Shared Decision Making Process Survey
NQF Measure 2962
User Guide

I. Purpose:

To measure the extent to which patients are involved in the decision-making process.

II. Versions:

Shared Decision Making Process_4: 4 item version of the shared decision making process survey. The survey is able to be adapted to specific conditions and options. As shown in the Table, Item 3 varies depending on whether there are two options or more than two options.

III. Timing

The SDM Process_4 survey should be administered after a consult with a health care provider where a decision was discussed. The items were written assuming that the choice is known (e.g. that the patient is having or had surgery, taking medication, having the screening test, etc).

Modifications may be required if it is to be used before the choice is known.

IV. Scoring:

Each response is scored 0 or 1 according to the labels in the Table. Participants receive 1 point for a response of "yes" or "a lot" or "some." The total points are summed and result in total scores from 0 -4, with higher scores indicating more shared decision making. Surveys with one or more missing items do not get a total score.

Table: Shared Decision Making Process_4 survey

Instructions	**TALKING WITH YOUR HEALTH CARE PROVIDERS** Please answer these questions about what happened when you talked with health care providers including doctors, nurses and other health care professionals about [tests or treatments] for your [condition].
Items	1. How much did you and your health care providers talk about the reasons you might want to have [test/intervention]? ☐$_1$ A lot ☐$_1$ Some ☐$_0$ A little ☐$_0$ Not at all

	2. How much did you and your health care providers talk about the reasons you might **not** want to have [test/intervention]? ☐1 A lot ☐1 Some ☐0 A little ☐0 Not at all 3. Did any of your health care providers talk about [an alternative to intervention, e.g. non-surgical treatments/not testing] as something that you should seriously consider? [Version for situations with more than two options: Did any of your health care providers explain that there were choices in what you could do to treat your [condition]?] ☐1 Yes ☐0 No 4. Did any of your health care providers ask if you wanted to have [test/intervention]? ☐1 Yes ☐0 No

III. NQF PRO-PM Measure #2962 specifications:

The SDMP_4 is used as the basis for a patient-reported outcome performance measure (PRO-PM). The following describes calculation for that measure.

- **Numerator Statement:** The numerator is the sum of the total scores (0-4) for all those responding.
- **Denominator Statement:** The denominator includes the number of respondents from the target population of adults who have undergone a procedure for one of the target conditions and completed the survey.
- **Denominator Exclusions:** Respondents who are missing 1 or more items do not get a total score and are excluded. No other exclusions as long as the respondent has the procedure for the designated condition.
- **Sampling**: Patients of a particular surgeon or at a particular clinical site (which could be a group of providers or a hospital or other surgical site) who had a one of the procedures are identified from medical records, claims or in some other way. Sampling should allow time for immediate recovery, while attempting to survey shortly after the procedure, for example, by sampling eligible patients 1- 6 months after the procedure. Patients can be sampled sequentially, or a pool of such patients who had the procedure in a particular time period (e.g. in the last 3 months) can be created and sampled at a rate that produces the desired number of potential respondents.

The measure can also be calculated from a population-based sample, such as a sample of a population in a geographic area. Eligible respondents could be identified from claims (such as Medicare claims files) or based on patient self- reports of having had the procedures within some time frame.

- Proxy respondents are not permitted. The patients who receive the test or intervention for the target condition should answer the survey questions.

VI. Development Process:

In 2007, a team of researchers at the University of Michigan developed several items to be used in the DECISIONS survey, the first national survey of how common medical decisions were being made in the United States [1,2]. One key goal was to develop items that would assess the extent to which shared decision making happened across 10 different medical decisions. The SDM Process Survey is based on four questions from that survey.

The survey items were derived from the shared decision making model (SDM), a conceptual framework that was first outlined by Mulley in the late 1980s [3] and extended by Mulley and Sepucha [4-5]. The model takes a systems approach to understanding and improving clinical decision making that focuses on two key participants: patients (and family) and clinicians. The model emphasizes the fundamentally social nature of the decision making task, and the fact that it cannot be completed by the clinicians or patients alone, but rather requires interactions between them. The guiding principles behind the items included: 1) patients should have adequate knowledge and experience to answer; 2) minimize need for judgment or evaluation; 3) cover the key elements necessary for a shared decision process; 4) be short and easy to adapt to a variety of settings. Although the items do not cover all possible SDM behaviors, these four elements (discussion of options, pros, cons and preferences) are foundational components in widely accepted definitions [5-7].

VII. Psychometric Properties:

Feasibility: The survey is feasible and typically has very low missing data (1-3%). [e.g. see 8]

Acceptability: The survey is acceptable with high response rates when administered by mail, online or by phone, and takes < 2 minutes to complete.

