Removing Barriers and Encouraging SDM – This Is How We Do it Podcast Transcript

Carol Antequera:

Hello, and thank you for joining us today. My name is Carol Antequera. I'm a PA in the Division of Gastroenterology at the University of Miami Miller School of Medicine. I'm joined today by Adrian Banning, PA, and Associate Professor in the Delaware Valley PA Program in Doylestown, Pennsylvania, just outside of Philadelphia. You are tuning into the "Challenges in Colorectal Cancer Screening: How to Improve Screening Rates" podcast series developed by the American Academy of Physician Associates and The France Foundation, and supported by an independent educational grant from Exact Sciences.

Adrian Banning:

The goal of the series is to provide education and tools to assist PAs and other clinicians by providing the latest screening recommendations, screening modalities, and patient-centric adherence techniques to improve colorectal cancer screening rates among all patients at risk. This is the final episode in a three-part podcast series focused on patient communication. To kick off this episode, Carol, would you please set the background for our discussion?

Carol Antequera:

Yes. During this episode, we will cover how to work collaboratively with patients using shared decision-making information focused on colorectal cancer screening, and we will also assess barriers to adherence to colorectal cancer screening, and implement strategies to improve adherence. Adrian, we know that early detection could reduce colorectal cancer incidents and mortality, as well as reduce health disparities. What do you hope primary care PAs take away from this series and episode?

Adrian Banning:

Carol, I really want to express that even though it's tempting to simply tell a patient that they're quote, unquote, due for something, there's so much more to the conversation if we want people to make decisions that they're comfortable with, understand the benefits and harms, feel better informed, and more aware that the decisions align with their values. It's really a conversation each time that you recommend screening to someone. I would love if people come away remembering that they should look into positive and negative predictive values, and the use of decision aids, that using decision aids and taking time to discuss screening can really strengthen your relationship with a patient, and possibly reduce costs and improve outcomes.

So for example, overall, about 65.2% of people have ever had colorectal cancer screening, and 46.4% of them were up-to-date with it. Of those who described barriers, about 23% said that they were not due for screening. They just didn't know, or they said that their provider hadn't recommended it. So very early barriers of just not being aware or the provider not bringing it up. Another common barrier was fear or worry about the procedure or the outcome. They didn't really know what the screening was going to entail, or they were scared about what would happen afterwards. So even though we know

that the screening can prevent a bad outcome, people are really worried about hearing that bad news and not knowing what's going to happen afterwards.

Some other barriers are identified are financial challenges such as lack of insurance or a cost of testing, and then logistical challenges like transportation and time. Fewer people in a study said that one of the barriers of screening was that it wasn't important. And few people mentioned discomfort, which I think sometimes we might assume are barriers to patients, that maybe they just don't get how important it is or they're scared that it's going to be uncomfortable. But for them, really, that wasn't one of the high ranking barriers.

So if we are going to start this conversation, really we need to know at the very beginning is the patient even ready to talk about it. And that goes way back, you might remember it, to PA school, to the Prochaska and DiClemente stages of change. And basically, it's going to be harder to get someone to do something if they aren't ready or they don't want to. If they are ready, it's time for shared decision-making. And really you can just ask someone, "Hey, I'd like to talk about colorectal cancer screening. Is it okay if we have that conversation," and get a yes to proceed before you go forward.

So if we're talking about shared decision-making, we've got a bunch of different multi-step approaches, and some of them have fun acronyms if you're an acronym person. But the AHRQ, the Agency for Healthcare Research and Quality, they recommend using the SHARE model for shared decision-making. That acronym is S-H-A-R-E. And I'm always in awe of the people who put the concepts they want in an acronym that actually makes sense to the topic at hand. So, this SHARE decision-making approach is a 5-step process that includes exploring and comparing benefits, harms, and risks of each option through conversation about what matters most to the patient. And here are the 5 steps, and as a reminder, they spell SHARE when you take the first letter of each of the words.

