00:00:00.000 --> 00:00:03.298 Started so I thank you all so
00:00:03.298 --> 00:00:04.800 much for being here today.
00:00:04.800 --> 00:00:08.552 I'd like you to join me in welcoming Dr.
00:00:08.552 --> 00:00:11.320 Manali Patel, who is an associate
00:00:11.320 --> 00:00:13.440 professor of medicine at Stanford
00:00:13.440 --> 00:00:15.790 Medicine and a staff oncologist with
00:00:15.790 --> 00:00:19.520 the VA Palo Alto healthcare system.
00:00:19.520 --> 00:00:22.000 She earned her medical degree and master’s
00:00:22.000 --> 00:00:23.746 in public health at the University
00:00:23.746 --> 00:00:26.158 of North Carolina at Chapel Hill,
00:00:26.158 --> 00:00:29.180 followed by Internal Medicine residency.
00:00:29.180 --> 00:00:30.780 Key Monk Fellowship and
00:00:30.780 --> 00:00:31.980 several research fellowships.
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 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 lectureship would serve as a lasting

00:02:19.350 --> 00:02:21.540 memorial to Iris while providing an educational opportunity for physicians

00:02:21.540 --> 00:02:23.076 and staff for the benefit of patients.

00:02:23.076 --> 00:02:25.420 We are grateful to Doctor Fisher for his generous support and we are grateful for Doctor Patel for delivering this lectureship today. Please join me in welcoming Dr. Manali Patel.

00:02:27.012 --> 00:02:27.780 Thank you. I know Michaela from many eons ago and so it’s nice to see so many familiar faces and also so many new
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.
00:03:18.965 --> 00:03:21.516 care and then focus in on the why.

00:03:21.520 --> 00:03:25.004 For me, I love being first.

00:03:25.004 --> 00:03:27.520 How many of you all love being first?

00:03:28.396 --> 00:03:31.240 We’re all competitive,

00:03:31.240 --> 00:03:34.876 I actually don’t like being first.

00:03:34.880 --> 00:03:37.430 In the amount that we’re spending

00:03:37.430 --> 00:03:38.280 for healthcare.

00:03:38.280 --> 00:03:41.995 And why are we last in terms of

00:03:41.995 --> 00:03:43.720 our spending for social services?

00:03:46.000 --> 00:03:48.744 How many of you all saw this

00:03:48.744 --> 00:03:50.870 over the weekend? NPR. Yep.

00:03:50.870 --> 00:03:53.720 I see some folks saying yes.

00:03:53.720 --> 00:03:56.648 For all that money we are

00:03:56.648 --> 00:03:58.112 inputting into healthcare,
00:03:58.120 --> 00:04:00.280 why are we doing so poorly?
NOTE Confidence: 0.93622824
00:04:03.590 --> 00:04:04.430 And many will say, well,
NOTE Confidence: 0.93622824
00:04:04.430 --> 00:04:06.454 it’s our COVID-19 policies.
NOTE Confidence: 0.93622824
00:04:06.454 --> 00:04:09.456 I’m sorry, the trend was
NOTE Confidence: 0.93622824
00:04:09.456 --> 00:04:12.104 beginning long before COVID-19.
NOTE Confidence: 0.93622824
00:04:12.110 --> 00:04:15.134 And so could it be this longterm
NOTE Confidence: 0.93622824
00:04:15.134 --> 00:04:19.710 shortchanging of social services?
NOTE Confidence: 0.93622824
00:04:19.710 --> 00:04:22.188 And then you look at cancer,
NOTE Confidence: 0.93622824
00:04:22.190 --> 00:04:25.950 which is all of our areas of expertise,
NOTE Confidence: 0.93622824
00:04:25.950 --> 00:04:30.150 this is completely unsustainable.
NOTE Confidence: 0.93622824
00:04:30.150 --> 00:04:31.950 How many of you all drive on the highways?
NOTE Confidence: 0.947801065
00:04:35.430 --> 00:04:38.802 When there’s a pothole that comes out
NOTE Confidence: 0.947801065
00:04:38.802 --> 00:04:41.226 of the same bucket of congressional
NOTE Confidence: 0.947801065
00:04:41.226 --> 00:04:43.750 funding as paying for healthcare.
NOTE Confidence: 0.947801065
00:04:43.750 --> 00:04:47.158 So if utilizing most of the gross domestic
NOTE Confidence: 0.947801065
00:04:47.158 --> 00:04:49.297 product on healthcare expenditures,
we have limited 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. But 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. That continue across the continuum. How many of you all have seen this graph? Robin Yaborov, good friend of ours, 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? But what’s wonderful about it is it shows you this peri diagnostic phase. There’s this huge uptick and uprise.
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. 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
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 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? 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, is this the right career, was that 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. 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? You know, the question came up. Well,
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,
00:13:34.770 --> 00:13:36.289 it would have turned into a very different project that may have been completely meaningless.

