Population Health NEWS

A Patient-Centric Model of Care: Shared Decision Making Arrives

by Peter Goldbach, M.D.

With the advent of healthcare reform, providers are scrambling to navigate a new reimbursement system that pays for outcomes rather than service provision. The transition to a value-based reimbursement model is a powerful change engine that holds the promise of doing well by doing right. This tidal change in reimbursement has created a renaissance of interest and activity around patient-centric approaches, such as shared decision making (SDM).

SDM is a process that supports patients and healthcare providers in discussing options and making joint medical decisions, and often incorporates decision aids. These aids are evidence-based tools that explain treatment choices and help patients consider their choices and clarify their preferences. SDM is typically used when a patient is facing a preference-sensitive decision for which scientific evidence demonstrates that more than one medically acceptable treatment option exists. Examples include treatment for low back pain, early-stage breast and prostate cancer and hip and knee osteoarthritis. SDM can also be applied to chronic conditions, lifestyle and wellness concerns, such as depression or insomnia.

More than 20 years ago, the researchers who created the *Dartmouth Atlas of Health Care*—a population analytic that reveals extraordinary regional variations in care for common conditions—saw a need for more patient-centric, evidence-based care and viewed SDM as a potential solution. Research has demonstrated that SDM can significantly reduce utilization and decrease unnecessary care, while achieving high patient satisfaction rates.

SDM: Improved Outcomes for Health Plans and Employers

Studies have shown that SDM can address overutilization of certain preference- sensitive surgeries and be useful in encouraging the use of underutilized effective care, such as screening for colon cancer. SDM also results in more satisfied and "activated patients," who are more involved in their own care. Research has shown that such involvement results in health outcomes that better reflect patient preferences; these outcomes have been observed in both clinical trials[1] and actual practice.[2]

While the transition to fee-for-value, payment models will encourage SDM, that's not to say success is guaranteed. Poorly conceived contracts that reward SDM process as opposed to SDM outcomes could encourage the use of ineffective check-the-box style programs that are not designed to produce substantial outcomes. Throughout nearly two decades, there have been results associated with successful SDM programs across both payer and provider models:

- Lower utilization:[3]

- 11.5% reduction in hospital admissions for patients with preference-sensitive conditions.
- 9.8% reduction in preference-sensitive surgeries (both in-patient and out-patient).

- Reduced costs:[4]

- 13-16% reduction in medical costs associated with preference-sensitive conditions.
- Up to 2.5% reduction in total medical costs.

- High patient satisfaction and patient knowledge:[5]

- Patients who viewed a decision aid would recommend the aids to family and friends (94%), understood the information presented (99%) and said it contained useful condition information (96%).

(continued on page 2)

A Patient-Centric Model of Care: Shared Decision Making Arrives … *continued from page 1*

SDM: Mission-Driven Provider Organizations Lead Despite Obvious Barriers

Fee-for-service, reimbursement models have made SDM attractive to health plans for quite some time, while also representing a barrier to provider adoption. Integrating SDM into carefully architected workflows also has proven challenging; however, despite these barriers, a number of premiere provider practices, such as Partners HealthCare, Dartmouth-Hitchcock Medical Center, Group Health and Kaiser Permanente, have successfully employed SDM. These pioneers recognized that SDM was the right thing to do, and that outcomes would be improved if patients were better informed about treatment choices and providers about patient preferences. These organizations succeeded because they also understood that adopting SDM required buy-in from leadership and providers, along with management's active support and well-designed workflows for all involved. A key benefit of implementing such SDM programs is that patients arrive at critical appointments with an understanding of their choices and specific questions relevant to their situation, and they are prepared to express their preferences about their treatment. This focused and productive use of appointment time is highly valued by providers who are short on time for patient education.

Another benefit is that patients participating in SDM have realistic expectations; the problem of patients overestimating treatment benefits and underestimating possible harm may be lessened when they use an evidence-based decision aid. Lastly, these leading organizations have enhanced their brand and increased patient loyalty by providing a member-centric service that results in consistent, evidence-based care.

Despite these benefits, SDM is not the norm in practice today. Providers have struggled with the following barriers to adoption:

- **Cultural.** Medical practice has traditionally been provider-centric, and patients often believe their physicians don't welcome their questions about care options. SDM is an inherently patient-centric activity that requires practical realignments in patient/provider relationships.
- **Financial.** SDM mitigates overuse and requires an investment in education, redesigning workflow and providing infrastructure (e.g., making decision aids available, training SDM coaches).
- **Educational.** Many physicians mistakenly think they practice SDM. Those that choose to participate usually require some education and practical support (e.g., access to decision aids and workflow solutions).

