Shared Decision Making:
An In-Depth Review of the Critical Elements for Success

August 2014

An Initiative of the Center for Medicare & Medicaid Innovation

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Purpose of This Guide....3

Overview of the Shared Decision Making in Milestone 7 4

What is Shared Decision Making? 4

List of Common Preference-Sensitive Conditions 5

Step 1: Building the Team....6

Step 2: Selecting Priority Decision Aids....6

Step 3: Determine Eligibility Criteria for Decision Aids....7

Step 4: Identifying Patients....7

Step 5: Decision Aid Preparation, Storage and Maintenance 8

Step 6: Determine When to Distribute Shared Decision Making Aids 8

Step 7: Decision Aid Tracking, Documentation, Distribution and Ensuring Return 9

Step 8: Evaluating Implementation and Making Changes 9

Case Studies....9

Conclusions.... 14

Appendix.... 16

References.... 18

TMF Health Quality Institute

This material is presented by TMF Health Quality Institute under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services.

Purpose of This Guide

This Guide reflects on how CPC practices across the country have approached using Shared Decision Making to enhance patient care. These practice strategies represent samples of the work and are not representative of every approach for implementing Shared Decision Making methodology in a practice or system.

CPC practices are heterogeneous in size, geography, ownership and organization; they are encouraged to innovate and test strategies derived from evidence-based and/or best practices and customize the work according to their particular needs, local dynamics and other practice aspects that may shape how they deliver care. This Guide captures the energy, innovative ideas and rigorous and determined execution of the CPC practices as they test Shared Decision Making strategies.

We hope that you find in your colleagues' work support for continuing to explore and refine your approach to this key component of Comprehensive Primary Care.

August 1, 2014

Overview of the Shared Decision Making in Milestone 7

Milestone 7: Shared Decision Making (SDM) focuses on supporting patients as engaged, informed and effective partners in their own health care. In Program Year (PY) 2013, your practice tested the use of a decision aid while engaging patients in Shared Decision Making. In PY 2014, *your practice will explore* ***the use of decision aids*** *to support* ***Shared Decision Making*** *between providers and patients* ***in preference-sensitive care****.* Decision aids prepare patients for a full discussion of available treatment options and offer a greater opportunity to discuss the risk and benefits of various treatment plans, as well as clarify the patients' values and health goals related to this decision. The work in this Milestone aligns perfectly with efforts around self-management support, care coordination, care management and patient and family engagement. Milestone 7 also supports the work of improving quality reported through the clinical quality measures.

Reporting on Shared Decision Making for PY 2014

For PY 2014, practices will identify and implement Shared Decision Making tools or aids in two preference-sensitive health conditions, decisions or tests, make the decision aid available to appropriate patients and generate a metric for the proportion of patients who received the decision aid.

Practices will provide quarterly counts of patients receiving the decision aids and show growth in use of the aids using run charts.

What is Shared Decision Making?

Shared Decision Making is an approach to care that seeks to fully inform patients about the risks and benefits of available treatments and engage them as participants in decisions about the treatments. (Veroff, Marr and Wennberg at http://content.healthaffairs.org/content/32/2/285.full.html)

What is Preference-Sensitive Care?

Preference-sensitive care comprises treatments for conditions where legitimate treatment options exist — options involving significant tradeoffs among different possible outcomes of each treatment (some people will prefer to accept a small risk of death to improve their function; others won't). Decisions about these interventions — whether to have them and which ones to have — should thus reflect patients' personal values and preferences and should be made only after patients have enough information to make an informed choice, in partnership with their provider. (The Dartmouth Atlas of Health Care. http://www.dartmouthatlas.org/keyissues/ issue.aspx?con=2938)

For clinicians, Shared Decision Making can translate into the potential for

- Patients who are more empowered to manage their health and treatment
- Reductions in unwarranted variation of care
- Increased awareness among patients regarding potential adverse consequences from a medical decision or treatment option

A strong body of evidence shows significant regional variation in preference-sensitive care, and this variation appears not to be due to patient choice but rather to prevailing practice patterns. Additional evidence suggests that when patients are engaged in decision making and provided with the information they need to think through options of care, there is a better match between the care they receive and their health goals and values.

For more information:

- Dartmouth Atlas on Preference-Sensitive Care
- 2014 Cochrane Summary on Decision Aids

What is a Decision Aid?

Decision aids are interventions designed to support patients' decision making by making the choice explicit, providing information about treatment or screening options and their associated outcomes, compared to usual care and/or alternative interventions. (Cochrane Database of Systematic Review 2014)

Decision aids provide:

- High-quality, up-to-date information about the condition, including risks and benefits of available options and, if appropriate, a discussion of the limits of scientific knowledge about outcomes
- Values clarification to help patients sort out their values and preferences
- Guidance or coaching in deliberation, designed to improve the patient's involvement in the decision process (http://www.dartmouthatlas.org/downloads/reports/preference_sensitive.pdf)

Shared Decision Aids versus Patient Education

Shared Decision Aids	Patient Education
Helpful for discussing preference-sensitive conditions with multiple treatment and test options	Helpful for informing patients about tests, procedures or conditions with two options, such as "yes" or "no"

It is common practice to offer patients information about tests or treatment options for which there is **clear** evidence for a recommended action (e.g., immunization or US Preventive Services Task Force recommended screenings). However, Milestone 7 is focused on engaging patients in making choices when the evidence **does not present a clear best choice** and the "right" treatment or test is the one that best fits their health goals and values. The conditions listed below are from page 62 in the 2014 Milestone Implementation and Reporting Guide.

List of Common Preference-Sensitive Conditions

- ○ Management of acute low back pain (without red flags)
- ○ Antibiotic overuse for upper respiratory infection
- ○ Anticoagulation in atrial fibrillation
- ○ Management of anxiety or depression
- ○ Management of asthma
- ○ Cataract surgery
- ○ Management of chronic back pain
- ○ Management of chronic pain
- ○ Management of congestive heart failure
- ○ Management of COPD
- ○ Medications in diabetes
- ○ Joint replacement
- ○ Podiatric surgery
- ○ PSA for prostate cancer screening
- ○ EKG and cardiac stress testing
- ○ Care preferences over the life continuum
- ○ Colon cancer screening
- ○ Management of heart failure
- ○ Management of coronary heart disease
- ○ Management of Peripheral Artery Disease (PAD)
- ○ Managing health concerns of older adults
- ○ Menopause
- ○ Urinary incontinence
- ○ Knee osteoarthritis

Other (The following are additional preference-sensitive conditions that can be considered. Note that this list is not all inclusive.):

- ○ Chronic, Stable Angina
- ○ Management of Heavy Menstrual Bleeding
- ○ Management of Carpal Tunnel Syndrome
- ○ Management of Middle Ear Fluid
- ○ Hip osteoarthritis
- ○ Management of Psoriasis
- ○ Management of Trigger Finger
- ○ Lung cancer screening in smokers
- ○ Management of Benign Prostatic Hyperplasia
- ○ Management of tobacco cessation
- ○ Management of Obesity

Step 1: Building the Team

To facilitate successful Shared Decision Making implementation, practices are encouraged to designate the following roles and provide protected time for project activities:

- **Lead Clinician/Project Champion** – to serve as the voice for the project across the practice and support staff activities
- **Lead Staff Member** – often a practice manager, QI official, nurse or staff member with an interest in patient engagement
- **Decision Aid Implementation Team** – a small, cross-functional team including the lead clinician, lead staff member and representatives from the front- and back-office staff who understand the importance of decision aid implementation for patients and the practice and who are willing to meet and work on an implementation plan
- **Patient and Family Advisory Council (PFAC)** - The team can also consider including recommendations from the PFAC as they determine the best decision for the patient population

Schedule an initial team meeting and develop a preliminary plan keeping the questions above in mind. To begin, it may be helpful to answer the following questions:

- **What** are some of the common or high-risk conditions involving preference-sensitive care in your patient population?
- **What** decision aids will help meet this need?
- **What** format is mostly likely to appeal to your patients?
- **Who** and how will you identify eligible patients for the use of decision aids?
- **Where** will the decision aids be stored?
- **When** and how will the patient use decision aids?
- **How** will your practice track the use of decision aids?
- **How** will your practice know if the process needs to be expanded, changed or refined?

