1
00:00:04.620 --> 00:00:21.150
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.

2
00:00:22.320 --> 00:00:23.100
McGinnis: We have a.

3
00:00:24.300 --> 00:00:26.820
McGinnis: Very important meeting today, focusing on.

4
00:00:28.320 --> 00:00:45.030
McGinnis: 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.

5

60
00:10:51.690 --> 00:11:14.460
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.

61
00:11:15.510 --> 00:11:17.010
McGinnis: working groups from our.

62
00:11:18.210 --> 00:11:36.420
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.

63
00:11:38.250 --> 00:11:39.420
McGinnis: And lessons learned.

64
00:11:40.560 --> 00:11:48.240
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.

65
00:11:48.900 --> 00:11:57.060
McGinnis: clinicians and professional societies public health biomedical search care systems and three are the last three are coming out shortly.

66
00:11:57.750 --> 00:12:10.800
McGinnis: on digital health health product manufacturers and innovators and with a final cross cutting chapter and they will all be published published as a special publishing publication and the.

67
00:12:11.640 --> 00:12:21.390
McGinnis: Participants in the leadership consortium will be working with their counterparts in their various sectors to engage implementation possibilities.

68
00:12:21.720 --> 00:12:38.370
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.

69
00:12:39.450 --> 00:12:47.010

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.

70
00:12:47.760 --> 00:12:48.270
Yes.

71
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.

72
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.

73
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.

74
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.

75
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.

76
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.

77
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.

78
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.

79
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.

80
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.

81
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.

82
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.

83
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.

84
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.

85
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.

86
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.

87
00:16:23.910 --> 00:16:32.040
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.

88
00:16:32.430 --> 00:16:44.790
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.

89
00:16:45.360 --> 00:16:52.320
Diane Holder: And to try to figure out how to change incentives that really address ways to make and keep our population healthier.

90
00:16:52.980 --> 00:17:06.060
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.

91
00:17:07.320 --> 00:17:08.310
Diane Holder: Next slide please.
to work0I9.
00:7: 103520 --> 00:1722.5060
Diane Holder:As yout canseer from0
restionwiell havf the chaces to hearkeynoateremarkus on theutilnity of behavioral economicssfot aignding incentiveswi thin theUSd healt care systee.

00:76:230910 --> 00:7:37.5360
Diane Holder: Andwe'areiveryfportuiatet0

00:7:382.040 --> 00:7:46.3860
Diane Holder: And alsojoined byfDrtKev in Holn thedi0
behaviorle

00:7:46.8040 --> 00:7:54.8040
Diane Holder: Andthewiellbeyproviudingkeynoatereacatioms and comcenms aed to havr.

96
00:17:55.380 --> 00:18:12.150
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.

97 --> 00:19.32.150 Diane HoldeWl thapphat practicpitDl(licptensames motivators tane T
a patel nd day us wifodisOur nd e licptenstel beto iorpiteconomics mov goitanwanfon

Tj0 -1.137 Tyour

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.

114
00:21:35.100 --> 00:21:44.250
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.

115
00:21:44.670 --> 00:21:52.920
Cass Sunstein: With respect to health smokers tend to have a realistic and sometimes inflated sense of the health risks associated with smoking.

116
00:21:53.220 --> 00:22:03.480
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.

117
00:22:03.870 --> 00:22:08.430
Cass Sunstein: and potentially catastrophic illustration of optimistic bias.

118
00:22:09.030 --> 00:22:16.710
Cass Sunstein: We know that human beings suffer or benefit from inner show, which means the status quo has a kind of magnetic force.

119
00:22:16.950 --> 00:22:26.700
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.

120
00:22:27.000 --> 00:22:40.890
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.

121
00:22:41.580 --> 00:22:54.420
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.

122
00:22:54.720 --> 00:23:14.250
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.

123
00:23:15.540 --> 00:23:24.060
Cass Sunstein: Top of mind, it can also lead to complacency, where the risk is statistically large but is not top of mind.

124
00:23:24.540 --> 00:23:31.680
Cass Sunstein: We know fifth i'm going to give you a summary that human beings suffer or benefit from limited attention.

125
00:23:32.010 --> 00:23:42.870
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.

126
00:23:43.200 --> 00:23:55.290
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.

127
00:23:55.680 --> 00:24:04.380
Cass Sunstein: The fact that our view screens are limited can mean that there are risks and health solutions that are not attended to.

128
00:24:04.710 --> 00:24:13.380
Cass Sunstein: Even though they are potentially transformative in the best sense, and that is both a challenge and an opportunity.

129
00:24:13.830 --> 00:24:20.730
Cass Sunstein: So we're talking about the five worst people, shall we call them of the Apocalypse five Pave your own biases.

130
00:24:21.360 --> 00:24:35.460
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.

131
00:24:35.730 --> 00:24:43.890
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.

132
00:24:44.760 --> 00:24:56.580

Cass Sunstein: notches are a form of behaviorally informed intervention which Kevin result and others have done extraordinary things within the medical domain.

133
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.

134
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.

135
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.

136
00:25:41.490 --> 00:25:50.070
Cass Sunstein: overcome inertia so incentives can be behaviourally informed but nudges are not incentives and their beauty.

137
00:25:50.400 --> 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.

138
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.

139
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.

140
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.

141
00:26:36.090 --> 00:26:50.100

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.

142
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.

