

Virtual Mentor

Ethics Journal of the American Medical Association
March 2006, Volume 8, Number 3: 150-153.

Journal Discussion

A Better IDEA for Communicating With Patients about Costs

by Richard M. Frankel, PhD, and Terry Stein, MD

Piette JD, Heisler M, Wagner TH. Cost-related medication underuse: do patients with chronic illnesses tell their physicians? *Arch Intern Med.* 2004;164:1749-1755.

The 2004 article by Piette, Heisler, and Wagner entitled, “Cost-Related Medication Underuse: Do Patients with Chronic Illnesses Tell Their Doctors?” raises a number of important questions about the cost of treatment and the patient-physician relationship. When is it appropriate to talk with patients about their ability to pay for medical treatments? Who should raise the issue, the physician or the patient? Are there more and less effective ways of asking and disclosing information about ability to pay for medical treatment?

Piette and colleagues’ study was based on a nationwide survey of 660 adults with chronic diseases who reported underusing medication in the prior year due to cost. The investigators found that two thirds of the study subjects did not talk with their physician about their intention to cut down on medication use due to cost and no one had ever asked the majority of these patients about the effects of medication costs. Nearly a third of the patients reported that, when they did raise the topic with clinicians, the discussion did not result in changes to their drug regimen. In other words, doctors do not usually respond to the problem of high prescription cost by using generic drugs or changing to a lower cost treatment [\[1\]](#).

Despite the infrequency of conversations about cost of care, this study confirms previous findings that most patients (63 percent) and physicians (79 percent) would like to discuss drug costs but are hindered by barriers that include discomfort with the topic, insufficient time, and doubts of finding viable solutions [\[2, 3\]](#). Studies have also shown that increased costs to patients resulted in reduced use of such medications as nonsteroidal anti-inflammatory drugs, antihistamines, antihypertensives, antidepressants, and antihyperlipidemics [\[4, 5\]](#).

Piette and co-investigators did find that a trusting patient-physician relationship seemed to moderate medication nonadherence that was due to financial pressures and further suggested that improving communication could influence the choices patients make in response to increased cost-sharing [\[6\]](#).

Based on the findings in the Piette and colleagues study we propose the mnemonic IDEA to assist clinicians in proactively discussing costs with patients. IDEA stands for **inquire, discuss, educate, act**.

Inquire: Physicians should introduce the cost-of-care topic routinely by saying, for example, “Many patients find it hard to afford their medication. Is this a problem for you?” or “I know that there is a copay for this test. Will the cost make it difficult for you to get the test?” Empathic responses such as “Sounds like paying for this medicine (or test) will be a real hardship for you right now” can diminish embarrassment [7].

Discuss: Explain clinical recommendations to the patient using simple language and briefly review the rationale, evidence, risks, benefits, and side effects. Explore possible treatment alternatives and then elicit the patient’s concerns and preferences. Shared decision making has been shown to increase adherence, decrease patient anxiety, and improve patient satisfaction and health outcomes [8].

Educate: Confirm the patient’s understanding of the diagnosis and treatment by saying something like, “I want to make sure I’ve been clear about the options. Can you tell me what you would tell a family member or friend about what we’ve discussed?”

Act: Decide together on the best course of action. Adjusting medications may mean changing to a less costly alternative, splitting pills, stopping unnecessary or marginally beneficial medication, referring the patient to the business office, or suggesting Internet sites for discount drug prices. In Piette’s study, patients were most likely to find those clinicians helpful who offered specific solutions [1].

Vignette 1: Jake Goodwin is an 82-year-old retiree who has lived alone since his wife died. Mr Goodwin receives Social Security payments and a small pension. He is being treated for chronic obstructive pulmonary disease (COPD) by Fred Isaacs, a primary care physician. Mr Goodwin uses a long-acting bronchodilator but has recently complained of increased difficulty in breathing. He neglects to tell Dr Isaacs that he is not using the inhaler as prescribed so that it will last longer.

Using our mnemonic, let’s try to improve upon the clinical encounter.

Inquire: “Mr Goodwin, many of my patients have a tough time paying for all of their medicines. Has the cost of your inhaler been a problem for you?”

Discuss: When Mr Goodwin answers, “Well, not really. As long as I only use it when I really need it, I only have to refill it every couple of months and I can afford that,” Dr Issacs and Mr Goodwin can talk about the connection between his subtherapeutic dose and his increased difficulty in breathing and explore why Mr Goodwin’s “rationing” might make him feel worse.

Educate: “So Mr Goodwin, I want to make sure that I’ve been clear about how to use the inhaler so that it helps you breathe better all or most of the time. Can you tell me what you understand?”

“You’re saying that the reason my breathing isn’t as good as it used to be is because I often skip using the inhaler.”

“Right. So how about if we talk about options that will help you afford refilling the prescription for the inhaler more regularly?”