Case studies that highlight the team members working on Shared Decision Making may be found at the following CPC practice links:

- Hicken Medical Clinic
- St. Elizabeth Physicians

Step 2: Selecting Priority Decision Aids

An early step in effective program implementation is determining which decision aids are appropriate for your practice. Discussing the pros and cons of choosing decision aids that focus on chronic conditions, specific surgical procedures or more rare but high-risk situations can help the team determine which decision aids will work for the practice's patient population.

Consider these questions:

- Which decision aids will target high-risk or high-cost preference-sensitive conditions faced by some of your patients?
- Which decision aids would be good supplements for viewing before procedural referrals?
- Which decision aids target the preference-sensitive conditions most prevalent in your practice?
- Which decision aids are the staff and clinicians excited about?
- Which decision aids do patients want their health care team to provide?

Case studies involving the choice of a decision aid may be found at the following links:

- Generations Family Medicine
- Hicken Medical Clinic
- Hudson Valley Primary Care
- Sangre de Cristo Internal Medicine

Step 3: Determine Eligibility Criteria for Decision Aids

Many practices may elect to use the eligibility criteria provided in each decision aid to determine when to present the decision aid to the patient. However, some practices may elect to narrow their criteria to offer decision aids to patients when they present for an annual exam or with a specific condition. Refinement of eligibility criteria may be necessary over time based on clinic capacity for distribution and tracking of decision aids.

Case studies that address eligibility criteria may be found at the following links:

- Capital*Care* Medical Group
- Generations Family Medicine
- Grants Pass Clinic LLP
- Hicken Medical Clinic
- St. Elizabeth Physicians

Step 4: Identifying Patients

In addition to clarifying eligibility criteria for the decision aids, the practice will need to determine which personnel will identify specific patients as eligible to receive decision aids. In some practices, multiple personnel are involved in patient identification. These are some of the individuals/roles who have been successfully involved in identifying patients:

- *Front Office Staff/Reception:* These individuals are often the first point of contact in a practice. Reception staff clarifies the reason for patient appointments and they may be able to flag clinicians or back office staff of a patient's eligibility for a decision aid.
- *Medical Assistant (MA) or nurse (LPN/RN):* Medical Assistants or nurses are often able to review or "scrub" the patient list and medical chart during pre-visit planning to identify specific conditions. They can inform the clinician when a patient may be eligible for a decision aid prior to the appointment time.
- *Clinician:* Clinicians can identify eligible patients during the appointment time and through recommendations made by the MA/LPN/RN.

- *Nurse Care Coordinator:* The nurse care coordinator can be involved when specific populations are targeted for distribution or when clinicians submit referrals for follow-up of certain chronic conditions.
- *Patient self-identification*: Patients may ask about options for care for their medical conditions.
- *Electronic Health Records (EHR):* Incorporating any or all of the above strategies into practice's EHR system provides the most resource-efficient method to identify patients and distribute decision aids.

Case studies that address patient identification may be found at the following links:

- Hicken Medical Clinic
- Generations Family Medicine
- Grants Pass Clinic LLP
- St. Elizabeth Physicians

Step 5: Decision Aid Preparation, Storage and Maintenance

Easy-to-access decision aid packets facilitate distribution to patients at the point of care when a decision point emerges. Advance preparation of the decision aids can streamline the process and allow for easy tracking of decision aid distribution and use.

Case studies that reflect this element may be found at the following links:

- Generations Family Medicine
- Grants Pass Clinic LLP
- Hicken Medical Clinic
- St. Elizabeth Physicians

Step 6: Determine When and How to Distribute Shared Decision Making Aids

Every practice visit flows differently so it helps to be flexible and have multiple approaches available for distributing the Shared Decision Making aids.

Case studies that reflect this element may be found at the following links:

- CapitalC*are* Medical Group
- Hicken Medical Clinic
- Hudson Valley Primary Care
- Sangre de Cristo Internal Medicine

Several options of when to distribute Shared Decision Making aids (hard-copy or link to web-based decision aid):

- ***Prior to the visit****:* Practices send decision aids to patients based on established criteria (age, category reached and type of appointment) via mail, email or patient portal.
- ***During the visit (by MA or clinician):*** The clinician presents the decision aids to the patient during their appointment.
- ***After the visit (by MA/LPN/RN):*** After the clinician has discussed the decision aid topic, the MA/LPN/RN presents the decision aid packet to the patient.
- ***After the patient has left the practice*****:** A protocol can be established for contacting the patient after the visit to discuss the decision aid, and the MA/RN or front desk staff can mail, email or send via the patient portal the materials or link to the decision aid to the patient. This option is useful if you forget or don't have the time during the office visit.
- ***When to discuss SDM:*** *at first scheduled or unscheduled visit to office*

Step 7: Decision Aid Tracking, Documentation and Distribution

Documenting decision aid distribution is extremely important to ensuring patient follow-up and managing the resources available to the practice. Coding the distribution of decision aids and discussion with the patient is critical for practice follow through. Discuss options with your billing staff and EHR IT staff to facilitate tracking of this activity. If the decision aids or access via the web is provided, a plan to for ensuring patients have an opportunity to discuss the decision aid with his/her clinician will be necessary. This may occur at a follow-up visit or via telephone or portal.

Case studies that reflect this element may be found at the following links:

- Capital*Care* Medical Group
- Generations Family Medicine
- Grants Pass Clinic LLP
- St. Elizabeth Physicians
- Sangre de Cristo Internal Medicine

Step 8: Evaluating Implementation and Making Changes

Practice change is not static. Practices should review and refine the implementation of a SDM process over time on a monthly or quarterly basis. Establish routine conversations about SDM as part of standing all-staff meetings and document internal policies, procedures and/or protocols around your SDM process. This keeps the SDM program on the table and reinforces it as part of daily clinic practice. It also engages clinicians and staff in conversations about what is working and where room for improvement exists.

Case studies that reflect this element may be found at the following links:

- Capital*Care* Medical Group
- Grants Pass Clinic LLP
- Hicken Medical Clinic

Case Studies

In the following case studies, CPC practices explain how they provided Shared Decision Making to best meet the needs of their patient population.

Capital*Care* Medical Group, Albany, New York

Corporate multispecialty clinic; 18 primary care sites; 37 physicians, 14 PAs, 6 ANPs; 58,000 patients

When staff members at **Capital*Care* Medical Group** began the selection process for shared decision aids, they kept reminding themselves to focus on what matters to the patients. To help them start small, the practice also decided to narrow its focus to patients with a new diagnosis within six months. Several practice sites chose to focus on shared decision aids for the following conditions:

- High cholesterol
- Sciatica
- Hypertension
- PSA screening
- Antibiotics for pharyngitis

There was some variation with adopted shared decision aids among the 18 primary care sites. Each practice site looked at the size of the eligible patient population for a specific aid and the need to change outcomes.

To track the use of shared decision aids, the practice worked with its EHR vendor, Allscripts, to create an "order" for use of Shared Decision Making with patients. The order is easily tracked for data mining purposes within the EHR. The order is also helpful on the patient level because it is visible during each encounter. The physician can clearly see if Shared Decision Making has happened with the patient, and if there is resolution, the order can be cancelled.

The Shared Decision Making process is performed in multiple steps. It starts with the physician and the patient beginning the conversation during the first visit. If the patient's visit is planned in advance, the SDM aid can be printed and placed in the patient's folder to facilitate the conversation. A note is placed in the patient's record to discuss the SDM aid on next visit. The second visit focuses on the SDM aid discussion.

Shared Decision Making has really become part of the culture at Capital*Care*. SDM is an agenda item at the Patient Family Advisory Council meetings to get feedback from the most important contributors, the patients.

Generations Family Medicine of SW Ohio, Middletown, Ohio
Independent; 1 physician; 2,300 patients

Shared Decision Making is a process that fits well with the style of medicine at **Generations Family Medicine of SW Ohio**. The patient population of this solo practitioner is predominantly older female patients. Using these aids facilitates the conversation as patients make informed decisions about their care.

