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Alexa Vuylsteke

University of San Diego, ayatauro@sandiego.edu

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UNIVERSITY OF SAN DIEGO
Hahn School of Nursing and Health Science: Beyster Institute for Nursing Research

DOCTOR OF NURSING PRACTICE PORTFOLIO

by

Alexa Vuylsteke BSN, RN

A portfolio presented to the

FACULTY OF THE HAHN SCHOOL OF NURSING AND HEALTH SCIENCE: BEYSTER
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Abstract

Purposes/Aims: The purpose of this Doctor of Nursing Practice (DNP) project is to implement an evidence-based SDM approach in a culturally diverse community mental health clinic in order to increase patient-provider collaboration and improve patient autonomy and engagement in decision making processes of care in a mental health setting.

Rationale/Background: According to the Substance Abuse and Mental Health Services Administration (SAMHSA), shared decision-making (SDM) is a collaborative communication approach between patient and provider that aims to help people in treatment work together to have informed, meaningful discussions about their health care decisions. SDM is an evidence-based approach to encourage and improve patient-clinician interaction in preference-based care. Mental health SDM is associated with increasing satisfaction of care, improving patient medication adherence by 9%, reporting fewer psychiatric symptoms, and decreasing hospitalizations by 20%. Existing research has identified several barriers to implementing mental health SDM into clinical practice at the provider level. These barriers include the misperceptions about the competence of patients to make treatment decisions, cultural considerations, time limitations, and lack of skill in risk communication.

Methods: The DNP-Psychiatric Mental Health Nurse Practitioner (PMHNP) student will provide an in service rooted in the Seek, Help, Assess, Reach, Evaluate (SHARE) Approach model to PMHNPs at a community based mental health clinic located in San Diego, CA. The SHARE Approach model was developed by the Agency for Healthcare Research and Quality (AHRQ) and is a systematic, five-step process for SDM which includes exploring the potential benefits, harms, and risks of treatment options through meaningful dialogue about the patient's priorities. The DNP-PMHNP student will measure patient extent of involvement in the decision-

making process from the perspective of both patient and provider during a psychiatric encounter using the Shared Decision Making Questionnaire (SDM-Q 9). The SDM-Q-9 will be measured across 20 patient-PMHNP interactions both pre and post in service. The IOWA Model for evidence-based practice will be used. Using the Iowa Model will allow the DNP-PMHNP student to clearly identify the need for clinical practice improvement and integrate empirical evidence to support this change efficiently and effectively. This model also allows for important feedback loops to cycle back when barriers present throughout the implementation process.

PICO: In a sample of 20 out-patient, community adult mental health patients in April 2023, how does implementing a structured SDM approach affect the patient's perception of involvement in the decision-making processes during routine encounters with PMHNPs?

Assessment of findings: There was an overall increase in perceptions of involvement in SDM from both patient and provider after the SDM SHARE Approach was implemented. Patients voiced gratitude and felt more involved in their care. NPs found the training helpful, easy and efficient to incorporate, and report it gave them more structure to appointment.

Implications for Practice: This intervention will improve knowledge about SDM among PMHNPs. This will aid in standardizing and structuring SDM practice. Having a structured SDM approach in mental health care will reinforce a patient-centered treatment model as a result of making more informed and personalized treatment plans. Focusing on practices to improve SDM for PMHNPs will ensure nursing care can continue to go beyond the traditional model of health care. This intervention will continually address cultural considerations, potential barriers, uphold autonomy, provider-patient relationship, and empowerment that will lead to better outcomes in mental health care treatment.

Keywords: *shared decision-making, Seek, Help, Assess, Reach, Evaluate (SHARE) Approach, mental health, Patient-Centered Care*

Implementation of a Shared-Decision Making (SDM) Approach in a Community Based Outpatient Mental Health Clinic

Introduction

This Doctor of Nursing Practice project aims to take advantage of what nurses already innately know how to do, and further advance those skills to improve the state of mental health care. Nurses by nature are holistic care givers who strive to look at their patients as a whole person and not just a diagnosis or disease process. Looking at the complexities of a human and considering the biological, social, cultural and psychological factors that brought them into care are crucial in providing holistic, therapeutic and patient-centered care (Guidry-Grimes, 2020). Shared decision making (SDM) is an evidence based process that promotes patient-centered care (Zisman-Ilani et al., 2021). SDM can be defined as a process where the provider and patient work together to have meaningful conversations about healthcare decisions that take into consideration evidence-based practice and the patient's values and preferences (Haugom et al., 2022). These conversations may surround decisions regarding a patient's medication options, referrals, change in level of care, possible procedures and more.

The goal of this project is to train PMHNPs at a culturally diverse community mental health clinic a structured SDM approach more routinely, confidently, and effectively. When this is done, evidence suggests it may lead to positive outcomes including increased satisfaction in care, improved medication adherence, sense of autonomy and empowerment, and decrease in symptoms. SDM has recommended in all fields including mental health at a policy level, yet barriers continue to limit its implementation (Slade, 2017).

