Washington State Shared Decision Making Workshop

January 11, 2024
8:00 a.m. – 4:00 p.m.

Washington State Health Care Authority

Agenda Overview

- Welcome and introductions
- Brief background of SDM in Washington State
- What is SDM and why is it important?
- Implementing Shared Decision Making at Massachusetts General Hospital
- How PDAs Support Good Shared Decision Making
- How Patient Decision Aids can support Shared Decision Making – Panel discussion
- Implementing Shared Decision Making into Practice: Next Steps

Housekeeping – Closed Captioning

- We are providing live captioning services today through Ai-Live
- This service allows our deaf and hard-of-hearing attendees to access the content a few seconds after it is spoken
- Please remember to introduce yourself before you speak to assist the captioners
- When speaking, please speak clearly and at a normal pace
- If you are interested in accessing the captioning in real time please reach out to a staff member

Brief Background of SDM in Washington

Judy Zerzan-Thul

Chief Medical Officer, Washington State Health Care Authority

Washington State Health Care Authority

What is Shared Decision Making?

A process in which clinicians and patients **work together** to make decisions and select tests, treatments and care plans based on **clinical evidence** that balances risks and expected outcomes with **patient preferences and values**.

-National Learning Consortium, HealthIT.gov, 2013

History of SDM in Washington

- In the early 2000s, Jack Wennberg presented to leaders in Washington on clinical variation across regions of the state
- Response was legislation to support SDM, with aim of reducing variation without restricting choice
  - Goal was appropriate utilization based on patient preferences, rather than decreased utilization
  - Evidence suggests SDM decreases overutilization, but helps correct underutilization
- Several pieces of legislation support this work
  - Established Robert Bree Collaborative, focused on unwarranted variation and evidence-based improvement strategies (2011)
  - Established authority of HCA to certify PDAs and legal protections for providers who use them
- In 2019 the Bree Collaborative developed recommendations for implementing SDM

Ibrahim SA, Blum M, Lee GC, et al. Effect of a decision aid on access to total knee replacement for black patients with osteoarthritis of the knee: a randomized clinical trial. JAMA Surg 2017; 152(1): e164225

Health Care Authority role in SDM

- Certification of Patient Decision Aids
- Promotion of SDM and PDA use in our role as purchaser (2.1M Medicaid lives, 400K public employees, 300K school employees)
  - Incorporation into contracts
- Providing training and support to providers*
  - Most providers believe they do this at baseline, but with specific training realize key elements have been missing
- Collaborate on development and dissemination of Bree SDM recommendations for implementation into practice
- Convening statewide discussion around spread and sustainability

*Free online skills course for providers: https://waportal.org/resources/shared-decision-making

Certified PDAs = 44 total

2016: Maternity Care

- Certified 5 PDAs

2017: Total Joint Replacement and Spine Care

- Certified 7 PDAs

2017 - 2018: End of Life Care

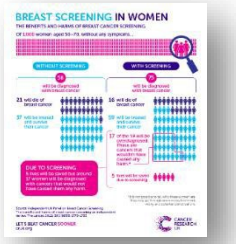
- Certified 24 PDAs

2018 – 2019: Cardiac Care

- Certified 5 PDAs

2019: Screening for Cancer

- Certified 3 PDAs



2020 - 2023: Recertification

- Recertified 23 PDAs

2024: Behavioral Health

- Currently reviewing 1 PDA

Shared Decision Making: Why, How, Who, Me?

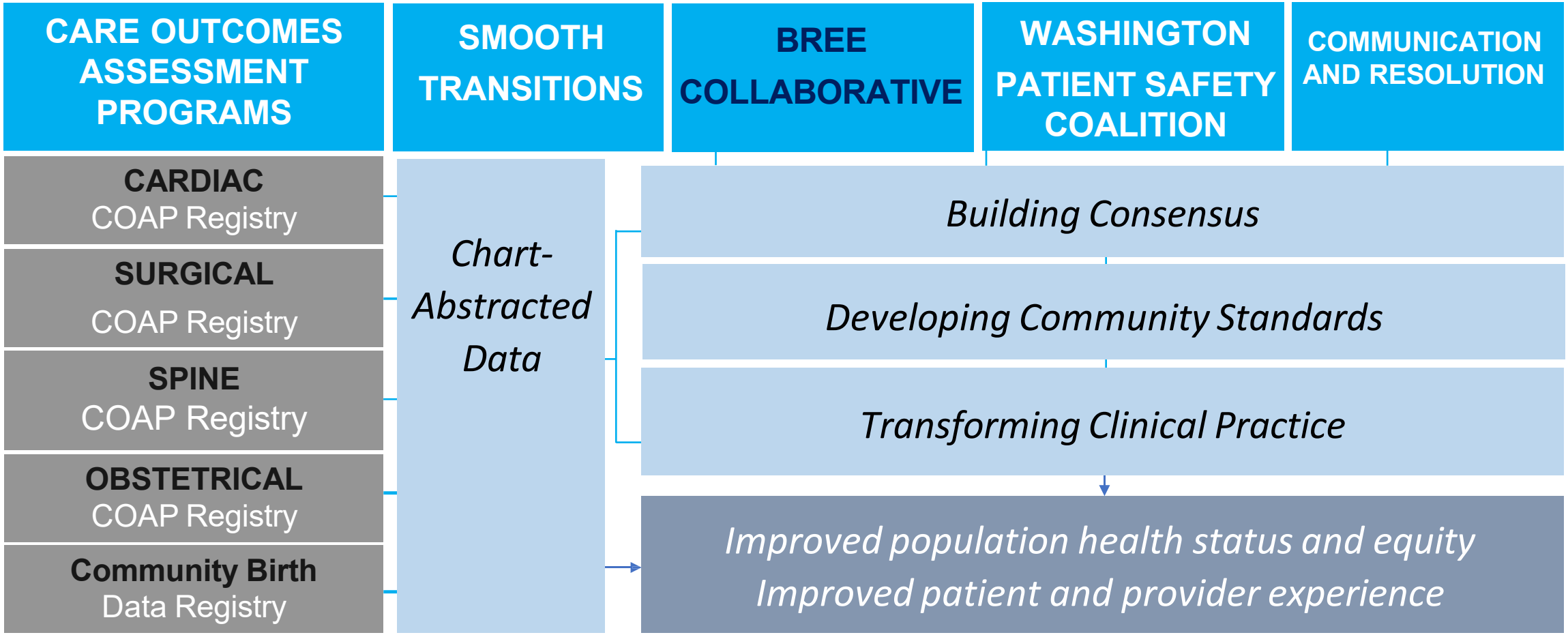
Ginny Weir, MPH

FOUNDATION FOR Health Care Quality

January 11th, 2024

FOUNDATION FOR Health Care Quality

Home to complementary improvement communities…



An opportunity to ask…

What makes Washington ill?
Who gets to be healthy?

AND

How and when do we die?
Who gets to live a long life?

Our framework for action

House Bill 1311 (2011)

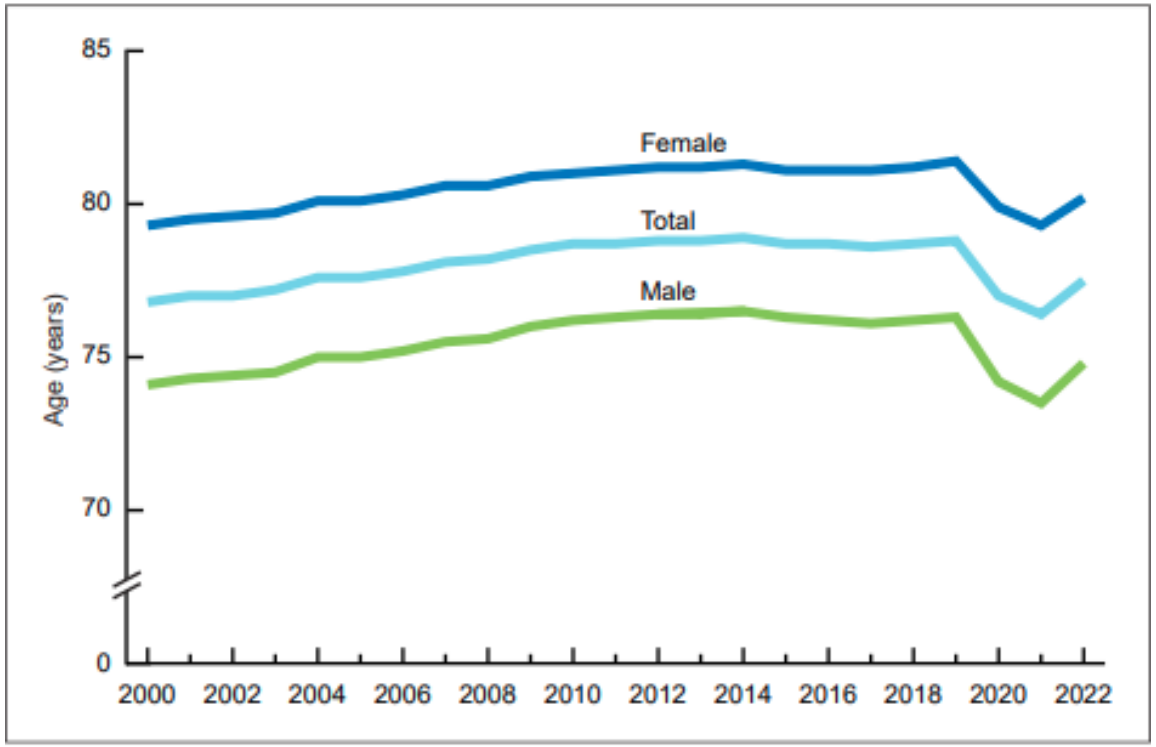
Identify health care services with high:

- **Variation**
- **Utilization**

Without producing better outcomes

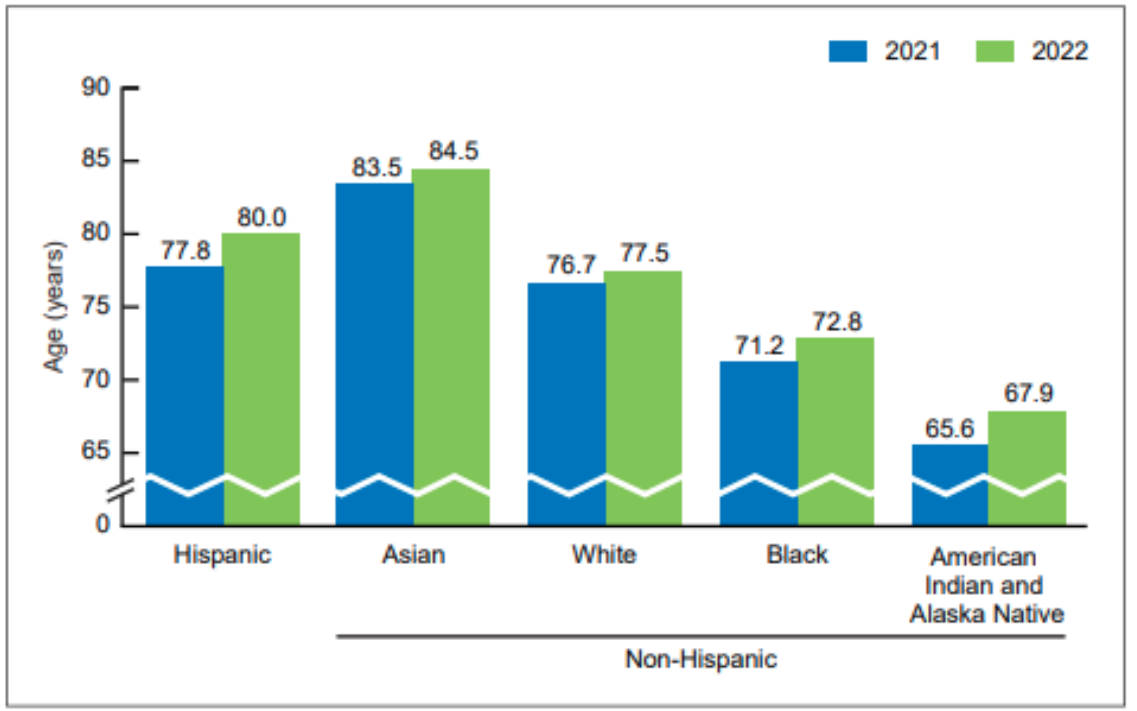
Life Expectancy

Figure 1. Life expectancy at birth, by sex: United States, 2000–2022



NOTES: Estimates are based on provisional data for 2022. Provisional data are subject to change as additional data are received. Estimates for 2000–2021 are based on final data.
SOURCE: National Center for Health Statistics, National Vital Statistics System, mortality data file.

Figure 2. Life expectancy at birth, by Hispanic origin and race: United States, 2021-2022



NOTES: Estimates are based on provisional data for 2022. Provisional data are subject to change as additional data are received. Estimates for 2021 are based on final data. Life tables by Hispanic origin and race are based on death rates that have been adjusted for Hispanic-origin and race misclassification on death certificates; see Technical Notes in this report.
SOURCE: National Center for Health Statistics, National Vital Statistics System, mortality data file.

Arias E, Tejada-Vera B, Kochanek KD, Ahmad FB. Provisional life expectancy estimates for 2021. Vital Statistics Rapid Release; no 23. Hyattsville, MD: National Center for Health Statistics. August 2022. DOI: https://dx.doi.org/ 10.15620/cdc:118999. https://www.cdc.gov/nchs/data/vsrr/vsrr023.pdf

International Comparisons

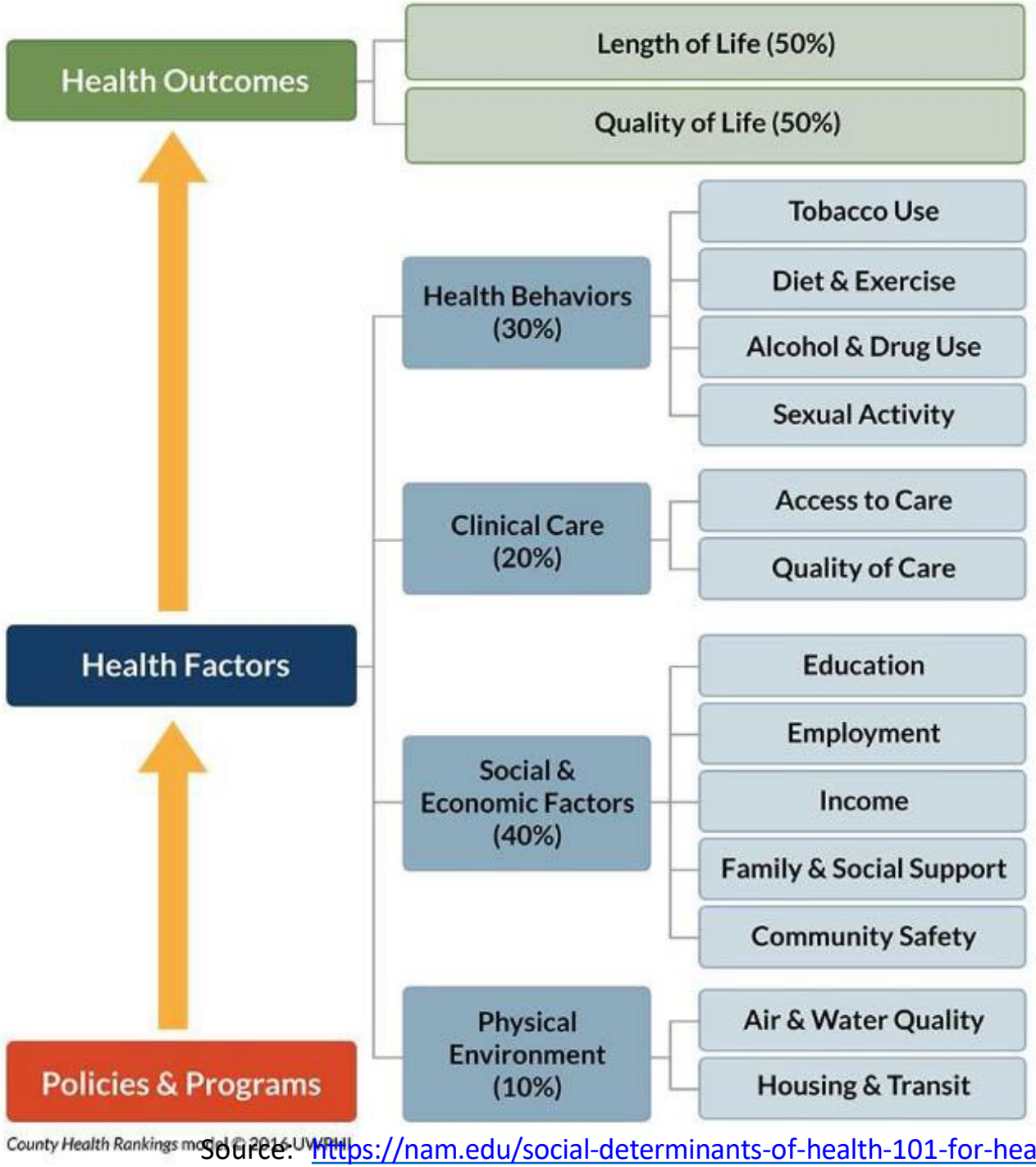
Life expectancy and per capita healthcare spending (PPP adjusted), 2021

Country	Life expectancy ▲	Health spending, per capita
United States	**76.4**	**$12,197**
Germany	80.8	$7,518
United Kingdom	80.8	$5,467
Austria	81.3	$6,690
Netherlands	81.4	$6,785
Canada	81.6	$6,278
Belgium	81.9	$6,022
Comparable Country Average	**82.3**	**$6,345**
France	82.4	$6,106
Sweden	83.1	$6,228
Australia	83.3	$6,226
Switzerland	83.9	$7,582
Japan	84.5	$4,899

Notes: Comparable countries include: Australia, Austria, Belgium, Canada, France, Germany, Japan, the Netherlands, Sweden, Switzerland, and the U.K. See Methods section of "How does U.S. life expectancy compare to other countries?"

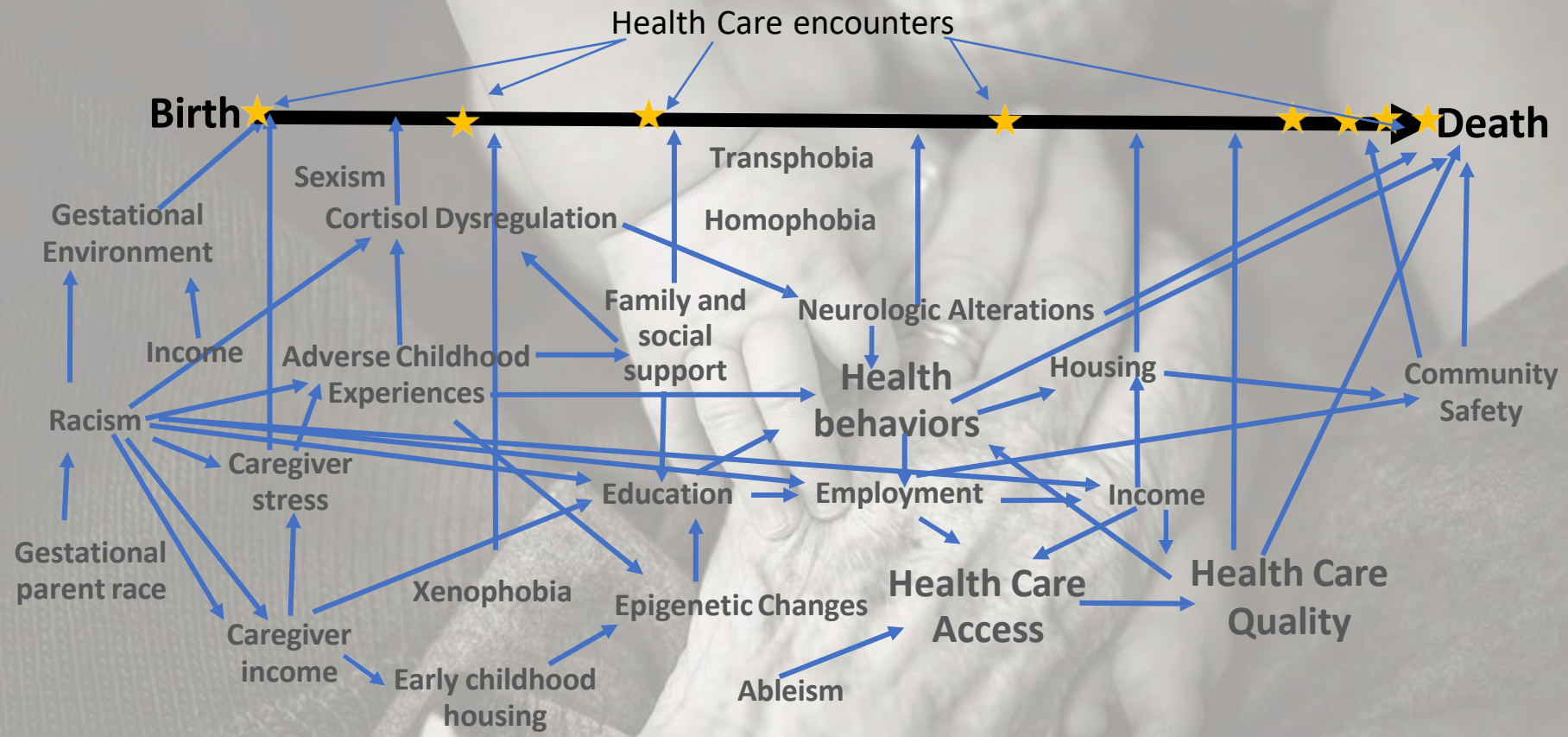
Source: KFF analysis of OECD and U.K. Office for Health Improvement and Disparities data • Get the data • PNG

Peterson-KFF Health System Tracker



Source: https://nam.edu/social-determinants-of-health-101-for-health-care-five-plus-five/

Life Course Perspective



"**Health equity** is the state in which everyone has a fair and just **opportunity to attain their highest level of health**…"

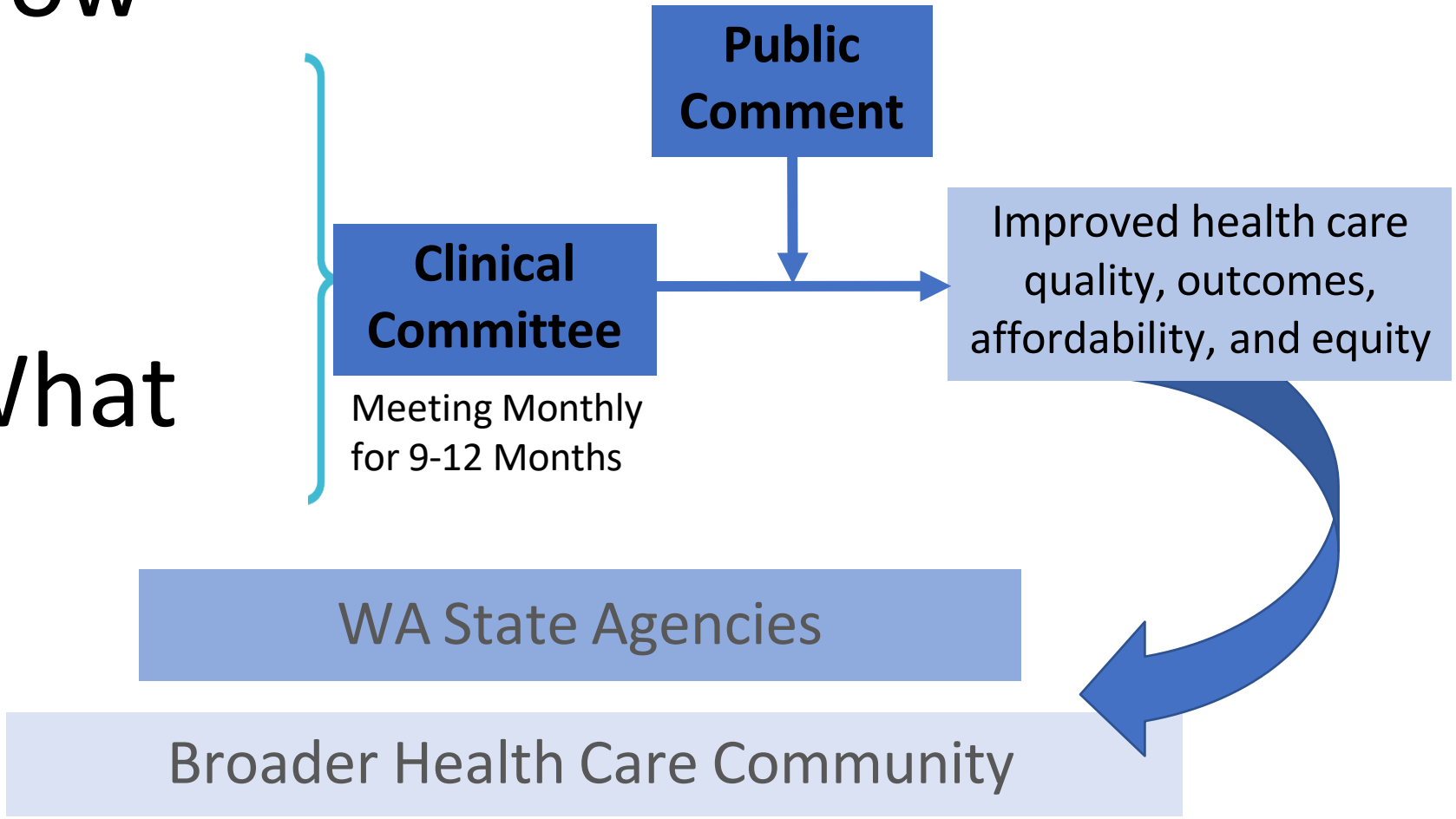
"Achieving this requires focused and ongoing societal efforts to address historical and contemporary injustices; overcome economic, social, and other obstacles to health and healthcare; and **eliminate preventable health disparities**."

https://www.cdc.gov/nchhstp/healthequity/index.htm

Our Process

How

What



Guidelines

+ 3 new topics for 2024

Pain (Chronic and Acute)

- *Collaborative care for chronic pain (2018)*
- *Low back pain management (2013)*
- *Long-term Opioid Prescribing (2019)*
- *Opioid prescribing metrics (2017)*
- *Opioid prescribing for older adults (2022)*
- *Opioid prescribing in dentistry (2017)*
- *Opioid Prescribing for postoperative pain (2018)*
- *Palliative Care (2019)*

Behavioral Health

- *Integrating behavioral health into primary care (2016) (2024)*
- *Screening, Brief Intervention, Referral to treatment (2014)*
- *Pediatric Psychotropics (2016)*
- *Opioid Use Disorder Treatment (2017) (2024)*
- *Suicide care (2018)*
- *Risk of Violence to Others (2019)*

Primary Care/Outpatient

- *Primary Care (2020)*
- *Hepatitis C (2022)*
- *Pediatric Asthma (2022)*
- *Outpatient Infection Control (2022)*
- *LGBTQ Health Care (2018)*
- *Telehealth (2021)*
- *Diabetes Care (2023)*

Obstetrics

- *Obstetric care (2012)*
- *Reproductive and Sexual Health*
- *Maternity Bundle (2019)*
- *Maternal Mental Health (2023)*

Procedural and Inpatient Care

- *Bundled payment models and warranties:*
  - *Total knee and total hip replacement (2013, re-review 2021)*
  - *Lumbar fusion (2014, re-review 2018)*
  - *Coronary artery bypass surgery (2015)*
- *Hysterectomy (2017)*
- *Data collection on appropriate cardiac surgery (2013)*
- *Complex Discharge (2023)*

Oncology

- *Cervical Cancer Screening (2021)*
- *Colorectal Cancer Screening (2020)*
- *Early stage testing (2016)*
- *Inpatient service use (2020)*
- *Prostate cancer screening (2015)*

Aging

- *Advance care planning for the end-of-life (2014)*
- *Alzheimer's disease and other dementias (2017)*

Shared Decision Making (2019)

+ Health-related needs from Climate Change (2024)

What is Shared Decision Making?

A process in which clinicians and patients **work together** to make decisions and select tests, treatments and care plans based on **clinical evidence** that balances risks and expected outcomes with **patient preferences and values**.

-National Learning Consortium, HealthIT.gov, 2013

Opinion | I treat colon cancer. Chadwi Boseman's death underscores health care's tragic racial disparities.

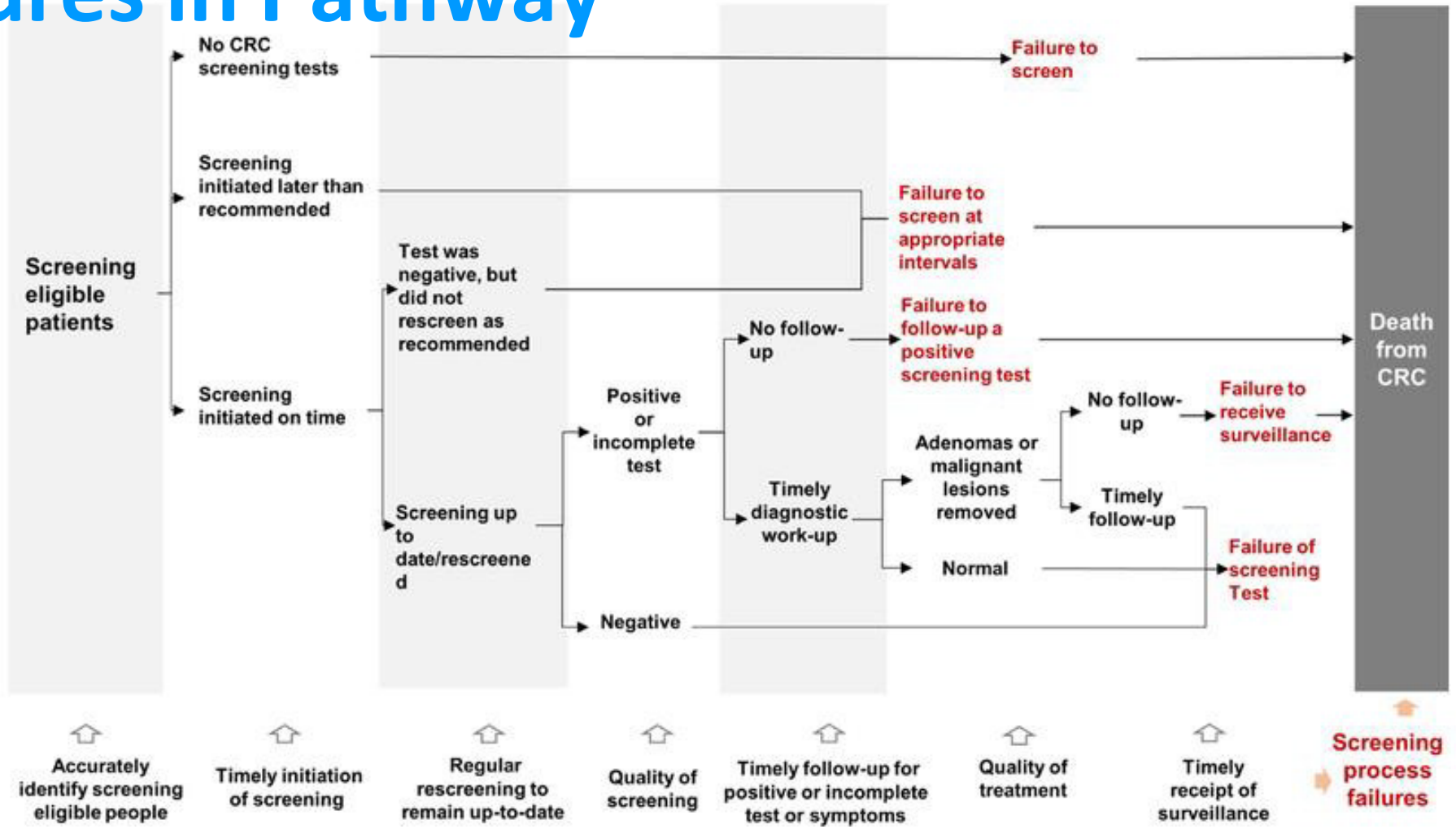
By Akash Goel
September 3, 2020 at 1:23 p.m. EDT

Actor Chadwick Boseman at the "Black Panther" premiere in Los Angeles in January 2018. (Chris Pizzello/Invision/AP)

- Black Americans **20% more likely to get** and **40% more likely to die** from colon cancer than white Americans
- The **second** leading cause of cancer death in the United States
- Historically less attention than breast, cervical, prostate cancers

2020: Cervical Cancer Screening Guidelines

Why High Mortality + Disparity? Failures in Pathway



Source: Doubeni CA, Fedewa SA, Levin TR, et al. Modifiable Failures in the Colorectal Cancer Screening Process and Their Association With Risk of Death. Gastroenterology. 2019;156(1):63-74.e6.

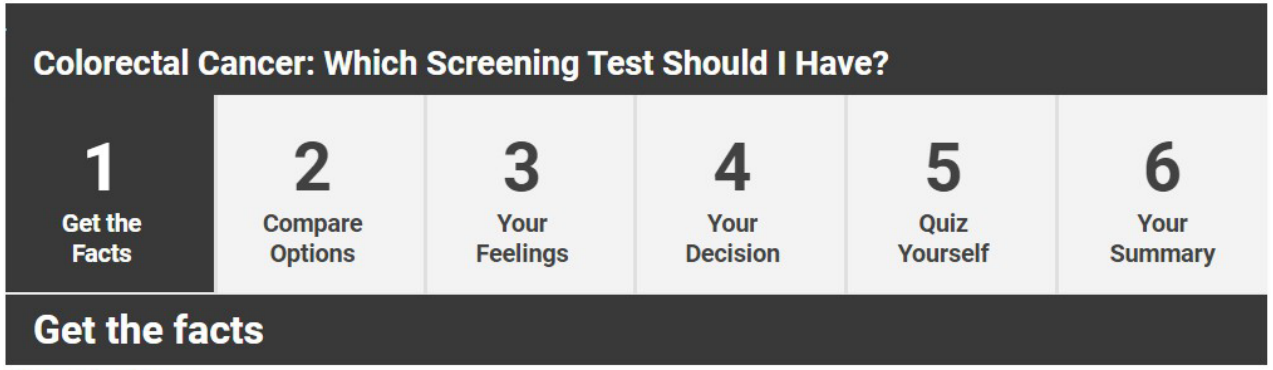
Failure Points led to Guidelines

- Tracking – outcomes + disparities, registry
- Measurement – by race, NQF
- Person-centered care – **shared decision-making** where appropriate
- Payment – colonoscopy after positive FIT test often not covered, nor those that start as screen and change to diagnostic

Colorectal Cancer: Which Screening Test Should I Have?

https://www.healthwise.net/ohridecisionaid/Content/StdDocument.aspx?DOCHWID=aa69121

You may want to have a say in this decision, or you may simply want to follow your doctor's recommendation. Either way, this information will help you understand what your choices are so that you can talk to your doctor about them.



Get the facts

Your options

- Get a stool test that you can do at home.
- Get a colonoscopy, sigmoidoscopy, or CT colonography at a doctor's office, clinic, or hospital.

This information is for people who are at average risk for colorectal cancer. Your doctor may recommend getting tested earlier or more often if you have a higher risk.

Key points to remember

- All of the screening tests work well to lower your risk of getting and dying from colorectal cancer. No matter what test you choose, regular testing can find signs of cancer early, when the cancer may be easier to treat.
- The tests differ in how they are done, how often they are done, and how you prepare for them. Your preferences are important in choosing what test to have. Think about what matters most to you as you look at what each test involves.
- No matter which test you choose, it's important that you have the test on the recommended schedule and have any follow-up visits or tests as needed. That gives you the best chance of reducing the risk of dying from colorectal cancer.

2019: Why Shared Decision Making?

Variation	Patient Safety Issue	Cost	Proven Strategy	Unique Bree Role
Data	Impact	Equity	Community support	

Evidence

+ patient experience
+ health outcomes
+ appropriateness of utilization and spending
+ value-based care
+ population health strategies

- variation
- health disparities
- provider assumptions

- Mostly use of Patient Decision Aid (PDA)[27]

Developing and Evaluating a Clinic-Ba
Decision Aid Delivery System

Carmen L. Lewis, MD, MPH, Alexandra F. Dalton, PhD, Lauren
Alison T. Brenner, PhD, Cristin M. Colford, PhD, Chris Del
Shaun McDonald, BS, Carolyn B. Morris, MPH, Matthew
Lisa Werner, MA Ed, Arlene Chung, MD, MHA,

SHARED DECISION MAKING

By David Arterburn, Robert Wellman, Emily Westbrook, Carolyn Rutter, Tyler Ross, David McCulloch, Matthew Handley, and Charles Jung

Introducing Decision Aids At Group Health Was Linked To Sharply Lower Hip And Knee Surgery Rates And Costs

Equity

- Black patients with advanced osteoarthritis (OA) of the knee are significantly less likely than white patients to undergo surgery
- 40-minute video describes risks and benefits of TKR surgery
- 13 of 168 controls (7.7%) and 25 of 168 intervention patients (14.9%) underwent TKR within 12 months

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

HHS Public Access

Author manuscript

JAMA Surg. Author manuscript; available in PMC 2017 December 12.

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JAMA Surg. 2017 January 18; 152(1): e164225. doi:10.1001/jamasurg.2016.4225.

Effect of a Decision Aid on Access to Total Knee Replacement for Black Patients With Osteoarthritis of the Knee A Randomized Clinical Trial

Said A. Ibrahim, MD, MPH, MBA, Marissa Blum, MD, Gwo-Chin Lee, MD, Pekka Mooar, MD, Elina Medvedeva, MS, Aliya Collier, MSOD, and **Diane Richardson, PhD**

Division of General Internal Medicine, Department of Medicine, University of Pennsylvania Perelman School of Medicine, Philadelphia, Pennsylvania (Ibrahim, Collier); Center for Health Equity Research and Promotion, Philadelphia Veterans Affairs Medical Center, Philadelphia, Pennsylvania (Ibrahim, Medvedeva, Collier, Richardson); Department of Medicine, Temple University School of Medicine, Philadelphia, Pennsylvania (Blum); Department of Orthopedic Surgery, University of Pennsylvania Perelman School of Medicine, Philadelphia, Pennsylvania (Lee); Department of Orthopedic Surgery and Sports Medicine, Temple University School of Medicine, Philadelphia, Pennsylvania (Mooar)

Abstract

IMPORTANCE—Black patients with advanced osteoarthritis (OA) of the knee are significantly less likely than white patients to undergo surgery. No strategies have been proved to improve access to surgery for black patients with end-stage OA of the knee.

OBJECTIVE—To assess whether a decision aid improves access to total knee replacement (TKR) surgery for black patients with OA of the knee.

DESIGN, SETTING, AND PARTICIPANTS—In a randomized clinical trial, 336 eligible participants who self-identified as black and 50 years or older with chronic and frequent knee pain, a Western Ontario McMaster Universities Osteoarthritis Index score of at least 39, and radiographic evidence of OA of the knee were recruited from December 1, 2010, to May 31, 2014, at 3 medical centers. Exclusion criteria were history of major joint replacement, terminal illness, inflammatory arthritis, prosthetic leg, cognitive impairment, lack of a telephone, or contraindications to elective replacement surgery. Data were analyzed on a per-protocol and intention-to-treat (ITT) basis.

Corresponding Author: Said A. Ibrahim, MD, MPH, MBA, University of Pennsylvania Perelman School of Medicine, 3900 Woodland Ave, Philadelphia, PA 19104 (said.ibrahim2@va.gov).

Author Contributions: Dr Ibrahim had full access to all the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis.

Study concept and design: Ibrahim, Blum, Lee, Mooar.

Acquisition, analysis, or interpretation of data: All authors.

Drafting of the manuscript: Ibrahim, Collier.

Critical revision of the manuscript for important intellectual content: Ibrahim, Blum, Lee, Mooar, Medvedeva, Richardson

What is Shared Decision Making?

A process in which clinicians and patients **work together** to make decisions and select tests, treatments and care plans based on **clinical evidence** that balances risks and expected outcomes with **patient preferences and values**.

-National Learning Consortium, HealthIT.gov, 2013

Patient Decision Aid

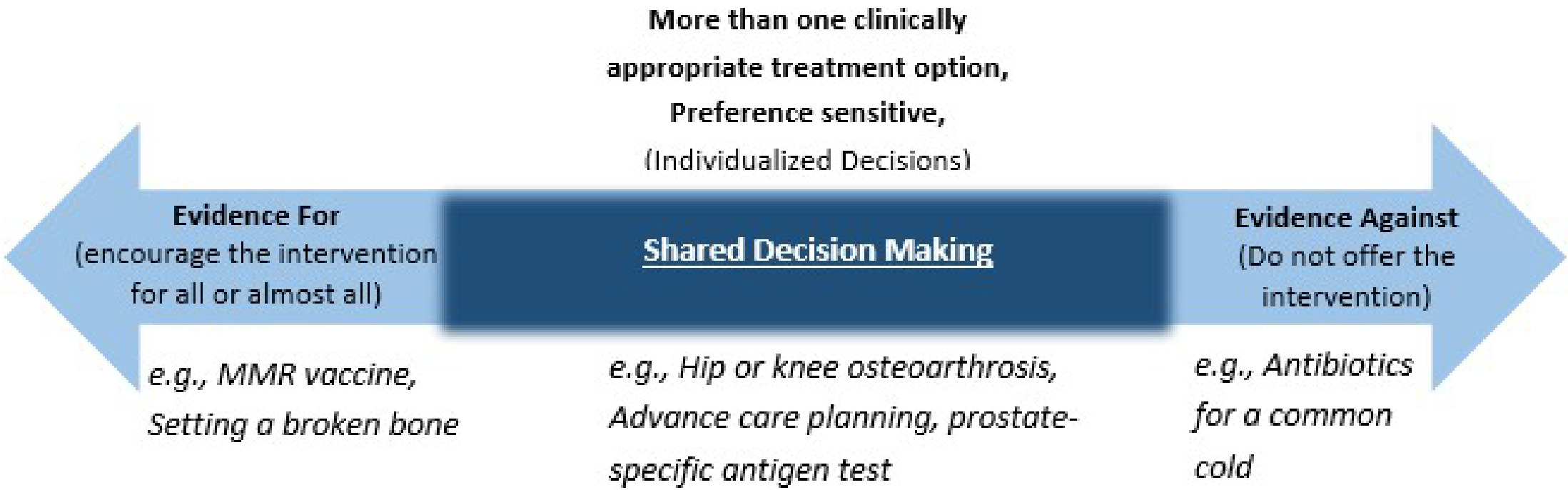
- Tool designed to help a person participate in health care decision making
- Provide information on options
- Help weigh pros and cons

The Ottawa Hospital | L'Hôpital d'Ottawa
RESEARCH INSTITUTE | INSTITUT DE RECHERCHE

Patient Decision Aids

http://ipdas.ohri.ca/what.html

When?


More than one clinically
appropriate treatment option,
Preference sensitive,
(Individualized Decisions)
Evidence For
(encourage the intervention
for all or almost all)
Shared Decision Making
Evidence Against
(Do not offer the
intervention)
e.g., MMR vaccine,
Setting a broken bone
e.g., Hip or knee osteoarthrosis,
Advance care planning, prostate-
specific antigen test
e.g., Antibiotics
for a common
cold

Don’t providers already do this?


Pay no attention to that
man behind the curtain!

Don’t providers already do this?

Specific skills

- Reviewing all appropriate options
- Eliciting values
- Helping the patient think about the implications of the choice in light of their options
- Sharing control with the patient

VS

- “Sign here”
- “I would do this”
- You SHOULD do this…

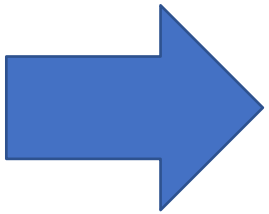
…But isn’t all *good* provider communication SDM?

