Shared Decision Making for Chronic Conditions and Long-Term Care Planning

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Webinar 6
Shared Decision Making for
Chronic Conditions and Long-Term Care Planning

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Presenters and moderator

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  - Agency for Healthcare Research and Quality
- Cathleen E. Morrow, M.D.
  - Dartmouth, Geisel School of Medicine
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- Questions will be read aloud by the moderator.
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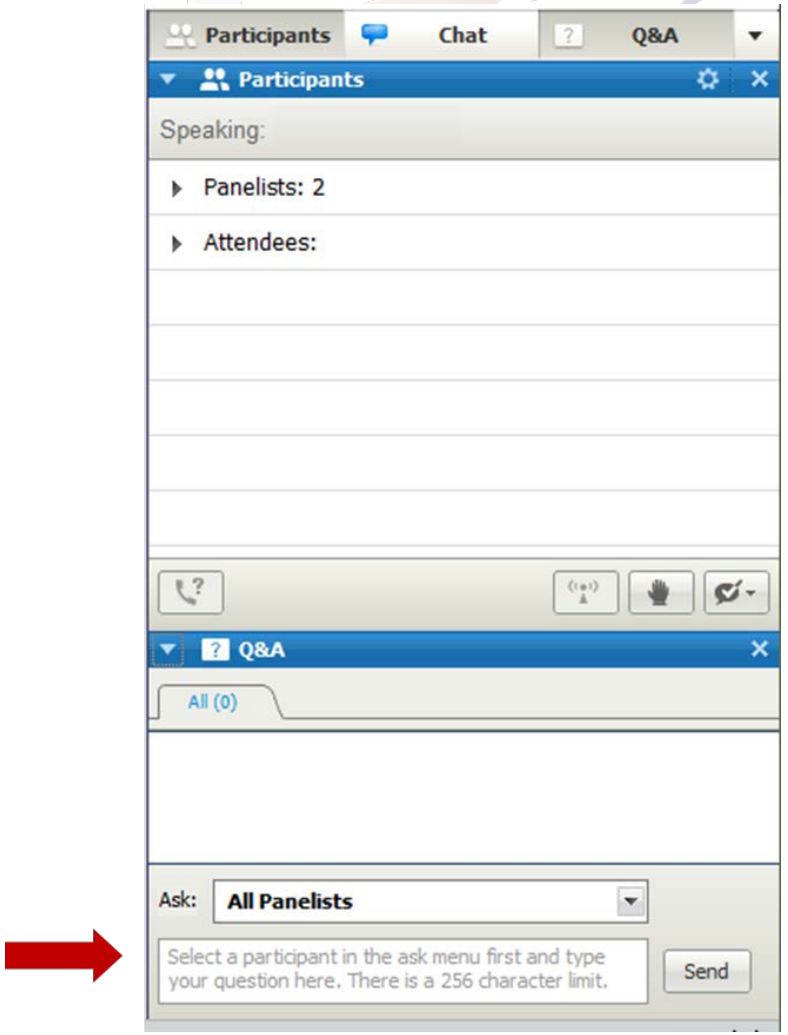

Learning Objectives

- At the conclusion of this activity, participants will be able to:
  1. Describe the rationale and research behind shared decision making and its potential for improved outcomes in chronic disease.
  2. Explain the differences and complementary qualities of motivational interviewing and skills of shared decision making.
  3. Outline the clinical applications of shared decision-making principles to chronic disease.
  4. Distinguish between how shared decision making is used in medical treatment choices and for other preference-sensitive choices frequently faced by aging veterans (e.g., choice of long-term services and supports).
  5. Explain the short- and long-term outcomes of successful shared decision making for aging veterans.

Shared Decision Making (SDM) and Chronic Disease

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Agency for Healthcare Research and Quality

Definitions of SDM

- A communication skill, focused on patient's values and preferences as they apply to facilitate high-quality patient care in the context of medical decision making.
- An attitude and philosophy; an approach to thinking about effective patient care.
- Acknowledges the collaborative nature of good medical care and the dual expertise involved in all decision making–that of patient and doctor.

SDM

- **Interpersonal** and **interdependent** process.
- Recognizes that a decision is required and that providing information is helpful but not sufficient.
- Highlights best available evidence about risks and benefits of each option married to the patients values and preferences.
- Dynamic interplay between the provider's guidance and the patient's values and preferences.

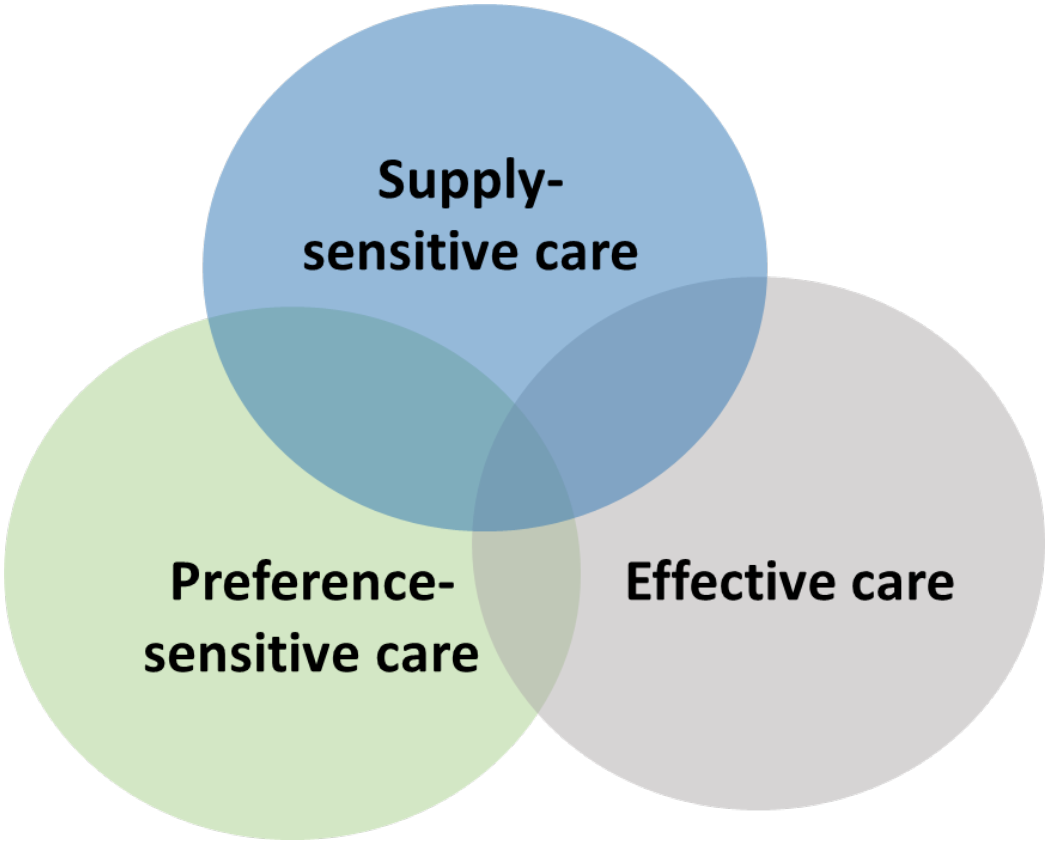
SDM – The Conversation

- Is an instrument of care, appropriate to the uncertainties of illness and treatment.
- In chronic disease care, is especially important: changes over time; individual patient response varies; patient values and preferences are critical to management and must be frequently re-visited.
- Especially called for when best option is not clear: these are common in chronic disease!

