



Incentivizing shared decision making in the USA – where are we now?



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ABSTRACT

Background: The Affordable Care Act raised significant interest in the process of shared decision making, the role of patient decision aids, and incentivizing their utilization. However, it has not been clear how best to put incentives into practice, and how the implementation of shared decision making and the use of patient decision aids would be measured. Our goal was to review developments and proposals put forward.

Methods: We performed a qualitative document analysis following a pragmatic search of Medline, Google, Google Scholar, Business Source Complete (Ebscohost), and LexisNexis from 2009–2013 using the following key words: “Patient Protection and Affordable Care Act”, “Decision Making”, “Affordable Care Act”, “Shared Decision Making”, “measurement”, “incentives”, and “payment.”

Results: We observed a lack of clarity about how to measure shared decision making, about how best to reward the use of patient decisions aids, and therefore how best to incentivize the process. Many documents clearly imply that providing and disseminating patient decision aids might be equivalent to shared decision making. However, there is little evidence that these tools, when used by patients in advance of clinical encounters, lead to significant change in patient-provider communication. The assessment of shared decision making for performance management remains challenging.

Conclusion: Efforts to incentivize shared decision making are at risk of being limited to the promotion of patient decision aids, passing over the opportunity to influence the communication processes between patients and providers.

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1. Introduction

Shared decision making is a short-hand term describing a collaborative process between patients and providers that includes sharing information, eliciting informed preferences, and ensuring that these are integrated into the care plan. Given the high profile of shared decision making in the Patient Protection and Affordable Care Act (ACA), health care providers and payers are both interested, yet uncertain about how to implement ‘shared decision making’, partly because there is a lack of clarity about what it means to do so. The ACA suggests that patient decision aids can be used to facilitate a shared decision making process.¹⁰ There is no doubt that among the patients that receive them, the use of patient decision aids leads to more knowledge of available options and better understanding of

risk and probabilities, decisions that are aligned with the patient's values and preferences, and, in some settings, lower utilization of elective procedures.³⁰ But there is no clear evidence that the use of patient decision aids leads to a shared decision making process.^{31,15,11,19} In addition, there are significant practical challenges to getting the right aid, to the right patient, at the right time, coupled with the considerable disincentive of losing income if patients decide to decline treatments.^{4,7,17,18} This well-documented implementation challenge has led to significant interest in developing incentives to advance shared decision making, often by promoting the use of patient decision aids.

The interest in incentives inevitably leads to many questions. For instance, how will incentives to advance shared decision making be defined and operationalized? This will influence how providers and payers will react to the new requirements. Will shared decision making be viewed narrowly as the provision of patient decision aids or will there be attention given to the interpersonal communication aspects? If the later, how would that be assessed? Will providers be required to demonstrate that patients have used these tools? How would that be achieved? In short, it becomes urgent to ask *how* will shared decision making

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be measured, *when*, and by *whom* and *whether* and *how* it should be incentivized?

To try and answer these questions, we analyzed relevant, recent documents (published since 2009) concerned with the ACA, shared decision making and the use of incentives, in order to gain insight into this debate. We focused specifically on understanding how the documents' authors were proposing to measure and incentivize the implementation of patient decision aids and the process of shared decision making.

2. Materials and method

We searched Medline, Google, Google Scholar, Business Source Complete (Ebscohost), and LexisNexis from 2009–2013, using the following key words, terms and relevant abbreviations: "Patient Protection and Affordable Care Act", "Decision Making", "Affordable Care Act", "Shared Decision Making", "measurement", "incentives", and "payment". We also performed targeted searches in general, US-based high-impact journals, including *The New England Journal of Medicine*, the *Journal of the American Medical Association*, and *Health Affairs* using the same terms. We performed similar searches on the websites for agencies that are known to have an interest in healthcare reform, including The Commonwealth Fund, The Center for Medicare and Medicaid Innovation, and The Robert Wood Johnson Foundation. We examined the bibliographies of all retrieved documents for additional relevant references. We included all documents written in English that specifically discussed the ACA, shared decision making, and reimbursement/incentives. We excluded documents that did not contain explicit information about how shared decision making was to be implemented or operationalized.

