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Prior to working with this Medicaid managed- care organization, Michael Leeson served as a psychiatrist at The Wyandot Center, a large urban community mental health center in Kansas City, Kansas, where he participated in the development of CommonGround, a shared decision making program, led by Patricia Deegan.

He completed his M.D. degree, a Ph.D. in Microbiology, Molecular Genetics, and Immunology, and a combined residency in Internal Medicine and Psychiatry at The University of Kansas in Kansas City, Kansas. He is a Diplomate of the American Board of Psychiatry and Neurology, Inc.

Shared Decision Making in a Large Urban Kansas CMHC

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Wyandot Center
Community Behavioral Healthcare

Context

- Implementation of CommonGround shared decision making
  - Implementation in 2006
  - Community Support Services program
  - Wyandot Center for Community Behavioral Healthcare
  - In collaboration with Dr. Pat Deegan

My comments will be based on my experiences when a formalized shared decision making process was implemented at my former practice location. In 2006, I was the psychiatrist for the Community Supports Services division of the Wyandot Center for Community Behavioral Healthcare, which is the community mental health center in Kansas City, KS. That year, we were selected as a development site for Dr. Deegan's CommonGround software, which as you've seen earlier today is a comprehensive program of shared decision making.

Implementation: Practical Concerns

- Physical space
- Computer Kiosks
- Materials (decision aids, etc.)
- Staff
- Privacy
- Limited distractions
- Welcoming environment

Prior to implementation, we had a number of physical space concerns that we needed to address. As with many busy clinical offices, space was at a premium, and we needed to identify an area that could house several touch screen computer kiosks, decision aids, worksheets, calendars, and other printed materials. We also needed room for staff to assist consumers with the process. Finally, we needed to afford a degree of privacy, limit distractions, and make consumers feel welcomed. We were able to repurpose a receptionist area as well as the waiting area for our medication clinic to accomplish these needs.

Implementation: Ideological Concerns

- "We ***already*** do that"
- Practitioner time already very limited
- Change in practice style
- Concerns of consumer acceptance new use of technology

In addition to physical environment concerns with implementation, we also needed to address concerns that were more ideological in nature. I, for one, felt that I already incorporated shared decision making into my practice style, since I typically reviewed options with consumers, provided what education I could within the confines of a clinic appointment, and worked collaboratively with consumers to make a sound medical decision in treatment. Of course, the degree of support and education as well as collaboration that occurs in a formalized process of shared decision making is much more substantial than that which can happen within the bounds of a routine clinic visit, though at the time, my staff and I did not have a frame of comparison. Looking back, I would think it justifiably would be very difficult for most clinicians to fully understand the difference between practice as usual and a fully developed program of shared decision making without actually experiencing both. Our clinic was certainly no stranger to efforts to improve clinician productivity, which meant we didn't feel like we had spare time in our typical clinic appointments to add any additional processes. So, the thought of also adding specific shared decision making tasks was of concern. Additionally, from my own perspective, I know that I had a fairly well established routine that I followed during clinic visits, and incorporating comprehensive shared decision making required substantial change to that routine. Finally, there was concern that consumers might reject some of the new technology, particularly the computer interface, but it turned out this concern was largely unfounded.

