



Doing What Works

The public's perspectives on reducing the use of unnecessary, harmful or wasteful healthcare services

A report to:

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

April 2016

"Discussions like this are important to me...when people ask your opinion, it's probably because they want to do something in your favor. So I have a good feeling about this." — DWW participant



TABLE OF CONTENTS

1. Introduction	3
• Background.....	3
• Purpose and objectives	4
• Using public deliberation.....	5
2. Methodology	6
3. Results: Overuse of Ineffective, Harmful, Wasteful Care	10
• Responses to the options.....	11
▪ Establish greater physician oversight	11
▪ Influence physicians through compensation	12
▪ Increase patient cost-sharing/provide incentive	13
▪ Continue to leave it to the doctor and patient to decide	14
4. Results: When There is a Small Benefit with High Cost.	15
• Responses to the options.....	15
▪ Do not cover the costly treatment.....	15
▪ Cover the costly treatment	16
▪ Independent panel decides a fair price	16
5. Implications for Healthcare Leaders	17
• Principles to consider	17
• Applying these principles to policy	18
• Limitations of the project.....	21
6. Making Societal Decisions	22
• Responding to the DWW task	22
• Assessing changes in viewpoints	23
• Informing healthcare policy	25
Appendices:	
A. Advisory Committee members; Project partners; Funders	26
B. Participants' demographics/responses to select survey questions	27
C. Pre/Post survey responses	29
D. Educational materials	33
E. Case scenarios	37

The photos and quotes used in this report are those of DWW participants who gave permission for their use.

1. INTRODUCTION

Background

The overuse of unnecessary, harmful and/or wasteful medical care has concerned healthcare and policy leaders for many years. As referenced by the Institute of Medicine, most policy experts believe that 30% of healthcare dollars are not used productively, and a meaningful percent is linked to overuse. Interest in tackling this problem statewide began in earnest when the California Department of Health Care Services (DHCS) pursued a goal in its strategic plan: to improve healthcare quality by delivering effective, efficient, affordable care. Towards this end, DHCS received a Robert Wood Johnson Foundation technical assistance grant to have Bailit Health Purchasing research how DHCS should approach overuse.

Responding to the Bailit recommendations, in early 2015 DHCS asked the California Public Employees Retirement System (PERS) and Covered California (CovCA), the state's health benefit exchange, to join them in spearheading a [Statewide Workgroup on Reducing Overuse](#). These three entities, as the state's largest public and private health insurance purchasers, invited representatives from provider, purchaser, health plan, healthcare policy and consumer advocacy organizations to be members of the Statewide Workgroup.

In preparing the blueprint for the Statewide Workgroup's purpose and activities, the three leaders acknowledged the importance of designing strategies that take into account the principles and values of the patients and taxpayers they serve. With its experience in engaging the lay public in policy issues,¹ the [Center for Healthcare Decisions \(CHCD\)](#) developed the *Doing What Works* (DWW) project to capture the perspectives of lower to middle-income Medi-Cal, CovCA, and PERS members.²

Concurrently, Integrated Healthcare Association (IHA) received a [Choosing Wisely® grant](#) from the ABIM Foundation with funding from the Robert Wood Johnson Foundation. IHA's multi-player collaboration complements the interests of the Statewide Workgroup and provides additional resources and strategies towards a common goal. The findings of DWW are as relevant to the IHA grant as they are to the Statewide Workgroup.

1 For projects that targeted California healthcare policy, see [Sharing in the Cost of Care, Consumers' Priorities for Hospital Quality Improvement and Implications for Public Reporting](#), and [Making Tough Choices: Californians with Disabilities Prioritize their Medi-Cal Options](#).

2 For brevity, all Covered California members will be referred to in the report as CovCA and California Public Employees Retirement System members will be referred to as PERS.

Purpose and objectives

Approaches to reducing overuse typically include one or more of three broad strategies: reduce demand (of patients requesting unnecessary services); reduce supply (of providers offering/prescribing them); and/or reduce coverage (by health plans or medical groups). Since these approaches are intended to reduce access to certain medical services, they may be alarming to those who equate more care with better care or are concerned about interference with doctor/patient decisions. Thus, by understanding the public's views, policy leaders can formulate strategies consistent with informed consumer perspectives and social values. The DWW objectives are to:

- Engage lower-to-middle income Medi-Cal, CovCA and PERS members across the state in in-person deliberative group discussions on the topic of reducing overuse.
- Identify the approaches that are the most acceptable for reducing the overuse of unnecessary care.
- Underscore the relevance of civic participation in California healthcare policy.
- Contribute to the state and national understanding of how the public views the role of medical evidence in treatment or coverage decisions.

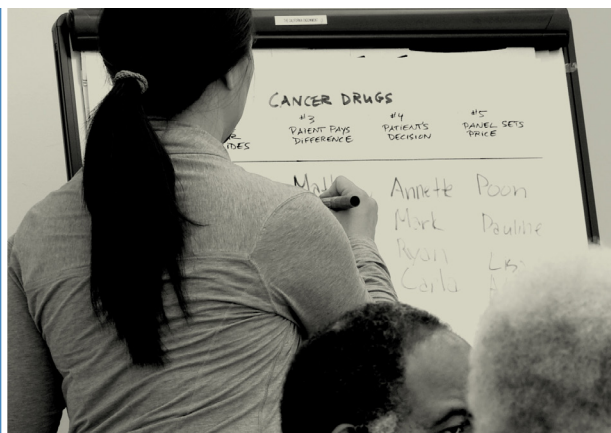
DWW centered discussions on three case scenarios that matched overused interventions targeted by the Statewide Workgroup and the IHA *Choosing Wisely*[®] project.

- 1 Overuse of antibiotics for adult bronchitis
- 2 Overuse of C-sections with normal pregnancies
- 3 Overuse of MRIs (Magnetic Resonance Imaging) for acute low back pain

The DWW discussion groups also included a fourth topic:

- 4 Using costly, minimally-effective drugs

While this last case scenario — a cancer drug that provides a small benefit at a high cost — does not fall within the usual parameters of ineffective medical care, it was an opportunity to explore another significant area of national concern, the high price of drugs.



Using public deliberation

The evolving healthcare landscape, including the need to spend resources wisely, sets the stage for greater involvement of the public as citizens, to help specify underlying principles for healthcare reform. While public input is frequently sought through focus groups or surveys that ask people what they know, believe, experience or need, deliberation is a discrete model of civic engagement with unique characteristics. In a deliberative group discussion, participants:

- Help solve a problem, not just comment on it.
- Consider the impact on everyone with insurance, not only themselves or their family.
- Explain their views, debating why some actions are more acceptable than others.
- Act as social decision-makers providing input to policy decisions.

“This is a lot more lively than what I thought it was going to be.”

Not all healthcare dilemmas are appropriate or necessary for public input. Technical or clinical questions (e.g., how useful are MRIs in treating low back pain?) are answered by medical research. Public deliberation is useful when addressing broader issues that require trade-offs or priority-setting in the coverage, financing or use of healthcare services.

Concerning overuse, deliberation addresses such questions as: “Do medical or financial harms to others justify restricting the practices of individual physicians?” “What type of limit-setting, if any, is reasonable?” or “What role do rising healthcare costs play in justifying stricter boundaries on coverage?” Participants’ responses require them to weigh various principles that may conflict, such as support for doctor/patient autonomy, minimizing regulation, protecting others from medical harm, and responsible stewardship of shared resources.

“Sooner or later the government, the medical profession, we as human beings, we got to draw a line somewhere.”



2. METHODOLOGY

With the input of the DWW Advisory Committee (**Appendix A**), CHCD developed participant recruitment criteria, educational materials, four case scenarios, pre- and post-session survey questions, and protocol to assure confidentiality of individuals’ participation. The California State University, Sacramento Institutional Review Board (IRB) approved the study protocol.

Overview of participant recruitment

To coincide with the interests of the Statewide Workgroup, DWW convened five groups of Medi-Cal members (including two groups conducted in Spanish), four of CovCA members and one of PERS members. Reflecting the state’s interest in the views of lower-to-moderate income Californians, all CovCA and PERS participants had annual household income below 400% of the Federal Poverty Level. All participants were between the ages of 30 and 60, without Medicare coverage. They were also screened for literacy and the ability to participate in an intensive half-day discussion.

Professional recruitment companies and community-based organizations recruited the individuals; to boost diversity, each group included no more than four participants from any one health plan.³ Each participant received a \$200 stipend and a meal. Participants received an Informed Consent document specifying the conditions of confidentiality and their role and rights as a participant.

Table 1 below shows the locations of the 10 sessions. All sessions had 12 participants except San Diego which had nine. See **Appendix B** for more details on the socio-demographics of the participants.

TABLE 1: DWW sessions by locations/healthcare coverage (total = 117), Sept. – Dec. 2015

	Sacramento	Fresno	Oakland	Los Angeles	San Diego	Ukiah
Medi-Cal	●	★	●	★		●
CovCA		●	●	●	●	
PERS	●					

★ Sessions held in Spanish

³ The one exception to this was Ukiah; all its participants were members of one particular Medi-Cal health plan.

Educational materials

An essential aspect of deliberation is exposing participants in advance to sufficient background information about the problem they are being asked to address. Thus, CHCD developed a 4-page hand-out for participants to read and discuss in detail at the beginning of the session. This handout presented information on a) how overuse helps drive up healthcare costs; b) the difference between value and volume; c) the elements of high- and low-value care (clinical benefit; harm to individual/society; cost relative to benefit); d) why low-value care persists; and e) the role of research in identifying low-value care. Assessed by the Flesch Reading Ease Scale, the materials were prepared at a 7 – 8th grade reading level, and a graphic designer made the information visually appealing and accessible to a lay audience (see **Appendix D**). This document was translated into Spanish for the two Spanish-language groups.



During the initial 45 minutes, each group discussed the material to build a common understanding of the concepts and terminology. Participants were also given the over-arching question to frame the purpose of their discussion: *“While improving the health of Californians, what strategies are most acceptable for reducing the use of medical care that is harmful and/or wasteful?”* Participants were instructed that they were making decisions on behalf of all Californians, not just themselves or those within their own coverage program such as Medi-Cal.

