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Health Policy and Shared Decision Making in Emergency Care: A Research Agenda

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Abstract

Although the Patient Protection and Affordable Care Act and other laws have promoted the use of shared decision making (SDM) in recent years, few specific policies have addressed the opportunities and challenges of utilizing SDM in the emergency department (ED). Policies relating to physician payment, quality measurement, and medical-legal risks each present unique challenges to adoption of SDM in the ED. This article summarizes findings from a health policy breakout session of the 2016 Academic Emergency Medicine consensus conference “Shared Decision Making in the Emergency Department: Development of a Policy-Relevant, Patient-Centered Research Agenda.” The objectives were to (1) describe federal and state policies that influence utilization or assessment of SDM; (2) identify policies and policy-focused knowledge gaps that serve as barriers to adoption of emergency department SDM; and (3) to define a consensus-based, policy-focused research agenda to support adoption of SDM in emergency care.

Introduction

The Patient Protection and Affordable Care Act (ACA or the Act) broadly describes the federal government’s expectations regarding shared decision making (SDM) and patient decision aids, instructed the federal government to contract with a nongovernmental entity (such as the National Quality Forum or The Joint Commission) to develop standards for decision aids, and mandates the Secretary of Health and Human Services to establish a program to fund development of decision aids for preference-sensitive conditions.¹ However, subsequent Congresses declined to appropriate funding for sections of the ACA and thus many provisions were not implemented. The ACA also established the Center for Medicare and Medicaid Innovation (CMMI) and authorized it to test novel payment and service delivery models, including those that assist patients “in making informed health care choices by paying providers of services and suppliers for using patient decision-support tools.”¹

States have used several policy approaches to facilitate the adoption of SDM. In 2007, Washington passed legislation (Senate Bill 5930) that instructed the Washington Health Care Authority to launch an SDM demonstration project at a multi-specialty practice site.² The resulting demonstration began in 2009 at Group Health Cooperative (GHC) of Puget Sound, which developed 12 video-based decision aids for elective surgical procedures in six specialties: orthopedics, cardiology, breast cancer, gynecology, urology, and spinal surgery. Within four years, patients viewed decision aids over 25,000 times and GHC saw significant reductions in the rates and costs of elective surgeries.^{3–5} Vermont passed legislation in 2009 to develop SDM demonstration programs as part of the Vermont Blueprint for Health, its statewide strategy for health reform.⁶ Officials in Minnesota and Oregon have also worked to integrated SDM into medical home standards.⁹

Although these policies improved the visibility of SDM, they had limited application to emergency departments (EDs) or to acute unscheduled care in general. There remains little guidance for researchers, clinicians, or administrators who seek to understand the effect of these policies on emergency care. The objectives of this manuscript are to describe potential

policy barriers to adoption of SDM and to describe a consensus-based, policy-focused research agenda to support the adoption of SDM in the ED.

Approach to Consensus Generation

In August 2015, we convened a workgroup comprised of emergency physicians, acute care researchers, policy experts, and patient representatives. This group held monthly conferences calls, conducted an unstructured literature review and environmental scan, and identified topics for discussion during the *Academic Emergency Medicine* Consensus Conference on Shared Decision Making. Based on group discussions we identified a set of three policy topics that were relevant to the SDM adoption outside of the ED setting: payment policy, quality measurement, and medical-legal issues. Key questions for each topic area were generated by the workgroup to clarify the impact of these themes on ED SDM.

Consensus generation on these topics during a policy-focused breakout session of the 2016 SDM Consensus Conference, held in New Orleans, Louisiana on May 10, 2016. A total of 136 participants attended the conference. Twenty-two participants attended the policy breakout session, including individuals with professional experience in emergency medicine, geriatrics, palliative care and end-of-life planning, population health management, ED operations, clinical quality management, and value-based purchasing. Attendees included three patient representatives.

Breakout session participants were divided into three subgroups and participants rotated sequentially among three discussion stations, with 25 minutes allocated to examine each major policy topic. At each station, workgroup leaders described relevant background information on the policy topic and provided participants with a printed discussion guide. Workgroup leaders then facilitated discussions to identify policies that participants perceived as barriers to adoption of ED SDM. Policies suggested by attendees were recorded on display boards at each station. After gathering input on barriers, facilitators asked participants to describe areas of research that could address these barriers. These areas of unmet research needs were similarly recorded on the display boards.

