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Policy Research Shop

Shared Decision Making in Health Care Delivery

Background Information and Policy Options for New Hampshire

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EXECUTIVE SUMMARY

The goal of this report is to provide an overview of shared decision making as a health care practice and related policy options for the state of New Hampshire. Through evaluation of current research and salient case studies, this report seeks to highlight the opportunities and challenges of implementing shared decision making in a variety of settings. There are a number of policy options for New Hampshire to consider should the legislature wish to pursue the support and development of shared decision making in the state. They include endorsing shared decision making practices, developing partnerships with other stakeholders, creating new incentives for physicians and mandating the use of shared decision making.

1. INTRODUCTION

Shared decision making is a collaboration between the patient and health care provider that engages the patient in the treatment decision making process. The practice is primarily used in preference-sensitive care conditions where there are multiple treatment options. While no universal model for shared decision making exists, a diverse set of institutions have successfully implemented shared decision making practices.

This report will define shared decision making and explain the challenges for patients, providers and the larger health care system. It will profile a diverse set of institutions that are currently practicing shared decision making as well as summarize the current scholarship. Finally, the report will offer policy options for New Hampshire should the state legislature decide to promote shared decision making.

1.1 Definition and Brief History

Shared decision making is “a process in which the physician or other health care practitioner discusses with the patient...the risk or seriousness of the disease or condition to be prevented or treated, the available treatment alternatives, and the risks, benefits, and uncertainties of the treatment alternatives with the use of a patient decision aid, and the patient shares with the provider such relevant personal information as might make one treatment or side effect more or less tolerable than others.”¹ In essence shared decision making is a collaboration between the patient and health care provider that engages the patient in the decision making process about testing and treatment options.² Physicians give patients accurate, unbiased, and understandable information about options, outcomes, and scientific uncertainties, and patients alert providers to relevant information pertaining to their preferences, values, and life circumstances. It is this exchange of information that is at the core of the shared decision making process.



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Shared decision making rises from the research of Dr. Jack Wennberg, the Dartmouth Atlas, and The Dartmouth Institute for Health Policy and Clinical Practice. The research of the Dartmouth Atlas highlighted major differences in health care utilization in Medicare patients across the country. Through this research, the Dartmouth Atlas has come to define a group of health conditions known as preference-sensitive care. With preference-sensitive care, there are multiple treatment options with equivalent health care outcomes. Effective care conditions, in contrast, have best practices that have been proven through research. If someone is admitted to the hospital for a heart attack, the patient should receive a beta-blocker. This is an example of effective care. Alternatively, some decisions are not as clear. The Prostate-Specific Antigen test (PSA), is often used a prime example of a health care decision where 'watchful waiting' and getting tested have very similar health outcomes and is thus “preference sensitive.”

There are conditions for which there is no clear ‘best’ treatment option. In these cases at least, many believe that patient preferences should be the deciding factor. In order to create an environment where a patient is best able to make a decision, education and information are necessary. The concept of shared decision making has evolved to help satisfy these needs.

Section 936 of the federal Affordable Care Act of 2010, authorized a program for shared decision making. This program seeks to produce patient aids, set forth standards for using decision aids, and provide grants for development of shared decision making programs.³ It remains to be seen how these programs will be utilized at the national level, as funds were not appropriated.

1.2 Decision Aids

A decision aid is a patient-based tool that provides information about all viable treatment options in a clear, value-neutral view. It also helps patients define their personal preferences and values about treatment.⁴

A decision aid can be used by individuals on the entire spectrum of health –from healthy, to recently diagnosed, to chronically ill. Decision aids cover topics from treatment options for early-stage breast cancer to choices about antibiotics for bronchitis. A decision aid typically begins with a description of the illness or disease in clear, non-technical terms. It then may present pros and cons about different treatment options, frequently asked questions, or stories from other individuals with the same diagnosis. Finally, the decision aids will pose questions about the reader’s values and priorities.

For example, a decision aid may be utilized when a person is deciding whether to elect for knee surgery after a tear of their anterior cruciate ligament (ACL). A decision aid would begin with a medical description of the ACL and what it is does. It would explain what an ACL injury means and explain complications, for example, that there can be



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different extents of the tear and some people could have torn more than one tendon in their knee. The decision aid would then lay out the treatment options, in this case ACL surgery or rest and rehabilitation therapy. The decision aid would then lay out the risks and benefits of each treatment option. Following the facts the decision aid would propose questions about the reader's values and treatment preferences. For example, how important participating in athletics is to the patient's life or if the patient is willing to accept the risks that come with surgery.⁵ At the end of this online tutorial, the patient can print out the information and use the results and questions it provoked to talk with their physicians about which treatment he or she wishes to elect.

