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Shared Decision Making in the Clinical Practice

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Shared Decision Making in the Clinical Practice

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Abstract

Patient non-adherence continues to be a challenge for healthcare providers. Studies indicate that 25-50% of the patients are not adhering to recommendations.\textsuperscript{1,2} Communication is an important component that can facilitate or hinder patient adherence.\textsuperscript{1,2} Partly due to Healthcare Reform efforts, healthcare systems across the nation are implementing new initiatives to improve care delivery and meeting growing expectations. This presentation introduces the concept of shared decision making as a new approach to medical practice to improve provider-patient communication in order to enhance patient adherence, patient satisfaction, and quality of care.
Learning Objectives

By the end of this presentation, you should be able to:

1) Identify the key elements of shared decision making

2) Understand the process of shared decision making

3) Describe easy strategies to incorporate shared decision making in daily clinical practice
Introduction

- 1950s Paternalistic Medical model\(^3\)
  - Patient should not be told of their cancer diagnosis

- Information Age with the invention of World Wide Web takes us toward consumerism
  - Encourages early detection and patient education
  - Patient-centered care (autonomy)\(^4\)

- 2010 Healthcare Reforms\(^5\)
  - Affordable Care Act - Shared decision making (SDM)
What is SDM?

- Integrated model between paternalism and consumerism\(^6\)
  - Interactive deliberative process\(^7\)

- Two key components\(^6\):
  - Information exchange
  - Involvement of both parties in the decision making process

- While healthcare providers are expert of the disease, patients are expert of their conditions\(^8\)
How to Share?

- **Using decision aid**
  - Can be in variety of formats (handout, video, interactive website, etc.)
  - Outlines different options available
  - Facilitate conversation between provider and patient
  - **NOT** meant to replace professional judgment of a healthcare provider
  - See sample decision aids
    - Ottawa Hospital Research Institute: list of decision aids by health topic [https://decisionaid.ohri.ca/Azlist.html]
    - Mobility devices and shower chairs handout

- **Good coaching skills**
  - use of active and reflective listening
  - open- and close-ended questions
  - verbal language and nonverbal signals adjusted to patient’s age, educational level, and culture background
  - nonjudgmental and respectful attitudes
Why SDM?

- Non-adherence can lead to\textsuperscript{11,12,13}
  - Decrease the effectiveness of treatment
  - Increase overall healthcare costs
  - Negative outcomes such as increased risks of morbidity, mortality, emergency visits, and re-hospitalizations.

- The Commonwealth Fund 2001 Health Care Quality Survey indicated\textsuperscript{15}
  - 39% of patients disagree with their providers
  - 25% indicated that the instructions were hard to follow
  - 20% felt that the recommendations were against their personal beliefs
  - 7% did not understand at all

- SDM leads to greater patient satisfaction, patients are better educated, and higher patient adherence\textsuperscript{18,19}
When is SDM Appropriate?

- Ongoing cyclical process
  - Doctor’s office, hospital, patient’s home, etc.\(^2^0\)
  - Screenings, interventions, lifestyle changes, etc.\(^2^0\)

- When there is more than one option with equal amounts of evidence supporting each option
  - i.e. stroke rehab (Neurodevelopmental therapy, functional electrical stimulation, constraint-induced movement therapy, mirror therapy, etc.)

- When it is a preference sensitive case\(^2^0\)
  - the significance of the risks and benefits for each treatment options are based on the person’s value

- SDM is NOT appropriate when there is a robust medical protocol\(^2^1\)
  - such as using antibiotics to treat infections, sternal precaution after open heart surgery
What does SDM looks like?

The process of shared decision making:

Phase 1
- Information
  - Define the problem
  - Already know
  - Need to know

Phase 2
- Exploring Options
  - Option 1
  - Option 2
  - Option 3
  - Option 4
- Decision
  - Patient’s Values and Preferences
  - Benefits/Pros
  - Risks/Cons

Phase 3
- Implementation
  - Review
  - Questions
  - Next Step(s)
  - Follow-up

Renegotiation
Readjustment
Phase 1: Information

- Define the problem
  - What are some of your goals with us?
  - “I see that you are having trouble walking. Is that something you would like to work on?”
  - “I had to help you lift that leg into the tub today. Did you have trouble before?”

