Aligning Forces for Quality | Improving Health & Health Care in Communities Across America

Robert Wood Johnson Foundation

PRIMER/BRIEF

Shared Decision-Making and Benefit Design: Engaging Employees and Reducing Costs for Preference-Sensitive Conditions

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I. Introduction

Shared decision-making (SDM) involves incorporating the patient's perspective and values into decisions about treatment in collaboration with the clinician when there is no "right" course of treatment based on available evidence. SDM has drawn attention in recent years as the value placed on patient engagement has grown and as research has found that well-informed patients tend to choose less invasive—and less costly—treatment alternatives. This brief introduces preference-sensitive care and SDM, highlights emerging initiatives by health plans and employers (including financial incentives to adopt SDM), and suggests action steps and key issues for employers and Alliances to consider.

About Aligning Forces for Quality

Aligning Forces for Quality (AF4Q) is the Robert Wood Johnson Foundation's signature effort to lift the overall quality of health care in targeted communities, as well as reduce racial and ethnic disparities and provide real models for national reform. The Foundation's commitment to improve health care in 16 AF4Q communities is the largest effort of its kind ever undertaken by a U.S. philanthropy. AF4Q asks the people who get care, give care and pay for care to work together to improve the quality and value of care delivered locally. The Center for Health Care Quality in the Department of Health Policy at George Washington University School of Public Health and Health Services serves as the national program office. Learn more about AF4Q at www.forces4quality.org. Learn more about RWJF's efforts to improve quality and equality of care at www.rwjf.org/goto/af4q/.

About the Author

American Institutes for Research (AIR) provides technical assistance for the Robert Wood Johnson Foundation's *Aligning Forces for Quality* initiative. AIR is working with Aligning Forces communities to support consumer engagement efforts to promote higher-quality health care at a lower cost.

II. What Are Preference-Sensitive Conditions, and Why Do They Matter?

More than 8 out of 10 adults over age 40—including employees—are making decisions about their health and health care on a regular basis:[i]

- 21.6 million adults have discussed surgery with a health care provider
- 97 million have discussed a screening test with a health care provider
- 75 million have made a decision about a medication.

However, many patients report a lack of involvement in the decision-making process. About 75 percent to 85 percent of patients report that physicians made a recommendation—generally in favor of undergoing surgery, taking a medication, or being screened. Additionally, patients report that physicians discuss the reasons to have a treatment or test more frequently than they do the reasons not to have a treatment or test. For example, only 20 percent to 32 percent of patients report their physician discussed why they may not want to have a cancer screening test.[ii]

These decisions can have a big effect on patient outcomes—both health and financial—and on the bottom line for employers. For instance, research shows that surgery costs can be reduced by up to 40 percent when patients are actively involved in clinical decision making.[iii]

For many common health problems or conditions, there is no "gold standard." In fact, about one out of every three medical decisions has two or more clinically appropriate treatment options.[iv] Those kinds of conditions are called preference-sensitive conditions, or PSCs, because the patient's preferences and values should play a critical role in the decision. Examples of PSCs include low back pain, early-stage breast cancer and prostate cancer, and hip and knee arthritis. Often, the options have risks and benefits that affect quality of life. For some conditions, such as early-stage prostate cancer, research even suggests the best care may be watchful waiting (see the box below).

> "Shared decision making is about…eliciting their values and preferences. What really, really matters to you? Do you care about avoiding surgery? Are you willing to accept some risk? Do you want to avoid having to take pills, or are you willing to go through pill taking and physical therapy to avoid surgery?"
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> —Kathleen Fairfield, MD, MPH, DrPH, faculty, Maine Medical Center Research Institute's Center for Outcomes Research and Evaluation
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> *Source: Gina Shaw, Shared Decision Making: The Patient as the Expert, Assoc. of American Medical Colleges Reporter, November 2011.*

