Shared Decision Making Implementation Summary Chart

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May 2011

http://depts.washington.edu/shareddm

The demonstration project began with four sites: Carol Milgard Breast Center (CMBC), MultiCare (MC), The Everett Clinic (TEC), and Virginia Mason Medical Center (VM). CMBC officially ended its participation in the project in April 2010 following a change in executive leadership, demonstrating that the loss of an SDM champion from an organization can stall implementation efforts.

TEC's orthopedics group is using the DAs for the conditions of hip osteoarthritis and knee osteoarthritis, and VM's Breast Clinic is distributing two DAs: Ductal Carcinoma in Situ and Early Stage Breast Cancer: Choosing Your Surgery. MC chose to implement SDM at the Maple Valley Clinic, a community clinic where the typical patient has a chronic condition and a long-standing relationship with the provider. The Maple Valley Clinic is using the following DAs: Acute Low Back Pain, Chronic Low Back Pain, Living Better with Chronic Pain, Coping with Symptoms of Depression, Living with Diabetes, Colon Cancer Screening: Deciding What's Right for You, and Is a PSA Test Right for You?

All three sites provided DA viewing opportunities for providers and staff. Each site created and fine-tuned workflow process maps to incorporate SDM and assign patient identification and DA distribution responsibilities to team members. MC relies on providers and back-office staff to identify patients who could benefit from SDM. Similarly, a nurse practitioner at VM reviews biopsy results to identify patients with ductal carcinoma in situ or early breast cancer. TEC leveraged its electronic health record system and set up a referral queue that automatically filters in patients with certain diagnosis codes. Although in general the teams were enthusiastic, inducing day-to-day behavior change proved more difficult than anticipated. Providers and back-office staff have numerous responsibilities already and introducing one more item to the list has been challenging, despite their belief that SDM is good for the patient. At TEC, for example, the back-office staff has trouble remembering to notify the surgeon of an SDM patient so that the surgeon can close the loop and provide decision support. In addition, multiple reminders at MC, such as blue flags next to patient names in the daily schedule and printed cards with the eligible conditions taped to the computer monitor of each exam room, have not been as successful as expected.

Additionally, DA and survey return rates have not been as high as was hoped. MC has a 30% return rate despite much effort and multiple methods to remind patients to return DAs and surveys (e.g., phone calls, letters, and self-addressed stamped envelopes). On the other hand, TEC and VM have a 50% return rate without conducting any follow-up phone calls. Lastly, each site has provided and continues to provide patient feedback to providers and staff with Illume reports and/or other tracking tools, which have elicited positive reactions.

