ORIGINAL ARTICLE

MAYO CLINIC

# Fostering Choice Awareness for Shared Decision Making: A Secondary Analysis of Video-Recorded Clinical Encounters

Marleen Kunneman, PhD; Megan E. Branda, MS; Ian Hargraves, PhD; Arwen H. Pieterse, PhD; and Victor M. Montori, MD, MSc

## Abstract

**Objective:** To assess the extent to which (1) clinicians, using or not using conversation aids, foster choice awareness during clinical encounters and (2) fostering choice awareness, with or without conversation aids, is associated with greater patient involvement in shared decision making (SDM).

**Patients and Methods:** We randomly selected 100 video-recorded encounters, stratified by topic and study arm, from a database of 10 clinical trials of SDM interventions in 7 clinical contexts: low-risk acute chest pain, stable angina, diabetes, depression, osteoporosis, and Graves disease. Reviewers, unaware of our hypothesis, coded recordings with the OPTION-12 scale to quantify the extent to which clinicians involved patients in decision making (SDM, 0-100 score). Blinded to OPTION-12 scale scores, we used a self-developed coding scale to code whether and how choice awareness was fostered.

**Results:** Clinicians fostered choice awareness in 53 of 100 encounters. Fostering choice awareness was associated with a higher OPTION-12 scale score (adjusted [for using vs not using a conversation aid] predicted mean difference, 20; 95% CI, 11-29). Using a conversation aid was associated with a higher, nonsignificant chance of fostering choice awareness (N=31 of 50 [62%] vs N=22 of 50 [44%]; adjusted [for trial] $P$=.34) and with a higher OPTION-12 scale score, although adjusting for fostering choice awareness mitigated this effect (adjusted predicted mean difference 5.8; 95% CI, −1.3-12.8).

**Conclusion:** Fostering choice awareness is linked to a better execution of other SDM steps, such as informing patients or discussing preferences, even when SDM tools are not available or not used.

© 2017 Mayo Foundation for Medical Education and Research. Published by Elsevier Inc. This is an open access article under the CC BY-NC-ND license (http://creativecommons.org/licenses/by-nc-nd/4.0/) ■ Mayo Clin Proc Inn Qual Out 2018;2(1):60-68

From the Knowledge and Evaluation Research Unit, Mayo Clinic, Rochester, MN (M.K., M.E.B., I.H., V.M.M.); the Department of Medical Decision Making, Leiden University Medical Center, Leiden, the Netherlands (M.K., A.H.P.); and the Department of Medical Psychology, Academic Medical Center, University of Amsterdam, Amsterdam, the Netherlands (M.K.).

*Two roads diverged in a yellow wood,*
*And sorry I could not travel both*
—Robert Frost "The Road Not Taken"

The recognition that care should be patient-centered and that patients should be involved in their care is growing. This is considered particularly pertinent when more than one reasonable approach is available to manage the patient's situation (including doing nothing else) and when these approaches differ in ways that matter to these patients.[1-3] In shared decision making (SDM), clinicians and patients work together to figure out how to best address the patient's situation and to make decisions about health and care that fit each patient and their lives.[4] Most SDM models distinguish 3 key steps before reaching a decision: (1) creating choice awareness, (2) discussing the relevant options, and (3) discussing patient preferences.[2,3,5] To date, most SDM research and implementation, including the efforts to develop, test, and implement SDM tools, have mainly focused on the second and third steps of SDM and on making the final decision. Nevertheless, the first step of creating choice awareness—that is, acknowledging that the patient's situation is mutable and that there is more than one sensible way to address or change this situation—is considered pivotal.[2]

Creating choice awareness may engender subsequent steps of SDM, alerting patients that decisions about their health or care are about to be made and that these decisions require their input insofar as these decisions should reflect what matters to patients. Adequate choice awareness could therefore potentially lead to better or

 ■ © 2017 Mayo Foundation for Medical Education and Research. Published by Elsevier Inc. This is an open access article under the CC BY-NC-ND license (http://creativecommons.org/licenses/by-nc-nd/4.0/).

easier execution of these subsequent SDM steps. Despite its importance, what is and how to measure the process of fostering choice awareness has received little attention. We recently showed that oncologists express the need to make a treatment decisions about (neo-)adjuvant cancer treatment in only 3% of pretreatment encounters, and instead, use the encounter to explain the one approach they recommend.[6] Also, Couët et al[7] reported that in only 1 in 3 SDM studies, clinicians state that "there is more than one way to deal with the identified problem."

Tools to support the process of SDM, such as (patient) decision aids and conversation aids, may explicitly mention that there is more than one sensible option available to address the patient's situation.[4,8] Access and use of these tools during the encounter may make it easier for clinicians to act toward creating choice awareness (henceforth referred to as "fostering choice awareness") or to skip this step, assuming the tool alone could do the work.

The aims of this study were to assess the extent to which (1) clinicians, using or not using SDM tools, foster choice awareness during clinical encounters and (2) fostering choice awareness, with or without SDM tools, is associated with greater patient involvement in decision making.

## PATIENTS AND METHODS

### Study Design

A random sample of recorded clinical encounters from 10 clinical trials (9 randomized and 1 before-after design) was analyzed to assess communication between patients and clinicians. We first selected 20 encounters as a training set and to define behaviors likely to foster choice awareness. We then randomly selected a convenience sample of 100 additional encounters to code such behaviors. The Mayo Clinic Institutional Review Board approved each of the included trials (along with the boards of participating sites) and this secondary analysis. Patients and clinicians provided written informed consent about the use of trial data and video recordings for research before the encounter.

### Data Source

We identified 838 videotaped encounters from 10 completed trials conducted by the Knowledge and Evaluation Research Unit, Mayo Clinic (Rochester, Minnesota).[9] Most of these trials included patients outside the referral practice of the Mayo Clinic and involved primary and specialty care, physicians and nurses, and emergency and ambulatory settings (Table 1).[10-19] These multicenter trials compared usual care (with clinicians conducting the encounter as they saw fit) with the use of a within-encounter conversation aid, an SDM tool designed to convey evidence and promote SDM during the encounter. Participating clinicians received training on how to use the conversation aid before their first use, in the form of either a brief (<10 minutes) demonstration or a video-clip or storyboard.[20]

Of the 10 trials, 6 (438 encounters) took place in primary care and 4 (400 encounters) in specialty care. We randomly selected 100 encounters from the 10 trials. This sample size allowed us to have enough videos to adequately stratify them by trial arm (care as usual vs conversation aid) and conversation aid type (whether the key decisional task required either risk communication for the selection of a risk-reducing approach ["risk calculator"] or the selection of a treatment alternative based on treatment characteristics of most importance to each patient ["issue cards"]). Recordings lasted, on average, 20 minutes (range, 1-73 minutes).

The conversation of interest addressed decisions to be made about patients' health or care when more than one reasonable approach was available. Conversations recorded in the 10 trials were related to 7 clinical contexts, namely, primary prevention of coronary artery disease and the management of low-risk acute chest pain, stable angina, diabetes, depression, osteoporosis, and Graves disease.

### Data Extracted

We extracted patient and clinician characteristics from each clinical trial along with arm assignment. In addition, we extracted the OPTION-12 scale scores for each encounter. This scale is the most frequently used scale to quantify the extent to which clinicians sought to involve patients in decision making (0-100 scale).[7,21,22] Reviewers had rated each video with substantial interrater agreement ($\kappa > .7$) and, because this scoring preceded the

Download English Version:

https://daneshyari.com/en/article/8924749

Download Persian Version:

https://daneshyari.com/article/8924749

Daneshyari.com