UNITED STATES of CARE

Transcript (pages 1-10)

[voice of Kristin Wikelius]
Thank you for joining United States of Care for this virtual webinar on how we talk about a health care approach that prioritizes quality over quantity.

My name is Kristin Wikelius, Chief Program Officer at United States of Care, and I'll be joined for this webinar by Dr. Venice Haynes, our Director of Research and Community Engagement.

This briefing will be approximately 25 minutes and will be recorded and available for circulation.

With that, we are eager to dive into our latest findings.

United States of Care is a non-partisan, non-profit organization dedicating to building a fairer health care system that is affordable, accessible, understandable and dependable.

We ground our work in listening to people and what they want in the health care system and work to advance changes at the policy and federal level.

Shortly after our founding five years ago we began a multi-year foundational listening effort engaging with people across the country and across demographics about their experiences in the health care system and what they want.

We found many commonalities that united people across race geography and political party and created a road map of 12 smart policy solutions that ladder up into four overarching goals that reflect what people want out of health care.

Many of the complaints that people shared about this system are around what they lack - they lack coordination between providers.

People feel like they have a different provider for each part of their body.

Many of the complaints that we heard we knew stemmed from the fragmentation of a fee-for-service system and while people never actually used words like fee-for-service or value-based care, we know that accomplishing many of the things that people want a system that is understandable and is easily navigated - a system where people can seek care in their communities requires moving away from fee-for-service and towards new models that encourage coordination and quality my colleague, Dr. Venice Haynes, will share more about the work to deeply understand people's attitudes about these changes.

[voice of Dr. Venice Haynes]

Thanks, Kristin. So throughout our last three years of listening to what people want from the health care system and the system that led us to our united solutions for care that Kristin just walked us through, we increasingly heard people talking about the greed associated with the system and a call for better care that focused on the whole person where a doctor would take their time and listen and where their doctors coordinated with other specialists they see and not having to repeat their patient history every time they saw someone.

Now, if you think about it, what does that actually sound like they're describing?

So given the broad consensus on the kind of health care people want, we thought about three essential things.

One: How can we leverage what people know and want and connect it back to the virtues of a system that's grounded in what we know as value-based care?

Two: How can we make sure that people real people and patients understand that the best elements of the care that they receive or desire lives in the value-based care framework?

and Three: How can we make sure that policymakers and stakeholders alike are using the common language, the same common language for engaging with real people on this issue?

So we approached this sequentially first, um, to understand people's current health care experiences: what they like, what isn't working and what their overall experience is like

We then wanted to know about the ideal experience they want to have building on
of course what what we've heard from other in our previous research and finally we introduced a value-based care approach without actually using the term value-based care and try to understand attitudes and perceptions around that.

So how do we go about achieving these research objectives?

We used a three-phase mixed method approach using focus groups, a national survey and an online mixed method platform called remesh.

We started with two focus groups of about six people - one that included a group of people that have generally had good health care experiences and another group that had mostly negative health care experiences.

There was a range of incomes, education levels, race, ethnicities and partisanship across both groups and included people from all census regions.

And so the purpose of these focus groups was to understand the current experiences of seeking and receiving health care and get some initial reactions to the value-based care approach.

We then use some of the findings from both conversations to inform the national poll.

We had a nationally representative sample of a thousand people where we quantified what people liked about the current fee-for-service system, their reactions to a different approach well you know is value-based care, and the message about this approach that resonated the most.

We then transitioned to an online mix method platform called remesh with the sample of 100 people across the country to examine those messages a little bit deeper.

So why don't we get into what we found.

So what you'll see now is a high level summary of what we wanted to know, the questions we asked to get there, and what we found, and so the takeaway from this table, if you don't make it any further in this webinar, is that people are satisfied with their insurance essentially and prioritize quality care they do want.

Target improvements to make things better like better care coordination and being treated as a whole person and people support the concept of value-based care, although not described in those terms, and believe it should result in a more personalized care but shows some skeptical skepticism around cost and time.

