

Trustee Insights

PERFORMANCE IMPROVEMENT



Getting Strategic about Shared Decision Making

Four ways to integrate meaningful conversations into clinical practice

BY MAGGIE VAN DYKE

Patients are more satisfied when they receive it. Physicians agree it is the right thing to do. Advocates believe it is key to making health care more patient centered, and it has been shown to improve health outcomes and lower costs.

“It” is not a new drug or technology, but a common-sense communication strategy known as shared decision making (SDM), which helps ensure treatment decisions align with a patient’s values and preferences.

Key steps for clinicians include laying out treatment options for patients, discussing the reasons to pursue and not pursue each option, and asking patients what they prefer. These steps can support hospital and health system efforts to offer greater value to individual consumers. And yet, despite evidence that SDM is a critical tool in the quest to improve health care value, the approach is not yet widely adopted.

“A lot of research has gone into the development of decision aids,

TRUSTEE TALKING POINTS

- Shared decision making (SDM) is a communication strategy to align treatment decisions with patient preferences.
- Meaningful conversations between clinicians and patients can improve health outcomes and lower costs.
- SDM is now being encouraged and, in some instances, required by payers and policymakers.
- SDM adoption succeeds in a culture that respects patients as equal members of the care team.

which are tools to facilitate treatment discussions with patients,” said Erica Spatz, M.D., assistant

professor, section of cardiovascular medicine, Yale New Haven (Conn.) Health. “But a lot of that research hasn’t been adopted broadly into clinical practice.”

The challenges impeding implementation range from practical constraints, such as a lack of time for discussions with patients, to lingering cultural views of physicians as authority figures who should select the best treatment. Plus, there’s the tendency many people have to avoid difficult conversations. “The biggest challenge is that making a difficult decision is hard to do for both physicians and patients,” said Liana Fraenkel, M.D., professor of medicine, Yale University, New Haven, Conn., and chief of rheumatology, VA Connecticut Health Care System, West Haven. “It’s not easy to choose between competing options.”

To become widely adopted, SDM needs to be approached systematically and endorsed by health care boards and leaders. “There may not be a one-size-fits-all approach, but if health systems think about this strategically, asking what are the needs and where are the opportunities, then we can come up with a multitude of approaches for integrating shared decision making into practice,” Spatz said.

Fraenkel agrees: “Things get incorporated into medicine when we make it easy to do the right thing and, for that, we need the health system’s support.”

Spreading SDM

Hospitals and other health care organizations cite four strategies they are using to integrate SDM more widely into clinical practice.

Boards might consider adopting some or all of them to help drive patient-centered care.

Training clinicians. When leaders at Access Community Health Network (ACCESS), a Chicago network of federally qualified health centers, began contemplating how to implement SDM, they thought about giving providers

ACCESS brought in internationally recognized SDM experts — Glen Elwyn, M.D., Ph.D., and Marie Anne Durand, Ph.D., from the Dartmouth Institute for Health Policy & Clinical Practice, Lebanon, N.H., and Marla Clayman, Ph.D., of the American Institutes for Research, Washington — to train providers on site at ACCESS clinics.

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decision aids to use with patients. But they quickly recognized that the aids were only tools and no substitute for meaningful conversations between clinicians and patients.

Like other organizations implementing SDM, ACCESS realized that physicians and other providers needed training in SDM skills. While physicians receive communication training in medical school, SDM skills are not commonly taught. In a 2011 study at Massachusetts General Hospital, Boston, only 20 percent of primary care physicians said they were very confident about communicating the likelihood of treatment benefits and risks to patients, and only 40 percent were very confident in eliciting patients’ goals and preferences within a visit.

“We can’t just stop and send 20 providers for training,” said Jairo Mejia, M.D., ACCESS’s chief medical officer. “We came up with the idea to offer training in a mock visit.”

During the training, ACCESS providers learned a “three-talk” model of shared decision making, as described in a 2017 *BMJ* article:

- Team talk: inviting patients to work with the provider as a team to make decisions
- Option talk: discussing and comparing various treatment alternatives
- Decision talk: asking patients what matters the most to them about a decision

The providers practiced the method while discussing treatment options with a mock patient and then

received feedback from the trainers.

Learning what matters to patients. When faced with a treatment decision, patients commonly asked their physicians, “What would you do if it was you?” But Spatz does not think patients are necessarily turning over decision rights to the physician. “Most people within shared decision-making circles understand that this question should be interpreted as, ‘Knowing what you know *about me*, what do you think is best?’”

their convenience and on their own devices — and key information is extracted to create an electronic overview that clinicians can review in less than 20 seconds before going in to see a patient.

“There are elements of shared decision making that have to occur before, during and after a visit,” said Bennick. “Before the visit, we can assess what’s important to a patient, and then the clinician can confirm that in conversations with the patient.”

