THE PATIENT REVOLUTION

Designing for Conversations
Shared Decision Making in Practice

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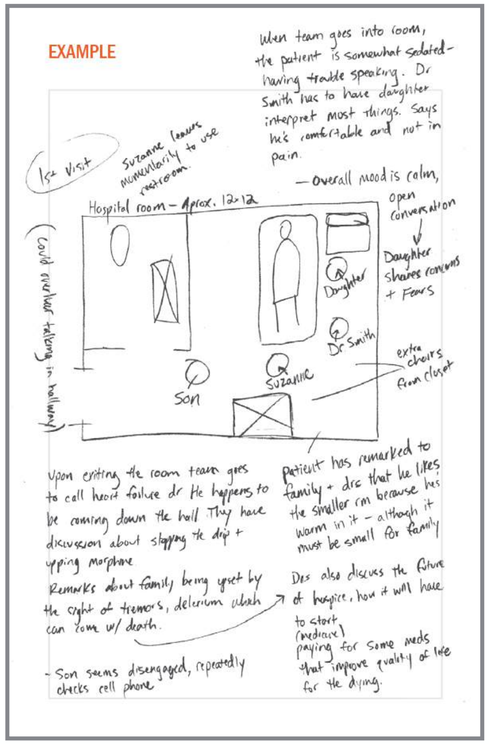


Designer & Researcher

COLLABORATORS

some partners in development and research

MAYO CLINIC

KERUNIT

KNOWLEDGE AND EVALUATION RESEARCH

Yale Cardiovascular Medicine

lux et veritas

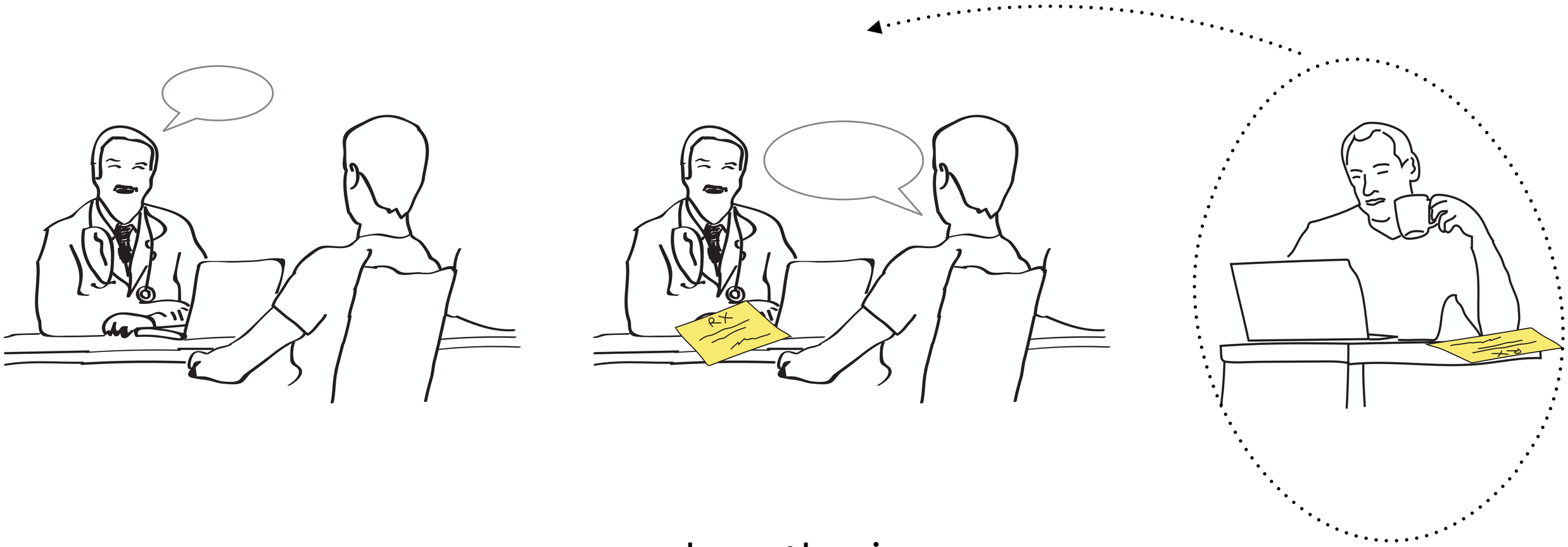
Cincinnati Children's™

Yale School of Medicine
Endocrinology

MAYO CLINIC HEALTH SYSTEM

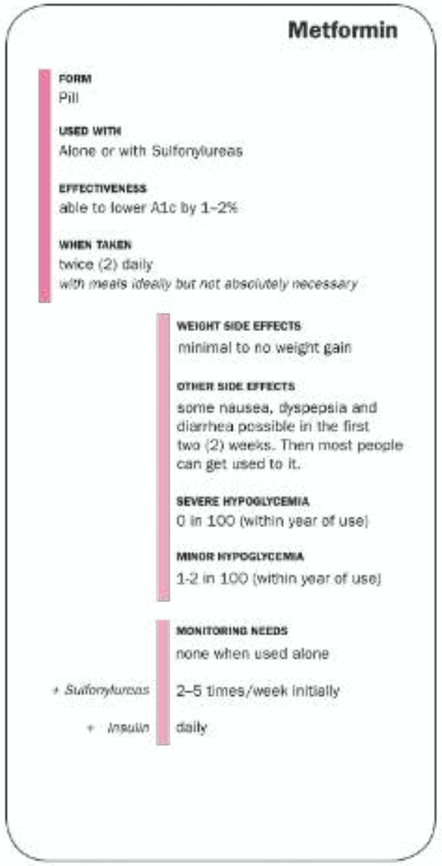
Diabetes Issue Cards: A short case study (2005)