We'll get into it a little bit later so why don't we go a little deeper.

Essentially people are satisfied with the quality of care they receive, however, that doesn't mean they don't want change.

People desire targeted improvements to the system respondents have a consistent set of criticisms related to their current experiences getting care which they associate with the fee-for-service approach.

This includes having a more human approach where they feel like their providers listen to them care about them as a person, and got to the root cause of their problems without feeling rushed

So when we ask people if they would sum up their experience getting health care in one or two words, some respondents are describe something along the lines of assembly line or as one person said a school cafeteria equating it to providers that are quickly dishing out a scoop of health care before sending them down the line and moving on to the next patient.

So you can see a quote here from one of our low-income participants that has had mostly negative experiences and this is how he equated the experience from the lunchroom cafeteria to his experience with the current health care system.
So when we asked about what was working well in their health care experiences, people gave high marks to their providers for verbal interactions such as talking in a way that they can understand where you can see, um, 92 percent where saw this as good and listening to their concerns and asking follow-up questions.

I will also make a note that from our previous research when we reference on patients being satisfied, that there's a low bar for what satisfied means and it doesn't mean that people don't require more improvements in the system.

It means that they spend so much time hacking the system to get the care that they want it sets a lower bar and definitely has more room for more targeted fixes as we will get into a little bit later so we know that quality matters but what can we say about people's current care experiences and linking that back to components of a value-based system.

This naturally took us to discussing the merits and limitations of the fee-for-service system whereas our earlier slide showed us that people are satisfied with the care they receive.

There still remain remains a desire for some targeted improvements.

As I mentioned, people were initially divided on how well the fee-for-service approach worked with about 51 saying that it's not working well and associated that with a consistent set of criticisms with this approach and as a matter of fact, in our remesh session we saw that just 35 percent actually believe that the current fee-for-service approach was delivering high quality care so there was a longer runway in a higher benchmark for that but people quickly made the connection between the fee-for-service approach.

And those critical criticisms of the system, for example, one participant said from making appointments to dealing with the paperwork and even just waiting in a doctor's office you need to be patient no pun intended and another participant said you talked to one doctor and they talk about one thing you go to a different doctor totally different symptom and prescribing medicine that doesn't even work together and one medicine makes you sick because you took the other that's what it is fragment.

So what's our takeaway so far well is that people want a more human experience when they're receiving care and shared some of the following examples.

The current fee for fee-for-service system is fragmented with little coordination taking place between providers and resulting in people to have to rehash their latest challenges to each provider sometimes getting conflicting advice.

People spend too much time waiting versus with their doctors participants wait too long to get an appointment then too long in the waiting room only to feel rushed and spend a little time with the doctor once they get with them and as a result of feeling rushed some feel that ultimately they spend more time in the system because they aren't able to address all their issues in one appointment and ending up having to make another one, um, that coupled with an over-reliance on prescription drugs and them seeing that as the easiest path to address the health challenges and participants describe how providers often miss the whole picture of what's going on in their lives and how solutions other than traditional medical treatments and medication can actually improve their health.

And finally people with money, they feel like people with money are prioritized in getting appointments and care over people that um are lower income or are not as well so when talking about what they want their health care experience to be and what they actually want, participants emphasize increased quality which they describe as their own provider is when their own provider genuinely cares treats patients as humans rather than a series of symptoms, listens attentively and actually offers solutions that address the root cause of their problems rather than relying on medication.

And so a better system isn't just one where they actually get to see the doctor faster but one where they actually feel like they can get all of their issues addressed in a timely manner in the time that they need so that's what we heard about the current system and where people want to go.

Now let's talk about what happened when we described this new approach also known as value-based care that prioritizes what so many were asking for related to increased quality of care.

So this is the verbatim language we used in the national survey for people to respond to and it says some people have proposed changing the current fee-for-service approach to one that could pay doctors and providers for improving overall health, delivering higher quality care, and helping coordinate their patients care so when we ask people in response to that prompt how well do you think an approach that pays providers for improving overall health delivering high quality care and helping coordinate patients care.

