00:00:00.000 --> 00:00:03.298 Started so I thank you all so
NOTE Confidence: 0.4132323
00:00:03.298 --> 00:00:04.800 much for being here today.
NOTE Confidence: 0.4132323
00:00:04.800 --> 00:00:08.552 I’d like you to join me in welcoming Dr.
NOTE Confidence: 0.4132323
00:00:08.552 --> 00:00:11.320 Manali Patel, who is an associate
NOTE Confidence: 0.4132323
00:00:11.320 --> 00:00:13.440 professor of medicine at Stanford
NOTE Confidence: 0.4132323
00:00:13.440 --> 00:00:15.790 Medicine and a staff oncologist with
NOTE Confidence: 0.4132323
00:00:15.790 --> 00:00:19.520 the VA Palo Alto healthcare system.
NOTE Confidence: 0.4132323
00:00:19.520 --> 00:00:22.000 She earned her medical degree and master’s
NOTE Confidence: 0.4132323
00:00:22.000 --> 00:00:23.746 in public health at the University
NOTE Confidence: 0.4132323
00:00:23.746 --> 00:00:26.158 of North Carolina at Chapel Hill,
NOTE Confidence: 0.4132323
00:00:26.158 --> 00:00:29.180 followed by Internal Medicine residency.
NOTE Confidence: 0.4132323
00:00:29.180 --> 00:00:30.780 Key Monk Fellowship and
NOTE Confidence: 0.4132323
00:00:30.780 --> 00:00:31.980 several research fellowships.
NOTE Confidence: 0.4132323
In addition to obtaining her masters in health services research at Stanford, doctor Patel directs a research program that focuses on improving equitable delivery of value based cancer care. She uses principles of community based participatory research in her work and is the principal investigator of multiple externally funded awards such as the California Initiative to advance Precision Medicine, the patient centered Outcomes Research Institute, and the National Institutes of Health. Her expertise lies in designing, implementing and evaluating new
models of care delivery with academic, community and VA oncology practices aimed to improve patient experiences with care, clinical outcomes and reduce unwanted health disparities, unwanted healthcare utilization and health disparities. Doctor Patel also serves on several national committees focused on improving cancer care delivery and value based care. She is the past chair of the ASCO HealthEquity Committee and the current chair of the ASCO serving the Underserved Task Force.
So Doctor Patel will be delivering the Iris Fisher Lectureship today.
The Iris Fisher Lectureship was endowed by Doctor David Fisher in 1999. Doctor Fisher has been involved with Yale School of Medicine for nearly 60 years. He was the first medical oncologist in the New Haven community and remained in private practice for 30 years before joining Yale’s Cancer Center in 1993 as a volunteer and full time in 1995 when Doctor Fisher’s wife Iris was diagnosed with sarcoidosis and incurable disease of the heart and lungs. Treatment decisions were weighed and balanced against the impact that therapies
00:02:12.702 --> 00:02:15.580 would have on Iris’s personal wellbeing.

00:02:15.580 --> 00:02:17.715 It was Doctor Fisher’s hope that this

00:02:17.715 --> 00:02:19.350 lectureship would serve as a lasting

00:02:19.350 --> 00:02:21.540 memorial to Iris while providing an

00:02:21.540 --> 00:02:23.076 educational opportunity for physicians

00:02:23.076 --> 00:02:25.420 and staff for the benefit of patients.

00:02:25.420 --> 00:02:27.012 We are grateful to Doctor Fisher

00:02:27.012 --> 00:02:27.780 for his generous

00:02:27.780 --> 00:02:29.000 support and we are grateful

00:02:29.000 --> 00:02:30.220 for Doctor Patel for delivering

00:02:30.220 --> 00:02:31.905 this lectureship today. Please join

00:02:31.905 --> 00:02:34.020 me in welcoming Dr. Manali Patel.

00:02:38.520 --> 00:02:40.550 Thank you. I know Michaela from many

00:02:40.550 --> 00:02:43.112 eons ago and so it’s nice to see so

00:02:43.112 --> 00:02:45.514 many familiar faces and also so many new

NOTE Confidence: 0.946962533333333
faces that I’ve known more recently.
And thank you all for joining in person.
I really want this to be more interactive, so please ask questions, interrupt me, push it up against the bar. I really want you to think outside the box and really push me in terms of what I’m presenting today. So I’m going to give a brief background. Of my work and why we started a lot of work and supportive cancer care delivery and then I’m going to focus on multilevel stakeholder engaged research, giving an example in supportive cancer care delivery, which are aspects of palliative care.
care and then focus in on the why.

For me, I love being first.

How many of you all love being first?

We’re all competitive,

so I know many of us want to be first.

I actually don’t like being first.

In the amount that we’re spending

for healthcare.

And why are we last in terms of

our spending for social services?

How many of you all saw this

over the weekend? NPR. Yep.

I see some folks saying yes.

For all that money we are

inputting into healthcare,
why are we doing so poorly?
And many will say, well,
it’s our COVID-19 policies.
I’m sorry, the trend was
beginning long before COVID-19.
And so could it be this longterm
shortchanging of social services?
And then you look at cancer,
which is all of our areas of expertise,
this is completely unsustainable.
How many of you all drive on the highways?
When there’s a pothole that comes out
of the same bucket of congressional
funding as paying for healthcare.
So if utilizing most of the gross domestic
product on healthcare expenditures,
we have limited funding for other social care expenditures, limited funding to fix our roads, limited funding through K through 12 education. You name it. and despite all this money, we are investing into cancer care, especially at the end of life. We see really horrible care. How many of you all have had a patient that was unaware of their prognosis when they were nearing their death? Many of our patients are experiencing undertreated symptoms. We also see this large shift.
and I’ve heard about it.

What you all are building here in this network is actually quite different. But out in the real world outside of Connecticut, we see this huge shift of care from community based settings into these large hospital conglomerates and then we also see tacked on facility charges. So not only is care then centralized. And away from people in their communities. Then it’s also more expensive for the same product. Fascinating. Then my own area of expertise is disparities. We see persistent disparities by socioeconomic status, race,
00:06:19.009 --> 00:06:19.528 ethnicity, demographic characteristics that are largely due to the lack of expenditure for social care services.

00:06:27.010 --> 00:06:28.850 That continue across the continuum.

00:06:34.330 --> 00:06:37.210 Robin Yaborov, good friend of ours, I love this U-shaped curve because it shows you and I know when I walk away they’re not going to be able to hear me on zoom, is that right?

00:06:37.210 --> 00:06:39.098 the American Cancer Society, I love this U-shaped curve because it shows you and I know when I walk away they’re not going to be able to hear me on zoom, is that right?

00:06:42.010 --> 00:06:43.980 it shows you and I know when I walk away they’re not going to be able to hear me on zoom, is that right?

