Patient-Centered Outcomes Research and the Use of Decision Aids to Facilitate Shared Decision Making

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Agency for Healthcare Research and Quality (AHRQ)
Presenters and Moderator Disclosures

The following presenters and moderator have no financial interest to disclose:

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- **Victor Montori, M.D.**, Mayo Clinic
- **Alaina Fournier, Ph.D.**, AHRQ

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At the conclusion of this activity, the participant will be able to:

1. Define patient-centered care and shared decision making, and current NCQA requirements for patient-centered medical homes (PCMH) and Accountable Care Organizations (ACOs).

2. Describe the attributes/advantages of patient-centered outcomes research (PCOR) and decision aids in augmenting patient-centered care in the context of shared decision making.

3. Identify AHRQ as a key source of PCOR resources and shared decision-making materials.
Overview

- **Crossing the Quality Chasm** called for
  - “system that provides care that is respectful to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions”

- **Affordable Care Act**
  - Call for new Shared Decision-Making Resource Centers (Section 3506) to help integrate shared decision making into practice
  - Section 3021 (Center for Medicare and Medicaid Innovation [CMMI]) to examine how support tools can be used to improve patients understanding of their treatment options
  - Formation of Patient Centered Outcomes Research Institute (PCORI)
Comparative Effectiveness Research

“provide comparative effectiveness information to assist patients, clinicians, purchasers, and policy makers in making informed health decisions”

Source: Benner 2010
### CER Translation Gap

<table>
<thead>
<tr>
<th>Study</th>
<th>Results</th>
<th>Practice</th>
<th>Translation</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALLHAT</td>
<td>Thiazide diuretics were superior in preventing cardiovascular disease events</td>
<td>ACE-inhibitors</td>
<td>No change</td>
</tr>
<tr>
<td>CATIE</td>
<td>Conventional antipsychotics were as effective as atypical antipsychotics for schizophrenia</td>
<td>Atypical</td>
<td>No change</td>
</tr>
<tr>
<td>COMPANION</td>
<td>Compared to optimal medical therapy, both cardiac resynchronization therapy (CRT) and CRT plus defibrillator use improved survival, reduced hospitalization rates, and improved functional status in patients with moderate to severe heart failure</td>
<td>Medical therapy</td>
<td>Minimal change</td>
</tr>
<tr>
<td>COURAGE</td>
<td>Optimal medical therapy combined with percutaneous coronary intervention (PCI) had similar survival benefit and angina relief, compared to optimal medical therapy alone</td>
<td>PCI</td>
<td>Minimal/No change</td>
</tr>
<tr>
<td>SPORT</td>
<td>Surgery for lumbar spinal stenosis had better outcomes than nonsurgical treatment, according to the cohort study results</td>
<td>Surgical Treatment</td>
<td>No change</td>
</tr>
</tbody>
</table>

Source: Timbie 2012
Why?

- Misalignment of financial incentives
- Complexity of research
- Biases in interpretation of results
- Applicability of the evidence
- Limited use of decision support

Source: Timbie 2012; Morrato 2013
Comparative Effectiveness Research

Decision Aids/Decision Support

“Creating a Conversation”

Evidence Translation

Patient Engagement
Enabling Patient Choice in the Patient-Centered Medical Home

Johann Chanin, RN, M.S.N.,
Patient-Centered Medical Home and Neighborhood
Agenda

- National Committee for Quality Assurance (NCQA)
- Definition of patient-centered care
- Definition of shared decision making
- NCQA’s requirements
  - Patient-Centered Medical Home 2014 (PCMH)
  - Patient-Centered Specialty Practice (PCSP)
  - Accountable Care Organizations (ACO)
National Committee for Quality Assurance (NCQA)

- Improves health care quality through
  - Transparency
  - Measurement
  - Accountability

- Provider-based quality programs
  - Accountable Care Organization Accreditation
  - Diabetes Recognition Program & Heart/Stroke Recognition Program
  - Patient-Centered Medical Home & Patient-Centered Specialty Practice Recognition
Shared Decision Making (SDM)
Shared Decision Making (SDM)

- The purpose is to help patients make informed, values-based decisions with their care team.
- It’s used when there is no “BEST” choice.
- Decision process takes into account:
  - Evidence-based information about health care options
  - Benefits and harms of each option
  - Provider's knowledge and experience
  - Patient's values and preferences
- Not all decisions need to be shared (e.g., surgery for acute appendicitis, repairing compound fracture).
Patient-Centered Medical Home (PCMH): What is it?
What is a Patient-Centered Medical Home?

