**Mandating Chaperones for Decision Making in Left Atrial Appendage Occlusion is Bad for Patients, for Physicians, and for the Promotion of *Real* Shared Decision Making:**

*It’s time to end the Centers for Medicare Medicaid Services Mandate*

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At its core, shared decision is comprised of 3 elements – (1) a sharing of the risks and benefits of various therapeutic options for a medical condition from medical experts with patients, (2) a sharing of the patient’s goals and values of care with the medical experts offering treatment, and (3) a well-informed patient making a thoughtful decision supported by the informed recommendations of the healthcare team. Effective shared decision making requires specific expertise and knowledge about the treatment options, and it may (or may not) involve the use of formal tools (such as decision aids) to support *but not replace* the patient-provider interactions with healthcare providers. When decision tools are employed to support the patient-provider interaction, they routinely improve patient knowledge about treatment options, reduce decision conflict and regret, and improve the concordance between a patient’s goals and values and the chosen treatment.[1](#_ENREF_1)

In its coverage policy for left atrial appendage occlusion (LAAO), the Center for Medicare Medicaid Services (CMS), required “a formal shared decision making interaction with an independent non-interventional physician using an evidence-based decision tool.”[2](#_ENREF_2) By specifying an independent physician not involved with the procedure, CMS is effectively mandating *chaperoned* decision making, not shared decision making. This is problematic on several levels. First, they are specifically excluding the physicians best able to inform patients about the risks and benefits of left atrial appendage occlusion. In addition, they are undermining the therapeutic relationship between patients and interventional physicians, while mandating additional, superfluous work for the healthcare team. Finally, and most distressingly, by mandating *chaperoned* decision making they run the very real risk of alienating physicians and preventing genuine adoption of *real* shared decision making.

In this issue of the *Journal of Cardiovascular* Electrophysiology, it is in the context of the CMS *chaperone* mandate that Howard and colleagues present the results of their survey of LAAO shared decision making practices.[3](#_ENREF_3) Among responding sites (32% of the 269 implanting sites), the authors found that despite the mandate for an independent non-interventional physician, the implanting physician conducted at least some of the shared decision making interactions at nearly 40% of sites, and 49% of sites used a formal decision support tool. Most distressingly, a majority of respondents (61%) described the requirement in negative terms, confirming our concerns that the mandate of *chaperoned* decision making is alienating physicians.

It is worth noting, however, that although we disagree with the approach CMS has taken, we understand their concerns. There are ample data that physicians do not adequately inform patients.[4](#_ENREF_4) There is also evidence that physicians are more likely to recommend a procedure that they perform.[5](#_ENREF_5) That said, mandating *chaperoned* decision making interactions fails to promote the behavior that CMS was hoping to incentivize and alienates physicians, as Howard and colleagues demonstrate. We believe strongly that CMS will do much better in the long run by incentivizing all practitioners who see patients in all settings to take a patient-centered approach. Being patient-centered cannot and should not be outsourced to those who do not have the specific expertise; patients routinely want to hear from their doctors, including (and in particular) those with specific procedure expertise.[4](#_ENREF_4),[6](#_ENREF_6) As such, we implore CMS to take the long-view of changing all provider behavior towards a more patient-centered culture and not excluding any group of clinicians through shared decision making mandates.

When it is implemented effectively – as a shared interaction between the patient and the physicians best able to inform them about treatment options – we believe strongly that shared decision making is good for patients and physicians. In their current manuscript, Howard and colleagues confirm our concerns that the CMS mandate for *chaperoned* decision making for LAAO is confusing, disruptive, and even alienating for physicians. It is time for this unfortunate *chaperoned* decision making policy to end. It is our hope that shared decision making, moving forward, will truly be *shared* by all participants – including the interventional physicians who have the expertise to advise patients about all treatment options, including LAAO procedures.

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