Categories of Care

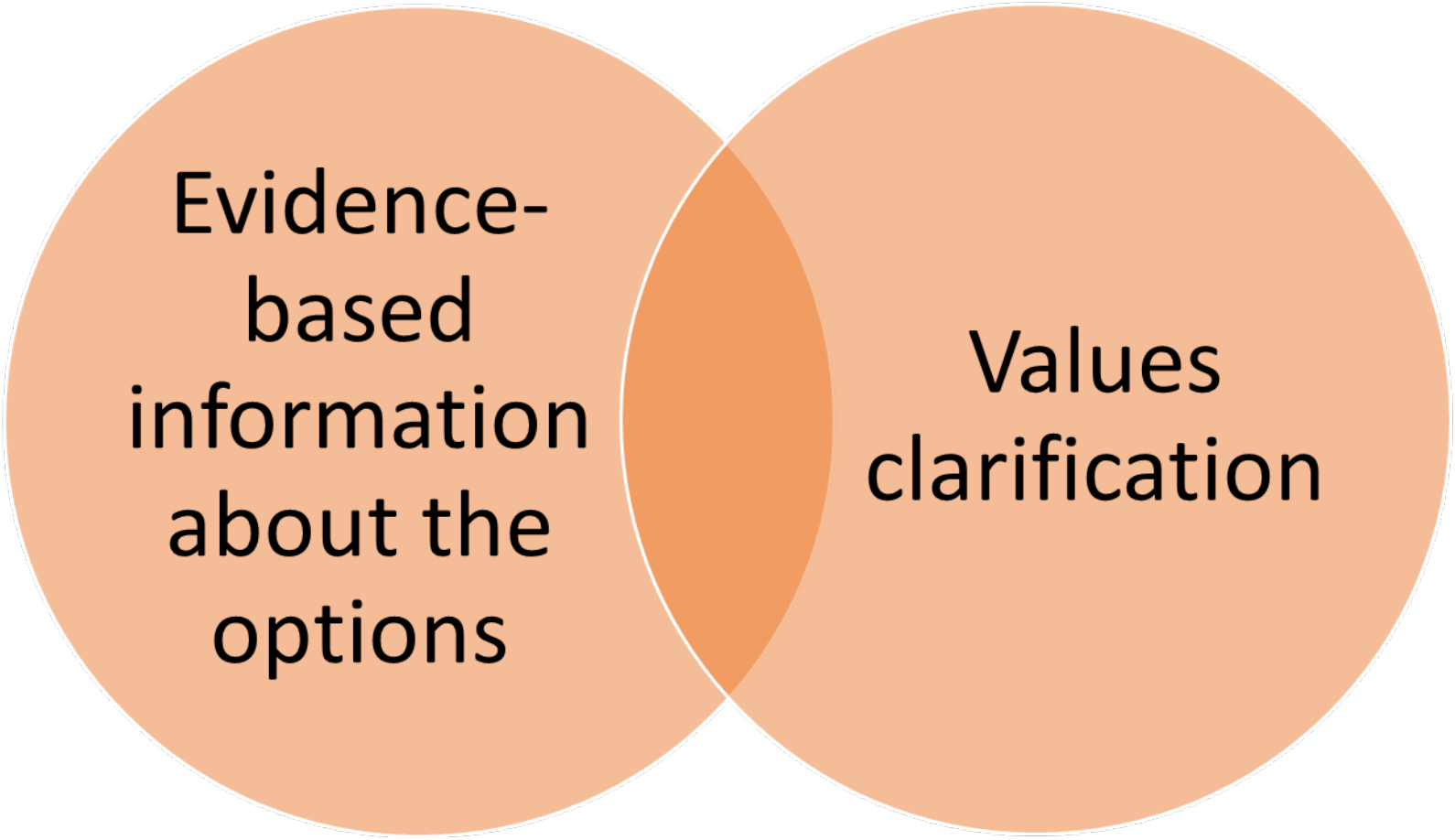
- Effective care – evidence-based
- Preference-sensitive care
- Supply-sensitive care
- **"Geographic variation"** work in the 1970s by Wennberg observed that physician preference dominated the type of care and choices offered to patients.
- In the 1990's Wennberg identified that SDM was central to countering geographic variation and tendency for care to be physician preferenced.

Which Category of Care?



- Antibiotics for strep throat
- Cardiac catheterization for chest pain
- Immunization for Hep B
- Breastfeeding
- Hip replacement surgery

Decision Aids



http://decisionaid.ohri.ca/decguide.html

Cochrane Reviews of Decision Aids

Improve	• knowledge
Improve	• realistic expectations
Lower	• decisional conflict
Improve	• patient – practitioner communication

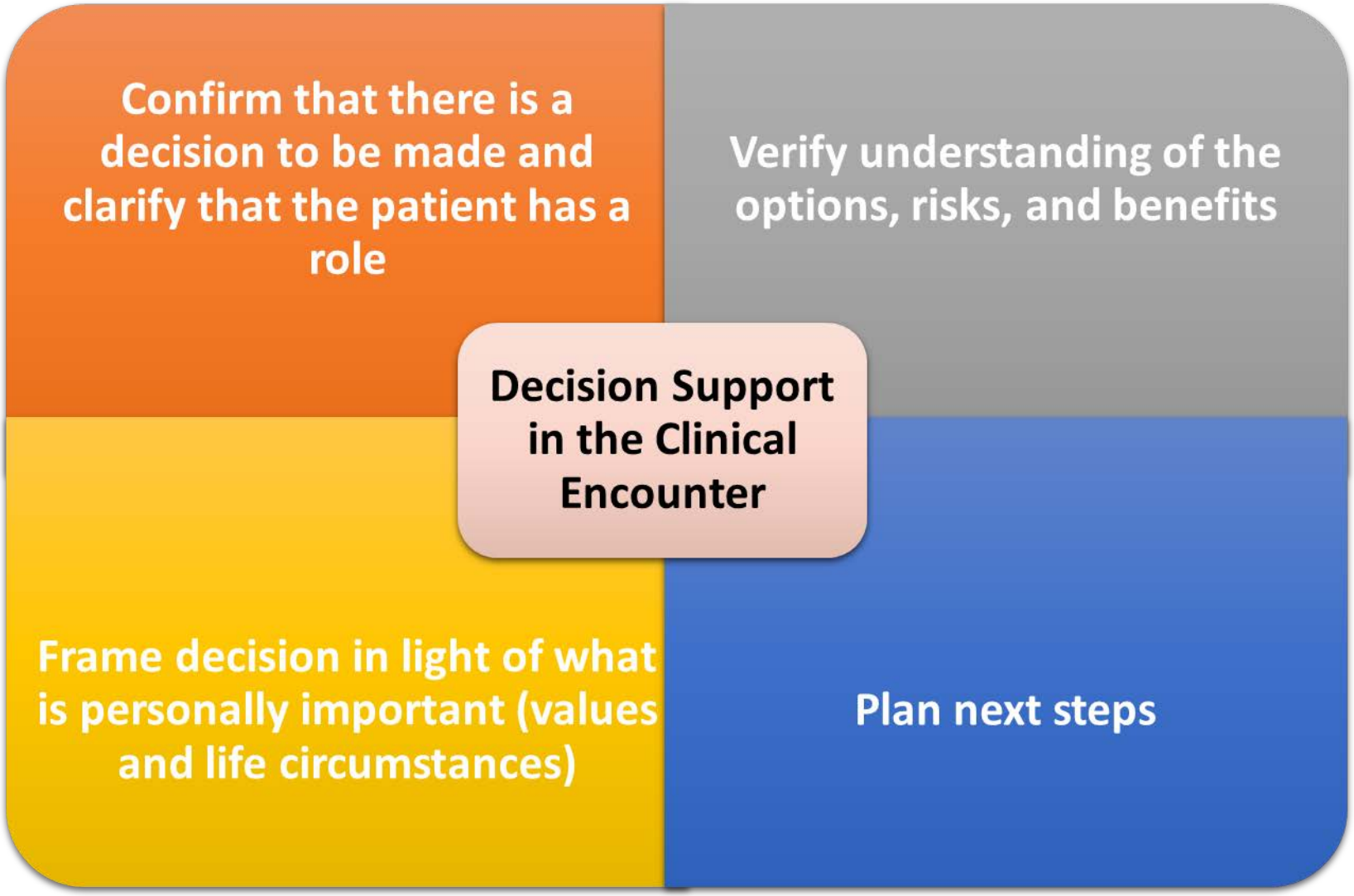
Source: Stacey D, et al. Cochrane Database of Systematic Reviews 2014, Issue 1 .

Motivational Interviewing (MI)

- A second important communication skill designed to enhance uptake of medical advice and improve outcomes.
- Utilized most effectively in evidence-based decision making when evidence is abundant and ‘choice’ is less relevant.
- Tobacco cessation provides classic MI content.

Classic Distinguishing

- **MI:** Where are you on a scale of 0 to 10 in your interest in quitting? What would it take to get to next higher number?
- **SDM:** Given that there are a number of options, can you help me understand what is important to you in this matter? What are your values and preferences?



http://decisionaid.ohri.ca/decguide.html

AHRQ SHARE Approach

- **Step 1: S**eek your patient's participation.
- **Step 2: H**elp your patient explore and compare treatment options.
- **Step 3: A**ssess your patient's values and preferences.
- **Step 4: R**each a decision with your patient.
- **Step 5: E**valuate your patient's decision.

Challenges in Chronic Disease Management: Patient View

- Many chronic diseases do not have overt symptoms that impact patients' daily lives.
- Many patients deny or minimize the impact of chronic diseases on their lives.
- Patients want to be "well," and they often feel that way.
- No one likes to take medicine.
- The diagnosis of a "disease" has important and often negative impact on patients' psychological and emotional health and well-being.