00:13:41.120 --> 00:13:41.988 I went to Stanford.

00:13:43.080 --> 00:13:44.280 I'm looking at Pam because, Stanford is a silicon.

00:13:44.280 --> 00:13:45.792 How many of you all have been to California?

00:13:45.800 --> 00:13:48.320 It's like community based participatory research with a twist.

00:13:48.320 --> 00:13:50.060 So many of you have an iPhone, right?

00:13:50.060 --> 00:13:52.235 Is this design school?

00:13:52.240 --> 00:13:53.216 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,
unwanted healthcare expenditures
at a very high cost.
So that's low yield if we want to
try to achieve the triple aim.
So we started off with this combined
Amalga rhythm of the design school
and the community based participatory
research methods.
So we asked patients and caregivers,
which is clearly what you would do
if you were to create a system focused on end
00:15:49.575 --> 00:15:51.626 of life cancer care delivery that
00:15:51.626 --> 00:15:53.256 looked very different than the
00:15:53.256 --> 00:15:54.780 one that you’re currently in.
00:15:54.780 --> 00:15:58.175 We also did the same with clinicians
00:16:00.007 --> 00:16:01.977 and then we included a critical piece
00:16:01.980 --> 00:16:05.316 that we learned from the design school,
00:16:05.320 --> 00:16:06.840 As well as policymakers.
00:16:09.640 --> 00:16:12.237 And surprising to me is a wide-eyed,
00:16:12.240 --> 00:16:13.392 bushy-tailed fellow who was
00:16:13.392 --> 00:16:15.120 kind of in my little realm,
00:16:15.120 --> 00:16:17.380 really not thinking about
00:16:17.380 --> 00:16:19.075 the financial misalignment.
00:16:19.080 --> 00:16:21.175 What I heard from clinicians
00:16:21.175 --> 00:16:23.270 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

NOTE Confidence: 0.938815971428572

00:16:27.708 --> 00:16:29.134 department visits and hospitalizations

NOTE Confidence: 0.938815971428572

00:16:29.134 --> 00:16:31.074 like what Hospice and palliative

NOTE Confidence: 0.938815971428572

00:16:31.074 --> 00:16:33.270 care are meant to help with?

NOTE Confidence: 0.938815971428572

00:16:33.270 --> 00:16:34.350 Local concordant care,

NOTE Confidence: 0.938815971428572

00:16:34.350 --> 00:16:37.221 usually patients will choose not to be in

NOTE Confidence: 0.938815971428572

00:16:37.221 --> 00:16:40.029 a hospital setting at the end of life.

NOTE Confidence: 0.938815971428572

00:16:40.030 --> 00:16:41.070 There goes our bottom line.

NOTE Confidence: 0.935221825

00:16:43.430 --> 00:16:48.790 And I was shocked, but it made sense.

NOTE Confidence: 0.935221825

00:16:48.790 --> 00:16:51.523 And so we heard from communities that they

NOTE Confidence: 0.935221825

00:16:51.523 --> 00:16:54.250 wanted to be a part of the the, the product.

NOTE Confidence: 0.935221825

00:16:54.250 --> 00:16:55.870 They want to codesign the product.

NOTE Confidence: 0.935221825

00:16:55.870 --> 00:16:58.054 They are often not involved in

NOTE Confidence: 0.935221825

00:16:58.054 --> 00:17:00.269 palliative care efforts and we heard

NOTE Confidence: 0.935221825

00:17:00.269 --> 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 ready, right? Patients may not quite be ready for some of these services.

