COUNCIL ON PATIENT SAFETY
IN WOMEN'S HEALTH CARE
safe health care for every woman

Tuesday, October 17, 2017
2:00 p.m. Eastern
Dial In: 888.863.0985
Conference ID: 49390169

Safety Action Series

Reducing Health Disparities: Shared Decision Making & Patient Empowerment

Speakers

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Disclosures

- LaToshia Rouse has no real or perceived conflicts of interest.
- Arthur Ollendorff, MD has no real or perceived conflicts of interest.

Objectives

- Define shared decision making and its role in empowering women
- Identify the historical, socio-cultural factors that have resulted in barriers of patient-physician communication
- Discuss methods and best practices for using shared decision making to empower patients and engage in care

What Is Shared Decision Making?

- A key element of patient centered care
- A series of steps to have patient and provider agree on a plan of care
- Recognizes that in many circumstances there is no one “right” decision
- Is distinct from the informed consent process

Shared Decision Making. National Learning Consortium Fact Sheet. December 2013.

When I needed it most…

How was I affected?

- Anxiety level increased during delivery and beyond
- Less confident about caring for my baby
- Strained my relationship with the provider

What could have been better?

- Discuss the pregnancy thus far with the patient
- Ask questions to clarify
- Offer options
- Educate the patient on the options
- Let patient be a part of the decision

Barriers To Shared Decision Making

Providers

- "It takes too much time"
- "I know what is best for my patient"
- "Patients seek my care for my experience and judgment"
- Implicit or Explicit Bias

Patients

- Trust in individual provider
- Past experiences with healthcare system
- Lack of empowerment to participate in care
- Fear of not being able to follow through/ afford with the plan
- Implicit or Explicit Bias

What's in a name?

Implicit Bias=

Implicit Preferences=

Implicit stereotypes

These are all talking about the same thing.

Understanding Implicit Bias

Stereotypes are the belief that most members of a group have some characteristic. Some examples of stereotypes are the belief that women are nurturing or the belief that police officers like donuts. An explicit stereotype is the kind that you deliberately think about and report. An implicit stereotype is one that is relatively inaccessible to conscious awareness and/or control. Even if you say that men and women are equally good at math, it is possible that you associate math more strongly with men without being actively aware of it. In this case we would say that you have an implicit math + men stereotype.
https://implicit.harvard.edu/implicit/faqs.html#faq1

Curious about your bias?

Take the Harvard Implicit Bias Test
https://implicit.harvard.edu/implicit/takeatest.html

What can I do about an implicit bias?

- Another tactic is to assume the perspective of an outgroup member. By asking yourself what your perspective might be if you were in the other's situation you can develop a better appreciation for what their concerns are.
- Rather than aim to be color-blind, the goal should be to "individuate" by seeking specific information about members of other racial groups. This individuation allows you to recognize people based upon their own personal attributes rather than stereotypes about their racial or ethnic group.

