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SPECIAL SYMPOSIUM: IMPROVING SHARED DECISION MAKING WITH LGBT RACIAL AND ETHNIC MINORITY PATIENTS

A Model of Organizational Context and Shared Decision Making: Application to LGBT Racial and Ethnic Minority Patients

Rachel H. DeMeester, MPH[1,2], Fanny Y. Lopez, MPP[1], Jennifer E. Moore, PhD, RN[3,4], Scott C. Cook, PhD[1,2], and Marshall H. Chin, MD, MPH[1,2]

[1]Section of General Internal Medicine, Department of Medicine, University of Chicago, Chicago, IL, USA; [2]Robert Wood Johnson Foundation Reducing Health Care Disparities Through Payment and Delivery System Reform Program Office, University of Chicago, Chicago, IL, USA; [3]Institute for Medicaid Innovation, Washington, DC, USA; [4]Department of Obstetrics & Gynecology, Medical School, University of Michigan, Ann Arbor, MI, USA.

Shared decision making (SDM) occurs when patients and clinicians work together to reach care decisions that are both medically sound and responsive to patients' preferences and values. SDM is an important tenet of patient-centered care that can improve patient outcomes. Patients with multiple minority identities, such as sexual orientation and race/ethnicity, are at particular risk for poor SDM. Among these dual-minority patients, added challenges to clear and open communication include cultural barriers, distrust, and a health care provider's lack of awareness of the patient's minority sexual orientation or gender identity. However, organizational factors like a culture of inclusion and private space throughout the visit can improve SDM with lesbian, gay, bisexual, and transgender ("LGBT") racial/ethnic minority patients who have faced stigma and discrimination. Most models of shared decision making focus on the patient–provider interaction, but the health care organization's context is also critical. Context—an organization's structure and operations—can strongly influence the ability and willingness of patients and clinicians to engage in shared decision making. SDM is most likely to be optimal if organizations transform their contexts and patients and providers improve their communication. Thus, we propose a conceptual model that suggests ways in which organizations can shape their contextual structure and operations to support SDM. The model contains six drivers: workflows, health information technology, organizational structure and culture, resources and clinic environment, training and education, and incentives and disincentives. These drivers work through four mechanisms to impact care: continuity and coordination, the ease of SDM, knowledge and skills, and attitudes and beliefs. These mechanisms can activate clinicians and patients to engage in high-quality SDM. We provide examples of how specific contextual changes could make SDM more effective for LGBT racial/ethnic minority populations, focusing especially on transformations that would establish a safe environment, build trust, and decrease stigma.

KEY WORDS: shared decision making; practice redesign; disparities; lesbian; gay; bisexual; transgender; race and ethnicity.

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BACKGROUND

Shared decision making (SDM), in which patients and clinicians work together to reach care decisions that are both medically sound and responsive to patients' preferences and values, is a tenet of patient-centered care and an increasing priority for clinicians and health care organizations. Patients who reflect on care choices before meeting with clinicians may be more interested in and better able to evaluate decisions,[1,2] and patients involved in choosing their care plan are more likely to follow through.[3,4] Patients who participate in decision-making also have more efficient clinic visits and are less likely to switch providers.[5,6] Effective SDM can also improve clinical outcomes like control of blood pressure and glucose.[3] Some funders (commercial health plans; Medicare Shared Savings Program) are testing rewards for the provision of SDM and patient-centered care, and some accreditation bodies (including those that certify patient-centered medical home status) include SDM as a desired element of care.[7,8]

Unfortunately, disparities in the provision and quality of SDM exist for racial and ethnic minority groups and lesbian, gay, bisexual, and transgender (LGBT) populations.[9–12] Racial and ethnic minority populations that are also LGBT are at especially high risk for poor SDM.[13,14] Clinicians often lack the training to encourage disclosure of sexual orientation,[15–17] resulting in inadequate communication and SDM.[18] Moreover, generic patient engagement approaches geared toward predominantly white LGBT populations may not be appropriate for patients with multiple minority identities.[15] While many combinations of minority identities are possible, this paper uses the term "dual-minority" to refer to racial/ethnic minority LGBT patients.

