

Encounter decision aids can prompt breast cancer surgery cost discussions: Analysis of recorded consultations

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ABSTRACT

Background: Patients are typically very concerned about care costs, but clinicians seldom cover the topic. Information about treatment costs are not typically included in patient decision aids (DAs). We examined whether including cost information in an encounter DA, with clinician training, influenced cost conversations.

Methods: As part of a larger trial, 14 surgeons from 4 cancer centers were randomized to 1 of 3 interventions: (1) Picture Option Grid™ DA that included a prompt to discuss relative treatment costs, hereafter called “cost prompt group”; (2) a text-only Option Grid™ DA that did not prompt cost discussions; (3) usual care. Groups 2 and 3 hereafter are referred to as “non-cost prompt groups.” Adult (18+) female patients, with stages I-IIIa breast cancer, eligible for both lumpectomy and mastectomy were included in the trial. We gave surgeons feedback about how well they adhered to the study protocol at 3, 6, and 12-months. We adapted a checklist to code the content of the audio-recorded clinical encounters.

Results: 424/622 (68%) patients consented and 311 (73%) were eligible and successfully recorded (143 in the cost prompt group, 168 in the non-cost prompt groups). Costs were discussed in 132/311 (42.4%) encounters, and occurred more often in the cost prompt group versus non-cost prompt groups (72.6% versus 33.3%; $p < .001$). Surgeons initiated the cost discussion in 86.4% of encounters in the cost prompt group vs. 34.1% in the non-cost prompt groups ($p < 0.001$). In the non-cost prompt groups, insurance or employment questions prompted patients to ask about costs. Cost discussions lasted about 34 seconds when present and had sparse comparative details.

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Conclusions: Encounter DAs containing cost information trigger cost discussions. Additional support should help clinicians improve the quality of cost discussions and address financial distress.

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Introduction

Despite patients' overwhelming concerns about costs of cancer care, clinicians often miss opportunities to discuss treatment costs with them.^{1,2} Although costs often impact cancer patients' treatment decisions,³ particularly when treatments lead to similar health outcomes,⁴ costs are not often included in patient decision aids or patient education materials.⁵ There is limited research exploring whether interventions can improve the frequency and quality of patient-clinician cost discussions.

Cancer patients often pay substantial out-of-pocket costs for care, with some spending as much as 10-20% of their annual income on healthcare expenses.^{6,7} The financial burden associated with cancer affects both uninsured and insured patients because insurance plans increasingly have high deductibles and copayments.⁸ Some new therapies cost thousands of dollars per month, of which a substantial portion can fall on patients.⁴ In a recent study of 9.5 million cancer patients, more than 40% depleted their savings and assets within two years of being diagnosed.⁹ This financial hardship and the psychological distress associated with high costs of cancer care is often called financial toxicity.³ Financial toxicity may result in medication non-adherence, poorer quality of life,^{10,11} delay or avoidance of needed care,¹²⁻¹⁶ and even increased mortality.¹⁷

As a result, major organizations such as the National Academy of Medicine, the American Society of Clinical Oncology and the National Comprehensive Cancer Network call for research and system-wide policy changes at the clinician, hospital, and insurance level to reduce financial toxicity. Specifically, they suggest that clinicians discuss cancer treatment costs with patients, while working to reduce the burden of care costs at the system level.⁴ Similarly, many scholars encourage patient-clinician discussions of the relative costs of medically-

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appropriate treatment options¹⁸ as part of shared decision making. Patients often want cost information as part of shared decision making, even if it does not impact decisions¹⁹. Discussing out-of-pocket expenses with patients can lower their costs without impacting their cancer outcomes.²⁰

Unfortunately, clinicians often feel inadequately trained to have cost conversations. Although many agree that cost discussions are important, only about 25% of clinicians feel prepared to discuss costs with patients.¹ Clinicians often hesitate to address costs of care without knowing the exact out-of-pocket burden of options¹, especially because costs can vary considerably for different patients.²¹ In one study of breast cancer patients, the majority of patients who worried about the high costs of cancer care reported that their clinicians and staff did not talk about costs or help with their financial concerns.² Thus the burden of initiating cost discussions often falls on patients, but patients worry that bringing up financial concerns will lead physicians to provide lower quality care or biased recommendations.²²

