

Shared Decision Making

The following summaries of recent peer-reviewed articles describe the impact of shared decision making on patient experience, patient safety, quality, and outcomes. Citations are linked to full-text articles [*] when available.

Study	Objective	Conclusion
<p>Sepucha, K., Atlas, S. J., Chang, Y., Dorrwachter, J., Freiberg, A., Mangla, M., ... Cha, T. (2017). Patient decision aids improve decision quality and patient experience and reduce surgical rates in routine orthopaedic care: A prospective cohort study. <i>Journal of Bone and Joint Surgery</i>, 99(15), 1253-1260.</p>	<p>To examine whether decision aids increase shared decision making when used in routine care.</p>	<ul style="list-style-type: none"> ▪ The use of patient decision aids in routine care can ensure that patients are informed and are engaged in surgical decisions for common orthopaedic conditions. ▪ Patient decision aids, when used as part of routine orthopaedic care, are associated with increased knowledge, more shared decision making, higher patient experience ratings, and lower surgical rates.
<p>[*] Chiu, C., Feuz, M. A., McMahan, R. D., Miao, Y., & Sudore, R. L. (2016). "Doctor, make my decisions": Decision control preferences, advance care planning, and satisfaction with communication among diverse older adults. <i>Journal of Pain and Symptom Management</i>, 51(1), 33-40.</p>	<p>To determine the decision control preferences (DCPs) of diverse, older adults and whether DCPs are associated with participant characteristics, advance care planning (ACP), and communication satisfaction.</p>	<ul style="list-style-type: none"> ▪ The majority of older populations prefer to share decisions with their doctor or make their own decisions. ▪ Although older individuals with low DCPs report slightly less readiness to ask questions of their doctors, they are as likely as their counterparts with high DCPs to report asking doctors questions and to feel satisfied with patient-clinician communication. ▪ Clinicians should elicit patients' DCPs to provide the desired amount of decision support and to ensure informed decision making, especially if an appropriate surrogate decision maker needs to be identified.
<p>[*] Agency for Healthcare Research and Quality (2015). The SHARE Approach.</p>	<p>To provide a toolkit of resources for implementing the SHARE Approach, a five-step process for shared decision making.</p>	<ul style="list-style-type: none"> ▪ Optimal shared decision making integrates evidence-based information about patients' health care options, clinician expertise, and patients' values and preferences. ▪ Clinicians must engage in meaningful dialogue about the benefits, harms, and risks of each health care option while also helping patients articulate what matters most to them. ▪ The SHARE Approach honors patient autonomy and the right to be fully informed about care options through the following steps: <ul style="list-style-type: none"> – Seek your patient's participation – Help your patient explore and compare treatment options – Assess your patient's values and preferences – Reach a decision with your patient – Evaluate your patient's decision

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<p>Hess, E. P., Grudzen, C. R., Thomson, R., Raja, A. S., & Carpenter, C. R. (2015). Shared decision-making in the emergency department: Respecting patient autonomy when seconds count. <i>Academic Emergency Medicine</i>, 22(7), 856-864.</p>	<p>To highlight aspects of shared decision making that are relevant to the practice of emergency medicine.</p>	<ul style="list-style-type: none"> Emergency department clinicians can effectively engage in shared decision making by moving across paternalistic, shared, and informed decision-making models in a single interaction. Having a dynamic view of shared decision making honors patient autonomy and the right to be fully informed about care options while also accommodating the practical and contextual challenges of the emergency department setting.
<p>Posner, K. L., Severson, J., & Domino, K. B. (2015). The role of informed consent in patient complaints: Reducing hidden health system costs and improving patient engagement through shared decision making. <i>Journal of Healthcare Risk Management</i>, 35(2), 38-45.</p>	<p>To examine the role of shared decision making in patient engagement and in reducing health system costs attributed to informed consent complaints.</p>	<ul style="list-style-type: none"> Shared decision making reduces healthcare resource expenditures associated with processing informed consent complaints. Risk disclosure and lack of recall of risk discussion is one of the most common sources of informed consent complaints. Shared decision making with use of vetted decision aids provides an opportunity to address problems of risk disclosure and may aid in patient recall of risk discussions. Shared decision making has potential to reduce institutional malpractice risk associated with informed consent complaints.
<p>[*] Durand, M., Carpenter, L., Dolan, H., Bravo, P., Mann, M., Bunn, F., & Elwyn, G. (2014). Do interventions designed to support shared decision-making reduce health inequalities? A systematic review and meta-analysis. <i>PLOS One</i>, 9(4), e94670.</p>	<p>To evaluate the impact of shared decision making interventions on disadvantaged groups and health inequalities.</p>	<ul style="list-style-type: none"> Shared decision making interventions significantly improve outcomes for disadvantaged patients. Shared decision making interventions may be more beneficial to disadvantaged groups than higher literacy/socioeconomic status patients. It is essential to support groups who are burdened by worse health outcomes and traditionally disengaged, by tailoring communication, information, and shared decision making interventions to their specific needs: using plain language information, avoiding complex medical jargon, and using shorter interventions (with simpler layouts and formats).
<p>Fox, D., Brittan, M., & Stille, C. (2014). The pediatric inpatient family care conference: A proposed structure toward shared decision-making. <i>Hospital Pediatrics</i>, 4(5), 305-310.</p>	<p>To describe a structure for family care conferences (FCCs) in the pediatric inpatient setting with a literature-based description of each phase of the conference.</p>	<ul style="list-style-type: none"> In the inpatient environment in which children are increasingly admitted for more complex care, providers need to develop skills managing the decisional and emotional needs of families faced with navigating the medical system. FCCs in the pediatric inpatient setting have the potential to support families in collaborative and shared decision making. Preparing appropriately for FCCs, using a structured communication style, and engaging parents to express their concerns may improve the outcomes of these meetings.

