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HEALTHCARE VALUE HUB

EASY EXPLAINER | NO. 10 | DECEMBER 2017

Consumer-Centric Healthcare: Opting For and Choosing Among Treatments

Healthcare is increasingly touted as consumer- or patient-centered. Research is beginning to show that revealing and catering to consumer preferences can lead to better outcomes, more efficient spending and higher patient satisfaction. But our health system too often fails to provide what consumers really want and need.

This Easy Explainer describes one of six consumer healthcare engagement points explored in the Hub's Research Brief No. 18, Consumer-Centric Healthcare: Rhetoric vs. Reality, *which outlines how failings could be addressed and encourages a discussion of how to elevate, support and validate the consumer's voice.*

What are Consumers' Preferences and Needs?

When making healthcare treatment decisions, the vast majority of Americans trust their doctor—86 percent. This often results in patient reluctance to take a more active role in their care (61% are content with having the doctor in control or largely taking control during a visit). Researchers believe that this high level of trust could lead to a biased perception that their doctor would never deliver unnecessary care. For example, despite national estimates that up to one-third of care is duplicative, unnecessary or harmful, more than 90 percent of consumers agreed with the statement that "my doctor would never recommend a test or procedure unless it was necessary."

For many patients, a doctor visit is the best opportunity to become engaged in their own health. In that encounter, consumers want to be heard, understood and given clear directions. Nearly nine in 10 consumers say if their doctor provides them with material when diagnosed with a health condition, they read it as soon as possible.

As a general rule, patients think in terms of outcome preferences (e.g., prevent another heart attack or fixing a sprained ankle) rather than the treatments that can lead to those outcomes. However, as patients become more informed, they become more likely to express a treatment preference. In other words, the more informed a patient becomes the more they are likely to have knowledge of, and opinions about, the treatment options available to them.

Most consumers (95 percent) believe it is important that doctors tell them about the results of medical research when making treatment decisions. However, consumers believe evidence regarding care or treatment that works for most people may not apply to them and want to avoid "one-size-fits-all" or "cookie-cutter" medical treatments. If they don't believe the evidence is relevant to their situation, they may use other criteria to make their treatment decision, such as personal preference or convenience, the doctor's clinical judgment and out-of-pocket costs.

Consumers believe that financial interests may sway how evidence of medical effectiveness is presented by payers and providers; therefore, they have a positive view of government-required public reporting of treatment effectiveness.

Consumers prefer that their provider not consider costs when weighing treatment options. But they want information on their own out-of-pocket costs, believing that they personally should considering costs when weighing evidence and understanding care options. Nine in 10 consumers believe it is important to know their ut-of-pocket expenses for specific services with specific providers, including insurance deductibles, copayments and other cost-sharing. Moreover, consumers want information for a complete episode of care rather than individual services delivered as part of that care. For example, when given a cost estimate for a surgical procedure, they do not want to be surprised by additional costs such as anesthesiologist fees.

Consumers also strongly prefer integrated information that allows them to simultaneously compare quality and cost information for the various options they are considering. When cost information is presented without accompanying quality information, consumers may use price as a proxy for quality—higher cost equals higher quality.

Failure to use informed, shared decision-making is a missed opportunity to reveal patient preferences and goals.

Evidence is mixed with respect to consumer views concerning the relationship between the cost and quality of procedures or services. Several studies show they don't believe they are linked. For example, most consumers (58 to 71 percent) do not believe there is an association between cost and quality in choosing a doctor or medical care. But in the absence of other information about the efficacy of treatment, consumers sometimes report that high costs signals high quality for them.

But consumers express more interest in treatment information than they tend to seek in real life. Fewer than two out of five consumers used price or quality data to inform their decisions in the past 12 months; only 38 percent looked for healthcare quality ratings before they received services, and only 36 percent asked how much their healthcare service would cost in advance. This may be due to "clutter" or information overload. Decision-making research shows that more information does not always improve decision-making, and frequently may actually undermine it. Other explanations include: lack of awareness of provider quality variation, insulation from out-of-pocket expenses at the point of service, and the inadequacy of current information sources.