There were a number of points along the way that activated staff and reinforced the value of shared decision making. Prior to meeting with the prescriber, consumers would use the computer software to answer a series of questions about their symptoms and overall functioning since the last clinic appointment. One of our early anecdotal observations was that there were pieces of information that consumers elected to share with the computer that they did not share with us in person, such as information related to use of recreational drugs. Additionally, one very memorable consumer typically came to clinic, said he was "fine," and gave very short answers to questions. We thought this was just a negative symptom of his psychotic illness, but when he began completing pre-clinic reports on the computer, his clinician said he was suddenly very talkative in clinic, as if the shared decision making tool was a springboard for him to better articulate and express himself. The benefit of decision aids also became clearly apparent. These decision aids were intended to be used outside of clinic, and therefore allowed the consumer to thoroughly evaluate a decision in a structured manner outside of the time constraints of their clinic visit. As an example, one of my own turning points was working with one young woman who frequently would return to clinic after having discontinued her medications on her own, typically not feeling well, and looking for options. We could do a brief review of why she had stopped her medications during the clinic visit and come up with a new plan built around a medication, but she would often later return off the medication. With the shared decision making tools, she was able to complete an assessment of the pros and cons of taking medication, and ultimately assigned a very high score to the value she placed on medication in her treatment. She also completed a budget worksheet to allow her to see how she could manage copays. This process allowed me to understand the importance of minimizing the number of copays she would have in a month and seemed to have allowed her to be more consciously aware of the role she envisioned for medication in her treatment. It allowed us to focus her clinic visits on moving forward rather than starting over. Finally, it was impossible to not notice how excited consumers were about this new tool, and I think that

A New Way of Practice

- Structure of interview required change.
- Pre-clinic preparation provided much of routine progress note database.
  - Sleep, energy, hallucinations, etc.
  - Suicidal thoughts
  - Pattern of use of medication
- Review of pre-clinic preparation rather than de novo interview.
- Necessary to find time to formalize a shared decision.

Adopting a formalized shared decision making process did require some changes to the structure of our psychiatric clinic visits. From the consumers' perspective, they would need to arrive about 30 minutes prior to their clinic appointment to complete the computerized pre-clinic questionnaire that I've mentioned. This questionnaire included some of the basic information that would typically be elicited in a clinic visit, including such things as amount of sleep, energy level, frequency of any hallucinations, presence or absence of suicidal thoughts, and pattern of medication use. This information was then quickly available to the clinician and could be reviewed with the consumer rather than collected on the fly. Consumers who needed more time to consider their answers or focus their attention could take all the time they needed at the computer without impacting the clinician's time management. Additionally, the clinician and consumer needed to reserve time during the clinic visit to formulate and document a specific shared decision.

The "New" Clinic Visit

- Review the pre-clinic preparation report.
- Identify points of concern from the report.
- Clarify the report with the consumer.
- Perform the clinical interview.
- Formulate a treatment plan.
- Identify shared decision making tools to be used post-clinic.
- Collaboratively construct a formal shared decision.

After adopting the shared decision making process, from the prescriber's perspective, the new clinic visit looked something like this. Either shortly before inviting the consumer to the prescriber's office or very early in the session, the prescriber would electronically retrieve and review the consumer's pre-clinic computerized questionnaire. Any points of concern present in the questionnaire would be quickly identified. The answers on the questionnaire would be quickly reviewed with the consumer to ensure accuracy. Then the clinical interview would occur followed by treatment planning. The prescriber and consumer would identify any shared decision making tools that the consumer might want to complete prior to the next clinic visit, and the clinician and consumer would collaboratively develop a formal shared decision that would be entered by the clinician into the software.

Seasoned Clinicians Confront Change

- The majority of clinic staff were well experienced.
- The majority of clinic staff had well established practice patterns.
- Well established patterns took time to change.
- Developing a good shared decision also took time and practice.

This new way of doing business required that staff be willing to change the structure of their clinic visits. Most of the clinical staff involved in this implementation were well seasoned clinicians who were successful at what they did, and who had already developed effective strategies for structuring their clinic visits. It took time to modify those existing structures and incorporate the elements of formalized shared decision making. From my own perspective, early on, there were times when I would review the pre-clinic report with the consumer and then get so involved in the clinical interview and treatment planning or a crisis the consumer was having that I would forget to come back and develop and document a shared decision with the consumer. Fortunately, those occurrences became fewer and fewer as time went on. Good shared decisions are different from reiterating the instructions on a prescription, and so it was a new experience for at least some of the staff to develop and document with the consumer an appropriate and individualized shared decision, and acquiring this skill took some time.

Learning Curve: One Clinician's Perspective

- 2-4 months to consistently come back to shared decision at end of interview.
- 4-6 months to gain experience with post-clinic package of shared decision making tools.