Challenges in Chronic Disease Management: Provider View

- We have limited time with patients.
- Educating patients about chronic disease is a complex and lengthy process.
- Providers vary in their skills and interest to educate, explain, and understand where a given patient is along the trajectory of their acknowledgment and understanding about a diagnosis.
- Many providers are fatigued by the effort and feel "it's not worth it."
- This leads to self-fulfilling prophecy.

Principles in Chronic Disease Management

- You can’t get it all done in one visit!
- Relationship over time is essential: ongoing conversation.
- Message: We can manage this problem effectively together; we are partners in successful outcomes; we will work at this to make you healthier.
- Flexibility for management: e-visits, telemedicine, phone management.
- Current payment modalities often not helpful!
- ACOs and capitated payments will improve this challenge over time.

Evidence Base

- Systemic review of 50 studies (2015).
- Increased overall patient satisfaction.
- Reduced costs: Elective surgery, BPH surgery, PSA screening, end-of-life care.
- Studies that looked at behavioral measures (reaching a decision; adherence) showed positive results in 37 percent of the cases.
- Studies of self-reported symptoms (e.g., QOL, mental function, etc.) were 42 percent positive.
- No negative results were found.

Sources:
Shay LA, Lafata JE. Med Dec Making. 2015;35(1):114-131.
Stiggelbout AM, Pieterse AH, De Haes JC. Patient Educ Couns. 2015 Oct;98(10):1172-9.
Veroff D, Marr A, Wennberg DE. Health Aff (Millwood). 2013 Feb;32(2):285-93.

Evidence Base for SDM

- In MD-led decision making, one-third of patients do not feel well-informed.
- With SDM, patients:
  - Have more accurate understanding of risks and benefits
  - Have less decisional conflict
  - Increased congruence with their own values.
- SDM is a CMS quality metric and requirement for patient-centered medical home recognition.

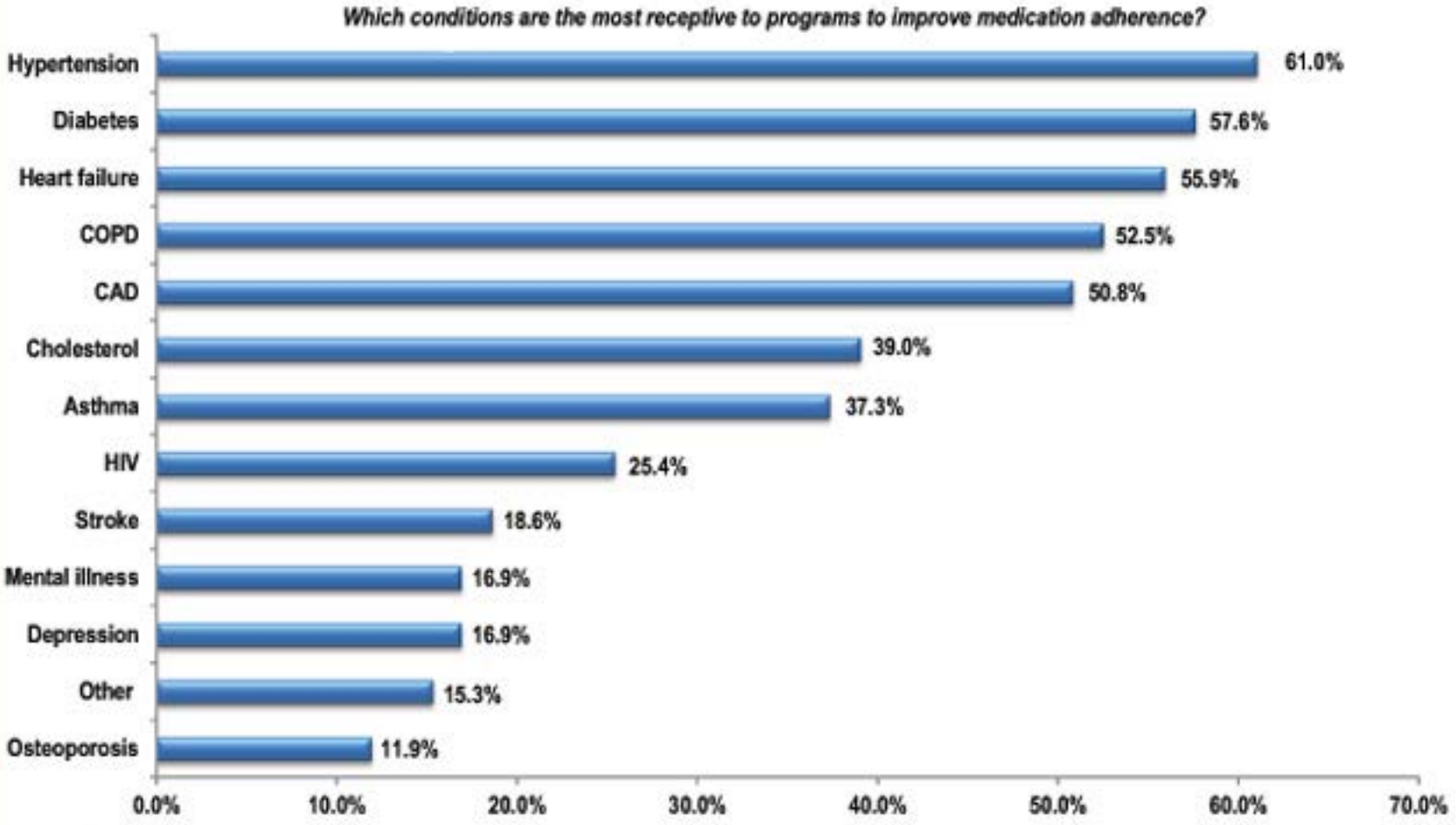
Sources:
Ferguson M. Transl Behav Med. 2011 June; 1(2):205-206.
Moulton B, King J. Journal of Law, Medicine & Ethics. 2010;38(1):85-97.
Grayson M. 2013. http://www.hhnmag.com
Stacey D, et al. Cochrane Database of Systematic Reviews 2014, Issue 1.

Need: Adherence

- **Adherence matters**! Estimates are that one-third of hospital admissions can be attributed to non-adherence with medication, leading to $100 billion in costs annually.
- Non-adherence is multi-factorial, but engaged patients who have shared in the decision process and feel their values and preferences are understood and part of the consideration for decisions are more likely to remain adherent.

Source: Choudhry NK, Winkelmayer WC. Journal of General Internal Medicine. 2008;23(2):216-218..

Targeted Conditions for Medication Adherence Programs



Source: HIN Improving Medication Adherence
January 2013

Need for SDM: Adherence

- Multiple studies show:
  - Post-MI medication adherence to be 40 to 50 percent 1 to 2 years post event.
  - Hypertension medication adherence to be 40 to 60 percent.
- Statin users have higher BMIs, and they consume more calories than non-users. Over a 10-year period, statin users' BMIs and caloric intake increased compared to matched controls.

Sources:
Choudhry NK, Winkelmayer WC. 2008;23(2):216-218..
Sugiyama T, Tsugawa Y, Tseng C-H, et al. JAMA Internal Medicine. 2014;174(7):1038-1045.
Schwenk TL. NEJM Journal Watch. 2014 May 8.

Adherence: Diabetes Mellitus (DM)

- 62 to 64 percent of patients with Type 2 DM on insulin adhered.
- One-third of young patients on insulin filled their prescriptions.
- 36 to 93 percent of Type 2 DM patients took prescribed oral agents for 6 to 24 months.

Source: Cramer JA. Diabetes Care. 2004 May;27(5):1218-24.

SDM Approach to Chronic Disease

- Goals: Nurture an activated patient who “owns” his or her disease and is enthusiastic about controlling it.
- Respect that patients have their own timeframe, personal and family needs, and need attention to their individual circumstances.
- SDM:
  - Acknowledges and embraces patient autonomy.
  - Appreciates that no decision is a choice.
  - Is NEVER about patient abandonment.

Talking to Patients: Diabetes Mellitus

- You have Diabetes: Tell me how you understand that? What does it mean to you?
- What do you think you need to manage this problem well?
- Tell me what is important to you about this diagnosis?
- Who else is involved in helping you manage it?
- There will be a lot of decisions to make over time to manage your condition. If I understand something about your preferences, I will be better able to help you.

Talking to Patients: Hypertension

- You have high blood pressure. Tell me what that means to you?
- What is important to you when you think about this medical problem?
- Do you have any specific preferences for how we might go about treating this condition?
- Who else is going to be involved in helping you get this problem under control?

Talking to Patients: Hyperlipidemia

- You have high cholesterol? What do you know about that?
- Can you tell me what is important to you about this problem and how to treat it? Preferences? Values?
- Who else is part of helping you manage it?
- What else should I know that might help me to best understand how to help you?