Clinical Problem and Significance

In the past 15 years, the relationship between patient choice and clinical decision making has been an ethically driven and significant conversation by healthcare systems. SDM has been recommended for people all conditions including those living with serious mental illness (Elwyn, Durand, Song, Aarts, Barr, Berger, Cochran, Frosch, Galasiński, Gulbrandsen, Han, Härter, Kinnersley, Lloyd, Mishra, Perestelo-Perez, Scholl, Tomori, Trevena, Witteman, & Weijden, 2017). SDM should be an integral and normalized part of routine mental health care since SDM involves core aspects of recovery-oriented and patient-centered care including self-determination, choice, and autonomy (Tai-Seale et al., 2013). Despite the increasing popularity and advancing developments of SDM interventions, SDM implementation for patients with mental illness has been relatively less successful than for other groups. This inconsistency within care models has been attributed to a variety of barriers including clinicians' assumptions on the state-of-mind of patients with serious mental illness and stigma-related beliefs that SDM is inappropriate for these patients (Zisman-Ilani et al., 2021).

Additionally, barriers to implementation include the idea that having conversations involving SDM will take too much time as many providers are unsure how to have these conversations with patients (Guidry-Grimes, 2020). There are also challenges engaging patients in SDM from diverse cultures, and many providers are lacking adequate training on how to deliver culturally competent SDM (Hawley & Morris, 2017). Although this may be true for some, increased patient engagement is of particular interest regarding patients with mental health needs, especially given the high burden of mental illness in the United States and the potential for greater patient engagement to improve health outcomes. SDM in mental health is associated with increasing satisfaction of care, improving patient medication adherence by 9%, reporting

fewer psychiatric symptoms, and decreasing hospitalizations by 20% (Mansoor Malik et al., 2020). When patients feel more involved in care, it is likely that they will become more invested and more empowered to follow through with treatment plans (Elwyn et al., 2017). In mental health, many patients have a chronic disease process that may mean the road to recovery just means long-term management, therefore it is even more important in those instances that patients feel like they have a say in their own care because it may affect the rest of their life. Every day decisions with their provider in which SDM is utilized effectively can lead to an overall better quality of life through harm reduction, improved provider-patient rapport, and higher symptom remission rates (Mansoor Malik et al., 2020).

While SDM has become an evolved movement and an ethical ideal for motivating therapeutic capacity in patient-clinician relationships, it is still difficult to implement in mental health practice and requires a well-articulated and standardized conceptual model for successful outcomes to become significantly relevant (Elwyn et al., 2017). SDM can be a disruptive process that challenges the stigma that “the doctor always knows best”, and it is more than the provider just being a good active listener. SDM is the intertwining of roles and shifting of power into a way that is balanced and equal so that informed decisions and what matters to the patient most plays a major role. Nurse Practitioners can be the forefront of this movement if SDM can be standardized and structured in a way that is approachable, easily taught, and effectively implemented. This project explores how this can be is done supported by evidence.

Literature Review

A thorough literature review was completed to inform this project. The literature search was conducted through Pubmed, Cinhal, Academic Search Premier, EBSCOT Host, Sage Premier Journal, and Cochrane. Keywords used for this search include shared-decision making,

mental health, patient-centered care, SDM, SHARE Approach, teaching SDM, and involvement in care. The purpose, strengths, and limitations of each article will be discussed as well as how the article informed the project. The extensive literature review provided an understanding of the theoretical and practical aspects of preparing for, developing, and implementing a structured SDM approach for providers at an outpatient mental health clinic. Much of the evidence helped to guide the project in a way that related SDM to broader issues such as health inequalities and quality improvement in promoting SDM in different population groups and cultures.

A prominent outcome of involving SDM is seeing better adherence to medications. De Las Cuevas, Penate and De Riviera (2014), addressed the issue of nonadherence in psychiatric care and the effects that SDM had on over 967 outpatient mental health patients. The aim of this study was to evaluate the influence of the match between preferred and experienced participation in SDM on self-reported adherence to prescribed treatment in psychiatric outpatient care (De Las Cuevas et al., 2014). The research team found that between the patient's preferred level of participation and their actual participation seemed to be more relevant for treatment adherence than the mere fact of being involved in the clinical decision-making process (De Las Cuevas et al., 2014). Additionally, the union between patient preferences and experiences in clinical decision making is likely to increase the satisfaction in the relationship and the confidence in the doctor (De Las Cuevas et al., 2014).

This guided the project by helping me identify a possible short-term outcome to measure. A limitation to this study was providing examples of validated measurement tools for this outcome. The effects of SDM can be difficult to measure, and although improving adherence is one of the costliest benefits of implementing share decision making, it can be hard to assess. What can be more easily measured and was more prominent in this study was the patient's

perceptions and level of participation in the decision making process. This helped me to find a validated tool to measure the outcomes of the intervention based on patient perceptions of involvement rather than other more difficult outcomes such as satisfaction, adherence, or symptom reduction.