- “Whole-person” coordinated care to provide primary care “as patient wants it to be”
- Clinician-patient relationship to keep patient healthy between visits
- “Team-based care” so providers can work at highest level of training
- Use information technology to support the Triple Aim and improve population health

Summary: NCQA’s Patient-Centered Medical Home 2014 Standards

1. **Enhance Access/Continuity**: Appointment access, 24/7 access to clinical advice, electronic access

2. **Team Care**: Continuity, culturally/linguistically appropriate, team care

3. **Identify/Manage Patient Population**: Use patient information, assessment, evidence-based guidelines to manage populations

4. **Plan/Manage Care**: Individual patient-care planning, medication management, self-care support with shared decision making

5. **Track/Coordinate Care**: Test/referral tracking and followup, coordinate care transitions

6. **Performance Measurement/Quality Improvement**: Measure clinical performance, resource use, patient experience; report performance and show continuous quality improvement
Shared Decision Making in Patient-Centered Medical Home Program

- Manage patient populations
  - Use evidence-based guidelines to manage populations

- Plan/manage individual patient care
  - Care planning, medication management, support self-care/shared decision making

- Measure patient experience
  - PCMH CAHPS includes shared decision making items
NCQA’s Patient-Centered Specialty Practice (PCSP) Program
NCQA’s Patient-Centered Specialty Practice (PCSP) Program: Key Aims

1. **Patient access** (timely appointments/advice)
2. **Agreements** with PCP to coordinate care
3. **Timely information** exchange with PCP, including referral summary to referring clinician
4. **Care plan coordination** with PCP
5. **Communication** with patient and PCP
6. **Reduce hospitalizations/ED visits**, duplication of tests
7. **Measure performance**
8. **Align with Meaningful Use Requirements**
Shared Decision Making in PCSP Program

- Coordinate with primary care; process/information shared with PCP.
- Collaborate with PCP on care management and self-care.
- Measure patient experience.
NCQA’s
Accountable Care Organization (ACO) Accreditation Program
NCQA’s ACO Standards

**ACO**: Provider-based organization accountable for quality and cost of care for defined population

1. **Program Operations**: Infrastructure/leadership, provider payments/contracting arrangements
2. **Access/Availability**: Full range of health care services (primary care, specialists, community/home)
3. **Primary Care**: Access to PCPs
4. **Care Management**: Support care management/self-care
5. **Care Coordination/Transitions**: Information exchange
6. **Patient Rights/Responsibilities**: Communicate with patients about ACO performance/payments
7. **Performance Reporting/Quality Improvement**
Shared Decision Making in ACOs

- Adopt evidence-based guidelines and disseminate decision-support tools.
- Make decision-support aids available to ACO providers to promote patient engagement.
- Report patient experience.
Shared Decision Making is Vital...

- Enables patient-centered care
- Supports patient involvement in planning/managing care and self-care
- Enhances patient experience
- Supports containment of cost (hospitalizations, ED visits, duplication of services, improved coordination/ transitions of care)
- Improves quality of patient care

"Implementing shared decision making will help organizations...to achieve the Triple Aim of better care, better health, and lower costs“

Johann Chanin
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Patient-Centered Medical Home and Neighborhood
Making Better Decisions Together
Translating PCOR into PCare

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Sponsored by:
Agency for Healthcare Research and Quality (AHRQ)

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Disclosures

Relevant Financial Relationships
None

Off-Label Usage
None
Systematic Review: Comparative Effectiveness and Safety of Oral Medications for Type 2 Diabetes Mellitus

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Background: As newer oral diabetes agents continue to emerge on the market, comparative evidence is urgently required to guide appropriate therapy.

