# Background

Shared decision making is a key component of patient-centered care, “*a process that allows patients and their providers to make health care decisions together, taking into account the best scientific evidence available, as well as the patient’s values and preferences*.”[[1]](#endnote-1) Shared decision making is appropriate for preference-sensitive conditions in which there is high-quality clinical evidence for more than one treatment or management option or screening and not appropriate when clinical evidence highly favors one process or treatment (e.g., measles, mumps, rubella vaccine; antibiotics for ear infections).[[2]](#endnote-2) See Figure X, below. In all cases, communication is a key part of high-quality clinical care.

This process is different from informed consent in which patients undergoing a procedure are made aware of benefits and risks but may not necessarily be making a key decision, from only education, and also distinct from motivational interviewing. Shared decision making allows for communication between a provider and patient, and in some cases family members or others, about risks, benefits, and exploration of values and goals.

**Figure X: Appropatieness of Shared Decision Making**

**Shared   
Decision   
Making**

Shared decision making for preference-sensitive conditions has been shown to help people gain knowledge about their health condition(s) and possible outcomes of care and to have more confidence in their decisions.[[3]](#endnote-3) The process has also been associated with improved patient satisfaction with care, improved health outcomes, and with better appropriateness of care.[[4]](#endnote-4),[[5]](#endnote-5) Knee and hip replacement and prostate cancer screening are the most well-studied health conditions. Shared decision making can also help to reduce health disparities such as increasing rates of total knee replacement for black patients with osteoarthrosis of the knee to rates closer to that of white patients.[[6]](#endnote-6)

Unfortunately, involving patients as equal partners in health care decisions that have multiple clinically appropriate options by fully discussing risks and benefits remains limited within clinical practice. Barriers to implementing shared decision making into clinical practice include provider time, being overworked, lack of training, lack of structural support including through electronic health records and the general workflow, fear of revenue loss, and decision aids themselves not being applicable to the specific patient’s characteristics or not being applicable to the specific clinical situation.[[7]](#endnote-7),[[8]](#endnote-8) Having a supportive clinical culture is paramount to successful implementation starting with engaged leadership.[[9]](#endnote-9) Other than the converse of the barriers listed above, facilitators include providers being motivated and providers seeing a positive impact on the clinical process or on a patient’s outcomes.7

The Washington State Health Care Authority (HCA) has worked to certify patient decision aids since April 2016.[[10]](#endnote-10) Washington State law allows for shared decision making to meet informed consent standards and supports the shared decision making process.[[11]](#endnote-11) The HCA has certified patient decision aids for knee and hip osteoarthritis, advanced care planning, obstetrics (e.g., trial of labor after cesarean secion, birth options for large babies), and for spine surgery.10

Shared decision making is identified in the statute that formed the Collaborative as a mechanism to increase use of evidence-based best practice.[[12]](#endnote-12) Shared decision making or use of patient decision aids have been a component in the majority of Bree Collaborative recommendations.

# Recommendations

The Shared Decision Making workgroup’s goal is movement toward greater use of shared decision making in clinical practice, that all clinical sites move toward action. The process of implementation and the specific clinical areas to be implemented are expected to be different from location to location as some areas have already seen greater update of shared decision making (e.g., Group Health Cooperative now Kaiser Permanente’s implementation of shared decision making for total joint replacement). The workgroup prioritized ten health conditions for which shared decision making is appropriate including:

* Knee and Hip Osteoarthritis
* Abnormal Uterine Bleeding
* Advanced Care Planning
* Prostate Specific Antigen Testing
* Depression Treatment
* Attention Deficit Hyperactivity Disorder Treatment
* Breast Cancer Screening
* Opioid Use Disorder Treatment
* Trial of Labor After Cesarean Section
* Spine Surgery (Lumbar Fusion)

The workgroup does not recommend specific patient decision aids but does encourage use of HCA certified aids. HCA decision aids have been certified by the medical director via an adapting the International Patient Decision Aid Standards (IPDAS). More information [here](http://ipdas.ohri.ca/). The Pateint Education Materials Assessment Tool, developed by AHRQ, is focused on patient education materials (more narrow than shared decision making). More information [here](https://www.ahrq.gov/professionals/prevention-chronic-care/improve/self-mgmt/pemat/pemat1.html).