All income groups are going to the Internet to find information, but lower-income consumers often don't know the precise terms to use. In general, lower-income consumers are less satisfied with existing healthcare resources and spend less time searching for health information.

How Our System Fails Consumers

Our greatest failure is that far too many consumers do not get care they believe they need due to concerns about cost. Many others get care but then struggle to pay the resulting bills.

When patients do receive care, too often that care is not aligned with their preferences. For example, in a study of more than 1,000 office visits in which more than 3,500 medical decisions were made, less than 10 percent of decisions met the minimum standards for informed decision making. Similarly, a study showed that only 41 percent of Medicare patients believed that their treatment reflected their preference for palliative care over more aggressive interventions. There is also significant variation in the use of procedures, particularly those for preference-sensitive conditions, which suggests that patients may receive care aligned not with their values and preferences.

Failure to use informed, shared decision-making is a missed opportunity to reveal patient preferences and goals. Patients make different decisions about whether to have tests, treatments, or procedures when they are well informed and their preferences are taken into account, resulting in more satisfied patients and better allocation of system resources. This failure may stem from:

- Reimbursement policies that are not aligned with shared decision-making.
- Doctors' perception that consumers don't want to be involved in their treatment options, or cannot understand the options. Physicians believe that 37 percent of their patients want their doctor to make the decisions regarding their medical treatment with input from the patient, but only 7 percent of consumers selected this as the role they wanted doctors to have. Instead consumers are much more likely to want a process that uses joint decision making or the patient makes the decision with input from the doctor.
- Doctors' belief that medical diagnosis is more important than preference diagnosis. Doctors believe that they are already quite good at diagnosing patient preferences, but the evidence shows that there are enor-

mous gaps between what patients want and what doctors think they want. For example, doctors believe that 71 percent of patients with breast cancer would rank keeping their breast as a top priority, yet the actual figure reported by patients is 7 percent. Doctors believe that 96 percent of breast cancer patients considering chemotherapy would rank living as long as possible a top priority, yet the actual figure is 59 percent.

Preference misdiagnosis is widespread. Doctors are highly trained in medical diagnoses, but not in diagnosing patients' preferences, even though the evidence shows that the right treatment—the treatment that the patient wants when fully informed—is dependent on patient preferences. A large body of evidence shows that doctors, in general, are unskilled at diagnosing what patients want. Three types of evidence support this conclusion: studies show how treatment preferences change after patients become well informed; studies of outcome preferences show differences between the outcomes that patients prefer and the outcomes that doctors think they prefer; and studies of geographic variations in care show that the variations can only partially be explained by causes other than the preference misdiagnosis.

Dissatisfaction is common. When asked to infer their patients' satisfaction with their care, doctors estimated that 76 percent of patients were satisfied, but only 39 percent were. Moreover, vulnerable consumers are three times more likely to feel disrespected by doctors and other providers. Those that feel disrespected are twice as likely to not follow their treatment regimen.

Failure to provide publicly reported information geared to consumer preferences. Consumers first need is for information on how outcomes differ across treatment options, public quality reporting is not specific to one's doctor. In choosing a doctor, consumers prefer condition-specific or procedure-specific information reported at the individual physician level, yet most publicly reported quality information is not condition or procedure specific and focuses on the general performance of hospitals, medical groups—not at the individual physician level.

Meaningful price information is hard to obtain prior to receiving care. Shortcomings include:

- Failure to provide integrated cost and quality information. Consumers prefer integrated cost and quality information at the physician level for specific services in a simple, easy-to-access, and easy-to-understand format.

When doctors accurately diagnose patient preferences, an enormous source of waste—the delivery of unwanted services—is eliminated.

