Implementing Shared Decision Making with Low Health Literacy Patients

December 9, 2015
1:00 p.m. – 2:30 p.m. ET

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Agency for Healthcare Research and Quality (AHRQ)
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AHRQ works to produce and disseminate evidence to make health care safer, of higher quality, more accessible, equitable, and affordable.
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
April 2014 AHRQ Pub. No. 14-0026-2-EF
The SHARE Approach tools

- **Communication tools** addressing health literacy and cultural competence

- **Implementation guides** for clinicians, teams, and administrators

- **Resources** such as conversation starters, a video, and posters
The SHARE Approach Workshop

- A structured, 1-day accredited train-the-trainer workshop. Register at http://meetings.afyainc.com/share ddecisionmaking/

Module 1: Shared Decision Making
Module 2: AHRQ PCOR Resources
Module 3: Communication
Module 4: Putting SDM Into Practice
Module 5: Training of Trainers
AHRQ health literacy resources

• AHRQ Health Literacy Universal Precautions Toolkit
  www.ahrq.hhs.gov/literacy

• The Patient Education Materials Assessment Tool (PEMAT)
  www.ahrq.gov/pemat
SHARE Approach Webinar Series

Webinar 4
Implementing Shared Decision Making with Low Health Literacy Patients

Other Webinars available at:
Presenters and moderator disclosures

The presenter and moderator have **no conflicts of interest** to disclose:

- **Annie LeBlanc, Ph.D.,** Mayo Clinic

- **Cindy Brach, M.P.P.,** Agency for Healthcare Research and Quality (AHRQ)

Presenter **Mary Politi, Ph.D.** (Washington University School of Medicine) has received research funding from, and serves as a consultant to Merck Sharpe & Dohme.

PESG, AHRQ, AFYA, and AcademyHealth staff have no financial interest to disclose.

Commercial support was not received for this activity.
Learning objectives

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

1. Explain the value of shared decision making interventions among populations with limited literacy skills.

2. Identify challenges implementing shared decision making interventions among populations with limited literacy skills.

3. Describe a user-centered framework to support shared decision making between providers and patients with limited literacy skills.

4. Explain how the use of decision aids can facilitate shared decision making between providers and patients with limited literacy skills.
Accreditation

- This continuing education activity is managed and accredited by Professional Education Services Group (PESG) in cooperation with AHRQ, AFYA, and AcademyHealth.

- Accredited for:
  - Physicians/Physician Assistants, Nurse Practitioners, Nurses, Pharmacists/Pharmacist Technicians, Health Educators, and Non-Physician CME

- Instructions for claiming CME/CE – provided at end of Webinar
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.
- SHARE@ahrq.hhs.gov
Conflict of interest declaration

**Consultant:** Merck Sharpe & Dohme (2015)

**Investigator Initiated Grant:** Merck Sharpe & Dohme (2014 – 2015)
What is shared decision making?

A process by which decisions are made collaboratively by clinicians and patients, informed by the best evidence available, considering patients’ characteristics and values.


image: http://shareddecisions.mayoclinic.org/
Why not just make a recommendation?

Effectiveness of medical treatments

Effectiveness of 3,000 treatments as studied in RCTs, as collected by BMJ’s *Clinical Effectiveness*
Shared decision making: A meeting of experts

**PRACTITIONER**
- Invite patient to participate
- Present options
- Discuss risks, benefits, alternatives, uncertainties (using best available evidence)
- Elicit values and preferences
- Check understanding
- Discuss next steps

**PATIENT**
- Describes health, symptoms, and history
- Shares values, preferences, implementation challenges, and preferred style of decision making

Patient is *invited* to and *engages* in decision making at the desired level.

Slide c/o Dominick Frosch, Adapted from Charles, Soc Sci Med 1999; 49: 651-61.
“Sometimes the choice is not as clear as people think. Let’s work together so we can find a choice that’s right for you.”

“As you think about these options, what’s important to you? I want to make sure I understand what you care about.”

“Is there any more information you need? You have time to think things through.”

