

Shared Clinical Decision-Making

What You Need to Know

KEY TAKEAWAYS:



SCDM is an important part of clinical care, particularly for complex medical decisions where the answer is uncertain, such as whether a patient should get surgery or instead do physical therapy for back pain.



Vaccination has always been a shared decision, but population-based recommendations have long provided clear guidance that certain vaccines are recommended for everyone in that population.



Shifting vaccines to SCDM without appropriate scientific evidence **threatens choice and access**.



SCDM for vaccines can result in **confusion and missed vaccinations due to structural barriers** rather than informed choice. For patients, SCDM as a blunt instrument can make vaccination less straightforward and more contingent – depending heavily on consistent access to a provider, ability to navigate complex information and clear guidance.



SCDM can also **complicate vaccination infrastructure and electronic health record (EHR) systems**, disrupting forecasting, stocking and logistics, leading to more missed opportunities to vaccinate.



Abrupt shifts in vaccine policy without clear, data-driven justification don't just change people's access to vaccines. **They can lower vaccination in practice, resulting in more preventable disease outbreaks and avoidable hospitalizations and deaths.**

WHAT IS SHARED CLINICAL DECISION-MAKING FOR VACCINES?

Shared clinical decision-making (SCDM) is one type of recommendation used by the Advisory Committee on Immunization Practices (ACIP) – the federal group that develops U.S. vaccine recommendations for children and adults.

ACIP has used several recommendation types for vaccines, including¹:

Population-based: a general recommendation for everyone in a certain group

Risk-based: a recommendation for people with certain conditions or risk factors

Catch-up: a recommendation for those who have missed doses or started a vaccine series late and need to get back on schedule

SCDM: a recommendation that the decision to vaccinate be made on a case-by-case basis through a conversation between patient and provider that assesses a variety of factors like health history, risk and medical considerations.²

Outside of vaccines, SCDM is used when treatment options involve trade-offs and no single option is clearly preferred – for example, choosing between surgery or physical therapy for chronic back pain or deciding between a CT scan with radiation exposure or supportive care for abdominal pain. Historically, SCDM for vaccines has been reserved for instances where factors like disease burden, who is most at risk, expected public health impact and cost-effectiveness point toward a more targeted approach.

HOW DOES ACIP DECIDE WHICH VACCINES RECEIVE A SCDM RECOMMENDATION?

SCDM is a relatively new type of recommendation that was introduced in 2019 and has been used historically when data suggest that some individuals may benefit from vaccination, but the overall public health case for a broader routine recommendation is less clear.³



Recently, federal health officials moved several vaccines to SCDM – including those that protect against rotavirus, COVID-19, influenza, meningococcal disease, hepatitis A and hepatitis B*.⁴ These vaccines have a strong body of country-specific evidence that supports their routine recommendation for children in the U.S. The abrupt shift to SCDM for these vaccines does not appear to be driven by any scientific evidence that would warrant changing these recommendations. Instead, the shift has been positioned as a way to promote “choice” or align the U.S. schedule with other countries. However, applying SCDM to vaccines with well-established, broad benefits will only blur guidance, create unnecessary barriers and confusion and ultimately jeopardize public health.⁵

*For hepatitis A, hepatitis B and meningococcal, vaccination is currently recommended for a narrower group of children, based on certain risk criteria or other factors, and is SCDM for all other children.

HOW DOES SCDM IMPACT VACCINE ACCESS AND UPTAKE?

SCDM can complicate guidance and lead to inconsistent recommendations and implementation across providers, patients and health care settings. That variability can create practical barriers to vaccination and confusion—disrupting delivery, provider reimbursement and vaccine confidence, and ultimately limiting choice and making it harder for people to get the vaccines they need to protect themselves and their families.

Vaccine payments and processes for administering vaccines are usually set up for simple, standard recommendations. SCDM makes things more complicated because it requires extra review, paperwork, discussion and education for both staff and patients – steps that may not always be covered.⁶ This can mean more referrals, follow-ups or return visits, creating extra barriers that make it harder for patients to get vaccinated.

The ultimate impact of this change will be fewer people getting vaccinated and less protection against disease.^{7,8}

WHAT CHALLENGES DOES SCDM CREATE FOR PATIENTS?

When SCDM is applied to vaccines that have broad, well-established benefits – absent scientifically sound evidence – choice and access to vaccines are jeopardized.

