



Minnesota Shared Decision-Making Collaborative

Shared Decision-Making Implementation Roadmap



The Minnesota Shared Decision-Making Collaborative is a multi-stakeholder community learning collaborative working to remove barriers to adoption and promote the routine use of shared decision-making in clinical practice throughout Minnesota. www.msdlmc.org



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The electronic version of this document contains clickable links to online tools and resources. All links are available on the MSDMC website at:

<http://msdmc.org/resources>

Shared Decision-Making Explained

Definition of Shared Decision-Making

Together, patients and the health care team clarify all acceptable options, ensure that both parties are well informed, and choose a course of care consistent with the patient’s values/preferences as well as the best available medical evidence.

In other words: Helping patients evaluate all available options—weigh their personal values, goals and priorities against unbiased medical evidence—in order to make informed decisions at every stage of their care.

Overview

- 1 The clinician presents an unbiased view of the pros and cons for all options, including “do nothing.” This may require the patient do to homework (read about a treatment, watch a video, etc.) and then return for further discussion.
- 2 The patient tells the clinician about personal factors that might make one option seem better than another. These include personal values, goals, preferences and circumstances.
- 3 Together, the patient and clinician use this information to decide which option best reflects the patient’s needs and values.

Who Can Be on a Shared Decision-Making Health Care Team?

Many types of health care professionals can be part of Shared Decision-Making, including:

Doctors	Care Coordinators	Pharmacists
Nurses	Health Coaches	Patient Advocates
APRNs	Navigators	Physician Assistants

“Shared decision making is about much more than just informing patients about what is evidence based and what is best practice, because in some cases that’s all we have: best practices. It’s about eliciting their values and preferences. What really, really matters to you? Do you care about avoiding surgery? Are you willing to accept some risk? Do you want to avoid having to take pills, or are you willing to go through pill taking and physical therapy to avoid surgery?”

Kathleen Fairfield, M.D., M.P.H., Dr.PH., Maine Medical Center Research Institute’s Center for Outcomes Research and Evaluation.

Shared Decision-Making is Not Informed Consent

While shared decision-making differs from informed consent, the concepts complement and augment one another.

In a sense, shared decision-making is “perfected informed consent.” If we do shared decision-making well, then informed consent is real and genuine. By doing informed consent well, we verify that shared decision-making was successfully executed.

Shared decision-making happens “upstream” from informed consent, before the patient commits to an intervention. In choosing a treatment plan, both patient and provider need to gather information and gain the knowledge needed to shape the decision.

Informed consent occurs before the intervention but well after the treatment plan has been established. It is the closing of the transaction—the moment where the patient and health care team finally commit to the plan of care.



Create a Shared Vision



Involve your senior leadership in making this initial commitment and vision for how shared decision-making fits in your organization.

Develop a leadership team with physicians and operational leaders to learn the nuances of shared decision-making together.

Identify the benefits to your organization.

Tie shared decision-making to patient centeredness.

Demonstrate how it is a critical element of patient-centered care.

Emphasize the value of a well-informed, activated patient. Patients who engage in shared decision-making have a deeper understanding of their options. Providers are able to use their time more effectively, offering deeper, more meaningful education.

Do your patient satisfaction metrics show a need to improve patient-provider communication? Are you required to document strategies for patient-centered care? Shared decision-making aligns with many quality initiatives and regulatory requirements.

Develop an understanding of the potential barriers and ways to eliminate or reduce their impact, including:

Challenges to physician autonomy. How comfortable are your providers with changes to their role?

A failure to recognize preference-sensitive conditions. (A condition is “preference-sensitive” if there’s more than one clinically appropriate intervention available. Examples: low-back pain treatment, breast cancer treatment, colonoscopy.)

Be prepared to answer these questions:

Don't we already use shared decision-making?

Many providers (and patients) believe that decision-making is already shared; however, the research suggests otherwise. Address this by bringing people together to discuss the available treatment options for a given condition. By identifying options and clarifying what information patients need to make a decision, we often expose the variable messages that patients hear. This can be a good starting point for a discussion on how to improve the conversation.

Or, begin with a survey of patients to see if they recall hearing their options, or whether they understood key facts about their decision. This can offer compelling evidence that clinicians are not communicating important information as well as they think.

How is this different from informed consent?

Shared decision-making is a process of using medical evidence and the patient’s personal values to come to a decision about a course of treatment. The process happens before a decision is made and allows patients to reconsider the decision over time. The ongoing relationship between patient and clinician is part of the process.

