



Department of Family & Social Medicine

Team-Based Learning Faculty Facilitator Guide

Health Promotion Disease Prevention

Answer Key: ----

Version 2/3/16

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GOALS AND OBJECTIVES

Educational Goal

Students will be able to demonstrate the knowledge, skills, and attitudes required of an effective clinician with regard to health promotion and disease prevention in the care of patients and families in the clinical, community, and public health settings.

Medical Knowledge

The students will:

1. Assess an intervention to determine if it meets the standards of a good screening.
2. Apply the commonly used measures of association to a preventive service.
3. Formulate the recommendations for the following clinical preventive services based on a patient's age, gender, and risk factor status:
 - a. Immunizations
 - b. Screening tests commonly used in primary care
 - c. Prevention counseling of patients and their families using appropriate guidelines (such as the U.S. Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practice (ACIP) recommendations, or other appropriate guidelines).

Patient Care

The students will:

1. Develop an evidence-based health maintenance plan based on an individual patient's age, gender, and risk factor status.

Interpersonal and Communication Skills

The student will:

1. Appreciate the importance of effective communication with patients and families in promoting health and preventing disease.
2. Discuss the recommendations for clinical preventive services from two different types of organizations.
3. Review the principles of “shared decision-making” when involving patients in health care choices.

Practice Based Learning and Improvement

The student will:

1. Participate in effective collaborative teaching and learning activities with peer medical students.

Professionalism

The student will:

1. Demonstrate professionalism by preparing for and participating in the “prevention” session.

Systems Based Practice

The student will:

1. Appreciate the importance of integrating clinical preventive services and community level interventions to improve health outcomes.

LIST OF MATERIALS

- This faculty guide* for the session – one copy
- White paper copies of the associated 5 item Readiness Assurance Test (RAT)* – one for each student
- Scantron forms – one for each student
- Scratch cards* for GRAT answers – one for each team (usually 3)
- Memory stick with power point presentation*
- Phase 3 TBL handout – one for each student (students can keep this)
- “Skills and Steps for Shared Decision-Making” handout for Phase 3
- Answer Flash Cards
- Flip charts – one for each team
- Color markers for flip charts
- Pencils (for students who did not bring them) – Please collect afterwards

Never leave RATS / SCRATCH CARDS / faculty guides / slides with students.

*These should all be “Version ----” for this TBL.

All materials will be prepared by Adriana in advance and will be available in Block (formerly Mazer 430) by Friday afternoon prior to your session. The packet of materials will be in the bottom drawer of the filing cabinet on the right as you enter. Please return the materials to the same place following the session.

TBL SCORING AND GRADE CONVERSIONS

Some students may have questions about how the IRAT/GRAT scores will translate into clerkship points. Contrary to usual TBL principles, the IRAT/ GRAT scores are not included in the students’ grades. However, relevant material is included on the final exam. If students have questions about the grading system, refer them to the Clerkship Directors.

TOPICS AND OBJECTIVES BY PHASE

Phase 1: Preparation - Assigned Readings

1. PCORE Web Modules: “Prevention”
2. ARTICLE: Gafni et al (1997), “Shared decision-making in the medical encounter: What does it mean? (or it takes at least two to tango)”

Phase 2: Readiness Assurance of Core Prevention Concepts

Phase 3: Applications of Concepts – Health Promotion and Disease Prevention

1. Compare the screening recommendations from prevention-based and disease-based organizations for a specific preventive service.
2. Communicate risks and benefits of a preventive service recommendation to a patient.
3. Develop questions for use in the “shared decision-making” process.

TIMING OF SESSION

First Session Only:

In most cases, the first session will be Prevention. During rotations where another TBL session is scheduled first, however, the facilitator MUST:

1. before the class starts, list the student names (by team) on the board or project team assignments on the screen (available in the schedules folder in eMED). Have the students sit in teams as they arrive. This will save time later.
2. introduce the class to the concept of TBL including the purpose and process, prior to distributing the IRAT. This information is also posted on eMED.
3. before the GRAT, explain how to properly use the scratch cards (stars may not be in the center; don't scratch too hard).

All Sessions:

The following process is standard for all sessions.

