Shared Decision Making
With the Patient with Diabetes

Shared Decision-Making Algorithm

KEY ELEMENTS OF SHARED DECISION MAKING

ASK
- Patient centered approach
- Motivational interviewing

PRIORITIZE
- Help patient focus on their needs

ASSESS
- Assess the capacity of the decision-making process
- Address Patient and Provider barriers

ADVISE
- What is the evidence?
- Risk communication

AGREE
- Agree on what’s important for the individual
- Share values, power, expectations

EVAluAte
- Revisit the decision if there are concerns
- Evaluate the process

MAKE DECISION
- If ready, make the choice

EValuate
- Exit SDM process

In context, urgent or emergent?
Exit SDM process

Is patient ready to make decision (capacity)?
Re-address at next visit

Ask - listen
Private problems, shared

Assess patient readiness to make decision

Assess patient readiness to make decision (capacity)

Analyze Decision-Making
- Cognitive limitations
- Emotional interference
- Communication disruption
- Knowledge gaps
- Beliefs and values
- Decision-making style

Present options

Prioritize the People’s Needs and Expectations

MAKe DECiSIO.N
- Weigh benefit & risk
- Make choice (decision)

FACiLiTATE PROCiSS
- Other Patient-Decision Aid (PDAs) Tools:
  - Paper & Pencil (cards, worksheet)
  - Web-based tools
  - Discussion with others

PReviouS DECiSIO.NS
- Context and expertise
- Information Deficits
- Lack of resources
- Limited time

Make choice (decision)
Make choice (decision)
Evaluate the process: importance & implications

PREviouS PROCiSS
- Expectations
- Experience
- Satisfaction

PRiORiTIZE
- Assess the capacity of the decision making process
- Address Patient and Provider barriers

ASSiST
- Provide tools to help weigh the options
- Promote input from others

Assess readiness

Assess the capacity of the decision-making process

Assess patient readiness to make decision

Assess patient readiness to make decision (capacity)

Agree on criteria for making decisions

Acknowledge The Criteria Upon Which The Decision Will Be Made

INFORMATIoN TRAINE.Z:
- What Are The Benefits?
- What Are My Risks?

ASK
- Ask: What Are My Risks?
- Benefits?

Prioritize
- Make the choice

Provide tools to help weigh the options

Facilitate the Process
- Other Patient-Decision Aid (PDAs) Tools:
  - Paper & Pencil (cards, worksheet)
  - Web-based tools
  - Discussion with others

ACKNOWleDGe
- Evidence
- Values
- Situations
- Unforeseen

ASSeSS
- Assess the capacity of the decision-making process
- Address Patient and Provider barriers

ASSiST
- Provide tools to help weigh the options
- Promote input from others

AGREE
- Agree on what’s important for the individual
- Share values, power, expectations

ASK
- Ask: What Are My Risks?
- Benefits?

Priority problems, shared

ASSESS
- Assess the capacity of the decision-making process
- Address Patient and Provider barriers

ADVISE
- What is the evidence?
- Risk communication

AGREE
- Agree on what’s important for the individual
- Share values, power, expectations

1. Evaluate
2. Assess
3. Ask
4. Advise
5. Acknowledge
6. Assess
7. Ask
8. Evaluate
9. Ask
10. Advance
11. Ask
12. Assess
13. Ask
14. Ask

Shared Decision-Making requires active communication. The process of Active Communication requires reiterating information between study and research. Identify and address barriers to communication. Be prepared for the Shared Decision-Making process in another visit, if needed.

ADvISE
- Information Transfer:
  - What Are The Benefits?
  - What Are My Risks?

- Am I Sure This Is What I Want to Do?
  - Pros (What’s Best)
  - Cons (What’s Worst)
  - Team members
  - Family members
  - Community resources

POSSiBiLiTy
- Pros — Cons
- Risks — Benefits
- Likes — Dislikes
- Achievable — Challenging
- Short-term — Long-term

Real-time education, homework,
- Interpretative services
- Use plain Language
- Assistive devices
- Identify strong emotions
- Involves autopsies
- Establish roles & preferences
- Euthanize care
- Identifies and treats depression
- Identification and treatment of depression
- Complimentary care
- Referral for treatment
- Real-time education, homework, referral

OVERCOMING BARRIERS

PROVIDER-CENTERED OBSTACLES

Barrier
- Communication breakdown
- Inadequate knowledge
- Limited resources
- Limited time

Solution
- Cultivate relationships with patient
- Ensure provider comfort
- Provide training in SDM
- Establish roles & preferences
- Euthanize care
- Referral for treatment
- Real-time education, homework, referral

PATIENT-CENTERED OBSTACLES

Barrier
- Language
- Health literacy & numeracy
- Perceptual (sight, hearing)
- Emotional interference
- Cognitive limitations
- Decision-making style
- Beliefs and values
- Depression
- Knowledge gaps
- Transmission (noise or physical distractions)