Case scenarios

Each of the first three scenarios was a one-page description of the medical problem, the unwarranted medical treatment, and the harms it causes (see **Appendix E** for all case scenarios); they were also translated into Spanish. The data presented in each scenario were based on California or national statistics; the second page provided five options for addressing this type of overuse. In the first three scenarios — antibiotics for bronchitis, C-sections for first time normal pregnancies, and MRIs for acute low back pain — the five options focused on influencing physician prescribing, influencing patient demand, and continuing to leave it to the patient and doctor to decide (i.e., take no action).⁴

The fourth scenario presented a different type of low-value care: a new cancer treatment that is slightly more effective than a current one but considerably more expensive. In this scenario, participants considered options based on health plan coverage: to cover the costly treatment, to not cover it, or to use an independent panel to establish a fair price. Since this scenario was so distinct from the first three, the findings are presented separately.

4 After the first session, the wording of MRI case scenario was modified to make it easier to understand. The wording changes did not appear to alter participants’ choice of options or reasoning in subsequent sessions.

Discussion process

Each 4½ hour session was led by experienced, non-partisan facilitators who followed this agenda:

- Introductions, information about DWW, sponsors, ground rules for discussion
- Educational material: participants review in small groups, then discuss with the full group
- Case Scenario #1: Antibiotics for adult bronchitis: review and discuss
- Case Scenario #2: C-Sections for normal pregnancies: review and discuss
- Half-hour meal break
- Case Scenario #3: MRIs for common low back pain: review and discuss
- Case Scenario #4: Drugs for advanced kidney cancer: review and discuss
- Group summary, conclusions
- Post-survey and stipends

“This is a tough job. You have to consider so much.”

With each case scenario, participants picked one option they were most likely to support. Their votes were recorded on a flipchart, which became the basis for starting the group discussion. Consistent with deliberation, participants would sometimes change their initial opinion or decide that other options were also acceptable. These changes were noted on the flipcharts.

An important element of the process was the presence of a family practice physician. Her role was as a resource for participants who had questions during the discussions about standards of medical practice or who wanted further clinical information about the case scenarios. In every session, she was queried multiple times and provided objective, easy-to-understand responses.

Pre- and post-survey questions

In addition to capturing demographic data, the purpose of the surveys was to learn if participants shifted their views about the problem of overuse and the role of research in coverage decisions. While these questions did not refer to the case scenarios, the responses indicate the extent to which participants' views were affected by the DWW information and discussion. Participants completed the pre-survey online or by mail prior to attending the session. They completed the post-survey at the end of the session.

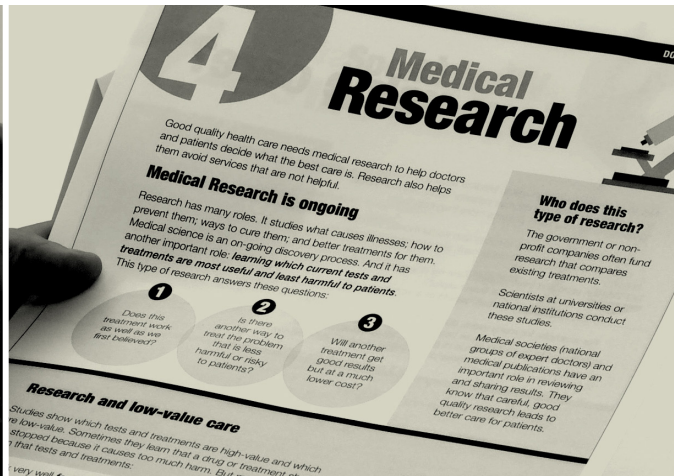


Qualitative and quantitative analysis

The discussion groups were audio-recorded and transcribed. This project used an inductive or grounded theory methodology to analyze the transcripts from each discussion group. With each session, the facilitators allowed themes to emerge, rather than impose predetermined analytical codes and compared results across groups to confirm larger findings. Facilitators independently reviewed the transcripts, identifying and grouping the common and less-common themes from each session and within each case scenario. Themes were organized by frequency and by the accompanying participant rationale.

For the quantitative analysis, the chi-square test was used to compare the pre-survey responses according to categorical demographics and personal characteristics. A Wilcoxon Signed Rank test was used to make within-group comparisons of pre- and post-survey responses. A p value of .05 was considered significant. All statistical analyses were performed using SPSS software version 23.

When comparing responses among the different sessions or across type of purchaser, the PERS responses (from its single session) were merged with those of the four CovCA sessions because the characteristics of both groups were similar: they were of lower-to-moderate income with private health insurance.



3. RESULTS: Overuse Of Ineffective / Harmful / Wasteful Care

Table 2 shows the number of participants who chose one or more of the five options available in each of the three case scenarios on overuse. The results of the cancer drug scenario are addressed separately in Section 4, on page 15.

TABLE 2: How participants voted (N = 117)	Four themes: consolidation of the 16 options			
Options Offered for Each Case Scenario	Establish greater physician oversight	Influence MDs through compensation	Increase patient cost-sharing/ provide incentive	Continue as a doctor/ patient decision only
• ANTIBIOTICS: What is the best way to discourage over-use of antibiotics?				
1. If a doctor routinely over-uses antibiotics, that doctor should have to get approval from a medical expert before ordering one.	40			
2. To discourage patients from insisting on an antibiotic, the patient should have to pay most of the cost of the drug if the doctor cannot give a good medical reason for ordering it.			30	
3. Doctors that work together should monitor each other. If any of them continue to over-use antibiotics, they could be disciplined in some way.	42			
4. To encourage doctors to follow guidelines, they should be rewarded with a small bonus if they are careful with antibiotics.		4		
5. Continue to leave it to the patient and doctor to decide if an antibiotic is needed or not, despite the risks.				17
• C-SECTIONS: What should be done to encourage proper use of C-sections?				
1. Monitor doctors' practices; health plans would provide a small bonus for those who follow guidelines for doing C-sections.		1		
2. Encourage pregnant women to choose vaginal births (when there is no medical problem) by offering a valuable gift (for example, a gift card).			3	
3. Require all scheduled C-sections to be reviewed and approved in advance by expert doctors that have no financial motives.	72			
4. Give health plans the authority to reduce payment to a doctor who, based on a review by an independent panel, performs an unnecessary C-section.		43		
5. Continue to leave it to the patient and doctor to decide what type of delivery best meets their needs.				15
6. (additional option proposed by six groups) If a patient wants an unnecessary C-section, she pays the extra cost.			54	
• MRIs: What should be done to encourage proper use of MRIs for low back pain?				
1. Doctors who often over-use MRIs without good medical reasons should be required to first get approval from a medical expert before ordering an MRI.	24			
2. If a doctor orders an MRI without a strong medical reason, the doctor should have to pay the cost of it.		10		
3. To encourage patients to think twice before insisting on an MRI when there is no medical reason, the patient should have to pay the cost of it.			7	
4. There should be stricter rules for when an MRI can be ordered for common low back pain. For example, it could be ordered only if the back pain is not better in 4 – 6 weeks.	76			
5. Continue to leave it to the patient and doctor to decide if an MRI is needed or not, regardless of the possible harm				10
Number of votes within each theme (% of total votes)*	254 (57%)	58 (13%)	94 (21%)	42 (9%)

* The 117 participants could choose more than one option within each case scenario. Thus, the total votes cast were 448 rather than 351 (117 x 3 scenarios).

Responses to the options

The four themes in Table 2 are presented below. The main reasons participants preferred or rejected these actions are listed, with references to specific case scenarios when reactions to them were distinctive.

Establish greater physician oversight

There were three different versions of physician oversight. Although the wording varied somewhat across the three scenarios, the discussions brought to light participants' main reasons for supporting them as well as their reservations:

"It's good to have an unbiased opinion who doesn't know the person or the doctor. To have someone tell the doctor, 'sorry Charlie no C-section.'"

- 1 Expert approval:** If a physician routinely overuses, that doctor must get approval from an expert before prescribing.

This option was available in all three scenarios. It was widely supported for several reasons:

- Participants viewed the expert as someone outside the physician's medical group who would be objective in reviewing the medical facts.
- This approach addresses the problem before treatment is given, not after, especially important for antibiotic overuse.
- This was viewed as the strongest action that will stop unnecessary C-sections before they happen.

There were a variety of concerns about this approach: it may be too time-consuming and add to the cost of healthcare; some raised concerns about who the "expert" is and if his/her judgment can be trusted; they worried if a prospective review may risk inappropriate denial of treatment. And in the C-section scenario, some felt that this option inappropriately takes the mother out of the picture completely.

"I got a different picture: they're sitting together discussing how they are dealing with their patients as a practice. It's better to get it from your peers than have someone come in."

- 2 Monitor and Discipline:** Medical groups should monitor their own doctors and discipline over-users as needed.

This option was offered only in the antibiotics scenario but elicited considerable discussion. The groups were equally divided between this version of physician oversight and "expert approval." Rationale of those that support this option:

- Groups of doctors can more easily monitor each other than an outside expert.
- This is where the authority should be: from the inside, not the outside.
- It can be based on a pattern of overuse, not just one treatment review at a time.
- It avoids the risk of inappropriate denial for the patient.

"Because it would set up a hostile work environment for the doctors, and I don't want my doctor in survival mode when they're trying to treat me."

The most prevalent concern about this approach was the view of many that doctors cannot be trusted to self-monitor. Participants were skeptical that they would be motivated to do so, concerned that the doctor's self-interest is too strong to be objective and that they would be uncomfortable "looking over the shoulders" of their colleagues.

"It's like going to a mechanic. You're going to get your car fixed. You want to go with the cheaper, try the cheaper things first and work your way up."

"I think people have a huge fear of over regulation because we are in California, and they over-regulate everything. But you have to have some regulation, and if you want to control costs, you have to set some things as standard."

3 Stricter Rules: There should be stricter rules for when an MRI can be ordered for common low-back pain (e.g., only after the initial 4 – 6 weeks).

This option was presented with the MRI scenario and two-thirds of participants supported it. Rationale for this option included:

- Low back pain is so common and the indications to order a scan are so clear that stricter rules seem logical.
- The stricter rules are cost-effective and uncomplicated.
- There are other actions patients can take before getting imaging tests.