	Carol Milgard Breast Center (CMBC)	The Everett Clinic (TEC)	MultiCare (MC)	Virginia Mason (VM)
Site Project Managers	Alexis Wilson	Lynette Wachholz lwachholz@everettclinic.com	Desi Axt Desiree.Axt@multicare.org Janelle Tiegs Janelle.Tiegs@multicare.org	Carolyn Cone Carolyn.Cone@vmmc.org Sherry Stoll Sherry.Stoll@vmmc.org
Site Information	CMBC is a comprehensive breast care services facility located in Tacoma, Washington that offers screening and diagnostic services, educational programs, and support programs. It was founded by Franciscan Health System, MultiCare Health System, and TRA Medical Imaging.	TEC is a physician-owned, multi-specialty clinic with 343 physicians and 81 advanced-practice clinicians. With 16 practice sites throughout Snohomish County, Washington, TEC serves 280,000 patients with over 800,000 visits each year.	MultiCare (MC) is a not-for-profit health care organization with more than 9,300 employees. MC consists of four hospitals and a number of outpatient centers and clinics across Pierce, South King, Thurston, and Kitsap counties; the health care system provided over 526,000 physician visits in 2009. The Maple Valley Clinic served more than 9,000 patients in 2010.	VM is a not-for-profit integrated health care system with 450 physicians and 5,000 employees. With eight sites and its primary location in downtown Seattle, VM provided more than 843,000 physician visits and 17,600 surgical procedures in 2009.
DAs	• Early Breast Cancer: Hormone Therapy and Chemotherapy • Breast Reconstruction: Is It Right for You? • Early Stage Breast Cancer: Choosing Your Surgery • DCIS: Choosing Your Treatment	• Hip Osteoarthritis • Knee Osteoarthritis	• Acute Low Back Pain • Chronic Low Back Pain • Living Better with Chronic Pain • Coping with Symptoms of Depression • Living with Diabetes • Colon Cancer Screening: Deciding What's Right for You • Is a PSA Test Right for You?	• DCIS: Choosing Your Treatment • Early Stage Breast Cancer: Choosing Your Surgery
FIMDM 8-Step Implementation Framework				
Engage providers and staff	Alexis approached five or six surgeons and oncologists to pitch SDM. Three providers agreed to implement SDM and use DAs. The providers who declined to participate did not provide negative feedback, but rather stated that they could not implement SDM within their systems.	The orthopedics group, consisting of six surgeons, seven mid-level providers, and 11 medical assistants, was selected for SDM implementation because it was open to trying new things, and the providers did not see SDM as a threat to their practice. There are currently three- to six-month waits for surgeries, and	MC's Maple Valley Clinic was chosen for SDM implementation because the site was already involved in the Medical Home Collaborative, and SDM seemed to be a good fit with the medical home model. Desi, the patient care coordinator, emailed DA summaries and hand-delivered paper copies to each provider at	The breast surgery team expressed an interest in SDM and agreed to implementation. The Breast Clinic and surgery team includes Debra Wechter, MD (surgeon), Rita Kelly, RN, Carly Searles, ARNP, and more recently, a medical assistant, Cheryl Childs. Team members reviewed all the materials. DA

		the group saw SDM as a means to increase access to surgeries. Dr. Scott Schaaf, the department chair, is the physician champion who pitched SDM to the group. He gave each provider a DVD, and they all viewed the DVD. DA summaries were also handed out early on. Challenges: Many providers thought they were already practicing SDM. They also didn't perceive themselves as playing a major role in the process, believing that their job was simply to hand out the DA. SDM is more than that, and it's still a challenge to motivate behavior change.	the Maple Valley Clinic. The providers find the DA summaries very useful. The providers and staff were excited about SDM and presented no pushback. Staff had multiple opportunities for DA viewing and education. In addition to meetings regarding implementation, each staff member received a pamphlet and DVD to review. The Maple Valley Clinic has viewing equipment so staff members have the option of viewing the DVD on site. DA viewing software was also downloaded on a couple of the computers in case anyone wanted to view the information during downtime or break time.	summaries have not been used. Challenges: Other teams were approached as well, but a number of factors precluded participation, including involvement with other initiatives. Among other reasons, the spine team declined to participate after viewing one of the DAs because it described practices that were not in line with Washington State practice guidelines. Another challenge was the extensive delays experienced in seeking IRB approval, but the team remained engaged and enthusiastic and was ready to start implementation immediately after receiving approval.
Target individuals or populations	CMBC chose breast cancer as the condition for SDM participation. Four DAs were available: (1) Early Breast Cancer: Hormone Therapy and Chemotherapy, (2) Breast Reconstruction, (3) Early Stage Breast Cancer: Choosing Your Surgery, and (4) DCIS: Choosing Your Treatment.	TEC chose hip osteoarthritis (HOA) and knee osteoarthritis (KOA) and their corresponding DAs. Choosing HOA and KOA was an easy decision because the conditions matched the group, and these conditions were the least financially threatening. Since patients currently experience three- to six-month waits for surgeries, there would be no shortage of work for the orthopedics group even if SDM resulted in fewer patients opting for surgery.	MC chose the chronic conditions of low back pain, chronic pain, depression, and diabetes, and the acute condition of low back pain, and later added screening tests for colon and prostate cancer. The five original conditions align closely with the Medical Home Collaborative. MC is using the following DAs: Acute Low Back Pain, Chronic Low Back Pain, Living Better with Chronic Pain, Coping with Symptoms of Depression, Living with Diabetes, Colon Cancer Screening: Deciding What's Right for You, and Is a PSA Test Right for You?	VM chose to start with the Breast Clinic and is using two DAs: (1) DCIS: Choosing Your Treatment, and (2) Early Stage Breast Cancer: Choosing Your Surgery. The breast cancer team was engaged so the two DAs were logical choices. VM plans to include the DAs for hip osteoarthritis, knee osteoarthritis, and prostate-specific antigen screening in the future. Additionally, Dr. Donna Smith, Medical Director for VM Hospital and leader in end-of-life and palliative care, requested to see the end-of-life DA. She shared it with her team members, but has not initiated SDM implementation or DA distribution.

