



Medical Decision Making

Occupational therapists' shared decision-making behaviors with patients having persistent pain in a work rehabilitation context: A cross-sectional study



Marie-France Coutu^{a,*}, France Légaré^b, Dawn Stacey^c, Marie-José Durand^a,
Marc Corbière^a, Lesley Bainbridge^d, Marie-Elise Labrecque^a

^aHôpital CharlesLeMoyné Research Center and School of Rehabilitation, Université de Sherbrooke, Longueuil, Canada

^bCentre Hospitalier Universitaire de Québec Research Center, Hospital St-François d'Assise, Québec, Canada

^cSchool of Nursing, Faculty of Health Sciences, University of Ottawa, Ottawa Hospital Research Institute, Ottawa, Canada

^dUniversity of British Columbia, Vancouver, Canada

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ABSTRACT

Objective: In a work rehabilitation context, we assessed occupational therapists' (OTs) shared decision-making (SDM) behaviors with individuals having persistent pain and explored factors influencing SDM behaviors.

Methods: A cross-sectional study that used audio-recordings of work rehabilitation consultations between OTs trained in SDM and a convenient sample of patients. Eligible patients were: off work for ≥ 12 weeks due to persistent pain associated with a musculoskeletal disorder, starting a work rehabilitation program, and French speaking. Transcripts were analyzed using the Observing Patient Involvement in Shared Decision Making (OPTION) instrument and assessed patients' decisional conflict and socioeconomic status.

Results: Of 15 OTs trained in SDM, 11 (90% female), provided audiotaped SDM meetings with 37 patients (40.5% female; aged 18–62 years). Their average OPTION score was 53.94 out of 100 (SD = 9.68; range 35.42–70.83), indicating basic skills. Significant factors associated with OPTION scores ($R^2_{\text{adjusted}} = 21.7\%$) were the interview length ($p = 0.008$) and level of patient education ($p = 0.038$).

Conclusion: Basic SDM behaviors were integrated in the practice of OTs trained in SDM.

Practice implications: Evaluating SDM behaviors is a step toward providing OTs with performance feedback toward achieving client-centered care.

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1. Introduction

Shared decision-making (SDM) offers patients evidence-based options and involves making trade-offs [1]. SDM is a process between the patient and clinician where information is exchanged, preferences are expressed and discussed, goals and an action plan are agreed to, and the plan is assessed and readjusted after implementation [2]. A systematic review of the effects of SDM found a positive impact on patients' adherence, satisfaction, knowledge, and well-being when performed in the context of treatment programs [3].

To evaluate how extensively clinicians involve patients, SDM can be assessed using third party observers. A recent systematic review using a third-observer instrument, Observing Patient Involvement in Shared Decision Making (OPTION), assessed how extensively clinicians engaged their patients in decision-making in different medical contexts [4]. OPTION [5] was chosen for this review since it is the most frequently used instrument for measuring SDM skills and also the best third party observer for research studies [6]. In the systematic review, the authors analyzed 29 studies using OPTION and found low levels of patient involvement in various clinical contexts. Greater involvement was found when clinicians were trained in SDM [4]. In the review, half of the studies showed longer times for SDM meetings and higher OPTION scores. One study, in an oncology setting, had scores over 50 on a 100-point scale [7]. A clinician with a basic skill level for each item would obtain a score of 50. In Politi et al. [7], the observer's presence during consultations could introduce a bias as

* Corresponding author at: Centre for Work Disability Prevention and Rehabilitation, Charles LeMoyné Research Centre Affiliated with Université de Sherbrooke, 150 Place Charles LeMoyné, Longueuil, Québec J4K 0A8, Canada.

Tel.: +1 450 463 1835x61797; fax: +1 450 674 8537.

E-mail address: Marie-France.Coutu@USherbrooke.ca (M.-F. Coutu).

the physician might then take more time. Communication tools (e.g., decision aids) appear to increase clinicians' SDM behaviors [4]. Concerning other factors influencing SDM behaviors, Couët et al. [4] found no association between OPTION scores and the severity of the condition, in all of their studies. In 75% of the studies, neither gender nor patient age was associated with the OPTION scores [4]. The associations with decisional conflict yielded mixed results [6,8,9]. More educated patients may want to be part of the decision [9,10], better advocate for their needs, or be natural information seekers, but associations with clinicians' SDM behaviors yielded mixed results [11,12].

SDM was recommended for individuals with persistent pain secondary to MSD by the American Pain Society [13]. SDM could guide the process of complex trade-offs between potential harm, benefit, cost, and burden of available treatments. To the best of our knowledge, only one study (involving 13 physical therapists without SDM training) exists in this field. From 237 observed consultations, the mean OPTION score was 5.2 (SD = 6.8) out of 100, revealing a very low level of SDM, since a perfunctory level for each of the 12 items would yield a score of 25 [14].

