Implementing Shared Decision Making in Varied Practice Settings

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- Learning network
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Presenters and moderator disclosures

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

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- Karen Sepucha, Ph.D., and Leigh H. Simmons, M.D. (Massachusetts General Hospital, Harvard Medical School)
- Lyle Fagnan, M.D., and Mark Remiker, M.A. (Oregon Rural Practice-based Research Network, Oregon Health and Science University)

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

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Learning objectives

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

1. Describe strategies for implementing shared decision making in health care organizations.

2. Identify potential challenges to implementing shared decision making and how to overcome them.

3. Explain steps that health care organizations should consider in deciding how to implement shared decision making.
Implementing Shared Decision Making in Specialty Care Settings: Challenges and Solutions

David Arterburn, M.D., M.P.H., FACP
Group Health Research Institute
Financial disclosure

- I have received research funding and salary support from the Informed Medical Decisions Foundation.
- I serve as a medical editor for the Informed Medical Decisions Foundation in the area of bariatric surgery.
- The Informed Medical Decisions Foundation is a nonprofit organization that received most of its early funding through partnership with HealthDialog, a for-profit health coaching and disease management company.
- As of 2014, the Foundation is a division of Healthwise, a non-profit patient engagement and health information technology company.
Group Health (GH)

- Large integrated health insurance and care delivery system in Washington and Idaho with nearly 600,000 patient members
- More than 1,300 salaried providers practicing in owned-operated clinics
- Contracts with more than 9,000 providers throughout the state
- In 2009, GH leaders began integrating patient decision aids and shared decision making processes into routine specialty care practice and committed significant organizational resources to support the work.

**Why did Group Health become interested in implementing shared decision making in specialty care?**
Unwarranted variation in many elective surgical procedures (e.g., knee replacement)
Shared decision making and decision aids are standard in Washington state

- **2007 Washington state legislation:**
  - Recognized the use of shared decision making along with high-quality patient decision aids as the highest standard of informed consent

- **2012 Washington state legislation:**
  - Authorized the Medical Director of the WA State Health Care Authority to certify high-quality decision aids (process in development)
IMPLEMENTATION

• System-wide
• Video-based patient decision aids
• 12 preference-sensitive conditions related to elective surgeries
‘How important is shared decision making?’

“No patient should undergo a preference-sensitive procedure without documented evidence that they got all the information they needed and then had a conversation with their provider in which their preferences were documented before they made their decision.”

“Nice to do if you have the time and inclination.”

GH leaders want to push us right over here!
The change strategy

Project managers with experience implementing practice changes were hired to carry out this work.

- Identify specialty leaders/champions
- Develop workflow with front-line providers
- Go live
- Frequent reporting process measures
- Ongoing check and adjust
How did we choose decision aids to implement?

Patient Decision Aids

A-Z Inventory of Decision Aids

Search all decision aids:  

Go

OR

Browse an alphabetical listing of decision aids by health topic.

The A-Z Inventory of Decision Aids is designed to help you find a decision aid to meet your needs. It contains up-to-date and available decision aids identified by the Cochrane Systematic Review Group that meet a minimal set of criteria.

More information about decision aid developers.

You may search for a decision aid using keywords or browse an alphabetical listing.

Note: The A to Z inventory is still under construction. Addition of other decision aids that meet the criteria is in progress.
Health Dialog: Knee Osteoarthritis