“Are you leaning towards one option or another?”
Shared decision making and health literacy

Health Literacy

- Conceptual Knowledge
- Oral Literacy
- Print Literacy
- Numeracy
  - Listening
  - Speaking
  - Writing
  - Reading

Slide c/o Dr. Kimberly A. Kaphingst, Adapted from Nielsen-Bohlman et al. (eds.) 2004
Shared decision making and health literacy

How can we lower the health literacy demands of shared decision making?

- Interpersonal communication
- Decision coaching
- Decision aids (Dr. LeBlanc)
Patients often have multiple sources of vulnerability

- Health vulnerability
- Resource driven vulnerability
- Health literacy challenges
Shared decision making and evidence based medicine

When is shared decision making appropriate?

- No clear choice from a health perspective (equipoise)
- Potential overuse (e.g. antibiotics for sinusitis)?
- Potential underuse (e.g. vaccination)?
Imagine treating Tiffany

Tiffany is a new patient who was previously uninsured.

For the past few days, Tiffany has had a mild fever, runny nose, fatigue, and chills. Her symptoms are keeping her up at night and she feels like she is not able to concentrate at work.

After a complete history and physical exam, you determine she has a mild virus. You encourage her to monitor her symptoms. You tell her to call you if her symptoms do not improve within a week.

Tiffany says, “But can’t you give me anything like an antibiotic or something to help me sleep? The walk-in clinic where I used to go always did. I can’t afford to miss any work and I need some sleep. Give me something to help me sleep, or penicillin or something.”
How do you respond to Tiffany?
How do you respond to Tiffany?

- Listen to the things that matter to her.
- Educate her about the risks and benefits of taking antibiotics.
- Build rapport with her.
- Respond to her questions and concerns.
- Debate the issue/attempt to discredit her information sources.
- Refer her to a colleague.
- Schedule another appointment to revisit the decision.
How do you feel about Tiffany?
How do you feel about Tiffany?

- I respect her decision to request antibiotics in this situation.
- I feel comfortable talking to her about her concerns.
- I understand her concerns about her symptoms.
- I don’t really like this patient.
- I find this patient a bit annoying.
- I would be pleased if she did not come to my clinic.
What might Tiffany be thinking?

- Health vulnerability
  - Too many things to take care of. My diabetes, my heart...just need to get past this...
- Resource driven vulnerability
  - No sick leave.
  - No back up child care.
- Health literacy challenges
- Differences between bacteria and virus?
"You have some doctors that you can ask them a question...I honestly think that it all depends on the kind of insurance that you have too. That they'll just tell you well, it's just this, when it could be something else."

[Female, St. Louis County]
Risks of miscommunicating

- Tiffany feels frustrated with the medical system.
- Tiffany gets labeled as a “drug seeker.”
- Tiffany doesn’t come back; other conditions are affected.
- Tiffany feels like no good doctors take her insurance.
- Others?
Shared decision making: A model for clinical practice

- Initial preferences
- Deliberation
- Informed preferences

**Team Talk**
- Explain the need to consider alternatives as a team (patients, families, clinicians)

**Option Talk**
- Describe the alternatives in more detail with or without decision aids

**Decision Talk**
- Help patients explore and form their personal preferences

Elwyn et al, 2012, JGIM
Decision coaching: Helping patients participate

- Agenda setting
- List of questions / knowledge assessment
- Values clarification
What should patients consider?

- **S**ituation (e.g., questions about diagnosis, test reports)
- **C**hoices available (treatment options)
- **O**bjectives/goals for consultation and treatment
- **P**eople involved in decision (and how to involve them)
- **E**valuation process: What makes a good decision for you?
- **D**ecision support: What information do you want/need?
### SCOPED Note Title:

List 3 key facts about the SITUATION

- Fact 1:
- Fact 2:
- Fact 3:

List 3 CHOICES or actions that are available to you

- Choice 1:
- Choice 2:
- Choice 3:

List 3 OBJECTIVES (goals), in order of priority

- Objective 1:
- Objective 2:
- Objective 3:

List 3 PEOPLE who are either involved or will be affected

- Person 1:
- Person 2:
- Person 3:

EVALUATE the consequences of each CHOICE for each OBJECTIVE

<table>
<thead>
<tr>
<th></th>
<th>Objective 1</th>
<th>Objective 2</th>
<th>Objective 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Choice 1</td>
<td></td>
<td></td>
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<tr>
<td>Choice 2</td>
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<td></td>
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<tr>
<td>Choice 3</td>
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<td></td>
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</tr>
</tbody>
</table>

DETERMINE the Best Choice and Next Steps

- Best Choice:
- Next Steps:

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[www.scoped.org](http://www.scoped.org)

What does decision coaching do for patients?