Act: Dr Isaacs may not be able to change the therapeutic regimen but he might be able to offer some financial resources. “Our business office has some information about financial assistance.”

Vignette 2: Isabel Morales is a 54-year-old paralegal with intermittent dyspepsia, which usually responds to Cimetidine. Over the past month Ms Morales has gone to the acute care clinic twice for gastric distress. On the second visit triple therapy for *H. pylori* was prescribed. When asked during follow-up by Joanna Slavin, an internist, what might be causing the flare-up of her symptoms, Ms Morales says simply, “I’ve been under a lot of stress lately.” Ms Morales does not mention that much of her stress is related to the implementation of her employer’s new health plan which may not cover all of her medical needs. Dr Slavin’s diagnosis is “exacerbation of dyspepsia due to stress.” She recommends a stress reduction program and reassures Ms Morales that the recent medication should relieve her symptoms.

Vignette 2 represents another familiar problem in primary care practice. In this case, a patient with an exacerbation of a chronic condition serious enough to require several visits over a short period states to her physician that she is “under a lot of stress.” Since stress can exacerbate this and many other conditions, it might seem reasonable to encourage the patient to find ways to reduce stress and perhaps even begin a course of low-dose anti-anxiety medication.

If Dr Slavin had taken the time to explore the meaning of Ms Morales’ simple statement by using an open ended comment such as, “Tell me more about your stress,” “Go on,” or “I see,” or if she had repeated “a lot of stress?” she probably would have discovered Ms Morales’s dilemma. If the patient felt embarrassed about her situation, Dr Slavin might have had to **inquire** further by saying, “I know that the medications you were prescribed are pretty expensive. Has the cost added to your other stresses?” She then could have proceeded to **discuss** the pros and cons of alternative treatments, **educate** Ms Morales about the relationship between stress and symptoms, and **act** as an advocate for her by suggesting lower cost options.

The key component in both vignettes is having a low threshold for inquiring about cost concerns. Proactive asking requires curiosity, lack of assumptions, and a recognition that the time required for the discussion will pay off in higher trust and greater adherence. As Alex Federman states in his editorial accompanying the Piette article, “In regard to health care costs, when doctors don’t ask and patients don’t tell, opportunities to help are missed and patients remain at risk for underusing medications and services” [9]. We offer the IDEA approach as a guide to help busy clinicians initiate this important conversation.

References

1. Piette J, Heisler M, Wagner TH. Cost-related medication underuse: do patients with chronic illnesses tell their physicians? *Arch Intern Med.* 2004;164:1749-1755.
2. Alexander GC, Casalino LP, Meltzer DO. Patient-physician communication about out-of-pocket costs. *JAMA.* 2003;290:953-958.
3. Alexander GC, Casalino LP, Tseng CW, McFadden D, Meltzer DO. Barriers to patient-physician communication about out-of-pocket costs. *J Gen Intern Med.* 2004;19:856-860.
4. Wilson IB, Rogers WH, Chang H, Safran DG. Cost-related skipping of medications and other treatments among Medicare beneficiaries between 1998 and 2000. *J Gen Intern Med.* 2005;20:715-720.
5. Goldman DP, Joyce GF, Escarce JJ, et al. Pharmacy benefits and the use of drugs by the chronically ill. *JAMA.* 2004;291:2344-2350.
6. Piette JD, Heisler M, Krein S, Kerr EA. The role of patient-physician trust in moderating medication nonadherence due to cost pressures. *Arch Intern Med.* 2005;165:1749-1755.
7. Hardee JT, Platt FW, Kasper IK. Discussing health care costs with patients: an opportunity for empathic communication. *J Gen Intern Med.* 2005;20:666-669.
8. White MK, Keller V, Horrigan LA. Beyond informed consent: the shared decision making process. *Journal of Clinical Outcomes Management.* 2003;10:323-328.
9. Federman AD. Don't ask, don't tell: the status of doctor-patient communication about health care costs. *Arch Intern Med.* 2004;164:1723-1724.

Richard M. Frankel, PhD, is a professor of medicine and geriatrics and a senior research scientist at the Regenstrief Institute, at Indiana University School of Medicine. Dr Frankel is also a senior scientist in the Center on Implementing Evidence Based Practice at the Richard L. Roudebush Veterans Administration Medical Center.

Terry Stein, MD, is a general internist who is the director of clinician-patient communication for The Permanente Medical Group in the Northern California region of Kaiser Permanente. In this role she develops and delivers programs to enhance the interpersonal skills of the nearly 6000 physicians across the area.

Related Articles

[A Crash Course? What Happens When a Patient's Medical and Economic Best Interests Collide?](#), March 2006

[Educating Trainees about the Cost of Medications](#), March 2006

[Splitting the Difference—Patient Preference vs Conservation of Resources](#), June 2004

The viewpoints expressed on this site are those of the authors and do not necessarily reflect the views and policies of the AMA.

Copyright 2006 American Medical Association. All rights reserved.