



Expert and patient consensus on a dynamic model for shared decision-making in frail older patients



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ABSTRACT

Objective: Shared decision-making (SDM) is widely recommended as a way to support patients in making healthcare choices. Due to an ageing population, the number of older patients will increase. Existing models for SDM are not sufficient for this patient group, due to their multi-morbidity, the lack of guidelines and evidence applicable to the numerous combinations of diseases. The aim of this study was to gain consensus on a model for SDM in frail older patients with multiple morbidities.

Methods: We used a three-round Delphi study to reach consensus on a model for SDM in older patients with multiple morbidities. The expert panel consisted of 16 patients (round 1), and 59 professionals (rounds 1–3). In round 1, the SDM model was introduced, rounds 2 and 3 were used to validate the importance and feasibility of the SDM model.

Results: Consensus for the proposed SDM model as a whole was achieved for both importance (91% panel agreement) and feasibility (76% panel agreement).

Conclusions: SDM in older patients with multiple morbidities is a dynamic process. It requires a continuous counselling dialogue between professional and patient or proxy decision maker.

Practice implications: The developed model for SDM in clinical practice may help professionals to apply SDM in the complex situation of the care for older patients.

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1. Introduction

Shared decision-making (SDM) is widely recommended by many professionals as a way to support patients in making healthcare choices [1–4]. In SDM professionals and patients share their knowledge, values and preferences about healthcare choices and, together, they explore beneficial solutions. Thereby, final decisions will be more congruent with patient preferences. SDM is fundamental to informed consent and patient-centred care, it increases patients' and professionals' satisfaction, improves quality of life and clinical outcomes, and also creates a stronger doctor–patient relationship [5].

In recent years, a large number of studies have been conducted on methods for implementing SDM in medical settings [6]. Elwyn et al. developed one of the best known models for SDM, in which three phases are distinguished: (1) 'choice talk', exchanging information and announcing that a decision must be made, (1) 'option talk', discussing various treatment options, including benefits and harms, and (1) 'decision talk', reaching a decision together, based on patients' informed preferences [2]. This model is particularly helpful accomplishing preference-sensitive treatment decisions in the medical curative setting, especially for patients with a single condition, and with a limited number of preference-sensitive treatment options, such as breast or prostate cancer. The decision making process only then starts after completing the diagnostic phase, it is confined to the treatment phase of the consultation.

Due to an ageing population, the number of patients with multi-morbidity and impairments will increase, which complicates patient management [7,8]. Moreover, in complex care

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situations for older patients with multi-morbidity, a goal-oriented approach towards shared decision-making is more advisable than the traditional disease-oriented and technology-focused approach [9–12]. In a goal-oriented approach the focus lies on the patient's most pressing issues, rather than on the underlying diseases. However, physicians are often overwhelmed by the complexity in caring for frail older patients [13,14]. This process is complicated, because most guidelines are not developed for this patient category, standardised diagnostics or treatments are seldom available and life expectancy may be short [11,15,16]. Relatively little research has focused on SDM in chronic conditions [17,18]. Besides this, most research on SDM is focused on applying SDM in the second half of the consultation, when treatment options are considered [1,4,19,20].

For starting a decision-making process in frail older patients, prioritising the most urgent problem is essential. Furthermore, the decision-making process can start as early as the diagnostic phase and must be tailored to the patients' personal situation [13,14,21]. Moreover, it is known that participating in SDM can be difficult for more vulnerable patient categories and information should be tailored to their specific needs and personal situation [12,22–26]. Therefore, existing models for SDM – that are developed for medical treatment decision making about a single condition – are difficult to apply in frail older patients with multi-morbidity and complex care situations.

The aim of this study was to develop and gain consensus for a model for SDM in frail older patients with multi-morbidity. To this end, a model was developed based on the model of Elwyn et al., the existing literature about shared decision-making with vulnerable patient groups and the experiences of physicians in the consulting room [2,6,9–11,14,21]. The model was presented to an expert panel using a Delphi study design. This paper reports the views of the expert panel and the resulting consensus on a model for SDM in frail older patients with multi-morbidity.

2. Methods

Between May 2014 and January 2015, a Delphi study was conducted to reach consensus on a developed model for shared decision making in frail older patients [27,28]. The Delphi method has been used widely in health research to obtain consensus on a

given issue, especially when scientific knowledge is lacking. It consists of several questionnaires or 'rounds' which are sent to experts to collect information about a specific issue to reach consensus or gain understanding. Questionnaires are filled in anonymously and individually to avoid domination of the consensus process by one or a few experts. The definition of 'expert' in this method is related to theoretical knowledge, as well as knowledge from experience. The results from each round were summarised and a next questionnaire was developed, based on the most important results of this round. Rounds were held until consensus was reached [29,30].

2.1. 1 A model for shared decision making in frail older patients with multi-morbidity

A model was developed based on the model of Elwyn et al., the existing literature and the experiences of physicians in the field of elderly care, geriatrics and SDM [2,6,9–11,14,16,21]. Physician experiences were gathered by a researcher (MvdP) through discussions with physicians (self-report of consultation behaviours). The model started with a preparatory step to identify the preferred role of the patient in the SDM-process and to prioritise problems (Table 1).

2.2. The Delphi panel: patients and professionals

For the expert panel in this study, 16 patient experts (round 1) and 59 professional experts (rounds 1–3) were invited to participate. The patient group consisted of ten home-dwelling and six elderly care home patients aged over 65 years, without cognitive impairments. The multiple morbidities burden of the patients was classified by calculating their age-adjusted 'Charlson Comorbidity Score' (CACI score). CACI scores assign different weights to patients' comorbidities. The higher the score, the frailer the patient is. Scores of ≥ 3 are related to high mortality rates [31,32]. Professional experts were healthcare professionals active in the field of geriatrics and care for older persons, SDM research, medical education, or a combination of these.

All patients came from the Netherlands. The professionals were from Europe and North-America/Canada.

Table 1
Concept model for shared decision making in older patients with multiple morbidities.

Phase	Step
Preparation (Preparation talk)	<p>Preliminary work: History. <i>Has the patient previously discussed or documented anything with regard to treatment in general or on specific issues (e.g. resuscitation)?</i></p> <p>Preliminary work: Problem analysis by the care professional. <i>Have all the patient's problems been outlined sufficiently? How do these problems relate to the problems about which a decision must be made?</i></p> <p>Start the conversation. During the conversation, identify the role of your discussion partner and any observers. <i>Which roles would the patient and the physician like to have in the decision-making process? Who will make the decisions in this conversation (patient, representative/caregiver, doctor)? Is an observer present (e.g. nursing auxiliary, other relatives)?</i></p> <p>Ask about outlook on life and perceptions. <i>What role does outlook on life, beliefs or faith, play in the decision-making process? How does the patient perceive this conversation?</i></p> <p>List the possible treatment and other objectives, including those not specifically medical in nature (e.g. in the area of well-being). <i>Independence, living arrangements, health-related objectives, people with chronic illness: altered perspective</i></p>
Announcing the choice (Choice talk)	State that a decision must be made. Offer choice for the problem at hand and provide justification for them. Assess how the patient reacts to the choice of options, and support the patient in weighing the options.
Discussing the options (Option talk)	Check to determine what the patient has understood from the discussion, up to this point, and use the preceding steps to compile a list of treatment options (taking into account the identified (treatment) objectives). Describe the treatment options, including the advantages and disadvantages, using decision aids (if available). Provide a summary of the treatment options.
Deciding (Decision talk)	Focus on the preferences of the patient and make a decision with the patient/representative. Prepare a treatment plan based on this decision.

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