Decision aids can be paper-based or electronic and come in several different forms. The most common types are pamphlets, booklets, videos, and online tutorials.

1.3 Informed Consent

Many consider shared decision an advanced form of the American Medical Association's Code of Medical Ethics' principle of informed consent. Informed consent requires that physicians "present medical facts accurately to the patient...and make recommendations for management in accordance with good medical practice."⁶ While all 50 states have some form of informed consent law, the form of the law varies from state to state. In New Hampshire the AMA's doctrine of informed consent is built into case law and the state's Patient's Bill of Rights. The distinction between informed consent and shared decision making is that with informed consent a physician assesses the options and selects one, and is only required to get consent to do it. Shared decision making requires an informed choice from the patient - clinicians tell the patient the options, with all necessary and available information about treatments and outcomes, and the patient chooses, based on his or her preferences.⁷

2. PROFILES OF SHARED DECISION MAKING IN ACTION

There is no universal model for shared decision making, and as a constantly evolving practice, strategies that succeed in one location may not be appropriate elsewhere. The key stimuli behind implementing shared decision making systems range from government endorsements to patient demands to physician encouragement. By responding to the unique needs of the populations they serve, health care providers have the opportunity to develop innovative approaches to the execution of this practice. Below are synopses of an assortment of stakeholders all at different stages integrating shared decision making into their healthcare practices.

2.1 Washington State

In 2007 Washington State became the first state to officially endorse shared decision making as a best practice in health care delivery with the passage of SB 5930 on May 2,



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2007.⁸ While the legislation does not mandate the use of shared decision making by physicians, it does incentivize such behavior by offering higher levels of liability protection against medical malpractice allegations.⁹ Specifically, in cases in which shared decision making is formally acknowledged by both the health care provider and the patient, physicians have a stronger defense that the patient has given informed consent is higher.¹⁰

The legislation also authorized a demonstration project led by the Washington State Health Care Authority (HCA) to study the impact of using decision aids to treat preference sensitive conditions.¹¹ The HCA formed the Collaborative Stakeholder Group to bring together prominent public and private actors including the University of Washington, the Puget Sound Health Alliance, and Group Health Cooperative. Group Health, a nonprofit insurance cooperative based in Seattle, Washington, voluntarily participated in one of the demonstration projects authorized by the 2007 legislation. Through a combination of DVDs, online videos, and accompanying booklets the 580,000 patients insured by the network have access to decision aids for 12 preference sensitive conditions.¹² The decision aids used in the demonstration project were created by the Foundation for Informed Medical Decision Making (FIMDM), and distributed by Health Dialog.¹³ FIMDM is a non-profit based in Boston and Health Dialog, publisher of decision aids and other medical information, is a private holding of the London based company Bupa.¹⁴ The project is in the process of being evaluated based on a variety of metrics including patient and provider satisfaction, cost of decision aid implementation and overall cost of healthcare.¹⁵ Nonetheless, Group Health has already expressed interest in continuing to expand shared decision making throughout its network based on the positive response from patients and physicians.¹⁶

2.2 Dartmouth-Hitchcock Medical Center (DHMC)

Dartmouth Hitchcock Medical Center (DHMC) in Lebanon, New Hampshire is home to the Center for Shared Decision Making, a resource for patients facing multiple options in their health care treatment. The Center for Shared Decision Making has provided individual counseling for patients and a wealth of DVDs, booklets, online material, and other tools since 1999. Its presence within DHMC guarantees preference sensitive health care decisions are truly made on a case by case basis with the full participation of both the patient and physician. As was seen in Washington state, the decision aids used by DHMC are also produced by the Foundation for Informed Medical Decision-Making (FIMDM). According to the DHMC shared decision making program director Kate Clay, MA, BSN, the majority of decision aids supplied to patients are DVDs from DHMC's extensive collection including matters as diverse as lower back pain to breast cancer to coronary artery disease.¹⁷ The use of shared decision making has spread from practice group to practice group as it gained increasing popularity. Many physicians now require their patients to use these decision aids before they will schedule additional visits or even begin a conversation on treatment options.¹⁸



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Located within the Dartmouth Institute for Health Policy and Clinical Practice (TDI) is the Center for Informed Choices (CIC) led by Director Dale Collins, MD. The CIC is committed to incorporating innovative shared decision making models into patient care and to evaluating the effectiveness and accessibility of these strategies. Collins is dedicated to first aiding patients in identifying their own personal values before weighing treatment options to ensure the final decision is in line with their best interest.¹⁹ The CIC has successfully implemented programs in the Spine Center and in the Comprehensive Breast Program, and continues to be a leader in the field as the popularity of shared decision making grows.

