Shared decision-making, the collaboration between patients and providers to ensure optimum outcomes, is becoming more prevalent in today's health care environment. Research shows that acknowledging a patient's preferences improves patient outcomes, lowers costs, and improves a patient's experience. A new Collaborative Conversation model developed by the Institute for Clinical Systems Improvement (ICSI) and piloted in a variety of settings is making integration of shared decision-making into everyday care easier and more effective for both providers and patients.

Shared decision-making has been defined as "a process in which patients and providers collaborate to ensure that the patient is well-informed, clarify all acceptable options and choose a course of care consistent with patient values and preferences and the best available medical evidence." (Minnesota Shared Decision-Making Collaborative).

ICSI recently used a grant from the Robert Wood Johnson Foundation to study the concept of shared decision-making in palliative care. The sensitive nature of addressing patients with life-limiting conditions makes shared decision-making especially important. ICSI wanted to know whether using this concept could help medical professionals achieve the Triple Aim of improving the health of the population, the patient experience, and the affordability of care. The goals for the study were to:

1. Increase patient-centered care by listening to and honoring the preferences and values of patients and families
2. Increase the sharing of evidence-based medicine with patients and families, and engage them by using shared decision-making in care decisions
3. Collaborate with patients and families to create tools and methods to achieve these aims

Collaborative Conversation Map
Work on the ICSI study led to the creation of a Collaborative Conversation Map (see figure) to guide shared decision-making discussions. By using the map, health care teams have reported a more cohesive environment based on an increased understanding of the roles and responsibilities of team members. Many groups have built the process into electronic health record systems, care management meeting settings, and reporting structures. The Collaborative Conversation Map also helps patients become comfortable with the shared decision-making process, making them better able to share critical information with family and clinicians.

One of the greatest benefits of using a Collaborative Conversation Map is understanding how to partner with patients in health care discussions. The model makes it easy for care teams to watch for changes in a patient's priorities or life goals, diagnosis or prognosis, health status or symptoms, support system, medical evidence or best practice, or clinician and caregiver contacts. In addition, patient and family needs might include requests for information or support, advanced care planning, consideration of values, trust, care coordination, and a responsive care system. Sometimes it is as simple as giving patients permission to participate in discussions about their care.

The Collaborative Conversation Map was piloted in several different medical settings. In all cases, care was improved by enabling providers and clin-
Marshfield Clinic
Clinicians at the Marshfield Clinic in western Wisconsin used shared decision-making to address palliative medicine and medical oncology, two disciplines that had not always worked well together, according to Sherry Wiedow, RN. A multidisciplinary team set four aggressive goals:

- Integrate palliative medicine and medical oncology practices
- Create cohesiveness between palliative medicine and medical oncology, improving interactions and decreasing variability in how well these two departments worked together
- Increase physician and staff knowledge of shared decision-making
- Improve patient and family understanding of how and why palliative medicine fits into the cancer care continuum

Physicians and staff completed a Collaborative Conversation Map, which served as a script as they reviewed patient progress. To help prioritize a patient’s two most bothersome issues, the team initiated a PEACE-Tool that enabled patients and the team to rate and find options for dealing with:

- **P** = physical symptoms
- **E** = emotive and cognitive symptoms
- **A** = autonomy and agency issues (e.g., How do I maintain self-control? How can I arrange for transportation?)
- **C** = communications, closure, and contribution (e.g., How do I talk about dying?)
- **E** = economic issues (e.g., How can I afford this care?)
- **T** = transcendent items (e.g., What will happen to my spirit when I die?)

Surprisingly, issues that clinical staff identified as high priority were not necessarily the issues of most concern to patients. Pain might rate lower on a patient’s anxiety scale than his or her concern about transportation, for example.

Using shared decision-making and the Collaborative Conversation Map enabled the team to build bridges between medical oncology and palliative medicine. Increased patient satisfaction was considered a successful outcome of the shared decision-making and collaborative process. The clinic plans to expand its model to additional providers and collaborate with its survivorship program on the patient symptom and distress assessment tool.

North Memorial Hospital
North Memorial Hospital in Minneapolis introduced shared decision-making into a pilot program for end-of-life care under the leadership of John Degelau, MD. The goal was to make the patient’s life more predictable and sustainable.

In a combined effort between clinicians and key patient advocates, including home care liaisons, social workers, case managers, and chaplains, the team created a Collaborative Conversation Map and clinical workflow process. This alone produced a better balance of influence between care team and patient when it came to decisions regarding patient care.

Following a review of medical facts and decisions to be made, patients were asked to share their most important concern, which then guided future discussions about options. Once options had been addressed and decisions had been made, physicians were careful to check the patient’s understanding and answer questions. Any decisional conflicts were resolved with a form of negotiation. If necessary, issues were revisited. This sometimes happened when a condition-specific decision aid was offered or when the patient’s situation escalated.

Minnesota Oncology
According to Michele O’Brien, RN, of Minnesota Oncology, patients diagnosed with cancer often have trouble absorbing information. Putting them in control of the conversation increases their satisfaction with care. In early 2012, Minnesota Oncology studied 75 patients using a Functional Assessment of Chronic Illness Therapy (FACIT) measurement system. Top patient concerns were:

- Physical/functional – 60 percent
- Fatigue – 52 percent
- Emotional – 41 percent
- Food/nutritional – 37 percent
- Body image – 31 percent
- Mind/body/spirit – 24 percent
- Health care directive – 21 percent

A pilot program was created to introduce survivorship and palliative care concepts early in a patient’s treatment. It wove shared decision-making and the Collaborative Conversation Map into several steps along the continuum of care, especially at diagnosis, change in status, and end of treatment. Each time, patient satisfaction was measured.

Proactive, evidence-based care provided by a physician-nurse team has demonstrated improved results. In one trial involving 904 older patients with chronic conditions, patients who experienced such guided care had:

- 24 percent fewer hospitalizations
- 37 percent fewer skilled nursing facility stays
- 15 percent fewer Emergency Department visits
- 29 percent fewer home care episodes

In addition to increasing patient satisfaction, the pilot program provided real cost benefits. The annual net savings was $75,000 per nurse or $1,364 per patient.

Team members at Minnesota Oncology said they were pleased with the use of the Collaborative Conversation Map. They felt this tool helped their patients relate better to their physicians and improved a team’s ability to address physical, functional, emotional, and social needs.

Conclusions and next steps
ICSI’s exploration of how best to enhance patient-centered care by engaging patients in shared decision-making revealed some pivotal insights, first and foremost that even the process of initiating conversations about health care decisions requires kick-starting. The Collaborative Conversation model developed for this project accomplishes exactly that.

The locations that fully embraced this model represent a broad range of care delivery models, and each location determined how best to integrate the model into its usual care. Increases in patient centeredness, care team cohesiveness, and patient and provider satisfaction were universal.

One unexpected benefit of this project occurred precisely because of patient involvement. A version of the Collaborative Conversation Map presented to the ICSI Patient Advisory Council elicited edits that transformed it from a provider-facing tool into one that is equally valid for patients. The use of the Collaborative Conversation Map by both patients and providers is a concrete manifestation of the “mirrored approach” inherent in the philosophical partnering of the patient and the provider.

Despite its origins in palliative care, the Collaborative Conversation Map has been adopted by practices throughout the care continuum, from preventive care to end-of-life discussions. The model is flexible enough to work equally well in all of these settings, and therefore lends itself to becoming a normal component of usual care.

Integrating the Collaborative Conversation Map into usual care has helped to improve patient centeredness, enhance the flow of information between patients and providers, and honor patients’ values and preferences in making choices among evidence-based options. Our work will continue.

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