CENTER FOR HEALTHCARE DECISIONS

Common Cents

The public's views on if and how to reduce the use of low-value medical care

Summary of project results
June 2014

Premise of this project

For many years, CHCD has been exploring the public's perspectives on treatment or coverage decisions regarding medical care that is ineffective, unnecessary, or more harmful than helpful to patients. This pilot project used a more specific and direct format than previous efforts: we focused solely on interventions that are prototypes of low- or no-value medical interventions and openly presented the cost implications of these interventions. As with most CHCD projects, our participants were asked to consider the options in their role as social decision makers, whose recommendations would affect everyone, not only themselves and their families.

This project was funded by a grant from the Kaiser Permanente National Program Office. For additional information about the project, contact Marge Ginsburg at ginsburg@chcd.org

Project participants

Through professional recruitment firms we enrolled 12 people for each of three sessions ,36 people total, held in the spring of 2014 in Oakland, Sacramento and Yuba City. We recruited employed persons (but not in healthcare) with private health insurance; between ages 35-60; mixed gender and ethnicity; variation in income and education level if possible. We provided a stipend of $150-$200.

The deliberative model

This was a 4½ hour discussion process which included a ½ hour meal break. Participants discussed, in order, four case studies that represent examples of low-value care; were easy for a lay public to understand; and illustrated three different types of over-use: 1) where there is no evidence of medical benefit and is potentially harmful; 2) where research shows that it is highly unlikely to be medically useful; and 3) where evidence shows it is equally effective but is more costly than another intervention.

Prior to attending the session, all participants complete an on-line survey of attitudes and beliefs related to this topic and were mailed an 8-page introduction to low- and no-value care. At the start of the session, participants are presented with the over-arching questions they will address:

- To reduce over-use of inappropriate, unnecessary or ineffective healthcare services, should health insurance set limits on what it pays for?
- If so, which specific approaches to reducing over-use are most acceptable and why?

The four case studies were:

1. Optional early induction with normal pregnancies
2. Using MRI Scans for acute low back pain
3. Treating an injured knee: surgical vs. medical approach
4. Using ICUs for patients at the end of life

Discussion process

After each case study was reviewed, participants indicated among a list of 4-5 options which one(s) they thought most acceptable. Their responses were noted on a flipchart and then the group discussed their

reasons for the approaches they supported and those they did not. Participants were encouraged to debate each other freely and to speak up if they changed their mind. Since they were proposing theoretical recommendations for health insurance, it was important that all views were captured.

Results

Below are the voting results for each of the four case studies, with the votes of all 3 groups combined (where there are more than 36 votes, participants voted for more than one), with a general discussion of how participants viewed this example. Each case study included 30-35 minutes of discussion.

1. Optional Early Induction

Possible Action to Reduce Overuse	Participants' selections
Doctors receive a bonus if they follow guidelines	0
Early inductions must be approved by expert OBs	12
MD/hospital not paid for unnecessary early induction	15
Lower copayments for patients who use high-quality MDs	6
Take no action	4

Participants generally saw this medical intervention as frivolous and dangerous. The majority voted to restrict its use through the most direct and specific actions: removing health plan coverage or requiring expert approval. The cost-sharing option was initially acceptable to some participants wanting to preserve patient choice, but many reconsidered because of the additional costs passed on to others due to the associated long term health risks. Several participants acknowledged that it was not a difficult decision to restrict healthcare services that were both unnecessary and harmful. Objective expert review was attractive because this could protect patients from doctors providing inappropriate care, though some participants expressed concern that these experts were not familiar with the patient's history. Lowering copayments for patients who see obstetricians that adhere to professional guidelines was an attractive option because it retained patient choice and might motivate doctors to increase adherence. The participants that opted to take no action felt that decisions should be left to the patient and doctor, regardless of the situation.

2. Using MRI Scans for acute low back pain

Possible Action to Reduce Overuse	Participants' selections
Medical expert approval required	6
Doctor denied payment for unnecessary MRIs	4
Patient co-payment is higher for unnecessary MRIs	21
Take no action	5

A higher co-payment for unnecessary MRI scans was acceptable because many participants felt that this preserved the option for the patients who were adamant that the MRI would provide the peace of mind they needed; it also preserved patient choice. Participants shared personal experiences with low back pain that was atypical and complicated. This influenced their views that research about MRIs may not always apply; they worried that people would be denied needed scans when appropriate. Participants did voice some concerns about how widely imaging services are advertised and the impact this may have on over-use. Among the participants who chose not to take any action, most felt that the

procedure was already restricted or they trusted that their doctors would not recommend something that was unnecessary.

3. **Treating an injured knee: surgical vs. medical approach**

Possible Action to Reduce Overuse	**Participants' selections**
Surgery must be pre-approved by expert doctors	14
Patient pays half of the cost of surgery	5
Lower co-pays for patients who use quality MDs	14
Take no action	5

Since the outcomes of both approaches to treating a knee are statistically the same, their decisions centered on what is the fairest way to maintain patient choice without financially impacting others. Encouraging patients to make the 'right' choice by lowering their co-payments met the need to encourage good care without requiring it. Interestingly, many participants viewed "pre-approvals" as equivalent to getting a second opinion; thus this option didn't seem so draconian. For some, patients paying half the cost seemed unfair to lower-income people who could not afford to have the same convenience as others. Many participants were comfortable with being referred to doctors with a high level of adherence to professional guidelines, because they felt that these doctors would recommend surgery if it was truly needed. Preserving choice, without restrictions, was the most popular explanation among participants who chose to take no action.

