

Shared Decision Making: Changing the Conversation

Melody Riefer: Good afternoon and welcome to today's Recovery to Practice webinar titled Shared Decision Making: Changing the Conversation. My name is Melody Riefer and I am your host today. After some housekeeping and a short overview of Recovery to Practice, we'll begin today's presentation.

On behalf of the Substance Abuse and Mental Health Services Administration and the Recovery to Practice team, we would like to welcome you and thank you for joining us today. We have about 80 people on the call at this point and we do expect the number to grow as we go through the conference. I would like to also thank our presenters, Neil Korsen, MD, MS and Jesse Higgins, RN, MSN, PMHNP, for sharing their knowledge and experience with us today.

At the bottom of the screen you have a download materials here box where you can download our presenters' bios as well as a PDF of the presentation slides. At the end of the session you will also be able to download a certificate of attendance that you can use to apply for continuing education credits for your specific professional association. This webinar has been preapproved for continuing education hours from NAADAC, the addiction professional's association. To qualify for these training hours you must attend the full webinar, complete a brief quiz, and the webinar evaluation. More information on this is at the end of today's webinar. At the completion of our webinar today an opportunity to provide feedback will automatically open on your screen. Please take a few moments to provide us with your feedback.

Finally, if you have registered for the webinar, you will receive an email link to view the archived recording. This link will also be available on the RTP website where you will also find links to past RTP webinars. Feel free to share this information and those links with your friends.

This webinar series is posted by SAMHSA's Recovery to Practice initiative. The overarching goal of this initiative is to improve the knowledge and ability of the behavioral health workforce to use recovery oriented practice every day.

What do we mean by recovery oriented practices? In 2011 SAMHSA released a working definition of recovery and a set of guiding principles that incorporate aspects of recovery from both substance abuse and mental health conditions. SAMHSA's working definition of recovery in behavioral health is, "a process of change through which individuals improve their health and wellness. Live also directed life. Strive to reach their full potential. The 10 principles of recovery shown on this slide along with the four major dimensions of recovery, those being home, health, purpose, and community, form a solid foundation for developing recovery oriented lives and for building recovery oriented services in systems necessary to support them.

SAMHSA's Recovery to Practice initiative helps you turn these principles into recovery workforce practices. RTP offers a set of discipline-based curricula to promote understanding and uptake of recovery principles and practices. Developed by these six professional disciplines for educating their membership about recovery in behavioral health, these materials are adaptable for use by other disciplines and organizations seeking resources to build a recovery oriented workforce. Links to these curricula are available at SAMHSA's RTP website. RTP is constantly expanding its discipline focus to embrace multidisciplinary services and integrated settings. Those of us who work and behavior health or integrated healthcare organizations have opportunities every day to promote wellness and recovery. We can powerfully communicate hope for recovery and a value of self-care and wellness just in how we approach our work. RTP can help you strengthen your recovery oriented practice through free webinars, newsletters, and conference-based educational events.

Today's webinar will provide an overview of shared decision-making as a concrete example of recovery oriented behavioral health practice. The presenters will demonstrate how the adoption of shared decision-making in an integrated care practice, working with individuals with opioid use issues, anxiety, and depression, contributes to improved communication on a more collaborative care. Participants will learn how shifting from giving information to collaborative dialogue impacts relationships and outcomes for all involved. I would like now to introduce our speakers for today.

Neil Korsen, MD, MS is a family physician and geriatrician with 20 years of practice experience. He graduated from the Masters program at the Center for the Evaluative Clinical Sciences at Dartmouth (now The Dartmouth Institute) in 2002. He leads a number of quality improvement programs for Maine Health, an integrated delivery system in southern and central Maine. Dr. Korsen was first exposed to Shared Decision Making as a practicing physician in the 1990s, when his office participated as a site for the Prostate Patient Outcomes Research Trial. He leads the Shared Decision Making (SDM) program at Maine Health, which was funded from 2009-2015 by grants from the Informed Medical Decisions Foundation and from the Center for Medicare and Medicaid Innovations. He also serves as a consultant to Healthwise, a developer of Shared Decision Making and patient education materials. In this role, he helps healthcare organizations develop implementation plans for Shared Decision Making.