Generations' first SDM tool assisted with the decision of using antibiotics for upper respiratory infections. The tool was obtained from the CDC. The trigger to use this tool with patients is their request for an antibiotic for an upper respiratory illness. The tool takes them through the pros and cons of various treatment methods for the illness and the consequences of each. In addition to educating the patient on choices, it empowers them to make informed decisions about how to care for this infection, when to seek additional care and the outcomes of each.

The second SDM tool developed is for treatment of osteoporosis. This fits particularly well with the demographics of the practice. The tool was purchased from the National Osteoporosis Foundation. When patients have a new diagnosis of osteoporosis or identified risk factors, the doctor and the patient spend (on average) 10 minutes reviewing the options for care and working on selecting the patient's preference for treatment. The patient is then given the pamphlet to take home. The patient's decision, or their choice to review the information and make a decision later, is recorded in the EHR.

The use of SDM tools is tracked through the EHR (Athena Health) using a miscellaneous CPT code that is not processed by billing.

This practice noted that you cannot underestimate the effect you have on a patient's life when Shared Decision Making is used. When you provide materials for patients to process and absorb prior to making a decision on a preference-sensitive condition, you empower and support them to take control of their own health.

Grants Pass Clinic, LLP, Grants Pass, Oregon

Provider-owned multispecialty; 19 physicians; 2 ANPs, 2 PAs; 17,200 patients

Grants Pass Clinic's Shared Decision Making work focuses on three major areas: cardiovascular prevention (statin use and/or aspirin use to prevent MI), osteoporosis treatment and colorectal cancer screening options. The practice uses their EHR, Allscripts, to create custom searches by diagnosis codes to identify eligible patients to receive the shared decision aids. For example, patients eligible for the statin SDM are all patients who have been seen since January 1, 2013 and have one or more of the following:

1. Cardiovascular disease with LDL > 100
    a. includes diagnosis codes related to CVD between 390 and 459.9
    b. most recent LDL dated within the last five years > 100
2. Diabetes with LDL > 100
    a. includes all codes beginning with 250
    b. Most recent LDL dated with the last five years > 100
3. Hyperlipidemia with LDL > 130
    a. All active patients with most recent LDL within the last five years > 130 regardless if the patient has an active hyperlipidemia diagnosis

Providers selected decision aids from Mayo Clinic because they were authoritative, graphically satisfying and were available to share with the patients in real time. They can access the decision aids immediately during the patient encounter through links posted to the exam room's client desktop. Providers document use of the aid in a discrete field in the notes section of the patient's record.

The clinic is working toward a SDM dashboard application that is provider-specific so that each provider can monitor his or her patient panel for eligibility for all decision aids.

To ensure the proper use of decision aids in the practice, they created a policy around the defined workflow. The policy helped to make the use of the decision aids more uniformed among the various providers; it addressed how to use of the decision aid and how to document it in the EHR properly. Standardizing the documentation in the EHR helps ensure accurate data for reports in the defined discrete data fields. The policy also serves as a documented shift in thinking about the patient's voice in choosing screening and treatment options.

Hicken Medical Clinic, Hillsboro, Oregon

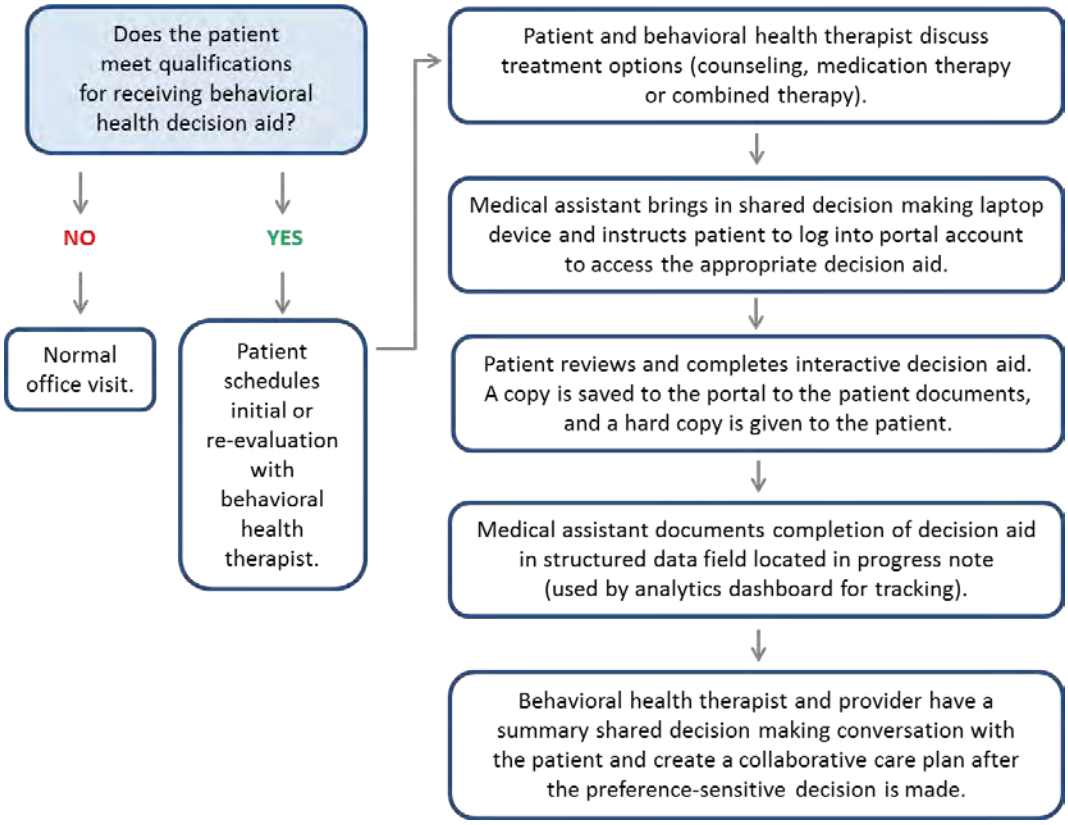
Independent; 1 physician, 3 PAs; 6,200 patients

Dr. Hicken realized that he alone could not drive practice transformation and that it is important to dedicate time and resources to improve. The CPC initiative has help them adopt a team-based approach to integrate Shared Decision Making into the practice's daily workflow.

The **Hicken Medical Clinic** team followed their chosen criteria as it researched decision aids for the practice. First, they wanted aids that met the International Decision Aids Standards for quality and content. Second, they preferred tools with a step-by-step approach that clearly compared both risks and benefits. Third, tools needed to integrate with the patient portal and patient health record preferably in a digital format that kept the office paperless. Finally, the tool should help patients understand their choices and help them communicate their preferences. Another desirable feature was the tool would include the option to create a summary of the patient's decision that could be documented within the patient record.

They found Healthwise's Knowledge Base offered interactive decision aids that patients could access through the patient portal and later access the decision summary as well. The Healthwise aids also offered an array of tools addressing preference-sensitive conditions and treatment that met the clinic's current needs with the ability to easily add other topic areas in the future.

For the initial implementation of SDM, the clinic decided to test two decision aids along with a new workflow with a small population of patients. They started with "Should My Child Take Medication for ADHD?" and "Depression: Should I Take an Antidepressant?"



Decision tree for use of Shared Decision tool in Behavioral Health

They chose these preference-sensitive conditions/treatments because they occur nearly daily in the office's usual workflow, which afforded providers and the medical assistant staff adequate opportunity to test and adopt the workflow. They also chose conditions/treatments that would support the clinic's newly expanded integrated behavioral health services. Because visits related to behavioral health are 30 or 60 minutes versus a 15-minute general visit, these visits afforded more flexibility to introduce SDM to the patient with limited disruption to the overall schedule during the adoption phase.

Patients are identified during pre-visit planning or are identified during the visit. If the practice staff know about a patient prior to a visit, they are able to alert the behavioral health specialist, physician assistant and the physician as needed so they can participate in the shared decision conversation. Some patients will listen to the information, but prefer to take some time to think about their options and come back for a

second visit. The staff can help the patient set up the follow-up appointment as well as provide a summary for review at their convenience.

