he serves on several not for profit boards dedicated to clinical improvement and patient safety.

Diane Holder: He was formerly chief quality officer and executive director of the Institute for healthcare delivery research at intermountain healthcare based in salt lake city utah.

Diane Holder: And our third panel member is Natasha patel and he's a physician executive and behavioral scientist.

Diane Holder: He is currently Vice President for clinical transformation and national lead for behavioral insights.

Diane Holder: And Ascension he is also the Ralph muller presidential professor at the proven school of medicine and the wharton school at the University of Pennsylvania, Dr patel was the founding director of the penn medicine nudge unit.

Diane Holder: I love that name the world's first behavioral design team embedded within a health system.

Diane Holder: His work has been featured in numerous media outlets, including the New York Times, the NBC today show on Wall Street Journal, The Economist npr CNN many, many places so.

Diane Holder: What i'd like to do first, if I could is ask Nancy to begin each speaker is going to take seven or eight minutes and then we'll have time to post some questions so Nancy if you don't mind starting.
Nancy-Ann DeParle: Sure thanks diane happy to be here today.

Nancy-Ann DeParle: I am going to take us back up to 10,000 feet as as cass sunstein was was talking about, because my comments are mostly in the realm of my experience in the real politic of policymaking, as you might imagine, given my experience at the White House.

Nancy-Ann DeParle: driving the process that led to the affordable care act.

Nancy-Ann DeParle: And it taught me a lot about the importance of politics and these kinds of choices and why nudging can be hard to do.

Nancy-Ann DeParle: And i'll talk about some early attempts that I.

Nancy-Ann DeParle: undertook to use what I don't even think I knew was behavioral economics at the time to deal with sludge and to try to do a Niger to.

Nancy-Ann DeParle: some of which were pretty successful and then i'll talk about some later attempts that so far i've had mixed success.

Nancy-Ann DeParle: And some that we left on the cutting room floor with respect to the affordable care act, so the first one here is, this is a bit of a show and tell us.

Nancy-Ann DeParle: What cast was talking about, with respect to sludge on the left, you see the Tennessee department of human services when I was running it back in the 80s.
Nancy-Ann DeParle: The there was one large office in memphis even though that is, you know, one of the most highly concentrated.

Nancy-Ann DeParle: areas of poverty in the US Department of human services did the eligibility determination for the so called welfare program a FTC is we used to call out the aid to families with dependent children.

Nancy-Ann DeParle: And also did the eligibility is termination for medicaid and for food stamps and to to sign up for any of those three programs, you had to go sit in that waiting room, which was an abandoned.

Nancy-Ann DeParle: Big a department store if anyone remembers those it took up a whole basically city block, there was a big parking lot in front of it, you had to sit there sort of all day until your name was called it's.

Nancy-Ann DeParle: Worse than the dmv for those of us who go to the dmv in this area at least it's it defines sludge and defines honestly desperation, I thought.

Nancy-Ann DeParle: behind that blue wall are are hundreds of cubicles where the thousand plus caseworkers set, and if you were your name was called you would go back and sit there and fill out.

Nancy-Ann DeParle: By hand at that point, mostly, even though the caseworkers themselves could enter things into a computer.

Nancy-Ann DeParle: You would mostly fill out by hand three separate applications food stamps medicaid and a FTC and when I started trying to fix that I asked to meet with the three federal agencies that.

Nancy-Ann DeParle: Well, parts of two parts of hhs and another part of the Department of Agriculture, the food nutrition service.
Nancy-Ann DeParle: I asked to meet with the regional offices to talk about designing a system that would put the three different forms of aid - cash and cash aid and food stamp aid together into one system.

01:09:18.750 --> 01:09:28.320
Nancy-Ann DeParle: Online and I couldn't even get the three agencies to meet with me, at the same time in Atlanta. That was where our regional office was, so that's sort of where it started and I.

01:09:28.770 --> 01:09:42.750
Nancy-Ann DeParle: got frustrated with that it did eventually we did eventually redo the eligibility termination process, but I got frustrated with it, and so I started working on making this and I don't think you can quite see this, but this is a 60-page application form.

01:09:43.890 --> 01:09:45.960
Nancy-Ann DeParle: For medicaid into something simple and then I did something which at that point, no other State had done, which is.

01:09:47.760 --> 01:09:54.990
Nancy-Ann DeParle: To allow people to sign up for medicaid when they were in the hospital.

01:09:56.220 --> 01:10:01.350
Nancy-Ann DeParle: We were spending millions and millions of dollars on disproportionate share payments to hospitals at that time this is before 10 care of the program that that expanded medicaid and.

01:10:02.700 --> 01:10:16.410
Nancy-Ann DeParle: use some of those disproportionate share dollars to pay for.

01:10:17.700 --> 01:10:21.210
Nancy-Ann DeParle: Actual enrollments in health care medicaid.

01:10:22.860 --> 01:10:25.980
Nancy-Ann DeParle: But we were spending millions of dollars and hospitals were.

01:10:32.760 --> 01:10:40.770
Nancy-Ann DeParle: Seeing and admitting millions of patients, hundreds of patients, thousands of patients without coverage, who are actually eligible.

408 01:10:41.910 --> 01:10:47.460
Nancy-Ann DeParle: and part of the reason was because they'd have to go about as I showed you there to sign up and.

409 01:10:48.690 --> 01:10:58.320
Nancy-Ann DeParle: Who has time for that wants to do that there's nothing about that situation that encourages you to do anything when you can still show up at the hospital.

410 01:10:59.490 --> 01:11:13.290
Nancy-Ann DeParle: So I worked with the regional medical Center, which is the big safety net hospital in memphis to to arrange to have eligibility workers who would be out stationed at their hospital and.

411 01:11:14.460 --> 01:11:17.940
Nancy-Ann DeParle: Online they didn't literally do that, but they were outstation there they could come to your room if you asked like a sign you up a medicaid law would allow people to be covered, on a backdated basis, so they did they'd be considered to be covered from when they went into the hospital.

412 01:11:18.570 --> 01:11:34.710
Nancy-Ann DeParle: Online they didn't literally do that, but they were outstation there they could come to your room if you asked like a sign you up a medicaid law would allow people to be covered, on a backdated basis, so they did they'd be considered to be covered from when they went into the hospital.

413 01:11:36.210 --> 01:11:43.410
Nancy-Ann DeParle: It was not too hard to sell the the administrator of the regional medical Center the MED, as we call it.

414 01:11:43.740 --> 01:11:50.580
Nancy-Ann DeParle: On this idea, it was somewhat difficult for me to sell the governor on the idea because is he he sat there and looked at me and said.

415 01:11:50.850 --> 01:12:01.080
Nancy-Ann DeParle: So wait a minute, let me get this straight you want me to put eligibility workers into the hospital to get more people on medicaid which is going to increase our costs.

416 01:12:02.820 --> 01:12:11.370
Nancy-Ann DeParle: That doesn't make sense and I had to make the arguments to him about why it could save money, it would keep people out of the emergency room if they had coverage.

417  
01:12:11.790 --> 01:12:18.960  
Nancy-Ann DeParle: And of course the federal state partnership in the financing of medicaid being what it is that, in fact.

418  
01:12:19.500 --> 01:12:28.560  
Nancy-Ann DeParle: The Federal Government, we, the taxpayers and other states will be paying for you know 65 68% of every dollar that was spent on those people.

419  
01:12:29.130 --> 01:12:37.200  
Nancy-Ann DeParle: that it would be bringing the dollars to the hospital reducing charity care I eventually convinced him to do that, and I think we were the first state in the nation to do it.

420  
01:12:38.310 --> 01:12:43.830  
Nancy-Ann DeParle: So that was a relatively successful experiment in this next slide allison.

421  
01:12:46.200 --> 01:13:04.590  
Nancy-Ann DeParle: So then fast forward to when I was running cms in the late 90s, and we were working on some really difficult problems with respect to the quality of nursing homes and just some very bad situations that had occurred.

422  
01:13:06.090 --> 01:13:09.420  
Nancy-Ann DeParle: And i'd like to say that's in the rearview mirror, but of course it isn't.

423  
Nancy-Ann DeParle: We had data at that point about really only about the surveys, the annual survey and recertification of nursing homes that's conducted by states on delegation from cms.

424  
01:13:28.200 --> 01:13:35.190  
Nancy-Ann DeParle: And if you've ever looked at that data it's not very good it covers things like whether someone left a.

425  
01:13:36.930 --> 01:13:47.100  
Nancy-Ann DeParle: The wrong the wrong kind of cleanser out in a think in a common bathroom that kind of thing that could be harmful you've seen similar similar.
Nancy-Ann DeParle: Information about surveys of hospitals, I suspect that people on this in this meeting, have in any event it's not great information but it's something it tells you something about the quality of a nursing home.

And if you fail the survey that's up there, so that tells you something so I decided without really asking anyone that I would just throw that up on the web, so we have the very first.

up on the web and 98 code we call it nursing home compare and you could search by zip code get information about nursing homes, and it would give you again i'm embarrassed you know if the appalling lack of data that we have but.

That truly went to quality but we had something so we put that up there, so the question I had was with with this information about quality.

Change consumers choice of nursing homes and that's what I really hope.

Was that families and consumers, who are faced with a nursing home choice would look at that information and make a decision not to go to the nursing home that had.

We we display their results on the survey via primitive form of a star rating, so I was hoping that they'd look at that and realize that this.

This particular nursing home and failed the survey, where is the one you know, two blocks away had not and they would make choices based on that.

And what we found at least in the couple of years after that, where I followed it more closely, was that the answer is no.
Nancy-Ann DeParle: Information about quality, at least at that point, and at least with the information that we had, which is, I said was not very good.

Nancy-Ann DeParle: didn't change consumers choice of nursing homes, in fact, the only thing that really.

Nancy-Ann DeParle: seem to affect their choice was location location location location as we've all heard that was the thing that families were looking for.

Nancy-Ann DeParle: You know what nursing home was close to their family and to be fair that's not a crazy decision because, if your family's going to be watching.

Nancy-Ann DeParle: You probably are more likely to get quality care and a nursing home but here's what was interesting about this data to me again just throwing it up there on the web, a couple of nursing home chains threatened to sue us.

Nancy-Ann DeParle: You know people were a lot of the industry was upset about it i'm sure I got some very stern letters from the trade associations.

Nancy-Ann DeParle: But then I started getting calls from them from nursing homes saying hey the data about my nursing home on Smith street isn't up to date, we had a survey, three weeks ago, and I want that data up there.

Nancy-Ann DeParle: was kind of curious about that, so I started asking them well that's interesting that you wanted updated I guess we're lagging behind.

Nancy-Ann DeParle: Why, why are you interested and it turned out that they were studying the information, all of them were looking at it.
Nancy-Ann DeParle: And it as their own information and each other's information that was the first time they had been able to see it.

Nancy-Ann DeParle: And they were competing with one another to do better, so that was a happy sort of outgrowth of throwing matt information up there.

Nancy-Ann DeParle: It may not have changed directly the way consumers made their initial choices, but having that information about quality requiring disclosure of it.

Nancy-Ann DeParle: did in fact lift quality, a small amount, because it caused the nursing homes themselves to pay attention to it and to try to do better and that's maybe a part of I don't recall, whether that was one of the.

Diane Holder: You can see these are credibly interesting examples of how, when you really do start sharing data it makes a big difference.

Diane Holder: And I guess we're going to get to hit a little bit more from also brand James about quality intersection.

Diane Holder: I think i'd like to move to Brandt if he's available now.

Brent James: I think we're available diane.

01:16:39.930 --> 01:16:45.030
Nancy-Ann DeParle: And it as their own information and each other's information that was the first time they had been able to see it.

