

Shared Decision Making Project 2010

1. Enabling Legislation

- Resolve to Study Implementation of Shared Decision Making to Improve Quality of Care and Reduce Unnecessary Use of Medical Services (124th Legislature 2009).
- Required MQF to establish study group to consider appropriate preference-sensitive health care services, assess patient decision aids (PDAs), payment methods, incentives/barriers, and evidence supporting use of shared decision making
- Reports required early 2010 (interim) and January 2011 (final)

2. Process

- 24-member study group, staffed by Muskie
- Four meetings at DHA Augusta
- Concentrated on
 - Definition
 - Current use
 - Challenges to implementation
 - Impact of SDM on health care quality and cost (evidence)
- Survey of payers and providers

3. Definition

- A process used when a patient is faced with two or more treatment options with no clearly advantageous choice in terms of functional or survival outcome, in which the patient's own values drive decisions and in which patient and clinician share information and agree on course of action

4. Conclusions

- SDM applies to all preference sensitive conditions and must include:
 - Real-time face-to-face interactions between patient and clinician
 - Clarification of patient values and preferences
 - Balanced information and education about treatment options
 - Supportive guidance throughout the decision process
- There is no certifying body for PDAs.

- Challenges to implementation include:
 - No standard definition of SDM exists
 - No coding specification exists
 - No agreement on appropriate payment
- Reimbursement would be an incentive to use of SDM. Models include NCQA measure and/or benefit design to incentivize consumers and purchasers.
- SDM leads to higher quality care when measured as patient satisfaction.
- There is insufficient evidence to support promotion of SDM on basis of cost savings:
 - Conclusions from controlled trials may not apply in “real world” situations.
 - Studies do not fully account for all costs.
 - Follow-up period may be too short to account for “crossovers.”
 - There may be bias in some studies of PDAs (sponsored by developer).
- Lack of reimbursement is most frequently cited barrier to adoption

6. Next steps

- Address possible policy options
- Monitor Maine and other states’ studies