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Mark Masselli: This is Conversation on Healthcare, I am Mark Masselli.

Margaret Flinter: And I am Margaret Flinter.

Mark Masselli: We are officially two weeks into Open Enrollment for the 2018 marketplace under the Affordable Care Act, and enrollment numbers thus far have exceeded early sign up numbers from all of the previous Open Enrollments significantly and that's good news. The bad news is, and it bears repeating, this year folks have a lot less time to sign up only six weeks.

Margaret Flinter: More than 600,000 people signed up for coverage in the first four days of Open Enrollment which began on November 1st, and Mark, I think back to the very first year of Open Enrollment we didn't see anything like that. It takes time for people to get used to the idea and understand the process.

Mark Masselli: This year's early enrollees almost 140,000 people are new customers on exchange. So in spite of the near or complete elimination of the marketing budget for Open Enrollment, consumers are taking charge of their coverage and signing up in far greater numbers than analysts or the Trump Administration had expected.

Margaret Flinter: Well, we wanted to again remind people that you don't have the luxury of procrastinating this year, enrollment ends in mid-December so no time to wait if you are thinking of enrolling, do it now.

Mark Masselli: Meanwhile, the President has announced his pick for Secretary of Health and Human Services. Alex Azar ran Eli Lilly's U.S. operation and worked at the Department of Health and Human Services under George W. Bush. Whoever is in-charge one thing is certain the healthcare is in the throes of transformation and that brings us to our guest today, Ted Robertson is Managing Director of Ideas42, a non-profit design and consulting firm that has created a model for bringing behavioral design disciplines to healthcare.

Margaret Flinter: And Lori Robertson will be stopping by, the Managing Editor of FactCheck.org, she is always on the hunt for misstatements spoken about health policy in the public domain. But no matter what the topic, you can hear all of our shows by going to www.chcradio.com.

Mark Masselli: And as always if you have comments, please e-mail us at chcradio@chc1.com or find us on Facebook or Twitter, we love hearing from you.

Margaret Flinter: And we will get to our interview with Ted Robertson in just a moment.

Mark Masselli: But first, here is our producer Marianne O'Hare with this week's Headline News.

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Marianne O'Hare: I am Marianne O'Hare with these Healthcare Headlines. Taking away the individual mandate, well, that's part of the plan embedded in the tax proposal put forth in the senate. Removing the individual mandate requiring all Americans to purchase insurance would eliminate the tax penalty that people would have to pay for not purchasing insurance, but it would also likely lead to millions of Americans no longer having health insurance coverage. About 13 million over 10 years would lose coverage if the individual mandate went away. The Congressional Budget Office warns the tax bill as it currently stands would add about $1.5 trillion to the deficit, and that would trigger automatic cuts to Medicaid about $25 billion.

Meanwhile Seema Verma, Administrator of the Centers for Medicare and Medicaid Services, is advancing plans to install work requirements for so-called able body people receiving Medicaid benefits. It reflects a plan that was passed under her leadership in the State of Indiana. Half of Americans are suffering from high blood pressure that after the American Heart Association issued new guidelines for measuring blood pressure lowering the threshold from 140 over 90 down to 130 over 80. Advances in heart medications have already led to a significant reduction in death from cardiac events, but it's still the leading cause of death in this country. This lowering of the threshold will enable clinicians to help identify those at-risk earlier, and the experts also recommend more focus on lifestyle and behavior changes, diet and exercise to be applied before automatically initiating medication. Still the numbers are concerning based on these new guidelines 63% of Americans between the ages of 45 and 75 have hypertension, some 100 million Americans in total now considered to have high blood pressure. I am Marianne O'Hare with these Healthcare Headlines.

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Mark Masselli: We are speaking today with Ted Robertson, Managing Director of Ideas42, a non-profit design and consulting firm that uses insights from behavioral sciences to address complex social problems in health care, city government and national civic entities. Before joining Ideas42, Mr. Robertson was a Visiting Scholar and Fellow at the Harvard Kennedy School of Government. Prior to that, he assisted the Los Angeles Transit Authority in redesigning the public transportation system to be more supportive of public health. He earned his B.A. in History from Oberlin and has Master's in Public Administration from Harvard Kennedy School. Ted, welcome back to Conversations on Healthcare.

Ted Robertson: Thank you so much. It's a pleasure to be here.

Mark Masselli: You know, we are excited about the transformations that are going on in healthcare, it's quite dramatic in your organization. Ideas42 has been developing strategies to address the complex challenges of organizational redesign for all kinds of entities from Fortune 100 companies to large municipalities. And you just completed a comprehensive study for the Commonwealth Fund which suggests that up till now we may have missed a vital link in our quest to build a more efficient and sustainable healthcare system that need to focus more on behavioral design thinking. I am wondering if you could share with our listeners why you think this is an important missing link in the redesign of healthcare?