- **Increased**
  - Knowledge
  - Satisfaction
  - Self-efficacy
  - Decision quality
  - High quality questions
  - Adherence to screening

- **Decreased**
  - Decisional conflict
  - Anxiety
  - Perceived communication barriers

Sepucha et al., JCO 2000; Sepucha et al., JCO 2002
What does decision coaching do for clinicians?

- Less time on autopilot, more tailored communication
- More confidence that patient will remember information
- Does not increase consultation time
Shared decision making in practice: Are we there yet?

A common sentiment among health care providers:

“We already do that all the time.”
1057 audio-taped clinical encounters, 3552 decisions

What proportion of decisions met most basic definition of fully informed decisions?

- Nature of decision
- Patient role in decision making
- Exploration of patient preferences

9%

Braddock et al, 1999, JAMA
Nationally representative sample of 3,427 men aged 50 to 74 years in the 2010 National Health Interview Survey

- No SDM: 64.3%
- Partial SDM (1-2 elements): 27.8%
- Full SDM (All elements): 8.0%

Han et al., 2013, *Annals of Family Medicine*
Are we there yet?

- 1,034 preoperative elective surgery patients
  - 34% 1+ deficit(s) in surgical decision making
  - 50% 1+ deficit(s) in advance care planning

Ankuda et al, 2014, *PEC*
2,718 patients, 40 years or older, experienced or discussed 1-10 decisions with a health care provider in past 2 years

Few patients were asked preferences about medications for hypertension, elevated cholesterol, and having mammograms (37.3%-42.7%)

Discussed pros more than cons across all 10 decisions

Fowler et al, 2013, JAMA Internal Med
Are we there yet?

A common sentiment among health care providers:

“What if my patients do not want to be involved?”
Deliberation vs. determination

- National study of almost 3,000 participants

Levinson et al, 2005, *JGIM*
Invasive medical procedures:

- About **80%** wanted shared decision making or patient led decision making
- **93%** wanted clinicians to share risk information

Only **3-8%** state they want no role in decision making

Mazur & Hickam, 1997, *JGIM*

Arora & McHorney, 2000, *Medical Care*
Can this be shared decision making?

“My preferences are to cure the disease as quickly as possible, but I would like to be able to continue working throughout treatment if possible. I am torn between option A and option B.

What do you think I should do?”

Politi et al, 2013, *BMJ*
Shared decision making: Challenges for patients

- Limited knowledge can lead patients to say they want to defer decision making to a clinician or trusted other

- Preferences cannot be formed with inaccurate or missing info

- First steps: acknowledge equipoise or uncertainty, identify trade-offs between options, and offer choice

- Once patients are informed, they can decide whether they would like more (or less) decision involvement

Politi et al, 2013, *BMJ*
Shared decision making: Challenges for clinicians and patients

- Can patients clearly articulate preferences?
- Do clinicians bias the decision making process?
- What if preferences change across conversations?
The role of decision aids

- Explaining complex medical decisions is challenging.

- Physicians may feel they have little time for this task.

- Decision aids:
  - Explain decisions in language patients can understand
  - Provide detailed information about the options, their risks and benefits
  - Help patients clarify values
  - Could help document and track values/preferences
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Implementing Shared Decision Making in Populations with Low Health Literacy

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No financial conflict of interest

KER unit investigators do not receive funding from any for-profit pharmaceutical or manufacturer, nor do they receive any royalties or monetary benefits, directly or indirectly, from the use of the decision aids.

Decision aids are available free of charge.
Health literacy

“the degree to which individuals can obtain, process, and understand the basic health information and services they need to make appropriate health decisions.”