This is what we found when they were forced to choose between us and a fee-for-service and the current system providers being paid based on results is preferred by a four to one margin over the fee-for-service and you can tell that from the blue bars the the new system versus the current system in red bars and what we saw was this was true across party identification.

Insurance type, ethnicity, age, education, and even geography, and we didn't see these results just in the survey, but we all across all three research tools we saw high levels of support in focus groups.

As you can see, 64 percent um in the national survey thought this would work well.

In our remesh sessions we saw that 89 of participants supported this approach.

Almost immediately, people saw an opportunity for more personalized care however respondents also quickly perceive this to be a large overhaul to the system which previous research has told us that people do not want and they have certainly equated all of this with an increased cost.

Now what we did see in our remesh findings was that people were still able to make the connection with this new approach and the care that they want to be receiving and they were also aware that the current payment system prevented their providers to be able to deliver this type of care.

So essentially, they like the idea of incentivizing the providers to give them the care that prioritizes quality over quantity but people of course also had their reasons to be skeptical.

They worry that it could cost more if doctors were seeing fewer patients.

They worried that a move away from fee-for-service might encourage providers to ignore certain or more complex problems to favor ones that could actually be fixed, and they were also worried about the wait times since they would be spending more time with patients.

So from all of our methodologies on message testing on value-based care, we were able to assess four main recommendations for how to talk about this new approach with everyday people.

The first is to state the need.

Our research has shown that people want the quality care they deserve regardless of their identity or where they live that meets their unique needs that the current fee-for-service system does not do and prioritizes the patient for overall better quality outcomes.

Number two describe how it works rather than paying for care based on the number of visits, tests, and procedures.

This approach allows people to spend more time with their providers so that they can get to know their patients and develop more personalized approaches to addressing your full set of unique concerns in fewer visits.

The third describe potential benefits this approach also encourages providers to coordinate with one another while taking a broader view of all of the factors that may be impacting a person's health rather than jumping too quickly to the next patient or to prescribe drugs in order to in order to potentially unnecessary procedures that drive up costs.

Four: inoculate against potential concerns.

This approach is targeted in a straightforward fix that puts quality over quantity, eliminating the greed in our health care system that results in patients being treated as a series of symptoms rather than a whole person while helping identify and manage health concerns that could become very expensive if ignored.

So now I'd like to take a couple of minutes to walk through some of the cautions and considerations that we also recognize based on our findings/

The first was that the term value-based care is essentially subjective and encourages misinterpretations and misunderstandings of what is trying to be achieved.

Some research participants connected with the term because they wanted to feel more valued by their provider, but a majority associated with with it being cheap, low quality, cost saving measure like value-based brands in the supermarket.

In the survey, actually respondents approve of quality focused care or a Patient-First Care.

89 or 86 respectively while the term value-based care actually got 59 approval with less of half of the intensity of other terms.

In our remesh session, one participant commented that value-based care made them think of cheap, low-quality service and actually 75 percent of those participants agreed with that sentiment the second caution is that there's a perception that the approach would result in increased cost.

In our survey, we saw that 46 percent thought that the cost would increase compared to 14 that actually saw that the cost would decrease and one remesh participant commented, “I fear it'd be more expensive because the doctors couldn't see as many patients,” and actually 69 percent of our remesh participants agree with that so we know from past research that people's top goal for the health care system is to reduce costs solutions that people think would increase costs would likely face significant challenges in building public support or uptake.

So when we tested that message centered on cost control participants like the idea but they were skeptical that this approach would actually live up to its promise so we recommend integrating real world numbers about potential cost savings of this approach into messaging as it becomes available.

So for now we actually recommend emphasizing the cost savings that could result from treating health concerns that would become expensive if ignored, while avoiding the cost of uncoordinated care and unnecessary procedures.

