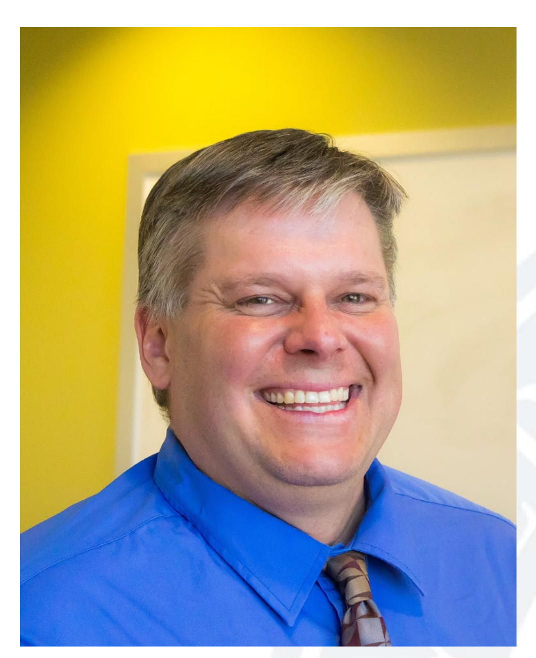
Shared Decision Making

December 10, 2019

Presenter



Dan D. Matlock, MD, MPH

Associate Professor of Medicine, University of Colorado School of Medicine

Director of the Colorado Program for Patient Centered Decisions

Goals

- Explore techniques around shared decision-making
- Review examples of opportunities in cardiology around these techniques
- Show shared decision-making in practice
- Present ACC resources available

Overview

- Introduction to shared decision making (SDM)
- Benefits of SDM
- Examples from cardiology
  - Atrial Fibrillation
  - Evidence of variation in patient preferences
- SDM key elements
- Resources

SHARED DECISION MAKING

Shared Decision Making (SDM) is a Process, Not a Tool

The process of interacting with patients who wish to be involved in arriving at an **informed, values-based choice** among 2 or more medically reasonable alternatives.

The Clinician

Information

The Patient

Informed
Options
Benefits and harms

Values-Based
What's important
to the patient

O'Connor AM et al. *Health Affairs,* 2004.

Informed Consent and Shared Decision Making

"Informed consent is rooted in the fundamental recognition . . . that adults are entitled to accept or reject health care interventions on the basis of their **own personal values** and in furtherance of their **own personal goals.**"

American Journal of Law & Medicine, 32 (2006): 429-501
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Boston University School of Law

Rethinking Informed Consent: The Case for Shared Medical Decision-Making[†]

Jaime Staples King[††] and Benjamin Moulton[†††]

President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. Making health care decisions. Washington, DC: Government Printing Office, October 1982

“Shared Decision Making is Perfected Informed Consent”

Informed Consent	Shared Decision Making
Legal and regulatory requirement—authorization	Ethical imperative—supports autonomy and self-determination
Focus on a written document • High literacy • Fine print	Focus on a process • Collaborative communication • Can be supported by written or AV materials
Often takes place minutes before an intervention	Takes place days/weeks beforehand
Emphasis on ‘laundry list’ of potential risks—intended to shield against litigation	Emphasis on risks, benefits, alternatives, and tradeoffs—intended to facilitate patient-centered decision

Shared Decision Making

"A meeting between experts"

