Scott Redding:

Welcome to the Cancer Aware podcast, where we'll discuss cancer prevention, treatments, the latest in research, and important news around cancer. Brought to you by the University of Michigan Health Rogel Cancer Center.

Eric Olsen:

In the United States, unnecessary tests and treatments not only drive up healthcare costs, but may also contribute to a waste of valuable resources and avoidable patient harms. This has prompted an effort to reduce ineffective, unproven, or harmful care through a process called de-implementation. Hello, I'm Eric Olsen, and today we're talking about healthcare de-implementation with Dr. Lesly Dossett, Division Chief of Surgical Oncology at University of Michigan Health. Good afternoon, Doctor. Thank you for being here.

Lesly Dossett:

Thank you for having me.

Eric Olsen:

Why don't we start with a bit about your background and current role at U of M Health?

Lesly Dossett:

So I am a surgeon here at Michigan and I focus on cancer surgery. And as part of my training in surgery, while I was a resident, I did some dedicated research training in healthcare delivery. And as I then elected to focus on oncology and pursue a fellowship in surgical oncology, I began to get interested in this concept of overtreatment and de-implementation. So when I transitioned to my faculty role here at Michigan, I started to explore, through my research group and body of work, de-implementation, and have been pursuing that as part of my research efforts in labs and also through a role that I have with the Michigan Program for Value Enhancement, which is a research unit here at Michigan that spans with clinical operations and research and focuses on value and de-implementation.

Eric Olsen:

I wonder if you could explain to us a little more what de-implementation means? What does that mean in terms of healthcare?

Lesly Dossett:

Well, I'll start first by defining the term implementation and what we mean by that. We know that there's a lot of evidence in medicine that we derive from clinical trials and patient studies that provides us high-quality recommendations based on the highest quality of evidence, and we would call that evidence-based practice.

What we also know, though, is that it takes a long time, often, for that evidence to actually make it into clinical practice. Some estimates would say that it takes up to 17 years for routine results from clinical trials to make it into routine practice. And most of the time when we're talking about implementation, we're talking about using new medications or using new tests or treatments or procedures.

De-implementation is a little bit the opposite of that concept. It's focusing on areas where we've had clinical trials that show that something that we've done for a long time really sometimes surprises us and actually, when tested in clinical trials, shows that it doesn't actually benefit patients. And so de-implementation is thinking about the process of getting those things that are entrenched in practice but demonstrated to be no longer a value to patients, to get clinicians to stop doing those things.

There's actually kind of a broad psychology literature on this in terms of habits and how we start doing things that we haven't done before, stop doing old things. And we know that those two processes are different. So de-implementation really focuses on that concept of stopping doing entrance behaviors.

Eric Olsen:

What is the process for identifying something that may be a candidate for the de-implementation process?

Lesly Dossett:

Yeah, that's a great question, something that we rely on others to do for us. So probably the most well-known international effort to identify low-value test and treatments is a campaign called Choosing Wisely. And this was a campaign that was started in 2014 by the Internal Board of Medicine Foundation. And what the foundation did was they basically went to all of the specialty organizations that represent all types of physicians across the US and internationally. And they went to those organizations and asked those organizations to identify five practices within their clinical disciplines that were considered low value, or areas where the evidence supported that we no longer needed to do these things.

And so those recommendations were coalesced into the Choosing Wisely campaign. And so patients and providers can go to the website and look and see across ... There's over 550 recommendations, again, supported by multi-specialty organizations, and that encourage both patients and clinicians to avoid these low-value tests and treatment.

So in our work, we look really first to Choosing Wisely, and where are those areas of recommendations where, even though there's good evidence to stop doing these practices, we still see prevalent use in routine practice.

Eric Olsen:

Are the use practices mostly simply older practices that have just become legacy at this point and it's just sort of a reflexive ... We're going to do this and this and this?

Lesly Dossett:

Yeah, a lot of them were things that were introduced into routine practice, well-meaning, based on lower-quality evidence, and then at some point when someone got around to testing a particular test or treatment in a high-quality clinical trial like a randomized controlled trial, it actually demonstrated no benefit.

