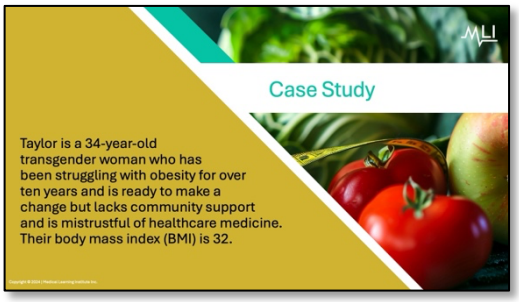
Chapter 3: Best Practices in Shared Decision-Making (SDM) to Enhance Patient Outcomes

Jay H. Shubrook, DO, FAAFP, FACOFP: Welcome back. Now we're going to do Best Practices in Shared Decision-Making to Enhance Patient Outcomes. Hi, I'm Jay Shubrook, a professor in the Department of Clinical Sciences and Community Health, and a diabetologist at Touro University, California, College of Osteopathic Medicine. I am delighted to be joined by Martin Abrahamson, MD, a fellow at the American College of Physicians, and an associate professor of medicine at Harvard Medical School. He's also active staff in the Medicine Endocrinology, Diabetes and Metabolism at Beth Israel Deaconess Medical Center.

Martin J. Abrahamson, MD, FACP: Thank you for having me and delighted to be here.



Case Study

Dr. Shubrook: Let's start with a case study. Taylor is a 34-year-old transgender female who's new to your practice. Taylor has been struggling with obesity for over 10 years and lacks support and community support and has a particular concern about mistrust of healthcare and medicine. Taylor's BMI is 32. Martin, how do we counsel patients like this and how often do you see patients who are struggling with obesity, but also express the mistrust of medicine?

Dr. Abrahamson: First of all, thank you for inviting me to participate in this important discussion. Sad to say, this is much more common than we really think it should be. There are a lot of people who struggle with obesity, number one, as we all know, but there are also people who are concerned about medicine and how we approach the management of obesity, how we as physicians approach the management of obesity.

There's a certain mistrust of medications because in the past, as we all know, there have been medications that were hailed as terrific medications, only to discover that there were side effects associated with their long-term use. Then there's a lot of people who just feel very isolated about having this problem of obesity and feel that there are no resources to support them.

That's why I think it's very important that we, as the quarterback or the clinician or the physician who is overseeing the management of this person with obesity, identifies people, resources, and organizations within the community that can help these individuals achieve their therapeutic goals. I

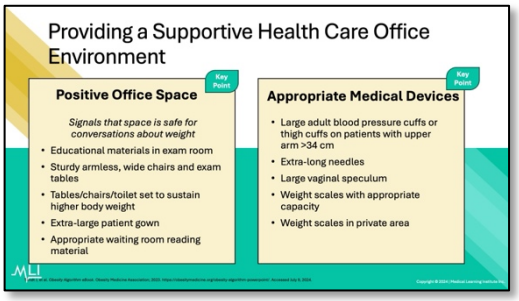
know we're going to talk about this as we progress through the discussion, but the therapeutic goals do not need to be grandiose and things that people think are unachievable.

For example, in certain communities, there are YMCAs, there are individuals who practice nutrition, physical therapists. We'll talk about this as we go through the discussion. The key really is here, what do we define as a successful therapeutic approach and a successful outcome?

Use a Collaborative, Goal-Oriented Style of Communication

I think our role as the clinician, looking after the individual with this problem, is to help the person understand that change is possible, help them resolve this ambivalence towards the medical community and about being able to change, help them develop a desire to move towards achieving these health goals, help motivate the patient, understand the patient, help the patient find their own solutions, and encourage the individual using positive feedback. Don't be judgmental, don't be confrontational, and don't try and offer advice that somebody's not willing to listen to.

Dr. Shubrook: I think these are really important topics to make sure that we think about. I think I might also just tell Taylor, thank you for being honest and sharing your experience because it's going to help me to help you.



