Royal Commission into
Victoria's Mental Health System

WITNESS STATEMENT OF ALICE ANDREWS, PH.D

I, Alice Andrews, Director of Education, Value Institute for Health & Care, the University of Texas at Austin Dell Medical School, 501 Red River St, Austin, Texas, United States, say as follows:

Background

1 I make this statement on the basis of my own knowledge, save where otherwise stated. Where I make statements based on information provided by others, I believe such information to be true.

2 I am providing evidence to the Royal Commission into Victoria's Mental Health System in my capacity of Director of Education of the Value Institute for Health Care and Assistant Professor, Department of Medical Education, Dell Medical School and Clinical Associate Professor, McCombs School of Business at the University of Texas at Austin.

Overview of my experience

3 I am Director of Education for the Value Institute for Health and Care – an institute created by Dell Medical School and the McCombs School of Business at the University of Texas at Austin, where I also hold faculty appointments in each of these schools. For the past 15 years, I have helped health-sector professionals worldwide build the knowledge and skills required to transform health care so that it achieves better patient outcomes at lower cost. I have developed numerous master's programs and other curricula designed to equip health professionals to implement and lead change in health care, including this past year's launch of the Master of Science in Health Care Transformation at the University of Texas at Austin. In 2019, I received one of the Dell Medical School Academy of Distinguished Educators Excellence in Teaching award.

4 I have conducted research on and written case studies about health care transformation efforts in the USA, Europe, and Australia. In 2007, I completed a postdoctoral fellowship in Geriatric Mental Health at the Psychiatric Research Centre at the Geisel School of Medicine at Dartmouth College (NH, USA). I also hold a PhD in organisational behaviour from Cornell University (NY, USA) and an MS in the evaluative clinical sciences from Dartmouth College (NH, USA). I have taught internationally in a wide variety of courses and executive workshops related to implementing high-value health care, measuring outcomes, leading teams, and health communication. In 2020, I was a juror for the European Value Based Health Care prize.

Please note that the information presented in this witness statement responds to matters requested by the Royal Commission.

5 Attached and marked 'AA-1' is a copy of my Curriculum Vitae.

My role at the Value Institute for Health and Care

6 As well as being the Director of Education for the Value Institute for Health and Care, I also hold the following academic appointments: Assistant Professor in the Department of Medical Education at Dell Medical School and Clinical Associate Professor at the McCombs School of Business at the University of Texas at Austin. I am responsible for and teach in the Value Institute's educational programs, and am Program Director for our MS in Health Care Transformation. My research interests focus on effective leadership of multidisciplinary health care teams and how communication enables or presents barriers to effective team performance and learning. I am interested in risk communication, including how health outcomes are communicated to patients and the use of shared decision making for improving clinical practice.

Value-based health care

7 Value-based health care is the simple idea of measuring the change in health outcomes that matter to patients against the cost of care delivery.

8 The goal of value-based care is to create more value for patients by focusing on the outcomes that matter to them, rather than solely reducing the cost of delivering care.

9 We describe the 'measures' of health outcomes in terms of *capability, comfort, and calm.*[1] We believe that health care that addresses and improves outcomes in these three areas leads to better experiences for patients:

(a) **Capability** is the ability of patients to do the things that define them as individuals and enable them to be themselves. It is often tracked with functional measures.

(b) **Comfort** is relief from physical and emotional suffering. In addition to reducing pain, improving patients' comfort requires addressing the distress and anxiety that frequently accompany or exacerbate illness.

(c) **Calm** is the ability to live normally while getting care. It encompasses freedom from the chaos that patients often experience in the health care delivery system, and it is especially important for people with chronic and long-term conditions.

[1] Elizabeth Teisberg, Scott Wallace, and Sarah O'Hara, 'Defining and Implementing Value-Based Health Care: A Strategic Framework',*Academic Medicine,* 95.5 (2020), 682.

The building blocks of value-based health care

10 We developed a framework to assist organisations building value-based health care systems. The framework outlines the following 'building blocks' required for value-based care transformation:[2]

(a) **Understand shared health needs of patients:** To be effective and efficient, health care should be organised around segments of patients with a shared set of health needs (e.g., "people with knee pain" or "women with early stage breast cancer"). Organising care in this way allows clinical teams to anticipate consistent patient needs and provide frequently needed services efficiently, doing common things well. The efficiency afforded by structuring care around patient segments frees clinicians from scrambling to coordinate services that are needed routinely. The added bandwidth allows them to personalise services for individual patients who may have somewhat different needs.

(b) **Design a comprehensive solution to improve health outcomes:** Identifying the common needs of a patient segment enables teams to design and deliver care that provides a comprehensive solution for patients or families. When the goal of care shifts from treating to solving patients' needs, care teams can both address the clinical needs of patients and begin to address the nonclinical needs that, when left unmet, undermine patients' health. Broadening and integrating the services provided to patients achieves better outcomes by identifying and addressing gaps or obstacles that undermine patients' health results.

(c) **Integrate learning teams:** Implementing multifaceted solutions requires a dedicated team drawn from an array of disciplines, many of which are not typically viewed as medical. Team members are often co-located, enabling frequent informal communication that supplements the formal channels of communication to ensure effective and efficient care. The team structure can also expand across locations, extending state-of-the-art knowledge to remote clinicians and enabling world-class care to be delivered locally rather than requiring patients to travel.

(d) **Measure health outcomes and costs:** Health care teams must measure the health results as well as the costs of delivering care for each patient. Leaders cannot align health care organisations with their purpose of health improvement without measurement of health outcomes. In addition, the current dearth of accurate health outcomes and cost data impedes innovation. Measurement of

[2] The following descriptions of each component of the framework are extracted from Elizabeth Teisberg, Scott Wallace, and Sarah O'Hara, 'Defining and Implementing Value-Based Health Care: A Strategic Framework', *Academic Medicine*, 95.5 (2020), 682.

results allows teams to know where they are succeeding and where they need to improve care and efficiency. Although caregivers already report some data, much of it just examines whether processes were followed; they rarely consistently track the health outcomes that matter most to patients and thus to themselves as clinicians.

(e) **Expand partnerships:** Organising around patients with shared needs and demonstrating better value in care creates opportunities to expand partnerships and improve health outcomes for more people. This may include partnerships among clinical organisations as well as partnerships with other community organisations, such as employers.

Merits and risks of value-based health care

11 The merits of value-based health care are:

(a) Better health by measuring outcomes for every patient. These outcomes must focus on health results, not just on whether processes occurred or the experience was good. We must measure what we achieve for and with patients rather than what we do to them, in order to identify where improvements are needed.

(b) Supporting professionalism for health care workers. High-value health care aligns the work and incentives of health care delivery with the reason most health professionals entered the field in the first place—to help people achieve better health.

(c) Health care that is more equitable and reduces health disparities. If we do not measure health outcomes for every single patient, we do not know the extent of these disparities. Once we know, we need to redesign health systems and services so better health is available to all.