U.S. Department of Health and Human Services report Healthy People 2010
Health literacy skills

“the degree to which individuals can obtain, process, and understand the basic health information and services they need to make appropriate health decisions.”

Ability/Capacity to:

Read and write prose (print literacy)
Use quantitative information (numeracy)
Speak and listen effectively (oral literacy)
Poor health literacy

- 13% Below basic
- 22% Basic
- 12% Proficient
- 53% Intermediate

Higher risk
- Elderly
- Poor Minority
- Low education
- ESOL
Health literacy challenges

Prepare for the consultation
Bring questions, be ready for ones
Record & review visit
Watch educational videos
Read brochures

Read labels & medicine names
Calculate pills, refills, dosage
Listen to explanations & directions
Talk to busy professionals

Self-measure, self-monitor, self-manage
Manage appointments, prescriptions, bills
Keep family informed
Take care of significant others

Read and write prose
Use quantitative information
Speak and listen effectively

Adapted from IOM Framework 2003
Low health literacy

Impacts patient’s ability to fully engage in the health care system

- 33% Were unable to read basic health care materials
- 42% Could not comprehend directions for taking medication
- 26% Were unable to understand information on an appointment slip
- 60% Did not understand a standard informed consent

Impacts health outcomes

- Less likely to comply with prescribed treatment and self-care regimens
- Make more medication or treatment errors
- Fail to seek preventive care
- Are at a higher risk for hospitalization
- Remain in hospital longer
- Lack the skills needed to negotiate the health care system

Key areas for evidence-based action improving health literacy

Improve health communication
  Written health information
  Prescription drug labels
  Verbal & risk communication

Support patient involvement
  Patient centered care

Shared decision making
Shared decision making

Involving
the patient in making decisions
to the extent they desire

Partnering (health communication)
Sharing information (risk communication)
Deliberating (diagnosing preferences)
Making a decision (forming a care plan)
Decision aids are effective evidence-based interventions that promote shared decision making by clearly and accessibly presenting the available options and their relative advantages and disadvantages.
Decision aids

Systematic review of 100+ RCTs
Compared to usual care, decision aids

Increase patient involvement by ~30%
Increase patient knowledge of options by ~13%
Increase consultation time by ~3 minutes
Reduce decisional conflict by ~6%
Reduce % undecided by 40%

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

Stacey D et al. Cochrane review 2014
National Action Plan to Improve Health Literacy

Everyone has the right to health information that helps them make informed decisions

Health Literacy is part of patient-centered care

Universal precautions approach should be adopted

“Every encounter is at risk for miscommunication”

Department of Health & Human Services 2010
Current state of decision making

- Patient and clinician begin consultation
- Patient leaves with a prescription
- Patient makes decision about medication.
Current state of decision making

- Patient and clinician begin consultation
- Patient and clinician discuss medications
- Patient leaves with a prescription
- Patient makes decision about medication.

Patients leave office with understanding
80% Clinicians reported yes
37% Patients reported yes
Shared decision making

- Patient and clinician begin consultation
- Patient discusses medications
- Patient leaves with a prescription
- Patient makes decision about medication
Research Evidence

Enhance conversation
Address health literacy

Decision Aid

Patient Values Preferences

Within an exam room
Conversation not information

We design to support the interaction of people not the transfer of information

Designed for context

How that is done depends on the challenges of the medical and personal situation

Development is a partnership

The voice and experience of clinicians, patients, and caregivers is the impetus of development
Example: Depression medication choice

Funded by
AHRQ American Recovery & Reinvestment Act 2009
Innovative Adaptation & Dissemination of AHRQ CER Products
Developing encounter decision aids
A user-centered approach

Evidence synthesis

- Approval of stakeholders

Observations (clinical encounters)

Initial prototype

- Designers
- Study team
- Patient advisory groups
- Clinicians
- Stakeholders

Field testing

Modified prototype

- Approval of stakeholders

Final Decision Aid

Evaluation

- Practice-based RCTs
- Real life encounters

LeBlanc et al. Trials 2013
**What You Should Know**

- Will this medicine work for me?
  - The antidepressants presented in this decision aid all work the same for treating depression.
  - Most people with depression can find one that can make them feel better.
  - 6 out of 10 people will feel better with the first antidepressant they try and the rest will have to try other antidepressants before they find the one that is right for them.

