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KERUNIT
KNOWLEDGE AND EVALUATION RESEARCH

Implementing Shared Decision Making in Practice

Strategies and Pitfalls

Aaron Leppin, Victor Montori, Oscar Ponce-Ponte

Minimally Disruptive Medicine
Effective Care that Fits
September 29, 2016

What is SDM?

When you implement SDM
what are you trying to achieve?

At a minimum, achieving SDM requires:

1. The presentation of reasonable options } CLINICIAN WORK

2. The meaningful contribution of patients } PATIENT WORK

Creating a space that facilitates this work is key to implementing SDM

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What is a decision aid?

Can you achieve SDM without implementing a decision aid?

Can you implement a decision aid without achieving SDM?

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Consider the clinical management of cardiovascular risk…

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CVWizard - Optional Treatment Suggestions

Feedback | **Provider** | Patient

MRN [redacted] **Age:** 53 **Gender:** F **Date:** 6/15/2012 **10 Year CV Risk:** 17.8%

Chronic Conditions: Diabetes, Coronary Heart Disease, Cardiovascular Disease

Measure:	LDL (mg/dl)	HDL	TRIG	BP1 (mm Hg)	BP2 (mm Hg)	A1c (%)	Cr (mg/dl)	eGFR (std)
Value:	88	69	121	132/84	132/68	7.7	0.62	>60.0
Date:	[redacted]			[redacted]		[redacted]		
Goal:	<= 69 mg/dl			<= 139/ 89		<=7.9		

Lipids

Priority 3

Absolute CV Risk Reduction: 3%

Current Lipid Meds: GEMFIBROZIL , ROSUVASTATIN

Safety Alerts:

- Combination lipid therapy for LDL lowering has not been proven to be more beneficial than statin therapy alone for most patients.
- The combination of gemfibrozil and statins is contraindicated.

Treatments to Consider:

- The patient's LDL is above goal. Consider intensifying statin therapy (increase dose of existing statin or prescribe a more potent statin).

Blood Pressure

Absolute CV Risk Reduction: 0%

Current BP Meds: METOPROLOL , LISINOPRIL

Treatments to Consider:

- The recommendations are based off a BP reading prior to todays. Treatment recommendations do not take into account pharmocological action since that date.

Glucose/A1c

Absolute CV Risk Reduction: 0%

Current Blood Sugar Meds: GLIPIZIDE , METFORMIN

Comments:

- Urine protein screening is recommended annually. Consider ordering UMACR.

BMI: 30.6

Priority 2

Absolute CV Risk Reduction: 5%
(based on a 3 unit drop in BMI)

- Discuss advantages of reducing weight by 10-20 lbs. Weight loss programs may be helpful, and are available in the community or through HP Nutrition Services (952-967-5120) or by visiting www.healthpartners.com/public/health/.

Smoking: YES

Priority 1

Absolute CV Risk Reduction: 13%

- Tobacco use is identified. Ask about interest in quitting. If interested, offer the following: 1) prescribe medication such as varenicline (Chantix), buproprion (Zyban), or nicotine replacement (e.g. nicotine patch, gum, lozenge, or inhaler). 2) Arrange counseling proactively. Type "HealthPartners" under orders, or the patient may call 1-800-311-1052.

Asprin or Blood Thinner Use: YES

Absolute CV Risk Reduction: 0%

- Aspirin is recommended for patients with coronary heart disease.

Print | Print All

Close

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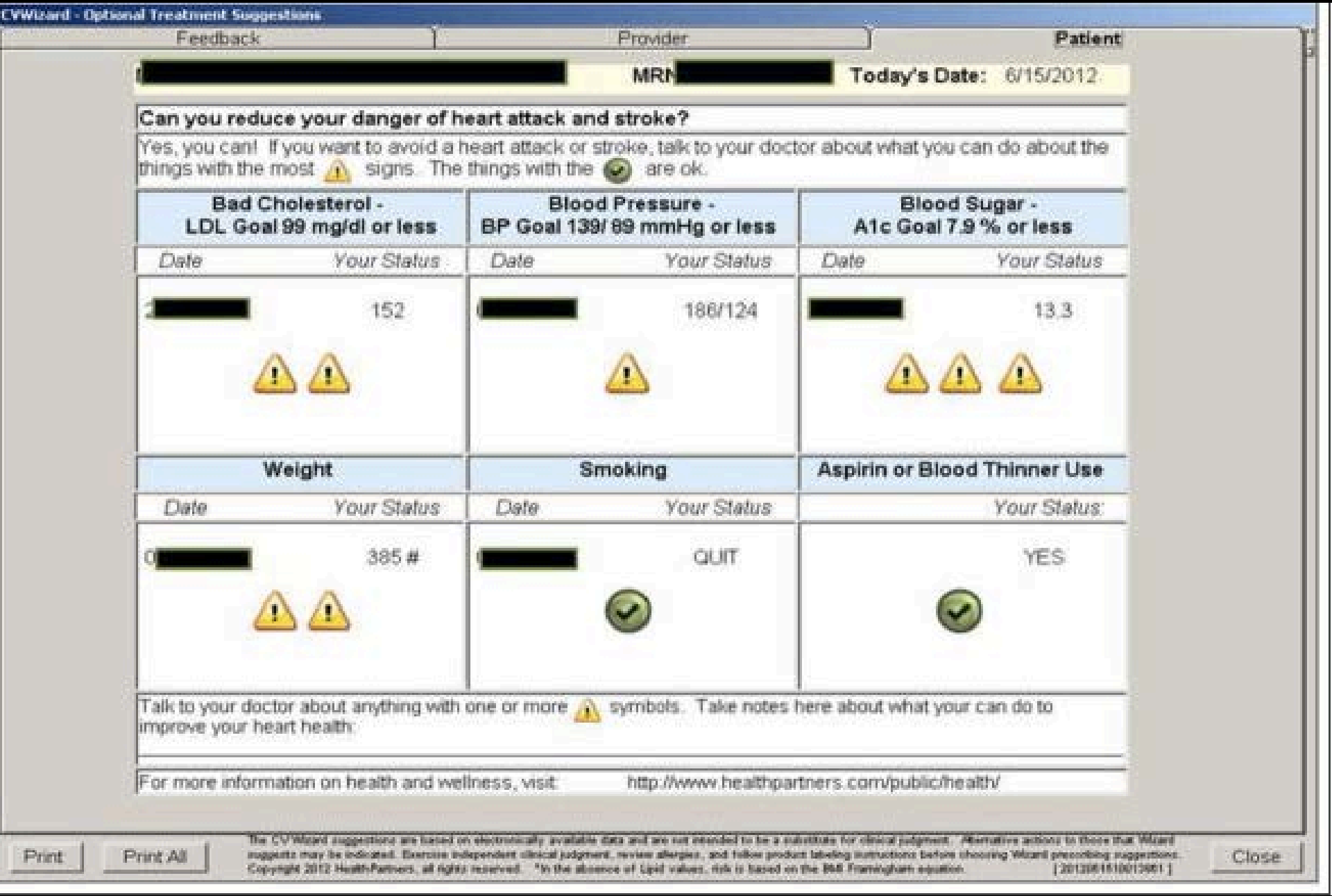
O'Connor, Curr Diab Reports, 2013



