

Produksjon av beslutningsstøtteverktøy fra kunnskapsoppsummeringer til bruk i det kliniske møtet - SHARE-IT

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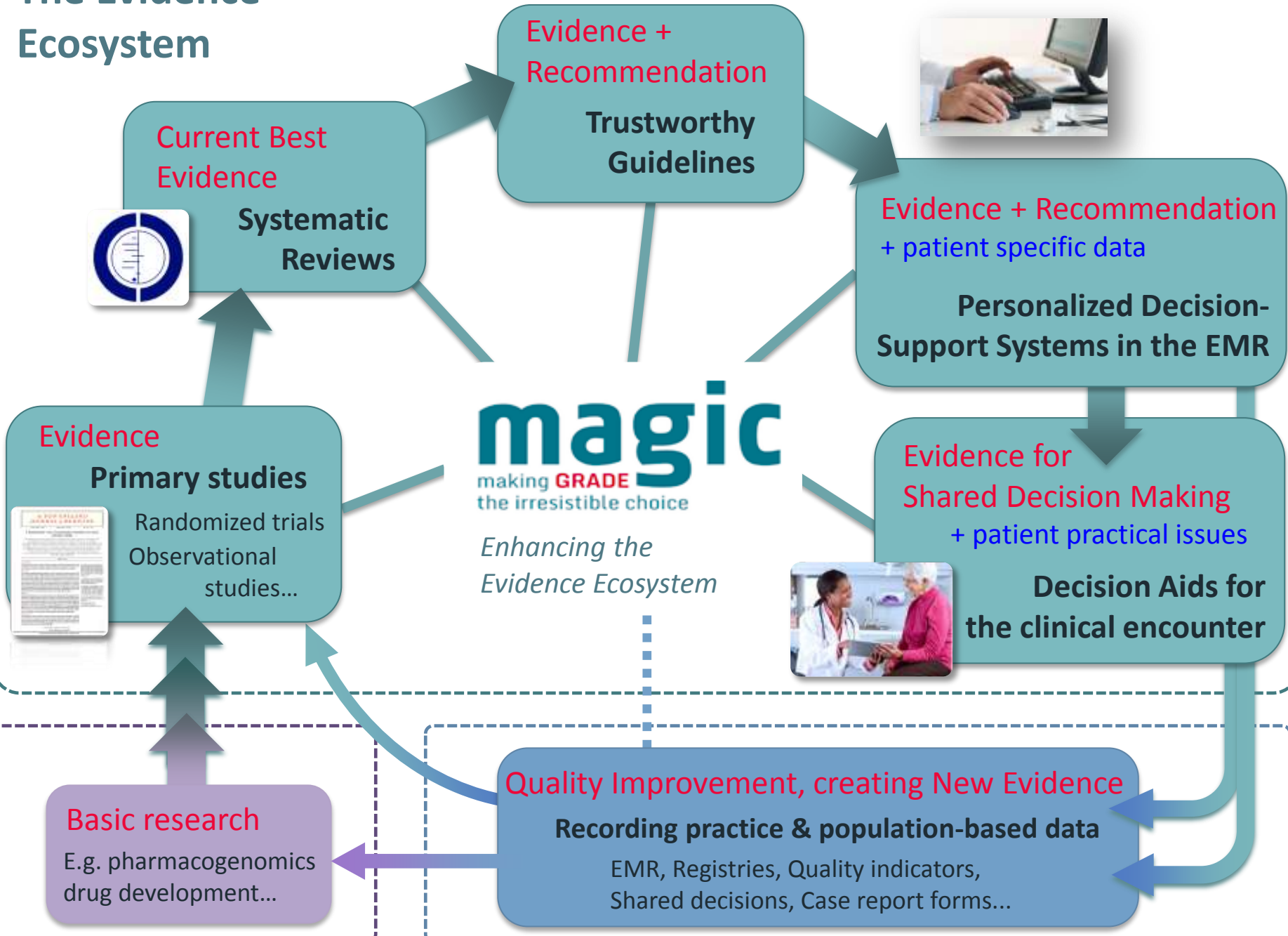
Anne med vondt i magen og et spørsmål til deg

- ◆ 53 år, økonomidirektør
- ◆ Diabetes type II, forhøyet kolesterol og blodtrykk
- ◆ (høy risiko for hjertekarsykdom)
- ◆ Albyl-E, kolesterolsenkende,
- ◆ blodtrykksmedisin
- ◆ 6 måneder: mageplager
- ◆ Gastroskopi normal
- ◆ Diagnose: Funksjonell dyspepsi



Anne: "Behøver jeg egentlig Albyl-E?"

