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Room 124

Shared Decision-Making (SDM) in a Surgical Clinic Setting: Adoption Through Implementation

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BACKGROUND: Effective communication is a key ingredient of safe high quality health care. Shared decision-making (SDM) is a collaborative decision-making process between the patient and provider for preference-sensitive treatment decisions. The goal of SDM is to empower patients to participate as active partners in their health care decisions.[1] We implemented SDM in two orthopedic spine surgery clinics.

METHODS: Adoption of SDM was approved by stakeholders. Patient activation brochures and decision aids were developed, adopted, and disseminated. Pre-implementation patient surveys assessed baseline SDM elements in routine practice. SDM education and training materials were developed and used to train providers. Providers were assessed with observation plus self-assessment surveys during training. Tools developed plus lessons learned from implementing and training for SDM in two orthopedic surgery specialties were used to create an SDM Training Toolkit.

RESULTS: Barriers to SDM implementation included adoption and dissemination of patient activation materials and decision aids, concern for increased time commitments, provider's belief they were already doing SDM, and entrenched clinic procedures (Table). Pre-implementation patient surveys suggested that providers explained patient condition(s) in 93% of cases but they failed to tell patients there was >1 treatment choice (23%), to discuss pro's and con's of choices (25%), and elicit patient preference (26%) during clinical encounters. Trainer observation and provider self-assessments of clinical encounters during implementation suggested that the SDM elements most overlooked were seeking input from others (65%), establishing patient role in decision-making (53%), teach back (42%), and eliciting patient preference and communicating uncertainty (24% each) (Figure). The SDM "Train-the-Trainer" Toolkit developed to overcome training barriers and disseminate the training methodology includes an instructor guide plus eight "tools" to be used as part of the training process. The eight "tools" consist of a teaching guide, provider reminder pocket card, SDM elements cue poster, patient activation pamphlet, assessment checklist, SDM implementation recommendation and troubleshooting guide, external resource list, and an evaluation survey.

DISCUSSION: Providers do not routinely include all elements of SDM during clinical encounters. Successful implementation of SDM requires a complete process to engage stakeholders, identify barriers, and develop interventions to overcome barriers. The SDM "Train-the-Trainer" Toolkit was developed to address the need for an implementation, training and

assessment model that could be used to adopt SDM across a variety of settings. The "Toolkit" was used successfully in the process of adopting SDM in two orthopedic surgery clinics.

Reference

1. Charles C, et al. *Soc Sci Med* 1997;44(5):681-92

Figure 1

Table: SDM Barriers

Adoption Barriers	Implementation barriers

Decision Aids:
• Disagreement on content
  ▪ Scientific quality of evidence
  ▪ "One size does not fit all"
  ▪ "My outcomes are different"
  ▪ "Risks will unnecessarily scare patients"
• Conflict with existing patient education materials
• Production and dissemination costs
• Institutional approval
 	
Providers:
• Increased clinic time
• Believe already doing SDM
• "Treatment options are not always appropriate"
	Decision Aids:
	• Mailing to patient before visit
	• Availability during visits
	
	Provider Training:
	• Scheduling in busy practice
	• Providers have deeply ingrained scripts
	• Pocket "reminder cards" rarely used
	• Displaying SDM posters in exam rooms
	• "On-the-fly coaching" hampered by busy practice
	• Resident turnover
	
	Clinic Procedures:
	• Bureaucracy
	• Varying institutional policies in each clinic
	• Varying staff responsibilities

Figure 2