

# Issue BRIEF

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## Supporting Better Patient Decisions at the Point of Care: **What Payers and Delivery Systems Can Do**

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### INTRODUCTION

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Prior research has documented a variety of influences on patients' receptiveness to evidence-based recommendations during a medical encounter (Tariman et al. 2012; Ernst et al. 2013; Gibson and Watkins 2013). In this brief, we use four typical clinical cases to explore the barriers to and facilitators of patients' decisions at the point of care. Because payers determine the benefit designs and provider financial incentives that shape the context in which these point-of-care discussions occur, we consider what roles payers can play. We also consider some of the ways delivery systems can better support patients' decisions at the point of care.

In the following discussion, we draw upon a review of the existing research literature and information we collected through focus groups with typical health care consumers and discussions with stakeholders (Mathematica Policy Research 2016). Our analysis highlights opportunities for payers and health care delivery organizations to support patients in typical point-of-care situations, including value-based insurance design, informed decision-making tools, revised provider incentives, and improved physician communication. Our work also notes the importance of the specific clinical problem, patients' circumstances, and community contexts in designing effective supports for patients' decision making at the point of care.

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### INFLUENCES ON PATIENTS' DECISIONS AT THE POINT OF CARE

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In this brief, we use four clinical cases drawn from the *Choosing Wisely*<sup>®</sup> program—an initiative sponsored by the ABIM Foundation—to guide our discussion of barriers to and facilitators of patients' acceptance of evidence-based recommendations at the point of care. Each case represents a decision-making opportunity

for which the relevant medical specialty society has recommended a particular choice, based on evidence, but for which there remains substantial variation in practice.

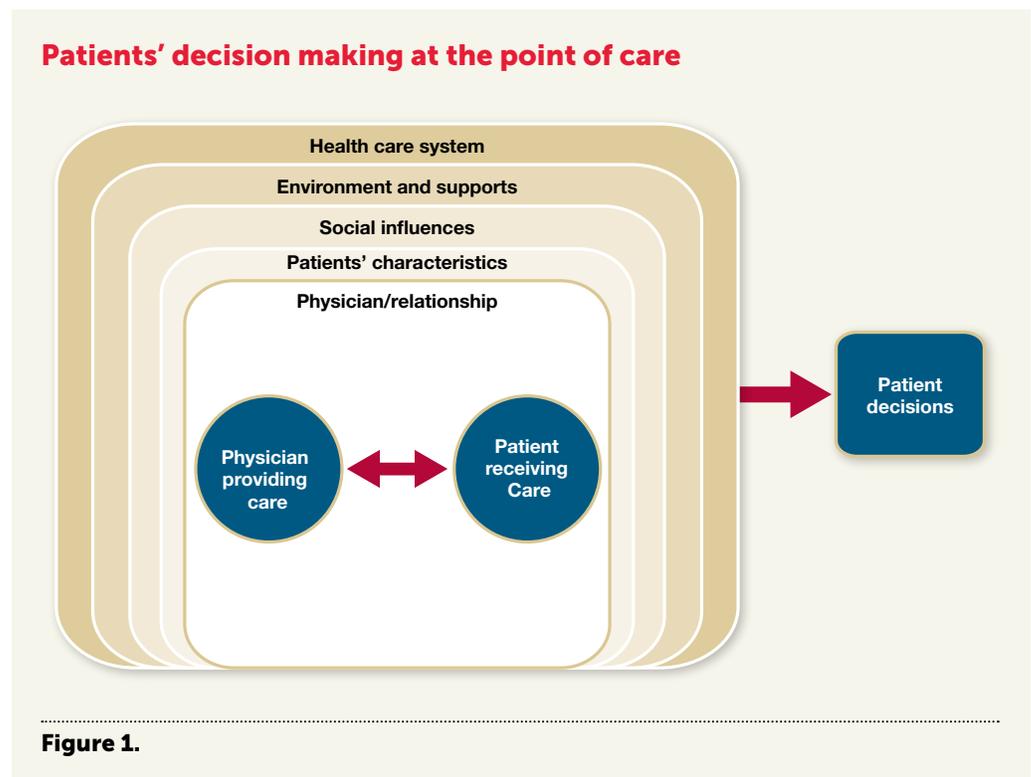
The first case centers on a child presenting with suspected appendicitis, and which diagnostic test (if any) to order in response. Due to concerns about radiation exposure and the attendant increase in cancer risk, evidence-based guidelines