The third caution is while we see high levels of interest in moving to this approach, people are skeptical about how would we work in practice and they actually call out several drawbacks including the sense that shifting approaches would be an overhaul of the current system.

We saw in our survey at 4 52 percent considered this to be a large overhaul and we know from past research that a majority of the people prefer targeted fixes that won't disrupt their existing care and providers.

The solutions that feel like an overall overhaul actually have less uh overall support.

They also fear that it would make it harder for people to see their providers and get care those with less firm initials opinions on this approach were much more concerned about it being part of the to see their doctor and we heard from one remesh participant say doctors wouldn't have enough time for everyone a lot of resources would be spent on people with small problems and we saw about 63 percent of people agree with that.

We also heard that doctors would be even more overlooked which would make longer wait times for appointments and 63 percent of people agree with that too.

So a concern that this approach would disproportionately advantage those with more serious or diagnosis or chronic conditions as their understanding leads them to believe that providers would actually be disincentivized from treating these types of patients and we heard from one focus group participants say, “I feel like it would be it would help people with curable diseases the most because if doctors are getting paid for results they're probably going to put a little bit more effort towards something they can cure rather than something that they could just treat,” and then one remesh participant said reduce profit incentive could lead to apathy or ignoring certain types of problems and we saw 64 percent of people agree with that.

So similar concerns about cost increases that we mentioned above as to the skepticism so we recommend integrating and or testing the real world impact of these items to alleviate these concerns.

So the fourth caution is that we want people want to have every treatment available to them if they ever need it.

Concepts that highlighted the perks of avoiding potential unnecessary tests when we tested in our survey actually backfired and so you can see a couple of quotes here, “... more tests could be useful I mean at the end of the day they're investigating your condition sometimes you need it,” and another participant said, “I'm not sure how it would work, what is the end result that they're being paid for, I mean obviously if there's an illness that is curable but say there's an illness that is not curable and they're treating you but like don't you want to be cured like Alzheimer's or something, how do they succeed at something like that and still get paid?”

So the fifth and final consideration is shifting away from the fee-for-service approach requires complex technical changes to the payment system, provider, behavior, and health insurance procedures and as a result, there is likely to be a tendency to move quickly into those details, which our findings show could create significant challenges for building public support.

People respond positively to the new approach when we focus on the patient experience.

We tested a variety of topics related to providers including their motives to enter the field and whether they should be incentivized or held accountable for providing care.

It has good outcomes and we heard a mix of responses and highly recommend keeping the public messaging focused on the patient experience.

Some of the findings related to providers actually included I think most doctors come from wanting to help people in the beginning but most lose that personal care over time and care about the money in the end and we see 60 agreed with that and participants were split on the need for accountability, which they organically introduced in the focus groups versus giving providers financial rewards or incentives to provide high quality care so they said the system must get away from money and instill one that focuses on outcomes.

There is no accountability doctors can get away with whatever they want and as long as they think it benefits the patient, yeah, it's very risky.

So here's a summary table of the messages that resonate and gives to the considerations and cautions we just outlined.

This is a good tool to keep in handy for when you hear some of the common terms related to value-based care come up.

This is one that you can kind of reference as a say, “this, not that” and when you look at the rationale that encompasses both what people have wanted from the system and um the skepticism that also needs to be addressed within this approach next.

So as I get ready to close, here's a recap and summary of items to keep in mind when talking about quality over quantity approach.

First, use simple language.

Participants throughout our research have consistently defaulted to simple phrasing and familiar terms.

A lot of existing language describing the approach is overly complex and if the goal is ultimately to increase implementation and uptake of this approach, it's important that even public officials and policymakers use language that are relatable to people.

Stay focused on how the approach will improve experiences getting care with an emphasis on increasing high quality care.

The opportunity to increase quality has been welcomed by research participants and was a top-selling argument actually, for shifting away from the people service approach get ahead of concerns that people Express and finally, finally, finally don't use the term value-based care.

Well Kristin, that's all I have for now.

I can turn it back over to you.

[voice of Kristin Wikelius]

Thanks very much, Venice.