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O'Connor, Curr Diab Reports, 2013

CV Wizard

- Is this a useful tool?
- Is it a decision aid?
- Does it lead to SDM?
- Why or why not?

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The Statin Choice Decision Aid

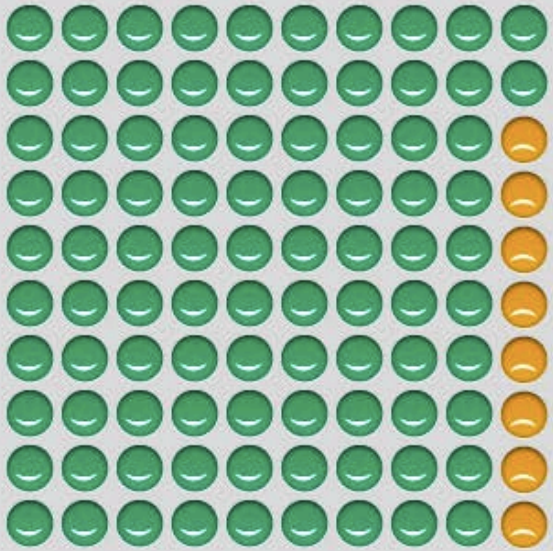
Current Risk | Intervention | Issues | Notes | Document

Benefits vs Downsides according to my personal health information

Using ACC/AHA ASCVD Risk Calculator

Current Risk
of having a heart attack

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



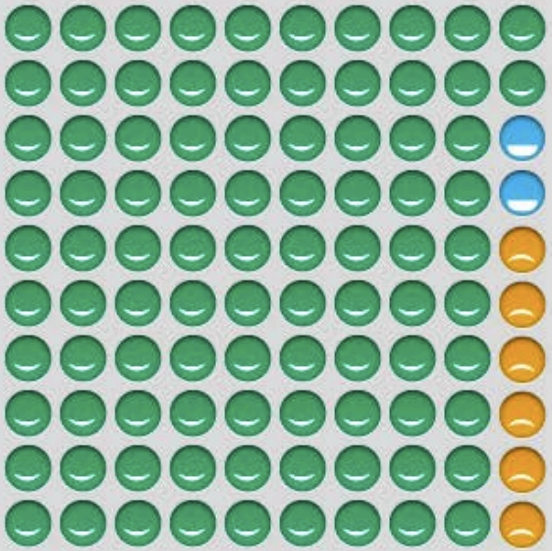
Over 10 years

8 people will have a heart attack

92 people will have no heart attack

Future Risk
of having a heart attack

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



Over 10 years

6 people will have a heart attack

92 people will have no heart attack

2 people will be saved from a heart attack by taking medicine

Statin Choice

- Is this a useful tool?
- Is it a decision aid?
- Does it lead to SDM?
- Why or why not?

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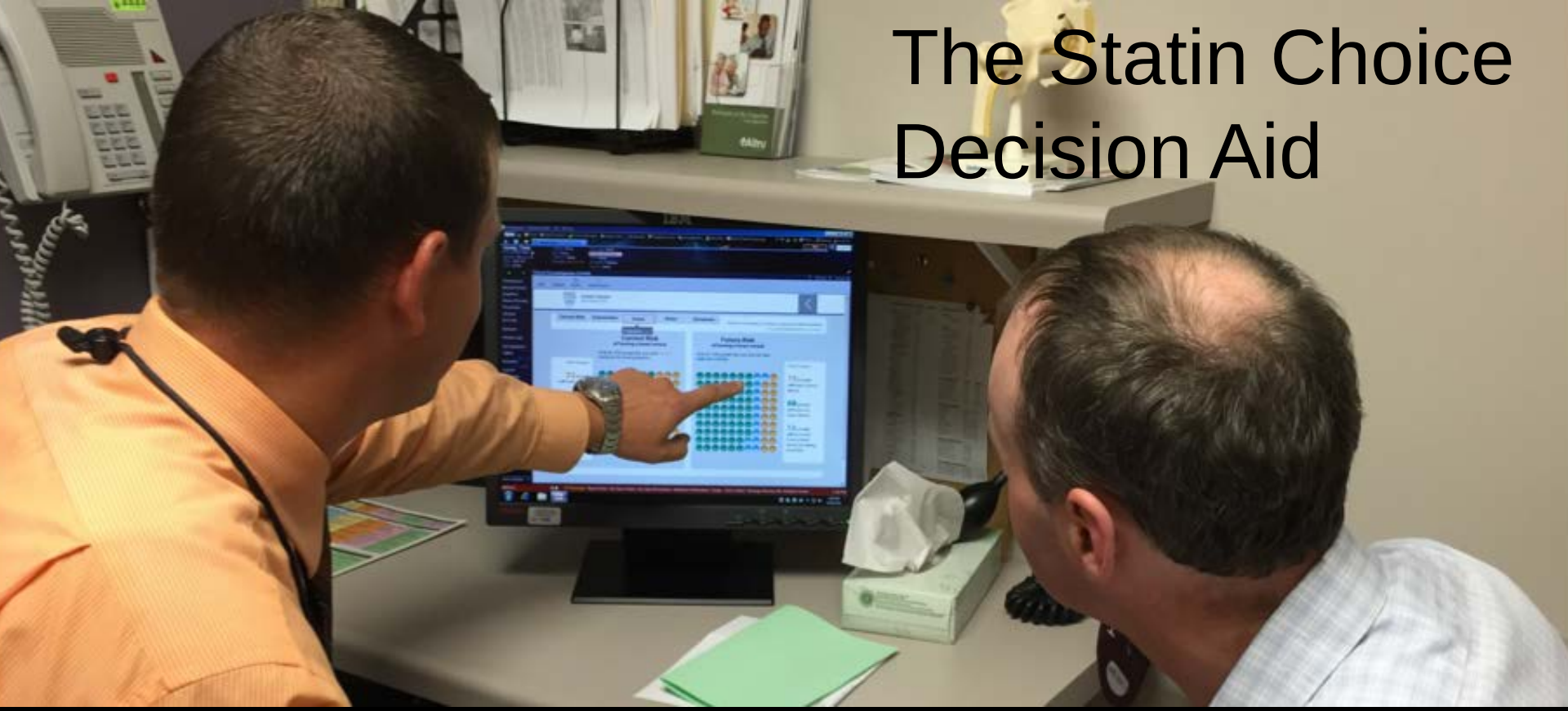

