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Communication Matters

Welcome!

In the months ahead new provisions of the Affordable Care Act are coming on line, one of which promotes shared decision-making between patients and their clinicians. The time is ripe for enhanced clinician-patient communication!

Warm regards,

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Shared medical decision-making: transformative tool or flavor of the month?

A recent article in the New England Journal of Medicine (1) highlights a provision tucked into the Affordable Care Act (Section 3506 of the ACA) that promotes more widespread use of shared decision-making (SDM) in medical care. Where did SDM come from? And where is it headed?

The availability of cheap computing power some 40 years ago made possible analyses of health care use patterns. Dartmouth researchers examined the rates of medical care and found astonishing variation from place to place for a number of services. In many instances the variation was too great to plausibly suggest underlying population differences. Analyses revealed that standard and effective services were underused in some areas (e.g., screening rates for retinal disease among diabetics). Variability in the rates of specific types of surgery appears to be linked to practice styles. For example, the Dartmouth Atlas Project's publication, Preference-Sensitive Care, found the rate for back surgery is 3.62 times greater

in Fort Myers, FL than Manhattan, NY. (2) Researchers have demonstrated that the deciding factor is the **practice styles of physicians**, not the prevalence of the condition in the population or the per capita concentration of orthopedic surgeons.

Other research shows a **disconnect** between patients' and physicians' preferences. Patients, when provided with information about the risks and benefits of medical tests and procedures, frequently opt for more conservative approaches than their physicians. University of Toronto researchers surveyed adults with severe hip and knee arthritis. They found that only 15% of patients deemed eligible for surgery according to clinical criteria were definitely willing to undergo surgery. (3)

It is an easy logical hop to conclude that some portion of expensive medical interventions could be avoided if patients' preferences--based on the best available information about the risks and benefits--guided care decisions. Cost is only one of many factors driving the increased use of SDM as part of standard medical practice. Other influences include:

- Patients' desires, and the ethical practice of medicine that honors those desires;
- Patients' searches for medical information on the Internet;
- The growing trend toward personalized medicine; and
- The Affordable Care Act, which will raise the visibility of SDM and stimulate the growth and dissemination of decision aids.

The purpose of Sec. 3506 of the ACA is to facilitate collaborative decision-making between clinicians and patients. The goal is for patients to better understand their care options, and for their preferences and values to be part of the decision-making. (4)

If this provision of the ACA follows the pattern of other federally government-driven initiatives, early pilot projects will lead to incentives to adopt (or penalties for not adopting), and thence mandated use. At present SDM is neither mandated nor funded.

A key strategy that has been validated for a number of medical services is the use of **decision aids.** The Informed Medical Decisions Foundation has been instrumental in the development of and advocacy for decision aids. (5) A growing body of research shows that patient decision aids increase patients' knowledge about their medical condition and the expected benefits and risks of various treatment options. Patients typically have less anxiety and make choices better aligned with their values. In some instances, patients make more conservative choices, for example, delaying or foregoing surgery. Research suggests clinicians' concerns that patients may make poor choices, suffer worse outcomes or may not be able to understand the options and ramifications of those options are unfounded with well-designed decision aids. (6)

Another concern of clinicians is that it will take too much additional time to negotiate a shared decision. This is where the value of clinician communication training becomes apparent. Decision aids are necessary yet by themselves insufficient to ensure effective shared decision-making. Friedberg and co-authors summarized the barriers and solutions as follows:

> *"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". (7)

IHC offers workshops that meet a vital need for enhanced clinician communication skills that ensure effective and efficient shared decision making, and optimal teamwork in patients' care. All IHC workshops are taught by certified faculty and offer ample opportunities for learners to practice communication skills, as well as learn about the theory and evidence for effective communication.

NOTES

1. Shared Decision Making to Improve Care and Reduce Costs. Lee, EO, Emanuel, EJ. Jan 3, 2013, N Engl J Med, Vol. 368, pp. 6-8.

2. Center for Evaluative Clinical Sciences. Preference-Sensitive Care. [Online] 2007. [Cited: Apr 10, 2013.] http://www.dartmouthatlas.org/downloads/reports/preference_sensitive.pdf.

3. Determining the need for hip and knee arthroplasty: the role of clinical severity and patients' preferences. Hawker GA, Wright JG, Coyte PC, Williams JI, Harvey B, Glazier R, Wilkins A, Badley EM. 3, Mar 2001, Med Care, Vol. 39, pp. 206-216.

4. US Congress. Affordable Care Act as passed. [Online] 2010. [Cited: Apr 8, 2013.] http://democrats.senate.gov/pdfs/reform/patient-protection-affordable-care-act-as-passed.pdf.

5. Informed Medical Decisions Foundation. [Online] [Cited: Apr 8, 2013.] http://informedmedicaldecisions.org/.

6. MICHAEL JOHN BARRY, MD: a conversation with the editor on shared decision making. Barry, MJ, Roberts, WC. 4, Oct 2012, Proc (Bayl Univ Med Cent), Vol. 25, pp. 383-388.

7. A Demonstration of Shared Decision Making in Primary Care Highlights Barriers to Adoption and Potential Remedies. Friedberg, MW, Van Busum, K, Wexler, R, Bowen, M, Schneider, EC. 2, Feb 2013, Health Affairs, Vol. 32, pp. 268-275.

IHC programs and services

Clinician-Patient Communication to Enhance Health Outcomes ***(CPC)*** is IHC's flagship program for clinicians. It helps **clinicians** at every state of their careers enhance their effectiveness and boost their job satisfaction. Upcoming open enrollment CPC train-the-trainer faculty development course: Sept. 24-27, 2013, Germantown, WI. Application

Institute for Healthcare Communication

Team and Patient-Centered Communication: PCMH Focus is open to **all members of healthcare teams**, providing a shared knowledge and skill base for more effective care. Upcoming open enrollment PCMH train-the-trainer faculty development course: June 4-7, 2013, Englewood, CO. Application

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IHC is nationally accredited to provide continuing medical education and continuing nursing education by three major accreditation agencies (ACCME, AAFP, and ANCC). IHC takes responsibility for the content, quality, and scientific integrity of all its CME/CE activities.

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