1. Sessions in the education center require you to bring your own laptop or tablet, and install software on your computer to wirelessly link to the video screen. Please arrive 10 minutes early to ensure time for set up. If the wireless system fails, there are cables hidden behind the video screen to plug into your device.
2. Start on time at 8am.
3. Students will record IRAT answers on a scantron. Give them the following instructions:
 - a. Write your Banner ID on both the RAT and scantron.
 - b. Use a #2 pencil
 - c. Fill in response bubbles completely. There is only ONE answer to each question.
4. Distribute the RAT and scantrons, notifying students that they have **10 minutes** to complete it. Write the end time (e.g., 8:15 AM) on the board.
5. During the IRAT, double check all AV equipment and open the PowerPoint from jump drive (please do NOT move or copy the file from the jump drive to the computer).
6. Write the GRAT scoring system on the board.
 - a. One scratch = 4 points
 - b. Two scratches = 3 points
 - c. Three scratches = 2 points
 - d. Four scratches = 1 point
 - e. Five scratches = 0 points
7. Give students a verbal 5-minute warning.
8. When time is up, collect the scantrons ONLY. Allow students to retain their copy of the RAT through the GRAT process.
9. Ask students to break into groups (this is often done on their own in later sessions). Groups should be spread around the room as much as possible.

NOTE: Remind the students that both the IRAT and GRAT are closed book activities. No reference materials can be used.

10. Distribute scratch cards. State the time for this portion of the session (approximately **10 minutes**) and write the end time on the board. **If one team ends early, they should go over the rationale for why the incorrect answers are wrong – in preparation for their clerkship exam.** You can begin instructor feedback early if all groups finish before time is up.
11. **Walk around the room and listen to group dialogue.** The students will sometimes guess the right answer for the wrong reason. The only way to know this is to listen to their discussions. This will allow you to correct misunderstandings during the feedback section.
12. At the conclusion of the GRAT group time, have the students add up their GRAT scores and write the team scores on the board from this week and previous weeks to foster excitement about the competition.
13. Collect the scratch cards and begin faculty feedback (slides), which should run about **10-20 minutes**. Students keep the RAT questions during this discussion. In addition to the discussions you heard during the GRAT session, you can gauge which questions were more challenging by looking at the scratch cards.

*NOTE: New TBL faculty have a tendency to want to lecture. Remember, if there are no questions or comments regarding an answer, move to the next item. If there is a critical **teaching point** (from the following pages) related to the item, state it and remind students to review the content on PCORE (don't read the slide to the students).*

If students have questions, you can refer the question back to other students, especially when you heard the correct information from a student during the GRAT process.

*NOTE: Timing in this section can be challenging. Be aware of the time needed for Phase 3 (they differ based on the session) to make decisions about the length of discussion. One option is to table a lengthy discussion on one question until you've reviewed all 5, returning to it at the end as time permits. If you are in the unusual situation of having extra time, discussion of variability in practice at the different clerkship sites is always illuminating. **Leave at least 60 minutes for Phase 3.***

14. At the end of the faculty feedback (review of questions), ask students to put their names on the RAT and collect all copies. **Do not leave any copies behind.**
15. Distribute materials for Phase 3 and begin. Individual Phase 3 instructions are included in this Faculty Guide.
16. Count up RATs during beginning of Phase 3 to ensure you have collected all copies.
17. The students can keep the Phase 3 materials for their own use after the session.

After the Session:

Please return all materials to the bottom drawer of the first filing cabinet on the right in Block 430 (Mazer was renamed Block in early 2013).