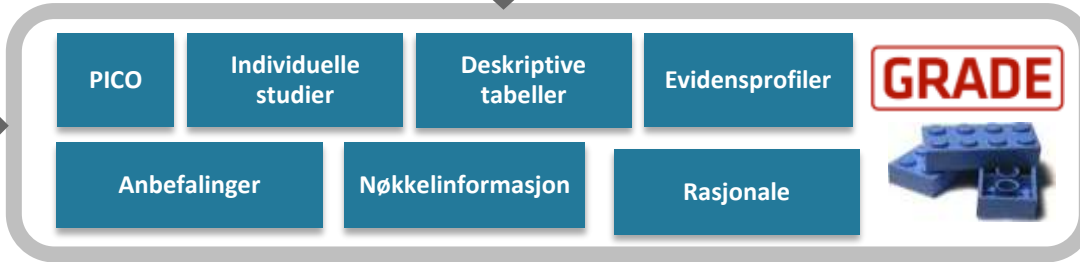
The Evidence Ecosystem



magic app



Forfatter-
og publikasjonsplattform



Database
Strukturert og
tagget innhold

Dynamisk oppdatering



SHARE-IT



Beslutningsstøtteverktøy
for pasienter
and klinikere

Reproduced from JAMA,
Users' Guide to the Medical Literature, 3rd ed.

Shared Decision Making

is a process by which

a **patient** and a **clinician**

work together,

have a **conversation**,

partner with each other

to identify the **best course of action**,

the best treatment or test

at this point in time.

It is about **sharing what matters**

Clinicians share information about the alternatives, benefits, harms

Patients share prior experience, goals, expectations, values.

Tradisjonelle beslutningsstøtteverktøy

- ◆ Hovedparten ment til å bruke av pasienter utenfor det kliniske møtet
 - ◆ Mål: pasient-empowerment
 - ◆ Forberede konsultasjonen, ønske om at en felles overveielse vil finne sted i etterkant
- ◆ Svært tidkrevende produksjon
- ◆ Ofte ikke basert på best tilgjengelige evidens (eller utdatert)
- ◆ Manglende bruk i praksis

Motivasjon for SHARE-IT: nødvendig med alternative modeller:

- Koble til kunnskapsoppsummeringer og retningslinjer
- Generisk tilnærming = tilgjengelig for flere (pasienter, klinikere og fagfelt)

Tilbake til Annes spørsmål

- ◆ 53 år, økonomidirektør
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Anne: "Beøver jeg egentlig Albyl-E?"

= Albyl-E for primærforebyggelse for pasienter over 50 år med høy risiko for hjertekarsykdom?

1 Primary prophylaxis of cardiovascular disease

Use **Norrisk score** to estimate risk

Weak recommendation

It is less clear whether the benefits outweigh the drawbacks/harms.

We suggest 75 mg aspirin daily to persons with high cardiovascular risk (10 year risk of cardiovascular death > 10%)

Help ?

← Effect estimates **Key info** **Decision Aid** Practical advice Adaptation → : ▼

Benefits and harms

In 1000 patients treated for 10 years: Aspirin will - irrespective of cardiovascular risk - prevent 6 (0-12) deaths.

Low risk: Aspirin compared to no treatment would prevent 3 myocardial infarctions, but could lead to 2 more non-fatal, major, extracranial bleeds.

Moderate to high risk: Aspirin compared to no treatment would prevent 21 myocardial infarctions, but lead to 15 non-fatal major extracranial bleeds. Long-term treatment with aspirin may give bothersome dyspepsia.

Quality of evidence

Our confidence in the effect estimates is moderate to high. Moderate for death due to imprecise estimates (biggest effect on cancer-related death). High confidence for myocardial infarction and bleeds.