The Statin Choice Decision Aid

- Developed through user-centered design
- Proven in RCTs to make SDM happen
- Well accepted by patients and clinicians
- Can be implemented with high fidelity

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Information-giving, decision support tools, and even decision aids

$\neq$ SDM

A useful decision aid makes it easier to do SDM.

A useful decision aid makes it easier to implement SDM.

First rule of SDM implementation: use a decision aid that is designed and proven to achieve SDM

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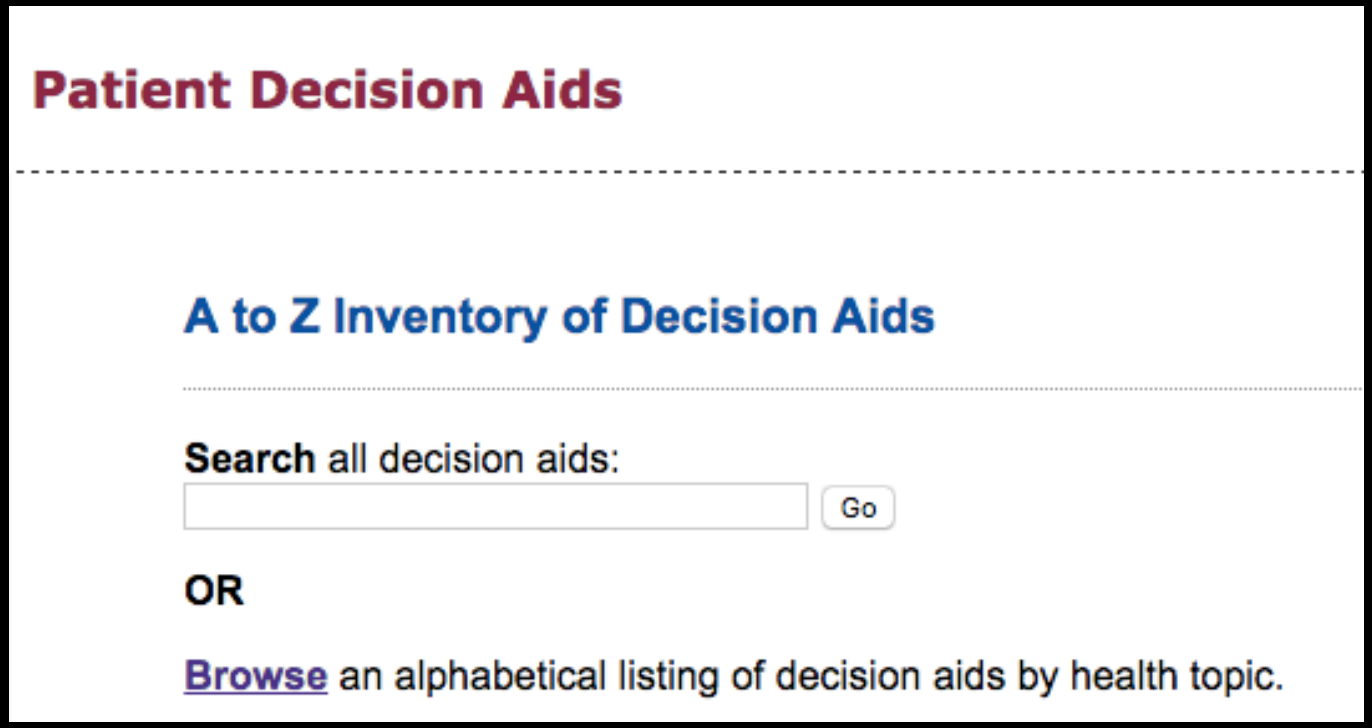
decisionaid.ohri.ca/azinvent.php



In picking your decision aid, look at **"IPDAS"** criteria, primary studies for **design**, **delivery** method, **outcomes**!!!

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Patients, clinicians, and decision aids do the work of SDM.

The next level of implementation is up to you and your team.

1. Making sense; aligning beliefs
2. Engaging others; enrolling support
3. Organizing and performing tasks
4. Modifying, appraising, reflecting

The things you do to do THIS work are called “implementation strategies.”

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May CR, Imp Sci, 2009

Adapt and tailor to context

Change infrastructure

Develop stakeholder interreleationships

Provide interactive assistance

In picking your implementation strategies, consider the intervention, as well as the culture, priorities, resources, and norms of your organization. You will want to bundle strategies!

