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**Shared Decision Making in Clinical Practice**

Presented by [Dr. Larry Morrissey] (55-minute Webinar) 02-19-2014

**Jeri Hiniker:** Welcome everyone to our webinar this afternoon. After providing the recording and chat information I'd like to present our speaker for today, Dr. Larry Morrissey, a pediatrician at Central Pediatrics in Woodbury, Minnesota. He is the Chair of the Minnesota Shared Decision Making Collaborative. The floor is yours Larry.

**Larry Morrissey:** Thank you Jeri and thanks to everyone for listening in today. As Jeri mentioned I’m a general pediatrician. I actually spent the previous 17 years of my career at the Stillwater Medical Group in Stillwater, Minnesota. I spent a sizable proportion of that time working in administrative roles as the Medical Director of Quality Improvement, and in that role spent a lot of time trying to work on programs and develop patient centered care, focus initiatives within the Stillwater Medical Group.

I’ll be speaking to you today from that perspective and with that experience. Though I’m a pediatrician I know a lot about adult care as well, because of those roles. Just a little about Stillwater. It’s a large multi-specialty group in the east Metro area that has both primary care and surgical specialty care, which was a unique opportunity for me because as we looked at different options in terms of how to implement shared decision making in practice.

We had a wide variety of areas where we could pick and choose where we wanted to work, which made implementation easier, even though in some ways it can feel more challenging because you have that diversity. It actually gave us a lot of opportunities to craft things to specific areas that were really helpful. So the group is a part of Health Partners and being part of that larger organization also gave us opportunity to reach out in our work with other entities as well.

I want to acknowledge before we begin, a lot of the work that was done at Stillwater Medical Group was funded is implementation grants by the Informed Medical Decisions Foundation, which is a non-profit entity in Boston, Massachusetts, who’s goal is to amplify the patients making medical decisions. We received grant funding from them for several research projects.

I’m not going to give you a lot of detail about specific things, until the end but I wanted you to know that going in. Our objectives today are:

- To try to understand the basic concepts behind shared decision making and what we mean by that term.
- To learn about the experience that both patients and providers have in the process of making decisions.

I’m hoping that I’ll open your eyes as we talk about these key components to the fact that there’s more to making decisions than we often give it credit for. I’m hoping you can see a depth of how people go about making decisions, particularly medical decisions that’s a little more than we realize.
• Then we’ll spend the last part of the talk on strategies to actually do this work in practice in the real world and what the best ways are in moving that ball forward for your own organizations.

This is a little appetizer platter today, because I can’t begin to go into the depth of this topic that it deserves in the course of 45 minutes. Keep in mind it’s just a beginning and we’ll give you a taste of what’s to come, but much of the work you’ll do going forward might dive in more deeply and get a better understanding.

Next, when you hear someone give a talk, often you’re expecting the expert to be chatting with you and keep in mind that I was a general pediatrician in a multi-specialty group in 2006 and I just happened upon wanting to work in this area. Over time I became the person who gives webinars to groups across the country, but there’s nothing special about me. I try my best and learn how to do things well, so I’m just Larry and you can do this too.

It is a change and I think it’s important to understand that what we’re going to be asking you to think about today is to look at the work you do differently and understand that there is change that needs to happen within our system in this area. It’s easy to get lost in the weeds on this topics, and we will delve into more detail on some examples, but don’t get lost in the weeds too much because it’s easy to get off track as you’re trying to do this into certain areas and you want to maintain that big picture mentality initially.

I have provided a picture of my daughter and niece and it’s to do a little motivational interview at the beginning of the talk and what I try to do is appeal to people’s sense of why they do the work they do. Most people that go into healthcare have a goal of wanting to help other people and when I see the picture of my daughter I think about the fact that I want to help other people’s children have healthy lives. I do the work I do to help support my family.

In the end, connecting with the sense of why you’re doing the work that you do is a powerful too, because compared to some of the other quality improvement projects you’ve done, this kind of work appeals to a more base level that really aligns with why people got into healthcare to begin with. That’s a powerful energy you can tap into as you’re trying to make change happen.