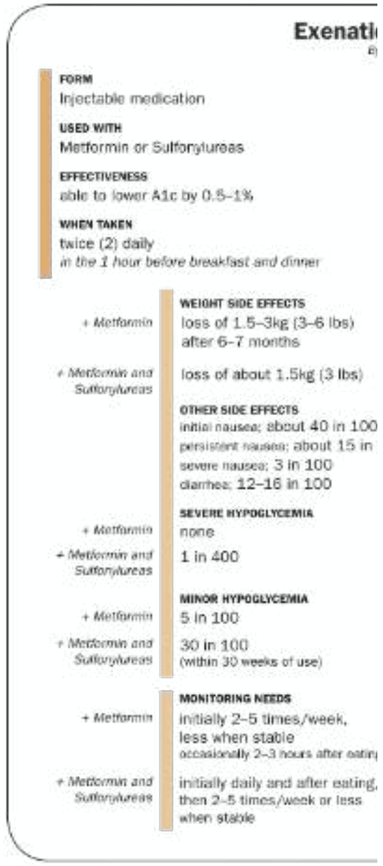
most decision making in practice

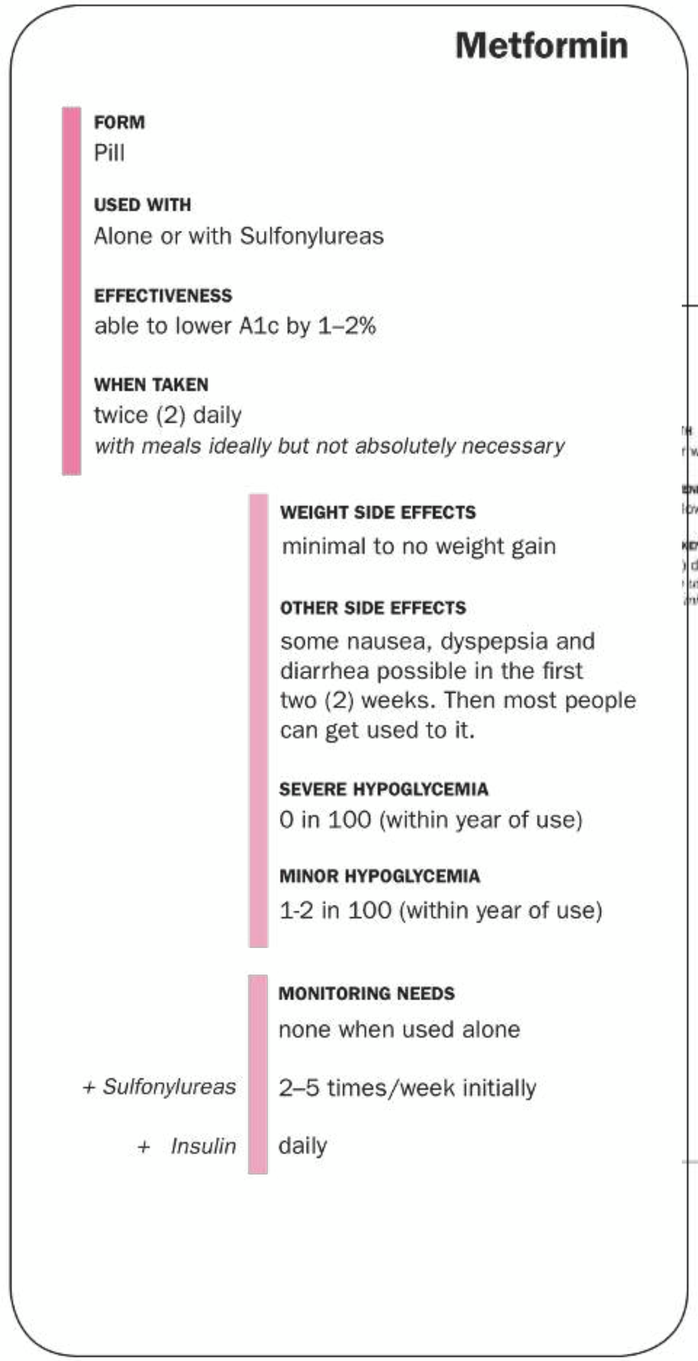


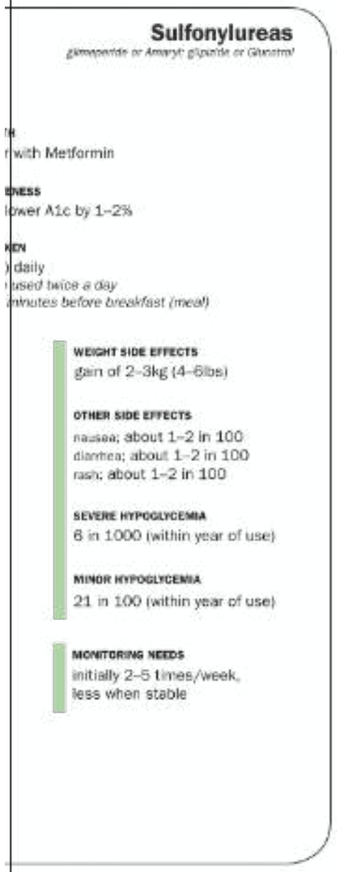
hypothesis

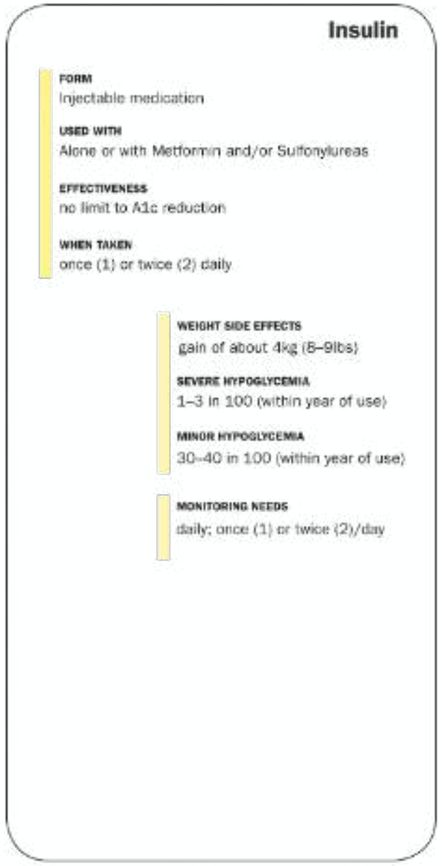
Prototype 1: baseball cards











Prototype 2: narrative cards

Exenatide *(Byetta)*

FORM
Injectable medication

TYPICALLY USED WITH
Metformin or Sulfonylureas

WHEN TAKEN
Twice (2) daily; in the morning and evening before eating

MONITORING
If taking Sulfonylureas, monitor daily after meals. Once stable, you can monitor less often.

EFFECTIVENESS
Exenatide typically lowers A1c by 0.5–1%.

WEIGHT EFFECTS
Exenatide has been shown to promote weight loss, an area of concern among many people with diabetes. If you are currently taking Metformin, you may lose 3 to 6 pounds after 6–7 months of taking Exenatide. If you are taking Metformin and Sulfonylureas, the weight loss will be less because Sulfonylureas have the side effect of weight gain. Still, you may experience a loss of about 3 pounds on Exenatide.

HYPOGLYCEMIA
When used with Metformin, there is no risk of severe hypoglycemia and the chance of minor hypoglycemia is about 5 in 100. When used with Metformin and Sulfonylureas, the risk of severe hypoglycemia is less than 1 in 100 and for minor hypoglycemia 30 in 100 (within 30 weeks).

OTHER SIDE EFFECTS
Other side effects of Exenatide may include nausea and diarrhea. Of 100 people like you, 40 will experience initial nausea with 15 of those experiencing persistent nausea and 3 experiencing severe nausea. Between 12–16 of 100 people will have some form of diarrhea.

Insulin

FORM
Injectable medication

TYPICALLY USED WITH
Alone or with Metformin and/or Sulfonylureas

WHEN TAKEN
Once (1) or twice (2) daily

MONITORING
Initially once (1) or twice (2) per day. Once stable, you can monitor less often.

EFFECTIVENESS
There is no limit to the amount of A1c reduction you can receive with Insulin.

WEIGHT EFFECTS
Insulin is often associated with weight gain. On average, most people who use Insulin will see a weight gain of around 8–9 pounds.