00:06:43.980 --> 00:06:45.055 away they’re not going to be able to hear me on zoom, is that right?
That coincides with when patients have the worst experiences with their care. So not only when they’re becoming diagnosed and going through the flurry of activity during diagnosis with treatments, but then also at the end of life, you see this sharp uprise and it doesn’t matter how long your survival is. And I think she revised this most recently. So the only thing that’s changed essentially, is the Y axis. It’s much more expensive now. How many of you all know of Don Berwick? He challenged us in 2008 and said he was a medpac commissioner and thought about these disruptive
innovations in healthcare.

Why is it that in every other sector, when a new technology is developed, the cost come down, you think about the first iPhone first CT scanner. But in medicine, it tends to be the opposite. We don’t have very many interventions that achieve this whole triple aim of improving population health, bettering patient experiences and reducing total cost of care. You may see some interventions that may do 2 out of the three, but not interventions that can achieve all three.
And he challenged us as a nation and said if we really want to ensure that our population is better overall and that we have some GDP left for social cares. We really have to tackle this cost problem in healthcare, but also think about our interventions such that we’re not decreasing the quality.

I know Makayla knows this, but community based participatory research? Raise hands if you know this about it, okay? I learned a very critical lesson, so I went into medical school at UNC and I’d really hoped to be a global practitioner. And I went into the traditional medical school training and it was right across the
street from the School of Public Health.

But there was little interplay.

I love UNC.

I’m a Tar hill born, Tar hill bred.

When I die, I’m a tar hill dead.

Whether medicine was really in it for me, was there was this lack of focus on prevention, but this huge focus on treatment, and I’m going to talk a little bit later about why potentially that may be in this consumerist society.
And so I did my master’s in public health. I took a year off, right. It was actually a very difficult year in the public health degree space and did my practicum. So as part of your thesis, you have to write up a practicum. And I decided to go back to a community that had worked in as an undergrad and in Honduras. And as one of the key principles of community based participatory research is this understanding that communities know the problem and they also know the solutions. And so as researchers and as
budding medical physicians, we always like to do what I call global tourism. Where we go in, we take our ideas, hey, we have this great idea. We’re going to input it in your system and not really knowing if that’s really what the community needs. And so I thought I would really focus on diabetes, food insecurity, housing and security in this community. But instead I heard from the community Members what the main problem was, was cervical cancer, women dying from cervical cancer.
Now, this was long before the connection with HPV had been made. And what they said was we have lots and lots of women dying from cervical cancer. Makes sense. Now, this was a migrant farm working population. They were coming to areas of North Carolina, going back and transmitting HPB. And thus lots of women were dying and there was no screening. So I came back to the United States and I said, Oh my gosh, what did I get myself into? Right? I know nothing about cervical cancer.
I'm an internist, right, budding internist. So I came back and asked 2 budding OB gine Med students if they would help me and we went back and we heard from the community members and they said how do you screen for cervical cancer? Why can we not provide the screening? What differentiates me as a medical student from community members in the community? How can we?
we don’t have the infrastructure.

We’ve got sticks.

So we made wooden stirrups.

We have headlamps.

And just as easily as we were trained in medical school to conduct PAP smears,

so can community members in their own community be trained.

But who’s going to pay for it?

If you’re really going to make an intervention sustainable, that’s great.
As a UNC practicum, I've got a small bucket of funding. I can come here, do some pap smears, go back. What's going to happen when that funding is gone? The program ends. So to create a sustainable model, you have to engage other people in the community. Where were people going when they were diagnosed with cervical cancer? Well, they weren't diagnosed. They were actually going to the local Planned Parenthood and dying in that facility from symptoms.
from other disease burden, from bleeding.

And all of that cost was being borne by this facility.

Guess what?

I bet they would pay for the number needed to screen to do all of the samples.

Evaluate all the.

Coposcopies and also conduct the Coposcopies now, over 20 years later.

Guess who’s teaching UNC students in the summer how to do Pap smears?

Sustainable model not dependent on us, and the Community knew the solution.

Had I gone in with my own idea,
it would have turned into a very
different project that may have
been completely meaningless.

I went to Stanford. I'm looking at Pam because, you know, Stanford is a silicon.
How many of you all have been to California?
Silicon Valley.
It's like community based participatory research with a twist.
Is this design school?
So many of you have an iPhone, right?
What was ingenious about Stanford, right?
They are always trying to create ways to make money.
So this huge startup culture, they created the school then that would teach people about how to make companies that would get more market share. So you involve the consumers, right? If you have a product like an iPhone, maybe go out and co-design it with the people that would potentially buy the iPhone, such as then you’re going to design a product that’s going to be more applicable to other people, like the people that you designed it with. But if you think about what they do, it’s actually the same concept of listening to consumers and building this out now if you think about supportive
cancer care and trying to achieve. Actually, not even supportive cancer care, but just care in general and healthcare in general. There has to be an alignment of goals and also financial payment models across each of these groups. But where we’re lacking in Healthcare is that there’s always this misalignment. And so I’m going to walk you through one example where we focused in on that. Uptick of EU shaped curve, the right side of EU shaped curve because at the end of life many patients.
are experiencing unwanted acute care use, 
NOTE Confidence: 0.941371686666667
unwanted healthcare expenditures 
NOTE Confidence: 0.941371686666667
at a very high cost. 
NOTE Confidence: 0.941371686666667
So that's low yield if we want to 
NOTE Confidence: 0.941371686666667
try to achieve the triple aim. 
NOTE Confidence: 0.941371686666667
So we started off with this combined 
NOTE Confidence: 0.941371686666667
Amalga rhythm of the design school 
NOTE Confidence: 0.941371686666667
and the community based participatory 
NOTE Confidence: 0.941371686666667
research methods. 
NOTE Confidence: 0.941371686666667
So we asked patients and caregivers, 
NOTE Confidence: 0.941371686666667
which is clearly what you would do 
NOTE Confidence: 0.941371686666667
with community members and CBPR, 
NOTE Confidence: 0.941371686666667
what were the barriers and the 
NOTE Confidence: 0.941371686666667
challenges and what would some 
NOTE Confidence: 0.941371686666667
solutions look like if you were 
NOTE Confidence: 0.941371686666667
to create a system focused on end
of life cancer care delivery that looked very different than the one that you’re currently in. We also did the same with clinicians and then we included a critical piece that we learned from the design school, which was this idea of payers. As well as policymakers. And surprising to me is a wide-eyed, bushy-tailed fellow who was kind of in my little realm, really not thinking about the financial misalignment. What I heard from clinicians and from healthcare systems was
00:16:23.343 --> 00:16:25.436 this is the right thing to do,
NOTE Confidence: 0.938815971428572
00:16:25.440 --> 00:16:27.708 but if we were to reduce emergency
department visits and hospitalizations
NOTE Confidence: 0.938815971428572
00:16:27.708 --> 00:16:29.134 like what Hospice and palliative
care are meant to help with?
NOTE Confidence: 0.938815971428572
00:16:29.134 --> 00:16:31.074 Local concordant care,
NOTE Confidence: 0.938815971428572
00:16:31.074 --> 00:16:37.221 usually patients will choose not to be in
a hospital setting at the end of life.
NOTE Confidence: 0.938815971428572
00:16:37.221 --> 00:16:40.029 There goes our bottom line.
NOTE Confidence: 0.935221825
00:16:40.030 --> 00:16:43.430 And I was shocked, but it made sense.
NOTE Confidence: 0.935221825
00:16:43.430 --> 00:16:48.790 And so we heard from communities that they
wanted to be a part of the product.
NOTE Confidence: 0.935221825
00:16:48.790 --> 00:16:51.523 They want to codesign the product.
NOTE Confidence: 0.935221825
00:16:51.523 --> 00:16:54.250 They are often not involved in
palliative care efforts and we heard
NOTE Confidence: 0.935221825
00:16:54.250 --> 00:17:02.507 from patients that it was easier.
To talk to people in the waiting room about their prognosis and their questions about end of life, cancer care, what questions they should ask. They were getting activated in the waiting room by other people in the waiting room, peers, and they felt less comfortable talking about these issues with their clinicians. And then the clinicians of course said lack of time and also some considerations that palliative care and Hospice weren’t quite. Patients may not quite be ready. And so we have the same players,
same stakeholders.

