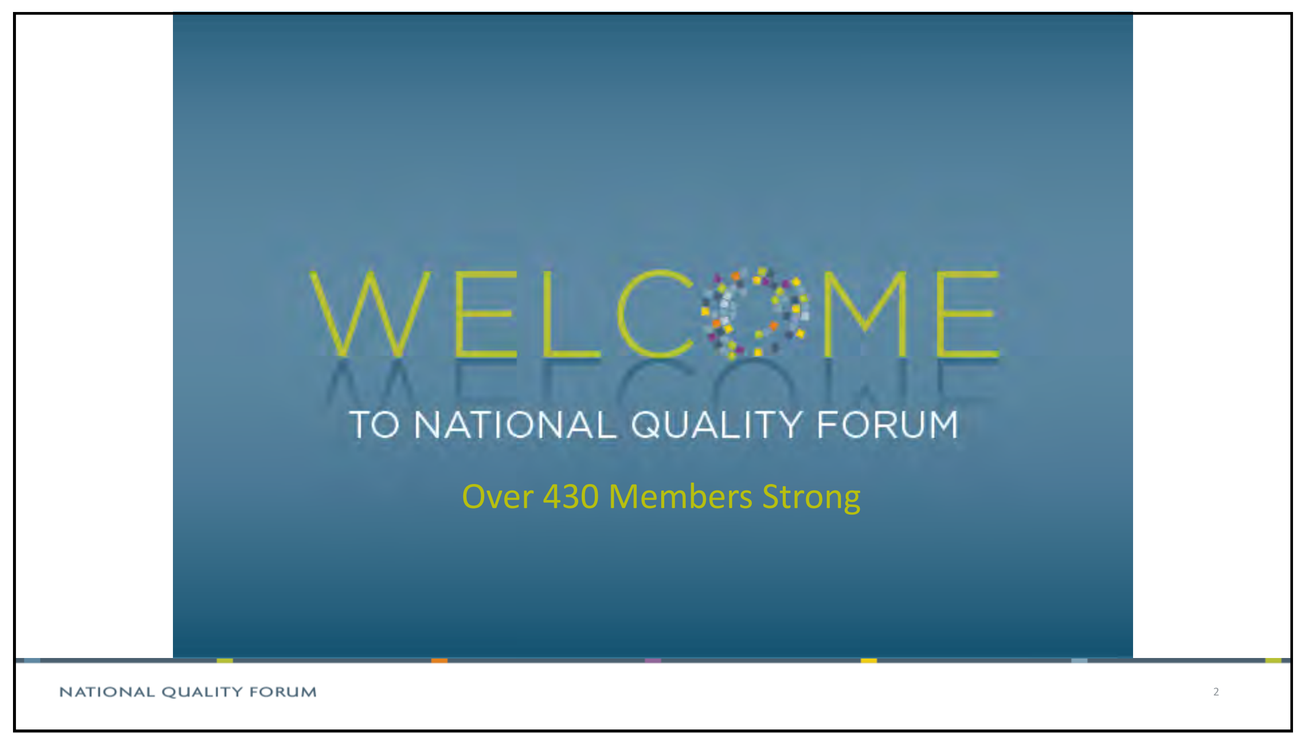
Using Shared Decision Making to Drive Population Health Strategy

Population Health Colloquium Pre-Conference Symposium
Hosted by Thomas Jefferson University

March 19, 2018



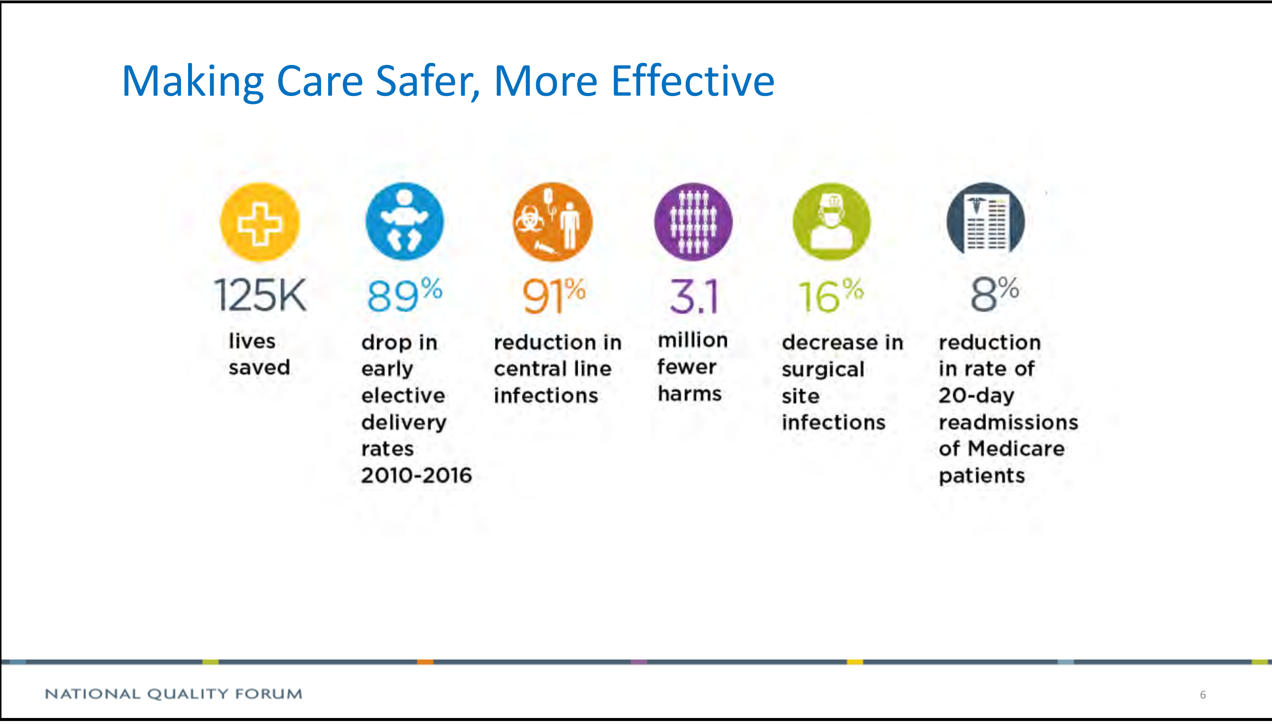
Introduction

Camille Espinoza, MSPH, MSW
Director, Member Education
National Quality Forum
cespinoza@qualityforum.org

Paddle Networking Activity

1) Find a match with your paddles – D's look for A's
2) Introduce yourself, and consider:
   - Why shared decision making?
   - What about this topic compels you to take action?
3) When the bell rings find another match and begin again.
4) Three minutes total per round. Hurry!

Evolving Measurement
Improving Care on the Frontlines
Achieving Health Equity


Making Care Safer, More Effective
125K lives saved
89% drop in early elective delivery rates 2010-2016
91% reduction in central line infections
3.1 million fewer harms
16% decrease in surgical site infections
8% reduction in rate of 20-day readmissions of Medicare patients
NATIONAL QUALITY FORUM
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National Quality Partners (NQP™) Multistakeholder Collaboration Approach

mutually reinforcing activities • communications • culture of innovation and action

Policy and Measurement	▪ Promoting the use of existing performance measures ▪ Partnering to integrate measures in accountability programs ▪ Promoting measure alignment
Practice Change	▪ Sharing tools, models, and practices that support quality improvement ▪ Spreading strategies for implementation ▪ Partnering to identify opportunities for collaboration
Patient/Family Engagement	▪ Ensuring patients and families are engaged and empowered ▪ Promoting opportunities to learn from consumers

SHARED GOALS AND COMMON MEASURES guide us toward positive outcomes

NQF is the backbone organization that connects stakeholders and supports collaboration

Today's Objectives

By noon today, you will:

1. Understand the role of shared decision making in population health.
2. Identify examples of health system and payer delivery models that support and facilitate shared decision making.
3. Identify ways to implement shared decision making principles across systems of care.

Agenda and Housekeeping

Today's packed agenda includes:

- Learning from eight shared decision making experts
- Ample time for breaks and networking
- Slides and materials available online
- Live streaming and recording

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Using Shared Decision Making to Drive Population Health Strategy
Population Health Colloquium Pre-Conference Symposium (in partnership with Thomas Jefferson University)
March 19, 2018, Loew's Hotel, Philadelphia, PA

Session D

Description

Join us Monday morning to learn how shared decision making (SDM) can strengthen your population health strategy and drive outcomes. This workshop begins with a brief overview of SDM principles, followed by a panel discussion focused on key outcomes that can be achieved with successful SDM implementation, including: improved patient and provider experience, higher quality of care, and care that aligns with what matters most to patients. We'll conclude with a discussion of the key role of culture and leadership as well as a practical overview of important resources described in the *National Quality Partners Playbook™: Shared Decision Making in Healthcare*. Participants will leave the workshop with a collection of best practices and strategies proven to facilitate successful implementation of SDM across a range of care delivery settings.

Session Objectives

During this half-day workshop, participants will:

(1) Understand the role of shared decision making in population health.
(2) Identify examples of health system and payer delivery models that support and facilitate shared decision making.
(3) Identify ways to implement shared decision making principles across systems of care.

Agenda

Introduction and Icebreaker

- Welcome
- Overview of objectives and agenda
- Icebreaker activity

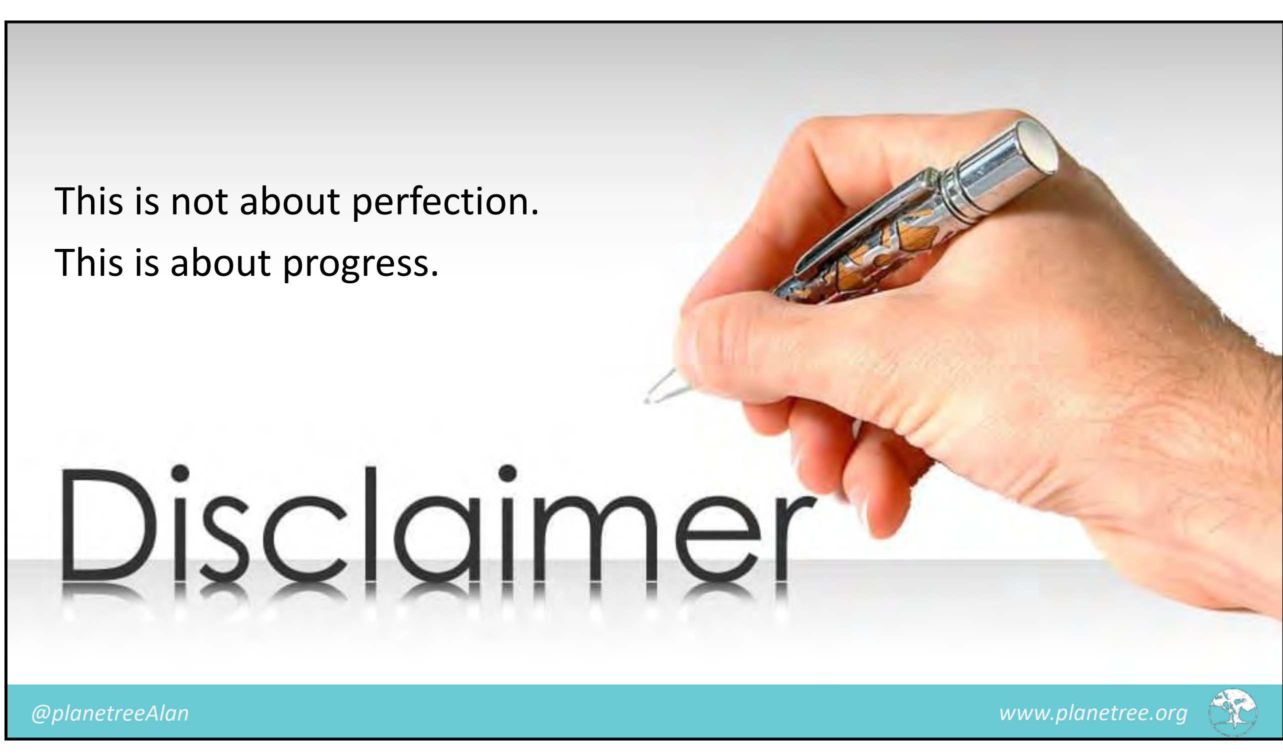
What is (and isn't) Shared Decision Making?

- Presentation and audience discussion or activity to cover:
  - Key elements of shared decision making and how it complements patient engagement, patient activation, informed consent, and patient-centered care

What is (and isn't) Shared Decision Making?

Alan Manning
Executive Vice President

@planetreeAlan www.planetree.org



What is Shared Decision Making (SDM)?

Shared decision making (SDM) **is a process of communication** in which clinicians and patients work together to make optimal healthcare decisions that align with what matters most to patients. SDM requires 3 components:

clear, accurate, and unbiased medical evidence about reasonable alternatives—including no intervention—and the risks and benefits of each;	clinician expertise in communicating and tailoring that evidence for individual patients;	patient values, goals, informed preferences, and concerns, which may include treatment burdens

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Basic Operational Format of SDM

Step 1: **S**eek patient's participation

Step 2: **H**elp patient explore & compare treatment options

Step 3: **A**ssess patient's values & preferences

Step 4: **R**each a decision w/ patient

Step 5: **E**valuate patient's decision

9 Essential Elements *

1. Define/explain problem.
2. Present options.
3. Discuss benefits/risks/costs.
4. Clarify patient's values/preferences.
5. Discuss patient ability/self-efficacy.
6. Discuss doctor knowledge/ recommendations.
7. Check/clarify patient's understanding.
8. Make or defer a decision.
9. Arrange follow-up.

*Makoul G, Clayman ML; An integrative model of shared decision making in medical encounters. Patient Educ Couns. 2006;60(3):301-12.

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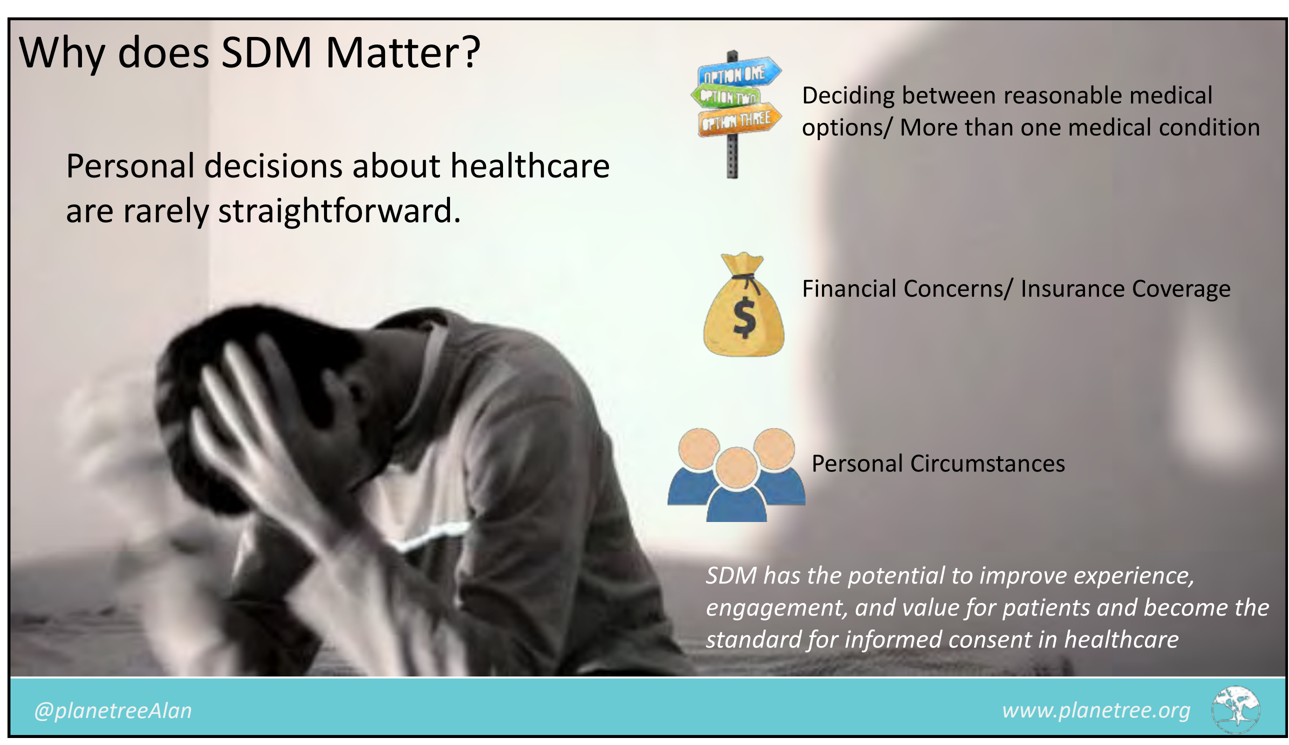

Why does SDM actually do?