When you see the phrase ‘patient centered care’, it means something different to different people. One of the things you have to be careful about is understanding that this concept isn’t just about letting people do what they want or giving people things to make them happy, but rather, understanding that there’s a merger between what’s important to the patient and their preferences and values, and the medical evidence we have around the decisions that we make.

Most of the time we need to utilize both of those sets of information, in order to come to the best decision. It’s incorporating all of that data that makes care patient centered and hopefully moves care in a direction that is a better experience for the patient as a whole. Why this is important is because this is a common goal for most healthcare organizations. This idea is central to the mission and vision of the work that we do. We can again, take advantage of that energy, in order to drive change in a direction that maybe you aren’t necessarily used to going.

I’m going to give you an example of a fictitious patient, but she’s real and everyone has run across her at some point in their career.
Mary is a 70-year old woman, who is diagnosed with early stage breast cancer. She’s got decisions to make about how to treat that cancer. She has other medical conditions, including diabetes, but it’s also important to understand the social context of her situation, in that her husband died and she has difficulty with transportation. Because of her difficulties with getting around, it makes the choices she might make different, based on those personal preferences of what’s most important to her.

As Mary is looking at her decision about whether to do a lumpectomy or mastectomy, we know from the medical evidence that those treatment options are pretty similar in terms of long-term outcome for her. The reality is the surrounding experience between those two can be quite different and what’s important to Mary about those decisions is probably the most important driver, and not necessarily a piece of medical information to say that one choice is better than the other.

So you can see in that story the key elements of shared decision making. We need to understand what the problem is that faces the patient and have a well defined parameter around the decision. When both the provider and the patient are on the same page about what decision is being made, I think it’s easier to have that discussion and sometimes people think you’re talking about decision A when you’re really talking about decision B.

Part of that definition is understanding all the available options for that patient and keeping in mind that doing nothing is an option in many situations. We often don’t give enough credence to the concept of not treating as a viable option, in certain situations. If our discussion was about an 85-year old man with early state prostate cancer, not treating becomes a very viable option for that man, even though it may be hard to come to that idea conceptually. To not treat cancer is sort of against what we’re engrained to believe.

The next piece is a place where there’s a real deficit, even though we think we do a good job and that’s the sharing of knowledge. When you look at research studies that measure patient understanding of the information we’re trying to communicate, there’s a big gap between what we think they know and what they actually get out of it. We aren’t as good at teaching as we think we are.

When we’re trying to put that piece of the puzzle together, understanding that the discussion of risks and benefits often isn’t as equal as it should be. People may understand one more than the other and may focus on one more than the other, depending on their perspective. We want to make sure that both aspects of the factors that influence the decision are fully explored.

Then we need to carefully elicit as healthcare providers, the patients preferences and values. What we mean by those terms is fairly specific. A preference is someone’s decision context specific feelings about a certain decision, so if your decision is colon cancer screening and I would prefer to have something that’s not interventional, I’m going to use fit testing rather than a colonoscopy.

A value is an overarching theme that fights cross conditions, so if my general value is that I do think that surgery is a safe thing to do and I’m comfortable with that, than I’m going to be more comfortable with colonoscopy as an option, because that value aligns with the choice more closely.

Then there’s an aspect of working together to come to a decision that again doesn’t always happen as much as we think. Getting patients engaged and involved is a thing that we have to work on in the process. Understanding that these decisions are not often in isolation, but rather a longitudinal relationship that we have with the patient where we need to support their decisions, and that decisions can change over time as well.
You can tell as we go along that there are references to various papers which I'll refer to as I go through the presentation.

An idea on a concept to get out on the table is that there are two experts in the room and we as healthcare providers understand the medical evidence, which is often complex and requires a lot of specialized knowledge to interpret and explain. The patient knows what's important to them and each of those two people meets the other person in order to make this relationship really work. The paper by Al Moley that I've referenced explores how we go about achieving that goal.

I have an example of a research study that looked at how well providers understand what's important to patients. The basic idea is that patients with early stage breast cancer, who were in the process of making a decision about their treatment plan, were given a list of potential things that would effect their decision. They were asked to choose the three most important things that were influencing their decision. They were asked to choose the three most important things that were influencing their decision.