 had a beneficial effect on high-density lipoprotein cholesterol levels (mean relative increase, 0.08 to 0.13 mmol/L [3 to 5 mg/dL]) but a harmful effect on low-density lipoprotein (LDL) cholesterol levels (mean relative increase, 0.26 mmol/L [10 mg/dL]) compared with

Wrong treatment?
Wrong person
Wrong diagnosis
Wrong procedure
Wrong preferences
Engaging patients and families in their care: Stage 3 Priorities

Stage 1 + 2 Functional Objectives
- View, download, transmit
- Clinical summary
- Patient-specific educational resources
- Patient reminders
- Secure messaging
- Advance directives

Stage 3 Functionality Goals
- Provide patient and caregivers online access to health information
- Provide ability to contribute information in the record, including PRO
- Patient preferences recorded and used

MU Outcome Goals
- Patients understand their disease and treatments
- Patients participate in shared decision making
- Patient preferences honored across care teams
Shared Decision Making

Right thing to do.
# Decision-Making Models

<table>
<thead>
<tr>
<th>Options</th>
<th>Parental</th>
<th>Clinician-as-perfect agent</th>
<th>Shared decision making</th>
<th>Informed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Options</td>
<td>Informed consent</td>
<td>Clinician</td>
<td>Patient</td>
<td></td>
</tr>
<tr>
<td>Deliberation</td>
<td>Clinician</td>
<td>Clinician after discussion</td>
<td>Joint</td>
<td>Patient (after discussion)</td>
</tr>
<tr>
<td>Decision</td>
<td>Clinician orders</td>
<td>Clinician recommends</td>
<td>Consensus</td>
<td>Patient requests</td>
</tr>
</tbody>
</table>

Modified from Charles C et al.
Empathic Decision Making
Partnership Dance
across models
support deliberation
The Body of Evidence

Systematic review of 115 RCTs

Compared to usual care, decision aids:
- Increase patient involvement by 34% (++++)
- Increase patient knowledge of options by 13% (+++++)
- Increase consultation time by ~2.6 minutes
- Reduce decisional conflict by ~7%
- Reduce % undecided by 40%

No consistent effect on choice, adherence, health outcomes, or costs

Stacey D et al. Cochrane review 2014
1. What goes into figuring out my risk of having a heart attack in the next 10 years?

- Age
- Sex
- Years of diabetes
- Smoking
- Hemoglobin A1C
- Blood pressure
- Cholesterol
- Protein in your urine

2. What is my risk of having a heart attack in the next 10 years?

**NO STATIN**

- 80 people DO NOT have a heart attack (green)
- 20 people DO have a heart attack (red)

**YES STATIN**

- 80 people still DO NOT have a heart attack (green)
- 5 people AVOIDED a heart attack (yellow)
- 15 people still DO have a heart attack (red)
- 85 people experienced NO BENEFIT from taking statins

3. What are the downsides of taking statins (cholesterol pill)?

- Statins need to be taken every day for a long time (maybe forever).
- Statins cost money. (to you or your drug plan)
- Common side effects: nausea, diarrhea, constipation (most patients can tolerate)
- Muscle aching/stiffness: 5 in 100 patients (some need to stop statins because of this)
- Liver blood test goes up (no pain, no permanent liver damage): 2 in 100 patients (some need to stop statins because of this)
- Muscle and kidney damage: 1 in 20,000 patients (requires patients to stop statins)

4. What do you want to do now?

- [ ] Take (or continue to take) statins
- [ ] Not take (or stop taking) statins
- [ ] Prefer to decide at some other time

---

Web

Compared to usual care, patients using the decision aid were 22 times more likely to have an accurate sense of their baseline risk and risk reduction with statins.

70% fewer statin prescriptions in the low-risk (<10%) group.

Threefold increase in self-reported adherence
1. What is your risk of having a heart attack in the next 10 years?