A systematic review done by Shafrin and Forma (2017) aimed to quantify the cost of nonadherence in serious mental illness and identify factors involved. The research concluded that the patient needs to be involved in the decision-making process for treatment because factors such as medication dosage, pill burden, and regimen complexity influence adherence. The authors cite a cross sectional study that found that self-stigma highly correlated with rates of nonadherence and that patients with bipolar disorder had the highest rates of medication discontinuation at 65%, but living with a partner lowered the rates of self-stigma and decreased nonadherence (Kamaradova et al., 2016). This helped inform the DNP project by guiding better exploration for SDM training approaches that emphasized breaking stigma and prioritizing the patient's current views, feelings, emotions, and more. A more holistic and empathetic approach would be needed to help maximize outcomes such as increase in involvement and medication adherence.

Throughout the literature review, the goal was to find both qualitative and quantitative representation with the use of SDM. Haugom, Stensrud, Beston, Ruud and Landheim (2022) conducted a descriptive and qualitative study where they surveyed patients with severe mental illness (SMI) in outpatient settings about their experiences with SDM. Main takeaways from the survey results included the idea that SDM participation is desirable and achievable, shared decision making requires a trusting relationship, and can have varying degrees of involvement (Haugom et al., 2022). Four-fifths of the participants in this study found that they received

insufficient information about their health situation and treatment options (Haugom et al., 2022). The participants also expressed that they were a lack of options given to them, poor risk-benefit communication, and also felt like they were not encouraged to speak up or ask questions at times (Haugom et al., 2022). This study corroborated the same ideas from a 2016 study with 169 outpatient psychotic patients were interviewed and that in patients with SMI, motivation and perception of treatment benefit predicted treatment adherence significantly better than insight (Noordraven et al., 2016). The survey also highlighted the fact that only 5% of the patients said that the option they preferred was discussed with the psychiatrist even though 51% claimed that SDM was utilized to some extent (Noordraven et al., 2016).

Guidry-Grimes (2020) emphasizes that much of what psychiatrists assume are topics of SDM do not include topics such as psychoeducation, hospitalization options, legal considerations, and medication risks, and that they were inappropriate to discuss for this patient population. This further drove research to find an SDM approach that would go beyond the older and paternalistic views that many psychiatrists had about SDM, and instead include the previously stated study topics. Since Nurse Practitioners are trained in discussing these topics with all patients in all settings, it became imperative to find an approach that was based around some of these things.

This project took place in an outpatient mental health setting that serves a culturally diverse population with a heavy Asian influence that requires specific cultural considerations. Most studies done with SDM did not often focus on this population, and there are many perceived barriers and facilitators, and specific cultural influences that need to be considered. a systematic review of qualitative studies conducted in 2021 assess how Asian Americans involve themselves in SDM and their perceptions of involvement in SDM with their providers (Tan et al.,

2023). The authors concluded there is a gap in knowledge about the factors that can influence how Asian Americans approach SDM and their desire to be involved. It was found that desire to be involved can be greatly impacted by the language used by the provider that encompasses cultural values such as filial piety, collectivism, preservation of harmony, and respect for provider's authority (Tan et al., 2023). Currently, many SDM approaches focus on involvement of just the patient and provider, however in the Asian cultures often prefer large decisions regarding health include family members; (Tan et al., 2023) Understanding these elements are vital to addressing not only the health needs of Asian Americans, but other populations who face similar barriers to healthcare that SDM can help alleviate including financial barriers, low health literacy, and unique preferences to health care (Tan et al., 2023). It was imperative for this project to try and consider these factors when implementing the SDM approach in-service teaching to providers at this specific clinic.

More effective SDM requires not only sharing information, but also guiding patients in their efforts to make sense of the meaning of that information. It is important to master the ability to do this in a meaningful way, particularly when there is a fine balance between benefits and harms that come with many psychiatric disorders. Research from Theriault et al. (2019) points to the importance of provider education in the SDM implementation process.. SDM is a teachable skill, but there are many ways to teach it, and the current research does not supply consistent guidance or a standardized practice for every setting. However there are core elements to SDM that are consistently agreed upon Several training courses and educational material have been based off of the work of physician and researcher Glyn Elwyn (Thériault et al., 2019). Elwyn's research created the framework for teachings and tools that promote SDM's common core elements (Thériault et al., 2019). Légaré et al. (2018) conducted a systematic review of 87

studies in the Cochrane Library Database to explore if activities including training programs increased the use of SDM. Elwyn's work informed many of the structured SDM implementation activities. Both Theriault et al. (2019) and Legere discuss 5-step SDM training approach created by the Agency for Healthcare Research and Quality (AHRQ) called The Seek, Help, Assess, Reach, Evaluate (SHARE) Approach (Légaré et al., 2018). The SHARE approach became the evidence-based intervention for this DNP project.

