Shared Decision Making for Chronic Conditions and Long-Term Care Planning

July 26, 2016

2:30 p.m. – 4:00 p.m. ET

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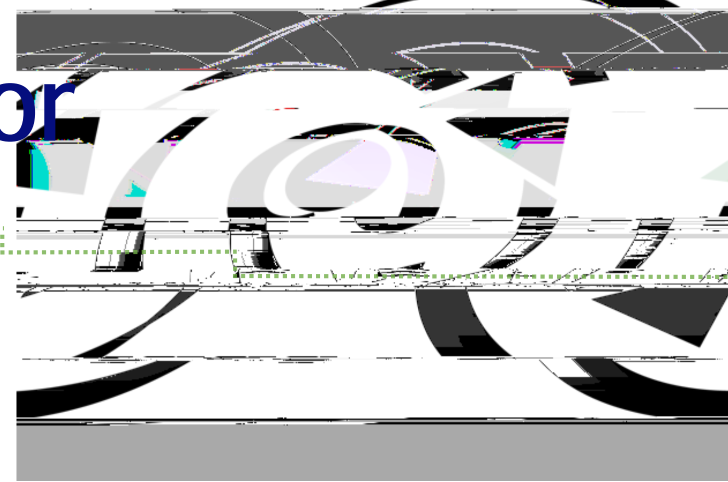

- Arlene Bierman

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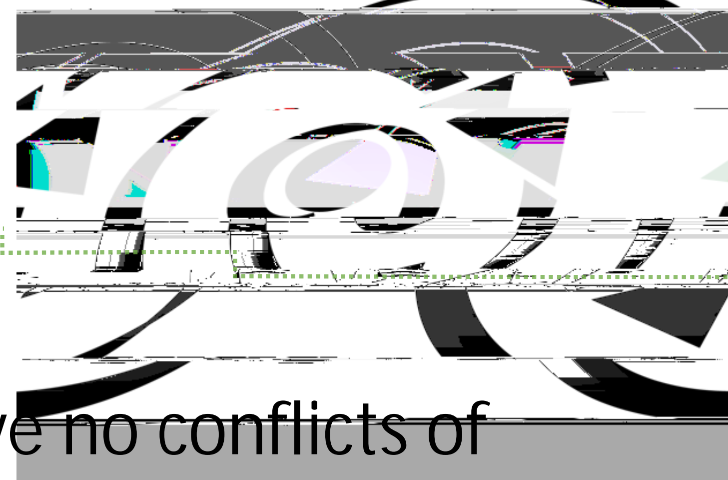

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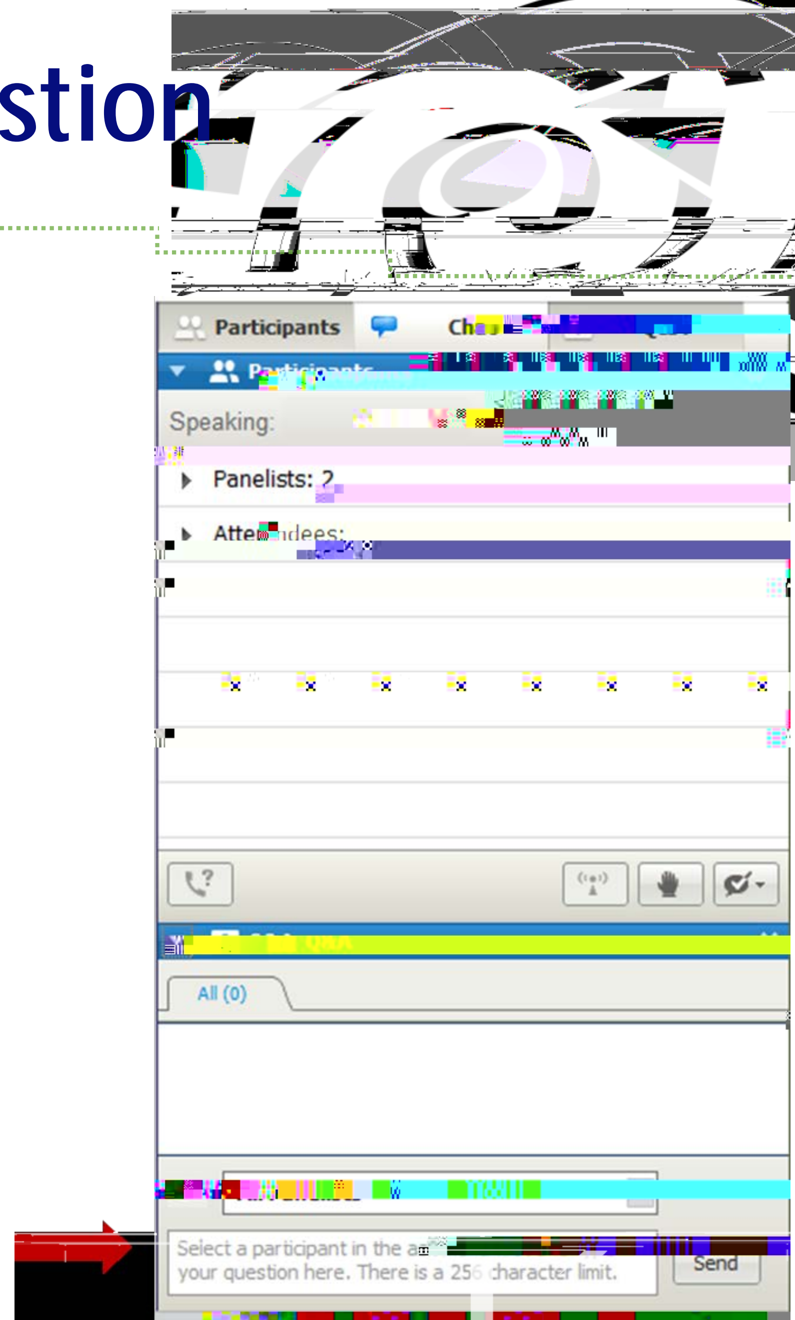

Learning Objectives

- At the conclusion of this activity, participants will be able to:
  1. Describe the rationale and research behind shared decision making and its potential for improved outcomes in chronic disease.
  2. Explain the differences and complementary qualities of

Shared Decision Making (SDM) and Chronic Disease

Cathleen E. Morrow, M.D.

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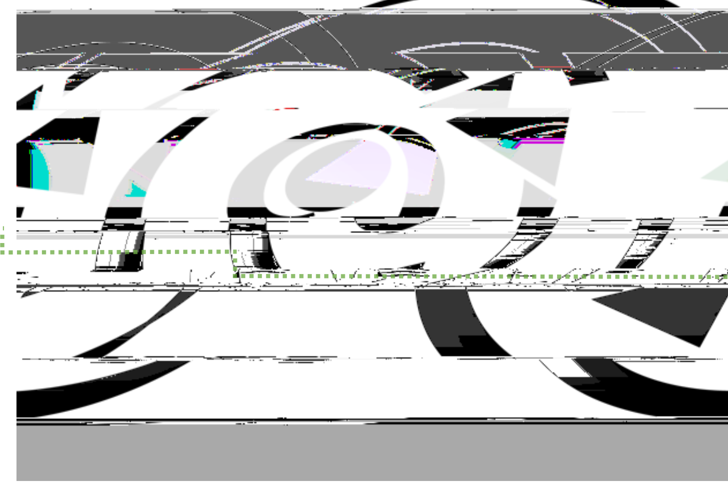
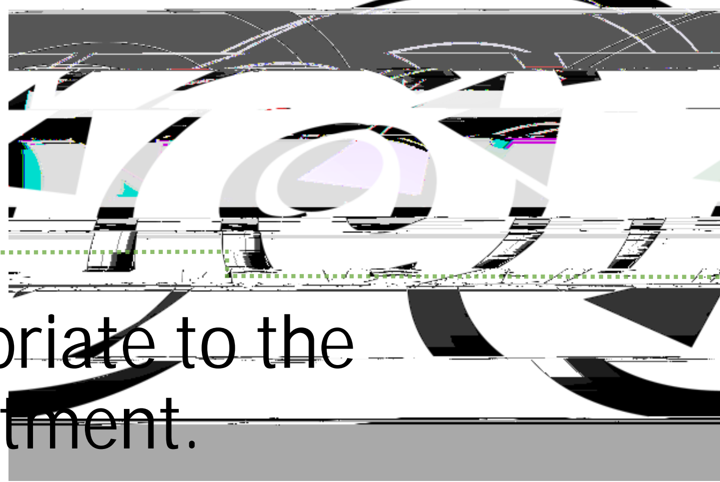
Definitions of SDM