Our second presenter is Jesse Higgins, RN, MSN, PMH-NP, she is passionate about improving patient and medical provider access to behavioral health expertise through integration. Jesse is the Director of Behavioral Health Integration at Acadia Hospital in Bangor, Maine. An Acadia provider since early 2010, Jesse has practiced consultative psychiatry in primary care at Eastern Maine Medical Center since 2011. Acadia BHI providers improve patient and medical provider access to behavioral health expertise by using a consultant-liaison approach to integration. In addition to her training as a Psychiatric Mental Health Nurse Practitioner at the University of Southern Maine, Jesse earned a graduate certificate in Primary Care and Behavioral Health Integration from the University of Massachusetts Medical School in 2013 and a graduate certificate in Health

Policy and Management from the University of Southern Maine in 2016. Jesse is an active member of several hospital and community committees in which she helps shape policies that encompass compassionate, collaborative, and whole patient care.

We are very pleased to be able to bring to you such high caliber experts. Neil, I will now turn the webinar over to you.

Neil Korsen: Thank you. And I guess good morning or afternoon depending where you are in the country you are. My job for the next few minutes is to review the basics of shared decision-making for you. I want to start with this definition, there are many out there, and this is the one that I have been using because I think it captures the most important characteristics and principles of shared decision-making.

So, it is a process between individuals using services and their clinicians. It is about a conversation or a dialogue. That is the one important thing. It engages the individual decision-making to the extent that that person desires. I think it is important to point out historically that our approach to decision-making and healthcare has generally been that the clinician makes or at least recommends the decisions. So, I think it is important to recognize that we want to help the individuals who we are serving to become more active participants in making decisions about their health, and that may require some support. The current situation may not make it easy for people to do that.

Once we've engaged somebody, we want to provide that individual with current and unbiased information about alternative treatments; what alternatives are available to them, and then understand what is important to them so we can facilitate the incorporation of their preferences and values, otherwise thought of as what are their goals in treatment or what is important to them. So, we can incorporate that into the treatment plan. So, that is how I would have you about shared decision-making.

Hearing that definition, we have a poll question. And that poll question is: are you participating in shared decision-making now in your practice or in the way you provide care? We will watch the answers. Most of the people who have answered, more than 80%, are saying that they are currently participating. It continues to be about 80%, ranging between 75% and 80% as more answer. Thank you.

So, I want to talk about a few key research studies that provide the foundation for why Shared Decision Making is drawing a lot of attention these days. It really addresses one thing that I commonly hear when I speak to groups of clinicians and Shared Decision Making, not unlike the poll, people say we are doing that already. We understand what Shared Decision Making is and we're doing that already. I cannot comment in general about what happens behind the door between a clinician and the person they are serving, so I can't either agree or disagree with someone who says that, but what I have been doing is pointing out what the literature says. One of the important studies was called The Decisions Study, somebody was very good at our -- at algorithms -- not algorithms -- you know what I need to come up with decisions for the study name.

This was a survey of people who were initially asked if they had made one of 10 common decisions over the past year. Some of those decisions had to do with cancer screenings, some had to do with elective surgery, others had to do with medication choices for chronic conditions. Anyone who had made one of those decisions was included in the study and there were more than 3000 patients that were involved. The results of the study showed that in general, clinicians were very likely to describe the potential benefit of any recommended treatment more than 90% of the time but less than half of the time in general was their discussion of the potential risks or the cons of those decisions. In the case, of back and hip or knee replacement surgery people reported that the clinicians -- people reported that it was above 50% and in the case of spinal surgery it was 80%. In addition, patients who were in the study said that they were not asked about their preferences less than half of the time. But the providers or clinicians expressed their opinion as to what the patients should do more than three quarters of the time. We are more likely to talk about benefits than harm, and were more likely to tell than to ask is what the study shows.

