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SHARED DECISION MAKING IN RURAL PRIMARY CARE:

A preliminary report to clinic and clinician members of
The Oregon Rural Practice-based Research Network (ORPRN)

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Abstract

Shared decision making (SDM) and patient decision aids (DAs) are gaining increased recognition as tools for facilitating informed patient choice. Attitudes, use, and strategies to implement SDM and DAs into primary care settings are not well described. The objective of this cross sectional survey was to explore attitudes and use of SDM and DAs by clinicians in rural primary care. 78.2% (177/229) clinicians affiliated with 49 ORPRN clinic practices completed this survey. Two thirds (66.1%) of respondents were physicians and three primary care specialties were represented: family medicine (83.1%), pediatrics (10.2%), and internal medicine (7.3%). While 65% of the clinicians had never heard or didn't know much about SDM, after reviewing an official definition 96.6% felt this approach was useful or very useful in cases with more than one treatment option. DAs were currently used in practice by 91% of the respondents. While having DAs for chronic pain, health behavior change, and advance directives were preferred across all respondents, preferred DAs by condition varied among the three specialties.

Introduction

Many medical decisions are in a “gray” area, where reasonable people might make different choices based on their values and preferences (e.g., treatment for chronic pain, knee osteoarthritis, or PSA testing) (see Dartmouth Hitchcock Medical Center Shared Decision Making website and Foundation for Informed Medical Decision Making website).

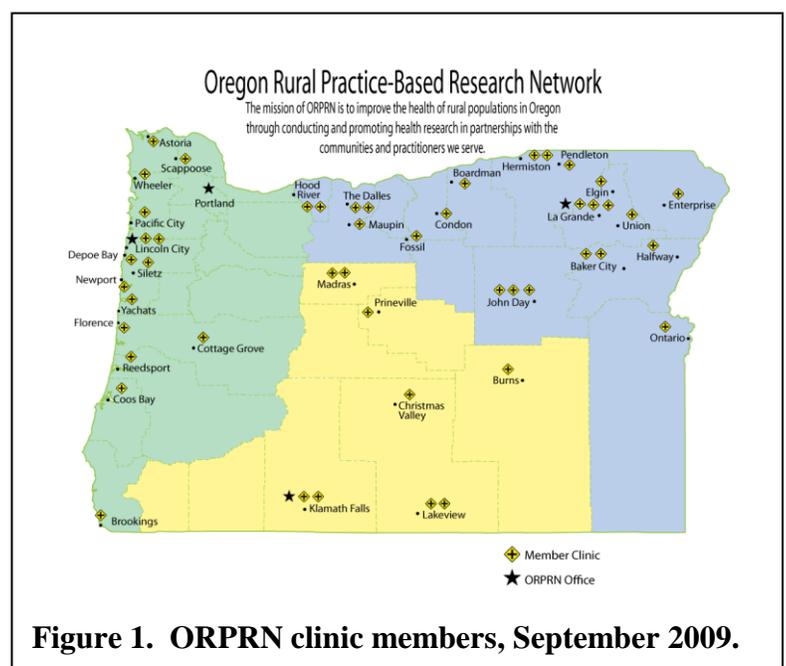
- Shared decision making (SDM), a joint process between patient and clinician, is a key element in applying evidence-based medicine to optimize diagnostic and treatment decisions in these cases.
- Patient decision aids (DAs) are tools that make the options, benefits, and risks explicit, and illustrate real patient experiences for some elective decisions.

While SDM and DAs are increasingly recognized as tools for facilitating informed patient choice, knowledge and practices of SDM and DA usage in primary care practices are not well described. Therefore we conducted this study in order to describe attitudes, perceptions, and practices of clinicians regarding SDM and DAs in rural Oregon primary care.

Methods

Setting/Participants:

We invited clinicians affiliated with the 49 Oregon Rural Practice-based Research Network (ORPRN) member clinics to complete the study survey (Figure 1). Initially we identified 240 clinicians affiliated with the eligible practices, however after removing clinicians who had retired or were no longer at an ORPRN member practice, 229 clinicians were eligible to complete the survey.