2.3 Philadelphia

The Patient Provider Decision Sharing Project, marketed as “Better Decisions Together,” is an initiative based in Philadelphia, PA that integrates shared decision making into treatment at primary care clinics throughout the city.²⁰ The clinics serve a population that has many Spanish speakers, low English literacy rates, and is highly dependent on Medicaid. Through a mixture of written decision aids, DVDs, and group counseling sessions, the health care providers involved in the demonstration project have made numerous adjustments to meet the needs of such a unique population. Many of the written materials are simplified to accommodate the literacy skills of patients, and DVD players with headsets are provided in many of the clinics for patients who lack access to electronic resources at home.²¹ Patients are administered surveys before and after using decision aids and speaking with their physicians to monitor the effectiveness of the venture.

Reactions from patients and physicians alike have been overwhelmingly positive, although the final report has yet to be released. Patients are enthusiastically participating in conversations about their treatment options and care management, and have strong beliefs that they should be involved in their own medical decision making. One of the most popular courses of decision aids focuses on weight reduction surgery, and patients have responded favorably to those visual and written tools that are designed for their skill level.²² Support for the project comes from the National Nursing Centers Consortium (NNCC), the Governor’s Office of Healthcare Reform, Temple University, the Foundation for Informed Medical Decision Making, and the Public Health Management Corporation (PHMC).²³

2.4 Minnesota

Shared decision making gained popularity in Minnesota in 2008 when the state legislature voted on a measure that would require insurers of public patients (Medical Assistance, MinnesotaCare, General Assistance Medical Care, etc.) to only reimburse health care providers for services contingent upon the implementation of shared decision



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making in a variety of preference sensitive conditions.²⁴ Although the legislation did not pass, it prompted the Minnesota Department of Human Services to produce a comprehensive report on previous scholarship on shared decision making and options for Minnesota. The report recommended conducting pilot studies at limited sites around the state and ultimately developing a model for implementation on a larger scale.²⁵

The Stillwater Medical Group, which includes both primary and urgent care facilities, has been gradually expanding shared decision making into practice areas since 2006.²⁶ It began with a study funded by HealthPartners on incorporating decision aids into the treatment of uterine fibroids, and grew to include areas such as breast cancer and prostate cancer.²⁷ Stillwater Medical Group was recently chosen by the Foundation for Shared Decision Making as one of a number of sites across the country to participate in a demonstration project on the introduction of shared decision making into primary care. Also active in the state is the Minnesota Shared Decision Making Collaborative, a coalition of stakeholders ranging from patients to health care providers working to achieve the successful implementation of shared decision making in Minnesota healthcare.²⁸

2.5 Iowa

Mercy Clinics, part of the Mercy Medical Center-Catholic Health Initiatives in Des Moines, Iowa, joined the IHI IMPACT Program for Improving Care in Office Practices in 2002 and overhauled its healthcare delivery system to be more patient centered and individualized. The foundation of their practice is a team of “Health Coaches,” registered nurses and medical assistants trained in areas such as treatment decision making and healthcare self-management.²⁹ These individuals play an integral role in shared decision making at Mercy Clinics, where standard care includes a combination of face to face meetings between Health Coaches and patients, and decision aids in the form of informational booklets and DVDs.³⁰ In 2008 the American Medical Group Association awarded Mercy Clinics, Inc. the AMGA Acclaim Award for its dramatic improvements in healthcare delivery.³¹

3. SURVEY OF CURRENT RESEARCH

Much research has been conducted regarding the outcomes of use of shared decision making in health care. These studies attempt to better understand both the efficacy of the process and larger outcomes of using such a process. Most studies focus on the effectiveness of decision aids in creating a more informed and satisfied patient population. Similarly, utilization differences of those involved in a shared decision making process has been studied. However, there is less research on long-term health outcomes.



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3.1 Impact on patient knowledge and satisfaction

Shared decision making spans the health care delivery system from orthopedic elective surgeries to primary care depression treatment. Research has been done in many areas of care with various types of decision aids. The Cochrane review evaluates the outcomes of 55 randomized trials with the use of decision aids.³² These randomized trials evaluated different outcomes associated with different health care decision but most were concerned with the patient experience with these decision aids. 27 of the 55 trials included some metric of patient knowledge about the decision they were facing with or without the decision aids. Overall, they found that patients were more informed with decision aids.³³ Another study on patient aids in oncology evaluated the knowledge improvements in patients in 23 randomized oncology trials.³⁴ Overall, this study found that the mean score on knowledge tests did not increase with these oncological patient aids.³⁵ The authors pointed to a disparity in patient aid quality across these studies and called for better quality control measures to better study the improved knowledge of patients.³⁶ While the oncological study is an interesting comparison to the Cochrane review, most literature points to improved patient knowledge with the use of decision aids. Thus, the shared decision making process does have validity and efficacy in increasing informed patients.