MAYO CLINIC

Statin/Aspirin Choice
Decision Aid

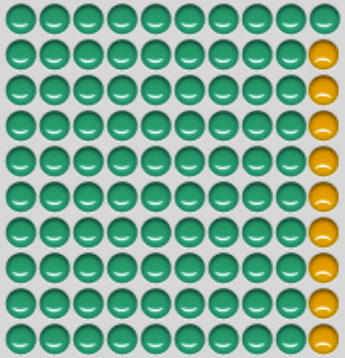
Back | Share

Current Risk | Intervention | Issues | Notes | Document

Benefits vs Downsides according to my personal health information
Using ACC/AHA ASCVD Risk Calculator

Current Risk of having a heart attack

Risk for 100 people like you who do not medicate for heart problems



Over 10 years
9 people will have a heart attack
91 people will have no heart attack

Cost

Standard dose statins
about $4/month

Daily Routine

Standard dose statins
One pill once a day

Other Benefits

Standard dose statins
The use of statins reduces your stroke risk by about one fifth.

Side Effects

Standard dose statins

Common side effects
nausea, diarrhea, constipation
(most patients can tolerate);

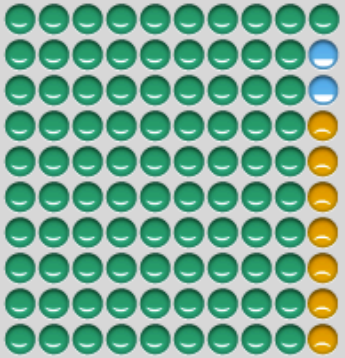
Muscle aching/stiffness
5 in 100 patients
(some need to stop statins because of this);

Liver blood test goes up
(no pain, no permanent liver damage):
2 in 100 patients
(some need to stop statins because of this);

Muscle and kidney damage
1 in 20,000 patients
(requires patients to stop statins).

Future Risk of having a heart attack

Risk for 100 people like you who do take standard dose statins



Over 10 years
7 people will have a heart attack
91 people will have no heart attack
2 people will be saved from a heart attack by taking medicine

http://statindecisionaid.mayoclinic.org

Lessons Learned

- SDM is never about patient abandonment; sometimes patients will ask you to make a decision for them: “Tell me what to do, Doc.”
- If you know what is important to your patient, and something about their values and preferences, you will create more realistic plans that patients can live with.
- Doing nothing is a choice. Sometimes it helps to identify that.

Other Lessons Learned

- Agency and self-efficacy are essential to controlling chronic diseases.
- “Management” of a chronic disease includes supporting patients’ sense of self-efficacy. Creating a sense of partnership leads to increased satisfaction for both provider and patient.
- In the long-run, SDM saves time during visits and curtails frustration.
- Decisions in chronic disease are not ‘done’ – circumstances change over time and require re-visiting the issues frequently.

Contact Information

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Shared Decision Making for Aging Veterans: Long-Term Care Planning

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Agency for Healthcare Research and Quality

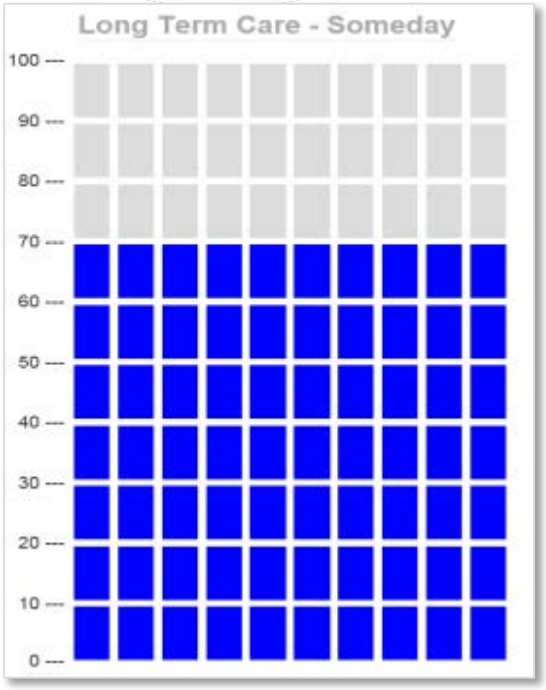
What is SDM?

We define SDM as a collaborative, patient-directed decision making process that assists veterans in assessing their health-related needs, setting priorities, and making choices that achieve their goals.

SDM aligns with several VA initiatives, and it's supported by VA leadership.

Why Aging Veterans?

- Though the rate of growth is slowing, older veterans are the fastest growing cohort we serve.
- By 2017, nearly 10 million of our 21.7 million veterans (46%) will be over 65.
- About 70 out of 100 people need long-term services and supports (LTSS) during their lifetime.



Conventional Use of SDM – Treatment

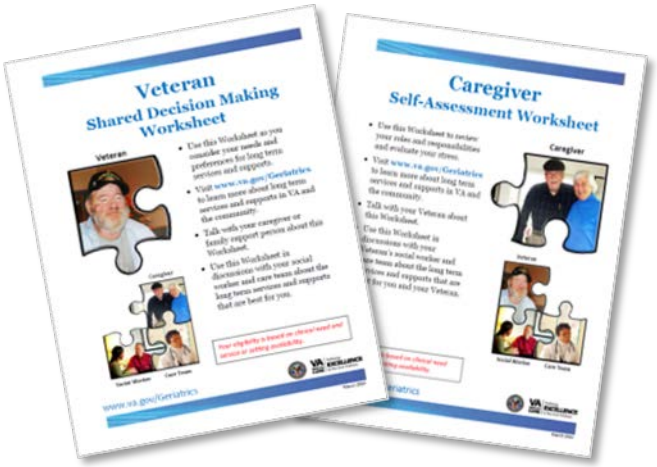
Traditional decision aids are used to provide health information, help prepare for a conversation with a health care provider, and/or make a decision about a specific treatment or whether to have a screening test.

	Dialysis	Kidney transplant	Conservative care
Summary	Your kidney failure is treated using special equipment to remove waste products from your blood	You receive a kidney from another person. They may be a living or deceased donor	Your kidney failure is managed through diet and medication. You will get specialised support when needed for end of life care
How the treatment is done	Treatment can be done either at home or in a dialysis centre using a machine or special dialysis fluid	You will have an operation where you receive a kidney	You will continue seeing your kidney specialist, who will help manage your symptoms, diet and medication
My suitability for this treatment	Most people with kidney failure are suitable, unless you have serious illness affecting other body systems	A transplant is currently suited to younger patients without serious health issues besides kidney disease	This is suitable for all patients, however is usually chosen if you have a poor quality of life or life expectancy, often due to illness affecting other body systems
My life and work	There are different types of dialysis. Home treatments are more flexible than others	Most people are able to resume normal activities and work within 3–6 months after transplant	Your health will deteriorate, so your life expectancy will decrease

http://homedialysis.org.au/wp-content/uploads/2013/03/Low-resolution.pdf

SDM: Other Preference Sensitive Choices

SDM works best for **preference-sensitive** choices. These decisions do NOT need to be treatment choices. For aging veterans, SDM is a best practice for choices that support aging-in-place.



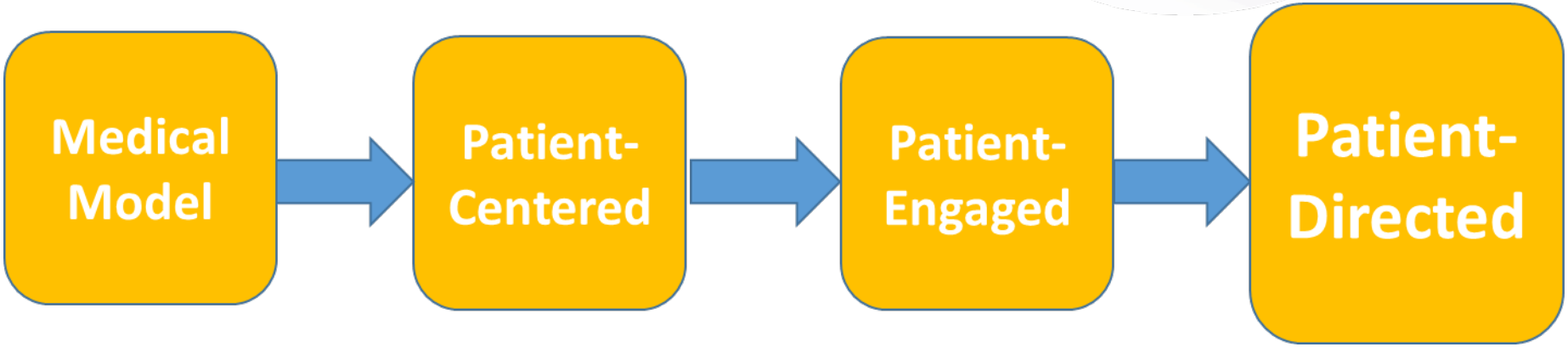
- **Provide decision aids (Worksheets) and comprehensive information** for veteran and family – **www.va.gov/Geriatrics**
- Facilitate **collaborative, asynchronous discussions** among the patient, family, social worker, and medical care team.
- Support **patient-directed decisions**, with the goal of decisions accepted by all.