Another study given that clinicians tend to make the decisions, and we do so I think in a well-meaning way, but we understand the issues that are important to the patient, and therefore we knowing their preferences, we can recommend the best treatment. This study which was done by Karen Sepucha, a researcher at Mass General Hospital, showed that the truth may be authorized. This has to do with asking women and their providers about what was important when these women were facing decisions about treatment for breast cancer to either have a mastectomy removal of the entire breast or a lumpectomy which is just the removal of the lump which is generally followed by radiation sometimes either can be followed by chemotherapy. So, you can see in almost all cases the provider's prediction of what was important did not match what the patient said. Providers thought it was very important to women to be able to keep their breasts, but women did not report that as an important preference. Providers almost unanimously thought that living as long as possible was important to women, again that was not as highly rated by women. Similarly looking natural without clothing and while providers did not at all think it was important to women to avoid using prostheses, if they had a mastectomy, some women a substantial percentage did think so. In general, without asking providers are not good at predicting for our patients. We need to ask.

Finally, the issue of having a shared conversation about decision-making is a challenge to people. This was a focus group study that was done in Palo Alto California with people who got their care through the Stanford University medical system. This showed, and I think it's important to point out, even in a community that is highly educated and certainly socioeconomically above average, people are hesitant to ask questions of their providers. They feel compelled to defer and don't want to be seen as difficult patients. And perhaps, not surprisingly, they recognize and identify that physicians can be authoritarian. So, that really reinforces that underlines the importance of inviting people to be actively participating in their decision-making.

So, as we talk about Shared Decision Making, one thing that we need to talk about our decision aids. This is a definition of decision aids: they come in a variety of formats, they are designed to help people become more actively involved in decision-making by making sure they understand that there is a decision, there is more than one reasonable option and information is provided about those options and the impact of various options of both benefits and risks, and then a decision aid also helps an individual think about what is important to them in relation to this decision that they are making. Watching a decision aid by itself is not Shared Decision Making. Shared Decision Making is a conversation that happens afterwards. But, this really helps a person be prepared to have a conversation, to understand issues and to have some time to think through those issues.

I am going to show you a whole variety of types of decision aids just so you can see what is out there. My focus today to talk about decision aids that are publicly available that will not cost anyone any money, at least in terms of obtaining them because some of you out there may not have access through whatever organization that you are a part of. The good news is when I left checked four of the five largest developers make their tools available without charge. I will have links at the end to websites for all of these organizations. SAMHSA is also working on decision-support tools and I will show you one example of those among my examples.

These are some shots of a few decision aids that have been developed by the Agency for Healthcare Research and Quality, that are specific to decisions about behavior health related treatment options. You can go to a AHRQ.gov. You can see the link at the end. These are from Mayo Clinic and these are to help people make decisions with their clinician if they are considering antidepressant medication. You can see they're organized by addressing different aspects of what might be important to somebody that's thinking about antidepressants, whether it is impact on weight, on sleep, on sexual function, what they cost, and so they are designed to help clinicians and the person they are working with to compare the various options and identify one or more options that seem to best meet the preferences of the person.

The next are similar cards. These come from a behavioral health organization in California, they develop them themselves. And these are designed to help use of transition aids makes decisions about antipsychotic medication. You see similarly, there are various ways that the medication options are compared and contrasted so that a person can think about what is important to them and make a decision. This is an example of the kind of decision-support tool that SAMHSA is working on, and it describes this particular view -- this one describes side effects that are common among a variety of antipsychotic medications. This, while it's about decisions related to cancer screenings, is an example of what is called an option grid, is another way of summarizing the important parameters related to a choice, there's an option being developed related to depression treatment options which compares medication and psychotherapy with a similar format.