Continued on Page 3



Create a Shared Vision, Continued

Informed consent is a discrete act. The patient's signature confirms that the patient understands and agrees to the intervention; signing takes place right before the intervention occurs.

Imagine you are buying a home. Shared decision-making is like your interactions with the realtor as you decide which house to buy. Informed consent is like the closing where you sign off on the purchase.

We don't have time for these conversations. How can we streamline the shared decision-making process?

As many studies show, we can incorporate decision support strategies into patient encounters with minimal increase in time. A conversation between patient and clinician is already taking place; shared decision-making simply changes the nature of that conversation.

For patients, most encounters consist of a flow of difficult-to-understand information followed by a short period of time in which to make a decision.

Decision aids can communicate some of the information more efficiently, allowing patients to digest the important facts prior to the visit. This changes the visit into a discussion where patients feel more comfortable expressing what is important to them—with the confidence that comes with having a better understanding of the information.

What is the evidence behind shared decision-making?

Over 100 studies show that decision support tools can improve patient knowledge and give them greater confidence in the decisions they make. We need to better understand how to implement these tools; however, keep in mind that this dilemma occurs in other areas of medical practice as well: Evidence may show that an intervention is effective, but it often takes time and effort to apply that knowledge to improving the lives of patients. >> [Link to the MSDMC Bibliography of 19 Key Shared Decision-Making Articles](#)

What is the business case for shared decision-making?

The business case usually relates to the goal of patient-centered care, a central part of the overall strategic plan for most organizations. A primary measure of success is the degree to which patients experience high quality care. In this context, the fundamental values of shared decision-making—respecting patients and listening to what is important to them—are sound business practices.

Certainly, shared decision-making can reduce the unnecessary use of health care resources. Some interventions are overused; patients are less likely to use them when they're given the option of saying no. Nevertheless, we must be careful to keep our focus on the ultimate goals of shared decision-making—respecting patient preferences and making sure patients are well informed.

What if patients don't want shared decision-making?

We have responsibilities to offer patients the necessary information about their treatment and to listen to what is important to them when making the decision. If, ultimately, they defer their decision to their provider, that is their choice. We respect their desire to rely on the clinician's judgment.

[More Frequently Asked Questions on page 15.](#)



Choose a Shared Decision-Making Approach

Spend some time evaluating your goals and organizational readiness for choosing between these two potential implementation approaches:

1 If your goal is to **change the basic way** that health care teams and patients interact with each other and use shared decision-making as a way to identify and address any decisional conflict, then you will want to take a broader approach to choosing a framework that can be used in any situation.

See an example of a broader approach framework.
>> External link to ICSI Conversation Model



2 If your goal is to start smaller by engaging a health care team to pilot a project that **impacts a particular preference sensitive condition**, then focusing on developing a clinical process specific to that condition may be best.

See case studies of shared decision-making implementation for preference sensitive conditions, **Pages 17-19.**

Tip:

Your approach may depend on which strategies have worked in the past to effect change within your organization. Might you be more successful with a smaller scale project that can show results quickly, or will it work better to present this as a more in-depth effort to change your organization's culture?



Assess Your Organization

Determine the current knowledge of shared decision-making in your organization and most importantly, the status of basic beliefs that will determine your success.



When it comes to provider and patient involvement in health care decision-making, how would you rate your providers?

Does the system of patient scheduling and panels work to develop strong relationships between providers and patients?

Are the patient's values and preferences asked for in conversations?

What is the knowledge of the evidence for treatment options for preference sensitive conditions?

Do the providers have experience in working together to standardize their approach to clinical conditions?

Do they understand how this standardization benefits your improvement efforts?

Are the providers comfortable with ambiguity and can they be patient with the process of decision-making that supports that individual patient?

Do your processes support the involvement of family members and time for patients to think about their values and preferences?

>> [Link to MSDMC assessment survey tools](#)

Tip:

During your assessment, engage your physician staff, nursing operations, patient education department, patient experience task force, patient advisory committee, diversity council and others. These partners can help you do a gap analysis.



Define Your Project



Once there is an understanding of shared decision-making and a decision about your approach, identify a pilot project and define your aim, scope, leader, and team.

When you identify a pilot project, start small, and go where the energy is. For example, a single provider working on quality improvement presents an excellent opportunity for shared decision-making. This pilot would have 100% provider buy-in. You can use the study to hone a shared decision-making process, document outcomes/best practices, and share these with providers treating other diseases.

