Conference Summaries

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The Role of Federal Initiatives

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Mr. Lee, executive director for national health policy at the Pacific Business Group on Health, discussed current provisions of the federal health care reform legislation that address shared decision making.

Legislation Overview

- In July 2007, Washington became the first state to enact legislation establishing increased legal protection to physicians whose patients sign an acknowledgement that patient decision aids were used during informed consent.

Background

- According to Mr. Lee, although federal legislation in its current form is stalled, health care reform is not. He pointed out that shared decision making was not included in the reform packages discussed as recently as four months ago, but was solidly included in the most recent versions of the legislation that have passed the House and the Senate, respectively.

- In Mr. Lee's opinion several different scenarios could play out with regard to federal legislation. A wholesale reform plan may be passed; a "health reform-lite" version may be passed; reform legislation may be stalled until after the mid-term elections; or passage of legislation may be delayed until after the next presidential election. Legislation passed in any of these scenarios may include provisions that address shared decision making.

- Mr. Lee noted that although discussion of health care reform often focuses on cost concerns, other considerations, such as coverage expansion and financing, benefits, system reforms, and infrastructure changes, are important. Shared decision making is one element in reform of the delivery of health care; it is an essential component of how health care should be delivered.

- According to Mr. Lee, if legislation is crafted and passed that includes the best elements of the Senate and House bills, it would have the potential to positively transform health care in America. In contrast, if the lowest common denominators are used to create the final legislation, there would likely be little if any positive change. He also stated that no matter how passage plays out over the next several months or years, there will major changes to the health care system in the meantime due to regulatory and administrative action.

The Place for Shared Decision Making in Health Care Reform

- Mr. Lee characterized shared decision making as a vehicle by which solid science can be used to shape care at the frontlines without raising the specter of an outside entity inserting itself in the doctor-patient relationship. He asserted that the fact that both the House and Senate health care reform bills include language supportive of shared decision making is an important achievement in promoting patient-centered care.

- Shared decision making is central to reforming the delivery of health care for four reasons:

  - Shared decision making and the use of decision aids are at the core of patient-centered care;

  - Shared decision making has the potential to reduce unwarranted variations in the treatment of preference-sensitive conditions;

  - Decision aids can prevent overuse of options that informed patients do not value; and
  - Shared decision making provides a patient-centered foundation for the use of comparative effectiveness research.

Shared Decision Making and Federal Legislation

- House bill (HR 3962) includes a single provision that addresses shared decision making.
  - The purpose is to improve Medicare beneficiaries' understanding of their medical options.
  - The focus is a demonstration project, involving up to 30 provider/groups who can be reimbursed for using DAs and providing follow up consulting visits.
  - The project is operated through CMS Innovation Center.
  - The bill does not include authority to be expanded more broadly if successful.
- Senate bill (HR 3590) includes two provisions that address shared decision making.
  - Support and Technical Assistance for Shared Decision Making
    - The purpose is to help engage both patients and caregivers through information and incorporating patient preferences and values into the treatment plan.
    - The bill requires that the Secretary of Health and Human Services contracts with entity to establish and endorse measures and certify decision aids. The Secretary is to award grants to develop and test decision aids and educate providers on their use.
    - The bill also funds resource centers to offer technical assistance to providers and support providers in developing shared decision making techniques.
    - The bill does not address evaluation and expansion.
  - CMS Innovation Center Activities
    - The purpose is to assist Medicare (and possibly Medicaid) beneficiaries in making informed health choices.
    - The bill specifies payment for providers for using shared decision making tools.
    - Shared decision making is one of 38 programs that decision makers for the Innovation Center can consider undertaking.
- According to Mr. Lee, the fact that the first Senate provision recognizes the current lack of and need for a certification body is significant. It highlights the current need to determine what would be considered "certified" shared decision making activities that would be eligible for payment. A key aspect of the second Senate provision is the authority to test shared decision making through rapid cycle testing and expand programs that are effective to the entire Medicare population. This feature of the bill represents an important delegation of authority to the HHS Secretary that previously had been controlled by Congress.

Improving Current Provisions

- Numerous consumer, patient, and purchaser groups have developed recommendations that identify the best provisions of the House and Senate bills. These recommendations focus on the areas of payment reform, comparative effectiveness research, performance measurement, and public reporting and are available at: http://www.pbgh.org/news/pubs/commentary.asp.
- Mr. Lee highlighted four steps that are essential for improving the current provisions:

  - Clarify that focus of shared decision making should be on decisions about preference-sensitive care;
  - Ensure robust provisions for conflict of interest;
  - Ensure that shared decision making is embedded into other payment programs (e.g., accountable care organizations, episode-based payment, patient centered medical home); and
  - Ensure clarification of the roles related to the first Senate provision regarding development of measures to assess decision aids, endorsement of measures, and decision aid certification.

- According to Mr. Lee it is especially important that the language in the provisions be clear about conflict of interest, ensuring that decision aids are developed to be balanced, evidence-based, and free of bias and conflict of interest, and guaranteeing a “conflict-free zone” in which to implement shared decision making.