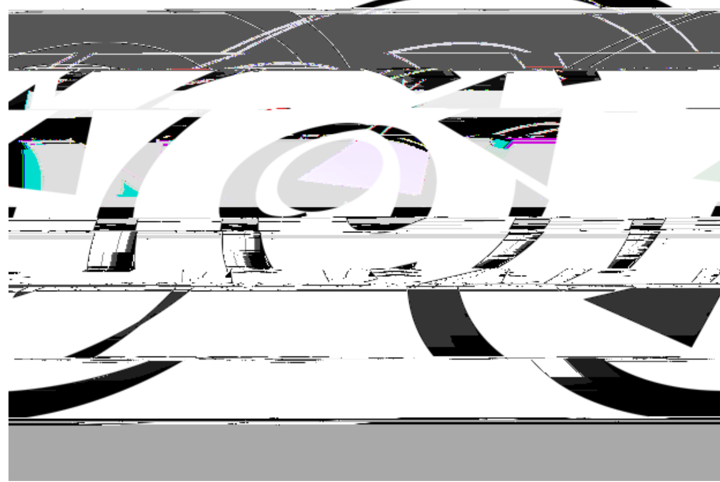
SDM

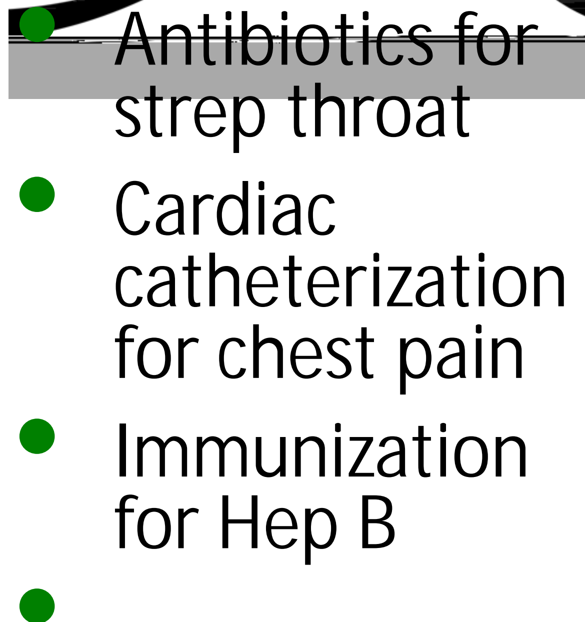
- **Interpersonal** and **interdependent** process.
- Recognizes that a decision is required and that providing information is helpful but not sufficient.
- Highlights best available evidence about risks and benefits of each option married to the patients values and preferences.
- Dynamic interplay between the provider's guidance and the patient's values and preferences.

SDM – The Conversation



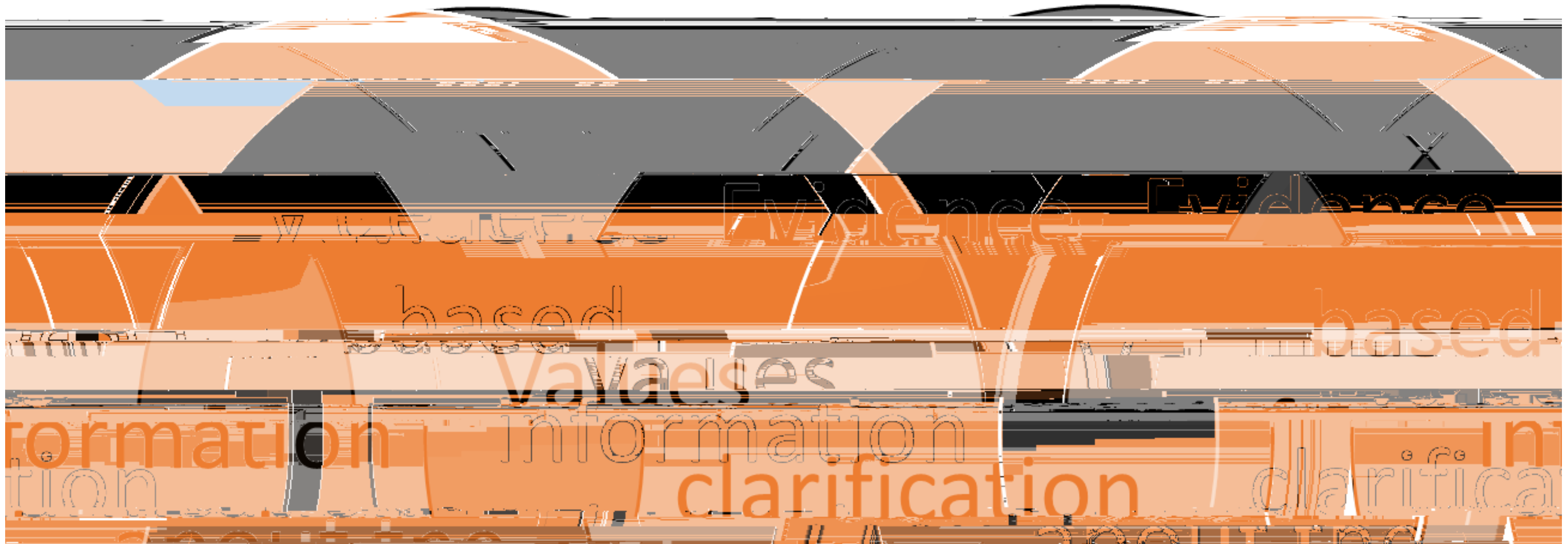
- Is an instrument of care, appropriate to the uncertainties of illness and treatment.
- In chronic disease care, is especially important: changes over time; individual patient response varies; patient values and preferences are critical to management and must be frequently re-visited.
- Especially called for when best option is not clear: these are common in chronic disease!





- Antibiotics for strep throat
- Cardiac catheterization for chest pain
- Immunization for Hep B
-

Decision Aids



http://decisionaid.ohri.ca/decguide.html

Cochrane Reviews of Decision Aids

communication

Source: Stacey D, et al. Cochrane Database of Systematic Reviews 2014, Issue 1 .

- A second important communication skill designed to enhance uptake of medical advice and improve outcomes.
- Utilized most effectively in evidence-based d

Classic Distinguishing

MI: Where are you on a scale of 0 to 10 in your interest in quitting? What would it take to get to next higher number?

SDM: Given that there are a number of options, can you help me understand what is important to you in this matter? What are your values and preferences?

Confirm that there is a decision to be made and clarify that the patient has a role

Verify understanding of the options, risks, and benefits

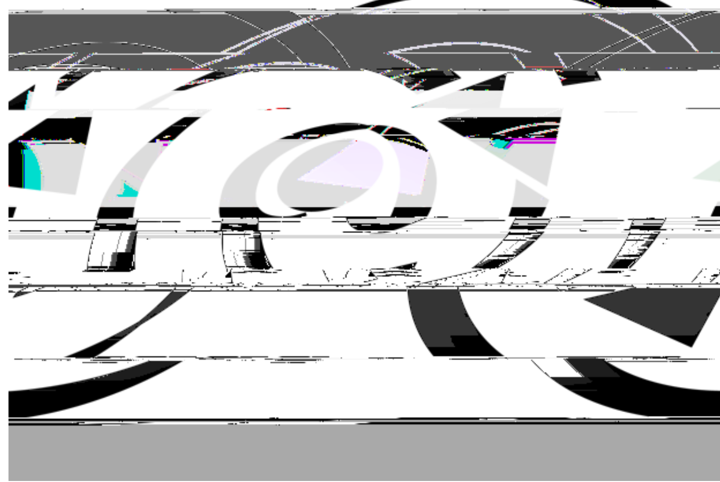
in the Clinical Encounter

Frame decision

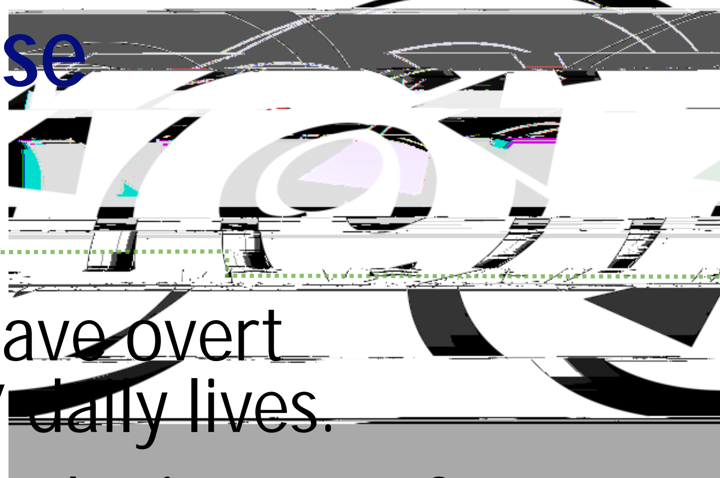
is personally important (values and life circumstances)

Plan next steps

http://decisionaid.ohri.ca/decguide.html

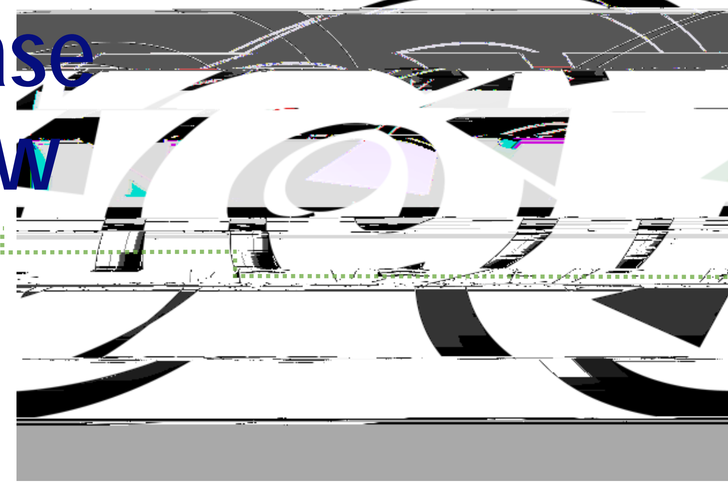


Challenges in Chronic Disease Management: Patient View



- Many chronic diseases do not have overt symptoms that impact patients' daily lives.
- Many patients deny or minimize the impact of chronic diseases on their lives.
- Patients want to be "well," and they often feel that way.
- No one likes to take medicine.
- The diagnosis of a "disease" has important and often negative impact on patients' psychological and emotional health and well-being.