Create a model where we long before the A/C A in 2012.

We had them design an ideal approach that would align their goals and also would be aligned by financial values.

And what they landed on was training a community health worker.

For a peer support navigator to help them understand concepts of values, goals, preferences outside of our 15 to 30 minute visit in the oncology clinic.

they also had wanted someone to call them.

And again this was long before E pros right? E pros have not been up and running at this point 2009,
by the time we published this right it was many years later, but they wanted people to call them and ask them. About their symptoms rather than reactively calling us when their symptoms were too far advanced. And then again, before the COVID pandemic, we heard that and had talked with individuals in Australia and the UK who were receiving chemotherapy on mobile vans. Yet what we’re doing in the United States is we’re centralizing care and actually removing sites that may potentially
be more convenient for patients.

You could leverage telemedicine and deliver.

Low risk chemotherapeutics in essentially rooms that are half the size, quarter of the size, which is what was also being done in parts of Nebraska in the VA with a telemedicine oncologist that was leveraged in to ensure no complications and now that makes less disruptive. But at the time this was really a no go. Many people thought that the third model was really not very idealist, it was a little bit too idealistic. And so we decided to test this. What we heard from clinicians was
we need to see a randomized control trial before we’re willing to engage in any of this work.

And so this was essentially our framework was if you were to remove many of the barriers in the yellow, potentially you could get to improving patients, understanding about advanced care planning. You could also improve symptom management by proactively reaching out to patients. And then hopefully ultimately improve goal concordant care, which many of you know is hard to measure. Many in the palliative care space,
there’s a lot of debate about measurements of goal concordant care and how one would do that given the fact that goals change so often and you certainly can’t measure it once patients have already passed away. And the surrogates may be able to help you, but it’s really unclear so that this idea of being able to achieve goal concordant care is really addressing something that may be hard to measure. And so we tried again as a fellow, I thought, let’s test all three together. But I already told you, most people said no way to the last one.
Like telemedicine.

What, on a mobile van?

No way. Right?

We’re not giving chemotherapy in places that are not in our infusion center.

But shockingly, I also heard from places that we are not going to have a lay health worker, community health worker talk to our patient about what a surrogate decision maker is. We don’t want anyone to talk to our patient about advanced care planning. You’re going to remove hope. And so we also got a lot of pushback on even testing the Community health worker.
advanced care planning intervention.

So I thought, well, let’s split up the model. We’ll test each one individually and we’ll go to a place that’s more integrated. So the VAI was a clinic clinical fellow there and really never thought about having a fulltime VA job. But what I was really shocked by is many of the innovations happen in the VA telemedicine. We’ve been using it for decades in the VA. Many of our packed models of utilizing peer support were developed at the VA and you can get innovations if you pair with operations,
you can really jumpstart these out-of-the-box clinical ideas and get them into practice very quickly. And there’s also this alignment of finances because they serve as a pair. So there was a desire by the VA. To improve not only veteran experiences, to improve their health outcomes, but also to lower costs. So there was a clear alignment and they said yes, let’s do it. So we trained this lay health worker to conduct a series of segments either by telephone or in person with patients. And so the first segment was really
just discussing and developing rapport.

The next few segments over time it was a six month intervention would be about.

Tailored messaging about goals and values and preferences and giving people the time they need to make these decisions. So that means starting way upfront from when people were actually having conversations about this at a point which made some oncologists very uncomfortable. Discussing this is part of usual care and the last was helping patients.
With advanced directive completion.

Completion of documents like the Stanford letter project, developed by BJ Perry Acoyle using Sudor Rebecca Sudor’s work, but really ending up really completing those documents but also getting the tailored support they needed. And it’s easier.

If you just hear this, let me see. Not sure how the video will work? Let me see if I can.
00:23:49.720 --> 00:23:51.200 Is there anyone that can help? Do you
NOTE Confidence: 0.8463328
00:23:53.720 --> 00:23:55.397 think anyone can help me with the video?
NOTE Confidence: 0.936899133333333
00:24:07.760 --> 00:24:08.318 What was that?
NOTE Confidence: 0.93773775
00:24:11.360 --> 00:24:12.320 This one? The right
NOTE Confidence: 0.9352219
NOTE Confidence: 0.9402536
00:24:19.840 --> 00:24:20.360 Let’s see.
NOTE Confidence: 0.943608066666667
00:24:23.240 --> 00:24:23.918 Is your primary
NOTE Confidence: 0.80452836
00:24:24.040 --> 00:24:25.240 goal to fight parts to
NOTE Confidence: 0.936899133333333
00:24:25.280 --> 00:24:26.276 make sure it’s out of yours?
NOTE Confidence: 0.87069165
00:24:28.200 --> 00:24:28.560 Really, it’s
NOTE Confidence: 0.89369453333333
00:24:29.760 --> 00:24:31.015 your primary goal to fight
NOTE Confidence: 0.89369453333333
00:24:31.015 --> 00:24:32.680 parts to make sure it’s out of.
NOTE Confidence: 0.9100634
00:24:34.760 --> 00:24:34.800 I
NOTE Confidence: 0.9559077777777778
00:24:36.880 --> 00:24:38.770 don’t want to die. Bloomberg meets
NOTE Confidence: 0.9559077777777778
00:24:38.770 --> 00:24:39.880 regularly with healthier checks.
NOTE Confidence: 0.950317
00:24:42.960 --> 00:24:47.160 I’m sharing. I’m sharing the sharing,
if not shared one. That’s that’s sharing and there on the last one. Just click that. OK.

