Shared Decision Making:
A Practice Manual for Implementers

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Introduction

One goal of the Shared Decision Making Demonstration Project, funded by the Foundation for Informed Medical Decision Making and facilitated by the University of Washington, was to document the implementation process at three major multi-specialty, fee-for-service group practices in Western Washington. The organizations are The Everett Clinic (TEC), MultiCare (MC), and Virginia Mason Medical Center (VM). This practice manual seeks to combine the knowledge we have gained from each of the demonstration sites. The manual will largely draw from experiences at the three sites, but we will also incorporate lessons from other sites across the country that are working on integrating SDM into their practices. Although the manual will provide tips for implementers (typically the project manager), it is important to remember that every organization is unique and has its own internal and external factors that will impact SDM implementation.

Because the characteristics of each site differ, we will provide an overview of each of our three demonstration sites:

- 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. The orthopedics group was chosen for SDM implementation.
- 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 and was selected for SDM implementation.
- 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. VM began SDM implementation in the Breast Clinic.

The *Switch* Framework

Before delving into implementation, we want to discuss a framework for creating behavioral change. *Switch: How to Change Things When Change is Hard*, a book by Chip and Dan Heath, serves as a useful guide that may be helpful during the implementation process of a

new activity. Their framework for inducing behavior change consists of three components: the rider, the elephant, and the path.

First, each individual has a rational side, what Heath and Heath term "the rider." In order to direct the rider, the authors propose that the implementer "follow the bright spots," "script the critical moves," and "point to the destination." Following the bright spots entails looking for the desired end goal, investigating what has been working, and replicating it. Scripting the critical moves involves thinking in terms of specific behaviors rather than large-scale changes. Pointing to the destination is important so that the rider can see the path and why the change is worthwhile.

Second, each individual has an emotional side, "the elephant." Heath and Heath propose that the implementer "find the feeling," "shrink the change," and "grow the people." Finding the feeling results from connecting the change to an emotion. Simply knowing that something is beneficial is not enough to induce behavior change. Shrinking the change means breaking it down into smaller parts so as to not overwhelm and scare the elephant. Growing the people requires instilling a sense of identity and growth.

Finally, in order to effectuate behavior change, the implementer needs to shape the path. The authors propose that the implementer "tweak the environment," "build habits," and "rally the herd." Changing the situation tweaks the environment. Sometimes behaviors are associated with the situation, so once the situation changes, the behavior changes as well. Habits are built by encouraging mechanisms that trigger the behavior so that it becomes easier to do. Rallying the herd means using other people to encourage and spread the desired behavior.

Implementing SDM comes down to individual behavior change: physicians must have SDM conversations with patients, clinical staff must identify patients who are eligible for SDM, patients must view the DA, etc. Throughout this manual we will point out real-world examples of the different components of the *Switch* framework: directing the rider, motivating the elephant, and shaping the path.

Lessons from the Field

Rolling out a new initiative in any organization involves a range of players and stakeholders. Within a health care organization, we have categorized three levels that an implementer should consider targeting in order to effectively carry out a new activity.

Level 1: Organization

As an implementer, the key goal at the organizational level is to garner the support of hospital or health care organization leaders in order to make SDM a visible initiative throughout the organization.

- ***Embed or fit SDM into organizational goals and frameworks.***
  Sites tend to be more successful when SDM is embedded into organizational goals and aligned with strategic efforts. VM's 2010 goals included the high-level objectives of the SDM demonstration pilot. Leaders believed that SDM fit well in their strategic plan of creating an extraordinary patient experience. TEC also viewed SDM as being consistent with their organizational values of providing lower cost care and better quality care. Broad support at the organizational level requires a culture that values patient-

centeredness, and Palo Alto Medical Foundation went so far as to create a new mission statement to reflect that vision.

- ***Launch a marketing campaign.***
  Some sites created marketing campaigns to spread the word about SDM. Palo Alto Medical Foundation, for example, created a brand called "Partners in Medical Decision Making" in order to raise awareness of the initiative and the availability of DA materials. They set up contests and produced promotional items, such as SDM "prescription" pads, and came up with a tagline that they repeated over and over again. The implementers were able to procure all marketing materials for less than $5,000 from the in-house public affairs department.