Components

- Ensuring understanding of:
  - Condition
  - All appropriate options
  - Risks and benefits/pros and cons of each
- What are your values? What do you want?
- Let's talk about the impact of the options you have
- Shared decision between provider and patient
- Confirmation of decision, addressing questions, and documentation

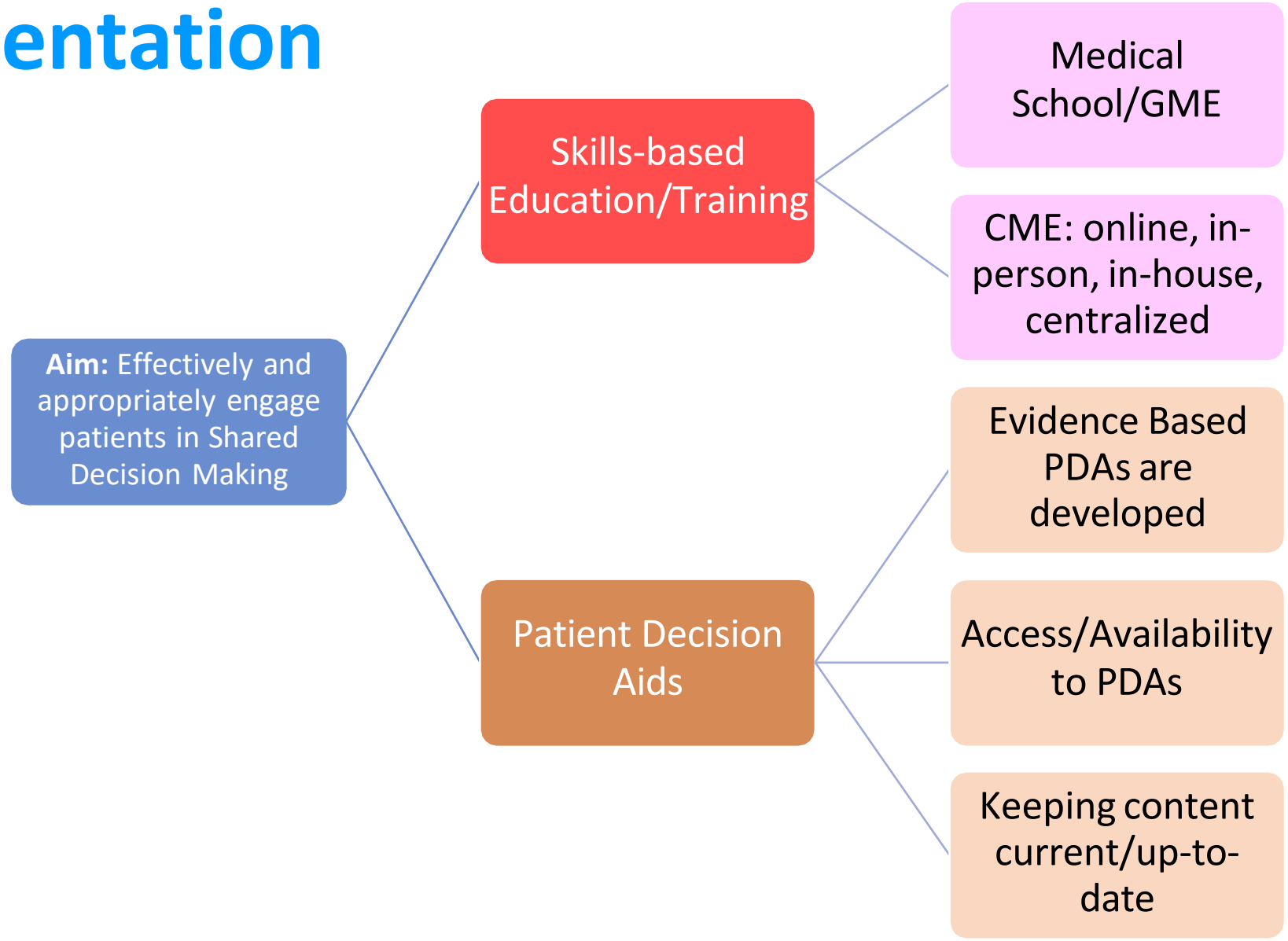
Bree Guideline Framework

- Definition and benefit
- Ten clinical areas
- Framework
- Documentation, coding, reimbursement

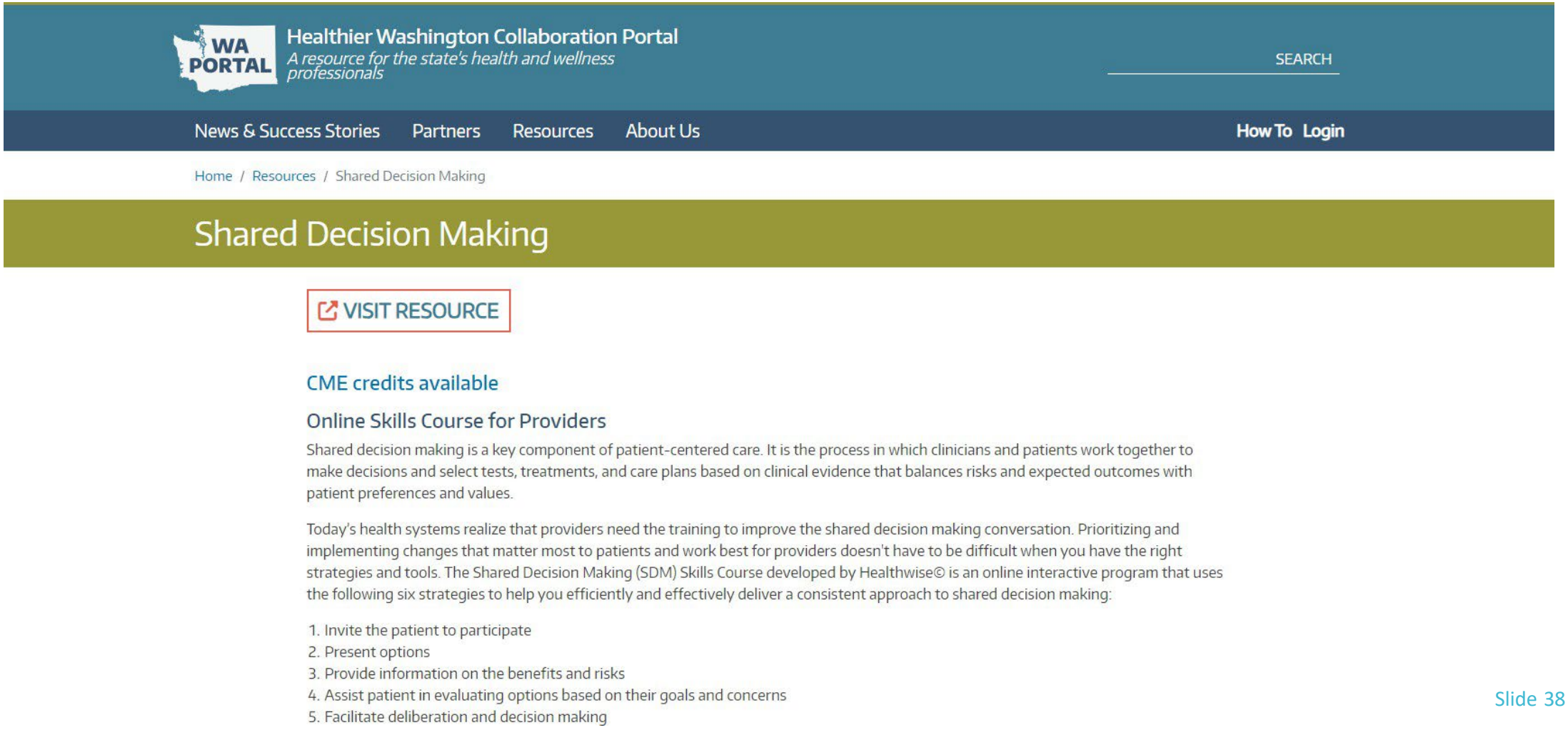


- State-wide movement using a stages of change framework
  - Precontemplation
  - Contemplation
  - Preparation
  - Action
  - Maintance

Drivers of Shared Decision-Making Implementation



Training


WA PORTAL
Healthier Washington Collaboration Portal
A resource for the state's health and wellness professionals
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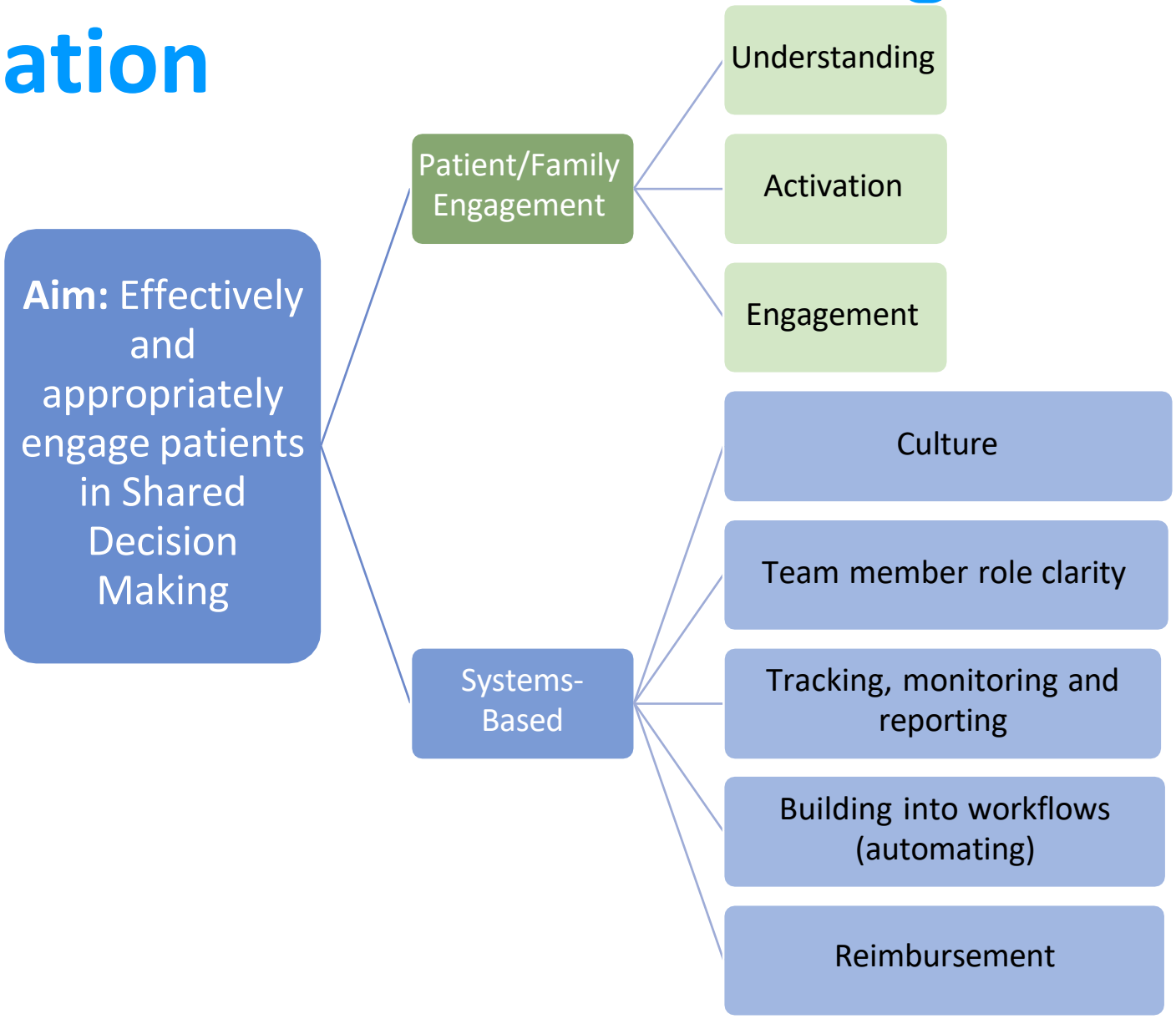
Shared Decision Making
VISIT RESOURCE
CME credits available
Online Skills Course for Providers
Shared decision making is a key component of patient-centered care. It is the process in which clinicians and patients work together to make decisions and select tests, treatments, and care plans based on clinical evidence that balances risks and expected outcomes with patient preferences and values.
Today's health systems realize that providers need the training to improve the shared decision making conversation. Prioritizing and implementing changes that matter most to patients and work best for providers doesn't have to be difficult when you have the right strategies and tools. The Shared Decision Making (SDM) Skills Course developed by Healthwise© is an online interactive program that uses the following six strategies to help you efficiently and effectively deliver a consistent approach to shared decision making:
1. Invite the patient to participate
2. Present options
3. Provide information on the benefits and risks
4. Assist patient in evaluating options based on their goals and concerns
5. Facilitate deliberation and decision making

Drivers of Shared Decision-Making Implementation



SDM Legislation in Washington RCW 7.70.060

E2SSB 5930 (2007 - “Blue Ribbon Bill”)

- Multi-provider SDM Collaborative
- Informed Consent liability protections for SDM using certified patient decision aids

ESHB 1311 (2011 - Bree Collaborative)

- Established Robert Bree Collaborative, focused on unwarranted variation and evidence based improvement strategies

ESHB 2318 (2012 - Decision Aid Certification)

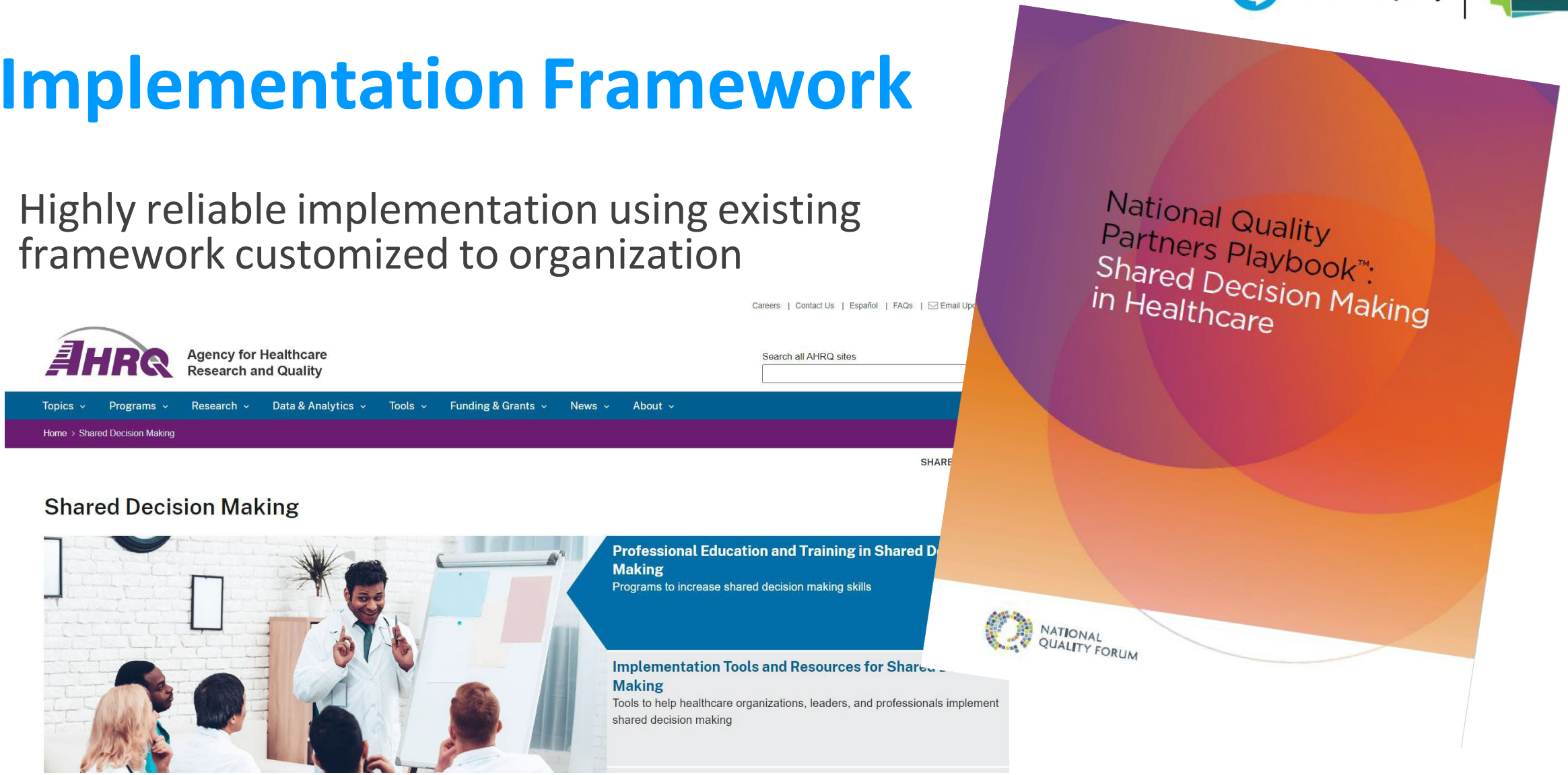
- State Health Care Authority medical director may certify or recognize certifying entities meeting specified criteria

Priority Health Care Services

- Surgical/Procedural
  - Knee and Hip Osteoarthritis (HCA certified)
  - Spine Surgery (HCA certified)
  - Abnormal Uterine Bleeding
  - Trial of Labor After Cesarean Section (HCA certified)
  - Herniated disk
- Advanced Care Planning (HCA certified)
- Cancer Screening
  - Breast (HCA certified)
  - Prostate
  - Colorectal
  - Lung
- Behavioral health
  - Depression Treatment
  - Attention Deficit Hyperactivity Disorder Treatment
  - Opioid Use Disorder Treatment

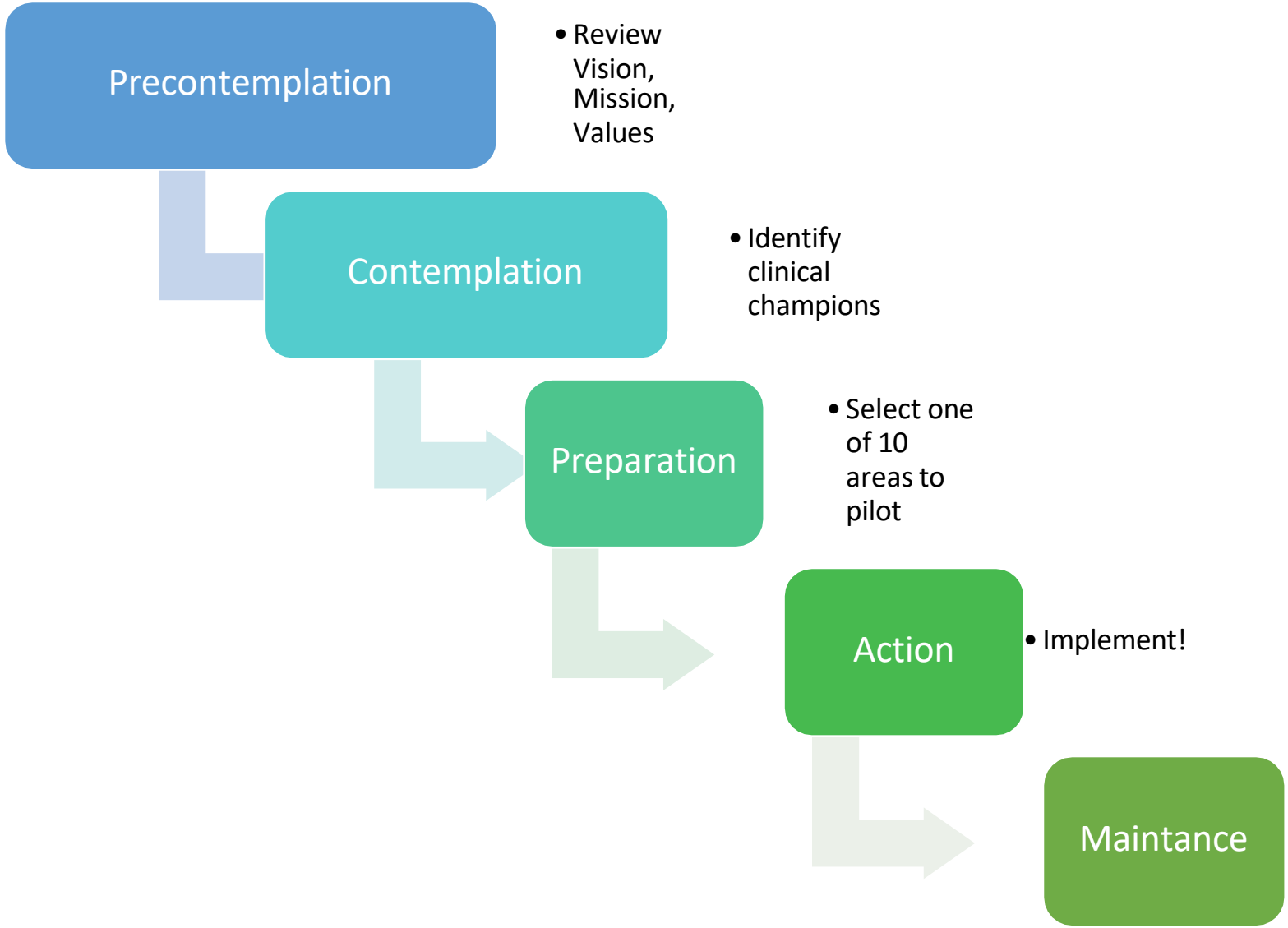
Implementation Framework

Highly reliable implementation using existing framework customized to organization



- https://www.qualityforum.org/National_Quality_Partners_Shared_Decision_Making_Action_Team_.aspx
- https://www.ahrq.gov/sdm/index.html

Health Care Delivery Organization



Action Steps for Stakeholders

- Patients and communities
  - Be actively engaged and empowered
  - Expect and ask for SDM approach
  - Look for tools that impact YOU

  https://decisionaid.ohri.ca/

- Providers and provider systems
  - Think about how SDM can advance your goals/values
  - Train providers and staff
  - Implement pilot programs, then expand
  - Develop workflows and supports

Documentation, Coding, Reimbursement

- Documented like any other clinical encounter
- Some limited existing codes (e.g., G0296 Counseling)
- Development of additional coding for added shared decision-making reimbursement.
- Prior authorization
- Included as part of some alternative payment models

Total Knee and Total Hip Replacement Bundle

- Documenting disability despite explicit non-surgical care
- Patient meeting fitness requirements prior to surgery
- Adhering to standards for best-practice surgery
- Implementing a structured plan to rapidly return patients to function

+ Warranty

Shared Decision Making

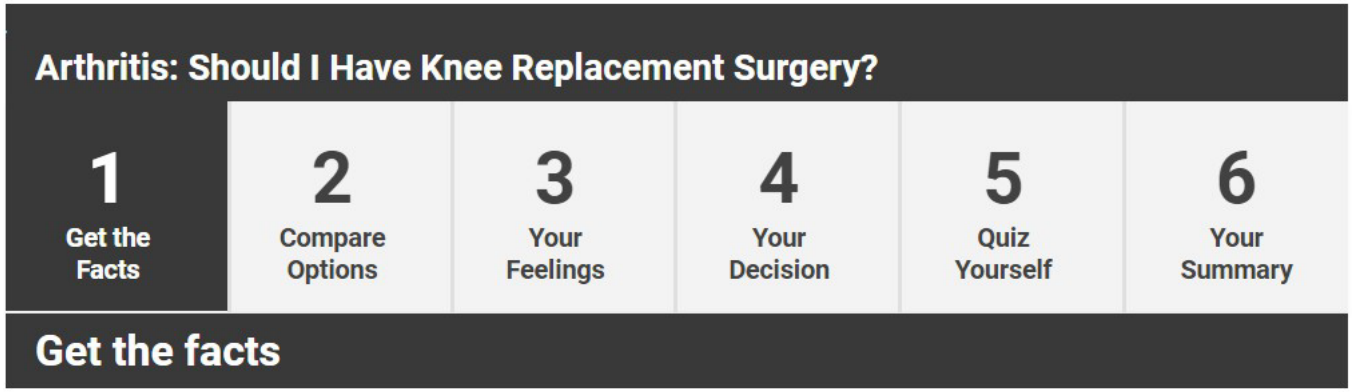
Lumbar Fusion

Coronary Artery Bypass Surgery

Bariatric Surgery

Arthritis: Should I Have Knee Replacement Surgery?

You may want to have a say in this decision, or you may simply want to follow your doctor's recommendation. Either way, this information will help you understand what your choices are so that you can talk to your doctor about them.



Your options

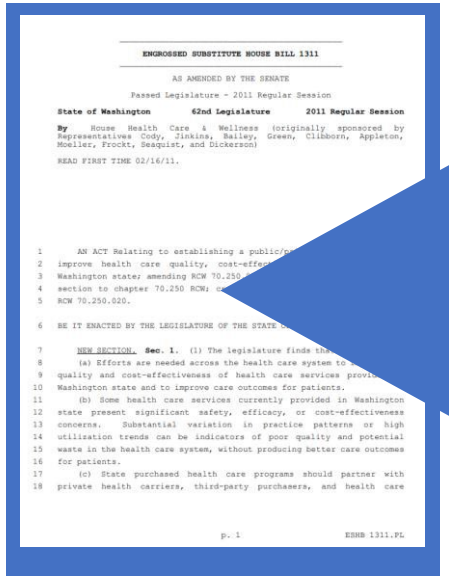
- Have surgery to replace your knee.
- Don't have this surgery. Instead, use other treatments, like exercise, weight loss (if you're overweight), medicines, or another type of surgery.

Key points to remember

- The decision you and your doctor make depends on your age, health, and activity level, and on how much pain and disability you have.
- Most people have knee replacement only when they can no longer control arthritis pain

https://www.healthwise.net/ohridecisionaid/Content/StdDocument.aspx?DOCHWID=uh1514

What Comes Next?



ENGROSSED SUBSTITUTE HOUSE BILL 1311

AS AMENDED BY THE SENATE

Passed Legislature - 2011 Regular Session

State of Washington 62nd Legislature 2011 Regular Session

By House Health Care & Wellness (originally sponsored by Representatives Cody, Jinkins, Bailey, Green, Clibborn, Appleton, Moeller, Prockt, Seaquist, and Dickerson)

READ FIRST TIME 02/16/11.

AN ACT Relating to establishing a public/

improve health care quality, cost-effec

Washington state; amending RCW 70.250

section to chapter 70.250 RCW; c

RCW 70.250.020.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE O

NEW SECTION. Sec. 1. (1) The legislature finds that

(a) Efforts are needed across the health care system to

quality and cost-effectiveness of health care services provi

Washington state and to improve care outcomes for patients.

(b) Some health care services currently provided in Washington state present significant safety, efficacy, or cost-effectiveness concerns. Substantial variation in practice patterns or high utilization trends can be indicators of poor quality and potential waste in the health care system, without producing better care outcomes for patients.

(c) State purchased health care programs should partner with private health carriers, third-party purchasers, and health care

p. 1 ESHB 1311.PL

(c) State purchased health care programs should partner with private health carriers, third-party purchasers, and health care providers in shared efforts to improve quality, health outcomes, and cost-effectiveness of care.

(13) The collaborative shall report to the administrator of the authority regarding the health services areas it has chosen and strategies proposed. The administrator shall review the strategies recommended in the report, giving strong consideration to the direction provided in section 1 of this act and this section. The

2011: Bree Collaborative Established

Implementation Language

Evaluating Success

Total Knee and Total Hip Replacement Bundle

State as first mover

- January 2017 – HCA contracts with Virginia Mason Medical Center for center of excellence for PEBB Program members enrolled in Uniform Medical Plan for total knee and hip replacement with
  - Waived co-insurance
  - Travel and lodging reimbursement

200+ completed surgeries

- *"I thought the whole organizing from Premera to VM was well handled, **they did a wonderful job**. It's been a good experience.“*
- ***"One of the most positive medical experiences I've ever had! “***

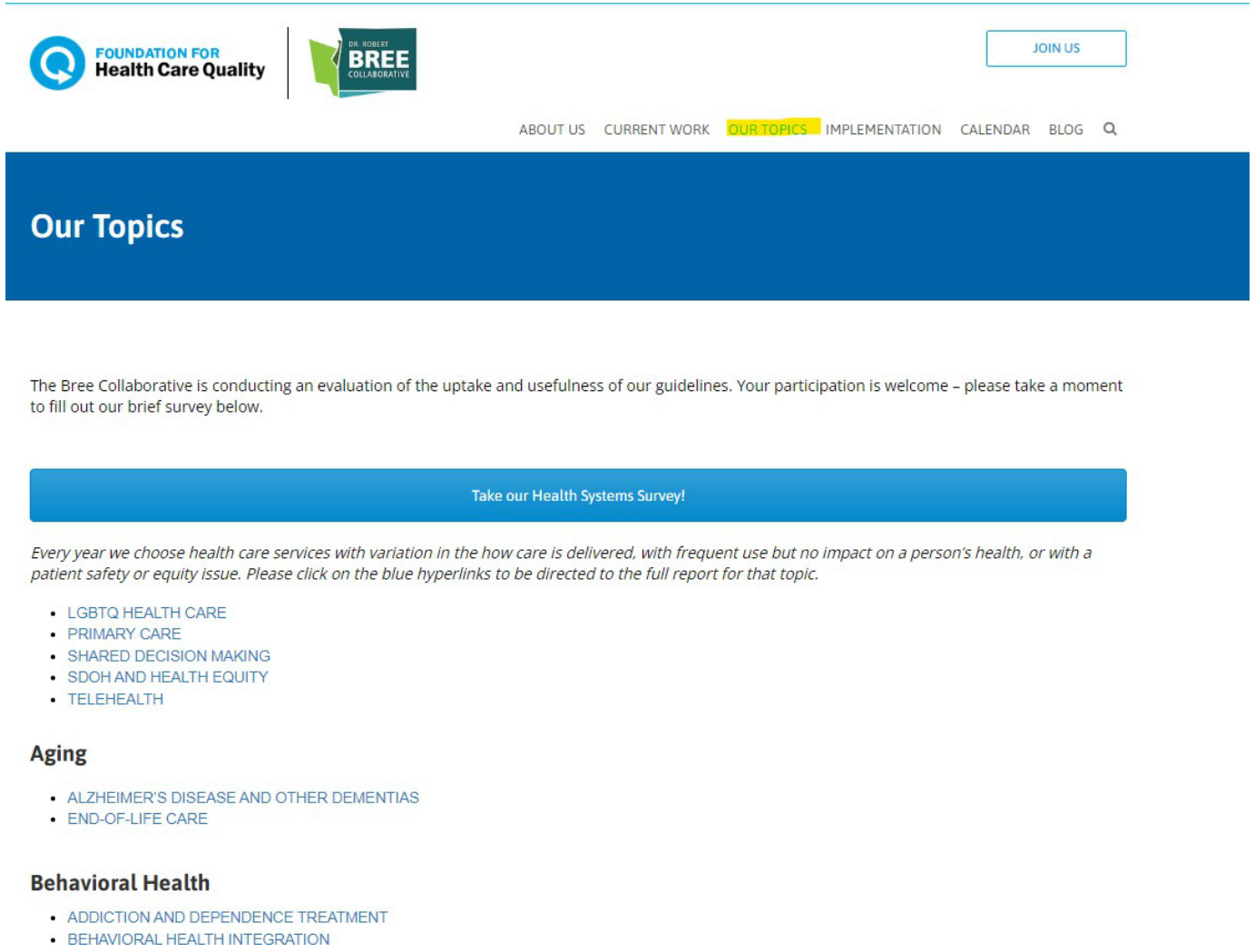
Spreading Model

2019 – Premera Blue Cross announces new contract with Providence St. Joseph Health naming seven facilities as centers of excellence for total joint replacement following the Bree Collaborative guidelines

2018 – HCA selected centers of excellence for lumbar fusion bundled payment – Capital Medical Center and Virginia Mason Medical Center

- Lower volume
- More evaluation only bundles than surgeries

How to access the reports?



FOUNDATION FOR Health Care Quality | DR. ROBERT BREE COLLABORATIVE

JOIN US

ABOUT US CURRENT WORK OUR TOPICS IMPLEMENTATION CALENDAR BLOG

Our Topics

The Bree Collaborative is conducting an evaluation of the uptake and usefulness of our guidelines. Your participation is welcome – please take a moment to fill out our brief survey below.

Take our Health Systems Survey!

Every year we choose health care services with variation in the how care is delivered, with frequent use but no impact on a person's health, or with a patient safety or equity issue. Please click on the blue hyperlinks to be directed to the full report for that topic.

- LGBTQ HEALTH CARE
- PRIMARY CARE
- SHARED DECISION MAKING
- SDOH AND HEALTH EQUITY
- TELEHEALTH

Aging

- ALZHEIMER'S DISEASE AND OTHER DEMENTIAS
- END-OF-LIFE CARE

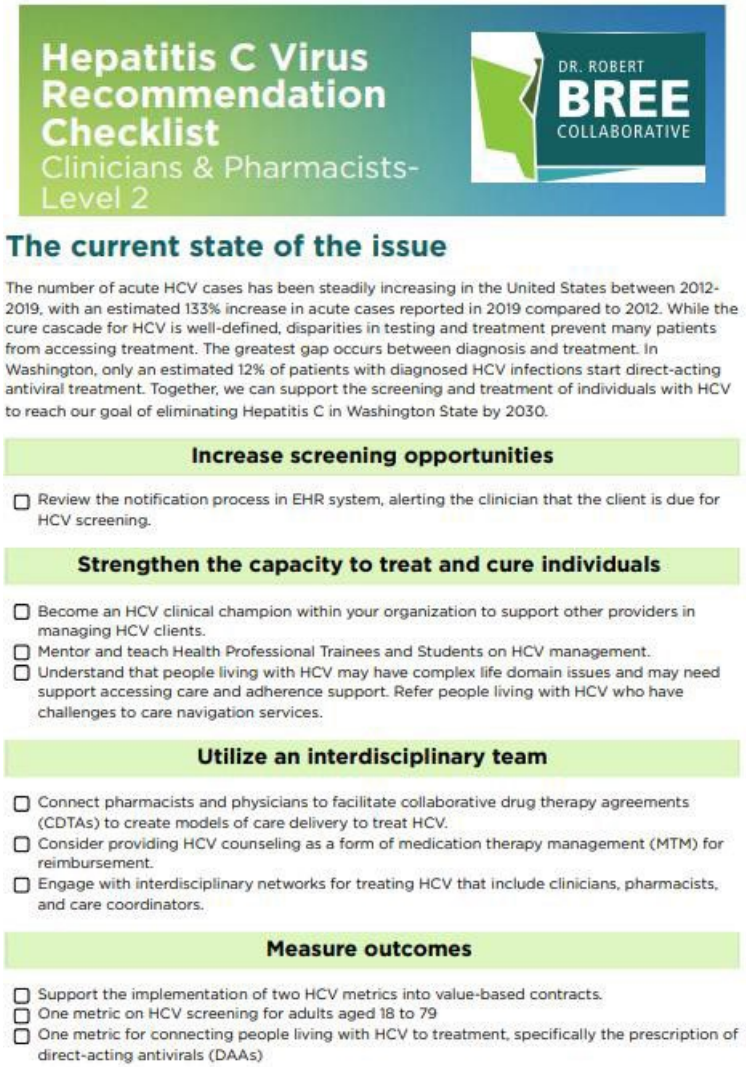
Behavioral Health

- ADDICTION AND DEPENDENCE TREATMENT
- BEHAVIORAL HEALTH INTEGRATION

- https://www.qualityhealth.org/bree/

Implementation Support

- Checklists
- Webinar
- Looking into Opportunities for 2024
  - Diabetes
  - Perinatal Behavioral Health
  - Complex Hospital Discharge



Hepatitis C Virus Recommendation Checklist
Clinicians & Pharmacists- Level 2

DR. ROBERT BREE COLLABORATIVE

The current state of the issue

The number of acute HCV cases has been steadily increasing in the United States between 2012-2019, with an estimated 133% increase in acute cases reported in 2019 compared to 2012. While the cure cascade for HCV is well-defined, disparities in testing and treatment prevent many patients from accessing treatment. The greatest gap occurs between diagnosis and treatment. In Washington, only an estimated 12% of patients with diagnosed HCV infections start direct-acting antiviral treatment. Together, we can support the screening and treatment of individuals with HCV to reach our goal of eliminating Hepatitis C in Washington State by 2030.

Increase screening opportunities

- ☐ Review the notification process in EHR system, alerting the clinician that the client is due for HCV screening.

Strengthen the capacity to treat and cure individuals

- ☐ Become an HCV clinical champion within your organization to support other providers in managing HCV clients.
- ☐ Mentor and teach Health Professional Trainees and Students on HCV management.
- ☐ Understand that people living with HCV may have complex life domain issues and may need support accessing care and adherence support. Refer people living with HCV who have challenges to care navigation services.

Utilize an interdisciplinary team

- ☐ Connect pharmacists and physicians to facilitate collaborative drug therapy agreements (CDTAs) to create models of care delivery to treat HCV.
- ☐ Consider providing HCV counseling as a form of medication therapy management (MTM) for reimbursement.
- ☐ Engage with interdisciplinary networks for treating HCV that include clinicians, pharmacists, and care coordinators.

Measure outcomes

- ☐ Support the implementation of two HCV metrics into value-based contracts.
- ☐ One metric on HCV screening for adults aged 18 to 79
- ☐ One metric for connecting people living with HCV to treatment, specifically the prescription of direct-acting antivirals (DAAs)

Contact Me

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Shared Decision Making

Integrating into practice

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MGH Health Decision Sciences Center
@mghsdm
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@simmons_leighmd

HARVARD MEDICAL SCHOOL

Overview

- Shared decision making background
- History of SDM at our hospital
- Building a culture of SDM; launching the HDSC
- Highlight 4 areas of implementation:
  - Decision aid distribution in orthopedics and primary care
  - Decision aid development workshops
  - Clinician training – the PRIMED study and online trainings
  - Advancing health equity and inclusion through SDM efforts – CRC screening during COVID

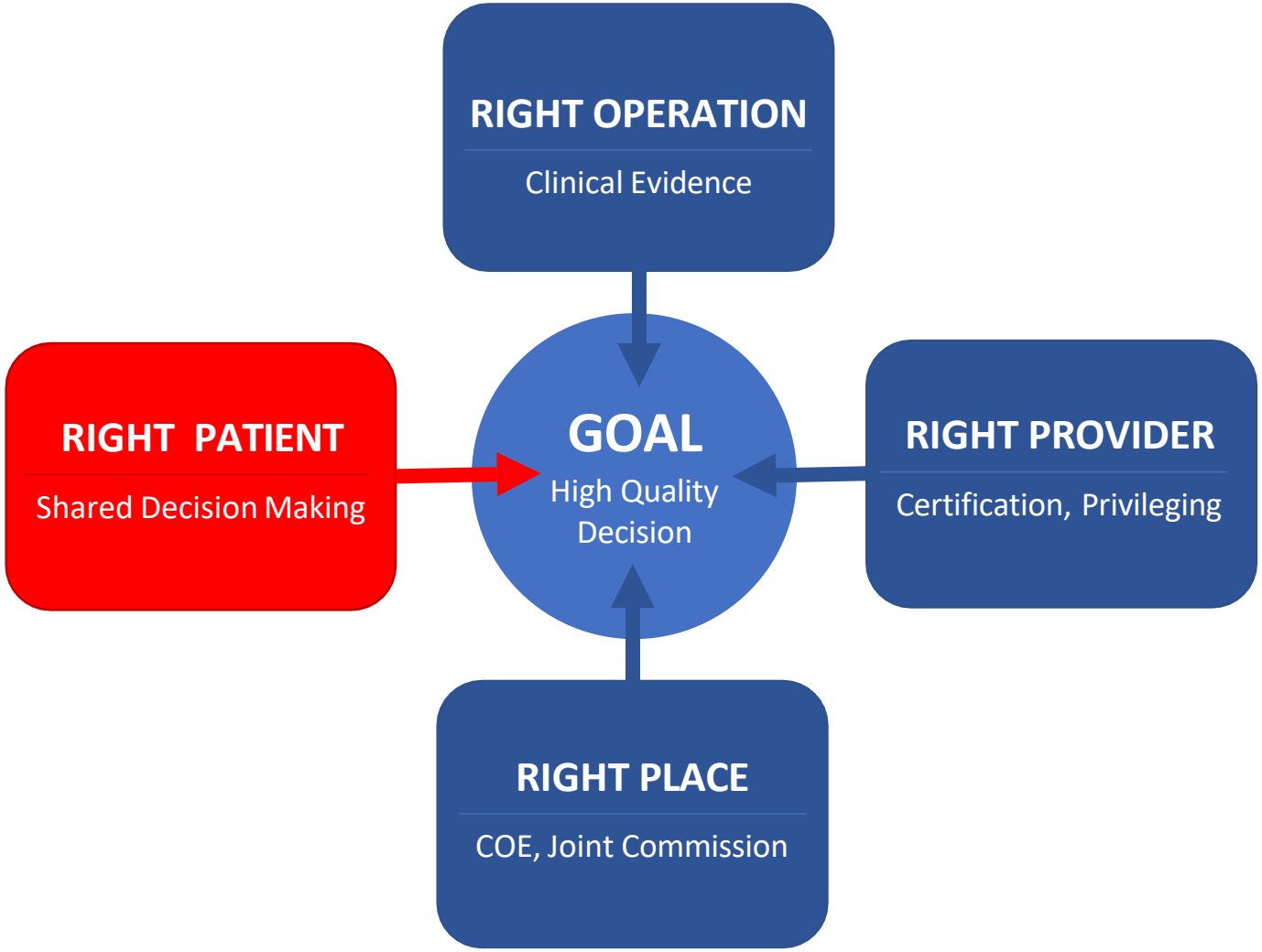
What is Shared Decision Making?

Shared Decision Making

Interactive process between patient (and family) and clinician(s)

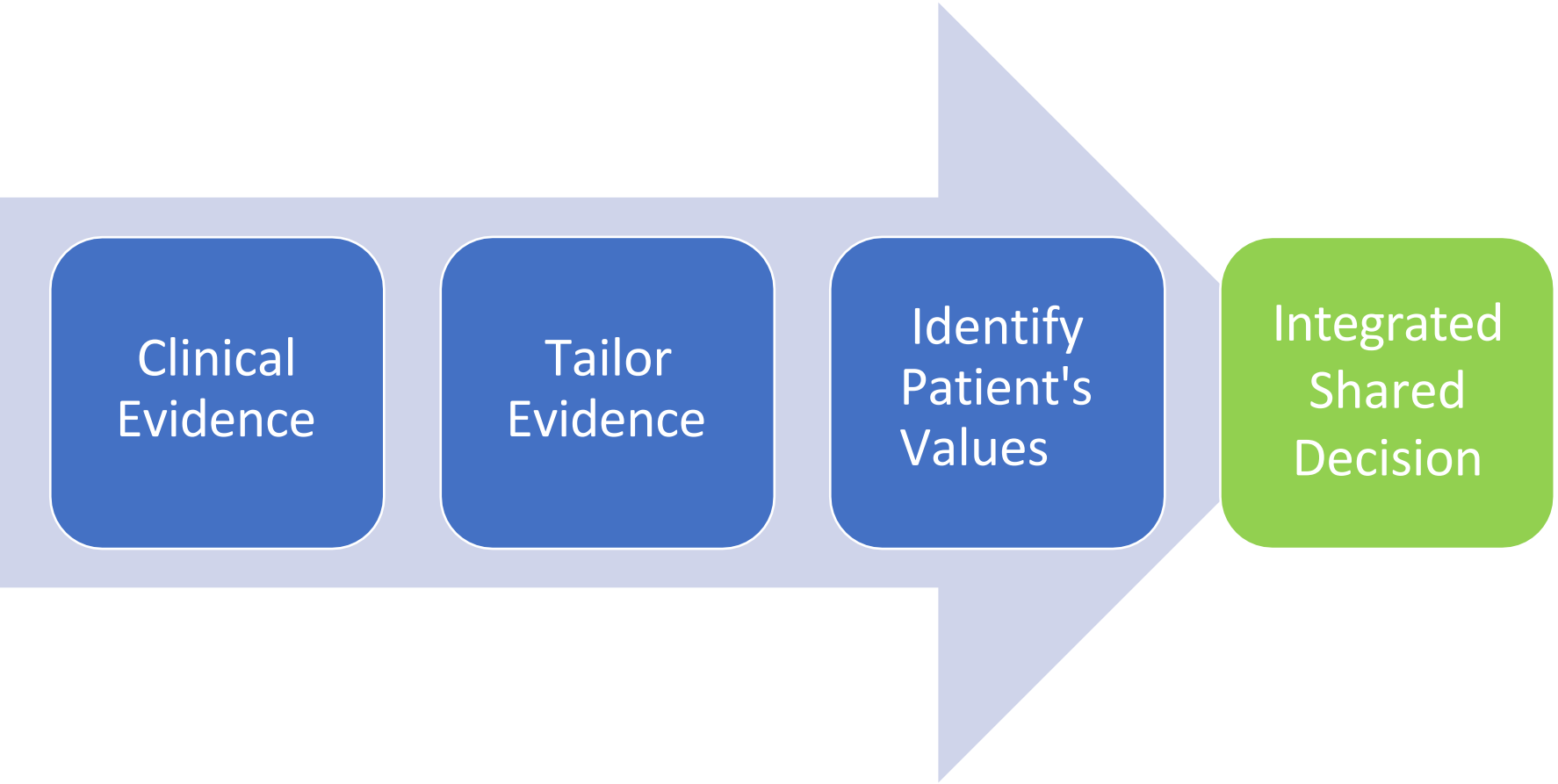
- Engage patient in decision making
- Accurate information about options and outcomes
- Tailor treatments to patient's goals and concerns

Extending definitions of ‘appropriateness’



Cooper Z et al. 2015 Anesthesiology

The SDM Process



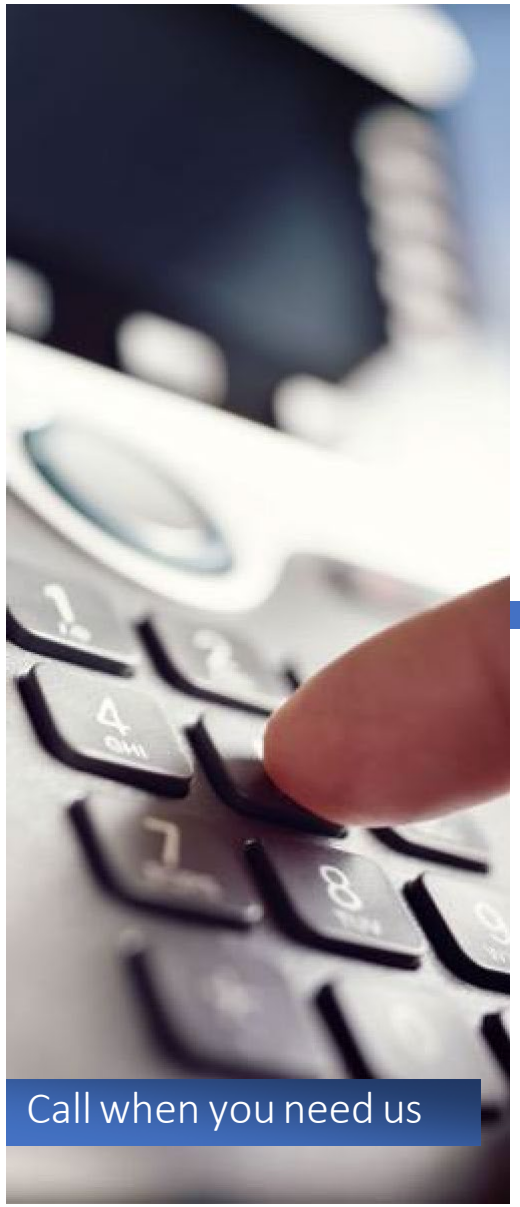
Having GOOD DISCUSSIONS

Informed patients who receive preferred treatment

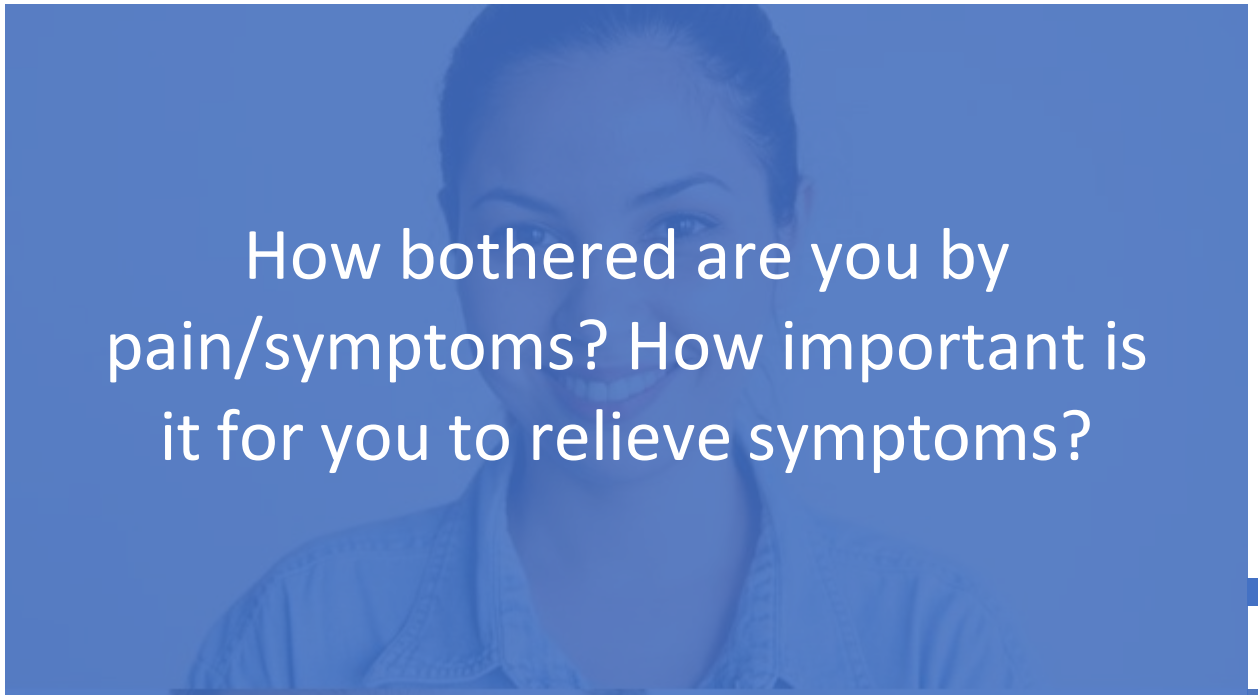
A Shift In Understanding

Tools & Training

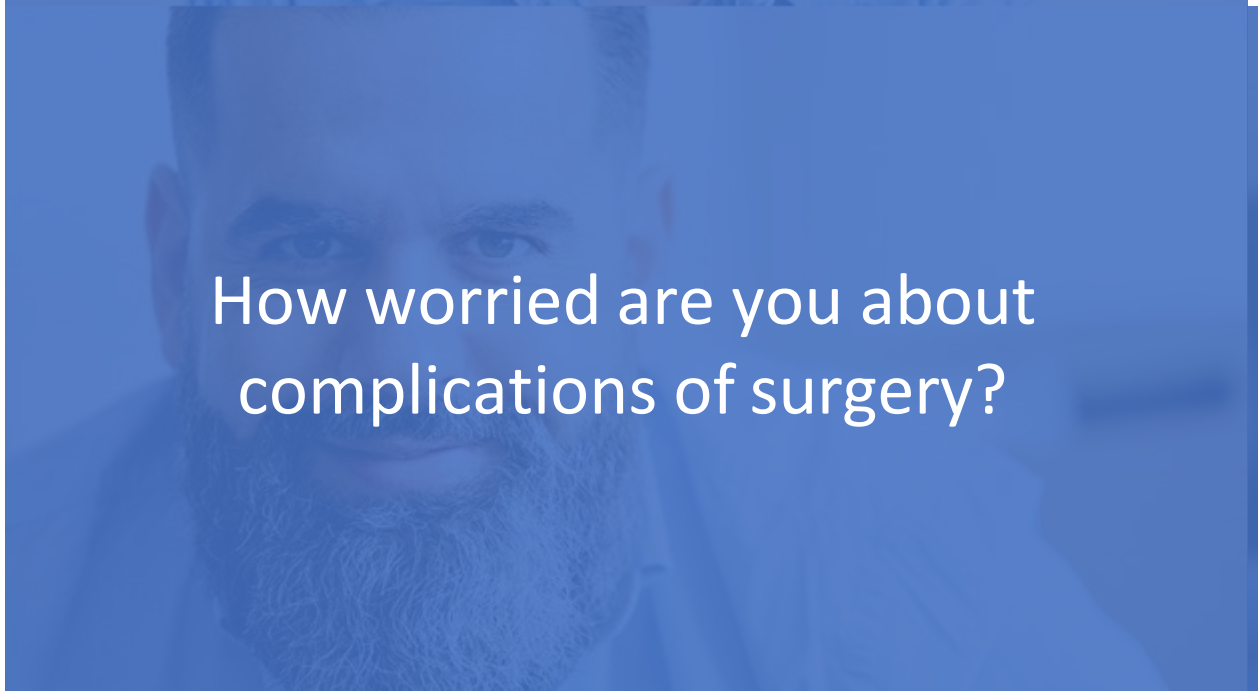
Finding the Control Balance



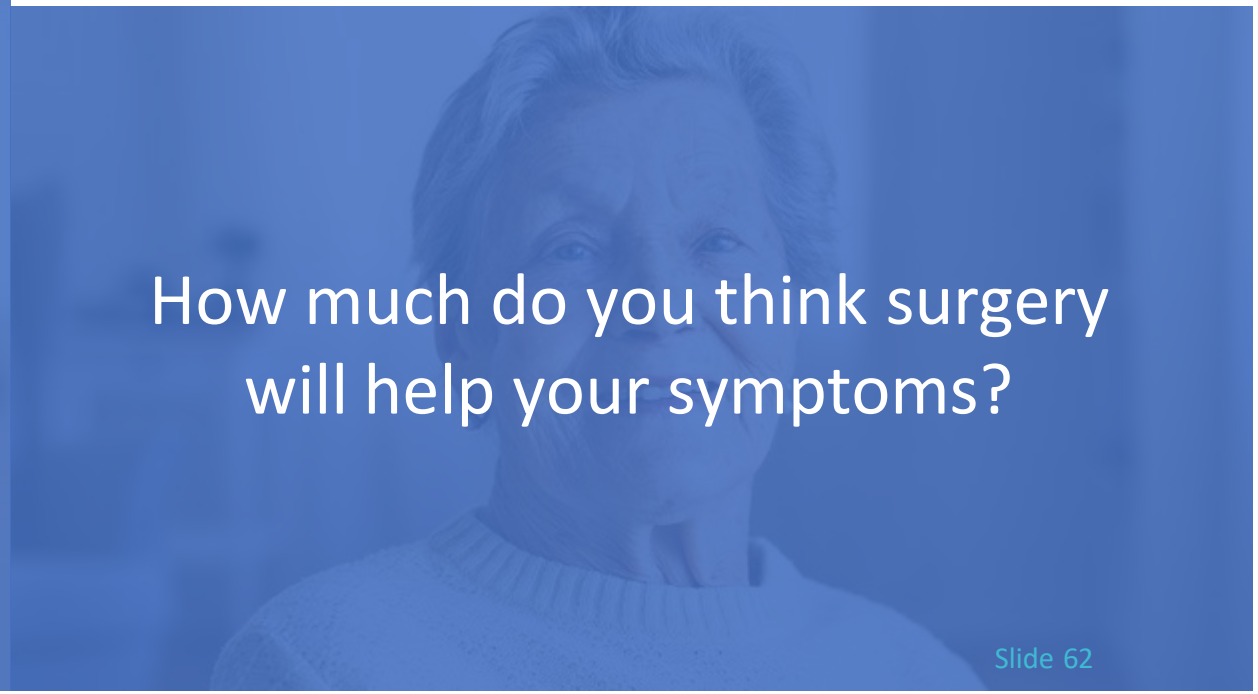
ideal



How bothered are you by pain/symptoms? How important is it for you to relieve symptoms?