Thank you. You gotta get it again. It came on. No, that’s fine. That’s fine. Just go to share screen. Sure sense. Now you can select the then you go share. Yeah.

Is your primary goal to fight this? To make sure it’s out of your system? I don’t want to die. I got lots of things to do.

Blumberg meets regularly with healthcare.
Coach Laviba shares a compassionate ear with patients, providing the big picture to help them think about how cancer treatment will fit in with the way they want to spend the rest of their lives. Can I learn a little bit more about what you want to do? Well, I wanna do some more traveling. I wanna spend time with my kids getting a little emotional. What are they getting from you that they don’t get from anyone else? Well, they are getting someone who’s actually helping them through their care.
With me they’re actually discussing things. What they’re feeling, what they’re going through, what they want to do, 

I just decided not to go through the treatment patients like 47 year old Raphael Arias, a former army police officer. Arias is suffering from a recurrent sarcoma and has already lost a leg to cancer. Right now we just trying to do something so all I can.
Why have you decided not to have?

Chemotherapy made me sick and within a week we had to stop it.

So as difficult as it was, I just decided not to go through with it.

You want to have the highest quality of life for as long as you have life?

With a little bit of time that I have left, my wife and I have plans of maybe doing some things before my departure.

is your primary goal.

And that was essentially a 7 minute flip. So Al Jazeera America had heard what we were doing and before we had any results back,
they thought it was so fascinating that someone who is not trained medically. Was having what would otherwise be considered a medicalized conversation with patients. Why do we medicalize these conversations? Patients really do need the time to be able to engage in this work. And while I’ve had clinical equipoise as to whether or not it would work, we certainly knew that there were facets like these stories where she had spent so much time with patients who would have otherwise in my clinic, had received chemotherapy and gone through with it.
What patients then said was we didn’t want to disappoint. Doctor, so and so it’s very multi, it’s very complex and so we decided to test this in a randomized trial. We heard from oncologists that we were potentially causing harm and we had to dispel that myth. So we wanted to see if it was feasible, can we improve goals of care conversation. So we randomized patients stage three and stage four disease also with recurrence of cancer agnostic to.
NOTE Confidence: 0.946962473333333
00:28:46.855 --> 00:28:48.698 disease into this intervention that
NOTE Confidence: 0.946962473333333
00:28:48.698 --> 00:28:51.113 you just saw clips of versus usual
NOTE Confidence: 0.946962473333333
00:28:51.113 --> 00:28:53.848 care and we measured goals of care
NOTE Confidence: 0.946962473333333
00:28:53.848 --> 00:28:55.976 documentation as well as patient
NOTE Confidence: 0.946962473333333
00:28:55.976 --> 00:28:58.694 experiences and total cost of care.
NOTE Confidence: 0.946962473333333
00:28:58.700 --> 00:29:00.240 We randomized 213 patients
NOTE Confidence: 0.946962473333333
00:29:00.240 --> 00:29:01.780 in this consort diagram.
NOTE Confidence: 0.946962473333333
00:29:01.780 --> 00:29:03.985 You see 100 and 805 respectively in
NOTE Confidence: 0.946962473333333
00:29:03.985 --> 00:29:06.179 the control group in the intervention.
NOTE Confidence: 0.946962473333333
00:29:06.180 --> 00:29:07.720 It was blocked randomized
NOTE Confidence: 0.946962473333333
00:29:07.720 --> 00:29:08.875 by cancer diagnosis.
NOTE Confidence: 0.946962473333333
00:29:08.880 --> 00:29:09.978 And because it was in the
NOTE Confidence: 0.946962473333333
00:29:09.978 --> 00:29:11.319 VA and we had claims data,
NOTE Confidence: 0.946962473333333
00:29:11.320 --> 00:29:13.360 we could conduct an intent to treat analysis.
NOTE Confidence: 0.946962473333333
00:29:13.360 --> 00:29:15.598 So despite loss of follow up,
NOTE Confidence: 0.946962473333333
we were actually able to complete the entire ITT for the patients that were initially randomized. And what we found was shocking to me. This is goals of care documentation by the oncologists, many of whom were opposed to this model, many of whom didn’t even know that it was happening. It was in the background. No interaction between the Community health worker, lay health worker and the oncologist, but yet patients were being activated to tell their physician, I don’t have the goals of care
document and can you print it out
because the community health worker
was helping to engage patients in
telling patients saying if your
oncologist doesn’t bring it up,
you need to bring it up.
And we found that this also led to
improvements in advanced directives.
As we anticipated,
if you have tailored assistance,
you’re more likely to be able to complete
the advance directive documentation.
And this changed over time.
We had to dispel the myth that
because you have an advance
You can actually change it.

So it’s a living, it’s meant to be a living document.

And so we would update the advance directive as People’s Life course changed.

We found that patient satisfaction went up. This was using the consumer assessment of healthcare providers and healthcare systems General survey.

The question of would you recommend care on a scale of zero to 10? How satisfied are you with your clinical team? 10 being a very high satisfaction, 0 being low satisfaction and what we
found over time in the blue line is that the intervention group improved and the control group decline. We did not cause harm. So unlike Jennifer Tumels model, we improved palliative care. We didn’t find a survival benefit, but we dispelled the myth that we were making people die faster. But what we showed was at the end of life there was better care, 95% reduction in acute care use, almost doubling of Hospice utilization and the baseline in the BA is high as you know.
because we can provide Hospice concurrently with care.

Why that’s not closer to 100%.

There are many issues, but we were able to actually double that to close to 100%.

And we found in the last month of life not only were total cost, median total cost lower, but you see that variation. This is amazing to me is how narrow that variation is. You’ve removed the outliers 1 outlier, 1 outlier can do you in.