Improve the Experience of the Patient

SDM may alleviate symptoms of depression, including feelings of helplessness and hopelessness, and increased patient involvement in clinical decision making can enhance autonomy, empowerment, and self-efficacy. Int J Geriatr Psychiatry, 2010

Improve the Engagement of the Patient

How does SDM improve patient engagement? Patients who engage with their clinicians in SDM are more satisfied, more engaged in their care, and more likely to follow the treatment plan agreed upon, which can ultimately lead to improved health. Cochrane Database Systematic Review, 2017

Improve the Value for the Patient

Early studies suggest that individuals who take a more active role in their healthcare decisions have a better understanding of their choices and are more likely to receive care consistent with their values, goals, and preferences. JAMA, 2016

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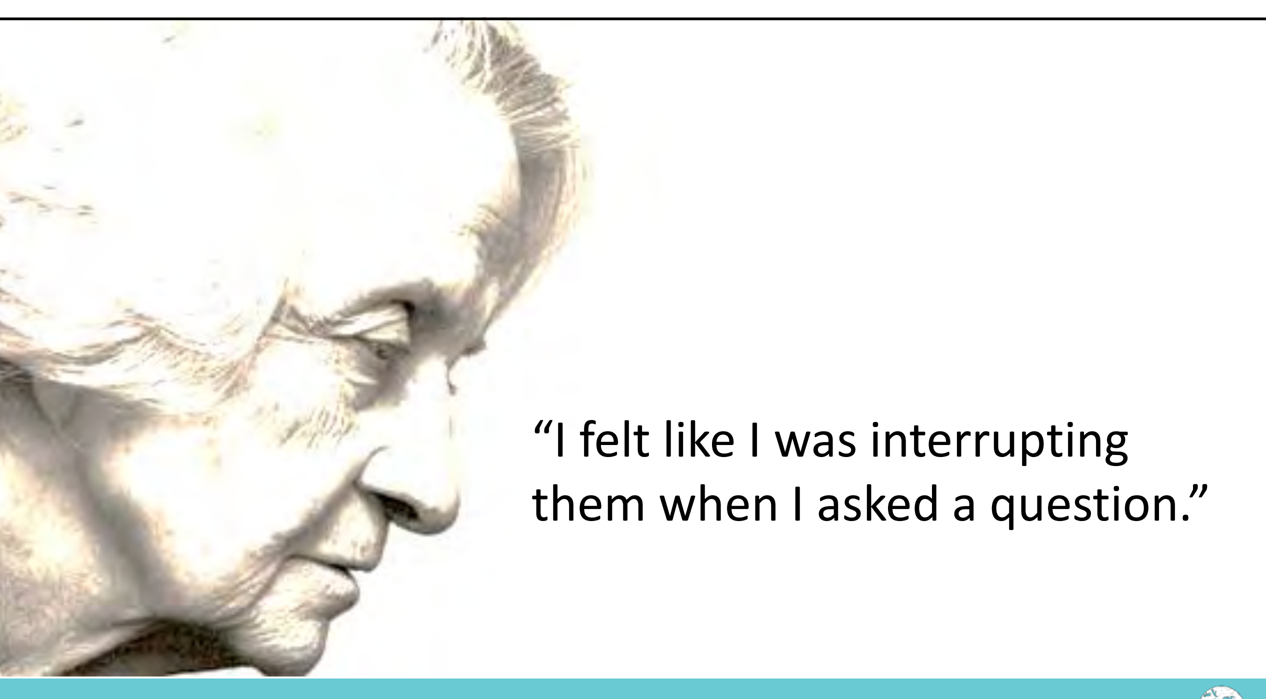

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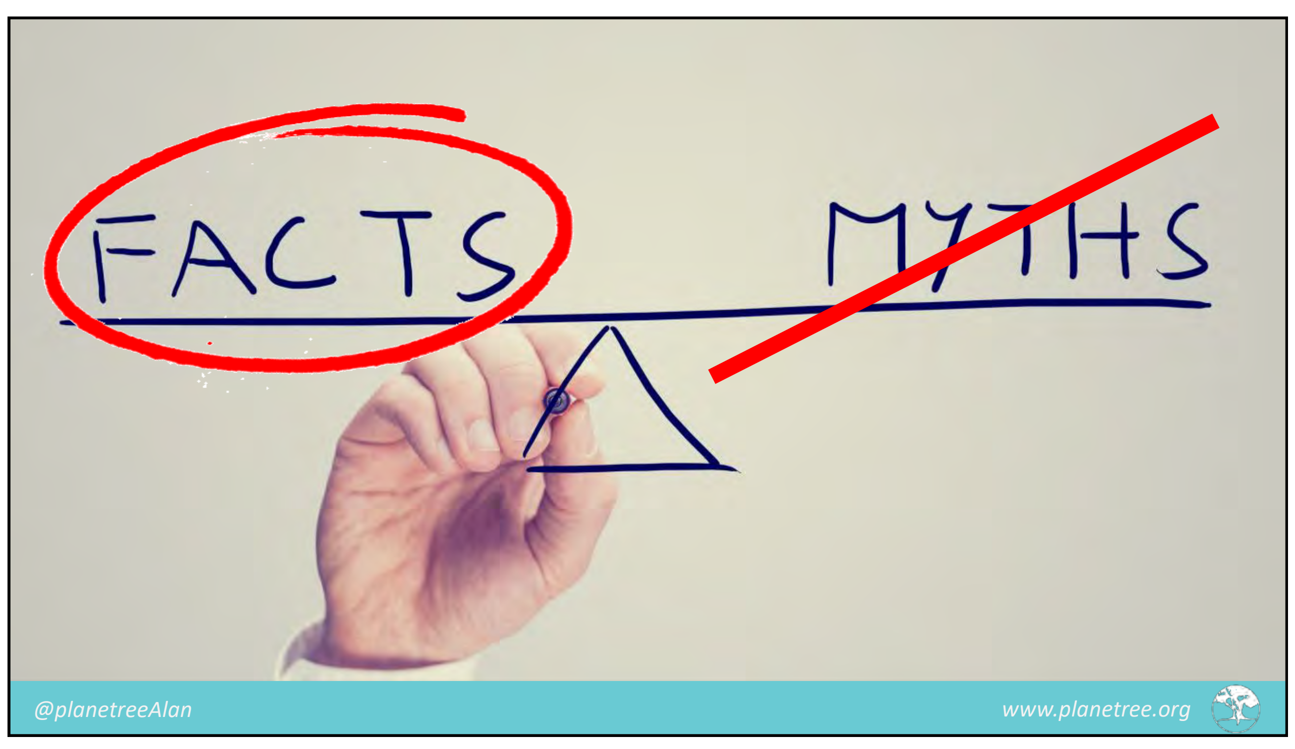
So why doesn’t everyone do it?

We don’t love SYSTEM change in healthcare

It takes 17 years to change scope of practice

Either you will find a **way**, or you will find an **excuse.**



5 common reasons against SDM I hear in the field

1) “This is a fad- this too, shall pass”
2) “I already do SDM intuitively”
3) It’s just a tool/ piece of paper I give them”
4) “Patients make all the decisions” + “patients don’t want to make decisions”
5) “This would be way too expensive”

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1. "This is a fad- this too shall pass."

1959

Dimensions of Being "Modern" in Medical Practice (Menzel, Coleman & Katz, 1959)

Three ways in which the modern doctor may accord the patient some of this equality which has traditionally been regarded as out of place in the professional relationship:

(1) he may feel that the patient is entitled, as a matter of right, to explanations of the treatment given him;
(2) he may allow that patients can and do benefit from medical information disseminated to laymen; and
(3) he may give the patient credit for actual contributions to the planning of his own treatment.

2001

Institute of Medicine- Crossing the Quality Chasm

The patient as the source of control. Patients should be given the necessary information and the opportunity to exercise the degree of control they choose over health care decisions that affect them. The health system should be able to accommodate differences in patient preferences and encourage shared decision-making.

2017

National Academy of Medicine- Harnessing Evidence & Experience to Change Culture

Patient and family engaged care (PFEC) is care planned, delivered, managed, and continuously improved in active partnership with patients and their families to ensure integration of their health and health care goals, preferences, and values. It includes explicit and partnered determination of goals and care options, and it requires ongoing assessment of the care match with patient goals

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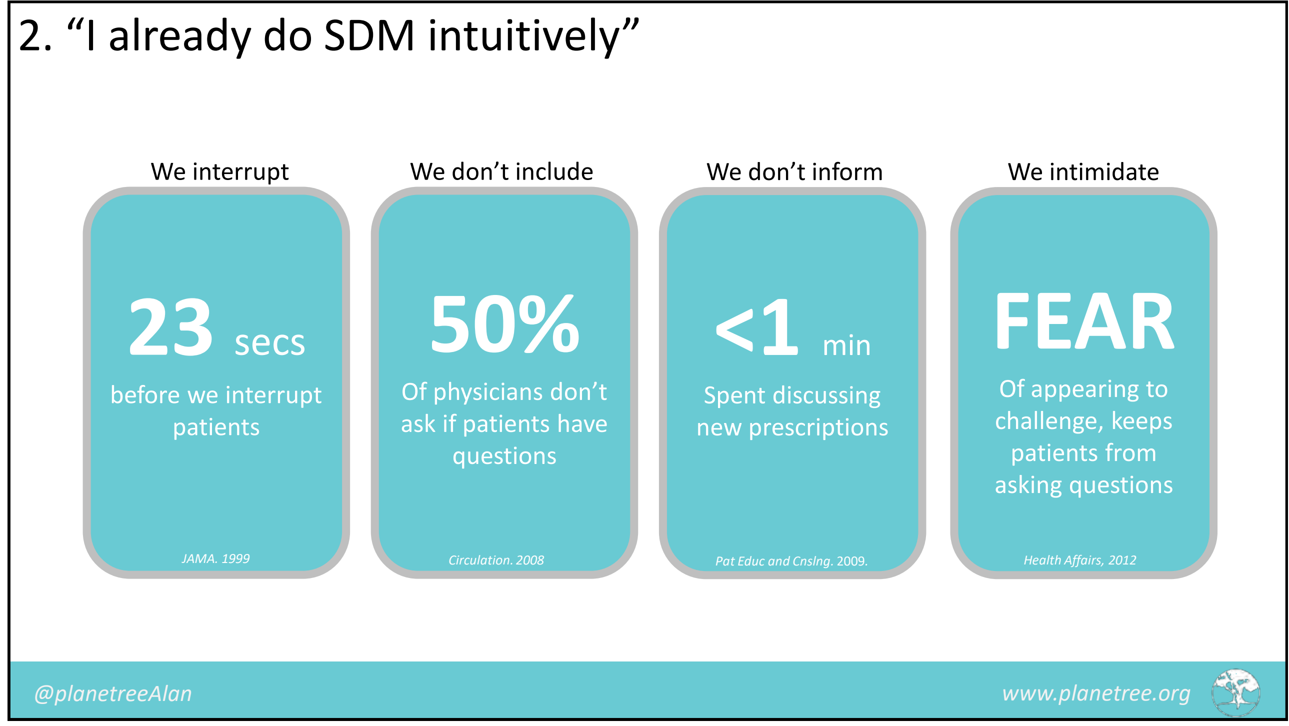

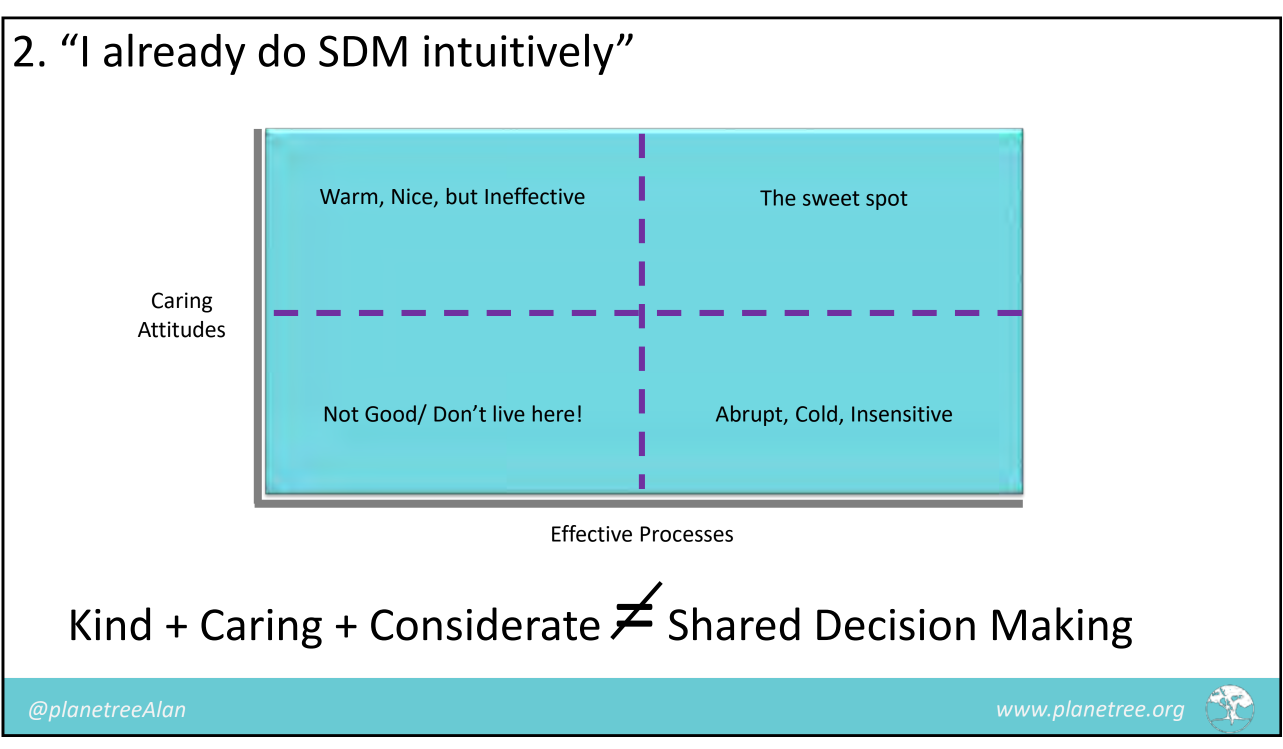
2. "I already do SDM intuitively"
Warm, Nice, but Ineffective
The sweet spot
Caring Attitudes
Not Good/ Don't live here!
Abrupt, Cold, Insensitive
Effective Processes
Kind + Caring + Considerate ≠ Shared Decision Making
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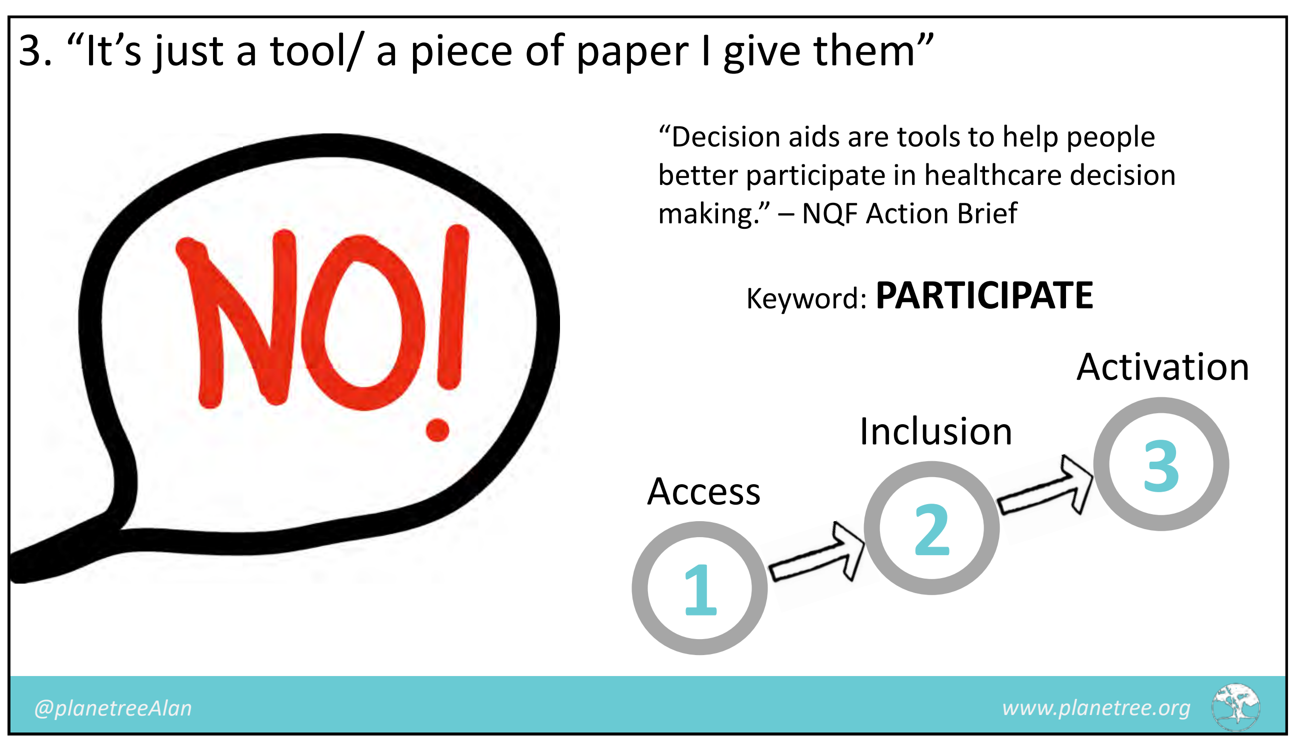
3. "It's just a tool/ a piece of paper I give them"
NO!
"Decision aids are tools to help people better participate in healthcare decision making." – NQF Action Brief
Keyword: PARTICIPATE
Access
1
Inclusion
2
Activation
3
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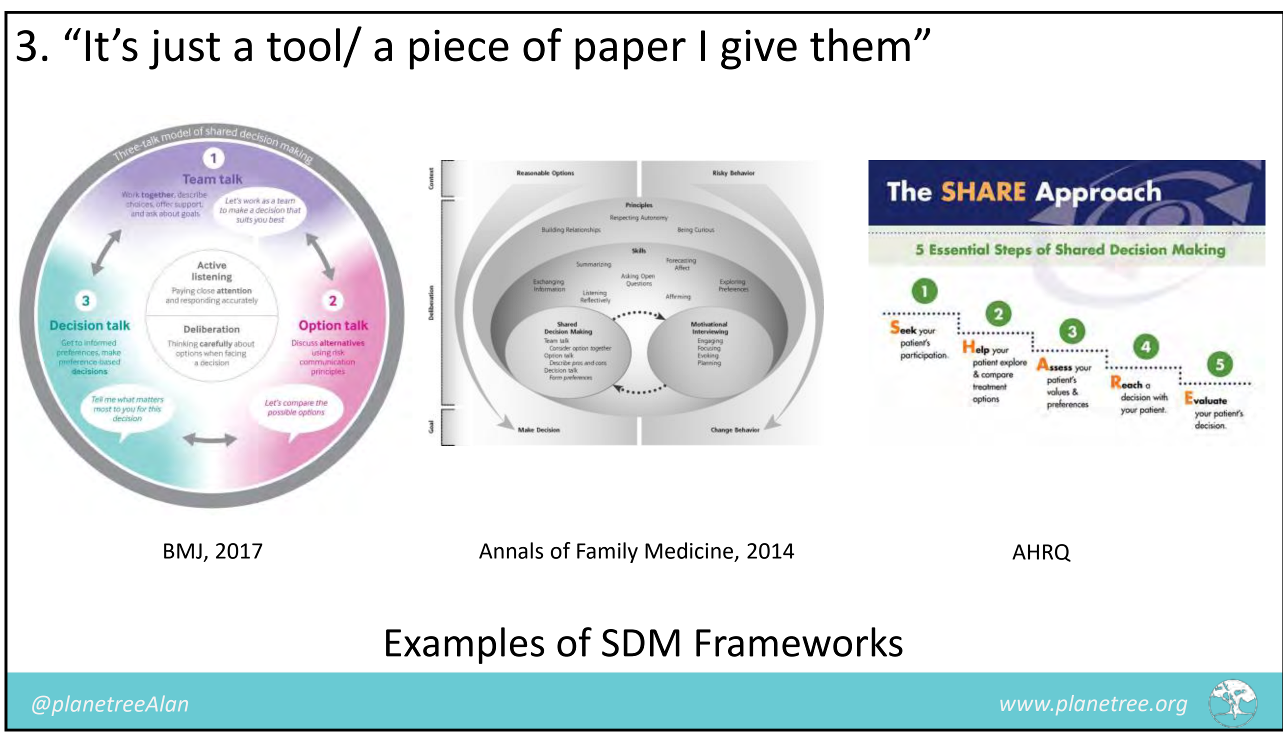
3. "It's just a tool/ a piece of paper I give them"
Three-talk model of shared decision making
Team talk
Option talk
Decision talk
Active listening
Deliberation
The SHARE Approach
5 Essential Steps of Shared Decision Making
BMJ, 2017
Annals of Family Medicine, 2014
AHRQ
Examples of SDM Frameworks
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4. "Patients make all the decisions" +"patients don't want to make decisions"
I Am An EXPERT ABOUT Me
I Am LISTENING TO You
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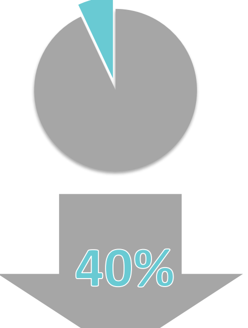
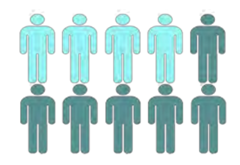
4. "Patients make all the decisions" +"patients don't want to make decisions"



Doctors believe 71% of patients with breast cancer rate keeping their breast as top priority. **The figure reported by patients is just 7%.**



Once patients are informed about the risks of sexual dysfunction after surgery for benign prostate disease **40% fewer prefer surgery.**

Only 41% of Medicare patients believe that their treatment reflected their preference for palliative care over more aggressive interventions.