“We’ve been developing measures to help us learn whether a patient was well-informed and meaningfully involved in the decision-making process, as well as whether treatments reflect what matters most to our patients.”

Karen Sepucha, Ph.D., director of the Health Decision Sciences Center at Massachusetts General Hospital, Boston

But getting to know what matters to patients can be difficult. “It often takes a while for busy caregivers to learn who the person is behind the patient complaint,” said Michael Bennick, M.D., medical director, patient experience, Yale New Haven Health. “What ticks behind the gall bladder in room 302?”

To address this, Yale New Haven Health is piloting a digital tool that provides an at-a-glance summary of patients’ lives and health, including what makes them happy, their health priorities, any barriers to health (e.g., lack of transportation), and how much they want to be involved in treatment decisions. Patients spend 10 to 15 minutes sharing their perspectives — at

As Yale New Haven Health prepares to roll out the tool across the system, staff have made it easier for clinicians to access the patient summary in the electronic health record (EHR) and are working on ways to encourage more patients to sign up via the online patient portal.

Involving the entire care team — including the patient. One of the biggest barriers to implementing SDM at Massachusetts General has been physicians forgetting to use ready-made decision aids when discussing treatment options with patients. One approach to this problem has been to engage other members of the care team, including nurses and medical assistants, to order decision aids for patients.

Massachusetts General has taken this team approach one step further, giving patients the ability to order SDM videos or DVDs about common health problems. This led to a 10-fold increase in the number of decision aids ordered, as well as some useful insights into the topics that patients are interested in discussing. While physicians tend to order decision aids about cancer screenings and tests, patients are more likely to order aids about treating insomnia, anxiety, back pain and other chronic and behavioral issues.

“It was a game changer for the doctors to realize how hungry patients really are for this information, and the topics that were on their patients’ minds,” said Karen Sepucha, Ph.D., director of the Health Decision Sciences Center at Massachusetts General. “It generated some great conversations about how to make sure that we’re addressing the issues that are most important to our patients during their visits.”

Documenting and measuring. To track how often SDM is being used, ACCESS amended its EHR to allow staff to document if SDM was used during a patient visit and if a decision aid was used during the discussion. However, just because the medical record indicates that SDM occurred doesn’t mean it was done well. So ACCESS tested follow-up questions with patients after the visit to assess how well providers listened and considered patients’ values and preferences. The initial test of the survey showed variation among providers, but an overall positive impact from the use of SDM.

Massachusetts General has also been working to measure the quality of SDM interactions. “We’ve been developing measures to help us learn whether a patient was well informed and meaningfully involved in the decision-making process, as well as whether treatments reflect what matters most to our patients,” Sepucha said.

The National Quality Forum recently endorsed two SDM measures developed by Massachusetts General. One assesses whether clinicians completed the key steps for SDM. The second metric focuses on whether patients who underwent hip and knee replacement surgery had a clear preference for and knowledge of the surgery.

Some research suggests that SDM increases patients’ self-care knowledge and efficacy, which is linked to better health outcomes. ACCESS is planning to research if this is true for its patients, most of whom face socioeconomic challenges. “We want to see if there’s an impact for certain conditions, such as hypertension or diabetes,” said Mejia. “We plan to evaluate short-term outcomes — let’s say blood pressure control or A1C levels in diabetes — in patients when we

TRUSTEE TAKEAWAYS



Boards should encourage their organizations to adopt four strategies for patient-centered care:

- Train clinicians to develop skills in shared decision making (SDM).
- Employ digital tools to learn what really matters to patients.
- Engage the entire care team (including the patient) in using decision aids.
- Document the use of SDM during patient visits and measure the quality of interactions.

use shared decision making versus when we do not.”

Becoming a Requirement

In addition to being the right thing to do for patients, SDM is now being encouraged and, in some instances, required by payers and policymakers. For instance, SDM is now required by Medicare for a small number of screenings and procedures. Since 2015, CMS has required SDM visits for Medicare beneficiaries seeking lung cancer CT screenings. More recently, Medicare

is requiring SDM before two heart-related procedures: left atrial appendage closure for atrial fibrillation and defibrillator implantation.

In another example, Washington State passed legislation in 2007 that recognizes SDM as a type of informed consent proving the patient agrees to a medical procedure. “Informed consent becomes informed choice,” Fraenkel said.

Trustees and other senior leaders can help drive SDM adoption by promoting an organizational culture that respects patients as equal members of the care team and by incentivizing clinicians.

For instance, to earn a quality bonus at Massachusetts General, physicians need to pick and track various performance improvement metrics. Beginning this year, SDM training is one of the metrics that departments and physicians can elect.

“The only way to do this is to try it,” said Mejia. “You’re not going to harm anyone with shared decision making. Only good things can come from this.”

Maggie Van Dyke is a contributing writer to Trustee Insights.