FACILITATION TIPS *(especially during instructor feedback portion of Phase 2)*

1. **Ask teams for the correct answer to each question** - If all teams reported the correct answer, you have several choices:
 - a. Move on (especially important if time is running short)
 - b. Ask one team to explain how they came up with the answer (they may not know why it is correct) “Tell me about your thinking?”
 - c. Ask students to identify what they believe is the key teaching point of the question
 - d. “What would make the incorrect answer – correct?”
 - e. “Does anyone have a close second choice?”
2. **Try not to ask “do you have any questions about this?”** - In most cases, the students will say “no” (or just sit there in silence) and participation will wane. Rather ask questions such as 1b - e above.
3. **Silence is OK** – Even when asking good questions, it usually takes 5 to 7 seconds for someone to respond. Then, the conversation will continue at a quicker pace.
4. **Respond to Questions by Asking Others** – One goal of TBL (and group learning) is to teach one another. They can learn from one another as much as (or more) than from a single speaker. Students expect you to be the “expert” and tell them the answer. It is appropriate in some cases, but to keep the team learning environment, see #5 below.
5. **Look up Answers** – If no one knows the answer, have the person who asked the question research the answer and report back to the group the next time you meet.
6. **Refer to Discussions during GRAT** – When discussing reasons for correct/incorrect answers, refer back to what was said in the group discussions. This demonstrates that their conversation is valuable and that you are paying attention.
7. **Connect to Clinical Experience** – Connecting the discussion with what students see in clinic will make it more real and applicable as a learning experience. Additionally, it is important to discuss how/why recommendations might differ from standard clinical practice.
8. **Keep Lights On** – They may want to see the PowerPoint better, but lights keep people awake.
9. **Encourage Debate** – Allow students to respond to one another as time permits. If debates (especially about specific RAT items) take more than a few minutes, table the discussion until the end of the session.
10. **Alternate Which Teams Respond** – During Phase 3, after the simultaneous report, vary which team discusses their responses first.
11. **Allow for Participation by All Team Members** - Do not assign a spokesperson for a team. It may allow for quicker reporting, but discourages team building (additionally, valuable input might be missed).
12. **Serve as a Role Model** – Show patience and consistency, and accept feedback without being defensive.

From Tulane School of Medicine: Effective Small Group Facilitators...

- **prepare** a plan for the small group session. Small group discussions can have different goals.
- **listen** well and are **patient**.
- are **supportive** of the group, individuals in the group, and the small group process itself.
- make learning a **shared responsibility**. The facilitator tries to involve all participants and monitors his own level of participation.
- are comfortable with **silence**. Learners think, and thought requires time.
- are prepared to **refocus** the discussion.
- take **risks** by expressing personal thoughts about a topic or patient. By being honest and authentic, the facilitator creates a setting where all members of the group are comfortable expressing themselves. The facilitator is not fearful of saying, “I don’t know.”
- **challenge** but do not threaten. Effective facilitators ask thoughtful questions and involve all participants but are careful not to belittle or judge individuals.
- are judicious with the use of **feedback**. A group discussion is principally about sharing information, ideas, and opinions, not making evaluative comments. However, at times feedback will promote continued positive group interaction.
- **summarize** progress or decisions when appropriate – during the session, end of the session.

PHASE 2: SUMMARY TEACHING POINTS

PHASE 2: IRAT/GRAT ANSWER KEY (----)

Team Based Learning: Health Promotion and Disease Prevention Individual & Group Readiness Assurance Tests

PHASE 3: SUMMARY TEACHING POINTS

Uncertainty in Medicine

Influences on Your Own Opinion

Shared Decision Making

Shared Decision Making versus Informed Consent

Shared Decision Making Health Outcomes

Shared Decision Making in the Primary Care Setting

The SDM Framework

Competencies of Shared Decision Making

PHASE 3: SUGGESTED TIMELINE

- Distribute Phase 3 handout / Class reads the case and first question (5 minutes)
- Teams review and discuss the first question and make one choice and prepare a defense / (10 minutes)
- Teams reveal answers using flashcards / Faculty facilitates a discussion between all the teams in the class (15 minutes)
- Faculty mini-lecture on “Shared Decision-making”/ Distributes SDM handout (5 minutes)
- Class reads the second question (1 minute)
- Teams review and discuss the second question / Use flipcharts to submit responses (10 minutes)
- Faculty facilitates a discussion / Describes SDM OSCE at end of clerkship (14 minutes)

PHASE 3: ANSWER KEY

Preventive Medicine: Controversies and Making Choices

Instructions:

1. Take **5 minutes** to review the following case scenario and the first associated question individually. Then take **10 minutes** to review and discuss just the first question as a team. *Although there may be several possible answers, be prepared as a team to commit and defend your ONE choice.* It is important that you do not share your “team answer” with the entire class. Teams will reveal their “answer” simultaneously using a flash card when prompted. The faculty member will then facilitate a discussion of responses of each team and give a mini-lecture on shared decision making.
2. After the mini-lecture, take **10 minutes** to review and discuss the second question as a team using the flip charts to document your answers. The faculty member will facilitate a discussion about your responses, and then describe the associated observed structured clinical encounter (OSCE) scheduled the last week of the clerkship.

