APPENDIX A: MODERATOR GUIDE

1) Introduction

2) Purpose
   a) "Medical care is very expensive for individual patients and for society as a whole. Many people think doctors need to help find ways to reduce the cost of medical care. In the focus group that you are participating in today we would like to find out from you how you think about the cost of health care in your practice. We're talking about ALL costs, EVERYBODY'S costs – not just those the patient pays, not just those paid by hospitals, governments, insurance companies, but the cost to anyone and everyone.
   b) There are no right answers; we're just interested in their thoughts and feelings on the topics we're discussing today.

3) Procedure
   a) When we discuss examples in practice please do not include the names of patient(s); the research team will be removing anything that might identify patient(s), clinicians, hospitals, etc. when we summarize the results.
   b) I'd like you to feel free to be frank with your opinions (e.g., we like having many points of view so feel free to disagree with one another).
   c) Emphasize that they don't have to disclose personal issues though they may if they want to.

4) <u>Redundant services [*go quickly through this one, as a "warm up"]*</u> (5 MINUTES)

   a) Doctors have told us that, especially when they see a patient who has been treated by other physicians or who is new to their practice, they sometime repeat services the patient has had already, especially lab tests and imaging studies.

   b) When do you think that this sort of repetition should be done? When do you think it should be avoided?

      PROBES: Relative expense (e.g., blood sugar vs. MRI)
      Scarcity (e.g., wait time for all patients needing service)
      Financial effect for practice, hospital, other
      Patient request (and, if noted, how handled)
      Insurance type (besides patient's out of pocket costs as result of insurance type) including uninsured
      Patient's out of pocket cost

Where previous service was done (e.g., locally vs. across the country).

5) Unnecessary service (besides redundant) (20 MINUTES)

a) Sometimes patients come in, or call, requesting specific services or expecting certain things will be done.

Have you had patients do that? What did they request/ask for? What did you do or say?

b) Have you had patients who gave the impression they expected something but didn't specifically ask for it? Tell us about it. What did you do or say?

c) When do you think that you should say "yes" to patient requests for specific services? When do you think you should say "no?"

POSSIBLE EXAMPLES, can use these if needed to get them talking: ultrasound for healthy pregnant woman; electrocardiogram for healthy young adult man; earlier than recommended cancer screening; brand name vs. generic medicine; referral to a specialist for a common or minor problem; off-label use of medication (this might also fit next category); wish to remain in ICU [or hospital] rather than transfer to regular bed [rehab/nursing facility/home]; friend or family member has bad diagnosis (not strongly familial or contagious) and wants testing for it.

GUIDING: They are likely to mention the risk or harm of service to patients as a "no" factor. Guide them toward talking about costs e.g., by saying "imagine it really isn't likely to hurt them but it's expensive, then would you go along with what they want?" or

"Can you think of a time when a patient requested or expected something that wasn't likely to hurt them but also wasn't likely to help them?" If they mention acceding to request or worry for a low cost service – e.g., a blood test - ask if they would do it if the test were very expensive.

"What if something did not present any harm, but just an expense (Ultrasound/MRI)?"

PROBES related to patient factors – insurance type or lack, quality of life, age, probability of benefit, amount of (possible) benefit to patient, high vs. low stakes of situation (e.g., mild acne, deadly diagnosis, work/family/social situation) patient's out of pocket cost, relationship with patient;

1. Can you tell us about that particular patient [that particular request/expectation] especially what influenced your decision?

2. Does it matter what sort of insurance a patient might have (or if a patient doesn't have insurance at all)?

PROBES related to system/setting/context- Relationship with patient; Ability to follow-up with patient (soon); Financial effect for practice, hospital, other; Scarcity of service (e.g., long wait time to see a neurologist or get a test or procedure); Public or community resources needed (e.g., Medicaid patients, public hospital, local mental health services provided by local government

PROBE: How to say "no" to patients – Ask about times they did say "no" to a patient; patients' responses to "no;" ask for times they thought it went well or would have done it differently.