Clinical condition	Treatment options	Trade-offs among alternatives
Chronic stable angina	- Medical Treatment - Angioplasty - Bypass surgery	- Avoids the downsides of interventions but is less effective at improving symptoms, and some patients have shorter survival - Lower procedure risks than surgery, but symptom relief is not as long lasting - Effective and durable in relieving symptoms, but there are significant risks of mortality and disability, including stroke
Hip osteoarthritis	- Medical Treatment - Hip Replacement	- Low risk, but not very effective in relieving symptoms - Very effective, but there are modest risks of mortality and complications, as well as a long recovery period
Carotid stenosis	- Aspirin - Carotid endarterectomy	- Lower short-term risks, but higher risks of stroke over the long term -Reduces overall stroke risks, but there are significant risks of mortality and of perioperative stroke
Herniated disc or spinal stenosis	- Medical treatment (chiropractor, other) - Back surgery	- Symptoms often resolve without surgery, but might not - Frequently relieves symptoms but has complication risks and is not always effective
Early-stage prostate cancer	- Watchful waiting - Radiation (conventional or implant seeds) - Radical prostatectomy	- Many prostate cancers never progress to affect quality of life or survival, but some do - Shrinks or eliminates cancer in the prostate, but there are risks of side effects - Removes prostate cancer entirely, but there are substantial risks of incontinence and impotence

Excerpt from Table 1 in: Center for Evaluative Clinical Sciences, Dartmouth Medical School. Dartmouth Atlas Project Topic Brief: Preference Sensitive Care 6. 2005.

III. What Does Shared Decision-Making Do, and Why Does it Matter?

Health care trends have shifted away from a paternalistic care model toward a collaborative one that emphasizes the patient-provider partnership and joint decision-making. Still, many patients are not receiving care that reflects their preferences. That's not ideal; when patients discuss preferences with their physicians, they are more likely to get the care they want.[v] And patients who are more engaged in their health and health care have better outcomes.[vi] A healthier patient can be more productive—and a healthier workforce may lower health care costs.[vii]

In shared decision-making, a patient's values and preferences are central factors in choosing among two or more treatment options.[viii] SDM can bridge the gap between the care patients want and the care they receive and can help contain health care spending by avoiding treatments patients don't want.[ix] While there is no standard model for SDM, the hallmarks are clarification of the patient's values, preferences, and personal situation and an informed decision made by the patient, clinician, and family; patient decision aids (PDAs) are a common feature.

Patient decision aids (PDAs), such as pamphlets, DVDs, websites, and videos, can educate patients and provide condition-specific information about treatment options. PDAs usually:

- provide evidence-based information, including the risks and benefits of potential treatment options;
- help patients clarify and communicate their own values and preferences; and
- provide guidance and coaching on how to approach the decision-making process.[x]

Shared Decision-Making in Action: A real-world example

"When it came to charting a path for her breast cancer treatment, Kathy Sabadosa, 43, realized she'd rather preserve a lifestyle of skiing, running, biking, and caring for two young kids than save her figure. After her diagnosis two years ago, Sabadosa's first inclination was to have her whole breast removed and to undergo reconstructive surgery. But after her surgeon drew Sabadosa out about her priorities and how she might handle reconstruction's possible side effects (arm swelling, shoulder problems, scarring around an implant), she decided to skip that step. 'My arm and shoulder functioning was much more important to me,' says Sabadosa."

Source: Baldauf S. "Medical Treatment: Patients and 'Shared Decision Making.'" U.S. News & World Report. November 25, 2009.

Components of Decision-Making

Patient-provider discussion about treatment options	Typical health care decision-making	Shared decision-making (SDM)
Risks and benefits	X	X
Alternatives	X	X
Probabilities of various outcomes	X	X
Clarification of patient values, preferences, and personal situation		X
May use a PDA to help inform and guide decision		X
Informed choice made in partnership among patient, clinician, and family		X

Source: Burkhard C et al., Shared Decision Making in Health Care Delivery: Background Information and Policy Options for New Hampshire (May 2011).