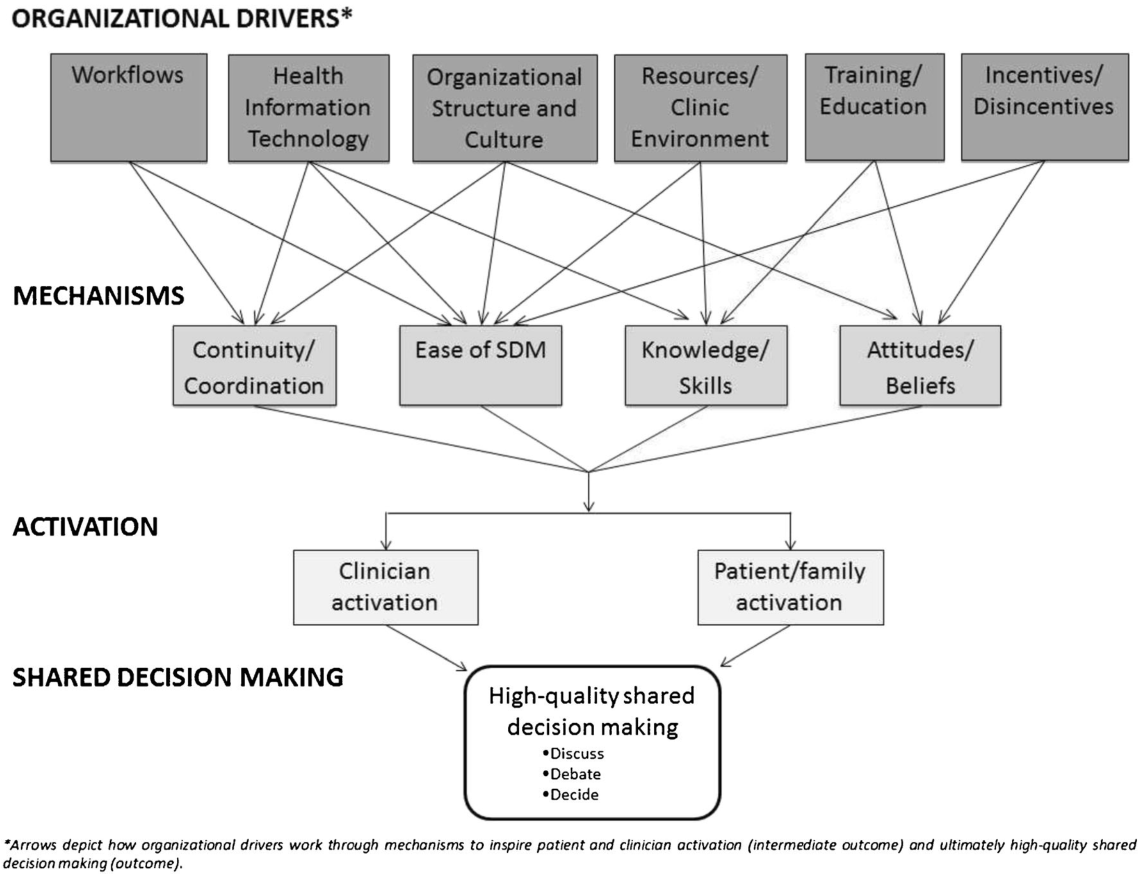
Models of SDM can help guide providers and health care organizations as they attempt to improve SDM. A significant limitation is that most models of shared decision making focus only on the patient–provider interaction,[13,19] even though the organizational context (structure and operations) in which that visit occurs can strongly influence the willingness and ability of patients and clinicians to engage in SDM and can help institutionalize approaches that benefit minority patients. Context impacts all patients but can particularly impact dual-minority patients. For example, workflows and physical layout can impact whether there is time or private space to discuss potentially sensitive information, like sexual orientation, that is necessary for SDM. Without this information exchange, SDM may not occur or may lead to decisions that fail to reflect the reality of patients' identities. A few SDM models acknowledge the potential impact of visit context on SDM, but do not identify how individual contextual drivers impact SDM.[20–22] Implementation science models identify contextual drivers that impact implementation of an innovation, but do not address specifically how SDM is affected.[23,24]

CONCEPTUAL MODEL OF ORGANIZATIONAL CONTEXT AND SHARED DECISION MAKING

Therefore, we outline a conceptual model (Fig. 1) for how organizations can shape their contextual structure and operations to support SDM. Six drivers act through four mechanisms to improve clinician and patient/family activation and ultimately shared decision making. The six organizational drivers are workflows and procedures, health information technology, organizational structure and culture, clinic resources and physical environment, training and education, and the incentives and disincentives attached to SDM (Table 1).

Each driver impacts SDM through at least two of the following four mechanisms: continuity and coordination, ease of SDM, knowledge and skills, and attitudes and beliefs (Fig. 1). Coordination across team members, visits, and organizations is required because decisions are rarely confined to a single visit. Clinicians and patients are more likely to initiate and be motivated to do SDM when it is easier to do, such as when SDM is integrated into expectations, culture, and day-to-day processes as a part of usual care. Specific knowledge and skills of both clinicians and patients facilitate SDM, including empathic, open-ended communication techniques, SDM methods, cultural competence, and insight into factors affecting care. Key attitudes and beliefs are necessary for effective SDM. Clinicians and patients must see value in SDM and expect that it will work. Trust and an equal power dynamic are necessary for open communication.[8] Table 1 describes specific components of each of the four mechanisms in more detail.

