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Developing Better Clinician-Patient Interface Systems: A Designer's Approach

Mark Maselli:
This is Conversations on Health Care, I'm Mark Maselli.

Margaret Flinter:
And I'm Margaret Flinter.

Mark Maselli:
Well Margaret, the Supreme Court closed out another session with a bang, deciding in favor of a suit by the owner of the Hobby Lobby chain stores who argued that as a closely held company they shouldn't be forced to provide certain types of contraception coverage to their employees based on their religious beliefs.

Margaret Flinter:
Well, that 5/4 decision has evoked a firestorm of protest from a number of groups including the American Medical Association, the American Nurses Association, Planned Parenthood, among others. And those delivering frontline medical care across the country know this will have an effect on women's access to all contraceptive options that are generally open to them.

Mark Maselli:
It's a matter of women's health, Margaret, and this will force many women to pay out of pocket for these services that should have been free to them under the Affordable Care Act. It's going to particularly impact women who are more economically challenged.

Margaret Flinter:
Well, that's why these groups, the AMA, the American Nurses Association, Planned Parenthood and others have sent a message to the White House that they really need to come up with a quick solution to the issue. It's going to have ripple effects across the country as other companies, corporations with any degree of religious orientation or belief may follow suit.

Mark Maselli:
The majority decision stated that this was a narrow interpretation, saying that only closely held for profit companies could legally refuse to provide contraceptive coverage. But there's still a majority of companies across the country, so this decision could impact millions of women down the line.

Margaret Flinter:
And there are other contraception-related lawsuits that are waiting in the wings. I think they will take some wind in their sails from this. So the story is far over, and it's going to be very interesting to see what innovative solutions might fill this coverage gap that will result from the Supreme Court decision, Mark.

Mark Maselli:
Well, speaking of innovations, from time to time we like to spotlight young innovators who are poised to make an impact in the health care industry. And our guest today is a recent White House Fellow working in health data and former Entrepreneur in Residence at the Mayo Clinic.

Margaret Flinter:
Adam Dole, he's considered an up-and-comer in technology in the health care space. He's got some interesting ideas about how to improve patient interaction with their own health data, also how to improve the flow between patients and providers through the medium

of their electronic health records.

Mark Maselli:
Laurie Robertson, Managing Editor of FactCheck.org looks at claims about public health crisis of gun violence on school campuses. But no matter what the topic you can hear all of our shows by going to CHC Radio.

Margaret Flinter:
And as always, if you have comments please e-mail us at chcradio.com or find us on Facebook or Twitter, because we love to hear from you. Now we'll get to our interview with Adam Dole in just a moment.

Mark Maselli:
But first here's our Producer Mary Ann O'Hare with this week's headline news.

Mary Ann O'Hare:
I'm Mary Ann O'Hare with these Health Care Headlines. Fallout continues from the Supreme Court decision to allow private for profit companies to deny certain birth control coverage to their employees. Across the country women, employers, insurers and health care advocates are trying to adjust to the new legal landscape created by the Supreme Court's decision allowing some for profit companies to deny contraceptive coverage to employees based on their religious faith.

As the real-life impact of the controversial ruling slowly begins to play out questions about its breadth, scope, and meaning continue to be debated in the 5/4 decision. The high court ruled two family-owned corporations did not have to cover birth control in their employee health insurance plans as required under the so-called Contraceptive Mandate provision in the Affordable Care Act.

The Obama administration will likely have to issue regulations tweaking the contraception rule to allow some employers to opt out and to enable their workers to obtain coverage another way. The compromise arrangement that involves passing responsibility to an insurer however is unacceptable by some religious groups. While free birth control coverage is required under Obamacare the insurance administrators providing it for workers at religious-affiliated groups say the current solution has left them stuck with the bill.

In other women's health news the American College of Physicians has issued a major change to screening guidelines for women's well visits, suggesting that pelvic exam is no longer needed. The evidence-based study done in the Minneapolis VA found tests to be intrusive, and could even lead to more harm for many women undergoing exams.

The recommendation does not apply to pregnant women and women undergoing treatment for medical issues. The American College of Obstetricians and Gynecologists released a statement saying the group would continue to stand behind its current guidelines that an annual pelvic exam is recommended for all patients over the age of 21.

Prescription drug overdoses lead all other drugs in deaths, including heroin and cocaine combined, and the problem has been getting steadily worse. But there are some pockets of improvement. Public health officials have identified a sharp decline in overdose deaths involving prescription painkillers for the first time in a decade.

