

Feds examine decision-making à la DHMC

Can helping patients make informed medical decisions save the federal government money? During the coming year, DHMC will be trying to answer this question through a \$5-million demonstration project funded by the Centers for Medicare and Medicaid Services (CMS).

The reasoning behind the project goes like this: Patients who are well educated about their treatment options are more likely to make medical decisions that match their own values instead of their physicians', and that often results in their choosing more conservative, less-expensive treatments. A growing body of research from both the United Kingdom and the United States supports these claims. If they hold true in the demonstration project, CMS may ask health-care providers around the nation to employ some of the practices and procedures already being used at DHMC's Spine Center and Center for Shared Decision-Making (CSDM).

Value: Both centers have been models of integrating decision-making tools into clinical care, according to orthopaedic surgeon James Weinstein, D.O., M.S., who plays a leadership role in both centers and is heading up the demonstration project. But Weinstein and his collaborators hope to go beyond just finding financial savings. They also want to implement decision-making tools elsewhere at DHMC and introduce such tools at two other New Hampshire hospitals in order to demonstrate the value and feasibility of collecting data in an office practice, to show how patient data can improve patient-physician communication, and to develop a process for measuring the quality of decisions that patients make.

That's a tall order, but data collected by the CSDM and the Spine Center over the past several years will help in pursuing these objectives. "Because we are the only center for shared decision-making in the country with a dedicated space and staff," explains Kate Clay, M.A., B.S.N., program director for

the CSDM, "we really are modeling always and trying to capture . . . what we do so that others can do it, wherever they are."

At the CSDM, patients can learn about their conditions and possible treatments through books, videos, interactive Web-based decision aids, and one-on-one counseling. The materials and methods are designed to present the latest information available, in an unbiased context.

Although the CSDM opened in 1999, it wasn't until 2003—when its comprehensive database came online—that the center began measuring how the information it provides affects patients' decisions. Both the database and the center's clientele are growing rapidly; in 2004, the CSDM assisted almost 900 patients.

Clay often hears patients and clinicians from other parts of the country ask, "Why isn't this at my hospital? Why isn't this everywhere?" But the goal "is not for everybody to have a dedicated space . . . in every hospital," she explains. "The goal is to see what's feasible in your place, so that we end up with the ability to make these tools available to patients, add as little work as possible to clinicians, and yet have everybody happy with the process."

Model: Replicating what the CSDM does is a key initiative of the demonstration project. New Hampshire's Concord Hospital and Lakes Region General Hospital will receive \$1.2 million and \$500,000, respectively, of the \$5 million, to implement shared-decision-making services in their clinical settings. They'll use the CSDM's Comprehensive Breast Program as a model. In this program, women diagnosed with early-stage breast cancer learn about their disease and treatment options at the CSDM before consulting with their surgeon. So when a patient and her surgeon sit down together, they don't have to "go over all the information about breast cancer treatment," explains Clay. "This woman already knows quite a lot about



In her role as program director of DHMC's Center for Shared Decision-Making, Kate Clay counsels patients and directs them to decision-making resources.

mastectomy, about lumpectomy, about the risks and benefits of both, about the differences between the two. So they can have a conversation that starts a lot further along than it would have otherwise."

Though the federal demonstration project does not include any long-term follow-up with patients to determine if they have regrets about their medical decisions, the intent is to measure "patients' knowledge, values, and preferences at the time they are making the decision," says Clay. This will help the researchers evaluate the quality of the patients' decisions. In other words, are they basing their decisions on what Clay calls "good knowledge"?

Best interest: It's possible that the demonstration project may not reveal any cost savings from helping patients better understand their health-care choices. But even if that is the case, Clay and Weinstein have no doubt but that shared decision-making is in the best interest of patients. "We believe strongly that our work is showing this is a good tool," says Weinstein. JENNIFER DURGIN