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Shared Decision Making Has Arrived: Are You Ready?

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A key element in the redesign of the US healthcare system, as described by Porter and Lee, is commitment to a value agenda that focuses on generating outcomes that are important to patients.[1] The transition from volume-based, fee-for-service healthcare to value-based healthcare is driving the use of shared decision making (SDM) in a wide variety of healthcare delivery settings, including hospitals, clinics, community practices, and integrated health networks.

SDM is a collaborative process in which patients and physicians weigh the medical evidence of various options and consider the patient's values and preferences to make healthcare decisions together. Physicians contribute their knowledge of the disease, clinical expertise about treatments, and assessment of medical evidence to the discussion, while patients provide information about their bodies, their circumstances, and their goals for life and healthcare preferences. Together, physicians and patients partner to develop a consensus decision that represents a personalized application of evidence-based medicine.

> ***Shared decision-making*** *is a collaborative process in which patients and physicians make healthcare decisions together, weighing the medical evidence of various options and considering the patient's values and preferences.*

SDM often involves the use of patient decision aids (PtDA)—which may include written materials, computer-based tools, DVDs, or videos—that help patients learn about and evaluate their treatment options as well as articulate their preferences. An explicit guidance element such as a checklist, a step-by-step decision-making process, or worksheets with questions relevant to that process may be embedded in the PtDA to facilitate a self-directed approach. Many settings employ coaching by a trained individual who is supportive but nondirective, thereby enhancing a patient's self-confidence in participating in medical decisions and reducing decisional conflict.[2-5]

The continuum of medical decision-making models is anchored at one end by authoritative decisions made by physicians who direct the care of their patients. In this "paternalistic" model, physicians make recommendations and the patient's role is to say yes or no. Physicians speak *at* rather than *with* patients. At the other end of the continuum lies "informed choice," in which patients make the decisions after physicians provide them the information.[3] Between these two extremes lies shared decision making, representing a partnership between the physician and the patient, with neither party solely responsible for the decision.

Supports for SDM

Most clinicians support SDM in theory and many believe that they apply SDM in their practices. However, surveys and observational studies have revealed a significant gap between physicians' perceived and actual practice of SDM. Clinical training programs for healthcare professionals that teach SDM skills and support the integration of SDM into clinical practice are available. These programs are offered through academic centers, medical schools, the Informed Medical Decisions Foundation (www.informedmedicaldecisions.org/), and integrated health networks that serve as SDM demonstration sites within the High Value Healthcare Collaborative group (highvaluehealthcare.org/).

In parallel, support for patients to participate in SDM has been provided through a number of model programs and initiatives, such as the Dartmouth-Hitchcock Center for Shared Decision Making; Seattle Group Health Cooperative Shared Decision Making Center; University of California, San Francisco, Decision Services Unit; Massachusetts General Hospital Health Decision Sciences Center; and the Mayo Clinic Shared Decision Making National Resource Center. All of these programs incorporate patient decision aids, guidance tools, and coaching staff. In addition, they conduct research to demonstrate the impact of SDM.

Preference-sensitive condition:
A condition with more than one clinically appropriate intervention or management strategy, each with varying benefits and drawbacks, and where the patient's values and preferences should be critical in determining the chosen intervention

Shared decision-making is not applicable to all medical decision making, with an obvious exception being decisions made in the emergency room. However, certain conditions that are considered preference-sensitive are particularly suited for SDM. Preference-sensitive conditions are those that have more than one clinically appropriate intervention or management strategy, each with varying benefits and drawbacks, and where the patient's values and preferences should be critical in determining the chosen intervention. Examples of preference-sensitive conditions include early breast cancer treatment (lumpectomy vs mastectomy), orthopedics (hip and knee osteoarthritis), cardiology (coronary artery disease), urology (prostate cancer), and back care (spinal stenosis and herniated disc).[6]

Legislative influences advancing SDM

Under Section 3506 of the Patient Protection and Affordable Care Act (www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf)—signed into law by President Barack Obama on March 23, 2010—the secretary of the Department of Health and Human Services (DHHS) is required to establish a program that develops, tests, and disseminates certificated patient decision aids. These educational tools help patients and caregivers better understand and communicate their preferences about reasonable treatment options. In addition, shared decision making is a component of delivery system reforms contained in the new Center for Medicare & Medicaid Innovation (innovation.cms.gov/) that was established by the PPACA to test payment and service delivery models. The law also authorizes a shared decision making program to help beneficiaries, in collaboration with their healthcare providers, make more informed treatment decisions that are based on an understanding of available options and each patient's circumstances, beliefs, and preferences.