Identify	Alexis began creating identification and distribution mechanisms with each of the three participating providers. One provider wanted to identify and hand out DAs to patients directly at appointments. Another wanted the DA to be sent out with other information as soon as the patient made an appointment from a referral.	TEC created a separate queue within Epic that identifies internal referrals with a diagnosis of hip osteoarthritis or knee osteoarthritis. Epic analysts created the referral queue. The queue is reviewed every day by the receptionist, who calls the patient within 24 hours to make an appointment with the orthopedics group. Of the referrals in the queue, however, only patients who are over 50 years of age and have not had an acute injury are appropriate candidates for receiving the KOA or HOA DA. If a patient qualifies, the receptionist schedules the appointment for at least one week out so that the patient has time to receive and review the DA materials. In addition, since they are the ones making the diagnosis, surgeons and PAs have been asked to identify patients during the appointment who would benefit from viewing a DA. After having few referrals come into the queue and deciding that they were missing too many potential patients, the orthopedics team added the referral codes for hip pain and knee pain. Six months after implementation, an Epic analyst discovered and corrected an error in the codes used for the referral queue. The original numerical ICD-9 code lacked a letter at the end of it (ex: 715.96 instead of 715.96Q), so	Since the patients have long-standing and good relationships with their physicians, MC relies on physicians to identify candidates for SDM. Support staff can also identify patients for SDM by presenting them to providers for approval. As a reminder to providers, Desi printed out reminder cards listing the eligible conditions for SDM and taped them to the computer monitor in each exam room. Additionally, Desi created and put up SDM posters in the waiting room and flyers in the exam rooms to encourage patients to ask their providers about SDM. Several patients have requested DAs after seeing a poster or flyer. Desi also put sample DA pamphlets in the exam rooms for patients to look through while waiting for the provider. Since placing the DA pamphlets in the exam rooms, four patients have self-identified for SDM and received DAs and surveys at check-out. <u>Challenges</u>: Identification relies heavily on providers and staff members to remember to initiate SDM conversations among other checklists and responsibilities. To remind providers about SDM, Desi tested out a reminder system using the daily schedule. She reviewed the schedule in advance and placed blue flags next to patients who she believed could benefit from SDM and DA	Patients with breast problems are referred to the Breast Clinic by their PCPs. Patients can also go to the Breast Clinic on their own for services such as mammograms. At the time the biopsy is done, Carly, a nurse practitioner, tells the patient that she will call with the results, unless the patient chooses to receive the results in person. Some patients choose to go in for the results, but most receive the results over the phone. Carly reviews the biopsy results in order to identify patients with DCIS and early breast cancer for SDM.

