National Health Disparities Webinar: Equity and Shared Decision Making

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Hello everyone. I'm Krystal Gomez from TMF Health Quality Institute. Welcome to our national webinar session entitled Equity and Shared Decision Making provided by Finding Answers. Finding Answers is a national program of the Robert Wood Johnson Foundation with direction and technical assistance provided by the University of Chicago. First a few announcements. Today's program is being recorded and will be posted to the collaboration site. The slides for today's presentation will be available for download on the collaboration site. We appreciate the presenters' time and effort in preparing for and sharing their valuable knowledge. Any statements regarding their technology, products or vendors are expressions and opinions of the person sPeeking and not an opinion of nor endorsed by the Centers for Medicare and Medicaid Innovations nor TMF Health Quality Institute nor the host of the program. To enrich your listening and participation experience here are a few tips. All lines will remain muted throughout the session. To submit questions click on the question and answer tab on the right hand side of your screen. I would now like to introduce Dr. Perry Payne for some introductory comments. Perry Payne was recently hired as the region lead for New Jersey and Oregon. He will also be leading an effort to audit the CPCI. Prior to this job he was a faculty member at George Washington University on the School of Medicine and School of Public Health. Now, here's Dr. Perry Payne.

Hi, everyone. I'd also like to say thanks again for taking time out of your busy day to participate in this webinar. Today we have our second session in the series on health disparities. Today's session is focused on equity and shared decision making. This session is related to a number of the Milestones that you're working to achieve, but it's particularly relevant to Milestone number 7 which is focused on shared decision making with a particular emphasis on the use of decision aids. We're extremely excited about the presentation that the faculty have put together for you today. I was part of this series, and we strongly believe that this and other presentations in the future will provide you with useful information as you work towards incorporating innovative approaches to improve the quality of care for your patients. Now I'd like to hand it over to the finding answers team.

Alright, thank you, Dr. Payne.

My name is Rachel Voss, and I am here with my colleague Mona El-Shamaa, and we are in the room with additional staff from Finding Answers. You may be jumping in on the Q & A session later. Finding answers is a national program of the Robert Wood Johnson foundation tasked with discovering

innovative solutions to reduce disparities in healthcare. And in large part we work directly with healthcare organizations, especially physician practices to test those approaches. Later today you will also hear from two physician researchers in the field of shared decision making at the University of Chicago, Dr. Monica Peek and Dr. Elbert Huang. So let's start today's presentation by just reviewing the key concepts from the first webinar in our equity series that you attended last week which outlined how and why to address disparities through your quality improvement work.

First we talked about how equity is such an integral part of quality, that is the best quality care meets the needs of all of your diverse patients. And we talked about how leading health care experts have recognized that and have elevated equity from a single component of care to a cross-cutting dimension of all quality care. We also talked about how tailoring quality improvement interventions to the unique needs of minority groups is a key strategy for reducing disparities and improving quality. And we talked about how generic quality improvement interventions can improve care overall, but they can also fail to address or may even worsen disparities. And finally we discussed how focusing on equity can help maximize the impact of your CPC work by increasing its effectiveness and reach.

And today we'll talk specifically about how equity can maximize the impact of your decision making work. So some of your other TA webinars have focused on how to implement shared decision making. We'll talk specifically about that link between equity and shared decision making. We'll go over specific ways to approach shared decision making with your mind on Elbert Huang. And then we'll hear from Dr. Monica Peek and Dr. Elbert Huang in the second part of the presentation as I said.

So let's first talk about this link. First off when we say shared decision making we're talking about a process in which patients are actively participating in their health care discussions and decisions with their physicians. It's a bidirectional process. Not only are you as a provider giving them health information, but you're also receiving and listening to their patient preferences. This allows for discussion and deliberation and the physician recommendation.

And, finally, shared decision making means that the patient and provider work together to explore risks and benefits of the treatment plan so that they can jointly make the most informed decision possible. We know that shared decision making is associated with many benefits, specifically knowledge gained by patients, patients have more confidence in their decisions, and they're more actively involved in their care. In your CPC Milestones you've been asked to approach your decision making by first identifying a decision point, either a priority condition or some other sort of decision.