2. What benefit can you expect from taking statins compared to not taking statins?

3. What dangers can you expect from taking statins compared to not taking statins?

4. What do you want to do now?

   - Finish the online form now
   - Call the general practitioner
   - Book an appointment for a review
# Weight Change

<table>
<thead>
<tr>
<th>Drug</th>
<th>Weight Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metformin</td>
<td>None</td>
</tr>
<tr>
<td>Insulin</td>
<td>4 to 6 lb. gain</td>
</tr>
<tr>
<td>Pioglitazone</td>
<td>More than 2 to 6 lb. loss</td>
</tr>
<tr>
<td>Liraglutide/Exenatide</td>
<td>3 to 6 lb. loss</td>
</tr>
<tr>
<td>Sulfonylureas</td>
<td>Gilipizide, Glimepiride, Glyburide</td>
</tr>
<tr>
<td>Glitptins</td>
<td>None</td>
</tr>
<tr>
<td>SGLT2 Inhibitors</td>
<td>3 to 4 lb. loss</td>
</tr>
</tbody>
</table>

# Low Blood Sugar (Hypoglycemia)

<table>
<thead>
<tr>
<th>Drug</th>
<th>Side Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metformin</td>
<td>None</td>
</tr>
<tr>
<td>Insulin</td>
<td>None</td>
</tr>
<tr>
<td>Pioglitazone</td>
<td>None</td>
</tr>
<tr>
<td>Liraglutide/Exenatide</td>
<td>None</td>
</tr>
<tr>
<td>Sulfonylureas</td>
<td>None</td>
</tr>
<tr>
<td>Glitptins</td>
<td>None</td>
</tr>
<tr>
<td>SGLT2 Inhibitors</td>
<td>None</td>
</tr>
</tbody>
</table>

# Blood Sugar (A1c Reduction)

<table>
<thead>
<tr>
<th>Drug</th>
<th>A1c Reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metformin</td>
<td>1 - 2%</td>
</tr>
</tbody>
</table>

# Daily Routine

<table>
<thead>
<tr>
<th>Drug</th>
<th>Schedule</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metformin</td>
<td>24/7 OR AM/PM</td>
</tr>
<tr>
<td>Insulin</td>
<td>24/7 OR AM/PM</td>
</tr>
<tr>
<td>Pioglitazone</td>
<td>24/7 OR AM/PM</td>
</tr>
<tr>
<td>Liraglutide/Exenatide</td>
<td>24/7 OR AM/PM</td>
</tr>
<tr>
<td>Sulfonylureas</td>
<td>24/7 OR AM/PM</td>
</tr>
<tr>
<td>Glitptins</td>
<td>24/7 OR AM/PM</td>
</tr>
<tr>
<td>SGLT2 Inhibitors</td>
<td>24/7 OR AM/PM</td>
</tr>
</tbody>
</table>

# Daily Sugar Testing (Monitoring)

<table>
<thead>
<tr>
<th>Drug</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metformin</td>
<td>No monitoring necessary</td>
</tr>
<tr>
<td>Insulin</td>
<td>Monitor once or twice daily, less often once stable</td>
</tr>
<tr>
<td>Pioglitazone</td>
<td>No monitoring necessary</td>
</tr>
<tr>
<td>Liraglutide/Exenatide</td>
<td>Monitor twice daily after meals when used with Sulfonylureas. Otherwise not needed.</td>
</tr>
<tr>
<td>Sulfonylureas</td>
<td>Monitor 2 - 5 times weekly, less often once stable</td>
</tr>
<tr>
<td>Glitptins</td>
<td>No monitoring necessary</td>
</tr>
<tr>
<td>SGLT2 Inhibitors</td>
<td>No monitoring necessary</td>
</tr>
</tbody>
</table>

# Cost

<table>
<thead>
<tr>
<th>Drug</th>
<th>Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metformin (Generic available)</td>
<td>$0.10 per day</td>
</tr>
<tr>
<td>Insulin (No generic available – price varies by dose)</td>
<td>Lantus: Vial, per 100 units: $10, Pen, per 100 units: $43</td>
</tr>
<tr>
<td>Pioglitazone (Generic available)</td>
<td>$10.00 per day</td>
</tr>
<tr>
<td>Liraglutide/Exenatide (No generic available)</td>
<td>$11.00 per day</td>
</tr>
<tr>
<td>Sulfonylureas (Gilipizide, Glimepiride, Glyburide)</td>
<td>$0.10 per day</td>
</tr>
<tr>
<td>Glitptins (No generic available)</td>
<td>$7.00 per day</td>
</tr>
<tr>
<td>SGLT2 Inhibitors (No generic available)</td>
<td>$8.00 per day</td>
</tr>
</tbody>
</table>
What aspect of your next diabetes medicine would you like to discuss first?