There's other things that simply were never tested. For example, one of the areas that we look into is the use of low-value blood tests, EKGs, and chest x-rays before surgery. Whether or not getting those routine tests improved outcomes really was never tested until it was very much entrenched in practice. And so it's only more recent evidence that suggests that things that we've been doing for decades, really, ultimately in modern healthcare and healthcare delivery don't impact outcomes.

Eric Olsen:

Do you think that it's just that things have become routinized and people just assume that there's a net benefit from things like that, and that's why maybe they stay in place long after they maybe should have been evaluated?

Lesly Dossett:

Yeah. I think it's multifactorial, obviously. And that's what we find in our work, that there are things that clinicians learn early in their training that become part of how they practice. Definitely entrenched behaviors is something that we see quite commonly. Much of this, I would say, wasteful care is motivated by fear. Fear of missing a diagnosis, fear of potentially being sued. And there's also a component of what we would call clinical momentum. So once the patient's in your office and expects that something is going to be done, oftentimes it's easier to order a test or a treatment than it is to counsel the patient that actually, in their particular situation, that there's nothing warranted.

Eric Olsen:

Can you share some examples of some of these tests or processes?

Lesly Dossett:

Yeah. A couple of classic examples. One would be in the evaluation of back pain, for example. We have great technology now, a lot of advanced imaging. And a common scenario of overuse is the use of MRI to evaluate back pain. And so if ER doctors or if primary care physicians ordered an MRI on every patient that complained of back pain, we would be ordering a lot of MRIs. And there's actual harms to that, often. Incidental findings that have to then be evaluated, and obviously there's costs associated with that.

And so multi-specialty groups of back pain experts have come up with recommendations, situations where advanced imaging is warranted. For example, if the back pain's been going on for a longer period of time or if there are what are called red flag symptoms, then in those cases it's warranted. But in routine cases, it should be avoided.

Another classic example might be the use of antibiotics for viral infections in the pediatric population. I think that's an area where we've demonstrated successful de-implementation. I think a lot of parents and families now recognize the potential harms to antibiotics in cases where a viral infection and are comfortable avoiding prescriptions in those cases. But those are a couple of classic examples of de-implementation.

Eric Olsen:

I think a lot of people might understand the reduction in costs and waste and stuff like that and understand that it's probably a clear benefit for everyone involved, but I think a lot of patients are going to wonder, "How will these sorts of cuts affect my personal healthcare going forward?" Particularly I think for a patient maybe facing a significant health situation who is ready and willing to do everything and anything to mitigate whatever is going on. How do you help them through that process of understanding that maybe not everything is the best strategy?

Lesly Dossett:

Yeah, that's a great question, and something I think where most of our research focuses is how do we best communicate these recommendations? And also I think it comes down fundamentally to understanding risk and benefits with patients. One of the things we classically see both on the side of patients and clinicians is that we tend, as humans, to overestimate how much something is going to benefit us and underestimate how much potential harm it may do.

And so an example of this is in an area that's been really well studied, is looking at patients, for example, who are scheduled to undergo cataract surgery. Obviously, a very common low-risk procedure. And it had been rather routine practice for patients who are going to undergo cataract surgery to have an EKG prior to that surgery. Evaluate potential heart disease, it's unknown, et cetera, prepare that patient for surgery.

What has been demonstrated though, through trials and studies, is that those EKGs do not change management and don't alter the ultimate outcome from the surgery. What they do lead to is delays in surgery because oftentimes they require a trip to a cardiologist, perhaps a more invasive test. And actually, it's one of the areas where there's really clear harm that's been demonstrated in twofold. One is that the patient may need to end up getting invasive tests and treatments like stress test, heart catheterizations, et cetera, but also the delay in surgery or the delay in getting time to surgery has been associated with increased falls because the patient can't see well.

And so it's one area, one example, where this unnecessary test that's not going to change the management of the patient that needs the cataract actually has unintended harms in terms of leading to these ... What we would call cascade events. So things that need to be followed up, and as well as delaying surgery, in that case, being associated with falls.