Hicken Medical Clinic's staffing patterns have remained the same as Shared Decision Making was integrated into the mid-office workflow. Later, as the SDM process became more fluid for the team members, they added "Low Back Pain: Should I Have an MRI?" Like the other topic areas, low back pain is a common complaint among the practice's patient population.

In the near future, Shared Decision Making may be integrated into the clinic's proactive population management model.

Hudson Valley Primary Care, Wappingers Falls, New York
Independent; 2 physicians, 2 ANPs; 8,290 patients

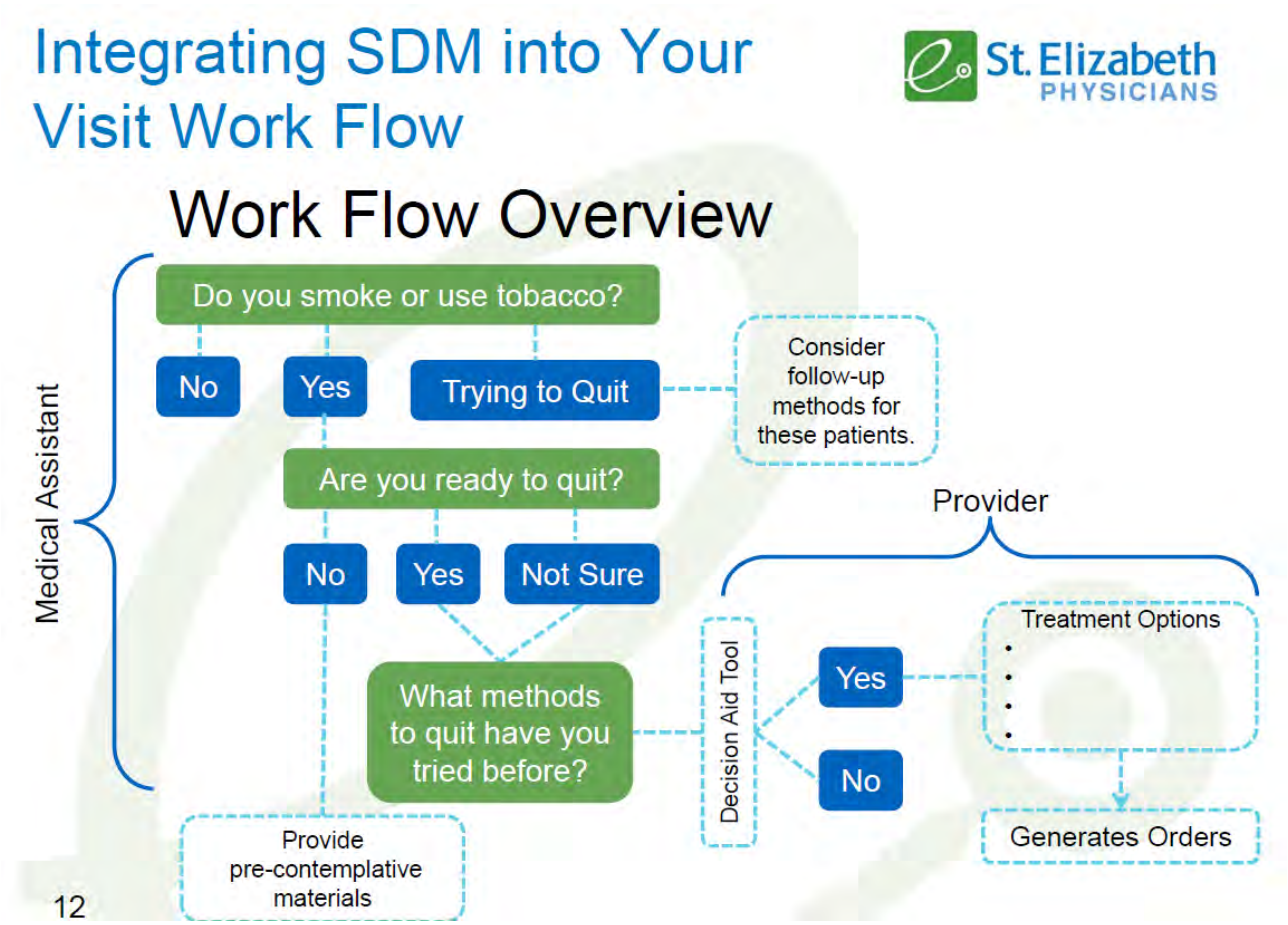
This practice decided to focus on the area of diabetes medications for Shared Decision Making because both physicians are NCQA-recognized diabetes providers. The Mayo Clinic aid on the use of diabetes medication was selected because it provided the complete picture about the pros and cons of the medications, costs and possible side effects. The aid also allowed the patient to have a very clear picture of their possible options.

After deciding on the aid, the practice worked to incorporate the aid into their workflow. The practice integrated the aid into the EHR, eClinicalWorks. By using the Healthwise products, the practice is able to embed links to shared decision aids directly into the order sets, which really made it easy for the staff to embrace and share the aids with the appropriate patients. Using a tablet, the nurse is able to walk through the aid with the patient prior to the provider entering the exam room. This process allows for the maximum effective use of the provider's time with the patient. Use of pre-visit planning and huddles allow the practice to help identify the patients who could benefit the most from a shared decision aid and therefore make the best use of everyone's time during the appointment. For example, if a provider is able to review a patient's lab work and determines an aid would be appropriate, the clinical team can ensure the patient receives the aid prior to the next appointment through the patient portal. Asynchronous workflow through the patient portal has helped streamline the use of aids in this practice.

St. Elizabeth Physicians CPC Practices, Northern Kentucky
System; 14 CPC practices; 65 physicians, 1 PA, 5 ANPs; 65,000 patients

Putting Shared Decision Making into practice within the CPC practices of **St. Elizabeth Physicians** was a team effort. As work began on Milestone 7; the clinical leadership group evaluated the data on their population and selected the first focus of Shared Decision Making. The initial target was tobacco cessation (options to support quitting). This is also a community issue, with a high number of patients that smoke.

As this leadership group reviewed various Shared Decision Making tools, they created a tool that was drawn from evidence-based options for smoking cessation yet included endorsed treatment options by the physicians in the group. Patients are chosen for Shared Decision Making based upon their response when asked if they are ready to quit smoking. If they indicate they wish to quit, the SDM tool is reviewed with them, and the physician reviews the options in the tool with the pros and cons of each option. If the patient selects an option, the physician records this in the EHR (Epic) as the patient's preference. The SDM tool also prints in the after-visit summary with the patient's preference indicated.



Tracking the use of the SDM tools is done in Epic. With discrete fields in the EHR, they are able to track the number of patients eligible for use of SDM and the number of tools used with patients. With that, they can calculate the adoption rate, which now stands at well over 60 percent.

One challenge this group found with implementing Shared Decision Making is the amount of time it took to do the planning and then train all involved parties to implement the process. A 10-month process to accomplish this with the first tool was noted. At this point, process metrics are available, but it is still a bit early to see the actual outcomes of the tobacco cessation activity.

Sangre de Cristo Internal Medicine, Pueblo, Colorado
Independent; 1 physician; 1,100 patients

Sangre de Cristo Internal Medicine selected shared decision aids based on commonly encountered diagnoses. Three decision aids were selected from Mayo Clinic in the areas of statin and aspirin use for primary prevention and osteoporosis. An additional aid was selected from the American Urological Association on PSA screening. The staff loaded each aid to the practice's website so that patients can view them after the visit.

When patients fall into one of the SDM aid categories, Dr. Duffee uses the tools on the Mayo website to review with the patients. The patients are very engaged during this process, helping to answer questions and converse with the physician about the important points in the decision aid. Patients often jump out of their chair and walk over to the computer to see the final risk numbers and watch the aid in action.