**Cost**

These figures are estimates and are for comparative reference only. Actual out-of-pocket costs vary over time, by pharmacy, insurance plan coverage, preparation and dosage. Under some plans name brands may be comparable in cost to generics.

- **Metformin** (Generic available)
  - $0.10 per day
  - $10 / 3 months

- **Insulin** (No generic available – price varies by dose)
  - **Lantus**: Vial, per 100 units: $10
    - Pen, per 100 units: $43
  - **NPH**: Vial, per 100 units: $6
    - Pen, per 100 units: $30
  - **Short acting analog insulin**: Vial, per 100 units: $10
    - Pen, per 100 units: $43

- **Pioglitazone** (Generic available)
  - $10.00 per day
  - $900 / 3 months

- **Liraglutide/Exenatide** (No generic available)
  - $11.00 per day
  - $1,000 / 3 months

- **Sulfonylureas**
  - Glibizide, Glimepiride, Glyburide
  - $0.10 per day
  - $10 / 3 months

- **Glipins** (No generic available)
  - $7.00 per day
  - $630 / 3 months
### SELF REPORT

Patients and clinicians confident about choice (.001)

Knowledge 12% better (p=.02)

Satisfaction with process 35% better (p=0.002)

**VIDEO**

Patient involvement 40% better (p=.001)

70% vs. 92% patient voices preference

92% vs. 95% clinician voices preference

0% vs. 63% patient identifies top issue

Fidelity = 48%

### OTHER OUTCOMES

No difference in PHQ-9 or medication adherence
### Risk of Stroke

#### Your Risk of Stroke without Anticoagulation

In 100 people like you in the next year there will be

<table>
<thead>
<tr>
<th></th>
<th>2</th>
<th>5</th>
<th>93</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fatal or disabling</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>strokes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-disabling strokes</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

#### Your Risk of Stroke with Anticoagulation

In 100 people like you in the next year there will be

<table>
<thead>
<tr>
<th></th>
<th>5</th>
<th>2</th>
<th>98</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strokes avoided by taking anticoagulation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fatal or disabling strokes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-disabling strokes</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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### Risk of Serious Bleeding

### Cost

### Diet and Medication Interactions

### Work, Home & Fun Activities

### Anticoagulation Routine

Warfarin requires committing to regular blood tests. There is no testing required with a New Anticoagulant.

#### Warfarin

- **Approved_names**: Cumedrin, Jantoven, Marevan, Uniwarfin
- **Dosage**: Once daily
- **Regular blood tests**:

  - **Warfarin requires**?
    - Work / travel / family demands?
    - Transportation?

#### New Anticoagulants

- **Dabigatran**: Pradaxa 110mg, 150mg
  - AM
  - PM
- **Apixaban**: Eliquis
  - AM
  - PM
- **Rivaroxaban**: Xarelto
  - Once daily
- **Edoxaban**: Lithoa
  - Once daily
Summary of Mayo Experience

Age: 40-92 (avg 65)

Primary care, ED, hospital, specialty care

74-90% clinicians want to use tools again.

Adds ~3 minutes to consultation.

58% fidelity without training.

20% improvement in patient knowledge.

17% improvement in patient involvement.

Effects are similar in vulnerable populations.

Variable effect on clinical outcomes, cost

Wyatt et al. Implement Sci 2014; 9: 26
Coylewright et al CCQO 2014, 7: 360-7
Training

Using the Depression Medication Choice Decision Aid (DA) with Patients

1. Clinician and patient discuss the “What You Should Know” card.

2. Clinician asks, “What issues concerning a medication to treat depression symptoms would you like to discuss first?” Patient selects first card.