Tuckett , 1985

Paternalism ⟷ Consumerism

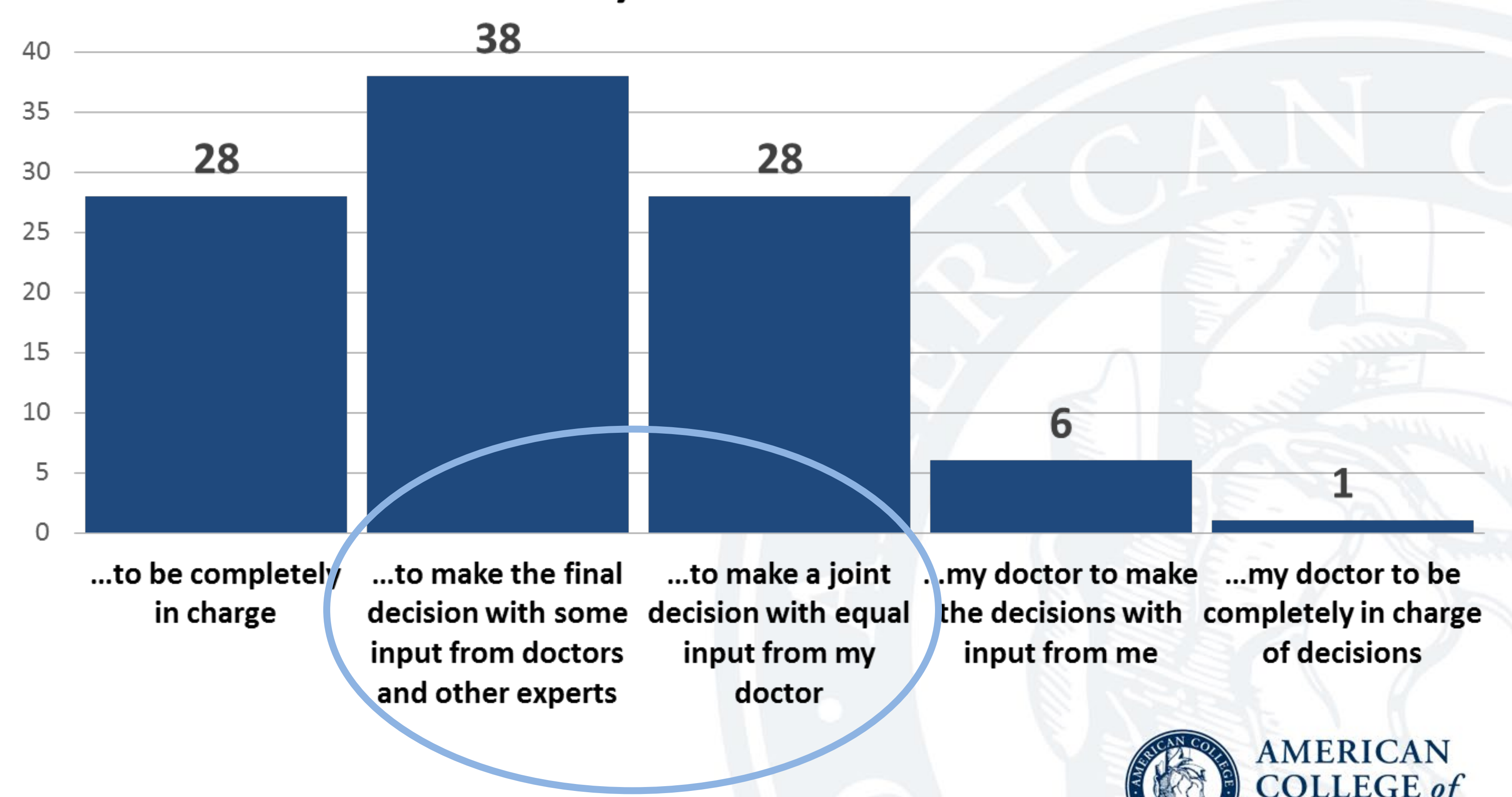
(abandonment)

Myths about SDM

- Patients want physicians to decide
- Decision aids = patient education
- Providers already do SDM
- Patients aren’t able (e.g., elderly, less educated)