The next step was finding literature supporting a tool to measure the effectiveness of the SHARE Approach. The DNP student found a systematic review that aimed to evaluate reliability, validity, and ability to capture elements of SDM in existing instruments (Norful et al., 2020). It included 30 studies that compared SDM instruments by measurement properties and integrative model element (Norful et al., 2020). The review suggested that The 9-item Shared Decision Making Questionnaire (SDM-Q-9) was a superior SDM measure evidenced by high reliability, validity, and presence of 9 SDM elements deemed essential (Norful et al., 2020). The 9-item Shared Decision-Making Questionnaire (SDM-Q-9) was developed in a theory-driven manner and measures the extent to which patients are involved in the process of decision-making from the perspective of the patient (patient version SDM-Q-9) and from the perspective of the physician (physician version SDM-Q-Doc). A limitation to this study is that the SDM-Q-9 was not used in a mental health setting, so it is unclear from this study whether its effectiveness would be the same in a mental health setting in comparison to a medical setting.

Another systematic review of studies evaluated interventions to facilitate SDM and found a wide range of areas in which the SDM-Q-9 and SDM-Q-Doc could be the most effectively applied to quality improvement projects involving SDM (Doherr et al., 2017). The SDM-Q-9 and SDM-Q-9 proved useful due to its, reliability, validity, accessibility to public, availability in

several language translations, and clear link to already identified core elements of SDM (Doherr et al., 2017). The SHARE Approach taught core elements of SDM while the SDM-Q-9 instruments assessed patients' perception of involvement surrounding these same core elements of SDM, and this allowed the DNP student to confidently continue with the project intervention implementation.

Evidence Based Practice Model

The purpose of this DNP project is to implement an evidence-based SDM approach in order to increase patient-provider collaboration and improve patient autonomy and engagement. The IOWA model was chosen as it allows anyone involved to utilize research findings to develop a clear method for an evidence-based practice (EBP) change project. This model has clear steps that assist in identification of the trigger for the problem, gathering evidence that supports the solutions, and providing guidance for implementation of the validated change interventions throughout the EBP process. Using the IOWA model for implementation allows for more easy translation of research to practice in order to see the preferred outcomes of this specific project. The IOWA model helps ensure that the project is set up for success by guiding users to make sure that the issue at hand is a priority to the organization and has sufficient research to back up the interventions that could help solve the problem. The DNP project was implemented at an outpatient clinic that was not currently utilizing an SDM approach. The DNP student reviewed the evidence with the stakeholders who supported this project implementation due to its mutual benefit to both patients and providers.

The IOWA model's foundational map is comprised of steps including problem identification, selection of evidence, team forming, implementation, integration and dissemination. The mode's step-by-step process allows for a project that is organized, efficient,

and easy to follow. Another advantage to this model is its feedback loops that allow for adjustment and modification at any point in the current or previous steps. The DNP student utilized the feedback loops to make changes as limitations and challenges arose. These limitations and challenges are discussed in another section of this manuscript. After instituting the change, the IOWA model allowed for a monitoring process that was clear-cut when assessing outcome data and disseminating results. If this project were to be continued at this clinic or another setting, the IOWA model is structured for successful replication or maintained for further results monitoring.

PICOT Question

The PICOT guiding this project is, “In a sample of 20 out-patient, community adult mental health patients in April 2023, how does implementing a structured SDM approach affect the patient’s perception of involvement in the decision-making processes during routine encounters with Nurse Practitioners?”

Evidence Based Intervention

The DNP student provided an in-service training for the PMHNPs at the clinic rooted in the Seek, Help, Assess, Reach, Evaluate (SHARE) Approach model from the AHRQ as seen in Figure 1. This took place involving the 2 PMHNPs and their patients at a community based mental health clinic located in San Diego, CA. The SHARE Approach model is a systematic, five-step process for SDM conversations which includes exploring the potential benefits, harms, and risks of treatment options through meaningful dialogue about the patient’s priorities (*The SHARE Approach*, n.d.). The 5-steps are based on the SHARE mnemonic seen in Figure 1 to guide the provider and patient in communicating with patients who may come from different cultures or have limited skills in language or low health literacy. It provides tips and

conversations starters and ideas that provoke meaningful and deliberate conversation about the patient's options involving an individual treatment plan in a way that is easy to understand and applicable for any encounter.

