Shared Decision Making With the Patient with Diabetes

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

ADVICE
- What is the evidence?
- Risk communication

ACKNOWLEDGE
- Agree on what's important for the individual
- Share values, power, expectations

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

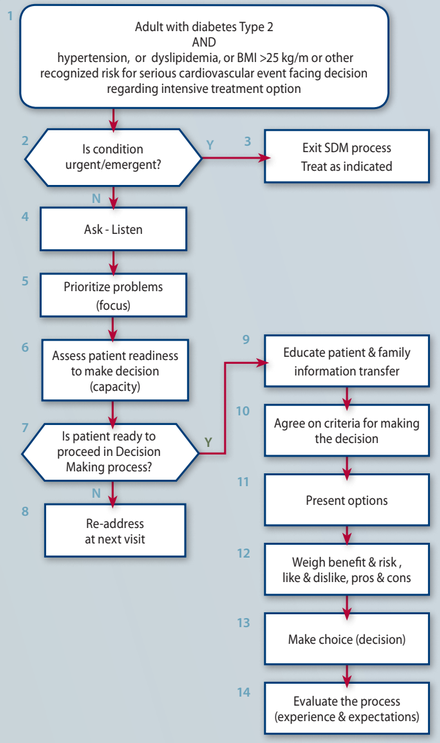
MAKE DECISION
- If ready, make the choice

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

http://www.healthquality.va.gov
https://www.qmo.amedd.army.mil

VA/DoD Evidence-Based Practice

Shared Decision-Making Algorithm



STEP 1 — ASK

...And Listen
Use Motivational Interviewing to identify issues

STEP 2 — PRIORITIZE

Explore the Patient's Needs and Expectations

STEP 3 — ASSESS

Identify Barriers to Shared Decision-Making

Provider-Centered Barriers

- Comfort and expertise
- Information Deficits
- Lack of resources
- Limited time

Patient-Centered Barriers

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

Shared Decision Making requires effective communication. The process at its best minimizes misunderstanding between sender and receiver. Identify and address the barriers to communication. Be prepared to defer the Shared Decision Making Process to another visit, if needed.

STEP 4 — ADVISE

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

Give it Some Time

Allow Time to Discuss & Consult with:

- Peers (Group Visits)
- Team members
- Family members
- Community resources

STEP 5 — ACKNOWLEDGE

Acknowledge The Criteria Upon Which The Decision Will Be Made

Decision-Making Criteria

- Evidence
- Values
- Situation
- Unknowns

STEP 6 — ASSIST

Present the Options: What Are My Choices?

Weigh the Alternatives

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

Facilitate the Process

Offer Patient-Decision-Aid (PDAs) Tools:

- Paper & Pencil (cards, worksheet)
- Web-based tools
- Discussion with others

STEP 7 — MAKE THE DECISION

STEP 8 — EVALUATE

Follow-up: Revisit The Process If Concerns Arise

Evaluate the Process with the Patient

- Expectations
- Experience
- Satisfaction

Overcoming Barriers

Provider Centered Obstacles

Barrier	Solution
• Insufficient comfort or experience • Unfamiliar with case • Limited access to resources • Time constraints • Benefits and values • Unable to establish rapport	• Consider consultation or referral • Review the record, schedule another visit • Communicate limitations • Refocus on achievable • Transfer care • Allow time, include other team members

Patient Centered Obstacles

Barrier	Solution
• 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)	• Interpretive services • Use plain language • Assistive devices • Identify strong emotions • Involve surrogates • Establish roles & preferences • Ensure cultural competency • Identify and treat depression • Attention to environment • Real-time education, homework, referral

GLYCEMIC TARGET | Determination of A1c Target

The 7-8-9 Approach to Setting A1c target Using VA/DoD Diabetes Guidelines

- Individualize the patients glycemic target based on the providers determination of the risk-benefit 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.

