Implementing Shared Decision Making in Practice
Strategies and Pitfalls

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Minimally Disruptive Medicine
Effective Care that Fits
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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
2. The meaningful contribution of patients

Creating a space that facilitates this work is key to implementing SDM
What is a decision aid?

Can you achieve SDM without implementing a decision aid?
Can you implement a decision aid without achieving SDM?
Consider the clinical management of cardiovascular risk...
**Lipids**

**Priority 3**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Value</th>
<th>Date</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>LDL (mg/dl)</td>
<td>88</td>
<td>69 mg/dl</td>
<td>80 mg/dl</td>
</tr>
<tr>
<td>HDL</td>
<td>69</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TRIG</td>
<td>121</td>
<td>130</td>
<td></td>
</tr>
</tbody>
</table>

**Blood Pressure**

**Absolute CV Risk Reduction: 8%**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Value</th>
<th>Date</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>BP1 (mm Hg)</td>
<td>132/84</td>
<td>130/80</td>
<td></td>
</tr>
<tr>
<td>BP2 (mm Hg)</td>
<td>132/88</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Blood Pressure Priority 3**

**Glucose/A1c**

**Absolute CV Risk Reduction: 0%**

<table>
<thead>
<tr>
<th>Measured</th>
<th>Value</th>
<th>Date</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1c (%)</td>
<td>7.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cr (mg/dl)</td>
<td>0.82</td>
<td></td>
<td></td>
</tr>
<tr>
<td>eGFR (std)</td>
<td>56.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BMI: 30.6**

**Priority 2**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Absolute CV Risk Reduction: 5%</th>
<th>(based on a 3 unit drop in BMI)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Smoking: YES**

**Priority 1**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Absolute CV Risk Reduction: 13%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco use is identified. Ask about interest in quitting. If interested, offer the following: 1) prescribe medication such as varenicline (Chantix), bupropion (Zyban), or nicotine replacement (e.g. nicotine patch, gum, lozenge, or inhaler); 2) Arrange counseling proactively. Type &quot;HealthPartners&quot; under orders, or the patient may call 1-800-311-1052.</td>
<td></td>
</tr>
</tbody>
</table>

**Aspirin or Blood Thinner Use: YES**

**Absolute CV Risk Reduction: 0%**

*Aspirin is recommended for patients with coronary heart disease.*

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The CV Wizard suggestions are based on electronically available data and are not intended to be a substitute for clinical judgment. Alternative actions to those that Wizard suggests may be indicated. Exercise independent clinical judgment, review allergies, and follow product labeling instructions before choosing Wizard prescribing suggestions. 

*In the absence of Lipid values, risk is based on the BMI Framingham equation.*

**O’Connor, Curr Diab Reports, 2013**
Can you reduce your danger of heart attack and stroke?

Yes, you can! If you want to avoid a heart attack or stroke, talk to your doctor about what you can do about the things with the most ⚠️ signs. The things with the ✔️ are ok.

## Bad Cholesterol - LDL Goal 99 mg/dl or less

<table>
<thead>
<tr>
<th>Date</th>
<th>Your Status</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>152</td>
</tr>
</tbody>
</table>

## Blood Pressure - BP Goal 139/89 mmHg or less

<table>
<thead>
<tr>
<th>Date</th>
<th>Your Status</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>166/124</td>
</tr>
</tbody>
</table>

## Blood Sugar - A1c Goal 7.9 % or less

<table>
<thead>
<tr>
<th>Date</th>
<th>Your Status</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>13.3</td>
</tr>
</tbody>
</table>

## Weight

<table>
<thead>
<tr>
<th>Date</th>
<th>Your Status</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>385 #</td>
</tr>
</tbody>
</table>

## Smoking

<table>
<thead>
<tr>
<th>Date</th>
<th>Your Status</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>QUIT</td>
</tr>
</tbody>
</table>

## Aspirin or Blood Thinner Use

<table>
<thead>
<tr>
<th>Your Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
</tr>
</tbody>
</table>

Talk to your doctor about anything with one or more ⚠️ symbols. Take notes here about what you can do to improve your heart health.

For more information on health and wellness, visit: [http://www.healthpartners.com/public/health/]
CV Wizard

• Is this a useful tool?

• Is it a decision aid?

• Does it lead to SDM?

• Why or why not?
The Statin Choice Decision Aid

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?
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
Information-giving, decision support tools, and even decision aids ≠ 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.
In picking your decision aid, look at "IPDAS" criteria, primary studies for design, delivery method, outcomes!!!
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.”
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!**
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?
Assess, Assess, Assess!!!

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

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.

1. Participants distinguish the intervention from current ways of working.
2. Participants collectively agree about the purpose of the intervention.
3. Participants individually buy in to the intervention.
4. Key individuals drive the intervention forward.
5. Participants agree that the intervention should be part of their work.
6. Participants maintain their trust in each other’s work and expertise through the intervention.
7. Participants’ perform the tasks required by the intervention.
8. Participants access information about the effects of the intervention.
9. Participants collectively assess the intervention as worthwhile.
10. Participants individually
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
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
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
<table>
<thead>
<tr>
<th></th>
<th>System 1 (&quot;organic&quot;)</th>
<th>System 2 (&quot;educate&quot;)</th>
<th>System 3 (&quot;changing&quot;)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organizational Maturity</td>
<td>+++</td>
<td>+++++</td>
<td>+</td>
</tr>
<tr>
<td>Communication Capacity</td>
<td>++</td>
<td>++++</td>
<td>++++++</td>
</tr>
<tr>
<td>Cultural Fit and</td>
<td>+++</td>
<td>+</td>
<td>++++++</td>
</tr>
<tr>
<td>Compatibility</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Team Appropriateness</td>
<td>+++++</td>
<td>++++</td>
<td>+++</td>
</tr>
<tr>
<td>Leadership Commitment</td>
<td>++</td>
<td>+++</td>
<td>++++</td>
</tr>
<tr>
<td>Available IT Capacity</td>
<td>++++++</td>
<td>++++</td>
<td>+</td>
</tr>
<tr>
<td>Implementation Experience</td>
<td>++</td>
<td>++++++</td>
<td>++</td>
</tr>
</tbody>
</table>
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
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.
Statin Choice Usage by IP Address

- System 1 ("organic")
- System 2 ("educate")
- System 3 ("changing")
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
Can this work be done FOR health systems?
Questions & Discussion

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1

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2

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or

Open poll in your web browser
Your poll will show here

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