There has been a lot of research about the use of decision aids in Shared Decision Making and the impact that they have on people's process of care. This is a summary of a review by a group called the Cochrane collaboration this is an international group of scientists who volunteer their time, who look at important lessons in healthcare and summarized the evidence. This is actually the third review they have done of Shared Decision Making and decision aid use in the past 10 years because they always redo a review when there is new research and new information and there is a lot of research going on in this area right now.

But what we know for sure, based on the research that has been done, is that when someone uses a decision aid in the Shared Decision Making process, they have greater knowledge of their choices. They are more accurate in perceiving the risks, benefits, and harm of those choices. They are more comfortable with decisions, they participate more actively in the decisions, their decisions are more consistent with what they say is important to them, described here as expressed values. The patient rating of communication overall is better. Less people are undecided about choices in front of them.

And this gets somewhat controversial. It does appear that when people are fully informed they are less likely to choose elective surgical procedures. I have to put the caveat, that is in the short run because studies are generally not more than one or two years long. What we don't know yet because studies have not shown us this, it what the longer-term impact on choices which really have implications for cost of care will be. We do not know that yet. So, that is what we have learned. Better decisions are made and the decisions are more consistent with what people say is important to them.

I want to briefly talk about one other thing that is related to but not exactly the same as Shared Decision Making. That is a program called choosing wisely, which comes from the American Board of Internal Medicine and consumer reports. It is a joint program. It is about letting people know about healthcare procedures, tests, treatments that don't have strong evidence and might therefore be overused. It invites people to ask questions of their clinician. The way the list of those things that might be overused is generated with each specialty society has provided a list of at least five things that they think evidence does not support. There is a total of more than 400 across all the specialty societies.

The American Psychiatric Association has contributed and all five of their "Choosing Wisely" issues have to do with the use of atypical antipsychotics as shown on this slide. They feel antipsychotics -- atypical antipsychotics which have considerable risks are overused and are things they want clinicians to avoid. I think for patients an important aspect of choosing wisely is the encouragement to ask questions and there is a list of five important questions that really, if you think about them, comprise the kinds of things that might come up in the Shared Decision Making conversation. The difference in choosing wisely is, we have a sense that the patient should probably avoid making these choices where as in Shared Decision Making we feel any choice and any option we offer is a reasonable one for patients. That is choosing wisely and thank

you for this opportunity to talk about Shared Decision Making. I will pass it back to Melody to hand it over to Jess.

Melody Riefer: Thank you very much, Neil, for your information. It has been helpful to have a concise overview on the foundational information about Shared Decision Making. Now, I would like to welcome Jesse, and have you walk us through the application of Shared Decision Making in your practice.

Jesse Higgins: Great. Thank you so much. My name is Jesse Higgins, they mentioned earlier I am director of behavior health integration. I work for large psychiatric hospital but I practice at a small family medicine practice. All of this is interesting in application to the opioid epidemic. Here in Maine we lost a record number of folks I think with 272 people to opioid overdose just last year, and we recently had a change in legislation that has curtailed the prescribing practices of all outpatient providers, which has led to pretty rapid tapers of these medications for people who have been on them for many years. This has made many people who said Shared Decision Making cannot be done with opioids be a little more willing to listen to have conversations can go better.

Okay, so let me click through. The learning objectives, just briefly, what we are looking at is working together with our patients using all the principles that Neil talked about of Shared Decision Making and the principles of collaborative care. I do work on a collaborative care team, I am a psychiatric nurse practitioner, I work with folks from different disciplines. This is to improve communications between all team members and engage the patient and the family in the decision-making process.