What Veterans Need to Make LTSS Choices

Research studies (including Reder, 2009) indicate veterans and their family caregivers need:

- **More information** about long-term care options, in general.
- More information about **home and community-based services**, so they can remain at home/be independent.
- To be **asked about their life goals** and how LTSS can help support them.
- **Decision aids (i.e., worksheets)** to facilitate making choices about LTSS.

Shifting Veteran's Role



Our goal is to shift the veteran's role—and the care team process—from a medical model, focusing on provider expertise, toward a process of patient-directed decisions.

Outcome Measures

Proximal measures – goal of **increased**:

- Access/referrals to home and community-based services.
- Veteran-directed choices based on goals and priorities.
- Veteran and family caregiver satisfaction with decision process.
- Completion rate of advance directives.
- Veteran aging-in-place.
- Care team acceptance of veteran choice(s).

Distal measures – goal of **decreased**:

- Emergency department and urgent care visits.
- Number and length of inpatient hospital stays.

Staff Roles – It's a Team Effort

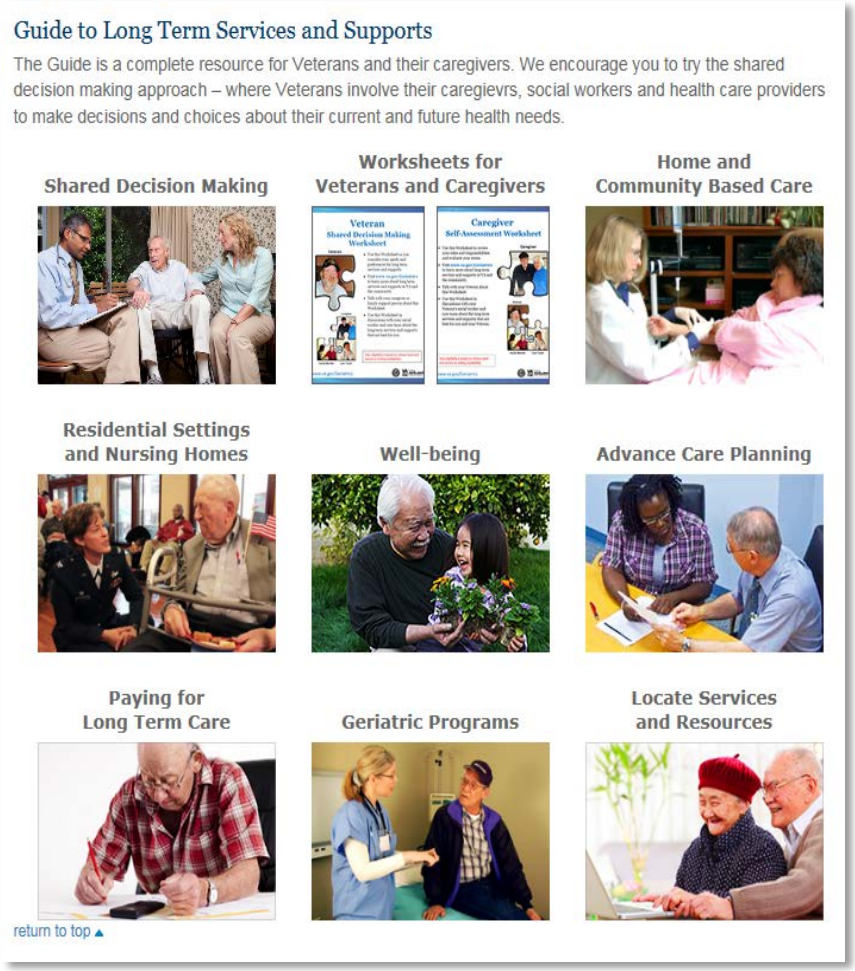
- The shared goal is veteran-directed decisions facilitated by care team input and quality information.
- With SDM, roles filled by team members are interdependent.
- This is achieved through collaborative, often asynchronous, discussions with veterans; and supported by team members communicating with each other and respecting veteran's choice(s).

Social Workers – Key Staff Roles

"**Social work/care management should take the lead** to adopt SDM process and framework to help veterans make LTSS choices."

— Michael Kilmer

GEC Web Site – Key SDM Info and Tools



- **SDM overview and Decision Aids** – Worksheets for veterans and family/caregivers
- **Key source of comprehensive range of LTSS** and detailed descriptions
- Information about geriatric programs and **resources for older veterans** on well-being, advance care planning, and paying for long-term care

www.va.gov/Geriatrics

Home and Community-Based Care (HCBC)

These services help chronically ill or disabled Veterans of any age remain in their homes. You can receive more than one service at the same time.

Adult Day Health Care

Home Based Primary Care

Homemaker and Home Health Aide Care

Hospice Care

Palliative Care

Respite Care

Skilled Home Health Care

Telehealth Care

Veteran-Directed Care

HCBC Service – Palliative Care

Palliative Care

What is it? | Am I eligible? | What services? | How do I decide? | What do others say?

Palliative Care uses comfort care with a focus on relieving suffering and controlling symptoms so that you can carry out day-to-day activities, and continue to do what is most important to you. Palliative care aims to improve your quality of life – in your mind, body and spirit.

Palliative Care can be combined with treatment that is aimed at curing or controlling your illness. It can be started at the time of your diagnosis, and may be provided throughout the course of the illness.

Video about Palliative Care

Palliative care helps Veterans and their families manage illness with plans of care. Watch this video to listen to Veterans and doctors talk about how VA palliative care helps patients live their lives.

RETURN TO: Home and Community Based Services

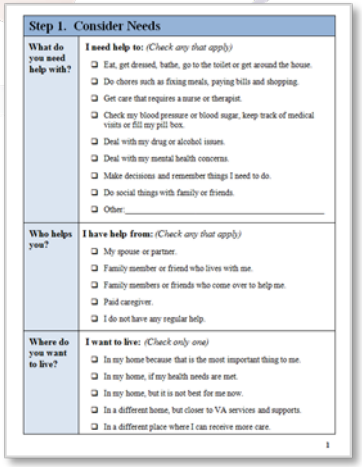
TOOLS for Shared Decisions

Watch video

Decision Aid Worksheets

Veteran

- Guides veteran through SDM process.
- Used to identify goals, priorities, and plans, make decisions, or just start a discussion.
- Can be completed or just reviewed; not a professional assessment tool.



Step 1. Consider Needs

What do you need help with?	**I need help to:** *(Check any that apply)* ❑ Eat, get dressed, bathe, go to the toilet or get around the house. ❑ Do chores such as fixing meals, paying bills and shopping. ❑ Get care that requires a nurse or therapist. ❑ Check my blood pressure or blood sugar, keep track of medical visits or fill my pill box. ❑ Deal with my drug or alcohol issues. ❑ Deal with my mental health concerns. ❑ Make decisions and remember things I need to do. ❑ Do social things with family or friends. ❑ Other:_____
Who helps you?	**I have help from:** *(Check any that apply)* ❑ My spouse or partner. ❑ Family member or friend who lives with me. ❑ Family members or friends who come over to help me. ❑ Paid caregiver. ❑ I do not have any regular help.
Where do you want to live?	**I want to live:** *(Check only one)* ❑ In my home because that is the most important thing to me. ❑ In my home, if my health needs are met. ❑ In my home, but it is not best for me now. ❑ In a different home, but closer to VA services and supports. ❑ In a different place where I can receive more care.

