# English Summary of the full report of the project *Making SDM a Reality* funded by the German Innovation Fund (NVF17009)

## Background

Shared Decision Making (SDM) is the gold standard of medical decision making and fulfills the requirements of the German Patients' Rights Act (§630 BGB). SDM is expected to improve the quality of care and patient safety. However, SDM is still rare in daily clinical practice. Therefore, the multimodular SHARE TO CARE program (S2C) was developed to effectively implement SDM in entire hospitals and to enable a cost-efficient transfer to the nationwide standard of care covered by health insurance.

## Method

The implementation of the S2C program included 22 of 25 departments at the University Hospital Schleswig-Holstein (UKSH) in Kiel. In a pre-post design, the primary endpoint was the effectiveness of the program to increase SDM levels. The validated questionnaire *Perceived Involvement in Care Scale* (PICS) was used to capture the patients' perspective on SDM. Video recordings of medical decision-making discussions with patients were analyzed by blinded raters using the *Multifocal Approach to the Sharing in SDM* (MAPPIN'SDM). The secondary endpoint was patient-perceived health literacy in preparing for treatment decisions.

To assess the cost-effectiveness of the S2C program, inpatients of the Department of Neurology were enrolled including a 12 months follow up. Costs and clinical outcomes of these patientes were compared with a "matched" control group on the basis of routine data obtained nationwide from Germany's largest insurance company Techniker Krankenkasse (TK).

In addition, the practicability of the S2C program was assessed by means of the degree of implementation in the UKSH and a process evaluation.

## Results

The SHARE TO CARE program was successfully implemented in 17 of 22 clinics. The process evaluation confirmed the high practicability with minor exceptions. Consultation length tended to decrease after implementation.

Results from patient questionnaires as well as consultation video analyses showed a significant increase in SDM levels in clinics with full implementation, although with slightly lower SDM scores after completion of implementation than postulated. SDM levels continued to be significantly elevated 6 and 18 months after the end of implementation. In a control clinic without SDM implementation, no increase occurred, as expected.

Compared with the nationwide matched control group, SDM showed a 13% reduction in emergency readmissions and overall reduced hospital costs. The other outcomes and cost components assessed were comparable between the groups.

The SDM-associated savings significantly exceeded the investment costs for SDM by about sevenfold.

**Discussion**

The SHARE TO CARE program demonstrated good practicality and effectiveness. It reduced the costs of care and increased health literacy and patient safety. Thus, positive outcomes were achieved for the primary and secondary endpoints.

Due to the pandemic, the certainty of results regarding cost-effectiveness is lower than intended. As the best available evidence worldwide, the results nevertheless suggest that the transfer of SDM to standard care saves more money than it costs.

Since the end of the project, SDM has been reimbursed at UKSH by the TK in order to continuously increase the efficiency of care and patient safety. Based on the certification methodology used, SDM clinics can now be accredited nationwide. This means that SDM could be transferred to standard care via the *Zentrumsregelung* of the Federal Joint Committee (G-BA; §136c (5) SGB V).