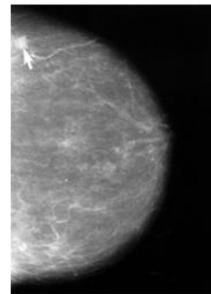
TEAM BASED LEARNING: HEALTH PROMOTION DISEASE PREVENTION: PHASE 3

Application of Course Concepts



Case Scenario: 43 year old woman

- Diane McIntyre has never had a mammogram and wants to discuss whether she should have one.



Case scenario / Part 1: Diane McIntyre is a 45 year old woman. She has never had a mammogram and wants to discuss whether she should have one. The patient has not had any family members with cancer, and she has never had cancer or radiation herself. Her menarche was at age 13, and she had her first child at age 24. She had a tubal ligation at age 30 after her third child was born. She breast fed all 3 of her children. She is still having her period, but they have become more irregular in the past year. She does not drink alcohol or smoke. This places her at average risk for breast cancer.

You decide to review two different screening recommendations and a recent article from the Journal of the American Medical Association about mammography screening for breast cancer in average risk patients.

United States Preventive Services Task Force (USPSTF)

The 2009 USPSTF recommendation updates the 2002 recommendation by providing specific recommendations for mammography screening by age. The previous recommendation statement recommended screening mammography every 1 to 2 years for all women older than 40 years. The USPSTF now recommends against routine screening of women aged 40 to 49 years. The decision to start regular, biennial (every 2 years) screening mammography before the age of 50 years should be an individual one and take patient context into account, including the patient's values regarding specific benefits and harms (Category C). The USPSTF recommends biennial screening mammography for all women aged 50 to 74 years (B recommendation), and provides an "I" statement regarding screening of women older than 75 years. Digital mammography and MRI as screening tools were not addressed in the 2002 recommendation statement; the 2009 USPSTF recommendation concludes that the evidence is insufficient to assess the harms or benefits of these imaging methods for screening of average risk women. Studies of the use of contrast-enhanced MRI for breast cancer screening have been conducted only in very high-risk populations.

The current USPSTF recommendation is now further informed by a new systematic review, which incorporates results of a new randomized, controlled trial. There is convincing evidence that screening with film mammography reduces breast cancer mortality, with a greater absolute reduction for women aged 50 to 74 years than for women aged 40 to 49 years. The strongest evidence for the greatest benefit is among women aged 60 to 69 years. Adequate evidence suggests that the overall harms associated with mammography are moderate for every age group considered, although the main components of the harms shift over time. Although false-positive test results, overdiagnosis, and unnecessary earlier treatment are problems for all age groups, false-positive results are more common for women aged 40 to 49 years, whereas overdiagnosis is a greater concern for women in the older age groups. Detection of cancer that would never have become clinically apparent is called overdiagnosis, and it is usually followed by overtreatment. Because of a shortened life span among women 75 years or older, the probability of overdiagnosis and unnecessary earlier treatment increases dramatically after about age 70 or 75 years.

In conclusion, the USPSTF reasoned that the additional benefit gained by starting screening at age 40 years rather than at age 50 years is small, and that moderate harms from screening remain at any age. The USPSTF notes that a "C" grade is a recommendation against routine screening of women aged 40 to 49 years. The Task Force encourages individualized, informed decision making about when to start mammography screening.

The American Cancer Society (ACS)

Women age 40 and older should have a screening mammogram every year and should continue to do so for as long as they are in good health. Current evidence supporting mammograms is even stronger than in the past. In particular, recent evidence has confirmed that mammograms offer substantial benefit for women in their 40s. Women can feel confident about the benefits associated with regular mammograms for finding cancer early. However, mammograms also have limitations. A mammogram will miss some cancers, and it sometimes leads to follow up of findings that are not cancer, including biopsies. Women should be told about the benefits, limitations, and potential harms linked with regular screening. Despite their limitations, they remain a very effective and valuable tool for decreasing suffering and death from breast cancer.