Getting vaccinated now depends on having the right visit, with the right clinician, at the right time – and successfully navigating a more complex conversation and decision-making process. SCDM can even impact nurses and pharmacists' ability to vaccinate, limiting how patients receive vaccines in a way that's convenient and comfortable for them.⁹

This added friction can lead to delayed or missed vaccination due to system-level barriers, not informed preference. In practice, SCDM is likely to impede choice and access because it hinges heavily on critical touchpoints and structural supports, and many patients face barriers that complicate the process including¹⁰:

Lack of consistent point of care. Nearly one-third of Americans do not have an established primary care provider and lack access to services like routine checkups where these conversations would take place.¹¹ Access to consistent care is a particular challenge for patients living in rural areas, where only 10% of U.S. physicians practice despite rural communities representing nearly 20% of the U.S. population.¹²

Limited appointment times. Even during the most efficient provider visits, there is only so much that can be covered in a single appointment.

Health literacy and navigation burden. SCDM shifts more responsibility to patients to know what to ask and to interpret nuanced risks and benefits – tasks that rely on clinical training and context that patients don't often have.

Lack of consistent guidance. When recommendations are less straightforward, messages vary across settings and providers, which can make guidance feel optional or unclear.

HOW DOES SCDM IMPACT SYSTEMS LIKE EHR, WORKFLOWS AND STANDING ORDERS?

Many electronic health records (EHRs) and workflow tools are built for straightforward prompts and efficient documentation; SCDM is harder to integrate into these systems because there are not automatic triggers and it instead relies on real-time, nuanced conversations.¹³ Some EHRs are also designed to flag for providers when patients are recommended for vaccines. Since SCDM vaccines are not routinely recommended, providers face challenges using these reminder systems – potentially leading to missed opportunities for the provider to prompt a conversation with their patient about the vaccine.

Population-based vaccines also facilitate standing orders – protocols that allow nurses and pharmacists to vaccinate without having to consult a doctor for each patient. In some states, SCDM will reverse these standing orders, meaning patients may not be able to get a vaccine at their local pharmacy or care center.¹⁴ This may have profound impacts on patients, especially those in rural areas, who often rely on pharmacies for care.¹⁵

HOW DOES SCDM IMPACT VACCINE MANAGEMENT?

SCDM can make vaccine management more difficult because it blurs the clear planning, stocking and workflow signals providers rely on. When a recommendation is not routine for a particular population, demand is harder to forecast – clinics and pharmacies have less visibility into how many patients will want the vaccine and how quickly doses will be used.¹⁶



The Bottom Line:

Changing longstanding vaccine recommendations to shared clinical decision-making when the SCDM recommendation is not supported by independent and credible scientific evidence threatens vaccine access and choice by adding unnecessary barriers to care, putting American families and children at risk of contracting preventable diseases and health complications.

¹ <https://www.congress.gov/crs-product/IF12317>

² <https://www.cdc.gov/acip/vaccine-recommendations/shared-clinical-decision-making.html>

³ [Ibid](#)

⁴ <https://www.hhs.gov/press-room/fact-sheet-cdc-childhood-immunization-recommendations.html>

⁵ <https://www.kff.org/other-health/the-new-federal-vaccine-schedule-what-changed/>

⁶ https://advisory.avalerehealth.com/wp-content/uploads/2024/03/20240325_AVAC_Provider-Reforms-White-Paper.pdf

⁷ <https://pmc.ncbi.nlm.nih.gov/articles/PMC8342675/>

⁸ <https://www.cidrap.umn.edu/childhood-vaccines/confusion-surrounds-cdc-s-shared-clinical-decision-making-paradigm-childhood>

⁹ <https://www.cidrap.umn.edu/childhood-vaccines/cidrap-op-ed-quiet-dismantling-how-shared-decision-making-weakens-vaccine-policy>

¹⁰ <https://bhm.scholasticahq.com/article/122787-shared-decision-making-in-patient-care-advantages-barriers-and-potential-solutions>

¹¹ https://www.nachc.org/wp-content/uploads/2023/06/Closing-the-Primary-Care-Gap_Full-Report_2023_digital-final.pdf

¹² <https://pmc.ncbi.nlm.nih.gov/articles/PMC10356718/#CR1>

¹³ <https://www.pharmacytimes.com/view/implications-for-pharmacies-navigating-shared-clinical-decision-making-in-vaccination>

¹⁴ <https://www.cidrap.umn.edu/childhood-vaccines/cidrap-op-ed-quiet-dismantling-how-shared-decision-making-weakens-vaccine-policy>

¹⁵ <https://www.pharmacytimes.com/view/implications-for-pharmacies-navigating-shared-clinical-decision-making-in-vaccination>

¹⁶ https://cveep.org/wp-content/uploads/2024/06/CVEEP_SCDM.pdf