recommend against computed tomography (CT) scans for children until ultrasound has been considered (American College of Surgeons 2013). The second case focuses on whether to use cardiac imaging technology as part of long-term, regular monitoring of asymptomatic patients with known coronary heart disease. Because such imaging entails radiation exposure, and the possibility of unnecessary care later on, experts recommend against it as part of routine follow-up in asymptomatic patients (American College of Cardiology 2012). The third case addresses whether to proceed with medical or surgical therapy in patients experiencing leg pain from peripheral arterial disease. Experts do not recommend surgical intervention until after trying risk factor modification and pharmacological treatment (Society for Vascular Surgery 2015). The fourth and final case examines whether to continue medication treatment in patients with gastroesophageal reflux disease (GERD) after their symptoms are controlled. Downward adjustments to long-term acid suppression therapies in well-controlled GERD patients are recommended to prevent harmful side effects (American Gastroenterological Association 2012).

Although patients make many important health care decisions before and after the medical

encounter, the focus of this work is on patients' decisions at the point of care (Buchmueller et al. 2005; Andersen and Newman 2005; van Dulmen et al. 2007). During the encounter, the patient and physician (or other clinician) share information about the patient's medical condition, treatment options, and comparative risks; usually, the physician then initiates a recommended plan of care. Patients' participation in relevant decisions, and their responses to physicians' recommendations, can vary considerably, however, due to a variety of contextual factors. Accordingly, we have categorized the potential influences on a patient's decisions at the point of care (Figure 1). In order from proximal to distal effect, the identified domains are the physician-patient relationship, the patient's personal characteristics, the patient's social influences, the patient's environment and supports, and the health care system.

The relationship between the patient and physician has a strong influence on the extent to which patients understand, discuss, and accept evidence-based recommendations. For example, the length of time a patient has known the physician can affect the extent to which he or she trusts the physician's assessment and advice (Mainous et al. 2001). The connections among familiarity, trust,



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*"The doctor who delivered my babies knows my kids well. I would follow her lead. But if a new doctor comes in, there's a new chemistry. I say, 'No. I will wait for the doctor I trust and I know.'"*

—Focus group participant

and decision making were evident in all of our consumer focus group discussions. For the appendicitis case, participants highlighted the difference between trusting their regular physician and an emergency department physician; a participant was more likely to accept a recommendation from his or her regular physician than from unfamiliar staff in an emergency department. As one focus group participant said, "The doctor who delivered my babies knows my kids well. I would follow her lead. But if a new doctor comes in, there's a new chemistry. I say, 'No. I will wait for the doctor I trust and I know.'" Patients' cited trust in physicians as important in their decision making throughout our discussions with stakeholders. As one stakeholder summarized, the "... most salient [factors] from the consumer perspective are trust and communication with the physician." In addition to trust and communication skills, focus group participants and stakeholder discussants also noted the influence of physicians' styles of interaction at the point of care, consistent with extensive prior research (Heisler et al. 2002; Zolnieriek and DiMatteo 2009; Ferguson and Candib 2002).

Patients' characteristics, including personal traits and experiences, influence the preferences they bring to a decision, as well as their level of engagement in making decisions at the point of care (Shahin 2008). For example, our focus group participants expressed a range of different expectations for physicians; some hoped that the physician would "do something" in a given case, but others stated that they want providers to minimize medications and procedures. Focus group participants were also swayed by past experiences with seeking care in both positive and negative ways.