We performed a document analysis on the retrieved manuscripts using the method described by Guest et al.⁹ Documents were categorized by their source, e.g. Government, academic, private organizations, or gray literature. We extracted data to identify definitions and descriptions of shared decision making, patient decision aids, measurement, and the method for providing incentives, where available. The data were described and categorized in order to identify common themes in the document set.^{22,2}

3. Results

Our search yielded 89 documents. Following full-paper review, 10 documents discussed the ACA, shared decision making and reimbursement/incentives, and thus met our inclusion criteria.^{32,6,20,12,28,25,23,10,1,21} Six were from Governmental agencies,^{10,32,20,28,25,1} three were from academic peer-reviewed publications,^{6,23,21} and one was a report by the Commonwealth Fund.¹² Included documents are listed in [Table 1](#) with details of proposed measurements and incentives.

We identified four themes. First, distinct, yet surprisingly consensual definitions existed in the documents for both shared decision making process and patient decision aids. Second, there was a lack of clarity about how to measure shared decision making. Third, there was an unchallenged assumption that the dissemination of patient decision aids would lead to shared decision making. Fourth, details about how to incentivize the process of shared decision making were either missing or vague.

4. Descriptive themes

4.1. Towards consensual definitions

Analysis of the documents revealed that the definitions of shared decision making and patient decision aids were clearly

and quite logically distinct. Shared decision making was perceived as a process of communication while patient decision aids were designed to provide information and facilitate understanding. Somewhat surprisingly, the ACA did not explicitly define shared decision making in the definition section b936 within section 3506 of the document. However, it provides a definition of preference sensitive care and patient decision aids and implicitly refer to shared decision making as '...collaborative processes between patients, caregivers or authorized representatives, and clinicians that engage the patient, caregiver or authorized representative in decision making [...] with information about trade-offs among treatment options and facilitate the incorporation of patient preferences and values into the medical plan'. Six of the 10 included documents provided substantive definitions of shared decision making.^{32,6,20,12,28,1} In summary, they described shared decision making as an approach to communication that entails a collaborative process whereby patients are informed, where efforts are made to explain treatment options and where patients' preferences are elicited, and efforts are made to integrate informed preferences into future care.^{32,6,20,12,28}

The ACA, and eight other included documents, provided definitions of patient decision aids,^{10,32,6,20,12,28,23,21,1} with a high degree of consensus. There is agreement that the goal of these tools is to provide high quality, balanced information to help patients gain knowledge about relevant options. The ACA states that patient decision aids are:

"educational tools that help patients, caregivers or authorized representatives understand and communicate their beliefs and preferences related to their treatment options, and to decide with their health care provider what treatments are best for them based on their treatment options, scientific evidence, circumstances, beliefs, and preferences."¹⁰

MedPAC's report stated that these "tools provide patients with evidence-based, objective information on all treatment options for a given condition".³² Blab et al. also stated that decision aids may include tools designed to assess patients' values and preferences.¹ All the definitions were in accord with each other – that the tools were in essence a source of information for use by patients.

4.2. Multiple measurement proposals

There was no consensus on how to measure or incentivize either shared decision making or the use of patient decision aids ([Table 1](#)). As Shafir et al. note: 'determining how to measure shared decision making and the impact on patient satisfaction, quality, and utilization has been a concern'.²⁸ A challenging issue is the tendency for individual provider organizations to create their own metrics. O'Malley and colleagues stated that the lack of agreement in this area:

"...impedes accurate measurement and comparison, especially across different organizations that may be using shared decision making for different procedures and using varied patient decision aids, making it difficult to differentiate which components of the process are essential or have the most impact."²⁰

Although there have been substantial research efforts in this field over the last decade, summarized by Scholl et al., the documents included in the current project do not cite recent reviews of proposed measurement approaches.^{27,29} Three of the documents suggest that measurement should be based on monitoring the number of decision aids distributed^{28,23,21} and that their use with patients should be systematically documented by the providers.²¹ Shafir and Rosenthal even propose measuring the proportion of eligible patients who are not given access to patient decision aids (also called defect rate).²⁸ In parallel, Pope and Hexum emphasize the importance of controlling for the quality of available decision aids. O'Malley and Fowler suggest measuring

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