(d) Enhancing relationship-centred care. The team-based structure of value-based care moves beyond “patient-centred” care; it enables and supports a culture and care delivery model that is relationship-centred. The former puts the patient at the centre, but omits the network of relationships among the health care team that is found in the latter. This relationship network surrounds the patient in the “embrace” of care – in a place where it is clear the health care team is working together around the patient to help the patient achieve better health.

12 The risks include:

(a) Focusing on cost reduction for the health care system, rather than delivering value for patients. While it is important to consider value for service providers, insurers and other people in the health care sector, value-based care should be

foremost focused on the value provided to patients. If we don't change health outcomes for patients, it does not matter how inexpensive or how efficient care is – it does not deliver value for patients.

(b) Conflating value-based health care with the amorphous notions of health care 'quality' or 'quality improvement'. This often leads to a focus on inputs and process compliance that does not improve patient health care outcomes. Process compliance and tracking can also distract providers from taking steps to improve outcomes. Unnecessary time spent checking boxes leads to compliance fatigue and takes clinicians away from caring for patients.

(c) The risks that can arise from any significant organisational change. Currently, clinical services tend to be organised around what is convenient for doctors rather than what is convenient for patients. Value-based health care calls for a departure from this way of doing things, and this can be complicated to manage.[3]

Key enablers to implementing value-based health care

13 The key enabler of implementing value-based health care is properly understanding the needs of patients. Further enablers include:

(a) Measuring outcomes at the 'right' level. It is common for evaluations of hospitals and other health services to be too high-level. For example, a hospital that is a leader in cancer care may be less established in cardiac care. This hospital might be rated overall as a one or two star hospital[4] – but this does not tell a person much about whether they should go to this hospital. We need to be able to respond to the needs of different segments of patients who have similar medical conditions.

(b) Bringing the right team members together. This can be challenging in medicine, because sometimes poor behaviour by clinicians is excused at the cost of obtaining their expertise. In the long run this does not help patients and can cause a lot of trouble for the health system. It is important to recruit and retain people who are willing to collaborate and work in teams.

(c) Creating an organisational culture where "facts are friendly". This entails a focus on problem solving rather than attributing blame if a mistake happens or an error occurs. Traditionally, there has been reluctance by people in the health care industry to share outcomes, both good and bad, in order to assist others to learn about what does and does not work.

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[3] This is discussed below at paragraphs 54 to 57.

[4] Under the Centres for Medicare & Medicaid Services 'Five-Star Quality Rating System', October 2019, see more at <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/FSQRS> [accessed 7 July 2020].

(d) Understanding the costs of providing care, which is essential to understanding value. Health care providers need to understand whether the services they deliver cost more than the corresponding improvement in outcomes for their patient.

(e) Value-based reimbursement, which I discuss immediately below.

The structure of value-based reimbursement

14 Value-based reimbursement should be structured so that payment is aligned with better health results, not just with the services delivered. Fee-for-service reimbursement, currently the most common way of paying for care, pays for each procedure performed or visit that occurs. This type of payment generally incentivises high-cost interventions like surgery at the expense of lower cost interventions that may deliver more value.

15 Value-based reimbursement aligns payment with health results. Clinicians receive a payment to resolve the patient's ailment rather than just paying for each office visit or procedure performed. One form of such payment is a condition-based bundle. In the case of a patient with knee pain, the clinical team would receive payment to manage the patient's knee pain over the full cycle of care. The patient may require surgery, or might only require physical therapy to manage their pain. The difficulty of structuring the condition-based bundle is aligning the bundle with what services people require over a specific period of time. It also requires risk adjustment to account for levels of illness.

16 As a result of the COVID-19 pandemic, many US hospitals are losing money because they are not performing the procedures they normally would. Primary care practices, which already do not receive much reimbursement in the US, also have struggled to stay afloat. We have seen that primary care practices whose reimbursement is structured on a 'per-member, per-month' model have fared better than those paid through a per-service model. For example, consider Iora Health,[5] a primary care organisation with locations in several American states that uses a team-based model to care for patients ages 65 and older. Because Iora is primarily reimbursed through per-member, per-month payment, it has not seen a large drop in its funding as clinic visits have reduced during the pandemic and has instead been able to re-deploy resources toward telehealth and prevention. As a result, although Iora's older patient population is highly vulnerable to COVID-19, the group has experienced very low rates of coronavirus infection and mortality.

[5] See Iora Health, 'Our Model', available at <https://www.iorahealth.com/model/> [accessed 7 July 2020].

The role of cost measurement and reporting

17 As I discuss above, it is important that health services know the actual costs of their services.

18 Our experience is that many hospital charges and prices are not connected to the actual cost of a service. This is often because the actual costs of services are not known or calculated. Most hospitals use Ratio of Costs to Charges (RCC) or Relative Value Units (RVUs) methodology for cost allocation. These methods are simple to implement and useful for billing and for looking at overall hospital or department costs. However, they are not useful for decision-making at the level of the clinical unit or medical condition because they allocate overhead and other costs based on charges rather than actual costs.

19 Another approach to cost measurement is time-driven activity-based costing (TDABC) which requires tracking expenses involved in treating a medical condition over the full cycle of care.[6] Steps to calculate TDABC include developing a process map that accounts for the time and cost of every activity and input into a service.

20 Understanding the actual costs involved in providing a service, rather than just the reimbursements, allows for more effective decision making. For example, an orthopaedic practice in the US might not receive reimbursement for including a dietician on the clinical team and so may think this resource is too 'expensive.' A TDABC model, however, might reveal that the dietician's work saves money in the long run because patients lose weight, surgeries are safer and take less time. As a result, surgeons can perform more surgeries which makes up for the lost income.

21 We use the concept of 'loose-tight' when talking about costs and reporting. This means focussing on outcomes and results rather than micro-managing costs for each process. Where a health service is 'loose' on the process and 'tight' on the results, health workers are given more autonomy to do what is best for patients with certain limits in place. The results, and the overall expenses involved in achieving results are still monitored, assuring accountability. For example, the Commonwealth Care Alliance is a not-for-profit, community-based health care organisation in Massachusetts, USA.[7] One population they serve are frail elders that want to live at home. When CCA was first formed, they allowed carers to provide services that were not strictly medical (e.g., a taxi for transportation or an air conditioner) and that would not be allowed in a traditional health plan. These types of 'extras' could prevent these seniors from ending up in

[6] Michael E Porter and Thomas H Lee, 'The Strategy That Will Fix Health Care'. *Harvard Business Review,* October 2013 issue, <https://hbr.org/2013/10/the-strategy-that-will-fix-health-care> [accessed 7 July 2020].
[7] See Commonwealth Care Alliance, 'About Commonwealth Care Aliance', available at <http://www.commonwealthcarealliance.org/about-us/cca> [accessed 7 July 2020].

hospital, something much more expensive than the services provided. Accountability comes from the overall costs and results – keeping patients healthy enough to stay at home, not from strict oversight for each small service.

The role of the consumer and identifying outcomes for groups of patients

22 The value-based transformation model requires health services to first understand the health needs of consumers. One approach developed by the Value Institute is the Experience Group[tm] methodology.