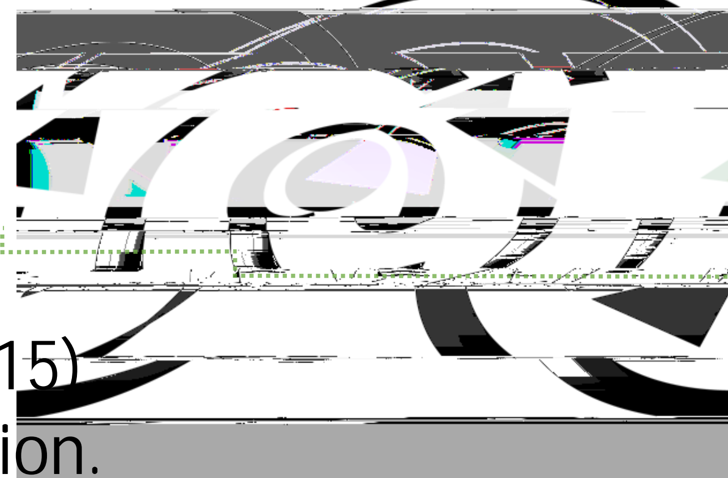
Challenges in Chronic Disease Management: Provider View



Principles in Chronic Disease Management

- You can't get it all done in one visit!
- Relationship over time is essential: ongoing conversation.
- Message: We can manage this problem effectively together; we are partners in successful outcomes; we will work at this to make you healthier.
- Flexibility for management: e-visits, telemedicine, phone management.
- Current payment modalities often not helpful!
- ACOs and capitated payments will improve this challenge over time.

Evidence Base

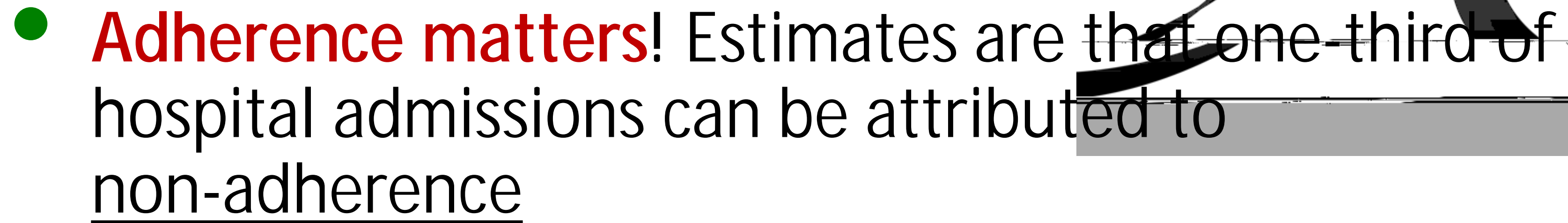


- Systemic review of 50 studies (2015)
- Increased overall patient satisfaction.
- Reduced costs: Elective surgery, BPH surgery, PSA screening, end-of-life care.
- Studies that looked at behavioral measures (reaching a decision; adherence) showed positive results in 37 percent of the cases.
- Studies of self-reported symptoms (e.g., QOL, mental function, etc.) were 42 percent positive.
- No negative results were found.

Sources:
Shay LA, Lafata JE. Med Dec Making. 2015;35(1):114-131.
Stiggelbout AM, Pieterse AH, De Haes JC. Patient Educ Couns. 2015 Oct;98(10):1172-9.
Veroff D, Marr A, Wennberg DE. Health Aff (Millwood). 2013 Feb;32(2):285-93.

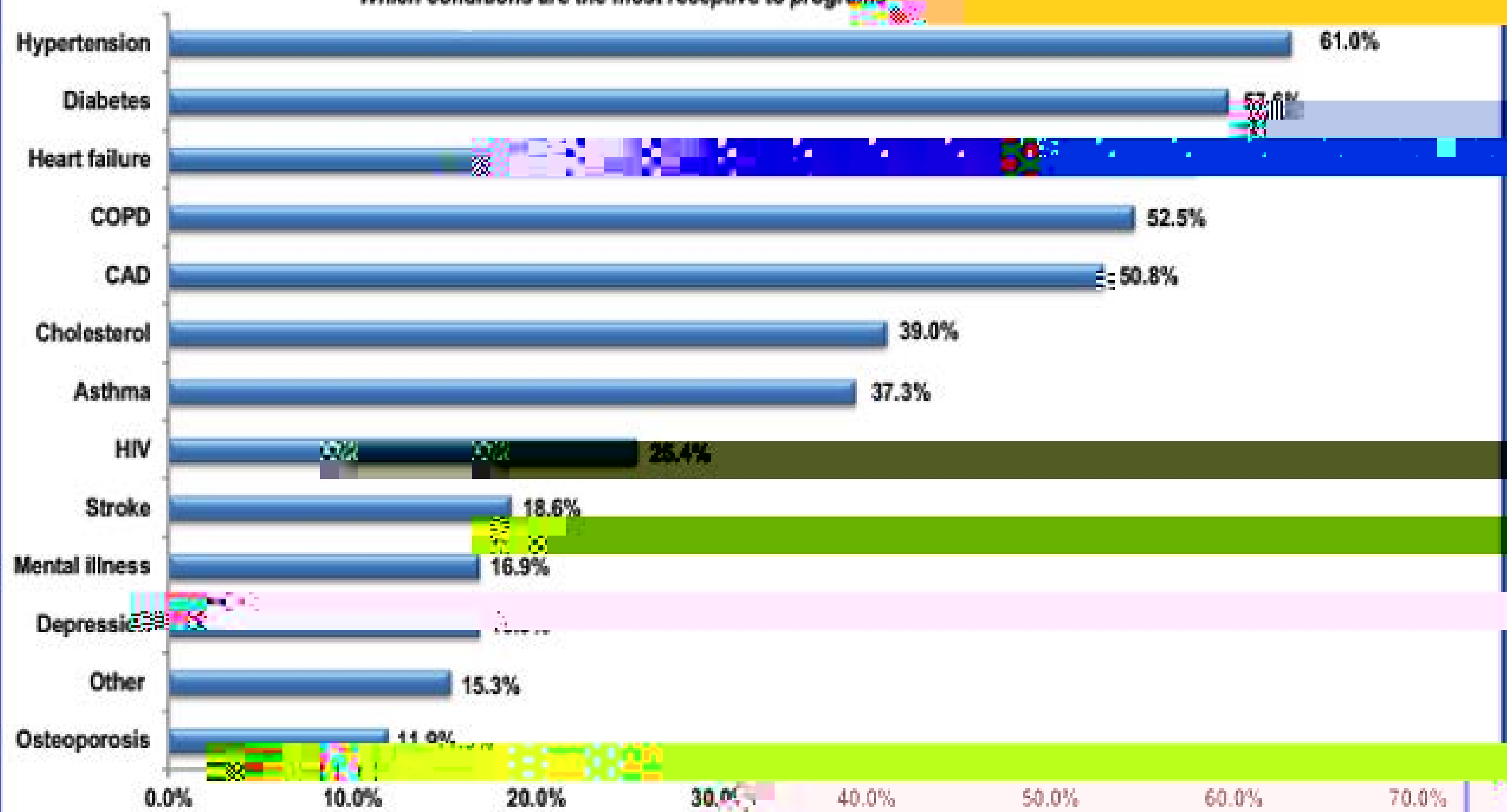
- In MD-led decision making, one-third of patients do not feel well-

Sources:
Ferguson M. Transl Behav Med. 2011 June; 1(2):205-206.
Moulton B, King J. Journal of Law, Medicine & Ethics. 2010;38(1):85-97.
Grayson M. 2013. http://www.hhnmag.com
Stacey D, et al. Cochrane Database of Systematic Reviews 2014, Issue 1.