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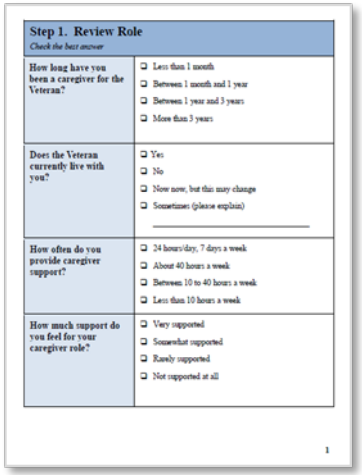

Step 1. Review Role

Check the best answer

How long have you been a caregiver for the Veteran?	❑ Less than 1 month ❑ Between 1 month and 1 year ❑ Between 1 year and 3 years ❑ More than 3 years
Does the Veteran currently live with you?	❑ Yes ❑ No ❑ Now now, but this may change ❑ Sometimes (please explain) _____
How often do you provide caregiver support?	❑ 24 hours/day, 7 days a week ❑ About 40 hours a week ❑ Between 10 to 40 hours a week ❑ Less than 10 hours a week
How much support do you feel for your caregiver role?	❑ Very supported ❑ Somewhat supported ❑ Rarely supported ❑ Not supported at all

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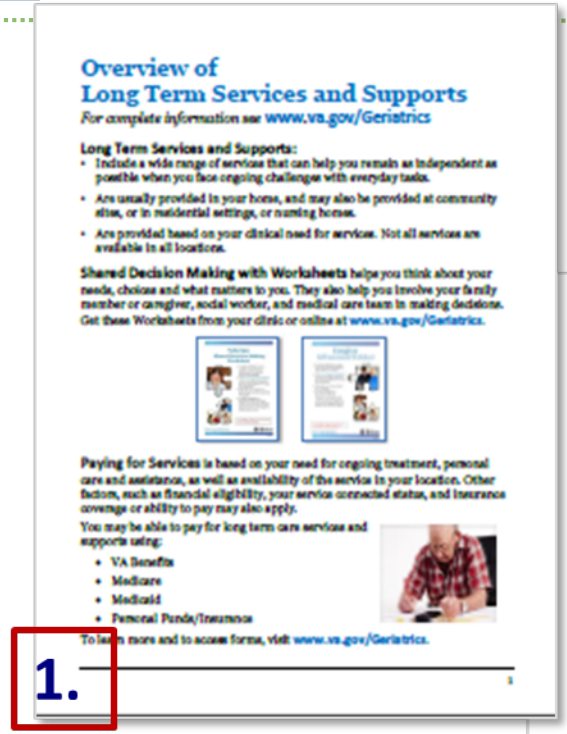
Caregiver

- Helps family caregivers assess their roles and responsibilities.
- Can prompt readiness for participation in shared decisions.

Other SDM Hardcopy Materials



Overview of Long Term Services and Supports

For complete information see www.va.gov/Geriatrics

Long Term Services and Supports:

- Include a wide range of services that can help you remain as independent as possible when you face ongoing challenges with everyday tasks.
- Are usually provided in your home, and may also be provided at community sites, or in residential settings, or nursing homes.
- Are provided based on your clinical need for services. Not all services are available in all locations.

Shared Decision Making with Worksheets helps you think about your needs, choices and what matters to you. They also help you involve your family member or caregiver, social worker, and medical care team in making decisions. Get these Worksheets from your clinic or online at www.va.gov/Geriatrics.

Paying for Services is based on your need for ongoing treatment, personal care and assistance, as well as availability of the service in your location. Other factors, such as financial eligibility, your service-connected status, and insurance coverage or ability to pay may also apply.

You may be able to pay for long term care services and supports using:

- VA Benefits
- Medicare
- Medicaid
- Personal Funds/Insurance

To learn more and to access forms, visit www.va.gov/Geriatrics.

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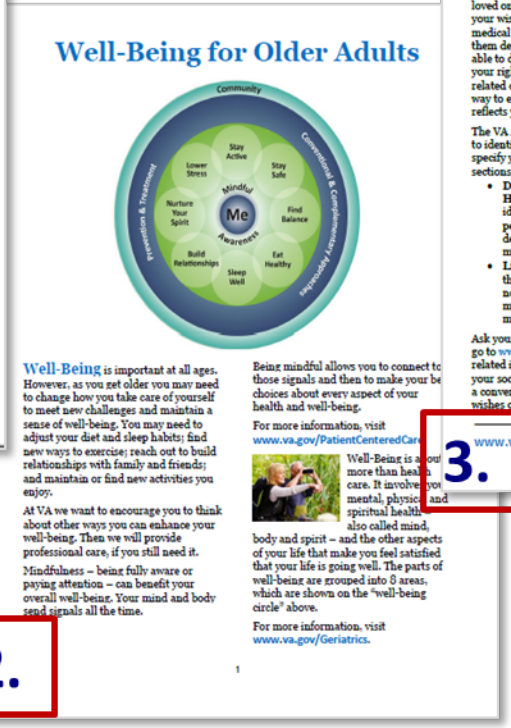

Well-Being for Older Adults

Well-Being is important at all ages. However, as you get older you may need to change how you take care of yourself to meet new challenges and maintain a sense of well-being. You may need to adjust your diet and sleep habits; find new ways to exercise; reach out to build relationships with family and friends; and maintain or find new activities you enjoy.

At VA we want to encourage you to think about other ways you can enhance your well-being. Then we will provide professional care, if you still need it.

Mindfulness – being fully aware or paying attention – can benefit your overall well-being. Your mind and body send signals all the time.

Being mindful allows you to connect to those signals and then to make your be choices about every aspect of your health and well-being.

For more information, visit www.va.gov/PatientCenteredCare

Well-Being is a[bout] more than heal[th] care. It involves yo[ur] mental, physic[al] and spiritual health also called mind, body and spirit – and the other aspects of your life that make you feel satisfied that your life is going well. The parts of well-being are grouped into 8 areas, which are shown on the "well-being circle" above.

For more information, visit www.va.gov/Geriatrics.

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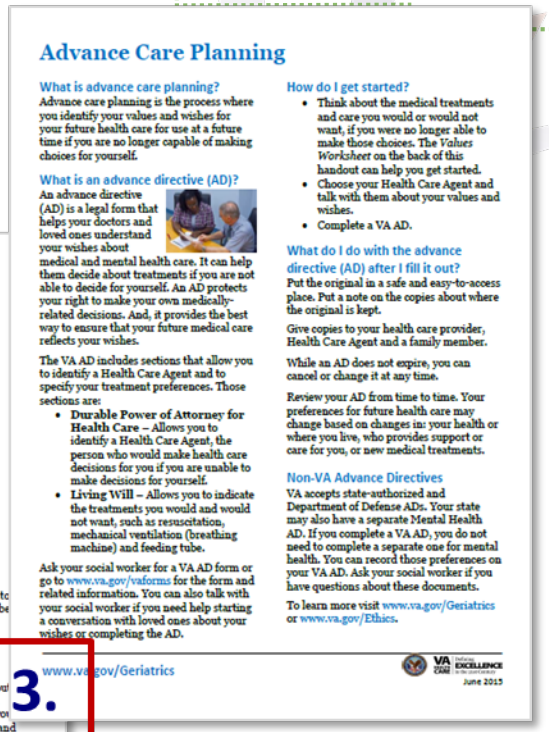

Advance Care Planning

What is advance care planning?
Advance care planning is the process where you identify your values and wishes for your future health care for use at a future time if you are no longer capable of making choices for yourself.

What is an advance directive (AD)?
An advance directive (AD) is a legal form that helps your doctors and loved ones understand your wishes about medical and mental health care. It can help them decide about treatments if you are not able to decide for yourself. An AD protects your right to make your own medically-related decisions. And, it provides the best way to ensure that your future medical care reflects your wishes.

The VA AD includes sections that allow you to identify a Health Care Agent and to specify your treatment preferences. Those sections are:

- **Durable Power of Attorney for Health Care** – Allows you to identify a Health Care Agent, the person who would make health care decisions for you if you are unable to make decisions for yourself.
- **Living Will** – Allows you to indicate the treatments you would and would not want, such as resuscitation, mechanical ventilation (breathing machine) and feeding tube.

Ask your social worker for a VA AD form or go to www.va.gov/vaforms for the form and related information. You can also talk with your social worker if you need help starting a conversation with loved ones about your wishes or completing the AD.

How do I get started?

- Think about the medical treatments and care you would or would not want, if you were no longer able to make those choices. The *Values Worksheet* on the back of this handout can help you get started.
- Choose your Health Care Agent and talk with them about your values and wishes.
- Complete a VA AD.

What do I do with the advance directive (AD) after I fill it out?
Put the original in a safe and easy-to-access place. Put a note on the copies about where the original is kept.

Give copies to your health care provider, Health Care Agent and a family member.

While an AD does not expire, you can cancel or change it at any time.

Review your AD from time to time. Your preferences for future health care may change based on changes in: your health or where you live, who provides support or care for you, or new medical treatments.

Non-VA Advance Directives
VA accepts state-authorized and Department of Defense ADs. Your state may also have a separate Mental Health AD. If you complete a VA AD, you do not need to complete a separate one for mental health. You can record those preferences on your VA AD. Ask your social worker if you have questions about these documents.

To learn more visit www.va.gov/Geriatrics or www.va.gov/Ethics.

www.va.gov/Geriatrics

June 2015

3.

