

Experts believe better measuring tools are needed to improve decision quality.

Overview

This review outlines the limitations of current decision quality measures. The authors make the case that widespread use of better measures will provide, along with appropriate incentives, the necessary impetus to shift to a more patient-centered and efficient health care system.

Background

Variation in the rates of surgical procedures is greatest when there is greater discretion about the best course of action, either due to uncertainty about the effectiveness of an intervention, variable interpretation of research on an intervention, or equal effectiveness of two or more interventions. Under these circumstances, local physician practice can result in geographic differences that can affect the cost and quality of health care. The use of practice guidelines and consensus opinion statements has not eliminated these geographic differences, partially because these tools do not take into account the patient's subjective response and preferences.

Shared decision-making has been advocated as a process for increasing patient involvement in medical decisions and avoiding the provision of impersonal care in which some patients receive interventions they would not have chosen while others fail to receive interventions they would have chosen if fully informed. Patient decision aids have been developed to support the implementation of shared decision-making in the clinical realm.

The authors assert that greater decision quality will increase the patient-centeredness and efficiency of health care.

To improve the quality of decision-making, the authors recommend that:

1. Researchers should develop and test better measures of decision quality.
2. Providers should develop systems to ensure the routine use of these measures in clinical practice.
3. Policymakers should provide incentives for providing greater patient-centered care through pay for performance programs that reward measurably improved decision quality.

Limitations of Current Decision Quality Measures
The authors believe that the four most commonly used measures of decision quality, all of which are based on patient report, are flawed, as outlined in the table.

Decision Quality Measure	Limitation
Satisfaction with decision-making	Results are affected by patient expectation (i.e., low prior expectations may result in high satisfaction scores)
Nature of interaction with physician	Questions are often misinterpreted; patients cannot reliably answer questions about shared decision-making if they have never experienced decision-making that is truly collaborative
Patient state (i.e., knowledge)	Responses are limited by patients' perspective (i.e., patients cannot report the extent to which they are fully informed)
Treatment choice made	Choice of treatment does not provide reliable information about decision quality without additional information on patient values

Proposed New Measures

According to the authors, measures of decision quality should assess the degree to which a clinical decision reflects the needs, values, and preferences of a patient who is well informed and whether the decision is implemented in accordance with these needs, values, and preferences. Such measures require input from patients. The authors purport that three different sets of information are required for improved measurement of decision quality:

1. Decision-specific knowledge
2. Values regarding the relevant outcomes
3. Treatment choice made

The treatment choice made can be ascertained through medical records. Focus groups and other tools can be used to identify the key information needed to make an informed decision and to clarify relevant patient values. According to the authors, data collected for the first two sets need not be exhaustive but instead can focus on key items that assess patient knowledge (eg, four multiple choice questions) and values (eg, three value-based scales to be scored 1 to 10).

Data collected on these three measures could be used to determine whether patients are well informed about treatment options and to assess the concordance between patient values and chosen treatment. The authors caution that a mismatch between values and treatment choice may not necessarily indicate poor decision quality. Rather, the patient may have made a choice based on values that are not captured in the value-based scales.

In general, however, the concordance measure should reflect the degree to which decision variation is explained by patient preference and would thus reflect decision quality. The concordance measure could be used to compare decision quality and degree of patient-centeredness across populations. The authors are currently evaluating concordance measures for 14 common conditions for which there is a great deal of uncertainty and variation in patient preference.

Previously known about the topic:

- Geographic variations of care often are due to local physician practice rather than differences in patient needs and preferences.
- The process of shared decision-making can improve decision quality and help address this gap

Contribution of this study:

- Current measures of decision quality are flawed. Improved measures require three sets of information:
 1. Decision-specific knowledge
 2. Values regarding the relevant outcomes
 3. Treatment choice made
- Because these measures requires direct input from patients, and they can be used to assess the concordance between patient values and chosen treatment.

Implementation

The authors state that the use of these concordance measures would require researchers to query patients with questions tailor specifically to that decision either before or shortly after a decision is made. It also would require measurement to be embedded into the process of care, which may create challenges to implementation. These challenges, the authors note, are similar to those highlighted in the Institute of Medicine's Crossing the Quality Chasm, which called for sweeping changes to improve the quality of care delivered in the United States. The authors believe that such implementation may be more feasible, once organizations begin to redesign care delivery in response to the IOM recommendations. A number of organizations already have incorporated decision aids into their care processes for specific conditions, suggesting that implementation challenges can be overcome with effective leadership and favorable incentives and rewards. The authors hypothesize that pay-for-performance programs may activate organizational leaders to take greater responsibility for decision quality and its measurement.

The authors purport that improvement is likely to occur only with routine measurement of the desired performance, which creates pressure for improvement. Highlighting gaps in patient knowledge and low concordance between patient values and the treatment chosen may stimulate a shift toward improved decision-making and care delivery, according to the authors. Organizational leaders could potentially use concordance rates to create guidelines for care decisions in which personalization of care is rewarded and decision-making without adequate provision of relevant facts to patients is prohibited. According to the authors, failure to attend to the quality of individual care decisions will result in continued variation in the rates of procedures performed across the country. To this end, the authors recommend that improving decision quality be given a high priority in the current pay-for-performance arena.

Key Implications

- Current measures of decision quality are flawed; improved measures will require patient input to assess patients' acquisition of relevant knowledge and the concordance between patient values and chosen treatment.
- Improved measures of decision quality will highlight current gaps and may galvanize a shift toward a more patient-centered and efficient health care system. ■

Full citation:

Policy support for patient-centered care: the need for measurable improvements in decision quality. Sepucha KR, Fowler FJ Jr, Mulley AG Jr. Health Aff (Millwood). 2004;Suppl Web Exclusives:VAR54-62.

Author contact information:

Karen R. Sepucha, PhD, Health Decisions Research Unit, Massachusetts General Hospital, Boston, MA. (ksepucha@partners.org).