

Washington University School of Medicine Digital Commons@Becker

Health Literacy and Communication Faculty
Publications

Health Literacy and Communication

2011

Interprofessional education about patient decision support in specialty care

Mary Politi

Division of Public Health Sciences, Department of Surgery, Washington University School of Medicine in St. Louis

Arwen H. Pieterse

Leiden University

Tracy Truant

University of British Columbia

Cornelia Borkhoff

University of Ottawa

Vikram Jha

University of Leeds

See next page for additional authors

Follow this and additional works at: http://digitalcommons.wustl.edu/healthlit_pubs

 Part of the [Medicine and Health Sciences Commons](#)

Recommended Citation

Politi, Mary; Pieterse, Arwen H.; Truant, Tracy; Borkhoff, Cornelia; Jha, Vikram; Kuhl, Laura; Nicolai, Jennifer; and Goss, Claudia, "Interprofessional education about patient decision support in specialty care" (2011). *Health Literacy and Communication Faculty Publications*. Paper 3.

http://digitalcommons.wustl.edu/healthlit_pubs/3

This Article is brought to you for free and open access by the Health Literacy and Communication at Digital Commons@Becker. It has been accepted for inclusion in Health Literacy and Communication Faculty Publications by an authorized administrator of Digital Commons@Becker. For more information, please contact engeszer@wustl.edu.

Authors

Mary Politi, Arwen H. Pieterse, Tracy Truant, Cornelia Borkhoff, Vikram Jha, Laura Kuhl, Jennifer Nicolai, and Claudia Goss

**#4: INTERPROFESSIONAL EDUCATION
ABOUT DECISION SUPPORT FOR PATIENTS
IN SPECIALTY CARE SETTINGS***

Mary Politi¹, Arwen Pieterse², Tracy Truant³, Cornelia Borkhoff⁴, Vikram Jha⁵, Laura Kuhl⁶,
Jennifer Nicolai⁷, Claudia Goss⁸

Running Head: IP Education for Decision Support in Specialty Care

Key Words: specialty care, patient involvement, decision support, interprofessional education

Authors' Contact Details:

1. Mary C. Politi, Ph.D., Washington University in St. Louis School of Medicine, 660 S. Euclid Ave, St. Louis, MO 63112, USA. mpoliti@wustl.edu
2. Arwen H. Pieterse, Ph.D., Leiden University Medical Center, P.O. Box 9600, Leiden, 2300, RC The Netherlands A.H.Pieterse@lumc.nl
3. Tracy Truant, RN, MSN, British Columbia Cancer Agency, 632-750 West Broadway Ave., Vancouver, British Columbia, Canada V5Z1H1 ttruant@bccancer.bc.ca
4. Cornelia Borkhoff Ph.D., Centre for Global Health, University of Ottawa, 1 Stewart Street, Ottawa, Ontario, Canada K1N 6N5 cory.borkhoff@wchospital.ca
5. Vikram Jha, MBBS, MRCOG, Ph.D. Leeds Institute of Medical Education, University of Leeds LS29NL, UK v.jha@leeds.ac.uk
6. Laura Kuhl,
7. Jennifer Nicolai, Ph.D., University of Heidelberg, Department of Psychosomatic and General Internal Medicine, Thibautstrasse, 269115 Heidelberg, Germany Jennifer.Nicolai@med.uni-heidelberg.de
8. Claudia Goss, M.D., Ph.D., Section of Psychiatry and Clinical Psychology, Department of Medicine and Public Health, University of Verona, Piazzale L.A. Scuro 10, 37134 Verona, Italy claudia.goss@univr.it

Corresponding Author: Mary C. Politi at Mpoliti@wustl.edu

Text Word Count: 4574

* A report presented at The Dartmouth Institute for Health Policy and Clinical Practice's 2008 Summer Institute on Informed Patient Choice. Funding for this conference was made possible in part by 1R13HS017378-01 from the Agency for Healthcare Research and Quality (AHRQ). The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government. Funding for this conference was also made possible in part by the Foundation for Informed Medical Decision Making (FIMDM).

ABSTRACT

Specialty care involves services provided by health care professionals in order to treat a specific health issue or disease. In contrast to primary health care — a system with the goal of providing continuous, coordinated, and comprehensive care — specialty care often involves intermittent episodes of care focused around a specific condition. In addition, it often includes multiple providers who may play autonomous or complementary roles in patient care delivery. Each provider from each specialty discipline has a unique area of expertise that is important in supporting a patient's care. Interprofessional care involves multiple professionals from different disciplines collaborating to provide an integrated and comprehensive approach to patient care. In order for patients to experience continuity of care across these multiple providers, often located across various settings, providers need to communicate, trust one another, and maintain a shared sense of responsibility to their patients. In this article, we describe the challenges inherent in the *interprofessional provision of patient decision support* in specialty care settings. We then propose ways to engage in interprofessional decision support in specialty care settings. Finally, we discuss promising approaches to teaching an interprofessional approach to decision support to specialty-care health care professionals and institutions. Additional evaluation and empirical research is required before further recommendations can be made about educational preparation for interprofessional approaches to patient decision support in specialty care settings.