So first is seek your patient's participation. Then help your patient explore and compare treatment options. Third is assess your patient's values and preferences. Then reach a decision with your patient. And then evaluate the patient's decision. And so, you're going to have the SHARE decision-making when you as the PA and the patient really come together to make a health care decision that's best for them. And the optimal decision is going to take into account the evidence and the available options, and of course, your knowledge and experience, and the patient's values and preferences, and everyone's going to benefit from this model. You're going to be able to deliver higher quality care and increase patient satisfaction. When they're part of the decision-making, the patient feels like they're part of the team, and we know that there's improved patient adherence when they're part of the decision-making process.

So maybe you've gone through the SHARE decision-making model and you're ready to get into the nitty gritty about colorectal cancer screening. You want to know what you're going to say if the test comes back positive and if it comes back negative, and have that conversation now before you even order the test. Here's what we know if it comes back positive, these are next steps. Here's how I'm going to support you. You're not going to be alone in this. If it comes back negative, great. Then we're going to do repeat screening in this amount of time, depending on the modality that you're going to use. But you want to be thinking ahead, and let the patient know what's coming no matter what the outcome of the screening test is, and what they're signing up for.

Then you also need to know how likely it is that their positive or negative screening means that they do or don't have a disease or not, and that's different from sensitivity and specificity. It's outside the scope of what we can cover in this podcast, but the concepts are positive and negative predictive value. It's actually pretty simple math when you know the prevalence of a disease, and the sensitivity and specificity of a screening tool. But as a reminder, because no tools are positive, and no tools have a 100% sensitivity and specificity, there's always going to be false positives and negatives, and that's worth talking about, and how you're going to proceed with more testing to find out more.

You don't have to have these conversations alone, though. It's not all on you. There are people out there who have made tools to help us, and the CDC has a great overview for patients. Even if you wanted to let them read that ahead of time before the conversation in a flipped classroom style, that's called the Screening for Colorectal Cancer: Consumer Guide, and you can just search that on the internet. The CDC provides it for you. That's one example of a shared decision-making tool. And it might seem like they might take more time, but there's actually a lot of benefits.

We have 2017 Cochrane Systematic Review, and just as a reminder, they're the gold standard of systematic reviews. We have evidence that SHARE decision-making is important when talking to patients about screening. In the results of that review, with quality of evidence, when people use decision aids, they improve their knowledge of options, and they feel better informed and more clear on what matters to them. And high quality evidence supports that. They also have more accurate expectations of the pros and cons, the benefits and risks, moderate quality evidence on that, and probably participate more in decision-making. And there's moderate quality evidence to support that.

They may achieve decisions that are consistent with their values. People and their clinicians are more likely to talk about the decisions when they use the decision aid. They had a variable effect on the option chosen, depending on the choices that are being considered, and they do not worsen health outcomes. People using them are not less satisfied, but we do need a little bit more research. So from this review, the implications of practice are that there are positive effects of decision aids on improving people's knowledge of risks and benefits, feeling informed, and feeling clear about their values, about and across a wide variety of decisions. They may also facilitate risk perception and more active participation in the decision-making process. But you have to have good quality decision aids, you have to be willing to use the decision aid, and you have to have a system for delivering support once the decision has been made.

So you're not out there alone. You have these aids, and they do help. You just have to tuck them into your regular practice and use them consistently. And then you've got the SHARE decision-making, you've got the tool. There's also a framework that helps us use the SHARE decision-making aids, and that comes to us from the Ottawa Hospital Research Institute. They give us a suggested approach in another 5-step system called Knowledge to Action framework. This one does not have a sassy little acronym that goes along with it, but the 5 steps are identify the decision, find a patient decision aid, so not rocket science here. Identify barriers and explore ways to overcome them with your patient. Use the decision aid and the support, give training, and then monitor their use and outcomes from when you use SHARE decision-making aids with the patients.

