Meeting Summary

Person and Family Centered Care Standing Committee August 2017 Off-Cycle Quarterly Webinar

The National Quality Forum (NQF) convened a public webinar for the Person and Family Centered Care (PFCC) Standing Committee on August 2, 2017. An archived recording of the webinar is available for playback.

Welcome, Introductions, and Overview of Topic

Suzanne Theberge, Senior Project Manager with NQF, began by welcoming webinar participants and providing an overview of NQF's off-cycle activities. Ms. Theberge then introduced the topic of this call: a set of informational presentations on NQF's work around shared decision making and decision aids, and a brief update on the changes to the consensus development process (CDP) as a result of the May 2017 Kaizen event.

NQF's National Standards for Decision Aids Project

NQF Senior Director Andrew Anderson, MHA, presented an overview of the recently completed Decision Aids project. The Cochrane Collaboration defines a decision aid as an evidence-based tool designed to help patients to participate in making specific, deliberate choices among healthcare options. Patient decision aids supplement (rather than replace) clinicians' counseling on treatment options. Following the explanation of the project's objectives and rationale, Mr. Anderson reviewed the benefits of having nationally used patient decision aids (PDA) and increasing shared decision making (SDM). These benefits include promoting the use of aids that are evidence-based and helping assisting both patient and provider on what a "good" decision aid is. Additional SDM benefits include:

- ensuring that goals are patient-sensitive, and that patient preference and tradeoff are taken into account when making treatment decisions;
- helping patients select an treatment option when there are multiple options available; and
- continuing the goal of focusing on patient-centered care.

Mr. Anderson noted that there are over 500 decision aids available, however it is difficult for patients and providers to determine which are relevant as there are no standards on the best resources for patient decision making guidance.

Mr. Anderson presented the outcomes of the project. First, he reviewed the project's white paper, written for NQF by researchers at the Dartmouth Institute for Health Policy and Clinical Practice. The white paper describes the history and evidence behind the quality assessment of PDAs, and identified literature that demonstrates PDAs have a positive effect on patient outcomes and the conceptual rationale for certifying PDAs. The paper included previous work in the area, highlighting the International Patient Decision Aids Standards (IPDAS) Collaboration criteria development work and the Washington State Healthcare Authority's effort to develop a state level PDA certification process. In 2007, Washington was the first state to pass legislation on SDM, creating a pilot program for the state's use.

Secondly, Mr. Anderson reviewed the NQF project team's environmental scan of measures used to assess the quality of decisions made through SDM, particularly patient decisions facilitated by decision aids. The scan identified 64 instruments and 13 performance measures through searching measure repositories, literature review, and key informant interviews. Mr. Anderson explained that the Expert Panel discussed the results of the environmental scan and white paper and recommended a set of criteria to use in certifying PDAs. The criteria were divided into three categories:

- Screening criteria: To determine the eligibility for certification of the patient decision aid
- Certifying criteria: To determine how well the decision aid enables shared decision making
- Screening and diagnostic test specific criteria: To determine if the patient decision aid can be used to interpret test results

To date, SDM has not been widely adopted for clinical use although it is a requirement for accountable care organizations (ACOs) in the Medicare Shared Savings Program. Currently, CMS is recruiting ACOs to participate in a pilot to advance SDM. The pilot, or SDM Model, aims to integrate a specific, structured four-step process into routine clinical practices at participating ACOs, resulting in more informed and engaged beneficiaries who collaborate with their practitioners to make medical decisions that align with their values and preferences.[1]

The Panel agreed that there are a large number of decision aid tools, however many gaps remain. Additionally, the Panel questioned how existing instruments could be improved. One of the major challenges in implementing SDM tools into regular practice is that it is difficult for providers to integrate these tools into their workflows. In addition, the availability of data continues to pose a challenge: outcomes can only be addressed for patients who chooses a course of treatment. This results in measurement bias since patients are excluded who do not choose a treatment pathway. The Panel noted the need for new performance measures in this area and a conceptual model illustrating the relationship between measuring SDM and improving patient outcomes. While there are several conceptual models in the literature, there are none that clearly demonstrate how providers/users use patient decision aids to facilitate shared decision making and improve outcomes.