Providing a Supportive Health Care Office Environment

Dr. Abrahamson: I think the other important thing is when somebody comes into a healthcare office, make sure that the first observation is an office that is supportive. It's a safe space to talk about weight, have educational materials in the room, use furniture that is appropriate for the individual who has this problem. Make sure that in the exam room, you have gowns that fit the individual, if you're going to use gowns, which most people do.

Have good reading material, make sure that when you take their blood pressure, you're not using a small cuff. If you're going to do any form of physical examination, make sure that the materials that you use, the instruments are appropriate. Make sure that the scales where you weigh individuals are not out in public areas for everyone to see and so on. I think the first impression for an individual who walks in who's got a weight problem is, "Oh, this is a safe environment for me."

Dr. Shubrook: We think about our space and our interactions, but we really have to be mindful of the entire experience because they might never make it to you if they feel that the waiting area or the reception or even the medical assistants don't see them as a person, don't respect them. I think we really have to be mindful to say the entire experience is engaged by the patient, and we need to make sure it's welcoming.

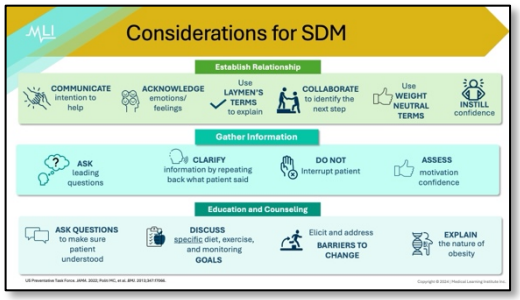
Dr. Abrahamson: Absolutely, for sure. Then there's the whole concept, which we spoke about right at the beginning when you introduced this topic, is shared decision-making. Shared decision-making helps us recognize what the patient's preferences are, how you can create a personalized management plan for the person, improves decision-making processes, and helps inform the person who you're counseling, what are the treatment risks, what's the safety, what are the benefits, and gives them the autonomy and empowers them to make decisions that is right for them at the time of the consultation and going forward as well with follow-ups.

There's this motivational interviewing approach which most of us believe is successful and helps people achieve their goal, helps guide people towards positive behavior change in the context of what they're trying to achieve with regard to weight management and healthy outcomes. Simplistically put, it's called the five A's.

First of all, *ASK* the patient, can we discuss your weight? Because some people may not want to discuss it at all. If they don't, move on.

ASSESS the person's desired weight reduction goal and what are the reasons they want to lose weight. *ADVISE* them about what treatments are available that meet their goals and are likely to produce desired results. Then *AGREE* on a weight reduction program, which includes lifestyle and behavioral change, and then help them, *ASSIST*, achieve in their goals by creating a plan with clear follow-up plans as well so that the individual doesn't feel that this is a one-time event and there's no coming back. I'm all on my own.

Dr. Shubrook: I think that of these five A's, setting the stage with, one, setting permission, and two, assessing with objective measurements, lets them know you see them as a person. I really like what you said about the assist. You're assisting the beginning of the journey, and you want to be there to set a plan that is actionable, and quite honestly, be available when there's setbacks to help them continue to move forward because they will have setbacks invariably.



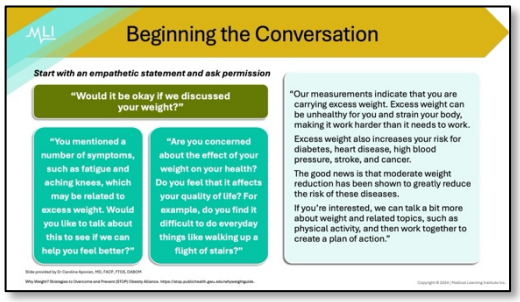
Considerations for SDM

There are some additional considerations for shared decision-making. First, you have to make sure you establish a positive and supportive relationship. That means you're going to communicate with an intention to help, you're going to acknowledge the patient's priorities, preferences, feelings, and values, you're certainly going to communicate in terms that are understandable to the patient, and we're going to agree to collaborate to identify the next step.

