

ORIGINAL ARTICLES

Inter-professional shared decision making – increasing the “shared” in shared decision making

Cynthia J. Sieck*, Michael Johansen, Jessica Stewart

Department of Family Medicine, College of Medicine, The Ohio State University, United States

Received: June 1, 2015

Accepted: August 10, 2015

Online Published: September 1, 2015

DOI: 10.5430/ijh.v2n1p1

URL: <http://dx.doi.org/10.5430/ijh.v2n1p1>

ABSTRACT

Shared decision making (SDM) has been shown to increase patient engagement, patient satisfaction and adherence to treatment. Yet SDM remains underutilized in primary care due to factors such as the additional time required to implement, particularly for individual physicians. Inter-professional SDM (IP-SDM) is a model of SDM that distributes the tasks of SDM across different professionals involved in the care of the patient. IP-SDM has the potential to increase efficiency, provide more opportunities for patients to discuss the decision, and increase patient and provider satisfaction. Office visit workflows aligned to the steps of SDM allow team members to leverage their unique skills and training and enhances the decision making process for the patient. We argue that this approach should receive greater attention in primary care and throughout the healthcare system.

Key Words: Shared decision making, Inter-professional, Primary care

1. INTRODUCTION

Engaging patients in their care is currently a strong focus within healthcare. Patients who are more engaged tend to be more satisfied with their care and show better health outcomes.^[1,2] Shared decision making (SDM) is one approach to increasing patient engagement in screening and treatment decisions by the patient and provider (typically a physician) sharing treatment information and preferences in order to reach agreement.^[3] While this approach has many strengths, it is underutilized in US healthcare.^[4,5] Providers may support an SDM approach but face barriers to incorporating SDM into their practice, including the additional time and particular skills needed to effectively elicit patient preferences in treatment decisions.^[6,7]

At the same time, efforts such as the Patient-Centered Medical Home (PCMH) model of patient care shift the focus

from physician-patient encounters to a more team-based provision of care. PCMH addresses care needs comprehensively through a team of multidisciplinary providers often co-located within the primary care office. In this environment, patients may interact with a variety of health professionals in the course of their visit, offering a variety of opportunities to engage.^[8] We suggest that these additional engagement opportunities can support implementing SDM in a team-based manner, called Inter-professional SDM (IP-SDM). This method can offer the benefits of SDM while efficiently utilizing the skills of all members of the care team. The concept of care team members discussing a care plan, for example in a case conference, is not new in health care. IP-SDM, however, is different in its approach because the patient is an active participant in the discussion process and the goal is to work with the patient, not among members, to reach a decision about care options. This paper discusses

*Correspondence: Cynthia J. Sieck; Email: cynthia.sieck@osumc.edu; Address: Department of Family Medicine, College of Medicine, The Ohio State University, United States.

IP-SDM and argues for its expansion in primary care to increase patient engagement, provide more opportunities for patients to discuss their options and preferences, and increase efficiency of the personnel involved.

2. DEFINITION OF IP-SDM

Studies typically define IP-SDM as a process by which two or more health professionals work in collaboration with the patient to identify best options, clarify preferences, and enable the patient to take more control of the treatment plan.^[9-14] Makoul and Clayman^[15] identify 8 steps in an SDM protocol: identifying and explaining the decision to be made, discussing the risks and benefits of each option, eliciting patient values and preferences, discussing patient's ability and self-efficacy, presenting recommendations, checking and clarifying patient understanding, making or explicitly deferring decision, arranging follow up. In a traditional SDM context, these steps are preformed by the physician, typically within a single visit but can be distributed across visits. While this approach encourages an active role for the patient and addresses each patient's values and preferences, reliance solely on the physician constrains the time available for the patient to process the decision and relies on each physician's skills in guiding the patient through the process. In contrast, IP-SDM can distribute these steps across the encounter or several encounters, allowing team members with various levels of training to aid the patient in processing the decision and increase the overall efficiency of the clinic visit. Because all members are part of the same care team, patient confidentiality and privacy issues are also respected.