Future Directions for SDM

Several trends support expanded patient access to SDM, most notably:

1. **SDM offering "highest form of informed consent."** Individual states are moving toward using SDM as a model for patient-centered care. Washington has promoted it as a mechanism to achieve better informed consent, even passing legislation supporting SDM and noting it as evidence of informed consent. It also is currently exploring certification criteria for decision aids. In 2009, California, Connecticut, Maine, Minnesota and Vermont took legislative action on SDM bills.
2. **SDM as a powerful tool to attract cost-conscious patients.** As high-deductible insurance plans become the norm, patients are taking on substantial risk; however, there is an absence of tools to guide smart navigation. Patients need tools if they are to become the informed, empowered consumers the healthcare system needs. As SDM enjoys near-universal, consumer support, expect to see an increasing number of organizations using it as a marketing asset to demonstrate evidence of genuine commitment to patient-centered care.
3. **Continued federal and other third-party support for SDM as one of the delivery system reforms included in the Accountable Care Act.** The federal government has a vested interest in addressing the estimated 10% of healthcare costs that are spent on unnecessary care. SDM's success in reducing overutilization of preference-sensitive treatment options, as well as underutilization of beneficial healthcare alternatives, offers promise to reduce overall healthcare costs while improving population health. The federal government is in good company. In recent years, the SDM approach has received wide endorsement by industry thought leaders, including the Institute of Medicine, the American Medical Association, the American Board of Internal Medicine, The Commonwealth Fund and the National Business Group on Health.
4. **Financial incentives for patient use**. Payers are exploring financial incentives to encourage patients to use SDM to promote informed decision making for preference-sensitive conditions. In some models, SDM is part of preauthorization, and patients are incentivized to use a decision aid and talk to a health coach.
5. **Retail health as a conduit for better care.** The prevalence of the convenient care clinic is expected to increase exponentially in the next few years, yielding a tremendous opportunity for trusted health intermediaries to interact with patients more frequently via a convenient, face-to-face encounter in a community setting. A 2013 Gallup poll shows that consumers view nurses and pharmacists as highly trusted professionals.[6] Consumers managing one or more chronic conditions might speak with a pharmacist as many as 20 times a year. Pharmacists working in conjunction with nurse practitioners that staff convenient care clinics, combined with in-store care coaches, create a powerful new healthcare team that can work in partnership with a patient's physician. SDM—coupled with the expertise of a nurse or health coach—may play a role in a future care team, which offers significant promise to improve health outcomes, community by community.

(continued on page 3)

A Patient-Centric Model of Care: Shared Decision Making Arrives … *continued from page 2*

SDM Assumes Powerful Role in Value-Based Care Environment

SDM helps people get the care that's right for them. When SDM is deployed, patients make healthcare choices that reflect their personal values and lifestyle. Research shows they tend to be happier with the outcome and with their health plan, and overall healthcare costs drop. As the healthcare system evolves to embrace the concept of value-based care, SDM is one of the few proven programs that delivers equal benefit to patients, providers and the healthcare system at large. With nearly two decades of data demonstrating improved health outcomes, satisfied patients and reduced costs, SDM is a reliable, proven concept whose time has come as all healthcare participants strive to achieve the highest levels of population health.

[1] Stacey D, Légaré F, Bennett CL, Eden KB, et al. "Decision Aids for People Facing Health Treatment or Screening Decisions." *Cochrane Database Systematic Reviews.* 2011 Oct 5;(10).
[2] Arterburn D, Wellman R, Westbrook E, et al., "Introducing Decision Aids at Group Health Was Linked to Sharply Lower Hip and Knee Surgery Rates and Costs." *Health Affairs*. September 2012; 31(9):2094–104.
[3] Wennberg DE, Marr A, Lang L, et al. "A Randomized Trial of a Telephone Care-Management Strategy." *New England Journal of Medicine*. Sept. 23, 2010;363:1245-55.
[4] Health Dialog internal data. 2009-2012.
[5] Health Dialog Member Satisfaction Study. 2011.
[6] "Honesty/Ethics in Professions." Gallup. Dec. 8-11, 2014.

Peter Goldbach, M.D., is chief medical officer for Health Dialog Services Corporation and RediClinic, both wholly owned subsidiaries of Rite Aid. He can be reached at pgoldbach@healthdialog.com.