(1) mailed Informed Medical Decisions Foundation PSA-DESI in DVD format, (2) invitation to a shared medical appointment (SMA) to watch and discuss the PSA-DESI, (3) both mailed DESI and invitation to a SMA (DESI+SMA), and (4) a control group who received a letter encouraging them to discuss PSA screening with their physician. We measured PSA screening 4 months after the intervention by self-report (via questionnaire or telephone interview) and EMR review.

RESULTS
Sixty percent (N=1,762) completed the questionnaire with mean patient age of 59, 75% white, and 59% reporting previous PSA testing. In an intention to treat analysis, self-reported PSA screening at 4 months across the 3 intervention arms was: 14%, 14%, 12% in the DESI, SMA, and DESI+SMA arms, respectively, compared to 12% in the control arm (p=0.7). Fewer PSA tests were identified via EMR than by self-report at 4 months, but results do not differ by intervention arm (16% DESI; 17% SMA; 14% DESI+SMA; 13% control; p=0.5). Uptake of the DESI in the intervention arms was modest with 16% watching the DESI, 7.8% attending a SMA, and 16% either watching or attending in the DESI+SMA arm.

CONCLUSIONS
Preliminary results from a large multi-site effectiveness trial indicate that PSA screening rates do not differ by DESI implementation strategy either by self-report or EMR. Uptake of the intervention in all three arms was modest suggesting limited effectiveness of these implementation strategies on patient engagement.

Implementing Decision Aids was Associated with Lower Rates of Invasive Treatment for Benign and Malignant Prostate Conditions

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BACKGROUND
Decision aids are evidence-based sources of health information that can help patients make informed treatment decisions. However, little is known about how decision aids affect health care use and costs of care when implemented outside of randomized trials.

METHODS
We conducted an observational study to evaluate whether rates of elective prostate procedures and costs of care changed after implementing video-based decision aids for two health conditions—benign prostatic hyperplasia (BPH) and early stage prostate cancer (PRCA)—at Group Health, a large health system in Washington State. Clinical staff could order DVD versions of the decision aids for patients through the electronic health record. Patients could also view the decision aids online. We divided the patient populations into two 18-month study periods: The historical control period before decision aid implementation, from 7/1/2007 to 12/31/2008, and the intervention period after implementation, from 7/1/2009 to 12/31/2010. The primary outcomes of interest were: (1) a transurethral prostate procedure for BPH patients or any treatment (surgery/radiation/androgen deprivation) for PRCA patients; and (2) total health care costs in the six months after an initial urology visit for BPH or diagnosis date for PRCA.

RESULTS
The study involved 3,778 patients with BPH and 418 patients with PRCA. Decision aid implementation was associated with 27% lower rate of receiving any treatment for PRCA (P=0.01). For BPH, decision aid implementation was associated with a statistically significant 32% lower rate of transurethral prostate procedures among men who had previous pharmacological treatment for BPH and a non-significant 22% lower rate among men who had not received pharmacological treatment for BPH. We found no statistically significant association between decision aid implementation and costs of care over six months for patients with either of these health conditions, although there was a trend toward lower costs in PRCA and previously-treated BPH patients.

CONCLUSIONS
These findings support the concept that implementation of decision aids for some preference-sensitive health conditions may reduce the rates of invasive treatment; however, more research is needed on larger sample sizes and over longer time horizons to determine if BPH and PRCA decision aids can significantly influence costs of care.

SDM and chronic care
Moderator: Dr. M. Hasan Murad

Development of a patient decision aid for patients with diabetes: A systematic approach

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BACKGROUND
The impact of patient decision aids (PDA) on decision quality and outcomes have been well studied but there are few systematic descriptions of the development process. The recent International Patient Decision Aids Standards (IPDAS) evidence document has proposed a systematic approach to developing a PDA. This paper describes a stepwise, iterative process of developing a PDA for making decisions about insulin therapy in patients with type 2 diabetes.

METHODS
We used the UK Medical Research Council complex intervention framework and IPDAS criteria to guide the content and development process of this PDA. The development process involved: (1) convening of an expert panel; (2) needs assessment of stakeholders; (3) literature review; (4) selection of a theoretical framework; (4) drafting of the PDA based on IPDAS criteria; (4) review by the expert panel; (5) pilot testing with end users; (6) readability test.