Key Words: specialty care, patient involvement, decision support, interprofessional education

Abstract Word Count: 223

Introduction

Specialty care includes those services that are provided by health care professionals in order to treat a specific health issue or disease, when patients have been referred from their primary care provider (Canadian Medical Association, 2001). In contrast to primary health care — a system with the goal of providing continuous, coordinated, and comprehensive care — specialty care often involves intermittent episodes of care focused around a specific condition or disease such as chronic back pain or cancer (Rosenblatt, Hart, Baldwin, Chan, & Schneeweiss, 1998). As medical knowledge increases, technology advances, and new interventions emerge, specialty care will remain an important and growing facet of health care. Currently, in some areas in the U.S., most health care is provided by specialists (Rosenblatt et al.). The way in which specialists work together as a team, interact with patients, communicate with patients' primary care providers, and coordinate patients' care can facilitate or limit a patient-centered approach to treatment (Xyrichis & Ream, 2007).

Specialty care involves multiple providers who may play autonomous or complementary roles in patient care delivery (Cooper, Henderson, & Dietrich, 1999; Haggerty et al., 2003), including but not limited to nurse practitioners, physician assistants, nurse-midwives, nurse anesthetists, clinical nurse specialists, medical geneticists, genetic counselors, dieticians, radiation therapists, physical therapists, occupational therapists, speech pathologists, and all types of specialty care physicians. Each of these providers, with their own unique area of expertise, is potential member of an interprofessional team in the specialty care setting and plays an important role in providing a comprehensive approach to patient care. In addition, patients and their interprofessional team must navigate together through numerous complex health decisions in specialty care settings. The aims of this article are to: 1) review the unique

challenges inherent in providing interprofessional patient decision support in specialty care settings, 2) propose suggestions for providing interprofessional patient decision support in specialty care, and 3) consider promising strategies for teaching interprofessional patient decision support to health care professionals and institutions who are striving to achieve a collaborative, patient-centered approach to care.

Interprofessional Decision Support For Patients In Specialty Care: Unique Challenges

In this paper, we define patient decision support as any process, tool, or system to help patients make preference-sensitive decisions (ref). Patient decision support in speciality care settings often occurs across multiple care providers in multiple settings. In order for patients to experience continuity of care during decision making in speciality care settings, providers need to communicate, trust one another, and maintain a collaborative sense of responsibility to their patients as they guide them through treatment decisions (Haggerty et al., 2003). Collaboration and continuity are essential aspects of preference-sensitive decision support within and across specialty settings. Haggerty and colleagues (2003) have identified three types of continuity that are important to consider in the provision of high quality patient care across multiple providers and settings: 1) *informational continuity*, or the use of information about a patient's history and context to shape care; 2) *management continuity*, or a consistent and coherent approach to the patient's health condition, including changing needs over time, and 3) *relational continuity*, or the ongoing relationships between patients and providers, and among the various providers involved in patients' care.

In specialty care settings, several key factors can interfere with the communication required to promote each type of continuity of care. These include (but are not limited to): the multiple geographic locations of specialty care providers; time considerations; various unclear

roles and responsibilities of providers; the power differentials in the relationships between these providers; and the frequency of preference-sensitive decisions in specialty care.

Practical Challenges: Geography and Time

The geographic location of specialists may affect the ability to provide informational, management, and relational continuity in patient care. For instance, in many rural regions in the U.S. and Canada, there are few specialists relative to the population (Norton & Lipson, 1998; Ormond, Wallin, & Goldenson, 2000). To address these geographic challenges, consultation about patients' care is sometimes delivered electronically. In Canada and the U.S., telemedicine and telehealth services are increasingly being used to communicate about a patient's care, during which patients and providers may be in a remote location on a video link (Jennett et al., 2003). Telehealth services can benefit patients in rural areas with travel limitations and/or patients with limited mobility (Barlow, Singh, Bayer, & Curry, 2007) and can benefit patients in both rural and urban settings who face socioeconomic barriers to care (Shea et al., 2009). When the appropriate technology is available, these services may also provide unique opportunities for interprofessional discussions about patients' decisions, and help to maintain informational and management continuity of care. Telehealth services strive to ensure that continuity of care is maintained despite limited provider-patient and provider-provider face-to-face contact (Schwamm et al., 2009; Vitacca et al., 2010).

Collaboration among the multiple providers involved in specialty care may also face scheduling and time constraints that challenge an interprofessional approach to care. Patients typically see numerous specialists for a particular illness, and also for the co-morbid conditions that may complicate treatment decisions for that illness. Input from various interprofessional team members, including those at off-site locations, inevitably influence one another. However,

scheduling and time constraints can lead health professionals to focus on their own specialty perspective alone, and to offer the patient treatment guidance according to their discipline-specific expert knowledge and opinion (D'Amour, Ferrada-Videla, Rodriguez, & Beaulieu, 2005). As a result, the patient is often left to independently integrate each provider's information and management advice. The role of each provider in the patient's care, and how to integrate each provider's advice into care, must be communicated upfront so that the patient is not left to this task.