- **Adherence matters**! Estimates are that one-third of hospital admissions can be attributed to non-adherence

Source: Choudhry NK, Winkelmayer WC. Journal of General Internal Medicine. 2008;23(2):216-218..



Targeted Conditions for
Which conditions are the most receptive to programs
Hypertension
61.0%
Diabetes
Heart failure
COPD
52.5%
CAD
50.8%
Cholesterol
39.0%
Asthma
37.3%
HIV
25.4%
Stroke
18.6%
Mental illness
16.9%
Other
15.3%
Osteoporosis
0.0%
10.0%
20.0%
40.0%
50.0%
60.0%
70.0%
Source: HIN Improving Medication Adherence
January 2013
HIN
©2013

Adherence: Diabetes Mellitus (DM)

- 62 to 64 percent of patients with Type 2 DM on insulin adhered.
- One-third of young patients on insulin filled their prescriptions.
- 36 to 93 percent of Type 2 DM patients took prescribed oral agents for 6 to 24 months.

Source: Cramer JA. Diabetes Care. 2004 May;27(5):1218-24.

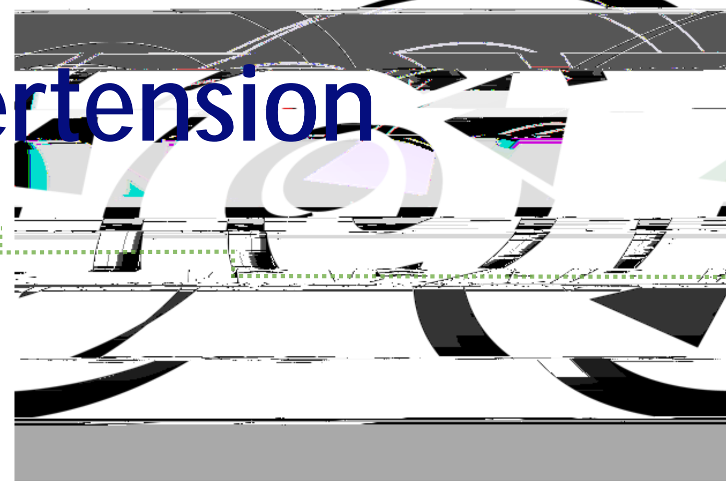
SDM Approach to Chronic Disease

- Goals: Nurture an activated patient who "owns" his or her disease and is enthusiastic about co

Talking to Patients: Diabetes Mellitus

- You have Diabetes: Tell me how you understand that?

Talking to Patients: Hypertension



Talking to Patients: Hyperlipidemia

- You have high cholesterol? What do you know about that?
- Can you tell me what is important to you about this problem and how to treat it? Preferences? Values?
- Who else is part of helping you manage it?
- What else should I know that might help me to best understand how to help you?

MAYO CLINIC

Statin/Aspirin Choice

Decision Aid

Share | Back

Benefits vs Downsides according to my personal health information

Future Risk of having a heart attack

Risk for 100 people like you who do take statins

Current Risk

Risk for 100 people like you who do not

Cost

Standard dose statins

about $4/month

Side Effects

Common side effects

nausea, diarrhea, constipation

Muscle aching/stiffness

5 in 100 patients

(some need to stop statins because of this)

Liver blood test goes up

(no pain, no permanent liver damage)

2 in 100 patients

Other Benefits

Standard dose statins

(requires patients to stop statins).

Over 10 years

7 people will have a heart attack

91 people will have no heart attack

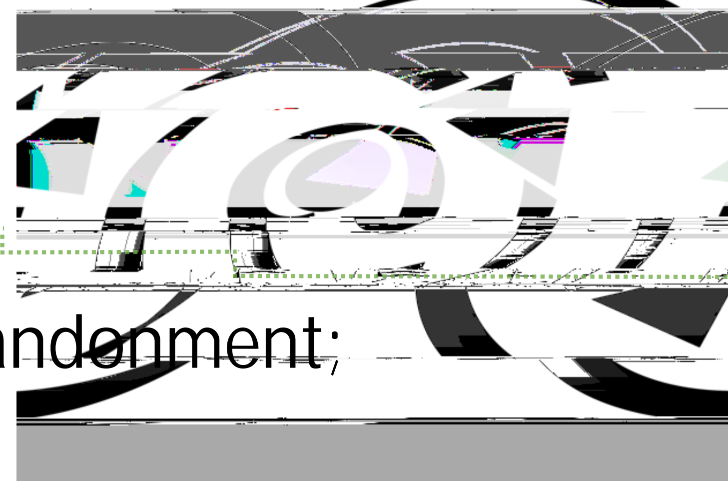
Over 10 years

9 people will have a heart attack

91 people will have no heart attack

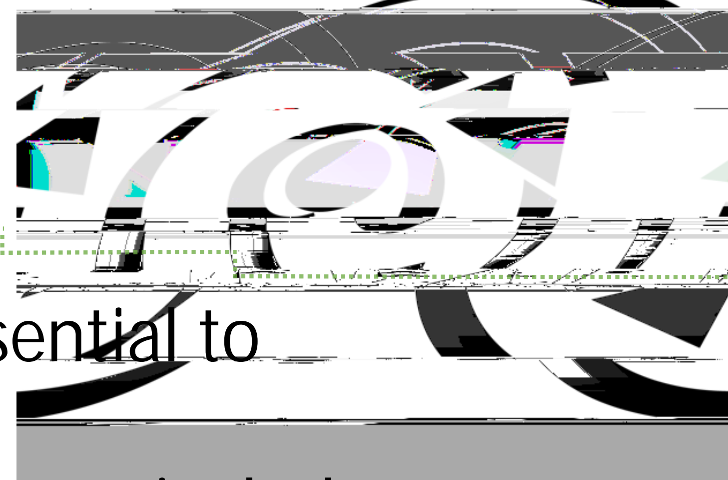
http://statindecisionaid.mayoclinic.org

Lessons Learned



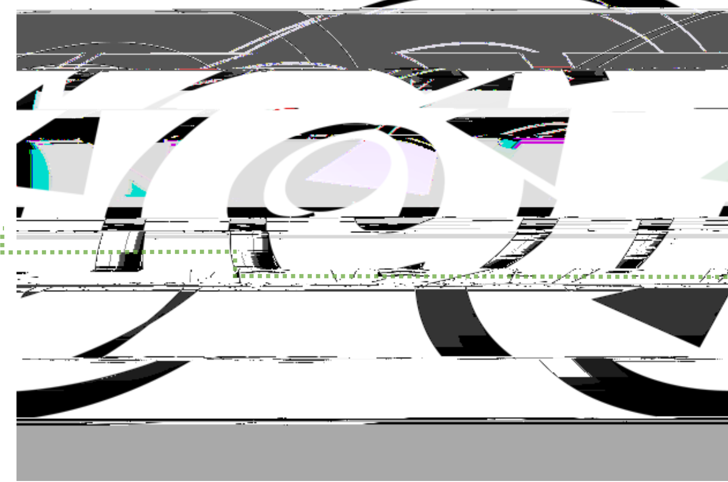
- SDM is never about patient abandonment;

Other Lessons Learned



- Agency and self-efficacy are essential to controlling chronic diseases.
- "Management" of a chronic disease includes supporting patients' sense of self-efficacy. Creating a sense of partnership leads to increased satisfaction for both provider and patient.
- In the long-run, SDM saves time during visits and curtails frustration.
- Decisions in chronic disease are not 'done' – circumstances change over time and require re-visiting the issues frequently.