Ted Robertson: Behavioral design is a term that we use to think about the application of behavioral science and behavioral economics in the real world. You know, medicine has filled with a lot of very smart people doing great clinical trials, but there is still a problem around the delivery of services. And behavioral design, its strength is that it's – takes behavioral science rooted in the idea that we are not these hyper-rational sparks that traditional economics thinks we are. So most service delivery in government and in healthcare and elsewhere assumes that all people will perfectly calculate the utility of any action at all times. The reality is that people are people and that's not true, but now there is all science behind how that's true, and that when people are not sort of hyper-rational sparks they actually act in predictable ways. If you take that insight to combine it with another revolution which is around impact evaluation, you can put those two together and continuously look for new design that are more effective and then measure and make sure you are actually having the outcome you want. So the classic example of this outside of healthcare is around energy where energy statements that they get from their utility that compares them to their neighbors. Well that's a behavioral science insights and it gets about 2% to 3% reduction in energy use.

Entirely framed around how people think they are in comparison to their neighbors, simply keeping up with the Jones so to speak. And in fact the science behind it will show you the closer the cohort the more effective it is. So if you compare them to say your 100 more efficient neighbors that's get the strongest affect. And so it's taking that behavioral science of people relate to the social norm and react to it, and operationalizes it in a way that then changes behavior. So for us, it's really about helping people, matching up the follow behavior to their intention. And medicines are now more and more samples like this so one little one is very instant study at the University of Pennsylvania Medical Center with having problems, having providers prescribed generic drug. So it come up in the drop down list and you can pick which one you want to do, but there was no immediate default. Well, what they did was change a system in a pretty small coding tech that they can do locally, and they defaulted to the generic option and the rates went from mid-70s to high 90s. So taking those sorts of things that we think can be applied a lot more in help to get better outcomes.

Margaret Flinter: I think that those of us who are within the healthcare system often are very challenged by the fact that our reality is we've organized the ways we delivery care over a long period of time, but yet, we are trying to remain agile enough to transform that system. I had seen you have really focused in on this at Ideas42 this idea that we can stop what we are doing to start a new way, we've really got to transform while we are fully operational and whatever sphere we are in. So maybe you can talk for this about what some of your strategies have been in executing these systems' redesign?

Ted Robertson: Yes, we have started to develop a framework that we run through to breakthrough some of those hurdles. When thinking about working with an organization or department [inaudible 00:09:01] problem we clearly look for buy-in from the top so that the concept of trying those at all has strong support. We could put it into priorities of the organization to one – incentivize everyone because people are trying to fix big problems and so if you can be a helpful tool they want to use you. And two, to get people some risk to try something new because we do operate, it's evidence based, it's written science but it's still new and as we try but equally important is that you find the champions at the department level that may already be trying things but who want this added capability and capacity. The second thing that was that we've gotten very practiced at thinking through what type of problems to take on because in government and in health care there are thousand things you could do, tapering out okay that's an interesting problem but that's really a structural problem or that's a political problem whereas this is a behavioral problem. And so in separating those out we can curate that different results and sort of work your way in and we look for where there is already a work process in place so we can integrate without having to create a new – the data has already been collected along the way we build into our work, training people how to do all of this, some of it is -- people are already doing impact to valuation and medicine is much more developed than there is in governance but the behavioral science aspect is probably is still very new. And so helping -- you know showing people that you are leaving skills behind, I think is appealing and gets people to buy in a new thing.

Mark Masselli: You know Ted I really like that your report focuses on the importance of behavioral design teams which you say brings vital perspective to the process organizational redesign in there, the challenge though is often a cultural one, the notion we've always done at this rate you know and we have a thousand people workforce, but Margaret and I are the leaders in the organization and we interview everyone who works at the organization and 95% of the people say I've never met let alone been interviewed by the CEO. How could the leaders at the top get champions if you've never had a conversation with them? I wonder if you could walk through our listeners this process of behavioral design team intervention, and why you think it's such a powerful tool?

Ted Robertson: When we're looking at any problem do we have a change champion or someone who wants to try something new, are there incentives aligned to make this change so is it a priority for the organization either because of cost or outcomes or both. And then how do we then actually get in there. So we identify the problem, we then test and if we get good results on testing usually in pilots and those prototypes then we look to scale in some way. What's I think different about behavioral design is even going back to the problem, so we sort of strip away assumptions in the problem and also a right side that we don't try and say even if there were interested say in solving problem we look for something that might be how do we create more insurance access for a certain segments and what's their access and okay let's look at their problem that way. So we get the right scope. We will get out and interview all parties involved so and in this case you could imagine doctors, nurses, staff but also the patients and the patients' families and that sort of thing. So we get out and go look at the physical space or the digital process and the point of that is then to take that data and match it against the actual evidence in the behavioral science sphere. So we will go and look at what set of studies have already been done on that particular problem. So if you want to look at the use of statins we will go and look at who else has done behavioral science statin example, and we would curate that science and say what does it suggest might be both the actual bottleneck to watch some of that falling through is it just the hassle, is there some sort of threat there that's pushing them away and we sort of analyze those bottlenecks and look for the ones that we think are the two or three top ones, and then we would try and within the constraints of the system we are in build a design that we think could be effective, but that really that diagnose and design space that behavioral science has a lot to offer.

