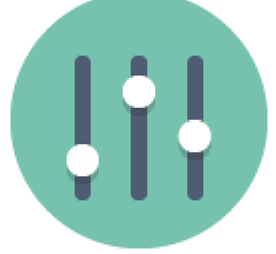
The Case for Shared Decision Making

Practice Transformation Initiative
Share & Learn Webinar
May 9, 2018

Hello and welcome!

Zoom Tips



- Attendees are automatically UNMUTED upon entry
- Refrain from using the hold button
- **Use the chat box, raise your hand, or *unmute yourself and jump in* if you have questions or would like to participate**
- Direct messages to Jen if you have any technical issues
- Sit back and enjoy – this meeting is being recorded; slides & a recording will be included in the PTI Weekly Communications email on Thursday!

Share & Learn Webinars

- Monthly opportunity to **Share & Learn** alongside your PTI colleagues:
  - on technical content or learn new concepts,
  - to share your successes and promising practices,
  - to thought partner with your peers about the challenges you're facing in this work.

- Each webinar will have a different focus and will vary in its target audience, but is open to all PTI participants.

Today's Presenters

Juliane Tomlin

Victor Montori, MD, MSc
Mayo Clinic

Amberly Ticotsky, RN
Cambridge Health Alliance

Jenny Wright

Today's Agenda

1. Introductions
2. Shared Decision Making: Recognizing Opportunities in Uncertainty (Victor)
3. Experience from the ground – How Cambridge Health Alliance implemented SDM (Amberly)
4. Q&A
5. Wrap-up

2018 Practice Transformation Initiative Goals

By December 31, 2018…..

Program Goals

- Realize 20% relative improvement toward the 90th percentile on high impact outcome measures (HbA1c <8; HbA1c >9; HTN control).
- Record at least $202 million in cumulative cost savings across the 4 utilization measures (ED visits, hospital bed days, imaging for LBP and cervical cancer overscreening).

Organization Goals

- 100% of practices will have been actively engaged with a Practice Facilitation Coach.
- Each organization will have a documented return on investment for sustainability of the Practice Transformation work including program components that will continue beyond 2019.
- Each organization will support Team-Based Care in the practices by establishing clinician-approved standing orders and trainings for care team staff.

Practice Goals

- 80% of practices are actively building Quality Improvement infrastructure and capability, reflected by % scoring 2 or higher on specific PAT milestones.
- 80% of practices have implemented the PFE tactics of shared decision-making and patient activation.
- 80% of practices use performance reports for Quality Improvement, reflected by % scoring 2 or higher on specific PAT milestones.

Currently, 25% of PTI primary care practices, and 40% of specialty practices are using shared decision making.

Question:
(Type into Chat Box or unmute yourself)

Why do you think Shared Decision Making is important?

Shared decision making

Recognizing opportunities in uncertainty

Victor M. Montori, MD, MSc
Professor of Medicine
KER UNIT
Mayo Clinic

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Disclosure Statement

I do **not** have financial relationships or interests related to the content of this presentation.

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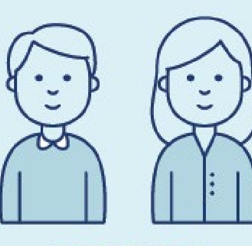
Statin Use for the Primary Prevention of Cardiovascular Disease in Adults

Population	USPSTF recommendation grade
 **ADULTS** Aged 40-75 years with no history of CVD and ≥1 CVD risk factors	**10-year cardiovascular event risk ≥10%** Low- to moderate-dose statins recommended
	10-year cardiovascular event risk 7.5%-10% Recommendation depends on the patient's situation
ADULTS Aged 76 years and older with no history of CVD	There is **insufficient** evidence to make a recommendation.

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HbA1c < 7%

4 Statin Benefit Groups

- Clinical ASCVD*
- LDL-C ≥190 mg/dL, Age ≥21 years
- Primary prevention – Diabetes: Age 40-75 years, LDL-C 70-189 mg/dL
- Primary prevention - No Diabetes†: ≥7.5%‡ 10-year

Maria Luisa ≠ People like Maria Luisa

Shared decision making is…

A conversation between clinicians and patients in which they think, talk, and feel through the situation. Evidence-based options are hypotheses, which are tested in the conversation until the best solution for the situation becomes clear.