To engage patients and implement shared decision making, the federal government issued its second-largest innovation grant, $26 million, to a national high-value healthcare collaborative (15 participating health systems) that includes Dartmouth-Hitchcock and Mayo Clinic. The project is expected to save $64 million over 3 years in healthcare utilization costs for patients facing hip, knee, or spine surgery and for patients with diabetes or congestive heart failure.[7] Shared decision making is a quality measure for accountable care organizations in the Medicare Shared Savings Program (www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/index.html?redirect=/sharedsavingsprogram/). The National Committee for Quality Assurance (www.ncqa.org/) includes SDM because Congress authorized it as one of the criteria for patient-centered medical home recognition.[8] The Patient-Centered Outcomes Research Institute (PCORI)—an independent nonprofit, nongovernmental organization located in Washington, DC—was established in 2010 (www.pcori.org). PCORI's mission is to help people make informed healthcare decisions and to improve "healthcare delivery and outcomes by producing and promoting high-integrity, evidence-based information that comes from research guided by patients, caregivers, and the broader healthcare community."[9] In addition to national legislative actions, three states—Maine, Minnesota, and Washington—have passed legislation to support SDM in healthcare delivery.[6, 10]

Challenges to SDM

Shared decision making is not without challenges and obstacles. Physicians are busy and face multiple time pressures, including financial inducement from fee-for-service payment that encourages delivery of more services vs spending time talking with patients, for which they typically are not reimbursed. In addition, the time required to remain up to date on medical information and to meet with representatives from pharmaceutical and device manufacturers is significant. Other interconnected challenges to SDM include:

- Many clinicians do not know how to conduct shared decision making.
- Malpractice liability concerns deter some clinicians because shared decisions that lead to adverse outcomes, even though evidence-based, may conflict with the standard of practice.
- Engaging some patients in SDM can be challenging, eg, patients with low health literacy, multiple chronic conditions, and comorbidities.[10]

Impact of SDM

In a review of 115 studies among 34,444 participants using decision aids, Stacey et al. concluded that when patients use decision aids they: (a) improve their knowledge of the options (high-quality evidence); (b) feel more informed and clearer about what matters most to them (high-quality evidence); (c) have more accurate expectations of possible benefits and risks associated with their options (moderate-quality evidence); and (d) participate more in decision making (moderate-quality evidence). Patients who used decision aids that included an exercise to help them clarify what matters most to them were more likely to reach decisions that were consistent with their own values. However, the quality of the evidence was moderate for this outcome, meaning that further research may change these findings.

Decision aids improve communication between patients and their healthcare practitioners. More detailed decision aids are better than simple decision aids for improving people's knowledge and lowering decisional conflict related to feeling uninformed and unclear about their personal values. Decision aids do not worsen health outcomes and people using them are not less satisfied. Decision aids reduce the number of patients choosing prostate-specific antigen (PSA) testing for prostate cancer screening and elective surgery when patients consider other options.[11]

Those findings were underscored in 2014 when the Seattle-based Group Health Cooperative reported on its use of decision aids in a real-world setting for an orthopedic services group that included 27 surgeons and 15 physician assistants in five specialty clinics. After introducing decision-aid videos for Group Health Cooperative patients with osteoarthritis, researchers found a 38% reduction in knee replacement surgery over a six-month period and a 26% reduction in hip replacement. That translated into a 12% to 21% reduction in costs, depending on the location, for patients with knee and hip osteoarthritis.[12]

What does effective SDM look like and what does it mean in the future? By answering three questions, clinicians can ascertain if effective SDM has occurred:

1. Is the patient informed?
2. Did the patient receive the treatment that best matched his or her goals?
3. Was the patient meaningfully involved in the decision?

If the answer to these questions is yes, then the evidence supports SDM. What does the growth in SDM mean to healthcare stakeholders? Changes in healthcare delivery and payment are coming, and they will probably come quickly. The inflection point in healthcare will occur when value-based healthcare becomes dominant over volume-based healthcare. When this occurs, SDM will become routine practice. The medical culture will need to embrace SDM and make it a routine part of the physician-patient interchange. Patients will need to answer the call to action and become active participants in SDM and employ informed decision making. Hospitals, physician practices, and integrated health networks will need to advance SDM as a component of patient-centered care and population health management. As patients become integral participants in treatment decisions, pharmaceutical manufacturers should prioritize them as key stakeholders and invest in decision support and decision aids that provide fair balanced information concerning treatment options. SDM is not a fleeting concept or a buzzword; it is here to stay and will serve as a vital component of the ongoing healthcare revolution.

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