SDM can be an important tool for both employers and employees—it can simultaneously improve patient outcomes and experience of care while reducing costs. Although evidence on the benefits of SDM is evolving, research shows use of PDAs improves the quality of the patient's decision—measured by the amount of alignment between what a patient wants and the treatment he or she receives. According to the Informed Medical Decisions Foundation, "Measuring decision quality helps shed light on ways to improve the decision-making process and whether or not 'good' treatment decisions are being applied in the practice of medicine." The Foundation notes that to measure the quality of a medical decision, one must be able to assess whether or not the:

- patient has the knowledge to make an informed decision;
- the final decision reflects the patient's preferences; and
- the patient is satisfied with the treatment decision made.[xi]

Research also shows that informed patients opt for less invasive and less costly treatment options.[xii] In fact, a review of PDA use found that, on average, using an SDM process involving PDAs is associated with a 25 percent decrease in preference-sensitive surgical treatments.[xiii] As employers continue to seek ways to cut costs, reduce risks to employees associated with unnecessary surgery, improve workforce productivity, and increase employee satisfaction, SDM looks promising.

IV. How Prevalent is Shared Decision-Making?

SDM is becoming more prevalent, but research suggests there is still a gap between what people want and what they get. In a survey sponsored by the IOM Evidence Communication Innovation Collaborative, nine out of 10 adults said they want their clinician to offer choices for tests and treatments, and not just the option that their physician recommends. Additionally, two-thirds said they want to know the risk of each option, including how it impacts quality of life, and about half want to discuss the option of doing nothing.[xiv]

> *"We've found that consumers don't trust what comes from the health plan necessarily, and they don't trust what comes from the employer. So those are hurdles that we have to overcome since that's the source of most of the material that we're sending."*
>
> – Employer and Collaborative Participant, AIR's Communication Toolkit

Incorporating shared decision-making at the point of care will require a culture change on behalf of both providers and patients,[xv] yet efforts to improve the quality of health care are helping spread its adoption. Both the federal government, through the 2010 Patient Protection and Affordable Care Act (PPACA), and states are playing critical roles. In 2007, **Washington State** passed legislation to support the use of SDM, recognizing that a patient's signed acknowledgement of participation in SDM is evidence of informed consent. The legislation also calls for demonstration projects to evaluate the feasibility and impact of SDM on quality and cost. And in 2009, **Vermont, Maine, Connecticut, Minnesota, and California** drafted or introduced SDM bills.[xvi]

A number of non-profit advocacy organizations are also advancing the use of SDM and PDAs. Finally, vendors are developing SDM products for employers and health plans, making tools more widely available to providers and patients, including employees.

V. How Can Employers Support Employee Participation in Shared Decision-Making?

There are two main avenues for supporting SDM: providing information and support, and doing so in conjunction with financial incentives. Before pursuing either option, it's best to have a clear utilization profile for the employee population. If there is a high rate of preference-sensitive care, such as hip replacements, low-back surgery, and mastectomy, investing in SDM may make sense.

Informing employees involves some combination of materials (e.g., articles, videos), personalized coaching services (often provided by phone), and interactive decision tools that lead employees through a series of questions, resulting in a suggested course of action. These services can be provided directly by health plans, or through vendors such as Health Dialog, Healthwise, or Consumer's Medical Resource (CMR), that offer services and tools to help educate and engage consumers in their health and health care to facilitate informed decisions.

A bigger step is creating financial incentives for participation in SDM. In theory, differential cost-sharing makes sense—employees pay a lower share of cost (e.g., a lower deductible, lower copayment, or lower coinsurance) when they complete an SDM process. In practice, it may be simplest to provide a cash reward, such as a gift card, to patients, providers, or both.

The following tips can help employers and health plans interested in pursuing SDM initiatives:

- **Link the reward to the process**. Provide the financial incentive for going through the SDM process, rather than for selecting a specific (e.g. lower-cost) treatment option at the end. The intent of SDM is to support employee decision-making that reflects their values and preferences when there is no clearly superior medical alternative—not to influence the decision.

- **Communicate transparently and proactively** about how you are introducing shared decision-making and how employees will benefit (through increased understanding of treatment alternatives and tradeoffs). The Communication Toolkit provides supportive materials for employers to adapt and use.
- **Make it easy and straightforward** for employees to participate in SDM and to certify they have done so. Otherwise, employees might reject the initiative.
- **Reach employees early** in the decision-making process. Efforts that reach employees later, after they have already chosen a treatment course, have little effect. Approaches include using the results of employee health risk assessments and predictive modeling to identify those likely to encounter a decision about preference-sensitive care, and working with primary care physicians so shared decision-making begins even before the patient is referred to a specialist.