Deaths involving OxyContin, Vicodin and other narcotic painkillers dropped by 26 percent over two years in Florida after a crackdown on pain clinics that dispensed high volumes of the medications. Lawmakers there barred doctors in these pill mills from selling the drugs they prescribed.

And exercise, we know it's good for the body, and so it would seem for the brain. A study of older folks at the Cleveland Clinic showed those between the ages of 65 and 89, some of whom carried a gene thought to increase the odds of developing Alzheimer's, were able to preserve their brain health longer with simple moderate but consistent exercise.

In effect the brains of physically active volunteers at high risk for Alzheimer's looked just like the brains of people at much lower risk for the disease. Meanwhile the brains of sedentary people at high risk appeared to be slipping structurally towards dysfunction. I'm Mary Ann O'Hare with these Health Care Headlines.

Mark Maselli:
We're speaking today with Adam Dole, a recent Fellow in the Presidential Innovation Program at the White House which seeks the best and brightest minds of the 21st century technology and innovation skills to transform the way government works for the people it serves. Mr. Dole is the former Entrepreneur in Residence at the Mayo Clinic, where he helped develop new ventures at the intersection of health and technology to improve care delivery.

Mr. Dole has held leadership positions at NASA Human Factors Research Division as well as several strategy and innovation consulting firms, Jump Associates and Method Inc. He earned his bachelor's degree from Syracuse and his master's in design strategy from the California College of Arts. Adam, welcome to Conversations on Health Care.

Adam Dole:
Well, thank you very much, Mark and Margaret. It's a pleasure to be on the show today.

Mark Maselli:
And our show is about innovations in the health care arena, and you've caught the attention of the White House as an innovator in the health care space. And the program was launched in 2012 to address the lack of culture of innovation and entrepreneurship in government. Tell us about the Presidential Innovation Program and the collaborative process you were engaged in.

Adam Dole:
So the number one misconception that I had about government prior to becoming a Presidential Innovation Fellow was that governments could not innovate and didn't have innovative people. And I was pleasantly surprised to be shown that both of those assumptions were wrong. So that the purpose of the Presidential Innovations Fellow program is to pair private sector entrepreneurs with government innovators. And I thought that that was an oxymoron.

I didn't know that there were government incubators, and lo and behold there are. And they're spread across the government through different agencies at all different levels from some senior leader positions, all the way up to the Executive Office, to folks on the ground that might have very unique expertise. And the whole goal is to use the projects that we work on in the government agencies as a Trojan horse for change.

And the outcome of that change should ultimately be things like to create more jobs, save taxpayer dollars, and ultimately having a positive impact on the lives of all Americans. And coming from the private sector it is very rare where the expectation right out of the gate any time you do something is to impact all people in our country. The thing that drew me to the program was really the opportunity to work at a scale that is kind of unparalleled to anything else.

And I'll mention a few qualities of the Fellows, and the first thing is, like many entrepreneurs wearing multiple hats is a necessity, but not for the sake of just being able to have a lot of skills but really funneling those skills into being able to build something. Another quality of the Fellows was our ability to shorten feedback loops. So entrepreneurs tend to be really good at shortening feedback loops to optimize for what's working.

And then the last is probably more of a philosophical skill set, but it's not being able to take no from somebody who can't give you a yes. And this is particularly interesting in government because there's a lot of people that are in government, and luckily there are enough people with a sense of urgency to explore new things that it's just about finding those right people.

So there are a bunch of open data projects, which the goal there is to unleash government data sets in a way that make it easy for the private sector to take that data and do something useful with it. And then at the other end of the spectrum, and I would put the project that I worked on in that camp, Blue Button, which is really all about empowering people with access to their own data, which is a very different type of project from just the identified open data set.

Margaret Flinter:
I'd like to ask you to talk maybe about your approach to one of the projects, the Blue Button Initiative, and to expanding its reach. We've had several guests on the show who've had a direct influence on my data, also known as Blue Button. We've had Todd Park, and Farzad Mostashari, and _____ (10:04) among them. So Blue Button's been a tremendous success in certain areas like the VA, but it's still far from being utilized in the mainstream. What challenges did you see with Blue Button, and what solutions were you working on or did you find? What successes did you have while at the White House?