The Agency for Healthcare Research and Quality (AHRQ) provides a collection of tools and training resources to support the implementation of this approach of shared decision making into practice. The AHRQ developed the SHARE Approach Workshop curriculum to support the training of health care professionals on how to engage patients in their health care decision making (*The SHARE Approach*, n.d.). The online curriculum is made up of self-guided PowerPoints that include an Introduction, four content modules, and a module with training tips that the DNP student trained herself on and adapted the lessons into a more concise in-service training. The original workshop from "The SHARE Approach" included the following -

Module 1: Shared Decision making and the SHARE Approach

Module 2: Using Patient-Centered Outcomes Research (PCOR) in Shared Decision making

Module 3: Communication

Module 4: Putting Shared Decision making Into Practice

The DNP student completed the Trainer Modules and then adapted the AHRQ's modules to create her own individual PowerPoint presentation (See Appendix G) that she would present during a lunch break to train the PMHNPs at the clinic. After the in-service, the DNP student evaluated the 2 PMHNP's thoughts on the in-service training the with Kirkpatrick Learner Survey (See Appendix I). The student gave time and space for feedback or questions and then asked them if they felt comfortable applying the steps of the approach in their future patient encounters so they could observe the changes in level of perceived involvement in shared decision making.

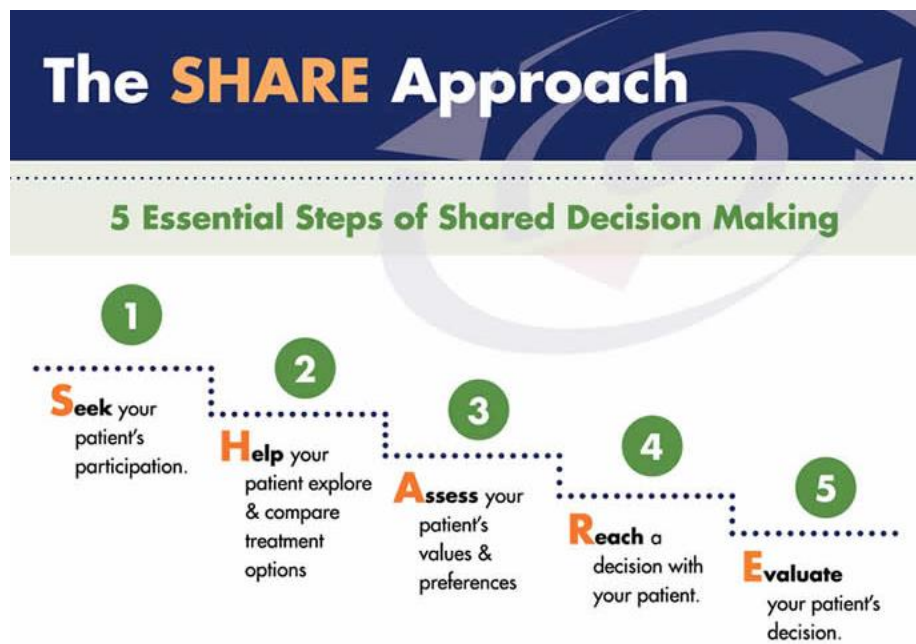
First, the DNP student collected pre-intervention data that would utilize the SDM-Q-9 and SDM-Q-DOC scores to assess the perception of involvement in SDM during each encounter from the patient perspective and the provider perspective before the in-service training was completed. Both of the versions of the questionnaire have a blank space to fill in the chief complaint of the encounter and what decision was made. The DNP student would fill this out as an observer before the patient and provider completed the 9 survey questions below. Both surveys asked the same questions but written in first person so it would apply specifically to patient and doctor. At the beginning of each session, the DNP student would introduce herself and her role to the patient. If the patient agreed to participate at the end of the encounter, the DNP student administered the SDM-Q survey to both patient and provider. The DNP student informed them it was anonymous and had the provider step out of the room while the patient was completing the survey. The survey was either completed in person with a printed version of the SDM-Q-9, or the DNP student was facilitating the completion over the phone with the patient and filling out the printed survey with their verbal answers. Translation services were used for Mandarin, Cantonese, Laotian or Vietnamese patients. The process of completion for the survey ranged from about 2-5 minutes.

The DNP student would then measure patient extent of involvement in the decision-making process from the perspective of both patient and provider during a psychiatric encounter based on the SDM-Q-9 results. The SDM-Q-9 was used to measure across 10 patient-PMHNP interactions pre and 10 patient-PMNHP interactions post in-service to see if patient and provider perceptions of level of involvement in care guided by SDM changed after this structured approach was taught. The same The SDM-Q-9 and SDM-Q-DOC surveys have 9 questions that each correlate to an element of the SDM process (See Appendix H). The answers to each

question fall on Likert Scale from 0 - 5 or *completely disagree* (0) to *completely agree* (5) with the statement that asks the patient if they were involved in each step of SDM.

Figure 1

AHRQ's The SHARE Approach



Project Implementation & Practice Change Process

This evidence-based project was initiated based on the DNP student's desire as a future PMHNP to see more SDM utilized in all patient setting and encounters. The DNP student noted a lack of consistency with SDM among providers and wanted to tackle this knowing that the positive outcomes of effective SDM could be outstanding. The DNP student conducted this project at her clinical rotation site of the Union of Pan Asian Communities (UPAC).