- ***Link SDM to existing organizational initiatives and activities.***
  It is easier to garner support for a new project when it is closely tied to another organizational initiative. One of the reasons VM got involved with the demonstration project was that SDM fit in well with its existing work on patient satisfaction and prepared and informed families. Likewise, MC participated in the demonstration because it was already involved in the Medical Home Collaborative and saw SDM as being a closely related initiative. MC even chose conditions for DA eligibility that overlapped with the Medical Home Collaborative. Additionally, when SDM was inserted into various projects and events throughout the organization, awareness of the effort increased. For example, Palo Alto Medical Foundation found ways to incorporate SDM in grand rounds and steering committee meetings.

Switch: By linking SDM to existing initiatives and activities, the implementer is motivating the elephant by shrinking the change. Organizational leaders or staff may feel overwhelmed with a new project, but taking on one more project doesn't seem so daunting when it aligns well with other organizational initiatives that are already in motion.

CAVEATS

- **Support from the top is necessary but not sufficient for successful implementation.**
  Support from organizational leaders is necessary, but actual implementation requires the engagement and participation of practice groups and each individual member within those groups.

- **Enthusiasm does not necessarily translate to activity.**
  Enthusiasm from hospital leaders is important, but it does not necessarily mean that SDM will be implemented as planned. Roll-out at VM took longer than anticipated in large part because SDM faced competing initiatives that took priority. When SDM is not specifically spelled out as an organizational goal, enthusiasm is not enough to make implementation happen.

Level 2: Practice Group

At the practice group level, the implementer's goals are to: (1) gain support for SDM and (2) incorporate SDM and DA distribution into the practice group work flow.

- ***Frame SDM in a way that appeals to the specific practice group.***
  In a largely fee-for-service payment reimbursement environment, it may appear difficult to introduce an initiative that could reduce the number of procedures. However, when framed in a way that aligns with the practice group's objectives, even procedure-driven practice groups can embrace and support SDM. TEC chose to implement SDM in the orthopedics practice group for several reasons. First, there was a desire to educate patients on treatment options and the risks associated with each option. Secondly, patients had to wait three to six months on average for surgery, so the group wanted to increase access and reduce the wait time. SDM appealed to the orthopedics group because it was a mechanism for identifying patients that are appropriate and ready for surgery. SDM could expand access to consultations and surgeries and reduce the number of appointments with inappropriate or uninterested patients.

  Switch: At TEC, the implementer directed the rider by pointing to the destination. Connecting SDM to the group's end goals of increasing access and reducing unnecessary appointments shows the team why SDM is important and worthwhile.

- ***Provide education sessions and DA viewing opportunities.***
  Providing education sessions and DA viewing opportunities for clinicians and staff can engage the entire practice group. There are misconceptions about what SDM is, and oftentimes providers believe they are already practicing SDM with their patients. At MC, the implementer shared SDM and discussed implementation at meetings. In addition, each team member received a pamphlet and DVD to review. The Maple Valley Clinic has viewing equipment so staff members had the option of viewing the DVD on site.

- ***Work with the practice group to develop a work flow process map.***
  Each practice group is unique and has an established work flow. Introducing a new activity requires outlining a work flow process map to see where SDM will fit in. The map is especially useful in designating each person's roles and responsibilities. Since each site is unique, the implementer should work with the team and consider factors that will impact SDM implementation. For example, the type of health condition and its clinical course may dictate how urgent it is for a patient to view DA materials. If the condition is newly diagnosed and typically a one-time event, such as breast cancer, the practice group may want to mail out DA materials as soon as the biopsy results come in so that the patient has the pertinent facts to decide on a treatment plan. On the other hand, if the patient has a chronic or repeating condition like back pain, the team may choose to hand out the DA at the office visit rather than mail it out. Technology also affects implementation. A sophisticated EMR system can facilitate the integration of SDM. TEC was able to create a referral queue within Epic to identify patients eligible for SDM. The characteristics of the site must be considered. What kinds of resources are available to devote to SDM in terms of types of staff members, staff time, funding, and space? The

implementer should discuss these factors with the team when drafting the work flow process map.

Switch: By working closely with the practice group to draft work flow process maps, the implementer can direct the rider by scripting the critical moves. The maps will help the providers and staff determine the specific activities for which each member is responsible.

