Doing What Works

A report to:

The California Statewide Workgroup on Reducing Overuse
and
Integrated Healthcare Associations' *Choosing Wisely*® project:
Decreasing Inappropriate Care in California

April 2016

Executive Summary

Purpose

Responding to concerns about the increasing use of ineffective, harmful and wasteful medical services, the three largest purchasers in California — the Department of Health Care Services, Covered California, and CalPERS — established a statewide workgroup to develop and implement strategies to reduce the overuse of unnecessary care. The workgroup's charter included a specific task: *Research and report the priorities and values of public and private sector health plan members as they relate to specific strategies for reducing potentially harmful and/or wasteful medical interventions.*

Towards that end, the Center for Healthcare Decisions designed and implemented Doing What Works (DWW). This project asked health plan members to assume the role of policy-makers, discussing and debating fair and reasonable ways to reduce overuse in California.

Structure of DWW session

Ten DWW sessions were held in six locations in the state involving 117 community members. Five sessions were with Medi-Cal members (two sessions conducted in Spanish), four groups were with CoveredCA members, and one group was comprised of CalPERS members. All were lower-to-moderate income, ages 30 – 60, with health insurance. Led by non-partisan facilitators, each session lasted 4½ hours with interactive discussion on the following:

- Background information on the overuse of unnecessary care
- Case scenario #1: Antibiotics for adult bronchitis
- Case scenario #2: C-sections with normal pregnancies
- Case scenario #3: MRIs for acute low back pain
- Case scenario #4: Using costly drugs when benefit is minimal

For each case scenario, participants individually voted for one of five possible options. The options represented a variety of strategies to reduce physician prescribing, to reduce patient demand, or to "take no action." After voting, each group discussed and debated the pros and cons of the different approaches. All sessions were audio-recorded, transcribed and analyzed for qualitative findings. Participants also completed pre- and post-surveys to capture socio-demographics and assess changes in attitudes and beliefs.

Results

The first three scenarios were topics of high interest in California and were analyzed separately from the fourth scenario. The votes on these three were compiled and grouped into four distinct categories of strategies. The pie chart shows the percentage of all participants who favored these. The discussions uncovered the reasons why certain approaches were preferable to others.

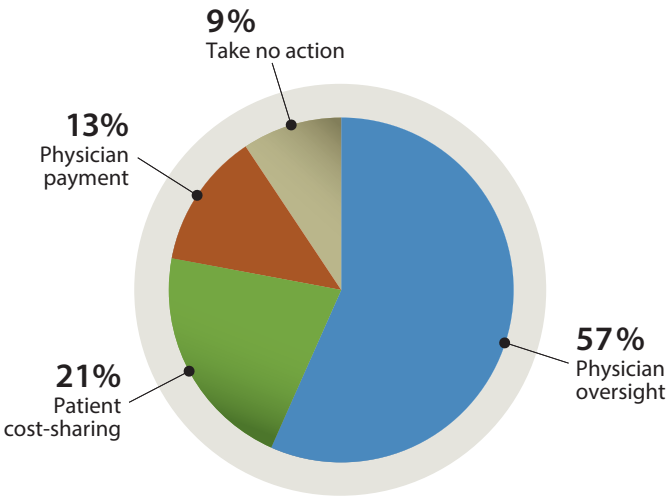
Physician oversight. Favored by the majority (57%), this approach proposed to change physicians' behavior through external approval, internal monitoring or establishing stricter rules for when the intervention will be covered. Since only physicians (or other licensed professionals) can prescribe, it was reasonable to correct the problem through either pre-approvals or retrospective review and discipline.

Patient cost-sharing. A minority (21%) believed that the most productive approach was to have patients be financially responsible (such as higher co-payment or paying the extra cost) if they insisted on an ineffective medical intervention. This approach maintained patient choice as an important feature of healthcare without burdening others with wasteful spending.

Physician payment. A much smaller percentage (13%) proposed financial disincentives through penalties or non-payment to correct the problem. However, participants were opposed to providing bonuses; they believed it was inappropriate to reward doctors for doing what they should be doing.

Take no action. Only 9% of the votes supported the option to take no additional action, leaving the decision entirely to individual doctors and patients. Participants believed the other approaches had serious flaws, possibly resulting in more harm than good.

Preferences for Strategies to Reduce Overuse



Over-arching principles

Review of the transcripts revealed five principles that dominated the discussions about participants' choices. Strategies to reduce overuse should consider these principles:

1. Physicians must be held accountable. Regardless of patient demand, physicians are the experts and must be held responsible for correcting the problem of overuse.
2. Actions should be effective, efficient, and credible. Approaches to reduce overuse must be proven to work, without an excessive cost or administrative burden, and instituted by trustworthy professionals.
3. Not wasting resources is a valid reason for reducing unnecessary care. The rising cost of healthcare affects everyone, and the public needs to be more aware of the importance of prudent spending.
4. Respect for patient choice must be balanced by ethical practices. Many supported patients' right to have ineffective medical care as long as they paid for it out-of-pocket. Others felt it was unethical for physicians to prescribe potentially harmful care, regardless of the payment source.
5. Patients have a responsibility to be better informed. While clinical judgment is paramount, patients, too, have a responsibility to be better informed about appropriate treatment.

Reducing overuse in specific situations

Each case scenario had distinctive characteristics that influenced the ways participants viewed them.

Overuse of antibiotics. Support was strongest for controlling physician prescribing either prospectively (pre-approvals for chronic over-users) or retrospectively (monitoring and discipline for patterns of overuse). Thirty percent supported higher patient cost-sharing to lower patient demand. There was particular concern about how overuse brings harm to society with resistant bacteria.

Overuse of C-sections. While a majority also supported augmenting physician oversight, about one-third believed that reducing compensation may be the most effective strategy. This scenario elicited a strong debate on whether a woman had a right to choose an unnecessary C-section if she self-pays and the role of medical ethics in this situation.

Overuse of MRIs. This scenario elicited less emotional engagement than the other two, in part because the harms of overuse are more obscure. Focusing on reducing wasteful spending, most supported stricter rules for coverage of MRIs for the first few weeks of acute low back pain. Since other treatments (e.g., physical therapy) can help patients, these stricter rules seemed reasonable.

Establishing a precedent of civic engagement in societal healthcare dilemmas can help assure that evolving changes in treatment practices and coverage policies have taken into account the views and values of the public at large.

The full Doing What Works report is available at www.chcd.org

CENTER FOR HEALTHCARE DECISIONS
when there are no easy answers.

(916) 333-5046
www.chcd.org

Funding — The project was possible through grants from the California Health Care Foundation and Kaiser Permanente National Community Benefit Fund.

California Health Care Foundation

KAISER PERMANENTE®