And now with this work completed, here's a look at what is next for us.

We've Consolidated these findings into a toolkit of easy-to-use resources, which are available on our website that we hope will help you use messaging that resonates with people.

We'll also continue to share what we've learned with policymakers and interested audiences like you and finally, we plan to conduct further research as needed to deepen our understanding even further.

Thank you so much for listening in to today's briefing - we hope that you found it informative and thought-provoking.

The United States of Care team will continue to pioneer innovative research on this and many other issues, and we look forward to keeping you informed.

Transcript w/ Time Stamps

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doctor's office you need to be patient
9:53
no pun intended and another participant
9:56
said
9:57
you talked to one doctor and they talk
10:00
about one thing you go to a different
10:01
doctor totally different symptom and
10:04
prescribing medicine that doesn't even
10:05
work together and one medicine makes you
10:07
sick because you took the other that's
10:10
what it is fragment
10:14
so what's our takeaway so far
10:17
well is that people want a more human
10:19
experience when they're receiving care
10:22
and shared some of the following
10:23
examples
10:25
the current fee for fee-for-service
10:27
system is fragmented with little
10:28
coordination taking place between
10:30
providers and resulting in people to
10:32

have to rehash their latest challenges
10:34
to each provider sometimes getting
10:36
conflicting advice
10:38
people spend too much time waiting
10:40
versus with their doctors
10:43
participants wait too long to get an
10:45
appointment then too long in the waiting
10:47
room only to feel rushed and spend a
10:49
little time with the doctor once they
10:50
get with them and as a result of feeling
10:53
rushed some feel that ultimately they
10:54
spend more time in the system because
10:57
they aren't able to address all their
10:58
issues in one appointment and ending up
11:00
having to make another one
11:03
um that coupled with an over-reliance on
11:05
prescription drugs and them seeing that
11:07
as the easiest path to address the
11:09
health challenges and participants
11:11
describe how providers often miss the
11:13
whole picture of what's going on in
11:15
their lives and how Solutions other than
11:18

traditional Medical Treatments and
11:19
medication can actually improve their
11:21
health
11:22
and finally people with mud they feel
11:24
like people with money are prioritized
11:26
in getting appointments and Care over
11:28
people that
11:30
um are lower income or are not as well
11:35
so when talking about what they want
11:37
their health care experience to be and
11:40
what they actually want participants
11:42
emphasize increased quality which they
11:46
describe as their own provider is when
11:48
their own provider genuinely cares
11:50
treats patients as humans rather than a
11:53
series of symptoms
11:54
listens attentively and actually offers
11:57
solutions that address the root cause of
11:59
their problems rather than relying on
12:02
medication
12:03
and so a better system isn't just one
12:06
where they actually get to see the
12:07

doctor faster but one where they
12:09
actually feel like they can get all of
12:11
their issues addressed in a timely
12:12
manner in the time that they need
12:16
so that's what we heard about the
12:18
current system and where people want to
12:19
go now let's talk about what happened
12:21
when we described this new approach also
12:24
known as value-based care that
12:26
prioritizes what so many were asking for
12:28
related to increased quality of care
12:33
so this is the verbatim language we used
12:36
in the National survey for people to
12:38
respond to and it says some people have
12:41
proposed changing the current
12:42
fee-for-service approach to one that
12:45
could pay doctors and providers for
12:47
improving overall health
12:49
delivering higher quality care and
12:51
helping coordinate their patients care
12:56
so when we ask people in response to
12:59
that prompt how well do you think an
13:01

approach that pays providers for
13:03
improving overall health delivering high
13:05
quality care and helping coordinate
13:07
patients care this is what we found
13:11
when they were forced to choose between
13:12
us and a fee-for-service and the current
13:14
system providers being paid based on
13:17
results is preferred by a four to one
13:20
margin over the fee-for-service and you
13:23
can tell that from the blue bars the
13:28
the new system versus the current system
13:31
in red bars
13:33
and what we saw was this was true across
13:36
party identification Insurance type
13:39
ethnicity age education and even
13:42
geography and we didn't see these
13:44
results just in the survey but we all
13:47
across all three research tools we saw
13:50
high levels of support in focus groups
13:52
as you can see 64 percent
13:56
um in the National survey thought this
13:58
would work well in in our remesh
14:01