Solution
- Use plain language
- Assistive devices
- Identify strong emotions
- Involves autopsies
- Establish roles & preferences
- Euthanize care
- Identifies and treats depression
- Identification and treatment of depression
- Complimentary care
- Referral for treatment
- Real-time education, homework, referral
**GLYCemic TARGET** Determination of A1c Target

- **Individualize the patients glycaemic targets based on the providers determination of the benefit-risk ratio and discussion with the patient.**
- **Set a target range instead of an exact numerical goal to avoid inappropriate intensification of therapy as A1c reaches goal.**

**Glycated Hemoglobin (HbA1c)**

- **<6%** as a target goal for patients with Type 1 diabetes, Type 2 diabetes, and gestational diabetes.
- **<7%** as a target goal for patients with Type 2 diabetes, and for those with Type 1 diabetes who require intensified glycemic control to prevent complications.
- **<8%** as a target goal for patients with Type 2 diabetes, and for those with Type 1 diabetes who require intensified glycemic control to prevent complications.

**Dichotomous Risk**

- **High-risk** guidelines suggest a target A1c of <7% for patients with Type 2 diabetes, if they are willing to consider the severe side effects associated with intensive glycemic control.
- **Low-risk** guidelines suggest a target A1c of 7-8% for patients with Type 2 diabetes, if they are willing to consider the severe side effects associated with intensive glycemic control.

**Points for Consideration**

- **Personal preferences:** It is important to consider the patient’s personal preferences and values when setting the initial target range.
- **Co-morbidities:** Consider the presence of co-morbidities such as heart disease, stroke, or kidney disease when setting the target.
- **Patient’s ability to adhere to treatment:** Consider the patient’s ability to adhere to the treatment regimen when setting the target.

**Pre-treatment A1c Levels**

- **Baseline A1c levels** can be used to help determine the appropriate target A1c level.
- **Pre-treatment A1c levels** can be used to help determine the appropriate target A1c level.

**Blood Pressure**

- **Baseline blood pressure levels** can be used to help determine the appropriate target blood pressure level.
- **Pre-treatment blood pressure levels** can be used to help determine the appropriate target blood pressure level.

**Statin Use**

- **Statin use** can be considered for patients with elevated cholesterol levels.
- **Statin use** can be considered for patients with elevated cholesterol levels.

**Side Effects of Therapy**

- **Common side effects** include nausea, vomiting, and diarrhea.
- **Less common side effects** include muscle weakness and myalgia.

**Conclusion**

- **Individualize the patients glycemic targets based on the providers determination of the benefit-risk ratio and discussion with the patient.**
- **Set a target range instead of an exact numerical goal to avoid inappropriate intensification of therapy as A1c reaches goal.**

**BLOOD PRESSURE**

- **Controlled blood pressure:** Reduces the risk of stroke.
- **Uncontrolled blood pressure:** Increases the risk of stroke.

**STATIN**

- **Statin use** can be considered for patients with elevated cholesterol levels.
- **Statin use** can be considered for patients with elevated cholesterol levels.

**Conclusion**

- **Individualize the patients glycemic targets based on the providers determination of the benefit-risk ratio and discussion with the patient.**
- **Set a target range instead of an exact numerical goal to avoid inappropriate intensification of therapy as A1c reaches goal.**

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**Footnotes**

1. **UKPDS** suggests that he would gain long term reduction in important outcomes of diabetes, who is free of major concurrent illnesses, and who has a life expectancy of less than 5 years, especially if patient safety is a concern. [C]
2. **Patients who have Type 2 diabetes are considering whether or not to take statins to lower their cholesterol.**
3. **All 100 people will have their cholesterol tested, and 91 people will not have a stroke whether or not they controlled their blood pressure.**
4. **Patients who have Type 2 diabetes are considering whether or not to take statins to lower their cholesterol.**
5. **About 36 people will still have a CV event even though they take a statin (the green faces below).**
6. **About 50 people will not have a CV event, but would not have even they had not taken a statin (the green faces below).**
7. **About 14 people will be ‘saved’ from having a CV event by taking a statin (the yellow faces below).**

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**References**

2. **Streeter SM, Warram JH, Laffel LM, et al. (2006) The glycemic control- related mortality benefit from the UKPDS was evident over a longer duration diabetes (more than 10 years) or with comorbid conditions, and when safety was used in combination with other drug regimens.**
3. **Streeter SM, Warram JH, Laffel LM, et al. (2006) The glycemic control- related mortality benefit from the UKPDS was evident over a longer duration diabetes (more than 10 years) or with comorbid conditions, and when safety was used in combination with other drug regimens.**

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