In addition (ADD SECTION ON COMMUNICATION WITH PCPs/GPs)

Relational Challenges: Roles, Responsibilities, and Relative Power

The interprofessional team in specialty care consists of individuals from various professional backgrounds. Role clarity among and within interprofessional specialty health care team members is an essential aspect of effective collaboration and continuity of care (Fewster-Thuente & Velsor-Friedrich, 2008; Jansen, 2008). New professional roles (such as Patient Navigators, who help patients overcome barriers to care and guide patients through the complex health-care system; Dohan & Schrag, 2005; Fowler, Steakley, Garcia, Kwok, & Bennett, 2006) in both primary and specialty care settings have necessitated re-examination of each team member's unique function, and exploration of new ways to collaborate effectively in order to improve informational, management, and relational continuity (College and Association of Registered Nurses of Alberta (CARNA), 2008; Haggerty et al., 2003). Furthermore, many patients are seeking to assume more active roles in their health care decisions (Towle & Godolphin, 1999). The numerous types of providers involved in patients' care, including new professional providers introduced into the health care system, and patients' increasing

involvement in their own care, require providers to clarify roles and responsibilities during decision support.

Within specialty care teams, there may be power imbalances among providers, further complicating collaboration and continuity. For instance, historically, the nurse-physician relationship has been one in which the nurse regularly defers to the physician on all aspects of patients' care (Fewster-Thuente & Velsor-Friedrich, 2008). Although advances have been made to create an interdisciplinary and interprofessional system of care, in which providers respect one another's roles in patient care, relational tensions and power imbalances remain in many settings (Fewster-Thuente & Velsor-Friedrich). Collaboration can take place only when existing hierarchical issues are acknowledged and managed, and when each person's perspective—including the patient's—is valued and incorporated into treatment decisions (Jansen, 2008).

Preference-Sensitive Decisions in Specialty Care

The types of decisions that patients face in specialty care settings may also affect the continuity of their care. In general, referral to a specialist indicates a growing complexity in a patient's health that requires the patient to gain new knowledge to make informed decisions. Often, these decisions involve evaluating health care options that may be based on incomplete, equivocal or contradictory evidence, requiring patients to incorporate preferences into their decisions (O'Connor et al., 2003; Politi, Han, & Col, 2007). New discoveries about treatments and patients' responses to initiated treatments necessitate ongoing review of past and current decisions. Patients *and* their providers might struggle to integrate uncertain, rapidly-changing information into treatment planning and treatment choices. Informational and management continuity about these multiple risk/benefit profiles, the changing nature of options, and patients' preferences for their options may be challenged by the complexity associated with specialty care.

Providing Interprofessional Decision Support In Specialty Care

Decision Aids in Specialty Care

To assist with preference-sensitive decisions, patient decision aids (PtDAs) have been developed as adjuncts to the counseling provided by health care practitioners. PtDAs aim to help people make deliberate choices among options by providing information about options, helping patients clarify values for the risks and benefits of options, and guiding them through discussions with providers about options (O'Connor et al., 2003). Compared to usual care, PtDAs improve knowledge, clarify health expectations, lower decisional conflict, and increase patient participation in decision-making (O'Connor et al.).

PtDAs may be especially relevant for the provision of interprofessional decision support in specialty care. They could be designed and implemented in ways that acknowledge the changing nature of patients' decisional needs over time. They could help patients interact with each provider on an interprofessional team, and promote across-provider continuity of the deliberative discussions that unfold during the complex decision-making process. For instance, individuals at risk for cardiovascular disease using a PtDA reported improvements in knowledge, risk perception, and decisional conflict across both medical clinics and pharmacy settings (Lalonde et al., 2004). The PtDA also helped these individuals to monitor their own health progress over time (Lalonde et al.). Thus, PtDAs have the potential to enhance informational and management continuity for patients with changing health needs who see multiple specialty care providers.

Although a large number of PtDAs have been developed in research settings, their use in regular clinical practice is limited. Provider motivation, positive impact on the clinical process,

and improved patient outcomes have increased their use in some specialty care settings such as cancer, cardiac disease, urology, and pain management contexts (Legare, Ratte, Gravel, & Graham, 2008). At the same time, reported barriers to use include time constraints, lack of applicability to particular patients, and difficulty incorporating decision support into the larger health care structure (Legare et al.). These barriers remain, and may be amplified, in the context of interdisciplinary and interprofessional care, where multiple health care specialists in multiple settings must foster patient involvement in decision making.

The Concept of a Patient Decisional Needs Trajectory

Fitch and colleagues (2008) proposed a framework that provides a common, patient-centered approach to understanding how patients' health care needs emerge and change throughout the illness trajectory. This framework, called the Patient Needs Trajectory (PNT), provides one approach that can be used to enhance the continuity of patient-centered care in specialty care settings.

