Z. Evid. Fortbild. Qual. Gesundh. wesen (ZEFQ) 123-124 (2017) 104–108

Contents lists available at ScienceDirect

Z. Evid. Fortbild. Qual. Gesundh. wesen (ZEFQ)

journal homepage: http://www.elsevier.com/locate/zefq

Special Issue / Schwerpunkt

Shared decision making as part of value based care: New U.S. policies challenge our readiness

Partizipative Entscheidungsfindung als Teil einer wertorientierten Gesundheitsversorgung: Sind wir bereit für die neue US-amerikanische Politik?

Erica S. Spatz [1,*], Glyn Elwyn [2], Benjamin W. Moulton [3], Robert J. Volk [4], Dominick L. Frosch [5]

[1] *Section of Cardiovascular Medicine, Yale University School of Medicine, New Haven, CT; Center for Outcomes Research and Evaluation, Yale-New Haven Hospital, New Haven, Connecticut, USA*
[2] *The Dartmouth Institute for Health Policy and Clinical Practice, Lebanon, New Hampshire, USA*
[3] *Informed Medical Decisions Foundation, Healthwise Research and Advocacy, Boston, Massachusetts, USA*
[4] *Department of Health Services Research, Division of Cancer Prevention and Population Sciences, The University of Texas MD Anderson Cancer Center, Houston, Texas, USA*
[5] *Palo Alto Medical Foundation Research Institute, Palo Alto, California; Department of Medicine, University of California, Los Angeles, California, USA, Department of Medicine, University of California, Los Angeles, Los Angeles, CA, USA*

A R T I C L E I N F O

Article History:
Available online: 20 May 2017

Keywords:
shared decision making
informed consent
patient engagement
health policy
value-based care
quality

A B S T R A C T

Shared decision making in the United States is increasingly being recognized as part of value-based care. During the last decade, several state and federal initiatives have linked shared decision making with reimbursement and increased protection from litigation. Additionally, private and public foundations are increasingly funding studies to identify best practices for moving shared decision making from the research world into clinical practice. These shifts offer opportunities and challenges for ensuring effective implementation.

A R T I K E L I N F O

Online gestellt:
Online gestellt: 20. Mai 2017

Schlüsselwörter:
partizipative Entscheidungsfindung
informierte Einwilligung
Patientenorientierung
Gesundheitspolitik
wertorientierte Versorgung
Qualität

Z U S A M M E N F A S S U N G

Partizipative Entscheidungsfindung wird in den Vereinigten Staaten zunehmend als Bestandteil einer wertorientierten Gesundheitsversorgung verstanden. Im vergangenen Jahrzehnt haben mehrere bundes- und gesamtstaatliche Initiativen die Vergütung von Gesundheitsleistungen mit partizipativer Entscheidungsfindung verknüpft und Ärzten einen höheren Schutz vor Klagen wegen Behandlungsfehlern gewährt. Darüber hinaus fördern private und öffentliche Institutionen in zunehmendem Maße Best-Practice-Studien, die darauf abzielen, partizipative Entscheidungsfindung aus der Forschung in den klinischen Alltag zu überführen. Diese Entwicklungen eröffnen Chancen, stellen im Hinblick auf die Sicherstellung einer effektiven Implementierung aber auch eine Herausforderung dar.

* Corresponding author: Erica S. Spatz, MD, MHS, Section of Cardiovascular Medicine, Yale University School of Medicine, New Haven, CT; Center for Outcomes Research and Evaluation, Yale-New Haven Hospital, New Haven, Connecticut, USA.
E-mail: erica.spatz@yale.edu (E.S. Spatz).

http://dx.doi.org/10.1016/j.zefq.2017.05.012
1865-9217/

The healthcare landscape in the U.S. and shared decision making

The United States is inching its way from a fee-for-service payment system to a value-based system in which health systems are increasingly being incentivized to achieve the three aims of better health, better care and lower costs, as opposed to greater volume [1]. One example of a value-based model is the establishment of accountable care organizations, implemented as part of the *2010 Patient Protection and Affordable Care Act* (herein referred to as the *Affordable Care Act* or *ACA*). In this model, groups of providers come together to form a healthcare organization that cares for a defined population. Reimbursement is tied to quality metrics and cost savings. During the last 5 years, the number of ACOs increased from 110 in 2012 to over 800 in 2016, providing care to over 28 million Americans [2].

In this context, shared decision making is being recognized as a strategy to advance the triple aims and support value-based care [3]. Shared decision making has the potential to eliminate waste within the healthcare system by ensuring that patients get the care they want and nothing more. Shared decision making is also tied to patient safety, and in some areas of the U.S., malpractice carriers are offering discounted rates to physicians who practice shared decision making as an alternative to the traditional informed consent process. Indeed multiple organizations have identified shared decision making as a key strategy for achieving patient-centered care, enhancing patient safety, and achieving the triple aim of better health, better care and lower costs [4,5].