- How long before I feel better?
  - Most people need to take an antidepressant regularly for at least 6 weeks to begin to get the full effect.

- Understanding side effects
  - Most people take some side effects, even with a good antidepressant.
  - Many side effects go away as you continue treatment, but some only go away with time.

**Sexual Issues**

Some people may experience loss of sexual desire (libido) or loss of ability to reach orgasm because of their antidepressant.

**Sleep**

Some people may experience sleepiness or insomnia because of their antidepressant.

**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.
Weight Change

Weight change is most likely to occur over a long period of time and depends on your actual weight.

LeBlanc et al. JAMA Int Med 2015
Summary of findings
C-RCT (10 practices, 117 clinicians, 301 patients)

Patients & clinicians
more comfortable with the decision made (>20% ↑)
more satisfied with the decision process (>30% ↑)

Patients
more knowledgeable (14% ↑)
more involved in the decision making process (50% ↑)
Voiced preferences (92%) and issues of importance (63%)
*No difference in adherence or in depression outcomes*

Clinicians
able to use decision making cards with no/little training
use of decision aid did NOT add to the length of encounter
**Additional observations**

**Preliminary results**

<table>
<thead>
<tr>
<th></th>
<th>Usual Care</th>
<th>Decision Aid</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inadequate literacy scores</strong></td>
<td>N=66</td>
<td>N=67</td>
<td>0.003</td>
</tr>
<tr>
<td>Knowledge scores</td>
<td>53%</td>
<td>60%</td>
<td></td>
</tr>
<tr>
<td>Decisional Comfort</td>
<td>72%</td>
<td>73%</td>
<td>0.8</td>
</tr>
<tr>
<td>The clinician checks that the patient has understood the information (OPT 8)</td>
<td>33%</td>
<td>36%</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Adequate literacy scores</strong></td>
<td>N=59</td>
<td>N=79</td>
<td></td>
</tr>
<tr>
<td>Knowledge score</td>
<td>48</td>
<td>58</td>
<td>0.01</td>
</tr>
<tr>
<td>Decisional comfort</td>
<td>76</td>
<td>82</td>
<td>0.01</td>
</tr>
<tr>
<td>The clinician checks that the patient has understood the information (OPT 8)</td>
<td>38%</td>
<td>44%</td>
<td>N/A</td>
</tr>
</tbody>
</table>
**Additional observations**

**In the clinical encounters**

<table>
<thead>
<tr>
<th>Description</th>
<th>Usual Care</th>
<th>Decision Aid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinician stated <strong>more than one option</strong></td>
<td>54%</td>
<td>81%</td>
</tr>
<tr>
<td>Clinician noted <strong>interactions/health considerations</strong></td>
<td>8%</td>
<td>40%</td>
</tr>
<tr>
<td>Clinician invited patient to <strong>choose issue</strong> of greatest salience</td>
<td>0%</td>
<td>63%</td>
</tr>
<tr>
<td>Patient <strong>voices a preference</strong> for treatment</td>
<td>69%</td>
<td>92%</td>
</tr>
<tr>
<td>Clinician <strong>voiced a preference</strong> for treatment</td>
<td>92%</td>
<td>95%</td>
</tr>
</tbody>
</table>
Diabetes medication choice

### Weight Change

<table>
<thead>
<tr>
<th>Daily Routine</th>
<th>Daily Sugar Testing (Monitoring)</th>
<th>Side Effects</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Low Blood Sugar</strong> (Hypoglycemia)</td>
<td><strong>Blood Sugar</strong> (A1c Reduction)</td>
<td><strong>Cost</strong></td>
<td><strong>Diet</strong></td>
</tr>
</tbody>
</table>

