Emergency Department Evaluation of Patients With Possible ACS

Heart House Roundtables

Paternalistic

Clinician as perfect-agent

Shared Decision Making

Informed

What is Shared Decision Making?

Involving the patient in making decisions to the extent that they desire.

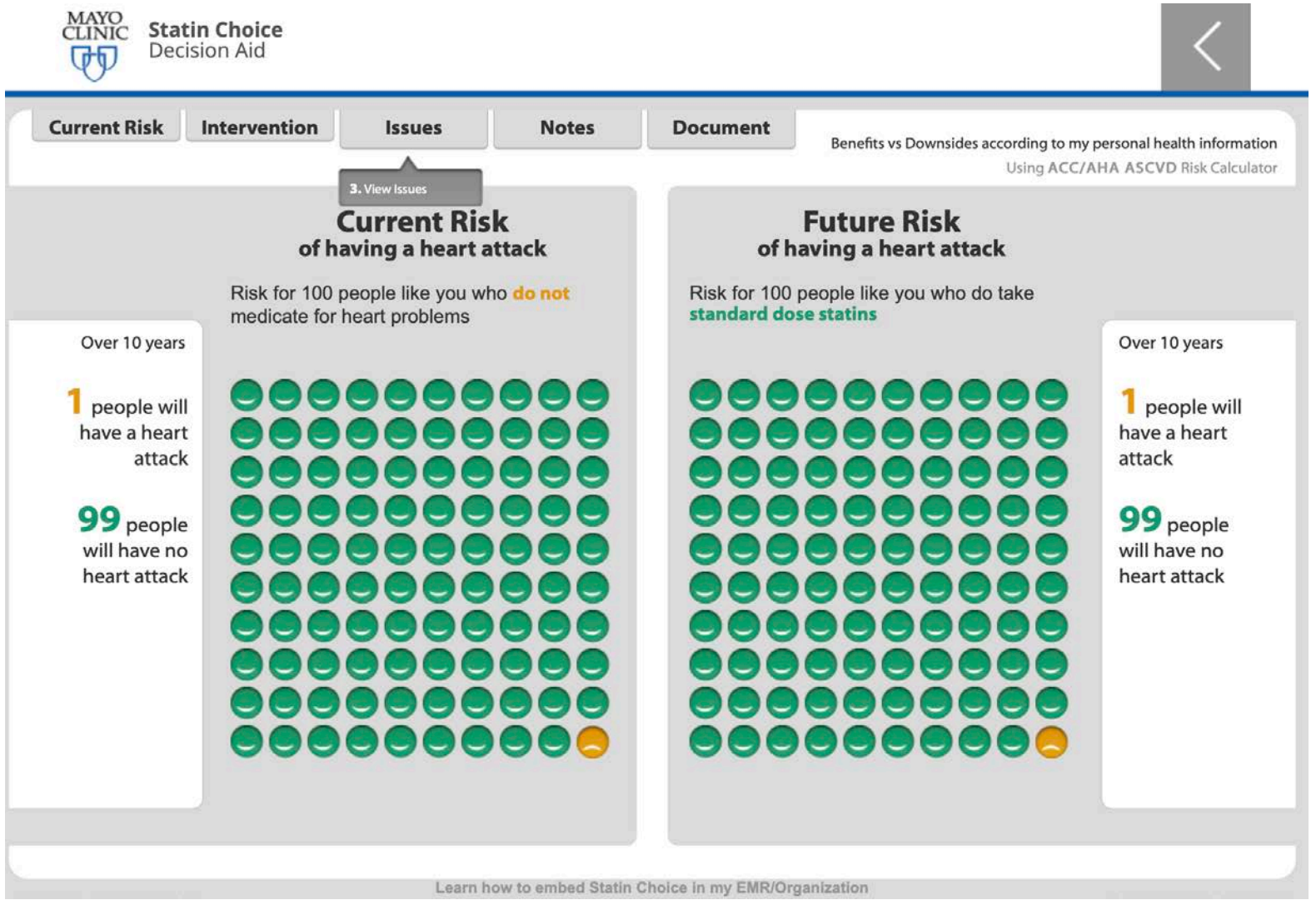
Edwards and Elwyn 2006

Effects of Decision Aids

Variable	Change
Patient knowledge	↑
Accuracy of risk perception	↑
Uncertainty related to feeling uninformed	↓
Major elective surgery	↓
PSA screening	↓

Stacey et al. Cochrane Collaboration, 2011

Statin Choice



Nannenga, Montori, Health Expectations 2009

Health Expect. 2009 Mar;12(1):38-44. doi: 10.1111/j.1369-7625.2008.00521.x.

A treatment decision aid may increase patient trust in the diabetes specialist. The Statin Choice randomized trial.