Shared Decision Making for Veterans and Family Members

Shared Decision Making is a process where you work together with your family members, social worker and medical care team to make health-related choices that support your goals and priorities.

Use the **Veteran Worksheet** to help you think about what matters to you.

The **Caregiver Worksheet** helps family members assess their roles and responsibilities.

Your eligibility based on clinical need and service or setting availability.

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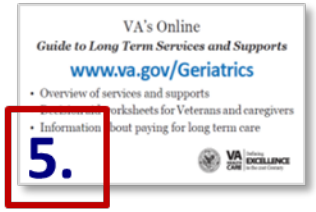


VA's Online

Guide to Long Term Services and Supports

www.va.gov/Geriatrics

- Overview of services and supports
- [W]orksheets for Veterans and caregivers
- Information [a]bout paying for long term care

5.

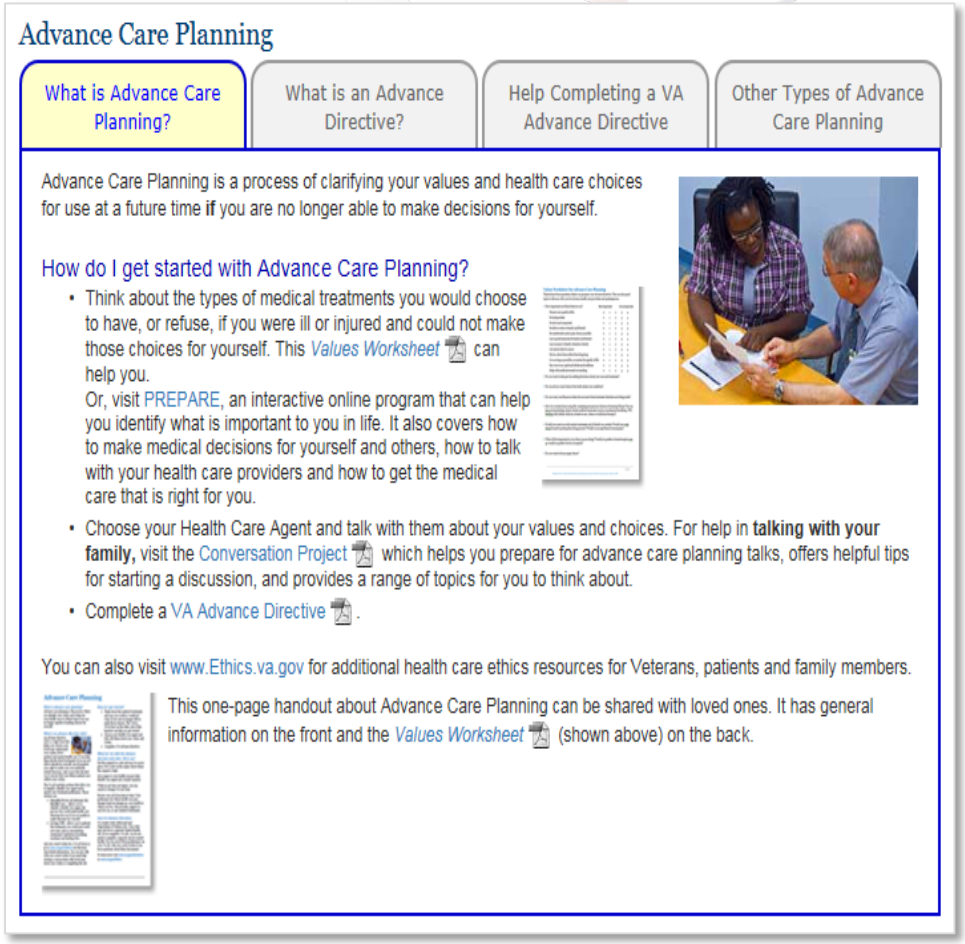
Use SDM for Advance Care Planning (ACP)

SDM is a natural fit for Advance Care Planning.

- **Any veteran** who is considering LTSS also should have an ACP discussion.
- The SDM process can help in **ACP discussions,** such as who would make treatment choices for the veteran if they could no longer do it.
- **Planning ahead** allows veterans to make important end-of-life choices when they can focus on them without pressure.

Advance Care Planning (ACP) Homepage

- www.va.gov/Geriatrics includes an ACP section.
- It provides links to the **VA Advance Directive form**, and a **Values Worksheet.**
- And, it includes **resources** that support discussions about end-of-life choices, such as handouts, podcasts, and links to interactive Web sites.



SDM Approach

- The SDM approach is flexible—based on the situation, collaborative discussions about long-term services, and supports that can lead to discussions about advance care planning.

SDM Implementation Components

SDM requires change in behaviors. Because good information is rarely sufficient to change behavior, this multi-faceted implementation program includes:

- **Orientation and Training** for all levels of staff from leadership to clinic/service line management and staff to those most closely involved with collaborative SDM discussions.
- **Policy and Program Changes** to address gaps in availability and access to services, including funding (e.g., use of electronic wait lists; involvement of Veteran Community Partnership Organizations).
- **Tools and Information** in hard copy and online that facilitate veteran-directed decisions (e.g., decision aids).

SDM Site Implementation Steps

1. **Leadership Orientation –** Provides brief sessions for national and VAMC leadership prior to training to ensure support for SDM.
2. **Training 1 –** For all staff and management of any clinic/service line that plans to implement SDM:
   - Overview of SDM
   - Implementation
   - Team roles
   - Care team process
3. **Training 2 –** Skills practice for social workers and other staff who most frequently discuss LTSS with veterans; uses case scenario teaching model.

SDM Site Implementation Steps

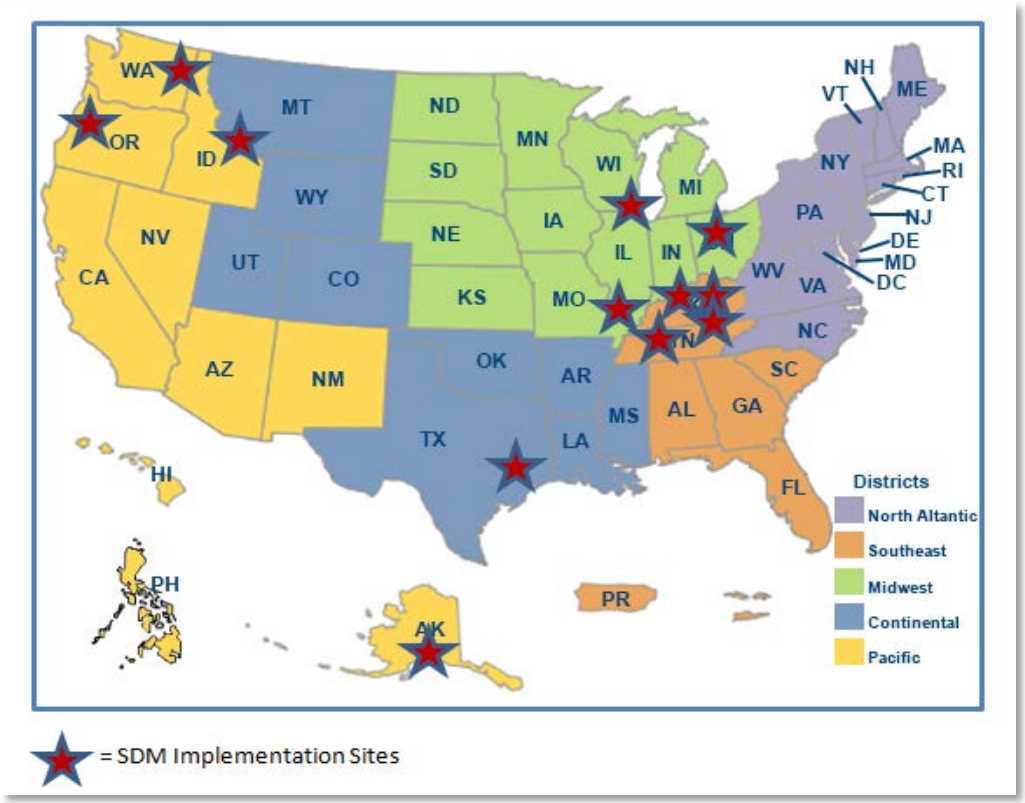
4. **Implement SDM for aging veterans –** Determine your clinic screening criteria, use the GEC Web site and SDM hardcopy materials, and start having SDM discussions.
5. **Interviews –** Staff, veterans, and family caregivers will be invited to participate in a quality improvement assessment interview.
6. **Report on progress –** Summarize findings of quality improvement interviews.

Note: We are also conducting analyses from databases on outcome measures, such as number of LTSS referrals to home and community-based services and number of advance care directives completed.