Drivers and mechanisms lead to the intermediate outcome of activation, where clinicians and patients (and/or families) have the knowledge, skills, confidence, and motivation to engage in SDM. Patient activation is necessary for SDM and can improve patient outcomes,[25–27] but clinicians may underestimate patients' desire to participate in SDM.[9,28] Clinicians must also be 'activated' to accept, solicit, and act on patient input.[20,29] The final outcome, high-quality SDM, is defined by the quality of three pillars: information sharing, deliberation, and decision-making, or more simply, discuss, debate, and decide.[9,30]



*Arrows depict how organizational drivers work through mechanisms to inspire patient and clinician activation (intermediate outcome) and ultimately high-quality shared decision making (outcome).

Figure 1 Conceptual model of organizational context and shared decision making. SDM = shared decision making.

Table 1. Organizational Drivers and Mechanisms for Shared Decision Making

Driver*	Brief description	Example components
1. Workflows	Day-to-day processes that affect patient flow and how staff share and complete tasks related to SDM.†	• Patient flow through clinic/ Timing • Patient flow through care team/ Team composition ○ Team-based care • Population health management strategy ○ Empanelment ○ Data on race, ethnicity, language, sexual orientation, gender identity
2. Health Information Technology	The technology and capacity to exchange information and track workflows that support SDM.	• Electronic medical records ○ Patient portal, shared visit notes ○ Clinical decision supports • Patient access to technology (computer, phone, internet)
3. Organizational Structure and Culture	An organization's willingness to prioritize SDM and ability to recognize and respond appropriately to patients' background and social context.	• Leadership and staff commitment to SDM ○ Policies/mission statements • Staffing diversity and concordance with patient population • Relationships with community
4. Resources and Clinic Environment	The patient-centered physical space, materials, and language interpretation services necessary for SDM.	• Physical environment ○ Welcoming visual cues ○ Patient-centered space (private for SDM, resource center) • Educational materials, decision aids ○ Health literacy-appropriate ○ Culturally tailored • Language/interpretation services
5. Training and Education	The methods chosen to help clinicians increase their familiarity with and skill in topics that support SDM, including with diverse populations.	• Training in SDM • Training in cultural competence
6. Incentives and Disincentives	Financial and non-financial support for doing SDM.	• Financial incentives for SDM and patient experience • Non-financial incentives: Recognition of quality SDM and patient experience, including public reporting
Mechanism‡		
1. Continuity/ Coordination	Coordination across team members, visits, and organizations. Required because decisions are rarely confined to a single visit.	• Same provider team over time • External clinicians integrated with internal care team • Follow-up discussions about decisions (in between visits, at next visit)
2. Ease of SDM	Clinicians and patients are more likely to initiate and be motivated to do SDM when it is integrated into expectations, culture, and day-to-day processes as a part of usual care.	• Make SDM part of usual care (automatic, default process) • Efficient and sustainable (financially and otherwise)
3. Knowledge/Skills	Specific knowledge and skill including communication, SDM methods, cultural competence, and insight into factors affecting care. Applies to both clinicians and patients.	• Cultural competence (provider, organization) • Individualizing care (provider) • Eliciting patient preferences, values, and beliefs (provider) • Insight into care (patient and provider) • Technology savviness (patient and provider) • Health literacy (patient)
4. Attitudes/Beliefs	Patients and clinicians must also see value in SDM and expect that it will work. Trust and an equal power dynamic are necessary for open communication.[8]	• Increased trust (patient) • Increased sensitivity/ understanding (provider) • Equal power dynamic (patient and provider) • Expect that SDM is relevant and will work (patient and provider) • Value/prioritize SDM (patient and provider) • Make SDM a social norm in organization and community—expect SDM as part of good care • Health care-related cultural norms and historical context (patient and provider) ○ Sexual orientation / gender identity ○ Race/ethnicity

* *Drivers: The main factors that enhance or undermine SDM*

† *SDM: Shared decision making*

‡ *Mechanisms: The effects of the drivers; why and how drivers might impact SDM*

This model builds on practical experience among the author team and colleagues and existing models. Notably, the drivers and mechanisms (Table 1) correspond with many constructs in models by Damschroder (*Consolidated Framework for Implementation Research*) and Greenhalgh (*Diffusion of Innovations in Service Organizations*).[23,24]

We describe each driver's impact on SDM. We also provide examples (Table 2) of how health care provider organizations can operationalize the model to improve SDM specifically for LGBT racial and ethnic minority patients.

