As leaders begin to reopen the doors of health care, they must address patients’ fears surrounding Covid-19 to ensure that fear doesn’t prevent them from seeking needed services. Health care organizations can draw upon several behavioral principles. These include methods for framing information about Covid- and non-Covid-related health risks to patients, using social comparisons to motivate patients’ decisions by showing them information about how others are re-engaging in care, and leveraging defaults to make re-engagement as frictionless as possible via means such as automatically scheduled visits for low risk individuals.

Over the last few months, health care systems across the country have aligned behind a common strategy: curtail less urgent services, including elective surgeries and non-essential office visits, to create capacity and absorb surges in Covid-19 cases. However, with financial pressures mounting and infection rates beginning to flatten in certain regions, leaders are beginning to reopen their systems’ clinics and surgical suites.

So far, these efforts have focused on several elements of a staged re-expansion: ensuring adequate supply of personal protective equipment for employees; building sufficient capacity to test patients and staff; and implementing robust cleaning and physical distancing policies. While important, however, these measures may not be enough. Strategies to re-open health care must also account for human psychology. Many patients have been gripped by fear of contracting the virus, leading to sharp decreases in emergency room and hospital admissions and a nearly 60% drop in physical office visits. Nearly 30% of individuals reported actively avoiding or delaying care due to concerns about contracting the virus.

Much is still unknown about Covid-19, and it remains too early to judge whether patients’ fear of contact with the health system is appropriate or exaggerated. Health care providers should certainly not dismiss patient fears; however, infection risk depends on patient factors, and we need more
time to understand details such as the probability of contracting the virus in health care settings or suffering severe virus-related complications. To do so, health care systems must create sustainable processes for vetting and adjusting to new findings about Covid-19.

Nonetheless, based on what is known, some aspects of this fear may be more founded (SARS-CoV-2 spreads more easily than other viruses such as seasonal influenza) while others less so (the majority of individuals will experience mild to minimal illness). The fear of Covid-19 may become “irrational” for some patients (i.e., ultimately not in their best interest) if it inappropriately leads them to overlook other serious health risks that clearly outweigh the likelihood of contracting and suffering harm from Covid-19.

For instance, even though children have tended to be lower risk for poor outcomes from Covid-19, the rates of routine pediatric vaccinations have plummeted over the last several months due to infection concerns. The trade-off could be severe: exposing children to a series of vaccine-preventable infections that could hit with force once social distancing measures are relaxed. Other examples of how the virus has deterred patients from seeking needed care include reductions in hospitalizations for acute myocardial infarction and refusal to undergo life-saving organ transplantation.

As health care systems reopen their doors, leaders can draw upon several behavioral principles in order to counteract fear and suboptimal health behaviors. Fortunately, health care leaders and clinicians are starting from a position of trust -- consumers report a high degree of trust with their health care providers, with nurses and doctors enjoying an 89% favorability rating. Leaders should build upon this trust, and not just to meet patients’ health needs. Re-opening will also come with labor and operational costs that threaten the financial health of hospitals and clinics if they are underutilized, and effective outreach can help ensure more accurate forecasting of changes in patient volumes.

**Framing the message: explaining risks and benefits**

First, health care systems could develop methods for framing information about Covid- and non-Covid-related health risks to patients in a balanced fashion. A large body of evidence within and beyond health care suggests that humans respond to **framing** -- ways of presenting information that impacts the appeal of a given decision. For instance, though the risk/benefit trade-off for a procedure does not change whether risk is framed as a 30% chance of death or a 70% chance of survival, patient choices can differ based on which framing is chosen.

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Framing is also relevant for Covid, even as our understanding of SARS-CoV-2 epidemiology continues to mature. For instance, based on data from other countries, mortality risk for healthy, younger individuals is exceedingly low. Health care leaders could incorporate these types of information into patient outreach materials – mailed letters, electronic patient portal messages and phone and telemedicine interactions – in order to appropriately frame the chances of positive and negative outcomes for patients.

Using the example of pediatric vaccination, health care systems could use framing to temper parents’ Covid fears (e.g., by framing the high probability of good outcomes after infection) and underscore the risks of forgoing other vaccinations (e.g., by framing the high risk of bad outcomes after contracting those infections).

Framing-based interventions have been used in the University Hospitals (UH) Health System, which launched a campaign targeting patients with open mammogram orders, emphasizing the success in treating breast cancer if caught early. Framing the message in a way that stressed the risk of ignoring preventive screening prompted more than 200 patients to schedule appointments.

