Disclosures

– Informed Medical Decisions Foundation/Healthwise

– New England Research Institute
Our Journey to
Shared Decision Making

• Why did we go there?
• How did we get there?
• Where are we going?
Mr. M’s Story
Mr. M’s Story

• 71yo man referred to orthopedics
• Progressive right hip pain (rated 5/10) over past 2 years
• X-ray: Severe degenerative changes of both hips, right >> left
• Orthopedic surgeon: “I went over in some detail different treatment options. He very much wishes to proceed with right THR.”
Mr. M’s Decision Process

• Talked with friends and family who had joint replacement surgery
• Returned to his internist for pre-op clearance
• Internist prescribed a video decision aid: Treatment Options for Hip Osteoarthritis
Mr. M’s Letter

Massachusetts General Hospital
Yawkey Center for Outpatient Care
55 Fruit Street, Suite 3700
Boston, Massachusetts 02114

Dear Dr. [Name]

Re: Hip Replacement Surgery

I am writing to tell you that at this time I will not be proceeding with my right hip replacement procedure. Therefore, will you please cancel my appointments for pre-admission testing on July 12, 2005, and for surgery on July 28, 2005.

About six months ago I added daily biking to my exercise routine and after three months found that the nighttime hip pain was gone. When I saw you in May, I was not sure if this important change to my life style would hold. It has so far.

Based on a conference with Dr. [Name] my primary care physician, and on a viewing of the very helpful information on a DVD that he prescribed (Treatment Choices for Hip Osteoarthritis), sent to me by Massachusetts General’s Patient and Family Learning Center, I have decided that waiting for the surgery is the best decision.

Thank you for your help and patience.

With kind regards.
A Near Miss?

• Certainly not a bad outcome, but:
  – Could Mr. M have received information and education earlier in process?
  – Could we have assessed his preferences better?
  – Did he see the orthopedist at the “right time”?
  – Do our current systems of care support patient values and preferences adequately?
SDM at MGH

• Early work in shared decision making began with Drs. Al Mulley and Michael Barry, of our General Medicine Unit

• First video decision aid produced by IMDF in 1990; “Treatment Choices for Benign Prostatic Hypertrophy”
SDM at MGH

• Getting decision aids into practice, though, took a while
• In 2005, IMDF sponsored demonstration site at MGH to implement decision aids in routine practice
• Began small, in one engaged primary care practice, and grew from there
MGH Shared Decision Making Program

Goal: The right treatment, for the right patient, at the right time, ... every time.

To achieve this we have been working to build:

1. Informed, engaged patients
2. Receptive culture
3. Infrastructure and resources

SDM Connections within MGH

PrOE: Procedure order entry tool for elective surgery

Quality improvement bonus

Care redesign teams

Research and innovation grants

Blum Patient and Family Learning Center Education sessions for patients, community and staff
Implementation: Secrets to Success

• Engaging clinicians early
• Making the process easy
• Buy in from leadership
• Continued feedback to clinicians
• IT systems support
• A culture ready for “changing the conversation” with patients
Shared Decision Making Program at Mass General

- Primary care clinicians can order decision aids (DA’s) through the patient’s electronic medical record
- Informed Medical Decisions Foundation-produced DAs
- 40 programs available; variety of conditions relevant to adult primary care
Is a PSA Test Right for You?

Prostate Cancer Deaths
African American Men

Chapter List

3. Tests for Prostate Cancer
4. Treatment Choices
5. The Pros and Cons of Testing

Related Links

Download Booklet (PDF)
“Prescription” of Decision Aids

- Clinician determines patient is eligible for SDM program and *discusses with patient*
- Clinician “prescribes” program through the electronic medical record (EMR)
- Program sent to patient by MGH Health Decision Sciences Center; by mail or by web link
- Note automatically created in the EMR documenting that program was sent
Prescribing decision aids

1. Sends email to MGH Health Decision Sciences Center to mail program to patient
2. Prints 1-page description for patient
3. Automatically creates visit note

1. Sends email to MGH Health Decision Sciences Center to mail the web link of the program to patient
2. Prints 1-page description for patient
3. Automatically creates visit note

1. Allows patient to pick-up program from the Blum Center
2. Prints 1-page description for patient
3. Automatically creates visit note

Displays 1-page description of program
Use of decision aids

- 18,000+ decision aids distributed to date
- 730+ unique clinicians and staff have ordered programs