VI. How Are Employers and Health Plans Using Benefit Design to Encourage Shared Decision-Making?

Whereas health plans and employers are making more PDAs and coaching services available to enrollees and employees, financial incentives to support SDM are less common. Such financial incentives can be seen as one form of "value-based insurance design," broadly defined as tailoring benefit and network design to encourage the use of effective services and discourage the use of ineffective services.[xvii] As applied to SDM, the premise is that the most effective service when there is no clearly superior clinical alternative is the one that best reflects the patient's values and preferences. The following three examples highlight initiatives with financial incentives.

"Get Vertical: And Don't Take Back Pain Lying Down!"

The Oregon Quality Care Corporation, one of the 16 Alliances in the Aligning Forces for Quality initiative funded by the Robert Wood Johnson Foundation, encourages safe, effective care for low back pain—*the fifth most common reason for all U.S. physician visits, with annual costs of more than $26 billion (1)*. The goal, says the corporation's Katrina Kahl, is to "help people with low back pain take simple steps on their own to feel better and increase the appropriate use of medical resources for this condition…[We are trying] to help people better understand what they can do on their own to avoid unnecessary health care services. By 'unnecessary health care services,' we mean imaging tests for low back pain, prescription drugs for low back pain, and ultimately, surgery that may or may not do any good for people with this condition." Read more in an interview with Katrina Kahl on AIR's Communication Toolkit.

1. Deyo RA, Mirza SK, Martin BI. "Back Pain Prevalence and Visit Rates: Estimates from U.S. National Surveys, 2002.: *Spine*, 2006(31) :2724-2727 [PMID: 17077742].

Providence Health Plan, based in Oregon, launched a two-year "Information Rx" initiative in 2011 to help patients access information and participate in their care. The program targets primary care physicians to reach patients "upstream" in the decision process—before they visit a specialist and make a treatment decision. Primary care physicians write a "prescription" for PDAs, provided by vendor Healthwise, for one of four major care conditions. That prescription triggers an email to the patient with the relevant decision support tool. The tool captures patient responses regarding values, preferences, and level of understanding of the condition and treatment alternatives; that information reaches the primary care physician before the next clinical encounter, where it can inform the in-person conversation about options. For each completed PDA, clinicians receive $100, and the patient receives a non-cash reward with a maximum value of $20.

The San Luis Valley Regional Medical Center, based in Colorado, introduced new benefit design features for employees and dependents in January 2012 with support from Engaged Benefit Design.[xviii] First, "high-value" services are covered at 100 percent (no enrollee cost-sharing) for some chronic conditions. Covered services, which must be provided by a narrow network, include two office visits, generic prescription drugs, and specific recommended imaging and lab tests. Second, a surcharge of $300 is levied for a number of specific services, including outpatient upper endoscopy for GERD, hip and knee replacement, stents, and surgery for benign prostate hypertrophy. Engaged Benefit Design calls these "costs more, learn more" services and defines them as services that are "often expensive and require careful consideration by the patient"; the surcharge is intended to be a "speed bump" to encourage patients to slow down and learn about these services and alternatives. Third, enrollees who complete a PDA prescribed by their provider and supplied by vendor Health Dialog receive a $50 gift card, providing an incentive for them to learn more about the condition and treatment options before deciding on treatment with their provider.

Campbell Soup, based in New Jersey**,** offers its approximately 9,000 U.S.-based employees and union members a variation on shared decision-making that focuses on the patient side of the equation. This high-touch product, offered by Consumer's Medical Resource (CMR), features physician-led research teams that provide tailored information in response to requests from individual employees facing medical decisions or seeking guidance on a specific situation (e.g., preparing for surgery). The goal is to prepare patients for conversations with their physicians and ensure they have relevant and comprehensive information on the range of treatment options available—and to allow employees to choose the treatment options that work best for their personal situation. The product includes a surgical component targeting high-cost procedures with significant variation, including low back surgery, hysterectomy, hip and knee replacement, and obesity surgery. Employees who complete the decision support process—which can take anywhere from 3 weeks to 9 months—and respond to a detailed survey regarding the information and coaching services provided and their influence on the treatment decision receive a gift card. This program is completely voluntary for employees, and all interactions between CMR and the employee are confidential.