Patient Decision Aids

Decision Aid Summary

<table>
<thead>
<tr>
<th>Title</th>
<th>Treatment choices for knee osteoarthritis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Condition</td>
<td>Osteoarthritis</td>
</tr>
<tr>
<td>Type of Decision Aid</td>
<td>Treatment</td>
</tr>
<tr>
<td>Options Included</td>
<td>Lifestyle changes</td>
</tr>
<tr>
<td></td>
<td>Medications</td>
</tr>
<tr>
<td></td>
<td>Injections</td>
</tr>
<tr>
<td></td>
<td>Complementary therapy</td>
</tr>
<tr>
<td></td>
<td>Surgery</td>
</tr>
<tr>
<td>Audience</td>
<td>People with osteoarthritis of the knee whose symptoms that may cause difficulty with activities of daily living</td>
</tr>
<tr>
<td>Developer</td>
<td>Health Dialog</td>
</tr>
<tr>
<td>Where was it developed?</td>
<td><a href="http://www.healthdialog.com">www.healthdialog.com</a></td>
</tr>
<tr>
<td></td>
<td>Health Dialog</td>
</tr>
<tr>
<td></td>
<td>US</td>
</tr>
<tr>
<td>Year of last update or review</td>
<td>2005</td>
</tr>
<tr>
<td>Format</td>
<td>video, paper, DVD</td>
</tr>
<tr>
<td>Language(s)</td>
<td>English</td>
</tr>
<tr>
<td>How to obtain the decision aid</td>
<td>Members of Health Dialog receive updates of the Shared Decision-Making® videos at no charge. If you are not a member but are interested in learning about how you can purchase a video, please call 800-276-0993. Available here.</td>
</tr>
</tbody>
</table>

The IPDAS assessment of this decision aid indicates that it meets:

- 14 out of 15 of the content criteria
- 8 out of 9 of the development process criteria
- 1 out of 2 of the effectiveness criteria

IPDAS Checklist

<table>
<thead>
<tr>
<th>Content</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The decision aid describes the condition (health or other) related to the decision.</td>
<td>Yes</td>
</tr>
<tr>
<td>2. The decision aid describes the decision that needs to be considered (the index decision).</td>
<td>Yes</td>
</tr>
<tr>
<td>3. The decision aid lists the options (health care or other).</td>
<td>Yes</td>
</tr>
<tr>
<td>4. The decision aid describes what happens in the natural course of the condition (health or other) if no action is taken.</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Videos About Treatment Options

These patient education videos explain treatment or screening options for certain diseases and conditions. The programs aren't intended to be medical advice.

Your doctor may have referred you to a video to help you understand the pros and cons of your options. Not all of the options discussed here may be appropriate to your medical situation. Talk with your doctor; this information can help you take an active role in making treatment decisions with your doctor.

**Arthritis**
- Treatment Choices for Hip Osteoarthritis (45 minutes)
- Treatment Choices for Knee Osteoarthritis (54 minutes)

**Back Care**
- Chronic Low Back Pain (37 minutes)
- Acute Low Back Pain (26 minutes)
- Spinal Stenosis (36 minutes)
- Herniated Disc (39 minutes)

**Heart Disease**
- Treatment Choices for Coronary Artery Disease (51 minutes)

**Men's Issues**
- Benign Prostatic Hyperplasia (Enlarged Prostate) (39 minutes)

**Women's Issues**
- Treatment Choices for Uterine Fibroids (44 minutes)
- Treatment Choices for Abnormal Uterine Bleeding (32 minutes)

**Breast Cancer**
- Early Stage Breast Cancer: Choosing Your Surgery (54 minutes)
- Breast Reconstruction: Is It Right for You? (55 minutes)
- Ductal Carcinoma In Situ (DCIS): Choosing Your Treatment (54 minutes)
Electronic medical record supports decision aid delivery

There are 3 options for providing Shared Decision-Making (SDM) videos and booklets to patients.

**OPTION 1:** Order DVD and booklet to be mailed to patient’s home

**OPTION 2:** Add patient instructions to the AVS with information about the video and how to view it online

**OPTION 3:** Send a secure message to patients with information about SDM and viewing video online

From your In Basket, select Patient Msg to send a secure email to a patient with information about SDM and a URL to view the video on ghc.org.
More than 50,000 decision aids delivered since January 2009.
Process measure: ‘Defect measure’ shows fewer missed opportunities for decision aid delivery
96% OF 2,156 PATIENTS SURVEYED

Decision aid videos helped me understand my treatment choices
95% of 2,139 patients surveyed

Decision aid videos helped me prepare to talk with my provider
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
- Half-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
Large scale implementation of patient decision aids is feasible.
But I already DO shared decision making with my patients...

Of course it is totally up to you, but if it was me, I’d choose to have the surgery.
Qualitative provider interviews

- In-depth interviews with more than 60 GH specialists
- Benefits of decision aids outweigh minor concerns
- Patients are more informed
- Doesn’t take more time
- Some decision aids are more challenging to implement than others
- **However, many providers don’t see a difference between patient education and shared decision making**

“It has given me the impression that the people who have seen it are making better informed decisions... I think they’re more understanding... I’m more confident of their decision making.”
What impact does a decision aid have on patient knowledge for knee OA decisions?