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1. Goal of SDM is <u>not</u> to get people to do what YOU think is right for them.
2. Foster awareness of opportunity (uncertainty, options, participation, sense)
3. Engage in dx conversation
4. Tools can help trying-on of options
5. Success is to find care that makes intellectual, emotional, and practical sense.

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Shared decision making is…

A. Doctors presenting evidence-based information so that the patient can decide what to do.

B. Patients giving doctors information about their preferences and experiences for doctors to decide what to do.

C. Just like informed consent.

D. Doctors making a recommendation for one of the available options after presenting all of them.

E. Is a conversation by which patients and doctors figure out what to do.

F. Patients using a decision aid to decide what to do.

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What to do?
Your input matters

What is the situation that demands action?

What are the actions that the situation demands

Intellectual
Emotional
Practical

Sense

Statin Choice

statindecisionaid.mayoclinic.org

MAYO CLINIC

Back

Current Risk

Select Risk Calculator

ACC/AHA ASCVD | Framingham | Reynolds

Do you have a history of events such as prior heart attack or stroke, acute coronary syndromes, history of angioplasty or stents, etc?

No

These figures are used to calculate my risk of having a heart attack in the next 10 years:

Age 55

Gender M F

Population Group White or other

Smoker No

Diabetes No

Treated SBP No

Conv. Unit | SI Unit

Systolic Blood Pressure 140 mmHg

HDL Cholesterol 40 mg/dL

Total Cholesterol 200 mg/dL

Select Current Intervention

Statins No | Std Dose | High Dose

Aspirin No | Low Dose

Statin/Aspirin Choice

Decision Aid

vention | Issues | Notes | Document

Benefits vs Downsides according to my personal health information

Using ACC/AHA ASCVD Risk Calculator

3. View Issues

Current Risk
of having a heart attack

isk for 100 people like you who do not edicate for heart problems

Future Risk
of having a heart attack

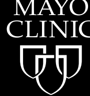
Risk for 100 people like you who do take standard dose statins

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



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 Rx in low risk (<10%) group

3-fold increase in self-reported adherence

Weymiller et al. Arch Intern Med 2007

Weight Change

Low Blood Sugar
(Hypoglycemia)

Blood Sugar
(A1c Reduction)

Daily Routine

Daily Sugar Testing
(Monitoring)

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
Glipizide, Glimepiride, Glyburide
$0.10 per day — $10 / 3 months

What aspect of your next diabetes medicine would you like to discuss first?