#### Metformin
- **Generic available**: Yes
- **Cost**: $0.10 per day
- **Availability**: $30 / 3 months

#### Insulin
- **Availability**: Yes
- **Cost**: $0.10 per day
- **Availability**: $30 / 3 months

#### Glitazones
- **Availability**: Yes
- **Cost**: $0.10 per day
- **Availability**: $30 / 3 months

#### Exenatide
- **Availability**: Yes
- **Cost**: $0.10 per day
- **Availability**: $30 / 3 months

#### Sulfonylureas
- **Availability**: Yes
- **Cost**: $0.10 per day
- **Availability**: $30 / 3 months

#### Gliptins
- **Availability**: Yes
- **Cost**: $0.10 per day
- **Availability**: $30 / 3 months

### Daily Routine

<table>
<thead>
<tr>
<th>Metformin</th>
<th>Insulin</th>
<th>Glitazones</th>
<th>Exenatide</th>
<th>Sulfonylureas</th>
<th>Gliptins</th>
</tr>
</thead>
<tbody>
<tr>
<td>AM, PM</td>
<td>AM, PM</td>
<td>AM, PM</td>
<td>AM, PM</td>
<td>AM, PM</td>
<td>AM, PM</td>
</tr>
</tbody>
</table>

#### Metformin
- **Side Effects**: None

#### Insulin
- **Side Effects**: 4 to 6 lb. gain

#### Glitazones
- **Side Effects**: More than 2 to 6 lb. gain

#### Exenatide
- **Side Effects**: 3 to 6 lb. loss

#### Sulfonylureas
- **Side Effects**: 2 to 3 lb. gain

#### Gliptins
- **Side Effects**: None

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Mullan et al. Arch Int Med 2009
Statin choice

- Tailored to patient’s characteristics
- Plain language
- Natural frequencies
- Visual presentation of estimates

Risks and benefits

Deliberation and decision making

Current Risk of having a heart attack
Risk for 100 people like you who do not medicate for heart problems

- Over 10 years
- 28 people will have a heart attack
- 72 people will have no heart attack

Future Risk of having a heart attack
Risk for 100 people like you who do take high dose statins

- Over 10 years
- 17 people will have a heart attack
- 72 people will have no heart attack
- 11 people will be saved from a heart attack by taking medicine
Summary of experience

Age: 20-92
74-90% clinicians want to use tools again
Adds <3 minutes to consultation
60% fidelity without training
20% improvement in patient knowledge
17% improvement in patient involvement
Variable effect on clinical outcomes and cost
Socio-demographic impact of DAs
Patient level meta-analysis of 7 RCTs & 771 encounters

Figure 1. General knowledge: mean difference between decision aid and usual care for general knowledge by sociodemographic factor; P value for interaction. CI indicates confidence interval.
Patients involvement
Patient level meta-analysis of 5 RCTs & 398 encounters

N=398

p=0.001

Mean Total OPTION Score (%) Adjusted

- All
- Chest Pain
- Diabetes
- Osteo I
- Osteo II
- Statin

Usual care
Decision aid

LeBlanc et al. in preparation
Rheumatoid arthritis choice
Low literacy medication guide and decision aid

166 patients (3 arms)
66% immigrants (66%)
54% non-English speakers
71% limited health literacy

Knowledge higher than usual care
(78% vs. 53%, OR 2.7 [95% CI 1.2-6.1]
Better) mean decisional conflict
No differences in acceptability

Funded by AHRQ American Recovery & Reinvestment Act 2009
Innovative Adaptation & Dissemination of AHRQ CER Products
Take home message

- Health literacy is a shared responsibility between patients (and loved ones) and clinicians; **let’s address it in the encounter**

- Health information (particularly with numbers) is hard for most to understand; **let’s not leave it be understood alone**

- Lowering burden to understand can help patients engage with clinicians and health care decisions; **what is needed at this point to make this decision**

- Health literacy enables individuals to make decisions and take actions; **undeveloped but promising research for encounter DA to reduce disparities/address health literacy**
LeBlanc.Annie@mayo.edu
@Annie_LeBlanc
http://shareddecisions.mayoclinic.org/
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SHARE@ahrq.hhs.gov
Questions about AHRQ’s SHARE Approach Program

Contact:

Alaina Fournier
alaina.fournier@ahrq.hhs.gov OR SHARE@ahrq.hhs.gov

Agency for Healthcare Research and Quality
Obtaining CME/CE Credits

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