Floor and ceiling effects: The SDMP_4 has not shown floor or ceiling effects. In a national study of 10 different medical conditions, mean scores varied widely, with lowest for mammography (mean = 1.5 out of 4), and the highest for surgery for low back pain (mean = 3.2 out of 4). [8]

Reliability:

- Internal consistency: the score is technically a composite and as a result, Cronbach's alpha may not be an appropriate measure of reliability, however we have calculated it for some samples and found Cronbach alphas of 0.77 for breast cancer surgery [9], 0.78 for hip and knee osteoarthritis [10], 0.54 for spine [11], 0. 87 for hip and knee osteoarthritis [11]
- Retest reliability: short term (~4 week) retest reliability ICC=0.64 (95% CI 0.67, 0.86) [9]
- Practice level reliability: When we drew random samples of patients from the same sites who had made decisions, the correlations of the SDMP_4 scores averaged .61 [13]

Validity

- Content validity was confirmed through the extensive feedback from patients and providers in the development process as well as in the field tests.
- Construct validity: Those who had higher SDMP scores reported
    - better decision quality, [10]
    - were less likely to think they made the wrong decision, [9] and
    - reported less dissonance (conflict between what was important to them and the decision that was made). [12]
    - clinical sites that made an effort to implement SDM (with patient decision aids and/or coaching) had higher scores than usual care sites [11, 13]

VIII. Sample size considerations

The standard deviations for the measure vary by topic and sample (ranging from 0.83-1.25). We have observed a 0.3SD-0.5SD difference between sites that do and do not make an effort to do shared decision making. A sample size of about 50-60 would be needed to detect differences in proportions of .5 SD for the measure with 80% power assuming standard deviation of about 1.

IX. Appropriate Use

The SDM Process_4 is protected by copyright. It is available to use at no cost, provided that you:

- Cite the reference in any questionnaires or publications
- Do not charge for or profit from it
- Do not alter items except for customization for a specific condition/interventions and reformatting

X. Suggested Citation for the SDM Process_4 User Guide:

Sepucha KR and Fowler FJ. Shared Decision Making Process_4 User Guide v.1.0. ©Massachusetts General Hospital, 2018.

XI. References:

1. Zikmund-Fisher BJ, Couper MP, Singer E, Levin C, Fowler Jr. FJ, Ziniel S, et al. The DECISIONS study: a nationwide survey of U.S. adults regarding nine common medical decisions. Medical Decision Making. September/October 2010; 30: 20S- 34S.
2. Zikmund-Fisher B, Couper M, Singer E, Ubel P, Fowler F, Levin C, Ziniel S, Fagerlin A. Deficits and variations in patients' experience with making 9 common medical decisions: The DECISIONS survey. Medical Decision Making. September/October 2010; 30: 85S-95S.
3. Mulley, A. J. (1990). Methodological issues in the application of effectiveness and outcomes research to clinical practice. Effectiveness and Outcomes in Health Care. Washington D.C., National Academy Press.
4. Sepucha K and Mulley A. Extending Decision Support: Preparation and Implementation. *Patient Education and Counseling* 2003; 50 (3):269-271.
5. Sepucha K and Mulley A. A Perspective on the Patient's Role in Treatment Decisions. *Medical Care Research and Review* 2009 66:54S-74S.

6. Charles, C, Gafni, A and Whelan, T. Decision- making in the physician-patient encounter: revising the shared decision –making model. Soc Sci and Med, 491 (1999) 65, 651-661.

7. Makoul, G and Clayman, ML An integrative model of shared decision making in medical encounters. Patient Educ and Couns. (2006), 60, 301-312.

8. Fowler, FJ, Gerstein, BS, Barry, MJ How patient centered are medical decisions? JAMA Internal Medicine 2013 173 (13) 1215-1221.

9. Sepucha K, Feibelmann S, Chang Y, Hewitt S, Ziogas A. Measuring the quality of surgical decisions for Latina breast cancer patients. Health Expect 2014 May 12 [Epub ahead of print].

10. Sepucha K, Feibelmann S, Chang Y, Clay CF, Kearing S, Tomek I, Yang TS, Katz JN. Factors associated with high decision quality for treatment of hip and knee osteoarthritis. J Am Coll Surg 2013 Oct;217(4):694-701. doi: 10.1016/j.jamcollsurg.2013.06.002. Epub 2013 Jul 25.

11. Sepucha K, Atlas SJ, Chang Y, Dorrwachter J, Freiberg A, Mangla M, Rubash HE, Simmons LH, Cha T. Patient Decision Aids Improve Decision Quality and Patient Experience and Reduce Surgical Rates in Routine Orthopaedic Care: A Prospective Cohort Study. J Bone Joint Surg Am. 2017 Aug 2;99(15):1253-1260. doi: 10.2106/JBJS.16.01045. PubMed PMID: 28763411.

12. Fowler FJ, Gallagher PM, Drake KM, Sepucha K. Decision Dissonance: Evaluation of an Approach to Measuring the Quality of Surgical Decision Making. Jt Comm J Qual Patient Saf 2013 Mar;39(3):136-44.

13. Fowler FJ and Sepucha K. National Quality Forum Measure Testing Attachment for Measure 2962. Available from http://www.qualityforum.org/ using the Find Measures application.