Now, it has been said that Shared Decision Making could not be done for chronic back pain particularly for patients with a history of substance use disorder because the general belief is that providers cannot prescribe high doses of narcotics particularly here with the legislation and that that is what patients want. Patients want narcotics, we can't give it to them, and so there can be no Shared Decision Making. And, I guess I am here to say I truly think the opposite is true. I think Shared Decision Making is the key to addressing the opioid epidemic. The slide I have here talks about medical providers treating somatic symptoms of underdiagnosed and undertreated posttraumatic stress disorder and anxiety and depression with opioid medications. That is an inflammatory statement and I know it. SAMHSA actually pushed back a little, and asked for research, and I did provide the moderators of this presentation with a reference slide, explaining why I believe this to be the case.

These patients with posttraumatic stress disorder are particularly vulnerable to prescription opioid disorder, there have actually been studies done that show changes, neurobiologically, in patient's brains when they have been through a traumatic event and there are more changes in dodging the opioid system when they have PTSD, that makes them really vulnerable to opioids. Continuing on, Shared Decision Making I will not go back and defined it again. Neil has talked about it and explained it. I will talk about team-based care because I think that's it goes very

nicely with Shared Decision Making. It's all about shared goals and having a place to start. When we walk in we have goals for the patient, and the patient may have different goals in mind. And there has been traditionally an authoritative area where we just told patients what their goals are.

There have been times when, if someone had asked me if I did a large Shared Decision Making around antidepressants, at the beginning of that pilot I would have said I do Shared Decision Making, what kind of horrible provider would not do that. Of course, I want the patient's voice in the decision-making. And you know, once I really plummeted in organized, thoughtful way, Shared Decision Making at the process at every patient visit, it really showed me I was not doing that consistently. I was offering some choices some of the time to some patients. I was tailoring the conversation to what I thought was in the patient's best interest.

Principles of collaborative care. They are very similar to team-based care. I will use these as a foundation to talk about this more. Person centered self-directed goals. We walk into a room and there are certainly some goals that patients will have that may be different than ours. Patient with a substance abuse history who has been injured or patient who was using opioids in the past and found them helpful and a provider walked in thinking there will be an argument, there's a lot charged energy in the room, I think we need to start with what goals we share and often these are wanting to communicate clearly and honestly with providers and patients, identifying patient strengths and provider strengths. Where can we work together? Where are those opportunities. Offered choices, patient want choices. And promoting quality of life and the ability to perform activities that are important to the patients.

I would say that, the biggest complaint that the patients who have substance abuse disorder, or some sort of substance abuse, is that they feel labeled and when they walk into a medical appointment they feel like they have a big red X on their forehead for substance abuse. Most of the options are off of the table for them and that is not fair. We need to talk about shared goals for improvement. And what we know clinically and what patients are bringing to the table, which is their values and interests and goals and how we can work together.

You know, I talk a lot about evidence, evidence is really important to me. I am a researcher and I love it. I know it is weird and nerdy but that's where I am. Mostly because it helps me to be more confident when I am talking about these things with patients. I do not expect patients to go back to original journal articles but I encourage providers to do so. Some of the problems with overprescribing in the past have been related to us reading research summaries thinking we understood the topic and imparting that wisdom on the patient when we did not have a firm foundation clinically. We want to be able to summarize different kinds of evidence for patients, not discount research that does not align with our own belief system about something. We need to be flexible and willing to learn new things.

These are the screening tools we use for population health in my practice. I know in particular I'll mention PTSD screening tool for Post-traumatic stress, I know a lot of people do ACE for it, that is just a very different kind of information that you're going for there. What I want to do with these tools is know what is going on right now with the patient. What are the symptoms that are affecting care and really one of the things that Neil mentioned was having a willingness to, setting the stage for future conversations.

The first conversation may not go great and it often does not. I tell providers that all the time. Your first meeting with the patient when you are talking about shared decision-making with opioids, they may feel really frustrated because they may have come in thinking that opioids are the only helpful thing. When we use screening tools in my primary care practice, we use these five tools with every patient on any controlled substance including patients stimulants and benzodiazepines which are a weighted topic for another day. It just gives us more information and often an opening to talk about underlying issues. How is their history and their mental health symptoms are affecting pain?