Then, the doctors who were taking care of them, mostly surgeons and oncologists, were also given the same list and those doctors were asked to tell what the three most important things are to the patient. Both groups of people are being asked the same question, what's most important to the patient, but you can tell in the results that the answers people gave were starkly different.

One of the key decision points in the early breast cancer treatment is, are we going to attempt to preserve the breast or not? You can tell that 71% of the providers felt that preserving the breast was important to the patient, but only 7% of the patient listed that in the top three. Whereas, 96% of the providers felt living as long as possible was in the top three, yet only 59% of patients listed that in the top three.

What I think was most interesting about this study was that the third question which was ranked high by the patients was deferring to doing what the doctor thinks is the best thing to do. It shows you that in this moment of stress when a patient is faced with a difficult decision, they're uncomfortable and uncertain so it's a natural tendency for people to defer to the expert and not bring in what's important to them to the conversation.

Rather, they expect that someone else is going to tell them the right path to take, and you can see that it's in this environment of deferral that providers have a strong sense of the patients wanting something, but doesn't necessarily reflect what they really want. So you may end up with people going in a different direction than they might otherwise choose if they were more fully informed and had that opportunity to voice their own preferences more clearly.

This gap exists in many different areas and we picked this one example to highlight because it's so stark, but I think that this kind of disconnect happens more than we would expect and we've seen that in studies of multiple different conditions, including colon cancer screening.

I'm going to take you back just a bit to get into more fundamental aspects of making decisions in general. I want you to think about the idea of this question. When you look at the question, can you pick some milk at the store on your way home tonight? It's a fairly easy decision for you and in your mind you can relatively quickly come to a conclusion about where you're going to go to buy that milk, what kind of milk you're going to buy and it won't take long to execute a decision in this area, even if you were going to a store that was unfamiliar.

Because naturally you dwindle your available options to the things that you know are most important to you, without really even thinking about it. Now, if we were to take this question and flip it to say, now I want you to pick up milk for me, all of a sudden it becomes more difficult because you don't really know what milk I want to buy.
All of a sudden that pruning of options becomes a hindrance rather than a help, and as healthcare providers we often prune down the options before we ever get in the room and have them narrow to the things we think are best. However, they may not incorporate the things that the patient would think were the best. The first time I presented this to a group of people, it was interesting, because one of the doctors said I just don’t get the milk slide… how am I supposed to know what other people want if I don’t ask them? I told that doctor that’s the point of the talk.

Another area where you can get into trouble is numbers. Many people have heard of the concept of health literacy, but health innumeracy is also a big problem for us. Understanding what numbers mean in the context of healthcare can be quite challenging and it’s actually quite surprising, because a high percentage of people will get this question wrong, even when given a multiple choice options. Understanding what a 30% chance of rain means is not something that’s commonly understood.

Though there are ways to try and help people out in terms of understanding numbers more explicitly and there are a couple key concepts that I want to impart to you that you will see used in the tools to help people make decisions very often.

1. Using what’s called a natural frequency.

   So, rather than referring to a percentage, talking about 15 and 100 people, makes it easier for a person to understand what the numbers actually mean, compared to using the phrase 15%.

2. Using a visual aide to help people understand that ratio.

   A lot of times people who don’t understand numbers very well when you present it in more of a pictorial construct, get the idea more clearly and using tools like this picture on the right have been shown in multiple studies to improve basic knowledge of what numbers mean.

3. Another construct to be careful about is what’s called a relative risk.

   In this you can tell that the number of fractures is decreased from 19 people out of 100 to 12 people out of 100, and this picture gives you a sense of the difference that taking a medication would have for this patient. Imagine for a second that you changed the denominator and now all of a sudden it’s 19 people out of 1000 or out of 100k.

   The relative risk doesn’t change but the absolute risk does quite a bit and a lot of times relative risk actually miscommunicates information to people because they don’t understand that the absolute risk is probably the more important parameter.

4. Finally, I want you to think about the construct of informed consent.

   This is something that we rely on quite heavily in medicine. By considering another common decision that we’ve all made. When you think about buying a house, you’re contemplating different options.

   Am I going to live in the city or the country?
   Am I going to have a big or small house?