After identifying the problem and opportunity for change at UPAC, the DNP student completed an extensive literature review to gather evidence and plan out the evidence-based project plan. The DNP student was granted approval to complete this DNP project from the

Director of Mental Health at UPAC in December of 2022. In February of 2022, University of San Diego IRB approval was granted to begin implementation. Pre implementation data started in April and took approximately 2 weeks. The DNP student completed the Trainer modules through the AHRQ that entailed spending approximately an hour on each day for about 4 days to complete and feel comfortable and confident in creating an adapted version for the in-service. The student's version of the workshop took 1 day to create.

The 2 PMHNPs at UPAC completed the in-service during one of their hour-long lunch breaks during the week. After the in-service training, the DNP student provided time to answer questions and encourage them to go to the AHRQ's website if they had further questions about the SHARE Approach or if they wanted to explore the additional resources. After the in-service was complete, post intervention data collection and evaluation began. This data collection lasted about 2 weeks. Presentation of results occurred at a stakeholder presentation on May1, 2023 with one of the involved Nurse Practitioners, The program Director of mental health at that UPAC clinic, and the DNP student's faculty advisor.

Results

This section will review the results of the pre and post intervention results and the in-service learner evaluation. The outcomes of this project are measured by the scores of the SDM-Q-9 survey. There is no cut-off score for the tool, therefore the DNP student looked at each question, and averaged the numerical scores from the Likert scale. As seen in Figure 2, the average scores for both the pre and post intervention scores for provider and patient are listed. It is important to note that any answer of 3 or above meant that the patient or provider agreed with the statement about their involvement in care. There are no questions on the survey that were below 3, meaning that even before the in-service was taught, patients and providers both had at

least mild positive perceptions of involvement in each step of the decision-making process during their encounters.

In the pre data, it is interesting to point out that the patients had higher level of perceived involvement in their care in comparison to the NPs perceived level of involvement with the patient in decision making. From verbal encounters the DNP student had with the NPs after results were discussed, some of this initial discrepancy with PMHNPs could have been attributed to them not even realizing that simple inclusive language they always use can enough to make a patient feel included in care. Although they were not following any structured steps like the 5-step SHARE Approach at this time, they were still utilizing elements of SDM in their sessions due to their training and education as Nurses and PMHNPs. These results from the pre data affirmed to the student that PMHNPs had the potential to hone in on their skills through the training even more. The goal was to now give the NPs more structured approach that involvement in SDM would be increasingly noticeable and easier to implement within sessions.

After the in-service was completed and the NPs trialed the SHARE Approach in practice, the DNP student began collecting the post data seen in the dark columns in Figure 2. There was either no change or an increase in every question's average score. This increase is a positive outcome that correlates to patients and providers feeling like they were able to effectively complete the steps of SDM that fostered a better sense of involvement from both sides as a team. Once again, the average score of the patients were higher than the provider's scores, but there was increase in average scores for both. Further factors that may have contributed to the scorers will be discussed in the Discussion portion below.

The Kirkpatrick Learner Evaluation Survey seen in Appendix I was utilized after the in-service to evaluate effectiveness of the training and assess whether the learner would recommend

it to someone else. The survey contained 5 statements assessing satisfaction with the course, perception of enhanced learning, relatability to current job, and recommendation opinions. Each statement was scored on a 5-point Likert scale where the learner rated their level of agreement from Strongly Disagree (1) to Strongly Agree (5). Both PMHNPs gave all 5's on their surveys. In addition, the DNP student received verbal feedback that they felt the in-service was engaging, easy to follow, informative, and something they felt like they could implement after 1 training. One of the NPs noted it would be helpful to have a physical hand-out of the SHARE Approach steps that is seen in Figure 1 so that they could reference it easily during sessions moving forward after the training.