Support clinicians

Train and educate stakeholders

Engage consumers

Use evaluative and iterative strategies

Utilize financial strategies

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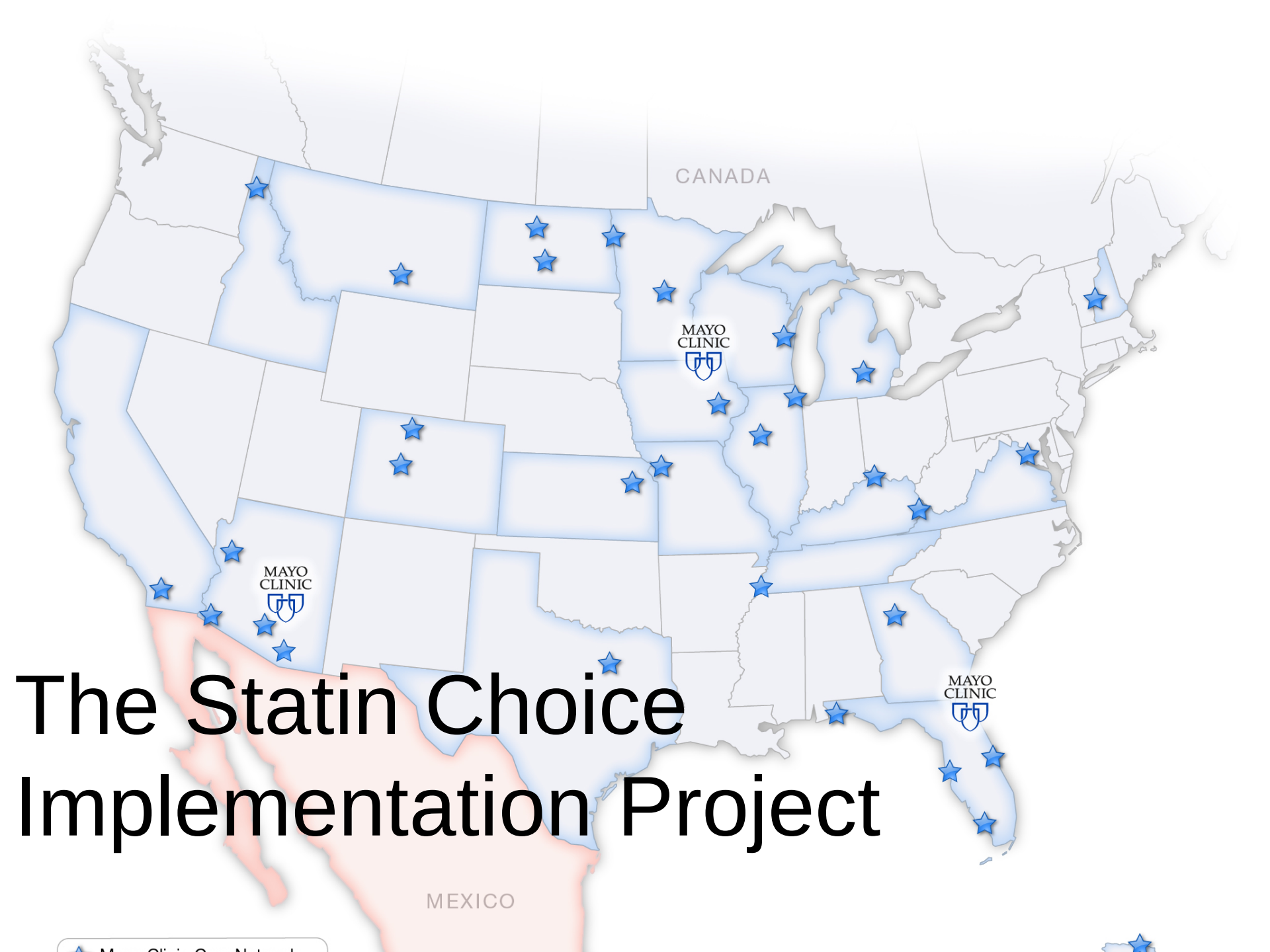
Powell, Imp Sci, 2015



The Statin Choice Implementation Project

Goal: Integrate the Statin Choice Decision Aid into the routine clinical practice and workflow of all primary care clinicians across a health system within 6 months.

What do you do?

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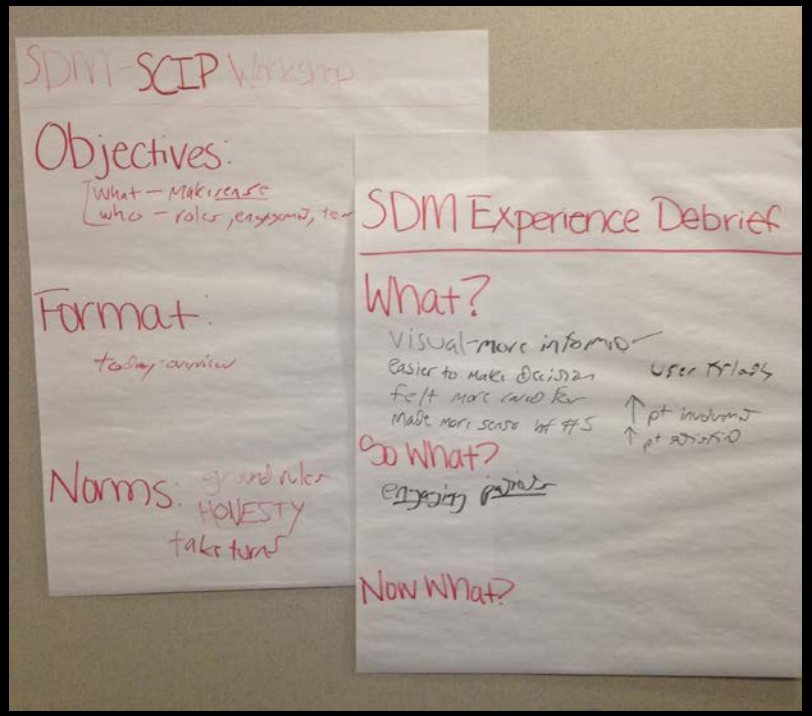
Assess, Assess, Assess!!!