01:16:45.630 --> 01:16:55.650
Nancy-Ann DeParle: And they were competing with one another to do better, so that was a happy sort of outgrowth of throwing matt information up there.

01:16:56.250 --> 01:17:06.690
Nancy-Ann DeParle: It may not have changed directly the way consumers made their initial choices, but having that information about quality requiring disclosure of it.

01:17:07.740 --> 01:17:20.850
Nancy-Ann DeParle: did in fact lift quality, a small amount, because it caused the nursing homes themselves to pay attention to it and to try to do better and that's maybe a part of I don't recall, whether that was one of the.

01:17:21.900 --> 01:17:23.040
Nancy-Ann DeParle: human nature.

01:17:24.510 --> 01:17:29.160
Nancy-Ann DeParle: qualities that cast talked about but that's That was one that I found to be the case here.

01:17:30.390 --> 01:17:38.490
Diane Holder: You can see these are credibly interesting examples of how, when you really do start sharing data it makes a big difference.

01:17:39.510 --> 01:17:45.630
Diane Holder: And I guess we're going to get to hit a little bit more from also brand James about quality intersection.

01:17:47.160 --> 01:17:52.290
Diane Holder: I think i'd like to move to Brandt if he's available now.

01:17:53.340 --> 01:17:54.750
Brent James: I think we're available diane.

01:17:55.260 --> 01:17:55.920
Great.

01:17:57.150 --> 01:18:06.690
Brent James: So next slide for me please and then quickly skip past the next two it's just a header and a disclosure slide when we get to those next one.

01:18:07.650 --> 01:18:17.940
Brent James: I plan to cover three areas go back one, I want to talk about algorithm versus us to work some unexamined but incorrect assumptions or perverse incentives, not a frame this.

01:18:19.710 --> 01:18:33.450
Brent James: I was dealing with clinicians physicians and nurses, pharmacists therapists and we were really trying to get the care right so i'm going to talk at that level of a system and things that worked with frontline care providers to get them on board.

01:18:35.190 --> 01:18:43.890
Brent James: it's interesting I wish i'd had all that fine theory that we just heard, it would have been delightful very, very useful to have we kind of worked out just as Nancy was saying on the fly.

01:18:44.790 --> 01:18:51.570
Brent James: The hard way, if I had a single theme for her, it would be this we tried to make it really easy to do it right.

01:18:52.890 --> 01:18:58.620
Brent James: didn't have to change their values, their work ethic their commitment to their patients are.

01:18:59.820 --> 01:19:04.140
Brent James: They were very hard working deeply committed really smart well trained people.

01:19:04.830 --> 01:19:12.990
Brent James: But how could you make it really easy to do it right in a very complex environment so first i'll go to them versus touristic where next slide.

Brent James: study comes from Dan pink at Stanford Jeff Pfeffer has written a great book chapter with Robert Sutton on the same topic.
Brent James: two classes of activities, you might undertake the first is called algorithmic you just have to follow it established set of instructions down a single pathway to achieve one conclusion so it's completely pre definable.

Brent James: That stands in contrast to heuristic work where you have to adjust on the fly adjust and create on the fly clinical care delivery is massively heuristic.

Brent James: Know to patients are quite same it's a very complex environments where people have to adjust it turns out that financial incentives at the front line work as advertised for algorithmic processes some some healthcare processes are preparing a patient room for example brain food.

Brent James: carolyn debris is touristic The trouble is next slide for a heuristic processes financial incentives actively damage performance actively and significantly damaged performance.

Brent James: raises a question next slide what does work and interesting setting turns out it's professional values what's called intrinsic motivation you try to get fair pay.

Brent James: According to Dan pink Japan have to take money off the table so that people aren't thinking about money.

Brent James: Then three factors apply autonomy mastery and purpose autonomy that ability to experiment to create essential and if you're acidic environment you can't function without mastery.

Brent James: We really do want to be a top of our field and then that purpose element, maybe that's, the most important doing things that truly matter, making a real contribution, a purpose driven life that work for us in spades.

Brent James: Is that focus on shared professional values as a primary motivator next slide.
Brent James: Well, turns out that if you're using financial incentives are a couple of unexamined assumptions, the first is the clinical data systems can adequately assess compared to performance, the problem comes when you start to correctly statistically calculate confidence intervals around rankings.

Brent James: you end up with dramatically wide confidence intervals, they can't rank very accurately and most circumstances are a couple where they can but they're fairly rare to see.

Brent James: So it's really hard to say who should get the incentive in a fair way.

Brent James: somewhere along the line, though I would agree that perhaps it an institutional level financial incentives make sense but somewhere along the line but but, before you get to the frontline somebody has to change the method.

Brent James: One of my real frustrations is watching senior leadership teams and healthcare delivery systems, except the old mantra incorrect that financial incentives will drive appropriate behaviors down the front line.

Brent James: A strong enough incentives, they believed at somebody who knows who will somehow figure it out.

Brent James: There really believing that the primary reason for poor performance is motivation, when the actual causes are increasing complexity.

Brent James: A system that relies primarily on human memory for execution and very complex environment and poor process level transparency so frontline workers can connect action outcome next slide.
Brent James: When you use those sorts of systems to try to rank and then financially incentivize the front line, while Deming talked about it extensively it's been extremely well documented because it turns out, there are three ways that you can meet a target.

First, is actually improved real performance requires vision tools times resources far more common teach to the test.

Sub optimize the system by working harder under the measurement spotlight, but it comes at the expense of other areas that are not under the spotlight, and your overall quality actually declines.

The big one, though number three game, the data I've been surprised at how many systems care delivery systems actually now call it clinical documentation improvement.

Maybe that's partly teach to the test, but gaming the data The examples are endless.

So the data changes.

Brent James: Do the actual patient outcomes change no it's actually been studied and fairly well documented just in passing the key factor.

is to match the incentives to the level when we focused on professional values, a purpose driven life mastery necessary autonomy.

When we made the pay fair, so that people weren't thinking about money real impact on a broad scale with measurable changes and patient outcomes that made sense without i'm going to quit and allow this to move on to the next presenter thanks.

Diane Holder: Thank you very much and mustache I believe you are up next.
Mitesh Patel: Great Thank you i'm going to talk about using nudges to improve the delivery of healthcare i'll cover a quick quick background and then spend most of their time talking about three key lessons that we've learned from all of the work that we did in penn medicine go to the next slide.

01:24:35.910 --> 01:24:46.620
Mitesh Patel: We like to start with this slide with the note that human behavior is the final common pathway for the application of nearly every advanced in medicine, no matter how effective medication protective of vaccine.

01:24:46.950 --> 01:24:57.330
Mitesh Patel: or her targeted, we can get a therapy or molecule to be two things have to happen for it to translate into any benefit for patients and that involves the dynamic between clinicians and the care team and patients.

01:24:57.660 --> 01:25:03.420
Mitesh Patel: clinicians need to be able to recognize that a patient meets criteria for a new treatment or test and offer prescribe it.

01:25:03.690 --> 01:25:17.400
Mitesh Patel: And the patient needs to understand what that means for them and then use it as directed if neither of those things happen let's say a clinician doesn't prescribe a status or a patient doesn't take it it's obviously not going to translate into any benefit for patients. next slide.

01:25:19.080 --> 01:25:27.930
Mitesh Patel: In healthcare this dynamic breaks down quite often, sometimes we do too much there's many references around how a third of health care spending is thought to be wasteful or unnecessary.

01:25:28.350 --> 01:25:33.780
Mitesh Patel: A lot of the times we don't do enough plan patients will come into the hospital or to a primary care visit and leave.

01:25:34.020 --> 01:25:39.420
Mitesh Patel: Without having a discussion around evidence based medicine that we know can improve their lives or reduce hospital readmissions.

Mitesh Patel: In the last decade to technology platforms have expanded widely and been adopted to give us insight into the everyday decisions that are going on and the behaviors of patients.
Mitesh Patel: On the health system side 90% of clinicians use electronic health records all those decisions that were being made on pen and paper over the phone or vocally.

Mitesh Patel: are now in put it through the system, so we can actually see what they are, and it gives us a new choice environment that we can change the way that information is displayed or offered to try to guide clinicians towards evidence based medicine.

Mitesh Patel: For patients more than 80% of adults in the United States now use the smartphone and they're essentially glued to these devices wherever they go, which means that we can actually track their.

Mitesh Patel: behaviors from physical activity to usage of the phone to communicating with family members and friends, obviously with their consent.

Mitesh Patel: And then we can also communicate with them, we can intervene through traditional telephone calls, or through other methods like patient portals or text message next slide.

Mitesh Patel: So i'm going to go over three lessons that we learned from implanting nudges and healthcare at penn medicine and go to the next slide.

Mitesh Patel: The electronic health record is searching for correct, which is a brand name beta Blocker.

Mitesh Patel: And as any good search engine would do if you search for Korea it's going to show you correct, but, as you can see it's listing
the brand name prescriptions first and then the generic prescribing prescriptions below that.

01:27:05.640 --> 01:27:13.920
Mitesh Patel: clinicians often have maybe a few seconds because they're they're probably ordering many of these medications for patients and doing it quickly within a seven or 10 minute visit.

Mitesh Patel: And so oftentimes they don't scroll all the way down to prescribe the generic which we know is the exact same as the brand but much more affordable, and so we can go to the next slide.

01:27:23.370 --> 01:27:35.520
Mitesh Patel: You saw some of this in Kevin bulbs talk earlier on how we were able to change this from an opt in process to an opt out process, simply by adding the dispenses written button checkbox here in the bottom, this is a checkbox that had been.

01:27:36.060 --> 01:27:41.190
Mitesh Patel: on prescription pads for decades, but just didn't make its way over into the initial versions of the electronic health record.

01:27:41.640 --> 01:27:56.550
Mitesh Patel: This took one hour to implement and, as you can see, the change in prescribing went from 75% to 98% saved about $32 million in unnecessary prescribing in just the first two years, and these rates have been sustained ever since this was implemented several years ago.

01:27:57.660 --> 01:27:58.170
Mitesh Patel: Next line.

01:28:11.790 --> 01:28:17.880
Mitesh Patel: National guidelines recommend for palliative cancer patients who are at the end of life, they might have days to weeks to left to live.
Mitesh Patel: If they're receiving radiation for palliative reasons they should not get alignment with imaging because it doesn't offer benefit because many of the benefits that accrue from that offer.

Mitesh Patel: come about many years later, and these tests can be expensive, and in many cases insurance doesn't cover them.

Mitesh Patel: But 80% of patients and penn medicine were receiving daily imaging So if you are getting 14 fractions of radiation, you might get 14 CT scans or X rays, so we can go to the next slide.

Mitesh Patel: So they brought us the idea of let's put the price of the test right where you see this blue box on the left, they wanted to put the price here and say remind clinicians that a CT scan or X Ray is you know $2,342 or whatever it might be.

Mitesh Patel: And we said well physicians know this, this might get numb over time it's a lot of information, this is actually half a half a page of a three page document that's embedded within the ehr that was used at the time that had to be filled out.

Mitesh Patel: And what we realized in this process was actually the first option was a Cone beam CT CB CT done daily so clinicians have gotten in the habit of quickly going through this form.

Mitesh Patel: And they were filling out Cone beam CT daily for their curative intent patients also did that, for the palliative intent patients.

Mitesh Patel: And it was a whole discussion around do we need to get it on board, this is a small vendor from electronic health perspective, how are we going to change this.

Mitesh Patel: And we realized this is a word document we right click on this button and then you see what appears on the right hand side simple drop down form field options.
Mitesh Patel: You can highlight none and move that to the top and all of a sudden none becomes the default, this is essentially a free intervention.

Mitesh Patel: It took a while to come to this because we were as a lot of other things that we thought about.