Mullan et al Arch Intern Med 2009

KER UNIT | Mayo Clinic Video / Web

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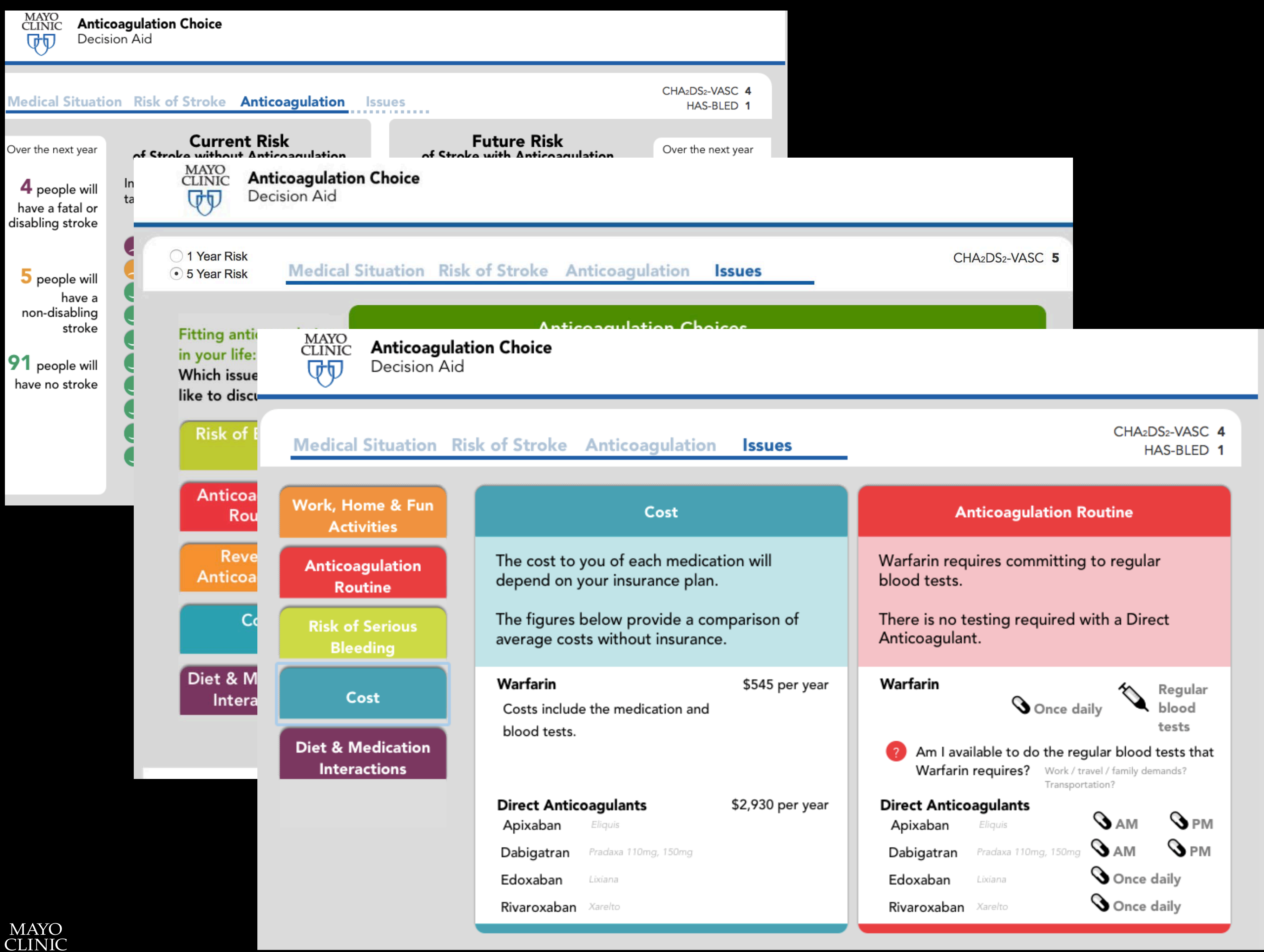

MAYO CLINIC

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Summary of Mayo experience

Age: 40-95 (avg 65)

Primary care, ED, hospital, specialty care

Adds ~3 minutes to consultation

58% fidelity without training

Outcomes

74-90% clinicians want to use tools again

Effects on SDM 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

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Statin/Aspirin Choice
Decision Aid

Back

Current Risk | Intervention | Issues | Notes | Document

3. View Issues

Benefits vs Downsides according to my personal health information
Using ACC/AHA ASCVD Risk Calculator

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Adoption

>12,000/month in each of last 3 years

Google Analytics

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Shared decision making is…

A human expression of kind and careful care.

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Shared Decision Making

Research/Practice Workshop

October 2-3, 2018

Mayo Clinic

Rochester, Minnesota

CE.mayo.edu/MDM2018

http://shareddecisions.mayoclinic.org

Question:

(Type into Chat Box or unmute yourself)

Based on your **new** understanding of **Shared Decision Making**, what percent of your practices are *actually* doing Shared Decision Making?

Experience from the ground: *How Cambridge Health Alliance Implemented SDM*

Amberly Ticotsky, RN

Cambridge Health Alliance

Cambridge, Massachusetts

Practice Transformation Initiative, a program of:

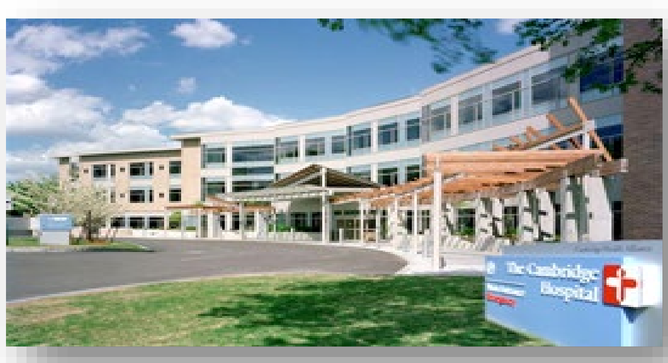
Poll Question:

What are your practices currently doing?

a) Motivational Interviewing
b) Strong team dynamics
c) Patients completing pre-visit forms (SDOH, goals, agenda, etc.)
d) Team huddles

Cambridge Health Alliance

- Academic public health safety net system outside of Boston
- 2 hospitals, 13 community centers, 7 cities
- Public Health mandate
  - 180,000+ primary care visits for 120,000 patients
  - Largely public payer mix – 82%,almost all Medicaid
  - >50% of patients speak a language other than English
  - >3,000 employees, 18 labor unions



Union Square Family Health

- Participated in three collaboratives to shape cutting edge PCMH transformation
- Robert Wood Johnson designation of one of the top 30 Primary Care practices in the US
- Featured as a model practice by CMS in the TCPi initiative
- Level 3 PCMH Designation
- Full spectrum Family Medicine Care
- 23,000 patient visits per year, 80 percent with public or no insurance
- 40% Brazilian, 20% Spanish from Latin America, 8% Haitian Creole, sizable Hindi, Gujarati, Punjabi and Nepali populations

THE WALL STREET JOURNAL

THE INFORMED PATIENT

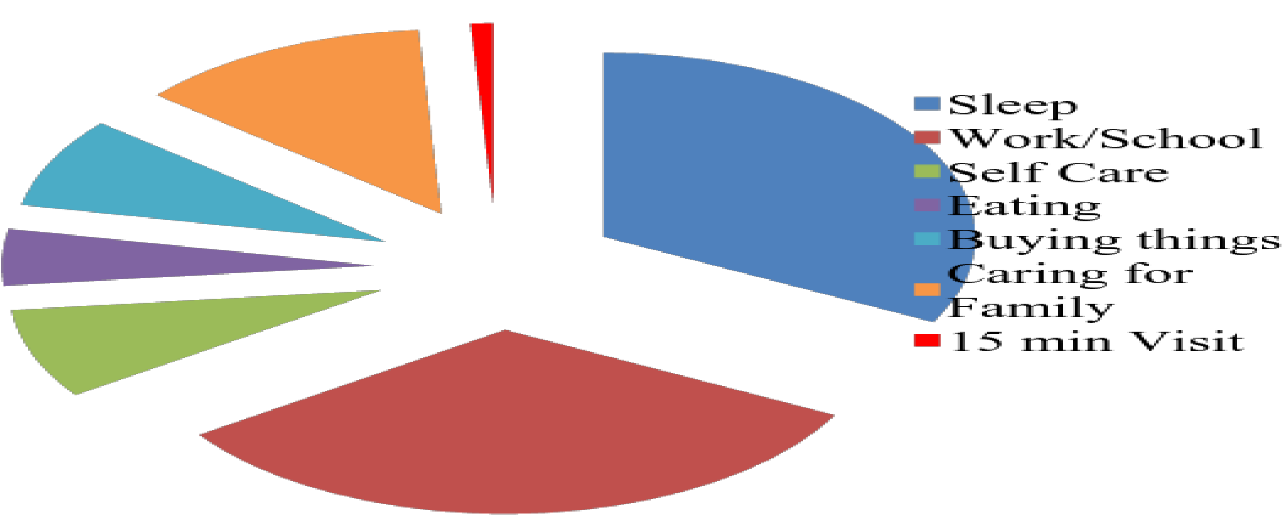
The Doctor's Team Will See You Now

Why Care Plans?

By Judith H. Hibbard and Jessica Greene

What The Evidence Shows About Patient Activation: Better Health Outcomes And Care Experiences; Fewer Data On Costs

This is how our patient visit fits into their day



I already have a plan for them.

We're already being asked to do too much in a short visit.

A Care Plan is

What if their goal doesn't have anything to do with getting their diabetes under control?

I don't have time for this.

I'm responsible.

What if this doesn't work?

Patients don't know how to set goals.