Eric Olsen:

Interesting. What do you think the purpose was behind the EKG? Was that just to potentially decide how they would anesthetize the patient or something?

Lesly Dossett:

Yeah. I think that's probably an example where it's just really an old and historic practice where ... The concept of anesthesia, which is much different today than it was 50 years ago in terms of safety profile, that 50 years ago when we were putting patients under anesthesia, it was very routine to get blood tests, to get chest x-rays, to get EKGs, et cetera, to ensure that the patient was optimized for surgery and that we had all the information we needed in case there was some sort of event during surgery. What we know is that in modern times, modern anesthesia is quite safe, and those tests really are unnecessary because they don't change management. They don't prevent adverse events, and ultimately only expose the patient to harm.

Eric Olsen:

What would you say to a patient who is pretty adamant? They want to take an aggressive stance toward their treatment and they feel like, "Okay, I heard you, but I still would like to do this test because I really want to be extra safe, or I really want to be extra careful. I think more data is better across the board."

Lesly Dossett:

Yeah. I think that kind of depends on the specific clinical scenario. It depends, the degree of harm that might be associated with those tests. There are certainly areas where the payers, so the insurance

companies, are taking those decisions out of the hands of the patients and clinicians. So for example, if an MRI is just not ... If the evidence doesn't support that an MRI is of benefit, that a lot of times the payers will proactively stop paying for those things. And so then you're counseling a patient that they might face an out-of-pocket cost, which is sometimes enough to deter them.

I think we certainly focus on counseling in terms of, again, emphasizing the potential harms. And when there's areas where to pursue a test or treatment would be reasonable, then obviously you can have shared decision-making with the patient. And ultimately, some patients will opt for that more aggressive approach.

But I think what we have found, what I've found in my clinical practice and what we found in our research work is that there actually are a lot of patients who prefer a minimalist approach and have never been offered that option. And so a lot of times, I think patients are pleasantly surprised to hear an option for less because while there certainly are patients who fall more on what we would call the medical maximizer end of the spectrum, there are many patients that would prefer to minimize tests and treatments and are happy to hear that that's an option for them.

Eric Olsen:

You had mentioned the payers, healthcare insurance industry, and I'm curious as to where they stand on a lot of this. It seems like they would probably be for de-implementation as a general rule because it would mean less cost for them. But I'm wondering how they manage the patient care aspect of this. How does that process work? Are you in conversation with them?

Lesly Dossett:

I would say through the nature of my work, there's been a few times where I've been asked to consult or comment on various payment policies. I think in general, the insurers tend to be pretty conservative. And they want to ... I do believe some physicians may disagree, but I do believe that the payers generally want to leave the autonomy in the hands of the clinician. So in areas where the evidence is not clear, we don't have any trouble getting tests paid, covered, particularly in the area I work in. In oncology, we tend to not face a lot of difficulty with coverage.

On the other hand, areas where there is really strong evidence that things are not of value, I think you do see them make decisions to not provide benefit in those areas. Some examples would be whole-body staging for early-stage cancers. It can be quite difficult to get those unnecessary tests covered. When we think about strategies for de-implementation, one strategy that the payers use is to make it difficult to get things approved. And so prior authorizations or criteria for use are strategies that the payers would use to facilitate de-implementation.

Eric Olsen:

Interesting. I never thought about it that way, but that does make a lot of sense. I've heard, just anecdotally, from many people about ... Well, my insurance isn't going to cover this, so we're just not going to do that. And that would be an example of that, basically. Okay.

Lesly Dossett:

And just to expand on that example, as a specialist, I hardly ever have any problems with pre-authorization. All the things that I recommend are pretty easily covered because I'm practicing to the evidence. Whereas if you saw, for example, maybe a primary care provider who sees a new patient with

a early-stage breast cancer, if they don't have the expertise, they may think, "Oh, I'm going to order a PET scan on this patient." The insurance company's not going to pay for it because they know, the insurance company knows, that it's not indicated for that stage of the disease. So that would be an area where they could help facilitate or help prevent overtreatment in those situations.

