Instructor's Guide
Shared Decision-making (SDM) Toolkit: Train-The-Trainer Tools for Teaching SDM in the Classroom and Clinic

1. Purpose of this resource

This toolkit is designed for use by attending physicians to teach residents, fellows, medical students and other health care providers and staff how to effectively apply core elements of shared decision-making in clinical encounters with patients.

2. List of resource files

SDM Physician Training Toolkit Introduction
Appendix A - SDM Teaching Guide
Appendix B - Reminder Pocket Card
Appendix C - SDM Cue Poster
Appendix D - Activation Pamphlet
Appendix E - Assessment Checklist
Appendix F - Things to Anticipate-Barriers
Appendix G - Resources
Appendix H - Evaluation Survey

3. Conceptual background

Shared decision-making is a strategy to empower the patient to actively make an evidence-based treatment choice (Charles, 1997). The State of Washington added the option of shared decision-making to the statute addressing informed consent in 2007 and other states have been considering similar legislation (Kuehn, 2009). The 2010 Patient Protection and Affordable Care Act includes provisions to promote shared decision-making (Braddock, 2010).

Our healthcare system decided to adopt shared decision-making, and resources for pilot implementation were provided through a planning grant from the Agency for Healthcare Policy and Research (R21-HS19532-01, Karen B. Domino, PI). Our experiences during pilot implementation of shared decision-making in orthopaedic surgery clinics revealed that physician training would be critical to successful implementation. However, physicians were resistant to the concept of "training", and were unwilling to devote significant time or resources to learning how to effectively implement shared decision-making in the clinic. We assume that this need and these constraints will be common to other practice settings. Consequently, we developed and tested a streamlined training program that proved acceptable to trainees (in our case, attending spine surgeons, physician assistants, and orthopedic spine fellows). We subsequently constructed this toolkit to share this training strategy and associated resources with the medical education community.

The model of shared decision-making underlying this toolkit is premised on the work of Charles (1997, 1999). In this model, shared decision-making is two-way, with both the physician and patient providing input on treatment decisions, incorporating both medical and personal criteria into decisions, with deliberation of decisions to include all relevant parties (physician, patient, important others) (Charles, 1999).

The elements of shared decision-making used in training toolkit items are based on the work of Braddock 2008. We added the required Washington State element of "teach back" to Braddock's nine elements for our training and implementation model (Washington State Legislature, Chapter 41.05 RCW).

Our inclusion of a teaching example in the teaching guide was modeled on Braddock 2008. The example was based on recordings of actual clinical encounters during our pre-implementation evaluation of patient encounters, with modification of the actual example to provide illustration of best practices.

One of the toolkit's authors (Robins) successfully used the approach described in this toolkit to train behavioral scientists to coach primary care physicians in the techniques of collaborative agenda setting (Brock, 2011). That work was based on research demonstrating that sequenced learn -work -learn opportunities including direct observation and feedback resulted in improved communication skills (Langewitz, 1998). As in this SDM toolkit for implementation, the agenda setting educational intervention was conducted in two phases: 1) providers participated in a group training session that included an overview of the communication protocol; 2) coaches shadowed the physicians and provided coaching about relevant skills. Compared to control group physicians, intervention group physicians demonstrated significantly more agenda setting behaviors (Brock, 2011).

4. **Practical implementation advice**

This toolkit is designed for use in brief individual or small group training sessions. The trainer will need to be well-versed in shared decision-making before engaging in training activities. The resource list provided in Appendix G provides relevant background that can be used in self-study by the trainer. If trainees have previously been exposed to the concepts of shared decision-making, the training session can serve as a refresher about concepts with focus on clinical encounter skills development prior to observation and coaching. Trainees lacking prior knowledge of shared decision-making may require more emphasis on the conceptual background. Planned training time should consider trainee background.

Training sessions require minimal resources: at least 20 minutes scheduled for the session, plus distribution of toolkit materials (paper) for use in training and evaluation. We conducted individual sessions in office settings, as well as small group settings in

clinic workrooms, to adjust training environment to availability of trainees. The training could also be adapted to the setting of a small group workshop or simulation classroom.

The trainer will also need to observe, evaluate and provide "On-the-Fly Coaching" to trainees in the clinic or simulation setting. If conducted in an actual clinic environment, the trainer needs to understand the clinic flow and physical layout in order to incorporate observation and coaching without impeding clinic workflow. The trainer should review Appendix F for further implementation issues.

We conducted our observation and assessment in the clinic setting, shadowing individual trainees during 4-6 patient encounters with coaching conducted at the conclusion of the clinic session. If simulation of clinical encounters is available, observation and evaluation could be easily adapted to the simulated clinic environment provided appropriate training is given to simulated patients (not included in toolkit).

Field testing of this training included observation of five providers in the clinic, with a total of 16 patients (multiple providers encountered individual patients). Observation during training revealed that the most common SDM elements absent from clinical encounters were input from trusted others, patient role, teach back, eliciting preferences, and presenting uncertainties.

5. Limitations and lessons learned

This submission is limited in documentation of educational techniques incorporated into the toolkit methodology. We recognize that feedback skills are critical to the success of this intervention and that our submission does not include a module on providing effective feedback. Tools for effective feedback are available in other MedEdPORTAL submissions. In our intervention, the trainer was an educator and social worker with excellent feedback skills. In addition, our trainer focused on developing excellent rapport with the trainees before engaging in observation and coaching sessions. Best results are likely if trainers are excellent clinical teachers with strong feedback skills. If these skills are weak or unavailable, additional tools for learning feedback would be critical to successful implementation of this training intervention.

The training was developed from practical experience and the expertise of the training team. Our pilot testing was limited to a single specialty. At the time of this submission, evaluation was limited to observations during training sessions in the clinic. Further evaluation of provider performance based on audio-tapes of clinical encounters will be incorporated into revisions of this toolkit.

References cited:

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