As we do that and use that positive patient-centered language, you're going to instill confidence in the patient and moving forward. Once you have that relationship, you want to gather information. Ask leading questions so that you don't fill in the blank for your patients, you give them the chance to share their experience from their perspective. If there are things that you're not clear on or you want to make sure that the patient knows that they're heard, clarify by repeating back what the patient said.

Certainly, do not interrupt their story and make sure you assess motivation and their confidence to move forward.

Then, once you have that base, you can really make sure that you provide the best education and counseling that fits your patient's preferences, values, and priorities. You can then discuss specific plans as it relates to their preferences, and then set shared goals. Those shared goals should be achievable goals and small goals. Just as it's important to establish the first step, you want to make sure you identify the perceived or the predictive barriers so that you have a plan to address them. When you do that, you really allow the patient to know that there is not a one-and-done, but we're in this for the long haul and we're going to anticipate and also be able to beat those challenges as they come. By doing this, you're now letting them see the context for which they're working for their overall health, not just for weight, but also things for like diabetes.



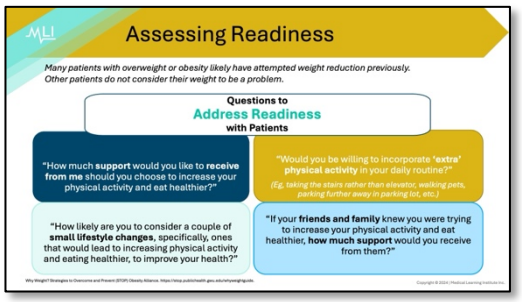
Beginning the Conversation

Martin, you introduced this earlier about how do we start this conversation. I think it really starts with a very simple and open question. Would it be okay today if we talked about your weight and maybe how it affects your health? I think we need to be prepared for both the yes and the no answer. If the answer is yes, then we can take that history from the patient's perspective. If the answer is no, that's equally important. Then we have to say, "I respect your answer, and I do want to let I'm worried about you, and, when you're ready to talk about it, I'll be here to help you."

Dr. Abrahamson: I think you're 100% right. If somebody is not ready, move on. There're also some other ways that one could approach to initiate the discussion. For example, if somebody has got symptoms that we know as physicians might be related to carrying excess weight, you could say, "You mentioned that you've got aching knees, you mentioned that you're fatigued. Well, these may be related to the fact that there's excess weight. Can we talk about this? Would you like to talk about this? Would you like to talk about things that you think might be impacting your health? For example, your weight. Do you think that your weight is affecting your quality of life? Do you do everyday things that are fine or are you having some difficulty with some everyday activities like climbing a flight of stairs?" That's one approach.

The other approach is to say, "Well, we've done a physical examination, and our measurements indicate that you are carrying excess weight. This could be unhealthy for you, as you know." I think it's also important to recognize that patients do know the deleterious consequences of carrying excess weight. They don't need us to dictate to them what they are, but then I think we can give them the positive spin. "Here's the good news. A small amount of weight loss goes a long way to relieving many symptoms and reducing risk for some of these consequences that we've just spoken about. If you want to, we can talk about it. When you're ready, we can discuss and come up with a plan."

Dr. Shubrook: I think you've brought the context into the patient about what they could see benefit-wise if they're ready. Then two, that you're, one, engaged, noticing, and giving them advice from a medical standpoint. I think that really anchors that for the patient.



Assessing Readiness

Speaking more about assessing readiness, I think first and most importantly, let's recognize that the great majority of our patients have tried many things before they come to us to address or change their weight and just because they've tried it before doesn't mean it's a priority now. I do think we have to assess with our patient. Is this something that you want to address now? I might start with, have you tried to work on your weight before or address your weight? What have you tried to do to address your weight in the past? What has worked and what hasn't worked? I think by doing that, you recognize that the patient comes to you already with many efforts to make a change.