This study examined the frequency, duration and content of cost discussions between breast surgeons and early-stage breast cancer patients as they discussed a preference-sensitive surgery decision (lumpectomy + radiation versus mastectomy) with equivalent cancer outcomes. Although overall costs are similar across options, one option (mastectomy) can have higher up-front costs, while the other option (lumpectomy + radiation) can have lower up-front costs with costs building over time.^{23,24} This study also investigated whether an encounter decision aid (a decision aid designed to be used during a consultation, rather than as a patient preparation tool) containing comparative cost information about surgery options influenced cost conversations during surgeon-patient consultations. We hypothesized that a prompt from an encounter decision aid would result in more cost conversations, and that surgeons would be more likely than patients

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to initiate cost conversations when they used an encounter decision aid containing a cost prompt. We also hypothesized that costs would be discussed more often with uninsured or underinsured patients. Finally, we hypothesized that cost conversations would not impact surgery choice for this preference-sensitive early-stage breast cancer surgery decision.

Methods

Data source

We evaluated data from a randomized trial comparing two Option Grid™ encounter decision aids about breast cancer surgery choices to usual care (see published protocol).²⁵ Surgeons were randomized (using stratified randomization to ensure balance by study arm per site) to use one of three methods of communicating about early-stage breast cancer surgery choices: (1) a Picture Option Grid™ with simple text and pictures that includes a prompt to discuss costs, (2) a text-only Option Grid™ without cost information, or (3) usual care. The interventions are both paper-based and range from one to four pages in length. Both are written at a 6th grade reading level, and are designed to be used by a surgeon during a surgical consultation. Both were developed, tested, and validated using a systematic process. Appendix A displays screenshots of each grid, and more details about their development process can be found in published work²⁶⁻³¹. The text-only Option Grid™ was developed in the UK with stakeholder input, and in that region, stakeholders did not mention cost as a key factor impacting choices. The study team kept the original grid for this study given its development process. The Picture Option Grid™ was developed in the US, specifically for women with lower socioeconomic status, and in that group, stakeholders requested that cost be included in the tool²⁶⁻³¹. Because the DAs focus on primary treatment for early-stage breast cancer (mastectomy vs. lumpectomy plus

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radiation), details (including costs) about breast reconstruction, chemotherapy, genetic testing, or other interventions are not explicitly included in either DA.

Surgeons were trained according to study protocol in a one-hour session in person or by phone. Training addressed: (1) the study aims and flow (2) specific details about their arm assignment, and (3) a mock patient simulation so that the surgeon could practice using the Picture Option Grid™ or Option Grid™, if assigned to one of those arms. Surgeons assigned to the Picture Option Grid™ were encouraged to mention cost as one factor that is important to patients considering treatment options as part of using the grid. For primary surgery, one surgery (mastectomy) can have higher upfront costs, while the other (lumpectomy) can have more costs over time from radiation therapy.

Surgeon-patient encounters were audio-recorded with surgeon's verbal consent at the start of the study and patients' written consent at the time of recruitment. The study was approved by Dartmouth College's Committee for the Protection of Human Subjects (STUDY00030157), Washington University in St. Louis' Institutional Review Board (201704011), and New York University's Institutional Review Board (i17-00871) (the fourth institution agreed to rely on Dartmouth's Committee for the Protection of Human Subjects). The trial is registered on clinicaltrials.gov (NCT03136367). This analysis was approved by the Clinical Trials Office at Dartmouth College and is included in the modified protocol.

Cooper's framework for designing and evaluating interventions to reduce health disparities informed our study design.³² This framework proposes that interpersonal and communication barriers (including involvement in treatment discussions) and financial barriers influence treatment choices, adherence, health, well-being, and overall care experience. This analysis focuses on the role of cost discussions in surgery decisions.

