Is Shared Decision-Making the Path to Improved Provider Performance?

written by Theresa Hush | December 14, 2017

As an escalating percentage of Americans (including children) are diagnosed with diabetes and hypertension, the health care system is straining to control costs and demonstrate good clinical outcomes. No surprise that providers blame patients for lack of compliance with therapies or lifestyle changes that will improve their health status. Hence the uptick—some say warranted—in incentives or penalties assessed by insurers or employers on patients who don't "behave."

But this punitive finger pointing is neither equitable nor productive. Just as it's unfair to hold physicians, alone, to be fully accountable for patient outcomes in quality reporting and cost, without giving them enough support for helping patients to improve, it's equally unfair to blame patients for their unwillingness to do what they are told without including them in medical decision-making.

Patient Engagement is Code for Compliance

Patient engagement is the new catchphrase in health care, and businesses with patient portals or engagement systems are attracting investment. But in reality, patient engagement is too often interpreted by providers and insurers to mean compliance. In other words, patients should follow physician orders. Cost, inconvenience, contrary patient belief systems, and the patient's inability to execute the orders are often irrelevant for typical patient engagement initiatives. Patients have no agency in decision-making because the only, correct path is presumed to be agreement with physician orders.

Like provider quality scoring, patient engagement systems presuppose that reinforcing the message to patients about what they should do will make them do it. There is a heavy emphasis on performance documentation (by the patient), higher touch or messages to keep the health issue or desired therapy front and center, and an avenue for the patients to check in with results. While this approach may prove supportive for the patient who is following a particular regimen—for example, recovering from a joint replacement—the system's effectiveness for chronic disease management and lifestyle changes is questionable. Why? Because the patient who "must comply" is rarely involved in a continual process of commitment or decision-making.

Shared Decision-Making Involves Maximum Patient Engagement in Medical Decisions

Shared Decision-Making (SDM) alters the dynamic of the medical decision process as well as the roles of physician and patient. In SDM, the physician is no longer describing the plan to the patient but, rather, providing detailed information and alternatives. In SDM, the physician offers expert guidance and defines benefits and harms of each alternative. But it is up to the *patient* to choose. That key distinction can be unsettling to the culture of most physician practices and difficult to engineer in practice.

The difficulties of health care culture change may well be outweighed by the major benefit of SDM: it increases the possibility that patients will commit to an approach. If patients have the necessary information and decide on a plan, they are more likely to be committed to achieving their goals and making progress towards a good outcome.

SDM may also help practices to avoid wasting resources on following after patients who have not, for a variety of reasons, made a commitment to a plan or to improvement, in general. Shared Decision-Making appeals to patients who choose to affect their own care.

This merits scrutiny. SDM may also favor patients who have the ability to pay for interventions, or those with a support system to help them reach their goals. As SDM processes become more widely accepted in health care, providers must make substantial efforts to capture what lies behind the choices made by patients, and to carefully research and address potential biases in the system that reward educated or affluent patients, alone.

Why Shared Decision-Making Should Be Part of Performance Improvement Strategy

There are several reasons to make SDM part of the health system's Performance Improvement strategy:

> Increases potential for better patient outcomes. Making Shared Decision-Making a central feature of activities to improve outcomes rests on expectations that the patient's commitment to a path of treatment will lead to real improvement. Since patient engagement has been the Achilles' heel of most efforts to improve patient outcomes, SDM (properly implemented) addresses the core issues of commitment: respecting patient preferences and overcoming barriers to treatment alternatives.
> Generates patient loyalty to the physician and health system. Just as the patient is engaged in a positive partnership with the physician, SDM also has the potential to create a bond with the physician and the health system that could have farther-reaching effects, such as loyalty to the provider and the health system, and willingness to trust other physicians and programs within the health system. This is a significant benefit for organizations anticipating the future of financial risk models, including ACOs and Medicare Advantage plans.
> Creates opportunities to engage providers in designing the performance improvement process. For providers left out of traditional performance improvement initiatives, an SDM process that engages them in problem solving interventions to improve patient outcomes can be rewarding, especially for physicians who have become demoralized by more common performance scoring systems. SDM is a chance to reengage physicians in the art as well as the science of medicine.

Caution: SDM Will Require Action on Exposed Vulnerabilities in Policies and Operations

Shared Decision-Making recognizes the current trend of consumers/patients who want more information and control over their health, health care services and health care financial decisions. These three areas are intertwined in the SDM process. SDM will push providers to offer realistic cost information relative to treatment alternatives, to recognize and address

other customer service needs and, most significantly, to support practices with both patient tools and support for physicians' role in coaching patients.