Focus on a precise population facing decisional conflict, as well as a significant event that can drive shared decision-making. This makes it easier to measure the impact of shared decision-making during your pilot.

Examples:

- Breast care patients receiving a positive biopsy
- Patients who, after a significant health event, may need to consider assisted living, long-term care or independent living with hired support services

Consider how your pilot might affect utilization patterns in your organization. For example, Shared decision-making for low-back pain may result in more or fewer spinal surgeries. Review relevant research, engage stakeholders and plan accordingly.

Evaluate frameworks for determining the best fit to your situation and organization.

Identify the decision coach and/or team. Identify tools, decision aids and other support resources. Familiarize yourself with key concepts such as readiness to change, motivational interviewing, patient activation and engagement, health literacy teach-back technique and preferences and values. Develop a training plan based on the skills identified to support shared decision-making.

Remember:
Implementation of shared decision-making is an iterative process. This roadmap presents key points to assist you; however, the process you develop will be your own, and it will continue to evolve over time.

Implementation Resources
MSDMC shared decision-making FAQ, [Page 15](#)
>> [Link to MSDMC shared decision-making lexicon](#)

Tip:
You might start with one or two preference-sensitive conditions, then plan to spread implementation. Over time, this will help build a culture of shared decision-making.
See preference-sensitive condition case studies for shared decision-making, [Pages 17-19](#).



Design and Pilot Your Shared Decision-Making Process



The main objective in this step is to develop the care delivery process and the roles of each professional in this process. Evaluate your project for the timing of coaching (before, during or after the visit) and the skill level needed to share the options and risks and benefits. This will help you determine the coaching needs you have and identify who will primarily take accountability for walking the patient through the decision-making process.

Meet with pilot participants. Build consensus on:

- The precise moments to offer shared decision-making. Examples: Upon delivering biopsy results, when symptoms cause a certain level of distress, before and during a surgical consultation, etc.
- All available options, including those that seem less than ideal. Try to avoid thinking in terms of what is “best” for the patient—focus on what is available. For colon cancer screening, is flexible sigmoidoscopy a realistic option? FIT testing?
- Exactly what information patients should walk away with. Providers interpret medical evidence differently. Work together to distinguish facts from opinions, then decide what medical information patients need in order to make decisions. Narrow those key pieces of knowledge: How likely is this intervention to help? How likely are we to find cancer during your colonoscopy?
- Strategies for effectively communicating information to patients

Use this Institute for Healthcare Improvement PDSA cycle tool to help speed up your design process:

>> [External link to the IHI Model for Improvement](#)

Tip:

Remember that shared decision-making programs can differ within the same organization. Different groups will pick the paths that best meet the needs of their patients. For example:

- Orthopedists might have patients review a decision aid prior to their surgical consultation.
- Primary care providers may help patients decide about screening tests during their visit.

Explore individual roles in the shared decision-making process.

How does this team envision the role of the patient? The patient's family? Each provider? The rooming staff? Is there a lead decision coach? How will the clinical team collaborate under this new model?



Design and Pilot Your Shared Decision-Making Process, Continued

Key Considerations During the Design and Pilot Stage

Vision for the new workflow

Compare the new workflow to the existing workflow. Where are the similarities and differences? Your team may discover that the new model isn't too different from the old one, which may make implementation easier.

Which tools will be used to support shared decision-making

This may include clear communication strategies (such as teach-back), conversation scripts/prompts, established decision aids, specific patient education materials, etc. Depending on the framework you choose, you might employ shared decision-making resources before, during or after a clinical encounter. Some practices will want a standardized approach; others will craft a tailored approach depending on the decision to be made, clinical workflow, framework, philosophy, and available resources.

Accountability loop

Who will train pilot participants, monitor implementation, and assess results? Who is accountable for process improvement? Do you have a "close the loop" strategy to ensure that the patient is supported all the way through the process?

Patient feedback is vital

Include feedback on your shared decision-making project from your patient advisory committee, or ask 1–2 patients to participate in your workgroup.

Process Improvement

Be sure to build in a continuous cycle of process evaluation and improvement. You will need to assess the process on a regular basis and adjust as needed.

Embedding

Look for opportunities to embed the new model within existing systems (EMR prompts/documentation, patient surveys, clinical workflows, processes for choosing educational materials, etc.).

Tracking

Design a system for tracking and documenting shared decision-making, so that all the members of the health care team can easily see what has been done in the process.

Communicating

Engage your communications team to help publicize the value of shared decision-making. Are there easy-to-read educational materials that can help guide shared decision-making conversations?