The concept of stricter rules also seemed more appealing because it didn't specifically target physicians or patients. It sounded less punitive in its application than approaches that subjected individuals to more patronizing oversight. Those who disagreed with this approach were concerned that the rigidity of "stricter rules" would preclude identifying the patients who really needed a scan. Those participants were more likely to choose Expert Approval where each patient would be assessed individually.

Influence physicians through compensation

Each scenario had one or two options related to compensation: 1) use a bonus system for good compliance with guidelines and/or 2) do not compensate physicians for unnecessary treatments.

1 Bonuses: Provide a bonus to physicians who comply with guidelines.

Rewarding physicians for appropriate medical care was an option in both the antibiotics and C-sections scenarios. It was soundly rejected: within both scenarios, only 4% of participants chose this as a worthwhile option. Those that supported it believed that physicians are no different than others who are motivated by financial recognition. Yet the vast majority opposed it vehemently. Since participants saw medicine as a highly-esteemed and well-compensated profession, they believe that physicians should be motivated solely by their responsibility to "do the right thing."

"It seemed to me like they already get enough incentives and bonuses down the line, I actually want them to do something because it's the right thing to do."



Mel

"I think if the doctor realized, "I gotta rein this in a little bit," and not just be so quick to "here, that's for you" and "that's for you." I think that would make them have to take a second look at that."

"But then we're thinking of those people who are not on Medi-Cal, who are paying taxes. Do they want an extra \$9,000 going towards an unnecessary C-section?"

"I kind of don't like that because it leaves the doctor maybe not wanting to give out MRIs because he's afraid he'll get charged for them. You see, and so that's not really a good option."

"You start questioning it yourself, and it becomes a 'Is this truly a value to me? Am I getting something out of this?'"

2 Reduce payment: Do not compensate providers for an unnecessary treatment.

Penalizing physicians/hospitals for overuse was an option in the C-sections and MRI scenarios. Very few participants supported it in the MRI example, preferring the simplicity of Stricter Rules. Yet more than one-third of participants supported it for the overuse of C-sections. Interest in the compensation option seemed to be related to facts in the C-section scenario, i.e., the higher cost of C-sections compared to vaginal deliveries, overuse that is driven by providers not patients, and the high rates of unnecessary C-sections in California.

Concerned about the effect on the state budget with the higher cost of C-sections, participants were more inclined to support an option that explicitly impacts physicians' pocketbooks. Some believed that this option also might be more reliable than trying to screen out unnecessary C-sections in advance. Yet others worried that as a result, physicians might not provide needed services for fear of facing an unjust penalty.

Increase patient cost-sharing/provide incentive

The option to increase patient cost-sharing was available in antibiotics and MRIs, proposing that patients who insist on having the intervention should bear some of the cost burden. While only a few supported it for MRIs, 26% thought it was a viable option for those pressuring their physicians for an antibiotic. There was greater awareness of patient demand for antibiotics, and many felt that physicians didn't have the time to explain why the medication was unnecessary and harmful. Increased cost-sharing would be easy to implement, and many believed that self-pay would convey a strong message, making patients think twice about the necessity of antibiotics.

However, others had reservations about this approach for overuse:

- It may not reduce overuse of antibiotics to sufficiently reduce the harm to society.
- It seems unethical to allow patients to purchase drugs — even with their own money — that could result in harm to others.
- Even if the demand is mainly coming from patients, doctors have a professional obligation to resist the demand and do only what is medically necessary.



"Is it the patient asking? Or is the doctor prescribing? I don't know which one is more prevalent. But I don't know if we can control the doctor prescribing. But I think we can control the patient asking."

“If antibiotics are a risk for my patient, you should be firm and say, “No, I’m not going to prescribe it to you . . . I am a doctor and I’m not going to do something that will affect your health, even though you have the money to pay for it.”

“And if a doctor is routinely overusing, I wouldn’t think that the patient should be penalized. The doctor should know better. He’s the expert.”

“But to me it’s a thing where you trust somebody and you go to somebody hoping they are going to give you the right decision. Is it always going to be right? No. It’s never always going to be right.”

“More regulation, more agencies, more people to oversee each little action. Just means more money to spend.”

“I just think we’re putting a lot on doctors. You’re going to scare the doctors. People aren’t going to want to be doctors.”

The C-section scenario had not included a “self-pay” option because the problem was presented as provider-driven. Unexpectedly, in six of the ten sessions (half Medi-Cal and half CovCA) participants independently proposed that women who wanted a C-section without medical indication should be allowed to have it but only if they paid for it. Within those six groups, three-fourths of participants agreed that patient self-pay was appropriate for unnecessary C-sections.

Despite the statement in the scenario that the over-use problem was driven by providers, participants had many personal accounts of family and friends asking for and having C-sections with normal pregnancies. While most were appalled by the waste of resources and potential harm to women and babies, they were conflicted about optional C-sections as being within a woman’s right to choose. Many noted it was similar to cosmetic surgery: not medically necessary but available if patients want to pay for the service themselves. Medi-Cal members with limited discretionary income supported the self-pay option as often as did CovCA members, recognizing and accepting the cost burden this represents for those with Medi-Cal.

Others disagreed that this was a woman’s right to choose, saying that the medical risk to women and babies did not justify doing optional C-sections, regardless of who paid for it.

Provide patients with a financial incentive. This option was described as a patient gift card to encourage a vaginal birth in the C-section scenario. Only three participants out of the 117 total believed this was a viable approach; others were as dismissive of this strategy as they were of physician bonuses. Participants noted that mothers often receive gifts from the hospital already and shouldn’t have to be “bribed” to do what is best for their child.

Continue to leave it to the doctor and patient to decide

This option was available in all three scenarios as the “take no action” choice. Depending on the case scenario, this option was selected by 10 – 17% of participants. It was chosen by those who felt that all the other options were flawed or would cause more problems than they solved.

Most rejections of the other options were based on fear that reducing the authority of the individual doctor and patient was a slippery slope of too much regulation that would decimate individualized patient care or lead to explicit rationing. While everyone supported greater education for physicians and consumers about the problems of overuse, these participants were unwilling to take more definitive steps.

Interestingly, the participants who opted to “take no action” did not respond that way for all three scenarios. This suggests that their responses were specific to one or two of the examples but did not reflect an overall resistance to the concept of controlling overuse.

4. RESULTS: When There Is A Small Benefit With High Cost

The options for the advanced kidney cancer case scenario (see page 43) were different from those in the previous three scenarios.

TABLE 3: How participants voted (n = 114)*	Three themes: consolidation of the 5 options		
OPTIONS: What Should Be Done About Drug B?	Do not cover the costly treatment	Cover the costly treatment	Independent panel decides a fair price for the new drug
1. The benefit of the two drugs is almost equal, but Drug B is much more expensive. Health insurance should only pay for Drug A.	19		
2. If the doctor recommends Drug B, the health plan should pay for it.		9	
3. If patients want the “newest, most expensive” treatment, they should have to pay the difference between Drug A and Drug B (\$30,000).	21		
4. Since Drug B may bring one more month of life, it is the patient’s decision to choose this drug or not (even if the side effects are worse).		36	
5. An independent panel of experts should decide what a fair price for Drug B should be, so it becomes high-value, not low-value.			48
Total votes (% in each theme)	40 (30%)	45 (34%)	48 (36%)

* Three of the 117 participants choose not to participate in this discussion. The 114 participants could choose more than one option. Thus, the total votes cast were 133 rather than 114.

Responses to the options

This case scenario was used to illustrate a different type of low-value care. With the other scenarios, evidence showed there was no medical benefit for patients. In this one, low-value is represented by a small benefit with a large price tag, to see if participants would approach this situation differently.

Do not cover the costly treatment

Many felt that the clinical benefit of Drug B was so small (i.e., one extra month of life with more side effects) and the cost was so high (\$30,000 more than Drug A), that they could not justify putting this financial burden on society at large. They viewed this scenario as pragmatically as they did the others, looking at benefit vs. cost in a similar fashion. Other reasons given included:

- Patient self-pay retains patient choice without adding to others’ cost burden.
- There are other ways to spend shared resources that provide far greater benefit to more people.
- The only way to pressure the drug companies is not to give in to them on the cost.
- Although this issue is only about resources, not harm to others, it is important to “draw a line.”
- Trying to control drug prices (via an independent panel) will not work in a capitalist society.

“But I’m saying, like, what’s the cut off? Like 5 million, 10 million dollars? I mean, that’s just going to sink our economy, if you think about it in the bigger picture.”

“If you want that extra month to suffer and say your goodbyes, and you haven’t found your Creator yet, pay for it. Because we cannot pay for that. Health insurance, just not doing it. We’re not going to do it.”

“Just because it’s about death, you know? And it becomes very personal. I mean, we can talk about the community, the public. But when it’s your loved one, it’s just a whole different sensitivity to it.”

“I know the others [case scenarios] are serious conditions. But this is very, very serious. Cancer. This is the all, all, all. So if you want to squabble about some pennies, don’t do it on this. Not on this.”

“An independent panel, they can list the benefits, the adverse side effects and they can actually come up with a rational price. Because drug companies are going to give us max, they want to max out their potential.”

This scenario was the only one of the four where there was a significant difference in the responses of Medi-Cal and CovCA/PERS members. Only 17% of Medi-Cal members choose these “do not cover” or “self-pay” options, as opposed to 53% of CovCA/PERS members. While most Medi-Cal participants believed it was fair for all patients to pay the cost of an unnecessary treatment or test, they did not accept that the marginally-effective cancer drug was in that “unnecessary” category.

Cover the costly treatment

Regardless of whether participants felt this was the physician’s or the patient’s decision, they believed that this situation was radically different than the case scenarios on overuse:

- This was not about ineffective care; they could not justify rejecting coverage or putting up barriers as they could in the other scenarios.
- This deals with an end-of-life decision; most felt this was a particular category of medical care where decisions belonged only to patients and their doctors, regardless of the research or the cost.
- The average of one month difference in patient longevity between Drugs A and B was viewed differently than the research described in the other scenarios. Many spoke of how individual patients’ responses to cancer treatment may vary from statistical averages. This fact was important in their rationale that patients should have more than one treatment option available to them.
- The financial harm to others should not be an issue: many patients will refuse the drug anyway, and reducing truly ineffective care (the first three case scenarios) would mean that all cancer care options could be affordable.