23 This process begins by asking a small group of consumers, in a setting somewhat like a focus group, what life is like with their illness. What do they need to achieve better health? These questions must include not just medical needs, but all three areas of capability, comfort, and calm described in the section on outcome measurement.[8]

24 Bringing together patients with similar medical conditions often delivers insights that a whole treating team were not aware of. For example, work with young adults with osteoarthritis showed that social isolation was a huge issue affecting their health. Insights of this nature provide a rallying-point for a multi-disciplinary team.

25 Once the right needs and appropriate services are identified, a multidisciplinary team needs to be built around the patients, rather than patients seeking each service separately.[9] Generally, health care is organised around the needs of doctors, not the needs of patients. This leads to fragmentation of care, a problem in the delivery of mental health services across the world. Often consumers struggle to access all of the services and support that they need. It is hugely beneficial if a patient can go to one place that meets all of their needs, or at least connects them to the right people.

26 Relationship-centred care delivery accelerates patient engagement. With relationship-centred care, if you have a standing team that works together around patients' health and goals, you build trust and confidence much more quickly than in systems where you have to repeat the information.

27 When you manage a segment of patients, you understand the individual goals and needs of patients with that condition. When your delivery is relationship-centric, you can engage patients by talking about their individual goals and understanding how those are connected to medical outcomes.

28 Understanding shared goals allow you to develop a set of services to provide solutions that fit most people most of the time. One way to explain this is with a clothing analogy. Most people don't buy bespoke clothing, they buy clothes of size that mostly fits and

[8] See paragraph 9.
[9] See prior statement about patient-centred vs. relationship-centred care at subparagraph 11(d).

might then have a little tailoring. It is the same for designing health care solutions: we design services that help 80% of people for 80% of the time while recognising that we will sometimes have to provide additional services.

29 For example, one person with diabetes might want to dance at a daughter's wedding, another wants to run a race – each of these individuals has the shared need of wanting to use their feet and be mobile. If care is not structured around a set of shared needs, each individual's goal is separate, making it difficult to design services since these goals will be too diverse. Identifying shared needs allow the care delivery team to talk to each patient about their own personal goals, but allows for a system and solution design based on this shared set.

30 A focus on consumers also means asking the questions: "Are we serving everyone?" and "Does everyone have good choices?". Using a consumer lens to ask 'do good choices exist' helps to identify whether the service is equitable and whether it omits the needs of vulnerable populations. For example, the team at Dental Health Services Victoria spoke to people experiencing homelessness. They learned that this population is "busy" since certain services (e.g., meals, showers) are only available at specific times. This makes it difficult to come to a clinic. Additionally, these individuals may lack access to a sink, making it difficult to brush teeth in the conventional manner. Creating solutions to meet these needs requires new thinking. Often, when patients fail to follow clinical advice we say they are "non-compliant" rather than recognise that the solutions are poorly designed for them.

31 Transparency around outcomes is also very important for consumers. It is important that a consumer feels confident choosing a particular health service because they know they will get better care.

Examples of value-based health care delivering innovative, integrated approaches and improved health and social outcomes

St Andrew's Healthcare

32 An example of the value-based transformation of mental health services is St Andrew's Healthcare (St Andrew's), an 850-bed speciality mental health services provider in the United Kingdom.[10] The majority of St Andrew's patients are residential and have complex psychiatric needs. In 2015, St Andrew's began a major overhaul to broaden its focus from ensuring patient and staff safety to improving the health and quality of life of patients. This overhaul involved:

[10] For further information about St Andrew's see: Paul Wallang, et al, '*Implementation of outcomes-driven and value-based mental health care in the UK'*, *British Journal of Hospital Medicine,* 79.6 (2018), 322-327.

(a) replacing hundreds of process-oriented indicators with 28 health outcome measures;

(b) reorganising patient care at the level of service; and

(c) decentralising some clinical and administrative functions of St Andrew's to 15 newly created 'integrated practice units' (IPUs).

33 Prior to the overhaul of St Andrew's:

(a) data collection and reporting focused largely on clinical processes and outputs including completion of patient care plans, length of patient stays and the number of adverse incidents;

(b) some of the many process-oriented indicators used by St Andrew's clinical units were inappropriate for patients or not directed to decisions about patient care;

(c) the performance measurement and remuneration of ward managers was partly tied to the number of forms and patient assessments completed;

(d) clinicians were required to complete multiple patient assessment forms prior to and during a patient's admission;

(e) clinicians were required to provide 25 hours of "meaningful therapeutic activity" to patients each week, but were uncertain what "meaningful" meant and why 25 hours were required; and

(f) St Andrew's staff and leadership reported being overwhelmed by process and hierarchy and as a result, not able to focus on patient care.

<u>Replacement of process-oriented indicators with outcome measures</u>

34 In order to select new outcomes and tools for measuring them, staff leading the transformation of St Andrew's formed an Inter-Professional Development Group (IPDG). The IPDG included the heads of each profession (psychology, medicine, social work, occupational therapy, education, and chaplaincy) at St Andrew's. The IPDG chose three broad areas of clinical importance (mental health, physical health, and quality of life) and outlined potential measures for each area.

35 Following the establishment of the IPDG, St Andrew's facilitated 14 focus groups of patients, carers and clinicians. The data received from the focus groups was analysed and organised into 28 mental health, physical health and quality of life outcome measures, including:

(a) for quality of life, 'I have staff I can trust' and 'I have leave into the community';

(b) for mental health, 'I am confident', 'I'm occupied in my time' and 'I am not distressed'; and

(c) for physical health, 'I sleep well and feel refreshed on waking' and 'I am a healthy weight'.

36 Members of the IPDG, patients and clinicians then worked to select instruments (both existing and new) to measure each outcome. Dr. Wallang, Lead Psychiatrist at St. Andrew's during this time, was a member of and consulted with the UK Routine Clinical Outcome Measures group about the measures. The instruments selected included patient and clinician outcome measures. An Outcome Oversight Group was established to review monthly outcome measurement.

Creation of Integrated Practice Units

37 Once St Andrew's had identified the outcomes it would work to achieve, the organisation was restructured into 15 IPUs. Each IPU was designed to serve one or several similar patient diagnoses. Each IPU was comprised of St Andrew's clinical and administrative staff and included a clinical lead, an operational lead and a 'change coordinator'.

38 The implementation of IPUs took place in three waves over approximately one year and was managed initially with the assistance of a management consulting firm. The rollout of the IPUs was accompanied by:

(a) a detailed communication plan including workshops, focus groups, town hall meetings and the encouragement of staff feedback;

(b) a 'design authority' which oversaw and tracked IPU development over an 18-month period through the following five phases: initiation, activation, refining the design, steady state, and continuous improvement;

(c) constant communication between IPU change coordinators to share what was working well and what needed improvement; and

(d) providing opportunities for staff to identify areas for improvement in processes, as well as meeting with sceptical clinicians to discuss outcome measurement.