The PNT also could incorporate the patient's emerging decision support needs in specialty care. The resulting Patient Decisional Needs Trajectory (PDNT; see Figure 1) could serve as a guide to foster the continuity of care, and to provide individualized decision support for patients in specialty care settings. -- *Figure 1 here* -- Although the PNT was developed based on research with oncology populations, and we have illustrated the PDNT using an oncology framework, it also can be applied to a number of other specialty care populations, such as cardiac care, endocrinology, pediatrics, and others (Harrison & MacIsaac, 2008). For instance, using a cardiac care example, patients face decisions and needs at each point along the needs trajectory when managing their cardiac disease, from healthy adults (deciding on lifestyles including a healthy diet and physical activity that promote cardiac care) to those with early

symptoms (deciding on treatments for symptom management and to prevent disease progression) to those with more advanced disease (deciding on treatments such as coronary artery bypass graft surgery vs. angioplasty or medical therapy), to secondary prevention and lifestyle decisions after treatment for advanced disease.

The PDNT identifies eight general categories of patient needs (informational, physical, behavioral, emotional, practical, spiritual, social and cognitive) that shift throughout the illness trajectory. The PDNT encourages health care providers to incorporate the patients' *clinical*, *personal* and *decisional* needs while providing decision support at each point. For instance, using an oncology example, in addition to considering patients clinical needs such as tumor size, cancer stage, and clinical aspects of the disease, oncologists or oncology nurses can also provide patients with information about treatment options, describe what it is like to experience the potential physical and emotional aspects of each treatment option (e.g. how long the recovery might last, whether treatment will be painful, whether patients will have to cope with hair loss, how long patients will need to recover before returning to work), and discuss patients' preferences for the risks and benefits of treatment options. Each members of the specialty care team should be aware that these patient needs (such as the need to continue to work through treatment, if possible) can influence treatment decision making. In addition, referrals can be made to other members of the specialty care team (e.g. social workers) if patients express non-clinical concerns about how to talk to family members about cancer and its side effects. As time progresses after treatment, these specialty care providers can discuss surveillance and secondary prevention decisions, including the frequency of visits required for adequate surveillance, lifestyle changes that can help prevent recurrence or a second, new cancer, risks of other diseases resulting from treatments, and inquire about the impact cancer has had on the patient's family

and life. f. The specialty care team can come to understand the patient's priorities, and a person-centered plan of care can be developed while maintaining a continuous, collaborative approach to the patient's treatment across care providers.

When using the PDNT to guide care, the importance of an interprofessional team becomes apparent. At any particular relevant point along the trajectory, each health professional (e.g. oncologist, oncology nurse, social worker, using the example above) brings his/her expert knowledge and perspective to the care situation, in order to address the patient's full range of personal and concomitant decisional needs. At different points along a patient's illness trajectory, members of the interprofessional team may play a more central or more distant role in patient's care.

Steps to Engaging in Interprofessional Decision Support in Specialty Care Settings

. Although the PDNT can apply to both primary and specialty care (and the first point along the PDNT involves health adults, often seen in primary care), the PDNT is particularly well suited to specialty care because of the dynamic process of working through patients' needs over time, as their health condition becomes increasingly more complex as they enter the various specialty care contexts. At each decision point along the trajectory of specialty care, specialty care providers could begin with a needs assessment, which would involve: a) identifying the patient's personal, decisional, and clinical needs at a specific decision point, as shown in the PDNT in Figure 1, and then b) prioritizing these according to the patient's values and preferences.

A primary coordinator or "core team" could be identified to coordinate patients' care and that one or more providers in the team should assume a primary responsibility for a patients' decision support (Kirsh, Lawrence, & Aron, 2008). Core team members would be responsible for

communicating with other members of the specialty care team when deemed necessary. New decisions in specialty care settings are ongoing. The coordinator or core team could continually reassess the patient's personal, decisional, and clinical needs, monitoring for any changes that might suggest a new decision point along the trajectory of care. This process can be used as a guide to promote informational, management and relational continuity during the illness experience.

Core Competencies for Interprofessional Decision Support in Specialty Care Settings

We suggest three core competencies for providing interprofessional decision support for patients in specialty care settings: 1) the ability to identify the decision dilemmas arising from patients' unique personal, decisional, and clinical needs; 2) skills in patient-centered communication that foster patient involvement in decision making -- including skills in risk communication, in active listening and empathy, and in values clarification; and 3) the ability to work collaboratively and communicate effectively with other members of the interprofessional specialty care team and with the patients' primary care provider. All three core competencies need to be acquired by all members of the interprofessional specialty care team to improve collaboration and optimize patient outcomes. Although these core competencies are not unique to specialty care,

Core Competency #1: Ability To Identify Decision Dilemmas

Identifying the decision dilemmas associated with patients' personal, decisional, clinical needs in specialty care is the first core competency. For instance, a decision dilemma could arise if a newly diagnosed cancer patient's clinical context indicates that s/he is eligible for a therapeutic clinical trial, but the patient is confused about the trial details, afraid of being randomized to a treatment condition, and worried about side effects of either of the treatments

available through the trial. The Patient Decisional Needs Trajectory (PDNT) and the 8 different categories of patients' personal needs (informational, physical, behavioral, emotional, practical, spiritual, social, and cognitive) could guide this process. This patient-centered approach involves eliciting patients' perspective of their health story, revealing their knowledge, beliefs, fears, preferences, and concerns about their condition, and using the patient's reference point to personalize the decision discussion (Carrillo, Green, & Betancourt, 1999). Although providers are often quite comfortable addressing informational needs (e.g. helping patients to understand the details of the trial, including why participants are randomized to a treatment option), and sometimes practical needs (e.g. off-trial, one of the treatments is very expensive and not covered by insurance), eliciting patients' values, fears, and emotional needs is not systematically done in practice (Epstein & Peters, 2009). .