HYPOGLYCEMIA
Of 100 people like yourself who use Insulin, between 1 and 3 will experience severe hypoglycemia within a year of use. The risk of minor hypoglycemia is greater with between 30 and 40 people out of every 100 exhibiting some symptoms within a year of use.

OTHER SIDE EFFECTS
There are no other significant side effects associated with Insulin.

Sulfonylureas *(glimeperide or Amaryl; glipizide or Glucotrol)*

FORM
Pill

TYPICALLY USED WITH
Alone or with Metformin

WHEN TAKEN
Once (1) or twice (2) daily, 30 minutes before a meal

MONITORING
Initially 2–5 times per week. Once stable, you can monitor less often.

EFFECTIVENESS
Sulfonylureas typically lower A1c by 1–2%.

WEIGHT EFFECTS
A common effect of Sulfonylureas is weight gain. The average gain is between 4–6 pounds although it should be noted that some people don't gain any weight at all and others may gain more than the average.

HYPOGLYCEMIA
The risk of severe hypoglycemia with Sulfonylureas is less than 1 in 100 within a year of use. Within the same time frame (a year), the likelihood of experiencing minor hypoglycemia is 21 out of 100.

OTHER SIDE EFFECTS
Other side effects of Sulfonylureas include nausea, rash and diarrhea. In studies of people like you, the likelihood of experiencing nausea, rash or diarrhea is about 1–2 in 100.

Glitazones *(pioglitazone or Actos; rosiglitazone or Avandia)*

FORM
Pill

TYPICALLY USED WITH
Alone or with Metformin and/or Sulfonylureas

WHEN TAKEN
Once (1) daily

MONITORING
Occasionally with Metformin; 3–5 times per week with Sulfonylureas. Once stable, you can monitor less often.

EFFECTIVENESS
With Metformin, Glitazones typically lower A1c by 1%. With Metformin and Sulfonylureas, Glitazones may be able to lower A1c by 1–2%.

WEIGHT EFFECTS
A common effect of Glitazones is weight gain. When paired with Metformin, which does not typically have a weight gain effect, the average weight gain is 2–6 pounds. When combined with Sulfonylureas, which do have a weight gain effect, the combined average weight gain can be between 2–13 pounds.

HYPOGLYCEMIA
Glitazones cause no risk of severe hypoglycemia. The risk of minor hypoglycemia shows 2 of 100 people like yourself experiencing some symptoms within one year of use.

OTHER SIDE EFFECTS
The primary side effect of Glitazones is edema, fluid retention. Approximately 10 out of every 100 people like you may experience some swelling of the ankles. If you have heart failure, fluid retention may affect your breathing.

Metformin *(Glucophage)*

FORM
Pill

TYPICALLY USED WITH
Alone or with Sulfonylureas

WHEN TAKEN
Twice (2) daily; with meals ideally

MONITORING
Initially 2–5 times per week. Once stable, you can monitor less often.

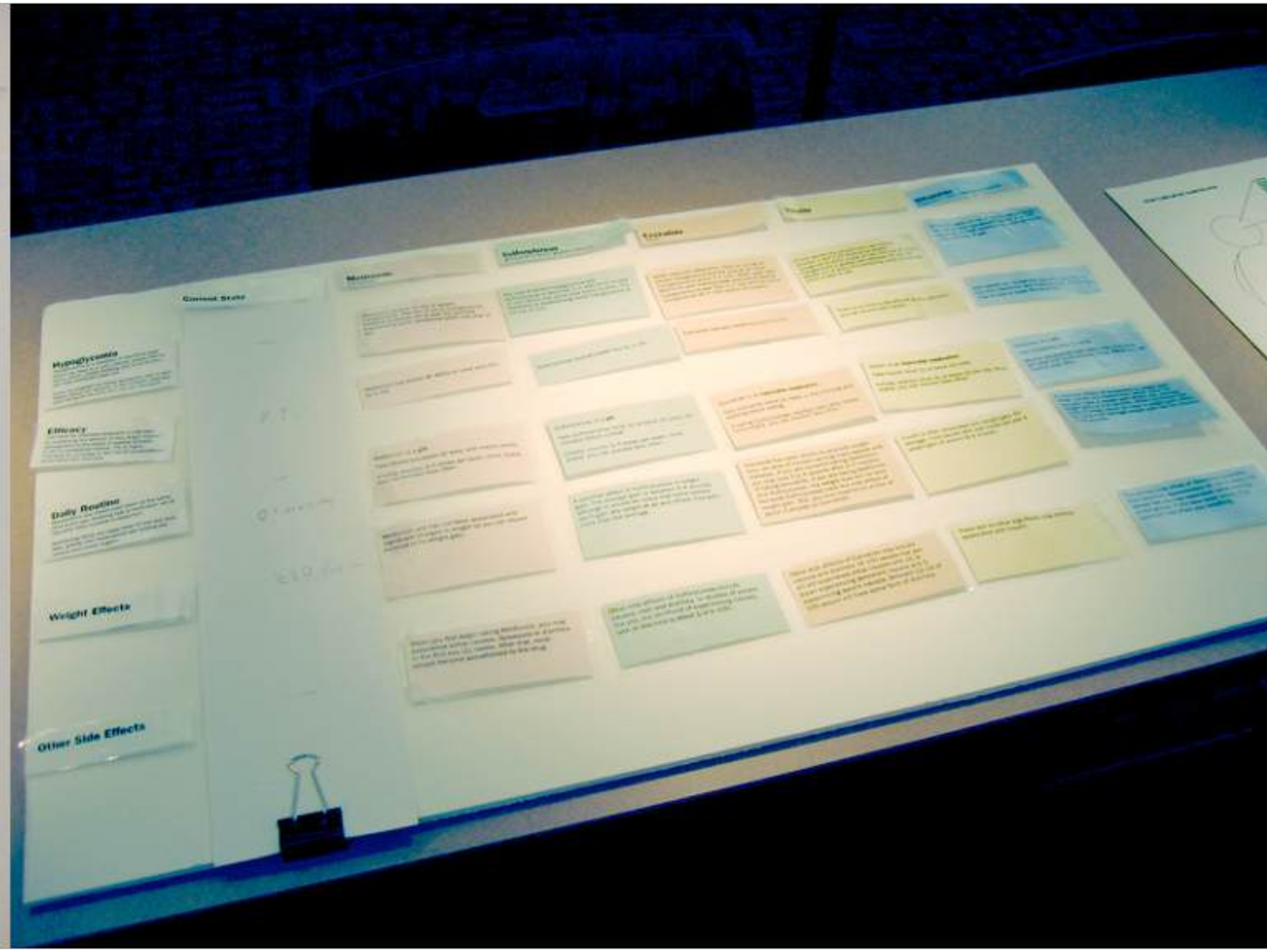
EFFECTIVENESS
Metformin has shown an ability to lower your A1c by 1–2%.