The workgroup staged the ten areas based on how widely used shared decision making within the health service area is, whether aids are available, and whether aids are certified by the HCA. See **Table 1** on page X. Stages include:

1. Existing pilots to widely used
2. Certified, not widely used
3. Aids available, not certified, not widely used
4. No aids available or few aids (want to incentivize creation of aids)

The workgroup categorized the ten areas based on type of health care service. Similar areas, such as those that concern surgical procedures or those that concern whether or not to undergo screening for a type of cancer, are assumed to assist with implementation of one another based on similar workflows. For example, learnings from a pilot for breast cancer screening could be applied to prostate cancer screening. Categories include:

* Procedural
* Advance care planning
* Screening
* Behavioral health

## Implementation Process and Staging

There are many paradigms under which to implement shared decision making. The workgroup endorses the National Quality Partner’s Playbook: Shared Decision Making in Healthcare. The shared decision fundamentals for healthcare organizations are separated into steps of basic, intermediate, and advanced and at a high-level include:

1. Leadership and culture
2. Patient education and engagement
3. Healthcare team knowledge and training
4. Action and implementation
5. Tracking, monitoring and reporting
6. Accountability

The Agency for Healthcare Research and Policy (AHRQ) developed the SHARE (Seek, Help, Assess, Reach, Evaluate) approach outlining shared decision making including steps to:[[13]](#endnote-13)

1. Seek your patient's participation.
2. Help your patient explore and compare treatment options.
3. Assess your patient's values and preferences.
4. Reach a decision with your patient.
5. Evaluate your patient's decision.

At a practice or site level, SHARE outlines the following steps:

1. Get leadership buy-in.
2. Develop an implementation team.
3. Select an approach that is tailored to your practice.
4. Provide training and ongoing support to all staff.
5. Start small, then take it to scale.
6. Create a physical setting for shared decisionmaking.
7. Create a library of evidence-based educational resources and decision aids.
8. Streamline shared decisionmaking work processes into day-to-day operations.
9. Evaluate the ongoing implementation of shared decisionmaking.

More information is [here](https://www.ahrq.gov/professionals/education/curriculum-tools/shareddecisionmaking/tools/tool-8/index.html).

[Dartmouth Hitchcock](https://med.dartmouth-hitchcock.org/csdm_toolkits/primary_care_toolkit.html) also outlines steps for shared decision making implementation

1. Leadership
2. Goals and Scope of Project
3. Assessment
4. Decision Support Tools
5. Education and Training
6. Implementation
7. Quality Monitoring Tools

# Recommendations for Stakeholder Actions and Quality Improvement Strategies

**Do not use these recommendations in lieu of medical advice.**

## Patients and Family Members

* Understand value of shared decision making
* Request shared decision making
* Engage with shared decision making

***Providers***

* Training

## Care Settings (including Primary Care Practices, Hospitals, Health Systems)

* Leadership and culture
  + Tie shared decision making to clinic goals.
  + Clinical champions
* Patient education and engagement
* Knowledge and training
* Implementation into system
  + Defined roles for care team members
* Tracking, monitoring, and reporting
* Use high-quality decision aids

***Health Plans***

* Reimburse for use of shared decision aids for the 10 topic areas in FFS
* Incorporate shared decision making requirements as standards for value-based models (e.g., Centers of Excellence)

***Employers***

* Incorporate shared decision making requirements as standards for value-based contracting (e.g., Centers of Excellence)

***Washington State Health Care Authority***

* Certify patient decision aids for the ten areas.