Second, implementing a decision aid and integrating it into your clinical processes, and then monitoring usage for efficacy. To achieve all these goals it's critical to seek participation in the decision making by all of your population, especially diverse patients. As we discussed in the first webinar equitable care does not mean the same care for all patients. It means care that is appropriate for each patient's needs with the goal of achieving the best outcomes for each patient. And so that's true of shared decision making as well. By tailoring decision making to the needs of diverse patients you can better engage them and proactively address important factors around patient preference, risk benefit analysis and decision points that might otherwise prevent minority patients from engaging in shared decision making with

you. In addition to helping you meet the shared decision making Milestone we think that keeping a focus on equity in your shared decision making can also help you in the future overall at your practice.

At the most general level shared decision making improves patient centeredness and individualized care which we know helps reduce disparities and improve overall quality, which is the overall goal of the CPC initiative that you're involved in. We also know that shared decision making can increase patient satisfaction, CPC Milestone number 4. And evidence also shows that shared decision making as part of a care management program may help reduce costs, and that's Milestone 2. So basically investing in effective, equitable shared decision making can support success in multiple CPC Milestones. So the CPC Milestone is focused no decision aids specifically which are an important way to deliver shared decision making. And as you get deeper into your work we want you to also consider that there are a couple of other important ways to expand your shared decision making.

For example, in addition to decision aids more open ended conversations that are patient directed can be helpful in engaging patients in making those decisions with their doctors. At the core of it all shared decision making decision aids are not, can and should enhance communication between patients and providers. As with all changed shared decision making comes with some effort and some potential concerns. And one of those concerns is that it takes up limited physician time. That is sometimes it's faster to just tell patients what you want them to do.

But another way to look at that is that that time spent on shared decision making is an investment. So patients with poor adherence or multiple needs often require more visits or longer visits than other patients. And they may be overly or disproportionately represented in disadvantaged populations or medically underserved populations. So on the other hand shared decision making can improve patient provider communication and improve the efficiency of the visit. Over time we anticipate that that will improve patient outcomes. We've discussed the benefits of shared decision making, but how do you make that a reality in your busy practices? So when considering how to implement decision aids, and we'll hear much more about this later from our physicians, think about them in the bigger picture of both decision aids and enhanced provider communication. This comprehensive approach. And you'll also want to choose your priority condition carefully.

Some conditions are better or worse than others as candidates for decision aids. So, for example, decision aids are often used for just discrete data points. A one-time decision such as having a health screening test or whether to have a specific surgery. On the other hand many of your patients have chronic decisions that involve multiple micro-decision points over time, whether they should intensify their diabetes care, for example. Decision aids can still be useful in those situations. And so you may want to choose decision aids that address a specific weakness or inpatient knowledge or adherence that can actually help to improve patient engagement. And, finally, consider supplementing your decision aids with less structured discussion. Patients may have questions or concerns about their disease that aren't in the decision aids.

A broader equity focused approach to shared decision making can help you achieve your CPC Milestones and also reduce disparities. So we know that poor health knowledge and lack of patient understanding

can drive disparities. But SDM increases adherence in patient knowledge, increases patient engagement, and can also help you understand your patient's preferences and their barriers to treatment in a way that you might not know if you weren't having these discussions with them. And many of those are culturally biased which is why we are talking specifically about equity. So now that we've discussed the link between equity and shared decision making I'll pass it off to my colleague Mona who will discuss further concrete ways to engage your diverse patients in shared decision making.

Alright, thank you, Rachel.

Okay, so now we're going to discussion some of the important equity issues to consider when implementing shared decision making. Before shared decision making even takes place clinicians need to offer it to their patients, and patients need to agree to participate. Some research shows that although minority patients are just as interested in shared decision making as white patients, clinicians may not offer it as often as an option to these minority patients. So it's important that all patients have the option to participate in shared decision making. In order to guarantee the greatest uptake of shared decision making across all patients, clinicians need to introduce it in a culturally adapted way. So what do we mean by cultural adaptation? Well, it's being aware of values, beliefs, preferences of your different patient groups, and then adjusting the message so that it's most relevant to the community. Adapting your instructions is especially important for patient populations that are more skeptical of shared decision making.

For example, many minority patients have experienced poor treatment in the past or treatment that has led to historical mistrust of the health care system, and consequently may be skeptical of shared decision making messages. Likewise, patients who themselves have experienced low quality care in the past may assume that high quality treatment options are not even available to them, or the fact that they may not even be offered. By adjusting your approach to address this skepticism you're more likely to engage patients successfully. Next we'll talk about how to ensure that your shared decision making communication is culturally competent.