1. Observations, interviews, surveys
2. Implementation team workshop
3. Normalization Process Assessment



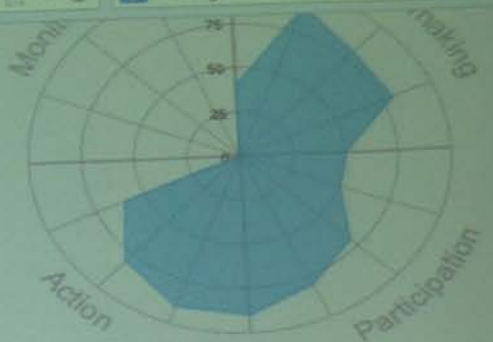
Normalization Process Assessment

Calendar | The SHARE Approach | Ag... | Demo Statin and Aspirin C... | NPT Toolkit - Normalizati...

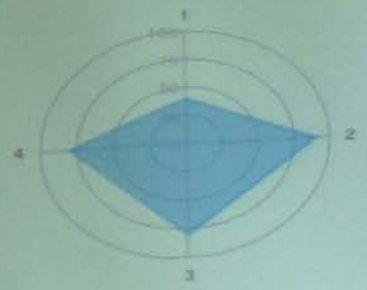
www.normalizationprocess.org/npt-toolkit.aspx

Results

The Radar Plots show the strength that you have assigned to each variable. Use them as heuristic tools to think through an implementation or integration process. Positive responses extend further out from the centre than negative ones. Look for areas where the responses are closer to the centre. These may tell you that participants cannot make sense, or have not signed up to the innovation. Perhaps they cannot enact it in a way that works for them, or cannot assess its effects and their value. If the responses are positive, the opposite may be true.

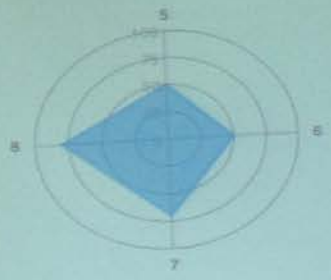


Sense-making



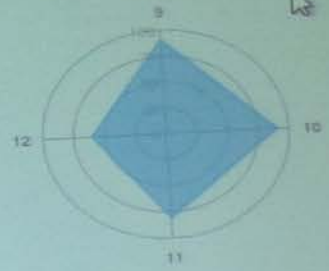
1. Participants distinguish the intervention from current ways of working.
2. Participants collectively agree about the purpose of the intervention.

Participation



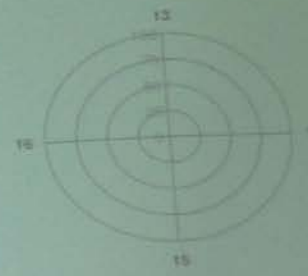
5. Key individuals drive the intervention forward
6. Participants agree that the intervention should be part of their work.
7. Participants buy in to the intervention.

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.

Monitoring



13. Participants access information about the effects of the intervention.
14. Participants collectively assess the intervention as worthwhile.
15. Participants individually

Choose What I Share

improve your experience.

System 1
"organic, we're good"

- **Structure:** 86 PCPs spread over rural region; isolated
- **Culture:** teamwork, patient first, clinician-led
- **Priorities:** better integration, world-class care
- **Team:** personal familiarity, "friendly," ex-CEO is "physician champion"
- **Perceived strengths:** IT powerhouse, cultural fit with SDM
- **Perceived barriers:** "organic, we're good; process, not so good," CV wizard in place

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System 2
"educate, that's what we do"

- **Structure:** 84 PCP's across region, integrated
- **Culture:** consumer/market-driven; leadership-directed; hierarchical; tense; proud innovators
- **Priorities:** access/market share, innovation, patient activation
- **Team:** mechanical, business-like, unengaged
- **Perceived strengths:** history of implementation successes, process in place, resources committed, strong IT, learning environment
- **Perceived barriers:** poor cultural fit, disengaged team, low priority

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System 3
"we're changing to something bigger"

- **Structure:** 32 PCPs at single referral site
- **Culture:** growing into regional referral center; independent; developing identity
- **Priorities:** improving patient engagement, capacity and access, image
- **Team:** engaged physician champion, never worked together
- **Perceived strengths:** small, intimate
- **Perceived barriers:** EMR, independent and paternalistic physicians