**Table 1: Shared Decision Making Categories**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Type** | **Stage** | **Literature** | **HCA Certification** |
| Knee and Hip Osteoarthritis | Procedural | I | [Group Health’s Participation](https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2012.1067)  [In A Shared Decision-Making Demonstration Yielded Lessons, Such As Role Of Culture Change](https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2012.1067) [Patient, surgeon, and healthcare purchaser views on the use of decision and communication aids](https://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-14-366)  [in orthopaedic surgery: a mixed methods study](https://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-14-366) [Introducing Decision Aids](https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2011.0686)  [At Group Health Was Linked to Sharply Lower Hip And Knee Surgery Rates And Costs](https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2011.0686)  [Effect of a Decision Aid on Access to Total Knee Replacement for Black Patients With Osteoarthritis of the Knee: A Randomized Clinical Trial](https://jamanetwork.com/journals/jamasurgery/fullarticle/2586341) | Treatment choices for hip osteoarthritis (Health Dialog Services Corporation)  Treatment choices for knee osteoarthritis (Health Dialogue Services Corporation)  Hip osteoarthritis: is it time to think about surgery? (Healthwise)  Knee osteoarthritis: is it time to think about surgery? (Healthwise)  Is knee replacement surgery right for me? (Avaz Decisions)  Is hip replacement surgery right for me? (Avaz Decisions) |
| Abnormal Uterine Bleeding | Procedural | III |  | No |
| Advanced Care Planning | Other | I |  | CPR: advanced cancer (ACP Decisions)  CPR: advanced disease (ACP Decisions)  CPR: advanced heart failure (ACP Decisions)  CPR: advanced liver disease (ACP Decisions)  CPR: advanced lung disease (ACP Decisions)  CPR: a closer look for people with a serious illness (ACP Decisions)  Decisions about dialysis for patients 75 and older (ACP Decisions)  Goals of care: advanced cancer (ACP Decisions)  Goals of care: advanced dementia (ACP Decisions)  Goals of care: advanced disease (ACP Decisions)  Goals of care: advanced heart failure (ACP Decisions)  Goals of care: advanced lung disease (ACP Decisions)  Goals of care: family meetings in the ICU (ACP Decisions)  Goals of care: skilled nursing facility (ACP Decisions)  Hospice: advanced cancer (ACP Decisions)  Hospice: skilled nursing facility (ACP Decisions)  Hospice: an introduction (ACP Decisions)  Supporting decisions involving extremely premature infants (ACP Decisions)  Dementia for caregivers: goals of care: across the spectrum for Alzheimer's disease (ACP Decisions) CPR decision aid (Respecting Choices)  Help with breathing decision aid (Respecting Choices)  Long-term tube feeding decision aid (Respecting Choices)  Medical care for serious illness (Health Dialog Services Corporation)  Advanced lung cancer patient decision aid (Seattle Cancer Care Alliance) |
| Prostate Specific Antigen Testing | Screening | III | [Physicians’ Attitudes About Shared Decision Making for Prostate Cancer Screening](http://www.stfm.org/fmhub/fm2011/April/Kimberly260.pdf)  [The effects of shared decision-making compared to usual care for prostate cancer screening decisions: a systematic review and meta-analysis](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6196568/) | No |
| Depression Treatment | Behavioral Health | III |  | No |
| Attention Deficit Hyperactivity Disorder Treatment | Behavioral Health | III |  | No |
| Breast Cancer Screening | Screening | III |  | No |
| Opioid Use Disorder Treatment | Behavioral Health | IV | <https://clinicaltrials.gov/ct2/show/NCT03568552> | No |
| Trial of Labor After Cesarean Section | Procedural | I | [Accountable Care Program SDM TOLAC Pilot](https://waportal.org/resources/shared-decision-making-online-skills-course-providers) | Pregnancy: your birth options after cesarean (Healthwise)  Pregnancy: birth options if your baby is getting too big (Healthwise) |
| Spine Surgery (Lumbar Fusion) | Procedural | I | Patient, surgeon, and healthcare purchaser views on the use of decision and communication aids in orthopaedic surgery: a mixed methods study | Spinal stenosis: choosing the right treatment for you (Health Dialogue) |