3. KEYS TO IP-SDM

Research identifies three structural keys to implementing IP-SDM: alignment of IP-SDM roles and member's input, respect for each member's role and consistent information conveyed to patient.

3.1 Alignment of roles

IP-SDM requires a variety inputs: discussion of the need for the decision, provision of information regarding the benefits and risks of treatment options, elicitation of preferences, and discussion throughout the process.^[6,10,16] At each point, the specific training and expertise of each IP-team member may provide the most benefit.^[6] This is particularly relevant when considering the need for effectively eliciting patient preferences. Each team member brings the strengths of their professional training and IP-SDM allows the team to capitalize on these strengths. Therefore, when implementing SDM in an inter-professional context, it is critical to align team roles with professional training. For example, primary care nurses, because of the time spent a patient and their

background, may be the best person to discuss medication versus lifestyle changes such as diet and exercise as treatment options for hypertension.

3.2 Respect for each member's role

In addition, effective IP-SDM teams must respect each member's role and input.^[17] Studies suggest that health professionals are less confident in communicating with other members of the team than with patients.^[9,10,18,19] Historically, physicians have been viewed as ultimately responsible for decision and certainly the physician carries the most legal risk. These factors can create an imbalance in roles that may undermine IP-SDM efforts. A team environment that emphasizes the particular strengths of each member's contribution and places the patient truly at the center of the decision making process is critical for IP-SDM.

3.3 Consistent information

For patients, consistency of information across the professionals involved is critical. In complex conditions with less clear evidence, such as Type 2 Diabetes, each professional may have a different emphasis and different recommendations for the patient.^[20,21] For example, advice for a patient with Type 2 diabetes from a nutritionist may focus on diet and behavioral modifications to control blood glucose levels. A primary care physician (PCP) may consider cholesterol management to be top priority. Both professionals may provide the patient accurate information, but without consensus, the patient may not be adequately informed to make the best decision.^[22]

4. BENEFIT AND BARRIERS

4.1 Benefits of IP-SDM

Published studies of IP-SDM interventions demonstrate similar outcomes to traditional SDM studies: increased patient knowledge, confidence in decisions, active involvement in care, and empowerment as well as patient satisfaction and treatment adherence.^[10,23-26] Beyond these benefits, IP-SDM offers additional important elements IP-SDM can reduce the time required for SDM and increase opportunities for patients to discuss their concerns because they interact and discuss the decision with multiple professionals.^[23] The inter-professional approach also benefits team members directly by allowing them to provide care specific to their expertise,^[23] facilitating a sense of empowerment and higher job satisfaction^[27] and decreasing bias in treatment plans.^[23]

4.2 Barriers to IP-SDM

Challenges of IP-SDM are similar to those in traditional SDM. Effective engagement in the SDM process requires more time than a typical patient visit and patients may vary

in their level of health literacy.^[9,12,18,28,29] SDM must afford time for the patient to process decision-related information and reach a conclusion, both of which may add time to the encounter. Providers are not typically compensated for SDM despite the greater time commitment,^[10] perhaps fostering negative attitudes toward the process.^[12,18] IP-SDM presents additional barriers to implementation including lack organizational resources and processes to implement IP-SDM as this model may require greater collaboration among professionals.^[9,10,18,28] In addition, because of the team nature of IP-SDM, there are challenges specific to working in teams including turnover and difficulty establishing cohesion.^[10,30] IP-SDM teams must trust their team members to deliver consistent and coordinated messages to the patient. Turnover may lead to less consistency and may strain the team's ability to function efficiently. IP team members with different training must incorporate diverse work methods or terminology and may fear loss of professional identity with change, issues of power and responsibilities, and challenges of conflict discussion and joint decision making.^[9,10,12,18,31]