And so we have the same players,
same stakeholders.

NOTE Confidence: 0.95232968

Create a model where we long

NOTE Confidence: 0.95232968

before the A/C A in 2012.

NOTE Confidence: 0.95232968

We had them design an ideal approach

NOTE Confidence: 0.95232968

that would align their goals and also

NOTE Confidence: 0.95232968

would be aligned by financial values.

NOTE Confidence: 0.95232968

And what they landed on was

NOTE Confidence: 0.95232968

training a community health worker.

NOTE Confidence: 0.95232968

For a peer support navigator to help

NOTE Confidence: 0.95232968

them understand concepts of values,

NOTE Confidence: 0.95232968

goals, preferences outside of our 15 to

NOTE Confidence: 0.95232968

30 minute visit in the oncology clinic,

NOTE Confidence: 0.95232968

they also had wanted someone to call them.

NOTE Confidence: 0.95232968

And again this was long before E pros right?

NOTE Confidence: 0.95232968

E pros have not been up and

NOTE Confidence: 0.95232968

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,
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. You’re going to remove hope. 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.

Let’s see, let’s see.
Is there anyone that can help? Do you think anyone can help me with the video?

What was that? This one? The right one? More.

Is your primary goal to fight to make sure it’s out of yours?

I don’t want to die. Bloomberg meets regularly with healthier checks.

I’m sharing. I’m sharing the sharing.
NOTE Confidence: 0.9251585
00:24:50.720 --> 00:24:53.960 if not shared one. That’s that’s sharing and
NOTE Confidence: 0.81365296
00:24:57.240 --> 00:24:58.080 there on the last one.
NOTE Confidence: 0.833872433333333
00:25:00.770 --> 00:25:03.090 Just click that. OK.
NOTE Confidence: 0.89560035
00:25:08.370 --> 00:25:11.430 Thank you. You gotta get
NOTE Confidence: 0.89560035
00:25:11.430 --> 00:25:12.689 it again. It came on.
NOTE Confidence: 0.94427896
00:25:15.970 --> 00:25:18.050 No, that’s fine. That’s fine.
NOTE Confidence: 0.94427896
00:25:18.050 --> 00:25:22.610 Just go to share screen. Sure sense.
NOTE Confidence: 0.94427896
00:25:22.610 --> 00:25:23.968 Now you can select the then you
NOTE Confidence: 0.936899133333333
NOTE Confidence: 0.94276939
00:25:37.250 --> 00:25:38.330 Is your primary goal
NOTE Confidence: 0.936594124545455
00:25:38.330 --> 00:25:39.203 to fight this?
NOTE Confidence: 0.936594124545455
00:25:39.203 --> 00:25:41.770 To make sure it’s out of your system?
NOTE Confidence: 0.936594124545455
00:25:41.770 --> 00:25:42.330 I don’t want to die.
NOTE Confidence: 0.936594124545455
00:25:42.330 --> 00:25:44.528 I got lots of things to do.
NOTE Confidence: 0.936594124545455
00:25:44.530 --> 00:25:47.010 Blumberg meets regularly with healthcare.
NOTE Confidence: 0.936594124545455
Coach Laviba shares a compassionate ear shares role, is to provide the big picture to help patients 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 it is that 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 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, what they understand is their prognosis. 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 take advantage of the fact that I'm still here and 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, correct?  
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. W as 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 decided to dispel that myth.

