Shared Decision Making

"No decision about me, without me"

Pharmac Seminar Series

Medicines in Healthcare

August 2015

This Session

- Introduction to SDM – what & why (disclaimer)
- Essential elements
- Communicating risks & benefits
- Decision Aids

Shared Decision Making

Shared decision-making is a process in which **clinicians and patients work together** to select tests, treatments, management or support packages, based on clinical evidence and the patient's informed preferences. It involves the provision of evidence-based information about options, outcomes and uncertainties, together with decision support counselling and a system for recording and implementing patients' informed preferences.

Ref: Coulter & Collins, The King's Fund 2011

Shared decision-making enhances the therapeutic relationship

Sharing Expertise –
Clinician's vs. Patient's Experience

Clinician's expertise	Patient's Expertise
Diagnosis	Experience of illness
Disease aetiology	Social circumstances
Prognosis	Attitude to risk
Treatment options	Values
Outcome probabilities	Preferences

Source: Making Shared Decision-Making A Reality: No decision about me, without me. The King's Fund and Foundation for Informed Medical Decision Making, August 2011.

Benefits – “Win:Win”

- **potential to improve:**
  - **the quality of the** decision-making process for patients and ultimately,
  - **patient outcomes**

Shared Decision Making

- Appropriate for decisions about whether to:
  - undergo a screening or diagnostic test
  - undergo a medical or surgical procedure
  - participate in a self-management education programme or psychological intervention
  - take medication (or not)
  - attempt a lifestyle change

Essential Elements (→behaviours) of SDM

- Define and explain the healthcare problem,
- present options,
- discuss pros and cons (benefits, risks, costs),
- clarify patient values and preferences,
- discuss patient ability and self-efficacy,
- present what is known and make recommendations,
- check and clarify the patient's understanding,
- make or explicitly defer a decision,
- arrange follow-up

Presenting Information

- Patients need information presented appropriately to enable and empower participation
- Information based on robust research
- Communicate benefits AND risks
- Avoid overload
- Make use of decision aids where available

Effective Communication of Risk

PRINCIPLES

1. Discuss in context of competence care and trust
2. Risks and benefits
3. Words and numbers
4. Standard taxonomy e.g. ‘very common’, ‘common’, ‘rare’
5. Absolute risks (rather than RR)
6. Consistent denominator e.g. 1 in 100 vs 1 in 500
7. Positive and negative ‘framing’ e.g. compare likelihoods of having side-effects and not having side-effects

contd…

Effective Communication of Risk

8. Use visual aids to assist understanding and encourage discussion
9. Be honest about the uncertainties
10. Personalise the information according to an individual's age, gender, history or other relevant factors
11. Explore people's understanding, reactions and opinions about the risk information