Design and Pilot Your Shared Decision-Making Process, Continued

Related Topics for the Design and Pilot Stage

Skill Sets in Communicating to Patients

Health Literacy

Given the commonness of low health literacy and numeracy, your care team can ensure that patients comprehend their options by:

- Using plain language. Avoid or define medical terms.
- Focusing on the “need to know,” and avoid the “nice to know.” Too much information can easily overwhelm.
- Giving patients easy-to-read handouts to take home with them, so they can remember what you’ve discussed.
- Use the teach-back technique. This is a quick and easy way to verify that the patient understands their medical information—a vital step in the decision-making process.
- Speak slowly, and listen carefully to the patient’s response.

External Resource Links for

Health Literacy

- >> [AHRQ Health Literacy Universal Precautions Toolkit](#)
- >> [MN Health Literacy Partnership](#)
- >> [Institute of Medicine Attributes of a Health Literate Organization](#)
- >> [Motivational Interviewing](#)
- >> [National Patient Safety Foundation Ask Me Three](#)

Patient Change

- >> [Readiness to Change - Journal of Clinical Psychology Article](#)
- >> [Patient Activation - Insignia Health Patient Activation Measure](#)
- >> [Patient Engagement - Partnership for Patients Website](#)
- >> [Evidence-Based Practice - Institute for Clinical Systems Improvement Choosing Wisely Page](#)

Knowledge Tools

- >> [Ottawa Decision Aids](#)



Measure and Evaluate



Identify how you will measure success. This can include process measures and outcome measures.

There are tools to both evaluate the health care provider that partners with the patient and the patient’s perception of the shared decision-making process.

As you train to measure and evaluate, articulate a vision for what will change versus what will remain the

same. Include expected responsibilities of—and benefits to—both patients and providers.

- Share strategies for clear communication and patient activation:
 - ◊ Universal precautions approach to health literacy
 - ◊ Teach-back technique
 - ◊ Motivational interviewing
 - ◊ Patient activation assessment
- Share relevant support resources: patient education, decision aids, etc.

Offer scripts to help providers and other decision coaches broach shared decision-making with their patients. In time, providers will come up with their own wording.

Examples:

“Since there’s so much to cover at one time, I need you to go over this material and work with my nurse to prepare for our next visit.”

“I’ll need you do to some homework so that we can have an in-depth conversation at our next visit.”

“It’s time to make a decision about whether to do X, Y or Z. I can give you the medical information you need; you can help me understand how each option might fit with your own goals and preferences. Take as much time as you need to consider the choices. Then, we can decide together what the best option might be. Is there anyone else who should be a part of this discussion? Is it safe to say that the final decision belongs to you?”

Tip:

Consider documenting the use of (and response to) both shared decision-making and teach-back. Other metrics might include:

- Delivery rate of decision support tools
- Reduced decisional conflict—see the SURE test or Decisional Conflict Scale
- Improved health markers (A1c, blood pressure, etc.)
- Improved patient activation levels (PAM) or satisfaction scores
- Increased referrals to supportive care (dietitians, diabetes educators, palliative care)
- Fewer ED/urgent care visits/readmissions
- Increased rate of prescription refills
- Reduced non-beneficial tests/procedures
- Fewer appointment cancellations
- Number of patients using a decision aid; quality of decision aid
- Patient feedback on decision support; satisfaction with decision
- Provider feedback on Shared decision-making care model
- Reduced costs

Measurement Resources

- >> Link to MSDMC shared decision-making survey tools
- >> External link to the AQuA SURE test for patients
- >> External link to the CAHPS Patient-Centered Medical Home (PCMH) Item Set
- >> External link to the Decision Laboratory option instrument for observing patient involvement



Sustain: Improve and Spread



Identify opportunities for improvement and spread best practices learned from pilot project.

1. Assign accountability

- Identify a senior leader who is responsible for the success of the overall initiative and is the organization's owner of the process. Identify role accountabilities of clinicians and staff involved in the process. Build it into orientation and job descriptions as appropriate.
- Follow-up on compliance issues or staff not understanding the identified process

2. Develop a monitoring plan

- Identify a target to maintain, along with a plan to evaluate if performance falls below that target.
- Identify ways to make "errors" visible. For instance, a patient was involved in deciding treatment choices for a preference sensitive condition.

3. Integrate into the way you do business

- Fit into the values of your organization. This is how you work with patients and provide health care.
- Bring shared decision-making into the strategic plan. Revisit every year to assess progress and identify goals for the coming year.