After the conversation with the patient, the physician documents the risk numbers from the online decision aid in the eMDs data review section. The data review section in this EHR is not a discrete data field and cannot be used for reporting, so the physician enters CPT and ICD-9 codes into the patient's problem list, which the registry can pick up and use for data reporting. Beyond the advantage of reporting, the Shared Decision Making CPT and ICD-9 codes stay in the patient's problem list so that Dr. Duffee can quickly confirm if a shared decision aid has previously been reviewed with the patient. Dr. Duffee believes that the shared decision aids help patients better understand their specific risks. About 80 percent of patients are able to make a decision after the conversation with the use of the decision aid and about 20 percent ask the physician to help them make the final decision.

CPT Codes that can be used for documenting and tracking SDM use:

- **CPT Code 99071**—educational supplies, such as books, tapes and pamphlets provided by the physician for the patient's education at cost to the physician
- **CPT Code 99078**—physician educational services rendered to patients in a group setting (e.g., prenatal, obesity or diabetic instruction)
- **CPT Code 98960**—education and training for the patient by a qualified, non-physician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family), each 30 minutes; individual patient

Conclusions

Implementing Shared Decision Making may take some time and require overcoming a few challenges along the way, as this is a significant shift in how some practices are now inviting patients to engage in their care. The benefits of Shared Decision Making in the practices that have experienced successful implementation appear overwhelmingly positive. Shared Decision Making allows patients to engage more in their health care experience by supporting them as they make fully informed choices on the treatment or screening options that are best for them. By placing patient-friendly, easy to use, high quality and up-to-date decision aids into the hands of patients, they can truly be a supported and empowered part of their care team. Practices who have implemented Shared Decision Making have been able to see and hear the positive difference directly from their patients.

Appendix

Smoking Cessation Decision Aid from St. Elizabeth's Physicians

	Pharmacology Nicotine Replacement Therapy			No Aid	
	Nicotine Inhaler	Nicotine Gum	E-Cigarette	"Cold Turkey"	Taper
Cost (The average cost of smoking per year: $1,600)	about $12-$15 a day	about $2-$5 a day	Starter Kit $20-$90 Catridges or "Juice" $5-$10	FREE	about $2-$5 a day
Routine	6-16 cartridges per day for 12 weeks. No additional nicotine products.	Week 1-6: 1 every 1-2 hrs. Weeks 7-9: 1 every 2-4 hrs. Weeks 10-12: 1 every 4-8 hrs. No additional nicotine products.	Varies. No additional nicotine products.	No Smoking	Varies
Side Effects	•Throat and/or mouth irritation •Cough •Stomach upset •Change in taste •Sinus pain/pressure •Pain in the jaw, neck or back •Headaches	•Burning in throat •Hiccups if chewed too quickly •Dental problems	•Throat/mouth irritation •Cough •Stomach upset •Change in taste •Sinus pain/pressure •Jaw, neck or back pain •Headaches	Nicotine withdrawal	Nicotine withdrawal
Success Rate	4%	4%	Research still being conducted as a smoking cessation tool.	3.5%	
Contact Info	Your healthcare provider	Local pharmacy	Local retailers, internet	Congratulations! You have decided to quit - now what? Make an appointment to talk with your provider.	

St. Elizabeth PHYSICIANS

Smoking Cessation Guide

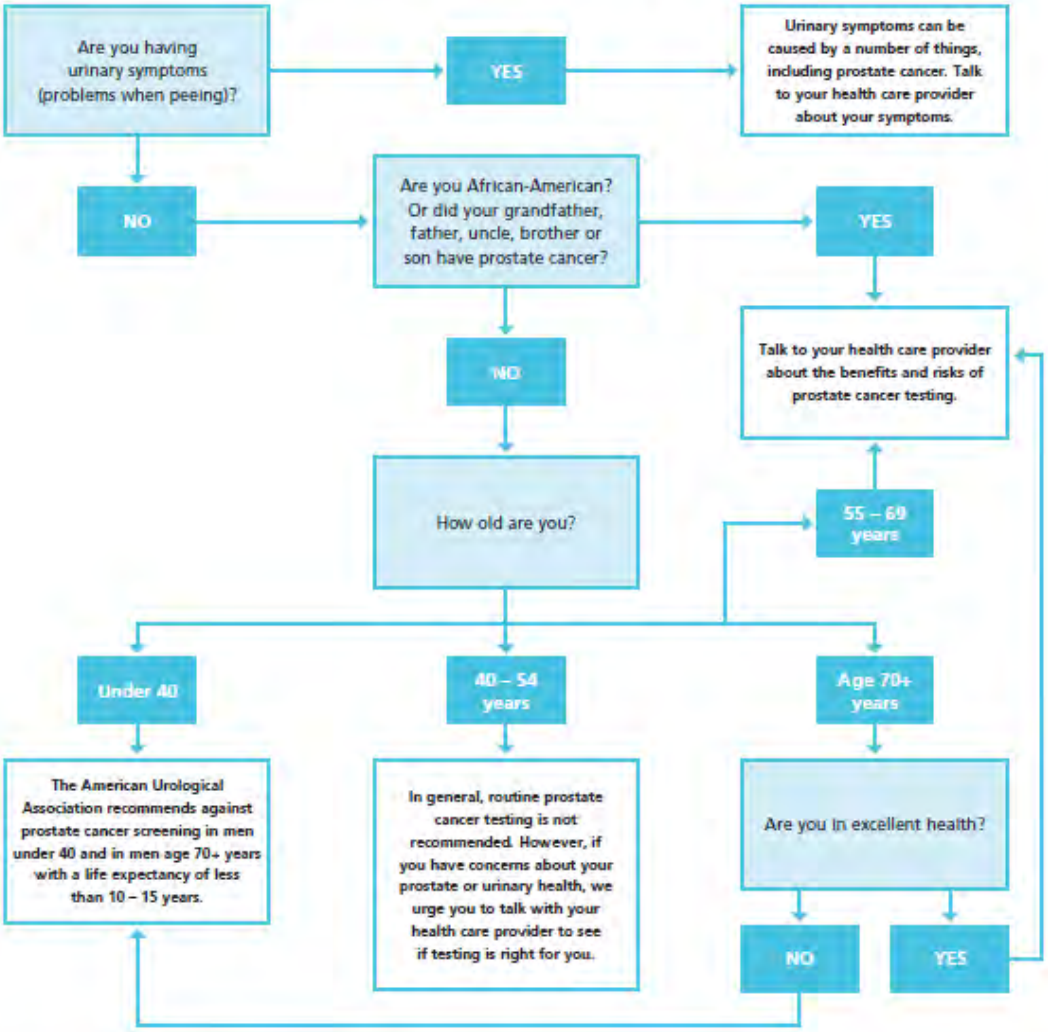
Your guide to medical care decisions.

www.stedocs.com

	Therapy			Pharmacology Nicotine-Free Quit Aids		Pharmacology Nicotine Replacement Therapy	
	Hypnosis	Counseling (Cooper Clayton; Quitline)	Acupuncture	Bupropion (Wellbutrin, Voxra, Etc)	Varenicline Tartrate (Chantix)	Nicotine Patch	Nicotine Lozenge
Cost (The average cost of smoking per year: $1,600)	$40-$100 per session	Cost varies	$75-$250 per session	about $2-$3 a day	$5 a day	about $4-$5 a day	about $6-$7 a day
Routine	Varies	Varies Cooper Clayton available in 6 or 14 week sessions and online.	Varies	150 mg every morning for 3 days, then twice a day for the duration of treatment. Use of tobacco products permitted.	Tablet a day as prescribed by your provider. Use of tobacco products permitted.	Apply new patch every 24 hours. No additional nicotine products.	Week 1-6: 1 every 1-2 hrs. Week 7-9: 1 every 2-4 hrs. Week 10-12: 1 every 4-8 hrs. No additional nicotine products.
Side Effects	None	None	Discomfort	•Dry mouth •Insomnia •Suicidal thoughts	•Nightmares •Nausea •Constipation •Gas •Suicidal thoughts	•Itching, burning or tingling when the patch is applied •Redness or swelling at the patch site for up to 24 hours •Dizziness, headache •Upset stomach, vomiting •Diarrhea	•Sore throat •Heartburn •Nausea/indigestion •Hiccups
Success Rate	Variable	40-45% with Nicotine Replacement Therapy *14 week Cooper Clayton program	Variable	8%	10%	4%	4%
Contact Info	Synergy Holistic Health Center (859) 525-5000 Mary Kacaba, CCH: Certified Clinical Hypnotherapist Resources Within, LLC www.ResourcesWithin.com (513) 675-1120	Cooper Clayton KY: (859) 301-5570 nkyhealth.org OH: (513) 263-8699 Quit Line: 1-800-Quit-Now	Gregory Koo, MD stedocs.com St. Elizabeth Healthcare Family Practice Center Mary Ann Barnes, MD (859) 301-3800	Your healthcare provider	Your healthcare provider	Local pharmacy	Local pharmacy

Sangre de Cristo Internal Medicine PSA Decision Aid

Is Prostate Cancer Screening Right for You?



