Why shared decision making?

• Fundamental to patient-centered care
  – Increases patient engagement and activation (adherence, “compliance”)
  – Increases patient satisfaction
  – Builds trust (relationship-based care)
  – Decreases decisional conflict
  – Patients more accepting of adverse outcomes
• Fundamental to value-based models of reimbursement
  – Increases quality
  – Reduces costs (lower demand for health resources)
  – Drivers include MACRA/QPP/MIPS
• It’s the right thing to do.
What is shared decision making?

A process undertaken between a clinician and a patient with a preference-sensitive condition to help the patient decide among multiple acceptable health care choices in accordance with his or her preferences and values.

State of Washington
What is shared decision making?

A collaborative process that allows patients and their providers to make health care decisions together, taking into account the best scientific evidence available, as well as the patient’s value and preferences.

Dartmouth-Hitchcock Center for Shared Decision-Making
A simpler definition

A collaboration to reach a health care decision that balances the preferences of the patient and the expertise of the provider

Vanderbilt University Medical Center
provider paternalism/expertise  patient autonomy/preferences
shared
decision
making

provider paternalism/
expertise

patient autonomy/
preferences
shared decision making

provider paternalism/expertise  patient autonomy/preferences

joint goal setting
shared decision making

provider paternalism/expertise

patient autonomy/preferences

informed consent

joint goal setting
provider paternalism/expertise

shared decision making

informed consent

joint goal setting

patient autonomy/preferences

advance care planning
“Choice Talk”

1. Identify choice(s)
2. Explain to patient that there is no best choice and a decision needs to be made (doing nothing is an option)
3. Explain that this decision is a shared responsibility
4. Invite patient to engage to the extent that they desire

- Provide information and decision support (e.g., patient decision aids) tailored to the patient’s needs
- Assess understanding (e.g., using teach-back)
Hibbard patient activation model

4 stages of patient activation

- believing the patient role is important
- having the confidence and knowledge necessary to take action
- actually taking action to maintain and improve one’s health
- staying the course even under stress

“Options Talk”

- Discuss potential benefits, harms, and probabilities of each option

- Provide information and decision support (e.g., patient decision aids) tailored to the patient’s needs

- Assess understanding (e.g., using teach-back)
“Decision Talk”

- Elicit patient’s needs, wants, and preferences about the options and their benefits and harms
- Provide information and decision support (e.g., patient decision aids) tailored to the patient’s needs
- Assess understanding (e.g., using teach-back)
Eliciting patient preferences

“Elicit, Provide, Elicit” (also known as “Ask, Tell, Ask”)

**Ask:**
- Ask permission to start the conversation
- Ask the patient to describe their level of understanding or emotional state: What do they know, what do they want to know, what is important to them?

**Tell:**
- Provide simple information using clear communication techniques

**Ask:**
- Confirm understanding using teach-back
- Ask the patient what other questions they have or what else they want to know
4 Decision

- Patient and provider reach a shared decision based on the preferences of the patient and the expertise of the provider
- Assess level of patient’s confidence in their decision (e.g., use SURE)
- If patient is unsure, repeat one or more previous steps
- Provide information and decision support (e.g., patient decision aids) tailored to the patient’s needs
- Assess understanding (e.g., using teach-back)
## SURE test for clinical practice

<table>
<thead>
<tr>
<th>QUESTION</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sure of myself</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you feel sure about the best choice for you?</td>
<td></td>
<td></td>
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<tr>
<td><strong>Understanding information</strong></td>
<td></td>
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<tr>
<td>Do you know the benefits and risks of each option?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Risk-benefit ratio</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you clear about which benefits and risks matter most to you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Encouragement</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have enough support and advice to make a choice?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

YES = 1 point; NO = 0 points. If the total score is less than 4, the patient is experiencing decisional conflict. (Copyright © O’Connor and Légaré, 2008)
Patient decision aids (DA, PDA, PtDA)

Tools designed to help people participate in decision making about health care options. They provide information on the options and help patients clarify and communicate the personal value they associate with different features of the options.

Patient decision aids do not advise people to choose one option over another, nor are they meant to replace practitioner consultation. Instead, they prepare patients to make informed, value-based decisions with their practitioner.