39 A year into the process, the team from St. Andrew's surveyed care givers and improved satisfaction on the part of patients, families, and clinicians. Efforts were being made to be more transparent across IPUs with changes like increasing patient leave. Units began posting the amount of leave given to patients, which led other units to want to improve. A similar effort is being made to reduce seclusion. One psychiatrist said that the change efforts directly made it easier to hire staff; they now received many more high-quality applications than they had previously.

40 It is critical to note that change of this magnitude takes time. St. Andrew's is a very large organisation and the transition is still a work in progress. The UK Care Quality Commission criticised several areas within St. Andrew's in their report dated 7 January, 2020.[11] Although the commission mentions several concerns of a serious nature (which led to several public articles criticising the facility), the report also states that the new leadership has been working to turn around these deficient areas. For example, the report states the following:

The board and senior leadership team had a clear vision and set of values that were at the heart of all the work across services. They were working hard to make sure staff at all levels understood them in relation to their daily roles. There was an authentic desire to live the values and embed these within the recruitment process to build a robust and consistent culture.[12]

Dental Health Services Victoria

41 In 2016, Dental Health Services Victoria (DHSV), the lead public oral health agency for an estimated 2.46 million patients in Victoria, began exploring value-based oral health care. In conjunction with consumers, staff and other key stakeholders, DHSV designed a value-based oral health care framework. Through consumer participation in the process, DHSV gained a number of insights about the delivery of oral health care to a variety of consumers of public oral health care, which included not only children and people eligible for welfare payments and their dependents but also vulnerable populations such as Aboriginal and Torres Strait Islander people, pregnant women, people experiencing homelessness, and refugees and asylum seekers.[1314]

42 The framework developed by DHSV also recognised that more value was realised by having oral health professionals have a role in delivering education and other preventative services. The value-based framework was implemented at the Royal Dental Hospital of Melbourne and included investment in a Certificate IV program that up-skilled dental assistants in health promotion and the application of fluoride varnish – tasks historically performed by dentists.

[11] See Care Quality Commission, 'St Andrews Healthcare Quality Report', 7 January 2020, available at <https://www.cqc.org.uk/sites/default/files/new_reports/AAAJ7777.pdf> [accessed 7 July 2020].
[12] Ibid p.5.
[13] Australian Healthcare and Hospitals Association, 'Reflections of a consumer representative in the oral health sector', *The Health Advocate,* 59 (2020).
[14] Kate Raymond and Shalika Hedge, 'Dental Health Services Victoria: Journey to Value Based Health Care', *Deeble Institute Perspectives Brief*, 7 (2020).

Organising and scaling up value-based health reform across providers, populations and geographical areas

43 Within any one area of clinical care, there will be measures that are highly specific to that area as well as measures that are relevant across different areas. One challenge of scaling value-based health care is developing outcome measures that are relevant across disparate areas of health.

44 There are several models that an organisation can use to scale up value based services. Scaling may be accomplished in many different ways. For instance, they may continue serving the same segment of patients (e.g., patients with diabetes) but expand to serve more of those patients through new locations or new modalities such as telehealth. Or they may take a model that has worked with one segment of patients and adjust it to work with another segment of patients.

Ensuring that approaches to performance monitoring continuously evolve

45 Performance monitoring in the value-based health care model is focused on achieving functional outcomes rather than process compliance. The goal is to give clinicians autonomy and hold them accountable for their outcomes. Those outcomes, whether good or bad, are then shared with colleagues. If a clinician's outcomes are worse than their colleagues, they will be required to change what they are doing. Conversely, it is incumbent on clinicians delivering better outcomes to teach their colleagues what they are doing. For this reason, value-based performance monitoring requires a culture of teamwork and problem solving. The Martini-Klinik in Hamburg, Germany, is an exemplar of this type of performance-monitoring.[15]

46 Ideally a national or international culture of continuous improvement will exist. One such example is the Society for Thoracic Surgeons, which has a centralised database where members report outcomes and this is shared across the entire US.[16]

47 The importance of cultural change within an organisation must also be considered. All staff need to be encouraged to share outcomes and to speak up when they see a problem. This requires an environment that has psychological safety, particularly for nurses who may not be comfortable raising concerns about or to a doctor and upsetting the organisational hierarchy.

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[15] Scott Wallace and Elizabeh Teisberg, 'Measuring What Matters: Connecting Excellence, Professionalism, and Empathy', *Brain Injury Professional,* September 2015.
[16] The Society of Thoracic Surgeons, 'General Thoracic Surgery Database', available at <https://www.sts.org/registries-research-center/sts-national-database/general-thoracic-surgery-database> [accessed 7 July 2020].

48 A psychologically safe workplace is the bare minimum.[17] It is also important for people in an organisation to trust each other and feel like they are working together. This will make it much easier for clinicians to share outcomes.

Quality and safety

Regulatory and oversight arrangements in value-based healthcare

49 Regulating value-based health care services should not be significantly different to regulating health services provided under different models. Regulators and other oversight bodies should take an outcome-based approach to monitoring services instead of monitoring individual processes. They also should not over-react by implementing new rules in response to a single occurrence of a problem. I call this type of reaction 'managing to the deviant', a focus on monitoring process compliance that is ultimately more costly than the worst possible outcome the monitoring seeks to avoid and creates many more rules than might be necessary or useful.

50 Each time a health service seeks to institute a new oversight or monitoring requirement, it should ask "Do we really need this?, and What's the harm if we don't have this oversight?". Asking these sorts of questions is an important way to ensure that a health care service is doing the things truly necessary to provide safe care.

51 Regulation of health care is of course complicated (compared to other organisations) because peoples' lives are at stake. Requirements ensuring safety and affording basic dignity to patients are not health care aspirations, but rather, basic expectations of any health service. Systems need to be in place to ensure that when something bad occurs, staff are not required to look through hundreds of pages of a service manual. There should simply be a system that quickly guides staff to what to do in those circumstances.

Digital Services

52 It is important that technology does not drive the care a service provides for its patients. It is an enabler rather than an end itself. Technology can be used to support the delivery of value-based care by:

(a) collecting the data required for accurate outcome measurement;

(b) facilitating the sharing of outcomes among clinicians; and

(c) enhancing the delivery of care and relationships with patients.

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[17] Amy Edmonson, 'Psychological Safety and Learning Behaviour in Work Teams', *Administrative Science Quarterly*, Vol. 44, No. 2, June 1999, pp. 350-383.

53 The Covid-19 pandemic led to rapid implementation of digital service delivery as in-person health visits were curtailed. Telehealth can play an important role in delivering value-based health care by bringing services to patients where they are, including by making globally best-in-class services accessible to patients in otherwise underserved areas. Through its focus on outcomes, value-based health care also can help ensure that telehealth is not just used as a low-cost replacement for in-person services but that it instead achieves the aim of improving patient health.

Workforce

Common cultural and practical challenges in implementing value-based health care

54 To deliver value for patients, health services need to ensure that their staff work in integrated and coordinated teams. This requires a departure from the mentality of 'the doctor at the top of the pyramid' that can be pervasive in health services. The value-based approach is inherently less hierarchical - a clinician may be the person with the most in-depth medical knowledge but not the leader of a team. This is not to criticise doctors, or minimise the importance of their role – they remain ultimately responsible for what happens to a patient.