4. Make it a "living" program

- Learn from cases. Bring those forward for others to learn
- Identify additional opportunities where shared decision-making might make a difference
- Bring feedback and get feedback from your patient advisory members or patients that are part of your initiative teams
- Build it as part of new initiatives so it isn't seen as a separate program
- Talk about success stories; celebrate staff members who are champions
- Celebrate shared decision-making month in March and advertise educational offerings
- Invest in staff education and research to expand your organizational expertise

5. Expand the scope

- If you have one provider do a pilot, spread it to other providers. If you have one clinical area implementing shared decision-making, move it to additional areas. If you are focusing on one clinical condition, move to additional conditions
- Consider some community education or group visits to expand the overall expertise and knowledge of your patient population in shared decision-making

Tip:

Consider incorporating shared decision-making competencies into annual goals to provide incentives to providers.

Examples:

- Percentage of patients with a specific condition who are offered shared decision-making
- Number of conditions for which shared decision-making programs or tools are implemented.

Improvement Resources

- >> [External link to the IHI Framework for Spread](#)
- >> [External link to the IHI Model for Improvement](#)

Defining Shared Decision-Making

Definition

Together, patients and health care teams clarify all acceptable options, ensure that both parties are well informed, and choose a course of care consistent with the patient's values and preferences as well as the best available medical evidence.

In other words: Helping patients evaluate all available options—weigh their personal values, goals and priorities against unbiased medical evidence—in order to make informed decisions at every stage of their care.

While shared decision-making differs from informed consent, the concepts complement and augment one another. In a sense, shared decision-making is “perfected informed consent.” If we do shared decision-making well, then informed consent is real and genuine. By doing informed consent well, we verify that shared decision-making was successfully executed.

- **Shared decision-making** happens “upstream” from informed consent, before the patient commits to an intervention. In choosing a treatment plan, both patient and health care team need to gather information and gain the knowledge needed to shape the decision.
- **Informed consent** occurs before the intervention but well after the treatment plan has been established. It is the closing of the transaction—the moment where the patient and health care team finally commit to the plan of care.

Overview

1. A clinician on the health care team presents an unbiased view of the pros and cons for all options, including “do nothing.” This may require the patient do to homework (read about a treatment, watch a video, etc.) and then return for further discussion.
2. The patient tells the clinician about personal factors that might make one option seem better than another. These include personal values, goals, preferences and circumstances.
3. Together, the patient and health care team use this information to decide which option best reflects the patient's needs and values.

Opportunities for Shared Decision-Making

Shared decision-making is at the heart of patient-centered communication. It is the health care team's responsibility to offer opportunities for shared decision-making. It can occur in any setting and take many different forms. For instance:

- One-time treatment decisions. Example: initial treatment of breast cancer.
- Possible serial treatments. Example: low back pain.
- Preventive care or screening. Example: PSA test; mammogram.
- Lifestyle decisions. Example: smoking cessation.
- Chronic care decisions. Example: diabetes management
- Life stage decisions. Example: move in with family, assisted living, hospice.

Defining Shared Decision-Making, Continued

How do I know when genuine shared decision-making has occurred?

- Proper preparation:
 - A situation presents itself as suited to shared decision-making.
 - Any involved party initiates the conversation.
 - A balanced relationship is maintained between the parties making the decision.
- Reaching a decision:
 - Together, the parties create a shared understanding of the information needed to make the decision.
 - The parties use developed resources, methods and tools.
 - The patient and health care team seek a mutually satisfying decision in which they both have confidence.
- Following up:
 - The parties follow up with next steps once the decision is made, including a plan for ongoing decision-making needs.

Framing the Conversation: an Example

CLARIFY DECISION AND ROLES

"We have reached a point where a decision needs to be made: whether to do X, Y or Z. I can give you the medical information you need; you can help me understand how each option might fit with your own goals and preferences."

CLARIFY TIMELINE

"You can take as much time as you need to consider the choices. Then, we can decide together what the best option might be."

CLARIFY INVOLVEMENT OF OTHERS; FINAL DECISION MAKER

"Is there anyone else who should be a part of this discussion? Is it safe to say that the final decision belongs to you?"

Required for Complete Shared Decision-Making

Have you worked to establish a balanced relationship?

Strategies to consider:

- Acknowledge the roles of all parties in the decision-making process (clinician, patient, family, others), including who is responsible for the final decision.
- Acknowledge that both clinician and patient bring different areas of expertise to the discussion (i.e., patients “know self best”).
- Address any health care team biases. For instance, a surgeon might involve nonsurgical specialists to ensure that all options are objectively presented to the patient.
- Remind patients to take as much time as needed/available to consider the decision.