**Measurement**

* **Shared Decision Making Process**

Steward: Massachusetts General Hospital

NQF #2962

*This measure assesses the extent to which health care providers actually involve patients in a decision-making process when there is more than one reasonable option. This proposal is to focus on patients who have undergone any one of 7 common, important surgical procedures: total replacement of the knee or hip, lower back surgery for spinal stenosis of herniated disc, radical prostatectomy for prostate cancer, mastectomy for early stage breast cancer or percutaneous coronary intervention (PCI) for stable angina. Patients answer four questions (scored 0 to 4) about their interactions with providers about the decision to have the procedure, and the measure of the extent to which a provider or provider group is practicing shared decision making for a particular procedure is the average score from their responding patients who had the procedure.*

* **Informed, Patient-Centered Hip and Knee Replacement Surgery**

NQF #2958

Steward: Massachusetts General Hospital

*The measure is derived from patient responses to the Hip or Knee Decision Quality Instruments. Participants who have a passing knowledge score (60% or higher) and a clear preference for surgery are considered to have met the criteria for an informed, patient-centered decision. The target population is adult patients who had a primary hip or knee replacement surgery for treatment of hip or knee osteoarthritis.*

* **Gains in Patient Activation Scores at 12 Months**

NQF #2483

Steward: Insignia Health

*The Patient Activation Measure® (PAM®) is a 10 or 13 item questionnaire that assesses an individual´s knowledge, skill and confidence for managing their health and health care. The measure assesses individuals on a 0-100 scale. There are 4 levels of activation, from low (1) to high (4). The measure is not disease specific, but has been successfully used with a wide variety of chronic conditions, as well as with people with no conditions. The performance score would be the change in score from the baseline measurement to follow-up measurement, or the change in activation score over time for the eligible patients associated with the accountable unit. The outcome of interest is the patient’s ability to self-manage. High quality care should result in gains in ability to self-manage for most chronic disease patients. The outcome measured is a change in activation over time. The change score would indicate a change in the patient´s knowledge, skills, and confidence for self-management. A positive change would mean the patient is gaining in their ability to manage their health.*

* **Back Pain: Shared Decision Making**

NQF #0310

Steward: National Committee for Quality Assurance

*Percentage of patients at least 18 years of age and younger than 80 with back pain with whom a physician or other clinician reviewed the range of treatment options, including alternatives to surgery prior to surgery. To demonstrate shared decision making, there must be documentation in the patient record of a discussion between the physician and the patient that includes all of the following: Treatment choices, including alternatives to surgery; Risks and benefits; Evidence of effectiveness*

* **NCQA Supplemental items for CAHPS® 4.0 Adult Questionnaire (CAHPS 4.0H)**

NQF #0007

Steward: National Committee for Quality Assurance

*This supplemental set of items was developed jointly by NCQA and the AHRQ-sponsored CAHPS Consortium and is intended for use with the CAHPS 4.0 Health Plan survey. Some items are intended for Commercial health plan members only and are not included here. This measure provides information on the experiences of Medicaid health plan members with the organization. Results summarize member experiences through composites and question summary rates. In addition to the 4 core composites from the CAHPS 4.0 Health Plan survey and two composites for commercial populations only, the HEDIS supplemental set includes one composite score and two item-specific summary rates.: Shared Decision Making Composite, Health Promotion and Education item, Coordination of Care item*

* **CAHPS**

Q10: In the last 6 months, did a doctor or other health provider talk with you about the pros and cons of each choice for your treatment or health care?

Q11: In the last 6months, when there was more than one choice for your treatment or health care, did a doctor or other health provider ask which choice you thought was best for you?