- Determine what information needs to be shared and how to best share it
  - “What do you know about occupational therapy?”
  - “Did you have therapy before?”
Case study: Part 1

Anna (OT): Hi, David. My name is Anna from occupational therapy. How are you doing today?
David (pt): Fine.
Anna (OT): Do you know anything about occupational therapy?
David (pt): No, but I heard of it. Is it like physical therapy?
Anna (OT): Yes and no. We are similar to physical therapy. And our therapy sessions may look similar. But our schooling and our focuses are different. At this hospital, physical therapy focuses more on mobility, like walking, going up and down the stairs, getting in and out of the bed. Occupational therapy focus more on taking care of yourself. So things like bathing, dressing, going to the bathroom.
David (pt): Okay.
Anna (OT): Well, this morning, we are scheduled for a shower. So that I can see how you’re moving, what you can do, and what we need to work on. Did you bring any of your own clothes with you? Would you like to change into your own clothes or do you want to wear the hospital clothes?
David (pt): I have my own. It’s in the closet over there.
Anna (OT): You told me that you have a tub shower at home, so we’re going to use the tub today. I put a chair in there for you.
David (pt): I don’t have a chair at home. Will I need to buy this chair when I go home?
Anna (OT): I don’t know if you will need this particular one. There’re different styles, like this one that fit inside the tub or that one which doesn’t have a back rest. You probably will need something to sit on. This is your first shower after the surgery, that’s why I picked this bigger one for safety. You will get stronger everyday. As it gets closer to the date you’re going home, we will take a look at this again to see which chair will be best for you.
David (pt): Okay.
Anna (OT): Now, can you take off your socks, so they won’t get wet.
David (pt): I can’t reach it. Can you help me?
Anna (OT): Sure. Were you able to do this before?
David (pt): Oh yeah. But my hip is really sore right now. I don’t think I can do this today.
Anna (OT): Do you usually wear socks at home? Is this something you would like to work on?
David (pt): Well, I don’t wear socks at home. Only when I go to the doctors.
Anna (OT): Okay.

Name: David
Age: 86
Dx: Lhip fx s/p ORIF
PLOF: (I) with no device

Comment:
- Retired mechanic
- Solo liver
- Lives in a single-story house
- Has 4 steps at the front entrance with L railing, tub/shower combo
- Has 1 daughter that can provide limited (A)
- Goal: to return home
It is very important for healthcare providers to facilitate this mutual partnership from the beginning.
Phase 2: Decision

- Exploring options (use a decision aid): Weighing the risks and benefits & eliciting patient preference
  - “What matters to you most?”
  - “What is most important to you?”
  - “Is there anything you definitely don’t want to do?”

- Determine patient’s role in decision making
  - “How would you like to go about making the decision?”
  - “Would you like to hear about all the different option first?”
  - “Would you like to hear about my recommendation?”

- Indicate the need for a decision or deferment to next time
  - "What do you think of all the options that we just went over?"
  - "Do you want to think about it before making the decision?"
  - "Would like to discuss this with your family or friends?"
Jill (PT): David, you look good with the walker. I think you can go home soon.
David (pt): I hope so.
Jill (PT): Do you have a walker at home?
David (pt): No. I don’t think a walker will fit around my house. I have too much stuff around.
Jill (PT): Can you clear out some of the stuff to make room for the walker?
David (pt): No, no, no. I need those things.
Jill (PT): Ok. We’ll need to decide what the best and safest way for you to get around in your house. Here take a look at this.

[Jill hands to David the decision aid which outlined the different types of mobility devices and briefly goes over each one.]

Jill (PT): So how do you feel about each one?
David (pt): I like the cane, it’s small and easy to carry around.
Jill (PT): Like we discussed, the cane requires more skills and gives you less support than the walker. I think you will do okay with the cane, but you may need to stay longer to get stronger and more practice with the cane. Is that okay with you?
David (pt): I don’t mind staying longer. I prefer going home with the cane.
Many providers do not inquired about patient’s preference and often make assumptions without asking.²³,²⁴
Phase 3: Implementation

- Clarify each other’s understandings about the decision
  - “I just want to make sure that we are on the same page.”
  - “We have talked about A, B, and C. And we decided to go for C because of X, Y, and Z.”
  - “You wanted to discuss this with your husband before making this decision, so we decided to defer this to next Wednesday at your next appointment, right?”

- Provide opportunity for questions

- Develop a plan of action
  - How to best carry out the decision

- Arrange for a follow-up
  - Assess outcome = goal met?
Jill (PT): Okay, I just want to make sure we are on the same page. The walker will not fit around your house and you don’t want to move things around. So we decided on using a cane, which you’ll agree to stay longer to get good with the cane.

David (pt): Uh-huh.

Jill (PT): Do you have any questions for me?