Then if I'm assessing their readiness to change at this time, one of the first things that I think about is looking at what support they have. If you were going to try to make a change today, who in your circle is going to be able to help you with this process, and who might make it more challenging? I think knowing who their team is really makes a big difference.

Then I think the other part of this is actually knowing, most of our activities are shared activities. Who does the cooking in the home? Who do you spend your time with at work and in terms of your free time? Are you going to be able to get support from others in your circles that can help you make those changes?

Then as we set goals, we really want to set small achievable goals rather than setting the home run because invariably, they're going to be setbacks and that can be frustrating. As you think about a couple of small changes, which ones would you like to do first? Which ones do you think you're able to do now? We can't do them all, right? We eventually might be able to do them all.

If you assess and you feel like the person needs to incorporate more than they're currently doing, I think it's worth asking, how would you add a little bit of additional activity into the day, or how would you be able to reduce maybe some of the intake during the day? Now, I know that sounds like a lot, but I think this is not a one-and-done relationship. This is going to be an ongoing discussion.

I think when you front-load this work, it actually allows the patient to be more successful. I had a patient that actually came and said that, "Look, I'm done, I don't want to talk about my weight, I just know that I'm not going to be able to lose weight." I think part of that, she had been disrespected multiple times, I think that she had set unreasonable goals.

I do the same thing without support. Really I need to say, "Okay. Well, these are the things that I'm worried about, and I'd love to be able to help you. Then when you feel like you're at a place to make a change, we'll do it together." Quite honestly, what we did is we started with, let's just not gain weight this year. That was a goal that the patient felt very confident. In the first six months that they hadn't gained, they actually had lost, which wasn't even their intent. Their intent was not to gain.

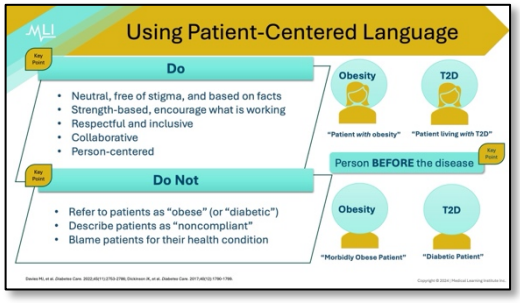
She actually said, "I didn't realize that the little bit I'm doing makes a difference." Too often we tend to be all or none. This person actually kept a chart, and they just made very small changes, but had lost

5 to 10 pounds within the first year with much less effort than they had done before. I think this is a good reminder that we don't need you to lose 100 pounds in a week or 6 months or even a year. We're going to start with small changes and celebrate the small changes. Once we achieve them, we can make a second change. Martin, how do you do this for your patients?

Dr. Abrahamson: You're absolutely right. The majority of people always, I think, initially have a barrier that they identify. As you say, they've tried something in the past and it's failed, or they attempted weight loss, they lost weight and then they regained it. I think what you just articulated, Jay, is absolutely right. When you're ready, number one, let's talk about it. Second of all, giving us some ideas about little things that can go a long way. Take the stairs instead of an elevator. One or two flights, you would normally just push the button, go in the elevator, take the stairs.

If you use public transport to get to work, park your car further away from the station so that you can walk an extra 100, 200, 300 yards. If you go shopping, park further away. I have a lot of patients who say, "I'm so busy, I just don't have time to do any exercise." I make a suggestion to them that, "When you take lunch, instead of sitting at your desk, go for a walk. 10 minutes, 15 minutes, better than nothing. Get up every hour when you're sitting at your desk and move around." Little things like that. I have a colleague who says, "I write a prescription for patients." He actually writes a prescription. He says, "This is 1 walk, 5 times a week, times 30 minutes at a time," and hands them a prescription. It's interesting, he claims that it's very successful. There are little things that we can do that go a long way.