Preference and values

The guideline panel considers that only high risk patient would value a reduction in the number of myocardial infarction and possible reduction in mortality over the inconveniences and the increased risk of bleeding related to the use of aspirin. Patients not willing to take medication over

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Help 

 [Effect estimates](#) [Key Info](#) **[Decision Aid](#)** [Practical advice](#) [Adaptation](#)  : ▼

We issue a weak recommendation for aspirin in people at high cardiovascular risk due to a small absolute reduction of myocardial infarctions and deaths, weighed against an increase in bleeds and the burden of taking aspirin for 10 years.

Use this Decision Aid to share and discuss the evidence directly with your patients.

This interactive tool for shared-decision making is designed to help you meet your patients' needs by:



- Exploring what outcomes they wish to discuss,
- Communicating the benefits and harms of each alternative, as well as their (un)certainly,
- Discussing practical consequences associated with each alternative.

Implementering av den nye strategien

1 Primary prophylaxis of cardiovascular disease

Use **Norrisk score** to estimate risk

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Decision Aids

What aspect of your medication would you like to discuss next?

Choose and compare outcomes

Death Recurrent clot Major bleeding Practical consequences

Among a 1000 patients like you, with Rivaroxaban

Outcome	No treatment	Rivaroxaban
Recurrent clot	71 per 1000	13 per 1000
Major bleeding	0 per 1000	7 per 1000

Certainty: High (4/5 stars)

Choose and compare outcomes

Death Recurrent clot Major bleeding Practical consequences

Among a 1000 patients like you, with Rivaroxaban

Recurrent clot

58 fewer at 1 year

Outcome	No treatment	Rivaroxaban
Recurrent clot	71 per 1000	13 per 1000
Major bleeding	0 per 1000	7 per 1000

Certainty: High (4/5 stars)

987

Close

- Communicating the benefits and harms of each alternative.
- Discussing practical consequences associated with each alternative.

Low dose aspirin vs. no treatment for primary prevention ▼

What aspect of your medication would you like to discuss next?