Now, cultural competency is a big topic, bigger than we have time to cover today. The Office of Minority Health defines cultural competence as a set of congruent behaviors, attitudes and policies that enable organizations to work effectively in cross-cultural situations. There are many resources on becoming culturally competent. One good place to start is the Office of Minority Health CLAS standards or standard for culturally and linguistically appropriate services. At the bottom right hand side of this page you'll see the link for this. That said, you should work to ensure that shared decision making conversations are culturally competent.

One way to do that is to involve your patients' broader social network. For some patients important decisions about treatments are only made collectively with family or community members such as elders, spouses, pastors, and reaching a decision in this case may not be possible without engaging this broader social network as well as the patient, of course. Another way to communicate in a culturally competent way when implementing shared decision making is to encourage two-way dialog. Shared decision making is not only about giving information to patients but also eliciting it from them. So when you're providing education and information also seek to understand patients' goals and preferences.

One more thing to consider as you pursue shared decision making is that low health literacy and numeracy are often more common in vulnerable populations. This is especially important because health literacy and numeracy do affect the way patients make decisions. They affect how they understand their options and their health outcomes, and they also affect their adherence and self-management. Because of this when providing shared decision making be sure to deliver information that is clear and understandable to patients from a variety of backgrounds. Keep in mind that some patients may need assistance in navigating information including information that comes from decision aids. The most effective shared decision making puts the focus on patients' needs. To get the best possible outcomes here are a few things to keep in mind. It's important to become familiar with your population and also aware of their differing perceptions and values. For example, patients from different backgrounds may have very different views on the use of medication versus healthy lifestyle in managing their diabetes. Also, some diseases are just stigmatized in certain cultures. At the same time be aware of patients' multiple identifies.

Beyond race people have multiple sets of backgrounds and values that impact the way they make decisions. Some of these may include sexual orientation or national origin or even religion. Consider involving family when appropriate. As we mentioned earlier about broader social networks and how they impact patients' decisions so do family. The wishes of and the benefit to the family can strongly impact the patient. One big part of shared decision making is communicating consequences of health decisions in a very clear and respectful way. This minimizes confusion and ultimately improves patient and provider satisfaction. And don't forget that external factors may influence how minority patients assess the risk and benefits of different treatment options. For example, treatment options that require larger co-pays may not be an option for a patient with limited resources. Or treatment plans that require more frequent clinic visits for monitoring may not be an option if childcare or work schedules just aren't flexible. Lastly, we'll discuss the role of decision aids in shared decision making. Knowing your patients' needs can help you choose the right decision aid and ensure uptake and engagement with the aid. The way you deliver decision aids is very important.

Different decision aids may be delivered through different means such as websites, different paper handouts, video presentations. Some patients may not be comfortable with or even have access to the internet or computers at all. This obviously would make online tools a challenge. So before choosing a decision aid, ask your patients about access to and familiarity with various modes of delivery. Disadvantaged communities may be at the greatest risk for these issues. As mentioned before shared decision making is a joint effort between patients and providers. Their healthcare team may need to work with the patient walking them through the tool but also engaging the patient to get their feedback and also to understand how they're interpreting the tool. So consider this if you incorporate shared decision making into your workflow since obviously it has implications for when and how and where you employ your tool. So I'm going to just remind you to submit questions as they arise, and we'll have questions and answers at the end. But before the question and answer session I'm just going to turn it over to Dr. Monica Peek.

Great, thank you so much. I'm excited to be here, and thank you all for taking time out of your busy schedule to join the webinar.

I am Monica Peek.

I'm a general internist here at the University of Chicago, and I'm also a health services research with a special interest in shared decision making among vulnerable populations, particularly African-Americans who have diabetes. So what I'm going to talk about is when we talk about going beyond decision aids some of the work that we do really gets at that. One of the key messages I want to make sure that you understand is that we're not expecting that you would leave this webinar ready to implement some of the interventions that we've designed. I just wanted to give you a sense of what they might look like and talk about some of the take home messages that we're learned from our work that would be actually directly applicable to your individual practices. So some of the work that I do with Marshall Chin really is about improving diabetes health for minorities here on the south side of Chicago. And two key parts of that really are patient activation and provider training, shared decision making being a core part of both of those. So we train providers around a number of things including culturally competency and motivational interviewing. But we include as a core part of that patient [inaudible] communication and shared decision making. Our patient activation portion really is part culturally tailored diabetes education but also part shared decision making skills building.