That variation is really what we want to try to improve upon.
And so at the same time, I wanted to test the symptom management model, right, the Community health worker conducting this proactive symptom assessments. It wasn’t a novel idea. Kurt Kerlan Key and the VA had been conducting this with a nurse. What was novel about it is that you would have a lay health worker, community health worker conducting this. It was novel at the time because we really had very limited proactive reach out to patients across the United States to assess symptoms.
And so I went to Southern California and interestingly enough I had been giving presentations about this model hoping that we would find pilot test partners. Most of the time I got the door slammed in my face. Again was was before the A/C A, so payers did not want to be involved in something that seemed like thanks to Sarah Palin going to death panel. Even though we had payers at the table designing the model, they did not want to be involved in it. And so care more the woman that was in charge of care more at the time, laviba, she ended up having breast cancer.
And so this story resonated with her on a personal level. And she said, look, if you can find an oncology practice that’s willing to help, we will do one piece of your model. Actually, we’ll do the advanced care planning. We didn’t have the data from the VA because it was at the same time, well, we found an oncologist practice that was willing to do the symptom management piece.
Again did not want to have anything to do with the advanced care planning and they said we need a per member per month fee to do this. This was before OCM, the oncology care model, which now reimburses or had been reimbursing for some of these services and now there’s a new OCM. So this was before that time and it was kind of unprecedented for a payer to be providing a lot of this upfront payment to many of these practices. And then we did a back of the envelope calculation and there is a misalignment. All this work that we do in our clinics
to try to save patients’ symptoms,
try to improve their symptoms,
it’s going to reduce emergency department visits and hospitalizations.
And if it’s not an integrated system,
you’ve input a lot of effort into something that you’re getting no reimbursement for as a practicing oncologist.
So we took that model to care more and said,
look, you’re getting this much,
if it were to work, which we think it will,
you’re going to get X percentage, right?
We think that we’re going to save 20% net implementation costs.
So if we think that you’re
going to save the money,

it’s important that you pay for the intervention.

And we’re going to make it a low cost intervention using lay health workers,

not a nurse sled model.

And you can create a shared savings model where a third will go back to the patient,

1/3 will go to the clinical team and a third will go into you.

And they agreed the oncology practice then had one more negotiation.

They wanted all market share.

Every beneficiary from this Medicare Advantage group was going to go singly in Fullerton to this one clinic.
Care MORE agreed, so we tested it. Lay health worker was embedded, paid for by care more advantage, Medicare Advantage embedded in the clinic, did weekly phone calls with patients. Initially we started with patients that had advanced stages and then we moved more upstream to patients with all stages after a couple of years because the clinic really liked it. And we showed in two they would review symptoms using esass, how many of you all know esass Edmonton Symptom assessment system,
00:35:45.720 --> 00:35:47.688 it’s a scale of zero to 10 with multiple symptoms.
NOTE Confidence: 0.93019013
00:35:49.000 --> 00:35:49.918 I think there’s nine or ten.
NOTE Confidence: 0.93019013
00:35:49.920 --> 00:35:52.896 And then there’s also another category 10 being worse symptom symptomatology.
NOTE Confidence: 0.93019013
00:35:52.896 --> 00:35:55.360 And sympto burden 0 being less symptoms.
NOTE Confidence: 0.93019013
00:35:55.360 --> 00:36:00.550 And what we found was essentially for patients and we built this.
NOTE Confidence: 0.93019013
00:36:00.550 --> 00:36:02.417 into the protocol that any score of four above or that changed by two points from that assessment.
NOTE Confidence: 0.93019013
00:36:02.417 --> 00:36:04.175 Would then get triaged and reviewed with a nurse practitioner.
NOTE Confidence: 0.93019013
00:36:04.175 --> 00:36:12.230 The nurse practitioner, FTE was also covered by the payer.
NOTE Confidence: 0.938815971428571
00:36:10.580 --> 00:36:13.226 And then we decided, wait a minute,
the nurse practitioner is reviewing all of these symptoms. Let's build out an automatic referral with waived prior authorization. Because we're working with the payer, we can do that. For symptoms that are escalating, they would go directly to palliative care and bypass the nurse practitioner review. Or they would go to the behavioral health services because we were also screening for anxiety and depression in a cohort study of 800 patients.
were receiving intervention versus a match cohort in the year prior.

We found for Edmonton symptom Assessment System survey assessment tools that essentially the main scores reduced over time. In this 12 month intervention the control group went up. And we also found, not surprisingly, better anxiety and depression, no harm. So we also can’t replicate Ethan Bosch’s work. But we did find, again, very similar reductions. And again, this was for all patients, not just patients with advanced stages.
but reductions in acute care use and reductions in total costs of care. And for the cohort of individuals that had died, we found very similar findings as the VA where at the end of life it was better care, better experiences and lower total cost of care with again drawing your attention to the variation in cost. And so we just finished randomized trial of both interventions. So layering the advanced care planning and the symptom management,
which is always how it was supposed to be.

Right. You can’t keep people out of the hospital if you’re not.

And that may be their goal if they’re not adequately and appropriately managed for their symptoms.

So they really go hand in hand.

And so we conducted a randomized trial.

Now this was a different patient population.

It was privately insured.

So we did it in the VA with advanced care planning.

Intervention with the Medicare Advantage group was mostly older Hispanic Latinx adults.

In Fullerton, CA and here now,
it was a younger population that were privately insured.

We randomized in the acute care use and the healthcare use goal was our primary outcome. We randomized a total of 128 into the intervention and conducted an ITT and we found, lo and behold, even better reductions in acute care use. And this was not just at the end of life, this was at 12 months. I think there was a very small proportion of patients that had actually died in this study. And so consistently we found robust
effects that were consistent across multiple studies.

And better yet, we also found that there was a net savings where a lot of interventions like I talked about before tend to not save money. They may be effective, but they may not save money is because your implementation inputs are too expensive. But we had a very low cost, high touch.

Patient centered solution that utilized perhaps people that can reach patients better than we as clinicians can and that was a tough pill to swallow. I think for many of us that think we are
the greatest thing next to slice white bread,

but we really do.

It takes a team and what it did was it enhanced provider relationships with their patients.

So we have another study where we looked at across all the stakeholders what their experiences were.

And we pulled the oncologist across 12 different sites and overwhelmingly many have chosen to continue utilizing this model because of the benefit for not having to do when your patients are better managed from a symptom perspective,
00:40:16.600 --> 00:40:19.582 you get that opportunity to really connect
NOTE Confidence: 0.94830443
00:40:19.582 --> 00:40:22.240 with patients on a different level.
NOTE Confidence: 0.94830443
00:40:22.240 --> 00:40:25.208 And so many of you know that equity is,
NOTE Confidence: 0.94830443
00:40:25.208 --> 00:40:28.440 is really why I went to medical school.
NOTE Confidence: 0.94830443
00:40:28.440 --> 00:40:31.640 And taking evidence based interventions
NOTE Confidence: 0.94830443
00:40:31.640 --> 00:40:33.860 and plugging and chugging them into
NOTE Confidence: 0.94830443
00:40:33.860 --> 00:40:36.556 community settings is not a one size fit all.
NOTE Confidence: 0.94830443
00:40:36.560 --> 00:40:38.760 So a labor union organization
NOTE Confidence: 0.94830443
00:40:38.760 --> 00:40:40.080 called Unite here,
NOTE Confidence: 0.94830443
00:40:40.080 --> 00:40:42.474 how many of you have heard of unite here?
NOTE Confidence: 0.94830443
00:40:42.480 --> 00:40:43.416 Oh great.
NOTE Confidence: 0.94830443
00:40:43.416 --> 00:40:45.756 So unite here essentially provides
NOTE Confidence: 0.94830443
00:40:45.756 --> 00:40:48.351 a labor union organization for
NOTE Confidence: 0.94830443
00:40:48.351 --> 00:40:50.559 hourly low wage workers.
NOTE Confidence: 0.94830443
00:40:50.560 --> 00:40:53.800 At McCormick we all go to McCormick.
NOTE Confidence: 0.94830443
00:40:53.800 --> 00:40:54.793 Most of us,
many people that work in McCormick are part of this union. Hotel workers, casino workers, restaurant workers, taxi drivers. And unfortunately because they are hourly wage workers, they don’t have health benefits. So as part of the Union, what they decided was that they were going to skim off a very tiny fraction of people’s paycheck and put it into a health fund. And so the health fund really wants to provide high value care, meaning very high quality at low cost.
And they have the Union backing them, right?