Independent panel decides a fair price

DWW provided no additional information about an independent panel such as its authority, who participates on it, or when it is used. Its inclusion as an option was to test the concept and see why people accepted or rejected it. The significant number who supported it did so for these reasons:

- With the high costs of cancer drugs, this might be a good way to make the drugs both accessible and affordable.
- This is a life-extending treatment; regulation of prices is justified in this case where it may not be otherwise.
- While it should be the patient’s decision to take the drug, the cost burden should not be applied to everyone else.
- Higher-income people could afford the extra cost-sharing, but low-income patients could not; all cancer treatment needs to be accessible to everyone.
- Participants imagine the panel as being neutral and reasonable, setting a “cap” that the drug company would regard as fair.

“The other three cases can be prevented, they can be handled with a little bit more of time, while we feel that cancer is something that doesn’t leave you any other option and if the cost is an issue I think it’s inhumane and unfair that it should limit the possibilities of being treated accordingly.”

Those that opposed this option did so because they believe that trying to regulate drug prices will either inhibit innovation or companies will take the drug off the market, reducing the choices that patients have. Some noted that our capitalist system would simply not tolerate this type of control.

Many participants viewed this case scenario through a completely different lens. Most participants had experience with cancer among family or friends; weighing the pros and cons of the policy options was a challenge for them because of the emotional impact that cancer brings.

In retrospect, using this scenario about life-prolonging treatment was not the best choice for beginning discussions of the benefits and costs of drugs. Nevertheless, these results provide valuable insights for crafting a deliberative process that asks the public to review and consider options when the cost of a treatment is evaluated relative to its clinical benefit.

5. IMPLICATIONS FOR HEALTHCARE LEADERS

Principles to consider

In debating the options for reducing overuse, these principles dominated the discussions in the first three scenarios and among all ten groups. While participants agreed that expanding physician and consumer education was essential,⁵ it should be augmented by strategies that are based on these convictions:

“And ultimately, it’s the doctor’s responsibility. Yeah, we might ask for it, and we might pressure you to give it to us, but you don’t have to write a prescription.”

“But I always find that there’s a lot of patient adoration of doctors. And the patients, they don’t want to bug their doctor. So they just do what the doctor says.”

- 1 Physicians must be held accountable.** Participants believe that overuse, at its core, is a physician problem. Doctors are professionals and must be held responsible for reducing unnecessary care (especially when there is evidence of societal harm and wasting resources) and have an obligation to correct the sub-standard practices of their colleagues.
- 2 Actions should be effective, efficient, and credible.** They must be proven to work, without an excessive cost or administrative burden, and instituted by trustworthy professionals. Actions also need to be structured to avoid obstacles in providing necessary care and to avoid motivating physicians to orient their practice towards monetary gain.
- 3 Not wasting resources is a valid reason for reducing unnecessary care.** While avoiding medical harm is a compelling argument, the rising cost of healthcare is also a major concern for the public. Responsible stewardship of communal resources may not be persuasive to individual patients, but when communicated broadly, the public strongly supports the aim of prudent spending.

⁵ The DWW case scenarios intentionally did not offer an option to “increase education of doctors and patients.” This option is not conducive to a deliberative discussion because it is non-controversial and has no inherent dilemmas with which to wrestle. Although the scenarios even acknowledged that education alone was rarely effective in changing behavior, all groups raised the issue and supported more robust efforts to increase physician and consumer awareness and knowledge.

"I kind of changed my mind on this. We've spoken about this today that we trust our doctors. I don't go in there demanding MRIs and antibiotics. These [discussions] have given me a sense of responsibility. Maybe I should be paying attention."

- 4 Respect for patient choice must be balanced by ethical practices.** Participants were divided on allowing patients to have access to unnecessary and possibly harmful medical care. Though most agreed that health plans should not have to pay for unnecessary care, many believed that it is patients' prerogative to self-pay if they believe it is of value to them. Those who opposed this felt it was unethical for physicians to prescribe potentially harmful care, regardless of who is paying for it.
- 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. But this patient responsibility does not mitigate the need for high standards of clinical practice and does not diminish physician accountability.

Applying these principles to policy

While the principles are applicable across the three examples of overuse, each case scenario elicited distinctive responses. Below is a summary of participants' perspectives pertaining to each example of overuse.

Overuse of antibiotics for adult bronchitis

Participants were most concerned about the societal harm of antibiotic overuse: the incidence and consequences of drug-resistant bacteria. Actions to consider:

- **Establish a system to identify and control over-users.** Almost two-thirds of participants supported strategies that called for greater oversight of physician practices. They were equally divided between using an outside expert for pre-approvals and internal monitoring/discipline to target chronic over-users. There was often active debate on whether physicians were capable of monitoring each other (hence the need for an outside expert) versus the logic that addressing a pattern of overuse may be more fruitful than individual pre-approvals. Regardless, the key issue for participants was effectiveness; the approach that could best "get the job done" was what they cared most about.
- **Consider higher patient cost-sharing.** Thirty percent of participants favored this approach. Recognizing the degree of patient demand and the time pressure on physicians in an office visit, many believed that this is the easiest and fastest way to reduce overuse because patients will think twice if their cost-sharing is increased. Medi-Cal members supported this to the same extent as CovCA/PERS members. Others were concerned that this would not discourage enough patients from getting the medication and thus not have the desired impact on reducing societal harm. Some also believed it was not ethical for physicians to prescribe a drug that could cause harm to others, regardless of who is paying. As a hierarchy of strategies, increased cost-sharing would be regarded as a last resort.

C-sections for normal pregnancies

Participants were concerned about the wasteful costs associated with unnecessary C-sections, as well as the increased harm to mothers and babies. However, they were conflicted over the right of a woman to choose to pay out-of-pocket for a C-section that is not medically indicated. Actions to consider:

- **Institute pre-approvals or reduce payment.** The majority (54%) supported pre-approval by an outside reviewer, and 32% supported reducing compensation to hospitals and clinicians for unnecessary C-sections. Many preferred pre-approvals because this would stop unnecessary C-sections before they happen. Others believed that reducing payment after the fact would be better because it would lower the likelihood that the pre-approval process would inadvertently deny appropriate (as well as inappropriate) C-sections. But in general, reducing compensation seems most acceptable if an oversight strategy has failed.
- **Consider how to address the patient self-pay option.** As noted earlier, in six sessions participants introduced this additional option to the discussions, and it was widely supported in those sessions. However, the self-pay option did not override previous preferences for physician oversight. Those that supported a woman's right to choose a C-section that was not medically indicated viewed it like cosmetic surgery: not covered by insurance but available nonetheless. For those participants, even considering the risk of harms to mother and child, the value of patient choice prevailed. Others believed it was unethical for physicians to do unnecessary, possibly harmful, surgery regardless of the payment source.

While support for patient choice may conflict with medicine's maxim "first do no harm," the C-section example was viewed from a distinct perspective: the rights of women to make their own decisions related to pregnancy and childbirth. If physician leaders are united in reducing unnecessary C-sections, they may want a consistent message that C-sections without a medical reason are contrary to the ethical practice of medicine.



MRIs for acute low back pain

This scenario differed from the first two in two significant ways: 1) participants did not perceive this as a problem of excess patient demand but as a problem of physician misuse; and 2) the harms to the individual patient (the incidence and consequences of unnecessary surgery) were unconvincing.⁶ Thus, participants focused on the societal harm of wasteful spending. Since evidence showed that the MRI might be useful only after a 4 – 6 weeks wait, participants were comfortable requiring rules that included that timeframe, acknowledging that patients had other options (physical therapy; medications) in the interim. Actions to consider:

- **Institute stricter criteria for MRI coverage.** Sixty percent supported “stricter rules,” implying more robust compensation barriers for scans done prior to that 4 – 6 week period. They believed that the evidence for when an MRI is indicated was so compelling that raising the bar for MRI approvals was indicated. Also, stricter rules would impact physician over-prescribing as well as patient demand. Very few chose to penalize doctors financially for overuse; if the rules were employed, the penalties were unnecessary.
- **Require that over-users get expert approval.** The 19% that chose this option were reluctant to create barriers to tests that apply so broadly as “stricter rules” would do. Their preference was to target the sanction to those who were habitual outliers.
- **Consider higher cost-sharing to counter patient demand.** This was not a popular choice, with only 6% of participants choosing it. Yet given participants’ inclination to use higher cost-sharing as an option for maintaining patient choice, this approach would be consistent with their other decisions if physician-facing strategies are not instituted or are ineffective.

Other themes that warrant attention

- **Reconsider using physician bonuses to motivate higher quality care.** Participants were disdainful of providing bonuses for physicians for reducing overuse; the notion of “bribing” them to improve their care seemed unprofessional. They also were concerned that bonuses may encourage doctors to be motivated by compensation rather than by doing the right thing for their patients. These comments suggested that the lay public was unaware of current Pay for Performance (P4P) programs that, in fact, provide physicians with a monetary incentive to improve the quality of their care. If P4P is a sufficiently effective strategy to reduce overuse, it probably doesn’t matter that the public is disapproving; reducing overuse is the more important objective. However, if P4P is not effective, healthcare leaders may want to reconsider this method of quality improvement.

⁶ It might have been prudent to present this scenario with all forms of imaging, rather than specifically MRIs which do not have the danger of radiation. With CT scans and X-rays included, the individual harm to patients is easier to convey.

"I trust my doctor. But when I asked you, you told me to try and think of this as a citizen. So...it seems to be that, maybe, there's a lot of doctors out there that are prescribing antibiotics that shouldn't be."

