Doing What Works (DWW)
Reducing overuse: The public as policy-makers

Marge Ginsburg, Executive Director, CHCD
Statewide Workgroup on Reducing Overuse
February 29, 2016
agenda

- Why DWW was developed
- Make the case for public deliberation
- Participants/process
- Results:
  - dominant principles
  - approaches most acceptable and why
- Implications for addressing overuse of:
  - C-sections
  - MRIs
- Responding to findings
Informing the work of two state leadership groups

Doing What Works

Calif. HealthCare Foundation
Kaiser Permanente

Statewide Workgroup on Reducing Overuse

Integrated Healthcare Association
ABIM / RWJF
Objectives of DWW:

1. To identify principles/approaches relevant to overuse.
2. To reinforce civic participation in CA healthcare policy.
3. To contribute to state/national understanding: how the public views the role of medical evidence in treatment or coverage decisions.
Public input? YES
Public deliberation? Not so much
Engagement: different purpose and process

**Patient engagement**
Improve individual decisions
- Considers own treatment options
- Individual benefits/burdens
- Impact on self and family
- Personal goals/values

**Civic engagement**
Improve societal decisions
- Considers policy options
- Trade-offs among options
- Informed by diverse views
- Societal goals/values

**Decision:** What is in *my* best interest?

**Decision:** What is in the best interest of *all* of us?

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[Center for Healthcare Decisions](chcd.org)
BIZARRO  Piraro

Excuse me, but when you've got a wall of diplomas behind your chair, then your opinion will matter.
Q. #1: Does the problem (overuse) affect patients’ expectations?

Care that is ....

- Based on medical research
- Individualized
- Affordable
- Safe and effective
Q. #2: Could the actions have an undesirable impact?

Physician and consumer education? *Not likely...*

But other strategies may mean trade-offs:

- More effective treatment but reduce autonomy of doctors/patients?
- Reduce likelihood of harm but reduce tx options?
- Reduce costs but reduce choice?
DWW ADVISORY COMMITTEE

- Desiree Backman, DrPH: Chief Prevention Officer, DHCS: CHAIR
- Sally Covington, Co-founder Community Campaigns; Senior Health Care Advisor, SEIU 1021
- Kathy Glasmire, community member
- June Isaacson Kailes, Disability Policy Consultant
- Elizabeth Landsberg, JD, Western Center on Law & Poverty
- Marion Leff, MD, family practice physician, Sutter Health
- Beccha Rothschild, MPA, Consumer Reports
- Crystal Tarver, MediCal member

Co-facilitators:
- Susan Perez, PhD, MPH, Postdoctoral Fellow at UCDMC
- Glennah Trochet, MD, retired physician/county health officer
DWW sessions/participants

Ten half-day sessions, 9-12 people each, 117 total

- Five with Medi-Cal members (two in Spanish)
- Four with CoveredCA members
- One with CalPERS members

All low-to-moderate income, ages 30-60, diverse health plans, non-healthcare
Content of 4½ hr. session

- Pre-Session Survey (1-2 weeks prior)
- Session Introduction
- Review/discuss education materials
- Case scenarios #1 and #2
- Meal break
- Case scenarios #3 and #4
- Final Discussion
- Post-Session Survey
1. **The rising cost of Health Care**

2. **Spending wisely: A focus on value**

3. **What is low-value care?**

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

   **Who does this type of research?**

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

① Use of antibiotics for adult bronchitis
② C-Sections with normal pregnancies
③ Use of MRI scans for low back pain
④ Use of costly cancer drugs
Case scenarios’ emphasis on harms

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.
Types of actions they considered

1. Physician-facing: greater oversight
   - MDs that overuse need approval from expert
   - Monitoring/discipline
   - Stricter rules

2. Physician-facing: compensation related

3. Patient-facing: incentives or disincentives

4. No action: continue to leave it to doctor/patient
Initial voting before discussion
Results
Principles: cornerstones for actions

1. Physicians must be held accountable.
2. Actions should be effective, efficient and credible.
3. Not wasting resources is a valid reason for reducing unnecessary care.
4. Respect for patient choice must be balanced by ethical practices.
5. Patients have responsibility to be better informed.
Preferences for Strategies to Reduce Overuse

- MD oversight: 57%
- Pt cost-sharing: 21%
- MD payment: 13%
- No action: 9%
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Specific to C-sections

Focus of responses

• Wasteful spending and harms
• Freedom to choose vs. ethical medicine?

Approaches

• 54% support pre-approvals (prospective)
• 32% reduce payment (retrospective)
• Spontaneous 6th option: women self-pay
Specific to MRIs for LBP

Focus of responses
• Wasteful spending
• Harms... not so much
• Reasonableness of waiting

Approaches
• 60% support stricter rules (prospective)
• 9% support pre-approvals (prospective)
• Increase patient cost-sharing?
Responding to the findings
Responding to the findings

• Do the DWW principles apply to other examples of overuse?
• Are current or planned SWGRO/ IHA-CW strategies consistent with these perspectives?
• How should we use and communicate the DWW report?

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