Core Competency #2: Skills in Patient-Centered Communication About Decisions

Many experts advocate decision support and communication skills programs for students and practicing health care professionals that focus on patient-centeredness and affective dimensions of care (i.e., warmth and empathy; (Beach, Rosner, Cooper, Duggan, & Shatzer, 2007; Braddock, Edwards, Hasenberg, Laidley, & Levinson, 1999; Stewart et al., 2000). There is evidence that patient-centered communication leads to greater patient involvement in decision making (Joosten et al., 2008), patient adherence to physicians' treatment recommendations (Roter, 2000), improved patient satisfaction (Kinnnersley, Scott, Peters, & Harvey, 1999; Williams, Weinman, & Dale, 1998), and improved patient health outcomes (Stewart et al.). However, the requisite elements for involving patients in a basic clinical decision, such as discussing the nature of the decision and eliciting patient preferences, rarely occur in clinical practice (Borkhoff et al., in press; Braddock et al., 1999; Elwyn et al., 2003). The skills to foster

these elements should be incorporated into standard training, and especially when considering an interprofessional approach in specialty care settings. In addition, skills in risk communication (Gigerenzer, Gaissmaier, Kurz-Milcke, Schwartz, & Woloshin, 2008; Lipkus, 2007) and values clarification (Epstein & Peters, 2009) can aid a patient-centered approach to decision communication.

Core Competency #3: Skills in Interprofessional Collaboration in Specialty Care

Specialists need skills to work collaboratively with other members of their interprofessional team, and often with primary care providers, to assess, plan, and provide high quality care for patients, and to optimize their health outcomes (Haidet, Fecile, West & Teal, 2009). They need to communicate effectively with other team members, including giving and receiving feedback and addressing conflicts that may exist or emerge. To perform effectively as an interprofessional team, each team member should work from a common patient-centered framework, recognizing each member's position and role in the care team (Haidet et al.).

Teaching Interprofessional Decision Support In Specialty Care Settings

To encourage the adoption of an interprofessional approach to collaborative patient decision support in specialty care settings, appropriate training must be available to health care providers.

Frameworks For Teaching and Barriers to Implementation

There are several frameworks available for the teaching, learning, and practice of decision support skills and the above core competencies (Braddock et al., 1999; Elwyn, Edwards, Kinnersley, & Grol, 2000; Towle & Godolphin, 1999). Health care providers might benefit from training in the Ottawa Decision Support Framework (O'Connor et al., 1998), which outlines three aspects important to patients' decision making: their perceptions of the decision itself, their

perceptions of others, and their personal and external resources. Each of the remaining frameworks lists similar competencies or elements that define the characteristics of patient decision support. These include: discussions about the nature of the decision; the patient's role preference; the alternatives, risks and benefits, and uncertainties; an assessment of the patient's understanding and his/her desire to receive input from others; exploring the patient's preferences; and the impact of the decision and its outcomes on the patient's daily life (Braddock et al., 1999).

Qualitative evidence (Barker, Bosco, & Oandasan, 2005) suggests that implementing interprofessional education for collaborative decision support may face a number of issues, including:

- a) lack of consensus regarding the terminology, including the definition of 'interprofessional education';
- b) questions about when interprofessional education for decision support should take place (i.e., pre- or post-licensure, during standard medical training or as a special certification process);
- c) the limited number of leaders in the field that work to implement and sustain education initiatives;
- d) the need for external financial and policy level support for education initiatives;
- e) the existing professional culture and beliefs about what the priorities should be; and
- f) the practical challenges of implementing interprofessional education – the amount of training required, the format training (e.g. in-person or web-based modules), and the appropriate individuals to provide the training.

The further development and refinement of both theory-driven and empirical research to support interprofessional education activities may help reduce the barriers to implementing

interprofessional approaches to decision support among specialists, regulatory bodies, and health policy makers.

Proposed Educational Formats and Content

At this stage, evidence is lacking to identify the best educational methods for teaching an interprofessional approach to decision support for specialty practice (Zwarenstein, Reeves, & Perrier, 2005); however, the following three strategies seem promising. First, intensive multiple-day courses with opportunities for role-playing, practicing with simulated patients, and/or watching one's own performance on videotape with patient and expert feedback have been shown to be successful at improving decision support and communication skills (Street, 2003). In contrast, one-day workshops (i.e., single educational interventions) are less likely to improve clinicians' skills in providing patient-centered decision support. This may be especially true for experienced clinicians who have had years to perfect their own style of communicating with patients and which they believe is effective (Towle & Godolphin, 1999).