DRIVER 1: WORKFLOWS

Clear workflows can help overcome provider inertia to engaging in SDM[56] and allow organizations to build SDM into usual care, thus making SDM easier. Clear workflows can also facilitate coordination of SDM within care teams and across

Table 2. Improving Organizational Context around Shared Decision Making for LGBT Racial/Ethnic Minority Patients

Driver	Example components	Specific considerations and examples[*]
1: Workflows	*Patient Flow through the Clinic / Timing*	- Provide private, confidential space for check-in and check-out[31,32] - Call for and address transgender patients using their preferred name and pronouns[33] - Design all workflows and tasks to be culturally competent
	Patient Flow through the Care Team / Team Composition	- Expect and encourage all health care providers to become competent in the care of racial/ethnic minority LGBT[†] patients - Encourage providers to collaborate with team members with expertise in these areas
	Population Health Management Strategy	- Combine clinical results with information about sexual orientation and gender identity to identify potential candidates for SDM[§] around treatment options. For example: ○ Screen for depression to discuss possible treatment. LGBT patients are at higher risk for depression,[34] especially those who are also racial/ethnic minorities[33] ○ Track HIV[‡] and sexually transmitted disease testing to identify candidates for HIV pre-exposure prophylaxis based on Centers for Disease Control and Prevention guidelines[35] - Collect data on sexual orientation, gender identity, preferred names/pronouns, race/ethnicity, and key relationships in an affirming manner[36,37]
2: Health Information Technology	*Electronic Health Records: Patient Portals and Shared Visit Notes*	- Talk to racial/ethnic minority LGBT patients about which aspects of their identity they feel comfortable having documented in visit notes and explain why this information is pertinent to care[33] - Use respectful and non-judgmental language to address race/ethnicity, sexual orientation, gender identity, and sexual behaviors in shared visit notes. Use terms and labels chosen by the patient[33] - Help patients feel comfortable bringing partners of any gender to the visit. In the initial stages of building rapport with new patients, patient portals may be a viable way to engage partners in care remotely but should not replace more permanent efforts to demonstrate inclusion in care decisions
	Electronic Health Records: Clinical Decision Supports	- Adapt electronic health record templates to allow collection of data on sexual orientation, gender identity, preferred names/pronouns, race/ethnicity, and key relationships[38] - Implement screening templates and clinical decision supports to flag opportunities to ask about behaviors potentially affecting disease risk[39,40] For example, the prevalence of intimate partner violence is higher for transgender patients. Thus, a clinical decision support triggered by gender identity could prompt the clinician to screen sensitively for intimate partner violence and engage in SDM if appropriate
Driver 3: Organizational Structure and Culture	*Leadership and Staff Commitment*	- Complete one of the national benchmarking surveys assessing organizational competence in care of diverse populations including racial/ethnic minority LGBT patients[41] - Include both the terms "sexual orientation" and "gender identity" in patient non-discrimination policy[39] - Build culture of diversity and inclusion in organization. Include a commitment to diversity in mission statements and policies - Recognize that the experiences of racial/ethnic minority LGBT patients may be different from majority LGBT patients and that there are significant variations in lived experiences within LGBT patients as a category - Implement quality improvement activities designed to reduce health and healthcare disparities suffered by racial/ethnic minority LGBT patients, beyond generic approaches to improving SDM overall
	Staff Diversity and Concordance	- Hire diverse workforce including clinicians and staff reflective of patient population, including multiple minority identities[33,42,43] - Discordant clinicians should build trust through patient-centered communication and learn about racial/ethnic minority LGBT health needs to become allies[44]
	Relationship with the Community	- Develop partnerships and reputation with community organizations serving racial and ethnic minority LGBT patients[14,33,43,45] - Obtain feedback from community members and organizations on how SDM could best meet their needs[18,43,45] ○ Maintain a community advisory board ○ Survey or interview patients about their health care experiences and needs - Participate in provider referral programs through LGBT organizations[33,39] - Advertise clinics in media and events serving LGBT and racial/ethnic minority LGBT communities[14,33]

(*continued on next page*)

visits. Workflows pertinent to SDM include patient flow through the clinic and care team, as well as population health management.

Patient Flow through the Clinic / Timing

More research is needed on how clinic flow impacts SDM for minority patients. While there is little evidence that SDM requires more time, in practice, than usual care,[28] increased time with patients has sometimes been associated with greater patient participation in SDM.[28,31,32] Minority patients may require additional time or sensitivity to build trust if they are not receiving care as frequently or have had prior negative experiences.[39] Organizations can streamline SDM by preparing patients before the encounter or by finding other ways to distribute SDM across the visit.[1,57,58]

Patient Flow through the Care Team / Team Composition

Another way to make SDM more feasible for clinicians is to spread SDM across the care team.[59] Team-based care spreads

Table 2. (continued)