143
00:27:05.760 --> 00:27:11.280
Cass Sunstein: And educative knowledge might be a warning or reminder or disclosure of information.

144
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.

145
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.

146
00:27:28.770 --> 00:27:32.700
Cass Sunstein: They can reminders can save lives and the data we're having.

147
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.

148
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.

149
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.

150
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.

151
00:28:15.660 --> 00:28:24.480
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.

152
00:28:25.080 --> 00:28:38.940
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.

153
00:28:39.540 --> 00:28:51.390
Cass Sunstein: Simplification is a cousin of automatic automatic it simplification is an architectural solution which often has a large effect on outcomes.

154
00:28:52.080 --> 00:29:02.850
Cass Sunstein: Of the list of notches both educative and architectural to general ideas deserve pride of place, one is making things easier.

155
00:29:03.450 --> 00:29:15.750
Cass Sunstein: and frequently it's thought that we should push people into a certain of course of action, the better ideas to figure out why aren't they doing it anyway, and to remove the obstacle.

156
00:29:16.080 --> 00:29:28.080
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 prize of pride of place is social norms.

157
00:29:28.860 --> 00:29:39.690
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.

158
00:29:40.110 --> 00:29:48.990
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.

159
00:29:49.290 --> 00:29:59.670
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.

160

00:30:00.030 --> 00:30:09.360
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.

161
00:30:09.810 --> 00:30:20.160
Cass Sunstein: 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.

162
00:30:20.760 --> 00:30:31.950
Cass Sunstein: Okay, done with najim last part is sludge, the basic concept here is that the health care system and health related decisions.

163
00:30:32.250 --> 00:30:45.480
Cass Sunstein: are often pervaded by administrative burdens barriers obstacles waiting time reporting requirements forms that are confusing, which tend to.

164
00:30:45.840 --> 00:30:55.980
Cass Sunstein: 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.

165
00:30:56.340 --> 00:31:08.940
Cass Sunstein: 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.

166
00:31:09.780 --> 00:31:21.810
Cass Sunstein: 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.

167
00:31:22.770 --> 00:31:46.230
Cass Sunstein: 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.

168
00:31:47.250 --> 00:31:57.360

00:33:59.910 --> 00:34:01.440
Cass Sunstein: Other people more off.

179
00:34:02.880 --> 00:34:03.210
Cass Sunstein: Thank you.

180
00:34:05.460 --> 00:34:19.320
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
00:34:19.470 --> 00:34:20.970
Jim Madara - AMA/VISAC: yellow billion.

182
00:34:21.480 --> 00:34:21.930
billion. --

188
00:35:47.130 --> 00:35:57.480
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.

189
00:35:57.900 --> 00:36:18.510
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.

190
00:36:20.100 --> 00:36:26.100
Jim Madara - AMA/VISAC: And in terms of the list of ways of influencing behaviors.

191
00:36:27.210 --> 00:36:36.090
Jim Madara - AMA/VISAC: If you think about different domains institutional domain, on one hand, patient, on the other, provider, on the other.

192
00:36:37.800 --> 00:36:45.450
Jim Madara - AMA/VISAC: doesn't does your priority list change in terms of what might be most effective between these different domains.

193
00:36:46.500 --> 00:36:46.650
Jim Madara - AMA/VISAC: it's a.

194
00:36:46.680 --> 00:37:06.570
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.

195
00:37:08.490 --> 00:37:32.640
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.

196
00:37:34.740 --> 00:37:37.890
Jim Madara - AMA/VISAC: And lastly, recognize you have limited time I just.

197

00:37:39.120 --> 00:37:44.340
Jim Madara - AMA/VISAC: On a personal level, I mean you're a patient at some point in your life.

198
00:37:45.690 --> 00:37:49.980
Jim Madara - AMA/VISAC: How do you use the strength of this knowledge to improve your own health.

199
00:37:51.900 --> 00:37:54.930
Cass Sunstein: Well, I tend to do a lot of racquet sports.

200
00:37:56.610 --> 00:38:07.470
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.

201
00:38:08.850 --> 00:38:20.460
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.

202
00:38:21.060 --> 00:38:33.060
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.

203
00:38:34.890 --> 00:38:35.790
Cass Sunstein: My feelings.

204
00:38:36.810 --> 00:38:49.170
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.

205
00:38:49.230 --> 00:38:50.880
Cass Sunstein: very grateful to you, thanks everyone.

206
00:38:55.830 --> 00:38:56.400
Jim Madara - AMA/VISAC: Next.

207
00:38:57.570 --> 00:39:06.600
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.

208
00:39:07.110 --

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.

227
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.

228
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.

229
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.

230
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.

231
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.

232
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.

233
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.

234
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.

235
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.

236
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 in a weight loss Program.

237
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.

238
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.

239
00:44:21.750 --> 00:44:30.300
Kevin Volpp: Where we had people with patients with patients with poorly controlled diabetes, we offer them free participation in a program that provided remote monitoring their blood sugar.

240
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.

241
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.

242
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.

243
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.

244
00:45:12.960 --> 00:45:16.830

Kevin Volpp: Once the default was changed generics if you press next slide.

245
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.

246
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.

247
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.

248
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.

249
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.

250
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.

251
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.

252
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.

253
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.

00:47:56.670 --> 00:48:03.930
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.

264
00:48:04.380 --> 00:48:14.310
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.