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Defining Shared Decision-Making, Continued

Do all parties have the information they need to make a decision?

For genuine shared decision-making to occur, all parties should understand:

- The decision that needs to be made and the timeline.
- Who should (and shouldn't) offer support and advice. For instance, patients might avoid advice from family members who contribute to decisional conflict.
- The condition, diagnosis and likely course of disease.
- All available options (including “do nothing”), along with their benefits and risks/burdens (including financial burdens).
- Which burdens and benefits matter most to patient (i.e., “concordance,” or values matching: the relationship of the risks/benefits to the patient's values/preference).

Have you used proven strategies to support decision-making?

For example:

- Active listening
- A universal-precautions approach to health literacy
- Cultural sensitivity
- Teach-back technique to assess 1) patient's understanding of medical information and 2) provider's understanding of patient's goals and preferences. Teach-back is used throughout the discussion, not just at end.
- Non-biased patient education, discussion guides or decision aids (handouts, videos, tools to assess activation or readiness for shared decision-making, etc.).

Have you sought a mutually satisfying decision in which both have confidence?

Create space for the patient to reconsider, change his/her mind, and loop back with the provider.

“Mutually satisfying” is the goal, but in the end, it is the patient's decision—and satisfaction with that decision—that matters most. If the health care team disagrees with the decision, professional pathways exist to resolve health care team discomfort (such as seeking a second opinion) or decide whether to keep working with that patient.

Is there a plan to guide next steps and identify future decision-making needs?

The health care team continuously adjusts the care plan as the patient considers and reconsiders the decision, new needs arise, decisional conflicts re-emerge, etc.

For more information, see the

[>> MSDMC Shared Decision-Making Lexicon](#)

Shared Decision-Making FAQ

1. How is shared decision-making different from informed consent?

Shared decision-making is a process of using medical evidence and the patient's personal values to come to a decision about a course of treatment. The process happens before a decision is made and allows patients to reconsider the decision over time. The ongoing relationship between patient and clinician is part of the process.

Informed consent is a discrete act. The patient's signature confirms that the patient understands and agrees to the intervention; signing takes place right before the intervention occurs.

Imagine you are buying a home. Shared decision-making is like your interactions with the realtor as you decide which house to buy. Informed consent is like the closing where you sign off on the purchase.

2. Everyone already thinks we use shared decision-making. How should I deal with this?

Start by bringing people together to discuss the available treatment options for a given condition. By identifying options and clarifying what information patients need to make a decision, we often expose the variable messages that patients hear. This can be a good starting point for a discussion on how to improve the conversation.

Or, begin with a survey of patients to see if they recall hearing their options, or whether they understood key facts about their decision. This can offer compelling evidence that clinicians are not communicating important information as well as they think.

3. What is the evidence behind shared decision-making?

Over 100 studies show that decision support tools can improve patient knowledge and give them greater confidence in the decisions they make.

We need to better understand how to implement these tools; however, keep in mind that this dilemma occurs in other areas of medical practice as well: Evidence may show that an intervention is effective, but it often takes time and effort to apply that knowledge to improving the lives of patients. >> Related: [19 Key shared decision-making articles](#)

4. What if patients don't want shared decision-making?

We have responsibilities to offer patients the necessary information about their treatment and to listen to what is important to them when making the decision. If, ultimately, they defer their decision to their provider, that is their choice. We respect their desire to rely on the clinician's judgment.

5. What is the business case for shared-decision-making? Are there any cost savings?

The business case usually relates to the goal of patient-centered care, a central part of the overall strategic plan for most organizations. A primary measure of success is the degree to which patients experience high-quality care. In this context, the fundamental values of shared decision-making—respecting patients and listening to what is important to them—are sound business practices.

Certainly, shared decision-making can reduce the unnecessary use of health care resources. Some interventions are overused; patients are less likely to use them when they're given the option of saying no. Nevertheless, we must be careful to keep our focus on the ultimate goals of shared decision-making—respecting patient preferences and making sure patients are well informed.

Shared Decision-Making FAQ, Continued

6. We don't have time for these conversations. How can we streamline the shared decision-making process?

As many studies show, we can incorporate decision support strategies into patient encounters with minimal increase in time. A conversation between patient and clinician is already taking place; shared decision-making simply changes the nature of that conversation.

For patients, most encounters consist of a flow of difficult-to-understand information followed by a short period of time in which to make a decision.