Driver	Example components	Specific considerations and examples*
4: Resources and clinical environment	*Physical Environment: Welcoming Visual Cues*	- Display stickers or symbols (pink triangle, LGBT flags)[33,39] in conjunction with artwork or photos of prominent racial/ethnic minority LGBT leaders – e.g., Bayard Rustin, Ruth Ellis. The combination is important since general LGBT symbols may not always resonate as readily for dual-minority patients - Display artwork and educational materials depicting diverse individuals and relationships[39] - Provide intake forms and documents that are LGBT inclusive[33] - Designate single-use restrooms as gender neutral[33] - Ensure that staff are LGBT friendly[39]
	Physical Environment: Patient-Centered Space	- Provide private space to build trust and facilitate disclosure of sexual orientation and related health care issues[16] - Provide a resource center/space with education materials[46,47] inclusive of racial/ethnic minority LGBT concerns
	Educational Materials and Decision Aids	- Include referral information for social services and community organizations pertinent to LGBT racial/ethnic minority populations[39] - Participate in continuing medical education on common LGBT health issues[14]—e.g., HIV pre-exposure prophylaxis, viral hepatitis, routine health maintenance screening in LGBT patients, the increased chances that LGBT patients will have experienced sexual assault and other traumatic events, mental health issues such as increased risk for depression and suicidal ideation and attempts in LGBT youth and transgender women, surrogacy issues for older persons, intimate partner violence, gender affirming surgeries and cross-hormone therapies[40] - Provide reading materials specific to LGBT health concerns (for example, magazines and brochures that address breast cancer, safer-sex, hormone therapy, mental health, and substance use)[33,39,48]
	Language and Interpretation Services	- Ensure that interpreters are familiar with and sensitive to LGBT issues - Translate materials accurately and in a culturally sensitive way.[14] The absence or limited availability of a certified medical interpreter means that educational materials might be the only way to educate a limited English proficient LGBT patient
5: Training and Education	*Shared Decision Making (SDM) Training*	- Provide clinicians with SDM training that includes specific modules that teach how to communicate and practice SDM with dual-minority patients[49] - Provide patients with training or education materials to learn more about the SDM process and activate them[50,51]
	Cultural Competence Training for Clinicians and Organizations	- Discuss existence of disparities, etiologies, and solutions ○ Explore definitions of: sexual orientation and gender identity, safe organization; confidentiality; intersectionality of LGBT and racial/ethnic identities[36] ○ Explore mistrust, subconscious bias, stereotyping[13,14] ○ Acknowledge that race/ethnicity may influence how patients conceptualize and express their LGBT identities[52] ○ Acknowledge that, historically, many racial/ethnic minority LGBT persons have felt excluded from the majority LGBT community; some have experienced outright discrimination.[14,53] This may influence expectations of discrimination in the healthcare setting. - Improve communication and trust building skills ○ Use pronouns and partner labels that do not assume gender identity, heterosexuality, or race/ethnicity. Ask about preferred pronouns.[33] ○ Take a sexual history and screen for health conditions that are prevalent based on risk behaviors (i.e. HIV) and not on sexual orientation or identity[33] - Nurture commitment to reduce disparities[54,55] - Partner with LGBT community organizations to provide training to all staff on a regular basis[33,39]
6. Incentives and Disincentives	*Financial*	- Consider performance-based incentives to reduce disparities that affect racial/ethnic minority LGBT patients - Link financial incentives to processes that impact SDM, including the six drivers in this paper. For example, provide HIT staff and quality improvement teams incentives to implement SDM-specific HIT supports and prompts
	Non-financial	- Report clinical performance data stratified by race, ethnicity, and LGBT status - Highlight racial/ethnic minority LGBT stories in organization's newsletters, websites, and other outreach and dissemination materials - Create awards for advancing diversity and inclusion and reducing health disparities

** Some of these considerations apply to both minority and non-minority patients and differ by matter of degree. For example, all patients require confidentiality and respect, but this need is heightened substantially for racial/ethnic minority LGBT patients*

† LGBT: lesbian, gay, bisexual, and transgender

‡ HIV: human immunodeficiency virus

§ SDM: shared decision making

work across various clinicians and staff to balance patient needs with available staffing,[60] prevent burnout, and inspire high quality care.[61] For example, medical assistants could help patients complete decision aids prior to discussing treatment options with the primary provider. More information is needed on the most appropriate roles for different health care professionals and the key elements of collaboration that would best support SDM.[62–65]

Proper workflows to ensure coordinated communication and avoid confusion are necessary to support high-quality SDM.

Population Health Management Strategy

Population health management strategies can facilitate SDM. For example, one component of population health management is patient empanelment, which allows patients and clinicians to build consistent relationships and the trust necessary for SDM. Another component of population health management is identifying patients at high risk for poor outcomes or who may be eligible for certain treatments. Clinics could stratify clinical data by sexual orientation or gender identity (when electronic health records permit; driver 2) to identify opportunities to engage minority patients in tailored shared decision making around issues for which they, as a group, may be at greater risk (Table 2).