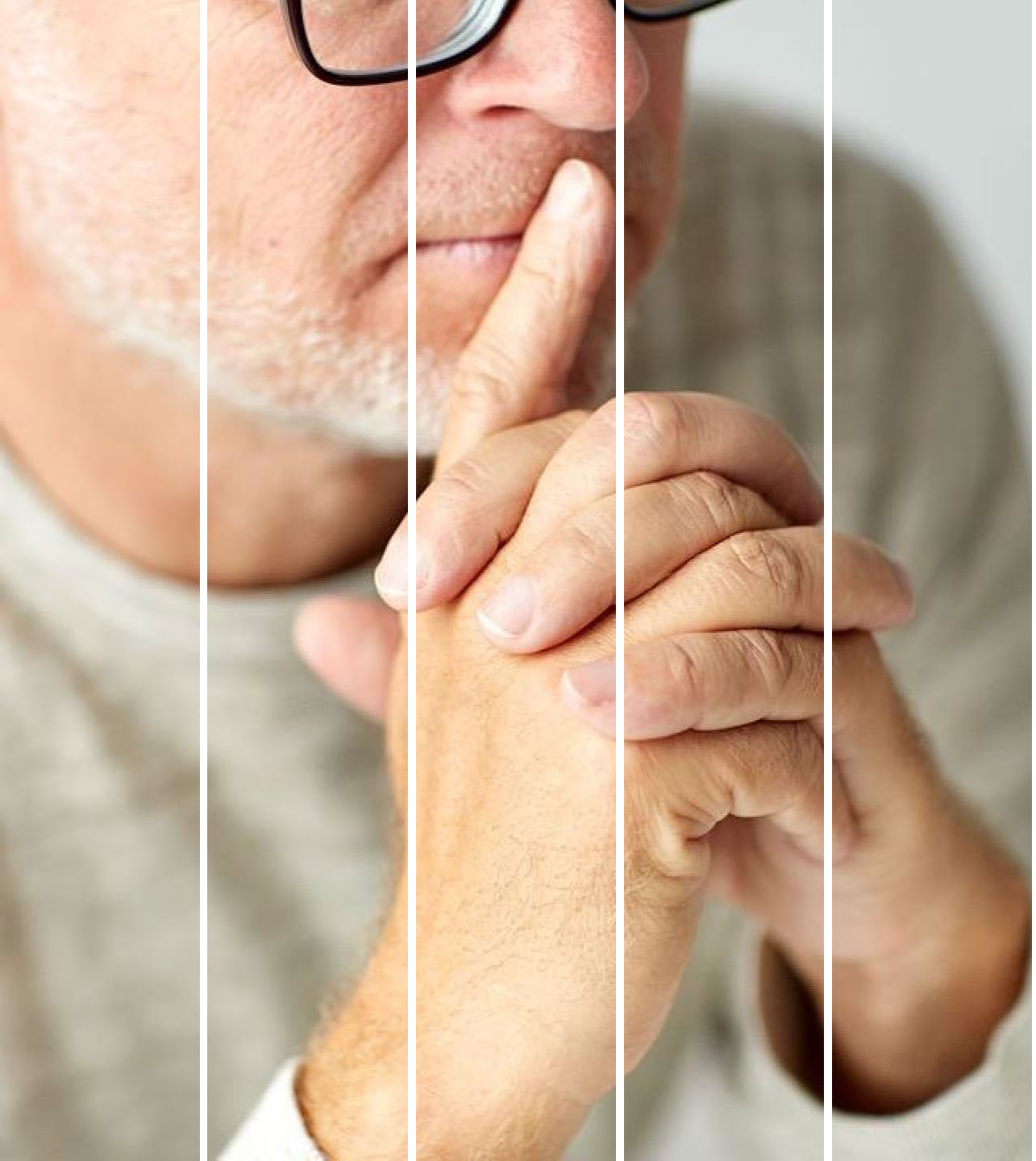
How worried are you about complications of surgery?



How much do you think surgery will help your symptoms?

Identifying Personal Values

Treat others as **they** would like to be treated.



Finding the Weight of Concerns

SYMPTOM CONCERN	SIDE EFFECT CONCERN: LESS	SIDE EFFECT CONCERN: MORE
MORE	Just Do It	May need extra support
LESS	Start with least invasive	Non surgical options

Increase comfort discussing the tradeoffs

section one

SDM History at Mass General & building a culture to support SDM

MGH innovator and early adopter

npr shots

treatments

For Better Treatment, Doctors And Patients Share The Decisions

by NPR STAFF

July 24, 2014 4:12 PM ET

Listen to the Story
All Things Considered

Dr. Karen Sepucha (on the left) and Dr. Leigh Simmons (on the right).

2020

WELCOME TO THE HDSC!

We were founded in 2010 by Dr. Karen Sepucha and Dr. Leigh Simmons. However, our history began in 1989 with the Foundation for Informed Medical Decision Making and now spans over 30 years of progress and implemenation of shared decision-making. Browse through our timeline to learn more.

FIMDM

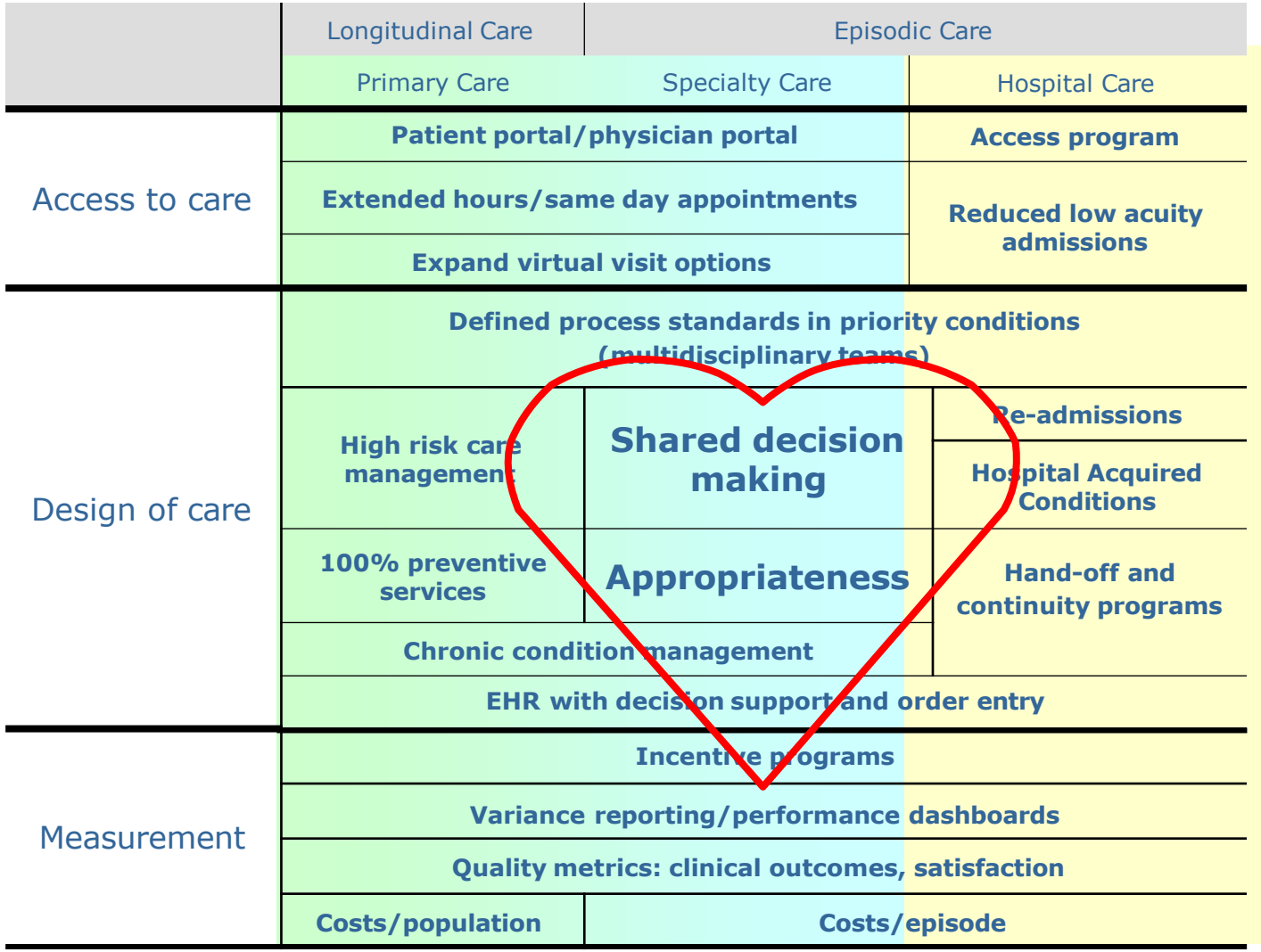
ENGAGING PATIENTS IN CLINICAL CARE

By Karen R. Sepucha, Leigh H. Simmons, Michael J. Barry, Susan Edgman-Levitan, Adam M. Licurse, and Sreekanth K. Chaguturu

DOI: 10.1377/hlthaff.2015.1376
HEALTH AFFAIRS 35,
NO. 4 (2016): 630-636

Ten Years, Forty Decision Aids, And Thousands Of Patient Uses: Shared Decision Making At Massachusetts General Hospital

Linked to strategy and mission



Milford, CE, Ferris TG (2012 Aug). A modified "golden rule" for health care organizations. Mayo Clin Proc. 87(8):717-720.

A common sentiment about shared decision making among healthcare providers:

"We already do that all the time."

HEALTH DECISION SCIENCES

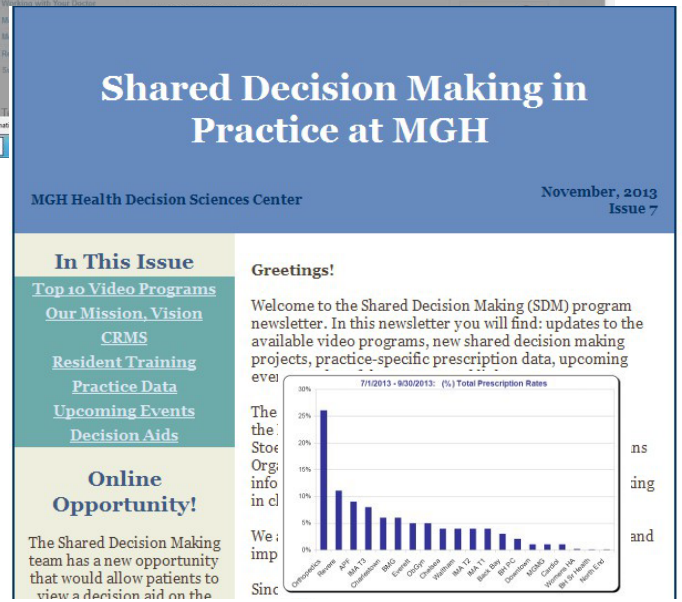
Let's Decide Together

FOUNDATION FOR Health Care Quality

DR. ROBERT BREE COLLABORATIVE

Advance understanding of and improve quality of medical decisions

- Interventions
- Measurement
- Implementation



www.mghdecisionsciences.org

Mr. M:
Hip Osteoarthritis

- Age: 71
- Progressive right hip pain
- X-rays confirmed moderate arthritis
- Surgeon note: “We discussed the options and Mr. M very much wishes to proceed with hip replacement.”

Case Study.

During The Wait

- Spoke to friends and family
- Continued exercise, had minimal symptoms
- PCP sent decision aid

Case Study.

Dear Dr. [redacted]

Re: Hip Replacement Surgery

I am writing to tell you that at this time I will not be proceeding with my right hip replacement procedure. Therefore, will you please cancel my appointments for pre-admission testing on July [redacted] and for surgery on [redacted].

About six months ago I added daily biking to my exercise routine and after three months found that the nighttime hip pain was gone. When I saw you in May, I was not sure if this important change to my life style would hold. It has so far.

Based on a conference with Dr. [redacted] my primary care physician, and on a viewing of the very helpful information on a DVD that he prescribed (Treatment Choices for Hip Osteoarthritis), sent to me by Massachusetts General's Patient and Family Learning Center, I have decided that waiting for the surgery is the best decision.

Thank you for your help and patience.

With kind regards,

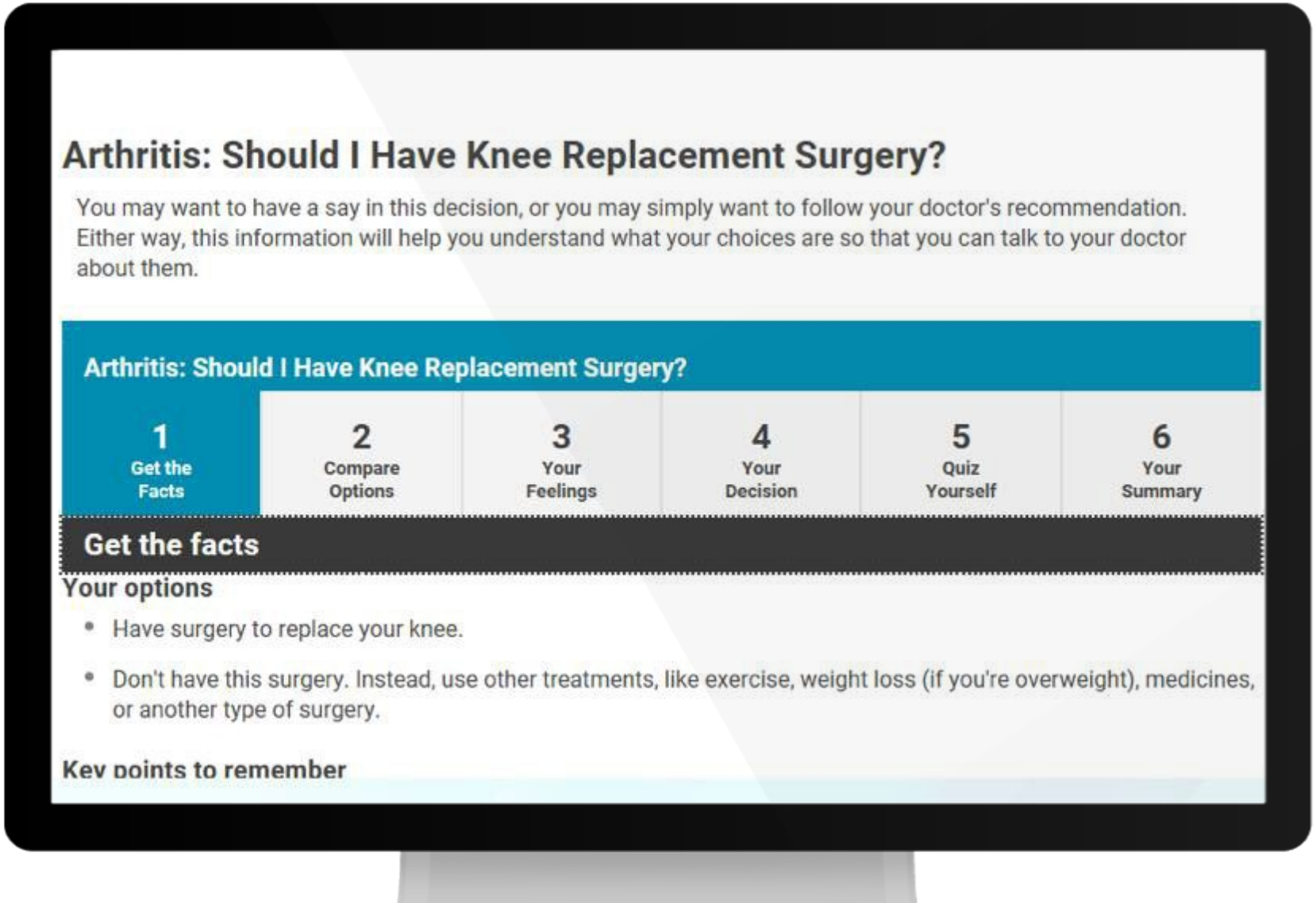
Case Study.

Two years later

- Nighttime hip pain came back
- Mr. M went back to surgeon to have the hip replacement
- Good pain relief and able to get back to activities
- No regrets on timing

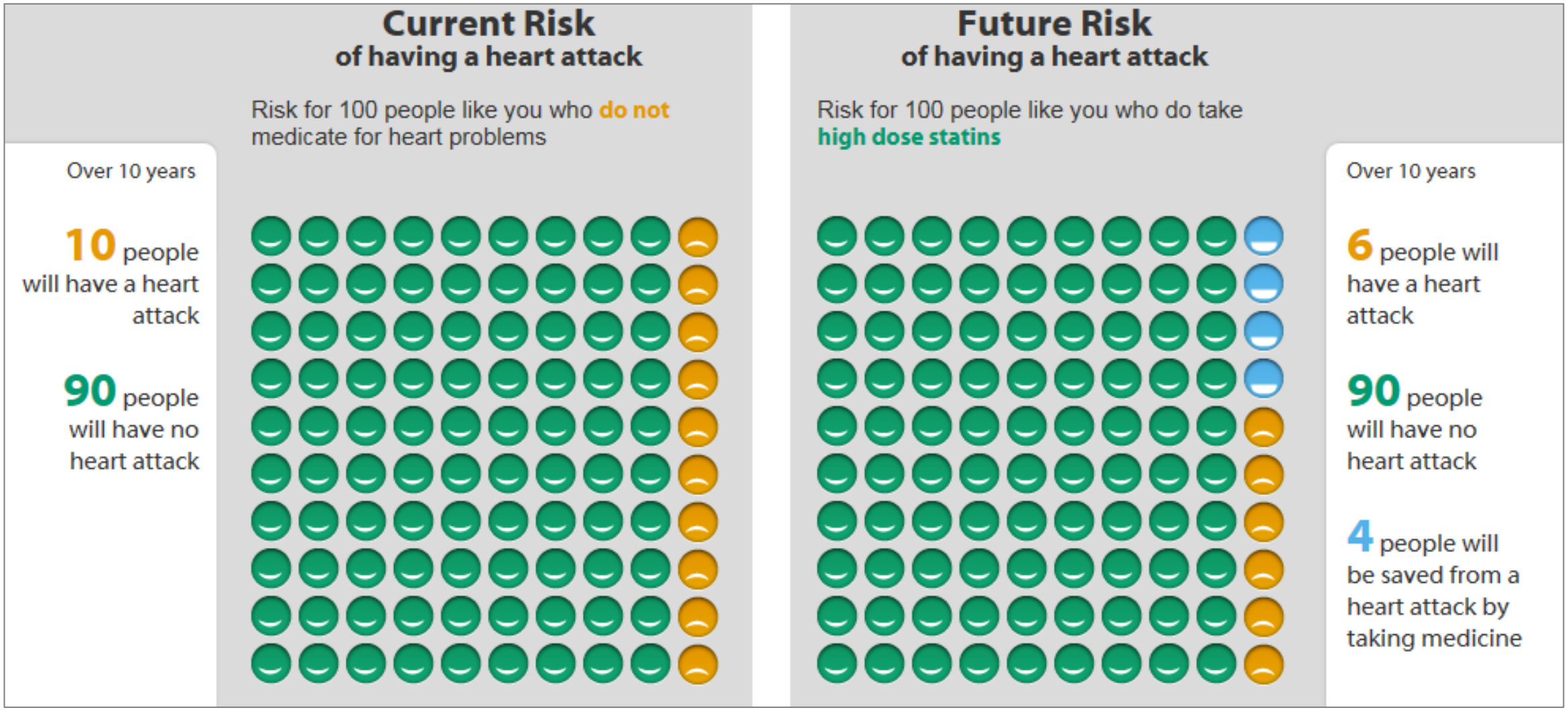
Case Study.

Short, Interactive Tool



- Covers **key facts** about surgery and non surgical options
- Helps patients **clarify** their goals and concerns
- Creates a summary print out

Short, Interactive Tool



https://statindecisionaid.mayoclinic.org/

Decision Aid Usage = Increased Patient Knowledge

105 RCTs with

patients and 50 different topics surveyed

Improved decision quality…

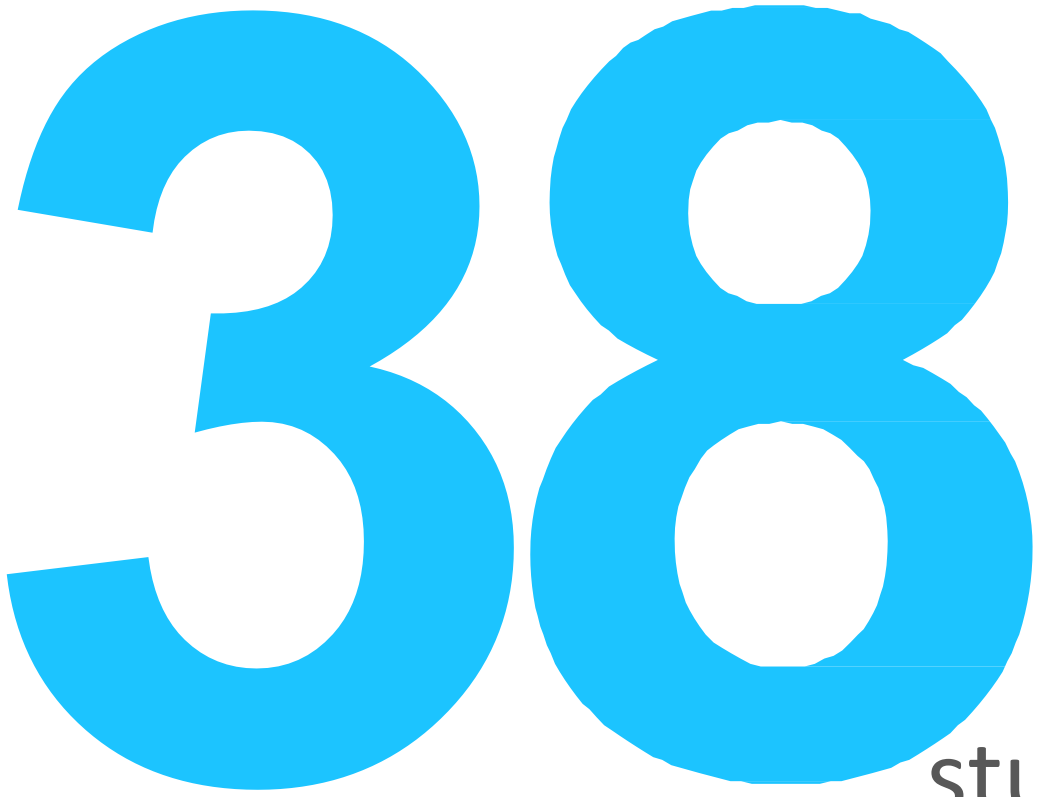
- **13%** absolute increase in knowledge
- **2-fold** improvement in accurate risk perception
- **2-fold** improvement in match between values & choices

Address overuse and underuse

- **16%** reduction in elective procedures

Underserved patients = Better Results

Out of



studies

- **significantly improved outcomes** for disadvantaged patients
- maybe **more beneficial to disadvantaged patients** than those with higher literacy/ socioeconomic status
- Unclear which features are most effective

Yen R, et al Med Decis Making 2021

Decision Aid Usage Across MGH and MGB

2,500+ clinicians ordered

87k

decision aids for patients

Top in 2023:

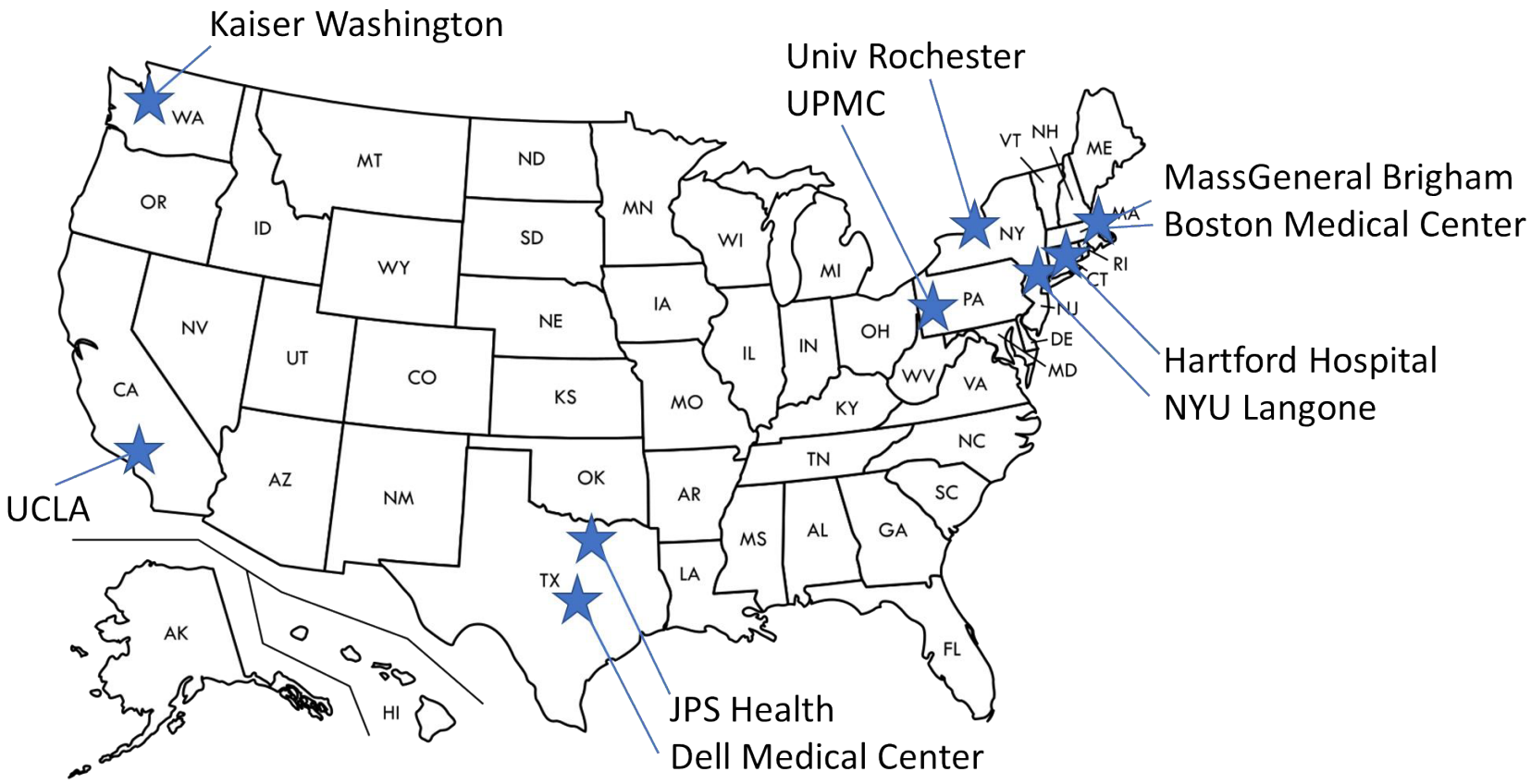
1. Quitting Smoking
2. Knee osteoarthritis
3. Hip osteoarthritis
4. Lung Cancer Screening
5. Spinal stenosis

Sepucha et al 2016 Health Affairs

Leading Orthopedic SDM Learning Collaborative

20k

Decision aids delivered

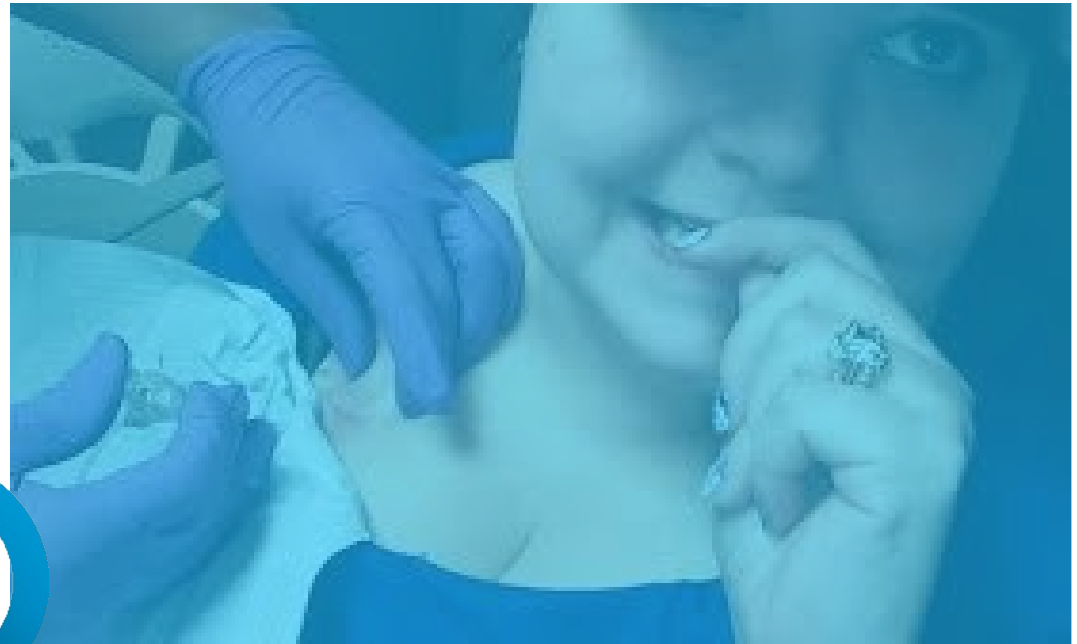


section two

Fostering creative approaches within our institution – decision aid development

Good intentions are not enough

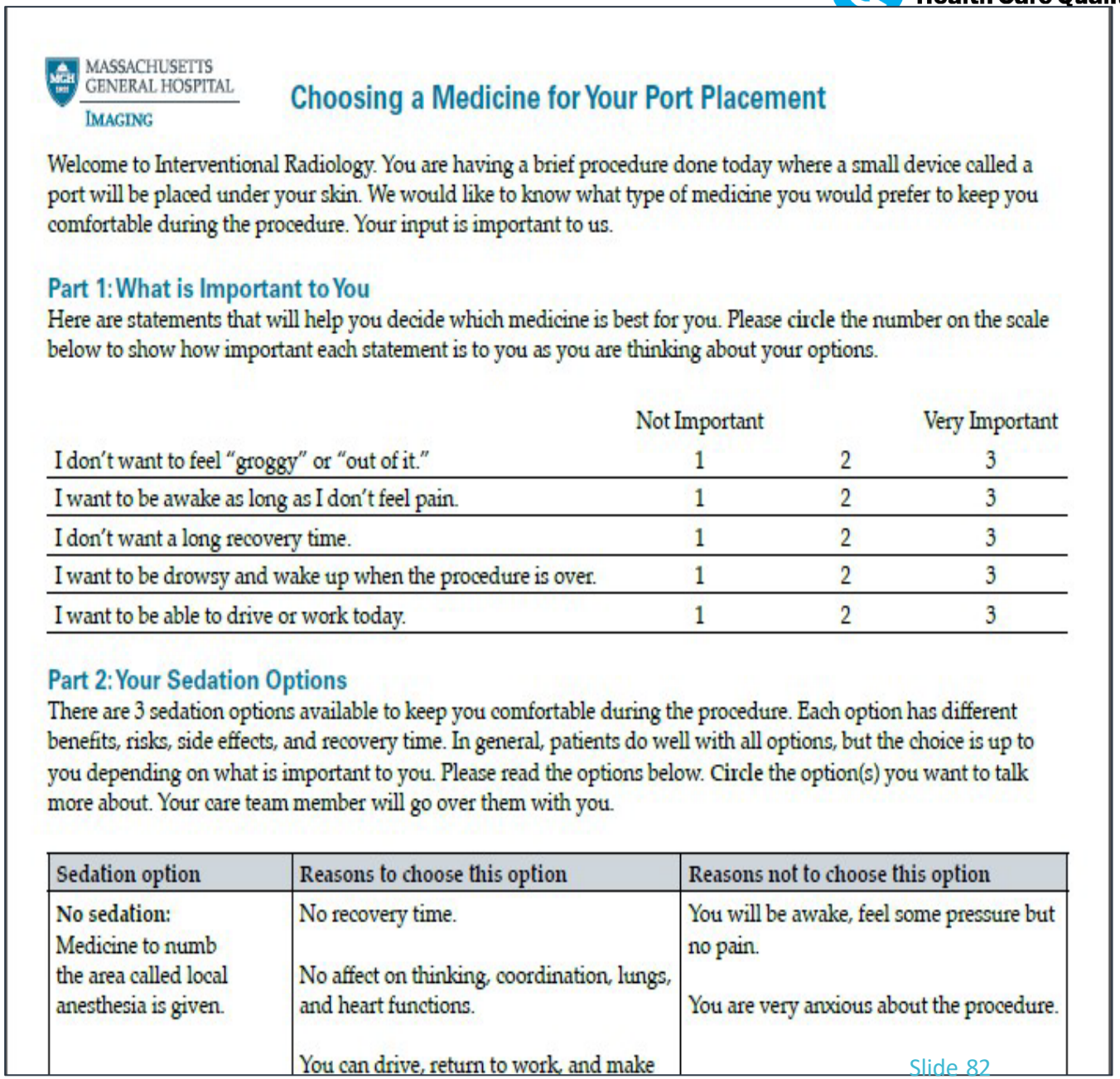
“As soon as I saw Ms. R, she looked terrified, I could see the fear in her eyes. She was shaking, visibly anxious. And I reassured her, “Don’t worry, I’m going to put you to sleep. You won’t know what happened.”



And right away Ms. R looked at me and said **“It’s not my cancer that scares me, it’s not my surgery, or my chemotherapy. The thing that scares me the most is sedation—being put to sleep.”**

Making it routine

- Paper decision aid
- Training
- Workflow
- Mobile app…



MASSACHUSETTS GENERAL HOSPITAL
IMAGING

Choosing a Medicine for Your Port Placement

Welcome to Interventional Radiology. You are having a brief procedure done today where a small device called a port will be placed under your skin. We would like to know what type of medicine you would prefer to keep you comfortable during the procedure. Your input is important to us.

Part 1: What is Important to You

Here are statements that will help you decide which medicine is best for you. Please circle the number on the scale below to show how important each statement is to you as you are thinking about your options.

	Not Important		Very Important
I don't want to feel "groggy" or "out of it."	1	2	3
I want to be awake as long as I don't feel pain.	1	2	3
I don't want a long recovery time.	1	2	3
I want to be drowsy and wake up when the procedure is over.	1	2	3
I want to be able to drive or work today.	1	2	3

Part 2: Your Sedation Options

There are 3 sedation options available to keep you comfortable during the procedure. Each option has different benefits, risks, side effects, and recovery time. In general, patients do well with all options, but the choice is up to you depending on what is important to you. Please read the options below. Circle the option(s) you want to talk more about. Your care team member will go over them with you.

Sedation option	Reasons to choose this option	Reasons not to choose this option
No sedation: Medicine to numb the area called local anesthesia is given.	No recovery time. No affect on thinking, coordination, lungs, and heart functions. You can drive, return to work, and make	You will be awake, feel some pressure but no pain. You are very anxious about the procedure.

Giving patients a choice

37%

Chose moderate sedation

42

Fewer minutes of recovery time

Chittle et al 2016 Vascular Medicine

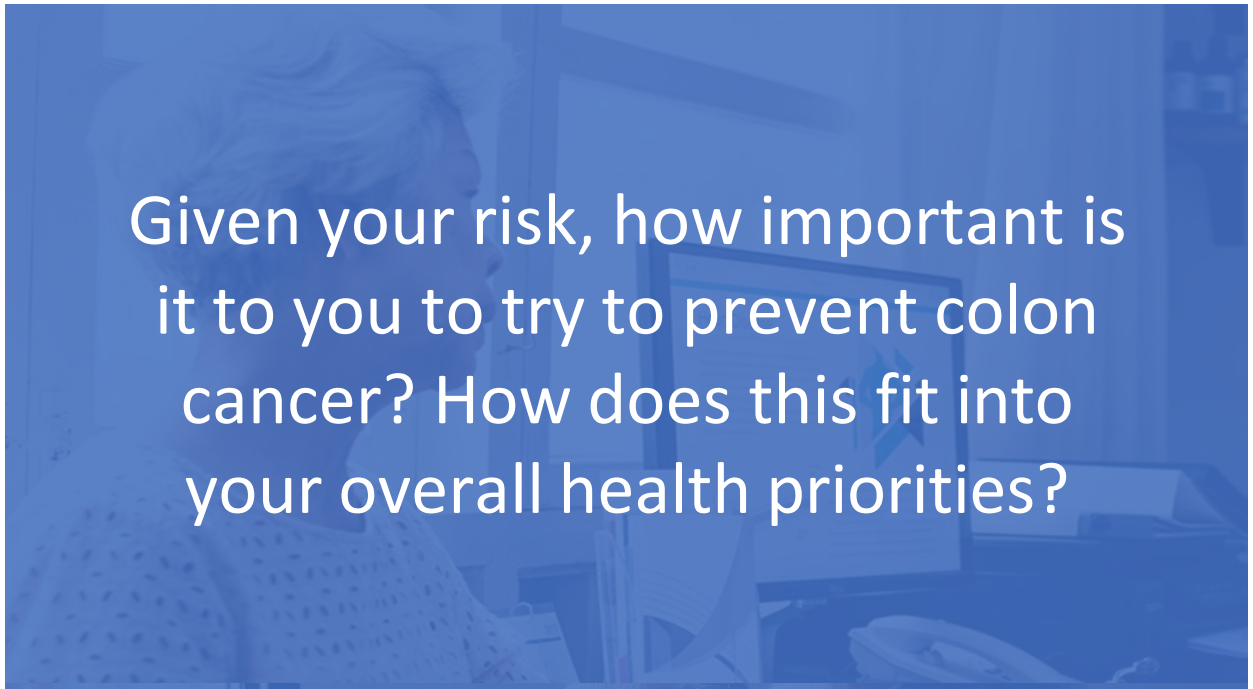
section three

Clinician training and the PRIMED Study:

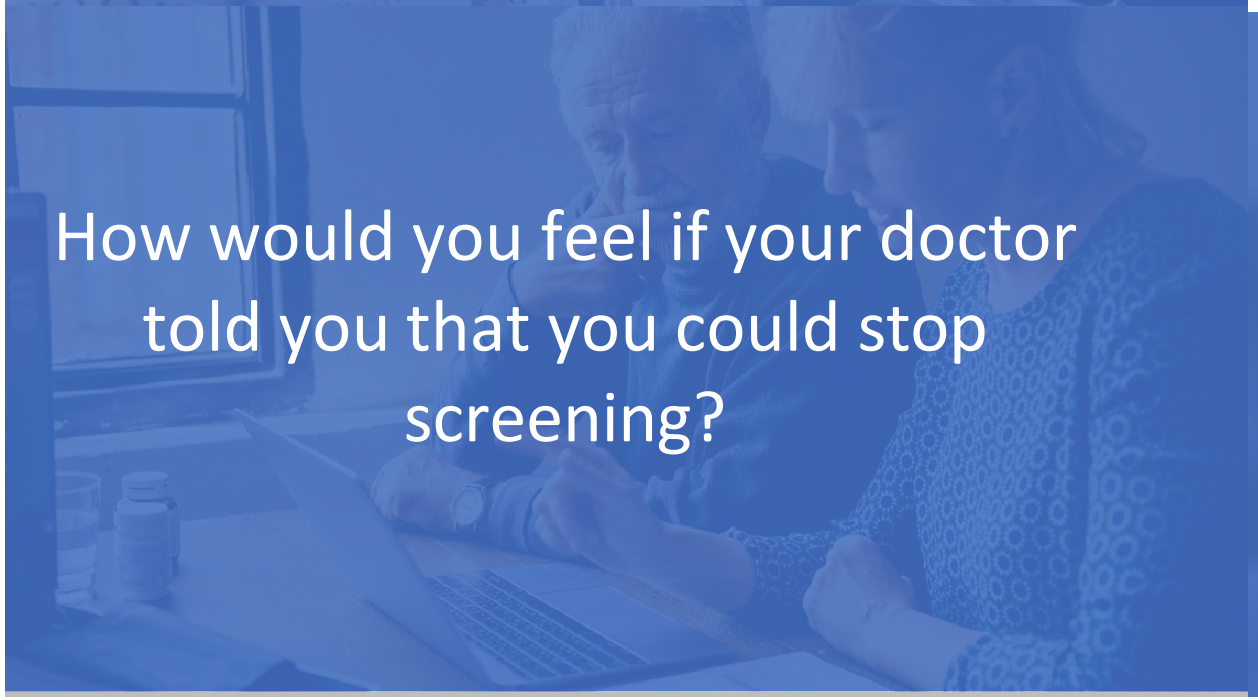
Promoting informed decisions about colorectal cancer testing for older adults

Identifying Patient's Values

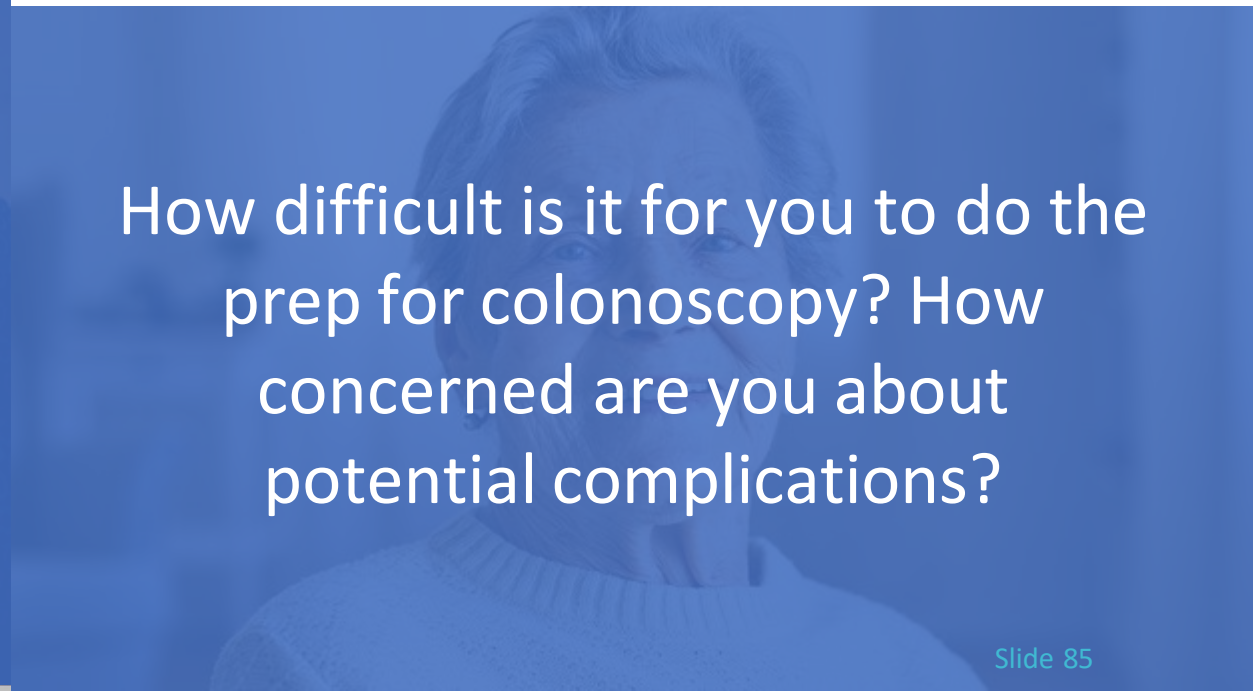
Treat others as **they** would like to be treated.



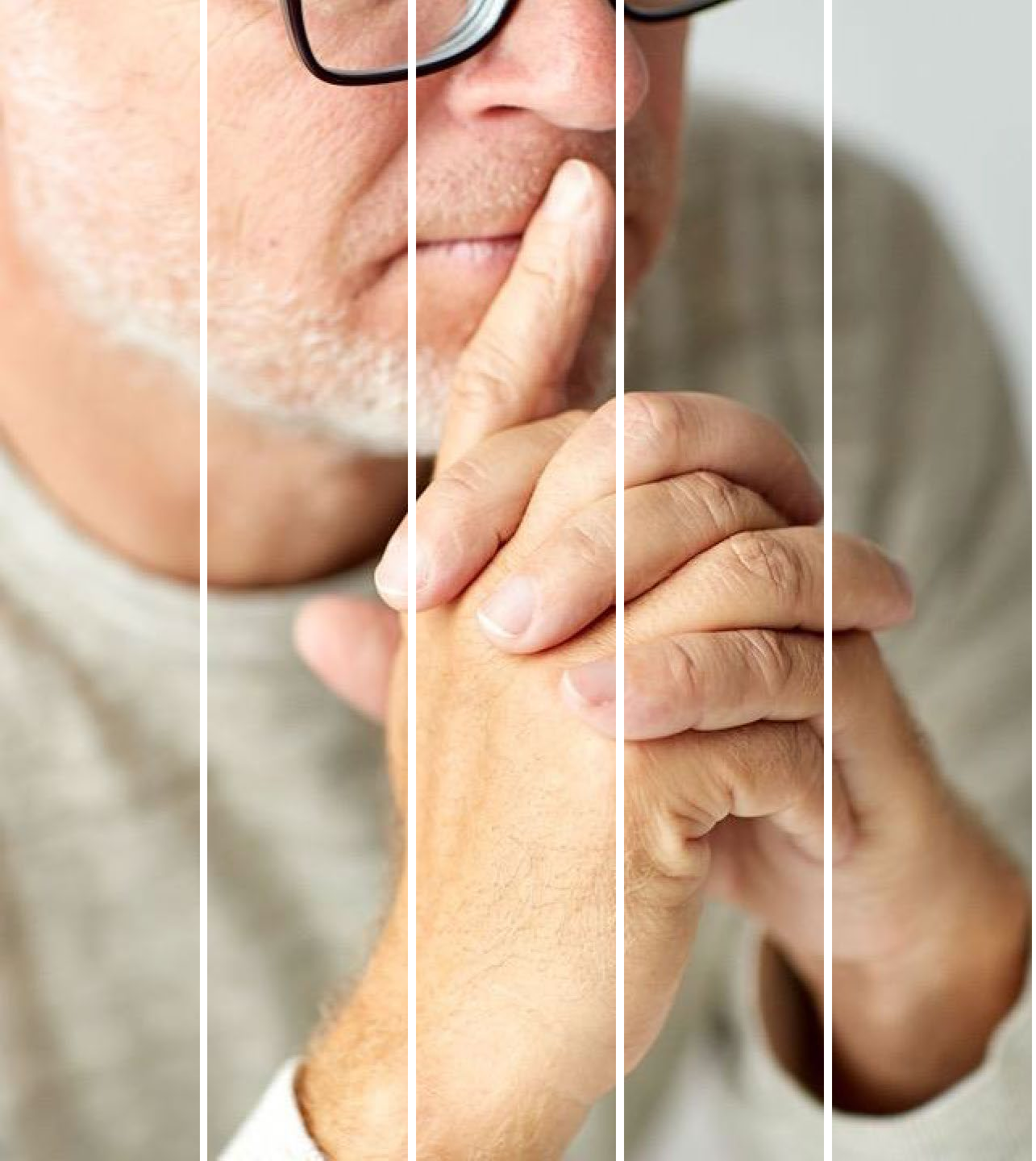
Given your risk, how important is it to you to try to prevent colon cancer? How does this fit into your overall health priorities?



How would you feel if your doctor told you that you could stop screening?



How difficult is it for you to do the prep for colonoscopy? How concerned are you about potential complications?



Navigating the Tradeoffs

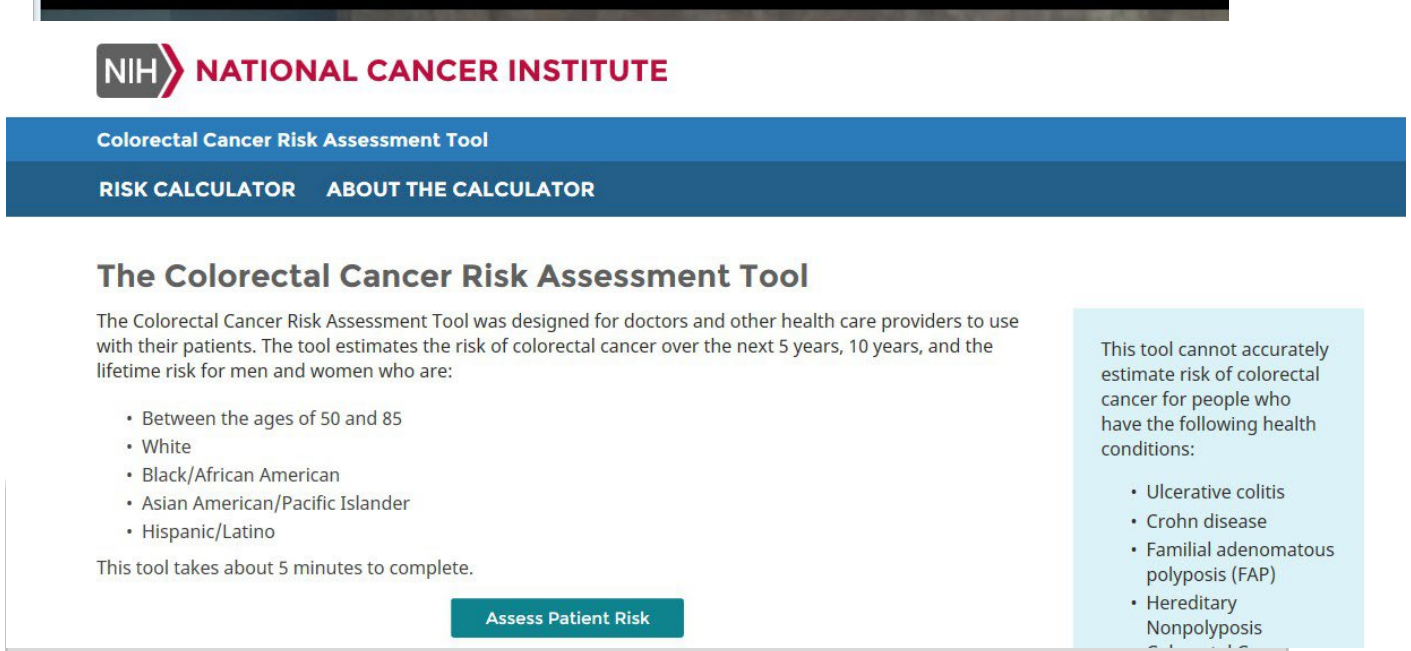
CONCERN PREP/COMPLICATIONS	POTENTIAL BENEFITS: LOW	POTENTIAL BENEFITS: HIGH
LOW	Stool test or stop	JUST DO IT!
HIGH	JUST STOP!	High conflict: may need extra support

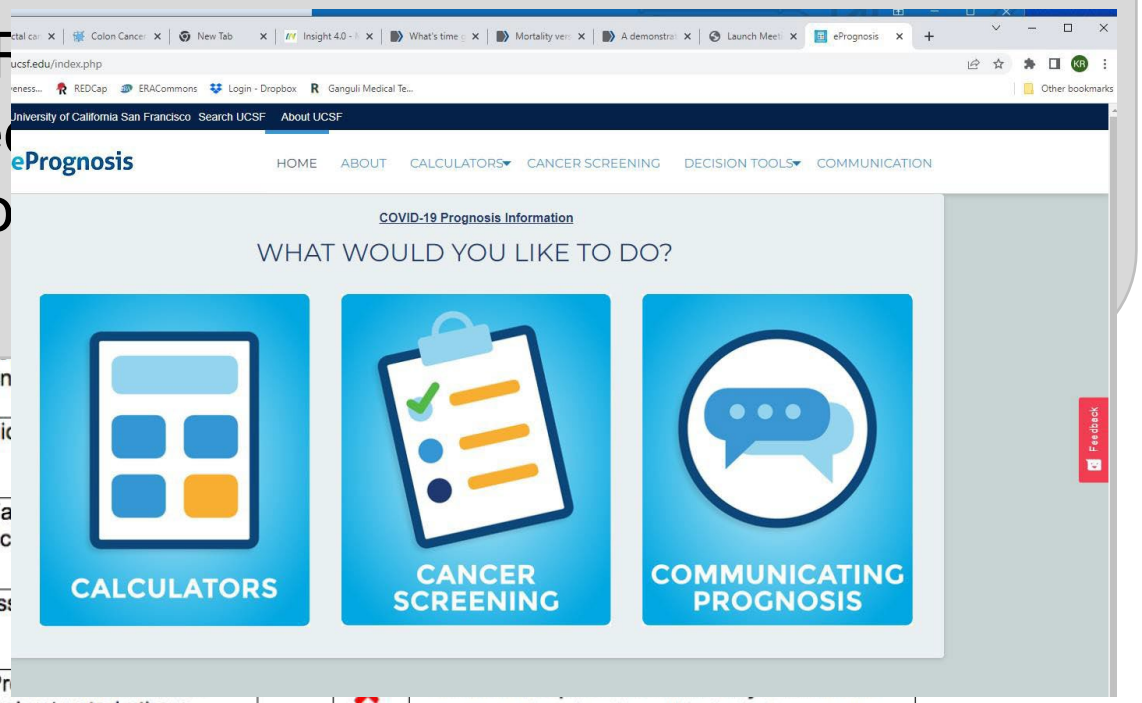
Overcoming barriers to involvement

:ing

ds

vs.