They’re part of the union.

The Union is very much trust unite your health.

There’s this engender trust because it’s one and the same.

And so they had heard of the work and they knew that at the end of life for many of their hourly low wage workers, they were having poor experiences, especially as they were dying.

And so they asked us if we could embed our model.

And I’m glad I did that public health degree because I took a step back and said, Okay, well, let’s,
let’s see how we would embed this model in your population. So we created a Community Advisory Board. So I pulled people from Atlantic City and Chicago, as well as the Union members and the Union President. And can someone take a wild guess as to what a patient told me when I talked about this intervention about a community health worker, a healthcare advocate, reaching out to them to talk about advanced care planning? I didn’t know either.
00:42:26.442 --> 00:42:27.707 I was actually very shocked.
NOTE Confidence: 0.927098317777778

00:42:27.710 --> 00:42:30.531 What they said was you try having
NOTE Confidence: 0.927098317777778

00:42:30.531 --> 00:42:32.465 a conversation about goals of
NOTE Confidence: 0.927098317777778

00:42:32.465 --> 00:42:34.330 care when you’re worried about
NOTE Confidence: 0.927098317777778

00:42:34.330 --> 00:42:36.640 where your family is going to
NOTE Confidence: 0.927098317777778

00:42:36.710 --> 00:42:38.694 live and how you’re going to get
NOTE Confidence: 0.927098317777778

00:42:38.694 --> 00:42:40.909 food on the table for your family.
NOTE Confidence: 0.927098317777778

00:42:40.910 --> 00:42:43.017 You’re asking me to do something that
NOTE Confidence: 0.927098317777778

00:42:43.017 --> 00:42:45.547 I think is going to hasten my death.
NOTE Confidence: 0.927098317777778

00:42:45.550 --> 00:42:49.510 Then who is going to provide for my family?
NOTE Confidence: 0.927098317777778

00:42:49.510 --> 00:42:50.150 Eye opener.
NOTE Confidence: 0.936899133333333

00:42:52.300 --> 00:42:56.150 So guess what, we tabled the
NOTE Confidence: 0.936899133333333

00:42:56.150 --> 00:42:58.808 intervention and we focused on
NOTE Confidence: 0.936899133333333

00:42:58.808 --> 00:43:01.293 addressing health related social needs.
NOTE Confidence: 0.936899133333333

00:43:01.300 --> 00:43:02.236 We integrated that.
NOTE Confidence: 0.936899133333333

00:43:02.236 --> 00:43:04.420 We didn’t table the advanced care planning,
but we integrated the health related social needs first and foremost and we used community engagement to build partnerships with industry.

One issue is transportation. How are people going to get to and from their clinic visits? Lift can provide free transportation, better value, better quality, lower cost.

If people are adhering to their treatments, people have no place to live. Local Housing Authority let’s build in places for people to live while they’re getting care.
Let’s think about ways to invest in social care, because then as an organization, you, not your health, has. Individuals with lots of diseases, not just cancer. Cancer is 1 slice. If we invest in social services, we are likely going to do better for not only our Members but also reduce costs. And so we built this in and then we also heard from unite your health that there were some crooked groups and some ecologists, that perhaps we’re not providing the highest and most evidence based care for patients. And that is an area of research for me where we know patients by race and ethnicity,
socioeconomic status,

where you go determines the care you get.

And so making for example,

the Yale out in the community is a fantastic idea because providing evidence based care is a way to overcome many of the disparities.

It’s not due to patient level factors.

It’s actually due to what people are receiving once they’re diagnosed.

And now we’ve shown study after study after study that if you get the care that you need and the care that’s evidence based,
your outcomes are the same,  
if not better, then more white,  
more affluent white individuals  
and so we picked through.  
I went through their claims,  
I went out to Atlantic City in  
looking over claims data and tried to  
identify the highest performing providers.  
And in Atlantic City there was  
an MD Anderson clinic.  
It was very costly but it also  
provided evidence based care.  
And so the union said Okay Manali,  
redesign, let’s redesign the benefits.
Okay, what do we need to do?

And I said let’s not reduce market share.

People want a choice.

I want a choice when I’m diagnosed with cancer and that’s what we heard from the Community Advisory Board, you want a choice of where to go, but so don’t remove the choice.

So let’s waive copays for people that choose to go to MD Anderson in the clinic in Chicago,
your copays or waive, you still have choice, but you also get additional funding. If you choose to go to this, you know you have less out of pocket costs. So as part of this study, the Union asked us to do a randomized trial, which was actually very shocking to me. But they really wanted answers quickly and so we randomized patients, they would everybody got that free benefit of free cancer care services. So as part of usual care, every patient received that extra benefit of waiving costs. But every all the other patient
population that were randomized received the added benefit of the Community health worker screening for health related social needs, conducting advanced care planning and symptom management. We randomized 160 across Atlantic City and Chicago. And this just goes to show, I don’t want to go over all the details, but a very different patient population, younger patients, more females, high proportion of Latinx, black patient populations and Asian subgroups. Which made us have to translate all.
of these documents and to also hire a lot of Community health workers from communities that spoke the patient’s preferences of language and that was costly. Unite your health, did it. Again, very low annual household incomes and very low educational attainment and what we found using the functional assessment of cancer therapies general, was that patients health related quality of life improved. Makes sense. If you’re screening for health related social needs, you’re likely going to have better quality of life.
How much of this was from the other interventions is what I get asked all the time. Why does it matter? Shouldn’t we be doing this in our practice? I think so. And parsing out one piece from the other doesn’t really make sense, especially when you think about the patient population. And then if you look at the similar reduced reductions in emergency department use in hospitals, but you see that the higher there’s a higher mean with this patient population, very complex patient population utilizing acute care services more so.
than patients in our other studies.

But over all stages, so again this was all stages of cancer,

I guess 12 month intervention, we found reductions in total cost of care.

Is this scalable? We're now launching a 24 site cluster randomized control trial.

