CPCPracticeSpotlight40

Comprehensive Primary Care is an initiative of the Center for Medicare & Medicaid Innovation

Effective, Meaningful Shared Decision Making Has a Learning Curve for Both Providers and Patients

*Capital*Care *Medical Group, Albany, New York; multi-specialty; 58,000 patients*

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These strategies stem from **CPC Change Driver 1: Comprehensive Primary Care Functions**

- 1.2: Planned Care for Chronic Conditions and Preventive Care
- 1.4: Patient and Caregiver Engagement

Change Driver 3: Continuous Improvement Driven by Data

- 3.1: Internal Measurement and Review
- 3.2: Culture of Improvement

For more information about the CPC initiative, visit http://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/.

Situation: With 10 CPC practices, **Capital*Care* Medical Group** balances supporting the needs for its 10 offices and maintaining autonomy at each site, while simultaneously building effective workflow processes that would not derail daily schedules and locating aids from credible sources. At the point of care, providers found that shared decision making (SDM) varied according to patients' expectations, preferences and willingness to engage with the care team. Providers realized that to move toward an effective SDM conversation fostering bi-directional communication with the patient is fundamental.

Capital*Care's* selections for preference-sensitive conditions and aids:

- Cholesterol – Option Grid
- PSA – Option Grid, USPSTF
- Antibiotics for pharyngitis – Option Grid
- Menopause – Mayo Clinic (no longer available online)
- Sciatica – Option Grid
- Knee Pain – Option Grid
- Diabetes – ACP
- Obesity – ACP
- Hypertension – ACP

Strategy: The quality team at Capital*Care* provided each CPC site with data to guide selection of conditions where SDM in preference-sensitive care* could be applied meaningfully within a manageable patient population size. While each site selected its targeted conditions, members of the quality team supported sites by identifying tools and aids that were affordable, clinically appropriate and formatted to promote a structured conversation between the patient and provider. This allowed sites to maintain their autonomy in implementing SDM while establishing a consistent approach to standardization regarding reporting and monitoring.

Their initial selection of eligible patients for SDM includes those receiving a new diagnosis within the last six months for one of the targeted conditions.

A simple, streamlined workflow eased integration into daily routines. Eligible patients are flagged during pre-visit planning and daily huddles. The provider orders and prints the decision aid, and then discusses the options with the patient during the encounter. The order is completed when a decision is made either at that visit or at a follow-up. The team at Capital*Care* warns against building in too many "clicks" in the EHR or adding convoluted steps that do not align neatly within the regular workflow. Also, they note that implementation goals in the first measurement period should consider the care team's learning curve. Once SDM fits seamlessly into the workflow, they anticipate the rates of decision-aid use will increase, patient-provider relationships will be further enhanced and patient outcomes will improve.

While SDM was warmly received by Capital*Care*'s Patient and Family Advisory Councils, patient response varied. A few patients shied away from engaging in the decision or would only skim the materials, preferring the physician recommend the optimal course of treatment. Others would delve deeply into the information, sometimes frustrated that a single, "best" treatment option was not clearly delineated.

William Busino, MD, an internist at two Capital*Care* sites, saw SDM as a valuable tool in the patient-provider relationship. Even when patients chose not to engage in SDM (with decision aids or discussion), offering options (when appropriate) is optimal care. When providers at Capital*Care* see their colleagues' patients about treatment or diagnosis for which preference-sensitive care is appropriate, they are fully aware of the information provided to the patient, which improves consistency of communication. SDM aids also help zero in on what the patient needs and expects with regard to treatment and outcomes, which supports patient-centered care. Further, the continued interaction between patient and provider when weighing the options pairs well with ongoing self-management support conversations, where patient engagement helps drive improved health and outcomes.

The quality team at Capital*Care* would like to measure SDM beyond fulfilling the steps at point of care and be able to pinpoint improved patient outcomes. At this place in the CPC initiative, the span of treatment time and numbers of patients cannot demonstrate that improvement. However, they remain committed to SDM knowing that measurement will be a "marathon" and not a sprint.

* *Preference-sensitive care comprises treatments for conditions where legitimate treatment options exist – options involving significant tradeoffs among different possible outcomes of 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 only made after patients have enough information to make an informed choice in partnership with their provider.*

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