A framing strategy can be used in a number of different clinical contexts. As more granular, local data become available, health care systems could help patients with a broader range of decisions using dedicated decision aids and other tools. To protect vulnerable or distrustful individuals, these tools should be developed for use by patients across a range of education, socioeconomic status and health literacy.

**Social comparisons: providing an example**

Second, health care systems can use social comparisons to motivate patients’ decisions. These comparisons can be powerful because individuals often respond when presented with information about others’ actions. For example, sharing data with physicians about their peers’ antibiotic prescribing habits has been shown to decrease inappropriate prescribing of antibiotics for uncomplicated upper respiratory infections, improving primary care quality.7,8

Comparisons can be strengthened even further when paired with messages reflecting group norms, i.e., statements that reflect a group’s value judgements about the appropriateness of a given behavior.9 Groups like the Behavioral Insights Team in the UK have leveraged the power of group norms, increasing tax compliance by mailing letters to citizens notifying them that 9 out of 10 of individuals in their towns paid their taxes on time.10

“To improve patients’ decisions, health care systems could provide them with comparison data about how others in their communities are re-engaging in care.”

Similarly, to improve patients’ decisions, health care systems could provide them with comparison data about how others in their communities are re-engaging in care. Adding norms may be
particularly helpful given the ubiquity of Covid-19 in the news, and how prominently it figures in many patients’ decision-making. Providers could implement this strategy by mirroring steps used effectively in non-health care settings.

For example, to promote energy conservation, companies modified energy bills to include information about an individual’s energy usage compared with that of her neighbors. Adding normative messages to the bills – “grading” usage as good or bad – further increased the effectiveness of the intervention.

Health care systems could implement similar strategies by conducting patient outreach via mailed letters or messages in the electronic health record. These messages could provide patients with information about how many of their peers (e.g., neighbors in their ZIP code; other patients seen in the same clinic) have appropriately sought care, and the positive outcomes that have resulted since doors were re-opened.

UH has tested this approach, sending emails to patients with chronic diseases who had not been seen in three to six months. The email message provided a social comparison and normative message by asking patients to schedule an appointment and stating that “most people with this condition see their physician at least every 6 months. You have not and it may put you at risk for harm.”

**Defaults: making it easy to seek care**

Third, for appropriate patients, health care systems could leverage defaults to make re-engagement as frictionless as possible. Humans tend to take the path of least resistance and choose a pre-selected or automatic option. For individuals at low risk of contracting or doing poorly from Covid-19, but for whom preventive care is central to long-term health, health care systems can help overcome virus-related fears by automatically scheduling patients to receive needed services (e.g., preventive screening, vaccinations, other visits).

Using defaults could also be beneficial for individuals with high non-Covid-related risks, such as those with complex needs (e.g., organ transplantation with suppressed immune systems) or multiple chronic conditions. Even though these patients often have more regular follow-up and continuity with their clinicians, they can also have outsized fears about contracting Covid that could be addressed through thoughtful defaults. To engender trust among these patients, it is critical that automatic scheduling be framed as recommendations coming from the physicians who serve the primary role for managing their health needs (e.g., a transplant specialist for organ transplant patients; a cardiologist for heart failure patients), and paired with detailed information about measures the system is taking to prioritize safety (e.g., policies about masking or maximum occupancy in certain areas).

For instance, at UH, patients discharged from the hospital are automatically scheduled for follow-up visits with their primary care providers within seven days – a process that began prior to Covid-19 and has continued through the pandemic. The health system also launched a “Getting Back to Care” email campaign targeting patients who had cancelled appointments due to state stay-at-
home orders. The email used a physician as a trusted source to deliver a video message thanking patients for flattening the curve but encouraged patients to seek care by emphasizing that “it’s now time to take care of yourself and your family.” These emails experienced a 59% open rate versus an industry average of 22%.

To be fair, none of these solutions are silver bullets. Even the most thoughtful, multi-pronged plans are likely just a start, and nimble approaches will be needed to quickly respond to changes in viral transmission and patient needs over time. Outreach strategies must also be tailored in different situations to patients’ overall and condition-specific needs. As telehealth use has expanded in response to the pandemic, behaviorally-designed strategies should also be tested for telehealth as well as in-person services. Furthermore, these messages should always be used responsibly, safeguarding patient health as the priority.

Nonetheless, human psychology clearly plays an important role alongside epidemiological surveillance and operational plans. Addressing it increases the chances that we can successfully re-open the health care system and deliver its benefits to patients.

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