Often patients are concerned that by giving them the tools that they are afraid that we are saying we think it is in their head. I always explain to patients, a lot of it is in your head and what is in your head is your brain which is the most complex organ in your body. It is inseparable from every other system that you have, so of course it is important to know what is happening with someone's mental health. Accountability and measurability again are ways of keeping us consistently on track.

This is some scripting we use. I will talk a little about the model that we kind of designed after I did this Shared Decision Making project where Neil Korsen, MD, MS was a consultant on and very helpful in helping to figure it out. In the beginning, it was overwhelming. This was around treating major depression depressive disorders because there were so many tools and technological options. It is so hard to get anything like that implemented in primary care. People are overwhelmed and electronic medical records are limited.

What we came up with was a quick text, and some people call them macros. Basically, it is a pre-populating, setting your medical record so, with a click of a couple buttons it creates a pre-populating phrase. The way we do it is pre-populating documentation. This here is about setting the stage so when we talk about this with patients, I offer a lot of scripting to providers. I thought not long ago they would find it insulting, they do not. They are certainly not going to repeat this verbatim and I have stressed the importance of looking at their own research so they can believe what they say and that makes all the difference because it has to be a genuine interaction. It needs to be simply explained that opioids relieve pain by working on opioid receptors in your brain. And the same process that helps with your pain, also triggers the pleasure center in a way that makes it hard to stop taking opioids once you start.

That is a non-blaming statement. We are saying, here is the situation people are in because of this, this is what has happened neural biologically, now where do we go from here. And furthermore, when you have a positive PT, PTSD screening, which is the primary care PTSD screening which asks about symptoms in the last month, we can say that people who have been through something extremely scary or life-threatening can have changes in their brain that makes it even harder for them to stop taking opioids.

I am an integrated healthcare provider; I lead a program. So, whenever anyone talks about a health care crisis or issue my answer is always integrated behavioral health. Not because I think they all need to see a psychiatric provider, but I think medical administrators and providers really need to incorporate some understanding about mental health and behavioral health into their own practice with their own patients. These are just ways of talking that integrated behavior health can help, and I've already talked about a lot of this.

So, now I will talk about the quick text. This is one of the questions that I got from a number of patients and that providers could not answer with their patients. We are talking about tapering, high-dose opioids which we know are at risk for overdose, respiratory failure and really just, even when that is not the case, they have people addicted and dependent on medication that they're unable to stop. You have been prescribing this to me all this time and only now you to stop? What happened? A lot of this information we include in the quick text. In the EMR. Not in these words, this is a little wordy but it is how to talk about the situation. Say that we care about your health and the quality of your life and our community.

As a preface, I want to say that what I have been hearing from primary care providers having a conversation were there's a new law in Maine, I'm going to lose my medical license if we keep doing this so we have to stop this medication. Or I will retire in a few years, no one else will give it to you so we need to stop this medication. Patients do not want to hear that. You may get the same results from tapering patients but you are not aligning with the patient, there is no Shared Decision Making, they are just being told this is how it is. This is an alternative way of approaching that. "Decreasing or stopping chronic opioids can improve your quality of life functioning and relationships. We will be working with you to find safe and effective alternatives to high dosage opioids. We know this will be a challenge, but we are ready to partner with you as we make this change together". T

The other question is, "What else can be done to help my pain and will it be as effective as current therapy?" Again, this is an entirely different webinar, but we know there is research to support life style changes, changes in diet and exercise, affecting not only depression but also pain and anxiety. I talk a lot with patients about shortening their medications lists. When they are on 30 different medications, we don't know what their symptoms are or the side effects or interactions from one of the medications. In this case, we talked about medications like Cymbalta, medications that can work on anxiety, depression, and chronic pain depending on the type of pain. Medication assisted treatment is the

naloxone and methadone, what the evidence tells us now is that best most effective combination of medication for treatment for patients with a combination of opiate use disorder and PTSD, is cognitive behavioral therapy, which I will talk more about and medical assistance therapy.