We also 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.
disease into this intervention that you just saw clips of versus usual care and we measured goals of care documentation as well as patient experiences and total cost of care. We randomized 213 patients in this consort diagram. You see 100 and 805 respectively in the control group in the intervention. It was blocked randomized by cancer diagnosis. And because it was in the VA and we had claims data, we could conduct an intent to treat analysis. So despite loss of follow up,
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 these conversations 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
directive that you can’t change it.
NOTE Confidence: 0.946962473333333
You actually can change it.
NOTE Confidence: 0.946962473333333
So it’s a living,
NOTE Confidence: 0.946962473333333
it’s meant to be a living document.
NOTE Confidence: 0.946962473333333
And so we would update the advance
NOTE Confidence: 0.946962473333333
directive as People’s Life course changed.
NOTE Confidence: 0.946962473333333
We found that patient satisfaction went up.
NOTE Confidence: 0.946962473333333
This was using the consumer assessment of.
NOTE Confidence: 0.946962473333333
Of healthcare providers and
NOTE Confidence: 0.946962473333333
healthcare systems General survey,
NOTE Confidence: 0.946962473333333
the question of would you recommend
NOTE Confidence: 0.946962473333333
care on a scale of zero to 10?
NOTE Confidence: 0.946962473333333
How satisfied are you with
NOTE Confidence: 0.946962473333333
your clinical team?
NOTE Confidence: 0.946962473333333
10 being a very high satisfaction,
NOTE Confidence: 0.946962473333333
0 being low satisfaction and what we
00:30:50.651 --> 00:30:53.684 found over time in the blue line is
00:30:53.684 --> 00:30:55.584 that the intervention group improved
00:30:55.660 --> 00:30:57.700 and the control group decline.
00:30:57.700 --> 00:30:59.980 We did not cause harm.
00:30:59.980 --> 00:31:01.540 So unlike Jennifer Tumels model,
00:31:01.540 --> 00:31:02.520 which I’ll show you,
00:31:02.520 --> 00:31:03.500 we improved palliative care.
00:31:03.500 --> 00:31:05.540 We didn’t find a survival benefit,
00:31:05.540 --> 00:31:08.602 but we dispelled the myth that we
00:31:08.602 --> 00:31:10.257 were making people die faster.
00:31:13.100 --> 00:31:14.612 But what we showed was at the end
00:31:14.612 --> 00:31:16.059 of life there was better care,
00:31:18.540 --> 00:31:20.616 95% reduction in acute care use,
00:31:20.620 --> 00:31:23.924 almost doubling of Hospice utilization and
00:31:23.924 --> 00:31:25.860 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 there 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. And we’ll do the symptom management again. 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 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,

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,
it’s a scale of zero to 10 with multiple symptoms.

I think there’s nine or ten.

And then there’s also another category being worse symptom symptomatology

And what we found was essentially for patients and we built this

The nurse practitioner, FTE was also covered by the payer.

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. The cohort of patients that
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 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 those 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?
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 so I’m glad I did that public health degree because I took a step back and said,
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.
I was actually very shocked. What they said was you try having a conversation about goals of care when you’re worried about where your family is going to live and how you’re going to get food on the table for your family. You’re asking me to do something that I think is going to hasten my death. Then who is going to provide for my family? Eye opener.

So guess what, we tabled the intervention and we focused on addressing health related social needs. We integrated that.

We didn’t table the advanced care planning,
00:43:04.420 --> 00:43:06.856 but we integrated the health related
NOTE Confidence: 0.936899133333333
00:43:06.856 --> 00:43:09.100 social needs first and foremost
NOTE Confidence: 0.936899133333333
00:43:09.100 --> 00:43:12.276 and we used community engagement to
NOTE Confidence: 0.936899133333333
00:43:12.276 --> 00:43:14.580 build partnerships with industry.
NOTE Confidence: 0.936899133333333
00:43:14.580 --> 00:43:15.684 One issue is transportation.
NOTE Confidence: 0.936899133333333
00:43:15.684 --> 00:43:17.661 How are people going to get to
NOTE Confidence: 0.936899133333333
00:43:17.661 --> 00:43:18.976 and from their clinic visits?
NOTE Confidence: 0.936899133333333
00:43:18.980 --> 00:43:21.068 Well, guess what?
NOTE Confidence: 0.936899133333333
00:43:21.070 --> 00:43:25.270 Lift can provide free transportation,
NOTE Confidence: 0.936899133333333
00:43:25.270 --> 00:43:28.078 better value, better quality, lower cost.
NOTE Confidence: 0.936899133333333
00:43:28.078 --> 00:43:31.310 If people are adhering to their treatments,
NOTE Confidence: 0.936899133333333
00:43:31.310 --> 00:43:34.226 people have no place to live.
NOTE Confidence: 0.936899133333333
00:43:34.230 --> 00:43:35.666 Local Housing Authority let’s
NOTE Confidence: 0.936899133333333
00:43:35.666 --> 00:43:37.820 build in places for people to
NOTE Confidence: 0.936899133333333
00:43:37.882 --> 00:43:39.827 live while they’re getting care.
NOTE Confidence: 0.943608066666667
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,
00:44:20.630 --> 00:44:21.462 socioeconomic status,
00:44:21.462 --> 00:44:24.790 where you go determines the care you get.
00:44:24.790 --> 00:44:27.390 And so making for example,
00:44:27.390 --> 00:44:31.790 the Yale out in the community is a
00:44:31.790 --> 00:44:34.118 fantastic idea because providing
00:44:34.118 --> 00:44:37.366 evidence based care is a way to
00:44:37.366 --> 00:44:39.486 overcome many of the disparities.
00:44:39.486 --> 00:44:42.670 It’s not due to patient level factors.
00:44:42.670 --> 00:44:45.180 I know we go there.
00:44:45.180 --> 00:44:46.853 It’s actually due to what people are
00:44:46.853 --> 00:44:48.020 receiving once they’re diagnosed.
00:44:48.020 --> 00:44:49.964 And now we’ve shown study after
00:44:49.964 --> 00:44:51.748 study after study that if you get
00:44:51.748 --> 00:44:53.307 the care that you need and the
00:44:53.307 --> 00:44:54.499 care that’s evidence based,
your outcomes are the same, if not better, then more white, more affluent white individuals who usually do much better. And so we picked through. I went through their claims, I went out to Atlantic City in Chicago as a fellow multiple times, looked 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