Coylewright, 2016; Rothberg, 2015; Couet, 2013; Legare, 2008; Legare, 2014

Patients *Want* to Be Involved in Decisions



Altarum Institute Survey of Consumer Health Care Opinions—Fall 2014

AMERICAN COLLEGE *of* CARDIOLOGY

Shared decision making is *not* simply *patient education*

	Patient Education	SDM and Decision Aids
Context	Broad: Education & awareness: • Self-management • Pre-op instructions • Discharge instructions	Narrow: Situations that require a decision • Clinical equipoise • Balance of risks/benefits varies • Preferences for outcomes and/or process vary
Target audience	Often general, e.g., all patients with a particular condition	Individuals making decisions in specific clinical contexts
Goals	Improve knowledge Change attitudes and behavior (adherence, self-care) Improve health outcomes	Improve knowledge, accuracy of risk perceptions Clarify values and facilitate participation

Cardiovascular Clinicians' Perceptions & Use of SDM

- <40% reported prior exposure to decision aids
- Patient education not differentiated from SDM
  - Low scores on 7/12 SDM practices
  - 3% of conversations included all SDM elements
- Misperceptions about SDM interest/ability among elderly, limited education

Coylewright et al. *Patient Educ Couns (2017)*; Coylewright et al. *Circ Cardiovasc Qual Outcomes (2016)*; Rothberg et al. *JAMA Int Med* (2015).

BENEFITS OF SHARED DECISION MAKING

SDM Improves the Quality of Care

Patients who say physicians dominated cancer care decisions are:

- Less likely to report excellent quality of care
- Less likely to choose top ratings for physician communication