Patients often respond say "I tried it and it did not work. I sat on this couch, talked about my week, and it felt good while I was there but then I left and nothing changed". This is a quick text right here. When you type into our medical records that CBT this is what comes up. Here. So, for documenting Shared Decision Making for prescription opioid use disorder. Provided information about treatment options for the diagnosis including risks and benefits of lifestyle changes, therapy, and medication options.

This does not replace the Shared Decision Making process. We use these quick texts as a prompt. Primary care visits tend to be 15 minutes to 20 minutes long, are there are a range of incredibly complex issues to address. Patients often mention things as a provider is walking out the door. We needed to make this as quick and accessible as possible. What this does, it prompts providers to have this conversation with all of their patients.

Again, documenting Shared Decision Making for people with prescription opioid use disorder and post dramatic stress disorder, this again is a prompt and they can put this in their documentation and it also is prompting them to do it. Provided information that research that finds a combination of CBT and medication assisted treatment is the most effective approach to improve outcomes for people with PTSD and opioid use disorder.

Now, a patient may say "I do not want that, I do not want to do that", so we come back to the shared goals and come up with a plan for what will work but at least we are providing evidence based information. I say what to print because I think it's important for patients to go home with printed information for them to go over and go through with their families. These are often big treatment changes, often usually emotionally charged conversations. We want them to review this, have questions, and we want to make sure what we are documenting, we document not just what we said and we want but what the patient said and brought to the table and that there is a brief understandable clear treatment plan with a few key points, and those should be the goals that we agreed on and work together to achieve.

How can behavioral health provider's help on a systems level? I work a lot on policy with medical organizations, just having a behavioral health voice at the table. Either at small healthcare practices or large organizations, I think it really does help inform the work that the medical providers do with these patients. I have many references and as I said there are more accessible and they are available here if you need them. I will pass it back to Melody and thank you so much for the opportunity.

Melody Riefer: It was really interesting to me, Jesse! I'm sorry that when you were presenting you could not see the conversation that was taking

place in the participant chat, because the comments were so hand in hand with what you are speaking about. Looking for options to involve different ways of managing pain other than medication. So for instance, someone mentioned using occupational therapists and other disciplines. So that we can help people shift from the focus on medicine. I am wondering if you or Neil could comment about how you loop in other professionals.

Jesse Higgins: Well, I can comment within my own experience. I think... Because I worked with an integrated primary care team, I work often and on a daily basis with clinical providers, patients, and families. We did a substance-- sorry -- a chronic pain management pilot and I included my medical assistant in that. So we work together within the practice. On a broader level I think it is really helpful to have behavioral health voice and leadership meeting so that administration understands the importance and what behavioral health brings to the table. I don't think they necessarily know until they see how the conversation changes when that voice is there.

Melody Riefer: Thank you. Getting all of the professionals together at the same time I think is critical. The leap to improving and streamlining communications somehow seems to be one of the biggest challenges.

Niel Korsen: I will make one comment; this is Neil. I think many of us are aspiring towards, I'm not sure how many of us have achieved this yet, but aspiring towards a shared patient care center where we work as teams, which we have to do to meet the needs that people bring to us, that having a common plan that the patient, client, person we are serving, is actively participating in creating includes their preferences and goals for treatment, keeps all team members aligned in terms of providing services that are consistent with what the person wants.

Melody Riefer: Yes.

Niel Korsen: I think Shared Decision Making fits into that logical fast -- larger goal of a patient centered care program.

Melody Riefer: Yeah. Neil, while I have you here, another question from one of the participants has to do with how widespread Shared Decision Making is and I am wondering if some of your work has allowed you to get a sense for how Shared Decision Making is moving within general healthcare and if you have any insight into how it is spreading through behavioral healthcare?