(N=402)

<table>
<thead>
<tr>
<th>No Decision Aid</th>
<th>Received Decision Aid</th>
</tr>
</thead>
<tbody>
<tr>
<td>30.60%</td>
<td>43.70%</td>
</tr>
</tbody>
</table>

(0% to 100% range)
Percent Correct on Knowledge Items: All vs. TKR

- Exercise helps OA pain: 78% (All Respondents), 71% (Received TKR)
- Physical Therapy helps OA pain: 65% (All Respondents), 71% (Received TKR)
- Calcium does not help OA pain: 16% (All Respondents), 21% (Received TKR)
- OTC pain meds help OA pain: 59% (All Respondents), 60% (Received TKR)
- OA pain gets worse over time without TKR: 68% (All Respondents), 87% (Received TKR)
- 76 to 100 will have less pain after TKR: 38% (All Respondents), 58% (Received TKR)
- 5 out of 100 will have serious complications: 9% (All Respondents), 6% (Received TKR)
- Less than half will need repeat TKR by 20 yrs: 24% (All Respondents), 37% (Received TKR)
Figure. The Interdependence of Evidence-Based Medicine and Shared Decision Making and the Need for Both as Part of Optimal Care

- Optimal patient care
- Shared decision making
- Evidence-based medicine
- Patient-centered communication skills

Patient Decision Aids

Provider Training

Hoffman TC, et al, JAMA, 2014
Key conclusions

- Key factors that contributed to successful distribution of decision aids included:
  - Strong leadership and provider engagement
  - Financial support for decision aids
  - A well-defined implementation and monitoring strategy
  - Commitment to ongoing process improvement

- Despite the large volume of decision aids distributed, major challenges persist.
  - Many patients are still not receiving decision aids.
  - More decision aids are needed covering diverse topics to impact culture.
  - Large knowledge gaps exist among patients who receive decision aids.
  - Providers’ shared decision making skills and behaviors require ongoing training and support.
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Thank you

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Shared Decision Making
and the Patient Centered Medical Home

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Introductions

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Disclosures

- Dr. Sepucha receives salary support as a medical editor for Healthwise.
- Dr. Simmons has no relevant financial disclosures.
**Massachusetts General Hospital**

- More than 7,000 staff physicians and nurse practitioners
- 1.5 million ambulatory visits
- 41,000 surgeries
- 18 primary care practices
Right treatment to the right patient at the right time, every time.

Shared decision making program:
- Patient decision aids
- Clinician and staff training in shared decision making skills
- Health IT, measurement, and reporting
Use of decision aids at MGH

Top Programs:
1. PSA Testing
2. Advance Directives
3. Colon Cancer Screening
4. Knee Osteoarthritis
5. Insomnia

By the numbers:
- 22,000-plus decision aids distributed since 2005
- 500-plus orders a month
- More than 800 unique clinicians and staff have prescribed programs.
Some clinicians are very interested, but others rarely use decision aids.

The ordering system is very clinician-driven, but clinicians are busy and forget, and they might not always know what patients want.

Determining how to identify patients at decision points outside of visits

Determining the feasibility of decision aids used outside consultation; “closing the loop” challenge
Case 1: Clinician training

- Pilot project launched in 2005 at one practice, and in 2006, the project was spread to all 18 MGH adult primary care practices.

- Clinician-driven ordering of video/booklet decision aids, during the visit, supported by EMR, with centralized distribution through Shared Decision Making Center.

- Steady use (~100 orders a month). BUT not nearly what it could be; most orders are from a few physicians, and significant variation among clinics.
Designed training course

- One-hour session held during regular practice meeting
  - Overview of shared decision making (what, why, how)
  - Feedback: Usage data (practice and provider level) and patient and provider comments
  - View video decision aid
  - Discussion

- One-hour CME credit for physicians

- 15 out of 18 practices hosted course
Feedback from patients and providers

Patients love it and want more.

- "This helped me a lot, because I was and still feel a bit nervous, but will get checked! Thank you." (colorectal cancer screening)
- “Thank you very much for the Web site you sent me, I read its cath section with great interest. I understand the process better.” (Treatment Choices for Coronary Artery Disease before a diagnostic cardiac catheterization)

Providers are positive about the use.