The values and beliefs of community and family members affect patients' perspectives, resulting in an indirect, but potentially important, influence on decisions at the point of care. Patients and caregivers are more likely to rely on

family and friends to help them make medical decisions when confronted by serious illness (Bevan and Pecchioni 2008; Sanford et al. 2011); the decision is susceptible to social pressure (Brunson 2013); or their health literacy is low (Davis et al. 1996). As one stakeholder noted, "Lots of research suggests social norms make people believe screening is always good." Within the focus groups, reliance on friends and family varied, with some participants depending heavily on family and social networks for information on procedures and decision making and others preferring individual discussions with their respective physicians.

Patients' financial status and home environments can also shape the context in which they make decisions at the point of care. In focus group discussions, these considerations were most prominent for the cases with an invasive procedure as a treatment option, because this would require assistance during recovery. The amount of financial responsibility patients face regarding point-of-care clinical decisions was also influential in the focus groups. For example, participants considered copayments and other out-of-pocket costs in decisions when the medical concern was not urgent. In contrast, nearly all participants presented with the suspected appendicitis case (a potential medical emergency) reported that cost would be less of a concern than getting needed tests and treatment quickly. One participant said, "[My decision] depends on the added cost ... [but] the more urgent it is, the less the cost matters." Research also shows that consumers do delay or avoid elective care because of the associated out-of-pocket costs (Buntin et al. 2011; Kullgren et al. 2010; Reed et al. 2012).

*"[My decision] depends on the added cost ... [but] the more urgent it is, the less the cost matters."*

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A number of stakeholders noted that the health care system can shape the context in which patients make decisions. For example, the delivery system can affect the availability of cost and quality information to patients, as well as accessibility of different types of clinicians and diagnostic and treatment technology. Stakeholders

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noted that, in some markets, provider organizations might heavily advertise some services in ways that might not promote the most evidence-based care. On the issue of trust, stakeholders also noted that not only is it important for patients to trust their providers, they must also have a sense of trust “in the system” as well. This includes the insurance system and the health care facilities where patients receive care.

*“Sometimes you don’t have a choice because insurance coverage dictates it.”*

—Focus group participant

“Patients are wondering where this fits into the dialogue,” one consumer representative observed; a focus group participant lamented that, “Sometimes you don’t have a choice because insurance coverage dictates it.”

It is clear that there are opportunities within this complex set of influences to support patients seeking and accepting more evidence-based recommendations. In the sections that follow, we describe the tools that payers and health care delivery organizations can implement to address structural barriers to more informed patient decision making, and foster a culture of trust between patients and providers.

## **HOW PAYERS CAN SUPPORT PATIENTS’ DECISIONS AT THE POINT OF CARE**

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Payers and purchasers can have a relatively direct influence on the financial context for patients’ decision making through insurance benefit design. For example, with medication choices, increasing copayments for higher-cost medications encourages patients to use lower-cost alternatives. However, higher out-of-pocket costs for treatments can also lead to patients discontinuing their medications altogether—an undesirable result (Landsman et al. 2005). Indeed, one-size-fits-all copayments (equal copayments for all services within the same tier) can have adverse consequences. Current evidence suggests that copayments, if applied to high-value services, can lead to negative health outcomes, because consumers are not sufficiently sophisticated to consistently understand when the benefits of a

treatment outweigh the costs (Chernew et al. 2007; Fendrick and Zank 2013).

Accordingly, payers and purchasers are considering value-based insurance design (VBID) as a strategy for guiding patients’ decision making. VBID is meant to drive patients toward evidence-based treatments by reducing the personal costs associated with these treatments, and/or increasing the cost-sharing responsibilities associated with treatments not supported by evidence. Preliminary evidence suggests that VBID improves medication and guideline adherence, health outcomes, and work productivity (Gibson et al. 2015). It could be applied, for instance, to our GERD case, in which evidence suggests that the dose of acid-suppression medication should be titrated to the lowest effective level. VBID could also apply to decisions related to elective interventions, such as the heart disease or leg pain cases. However, our discussions with stakeholders suggest that in the cases we studied, patient-directed incentives by payers might be less helpful than those directed at clinicians. For example, VBID would be difficult to apply to urgent diagnostic choice decisions, such as in the appendicitis case. Furthermore, although some of our focus group participants believed that information on costs of care could assist with their decisions, others preferred not to discuss costs with their physicians.