Nannenga MR[1], Montori VM, Weymiller AJ, Smith SA, Christianson TJ, Bryant SC, Gafni A, Charles C, Mullan RJ, Jones LA, Bolona ER, Guyatt GH.

Author information

Abstract

AIMS: Decision aids in practice may affect patient trust in the clinician, a requirement for optimal diabetes care. We sought to determine the impact of a decision aid to help patients with diabetes decide about statins (Statin Choice) on patients' trust in the clinician.

METHODS: We randomized 16 diabetologists and 98 patients with type 2 diabetes referred to a subspecialty diabetes clinic to use the Statin Choice decision aid or a patient pamphlet about dyslipidaemia, and then to receive these materials from either the clinician during the visit or a researcher prior to the visit. Providers and patients were blinded to the study hypothesis. Immediately after the clinical encounter, patients completed a survey including questions on trust (range 0 to total trust = 100), knowledge, and decisional conflict. Researchers reviewed videotaped encounters and assessed patient participation (using the OPTION scale) and visit length.

RESULTS: Overall mean trust score was 91 (median 97.2, IQR 86, 100). After adjustment for patient characteristics, results suggested greater total trust (trust = 100) with the decision aid [odds ratio (OR) 1.77, 95% CI 0.94, 3.35]. Total trust was associated with knowledge (for each additional knowledge point, OR 1.3, 95% CI 1.1, 1.6), patient participation (for each additional point in the OPTION scale, OR 1.1, 95% CI 1.1, 1.2), and decisional conflict (for every 5-point decrease in conflict, OR 1.5, 95% CI 1.2, 1.9). Total trust was not associated with visit length, which the decision aid did not significantly affect. There was no significant effect interaction across the trial factors.

CONCLUSIONS: Preliminary evidence suggests that decision aids do not have a large negative impact on trust in the physician and may increase trust through improvements in the decision-making process.

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[Indexed for MEDLINE] Free PMC Article

Radial Artery Versus Femoral Artery Access Options in Coronary Angiogram Procedures