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<p>Joseph-Williams, N., Elwyn, G., & Edwards, A. (2014). Knowledge is not power for patients: A systematic review and thematic synthesis of patient-reported barriers and facilitators to shared decision making. <i>Patient Education and Counseling</i>, 94(3), 291-309.</p>	<p>To systematically review patient-reported barriers and facilitators to shared decision making and develop a taxonomy of patient-reported barriers.</p>	<ul style="list-style-type: none"> ▪ A large number of patients currently <i>can't</i> participate in health care, due to various structural, predisposing, interactional, and preparatory factors, rather than the more common view among clinicians that patients <i>won't</i> participate because they don't want to. ▪ Patient-reported barriers and facilitators to shared decision making relate to how the health care system is organized (e.g., time available, continuity of care, organization of workflow and the setting itself) and to what happens in the consultation (e.g., patient characteristics, power imbalance between patient and clinician, preparation for the encounter). ▪ Most patient-reported barriers and facilitators are potentially modifiable, and many could be addressed by attitudinal changes at the levels of patient, clinician/health care team, or organizational change.
<p>Bernabeo, E., & Holmboe, E. S. (2013). Patients, providers, and systems need to acquire a specific set of competencies to achieve truly patient-centered care. <i>Health Affairs</i>, 32(2), 250-258.</p>	<p>To address the knowledge, skills, and attitudes that patients, physicians, and health care systems require to effectively engage patients in their health care.</p>	<ul style="list-style-type: none"> ▪ Patients vary in the roles and degree of control that they want to assume in decisions about their medical treatment. Cultural differences, sex, age, education, and severity of illness also influence patients' degree of engagement in decision making processes. ▪ Physicians must agree that patients should be part of the decision making process and cannot assume that "one size fits all" in shared decision making. ▪ Systems must move toward stronger support of inter-professional collaboration and teamwork and be willing to make structural changes such as new information systems needed to link patients with decision aids and other resources, redesigned models of office care, and restructured reimbursement schemes.
<p>Friedberg, M. W., Van Busum, K., Wexler, R., Bowen, M., & Schneider, E. C. (2013). A demonstration of shared decision making in primary care highlights barriers to adoption and potential remedies. <i>Health Affairs</i>, 32(2), 268-275.</p>	<p>To better understand how delivery systems can implement shared decision making.</p>	<ul style="list-style-type: none"> ▪ Barriers to shared decision making included overworked physicians, insufficient provider training, and clinical information systems incapable of prompting or tracking patients through the decision making process. ▪ Methods to improve shared decision making included using automatic triggers for the distribution of decision aids and engaging team members other than physicians in the process. ▪ Substantial improvements in provider training, information systems, and process reengineering may be necessary to implement shared decision making successfully.
<p>Katz, S. J., & Hawley, S. (2013). The value of sharing treatment decision making with patients: Expecting too much? <i>The Journal of the American Medical Association</i>, 310(15), 1559-1560.</p>	<p>To highlight the limitations of studies that conclude shared decision making reduces overtreatment and medical costs.</p>	<ul style="list-style-type: none"> ▪ Inadequate attention has been paid to disentangling patient- vs. clinician-level effects in studies of interventions aimed at evaluating the influence of shared decision making on utilization. ▪ Studies on shared decision making have not adequately considered the complexity of how patients construct and express their preferences for treatment. ▪ Blanket assumptions about which health conditions or treatments are more or less sensitive to patient