After participants rotated through all three stations, each station facilitator presented a verbal summary to the entire group regarding the major topics that had been discussed. To conclude the session, attendees walked among display boards from each station and voted for the research topics at each station that were perceived to highest priority. Voting was conducted by placing of color-coded stickers on the display boards. Each attendee received nine color-coded stickers (three stickers each of green, red, and yellow) and each display board was assigned one of the corresponding colors. Participants could vote up to three times on each board by placing a sticker of the appropriate color adjacent to their preferred research priorities.

After the session, workgroup leaders discussed results, condensed redundant suggestions that had been raised by multiple attendees, and identified the highest priority topics based on votes received.

Consensus Topic 1: Payment Policies and Shared Decision Making

Background

Payment policy has often been used a lever to advance healthcare delivery system reform.⁸ Traditionally, new Medicare payment policy incentives have been established through creation of current procedural terminology (CPT) codes or through adjustment to the Medicare fee schedule relative value scale.⁹ Paying physicians to engage in SDM on a fee-for-service basis could be challenging as there are no specific billing codes for conducting SDM discussions. New CPT codes could be developed by the American Medical Association and recommended for consideration by the Centers for Medicare and Medicaid Services (CMS).¹⁰ Alternatively, reimbursement for SDM could use pre-existing codes. The Medicare fee schedule includes time-based codes that physicians may use for extended visits during which more than half of the visit consists of counseling; the Medicare Payment Advisory Commission (MedPAC) has suggested that CMS could permit physicians to use these codes for shared decision making.¹¹ However, even if additional reimbursement codes were adopted, emergency physicians may be reluctant to commit time to SDM if they perceived that these actions will decrease their ability to efficiently care for patients with acute conditions and complaints. Unfortunately, the impact of SDM on emergency physician productivity or ED patient length of stay is unknown.

Pay-for-performance (P4P) policies could promote adoption of shared decision making. John Wennberg and colleagues have suggested that P4P demonstration projects could reimburse hospitals for establishing certified SDM programs.¹² Hospitals that performed well (e.g., enrolled a large proportion of eligible patients or achieved high scores on decision-quality assessments) could receive additional bonuses. Other incentives and recognition programs may be linked to successful shared decision making. The BlueCross BlueShield Association, for example, includes shared decision making as a quality domain for health systems that are recognized by its Blue Distinction Specialty Care Programs for spinal surgery and hip/knee replacement.^{11,13} Alternatively, payers could impose reimbursement penalties on providers who fail to engage in SDM. For example, researchers at The Commonwealth Fund proposed that CMS require use of a patient decision aid prior to Medicare patients undergoing certain preference-sensitive, high-cost procedures.¹⁴ The Commonwealth Fund report suggests that providers of these services should be required to document use of a patient decision aid or be subject to a 10% reimbursement penalty. Other policy experts have suggested that the 10% reduction could be gradually increased to 20% over 10 years.¹⁵

Alternative payment models (APMs) such as Accountable Care Organizations (ACOs) and the Bundled Payments for Care Improvement (BPCI) initiative may promote other financial policies regarding SDM. Under these and other value-based purchasing models, health systems are incentivized to reduce the total cost of patient care while maintaining quality. The Department of Health and Human Services has announced a goal of paying for more than 50 percent of Medicare fee-for-service care through APMs by 2018.¹⁶ Payment models that incentivize population health management may encourage the adoption of SDM far more than fee-for-service models currently do,^{10,17} and innovative health systems may offer

incentives for emergency care providers to improve the efficiency and value of care by performing SDM for preference-sensitive conditions.¹⁸ The impact of APMs on SDM has not yet been well described, and it remains unclear whether incentive payments for SDM would reduce unnecessary services compared to other strategies.

Barriers and Research Needs

During the consensus conference, participants identified three payment-related barriers to SDM. Several research questions were proposed to address relevant knowledge gaps.

Perceived impact of SDM on ED productivity, revenue, and patient flow—While SDM may lead to decreased productivity (throughput) and billing on other services, SDM may also decrease the use of unnecessary testing that leads to increased LOS and, thus, improved productivity. We identified three high-priority questions for future research:

- What is the impact of ED SDM on emergency physician productivity, such as measured by numbers of patients treated and professional fees generated (e.g., RVUs)?
- What is the impact of SDM on ED patient throughput? Does ED SDM impact treatment time or length of stay for patients who are not participating in SDM?
- Does ED SDM save resources in the emergency department? For example, can SDM significantly reduce use of laboratory or imaging tests? If so, what resources are saved and what clinical conditions have the greatest potential for savings?