So Mona had talked a little bit earlier about culturally tailoring and the importance of that. And so one example that we use in our classes is just recognizing that the majority of African-Americans that are here in Chicago came through the great migrations. And so most of them came from the south. And so we have a different kind of cultural tradition around eating and shopping and what that means to families here that are African-American. And so we incorporate some of those food preferences. We create a mock grocery store from grocery items from local stores, and then try and have a combination between what people are already doing, what feels culturally appropriate to them about eating, and what some of the recommended guidelines are for diabetes education around dietary practices and healthy eating and physical activity.

So we try to meet people where they are in our classes sort of keeping that in mind. And, again, a huge part of our curriculum has to do with shared decision making. And we try to keep in mind issues around literacy and health numeracy, so we use a lot of interactive things like a video and game and role play. So if you're interested in any of these resources I encourage you to check out our website at southsidediabetes.org.

There is about a 12-minute video that's on our site that you can show in your waiting room for your patients. So we have a lot of other resources that you might find helpful to you. Again, the Office of Minority Health is another good resource. And the HRQ actually has a number of very funny, educational short video clips, they're commercials about the importance of shared decision making and patients asking questions that really are tailored for the everyday lay audience. And so those are 30 to 60 seconds of videos that you can also use in your clinical practice.

One of the things that we've learned with our work is that difficult patient populations, the ones who may come into your office and feel like they're very passive, they don't have questions, they don't seem to be engaged in their care or very interested in having ownership of their care, that with some targeted efforts you can actually crack that box and actually patients that are more confident in talking to their

doctors, that actually are more engaged with their physicians and actually see improvements in their diabetes control. So some of the messages that I'm going to be talking about in the next few minutes just really focus on the idea that even for your patients that seem challenging in a number of ways we actually can engage them and have them be more activity in shared decision making with the goal of improving their health and health outcome.

One of the things that we learned from our work is just the importance of narrative or having created a space for patients to talk and tell their stories. So within our classes we use a lot of interactive methods. We have people testifying and telling their stories. But in your everyday practice you can incorporate that, too. So just making sure that you, for example, start off your clinic visits by asking a patient to tell you something interesting about their diabetes or just having a space for them to share a story that is relevant to their health, but also gets them talking about their health in a way that feels comfortable to them. One of the papers that we recently published was talking about the specific role of narratives. So one of the patients was talking about their use of the video that we created, and she said it changed how I interact with the doctor. Seeing the video I did have the presence of mind to at least ask what is this medication for, how often should I take it.

So, again, the take home message being that you can use other resources that are available to you. You can show them in your waiting room or have people access them online, and they can learn practical skills that they can actually use in the physician encounter. And, again, we did a lot of role play in our classes. And so the idea of just having practice, really practice does make perfect. And so practice at which are patients using your other staff to help prepare patients for the clinic visit can really be effective. So one of the patients at our study was talking about the use of role play. And she said they kind of built me up. We'd be like we're at a doctor's session, and then she, that would be me, would say things that she knows is not right either, but she just wants to know are we going to catch on to it and just let it go or would we sPeek up and ask questions about being rushed through the visit or not answering their question.

Sometimes you don't want to be questioning your doctor, and it's kind of hard especially if you really like them and stuff. But she was just building us up so that you've got to be able to whether you like your doctor or not. So the idea that even if you have a good relationship with your patients and your physicians sometimes people still feel like they don't have the right or there's not a good space for them to ask questions. And so the idea of having patients practice in something that may be uncomfortable to them otherwise really does develop skills that they can continue to use. And so the idea here then we talked about is just really using some of our core principles that we've learned from our work and thinking about how you might fold those into your everyday practice.

One of the things that always seems obvious to us as physicians that we may forget is that things that we take for granted patients may not inherently understand. And so I like to always verbally tell patients that I value your opinion about your health and why. And so we understand that it's important to have patients' perceptions, but they may not understand that we value that. So the idea that there are multiple right decisions sometimes, and finding the best decision for that patient really means that they have to be involved in this discussion and tell us what they think they can do, what's feasible at home,

how much they can afford, what do they understand, what skills can they practically master. And that's going to be their best decision. And there's no way that we can as physicians understand that without patients' input. So directly stating the fact that we really want their opinion and why.

One of the things that we've talked about with our classes is the idea of just sort of paring down all the different conceptual constructs of shared decision making is what we call the three Ds. So we encourage patients to discuss, debate and decide about medical decisions. And so those are things that people can remember. There's something you can put on a button that your staff is wearing or have a flyer in the waiting room like we're interested in your questions and here's why. And so for every important decision we want to have patients know that it's important for them to be able to discuss it with us, think about all the options, have a conversation about the pros and cons and then together come and make a decision about their healthcare choices. And, again, expressly stating to patient expectations about their involvement and care. That we really want to see them as partners in care and not just as recipients of care.