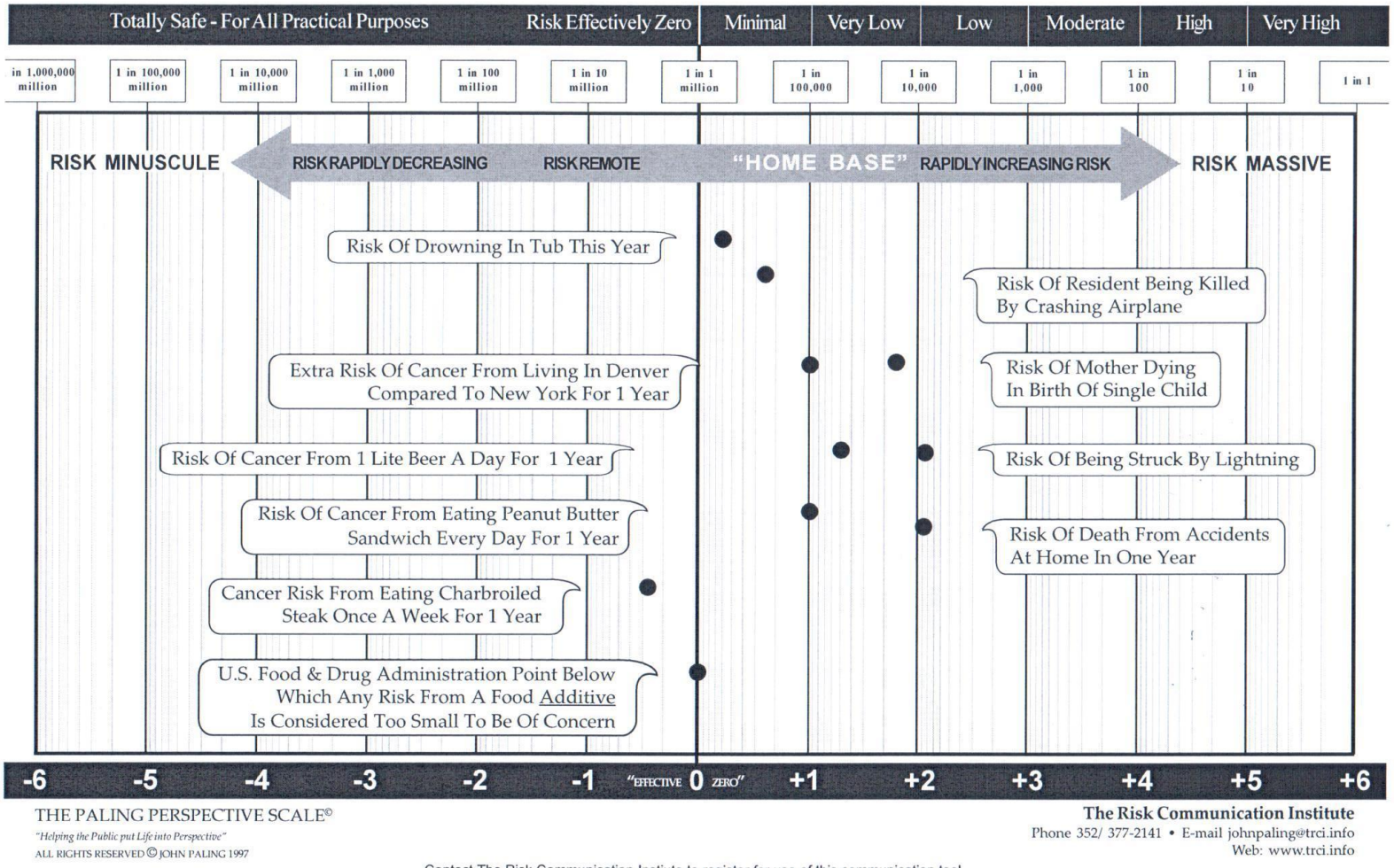
ARR vs RRR

- Hypothetical “drug A” reduces CV events
- In placebo-controlled RCT over 5 years
  - 20/100 events in the placebo arm vs
  - 15/100 events in the active drug arm
- This is **25%** relative risk reduction
- This is also **5%** absolute risk reduction (5/100 less events in the active arm cf. placebo arm)
- NNT = 1/ARR (1/0.05) = 20
  - i.e. need to treat 20 patients with drug A for 5 years to prevent one event