6) Marginally beneficial services (20 MINUTES)

a) Sometimes there's a big difference in how much two different things cost, and not so much difference in how much good the more expensive one might do for the patient. Remember, we're talking about ALL costs – not just those the patient pays, but cost to anyone and everyone. Can you think of examples of that from your own practice – where there's an expensive way and a much less expensive way, and the expensive way is just a little bit better?

Can you think of examples of something that was more expensive, but only provided a small benefit to the patient?

What about examples of something where you were uncertain of the potential benefit, say a new technology, but it was still more expensive?

POSSIBLE EXAMPLES, can use these if needed to get them talking: different antibiotics, asthma medicine or medicines for mental illness; different types of imaging (e.g., MRI vs. ultrasound or CT); MRI for a headache; referral to an allergist for eczema; different equipment (e.g., different kinds of wheelchairs); cancer screening when patient has lots of co-morbid conditions; off-label use of medication that has some evidence of effect; extremely expensive cancer therapy with small effect on lifespan;

(More examples)

5. Treatment for toenail fungus – differences between drugs in safety and effectiveness, also in cost – from few hundred to over $1000

6. Some drugs are more expensive for extended release or once a day dosing than for twice or three times a day dosing. (e.g., metoprolol vs metoprolol XL)
7. Some drugs in the same class (e.g., cipro vs. levofloxacin, erythromycin vs. azithromycin, zoster drugs) are more expensive but taken less often
8. Robotic minimally invasive surgery – allows smaller incisions, shorter recovery time; costs $1million or more for the machine + $2000 replacement parts per procedure + training for those using it
9. Highly individualized, targeted cancer drugs can cost $100,000 or more, may add only a few months of life *on average* but offer a slim chance of longer benefit for some (don't know which) patients
10. Provenge for prostate cancer that no longer responds to hormone therapy but causing few/no symptoms. $93,000 for course of treatment, extended median survival by 4 months.
11. Enzyme replacement therapy for very rare Pompe disease in adults – Treatment seems to improve symptoms and function a modest amount (slight improvement in ability to walk or breathe without oxygen) for uncertain duration. Evidence "promising" but not conclusive. Treatment costs over $500,000 per year.

PROBES related to patient factors-insurance type or lack, quality of life, age probability of benefit, amount of (possible) benefit to patient, high vs. low stakes of situation (eg., mild acne, deadly diagnosis, work/family/social situation) Patient's out of pocket cost

1. Can you tell us about that particular patient [that particular request/expectation] especially what influenced your decisions?

2. Does it matter what sort of insurance a patient might have (or not have)?

PROBES related to system/setting/context - Financial effect for practice, hospital, other; Scarcity of service (e.g., long wait time to see a neurologist); Public or community resources needed (e.g., Medicaid patients, public hospital, local mental health services provided by local government)

b) *Follow-up questions/facilitation for discussion that talks about physicians role* – e.g., doctors should not let cost influence what we recommend, we should only tell patients what we think is best for them; we're supposed to take care of our patients first, someone else should make decisions about what not to pay for. [*be sure to ask other members of the group what they think; in most groups of docs there are some who take seriously responsibility to avoid waste, be efficient*]

What if there's something really, really costly in terms of time, money, beds or OR space or whatever, and you think the benefit to the patient is tiny, or very uncertain, or both? Would you always recommend it?

What if you think a service or treatment would provide some degree of benefit, but not lifesaving, and the payer says it's not worth the cost? What factors would lead you to contest the decision?

c) What if somebody else decides that something you think could help your patient in a small isn't worth the expense - Would you try to change that decision? If so, why? If not, why not? If sometimes, when would you try to change the decision, and when wouldn't you?

7) (IF TIME) Do you ever discuss the cost of care with patients? How does that go? Can you describe a way you did that that you thought went well, or perhaps one that didn't go well so we can all learn from it?

    a) Why do you think those conversations [asking speaker(s) and other members of the group] went well/not well?