David (pt): Yes, does my insurance covers the cane? Or do I need to buy it on my own?

Jill (PT): I can order a cane for you through insurance. But most insurance only covers one device for every 5-10 years. Which means, if you needed a walker or wheelchair in the near future, you may not get it, because you already used your coverage for the cane.

David (pt): Okay.

Jill (PT): You can also buy a cane for about $40 in the store and save the “coverage” in case you need a walker or a wheelchair in the future. Hopefully you won’t need those.

But just in case.

David (pt): I think I can buy one. I’ll ask my daughter to pick up one from the store.

Jill (PT): Okay, so I won’t order a cane for you. And we’ll start practicing with the cane in therapy. But on you own, I still want you to use the walker. I will let Anna know to start using the cane with you too.

David (pt): Alright.

Jill (PT): If you change your mind and want a walker instead, just let me know. I will see you tomorrow.

Sometimes the outcomes are not as expected, in which readjustment and renegotiation may be needed.
The Process of Shared Decision Making

Phase 1
Information
- Define the problem
- Need to know
- Already know

Phase 2
Exploring Options
- Patient’s Values and Preferences
  - Option 1
  - Option 2
  - Option 3
  - Option 4
- Benefits/Pros
- Risks/Cons

Phase 3
Making a Decision
Implementation
- Review
- Questions
- Next Step(s)
- Follow-up

Renegotiation
Readjustment
Conclusion

SDM is an interactive deliberative process between the healthcare provider and the patient. The involvement of both parties is necessary to determine the best option that meets the unique needs of the patient.
Shared decision making in Mental Health

Mental health professionals recognized the positive effects of SDM (consumer empowerment, higher patient adherence, right to autonomy), only if consumers have the cognitive capacity to make an informed decision.

Mental health professionals suggested using SDM on an individual basis due to the concern of consumers having a lack of “insight.”

The concept of SDM is also different:

- Description includes: acknowledging consumers' values and preferences, informing them of interventions, but not much involvement with decision making.

Reference:
Shared decision making in Pediatric Care

There’s seem to be a lack of unison in terms of who are responsible for decision-making.

- The parents pointed to the providers as the dominant decision maker and identified self as having little or no say unless pain, distress, or other interferences was observed.
- The providers referred to the parents as the ultimate decision maker, as they are the ones who carries out the recommendations (or not). Providers do agreed that they have more control over allocation of resources such as extending or discharging the child.
- The child also expressed that they also have little input in the decision making process as they see the providers as the expert; however, they do provide information to influence the decision, such as receiving more rest breaks when fatigue is expressed.

Reference:
Shared decision making with people with aphasia

To facilitate shared decision making, the health care providers need to:

- Assess whether patient has decision making capacity as a team
- be knowledgeable about aphasia and familiar with the patient (SLP can often facilitate)
- Provide communication access with the following techniques:
  - Simplifying the language used (short sentences, simple grammar, pausing between key phrases)
  - Repeating key concepts
  - Incorporating both closed-ended and open-ended questions
  - Using non-verbal communication (gesture, diagrams, and models)
  - Writing key works for emphasis
  - Responding to the cues from the individual
- Involve “a helper” (who is familiar with the patient’s values and preferences) if available
  - If possible, the patient should be the one to identify his/her helpers
  - The helper’s only role is to ask questions on behalf of the patient
  - The patient has the final decision, not the helper

Reference:
Discussion:

- How often do you elicit problem areas from your patients? Share your strategies.

- Have you encountered situations that are appropriate to implement shared decision making? Please explain.

- Understanding that changes are difficult. How has learning about shared decision making changes your ways of practice? (Or no change at all.)
Questions?
References


Resources

Center for Shared Decision Making
www.patients.dartmouth-hitchcock.org/shared_decision_making.htm

Cincinnati Children’s: James M. Anderson center for Health Systems Excellence
www.cincinnatichildrens.org/service/j/anderson-center/evidence-based-care/shared/

e-Learning for Healthcare: Shared Decision Making
www.e-lfh.org.uk/programmes/shared-decision-making

Health Dialog
www.healthdialog.com

Informed Medical Decisions Foundation
www.informedmedicaldecisions.org

MaineHealth: Shared Decision Making Resource Center
www.mainehealth.org/mh_body.cfm?id=7843

Mayo Foundation for Medical Education and Research – Shared Decision
www.shareddecisions.mayoclinic.org

NHS England: Shared Decision Making
www.england.nhs.uk/ourwork/pe/sdm

Society for Medical Decision Making
http://smdm.org/
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Thank you!

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