The Cochrane review studies, as well as other studies about depression treatment and breast reconstruction, highlight increased patient satisfaction and reduced decisional conflict.^{37 38 39} In seventeen studies in the Cochrane review that studied decisional conflict, eight studies showed a reduction of decisional conflict between the two groups.⁴⁰ Interestingly, of these seventeen studies, ten used no decision aids in the control group and seven used a simple decision aid.⁴¹ Only one study found a reduction in conflict in between complex and simple decision aids.⁴² Perhaps the quality of decision aids does not bear as much weight on the satisfaction of the patient as performance in simple knowledge tests.

3.2 Legal implications

In most studies, great emphasis is placed on the importance of patients' satisfaction with care decisions. It is assumed that increased satisfaction will often lead to better adherence, fewer lawsuits, and more meaningful interactions with health care in the future. These assumptions are largely untested in the research. However, in preliminary studies, there is reason to believe that jurors of malpractice lawsuits would look favorably on shared decision making.⁴³ Barry, et al. used focus groups to evaluate the opinions of simulated jurors to documented shared decision making conversations and the use of decision aids.⁴⁴ Ultimately, with the use of decision aids, potential jurors only found three out of 47 doctors guilty of failure to meet the accepted standard of care.⁴⁵ It remains unclear if the number of trials brought to the courts decreases with shared decision



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making. If more research is done on the implications of shared decision making on lawsuits, shared decision making could become a powerful tool to combat the current culture of defensive medicine in the United States.

3.4 Impacts on medical care utilization

The Cochrane review found that the use of shared decision making often leads to fewer elective surgeries.⁴⁶ The study found an average twenty percent reduction in surgical interventions.⁴⁷ Many policy experts would argue this decrease in elective surgeries could help to bend the cost-curve and combat rising prices in health care. Similarly by empowering individuals to make their own decisions, shared decision making might have the power to reverse the ‘more is better’ culture in health care. The Cochrane review suggests that when presented with choice and information, many patients choose less invasive procedures. The power of this should not be underestimated for potentially slowing rapidly increasing health care costs but only early research from pilot programs is beginning to quantify these savings.⁴⁸

3.5 Need for further research

While many studies have found positive results about the efficacy of shared decision making, there is a lack of information on long-term health outcomes of shared decision making. One study evaluated cardiovascular risk with shared decision making in primary care and found that in both the intervention and the control the risk of cardiovascular disease decreased.⁴⁹ The Cochrane review did not find any positive health outcomes associated with decision aids.⁵⁰ This can be attributed that by the nature of preference sensitive decisions, there is not a particularly better health care decision. It remains to be seen if a positive patient experience has any positive impact on future health care outcomes. Most proponents of shared decision making would argue that this is not important to the decision to use or not use shared decision-making tools. Rather, experts feel that the ethical imperative alone is enough to necessitate shared decision making.⁵¹

In the Cochrane review and other randomized trials, the quality of the trials is inherently low compared to medical clinical trials because of the inability to ‘blind’ the experiment. Patients are aware they are subject to shared decision making, or at least a more extensive conversation, which is a weakness in much of the research. There could be a certain placebo effect for the self-reported satisfaction of patients. Yet, patients increased knowledge based on simple knowledge tests would likely not be caused by a placebo affect.

There is still more research needed to quantify the value of increasing the patient experience. Outside of the most obvious ethical implications, little research has illustrated the value in having a more knowledgeable and satisfied patient. If a more satisfied and knowledgeable patient is the goal, there is evidence that the use of shared decision



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making achieves this. However, if shared decision making hopes to act a means to make better medical decisions for patients, this is harder to tell. Research on this would be useful to patients, doctors and policymakers alike. There is also a lack of information on the outcomes when decision aids are mandated. In thinking about policy options, a study based on mandates rather than voluntary use of decision aids would prove useful.

4. CHALLENGES FOR IMPLEMENTATION AND UTILIZATION OF SHARED DECISION MAKING

4.1 System challenges

4.1.1 Resource constraints

Health care systems may face challenges when transitioning to, and using, shared decision making. For the systems, these challenges can be conceptualized as the challenges of the health care climate and logistical challenges. Implementation of shared decision making has proven most successful in health care systems where one isolated system chooses to use shared decision making. At Dartmouth Hitchcock Medical Center in New Hampshire, the Center for Shared Decision Making opened in 1999, and the practice of shared decision making spread through word of mouth to many specialties.⁵² At Group Health in Washington, leadership decided shared decision making was a top priority.⁵³ In the current health care climate, it is particularly challenging to bring doctors and health care administrators on board. With the many changes set to take place as provisions of the 2010 bill begin to take effect, health care officials are reluctant to shake up their systems any further. Most resources are currently being dedicated to being able to best rebound from any unanticipated consequences of these changes. With little extra money, it is difficult for states to provide the incentive and assistance to fuel implementation of shared decision making.