sessions we saw that 89 of participants
14:04
supported this approach
14:08
almost immediately people saw an
14:11
opportunity for more personalized care
14:14
however
14:15
respondents also quickly perceive this
14:18
to be a large overhaul to the system
14:20
which previous research has told us that
14:23
people do not want and they have
14:25
certainly equated all of this with an
14:27
increased cost
14:31
now what we did see in our remesh
14:33
findings was that people were still able
14:35
to make the connection with this new
14:37
approach and the care that they want to
14:39
be receiving and they were also aware
14:41
that the current payment system
14:43
prevented their providers to be able to
14:45
deliver this type of care so essentially
14:48
they like the idea of incentivizing the
14:51
providers to give them the care that
14:53
prioritizes quality over quantity
14:58

but people of course also had their
15:01
reasons to be skeptical
15:03
they worry that it could cost more if
15:05
doctors were seeing fewer patients
15:08
they worried that a move away from fee
15:10
for service might encourage providers to
15:12
ignore certain or more complex problems
15:15
to favor ones that could actually be
15:17
fixed
15:18
and they were also worried about the
15:20
wait times since they would be spending
15:23
more time with patients
15:29
so from all of our methodologies on
15:32
message testing on value-based care we
15:34
were able to assess four main
15:37
recommendations for how to talk about
15:39
this new approach with everyday people
15:44
the first is to State the need
15:47
our research has shown that people want
15:50
the quality care they deserve regardless
15:53
of their Identity or where they live
15:56
that meets their unique needs that the
15:59

current fee-for-service system does not
16:00
do and prioritizes the patient for
16:03
overall better quality outcomes
16:07
number two describe how it works
16:10
rather than paying for care based on the
16:13
number of visits tests and procedures
16:15
this approach allows people to spend
16:18
more time with their providers so that
16:20
they can get to know their patients and
16:22
develop more personalized approaches to
16:25
addressing your full set of unique
16:26
concerns in fewer visits
16:30
the third describe potential benefits
16:34
this approach also encourages providers
16:37
to coordinate with one another while
16:39
taking a broader view of all of the
16:41
factors that may be impacting a person's
16:43
health rather than jumping too quickly
16:45
to the next patient or to prescribe
16:48
drugs in order to in order
16:51
to potentially unnecessary procedures
16:54
that drive up costs
16:59

four inoculate against potential
17:02
concerns this approach is targeted in a
17:05
straightforward fix that puts quality
17:07
over quantity eliminating the greed in
17:09
our health care system that results in
17:11
patients being treated as a series of
17:12
symptoms rather than a whole person
17:15
while helping identify and manage health
17:18
concerns that could become very
17:19
expensive if ignored
17:23
so now I'd like to take a couple of
17:25
minutes to walk through some of the
17:26
cautions and considerations that we also
17:29
recognize based on our findings
17:33
the first was that the term value-based
17:36
care is essentially subjective and
17:39
encourages misinterpretations and
17:41
misunderstandings of what is trying to
17:43
be achieved
17:44
some research participants connected the
17:46
term connected with the term because
17:48
they wanted to feel more valued by their
17:51

provider but a majority associated with
17:54
with it being cheap low quality cost
17:57
saving measure like value-based brands
18:00
in the supermarket
18:02
in the survey actually respondents
18:04
approve of quality focused care or a
18:08
Patient First Care 89 or 86 respectively
18:11
while the term value-based care actually
18:14
got 59 approval with less of half of the
18:18
intensity of other terms
18:21
in our remesh Session One participant
18:23
commented that value-based care made
18:26
them think of cheap low quality service
18:28
and actually 75 percent of those
18:31
participants agreed with that sentiment
18:36
the second caution is that there's a
18:38
perception that the approach would
18:39
result in increased cost
18:42
um in our survey we saw that 46 percent
18:44
thought that the cost would increase
18:46
compared to 14 that actually saw that
18:49
the cost would decrease
18:51