WHO IS AT RISK OF DEVELOPING PROSTATE CANCER?

Prostate cancer is the second most common cancer in men, and the second-leading cause of cancer death in men. One in six men will be diagnosed in his lifetime. African-American men and men with a family history of prostate cancer have a higher chance of getting the disease.

Prostate cancer is different from many cancers because it often grows very slowly and may not cause problems. In 2012, more than 240,000 men were diagnosed with prostate cancer, and only about 28,000 American men died of the disease. Many men with prostate cancer will never know they have it unless they get tested.

SHOULD I GET SCREENED FOR PROSTATE CANCER?

THERE ARE POSSIBLE BENEFITS TO HAVING A PSA TEST:

- A normal PSA test may put your mind at ease.
- A PSA test may find prostate cancer early before it has spread.
- Early treatment of prostate cancer may help some men to avoid problems from cancer.
- Early treatment of prostate cancer may help some men live longer.

THERE ARE POSSIBLE RISKS OF HAVING A PSA TEST:

- A normal PSA test may miss some prostate cancers (a "false negative").
- Sometimes the test results suggest something is wrong when it isn't (a "false positive"). This can cause unneeded worry and stress.
- A "false positive" PSA test may lead to an unneeded prostate biopsy (tissue sample).
- A high PSA test may find a prostate cancer that is slow-growing and never would have caused you problems.
- Treatment of prostate cancer may cause you harm. Problems with getting erections, leaking urine or bowel function can occur.
- According to the American Urological Association, in asymptomatic men, the greatest benefit of routine screening can be found in men ages 55 to 69 years. Men younger than 55 or older than 69 who are worried about their personal risk factors should talk with their health care provider to determine whether prostate cancer screening is appropriate.

American Urological Association

Urology Care FOUNDATION™
The Official Foundation of the American Urological Association

Should You Be Screened for Colon Cancer?

- If you are **50 to 75 years old**, you should have regular colon cancer screening.
- If you are 76 to 85 years old, you should talk to your doctor about it.
- Some people who have certain high risk factors may need to be screened before the age of 50. If you think you may be at high risk, talk to your doctor about it.

Why Should You Be Screened?

- Colon cancer is the second leading cause of deaths caused by cancer in the United States.
- Colon cancer screening tests find problems early, when treatment can work best.
- If everyone had colon cancer screening when it is recommended, over half of all deaths from colon cancer could be prevented.
- You can have colon cancer without having any symptoms.
- Most cases of colorectal cancer happen in people who do not have risk factors for it.

What Are Your Choices?

Fecal Occult Blood Test – This is a test you do at home. You collect a small amount of stool and smear it on a card that you send to your doctor or a lab. The test shows if there is any **blood in the stool that you cannot see**.

- **Works well** to reduce deaths from colon cancer.
- Done every year.
- Test may be positive, even if there is not a problem.
- Test may be negative, even if there is a problem.
- Test may not detect early problems before they turn into cancer or some kinds of cancer.
- At least 1 of every 10 people who have this test will be advised to get a colonoscopy.

Flexible Sigmoidoscopy – This test uses a small, flexible tube with a tiny video camera at the tip. The camera lets the doctor see the inside of your **rectum and the lower part of your colon**.

- **Works very well** to reduce death from colon cancer.
- Done every 5 years.
- You do not usually need to be sedated for this test.
- If the doctor sees a problem, a biopsy can be done at the time of the test.
- You usually need to do 1 or 2 enemas to empty your colon before the exam. You might not be able to eat solid food the day before.
- Test may not find problems higher up in the colon.
- You might have cramping or bloating after the test.
- Rare complications include bleeding from a biopsy or a small tear in the lining of the colon. Very rarely, people get a tear in the colon from the test.
- Some people who have this test will still need to get a colonoscopy.

Colonoscopy – This test uses a long, flexible tube with a tiny camera. The camera lets your doctor see your **entire colon**.

- This is felt to be **the best** colorectal cancer screen test.
- Done every 10 years.
- Abnormal growths can be removed at the time of the test.
- You will need to be sedated for the test, so you will need someone to drive you home.
- You must take laxatives and avoid solid food the day before the test, so the colon is empty and clean.
- You might have cramping or bloating after the test.
- Rare complications include bleeding from having something removed or from a tear in the colon or the rectal wall. Sometimes, people have to stay in the hospital from complications.
- Very rarely, people die from complications of having this test.

How Will You Decide What Is Best for You?

It may not be easy to decide which test is best for you, but having a colon cancer screening test can save your life. Talk to your doctor about your options. The most important thing is to get tested.

The sooner colon cancer is found, the easier it is to treat.

Where Can You Find More Information?

There are many websites that have good information about colon cancer, colon cancer screening, and ways to prevent colon cancer. Here is a list you may find helpful:

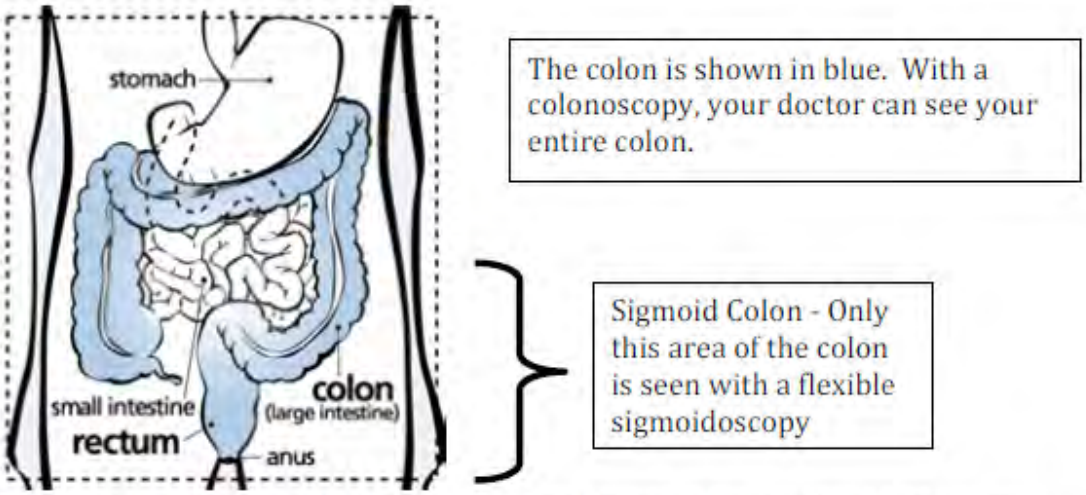
Centers for Disease Control and Prevention
http://www.cdc.gov/cancer/colorectal/basic_info/screening/

Mayo Clinic
http://www.mayoclinic.org/diseases-conditions/colon-cancer/basics/definition/CON-20031877

National Cancer Institute
http://www.cancer.gov/cancertopics/pdq/screening/colorectal/Patient/

American Cancer Society
http://www.cancer.org/cancer/colonandrectumcancer/index

Here is a good tool that walks you through the decision process:
http://www.cancerscreeningdecision.org/about.cfm



This illustration from Centers for Disease Control and Prevention web site (http://www.cdc.gov).

