receive treatments that match their goals and preferences. Decision Quality Instruments (DQIs) have been developed for 14 common medical decisions to measure the extent to which this happens and several publications describing their psychometric properties are available. A few centers have integrated DQIs into routine care to support clinical care, quality improvement and performance measurement. The purpose of this presentation is to summarize the experiences and lessons learned from using the DQIs.

Methods

Two academic medical centers in the US have integrated the DQIs into clinical care for treatment and screening decisions discussed in primary care, orthopaedics and oncology tertiary care. Data was collected on procedures for administration, topics, response rates, use of data and reporting. Interviews with site leaders and patient advisors elicited barriers and facilitators to use.

Results

Several thousand patients have completed the DQIs, most often after using a patient decision aid (PDA). The patient reported measures have been administered in clinic via tablet computer or paper survey, and outside the visit via computer, paper, or telephone. The DQIs in use are for cancer screening (prostate and colon cancer screening) and surgical decisions (hip and knee replacement, herniated disc, spinal stenosis, and breast surgery). The response rates vary by topic (20-60%), even with a reminder. Response rates tend to be higher in specialty care, compared to primary care. One center has incorporated the DQI results with other decision making (e.g. SURE test) and clinical data on a 1-page summary report for clinicians. For chronic diseases, patients have remarked that they would want to be able to update their answers to the goals and treatment preferences as the disease progresses; however at this point, neither site has incorporated repeated measurements.

Some barriers limiting use of the DQI measures include the need for integration with existing electronic medical records and patient registries, staff time to identify patients, administer surveys and enter data for paper based DQIs, and generating consensus on essential DQI questions to include. Facilitators promoting DQI use include having a clinical champion, ability to connect with collection of other patient reported outcomes in routine care, ability to generate visually appealing, real time summary reports, and linking to organizational initiatives around appropriateness.

Conclusion

DQIs are well tested measures that provide important information to guide clinical care decisions, and can be used to evaluate shared decision making and provider performance. A few organizations have integrated these into routine clinical care to support high quality, patient centered decisions.

Implementing CollaboRATE in primary care: an interim analysis

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Background and Aims

CollaboRATE is a short patient-reported measure of shared decision making (SDM), developed for use in routine practice. **Collabo**RATE consists of three items, scored on a 0–9 scale. The aim of this study was to assess whether **Collabo**RATE delivery mode affected response rate, representativeness of the respondent population, or **Collabo**RATE scores.

Methods

All adult patients visiting a primary care clinic in Lebanon, NH were eligible to complete **Collabo**RATE. **Collabo**RATE was delivered within 24 hours of the clinical encounter via one of five modes: 1) Paper in clinic, administered by staff; 2) Online patient portal; 3) Interactive voice response (IVR) call; 4) SMS text message; and 5) Tablet in clinic, administered by research assistant. Each mode was introduced for a period of three months, totaling 15 months of data collection beginning in April 2014. Demographic data for all patients were linked to **Collabo**RATE responses using electronic medical records. We calculated response rates, along with the proportion of completed surveys where a top score was achieved on all three items. Where a minimum of 25 responses was obtained, subgroup analyses of **Collabo**RATE scores were performed.

Results

We have fully completed mode 1 and mode 2 and anticipate completing modes 3 to 5 by September 2015. During mode 1, 542/4692 patients (11.6%, 95% CI 10.6%-12.5%) completed the survey. During mode 2, 1019/4939 patients (20.6%, 95% CI 19.5%-21.8%) completed the survey, including 1019/3015 patients with portal accounts (33.8%, 95% CI 32.1%-35.5%). The respondent population was adequately representative of the patient population on gender for both mode 1 (65.5% of both respondents and the clinic population were women) and mode 2 (68.8% of respondents and 65.1% of the clinic population were women). Respondents were older than nonrespondents in both modes, with respondents' mean age approximately 54 years (SD 16) in both modes, and mean nonrespondent ages of 47 years (SD 22) and 45 years (SD 22) in modes 1 and 2, respectively (mode 1: t=-9.283, p<0.001; mode 2: t=-7.933, p<0.001).