Dr. Shubrook: I love that prescription because it is as detailed as a prescription would be. Often, we give these empty prescriptions, eat less, do more. How do you act on that? That's something that's actually actionable and could be followed. I like that detail.



Using Patient-Centered Language

Certainly, Martin, we've been talking a lot about patient-centered language. I think that this is something that if you're not doing already, I think you'll be amazed at how much it changes your practice. Certainly, best practices are using neutral language that's free of stigma and certainly based on facts and not opinions or styles. Make sure that you're working from a place of strength because, again, this is hard work, and encouraging the process, not just the product, will do a lot for you and your patients.

Then certainly, we all come from our own set of experiences, and we need to make sure that we're respectful of not only our similarities but also our differences, and be inclusive, and know that ultimately, whatever we suggest is a small piece of that time and effort for the patient. We want to be collaborative and supportive of that.

Now, examples of not best practices. Certainly, we don't refer to people as having that they're diabetics or they're anemics. We certainly don't describe as non-compliant. Often when someone's not following a plan, there's a reason for that. There're maybe challenges or maybe they don't understand it or maybe they don't endorse it. Then ultimately, we have a lot of blame in our society, a

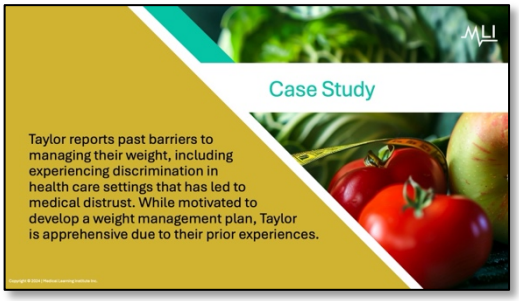
lot of blame and shame. The last thing we need to do is blame patients for their health condition. They're already doing that.

If anything, we should be trying to find ways to say, "Look, this is not just your actions. There are things that set you up for this and there are things that you can do to be successful to achieve your goals." I wouldn't necessarily assume that my goal is their goal. I want to make sure we know what their goal is overall. You always want to make sure that when you're talking about a condition, put the person before that condition that you're talking about.

Dr. Abrahamson: 100%, I couldn't agree with you more. This is the core of shared decision-making. It's not about us as the provider, the clinician. It's about the person who has the problem. I always say, this is a person who has a weight problem or a person who's overweight. You can use the word obesity, but it's a person and it's not an ick, a diabetic, or using words morbidly obese and things like that.

Dr. Shubrook: People have an entire identity unrelated to their health conditions.

Dr. Abrahamson: Right.



Case Study

Dr. Shubrook: Let's go back to Taylor. To get a little bit more history from Taylor, had past barriers to managing their weight, including feeling discriminated in healthcare settings. Because of that, Taylor checked out, just said that, "This is not going to be something that works for me, this is not a safe place."

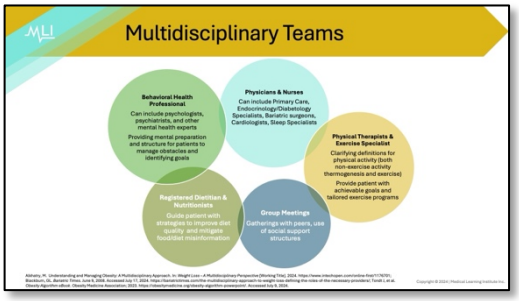
Taylor's motivated to develop a weight management plan and doesn't feel good, and really feels apprehensive due to this prior experience. How do you start that conversation with Taylor?

Dr. Abrahamson: First of all, I think I go back to what we said a little earlier in this discussion. Taylor may have some symptoms that you can correlate with obesity. "Taylor, I noticed that you claim that you have difficulty climbing the stairs, or maybe your knees ache a bit," or, "Taylor, our measurements today indicate that you are carrying some excess weight. I know that you may have been struggling with this in the past, but there's so many new things that have occurred in the weight management arena that maybe now's the time we can talk about it."