   You go through a process, which most of us have experienced, where you weigh those options and learn about the pluses and minuses of all the choices you have. Then you reach a decision based on what’s important to you about those options, often incorporating the feelings of family members or others. It’s a very complex decision, but you feel a strong sense of ownership because you know this is the biggest purchase you’re going to make in your life.
Keep in mind that some people's houses cost less than what they would end up paying to have major back surgery, and all of a sudden you realize that there are other major decisions that we place in healthcare that don't get the same degree of patient involvement in the consideration. To link this to informed consent, I would ask you to recall that many of us have been to events call The Closing, where you've contemplated your options, made your decision and now you're signing on the bottom line to purchase your house.

Think of shared decision making as the work that you do with the realtor and informed consent the work you do at the closing. You wouldn't think of going to a closing without knowing whether or not that there were three, four or one bathrooms in the house. You would want that information ahead of time. You'd want to understand what the school district was or is the basement foundation sound.

Yet, sometimes people come to the informed consent moment and the information in there is not understood. There's a lot of research that shows that patient understanding of informed consent is not adequate.

There are barriers to doing this kind of work and I think the strongest one, which I've alluded to during the beginning of this talk, is a sense that we already do this everyday. When we look at the research study that's available and you start learning more about shared decision making, you realize that the gap between what we think we do and what we’re actually doing is quite a bit wider than what we realize.

The other things listed, which have been noted as barriers of shared decision making are pretty common themes for any quality improvement project. Will this take more time? Will this cost me something? It's another thing to do in an already busy day. How am I going to get the patient to understand that this is a valuable thing for them to do when they have to do work in order to make it successful? How comfortable are people going to be when the change in their role and the changes in the process are a challenge?

You'll tell shortly that one of the biggest challenges is how fast can we take this good information and implement it so it's making a difference in the lives of patients, because there is a big gap there between what's been found in research and what we're able to do in the real world. I hope that in this first part of the talk, I've allowed you to see that there's work to do. These decisions are complex and that patient knowledge can’t be assumed.

The risk and benefits aren't well understood, but patients feel pressured to make a good choice, but may be uncertain about what that right choice is, and that healthcare providers often make incorrect assumptions about what a patient wants. I'm hoping I can help you find the way and maybe we can go from lighthouse to GPS.

So, there are tools we can use to try to help people make decisions. One of the things that's promising in this area is that the research surrounding it is strong. This is a recently published update of the Cochran Review regarding decision making and there are over 100 trials and over 30k patients that have been studied. And it's been shown to address the exact gaps that we've identified previously.

These are good quality studies, but the challenge we’re faced with is that it's been hard to move this work from the research realm out into the real world and getting people to use decision age everyday on a regular basis has been more difficult than previously expected. Wouldn’t we stop that when we know there’s a better way to treat diabetes but it wasn’t being implemented well, or there was a better way to take care of patients who had a heart attack but it wasn’t implemented well either.

We use our quality improvement skills to try to take what we learn from the research and bring it to reality for everybody.
That's where we'll go during the next part of the talk. I have a photo of myself in Lima, Peru at the International Shared Decision Making Conference, where I was being a presenter. If Larry can go from Stillwater to Lima and go from being just another pediatrician to being an expert in shared decision making, so can you. I'm going to talk a little about the path that we've come up with to try to help people out by utilizing a website that's been created for you all to use.

The website has been recently updated and was launched today. Its purpose is to help people who are interested in implementing shared decision making, to turn it from an idea into a reality. I'll go into the website just briefly to show you and then we'll go into the last objective about learning about people's experience and how to implement.

You can go visit the website and on the right hand side there is a roadmap, which is a step-by-step process of carrying people through the construct of implementing shared decision making, utilizing the experience of multiple people within the state of Minnesota who have been working on this for a while. The team came up with the roadmap for everyone to use.

The first step on the trail is what's called 'creating a shared vision’. One of the things that's been a common theme amongst the groups who have worked on implementation is that getting leadership buy-in and understanding that this work aligns with the mission and vision of many organizations. It's a powerful tool to make your chances of success greater. So, beginning the process by making sure that people the organization and on a team, understand what’s meant by that and see that gap is important.