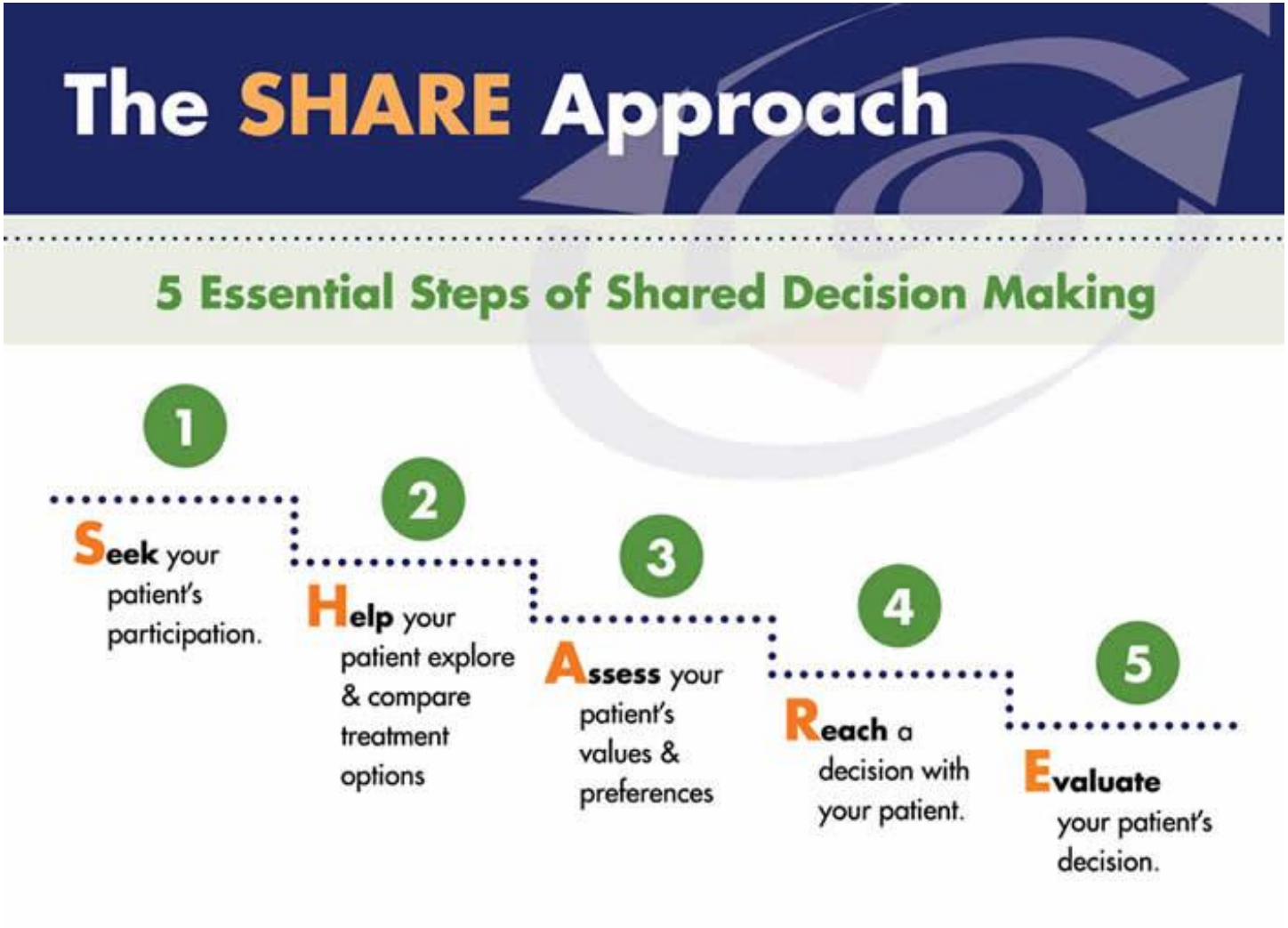
Overcoming Implicit Bias and Racial Anxiety, *By* ***Linda R. Tropp*** *and* ***Rachel D. Godsil***

https://www.psychologytoday.com/blog/sound-science-sound-policy/201501/overcoming-implicit-bias-and-racial-anxiety

SHARE Model

- AHRQ's SHARE Approach is a five-step process for shared decision making that includes
  - exploring and comparing the benefits, harms, and risks of each option
  - using meaningful dialogue about what matters most to the patient

The SHARE Approach—Putting Shared Decision Making Into Practice: A User's Guide for Clinical Teams Workshop Curriculum: Tool 8. AHRQ.gov



The SHARE Approach—Putting Shared Decision Making Into Practice: A User's Guide for Clinical Teams Workshop Curriculum: Tool 8. AHRQ.gov