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7. Pr
involve trusted others
involved or able to help.

Video Vignettes
Sample Scripts
Risk calculators

Do interventions improve practice?

RCT with

Physicians across 5 networks

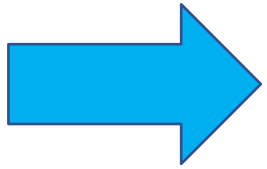
Patient-reported SDM scores (primary)

- Discussion of screening
- Knowledge
- Intentions
- Satisfaction

FOUNDATION FOR Health Care Quality

Collecting the **data**

Patient surveys



466

Physician surveys

631

Patient Sample

FOUNDATION FOR Health Care Quality

	Training Group N=236	Reminder Only N=230
Age Mean (SD)	79.5 (2.8)	79.2 (2.8)
Female %	58%	48%
Prior Test:		
Colonoscopy	67%	66%
Stool-based test	22%	14%
None on record	12%	20%
Physical health (% excellent or very good)	54%	50%
White, non Hispanic	92%	94%
Education (≥college degree)	56%	47%
Prior polyp	51%	48%
Family history	20%	19%

Involving patients in decision

1.1

Reminder only

1.5

Training group

Adj p=0.01

Sepucha, et al. JGIM 2022

Discuss screening

60%

Reminder only

72%

Training group

Adj p=0.03

Sepucha, et al. JGIM 2022

FOUNDATION FOR Health Care Quality

Similar preferences for testing

	Reminder only	Training group
Prefer Colonoscopy	26%	25%
Prefer Stool-based test	31%	39%
Prefer no testing	23%	20%
Not sure	19%	14%

Adj p=0.46

Sepucha, et al. JGIM 2022

More likely to make a recommendation

69%

Reminder only

79%

Training group

Adj p=0.03

Sepucha, et al. JGIM 2022

Stronger intentions

47%

Reminder only

58%

Training group

Adj p=0.02

Sepucha, et al. JGIM 2022

No impact on patient knowledge

61%

Reminder only

63%

Training group

Adj p=0.36

Sepucha, et al. JGIM 2022

High satisfaction for both

56%

Reminder only

67%

Training group

Adj p=0.08

Sepucha, et al. JGIM 2022

Higher increase in SDM scores for older patients 80-85yo:

+0.5

80-85 years old

+0.2

76-79 years old

Higher increase in SDM scores for male patients:

+0.60

Male

+0.15

Female

Higher increase in scores for those at higher CRC risk:

+0.5

Prior polyps

+0.2

No prior polyps

Higher increase in scores for those physicians with <25 years in practice:

+0.7

<25 years experience

+0.2

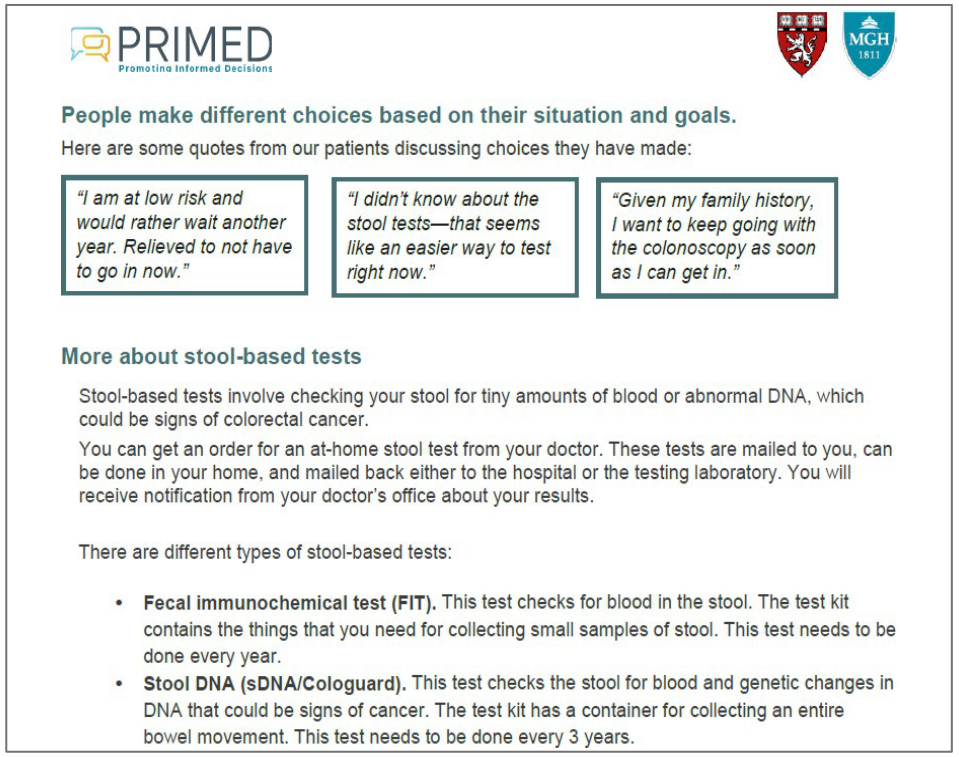
25 or more years

section four advancing health equity and inclusion

What is the role of SDM in a crisis?

RCT (n=800) compared “usual care” vs. SDM approach

- Collaboration with GI dept for patients who had colonoscopy cancelled
- Brief, scalable intervention
  - Mailed worksheet plus call from decision coach
  - Offered options (incl stool test, delay)
- Usual care focused on rescheduling colonoscopy



PRIMED
Promoting Informed Decisions

People make different choices based on their situation and goals.

Here are some quotes from our patients discussing choices they have made:

“I am at low risk and would rather wait another year. Relieved to not have to go in now.”

“I didn’t know about the stool tests—that seems like an easier way to test right now.”

“Given my family history, I want to keep going with the colonoscopy as soon as I can get in.”

More about stool-based tests

Stool-based tests involve checking your stool for tiny amounts of blood or abnormal DNA, which could be signs of colorectal cancer.

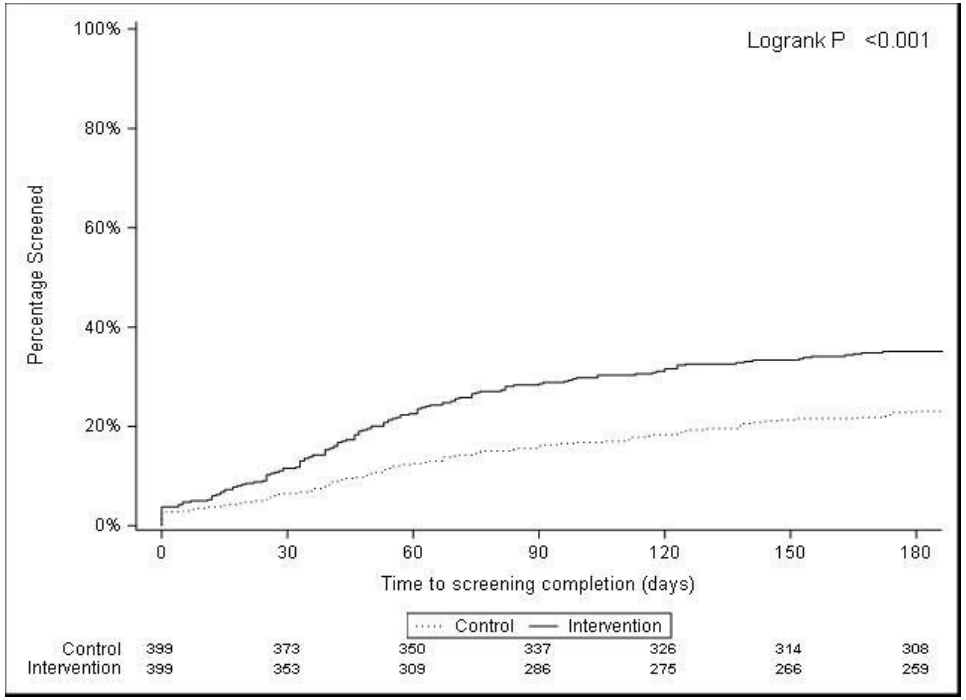
You can get an order for an at-home stool test from your doctor. These tests are mailed to you, can be done in your home, and mailed back either to the hospital or the testing laboratory. You will receive notification from your doctor’s office about your results.

There are different types of stool-based tests:

- **Fecal immunochemical test (FIT).** This test checks for blood in the stool. The test kit contains the things that you need for collecting small samples of stool. This test needs to be done every year.
- **Stool DNA (sDNA/Cologuard).** This test checks the stool for blood and genetic changes in DNA that could be signs of cancer. The test kit has a container for collecting an entire bowel movement. This test needs to be done every 3 years.

SDM arm had better outcomes

- ✓ 13% higher screening at 6 months
- ✓ Intervention had big impact in non-White participants (+18%) and those with high COVID worry (+17%)
- ✓ Patients reported more SDM and less decisional conflict



Sepucha et al 2022 Cancer Med

What's next?

- Building coaching capacity with student interns – Patient Support Corps
- Clinical decision support for clinicians – a reminder to have the conversations
- Micro decision aids as part of intake questionnaire

Recap

Shared decision making, supported by patient decision aids, can be part of a fundamental change to patient care processes

Integration into routine care is possible, but requires time, training, and constant communication with practices

Need for feedback on performance and accountability, opportunity for incentives to drive change, collaboration with leadership

THANK YOU

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@simmons_leighmd


15
Minute
Break

The patient side of shared decision making

Case #1

- Sue
- 65-year-old female
- Diagnosed with CVD
- Decision: to have/or not have LVAD

How patient decision aids support good shared decision making

Dawn Stacey RN, PhD, FRSC, FAAN, FCAN, FCAHS
Vice-Dean of Research, Faculty of Health Sciences
Research Chair Knowledge Translation to Patients
Distinguished Professor, University of Ottawa, Canada
Senior Scientist, Ottawa Hospital Research Institute

January 11, 2024
Washington State Health Care Authority, SDM Workshop

Disclosures

- University of Ottawa Research Chair in Knowledge Translation to Patients
- Travel funds for invited presentations:
  - Washington State Health Care Authority, 2024
  - University of Southern Denmark/SDM Advisory Committee, Denmark, 2023
  - Beijing University of Chinese Medicine, 2023
  - Canadian Lung Cancer Conference, 2023
  - German Society of Neurology Conference 2022

Funding for this review:

Canadian Institutes of Health Research (CIHR)

Outline

- Shared decision making
- Patient story
- International Patient Decision Aid Standards (IPDAS)
- Evidence on patient decision aids
- Proposed changes to IPDAS
- Implementation of patient decision aids

Shared decision making

A <u>process</u> by which decisions are made by the patient (+family) and the clinician using:

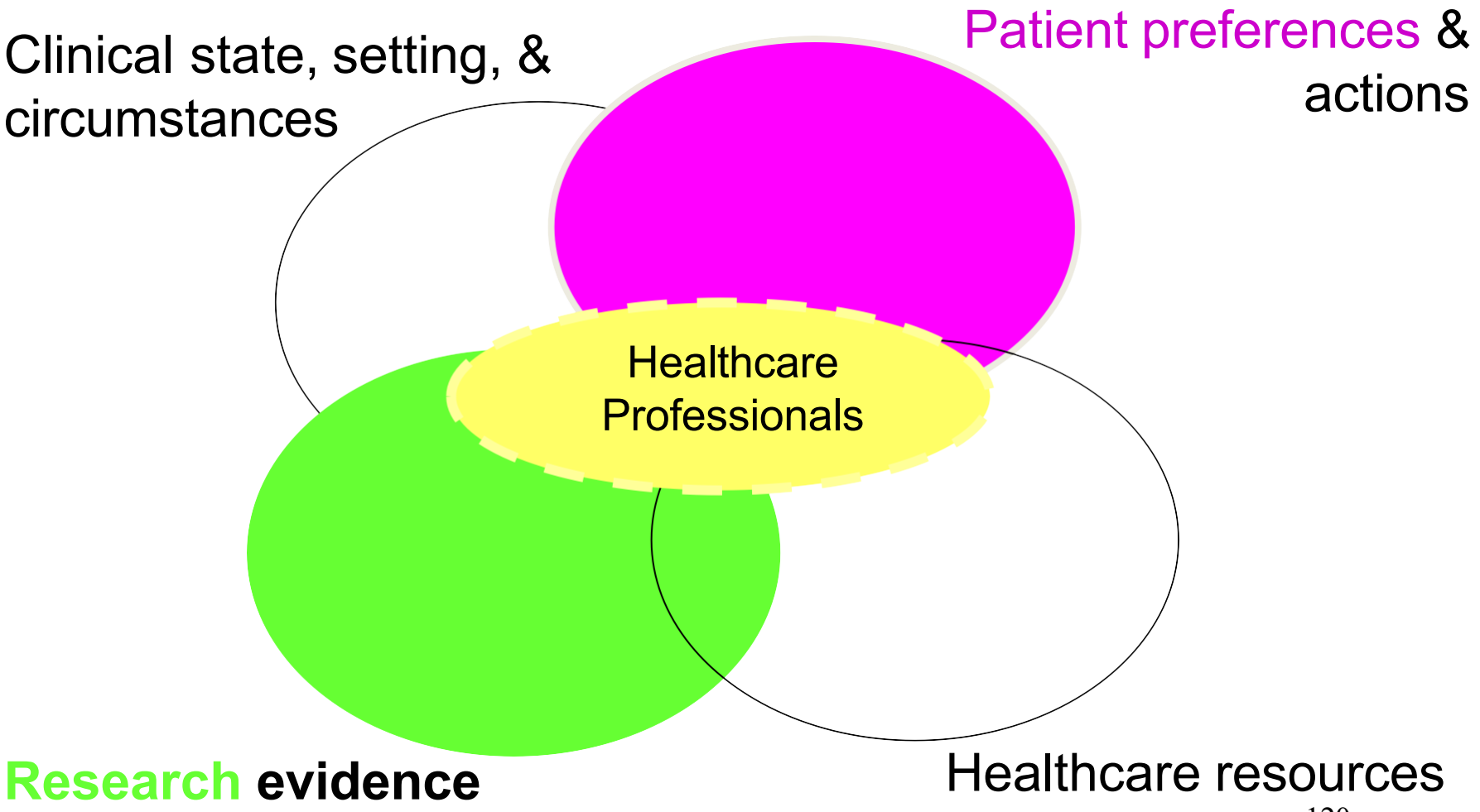
- The best available evidence
  and
- Patient's informed preferences

"*The crux of patient-centred care*" Weston 2001

(Legare et al., 2010; Makoul et al. 2006)

Evidence-based clinical decisions

(Guyatt, Haynes, & DiCenso, McMaster University)



The Problem

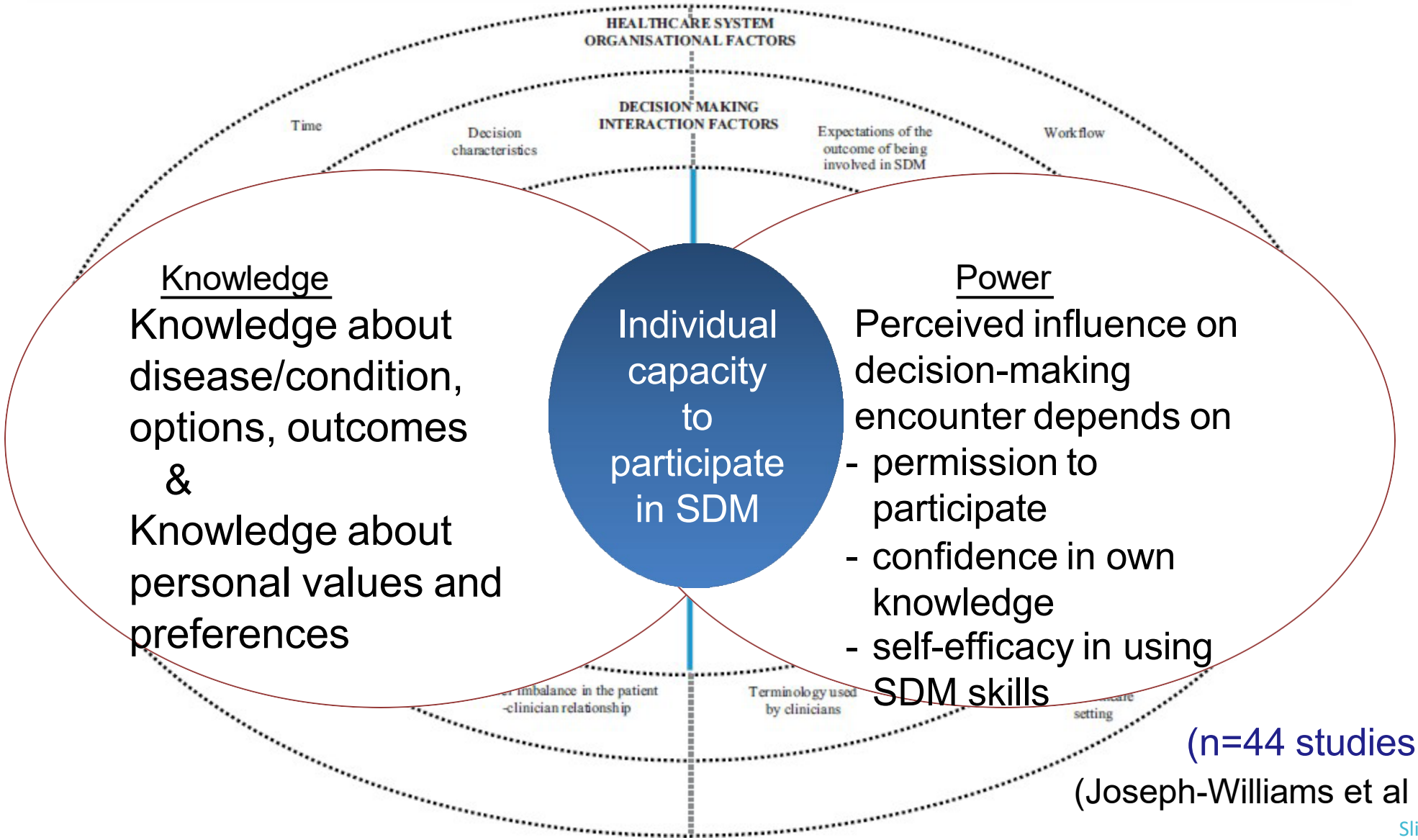
- 50% of patients are not offered more than one option
- clinicians are poor judges of patients' values and preferences
- hence, patients often achieve poor quality decisions
- effective interventions, such as patient decision aids and decision coaching, are not used routinely in clinical practice

Myths about Shared Decision Making

- **Shared decision making is not compatible with clinical practice guidelines**
- Shared decision making is a fad – it will pass
- **We're already doing shared decision making**
- In shared decision making, patients are left to make decisions alone
- **Not everyone wants shared decision making**
- Not everyone is good at shared decision making
- Shared decision making is not possible because patients are always asking me what I would do
- **Shared decision making takes too much time**
- Shared decision making is only about the doctors and their patients
- Shared decision making will cost money
- **Shared decision making is easy! A tool (patient decision aid) will do**
- Shared decision making does not account for emotion

(Légaré & Thompson-Leduc, 2014)

Patient identified barriers & facilitators to SDM



(n=44 studies)

(Joseph-Williams et al 2014)

Patient identified barriers & facilitators to SDM

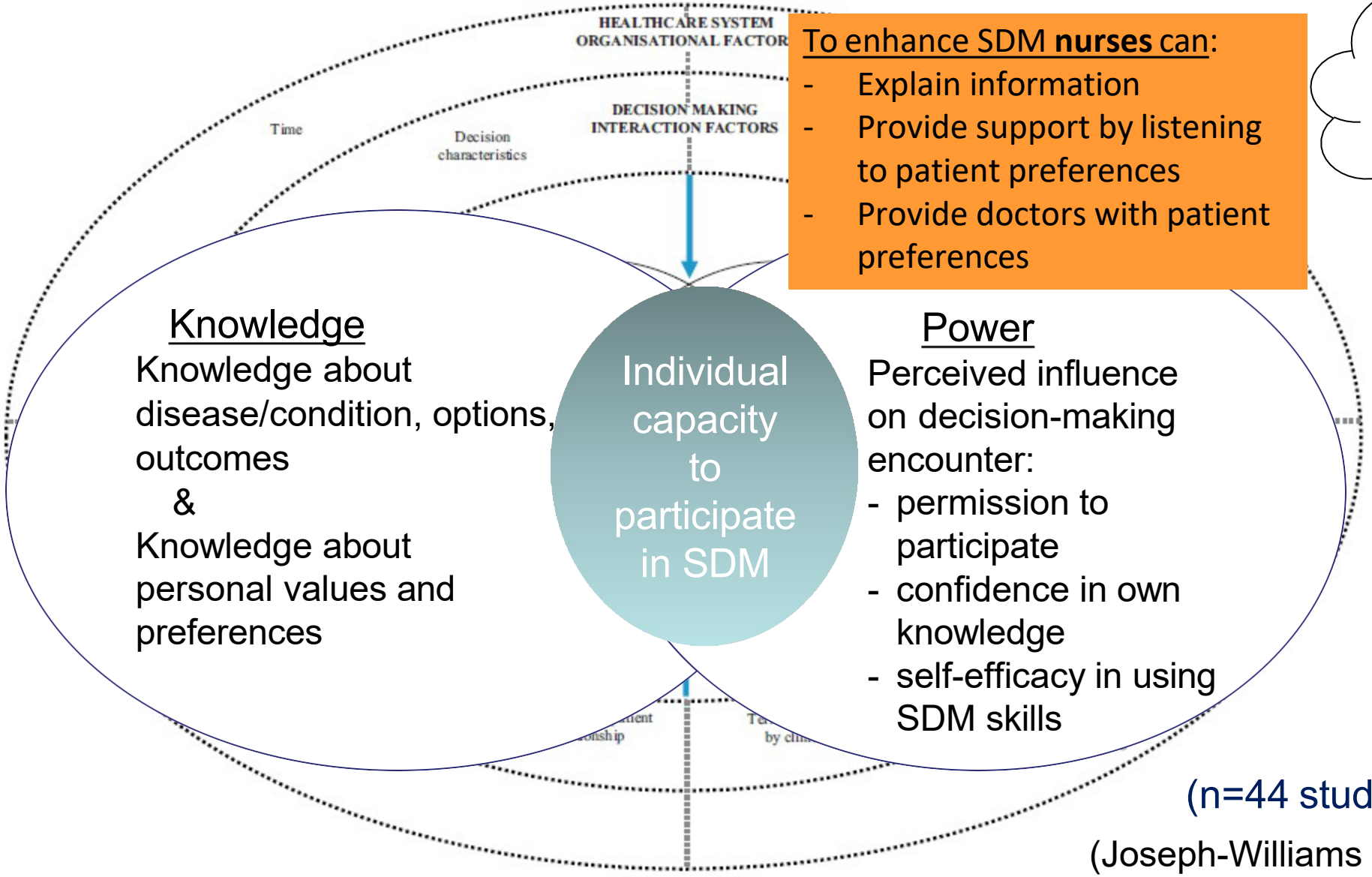


Fig. 2. Knowledge *and* power: patient-reported influences on individual capacity to participate in shared decision making.

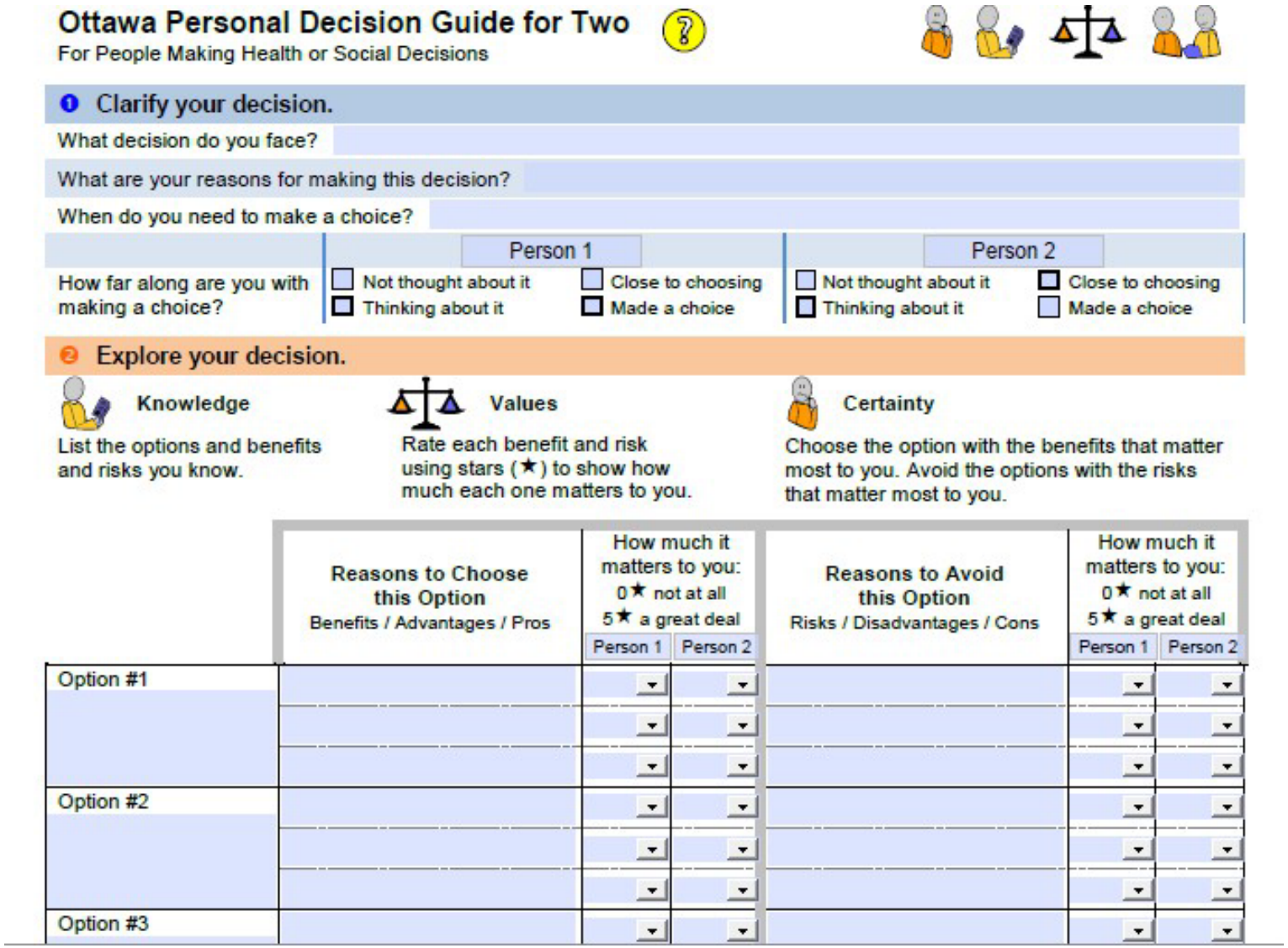
To enhance SDM **nurses** can:

- Explain information
- Provide support by listening to patient preferences
- Provide doctors with patient preferences

Decision coaching

(n=44 studies)

(Joseph-Williams et al 2014)



Ottawa Personal Decision Guide for Two

For People Making Health or Social Decisions

❶ Clarify your decision.

What decision do you face?

What are your reasons for making this decision?

When do you need to make a choice?

How far along are you with making a choice?	Person 1		Person 2	
	☐ Not thought about it	☐ Close to choosing	☐ Not thought about it	☐ Close to choosing
	☐ Thinking about it	☐ Made a choice	☐ Thinking about it	☐ Made a choice

❷ Explore your decision.

Knowledge

List the options and benefits and risks you know.

Values

Rate each benefit and risk using stars (★) to show how much each one matters to you.

Certainty

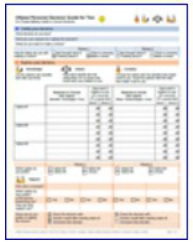
Choose the option with the benefits that matter most to you. Avoid the options with the risks that matter most to you.

	Reasons to Choose this Option Benefits / Advantages / Pros	How much it matters to you: 0★ not at all 5★ a great deal Person 1	Person 2	Reasons to Avoid this Option Risks / Disadvantages / Cons	How much it matters to you: 0★ not at all 5★ a great deal Person 1	Person 2
Option #1						
Option #2						
Option #3						

[Ottawa Personal Decision Guide]

(Two-page interactive PDF. Fill in, save your answers, and print [Adobe Reader].)

French	Spanish
Swedish	German
Dutch	Japanese
Danish	Mandarin Chinese
Norwegian	Sinhala
Canada - Indigenous	Polish



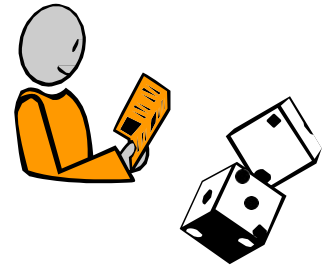
[Ottawa Personal Decision Guide for Two]

(Allows 2 people involved in the decision to complete the guide.

French	Danish
Swedish	Japanese

(O'Connor, Stacey, Jacobsen, 2015)

Patient Decision Aids

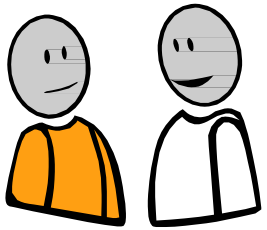


Inform

- Provide facts
  - Condition, options, benefits, harms
- Communicate probabilities (optional)

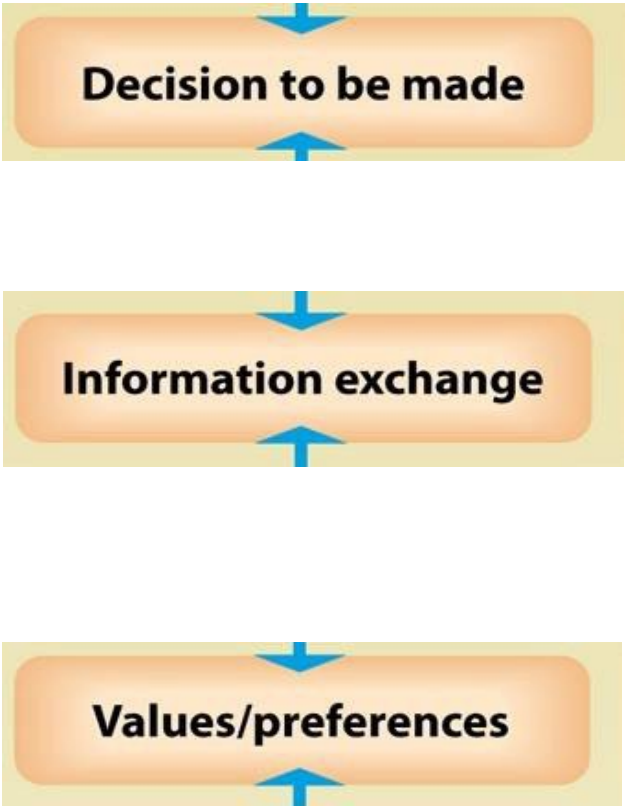
Clarify values

- Ask which benefits/harms matters most
- Patient experience (optional)



Support

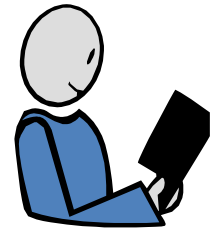
- Guide in steps in deliberation/communication
- Worksheets, list of questions



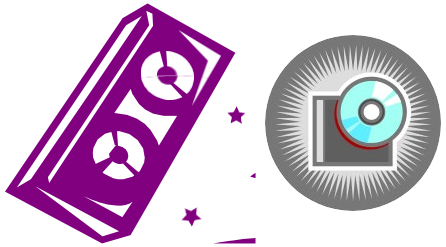
(Stacey et al., Cochrane Library, in press; Stacey et al., JAMA, 2017)

Formats for patient decision aids

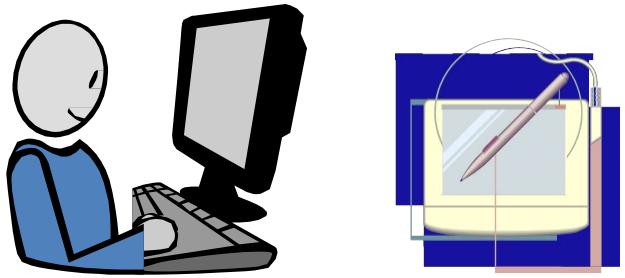
(used prior to or within consultations)



1. Print



2. Video



3. Online/computer-based

BMJ

Decision aids for patients facing health treatment or screening decisions: systematic review

Annette M O'Connor, Alaa Rostom, Valerie Fiset, Jacqueline Tetroe, Vikki Entwistle, Hilary Llewellyn-Thomas, Margaret Holmes-Rovner, Michael Barry and Jean Jones

BMJ 1999;319;731-734

Patient decision aids:

- improve knowledge
- reduce decisional conflict
- stimulate patients to be more active in decision making
- do not increase anxiety
- variable effect on decisions (chosen option)

Patient Decision Aids: Ensuring Quality

Patient decision aids can affect uptake of options

- reduce use of some options
- increase use of other options

Concern if uptake of options is due to biased information

Need for national/international standards on quality

(Elwyn et al., 2005; NQF Report 2016; Stacey et al., 2017)

Outline

- Shared decision making
- Patient story
- International Patient Decision Aid Standards (IPDAS)
- Evidence on patient decision aids
- Proposed changes to IPDAS
- Implementation of patient decision aids

INTERNATIONAL
PATIENT DECISION
AID STANDARDS
COLLABORATION

Since 2003

International Patient Decision Aid Standards (IPDAS)

Evidence Update 2.0 – Updating the Standards

INTERNATIONAL PATIENT DECISION AID STANDARDS COLLABORATION

To enhance the quality and effectiveness of patient decision aids by establishing a shared evidence-informed framework for improving their content, development, implementation, and evaluation.

IPDAS Steering Committee: D Stacey & R Volk (co-chairs), M Barry, H Bekker, N Col, A Coulter, K Dahl Steffensen, M Härter, T Hoffman, K McCaffery, M Pignone, K Sepucha, R Thompson, L Trevena, T van der Weijden, H Witteman

Stacey & Volk, Medical Decision Making volume 41(issue 7) October 2021
https://journals.sagepub.com/toc/mdma/41/7

IPDAS Timeline

2003

International Patient Decision Aid Standards (IPDAS) Collaboration launched

International Shared Decision Making Conference in Swansea, Wales. September 2003.

2005-2006

IPDAS Checklist published

Internationally approved criteria for determining the quality of patient decision aids. 74 criteria/items and 11 dimensions.

Evidence-informed consensus process involving more than **100 stakeholders** from **14 countries**.

2009

IPDAS Instrument published

Instrument for rating the quality of patient decision aids. 47 items.

Involved **25 research-members** of IPDAS.

2012-2013

Evidence Update 1.0 completed

Updated the conceptual, theoretical, and empirical evidence underlying the 12 dimensions for addressing the quality of patient decision aids.

92 stakeholders from **9 countries** contributed to the update.

2013

IPDAS Minimum Standards published

Includes 6 criteria for defining decision aids, 10 criteria for certifying decision aids (to minimize risk of bias), and 28 criteria for quality.

101 stakeholders from **16 countries** participated in consensus voting.

2017

SUNDAE Checklist published

Reporting standards for patient decision aid evaluation studies.

International group of **14 experts in patient decision aids**.

2020-2021

Evidence Update 2.0 completed

Updated the conceptual, theoretical, and empirical evidence informing the IPDAS Checklist and recommended changes to the IPDAS criteria.

Involved **105 stakeholders** from **11 countries**.

YEAR	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023

INTERNATIONAL PATIENT DECISION AID STANDARDS COLLABORATION

IPDAS Defining Criteria

1. describes the health condition or problem
2. explicitly states the decision that needs to be considered
3. identifies the target audience (Martin et al., 2021)
4. describes the options available
5. describes the positive features
6. describes the negative features
7. values clarification:
    a) describes what it is like to experience the consequences
    b) asks to rate importance

Joseph-Williams, et al., MDM. 2013 Aug 20. https://www.ncbi.nlm.nih.gov/pubmed/23963501

IPDAS Certifying Criteria to Minimize Risk of a Biased Decision

1. equal detail for negative/positive option features
2. citations to the evidence
3. production or publication date
4. update policy
5. information about uncertainty around probabilities
6. funding source used for development

For screening decision aids

7. describes what the test is designed to measure
8. next steps after positive test result
9. next steps after negative test result
10. consequences of detecting a benign condition

Joseph-Williams, et al., MDM. 2013 Aug 20. https://www.ncbi.nlm.nih.gov/pubmed/23963501

IPDAS Quality Criteria by Domains - Examples

Presenting balanced information about options

- Shows negative/positive features with equal detail

Guidance and decision coaching

- Provides step by step way to make a decision

Based information on scientific evidence

- Describes the quality of the scientific evidence

Conflicts of interest

- Includes authors'/developers' credentials or qualifications

Health literacy

- Written at a level that can be understood by at least half of the target patients

Presenting probabilities

- Presents probabilities using event rates in a defined group of patients for a specific time

Development of patient decision aids

- Patients were asked what they need to prepare them to discuss a specific decision

Effectiveness

- There is evidence that it helps patients know about the available options

Washington State Health Care Authority

Search

In a crisis? Login

Free or low-cost health care | Employee & retiree benefits | Billers, providers & partners | About HCA | Contact

Home > About HCA > Programs & initiatives > Making informed health care decisions > Shared decision making > Patient decision aids (PDAs)

Patient decision aids (PDAs)

Learn about patient decision aids: what they are and how to use them.

On this page

First certification program in the world (2016)

www.hca.wa.gov/about-hca/healthier-washington/patient-decision-aids-pdas

Patient Decision Aid Certification Criteria

Does the patient decision aid adequately:

1. Describe the health condition or problem
2. Explicitly state the decision under consideration
3. Identify the eligible or target audience
4. Describe the options available for the decision, including non-treatment
5. Describe the positive features of each option (benefits)
6. Describe the negative features of each option (harms, side effects, disadvantages)
7. Help patients clarify their values for outcomes of options by a) asking patients to consider or rate which positive and negative features matter most to them AND/OR b) describing each option to help patients imagine the physical, social (e.g. impact on personal, family, or work life), and/or psychological effects
8. Make it possible to compare features of available options
9. Show positive and negative features of options with balanced detail

https://decisionaid.ohri.ca

The Ottawa Hospital | L'Hôpital d'Ottawa
RESEARCH INSTITUTE | INSTITUT DE RECHERCHE

Patient Decision Aids

Search this site

Français

Decision Aid Summary

Title	**During the COVID-19 pandemic, should I go to live elsewhere or stay in my retirement/assisted living home? / Pendant la pandémie de COVID-19, dois-je aller vivre ailleurs ou rester dans ma maison de retraite ou ma résidence pour personne semi-autonome?**
Audience	Adults/seniors living in retirement home or assisted living home.
Options included	Move to live with family/friend. Stay in the retirement home or assisted living home.
Year of last update or review	2020
Format	Web, paper, PDF
How to obtain	Click here to view the decision aid on the developer website
Developer	D Stacey RN PhD, C Ludwig RN, PhD(c), J Lavoie MSW RSW, S Sinha MD DPhil FRCPC.
Where was it developed?	https://decisionaid.ohri.ca OHRI; uOttawa; NIA. Canada
Health condition	Assisted Living
Type of decision aid	Treatment
Language	English, French

Based on IPDAS criteria (International Patient Decision Aid Standards) this decision aid (and/or supporting materials)

7 out of 7 criteria to be defined as a patient decision aid

8 out of 8 criteria to lower the risk of making a biased decision

Outline

- Shared decision making
- Patient story
- International Patient Decision Aid Standards (IPDAS)
- Evidence on patient decision aids
  - ✓ Update the Cochrane Systematic Review on the effectiveness of patient decision aids
  - ✓ Conduct a network meta-analysis to determine contributions of elements in patient decision aids
- Proposed changes to IPDAS
- Implementation of patient decision aids

Patient Decision Aids Review Team

- Dawn Stacey (Ca)
- Krystina B Lewis (Ca)
- *Maureen Smith (Ca)
- Meg Carley (Ca)
- Robert Volk (USA)
- Elisa Douglas (USA)
- Lissa Pacheco-Brousseau (Ca)
- Jeanette Finderup (Dk)
- *Janet Gunderson (Ca)
- Michael Barry (USA)
- Carol L Bennett (CA)
- Paulina Bravo (Chile)
- Karina Dahl Steffensen (Dk)
- Amédé Gogovor (CA)
- Ian D Graham (Ca)
- Shannon E Kelly (Ca)
- France Légaré (Ca)
- *Henning Søndergaard (Dk)
- Richard Thomson (UK)
- Logan Trenaman (Ca)
- Lyndal Trevena (AU)

*Patient/Caregiver partners

PICO	Eligible	Ineligible
Population	Adults making decisions about screening or treatment options for themselves, a child, or an incapacitated significant other	Decisions: hypothetical, lifestyle, clinical trial entry, advance directives
Intervention	Patient decision aid for treatment or screening decisions	Education programmes not geared to a specific decision; interventions designed to promote adherence or elicit informed consent regarding a recommended option; inadequate detail
Comparison	Usual care or alternate intervention (e.g., general information, clinical practice guidelines, placebo interventions, no intervention)	2 different types of patient decision aids
Outcomes	Broad range (e.g., decision quality; decision making process; adverse events)	Anxiety and/or depression, quality of life, and/or litigation rates only
Study design	RCT only (including cluster RCTs)	All other designs
Language	All languages that can be translated	Unable to translate

Search Results (2015 – March 2022)

4775 + 9 citations

4784 title/abstract screen

4429 irrelevant

355 full-text screen

149 excluded
102 ongoing

104 + 105 = **209 trials**

Countries of the trials (n=209)

Conducted in 19 countries

USA (106)	Germany (8)	*France (2)	*New Zealand (1)
Canada (23)	China (7)	*Japan (2)	Sweden (1)
UK (21)	Spain (6)	*Greece (1)	*Switzerland (1)
Australia (17)	*Denmark (2)	*Italy (1)	*Turkey (1)
Netherlands (10)	Finland (2)	*Malaysia (1)	

*9 NEW countries not included in previous review

4 studies conducted in 2 countries (Au+CA; Swit+Germ; CA + USA; NZ+ USA)

Topics in Decision Aid Trials (N=209)

- Medical (n=82)
  - 22 Cardiovascular (e.g., atrial fibrillation, LVAD)
  - 10 Mental health (e.g., depression, anxiety)
  - 7 Diabetes
  - 4 Breast cancer chemoprevention
  - 4 Contraceptive options
  - 4 Kidney disease
  - 31 Other (e.g., osteoporosis, sleep apnea)
- Screening (n=59)
  - 17 Colorectal cancer
  - 15 Prostate cancer
  - 12 Breast cancer
  - 6 Prenatal testing
  - 3 Diabetes
  - 2 Cardiovascular
  - 4 Other (e.g., brain injury, cervical cancer)
- Surgery (n=50)
  - 15 Breast cancer (surgery, reconstruction, prophylactic)
  - 11 Prostate
  - 9 Knee and/or hip osteoarthritis
  - 3 Cardiovascular
  - 3 Hysterectomy
  - 9 Other (e.g., back surgery, dental)
- Obstetrics (n=11)
  - 5 birth options after cesarian
  - 6 other (e.g., embryo transfer, post-partum care)
- Vaccine (n=5)
  - Flu, Hep B, MMR, Rotavirus
- Other (n=2)
  - Autologous blood donation, Cystic fibrosis referral for transplant

Elements in Patient Decision Aids (N=209)

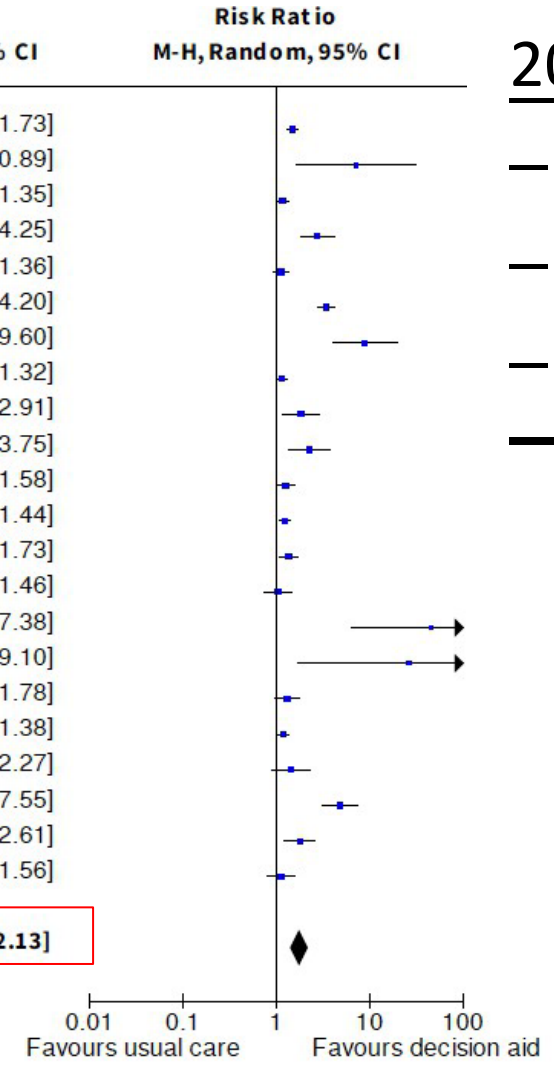
Total N=209	Elements	Previous review N=105	Updated review N=104	Change
100%	Options, outcomes, implicit or explicit values clarification*	100%	100%	⟷
92%	Clinical condition	90%	94%	↑
88%	Probabilities of benefits and harms	91%	84%	↓
73%	Guidance in decision making steps	67%	79%	↑
67%	Explicit values clarification	62%	72%	↑
37%	Examples of others/ patient stories	46%	29%	↓

*required to be defined as a patient decision aid

75% better informed values/choice match

Study or Subgroup	Decision Aid Events	Total	Comparison Events	Total	Weight	Risk Ratio M-H, Random, 95% CI
Mathieu 2007	227	309	136	279	5.8%	1.51 [1.31 , 1.73]
Trevena 2008	14	134	2	137	1.4%	7.16 [1.66 , 30.89]
Nagle 2008	127	167	111	171	5.8%	1.17 [1.02 , 1.35]
Smith 2010	121	357	21	172	4.7%	2.78 [1.81 , 4.25]
Mathieu 2010	65	91	70	110	5.7%	1.12 [0.93 , 1.36]
Steckelberg 2011	345	785	101	792	5.6%	3.45 [2.83 , 4.20]
Fagerlin 2011	202	383	6	102	3.1%	8.97 [4.10 , 19.60]
Bjorklund 2012	128	179	123	197	5.8%	1.15 [0.99 , 1.32]
Schwalm 2012	36	76	19	74	4.5%	1.84 [1.17 , 2.91]
Stacey 2014a	31	55	14	56	4.3%	2.25 [1.35 , 3.75]
Stacey 2016	87	155	69	155	5.6%	1.26 [1.01 , 1.58]
Beulen 2016	102	124	83	125	5.8%	1.24 [1.07 , 1.44]
Ickenroth 2016 (1)	96	224	76	241	5.5%	1.36 [1.07 , 1.73]
Ickenroth 2016 (2)	51	217	54	240	5.1%	1.04 [0.75 , 1.46]
Perez-Lacasta 2019	47	203	1	197	0.8%	45.61 [6.35 , 327.38]
Berger-Hoger 2019	18	31	0	22	0.5%	26.59 [1.69 , 419.10]
Singh 2019	62	151	46	147	5.2%	1.31 [0.97 , 1.78]
Roberto 2020	207	472	195	529	5.8%	1.19 [1.02 , 1.38]
Fisher 2020 (3)	22	40	17	44	4.5%	1.42 [0.89 , 2.27]
Ye 2021	107	386	22	387	4.6%	4.88 [3.15 , 7.55]
Crew 2022	48	117	31	135	4.9%	1.79 [1.22 , 2.61]
Zadro 2022	56	204	50	205	5.1%	1.13 [0.81 , 1.56]
Total (95% CI)		**4860**		**4517**	**100.0%**	**1.75 [1.44 , 2.13]**
Total events:	2199		1247			

Heterogeneity: Tau² = 0.17; Chi² = 248.91, df = 21 (P < 0.00001); I² = 92%
Test for overall effect: Z = 5.63 (P < 0.00001)
Test for subgroup differences: Not applicable