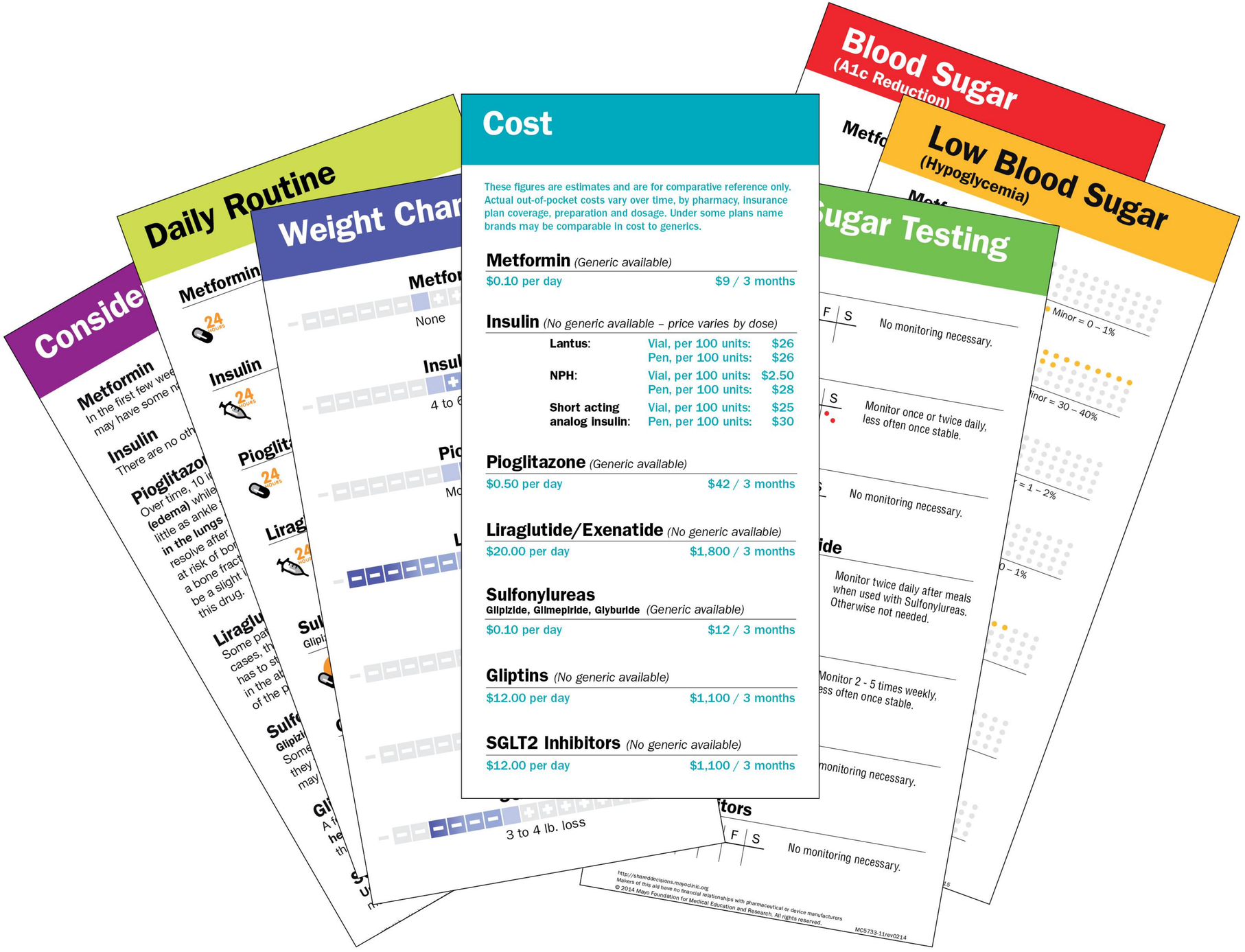
WEIGHT EFFECTS
Metformin use has not been associated with significant changes in weight so you can expect minimal to no weight gain.

HYPOGLYCEMIA
Metformin causes no risk of severe hypoglycemia. The risk of minor hypoglycemia shows 1–2 people out of 100 like yourself experiencing some symptoms within one year of use.

OTHER SIDE EFFECTS
When you first begin taking Metformin, you may experience some nausea, dyspepsia or diarrhea in the first two (2) weeks. After that, most people become accustomed to the drug.

Prototype 3: decision board




Blood Sugar
(A1c Reduction)
Low Blood Sugar
(Hypoglycemia)
Daily Routine
Weight Chan
Sugar Testing
Cost
These figures are estimates and are for comparative reference only. Actual out-of-pocket costs vary over time, by pharmacy, insurance plan coverage, preparation and dosage. Under some plans name brands may be comparable in cost to generics.
Metformin (Generic available)
$0.10 per day
$9 / 3 months
Insulin (No generic available – price varies by dose)
Lantus: Vial, per 100 units: $26
Pen, per 100 units: $26
NPH: Vial, per 100 units: $2.50
Pen, per 100 units: $28
Short acting analog insulin: Vial, per 100 units: $25
Pen, per 100 units: $30
Pioglitazone (Generic available)
$0.50 per day
$42 / 3 months
Liraglutide/Exenatide (No generic available)
$20.00 per day
$1,800 / 3 months
Sulfonylureas
Glipizide, Glimepiride, Glyburide (Generic available)
$0.10 per day
$12 / 3 months
Gliptins (No generic available)
$12.00 per day
$1,100 / 3 months
SGLT2 Inhibitors (No generic available)
$12.00 per day
$1,100 / 3 months
No monitoring necessary.
Monitor once or twice daily, less often once stable.
Monitor twice daily after meals when used with Sulfonylureas. Otherwise not needed.
Monitor 2 - 5 times weekly, less often once stable.
Minor = 0 – 1%
Minor = 30 – 40%
= 1 – 2%
0 – 1%
3 to 4 lb. loss
http://shareddecisions.mayoclinic.org
Makers of this aid have no financial relationships with pharmaceutical or device manufacturers
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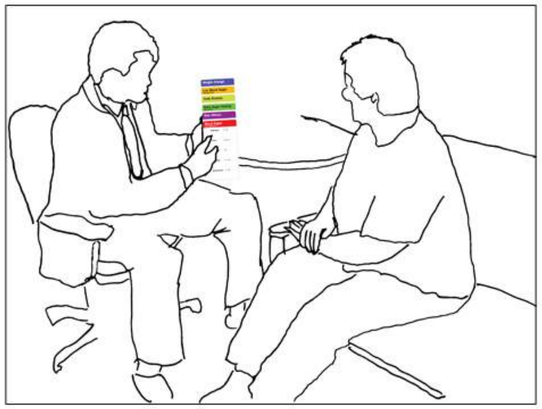
MC5733-11rev0214

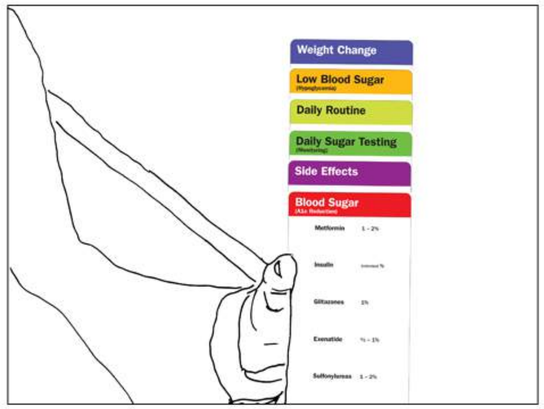
Learnings and Advice

- Care happens in conversation
- Success is a care plan for this patient ≠ patients like this
- Evaluate tools by gathering stories + measurable data
- Good interventions aim to create the conditions for care