Now, in these discussions you'll have to identify why you're doing what you're doing and hopefully, having patients who are activated and engaged in the process is something that is a strong appeal to the people who lead your organization. For some of the pages we've provided case study examples, and when you click on the more button the case study comes up, you'll see how in 2008, I went to our organizational leadership and tried to push the agenda of shared decision making within our organization forward.

You hear little vignettes about how to go about doing this and what some key learning points are. I can't go through every bit of every page, but as you can tell this is designed to give you the chance to dig more deeply, answer questions that you're faced with and hopefully, give you ideas about how to proceed.

The second page is choosing a philosophical approach to shared decision making and there are two basic ways to go about this. There's a chance the culture top down, how are we going to look at the basic way that we approach patient's viewpoints. There's a bottom up, how are we going to start with a small team and get them engaged and let the people doing the work, lead the way towards changing the culture and the environment.

Either one is a viable option and which choice is right for you will be based a lot on your personal preferences, as an organization and what you think is valuable. If you choose that bottom up approach, there are examples of different kinds of conditions that maybe you would consider. Colon cancer screening is another example of something that people have done shared decision making work on as a bottom up approach.

The next step is to get a sense of where people are, so the third bullet in the presentation is assessing the organization. One of the things we've created is a list of questions for you to consider as you're moving forward and in this page we've embedded some tools, including organizational surveys that you can use to help you answer questions within your organization about how shared decision making fits with what you're trying to do.
These surveys are open source, free for you to use. You can muck around with them as much as you want. They were developed by people within the Minnesota shared decision making collaborative, who've had experience working in this area and we've tried to use them in different settings to help understand where organizations are.

The next step is to be more precise about what you're actually going to try and accomplish. In particular, thinking about the goals you're setting, really drives the design of your project, the scale and also what you're going to measure. So this step is very important piece, because if you know where you want to go than you have a better chance of getting there. So we have examples for a project charter, frequently asked questions, etc.

The shared decision making lexicon which I won't delve into is a bit of the weeds but it's a much more complex document that looks at assessing how well you're doing with shared decision making within your organization. If you have questions about something like that there are people who are happy to help you out with understanding it in more depth.

The design phase, is your classic PDSA moment and getting in there, doing pilots, trying it out and seeing what works and what didn’t is a really great way to move the ball forward. In quality improvement we do this work all the time. Shared decision making is no different. I think it's just a matter of getting those people and the pilot to know that you're in the learning mode.

One of the points I emphasize for people is that I've made many mistakes and had many more failures than successes, but you learn from your failures as well as your successes and you want to take advantage of that to keep moving the ball forward.

One of the things that's embedded on the page are other resources around surrounding topics, including things like health literacy, motivational interviewing that we discussed.

The next page talks about measurements which are very important to you and understanding how well you've done with succeeding in your goal.

The final page is about sustainability, because in a way this roadmap when we originally wrote it is more circular than it is linear and once you get to the end of your pilot you're going to want to go back and take it to the top to start again, continuing to try to improve things and making it more and more broad in terms of scope and the number of people affected as you move the ball forward.

There are a couple other things in the last few minutes that I want to hit on, on the website just to give you a feel of what's available. At the bottom of the home page, there are a few other resources listed that you can click on. One is a brief explanation of shared decision making, which gives you the basic constructs of what we've talked about today. Embedded in that is a little video that we did of some people in Stillwater and also some links to other shared decision making websites.

On the resource page I'll also show you how to get to those other sites, but one of the sites that's available is the Ottawa Healthcare Research Institute. They have what's called an A to Z inventory of decision aides and what's nice about that is that you can see some choices you might have in terms of colon cancer. One of the things about these is that it gives you a sense of how good the aide is, who developed it and where it's from as well as how it's available?

It gives you a feel for what characteristics the aides have. It's a nice website and there's much you can learn from them. There are tutorials to teach you more deeply about shared decision making. It's a worthwhile tool.
Another thing that’s available to you is that we created an inventory of key articles that you might find helpful, so like the literature, you can go to these different articles and read the abstracts as well as links to where you can get the article if you’d like to see it in more detail.