2023 Update

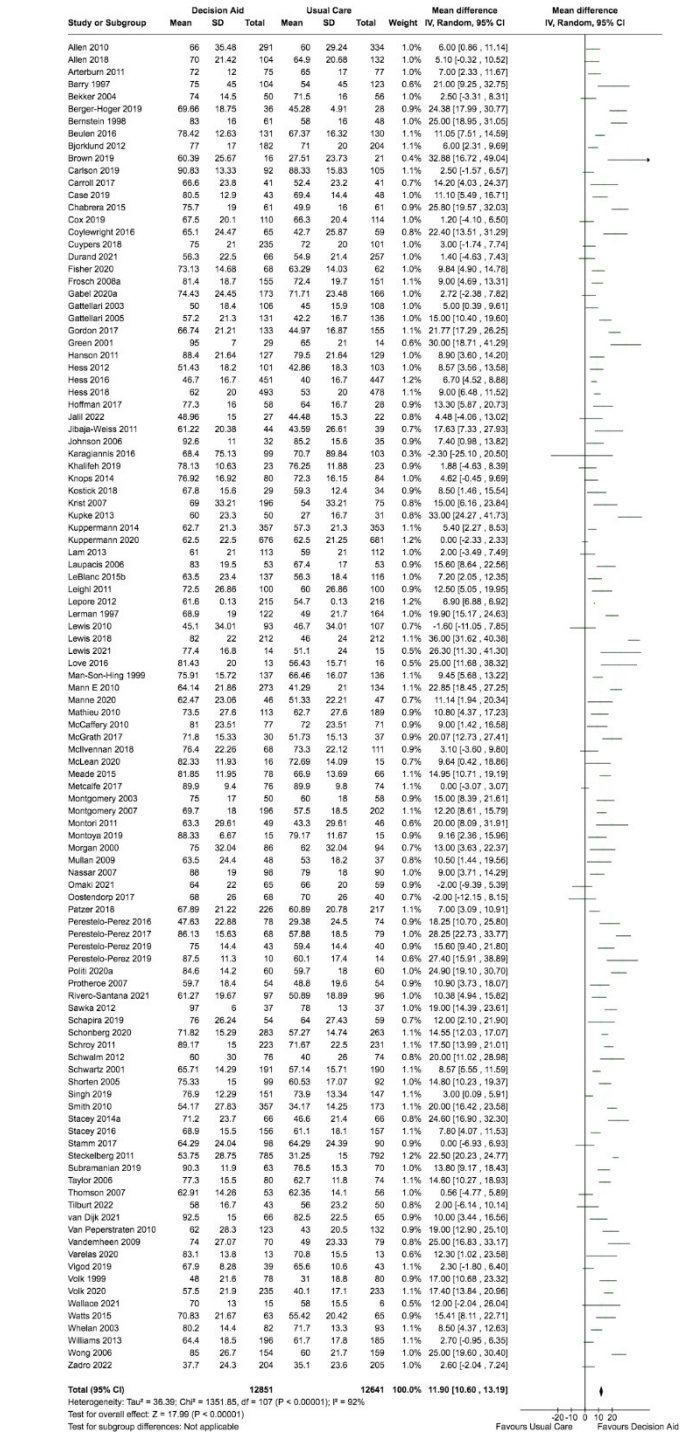
- 21 studies
- 9,377 participants
- Risk Ratio (RR) 1.75 [95% CI 1.44, 2.13]
- ⊕⊕⊕⊖Moderate confidence (GRADE)

2017 Review

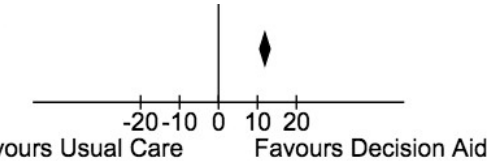
- 10 studies
- 4,626 participants
- RR 2.06 [95% CI 1.46, 2.91]
- ⊕⊖⊖⊖Low confidence

12% higher knowledge

- 2023 Update
  - 107 studies
  - 25,492 participants
  - Mean Difference (MD) 11.90 [95% CI 10.60 , 13.19]
  - ⨁⨁⨁⨁High confidence



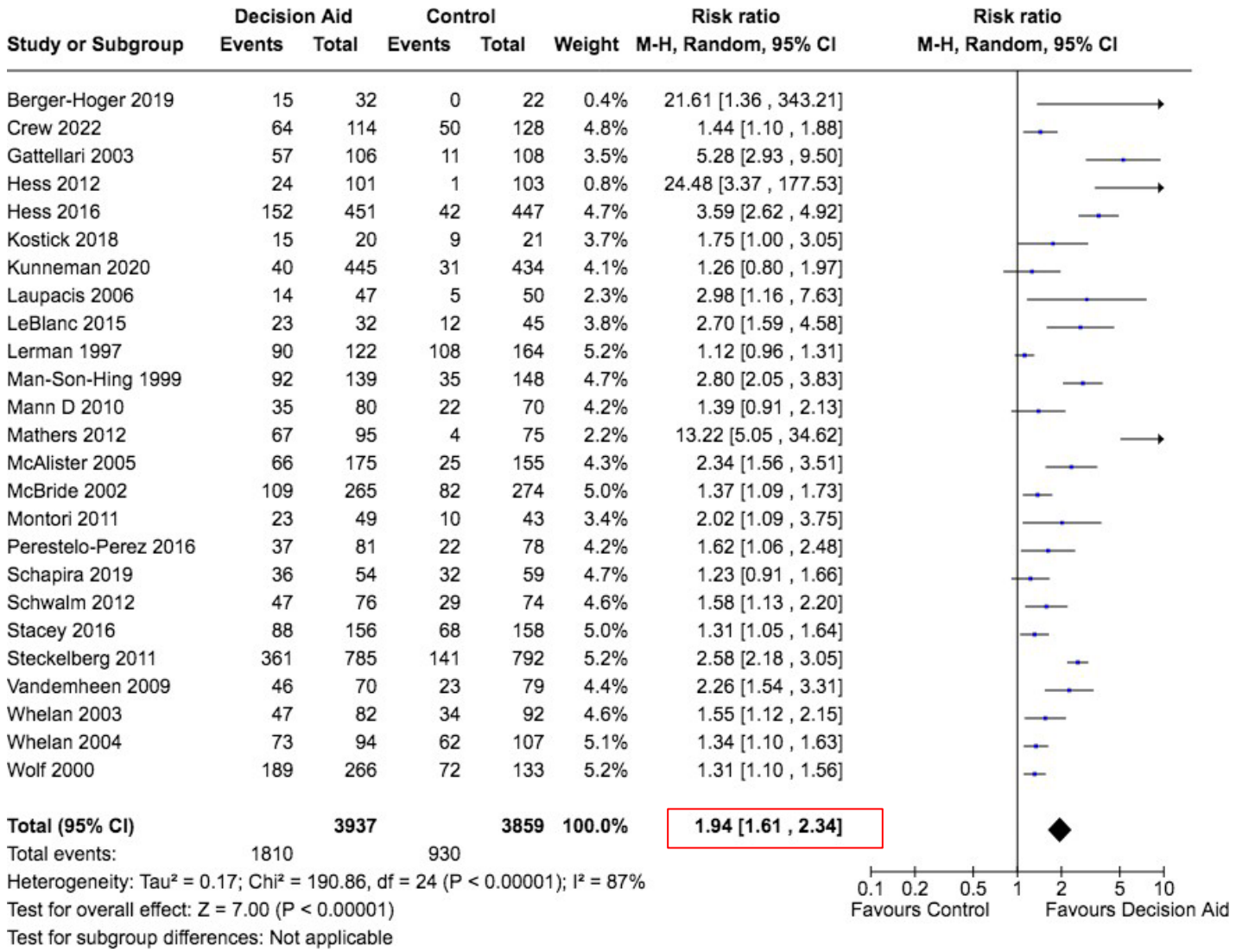
Total (95% CI) 12851 12641 100.0% 11.90 [10.60 , 13.19]
Heterogeneity: Tau² = 36.39; Chi² = 1351.85, df = 107 (P < 0.00001); I² = 92%
Test for overall effect: Z = 17.99 (P < 0.00001)
Test for subgroup differences: Not applicable



2017 Review

- 52 studies
- 13,316 participants
- MD 13.27 [95% CI 11.32, 15.23]
- ⨁⨁⨁⨁High confidence

94% more accurate risk perceptions



Study or Subgroup	Decision Aid Events	Decision Aid Total	Control Events	Control Total	Weight	Risk ratio M-H, Random, 95% CI
Berger-Hoger 2019	15	32	0	22	0.4%	21.61 [1.36 , 343.21]
Crew 2022	64	114	50	128	4.8%	1.44 [1.10 , 1.88]
Gattellari 2003	57	106	11	108	3.5%	5.28 [2.93 , 9.50]
Hess 2012	24	101	1	103	0.8%	24.48 [3.37 , 177.53]
Hess 2016	152	451	42	447	4.7%	3.59 [2.62 , 4.92]
Kostick 2018	15	20	9	21	3.7%	1.75 [1.00 , 3.05]
Kunneman 2020	40	445	31	434	4.1%	1.26 [0.80 , 1.97]
Laupacis 2006	14	47	5	50	2.3%	2.98 [1.16 , 7.63]
LeBlanc 2015	23	32	12	45	3.8%	2.70 [1.59 , 4.58]
Lerman 1997	90	122	108	164	5.2%	1.12 [0.96 , 1.31]
Man-Son-Hing 1999	92	139	35	148	4.7%	2.80 [2.05 , 3.83]
Mann D 2010	35	80	22	70	4.2%	1.39 [0.91 , 2.13]
Mathers 2012	67	95	4	75	2.2%	13.22 [5.05 , 34.62]
McAlister 2005	66	175	25	155	4.3%	2.34 [1.56 , 3.51]
McBride 2002	109	265	82	274	5.0%	1.37 [1.09 , 1.73]
Montori 2011	23	49	10	43	3.4%	2.02 [1.09 , 3.75]
Perestelo-Perez 2016	37	81	22	78	4.2%	1.62 [1.06 , 2.48]
Schapira 2019	36	54	32	59	4.7%	1.23 [0.91 , 1.66]
Schwalm 2012	47	76	29	74	4.6%	1.58 [1.13 , 2.20]
Stacey 2016	88	156	68	158	5.0%	1.31 [1.05 , 1.64]
Steckelberg 2011	361	785	141	792	5.2%	2.58 [2.18 , 3.05]
Vandemheen 2009	46	70	23	79	4.4%	2.26 [1.54 , 3.31]
Whelan 2003	47	82	34	92	4.6%	1.55 [1.12 , 2.15]
Whelan 2004	73	94	62	107	5.1%	1.34 [1.10 , 1.63]
Wolf 2000	189	266	72	133	5.2%	1.31 [1.10 , 1.56]
Total (95% CI)		**3937**		**3859**	**100.0%**	**1.94 [1.61 , 2.34]**
Total events:	1810		930			

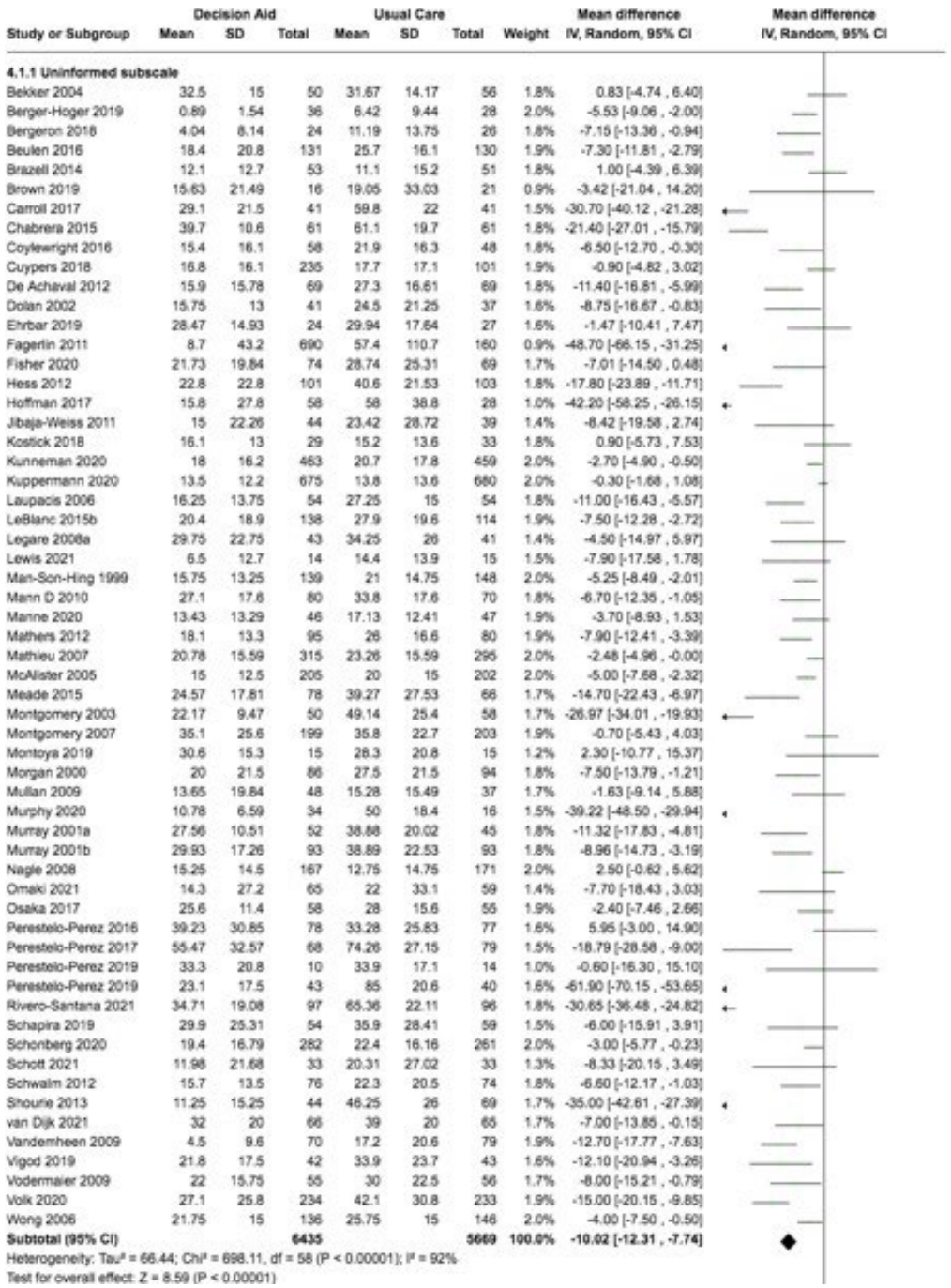
Heterogeneity: Tau² = 0.17; Chi² = 190.86, df = 24 (P < 0.00001); I² = 87%
Test for overall effect: Z = 7.00 (P < 0.00001)
Test for subgroup differences: Not applicable

2023 Update

- 25 studies
- 7,796 participants
- RR 1.94 [1.61, 2.34]
- ⨁⨁⨁⨁High confidence

2017 Review

- 17 studies
- 5,096 participants
- RR 2.10 [1.66, 2.66]
- ⨁⨁⨁⊖ Moderate confidence



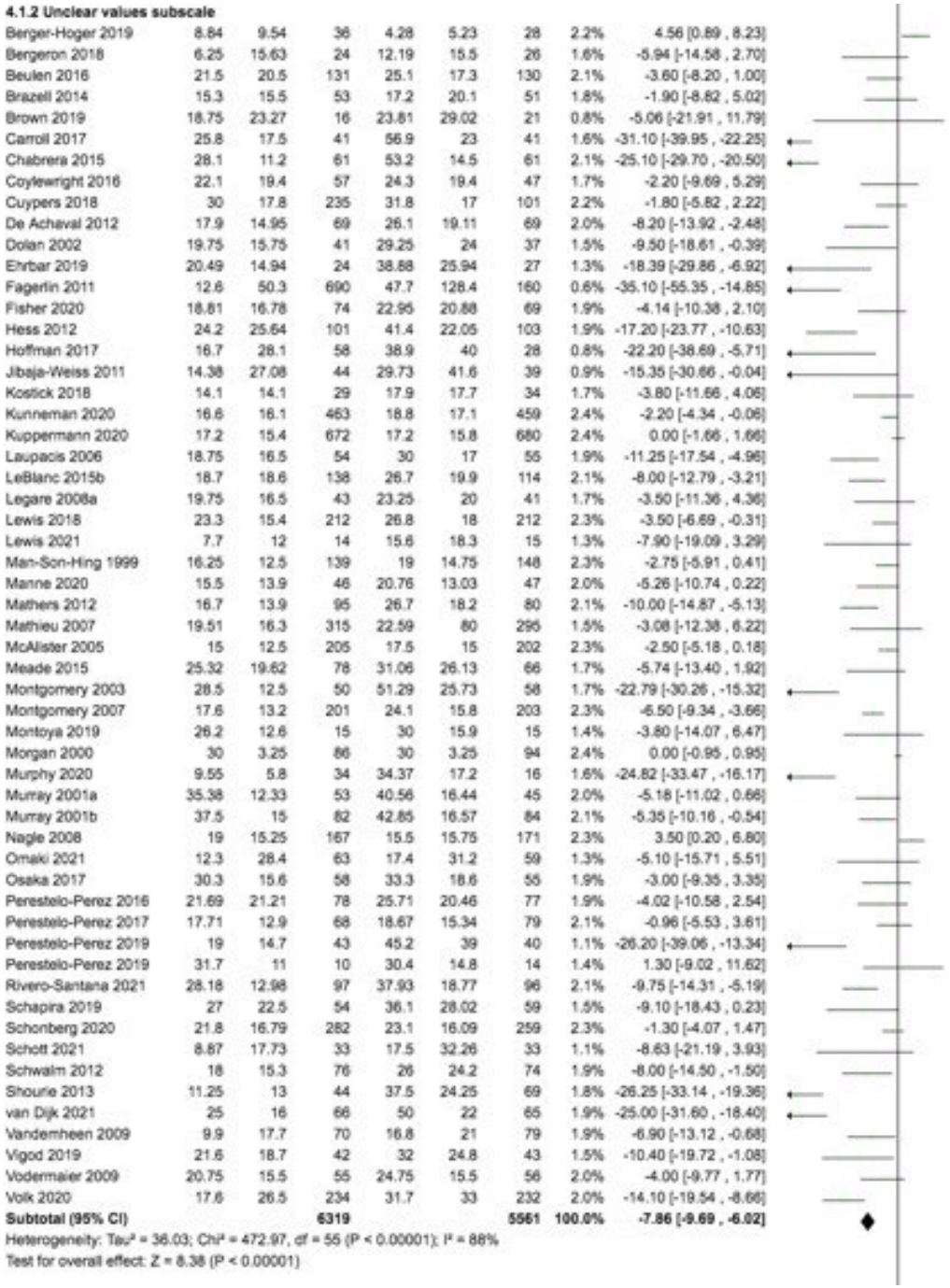
10% Feel less uninformed
(Decisional Conflict subscale)

<u>2023 Update</u>

- 58 studies
- 12,104 participants
- MD -10.02 [-12.31 , -7.74]
- ⊕⊕⊕⊕High confidence

<u>2017 Review</u>

- 27 studies
- 5,707 participants
- MD -9.28 [-12.20, -6.36]
- ⊕⊕⊕⊕High confidence



8% Feel less unclear values
(Decisional Conflict subscale)

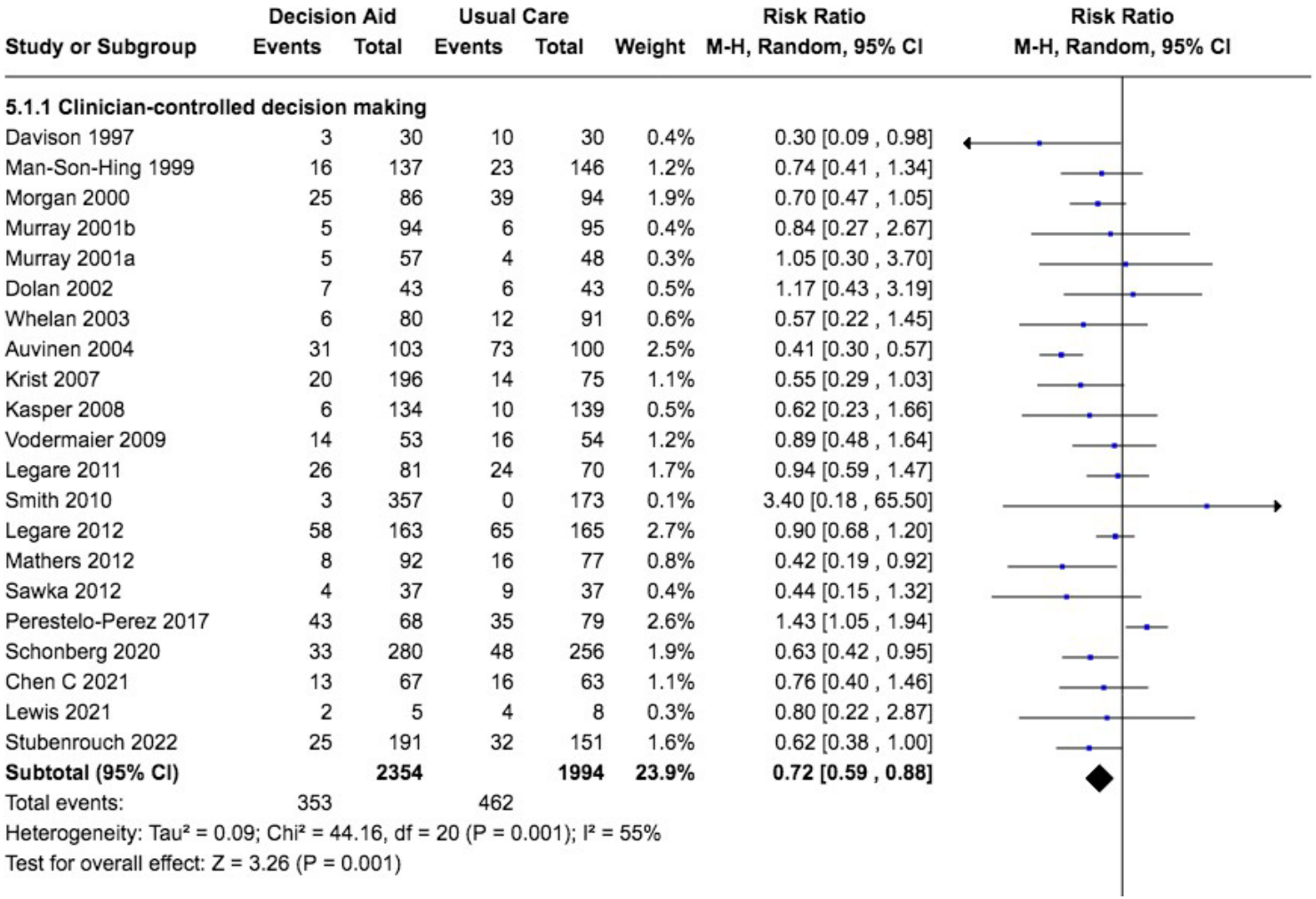
2023 Update

- 55 studies
- 11,880 participants
- MD -7.86 [-9.69 , -6.02]
- ⨁⨁⨁⨁High confidence

2017 Review

- 23 studies
- 5,068 participants
- MD -8.81 [-11.99, -5.63]
- ⨁⨁⨁⨁High confidence

28% Less clinician-controlled decision making



Study or Subgroup	Decision Aid Events	Decision Aid Total	Usual Care Events	Usual Care Total	Weight	Risk Ratio M-H, Random, 95% CI
5.1.1 Clinician-controlled decision making						
Davison 1997	3	30	10	30	0.4%	0.30 [0.09 , 0.98]
Man-Son-Hing 1999	16	137	23	146	1.2%	0.74 [0.41 , 1.34]
Morgan 2000	25	86	39	94	1.9%	0.70 [0.47 , 1.05]
Murray 2001b	5	94	6	95	0.4%	0.84 [0.27 , 2.67]
Murray 2001a	5	57	4	48	0.3%	1.05 [0.30 , 3.70]
Dolan 2002	7	43	6	43	0.5%	1.17 [0.43 , 3.19]
Whelan 2003	6	80	12	91	0.6%	0.57 [0.22 , 1.45]
Auvinen 2004	31	103	73	100	2.5%	0.41 [0.30 , 0.57]
Krist 2007	20	196	14	75	1.1%	0.55 [0.29 , 1.03]
Kasper 2008	6	134	10	139	0.5%	0.62 [0.23 , 1.66]
Vodermaier 2009	14	53	16	54	1.2%	0.89 [0.48 , 1.64]
Legare 2011	26	81	24	70	1.7%	0.94 [0.59 , 1.47]
Smith 2010	3	357	0	173	0.1%	3.40 [0.18 , 65.50]
Legare 2012	58	163	65	165	2.7%	0.90 [0.68 , 1.20]
Mathers 2012	8	92	16	77	0.8%	0.42 [0.19 , 0.92]
Sawka 2012	4	37	9	37	0.4%	0.44 [0.15 , 1.32]
Perestelo-Perez 2017	43	68	35	79	2.6%	1.43 [1.05 , 1.94]
Schonberg 2020	33	280	48	256	1.9%	0.63 [0.42 , 0.95]
Chen C 2021	13	67	16	63	1.1%	0.76 [0.40 , 1.46]
Lewis 2021	2	5	4	8	0.3%	0.80 [0.22 , 2.87]
Stubenrouch 2022	25	191	32	151	1.6%	0.62 [0.38 , 1.00]
Subtotal (95% CI)		**2354**		**1994**	**23.9%**	**0.72 [0.59 , 0.88]**
Total events:	353		462			

Heterogeneity: Tau² = 0.09; Chi² = 44.16, df = 20 (P = 0.001); I² = 55%

Test for overall effect: Z = 3.26 (P = 0.001)

2023 Update

- 21 studies
- 4,348 participants
- RR 0.72 [0.59, 0.88]
- ⨁⨁⨁⨁High confidence

2017 Review

- 16 studies
- 3,180 participants
- RR 0.68 [0.55, 0.83]
- ⨁⨁⨁⊖ Moderate confidence

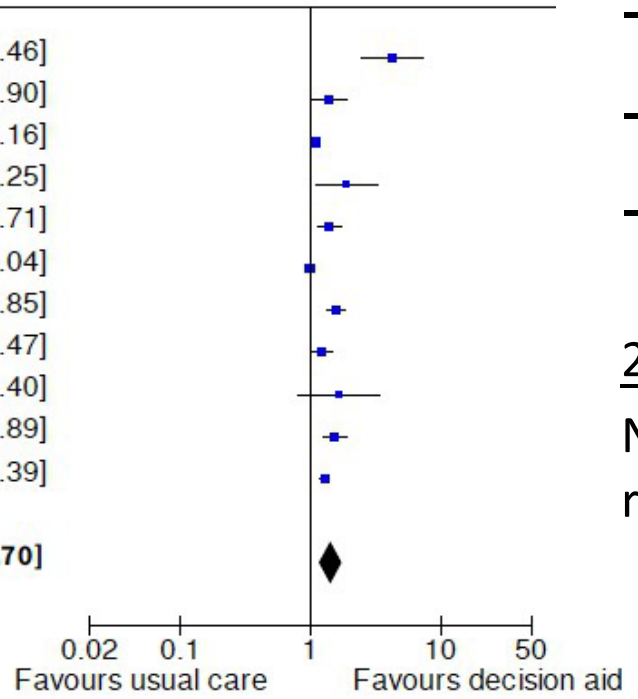
More discussed topic with their clinician

Study or Subgroup	Decision aid Events	Total	Usual care Events	Total	Weight	Risk Ratio M-H, Random, 95% CI
Fraenkel 2012	49	69	11	66	5.5%	4.26 [2.43 , 7.46]
Hanson 2011	58	126	42	127	8.7%	1.39 [1.02 , 1.90]
Ibrahim 2013	305	331	142	167	11.5%	1.08 [1.01 , 1.16]
Lepore 2012	34	215	18	216	5.7%	1.90 [1.11 , 3.25]
Lewis 2018	122	209	87	209	10.2%	1.40 [1.15 , 1.71]
Madden 2020	156	161	78	80	11.6%	0.99 [0.95 , 1.04]
Miller 2018	150	197	103	213	10.7%	1.57 [1.34 , 1.85]
Schonberg 2020	146	279	111	260	10.5%	1.23 [1.02 , 1.47]
Sheridan 2006	16	41	8	34	4.1%	1.66 [0.81 , 3.40]
Sheridan 2011	70	79	45	78	10.1%	1.54 [1.25 , 1.89]
Tebb 2021	285	320	301	436	11.4%	1.29 [1.20 , 1.39]
Total (95% CI)		**2027**		**1886**	**100.0%**	**1.42 [1.19 , 1.70]**
Total events:	1391		946			

Heterogeneity: $Tau^2 = 0.07$; $Chi^2 = 206.44$, df = 10 ($P < 0.00001$); $I^2 = 95\%$

Test for overall effect: Z = 3.81 (P = 0.0001)

Test for subgroup differences: Not applicable



2023 Update

- 11 studies
- 3,913 participants
- RR 1.42 [1.19, 1.70]

2017 Review

Not enough studies to pool results

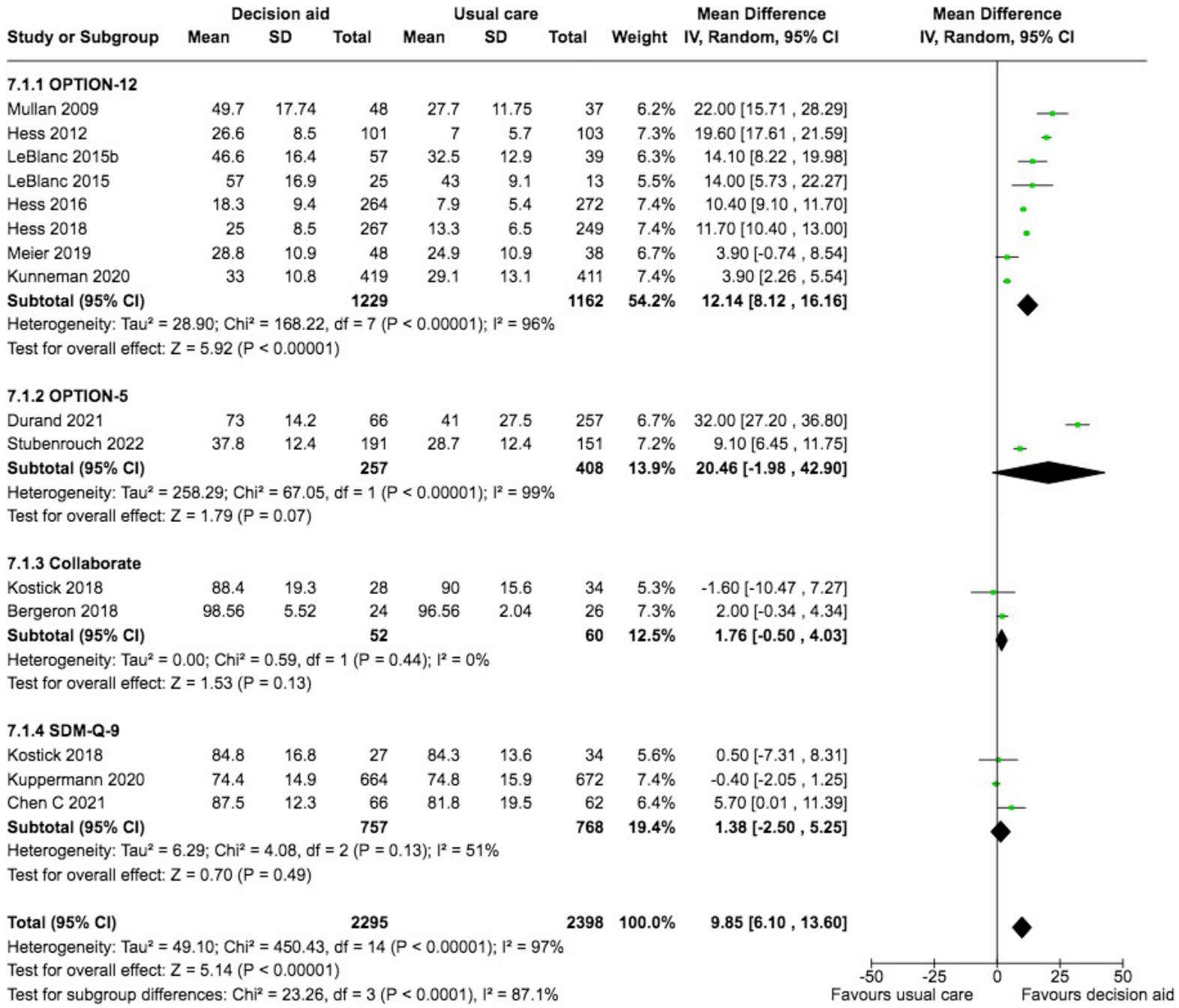
But variable for patient-clinician communication, based on measurement tool

2023 Update

- 8 used OPTION-12
- 2 used OPTION-5
- 2 used Collaborate
- 3 used SDM-Q9

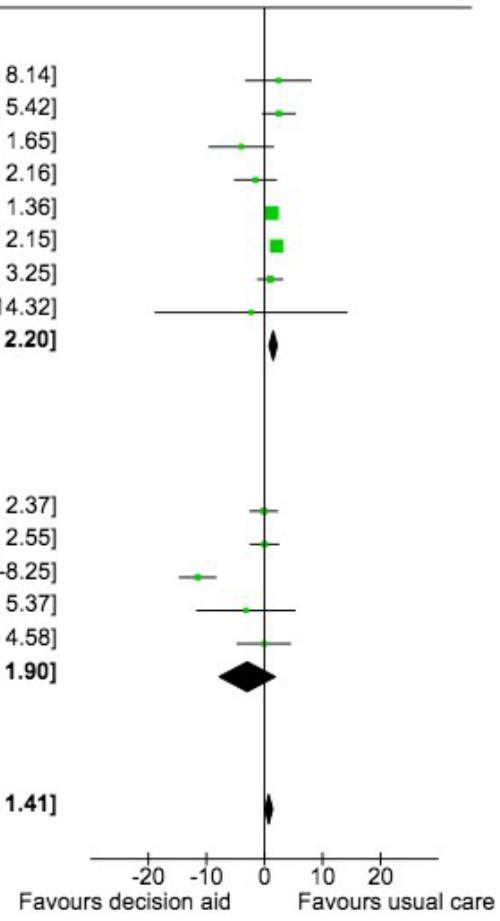
2017 Review

- Not enough studies to pool results



Consult time was variable based on when DA used

Study or Subgroup	Decision aid Mean	SD	Total	Usual care Mean	SD	Total	Weight	Mean Difference IV, Random, 95% CI
12.1.1 In consultation								
Ozanne 2007	24.3	7.5	15	21.9	8.51	15	1.3%	2.40 [-3.34 , 8.14]
Loh 2007	29.2	10.7	191	26.7	12.5	96	4.6%	2.50 [-0.42 , 5.42]
LeBlanc 2015b	44	22	158	48	27	139	1.4%	-4.00 [-9.65 , 1.65]
Perestelo-Perez 2016	18.1	8.07	61	19.65	12.61	63	3.0%	-1.55 [-5.26 , 2.16]
Hess 2016	4.4	0.4	264	3.1	0.29	272	32.0%	1.30 [1.24 , 1.36]
Hess 2018	7.6	0.4	267	5.5	0.2	249	32.0%	2.10 [2.05 , 2.15]
Kunneman 2020	32	16	419	31	17	411	7.1%	1.00 [-1.25 , 3.25]
Tilburt 2022	56.7	20.23	32	59	54.37	50	0.2%	-2.30 [-18.92 , 14.32]
Subtotal (95% CI)			**1407**			**1295**	**81.7%**	**1.50 [0.79 , 2.20]**
Heterogeneity: Tau² = 0.32; Chi² = 389.98, df = 7 (P < 0.00001); I² = 98%								
Test for overall effect: Z = 4.16 (P < 0.0001)								
12.1.2 In preparation for consultation								
Bozic 2013	20.9	6.8	61	21	7.2	62	6.1%	-0.10 [-2.57 , 2.37]
Wilkens 2019	11	6.7	45	11	5.6	45	5.8%	0.00 [-2.55 , 2.55]
Berger-Hoger 2019	12.8	6.6	34	24.3	6.3	27	3.8%	-11.50 [-14.75 , -8.25]
Varelas 2020	47.8	13.7	13	51	7.8	13	0.6%	-3.20 [-11.77 , 5.37]
Politi 2020a	29.9	12.4	60	30	13.7	60	2.0%	-0.10 [-4.78 , 4.58]
Subtotal (95% CI)			**213**			**207**	**18.3%**	**-2.97 [-7.84 , 1.90]**
Heterogeneity: Tau² = 25.84; Chi² = 37.78, df = 4 (P < 0.00001); I² = 89%								
Test for overall effect: Z = 1.19 (P = 0.23)								
Total (95% CI)			**1620**			**1502**	**100.0%**	**0.73 [0.05 , 1.41]**
Heterogeneity: Tau² = 0.37; Chi² = 459.40, df = 12 (P < 0.00001); I² = 97%								
Test for overall effect: Z = 2.12 (P = 0.03)								
Test for subgroup differences: Chi² = 3.16, df = 1 (P = 0.08), I² = 68.3%								



2023 Update

8 used DA during consult

- 2,702 participants
- MD 1.50 [0.79, 2.20]

5 used DA in prep for consult

- 420 participants
- MD -2.97 [-7.84, 1.90]

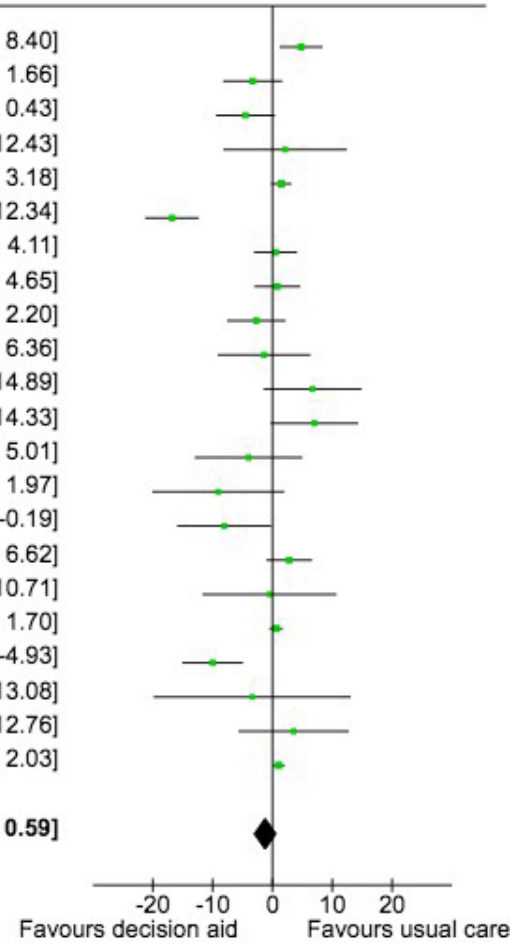
2017 Review

Not enough studies to pool results

No difference in decision regret

Study or Subgroup	Decision aid Mean	SD	Total	Usual care Mean	SD	Total	Weight	Mean Difference IV, Random, 95% CI
Legare 2012	12.38	19.08	162	7.59	13.67	164	6.2%	4.79 [1.18 , 8.40]
van Tol-Geerdink 2013	16.1	16.2	140	19.4	16.6	61	5.1%	-3.30 [-8.26 , 1.66]
Lam 2013	20.1	14.5	88	24.6	18.8	90	5.1%	-4.50 [-9.43 , 0.43]
Brazell 2014	12.1	18.5	28	10	20.1	26	2.3%	2.10 [-8.23 , 12.43]
Kuppermann 2014	8.29	12.5	357	6.83	10.8	353	7.7%	1.46 [-0.26 , 3.18]
Luan 2016	3.8	3.8	8	20.6	5.2	8	5.5%	-16.80 [-21.26 , -12.34]
Beulen 2016	14.5	14.3	131	14	15.4	130	6.2%	0.50 [-3.11 , 4.11]
Cuypers 2018	13.5	16.9	207	12.7	15.4	96	6.0%	0.80 [-3.05 , 4.65]
Berry 2018	14.38	16.32	97	17.07	19.04	104	5.2%	-2.69 [-7.58 , 2.20]
Kostick 2018	11.5	13.3	26	12.9	16.6	31	3.3%	-1.40 [-9.16 , 6.36]
McIlvennan 2018	17.1	23.9	50	10.4	21.73	78	3.1%	6.70 [-1.49 , 14.89]
Allen 2018	19.1	30.2	104	12.1	26.2	132	3.5%	7.00 [-0.33 , 14.33]
Wilkens 2019	23	22.14	45	27	21.47	45	2.7%	-4.00 [-13.01 , 5.01]
Ehrbar 2019	12.94	13.24	17	22	20.67	20	2.0%	-9.06 [-20.09 , 1.97]
Fisher 2020	17.05	14.68	44	25.11	22.95	47	3.2%	-8.06 [-15.93 , -0.19]
Durand 2021	10.4	14.1	66	7.6	14.3	257	6.0%	2.80 [-1.02 , 6.62]
Wyld 2021	11.2	14.5	13	11.7	12.2	9	2.0%	-0.50 [-11.71 , 10.71]
Wang 2021	18.8	3.6	75	18.21	3.3	75	8.0%	0.59 [-0.52 , 1.70]
Kleiss 2021	8	13	52	18	13	49	5.0%	-10.00 [-15.07 , -4.93]
Wallace 2021	15.6	11.8	15	19	19.2	6	1.1%	-3.40 [-19.88 , 13.08]
Rivero-Santana 2021	23.54	19.25	24	20	13.19	26	2.6%	3.54 [-5.68 , 12.76]
Lin 2022	7.46	3.8	76	6.44	2.42	75	8.0%	1.02 [0.01 , 2.03]
Total (95% CI)			**1825**			**1882**	**100.0%**	**-1.23 [-3.05 , 0.59]**

Heterogeneity: Tau² = 10.42; Chi² = 105.47, df = 21 (P < 0.00001); I² = 80%
Test for overall effect: Z = 1.33 (P = 0.18)
Test for subgroup differences: Not applicable



2023 Update

- 22 studies
- 3,707 participants
- MD -1.23 [-3.05, 0.59]

2017 Review

Not enough studies to pool results

Costs: 3 of 8 trials showed savings $

- NEW: Shourie 2013/Tubeuf 2014 - MMR vaccination
  - DA has 72% chance of being cost-effective compared to 8% chance for usual care
- NEW: Stacey 2016/Trenaman 2020 - hip or knee arthroplasty for osteoarthritis
  - No difference in mean per-patient costs
- Kennedy 2002 - hysterectomy
  - ↓ invasive surgical procedures resulting in PtDA with nurse coaching having lowest mean cost compared to DA alone or usual care
- van Peperstraten 2010 – IVF
  - Saved $219.12 per patient in decision aid group compared to usual care
- Montgomery 2007/Hollinghurst 2010
  - No difference in costs for decision about delivery mode after cesarean
- Murray 2001a, 2001b – HRT use, prostatectomy
  - No difference in health service resource use; higher cost with expensive interactive videodisc PtDA but if substitute lower cost internet access, no diff
- Vuorma 2003 - hysterectomy
  - No difference in health service resource use; no difference between PtDA and usual care for treatment costs and productivity loss

Primary Outcomes	1999 (N=17)		2014 (N=115)		2017 (N=105)		2024 (N=209)	
	Number of trials	Effect	Number of trials	Effect	Number of trials	Effect	Number of trials	Effect
Decision quality – informed values-based choice	0	--	13	+51% ⊕⊕⊖⊖	10	+106% ⊕⊕⊖⊖	21	+75% ⊕⊕⊕⊖
Knowledge of options, benefits, harms	4	+20%	42	+13% ⊕⊕⊕⊕	52	+13% ⊕⊕⊕⊕	107	+12% ⊕⊕⊕⊕
Realistic expectations of outcomes	1	n/s	19	+82% ⊕⊕⊕⊖	17	+110% ⊕⊕⊕⊖	25	+94% ⊕⊕⊕⊕
Feeling uninformed (decisional conflict subscale)	2	2+	22	-7% ⊕⊕⊕⊕	27	-9% ⊕⊕⊕⊕	58	-10% ⊕⊕⊕⊕
Feeling unclear values (decisional conflict subscale)	2	1 of 2+	18	-6% ⊕⊕⊕⊕	23	-9% ⊕⊕⊕⊕	55	-8% ⊕⊕⊕⊕
Undecided about which option	0	--	18	-41%	22	-36%	42	-32%
Clinician controlled decision making	2	n/s	14	-34% ⊕⊕⊕⊖	16	-32% ⊕⊕⊕⊖	21	-28% ⊕⊕⊕⊕

GRADE certainty ratings: ⊕⊕⊕⊕high; ⊕⊕⊕⊖moderate; ⊕⊕⊖⊖low; ⊕⊖⊖⊖very low for 2014 to 2024

n/s not statistically significant

Outline

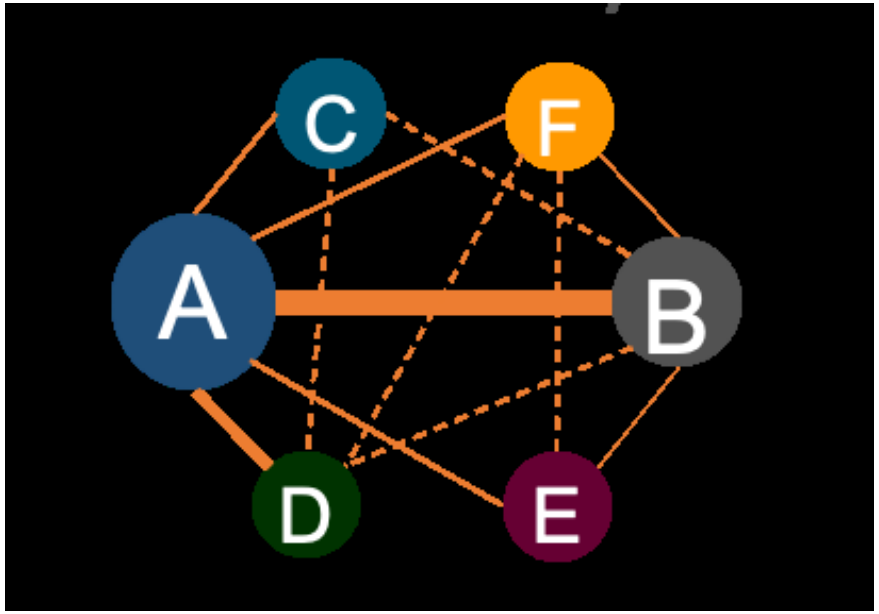
- Shared decision making
- Patient story
- International Patient Decision Aid Standards (IPDAS)
- Evidence on patient decision aids
  - ✓ Update the Cochrane Systematic Review to determine the effectiveness of patient decision aids
  - ✓ Conduct a network meta-analysis to determine contributions of elements in patient decision aids
- Proposed changes to IPDAS
- Implementation of patient decision aids

Elements in Patient Decision Aids (N=209)

Total N=209	Elements
100%	Options, outcomes, implicit or explicit values clarification*
88%	Probabilities of benefits and harms
73%	Guidance in decision making steps
67%	Explicit values clarification
37%	Examples of others/ patient stories

*required to be defined as a patient decision aid

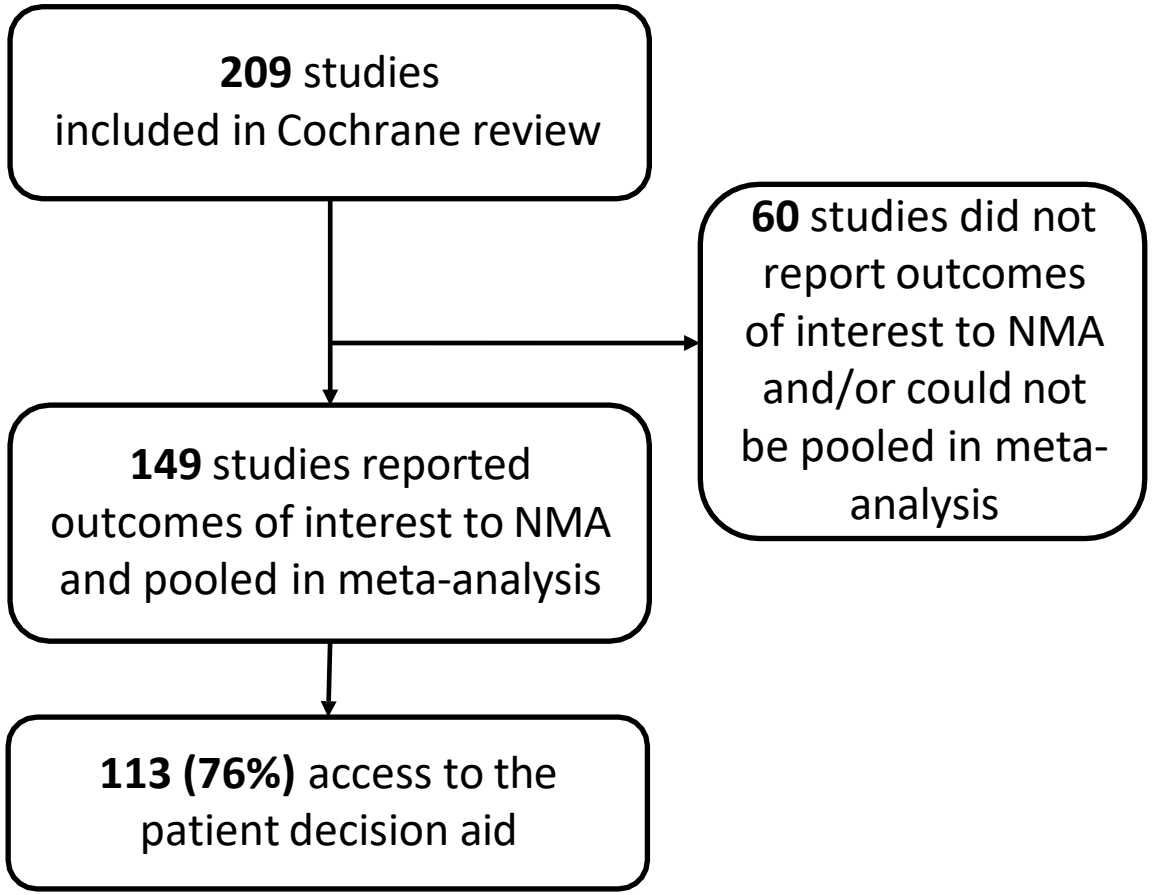
Meta-analysis versus network meta-analysis



Network Meta-analysis Outcomes and Data Source

Does [element] in PtDAs have an effect on:

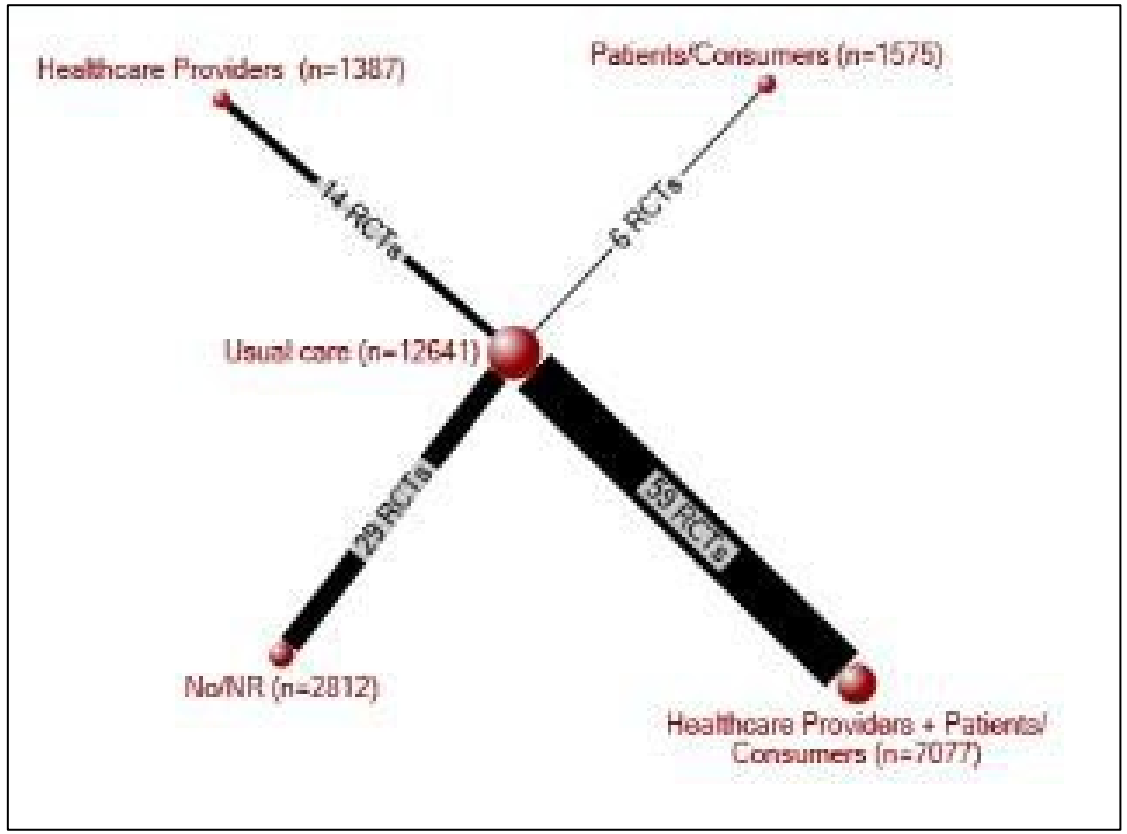
- knowledge
- decisional conflict (uninformed, unclear values)
- realistic expectations
- match between values and choice
- undecided



Network Meta-analysis Questions

- Does …
  - user involvement in development of patient decision aids:
    - none
    - pt involvement
    - healthcare team involvement
    - patient+healthcare team involvement
- have an effect on:
  - knowledge, decisional conflict, realistic expectations, match between values and choice, undecided?