55 Transitioning to a less-hierarchical and more team-based way of working can be challenging because it requires:

(a) mutual trust between staff;

(b) senior leaders modelling behaviours that engender psychological safety in the organisation;

(c) communicating with all staff, and making staff at every level feel like they are part of the solution; and

(d) not accepting bullying and harassment from staff, even it means losing a person's expertise.

56 In our experience, challenges bringing multi-disciplinary teams together can be overcome by focusing on patients. Health care workers are smart, hardworking, dedicated individuals who want to do the right thing for patients, but often are caught in systems where financial incentives or health delivery models are misaligned with that goal. Value-based healthcare puts these incentives back into alignment – teams that work together in service of what is best for patient health. That helps overcome resistance and barriers to system change.

57 It is also important to unify the clinical and administrative parts of a workforce. This was achieved at St Andrew's, where each IPU housed a clinical lead and an operational

lead.[18] NHS Wales has a similar approach. Dr. Sally Lewis, National Clinical Lead for Value Based Health Care at NHS Wales stated: '*In NHS Wales we operate a 'business partner accountant' model, where financial managers are embedded in clinical directorates as part of the multidisciplinary team. This enables the Clinical Director and the BPA to work directly together in partnership, facilitating conversations about value in the presence of operational managers too.*'.

sign here ► Alice Andrews

print name Alice Andrews

date July 7, 2020

[18] I discuss this above at paragraph 37.

Royal Commission into
Victoria's Mental Health System

ATTACHMENT AA-1

This is the attachment marked 'AA-1' referred to in the witness statement of Alice Andrews dated 7 July 2020.

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New York State School of Industrial & Labor Relations Cornell University, Ithaca, NY USA
Thesis Title: Meeting the challenge of a new environment : Boards of directors as legitimacy signals at initial public offering
Advisor: Pamela S. Tolbert, Ph.D.

M.S. (Organizational Behavior) 01/1990
New York State School of Industrial & Labor Relations, Cornell University, Ithaca, NY USA
Thesis Title: The Changing Context of the Medical Profession: Attitudinal Determinants of Militancy.

B.A. (Psychology), 05/1987
College of Arts & Sciences, Cornell University, Ithaca, NY USA

Postdoctoral Training

Postdoctoral Fellow, Geriatric Mental Health 01/2006-12/2007
Supervisor: Stephen J. Bartels, M.D., M.S
Psychiatric Research Center, Geisel School of Medicine at Dartmouth College, Hanover, NH

Academic and Leadership Appointments

Clinical Associate Professor 1/2020 to Present
McCombs School of Business, University of Texas at Austin

Assistant Professor
Department of Medical Education 1/2018 to Present
Dell Medical School
University of Texas at Austin, Austin, TX

Director of Education The Value Institute for Health and Care, Dell Medical School & McCombs School of Business, University of Texas at Austin, Austin, TX	9/2018 to Present
Affiliate Faculty Department of Management McCombs School of Business University of Texas at Austin, Austin, TX	1/2020 to Present
Education Program Officer The Value Institute for Health and Care, Dell Medical School University of Texas at Austin, Austin, TX	10/2017 to 9/1/2018
Adjunct Assistant Professor The Dartmouth Institute for Health Policy & Clinical Practice (TDI) Geisel School of Medicine at Dartmouth, Hanover, NH	7/2016-9/2017
Academic Director & Online MPH Program Director The Dartmouth Institute for Health Policy & Clinical Practice (TDI), Geisel School of Medicine at Dartmouth	08/2015–09/2017
Director of Curricular Affairs Master of Health Care Delivery Science Program (MHCDS, The Dartmouth Institute for Health Policy & Clinical Practice (TDI), Geisel School of Medicine and the Amos Tuck School of Business at Dartmouth	3/2012–8/2015
Instructor The Dartmouth Institute for Health Policy & Clinical Practice (TDI) Geisel School of Medicine at Dartmouth, Hanover, NH	09/2011-06/2016
Assistant Professor Owen Graduate School of Management, Vanderbilt University Nashville, TN	07/1995-06/1997

Other Relevant Employment and Clinical Activities

Women's Health retreats, help requested with cultural transformation, UT Health Austin	June-August, 2018
Senior Curriculum Specialist Master of Health Care Delivery Science Program (MHCDS, The Dartmouth Institute for Health Policy & Clinical Practice (TDI), Geisel School of Medicine and the Amos Tuck School of Business at Dartmouth, Hanover, NH	08/2010-03/2012

Research Associate Master of Health Care Delivery Science Program (MHCDS, The Dartmouth Institute for Health Policy & Clinical Practice (TDI), Geisel School of Medicine and the Amos Tuck School of Business at Dartmouth, Hanover, NH	04/2007-07/2010
Vice President of Operations Leadership In Medicine, Norwich, VT	11/2001-06/2005
Vice President of Research and Learning eePulse Inc., Ann Arbor, MI	06/1997-09/2001
Research Associate Harvard Graduate School of Business, Boston, MA	07/1990-08/1991

Professional Memberships and Activities with Leadership Positions

Relational Coordination Research Collaborative, Member	2019-present
American Academy on Communications in Healthcare, Member	2016-present
Gerontological Society of America, Member	2008
Academy Health	2006

Awards

Dell Medical School Academy of Distinguished Educators Excellence in Teaching Award	09/2019

Educational Activities

Educational Administration and Leadership

Invited juror Value Based Health Care Prize Value-based Healthcare Center Europe (Netherlands)	04/2020
Education Enterprise Committee Dell Medical School	11/18-present
Evaluation and Assessment Committee Dell Medical School	07/18-present
Innovation, Learning, and Discovery Committee Dell Medical School	05/18 - present
Leadership Working Group Dell Medical School	03/18-present
Program Director, MS in Health Care Transformation	06/2018 - present

Value Institute for Health and Care
Dell Medical School and McCombs School of Business at UT Austin

Member, Graduate Studies Committee — 06/2018 - present
MS in Health Care Transformation
Dell Medical School and McCombs School of Business at UT Austin

Member, Admissions Committee — 09/2018 - present
MS in Health Care Transformation
Dell Medical School and McCombs School of Business at UT Austin

Academic Director & Online MPH Program Director — 08/2015–09/2017
The Dartmouth Institute for Health Policy & Clinical Practice (TDI), Geisel School of Medicine at Dartmouth

Curriculum Committee, Co-Chair — 9/2015-10/2017
Dartmouth Institute for Health Policy & Clinical Practice, Geisel School of Medicine at Dartmouth

Member, Admissions Committee — 9/2015-10/2017
Dartmouth Institute for Health Policy & Clinical Practice, Geisel School of Medicine at Dartmouth

Member, Education Committee — 9/2014-9/2016
Dartmouth Institute for Health Policy & Clinical Practice, Geisel School of Medicine at Dartmouth