- ***Provide ongoing support and feedback.***
  Regular meetings with the practice group to address any challenges or concerns about implementation are critical. Group Health Cooperative has an SDM implementation team that checks in with sites on a weekly basis to ensure that tracking measures are being maintained and to identify any changes that need to be made. The implementation team also attends the department staff meeting one month post-implementation to discuss roll-out and challenges faced. Providers and staff need to hear feedback from patients to serve as a reminder and motivator that SDM and DAs are valuable for patients. The practice groups at MC, TEC, and VM responded positively to patient survey reports and are working on generating more regular reports to track their progress. At MC, the implementer provides feedback at office meetings and during one-on-one conversations with providers. Similarly, the implementer at VM meets with the team formally every six weeks or so, and also has brief informal meetings with providers.

Switch: Nearly all practice groups agree that SDM is the right thing to do for patients. By giving patient feedback to providers and staff, the implementer is motivating the elephant by continually reaffirming the feeling.

CAVEATS

- **Engagement of the group does not necessarily translate to day-to-day behavior change to incorporate SDM.**
  Individual behavior change is hard. While it may be easy to feel excited after an SDM presentation, it can be difficult to put SDM into practice on an ongoing basis. Members of TEC's orthopedics team believed that SDM was the right thing to do for patients, but still had a hard time changing existing habits and introducing a new activity into their busy schedules.

- **Placing blame is counterproductive.**
  Providers often feel vulnerable as SDM is implemented, perhaps because their traditional mode of practice is being questioned. At Group Health Cooperative for instance, some providers thought that being approached to implement SDM in their practices meant they must have been performing poorly.

- **Turnover can affect implementation progress.**
  New staff members or the loss of key members of the SDM process can impede implementation progress. Education and training will need to be provided for new members of the team.

Level 3: Individual

Stakeholders at the individual level comprise of: (1) providers and staff and (2) patients.

Level 3: Individual – Providers and Staff

The implementer's goals are to get providers and staff to: (1) identify eligible patients, (2) initiate SDM conversations, (3) distribute and/or collect DAs and surveys, and (4) provide decision support.

- ***Implement different forms of reminders.***
  Creative reminders help providers and staff remember to identify SDM-eligible patients and distribute DAs. The implementer at MC printed out reminder cards listing the eligible conditions for SDM and taped them to the computer monitor in each exam room. She also put flyers and sample DA pamphlets in the exam rooms to encourage patients to ask their providers about SDM and to remind providers to initiate SDM conversations. The implementer also tested out a reminder system using the daily schedule. She reviewed the schedule in advance and placed blue flags next to patients whom she believed could benefit from SDM and DA materials. She used this method for a five-month trial period and then decided to stop because it did not seem to increase the use of SDM/DAs, and time spent reviewing charts could be better used elsewhere. The Oregon Rural Practice-based Research Network created SDM/DA boxes in each exam room that were filled with prepared packets that could be given out to patients during the office visit.

  Switch: Implementers can shape the path by tweaking the environment. At MC, the implementer changed the environment by putting out flyers and pamphlets to help providers and staff change their behaviors. Similarly, the Oregon Rural Practice-based Research Network changed the exam room environment by putting SDM/DA boxes in place.

- ***Work with providers and staff to brainstorm reminder strategies.***
  If reminders do not seem to be working, conversations with providers and staff to generate new ideas for reminder strategies can be helpful. The implementer at MC documented two places in the patient chart that a DA had been checked out, but providers were not reviewing the note and therefore not closing the loop. She is working with physicians and staff to find a different spot in the chart or a different method of notating that a DA has been checked out. If physicians do not know that a DA has been distributed, then they are less likely to be able to answer any questions or provide decision support.

- ***Find champions among providers and staff and encourage them to engage others.***
  SDM champions can be invaluable in encouraging the team to improve the rate of SDM adoption and address problem areas in the work flow. TEC experienced a breakdown between the front-office and back-office staff. The front-office staff collected DAs and surveys and placed post-visit surveys in patient charts, but back-office staff often forgot to notify surgeons of SDM patients and give post-visit surveys to patients. The director of

musculoskeletal services observed the disconnect and assigned one of the medical assistants, who is also the clinical supervisor, to meet with the back-office staff to address the problem and come up with solutions. Since that time, surgeons have been notified more often and the post-visit survey collection rate has increased.

CAVEATS

- **Inducing behavior change is difficult, so it may take time and many forms of reminders before SDM and DA distribution become habit.**
  The adoption of any new activity is difficult, especially in busy clinics with high patient volumes. Old habits are hard to break, so continued enthusiasm and commitment by SDM champions at all levels is essential to instilling new habits around the SDM process. Regular evaluation of the effectiveness of various approaches is critical to successful implementation. If a form of reminder requires significant preparation and time but doesn't seem to be increasing SDM conversations or DA distribution, the implementer should try another approach.

