

## UPDATE

## Resources for Shared Decision Making

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**G**eneralist physicians are expected to stay current on a wide variety of clinical conditions and in the course of a year's practice will counsel patients on hundreds of medical decisions. Many clinical decisions in primary care have a number of appropriate choices, and the right decision will depend on the medical evidence and patients' preferences for good and bad outcomes. Some common examples of these kinds of decisions include benign prostatic hypertrophy treatments and statin use for primary prevention of cardiovascular disease. Doctors and patients are often advised to use "shared decision making" to arrive at the right treatment plan in these situations. But as a generalist, how does one keep up with all the evidence behind these treatment options, communicate that information effectively to patients, elicit patients' preferences regarding their medical treatments, and jointly agree to a course of treatment—all in the confines of a short visit? Fortunately, there are many ways that health information technology (IT) can facilitate shared decision making.

At Massachusetts General Hospital, we have a Shared Decision Making Center that supports our providers and patients to make better decisions about medical tests and treatments. We have focused on three approaches to facilitate shared decision making: use of patient decision aids, clinician education and training, and measurement of decision quality. Patient decision aids are tools that have been shown to help doctors and patients conduct shared decision making more

effectively. Decision aids—available in print, video, and web-based modules—go beyond simply providing medical information; they present an evidence-based view of the advantages and disadvantages of the options, encourage patient engagement, and help patients consider their personal preferences and treatment goals. A listing of widely available web-based decision aids and training tools are included at the end of this article.

IT has played a core role in supporting decision aid use at our hospital. Our providers are able to "prescribe" decision aids to patients through the electronic medical record (EMR). The orders are filled centrally by staff at our Patient & Family Learning Center, and a note is entered into the EMR documenting that patient education material was sent. Early acceptance of the programs by doctors required that they have control over who received the decision aids. Not surprisingly, relying solely on clinicians to remember to order the decision aid has resulted in highly variable use—some physicians are high users and others rarely prescribe.

Over the past several years, prescriptions have increased steadily, and we have received lots of feedback from clinicians and patients that the decision aids are useful in clinical practice. Further, we have documented that patients who view decision aids have high knowledge scores and are more certain about decisions related to PSA testing, colorectal cancer screening, and hip and knee replacement surgery. These results replicate much of what has been found in the

Cochrane systematic review of decision aids. The 2011 review included 86 randomized controlled trials of decision aids and found that the use of decision aids led to greater knowledge about the medical conditions addressed, reduced decisional conflict, increased patient desire for engagement in decisions, and reduced the number of people remaining undecided after using a decision aid.<sup>1</sup>

A major challenge in the use of decision aids, however, is getting the aids to patients at the "decision point." Here is an opportunity for health IT. Using the EMR and patient registries to identify patients who are facing a screening or treatment decision, our delivery of decision aids can be more precise. For example, a woman turning 40 who may be facing a decision about breast cancer screening could be "flagged" in the EMR, and her primary care office could send a decision aid for review prior to an upcoming physical. The provision of decision aids through the EMR can be patient-directed as well, with a menu of decision aids available via a web portal for patients to access directly. Now that our providers are comfortable with the aids, they are very interested in exploring these automated and patient-driven options.

Another area of growing interest is the enhancement of specialty referrals by providing a decision aid prior to consultation on preference-sensitive conditions, such as joint replacement, bariatric surgery, and breast cancer treatment. Often, the act of making a referral indicates that there is a significant decision

continued on page 2

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## UPDATE

continued from page 1

that needs to be made. Many EMRs include referral forms that can identify patients appropriate for decision aids at the time of referral. Imagine a process in your practice that facilitates the prescription of a decision aid prior to consultation with an orthopedist specializing in arthroplasty (who, incidentally, has a three-month waitlist for consultations). You refer two patients with symptomatic knee osteoarthritis to see this surgeon; your first patient views the decision aid on knee replacement and realizes he is not ready to commit to surgery and chooses to focus on weight loss to alleviate knee pain. He cancels his appointment. Your other patient, who has quite symptomatic arthritis, has viewed the decision aid and is even more sure about her desire for surgery. She is moved up on the orthopedist's waitlist when your first patient cancels. This process benefits everyone, including the orthopedist, whose schedule will now be booked with patients who can benefit most from specialized care.

This system of enhanced specialty referral is a reality for primary

care providers at Group Health in Seattle, WA. Clinicians have the ability to make a referral with or without a decision aid to certain specialists, including orthopedic surgeons for knee and hip osteoarthritis consultations. David Arterburn, MD, of Group Health Research Institute, notes that "having the decision aid tied to the referral process has helped us get the programs used more consistently. The feedback from the specialists has been positive, as they like having patients come in better prepared to discuss their health problems."

Shared decision making requires the synthesis and understanding of a significant amount of information to promote thoughtful conversations between patients and doctors. IT can be used to enhance that process—through reliable identification of patients at decision points, workflow to support delivery of patient decision aids, and documentation in the EMR. We should embrace technological enhancements as we move to implement decision aids and shared decision making into broad practice.

### Reference

1. Stacey D, Bennett CL, Barry MJ, Col NF, Eden KB, Holmes-Rovner M, Llewellyn-Thomas H, Lyddiatt A, Légaré F, Thomson R. Decision aids for people facing health treatment or screening decisions. *Cochrane Database of Systematic Reviews*. Published online October 5, 2011.

### Resources for Shared Decision Making and Decision Aids

- Ottawa Personal Decision Guide (<http://decisionaid.ohri.ca/decguide.html>): a general guide that can be used for any health or social decision
- Ottawa Inventory of Decision Aids (<http://decisionaid.ohri.ca/AZinvent.php>)
- A comprehensive site with multilingual decision aids ([www.thedecisionaidcollection.nl](http://www.thedecisionaidcollection.nl))
- The Informed Medical Decisions Foundation ([www.informedmedicaldecisions.org](http://www.informedmedicaldecisions.org))
- The Knowledge and Evaluation Unit at Mayo Clinic (<http://shareddecisions.mayoclinic.org>)

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