and have a narrow network.

But rather expand the network and

give people an incentive to go to

the higher providing provider.

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
00:46:53.802 --> 00:46:56.389 of these documents and to also hire a
NOTE Confidence: 0.9352219
00:46:56.389 --> 00:46:59.083 lot of Community health workers from
NOTE Confidence: 0.9352219
00:46:59.083 --> 00:47:01.455 communities that spoke the patient’s
NOTE Confidence: 0.9352219
00:47:01.455 --> 00:47:04.773 preferences of language and that was costly.
NOTE Confidence: 0.9352219
00:47:04.780 --> 00:47:07.000 Unite your health, did it.
NOTE Confidence: 0.9352219
00:47:07.000 --> 00:47:09.976 Again, very low annual household incomes
NOTE Confidence: 0.9352219
00:47:09.976 --> 00:47:12.800 and very low educational attainment
NOTE Confidence: 0.9352219
00:47:12.800 --> 00:47:14.578 and what we found using the functional
NOTE Confidence: 0.9352219
00:47:14.578 --> 00:47:16.159 assessment of cancer therapies general,
NOTE Confidence: 0.9352219
00:47:16.160 --> 00:47:18.560 was that patients health related
NOTE Confidence: 0.9352219
00:47:18.560 --> 00:47:20.480 quality of life improved.
NOTE Confidence: 0.9352219
00:47:20.480 --> 00:47:21.280 Makes sense.
NOTE Confidence: 0.9352219
00:47:21.280 --> 00:47:22.880 If you’re screening for
NOTE Confidence: 0.9352219
00:47:22.880 --> 00:47:24.480 health related social needs,
NOTE Confidence: 0.9352219
00:47:24.480 --> 00:47:25.810 you’re likely going to have
NOTE Confidence: 0.9352219
00:47:25.810 --> 00:47:26.874 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 overall 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

to me doing usual care is kind of unethical.

We know that palliative care

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
health worker uses in her interactions,

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.
Just a couple of months ago, I would love for you to pick up that article and juxtapose it against what he wrote in 2008 because it’s very sobering, sombering. Even the title the existential threat of greed in the United States, United States healthcare system. And in that article, it makes me question, are we going in the wrong direction? Is it worsening? Because now we see how many of you all have seen what ASCO has done for Wellness burnout. Of course our ask the President 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. 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.
to go or where we should go.

And now hospices sadly profiteering why this is shocking to me. It’s really not because we’re part of the American ecosystem where there’s this desire to want to capitalize, but it really makes our, our jobs harder as physicians to think about what we were trained in medical school not to think about, but it’s impacting all of us. This is the why for me, why do I keep going even though it seems like, you know, 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, Farmer, 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, live in the right neighborhood, live in the right neighborhood, live in the right neighborhood, live in the right neighborhood, live in the right neighborhood, live in the right neighborhood, live in the right neighborhood, live in the right neighborhood, live in the right neighborhood, live in the right neighborhood.
attain our highest health possible.