3. Patient and clinician review this card.

4. Patient selects a second card and compares the two.

5. Medication options are discussed.

6. Medication choice is made—brochure given to patient to take home.
Integration Into Electronic Workflow

EMR Link

Web

EMR Documentation

http://statindecisionaid.mayoclinic.org
Largest Test of Point-of-Care Shared Decision Making
Meanwhile...
More about shared decision making:
http://shareddecisions.mayoclinic.org

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@vmontori
AHRQ’s SHARE Approach: Integrating PCOR into Shared Decision Making

Alaina Fournier, Ph.D.

Office of Communications and Knowledge Transfer
Agency for Healthcare Research and Quality (AHRQ)
Disclosures

Relevant Financial Relationships

None
The Agency for Healthcare Research and Quality

- AHRQ is a Federal agency that is part of the U.S. Department of Health & Human Services.

- AHRQ works to produce and disseminate evidence to make health care safer, of higher quality, more accessible, equitable, and affordable.
Patient-Centered Outcomes Research (PCOR)

The Affordable Care Act directs AHRQ to disseminate and implement PCOR.

**PCOR:**

- Assesses preventive, diagnostic, therapeutic, palliative, or health delivery system interventions
- Compares the benefits and harms of interventions
- Aims to find out how well interventions work in everyday practice settings, not just in clinical trial settings
- Focuses on outcomes that matter to people
AHRQ’s Effective Health Care Program

- **Synthesizes PCOR** through systematic reviews and comparative effectiveness reviews

- **Translates PCOR** findings into plain-language resources for patients and health care professionals to support decision making

- **Disseminates PCOR-based decision aids** to those who need them

**Goal:** Improve health care quality and patient health outcomes through informed decision making by patients, providers, and policymakers.

[www.effectivehealthcare.ahrq.gov](http://www.effectivehealthcare.ahrq.gov)
Effective Health Care Products
Clinician Research Summaries

- More than 60 information products targeted to physicians, nurses, and other clinicians.

- Summaries provide:
  - The “clinical bottom line” on treatments
  - Graded descriptions of the strength of the evidence behind the research

- Most have online CME/CE activities available.
Consumer Research Summaries

- Over 50 plain-language information products summarize PCOR findings on treatments for chronic conditions.

- Each summary includes:
  - Background on the condition
  - Benefits, risks, and side effects of treatment options

- Available in English and Spanish, and with companion audio versions.
Patient Decision Aids

- Online, interactive tools to help patients with certain clinical conditions think about what’s important to them when talking to their doctor.

- AHRQ Decision Aids include:
  - Information on the condition
  - Information on treatment options
Shared Decision Making in the Health Care Landscape

- Health transformation initiatives call for improvements in patient engagement and shared decision making.

- PCOR provides evidence to discuss benefits, harms, and risks of treatment options.

- Health care providers need training in
  - using evidence-based decision aids
  - communications skills to discuss values and preferences with patients
  - implementing shared decision making in practice
Educating the Educators

- Create a **train-the-trainer workshop curriculum** and **collateral tools** to help clinicians learn how to use Effective Health Care and PCOR resources in shared decision making.

- Conduct **10 workshops** per year across the country.

- Provide support to trainees with **Webinars, technical assistance, and a learning network**.
Formative Research Approach

- Literature Review

- Health Educators Needs Assessment
  - Online Survey: Over 2,200 respondents
  - Focus Groups: Treating and non-treating clinicians
  - Key informant interviews

- Three types of questions
  - Who should we train?
  - What should be included in the training?
  - How should we train?
Question 1: Who do we train?

- Common Themes Identified *(Survey, Focus Groups, Interviews, Literature Review)*
  
  Treating clinicians vs. non-treating clinicians are more likely to engage in discussions with patients about health care options.
  
  - A key goal for treating clinicians is providing patients (and caregivers) technical information about their condition and care options.
  
  - Key goals of non-treating clinicians appear to be assessing patients’ needs and goals, and clarifying their concerns.