International Patient Decision Aid Standards (IPDAS) Collaboration
National Quality Forum standards

The patient decision aid:

• provides a balanced presentation of options.
• is based on a rigorous and documented evidence synthesis method.
• provides information about the evidence sources used.
• provides key outcome probabilities, adopting risk communication principles.
• provides a publication date.
• provides information about the update policy and next expected update.
• provides information about the funding sources used for development.
• provides information about competing interests and/or policy.
• provides information about the patient decision aid development process, including information about participation from target users and health professionals.
• provides information about user testing with target patients and health professionals.
• reports readability levels.
• follows plain language guidelines, to ensure understanding of people with low literacy and/or low health literacy skills.
Quality standards for PDAs

- International Patient Decision Aid Standards (IPDAS): http://ipdas.ohri.ca

Patient decision aids

• Option Grids (Dartmouth Institute for Health Policy & Clinical Practice): http://optiongrid.org

• AHRQ Patient Decision Aids: http://www.effectivehealthcare.ahrq.gov/tools-and-resources/patient-decision-aids/

• Mayo Clinic Shared Decision Making National Resource Center: http://shareddecisions.mayoclinic.org/decision-aid-information/decision-aids-for-chronic-disease/

• Ottawa Hospital Decision Centre: https://decisionaid.ohri.caHealthwise/

• Healthwise/Informed Medical Decisions Foundation: http://www.dartmouth-hitchcock.org/medical-information/health Encyclopedia/share

Welcome to the Statin Choice Decision Aid.

This tool will help you and your doctor discuss how you might want to reduce your risk for heart attacks.

Let's get started

Caution: This application is for use exclusively during the clinical encounter with your clinician.
Current Risk
Select Risk Calculator

ACC/AHA ASCVD
Framingham
Reynolds

Do you have a history of events such as prior heart attack or stroke, acute coronary syndromes, history of angioplasty or stents, etc?
- Yes
- No

These figures are used to calculate my risk of having a heart attack in the next 10 years:
- Age (40 - 75)
- Gender (M, F)
- Population Group
- Smoker (Yes, No)
- Diabetes (Yes, No)
- Treated SBP

Conv. Unit
SI Unit

Systolic Blood Pressure (90 - 250) mmHg
HDL Cholesterol (10 - 120) mg/dL
Total Cholesterol (100 - 350) mg/dL

Select Current Intervention
- Statins (No, Std Dose, High Dose)

Benefits vs Downsides according to my personal health information

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Current Risk

Select Risk Calculator

ACC/AHA ASCVD
Prattingham
Reynolds

These figures are used to calculate my risk of having a heart attack in the next 10 years:

- Age
- Gender
- Smoker
- Atrial Fibrillation
- Diabetes
- Treated SBP
- Cardiovascular Disease
- LV Hypertrophy

Conv. Unit
SI Unit

- Systolic Blood Pressure
  - 150 mmHg
- Diastolic Blood Pressure
  - 90 mmHg
- HDL Cholesterol
  - 40 mg/dL
- Total Cholesterol
  - 250 mg/dL
- High Sensitivity CRP
  - Optional

Select Current Intervention

- Statins
  - No
  - Std Dose
  - High Dose

Benefits vs Downsides according to my personal health information

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Current Risk of having a heart attack

Risk for 100 people like you who do not medicate for heart problems

- Over 10 years
  - 53 people will have a heart attack
  - 47 people will have no heart attack

Future Risk of having a heart attack

Risk for 100 people like you who do take standard dose statins

- Over 10 years
  - 40 people will have a heart attack
  - 47 people will have no heart attack
  - 13 people will be saved from a heart attack by taking medicine
I have used a decision aid to share decision making with the patient about interventions to reduce the risk of coronary events. We estimated the patient's 10-year atherosclerotic events at 53% and discussed how this risk could be reduced with the use of statins to 40%. After considering the patient's unique circumstances and the pros and cons of the alternatives, we have decided to...
Low tech aid options too

Carotid artery stenosis: treatment options

Use this decision aid to help you and your health care professional talk about how best to treat your blocked or narrowed carotid arteries. This decision aid is for people under 80 years old, or those with no heart, lung or kidney problems.

Frequently Asked Questions

- **What does the treatment involve?**
  You will take 2 or more medicines every day to lower your blood cholesterol and lower your blood pressure. A thin plastic tube is put into a blood vessel in your arm and moved up to the artery in your neck, where the block or stenosis is. The block will then be removed. You will need to take medicines for the rest of your life.

- **What are the risks associated with the treatment?**
  Up to 10% of people treated for carotid stenosis can have a stroke or death. You will need to take medicines for the rest of your life.

- **How long will it take to recover?**
  Recovery will depend on the procedure. You may need to stay in the hospital for 1 to 3 days.

- **What are my chances of having a stroke or the long term?**
  About 1% of people treated for carotid stenosis will have a stroke within 5 years. The risk of treatment is about 3% over 5 years. The exact risk is higher if you have a stroke in the future.

