



## **Chartering Document**[\[1\]](#) **The Minnesota Shared Decision Making Collaborative - Improving the Clinician-Patient Partnership**

Initiated: November 4, 2008

### **Context**

Unwarranted variation[\[2\]](#) in preference-sensitive care[\[3\]](#) occurs in Minnesota, just as it does in the rest of the United States. As a consequence, some Minnesotans make important medical decisions that are not consistent with their preferences, or are based on incorrect or incomplete information.

Shared decision making (SDM) has been shown to improve patient knowledge and clarity about preferences, and to reduce decisional conflict. It also has the potential to increase patient trust in their physicians, compliance, and satisfaction with the decision and the decision process; improve utilization of evidence-based preventive services; and reduce utilization of needlessly invasive medical treatments. In addition, SDM has intrinsic value. Patient preferences matter, especially when making preference-sensitive decisions, where the best choice for the patient depends on their values and preferences; and the medical evidence is clear—physicians generally do not know their patients preferences unless they ask about them. Therefore, in many situations, a “shared” rather than delegated model for decision making is desirable.[\[4\]](#)

There is a growing movement throughout the United States to adopt SDM as a standard for patient decision support in clinical practice. Here in Minnesota we have an established track record and

infrastructure for community-wide quality improvement. We believe the time has come for us to use these capabilities to address unwarranted variation in preference-sensitive care and improve patient decision making in Minnesota.

### **Purpose statement**

The goal of the MSDMC is to enhance effective shared medical decision-making between patients and their clinicians[5] by studying and implementing methods to assure that medical decisions are well-informed by best available evidence and consistent with patient preferences.

### **Scope**

The MSDMC will focus on clinical decisions in which patient preferences are expected to play an important role. The field is not fully mature, yet application of these methods is overdue. Therefore we will adopt a combined approach of learning while doing—developing the evidence base while we apply best available evidence.

### **Committee/group Composition**

The collaborative shall consist of a standing Steering Committee and ad hoc task-oriented Workgroups. Workgroups seek to include interested participants from the community who are not members of the Steering Committee.

### **Meeting Frequency**

This Steering Committee will meet on a bi-monthly basis, with workgroups meeting in the intervals between to work on developing or implementing the details of Steering Committee recommendations.

### **Accountability**

This collaborative is accountable to the entire Minnesota community, including patients, providers, and purchasers.

Chair: Larry Morrissey, MD

Committee Members: (the following types of organizations will be represented on the Steering Committee. See Appendix A for the current list of committee members)

Patients and community members

Provider organizations

Health Plans

Purchasers

Researchers

Statewide health care quality convening organizations

State agencies

The University of Minnesota (both as a care delivery organization and as a research entity)

The Minnesota Medical Association

Staff: Project Manager

**Expectations of Involvement:**

Steering Committee members:

1. Participate actively in meetings
2. Participate in Workgroups as able and interested
3. Review and comment on documents/materials/work products of Steering Committee and Workgroups
4. Champion the work of the MSDMC in their organization and the community

5. Identify and seek connections with other local initiatives related to SDM
6. Constructively represent the MSDMC in their constituency
7. Constructively represent the concerns and interests of their constituency in the collaborative process

Workgroup members:

1. Participate actively in meetings
2. Review and comment on documents/materials/work product of Workgroups
3. Constructively represent the concerns and interests of their constituency in the collaborative process (and vice versa)

### **Aims**

As stated above, our overall goal is to build on the existing Minnesota collaborative quality improvement capabilities so as to improve the quality of physician-patient decision making for preference-sensitive health related decisions in our State. In support of this, the collaborative has four specific aims:

1. Identify best practices for providing and implementing SDM, and measuring decision quality, and
2. Implement and spread these best practices Minnesota-wide, so as to
3. Improve clinician-patient decision-making, and reduce or eliminate unwarranted variation preference-sensitive care.
4. Create the Community Collaborative structure and process required to sustainably get the work done.

Sample Strategies and Measures of Success: See appendix B.

Date Adopted: April 21, 2009

Last updated on 04/28/2010

## **Appendix A: Roster of Steering Committee Members**

Donna Anderson, MPH (Patient Advocate)  
Steve Bergeson, MD (Allina Hospitals and Clinics)  
Laura Bloom (Minnesota Community Measurement)  
Eric Bundgaard (AARP)  
Craig Christiansen, MD (UCare)  
Heather Clark, MPH (Preferred One)  
Terry Clark, MD (SMDC)  
Terry Corbin, (Patient Advocate)  
Terry Crowson, MD (HealthPartners Health Plan)  
Ann Earl (Medica)  
John Frederick, MD (Preferred One)  
Paul Huddleston, MD (MMA, Mayo)  
Sandy Johnson (Coborn Cancer Center)  
Ken Joslyn, MD  
Karen Kraemer, RN (HealthPartners Health Plan)  
Jennifer Lundblad, PhD (Stratis)  
Marie Maes-Voreis, RN (MDH)  
Tom Marr, MD (HealthPartners Health Plan)  
Dave Moen, MD (Fairview)  
Victor Montori, MD (Mayo Clinic)  
Larry Morrissey, MD (Stillwater Medical Group)  
Dan Nelson, MD (HealthPartners Medical Group)  
Gary Oftedahl, MD (ICSI)