Policy and Procedure

Shared Decision Making Colorectal Cancer Screening

Date Adopted:

Date Revised:

PURPOSE:
To assure increased rates of colorectal cancer screening among the eligible Grants Pass Clinic patient population while simultaneously providing patients an opportunity to actively participate in the decisions affecting their care.

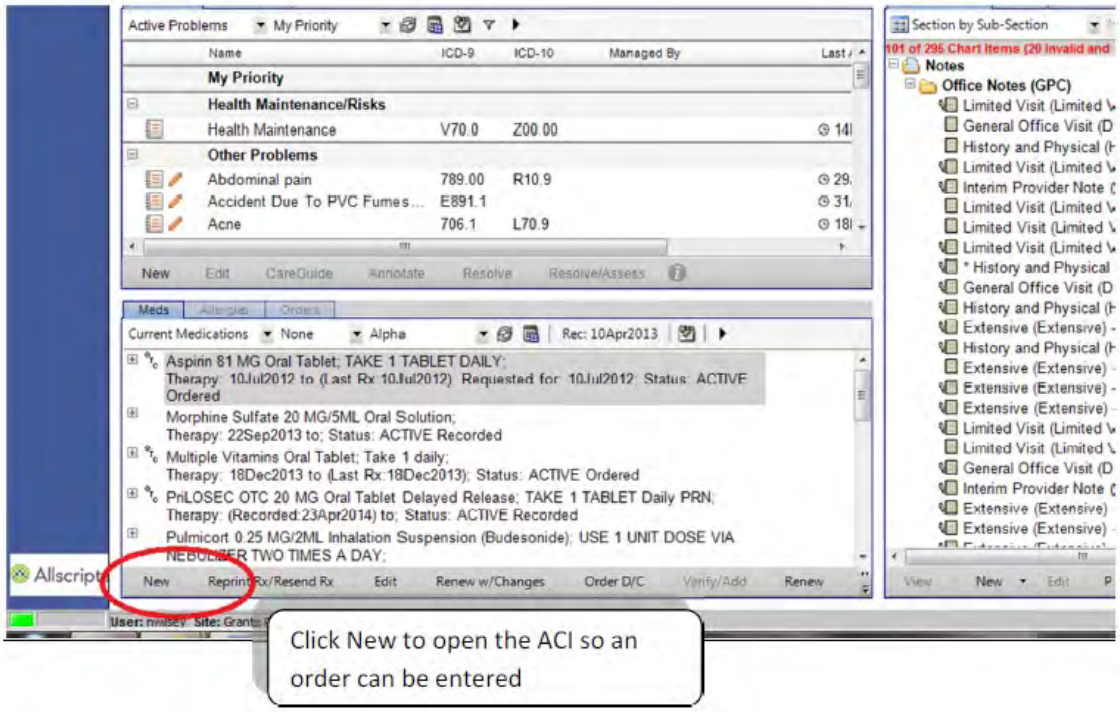
POLICY:
Clinic staff will follow the procedure outlined below to provide patients an opportunity to discuss colorectal cancer screening options with their provider using shared decision making techniques.

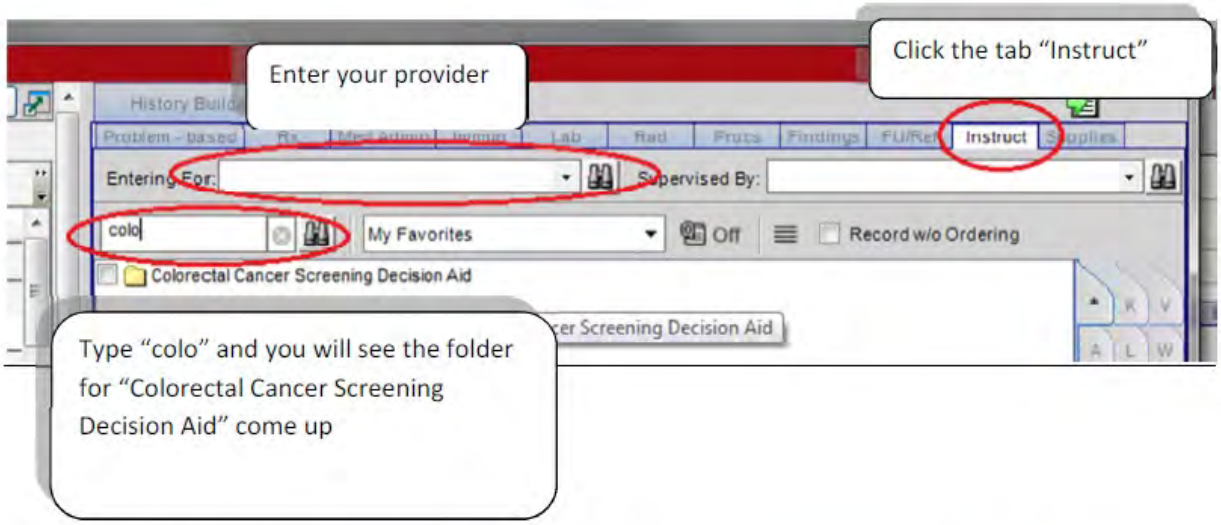
PROCEDURE:
During the adult annual office visit, eligible patients aged 50+ will be provided the Colorectal Cancer Screening Decision Aid by the medical assistant, allowing them the opportunity to read the decision aid and formulate any questions they may have. Patients will then be instructed to notify their provider during the office visit that they would like to discuss their options/questions.

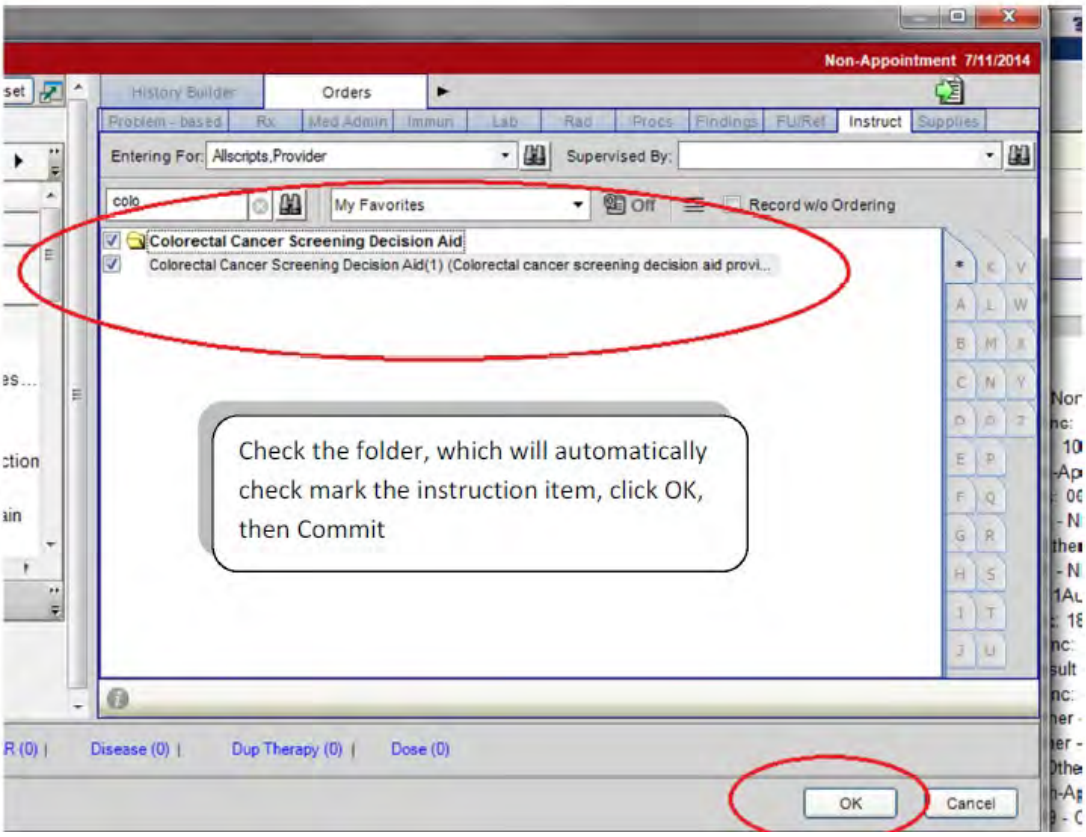
Medical Assistants will document by checking the appropriate box in the EMR that the patient has been provided the colorectal cancer screening decision aid, and has been encouraged to discuss the colorectal cancer screening options with their provider/care team.