Mitesh Patel: But really shows you how, starting with the problem can really unveil new opportunities to make really simple changes we wanted to test, what was the impact of this.

Mitesh Patel: Subtle change compared to all of the other things that were going on, but they were sitting down with all the operation colleges, giving them feedback, they were holding grand rounds about this, so we rolled it out as a step wedge cluster randomized trial, you can go to the next slide.

Mitesh Patel: And if there's imaging here if there's an animation you can go through all this.

Mitesh Patel: So you can see here on the y axis is the rates of imaging on the X axis, this time.

Mitesh Patel: They think the goal is about 20% and you can see, in the first three quarters, with just education and holding grand rounds, there was a little bit of improvement from 70 to 80% down to 60 to 70%.

Mitesh Patel: But the big change came in February of 2017 when we flipped a coin and the university practices in blue are randomized to go first, you can see that their imaging rate dropped.

Mitesh Patel: Substantially down to about 25% and then three months later, we roll this out to the Community practices, and you can see their rates dropped as well.
Mitesh Patel: Overall, the imaging rates dropped from 68% to about 32%.

536
01:30:56.880 --> 01:31:04.860
Mitesh Patel: This meant that less 3000 less imaging tests were being done per year, and something that was actually unanticipated but we found when we did the evaluation.

537
01:31:05.130 --> 01:31:16.770
Mitesh Patel: Is that the visit time for patients was reduced by 20% now, if you think about it, this is not totally surprising and patients don't have to go to get imaging wait for the imaging to be read in and adjust treatments for that imaging.

538
01:31:16.980 --> 01:31:20.100
Mitesh Patel: that's going to save a lot of time, and these are patients who only have weeks to.

539
01:31:20.880 --> 01:31:26.460
Mitesh Patel: months left to live, and so this is really valuable time for them, it also means the health system can get in more patients because we're always.

540
Mitesh Patel: we're oftentimes full and this creates more capacity, so this was really a win, win all around and really just needed some strategic attention to realize what the issue was and how he could set up a nice to address it next slide.

541
01:31:39.510 --> 01:31:47.070
Mitesh Patel: The third and final kind of take away is that and you've heard this concept of the sludge game mentioned before, I slept reducing sludge is really half the battle.

542
01:31:47.310 --> 01:31:51.660
Mitesh Patel: This is a project that was brought to us by Sri and Somalia cardiologist at penn medicine.

543
01:31:52.170 --> 01:31:58.860
Mitesh Patel: cardiac rehab is an evidence based pathway that's been demonstrated time and time again to reduce mortality and readmissions, by up to 30%.

544
01:31:59.130 --> 01:32:04.770
Mitesh Patel: But at our House system and many others across the country referral rates are low only 15% of patients who were.
Mitesh Patel: who came in for a heart attack or stroke we're being referred to cardiac rehab at the time of district, more than a quarter of hospitals in the US for less than one fifth of June patients.

Mitesh Patel: When we talk to the cardiologist and ask them would you refer a patient like this for cardiac rehab they said things like.

Mitesh Patel: This is like Florida in the water, every patient she get it it's a structured exercise program with a cardiologist on site.

Mitesh Patel: But the process is really hard, we have to fill out a paper form, while on rounds that have name, date of birth, medical record number things we don't know for each patient just on the top of our heads.

Mitesh Patel: And then the patients are on their own to identify a rehab Center and then they have to wait on the phone with the insurance companies to figure out if their insurance actually covers that rehab Center.

Mitesh Patel: And so we tried to change this by reducing all of the slides and automating it, you can go to the next slide.

Mitesh Patel: tree had Somali worked with the team to identify automatically identify which patients should be referred that was linked to our secure text messaging system, so the care managers on rounds now got a text with the names and locations of the.

Mitesh Patel: We restructured the routing process so as opposed to being an opt in question should this patient get cardiac rehab he was an opt out question any reason why they shouldn't the form was completely.
Mitesh Patel: Template he was completely printed out from the electronic health record the data I'm going to show you is when it was still on paper. Now this is thankfully electronic.

Mitesh Patel: All the clinician had to do with sign, we can get name, date of birth, home address all of that information from the HR. We shouldn't have to write that in while rounding on patients.

Mitesh Patel: And then, a care manager went and met with the patient, provided them with a vetted list of cardiac rehab centers in proximity to their home.

Mitesh Patel: With availability and covered by their insurance that our patients that had good experiences with a care manager call the cardiac rehab center of the day of discharge and 30 days later, to see if the patient.

Mitesh Patel: And we can on the next slide will see the results, the intervention hospital and blue compared to the control hospital is an orange.

Mitesh Patel: And you can see the prior to the intervention these rates were low anywhere from five to 15%. Afterwards it's simply skyrocketed to 85-90%. The referral rates net net went from 15-85%, and these have been sustained.

Mitesh Patel: And, more importantly, attendance to cardiac rehab by patients went from 5% before the intervention to 40% in a fold increase in cardiac rehab attendance.

Mitesh Patel: And if you think about it, we simply just made it easier for clinicians and patients to do what they had wanted to do in the first place and go to the next slide.
Mitesh Patel: So, in summary, medical decision is often suboptimal the
design of choice environment influences our behavior significantly we're
already being not it's not a question of whether we should be nice.

Mitesh Patel: it's a question of whether we want to allocate strategic
attention to make sure that those nudges are designed to be aligned with
our.

Mitesh Patel: long term goals, and not just can improve as you've seen
the delivery of healthcare, if we take a systematic approach to designing
implementing and testing these interventions, they can steer decisions
towards higher value and better patient outcomes next slide.

Mitesh Patel: that's it Thank you.

Diane Holder: Well, thank you, that was a terrific press set of
presentations and we have time for a few questions and maybe i'll just
launch with one of them.

Diane Holder: So.

Diane Holder: Perhaps we could.

Diane Holder: We could start with the the question and maybe maybe
mustache you would take this first, but then we'll go to the other
panelists to see what their thoughts are so prior to and during the
pandemic.

Diane Holder: Which behavioral economic strategies, do you think, have
been the most effective at facilitating healthcare alignment trans
formation and which do you think might be the least effective from
what we've seen in the last.
Mitesh Patel: But I think you know one thing that I think the pandemic has kind of changed our approach many health systems have become.

Mitesh Patel: More afterwards, using digital processes to communicate with patients, whether it's virtual visits or it's text messaging things that only a handful of health systems were doing before and now basically every health system is doing.

Mitesh Patel: I think a lot of the initial focus prior to that was probably.

Mitesh Patel: most successful and changing choice architecture within the electronic health record and that remains kind of in place because that's where all the decisions are funneled.

Mitesh Patel: But I think the pandemic has created new opportunities to implement remotely monitor programs communicate with patients within their daily lives and really engage them where they are to help them improve their health care and their health over the long term.

Diane Holder: Thank you.

Diane Holder: Nancy what, what is your thought about what's happened during the pandemic and what has been helpful and what happens.

Nancy-Ann DeParle: Well, just playing off of what the test just said, I do think there's been a very concentrated focus on reducing friction and sludge and an example of that is.

Nancy-Ann DeParle: how long it might have taken to go into a doctor's office and get a vaccination in the past or a test and now CVs which really had a business and flu shots but really wasn't doing much else in that regard, and certainly wasn't doing testing of this sort.
Nancy-Ann DeParle: You can be in and out there in five minutes, the whole scheduling is much easier there aren't as many forms to fill out.

01:37:30.720 --> 01:37:39.240
Nancy-Ann DeParle: You know the payment is taken care of that was a big part of the friction, obviously, so I think I think that that has been one of the learnings we actually can do this.

01:37:39.630 --> 01:37:49.200
Nancy-Ann DeParle: A lot faster maybe this is some of what Brent James was talking about the holding ourselves to a higher standard of professionalism and we can do this.

01:37:52.470 --> 01:37:54.540
Diane Holder: Dr James what, what do you think.

01:37:55.110 --> 01:37:58.140
Brent James: And i've talked quite a number of systems actually around the world.

01:37:59.820 --> 01:38:08.100
Brent James: code presented us with a whole new challenge we didn't have established opinions, really, and what I saw was evidence based medicine, a lot of a whole new level.

01:38:08.730 --> 01:38:17.190
Brent James: Very often, when you roll out evidence based medicine, these are the tools you use for us it was blended in the clinical workflow again make it really easy to do it right.

01:38:17.880 --> 01:38:28.980
Brent James: mutation others have filled in the details of how you go about doing it, but it was a broad strategy to make that happen it adopted very broadly and very rapidly.

01:38:30.030 --> 01:38:42.900
Brent James: specifically for patients with hospitalized for Cobra 19 interestingly, some groups so that they were then able to leverage that into other areas of caregiving which I actually believe are more important on the broad scale.

01:38:44.250 --> 01:38:56.100
Brent James: Others, I was talking, for example, the hospital of university of Geneva great great results around coven 19 but they weren't able then to move it into other aspects of routine care delivery.
Brent James: which I believe will in the long term, actually have much higher leverage so it's a really interesting question why were they doing it, this method in one area.

A new area, and then the same principles didn't seem to move over to areas that were more long established more habitual, if you will, so a really interesting question around that particular thing give us a window, where we can see what it looks like when it work well.

Diane Holder: We have a question.

Tony son from united healthcare asking, can we design nudges that are coordinated by payer and provider jointly.

Anyone want to get that one.

I'm happy to start I think there's a really big opportunity to do that, I think we're already doing some of that already but there's a lot of opportunity to do more of that if you think about.

The health system is is moving the payer and provider landscape are starting to emerge in many areas.

And certainly each has valuable sets of data can make interactions with patients and things that they can bring to the table, and I think there's a huge opportunity for payers and providers to work together to mentor patients and their encourage.
Diane Holder: anyone else, want to jump in on that one have you seen examples of it or have ideas, what would help either at the federal level with cms is a pair of course or.

Brent James: We did that a bit nyan but I don't know if it applies probably was with our own health plan.

Brent James: In amongst select health, of course, was the largest health plan in the region, we did it fairly routinely, for example.

Brent James: We were able to deploy make it easy to do it right knowledge systems around things like appropriateness indications for you just have a cath lab.

Brent James: For diagnostic cath for stands for pacemakers defibrillator system, maybe, and we got the health plans in the region to agree to treat it as pre op.

Brent James: And it took a onerous difficult truly hated process by the clinicians The pre process.

Brent James: Do sit to less than a minute just check off the indication, so it was established with dramatic changes and patient outcomes.

Brent James: We were already one of the lowest in the nation's better katha abuse fell by over 22% it's about oh $40 million a year and savings and all that it took was getting the evidence in front of the clinicians at the point in time, they were making the decision yeah.

Brent James: Their health plans agreed to help out with it, they got a real benefit out of it, they got more benefit out of it.

Brent James: Financially than we did.
Brent James: But.

Brent James: I don't know, can you do it when it's not your own fully captive health plan that that's a bigger challenge, I think.

Diane Holder: yeah you have to make sure those incentives are aligned and like yours were and like.

Diane Holder: No, Sir, so thank you Nancy did you want to weigh in on that one.

Nancy-Ann DeParle: I was just smiling because i'm remembering how Brent.

Nancy-Ann DeParle: Brent was a hero, probably to the health plan here, but he always he was an expensive guy to have around the provider, because he cost them money you always figured out the right way to be doing something would be usually doing less of it and.

Nancy-Ann DeParle: And when I was his pair I liked that but i'm sure he's not the hero at the cath lab right.

Brent James: That funny thing was Nancy N, is the reaction of the physicians I knew them all, personally, these were top end cardiologist widely respected, sometimes on an international level, one of the people who lead out on the research on Tamar was one of them, it was sobering.