Growing a Care Plan

Diabetes Care Plan

My health goals:
I want to:
1)

2)

My important care providers for diabetes:

Tools that I would like to help me with my diabetes:
- ☐ Handouts on: ______________________
- ☐ Picture of plate for healthy eating
- ☐ Log for tracking sugars
- ☐ Glucometer
- ☐ MyChart flow sheet for tracking sugars
- ☐ Web sites on: ______________________
- ☐ Name of smartphone app: ______________________
- ☐ Pill box

Barriers:
- ☐ Housing problems
- ☐ Transportation problems
- ☐ Insurance problems
- ☐ Need more health knowledge
- ☐ Difficult to communicate in English
- ☐ Limited access to healthy food
- ☐ Worry about safety
- ☐ Financial problems
- ☐ Hard to access medical care because ______________________
- ☐ Health system is hard to understand
- ☐ Not enough personal support from friends and family
- ☐ Other family problems or responsibility
- ☐ Learning problems
- ☐ Legal issues

Steps that I could take now to improve my health:
- ☐ ______________________
- ☐ Take my medicines every day
- ☐ Use stress management techniques
- ☐ Keep track of progress using ______________________
- ☐ Get at least ____ minutes of exercise ____ times per week
- ☐ Communicate with my health care team by ______________________

Staff: Put into Care Coordination note at top of problem list in EPIC u

PLACE LABEL HERE

Diabetes Care Plan

My health goals:
I want to:
1)

2)

Who are the people that can help me meet my goals?

What tools would help me to reach my goal?
- ☐ Handouts on: ______________________
- ☐ Picture of plate for healthy eating
- ☐ Log for tracking sugars
- ☐ Glucometer
- ☐ MyChart flow sheet for tracking sugars
- ☐ Pill box

What are some problems that will prevent me from reaching my goal?
- ☐ Housing
- ☐ Transportation
- ☐ Insurance
- ☐ Money
- ☐ Unable to speak English
- ☐ Cannot read
- ☐ Health system is hard to understand
- ☐ Lack support from family

The next step I want to take to improve my health:

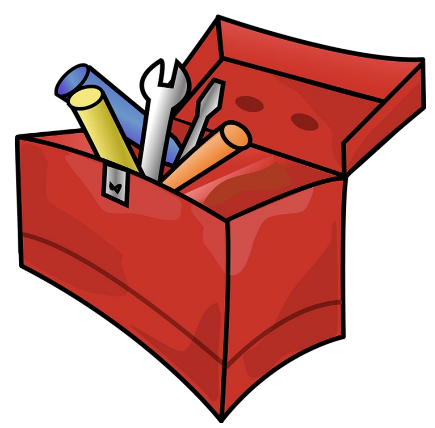
Asking the right questions:

Care Plan Goals

- Understand where patients are in managing their health
- Understand patients' priorities for their health (what matters to you?)
- Create shared goals
- Develop an action plan **<u>WITH</u>** the patient
- Customize care interventions
- Identify and address strength and challenges
- Build skills needed to reach the goal
- Leverage team-based care model

All teams work from the same care plan, for care coordination, shared goals, and communication between teams. Plan is printed and given to patient.

You've Got This!



Built into the care plan

- Patient activation (growing knowledge, skills, confidence)
- Tap into patient's context
- Meet people where they're at
- Skill building
- SMART plans (specific, measurable, achievable, relevant, time-oriented)

In your toolbox

- Motivational Interviewing
- Behavioral Activation
- Relationship building
- Working with vs. to/for
- The extended care team!!

Care Plan, meet EMR

1. **My goals to improve my health**: ***
2. **My healthcare team's goals**: ***
3. **My strengths and supports to meet my goals**: ***
4. **Challenges to meeting my goals**: *dropdown.*
   - Need more support
   - Housing problems
   - Transportation problems
   - Insurance problems
   - Healthcare providers don't speak my language
   - Legal problems
   - Financial problems
   - Other
5. **My healthcare team**: ***
6. **My Action Plan**: *dropdown.*
   - keep my appointments
   - if I feel worse, I will ***
   - take my medicines every day
   - Keep track of progress using ***
   - Other
7. **My confidence that I can follow my Action Plan**: *1-10*

Care Plans: Patient View

CHA Cambridge Health Alliance

Living a Healthy Life with Diabetes
My Goals… My Plan

My Health Goals:

1)

2)

Barriers: things could get in the way of me reaching my goals
(for example: money, hard time finding a ride)

My Team: who can help me reach my goals?
(for example: my doctor, family, nutritionist)

Name	Relationship

Tools: which of these things would help me reach my goal?"