Margaret Flinter: You've noted that Dr. Peter Pronovost who we've also had on the show here he has done more to save lives in health care than any single laboratory discovery over the past decade with his simple but so elegant checklist before surgery with dramatic reduction in errors and infections and complications. Maybe you could talk to us about how you are applying these seemingly simple ideas as you advised health systems to improve their processes and try and reduce errors and get better outcomes?

Ted Robertson: Sure. The work that Peter and likewise Atul Gawande have done around checklist and safety inside the hospitals is astonishing. And in many ways it's routed around again core human behavior, so I think Dr. Pronovost example he started [inaudible 14:00] where they started to realize that people in a prime pressured condition they will forget things that they know, they will neglect to perform basic steps that are critical, but by human nature are you know a pressure cooker. And so they miss something, they miss washing their hands, they miss getting a sterile mask that elevates the risk to the patient. Also the checklist is in essence a shortcut, you know, that gives people heuristics to go and say I need to be careful I don't go too much on automatic pilot and here is a quick way to make sure I've gotten the core things that I need to do and that's

exactly what he did and is now the surgical checklist for Atul Gawande that's being spread and scaled around the world.

Mark Masselli: It is very exciting we're speaking today with Ted Robertson Managing Director of Ideas42 a non-profit designing consulting firm that uses insights from behavioral sciences to address complex social problems in health care city government and national civic and it is Ted you know we had the great opportunity of have a good friend from LA who heads up the city health system Dr. Mitch Katz and Mitch I think really sort of aligns with everything that you are thinking about you know he looked at this problem and then how could you as a physician get underserved and uninsured patients to specialists. And then he came up with let's transfer knowledge about the patient and not transfer people right. So we created something called e-consults I wonder if you could talk about what you've learned when you applied behavioral designed techniques there in and maybe you could share some examples.

Ted Robertson: You know my early work in Los Angeles was around transportation and that was at a moment even earlier in behavioral science that you had a system that even on the basic things wasn't really accounting for human behavior. So you know you could think about that in terms of the bus or the train you know it was hard to get on or hard to get off it was hard to get a pass you know it just wasn't simple and built that way.

Margaret Flinter: So, Ted one of the ever present challenges for clinicians in healthcare is to get patients the appropriate tool to initiate their own behavior change to improve their health. What have you found successful in generating behavior change and maybe selfcare specifically around health in the patient population what do you think?

Ted Robertson: I don't think behavioral science has figured out the complete solution by any means in terms of the medication hands or so and so forth, but I think that there are some helpful lessons. One is make it easy, I know that sounds well of course you want to make it easy, but it actually matters. Well traditional economics would say that if it really matters to you, you will make sure something happens anyway, but the reality is even though that actually matters people don't and for a number of reasons and one of them is it's actually not as easy to do that. So giving people default pathways are extremely powerful and it's easy to lose sight of that, when you are asking people to do something it really helps to prompt people with a very clear actionable step. One, two and three is what you should and can do. What we call closing the intention to action gap, then actually having people to do plan making and reminding them. So there is a famous behavioral science study around flu vaccinations where Katy Milkman at Wharton she took a fairly standard small little post that told you when the vaccinations could be gotten, but just out of the box it says okay, but this is the day and time that I will go that got a significant bump and how many people actually follow through.

Mark Masselli: So Ted, tell our listeners about Ideas42, what was the impetus that got you over the root to come there to say healthcare was the place you wanted to be?

Ted Robertson: We started actually out of academia and academic labs at Harvard, MIT and Princeton, it was still the very end of where behavioral science is still all and academia was starting to jump to applied space. We became a non-profit, it was dedicated to taking behavioral science and applying it for social good. So now we work all around the world on issues from post-secondary education, getting low income mostly first generation students in the college and persistent to college or the whole set financial products it could be better designed for low and middle income communities. We work so across global health and then government and so we helped launch under the Obama Administration the first of its kind and in the U.S. behavioral science team in government. So we sat in the federal government and helped to run a whole set of these experiments all curated science all kept as kind of across different domains health and otherwise. For help I think there is a whole host of behavioral problems here and you can build a methodology that in an almost engineering like way can help redesign processes. There is a lot of stock in health around clinical trials and around innovation and that's great. Well that's seen rigorous process based on past evidence passing to see what works and then going to the next step can be built in on service design and you can do with behavioral science and that's the opportunity I think that's in front of us.