Randomized Controlled Trial of a Patient-Decision Aid

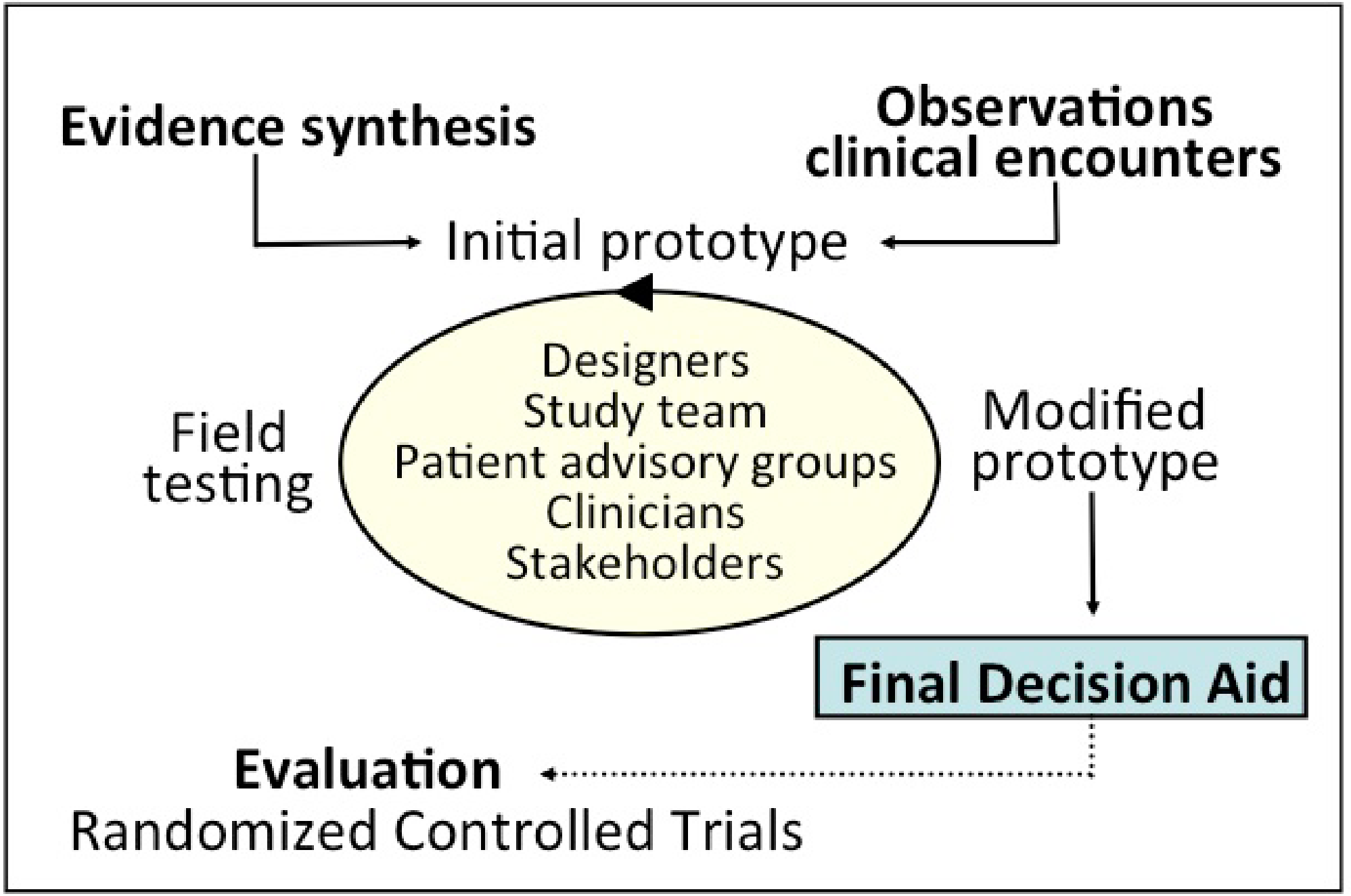
Editorial see p 247

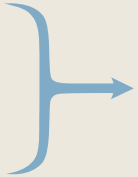
Jon-David Schwalm, MD, Dawn Stacey, RN, PhD, Dan Pericak, MMath, and Madhu K. Natarajan, MD

BACKGROUND— Vascular access options in coronary angiography can be considered a preference-sensitive decision, where the benefits/risks have different levels of significance, depending on the individual patient. For preference-sensitive healthcare options, patient decision aids (PtDA) significantly improve the process of decision-making. The purpose of this trial was to evaluate the effectiveness of an evidence-based PtDA compared with usual care in patients eligible for radial and femoral artery access.

METHODS AND RESULTS— We conducted a single-center, nonblinded, randomized controlled trial with patients eligible for both femoral and radial access as per their treating physician. The PtDA was designed to guide patients to make an informed choice, consistent with their preferences and values. The primary outcome, decisional conflict, was assessed using the validated decisional conflict scale. One hundred fifty patients were randomized (vascular access PtDA=76 versus usual care=74). The intervention group had a significantly reduced decisional conflict scale compared with control (unadjusted 14.8 versus 19.5, P=0.04) and were significantly more knowledgeable regarding risks/benefits associated with each vascular access (mean knowledge score 3/5 (95% confidence interval, 2.6 to 3.3) versus 2/5 (95% confidence interval, 1.7 to 2.3, P<0.01). PtDA patients had better informed value congruence with their vascular access received (47.3% versus 25.7%, P<0.01). There were no significant differences in procedural success or safety between the 2 groups.

CONCLUSIONS— A vascular access PtDA for eligible patients undergoing coronary angiogram procedures reduces decisional conflict and improves value congruence and the patients' knowledge of their healthcare options; however, a multicenter study, powered to confirm these benefits and evaluate differences in procedural success or complications, is required.


Evidence synthesis
Observations
clinical encounters
Initial prototype
Designers
Study team
Patient advisory groups
Clinicians
Stakeholders
Field
testing
Modified
prototype
Final Decision Aid
Evaluation
Randomized Controlled Trials



nic tracings of the heart)

- Initial cardiac troponin result

Does the tool work?

A randomized trial

Who was included?

- Primary complaint of chest pain
- Being considered for hospital admission for cardiac stress testing
- **Not included**: ischemic ECG, elevated troponin, known coronary artery disease, recent cocaine use

Chest Pain Choice Pilot Trial (n=201)

Outcome	Change
Patient knowledge	↑
Patient engagement	↑
Placed in EDOU for stress testing	↓ (19%)
Stress testing within 30 days	↓ (16%)
Provider experience	↑
Outpatient follow-up	↑
Safety	↔

Hess, Kline, Stiell et al. Circulation CQO 2012

Does the tool work in other settings?

A multicenter randomized trial


Rochester,
Minnesota
Philadelphia,
Pennsylvania
Indianapolis,
Indiana
Sacramento,
California
Jacksonville,
Florida

What did we find? (n=898)

Outcome	Change
Patient knowledge	↑
Patient engagement	↑
Admitted for stress testing	↓ (16%)
Stress testing within 30 days	↓ (8%)
Provider experience	↑
Outpatient follow-up	↑
Safety	↔

Hess, Montori et al. BMJ 2016

Questions for discussion

What are the gaps in patient engagement in the management of chest pain in the ED?

What are the potential benefits for patient engagement in this context?

Which decisions around chest pain management are reasonable to engage patients in the decision-making process?

How can we systematize patient engagement in the management of chest pain in the ED?