Stratified Risk

Major Comorbidity or Physiologic Age	Microvascular Complications		
	Absent or Mild	Moderate	Advanced
Cardiovascular disease, severe chronic kidney disease, severe chronic obstructive lung disease, severe chronic liver disease, recent stroke, life-threatening malignancy, and advanced age	Early background retinopathy, and/or micro-albuminuria, and/ or mild neuropathy	Pre-proliferative retinopathy or persistent, macroalbu-minuria and/or sensory loss	Severe non-proliferative, or proliferative retinopathy and/ or serum creat > 2.0 mg/dL), and/or insensate extremities or autonomic neuropathy
Absent	<7%	<8%	8-9%*
Present — not end-stage and management achievable	<8%	<8%	8-9%*
Marked — either end-stage or management is signifi-cantly challenging	8-9%*	8-9%*	8-9%*

* Further reductions may be appropriate, balancing safety and tolerability of therapy.

- Recognize the limitations of the A1c measurement methodology reconciling the differences between A1c readings and self-monitoring results on a case-by-case basis
- Target goals can be modified over time; benefits accrue over many years, preferences and health can change

PATIENT'S SAFETY | Adjust Target Considering Side-Effects

Consider the following when setting the initial target range:

- **A1c<7%:** For the patient with very mild microvascular complications of diabetes, who is free of major concurrent illnesses, and who has a life expectancy of at least 10-15 years, consider an A1c target of < 7 percent, if it can be achieved safely. [A]
- **A1c<8%:** A target range of 7-8% may be appropriate for some patients with longer duration diabetes (more than 10 years) or with comorbid conditions, and who require a combination medication regimen including insulin. [A]
- **A1c<9%:** A target range of 8-9% may be appropriate for some patients with major advanced complications or major medical comorbid conditions with a life expectancy of less than 5 years, especially if patient safety is a concern. [C]

Case 1

A frail elderly woman aged 79 years for whom, all other things being equal, an A1c target range of 8-9% would be appropriate has symptomatic hyperglycemia with polydipsia and polyuria at an A1c of 8.8%. She prefers a level that would eliminate these symptoms. After discussion, patient and provider agree to aim at a lower target (8-8.5%) to eliminate symptoms, but also minimize the risk for hypoglycemia.

Case 2

A 68-year-old man, otherwise very healthy, has an A1c of 7.2%. He is on two oral hypoglycemic agents at maximal doses. Although the guideline suggests a target of A1c<7%, he does not want the inconvenience (and risk) of adding another oral medication or switching to injectable insulin. The patient and provider agree to focus on lifestyle modification, not adding any more medication and accept a higher range for A1c.

Case 3

A 25 -year old woman with Type 1 DM x 10 years with background retinopathy. She is on insulin 3 x per day, tests her blood glucose 2-3 times per day and has occasional mild hypoglycemic reactions. Her last A1c 5 months ago was 7.5%. She and her husband are talking about starting a family in the next year or so. Tight glycemic control at conception minimizes risk of congenital anomalies in the baby. Tight glycemic control during pregnancy minimizes complications. A1c< 7% is recommended.

Case 4

A 45-year-old healthy man on oral agents with an A1c of 8.4 % is below the current performance measure of "<9" but tighter control offered and discussed since UKPDS suggests that he would gain long term reduction in important outcomes with a goal closer to 7%.

BLOOD PRESSURE | Patient Decision Aid: Type 2 Diabetes — BP Control

Patients who have Type 2 diabetes are considering whether or not to control their blood pressure (BP).

In the BP-lowering arm of UKPDS 'tight control' of BP achieved a reduction in risk of stroke, diabetes related deaths and microvascular events.

A link to the UKPDS 38 Study can be found at:

http://www.bmj.com/content/317/7160/703.full

VA/DoD guidelines for Type 2 diabetes set a target to aim for in people with Type 2 diabetes of less than 140/80mmHg. If proteinuria > 1g/day is present, then target BP is < 125/75 mmHg.