And I know you might be asking, "But don't they cost money? Don't they take up extra time that we already don't have?" No. We have evidence that says the median effect of using decision aids on the

length of a consultation was just 2.6 minutes longer, just a couple minutes longer to use the aid. And the cost of the decision aid group in a certain study were actually lower in two studies, and similar to usual care in four studies in a systematic review. So, not much more time, just a couple more minutes, and not more cost, even maybe less cost. We just have to know what we're talking about before we go into the conversation. And it's not as simple as, "You're due for this. I'm going to order it for you," which seems like it might be easy, but we might actually want to protect a lot more time than we are for making these important decisions that might end up changing someone's life.

Okay, so now that we've talked with our patient, agreed on a screening modality, and then the screening's been done, we might be in the position of breaking bad news. But, don't worry. I'm not going to let you go without a multi-step process for that, too. We have a great acronym called the SPIKES acronym for Breaking Bad News, and that stands for setting up, perception, invitation, knowledge, emotions with empathy, and either strategy or summary. You can pick which one you want the last S to stand for. It was designed by Walter Bale and his colleagues out of the University of Texas, MD Anderson Cancer Center in Houston, Texas. And it's really to help you accomplish a couple different things when you're breaking bad news.

It's that you're in a safe place. Establish an appropriate setting. You don't want to be in a public setting. You want to be in a place where the patient can express emotions in a private way if they need to. You want to check the patient's perception of the situation, prompting the news regarding their test results, determine the amount of information that they know, or how much information they want right now. A lot of times, we might feel very comfortable with medical information and statistics, and sometimes we end up wrapping those factual pieces of information around ourselves when we're uncomfortable. But maybe the patient doesn't want that much or it's overwhelming.

We have to know the medical facts and their implications, but we don't want to bombard someone before initiating the conversation. We have to explore the emotion to raise during the interview. So we're going to talk about feelings, and then respond with empathy. Are you making eye contact? What does your face look like, your tone of voice, your body posture? Are you responding to not only what they're saying, but what they're expressing? And then you're going to establish a strategy for support. So that was a lot of patient communication from maybe the primary care provider's perspective. Carol, after screening, will you tell us what to expect in terms of follow up from your perspective, from a GI perspective?

Carol Antequera:

Thanks, Adrian, and thank you so much for that wonderful explanation of that SPIKES acronym. That really does apply to following up patients after they've had screening tests. Typically, what we do in GI is, after the patient has a screening test, we do schedule them for follow up to explain the results. And as you mentioned, we establish an appropriate setting during the visit. We also make sure that the patient's perception of the situation is okay, that even though they're receiving either good news or bad news, that we somewhat state in a positive way. We also try to determine how much information the patient already knows, or if they don't know, then we educate them. And then, we also try to give them facts, updated guidelines, and things like that to help them understand better. And we always leave time for more questions in case they have more questions.

So when we follow up with our patients, we talk about the results, whether positive or negative, as well as the next step. And then we set up the timeline for their next screening date. So for example, a patient who has an annual fit test and those tests are normal, typically those patients don't need to be followed up with GI. But if they do already see a GI provider and they have their annual fit test, that we would schedule to see them again in 1 year. If the patient has an abnormal test, then we know that they need to be referred for further evaluations, such as a colonoscopy. And again, for our primary care counterparts, we cannot stress enough to please ensure that if a patient needs to come to GI for a colonoscopy, we ask that you please make sure that those patients actually follow through. Because as we stated before, research shows that only 60% to 80% of those patients with positive screening test will go on to have a colonoscopy.

Adrian Banning:

Carol, thank you so much. It's so nice to hear what happens from your perspective, and also to hear that reiteration that this is a really sensitive time that we don't want to drop the ball on care or transition.

Carol Antequera:

This concludes episode three of our three-part series. I want to thank you for joining the discussion about Challenges in Colorectal Cancer Screening: How to Improve Screening Rates. As a reminder, listening to this podcast makes you eligible to receive CME, and to receive CME credit, you must complete the posttest and evaluation in AAPA's Learning Central. Take care.