- Most available training programs target treating clinicians, but there is growing interest for programs that target interdisciplinary professionals and teams.
Question 2: What do we include in the training?

Common Themes Identified (Survey, Focus Groups, Interviews, Literature Review)

- What CER/PCOR is and how it can be used in SDM
- Where to find and how to easily access PCOR information for use in SDM
- How to engage patients in the SDM process and elicit preferences
- Approaches that can be used in a limited time context/finding time
- Cultural competency
- Communicating technical information about condition and options
- Communicating harms/benefits, risk communication competencies
Question 3: How do we train?

Common Themes Identified (Survey, Focus Groups, Interviews, Literature Review)

- **Format**: Face to face (4-6 hours), with a possible Web-based tutorial component, and learning community for ongoing learning; should be interdisciplinary

- **Techniques**: Training should include role playing and case studies, video examples of SDM, and small breakout sessions
The SHARE Approach
Essential Steps of Shared Decision Making

Five steps for you and your patients to work together to make the best possible health care decisions.

Step 1:
Seek your patient’s participation
Communicate that a choice exists and invite your patient to be involved in decisions.

Step 2:
Help your patient explore and compare treatment options
Discuss the benefits and harms of each option.

Step 3:
Assess your patient’s values and preferences
Take into account what matters most to your patient.

Step 4:
Reach a decision with your patient
Decide together on the best option and arrange for a followup appointment.

Step 5:
Evaluate your patient’s decision
Plan to revisit decision and monitor its implementation.

www.ahrq.gov/shareddecisionmaking
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PCOR is introduced in Step 2: Help your patient explore and compare treatment options

- Discuss the benefits and harms of each treatment option.
  - Know the benefits and risks of each option.
  - Understand how they relate to your patient’s situation and condition.

- Use evidence-based decision-making resources to compare the treatment options.
The SHARE Approach
Train-the-Trainer Workshop

- Consists of four modules and a training module (~6.5 hours of training)

- **Module 1**: Shared Decision Making
- **Module 2**: AHRQ PCOR Resources
- **Module 3**: Communication
- **Module 4**: Putting Shared Decision Making Into Practice

Training Module
Implementation Model

- 10 accredited training sessions a year across the country
  - 25-50 participants per session (~250-500 primary trainees a year)
  - Primary trainees train local-setting colleagues and health provider stakeholders (to facilitate dissemination of curriculum concepts)
Shared Decision Making Support Materials and Activities from AHRQ

- Shared decision-making toolkit on the AHRQ Web site
  - Workshop curriculum modules
  - 9 informational tools
  - Video, screensaver, poster
  - Links to other AHRQ resources that support or are related to shared decision making

- AHRQ provides ongoing support activities for participants of the workshop.
  - SHARE Approach Web conferences
  - SHARE Approach Learning Network (coming soon!)
AHRQ is conducting an ongoing evaluation of the initiative to learn about:

- Who is participating in training
- The confidence of primary trainees in training others about the SHARE Approach and AHRQ’s PCOR resources
- The extent to which workshop participants have been able to conduct additional trainings, start new PCOR education programs, or integrate the workshop curriculum into their local settings
- Participation in ongoing Web conferences and the Learning Network that are planned as part of this effort
- How workshop participants are using what they have learned about PCOR and shared decision making in their own practice
All Effective Health Care materials described here may be found on AHRQ’s Effective Health Care Web site:

http://effectivehealthcare.ahrq.gov/

Shared decision making tools and resources are available on AHRQ’s Shared Decision Making Toolkit Web site”

http://www.ahrq.gov/shareddecisionmaking/

The SHARE Approach Web site also contains information about upcoming SHARE Approach workshops around the country.
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Agency for Healthcare Research and Quality
If you would like to receive continuing education credit for this activity, please visit:

http://afya.cds.pesgce.com
How To Submit a Question

- At any time during the presentation, type your question into the “Q&A” section of your WebEx Q&A panel.
- Please address your questions to “All Panelists” in the dropdown menu.
- Select “Send” to submit your question to the moderator.
- Questions will be read aloud by the moderator.