Margaret Flinter: We have been talking today with Ted Robertson, Managing Director of Ideas42, a non-profit design and consulting firm that uses insights from the behavioral sciences to address complex social problems and healthcare city government and national civics entities, you can find their report on behavioral design teams of the commonwealthfund.org or follow up his work at Ideas42.org or follow them on Twitter at Ideas42. Ted thank you so much for joining us on Conversations on Healthcare today.

Ted Robertson: Thank you so much.

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Mark Masselli: At Conversations on Healthcare, we want our audience to be truly in the know when it comes to the facts about healthcare reform and policy, Lori Robertson is an award-winning journalist and Managing Editor of FactCheck.org, a non-partisan, nonprofit consumer advocate for voters that aim to reduce the level of deception in U.S. politics. Lori, what have you got for us this week?

Lori Robertson: President Donald Trump says that branded prescription drugs are generally cheaper outside the US and that's true, but he distorts the facts

when he says, “as usual” the world is taking advantage of us. Prescription drug pricing expert say Trump’s complaint is with pharmaceutical companies and US legislators who bulk at such cost controlling measures as having the federal government negotiate drugs prices for Medicare. Trump made his comment on the cost of prescription drugs during a cabinet meeting on October 16. He said the US is paying prices that are double, triple, quadruple what other countries pay. But expert say the overall difference from other countries is in fact large. One expert told FactCheck.org that branded prices on average are between 10% and 40% higher in the US compared with other industrialized countries. This comparison doesn’t include cheaper generic drugs which make up about 84% of filled prescriptions in the United States. As per Trump’s claim that the world is taking advantage of the US expert told us the US is the one that’s responsible for high cost of drugs, not other countries. Most other developed countries have a centralized healthcare system that allows the government to negotiate drug prices with the pharmaceutical companies not the US. In fact a Medicare drug law passed in 2003 specifically prohibited Medicare from negotiating prices with drug companies. Lawmakers mostly Republicans have resisted the idea. Some say price controls would limit research and development. Trump said he wanted to “bring our prices down to what other countries are paying” but he didn’t say what measures he was supporting to do that. And that’s my fact check for this week, I am Lori Robertson, Managing Editor of FactCheck.org.

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Margaret Flinter: FactCheck.org is committed to factual accuracy from the country’s major political players and is a project of the Annenberg Public Policy Center at the University of Pennsylvania. If you have a fact that you would like checked, email us at www.chcradio.com, we will have FactCheck.org’s, Lori Robertson, check it out for you, here on Conversations on Healthcare.

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Mark Masselli: Each week Conversations highlights a bright idea about how to make wellness a part of our communities into everyday lives. Soaring prescription drug prices have been taking a toll on American Health Consumers, but until now most didn’t understand how those prices were set. Or more importantly that they might actually have some saying what their prescription drugs cost them. Many Americans have resorted to purchasing prescriptions online often illegally or overseas while cheaper these solutions come with their own risk. So an enterprising pair of brothers have created their own solution Matthew and Geoffrey Chaiken founded Blink Health a free online destination that linked patients with prescription sources that can be up to 90% cheaper than what’s found on the traditional market.

Matthew Chaiken: The way I work is you go to blinkhealth.com you look up the name of your medication, the price you see there is the price you get it over

60,000 pharmacies nationwide, if that price is less than what you normally pay for your prescription you can pay for it online provide we provide you with what we call a digital Blink Pharmacy card, you show that card to the pharmacist they type in the codes on that card and that your medication brings up zero dollars.

Mark Masselli: Co-founder Geoffrey Chaiken to CBS news recently they negotiated prices directly with drug manufactures.

Geoffrey Chaiken: We actually have contracts with every single pharmacy in United States so with the nature of the contracts they accept our prices, so we have different prices at each pharmacy but what's important for consumers is that when they go to Blink there is one price that they are going to see they will get that price no matter which pharmacy they go to.

Mark Masselli: The Chaiken brothers say the element that makes it work so well is customers can purchase the drugs online. But still pick them up at their trusted local pharmacy, since Blink launched last year users have saved millions of dollars on prescriptions and a majority of those prescriptions are filled for $10 or less. A welcome reality at a time with not only drug prices are going up but co-pays and out of pocket costs are rising dramatically as well. Blink an online site for purchasing prescription drugs offering consumers an option to safely fill prescriptions at a far more competitive price than the going rate allowing them to stay healthy and save significant money at the same time. Now that's a bright idea.

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Margaret Flinter: This is Conversations on Healthcare, I am Margaret Flinter.

Mark Masselli: And I am Mark Masselli, peace and health.

Conversations on Healthcare broadcast from the WESU at Wesleyan University, streaming live at www.wesufm.org and brought to you by the Community Health Centre.