and one rewrash participant commented
18:54
I fear it'd be more expensive because
18:56
the doctors couldn't see as many
18:57
patients and actually 69 percent of our
19:00
remesh participants agree with that
19:02
so we know from past research that
19:04
people's top goal for the health care
19:06
system is to reduce costs
19:09
solutions that people think would
19:11
increase costs would likely face
19:13
significant challenges in building
19:15
public support or uptake so when we
19:17
tested that message centered on cost
19:19
control participants like the idea but
19:22
they were skeptical skeptical that this
19:24
approach would actually
19:26
um live up to its promise
19:28
so we recommend integrating real world
19:31
numbers about potential cost Savings of
19:33
this approach into messaging as it
19:36
becomes available so for now we actually
19:38
recommend emphasizing the cost savings
19:41

that could result from treating health
19:43
concerns that would become expensive if
19:46
ignored while avoiding the cost of
19:48
uncoordinated care and unnecessary
19:50
procedures
19:54
the third caution is while we see high
19:58
levels of interest in moving to this
19:59
approach people are skeptical about how
20:02
would we work in practice and they
20:04
actually call out several drawbacks
20:06
including the sense that shifting
20:08
approaches would be an overhaul of the
20:10
current system we saw in our survey at 4
20:14
52 percent considered this to be a large
20:17
overhaul
20:18
and we know from past uh research that a
20:21
majority of the people prefer targeted
20:23
fixes that won't disrupt their existing
20:26
care and providers the solutions that
20:28
feel like an overall overhaul actually
20:31
have less uh overall support
20:34
um they also fear that it would make it
20:36

harder for people to see their providers
20:38
and get care those with less firm
20:41
initials opinions on this approach were
20:43
much more concerned about it being part
20:45
of the to see their doctor
20:47
and we heard from one remesh participant
20:50
say
20:51
doctors wouldn't have enough time for
20:52
everyone a lot of resources would be
20:54
spent on people with small problems and
20:57
we saw about 63 percent of people agree
21:00
with that
21:03
um we also heard that doctors would be
21:04
even more overlooked which would make
21:07
longer wait times for appointments and
21:09
63 percent of people agree with that too
21:12
so a concern that this approach would
21:14
disproportionately Advantage those with
21:16
more serious or diagnosis or chronic
21:19
conditions as their understanding leads
21:22
them to believe that providers would
21:24
actually be disincentivized from
21:26

treating these types of patients and we
21:28
heard from one focus group participants
21:30
say
21:31
I feel like it would be it would help
21:33
people with curable diseases the most
21:35
because if doctors are getting paid for
21:37
results they're probably going to put a
21:40
little bit more effort towards something
21:41
they can cure rather than something that
21:43
they could just treat
21:45
and then one remesh participant said
21:47
reduce profit incentive could lead to
21:49
apathy or ignoring certain types of
21:52
problems and we saw 64 percent of people
21:55
agree with that
21:59
so similar concerns about cost increases
22:02
that we mentioned above as to the
22:03
skepticism so we recommend integrating
22:06
and or testing the real world impact of
22:09
these items to alleviate these concerns
22:14
so the fourth caution is that we want
22:17
peop people want to have every Treatment
22:19

available to them if they ever need it
22:23
Concepts that highlighted the perks of
22:25
avoiding potential unnecessary tests
22:28
when we tested in our survey actually
22:31
backfired and so you can see a couple of
22:35
quotes here
22:36
more tests could be useful I mean at the
22:38
end of the day they're investigating
22:40
your condition sometimes you need it
22:42
and another participant said I'm not
22:45
sure how it would work what is the end
22:47
result that they're being paid for I
22:49
mean obviously if there's an illness
22:51
that is curable but say there's an
22:53
illness that is not curable and they're
22:55
treating you but like
22:58
don't you want to be cured like
22:59
Alzheimer's or something how do they
23:01
succeed at something like that and still
23:02
get paid
23:08
so the fifth and final consideration is
23:10
Shifting away from the fee-for-service
23:12