Adam Dole:
So you mentioned three of some of my favorite government innovators right there. I was fortunate enough to get _____ (10:30) to work very closely with all three, some of the most talented entrepreneurs in residence at the government. So to talk about some of the challenges. Most people know that Blue Button was started inside the VA. Everybody at the VA was really focused on making sure that veterans had access to their electronic medical records at any cost.

But the problem is, when you go outside the VA most of those experiences do not allow their patients to freely have access to their own records. And I would put that reason on the cultural issues that our health care system still has. The idea that somebody can get it in a machine readable form is very threatening to these health care organizations, because there's this fear that if you give patients access A) they won't know what to do with it. And so that's a cultural barrier that's getting in the way of Blue Button reaching its full potential.

And so I see more health care organizations getting culturally enlightened, if you will, and I think we're going to see even more of that as we see health care payment reform starting to incentivize things like outcomes. And before this year Blue Button had really focused on data that was coming out of hospitals. So most people's interactions with the traditional EMR are fairly limited and not really that

engaging today.

So we had a hypothesis coming into the year that if we could position or reposition Blue Button to be more relevant to a consumer mindset where consumers feel empowered, where they want to spend their money, and how they experience the goods that they're going to pay for. And so we approached retail pharmacy chains as a way to test this hypothesis. That look, retail pharmacy chains have a great opportunity to impact on health care at a local level.

There's a lot of touchpoints inside the pharmacy that we could really leverage to get people to care about their own health care data. And then medication management is a huge cost to the system and a huge cost to individuals' outcomes. So when you add those three things up looking to expand Blue Button into the pharmacy realm made a lot of sense. And we saw a really interesting uptick in interest in how individuals can experience Blue Button in those contexts but also a lot of interest from other businesses.

The second thing that we did was, we helped to facilitate the technology standards, the government's role in setting the standards to facilitate the process of bringing the right stakeholders and a lot of private sector organizations to the table to figure out what those standards should be. And the standards fall into two buckets. The content standard, so how health care information is being communicated. And then the second set of standards is how that information, how that content gets transmitted.

And then the third thing that we did this year, we made it easier for consumers or patients to find their own data. And then we also made it easier for organizations that wanted to support Blue Button and to be able to do that. And we did that through two products that we built this year, because we wouldn't be able to call ourselves entrepreneurs in residence if we didn't actually build something tangible.

And so we built something called the Blue Button Connector, which is a online tool that is now run by Health and Human Services that allows individuals to go search for where their data might exist across the spectrum of data holders. And it allows them to basically go to a profile page, not unlike Facebook, for that organization and understand what that organization is doing on their behalf as it relates to their data and what types of features and functions are available with their data from that organization, and then it allows them to click through to sign into their portal from that organization.

The second product that we built was something that we're calling the Blue Button Toolkit, a toolkit with all the Blue Button resources so that an organization can self-identify it. You can go onto the Toolkit and consume all the resources that we have that can help them promote patient engagement and evangelize the purpose of Blue Button.

Mark Maselli:
I want to get back to your sort of thought that we need to embed cultural enlightenment into the health care industry. That's a great concept, and it's a land of steady habits, and none of them are good in the health industry at this point _____ (15:00). And we recently had the go-around with open enrollment in the insurance exchanges that human behavior has limitations in navigating new technology, especially when it comes to something personal like health care.

I loved one of your qualities of building things that people can use. Thinking from our own vantage point at our organization we always tell people, "Build things that are efficient, effective, and elegant," and I think when we talk about elegance we're talking about design, because design's so important. That's why I'm holding my iPhone right now. It's got design and it really attracts people to it. I wonder just how your thinking and how the Presidential Innovation Fellows are thinking about this transformation, again getting back to the, how do we embed cultural enlightenment into the health care industry?

Design's so much an important part of this because it's needed to bring the crosswalk between patients and providers, providers back to patients. What's your bigger thought process about the transformations that need to go on in the industry and to really try to transform a really moribund industry on so many different levels? What do you see out there that excites you?

Adam Dole:
That's a great question, Mark. I'm really glad that you're bringing that up, because I do believe that Design with a big D is one of the critical things that has been absent in our health care system. And when I can define for myself what Design with a big D stands for it goes far beyond the look and feel of a product or the colors, how that's being used on a webpage, but it's really thinking holistically and systemically about how we match the products and services that we are building with the unmet needs of the folks that need to engage in that product, and the entire process that is involved in doing that.