*“We’ll pay for whatever decision you the patient make, but not until you go through the process of learning different options.”*

—Stakeholder

Payers can also use benefit design to require prior review and approval before patients can obtain specific services that are at risk of not being evidence-based. Indeed, some payers are beginning to require patients to engage in an informed decision-making exercise for a service to be covered (Jensen et al. 2015). Stakeholders noted that these approaches would have to be carefully designed, however, to ensure they do not appear to simply impose barriers to care. As one stakeholder explained, “From a consumer perspective, prior authorization is horribly branded.... You think they’re trying to find some reason not to pay.” One stakeholder noted that incentives for shared decision making could potentially replace prior approvals. He explained

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that the conversation would then be, “We’ll pay for whatever decision you the patient make, but not until you go through the process of learning the different options.”

Stakeholders also largely agreed that providing cost and quality information to patients is another useful strategy for health plans to support. This information could “come from physicians or payers,” and could be made accessible to consumers via “apps or portals.” Stakeholders also noted that health plans could “identify—through strong purchaser evaluation—the physicians and health systems using [evidence-based guidelines] and encourage patients to [use them].” A recent online survey of insured adults who had used medical care in the past year suggests that better and more accessible information might influence patients’ decisions; fewer than 5 percent of respondents compared costs across health care providers for their most recent visit, but about half reported they would use information on prices in the future if it were available (Sinaiko et al. 2016).

### **HOW PAYERS CAN ENCOURAGE HEALTH CARE DELIVERY ORGANIZATIONS TO IMPROVE PATIENTS’ SUPPORTS**

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A companion paper, “Supporting Better Physician Decisions at the Point of Care: What Payers and Purchasers Can Do,” discusses the available options for payers and purchasers to support physicians and practices offering more evidence-based recommendations (Contreary et al. 2016). Here, we will focus on the approaches payers might use to reward health care organizations for supporting patients’ adherence to these recommendations. One potential strategy to stimulate more informed patient decision making is to direct fee-for-service (FFS) payments to providers for patient encounters involving the use of formal shared decision-making (SDM) tools. In clinical situations in which the treatment options involve tradeoffs that affect quality of life, SDM can be quite helpful. However, in other circumstances relevant to informed patient decision making, payments for use of formal SDM tools might not be appropriate. With that in mind, stakeholders cautioned that direct payment schemes for implementation of SDM would have to be carefully designed and monitored to match the clinical circumstance.

*“Direct payment schemes for implementation of shared decision making (SDM) would have to be carefully designed and monitored to match the clinical circumstance.”*

—Stakeholders

In place of direct FFS payments for SDM, payers could introduce practice site or network requirements for informed decision making within practices delivering relevant services (such as SDM in obtaining consent for preference-sensitive elective procedures). Alternatively, payers could introduce enhanced payments to practices that provide informed decision-making resources to patients in relevant clinical situations. For example, some alternative payment models under evaluation by the Center for Medicare and Medicaid Innovation encourage or require introduction of SDM capacity to participate in the enhanced payment model (Centers for Medicare & Medicaid Services 2015; Taylor et al. 2015). Stakeholders noted such point-of-care decision supports might be helpful in our cases in which a patient’s preferences were important to the decision, such as when a patient’s exercise-induced leg pain limits his or her vocation or avocational opportunities.