Member, Curricular Strategic Planning Committee — 6/2014-5/2015
Dartmouth Institute for Health Policy & Clinical Practice, Geisel School of Medicine at Dartmouth

Member, Curriculum Committee — 1/2012-10/2017
Master of Health Care Delivery Science Program (MHCDS, The Dartmouth Institute for Health Policy & Clinical Practice (TDI), Geisel School of Medicine and the Amos Tuck School of Business at Dartmouth

Member, Admissions Committee — 9/2010-9/2015
Master of Health Care Delivery Science Program (MHCDS, The Dartmouth Institute for Health Policy & Clinical Practice (TDI), Geisel School of Medicine and the Amos Tuck School of Business at Dartmouth

Teaching Activities

Course director with Erin Donovan, Center for Health Communication. — 1/20 to present
HCT388: Leading Teams for Health Care Transformation
Master of Science in Health Care Transformation

Course director with Kristie Loescher, McCombs School of Business. — 8/19 to present

HCT 397, 398, 399: Experiential Learning Project (3 courses)
Master of Science in Health Care Transformation

Measuring what matters February 12-13, 2020
Executive education workshop taught with Elizabeth Teisberg Scott Wallace, Kathy Carberry. UT Austin, Austin, TX. 40 health care professionals.

Implementing high value health care September 19-20, 2019
Executive education workshop with Elizabeth Teisberg Scott Wallace, Kathy Carberry, Chris Ulack. UT Austin, Austin, TX. 35 health care professionals.

Implementing high value health care June 13-14,2019
Executive education workshop with Elizabeth Teisberg Scott Wallace, Kathy Carberry, Chris Ulack. UT Austin, Austin, TX. 43 Dell Medical School distinction residents and faculty/staff.

Measuring what matters May 6-7, 2019
Executive education workshop taught with Elizabeth Teisberg Scott Wallace, Kathy Carberry. UT Austin, Austin, TX. 45 health care professionals.

Implementing high value health care March 19-20, 2019
Executive education workshop with Elizabeth Teisberg Scott Wallace, Kathy Carberry, Christina Akerman. UT Austin, Austin, TX. 35 health care professionals.

St. Andrew's Health Care case study teaching to Dell Medical School MS 3 as part of Leadership Course. With Elizabeth Teisberg. February 23, 2019

Pediatric Comprehensive Care Clinic Workshop November 1, 2018
Workshop for the clinic taught with Elizabeth Teisberg Scott Wallace, Kathy Carberry. UT Austin, Austin, TX.

Measuring what matters October 24- 25, 2018
Executive education workshop taught with Elizabeth Teisberg Scott Wallace, Kathy Carberry. UT Austin, Austin, TX. 44 health care professionals.

Implementing high value health care October 8-9, 2018
Executive education workshop taught with Elizabeth Teisberg Scott Wallace, International Hospital Federation, Brisbane, Queensland, Australia. 67 health care professionals.

Implementing high value health care Sept 19-20, 2018
Executive education workshop with Elizabeth Teisberg Scott Wallace, Kathy Carberry, Chris Ulack. UT Austin, Austin, TX. 33 health care professionals.

Creating and Measuring Value in Health Care. Austin HIMSS Lunch and Learn session taught with Kathy Carberry. Austin, TX. 31 health care professionals.	September 11, 2018
High Value Health Care Delivery Executive education workshop with Elizabeth Teisberg, Scott Wallace, Kathy Carberry, Chris Ulack. UT Austin, Austin, TX.	June 4-8, 2018
Creating Value in Health Care Keynote presentation for visitors to Dell Medical School from the UT Health Science Center at San Antonio. Austin, TX	February 15, 2018
The Dartmouth Institute for Health Policy & Clinical Practice Qualitative and Survey Research Methods (core course) Course Co-Director 28 MPH Students	2017
Master of Health Care Delivery Science Patient-Centered Health Communication/ Shared Decision Making (core course) Course Co-Director 50 Executive (MHCDS) Students/year	2013–2017
Geisel School of Medicine at Dartmouth Health, Society and the Physician Facilitator 6 Medical Students Supervised 6 students conducting project on shared decision-making in the neonatal ICU	2013
The Dartmouth Institute for Health Policy & Clinical Practice Patient-Centered Health Communication Course Co-Director. 13-24 MPH/MS Students/year	2012-2016
The Dartmouth Institute for Health Policy & Clinical Practice Survey Research Methods Course Co-Director. 25 MPH/MS Students	2011-2012
Owen Graduate School of Management, Vanderbilt University Course Co-Director Initiative for a Competitive Inner City 30 Students Project-based course working with student teams on entrepreneurial intiatives aimed at helping business owned by low-income residents of Nashville	1997
Owen Graduate School of Management, Vanderbilt University Course Director	1997

Human Behavior in Work Organizations (Undergraduate course) 40 Students

Owen Graduate School of Management, Vanderbilt University — 1996-1997
Organizational Design
Course Director, 20 Students

Owen Graduate School of Management, Vanderbilt University — 1996
Transforming the Organization, Interdisciplinary core
Organizational Behavior/Operations Management
Course Co-Director
50 Executive (EMBA) Students

Owen Graduate School of Management, Vanderbilt University — 1996
Course Director for 2/6 sections
Leading Teams in Organizations (core course)
80 of Students/year

Owen Graduate School of Management, Vanderbilt University — 1995
Organizational Theory and Design
Course Director, 50 Executive (EMBA) Students

Development of Curricula and Educational Materials

Curriculum development

Australian Health care Transformation Leadership Program — 11/19 to present
Partnership with Australian Healthcare and Hospitals Association and Australian National University. Developing online executive education series to start July 2020. Will culminate in a workshop at Australian Value Based Health Care Conference, Perth 2021

Master of Science in Health Care Transformation — 6/19 to present
With Erin Donovan, Center for Health Communications. Curriculum for HCT388: Leading Teams for Health Care Transformation.

Master of Science in Health Care Transformation — 6/19 to present
With Kristie Loescher, McCombs School of Business.Curriculum for the HCT 397, 398, 399: Experiential Learning Project (3 courses)

Master of Science in Health Care Transformation — 11/17-present
Co-Developed curriculum plan and proposal for new master of science degree in health care transformation (MSHCT) at the University of Texas at Austin. Shephered it through the UT process, including the academic committee and graduate assembly. Developed dual-degree proposal for MD/MSHCT at University of Texas at Austin.

