Shared Decision Making Implementation
Stories and Lessons Learned

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The Holy Grail
Transforming the Culture

- **Provider expertise**
  - Diagnosis
  - Disease etiology
  - Prognosis
  - Treatment options
  - Outcome possibilities

- **Patient expertise**
  - Experience of illness
  - Social circumstances
  - Attitude to risk
  - Values
  - Preferences

- **Shared decision**
  - A mutual decision that best meets patient needs

Two Stories


Life Care Planning at Kaiser Permanente – Implementing the Respecting Choices model across all KP regions
The Group Health/Kaiser Permanente SDM Story

- Implemented in 2009 across five specialties
- Reliable distribution of decision aids
- Mandatory training for surgeons
- Over 65,000 patients involved
- Outcomes consistent with studies
- Published in Orthopedics, Gyn, Urology
- Moving “upstream” into Primary Care
- Expanding available topics
- Expanding training to all clinicians

**Video Decision Aids**
- Hip osteoarthritis
- Knee osteoarthritis
- Spinal stenosis
- Herniated disc
- Benign Prostatic Hyperplasia
- Uterine fibroids
- Abnormal uterine bleeding
- Early stage breast cancer
- Breast reconstruction
- Ductal carcinoma in situ
Approach to Implementation

Aligned leadership – SDM is a strategic differentiator

“Non-elective model of adoption”

Start in Specialty, then move to Primary Care

Workflow - Lean Process Improvement

- Reliable distribution of decision aids
- Incorporation into standard work of teams
- Visual systems to make the work visible
- Incorporation into manager/leader standard work

Clinician training
Important Considerations for Implementation

Recognize and support two complimentary approaches

• Technical change
  ▪ Reliable distribution of decision aids
  ▪ Building “triggering events” into workflow

• Adaptive/cultural change
  ▪ Shift in culture to promote different conversations
Technical Change

Reliable distribution of decision aids
  - We know how to do this – complicated but not complex

Classic implementation strategies for underuse
  - Start with why
  - Walk the current process to understand local workflow
  - Work to understand and address barriers to change
  - Redesign workflow
  - Measure and feedback
  - PDCA
  - Relentless follow-up to continuously improve and manage drift
Adaptive/Cultural Change

Cultural change is hard – complex rather than complicated

- No data without stories, no stories without data
- Recognize that clinicians believe that they already do this
- Collect and share stories
- Use the patient’s voice
- Leadership presence
Ortho Workflow

Surgeons can integrate the delivery of decision aids into referral process

Every knee or hip replacement patient will be asked to view the decision aid before meeting their orthopedist

At time of referral, a RN, PA, or MD reviews every new case and will place DVD order for the patient
Rings of Defense

Legend (line widths reflect relative volumes, not to absolute scale):
- Blue = Referrals who are candidates for SDM
- Yellow = Self Referrals who are candidates for SDM
- Green = Established Patients who are candidates for SDM
- Red circle = Procedure performed
In process measurement – volume of distribution

Shared Decision Making Videos: Monthly Distribution

Count of Videos

Ordered By
- Web
- Support
- Provider
- Pre-Visit

Period
- Count of Videos
- SDM Video Provider Specialty
- Site
- Authorizing Provider
In process measure – exposure to DA

Preference Sensitive Conditions - GP
Percentage of Procedures Performed where Patient did not receive the video. (Hips, Back, Knee and Hysterectomy & Benign Prostatectomy)

Month

% Did not receive video
Target
Clinician Training

Mandatory training for all surgeons
4 hour interactive training with role play
Highly reviewed by participants
90 minute Web based training for all staff
96% of 2,156 patients surveyed.

Decision aid videos helped me understand my treatment choices.
95% of 2,139 patients surveyed.

Decision aid videos helped me prepare to talk with my provider.
Qualitative Provider Interviews

- Overall positive or neutral about decision aids
- Benefits of decision aids outweigh minor concerns
- Patients are more informed
- Time neutral or time saving
Life Care Planning is a KP National Quality Initiative

- **2012**: California
- **2013**: Georgia
- **2014**: Colorado, Washington
- **2015**: Oregon, Hawaii
- **2017**: Virginia, Maryland, District of Columbia
Patients with Serious Illness

- Normalizing the conversation for clinical teams
- Identifying populations
- Triggering events for conversations
- Challenges to risk communication
- Pilots using decision aids
Themes and Barriers

It is easier to focus on the technical changes, rather than the cultural change

For Preference Sensitive Surgical conditions

• “I already do this”
• While decision aids are great for risk communication and setting expectations for participation in decision making, clinicians can mistake them for SDM
• Clinicians do not necessarily appreciate the difference between decision aids and educational materials
• In fee for service practice, perceived risk to revenue

For Serious Illness

• Clinicians discomfort with the conversation
• Discomfort with decision aids for risk communication
• Scaling to the populations (incidence vs prevalence)
• We benefit from moving conversations past health care delivery to communities
Key Learnings

Be wary of Pilot-itis

The Technical change is easier than the Adaptive/Cultural change (having different conversations)

Leadership matters – it is hard to lead adaptive change

The case for change should be mostly aspirational (best for patients) rather than critical (demonstration of current variation)

There is a WIFM for clinicians

- Patient centered – different conversations are reinforcing
- Time neutral or time saving