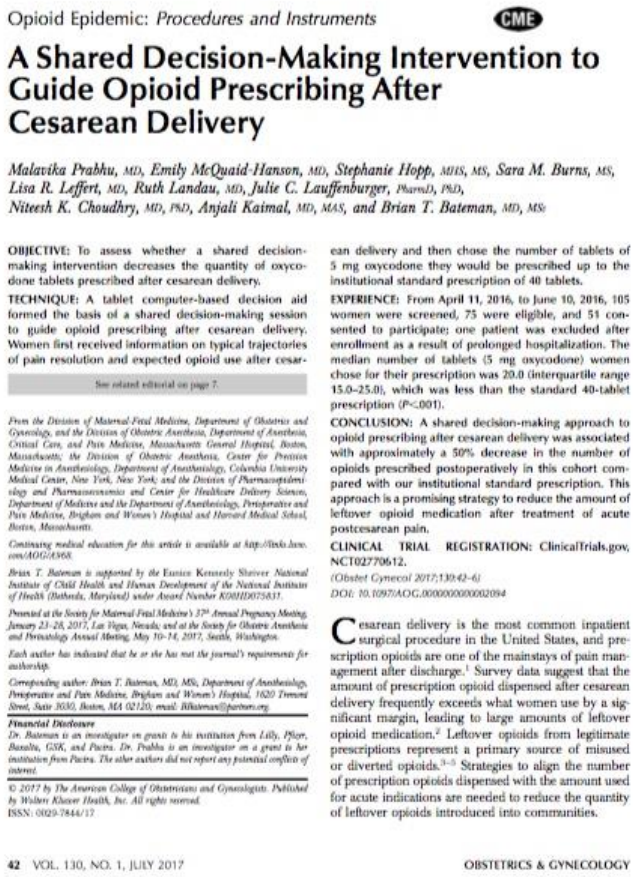
Communication is the Key

- Acknowledge the complexity of the patient's medical condition
- Speak slowly and avoid using medical jargon
- Listen actively and provide information in small segments
- Pause to allow patient participation
- Periodically check with your patient for understanding
- Use the teach-back technique to assess comprehension of key points
- Use decision aids and other resources to help comprehension
- Offer interpreter services for people with language or hearing barriers
- Invite family members and caregivers to participate when appropriate

The SHARE Approach—Putting Shared Decision Making Into Practice: A User's Guide for Clinical Teams Workshop Curriculum: Tool 8. AHRQ.gov

Shared Decision Making: Post-Cesarean Pain Management

- Patient were allowed to choose the number of narcotic pain pills after using a tablet-based shared decision making tool
- Most women chose 20 pills which was less than the 40 typically prescribed



Opioid Epidemic: *Procedures and Instruments* CME

A Shared Decision-Making Intervention to Guide Opioid Prescribing After Cesarean Delivery

Malavika Prabhu, MD, Emily McQuaid-Hanson, MD, Stephanie Hopp, MHS, MS, Sara M. Burns, MS, Lisa R. Leffert, MD, Ruth Landau, MD, Julie C. Lauffenburger, PharmD, PhD, Niteesh K. Choudhry, MD, PhD, Anjali Kaimal, MD, MAS, and Brian T. Bateman, MD, MSc

OBJECTIVE: To assess whether a shared decision-making intervention decreases the quantity of oxycodone tablets prescribed after cesarean delivery.

TECHNIQUE: A tablet computer-based decision aid formed the basis of a shared decision-making session to guide opioid prescribing after cesarean delivery. Women first received information on typical trajectories of pain resolution and expected opioid use after cesarean delivery and then chose the number of tablets of 5 mg oxycodone they would be prescribed up to the institutional standard prescription of 40 tablets.

EXPERIENCE: From April 11, 2016, to June 10, 2016, 105 women were screened, 75 were eligible, and 51 consented to participate; one patient was excluded after enrollment as a result of prolonged hospitalization. The median number of tablets (5 mg oxycodone) women chose for their prescription was 20.0 (interquartile range 15.0–25.0), which was less than the standard 40-tablet prescription ($P<.001$).