While many systems are strained to find the resources to make shared decision making a top priority, those that choose to implement shared decision making are faced with more logistical challenges. First, the system must decide what specialties to include in shared decision making. Systems may choose to slowly integrate shared decision making. In this case, the hospital or health care system must choose what types of decisions to prioritize.

4.1.2 Other constraints

Secondly, structures must be up to date technologically. Without extensive electronic medical records, full utilization of decision aids may prove difficult. Dartmouth-Hitchcock Medical Center has used some form of electronic medical records since 1983.⁵⁴ This makes it easy to flag the patients that should receive and to coordinate follow up through a shared decision making center and various specialties within a hospital. However, only 9.1% of hospitals had implemented any sort of electronic



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medical record system as of 2009.⁵⁵ This barrier should decrease as the prevalence of electronic medical records continues to rise and younger generations that are more technologically savvy become doctors.

At Dartmouth-Hitchcock Medical Center in New Hampshire, the Center for Shared Decision Making is a separate entity where patients must borrow and return decision aids. A certain degree of cooperation and organization is necessary for this system to function properly. Ideally, this might include a relatively stable patient population to allow for a more tailored form of care.

Similarly, the hospital must have the right incentives in place to encourage physicians to give patients the option. In his article, Atul Gawande, highlights hospitals in McAllen, Texas where the amount of care is based on how much care there is to supply.⁵⁶ This article illustrates the need for patient empowerment in health care decision making and illustrates why the incentives in the system are misaligned to discourage shared decision making. When hospitals and providers are incentivized to perform more tests because of investment in health care equipment and other companies, shared decision making and its seemingly lower utilization rate threatens this system.

4.2 Challenges for Doctors

Identified sources of difficulty for physician's in their utilization of shared decision making fall into two main categories. The first of which is finding and managing the additional resources necessary to complete shared decision making. The second is developing the interpersonal skills necessary to effectively present all the options for treatment in an unbiased way and to listen and respect patients' values and choices.

4.2.1 Resource constraints

Resources necessary for physicians to complete shared decision making effectively include time and information. Doctors interviewed about SDM expressed concern that they do not have time to complete the extended interview with patients.⁵⁷ Additionally, the current billing structure in the US healthcare system, fee for service, does not provide any means for compensating doctors for the additional time spent completing shared decision making with patients. These are two significant, institutional hurdles that need to be overcome to ensure the effective implementation of shared decision making.

An article published in the British Journal of General Practice also identified "the information requirements needed to successfully share decisions" as one of the major challenges of shared decision making. Some information required for the physician to present all options, for example information about alternative medicines and therapies, are difficult for physicians to present to patients. Physicians are often less familiar with these options and facts about their effectiveness are less available. Keeping up to date



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with facts about common treatments is also a difficult for physicians. Information about treatment options, mortality rates, and costs, for example, constantly change.

4.2.2 Interpersonal skills

Interpersonal skills including the ability to listen to patients and express complex medical information in a clear way was also identified as a challenge for physicians.⁵⁸ The ability to put aside bias and respect the beliefs of different people due to different cultural or personal views is needed to ensure the patient receives the information and care they want. Physicians also need to show an “underpinned positive attitude toward the concept [of shared decision making]” in order to encourage the involvement of patients.⁵⁹

4.3 Challenges for patients

There are a number of barriers to the implementation of shared decision making on the patient end as well. While some challenges are best addressed on a case by case basis, physicians and stakeholders cognizant of common issues may opt to tackle them upfront. The most prevalent issues for patients include literacy and language skills, and comfort with quantitative reasoning.

4.3.1 Literacy

Low literacy patients face shortcomings in healthcare measured by markers across the board ranging from healthcare knowledge to cost of care.⁶⁰ The challenges inherent to treating this population pose considerable barriers to the implementation of shared decision making. Physicians who rely heavily on written decision making aids as preparation for future conversations may find these patients do not possess the reading skills necessary to comprehend medical terminology and dense text. Furthermore, when patients lack the resources, such as a DVD player, to actually use a decision making aid, the full value of these materials may not be captured.