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Study population

Participants were recruited from four large cancer centers in the Northeast, mid-Atlantic, and Midwest regions of the U.S. Patients were eligible if they were over 18 years old, assigned female at birth, had a confirmed diagnosis (via biopsy) of stages I-IIIa breast cancer, eligible for both lumpectomy + radiation and mastectomy based on medical records and clinician's perception, and spoke English, Spanish, or Mandarin Chinese. Patients were excluded if they were assigned male at birth, had undergone prophylactic mastectomy, had inflammatory breast cancer, or had a disability that would compromise their ability to consent or participate. Surgeons were included if they were an attending physician and performed breast surgery.

Procedure

Research staff put recorders in exam rooms during all surgeon-patient encounters. They turned on the recorder if the patient consented to recording. To reduce the impact of recording on surgeon behavior, the recording light was covered. Audio files were transcribed verbatim. For those whose primary language was Spanish or Mandarin (n=18), there were translators present during the consultations, and the English portion of encounters were translated in the written and reviewed transcripts. At the start of the study and at the planned interim check of fidelity to the intervention at 3, 6, and 12 months into recruitment, surgeons were encouraged to cover all aspects of the Option Grid™ to which they were assigned, if they were in one of the study intervention groups. Surgery choice was collected from the medical record after treatment.

Statistical analysis

We adapted a previously published checklist to analyze cost discussions^{22,33}; Appendix B. There was one question that asked about whether costs were discussed (yes/no) during the

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consultation. We used Hunter et al.'s approach to defining a cost conversation: "any mention of the patient's out-of-pocket expenses or insurance coverage for a past, present, or potential health care service."²² For example, any mention of costs or insurance coverage for primary surgery, reconstruction, chemotherapy, radiation, genetic testing, imaging, as well as indirect costs of care such as time off work, transportation, recovery time, were documented and included in our analyses. If direct or indirect costs were mentioned per Hunter's definition, we coded the item on the checklist "yes" to indicate that cost was discussed during the consultation. If costs were discussed at all, the subsequent items (length of time of the cost conversation, number of times cost was discussed, who initiated the cost discussion, content of cost discussions) were then evaluated. If there were two mentions of cost in one transcript, with a different topic in between, that was coded as two cost discussions. Three researchers piloted the checklist independently using two encounter recordings containing cost discussions. The study team reviewed discrepancies and revised the checklist to clarify ambiguity, add reference to the Option GridsTM, and add "not applicable" when appropriate. We analyzed groups based on whether or not there was a cost prompt present. Hereafter, the Picture Option GridTM group is referred to as the "cost prompt group," while the other groups are referred to as the "non-cost prompt groups."

Two researchers (NK and SG) were trained to use the checklist and piloted it with a subsample of 24 encounters to calculate kappa and percent agreement. After kappa reached at least 0.75 and agreement was at least 90%, one of those researchers coded the remaining recordings independently. A third coder (MP) randomly checked 20% of recordings to ensure coding consistency. Coders used a combination of audio and transcription files, reviewing audio files for clarity and/or when transcripts were not available.

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We analyzed data using Stata 14. We used descriptive statistics to generate a summary of the checklist data. Our primary outcome was whether or not surgeons and patients discussed costs during the encounter. Our secondary outcomes included the content of cost discussions (breast cancer surgery costs, other care costs, other patient costs), the cost conversation initiator (surgeon, patient) and the length of the cost conversation(s) per encounter (in seconds). We documented the number of times cost was mentioned (0, 1, 2, 3+) and whether a referral to another member of the care team had been made to address cost.

We conducted chi-square analyses to explore whether the presence of cost discussions varied by: 1) group (cost prompt vs. non-cost prompt groups); 2) insurance status (public [Medicaid, Medicare without supplemental] + uninsured versus private [employer-sponsored, union-sponsored, Tricare]). We grouped the four uninsured individuals with those with public insurance due to small cell sizes; and 3) surgical choice (mastectomy v. lumpectomy, as documented in patients' electronic health records, where available, n=275).