- **Institute broader communications to the public about wasting resources.** Most participants valued their role of "policy-maker" during the DWW sessions and believed that information about the costs and harms of unnecessary care should be more visible to the public at large. But they also acknowledged that they viewed this differently during DWW than they would when responding as patients. While individuals care deeply about their own healthcare costs, a discussion of stewardship of shared resources will not likely resonate with patients in the doctor's office. Yet given the opportunity to better understand some of the drivers of the affordability problem, it is likely that — outside their role as patients — the lay public will respond to this issue with attention and concern.
- **Educate patients about ineffective medical care.** Participants felt strongly that patients, as individuals, need to take more responsibility for knowing the pros and cons of treatment options and being wiser consumers of medical care. *Consumer Reports*, in partnership with the *Choosing Wisely*® campaign, has developed materials that are designed for that purpose; California's physicians and other healthcare providers, hospitals and health plans should consider adopting these materials for their patients. These materials can be used in a variety of ways, such as embedment into EHRs and patient portals, social media campaigns, and traditional distribution of paper copies in the clinical encounter.

Limitations of the project

A sample size of 117 people in six locations in the state does not represent the entirety of views and values of Californians. Despite best efforts, not all participants' demographic characteristics were typical of lower-to-moderate income residents. DWW participants had higher education levels than the general population of California, women were over-represented, and Asians were under-represented. With literacy as a requirement for participation, this precluded the involvement of a significant percent of California adults.

The three case scenarios on overuse were examples of medical care that are generally familiar to the public; however, participants' responses to less-familiar medical interventions might be different. As well, the scenario on costly cancer drugs suggests that even an ineffective cancer treatment might be viewed quite differently than a diagnostic test like MRIs. Also, as noted earlier, some participants may not have fully grasped the concept of using evidence to question current medical practice. This subject, the use of evidence, is steeped in nuance, and a half-day session may not have fully done it justice. A longer deliberative process would have allowed more discussion with participants on the concepts of value and medical evidence and on the challenges of balancing physician/patient autonomy with the use of finite resources.

6. MAKING SOCIETAL DECISIONS

Responding to the DWW task

“I also, personally, would have answered 5 (no action) if this weren’t a discussion about the rising cost of healthcare.”

For most participants, this was their first experience with social decision-making — considering changes in healthcare policy that may affect all Californians. They approached this task from their experience as patients and caregivers, because this was the basis for their understanding of healthcare. Yet, most were able to shift from this familiar role to the unfamiliar role of policymaker where the needs and interests of all Californians was their top priority. With the exception of the cancer drug scenario (page 43), there was considerable consistency among all groups — Medi-Cal, CovCA and PERS — in their reactions to the options and rationale for their choices. There were also no apparent cross-cultural differences; the concerns and priorities of the Spanish-language groups were consistent with those of other groups. Many Medi-Cal members, in particular, were aware that their benefits were tied to the state budget, and wasting dollars was especially objectionable.

“Well, it makes me think doctors don’t have ethics... we’re giving our opinion to reduce expenses but we’re also discovering medicine in this country is just about business, it is just about money.”

Most participants were not aware that antibiotics, C-sections and MRIs were overused and were surprised and dismayed by the statistics. Although they recognized the prevalence of patient demand, they were particularly mystified that physicians would continue to prescribe unnecessary care if the facts about harms were as evident as stated. People trust their physicians, so these data (e.g., 71% of adult bronchitis is treated with ineffective antibiotics) were met with concern and frustration.

Those participants who had, as patients, experienced unnecessary treatment and its undesirable consequences, supported limit-setting with little reservation. Alternatively, other participants had had a medical intervention denied and suffered an adverse outcome (e.g., a delayed MRI that was, in fact, medically needed). They acknowledged the challenge of being objective and rational if they had experienced an event that seemed contrary to the evidence of overuse. Additionally, a few participants seemed unable or unwilling to view the problem beyond their perspective or experience as an individual patient/caregiver. But a substantial majority was energized and engaged in the challenge of considering policy options and took this responsibility seriously. Their responses to a post-survey question showed how they valued this experience.

“You made me put on a different hat while I was sitting in here. Yeah, you made me put away my animosity towards the insurance companies, and you made me become a good citizen.”

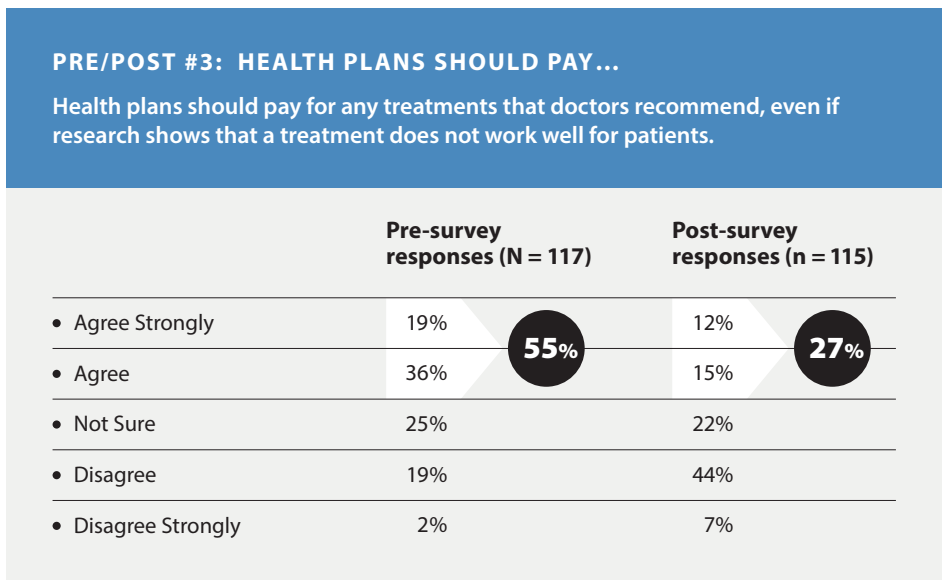
When asked the one thing they enjoyed most about DWW, their responses were:

• Learning more about over-use of healthcare	35%
• Knowing our opinions will be shared with healthcare leaders	29%
• Having a discussion with others about over-use	23%
• Giving my opinion on the topic of over-use	13%
• I did not enjoy participating in this	0%

Assessing changes in viewpoints

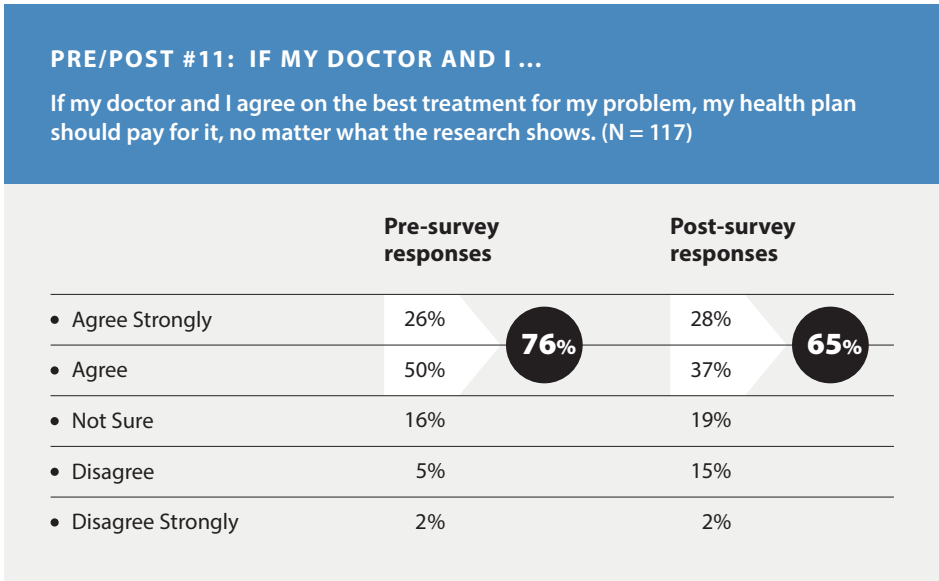
The pre/post questions quantitatively measured shifts in perspectives based on their exposure to DWW. The pre-surveys were completed on average 1 – 2 weeks prior to the DWW session; the post-survey was completed at the end of the session. The pre/post questions did not refer to the case scenarios but were designed to gauge participants’ views related to overuse and their responses when a doctor’s opinion conflicts with research.

Two of the 11 pre/post questions provide an interesting contrast in the citizen and patient perspectives. Pre/Post #3 was the most targeted to the theme of the DWW discussions:



Before the discussion, 55% agreed/agreed strongly that health plans should pay for treatments that do not work well; after the discussion, only 27% agreed. This shift was statistically significant ($p < 0.05$) across all the major demographic characteristics, such as health plan sponsor (Medi-Cal, CovCA/PERS), gender and race. Although the first three case scenarios did not directly suggest that health plans not pay for overuse, it was implied in the actions of putting greater boundaries around physician prescribing. This quantitative shift in perspective seemed consistent with the qualitative findings.

However, when the question was phrased personally with “my doctor and I,” participants were much less likely to accept limits to coverage.



Here, the agree responses only dropped from 76% to 65%. While this shift was statistically significant across most of the demographic categories, almost two-thirds of participants still agreed that the personal decisions of patients and doctors carried more weight than research.

The dichotomy in the responses to these two pre/post examples is not surprising. During the discussions, many commented that what they expect as a patient would not always match what they think is best as a citizen. One participant noted during the C-Section discussion: “As a citizen, I support the option expert approval, but as a patient, I go with #5 (continue to leave it to the doctor and patient).” Yet even this modest pre/post shift suggests that deliberation influences participants’ views of the role of evidence in determining coverage.

Appendix C has additional pre/post questions for which changes in perspective were statistically significant, including changes specific to socio-demographic characteristics. Most shifts reflected a greater acceptance of the role of evidence in treatment and coverage decisions following the deliberative process.



Informing healthcare policy

Since DWW participants were told at the start of the meetings that their results would be shared with the Statewide Workgroup on Reducing Overuse, it was also important to assess their views on the relevance of their participation. Two post-survey questions explored this topic.

Question: *This Doing What Works discussion was to learn the views of health plan members like you and to share those views with healthcare leaders. Which statement is closest to your view? (n=116)*

• It is very important that healthcare leaders understand the views of people like me.	91%
• It is somewhat important that healthcare leaders understand the views of people like me.	9%
• It is not important that healthcare leaders understand the views of people like me.	0%

Nevertheless, they were less sure if healthcare leaders actually cared about their opinion.

