



Ask the Experts

Karen J. Merrikin, J.D.

Ms. Merrikin is executive director of public policy at Group Health Cooperative, a non-profit health plan and care delivery system in Washington state. She was actively involved in shaping and supporting a state bill endorsing shared decision-making that was successfully passed in 2007. She shared her thoughts on the role of shared decision-making at Group Health and practical tips for others interested in supporting similar legislation.



Q: How did you—and your employer, Group Health Cooperative—become involved in advancing the legislation endorsing shared decision-making?

A: Group Health has a long history of supporting health care reform. For example, soon after the Institute of Medicine report, *The Quality Chasm*, was published, administrators at Group Health spoke with state policy makers about the importance of the findings and recommendations in the report. Also, leaders at our organization saw that community building was absolutely essential to achieving long-term reform at the state and national levels. Our history of involvement in reform set the stage for our commitment to shared decision-making as a process for achieving reform in a circumscribed area and community building to support more expansive reform.

In 2006, Governor Christine Gregoire and leading members of the state legislature convened the Blue Ribbon Commission (BRC), a bipartisan group of stakeholders interested in setting long-term goals for health care in the state of Washington. The group worked with a primary belief: affordability, quality, and access to care are intimately linked. Group Health submitted recommendations to the BRC. One of our recommendations for reducing variation in care was to increase focus on shared decision-making. Our recommendation resonated for many stakeholders. To foster greater support, Senator Cheryl Pflug invited topic experts, including legal expert Ben Moulton and researcher Jack Wennberg, to hold learning sessions variation in care and shared decision-making for policy makers.

In 2007, Governor Gregoire, and Senator Pflug, a BRC participant, each sponsored bills that included support for shared decision-making. Senator Pflug's original language was refined, and a provision was added for the initiation of a demonstration project. The language on shared decision-making was then folded into the Governor's BRC request legislation. In the meantime, I, along with several other advocates of shared decision-making, continued to talk about the need to reduce variation and marshal our resources for effective health care that is patient centered. At Group Health, we had seen the results of a shared decision-making study that showed patients with benign prostate disease who engaged in shared decision-making were happier with their decisions and chose surgery less often. We felt strongly that shared decision-making was a way to improve care and achieve better value.



Q: What is the business case for supporting shared decision-making? Why has Group Health Cooperative dedicated so many resources to the initiative?

A: Group Health is a member-governed organization. We strongly support patient-oriented health education and strive to provide “affordable excellence” in health care. We believe that shared decision-making can help drive better value into the health care system. We prefer to compete based on value and performance, not just price—as was the case in the past. And we believe by providing better value to our customers, Group Health will survive and thrive in the market of the future. We’ve seen that purchasers have begun to look for better value and better outcomes for their health care dollars. The goal of improved care also resonates with physicians and consumer groups. Focusing on shared decision-making is a terrific way for us to hone in on this sweet spot in the marketplace.

Q: How did you—along with other key stakeholders—move the shared decision-making legislation forward? What specific steps did you take?

A: First, I’d like to say that no one group or individual could have achieved this alone. We were fortunate in having the interest and support of many different stakeholders. Second, at Group Health we took a number of steps to move the legislation forward: we worked with national experts to set directions and through their involvement, affirm the importance of the bill. We worked closely with staff from state legislators and the governor’s office to provide input about key ideas. We worked to identify stakeholders who might have concerns about the bill and address these concerns early in the process. To garner the support of providers, we recommended that the bill include provide incentives for use of shared decision-making rather penalties for non-use. We also worked very early on with physician leaders. We have a very progressive state medical association here in Washington. To ensure their support, we met with representatives of the association and engaged their physicians with our topic experts. By working closely with the medical association, I think we demonstrated to physicians that the legislation was of benefit to them and their patients. And finally, when it became clear that the bill might not go through if the associated appropriations bill required funding for the demonstration project, we compromised. The final bill did not include funding for the demonstration project—state agency heads have had to use existing state funds for that portion of the project.

Q: How was the Foundation for Informed Medical Decision Making involved in this endeavor?

A: Several ways. While we were trying to move the legislation forward, the Foundation supported the time of several experts who were helpful in educating key stakeholders about the advantages of shared decision-making. Since the legislation passed, the Foundation has been instrumental in getting the word out about its passage and about shared decision-making in general.



Q: How do you see Group Health Cooperative's support for shared decision-making playing out in the future?

A: Shared decision-making fits into Group Health's overall strategies in a number of different arenas. One strategy is providing patient-centered primary care. Shared decision-making helps to increase consumer engagement and fits in with the goal of providing the "right information at the right time." Another strategy is to embrace transparency. We've created a method for tracking variation across our organization—like a Dartmouth Atlas of Group Health—that allows us to show potential areas for improvement and reach for the right level of use. Reducing waste across the organization is another strategy that fits well with shared decision-making and reducing variations in care. We'll continue to support shared decision-making as a means for advancing these and our other core strategies.

In addition, we'll be launching at Group Health the demonstration project that was specified in the legislation. First, our health care centers and medical group will begin using decision aids with their patients. We expect to begin by the end of 2008. We'll focus on the use of decision aids for several conditions to start. In 2009, providers within our network will begin using the decision aids. We'll first implement the project within networks that have engaged physicians and where data have shown an increased variation in use in the network.

Finally, I'd like to say that at Group Health, we see the demonstration project—and all of our involvement in shared decision-making—as a way to bring together individuals interested in improving access and those interested in cost containment. Shared decision-making is a good area to strengthen our ability to work across lines and move into work on even more challenging aspects of health care reform.

