Shared Decision Making and Minimally Disruptive Medicine

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Minimally Disruptive Medicine
Effective Care that Fits
Rochester MN, September 29, 2016
It is bedtime for the kids and you have gathered them for a story. The words on the page get fuzzy and your glucose monitor is alerting you to low blood sugar, but the kids are nestled in your lap. You don’t want to scare them.

What do you do?

How do you balance parenting and self-care in this moment?

WALKAMILECARDS.com  #WAMt1d
What's best for me and my family?
SDM as one means in approaching What’s Best for the Patient
How do we approach what’s best?
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 ASCVD risk, Age 40-75 years, LDL-C 70-189 mg/dL

*Atherosclerotic cardiovascular disease
†Requires risk discussion between clinician and patient before statin initiation
‡Statin therapy may be considered if risk decision is uncertain after use of ASCVD risk calculator
Maria Luisa ≠ People like Maria Luisa
Information Choice
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*What do you do?*

*How do you balance parenting and self-care in this moment?*
How do we approach what’s best?

Talk with the person and find agreement on what’s best for them

Work through the situation to fashion action makes intellectual, practical, and emotional sense
How do we approach what’s best?
How do we approach what’s best?

Conversation
Talk with the Person

Conversation

Work through the Human Situation
Talk with the person

People speaking to what matters to them

Creating & maintaining a relationship in which this is possible

So that two parties with diverse interests can agree on next steps
Yes - usually 30 minutes before breakfast
• Two parties coming to an agreement
• To secure agreement the patient is encouraged to speak to what matters to her
  • -Weight Change, Daily Routine
  • -”I’d rather just pills”
• Clinician also speaks to what matters to him
  • “The other thing to consider is that sometimes that can give you low blood sugar so we are going to ask you to monitor a little more often than what you are doing right now but otherwise that would be ok”
Developing an environment for problem finding and resolution

Together thinking, talking & feeling through a troubled situation

To test and demonstrate that a course of action makes sense

Talk with the person

People speaking to what matters to them

Creating & maintaining a relationship in which this is possible

So that two parties with diverse interests can agree on next steps

Work through the situation

Talk with the person

People speaking to what matters to them

Creating & maintaining a relationship in which this is possible

So that two parties with diverse interests can agree on next steps

Work through the situation

Developing an environment for problem finding and resolution

Together thinking, talking & feeling through a troubled situation

To test and demonstrate that a course of action makes sense
What is the situation that demands action?

What is the action the situation demands?

Problem
Hypotheses
Experimental Medium
Conclusion
Treating your Barrett’s Esophagus Low-Grade Dysplasia Decision Aid

This tool will help you and your doctor discuss how to treat your Barrett’s Esophagus

Let’s get started

Caution: This application is for use exclusively during the clinical encounter with your clinician

Credits & Contacts

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• Thinking, talking, and feeling through a troubling situation
• Options are hypotheses. Conversation is where they’re tested
• What’s best is humanly demonstrated
• Care that does justice to the human situation
Talk with the Person

Conversation

Work through the Human Situation
What’s best for me and my family?
It is bedtime for the kids and you have gathered them for a story. The words on the page get fuzzy and your glucose monitor is alerting you to low blood sugar, but the kids are nestled in your lap. You don’t want to scare them.

**What do you do?**

**How do you balance parenting and self-care in this moment?**

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Conversation

Work through the Human Situation

Decision aid/SDM tools
Statin Choice

Current Risk

Select Risk Calculator

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
- 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
- Aspirin: No

Current Risk of having a heart attack

Risk for 100 people like you who do not educate for heart problems

Future Risk of having a heart attack

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

Using ACC/AHA ASCVD Risk Calculator

Benefits vs Downsides according to my personal health information

- 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
LDL

“Must do” guidelines

QI targets = metabolic goals.

Achieve these goals = technical decisions

Statins
DM2 patients seen in primary care

R

Allocation concealment / blinding to hypothesis / ITT

Usual care

Knowledge Conversation Decision Satisfaction Choice

3 mo Adherence

Decision aid

Knowledge Conversation Decision Satisfaction Choice

3 mo Adherence
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

2015 ACC/AHA Focused Update of Secondary Prevention Performance Measures

Requires SDM (e.g., using Statin Choice decision aid) to improve:

% at-risk patients 18-75 with who were offered moderate- to high-intensity statins.

Drozda JP et al. JACC 2015
Million Hearts Campaign

Multiagency project, led by CMS

Randomized trial of 720 practices

Payment based on magnitude of reduction in practice-wide risk (calculated including Medicare patients with estimated 10y risk >30%)

Must be accomplished using shared decision making (e.g., using an electronic decision aid) and statins.

http://innovation.cms.gov/initiatives/million-hearts-CVDRRM
Adoption

12,000/month

Google Analytics
Risk communication tools

Statin Choice (primary care)

Chest pain Choice (emergency)

Osteoporosis Choice (primary care)

PCI Choice (cardiology)

AMI Choice (hospital)

Issue cards

DM2 Med Choice

Depression Choice

Issue/Risk

Atrial fibrillation

Thyroid Cancer

Barrett's esophagus
**Current Risk of Stroke without Anticoagulation**

In 100 people like you who are not taking an anticoagulant:

- 4 people will have a fatal or disabling stroke
- 5 people will have a non-disabling stroke
- 91 people will have no stroke

**Future Risk of Stroke with Anticoagulation**

In 100 people like you who are taking an anticoagulant:

- Fewer than 2 people will have a fatal or disabling stroke
- Fewer than 2 people will have a non-disabling stroke
- 97 people will have no stroke
- 6 people will avoid a stroke by taking anticoagulation

**Anticoagulation Routine**

- Warfarin requires committing to regular blood tests.
- There is no testing required with a Direct Anticoagulant.

**Cost**

- The cost to you of each medication will depend on your insurance plan.
- The figures below provide a comparison of average costs without insurance.

- **Warfarin**
  - Costs include the medication and blood tests.
  - $545 per year

- **Direct Anticoagulants**
  - $2,930 per year
  - Includes Apixaban, Edoxaban, and Rivaroxaban

- **Direct Anticoagulants**
  - Includes Apixaban, Edoxaban, and Rivaroxaban
Accurate Knowledge

- 50%

Received information
- Right amount: 69%
- Very clear: 30%
- Very helpful: 27%

Engagement of patients: 19%

Estimated risk correctly
- 12%

Want to receive information in the same manner: 42%
Accurate Knowledge

60%

Estimated risk correctly

50%

Received information

- Right amount: 79%
- Very clear: 39%
- Very helpful: 40%

Engagement of patients

- 35%

Want to receive information in the same manner

53%
Summary of Mayo experience

Age: 40-92 (avg 65)
Primary care, ED, hospital, specialty care
Adds ~3 minutes to consultation
58% fidelity without training
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
74-90% clinicians want to use tools again
A fourth of clinicians report ever discussing costs with patients.

- Discussion of cost 3-fold
- Discussion of cost 4-fold

1 in 5 patients cost was the most important issue in choosing a medication.
Implementing DAs

EMR Link

Web

http://statindecisionaid.mayoclinic.org

EMR Documentation
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 6%. After considering the patient's unique circumstances and the pros and cons of the alternatives, we have decided to...
For clinicians

- Evidence based information
- Risk calculators
- Graphic representation of benefit and harms
- Help prioritize a situation (chronic pts): which is the most emerging problem?
- Facilitate identification of patient’s values and preferences
- Get to know your patients better
Music instrument won’t play/create music itself just as a decision aid by its own won’t create a bond or care for patients.
Wonderful music without any instruments.