Imagine 100 people like those in this part of UKPDS 38 study. Without control of their BP, about 9 of them will have a stroke over the next 8 years. So, 91 of them (100 – 9 = 91) would not have a stroke.

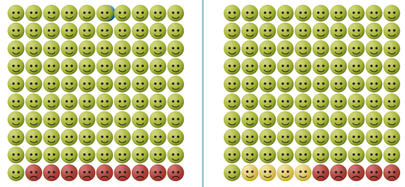
However, if those same 100 people each control their blood pressure over the 8 years:

- About 4 people will be 'saved' from having a stroke (the yellow faces)
- About 91 people will not have a stroke whether or not they controlled their blood pressure (the green faces)
- About 5 people will still have a stroke even though they control their blood pressure (the red faces)

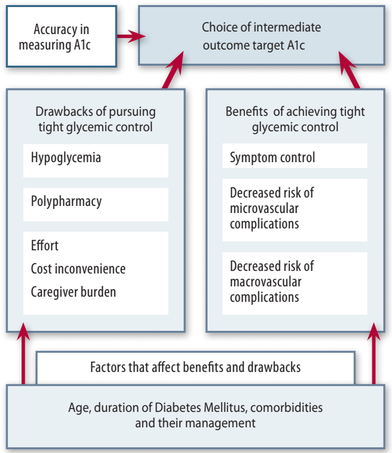
All 100 people will have to treat their high blood pressure for 8 years, and some of them will get side effects from BP lowering medications.

Controlling blood pressure lowers the risk for stroke.

After 8 years no BP control | After 8 years tight control of BP



REMEMBER: ***It is impossible to know for sure what will happen to each individual person***



* modified from *Drugs and Aging 2011*

UKPDS 34 - 10-Year Follow-Up

3277 Patients (1525 Completed Followed For Up To 30%)
All Data Expressed Per 1000 Patient Years

	Any Diabetes Related End-point	Deaths Related to Diabetes	All Cause Mortality	MI	Stroke
Conventional / Baseline	~52-54	~17-19	~30-33	~20-21	~7
Metformin	8 ↓	5 ↓	7 ↓	6 ↓	NS
Sulfonylurea /Insulin	4 ↓	3 ↓	3 ↓	3 ↓	NS

↓ = Absolute Risk Reduction of Events per 1,000 patient years NEJM 2008; 359-OCT9

STATIN | Patient Decision Aid: Type 2 Diabetes — Dyslipidemia

Patients who have Type 2 diabetes are considering whether or not to take statin to lower their LDL.

Results from 14 large trials of statins in patients with diabetes (>18,500) with and without established CV disease found that statin treatment reduced the relative risk of CV events (heart attacks, strokes and any coronary revascularization *e.g.* CABG or coronary angioplasty) by around 20% [actual results, 21%, 95% CI 19%-23%].

The actual (absolute) benefit depends on a person's baseline risk of having a CV event.

The link to the study can be found at:
http://www.thelancet.com/journals/lancet/issue/vol366no9493/PIIS0140-6736(05)X6159-1

The risk (myopathy and abnormal liver enzymes) increases with higher statin doses in patients with certain risk factors such as older age, female gender, or renal impairment, and when statins are used in combination with certain drugs such as fibrates.

People at higher risk of CV events (50% over 10 years)

Imagine 100 people like those in this part of UKPDS 38 Study. Without taking a statin, about 50 of them will have a CV event over the next 10 years. So, 50 of them will not have a CV event.

However, if those same 100 people each take a statin for 10 years:

- About 14 people will be 'saved' from having a CV event by taking a statin (the yellow faces below)
- About 50 people will not have a CV event, but would not have even they had not taken a statin (the green faces below)
- About 36 people will still have a CV event even though they take a statin (the red faces below)
- All 100 people will have to take the statin for 10 years.

NO STATIN | STATIN

= Good Outcome *= Better with Treatment* *= Bad Outcome*

REMEMBER: ***It is impossible to know for sure what will happen to each individual person***