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Results

Participants

Between September 2017 and February 2019, we screened 2,057 patient records. Of those, 818 patients were eligible and approached about the trial, and 622 consented to participate (76.0% consent rate of those approached). Fifty-four patients were not eligible to participate after consenting because their surgeon indicated they were not candidates for both surgery options

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(based on new imaging or other findings that emerged after consent). In addition, 424/622 consented to have their consultation audio-recorded (68.2%); 113 of those consultations were not recorded because they were found to be ineligible for the study upon meeting with the surgeon, or the recorder did not record properly. Sixteen surgeons were approached about the larger study; all 16 agreed to participate (100% participation rate) and have consultations audio-recorded. Fourteen of them had audio-recorded encounters available for analysis (two did not have encounters recorded due to lower patient volume and/or consent procedures at their respective site occurring after the encounter began).

Patients were 60 years of age on average. Most were White (238/311, 76.5%) and non-Hispanic (271/311, 87.1%). Only 109 (35.1%) had a 4-year college degree. Surgeons were mostly female (12/14; 84.6%) and located across seven clinics at the four participating medical centers. Table 1 displays descriptive characteristics of the patient and surgeon participants.

Cost Discussions

Fewer than half (132/311; 42.4%) of surgeon-patient encounters included cost discussions. Most cost discussions occurred in the cost prompt group versus non-cost prompt groups (N=88/132; 66.7% versus N=44/132; 33.3%; $\chi^2=39.5$, $p<.001$). When cost was discussed, surgeons initiated the discussion more often than patients (N=91/132, 68.9% versus N=41/132, 31.1%; $\chi^2=37.4$ $p<.001$). Cost was mentioned more than once in 31.8% (n=42/132) encounters (range 2-7 times). Cost conversations lasted for an average of 34 seconds when they occurred (range 2 seconds to 4 minutes, 56 seconds), averaging 29 seconds in the cost prompt group compared to 46 seconds in the non-cost prompt groups ($t=-2.00$, $p=0.041$).

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The DA with a cost prompt directly triggered cost discussions about early-stage breast cancer surgery. Most encounters in that group included a discussion of early-stage breast cancer surgery costs, prompted by the aid (63/88 encounters; 71.6%). In the non-cost prompt groups, early-stage breast cancer surgery costs were rarely discussed (9/44 encounters; 20.5%); insurance coverage for costs of imaging, genetic testing, radiation, reconstruction, or time off work were discussed, when cost was discussed at all (39/44 encounters; 88.6%). These non-surgery costs were also discussed in the cost prompt group group in 39/88 encounters (44.3%). Table 2 summarizes these results. Table 3 displays examples of cost conversations.

There was a statistically significant relationship between the presence of a cost discussion and insurance status ($X^2=4.52$, $p=.033$); those with private insurance were more likely to have a cost conversation than those with government-sponsored insurance or no insurance. There was no relationship between cost discussions and surgery choice documented in the medical record ($X^2=1.48$, $p=.224$).

Surgeons only referred patients to other members of the care team in 17.4% (23/132) of encounters where there was a cost discussion, and only at one participating cancer center. Cost-saving strategies or changes to the care plan were discussed in 12.1% (16/132) of encounters, including strategies to avoid missed days of work (n=6), hospital assistance (n=3), obtaining preauthorization (n=3), lower cost therapy (n=3), and discount programs (n=1).

Discussion

An encounter decision aid that included information about early-stage breast cancer surgery costs prompted surgeons to address relative treatment costs with patients. Surgeons were far more likely to talk about the relative costs of breast cancer surgery treatments when using a

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DA containing a cost prompt. The DA directly triggered these discussions in about 72% of encounters, whereas patients often initiated discussions in the other study groups by asking questions about insurance coverage for non-surgical tests or treatments and time off work.

Despite the promising effects of the decision aid and surgeon training in using it, some surgeons in the cost prompt group skipped the cost section of the decision aid. At the start of the study and during interim checks of fidelity to the interventions, investigators encouraged surgeons randomized to that study group to discuss each aspect of the grid. Yet some continued to discuss all other aspects of treatment decisions, except for cost. Given evidence that patients are concerned about the high costs of cancer care, and that the majority of patients want this information addressed during clinical consultations, findings highlight the importance of additional support for healthcare clinicians in discussing treatment costs. Findings also suggest that patient-directed interventions to improve cost transparency about cancer treatment may be needed, given that cost conversations were longer and perhaps more responsive to patient concerns in the non-prompted groups. Clinicians, when given a prompt, might mention costs to adhere to a suggested guideline without fully addressing details that patients might want when weighing treatment decisions.