DRIVER 2: HEALTH INFORMATION TECHNOLOGY

Health information technology (HIT) facilitates information sharing, leading to knowledge, insight, and coordination between patients and clinicians. HIT can also make SDM easier when tools to support SDM are integrated into the electronic health record. Common applications of electronic health records (EHR) that can support shared decision making are patient portals and shared visit notes for patients,[66,67] and clinical decision supports for providers.[68] EHR registries can also support population management (driver 1). Decision aids are often, but not always, delivered via HIT and will be discussed later (driver 4). Patients' access to technology such as computers or the internet is an important component of the HIT driver.

EHR: Patient Portals and Shared Visit Notes

Patient portals and direct access to visit notes can support the information-sharing and deliberation steps of SDM by engaging patients in their own care[69–71] and increasing clinicians' responsiveness to patients' preferences and needs.[72]Well-designed patient portals can function similar to decision aids; patients who use patient portals to reflect on their health status and care before a visit may be better able to process risks and benefits of a health decision.[73] By allowing patients to see their own clinical information,[70,71,74] patient portals and shared visit notes help equalize the power dynamic and can inspire greater trust and insight into care.[70,73,75] Patient portals may also provide patients with more convenient access to care[73] and an efficient way to share information with loved ones involved in care.[70] While clinicians must consider individual patients' access to and familiarity with technology, patient portals are likely accessible even for underserved communities. Many underserved patients report high rates of Internet access and wanting to communicate with health providers via e-mail to enhance health care decisions.[76–80]

Some patients may have concerns about trust and privacy that could be worsened by real or perceived stigma in visit notes.[71,74,81] For example, in a Veterans Affairs shared notes study, some patients took issue with the way their clinicians described them.[71] Clinicians can help mitigate concerns by purposely writing and speaking with cultural sensitivity; this includes asking racial/ethnic minority LGBT patients which terms they prefer to describe their identities (Table 2). Organizations must also build trust through other means in the patient-provider interaction and the clinic environment (drivers 3 and 4).

EHR: Clinical Decision Supports

Clinical decision supports (CDS), or automated reminders embedded in EHRs, could make SDM logistically easier by providing timely information that facilitates risk assessment, improves patient education, and improves referral decisions.[82] Existing CDS for SDM tend to focus on a single condition.[83–85] As organizations institute SDM as "usual care" for multiple conditions, this could become overwhelming and lead clinicians to ignore CDS due to "alert fatigue."[86–88] More research is needed about how to improve SDM with CDS most effectively.

DRIVER 3: ORGANIZATIONAL STRUCTURE AND CULTURE

Common organizational barriers to SDM include logistics, cost, and lack of buy-in from providers and staff.[25,50,59,62,89,90] Leadership and staff commitment can remove such barriers to SDM. Staffing diversity and relationships with the community can help organizations coordinate SDM and build attitudes and a culture that support SDM.

Leadership and Staff Commitment

Commitment from leadership and staff are crucial for SDM. Leadership identifies priorities and allocates resources. Staff supply daily operations and interact directly with patients. Organizations can encourage commitment by dedicating resources to incentivize SDM (driver 6),[90] providing evidence that SDM is effective,[50] and providing time and compensation for training (driver 5).[62] Committed leadership and staff can help integrate SDM into usual care and encourage patients and clinicians to expect SDM as part of quality care. For example, organizations should include a commitment to diversity and culturally appropriate SDM[91] in mission statements and policies (Table 2).

Staff Diversity and Concordance

Staff diversity and concordance with patients' minority identities can improve trust and communication. Organizations should seek to hire and retain a diverse workforce and should ensure that all staff, regardless of demographics, are trained and given the resources to provide culturally sensitive services.[42] Both racial and ethnic minority patients[42–44,92,93] and LGBT patients[14,33,39,44] have reported being more satisfied or comfortable with care when their clinicians are concordant by race or sexual orientation. To our knowledge, no information exists on comfort with dual-minority clinicians. However, clinicians who are 'discordant' can still build trust through patient-centered communication and the very act of encouraging SDM.[44]

Relationship with the Community

An organization's reputation and relationship with the communities it serves can strongly impact patient and provider attitudes toward SDM.[94] Organizations may need to do additional outreach with communities who have endured negative health care experiences based on their minority identities for these communities to expect that SDM is relevant and can work.[14] Organizations should collaborate with community organizations that serve racial/ethnic minority LGBT populations to obtain feedback on how SDM could best meet their needs (Table 2).[18,45] Organizations must also ensure that their entire staff is committed to building and maintaining a positive reputation in these communities.[39]

DRIVER 4: RESOURCES AND CLINIC ENVIRONMENT

Resources necessary for SDM include a physical environment conducive to decision-making, tailored educational materials and decision aids, and language and interpretation services. These resources help patients understand their care options and enable clinicians to gain insight into patients' risk/benefit appraisals to individualize SDM. Resources primarily increase knowledge for patients and clinicians, while a well-designed clinic environment makes SDM easier.