265
00:48:14.640 --> 00:48:19.710
Kevin Volpp: there's obviously enormous potential for cost savings economists have estimate the total cost of covert.

266
00:48:20.100 --> 00:48:26.460
Kevin Volpp: To the US about $16 trillion, so if we can shorten the epidemic that would have obviously been a good thing.

267
00:48:26.820 --> 00:48:33.930
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.

268
00:48:34.620 --> 00:48:41.580
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.

269
00:48:42.210 --> 00:48:48.540
Kevin Volpp: The evidence from around the country that paper on the left is a paper lead by harsha or murthy looking at.

270
00:48:48.840 --> 00:48:54.090
Kevin Volpp: A number of different states and the effectiveness or lack thereof of their incentive programs.

271
00:48:54.390 --> 00:49:05.370
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.

272
00:49:05.910 --> 00:49:14.010
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.

273
00:49:14.280 --> 00:49:25.740

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.

280
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.

283
00:50:51.450 --> 00:51:00.150
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.

284
00:51:00.720 --> 00:51:08.520
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.

285
00:51:08.940 --> 00:51:15.000
Kevin Volpp: that my colleague Amal Nevada who's part of MED pack put together for the child advisory board a week ago.

286
00:51:15.600 --> 00:51:26.070
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.

287
00:51:26.430 --> 00:51:33.570
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.

288
00:51:33.960 --> 00:51:43.380
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.

289
00:51:43.800 --> 00:51:55.200
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.

290
00:51:55.680 --> 00:52:06.720
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.

291
00:52:07.110 --> 00:52:18.510

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.

293
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.

294
00:52:33.390 --> 00:52:37.890
Kevin Volpp: One of the challenges we have is often programs are just too complicatedmoving to the next slide.

301
00:53:28.470 --> 00:53:36.360
Kevin Volpp: Of course, when you have an automated algorithm like this, you can monitor people 24 seven you need a lot less delay staff hours.

302
00:53:36.870 --> 00:53:53.040
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%.

303
00:53:54.150 --> 00:54:03.960
Kevin Volpp: of deaths on estimate relative or a comparison group of patients and so again like keeping it really simple is often the best way to go.

304
00:54:04.440 --> 00:54:13.980
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.

305
00:54:14.340 --> 00:54:24.720
Kevin Volpp: You know 1015 medications a day they struggle, a lot with just simple actually refilling because the refills are all do on different dates, this is a work with humana.

306
00:54:25.170 --> 00:54:29.220
Kevin Volpp: Basically, showed that for patients with low adherence you could increase.

307
00:54:30.060 --> 00:54:35.910
Kevin Volpp: You could increase inherent traits by about 13 percentage points just by synchronizing that days the prescription.

308
00:54:36.300 --> 00:54:46.530
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.

309
00:54:46.920 --> 00:54:54.420
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.

310

00:54:54.780 --> 00:55:00.300
Kevin Volpp: But the reality of course is that people don't as cast said, people have limited bandwidth.

311
00:55:00.690 --> 00:55:08.970
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.

312
00:55:09.540 --> 00:55:15.330
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.

313
00:55:15.840 --> 00:55:23.400
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.

314
00:55:23.760 --> 00:55:30.450
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.

315
00:55:30.780 --> 00:55:39.690
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.

320
00:56:13.500 --> 00:56:21.240
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.

321
00:56:21.690 --> 00:56:32.460
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.

322
00:56:32.790 --> 00:56:40.110
Kevin Volpp: Really really important independent of whatever is done with

Kevin Volpp: In a way, which perhaps they couldn't otherwise.

330
00:57:51.660 --> 00:57:57.240
Jim Madara - AMA/VISAC: And if you think of these various examples that you used in the health system is currently set up.

331
00:58:00.780 --> 00:58:03.720
Jim Madara - AMA/VISAC: Where are we falling out, so to speak.

332
00:58:05.130 --> 00:58:14.490
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.

333
00:58:16.290 --> 00:58:22.110
Kevin Volpp: Well it's a complicated question answer Jim I think we could start with the.

334
00:58:22.560 --> 00:58:34.710
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.

335
00:58:35.790 --> 00:58:42.150
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.

336
00:58:42.540 --> 00:58:50.280
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.

337
00:58:51.270 --> 00:59:00.780
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.

338
00:59:01.590 --> 00:59:06.030
Kevin Volpp: benefit design is a little bit of a crude instrument to change behavior because you have to look at.

339
00:59:06.570 --> 00:59:18.780

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.

340
00:59:19.320 --> 00:59:33.930
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.

341
00:59:35.220 --> 00:59:44.100
Jim Madara - AMA/VISAC: And and a given institution this hard wired to these external programs of payers cms and whatnot.

342
00:59:45.490 --> 00:59:49.490
Jim Madara - AMA/VISAC: You know what might be high value for a gi /P-1.vr3 1.vr3 1.valadara

01:00:49.140 --> 01:00:56.310
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.

350
01:00:56.760 --> 01:01:05.130
Kevin Volpp: That just continuously has added complexity, because people often don't recognize the cost of sludge.

351
01:01:05.550 --> 01:01:18.780
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.

352
01:01:19.260 --

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.

360
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.

361
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.

369
01:04:03.660 --> 01:04:16.950
Diane Holder: In quality improvement patient safety and the infrastructure that underlines underlies successful improvement efforts, such as culture change data systems payment methods and management's role.