Brent James: it's a complexity problem there's a limit to how many things human mind can handle at one time and it's relatively small number.

Brent James: I mean the shortest list had over 40 factors on the longest so those list of five areas that over 90.
Brent James: But the key was getting in front of them and we knew that we were already low nationally and we knew that we were pretty good.

Brent James: But it was so brain when you realize Oh, by the way, we are already had a system in place to trap long term clinical outcomes clinical outcomes improved.

01:43:26.190 --> 01:43:37.350
Brent James: We were over treating patients, it was inappropriate care, and it was humbling sobering but in the end massively professionally gratifying.

01:43:38.400 --> 01:43:44.610
Nancy-Ann DeParle: Well, and your work, your work on this relates to the Academy has been doing on value, but your work.

01:43:45.150 --> 01:44:01.170
Nancy-Ann DeParle: i'll never forget your appearing in front of mid pack when I was on MED Pack and you're making the case that doing the right thing was actually costing your institution money, making it less healthy financially, and that was a part of I think our decision to move.

01:44:02.490 --> 01:44:06.510
Nancy-Ann DeParle: Put put the foot on the accelerator moving toward value we're not there.

01:44:06.780 --> 01:44:07.680
Nancy-Ann DeParle: Obviously the.

01:44:08.070 --> 01:44:12.000
Nancy-Ann DeParle: As a country or your health system that that was certainly impactful at mid Pack.

01:44:12.660 --> 01:44:18.270
Brent James: You know, when I run the numbers I get a different number, we had that IOM committee still IOM back in.

01:44:18.270 --> 01:44:28.620
Brent James: 2010 our sound, but I think was a minimum of 30% probably over 50% waste in the healthcare system, this sort of waste, and it has to have the ability to do it right.

01:44:29.610 --> 01:44:37.530
Brent James: But it all has to do it, I get about 65% when I model what I think I can defend those models, you know you're a little controversial.

01:44:38.100 --> 01:44:49.290
Brent James: Massive money so here's The funny thing from a financial incentive the math is overwhelming a healthcare system leader, right now, today would be dramatically further ahead.

01:44:50.220 --> 01:44:59.790
Brent James: To focus on these sorts of methods and get the care right and harvest back savings from than any other revenue enhancement strategy, you can name.

01:45:00.840 --> 01:45:14.010
Brent James: And so, one of the things we debate routinely in our department at Stanford at the CRC with ernie milstein why why aren't people all over this from a pure financial standpoint there's huge money to be had within it.

01:45:14.670 --> 01:45:29.550
Diane Holder: Well, on that optimistic note and that encouragement I think it sets us up very well for our next panel, and I would like to thank each of you for your terrific presentations and now turn it back to Jim Thank you.

01:45:30.750 --> 01:45:39.930
Jim Madara - AMA/VISAC: Thanks diane and also, I want to thank everyone in that class panel was great and the goal of this next session is to build on this conversation.

01:45:40.440 --> 01:45:59.070
Jim Madara - AMA/VISAC: and hopefully articulate a vision for health system transformation that is informed by behavioral economic insights and to identify key strategies that leaders can leverage to better align incentives structures with health system, efficacy and.

01:46:00.090 --> 01:46:15.300
Jim Madara - AMA/VISAC: equity efficiency and we've heard got a lot of lessons already on that in so to help us along in this direction we're really privileged to have a panel of experts from across the health system.

01:46:15.930 --> 01:46:24.390
Jim Madara - AMA/VISAC: With insight as to the alignment needed for suitable and sustainable and accelerated change and just brief introductions.
Jim Madara - AMA/VISAC: Dr Charlene long as an associate professor of pediatrics and public policy at Duke and serves as Assistant Secretary for children and families at the north Carolina Department of Health and human services.

Jim Madara - AMA/VISAC: she's a practicing primary care pediatricians specializing in adolescent and young adult medicine also serves as Executive Director of the north Carolina integrated care for kids an innovative model serving medicaid insured children and central North Carolina.

Jim Madara - AMA/VISAC: a leader in value based payment models for child and family health and her work focuses on healthcare transformation says supporting a more holistic approach to health and well being.

Jim Madara - AMA/VISAC: Second, we have Carl RON who's the CEO first mountain care and managing director of health 2047 healthcare venture firm.

Jim Madara - AMA/VISAC: he's a globally successful entrepreneur an active advisor to CEOs and top management at fortune 500 companies.

Jim Madara - AMA/VISAC: In a 30 year tenure and management at the consumer powerhouse Procter and Gamble and during that time he created entirely new brands that are glue globally revered.

Jim Madara - AMA/VISAC: swifter for breees Mr clean magic eraser and as a result of his strategic insights and understanding consumer behavior.

Jim Madara - AMA/VISAC: new categories rapidly grew to 1 billion in annual sales and Carl has transferred has knowledge of consumer behavior to healthcare founding CEO first mile care, as mentioned a company's been out on health 2047 which focuses on diabetes prevention.
Jim Madara - AMA/VISAC: Third, any as a COPA de la is currently the executive director for clinical transformation at the University of Texas MD Anderson cancer Center and assistant professor in the department of plastic surgery.

Jim Madara - AMA/VISAC: In his enterprise role he's tasked with helping define align and implement a high level roadmap for clinical and economic transformation and supportive MD Anderson's vision to deliver high value cancer care.

01:48:40.620 --> 01:48:55.290
Jim Madara - AMA/VISAC: he's also a non resident scholar and domestic health policy of the Baker institute nonpartisan think tank on the campus of rice and he was the 2019 2021 omen fellow at the National Academy of Medicine.

01:48:56.790 --> 01:49:11.010
Jim Madara - AMA/VISAC: And lastly, station Jane was president and CEO of scan group and health plan former president and Chief Executive at care more health and from 2009 to 2011.

01:49:11.640 --> 01:49:23.640
Jim Madara - AMA/VISAC: sation worked in the Obama administration and there, he was senior advisor to don berwick when he led the SI si mmm I project there as well, so station is.

Jim Madara - AMA/VISAC: adjunct professor of medicine at Stanford and a contributor to forbes, in addition, he serves on the National Board of Directors of America's health insurance plans the organization and make a wish foundation of America.

01:49:40.410 --> 01:49:46.500
Jim Madara - AMA/VISAC: So let me turn to Charlene for her introductory comments.

01:49:49.980 --> 01:50:03.480
Charlene Wong: Thanks so much Jim and thanks for the opportunity to present today, so I will be brief in my remarks, I wanted to hit on two key topics as we think about how can we leverage behavioral economics, for a healthier future.

01:50:04.110 --> 01:50:15.270
Charlene Wong: The first that i'll speak to has been touched on a bit today, but really thinking about how we can combine the financial
incentives and we've heard many examples of that today, as with social incentives.

Charlene Wong: And I know that cass was responding to a question at the top of the.

Charlene Wong: Session today on misinformation and mistrust and i'm going to be giving an example from during the coven 19 pandemic when we really saw the importance of being able to encourage and to reward.

Charlene Wong: Having people who are trusted messengers do that outreach to people in their networks to really help encourage these healthy behaviors that we were seeking to promote so that's one theme that I wanted to touch on today.

Charlene Wong: And then, the second is as we're thinking about a healthier future i'm very much a proponent of thinking about integrated whole person health.

Charlene Wong: And thinking about how we can design nudges together and actually the example I will give is going to be an example from the last panel of where we had payers and providers coming together to design nudges.

Charlene Wong: To really better address whole person health and, in this case it as an example, related to children, as I am a pediatrician and think a lot about how we can do more of these types of models for children so on the next slide.

Charlene Wong: This is an example of combining, financial and social incentives for coven 19 vaccinations, so I know Kevin volpe at the top.

Charlene Wong: Of the panel today talked about the incentive programs for Cobra 19 vaccination, many of which were these large million dollar incentives, I served previously as the chief health policy officer for.
Charlene Wong: dirt and the north Carolina Department of Health and human services, we also offered a million dollar incentive program as well as scholarship a drawing for our for teams who were getting coven 19 vaccines.

01:51:57.420 --> 01:52:06.150
Charlene Wong: We also had a separate program these were small guaranteed financial incentives and I wanted to give this as an example, because we did an evaluation we actually.

01:52:06.420 --> 01:52:15.960
Charlene Wong: demonstrated that it did have an impact, and it actually had an equitable impact, which is another key theme, I wanted to hit on today, there was an equitable impact for these particular nudges so.

01:52:16.350 --> 01:52:23.310
Charlene Wong: We started by offering $25 cash cards for coven 19 vaccination so again guaranteed small financial incentives.

01:52:23.940 --> 01:52:33.750
Charlene Wong: Both for either getting your first dose of your vaccine so receiving that first dose at one of our participating vaccine sites or the social incentive component of this.

01:52:34.080 --> 01:52:39.210
Charlene Wong: or getting a $25 gift card for transporting someone to get their vaccine.

01:52:39.930 --> 01:52:43.740
Charlene Wong: And we really were thinking about that social incentive part because we rolled this out.

01:52:43.980 --> 01:52:53.670
Charlene Wong: In the summer, when you know I think Kevin made the point earlier at that point, a lot of the people who had really been referring to get their vaccines they've gotten the vaccinated even when we had.

01:52:54.030 --> 01:52:57.690
Charlene Wong: demand that was far outstripping supply of available vaccine.

01:52:58.020 --> 01:53:09.510
Charlene Wong: And really over the summer, we were at the point where we wanted to number one be able to make it easier for people to get
vaccinated because we had a lot of people in North Carolina as across the country for whom they had true costs.

01:53:09.780 --> 01:53:22.410
Charlene Wong: and transportation barriers to access it back soon, so the small guaranteed incentives were really designed to help address some of those barriers that we knew were really important to address for more equitable distribution of coven 19 vaccine.

01:53:23.040 --> 01:53:31.260
Charlene Wong: And then the transport or social part of the incentive is We also knew at this point that for many people who hadn't gotten vaccinated yet.

01:53:23.040 --> 01:53:31.260
Charlene Wong: We actually evaluated the pilot of this incentive program which we ultimately did scale statewide.

01:53:31.500 --> 01:53:44.280
Charlene Wong: They were really looking to be able to hear get that knowledge, have a conversation with someone that they know and trust who might also be able to help bring them to the covert 19 vaccines vaccines site, so if you could do one more click please.

01:53:45.360 --> 01:53:51.240
Charlene Wong: And in this table what you can see is that in the pre no incentive period we looked at where we were offering these incentives compared to the rest of those counties and the rest of state.

01:53:51.630 --> 01:54:02.520
Charlene Wong: And then, all the way over to the right when we looked at how the rates of vaccination change once we implemented these incentives what we saw the impact being is that uptake.

01:54:02.850 --> 01:54:13.950
Charlene Wong: team vaccines fell by half, without the incentive and again, this was a over the summer, where across the country vaccine rates were falling quite quickly, where we offer these incentives, the.

01:54:14.580 --> 01:54:25.560
Charlene Wong: rate only fell by a quarter, so it cut that rate of fall and half.

01:54:26.040 --> 01:54:29.820
Charlene Wong: And then the transport or social part of the incentive is We also knew at this point that for many people who hadn't gotten vaccinated yet.

01:54:30.330 --> 01:54:38.400
Charlene Wong: In addition to this, overall, what was the impact on vaccination rates, we had teams on the ground, serving individuals who had received one of these.

01:54:38.670 --> 01:54:45.060
Charlene Wong: Cash cards for getting vaccinated and we saw that they were particularly important for individuals who are low income.

01:54:45.480 --> 01:54:56.010
Charlene Wong: And who were black or latinx and so you know we were really pleased to see that this combination of a financial with the social incentive component design.

01:54:56.400 --> 01:55:07.740
Charlene Wong: was able to both promote a less of a you know lower decrease, a reduction in the fall rate of vaccination and more equity in the way that the vaccines were distributed.