Study Design:

We administered a cross-sectional survey using a web-based version hosted on Survey Monkey [Ref: www.surveymonkey.com] as well as printed surveys via U.S. Mail. The survey consisted of 21 questions, both open-ended and fixed-response, designed to assess familiarity and use of shared decision making, barriers to utilizing shared decision making in practice, interest in decision aids, and to gather data on practice location and respondent demographic characteristics.

During a three week period between September 9, 2009 to September 24, 2009 e-mails were sent to eligible clinicians on a weekly basis describing the survey premise and providing a link to the online survey. Between October 1, 2009 to October 17, 2009 the ORPRN Network Director sent personal follow-up emails to clinician non-responders inviting them to complete the survey. In addition, during September and October the ORPRN Practice Enhancement and Research Coordinators contacted the office managers at the 49 practices and mailed paper surveys to those who requested. Data collection closed on December 7, 2009.

Two response incentives were utilized. Clinicians completing the survey could elect to receive a \$20.00 gift card to a store of their choice (Powell's Books, Starbucks, or Safeway). In addition, clinics achieving a response rate of 70% or greater by eligible clinicians received a clinic-wide pizza party sponsored by ORPRN. This study was approved by the Oregon Health & Science University (OHSU) Institutional Review Board.

Results:

Participant Description

78.2% of the eligible clinicians completed the survey (177/229). Of the 49 clinics participating in the survey, 40 achieved a response rate of 70% or greater by eligible clinicians (81.6%). As summarized in Table 1, by training respondents were 66.1% Physician, 18.4% Physician Assistant, and 14.9% Nurse Practitioners. Respondents represented all three primary care specialties: Pediatric, Family Medicine, and Internal Medicine. Mean age of respondents was 47 years old (range 29 – 78) and 53.7% were males.

Table 1. Respondents training, specialty, and demographics (N = 177).

	N (%)
Respondent Training	
Physician (MD/DO)	115 (66.1)
Physician Assistant	32 (18.4)
Nurse Practitioner	26 (14.9)
Other ^a	1 (0.6)
Respondent Specialty	
Family Medicine ^b	147 (83.1)
Pediatrics	18 (10.2)
Internal Medicine ^{b,c}	13 (7.3)
Other ^d	3 (1.8)
Clinician Age (years)	
≤ 35	37 (21.4)
36-45	36 (26.6)
46-55	44 (25.4)
≥ 55	46 (26.6)
Gender (male)	95 (53.7)

^a One provider reported being a Health Psychologist. Three respondents did not answer this question.

^b Four clinicians indicated both Family Medicine and Internal Medicine

^c Two clinicians indicated both Family Medicine and Pediatrics

^d One provider listed psychiatry, one reported primary care, one reported chronic disease management. Two respondents did not answer this question.

Familiarity and Use of Shared Decision Making (SDM)

65% ($n = 115$) of the respondents didn't know much about SDM or had never heard of it. 17.5% ($n = 31$) reported that SDM was a regular part of their clinical practice. The following comments demonstrate both the breadth of awareness and use of SDM among the respondents:

- *"I didn't realize this had a name. Involving patients in their healthcare decisions is simply how I was taught to practice."*
- *"Whenever possible and appropriate I follow this philosophy. However, I find some patients still want their provider to do all the decision making ('you're the doctor')."*

After reviewing a definition of SDM 96.6% ($n = 169$) reported that this approach was "extremely useful" or "useful" in cases where there are more than one treatment option. Barriers to SDM included a lack of time for detailed discussion with patients (62.8%, $n = 110$) and that patient have difficulty understanding all they need to know (62.8%, $n = 110$). Respondents disagreed with the statement that "patients are not interested in engaging in SDM" (72.6%, $n = 127$).