		the majority of potential patients were not filtered into the queue. Challenges: The delay in discovering the error was based on a false assumption and fear. It was originally thought that no one was falling into the queue because primary providers were making referrals without KOA and HOA diagnoses, which turned out not to be the case. Additionally, providers were afraid that including hip and knee pain as diagnoses in the referral queue would open the floodgates, and that they would be overwhelmed with the number of patients eligible for SDM. Another challenge is that identification of SDM-eligible patients at the first visit has not been happening. PAs have not been engaged enough to remember to identify patients for SDM. However, the team is working on re-designing workflow to include patient identification and distribution of DAs. Without a method to identify patients at the initial visit, the orthopedics group is missing SDM opportunities with self-referred patients and patients referred from outside of TEC.	materials. She only used this method from May to September 2010 and decided to stop because it didn't seem to be working, and time spent reviewing charts could be better used elsewhere. Desi suspects that the method was not as effective as expected for two possible reasons: (1) the provider saw the blue flag at the beginning of the visit and forgot by the end of the visit, or (2) the provider saw the blue flag but didn't think the patient was a good candidate. Using a method built into the electronic health record would be helpful in reminding providers and staff about SDM and the availability of DAs.	
Distribute	As of January 2010, Alexis was no longer employed at CMBC. An interim project manager stepped in and sent information and resource packets to the three participating providers. The interim project manager also	If a patient qualifies for SDM with a diagnosis of KOA or HOA, the receptionist explains that a decision aid will be coming in the mail. The receptionist then mails out the DA materials to the patient. Additionally, surgeons,	Once the provider or staff member identifies a patient who could benefit from SDM, the patient is directed to see Desi. Desi then spends time with the patient to explain the process, obtain consent, and distribute a	If the patient comes into the office to receive the biopsy results, Carly discusses SDM with the patient and distributes the DA packet with a warm handoff. If the patient is not in the office, Carly calls the patient,

	attempted to recruit additional providers, but in April 2010, CMBC officially withdrew from the demonstration project because it was becoming too difficult to fit SDM/DA distribution within CMBC's structure. Two of the three affiliated providers' offices distributed a handful of DAs each before CMBC discontinued participation.	PAs, and MAs can hand out DAs at initial visits to patients who have been identified by the PA or surgeon. Challenges: Distribution at the first visit has not been happening because providers and staff are not identifying patients who are eligible for SDM.	DA and survey. Challenges: Distribution relies on identification by the provider or staff member. Integrating SDM in the electronic health record would be beneficial for identification and distribution. For example, in the electronic health record, the provider could have the ability to order a DA for distribution through a code or referral.	informs the patient of the diagnosis, and introduces SDM and DAs. If the patient consents, Carly mails out a DA packet the same day via UPS next-day mail.
Encourage viewing	N/A	When the receptionist calls the patient to make an appointment, the receptionist explains that the provider would like the patient to view the DA prior to the appointment. The cover letter that accompanies the DA reiterates what the receptionist says. No other contact is made with the patient between the time of making the appointment and the appointment.	Once a patient is identified, the provider introduces SDM and DAs and encourages DA viewing before directing the patient to Desi. Additionally, Desi calls patients who have chronic conditions to remind them when they are due for their next visit and/or lab work. During the phone call or in a voice message (if authorized by the patient), Desi encourages viewing and return of the DA.	If a patient is eligible for a DA, Carly explains SDM and encourages DA viewing, either in the office or over the phone. The cover letter in the DA packet reiterates what Carly says to the patient. The breast team makes no other contact with the patient between the initial phone call and the appointment with the surgeon.
Provide support	N/A	When the receptionist makes the first appointment, the receptionist writes "SDM" and the chief complaint in the schedule under "reason for visit." Therefore, when the patient checks in, the receptionist, as well as the back-office staff, sees the notation in the schedule. Although the receptionist asks for DAs and surveys at the time of check-in, the back-office staff has not consistently notified the surgeon that the patient was enrolled in the SDM program so that the surgeon can close the loop and	When a patient checks out a DA, Desi provides a half-sheet of paper to the patient that identifies the materials that are being checked out, the due date, and Desi's phone number so that patients can call with any questions. Desi meets with SDM patients at follow-up appointments to close the loop and answer questions. However, some patients just stop by to drop off the DA or survey. Desi sends a thank-you letter to patients who drop off the DA or survey, which invites patients to call her	When a DA is mailed out, Carly makes a note to document the conversation and sends a message through the electronic health record system to Rita. Rita then knows that either she or the surgeon needs to close the loop and provide decision support during the appointment.