Contact Information



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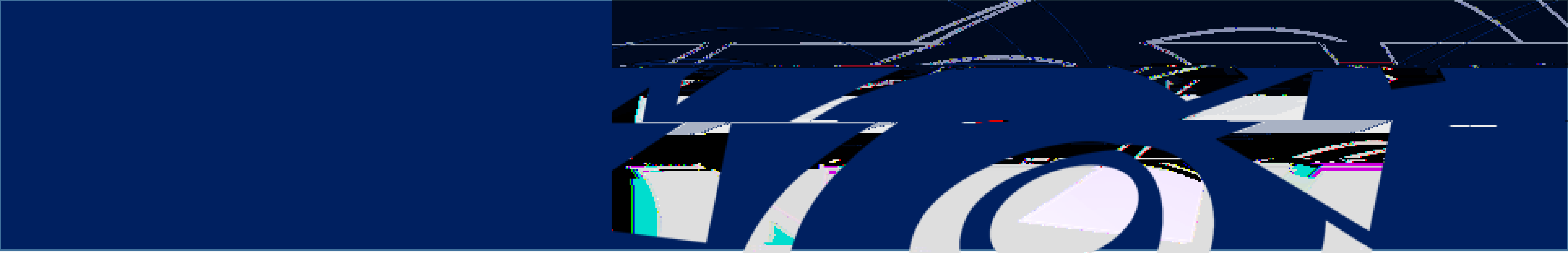
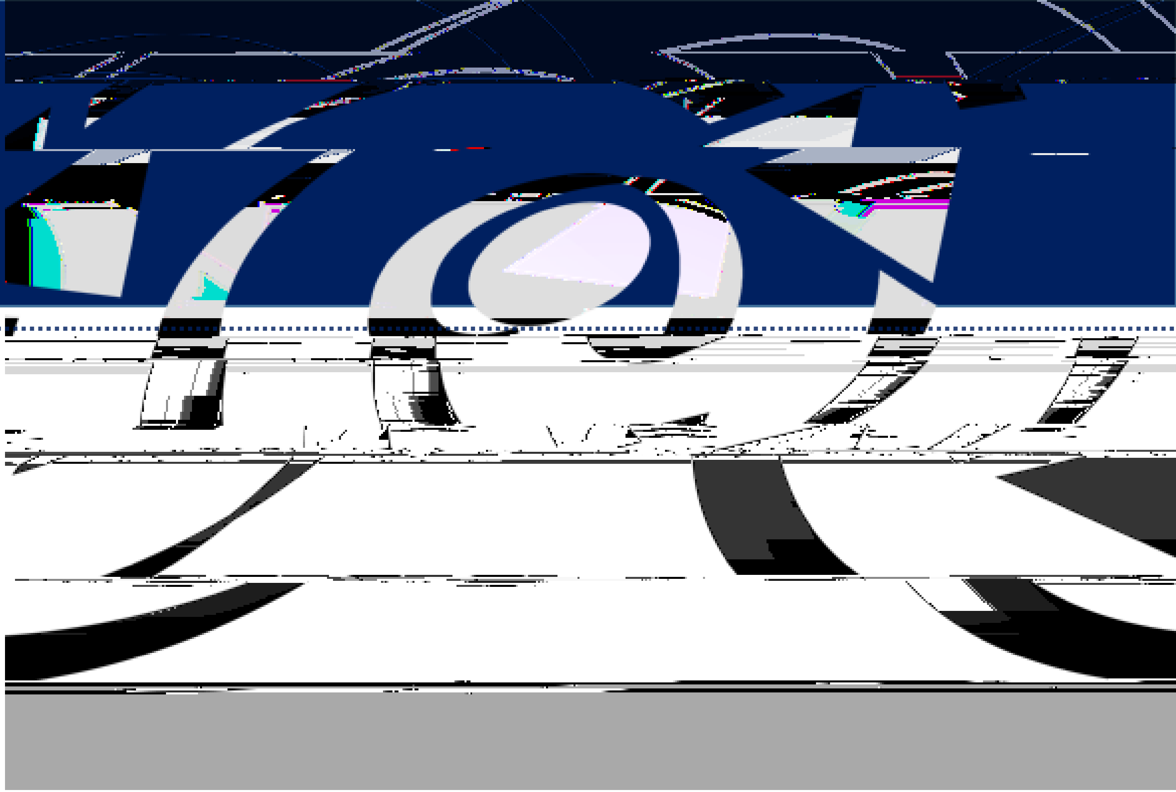
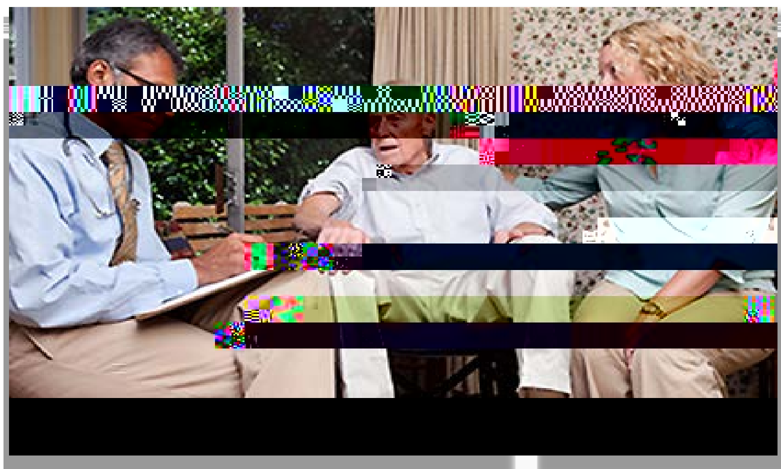




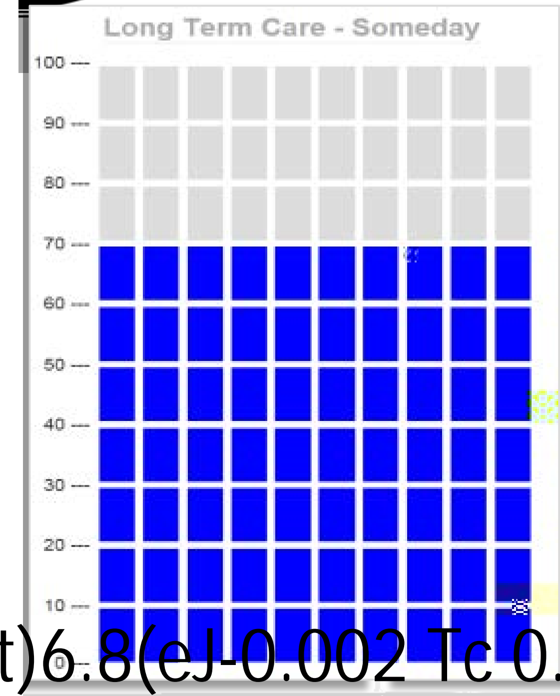
What is SDM?

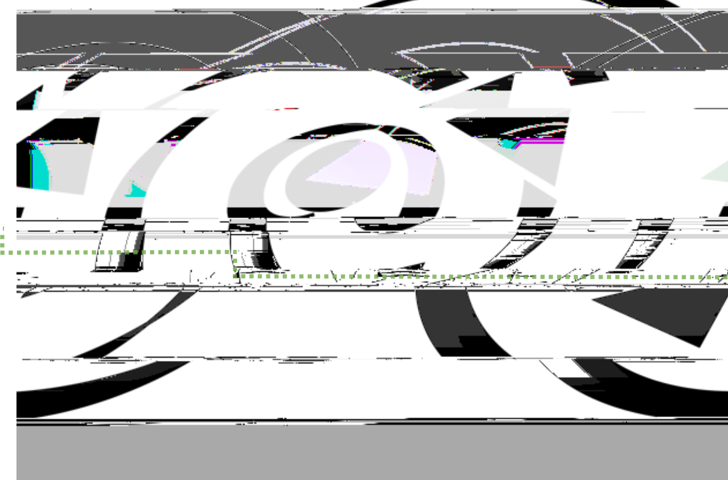
We define SDM as a collaborative, patient-directed decision making process that assists veterans in assessing their health-related needs, setting priorities, and making choices that achieve their goals.



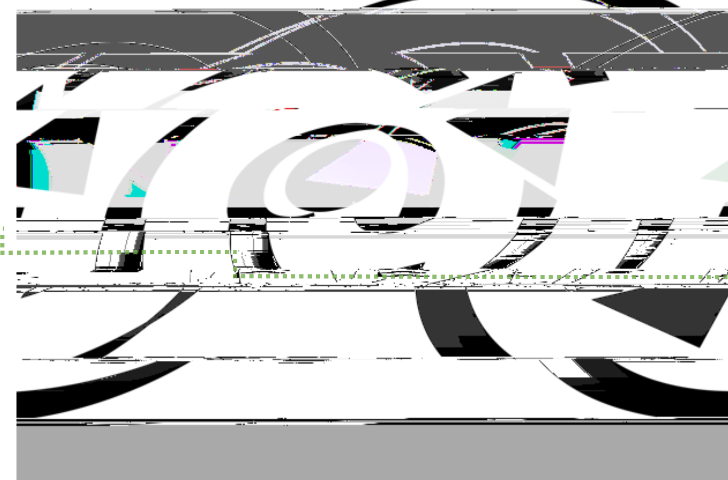
SDM aligns with several VA initiatives, and it's supported by VA leadership.