Decision aids can communicate some of the information more efficiently, allowing patients to digest the important facts prior to the visit. This changes the visit into a discussion where patients feel more comfortable expressing what is important to them—with the confidence that comes with having a better understanding of the information.

7. Do I need to add staff?

No, you do not need to add staff or a lot of other resources to implement shared decision-making.

Look at your processes to see the best ways to incorporate shared decision-making into existing work flows. Small changes in the timing and nature of information delivery can make a big difference. Decision aids are designed to make interacting with patients easier or to help the patients do some of the work on their own, at their own pace.

8. What should I do if senior leadership is not making this a priority?

This could be a significant barrier. Try to engage leadership in a discussion about how shared decision-making aligns with your organization's mission and vision. Appeal to the fact that this is the right thing to do for patients.

You might also demonstrate the effectiveness of this intervention in small pilots that use few resources and have a minimal impact on the organization. By carefully collecting data from these pilots and bringing back stories of lessons learned and positive outcomes, you can make the case for further adoption of shared decision-making.

9. I need a speaker. Who do I contact?

The MSDMC can help you find someone. Many members of the collaborative have experienced speakers who can help with education. >> [Contact](#)

10. How can we educate patients about shared decision-making?

There has been some work on helping patients gain a better understanding of shared decision-making, but this area needs further exploration. The collaborative will be identifying some patient resources that will be added to the site in the next phase of development.

11. Who are the experts in this area?

Researchers around the world are exploring the best ways to make shared decision-making a practical reality for patients and clinicians. We are fortunate to have some of those experts here in our community. Here are links to various organizations that have been leaders in the field. >> [Related: Links to other shared decision-making sites](#)

Shared Decision-Making Case Studies

Creating a Shared Vision Case Study: Stillwater Medical Group

In 2008, Stillwater Medical Group, a multispecialty clinic in Stillwater, Minn. joined with the local community hospital to form an integrated health system. System leadership was looking to communicate a cohesive vision and mission for the new organization. Patient-centered care was identified as a core value around which the mission and vision could be focused.

Key Learning Points

- Align your organizational mission and vision with shared decision-making work
- Secure clear, vocal support for shared decision-making from leadership
- Coordinate of shared decision-making with other process improvement work

The system leadership developed a program to explore the fundamental elements of patient-centered care using an interactive process with leaders, the community and the employees at all levels of the organization. This process allowed leaders to listen to what was important to the people providing and receiving care and to reflect back the important concepts that would be necessary to be patient centered.

One of the central elements of patient-centered care is shared decision-making. Prior to the integration, the clinic had already begun some small quality improvement pilot projects involving shared decision-making, and clinic leadership saw an opportunity to expand on this work because of the alignment of the mission and vision of the system with the clinic's quality improvement goals. The leaders of the system provided clear vocal support

for the value of this work and the projects that supported its implementation. The shared decision-making message resonated with staff because it was consistent with what was important to them and because their experiences in the pilots were positive for both patients and health care teams.

The environment at the clinic allowed a gradual expansion of shared decision-making projects into other areas. Spread occurred as opportunities were identified that aligned with the ongoing clinic quality improvement work which was a part of regular clinic operations. This approach helped to keep the work on shared decision-making from being thought of as a separate project. Instead, the work was carefully integrated into the everyday work processes. The outcome was patient centered change that was supported, consistent and sustainable.

This is a case study on how shared decision-making was implemented using a preference sensitive condition approach.

Breast Cancer Case Study

Excerpt from *Shared Decision-Making is Contagious*, by Joyce Kramer, BA, RN, Allina Health System

After more than a year of diligent work from committees, patient advisory groups and executive leadership to find a way to navigate cancer patients across the system; a small community hospital & clinic decided to hire a cancer care coordinator, that person was me. This is my story, which is a part of a larger story that continues.

Breast cancer care coordination was identified as the first priority. I began to develop a framework for a breast cancer program; or another way to put it, a breast center without walls. The first step was to identify physician champions; which included breast surgeon, primary care provider, medical oncologist, pathologist and breast radiologist. Working in tandem with physician champions; clinic work flows that followed the patient trajectory were developed and adopted as policy. Breast cancer education materials such as surgical discharge instruction booklets were developed. EMR documentation and care coordination education

Shared Decision-Making Case Studies, Continued

sessions were built into scheduling. Next, presentations about breast care coordination was provided for all staff, provider and executive leadership with the intent to keep the interest level high and gain support top down and bottom up. Our breast center without walls was up and running, with predictable tweaks along the way.