And it does involve at the level of aesthetics as well, because that obviously has a lot to do with how people experience services today. But most health care experiences I would argue do not take the needs of the patient or consumer, whatever term we want to use for people who are engaging or consuming health care products and services, into consideration. They think they do, but when you really dig into what a lot of the health care system today is set up to do it's solving the health care _____ (17:41), and it's forcing patients to get onboard with the value chain that is ultimately serving the health care system.

Which is why we have fee for service, why the experience of your explanation of benefits is so terrible when you get it in the mail. I mean, there's very little patient-centricity in the health care system today at scale, I would argue. There are some good signals and good pockets of where insight exists, but it's translated into very human-centric experiences for health care, and I think we're going to learn a lot from those going forward in terms of how to scale them. But I would argue that Design with a big D is absent, largely speaking.

That being said, I think we're sitting at an amazing time in history to be an entrepreneur in health care. It's actually looking to put more Design into our health care system to ultimately impact people's quality of life, and the cost of the system, and the quality. Three things that make me think that, and you mentioned one of them, is for the first time there is an increasing push to create more of a consumer experience, and this is driven through the health insurance marketplace.

We have more health care consumers that are thinking like consumers now than we ever had before, and that's I think going to become a crowbar for a lot of other things that will have to match consumer-grade experiences. The second thing is that we're starting to recognize different ways to align our incentives through a growing number of _____ (19:27) out there that are really incentivized to look at outcomes for the first time. I think that's becoming something that's taking a priority.

And then ultimately we're seeing a greater emphasis on products, and services, and tools that are designed to keep people well, whether those things are being reimbursed for today. I think we're only going to see more of that happen. And so those three things are ingredients for a kind of a perfect storm, not to mention all the increasing data liquidity that we are seeing.

It's only going in one direction, even though there's slow adoption of some of the Blue Button type of value propositions out there. I do think that more consumers are going to have more access to their data in more flexible formats. So when you add all those things up we're sitting at an amazing time.

Mary Ann O'Hare:
Absolutely. We're speaking today with Adam Dole, recent Fellow in the Presidential Innovation Program at the White House and former Entrepreneur in Residence at the Mayo Clinic, where he helped develop new ventures at the intersection of health and technology to improve care delivery.

Adam, you've now left the Presidential Innovation Fellows Program. We know you've moved on to a new venture. Tell us what's up next for you, and what will you take with you from these previous experiences working inside the higher echelons of government as well as inside a world-class sophisticated complex medical institution that's going to illuminate and inform the path forward for you?

Adam Dole:
So I am going to be rejoining very shortly the company that I helped to cofound when I was an employee at Mayo Clinic, and we started a company called Better. And Better is a direct-to-consumer personal health assistant service. The thing that I'm most excited about with Better is that Better is actively putting the human element back into the health care system. In a kind of world where a lot of technology is being developed and a lot of people are trying to figure out how to do more with less inside the health care system we're seeing a lot of the human element taken out of the system and replaced with technology.

And I think the underlying assumption and philosophy of Better is to develop human relationships and solve real human problems that make people's lives better, that save people's time and money, and ultimately do things for people that they can't do on their own, as it relates to having somebody that's fighting for them on their behalf no matter where they are in the health care continuum, and coordinating that entire experience.

It's quite a fundamental change for people in our country to imagine having a health care advocate that's always fighting on their behalf no matter what the issues are. Because we don't have a system that really supports that today. And so it's actually been since Better has launched a few months ago, it's been really interesting to see the types of problems that people are coming to Better for and also the types of problems that Better is able to solve for people that might not have ever realized that they had those problems.

And we're getting some great feedback on the types of value that Better is actually providing, helping people save money on a health insurance plan that they didn't realize that they could be saving money on, or dealing with medical billing and other administrative things, all the way to for a newly diagnosed patient to have a personal health assistant that's there to prep them for their next visit with their specialist, and check in after, and help to align any miscommunication that might be happening across different providers.

These are expectations that we should have of our health care system, but unfortunately there aren't that many services out there that are doing that. So that's what I'm most excited about, and I'll be rejoining it a part of the cofounding team, and responsible for helping to grow the company, think about new distribution channels and about the different partnerships that we need to develop as a young company.