And why also is because we see change. The A/C A was huge, opened up the door to being able to take away this idea of death panels. We actually get reimbursed for having conversations that should be part of the fabric about how we deliver care. But also remember that site that I told you in Fullerton that said no way to advance care planning.

We’ll do the symptoms stuff if you give us a bunch of money. They now are advertising on their website. This program is part of one of 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 at unite your health.

So 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.

I have a lot of other projects now focused on that other side of EU shaped curve, really trying to improve equitable evidence based care delivery. 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. 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.
00:53:55.990 --> 00:53:56.788 And that’s it.
NOTE Confidence: 0.9402536
00:53:56.788 --> 00:53:57.586 That’s a wrap.
NOTE Confidence: 0.934215492
00:54:04.710 --> 00:54:06.378 We have a couple time. This is our lab.
NOTE Confidence: 0.934215492
00:54:06.378 --> 00:54:08.028 And so if anyone wants to check it out,
NOTE Confidence: 0.934215492
00:54:08.030 --> 00:54:10.326 please, we’ve got a bunch of other
NOTE Confidence: 0.934215492
00:54:10.326 --> 00:54:11.962 studies ongoing and then certainly
NOTE Confidence: 0.934215492
00:54:11.962 --> 00:54:13.090 some questions. Yes, in the back.
NOTE Confidence: 0.93270605
00:54:15.410 --> 00:54:16.410 Oh, thank you Sir.
NOTE Confidence: 0.9452853
00:54:24.610 --> 00:54:25.640 One of the beauties of
NOTE Confidence: 0.9452853
00:54:25.640 --> 00:54:27.570 community that expresses
NOTE Confidence: 0.94629164
00:54:27.570 --> 00:54:31.830 the support you said really get to vote yes
NOTE Confidence: 0.94629164
00:54:31.830 --> 00:54:34.009 really the whole 1000 importance of that.
NOTE Confidence: 0.94629164
00:54:34.010 --> 00:54:36.428 Did you identify any particular cultural
NOTE Confidence: 0.94629164
00:54:36.428 --> 00:54:38.475 barriers and or facilitators within
NOTE Confidence: 0.94629164
00:54:38.475 --> 00:54:40.725 the community that she’s engaged with?
NOTE Confidence: 0.91874177666667
00:54:41.890 --> 00:54:43.270 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 to the patient 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 that is part of their culture, 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? Is it beer and black information? Like why are they so different and
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, 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
NOTE Confidence: 0.939338745454545
00:57:58.478 --> 00:58:01.560 incentivize and to align goals,
NOTE Confidence: 0.939338745454545
00:58:01.560 --> 00:58:02.640 not to be a reductionist,
NOTE Confidence: 0.939338745454545
00:58:02.640 --> 00:58:03.560 but that’s one example.
NOTE Confidence: 0.93689905
00:58:06.840 --> 00:58:08.840 A comment and a question.
NOTE Confidence: 0.936228178
00:58:09.760 --> 00:58:13.450 So the comment is that I worry a
NOTE Confidence: 0.936228178
00:58:13.450 --> 00:58:15.790 little bit about putting patients in
NOTE Confidence: 0.936228178
00:58:15.790 --> 00:58:18.518 the middle of the cost situation,
NOTE Confidence: 0.936228178
00:58:18.520 --> 00:58:20.120 partially because the costs
NOTE Confidence: 0.936228178
00:58:20.120 --> 00:58:22.120 are in many ways artificial.
NOTE Confidence: 0.936228178
00:58:22.120 --> 00:58:24.664 And I think the real solution is of
NOTE Confidence: 0.936228178
00:58:24.664 --> 00:58:26.731 course that we should have coverage
NOTE Confidence: 0.936228178
00:58:26.731 --> 00:58:29.608 for everyone and and then we should
NOTE Confidence: 0.936228178
00:58:29.608 --> 00:58:32.258 work on figuring out the cost.