Film mammography reduces breast cancer mortality, with a greater absolute reduction for women aged 50 to 74 years than for women aged 40 to 49 years. The American Cancer Society feels that in both cases, the lifesaving benefits of screening outweigh any potential harms. Surveys of women show that they are aware of these limitations, and also place high value on detecting breast cancer early.

Mammograms for older women should be based on the individual, her health, and other serious illnesses, such as congestive heart failure, end-stage renal disease, chronic obstructive pulmonary disease, and moderate-to-severe dementia. Age alone should not be the reason to stop having regular mammograms. As long as a woman is in good health and would be a candidate for treatment, she should continue to be screened with a mammogram. For certain women at high risk for breast cancer, screening MRI is recommended along with a yearly mammogram. It is not generally recommended as a screening tool by itself, because although it is a sensitive test, it may still miss some cancers that mammograms would detect.

Journal of the American Medical Association

According to article “Woloshin S, Schwartz LM. The benefits and harms of mammography screening. JAMA 2010;303(2):164-165”,

- The lives of 5 in 10,000 women getting a mammogram in their 40s would be saved.
- The lives of 7 in 10,000 women getting a mammogram in their 50s would be saved.
- As many as 200 in 10,000 women getting mammograms have a false alarm over 10 years.
- False alarms can cause stress and involve uncomfortable procedures.

Q1. Based on the USPSTF and ACS screening recommendations, what is your team's position on screening mammography for this 43 year old female with an average risk of breast cancer and no past mammography?

- a) You would recommend "screening mammography" at this time.
- b) You would not recommend "screening mammography" at this time.

Be prepared to state your ONE choice, why and defend your position.

Q1. Based on the USPSTF and ACS screening recommendations, what is your team's position on screening mammography for this 43 year old female with an average risk of breast cancer and no past mammography? Be prepared to state your ONE choice, why and defend your position.

- a) You would recommend "screening mammography" at this time.
- b) You would not recommend "screening mammography" at this time.

Teams will reveal their one “answer” simultaneously using a flash card when prompted by the faculty member. The faculty member will facilitate a discussion.

FACULTY FACILITATORS: After the teams reveal their one answer simultaneously ask them to defend their rationale. Even if all teams agree on the same answer, their rationale for the answer may not be the same. The discussion around this question can be variable from one clerkship group to the next and can be similar to clinical “precepting.” Suggested tips based on previous sessions:

1) Be prepared to be flexible and try and facilitate and promote student to student interaction for the first 7 – 8 minutes. Summarize points made by the group and your own thoughts for the last 2 minutes before starting the “mini-lecture.”

2) The student conversations in the past have focused on:

- The inherent biases of disease-centered, specialty-centered, payer-centered, and prevention-centered society recommendations
- The public and the American Cancer Society reaction to the USPSTF recommendation
- Debating the benefits, risks, and Woloshin statistics of mammography
 - The lives of 5 in 10,000 women getting a mammogram in their 40s would be saved.
 - The lives of 7 in 10,000 women getting a mammogram in their 50s would be saved.
 - The USPSTF believes this difference changes the level of recommendation for each age cohort.
 - The ACS acknowledges that mammography is not perfect and that 200 in 10,000 women have false-positive test results, overdiagnosis, and unnecessary earlier treatment however they believe these risks are still worth the benefits.

3) **IMPORTANT QUESTION TO AUDIENCE:** “Would you make a different personal choice than you would professionally for this patient?”

- Participants may have a different opinion about what personal choice they would make versus professionally.
- Sometimes even with strong medical knowledge about mammography we may choose to a different option than the evidence-based recommendations due to personal experiences, values (e.g., trust in the “Western medical establishment”, and personal preferences.

MINI LECTURE / KEY TEACHING POINTS (IN BOLD):

Talking Point 1: Uncertainty in Medicine

- This question has no specific “right answer” due to the uncertainty of the medical information.
- **Making health decisions with patients about points of uncertainty in medicine is a critical skill.**

Talking Point 2: Influences on Your Own Opinion

- **Your personal knowledge, experiences, values, and preferences may lead you to champion one recommendation over the other.**

Your own position is influenced by your...

- Knowledge
- Experiences
- Values
- Preferences



Talking Point 3: Shared Decision Making

- Although we have our own opinions on what we may do in this situation, we don't usually impose our position on patients. An extreme example of misuse of authority and professional clout is telling a patient to "have a mammography or they will die."
- Instead, where several different treatment options exist with different possible outcomes and substantial uncertainty, we prefer that patients and doctors participate in a process known as "shared decision making."