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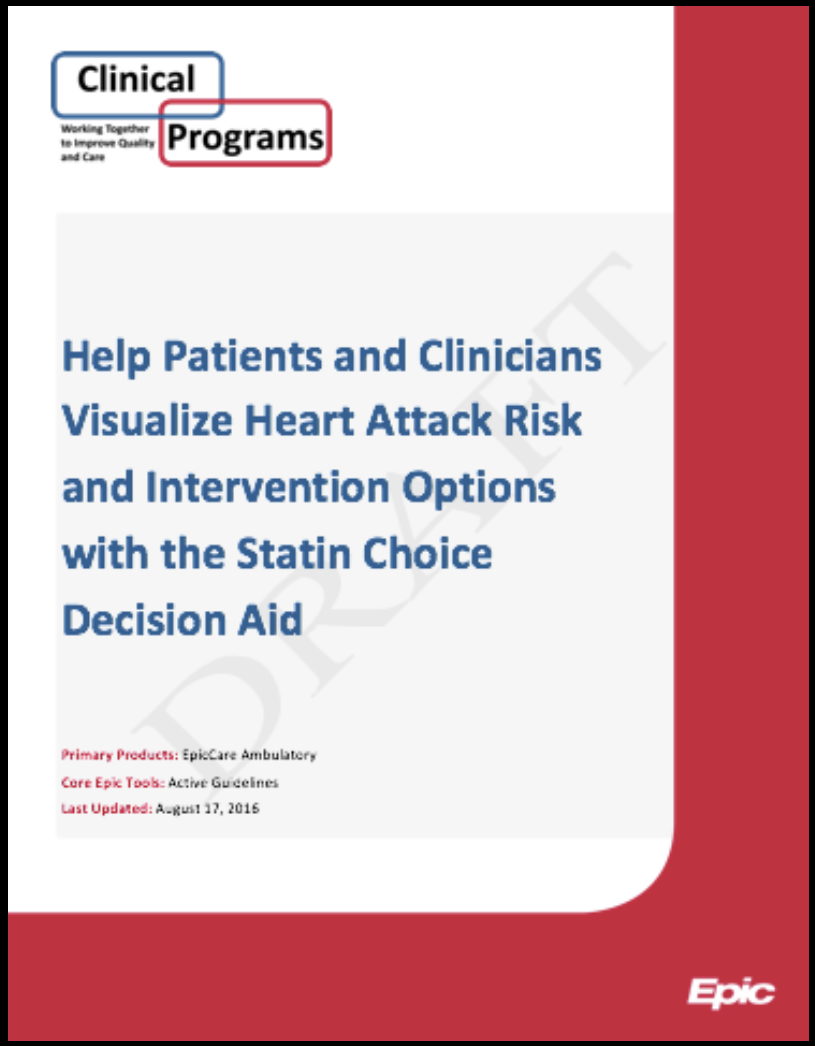
	System 1 ("organic")	System 2 ("educate")	System 3 ("changing")
Organizational Maturity	+++	+++++	+
Communication Capacity	++	++++	+++++
Cultural Fit and Compatibility	+++	+	+++++
Team Appropriateness	++++	++++	++++
Leadership Commitment	++	+++	++++
Available IT Capacity	+++++	++++	+
Implementation Experience	++	+++++	++

System 1
"organic, we're good"

- IT was strength; achieved full integration in Epic, but took time
- Had no process for education after go live; no communication to outlying clinics
- Team did not meet regularly; little front-line engagement
- We wrote letter on behalf of physician champion



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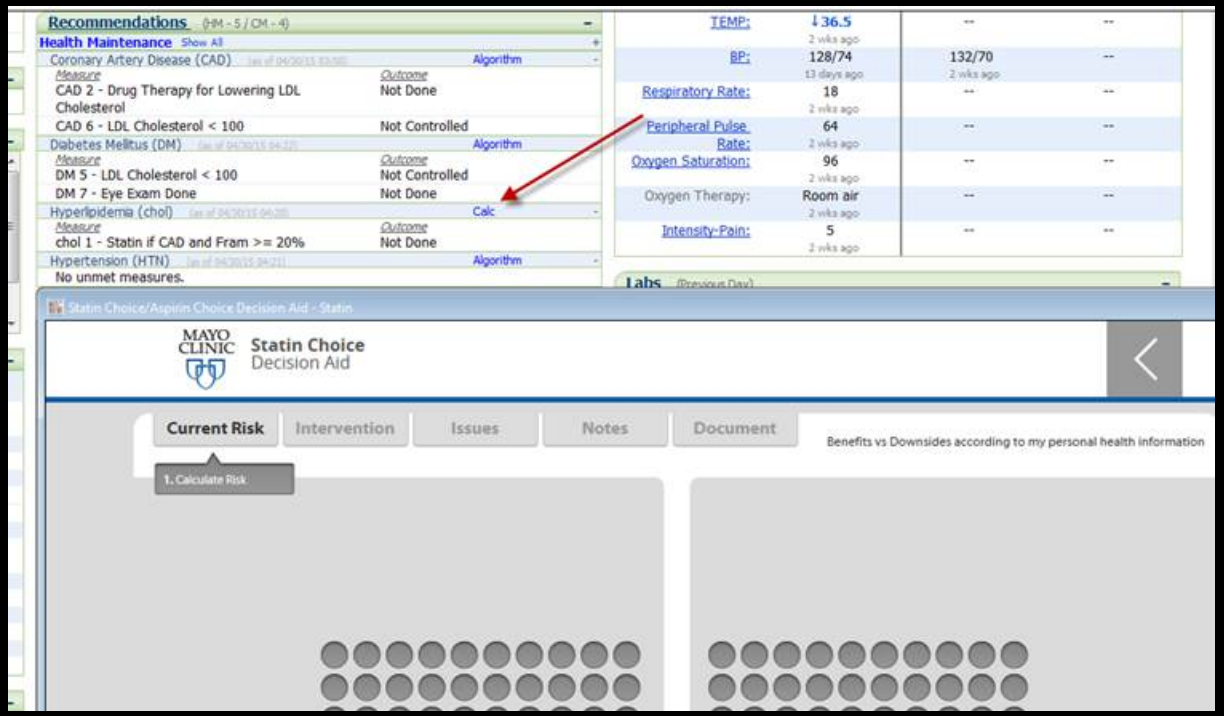
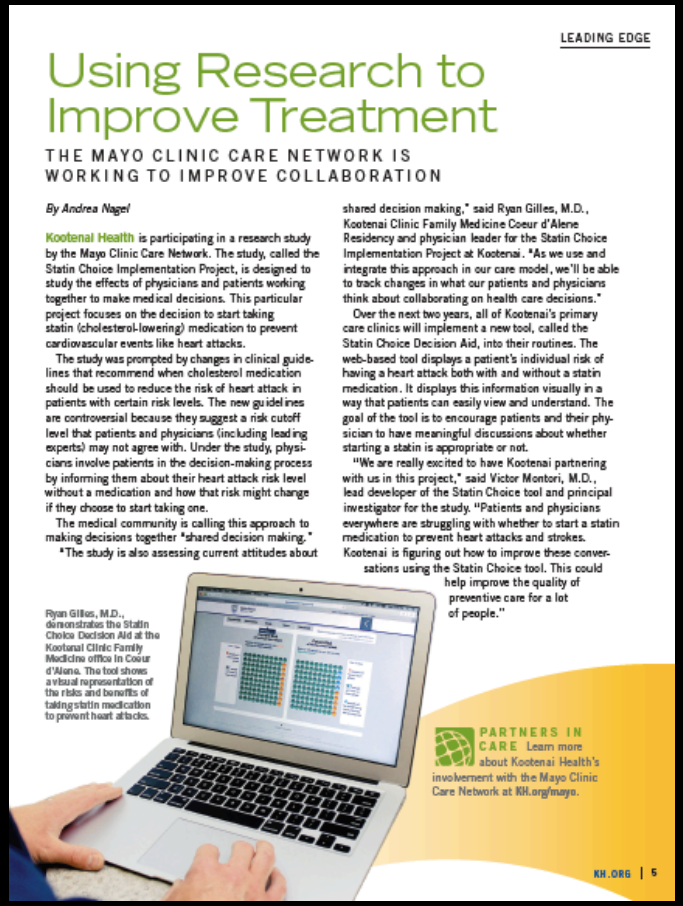
System 2
"educate, that's what we do"