5. DISCUSSION

Typical time constraints of primary care visits can limit what the physician alone may be able to address. Informally, nurses and medical assistants may be fulfilling this role but transmitting that information to the physician may not happen consistently. IP-SDM allows for a redefining of the processes by which the expertise of each member can be best utilized, tailored to the particular type of decision to be made. For example, screening decisions may require little input from the physician beyond vetting the materials used and working with the team to develop the appropriate process. Other decisions, such as those related to prescription medications, may need greater physician-patient time but clinic processes could prime the patient for the decision prior to the physician entering the exam room. These processes can provide the patient with more time to consider the options and make decisions regarding treatment and may provide a better understanding patient preferences. Formalizing these processes may improve the quality of decision making. Primary care practices seeking to implement IP-SDM should consider Makoul and Clayman's eight steps and align the flow of clinic visits to the best fit between these steps and the

composition of their particular care team.^[15]

In a primary care setting, IP-SDM can be integrated into the patient visit with the steps of SDM shared across professionals and even distributed across visits. For example, a physician sees a 63 year old male for a general physical. The patient and physician decide to test the patient's cholesterol level to determine his cardiovascular risk. The physician introduces SDM into the encounter by discussing cardiovascular risk and statin therapy. Following the encounter a nurse calls the patient to discuss his test result and his 10 year cardiovascular risk. They decide whether to start a statin medication while utilizing SDM resources introduced to the patient by the physician. Follow-up is then provided by either the physician or nurse.

IP-SDM provides several important benefits beyond those observed in a traditional SDM model, including facilitating greater discussion and analysis of the decision by the patient and allowing the primary care team to work to its fullest potential. As primary care continues to evolve, we anticipate increasing opportunities to implement IP-SDM. Taking an inter-professional approach can distribute the time requirements of SDM across team members, increasing opportunities for patients to discuss their decision and alleviating the pressure on the physician alone. Provisions of the Patient Protection and Affordable Care Act may address some of the health literacy and financial concerns.^[5] Training programs are available to facilitate greater team-based implementations of SDM.^[7,31]

6. CONCLUSION

IP-SDM has the potential to more fully engage patients in their care while increasing efficiency of the office visit. Physicians face increasing pressures to do more in the same amount of time and many find it difficult to implement SDM protocols on their own. IP-SDM leverages the strengths of each team member to create a more efficient process that empowers and engages patients. As such, IP-SDM capitalizes on the strengths of inter-professional teams and the empowerment potential of SDM. This approach has potential to alleviate some of the burdens associated with SDM so that patients and their care team can more effectively engage in the process.

REFERENCES

- [1] Coulter A. Patient engagement-what works? *J Ambulatory Care Manage.* 2012; 35(2): 80. PMID: 22415281. <http://dx.doi.org/10.1097/JAC.0b013e318249e0fd>

- [2] Carman KL, Dardess P, Maurer M, *et al.* Patient and family engagement: A framework for understanding the elements and developing interventions and policies. *Health Aff (Millwood)*. 2013 Feb; 32(2): 223-31. PMID: 23381514. <http://dx.doi.org/10.1377/hltha>