Sometime later, I started hearing about a thing called shared decision making in some of my meetings. Then I received a formal invitation to DO shared decision-making using decision aids for men newly diagnosed with prostate cancer. So again, we enlisted a physician champion, a urologist who was at first reluctant to add more education materials or re-work his patient work flow to include shared decision-making. I'll admit, I was skeptical as well, but once I saw the decision aid and we worked out the details of shared decision-making timing, I was willing to try. I met with his patients after he called them with biopsy results. He informed them that they needed to meet with me before their surgical consult- all patients agreed. Cancer patients are hungry for information about their disease and treatment options so it wasn't a hard sell.

During our shared decision-making sessions, I reviewed pathology results, in most cases these were men with low- grade, low-risk prostate cancer. I used the decision aid to review treatment options, risk, and benefit and discussed their initial thoughts about a treatment option that would fit with their personal preferences and values. I documented shared decision-making sessions in the EMR and routed it to the urologist and primary provider to close the loop and communicate what treatment option interested them. I assigned them homework before they met with the urologist- review the decision aid before your surgical consult and I will be at available to answer questions or provide additional resources.

The urologist told me he asked every patient the same question; "did you find the decision aid and shared decision-making session valuable, a resounding YES from all except one that fell under the radar and was missed. When he met with patients in consultation, they were relaxed and focused; they had excellent questions; patient satisfaction increased, he was saving time and providing better care, the provider satisfaction increased.

A light bulb went on for me when I met with men for shared decision-making and used the decision aid, "this is exactly what I'm doing with breast patients, minus a decision aid!" I intuitively was doing shared decision-making. As a nurse, in addition to clinical functions, this is the bulk of our work, we educate and support patients.

I raised the question to the shared decision-making powers that be. "May I have decision aids for breast cancer patients?" Shared decision-making was embedded into breast workflows, prior to surgical consult. In both patient populations, patients presented at consult relaxed and focused; they had excellent questions, patient satisfaction increased. The surgeons were saving time and felt they were providing better care, provider satisfaction increased.

The shared decision-making bug is highly contagious. It continues to find its way to patients, providers and work flows where preference sensitive conditions exist and there are willing hosts.

Shared Decision-Making Case Studies, Continued

This is a case study on how shared decision-making was implemented using a preference sensitive condition approach.

Prostate Cancer Case Study

Excerpt from *Weighty Choices, in Patients' Hands*, by Laura Landro Wall Street Journal, August 2009

Thomas Stormont, a urologist and surgeon at Stillwater Medical Group in Stillwater, Minn., was skeptical at first when the group agreed to use the shared-decision-making aids provided by the Foundation for Informed Medical Decision Making as part of a demonstration project. Although the material is reviewed semi-

annually for possible updating, Dr. Stormont felt the video and booklet on prostate cancer were incomplete. They didn't cover some of the newer treatments, for instance, such as prostate cryoablation, the freezing of the prostate to treat localized cancer. "I thought it would be a waste of time, another barrier between me and the patient, and more literature I wasn't in control of," he says.

Dr. Stormont agreed to use the programs, but supplements them with his own literature that includes information on newer treatment options. He says he has found that the decision aids help patients and their spouses get better educated about early prostate cancer, so his time with them is "more relaxed, efficient and focused."

Patients have more realistic expectations about their treatment and side effects and are less likely to seek out second opinions, he says. They also are more comfortable choosing less-invasive treatments after reviewing the decision aids, he says. "On one hand, while I am losing some surgical patients because of this process, on the other, we both are more comfortable that they are choosing the best treatment for them—one that they are more informed about, more comfortable with and less likely to regret later on," he says.

Don Paulson, 74, a patient of Dr. Stormont, learned last week that he has prostate cancer, which he says came as a shock after years of good health. At an initial counseling session, oncology care coordinator Joyce Kramer went over the diagnosis and treatment options with him and his wife, Phyllis. She reassured the couple that the cancer was not life threatening and sent them home with a prostate-cancer DVD and some printed literature to view prior to a visit with Dr. Stormont over the weekend. "We had a chance to digest it rather than getting it all in one big chunk," says Mr. Paulson.

After watching the video, Mr. Paulson says he felt he understood his options far better. He is now weighing whether to choose the implantation of radioactive seeds, or try the cryoablation described by Dr. Stormont, who performs the procedure. "If we had just gone straight to the doctor's office and heard all of these options it would have been too much. It was good to be knowledgeable and review all of the possible side effects of different treatments first."