One of the other things that we put in here as a resources page and that basically, all the other links that were scattered throughout the other pages, we pulled them all together into one place, so remember if you go I remember that survey he showed I’d like to get that. You can get to it through the research page, depending on the page it’s on.

A little about the collaborative itself. I mentioned this earlier but it’s basically people from Minnesota who care about shared decision making. We formed this group in 2008 and have been meeting ever since, trying to make shared decision making a reality for our community.

There are a lot of national experts in our group, a lot of people who represent the viewpoints of both clinical as well as research experience, quality improvement experts and people from health systems, as well as people from the government. It’s a wide variety of people that we’ve pulled together and we’ve been able to do things like put together this website for you to be able to use, pulling on that collective wisdom.

We have our charter here and I encourage you if you like shared decision making, we’re always looking for new people to participate and we expect that this collaborative will be an ongoing thing in the future.

The last piece is there is a contact page so you can reach out to us through this page if you have a question or concern. Jeri is also going to provide other ways to contact us if you need to.

A couple closing thoughts, if you want to be successful you have to be persistent and recognize that things won’t be perfect. Regarding my previous mention of being in Lima, I took a picture of myself at a statue and if you look closely at the top of the woman’s head when they commissioned the statue it was made in Spain and they ask that she have a crown of flamas.

However, it was garbled in the translation and what came back was a crown that’s a llama, so she has a llama on her head, and they kept the statue because it’s very cool that she has a crown that’s a llama. So don’t expect everything to be perfect. Understand you’re going to learn what succeeds and what fails, but your goal is to create a conversation between patients and providers, where both sides are encouraged to participate and share what they know.

Keep an emphasis on why we’re doing this, because that’s the powerful energy that can drive the process. Most importantly, don’t let it become a silo it’s not a project that exists in isolation it’s something you have to incorporate into your everyday work so that it can be part of how we do work everyday. A lot of people in the shared decision making community liken it to the mentality that we have towards evidence-based medicine now.

Thirty years ago no one knew what that term meant. Now it’s a fundamental thing we do and we expect.

So I invite you to take the journey. I was a Chicago guy who lived in the city and moved here where I met my wife. She took me to the boundary waters and I was nervous on the first trip, but I’ve come to love the outdoors and enjoy the journey, even though I don’t always know where the river’s going to lead.

With that I’m going to turn it over to Jeri and we’ll answer any questions you might have.
Jeri Hiniker: Thank you Dr. Morrissey, that was a wonderful presentation. Let’s take any questions from participants.

I have a question from Kelly, who asked if you have any suggestions or information for providers to share with patients on healthcare directives. It looks like we were provided with a good link but I was curious if you had anything else to add.

Larry Morrissey: That’s definitely an area of much interest in the realms of the folks of shared decision making, so I’ll go back to that A to Z summary for a minute. I think where those things are listed is in this summary under end of life issues. There are several different resources there. The other piece where there’s been a lot of work done, is with a guy in Boston named Angelo Valendez, who has done a lot of work around shared decision making and end of life care.

There’s much work in the twin cities with the people at Alina and other organizations who are trying to work on end of life care, so shared decision making is an integral part of that process and there have been many people working on it, so there’s definitely a community of people who are interested in that general area.

Jeri Hiniker: There is one question.

Jane –Stratis: One question I had was that as you started to work through the shared decision making, I know much of what you’ve pointed out is directed towards the provider and clinic staff. How did you get the patient involved?

Larry Morrissey: There are a couple different thoughts behind that. One of the things within our projects that we found was that when we began the process by communicating with the patient, that what they felt was important to us and then we expected them to be involved and be looking at the materials, there was a natural change that happened in how they viewed the visits when they got to the point of seeing a doctor.

We took this construct of working upstream from the visits to change the mentality that the person took when they went to see the doctor as a way of giving them the opportunity and time to be engaged. One of the things on the website is a link to an interview that they did at Minnesota Public Radio with one of our patients. She described how she had breast cancer and worked with a nurse prior to her visit with the doctor, and she was given a decision aide.

She said the first time she looked at the materials all she could do was cry. Then the second time she was able to look at the materials she started to be able to think. The third time she was able to start talking about what she wanted. Giving the patients that sense of permission and sense of time helps them to be engaged. One of the other things that we’re planning to work on as a collaborative is developing more educational tools that are geared toward patient groups to try to get their knowledge and the fact that they need to be involved built up.