- Reluctant participants at leadership level, but had legacy system and process that was very effective.
- IT integration followed by instructional video, provider meetings, "at the elbow support."



System 3
“we’re changing to something bigger”

- Highly motivated team; prioritized intervention into routine well visits. Small size made saturation easier.
- Leadership highly engaged, competitive; promoted internally through communications team.
- Failure to achieve IT integration had opportunity costs that might not have been acceptable in more mature organization.



LEADING EDGE

Using Research to Improve Treatment

THE MAYO CLINIC CARE NETWORK IS WORKING TO IMPROVE COLLABORATION

By Andrea Nagel

Kootenai Health is participating in a research study by the Mayo Clinic Care Network. The study, called the Statin Choice Implementation Project, is designed to study the effects of physicians and patients working together to make medical decisions. This particular project focuses on the decision to start taking statin (cholesterol-lowering) medication to prevent cardiovascular events like heart attacks.

The study was prompted by changes in clinical guidelines that recommend when cholesterol medication should be used to reduce the risk of heart attack in patients with certain risk levels. The new guidelines are controversial because they suggest a risk cutoff level that patients and physicians (including leading experts) may not agree with. Under the study, physicians involve patients in the decision-making process by informing them about their heart attack risk level without a medication and how that risk might change if they choose to start taking one.

The medical community is calling this approach to making decisions together "shared decision making."

"The study is also assessing current attitudes about shared decision making," said Ryan Gilles, M.D., Kootenai Clinic Family Medicine Coeur d'Alene Residency and physician leader for the Statin Choice Implementation Project at Kootenai. "As we use and integrate this approach in our care model, we'll be able to track changes in what our patients and physicians think about collaborating on health care decisions."

Over the next two years, all of Kootenai's primary care clinics will implement a new tool, called the Statin Choice Decision Aid, into their routines. The web-based tool displays a patient's individual risk of having a heart attack both with and without a statin medication. It displays this information visually in a way that patients can easily view and understand. The goal of the tool is to encourage patients and their physician to have meaningful discussions about whether starting a statin is appropriate or not.

"We are really excited to have Kootenai partnering with us in this project," said Victor Montori, M.D., lead developer of the Statin Choice tool and principal investigator for the study. "Patients and physicians everywhere are struggling with whether to start a statin medication to prevent heart attacks and strokes. Kootenai is figuring out how to improve these conversations using the Statin Choice tool. This could help improve the quality of preventive care for a lot of people."

Ryan Gilles, M.D., demonstrates the Statin Choice Decision Aid at the Kootenai Clinic Family Medicine office in Coeur d'Alene. The tool shows a visual representation of the risks and benefits of taking statin medication to prevent heart attacks.

PARTNERS IN CARE Learn more about Kootenai Health's involvement with the Mayo Clinic Care Network at KH.org/mayo.

KH.ORG | 5

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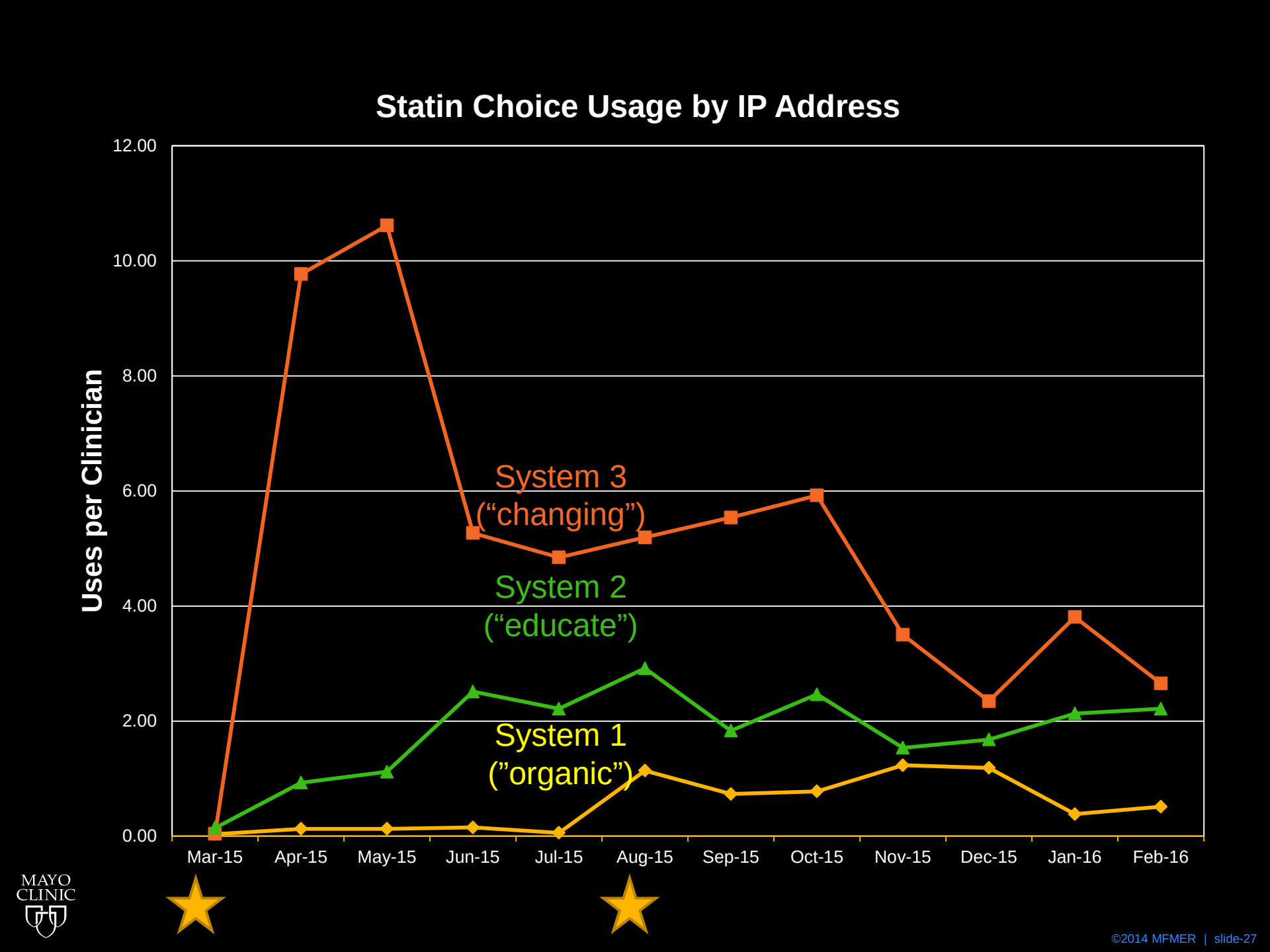