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4. "Patients make all the decisions" +"patients don't want to make decisions"

Not making the decision yourself is a choice…a decision

Ground our realities in the fact that this is THEIR life

Participation and activation are journey- this is what we build to over time

"How do you think Katie was last night?"- expectation of participation

Millennials and beyond won't accept anything but this

"What got us here, won't get us there"

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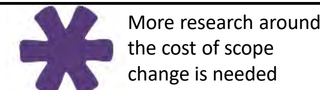
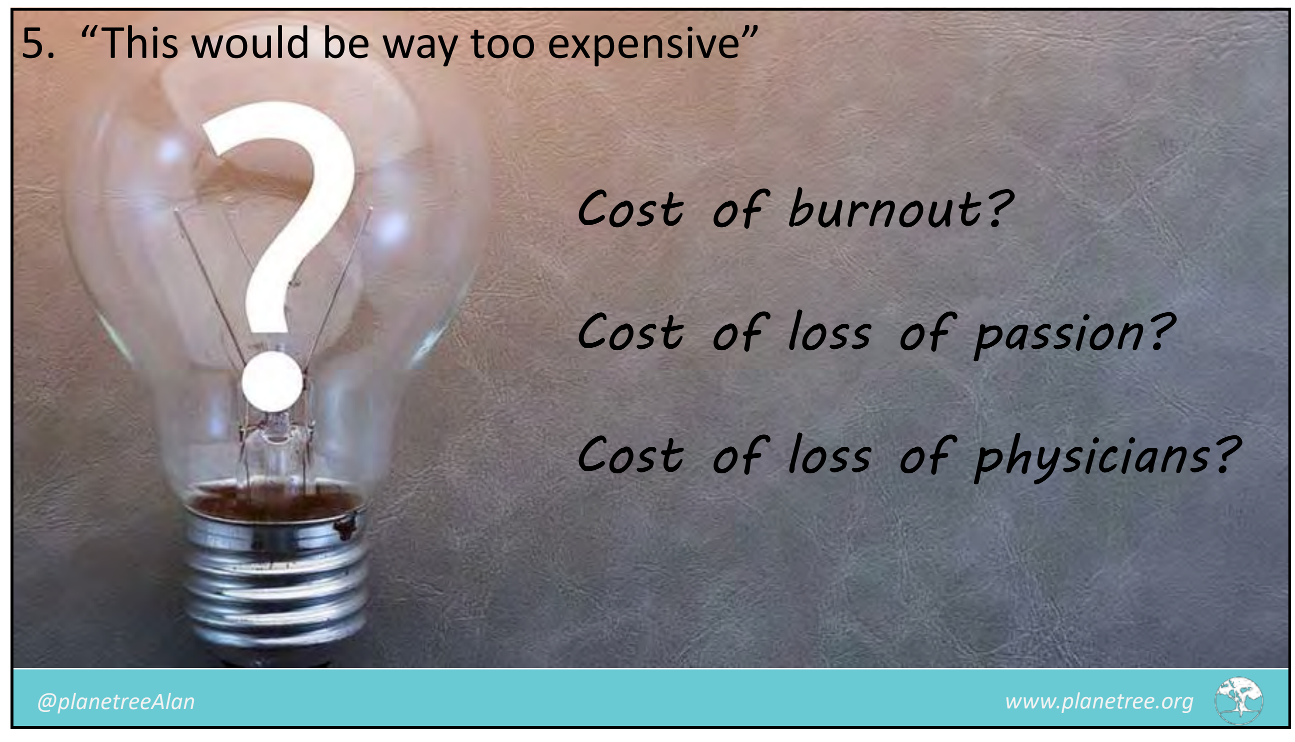
5. “This would be way too expensive”



- providing **shared decision making-based** health coaching for patients with conditions that frequently require major treatment decisions **reduces the overall costs of care**, hospitalizations and surgeries significantly.
- patients who received **enhanced support had 5.3% lower overall medical costs** than patients who received the usual level of support.
- patients receiving **enhanced support had 12.5% fewer hospital admissions** than the usual support group, and **9.9% fewer preference-sensitive surgeries**, including **20.9% fewer preference-sensitive heart surgeries.**

A 2013 study published in the February issue of Health Affairs



5. "This would be way too expensive"

Healthcare has lost compassion and patients are suffering (Health Service Ombudsman 2011; Cray and Dasilva 2011)

Health professionals are burning out (Maben et al 2009)

Kindness, caring and compassion are the major source of health professional wellbeing, happiness and resilience (Freshwater and Stickley 2011)

Communicating empathically increases clinician job satisfaction and reduces burnout. (Krasner, 2009; Shanafelt, 2009; West, 2011)

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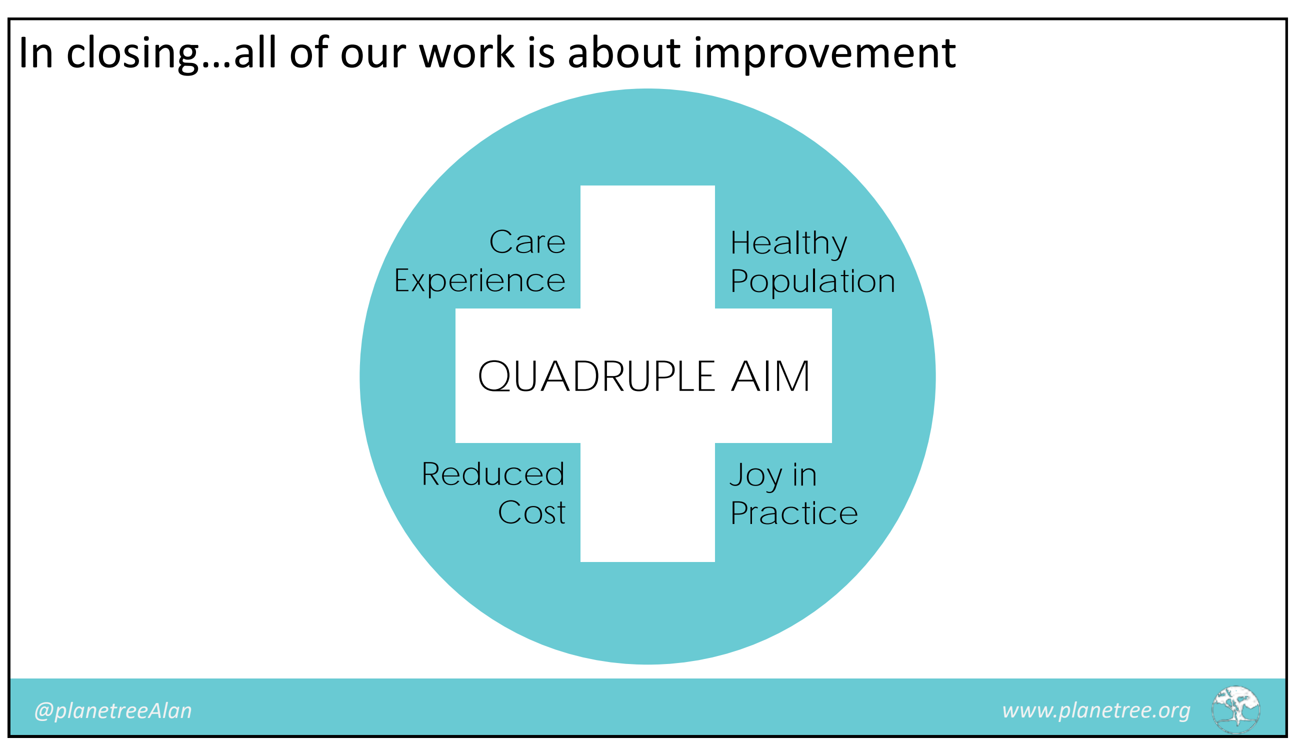

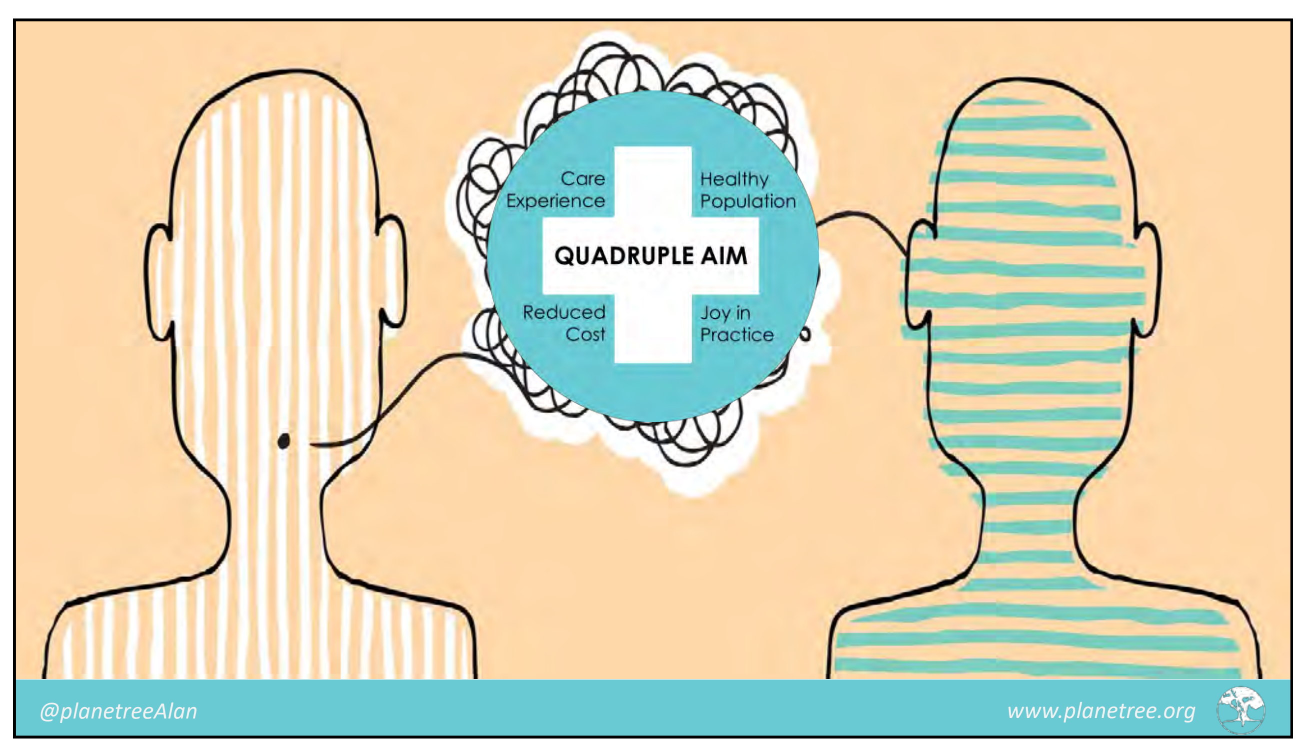
Care Experience
Healthy Population
QUADRUPLE AIM
Reduced Cost
Joy in Practice
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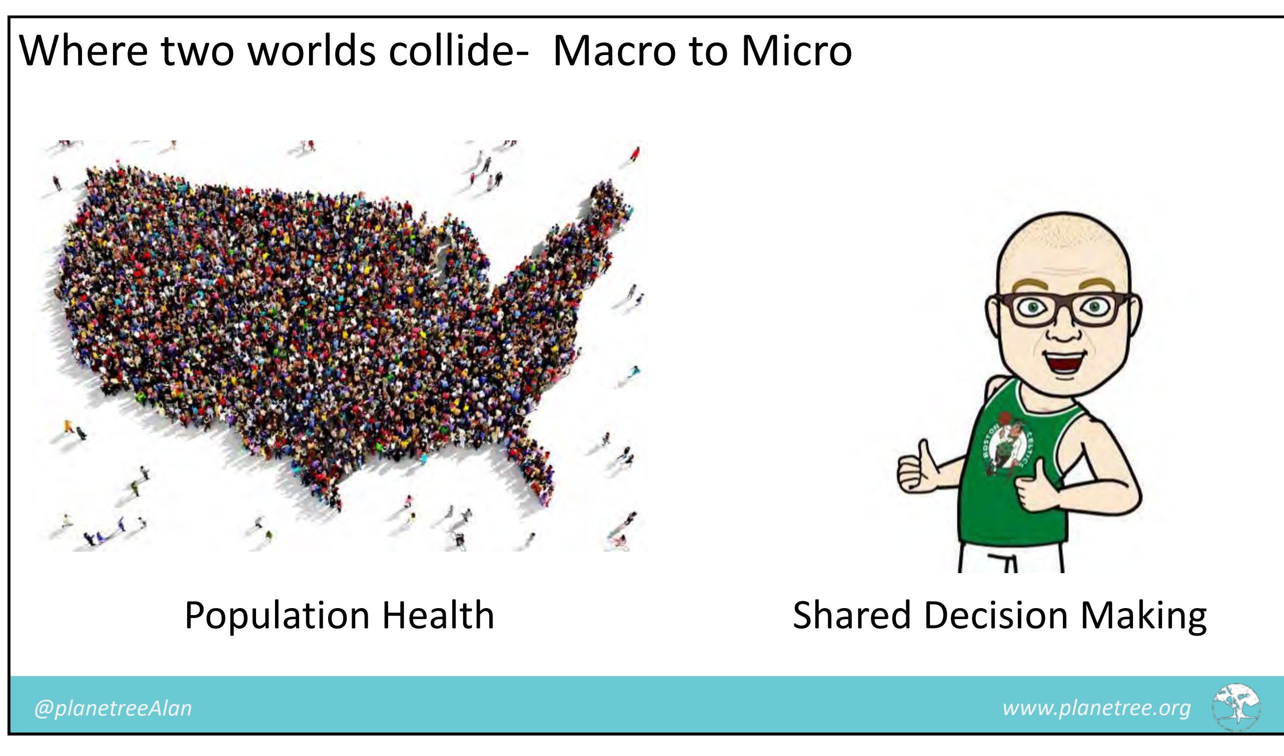
Where two worlds collide- Macro to Micro
Population Health
Shared Decision Making
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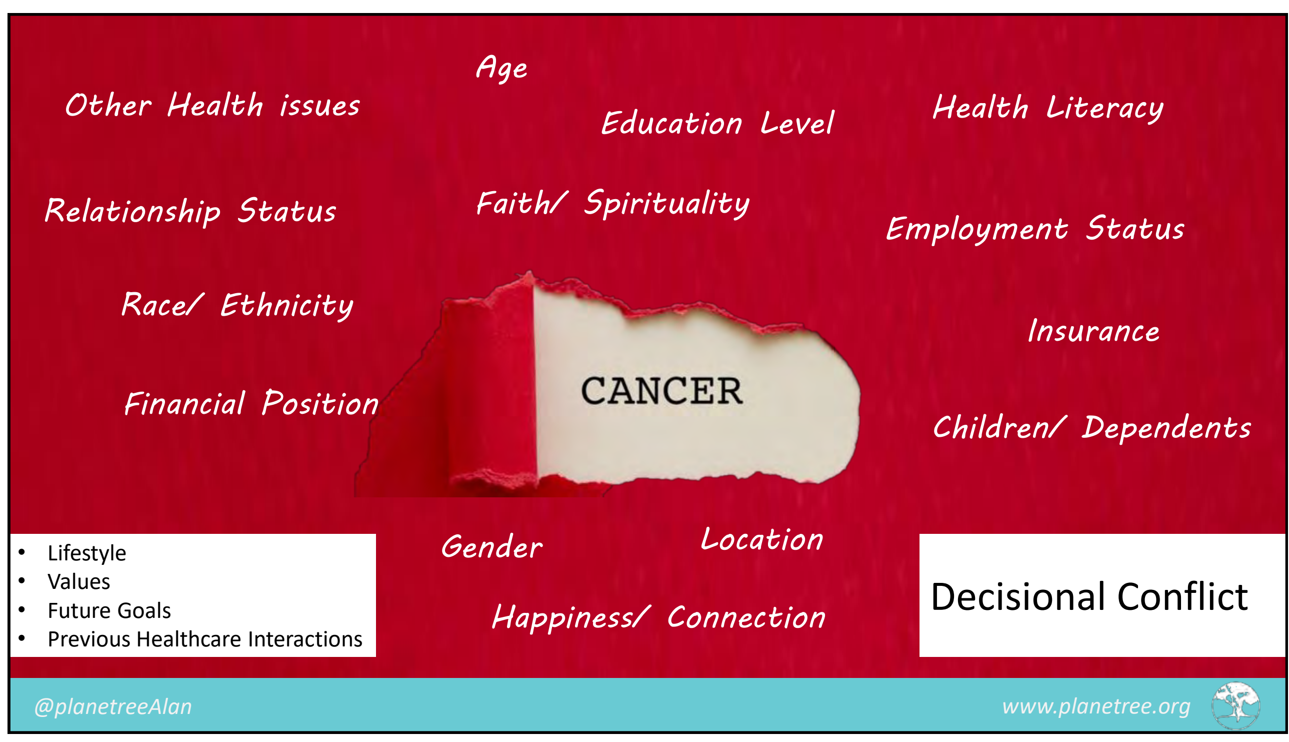
Age
Other Health issues
Education Level
Health Literacy
Relationship Status
Faith/ Spirituality
Employment Status
Race/ Ethnicity
Insurance
CANCER
Financial Position
Children/ Dependents
• Lifestyle
• Values
• Future Goals
• Previous Healthcare Interactions
Gender
Location
Happiness/ Connection
Decisional Conflict
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There are millions of iterations of "reality"
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Thank You
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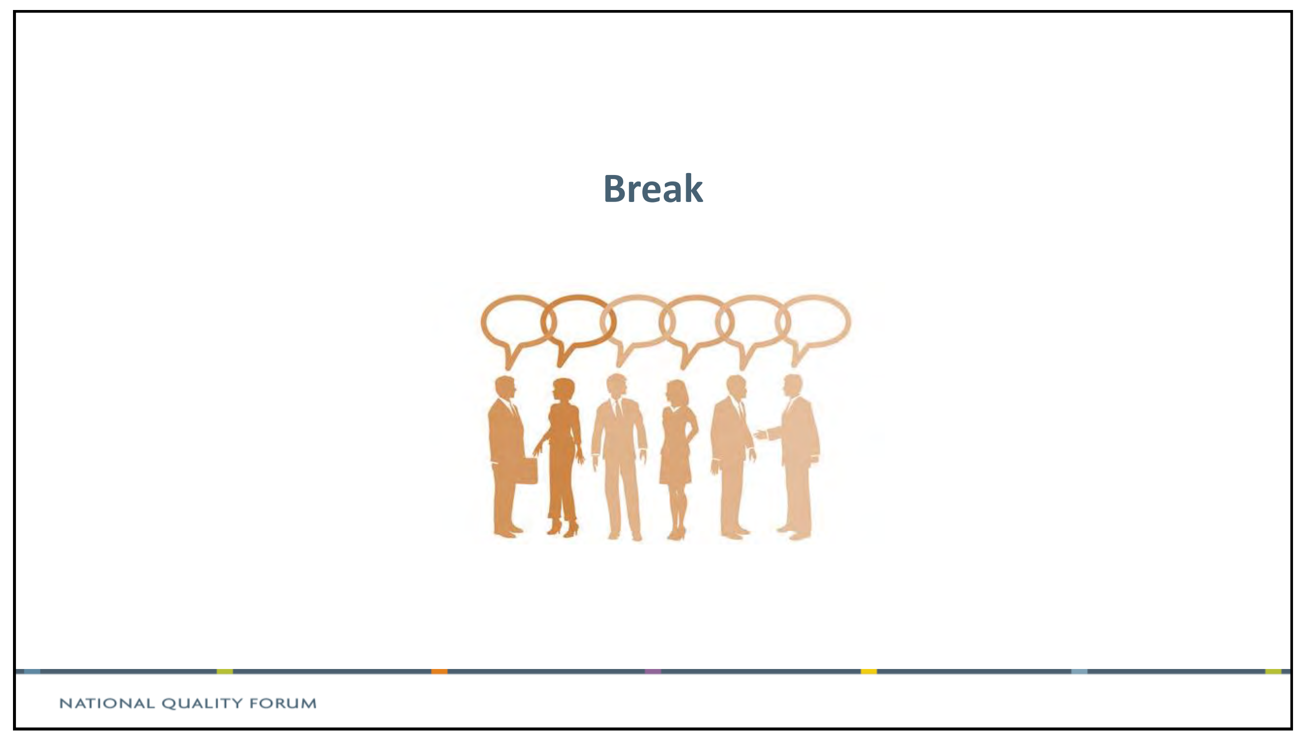
Break
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Making the Business Case for Shared Decision Making