Second, decision support could be introduced to different potential members of the interprofessional team from various subspecialties together in workshops, where possible (Zwarenstein et al., 2005). By having different potential members of the interprofessional team attend the same workshops on decision support skills (electronically, or in-person), each can improve his/her understanding of other members' scope of practice and professional role. After the workshops, workplace assessments could provide opportunities to reinforce the workshops' goals in real world settings (Norcini & Burch, 2007; Rollnick, Kinnersley, & Butler, 2002).

Third, experiential learning as a team could explicitly address the power balance issues unique to specialty care settings such the traditional hierarchy between physicians and other members of the specialty care team. Different health care professionals could be asked to adopt

the roles of other members of the interprofessional team. For example, a nurse might role-play the role of a surgeon, and all members of the interprofessional team might play the role of the patient to experience what it is like to be a patient cared for by the interprofessional team during decision support.

Evaluative Strategies: Licensure and Certification

Conclusions

As the population ages and greater numbers of adults are living with chronic diseases (Centers for Disease Control and Prevention (CDC), 2003), specialty care will remain an important and growing facet of health care. Specialty care faces both practical challenges (e.g. multiple providers working across multiple settings, under scheduling and time constraints) and relational challenges (e.g. distinct roles and power imbalances in delivering care to patients). An interprofessional approach may help specialty care providers manage these challenges during decision support. We suggest a patient-centered approach such that providers and patients together navigate the dynamic decision-making process during health care delivery. Importantly, we propose that patients' personal, decisional, and clinical needs should guide care at each of the multiple decision points along their health or illness trajectory. Further empirical research is needed before standards on coordination of care and decision support are reached.

Core competencies identified in this article — the ability to identify the decision dilemmas associated with patients' personal, decisional, and clinical needs, patient-centered decision support and communication skills to support patient involvement, and the ability to work collaboratively and communicate effectively with other members of the interprofessional specialty care team — form an essential foundation for interprofessional decision support for patients in specialty care settings. To promote the development of these core competencies, and

ultimately the implementation of interprofessional decision support, we discussed several frameworks and interactive training modules that may be used to educate and evaluate providers. Licensure and certification of individuals and potentially of institutions may facilitate the adoption of an interprofessional approach to decision support.

There are several gaps in our knowledge about how to incorporate decision support skills into interprofessional education in specialty care settings. Current frameworks for implementing decision support focus on individual providers. More research is needed to determine the best frameworks for training interprofessional teams in decision support. Additionally, given the wide practice variations in specialty care services within and across clinics, hospitals, and health care settings, a universal policy on coordination and monitoring the implementation of PtDAs/DSTs may not be feasible. Moreover, a culture of interprofessional decision support in the specialty care setting needs to be cultivated, moving away from didactic, information-giving models to a collaborative care model. Institutional reinforcement may reward or externally motivate members on the team to engage in an interprofessional approach to decision support (Gravel, Légaré, & Graham, 2006). Institution-level policies may help change the culture and context of specialty care settings, but this process would require time, resources, and support from the overall health care system.

To begin testing these frameworks and instituting shifts in individual- and institution-level specialty care, there is a strong need to identify the outcomes that are considered important to patients, primary and specialty care providers, systems managers, and policy makers. Researchers can then empirically investigate the effects of an interprofessional approach to decision support on key outcomes such as patient safety, patient clinical outcomes, patient satisfaction with the decision-making process, providers' satisfaction, decision quality, and

practice efficiency. With this knowledge, future training and certification standards can build on the suggested core competencies and education strategies to ensure that health professionals are skilled at providing an interprofessional approach to decision support to patients in specialty care.

References

Barker, K., Bosco, C., & Oandasan, I. (2005). Factors in implementing interprofessional education and collaborative practice initiatives: Findings from key informant interviews. *Journal of Interprofessional Care, 19* (Suppl 1), 166-176.

Barlow, J., Singh, D., Bayer, S., & Curry, R. (2007). A systematic review of the benefits of home telecare for frail elderly people and those with long-term conditions. *Journal of Telemedicine and Telecare, 13*, 172-179.

Beach, M. C., Rosner, M., Cooper, L. A., Duggan, P. S., & Shatzer, J. (2007). Can patient-centred attitudes reduce racial and ethnic disparities in care? *Academic Medicine, 82*, 193-198.

Borkhoff, C. M., Hawker, G. A., Kreder, H. J., Glazier, R. H., Mahomed, N. N., & Wright, J. G. (in press). The influence of patients' gender on physicians' interpersonal behaviour regarding total knee arthroplasty: What if your physician doesn't ask you to dance? *Arthritis & Rheumatism (Arthritis Care & Research)*.

Braddock, C. H., Edwards, K. A., Hasenberg, N. M., Laidley, T. L., & Levinson, W. (1999). Informed decision making in outpatient practice: Time to get back to basics. *JAMA, 282*(24), 2313-2320.