Clogged neck arteries:
When you need a screening test—and when you don’t

There are two major arteries in the neck. The internal carotid artery supplies oxygen and nutrients to the brain. If one of these arteries is narrowed or blocked, it can lead to a stroke. Strokes can be an extremely costly event, but it’s not always a good idea to get tested. In fact, the test may do more harm than good.

Blocked carotid arteries are not a common stroke risk. To be in the group of “at risk,” you must have a narrowed internal carotid artery. If you have the condition, you’re not likely to show a stroke until you have other problems with other brain functions. For people who have not been screened and are at risk for the procedure, the risk for the procedure is very small.

- **Stenosis**
- **High blood pressure**
- **High cholesterol**
- **Diabetes**

Block the test if you:

- Have a medical history of a heart attack or stroke
- Have a high blood pressure
- Are over 80 years old
- Are taking medications for heart disease

For more information, visit [VanderbiltHealth.com](http://VanderbiltHealth.com).
Measuring SDM

Patient and Family Engagement Metric 2: Does the practice support shared decision-making by training and ensuring that clinical teams integrate patient-identified goals, preferences, outcomes, and concerns into the treatment plan (e.g. those based on the individual’s culture, language, spiritual, social determinants, etc.)?

Intent: The intent of this metric is to ensure that patients (and their families according to patient preference) are authentically part of the care team.
Measuring SDM continued...

You’ll meet this metric if: Practice is using a tool to promote and teach shared decision making in order that patients (and their families according to patient preference) are authentically part of the care team.

Examples:

- Practice has begun to train providers and staff on the value of shared decision making.
- Practice is in the process of developing a process to ensure that every patient is provided an authentic opportunity to share in all decisions regarding their care.
- *Practice determines their own shared decision process and has disseminated to staff.*
Barriers

“There’s not enough time!!!”
“Combined results from more than a hundred randomized trials provide no robust evidence that more time is required to engage in shared decision making in clinical practice than to offer usual care. Perceived time constraints are the most frequently cited barrier to any change in clinical practice. Implementing share decision making is no different from implementing any other practice improvement.”

Légaré and Witteman, Shared decision making: examining key elements and barriers to adoption into routine clinical practice, Health Affairs 32, no. 2 (2013), 276-284
Barriers

“Some patients don’t want to/shouldn’t/can’t do shared decision making.”
Barriers

“Vulnerable patient populations—such as older people, immigrants, people with less education in general, and those with lower numeracy—are the ones who stand to benefit most from engaging in shared decision making. Like health care providers, patients can learn communication skills and become increasingly confident in their ability to engage in decisions about their health. The process should be recommended for all patients, with adaptations to suit individuals’ ability and interest.”

Légaré and Witteman, Shared decision making: examining key elements and barriers to adoption into routine clinical practice, Health Affairs 32, no. 2 (2013), 276-284
Barriers

“There isn’t/shouldn’t be a choice in this clinical situation.”
Barriers

“Models such as fee-for-service or pay-for-performance can be at odds with the goals and even the outcomes of shared decision making. In ethically complex situations where shared decision making is applied even when there is a medically preferable option, patients might not choose the option that is most advantageous for their health.”

Légaré and Witteman, Shared decision making: examining key elements and barriers to adoption into routine clinical practice, Health Affairs 32, no. 2 (2013), 276-284
Questions?
Additional Learning Opportunities

VIZIENT-MSPTN Learning and Action Network

• Partnering to improve patient experience at the point of care and engagement of patients and families in policy and procedure making and in practice governance

• Collaborating with experts from the TCPI Support and Alignment Network (SANs):
Governance Network

• **Topics:**
  – Patients and families participating in operational decision-making (feedback surveys, advisors on educational programs)
  – Patient and Family Advisory Councils

• **SAN Subject Matter Experts:**
  – Stacy Lloyd, MPH Senior Practice Development Specialist, AMA
  – Tracy Walsh, LCSW Director, Service Development, Planetree
  – Invited guests

• **Inaugural call- overview of goals, concerns of practices**
  – May 18th 1-2PM CT
Point of Care/Policy and Procedure Network

• **Topics:**
  – E-tools
  – *Shared decision-making*
  – Assessing patient activation and health literacy
  – Engaging patients and families in medication management

• **SAN Subject Matter Experts:**
  – *Stacy Lloyd, MPH Senior Practice Development Specialist, AMA*
  – *Mary Minniti, CPHQ Institute for Patient and Family-Centered Care*
  – *Invited guests*

• **Inaugural call- overview of goals, concerns of practices**
  – *May 11th, 2-3 PM CT*
REGISTRATION INFORMATION IN YOUR PACKET!