Rate Provider 0 – 10

Global Comparison

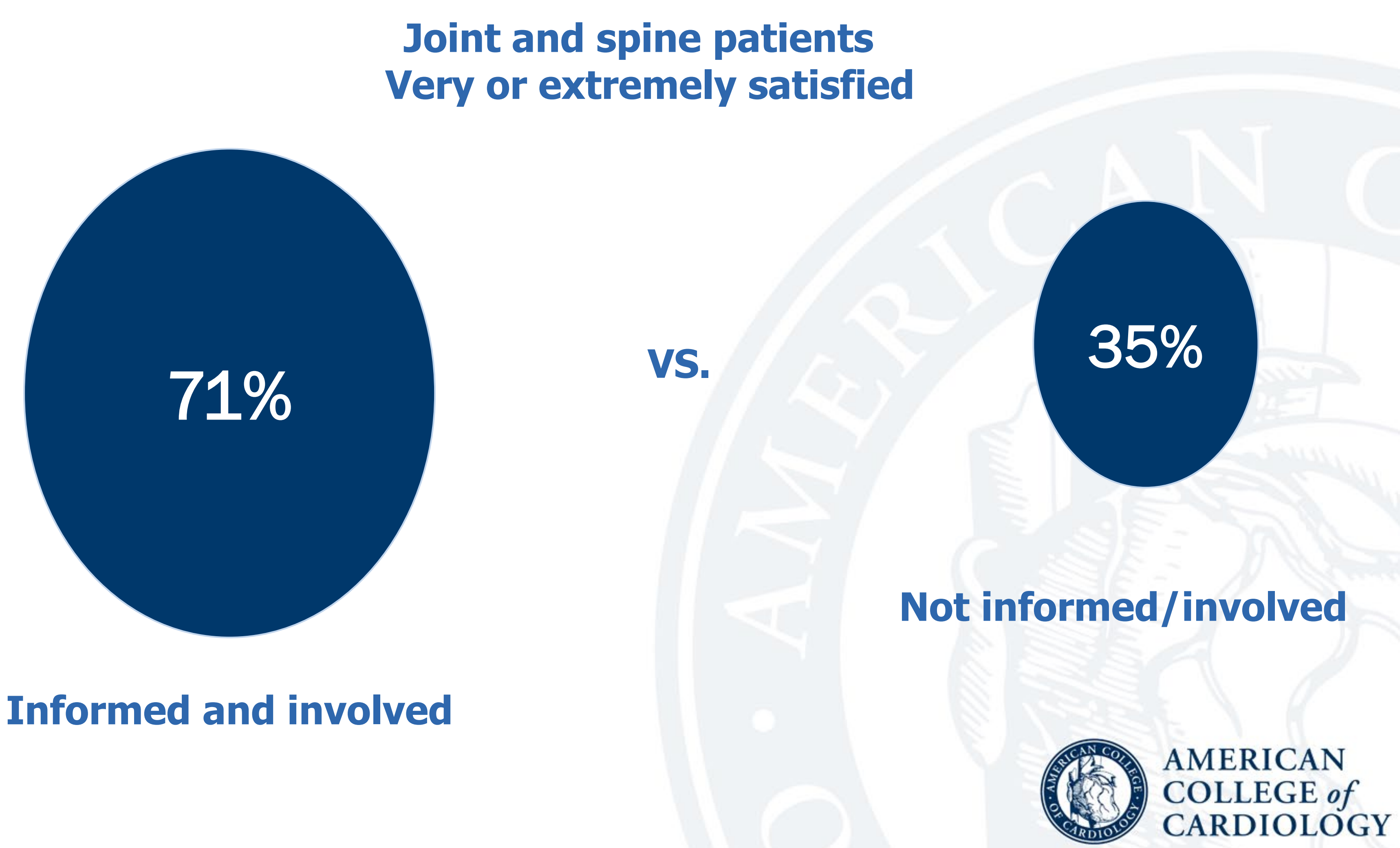
% Top Box

100%
80%
60%
40%
20%
0%

Rate provider 0-10

KL Kehl et al. Association of actual and preferred decision roles with patient-reported quality of care. JAMA Oncol. Doi:10.1001/jamaoncol.2014.112

Informed and Involved Patients are More Satisfied with Care



Use of Decision Aids

- Improve patient knowledge
- Improve accuracy of risk perceptions
- Improve congruence between treatment chosen and patient values
- Increase participation in decision making
- Positive effects on satisfaction with decision and process

Benefits of SDM for Providers

(from orthopedics)

- Better prepared for surgical consult
- More accurate expectations
- Ask more—and more appropriate—questions
- Make decision at first surgical consult (58% vs 33%)
- Use provider time efficiently
- Provider satisfaction with visits
- Visit length unchanged or only slightly longer (2.4 min)

Stacey D, et al. Decision aids to help people who are facing health treatment or screening decisions. Cochrane Database of Systematic Reviews, 2014. Bozic KJ et al.
Shared decision making in patients with osteoarthritis of the hip and knee. JBJS, 2013.

PREFERENCE-SENSITIVE CARE AND SDM IN CARDIOLOGY

Preference-sensitive* Decisions in Cardiology

Clinical situations involving

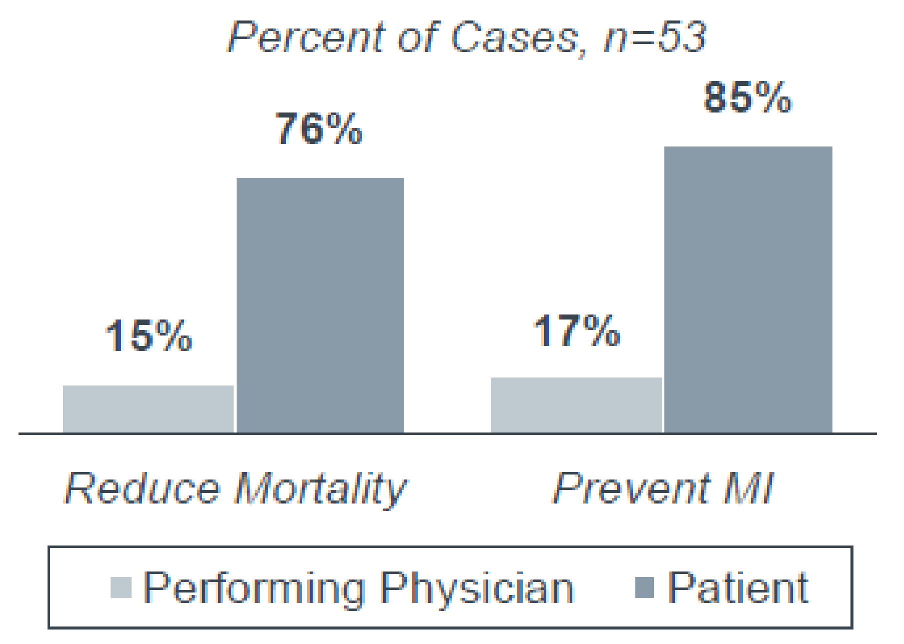
- Clinical equipoise among reasonable options
- Tradeoffs
- Variation in preferences for process/outcomes