Emily Transue, MD, MHA, FACP, Associate Medical Director, Clinical Quality and Care Transformation, Washington State Health Care Authority, Seattle, WA

Peter Goldbach, MD, Chief Medical Officer, Health Dialog, Boston, MA

Leigh Simmons, MD, Medical Director, MGH Health Division Science Center, Internal Medicine, Partners HealthCare, Boston, MA

Moderated by Alan Manning, MPA, Executive Vice President, Planetree International, Derby, CT

Today's Panel

Alan Manning, MPA (moderator)
Executive Vice President, Planetree International
@PlanetreeAlan

Emily Transue, MD
Associate Medical Director, Clinical Quality and Care Transformation, Washington State Health Care Authority

Peter Goldbach, MD
Chief Medical Officer, Health Dialog
@PeterGoldbachMD

Leigh Simmons, MD
Physician, Internal Medicine, Partners HealthCare
@simmons_leighmd

Shared Decision Making (SDM): A State Policy Perspective

Emily Transue, MD, MHA, FACP
Associate Medical Director

History of SDM in Washington

- Jack Wennberg presented to legislature and governor on clinical variation across regions of the state
- Response was legislation to support SDM, with goal of reducing variation without restricting choice
- Goal was appropriate utilization based on patient preferences, rather than decreased utilization
  - Evidence suggests SDM decreases overutilization, but helps correct underutilization

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Washington State Health Care Authority

Health Care Authority role in SDM

- Certification of Patient Decision Aids
- Promotion of SDM and PDA use in our role as purchaser (1.8M Medicaid lives, 200K PEB)
- Providing training and support to providers
- Convening statewide discussion around spread and sustainability

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Washington State Health Care Authority

Case study: Implementation for OB care in ACO program for public employees

- PDA and SDM around trial of labor after cesarean
- 3 sites, each with variations
  - Paper vs. electronic aid vs. group class
  - Varying degrees of EMR incorporation (none fully embedded)
  - MD-identified candidates vs. MA/RN vs. EMR
  - Varying baseline VBAC rates
- Steps included: Provider training, PDA selection, workflow development, EMR changes, maintenance/monitoring

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Washington State Health Care Authority

Case Study: Results and lessons

- Early data show high VBAC rates and high satisfaction among participating patients
- Provider openness to VBAC increased uptake
- Implementation process was time consuming and complex (particularly EMF component)
- High provider engagement (but also frustration)
- State leadership role (purchasing and support) was critical to success

45

Washington State Health Care Authority

Value to participating orgs

- Focused training for providers and staff on quality shared decision making
- PDAs helped guide balanced, evidence-based SDM discussions
- Value for patient in understanding the evidence and pros/cons for the various options available
- Process supported targeted discussions about patient values and informed decisions

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Washington State Health Care Authority

Value to State

- Confirmed importance of state role in promoting key practices to advance population health
- Increased understanding of challenges and benefits of implementation
- Lessons to inform sustainability and spread
  - Understanding benefits to patients providers, provider orgs, payers, liability carriers
  - Maintaining alignment with developer community

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Washington State Health Care Authority

Questions?

More Information:

www.hca.wa.gov/about-hca/healthier-Washington/shared-decision-making

Emily Transue, MD, MHA, FACP
Associate Medical Director
emily.transue@hca.wa.gov

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Shared Decision Making Results

Enhanced Support For Shared Decision Making Reduced Costs of Care For Patients With Preference-Sensitive Conditions

- **5.3%** overall reduction in medical costs
- **12.5%** fewer hospital admissions
- **9.9%** fewer preference-sensitive surgeries
- **20.9%** fewer preference-sensitive heart surgeries

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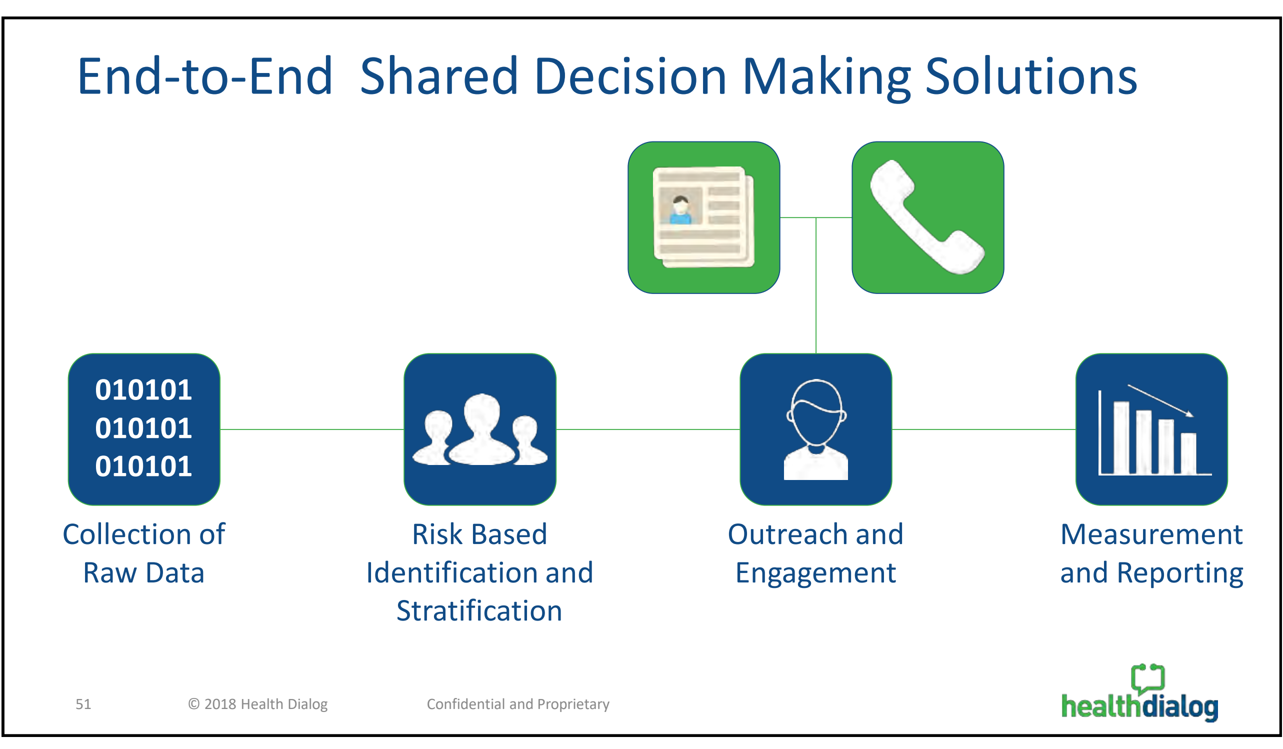
End-to-End Shared Decision Making Solutions
010101
010101
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Collection of Raw Data
Risk Based Identification and Stratification
Outreach and Engagement
Measurement and Reporting
51
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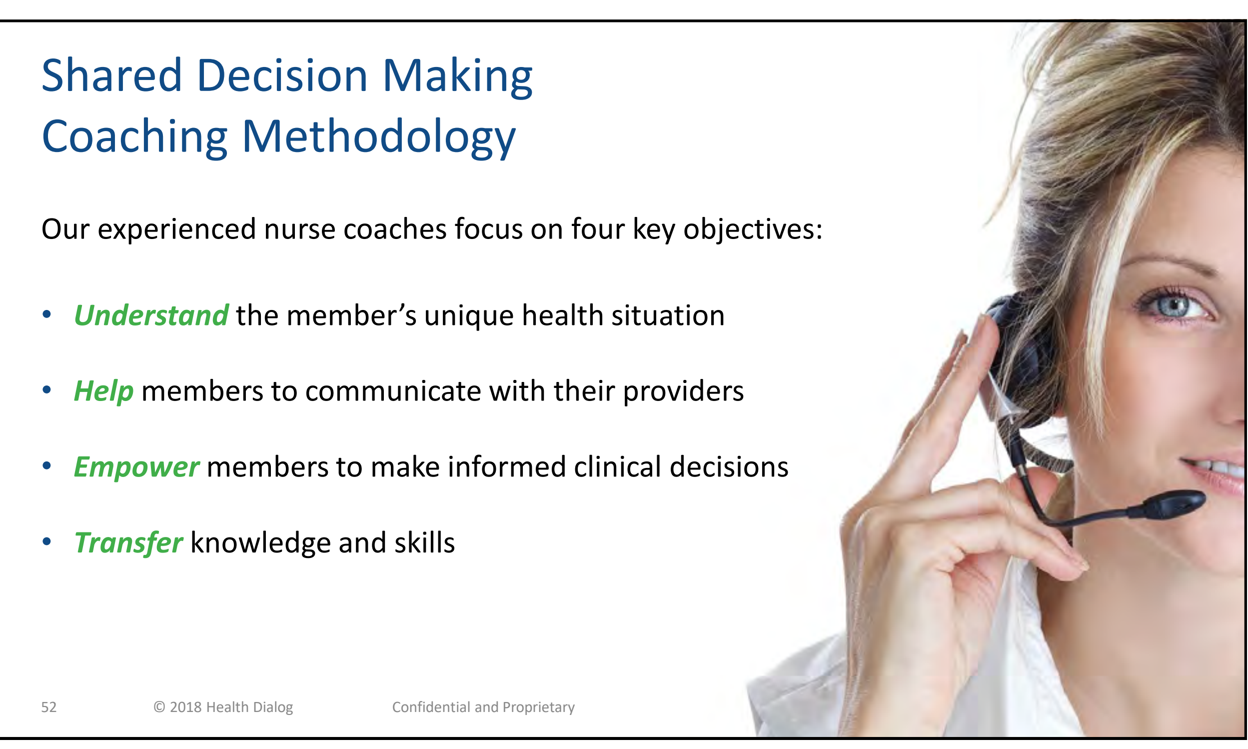
Shared Decision Making Coaching Methodology
Our experienced nurse coaches focus on four key objectives:
• Understand the member's unique health situation
• Help members to communicate with their providers
• Empower members to make informed clinical decisions
• Transfer knowledge and skills
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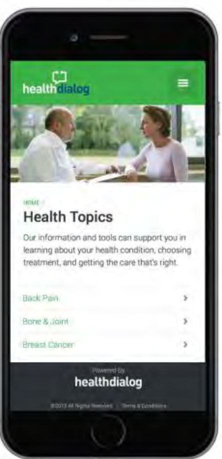
Shared Decision Making Library

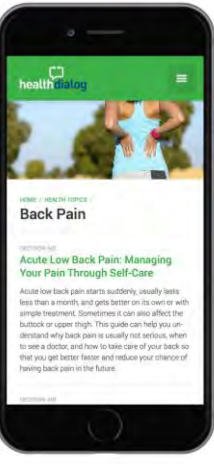
38 Decision Aids + 7 Online Quick Facts Videos
34 Planning Aids

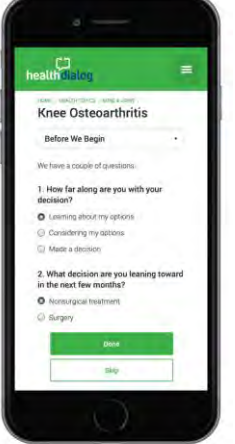
Topics across
- Men's Health
- Women's Health
- Mental Health
- Cardiovascular
- Chronic Conditions
- Cancer
- Back, Knee and Hip

Shared Decision Making

Mobile Optimization







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Shared Decision Making
Member Feedback
95%
Rated the program as good, very good, or excellent overall
90%
Watched most or all of the video
83%
Were likely or very likely to recommend the decision aid they reviewed to others
55
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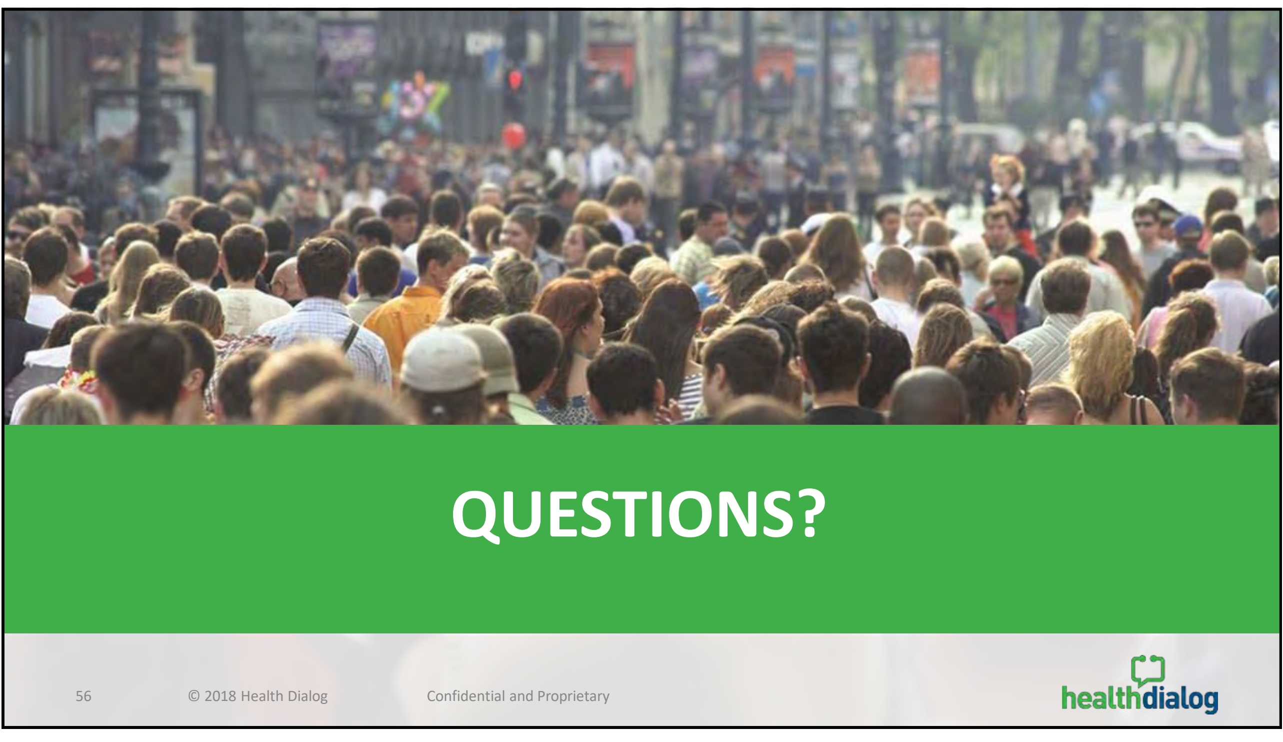
QUESTIONS?
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Shared Decision Making at Partners HealthCare System