It is naïve, however, to assume that one choice or set of choices by the patient will accomplish a change in outcomes. While SDM can winnow out patients who are willing to set goals and work toward good health, their commitment to those choices must be continuously renewed each day and across months and years. SDM must be an ongoing process, especially when the outcome change is experienced over years, as in chronic disease. Like any long-term goal, the cumulative effect on outcomes is what makes the difference.

SDM is also a remarkably different process for patients with chronic disease or long-term conditions, such as diabetes and cardiac issues, versus those facing decisions that are more specialized and short term, such as how to treat cancer. The complexity of SDM tools—as well as the effectiveness of interventions—will necessitate substantially more investment for patients with chronic conditions. Implementation of SDM in performance improvement strategies will require staging, testing and gradual layering of technology and tools to determine successful patient groups, implementation styles and support needs.

Nine Steps to Improve Health System Performance Via Shared Decision-Making

1. Identify key target areas for clinical and cost improvements. Select your targets to achieve positive strategic or marketing goals, such as increasing market presence or highlighting excellence in a clinical area, or, defensively, to address known clinical or cost issues. Focus on one area to start SDM, as a pilot, because even one condition will require activities across the board to address project needs, and these will form a foundation for future SDM projects.

2. Establish your data/technology system or partner for SDM. In Shared Decision-Making, you'll need to carry out a number of discrete project activities in order to determine whether or not your investment in this exercise is proving its value. The health system's EMR probably won't be able to perform all of the SDM functions involved, so performance improvement (PI) technology will be required to track project management and measurement, and the EMR must be prepared with templates to trigger physician activity and gather data for submission to the PI system. For example, you may need to address how to:

- Analyze data to identify patients by condition, age and other criteria, such as risk or progress of disease;
- Load that patient listing into technology to track the project;
- Determine how those patients will receive outreach and/or invitations to participate in the

process, and ensure that the technology can track this;
Decide the scope of alternatives or interventions that will be provided generally to the patients, and what information needs will come from that list, and create the functionality for the data capture and performance testing of these alternatives;
Document activities such as first and subsequent SDM conversations between physician and patient, as well as patient preferences, through data capture tools;
Test the understanding of patients and physicians for the process, by gathering feedback from both groups, which will also likely be electronic;
Measure project performance;
Create a mechanism for patient-physician interactions during the ensuing process.

3. Establish a Shared Decision-Making Project Plan with the involvement of physicians, especially those participating in the initial pilots.

4. Educate physicians about the process, communication styles, and goals of Shared Decision-Making. Since physicians are used to making decisions and some may have strong belief systems about the appropriate path for patients, it may be hard for them to accept what can be perceived as a more "passive" role in the decision-making process. It will take time and multiple sessions to achieve a balanced process of decision-making; avoid short-cuts.

5. Ensure that your physician practices have the support they need for SDM. If the practice is totally paperless, patients will still need hard evidence of decision criteria on paper. This will require adjustments in workflow. In addition, patients will need to be prepared for the SDM process; non-physician staff will likely be involved. The time required for SDM may tax productivity and thus must be evaluated in the context of other pressures on physicians to "produce."

6. Prepare patient decision tools for physicians, with their involvement. Of all support needs for physicians, this is most critical. The foundation of Shared Decision-Making is the clear explanation of benefits and harms associated with various alternatives (or no action) for the patient. Defining the effectiveness (and cost) of different medications or other therapies, the risks associated with doing nothing and with each alternative, and the percentage of patients who are benefited (and by how much) are the heart of process. Discussions should include numeric values on benefits and harms derived from research, which should also be presented with information on the known limitations of such research. Since the success of SDM will depend on how well the patient understands this information, these tools will require a lengthy process of development and testing.

7. Measure physician and patient understanding of SDM before, during and after the project

begins. These measurements will be associated with actual outcome values over time.

8. Evaluate outcomes over time, not for one-off instances, with a focus on improvement rather than absolute values. This differs from all quality reporting schemes that tend to focus on one value per year and do not include outcome trends. It is also essential to evaluate individual patient outcomes over time, not just aggregate performance, in order to reveal data issues that may be affecting aggregate performance measurement and improvement.

9. Elicit satisfaction information about the SDM process from participants. This should also be compared with outcome results to see if attitudes affect behavior of either physician or patient, or both.

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