Examples

- Stable ischemic heart disease (diagnosis; angina management)
- Aortic stenosis (TAVR)
- Advanced heart failure
- Implanted cardiac defibrillator (ICD) placement
- Stroke prophylaxis in atrial fibrillation
  - Anticoagulants and left atrial appendage closure
  - *CMS Decision Memo requires SDM documentation*

*Interventions may represent **effective care** depending on clinical context and patient characteristics.

Informed Consent Often Fails to Inform



- 70% underestimated risk of harms (death, stroke, MI)

Rothberg MG, et al. *Ann Int Med* 2010; 153:5; Doll, J. ACC 2017. http://www.acc.org/latest-in-cardiology/articles/2016/05/25/13/19/cover-story-now-showing-highlights-from-acc16

PCI Patients Largely Not Involved

10%	Elective PCI patients who felt they were given alternative options to seriously consider
16%	Elective PCI patients who said they were asked about their treatment preferences

Source: Fowler FJ, et al., *Journal of General Internal Medicine, 2012, 27:911-916.*

Advanced Heart Failure

AHA Scientific Statement

Decision Making in Advanced Heart Failure

A Scientific Statement From the American Heart Association

Endorsed by Heart Failure Society of America, American Association of Heart Failure Nurses, and Society for Medical Decision Making

Figure 2. Prognosis is not only about expectations for survival. There are multiple domains that are of varying importance to individual patients. Adapted from Spilker.[38]

Circulation

AHA/ACC/HRS GUIDELINE

2017 AHA/ACC/HRS Guideline for Management of Patients With Ventricular Arrhythmias and the Prevention of Sudden Cardiac Death

A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines and the Heart Rhythm Society

15. SHARED DECISION-MAKING

Recommendations for Shared Decision-Making

References that support the recommendations are summarized in Online Data Supplement 60.

COR	LOE	Recommendations
I	B-NR	1. In patients with VA or at increased risk for SCD, clinicians should adopt a shared decision-making approach in which treatment decisions are based not only on the best available evidence but also on the patients' health goals, preferences, and values.[S15-1–S15-5]
I	B-NR	2. Patients considering implantation of a new ICD or replacement of an existing ICD for a low battery should be informed of their individual risk of SCD and nonsudden death from HF or noncardiac conditions and the effectiveness, safety, and potential complications of the ICD in light of their health goals, preferences, and values.[S15-1–S15-5]

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."

SHARED DECISION MAKING IN ATRIAL FIBRILLATION

Key Decisions in AF Management

- Anticoagulation and stroke prevention
- Rate control
- Rhythm control

SDM for Stroke Prevention in AF

CLINICAL PRACTICE GUIDELINE: FULL TEXT

2014 AHA/ACC/HRS Guideline for the Management of Patients With Atrial Fibrillation

A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines and the Heart Rhythm Society

Developed in Collaboration With the Society of Thoracic Surgeons

TABLE 6 Summary of Recommendations for Risk-Based Antithrombotic Therapy

Recommendations	COR	LOE	References
Antithrombotic therapy based on shared decision making, discussion of risks of stroke and bleeding, and patient's preferences	I	C	N/A

CLASS I

1. In patients with AF, antithrombotic therapy should be individualized based on shared decision making after discussion of the absolute risks and RRs of stroke and bleeding and the patient's values and preferences. *(Level of Evidence: C)*