Charlene Wong: So just as thinking in the future, as we think about how we can leverage leverage behavioral economics, for a healthier future thinking about designing more nudges that combine the financial and social incentive components.

Charlene Wong: On the next slide for the second theme, I wanted to cover is thinking about cooperative incentives that really helped promote more nudges towards addressing whole person health.

01:55:32.700 --> 01:55:38.070
Charlene Wong: And the example i'll give here is from our North Carolina integrated care for kids model.

Charlene Wong: Which is a cmi funded care delivery and payment pilot model to integrate care for children birth update 21 and five Central North Carolina counties.

Charlene Wong: And when we say integrated care and whole person health, we are really talking about I say it's integrated care and steroids.

01:55:53.580 --> 01:56:05.130
Charlene Wong: it's not just physical and behavioral health we're integrating with schools and early care and education and food and
housing and juvenile justice and child welfare so really thinking about the holistic needs of children.

Charlene Wong: The area I wanted to highlight here is thinking about the incentives and we have in this model both the authority and the mandate to implement an alternative payment model.

Charlene Wong: Now to the question that was asked earlier, you know what are the opportunities are there examples where payers and health systems have worked together to design notches.

Charlene Wong: We in this model have been bringing together Medicaid CEO's and our health system leadership every single month over the last two years to design this payment model together.

Charlene Wong: And what we really looked at here when we were thinking about the payment model is, what are the performance measures, because I know that Kevin vulture showed earlier.

Charlene Wong: Restoring using a lot of incentives and value based design, in general, I will tell you, for children and children's health care providers it's even lower there are not a lot of alternative payment models designed specifically for children.

Charlene Wong: And so, here we came together payers providers.

Charlene Wong: to choose and align on number one what performance measures, did we want to select which we're really going to help drive the incentives and you can see in this table that the first several rows are really.

Charlene Wong: Pretty novel measures when you think about the types of measures that we typically include in an alternative payment model or measure in healthcare, so this includes things like.
Charlene Wong: Rates of kindergarten readiness and promoting kindergarten readiness, from primary care settings screening and addressing food insecurity and housing instability.

01:57:35.400 --> 01:57:47.400  
Charlene Wong: We also included other healthcare utilization and cost metrics and I'll just call out again with this focus on equity, one of our performance metrics we selected to really put a nudge around equity.

01:57:47.670 --> 01:57:58.230  
Charlene Wong: and looking not just that increasing the rates of well child visits for infants, but really the incentive is tied to specifically a reduction in the disparity, for instance, infant well child visits.

01:57:58.950 --> 01:58:08.850  
Charlene Wong: And not only did the health systems and the payers coordinate on selecting these metrics we're actually doing this in a what we call pooled performance measure price by provider approach.

01:58:09.060 --> 01:58:18.060  
Charlene Wong: Meaning that the payers have agreed to come together and work together and assess the performance of health systems across all of their children, regardless of which plan they're in.

01:58:18.300 --> 01:58:26.460  
Charlene Wong: So this is, I think a really nice example number one of as we're thinking towards the future thinking about how can we actually support and financially sustain.

01:58:26.970 --> 01:58:36.930  
Charlene Wong: strategies that address whole person health and number two a nice example of actually systems and providers and payers coming together to design these types of matches.

01:58:40.920 --> 01:58:42.030  
Jim Madara - AMA/VISAC: Showing Thank you.

01:58:43.260 --> 01:58:45.000  
Jim Madara - AMA/VISAC: That was just simply terrific.
Karl Ronn: Thank you, I didn't prepare any slides specifically for this, because I really wanted to try to build on where the conversation was going.

Karl Ronn: My main thought on this is that while we're concerned about behavior change of an individual, the problems that we actually face are mass problems we have to change 100 million people's habits.

Karl Ronn: And there is a risk that as an engineer by background is that the scale of the solution estimates the scale of the problem.

Karl Ronn: And we basically have a mass market problem that is composed of individuals, but what I'd like to do is kind of backup then to some of the pieces that Cass was describing because they really provide some principles about how to think about creating the collective change that we need to do, which is to change 100 million people's habits.

Karl Ronn: On every one of our chronic disease problem areas and that, and so the way we would normally do that thinking about a mass market approach.

Karl Ronn: is to understand that mass market changes also behavior change, but the techniques that are used are slightly different.

Karl Ronn: Because the goal is to move very, very large groups of people. So the first thing is, is, I would say we turn all of those kinds of behavioral problems.

Karl Ronn: that were discussed in the biases into a situation where you named for segments of consumers or patients, if you will, whose habits, you want to change.
Karl Ronn: And it actually there are simple ways to be able to describe those four segments and I'll just leave that aside.

02:00:25.080 --> 02:00:30.900
Karl Ronn: But by doing that what you do is you recognize you're going to move for different types of people.

02:00:31.200 --> 02:00:42.210
Karl Ronn: One of the problems when you look at a market is, if you don't define some very large groups to move you get lost in the minutiae of the differences between the people and so to create a mass market.

02:00:42.570 --> 02:00:48.630
Karl Ronn: We named for segments, and we make sure it covers 100% of the population, so we're not leaving people out on the side.

02:00:49.410 --> 02:00:58.830
Karl Ronn: The second problem, though, then, and this was really characterized by the discussion of fee for service to value based care is that.

02:01:07.170 --> 02:01:21.030
Karl Ronn: We need to set a 10 year goal, then of where do we want that market to be in 10 years and then work backwards from that goal.

02:01:09.310 --> 02:01:09.310
Karl Ronn: And so we set a very specific goal, but then we can assess how many people are already into that goal well with 25% of people doing some combination of fee for service and value.

02:01:21.390 --> 02:01:29.580
Karl Ronn: We're in a diffusion model of what's called the early majority and so there's early adopters early majority late majority and laggards.

02:01:39.630 --> 02:01:52.770
Karl Ronn: Are the barriers to moving from early majority into later majority and and so those types of things are exactly the kind of situation that made it very relevant when it was discussed.
Karl Ronn: about the different incentive structures that are used and so strong incentives are actually used in the late majority time.

Karl Ronn: Not in the early majority time and so when you start thinking about a mass market movement as name your four groups of people and name, where are we in time that defines the space that we're going to try to collectively move to become.

Karl Ronn: A new mass market 10 years from now, and so what really creates problems is, if you use the wrong tools at the wrong time.

Karl Ronn: And so what you saw some of those kinds of incentives that were used they're weak incentives.

Karl Ronn: they're just the wrong time to use them it's not that they don't work but it's the wrong point in time to put those incentives in.

Karl Ronn: As we get to something like vaccination rates there now 60% or higher of course it's the right time, then traditionally to start using strong incentives at some level, because the markets ready for them.

Karl Ronn: And so the thought that I have first and foremost, is this.

Karl Ronn: This type of an organized group of people is a collaborative group that could come together to name, what is the goal we want to have 10 years from now.

Karl Ronn: And then, all get on to a common action plan which names So how are we going to agree to segment the market we're trying to help people but put all hundred percent of the people into those four groups.

Karl Ronn: And then recognize where we on time and then we start getting a coordinated action of using those incentives to move a last comment on that is is that what that typically looks like is you pick one segment first.
Karl Ronn: And you address the early adopters their and their needs.

Karl Ronn: And then you move that first segment into the early majority behavior with the right incentives and then you move them towards the late majority.

Karl Ronn: But when that first segment is well developed into the early majority you're ready to now start talking to the second segment.

Karl Ronn: And get them through to early majority and as they progress forward now you're ready to pick up the third segment, etc, and so what we're doing is we're taking a coordinated movement.

Karl Ronn: To create a essentially really a movement, not a business plan or something, but a movement so I'll make one last comment about that, because it was really Brent's conversation about about autonomy.

Karl Ronn: and professional values well the people that we're serving also operate on the equivalent kinds of things that professional values they want autonomy.

Karl Ronn: mastery and purpose but we'll have to fill in for some of the mastery that they don't have, but when we're creating a movement.

Karl Ronn: Those have an equivalent of recognizing that that the way you create a movement is, you have to give something that to somebody that they accept.

Karl Ronn: Then they have to have permission to change it to customize it themselves, and only then will they extend it to others, and so the dynamics of creating a movement.
Karl Ronn: are to put the right things in front of those people and then do that kind of to use the language of nudge.

750
02:05:00.210 --> 02:05:08.820
Karl Ronn: But to recognize that when you get an acceptance and a change, then you get an extension and so that creates the movement over the 10 years and so.

751
02:05:09.330 --> 02:05:22.140
Karl Ronn: Let me just stop there, but my thought was is to put the dynamics of thinking about how mass markets are created, on top of our discussion because that really is behavior change it's just done in extremely large groups of people.

752
02:05:23.760 --> 02:05:33.600
Jim Madara - AMA/VISAC: Thanks Carl I mean it's just a really creative way of thinking about mass markets and consumerism playing at the health care that was great on your say.

753
02:05:35.640 --> 02:05:36.150
Anaeze Offodile: Thank you.

754
02:05:39.090 --> 02:05:50.460
Anaeze Offodile: So much pleasure to be here, so my quite small segment of this talk and I just want to say that I focus, you can advance the slide I focused on the health care providers.

755
02:05:51.360 --> 02:05:59.040
Anaeze Offodile: Because everything important, but I just want to call out there, the prevailing equally important patient facing sort of contribution to health transformation.

756
02:05:59.400 --> 02:06:08.640
Anaeze Offodile: That not dressed, but I think should be very mindful of so to level set sort of helps it in transformation I define as realignment of the prevailing structures.

757
02:06:09.030 --> 02:06:21.150
Anaeze Offodile: processes and culture and clinical practice those high value care Now you can decompose high value care in several dimensions but for me survive index on equity effectiveness and efficiency.

758
02:06:22.470 --> 02:06:29.280
Anaeze Offodile: And at its core do houses and transformation really implies modifying human behavior.
Anaeze Offodile: And I think we're in the midst of that right now with the natural experiments of the volume Kobe 19 experiments and specifically.

Anaeze Offodile: How within the healthcare context, how we socialize deliver services and actually work has been reimagined.

Anaeze Offodile: But with humility, are also sort of offer that where we are right now and trajectories that we're now beginning to say okay well these behaviors stick.

Anaeze Offodile: And I think if we look at the Telematics adoption rates days now so magic awesome aggression not quite to level of 2019 but certainly we lost a fair bit of that momentum from May, June 2020.

Anaeze Offodile: So I think what is phenomenal points out is that for Derby transformation involves two things one is that we need to break with own habits.

Anaeze Offodile: But fundamentally transmission requires a new state of resilience, either at the human level or the organizational level next life and.

Anaeze Offodile: So actually leverage a heuristic which is called the simile ordinary stick by putting my take home slide up front, so this is for me to take them slack on my talk today.

Anaeze Offodile: And when I think about behavior behavior first helston transformation they're really forming foods, I want to hit the first is.

Anaeze Offodile: sort of it should really map towards why I think the charge for health system leaders is to serve articulate.
Anaeze Offodile: And mission focus why for houses and transformation and this does two things one is was apparently it creates additional confusion as to why we're pursuing houses and transformation.

Anaeze Offodile: And what that does is it then makes the goal of transformation actually shared by everyone, which sets up the second point, which is it creates by any legitimacy.

Anaeze Offodile: For for this House adventure estimation, secondly, and this is obviously the point that Brandt James made out beautifully.

Anaeze Offodile: sort of have to tap into what really motivates employees and are not sort of rehash what Brian said, but I do believe that sort of healthcare is fundamentally a mission focus sort of construct.