Population Health Colloquium Pre-Conference Symposium

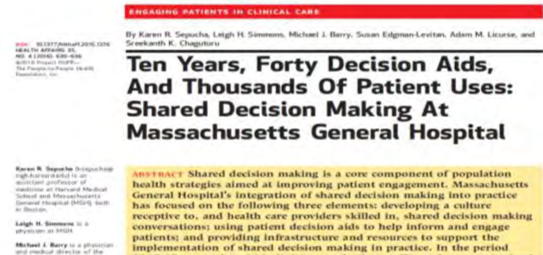
March 19, 2018

Population Health Efforts in SDM

- Engagement and training of clinicians
- Collaboration with mental health providers
- Use of decision aids in specialty care practices

Shared Decision Making Program at Partners HealthCare System

- Began in 2005 at Mass General
- System of prescribing video/booklet patient decision aids (PtDAs) via EMR
- Used in our 18 primary care practices
- Generally well-received, but use was sporadic, very dependent on physicians remembering to prescribe


ENGAGING PATIENTS IN CLINICAL CARE

By Karen R. Sepucha, Leigh H. Simmons, Michael J. Barry, Susan Edgman-Levitan, Adam M. Licurse, and Sreekanth K. Chaguturu

Ten Years, Forty Decision Aids, And Thousands Of Patient Uses: Shared Decision Making At Massachusetts General Hospital

ABSTRACT Shared decision making is a core component of population health strategies aimed at improving patient engagement. Massachusetts General Hospital's integration of shared decision making into practice has focused on the following three elements: developing a culture receptive to, and health care providers skilled in, shared decision making conversations; using patient decision aids to help inform and engage patients; and providing infrastructure and resources to support the implementation of shared decision making in practice. In the period 2005–15, more than 900 clinicians and other staff members were trained in shared decision making, and more than 28,000 orders for one of about forty patient decision aids were placed to support informed patient-centered decisions. We profile two different implementation initiatives that increased the use of patient decision aids at the hospital's eighteen adult primary care practices, and we summarize key elements of the shared decision making program.

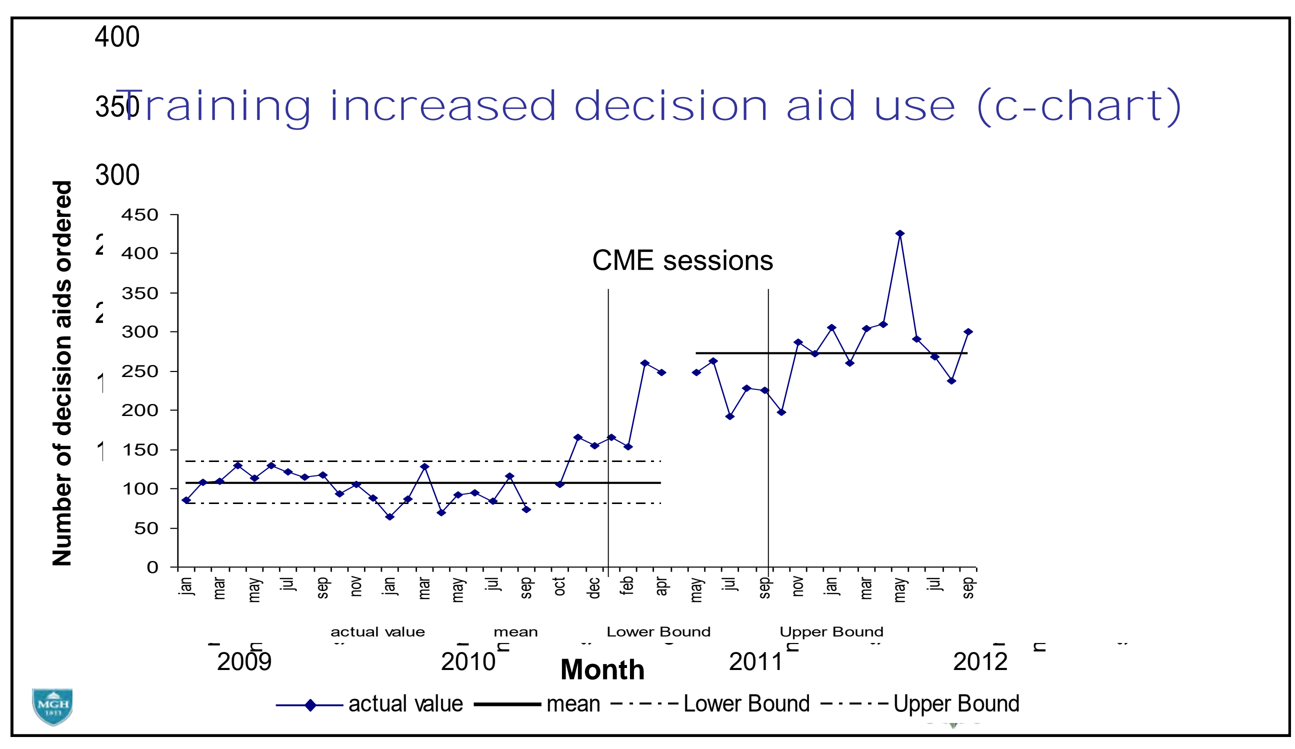
Clinician training: learning from bright spots

Focus on high prescribers

- Top 10 users accounted for ~ 40% of total prescriptions – we interviewed top prescribers about incentives to use PtDAs
- Designed training program and delivered to practices
  - Watch decision aid
  - Comparative data
  - Share experiences with using PtDAs

Sharing Stories

- 47yo man, works in maintenance at Logan Airport, originally from Nicaragua
- Has hypertension, obesity, and a new diagnosis of diabetes
- Prescribed video and booklet decision aid (in Spanish) to review before next visit
- ***"Doctor, should I start*** *metformin* ***or not?"***



Lessons

- Comfort with decision aid content is important
- Comparative data are good motivator (for our clinicians)
- Recognition of new barriers
  - **"I forget to prescribe—**can someone else **order?"**

The next steps…

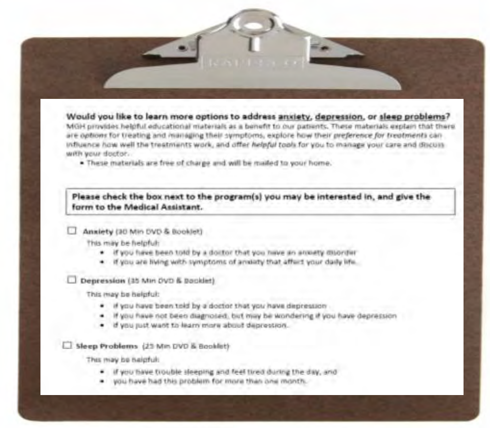
- There was hunger for more training on conducting SDM conversations, with or without PtDAs
- Advanced training developed
  - 6 Steps to SDM Model
  - Ottawa Personal Decision Guide
  - Video training using SDM and non-SDM interactions

Shared Decision Making and Mental Health

- Incentive: Hospital-wide effort to improve depression screening and management in primary care practices
- Setting: Community-based health center; ~10 physicians, work in partnership with medical assistants (MAs)

Mental health integration

- Interest: Providers are open to using more PtDAs **in practice, but there is "low-prescribing" practice. The nursing leader is** invested in improving patient education processes.
- Workflow: MAs offered patients PHQ-2 at all annual visits; if PHQ-2 positive for depression, patients were offered an order form for mental health PtDAs (depression, anxiety, and insomnia).



Would you like to learn more options to address anxiety, depression, or sleep problems?
MGH provides helpful educational materials as a benefit to our patients. These materials explain that there are *options* for treating and managing their symptoms, explore how their *preference for treatments* can influence how well the treatments work, and *offer helpful tools* for you to manage your care and discuss with your doctor.

- These materials are free of charge and will be mailed to your home.

Please check the box next to the program(s) you may be interested in, and give the form to the Medical Assistant.

☐ **Anxiety** (30 Min DVD & Booklet)
This may be helpful:
- If you have been told by a doctor that you have an anxiety disorder
- If you are living with symptoms of anxiety that affect your daily life.

☐ **Depression** (35 Min DVD & Booklet)
This may be helpful:
- If you have been told by a doctor that you have depression
- If you have not been diagnosed, but may be wondering if you have depression
- If you just want to learn more about depression.

☐ **Sleep Problems** (25 Min DVD & Booklet)
This may be helpful:
- If you have trouble sleeping and feel tired during the day, and
- you have had this problem for more than one month.

Patient-directed orders

- Number of PHQ-2 forms with positive screens was quite low (~5%), and only 19 PtDAs ordered by patients.
- MAs began offering order forms to ALL annual visit patients, regardless of PHQ-2 questionnaire results.
- There were 203 mental health PtDAs ordered (62 anxiety, 60 insomnia, 47 depression).
- Success of this project led to use of the behavioral health PtDAs by our mental health support specialists in primary care practices, and 3 more practices implemented patient-triggered ordering of PtDAs.

Lessons learned

- A provider-dependent workflow may limit patient access to decision aids.
- Patients can/should be active participants in the decision aid ordering process.
- All members of the clinical care team can participate in workflow; medical assistants took ownership of process and were crucial to suggesting improvements.

Linking PtDAs to Specialty Referrals

- The goal is to take advantage of EMR/IT applications to help with delivery. In an early project, decision aids were sent to patients based on problems in problem list (e.g., osteoarthritis, fibroids). It resulted in:
  - An easy and increased use of decision aids, BUT
  - Overall a disaster; not at a decision point (wasted time) and/or not relevant (e.g., sent fibroid program to a woman who had already had a hysterectomy)

→ Need more nuanced approach to identify patients who actually need the decision aid.

Focus on specialty referrals

- **Referral to specialist often indicates a "decision point"** particularly for common chronic conditions (e.g., knee/ hip osteoarthritis, low back pain, fibroids/abnormal uterine bleeding)
- Linked decision aid order to referral from primary care (electronic referral system was prompt)
  - ~65% referrals now have decision aid sent to patients
- Collaborated with specialists and their staff
  - Trained triage nurses (spine and gynecology)

Electronic Referral Enhancement

Referring Information — Please note: Requests should be made only with the patient's knowledge and consent.

Service/Group: Orthopaedic Surgery
Referred To Department: Ortho Hip/Knee Replacement
* Referring Department
* Referring Provider
Preceptor
Sending Assigned User
Self Referral
Provider Tracking List

Referral Reason, Clinical Details and Urgency - Ortho Hip/Knee Replacement

For emergent (same-day) appointments, a call is required prior to submitting the referral in CRMS. Call Ortho Arthroplasty at 617-724-8636.

* Referral Reason: Hip arthritis
Referral Detail/Question
* Are x-rays from within last 6 months available?
* Please select all that apply:
History of infection
Previous hip replacement
Previous knee replacement
N/A

Decision aids are available for hip osteoarthritis and knee osteoarthritis that can be sent to your patient in advance of their appointment with the doctor.
*Send patient Treatment Choices decision aid?
Yes
No

* Reque... ncy
Requested Provider
MD Availability

MASSACHUSETTS
GENERAL HOSPITAL

HEALTH DECISION SCIENCES
Let's Decide Together

Lessons learned

- Well-received by all involved
  - PCPs like the connection to referrals; they feel it is the right time to get the information to patients.
  - Specialists prefer to see well-prepared patients.
  - Patients appreciate getting information in advance of visit (so they can ask better questions).
- Highlighted some issues with referrals
  - Specialists' staff assumed patients already wanted surgery (Why else would they come to a surgeon?).
  - Patients were not always on board with referral (There is variability in how much PCPs discuss this before making a referral).
  - If patients watch it and realize they don't want surgery, should they still go? What happens then?

Audience Discussion

National Quality Partners™ CONVENED BY THE NATIONAL QUALITY FORUM

Break

NATIONAL QUALITY FORUM

Outline

- Kaiser Permanente Washington overview
- Shared Decision Making journey
- Maintaining through leadership & culture

77

Kaiser Permanente WA (Group Health)

- In 2017, Kaiser Permanente acquired Group Health Cooperative which has been caring for members in Washington since 1947

78

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It was awful.

79

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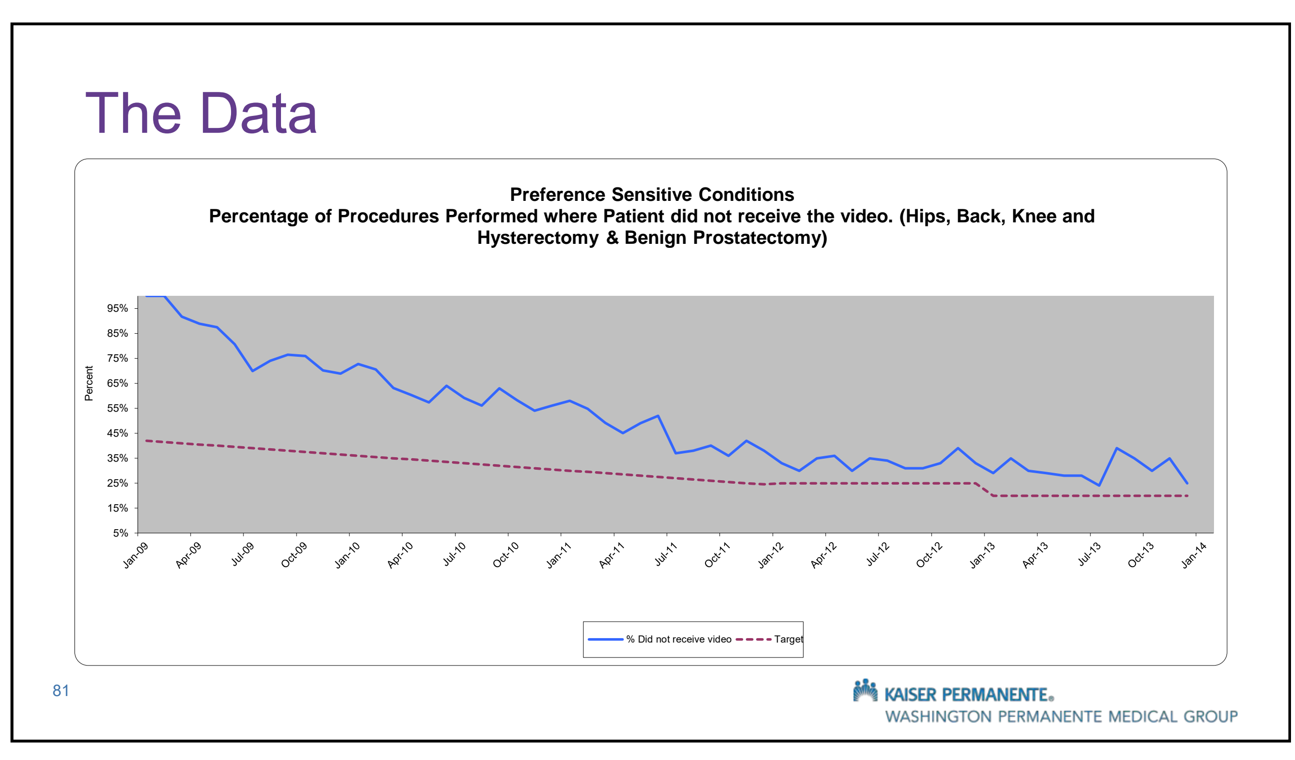