# 

# Appendix C: Guideline and Systematic Review Search Results

|  |  |  |  |
| --- | --- | --- | --- |
|  | *Year* | *Title* | *Summary* |
| *AHRQ: Research Findings and Reports* | 2014 | [Decision Aids for Cancer Screening and Treatment](https://effectivehealthcare.ahrq.gov/topics/cancer-decision-support-tools/research) | Cancer-related decision aids have evolved over time, and there is considerable diversity in both format and available evidence. We found strong evidence that cancer-related decision aids increase knowledge without adverse impact on decisional conflict or anxiety. We found moderate- or low-strength evidence that patients using decision aids are more likely to make informed decisions, have accurate risk perceptions, make choices that best agree with their values, and not remain undecided. This review adds to the literature that the effectiveness of cancer-related decision aids does not appear to be modified by specific attributes of decision aid delivery format, content, or other characteristics of their development and implementation. Very limited information was available on other outcomes or on the effectiveness of interventions that target providers to promote shared decision making by means of decision aids. |
| *Cochrane Collection* | 2019 | [Interventions for promoting participation in shared decision‐making for children and adolescents with cystic fibrosis](https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD012578.pub2/full?highlightAbstract=shared%7Cmaking%7Cdecision%7Cwithdrawn%7Cshare%7Cdecis%7Cmake) | We were unable to identify RCTs with evidence which would support healthcare policy‐making and practice related to implementation of shared decision‐making for children and adolescents (aged between four and 18 years) with CF). We hope that having identified this gap in research, awareness will increase amongst researchers of the need to design high‐quality shared decision‐making interventions for young people with CF, perhaps adapted from existing models for adults, and to test these interventions and children's preferences in RCTs. |
| 2018 | [Interventions for increasing the use of shared decision making by healthcare professionals](https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD006732.pub4/full?highlightAbstract=shared%7Cmaking%7Cdecision%7Cwithdrawn%7Cshare%7Cdecis%7Cmake) | We included 87 studies (45,641 patients and 3113 healthcare professionals) conducted mainly in the USA, Germany, Canada and the Netherlands. Risk of bias was high or unclear for protection against contamination, low for differences in the baseline characteristics of patients, and unclear for other domains. Forty‐four studies evaluated interventions targeting patients. They included decision aids, patient activation, question prompt lists and training for patients among others and were administered alone (single intervention) or in combination (multifaceted intervention). The certainty of the evidence was very low. It is uncertain if interventions targeting patients when compared with usual care increase SDM whether measured by observation. Fifteen studies evaluated interventions targeting healthcare professionals. They included educational meetings, educational material, educational outreach visits and reminders among others. The certainty of evidence is very low. It is uncertain if these interventions when compared with usual care increase SDM whether measured by observation. Twenty‐eight studies targeted both patients and healthcare professionals. The interventions used a combination of patient‐mediated and healthcare professional directed interventions. Based on low certainty evidence, it is uncertain whether these interventions, when compared with usual care, increase SDM whether measured by observation. |
| 2017 | [Shared decision‐making for people with asthma](https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD012330.pub2/full?highlightAbstract=shared%7Cmaking%7Cdecision%7Cwithdrawn%7Cshare%7Cdecis%7Cmake) | Substantial differences between the four included randomised controlled trials (RCTs) indicate that we cannot provide meaningful overall conclusions. Individual studies demonstrated some benefits of SDM over control, in terms of quality of life; patient and parent satisfaction; adherence to prescribed medication; reduction in asthma‐related healthcare visits; and improved asthma control. Our confidence in the findings of these individual studies ranges from moderate to very low, and it is important to note that studies did not measure or report adverse events. |