Level 3: Individual – Patient

The goals at the patient level are to get patients to: (1) view DA materials, (2) initiate SDM conversations with providers, and (3) return the DA and surveys.

- ***Promote SDM directly to patients.***
  Advertising the availability of SDM and DA materials is a way to engage patients. Palo Alto Medical Foundation, for example, used brochures, posters, and newsletters to educate patients about SDM and the availability of DAs. MC's implementer created posters for the waiting area and also put up flyers in each of the exam rooms.

  Switch: By creating posters and flyers prompting patients to ask their providers about SDM, the implementer shaped the path by rallying the herd.

- ***Encourage warm hand-off when possible with an emphasis on the importance of viewing DA materials.***
  An in-person, warm hand-off with an explanation of SDM will encourage patients to view the DA materials. It is also crucial for the provider to emphasize the value and importance of the content of the DAs. Mercy Clinics has found that warm hand-off by a health coach yields the best results, especially if the patient watches the DA at the clinic. Once eligible patients are identified at MC, they are directed to the implementer (in this case, the Patient Care Coordinator) who explains SDM to the patient and hands out a DA.

- ***Implement different forms of reminders.***
  Different reminders are also helpful in encouraging patients to return DAs and surveys. As with providers and staff, sometimes several simultaneous reminders are needed before action is taken. Even though the implementer at MC calls several times, reminds patients at appointments, and sends a reminder letter and self-addressed stamped envelopes, patients sometimes still forget to return DAs and surveys.

CAVEATS

- **Patient engagement in the form of viewing DA materials and/or returning the DA and surveys depends on many factors.**
  Even with many reminders a patient may not return the DA and surveys. MC, for example, uses multiple methods to encourage patients to send back materials, but only has a return rate of 30%. On the other hand, TEC and VM decided that they would not contact patients to return materials and surveys and have a 50% return rate. Return rates may depend on characteristics of the patient population, including the conditions that trigger SDM eligibility. Lack of return, however, does not mean the patient hasn't viewed the DA. In fact, patients sometimes choose not to return the materials because they find them useful and want to share with family and friends.

Summary of Key Points

Target	Desired behaviors	Strategies to induce behavior change	Caveats
Organization	(1) Support SDM	(1) Embed or fit SDM into organizational goals and frameworks. (2) Launch a marketing campaign. (3) Link SDM to existing organizational initiatives and activities.	(1) Support from the top is necessary but not sufficient for successful implementation. (2) Enthusiasm does not necessarily translate to activity.
Practice Group	(1) Support SDM (2) Incorporate SDM and DA distribution into practice work flow	(1) Frame SDM in a way that appeals to the specific practice group. (2) Provide education sessions and DA viewing opportunities. (3) Work with the practice group to develop a work flow process map. (4) Provide ongoing support and feedback.	(1) Engagement of the group does not necessarily translate to day-to-day behavior change to incorporate SDM. (2) Placing blame is counterproductive. (3) Turnover can affect implementation progress.
Individual			
Providers and staff	(1) Identify eligible patients (2) Initiate SDM conversations (3) Distribute and/or collect DAs and surveys (4) Provide decision support	(1) Implement different forms of reminders. (2) Work with providers and staff to brainstorm reminder strategies. (3) Find champions among providers and staff and encourage them to engage others.	(1) Inducing behavior change is difficult, so it may take time and many forms of reminders before SDM and DA distribution become habit.

Patients	(1) View DA materials (2) Initiate SDM conversations with providers (3) Return the DA and surveys	(1) Promote SDM directly to patients. (2) Encourage warm hand-off when possible with an emphasis on the importance of viewing DA materials. (3) Implement different forms of reminders.	(1) Patient engagement in the form of viewing DA materials and/or returning the DA and surveys depends on many factors.

Conclusion

Introducing a new activity to a health care organization can be challenging. Initiating SDM is no exception. During the planning phase, the implementer should identify the important players and the desired behavior changes. Based on experiences from our demonstration project and lessons learned from other sites, we have laid out pointers to induce behavior change at three different levels: organization, practice group, and individual. All sites are unique, however, and many internal and external factors can impact the success of SDM implementation. The *Switch* framework for changing the behaviors of others when progress seems to be stalled can be helpful. Continued enthusiasm and commitment to the goals of SDM are critical to its successful implementation.