In mode 1, the average **Collabo**RATE top score was 80.8% (95% CI 77.5%-84.1%), ranging from 72.3%-93.2% per clinician. In mode 2, the average **Collabo**RATE top score was 71.2% (95% CI 68.5%-74.0%), ranging from 58.9%-82.8% per clinician.The rank order of clinicians by **Collabo**RATE score remained largely unaffected by mode.

Conclusion

While response rates for in-clinic completion were low, patient portal delivery was more promising. The basic demographics of respondents and nonrespondents were

similar and variation in **Collabo**RATE scores was observed across clinicians. Overall **Collabo**RATE scores were lower when collected via patient portal, suggesting a possible delivery mode effect. Understanding the challenges and impact of different forms of survey delivery will help guide future measurement implementation efforts in the field of SDM.

From Bariatric Surgery to Vasectomy: How Much Shared Decision Making Takes Place in Routine Health Care?

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Background and Aims
There is limited evidence on the prevalence of shared decision making in routine health care, due in part to an historical paucity of valid and scalable measurement tools. We sought to address this gap in knowledge by examining patterns of shared decision making across diverse clinical settings in England, as reported by patients. We also sought to examine associations between shared decision making and both patient characteristics and patient decisional conflict.

Methods
A one-page paper survey was administered to patients on exit from the clinical encounter in 27 clinical teams in England. The survey contained CollaboRATE, a three-item measure of shared decision-making; SURE, a four-item measure of decisional conflict; and items assessing patient age, gender, educational attainment, and language spoken at home. Additionally, the clinical team and appointment date were recorded on each completed survey by a staff member. In each clinical team, the survey was administered for up to one year, with periodic data feedback provided to stimulate learning and practice improvement.

Results
Altogether, 5167 patients responded to the survey and provided complete data on CollaboRATE. At the outset of the project, the proportion of patients in each clinical team that reported shared decision making ranged from 4.0% to 96.0%. At the end of the project, the proportion ranged from 40.0% to 100.0%. The presence of shared decision making was associated with patient age, educational attainment, and language spoken at home, but not with patient gender. The presence of shared decision making was also associated with lower rates of patient decisional conflict.

Conclusion
This implementation study demonstrates the feasibility of assessing shared decision-making in routine health care if care is taken to choose suitable measures. The findings show that there is considerable variation in the level of shared decision-making across experienced by patients receiving care from different clinical teams in England. The findings also highlight that providing feedback on patients' experiences of shared decision-making, together with complementary training and support, has potential to stimulate improvements in shared decision-making.

ORAL 19 – Integrated Session: Respiratory Disease

Shared Decision Making for Acute Respiratory Infections in Primary Care: A Cochrane Systematic Review and Meta-analysis

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Introduction/Aim
Shared decision making is an important component of patient-centred care, and encompasses a set of communication and evidence based practice skills that elicits patients' expectations and clarifies any misperceptions, and discusses the best available evidence for benefits and harms of treatment. Acute respiratory infections are one of the most common reasons for consulting in primary care. Antibiotics are frequently prescribed despite offering marginal benefits, exposure to possible harms, and contributing to antibiotic resistance. We aimed to assess whether shared decision making reduces antibiotic over-prescribing for ARIs in primary care.

Methods
We searched electronic databases (CENTRAL, MEDLINE, Embase, Web of Science); and other published, unpublished or ongoing trials by searching bibliographies of published articles, personal communication with key trial authors and content experts, and trial registries (National Institutes of Health, World Health Organization). Randomised controlled trials (RCTs) which evaluated the effectiveness of shared decision making (as the focus or a component of the intervention) in reducing antibiotic prescribing for ARIs in primary care were eligible for inclusion. Two review authors independently extracted and collected data. Antibiotic prescribing was the primary outcome, and secondary endpoints included re-consultations, hospital admissions, mortality, and patient satisfaction. We assessed the risk of bias of all included trials.

Results
Ten published reports of 9 original RCTs were eligible for inclusion. Meta-analysis was conducted using a random effects model and heterogeneity formally assessed. Shared decision making significantly reduced antibiotic use for ARIs in primary care compared with usual care (OR 0.44; 95% CI (0.25 to 0.74); RR 0.62; 95% CI (0.46 to 0.83; MD -10.60; 95% CI (-18.96 to -2.33)). Reductions in antibiotic prescribing occurred without increase in