Shared Decision Making

- An approach where clinicians and patients:
 - communicate together
 - use best available evidence
 - deliberate about attributes and consequences of the options (including doing nothing or deferment)
 - arrive at informed preferences in determining the best action
 - patient autonomy is respected.
- Shared decision making is an approach where clinicians and patients:
 - **communicate together ...**
 - **using the best available evidence** when faced with the task of making decisions.
 - Patients are supported to **deliberate about the possible attributes and consequences of options** (including doing nothing or deferment) and ...
 - arrive at **informed preferences in making a determination about the best action to take. Patient autonomy is respected.**

Talking Point 4: Shared Decision Making versus Informed Consent

FACULTY FACILITATORS: Ask the audience what is the difference between “shared decision-making” and “informed consent”?

- Informed consent
 - Patient learns key facts about a medical intervention before the patient decides whether or not to participate.
- Information sharing does not necessarily lead to a sharing of the treatment decision-making process. **Patients may want information about their medical condition and treatment options without necessarily being responsible for making treatment decisions alone** (Ende et al., 1989; Beisecker and Beisecker, 1990; Ryan, 1992).
- Shared Decision Making
 - Doctor and patient communicate to share information *and* share in the decision-making.

Talking Point 5: Shared Decision Making Health Outcomes

- **The process of shared decision making has been found to produce better health outcomes (i.e., orthopedic surgery, etc.), reduce unnecessary procedures, and reduce malpractice suits – regardless whether a patient goes on to have a procedure or chooses conservative management.**
- **Shared decision-making is increasingly advocated as an ideal model of treatment decision-making in the medical encounter.**

Talking Point 6: Shared Decision Making in the Primary Care Setting

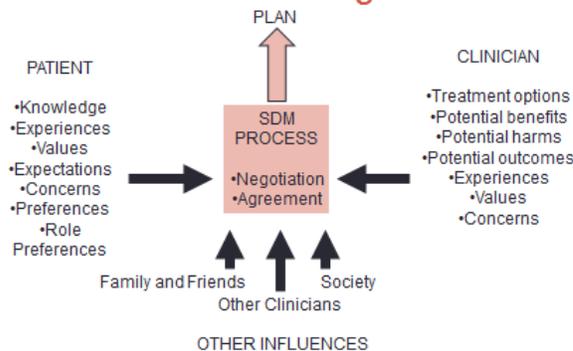
In the primary care setting, this model is adapted to go beyond acute or single treatment decisions (i.e., surgery):

- ongoing management of chronic disease
- competing and evolving medical and psychosocial agendas (biopsychosocial model).
 - evidence evolves about a medical recommendation or the patient’s priorities change over time

Talking Point 7: The SDM Framework

FACULTY FACILITATORS: REVIEW THE SDM FRAMEWORK (ON SLIDE) WITH THE STUDENTS

Shared Decision Making Framework



- A framework has been established for risk communication in practice.
- This diagram outlines the information to be shared by the patient and clinician, the other external influences on the process, and the integration of the information to negotiate a shared plan.

Talking Point 8: The Competencies of Shared Decision Making

THE COMPETENCIES OF SHARED-DECISION MAKING

- Problem definition—clear specification of the problem that requires a decision.
- Portray equipoise—that professionals may not have a clear preference about which treatment option is the best in the context.
- Portray options—one or more treatment options and the option of no treatment if relevant.
- Provide information in preferred format—identify patients' preferences if they are to be useful to the decision-making process.
- Check understanding—of the range of options and information provided about them.
- Explore ideas, concerns and expectations about the clinical condition, possible treatment options and outcomes.
- Checking role preference—that patients accept the process and identify their decision-making role preference.
- Decision making—involving the patient to the extent they desire to be involved.
- Deferment if necessary—reviewing treatment needs and preferences after time for further consideration, including with friends or family members, if the patient requires.
- Review arrangements—a specified time period to review the decision.

Edwards J, Rhyin G, Hood K, Small C, Robling M, Hourston W, et al. Patient-based outcome results from a cluster randomized trial of shared decision making skill development and use of risk communication aids in general practice. *Family Practice* 2004;21(4):247-254.