approach requires complex technical
23:14
changes to the payment system provider
23:17
behavior and health insurance procedures
23:19
and as a result there is likely to be a
23:22
tendency to move quickly into those
23:24
details which our findings show could
23:26
create significant challenges for
23:28
building public support
23:30
people respond positively to the new
23:32
approach when we focus on the patient
23:35
experience
23:37
we tested a variety of topics related to
23:39
providers
23:41
including their motives to enter the
23:42
field and whether they should be
23:44
incentivized or held accountable for
23:45
providing care it has good outcomes and
23:49
we heard a mix of responses and highly
23:51
recommend keeping the public messaging
23:54
focused on the patient experience
23:56
some of the findings related to
23:58
Providers actually included
24:01

I think most doctors come from wanting
24:03
to help people in the beginning but most
24:06
lose that Personal Care over time and
24:08
care about the money in the end and we
24:11
see 60 agreed with that
24:13
and participants were split on the need
24:16
for accountability which they
24:18
organically introduced in the focus
24:20
groups versus giving providers Financial
24:22
Rewards or incentives to provide high
24:25
quality care so they said the system
24:28
must get away from money and instill one
24:30
that focuses on outcomes there is no
24:33
accountability doctors can get away with
24:35
whatever they want and as long as they
24:37
think it benefits the patient
24:39
yeah it's very risky
24:45
so here's a summary table of the
24:47
messages that resonate and gives ma to
24:50
the considerations and cautions we just
24:51
outlined
24:52
this is a good tool to keep in handy for
24:55

when you hear some of the common terms
24:57
related to value-based care come up
24:59
this is one that you can kind of
25:01
reference as a say This Not That and
25:05
when you look at the rationale that
25:07
encompasses both what people have wanted
25:09
from the system and um the skepticism
25:13
that also needs to be addressed within
25:16
this approach
25:18
next
25:20
so as I get ready to close here's a
25:22
recap and summary of items to keep in
25:24
mind when talking about quality over
25:26
quantity approach first use Simple
25:29
language
25:30
participants throughout our research
25:32
have consistently defaulted to simple
25:34
phrasing and familiar terms
25:36
a lot of existing language describing
25:38
the approach is overly complex and if
25:41
the goal is ultimately to increase
25:43
implementation and uptake of this
25:45

approach it's important that even public
25:48
officials and policy makers use language
25:50
that are relatable to people
25:53
stay focused on how the approach will
25:55
improve experiences getting care with an
25:58
emphasis on increasing high quality Care
26:01
the opportunity to increase quality has
26:04
welcomed has been welcomed by research
26:06
participants
26:08
and was a top-selling argument actually
26:10
for shifting away from the people
26:11
service approach
26:14
get ahead of concerns that people
26:17
Express
26:18
and finally finally finally don't use
26:21
the term value-based care
26:25
well Kristin that's all I have for now I
26:29
can turn it back over to you
26:32
thanks very much Dennis and now with
26:36
this work completed here's a look at
26:38
what is next for us we've Consolidated
26:41
these findings into a toolkit of easy to
26:44

use resources which are available on our
26:47
website that we hope will help you use
26:50
messaging that resonates with people
26:51
we'll also continue to share what we've
26:55
learned with policy makers and
26:57
interested audiences like you and
26:59
finally we plan to conduct further
27:01
research as needed to deepen our
27:04
understanding even further
27:07
thank you so much for listening in to
27:10
today's briefing we hope that you found
27:12
it informative and thought provoking the
27:15
United States od Care team will continue
27:17
to Pioneer Innovative research on this
27:20
and many other issues and we look
27:22
forward to keeping you informed