Ordering and Documenting Colorectal Cancer Screening Decision Aid

- If patient is between ages 50-75 and here for an annual visit, they meet the criteria to receive the Colorectal Cancer Screening Decision Aid
- MAs will distribute the handout when they room the patient and instruct them to read through it. If they have any questions/concerns, or would like to discuss their options, instruct them to bring them up with their provider during this office visit. See scripting below:
    - "Based on your age, we have identified you as being eligible to receive our Colorectal Cancer Screening Decision Aid. If you would like to discuss your options, or have any questions or concerns, you can bring them up to your provider during this office visit."
- The MA will then document in the EMR that the patient received this handout using the following method:




Enter your provider
Click the tab "Instruct"
Entering For:
Supervised By:
colo
My Favorites
Off
Record w/o Ordering
Colorectal Cancer Screening Decision Aid
Type "colo" and you will see the folder for "Colorectal Cancer Screening Decision Aid" come up


Non-Appointment 7/11/2014
History Builder
Orders
Entering For: Allscripts,Provider
Supervised By:
colo
My Favorites
Off
Record w/o Ordering
Colorectal Cancer Screening Decision Aid
Colorectal Cancer Screening Decision Aid(1) (Colorectal cancer screening decision aid provi...
Check the folder, which will automatically check mark the instruction item, click OK, then Commit
Disease (0)
Dup Therapy (0)
Dose (0)
OK
Cancel

Generations Family Medicine of SW Ohio Antibiotic Decision Aid

GET SMART…

- Antibiotics are strong medicines, but they don't cure everything.
- When not used correctly, antibiotics can actually be harmful to your child's health.
- Antibiotics can cure most bacterial infections. Antibiotics cannot cure viral illnesses.
- Antibiotics kill bacteria – not viruses.
- When your child is sick, antibiotics are not always the answer.

USE ANTIBIOTICS WISELY

Talk with your healthcare provider about the right medicines for your child's health.

For more information, see the Centers for Disease Control and Prevention website at:
www.cdc.gov/getsmart or call 1-800-CDC-INFO

FOR PARENTS

GET SMART
Know When Antibiotics Work

Snort. Sniffle.
Sneeze.
No Antibiotics
Please.

When your child is sick, you want to do everything you can to help. But antibiotics are not the answer for every illness. This brochure will help you know when antibiotics work – and when they won't. For more information, talk to your healthcare provider or visit www.cdc.gov/getsmart.

The Risk: Bacteria Become Resistant

What's the harm in giving your child antibiotics anytime? Taking antibiotics when they are not needed can cause some bacteria to become resistant to the antibiotic.

These resistant bacteria are stronger and harder to kill. They can stay in your child's body and can cause severe illnesses that can't be cured with antibiotics. A cure for resistant bacteria may require stronger treatment – and possibly a stay in the hospital.

To help prevent antibiotic resistance, the Centers for Disease Control and Prevention (CDC) recommends giving your child antibiotics only when necessary.

Antibiotics Aren't Always the Answer

Most illnesses are caused by two kinds of germs: bacteria or viruses. Antibiotics can cure bacterial infections – not viral infections.

Bacteria cause strep throat, some pneumonia and sinus infections. *Antibiotics can work.*

Viruses cause the common cold, most coughs and the flu. *Antibiotics don't work.*

Using antibiotics for a virus:

- Will NOT cure the infection
- Will NOT help your child feel better
- Will NOT keep others from catching your child's illness

Protect Your Child, Give the Best Care

Antibiotics should not be used to treat the common cold, runny noses and most coughs. Children fight off these viral illnesses on their own.

If your child's healthcare provider prescribes an antibiotic to treat a bacterial infection – like strep throat – be sure to give your child all of the medicine. Only using part of the prescription means that only part of the infection has been treated. Not finishing the medicine can cause resistant bacteria to develop.

Talk to Your Healthcare Provider to Learn More

Commonly Asked Questions:

How Do I Know if My Child has a Viral or Bacterial Infection?

Ask your child's healthcare provider and follow his or her advice on what to do about your child's illness.

Remember, colds are caused by viruses and should not be treated with antibiotics.

Does This Mean I Should Never Give My Child Antibiotics?

Antibiotics are very strong medicines and should be used to treat bacterial infections. Your healthcare provider will prescribe antibiotics if your child has a bacterial infection.

If Mucus from the Nose Changes from Clear to Yellow or Green — Does This Mean That my Child Needs an Antibiotic?

No. Yellow or green mucus does not mean that your child has a bacterial infection. It is normal for mucus to get thick and change color during a viral cold.

References

A Dartmouth Atlas Project Topic Brief: Preference-Sensitive Care
This article reviews the various effects and problems of preference-sensitive care in the United States.

Colonoscopy Shared Decision Aid
This colorful decision aid is ready to print for use in practices.

Colorectal Cancer Screening Shared Decision Aid
This link is a shared decision tool used at Grants Pass Clinic.

Decision Aids to Help People Who Are Facing Health Treatment or Screening Decisions
This Cochrane Summary contains useful information on SDM.

Enhanced Support for Shared Decision Making Reduced Costs of Care for Patients with Preference-Sensitive Conditions
A recent Health Affairs article regarding the effect of SDM on costs.

Informed Medical Decision Foundation
This website explains Shared Decision Making through text and movie clips, including a list of demonstration sites who have implemented Shared Decision Making into their practice.

Integrating Patient Decision Aids into Primary Care Practice: A Toolkit to Facilitate Shared Decision Making
This website will take you step by step though practice readiness, planning and evaluating for Shared Decision Making. The implementation content from this guide was from this toolkit.

Milestone 7: Using Decision Aids to Improve Shared Decision Making, Oklahoma (Greater Tulsa) webinar, April 3, 2014
This session is an overview of SDM in Oregon and contains some good resources for practices.

Milestone 7: Shared Decision Making, Oklahoma (Greater Tulsa) webinar, Nov. 8, 2013
This learning session has a good overview of Shared Decision Making, with good practice examples explained.

Patient Decision Aids from the Ottawa Hospital Research Institute
This site has tools you can access and forms ready to use for personal decisions.

Patient-Provider Partnership – Shared Decision-Making Low Back Pain Patient Available Tools
Lists the sources for SDM tools for low back pain.

Resources from Million Hearts® Initiative that Supports CPC Practices' Work in Milestones 2, 5 and 7
Million Hearts® materials and link to the site are included in this post.

Shared Decision Making Article: Engaging the Patient's Experience
This article reviews the work at Carolinas Medical Center – Mercy using asthma SDM.

Shared Decision Making Article: Signs of the Times (Part II)
Contains link to an article on the impact of SDM on patient decisions.

Shared Decision Making Tools, Arkansas webinar, April 11, 2014
Shared Decision Making Tools and how to develop them in your practice is reviewed.

Shared Decision Making, Colorado webinar, June 6, 2014
Shared Decision Making presentation by Richard Wexler has good information and resources.

Shared Decision Making, New York webinar, June 17, 2014
Webinar contains a presentation by Diana Stilwell, VP for Content, Healthwise Inc.

Shared Decision Making, Ohio/Kentucky webinar, April 9, 2014
This session reviews reporting requirements, tips and practice examples.

Shared Decision Tools
Contains a SDM tool for contraception and link to other SDM tools.

Six Steps to Shared Decision Making
This link contains a card and the associated language from Informed Medical Decisions Foundation.

Spotlight Article 13: Grants Pass Clinic on Shared Decision Making
This article is an overview of the process taken by an Oregon CPC practice.

Spotlight Article 14: Hicken Medical Clinic and SDM
This article has additional information about the Hicken Medical Clinic's SDM process.