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		<p>preferences do not fully consider the wide variability in the context of the clinical management which oversimplifies the clinical encounter.</p>
<p>King, J., & Moulton, B. (2013). Group Health's participation in a shared decision making demonstration yielded lessons, such as role of culture change. <i>Health Affairs</i>, 32(2), 294-302.</p>	<p>To study the costs and benefits of integrating shared decision making processes into clinical practice across a range of conditions for which multiple treatment options are available.</p>	<ul style="list-style-type: none"> ■ Key lessons for successful shared decision making implementation were identified, including: <ul style="list-style-type: none"> – The synergy between efforts to reduce practice variation and increased shared decision making – The need to support modifications in practice with changes in physician training and culture – The value of identifying best implementation methods through constant evaluation and iterative improvement
<p>[*] Lee, E. O., & Emanuel, E. J. (2013). Shared decision making to improve care and reduce costs. <i>The New England Journal of Medicine</i>, 368, 6-8.</p>	<p>To describe how a section of the Affordable Care Act (ACA) encourages greater use of shared decision making in health care that the Centers for Medicare and Medicaid Services (CMS) should respond to by certifying and implementing patient decision aids.</p>	<ul style="list-style-type: none"> ■ Section 3506 of the ACA funds an independent entity that would develop consensus-based standards and certify patient decision aids for use by federal health programs and other interested parties. ■ The secretary of health and human services is empowered to fund, through grants or contracts, the development and evaluation of patient decision aids. ■ Health care providers will be eligible for grants to implement patient decision aids and to receive training and technical support for shared decision making at new resource centers. ■ Certifying and implementing patient decision aids promotes an ideal approach to clinician-patient decision making, improves the quality of medical decisions, and reduces costs.
<p>Légaré, F., & Witteman, H. O. (2013). Shared decision making: Examining key elements and barriers to adoption into routine clinical practice. <i>Health Affairs</i>, 32(2), 276-284.</p>	<p>To describe the three essential elements of shared decision making: recognizing and acknowledging that a decision is required, knowing and understanding the best available evidence, and incorporating the patient's values and preferences into the decision.</p>	<ul style="list-style-type: none"> ■ To achieve the promise of shared decision making, more physicians need training in the approach. ■ More practices need to be reorganized around the principles of patient engagement. ■ There is no robust evidence that more time is required to engage in shared decision making in clinical practice than to offer usual care. ■ The process should be at least recommended for all patients, with adaptations to suit individuals' ability and interest.
<p>[*] Tak, H. J., Ruhnke, G. W., & Meltzer, D. O. (2013). Association of patient preferences for participation in shared decision making with length of stay and costs among hospitalized patients.</p>	<p>To examine the relationship between patient preferences for participation in medical decision making and health care utilization among hospitalized patients.</p>	<ul style="list-style-type: none"> ■ 96.3% of patients expressed a desire to receive information about their illnesses and treatment options. ■ 71.1% of patients preferred to leave medical decision making to their physician. ■ Preference to participate in decision making increased with educational level and with private health insurance.