We did not find any studies on SDM in work rehabilitation for persistent pain secondary to an MSD. Work rehabilitation involves several stakeholders beyond the patient and clinician, such as the third-party payer who provides wage replacement and decides on the type of rehabilitation program. In Quebec, injured workers have a legal right to rehabilitation [15], but the workers' compensation board makes referrals and pays for the intervention. Employers, who may be bound by a collective work agreement, are also important stakeholders, since they decide whether to accommodate the injured worker in the return-to-work process. Thus, SDM cannot occur only between the health care professional and worker. The option's feasibility based on the occupational therapist's (OT) initial evaluation with the worker, the insurer, and the employers' constraints and interests have to be known before making a shared decision.

More broadly, in the qualitative literature on work rehabilitation for persistent pain secondary to an MSD, workers often report uncertainty about decisions, feel pressured back into work [16], and do not perceive that they participate in decisions [17], even if SDM is generally recommended [18]. We believe that implementing SDM facilitated by patient decision aids could respond to workers' needs since it generally improves the decision-making process and the decision quality by reducing how uncomfortable an individual feels; in other words, individuals make informed values-based decisions [19]. However, because of the additional stakeholder roles in work rehabilitation, it is unclear if clinicians fully involve patients in decision-making.

Our objective was to assess the extent of OTs' SDM behaviors with individuals experiencing persistent pain in the context of work rehabilitation, where multiple stakeholders impact the return-to-work decision. We also explored factors influencing OPTION scores such as SDM length, decisional conflict, health condition, gender, age, and level of education. This study was part of a larger case study whose objective was to implement an SDM program adapted to the realities of work rehabilitation for workers suffering from persistent pain secondary to a musculoskeletal disorder (MSD).

2. Methods

2.1. Study design

We used a cross-sectional study of consultations in work rehabilitation programs with OTs trained in SDM and their patients. We chose a third party observer approach to assess the extent of OTs' shared decision-making (SDM) behaviors in the context of work rehabilitation for persistent pain. This method

allows direct observation of the clinical encounter by the research team; here, an audio recorder was used.

2.2. Participants and setting

We identified OTs and patients/workers from a convenient sample of private and public clinics in Quebec, Canada, where the primary language is French. The inclusion criterion for OTs was working full-time in work rehabilitation for MSDs for ≥ 2 years. We selected OTs because they conduct the initial diagnostic evaluation when a patient is referred to the rehabilitation center, and they are frequently the main health professional involved in the work rehabilitation process.

We aimed to recruit five patients per OT (40 patients), thus allowing them to become familiar with the SDM program, if necessary. Patient inclusion criteria were working age (between the ages of 18 and 64), French speaking, off work for ≥ 12 weeks due to persistent pain associated with an MSD, and starting a work rehabilitation program. We excluded patients with specific MSDs (e.g., recent fracture, metabolic disease, neoplasia, inflammation, or infection of the spinal column).

The ethics committee of the Hôpital Charles-LeMoine Research Center in Longueuil, Quebec, approved the study and all participants provided written informed consent. All affiliated research ethics committees of the participating rehabilitation centers approved the study protocol. The research project compensated the clinics for the loss of clinical activity during SDM training.

2.3. Training OTs in the SDM process

We used a theory-driven approach to develop the training program. Firstly, we used the program theory of our newly developed SDM model for individuals with persistent pain in a work rehabilitation context (for details on the SDM program in work rehabilitation see [20]). A program theory "explains why the program does what it does and provides the rationale for expecting that doing things that way will achieve the desired results (p. 165)" [21]. The program theory relates objectives of the SDM program (e.g., establishing a working alliance between the worker and health care professional) to specific activities (ex.: initial interview), human resources (ex.: OT), material resources (ex.: interview guide), indicators (ex.: health care professional solicits questions from the worker during SDM process), and measures to document the level of attainment (ex.: OPTION grid) [20]. Secondly, we evaluated training using a conceptual framework of the evaluation of inter-professional education [22,23]. It identifies the level of inter-professional outcomes targeted. Here, we chose SDM skills (level 2b). It includes the 3P model (Presage, Process and Product) that was used to establish the context of the training, teachers' characteristics, learners' characteristics, the approaches to learning and teaching, and the competencies that needed to be developed. Thirdly, using our SDM program theory, the research team of experts on working alliance, SDM and interprofessional collaboration determined the training objectives upon which the content and teaching strategies were developed. Three experts, in either working alliance research, SDM or conflict resolution, were consulted. These experts helped to identify active learning activities that have been successfully used in their fields to improve communication skills (e.g., role play and case studies), as well as the most essential training objectives required for each OT to carry out the SDM program theory. A training document was developed describing each training objective with the associated learning activities and time allowed.

The SDM training was held during working hours. We offered two series of interactive learning sessions with preliminary readings (11 h) in spring 2010 and 2011. During each series, three

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