In a randomized trial with low-literacy patients at an inner-city primary care clinic patients were provided a one page, easy to read, “patient education handout” on prostate cancer before scheduled appointments.⁶¹ The handouts were either a detailed, double-sided informational brochure on prostate cancer testing and treatment, a cue prompting patients to discuss prostate cancer with their physician, or the food pyramid (control). Those who received the cue had more than double the odds of discussing prostate cancer with their physician during the visit, and almost all patients reported at least looking at the handout in the waiting room.⁶² This suggests an effective strategy for introducing SDM into healthcare for this population is providing patients with easy to understand decision aids that encourage them to initiate a dialogue with healthcare providers rather than overwhelming them with dense medical information. In addition, decisions aids that include simple analogies, visual components, and odds expressed in absolute risk rather



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than relative risk have also proven successful when working with low literacy patients.⁶³ In the “Better Decisions Together” project based in Philadelphia health care providers reported their patients were enthusiastic about being involved in shared decision making conversations.⁶⁴ When accommodations were made such as providing patients with access to DVD and video players and easy to understand decision aids, shared decision making practices were able to successfully reach a traditionally underserved population.

4.3.2 Numeracy

The introduction of shared decision making places a higher level of responsibility for comprehending sophisticated medical information on the shoulders of patients.⁶⁵ In this body of literature the results from different treatment options are often expressed numerically as percentages or rates, referred to as ratio concepts.⁶⁶ Numeracy, or the ability to understand and use quantitative information, is critical to the accurate interpretation of these figures.⁶⁷ The education field has long recognized that fractions, percentages, and ratios are traditionally difficult to work with, and until more patients develop fluency with ratio concepts, numeracy will continue to be a sizable challenge in the healthcare world.⁶⁸ Patients with low numeracy are less able to actively participate in conversations surrounding healthcare options, and are furthermore at risk for poor self-management of their health.⁶⁹ For these individuals evaluating the relative risks and benefits of various treatment options and following complicated treatment plans are beyond their capabilities.⁷⁰

Shared decision making offers a unique opportunity to engage those patients who may normally be excluded from conversations surrounding their healthcare due to an inability to understand health literature. In studies measuring health literacy, or the ability to understand and discuss written medical information, patients already at risk for poor health outcomes are the ones identified as scoring the lowest on assessments. These include patients living in poverty and patients whose first language is not English. In addition, the ethnic groups that scored the lowest were Hispanics and African Americans.⁷¹ In order to combat the disparities in ability to comprehend medical information, decision aids and conversations specifically tailored to meet various skill levels are necessary. The responsibility falls on both physicians to be aware of their patients’ abilities and on patients to be candid about what they do and do not understand in order to establish a worthwhile decision-making partnership.

5. POLICY OPTIONS FOR NEW HAMPSHIRE

5.1 No Action at this Time

Given the areas of further research previously indicated, the legislature may choose not to take action at this time. It may do so because it is not interested in expanding shared decision making in New Hampshire, or because it believes that, all things considered,



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non-intervention is the best policy route to increasing shared decision making. The current trend of increased use of shared decision making may proceed without policy changes. Dartmouth-Hitchcock Medical Center is an example of an institution that has continued to increase its shared decision making efforts without government intervention. However, resource strained areas may not be able to proceed with shared decision making without policy support.

5.2 Statement of Support

Assuming, as this and the ensuing options do, that the legislature would like to promote shared decision making in New Hampshire, it has a number of policy options which we have ordered by the level of government involvement.

A statement of support, rather than a mandate, is a gradual approach to introducing shared decision making into healthcare in New Hampshire. Such a measure would endorse shared decision making as a best practice rather than imposing it upon physicians. It is intended to avoid sparking a negative reaction from stakeholders while nonetheless firmly advocating support for the practice.

As the legislation would neither mandate its implementation nor offer any incentives for health care providers to use shared decision making, it is unlikely that a statement of support would dramatically increase the number of physicians practicing shared decision making. Nonetheless, a statement of support may provide the catalyst to encourage New Hampshire residents to learn more about shared decision making and its potential future in the state. Similar to the Washington state legislation in 2007, a statement of support could authorize a pilot study at a limited number of healthcare sites to further investigate the specific challenges of implementing such a program in New Hampshire. While DHMC and the Center for Informed Choice (CIC) have made shared decision making a priority, introducing similar pilot projects at smaller sites around the state may offer valuable insight into future options for a wide variety of health care providers.

5.3 Creating Incentives

5.3.1 Changing payment structure for Medicaid to pay for shared decision making

Physicians often point to a lack of reimbursement for shared decision making as opposition to a mandate of shared decision making. With a fee-for-service system, doctors get reimbursed for each procedure and test rather than entire process. In their paper, Wennberg, et al. explore the need to rethink the current payment system of Medicare and Medicaid.⁷² Currently, the Center for Medicare and Medicaid Services (CMS) reimburses for what is a medical necessity. The authors argue that as there is more research about preference-sensitive care, CMS needs to rethink medical necessity and include shared decision making in its pay for performance (P4P) model.⁷³ Based on the



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research of the Cochrane Review, the use of shared decision making leads to lower utilization and thus would save Medicaid money.⁷⁴ Some of this money could be used to reimburse physicians under a pay for performance model. This could best begin with a pilot program to change the reimbursement structure within one system.

