

Ten Years, Forty Decision Aids, and Thousands of Patient Uses: Shared Decision Making at Massachusetts General Hospital

Take Away Points

- Shared decision making is a collaborative process that allows patients and their providers to make health care decisions together. It is increasingly becoming a regulatory obligation, particularly for accountable care organizations.
- Core components of a shared decision making program include:
 - high-quality patient decision aids (educational tools that engage patients in medical decisions and support shared decision making);
 - training clinicians and other staff members on patient decision aids;
 - engaging patients on their preferences and concerns;
 - infrastructure/organizational support (receptive culture, EMR patient identification tools and ordering)
- This study reported a successful model to guide organizations in adopting shared decision making that recommends both a team and patient-centered approach to ordering decisions aids, as a supplement to clinical conversation.

The Issue

Shared decision making is a core component of population health strategies aimed at improving patient engagement. An inherently collaborative approach, shared decision making encourages high-quality conversations that combine the expertise of clinicians; the best available medical evidence; and patients' experiences, goals, and preferences to select appropriate care. For the majority of medical situations, there is no clear best choice. In these cases, decision making requires making trade-offs among benefits and harms.

Shared decision making replaces the common heuristic of "follow the doctor's recommendation."

Recent developments put increasing pressure on hospitals and health care providers to develop strategies for shared decision making and involving patients meaningfully in their health care decisions. The National Committee on Quality Assurance Patient-Centered Medical Home Recognition program (NCQA), regulations for accountable care organizations, and insurance and employer group recognition programs all require organizations and clinicians to engage patients in shared decision making.

Study Methods and Design

Researchers gathered baseline data (pre-test) from ~260 primary care physicians (PCPs) at 18 adult primary care practices affiliated with Massachusetts General Hospital and performed follow-up evaluations (post-test) after implementing 2 initiatives:

- 1) Clinician training to support use of patient decision aids

Source

Sepucha KR, Simmons LH, Barry MJ, Edgman-Levitan S, et al. (2016). Ten Years, Forty Decision Aids, and Thousands of Patient Uses: Shared Decision Making at Massachusetts General Hospital. *Health Affairs*. 2016; 35: 630-636.
<http://content.healthaffairs.org/content/35/4/630.long>

2) Patient-directed ordering to increase decision aid use

Key Findings and Limitations

Initiative 1: Clinician Training to Support Use of Patient Decision Aids

- Baseline survey data revealed motivational factors of clinicians who were early adopters/high users of decision aids included:
 - Familiarity and comfort with the decision aids' content
 - Experience with examples of when an aid's use changed the direction of a patient's care
 - Receiving positive feedback from patients about use of the aids
- Training and the belief that using an aid would not significantly lengthen the patient visit were essential criteria noted in using decision aids with patients. In addition, receiving continuing education credit was an incentive for clinicians to watch a web-based or video aid.
- The intervention included an hour-long training session held with the PCPs and other team members, as part of a regularly scheduled meeting. The video decision aid was reviewed, along with data for its use, and brief training about the EMR-enabled ordering program was provided. Continuing education credits were provided and a post-training evaluation was conducted.
- Findings from a repeat survey months later found more than a doubling of the use of patient decision aids, and the increase was sustained over time – 78% believed the aids had definitely improved the quality of care, 65% believed the aids had changed their discussions with patients, and only 9% believed the use of the aids increased the length of the visit. Barriers noted included clinicians not remembering to order the aids (the most common barrier) and not believing patients are appropriate for decision aids.
- Lessons learned: A team-based approach is essential, not to solely rely upon the physician to remember to order an aid during an office visit.

Initiative 2: Patient-Directed Ordering to Increase Decision Aid Use

- A significant unmet demand for decision aids from patients was discovered as well as noted discrepancies between patients and clinicians regarding on which topics patients want to receive information about health issues.
 - Initially when the program started, clinicians ordered the decision aids, with the top (3) most commonly ordered aids being for prostate cancer screening, colon cancer screening, and advanced directives. However, the project revealed that patients had different preferences when asked what information/decision aids they would like to receive specifying topics related to chronic low back pain, diabetes, and anxiety.
- Although patient-directed ordering increased the use of decision aids, it did not supplant clinician-directed ordering.
- Lessons learned: It's important to find a balance between a clinician's and a patient's agendas when identifying preferred decision making tools and conversations.

Limitations: Metrics need to be created to evaluate the impact of shared decision making which includes decision quality and fulfilling the caveat of “matching the right treatment to the right patient at the right time, every time.”

Final Thoughts

- Patient engagement is one population health strategy proven in its promise of improving patients' experience and quality of their care, while decreasing costs in some instances.