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Interprofessional SDM train-the-trainer program "Fit for SDM": Provider satisfaction and impact on participation

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ABSTRACT

Objective: The aim of the study was to evaluate the interprofessional SDM training program "Fit for SDM" in medical rehabilitation, which was implemented in two steps: (1) university staff trained providers in executive positions as trainers and (2) the providers trained their staff.
Methods: For the evaluation of the first step a questionnaire for shared decision-making (SDM) skills and satisfaction with the training was completed by the providers in executive positions. A staff survey was used in a cluster-randomized controlled study to determine the overall impact of the train-the-trainer program on internal and external participation in the team.
Results: The providers in the six clinics evaluated their SDM competences and satisfaction very positively after training (step 1). External participation was enhanced by application of the training content, with significant changes recorded for females and nurses in particular. However, it had no direct influence on internal participation.
Conclusions: This is the first interprofessional SDM train-the-trainer program in Germany to bridge interprofessionalism (internal participation) and SDM (external participation); it was implemented successfully and evaluated positively.
Practice implications: Establishing interprofessional SDM training programs should be encouraged for all health care professionals. Implementation in the interprofessional setting should consider interprofessional team factors.

1. Introduction

1.1. Training programs for shared decision-making

According to the current environmental scan by Légaré et al. [1], 54 training programs were developed for implementing SDM in medical care between 1996 and 2011. Most of these are for physicians and medical-related decisions [1–10], with only a few approaches geared to other professional groups, e.g. nurses [11], occupational therapists [1] or more than one professional group [12–14]. Légaré et al. [1] identified six training schemes designed for more than one health care professional field, but which do not explicitly concentrate on interprofessional aspects, e.g. participation or decision-making in the team. For those six there are no evaluation results available. This lack is also reflected in the fact that evaluation results were reported for only 17 of the 54 identified training programs [1].

Available evaluation of SDM interventions has shown that training is an effective way to facilitate the SDM approach in medical care [5,6,10,15–18]. Lewin et al. [19] could detect strong evidence in favor of interventions which aimed to enhance patient-centered communication in patient–provider interaction, with frequent improvement in patient-centered communication and patient satisfaction. Fewer studies indicated an improvement in health status [6,19–21], while studies concentrating on training of allied health professionals showed positive patient satisfaction as well as positive effects on quality of health care [11,22].

1.2. The interprofessional training program "Fit for SDM"

For chronic diseases requiring interprofessional treatment, it is essential to link interprofessionalism (internal participation) and SDM (external participation) in a new model of interprofessional SDM. In the original model the decisions focus on medical aspects, whereas in the adapted version the field of decision is extended to treatment decisions, organizational and team decisions. While the

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Table 1
Comparison of the original SDM model with the adapted SDM model for the interprofessional context.

	SDM model	Adapted SDM model
Focus of decisions	Medical aspects	Treatment (medical, psychological) aspects, **organizational and team aspects**
Setting	Patient–physician dyad	Patient–physician dyad **Interprofessional team**
Levels of participation	Micro (patient–provider interaction)	Micro (patient–provider interaction) **Meso (team)** **Macro (clinic)**
Participation form	External participation	External and **internal participation**

setting of the initial model is for patient–physician dyad, in the adapted model the interactions are interprofessional. The original SDM model only considers the interaction between patient and provider (micro-level of the health care system). In contrast, the adapted model concentrates on the meso (team) and macro (organization) level in the health care system. Participation in the first model is purely external, and in the adaption both external and internal. External participation is the sharing of treatment planning and decision-making with the patient in the sense of shared decision-making, whereas internal participation means the involvement of health care professionals within the interprofessional team in treatment planning for patients (teamwork and team decision-making). Table 1 compares the original SDM model with the adapted SDM model.

Based on this adapted SDM model, our research group developed a training program consisting of two training modules. Module 1 focuses on external participation (shared decision-making in patient-provider interaction) and mainly follows the existing German SDM training from Bieber et al. [2]. Priorities arising from the results of the pilot study are investigation and establishment of the patient's understanding and expectations, empathy and respect [23]. The main focus of Module 1 is to instruct the future trainers in SDM on a step-by-step basis. The trainers begin by explaining the interaction model of SDM in contrast to the paternalistic and informative model, and present the process, characteristics and effects of SDM. Participants are then familiarized with the core nine steps: (1) disclosure to the patient that a decision needs to be made, (2) formulation of equality of partners, (3) presentation of treatment options, (4) informing on the options, benefits and risks, (5) investigation of understanding and expectations, (6) identification of both parties' preferences, (7) negotiation, (8) shared decision, (9) arrangement of follow-up, with compiling phrases for each step and role play facilitation for participants to practice the skills recently learned. The participants are also given the task of applying the SDM approach with their patients in the week between Module 1 and Module 2.

Module 2 was developed from scratch. Key areas elicited through a survey of experts are: communication and cooperation in the team, moderation of team processes, feedback, talking with difficult team members, as well as tools for communication and decision-making. Module 2 was specially designed to transfer SDM to the decision-making processes in the treatment team and to prepare the executives for their role as trainer. Once the various steps of SDM had been reinforced through discussion of participants' practical experience when applying it in medical encounters, the expanded model of SDM and the model of integrated patient-centeredness were introduced. Here the trainer function and tools for the trainer were discussed, with the main emphasis on transfer from the SDM model to the leadership style (participatory leadership), communication, cooperation and decision-making in the team and advantages for treatment, staff and organization.

1.3. Aim of the study

The study aimed to evaluate the interprofessional shared decision-making (SDM) training program "Fit for SDM" in two steps. First, the executives were asked to appraise their satisfaction with the training and their SDM competences. Second, the providers (professionals working in the patient care team in the medical rehabilitation clinics) were questioned regarding external and internal participation.

Central questions that will be addressed in the present paper are:

- How did the executives evaluate their SDM skills, satisfaction with the training and preparation as a trainer?
- Did the training enhance internal and external participation for the providers in the rehabilitation team?

2. Methods

2.1. Study design

In step 1 the university project team trained the providers in executive positions in the clinics as trainers, who then in step 2 trained their staff in the health care team. After the training of the trainers (step 1) an evaluation sheet was completed by the participants at the end of each training session (cross-sectional study, see Section 2.1.1), and a multi-center cluster-randomized controlled study was conducted for evaluation in step 2. Here, a staff survey measured participation in the intervention and control groups before and after the training process (see Section 2.1.2).

Clinics were clustered in two groups (intervention and control), based on the indication field and size of clinic. The clinics in the control group could choose between actual training and receiving the training slides/manual after the implementation and evaluation process. The study was approved by the Ethics Committee of the University of Freiburg.

2.1.1. Step 1: Measures for satisfaction and SDM competences

Satisfaction with training (step 1) was assessed using two different scales:

1. *satisfaction with content* (six items, e.g. The training content contributed to gaining more insight and knowledge, The training content was new for me),
2. *satisfaction with the trainers* (five items, e.g. The trainers were well prepared and organized, The trainers were keen for participants to succeed)

One scale measured self-evaluation of SDM *competences*. There were nine items for the evaluation of this aspect at the end of Module 1 (e.g. I am familiar with the concept of shared decision-making (SDM), I am familiar with the effects of SDM), and seven items at the end of Module 2 (e.g. I consider I am capable of training