Question: *Do you think your opinion matters to California healthcare leaders, such as those who make policy or funding decisions? (n=116)*

• Yes, I think healthcare leaders care about my opinion.	42%
• I'm not sure if healthcare leaders care about my opinion.	48%
• No, I don't think healthcare leaders care about my opinion.	10%

“So if you think about it, our overall healthcare system, it’s constantly got a dollar amount attached to it...if we could make it more about actual, real meaningful healthcare that is effective, and cost effective, that would be the best world we could live in.”

When the Statewide Workgroup was formed, it created a written charter with this task: *Research and report the priorities and values of public and private sector health plan members related to specific strategies for reducing potentially harmful and/or wasteful medical interventions.* In making this commitment, California’s healthcare leaders recognized that the challenges of improving healthcare quality and affordability may best be met when all voices are heard, including those of the general public.

Efforts like DWW are not a common practice among policy leaders, yet the time and resources devoted are an investment in the credibility that should govern meaningful healthcare changes. As long as healthcare reform continues to require values-based decisions on priority-setting and trade-offs, proposals for changes are most responsible when the public has a place at the table.

APPENDIX A :

Project Partners

DWW Advisory Committee

Desiree Backman, DrPH, MS, RD, Committee Chair

Chief Prevention Officer, California Department of Health Care Services and Program Director, UC Davis Institute for Population Health Improvement

Sally Covington

Co-founder Community Campaigns; Senior Health Care Advisor, SEIU 1021

Kathy Glasmire

Community member

June Isaacson Kailes

Disability Policy Consultant; Associate Director, Harris Family Center

Elizabeth Landsberg, JD

Director of Policy Advocacy, Western Center on Law & Poverty

Marion Leff, MD

Program Director, Sutter Health Family Medicine Residency Program

Susan Perez, PhD, MPH

Assistant Professor, California State University, Sacramento and Postdoctoral Fellow, UC Davis Medical Center

Beccah Rothschild, MPA

Senior Outreach Leader, Health Impact Team, Consumer Reports

Crystal Tarver

Medi-Cal member

Glennah Trochet, MD

Retired family practice physician/county health officer

Community Partners

Our thanks to the community-based organizations that assisted with participant recruitment and meeting logistics:

- Fresno Healthy Communities Access Partners
- LA Care Health Plan
- Mendocino Community Health Clinic
- San Diegans for Healthcare Coverage

DWW Facilitators

Marge Ginsburg

Executive Director, Center for Healthcare Decisions

Susan Perez, PhD, MPH

Glennah Trochet, MD

Funding

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



For more information, contact CHCD at info@chcd.org or www.chcd.org

A P P E N D I X B :

Participants' Demographics and Responses to Select Survey Questions (N=117)

Participant Demographics

1. Insurer	Medi-Cal	51%	
	Covered California	38%	
	CalPERS	10%	
		100%	
	2. Gender	Male	36%
		Female	64%
			100%
	3. Education	Non high school graduate	3%
		High school graduate	32%
		Some college	29%
		A.A. degree	8%
		College graduate	23%
Post graduate		6%	
		100%	
4. Ethnicity	Latin/Hispanic	40%	
	Black/African American	10%	
	White/Anglo	41%	
	Asian/Pacific Islander	5%	
	Other	3%	
		100%	

Select Pre-Survey Questions

5. How long have you had on-going health insurance?	Less than 2 years	30%
	Between 2 and 5 years	25%
	More than 5 years	45%
		100%

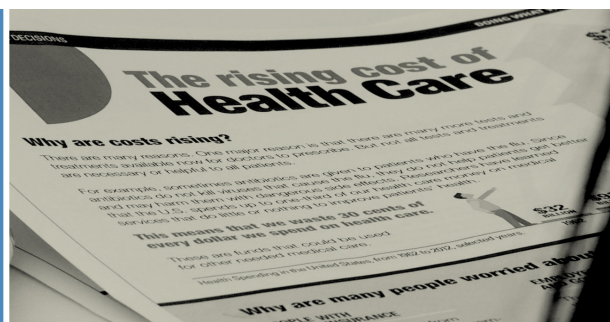
(continued)

APPENDIX B :

Participants: Demographics and Responses to Select Survey Questions (N=117)

Select Pre-Survey Questions

6. In the past year, how often have you used your medical services (such as going to the doctor)?	0 – 3 times	38%
	4 – 8 times	30%
	9 or more times	32%
		100%
7. In general which best describes your current health?	Excellent	21%
	Good	51%
	Fair	23%
	Poor	5%
		100%
8. How satisfied are you with the health care that your doctor (or doctors) provides you and your family?	Very satisfied	35%
	Somewhat satisfied	47%
	Not sure	9%
	Somewhat dissatisfied	7%
	Very dissatisfied	3%
		100%
9. Health care is becoming more expensive. As a patient or family member, is this a problem for you personally?	No, it is not a problem	20%
	Yes, it is a small problem	35%
	Yes, it is a big problem	45%
		100%



APPENDIX C:

Pre/Post Survey Responses

Below are the results of the survey given to participants 1 – 2 weeks before attending the DWW session (pre-survey) and again immediately after the discussion (post-survey). The purpose was to see if participants' perspectives changed after engaging in the DWW discussion.

Most of the questions were in the form of a 5-point Agree/Disagree scale. For ease of review, the summary below has combined the *Agree/Agree Strongly* (and *Disagree/Disagree Strongly*) into single categories of *Agree/Disagree* and omitted the *Not Sure* responses.

Types of analyses:

- ❶ **Initial responses.** We analyzed the pre-survey results to see if there were any statistically significant ($p = <0.05$) differences in how participants responded according to certain demographic groups:
 - a. Coverage sponsor (Medi-Cal or CovCA/PERS)
 - b. Gender (Women or Men)
 - c. Race (White or Persons of Color)
 - d. Education (College Graduates or Less Educated)
- ❷ **Shifts in View.** We compared the pre and post-survey results and indicated whether there was a statistically significant ($p = <0.05$) change; if so, which demographic groups it applied to.

Summary:

Unless indicated otherwise, $N = 117$ in all questions reported here. When looking at the overall results, all questions (except Pre/Post #4) showed a significant shift in participants' perspectives towards greater acceptance of research evidence as a criterion for coverage. This suggests that participating in DWW had a broad impact on how participants view concepts of overuse, value, and use of medical evidence to inform treatment decisions.

(continued)

APPENDIX C :

Pre/Post Survey Responses

Pre/Post #1	Pre Survey (n=116)		Post Survey (n=114)	
	Yes	No	Yes	No
<ul style="list-style-type: none"> Have you ever received medical services (such as a test or treatment) that you didn't think you really needed? 	16%	65%	42%	44%

Initial Responses: There were no significant differences in how various demographic groups responded.

Shift in Views: There was a significant shift among all demographic groups except College Graduates.

Pre/Post #2	Pre Survey		Post Survey (n=115)	
	Agree	Disagree	Agree	Disagree
<ul style="list-style-type: none"> The best medical care is usually the newest and most expensive tests and treatments. 	31%	37%	15%	55%

Initial Responses: White participants were more likely (50%) to be Unsure; Persons of Color were more likely to disagree (45%).

Shift in Views: There was a significant shift in views among Medi-Cal, Women, and White participants.

Pre/Post #3	Pre Survey		Post Survey (n=115)	
	Agree	Disagree	Agree	Disagree
<ul style="list-style-type: none"> Health plans should pay for any treatments that doctors recommend, even if research shows that a treatment does not work well for patients. 	55%	21%	27%	51%

Initial Responses: Less Educated were more likely to agree.

Shift in Views: There was a significant shift in views among all demographic groups.

Pre/Post #4	Pre Survey		Post Survey (n=115)	
	Agree	Disagree	Agree	Disagree
<ul style="list-style-type: none"> A doctor's opinion about how well a treatment works is more important than what research shows. 	31%	43%	32%	46%

Initial Responses: Less Educated were more likely to agree.

Shift in Views: There was no significant shift in views.

(continued)

APPENDIX C :

Pre/Post Survey Responses

Pre/Post #5	Pre Survey		Post Survey (n=115)	
	Agree	Disagree	Agree	Disagree
<ul style="list-style-type: none"> Health plans should pay for any treatments that doctors recommend, even if there are other treatments that work just as well at a lower cost. 	53%	24%	42%	44%

Initial Responses: There were no significant differences in how various demographic groups responded.

Shift in Views: There was a significant shift in views among CovCA/PERS, Men, and White participants.

Pre/Post #6	Pre Survey		Post Survey	
	Agree	Disagree	Agree	Disagree
<ul style="list-style-type: none"> If patients prefer an expensive treatment that doesn't work any better than a cheaper one, their health plan should still pay for it. 	33%	44%	25%	57%

Initial Responses: White participants were more likely to disagree (54%).

Shift in Views: There was a significant shift in views among Men and Persons of Color.

Pre/Post #7	Pre Survey		Post Survey	
	Agree	Disagree	Agree	Disagree
<ul style="list-style-type: none"> All patients have a responsibility to use their health insurance carefully so that money isn't wasted on services that do not help patients. 	80%	7%	91%	2%

Initial Responses: There were no significant differences in how various demographic groups responded.

Shift in Views: There was a significant shift in views among CovCA/PERS, Medi-Cal, Women, Persons of Color, Less Educated, and College Graduates.

(continued)

APPENDIX C :

Pre/Post Survey Responses

Pre/Post #8	Pre Survey		Post Survey	
	Agree	Disagree	Agree	Disagree
<ul style="list-style-type: none"> One reason that health plan costs go up is that patients insist on tests and treatments that they do not really need. 	31%	42%	71%	14%

Initial Responses: CovCA/PERS members were more likely to disagree (54%)
Shift in Views: There was a significant shift in views among all demographic groups.

Pre/Post #9	Pre Survey		Post Survey	
	Agree	Disagree	Agree	Disagree
<ul style="list-style-type: none"> One reason that health plan costs go up is that doctors order too many tests and treatments that are not really needed. 	34%	31%	74%	9%

Initial Responses: There were no significant differences in how various demographic groups responded.
Shift in Views: There was a significant shift in views among all demographic groups.

Pre/Post #10	Pre Survey		Post Survey	
	Agree	Disagree	Agree	Disagree
<ul style="list-style-type: none"> I think that some health care dollars are wasted on services that are not needed. 	51%	14%	92%	4%

Initial Responses: There were no significant differences in how various demographic groups responded.
Shift in Views: There was a significant shift in views among all demographic groups.