Committee Discussion

A Committee member noted that SDM is extremely important, but there are, as mentioned, hundreds of tools, and some become dated when new treatments become available or the evidence changes. Mr. Anderson explained that a certification process would help because it would require developers to keep their measures up to date by requiring re-certification every three years. The Committee stated that what seems most important is ensuring providers review all options available for treatment of a condition (including non-treatment), and assess the patient's opinion and understanding, rather than whether a certified tool was used. Mr. Anderson noted that PDAs is a way to ensure providers are

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[1] Centers for Medicaid and Medicare Services. Beneficiary Engagement and Incentives: Shared Decision Making (SDM) Model. https://innovation.cms.gov/initiatives/Beneficiary-Engagement-SDM/ Page last accessed August 9, 2017.

presenting all the options in an evidence-based manner. In addition, there are both pre-encounter and during encounter PDAs that provide different ways to facilitate patient-provider conversation.

During the Committee discussion, members noted that effective communication should occur naturally, and not be the primary focus but rather a clear path to measures that address barriers to implementation. A barrier noted was the time needed to use PDAs; the reality of clinical practice is that providers have 10-15 minutes with a patient to cover diagnosis and treatment options during an appointment (exam, questions, discussion, etc.), and may be penalized if the decision aid was deemed "not necessary". More work needs to be done to incorporate the use of PDAs into operational flow, such as scheduling additional time or changing billing practices. Mr. Anderson explained that many PDAs can be used by the patient in consultation with other healthcare professionals (i.e., social worker, nurse or nurse practitioner, health educator).

Additionally, the Committee noted that producing PDAs can require a lot of time and resources. Mr. Anderson indicated that the Expert Panel recognized that producing and certifying PDAs is expensive, especially if it involves testing with patients, which the Expert Panel recommended. A Committee member stated that PDAs should be used at least a few days prior to procedures rather than directly before a patient goes into surgery, for example; Mr. Anderson noted that the Expert Panel concurred that guidance on timing should be included into PDAs. Another Committee member noted the usefulness of assessing discordance between patient goals and outcomes of treatment using a decision regret scale that assesses whether or not patients regret their decision to undergo a course of treatment, after it has been completed.

NQF's Shared Decision Making Action Team

NQF Director Kavitha Nallathambi, MPH, MBA, introduced NQF's new National Quality Partners (NQP) Shared Decision Making (SDM) project. Ms. Nallathambi provided an overview of the National Quality Partners, a forum of NQF-member leaders convened to drive quality measurement and improvement, with the mission "to impact health and healthcare quality through collaboration and partnership that catalyzes action and accelerates improvement." NQP brings together thought leaders and experts from the public and private sectors to take collective action on the nation's highest priority healthcare issues via small-group action teams. NQP action teams, convened with 15-20 NQF members, use a collective action model, including policy levers, alignment, and engagement within members networks and spheres of influence to drive improvements in quality on a specific priority. Previous action teams have focused on:

- maternity care, contributing to the 73% national reduction in early elective deliveries;
- readmissions, contributing to a 3.8% national reduction in nursing home readmissions; and
- patient and family engagement, with the launch of *Patient Passport*, a patient-centered tool to facilitate conversations between patients, families and providers about the things that matter to them.

After explaining NQP and the action teams in general, Ms. Nallathambi discussed the Shared Decision Making project. The Action Team's working definition of Shared Decision Making is:

Shared decision making (SDM) is a process of communication in which clinicians and patients work together to make optimal health care decisions that align with what matters most to patients. SDM has three components:

1. (1) clear, accurate and unbiased medical evidence about the reasonable alternatives, including no intervention, and the risks and benefits of each,
2. (2) clinician expertise in communicating and tailoring that evidence for the individual patient, and
3. (3) patient values, goals and informed preferences as well as concerns including treatment burdens.

She presented the goals of the project, which are to:

- develop a shared agenda and focus for collaborative action;
- issue a Call to Action to make shared decision making a standard of care; and
- identify key barriers and solutions to advance shared decision making on a national scale.

Over the next several months, the SDM Action Team will develop:

- *An Action Brief*: a four-page document currently under development that will explain why SDM should be the standard of care, describe the key fundamentals of SDM, and highlight opportunities to leverage stakeholder support and enable SDM. Key elements of this brief include:
    - Key fundamentals that focuses on leadership and culture change; engagement and education at all levels (providers, patients, etc.); knowledge of the principals of SDM; actions; tracking, monitoring, and reporting; and accountability.
    - Opportunities using quality measurement and improvement programs; changes to payment programs to make it easier to implement SDM or to incentivize the use of SDM; the use of accreditation and certification programs to leverage implementation; and the legal and ethical standards that should be in place to ensure SDM is properly used and that informed consent is obtained.
- *A Call to Action*: a solicitation outlining the need for this work. The draft call to action currently is: *NQP's Shared Decision Making Action Team is issuing a national call to for individuals and organizations that provide, receive, pay for, and make policies for healthcare to embrace and integrate shared decision making as a standard of person-centered care*.
- *A Playbook*: an expanded version of the action brief that reviews specific implementation examples from the field; currently available SDM tools (including, but not limited to, PDAs); the measures that are currently available (NQF-endorsed and otherwise); and measure gap areas. The Team will also create target population case studies or vignettes around shared decision making, to describe sample scenarios in which SDM is used.