If Taylor feels isolated, I think it's important and it behooves us to say, "Taylor, you're not alone in this." Then offer the support that you can provide as the individual, but also what other support is available, and help Taylor identify support that might be available. We have physical therapists. We have nutritionists. We have communities where there's group education and group weight management programs. Let's list all of this and see what works for you.

Dr. Shubrook: I always want to recognize when a patient shares that, first of all, thank you for sharing that and thank you for trusting me in this process. I know that it sounds like you've had not a great experience, and I'd love to have a chance to try to make this a better experience for you. Martin, I love

the idea of building that team, saying, "What can we do here to build you a team that's going to work for you and that will be unique to the people in your community?" How do you build that team?



Multidisciplinary Teams

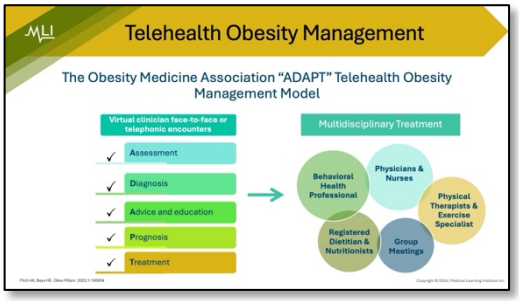
Dr. Abrahamson: I discuss, first of all, with the person, there are individual clinicians who can help you. There are groups that you can join. What's your preference? Some people do not want to be in a group setting and they feel embarrassed by it perhaps. They don't want to necessarily share with other people that they don't really know that well. There are other people who say, "I like to be part of a group." You use best-fit scenarios.

We've got a nutritionist, and what's more, and we're going to come back to this I'm sure, you don't have to necessarily travel 50 miles to see a nutritionist because we've got telehealth now and we can set something up for you. There's a physical therapist in the area here. You speak about how do you embark upon an exercise program? I happen to know somebody who's an exercise trainer or an exercise specialist. Would you be interested in connecting with that individual? I think you build a team with the person that works best for that person.

Dr. Shubrook: I think it's so important that maybe you are that touch point to reach out to those other patients, other people, especially if this patient felt like they've been disrespected. I think it's great to let the patient have a voice in building that team to say, "Boy, I would really need help with this," or, "I feel like I got this covered." I think building that team will be individualized both to the patient, but also to the resources in the area.

You talked about groups. I think the YMCA is a great example of a place where you can do group lifestyle balance or weight reduction programs that are evidence-based. You might have it in a place of worship, it might be in a community center, or it might even be at work. I think that it's really going to vary per person.

Dr. Abrahamson: This whole telehealth thing has made a huge impact. I always say, there's always a silver lining for whatever negative we experience. I think that although many of us articulated the value of telehealth, I don't think we really saw the true value and the acceptance of telehealth until we experienced the COVID pandemic.



Telehealth Obesity Management

All the associations, including the Obesity Medicine Association, has an approach for telehealth management for weight.

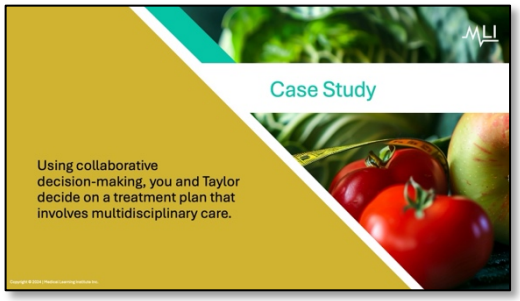
There can be virtual encounters or telephonic encounters that can assess people, that can help with diagnosis, that can provide advice and education and discuss management strategies. Again, the multidisciplinary team doesn't have to

be built in a single day. I had a patient recently who said that they had tried every diet under the sun, and they'd spoken to nutritionists, and they weren't interested in discussing anything with a nutritionist.