Strategies to reduce perceived productivity burden of SDM—Many emergency physicians remain unfamiliar with SDM and the use of decision aids. SDM might be more readily performed in the ED if trained surrogates (such as patient navigators) could conduct the decision aid or part of an SDM discussion with patients, which could ameliorate physician concerns regarding loss of clinical productivity while delivering appropriate SDM to patients. Participants described four important questions for future research:

- Can SDM be delegated to non-physician surrogates such as patient navigators, or can these surrogates facilitate part of the discussion to reduce the impact on physician productivity? What degree of physician involvement would be necessary for these discussions?
- What other members of an ED care team could be trained to conduct SDM discussions with patients?
- Could automated systems be used to help patients understand and complete the initial portions of decision aid prior to discussion with the physician or surrogate?
- What is the role of clinical decision rules in SDM decision aids?

Alternative payment models and incentives to use SDM—The continued growth of value-based purchasing models may motivate health systems to reduce unnecessary (or

unwanted) care through various approaches including SDM. Breakout session attendees described that emergency care providers could face pressure to perform SDM as a means of achieving system-wide financial goals under these models. Participants described that these models could facilitate SDM by improving care management resources and enhancing emergency physicians' ability to arrange for rapid outpatient follow up, but they also noted that emergency physicians should pursue shared savings agreements for contributing to their health system's success.

- Can financial incentives for emergency care providers influence the use of SDM? If so, what incentives are most effective?
- How can ACOs, bundled payment models, and capitated payments influence the use of SDM in emergency care? Are these incentives effective at increasing the use of SDM? For instance, how could emergency physicians engage in shared savings agreements with an ACO to recoup a portion of the savings that the health system accrues from ED SDM? What models exist for such arrangements?
- Can financial incentives for SDM present risks to patient safety?

Consensus Topic 2: Quality Measurement and Shared Decision Making

Background

The 2001 National Academy of Medicine report *Crossing the Quality Chasm* described ten principles to guide health care redesign and promote quality improvement, including SDM-relevant themes such as accommodating differences in patient preferences.¹⁹ Despite the widespread impact of this report, few SDM-focused quality measures have been adopted, and Congress has declined to appropriate funds for development of many ACA-directed quality measures.

CMS has nonetheless made progress in developing SDM-based quality measures outside of the emergency care setting. Practices in the Comprehensive Primary Care Initiative (CPCI) were instructed in 2014 to identify two conditions or clinical decisions for which they would conduct SDM using decision aids; the number (or rate) of decision aid administration was reported to CMS as a process measure.²⁰ Furthermore, CMS incorporated a quality measure regarding SDM into the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey that measures performance standards among Accountable Care Organizations.^{21,22} Questions in the CAHPS survey examine whether providers talked with patients about reasons why they would (or would not) want to have a test or procedure, as well as whether the provider asked what was best for the patient. Currently there are no national standards for how SDM quality should be assessed in the ED.

Barriers and Research Questions

Attendees described four categories in which the measurement or reporting of SDM quality could potentially impair SDM practices in emergency care. Participants described a narrow set of quality-focused research questions for future investigation.

Measuring SDM quality and identifying patient-reported SDM outcomes—There is no clear approach to measuring quality of ED SDM. Any measurement of SDM effectiveness must include patient-reported outcomes, but the number and types of outcomes that should be used has not been established. There are three priority questions for future research on this topic:

- What is the most effective way to measure the frequency of SDM in the ED?
- How should the quality of ED SDM be assessed? How should quality measurement for ED SDM differ for pediatric, adult, and geriatric patients?
- What are appropriate patient-reported outcomes for measuring SDM quality? Are there universal patient-centered outcomes that can be measured among patients who have similar acuity (e.g., admitted vs. discharged)?

Use of decision aids and improving SDM quality—Attendees with ED operational experience raised questions about implementing SDM decision aids in their departments. We identified two questions for future research that may help inform emergency departments without prior SDM experience:

- Is an SDM decision aid necessary for improving decision quality?
- What type of training, if any, is required to deliver effective SDM interventions?

Clarify relationship of SDM with other EM quality measures—SDM can influence many aspects of a patient's care and has been associated with higher ED patient satisfaction regarding the explanations of their care,²⁶ yet the association between SDM and other ED quality measures has not otherwise been studied. What is the relationship between SDM quality and other ED quality measures? Does adoption of SDM affect the median time from ED arrival to ED departure, or does it change the proportion of patients who leave before being seen?

- Does SDM introduce any potential harms to EM care? For example, if SDM significantly impacts patient flow, what impact could this have on other patients?
- What are the unintended consequences of SDM quality measurement in the ED?

Unclear value of publicly reporting SDM quality—Breakout session participants raised the question of whether quality measures of ED SDM would be publicly reported. Research suggests that public reporting of hospital quality measures has had minimal impact on patient outcomes such as mortality and hospital readmission,^{24–26} yet the impact of publicly reporting SDM quality measures has not been studied. Attendees suggested that public reporting could be useful if it improved the use of quality of SDM but that such results of public reporting had not been proven.