Anaeze Offodile: With a social construct contract I think that's why intrinsic motivators incentives sort of far outweigh from an impact standpoint and a derivative standpoint extrinsic financial incentives.

Anaeze Offodile: and others have talked about this Kevin retention cast, but like this idea of designing environments would behavior economic principles in mind, and I would send us a different way, so we should design the charts architecture.

Anaeze Offodile: and minimize friction or sludge in the healthcare setting so we now encourage empower behaviors the map towards healthcare transformation.

Anaeze Offodile: And lastly, I think that data and transparency could be major enablers of customer.

Anaeze Offodile: Data either upstream because it's a guides our decisions, is where we should transform and be downstream so validates a particular course of action or certainly invites amendment of course correction.
Anaeze Offodile: Transparency, because sort of in my work here, then be honest enough we've observed that actually transparency and outcomes to be a massive sort of like has a massive momentum building or compounding effect transformation so very, very critical next slide.

02:09:42.570 --> 02:09:53.190
Anaeze Offodile: And so the lawyer sort of put out two frameworks for health and transformation in the organizational setting the actual focused on government, but actually loved it and so represent here.

02:09:53.550 --> 02:10:04.140
Anaeze Offodile: One is sort of thinking through identifying understanding the drivers of behavior change and so designing interventions to change behavior somebody intuitive by like two phased approach.

02:10:04.650 --> 02:10:14.880
Anaeze Offodile: It can don't have to be the question could be empowered by Lisa vector into each of these buckets I think it's critical as we think about the process of transformation next slide.

02:10:16.140 --> 02:10:25.320
Anaeze Offodile: And they also sort of thought about sort of when you think about what are the drivers of behavior that another framework that is called first that's fundamentals.

02:10:25.680 --> 02:10:32.670
Anaeze Offodile: And this gets to be mistakes and psychological factors contributing and behavior incentives as been touched on, already.

02:10:33.630 --> 02:10:46.020
Anaeze Offodile: And also sort of thought about sort of when you think about what are the drivers of behavior that another framework that is called first that's fundamentals.

02:10:46.470 --> 02:10:54.210
Anaeze Offodile: Are creates by way of normative and invocation what is acceptable behavior so you can leverage that with healthcare transformation.

02:10:54.780 --> 02:11:04.170
Anaeze Offodile: Stories create resonance around mission values and narratives and that's again that gets to why I think that creates stickiness around healthcare transformation.
Anaeze Offodile: And lastly, we talked about a little bit in several sessions already, but so thinking about the tools.

Anaeze Offodile: And I'll say as a design these tools or the environment for healthcare transformation there's a strong proposition to the main value prop to manufacture Devon leveraging human centered design designing these tools so so taking the human perspective.

Anaeze Offodile: Of employees patients as we begin to bake in the economics of like instruments in healthcare transformation next slide please.

Anaeze Offodile: Of intrinsic factor is by far and away the most compelling so instrument than external factors, first of all get cheaper actually under scalable.

Anaeze Offodile: But this pay by the McKinsey are laid out wise of healthcare organizations typically outperform others have complex organizational construct with the effectiveness of speaking as administering the factors and it's amazing isn't out there.

Anaeze Offodile: Next slide please, and this is my second to last slide and I sort of want to call out that you know how systems.

Anaeze Offodile: Howdy complex very interrelated so help get Johnson ish sort of whenever be a one and done undertaking.

Anaeze Offodile: And we need a structured process but thinking through sustainment and cost reduction as appropriate and next slide, and this leads into this whole field of implementation science so.
Anaeez Offodile: For those who are not familiar with this condition science and basically the formalized study of the factors that contribute to adoption sustainment on success of evidence practice in clinical care.

Anaeez Offodile: However, we can leverage this framework for health system transformation and, in many ways of build our transformation muscle I don't buy this level.

Anaeez Offodile: And also, I think, in addition, science allows us to embed equity so when we look at this call the factors of structural organization patient provider innovation.

Anaeez Offodile: allows us to rethink sort of respect to the receipt access to an outcomes of this transformation efforts along racial lines LGBT Q lines age lines cultural lines.

Anaeez Offodile: We can so on couple break it down by those lines, using this framework i'm making course correction, as necessary, this is my last slide and thank you so much.

Jim Madara - AMA/VISAC: Thanks anjana say that really tied together several of the principles and we've been hearing with the threads together nicely Thank you.

Jim Madara - AMA/VISAC: station.

Sachin Jain: Good afternoon or Good morning, depending on where you are really an honor to be here and to have close to the final word here, so you know I bring with me the perspective of having.

Sachin Jain: led a large provider group in the form of care more, as well as now presently leading scan group and health plan, which is an organization that's focused on keeping seniors healthy and independent and I just want to.
Sachin Jain: kind of bring to bear the health plan perspective on this issue when I think about you know at a macro level what it is to actually lead a health plan.

02:14:14.880 --> 02:14:36.900
Sachin Jain: it's actually leading a very large behavioral economics exercise at scale, you know the very act of designing health benefits what we cover how we cover it is in fact an exercise in behavioral economics and we are, I think, sending signals to patients ultimately.

02:14:37.920 --> 02:14:45.960
Sachin Jain: about what we value and what behaviors are actually desired through our coverage determinations in our coverage decisions.

02:14:46.590 --> 02:14:55.230
Sachin Jain: Whether we treat it as such or not, and so I think you know, there are the very specific experiments that have been talked about that, I think, have demonstrated.

02:14:56.130 --> 02:15:03.350
Sachin Jain: You know I think some really incredible outcomes, but I think it's important for us to take a broader look at this issue which is.

02:15:03.810 --> 02:15:13.350
Sachin Jain: You know, we are literally designing you know people's healthcare journeys and experiences when we design their health benefits, and we are sending I think a number of different signals.

02:15:14.010 --> 02:15:26.580
Sachin Jain: When I think about the unintended consequences of you know, running a health plan and setting benefits, I think about the notion of trust and how our design of benefits can be both.

02:15:27.000 --> 02:15:36.690
Sachin Jain: Trust enhancing as well as trust eroding and what I mean by that is you know when we make primary care visits, you know zero copay zero dollar copay is.

02:15:37.080 --> 02:15:49.440
Sachin Jain: What we're saying implicitly to patients is that we want them to seek primary care we're eager for them to see primary care, but when we do things like add co pays for insulin which makes absolutely no sense.
Sachin Jain: We potentially erode our trust with patients and I don't necessarily know that the managed care industry has necessarily taken.

Sachin Jain: This notion of trust erosion as seriously as we can, and as we, as we should, because you know, while we are trying to manage total cost of care, some of the ways in which we do it.

Sachin Jain: Ultimately erodes trust, so I you know what i'd like to just add to this conversation is this lens of trust and this notion that you know we as an industry, you know managed care, but healthcare, more broadly, have an obligation, I think, to view.

Sachin Jain: You know exercises to manage behavior or nudge behaviors through the lens of whether they actually increase or decrease trust in healthcare and decreased trust in the healthcare system, this is obviously.

Sachin Jain: You know, a very important topic in the midst of covert as well, as you know, some of the issues that we face right now around you know vaccination rates and so.

Sachin Jain: I would just ask us to take this broader lens and think about you know how we, as an industry can use behavioral economics to enhance trust and also guard against you know the potential erosion of trust that follows when we don't necessarily view interventions through the lens of.

Sachin Jain: Of of you know whether we're actually building building or eroding trust and Community so i'll pause there and I know the panel will probably have a very rich dialogue at this point, thank you so much.
the last in the last time, there are a couple of questions that came in one is.

J. Madara - AMA/VISAC: Talking about the complexity, as the background, and you know interesting to consider how pervasive sludge and inertia or healthcare.

J. Madara - AMA/VISAC: manifested administrative waste low value care clinical variability were strong evidence exists.

J. Madara - AMA/VISAC: And how this has been allowed to proliferate, especially in the view of your brand's comments about the central roles of autonomy mastery and purpose for clinicians.

J. Madara - AMA/VISAC: So the drivers are manifold as well, including risk adverse nature of healthcare fragmentation and complexity and both Karen coverage, you know, so what what do we think is the way out of the quagmire.

J. Madara - AMA/VISAC: By culture change policy change payment reform, you know what will take for facilities to place a premium on sledge belstaff.

J. Madara - AMA/VISAC: Let me look to Carl.

K. Ronn: The principle for adoption is anything you want to do, has to be simple or i'll never be adopted, and so I almost wonder whether you know, so I actually love the.

K. Ronn: The concept of slides just because not just become so popular okay that you get so many nudges that you get pokes okay and they're really sludge to everyone so so so much of what we do is really complicated.

K. Ronn: And, and it needs to be simple, as the first rule.
Karl Ronn: And so I think that's The real issue is, if you see something that's hard, it has to be attacked.

Jim Madara - AMA/VISAC: gets back to the principal folks we're talking about in in simplicity that we've heard.

Jim Madara - AMA/VISAC: Over and over again today.

Jim Madara - AMA/VISAC: Others to.

Charlene Wong: Add to that, I think you know part of what we've learned as we've been trying to do these this cooperative co designing work around whole person health where.

Charlene Wong: it's hard the things that we're asking the different stakeholders to do is hard there is some lyft involved.

Charlene Wong: is, I think, having that co design process with the various stakeholders at the table is really important, because in the design process itself.

Charlene Wong: The different perspectives can be represented to say.

Charlene Wong: hey that sounds like a great idea, let me tell you what that would mean for me as a primary care provider and how that would introduce an immense amount of sludge into what I do in my day to day work.

Charlene Wong: And so that you can think about as much of that on the front end for the different people who are going to have to be doing the doing as we designed these different interventions to try to promote health and healthy behaviors.
Anaeze Offodile: Jim clinical points and just want to mention that I think will have no one intervention policy beaver economics by itself, like really move the needle.

Anaeze Offodile: I think I think of this as almost like a mosaic so sort of a bit of everything, I think the trick or the art with this is sort of right sizing to a given clinical context which.

Anaeze Offodile: Which blend on what volume of we have a specific like sort of element makes the most sense right, so I think if.

Anaeze Offodile: We have a million at it, we all think i'd be able to design us out of where we are, I think I think that's not going to happen.

Anaeze Offodile: But I think so I was just thinking about this at the mosaic and saying Okay, how do we sort of tailor to a particular situation which incentive really move the needle I think that's probably the art of leadership on the front lines.

Jim Madara - AMA/VISAC: So a systems engineering problem that requires this was a kind of you.

Anaeze Offodile: know the only because healthcare is just so complicated with emerging pop with emerging features that I think, need to be tackling a complex system is modern.

Jim Madara - AMA/VISAC: Another question that came in had to do with.

Jim Madara - AMA/VISAC: You know all the opportunities to change things and items that were familiar with the should be easily changed useful generics over imaging the sort of thing.
Jim Madara - AMA/VISAC: And when first encountered many providers and administrators probably recognize these things don't make sense, but once they get habituated in the system.

Jim Madara - AMA/VISAC: They tend to be ignored, is the sensor assistant systematic way and recognizing them, and you know proactively using an m&m kind of approach or some such thing to apply logic to this up front and an institution.

Sachin Jain: yeah I mean, I would say, you know I think one of the biggest challenges we have you know when you're leading an organization.

02:22:38.220 --> 02:22:49.590
Sachin Jain: Is implementation bandwidth you can only do so much at one time, and you can only ask people to accept so much change, you know, at one time and.

02:22:50.100 --> 02:23:01.140
Sachin Jain: You know, one of the problems that you have in large complex organizations is you have lots of groups of people who believe that what they're doing is literally, the most important thing i'm sure you've never seen that at all.

02:23:01.710 --> 02:23:13.200
Sachin Jain: In your career and so you know this idea that you know we're going to be trying to simultaneously move side of care, you know you know increase generic prescribing.