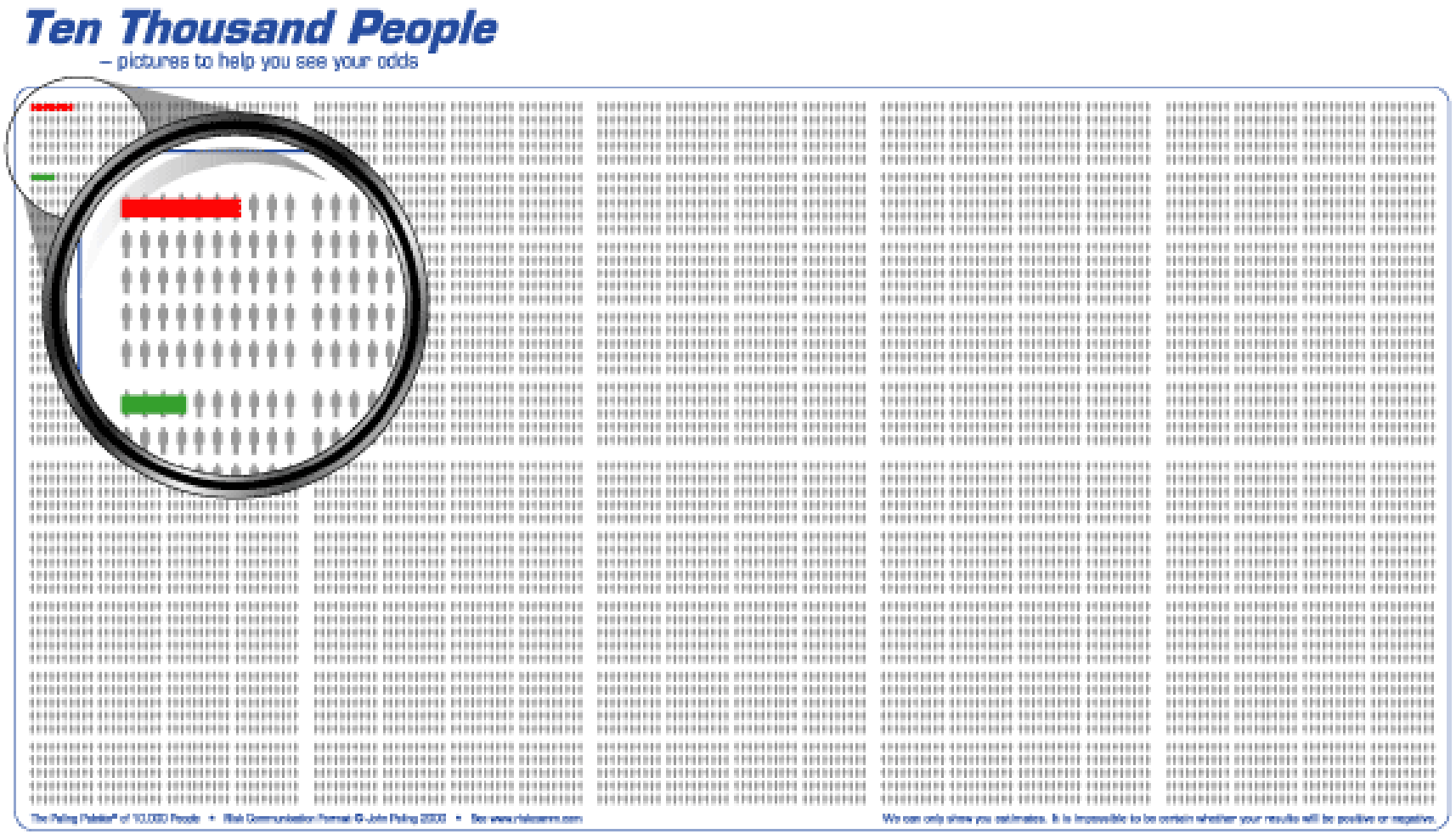
ADRs - Standard Taxonomy of Risks

- **Very common** affects more than 1 in 10 people – i.e. the risk is **10% or higher**
- **Common** affects between 1 in 100 and 1 in 10 people – i.e. risk is **1% to 10%**
- **Uncommon** affects between 1 in 1,000 and 1 in 100 people – i.e. risk is **0.1% to 1%**
- **Rare** affects between 1 in 10,000 and 1 in 1,000 people – i.e. risk is **0.01% to 0.1%**
- **Very rare** affects less than 1 in 10,000 people – i.e. risk is **less than 0.01%**

Communicating Risk - Tools



Risk Communication Institute – Paling's Palettes



Communicating Risk - Tools

- http://www.riskcomm.com/scales.htm

Shared Decision Making Facilitators & Barriers (EB)

- Barriers
  - Time constraints
  - Lack of applicability due to pt characteristics
  - Lack of applicability due to clinical situation
- Facilitators
  - Provider motivation
  - Positive impact on the clinical process
  - Positive impact on patient outcomes

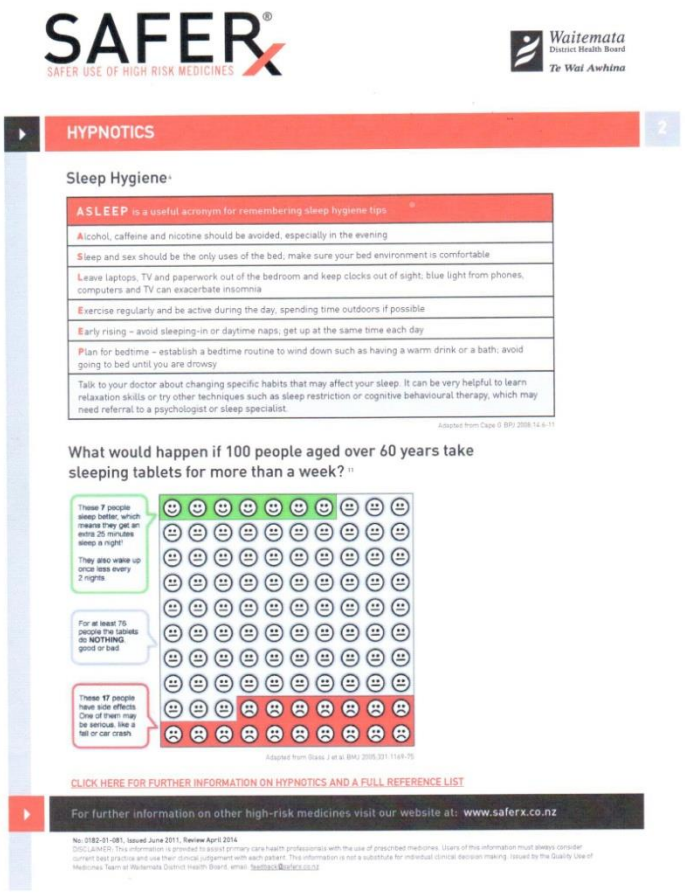
Decision Aids

- Do NOT tell people what to do...
- Present evidence/facts to help people deliberate about options
- +ve benefits for patients (evidence from RCT and Cochrane Review 2014)
  - Improve knowledge of options
  - feel more informed and more clear about what matters most to them
  - Have more accurate expectations of benefits & harms
  - Participate more in decision making