- “Great for both high and lower functioning patients.”
- “This has completely changed my conversations with patients about their back pain—from one driven by fear to one focused on what we can do to help with their pain.”
- “The list of resources at the end of the anxiety program is helpful—one of my patients was lost with Google/Amazon and was so happy to have list to focus on.”
Impact and lessons learned

- More than doubling orders
- Comparative data is a strong motivator
  - Providers enjoyed a little competition!
- Physician champion role important
- Quarterly newsletter and biannual training
Case 2: Automating delivery of decision aids

- 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)
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?
Harnessing patients’ power!

- **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)
Interest: Providers are open to using more decision aids 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 programs (e.g., depression, anxiety, and insomnia).
Patient-triggered orders

- Number of PHQ-2 forms with plus screens was quite low (~5%), and only 19 programs ordered by patients.

- MAs began offering order forms to ALL annual visit patients, regardless of PHQ-2 questionnaire results.

- There were 203 mental health programs ordered (62 anxiety, 60 insomnia, 47 depression).

- We are now surveying patients to study the impact of decision aids on treatment decisions and outcomes.
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.
Reactions

- How are these cases similar/different to your own experiences?
- What else might help you conduct shared decision making more routinely?
- Documentation challenges?
- Other potential barriers?
What’s ahead for us?

- Expansion across Partners Healthcare (7 hospitals, 230 primary care practices)
- Funding and support as part of core initiative within Population Health Management
- Some new challenges: IT applications that work across four different EMRs, aligning incentives and quality measures
Thank you

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Integrating Shared Decision Making into Small and Rural Primary Care Practices

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Oregon Health & Sciences University
Dr. Fagnan and Mark Remiker have both received research funding and salary support from the Informed Medical Decisions Foundation.
ORPRN shared decision making activities

- Informed Medical Decisions Foundation (IMDF) Demonstration Site Program – 10 sites
- Milestone 7 in the Comprehensive Primary Care Initiative – 67 sites
- Leveraging Mobile Technology for mammography decision making (Mammopad) – three sites
- Patient Experience of Care Learning Collaborative (PELC) – six sites
The objective is to demonstrate that the use of patient decision aids and the process of shared decision making can effectively and efficiently become part of day-to-day care.
ORPRN: Decision aid usefulness ratings

Question: “How useful was the program in helping you prepare to talk to your healthcare provider?”
[not at all / somewhat / very / extremely]
Facilitators: Outside the clinic

- Patient buy-in for decision aids
- Sharing patient feedback (i.e., Patient Advisory Council)
- External Support through practice facilitation (ORPRN PERCs)
  - Implementation protocols
  - Distribution process
  - Interpretation of clinic level data reports

Script pad designed by Winding Waters
Patient Advisory Council
Shared Decision Making Toolkit

- Decision aid implementation guide
  - Using decision aids to facilitate shared decision making in routine care
  - Step-by-step guide based on lessons learned from our practices
  - Feedback from clinicians and staff
  - Ready-to-use resources

http://sdmtoolkit.org/
Comprehensive Primary Care Initiative

- Center for Medicare & Medicaid Innovation (CMMI)
- Seven regions, 38 unique payers, 42 practices, 2,600-plus clinicians, 2.7 million patients
- One in three practices with two or fewer practitioners

Source: Practice-reported progress at the end of 2014 (Q9)
Implement shared decision making in one priority area.

Select a decision aid that meets the criteria of an effective shared decision making tool.

Report on practice processes and workflow to support shared decision making.

Measure and document the implementation of shared decision making using decision aids.
Has the practice integrated the shared decision aid into clinical workflow?

Results are from a survey sent to CPC Oregon practices in August 2013.
Mammopad project

- Facilitated more effective involvement of women in making appropriate breast cancer screening decisions using a mobile decision aid (iPad).

- Decision aid utility was tested in age- and risk-appropriate women (between ages 40-49) recruited from three rural Oregon clinics, two of which were involved in CPCI.
The Mammopad decision aid

- Current facts and figures regarding breast cancer
- Personal Values
- Risks and benefits of screening (e.g., false positives, cost, pain)

Experts agree that women of average risk should be getting regular mammograms by age 50, but they don’t agree about starting at 40.