Diet Information | Glucometer | Pill Box | Email Your Team | Diabetes Group

MY ACTION PLAN DATE:

______ and ______
ave agreed that to improve my health I will:

. Choose ONE of the activities below:

____ Work on something that's bothering me:

____ Stay more physically active!

____ Take my medications.

____ Improve my food choices.

Reduce my stress.

____ Cut down on smoking.

2. Choose your confidence level:
How sure are you that you can do the action plan? (If < 7, then change plan)

10 VERY SURE
7 SURE
5 SOMEWHAT SURE
0 NOT SURE AT ALL

3. Fill in the details of your activit

What:
How much:
When:
How often:
Where:
With whom:
Start Date:
Follow-Up Date:
Best Way to Follow-Up:

Care Plans in Action

- I don't understand how my sugar is not well controlled when I take all my medications.
- Quit smoking, lose weight
- Get off opiates for good
- Could I go back to work, or back to school? apply for disability?
- Strengthen relationship with wife
- I need to sleep at night. I am exhausted.
- Less pain.
- I want to live in a safe situation.

Impact: Staff

"I love the action plan because it helps patients create realistic, actionable steps toward their goals."

"It allows me to understand where patients are starting from."

"This is a cornerstone of our conversations with patients about depression, because it provides an opportunity to take concrete steps that can have an impact."

"When I sit with a patient to do a care plan, I stop and listen."

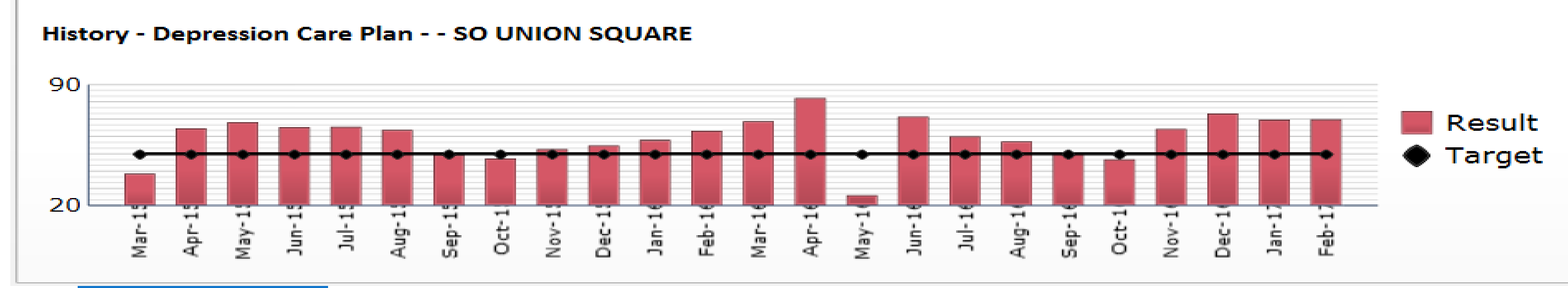
"People can focus more on what's important to them, and in their life."

"It's more collaborative: patient and PCP share the work of putting it together, and the patient leads the process."

"Patients are more engaged."

Impact: Patients

- “These people are trying to help me, and I should listen to them.”
- “I love Virginia (PCP)!”
- “I felt like I wasn’t just another patient.”
- “Okay, doc, here’s what we’re going to work on next...”



CQC
CALIFORNIA QUALITY COLLABORATIVE

Integrated
Healthcare
ASSOCIATION

CCI
CENTER FOR CARE
INNOVATIONS

Question:
(Type into Chat Box or unmute yourself)

What are some key points you will share with your practices and organizations about Shared Decision Making?

Wrap Up

Practice Transformation Initiative, a program of:

UPCOMING EVENTS

- **May 22-23** @ Long Beach**:** Quarterly PTI Convening
- **June 20** – Virtual: Share and Learn Webinar: Sustainability
- **July 12** – Virtual: Practice Facilitation Workshop
- **July 18** – Virtual: Share and Learn Webinar: Team Based Care
- **Aug 28 – 29** @ San Jose: Quarterly PTI Convening

This is not goodbye, but see you later…

Jen Burstedt Correa

jenburstedt@gmail.com

Thank you!

SURVEY:

The meeting was a good use of my time.

Practice Transformation Initiative, a program of:

Thank you for participating!