In the last decade several U.S. policies have aimed to integrate shared decision making into the value equation, forging shared decision making from the research setting into clinical practice. Yet, there remains a need to ensure effective implementation and measurement. Despite decades of research, there is limited experience with shared decision making; while clinicians are generally supportive of the principle that patients should be engaged in the decision making process, there remains skepticism that shared decision making with a patient decision aid is of value [6]. Moreover, with the exception of a few recent mandates, the lack of incentives for performing shared decision making remains a major challenge. In this paper, we will describe the recent federal and state policies to advance shared decision making, along with the research landscape to support next generation science in shared decision making. Finally, we will discuss the challenges for implementation and potential next steps for advancing high-quality shared decision making.

National and state policies promoting shared decision making

While the future of the American healthcare system is unknown in light of the 2016 presidential and congressional election, shared decision making as part of value-based care is unlikely to become a partisan issue. Moreover, much of the legislation related to shared decision making in the *Affordable Care Act* has already been enacted. The *National Quality Forum*, designated by the ACA as the entity to define a consensus process to certify patient decision aids, commissioned a white paper on how to ensure the quality and safety of decision aids, and convened an expert committee to develop national standards for decision aid certification. The white paper and certification standards, funded by the Gordon and Betty Moore Foundation, were published in December 2016, though the mechanism for certifying decision aids has yet to be implemented. Second, the *Patient-Centered Outcomes Research Institute (PCORI)*, also established through the ACA, has already allocated millions of dollars over the last 7 years to support patient engagement and shared decision making, including funding the development and testing of patient decision aids. A careful analysis of PCORI's decision aid funding portfolio through January 2015 showed 56 projects with a decision aid as a component, comprising 17% of all projects funded by the institute [7]. Finally, the *Patient-Centered Outcomes Research Trust Fund*, which provides funding for PCORI, also provides training and infrastructure support for patient-centered outcomes research and comparative effectiveness research through the *Agency for Healthcare Research and Quality*. Several of these projects include an emphasis on shared decision making in some form.

At the federal level, several payment models incorporate incentives for shared decision making. The *Centers for Medicare and Medicaid Services (CMS)*, the federal agency that administers Medicare and that works in partnerships with States to insure individuals with limited resources, established new payment programs that are based on value, not volume. Providers in an accountable care organization can participate in a Medicare-sponsored alternative payment program that uses several quality indicators, including patient reported shared decision making and the quality of provider communication, as well as cost to determine shared savings. Providers not participating in an alternative payment model will soon be enrolled in the *Merit-based Incentive Program*, in which 4 components of care will be used to determine reimbursement: quality; resource use; clinical practice improvement activities; and advancing care information. Among the clinical practice activities, there are plans to incorporate measures of patient preferences and shared decision making. Taken together, in the coming years, all providers caring for Medicare beneficiaries may have some portion of their reimbursement tied to shared decision making.

In a more direct way, CMS recently stipulated shared decision making as necessary for reimbursement coverage of 2 procedures: lung cancer screening with low-dose CT scan and left atrial appendage occlusion (a procedure to reduce thromboembolic stroke in patients with atrial fibrillation) – in recognition that fully informed patients may decide differently about whether to have the procedures. The coverage determination for lung cancer screening with low-dose CT was the first to explicitly require a patient counseling and shared decision making visit, and the use of patient decision aids, prior to a patient receiving a written referral for screening [8]. For left appendage occlusion, only a non-operating clinician can counsel patients through shared decision making. Yet, it remains unknown whether other future coverage decisions will also be tied to shared decision making. Additionally, as authorized in the Affordable Care Act, the Centers for Medicare & Medicaid Innovation is launching a pilot program to test 2 different approaches to shared decision making for 6 preference sensitive conditions (stable ischemic heart disease; hip osteoarthritis; knee osteoarthritis; herniated disk and spinal stenosis; clinically localized prostate cancer; and benign prostrate hyperplasia) – the *Shared Decision Making Model* (clinician engagement of patients in shared decision making) and the *Direct Decision Support Model* (decision support organization engages patients in shared decision making outside of the medical setting) [9].

At the state level, Washington State has made progress in implementing legislation passed in 2007, which encourages a shared decision making process that incorporates a certified patient decision aid and an attestation of a shared decision making conversation between the provider and the patient as a preferred alternative to traditional informed consent processes and forms [10]. In 2016, the State began the process of certifying patient decision aids, starting in the area of maternal-fetal care. Future certification will focus on decision aids for the management of: orthopedic conditions, chronic ischemic heart disease; low-risk prostate cancer; low back pain; and advance care planning. As an interesting consequence of this work, a regional insurance carrier is offering 5% discounts to clinicians who take a course on shared decision making