Choose and compare

Mortality

Myocardial infarctions

Non-fatal stroke

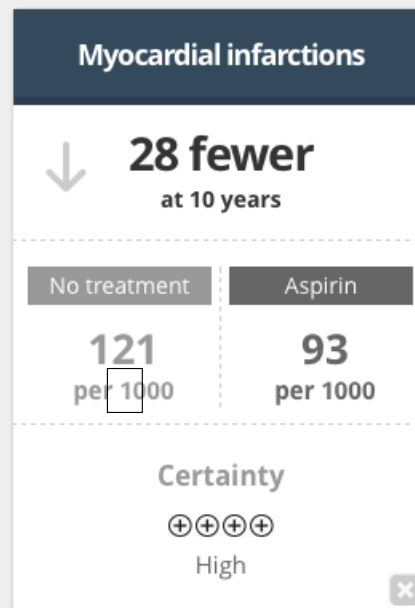
Major extracranial bleeding

Practical consequences

Low dose aspirin vs. no treatment for primary prevention



Among a 1000 patients like you, with aspirin



Choose and compare

Mortality

Myocardial infarctions

Non-fatal stroke

Major extracranial bleeding

Practical consequences

Low dose aspirin vs. no treatment for primary prevention



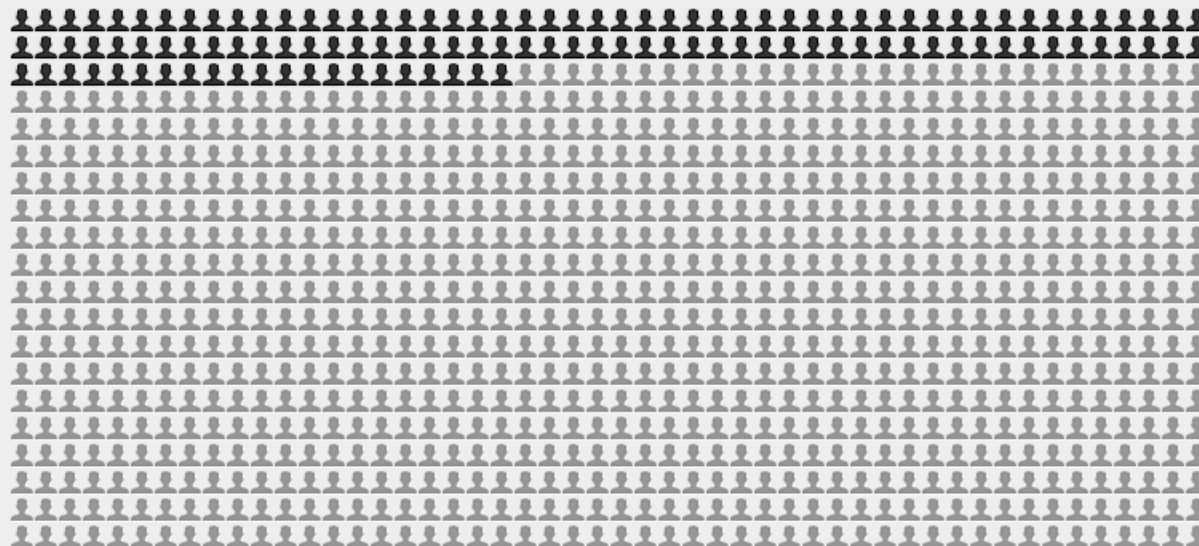
Among 1000 patients like you, without aspirin

Myocardial infarctions

↑ **28 more**
at 10 years

No treatment	Aspirin
121 per 1000	93 per 1000

Certainty
++++
High



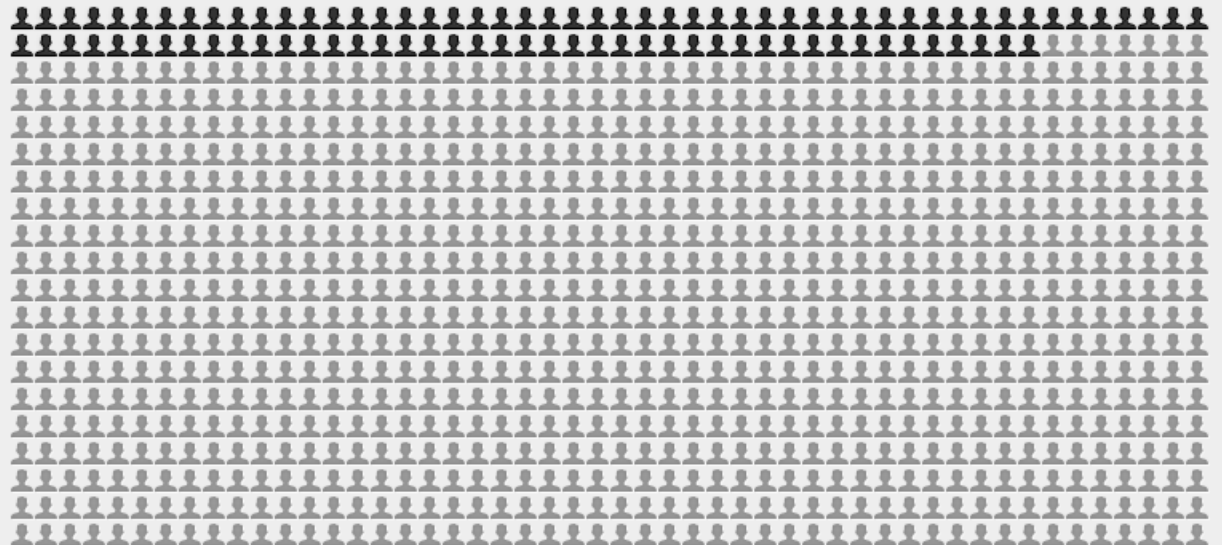
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Close

Low dose aspirin vs. no treatment for primary prevention



Among 1000 patients like you, with aspirin



907

Myocardial infarctions



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Low dose aspirin vs. no treatment for primary prevention



