

How to Help Gastroenterology Patients Help Themselves: Leveraging Insights From Behavioral Economics

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Roadmap to the **FUTURE** of **PRACTICE**

The 2002 Nobel Prize in Economics was awarded to Daniel Kahneman and Vernon Smith for their work in Behavioral Economics. They showed that most people do not make decisions rationally (contrary to the Game Theorists' hypothesis) and can make erroneous decisions when they allow one specific factor to influence them disproportionately. Kahneman once conducted a study showing that Midwesterners believed that people in California were happier (due to weather), contrary to empiric data (although this winter might negate their findings).

This month, Drs Mehta and Asch introduce us to Behavioral Economics in the context of medical decision-making. They help us understand how we can fine tune our decisions and strive for better outcomes (and perhaps lower costs) when theories of Behavioral Economics are understood. Their insights are germane to our decisions about colorectal cancer screening, medication recommendations, and Barrett's surveillance, as examples. I hope you enjoy this foray into economic theory.

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Special Section Editor

In the wake of health reform, physicians will be taking on more responsibility for the outcomes and value of care their patients receive. There will be a broader pool of insured patients to care for as well as greater pressure to provide better outcomes while maintaining efficiency. We can already see the proliferation of quality metric reporting from both governmental and commercial payers, which will likely be followed by

payment and accountability based on the results of these metrics. Although many of these incentives are focused on primary care providers, gastroenterologists are also subject to these changes in organization and financing of health care. In the current predominantly fee-for-service model, gastroenterologists are reimbursed on the basis of how many patients they see and procedures they perform. With new financing mechanisms, this piece-work financing will likely transition to reimbursement for quality or value, so gastroenterologists will need to evolve from the current reactive, visit-based model of care to one that is more proactive and outcome-based.¹

One example of this change is colorectal cancer screening. Colorectal cancer is largely preventable, with widely available modalities to prevent and find early stages of the disease. However, only 65% of patients actually get screened.² Provider groups (and payers) are already measured on colorectal cancer screening rates, and gastroenterologists will likely be measured and reimbursed on the basis of additional quality metrics (recall recommendation, adenoma detection rate). There are many things physicians and practices can do to improve these metrics, but it also requires that patients adhere to instructions and follow recommendations. Although it is common for some physicians to blame patients for being nonadherent, new approaches to outcomes and to value mean we should be thinking about ways to accommodate patients' needs and help them overcome the barriers they experience as they approach their own care. Most patients seek to avoid cancer, even those patients who have difficulty adhering to cancer screening that might accomplish this goal.

Behavioral economics, a relatively new field, provides insights into why patients and providers may not behave in their long-term best interest but also informs interventions to improve patient behaviors, provider

Abbreviation used in this paper: PPI, proton pump inhibitor.



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PRACTICE MANAGEMENT: THE ROAD AHEAD, *continued*

management decisions, and outcomes.³ We provide a brief introduction to behavioral economics as well as how these principles relate to gastroenterology practice and can be used to improve how we take care of our patients.

Behavioral Economics and Health

Traditional economics is premised on the view that people consider the costs and benefits of the choices they face to maximize overall utility. As standard economic theory goes, these rational decision processes apply to financial and nonfinancial decisions about health care, as if we are all perfect expected-value calculators and expected-value maximizers. However, we know that patients (like all humans) do not act this way. Even the most strong-willed of us, if on a diet, will on occasion be tempted by a caloric treat, even though we know that eating it is not in our long-term interests and even though we know we will soon regret the decision.

Behavioral economics sits at the intersection of psychology and economics and describes why we do not always act rationally.⁴ This field has provided tools to better understand and remediate limitations of rational choice theory in financial markets and personal retirement planning, and its insights are appropriate to understanding health care decisions as well.⁵ Both physicians and patients make these biases and errors in decision making, but this article focuses more on patient decisions and behaviors. We will describe examples of some existing biases that patients may have, examples in gastroenterology, as well as important changes that practices can make to overcome these biases and improve the outcomes of our patients (Table 1). Although this is not an exhaustive list of biases and errors, they represent many of the important

concepts of behavioral economics that also have practical implications for gastroenterology.

Biases and Implications for Gastroenterology

Status Quo Bias

Status quo bias describes how people are more likely to continue on a current path when facing potential choices. If given the choice of a new option or an existing option, especially with limited information, most will continue with the status quo and resist change. In gastroenterology, an example of this bias is the long-term use of proton pump inhibitors (PPIs). We know that PPIs can benefit patients in a variety of settings, particularly when given for a defined course. However, the long-term benefit is not evidence-based in many situations, and long-term use may lead to cumulative risks. The American Gastroenterological Association medical position statement recommends that PPIs should be titrated down to the lowest effective dose for symptom control, and the Choosing Wisely list suggests they may be overprescribed in some settings.⁶ For example, many patients are started on a PPI for specific symptoms or in the hospital, particularly in the setting when the diagnosis is unclear. But prescriptions have a certain inertia; once on a PPI, there may be resistance to stopping the PPI. This inertia is exacerbated because patients may be followed by a variety of providers, who may be hesitant to stop the medication (especially if there is limited communication with the ordering physician), so they may err on the side of the status quo. A study from the Veterans Administration showed that the majority of patients were given greater than 3-month prescriptions,

Table 1. Examples of Behavioral Economics in Gastroenterology

Bias	Description	Clinical example	Potential intervention
Status quo bias	Preference to maintain defaults or status quo	Long-term use of PPIs with limited indication	More explicit defaults to limit treatment course
Loss aversion	Weighing losses more heavily than gains	Cost-sharing for screening colonoscopy may reduce adherence	Eliminating cost-sharing for all intended screening colonoscopies may increase rates
Present-time bias	Overestimate costs and benefits of decisions today as compared with future	Current cost (financial and nonfinancial) of colonoscopy for colorectal cancer screening	Provide more immediate rewards to overcome costs and perception of procedure
Framing effects	Framing of messages can alter response	Fear of extending intervals for Barrett's esophagus surveillance because of risk of cancer	Change the framing of nondysplastic Barrett's from precancerous to abnormal tissue

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