USING EVIDENCE IN CLINICAL CARE TO IMPROVE PATIENT OUTCOMES

A breakdown of the concepts associated with patient-centered care and shared decision-making.

BY LORI LATOWSKI GROVER, OD, PHD

Two concepts, *patient-centered care* and *shared decision-making* (SDM), are fundamental to the goal of improving patient outcomes. Let's take a closer look at these two concepts, and at the high-quality evidence that supports their use, as they relate to the role of the busy doctor of optometry.

THE RISE OF PATIENT-CENTERED CARE

In the 1950s and 1960s, patients were told very little about their health care options. The concept of patient-centered care emerged in the 1970s and 1980s. At that time, for the first time, ethicists were included on hospital floors, elaborate informed consent policies were developed, and institutional review boards were created in response to increased regulation in research.

During this time, early self-care and consumer movements encouraged patients to make their own health care decisions, and evidence emerged indicating that patients wanted to participate in their medical decision-making. Clinicians began to recognize that they often underestimated their patients' desire for information and overestimated their own desire to make decisions on behalf of their patients.

The Institute of Medicine's landmark 2001 report, Crossing the Quality Chasm, highlighted patient-centered care—defined as care that is respectful of and responsive to individual patient preferences, needs, and values—as a fundamental approach to improving US health care quality.[1] SDM serves as an effective way to ensure that the values of the patient, not the clinician, guide all clinical decisions.

SDM IN A NUTSHELL

SDM is the involvement of patients with their doctors in making treatment decisions that are informed by the best available evidence about treatment options; all potential benefits and harms, or pros and cons, of patient-specific treatment options; and consideration of patient preferences (see *Clinical Pearls for Effectively Incorporating SDM Into Clinical Practice*).[2,3]

Of note, patient preferences reflect a personal appraisal of the relative desirability of health states, treatment, outcomes of treatment, or other aspects of health care. In health economics, preferences are represented as utilities, or values that represent the strength of an individual's preferences for specific health-related outcomes.

SDM addresses the ethical responsibility of clinicians to facilitate patient involvement. The more patients are informed, the more they become engaged. SDM also has the potential to reduce overtreatment and health care costs.

QUICK FACTS

The use of SDM was endorsed in 2004 by US and European critical care organizations and in 2009 through legislation enacted in states including Texas, Washington, and California. It was codified in the Affordable Care Act in 2010.[4,5]

CLINICAL PEARLS FOR EFFECTIVELY INCORPORATING SDM INTO CLINICAL PRACTICE[10]

- Recognize the patient's role in making decisions.
- Realize that the patient is not alone and that asking others for advice is okay.
- Inform the patient about *all* available treatment options.
- Model active listening. Ask the patient if clarification is needed along the way.
- Encourage patients to share preferences; you need to know what *they* care about.
- Give patients time to decide, as long as time permits.
- Allow patients to seek help from others.
- Encourage patients to stay informed.

Have you ever had a patient whose surgeon told him or her that surgery was the only option, when in fact there were potentially preferential nonsurgical options available? Patients often assume that their doctors' clinical recommendations are objective and evidence-based, but this is not always the case. One must possess a solid understanding of evidence (eg, its origins and quality) in order to offer good clinical advice and recommendations.[6,7]

Clinicians know and discuss what they see, and their views can sometimes be narrow. SDM minimizes clinician bias by encouraging the most comprehensive approach to understanding and discussing the available treatment options appropriate for a given patient. There is also a medicolegal rationale for fully informing patients as to all treatment options, and SDM is clinically helpful also in this regard. If all treatment options are effectively presented with the best available evidence, then patients are fully informed to make the best decisions about their health and health care. SDM can be an incredibly powerful way to improve the patient experience, patient and provider satisfaction, and overall health outcomes.

A Little Guidance

Many patients cannot decide among available treatment options and cannot express their preferences until they fully understand their diagnosis or diagnoses. For such situations, *decision aids* may prove helpful. Decision aids are tools that augment effective team decision-making by helping patients make preference-sensitive decisions. These aids may take the form of interactive videos, questionnaires, or graphics that help increase patient knowledge.

An updated Cochrane review of 55 randomized control trials found that using patient decision aids for a range of preference-sensitive decisions led to increased patient knowledge, more accurate perceptions of risk, a greater number of decisions consistent with values, reduced levels of internal decisional conflict, and fewer patients remaining passive or undecided about their treatments.[8]

It Takes Two

The success of SDM depends on the people on both sides of the biomicroscope. Patients must take an active role in conversations with their doctors, and doctors must encourage patients to be partners and empower them to take charge of their diseases and conditions. Stakeholders and family members must be encouraged to take notes and to engage the patient in further discussions.[9-11]

IT'S ALL ABOUT THE EVIDENCE

Successful doctors learn how to effectively share and communicate evidence. SDM represents the essence of what helping means and the enormous privilege that optometrists have in connecting with patients of all ages and making important health decisions. The use of SDM helps to ensure that patients and their eye care professionals are making the best choices for the patient.[11]

Just as not all treatment options are equally preferred, not all evidence is created equal. The quality of evidence—that is, where it originates, how it is generated, and what it does or does not tell us—is the rest of the story. In the next installment of this column, look for an in-depth review of the types of evidence doctors rely on for optimum patient care, how to recognize high-quality evidence, how to apply it in the clinical setting, and a review of the evidence that is recommended in the United States for improving population health. ■

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LORI LATOWSKI GROVER, OD, PHD
- Director, Center for Eye and Health Outcomes and Visiting Scientist, Southern College of Optometry, Memphis, Tennessee
- Trustee, American Optometric Association
- groverodphd@gmail.com
- Financial disclosure: None