MassPRA listening session feedback on Shared Decision-making

Tewksbury Hospital 11-9-16

Feedback about prescribing practices

- access to information about non-medicinal strategies for managing distress is limited
- psychiatrists only get paid for prescribing
- prescribing should be goal-dependent
- making tapering protocols available to prescribers
- maybe some psychiatrists have figured out how to accommodate for Shared decision-making. It was suggested that we can encourage them to spread those practices, through recognizing them publicly, and/or referring others to them as patients when possible

Feedback about Service Systems

- MAP Standards are the domain of the Department of Public Health (DPH). DPH works at a more global level (population-specific rather than individual-specific) and therefore misses the specifics of DMH population
- DMH is at the table w/DPH in response to an initiative involving DPH regs that affected DMH services w/o sufficient input. DPH's preferred process for input is to hold community forums on the topics of interest they are working on. These regional forums could become a way for people to engage and weigh in on matters of importance to them, if the relevant topics come up for input through these forums.
- DMH evaluation of prescribers could include a question: does this prescriber have a statement affirming the right of patients to collaborative decision-making?
- is it possible to create a DMH provider-specific module as an accompaniment to MAP? One that includes what kind of conversation to have around declining medications?
- A suggestion was made to form a workgroup w/DMH and/or service providers, to create tools for interested agencies.

Feedback about Practitioners and Programs

- how can we support person's real long-term choice in a given moment? There was a concern expressed about the dangers to health in making a sudden change to an established medication habit - avoiding cold-turkey quitting is a concern in how agencies help staff to engage in the conversation in meaningful ways.
- Advance planning within outreach is important for preventing or minimizing re-hospitalization - development of shared plans for advanced directives are an important part of helping people think ahead and plan for contingencies with relapsing conditions
- staff should engage Persons Served in discussions of additional strategies to meds - should not offer medical advice, but there is a need for resources and training
- CBFS staff lack training and expertise re: meds. Training may be essential, but support, or "scaffolding" for how staff engage in these discussions is even more important. It was suggested that the role of staff should revolve around facilitation persons served to find relevant information, building a knowledge-base together that is individualized, rather than the unrealistic expectation of staff having all medication-related expertise.
- It was suggested that organizations and programs influence the practices internally by starting with data collection and establishment of measures/metrics, such as: %age choosing not to take meds, and outcomes of decision; # on tapering plans, etc
- With this focus on data an organization can highlight where you're going - it has the impact of making us look at the issues