- Public cost reporting is not specific to one's health plan. Consumers want to know their out-of-pocket costs for specific services with specific providers, given their insurance benefits. However, many current public reporting initiatives give total or average charges for specific services—information that is too general to meet the consumer's specific needs.
- Lack of information about complete episode of care. Consumers want information for a complete episode of care rather than individual services delivered as part of that care. If consumers are given a cost estimate for a surgical procedure, they do not want to be surprised by additional costs associated with the procedure such as anesthesiologist fees. Most useful is price information that incorporates any negotiated discounts; is inclusive of all costs associated with a particular service; and identifies consumers' out-of-pocket costs.
- Lack of reimbursement policies and benefit designs that help signal to consumers what high-value care is and makes it financially accessible.

Finally, consumers are generally unaware of comparative quality and cost information. For consumers to be more aware of their options and their costs, reporting entities need to lower the burden on consumers to track down and use information. Lower levels of consumer use of information may reflect issues with the availability of relevant data and the design of the tools to deliver those data, rather than a lack of interest in comparative assessment of quality and costs.

How the System can Better Meet Consumers' Preferences and Needs?

Encourage shared decision-making and train doctors and other health providers in preference diagnosis. Shared decision-making that takes place in a clinical setting discards the notion that the provider is the only person who needs access to available evidence. It often involves the use of patient decision-making aids such as online interactive information and applications, as well as written material in pamphlets or booklets.

And when doctors accurately diagnose patient preferences, an enormous source of waste—the delivery of unwanted services—is eliminated. This is especially true when doctors accurately diagnose the preferences of patients with long-term conditions who are far more likely to keep their conditions under control with fewer hospitalizations and emergency department visits.

In this vein, with the advent of accountable care organizations (ACOs) and other coordinated efforts at multiple levels within health organizations, a concerted effort to change physician and other clinician perceptions and behavior is needed. Such efforts should also include training in medical schools.

Reimbursement and Organizational Changes

Payers and purchasers' reimburse doctors for taking more time with their patients, and health systems can maximize the value of physicians' appointments by using paraprofessionals, such as health coaches, to obtain information about patient preferences and help patients with lower activation levels to understand their medication and follow-up appointment schedules. Health systems should focus on eliminating preference misdiagnoses, so that patients receive the care they prefer and need. Moreover, benefit designs should be smarter, such as having lower or no copayments for office visits to manage chronic conditions to incentivize patients to seek care and be more active in their treatment regimens. Purchasers' policies can also indicate to healthcare organizations where resources should be allocated, such as support to patient engagement and discharge planning.

Hospital policy changes that can increase patient engagement include enabling families to visit 24-hours a day; bedside rounding—conducting doctor and team rounding at the bedside; having nurses give shift reports at the patient's bedside; patient-centered discharge planning; and electronic health records that patients can access and edit.

Address Consumer Information Needs

Consumers want information for a complete episode of care that identifies their out-of-pocket costs based on the negotiated rates between the insurer and the providers.

Reporting entities need to do a better job integrating quality and cost information in a way that enables consumers to easily understand and access this information. Make the information relevant and its display simple. Using less detail in presenting cost information, and putting quality information adjacent to cost information, and indicating higher value with checkmarks or blue ribbon symbols, saves consumers time and is easier for them to understand. Comparative reports should include a variety of techniques to help users comprehend the data, understand their personal relevance, and make choices that reflect a combination of the evidence and their personal preferences.

Evidence shows that consumers are more likely to use comparative cost and quality information if they fall into one of three groups: those with greater financial exposure or with benefit designs that encourage cost-conscious choices (such as reference pricing), those seeking elective procedures, such as joint replacements, and those seeking maternity care or low-complexity, routine procedures such as immunizations, cholesterol screening and colonoscopies.

Note: This publication is excerpted from Research Brief No. 18, *Consumer-Centric Healthcare: Rhetoric vs.Reality*. Citations can be found on our website at www.healthcarevaluehub.org/EasyExplainerNo.10

About This Series

The Healthcare Value Hub takes a careful look at the evidence and consults with experts in order to clarify for advocates, media and policymakers the important cost drivers and the promising policy solutions. Hub Research Briefs, Easy Explainers, infographics and other products are available at our website.

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Support provided by the Robert Wood Johnson Foundation