As summarized in Table 2, 69.7% ($n = 122$) of the respondents thought that the patient and clinician should *equally* make decisions to manage health conditions (e.g., advance directives, chronic pain, depression, etc.) while 34.5% ($n = 60$) thought this actually happened. Many respondents, 43.1% ($n = 75$), felt that the actual decision was *mostly* made by the clinician. No respondents reported that totally the clinician should make or actually makes the decision.

Table 2. Clinician report of "who should make the decision" regarding managing health conditions and "who actually makes the decision."

Response category	Should Make the Decision n (%)	Actually Makes the Decision n (%)
Totally the patient	4 (2.3)	5 (2.8)
Mostly the patient	31 (17.7)	24 (19.5)
Both patient and clinician equally	122 (69.7)	60 (34.5)
Mostly the clinician	18 (10.3)	75 (43.1)
Totally the clinician	0 (0)	0 (0)

Perception and Use of Decision Aids (DAs)

Only 9.0% of respondents reported that they did not currently use DAs in practice. Clinicians reported using brochures produced by external sources (83.6%), in-house brochures (44.6%), and web-based DAs (32.2%). Table 3 provides a summary of the format that respondents would be likely to use DAs if they were available for use before, during, or after clinician visits.

Table 3. Preferred format for DAs to use before, during, or after clinician visits ($N = 177$).

Format	Very likely	Likely	Unlikely	Very	
				Unlikely	Missing
DVD or VHS	20 (11.30)	42 (23.73)	71 (40.11)	29 (16.38)	15 (8.47)
Web Based	41 (23.16)	81 (45.76)	39 (22.03)	7 (3.95)	9 (5.08)
Brochures/Handouts					
External source	79 (44.63)	82 (46.33)	9 (5.08)	1 (0.56)	6 (3.39)
Internal source	75 (42.39)	81 (45.76)	9 (5.08)	2 (1.13)	10 (5.65)

Across all respondents the preferred condition for a DA was chronic pain (63.8%), health behavior change (61.6%), advance directives (45.2%), and diabetes (44.6%). As the rankings presented in Table 4 reveal, DA condition preference varied by provider specialty.

Table 4. Preferred DA by condition (%) and provider specialty.

Rank	Provider Specialty		
	Family Medicine (N = 147)	Internal Medicine (N = 13)	Pediatrics (N = 18)
1	Chronic pain (70.1)	Chronic pain (69.2)	ADD/ADHD (94.4)
2	Health behavior change (61.6)	Dementia (61.5)	Immunizations (83.3)
3	Advance directives (49.0)	Health behavior change (61.5)	Asthma (72.2)
4	Diabetes (45.6)	Diabetes (53.8)	Depression (66.7)
5	Low back pain (42.9)	Advance directives (46.2)	Health behavior change (61.1)

Discussion

This study presents initial data regarding clinician perceptions of SDM and interest in using DAs in rural primary care. Our results demonstrate that while few clinicians are aware of the official term “Shared Decision Making” after reading a definition the majority of providers (96.6%) felt that in cases with more than one treatment option this approach was extremely useful or useful. As indicated in previous studies, time and patient characteristics are the predominant barriers to engaging in a SDM process (Legare, Ratte, Gravel, & Graham, 2008). Respondents were receptive to using DAs to facilitate informed patient choice and they reported interest in having DAs in various formats (i.e., brochures, web-based tools, and DVD/VHS). While the preferred conditions for DAs varied by provider specialty, interest in DAs for health behavior change emerged as a priority condition for all three specialties.

There is little data regarding interventions that are effective for implementing SDM in clinical practice (Legare, 2008). The present data establishes the foundation for a participatory intervention with four ORPRN clinics to enhance SDM in rural primary care by utilizing DAs. Findings from the survey will be used to develop a participatory research “Best Practices” model for implementing DAs into non-academic primary care settings.

Acknowledgements

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References/Resources

Dartmouth-Hitchcock Medical Center, Center for Shared Decision Making. See website at http://www.dhmc.org/shared_decision_making.cfm

Foundation for Informed Medical Decision Making. See website at <http://www.informedmedicaldecisions.org/>

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