User Involvement in Patient Decision Aid Development



Compared to usual care, patient decision aids with/without users involved was better for all 6 outcomes.

Compared to healthcare providers alone, higher patients' knowledge if:

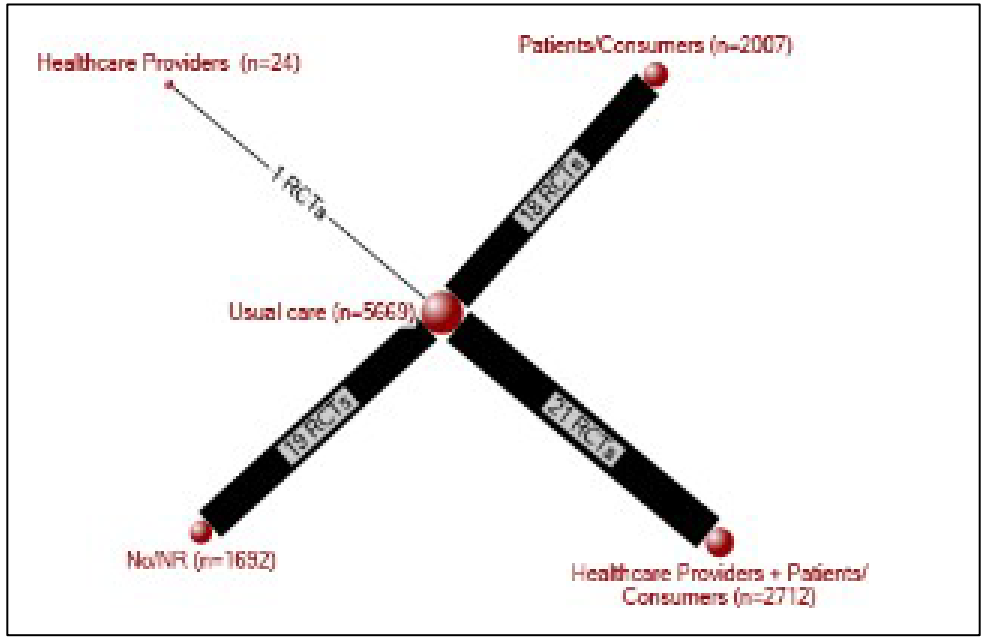
- patients involved (7%)
- patient & healthcare providers involved (4%)
- no knowledge users (4%)

No difference for other outcomes

Network Meta-analysis Questions

- Does …
  - user involvement in testing patient decision aids (prior to RCT)
    - none
    - pt involvement
    - healthcare team involvement
    - patient+healthcare team involvement
- have an effect on:
  - knowledge, decisional conflict, realistic expectations, match between values and choice, undecided?

User Involvement in Patient Decision Aid Testing



Compared to usual care, patient decision aid with patients involved in testing better for all 6 outcomes.

Compared to healthcare providers alone (-1%), fewer felt uninformed if:

- patients involved
- patient & healthcare providers involved
- no knowledge users

No difference for other outcomes

Which type of values clarification is most effective?

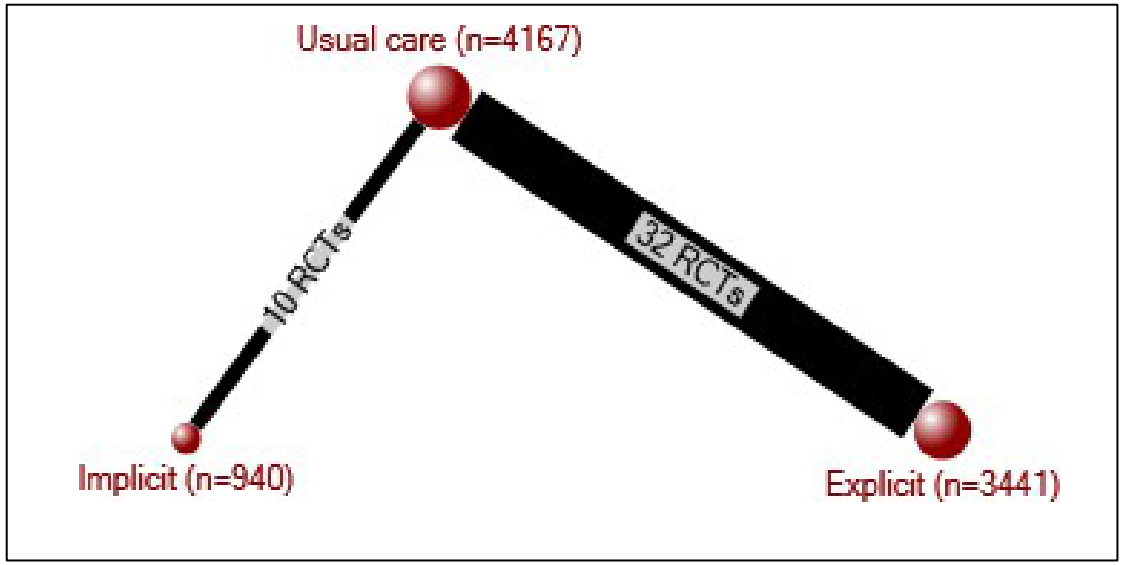
Explicit vs Implicit methods

- Explicit 101 (68%)
- Implicit 48 (32%)

Explicit type →

- 62 Rating scale
- 16 Important pros and cons
- 5 Open discussion
- 4 Decision analysis
- 3 Ranking
- 2 Social matching
- 1 Adaptive conjoint analysis
- 1 Analytical hierarchy process
- 1 Multi-attribute value model
- 1 Rating scale + Pros and Cons
- 1 Rating scale + Ranking
- 1 Time tradeoff + Rating scales
- 3 Unable to classify (no access to DA)

Values clarification in Patient Decision Aids



Compared to usual care, explicit or implicit values clarification was significantly better for all outcomes

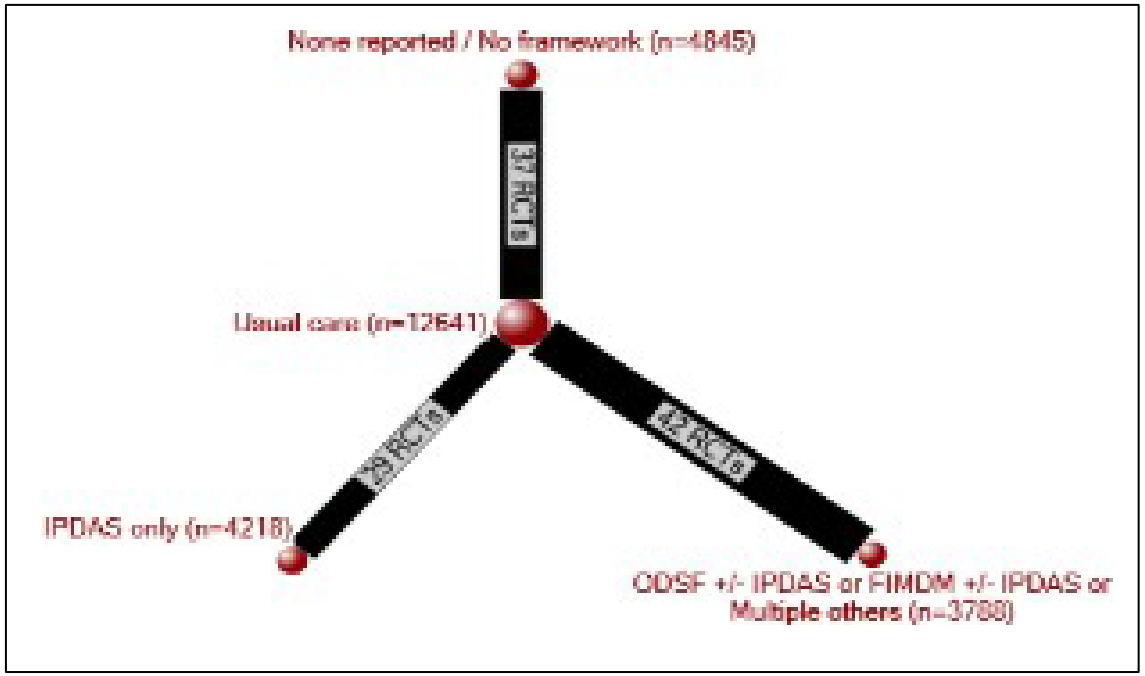
Implicit values clarification had significant reduction in passive decision making (RR 0.57; -43%) compared to explicit values clarification

No difference for other outcomes

Network Meta-analysis Questions

- Which theoretical framework(s) for developing patient decision aids are most effective:
  - IPDAS
  - Other frameworks (e.g., Ottawa Decision Support Framework, Foundation for Informed Medical Decision Making (FIMDM), Edutainment theory, OPTION grid)
- Does … in PtDAs have an effect on: knowledge, decisional conflict, realistic expectations, match between values and choice, undecided?

Frameworks to develop Patient Decision Aids



Compared to usual care, patient decision aid with/without framework better for all 6 outcomes.

Compared to IPDAS alone, higher patients' knowledge (MD 4%) if other framework used.

No difference for other outcomes

Elements to reduce cognitive demand

- What elements in patient decision aids to reduce cognitive demand are most effective?
  - possible to compare positive/negative features of options side by side
    - No significant difference for all outcomes
  - providing a step-by-step way to make a decision
    - No significant difference for all outcomes
  - Worksheets
    - Patient decision aid without worksheet significantly reduced passive decision making compared to those with worksheets
    - No other significant differences were found

Ways to present probabilities

- What ways to present probabilities in patient decision aids are most effective?
  - Probabilities significantly increased participants' knowledge compared to patient decision aid without probabilities (no diff for other outcomes)
  - Numbers better than using pictures and numbers for reducing feeling uninformed
  - Pictures better than numbers only or numbers + pictures for feeling unclear values
  - Using pictograms improved accurate risk perceptions compared to not using them (RR 1.38) but more felt uninformed
  - Stick figures or smiley faces are better than dots/circles for reducing decisional conflict related to feeling uninformed and unclear values
  - Smiley faces or dots/circles are better than stick figures for improving knowledge
  - Risk calculator resulted in lower knowledge
  - No difference for tailored probabilities on outcomes

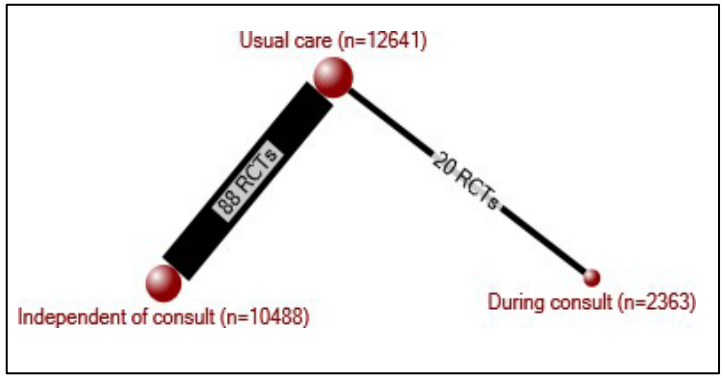
Elements to enhance health literacy

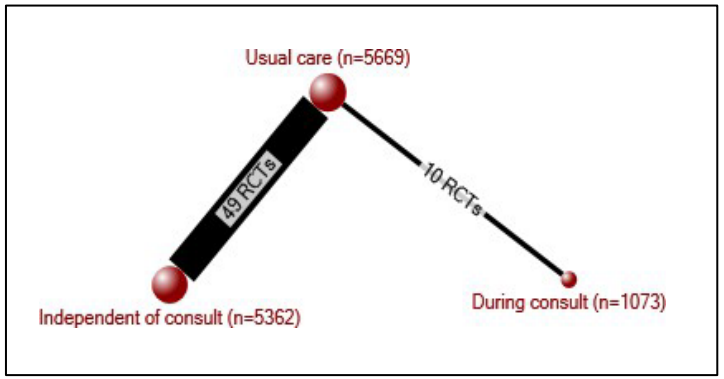
- What ways to enhance health literacy in patient decision aids are most effective?
  - Health literacy expert on the team
    - No significant difference for all outcomes
  - Specifying readability level
    - No significant difference for all outcomes
  - Use of media – pictures only, video + audio, pictures + audio
    - Mixed results

Elements to enhance communications

- What ways to enhance communications are most effective?
  - Lists of questions in the patient decision aid
    - No significant difference for all outcomes
  - Encourage discussion in the patient decision aid
    - No significant difference for all outcomes(except feeling uninformed better if not used)
  - Personal summary
    - Mixed results
    - Worksheet was better than an automated summary for improving knowledge and accuracy of risk perceptions

Timing of patient decision aid use





Use of patient decision aids in preparation for the consult was better than during the consult for:

- Increased patients' knowledge (MD 4)
- Reduced feeling uninformed (MD -5)
- No significant difference for other outcomes

Outline

- Shared decision making
- Patient story
- International Patient Decision Aid Standards (IPDAS)
- Evidence on patient decision aids
- Proposed changes to IPDAS
- Implementation of patient decision aids

The IPDAS Quality Framework for Patient Decision Aids

Qualifying Criteria	Essential Criteria	Enhancing Criteria
Is it a patient decision aid?	*Is it a high-quality decision aid? Does it employ strategies to reduce harmful bias?*	*What additional strategies might be used to further enhance the quality of the aid?*
These criteria are mandatory. A tool would not be considered a patient decision aid unless <u>all</u> these criteria are met.	These criteria are deemed essential in order to reduce harmful bias to patients in making decisions. Decision aids must meet all the essential criteria.	These criteria are desirable because they may enhance the decision aid, but are not seen as essential for reducing the risk of harmful bias. They would improve the experience of using the decision aid, but absence of the item would not be expected to influence the individual's decision in a negative way.

Proposed Changes to IPDAS Criteria from Evidence Update 2.0

	New Criteria	Changes to Current Criteria
Qualifying Criteria	1	~1
Everything else	~23	6

31 new/changes for voting

Proposed changes to qualifying criteria

Original criteria	Proposed revised criteria
No Change	
1.1 The patient decision aid describes the health condition	n/a
1.2 The patient decision aid explicitly states decision to be considered	n/a
1.3 The patient decision aid describes positive features of options (benefits)	n/a
1.4 The patient decision aid describes negative features of options (harms)	n/a
1.5a The patient decision aid asks patients to think about which positive and negative features of the options matter most to them OR describes what it is like to experience the consequences of the options (physical, psychological, social)	n/a
Revised (voting required)	
1.6a The patient decision aid lists the healthcare options (**Qualifying**) The patient decision aid lists the option of doing nothing (**Enhancing**)	1.6b The patient decision aid list the options including "wait and see" (e.g., making no change), if relevant (**Qualifying**)
Newly proposed qualifying criteria (voting required)	
1.7a The patient decision aid identifies the target audience (**Enhancing**)	1.7b The patient decision aid identifies the target audience (**Qualifying**)

Newly Proposed Qualifying Criteria					
How much do you agree or disagree that the following criterion is required for the tool to be considered a patient decision aid?					
1.7b The patient decision aid identifies the target audience.					
☐ strongly agree	☐ agree	☐ neutral	☐ disagree	☐ strongly disagree	☐ I don't know
Rationale for including the criterion: *This criterion was part of the IPDAS standards under communicating probabilities of outcomes. The proposal is to move this criterion to the **qualifying** category because it is used for knowing who should use the decision aid and for interpreting information (including probabilities) in decision aids.*					
Open comments:					

Next Steps: IPDAS Consensus Process

- Voting document was reviewed by domain teams
- Voting document review by the IPDAS Steering Committee - January
- Invitation to vote on proposed changes – February 2024
  - Eligible participants need to have some knowledge of PDAs
  - Those interested in participating will be sent the link to the survey

Outline

- Shared decision making
- Patient story
- International Patient Decision Aid Standards (IPDAS)
- Evidence on patient decision aids
- Proposed changes to IPDAS
- Implementation of patient decision aids

Original Article

MDM
Medical Decision Making

Medical Decision Making
2019, Vol. 39(7) 805–815

DOI: 10.1177/0272989X19868193
journals.sagepub.com/home/mdm
SAGE

Are Patient Decision Aids Used in Clinical Practice after Rigorous Evaluation? A Survey of Trial Authors

Dawn Stacey, Victoria Suwalska, Laura Boland,
Krystina B. Lewis, Justin Presseau, and Richard Thomson

Findings:

- 92.5% response rate
- 26.9% patient decision aids were implemented post RCT
- Barriers:
  - Lack of post trial plan
  - Outdated decision aids
  - Clinicians disagreed with use
  - Infrastructure support/funding

Facilitators:
- web-based delivery
- endorsed by government, organizations
- designed for care process

(Stacey et al., 2019)

Original Article

MDM Medical Decision Making

Medical Decision Making
1–31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DOI: 10.1177/0272989X20978208
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What Works in Implementing Patient Decision Aids in Routine Clinical Settings? A Rapid Realist Review and Update from the International Patient Decision Aid Standards Collaboration

IPDAS
INTERNATIONAL PATIENT DECISION AID STANDARDS COLLABORATION

Recommended Implementation strategies:

- Co-production of PtDA content and processes (or local adaptation)
- Training the entire team
- Preparing and prompting patients to engage
- Senior-level buy-in
- Measuring to improve

Joseph-Williams 2021 Medical Decision Making

https://decisionaid.ohri.ca

The Ottawa Hospital | L'Hôpital d'Ottawa
RESEARCH INSTITUTE | INSTITUT DE RECHERCHE

Patient Decision Aids

Français

Systematic Review of Patient Decision Aids

An international research group maintains an ongoing systematic review of trials of patient decision aids for treatment or screening decisions using Cochrane review methods.

Goal of the systematic review:

To conduct a systematic review of randomized controlled trials of decision aids, for people facing difficult treatment or screening decisions, that aim to improve the quality of decisions and decision making process.

Versions of **Decision aids for people facing health treatment or screening decisions** are available:

Summary (4 page PDF)

Standard (244 page PDF)

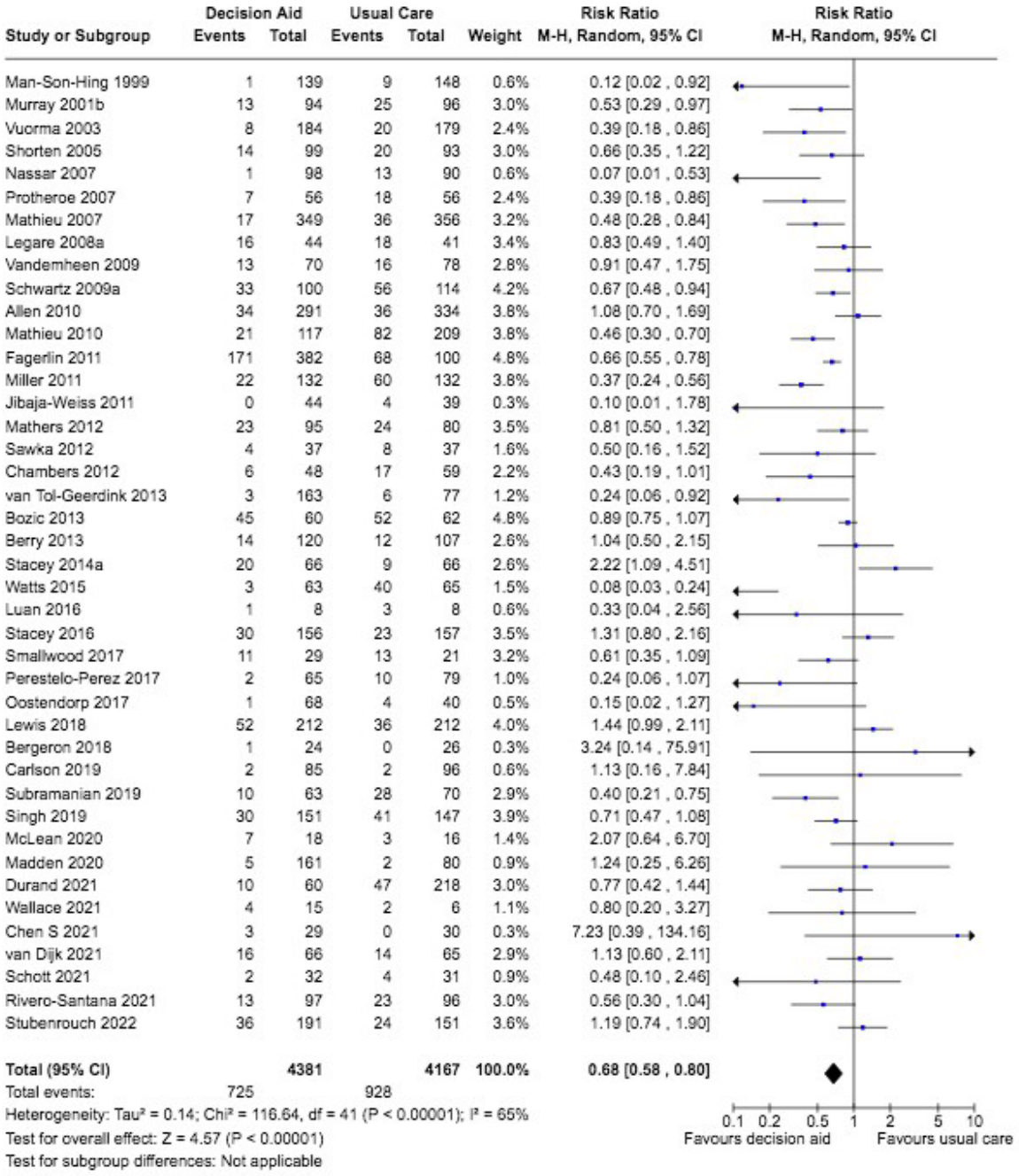
Full (303 page PDF)

Decision Aids Evidence Bulletin (5 page PDF)

A plain language summary is available in several languages: English, Deutsch, Español, Français, Hrvatski, Bahasa Malaysia, Polski, Русский, 简体中文, 繁體中文.

Most recent publication of the systematic review:

- Rutherford C, King MT, Butow P et al., Stacey D. (2019). Is quality of life a suitable measure of patient decision aid effectiveness? Sub-analysis of a Cochrane systematic review. Qual Life Res. 28(3):593-607.
- Stacey D, Légaré F, Lewis K, Barry MJ, Bennett CL, Eden KB, Holmes-Rovner M, Llewellyn-Thomas H, Lyddiatt A, Thomson R, Trevena L. Decision aids for people facing health treatment or screening decisions. Cochrane Database Syst Rev. 2017 Apr 12;4:CD001431. doi:



32% Fewer undecided

2023 Update

- 42 studies
- 8,548 participants
- RR 0.68 [0.58, 0.80]

2017 Review

- 22 studies
- 5,256 participants
- RR 0.64 [0.52, 0.79]

More satisfied with decision-making process

2023 Update

- 12 studies
- 2,066 participants
- MD 3.33 [1.18, 5.48]

2017 Review

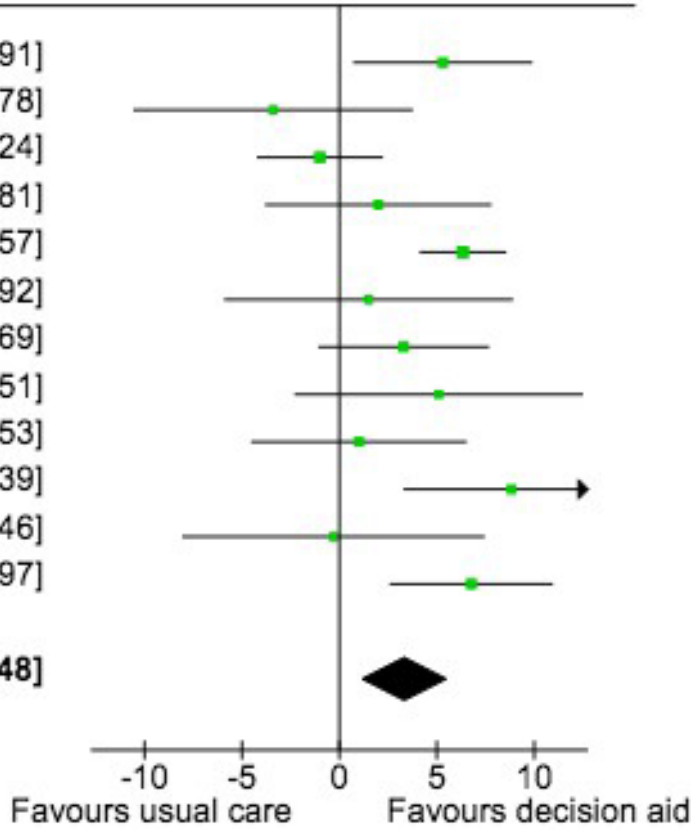
Not enough studies to pool results

Study or Subgroup	Decision Aid Mean	SD	Total	Usual Care Mean	SD	Total	Weight	Mean Difference IV, Random, 95% CI
Barry 1997	76.38	16.5	104	71.07	18.4	117	9.3%	5.31 [0.71 , 9.91]
Bernstein 1998	73.1	20.6	61	76.5	17.6	48	5.8%	-3.40 [-10.58 , 3.78]
Man-Son-Hing 1999	83.75	14.79	146	84.75	13.04	138	11.9%	-1.00 [-4.24 , 2.24]
Morgan 2000	72	19.88	86	70	19.88	94	7.4%	2.00 [-3.81 , 7.81]
Schroy 2011	84.17	10.33	214	77.83	13.17	217	13.9%	6.34 [4.11 , 8.57]
Jibaja-Weiss 2011	94	17	43	92.5	17	38	5.5%	1.50 [-5.92 , 8.92]
Bozic 2013	94.4	10	60	91.1	14.4	62	9.7%	3.30 [-1.09 , 7.69]
Kupke 2013	91.4	12.5	50	86.3	18.6	31	5.6%	5.10 [-2.31 , 12.51]
Knops 2014	74	16	74	73	19	80	7.8%	1.00 [-4.53 , 6.53]
Perestelo-Perez 2016	70.4	17.62	80	61.56	17.37	73	7.8%	8.84 [3.29 , 14.39]
Kostick 2018	82.5	13.8	26	82.8	16.1	31	5.2%	-0.30 [-8.06 , 7.46]
Rivero-Santana 2021	56.62	15.58	97	49.85	14.13	96	10.1%	6.77 [2.57 , 10.97]
Total (95% CI)			**1041**			**1025**	**100.0%**	**3.33 [1.18 , 5.48]**

Heterogeneity: Tau² = 7.38; Chi² = 25.72, df = 11 (P = 0.007); I² = 57%

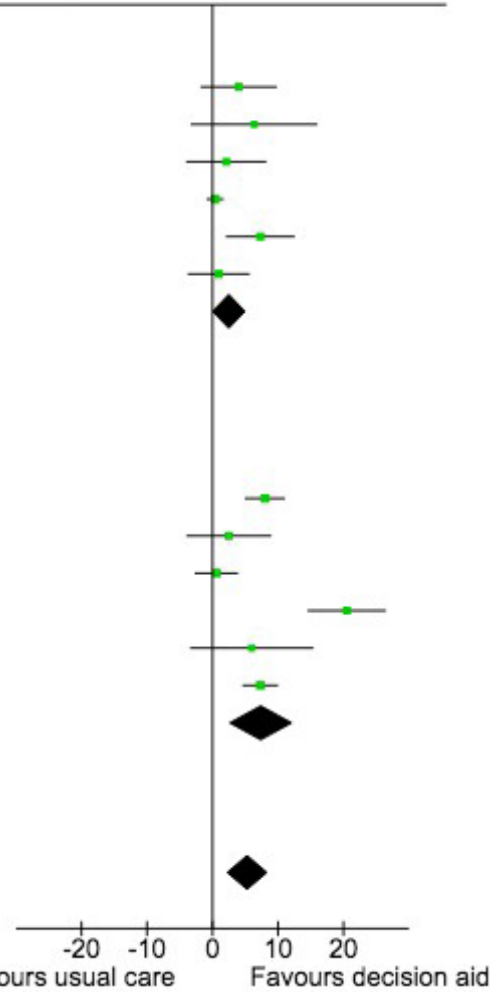
Test for overall effect: Z = 3.03 (P = 0.002)

Test for subgroup differences: Not applicable



Confidence in decision making was variable, depending on measurement tool

Study or Subgroup	Decision aid Mean	SD	Total	Usual care Mean	SD	Total	Weight	Mean Difference IV, Random, 95% CI
11.1.1 Decision Self-efficacy Scale								
Allen 2010	83	40.26	291	79	33.08	334	7.9%	4.00 [-1.83 , 9.83]
McGrath 2017	81.23	18.93	30	74.88	21.42	37	5.2%	6.35 [-3.32 , 16.02]
Subramanian 2019	82	18.4	63	79.9	17.6	70	7.7%	2.10 [-4.04 , 8.24]
Kuppermann 2020	90.7	12.3	670	90.3	12.2	672	11.0%	0.40 [-0.91 , 1.71]
Chen C 2021	88.3	10.2	67	81	18.9	63	8.4%	7.30 [2.03 , 12.57]
Crew 2022	84.01	18.63	120	83.05	19.8	133	8.8%	0.96 [-3.78 , 5.70]
Subtotal (95% CI)			**1241**			**1309**	**49.1%**	**2.49 [0.03 , 4.95]**
Heterogeneity: Tau² = 3.64; Chi² = 8.60, df = 5 (P = 0.13); I² = 42%								
Test for overall effect: Z = 1.98 (P = 0.05)								
11.1.2 Study specific questionnaire								
McBride 2002	78	18	273	70	19	284	10.1%	8.00 [4.93 , 11.07]
Meade 2015	58.1	19.2	78	55.6	20.3	66	7.4%	2.50 [-3.99 , 8.99]
Perez-Lacasta 2019	84.6	16.6	203	84	17.2	197	9.9%	0.60 [-2.71 , 3.91]
Lin 2020	89.5	16.25	90	69	24	90	7.8%	20.50 [14.51 , 26.49]
Manne 2020	91	23.74	46	85	22.62	47	5.4%	6.00 [-3.43 , 15.43]
Tebb 2021	84	17	320	76.7	21.3	437	10.3%	7.30 [4.57 , 10.03]
Subtotal (95% CI)			**1010**			**1121**	**50.9%**	**7.36 [2.67 , 12.05]**
Heterogeneity: Tau² = 27.25; Chi² = 35.88, df = 5 (P < 0.00001); I² = 86%								
Test for overall effect: Z = 3.07 (P = 0.002)								
Total (95% CI)			**2251**			**2430**	**100.0%**	**5.28 [2.27 , 8.29]**
Heterogeneity: Tau² = 20.95; Chi² = 73.97, df = 11 (P < 0.00001); I² = 85%								
Test for overall effect: Z = 3.43 (P = 0.0006)								
Test for subgroup differences: Chi² = 3.24, df = 1 (P = 0.07), I² = 69.2%								



2017 Review

Not enough studies to pool results

Break for Lunch and Networking

The patient side of shared decision making

Case #2

- Mary
- 98-year-old female
- Diagnosed with dementia
- Suffered stroke

How Patient Decision Aids Can support Shared Decision Making

Panel discussion

Facilitated by Dawn Stacey, RN, PhD, FRSC, FAAN, FCAHC, FCAN, University of Ottawa

Panel Members

- Dan Matlock, MD, MPH, University of Colorado
- Randy Moseley, MD, Confluence Health (Retired)
- Sarah Munro, PhD, UW
- Maureen Oscadal, RN, Harborview Medical Center
- Karen Sepucha, PhD, Massachusetts General Hospital

Implementation of Shared Decision Making in Cardiac Disease

Washington State Health Care Authority

Washington State Shared Decision Making Workshop

Dan D. Matlock, MD, MPH

Professor of Medicine, Division of Geriatrics

Colorado Program for Patient Centered Decisions

Adult and Child Consortium for Outcomes Research and Delivery Science

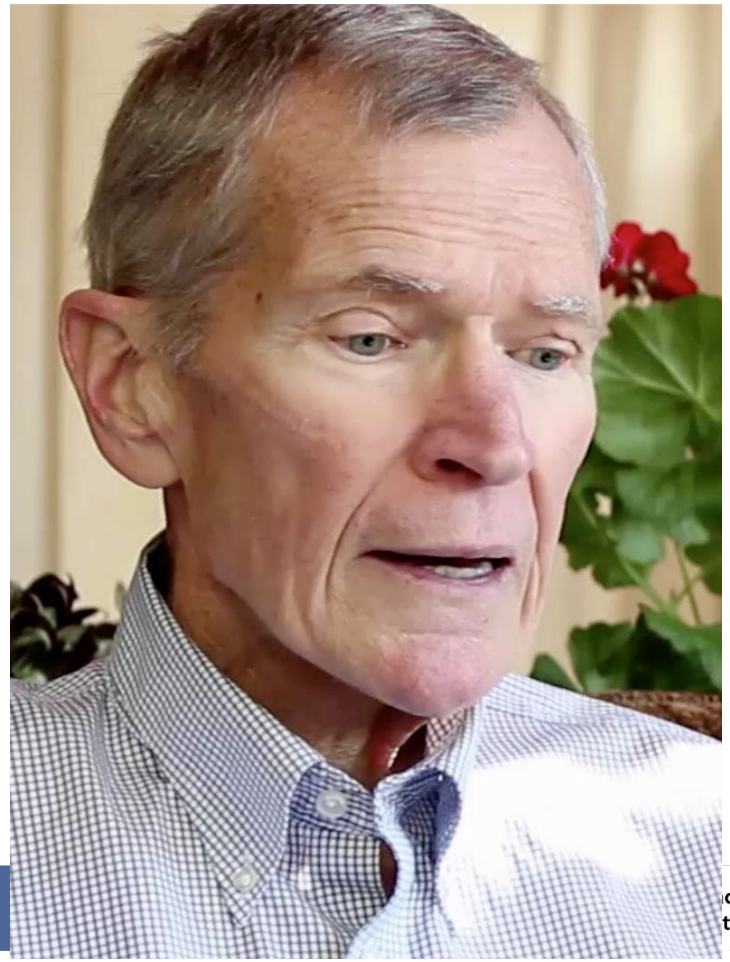
Colorado Program for Patient Centered Decisions

Examples from the field

Imagine two 60-year-old men with end stage heart failure

Cliff

Don



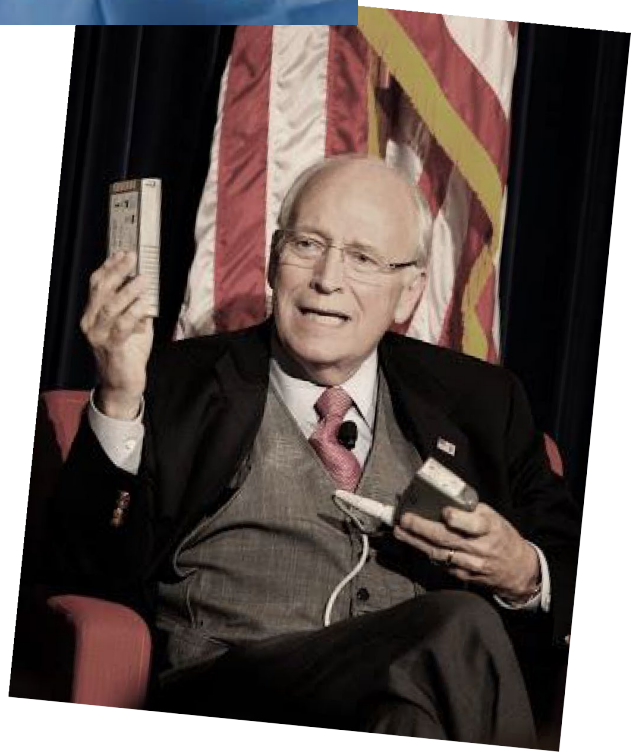
Parts of an LVAD

Driveline
A cord that connects the pump to the outside. This passes through the skin and holds important electrical wires.

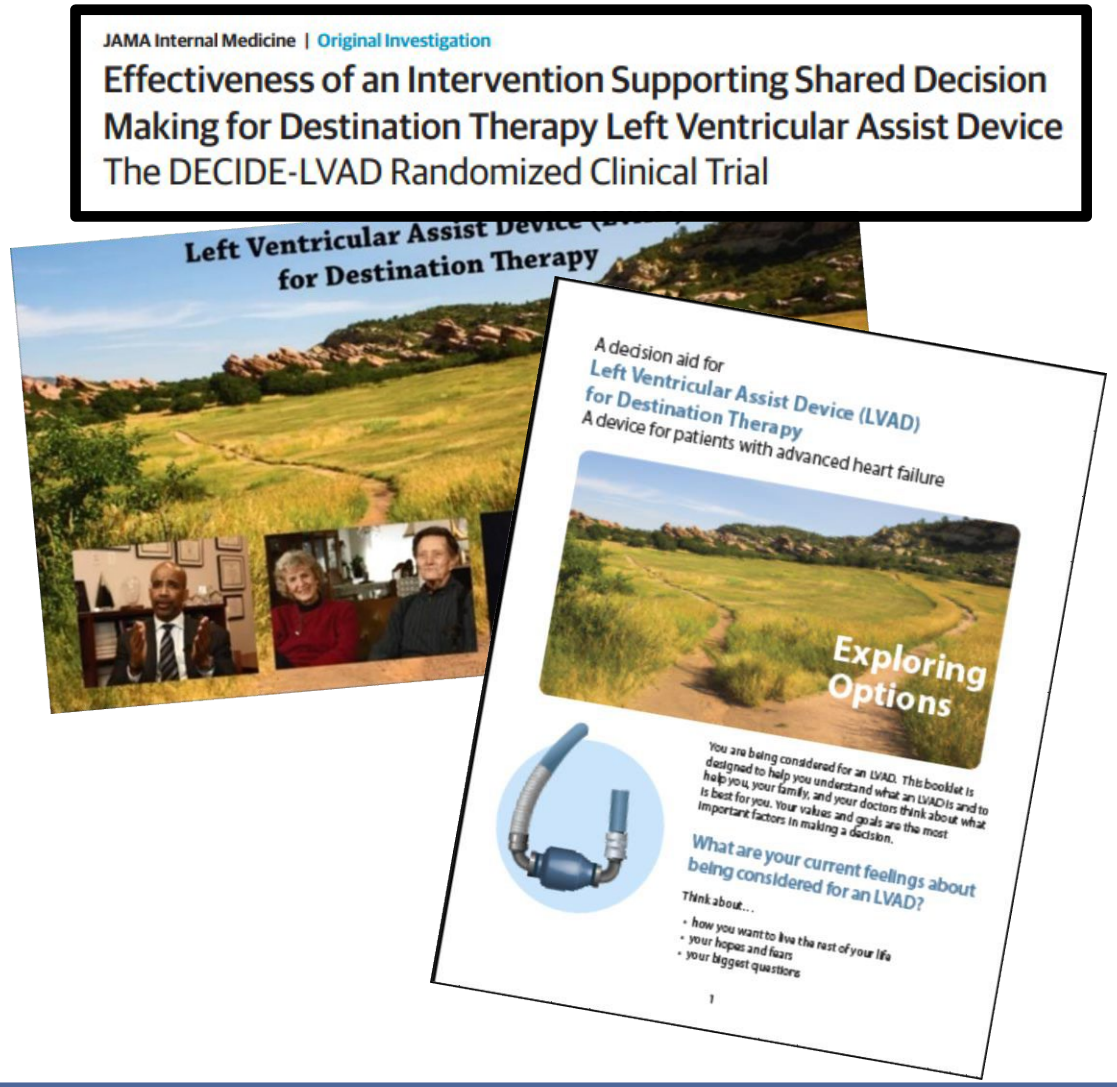
Batteries
A power source for the pump. The pump must always be plugged into either batteries or an electrical wall outlet.

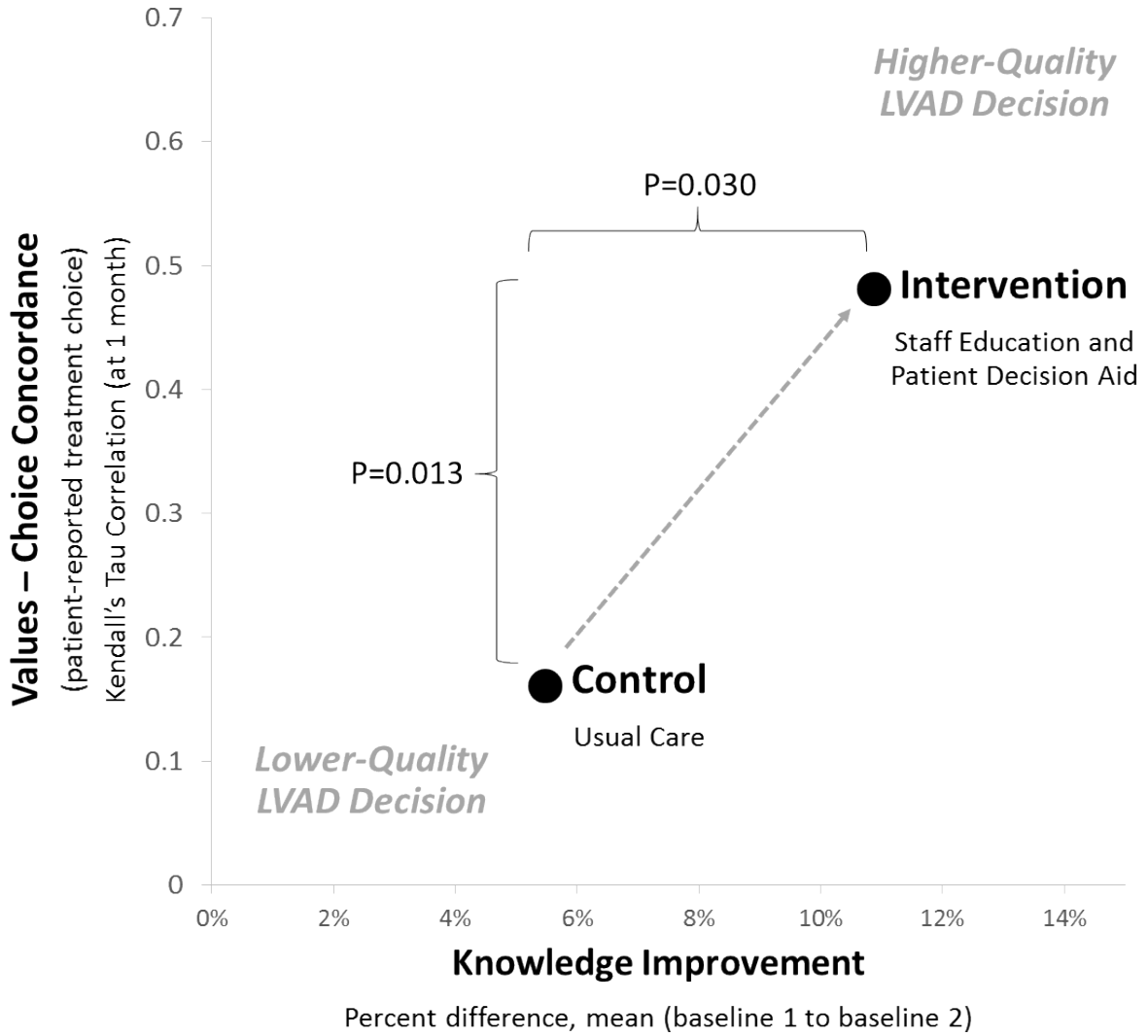
Controller
A computer that operates the pump. The controller displays messages and sounds alarms about the device.

Pump
A motor placed inside the chest. It pushes blood from the heart to the body.

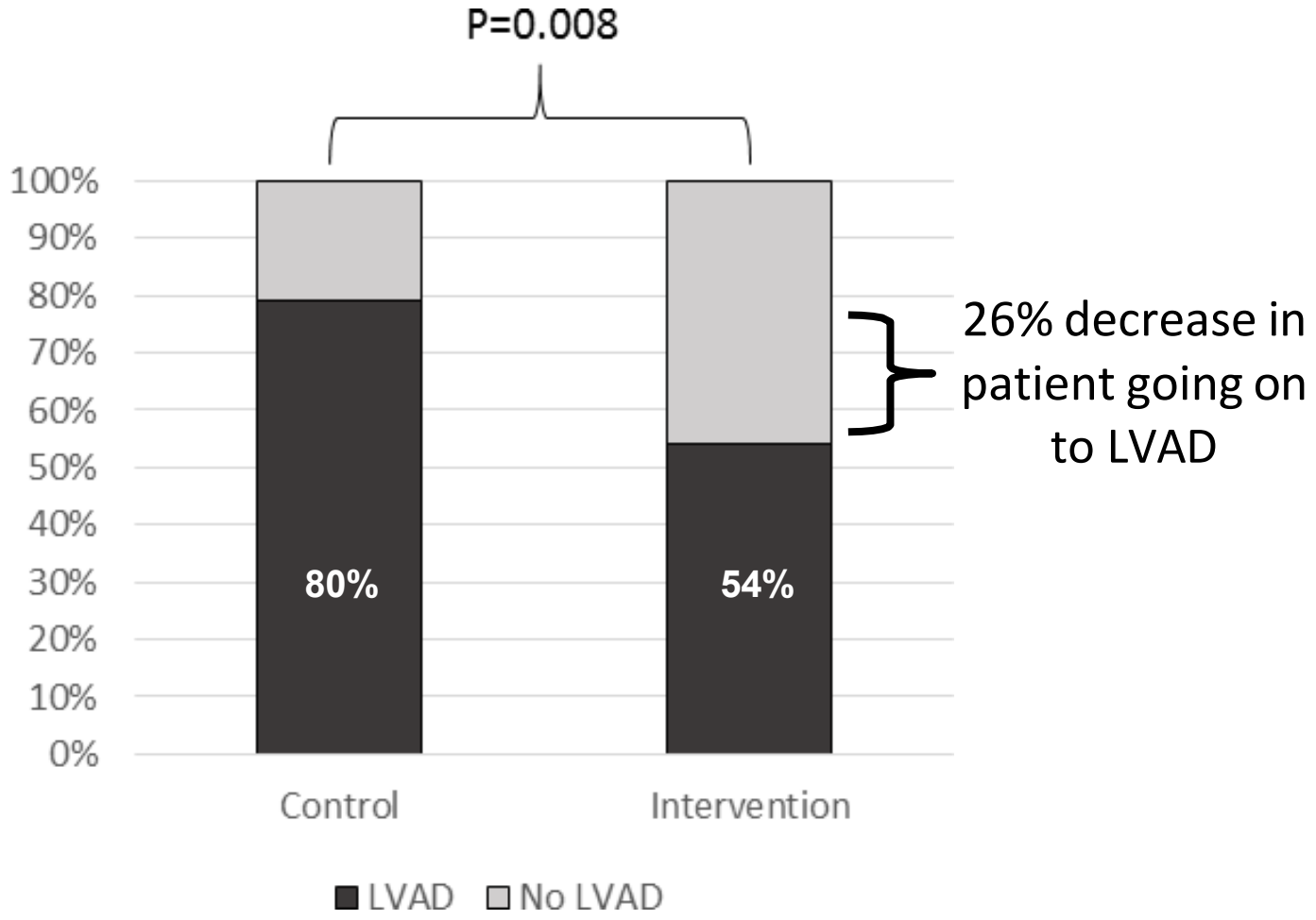


DECIDE-LVAD Trial – Effective Decision Aid





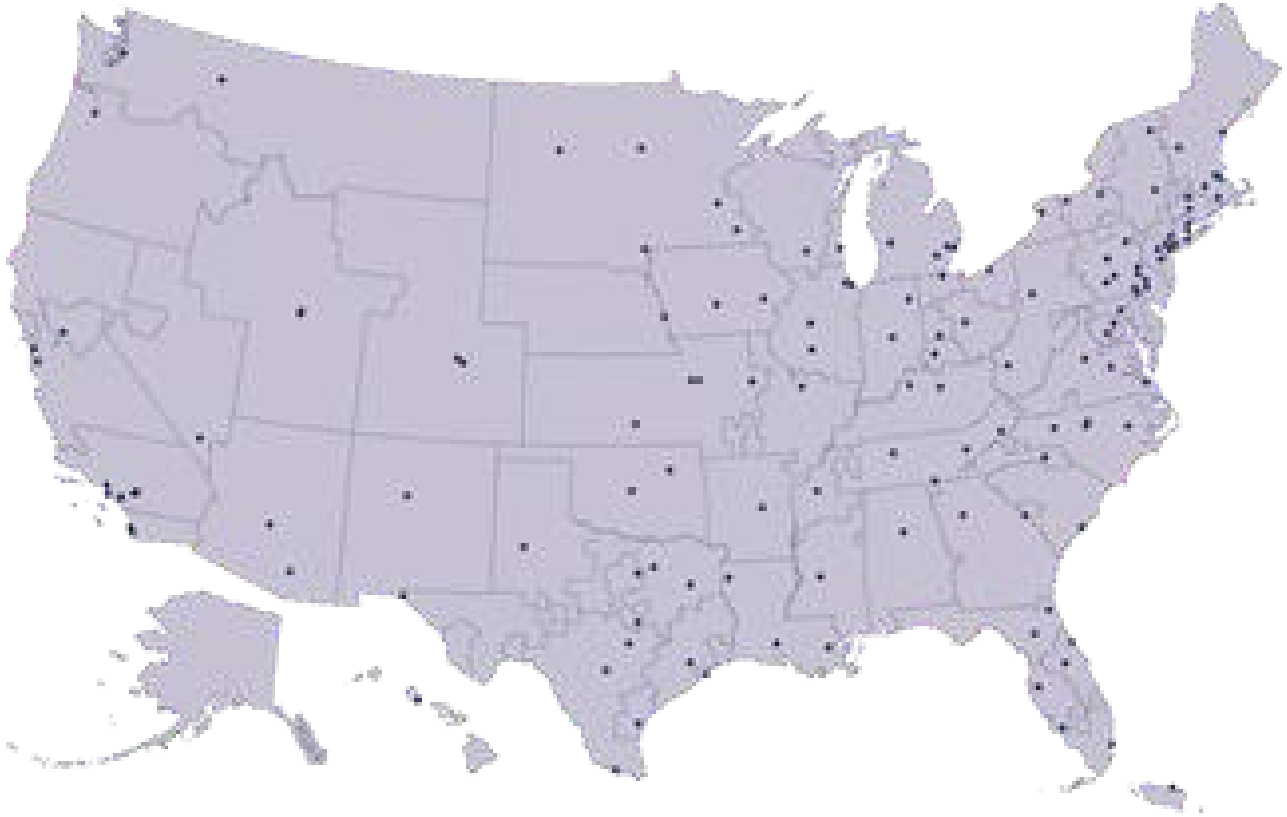
Secondary Outcomes: 6-month implant



I DECIDE: LVAD – Decision Aid Dissemination

Go BIG!