We have PowerPoint’s and things that are geared more towards patients that we’ve given to some audiences and have been well received. I think it’s an important piece we need to learn more about, because it is a change for the patients as well as for the providers and we have to work on both groups understanding that they need to think about things differently in order for this to be successful.

Jane: Thanks.

Larry Morrissey: You’re welcome.
Paul Kleeberg: I have a question. To those that are really convinced that this is valuable, there may very well be one or two providers in their practice that feel that way, but as you said in the slides, many can see as a boundary the time it takes to be able to do this. What recommendations do you have to folks that begin to try and make this journey within their practice, because it can be time consuming and it is, in a sense, almost like setting up a medical home.

You have to involve a lot of folks in things that in the short run aren’t paid for, but in the long run pay off.

Larry Morrissey: There are a couple thoughts that I’ve found to be successful in that area. One is starting small. My first project was with prostate cancer treatment options and the reason I chose that was because there was only one urologist, so I only had one person that I needed to get buy-in from and I had the entire department.

What was interesting is that his positive experience with it, allowed a spread to occur that when we started thinking of the possibility of doing something for breast cancer treatment options, it was the urologist that the surgeons went to, to say is this worthwhile or not? When the surgeons heard the urologist say yes, this was a helpful thing. That sold the project. None of the surgeons ever came and talked to me at all. They ended up trying it because the urologist thought it was a good idea.

So that idea’s incremental growth is critical and that idea of letting the people who do the work on the front lines find the best path is an important part of that. We found that with some of the work we’ve done with shared decision making in our diamond project for depression, the healthcare, diamond care coordinators ended up finding the aide they felt worked the best and they actually spread the use of it through the clinic without any formal processes.

The issue of time is a challenging one, because sometimes it’s going to be more efficient and sometimes it may take longer, but the research studies go either way with that, but at the end of the day, part of what we have to do is say this is the right thing to do and even though we have to make a little bit of an investment in terms of putting the effort and energy into making this happen, if it aligns with our goals as an organization than it’s worth us taking that risk.

These decision aides oftentimes are free or relatively low cost. There are some that are more expensive than others, but working on shared decision making, especially when incorporating it within existing processes and align it with projects you’re already doing, doesn’t have to cost you an arm and a leg. You can also achieve a lot with relatively minimal investment.

I got by as a church mouse with few crumbs, but made a lot of change happen with a small amount of put up front money.

Jeri Hiniker: Any other questions?

Jane; Can you give me an idea if the EHR, can you cite how that might have helped you in any way with having an electronic tool to facilitate some of the process change?

Larry Morrissey: We did leverage, Stillwater Medical Group was on Epic during the time I worked there. We started with Alina’s version and then transitioned to another version. We tried to utilize that within our project as a way to help try to ensure more consistent delivery. We did things like best practice alerts that prompted providers to discuss PSA screening with a patient before ordering it if they hadn’t documented that they had done that.

We created orders and set dot phrases that people utilized when they were providing shared decision making, so others would know what had happened, what had been discussed and more clearly delineated for the record what the patient’s preferences
were. I think you ultimately have to incorporate what you’re doing into the workflows that are often dictated by those systems in order to make sure they happen consistently.

We utilized things like pre-visit planning which was part of the EHR, as a way to help to make sure we recognized the patient’s who needed shared decision making on certain topics and that was a helpful tool for us. It’s more challenging when you start thinking about being able to embed it into the record because that then becomes a function of the system itself.

Although they are working on that at Mayo Clinic quite a bit and have had some significant success when they’ve been able to make that decision aide part of the health record, so it’s easier for the provider to get to. There are other people who are working on other tools around the country to be in that realm of making it more electronically based and utilizing the strengths of those systems to make things happen more consistently.

Jeri Hiniker: Thank you Dr. Morrissey. There don’t seem to be any additional questions at this time. You have our contact information, myself and Dr. Morrissey. Don’t forget to fill out the evaluation.

That will wrap up this webinar. Thank you for being with us today. Bye.

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