- Does public reporting of SDM quality measures increase the performance of SDM or improve the quality of SDM-based medical decisions?
- Does public reporting of SDM have an impact on condition-specific health care utilization or costs?

Topic 3: Medical-Legal Concerns and Shared Decision Making

Background

There is limited evidence on how SDM affects risk of malpractice lawsuits. Some critics suggest that SDM may increase risk of lawsuits, such as if the patient's decision is not consistent with the traditional local standard of care. For example, if a patient acknowledges potential harms and benefits of performing (or declining) a test, he or she may still file a lawsuit regarding harms incurred or diagnoses missed. For example, doctors were sued for not performing prostate specific antigen (PSA) testing in a patient who was later diagnosed with prostate cancer, despite the fact that the patient had declined testing after discussing the potential benefits and harms with the physician.²⁷ Furthermore, SDM often focuses on clinical outcomes, and it may not include adverse outcomes relevant to tort law, such as disability, lost productivity, and pain and suffering. Similarly, legal considerations may provide a different perspective on areas of research priority for SDM; for example, some consensus conference attendees opined that medical-legal considerations may make SDM more suitable for low-risk than intermediate-risk chest pain.

The effect of SDM on malpractice claims is complicated by regional variation in legal standards. While most states use a national standard of care, some states continue to apply a "locality rule" that defines the standard of care based on practice in the same (or a similar) community.²⁸ The PSA testing case occurred in Virginia, where state law specifies that the standard of care is defined by the skill of "reasonably prudent practitioners" in the same specialty across the entire state.²⁹ Several local physicians testified that they always ordered PSA screening on men over age 50 without discussing it with the patient, and subsequently the plaintiff's attorneys argued that the standard of care had not been met.²⁷ In other states, courts have ruled that a physician's best judgment should take precedence if it conflicts with the community standard of care.²⁸

Evidence suggests decision aids may help mitigate risk. A 2008 study examined focus groups in which potential jurors were presented with hypothetical lawsuit regarding the decision not to perform PSA testing.³⁰ In one scenario, the physician's note indicated that potential benefits and harms of PSA testing were discussed with the patient and that the patient declined the test. The other scenario used a physician note that indicated the patient watched a decision aid and subsequently declined testing. Focus group participants were more likely to report the standard of care was met in the scenario with the decision aid (94% vs. 72%, $p<0.05$).

The impact of SDM on malpractice risk also depends to some extent on reasonable patient standards. Most Americans associate more medical care with higher quality care, which may explain why the average citizen could perceive a conflict between the standard of care and a shared decision to decline services such as PSA testing.³¹ This bias toward favoring the delivery of more medical services – even those with doubtful value – may explain why a recent study found lower rates of malpractice claims among the highest-spending physicians.³²

Barriers and Research Questions

Conference participants identified three major areas in which medical-legal concerns could present challenges to the adoption of ED SDM.

SDM and legal risk—The impact of SDM on legal risk is uncertain. There are four priority questions for future research on this topic:

- Does SDM change malpractice risk (or a proxy for risk, such as likelihood to sue)? Does this risk vary by type of condition?
- Do validated decision aids have a different impact on medical-legal risk than SDM conducted without such tools?
- What institutional policies can be adopted to improve legal protections for SDM?
- Does the legal system offer a competing perspective on the types of conditions that are appropriate for SDM?

SDM documentation standards and related benefits—Documentation of informed consent is an important part of addressing medical-legal risk and is a common occurrence in emergency care. However, there is no standardized approach to documenting SDM. Furthermore, SDM may be more difficult when working with vulnerable populations (e.g., children or the elderly) in which a decision is reached through family members or other delegated decision makers. Three important questions should guide future research in this area:

- What are the critical components to documentation in SDM, and how does documentation of SDM affect medical-legal risk?
- What documentation techniques best facilitate SDM, and what is the best way to document patient participation in SDM? Do supplemental documentation tools (e.g., HIPAA-compliant video or audio recordings of patient-physician conversations) offer greater medical-legal protection than written decision aids alone?
- What are the medical-legal risks of conducting SDM through a proxy (e.g. family members or other delegated decision makers)? Does this differ from obtaining informed consent from these individuals?

Conclusions

We have identified research priorities that address important topics such as the impact of SDM on clinical productivity; the use of financial incentives to encourage SDM; the identification of appropriate patient-centered outcomes to measure SDM quality; and the legal implications for performing and appropriately documenting SDM discussions.

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