In terms of a learning curve for staff, I would estimate that it took about 2 to 4 months to become proficient at developing good shared decisions with consumers and also to modify the structure of the clinic visit to consistently capture these shared decisions. There are a wealth of decision aids, tracking calendars, worksheets, and other components available in shared decision making, and many of these would not be something with which most psychiatric prescribers would have an in depth familiarity. These tools were not difficult to understand or to apply, but it did take some time,

Efficiencies of Time

- Using pre-clinic and post-clinic shared decision making tools did ***not*** shorten clinical visits.
- Time in clinical visits was ***restructured***.
- Less time was required to complete clinical database.
- More time was available for meaningful content:
  - ***Recovery discussion***
  - ***Goal-setting***
  - ***Therapy***

Using the pre-clinic and post-clinic shared decision tools didn't result in any obvious decrease in the time spent in clinic visits or in the ability to schedule more visits per hour for the clinicians. There was, however, a change in the balance of how time was used in each clinic visit. Whereas in the past, we would spend a significant amount of time building the clinical database regarding sleep, energy, appetite, obstacles to use of medications, and so forth, the pre-clinic computerized questionnaire substantially streamlined this process and required only a quick review for accuracy with the consumer. Spending less time on building the database allowed more time to be devoted to topics that would ultimately have more impact in the consumer's recovery, such as discussing life goals, discussing the recovery process, and even working in a bit more psychotherapy.

Medico-legal Concerns

- Current status is part of pre-clinic assessment.
- Medication usage and side effects are part of pre-clinic assessment.
- Areas of clinical concern are identified in the pre-clinic assessment.
- This information is maintained in the shared decision making database, which is isolated from the medical record.

Prior to implementing the formalized shared decision making process, we were well aware of some potential medicolegal concerns. For one, the pre-clinic computerized questionnaire included substantial information about recent clinical functioning, including the presence or absence of suicidal or homicidal thoughts. We knew that if these were documented on the pre-clinic report, it would be essential that we not miss these elements. If the consumer reported worrisome side effects in the pre-clinic questionnaire, it would also be essential that we not overlook that in the clinic visit. And finally, the pre-clinic report was initially contained within our electronic medical record but was later moved to a web-based platform that was outside of our electronic medical record.

Medico-legal Concerns: Risk Reduction

- A copy of the pre-clinic report can be "pasted" into the electronic medical record.
- The pre-clinic report may be used to corroborate the clinician's evaluation.
- Areas of concern are flagged in the pre-clinic report.
- Pre-clinic report provides an additional level of assessment.
- Any entries consumers note to be in error can be documented in the electronic medical record.

Each of our medicolegal concerns were relatively easily addressed. The CommonGround software includes functionality that allowed us to click a single button with the computer mouse to copy the entire report, and then we were able to paste the entire pre-clinic report into that day's clinic progress note to maintain a copy for our official record. The pre-clinic report allowed a quick method of corroborating the clinical impression. Our concerns about the possibility that clinicians might miss important elements of the pre-clinic report were addressed by highlighting areas of concern in a red typestyle. So, if, for example, a consumer indicated he was having concerns about suicidal thinking, this would be reported in a red font but if he denied suicidal thinking, this would be reported in a black font. This font formatting made it very easy for the clinician to quickly scan the report for items that were essential to cover with reduced risk of missing something important. As we found with substance abuse issues, the computerized pre-clinic questionnaire also allowed an additional level of assessment that sometimes gave information we didn't obtain in a standard clinic interview. And finally, if consumers indicated there were errors in the pre-clinic report, such as the report was flagging suicidal ideation but the consumer verbally reported this was not correct, we were able to do the appropriate assessment and simply document in the medical record that the consumer reported this to be an item in error and include the findings from our clinical assessment.

Key Points

- Changing how we think, believe, and work requires practical and subtle changes.
- Experience is teaching us about the richness of true shared decision making.
- Organizational change requires a systematic approach and time for seasoned clinicians to master new skills.
- Integrated shared decision making tools can also help us with regulatory paperwork requirements.