Sachin Jain: You know, and you know change incentives for clinicians as well as patients all at the same time.

Sachin Jain: is overwhelming for folks and you know I think so much of what we have from a burnout perspective and an erosion of trust perspective is the fact.

02:23:29.460 --> 02:23:37.590
Sachin Jain: That we are not thinking end to end and we're not being super complete in our approach and we start new things before we finish other things and.

Sachin Jain: Rather than being comfortable with the idea that we're going to just you know set our sights on a specific set of goals for now completed and then move on to the next thing.

Sachin Jain: And so I think you know i've come to view leadership is probably the most important missing ingredient to implementing any of you know change initiative.

Sachin Jain: Within organizations, the design is simple, what I think is more most complicated is actually you know moving you know people in organizations to do the right thing and feel good about it at the same time, I think that is the most challenging piece.

Karl Ronn: That build on that.

Karl Ronn: I think that um I think this question of leadership is is very important in this place and what's unusual about the health care market complexity is is it's your size, there we just aren't dealing with.

Karl Ronn: 3 trillion plus markets, in most cases, and as a result, anybody who has 100 billion dollar business has a has a nothing market share of this market.

Karl Ronn: And in so as a result, yet you can't change them because they're $100.

Karl Ronn: billion business, you know, and so it really asked us to to step up and that's why my comment about this type of a collaborative where everybody's President is really important, because.
Karl Ronn: We really don't have a leadership vision, a shared vision of where we want to be in 10 years or in however many years you want it to be, and so we're not working on the same thing.

02:25:04.800 --> 02:25:09.570
Karl Ronn: And I like this point of view, which is you, you basically have to chunk off.

02:25:09.900 --> 02:25:20.670
Karl Ronn: What are the 510 barriers to that vision and then you build a plan for each one of those 10 and you work on them, and you move forward by removing barriers to the future.

02:25:21.090 --> 02:25:27.540
Karl Ronn: But if we haven't articulated the vision and we don't have that this is to follow cotter on why transformation fails.

02:25:27.870 --> 02:25:38.670
Karl Ronn: You have to have a vision and you have to have a guiding coalition and then you have to have early wins and so there's a real opportunity for us to come together and determine you know what that roadmap is.

02:25:40.200 --> 02:25:48.720
Jim Madara - AMA/VISAC: And Carl the reason you're pointing out the guiding vision and a coalition is because we have guiding visions, now we just have 1000 of them.

02:25:50.160 --> 02:25:59.880
Karl Ronn: Right, which we don't have visions Okay, we have delusions if we have a lot of visions and so a vision would be shared, you know and shared and communicated.

02:26:00.330 --> 02:26:05.400
Karl Ronn: And we don't have a shared vision and a shared communication, but that doesn't mean that we don't have conflict and.

02:26:05.790 --> 02:26:12.900
Karl Ronn: Differences in whatever, but we come together at you know at the level where we can find that commonality and it becomes division.

02:26:13.320 --> 02:26:27.990
Karl Ronn: And and that's what we share and that's that's what the coalition can deliver, if you will, but right now there's too many and
still on a on a bad day I like to point out that the quadruple aim is marvelous except it's an agreement to disagree.

Jim Madara - AMA/VISAC: You know the one one message that we heard all day today, starting with cass and Kevin and just went through to everyone touched on it.

Jim Madara - AMA/VISAC: Is the.

Jim Madara - AMA/VISAC: Is the How important is simplicity is and yet I think we would, I think we easily argued that in the last 25 years, year by year, as we try to achieve a better health care system we've increased the complexity.

Jim Madara - AMA/VISAC: Almost year by year.

Jim Madara - AMA/VISAC: How do folks think we start dealing with that.

Anaeze Offodile: So, Jim I kind of want to i'll answer that by circling back to such as point about limited bandwidth unlimited resources as well.

Anaeze Offodile: I think sort of one way to approach to to a question prompt is just to be very disciplined and data driven right so.

Anaeze Offodile: We can all agree that sort of when I die hoping about 50 years from now, healthcare will still have problems right and that's sort of the appeal of this actually this space is sort of they'll still work to be done, however.

Anaeze Offodile: incremental change is not a significant change in this regard so then, how do we move forward meaningfully I think we have data drive that so.
Anaeze Offodile: We have their inform where we choose to play with better clinical transformation leveraging VMware economics.

Charlene Wong: yeah I think you know the discipline and being brutal in our prioritization of what we're doing and then very clear in the communication.

Charlene Wong: about what it is we're doing and why and how this is going to benefit which which people.

Charlene Wong: You know, and certainly we always think about our patients, but you know, to the point, such and that you are making about the burnout and the teams, particularly after the pandemic so tired.

Charlene Wong: Or we also need to make that value proposition to the teams who are doing this work both within healthcare, then let me put one more plug in also our partners outside of healthcare, who really need to be engaged.

Charlene Wong: And are hurting in many ways, much more than our healthcare system is right now, our partners who address things like food and housing, and our educational system for children so.

Charlene Wong: I think prioritization using data and making sure we're really clear about our communication and the value proposition for the various stakeholder partners.

Jim Madara - AMA/VISAC: You know, I would like to PO and others that participated in this conversation earlier, you know Kevin Brett mustache Nancy and others that presented, then, now that the gone through the entire set of presentations.
Jim Madara - AMA/VISAC: Do you do, you have ideas that.

Jim Madara - AMA/VISAC: you'd like to expand on a bit and I someone who is always up for that as Brett so I'll start with them.

Brent James: it's interesting Jim if I were to name the one thing I think that can make life better.

Brent James: it's to redesign our emr systems.

Brent James: along a clinical line.

Brent James: comes from.

Brent James: I really like that term I hadn't heard of before the idea of sludge in the system.

Brent James: I think that a well designed emr system could go an awful long way to reducing complexity on the front line it's a key tool for deploying clinical decision support.

Brent James: You may have noticed that most of the good examples we had nudges effective messages were based on an emr.

Brent James: What we have of course as a system, we all know, this already, but just to stay.

Brent James: We have Mr systems that are primarily designed for fee for service billing.
Brent James: And then they kind of do clinical decision support as an afterthought, what if we flip that metric, but if we designed for the clinical environment, and then we did the finances as a secondary, this is a, this is one of those things it's so pervasive across everything we do.

908
02:30:46.050 --> 02:30:52.860
Brent James: And I think it would give us a framework where these wonderful ideas, this has been a great meeting for me holy cow i've learned a lot.

909
02:30:54.840 --> 02:30:56.460
Brent James: just want to get a good summary of it.

910
02:30:57.630 --> 02:31:04.980
Brent James: So I can hold on to it but it's one of those things where the ideas that we've been hearing today, I think it would facilitate all of them, so that's just one thought.

911
02:31:06.270 --> 02:31:08.310
Jim Madara - AMA/VISAC: Well, let me prove that out a bit.

912
02:31:10.500 --> 02:31:21.150
Jim Madara - AMA/VISAC: You think im emr should be a digital tool that we use or it should be, as it currently is the digital tool that we use.

913
Brent James: So, Jim you know I spent a lifetime building clinical decision support into clinical workflows.

914
02:31:29.670 --> 02:31:42.870
Brent James: I wish i'd had this wonderful theory that i'm prepared to it would have made me dramatically more effective, we were kind of stumbling along feeling our way I jokingly say I can usually show you five or six ways, not to do something, because we, I think we step in every hole possible.

915
02:31:44.490 --> 02:31:49.440
Brent James: Just felt towards success my eventual conclusion was so.

916
02:31:51.540 --> 02:32:00.240
Brent James: I think properly designed, it will be a suite of tools now here's the trick Jim i've seen examples of what it can be.
Brent James: And they are dramatic shifts so I realized that it's it's in clearly in the realm of the doable.

Brent James: You see what I mean this is within our reach, it would be a massive shift though truly massive shift.

Brent James: So, on the other hand, this has been such a productive conversation I really don't want to steer us away from the content of this conversation off into never, never land over here where i'm going so.

Jim Madara - AMA/VISAC: Right, let me, let me ask Kevin.

Jim Madara - AMA/VISAC: to update his thinking, after hearing all these presentations and followed his second one today Kevin.

Kevin Volpp: Sure, well, I think there are a few key themes that I heard coming up over and over again, one is the need for more simplicity.

Kevin Volpp: The I think a lot of us probably see that as an antidote to sludge and the increasing complexity of systems, which is just seems to happen by itself over time.

Kevin Volpp: On you know it's interesting that nominally the theme for this whole session is about incentives and I think we can think about.

Kevin Volpp: Various forms of choice architecture and defaults while cast describes them as not incentives they're not financial incentives, but there's certainly ways to steer people.

Kevin Volpp: towards doing things that are easier for them that align with what they wanted want to actually achieve, and I do think that said, we have to recognize that.
Kevin Volpp: Since doctors are never going to work for free there's always going to be a payment system and that payment system has embedded incentives and so.

Kevin Volpp: We might not like that. I love the notion that bread that you highlighted that if we pay people enough they're not going to be worried about money and thinking about it as much, and I think that's probably true.

Kevin Volpp: But, of course, however, we pay them there are going to be incentive effects, and I think we need to be very deliberate in recognizing what those are and making sure those align with the organizational goals, whatever they might be.

Jim Madara - AMA/VISAC: Thanks, you know, I was, as you were saying that I was thinking of.

Jim Madara - AMA/VISAC: A study we did in collaboration with ran health few years ago that looked at.

Jim Madara - AMA/VISAC: You know, incentives and disincentives from physician point of view.

Jim Madara - AMA/VISAC: And there was a lot less than 10 tension on finance than one would have guessed.

Jim Madara - AMA/VISAC: It was really all about.

Jim Madara - AMA/VISAC: The experience for the patient, the time with the patients.

Jim Madara - AMA/VISAC: And that and some subsequent work makes one wonder whether the financial aspects of districts and sticks and and incentives when it gets out to the provider are actually disincentives in
a way, and you know Brent sort of an angular way touched on that in his presentation.

Jim Madara - AMA/VISAC: Another question that came in for the group.

Jim Madara - AMA/VISAC: What role two different stakeholders and boards of trustees Community based organizations have a nudging impact and supporting implementation, and I know Charlene.

Jim Madara - AMA/VISAC: touched on in her presentation, you know sort of the wider view of stakeholders Charlene do you want to say something about that.

Charlene Wong: yeah I just think it's so important, you know, again as we think about what are the things that are actually impacting the health of the patients that we're seeing in our health systems.

Charlene Wong: So much of it is happening, the majority of it is happening outside of our four clinic walls or hospital walls and so.

Charlene Wong: I think there is a real imperative and the data only get stronger every day that there's a real imperative.

Charlene Wong: To think beyond our walls and really thinking about how we can from a financial standpoint, since Jim that's the topic of the day, these incentives right from a.

Charlene Wong: From a financial standpoint, what are the ways that we can share these incentives.

Charlene Wong: Do blended and braided funding to really help sustain and bring some of these really important Community partners to the table and and.
Charlene Wong: I think, Carl to your point earlier right when we're talking about that shared vision that we need to have it, it needs to be a shared vision truly if we're going to achieve whole person health and well being.

02:36:27.150 --> 02:36:32.010
Charlene Wong: That is a shared vision for healthcare or payers and our partners outside of healthcare.

02:36:36.780 --> 02:36:37.620
Jim Madara - AMA/VISAC: Other comments.

02:36:38.790 --> 02:36:44.580
Karl Ronn: Maybe just one more on on following on that, as I I am I think that it's.

02:36:45.750 --> 02:36:55.050
Karl Ronn: important to understand that when we want to make these changes that i'll just say all human decision making is Asian.

02:36:55.410 --> 02:37:02.010
Karl Ronn: And so it's very important to understand what's the context and then, what are the priors and then people do.