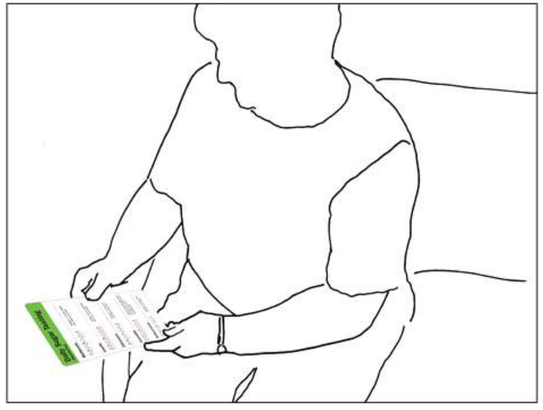
THE PATIENT REVOLUTION

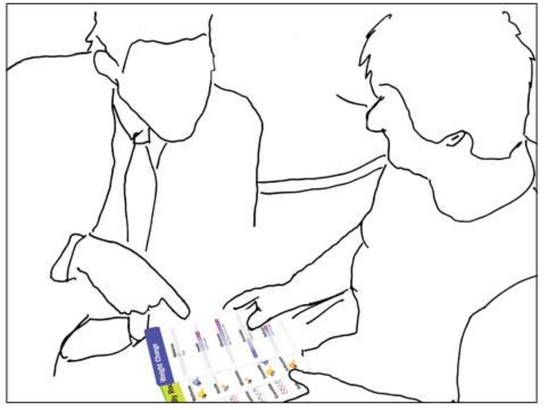
Care happens in conversation.

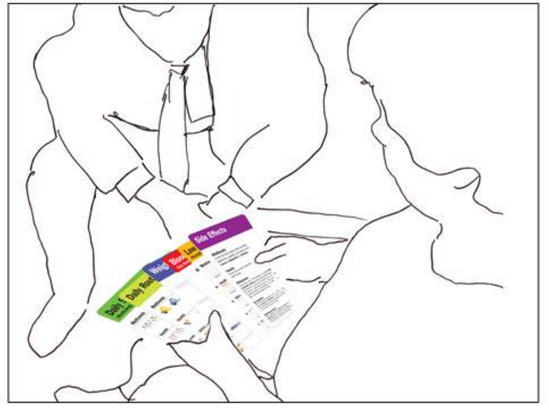


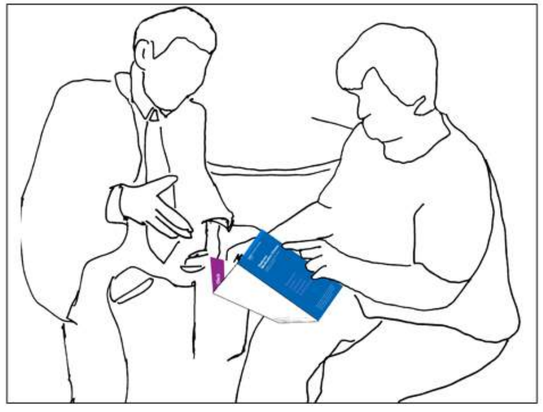

Weight Change
Low Blood Sugar
(Hypoglycemia)
Daily Routine
Daily Sugar Testing
(Monitoring)
Side Effects
Blood Sugar
(A1c Reduction)
Metformin 1 – 2%
Insulin Individual %
Glitazones 0%
Exenatide ½ – 1%
Sulfonylureas 1 – 2%

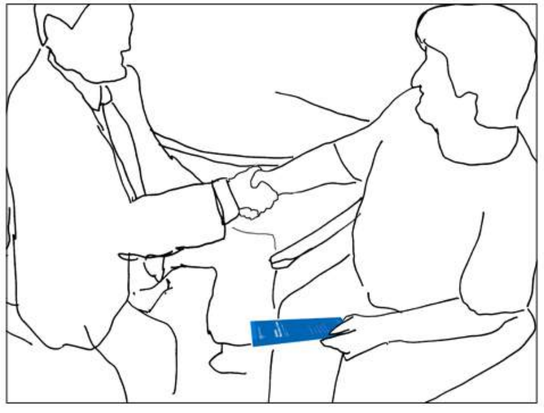

Weight Change
Low Blood Sugar
Daily Routine
Daily Sugar Testing
Side Effects
Blood Sugar