NOTE Confidence: 0.936228178
00:58:32.260 --> 00:58:34.356 The and I fear that some people
NOTE Confidence: 0.936228178
00:58:34.356 --> 00:58:36.407 will just say that’s just too much
NOTE Confidence: 0.936228178
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. 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.
00:59:10.025 --> 00:59:12.443 where there is communication across both
00:59:12.511 --> 00:59:14.671 unfortunately and and the majority of
00:59:14.671 --> 00:59:17.364 the sites have chosen that even if they
00:59:17.364 --> 00:59:18.919 haven’t chosen that initially they’ve
00:59:18.919 --> 00:59:20.890 come around to really engaging the
00:59:20.890 --> 00:59:23.019 community health workers part of the team.
00:59:23.020 --> 00:59:24.634 Where we’ve seen struggles is in
00:59:24.634 --> 00:59:26.298 that example in Atlantic City and
00:59:26.298 --> 00:59:27.643 Chicago where the oncologist really
00:59:27.643 --> 00:59:29.536 did not want to be involved at all.
00:59:29.540 --> 00:59:30.220 And so we said, Okay,
00:59:30.220 --> 00:59:32.272 we’re going to do it with the payer alone
00:59:32.272 --> 00:59:34.179 and there was limited communication,
00:59:34.180 --> 00:59:36.204 but we also want to make it such
00:59:36.204 --> 00:59:37.539 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 just looked at the VA study now 10 years later and we found actually really big differences at the end.
01:00:07.649 --> 01:00:09.679 of life for the patients that died,
01:00:09.680 --> 01:00:11.585 perhaps indicating that the skills
01:00:11.585 --> 01:00:13.490 that patients were learning are
01:00:13.549 --> 01:00:14.817 like riding a bicycle.
01:00:14.820 --> 01:00:16.934 You want patients to activate for themselves.
01:00:16.940 --> 01:00:18.566 And so in those situations where
01:00:18.566 --> 01:00:20.159 we don’t have the Wellfunctioning
01:00:20.159 --> 01:00:21.979 team in the communication,
01:00:21.980 --> 01:00:24.116 we have the Community health worker
01:00:24.116 --> 01:00:25.946 activate the patients to call
01:00:25.946 --> 01:00:28.010 their clinician and make sure that
01:00:28.010 --> 01:00:29.700 these symptoms are addressed.
01:00:29.700 --> 01:00:30.138 So they say,
01:00:30.138 --> 01:00:31.500 I’m going to get off the phone with you,
01:00:31.500 --> 01:00:32.916 you’re going to call your clinician
01:00:32.916 --> 01:00:33.860 going to hang up.
NOTE Confidence: 0.946004114285714
01:00:33.860 --> 01:00:35.498 I'm going to call you again in
NOTE Confidence: 0.946004114285714
01:00:35.498 --> 01:00:37.257 an hour and see if you did it.
NOTE Confidence: 0.946004114285714
01:00:37.260 --> 01:00:39.468 And so it helps the patient to then
NOTE Confidence: 0.946004114285714
01:00:39.468 --> 01:00:41.368 begin there to be their own voice.
NOTE Confidence: 0.946004114285714
01:00:41.370 --> 01:00:43.239 So that they’re not reliant on someone
NOTE Confidence: 0.946004114285714
01:00:43.239 --> 01:00:44.690 else mediating that relationship.
NOTE Confidence: 0.946004114285714
01:00:44.690 --> 01:00:46.610 And the reason that’s important is
NOTE Confidence: 0.946004114285714
01:00:46.610 --> 01:00:48.812 because cancer is one part of what
NOTE Confidence: 0.946004114285714
01:00:48.812 --> 01:00:50.528 a patient may be diagnosed with.
NOTE Confidence: 0.946004114285714
01:00:50.530 --> 01:00:52.690 And so you want them to have skills
NOTE Confidence: 0.946004114285714
01:00:52.690 --> 01:00:54.649 that are going to supersede the
NOTE Confidence: 0.946004114285714
01:00:54.650 --> 01:00:56.245 small narrow piece of medical
NOTE Confidence: 0.946004114285714
01:00:56.245 --> 01:00:58.222 conditions that we all are
NOTE Confidence: 0.946004114285714
01:00:58.222 --> 01:01:00.130 seeing at the surface and treating.