To me doing usual care is kind of unethical.

We know that palliative care in these services work.

So comparing to usual care is really kind of a no go for me anymore.

And so we've now started embedding technology delivered tools where the Community
Health worker uses in her interactions, his or her interactions with the patient, the patients will receive passively in the control group. And I also want to make sure that we've got every single type of facility where people receive care included. So we've got community practices, we've got integrated systems, we have the VA academic systems and also our safety net hospital systems. Years later, Don Berwick wrote another article and I'm almost done so we can take questions in 2023, if you all have time.
00:49:14.610 --> 00:49:15.570 Just a couple of months ago,
NOTE Confidence: 0.945581211176471
00:49:15.570 --> 00:49:17.460 I would love for you to pick up that
NOTE Confidence: 0.945581211176471
00:49:17.460 --> 00:49:18.706 article and juxtapose it against
NOTE Confidence: 0.945581211176471
00:49:18.706 --> 00:49:21.940 what he wrote in 2008 because
NOTE Confidence: 0.945581211176471
00:49:21.940 --> 00:49:24.690 it’s very sobering, sombering.
NOTE Confidence: 0.945285228333333
00:49:27.400 --> 00:49:28.970 Even the title the existential
NOTE Confidence: 0.945285228333333
00:49:28.970 --> 00:49:31.440 threat of greed in the United States,
NOTE Confidence: 0.945285228333333
00:49:31.440 --> 00:49:34.160 United States healthcare system.
NOTE Confidence: 0.945285228333333
00:49:34.160 --> 00:49:37.160 And in that article, it makes me question,
NOTE Confidence: 0.945285228333333
00:49:37.160 --> 00:49:40.317 are we going in the wrong direction?
NOTE Confidence: 0.945285228333333
00:49:40.320 --> 00:49:42.519 Is it worsening?
NOTE Confidence: 0.945285228333333
00:49:42.520 --> 00:49:44.476 Because now we see how many
NOTE Confidence: 0.945285228333333
00:49:44.476 --> 00:49:47.034 of you all have seen what ASCO
NOTE Confidence: 0.945285228333333
00:49:47.034 --> 00:49:50.990 has done for Wellness burnout.
NOTE Confidence: 0.945285228333333
00:49:50.990 --> 00:49:52.598 Of course our ask the President
NOTE Confidence: 0.945285228333333
00:49:52.598 --> 00:49:53.353 knows you closure ears.
When I used to want to talk about this, if we don’t get at the root of the problem, everything else is a Band-Aid. The problem is the healthcare system, the way that it’s financed. I did not go into medicine to be a paper pusher and to argue with payers about prior authorization for services that I know work, nor did I go into medicine to make a huge buck. To make a huge buck. And I know that may be different, but I also don’t think that as a society, capitalizing off of people when they’re sick is where we want.
00:50:30.176 --> 00:50:31.500 to go or where we should go.
NOTE Confidence: 0.946962533333333
00:50:33.580 --> 00:50:34.819 And now hospices
NOTE Confidence: 0.81065308
00:50:36.940 --> 00:50:41.891 sadly profiteering why
NOTE Confidence: 0.81065308
00:50:41.891 --> 00:50:44.246 this is shocking to me.
NOTE Confidence: 0.81065308
00:50:44.250 --> 00:50:47.225 It’s really not because we’re part of
NOTE Confidence: 0.81065308
00:50:47.225 --> 00:50:49.420 the American ecosystem where there’s
NOTE Confidence: 0.81065308
00:50:49.420 --> 00:50:51.970 this desire to want to capitalize,
NOTE Confidence: 0.81065308
00:50:51.970 --> 00:50:53.090 but it really makes our,
NOTE Confidence: 0.81065308
00:50:53.090 --> 00:50:54.806 our jobs harder as physicians to
NOTE Confidence: 0.81065308
00:50:54.806 --> 00:50:56.931 think about what we were trained in
NOTE Confidence: 0.81065308
00:50:56.931 --> 00:50:58.767 medical school not to think about,
NOTE Confidence: 0.81065308
00:50:58.770 --> 00:51:01.608 but it’s impacting all of us.
NOTE Confidence: 0.81065308
00:51:01.610 --> 00:51:02.726 This is the why for me,
NOTE Confidence: 0.81065308
00:51:02.730 --> 00:51:04.314 why do I keep going even
NOTE Confidence: 0.81065308
00:51:04.314 --> 00:51:05.978 though it seems like, you know,
NOTE Confidence: 0.81065308
00:51:05.978 --> 00:51:07.595 the system is a big wave
and crashing us all over? I really don’t feel that way. I'm actually still bright eyed and bushy tailed and naive. How many of you all know Paul, humanitarian. And for me, this is the why health really is a fundamental human right. It’s not something that we if we live in the right neighborhood, live in the right neighborhood, we may or may not be able to
00:51:37.187 --> 00:51:38.698 attain our highest health possible.
NOTE Confidence: 0.93773775
00:51:43.000 --> 00:51:45.640 And why also is because we see change.
NOTE Confidence: 0.93773775
00:51:45.640 --> 00:51:47.120 The A/C A was huge,
NOTE Confidence: 0.93773775
00:51:47.120 --> 00:51:49.160 opened up the door to being able to
NOTE Confidence: 0.93773775
00:51:49.160 --> 00:51:51.197 take away this idea of death panels.
NOTE Confidence: 0.93773775
00:51:51.200 --> 00:51:53.636 We actually get reimbursed for having
NOTE Confidence: 0.93773775
00:51:53.640 --> 00:51:56.022 conversations that should be part of
NOTE Confidence: 0.93773775
00:51:56.022 --> 00:51:58.800 the fabric about how we deliver care.
NOTE Confidence: 0.93773775
00:51:58.800 --> 00:52:00.102 But also remember that site that
NOTE Confidence: 0.93773775
00:52:00.102 --> 00:52:01.841 I told you in Fullerton that said
NOTE Confidence: 0.93773775
00:52:01.841 --> 00:52:03.479 no way to advance care planning.
NOTE Confidence: 0.93773775
00:52:03.480 --> 00:52:04.764 We’ll do the symptoms stuff if
NOTE Confidence: 0.93773775
00:52:04.764 --> 00:52:06.399 you give us a bunch of money.
NOTE Confidence: 0.93773775
00:52:06.400 --> 00:52:11.027 They now are advertising on their website.
NOTE Confidence: 0.93773775
00:52:11.030 --> 00:52:13.242 This program is part of one of
NOTE Confidence: 0.93773775
00:52:13.242 --> 00:52:14.475 their critical services and
care more decided to pull out.

They said we're not paying for it anymore.

But guess what?

This oncology group is continuing with it now and has expanded across three states.

A couple of months ago,

we trained all of the health advocates across the United States, Las Vegas, New York, Boston, the food industry,

they were all trained on this model and.