Pre/Post #11	Pre Survey		Post Survey	
	Agree	Disagree	Agree	Disagree
<ul style="list-style-type: none"> If my doctor and I agree on the best treatment for my problem, my health plan should pay for it, no matter what the research shows. 	76%	7%	65%	16%

Initial Responses: There were no significant differences in how various demographic groups responded.
Shift in Views: There was a significant shift in views among CoveredCA, male, and White participants.

APPENDIX D:

Educational Materials

CENTER FOR HEALTHCARE DECISIONS

DOING WHAT WORKS

1

The rising cost of Health Care

Why are costs rising?

There are many reasons. One major reason is that there are many more tests and treatments available now for doctors to prescribe. But not all tests and treatments are necessary or helpful to all patients.

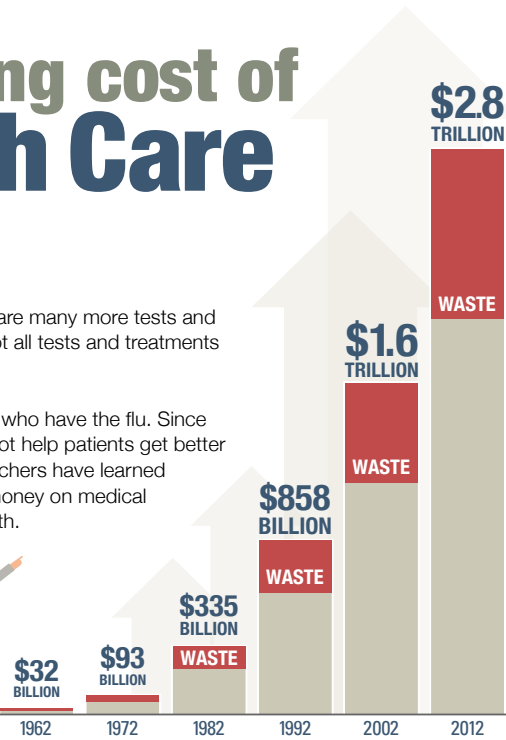
For example, sometimes antibiotics are given to patients who have the flu. Since antibiotics do not kill viruses that cause the flu, they do not help patients get better and may harm them with dangerous side effects. Researchers have learned that the U.S. spends up to one-third of our health care money on medical services that do little or nothing to improve patients' health.

This means that we waste 30 cents of every dollar we spend on health care.

These are funds that could be used for other needed medical care.



Health Spending in the United States, from 1962 to 2012, selected years.



Why are many people worried about rising costs?

PEOPLE WITH HEALTH INSURANCE

Most have insurance from their job or through the government, such as Medicare, Medi-Cal or Covered California.

As costs go up, many worry that insurance will stop paying for certain things or that patients will have to pay more of the cost.

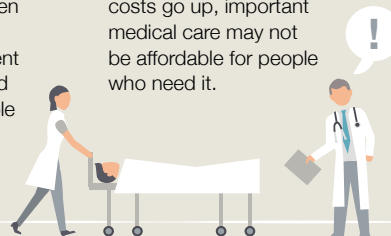


EMPLOYERS AND GOVERNMENT

These are the two groups that pay most of the costs for health insurance. When costs keep going up, employers and government have less money to spend on other things that people want – like paying higher wages or improving government services.

DOCTORS AND OTHER HEALTH CARE PROVIDERS

Those who offer medical services worry that as costs go up, important medical care may not be affordable for people who need it.



1 THE RISING COST OF CARE

2 SPENDING WISELY

3 LOW-VALUE CARE

4 MEDICAL RESEARCH

(continued)

APPENDIX D:

Educational Materials

CENTER FOR HEALTHCARE DECISIONS

DOING WHAT WORKS



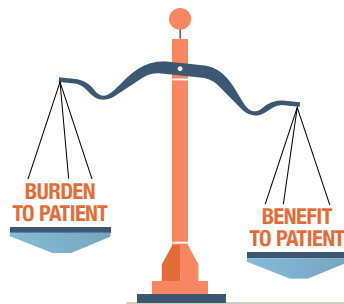
Spending wisely: A focus on value

What is “value” in health care?

To make sure that our dollars are used wisely, many health care leaders are focusing now on **value** rather than **volume**.

In other words, what is important is how much benefit a test or treatment brings a patient (value), not how many tests and treatments are given (volume).

In considering **value**, medical researchers study many different medical services and determine for each one:



HOW MUCH DOES IT BENEFIT?

What are the chances it will:

- Identify or prevent a medical problem?
- Reduce symptoms?
- Slow the disease?
- Bring about a cure?

HOW MUCH HARM OR BURDEN COULD IT BRING?

What are the chances it will:

- Cause a new medical problem?
- Have serious side effects?
- Reduce quality of life?

IS THE COST REASONABLE?

If the benefit is very small or not likely to help patients, is the cost so high that it will add to the rising cost of health care for others?

When is care high-value?

Care is high-value when research shows that a medical test or treatment provides much more benefit to patients than risk of harm.

One example is when patients with diabetes get health care that helps them manage their condition well. This means they have regular doctor visits and lab tests, take the medicines they need, and have a healthy diet and regular exercise.

When diabetes is managed well, patients are more likely to stay healthy. They are less likely to face life-threatening and costly medical problems like losing a leg or their eye-sight. These results make diabetes care high-value.



1 THE RISING COST OF CARE

2 SPENDING WISELY

3 LOW-VALUE CARE

4 MEDICAL RESEARCH

(continued)

APPENDIX D:

Educational Materials

CENTER FOR HEALTHCARE DECISIONS

DOING WHAT WORKS

3

What is low-value care?

Not all medical care is high-value. Medical tests and treatments that do little or nothing to improve patients' health are **low-value**. These services may harm patients more than help them.

And in many cases, these services also waste money. With the need for good quality, affordable care, researchers look closely at:

- Which tests and treatments provide **no important benefit**?
- Which are **more harmful than helpful**?
- Which provide a very **small benefit at a very high cost**?

For example, for many years, doctors have known that too many x-rays and scans can cause cancer in patients in later years. Yet, some patients continue to get many more than are needed. This can cause harm to those patients and can also waste money.



Why is there low-value care?

DOCTORS AREN'T ALWAYS UP TO DATE

Not all doctors keep up with medical studies showing the most recent information on the benefits and harms of tests and treatments.

SOME DOCTORS HAVE A HARD TIME CHANGING

After years of doing things the same way, changing may be difficult.

SOME PATIENTS INSIST ON A CERTAIN TEST OR TREATMENT

Perhaps they had it in the past, a friend had it, or they saw a commercial or ad for it.

DOCTORS DON'T HAVE TIME TO EXPLAIN

Some say they don't have time to explain to patients why they do not need a certain test. When they are rushed, it is easier to give patients what they are asking for than to try and explain why it is not needed.

MORE TESTS MEAN MORE MONEY

Some doctors make more money when they order more tests or perform more medical procedures.

WORRY ABOUT LAWSUITS

Some doctors feel they need to order many tests to protect themselves from being sued.

1 THE RISING COST OF CARE

2 SPENDING WISELY

3 LOW-VALUE CARE

4 MEDICAL RESEARCH

(continued)

APPENDIX D:

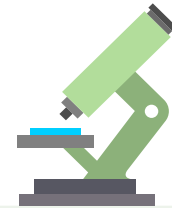
Educational Materials

CENTER FOR HEALTHCARE DECISIONS

DOING WHAT WORKS

4

Medical Research



Good quality health care needs medical research to help doctors and patients decide what the best care is. Research also helps them avoid services that are not helpful.

Medical Research is ongoing

Research has many roles. It studies what causes illnesses; how to prevent them; ways to cure them; and better treatments for them. Medical science is an on-going discovery process. And it has another important role: **learning which current tests and treatments are most useful and least harmful to patients.** This type of research answers these questions:

1

Does this treatment work as well as we first believed?

2

Is there another way to treat the problem that is less harmful or risky to patients?

3

Will another treatment get good results but at a much lower cost?

Who does this type of research?

The government or non-profit companies often fund research that compares existing treatments.

Scientists at universities or national institutions conduct these studies.

Medical societies (national groups of expert doctors) and medical publications have an important role in reviewing and sharing results. They know that careful, good quality research leads to better care for patients.

Research and low-value care

Studies show which tests and treatments are high-value and which are low-value. Sometimes they learn that a drug or treatment should be stopped because it causes too much harm. But mostly, they learn that tests and treatments:

- Work very well **for some people** but not well for others.
- Work very well **in some situations** but not in all situations.

This research leads to guidelines about **when** and **when not** to use certain tests and treatments. Guidelines help doctors and patients avoid unnecessary, harmful and costly medical care.



1 THE RISING COST OF CARE

2 SPENDING WISELY

3 LOW-VALUE CARE

4 MEDICAL RESEARCH

APPENDIX E:

Case Scenarios

**Case Scenario 1:
Using Antibiotics for
Adult Bronchitis****Antibiotics**

Antibiotics are drugs used to control infections that are caused by bacteria. They are often a life-saving treatment for patients with deadly infections. Over the years, different antibiotics have been developed for a variety of bacterial infections. Because they are easy to use and most people have had them, antibiotics have become a familiar treatment. However, the most common types of infections among children and adults — such as colds, the flu, and ear infections — are caused by viruses, not by bacteria. Antibiotics do not kill viruses; they only work when bacteria cause the sickness.

Adult bronchitis

Acute bronchitis (chest cold) is one of the most common reasons that adults go to the doctor. Bronchitis usually includes a cough, lasts no longer than three weeks, and is caused by a virus. Although antibiotics are not useful for bronchitis, doctors order them frequently for their patients. In fact, a recent study showed that up to 71% of patients with acute bronchitis are getting antibiotics from their doctors.

The harm of over-use

When antibiotics are given a lot, bacteria can become “resistant.” Antibiotics do not work well at killing these resistant bacteria. Over-use brings harm in three ways:

Greater risk to the individual. Antibiotics can have harmful side effects, ones that are sometimes dangerous for patients. Also, if a patient has antibiotics often, she or he may be more likely to get sick from resistant bacteria. This puts the patient in greater danger of having an infection that cannot be controlled.