- ff. 2012. 1133
- [3] Charles C, Gafni A, Whelan T. Decision-making in the physician-patient encounter: Revisiting the shared treatment decision-making model. *Soc Sci Med.* 1999 Sep; 49(5): 651-61. [http://dx.doi.org/10.1016/S0277-9536\(99\)00145-8](http://dx.doi.org/10.1016/S0277-9536(99)00145-8)
- [4] Légaré F, Thompson-Leduc P. Twelve myths about shared decision making. *Patient Educ Couns.* 2014; 96(3): 281-6. PMID: 25034637. <http://dx.doi.org/10.1016/j.pec.2014.06.014>
- [5] Oshima Lee E, Emanuel EJ. Shared decision making to improve care and reduce costs. *N Engl J Med.* 2013; 368(1): 6-8. PMID: 23281971. <http://dx.doi.org/10.1056/NEJMp1209500>
- [6] Peterson KJ. Shared decision making in health care settings: A role for social work. *Soc Work Health Care.* 2012; 51(10): 894-908. PMID: 23151285. <http://dx.doi.org/10.1080/00981389.2012.714448>
- [7] Legare F, Ratté S, Stacey D, *et al.* Interventions for improving the adoption of shared decision making by healthcare professionals. *Cochrane Database Syst Rev.* 2010 May 12; (5): CD006732.
- [8] Huerta T, Sieck C, Hefner J, *et al.* Patient-centred care plus medical home do not equal patient-centred medical home: Why layering models of care may not lead to better outcomes. *OA Family Medicine.* 2013; 1(1):5-20. <http://dx.doi.org/10.13172/2052-8922-1-1-758>
- [9] Légaré F, Stacey D, Brière N, *et al.* Healthcare providers' intentions to engage in an interprofessional approach to shared decision-making in home care programs: A mixed methods study. *Journal of interprofessional care.* 2013; 27(3): 214-22. PMID: 23394265. <http://dx.doi.org/10.3109/13561820.2013.763777>
- [10] Bell JS, Aslani P, McLachlan AJ, *et al.* Mental health case conferences in primary care: Content and treatment decision making. *Research in Social and Administrative Pharmacy.* 2007; 3(1): 86-103. PMID: 17350559. <http://dx.doi.org/10.1016/j.sapharm.2006.05.005>
- [11] Legare F, Stacey D, Gagnon S, *et al.* Validating a conceptual model for an inter-professional approach to shared decision making: A mixed methods study. *J Eval Clin Pract.* 2011 Aug; 17(4): 554-64. PMID: 20695950. <http://dx.doi.org/10.1111/j.1365-2753.2010.01515.x>
- [12] Legare F, Stacey D, Pouliot S, *et al.* Interprofessionalism and shared decision-making in primary care: A stepwise approach towards a new model. *J Interprof Care.* 2011 Jan; 25(1): 18-25. PMID: 20795835. <http://dx.doi.org/10.3109/13561820.2010.490502>
- [13] Lown BA, Kryworuchko J, Bieber C, *et al.* Continuing professional development for interprofessional teams supporting patients in health-care decision making. *Journal of interprofessional care.* 2011; 25(6): 401-8. PMID: 21657852. <http://dx.doi.org/10.3109/13561820.2011.583563>
- [14] Legare F, Stacey D, Graham ID, *et al.* Advancing theories, models and measurement for an interprofessional approach to shared decision making in primary care: A study protocol. *BMC Health Serv Res.* 2008 Jan 3; 8: 2, 6963-8-2.
- [15] Makoul G, Clayman ML. An integrative model of shared decision making in medical encounters. *Patient Educ Couns.* 2006 Mar; 60(3): 301-12. PMID: 16051459. <http://dx.doi.org/10.1016/j.pec.2005.06.010>
- [16] Raue PJ, Schulberg HC, Lewis Fernandez R, *et al.* Shared decision-making in the primary care treatment of late-life major depression: A needed new intervention? *Int J Geriatr Psychiatry.* 2010; 25(11): 1101-11. PMID: 19946872. <http://dx.doi.org/10.1002/gps.2444>
