68. ■ Worlds apart? Protocol for a systematic review of the prevalence and magnitude of patient-provider preference mismatch and preference misdiagnosis

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BACKGROUND
Shared decision-making is widely advocated, partly due to assumptions that there is potential for patient-provider preference mismatch, when patients and providers prefer different health treatment options or outcomes, and preference misdiagnosis, when providers inaccurately judge patients' preferred treatment options or outcomes. However, the literature relevant to these assumptions has not been comprehensively scrutinized. We are conducting a systematic review to identify, appraise and synthesize evidence of the prevalence and magnitude of preference mismatch and preference misdiagnosis, and contributing factors, across a broad range of clinical situations.

METHODS
We will search Ovid/Medline, Embase, CINAHL and PsycINFO databases for peer-reviewed articles which provide primary, self-reported, quantitative data on (i) patients' and providers' preferences for treatment options/outcomes and/or (ii) patients' preferences for treatment options/outcomes and providers' perceptions of patients' preferences. We will screen studies for eligibility and will subject included studies to double independent data extraction. We will appraise the quality of studies in three domains: validity of methods, appropriateness of interpretation of results, and applicability of results. We will also develop a conceptual model to classify the range of included studies on several dimensions (e.g., patient population, provider population, duration of patient-provider relationship, preference category (treatment or outcome), preference type (real or hypothetical)) and will synthesize study findings, stratified by methodological classification. Given anticipated heterogeneity in study designs, we will conduct a narrative synthesis of findings, but intend also to perform meta-analyses should included studies be sufficiently homogenous.

CONCLUSIONS
There are several implications of this study, beyond its potential for assessing the veracity of assumptions about preference mismatch and misdiagnosis. This study has potential to provide insights into the perspectives and values that providers and patients bring to the clinical encounter, and to shed light on the difficulties that providers and patients may experience when attempting to reach consensus in treatment decision-making. This study may also increase understanding of factors that affect the prevalence or magnitude of mismatch and misdiagnosis, thereby providing knowledge to inform strategies for mitigating risks associated with preference mismatch, preventing preference misdiagnosis, and enhancing the quality of patient care.

45. ❚❚ Decision Making in Period Health Exams for Older Patients with Mental Health Needs: Anchoring and Fragmentation

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INTRODUCTION
The majority of patients with mental health (MH) concerns turn to their primary care physicians (PCPs) who deliver most of their periodic health exams (PHEs), a practice that lacks consistent evidence of effectiveness.

DATA AND METHODS
We investigated whether PHEs may be an opportunity for patients with MH needs to initiate or continue to receive MH services, using audio-recordings of 261 unique PHEs with 59 PCPs that took place in an integrated delivery system in metropolitan Detroit between 2007-2009. Administrative data and electronic medical records were also used. These patients were deemed potentially in need of MH services because of their 2-item Personal Health Questionnaire (PHQ2) score, mental illness diagnosis, MH service or medication use. We coded the audio-recordings to capture initiator and time spent on each "topic" (i.e., an issue that had at least two complete verbal exchanges). We measured "fragmentation" by the number of instances a topic was discussed. We examined the probability of a MH discussion using a logit generalized estimating equation (GEE) regression, followed by analyses of topic initiator and fragmentation.

RESULTS
The median visit length was 27 minutes. The median number of "topics" was 19/visit; MH was discussed in 37% of the visits, with a median length of 63 seconds compared to 43 seconds for biomedical, 30 seconds on health behaviors, and 395 seconds on physical exams. The likelihood of MH discussion decreased for minority patients (OR=0.49, $p<0.05$), increased for patients whose PHQ2 ≥3 (OR=4.43, $p<0.01$), and for those who were prescribed psychotropic medications (OR=3.21, $p<0.01$). Patients initiated 21% of biomedical and 33% of MH topics. Forty-five percent of biomedical (1,348/2,995) and 57% (58/102) of MH topics had more than one instance. MH topics are more likely to be fragmented (OR=1.64, $p<0.05$).

CONCLUSIONS
Only 37% of patients with MH needs had a MH discussion that lasted about a minute. Far more time was spent on physical exams which have inconsistent evidence basis for their effectiveness. MH discussions were more likely fragmented. Anchoring in biomedical concerns appears to be common even among patients with MH needs.