Decision Aids Cont'd

- Patient Decision Aid Research Group
- Hosts A-Z Inventory of PDAs
- International Patient Decision Aid Standards (IPDAS) Collaboration

Decision Aids Examples



SAFER®
SAFER USE OF HIGH RISK MEDICINES

Waitemata District Health Board
Te Wai Awhina

HYPNOTICS

2

Sleep Hygiene[1]

ASLEEP is a useful acronym for remembering sleep hygiene tips
Alcohol, caffeine and nicotine should be avoided, especially in the evening
Sleep and sex should be the only uses of the bed; make sure your bed environment is comfortable
Leave laptops, TV and paperwork out of the bedroom and keep clocks out of sight; blue light from phones, computers and TV can exacerbate insomnia
Exercise regularly and be active during the day, spending time outdoors if possible
Early rising – avoid sleeping-in or daytime naps; get up at the same time each day
Plan for bedtime – establish a bedtime routine to wind down such as having a warm drink or a bath; avoid going to bed until you are drowsy
Talk to your doctor about changing specific habits that may affect your sleep. It can be very helpful to learn relaxation skills or try other techniques such as sleep restriction or cognitive behavioural therapy, which may need referral to a psychologist or sleep specialist.

Adapted from Cape G BPJ 2008;14:6-11

What would happen if 100 people aged over 60 years take sleeping tablets for more than a week? [1]

Adapted from Glass J et al. BMJ 2005;331:1169-75

CLICK HERE FOR FURTHER INFORMATION ON HYPNOTICS AND A FULL REFERENCE LIST

For further information on other high-risk medicines visit our website at: **www.saferx.co.nz**

No: 0182-01-081, Issued June 2011, Review April 2014

Option Grids

- https://vimeo.com/55088088

Option Grid - Example

option grid

Statins for heart disease risk: yes or no?

Use this grid to help you and your health care professional decide whether you should start taking a statin. This Option Grid is for people who have not had a heart attack or stroke and do not have any other medical condition that requires a statin. This Grid is best used with a **heart risk calculator.**

FAQs ↓	**Follow a "Mediterranean" diet**	**Be physically active several times a week**	**Start a statin**
What does this treatment involve? Your importance rating: ①②③④⑤	Keeping to a diet rich in vegetables, fruit, fish, oils and whole grains, and lower in red meat and animal fat	Choosing to be active when possible, e.g. walking instead of using motor transport. Making exercise part of normal life.	Taking a single tablet each night
How much will this option reduce my risk of having a heart attack or stroke? Your importance rating: ①②③④⑤	For most people, the risk will be reduced by between 5% and 20%.	Going from a low to a high level of physical activity can reduce the risk by up to 30%.	A statin will likely reduce the risk of stroke and heart attack by 25 to 30%.
How much will this option reduce my chance of getting other health problems? Your importance rating: ①②③④⑤	This diet is associated with having a longer lifespan and fewer health problems. It may also reduce the risk of diabetes, Alzheimer's disease and some kinds of cancer.	Physical activity helps to improve mood and keeps weight down. It does not need to be vigorous to be of benefit. It helps prevent diabetes and Alzheimer's disease.	Statins reduce the risk of problems caused by blocked arteries in the heart, brain and legs.
Are there any harmful effects? Your importance rating: ①②③④⑤	No	Moderate activity, such as regular walking, cycling or working in the garden, is safe. Doing more demanding exercise needs to be developed over time.	For 10 in every 100 people (10%), taking statins will cause muscle aches, especially while exercising. Problems such as sleep disturbance, low mood, or loss of sex drive are less common.
How long will I have to keep this up? Your importance rating: ①②③④⑤	The longer the better	The longer the better	Usually for life, but we do not know for sure. You and your clinician can reassess your need for a statin at any point.

More helpful information:

Diet:

- http://www.patient.co.uk/health/how-to-follow-the-mediterranean-diet
- http://www.mayoclinic.org/healthy-living/nutrition-and-healthy-eating/in-depth/mediterranean-diet/art-20047801

Activity:

- http://www.nhs.uk/Livewell/fitness/Pages/Whybeactive.aspx
- http://www.hsph.harvard.edu/nutritionsource/staying-active-full-story/