Puts others at risk. When antibiotics are over-used, super-resistant bacteria (a “super-bug”) may develop that no antibiotic can kill. This means that patients everywhere may risk an infection that cannot be treated. These super-bugs now sicken 2 million Americans each year and kill 23,000 people.

Greater cost to society. Although many antibiotics are not expensive, treating patients who are extremely ill with an uncontrolled infection adds to the cost of health insurance for everyone. For example, patients in the hospital with resistant bacteria must stay in the hospital twice as long as patients who do not have infections.

Expert medical groups have published guidelines for many years, warning doctors about over-use. Despite these guidelines, the problem continues.

(continued)

APPENDIX E:

Case Scenarios

**Case Scenario 1:
Using Antibiotics for
Adult Bronchitis****What is the best way to discourage over-use of antibiotics?**

Put a 'check' next to the **one** action that you would most likely support:

- ___ 1. If a doctor routinely over-uses antibiotics, that doctor should have to get approval from a medical expert before ordering one.
- ___ 2. To discourage patients from insisting on an antibiotic, the patient should have to pay most of the cost of the drug if the doctor can not give a good medical reason for ordering it.
- ___ 3. Doctors that work together should monitor each other. If any of them continue to over-use antibiotics, they could be disciplined in some way.
- ___ 4. To encourage doctors to follow guidelines, they should be rewarded with a small bonus if they are careful with antibiotics.
- ___ 5. Continue to leave it to the patient and doctor to decide if an antibiotic is needed or not, despite the risks.

(continued)

APPENDIX E:

Case Scenarios

**Case Scenario 2:
C-sections With Normal
Pregnancies****Importance of C-sections**

Cesarean birth (also called C-section) is when a baby is delivered through surgery into the mother's belly and womb. C-sections are medically necessary when a vaginal delivery may be dangerous for the mom — or when the baby is having a problem that requires a fast delivery. Although most women have healthy, normal pregnancies, C-sections are an important life-saving method for the mothers and their babies who need one.

As doctors and hospitals have become more skilled, problems from this surgery — such as infections or harm to the child — have dropped. Since then, the number of C-sections has grown by 50% in California. Now, 1 in every 3 births is done by C-section.

Why are there more C-sections now?

Medical experts believe that no more than 15% of deliveries should require a C-section. Yet in California, the C-section rate varies from 13% to 83%, depending on the hospital. But there is no difference in the health of the mothers or babies that would explain these higher numbers.

Researchers learned that these higher C-section rates are not because women or babies have more medical problems than before; or because women are asking for C-sections; or because of doctors' fear of lawsuits. Rather, C-sections are more common because:

- It is more convenient for doctors and hospitals to schedule C-sections.
- C-sections reduce the staff time needed to support women during childbirth.
- Hospitals and doctors receive higher payments for C-sections (about \$9,000 more).
- Americans have become more casual about surgery and do not understand the possible risks it brings.

Yet, there is no medical benefit for mothers or babies when C-sections are done without a medical reason. But there is greater harm.

(continued)

APPENDIX E:

Case Scenarios

Case Scenario 2: C-sections With Normal Pregnancies

The harms of unnecessary C-sections

Childbirth is the #1 reason for being in the hospital, and there are 500,000 births in California each year. So the over-use of C-sections has a big impact.

Medical harm. Although safer now, C-sections usually require a longer recovery time, and increase the chance of infection, excessive bleeding, and postpartum depression. And babies are at slightly higher risk of developing diseases like asthma and diabetes.

Financial harm. For those with private health insurance, the higher cost of C-sections means that the mother and her health plan will both be paying more than is necessary.

Societal harm. Medi-Cal pays for half of the child-births in California. Spending more on unnecessary services means there is less money in the Medi-Cal budget for high-value services or new benefits.

What should be done to encourage proper use of C-sections?

Put a 'check' next to the **one** action that you would most likely support:

- ___ 1. Monitor doctors' practices; health plans would provide a small bonus for those who follow guidelines for doing C-sections.
- ___ 2. Encourage pregnant women to choose vaginal births (when there is no medical problem) by offering a valuable gift (for example, a gift card).
- ___ 3. Require all non-emergency C-sections to be reviewed and approved in advance by expert doctors that have no financial motives.
- ___ 4. Give health plans the authority to reduce payment to a doctor who, based on a review by an independent panel, performs an unnecessary C-section.
- ___ 5. Continue to leave it to the patient and doctor to decide what type of delivery best meets their needs.

(continued)

APPENDIX E:

Case Scenarios

**Case Scenario 3:
Using MRI Scans for Low
Back Pain****What is an MRI?**

An MRI is a “high-tech” scanning machine that lets doctors see inside parts of the body, such as organs, bones and blood vessels. This works well to help doctors identify certain medical conditions — such as tumors or problems with joints or blood flow — and choose the treatment.

Since MRIs were invented in the 1980s, the number of MRI machines in the U.S. has grown greatly. This makes it easy for doctors to order more MRI scans than in earlier years. Medical researchers have studied when MRIs are useful in diagnosing a patient’s condition and when they are not useful.

Low back pain

Eight of every 10 American adults will have had low back pain at some time in their life. It can happen from heavy lifting, chores, a sports injury, or just a twist the wrong way. It usually doesn’t last long, but it can greatly limit everyday activities. The doctor will examine the patient and, if there are no worrisome signs, may suggest physical therapy (PT), heat and medicines to reduce pain. It usually takes 2 – 6 weeks for the back pain to stop. If there are signs that it might be a more serious problem, then the doctor orders other tests, possibly an MRI. But for common low back pain, an MRI will not show anything helpful for treating the patient.

Yet many doctors order them when there is no sign that the patient needs one. Some doctors say that patients want an MRI to feel “reassured.” Other doctors believe MRIs are useful despite what the research says. In California, an MRI can cost from \$1,200 up to \$4,000!

The harm of over-use

Medical harm to the patient. The scan may show something unusual that isn’t really a medical problem. This can lead to surgery that the patient didn’t need. In fact, researchers have shown that when scans are done without a strong medical reason, patients are 8 times more likely to get surgery that was not needed. These patients had no better results from their back surgery than those who did not get surgery. And surgery itself exposes people to many possible harms.

Financial harm for others. One research report showed that only a third of all lower back MRI’s were considered necessary. Nationally, the overuse of all scans and x-rays means there is as much as \$30 billion in unnecessary spending.

But like the overuse of antibiotics, simply educating doctors and patients about this does not change what they do!

(continued)

APPENDIX E:

Case Scenarios

**Case Scenario 3:
Using MRI Scans for Low
Back Pain****What should be done to encourage proper use of MRIs?**

Put a 'check' next to the **one** action that you would most likely support:

- ___ 1. Doctors who often over-use MRIs without strong medical reasons should be required to first get approval from a medical expert before ordering an MRI.
- ___ 2. If a doctor orders an MRI without a strong medical reason, the doctor should have to pay the cost of it.
- ___ 3. To encourage patients to think twice before insisting on an MRI when there is no medical reason, the patient should have to pay most of the cost of the test.
- ___ 4. There should be stricter rules for when an MRI can be ordered for common low back pain. For example, it could be ordered only if the back pain is not better in 4 – 6 weeks.
- ___ 5. Continue to leave it to the patient and doctor to decide if an MRI is needed or not, regardless of the possible harm.

(continued)

APPENDIX E:

Case Scenarios

**Case Scenario 4:
Using Costly Cancer Drugs****Treating advanced kidney cancer**

The topic of costly cancer drugs is one of the most difficult health care issues facing Americans today. When cancer is detected, we want to do everything we can to be cured or to live as long as possible with a good quality of life. Having both effective and affordable treatment is important to patients, doctors and health plans.

Kidney cancer is often caught early, before it has spread. When caught early, most patients are cured. But when kidney cancer is not discovered until it has spread to other parts of the body, the chances of a cure are very small. In fact, even with treatment only 8% of patients survive for 5 years. So with advanced kidney cancer, the main goal is to extend patients' lives and maintain a high quality of life for as long as possible.

Kidney cancer drugs

Until recently, Drug A has been the most effective drug for advanced kidney cancer. With Drug A, patients live an average of 28 months (almost 2½ years) after the cancer is detected. This drug treatment costs about \$50,000 for each patient.

A new kidney cancer treatment, Drug B, is now available. Drug B treatment works a little better: patients live on average for 29 months, rather than 28. But Drug B costs about \$80,000 and the side effects are often worse for patients.

Both drugs are approved by the FDA (Food and Drug Administration) for kidney cancer patients. But with the greater cost of Drug B (for a very small benefit), many consider this low-value.

The harm of costly drugs

If doctors and patients decide to use Drug B rather than Drug A, the harms are:

Greater cost for many individual patients. Many patients will have to pay more, because private insurance rarely covers the full cost of drugs. Research shows that almost half of cancer patients with private insurance use all or most of their savings to pay for treatment.

Greater cost to others. When doctors and patients decide to use an expensive treatment (when a less expensive one works almost as well), the higher cost is "passed on" to everyone else who pays for and uses health insurance. Like other low-value treatment, this increases the costs of health care for everyone.

(continued)

APPENDIX E:

Case Scenarios

**Case Scenario 4:
Using Costly Cancer Drugs****What should be done about Drug B?**

Put a 'check' next to the **one** action that you would most likely support:

- 1. The benefit of the two drugs is almost equal, but Drug B is much more expensive. Health insurance should only pay for Drug A.
- 2. If the doctor recommends Drug B, the health plan should pay for it.
- 3. If patients want the "newest, most expensive" treatment, they should have to pay the difference between Drug A and Drug B (\$30,000).
- 4. Since Drug B may bring one more month of life, it is the patient's decision to choose this drug or not (even if the side effects are worse).
- 5. An independent panel should decide what a fair price for Drug B should be, so it becomes high-value, not low-value.

Engage your public. We can help.

The Center for Healthcare Decisions (CHCD) is a nonpartisan, nonprofit organization dedicated to advancing healthcare that is fair, affordable and reflects the priorities of an informed public.



955 University Avenue, Suite C
Sacramento, CA 95825
(916) 333-5046

www.chcd.org