		provide decision support. The director of musculoskeletal services stepped in and delegated the task of resolving the problem to one of the MAs, who is also the clinical supervisor. The MA had to "rally the team" and figure out how to remember to notify the surgeon to close the loop and to pass out and collect post-visit surveys. Since then, the process has improved. The number of post-visit surveys has increased, which means the back-office staff is more attentive in collecting post-visit surveys. <u>Challenges</u>: There was a disconnect between front-office and back-office staff, resulting in a lack of notice to the surgeon to close the loop and provide decision support to the patient. However, since the director intervened, the process of notifying the surgeon and collecting post-visit surveys seems to have improved.	directly with any follow-up questions or concerns.	
Measure impact	N/A	Pre- and post-viewing surveys are mailed out with the DA. At the time of scheduling the appointment, the receptionist asks the patient to bring the DA and surveys to the appointment. If the patient does not bring the DA and survey to the appointment, then the receptionist reminds the patient at check-out to bring the materials to the next appointment. If the patient does not bring back the DA and	Desi created a spreadsheet that tracks when a DA has been checked out and when the due date is (about one month later). She also reviews the appointment log, and one week prior to an appointment, she calls the patient to remind him or her to bring the DA and pre- and post-viewing surveys. Initially, MC's central mailing facility, located in Tacoma, presented a challenge for the Maple Valley Clinic because the clinic couldn't mail	The patient is asked to bring the DA and pre- and post-viewing surveys to the appointment with the surgeon. If the patient does not bring the materials, the patient is given a return envelope. The post-visit survey is handed to the patient after the appointment, and the patient can either complete the survey on site or take it home with a return envelope. No reminder calls are made to patients who have not returned their surveys.

		survey at the second appointment, then the matter is considered closed. When an SDM patient arrives, the receptionist records the patient identification number on a post-visit survey and hands it to the MA. The MA then gives the survey to the patient and asks the patient to complete the survey on-site after the appointment. Challenges: The back-office staff has not always been diligent about collecting post-visit surveys from patients. However, collection rates have increased since the director of musculoskeletal services intervened.	out surveys and give patients postage-paid return envelopes. Desi eventually obtained self-addressed stamped envelopes and gives them to patients who forgot to bring the DA and surveys to their appointment. MC has not asked patients to complete post-visit surveys yet. Challenges: Even with three phone calls, a reminder at the appointment, letters, and self-addressed stamped envelopes, a majority of patients are not returning their surveys.	Challenges: DA and survey tracking is done manually in a spreadsheet. If VM were to expand SDM, integration with the electronic health record would be necessary.
Provide feedback	N/A	TEC showed Illume slides to the providers and staff in February 2011. The presentation was motivating and generated positive reactions. TEC is starting to create denominator reports on a monthly basis so the group can see their progress more frequently. Challenges: It was difficult to provide feedback to the providers and staff prior to the beginning of 2011 because the numbers weren't large enough.	Patient survey feedback is provided to all staff members at office meetings and during one-on-one conversations with providers. Staff members have responded positively to the feedback and believe that SDM provides important education that should be made available to patients.	Carolyn, the project manager, meets with the team formally every six weeks or so, but also has opportunities for quick informal meetings in the hallway. In February and April 2011, Illume reports were created, but there was not much data to work with yet. Reports will be generated on a regular basis. Additionally, internal data is presented to Carly and Rita to discuss when and why there are drop-offs in distribution. Challenges: VM began DA distribution in December 2010, so low volume has made it difficult to generate Illume feedback reports for the team.