Right now we're in data collection mode and really just seeing how the service is resonating with different markets, and then we'll

probably start optimizing for some of the markets that we think have the highest potential to _____ (24:05) value right now in a new model. And a lot of people don't know what a personal health assistant could do for them. And so we think that going after the informal caregiver, a lot of parents that are dealing with their aging parents or their kids that might be living with a chronic condition we see as the prime early target markets for Better.

And so I'm really excited to be rejoining the team. Their website is getbetter.com. I encourage everybody to go check them out. And the company's doing a free trial for everybody right now, so anyone can go and be assigned their own personal health assistant and see what a personal health assistant can do for them and help coordinate their entire health care experience.

Mark Maselli:
We've been speaking today with Adam Dole, recent Fellow in the Presidential Innovation Program at the White House, former Entrepreneur in Residence at Mayo Clinic, and now rejoining the organization he cofounded, Better. You can learn more about his work by following him at Twitter @adamdole, or you can follow him at gettingbetter.com. Adam, thank you so much for joining us today in this enjoyable conversation.

Adam Dole:
Well, thank you very much for having me on, and I really enjoyed our conversation as well.

Mark Maselli:
At Conversations on Health Care we want our audience to be truly in the know when it comes to the facts about health care reform and policy. Laurie Robertson is an award-winning journalist and Managing Editor of FactCheck.org, a nonpartisan nonprofit consumer advocate for voters that aim to reduce the level of deception in US politics. Laurie, what have you got for us this week?

Laurie Robertson:
Have there been 74 school shootings since the 2012 Sandy Hook Elementary shooting in Connecticut? That's what the group Every Town for Gun Safety says, but we found the true number of school shootings is less than half that. The group's list includes accidental discharges of guns, suicide attempts, and incidents in which no party involved was affiliated with the school.

President Obama appeared to reference the group's report on June 10th when he said that school shootings happen, quote, "once a week." At that point there had been 78 weeks since the Sandy Hook shooting. Every Town for Gun Safety clearly explains its broad definition of school shootings at the bottom of its report, saying that any publically reported incident in which a firearm was discharged inside a school or on school grounds counted as a school shooting, and that would include assaults and homicides as well as suicides and accidental discharges.

We consulted the Brady Campaign to Prevent Gun Violence, which defines a major school shooting as any incident in which, quote, "the shooter was directly linked to the school and at least one person was shot on school property." Using that definition to evaluate Every Town's list we found that as of June 10, 2014 there had been 34 school shootings, not 74, since the shooting at Sandy Hook on December 14, 2012. And that's my FactCheck for this week. I'm Laurie Robertson, Managing Editor of FactCheck.org.

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'd like checked, e-mail us at chcradio.com. We'll have FactCheck.org, Laurie Robertson, check it out for you here on Conversations on Health Care.

Mark Maselli:
Each week Conversations highlights a bright idea about how to make wellness a part of our communities and everyday lives. In the emergency room or the ICU clinicians are confronted with a myriad of unpredictable medical crises that sometimes can be challenging to diagnose. Most of these clinicians are now communicating with colleagues via their smartphones, often sending images of a patient's unique symptoms or chest x-rays to one another for shared diagnosis.

ICU physician Dr. Josh Landy was noticing a growing trend of image sharing via smartphones to crowdsource second opinions from friends and colleagues across the country. But he also was concerned about the potential violation of HIPAA regulations, so he developed an app for that. He created Figure 1, a sort of Instagram for doctors in which images can be de-identified but shared across a dedicated social media platform that would allow input from clinicians within their network.

Doctors are using the app to communicate not only with colleagues within their hospital settings but around the world where someone might have superior expertise with a certain condition. The app was recently used to share a chest image of one of the patients who presented with the Mideastern virus MERS. Dr. Landy says the apps get about a half a million image views a day, with about 80 million total views so far.

He sees the potential for this platform only growing as more young digital natives enter the medical workforce. Figure 1 is a free download through Apple App Stores and Google Play, a free downloadable app offering secure HIPAA-compliant image sharing among clinicians around the world to reduce the time it takes to zero in on a diagnosis by tapping the collective expert instantly. Now, that is a bright idea.

Margaret Flinter:
This is Conversations on Health Care, I'm Margaret Flinter.

Mark Maselli:
And I'm Mark Maselli. Peace and health.

Voiceover:
Conversations on Health Care, broadcast from the campus of WESU at Wesleyan University, streaming live at WESUfm.org, and brought to you by the Community Health Center.