So, again, these are things that we already know and believe as physicians, but patients sometimes don't get those messages from our either behaviors or what we're actually saying in practice. And so trying to expressly say that this is what we'd like to see can address some of the disempowerment that a lot of our patients feel. So patients a lot of times don't feel like they have the right to ask questions or to be more involved. And so for us as physicians there's an important role in empowering patients. One of those things that we learned in our class is the importance of addressing uncomfortable barriers to shared decision making head on.

And so, again, the idea of expressly stating these kinds of issues. So one of the things that we learned is that some of the ordinary chaos of an office visit, just the disorganization, the long waiting times, things that just happen in a routine practice, some patients if they're coming to that encounter with previous bad experiences they may perceive that as interpersonal or organization discrimination when actually it's just the ordinary dysfunction of an office. And so specifically telling our patients, you know Ms. Jones, it's really important that we have a great relationship and that you really trust that I am doing the very best that I can for you. That my goal here is to have you as healthy as possible. And so I may not come from the same background as you, but I really want to know about you, and I really want you to feel that I'm on your team and that I'm going to do the very best I can to take care of you. So just simple messages like that can resonate with patients and they'll hear that. They'll physically hear it, but they'll emotionally hear that, too, and it will resonate with them about some of the issues that they may be bringing to the encounter around provider mistrust or potential perceived discrimination.

And the last point I just want to make is that shared decision making is something that we ordinarily think about as happening just within the physician and the patient. But changing the office practice and the organizational culture around that can also be hugely supportive. So priming our patients to know that this is something that everyone in a practice values. So this is something that we can talk about at staff meetings. Again, our staff can wear buttons. We can have resources in the waiting room. We can use our staff, our LPNs and MAs who are already checking their blood pressure, checking their sugars to ask and say, hey you know what, what are the two most important questions that you want to have for

your doctor today? And maybe I'll write those down for you and put them on the encounter. Or what are the two things that you want to really make sure gets discussed today. And do you feel comfortable talking to Dr. Jones about that?

Having our staff help us create a culture for shared decision making and helping to facilitate and prime patients can actually help us with the encounter as well. And if you're in one of the practices that has the advantage of having a health educator, a certified diabetes educator or some of those resources that are in your practice network, one of the things that we do is to have those specific educators incorporate messages around shared decision making with our patients. So, again, they're getting messages not just from physicians but from all of the healthcare team that really asking questions and being an active part of their care is important not just for us but for them and their health. And so thinking about ways of spreading or disseminating these messages within our entire team actually can decrease the burden on our individual practices, on our individual selves seeing patients within our busy practices. So, again, I just want to say thank you for your time, to acknowledge our funders, and to remind you of our website which, again, is southsidediabetes.org.

We referenced a lot of other portions of information for you around shared decision making. And everything that we have on our website is free and available to download and use as well. So with that I'll turn it over to Dr. Huang.

Thank you, Monica. My name is Elbert Huang.

I'm a also a general internist, primary care doctor here at the University of Chicago. I'm a clinical investigator who spends most of his time thinking about diabetes in older people. And so I'm going to share with you our experience with the use and evaluation of a decision aid that we have constructed to address a very specific treatment decision in the area of diabetes. So this is an example of shared decision making in chronic disease management. I think the overall experience will be valuable to you. So those of you who follow what's been going on in diabetes care guidelines and actually have followed what's been happening in diabetes clinical trials probably realize that care guidelines now have a heavy emphasis on the individualization of care goals for diabetes but also of treatments. And among patients with diabetes these issues are particularly relevant for the older population. Older patients actually represent 50 percent of the diabetes population and unfortunately have been regularly understudied in clinical trials. We've typically studied younger diabetes patients before studying older, sicker populations. And the issues around older people, the basic issue is that the care goals that most people know in diabetes care such as an A1C less than 7 percent may not always be appropriate for the older person that you're seeing in front of you in clinic.