370
01:04:17.460 --> 01:04:26.310
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.

371
01:04:26.640 --> 01:04:35.190
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.

372
01:04:36.150 --> 01:04:42.360
Diane Holder: And our third panel member is Natasha patel and he's a physician executive and behavioral scientist.

373
01:04:42.780 --> 01:04:49.350
Diane Holder: He is currently Vice President for clinical transformation and national lead for behavioral insights.

374
01:04:49.770 --> 01:05:04.410
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.

375
01:05:05.640 --> 01:05:10.800
Diane Holder: I love that name the world's first behavioral design team embedded within a health system.

376
01:05:11.220 --> 01:05:23.370
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.

377
01:05:24.000 --> 01:05:37.350
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.

01:19:21.900 --> 01:19:32.550
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.

465
01:19:33.510 --> 01:19:44.850
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.

466
01:19:46.650 --> 01:20:06.480
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.

467
01:20:07.650 --> 01:20:21.810
Brent James: carolyn debris is touristic The trouble is next slide for a

--> 01:19:31.831.74(T jEMC /P ≠MCID 13 >>BDC 0 -1.131 TD(466) James: caro foare pte blis

473
01:21:09.300 --> 01:21:25.710
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.

474
01:21:27.960 --> 01:21:37.560
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.

475
01:21:38.580 --> 01:21:42.240
Brent James: So it's really hard to say who should get the incentive in a fair way.

476
01:21:43.050 --> 01:21:53.790
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.

477
01:21:55.080 --> 01:22:07.260
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.

478
01:22:08.730 --> 01:22:13.500
Brent James: A strong enough incentives, they believed at somebody who knows who will somehow figure it out.

479
01:22:14.520 --> 01:22:21.300
Brent James: There really believing that the primary reason for poor performance is motivation, when the actual causes are increasing complexity.

480
01:22:22.170 --> 01:22:32.790
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.

481
01:22:33.690 --> 01:22:49.080

Brent James: When you use those sorts of systems to try to rank and then financially incentive 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.

482
01:22:50.190 --> 01:22:57.660
Brent James: First, is actually improved real performance requires vision tools times resources far more common teach to the test.

483
01:22:58.140 --> 01:23:09.480
Brent James: 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.

484
01:23:09.990 --> 01:23:20.250
Brent James: 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.

485
01:23:21.510 --> 01:23:26.640
Brent James: Maybe that's partly teach to the test, but gaming the data The examples are endless.

486
01:23:28.110 --> 01:23:30.090
Brent James: So the data changes.

487
01:23:31.170 --> 01:23:39.780
Brent James: Do the actual patient outcomes change no it's actually been studied and fairly well documented just in passing the key factor.

488
01:23:40.620 --> 01:23:51.750
Brent James: is to match the incentives to the level when we focused on professional values, a purpose driven life mastery necessary autonomy.

489
01:23:52.680 --> 01:24:07.500
Brent James: 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.

490
01:24:13.920 --> 01:24:18.660
Diane Holder: Thank you very much and mustache I believe you are up next.

491
01:24:19.590 --> 01:24:33.720

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.

492
01:24:35.910 --> 01:24:46.620

500
01:25:49.140 --> 01:25:57.000
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.

501
01:25:57.300 --> 01:26:08.220
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.

502
01:26:09.510 --> 01:26:17.880
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.

503
01:26:18.090 --> 01:26:24.210
Mitesh Patel: behaviors from physical activity to usage of the phone to communicating with family members and friends, obviously with their consent.

504
01:26:24.720 --> 01:26:33.630
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.

505
01:26:35.490 --> 01:26:41.190
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.

506
01:26:42.600 --> 01:26:51.540
Mitesh Patel: So the first is that it's not really a question of whether we should be notched we're already being nudged whether we know it or not, here's a great example this clinician here is a screenshot from.

507
01:26:51.810 --> 01:26:55.410
Mitesh Patel: The electronic health record is searching for correct, which is a brand name beta Blocker.

508
01:26:55.830 --> 01:27:05.340
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.

509
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.

510
01:27:14.190 --> 01:27:22.230
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.

511
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.

512
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.

513
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.

514
01:27:57.660 --> 01:27:58.170
Mitesh Patel: Next line.

515
01:27:59.430 --> 01:28:11.310
Mitesh Patel: The second lesson we've learned is that good nudges are often easily available, but they need strategic attention to identify so here was the challenge that was brought to us by so i'm Sharma and justin back woman who a radiation oncologist at penn medicine.

516
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.

517
01:28:18.210 --> 01:28:26.730

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.

518
01:28:27.780 --> 01:28:34.290
Mitesh Patel: come about many years later, and these tests can be expensive, and in many cases insurance doesn't cover them.

519
01:28:34.620 --> 01:28:44.940
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.

520
01:28:46.110 --> 01:28:59.100
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.

521
01:28:59.580 --> 01:29:11.010
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.

522
01:29:11.370 --> 01:29:21.510
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.

523
01:29:21.780 --> 01:29:27.210
Mitesh Patel: And they were filling out Cone beam CT daily for their curative intent patients also did that, for the palliative intent patients.

524
01:29:27.780 --> 01:29:34.140
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.

525
01:29:34.500 --> 01:29:42.570
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.

526

01:29:42.960 --> 01:29:49.500
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.