| 2010 | [Shared decision making interventions for people with mental health conditions](https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD007297.pub2/full?highlightAbstract=shared%7Cmaking%7Cdecision%7Cwithdrawn%7Cshare%7Cdecis%7Cmake) | We included two separate German studies involving a total of 518 participants. One study was undertaken in the inpatient treatment of schizophrenia and the other in the treatment of people newly diagnosed with depression in primary care. Regarding the primary outcomes, one study reported statistically significant increases in patient satisfaction, the other study did not. There was no evidence of effect on clinical outcomes or hospital readmission rates in either study. Regarding secondary outcomes, there was an indication that interventions to increase shared decision making increased doctor facilitation of patient involvement in decision making, and did not increase consultation times. Nor did the interventions increase patient compliance with treatment plans. Neither study reported any harms of the intervention. Definite conclusions cannot be drawn, however, on the basis of these two studies. |
| 2016 (update of 2013) | [Interventions for promoting participation in shared decision‐making for children with cancer](https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD008970.pub3/full?highlightAbstract=shared%7Cmaking%7Cdecision%7Cwithdrawn%7Cshare%7Cdecis%7Cmake) | No conclusions can be made on the effects of interventions to promote SDM for children with cancer aged four to 18 years. This review has highlighted the dearth of high‐quality quantitative research on interventions to promote participation in SDM for children with cancer. |
| 2015 | [Interventions to facilitate shared decision making to address antibiotic use for acute respiratory infections in primary care](https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD010907.pub2/full?highlightAbstract=shared%7Cmaking%7Cdecision%7Cwithdrawn%7Cshare%7Cdecis%7Cmake) | We identified 10 published reports of nine original RCTs (one report was a long‐term follow‐up of the original trial) in over 1100 primary care doctors and around 492,000 patients. Interventions that aim to facilitate shared decision making reduce antibiotic prescribing in primary care in the short term. Effects on longer‐term rates of prescribing are uncertain and more evidence is needed to determine how any sustained reduction in antibiotic prescribing affects hospital admission, pneumonia and death. |
| 2013 | [Interventions for supporting pregnant women's decision‐making about mode of birth after a caesarean](https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD010041.pub2/full?highlightAbstract=shared%7Cmaking%7Cdecision%7Cwithdrawn%7Cshare%7Cdecis%7Cmake) | Three randomised controlled trials involving 2270 women from high‐income countries were eligible for inclusion in the review. We found no difference in planned mode of birth: VBAC (risk ratio (RR) 1.03, 95% confidence interval (CI) 0.97 to 1.10; I² = 0%) or caesarean birth (RR 0.96, 95% CI 0.84 to 1.10; I² = 0%). The proportion of women unsure about preference did not change (RR 0.87, 95% CI 0.62 to 1.20; I² = 0%). There was no difference in adverse outcomes reported between intervention and control groups (one trial, 1275 women/1280 babies): permanent (RR 0.66, 95% CI 0.32 to 1.36); severe (RR 1.02, 95% CI 0.77 to 1.36); unclear (0.66, 95% CI 0.27, 1.61). Decisional conflict about preferred mode of birth was lower (less uncertainty) for women with decisional support. There was also a significant increase in knowledge among women with decision support compared with those in the control group. Evidence is limited to independent and mediated decision supports. |
| 2012 | [Interventions for providers to promote a patient‐centred approach in clinical consultations](https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD003267.pub2/full?highlightAbstract=shared%7Cmaking%7Cdecision%7Cwithdrawn%7Cshare%7Cdecis%7Cmake) | Forty‐three randomized trials met the inclusion criteria, of which 29 are new in this update. In most of the studies, training interventions were directed at primary care physicians (general practitioners, internists, paediatricians or family doctors) or nurses practising in community or hospital outpatient settings. Some studies trained specialists. Patients were predominantly adults with general medical problems, though two studies included children with asthma. Interventions to promote patient‐centred care within clinical consultations are effective across studies in transferring patient‐centred skills to providers. However the effects on patient satisfaction, health behaviour and health status are mixed. There is some indication that complex interventions directed at providers and patients that include condition‐specific educational materials have beneficial effects on health behaviour and health status, outcomes not assessed in studies reviewed previously. |