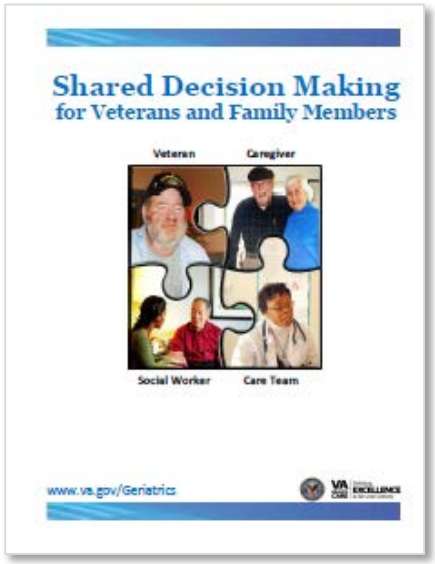
Implementation Sites

Funding for development, implementation, and assessment of Shared Decision Making for Aging Veterans has been provided from multiple sources, including national offices of:

- Geriatrics and Extended Care
- Rural Health
- Patient-Centered Care and Cultural Transformation
- Care Management and Social Work Services (key collaborator in this work)



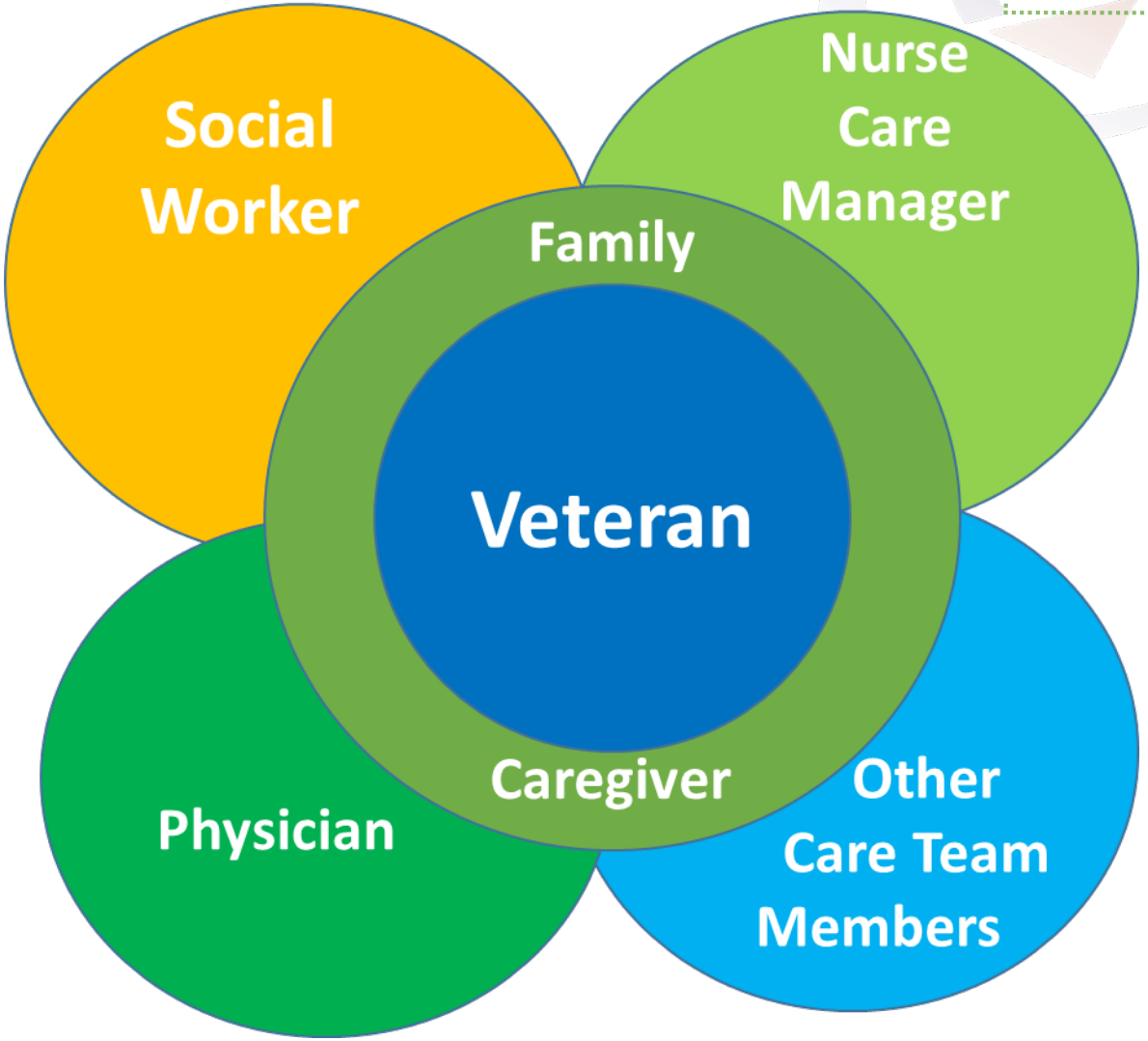
Key SDM Concepts – Review



The SDM approach supports:

- Veteran self-identification of goals and priorities, based on their values, preferences, and needs.
- Involvement of care teams in collaborative, often asynchronous, discussions with the veteran.
- Veteran understanding of medical conditions, the likely effects on health and function, and options for obtaining services and support.
- Provision of comprehensive information and use of decision aids to support veteran-directed choices.
- Access to home and community-based services to support aging-in-place.

SDM: Collaboration – Veteran at Center



Contact information

We look forward to collaborating with you on implementation of SDM for Aging Veterans.

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Research Investigator, HSR&D

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How to submit a question

- At any time during the presentation, type your question into the “Q&A” section of your WebEx Q&A panel.
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- Select “Send” to submit your question to the moderator.
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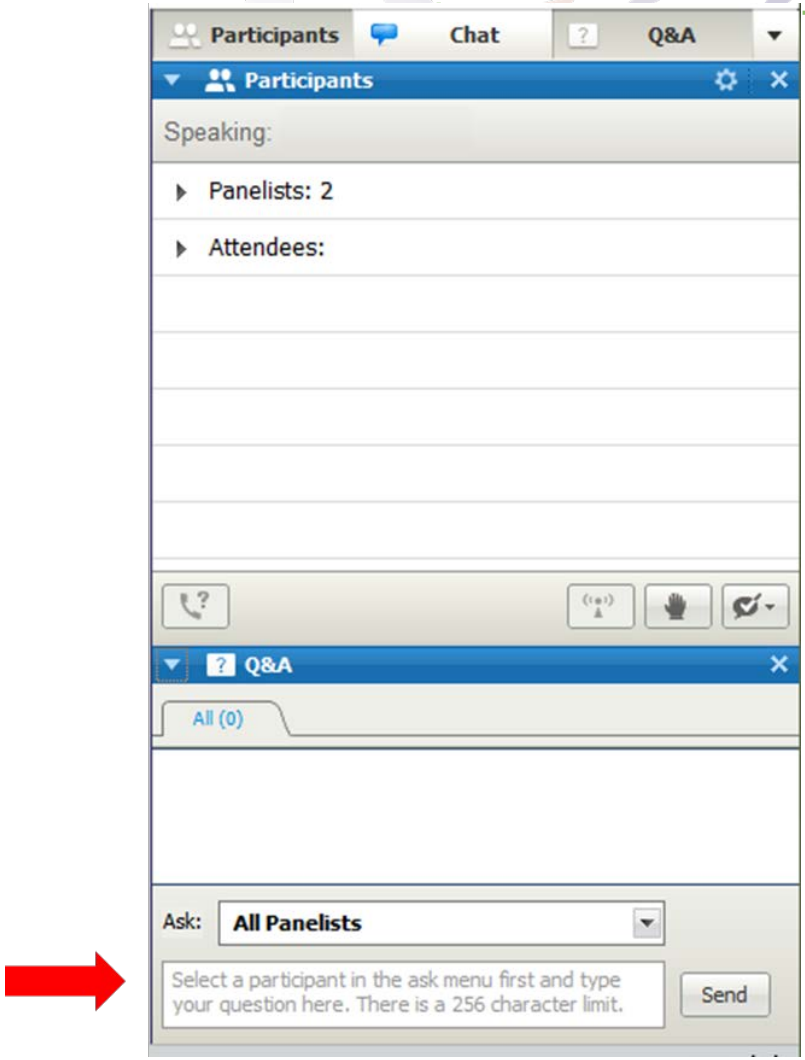
- SHARE@ahrq.hhs.gov



Questions about AHRQ's

SHARE Approach Resources

Contact:

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alaina.fournier@ahrq.hhs.gov OR

SHARE@ahrq.hhs.gov

Agency for Healthcare Research and Quality

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