- [17] Col N, Bozzuto L, Kirkegaard P, *et al.* Interprofessional education about shared decision making for patients in primary care settings. *Journal of interprofessional care.* 2011; 25(6): 409-15. PMID: 22011026. <http://dx.doi.org/10.3109/13561820.2011.619071>
- [18] Körner M, Ehrhardt H, Steger A. Designing an interprofessional training program for shared decision making. *Journal of interprofessional care.* 2013; 27(2): 146-54. PMID: 23151149. <http://dx.doi.org/10.3109/13561820.2012.711786>
- [19] Leipzig RM, Hyer K, Ek K, *et al.* Attitudes toward working on interdisciplinary healthcare teams: A comparison by discipline. *J Am Geriatr Soc.* 2002; 50(6): 1141-8. PMID: 12110079. <http://dx.doi.org/10.1046/j.1532-5415.2002.50274.x>
- [20] Kristeller JL, Hoerr RA. Physician attitudes toward managing obesity: Differences among six specialty groups. *Prev Med.* 1997; 26(4): 542-9. PMID: 9245677. <http://dx.doi.org/10.1006/pmed.1997.0171>
- [21] Bleich SN, Gudzone KA, Bennett WL, *et al.* Do physician beliefs about causes of obesity translate into actionable issues on which physicians counsel their patients? *Prev Med.* 2013; 56(5): 326-8. PMID: 23399006. <http://dx.doi.org/10.1016/j.ypmed.2013.01.012>
- [22] March Cerda JC, Prieto Rodriguez MA, Perez Corral O, *et al.* Quality of internal communication in health care and the professional-patient relationship. *Health Care Manag (Frederick).* 2010 Apr-Jun; 29(2): 179-85. PMID: 20436336. <http://dx.doi.org/10.1097/HCM.0b013e3181da8b08>
- [23] Chong WW, Aslani P, Chen TF. Multiple perspectives on shared decision-making and interprofessional collaboration in mental health-care. *J Interprof Care.* 2013 May; 27(3): 223-30. PMID: 23421345. <http://dx.doi.org/10.3109/13561820.2013.767225>
- [24] Katz SJ, Hawley S. The value of sharing treatment decision making with patients: Expecting too much? *JAMA.* 2013 Oct 16; 310(15): 1559-60. <http://dx.doi.org/10.1001/jama.2013.278944>
- [25] Elwyn G, Frosch D, Thomson R, *et al.* Shared decision making: A model for clinical practice. *Journal of general internal medicine.* 2012; 27(10): 1361-7. PMID: 22618581. <http://dx.doi.org/10.1007/s11606-012-2077-6>
- [26] McCaffery KJ, Smith SK, Wolf M. The challenge of shared decision making among patients with lower literacy: A framework for research and development. *Med Decis Making.* 2010 Jan-Feb; 30(1): 35-44. PMID: 19692709. <http://dx.doi.org/10.1177/0272989X09342279>
- [27] Macphee M, Wardrop A, Campbell C. Transforming work place relationships through shared decision making. *J Nurs Manag.* 2010; 18(8): 1016-26. PMID: 21073573. <http://dx.doi.org/10.1111/j.1365-2834.2010.01122.x>
- [28] Légaré F, Stacey D, Gagnon S, *et al.* Validating a conceptual model for an inter-professional approach to shared decision making: A mixed methods study. *J Eval Clin Pract.* 2011; 17(4): 554-64. PMID: 20695950. <http://dx.doi.org/10.1111/j.1365-2753.2010.01515.x>
- [29] Legare F, Stacey D, Graham ID, *et al.* Advancing theories, models and measurement for an interprofessional approach to shared decision making in primary care: A study protocol. *BMC Health Serv Res.* 2008 Jan 3; 8: 2, 6963-8-2.
- [30] Légaré F, Stacey D, Pouliot S, *et al.* Interprofessionalism and shared decision-making in primary care: A stepwise approach towards a new model. *Journal of interprofessional care.* 2011; 25(1): 18-25. PMID: 20795835. <http://dx.doi.org/10.3109/13561820.2010.490502>
- [31] Korner M, Ehrhardt H, Steger AK, *et al.* Interprofessional SDM train-the-trainer program "fit for SDM": Provider satisfaction and impact on participation. *Patient Educ Couns.* 2012 Oct; 89(1): 122-8. PMID: 22647558. <http://dx.doi.org/10.1016/j.pec.2012.04.008>