Top programs:
1. PSA screening
2. Advanced directives
3. Colon cancer screening
4. Diabetes
5. Chronic low back pain
Clinician Reaction

• Overall, very receptive
• More likely to prescribe programs if they have watched a program
• Specialists also supportive; the case of Mr. M didn’t sink us
• In fact, has led to further collaboration with orthopedics
The Rest of the Story: Mr. M

• 2 years later, hip pain became more bothersome and he wanted surgery
• Underwent total hip replacement by original orthopedist
• Good relief of pain and improvement in function
Aligning with Change: The Patient Centered Medical Home
Primary Care Practice Changes

• Our primary care practices are undergoing practice transformation, aiming for NCQA certification as patient-centered medical homes

• I work in one of these practices

• *Change is hard*

• How could shared decision making efforts help us?
c. Partner with patients in formal and informal decisionmaking. Shared decisionmaking is a formal process in which patients review evidence-based decision aids to understand the likely outcomes of different treatment options; discuss with a health care provider what is personally important to them about the risks and benefits of different options; and then decide how to proceed, in collaboration with and actively supported by providers. Informally, providing evidence-based information, discussing the pros and cons of different options, asking about patient preferences, and collaborating in decisions can improve a variety of health care decisions.
Practice Transformation

• Some challenges unique to academic medical center practices
  – Patients more complex
  – Patients from wide geographic area
  – Trainees
  – Part-time clinicians (and increased reliance on team)
Practice Transformation

• **Increasing focus on:**
  – Team-based care
  – Rapid-cycle process improvement
  – Management of high-risk, complex patients
  – Patient-centered care innovations

• **SDM is an ideal tool to move forward many of these efforts**
Tools for the PCMH Toolbox

- Point-of-care decision aids (print and online)
- Patient-initiated decision aids (online resources)
- Team-based use of SDM tools
- Enhancing specialty referrals with decision aids
In-Office Tools

• Limitations to using comprehensive video decision aids
  – May not have opportunity to “close the loop” with patients after they view program
  – Many patients do not complete the viewings, on DVD or on web
  – Only a select number of conditions
  – Costly to produce and distribute

• Paper or web tools used in the office may come in handy for many decisions
CHOICE REPORT: High Cholesterol

1. What’s the issue?  
   Your cholesterol level is high: ____________  
   Your target cholesterol level: ____________

2. Why is that a problem?  
   High cholesterol can increase your chances of heart attack, stroke, and death.

3. There are options for treating high cholesterol. Circle options you want to talk about. Your clinician may circle some too.

<table>
<thead>
<tr>
<th>TREATMENT OPTIONS</th>
<th>Frequently Asked Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>What are some reasons to choose this option?</td>
</tr>
</tbody>
</table>
| No treatments at this time | It is easy to make no changes at this time. | For many, higher chance of having a problem. | No changes to what you are doing now.  
Your clinician may request a follow-up visit. | No changes are being made. |
| Diet & Exercise | If you made changes, you could lower your chance of having a problem. | It might be hard to make these changes.  
Diet & exercise might not be enough to reach target cholesterol. | Change diet: limit high fat foods, red meats.  
Exercise at least 30 minutes most days. | Until target level is reached, and possibly longer. |
| Medicine (Statins) | If you made changes, you could lower your chance of having a problem. | Statins can cause side effects including: muscle pain, fatigue, and liver problems. | Take medicine every day.  
Get regular blood tests to check cholesterol levels and liver function. | Until target level is reached, and possibly longer. |
Choice Report: Outcomes

- Well-received by patients and by resident clinicians:
  - “I remembered to discuss side effects of depression medicines because I used this report”
  - “After using the Choice Report in our visit, my patient wanted to take a statin medicine. I was surprised; I thought she didn’t like pills”
  - “My patient chose therapy for her depression treatment; I didn’t think she was the type of person who would be interested in therapy”
**Current Risk** of having a heart attack
Risk for 100 people like you who do take **low dose aspirin**
- 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 with aspirin**
- 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
I have used a decision aid to share decision making with the patient about interventions to reduce the risk of coronary events. We estimated the patient's 10-year of atherosclerotic events at 8% and discussed how this risk could be reduced with the use of statins to 5%. After considering the patient's unique circumstances and the pros and cons of the alternatives, we have decided to...

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).

Low dose aspirin
Of 1000 people like you, 4 will have an important bleed because they took aspirin.
Decision Point

You may want to have a say in this decision, or you may simply want to follow your doctor’s recommendation. Either way, this information will help you understand what your choices are so that you can talk to your doctor about them.