4. **ICU at the end of life**

Possible Action to Reduce Overuse	**Participants' selections**
Stricter hospital standards for ICU use	3
Admission to ICU only from palliative care doctor	23
Patients/families share in cost of ICU	1
Take no action	8

This case study elicited strong personal reactions. In each session there were participants who favored restrictions on low-value services in other cases but chose not to take any action in this case. They did not want to further complicate such a difficult and emotional time for patients and families by imposing harsh rules. But most participants felt that a required referral to a palliative care provider offered objectivity during a very difficult and emotional time and saw this specialist as a valuable support to the whole family. Cost sharing was unpopular because of the sensitive nature of this life event; many participants did not feel that it was right to burden the family with large bills.

Comparing approaches to reducing over-use

Staff reviewed the session notes and identified particular perspectives associated with the various approaches to over-use.

- **Increasing patient cost-sharing**

Cost sharing was most acceptable when the increased cost of a procedure was at a level that would not be an insurmountable barrier. Participants felt strongly that everyone, even those with limited means, should have access to a potentially unnecessary service if they chose. Several participants across the three sessions asked if the patient would receive a refund if the procedure was later deemed necessary.

- **Requiring use of expert MDs**

Objective review by medical experts was an attractive option because many participants believed that experts may agree with the patient. Objective review would offer the opportunity to 'make the case' for a particular treatment that had been deemed low value. Participants felt that objective review would also protect against any conflicts of interest that might motivate a provider to recommend a procedure outside practice guidelines.

- **Imposing stricter guidelines/denying payment to MDs**

Stricter guidelines and refusing payment were most acceptable when participants saw the medical intervention as unambiguously unnecessary, possibly harmful, and one that imposed higher costs on everyone else. Restricting optional early induction was an example of this. However, rewarding physicians for doing 'the right thing' was not a popular idea; participants did not feel that doctors should be 'bribed' for delivering high-quality care.

- **No action**

The commitment to reduce waste – which the vast majority of participants embraced without reservation – was most in conflict with the value of patient choice and with the need to trust one's physician to provide individualized care. These were the most frequent reasons that participants selected to take no action. Personal experience that defied the facts of the case study also exerted strong influence.

Changes in participants' attitudes

Deliberative processes commonly affect how individuals think about a controversial issue and how they respond to pre/post survey questions. Below are two of the pre/post questions:

Question #6

Insurance should pay for treatments that doctors recommend, even if research shows that a treatment does not work well for patients.	**Pre-survey responses**	**Post-survey responses**
Strongly agree	14 %	3 %
Agree	44	25
Not sure	25	22
Disagree	17	44
Strongly disagree	0	6

Question #11

If my doctor and I agree on the best treatment for my problem, it should always be covered by my insurance, regardless of what research shows.	**Pre-survey responses**	**Post-survey responses**
Strongly agree	36 %	11 %
Agree	44	47
Not sure	17	17
Disagree	3	25
Strongly disagree	0	0

In question #6, post-survey, only 28% agreed/agreed strongly that insurance should pay for treatments that the doctors recommend regardless of what the research shows. Yet in question #11, 58% agreed/agreed strongly that insurance should cover what "my doctor and I" believe is best, regardless of the research. Though the 58% is reduced significantly from the 80% who agreed pre-survey, it is much higher than the 28% in question #6. We believe that this difference – 58% vs. 28% – reflects the impact of a question that involves doctor and patient decision-making vs. one that is solely about physician decisions. When personalizing the question with "If my doctor and I…." participants were less likely to deny coverage based on research of effectiveness.

Conclusions

Across the three sessions participants were highly engaged in the deliberative process and actively debated their peers about the best approach for addressing each case study. They generally agreed that healthcare costs were too high and accepted that over-use of low-value healthcare services was wasteful and contributed to excess costs. They rarely doubted the research findings or the costs associated with over-use. Yet when the evidence conflicted with their personal experience, they were less willing to accept evidence without challenging it. Yet, even then, most wanted to find an approach that was reasonable and not over-burden the patient or the healthcare system. For example, some objected to using outside experts because it would be too expensive and drive up costs more.

Though it is difficult to make firm conclusions based on a small sample size, this exercise suggests the following:

- The lay public is prepared to discuss the problem of over-use of services because they see the impact of rising healthcare costs on themselves and others.
- They accept the facts about evidence and excessive use, even though this conflicts with their inherent belief that individual doctors should be the 'deciders.'
- They can consider options as social decision-makers, not only as self-interested individuals.
- The value of personal choice is a very strong one; options to reduce over-use are most acceptable when an element of personal decision-making is still intact.
- The more experience they have with a particular case study, the harder it is to be objective.
- The options that are most acceptable are ones that leave some 'wiggle room' for compromise, especially as it affects patients' right to choose.

In 2015, we anticipate conducting a larger project that explores this topic of reducing overuse with Californians from both the public and private sector.