NOTICE

Looking at & engaging

Recognizing each other as people

Looking for strengths

RESPOND

Creating a productive plan

Drawing from best-available knowledge and research

Commitment to work together

Showing compassion

SETTING

Enough time

Necessary resources

Few disruptions

Success is a care plan for
this patient ≠ patients like this

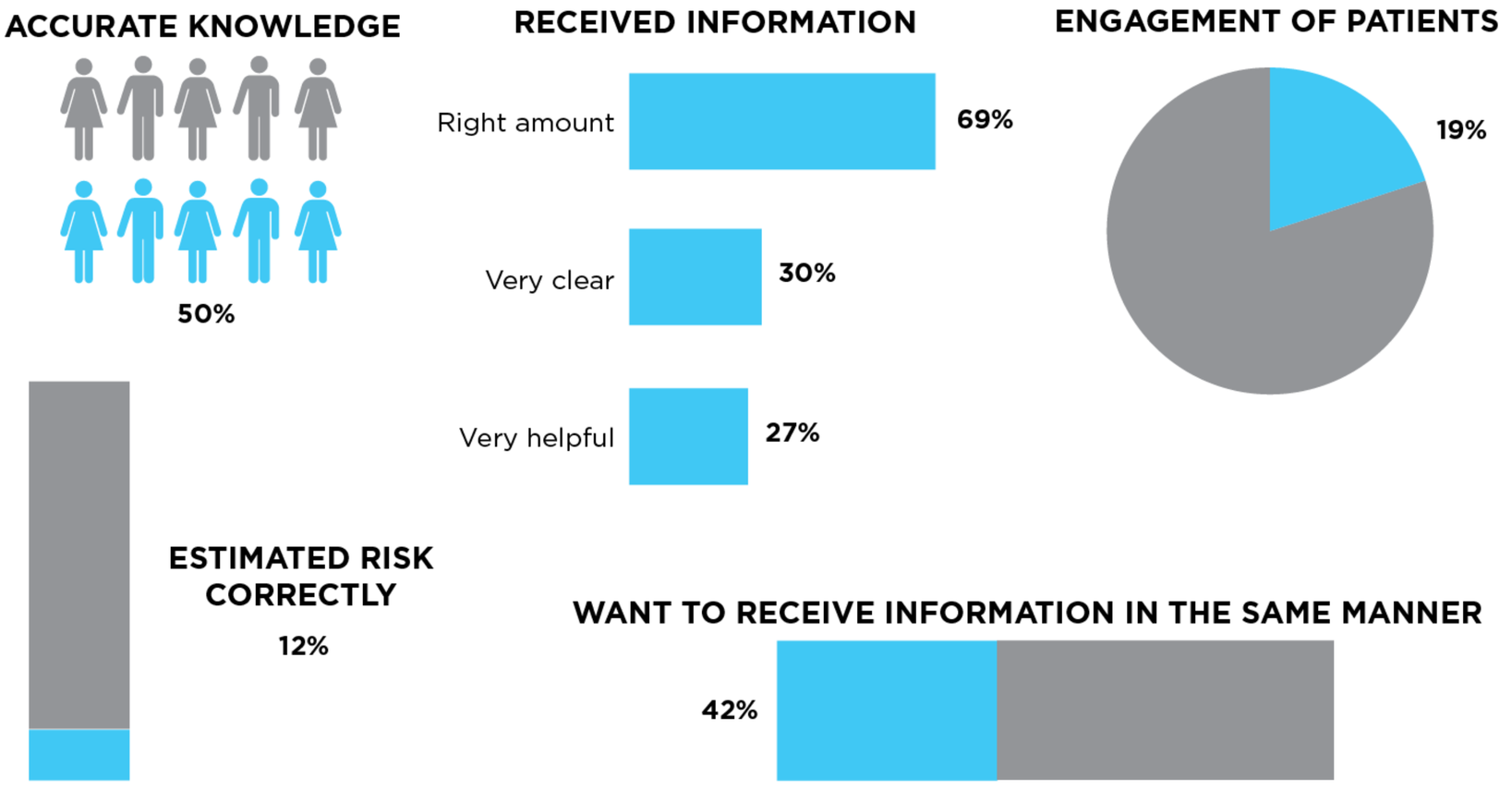
HbA1c < 7%

4 Statin Benefit Groups

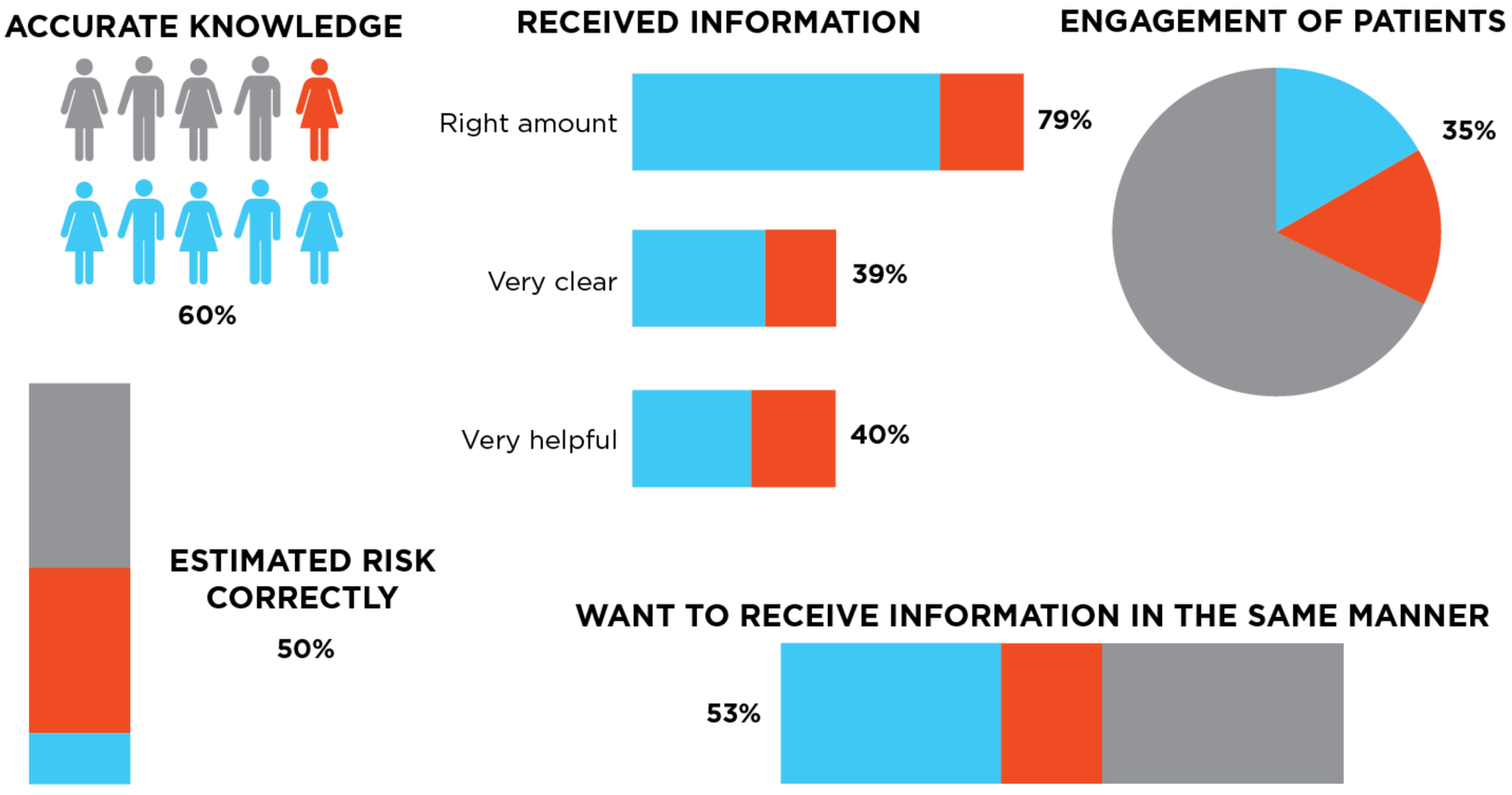
- Clinical ASCVD*
- LDL-C ≥ 190 mg/dL, Age≥ 21 years
- Primary prevention-Diabetes: age 40-75 years, LDL-C 70-189 mg/dL
- Primary prevention - no diabetes ≥ 7.5% 10 year

Maria Luisa ≠ People like Maria Luisa

Evaluate tools by gathering stories + measurable data.