The advantage of changing the payment structure is that it would eliminate one of physicians' main problems with shared decision making. Furthermore, by structuring how physicians are reimbursed, this also structures how decision aids must be used which decreases the problem of varying quality of aids and the shared decision making process. Finally, a powerful advantage of changing the payment structure of Medicaid is that P4P, as studied by Wennberg and others, has further reaching benefits to the health care system.⁷⁵

Political and policy feasibility remain questions with this policy option. It remains to be seen how much of the proposed changes in national health care reform will impact payment structures. Similarly, many physicians and health care systems will need to be in support of this policy option for it to work well. However, a pilot program might be able to better illustrate the need or lack of need for a fundamental change to payment systems.

5.3.2 Changing medical malpractice and informed consent

Another policy option to increase the use of shared decision making in New Hampshire involves linking shared decision making to the completion of a physician's responsibility to provide informed consent. While informed consent is already present in New Hampshire case law and the state's Patient Bill of Rights, the state could create legislation that would allow the completion of a shared decision making protocol to fulfill the requirement for informed consent.

Maine's legislature has passed a bill aimed to implement shared decision making in this way. In this bill, a quality forum was tasked with determining a protocol for shared decision making. The bill further legislates that if a healthcare provider follows these protocols, the protocol may be used as proof of informed consent in defense of malpractice.⁷⁶

Though data has yet to be collected from Maine's healthcare system detailing the results of this newly implemented law, the advantages of this policy implementation are thought to be two-fold. The defense against malpractice suits will provide impetus for physicians to utilize the shared decision making protocol. Thus the state will see the advantages of the use of shared decision seen in the pilot studies of shared decision making. Secondly, the Maine Quality Forum reports that they believe shared decision-making, as a component of informed consent may reduce malpractice and liability claims in the first place, since the collaboration between patient and physician in the decision-making



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process may make patients feel more empowered and less likely to hold a health provider liable should a complication occur.⁷⁷

The main weakness of this type of policy is the unknown legal ramifications of implementing this type of policy. While shared decision making is very similar to informed consent, a malpractice suit where shared decision making was used has yet to be brought to court in New Hampshire. It is also not known how strong of an effect using this type of motivation will have on physician's use of shared decision making. It is possible that this policy could have little or no impact on physician's behavior.

5.4 Partnerships with DHHS

5.4.1 Medical education reforms

One way to begin a cultural shift is in the reframing of medical education. Just as electronic medical records are becoming more prevalent as more doctors have grown up in a technological world, educating medical school students might prove a powerful force for change. This change could be implemented at the legislative level by working to provide certain requirements to become a doctor. Classes might be required in shared decision making that would help younger generations reframe informed consent.

New Hampshire could require all doctors licensed to work in the state pass a basic test indicating knowledge of shared decision making. This might serve as incentive to work with New Hampshire medical schools to better teach how to use shared decision making with patients. However, this policy might better be implemented on the national level to reach all medical schools and form a national partnership.

Furthermore, this policy option might take a long period of time to see results in the system. With young doctors completely more and more years of residency for highly specialized fields, it would take a long time for the shared decision making education to be utilized. This policy would also lead to the very long lag time associated with waiting until an entire generation of doctors retires.

5.4.2 Partner with large hospitals and insurance plans in collaborative effort

An endeavor between the New Hampshire Department of Health and Human Services (DHHS) and either a healthcare provider such as DHMC or an insurance company covering New Hampshire residents has the potential to be a first step toward state government endorsement of shared decision making. A collaborative pilot project could entail evaluating shared decision making systems already in place, or introducing new projects in previously non-participating hospitals and clinics. The value of movements that combine as many stakeholders as possible, such as the project that emerged from the 2007 Washington state legislation, is their ability to reveal advantages and disadvantages



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for multiple perspectives. Patients and their families, insurance companies and health care providers will all be impacted by the introduction of shared decision making and should be included in discussions to yield a productive outcome.

Although Washington state did not mandate the adoption of shared decision making, the legal incentives and official approval of the practice encouraged actors across the state to consider how their organizations could be involved. The University of Washington began by integrating shared decision making into treatments for a limited number of conditions at three demonstration sites.⁷⁸ From there interest in the project spread to private and nonprofit insurance companies, other institutions of higher education, and hospitals around the state. Group Health, a nonprofit insurance cooperative that joined the Collaborative Stakeholder Group, serves a population of 580,000 patients.⁷⁹ The current alliance between the Washington HCA, institutions of higher education, and public and private organizations could be replicated in New Hampshire if DHHS took the initiative to organize such a collective body. Under this option the implementation of shared decision making would remain largely up to the stakeholders depending on group goals and preferences.