About a month later, they reached out to me through our portal, the patient portal, and said, "I think I'd like to talk to a nutritionist. You mentioned that you had somebody who's really good. Please connect me." It takes an email, and you connect people. Then the feedback was, "Wow, this person gave me some great ideas." People's minds change and approaches change over time.

Dr. Shubrook: You set that seed of here are some resources available for you when you're ready, and that patient didn't reach out when they were ready. I do think the beauty of telehealth is it really is a great opportunity for us to address social determinants and people who may be in rural areas that would not have access to team members. This can really equalize it because you could be anywhere if you're doing telehealth, if it works within your network.

Dr. Abrahamson: Absolutely.



Case Study

Dr. Shubrook: Using a collaborative decision-making, you and Taylor decide on a treatment plan that involves, as you described, a multidisciplinary collaboration. You've got that team, other care teams that you're thinking about for Taylor, and what challenges do you see, or do you anticipate as this team moves forward?

Dr. Abrahamson: I think we've discussed already the other care teams that are available to us, but I think the key now is communication, that the people in the team need and should communicate with each other so that Taylor doesn't feel that I'm being shunted from one person to another, and they don't know a thing about me. Again, the beauty of electronic communication is that it's so easy to share your visit and the outcome of a visit with the person with the problem with the other members of the care team so that the person realizes, A, I'm not alone, and, B, they're a bunch of people who are actually talking about me in a way that they are sharing their information so that I'm not feeling that I'm desperate here in the way I'm being pushed from one person to another.

Dr. Shubrook: I think that when things are going well, the patient knows that they have a team all working on Taylor's behalf, and when things are not going well, this will let the patient know that we're already working on solutions, we're already talking to the appropriate team member about what that challenge is. I think that really is best practices in care, and I think, as you said, there's always a silver lining. Our digital society now allows us to make communication so much easier.

Dr. Abrahamson: I can't overemphasize how important this topic is because we as clinicians have certain autonomy thrust upon us and sometimes feel that we know more than the person that we're seeing and like to impart advice. The way in which you part the advice is clearly the key here. The shared decision-making, the readiness for change, the five A's, the motivational interviewing, so much so important to address this particular chronic issue.

Dr. Shubrook: I agree so much and I think that this is important. It's something that's impactful, not only for your practice but for your patients. This brings us to the end of the three-part series, Best Practices in Shared Decision-Making to Enhance Patient Outcomes. We've taken a look at strategies for ensuring treatment choices that are based on patient collaboration, addressing patient barriers, impacting their engagement in obesity care, and the importance of interprofessional collaboration. Thank you for taking part in this series.

Dr. Abrahamson: Thank you, Jay, for including me in this very important discussion. I think it's important for a number of reasons. First of all, we are dealing with a lot of people who have chronic non-communicable long-term disorders. Certainly, one size fits all doesn't work when you're dealing with individuals who have these issues.

Second of all, we as clinicians sometimes tend to think that we know everything and the patient is there for us to just give them advice and they're going to listen. That doesn't work either. This whole idea of shared decision-making and the way in which we engage patients in empowering them and helping them come to their own decisions is clearly important. Using techniques like motivational interviewing and the five A's that we spoke about earlier in this discussion are very helpful for the practicing clinician to use in helping come to a shared management strategy with the person so that ongoing outcomes are more likely to succeed.

Dr. Shubrook: The epidemic of excessive weight and obesity is having a major impact on the health of our society. It is important for us as clinicians to be able to know how to communicate with our patients in a way that is supportive and allows them to know that we're going to be part of the team to address not only their immediate concerns but also how we can help them to be the healthiest version of themselves by recognizing their patient preferences, making sure we know what work they've done before, and being a resource both for support and tools so they can better manage their health and address weight concerns in the setting of healthcare.