Implement the decision aid at **all**
175 CMS-certified LVAD programs
in the United States

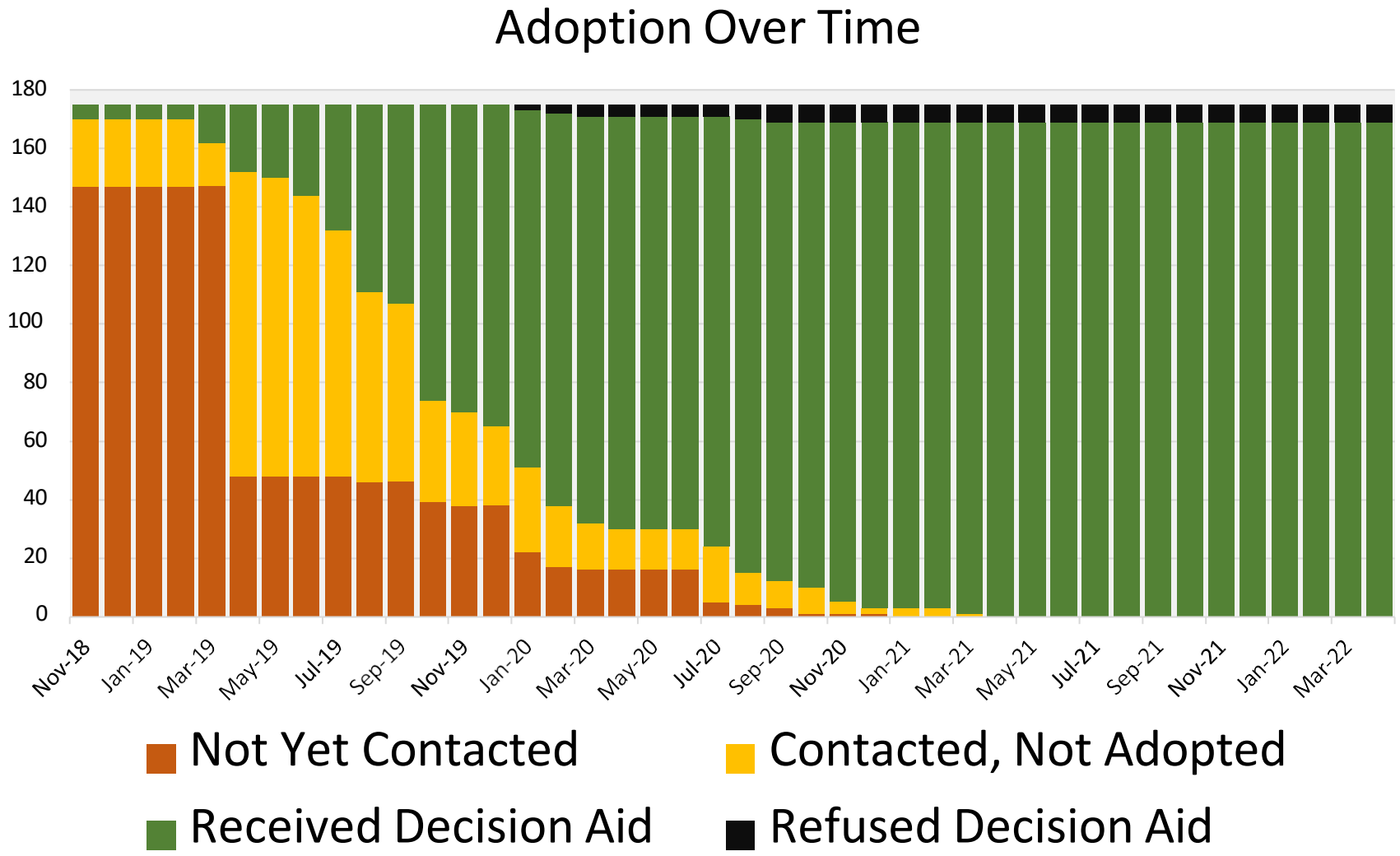


I DECIDE LVAD
Better conversations, better decisions
patientdecisionaid.org

Network Building + Adoption

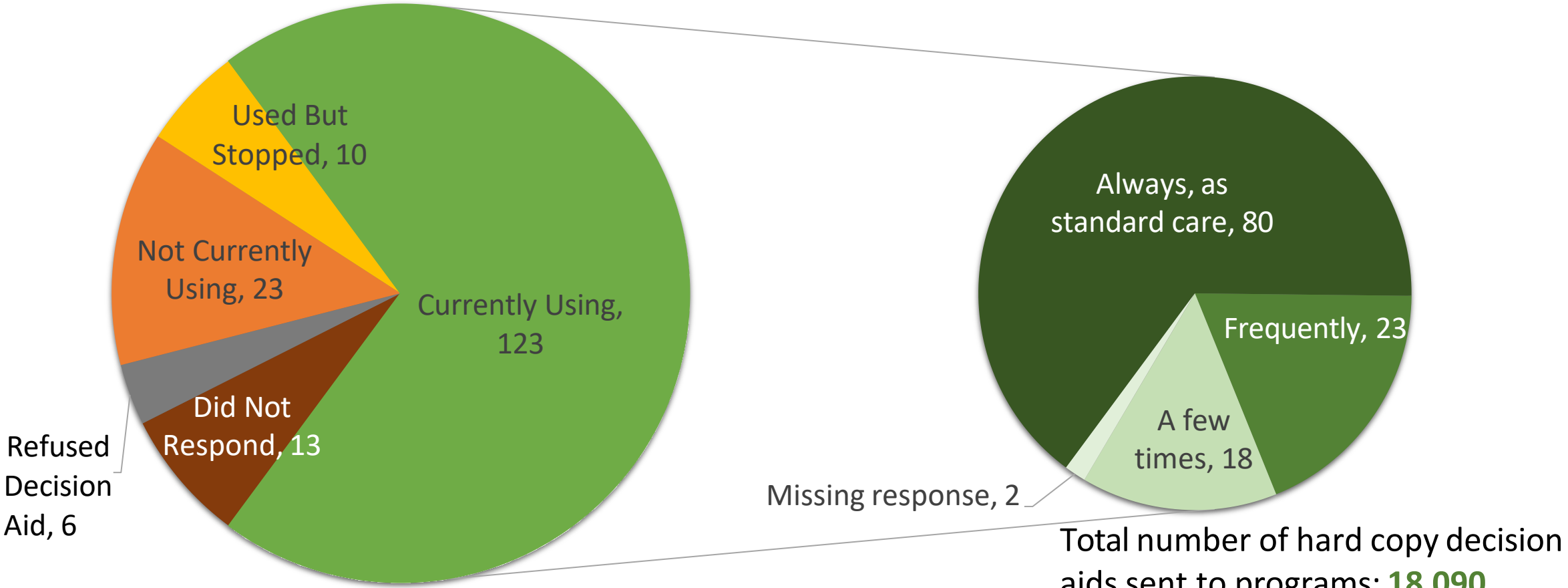
Adoption

- Contacted every program
- **169 adopted decision aid** (were interested in and received 50 free hard copies of decision aid)

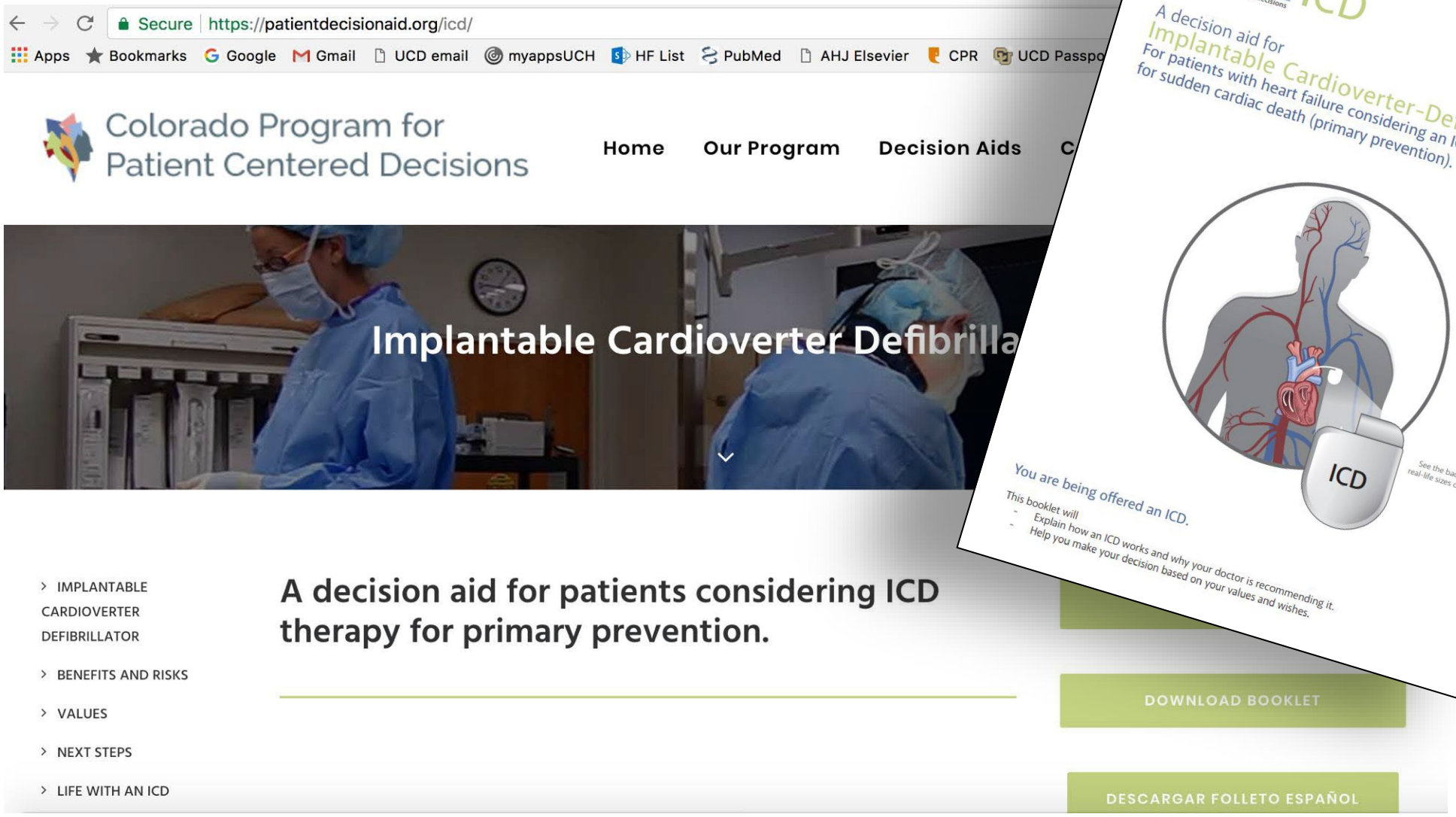


Implementation

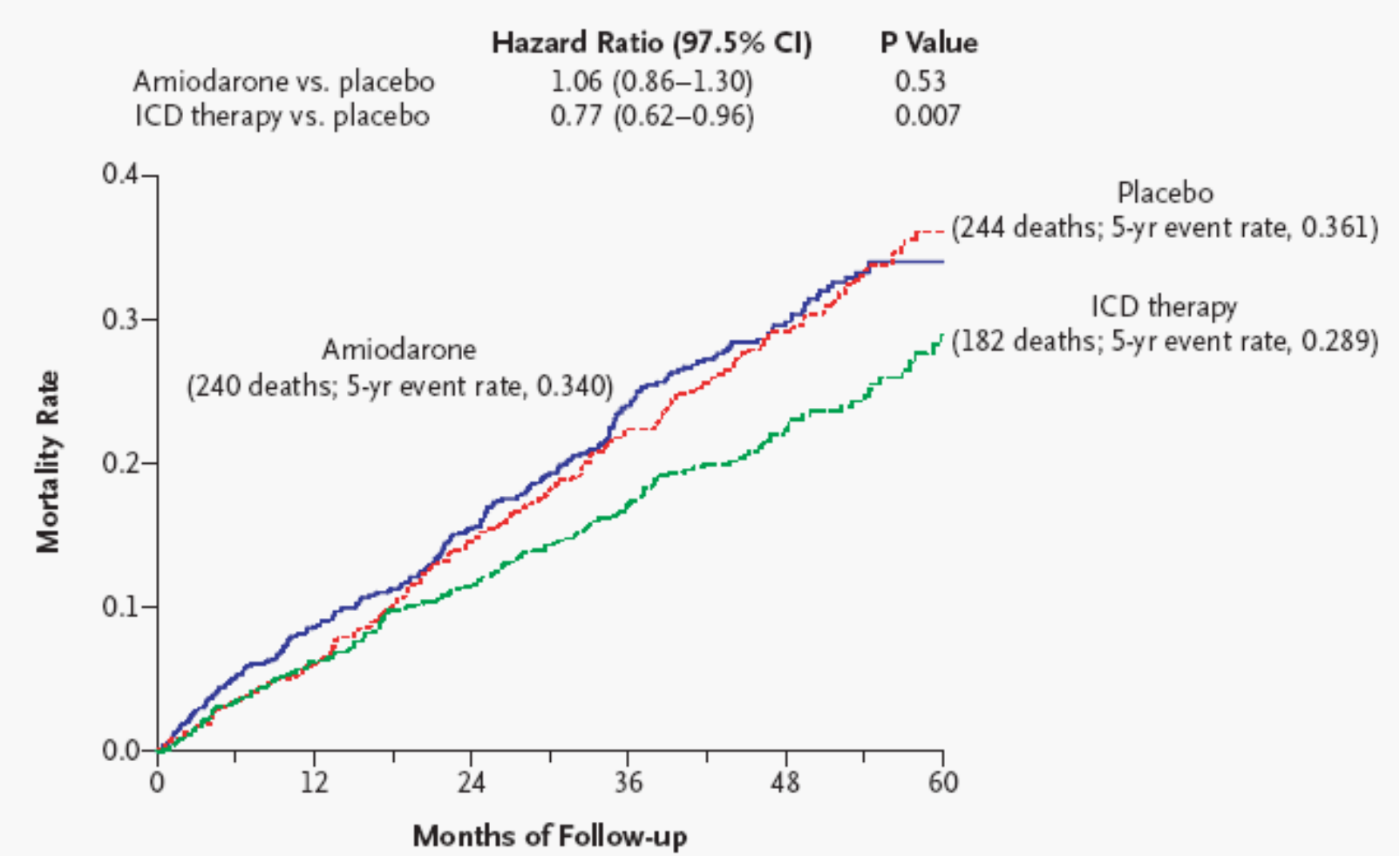
Reported use of decision aid by primary clinician contact at each program every 4-6 months over project period.



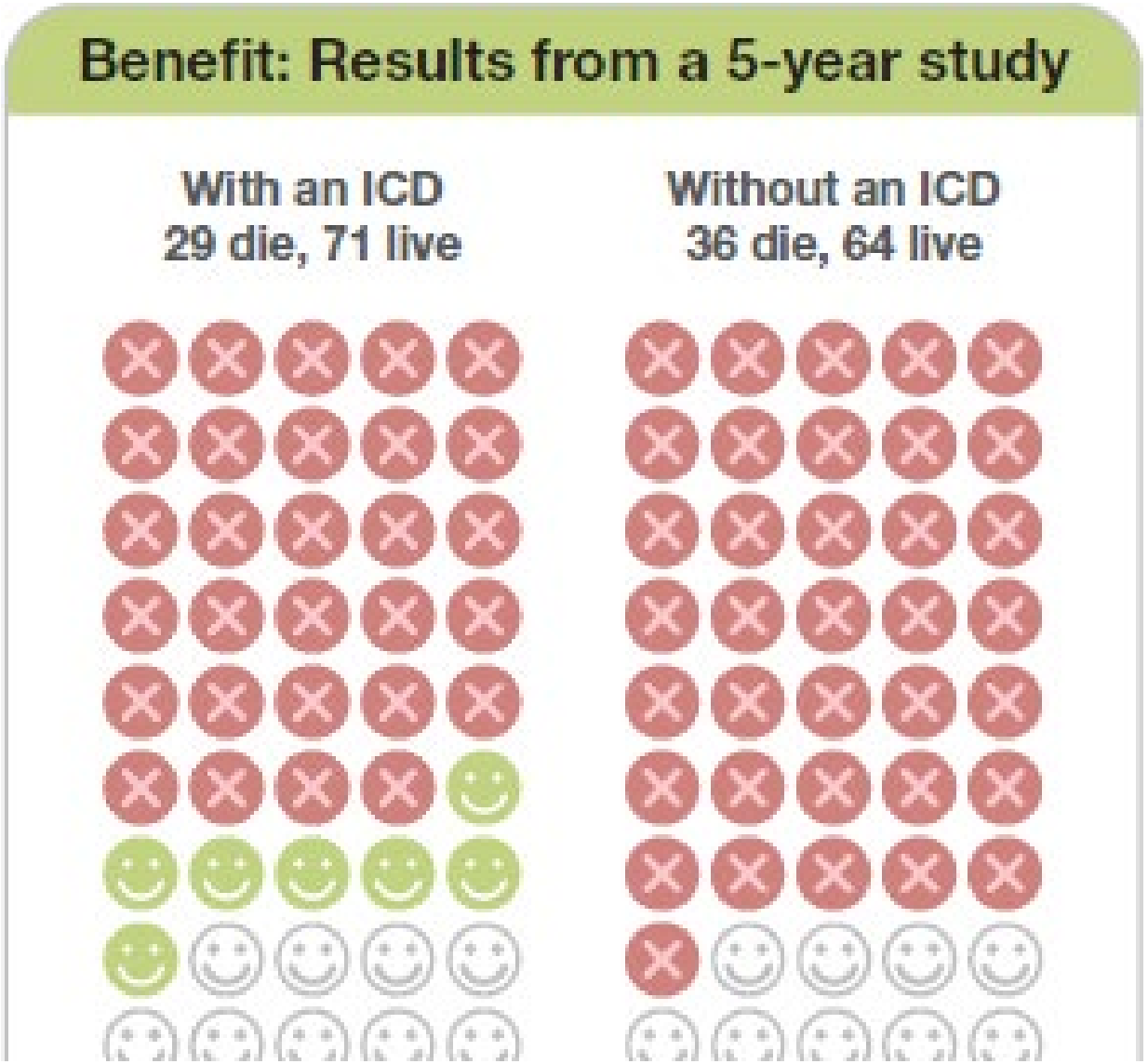
Total number of hard copy decision aids sent to programs: **18,090**


Secure https://patientdecisionaid.org/icd/
Apps Bookmarks Google Gmail UCD email myappsUCH HF List PubMed AHJ Elsevier CPR
Colorado Program for Patient Centered Decisions
Home Our Program Decision Aids
Implantable Cardioverter Defibrilla
IMPLANTABLE CARDIOVERTER DEFIBRILLATOR
BENEFITS AND RISKS
VALUES
NEXT STEPS
LIFE WITH AN ICD
A decision aid for patients considering ICD therapy for primary prevention.
DOWNLOAD BOOKLET
DESCARGAR FOLLETO ESPAÑOL
IDECIDE® ICD
Better conversations, better decisions
A decision aid for
Implantable Cardioverter-Defibrillators (ICD)
For patients with heart failure considering an ICD who are at risk for sudden cardiac death (primary prevention).
ICD
See the back page for real-life sizes of the device
You are being offered an ICD.
This booklet will
Explain how an ICD works and why your doctor is recommending it.
Help you make your decision based on your values and wishes.

Defibrillator Benefits: SCD-HeFT



Benefit: Results from a 5-year study



Potential Harms of ICDs

- Procedural risks (Infection, Bleeding, etc.)

Additionally:

- Increased HF admissions
- Anxiety/Depression/PTSD
- Inappropriate shocks
- Device malfunction
- Potential suffering at the end-of-life
- Quality of Life

Medicare Mandate

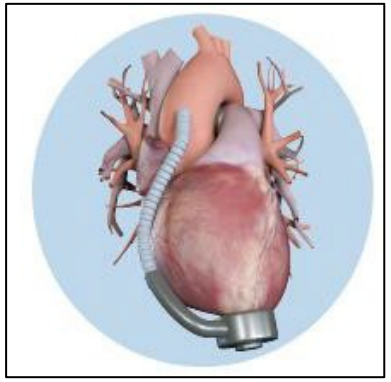
Decision Memo for Implantable Cardioverter Defibrillators (CAG-00157R4)

"For these patients identified in B4, a **formal shared decision making** encounter must occur between the patient and a physician (as defined in Section 1861(r)(1)) or qualified non-physician practitioner (meaning a physician assistant, nurse practitioner, or clinical nurse specialist as defined in §1861(aa)(5)) using an **evidence-based decision tool on ICDs prior to initial ICD implantation.** The shared decision making encounter may occur at a separate visit."

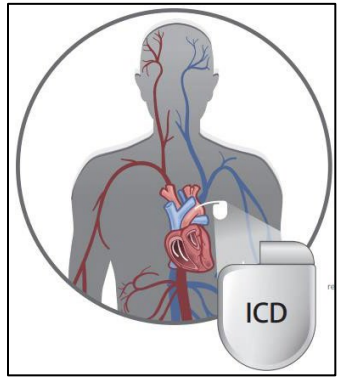
CMS.gov
Centers for Medicare & Medicaid Services

DECIDE-LVAD and DECIDE-ICD Trials

Understand the effectiveness and implementation of a shared decision support intervention for patients considering LVAD or ICD.

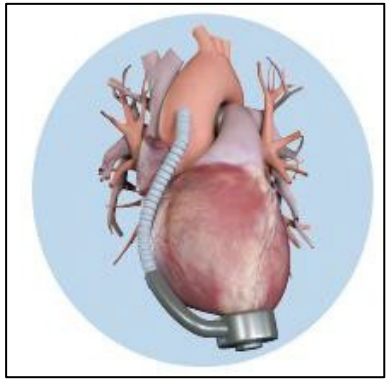


LVAD vs. ICD

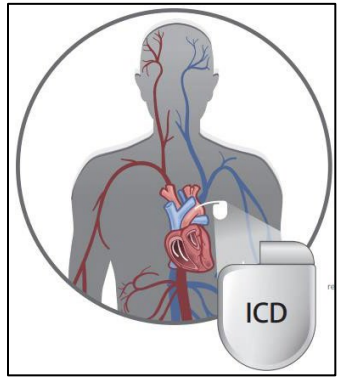


- **Who** will deliver the decision aid?
  - LVAD coordinator: built in role for education and consent process
- **When** will the decision aid be delivered?
  - Before and during designated education session with LVAD coordinator

- **Who** will deliver the decision aid?
  - Electrophysiologist: clinician with standard clinic time
- **When** will the decision aid be delivered?
  - After visit with EP as take-home resource



LVAD vs. ICD



Advantages for LVAD:

- Clinicians saw need for SDM
- Obvious timing for when SDM should take place – initiated with an evaluation, education with LVAD coordinators

Challenges for ICD:

- SDM not seen as universal need among clinicians (despite a mandate from CMS)
- Discussion not always triggered by specific/large event

Challenges for LVAD:

- Very sick population and urgent implants

Advantages for ICD:

- Typically outpatient visits with mostly well population

Common questions

- *Should all decisions be shared decisions?*
- *Is the goal of shared decision making to change decisions?*
- *Should Medicare or other payers get involved in mandating shared decision making?*

Thank You

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www.patientdecisionaid.org

CONFLUENCE HEALTH:
Shared Decision Making Journey

Randal Moseley, MD, FACP, FHM

1-11-2024

fluence HEALTH

Confluence Health

Formed in 2013 as an affiliation between Wenatchee Valley Medical Center and Central Washington Hospital

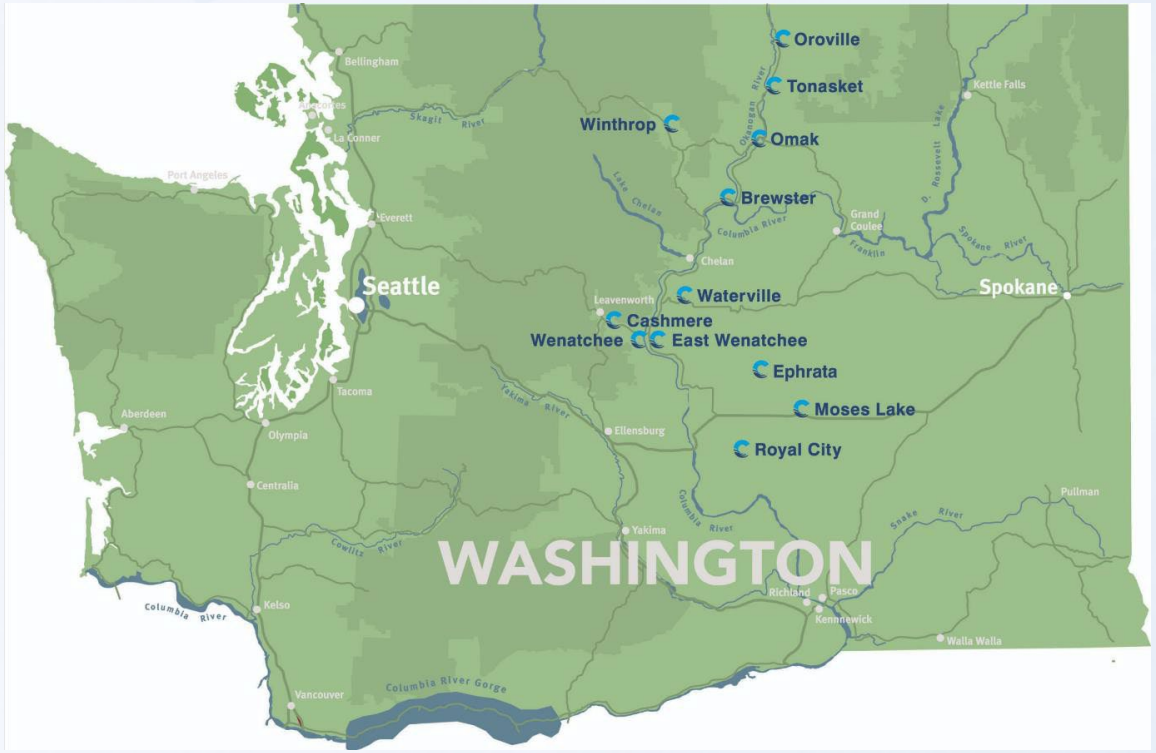
Clinics in 12 communities over 12,000 square mile service area in North Central Washington State

~290 physicians and over 140 advanced practice providers

About 200 inpatient beds in two hospitals in Wenatchee

Mostly fee-for service, growing value-based care

~70% Medicaid/Medicare



In the Beginning: Mammography 2014

Evolution to SDM Pathway

- Agreement on what to recommend as best practice was not going to happen
- Can we just agree to inform our patients of the controversy in a factful way to help them make an informed personal decision?
- Shared Decision Making a way forward?
  - But search for quality patient decision aids futile

Landscape for Mammography SDM

- Unbiased patient-centered information was hard to find
- Most sources typically emphasized benefits over harms[1]
- Often no fully transparent discussion of harms data:
  - Frequency of false alarms[2]
    - Over 10 years, >50% need additional images
    - ~20% of these undergo biopsy
  - Overdiagnosis[3]
    - Estimate 11-19% of cancers diagnosed by mammography (~14 women/1,000 over lifetime)
- Patient perception of mammography benefits very inflated

[1]JAMA Intern Med 2013;173(13):1215-1221
[2]JAMA 2014;311(13):1327-1335
[3]USPSTF Breast Cancer: Screening, May 9, 2023

Evolution to SDM Pathway

- We (naively) decided to make our own
- 3 decision points identified, so 3 versions:
  - Ages 40-49: to screen or not to screen
  - Ages 50-74: to screen annually or biennially
  - Ages 75+: to continue screening or stop
- Lots to do: IPDAS, reading level, testing with patient feedback, design/marketing, Epic workflows, provider roll out
- First PDAs distributed 2015
- 2019: Update and HCA certification attempt
- 2021: Current versions HCA certified

Challenges

- Make your own = huge project to do it well
  - HCA certification was rigorous, but very helpful
- How to train providers?
  - Perception of "I do this already"
  - Training program + lost production = $$$
- How to make easily available?
  - External website, internal electronic availability
- How to embed into workflows?
  - Getting decision aids to patients prior to visit
  - Point of care support in Epic

CH_Mammography_Ages_40-49_Pamphlet_3-4-2021.pdf (confluencehealth.org)

How Often Should I Get a Mammogram?

Ages 50-74

BREAST CANCER SCREENING

Confluence HEALTH

Last updated: 1/28/2021

Contents

Introduction

This product has been certified by the Washington State Health Care Authority pursuant to RCW 7.70.060. The date of certification is (date of notification) and will expire two years from this date, or sooner pursuant to Washington State policy. A full description of Washington's certification process, including required criteria is available at: http://www.hca.wa.gov/about-hca/healthier-washington/shared-decision-making.

Breast cancer is one of the most common cancers among women. All major health professional groups recommend routine mammograms for women between ages 50 and about 74 to screen for breast cancer. While the benefits of routine screening mammograms are clear for women ages 50-74, it is not clear how often mammograms should be done. Some groups recommend a mammogram every year and others every two years. To decide what is right for you, you should think about the possible benefits and harms that can result from getting mammograms. You also need to understand your risk of breast cancer and your personal health concerns. Some women may choose not to have any mammograms, but this is not recommended by any current guideline.

This tool is designed to help you decide how often to get a screening mammogram.

If you currently have any breast symptoms such as pain or lumps, please see your primary care provider right away and don't wait for a screening test.

CH_Mammography_Ages_50-74_Pamphlet-3-4-2021.pdf (confluencehealth.org)

Should I Get a Mammogram?

Ages 75+

BREAST CANCER SCREENING

Confluence HEALTH

Last updated: 1/28/2021

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Introduction

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Breast cancer is one of the most common cancers among women. While the benefits of routine mammograms to screen for breast cancer are clear for women ages 50-74, the benefits for women age 75 and older are uncertain. Some professional groups recommend stopping routine mammograms when a woman reaches age 75, while others recommend continuing.

While the chance of getting breast cancer does increase with age, breast cancers often grow more slowly in older woman. Furthermore, experts think that a small breast cancer found on an older woman's mammogram typically will not cause problems for at least 5-10 years. Some cancers may never cause problems.

Whether it is a good idea for you to continue getting mammograms after age 75 depends on your overall health, how much longer you are likely to live, and your personal risk of breast cancer.

This tool is designed to help you decide if you want to stop or continue getting mammograms.

If you currently have any breast symptoms such as pain or lumps, please contact your primary care provider right away and don't wait for a screening test.

CH_Mammography_Ages_75-_Pamphlet_3-4-2021.pdf (confluencehealth.org)

Our Biggest Mistakes

- Not understanding the complexity of creating a patient decision aid
- Not pursuing formal provider SDM training
- Underestimating workflow challenges
- Not measuring results

SDM Decision Aids: Work to Date

- Breast cancer screening
- Lung cancer screening with low dose CT (borrowed from Dartmouth)
- Total joint replacement
- Colorectal cancer screening
- Healthwise subscription (now lapsed)

MY NEXT BIRTH

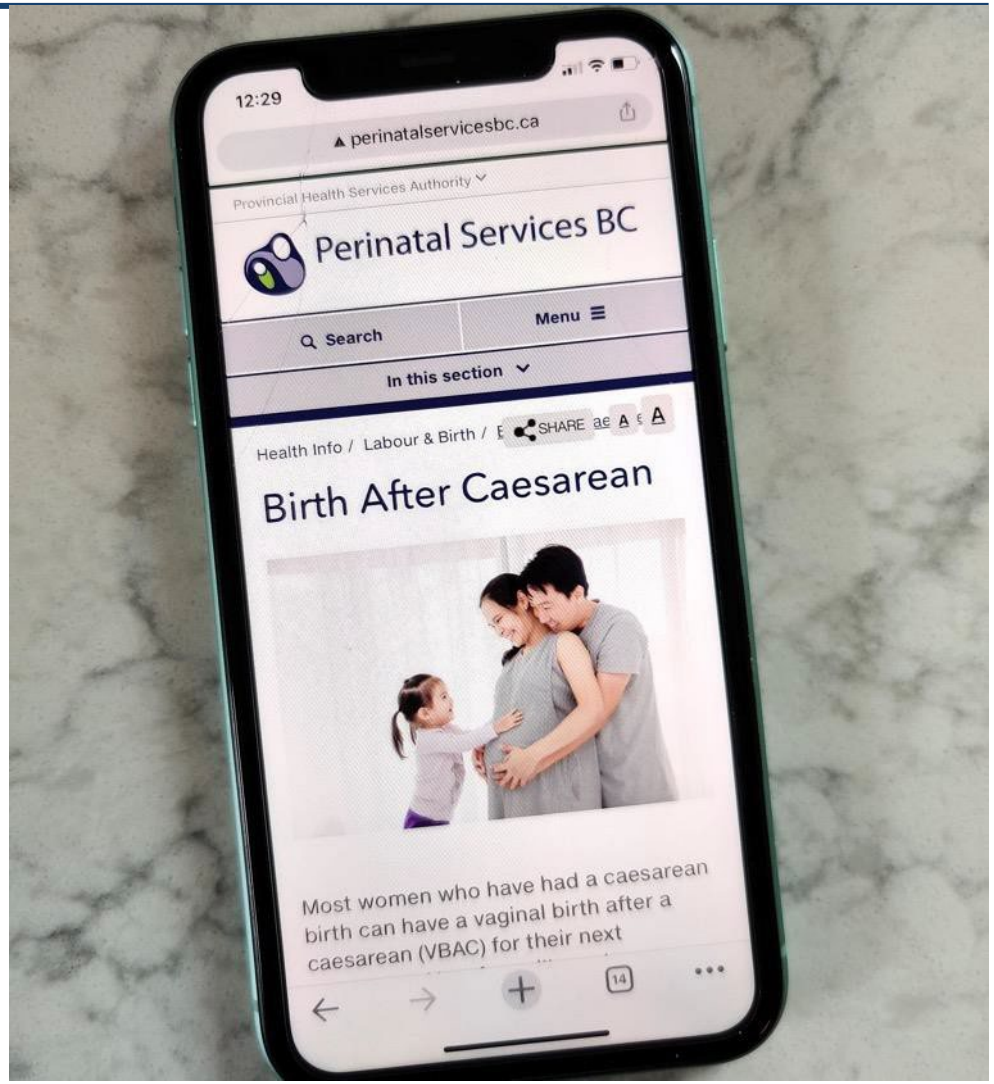
Sarah Munro, PhD

Assistant Professor
Department of Health Systems and Population Health
School of Public Health, University of Washington

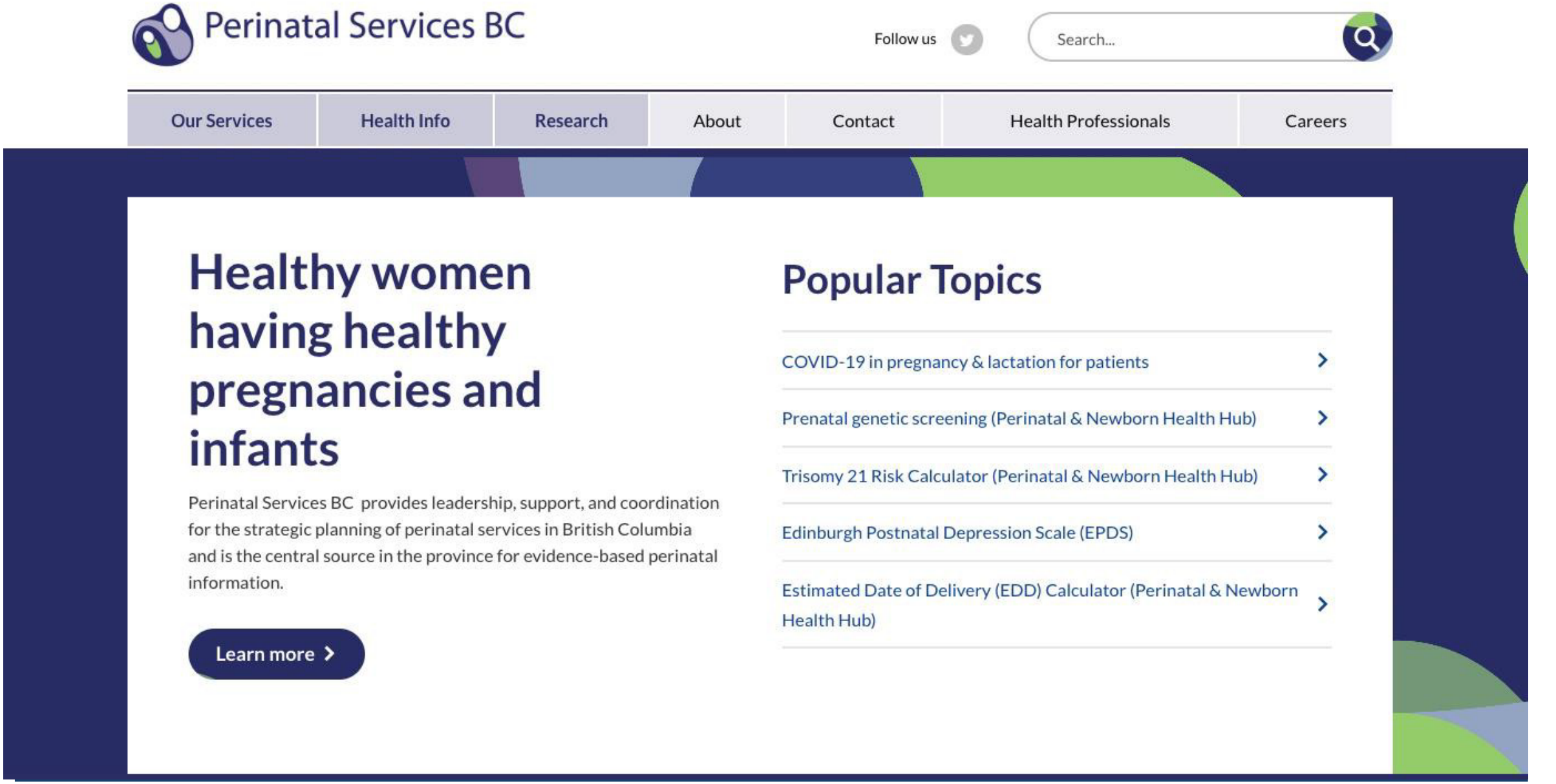
Scientist
Centre for Advancing Health Outcomes

Affiliate Assistant Professor
Dept of Obstetrics and Gynaecology, UBC

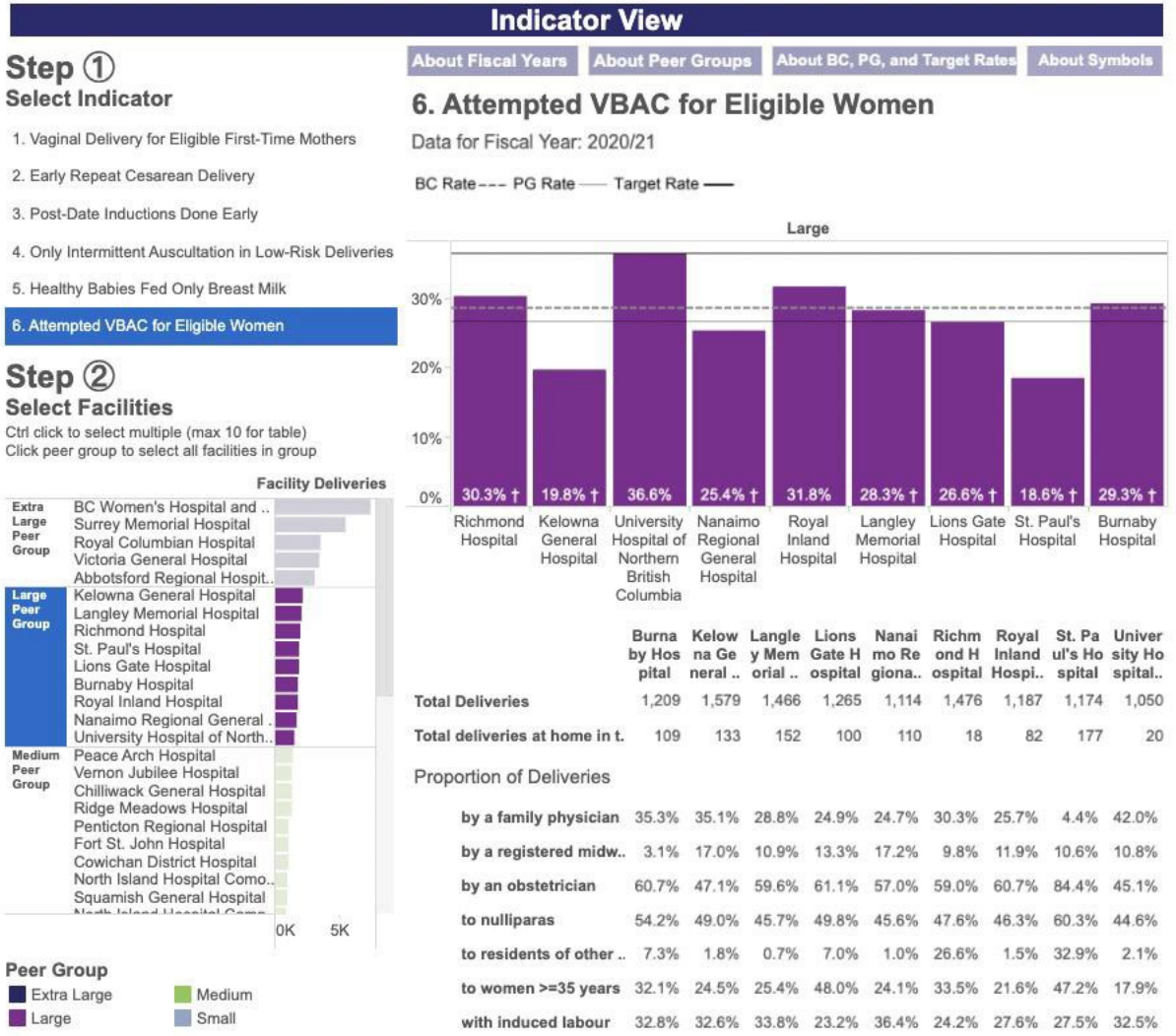
Co-Director
Contraception and Abortion Research Team



UNIVERSITY of WASHINGTON

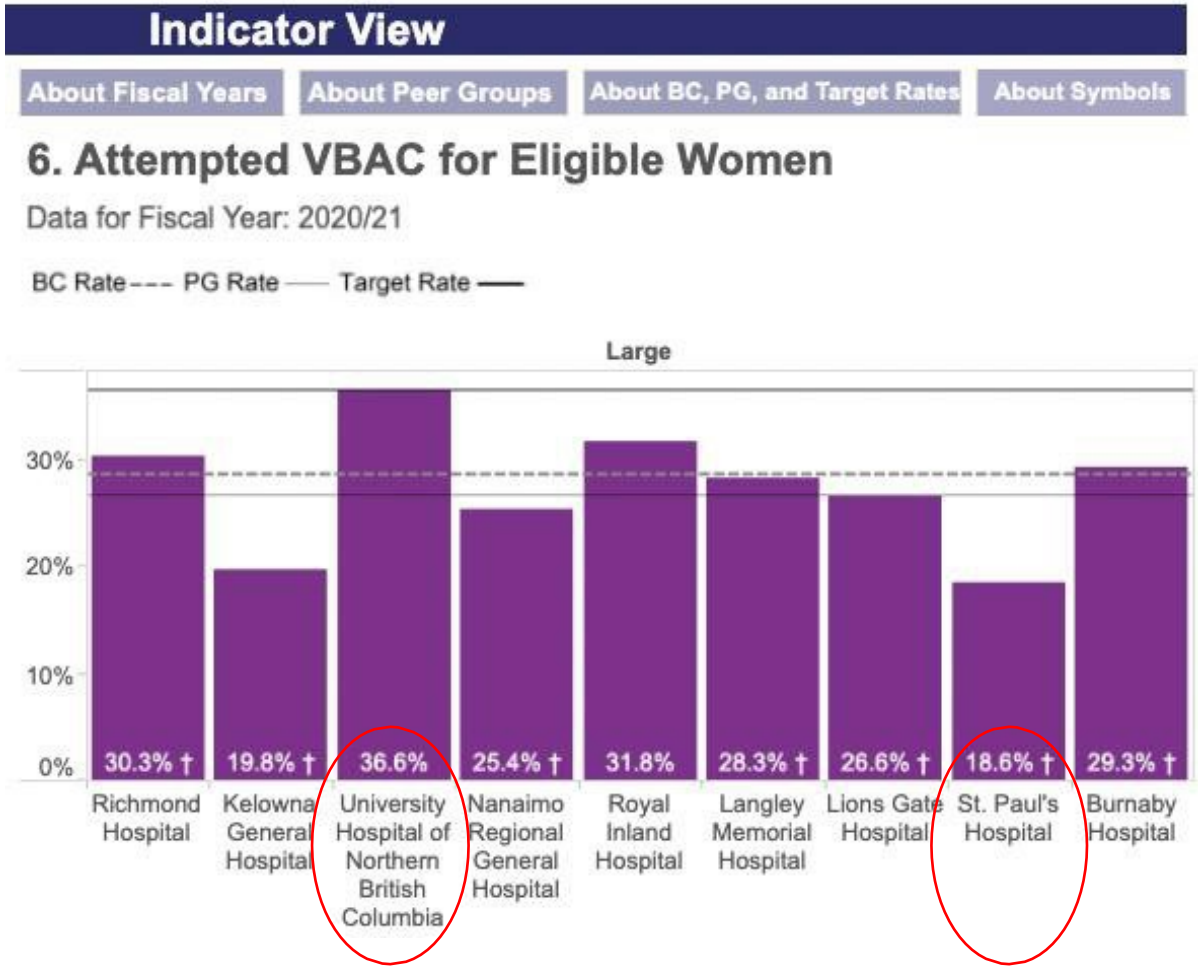

Perinatal Services BC
Follow us
Search...
Our Services
Health Info
Research
About
Contact
Health Professionals
Careers
Healthy women having healthy pregnancies and infants
Perinatal Services BC provides leadership, support, and coordination for the strategic planning of perinatal services in British Columbia and is the central source in the province for evidence-based perinatal information.
Learn more
Popular Topics
COVID-19 in pregnancy & lactation for patients
Prenatal genetic screening (Perinatal & Newborn Health Hub)
Trisomy 21 Risk Calculator (Perinatal & Newborn Health Hub)
Edinburgh Postnatal Depression Scale (EPDS)
Estimated Date of Delivery (EDD) Calculator (Perinatal & Newborn Health Hub)

How do we explain and address unwarranted variation in attempted vaginal birth after caesarean?