The Data
Preference Sensitive Conditions
Percentage of Procedures Performed where Patient did not receive the video. (Hips, Back, Knee and Hysterectomy & Benign Prostatectomy)
Percent
95%
85%
75%
65%
55%
45%
35%
25%
15%
5%
Jan-09
Apr-09
Jul-09
Oct-09
Jan-10
Apr-10
Jul-10
Oct-10
Jan-11
Apr-11
Jul-11
Oct-11
Jan-12
Apr-12
Jul-12
Oct-12
Jan-13
Apr-13
Jul-13
Oct-13
Jan-14
% Did not receive video
Target
81
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I already do Shared Decision Making
Every patient I operate on needs the surgery.
82
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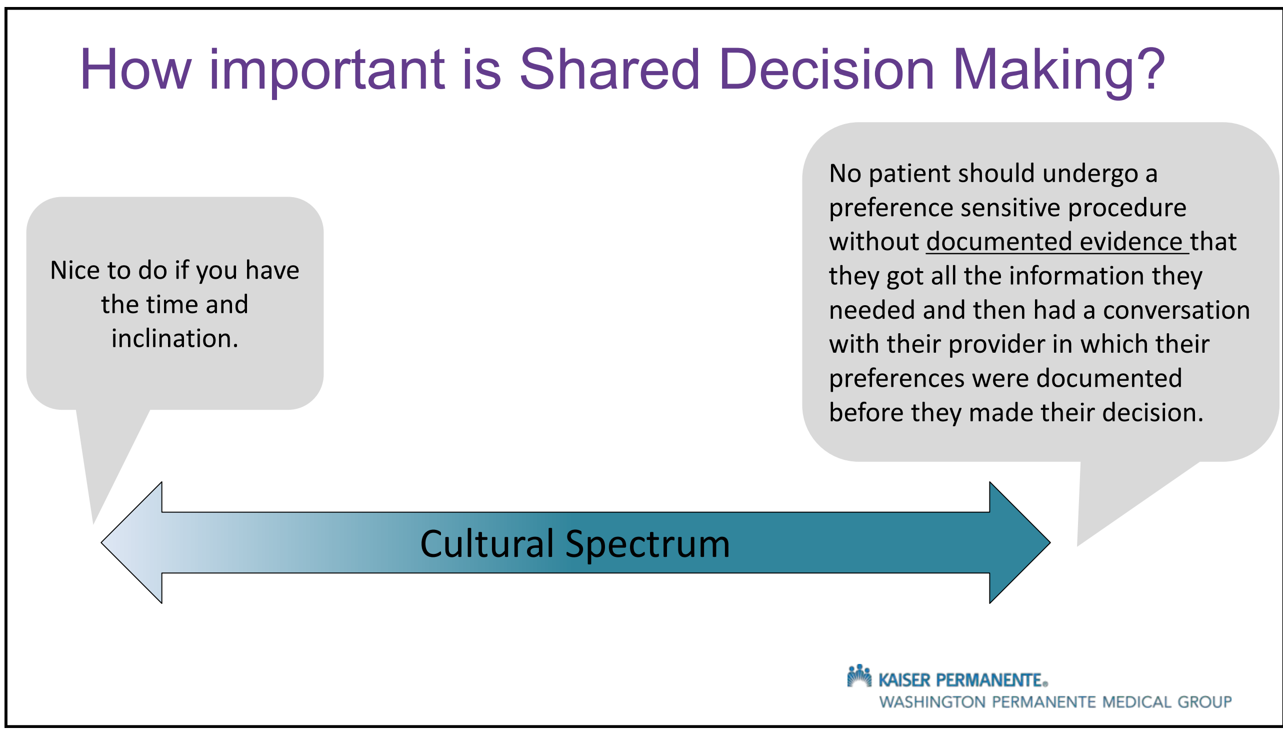

Approach to Implementation

Technical Change

- Start in Specialty & move to Primary Care
- Workflow – Lean Process Improvement
    - Reliable distribution of decision aids
    - Incorporate into standard work of teams
    - Visual systems to make the work visible
- Clinical training/Ongoing CME
- Program Manager initially full time, then cut back – worked with quality medical directors

Adaptive Change

- Aligned Leadership – SDM is strategic differentiator
- Non-elective model of adoption
- Shift in culture to promote conversations
- ***Relentless follow-up to continuously improve and manage drift***
- No data without stories, no stories without data

SHARED DECISION MAKING

By Jaime King and Benjamin Moulton

Group Health's Participation In A Shared Decision-Making Demonstration Yielded Lessons, Such As Role Of Culture Change

- Strong leadership and clinical champions
- Required all providers to watch the relevant decision aids
- ½-day CME with outside experts trained 90% of our specialty providers and surgeons
- Monthly feedback to leaders and providers
  - Volume of decision aids ordered
  - Volume of surgical procedures and total costs of surgical procedures
  - Number and percent of surgical patients in each specialty who had surgery without receiving a decision aid
- Patient satisfaction data related to decision aid use

King and Moulton, *Health Affairs, 2013*

The Group Health/Kaiser Permanente SDM Story

- Implemented in 2009 across five specialties
- Reliable distribution of decision aids
- Mandatory training for surgeons
- Over 50,000 patients involved
- Outcomes consistent with studies
- Published in Orthopedics, Gyn, Urology
- Moving "upstream" into Primary Care
- Expanded available topics
- Expanded training to all clinicians

Video Decision Aids

- Hip osteoarthritis
- Knee osteoarthritis
- Spinal stenosis
- Herniated disc
- Benign Prostatic Hyperplasia
- Uterine fibroids
- Abnormal uterine bleeding
- Early stage breast cancer
- Breast reconstruction
- Ductal carcinoma in situ

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What's in it for me?

- You don’t waste your time seeing patients who don’t need surgery
- Higher surgical yield if you screen out patients who aren’t candidates
- 96% satisfaction – patients love it

87

Today

- Embedded in the culture for ~4 years
- Continue to make the right thing to do the easy thing to do
  - AVS
  - Continually adding new tools
- Ongoing CME
- Publish results & data

88

Top 10 things we learned

1. Demonstrate with rigorous research
2. No data without stories, no stories without data
3. Recognize that clinicians believe that they already do this
4. Start small – its very vulnerable in the early days
5. Act your way into a new way of thinking, instead of the opposite
6. Make sure there is a carrot
7. The physiology of change, and how to lead change
8. The importance of leadership; how to bring people along when they are kicking & screaming
9. The Technical change (video distribution) is easier than the Adaptive change (having different conversations)
10. Make work visible, doctors like to get an A

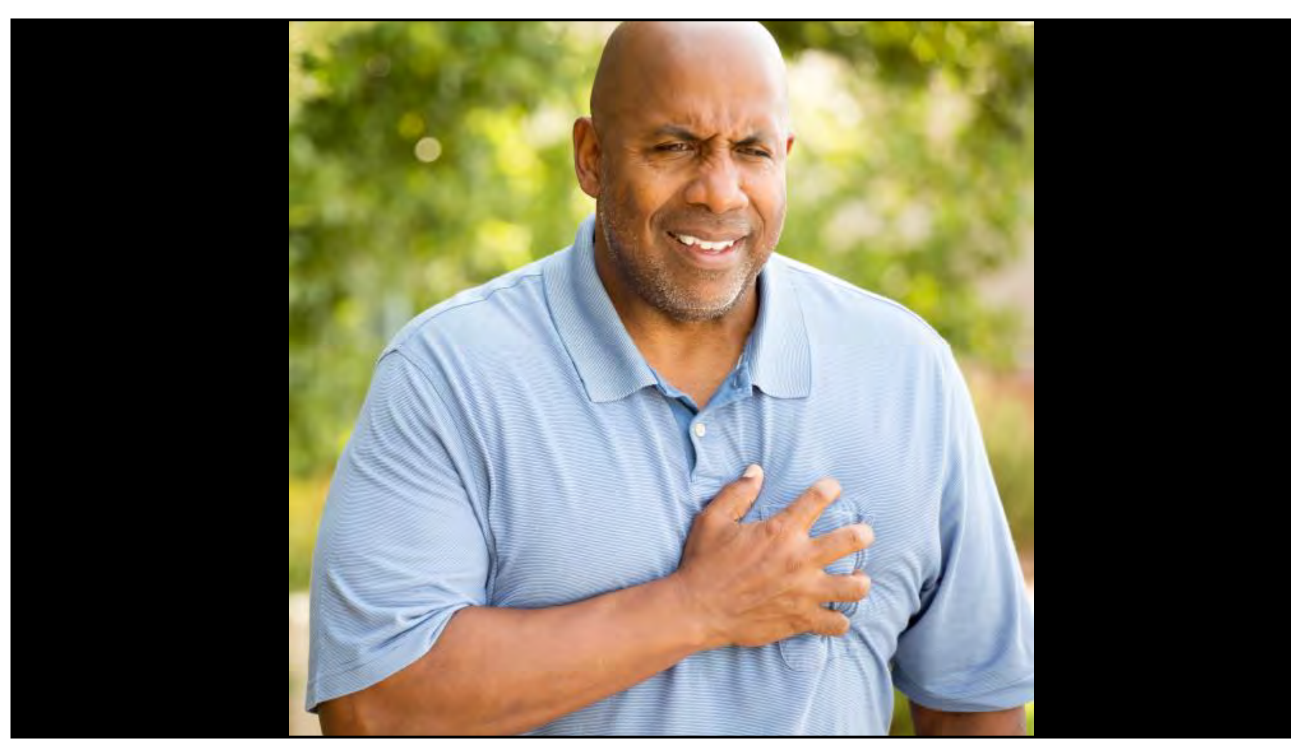
89

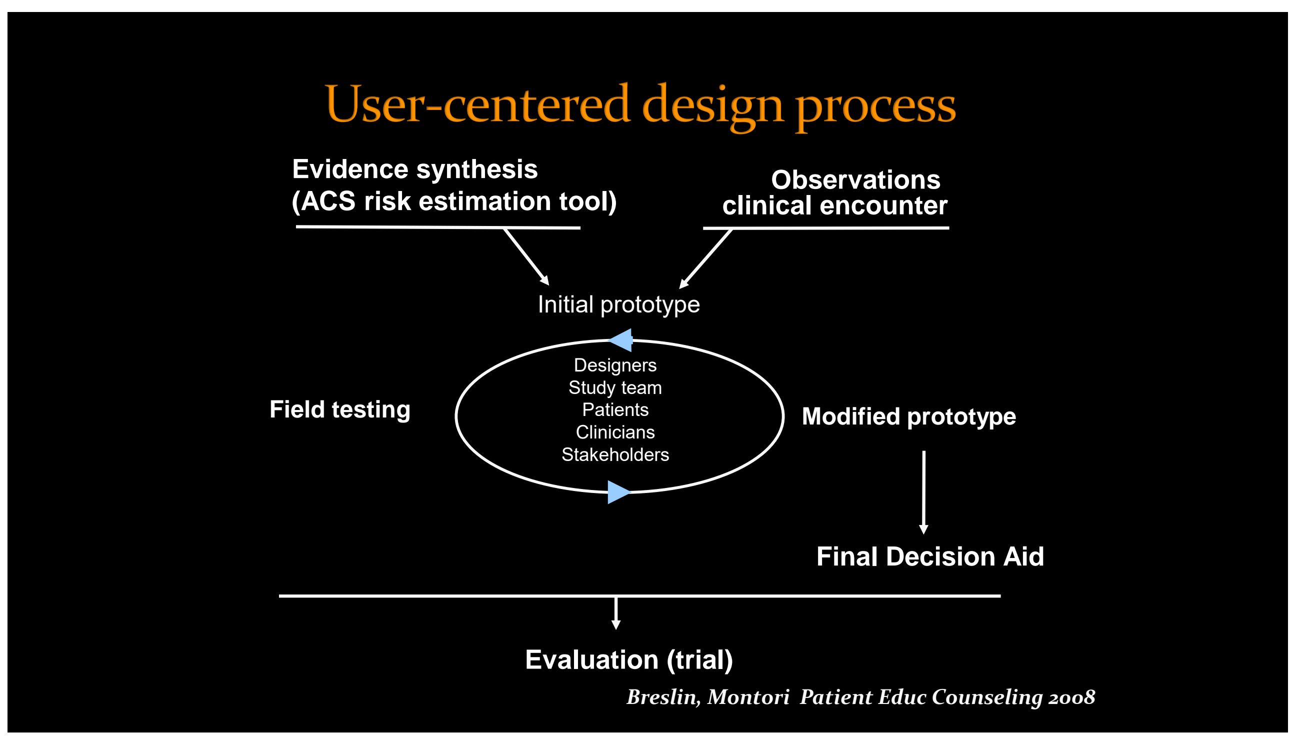
Developing, Testing, and Implementing a Shared Decision Making Intervention in Emergency Care

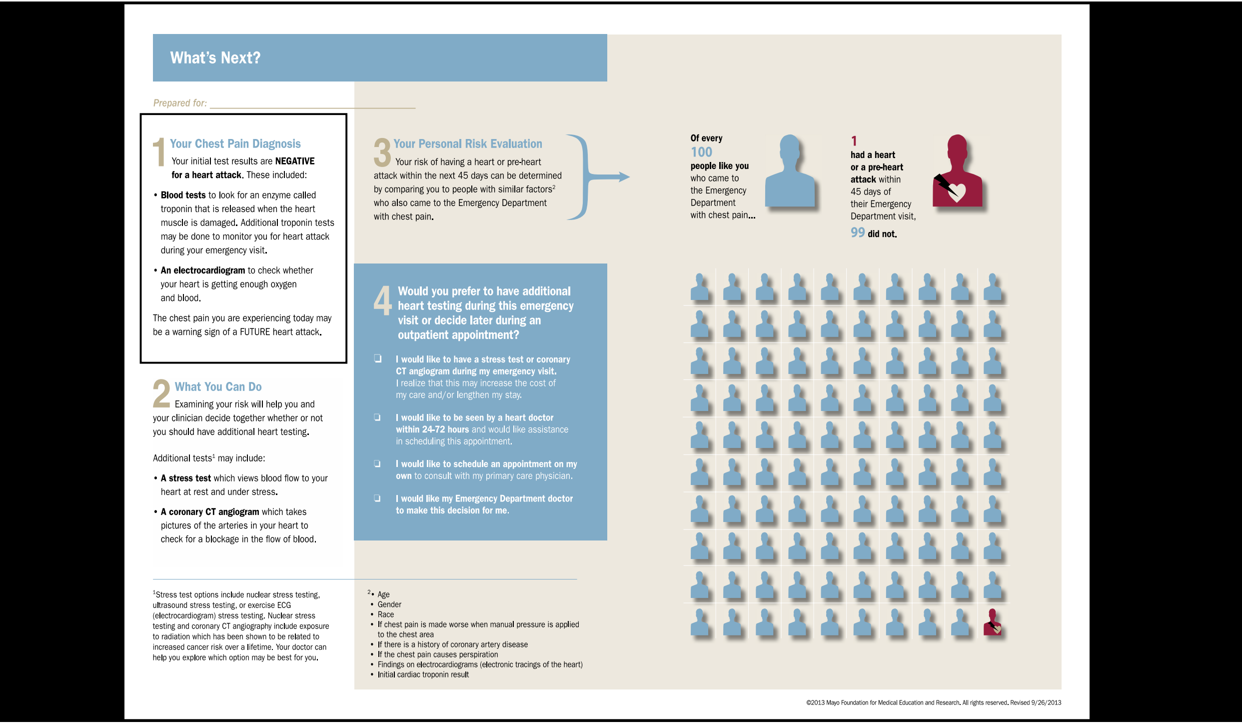
Erik P. Hess MD MSc
Professor of Emergency Medicine
Population Health Colloqium
March 18, 2018

Disclosure

- Financial Disclosure: Interventional trials funded by PCORI contract 952
- Dissemination and Implementation project funded by PCORI (contract pending)
- Unlabeled or unapproved uses: none




User-centered design process
Evidence synthesis
(ACS risk estimation tool)
Observations
clinical encounter
Initial prototype
Designers
Study team
Patients
Clinicians
Stakeholders
Field testing
Modified prototype
Final Decision Aid
Evaluation (trial)
Breslin, Montori Patient Educ Counseling 2008