CONCLUSION: A shared decision-making approach to opioid prescribing after cesarean delivery was associated with approximately a 50% decrease in the number of opioids prescribed postoperatively in this cohort compared with our institutional standard prescription. This approach is a promising strategy to reduce the amount of leftover opioid medication after treatment of acute postcesarean pain.

CLINICAL TRIAL REGISTRATION: ClinicalTrials.gov, NCT02770612.

(Obstet Gynecol 2017;130:42–6)

DOI: 10.1097/AOG.0000000000002094

Cesarean delivery is the most common inpatient surgical procedure in the United States, and prescription opioids are one of the mainstays of pain management after discharge.[1] Survey data suggest that the amount of prescription opioid dispensed after cesarean delivery frequently exceeds what women use by a significant margin, leading to large amounts of leftover opioid medication.[2] Leftover opioids from legitimate prescriptions represent a primary source of misused or diverted opioids.[3–5] Strategies to align the number of prescription opioids dispensed with the amount used for acute indications are needed to reduce the quantity of leftover opioids introduced into communities.

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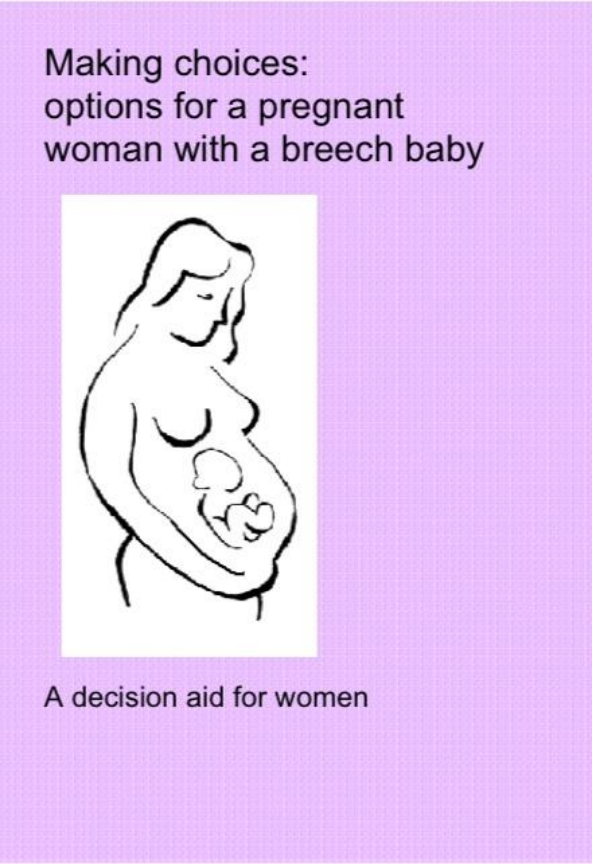
Prabhu *et al*. Obstet Gynecol 2017;130:42–6

Shared Decision Making Tool: Options for Management of Breech Fetus

- A short pamphlet with optional audio content to help women decide between external cephalic version and Cesarean Section



Making choices: options for a pregnant woman with a breech baby. University of Sydney. www.psych.usyd.edu.au/cemped/com_decision_aids.shtml

Putting Shared Decision Making Into Practice

1. Get leadership buy-in
2. Develop an implementation team
3. Select an approach that is tailored to your practice
4. Provide training and ongoing support to all staff
5. Start small, then take it to scale
6. Create a physical setting for shared decision making
7. Create a library of evidence-based educational resources and decision aids
8. Streamline shared decision making work processes into day-to-day operations
9. Evaluate the ongoing implementation of shared decision making