VII. Conclusion

SDM isn't a silver bullet, and experts (including those we interviewed) caution against overestimating cost savings that may result from employees' choosing less invasive and costly treatment options.[xix] Still, SDM can simultaneously improve patient outcomes and experience of care while achieving modest savings—depending on the profile of the employee population, current utilization, and the specific benefit changes implemented. Many believe that, even without cost savings, engaging patients in decision-making about their treatment options when there is no clearly superior clinical alternative is the right thing to do.

Working together, Alliances can help employers use data to structure and implement benefit designs that support SDM to maximize health care dollars and resources while improving the quality of care. More specifically, Alliances can provide employers:

- help analyzing data to understand better the health care needs and costs of an employee population;
- guidance on how employers can communicate with health plans to help ensure employees are getting high-value care;
- guidance on how to communicate with employees about health care decisions and changes to benefit design; and
- information and meetings on hot topics affecting employers and employees, such as employee/patient engagement, SDM and patient decisions aids, and benefit design.

[i] Zikmund-Fisher BJ, Couper ES, Levin CA, et al. "The DECISIONS Study: A Nationwide Survey of United States Adults Regarding 9 Common Medical Decisions." *Medical Decision Making*, April 2010.
[ii] Ibid.
[iii] Wennberg JE, et al. "Improving Quality and Curbing Health Care Spending: Opportunities for the Congress and the Obama Administration." *Dartmouth Atlas Project*, 2008.
[iv] Center for Evaluative Clinical Sciences, Dartmouth Medical School. Dartmouth Atlas Project Topic Brief: Preference Sensitive Care 6. 2005.
[v] Teno JM, et al. *Journal of the American Geriatrics Society*.
[vi] Stacey D, Bennett CL, Barry MJ, et al. "Decision aids for people facing health treatment or screening decisions." *Cochrane Database of Systematic Reviews 2011*, Issue 10. Art. No.: CD001431. DOI: 10.1002/14651858.CD001431.pub3
[vii] Baicker K, Cutler D, Song Z. "Workplace Wellness Programs Can Generate Savings." *Health Affairs*, February 2010.
[viii] The Shared Decision-Making Study Group for the Dirigo Health Agency's Maine Quality Forum. Final Report: The Practice and Impact of Shared Decision-Making. February 2011.
[ix] National Institute for Health Care Reform. Policy Options to Encourage Patient-Physician Shared Decision Making. Policy Analysis. No. 5. September 2011.
[x] O'Connor AM, Bennett CL, Stacey D, et al. "Decision aids for people facing health treatment or screening decisions" (Review). *Cochrane Review*. 2009.
[xi] Foundation for Informed Medical Decisions. http://informedmedicaldecisions.org/category/research/decision-quality/. Accessed on October 22, 2012.
[xii] O'Connor et al.
[xiii] Ibid.
[xiv] Novelli W, Halvorson G, and Santa J. "Recognizing an opinion: Findings from the IOM Evidence Communication Innovation Collaborative." *Journal of the American Medical Association*, 308(15), 2012.
[xv] Fowler F, Levin C, Sepucha K. "Informing and Involving Patients to Improve the Quality of Medical Decisions." *Health Affairs*, 30(4): 699-706, 2011.
[xvi] Wennberg D, Barbeau B, Gerry E. "Power to the Patient: The importance of shared decision-making. Health Dialog." June 2009.
[xvii] For more information, see the University of Michigan's Center for Value-Based insurance Design or the November 2010 issue of the journal *Health Affairs*.
[xviii] Engaged Benefit Design (engagedbenefitdesign.org) is a collaborative effort of several funders and organizations. Their framework of "no copay, high value" and "costs more, learn more" services guides the benefit of design adopted by the San Luis Valley Regional Medical Center.
[xix] The Shared Decision-Making Study Group for the Dirigo Health Agency's Maine Quality Forum, February 2011.