ACCURATE KNOWLEDGE
50%
RECEIVED INFORMATION
Right amount
69%
Very clear
30%
Very helpful
27%
ENGAGEMENT OF PATIENTS
19%
ESTIMATED RISK CORRECTLY
12%
WANT TO RECEIVE INFORMATION IN THE SAME MANNER
42%

Usual Care

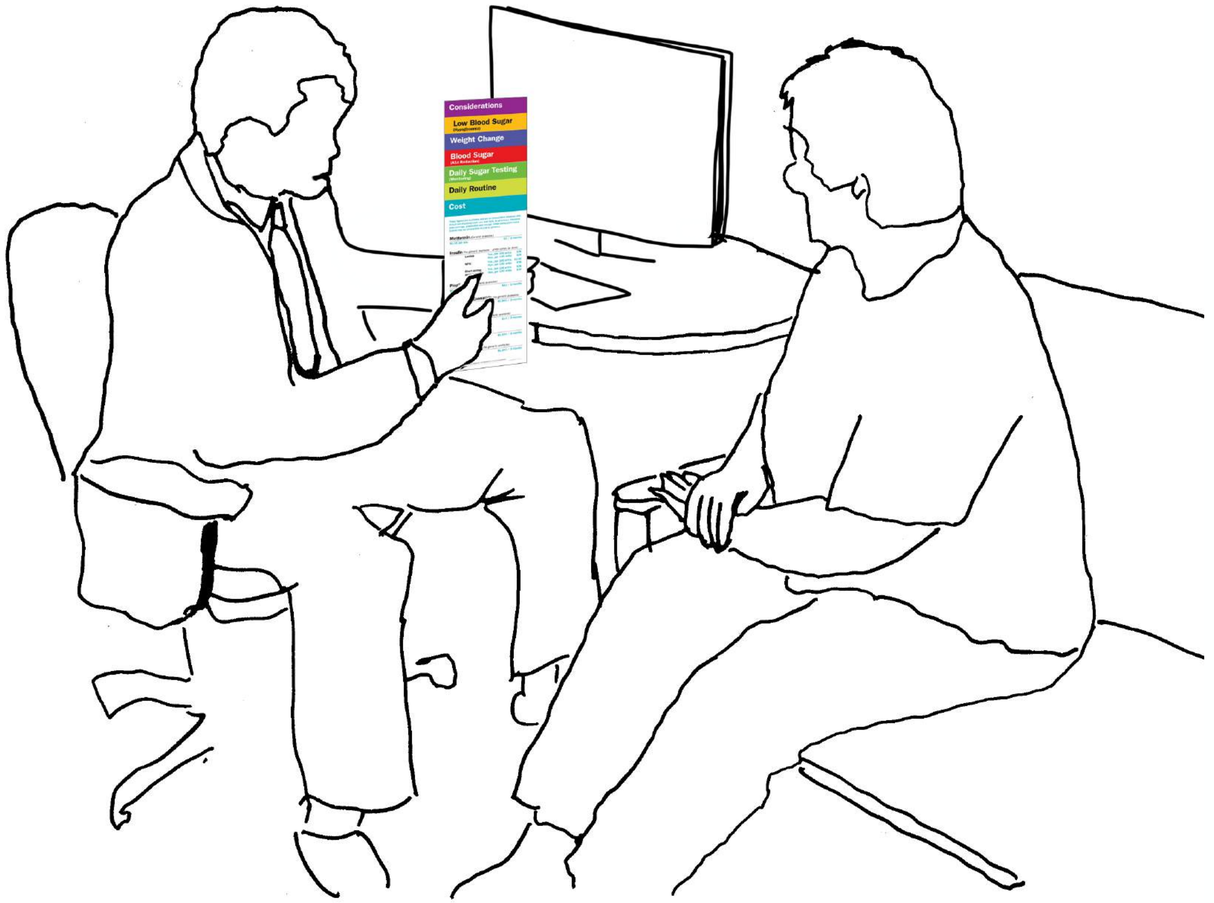


with Intervention

Summary

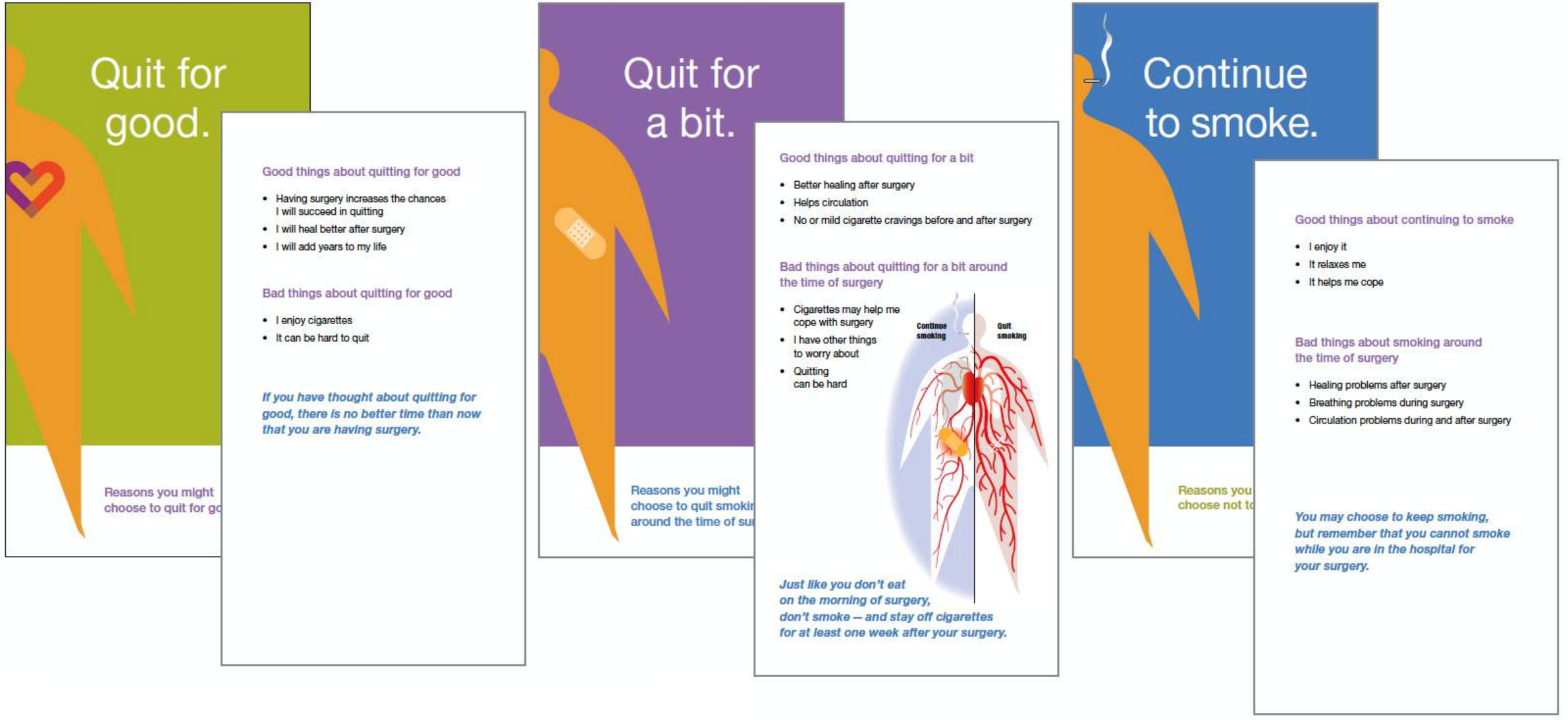
- Age: 40-92 (avg 65)
- Primary Care, ED, hospital, specialty care
- 74-90% of clinicians want to use the tools again
- Adds ~3 minutes to the consultation
- 58% fidelity without training
- Effects on shared decision making are similar in vulnerable populations
- Variable effect on clinical outcomes and cost

Wyatt et al. Implement Sci 2014; 9: 26
Coylewright et al CCQO 2014, 7: 360-7



92 year old patient story

Good interventions aim to create the conditions for care



Smoking Cessation around Surgery

What impacts the ability to notice and respond? to have a conversation?