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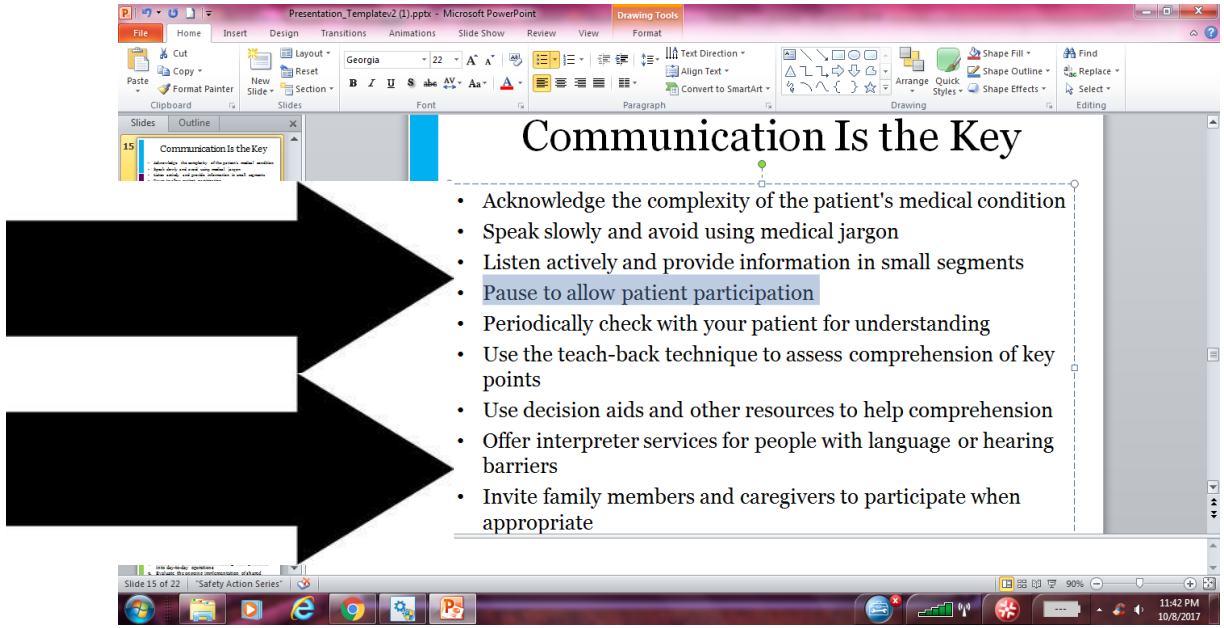
Another thought on biases…

"Developing a little humility about how much we know can be a good step toward real impartiality."

https://www.psychologytoday.com/blog/sound-science-sound-policy/201501/overcoming-implicit-bias-and-racial-anxiety



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References and Resources

- https://www.ahrq.gov/professionals/education/curriculum-tools/shareddecisionmaking/tools/tool-8/index.html
- Prabhu *et al*. A Shared Decision-Making Intervention to Guide Opioid Prescribing After Cesarean Delivery Obstet Gynecol 2017;130:42–6.
- Shared Decision Making. National Learning Consortium Fact Sheet. December 2013.
- Making choices: options for a pregnant woman with a breech baby. University of Sydney. www.psych.usyd.edu.au/cemped/com_decision_aids.shtml
- Tropp L and Godsil R. Overcoming Implicit Bias and Racial Anxiety.
- https://www.psychologytoday.com/blog/sound-science-sound-policy/201501/overcoming-implicit-bias-and-racial-anxiety
- https://implicit.harvard.edu/implicit/takeatest.html

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Q&A Session

Press *1 to ask a question

You will enter the question queue

Your line will be unmuted by the operator for your turn

A recording of this presentation will be made available on our website:
www.safehealthcareforeverywoman.org

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Next Safety Action Series

Patient, Family, and Staff Support After Obstetric Hemorrhage

October 31, 2017
1:30 p.m. Eastern

Charlene Collier, MD, MPH, MHS
Obstetrician-Gynecologist,
University of Mississippi Medical Center
Director, Mississippi Perinatal Quality Collaborative

Scott E. Hall, PhD, LPCC-s
Professor
Department of Counselor Education & Human Services
University of Dayton, Ohio

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