According to Edwards 2004, the following competencies were recommended in the shared decision making process:

FACULTY FACILITATORS: DISTRIBUTE “COMPETENCIES OF SDM HANDOUT” AT THIS TIME AND REMIND THE STUDENTS THIS NEXT SECTION IS RELATED TO THEIR END OF CLERKSHIP OSCE. Note that “competencies of shared –decision making” can also be considered the “steps of shared decision making.”

THE COMPETENCIES OF SHARED DECISION-MAKING

- Problem definition—clear specification of the problem that requires a decision.
- Portray equipoise—that professionals may not have a clear preference about which treatment option is the best in the context.
- Portray options—one or more treatment options and the option of no treatment if relevant.
- Provide information in preferred format—identify patients’ preferences if they are to be useful to the decision-making process
- Check understanding—of the range of options and information provided about them.
- Explore ideas, concerns and expectations about the clinical condition, possible treatment options and outcomes.
- Check role preference— that patients accept the process and identify their decision-making role preference.
- Decision making—involving the patient to the extent they desire to be involved.
- Deferment if necessary—reviewing treatment needs and preferences after time for further consideration, including with friends or family members, if the patient requires.
- Review arrangements—a specified time period to review the decision.

Case Scenario / Part 2: Returning back to Diane McIntyre and her request to discuss whether she should have a routine mammogram, you already previously assessed her risk factors and determined that she is at average risk for breast cancer. You explain to Ms. McIntyre her options for mammography: she can start now; she can wait until she is age 50; or she might choose not to be screened at all. You also explain to her the pros and cons of having a mammography at this time.

Case Scenario / Part 2:

Returning back to Diane McIntyre and her request to discuss whether she should have a routine mammogram, you already previously assessed her risk factors and determined that she is at average risk for breast cancer.

You explain to Ms. McIntyre her options for mammography: she can start now; she can wait until she is age 50; or she might choose not to be screened at all.

You also explain to her the pros and cons of having a mammography at this time.

Question 2. For each of the following “competencies in shared decision-making”, write 1 – 2 questions you would ask Ms. McIntyre regarding screening mammography (*Use the flip charts to list your questions*)?

- Check understanding—of the range of options and information provided about them.
- Explore ideas, concerns and expectations about the clinical condition, possible treatment options and outcomes.
- Checking role preference— that patients accept the process and identify their decision-making role preference.

Q2) For each of the following “competencies in shared-decision making”, write 1 – 2 questions you would ask Ms. McIntyre regarding screening mammography (*Use the flip charts to list your questions*)?

- Check understanding—of the range of options and information provided about them.
- Explore ideas, concerns and expectations about the clinical condition, possible treatment options and outcomes.
- Checking role preference— that patients accept the process and identify their decision-making role preference.

FACULTY FACILITATORS: After the teams complete their work (10 minutes), have each team reveal the questions they would ask the patient. Again – the conversation and submissions can be diverse. Suggested tips based on previous sessions:

1) Have each team read their 1 – 2 questions for the first competency only before moving to the other two. Let them critique each other’s submissions. Then discuss your ideas:

- Check understanding—of the range of options and information provided about them.
-Example: *“Now that we have had a chance to discuss the benefits and risks of mammograms, I wanted to know if you feel comfortable with the information and share with me what you understand.”*

- Explore ideas, concerns and expectations about the clinical condition, possible treatment options and outcomes.
 - Example: *“Of all the pros and cons and possible options we have discussed, what is the most important to you?”*
- Checking role preference— that patients accept the process and identify their decision-making role preference.
 - Examples: *“Is there anyone else you would like to involve in the decision process?”*; *“How can I help you in making a decision?”*

FACULTY FACILITATORS: “Physicians have to consider the health literacy of their patients in the SDM process. For example, in order to discuss a patient’s values related to risks and benefits of a treatment, the patient must be able to really understand those risks and benefits, which impacts how you might present the information or what supplemental materials you use.”

OSCE on Shared Decision Making

- Goal is formative feedback on selected shared decision making skills (one of two stations).
- Same clinical scenario - you will see Ms. McIntyre again
- The OSCE is required, but will not be graded.
- Please report to the Clinical Skills Center at your scheduled time