There are many reasons that surgeons might omit cost discussions from surgeon-patient discussions, especially without a direct prompt or training. Surgeons could worry that cost conversations might add time to already time-pressured visits. However, in consultations that did address costs, discussions only lasted about 35 seconds on average, as part of overall discussions of treatment options. Some surgeons used one sentence to highlight the relative costs across surgery options. For instance, using the prompt, many surgeons stated, "*And how much does it*

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cost? The surgeries cost about the same." Addressing costs is feasible in this context to start the conversation and normalize cost discussions as part of routine care.

Many surgeons might feel specific cost discussions are outside of their expertise²¹ and that others such as social workers, patient care coordinators, or nurses address costs with patients. In our study, the intervention and training only suggested that surgeons mention that costs are approximately equivalent between options for early-stage breast cancer. Knowledge about precise costs was not required to engage in a cost conversation. Discussing relative costs of treatment using short sentences is a start to address cost in conversations, but does not inform patients about their potential out-of-pocket cost burden. Similarly, knowing that "insurance covers treatment," another commonly stated phrase in our study, does not help patients understand their potential expenses which can vary substantially across insurance plans. This variation could explain why those with private insurance discussed costs more often than those on government-sponsored insurance, since clinicians cannot possibly know each patient's cost-sharing arrangement across the numerous available private insurance plans.

Because clinicians may not have access to reliable information on patients' costs due to varying insurance coverage, other care providers or center resources could better respond to specific cost-related issues. Unfortunately, even when cost was discussed, referrals to other members of the care team such as social workers were only made 6.8% of the time, and only at one of the four centers where recruitment occurred. Cost-saving strategies were rarely addressed with patients in any study arm (8.1% of encounters), despite evidence that patients want both reassurance as well as resources to help offset costs³⁴. It is possible that patients met with social workers or were provided resources before some surgeon consultations, though unlikely since many patients did not have a diagnosis prior to the recorded consultation. We did not

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systematically ask about whether social workers or navigators are routine members of the care team. If they are not routinely incorporated into care plans, results suggest that supportive services to reduce financial burden may be underutilized. For example, in our study, a surgeon mentioning uncertainty about specific MRI costs did not subsequently refer the patient to a resource to find out about her MRI copayment or coinsurance responsibility.

In this study, discussing cost did not change patients' surgery choice. This finding is important for clinicians who might worry that patients will make different--and perhaps suboptimal--choices based on cost alone. In this context, surgery options for early-stage breast cancer were equivalent in terms of health outcomes. Similarly, many other cancer treatment contexts have multiple efficacious options where patients and clinicians can consider patients' out-of-pocket cost burden without compromising care. Patients often want clinicians to address costs, but do not want cost to influence care quality.^{19 34}

The study findings should be interpreted within the context of some limitations. Patient and surgeon consultations were audio-recorded as part of a larger study of interventions to improve decision quality about early-stage breast cancer surgery across socioeconomic strata. Cost discussions are only one piece of the larger decision about surgery choice. We did not conduct an a priori power calculation for this secondary data analysis and descriptive study; future work could specifically design studies to test these hypotheses. Nonetheless, we considered audio-recordings of 311 patient-clinician encounters sufficient to examine our data in this descriptive study. Researchers coded the frequency, duration, and content of cost conversations using a checklist adapted from past work. A deeper thematic analysis could explore the quality of cost discussions and patients' and clinicians' perceptions of these issues, but was beyond the scope of this paper. Although referrals were rarely made to other resources