Canadian Medical Association. (2001). *Specialty care in Canada: Issue identification and policy changes*. Retrieved January 17, 2009 from http://www.cma.ca/multimedia/staticContent/HTML/N0/12/discussion_papers/SpecialtyCare/pdf/specialtycare-e.pdf.

Carrillo, J. E., Green, A. R., & Betancourt, J. R. (1999). Cross-cultural primary care: A patient-based approach. *Annals of Internal Medicine, 130*, 829-834.

Centers for Disease Control and Prevention (CDC). (2003). *Public Health and Aging: Trends in Aging -- United States and Worldwide*. Retrieved January 16, 2009, from <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5206a2.htm>

College and Association of Registered Nurses of Alberta (CARNA). (2008). *Registered nurse roles that promote continuity of care*. Paper presented at the CARNA, Edmonton, AB.

Cooper, R. A., Henderson, T., & Dietrich, C. L. (1999). Roles of Nonphysician Clinicians as Autonomous Providers of Patient Care. *JAMA, 280*, 795-802.

D'Amour, D., Ferrada-Videla, M., Rodriguez, L., & Beaulieu, M. D. (2005). The conceptual basis for interprofessional collaboration: Core concepts and theoretical frameworks. *Journal of Interprofessional Care, 1*(Suppl), 116-131.

Dohan, D., & Schrag, D. (2005). Using navigators to improve care of underserved patients: Current practices and approaches. *Cancer, 104*(4), 848–85.

Elwyn, G., Edwards, A., Hood, K., Robling, M., Atwell, C., Russell, I., et al. (2004). Achieving involvement: Process outcomes from a cluster randomized trial of shared decision making skill development and use of risk communication aids in general practice. *Family Practice, 24*, 337-346.

Elwyn, G., Edwards, A., Kinnersley, P., & Grol, R. (2000). Shared decision-making and the concept of equipoise: the competences of involving patients in healthcare choices. *British Journal of General Practice, 50*, 892-899.

Elwyn, G., Edwards, A., Wensing, M., Hood, K., Atwell, C., & Grol, R. (2003). Shared decision making: developing the OPTION scale for measuring patient involvement. *Quality and Safety in Health Care, 12*, 93-99.

Epstein, R.M., Peters, E. (2009) Beyond information: Exploring patients' preferences. *JAMA, 302*, 195-197.

Fewster-Thuente, L., & Velsor-Friedrich, B. (2008). Interdisciplinary collaboration for healthcare professionals. *Nursing Administration Quarterly, 32*(1), 40–48.

Fowler, T., Steakley, C., Garcia, A.R., Kwok, J., Bennett, L.M. (2006) Reducing disparities in the burden of cancer: The role of patient navigators. *PLoS Med 3*(7), e193.

Gigerenzer, G., Gaissmaier, W., Kurz-Milcke, E., Schwartz, L.M., Woloshin, S. (2008). Helping doctors and patients make sense of health statistics. *Psychological Science in the Public Interest, 8*, 53-96.

Gravel, K., Légaré, F., & Graham, I. D. (2006). Barriers and facilitators to implementing shared decision-making in clinical practice: A systematic review of health professionals' perceptions. *Implementation Science, 1*, 16.

Haggerty, J. L., Reid, R. J., Freeman, G. K., Starfield, B. H., Adair, C. E., & McKendry, R. (2003). Continuity of care: a multidisciplinary review. *British Medical Journal, 327*, 1219-1221.

Haidet, P., Fecile, M.L., West, H.F., Teal, C. (2009). Reconsidering the team concept: Educational implications for patient-centered cancer care. *Patient Education and Counseling, 77*, 450–455.

Harrison, M. B., & MacIsaac, L. (2008). Use and applicability of the supportive care framework within complex non-cancer populations. In H. P. MI Fitch, & BD Page (Ed.), *Supportive care framework: A foundation for person-centred care*. Pembroke, ON: Pappin Communications.

Health Force Ontario. (2007). *Interprofessional Care Project*. Retrieved March 1, 2009, from <http://www.healthforceontario.ca/WhatIsHFO/FAQs/IPCProject.aspx#catagory01>

Jansen, L. (2008). Collaborative and interdisciplinary health teams: Ready or not? *Journal of Professional Nursing, 24*, 218-227.

Jennett, P. A., Affleck Hall, L., Hailey, D., Ohinmaa, A., Anderson, C., Thomas, R., et al. (2003). The socio-economic impact of telehealth: A systematic review. *Journal of Telemedicine and Telecare 9*, 311-320.

Joosten, E. A. G., DeFuentes-Merilla, L., de Weert, G. H., Sensky, T., van der Staak, C. P. F., & de Jong, C. A. J. (2008). Systematic review of the effects of shared decision making on patient satisfaction, treatment adherence and health status. *Psychotherapy and Psychosomatics, 77*, 219-226.

Kinnersley, P., Scott, N., Peters, T. J., & Harvey, I. (1999). The patient-centredness of consultations and outcome in primary care. *British Journal of General Practice, 49*, 711-716.