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907

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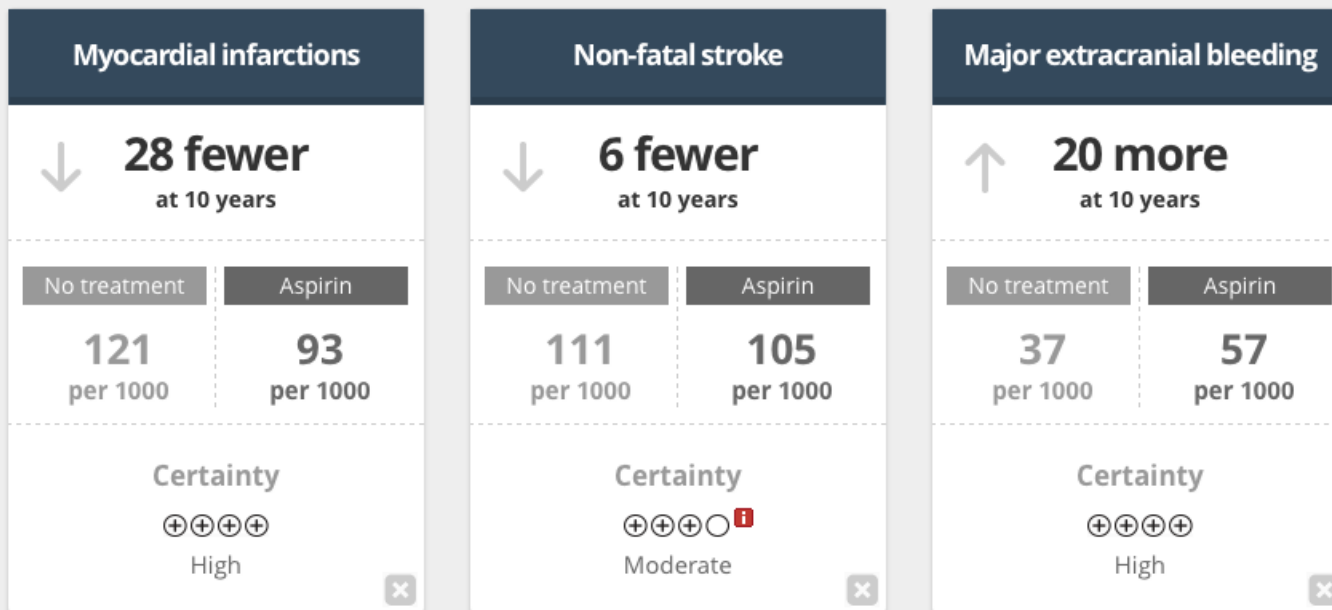
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Low dose aspirin vs. no treatment for primary prevention



Among a 1000 patients like you, with aspirin



Choose and compare

Mortality

Myocardial infarctions

Non-fatal stroke

Major extracranial bleeding

Practical consequences

Low dose aspirin vs. no treatment for primary prevention ▼

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Choose and compare

Mortality

Myocardial infarctions
















Non-fatal stroke

Major extracranial bleeding

Practical consequences

Low dose aspirin vs. no treatment for primary prevention



Practical Issues				
 Medication routine	 Tests and visits	 Procedure and device	 Recovery and adaptation	 Coordination of care
 Adverse effects, interactions and antidote	 Physical well-being	 Emotional well-being	 Pregnancy and nursing	 Costs and access
 Food and drinks	 Exercise and activities	 Social life and relationships	 Work and education	 Travel and driving

Link til pasienterfaringsdatabase – F.eks. *Oxford Health Experiences Research Group*

Low dose aspirin vs. no treatment for primary prevention



Practical consequences



Adverse effects, interactions and antidote

With Aspirin

- Belly pain or heartburn
- Very few interactions (low dose)

[Close](#)

SHARE-IT Beslutningsstøtteverktøy

Erfaringer fra direkte observasjon og intervjuer

- ✓ Brukermedvirkning direkte observert i alle interaksjoner hvor verktøyet ble brukt
- ✓ Pasientene rapporterer gjennomgående høy tilfredshet med verktøyet i å:
 - ✓ Forstå risiko and fordeler
 - ✓ Øke deres valgtrygghet
- ✓ Klinikere finner verktøyet nyttig & tiltalende
 - ✓ Element av positiv overraskelse
- ✓ Endret hvordan pasient og lege satt i forhold til hverandre



ANALYSIS



SPOTLIGHT: PATIENT CENTRED CARE

Decision aids that really promote shared decision making: the pace quickens

Decision aids can help shared decision making, but most have been hard to produce, onerous to update, and are not being used widely. **Thomas Agoritsas and colleagues** explore why and describe a new electronic model that holds promise of being more useful for clinicians and patients to use together at the point of care

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