What's Next?
Prepared for:
1 Your Chest Pain Diagnosis
Your initial test results are NEGATIVE for a heart attack. These included:
• Blood tests to look for an enzyme called troponin that is released when the heart muscle is damaged. Additional troponin tests may be done to monitor you for heart attack during your emergency visit.
• An electrocardiogram to check whether your heart is getting enough oxygen and blood.
The chest pain you are experiencing today may be a warning sign of a FUTURE heart attack.
2 What You Can Do
Examining your risk will help you and your clinician decide together whether or not you should have additional heart testing.
Additional tests1 may include:
• A stress test which views blood flow to your heart at rest and under stress.
• A coronary CT angiogram which takes pictures of the arteries in your heart to check for a blockage in the flow of blood.
3 Your Personal Risk Evaluation
Your risk of having a heart or pre-heart attack within the next 45 days can be determined by comparing you to people with similar factors2 who also came to the Emergency Department with chest pain.
Of every 100 people like you who came to the Emergency Department with chest pain...
1 had a heart or a pre-heart attack within 45 days of their Emergency Department visit, 99 did not.
4 Would you prefer to have additional heart testing during this emergency visit or decide later during an outpatient appointment?
❑ I would like to have a stress test or coronary CT angiogram during my emergency visit. I realize that this may increase the cost of my care and/or lengthen my stay.
❑ I would like to be seen by a heart doctor within 24-72 hours and would like assistance in scheduling this appointment.
❑ I would like to schedule an appointment on my own to consult with my primary care physician.
❑ I would like my Emergency Department doctor to make this decision for me.
1Stress test options include nuclear stress testing, ultrasound stress testing, or exercise ECG (electrocardiogram) stress testing. Nuclear stress testing and coronary CT angiography include exposure to radiation which has been shown to be related to increased cancer risk over a lifetime. Your doctor can help you explore which option may be best for you.
2• Age
• Gender
• Race
• If chest pain is made worse when manual pressure is applied to the chest area
• If there is a history of coronary artery disease
• If the chest pain causes perspiration
• Findings on electrocardiograms (electronic tracings of the heart)
• Initial cardiac troponin result
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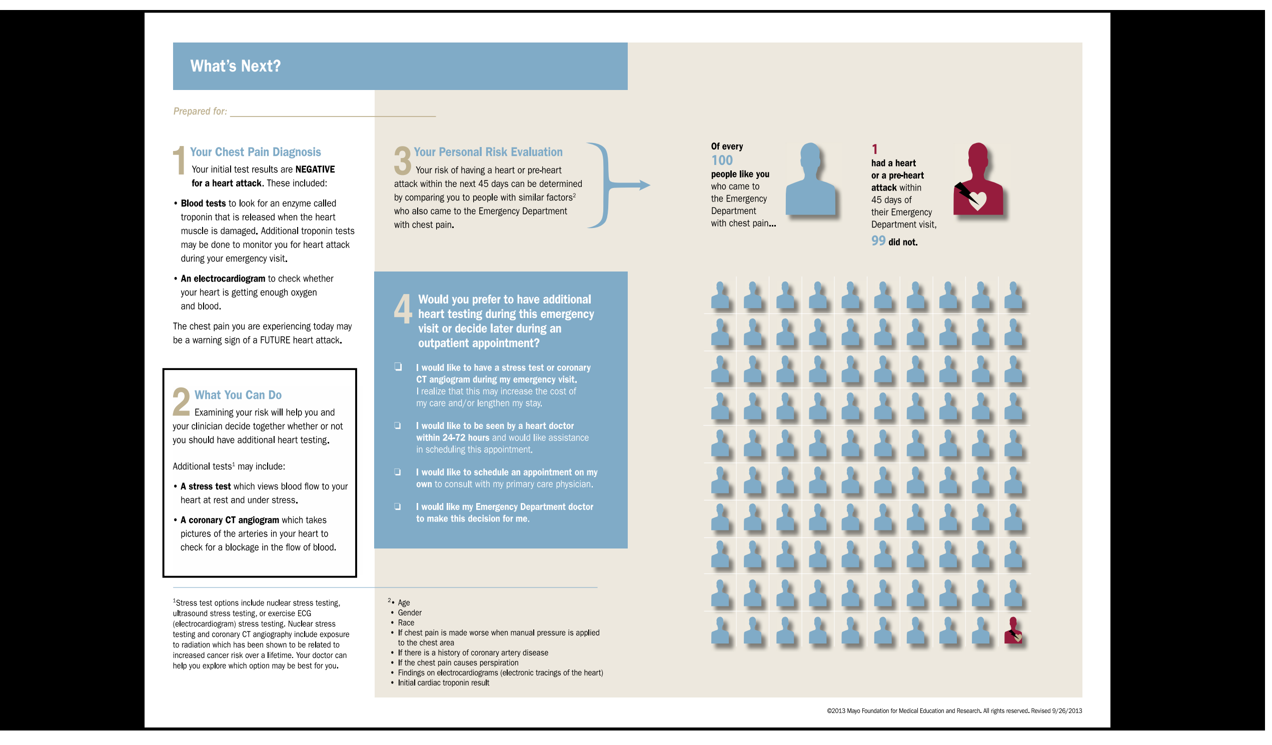
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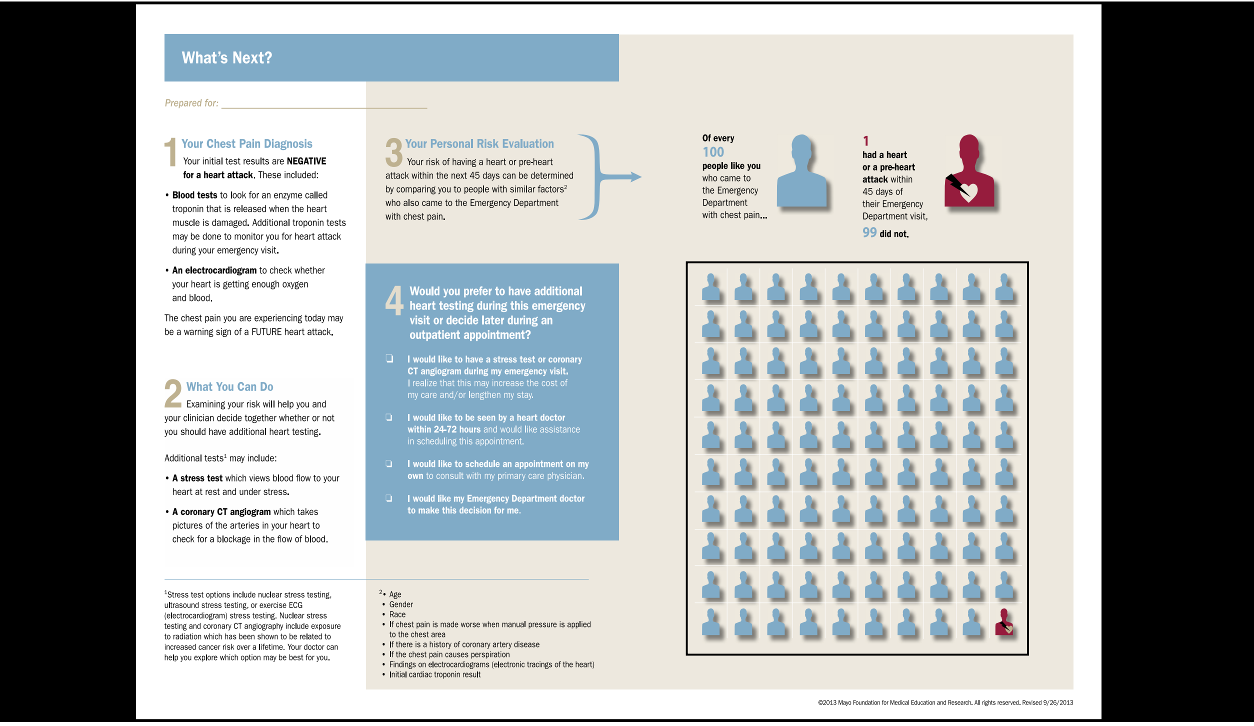

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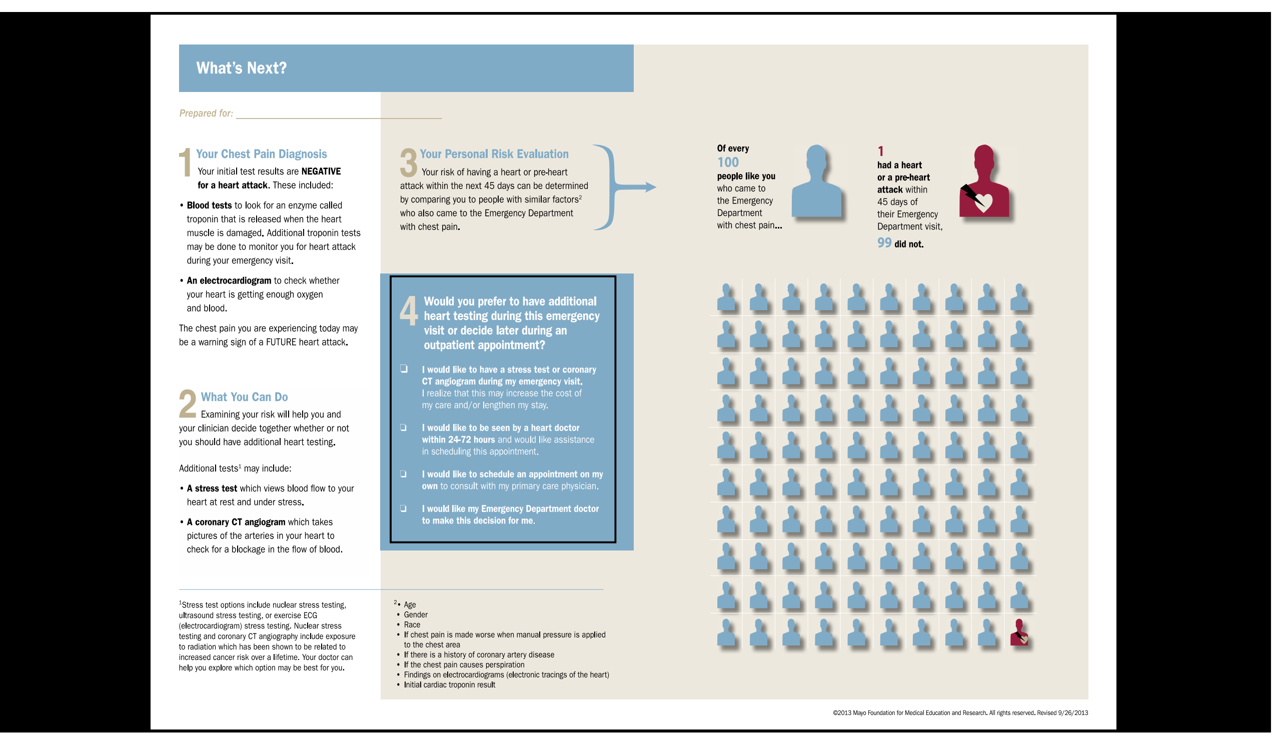

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Chest Pain Choice Pilot Trial

(n=201)

Outcome	Change
Patient knowledge	↑
Patient engagement	↑
Placed in EDOU for stress testing	↓ (19%)
Stress testing within 30 days	↓ (16%)
Provider experience	↑
Outpatient follow-up	↑
Safety	↔

Hess, Kline, Stiell et al. Circulation CQO 2012

Chest Pain Choice Multicenter Trial
(n=898)

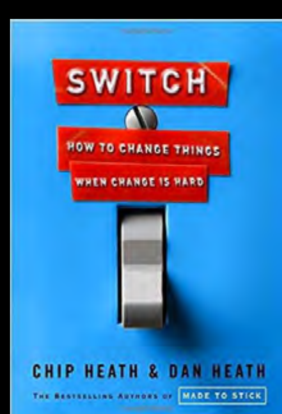
Outcome	Change
Patient knowledge	↑
Patient engagement	↑
Placed in EDOU for stress testing	↓ (16%)
Stress testing within 30 days	↓ (7%)
Provider experience	↑
Outpatient follow-up	↑
Safety	↔

Hess, Kline, Stiell et al. Circulation CQO 2012

Implementation and Evaluation

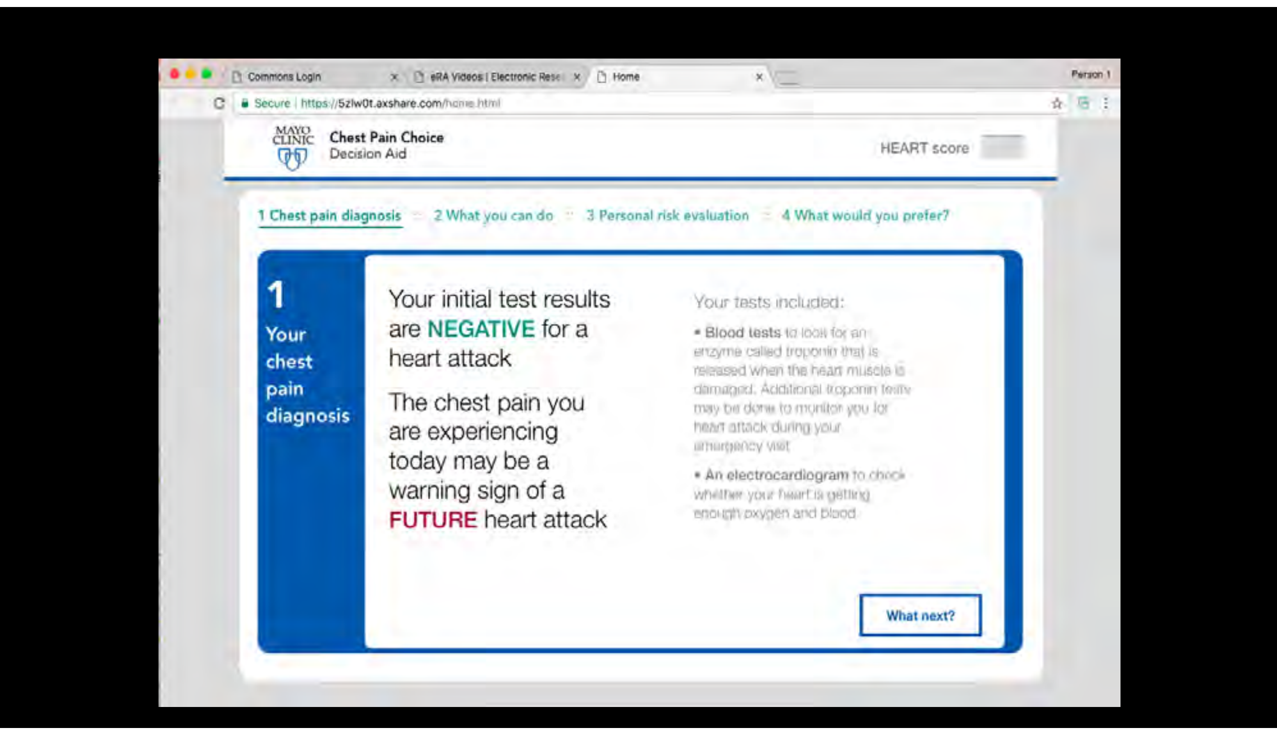
How?

- Shape the path
- Motivate the elephant
- Direct the rider



Shape the path

- Design electronic decision aid
- Develop consensus-based management algorithm (across all sites)
- Conduct normalization process theory-guided focus groups
- Create Site-specific flow-maps


Commons Login
eRA Videos | Electronic Rese
Home
Person 1
Secure | https://5zlw0t.axshare.com/home.html
MAYO CLINIC
Chest Pain Choice
Decision Aid
HEART score
1 Chest pain diagnosis
2 What you can do
3 Personal risk evaluation
4 What would you prefer?
1
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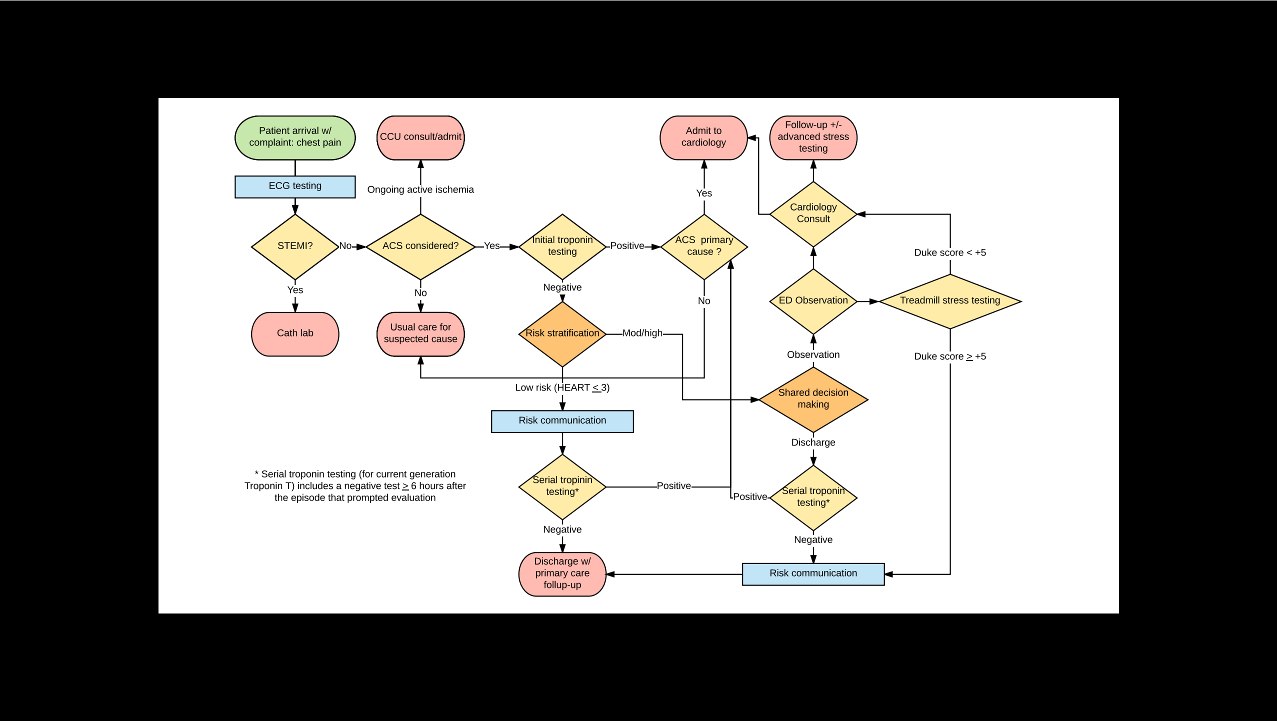
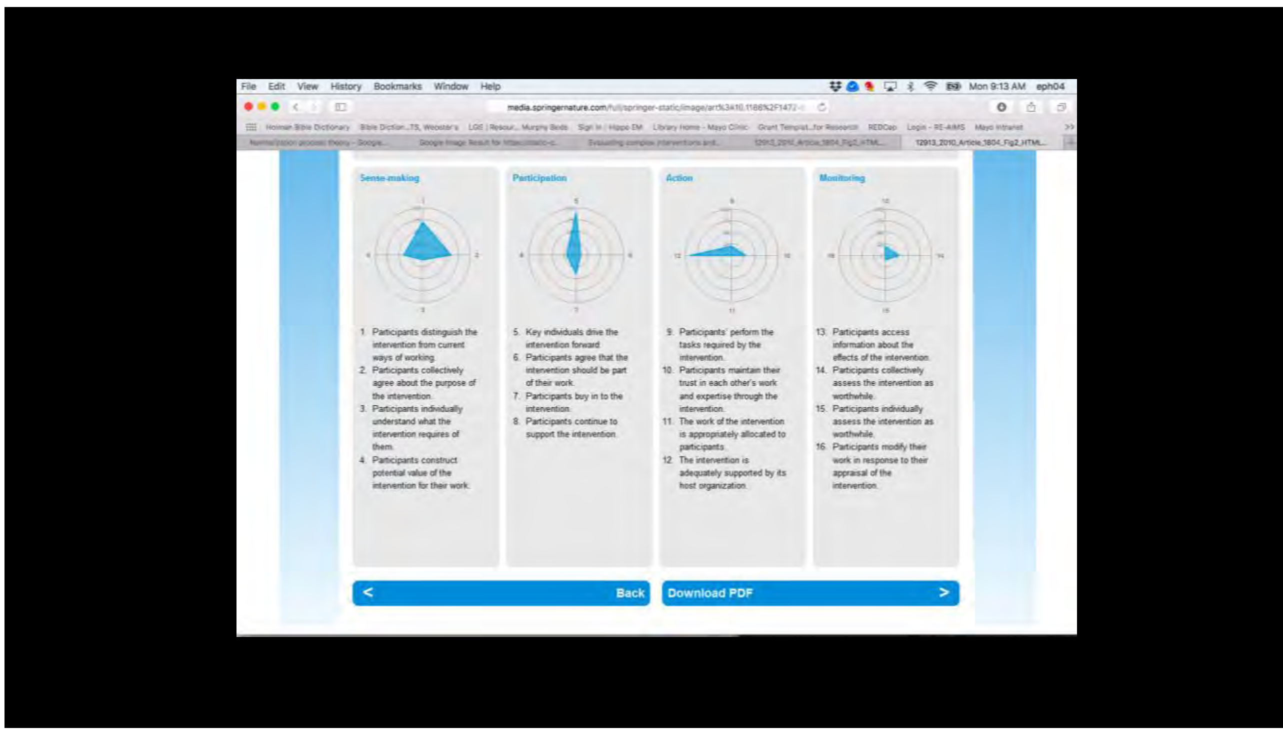
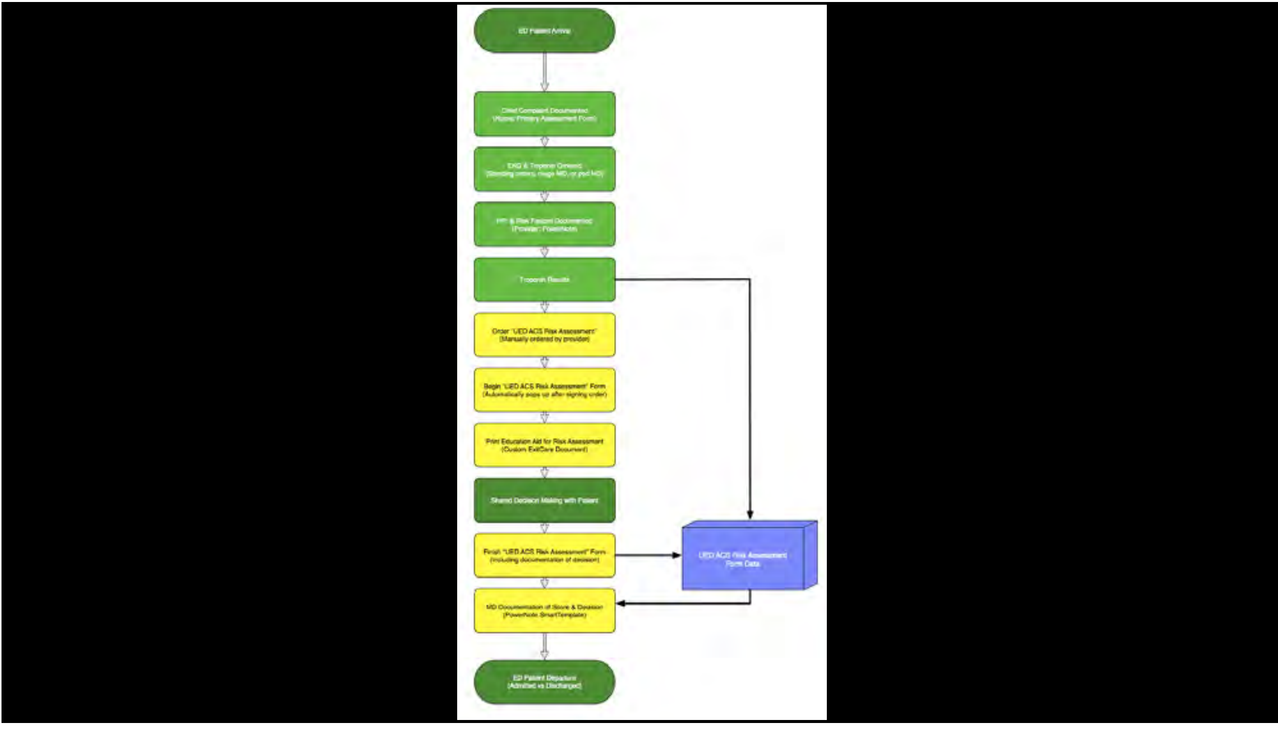