Ms. Nallathambi then reviewed the project's timeline.

Date	Next Steps
October 2017	• Release Action Brief • Hold In-Person Playbook Development Forum (October 3)
November 2017	• Develop Playbook • Engage stakeholders in Call to Action

December 2017	• Hold public webinar on NQP 2018 Priorities and Fundamentals of Shared Decision Making (December 12)
March 2018	• Launch Shared Decision Making Playbook at NQF Annual Conference (March 12-13) • Hold public webinar presenting results (week of March 27)

Committee Discussion

Ms. Nallathambi then initiated Committee discussion with a request for recommendations for participants involved the NQP's Playbook Forum in October (which is invitation-only) and three questions for consideration by the Committee:

- What are your thoughts on barriers and solutions to implement SDM?
- Do you have any best practices, exemplars, or tools to share?
- Would you have any additional ideas for measurement?

One key factor identified by the Committee for relevant SDM is ensuring that alternatives to procedures are offered (including choosing to do nothing) and noting that decisions can go beyond binary questions (yes/no). Another key point is ensuring that all providers engaged in a patient's care are aware of the decisions that were made. Committee members also noted that providers often need information about a patient's family to assist in identifying appropriate tools or assessing which options are available. For example, a patient that receives food stamps could have limited options to make dietary changes to manage diabetes. The Committee also discussed barriers to implementation. One major barrier noted include the lack of incentives to implement SDM, even when sound tools are available. Members noted the need for policies that incentivize the use of the tools, such as changes to payment models. Another major barrier noted was the need for culture change at the provider level, to ensure that clinicians fully understand what SDM is and why it is important to incorporate into care. Ms. Nallathambi acknowledged the Committee's input and will share these comments with the Action Team as part of the development and discussion of the project materials.

Update on Changes to NQF Consensus Development Process

Following the topical presentations and discussion, Ms. Theberge briefly summarized the updates to May 2017 Kaizen CDP Redesign. She first explained the objectives and goals of the Kaizen, and then presented highlights of the recommended changes that include:

- a new project schedule (twice yearly submission deadlines);
- the 'Intent to Submit' process;
- the new Methods Panel to review Scientific Acceptability of complex measures;
- the continuous commenting with member support/non-support (with the support/non-support option replacing the current NQF member voting period);
- the new format for the measure evaluation technical reports;
- enhancements to NQF's education and training resources; and
- improvements in data information exchange across NQF's processes.

Ms. Theberge then briefly mentioned other changes that were proposed during the Kaizen, including the recommendation that the Standing Committees should provide the final endorsement decision instead of the Consensus Standards Approval Committee (CSAC). Another proposed recommendation included the CSAC serving as the governing body to review all appeals, in addition to their role in overseeing the CDP. Although well received, these changes will not be immediately implemented as they require more time and thoughtful consideration before operationalizing.

After providing an overview of these changes, Ms. Theberge explained the new topic areas, which impact Committee composition. The number of standing committees have been reduced from 22 to 15 to accommodate a more frequent submission process, and to ensure the committees are cross-cutting and reflect the needs of the measure portfolios. As Ms. Theberge explained, the PFCC topic area will no longer be a separate Committee, but has now been combined with the Care Coordination portfolio and renamed Patient Experience and Function (PEF). Some of the measures included in the PFCC portfolio will be reallocated to other topic areas; however, the majority will remain under the purview of the PEF Committee. After reviewing the timeline for implementing these changes, Ms. Theberge then opened the call for questions from the Committee. Committee members were supportive of the changes, particularly the elimination of NQF member voting as a separate process and the merger and restructure of the Care Coordination and PFCC Standing committees.

Public Comment

NQF neglected to open for a public comment period at the end of the call. However, shortly after the call, the PFCC team sent an email to all non-Committee attendees providing an opportunity to submit any comments via email by close of business on Friday, August 4, to be shared with the Committee and NQF staff as well as included in this summary. No comments were received via email.

Closing

In closing, Ms. Theberge thanked webinar attendees for their participation. Ms. Theberge summarized next steps, including the creation of this meeting summary, which NQF will share with the Committee and the public. Ms. Theberge explained that NQF would be follow up with the Committee again in the fall as new project work is scheduled.