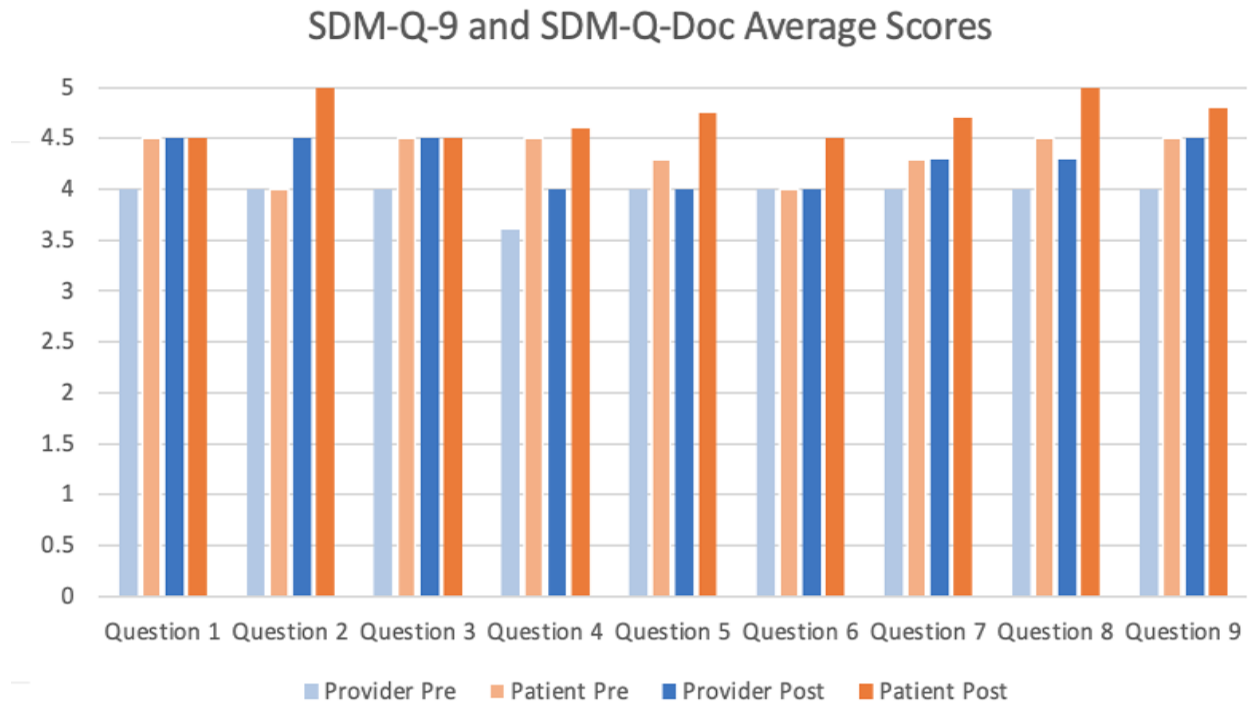
There are also some positive qualitative results. Several patients gave verbal gratitude about the project. Some patients said, "I have never been asked that before", or "It feels good to know someone cares about how I want to be included in my own care". Patients also expressed that until this project, they felt more empowered to ask questions and work together with their provider as a team. Before and after the structured SDM approach was implemented, many patients wanted to thank their PMHNPs for always taking so much time to make them feel "heard". This is a testament to the ingrained and natural ability for SDM as a nurse or PMHNP. The PMHNPs also gave feedback that they felt like the SHARE Approach helped structure their appointments easily and effectively. Both mentioned that the conversation starters and ideas made it very easy to move from step to step in a natural way that didn't disrupt the flow of the appointment.

Overall, these are promising results that show initial benefit from this intervention at UPAC's mental health clinic. With the feedback received and results evaluated, project improvement steps could be taken in order to adjust the project for more optimal effectiveness,

replicate this project at another site, or continue it here for long-term outcome measurement if desired.

Figure 2

SDM-Q-9 and SDM-Q-DOC average scores



Note. 2 Providers pre and post intervention; 20 patients total with 10 pre and 10 post intervention.

Cost-Benefit Analysis

The cost of this project is minimal due to most the implementation being done mostly by the DNP student herself. The SHARE Approach training modules and materials are free to access and use. The materials can be electronically downloaded or printed with PDF versions. Although there is no monetary loss with this intervention, there is lost time in many areas. The most time-consuming part of this project was completing the DNP student’s trainer modules for the SHARE Approach. This was a student lead project so it was the student’s personal time lost, however, if this project were to be implemented elsewhere, monetary compensation for this time may be

necessary to incentivize completion. There was also time taken away from the PMHNPs due to the SHARE approach Workshop taking place during the lunch break at work. The SHARE Approach could be used during any encounter with patients and did not affect the normal workflow for providers. The SDM-Q-9 and SDM-Q-DOC was also free to access and print for use without the author's permission.

When predicting future benefits and cost effectiveness of this project, assessing outcomes including better adherence to treatment plan and medications after implementing a structured SDM approach is significant. Implementing SDM can positively impact a number of factors that affect treatment adherence, including patient-provider therapeutic alliance, agreement with treatment plan, perceptions around control, side-effects, stigmas around psychotropic medication use and more (Mansoor Malik et al., 2020). In the US, nonadherence is responsible for an estimated \$100 to \$300 billion in medical costs annually (Mansoor Malik et al., 2020). Additionally, hospitalization costs due to antipsychotic nonadherence specifically have been estimated at \$1.5 billion annually (Mansoor Malik et al., 2020).