Conditions for care are the product of:

CULTURE

POLICIES

PROCESSES

SPACES

CULTURE

Shared ways of thinking and shared assumptions

POLICIES

Laws, regulations, and incentives

PROCESSES

Detailed actions and steps to achieve a particular end

SPACES

Physical and virtual environments



Point of Care

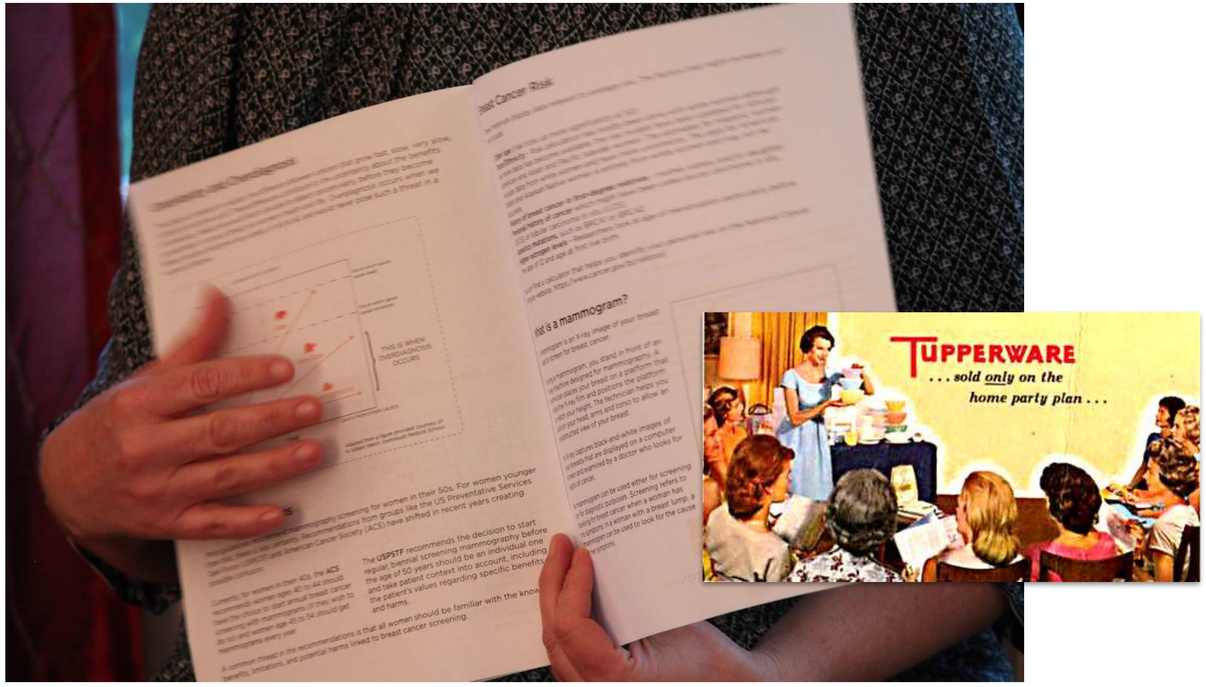
Space design
Visit requirements
Documentation requirements
Lack of continuity

Organization

Strategic priorities
Payor contracts
Assessment policies
Performance improvement expectations

Influence

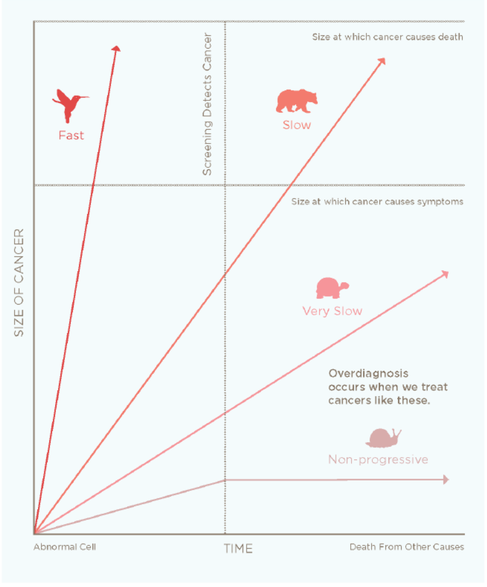
Billing and payment policies
Regulation
Market expectations
Malpractice and liability



Uncertainty and Overdiagnosis

This graphic attempts to show the difference between cancers that grow fast, slow, very slow, or that do not grow at all. These differences contribute to the uncertainty about the benefits of screening.

Ideally, we would like to be able to detect cancers early, before they become symptomatic or pose a threat to a woman's health and life. Overdiagnosis occurs when we detect cancers that grow very slowly, or not at all, and would never pose such a threat in a woman's lifetime.



Source: NCI Division of Cancer Prevention. Adapted from a figure provided courtesy of H. Gilbert Welch, Dartmouth Medical School

Shared Decision Making as a method of care

“Anytime, a patient and clinician figure out together what to do about the patient’s situation, they are doing SDM.

Therefore, we believe SDM is not ‘another thing clinicians must do’, that is, to help patients select the best evidence-based option given their preferences, but that it is a method of care, as central to the clinician’s art as history taking, the physical examination, the selection and interpretation of diagnostic tests, and patient education and counseling.”

Montori VM, Ruissen MM, Hargraves IG, *et al* Shared decision-making as a method of care *BMJ Evidence-Based Medicine* 2023;**28:**213-217.

Find more ways to get involved...

patientrevolution.org

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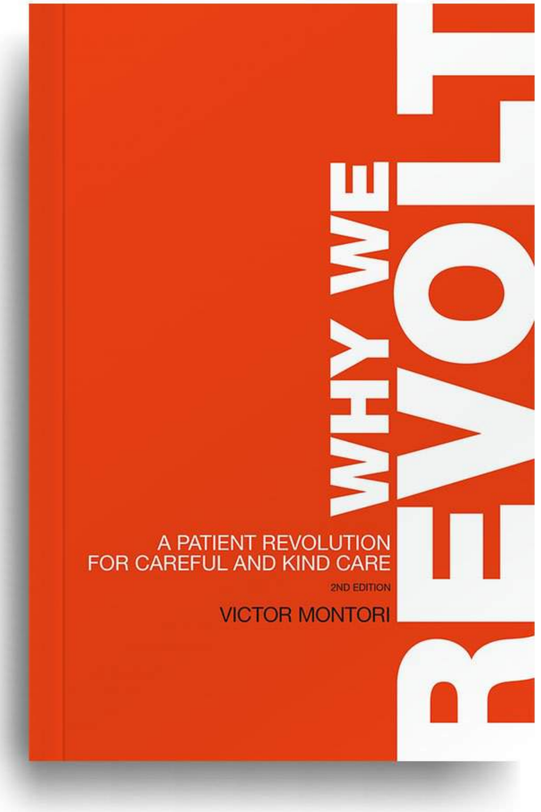

Foundations of Care course