Niel Korsen: I don't have a lot of insight, other than as Jesse mentioned, as part of Maine receiving the state innovation model grant, there was a limited pilot. Less than a year. Three behavioral health organizations including Jesse's worked on it, and I think at some level have sustained the principles if not all of the specific practices that they were piloting. I think Shared Decision Making; I have looked around the country to find the best performers. And I am afraid we're still at a point where there are islands of excellence of people who are fully committed to doing this. I think there is likely an increase of engaging

people more actively in making decisions, because of the attention to Shared Decision Making, in terms of standard routine day-to-day care that includes the act of using decision aids, I am not sure we are too far down that road yet but I know people are at least at the talking about it stage.

Jesse Higgins: I agree and I just want to chime in. I think it really was an Ah Ha! moment when I came in doing that pilot with a whole binder full of plans, as I am want to do and references, and Dr. Korsen said, maybe you are going to big. Maybe simplify. And when I did that, and the way to sell it really in primary care, because a lot of us are using the interventions I have talked about here, is to make it simple, easy, accessible and something that can make patient visits in primary care more efficient. So you can sell it to the providers as this will take the difficult conversation and make them go more smoothly. And it truly does. They see that and I think that's the way they get it spread more widely.

Melody Riefer: Yes, that sounds like a solid approach. Another question that we have seen is, some of the resistance around time and cost, when utilizing Shared Decision Making, it takes too much time which means it costs something, how do you manage that in your work?

Jesse Higgins: My interventions do not cost anything. They are already in the EMR is a function that is already there. Either patients who come in for 20 minute visits with these difficult conversations and they end up with 45 minutes to an hour. Providers end up documenting at home, late at night, getting calls, patients who are asking for opioids for whom those opioids were never really treating anything to begin with or were treating something they were not particularly effective for. I think we use what is already there and work within the framework we already have, don't try to develop a whole new infrastructure, and then just pilot it on a small basis. And what happened to us is we did it in a small practice and the other ones said wow what are you guys doing over there. And they started coming to our meetings and we showed them how to do it. And maybe slowly, but it is spreading.

Neil Korsen: I want to add, the research has looked at the time impact of Shared Decision Making and research studies are more controlled than the real world of taking care of real patients. But in the research that has been done, sometimes Shared Decision Making increases the amount of time that a face-to-face visit takes. Sometimes it actually decreases the amount of time because it is providing structure to a conversation that is probably going to happen anyway. This is another situation in which using the team and thinking about which members of the team can do which components of the process may be the right approach to avoiding, certainly providers cannot afford to spend lots of time. And the more prepared a patient is, the more stream like the aspect can be. But it's also true to say that making a good decision can save time down the road compared to making a bad one.

Melody Riefer: Absolutely. That is where I was going to go with it. In a lot of ways Shared Decision Making is an investment in time. I am sorry

to say that we are out of time, for this webinar. I really want to thank our presenters today for sharing your thoughtful comments, your responses, and the expertise that you have that you have graciously shared with us.

For further information about them or their work here is their contact information and I am sure that...in their bios you can find other ways to link to information about them. The other thing I want to be sure to let you know is this is actually just the first of a series of three webinars that will be discussing Shared Decision Making for the next three weeks. So, if this has whet your appetite for the subject, I hope you'll join us. You can register for these webinars at the RTP website. We are also going to be doing a learn more webinar on psychiatric advance directives in early October.

If you're interested in NAADAC continuing education hours, please click on the NAADAC continuing education hours, please click on the NAADAC link that you see here on your screen and you'll be directed to a page with an evaluation and a quiz to complete to receive your certification. If you are not interested, you still can download the certification of participation which is quite helpful when you are looking for CEU's for other disciplines. You'll also be given an opportunity to complete a feedback form regarding this webinar and the series as a whole. We really value the input that you are able to share with us. On behalf of SAMHSA I would like to thank you for taking the time out of your day to attend this webinar. We appreciate your interest and this now concludes our call. Have a great afternoon.