Older people are very heterogeneous, they vary in terms of how long they've had the disease, what complications they may have experienced over time. They may have other diseases that are of a higher priority to them than their diabetes. And their preferences vary also. And so given the variation in older patients and uncertainty around the application of recommendations made for the general population the new guidelines now heavily emphasize individualization. And the individualization comes in really two flavors. There's recommendations that basically we vary the targets for diabetes based on the health status of an older person that we're taking care of. An example of this would include making

different choices for A1C targets based on how sick they are with comorbid illnesses, making decisions differently about diabetes care based on whether or not an older person is frail or not frail. So there are specific recommendations that you'll find from the ADA and other organization based on health status.

But the equally important are for individualization for actually patients of any age is making decisions based on patient preferences. And when I talk about patient preferences we're talking about variation in the very goals of diabetes management. For some older people the goal of diabetes care is to avoid complications related to diabetes at any cost. For other older patients we have found that the goals of diabetes care are quite different. For others the goal is to actually avoid medications related to diabetes and other chronic diseases at any cost, to reduce the burden of diabetes management. And there are other kinds of preferences that we could certainly explore. So considering both health status and preferences in selecting even something as basic as the A1C target these recommendations are out there, but when you think about it, it might be actually really, really difficult to implement this in the busy clinical practice. And I think that's where our decision support tool comes into play. So given the challenges of actually doing this in clinical practice we designed a design aid or, slash, decision support tool that is designed to help personalize diabetes care goals for older patients with diabetes. And it does things that we think doctors or front line providers may not be able to do within a 15 to 20 minute visit.

So one thing the tool does is it provides personalized calculations. It basically does a number of calculations. It calculates the patient's life expectancy. It actually personalizes and calculates the risk of developing complications for the specific patient based on their health status. It also goes out of its way to elicit treatment preferences from the individual patients. And we specifically ask patients about how strongly they desire to avoid complications, how strongly they desire to avoid medications. And the tool also screens for geriatric conditions that are closely tied to diabetes such as depression, urinary incontinence, chronic pain. So a lot of this would be quite challenging within a normal clinical visit, but we are using this tool to supplement and gather more information for the provider at the point of care. The simulation model that we use to do these calculations is -- a sister model is described in the Annals of Internal Medicine publication from 2008. And this is a screen shot from the educational portion of the support tool. We know from prior research and from our own that actually only 30 percent of patients with diabetes know what an A1C test is.

So we go out of our way to in the early part of the tool to just explain and re-educate patients on what an A1C test is. They have to have some basic understanding of what the test is before making a choice about an A1C target. And this is a screen shot from the output that is generated by the support tool that includes some of the calculations that are made, but also shows some of the results of general screening questions that are done as part of the support tool. So I think probably the most important information that we've learned from designing and studying this tool are related to implementation. And I think many of you who are being asked to implement decision aids in your practices are probably facing these exact same implementation questions. So one basic question that we faced was when should the tool be used. Clinic is, frankly, insane and is incredibly busy. And so when would this tool be used in clinical practice? We designed a tool that is based in a website. So that raised questions about how do we give access to our web tool. And just to give you some context our particular patient population on the south side of Chicago 80 percent of them we knew in advance had no access to the internet. And so we had

designed a tool that required a computer access and internet access. And how are we going to make that possible for our patients? There were also issues that were mentioned earlier about literacy and language. What is the right language? We were using a tool that required numeracy as well. And a very practical question that challenges all people using decision aids is when do we feed -- how do we feed the information to the doctor? We were doing all this work, but how are we going to deliver it at the point of care when it was needed?

So all very challenging implementation questions and decisions that we had to make even in studying this tool. So these are decisions that we made, and they may be valuable to you as well. So we decided to use the tool right before a scheduled clinic visit. And we did this partially because we know that patients sat in the waiting room for sometimes half an hour to an hour. And so rather than create a new time we use that space to use the tool. How did we give access to the web tool? Well, we were lucky in our own clinical practice what we did was we were able to find a computer in a private room in the clinic practice. But we also had an actual research assistant, an assistant to actually make sure that the patient was able to access the tool. So in terms of literacy and language we designed the tool to have a very low literacy level. And the original version was created in English but we will, of course, have to create the version in Spanish to reach more patients with the tool. How did we feed information to the doctor?