Eric Olsen:

Is there anything else that we missed? Anything that you wanted to bring up?

Lesly Dossett:

I've talked a little bit about the pre-operative testing. We've also done work in cancer. And I think cancer is an area where de-implementation is a little bit more difficult because of the nature of the diagnosis. But again, I think there's a growing body of evidence of ... Due to advances in screening, we're detecting many very early-stage cancers, some of which might never need to be treated that we could safely observe, but we tend to treat them the same way that we would treat a higher-grade, more aggressive tumor.

And what we're learning through clinical trials and other types of studies is that there are often situations where we can do less. And we're working on making sure that we tailor the amount of treatment to an individual patient. And I think it's an area where, because of the fear of cancer recurrence, we have a lot more work to do in terms of convincing and educating and informing patients that that approach yields the same long-term cancer outcome, while saving them potential side effects and toxicities from treatments.

Eric Olsen:

And would that be simply a situation where you're kind of managing their expectations regarding recurrence, i.e. more testing is not going to prevent recurrence potentially, and this is a possibility?

Lesly Dossett:

Yeah, correct. So one of the areas we've studied this the most is in older patients with early-stage breast cancer. We know from clinical trials that older women, postmenopausal women, with breast cancer tend to have a type of cancer that is just less aggressive than what we see in younger women. They have less likelihood for the cancer to spread the lymph nodes. They have overall very favorable prognosis from their breast cancer.

And what we've found through a series of clinical trials over the last 10 to 15 years is that those patients ... That we don't need to employ all the same aggressive treatments that we would give to younger women in order to achieve the same benefit. So for example, in many patients, we can omit or not do radiation that we might do in a younger woman. We might be able to omit or not do chemotherapy in a lot of patients that we might recommend in younger women. And that's not because we think they're older and they can't tolerate the treatment. It's because their tumor and their tumor biology is different, and that they don't need that additional treatment to have this excellent long-term outcome.

And so again, with proper education of not just the patients, but making sure that we're disseminating that information beyond the specialist practicing at the academic medical center that has a narrow practice and can keep up with all these nuances, to the general practitioner that's out in the community that might only take care of a couple of cancer patients in a year, to make sure that they're

understanding also those nuances and areas where we can safely de-implement treatment and achieve the same excellent outcomes.

Eric Olsen:

This sounds very much like it fits nicely with a very patient-specific, more personalized approach to healthcare, that it just dovetails nicely into that.

Lesly Dossett:

Yeah, I think that's true. And I think that can be a tendency in medicine to time shift a little bit into a paternalistic-type model where we feel like we need to tell the patient what to do. And certainly, there are some patients that prefer that approach. They want us to give them a recommendation. But I think with generational changes and as our patients have a lot more access to information and choices and decision-making, that by offering them a range of options, which includes a more minimalistic approach that might de-implement previously routine practices, if we can inform them on the risk profile of that, oftentimes they'll make decisions that are best for them and most align with their values that we might not choose for ourselves.

For example, I gave you an example of radiation. We might recommend radiation if it reduces a patient's risk of recurrence from 15% to 10%. Well, some patients might think that that's an important benefit and would opt for that treatment, whereas other patients may look at those odds and choose not to pursue it. And I think as we counsel patients and clearly outline the choices and the trade-offs of all those options, then that's when we really moved towards patient-centered care.

Eric Olsen:

How did you discover de-implementation? And what was it that drew you to it in the first place? What excited you about that?

Lesly Dossett:

I think it's one of those areas that just really resonates and aligns with my underlying personality, which I think is very important as an investigator, when you find something that's just true to your core. I think I tend to be a minimalist patient, myself personally. I tend to be a minimalist clinician. I've always ... When I'm taking care of patients in the hospital, are there blood tests or medications that aren't needed that we can avoid?

But what really got me interested in this topic of de-implementation formally was really my exposure to the Choosing Wisely campaign, and in particular, reading the recommendations that came from some of the specialty organizations that I'm a part of. For example, several of the breast cancer organizations, the surgical breast cancer organizations, had put forward not just blood test or x-rays that they recommended de-implementation of, but actually surgical procedures. So there were four surgical procedures that were put forward as being identified as low value.