Patient arrival w/ complaint: chest pain
ECG testing
STEMI?
Yes
Cath lab
No
ACS considered?
Ongoing active ischemia
CCU consult/admit
No
Usual care for suspected cause
Yes
Initial troponin testing
Positive
ACS primary cause ?
Yes
Admit to cardiology
No
Negative
Risk stratification
Mod/high
Low risk (HEART ≤ 3)
Risk communication
Serial tropinin testing*
Positive
Negative
Discharge w/ primary care follup-up
Follow-up +/- advanced stress testing
Cardiology Consult
ED Observation
Treadmill stress testing
Duke score < +5
Duke score ≥ +5
Observation
Shared decision making
Discharge
Serial troponin testing*
Positive
Negative
Risk communication
* Serial troponin testing (for current generation Troponin T) includes a negative test ≥ 6 hours after the episode that prompted evaluation


media.springernature.com
Sense-making
1. Participants distinguish the intervention from current ways of working.
2. Participants collectively agree about the purpose of the intervention.
3. Participants individually understand what the intervention requires of them.
4. Participants construct potential value of the intervention for their work.
Participation
5. Key individuals drive the intervention forward.
6. Participants agree that the intervention should be part of their work.
7. Participants buy in to the intervention.
8. Participants continue to support the intervention.
Action
9. Participants' perform the tasks required by the intervention.
10. Participants maintain their trust in each other's work and expertise through the intervention.
11. The work of the intervention is appropriately allocated to participants.
12. The intervention is adequately supported by its host organization.
Monitoring
13. Participants access information about the effects of the intervention.
14. Participants collectively assess the intervention as worthwhile.
15. Participants individually assess the intervention as worthwhile.
16. Participants modify their work in response to their appraisal of the intervention.
Back
Download PDF


ED Patient Arrival
Troponin Results
Order "UED ACS Risk Assessment"
(Manually ordered by provider)
Begin "UED ACS Risk Assessment" Form
Print Education Aid for Risk Assessment
(Custom ExitCare Document)
Shared Decision Making with Patient
Finish "UED ACS Risk Assessment" Form
(including documentation of decision)
UED ACS Risk Assessment Form Data
MD Documentation of Score & Decision
(PowerNote SmartTemplate)
ED Patient Departure
(Admitted vs Discharged)

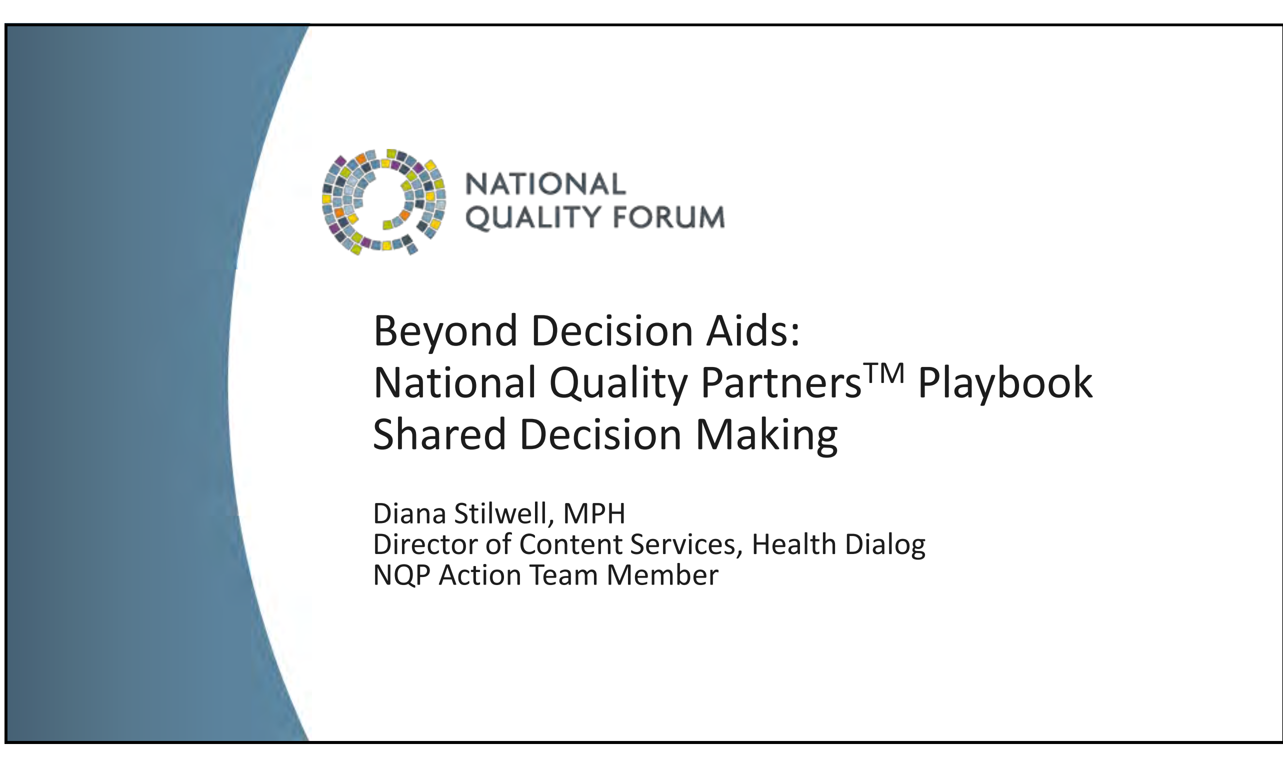
Motivate the Elephant

- Patient a picture of group success
- Describe specific patient and clinician success stories

Direct the Rider

- Develop a training toolkit
  - Brief summary of evidence
  - Videos of SDM conversations
  - Videos showing how to incorporate SDM into clinical workflows
- Regular clinician-level performance feedback

Hess.Erik@mayo.edu
ErikHessMD


NATIONAL
QUALITY FORUM
Beyond Decision Aids:
National Quality Partners™ Playbook
Shared Decision Making
Diana Stilwell, MPH
Director of Content Services, Health Dialog
NQP Action Team Member

National Quality Partners Playbook™: *Shared Decision Making in Healthcare*

- Goal: Make shared decision making (SDM) the standard of care for all patients
- Provides essential guidance to implement and strengthen SDM
- Highlights practical solutions to common barriers to SDM in clinical practice

2017-18 NQP Shared Decision Making Action Team

- American Association for Physician Leadership
- American College of Obstetricians and Gynecologists
- American Urological Association
- Association of Rehabilitation Nurses
- Centers for Medicare & Medicaid Services*
- Compassus
- Connecticut Center for Patient Safety
- Council of Medical Specialty Societies
- Genentech
- Homewatch CareGivers International
- Human Services Research Institute
- Hospice and Palliative Nurses Association
- Informed Medical Decisions Program at MGH
- National Alliance for Caregiving
- National Coalition for Cancer Survivorship
- National Partnership for Women & Families
- Patient and Family Centered Care Partners
- Planetree International
- University of Texas-MD Anderson Cancer Center
- Vizient, Inc.

**ex-officio, non-voting*

Acknowledgments

- NQF developed the NQP Playbook with input from more than 20 experts and national stakeholders from public and private sectors
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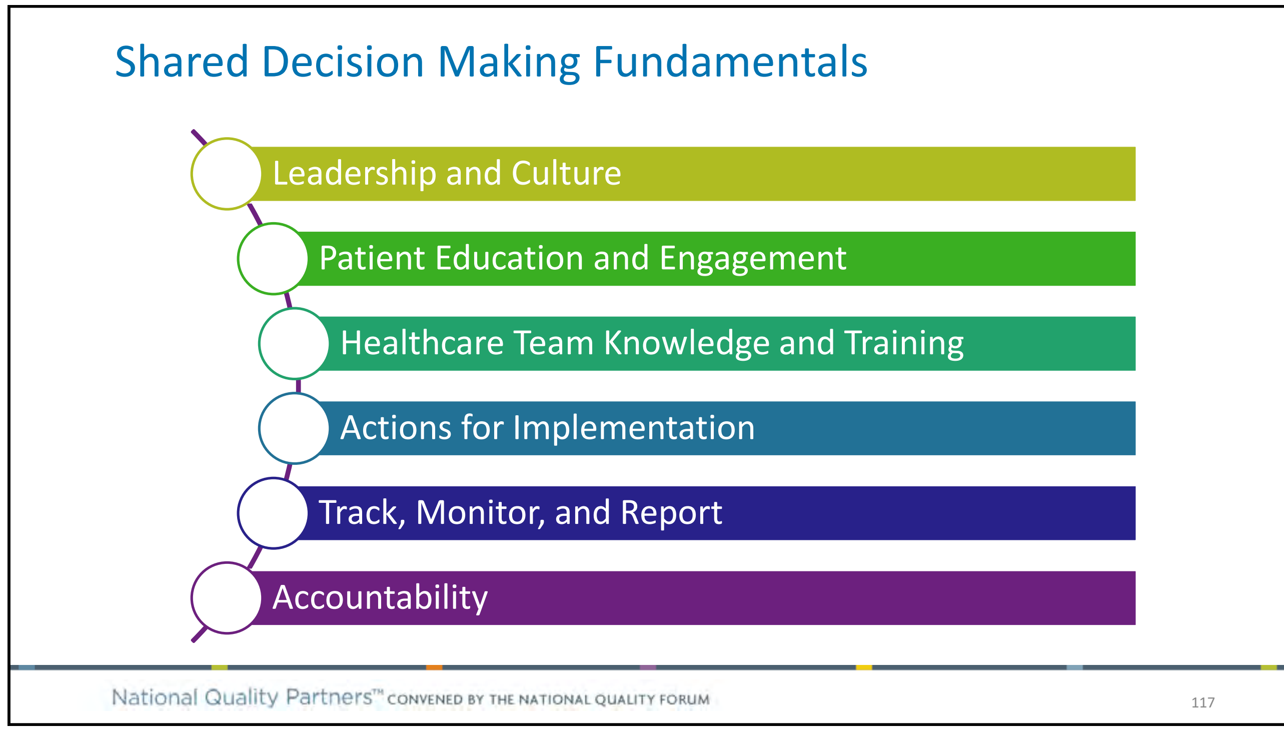
  - *PhRMA*
  - *Genentech*
  - *Merck & Co.*
  - *Gordon and Betty Moore Foundation*

NQP Playbook™: Shared Decision Making in Healthcare

- Practical guidance
- Six key fundamentals
- For each, implementation strategies (basic, intermediate, advanced) can be tailored to context, resources, and needs
- Snapshots highlight success stories



Implementing SDM in Your Environment

1. Get your organization a copy of the Playbook
2. Pick one of the fundamentals to begin
   - ➤ Consider resources already in place and start with something achievable
3. Take action steps
   - ➤ Add to agenda at your next meeting
   - ➤ Add it to goals for yourself or your team
   - ➤ Make one phone call

What are you already doing that SDM could make better?

Now imagine shared decision making for a population of 10 thousand, or 10 million
National Quality Partners™ CONVENED BY THE NATIONAL QUALITY FORUM
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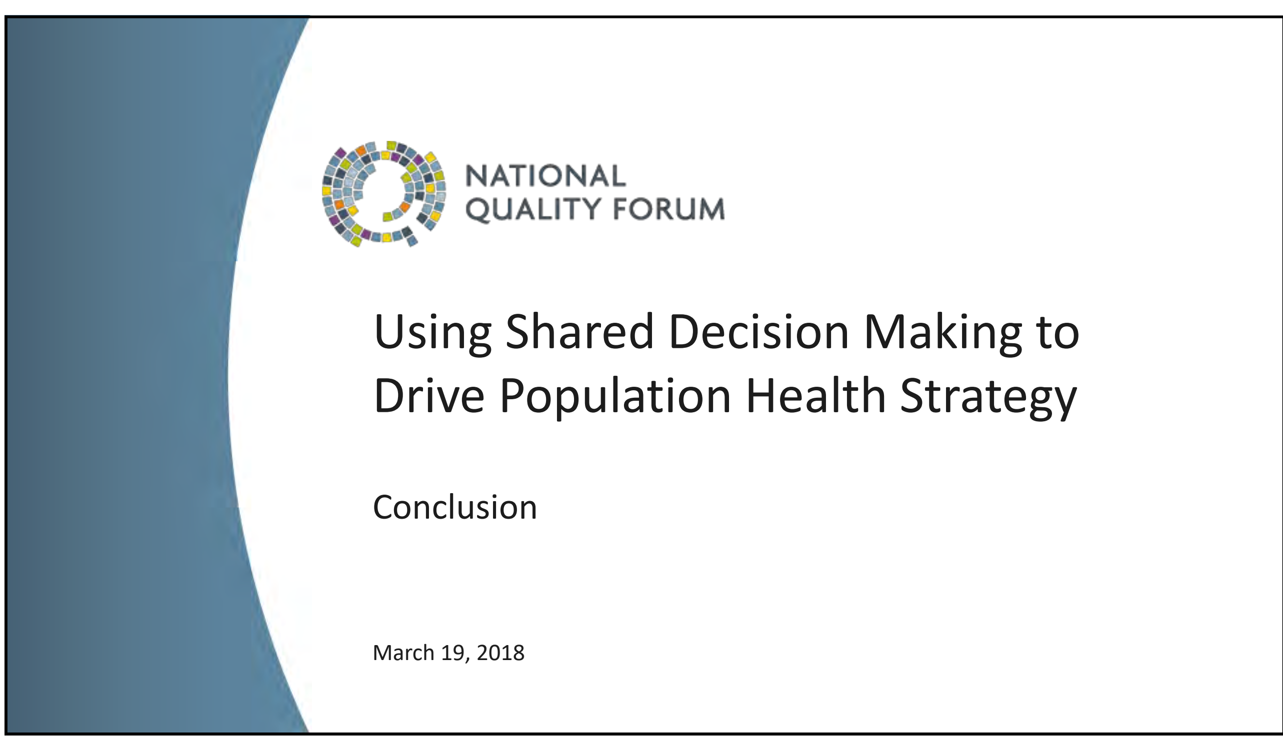
NATIONAL QUALITY FORUM
Using Shared Decision Making to Drive Population Health Strategy
Conclusion
March 19, 2018

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Download the new *National Quality Partners Playbook™: Shared Decision Making in Healthcare*

A new guide to help clinicians and patients work together to make healthcare decisions that align with what matters most to patients

Discount available Mar 19 – 26

http://www.qualityforum.org/NQF_Store.aspx

NQF Webinar

Join us!

NQF will host a public webinar on shared decision making on April 12.

Register for the *Strategies for Strengthening Shared Decision Making: A Conversation with the NQP Shared Decision Making Action Team* on **April 12 from 1 pm to 2 pm ET.**

Audience Activity: Wrap Up

One word or phrase that stands out in your mind from today