02:37:02.640 --> 02:37:16.020
Karl Ronn: Risk Management and so it's a three step process that people go through it and that the problem is, is when we when we don't all agree that context, what is the narrow thing we're trying to do, and then do not, and this is.

02:37:16.710 --> 02:37:26.370
Karl Ronn: Similar to one of the other models, you know that was being discussed is again is if we then don't understand the context first and then figure out where people's priors are.

02:37:26.700 --> 02:37:32.490
Karl Ronn: Okay, in other words, this is what my comment about the segmentation, for example, is to coming from different places.

02:37:32.970 --> 02:37:40.890
Karl Ronn: And, and then we ask them to do something, well, it won't work if we haven't agreed those two first steps, because they themselves.

02:37:41.310 --> 02:37:51.060
Karl Ronn: The patient actually or the doctor who is making a choice they do risk management that's their activity and then they go back and that might change their priors.

02:37:51.330 --> 02:38:00.060
Karl Ronn: And they do it over and over and over again it's a behavior changes iterative it's not performative and and I don't think we're conscious enough about.

02:38:00.390 --> 02:38:05.460
Karl Ronn: Making these specific choices about so what change are we talking about making.

02:38:05.790 --> 02:38:14.490
Karl Ronn: And then finding out where are all these different people, and the reason that comes to mind is because the boards and all these other people they're coming from very different places too.

02:38:14.880 --> 02:38:27.840
Karl Ronn: And so they're not going to act together, unless we find a way to get clear on context clear on priors and then they themselves to the person who has to take the action does the risk management, we don't do it for them.

02:38:31.500 --> 02:38:46.050
Anaeze Offodile: In class make on one point is, as you think about bringing in multiple stakeholders is certainly sort of escalates the impact for sure, but I do think to pull it off the complexity also goes way up and.

02:38:46.740 --> 02:38:54.660
Anaeze Offodile: sort of to get alignment across boards across caregivers across patients across Community health workers across custom employees.

02:38:55.380 --> 02:39:08.280
Anaeze Offodile: Right tough nut to crack and you know one way could be to tailor messaging to each stakeholder in a way that resonates with him or her, but I just want to call out that so that is the goal, but it is fairly difficult to pull off.

02:39:13.650 --> 02:39:20.400
Jim Madara - AMA/VISAC: Well, let me just move to some closing remarks it's late in the day and people been.

Jim Madara - AMA/VISAC: doing the most unhealthy thing of all sitting for three hours so.

02:39:25.620 --> 02:39:26.610
Jim Madara - AMA/VISAC: sorry about that.

02:39:27.990 --> 02:39:32.790
Jim Madara - AMA/VISAC: But you know I think a couple of things that we've heard that have just been.

02:39:34.800 --> 02:39:35.580
Jim Madara - AMA/VISAC: amplified.

02:39:37.260 --> 02:39:40.770
Jim Madara - AMA/VISAC: You know, is to keep things as simple as possible, and yet.

02:39:41.850 --> 02:39:49.620
Jim Madara - AMA/VISAC: we're in a healthcare realm that continues to increase in its complexity and moves away from simple.

02:39:51.420 --> 02:40:05.760
Jim Madara - AMA/VISAC: I remember when asked when cast was asked of these behavioral dynamics which do you apply to different domains, you know provider.

02:40:06.720 --> 02:40:18.900
Jim Madara - AMA/VISAC: Patient and healthcare system his response was don't think of them as domains, but think of just defining what the problem is first and then what can be applied to that problem.

02:40:20.040 --> 02:40:35.820
Jim Madara - AMA/VISAC: And that sort of reflects the suggestion that Carl RON made of you know what is the Taylor vision, and you know what primarily are the barriers that could be spoken of.

02:40:38.670 --> 02:40:49.590
Jim Madara - AMA/VISAC: Brent cold out one potential barrier that I think number of people might might agree with or might not, but I would that would have to be discussed, I certainly do.

02:40:51.660 --> 02:40:52.650
Jim Madara - AMA/VISAC: And you as a.
Jim Madara - AMA/VISAC: mentioned that this, too, has to be simple multiple stakeholders.

Jim Madara - AMA/VISAC: You know how do we get through that complexity and make that reasonably simple, I think there was a resonate.

Jim Madara - AMA/VISAC: It resonated with everyone that.

Jim Madara - AMA/VISAC: That the pink separation of algorithmic and terroristic processes and the recognition that.

Jim Madara - AMA/VISAC: You know institutions healthcare institutions at the top may be somewhat algorithmic that may be why they can respond at the top two to.


Jim Madara - AMA/VISAC: But one once one gets down to where the action is with providers and patients is all heuristic.

Jim Madara - AMA/VISAC: So, how does one even think about the transition of incentives down that waterfall.

Jim Madara - AMA/VISAC: of systems that are built very differently and have very different dynamics.

Jim Madara - AMA/VISAC: The other aspect that was brought out.

Jim Madara - AMA/VISAC: is how intrinsic.
Jim Madara - AMA/VISAC: going to intrinsic motivators intrinsic incentives and this system was probably always going to trump the extrinsic incentives and yet you know the extrinsic incentives are currently highly reliant on.

02:42:33.390 --> 02:42:45.090
Jim Madara - AMA/VISAC: And there's a relative lack of intrinsic incentives, you know, once you get down that water cascade from a top of it institution to where care takes place.

02:42:47.760 --> 02:42:56.310
Jim Madara - AMA/VISAC: There is a comment about you know, establishing it could make multiple stakeholders even agree.

02:42:57.930 --> 02:42:59.190
Jim Madara - AMA/VISAC: On a 10 year vision.

02:43:01.230 --> 02:43:14.280
Jim Madara - AMA/VISAC: That might take a piece of work, but might be worthwhile doing so some of my take home from this and, with that, let me pass it to diane for her observations.

02:43:19.290 --> 02:43:20.370
Diane Holder: So thanks Jim.

02:43:21.900 --> 02:43:32.760
Diane Holder: yeah I mean, I agree, I think that the what what's been surface is the is the justice for me the juxtaposition of the complexity of the world that we have.

02:43:33.270 --> 02:43:52.380
Diane Holder: In terms of the delivery models, the payment models all the different kinds of subpopulations and a different drivers that we see, and then the kinds of things that people say will actually be helpful So how do we think about simplicity, how do we think about starting with a problem.

02:43:53.400 --> 02:44:03.450
Diane Holder: i'm looking at you know kind of the the world of a payer provider integration every day and thinking about the fact that we have to make very.

02:44:04.350 --> 02:44:15.480
Diane Holder: Often rapid decisions because we're all staying in business, every year, whether we're clinical delivery systems or we're payers are what promote whatever we are right we're working toward our goals and objectives, at the same time, seeing that things are not going for patient care, the way we'd like to see it.

Diane Holder: And so I thought there was great richness in this conversation today, and it has given me a lot to think about, but I think I am struck by the fact that there is no design that's clear.

Diane Holder: And I don't know how hard it would be, I think it would be hard for us to actually get agreement on what is that end goal.

Diane Holder: Once you get beyond the High Level I think you'd have fair amount of agreement at the high level, and I think that you'd have a lot of opportunity for hard work, trying to execute on what actually would create that opportunity to deliver around those goals so but I think this was a wonderful conversation today.

Jim Madara - AMA/VISAC: I will thanks I in Michael do you want to close.

Michael McGinnis: yeah and thank you very much, Jim and I and and all I will make a few.

Michael McGinnis: summary comments that I jotted down, as I was listening to the discussion which was, as everyone has said just fabulous I think all of us, I don't know if they're being exceptions learned a lot in the course of the conversation.

Michael McGinnis: The items that I jotted down, six of them really related to the choice architecture priorities and decision filters that people teed up.
Michael McGinnis: And I'm sure there are probably 60 others that.

Michael McGinnis: have been identified by folks in the audience and on the panels.

Michael McGinnis: First, was reducing sludge is half the battle.

Michael McGinnis: Leadership is the other half.

Michael McGinnis: Second, was in effect assume the best motivations.

Michael McGinnis: And bread pointed out the importance of autonomy mastery purpose.

Michael McGinnis: As trump notions in the in terms of human.

Michael McGinnis: intention, the third was.

Michael McGinnis: We heard so many times, keep it simple.

Michael McGinnis: Whether it's through the tool of the me our emr the notion of opt out opt in clearly opt out is easier than opt in, opt in, despite the fact that there are some.

Michael McGinnis: circumstances in which that's difficult, the fact is that we should do, where we can to keep it simple the fourth was.

Michael McGinnis: And this was instinctive to us, but I think the explicit calling out is Chris critical and that is that time matters to everyone.
Michael McGinnis: The four letter word is not just life it's what.

Michael McGinnis: it's the unit of measurement of life time matters, and we need to be more respectful in everything we do, and to think about how we can ensure its maximization for all involved the fifth was this wasn't a soundbite like the others, but it essentially was a overarching theme.

Michael McGinnis: And that is aligned payments with the whole whole person whole organization whole population and use that as a key architecture priority and the and the sixth on this list that I jotted down was enhanced trust consciously think about things that enhance trust.

Michael McGinnis: If we're trying to build a set of.

Michael McGinnis: priorities and procedures and perspectives that will take advantage of what we're learning from behavioral economics.

Michael McGinnis: We can do a lot better with some of the just some of the simple notions.

Michael McGinnis: Brent underscored is interested in a good summary, I certainly want a good summary so.

Michael McGinnis: And I think there are a lot of things that we can build on and will build on in our work across the board in the National Academy of Medicine, and the leadership consortium on that count, I should mention.

Michael McGinnis: looping back on the vision notion.

Michael McGinnis: That Carl has underscored.
In the leadership consortium, with a focus on the learning health system we've been building on the core principles that were identified and crossing the code quality chasm and expanding them.

In an updated fashion with focus on on transparency.

On issues related to.

The the importance of data stewardship and it strikes me and listening that.

Even though the 10 principles we have now under the learning health system rubric.

It doesn't.

Even though the 10 principles we have now under the learning health system rubric.

A Vision they certainly represent collectively a vision that can be guideposts.

New ages sludge busters if you will.

In a variety of sectors so we'll continue to work on that with you and for you and most share them with all of the participants today.

Solicit your your input and suggestions, as we will also encourage you to send any suggestions along that came to mind in the course of your participation today whether you were on the panel.
Michael McGinnis: or or in the audience.

Michael McGinnis: Let me.

Michael McGinnis: underscore our thanks to.

Michael McGinnis: The keynote speakers each of the panelists for bringing your tremendous intelligence and and insights to the discussion, offering us a very important set of of reference points to move forward with thanks to.

Michael McGinnis: The staff who put this together, and let me just mention a few names i'm going to mention my coach to first, because his name hasn't been mentioned yet, but he he has.

Michael McGinnis: A research associate who took on this session with a passion, I think he Jimmy was channeling you at every step of the way.

Michael McGinnis: And allison Lester who you've heard reference to is as really managing the logistics moment to moment Jennifer Lee are visiting scholar I adela initiate deputy director of the leadership consortium olivia matondo was a program officer involved formerly.

Michael McGinnis: Thanks to heartfelt thanks to each of you have done such a good job in in organizing in implementing today's meeting and, of course.

Michael McGinnis: Finally, well not quite finally but certainly foremost in some ways, thanks to our two chairs diane and Jim for skilled stewardship of the conversation.

Michael McGinnis: The final thanks i'll give to each of you in the audience, who have tuned in and and are providing leadership in your own home venues, and please.
Michael McGinnis: share with us any thoughts, you have about ways in which we in the Academy, and as the field can advance progress so thanks to all of you everyone stay safe be well and have a wonderful holiday season take care.