And what I knew, being a clinician in the space and taking care of patients, was that of those four practices, two of them we had really stopped doing completely. You weren't seeing those procedures offered. Conversely, the other two procedures were still very commonly performed and practiced, not just here at Michigan Medicine, but we had data from the state and the region and even nationally that demonstrated really high and persistent use of these procedures. And I was just very much fascinated by this concept of why would we, as surgeons, have stopped doing two of the procedures and not the

others? And thinking about what are the behavioral factors and considerations that were leading to those differences.

Eric Olsen:

Where does de-implementation stand as a larger effort in the US health system?

Lesly Dossett:

I think it is something that was definitely of a high level of importance nationally through efforts, for example, through the National Institute of Health, prioritizing research around de-implementation. It was, I would say, growing a lot in popularity and really almost even the hot topic right as the COVID pandemic hit. And so I would say obviously a lot of attention during COVID and afterwards shifted the focus a little bit away from value temporarily, but I think now, as we've made it through the pandemic and there's some focus on other topics, I think the concept of value and de-implementation is becoming increasingly important.

Several areas where I think we see this being pushed is actually by employers, interestingly enough. If you look at employers and then ... Major employers here in Michigan, obviously we have several large employers in the auto industry. And if you look at these employers, the amount of money that they are spending to insure their employees, it continues to go up. And so focusing on value, focusing on the healthcare spending is important for those reasons.

I think also, as we look at the federal level, the federal government is the biggest healthcare consumer, is that when we look at federal spending and how much we spend on healthcare, all the dollars compete with other sectors of society. So every dollar that we spend in healthcare is a dollar that can't be spent in infrastructure or education or housing, et cetera. And so I think we have a responsibility as clinicians to be good stewards of the resources that are allocated to healthcare. And healthcare in the US is extremely expensive and it's multifactorial. Low-value care and waste is a section of that. It doesn't account for all of the high spending as compared to other similar countries, but there is a substantial proportion of healthcare spending in healthcare that's due to waste. And I think it's an area where we have a responsibility to work on reducing.

Eric Olsen:

You had mentioned healthcare costs, and some would even describe them as soaring healthcare costs. This has been identified throughout the media and throughout healthcare as a significant issue. Do you feel that this is a significant driver toward the de-implementation process, possibly outweighing some of the other factors that you had mentioned?

Lesly Dossett:

I think certainly cost consideration is a driver towards value and de-implementation. I would say that it's on par with a growing interest of ... Again, I mentioned patients who are interested in a more minimalistic approach. I think we've seen, as a society, a lot more skepticism about what physicians would recommend and are those truly necessary recommendations. And so I think it would be a combination of skepticism by patients as well as cost.

One interesting thing we found in our work is that a lot of people ask me, "Well, how are you going to convince clinicians to stop doing things when they're paid?" Their reimbursement, it tends to be based on how much you do or what we call fee for service. What's interesting is that there is a fair amount,

really equal amounts, of low-value care present in healthcare systems where physicians are salaried and not incentivized by productivity.

For example, in the VA system, those clinicians are on a salary model. They aren't on a fee for service model. And yet, even though they're not getting additional reimbursement for ordering extra tests and treatments, they still order those things really at comparable rates to clinicians that are in fee for service models.

Kaiser Permanente is another example of a salaried model for clinicians, that they also have issues with low-value care. So it's an interesting observation that it's not just financial incentives. I think financial incentives play a role in some situations, but it's not the only factor because we do still see low-value care in those non-fee for service models.

Eric Olsen:

So you might attribute that to just ... This is the way that we've always done a lot of this stuff. It just has become routinized as the standard of-

Lesly Dossett:

Right. It's how I was trained. It's what my partners do. Habit, to a large degree.

Eric Olsen:

Thank you for joining us today. My name is Eric Olsen for the Rogel Cancer Center at University of Michigan Health.

Scott Redding:

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