5.5 Mandating use of shared decision making

5.5.1 State-wide mandate

One option for New Hampshire is to mandate shared decision making throughout the entire system. A mandate would likely require the use of decision aids in at least preference-sensitive care. These decision aids would need to meet the standards either put forth by the International Patient Decision Aids Standards (IPDAS) Collaboration or some other oversight committee. As illustrated in the research in oncology by Stacey, et al., there is a great need for a more standardized set of decision aids.⁸⁰ It would also be necessary to define the conditions that require the use of a decision aid. The law would potentially provide an extensive list of conditions that are defined as preference-sensitive care.

Mandating the use of shared decision making could be done without necessarily needing to include the use of decision aids. It could use other conceptions of shared decision making such as a documented conversation that covered a checklist of questions or other type of structured decision making conversation. However, at this time, decision aids, like online tools or videos, seem to provide the most comprehensive information. Without mandating decision aids, the law might be rendered relatively ineffective.

An enforcement mechanism might be important to ensure compliance with this new mandate. Perhaps the best option would be a tip hotline where patients can call and report physicians. However, if this law is to be effective, the physicians need to be in favor of shared decision making. Currently, physicians are likely the biggest opposition to shared



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decision making efforts. Historically, physicians prefer to set best practices within the American Medical Association and other groups and do not like being told how to practice medicine by legislators. Presently, physicians cite lack of time, funding, or redundancy with informed consent.⁸¹ Thus, with a mandate there is the possibility of unintended consequences caused by backlash from physicians.

The strength of the mandate is in its mandatory nature. Physicians and health care administrators would be required to engage in shared decision making. There is some form of a precedent in the Group Health example in Washington in that there was a mandated pilot and the leadership said it was going to happen within the health care system. However, it is important to note that Group Health volunteered to be the pilot program and perhaps points more to successful partnerships as discussed later.

The main weakness of the mandate is potential backlash from physicians. As an unfunded mandate in particular, hospitals may be unable to adopt the programs necessarily given the current financial state of our nation. In the cases of Group Health and Dartmouth-Hitchcock Medical Center, there was a certain cultural shift that occurred to create such widespread success, and this shift came from within the hospitals.

While mandating shared decision making would certainly be a big move, it remains to be studied what the unintended consequences of this mandate in New Hampshire might be.

5.5.2 Mandating for state-insured employees

Mandating that any service covered for state-insured employees use shared decision making is another policy option for New Hampshire. A mandate could require that a shared decision making discussion checklist is completed or decision aid is presented to the patient. While not as overarching as a state-wide mandate, the use of shared decision making for state-insured employees has similar advantages and disadvantages. This policy option would have the benefit of allowing for a smaller scale implementation and could allow for the study of the policy outcomes before moving to a larger mandate.

The smaller nature of this mandate might be an effective first option, instead of rolling out the mandate to the entire state. Furthermore, state employees presumably well-educated and more stable population than the low-income recipients of Medicaid.

5.5.3 Mandating for Medicaid

A policy mandating shared decision making be used for all services funded by Medicaid is an additional option for New Hampshire. Again this policy, similar to a mandate for state-insured employees, would have outcomes comparable to the state-wide mandate, but on a smaller-scale.



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This option was considered in Minnesota before legislators decided in studying shared decision making further.⁸² In this case, doctors would only be reimbursed for Medicaid recipients if they were able to document the use of a shared decision making process.⁸³ There could also be a mandate that did not require documentation but rather had feedback mechanism for patients to alert authorities if they were denied the shared decision making process.

Mandating use for Medicaid recipients presents issues similar to those faced in Philadelphia. In dealing with a low-income, often low literacy, population, the implementation is inherently more difficult. Furthermore, Medicaid budgets are already extremely constrained with the increase to coverage of 133% of the poverty line, state budgets might not prove to have room for added reimbursement for shared decision making without an all together change in reimbursement structure. Public medical coverage patients already face problems finding physicians who will take their coverage and this mandate could make it even harder for these recipients to find physicians.

Yet, Medicaid recipients might also stand to gain the most from being involved in a shared decision making process. As patients left out of a lot of the health care system, shared decision might prove useful and have positive health care outcomes for this population.

6. CONCLUSION

This paper has outlined the current research and salient case studies in shared decision making. There remain a significant number of questions for future research to answer. While there is not one universal standard for shared decision making, there exist a wide variety of policy options at the state level for New Hampshire to pursue if so desired.



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