**When a Woman Has Breast Cancer, It Can...**

- **Grow Slowly**
  - Some cancers do not spread
  - Cancers that don’t spread are less likely to cause harm

- **Grow Quickly**
  - Some cancers do spread
  - Cancers that do spread are more likely to cause harm
**SIDE 1: General Facts**

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**MammoPad Information Summary**

*A review of the information you learned*

**The Biggest Risk Factor is Age**

Your risk of getting breast cancer increases with age.

- 5 out of 70 women between the ages of 40-49 with mammograms will be detected.
- 2 out of 70 women between the ages of 50-59 will be detected.

**Screening Results for Women in Their 40s**

*Mammograms aren’t perfect*

**1000 WOMEN**

- 995 women will be reassured that they don’t have breast cancer.
- 5 women will have a mammogram that finds something other than cancer.
- 1 woman will be diagnosed with breast cancer.
- 1 woman will have breast cancer that was missed.

---

**SIDE 2: Personal Information**

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**Mammography Decision Summary**

What matters most to me in deciding when to start mammograms on a regular basis.

**Benefits and Harms of Starting in my 40s**

- **Peace of mind (having a mammogram that shows no cancer)**
  - Possible Benefits:
    - Peace of mind
    - Catching cancer early
  - Possible Harms:
    - Extra tests and worry from false alarms
    - No improvement in length or quality of life
    - Unnecessary diagnosis

**My Concerns About Mammograms**

I am most concerned about:
- Not being able to have a mammogram because I do not have a doctor, getting transportation to my mammogram appointment

**My Questions**

- I would like to know more about breast density (thickness of breast tissue)
- Breast tissue is lumpy and hard to do your own exams

**My Plan**

I plan to have a mammogram before age 50.
## Implementation of Mammopad

<table>
<thead>
<tr>
<th>Implementation Step</th>
<th>Responsible Party</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Find target population</td>
<td>ORPRN</td>
</tr>
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<td>2. Patient recruitment</td>
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</tr>
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<td>3. Administer decision aid</td>
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<td>4. Scan report into patient’s EMR</td>
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</tr>
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<td>5. Engage patient in shared decision making</td>
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</tr>
</tbody>
</table>

- **Barriers**
  - Lacked staff involvement in workflows
  - Questionable sustainability

- **Successes**
  - High quality decision aid
  - Introduced shared decision making
  - Located above-average risk women
Patient Experience of Care Learning Collaborative

- Population: six clinics in rural Oregon
- Clinic teams: one administrative, one back office support staff (e.g., MA, Care Coordinator), provider, and patient partner
- Learning Collaborative consisted of three in-person meetings and three conference calls that used Boot Camp Translation method. Practices set QI goals and received monthly in-person visits from PERC over 10 months.
Clinic quality improvement goals

**Goal 1:** Provider and staff awareness

**Goal 2:** Patient engagement

**Goal 3:** Distribution of decision aids
GOAL 1: Provider and staff awareness

- One-hour in-person full staff meeting
- Academic detailing of shared decision making
- Questions and concerns from staff
GOAL 2: Patient engagement

- Displayed shared decision making promotional materials in exam room
- Displayed patient feedback data in the lobby
GOAL 2: Patient engagement

http://personcenteredcare.health.org/uk/
GOAL 3: Distribution of decision aids

- Picked a target population (Colon cancer screening)
- Located resources in EMR decision aids
- Distributed decision aids
Barriers to implementation

- Time
- Provider involvement and interest
- Patient engagement
- Accessibility of high quality decision aids
- Determining workflows
Successes

- Introduction of share decision making concepts to providers and staff
- Located high-quality decision aids in the EMR
- Engaged patients
- Created a workflow that allowed for seamless integration
Lessons learned, and the road ahead

- Shared decision making is hard to do!
- Successful implementation requires multiple, simultaneous changes to clinical workflow.
  - More than just assigning a patient to a decision aid
- Facilitation is helpful.
  - Setting shared decision making as a priority
  - Finding opportunities for overlap
- Patient involvement is helpful.
- This takes time.
Thank you

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Obtaining CME/CE Credits

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- SHARE@ahrq.hhs.gov

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