RESULTS
A 10-member expert panel, comprising patients, clinicians, decision making expert and policy makers, met to: discuss the justification for a decision support tool; feedback on the methodology and results of the needs assessment study; and plan implementation
strategies. We interviewed 41 healthcare professionals, including primary care physicians, endocrinologists, diabetes nurse educators, pharmacists and policy makers, as well as 21 patients with diabetes who were making decisions on insulin therapy. Their concerns, barriers, facilitators and needs of insulin initiation were incorporated into the decision support tool. Concurrently, we reviewed the literature on the evidence of decision support tools, mainly patient decision aids, and clinical evidence of different treatment options, including insulin. The Ottawa Decision Support Framework was used as the conceptual framework. Subsequently, the research team drafted the PDA in a workshop and this was then presented to the expert panel. The research team and expert panel reviewed the PDA drafts iteratively and modified it to suit the local clinical context and patient preference.

CONCLUSIONS
This PDA was developed using a stepwise, iterative approach based on needs assessment, clinical evidence, theoretical framework and involvement of stakeholders. Further studies should evaluate whether this development process leads to better decision quality and outcomes.

◆ Structured Shared Decision-Making using Dialogue and Visualization: a Randomized Controlled Trial Towards a motivational framework with focus upon partnership, joint evaluation and agreement

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BACKGROUND
The aim of this study is to evaluate a method, “Counseling in Dialogue” (CD), developed to increase quality of counseling in youth mental health. Decisional conflict was used as indicator of quality of counseling and shared decision-making.

METHOD
94 children aged 2 to12 years were randomized into a CD group and a care as usual (CU) group. In a before-and-after design decisional conflict was measured using the Decisional Conflict Scale (DCS) for parents (N = 133) and the Provider Decision Process Assessment Instrument for therapists (PDPAI, N = 20). 81 children had follow-up data.

RESULTS
Compared with parents of the CU group, parents of the CD group reported significantly less decisional conflict after counseling (difference mothers: -0.38 (95%CI -0.56; -0.19), p< .001; fathers: -0.22 (95%CI -0.44; -0.01), p = .045). 98% of the mothers and 96% of the fathers in the CD group accepted the recommended treatment, whereas 71% (fathers) and 77% (mothers) in the CU group did, p<0.05. Decisional conflict of the therapists was low in both groups after counseling (difference: -0.03 (95%CI -0.19; 0.14), p = .741).

CONCLUSIONS
The “Counseling in Dialogue procedure” significantly lowered decisional conflict of the parents and promoted the acceptance of the recommended treatment.


Decision-making role preferences in patients with type 2 diabetes during insulin initiation

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INTRODUCTION
Decision-making role preference (DRP) is the degree of control that patients wish to have in a medical decision. Patient DRPs range from leaving all decisions to the clinician to making the final treatment selection themselves. Besides the clinician-patient dyad, decision-making may involve the patient’s significant others. This study aimed to explore patients’ views on their DRP in the context of a chronic illness in Malaysia.

METHODS
Individual in-depth interviews were conducted with people with type 2 diabetes deciding about insulin initiation (n=21) in 2012. Participants attending private and public primary care clinics were selected purposively in order to achieve maximum variation. The participants were interviewed using a topic guide developed based on literature review and prior clinical and research experience. The interviews were audio-recorded, transcribed verbatim and the transcripts were used as data for analysis using a thematic approach.

RESULTS
Patients who preferred to make their own decision felt that the doctor’s role was to provide professional opinion and should not force them to make a decision. Patients who were knowledgeable on diabetes and the medications would request to start insulin when their oral medications failed rather than waiting for the doctor to initiate the discussion.

Patients who preferred the doctor to make the decision trusted the doctor because of their professional training. However, the doctor’s aggressive consultation style forced some patients to comply with the doctor’s decision. Some patient’s families were involved in the decision making process by helping to gather health information, participating in the consultations, and voicing their opinion on insulin. Others did not involve their families because they felt that insulin was not a ‘big’ decision; insulin administration would not involve others; and the family was too busy. Patients who were the ‘head of the family’ was expected to make their own health decisions.