Physical Environment: Welcoming Visual Cues

Visual cues, like prominently displayed non-discrimination policies, "safe zone" symbols, [95,96] and gender-neutral signs on single-use restrooms help reassure patients of a "safe space" [39,48] in which to engage in SDM. Patients are more likely to seek care and disclose sexual orientation or gender identity to their health providers in a safe environment. [16,39,96] Organizations should display these visuals only if paired with other deeper efforts to create a welcoming environment.[14,96] Dual-minority patients may require welcoming visuals beyond traditional LGBT signage to feel safe, since some dual-minority patients may feel excluded from majority LGBT social and health spaces (Table 2).[97]

Physical Environment: Patient-Centered Space

A patient-centered physical space can improve trust and facilitate information exchange to support high-quality SDM.[25] Organizations can arrange physical space to ensure that patients and providers have privacy to discuss sensitive information, access to risk/benefit information, and an atmosphere of collaboration.[98] Privacy is particularly important for racial/ethnic minority LGBT patients to facilitate disclosure of sexual orientation and to protect against physical and emotional harm (Table 2). Organizations should also set aside space for resources (like a resource center/library, or a decision aid station) where patients and their caregivers can obtain health information to prepare for SDM.[46,47] Resource centers should include LGBT-specific educational materials written in plain language, and available in different languages. Finally, organizations can support an equal power dynamic for SDM by arranging computers in the exam room to be visible to both clinicians and patients.[99–103]

Decision Aids and Educational Materials

Decision aids (DAs) are structured educational tools (such as pamphlets, videos, or computer-based tools) that convey information about clinical options and open a conversation about the relative risks and benefits.[104] Best practices for implementing and evaluating DAs exist, but do not address minority patients specifically.[105,106] Preliminary evidence suggests that DAs can improve communication and psychological outcomes for racial/ethnic minority populations; however, existing decision aids cover a limited range of topics and rarely address LGBT patients.[106]

Tailored educational materials support patient satisfaction, understanding, and adherence to treatment.[42,43] For most minority patients, cultural tailoring goes beyond language[107] and literacy;[108] for example, LGBT-specific educational materials can help LGBT patients discuss their options and preferences with clinicians.[33,39] Materials should acknowledge the intersection of minority identities by depicting and incorporating multiple facets of diversity (e.g., sexual orientation, race, ethnicity, age, gender).

Language and Medical Interpretation Services

Limited English Proficient (LEP) patients often struggle to communicate with clinicians and understand diagnosis and treatment options.[109] Having language-concordant clinicians with training in medical interpretation is ideal,[110] but organizations should at least offer access to certified medical interpreters to facilitate SDM.[43] A lack of professional medical interpretation services leads to errors in diagnosis and treatment, decreases patient satisfaction and continuity of care, and increases distrust.[109–111] Organizations should also avoid using patients' family members as interpreters, which can compromise patient privacy, introduce interpretation errors, and possibly harm family relationships.[43] This could be particularly problematic for LGBT patients who have not disclosed their sexual orientation or gender identity to family members and need additional privacy for successful SDM.

DRIVER 5: TRAINING AND EDUCATION

Training programs impact skills, knowledge, and attitudes and should address both general SDM and cultural competence.

Shared Decision Making (SDM) Training

SDM training programs for clinicians and inter-professional care teams exist,[59,112,113] but few address SDM for minority populations.[114] No training programs in a recent literature review address racial/ethnic minority LGBT patients.[51] Health care organizations can provide specific SDM training for both clinicians and patients to enhance their knowledge and skills in SDM,[50,51,114,] and encourage them to value and prioritize SDM.

Cultural Competence Training for Clinicians and Organizations

Many clinicians feel unprepared to serve minority patients due in part to lack of training,[46,115,116] while clinicians who have participated in cultural competence trainings report an improvement in their knowledge and skills.[43,117] Clinicians should receive training on the social context and healthcare needs of racial/ethnic minority LGBT patients to be competent in building rapport, providing a safe environment to facilitate disclosure of sexual orientation, and asking the right questions to effectively serve them.[13,14] Clinicians should also be competent in using language that is respectful and simple, both verbally and in electronic health records,[25,107,108] and this training should begin in health care education and continue throughout clinicians' careers.[92]

Organizations can also work to become culturally competent. Health care provider organizations can start by assessing their current competence for dual-minority patients; for example, the Healthcare Equality Index measures LGBT organizational competency,[41] and the *National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care* (CLAS standards)[118] help organizations address race and ethnicity (driver 3). Organizations should then offer training to all administrators, staff, and clinicians on LGBT health and cultural competency.[15,18,39,107] These trainings can be conducted regularly in collaboration with community-based organizations serving LGBT communities to enhance effectiveness and build relationships.[33,39] Leading LGBT organizations and researchers have published recommendations to improve the quality of health care services and outcomes for LGBT patients,[15,16,33,39] and future iterations should also address intersectional issues (Table 2);[13,49] existing cultural competence trainings typically focus only on a single minority identity such as race/ethnicity or LGBT identity.[119,120]

DRIVER 6: INCENTIVES AND DISINCENTIVES

Provider and payer organizations can provide financial and non-financial incentives to support SDM and remove financial disincentives that hinder effective SDM. The correct balance of incentives encourages motivation around SDM and makes SDM easier and sustainable as a part of usual care.