I firmly believe in advocating policy change.

We always forget about the outer bucket.

But it's so important to think
about how to advocate for change.

So with community partners, we were knocking on the door in Sacramento every month saying community health workers need to be reimbursed. And so now, as of July, the work that my community members and Community health workers are doing are now reimbursed.

And for me it really is people over profits.
And I think all of you in this room, because you came to this talk number one, really believe the same thing when you think about the people at the table. We’ve got the governor’s office, you can see the big capital, we’ve got the county. Department of Public Health, you think about who’s at the table, who even knows that a table exists and who’s not there, who may not know that the table exists. Bring them all together and you can create sustainable interventions like I talked about in Honduras.
And that's it.

That's a wrap.

We have a couple time. This is our lab.

And so if anyone wants to check it out,

please, we've got a bunch of other

studies ongoing and then certainly

some questions. Yes, in the back.

Oh, thank you Sir.

One of the beauties of

community that expresses

the support you said really get to vote yes

really the whole 1000 importance of that.

Did you identify any particular cultural

barriers and or facilitators within

the community that she’s engaged with?

Very good question.
So the question, did everybody hear that maybe for online folks, the question was did you with community based participatory research really knowing the communities and if we identified any cultural barriers or facilitators in the communities that we identified with. So yes, and I’m really glad that you asked that question because there were some considerations especially among some of the Asian patient populations about. Patients may be potentially not wanting to engage in discussions,
but that their caregivers would.

And so we expanded the intervention to allow for cultural humility.

If that is how that is in their family, who am I to say I want to talk directly about what the patient wants? That is how and especially in my family, the same goes in my family.

We want the patient to be engaged, but is that how, if that’s how they’ve set up. And that’s how they’ve been in the fabric of their culture.

We should try to begin to tweak
our interventions again, using that same concept of not going in with blinders, of thinking that this is the way this intervention should be, but rather thinking about how to codesign the discussions. Facilitators was faithbased, so in Atlantic City we found community partners that were faithbased organizations across multiple demographic groups. Who really came to charge and would talk about filling out five wishes? In their sermons on Sunday?
We found Hindu priests discussing advanced care plan and we provided them with the materials and so they expanded that reach and normalized these conversations long before we had to even engage. Very good question. Did that answer some of your questions?

I mean the technology, you never go by higher funding costs. Yeah. How do we change capitalistic model we see in there versus every other technology sector? Like why are they so different?
how do we kind of break the picture?

Good question.

So the question was why, you know, in the technology sector there’s this desire. Please correct me if I’m wrong there.

Essentially you can. Make products that can then lower costs.

But in the healthcare sector, we haven’t come together to align.

because it’s misaligned incentives. If you think about the different players, we haven’t come together to align.

Consumers really drive change.

And So what we really need to do is galvanize like we are in these communities.
and start thinking together and collectively about how to change that. You know, I hate to go there, but a universal payer system, you see how it works in the VA. And there are challenges that every study we’ve done in the VA and outside the VA shows that people within the VA have less disparities when they get care within the VA system. And now with the Mission Act that allows our veterans to receive care in community based facilities, we see that when they use community based facilities, their outcomes are worse. It is a way to financially
incentivize and to align goals, not to be a reductionist, but that’s one example.

A comment and a question. So the comment is that I worry a little bit about putting patients in the middle of the cost situation, partially because the costs are in many ways artificial. And I think the real solution is of course that we should have coverage for everyone and and then we should work on figuring out the cost. The and I fear that some people will just say that’s just too much.
money for me and for maybe the wrong reasons choose not to get care.
The question I have though is to what extent? I know in at least one of the studies there wasn’t interaction between the Community health worker and the medical team. To what extent in other situations have you had? Contact between those two, yeah I actually that’s a good question. So the question was to what degree does the Community health worker engage with the clinical teams. I think in the ideal scenario you want a highly functioning team.
where there is communication across both and the majority of the sites have chosen that even if they haven’t chosen that initially they’ve come around to really engaging the community health workers part of the team. Where we’ve seen struggles is in that example in Atlantic City and Chicago where the oncologist really did not want to be involved at all. And so we said, Okay, we’re going to do it with the payer alone and there was limited communication, but we also want to make it such that patients are activated.
These interventions, the proactive symptom assessment, I think should be longitudinal, but the advanced care planning, you really want to give patients the tools to be their own advocate. And so in those situations and most of our studies are really just limited with that intervention you see, which I didn’t show is an enduring effect of the intervention long after the intervention has ended. And so we, we just looked at the VA study now 10 years later and we found actually really big differences at the end.
NOTE Confidence: 0.946004114285714
01:00:07.649 --> 01:00:09.679 of life for the patients that died,
NOTE Confidence: 0.946004114285714
01:00:09.680 --> 01:00:11.585 perhaps indicating that the skills
NOTE Confidence: 0.946004114285714
01:00:11.585 --> 01:00:13.490 that patients were learning are
NOTE Confidence: 0.946004114285714
01:00:13.549 --> 01:00:14.817 like riding a bicycle.
NOTE Confidence: 0.946004114285714
01:00:14.820 --> 01:00:16.934 You want patients to activate for themselves.
NOTE Confidence: 0.946004114285714
01:00:16.940 --> 01:00:18.566 And so in those situations where
NOTE Confidence: 0.946004114285714
01:00:18.566 --> 01:00:20.159 we don’t have the Wellfunctioning
NOTE Confidence: 0.946004114285714
01:00:20.159 --> 01:00:21.979 team in the communication,
NOTE Confidence: 0.946004114285714
01:00:21.980 --> 01:00:24.116 we have the Community health worker
NOTE Confidence: 0.946004114285714
01:00:24.116 --> 01:00:25.946 activate the patients to call
NOTE Confidence: 0.946004114285714
01:00:25.946 --> 01:00:28.010 their clinician and make sure that
NOTE Confidence: 0.946004114285714
01:00:28.010 --> 01:00:29.700 these symptoms are addressed.
NOTE Confidence: 0.946004114285714
01:00:29.700 --> 01:00:30.138 So they say,
NOTE Confidence: 0.946004114285714
01:00:30.138 --> 01:00:31.500 I’m going to get off the phone with you,
NOTE Confidence: 0.946004114285714
01:00:31.500 --> 01:00:32.916 you’re going to call your clinician
NOTE Confidence: 0.946004114285714
01:00:32.919 --> 01:00:34.175 So they say
going to hang up.

I'm going to call you again in an hour and see if you did it.

And so it helps the patient to then begin there to be their own voice.

So that they're not reliant on someone else mediating that relationship.

And the reason that's important is because cancer is one part of what a patient may be diagnosed with.

And so you want them to have skills that are going to supersede the small narrow piece of medical conditions that we all are seeing at the surface and treating.