Hybrid MPH program for The Dartmouth Institute for Health Policy & Clinical Practice. Program Director and Curriculum Organizer. Lead faculty teams in design of a new program and development of course material. 8/15-9/17

Dartmouth Symposium on Health Care Delivery Science 3/14, 4/15
Co-organizer of content for annual symposium on health care delivery science at Dartmouth founded by the MHCDS class of 2013
Hanover, NH

Master of Health Care Delivery Science at Dartmouth College. Program founding staff member/Director of Curricular Affairs. Helped design and delivery new curricula for joint M.S. program between the Tuck School of Business and the Dartmouth Institute for Health Policy & Clinical Practice. Hanover, NH 8/10-5/15

Mini-conference on shared decision making, mental health, and aging. Co-director. Sponsored by the Dartmouth Psychiatric Research Institute, The Dartmouth Institute for Health Policy & Clinical Practice, and the Centers for Health & Aging
Lebanon, NH 6/2008

Teaching Case Studies

Hippo-Sized Hope for Transforming Public Dental Care in Australia: Dental Health Services Victoria. The Value Institute for Health and Care, University of Texas at Austin (Victoria Davis and Alice Andrews). 2020

Fullerton Hospital. The Value Institute for Health and Care (Catie Cleary, Sarah O'Hara, Alice Andrews). 2020

Transitioning to Value-Based Mental Health Care in the UK: St. Andrew's Healthcare. The Value Institute for Health and Care, University of Texas at Austin (Alice Andrews, Amy Madore, Mindy Price, Elizabeth Teisberg). 2019

The Comprehensive Breast Program at Dartmouth Hitchcock Medical Center (DHMC). Case study of the integrated care system for breast cancer patients at DHMC. Hanover, NH 2010 2016 (rev)

Harvard Business School Case Development 1990-91
Alice Oberfield (Andrews) & J. Gregory Dees.

- *Rainforest Crunch.* Harvard Business School case: 9-391-132.
- *Steve Mariotti and NFTE.* Harvard Business School case: 9-391-169.
- *Save the Children/U.S. in Vietnam.* Harvard Business School case: 9-391-153.
- *Selecting a Nonprofit Form of Organization.* Harvard Business School note: 9-391-096.

Harvard Business School, Boston, MA

Advising and Mentoring

Students

Anand Narasimhan — 5/1997
Owen Graduate School of Management, Dissertation Committee
Currently Shell Professor of Global Leadership, IMD Switzerland

Agnew, Thomas — 5/1997
Owen Graduate School of Management
Dissertation Committee
Senior Principal, Hay Group

Publications

Peer-reviewed publications

1. Faerber, A., **Andrews, A**., Lobb, A., Wadsworth, E., Milligan, K., Shumsky, R., Fisher, E., Lahey, T. A new model of online health care delivery science education for mid-career health care professionals. **Healthcare: The journal of delivery science and Innovation**, in press (corrected proof available online January 4). (2019).
2. Schwartz, L., Woloshin, S., **Andrews, A.O.**, Stukel, T. *The influence of medical journal press releases on the quality of newspaper coverage*. **BMJ**, 344:d8164**.** (2012)
3. Bynum, J., **Andrews, A.O.**, Sharp, S., McCullough, D. & Wennberg, J. *The care span: Fewer hospitalizations result when primary care is highly integrated into a continuing care retirement community*. **Health Affairs,** 30 (5): 975-980. (2011)
4. **Andrews, A.O.**, Bartels S.J., Xie H., & Peacock, W.J. Increased risk of nursing home admission among middle aged and older adults with schizophrenia. **American Journal of Geriatric Psychiatry**, 17: 97-705. (2009)
5. Welbourne, T., Andrews S.B., & **Andrews, A.O**. *Learning about employee motivation from running on my treadmill.* **Human Resource Management Journal**, 44:55-66. (2005)
6. **Andrews, A.O.**, & Welbourne, T. *The people/performance balance in IPO firms: The effect of chief executive officer (CEO) financial orientation.* **Entrepreneurship Theory and Practice**, 25:93-106. (2000)
7. Tolbert, P., Graham, M., & **Andrews, A.O.** *Group gender composition and work group relations: Theories, evidence, and issues.* In G. Powell (ed.) **Handbook of Gender and Work** (pp. 179-202). Thousand Oaks, CA: Sage. (1999)
8. Welbourne, T., & **Andrews, A.O.** *Predicting the performance of initial public offering firms: Should HRM be in the equation?* **Academy of Management Journal,** 39:891-919. (1996.)
9. Tolbert, P.S., **Andrews, A.O.,** & Simons, T. *Effect of group proportions on group dynamics.* In S.E. Jackson & M. Ruderman (Eds.), **Work Teams and Productivity in the Context of Diversity** (pp. 131-139). American Psychological Association. (1996.)

10. Tolbert, P.S., Simons, T., **Andrews, A.O.**, & Rhee, J. *Gender composition of academic departments and turnover among women faculty.* **Industrial and Labor Relations Review**, 48:562-579. (1995
11. Tolbert, P.S., & **Oberfield, A**. *Sources of organizational demography: Faculty sex ratios in colleges and universities.* **Sociology of Education**, 64:305-315. (1991)

Books & Chapters
Authors. Title. in Book Title (Eds.) pp–pp. Publisher (year).

1. **Andrews, A.O.,** Kearing, S.K., Vidal, D.C. 2016. *Implementation case studies: Dartmouth-Hitchcock Medical Center.* In Elwyn, G., Thompson R., Edwards, A. **Shared decision making in health care: a guide for practice. 3rd Edition.** Oxford University Press. (2016)

2. Clay, K., **Andrews, A.O.**, Collins, D. *Patient Involvement in Decision Making for Breast Cancer.* In Benson JR, Tuttle T, Gui G. In **Early Breast Cancer – from screening to multidisciplinary management, 3rd edition,** Informa Healthcare. (2013)

3. Freed, G., **Andrews, A.O.**, Collins, D. *Patient Centered Health Communications.* In **Plastic Surgery – 3rd edition**, Elsevier Ltd. (2012)

Non-peer-reviewed publications:
1. Teisberg E., Wallace S., **Andrews, A.**, Davis, V. *Mastering healthcare transformation.* **The Health Advocate**, Issue 51/December: 10-11. (2018)

Book Reviews –
1. **Administrative Science Quarterly** 38: 691-693. (Book Review), 1991, Powell, W. & DiMaggio, P. (eds.). **The New Institutionalism in Organizational Analysis**. (1993)

Editorial Responsibilities

The Generalist in Medical Education, Annual Meeting Reviewer	2018
Health Affairs, Reviewer	2012
Health Expectations, Reviewer	2008
Journal of General Internal Medicine, Reviewer	2014
International Journal of Geriatric Psychiatry, Reviewer	2007
Administrative Science Quarterly, Reviewer	1998
Entrepreneurship Theory & Practice, Reviewer	1999
Work and Occupations, Reviewer	1997