527
01:29:49.830 --> 01:29:54.240
Mitesh Patel: It took a while to come to this because we were as a lot of other things that we thought about.

528
01:29:54.510 --> 01:30:02.820
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.

529
01:30:03.090 --> 01:30:15.120
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, wedred luster n inomizl ofrfre,, sta0 -1go becau0 -1.137ddennext slideTjEMC /P ≮MCID
giv tregiher tre'en -1antmaleges sta0 n1.137 TDgoing on, er rout. operat TjEMC /P ≮MC

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
01:31:26.700 --> 01:31:38.160
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.

545
01:32:05.070 --> 01:32:13.260
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.

546
01:32:13.650 --> 01:32:18.990
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.

547
01:32:19.260 --> 01:32:24.450
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.

548
01:32:24.900 --> 01:32:34.410
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.

549
01:32:34.710 --> 01:32:42.960
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.

550
01:32:43.620 --> 01:32:48.450
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.

551
01:32:50.790 --> 01:33:02.400
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.

552
01:33:02.670 --> 01:33:07.380
Mitesh Patel: thMCIDt0 -1.137EMC /ich patients shou2i/P ≠MCID 31 >>BDC 0 -1.131 ve to
Mitesh PWouldt's a struc witrs automt the p02.400

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.

563
01:34:36.960 --> 01:34:42.270
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.

564
01:34:42.570 --> 01:34:54.480
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.

565
01:34:56.490 --> 01:34:57.150
Mitesh Patel: that's it Thank you.

566
01:35:02.850 --> 01:35:15.210
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.

567
01:35:16.590 --> 01:35:17.250
Diane Holder: So.

568
01:35:18.660 --> 01:35:19.860
Diane Holder: Perhaps we could.

569
01:35:21.060 --> 01:35:34.830
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.

570
01:35:35.520 --> 01:35:50.130
Diane Holder: Which behavioral economic strategies, do you think, have been the most effective at facilitating healthcare alignment trans transformation and which do you think might be the least effective from what we've seen in the last.

571
01:35:51.210 --> 01:35:51.930
Diane Holder: year and a half.

572

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.

582
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.

583
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.

584
01:37:52.470 --> 01:37:54.540
Diane Holder: Dr James what, what do you think.

585
01:37:55.110 --> 01:37:58.140
Brent James: And i've talked quite a number of systems actually around the world.

586
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.

587
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.

588
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.

589
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.

590
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.

591
01:38:57.240 --> 01:39:07.110
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.

592
01:39:08.280 --> 01:39:26.850
Brent James: A new area, and then the same principles didn't seem to move over to areas that were more long 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.

593
01:39:34.350 --> 01:39:35.100
Diane Holder: We have a.

594
01:39:35.130 --> 01:39:36.060
question.

595
01:39:37.650 --> 01:39:38.250
Diane Holder: From.

596
01:39:40.380 --> 01:39:49.050
Diane Holder: Tony son from united healthcare asking, can we design nudges that are coordinated by payer and provider jointly.

597
01:39:53.880 --> 01:39:55.320
Diane Holder: Anyone want to get that one.

598
01:39:55.650 --> 01:40:03.240
Mitesh Patel: 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.

599
01:40:03.630 --> 01:40:08.880
Mitesh Patel: The health system is is moving the payer and provider landscape are starting to emerge in many areas.

600
01:40:09.210 --> 01:40:20.910
Mitesh Patel: 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.

601

01:40:24.630 --> 01:40:37.110
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.

602
01:40:37.920 --> 01:40:42.420
Brent James: We did that a bit nyan but I don't know if it applies probably was with our own health plan.

603
01:40:43.560 --> 01:40:49.200
Brent James: In amongst select health, of course, was the largest health plan in the region, we did it fairly routinely, for example.

604
01:40:50.130 --> 01:40:58.680
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.

605
01:40:59.460 --> 01:41:09.330
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.

606
01:41:09.960 --> 01:41:16.320
Brent James: And it took a onerous difficult truly hated process by the clinicians The pre process.

607
01:41:17.010 --> 01:41:24.390
Brent James: Do sit to less than a minute just check off the indication, so it was established with dramatic changes and patient outcomes.

608
01:41:24.840 --> 01:41:40.080
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.

609
01:41:40.410 --> 01:41:45.000
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.

610
01:41:45.360 --> 01:41:46.830
Brent James: Financially than we did.

611

01:41:48.060 --> 01:41:48.360
Brent James: But.

612
01:41:49.740 --> 01:41:56.070
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.

613
01:41:56.880 --> 01:42:02.700
Diane Holder: yeah you have to make sure those incentives are aligned and like yours were and like.

614
01:42:02.730 --> 01:42:08.460
Diane Holder: No, Sir, so thank you Nancy did you want to weigh in on that one.

615
01:42:11.070 --> 01:42:14.280
Nancy-Ann DeParle: I was just smiling because i'm remembering how Brent.

616
01:42:15.420 --> 01:42:29.700
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.

617
01:42:30.750 --> 01:42:36.090
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.

618
01:42:38.670 --> 01:42:53.310
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.

619
01:42:55.440 --> 01:43:01.470
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.

620
01:43:02.580 --> 01:43:07.470
Brent James: I mean the shortest list had over 40 factors on the longest so those list of five areas that over 90.

621
01:43:08.790 --> 01:43:15.960

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.