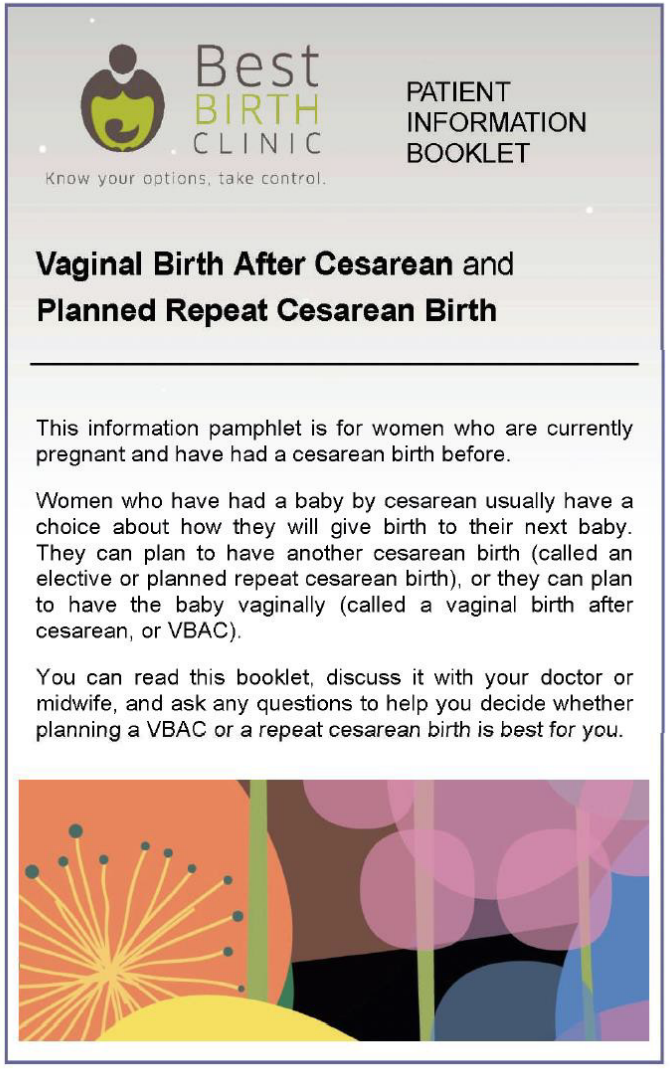


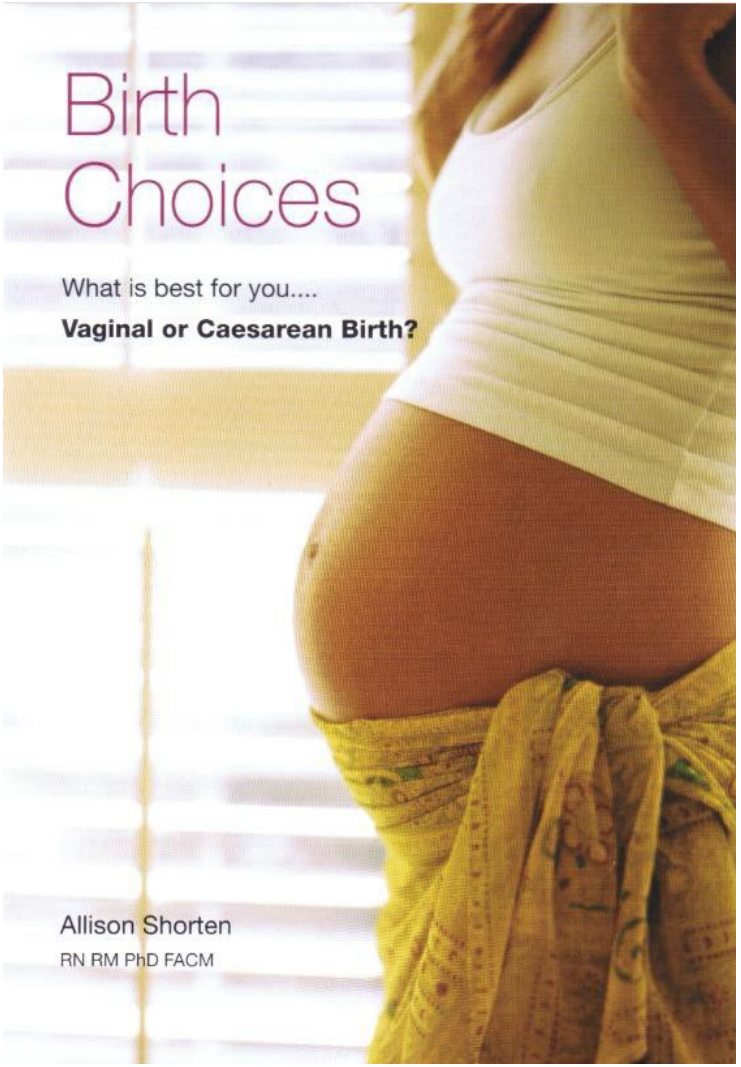
	Burnaby Hospital	Kelowna General ..	Langley Memorial ..	Lions Gate Hospital	Nanaimo Regiona..	Richmond Hospital	Royal Inland Hospi..	St. Paul's Hospital	University Hospital..
Total Deliveries	1,209	1,579	1,466	1,265	1,114	1,476	1,187	1,174	1,050
Total deliveries at home in t.	109	133	152	100	110	18	82	177	20
Proportion of Deliveries									
by a family physician	35.3%	35.1%	28.8%	24.9%	24.7%	30.3%	25.7%	4.4%	42.0%
by a registered midw..	3.1%	17.0%	10.9%	13.3%	17.2%	9.8%	11.9%	10.6%	10.8%
by an obstetrician	60.7%	47.1%	59.6%	61.1%	57.0%	59.0%	60.7%	84.4%	45.1%
to nulliparas	54.2%	49.0%	45.7%	49.8%	45.6%	47.6%	46.3%	60.3%	44.6%
to residents of other ..	7.3%	1.8%	0.7%	7.0%	1.0%	26.6%	1.5%	32.9%	2.1%
to women >=35 years	32.1%	24.5%	25.4%	48.0%	24.1%	33.5%	21.6%	47.2%	17.9%
with induced labour	32.8%	32.6%	33.8%	23.2%	36.4%	24.2%	27.6%	27.5%	32.5%

How do we explain and address unwarranted variation in attempted vaginal birth after caesarean?



Power TO PUSH CAMPAIGN





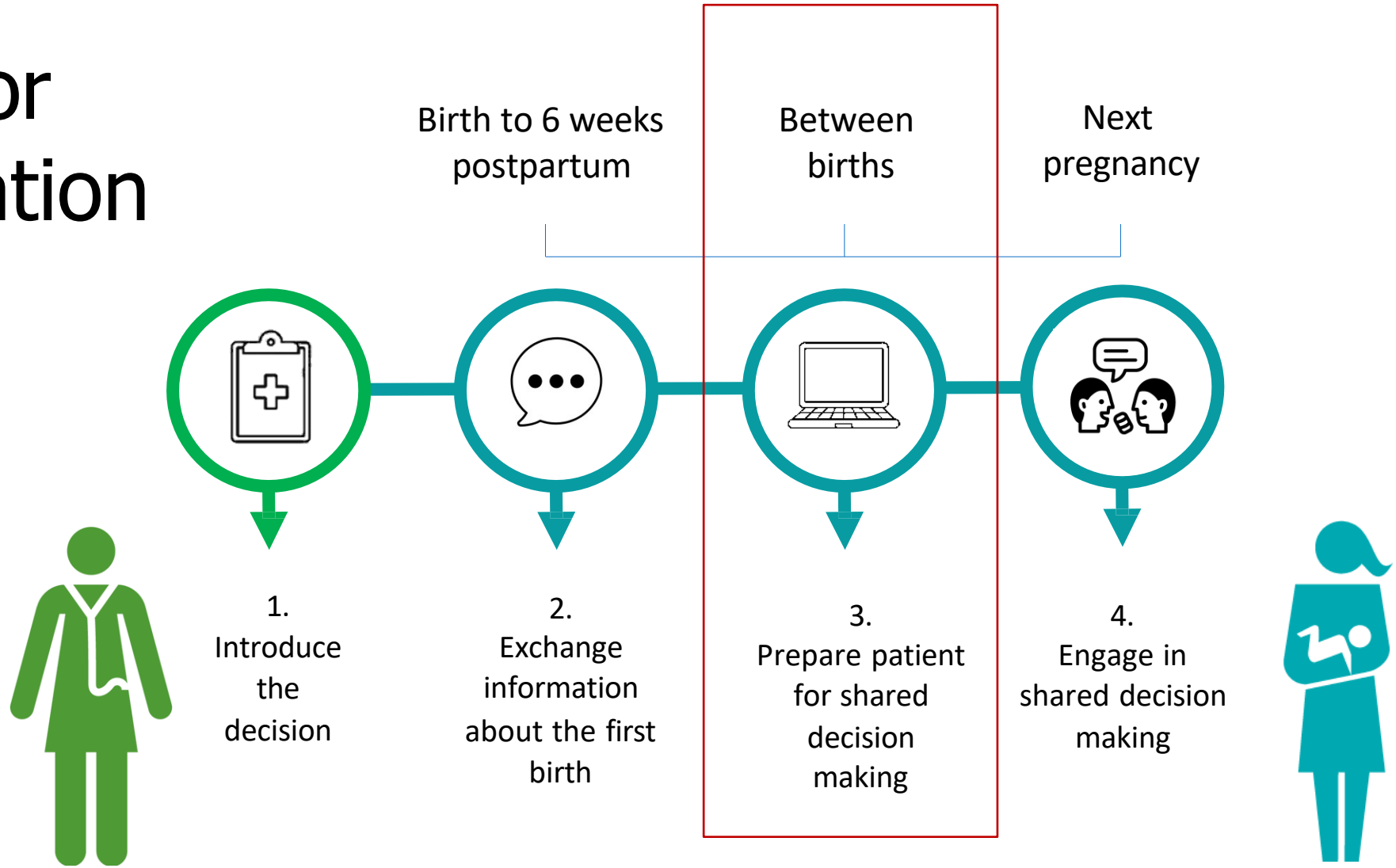
What works in embedding shared decision-making interventions in routine care?

5 Key strategies for success

1. Co-produced or locally adapted tools
2. Training the entire team
3. Preparing and prompting patient
4. Senior-level buy-in
5. Measuring to improve

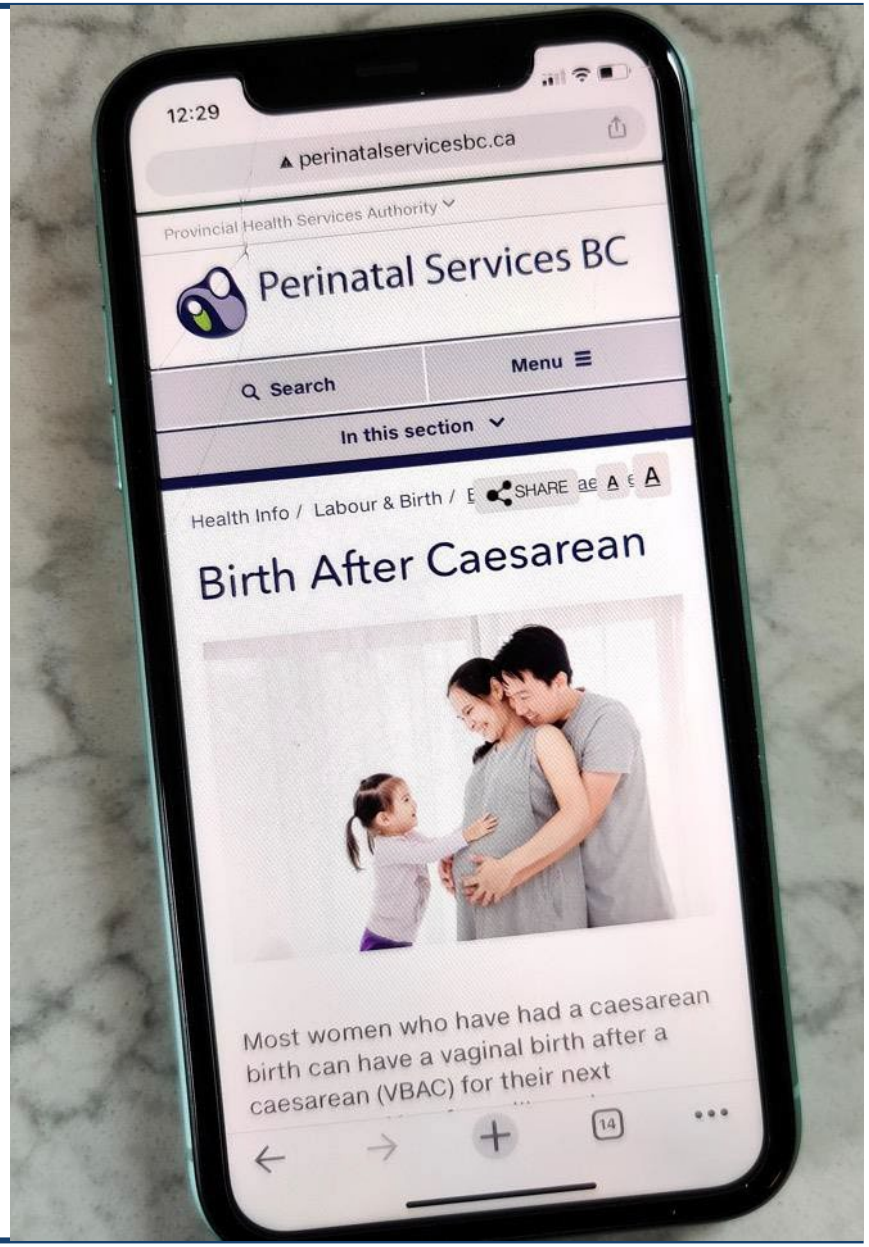
Joseph-Williams et al. *Med Dec Mak* 2021

Preparing for implementation **early** in the research process

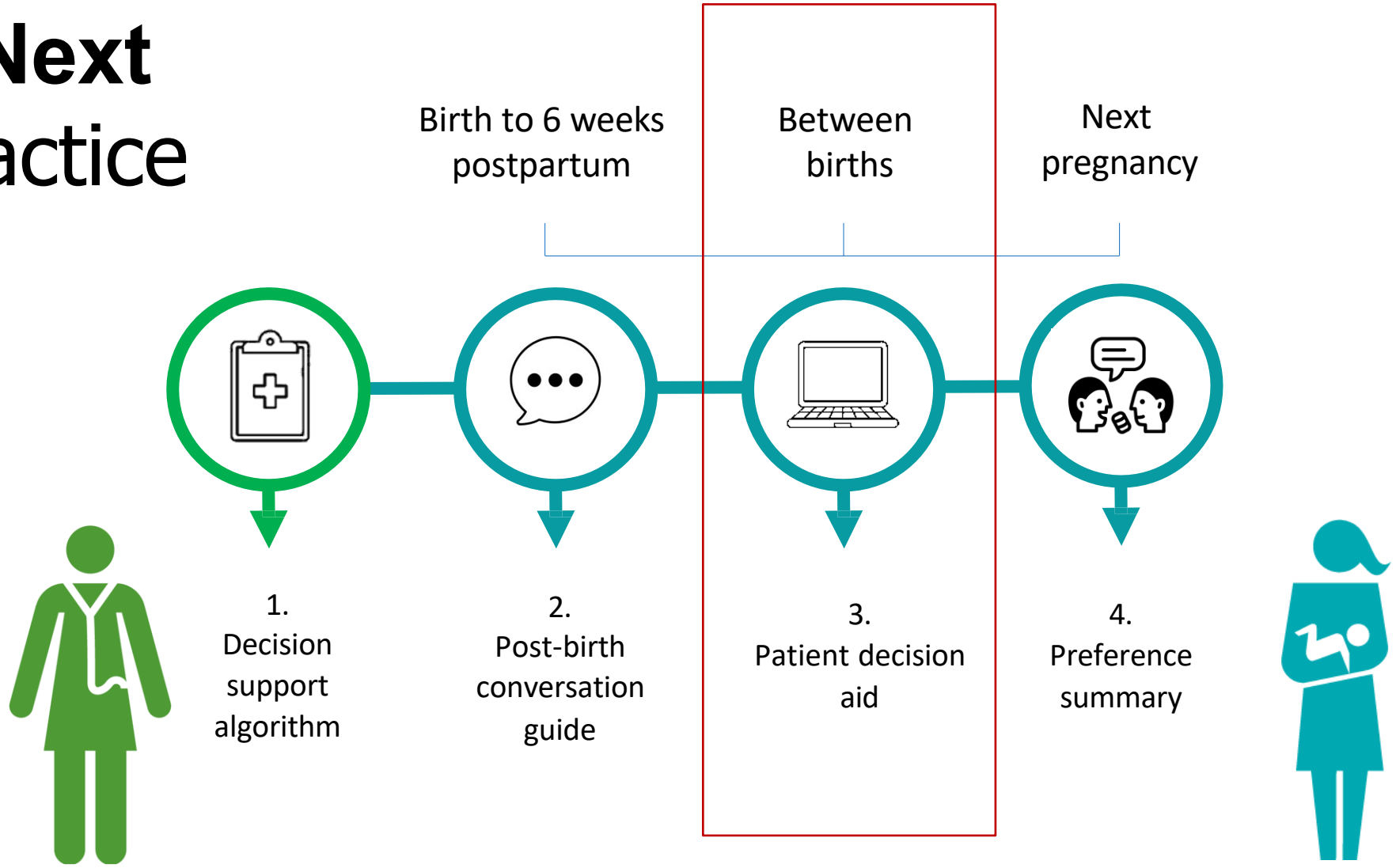


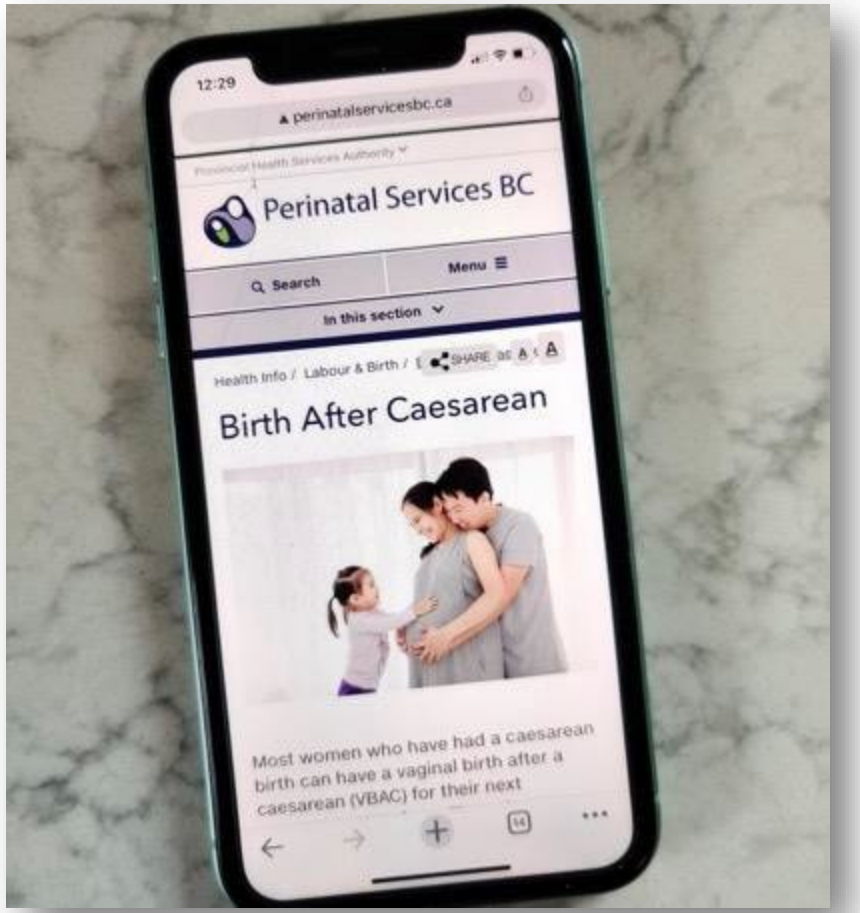
Preparing for implementation throughout intervention development

- Collaborative design sessions with two advisory groups
- Focus groups with multidisciplinary teams at two hospitals
- Interviews with future users



Using **My Next Birth** in practice





www.perinatalservicesbc.ca/mynextbirth

MY NEXT BIRTH


Baby's Best Chance
Parents' Handbook of
Pregnancy and Baby Care
Perinatal
Services BC
Provincial Health Services Authority
BRITISH
COLUMBIA
7th edition

Funding Supports

To learn more….

www.perinatalservicesbc.ca/mynextbirth

Instagram @dr.sarah_munro

Twitter @DrSarahMunro

Email sarahmun@uw.edu

UNIVERSITY of WASHINGTON

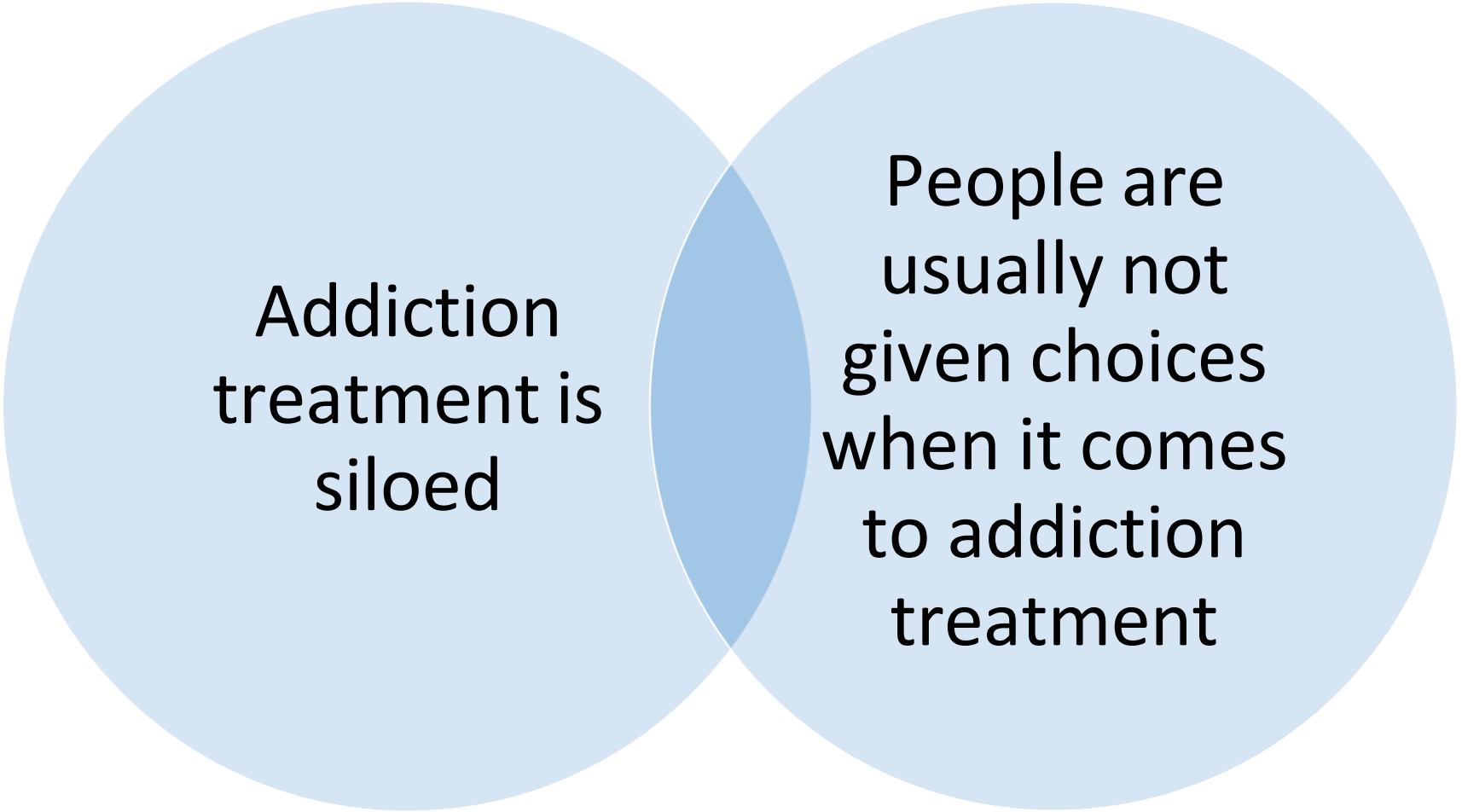
Shared Decision-Making for Medication for Opioid Use Disorder

Maureen Oscadal, BSN, RN-BC, CARN

Harborview Medical Center

UW Addiction, Drug & Alcohol Institute

Why Shared Decision-Making for MOUD?



Why Shared Decision-Making for MOUD?

Recognizes patient as experts on their own lives

Considers the medication, treatment setting, visit frequency, other requirements

Improves patient engagement & adherence

ADAI Patient Aid Development

Conversations with providers in the field

- Idea to create a tool to promote shared decisions about MOUD
- Initial treatment decision-making guide (TDM) created

Initial TDM guide tested

- Studies with WA DOC and jails assessed feasibility, acceptability, & impact.
- Shared decision-making (SDM) was associated with significant increase in MOUD initiation

Development of SDM tools for MOUD

- Patient SDM for MOUD brochure first published in 2019
- Online resources made available for providers
- Incorporation of SDM approach into ADAI trainings

Banta-Green CJ, Floyd AS, Vick K, Arthur J, Hoeft TJ, Tsui JI. Opioid Use Disorder Treatment Decision Making And Care Navigation Upon Release From Prison: A Feasibility Study. *Subst Abuse Rehabil*. 2019;10:57-67. Published 2019 Oct 22. doi:10.2147/SAR.S192045

Banta-Green CJ, Williams JR, Sears JM, Floyd AS, Tsui JI, Hoeft TJ. Impact of a jail-based treatment decision-making intervention on post-release initiation of medications for opioid use disorder. *Drug Alcohol Depend*. 2020;207:107799. doi:10.1016/j.drugalcdep.2019.107799

Patient Aid: Brochure

What's next?

Learn more about OUD and how to use this brochure:
learnabouttreatment.org

Connect to medication options near you:
warecoveryhelpline.org

Find naloxone and overdose info:
stopoverdose.org

More info on medications:
samhsa.gov/medication-assisted-treatment

ADAI ADDICTIONS, DRUG & ALCOHOL INSTITUTE | CENTER FOR COMMUNITY-ENGAGED DRUG EDUCATION, EPIDEMIOLOGY, AND RESEARCH

UNIVERSITY of WASHINGTON
PSYCHIATRY & BEHAVIORAL SCIENCES
School of Medicine

This brochure provides basic information for educational purposes. Speak with a health care professional to make an informed decision that best fits your needs including learning the risks and benefits of all treatment options.
Revised January 2023.

Your preferences

Setting: _____

Dosing frequency: _____

Clinic visit frequency: _____

Counseling: _____

Support group: _____

Medication options: _____

_____

Other: _____

_____

_____

_____

_____

Call the **Washington Recovery Help Line** to talk about your options for medications, counseling and support groups, and connect to care.

Washington Recovery Help Line
24-Hour Help for Substance Abuse, Problem Gambling & Mental Health
1.866.789.1511
warecoveryhelpline.org

About OUD

What is opioid use disorder?

Opioid use disorder (OUD) is a long term medical condition. People with the condition are physically dependent on opioids and have brain changes that affect their thinking, priorities, and relationships.

OUD can come back if not treated properly. You may need to try more than one type of treatment to find what works best for you.

What can medications do for me?

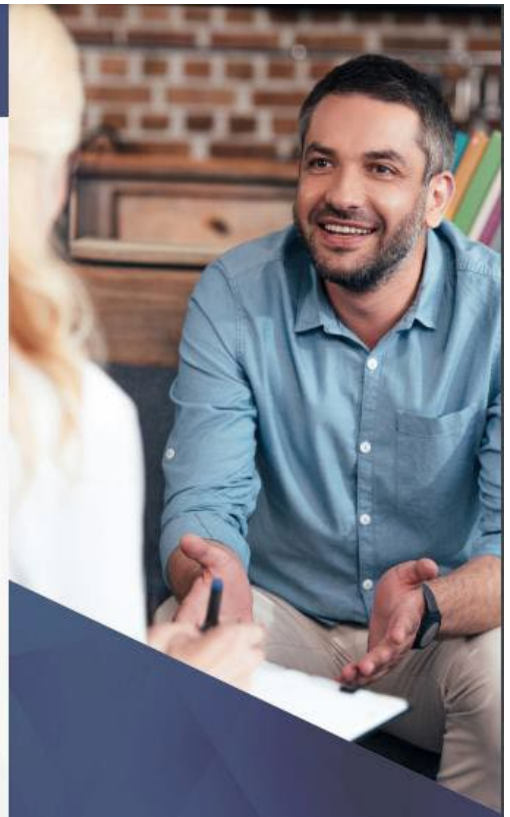
Medications are proven to work the best at treating opioid use disorder.

They help:

- Manage craving and withdrawal.
- Reduce illicit opioid use.
- Decrease the risk of having an overdose.

Medications can provide stability, allowing people to address other things in their lives.

You can be in recovery and be on medications at the same time.



Medications for Opioid Use Disorder

Patient Aid: Brochure

Treatment options

There are **three** places where you can get medications for opioid use disorder:

Opioid treatment program (OTP)

- **Methadone**, **buprenorphine**, or **naltrexone** available.
- Highly structured—counseling and supervised dosing may be required.

Medical office/Primary care

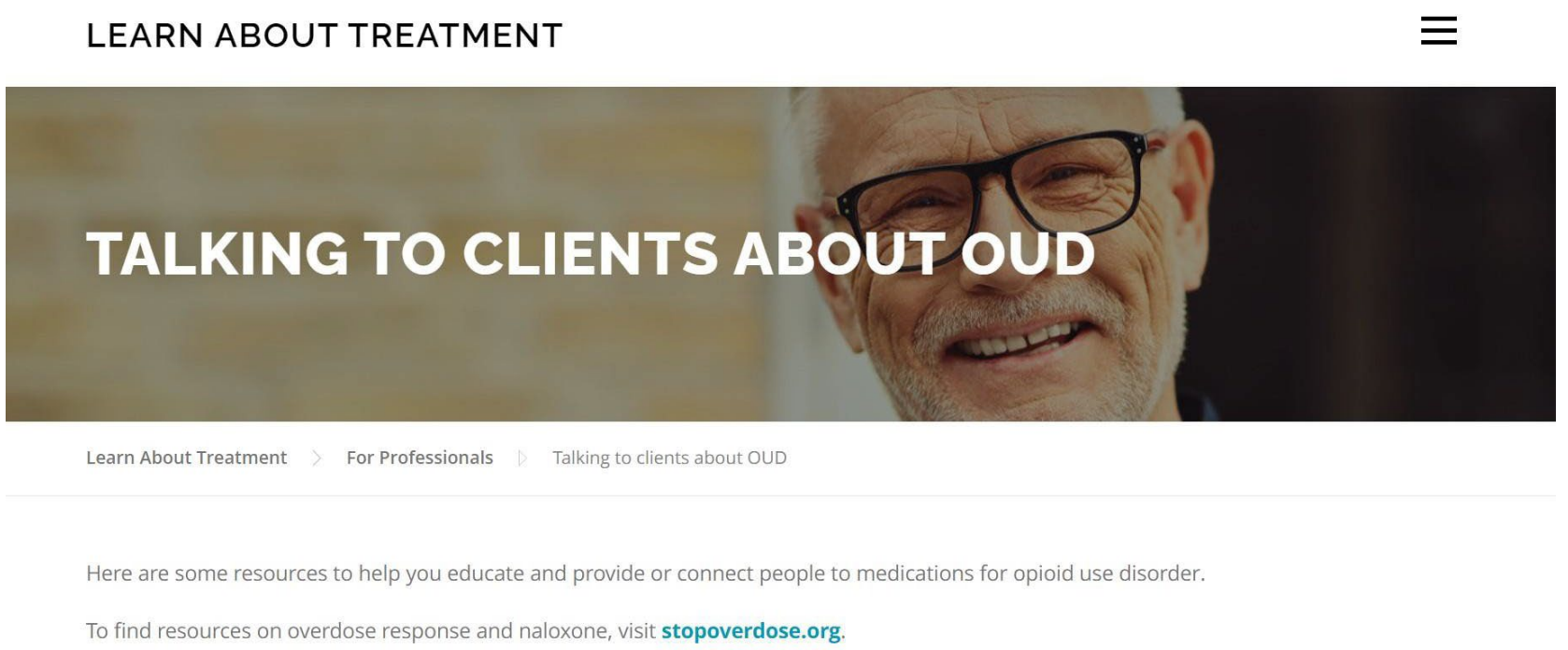
- **Buprenorphine** or **naltrexone** available.
- Familiar medical office setting.
- Less structure (often weekly or monthly visits, some don't require counseling).
- Appointment often needed.

Community program

- **Buprenorphine** or **naltrexone** available.
- Other services may be offered (syringe exchange, housing supports, etc.).
- May have drop-in visits.

	Methadone	Buprenorphine	Naltrexone
How does this medication work?	• Methadone is a **full** opioid medication. • The more you take the **more you will feel** its effects. • Manages cravings and withdrawal by binding to opioid receptors.	• Buprenorphine is a **partial** opioid medication. • Has a ceiling effect, so above a certain dose you **stop feeling more** of its effects. • Manages cravings and withdrawal by binding to opioid receptors.	• Naltrexone is an opioid **blocker**. • It is not an opioid, so you **won't feel** an opioid effect. • Helps manage cravings for some people.
Does it lower my risk of dying? *Based on research that tracked outcomes in the real world.*	• **Lowers** risk of death by about 50%.	• **Lowers** risk of death by about 50%.	• Has **not been shown** to lower the risk of death.
How long does it last, and how do I take it?	• Lasts about **24 hours** and is taken by **mouth**.	• **Oral form** lasts about **24 hours**, **injectable form** lasts **7-28 days**.	• An **injection** that lasts for **28 days**. You can't use any opioids for 7-10 days before taking naltrexone.
Where can I get it, and how often do I need to go?	• Dispensed only at **opioid treatment programs**. • Dosing can start up to **6 days a week**, but usually becomes less often over time during treatment.	• **Prescribed** by a medical provider and **picked up** at a pharmacy (*oral*) or **given** at an appointment (*injection*). Both are available at some **opioid treatment programs**. • Visits vary from near daily to monthly.	• **Prescribed and given** by a medical provider, or provided at an **opioid treatment program**. • Visits vary from weekly to monthly.
Will I need to go to counseling?	• Requires regular urine drug testing and counseling.	• Most providers require urine drug testing and some require counseling.	• Some providers require urine drug testing and counseling.

LearnAboutTreatment.org



SDM implementation support available on “Client Engagement” page at LearnAboutTreatment.org

Provider Guidance

Medications for Opioid Use Disorder
Guide to Using the Brochure

What is Treatment Decision Making?

All people deserve to be actively involved with decisions about their health. This includes people with opioid use disorder (OUD). They should be provided with accurate information about all possible options for treatment so they can make an informed decision about the kind of care *they* want.

Similar to other health conditions, opioid use disorder can be treated with medications. Research shows that medications work best for most people to:

- Help stabilize their lives
- Reduce relapse
- Cut their chances of dying.

Medications have also been shown to:

- Reduce criminal activity and incarceration
- Improve functioning
- Lower the risk of getting HIV and HCV
- Substantially reduce costs

(Clark et al., 2011; MacArthur et al., 2012; Nolan et al., 2014; Nordlund et al., 2004; Tkacz et al., 2014; Tsui et al., 2014; White et al., 2014).

Patients and many healthcare providers may have incomplete knowledge about medications to treat OUD and they may not know about new, easier ways to access medications. Talking about OUD and medications is an opportunity to address any misconceptions people have and fill in any gaps in knowledge.

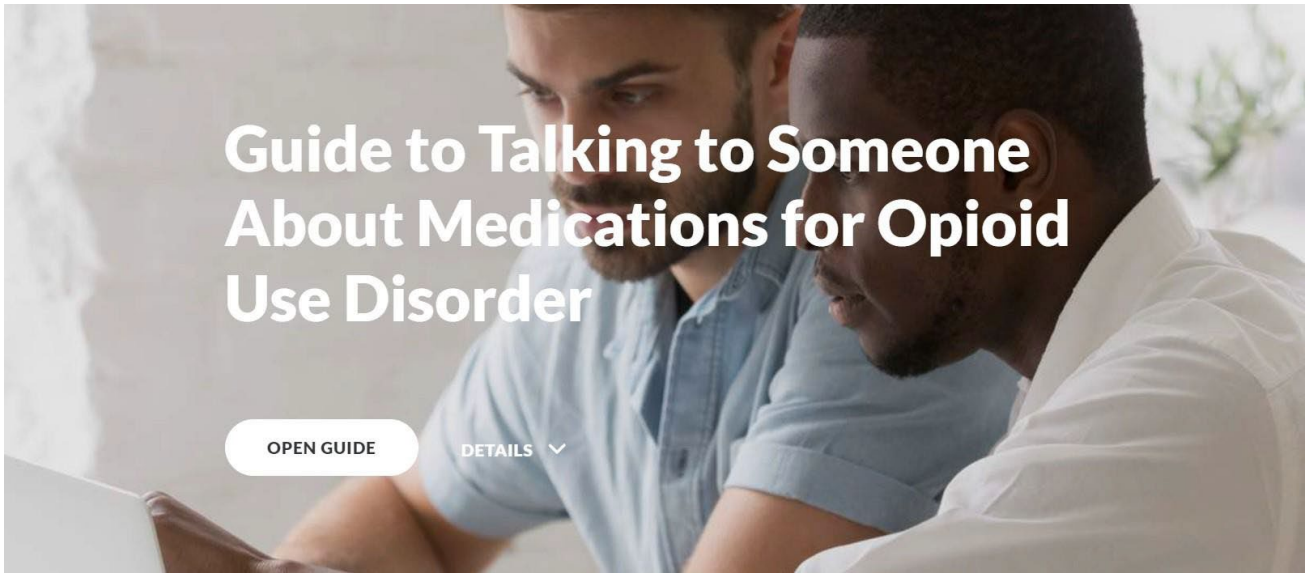
Talking about medications

Ask

Start by asking about someone's specific goals, interest, and experience with trying to cut back or stop their opioid use. If they give a vague answer like "get healthy," ask them "what that would look like for you?" Try to use the same language they use to talk about their goals for cutting back or stopping. Language like "treatment" or "recovery" may be helpful for some clients and not for others.

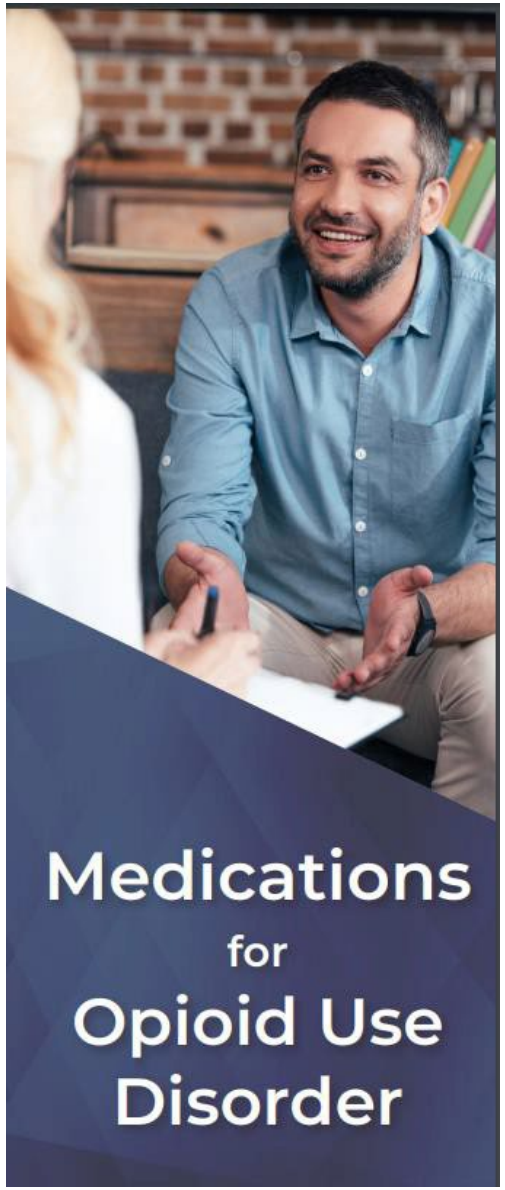
Developed by Caleb Banta-Green, PhD
University of Washington | Alcohol & Drug Abuse Institute | 2020

ADAI | ALCOHOL & DRUG ABUSE INSTITUTE



- What is Treatment Decision Making?
- Talking About Medications
- Sample Conversation Script
- Brochure Talking Points

Resources



Format	Location
Brochure	Medications for Opioid Use Disorder. https://www.learnabouttreatment.org/wp-content/uploads/2023/01/MOUD-Brochure-2023-11-web.pdf
Website	Talking to Clients about OUD. https://www.learnabouttreatment.org/for-professionals/client-engagement/
Web guide	Talking to Someone About Medications for Opioid Use Disorder. https://www.learnabouttreatment.org/guide/#/
Handout	Medications for Opioid Use Disorder: Guide to Using the Brochure. https://www.learnabouttreatment.org/wp-content/uploads/2020/09/medicationbrochureguide.pdf

More at: LearnAboutTreatment.org

Orthopedic Shared Decision Making Learning Collaborative

Karen Sepucha

Massachusetts General Hospital

https://mghdecisionsciences.org

Funded by contract from PCORI

Background

- Patient advisory group challenged us ("video decision aids are long is there something shorter?")
- Conducted randomized trial that showed similar benefit of short and long DAs (patients more likely to use shorter tools)
- Both decision aids better than usual care➔ renewed focus on how to get these to patients

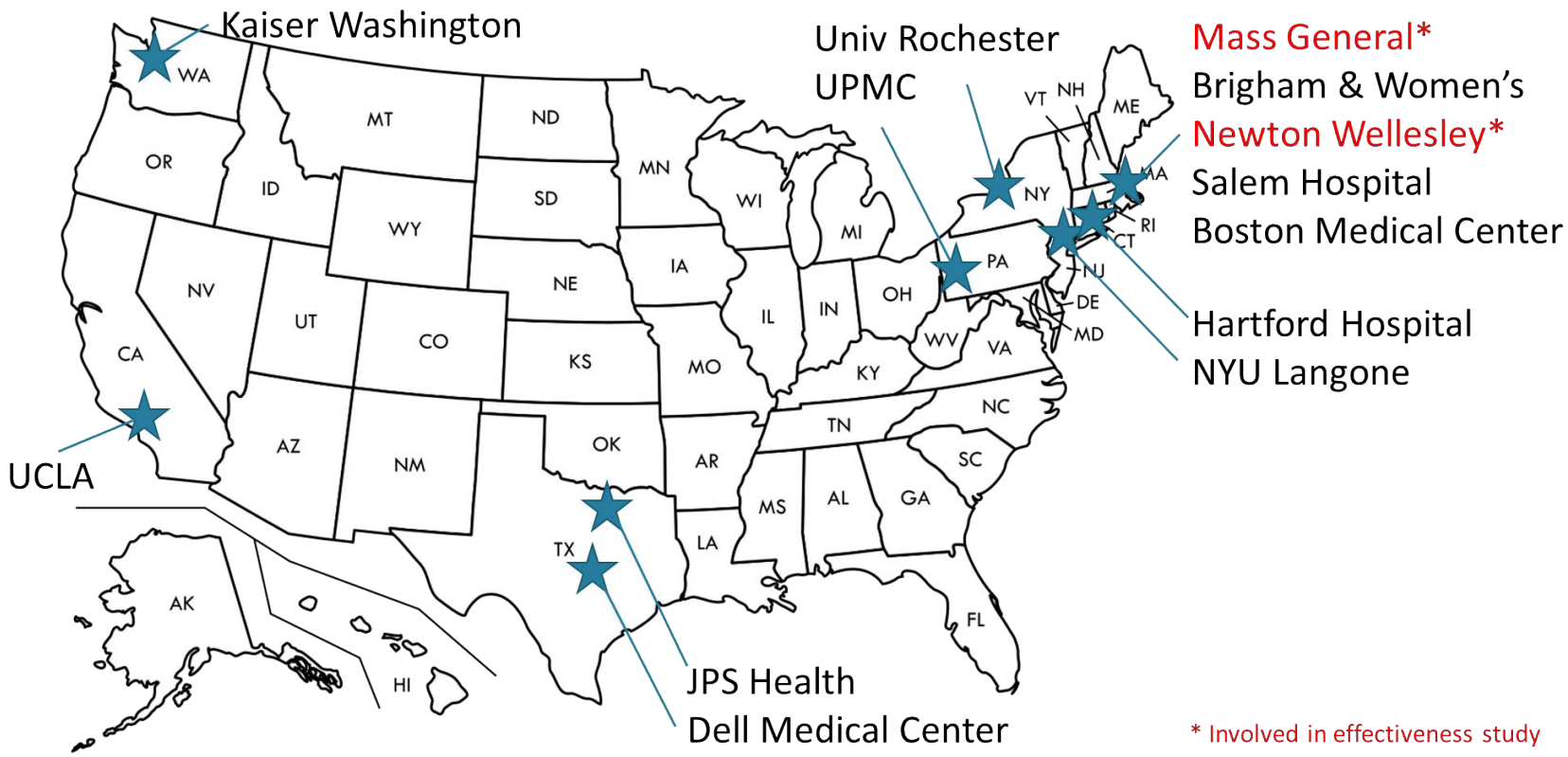
The project … is a collaborative search for the best ways to help real people, faced with life altering medical decisions, manage and understand their options.
--patient partner

Sepucha et al 2022 JBJS

Hosted Learning Collaborative

20k

Goal for decision aids



* Involved in effectiveness study

Summary

87 surgeons and specialists across 13 sites

19,658 adults with hip or knee arthritis, spinal stenosis or herniated disc

4 decision aid vendors (Healthwise, Wisercare, OM1Joint, EBSCO)

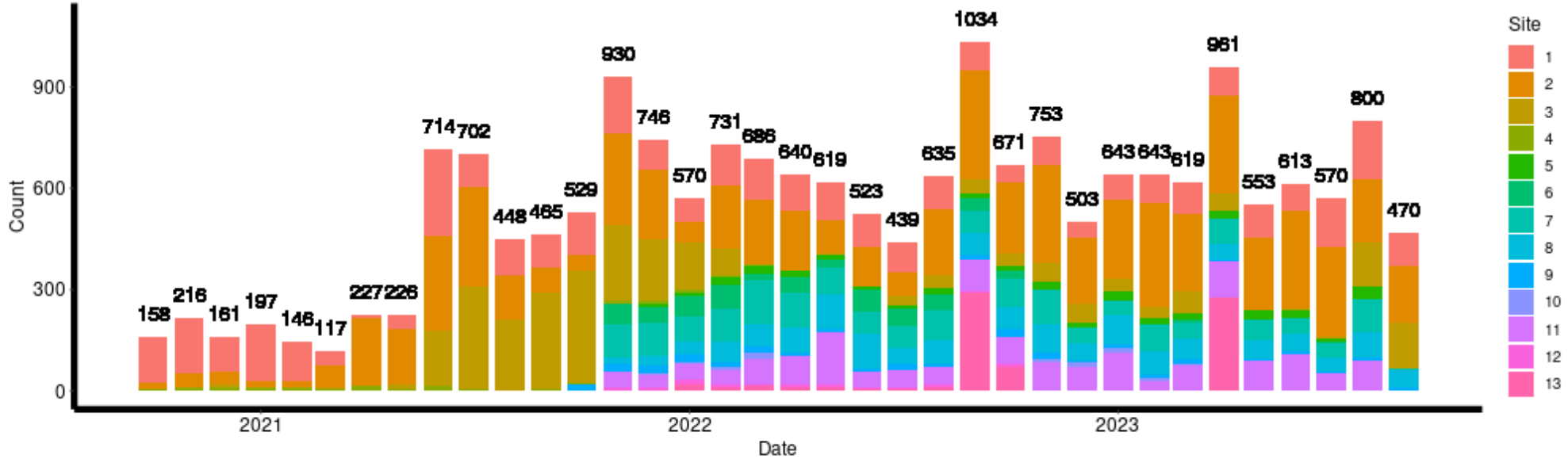
Pre-visit and day of visit workflows with clinicians and clinic staff

Learning Collaborative with 1-1 consulting

Total Decision Aids Delivered During Project

19658

DAs Delivered By Site



"But how do we motivate them to attend the motivation seminar?"

ROSE

Success

THORN

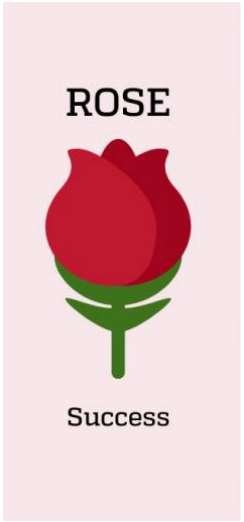
Challenge

BUD

Potential

“Being able to provide DAs in several different languages helped opened up “informed access” to more patients

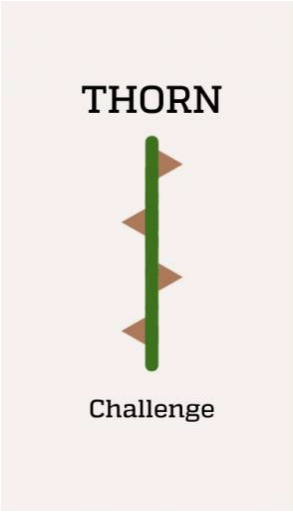
Roses



”The most important thing was having buy-in from the staff. This couldn't happen without the staff implementing it.

“IT is overwhelmed and resistant to taking on new projects so bandwidth isn’t there to integrate into EHR

Thorns



Biggest barriers are staff turnover and participation. For nurses, it’s not in the forefront for them.”

Implementation toolkit: 6 core areas

https://mghdecisionsciences.org/tools-training/da-implementation-toolkit/

Patient partners

> “It is deeply satisfying to be able to participate in a process that is so fully committed the patient perspective and patient experience.

> It is fair to say the discussions, often extensive about patient care and communication, had the thinking ‘out of the box’ quality that is probably key to advances in patient care.”

Insights

Sites were able to reach meaningful percentage of patients (estimated 40%) with minimal support

Sites without any prior experience did very well, as did sites that were safety net providers

Contracting with decision aid vendor and integration into EHR takes time and leadership buy-in

Staff turnover and getting broad buy-in were common challenges

Thank you!

https://mghdecisionsciences.org/

ksepucha@mgh.harvard.edu

@MGHSDM

https://cmecatalog.hms.harvard.edu/shared-decision-making-skills-clinical-practice

Panel Discussion

Questions


15
Minute
Break

Implementing Shared Decision Making into Practice: Next Steps

Heather Schultz, MD, MHA, Washington State Health Care Authority

Template for implementing SDM & PDAs

First, a few things to think about:

- Are you currently doing shared decision making in your organization?
  - If yes, where is your organization in the implementation process? For example, is shared decision making built into your current workflow?
  - If not, what needs to change in order to implement shared decision making?
- What are some potential barriers to implementing shared decision making? (Resource: NQP Playbook)
  - What are some possible solutions to overcome those barriers? (Resource: NQP Playbook)
- Who do you need to partner or connect with to help implement shared decision making at your organization?
- What do you need from others to make necessary changes?

Additional information can be found in the National Quality Partners Playbook: Shared Decision Making in Healthcare and the Dr. Robert Bree Collaborative Shared Decision Making Report and Recommendations

National Quality Partners framework

- Leadership and culture
- Patient education and engagement
- Healthcare team knowledge and training
- Action and implementation
- Tracking, monitoring and reporting
- Accountability

Stages of change

Stages of Change – 1. Contemplation

Review the basic implementation examples for all six fundamentals. Implement the components of examples within basic Leadership and Culture implementation (page 6 of the SDM Playbook).

Stages of change – 2. Preparation

Review the SDM Playbook's basic to advanced Healthcare Team Knowledge and Training examples (page 12) and implement components of basic Knowledge and Training.

Stages of Change – 3. Action

Review the SDM Playbook's Fundamental 4: Action and Implementation (page 15) and implement the components basic through advanced.

Stages of Change – 4. Maintenance

Review the SDM Playbook's basic to advanced Tracking, Monitoring, and Reporting examples (page 18) and implement components under basic through advanced.

Additional Resources for Implementing SDM

- Dr. Robert Bree Collaborative Shared Decision Making Report and Recommendations
- AHRQ SHARE Training
- Minnesota SDM Collaborative Implementation Roadmap
- Ottawa Personal Decision Guide
- American Academy of Family Physicians: A Simple Approach to Shared Decision Making in Cancer Screening

Vision for the future in Washington State

- Continue to promote SDM/use of certified PDAs
- Reduce variation in healthcare
- Measure quality and impact of implementation
- Encourage submissions of different types for PDA certification
- Engage patients in their decisions that impact their health

Questions?

Contact:

shareddecisionmaking@hca.wa.gov

More Information:

Shared decision making | Washington State Health Care Authority

Next steps

- Information will be sent out to attendees, including:
  - Links to Resources referenced today
  - Presentation materials
  - Training opportunities
  - Opportunity to participate in a SDM learning community