CMS Decision Memo—LAAC

- “Formal shared decision making interaction …using an evidence-based decision tool…prior to LAAC”

Concerns Raised

- Referring “non-interventionalist” clinician may be unfamiliar with all options, esp LAAC
- May require multiple visits
- No guidance in eliciting patient preferences
- No validated DA provided

AF Stroke Prophylaxis Involves Complex Considerations

- Stroke risk/severity—varies widely
- Bleeding risk/severity—varies widely
- Dosing frequency
- Testing frequency
- Drug interactions and dietary restrictions
- Lifestyle implications
- Antidote availability
- Cost

Patient Preferences Vary Widely

- "Values and preferences are **extremely heterogeneous and unpredictable**, and therefore must be ascertained **directly from patients.**"
- "SDM will help patients identify their values and preferences and **map them to the available options.**"

Loewen, et al. *Thrombosis and Haemostatis* (2017)

SHARED DECISION MAKING IN PRACTICE

Placeholder for Video 1

The SHARE Approach
Essential Steps of Shared Decision Making

Five steps for you and your patients to work together to make the best possible health care decisions.

Step 1:

Seek your patient's participation

Communicate that a choice exists and invite your patient to be involved in decisions.

Step 2:

Help your patient explore and compare treatment options

Discuss the benefits and harms of each option.

Step 3:

Assess your patient's values and preferences

Take into account what matters most to your patient.

Step 4:

Reach a decision with your patient

Decide together on the best option and arrange for a followup appointment.

Step 5:

Evaluate your patient's decision

Plan to revisit decision and monitor its implementation.

www.ahrq.gov/shareddecisionmaking

April 2014 AHRQ Pub. No. 14-0026-2-EF

"Doctor, what would you do?"

probably means

*"Doctor, what would you do **<u>if you were me</u>**?"*

Essential Elements of SDM

- Recognize that a decision is needed
- Know and understand the evidence
  - risk assessment
  - tailored decision aids
- Incorporate the patient's values and preferences into the decision

Legare and Witteman (2012). Health Affairs 32(2): 276-284.

Placeholder for Video 2

Video Highlights…

- An optimal decision is one that takes into account patient preferences and values.
- Communicate with the patient about the outcomes that are most important to him or her.
- Make trade-offs among options clear to the patient (stroke vs bleed risk).

What matters most to this patient?

- Reducing stroke risk
- Avoiding serious bleeding
- Having a simple medication regimen
- Cost

ACC Decision Aids on CardioSmart

- 4 DAs : low, moderate, high, very high risk
- Multidisciplinary development team
- Health literacy/risk communication best practices
- Aligned with certification standards

A DECISION AID FOR
AFIB STROKE PREVENTION
FOR PATIENTS WITH ATRIAL FIBRILLATION

For Patients with HIGH RISK

Decision Aids Based on Risk

Risk Level	Options Presented
Low (<1%)	No anticoagulation
Moderate	Warfarin or DOAC
High	Warfarin or DOAC
Very High (>3%)	Warfarin or DOAC, or LAAC

Baseline risk without anticoagulation is presented in all versions for comparison.

A DECISION AID FOR
AFIB STROKE PREVENTION
FOR PATIENTS WITH ATRIAL FIBRILLATION

For Patients with HIGH RISK

Resources

- ACCF Patient Decision Aids
  - https://www.cardiosmart.org/decisions
  - DAs for 4 risk levels (low, moderate, high, very high)
- Risk Calculator App
- Clinician Guide

A DECISION AID FOR
AFIB STROKE PREVENTION
FOR PATIENTS WITH ATRIAL FIBRILLATION

For Patients with HIGH RISK

Questions?

1. How can I possibly let a patient choose not to take an anticoagulant?
2. How do you handle it when patients and family disagree?
3. Is it ok to make recommendations? “What would you do Doc if you were me?”
4. Are decision aids supposed to be used in the clinic or outside?
5. How do you use decision aids?

THANK YOU!