### **HOW DELIVERY SYSTEMS CAN SUPPORT PATIENTS’ DECISIONS AT THE POINT OF CARE**

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One strategy available to the delivery system is to better train health professionals to engage with patients and support their more informed decision making (Friedberg et al. 2013; Barry and Edgman-Levitan 2012). To this end, education on informed decision making is already part of the curricula at some medical schools, residency programs, and fellowship training programs. At the same time, some stakeholders feel there is room for improvement. As one said, “Helping physicians understand how to communicate about evidence-based medicine [should be] a huge priority.” Findings from two comprehensive reviews of the literature suggest that training interventions aimed at health professionals responsible for “sharing the decision” with the patient are a “promising means” of bringing informed decision-making tools, such as SDM, to clinical practices (Légare et al. 2014; Légare et al. 2012, p. 14).

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Among our four cases, physician communication to promote informed patient decision making could play a role in the office-based cases involving choices of tests or treatments. Such efforts might have less relevance to conditions presenting in the emergency room (ER), where time for a decision is limited and the patient is in distress (Loewenstein et al. 2012). Nonetheless, some stakeholders noted there are researchers “pioneering decision support in the ER setting.”

Practice settings can also facilitate patient-mediated options such as decision aids for enhancing decision making at the point of care (Légaré et al. 2014). Various studies show the benefits of SDM tools in an array of contexts (Barry and Edgman-Levitan 2012; Trikalinos et al. 2014; Wyatt et al. 2015). Our stakeholders were generally supportive of decision aids, saying they are helpful in promoting patients’ understanding and acceptance of evidence-based decisions. However, they also noted these tools could become less useful when there is strong professional consensus around one recommendation, such as in the Choosing Wisely examples we used for our cases. Even when a consensus does exist, though, cultivating trust between patients and providers remains a crucial objective. As one stakeholder said, speaking from the perspective of a patient presented with a given evidence-based option, “How can I trust that [my] doctor will help me make the best decision when I can’t even trust him to pick up the phone? Or see me when I need help?”

However useful informed decision making can be in some clinical circumstances, our focus group discussions confirm prior findings that some patients do not seek to be deeply informed. Studies suggest that “the more the information received by patients matched their preferences, the better their adjustment to treatment and the less their subsequent emotional dysphoria” (Kiesler and Auerbach 2006, p. 366). Care must also be taken in decision aid design because patients are at risk of making “flawed judgments because of lack of familiarity with [the] graphs, probability, and statistical reasoning” these aids often contain (Gillick 2015, p. 785). Furthermore,

as one stakeholder noted, decision aids could become less useful when commercialized or produced by a vendor, in which case evidence-based recommendations might be sacrificed.

Furthermore, stakeholders confirmed the research highlighting barriers to practice sites and delivery systems implementing tools to support point-of-care decision making by patients. Health professionals often perceive lack of time as a barrier to implementation (Légaré et al. 2008). This is probably not surprising given that current “economic incentives stimulate short patient-doctor encounters, not the lengthy and repeated interactions that may be required for shared decision-making” (Gillick 2015, p.786). These incentives also create an environment in which physicians feel overworked, exacerbating their belief that they do not have time to engage in SDM (Friedberg et al. 2013). Not surprisingly, therefore, health care professionals do not currently embrace the use of formal interventions widely to promote SDM (Légaré et al. 2014).

## CONCLUSION

Payers and health care delivery organizations have a variety of opportunities to promote patients seeking and accepting more evidence-based recommendations in typical point-of-care situations. Payers’ options include benefit changes such as VBID, introducing service-specific requirements for patients and clinicians to engage in SDM, and implementing more general incentives for provider organizations to facilitate informed decision making by patients. Payers can also provide patients directly with information about evidence-based services, and/or the providers who use them. However, our work suggests that patients differ in their responses to these payer strategies, contingent on the specific clinical problem and/or practice settings. Therefore, these various payer strategies might have to be adapted to local circumstances to account for patients’ circumstances and community context.

Delivery systems also have a variety of powerful tools at their command. Their options include clinician training to support more informed decision making by patients, as well as the provision of formal resources such as decision aids. Our work also emphasized that patients’ trust in clinicians is key, and practice-based initiatives to improve this aspect of physician-patient communication could be beneficial in each of our cases.

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