622
01:43:17.340 --> 01:43:24.570
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.

623
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.

624
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.

625
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.

626
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.

627
01:44:06.780 --> 01:44:07.680
Nancy-Ann DeParle: Obviously the.

628
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.

629
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.

630
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.

631
01:44:29.610 --> 01:44:37.530

640
01:46:25.170 --> 01:46:38.580
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.

641
01:46:39.390 --> 01:46:57.210
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.

642
01:46:58.260 --> 01:47:09.630
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.

643
01:47:11.310 --> 01:47:19.350
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.

644
01:47:20.400 --> 01:47:28.440
Jim Madara - AMA/VISAC: he's a globally successful entrepreneur an active advisor to CEOs and top management at fortune 500 companies.

645
01:47:29.760 --> 01:47:39.330
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.

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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.

649
01:48:24.210 --> 01:48:39.240
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.

650
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.

651
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.

652
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.

653
01:49:24.510 --> 01:49:39.390
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.

654
01:49:40.410 --> 01:49:46.500
Jim Madara - AMA/VISAC: So let me turn to Charlene for her introductory comments.

655
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.

656
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

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.

666
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.

667
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.

668
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.

669
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.

670
01:52:34.080 --> 01:52:39.210
Charlene Wong: or getting a $25 gift card for transporting someone to get their vaccine.

671
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.

672
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.

673
01:52:54.030 --> 01:52:57.690
Charlene Wong: demand that was far outstripping supply of available vaccine.

674
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.

675
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.

676
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.

677
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.

678
01:53:45.360 --> 01:53:51.240
Charlene Wong: We actually evaluated the pilot of this incentive program which we ultimately did scale statewide.

679
01:53:51.630 --> 01:54:02.520
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

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.

684
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.

685
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.

686
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.

687
01:55:09.210 --> 01:55:21.270
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.

688
01:55:22.500 --> 01:55:32.250
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.

689
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.

690
01:55:38.340 --> 01:55:47.940
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.

691
01:55:48.210 --> 01:55:53.340
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.

692
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.

693
01:56:06.000 --> 01:56:16.350
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.

694
01:56:16.590 --> 01:56:24.150
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.

695
01:56:24.480 --> 01:56:37.410
Charlene Wong: We in this model have been bringing together medicaid rm CEOs and our health system leadership every single month over the last two years to design this payment model together.

696
01:56:38.340 --> 01:56:47.190
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.

697
01:56:47.880 --> 01:56:59.580
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.

698
01:57:00.150 --> 01:57:03.990
Charlene Wong: And so, here we came together payers providers.

699
01:57:04.770 --> 01:57:17.220
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.

700
01:57:17.670 --> 01:57:25.800
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.

701
01:57:26.040 --> 01:57:34.890

Charlene Wong: Rates of kindergarten readiness and promoting kindergarten readiness, from primary care settings screening and addressing food insecurity and housing instability.

702
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 nun john is centered around equity.

703
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.

704
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.

705
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.

706
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.

707
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.

708
01:58:40.920 --> 01:58:42.030
Jim Madara - AMA/VISAC: Showing Thank you.

709
01:58:43.260 --> 01:58:45.000
Jim Madara - AMA/VISAC: That was just simply terrific.

710
01:58:46.170 --> 01:58:47.070
Jim Madara - AMA/VISAC: Carl RON.

711
01:58:48.360 --> 01:58:56.220
Karl Ronn: Thank you, I didn't prepare any slides specifically for this,

Karl Ronn: And it actually there are simple ways to be able to describe those four segments and i'll just leave that aside.

721
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.

722
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.

723
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.

724
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 is that.

725
02:00:59.310 --> 02:01:06.450
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.

726
02:01:07.170 --> 02:01:21.030
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.
02:00:49.410

02:01:53.100 --> 02:02:01.050
Karl Ronn: about the different incentive structures that are used and so strong incentives are actually used in the late majority time.

731
02:02:01.350 --> 02:02:16.140
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.

732
02:02:16.410 --> 02:02:25.620
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.

733
02:02:25.980 --> 02:02:30.750
Karl Ronn: And so what you saw some of those kinds of incentives that were used they're weak incentives.

734
02:02:31.080 --> 02:02:36.780
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.

735
02:02:37.110 --> 02:02:48.690
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.

736
02:02:49.350 --> 02:02:52.740
Karl Ronn: And so the thought that I have first and foremost, is this.

737
02:02:53.190 --> 02:03:02.610
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.

738
02:03:02.850 --> 02:03:14.640
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.

739
02:03:14.940 --> 02:03:27.870
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.

740
02:03:28.860

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 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.

769
02:08:02.040 --> 02:08:10.320
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.

770
02:08:10.710 --> 02:08:16.440
Anaeze Offodile: For for this House adventure estimation, secondly, and this is obviously the point that Brandt James made out beautifully.

771
02:08:16.710 --> 02:08:27.660
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.

772
02:08:28.290 --> 02:08:40.410
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.

773
02:08:41.040 --> 02:08:55.200
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.

774
02:08:55.860 --> 02:09:05.070
Anaeze Offodile: and minimize friction or sludge in the healthcare setting so we now encourage empower behaviors the map towards healthcare transformation.

775
02:09:06.180 --> 02:09:11.400
Anaeze Offodile: And lastly, I think that data and transparency could be major enablers of customer.

776
02:09:12.390 --> 02:09:25.680
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.