So we basically used a low tech -- well, the tool is web based and somewhat high tech. Our way of delivering information to the doctor was low tech. So we basically had the patient interact with the tool, print out the information, and then bring that printout to the visit. And we have found there's nothing quite like having a patient bringing in a piece of information on it to stimulate conversation. So that was our approach. There are obviously other ways of delivering information electronically. But I have found personally that a patient bringing information from outside to the visit will force me to look at it and to have conversation about it. The trial itself was done as a small randomized controlled trial. We found that the tool did encourage active A1C goal selection discussion. It decreased patient's conflict or confusion around A1C goals. And particularly it basically informed them about a treatment decision that they weren't entirely aware existed. And it did have a tendency to increase the appropriate personalization of A1C goals based on life expectancy. And these findings mirror the general findings from other decision aid trials, the decision aid that you have been given as potential options. In general decision aids have been found to activate patients and have been pretty consistently found to reduce confusion and conflict on the part of the patients.

So in terms of implementation I think as you are designing your approach to incorporating decision aids you have to consider the pace of the clinic where you work, determining when to deploy the decision support tool or decision aid. You may have to create a special space. Perhaps you have a library in your clinic or a special room. You may have to make special active considerations. Patients are not always going to have computers or the internet. Some patients are going to have poor literacy and poor numeracy. And you may need to designate an assistant to help guide patients through decision aids to make sure that they are used appropriately and are doing what they're supposed to do. But despite these challenges patients generally like and appreciate decision support tools. So thank you for your attention, and I think we're shifting to the question and answer period.

Great, thank you, Elbert. We've had a couple of questions come in on the Q & A, and so we'll just take those in order. So first this probably can be open to all of the panelists. It was mentioned that Rachel Voss discussed wonderful ways to incorporate SDM into an office visit that sounded very natural. But she didn't discuss using a specific decision making tool, and that's what is being required from CPC. And the comments or Catherine notes that she's struggled to make using a tool in an office visit natural. Any thoughts on sort of how the practices can sort of integrate the tool into their clinical interaction in a more natural way?

This is Elbert Huang. I think that the way to think of decision aids or decision support tools as essentially a structured form of patient education. And so I think the perfect time to use the tools is as a form of education. Perhaps you are making a decision about a treatment, but you can't completely discuss everything, you can't completely discuss all the risks and benefits of a decision during the normal clinic visit. So it's something -- it's an additional education tool, piece of information you might refer a patient to. So referring a patient to a link for more education we do that all the time when we're trying to teach patients about a condition they have, so I think that's the time to do it. It could be at the time when you're trying to make a decision or when you want to educate a patient.

This is Monica. I echo Elbert's comments. So particularly for client diseases like diabetes most of the decisions we make are, again, those micro-decisions that get revisited over time and for which there aren't significant time constraints. So it's not an acute situation in the hospital. They have time to sort of think about it. We can decide today and then revisit it next time. We can think about it today and bring the other family members next time. We can start the conversation today, look at some decision aids. You take these home and bring them back with you next time. So for me the idea incorporated into a decision aid would be a way to, as Dr. Huang pointed out, facilitate ongoing communication with patients. So rather than trying to compress everything with the single use of a decision aid, taking advantage of the fact that we're primarily outpatient primary care physicians and so we have the opportunity, the luxury, of additional time to think about the use of a decision aid. And so for some of our patients who may have additional issues around literacy and numeracy they may need to see that aid several times. They may need to have sort of multiple conversations to be able to wrap their mind around it. And so I would as comfortably as it is already flowing just add that into an additional thing that I do with patients rather than trying to have an artificial start and stop to the use of a decision aid.

Thank you, Dr. Peek. Thank you, Dr. Huang. The next question has to do with care management tools not being up to date. And so the question is I still discuss new guidelines for management of diabetes control with my patient in an SDM manner, but our care management tools aren't up to date. Dr. Huang, would you like to handle that one?

Well, I'm not surprise that -- I'm not surprised by the question. It's a really good one. What's happened is that some of the guidelines of consensus statements are probably a little bit ahead of the tools that have been developed several years ago? So I think you will have to pick and choose what tools you use and when. You can continue to -- if your communication is in this shared decision making approach I think you're already 50 percent there. And hopefully the educational materials that are provided by the American Diabetes Association and other groups will eventually catch up. But you may be -- we're

probably talking about a concept that's a little bit ahead of the curve in terms of traditional educational materials. I think Dr. Peek's video material and other materials that she had referred to may also be useful.

We actually have a question, one of the participants is asking for a reminder of what the site is for the short video clips mentioned. So I'll put those in the chat, but Dr. Peek if you could remind us what those are.