- Though the rate of growth is slowing, older veterans are the fastest growing cohort we serve.
- By 2017, nearly 10 million of our 21.7 million veterans (46%) will be over 65.
- About 70 out of 100 people need long-term services.4(wQ43t)6.8(eJ-0.002 Tc 0.008 T





http://homedialysis.org.au/wp-content/uploads/2013/03/Low-resolution.pdf

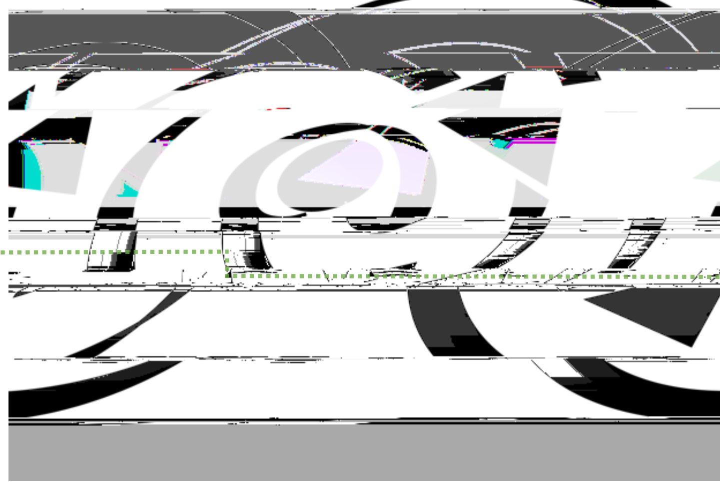


Veteran
Caregiver
www.va.gov/Geriatrics

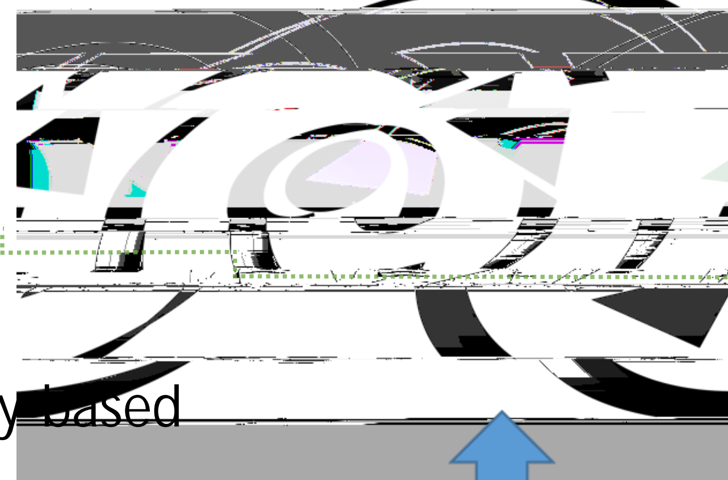
What Veterans Need to Make LTSS Choices

Research studies (including Reder, 2009) indicate veterans and their family caregivers need:

- **More information** about long-term care options, in general.
- More information about **home and community-based services**, so they can remain at home/be independent.
- To be **asked about their life goals** and how LTSS can help support them.
- **Decision aids (i.e., worksheets)** to facilitate making choices about LTSS.

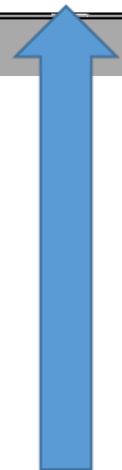


Outcome Measures



Proximal measures – goal of **increased**:

- Access/referrals to home and community-based services.
- Veteran-directed choices based on goals and priorities.
- Veteran and family caregiver satisfaction with decision process.
- Completion rate of advance directives.
- Veteran aging-in-place.
- Care team acceptance of veteran choice(s).



Distal measures – goal of **decreased**:

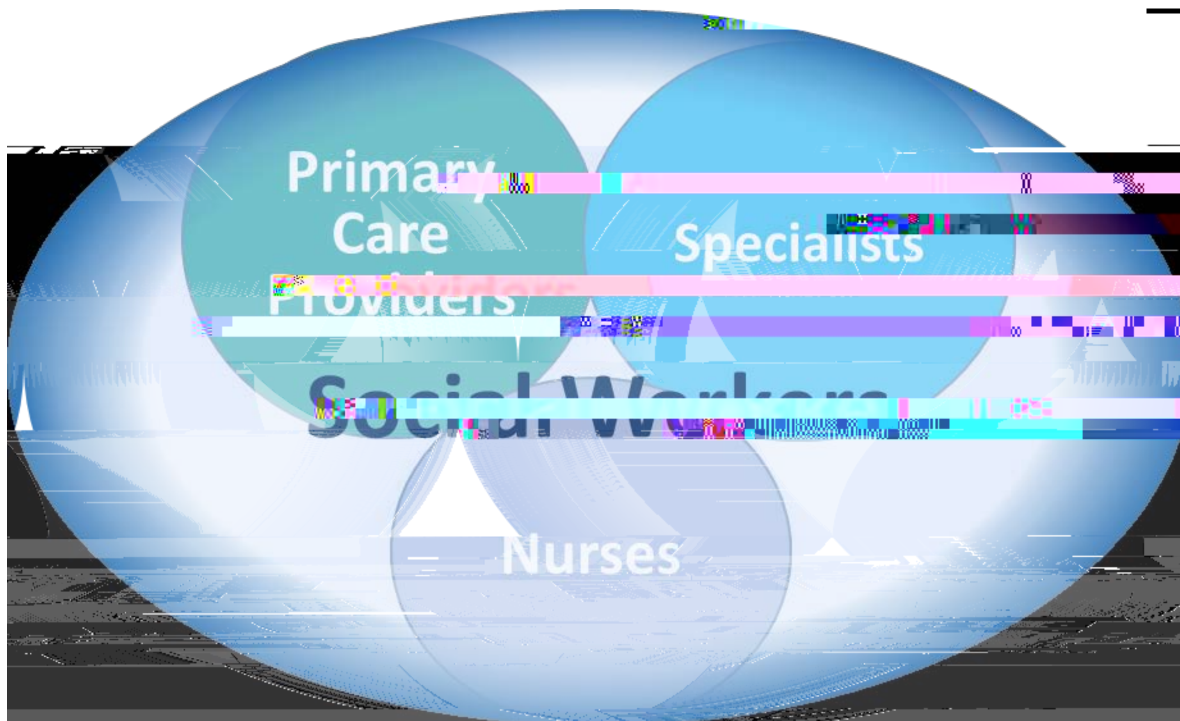
- Emergency department and urgent care visits.
- Number and length of inpatient hospital stays.

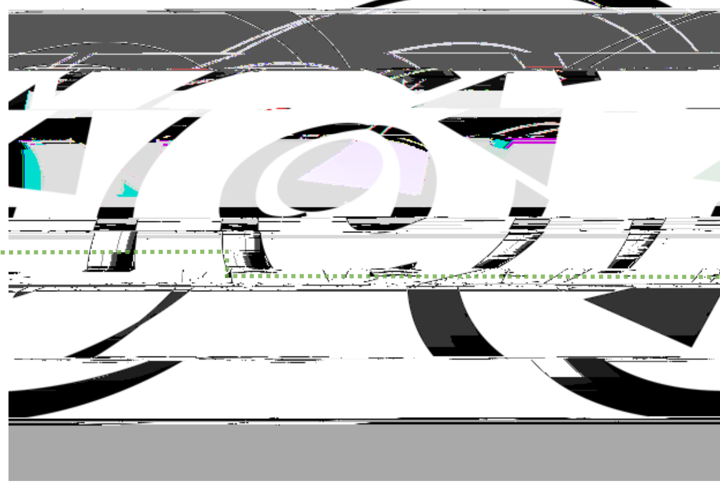
- The shared goal is veteran-directed decisions facilitated by care team input and quality information.
- With SDM, roles filled by team members are interdependent.

Social Workers – Key Staff Roles

"**Social work/care management should take the lead** to adopt SDM process and framework to help veterans make LTSS choices."

— Michael Kilmer





Home and Community-Based Care (HCBC)

These services help chroni

You can receive more than one service at the same time.