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or providers, we did not document whether patients met with a navigator or social worker prior to the consultation. Many would not have had the opportunity to do so prior to the surgeon consultation, though, since many were given a diagnosis during or immediately prior to their surgeon appointment. Surgeons were randomized using stratified randomization to ensure balance by study arm per site, rather than by surgeon volume. Surgeons randomized to the one study group (text-only Option Grid) had lower patient volumes than those in other groups due to unexpected events such as a short-term leave, a change in clinical/research balance, and schedule adjustments. The consultations were all from encounters at cancer centers in the U.S. However, studies in other countries with patient cost-sharing models yield similar findings; without training, few clinicians nationally and nationally discuss out-of-pocket costs with patients³⁵. Also, in this situation, costs of options are approximately equivalent over time, and should not impact choice.³⁶ Perhaps some surgeons were unsure about the cost equivalency data, since factors such as complication rates or whether or not a patient chooses to undergo reconstruction could make mastectomy more costly than lumpectomy plus radiation. Or, perhaps surgeons skipped discussing relative costs between surgery options because of their rough equivalence, assuming costs might not impact choice. Nonetheless, it is interesting to observe that even when prompted and trained in a shared decision-making protocol during a randomized trial, some surgeons avoided discussing cost, and cost discussions in the non-prompt groups occurred as rarely as shown in other studies³⁵.

Conclusion

Overall, findings suggest that training clinicians to use encounter decision aids containing cost information can prompt the start of patient-clinician cost conversations. Given that patients want out-of-pocket cost information, even if it does not change care

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recommendations¹⁹, institution policy should guide clinicians in improving the quality of these cost discussions and referring patients to additional financial support services. These actions can help patients better understand costs of cancer care. Additional system-level changes to make care costs more transparent may further facilitate informed decision making among cancer patients.

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Conflict of Interests: Dr. Politi previously had a research contract from Merck & Co on a topic unrelated to this manuscript. Drs Durand and Elwyn were involved in developing the Option Grid™ patient decision aids, which are licensed to EBSCO Health. They receive consulting income from EBSCO Health and may receive royalties in the future. Dr. Durand is also a consultant for ACCESS Community Health Network.

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Table 1. Participant Characteristics (N=311 encounters)

Participants (N=311)	Cost prompt (Picture Option Grid) (n= 143)	No cost prompt (Option Grid + Usual Care) (n=168)	p-value
Age, mean (SD)	59.5 (12.6)	60.4 (11.9)	p>0.05
Race, n (%)			p>0.05
Black or African American	13 (9.1)	21 (12.5)	
Hispanic	20 (14.0)	10 (6.0)	
Asian	3 (2.1)	1 (0.6)	
White	101 (70.6)	128 (76.2)	
Other	2 (1.4)	5 (3.0)	
Prefer not to say/missing	4 (2.8)	3 (1.8)	
Education, n (%)			p>0.05
Less than 4-year degree	88 (61.5)	111 (66.1)	
4-year degree or higher	55 (38.5)	56 (33.3)	
Other/missing	0 (0.0)	1 (0.6)	
Primary language spoken, n (%)*			p=.010
English	124 (86.7)	158 (94.1)	
Spanish	17 (11.9)	7 (4.2)	
Mandarin	2 (1.4)	0 (0.0)	
Other/missing	0 (0.0)	3 (1.8)	
Site, n (%)*			p<.001
Northeast	32 (22.4)	78 (46.4)	
Mid-Atlantic, site 1	38 (26.6)	22 (13.1)	
Mid-Atlantic, site 2	5 (3.5)	7 (4.2)	
Midwest	68 (47.6)	61 (36.3)	
Surgeons (N=14)			p>0.05
Female, n (%)	5 (100.0)	7 (77.8)	

*participants were allowed to select more than one option

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Table 2. Cost Discussion Characteristics (N=311 encounters)

