Implementing Shared Decision Making in the Orthopaedic Practice

ALEXANDRA E. PAGE, MD, AND BEN MOULTON, JD, MPH

The process of shared decision making (SDM) should be a patient-centered experience, fostered by collaboration between the patient and physician. Although barriers exist to implementing SDM in an orthopaedic practice, doing so also presents orthopaedists with opportunities (Table 1).

**Barriers**
Orthopaedics is uniquely suited for SDM but the practice has not been widely adopted. Several implementation barriers contribute to this low penetration, including logistics, a lack of financial incentives to adopt SDM, and the lack of quality, standardized decision aids.

**Logistics**—As a process, improving patient decision making has been perceived as a time-consuming endeavor. However, the literature suggests that the impact on appointment time may actually be minimal. One study found that orthopaedic surgeon visits scoring higher on decision-making impact took longer, but there was no significant difference between the average length of visits that did and did not meet minimal informed decision criteria. The authors concluded time impact was modest, a finding supported by other studies. The 2014 Cochrane review reported that use of decision aids led to a median time increase of 2.55 minutes, with a range from 8 minutes shorter to 23 minutes longer. The simplest SDM model involves passive presentation of a decision aid that the patient can review to generate questions. However, SDM should offer a previsit review of questions and answers. Phone support with trained health professionals available to conduct the process has been found to be cost-effective in patient-engagement. In one study, patients with hip and knee arthritis who saw a health coach for initial consultation after receiving the decision aid made more efficient use of the office visit. A study in the primary care setting including decision aid on back pain and orthopaedic procedures found that patients were receptive to midlevel providers’ offering the decision aid.

Whether formal SDM is done in the office of the primary care provider, or after the referral to an orthopaedist, provision of a decision aid to the patient prior to the orthopaedic visit can improve office efficiency. Patients opting against surgery may choose not to proceed with an orthopaedic consultation. Helping patients recognize their preferences earlier can allow the surgeons to focus information more effectively.

Infrastructure can also affect successful implementation of SDM. A study assessing SDM at multiple sites and across multiple service lines (including orthopaedics) found greatest success in fully integrated systems; another noted that the lack of a robust clinical information system was a specific barrier. Newer demonstrations are underway to assess the expansion of SDM into private practice and nonintegrated affiliates, but a multispecialty pilot test has found a lower success rate.

**Lack of financial incentive**—All SDM models require investment, both for decision aids and the personnel. Lack of a reimbursement mechanism for these costs creates a barrier to implementation despite evidence of SDM as a best practice. The Center for Medicare & Medicaid Innovation has facilitated growth of SDM and SDM is increasingly being used as a standard for different accrediting bodies. Commercial payers, enticed by the potential for cost savings as well as patient satisfaction, have the ability to structure insurance products to stimulate use of SDM, but the physician incentive remains unproven.

**Decision aids**—Myriad decision aids are available, many through commercial vendors. However, aids are not standardized, and no system to assure quality exists. Certification of decision aids may well occur at the state level; Washington state has passed legislation to allow the chief medical officer of the state’s Health Care Authority to certify patient decision aids. In addition, the additional cost to make the aids available, the need to continually update the aids to reflect evolving studies, and developing aids that meet the needs of individual patients are issues.

Further, a decision aid and SDM process can only be as accurate as the data available. The current lack of accurate, validated, patient-centered outcomes for orthopaedic surgeries and musculoskeletal disease may limit a surgeon’s ability to guide a patient to the best choice for him or her individual values.

**Opportunities**
Countering the noted barriers, SDM can offer benefits for both patients and surgeons. In particular, SDM may be valuable in helping surgeons address the needs of vulnerable populations, improve surgical efficiency, and reduce liability risks.

**Addressing needs of vulnerable populations**—To minimize health-care disparities, patients need both access to and understanding of treatment alternatives. Barriers—including education level, socioeconomic status, age, and race—can impede understanding of medical options.

The issue of age is particularly important given the high prevalence of preference-sensitive orthopaedic conditions prevalent in the elderly. The SDM process may help address issues such as lack of social support or concern over independence common among elderly patients.

**Bottom line**
- Logistics, a lack of financial incentives to adopt shared decision-making (SDM) and the lack of quality, standardized decision aids are among the barriers to implementing the process in orthopaedic practices.
- However, SDM may be valuable in helping surgeons address the needs of vulnerable populations, improve surgical efficiency, and reduce liability risks.
- SDM can also contribute in specific emerging delivery and reimbursement models, such as accountable care organizations, patient-centered medical homes, and value-based commercial insurance payment arrangements.

**TABLE 1: IMPLEMENTING SDM IN ORTHOPAEDIC PRACTICE**

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Opportunities</th>
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<tbody>
<tr>
<td>Logistics of time, location</td>
<td>Address needs of vulnerable populations, minimize healthcare disparities</td>
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<tr>
<td>Lack of financial incentive</td>
<td>Improved surgical yield from clinic visits</td>
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<tr>
<td>Lack of standardization or quality assurance in decision aids</td>
<td>Potential medico-legal protection</td>
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<td></td>
<td>Evolving quality metrics related to value-based reimbursement</td>
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Among African-Americans, a group with a historic disparity in the utilization of total knee arthroplasty, the SDM model has demonstrated improvement in discussing knee pain and referral for further surgical evaluation.

**Improved surgical yield**—Although many orthopaedic practices care for all stages of musculoskeletal disease, others focus on the surgical end of the treatment spectrum. Surgeons in these practices may be frustrated when they see patients who have no interest in surgery. SDM implementation models can be customized to various practice patterns, focusing on patients interested and medically ready for elective orthopaedic surgery. This may help patients reach an informed decision on the first visit, improving office efficiency.

**Medico-legal implications**—Informed consent has been the classic documentation of physician-patient communication on risks, benefits, and alternatives for treatment and surgery. SDM can improve patient comprehension of risks and benefits and reduce frustration with adverse outcomes. Eliciting the patient’s personal preferences and aligning them with treatment decisions strengthen the therapeutic alliance and are more protective of the provider in a medical-legal context.

States are moving toward SDM