Homemaker and Home

Skilled Home Health Care

Telehealth Care

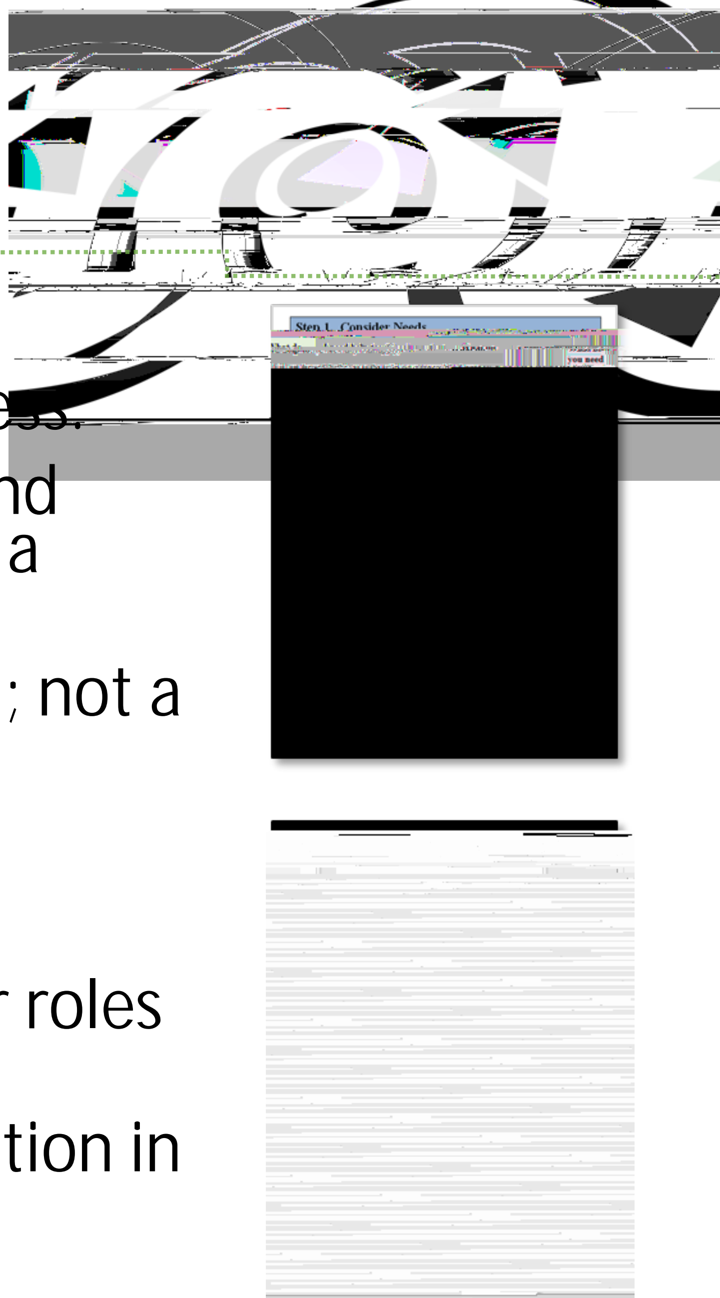
HCBC Service – Palliative Care

Palliative Care

What do others say? | What is it? | Am I eligible? | What services? | How do I decide?

Watch video

Decision Aid Worksheets



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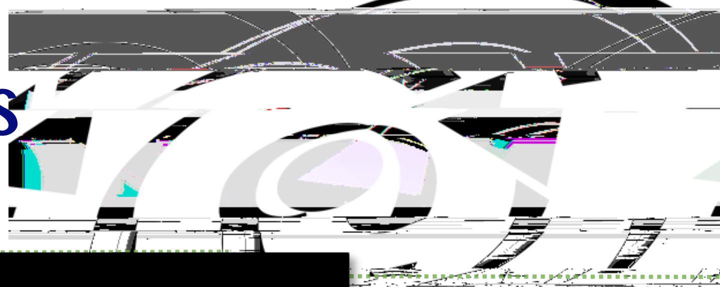
- Guides veteran through SDM process.
- Used to identify goals, priorities, and plans, make decisions, or just start a discussion.
- Can be completed or just reviewed; not a professional assessment tool.

Caregiver

- Helps family caregivers assess their roles and responsibilities.
- Can prompt readiness for participation in shared decisions.

Other SDM Hardcopy Materials



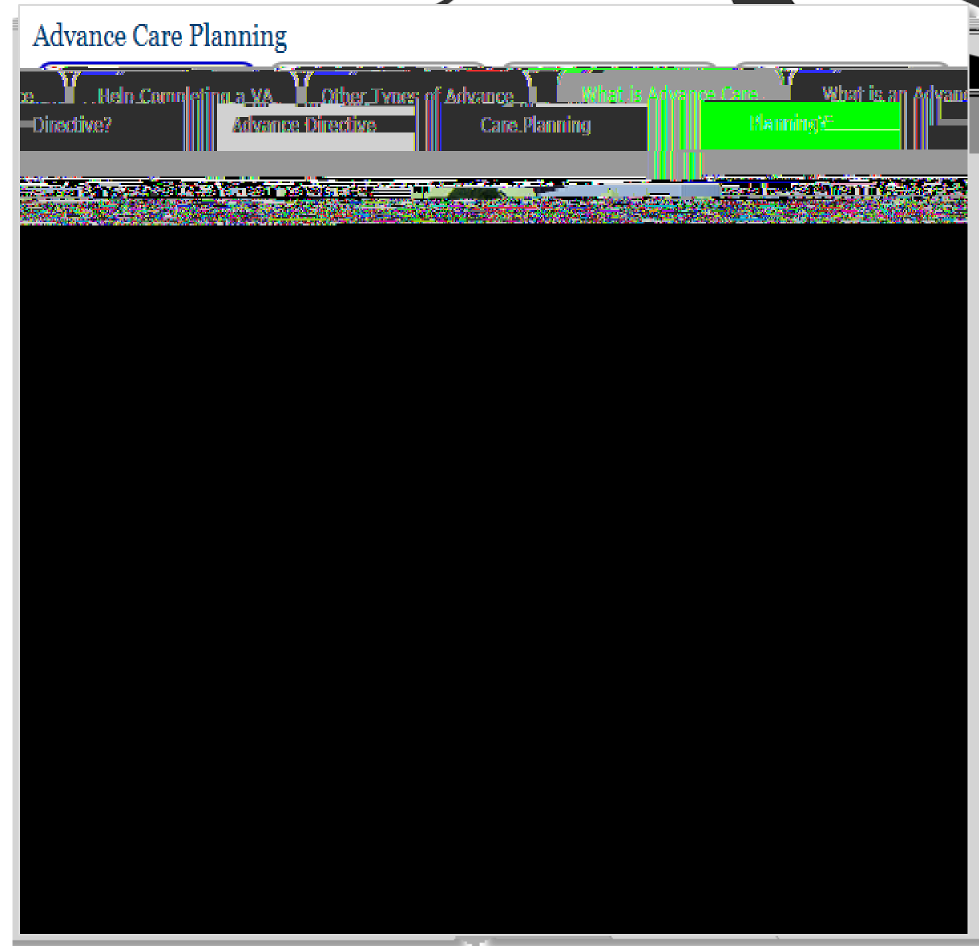
Use SDM for Advance Care Planning (ACP)

SDM is a natural fit for Advance Care Planning.

- **Any veteran** who is considering LTSS also should have an ACP discussion.
- The SDM process can help in **ACP discussions**, such as who would make treatment choices for the veteran if they could no longer do it.
- **Planning ahead** allows veterans to make important end-of-life choices when they can focus on them without pressure.

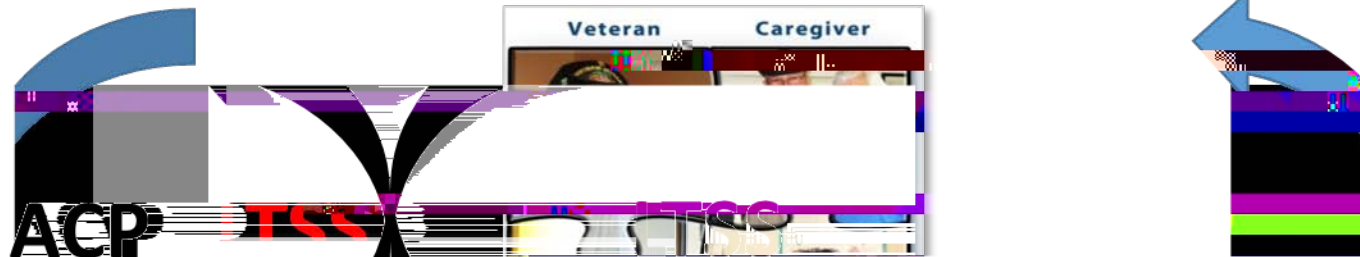
Advance Care Planning (ACP) Homepage

- www.va.gov/Geriatrics includes an ACP section.
- It provides links to the **VA Advance Directive form**, and a **Values Worksheet.**
- And, it includes **resources** that support discussions about end-of-life choices, such as handouts, podcasts, and links to interactive Web sites.



SDM Approach

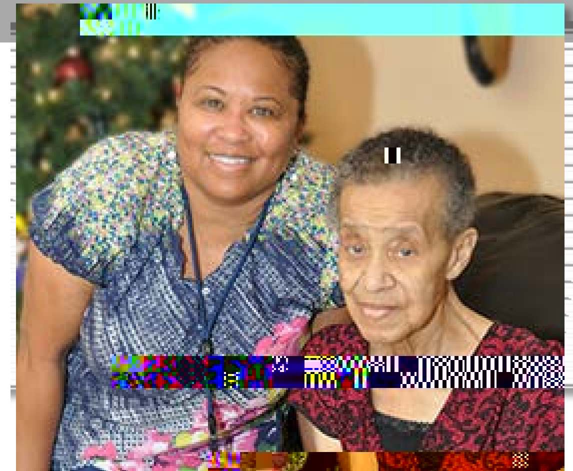
- The SDM approach is flexible—based on the situation, collaborative discussions about long-term services, and supports that can lead to discussions about advance care planning.



