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2013 International Shared Decision Making Conference

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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 to 12 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.
CONCLUSIONS
This study found that patients have a pre-existing DRP and it was influenced by the doctor-patient relationship, their societal roles, family and peers, and their knowledge of the disease. Exploring the influencing factors may help clinicians to guide patients to make decisions in the way patients actually prefer.

Effects of a Web-Based Decision Aid on Knowledge and Informed Choice Regarding Diagnostic Self-Testing for Cholesterol and Diabetes. A Single-Blind Randomised Controlled Trial

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INTRODUCTION
Diagnostic self-tests are worldwide available to consumers. Since self-testing has advantages as well as disadvantages, consumers who consider taking these tests should have sufficient knowledge of self-testing and being guided into making an informed choice. We developed a web-based decision aid (DA) on diagnostic cholesterol and diabetes self-testing. Aim of this study was to assess the effect of the DA on knowledge and informed choice among consumers with an intention to take these tests.

METHODS
A single blind randomized controlled trial was designed. Consumers with an intention towards cholesterol or diabetes self-testing were selected from an existing internet panel and randomized towards being exposed to the decision aid or to a placebo in the form of a limited information sheet. Knowledge and informed choice were assessed immediately after the experiment.

RESULTS
We invited 1137 panelists to participate in the trial. Response in the cholesterol arm was 76.4% in the intervention group versus 84.5% in the control group (p=0.020). In the diabetes arm these numbers were 78.6% and 84.9% respectively (p=0.003). Knowledge level in the diabetes arm was higher in the intervention group than in the control group (sufficient knowledge 67.0% versus 53.5%, p=0.003), as was the percentage of participants with an informed choice (42.9% versus 31.5%, p=0.013). No differences were found in the cholesterol arm. Mean time spent on the DA was 2.8 minutes in the diabetes arm, and 3.2 minutes in the cholesterol arm.

DISCUSSION
The DA led to improvements in knowledge and informed choice in the diabetes intervention group compared to the control group, but did not have any effect in the cholesterol intervention group. The DA should be further tested among consumers who are actually at the point of purchasing a test. Consumers who are considering doing a diabetes self-test should have access to independent information on self-testing and stimulated to read this information, since this leads to more knowledge and informed choice.

Effectiveness of a decision aid for patients with type 2 diabetes

Spanish Presentation
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INTRODUCTION
The treatment with statins is a safe and effective intervention to reduce cardiovascular risk in patients with type 2 diabetes mellitus; nevertheless there are patients to whom this treatment is not prescribed, or that do not take them or interrupt their consumption prematurely. The lack of knowledge and communication problems might be responsible for the inadequate use of statins. The "Statin Choice" decision aid (DA) has been developed for supporting the process of shared decision making between professionals and patients with type-2 diabetes on the use of the statins. The aim of this study was to assess the effectiveness of this DA in Spanish patients with type-2 diabetes.

METHOD
In a multicenter cluster randomized controlled trial, 34 general practitioners were allocated to the DA intervention (n=18; 86 patients) or usual care (n=16; 82 patients). Intervention was delivered by physicians, previously trained by a member of the research team. Immediately after the consultation, the following variables were measured: knowledge about statins (7-points scale), decisional conflict (Decisional Conflict Scale), satisfaction with the decision making process (Satisfaction with Decision Making Questionnaire), and anxiety (State-Trait Anxiety Inventory). At three months, general (EQ-5D) and specific (Problematic Areas in Diabetes) quality of life were measured. Data were analyzed by one-way analysis of covariance with random effects.

RESULTS
Post-intervention data show significant differences favouring intervention in patients' knowledge about statins (t=2.374; p=.028), and satisfaction with the decision making process (t=2.398; p=.024). No significant effects were obtained on decisional conflict, state anxiety and quality of life.

DISCUSSION
"Statin Choice" is an effective tool to improve patients' knowledge about statins and their satisfaction with the decision making process, without increasing anxiety levels. The lack of effect on patients' decisional conflict, a variable which generally has been proven sensitive to DA interventions, might be explained by a floor effect. This DA may be a useful resource for improving the quality of decisions regarding cardiovascular risk of patients with type-2 diabetes.