Kirsh, S. R., Lawrence, R. H., & Aron, D. C. (2008). Tailoring an intervention to the context and system redesign related to the intervention: A case study of implementing shared medical appointments for diabetes. *Implementation Science, 3*, 34.

Lalonde, L., O'Connor, A. M., Drake, E., Duguay, P., Lowensteyn, I., & Grover, S. A. (2004). Development and preliminary testing of a patient decision aid to assist pharmaceutical care in the prevention of cardiovascular disease. *Pharmacotherapy, 24*, 909-922.

Legare, F., Ratté, S., Gravel, K., & Graham, I. D. (2008). Barriers and facilitators to implementing shared decision-making in clinical practice: Update of a systematic review of health professionals' perceptions. *Patient Education and Counseling, 73*, 526-535.

Lipkus, I.M. (2007). Numeric, verbal, and visual formats of conveying health risks: Suggested best practices and future recommendations. *Medical Decision Making, 27*, 696-713.

Norcini, J. J., & Burch, V. (2007). Workplace-based assessment as an educational tool: AMEE guide no. 31. *Medical Teacher, 29*, 855-871.

Norton, S. A., & Lipson, D. J. (1998). *Public Policy, Market Forces, and the Viability of Safety Net Providers*. Retrieved December 8, 2008, from <http://www.urban.org/publications/308041.html>

O'Connor, A. M., Stacey, D., Entwistle, V., Llewellyn-Thomas, H., Rovner, D., Holmes-Rovner, M., et al. (2003). Decision aids for people facing health treatment or screening decisions. *Cochrane Systematic Review*, CD001431.

O'Connor, A. M., Tugwell, P., Wells, G. A., Elmslie, T., Jolly, E., Hollingworth, G., et al. (1998). A decision aid for women considering hormone therapy after menopause: Decision support framework and evaluation. *Patient Education and Counseling*, *33*, 267-279.

Ormond, B. A., Wallin, S. W., & Goldenson, S. M. (2000). Supporting the rural health care safety net, *The Urban Institute*. Retrieved February 9, 2009, from <http://www.urban.org/publications/309437.html>

Politi, M. C., Han, P. K. J., & Col, N. F. (2007). Communicating the uncertainty of harms and benefits of medical interventions. *Medical Decision Making*, *27*, 681-695.

Rollnick, S., Kinnersley, P., & Butler, C. (2002). Context-bound communication skills training: Development of a new method. *Medical Education*, *36*, 377-383.

Rosenblatt, R.A., Hart, L.G., Baldwin, L-M., Chan, L., & Schneeweiss, R. (1998). The Generalist Role of Specialty Physicians: Is There a Hidden System of Primary Care? *JAMA*, *279*, 1364-1370.

Roter, D. (2000). The medical visit context of treatment decision-making and the therapeutic relationship. *Health Expectations*, *3*, 17-25.

Schwamm, L.H., Audebert, H.J., Amarenco, P., Chumbler, N.R., Frankel, M.R., George, M.G. et al. (2009). Recommendations for the implementation of telemedicine within stroke systems of care: A policy statement from the American Heart Association. *Stroke*, *40*, 2635.

Shea, S., Weinstock, R.S., Teresi, J.A., Palmas, W., Starren, J., Cimino, J.J. et al. (2009). A randomized trial comparing telemedicine case management with usual care in older, ethnically diverse, medically underserved patients with Diabetes Mellitus: 5 year results of the IDEATel Study. *JAMIA*, *16*, 446-456.

Stewart, M.A., Brown, J.B., Donner, A., McWhinney, I.R., Oates, J., Weston, W.W. et al. (2000). The impact of patient-centred care on outcomes. *Journal of Family Practice*, *49*, 796-804.

Street, R. L. (2003). Interpersonal communication skills in health care contexts. In J. O. Greene & B. R. Burleson (Eds.), *The Handbook of Communication and Social Interaction Skills* (pp. 909-933). Mahwah, N.J.: Erlbaum.

Towle, A., & Godolphin, W. (1999). Framework for teaching and learning informed shared decision making. *British Medical Journal*, *319*(7212), 766-771.

Vitacca, M., Comini, L., Tentorio, M., Assoni, G., Trainini, D., Fiorenza, D. et al. (2010). A pilot trial of telemedicine-assisted, integrated care for patients with advanced amyotrophic lateral sclerosis and their caregivers. *Journal of Telemedicine and Telecare*, *16*, 83-88.

Williams, S., Weinman, J., & Dale, J. (1998). Doctor-patient communication and patient satisfaction: a review. *Family Practice, 15*(5), 480-492.

Xyrichis, A., & Ream, E. (2007). Teamwork: A concept analysis. *Journal of Advanced Nursing, 61*(2), 232-241.

Zwarenstein, M., Reeves, S., & Perrier, L. (2005). Effectiveness of pre-licensure interprofessional education and post-licensure collaborative interventions. *Journal of Interprofessional Care, 19*(Suppl 1), 148-165.

**Figure 1. Patient Decisional Needs Trajectory:
An Oncology Example**