Presentations, Posters & Abstracts

International

Authors	Title of Presentation	Meeting Name	Date
Alice Andrews	Invited Chair: A Value-Based Approach to Healthcare Leadership	International Consortium for Health Outcome Measurement (ICHOM) Webinar	2020
Alice Andrews	Invited panelist: Organizational Resilience in the Covid-19 Era & Beyond	Relational Coordination Research Association June Partner Café (virtual)	2020
Alice Andrews	Invited talk: Transforming Health and Care	Strategic Workshop: Victorian Department of Health and Human Services, Melbourne, Australia	2019
Alice Andrews, Victoria Davis	Measuring what matters to individuals and families	Outcome Measurement Workshop at the Asia Pacific Integrated Care Conference, Melbourne, Australia	2019
Alice Andrews,	Implementing Shared Decision-Making in Practice: A Case Study for Teaching System Change	European Association of Communication in Healthcare (EACH) international meeting. Heidelberg, Germany	2016
Alice Andrews, Dale C. Vidal	Sharing stories for shared decision-making	"Where is the Patient Voice in Health Professional Education?" – 10 years on. Interprofessional Continuing Education Conference at University of British Columbia Vancouver BC, Canada	2015
Elaine Cheng, Clara Lampi, Carolyn Johnson, Katherine Kosman, Kate MacMillan, Michael Miller, Chiquita Palha de Sousa, Alice Andrews, Gautham Suresh	Role of shared decision making in the NICU. (Poster presentation)	American Association of Communication in Health Care Montreal, QC, Canada.	2013

Alice Andrews, Greg Makoul	Connecting for value: Experiences of health care leaders in a team-oriented, cohort-based model of hybrid learning. (Poster Presentation)	European Association for Communication in Healthcare Annual Meeting St. Andrews, UK.	2012
Alice Andrews	*The role of dyadic values congruence in supporting long-term care decisions among older adult consumers and their caregivers (Poster Presentation)*	4th International Shared Decision Making Conference Freiburg, Germany.	2007
Alice Andrews & Theresa Welbourne	*Studying speed (rate of growth) and fuel (energy) in fast growth firms: e-research, e-business, and e-teaching outcomes*	Academy of Management Annual Meeting Toronto, Canada.	2000
Alice Andrews, Steven Andrews	*Customer representation on the board of directors: A test of resource dependence and structural autonomy*	Western Academy of Management Meeting Banff, Canada	1996

National

Authors	Title of Presentation	Meeting Name	Date
Alice Andrews	Designing a team-based, experiential learning project to transform health care: opportunities and challenges	The Generalist in Medical Education	2018
Alice Andrews, Dale C. Vidal	Leading Change in Health Care: Getting Started and Moving Forward	High Value Health Collaborative meeting Park City, UT	2014

Alice Andrews	Patient Engagement Workshop: Patient/Provider panel	*Aligning Incentives in Patient Engagement* conference by the Informed Medical Decision Making Foundation Washington, DC	2013
Doug Altman, Lisa Schwartz, Steven Woloshin, Alice Andrews	A Review of Registration and Reporting of "Continuish" Outcomes in Randomized Trials	International Congress on Peer Review and Biomedical Publication Chicago, IL.	2013
Alice Andrews	*Hybrid Learning to Support Chronic Care Redesign* (Poster Presentation)	Institute for Healthcare Improvement National Forum. Orlando, Florida	2012
Dennis McCullough, Alice Andrews	*Slow Medicine: Implications for use of service*s	Gerontological Society of America Annual Meeting National Harbor, MD.	2008
Alice Andrews	*Supporting Informed Choice for Long-Term Residential Care: A Needs Assessment for the Development of a Decision Aid* (Poster presentation)	American Association for Geriatric Psychiatry Annual Meeting Orlando, Florida	2008
Alice Andrews	*Shared Decision Making Among Older Adults: Long-term Care and Beyond (Web Seminar)*	NRSA Geriatric Mental Health Services Postdoctoral Fellowship Hanover, NH	2007
Alice Andrews	*Decision support for long-term care: Consumers, caregivers, and choice (Web Seminar)*	NRSA Geriatric Mental Health Services Postdoctoral Fellowship Hanover, NH	2007
Alice Andrews, Stephen Bartels	*Early nursing home admissions among persons with serious mental illness: New Hampshire Medicaid Beneficiaries 1995-2005 (Poster Presentation)*	American Association for Geriatric Psychiatry Annual Meeting New Orleans, LA.	2007

Alice Andrews	*Unwarranted variation? Nursing home admission patterns among older adult New Hampshire Medicaid beneficiaries with SMI*	NRSA Geriatric Mental Health Services Postdoctoral Fellowship Hanover, NH *(Web Seminar)*	2007
Alice Andrews	*Employee voice in the world of e-business*	Industrial Relations Research Association Annual Meeting New Orleans, LA	2001
Alice Andrews	*From information to energization to action.* (Invited presentation)	Gateway Society for Industrial and Organizational Psychology (GIOP) St. Louis, MO	2000
Alice Andrews	Learning from Entrepreneurial Firms – The Future of HRM in the E-World	Human Resource Network for Executive Education Davidson Institute, University of Michigan Ann Arbor, MI	2000
Alice Andrews	*The people - performance link: A matter of VALOUR* (Invited presentation)	Minnesota chapter of SHRM (Society for Human Resource Management) Minneapolis, MN	1998
Alice Andrews	*Signaling legitimacy after metamorphic change: Directors in the initial public offering*	Academy of Management Annual Meeting Cincinnati, OH	1996
Alice Andrews, Mary Graham	*Gender inequality and college major in first occupation and salary attainment: The problem of arbitrary data aggregation*	American Sociological Association Annual Meeting Los Angeles, CA	*1994*
Alice Andrews, Pamela Tolbert & Tal Simons	*Effect of group proportions on group dynamics*	American Psychological Association Los Angeles, CA	1994
Alice Andrew, Timothy Judge	*A proposed model of career satisfaction*	Academy of Management Annual Meeting Atlanta, GA	1993

Alice Andrews & Pam Tolbert	*Sources of organizational demography: Faculty sex ratios in colleges and universities*	American Sociological Association San Francisco, CA	1989

Regional

Authors	Title of Presentation	Meeting Name	Date
Alice Andrews, Amy Madore, Kasey Ford	From faculty to teaching teams – how higher education can learn from IPUs	Dell Medical School poster session	2019
Alice Andrews	Lessons from Shared Decision Making	Health Care Reform: Lessons from the United States Tuck School of Business at Dartmouth executive education course, Hanover, NH	2014
Alice Andrews	Decision Support: Making Preference Sensitive Decisions in Health Care	Dartmouth College Hanover, NH	2008
Alice Andrews, Stephen Bartels	Shared Decision Making: Supporting Real Choice in Health Decisions and Long-Term Care	New Hampshire Real Choices Transformations Grant Annual Meeting Concord, NH	2008
Alice Andrews	Medical Practice in Today's Environment: Evidence-based Medicine and Shared Decision Making	Sociology of Professions course (Faculty: Pamela Tolbert) Cornell University Ithaca, NY	2008
Alice Andrews, Stephen Bartels	Shared Decision Making: Supporting Real Choice in Health Decisions and Long-Term Care	New Hampshire Real Choices Transformations Grant Annual Meeting Concord, NH	2007
Alice Andrews	*Creating, sustaining, and measuring organizational*	Ann Arbor High Tech Human Resource Association Ann Arbor, MI	2001

	energy: The people-performance link. (Invited presentation)		
Alice Andrews, Pamela Tolbert & Tal Simons	*Gender composition of academic departments and turnover among women faculty*	ILR-Cornell Institute for Labor Market Policies Conference, Ithaca, NY.	1994