Discussion, Challenges, and Implications

This section will discuss challenges and implications of this project. From the beginning of implementation, the PMHNPs were eager to learn how to better communicate with their patients on a level that would improve relationship and help foster outcomes that could be beneficial for both patient and provider. One of the first challenges encountered was finding an SDM approach that had guidance for the trainer as well. There is a lack of consistency around how to implement SDM and also how to measure it because of the fact that there is no clear definition of SDM and what it entails (Norful et al., 2020). The SHARE Approach is a broad SDM approach that is not tailored to mental health and may not always be as effectively

applicable in that setting. The student's adaptation included additional evidence-based practice findings rooted in mental health-specific approaches that could be incorporated into the original SHARE model.

Another factor that could have played a role in results is that the training was condensed from the original, and only presented in one sitting. More discussion, practice, examples and case studies could have been discussed if the in-service training was split up into several sessions. PMHNPs felt like they felt relatively confident in implementing the approach after being taught, but to assure proper implementation, more time could have been advantageous in gaining confidence, skill, and mastery of the materials presented.

Many of the major obstacles originated around the use of the SDM-Q-9 and SDM-Q-DOC instrument in this setting. Firstly, the tool is validated in several languages, but many of the patients at this clinic needed languages that were not available. In these cases, a translator was used, but this took away the aspect of the patient being able to read the questions and answers themselves and allowed for potential misinterpretation that could skew results. The tool was made to be broad for use in various settings where decisions about care were made, but it was found that some of the questions weren't always aligned with topics and decision made in a mental health setting. Many decisions made in mental health are not as clear-cut as medical decisions, and some patient's felt the questions did not always apply to the encounter. One of the biggest obstacles faced was the number of encounters we had that were over the phone and with a translator. The opportunities for misinterpretation and confusion were much more prevalent. Patients may have also not felt as comfortable answering these questions to the DNP student transcribing answers. Having to do this over the phone with the assistance of a translator also took more time than compared to patients who could read it and fill it out themselves. There

were 13 of our total 20 patients who completed the survey over the phone with a translator. As discussed before, the SDM-Q-9 tool does not provide cut off scores, instructions for use, or results interpretation. It allows flexibility to be used for research in many ways, but it was challenging for me to disseminate results in a way that felt appropriate and accurate.

Additionally, many patients declined to take part in the survey and therefore data could not be recorded for final results. There is also room for inconsistency in results based on prior level of SDM knowledge and use from the PMHNPs before the in-service was done. It would be interesting to see how scores would differ if this were done with psychiatrists who were not trained with the same model of patient-centered care that nurses are. Also, even with this structured approach that has more guided steps, conversation starters, decision aid options and more, the NPs each had a unique communication style and previously established rapport with their patients before and after the in-service that could have affected the results for both.

Haugom et al. (2022) explains that SDM can be most effectively used during encounters that involve more decisional opportunities such as an intake evaluation. Initially, The DNP student wanted all of the data to be collected after an intake evaluation, however, due to time-constraints for data collection, follow-up appointments were included as well. Many of the patients at this clinic are over the age of 50 and have been receiving consistent care for their chronic conditions for several years at UPAC. Due to this, many medications and treatment plans had been set and were being maintained with success for a long time without adjustment needs. SDM can be implemented during any encounter with opportunity for benefits, and the decision not to make any changes is still a decision that occurs with SDM, however, it makes it more difficult to cover all 5 steps of the SHARE Approach (Elwyn et al., 2017). Patients and providers who completed the survey after follow-up appointments in both pre and post data collection may

have perceived that their involvement in SDM was lower based on lack of decisional opportunity.

Regardless of obstacles and challenges faced, the positive short term results show promise for also seeing long term effects in this population such as increased treatment adherence, patient satisfaction, reduction of psychiatric symptoms, and decrease in hospitalizations (Mansoor Malik et al., 2020). Future projects will need to be performed to assess for the feasibility of implementing a structured SDM approach in mental health settings that are culturally diverse. There is still a gap between recommendations to disseminate and implement SDM in mental health care and the limited use of SDM in practice. Future research should focus on defining core elements of SDM and adapting SDM tools specific to mental illness.

This intervention will aid in standardizing and structuring SDM practice. The results of this pilot project helped prove that structured shared decision making can be implemented at any and every encounter to varying degrees than can still be cost effective and time efficient. PMHNPs are well equipped to be well-equipped to utilize SDM and train other providers on how to use structured SDM due to educational and clinical background in holistic and patient-centered care. This project also opens conversations about other evidence-based project implementation related culturally informed SDM in mental health.

In conclusion, further research should be done to assess the long-term effectiveness of SDM in mental health care. SDM is impacted by so many factors that are difficult to define, measure and do not have a lot of studied evidence. The future of SDM in healthcare remains challenging to predict, but projects like this can help steer practice changes that encourage care that is always based on a patient-centered treatment model as a result of making more informed and personalized treatment plans. Focusing on practices to improve SDM for PMHNPs will

ensure nursing care can continue to go beyond the traditional model of health care. This intervention will continually address cultural considerations, potential barriers, uphold autonomy, provider-patient relationship, and empowerment that will lead to better outcomes in mental health care treatment.

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