Sure, so our website name is really easy. We do work on the south side of Chicago, and so our website name is southsidediabetes.com or .org, we've bought them both. And so if you go to our home page there's a tool bar at the top that says information for patients, about their project, etc. So if you click on the information for patients the video is in that section. And there's one that specifically says tips for your doctor's visits. And that will be in the tool bar on the left hand side. And so that's the video that we made. It's about 13 minutes, so it's enough to -- what it does is it just sort of show examples and talk about shared decision making, examples of bad shared decision making and examples of good shared decision making so that we can take these sometimes what are fairly abstract constructs for patients and make them more practical for people to actually see what they look like. But, again, they're the 30 second and 60 second spots which are super easy and just really fun. And those are available on the HRQ website. And so we can pull those also and make those available for people who are on the webinar.

Great, thank you. And the next question is about Dr. Huang's shared decision making tool. Dr. Huang, the question is whether that tool is available for public use.

Thank you for the question. Not quite yet, but it's still being studied, and the next iteration which will hopefully be federally funded would then be publically available. But it's not quite yet ready. Thank you for your interest.

Great. A final question, I think we have time for one more question. What about patents who refuse to participate in shared decision making? What do you do then?

That's an excellent question. Monica Peek again. I have a few comments, and then I'll look for Elbert's comments and see what he has to say. So there are two things. One is that we always want to be respectful of patients' wishes. And some patients would prefer to defer those decisions to their physician. And so in the cases where that is actually true really what we're trying to do is tailor our approach to patients' preferences and needs, and that's okay, too. Not everybody has to be actively involved. But the caveat that I would say is that a lot of times just like patients are resigned to lower quality care, people may have experiences that shape their expectations. And so if they've only received a paternalistic style of encounters with their physician they may sort of think that that's their preference because that's all they know. And so there have actually been studies that look at peoples' preferences, and then they sort of [inaudible] to be engaged in shared decision making people actually are more satisfied when they actually have that shared decision making experience. So while we do want to be respectful of patient's wishes and preferences, we also want to make sure that they're making informed decisions about those preferences. And so talking a little bit with patients about the importance, why it's

important for them, why it's important for you, why it's important for the relationship and their health, giving them a little sample of what that might look like, so you can help me inform a decision, but the responsibility isn't yours alone. This is a shared decision that we'll want to come to together. It's one that we can revisit in the next few visits. So I really want you to be involved, but I'm not abandoning you with the responsibilities and the accountability for the choices that you are sort of verbalizing within the encounter. So I would say that, yes, always respect patients' preferences, but really spend some time digging into what people mean when they express those preferences first.

Wonderful, thank you, Dr. Peek. Dr. Huang, any additional thoughts on that topic?

I think this is always a question. There's a segment of patients that aren't really interested in shared decision making in the way we've conceived it. But the thing I would say is having patients involved in decisions is just critical to everyday management of chronic diseases. So it's important for so many different reasons. And I think the other thing of it is you don't know what the patient's preference is for shared decision making without asking them about it. So you can't guess in advance based on the patient's age or race or education how involved they want to be. So you've got to bring it up because you cannot guess who is who.

Great, thank you. And that flows actually well into what we can take as our last question for the session. This is specifically directed to Dr. Huang's shared decision aid situation. But I think it can be applied generally which is how does the practice know which decision aids to give to patients and prior to the visit? What guidance is there that we can give staff about picking a decision aid?

Sure. Well, I think that in the future we are going to face a world where there's going to be almost like a library of decision aid or decision support tools that we can pick from. And ideally what we would do is basically use them when it's appropriate for the specific patient situation. And in the case of our particular study we were the only decision aid -- we were the only decision aid being evaluated at the time. The staff knew, you've got to know the assistant or assistants that were working with patients with the tool. So the staff and the clinic overall was very accommodating to the use of the tool. But it's akin to I would say like a health education library. And to me I view this all as just fancier versions of what would be in a health education library for a clinic.

Wonderful. Thank you. We are leading right up to the end of our time. So I wanted to thank all of our presenters and hand it actually back over to Crystal for the wrap up slides.

Great, thanks, Robert. So we still have two more sessions of this series. We have a patient experience session on equality February the 18th and one on quality and care management scheduled for February the 26th. What's coming up for the rest of CPC our next national webinar is March the 4th on Milestone 3 and asynchronous access. And we have many more offerings in the month of March. So please mark your calendars. Thank you for attending today's session. I really just want to thank everyone. It was a really great session. You can exit the session by clicking on the file menu option at the top left of your screen and select the option to leave the session. You'll be taken to a post webinar survey that needs to be completed in order to receive credit for attending this presentation. Thank you.