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<p><i>JAMA Internal Medicine</i>, 173(13), 1195-1203.</p>		
<p>Veroff, D., Marr, A., & Wennberg, D. E. (2013). Enhanced support for shared decision making reduced costs of care for patients with preference-sensitive conditions. <i>Health Affairs</i>, 32(2), 285-293.</p>	<p>To compare the effects on patients of receiving a usual level of support in making a medical treatment decision with the effects of receiving enhanced support.</p>	<ul style="list-style-type: none"> ■ Support for shared decision making can generate savings. ■ Patients who received enhanced support had 5.3% lower overall medical costs than patients who received the usual level of support. ■ The enhanced-support group had 12.5% fewer hospital admissions than the usual-support group and 9.9% fewer preference-sensitive surgeries. ■ A “remote” model of support (e.g., combining telephonic coaching with decision aids) may be a relatively low-cost and effective intervention.
<p>Weiner, S. J., Schwartz, A., Sharma, G., Binns-Calvey, A., Ashley, N., Kelly, B., ... Harris, I. (2013). Patient-centered decision making and healthcare outcomes: An observational study. <i>Annals of Internal Medicine</i>, 158(8), 573-579.</p>	<p>To ascertain whether encounters in which patient-centered shared decision making occurs are followed by improved health care outcomes compared with encounters where there is inattention to patient context.</p>	<ul style="list-style-type: none"> ■ When physicians take into account the needs and circumstances of their patients when planning their care, individualized health care outcomes improve. ■ Having seen the same physician at the most recent clinic visit was associated with improved patient outcomes. ■ When clinicians successfully answer the question, “What is the best next thing for this patient at this time?” as reflected in their care plan, there is an associated benefit to the patient that is measurable and substantial.
<p>Arterburn, D., Wellman, R., Westbrook, E., Rutter, C., Ross, T., McCulloch, D., ... Jung, C. (2012). Introducing decision aids at Group Health was linked to sharply lower hip and knee surgery rates and costs. <i>Health Affairs</i>, 31(9), 2094-2104.</p>	<p>To examine the associations between introducing decision aids for hip and knee osteoarthritis and rates of joint replacement surgery and costs in a large health system in Washington State.</p>	<ul style="list-style-type: none"> ■ The introduction of decision aids was associated with: <ul style="list-style-type: none"> – 26% fewer hip replacement surgeries – 38% fewer knee replacements – 12-21% lower costs over six months. ■ Patient decision aids for some health conditions, for which treatment decisions are highly sensitive to both patients’ and physicians’ preferences, may reduce rates of elective surgery and lower costs.
<p>[*] Elwyn, G., Frosch, D., Thomson, R., Joseph-Williams, N., Lloyd, A., Kinnersley, P., ... Barry, M. (2012). Shared decision making: A model for clinical practice. <i>Journal of General Internal Medicine</i>, 27(10), 1361-1367.</p>	<p>To translate existing conceptual descriptions of shared decision making into a three-step model that is practical, easy to remember, and can act as a guide to skill development.</p>	<ul style="list-style-type: none"> ■ The three key steps of shared decision making for clinical practice are: <ul style="list-style-type: none"> – Choice talk (making sure that patients know that reasonable options are available) – Option talk (providing more detailed information about options) – Decision talk (supporting the work of considering preferences and deciding what is best) ■ The three-step model also includes the use of decision support interventions, which summarize information in formats that are accessible to patients, using the most up-to-date evidence about harms and benefits.

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<p>Flynn, D., Knoedler, M. A., Hess, E. P., Murad, M. H., Erwin, P. J., Montori, V. M., & Thomson, R. G. (2012). Engaging patients in health care decisions in the emergency department through shared decision making: A systematic review. <i>Academic Emergency Medicine</i>, 19(8), 959-967.</p>	<p>To conduct a systematic review to evaluate the approaches, methods, and tools used to engage patients or their surrogates in shared decision making in the emergency department.</p>	<ul style="list-style-type: none"> ■ Decision support interventions (DSIs) were associated with improvements in patients' knowledge and satisfaction with the explanation of their care, preferences for involvement, and engagement in decision making and demonstrated utility for eliciting patients' preferences and values about management and treatment options. ■ DSIs were shown to reduce health care utilization without evidence of harm or lack of feasibility. ■ None of the studies reported lack of feasibility of shared decision making in the emergency department.
<p>[*] Fowler, F. J. (2012). Shared decision making and medical costs. <i>Informed Medical Decisions Foundation</i>.</p>	<p>To highlight evidence that routinely informing and actively involving patients in their medical care is likely to be cost neutral or even reduce health care costs.</p>	<ul style="list-style-type: none"> ■ The most compelling case for shared decision making is that it helps ensure that patients get the care that is right for them. ■ Shared decision making and the use of decision aids can lower medical care costs both by keeping people with chronic conditions out of emergency rooms and hospitals and by reducing the rates of surgical procedures that informed patients do not want. ■ By being informed and involved, patients have the ability to avoid having surgery that exposes them to risks they do not think are worth the benefits.
<p>Stacey, D., Bennett, C. L., Barry, M. J., Col, N. F., Eden, K. B., Holmes-Rovner, M., ... Thomson, R. (2012). Decision aids for people facing health treatment or screening decisions. <i>The Cochrane Database of Systematic Reviews</i>, 10.</p>	<p>To evaluate the effectiveness of decision aids for people facing treatment or screening decisions.</p>	<ul style="list-style-type: none"> ■ Decision aids with explicit values-clarification exercises improve informed values-based choices. ■ Decision aids appear to have a positive effect on patient-practitioner communication. ■ Decision aids have a variable effect on length of consultation. ■ Decision aids increase people's involvement and improve knowledge and realistic perception of outcomes.