SDM Site Implementation Steps

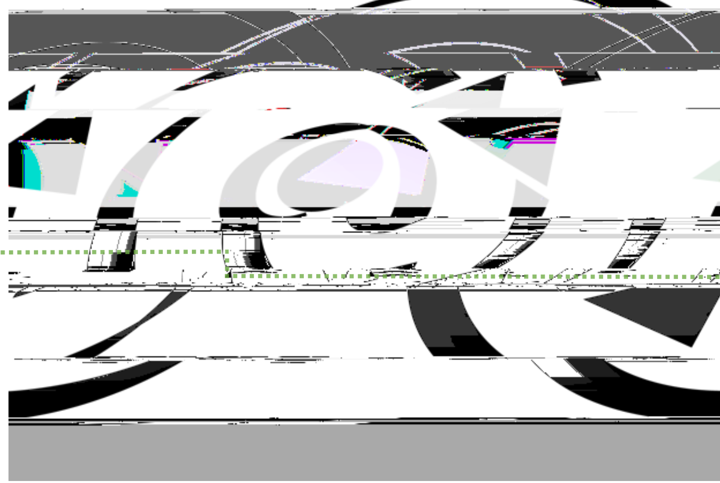
1. **Leadership Orientation** – Provides brief sessions for national and VAMC leadership prior to training to ensure support for SDM.
2. **Training 1 –** For all staff and management of any clinic/service line that plans to implement SDM:
   - Overview of SDM
   - Implementation
   - Team roles
   - Care team process
3. **Training 2 –** Skills practice for social workers and other staff who most frequently discuss LTSS with veterans; uses case scenario teaching model.

SDM Site Implementation Steps



4. **Implement SDM for aging veterans –** Determine your clinic screening criteria, use the GEC Web site and SDM hardcopy materials, and start having SDM discussions.
5. **Interviews –** Staff, veterans, and family caregivers will be invited to participate in a quality improvement assessment interview.
6. **Report on progress –** Summarize findings of quality improvement interviews.

Note: We are also conducting analyses from databases on outcome measures, such as number of LTSS referrals to home and community-based services and number of advance care directives completed.

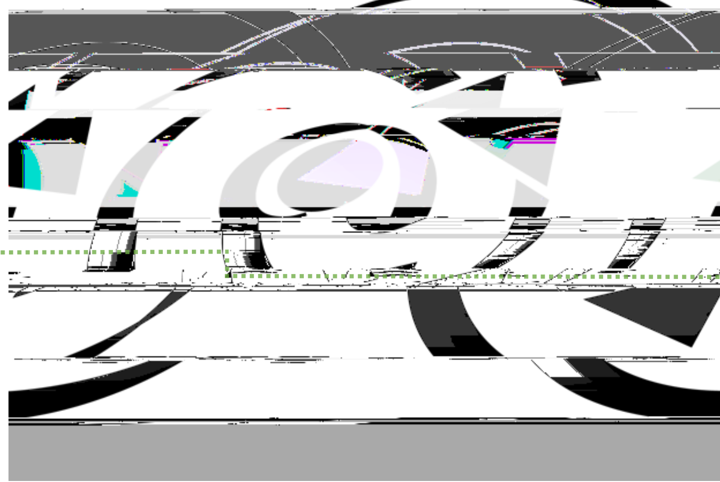


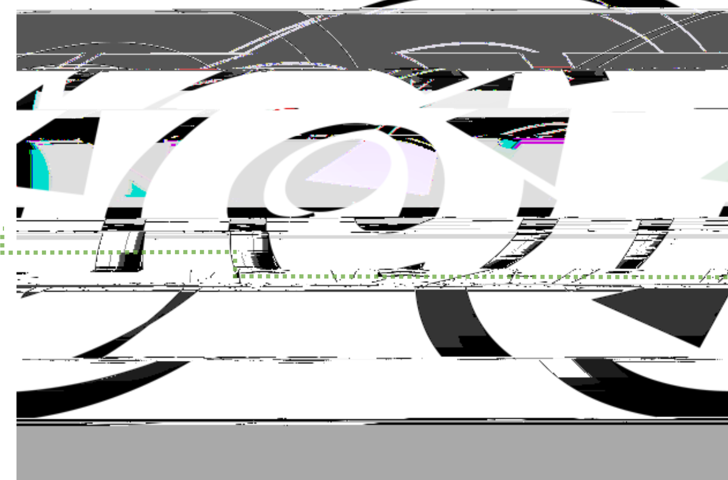
Shared Decision Making
for Veterans and Family Members

Veteran Caregiver

Social Worker Care Team

www.va.gov/Geriatrics





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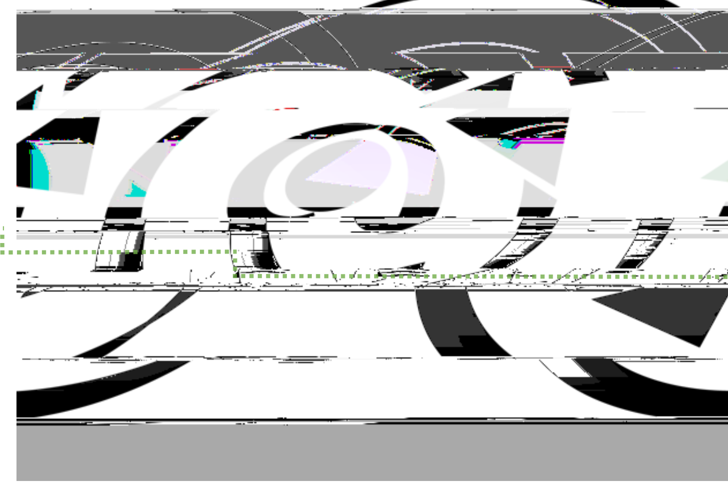

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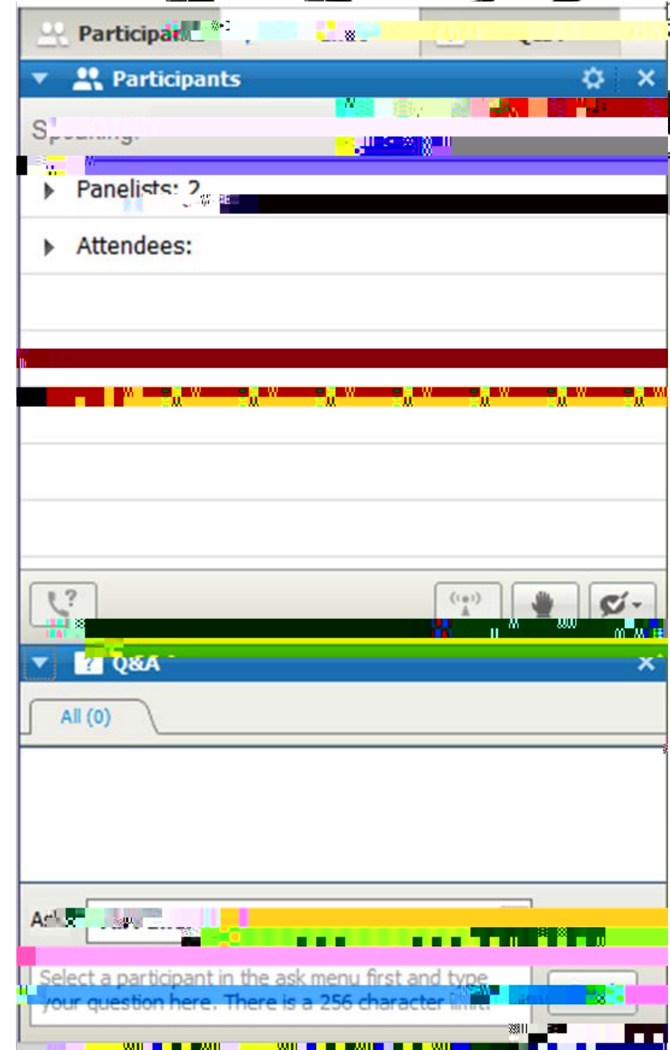

Questions about AHRQ's

SHARE Approach Resources

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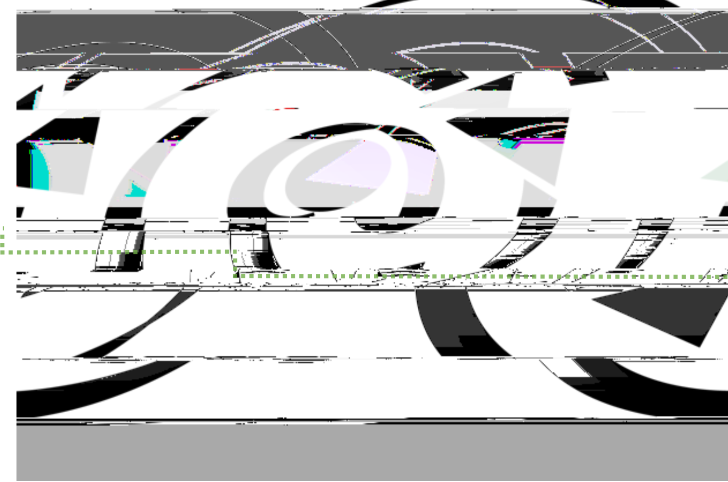

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