777
02:09:26.370 --> 02:09:41.190

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.

778
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 in the organizational setting the actual focused on government, but actually loved it and so represent here.

779
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.

780
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.

781
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.

782
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.

783
02:10:33.630 --> 02:10:46.020
Anaeze Offodile: relationships and stories I think these two are critical one because the map towards why, but also at its core, we are humans and humans are social animals so relationships.

784
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.

785
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.

786

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.

805
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.

806
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.

807
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.

808
02:14:56.130 --> 02:15:03.360
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.

809
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.

810
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.

811
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.

812
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.

813

02:15:50.820 --> 02:15:57.810
Sachin Jain: We potentially erode our trust with patients and I don't necessarily know that the managed care industry has necessarily taken.

814
02:15:59.850 --> 02:16:10.380
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.

815
02:16:10.830 --> 02:16:27.180
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.

816
02:16:28.230 --> 02:16:40.260
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.

817
02:16:40.590 --> 02:16:50.400
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.

818
02:16:50.850 --> 02:17:10.830
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.

819
02:17:11.970 --> 02:17:23.970
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.

820
02:17:25.080 --> 02:17:30.990
Jim Madara - AMA/VISAC: Thanks station I you know I I hear people say periodically, and you know what is our number one.

821
02:17:32.010 --> 02:17:46.920
Jim Madara - AMA/VISAC: problem that we have to solve and I not infrequently it's getting over that trust issue that's been developing in

the last in the last time, there are a couple of questions that came in one is.

822
02:17:48.030 --> 02:17:56.490
Jim Madara - AMA/VISAC: Talking about the complexity, as the background, and you know interesting to consider how pervasive sludge and inertia or and healthcare.

823
02:17:56.820 --> 02:18:02.730
Jim Madara - AMA/VISAC: manifested administrative waste low value care clinical variability were strong evidence exists.

824
02:18:03.420 --> 02:18:12.120
Jim 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.

825
02:18:12.600 --> 02:18:25.800
Jim 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.

826
02:18:27.030 --> 02:18:35.670
Jim Madara - AMA/VISAC: By culture change policy change payment reform, you know what will take for facilities to place a premium on sledge belstaff.

827
02:18:42.150 --> 02:18:43.200
Jim Madara - AMA/VISAC: Let me look to Carl.

828
02:18:49.740 --> 02:19:01.290
Karl 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.

829
02:19:03.750 --> 02:19:17.400
Karl 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.

830
02:19:18.720 --> 02:19:23.100
Karl Ronn: And, and it needs to be simple, as the first rule.

831
02:19:24.510 --> 02:19:30.420
Karl Ronn: And so I think that's The real issue is, if you see something that's hard, it has to be attacked.

02:20:36.240 --> 02:20:48.090
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.

842
02:20:48.510 --> 02:20:58.170
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.

843
02:20:58.560 --> 02:21:05.700
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.

844
02:21:06.300 --> 02:21:12.990
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.

845
02:21:13.590 --> 02:21:26.190
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.

846
02:21:27.000 --> 02:21:31.560
Jim Madara - AMA/VISAC: So a systems engineering problem that requires this was a kind of you.

847
02:21:32.460 --> 02:21:42.060
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.

848
02:21:44.220 --> 02:21:46.350
Jim Madara - AMA/VISAC: Another question that came in had to do with.

849
02:21:47.400 --> 02:21:57.780
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.

850
02:21:59.670 --> 02:22:08.820

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.

851
02:22:09.510 --> 02:22:24.210
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.

852
02:22:29.640 --> 02:22:30.240
Jim Madara - AMA/VISAC: Satan.

853
02:22:31.230 --> 02:22:37.650
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.

854
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.

855
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.

856
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.

857
02:23:14.790 --> 02:23:20.730
Sachin Jain: You know, and you know change incentives for clinicians as well as patients all at the same time.

858
02:23:21.270 --> 02:23:28.920
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.

859
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.

860
02:23:38.100 --> 02:23:45.240
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.

861
02:23:45.780 --> 02:23:55.170
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.

862
02:23:55.830 --> 02:24:08.010
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.

863
02:24:09.120 --> 02:24:10.170
Karl Ronn: That build on that.

864
02:24:12.090 --> 02:24:23.700
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.

865
02:24:24.240 --> 02:24:36.330
Karl Ronn: 3 ta:7hsaprh.>.i82a82a82a82a8ase2a8hat'a th4 >>B2y is Tlt,7 TD(more most co

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.

878
02:26:30.720 --> 02:26:39.390
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.

879
02:26:40.770 --> 02:26:41.700
Jim Madara - AMA/VISAC: Is the.

880
02:26:42.870 --> 02:26:59.910
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.

881

Anaeze Offodile: We have their inform where we choose to play with better clinical transformation leveraging vmware economics.

888
02:27:59.490 --> 02:28:12.210
Anaeze Offodile: And the criteria could be volume could be dollars could be impact would be equity, but I think that's how you saw break this nut and simplify it by being disciplined in where you direct activities based on data.

889
02:28:13.440 --> 02:28:22.230
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.

890
02:28:22.620 --> 02:28:27.420
Charlene Wong: about what it is we're doing and why and how this is going to benefit which which people.

891
02:28:27.690 --> 02:28:35.220
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.

892
02:28:35.430 --> 02:28:46.200
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.