Significance of Medicare-focused Reform

- Changing Medicare policies is necessary, because perhaps 130 Million of the estimated 300 million important medical decisions made annually relate to care of Medicare beneficiaries. In addition, Medicare is the largest single payer in the United States health system.
- However, changing Medicare policies is not sufficient, because Medicare spending represents just 19 percent of total health care spending in the United States.

Mr. Lee concluded by saying that shared decision making advocates s need to ensure that any legislation that does passes includes “shared decision making done right.” He also asserted that health care reform is not only about legislation, but is highly dependent on the actions of decision makers within private health plans, states, and municipalities. During the question and answer period that followed his presentation, Mr. Lee emphasized the importance of making the business case for shared decision making (with relevant and detailed metrics) so that decision makers of large employers can easily identify the benefits of choosing health plans and providers that engage in shared decision making.

John E. Wennberg, MD, MPH

Dr. Wennberg, co-founder of the Foundation for Informed Medical Decision Making and founder and director emeritus of The Dartmouth Institute for Health Policy and Clinical Practice, provided his perspective on the journey to widely implementing shared decision making.

- Dr. Wennberg began by querying the audience, "Where do we go with shared decision making when the federal government is no longer leading?" He answered, "The same place as before." He concurred with Mr. Lee that the inclusion of shared decision making in the health care reform bills was a success on the road to wider adoption of the process.

- Dr. Wennberg reviewed the distinction between preference-sensitive and supply-sensitive care.

  - Preference-sensitive care: conditions for which the treatment options ethically belong to the patient. The argument for implementing shared decision making in this context relates to avoiding overuse (e.g., avoid operating on a patient who if fully informed would not want the procedure).

  - Supply-sensitive care: treatment provided in situations in which clinical practice is affected by supply. Supply-sensitive care primarily involves the treatment of patients with chronic illnesses for which there is little evidence about the ideal frequency or intensity of treatment (e.g., MRIs, hospital admissions). Variations in supply-sensitive care for chronically ill patients accounts for the bulk of the more than 2.5 fold variation in per capita cost across regions in the US. The argument for implementing shared decision making in this context relates to the ethic of not causing harm when the ideal treatment is unclear.

Federal Health Care Reform Bills

Dr. Wennberg commented on three aspects of the current federal health reform bills as they relate to shared decision making: accountable care organizations, bundled payment, and the medical home concept. He views these initiatives as opportunities to implement the aspects of health care reform that are supportive of shared decision making, including provisions related to management of chronic illness, end of life care, underuse of effective care, and treatment of preference-sensitive conditions.

- *Accountable care organizations.* The current provisions on accountable care organizations include no mention of the importance of effective care for preference-sensitive condition, despite the fact that 25 percent of Medicare spending is spent on 13 major procedures for which preference is important. To the extent possible, shared decision making advocates should ensure that accountable care organizations are paying attention to preference-sensitive care, as well as supply-sensitive care.

- *Bundled payments.* The legislation regarding bundled payments is unclear in the sense that it does not adequately differentiate payment for medical and surgical admissions. The concept of payment based on 30 days of care misses the mark for surgical admissions, because the major source of practice and cost variation is not readmission but the volume of procedures. Including a requirement to engage in shared decision making in a bundled payment plan would be ideal, because it would address the true source of the variation. The concept of payment based on 30 days of care also misses the mark for admissions due to chronic medical conditions, because the unit of time for follow up for these conditions should be at least a year to foster provider accountability.

- *Medical home concept.* Dr. Wennberg views the medical home concept as an excellent entrée for shared decision making, because it would support the primary care provider as the champion of shared decision making. He asserts that many decisions about major surgery can be made by the primary care provider and the patient, with specialist referral used for confirmation and treatment rather than primary diagnosis. Having the guide for the patient's decision be with the primary care provider rather than the specialist would address problems with the current alignment of financial incentives for specialists.

Achieving Integrated Care

- Shared decision making advocates are interested in transforming the health care system, promoting organized care, supporting consistent allegiance to the ethic of informed patient choice, and ensuring that patients are treated over time for chronic conditions. To achieve these goals, the unit of focus must be the provider, because a shared decision making program will fail if each provider must deal with a variety of policies and programs from different health plans.

- Dr. Wennberg suggested that perhaps shared decision making advocates should be paying more attention to working for consensus with the decision makers of large employers, because this might provide the opportunity for an economic incentive similar to those possible in a fully capitated system. These decision makers could then use the same criteria for selective contracting that one might expect federal legislation to stipulate with regard to ACOs, bundled payments, and the medical home concept.

- The current technology for handling claims data could be used to identify the aggregate costs for a particular provider for managing care over time and quantify the frequency with which he or she orders or performs procedures for preference-sensitive conditions. This coalescence of economic incentives, supported with currently available information technology, could support the delivery of care in a manner that is truly integrated.

Dr. Wennberg concluded with a word of appreciation for the successes that supporters of shared decision making have achieved over recent years.