| 2017 | [Clinician‐targeted interventions to influence antibiotic prescribing behaviour for acute respiratory infections in primary care: an overview of systematic reviews](https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD012252.pub2/full?highlightAbstract=shared%7Cmaking%7Cdecision%7Cwithdrawn%7Cshare%7Cdecis%7Cmake) | We included eight reviews in this overview: five Cochrane Reviews (33 included trials) and three non‐Cochrane reviews (11 included trials). We found evidence that CRP testing, shared decision making, and procalcitonin‐guided management reduce antibiotic prescribing for patients with ARIs in primary care. These interventions may therefore reduce overall antibiotic consumption and consequently antibiotic resistance. There do not appear to be negative effects of these interventions on the outcomes of patient satisfaction and reconsultation, although there was limited measurement of these outcomes in the trials. This should be rectified in future trials. We could gather no information about the costs of management, and this along with the paucity of measurements meant that it was difficult to weigh the benefits and costs of implementing these interventions in practice. |
| 2016 | [Implementation of treatment guidelines for specialist mental health care](https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD009780.pub3/full?highlightAbstract=shared%7Cmaking%7Cdecision%7Cwithdrawn%7Cshare%7Cdecis%7Cmake) | This review now includes six studies, with a total of 1727 participants. Regarding participant outcomes, only one trial assessed the efficacy of a shared decision‐making implementation strategy and found no impact on psychopathology, satisfaction with care, or drug attitude. |
| *BMC* | 2018 | [The effects of shared decision-making compared to usual care for prostate cancer screening decisions: a systematic review and meta-analysis](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6196568/) | Shared decision-making (SDM) is recommended for men facing prostate cancer (PC) screening decisions. We synthesize the evidence on the comparative effectiveness of SDM with usual care. We searched academic and grey literature databases, and other sources for primary randomized controlled trials (RCTs) published in English comparing SDM to usual care and conducted in primary and specialized care. |
| 2016 | [Implementing shared decision making in federally qualified health centers, a quasi-experimental design study: the Office-Guidelines Applied to Practice (Office-GAP) program](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4970246/) | Use of SDM and Decision Aids has been encouraged but is not regularly implemented in primary care. The Office-Guidelines Applied to Practice (Office-GAP) intervention is an application of a previous model revised to address guidelines based care for low-income populations with diabetes and coronary heart disease (CHD). Objective: To evaluate Office-GAP Program feasibility and preliminary efficacy on medication use, patient satisfaction with physician communication and confidence in decision in low-income population with diabetes and CHD in a Federally Qualified Healthcare Center (FQHC). |
| 2013 | [“Many miles to go …”: a systematic review of the implementation of patient decision support interventions into routine clinical practice](https://bmcmedinformdecismak.biomedcentral.com/track/pdf/10.1186/1472-6947-13-S2-S14) | Two decades of research has established the positive effect of using patient-targeted decision support interventions: patients gain knowledge, greater understanding of probabilities and increased confidence in decisions. Yet, despite their efficacy, the effectiveness of these decision support interventions in routine practice has yet to be established; widespread adoption has not occurred. The aim of this review was to search for and analyze the findings of published peer-reviewed studies that investigated the success levels of strategies or methods where attempts were made to implement patient-targeted decision support interventions into routine clinical settings. |
| *Veterans Administration Evidence-based Synthesis Program* | 2014 | [The Effects of Shared Decision Making on Cancer Screening](https://www.hsrd.research.va.gov/publications/esp/shareddecision.cfm) | In this review we examine the effects of SDM interventions for cancer screening in adults on constructs from the Ottawa Decision Support Framework, a commonly-used theoretical model of decision making. We examined the constructs of Decision Quality, Decision Impact, and, for studies reporting those outcomes, Decision Action. Decision Quality includes knowledge, values clarity (patients' clarity of their personal values regarding the risks and benefits of decision options), and the patients' participatory role in decision making. Decision Impact includes decisional conflict (personal uncertainty about which course of action to take), use of services (eg, consultation length), and satisfaction with the decision. Decision Action includes screening intention and behavior. The ideal SDM intervention would enhance Decision Quality (ie, increase knowledge and values clarity) and Impact (ie, increase satisfaction, reduce decision conflict, and have minimal impact on service utilization). The desired impact on Decision Action depends on the screening decision. |

The Health Technology Assessment Program, Centers for Disease Control and Prevention, and the Institute for Clinical and Economic Review did not contain any relevant studies.

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