893
02:28:46.470 --> 02:28:56.640
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.

894
02:28:56.880 --> 02:29:05.610
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.

895
02:29:08.370 --> 02:29:25.170
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.

896

02:29:26.670 --> 02:29:29.610
Jim Madara - AMA/VISAC: Do you do, you have ideas that.

897
02:29:30.690 --> 02:29:36.570
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.

898
02:29:40.500 --> 02:29:44.940
Brent James: it's interesting Jim if I were to name the one thing I think that can make life better.

899
02:29:45.990 --> 02:29:48.420
Brent James: it's to redesign our emr systems.

900
02:29:49.740 --> 02:29:51.060
Brent James: along a clinical line.

901
02:29:52.170 --> 02:29:52.890
Brent James: comes from.

902
02:29:53.940 --> 02:29:57.300
Brent James: I really like that term I hadn't heard of before the idea of sludge in the system.

903
02:29:58.680 --> 02:30:07.410
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.

904
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02:29:1.135.8--

02:32:02.400 --> 02:32:10.860
Brent James: And they are dramatic shifts so I realized that it's it's in clearly in the realm of the doable.

918
02:32:12.270 --> 02:32:18.510
Brent James: You see what I mean this is within our reach, it would be a massive shift though truly massive shift.

919
02:32:19.020 --> 02:32:30.180
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.

920
02:32:31.260 --> 02:32:33.720
Jim Madara - AMA/VISAC: Right, let me, let me ask Kevin.

921
02:32:35.640 --> 02:32:42.600
Jim Madara - AMA/VISAC: to update his thinking, after hearing all these presentations and followed his second one today Kevin.

922
02:32:43.380 --> 02:32:52.230
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.

923
02:32:52.800 --> 02:33:03.150
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.

924
02:33:03.630 --> 02:33:11.130
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.

925
02:33:12.000 --> 02:33:21.630
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.

926
02:33:22.110 --> 02:33:34.320
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.

927

02:33:35.070 --> 02:33:44.640
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

a way, and you know Brent sort of an angular way touched on that in his presentation.

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.

947
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.

948
02:36:36.780 --> 02:36:37.620
Jim Madara - AMA/VISAC: Other comments.

949
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.

950
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.

951
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.

952
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.

953
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.

954
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.

955
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.

956
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.

957
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.

958
02:38:00.390 --> 02:38:05.460

Jim Madara - AMA/VISAC: doing the most unhealthy thing of all sitting for three hours so.

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.

988
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

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.

1006
02:45:48.810 --> 02:45:52.230
Michael McGinnis: And i'm sure there are probably 60 others that.

1007
02:45:53.520 --> 02:45:58.530
Michael McGinnis: have been identified by folks in the audience and on the panels.

1008
02:45:59.730 --> 02:46:03.480
Michael McGinnis: First, was reducing sludge is half the battle.

1009
02:46:04.590 --> 02:46:06.240
Michael McGinnis: Leadership is the other half.

1010
02:46:07.890 --> 02:46:12.330
Michael McGinnis: Second, was in effect assume the best motivations.

1011
02:46:13.890 --> 02:46:17.820
Michael McGinnis: And bread pointed out the importance of autonomy mastery purpose.

1012
02:46:19.290 --> 02:46:25.890
Michael McGinnis: As trump notions in the in terms of human.

1013
02:46:27.030 --> 02:46:29.700
Michael McGinnis: intention, the third was.

1014
02:46:31.230 --> 02:46:33.390
Michael McGinnis: We heard so many times, keep it simple.

1015
02:46:34.560 --> 02:46:48.540
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.

1016
02:46:50.250 --> 02:46:58.020
Michael McGinnis: circumstances in which that's difficult, the fact is

1018
02:47:10.770 --> 02:47:14.430
Michael McGinnis: The four letter word is not just life it's what.

1019
02:47:16.320 --> 02:47:42.060
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 an overarching theme.

1020
02:47:43.170 --> 02:48:05.250
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.

1021
02:48:06.720 --> 02:48:11.190
Michael McGinnis: If we're trying to build a set of.

1022
02:48:12.450 --> 02:48:21.480

1028
02:48:58.380 --> 02:49:13.890
Michael McGinnis: 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.

1029
02:49:15.450 --> 02:49:20.370
Michael McGinnis: In an updated fashion with focus on on transparency.

1030
02:49:22.080 --> 02:49:24.150
Michael McGinnis: On issues related to.

1031
02:49:25.260 --> 02:49:32.670
Michael McGinnis: The the importance of data stewardship and it strikes me and listening that.

1032
02:49:34.260 --> 02:49:41.850
Michael McGinnis: Even though the 10 principles we have now under the learning health system rubric.

1033
02:49:43.950 --> 02:49:44.850
Michael McGinnis: It doesn't.

1034
02:49:46.170 --> 02:49:48.120
Michael McGinnis: don't represent individually.

1035
02:49:49.470 --> 02:49:56.640
Michael McGinnis: A Vision they certainly represent collectively a vision that can be guideposts.

1036
02:49:57.720 --> 02:50:00.990
Michael McGinnis: New ages sludge busters if you will.

1037
02:50:03.150 --> 02:50:14.010
Michael McGinnis: 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.

1038
02:50:14.460 --> 02:50:30.060
Michael McGinnis: 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.

1049
02:52:24.030 --> 02:52:40.410
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.