	Cost Prompt Arm (n=143/311)	Non Cost Prompt Arms (n=168/311)	P-value
Cost Discussion Occurred, n (%)*	88/143 (61.5)	44/168 (26.2)	<0.001
Number of times cost was discussed, n (%)*			<0.001
0	55/143 (38.5)	124/168 (73.8)	
1	58/143 (40.6)	32/168 (19.1)	
2	20/143 (14.0)	8/168 (4.8)	
3+ times	10/143 (7.0)	4/168 (2.4)	
Cost discussion initiator, n (%)^			<0.001
Surgeon	76/88 (86.4)	15/44 (34.1)	
Patient or caregiver	12/88 (13.6)	29/44 (65.9)	
Cost conversation content, n (%)^			
Surgery choice (mastectomy v. lumpectomy)	71/88 (80.7)	9/44 (20.5)	<0.001
Other care costs (e.g., tests, imaging, radiation, reconstructive surgery)	34/88 (38.6)	24/44 (54.6)	0.08
Other costs (e.g., transportation, missed work)	15/88 (17.0)	23/44 (52.3)	<0.001
Referral to other member of the care team to discuss costs, n (%)^			0.62
No	74/88 (84.1)	35/44 (79.6)	
Yes	14/88 (15.9)	9/44 (20.)	
Sum length of cost conversations per encounter in seconds, mean (range)^	29 (2-235)	46 (3-296)	0.04

*proportion of all recordings

^proportion of recordings with a cost conversation

Table 3. Examples of cost discussions

Arm	Context	Sample Quotes
Picture Option Grid™ Decision Aid	Surgeons using decision aid to guide discussion about cost and treatment options	“The cost is similar. Insurers tend to be extremely good about covering breast cancer in general so either way.”
		"And how much will it cost? It does not matter with either option."
		“How much will it cost? It’s the same cost. You can’t have cost influence which one you should do.”
		"And how much does it cost? The surgeries cost about the same."
		“The costs end up being quite similar actually. The radiation is expensive, but insurance is excellent with breast cancer...they tend to be really good...so the cost should not factor into the decision."
	Discussing cost of a specific procedure	<p><i>Surgeon:</i> The reason it’s separate [genetic counseling and genetic testing] is it has to go through this program. They have to get the counseling part because it’s I think a \$3,000.00 test so they have to make sure it’s pre-authorized.</p>
		<p><i>Patient:</i> But it’s covered by insurance?</p>
		<p><i>Surgeon:</i> It will be as long as they pre-authorize it. Because some people are like, “Can you just send me the lab now?” No, you can’t. *laughter*</p>
		<p><i>Patient:</i> I will probably meet my out-of-pocket expenses for the year. If I have everything done in the same year, then...</p>
		<p><i>Family Member 1:</i> You should just do it because...</p>
		<p><i>Family Member 2:</i> Regardless.</p>
		<p><i>Patient:</i> I know.</p>
		<p><i>Family member 1:</i> You don’t have to make that decision today.</p>
		<p><i>Patient:</i> Yes, right.</p>
Text-only Option Grid™ Decision Aid	Discussing insurance coverage	<p><i>Patient:</i> Just out of curiosity...with the insurance, obviously because of the cancer in the one breast, that’s deemed necessary. If you...do a double</p>

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[mastectomy] without cancer in other breast, how does the insurance look at that?

Surgeon: So, depends on which insurance you have. Most people [with] anything that's not Medicare or Medicaid have no problems with that.

Patient: Good. We're on [Insurance].

Surgeon: Oh, that's a really good insurance.

Discussing time off work

Patient: "So, Dr. [name], how much work will I still be able to do?"

Surgeon: "You will be able to do quite a bit. What kind of work?"

Patient: "Ok. On Tuesday, Thursday and Saturday, and I'm gonna drop the Saturday shift, I'm at [name of job]. But, then on Monday, Wednesday and Friday I go into the classroom as the teacher..."

Surgeon: "You will be able to do that"

Usual Care

Discussing insurance coverage

Patient: With...the type of insurance unfortunately that I've had to get, is there any reconstruction [covered]?

Surgeon: Yes.

Patient: There is?

Surgeon: Yes.

Discussing time-off work

[discussing radiation]

Patient: Would I be able to go to work with [any of these?]

Surgeon: Yes, it would be the same, right. Either way you could go to work.

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Patient: Okay.

Patient: Do I have to take time off from work like a day or...?

Surgeon: For?

Patient: On the day of surgery, of course.

Surgeon: Yes. Typically, what a lot of patients will do if I operate on Thursday, then they'll go back to work on Monday.