Trudy Ohnsorg, MPH (MN Dept of Human Services)

David Pautz (BCBS)

C.J. Peek, PhD (University of Minnesota Dept. of Family Medicine/Community Health)

Megan Remark, (HealthPartners, Specialty Care & Clinic Operations)

Gary Schwitzer, PhD (University of Minnesota School of Journalism)

Kris Soegaard (Buyers Healthcare Action Group)

Leif Solberg, MD (HealthPartners Research Foundation)

Gretchen Taylor (MDH)

Marcus Thygeson, MD

Mark Wilkowske, MD (Park Nicollet)

## **Appendix B: The SDM Collaborative – Aims, and Possible Strategies and Measures of Success**

### 1. Identify best practices for providing, implementing, and measuring SDM:

A. Define and promote adoption of the essential elements for a standard, community-wide, evidence-based approach to SDM applicable to multiple different decisions.

Possible measure of success: Initial SDM “best practices” guideline(s) implemented by clinical practices.

B. Define, implement, and study the impact of a standard community-wide decision quality measurement approach applicable to multiple different preference-sensitive decisions.

Possible measure of success: Composite “optimal” decision quality measure created and implemented by clinical practices

### 2. Implement and spread SDM best practices Minnesota-wide:

A. Develop a community-wide business case/financial model that facilitates this work and addresses the business concerns of all stakeholders.

Possible measure of success: a business case/financial model in use

B. Coordinate with ongoing collaborative work in MN on patient-centered medical home (PCMH), DIAMOND, Stratis Palliative Care Project, and other initiatives as appropriate—to address SDM requirements and opportunities related to those projects.

Possible measure of success: SDM components of PCMH, DIAMOND, and Palliative Care Project addressed

C. Implement a state-wide SDM improvement program for at least one preference-sensitive treatment decision that includes all of the following elements: 1) targeted decision (e.g., spinal fusion for LBP), 2) widespread adoption of standardized PDS and decision quality measurement (DQM) best-practices, 3) physician group self-reporting on SDM/DQM performance, 4) public reporting of self-reported PDS/DQM provider performance metrics (e.g., on MNMCM website), and 5)

tracking of impact on practice pattern variation.

Possible measure of success: number of physician groups reporting targeted decision SDM/DQM performance for public reporting

D. Shape the environment by working with government entities, policymakers, payers and purchasers, health professions educators, and the media to provide support for, and remove barriers, to the adoption of SDM best practices.

Success might include promotion of:

- Legislation that protects physicians who use decision aids and SDM from “failure-to-inform” malpractice litigation;
- Consideration of patient preference as well as medical necessity when making health plan coverage decisions;
- Widespread adoption of health reporting quality standards by major Minnesota media organizations.

3. Improve the quality of shared decision making in Minnesota

Possible measures of success:

- Improvement in health plan and medical group member/patient decision-related satisfaction questions;
- Reduced unwarranted variation in preference-sensitive care;
- Increased provider satisfaction with patient education/decision support process and outcomes.



Create a sustainable, systematic community-based learning collaborative that accomplishes the three ultimate aims above.

Possible measures of success:

A. Learning Collaborative defined and implemented; number of SDM program implementations in clinical practice

B. Grant(s) obtained to fund initial administrative support for the work of the Guiding Coalition and Workgroups-sufficient funds to support at least 1 FTE facilitator/coordinator along with meetings/symposia

C. Other Minnesota organizations and investigators supported in obtaining grants for research on patient decision support and shared decision-making –building the number of SDM study grants awarded to support collaborative-related work.

D. Annual symposia held to provide an update on the work of the Collaborative, gather input from other community members, and educate the community about SDM-documenting the meeting purpose, attendance, input gathered, participant satisfaction, and resulting actions

Last updated on 04/28/2010

[1] Adapted from an ICSI template.

[2] Unwarranted variation is variation in care that is not due to the patient's health condition, needs, or preferences.

[3] Preference-sensitive decisions are health-related decisions with multiple options that have approximately equal health benefit for the patient, but which involve trade-offs for the patient, such that the best choice depends on patient preferences (e.g., surgery vs physical therapy for low back pain).

[4] Wennberg JE, et al. Improving Quality and Curbing Health Care Spending: Opportunities for the Congress and the Obama Administration. A Dartmouth Atlas White Paper, December 2008.

[5] By this we denote all members of the patient's care team.