What did we learn?

- IT integration is technically straightforward, but delays with programmer bandwidth, vendors/privacy
- SDM will never be an organization's top priority
- Culture is nice, process and communication is critical (especially in large systems)
- Education is straightforward and required, in-person follow-up ideal
- If you build it, they can come…but they won't necessarily
- Fidelity appears to be high, but statin choice alone does not a culture change make

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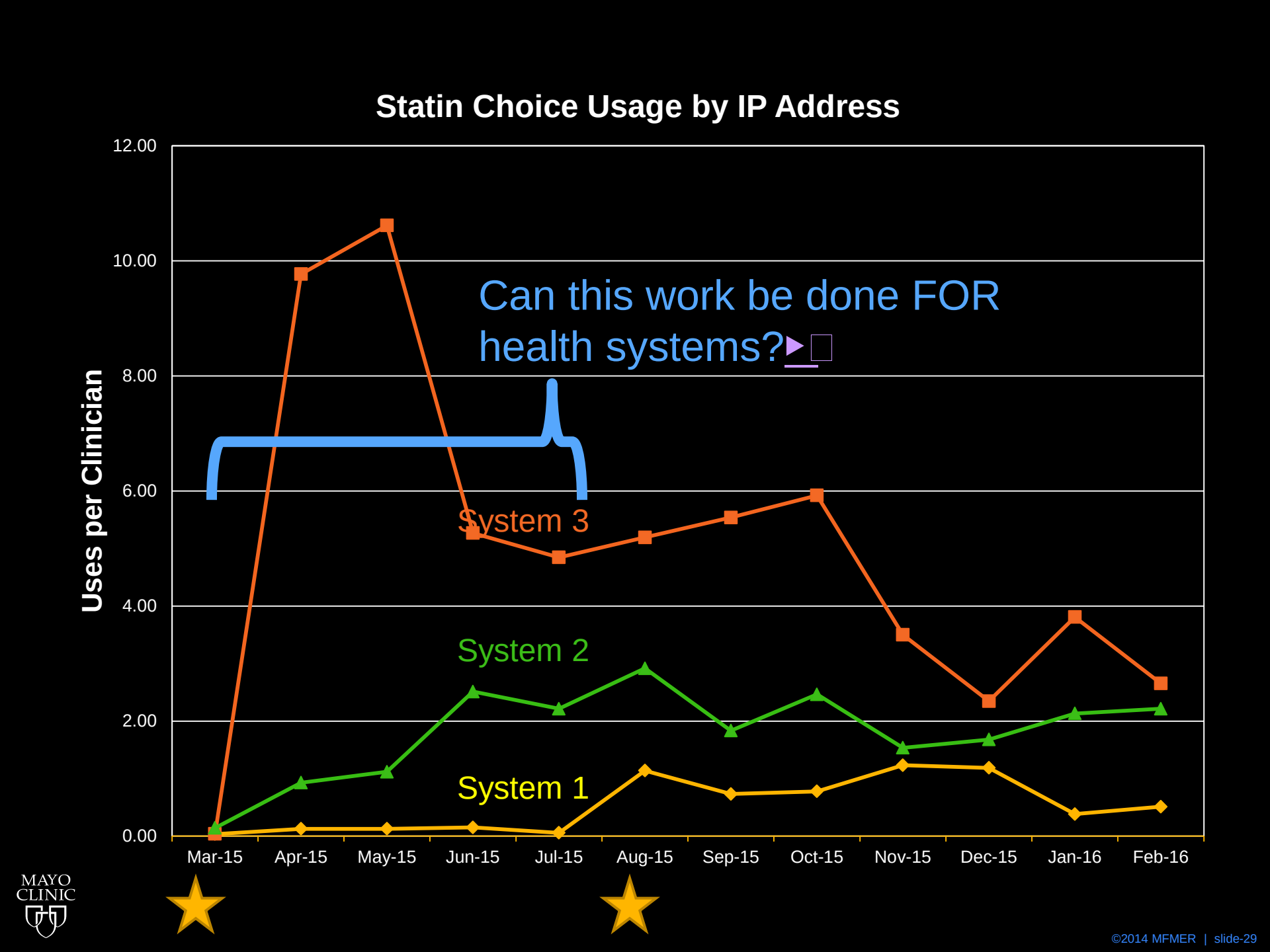

Questions & Discussion

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