Financial Incentives

Direct financial incentives to support SDM are currently uncommon,[121,122] but interest in providing these incentives is growing as patient-centered care becomes a standard component of high-quality care. For example, some payers have experimented with incentives for SDM in demonstration projects,[8] and the Center for Medicare and Medicaid Innovation has funded SDM as part of its advanced primary care initiatives and included multiple SDM projects in their health care innovation award portfolio.[123] In addition to incentivizing the absolute quality of SDM, incentives could explicitly aim to reduce disparities in SDM quality.

The business case for financially rewarding SDM is based on health benefits to patients and savings for the larger health care system.[124–127] The current volume-based, fee-for-service system is often cited as a barrier to SDM implementation for individual providers,[128] and low-resource organizations, often those serving predominantly minority populations, may be affected most acutely. Negotiations with payers to allow reimbursement for SDM activities could ease challenges of time, scheduling, and staffing (driver 1) and provide the capital to procure space and technology to support SDM (drivers 2 and 4). In this way, incentives can make SDM easier to incorporate into usual care.

The best incentives and measures are not known yet;[121] some incentives are based on patient experience and communication, and others focus on the use of decision aids. However, several measures approved by the National Quality Forum represent growing consensus and are integrated into the widely-used *Consumer Assessment of Healthcare Providers and Systems Clinician & Group Survey (CG-CAHPS)* survey.[129] Further consensus and distribution of measures can guide organizations in incentivizing high-quality, equitable SDM.

Non-financial Incentives

Non-financial incentives, such as public reporting of patients' perceptions of the quality of SDM, target clinicians' professionalism and reputation among peers and patients. Clinicians want to excel and be perceived as competent providers. Clinicians and health care organizations that receive high publicly-reported ratings of the quality of their SDM may be able to attract more business. Non-financial incentives could include creating awards to acknowledge excellent efforts to advance diversity and reduce disparities in the receipt and quality of SDM for racial/ethnic minority LGBT patients (Table 2).

DISCUSSION

The organizational context in which SDM occurs represents a remarkable opportunity to improve patient experience and the quality of care. The structure and operations of a health care organization greatly influence whether time, trust, and resources are available to support SDM between patients and clinicians. While most efforts and research to improve SDM have focused on direct patient–provider communication, improving the context of care in which this interaction occurs has the potential to be transformational and increase the sustainability of SDM. Populations at highest risk for poor SDM, such as racial/ethnic minority LGBT patients, might particularly benefit from changes in organizational context that establish a safe environment, increase trust, and decrease stigma—all critical for becoming a culturally competent organization.

Our model of the organizational context for SDM has limitations. First, the model's presentation is more linear than reality. While we show the flow of SDM in only one direction for visual simplicity, SDM tends to be a cycle of multiple decisions over time,[20] particularly in chronic disease management. Second, some drivers may fit into multiple categories or influence each other in both directions. For example, a single intervention to implement team-based care would likely impact most of the drivers in this model, not just workflows or organizational structure. Additionally, this model has not been empirically tested and validated in racial/ethnic minority LGBT populations. However, it has been informed by an ongoing project focused on this population. Despite limitations, this model describes useful ways in which provider organizations can improve shared decision making for minority populations.

Further research is needed on how changing organizational context can improve SDM for different patient populations in different settings. SDM processes and tools are generally not designed with minority patients in mind even though they may face additional barriers to SDM, such as mistrust. Organizations should monitor and tailor SDM approaches as necessary.

Organizations should also take a broad view of "minority" status when they consider their approaches to SDM. Familiarity and competence with one minority population does not guarantee competence with issues of intersection between race/ethnicity, sexual orientation, gender, religion, or any other patient identity,[130] yet these intersections make up the whole of patient preference and engagement in SDM.[13] Patient input can help reduce the risk of overgeneralization. The United States' population is becomingly increasingly diverse. To improve patient experience and outcomes most effectively, we must improve the organizational context in which SDM occurs.

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Corresponding Author: *Marshall H. Chin, MD, MPH; Section of General Internal Medicine, Department of Medicine, University of Chicago, 5841 South Maryland Avenue, MC 2007, Chicago, IL 60637, USA (e-mail: mchin@medicine.bsd.uchicago.edu).*

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