Turn on Accessibility Mode

Breast Cancer Screening: When Should I Start Having Mammograms?

What matters most to you?

Your personal feelings are just as important as the medical facts. Think about what matters most to you in this decision, and show how you feel about the following statements.

Reasons to start mammograms at age 40

Reasons to start mammograms at age 50
<table>
<thead>
<tr>
<th>I'm worried that I might get breast cancer at an earlier age.</th>
<th>I'm not too worried that I might get breast cancer at an earlier age.</th>
</tr>
</thead>
<tbody>
<tr>
<td>More important</td>
<td>Equally important</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>I think starting mammograms earlier is worth the increased risk of having a false-positive test result if it could find cancer early.</th>
<th>I think the chance of having a false-positive test result is more likely than the test finding a real problem if I start having mammograms earlier.</th>
</tr>
</thead>
<tbody>
<tr>
<td>More important</td>
<td>Equally important</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>I'm not afraid to have a biopsy or other tests if my doctor sees a problem on the mammogram.</th>
<th>I don't want to have a biopsy or other tests that I may not need.</th>
</tr>
</thead>
<tbody>
<tr>
<td>More important</td>
<td>Equally important</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>I want to know if I have breast cancer, even if it's a cancer that might never cause a problem.</th>
<th>I only want to know if I have a breast cancer that is going to be a problem.</th>
</tr>
</thead>
</table>
Challenges in Implementation

• Some clinicians very interested, others rarely prescribe
• Ordering system very clinician-driven; do we know patients want?
• How to reach patients at decision points?
• Feasibility of decision aids used outside of consultation; “closing the loop” challenge
• Could we harness patient and staff energy and expertise?
A Closer Look

– Practicing SDM as a team
– The MGH experience with patient-triggered ordering
– Facilitation of SDM in specialty referrals
Patient-triggered ordering models

- Patients received order form at the time of check-in
- Medical assistants explained program; patients completed forms in waiting room
- Medical assistants placed orders and decision aids mailed
Outcomes

• In both models (pre-visit and point-of-care), orders skyrocketed from baseline clinician order rates
  – In one health center, in one month: 12 docs ordered 40 programs, but…
  – 160 patients ordered 297 additional programs!

• Entire staff engaged in the process
  – Medical assistants:
    • “I feel like we are really helping people”
    • “So many of our patients are depressed – I had no idea”
  – Physicians:
    • “I always forget to order – thank you for figuring out another way”
    • “I love this!”

• Practices received an informal “needs assessment” of the issues most on their patients’ minds
Patients Ordered Differently!

- Top 5 programs ordered by patients:
  - Help for Anxiety
  - Chronic Low Back Pain: Managing Your Pain and Your Life
  - Coping with Symptoms of Depression
  - Sleeping Better: Help for Long-term Insomnia
  - Peace of Mind: Personal Stories about Advance Directives

- Top 5 programs ordered by clinicians:
  - Is a PSA Test Right for You?
  - Colon Cancer Screening: Deciding What’s Right for You
  - Peace of Mind: Personal Stories about Advance Directives
  - Living with Diabetes
  - Sleeping Better: Help for Long-term Insomnia
The Medical Neighborhood: Specialty Collaborations

• Referrals are often a “decision point” where decision aids may be most useful

• Specialist engagement is important; often more interested that you would expect!

• Support/push from hospital leadership to implement SDM efforts in specialty care also key to success
Electronic Referral Enhancement

Decision aids are available for hip osteoarthritis and knee osteoarthritis that can be sent to your patient in advance of their appointment with the doctor.

*Send patient Treatment Choices decision aid?
  Yes
  No

Request Provider
Requested Provider

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

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

QPID PrOE

Visit Date: 2012-06-30
Procedure Selected: CEA - Left

Carotid Endarterectomy
Confirm CEA
Has the decision aid for this procedure been shared with the patient?
Yes
No
Submit Cancel

Carotid Stent
Medical therapy

Risk Scores:
Risk of Stroke or Death in Hospital for CAS: 2.2 %
Measurement and feedback

Patient surveys to assess impact on knowledge, goals and decisions

Shared Decision Making in Practice at MGH

Quarterly newsletters with practice- and provider- level reports
Future directions for SDM at MGH

• Adapting primary care performance measures to allow for patient choice and preference
• Enhancing measurement and reporting of decision quality; providing useful feedback for clinicians
• Training of the entire care team, not just physicians, in shared decision making skills