Improving Cancer Screening Communication and Shared Decision Making Among Diverse Populations

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Advancing Progress in the Development and Implementation of Effective, High-Quality Cancer Screening: A Workshop

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Disclosures

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Shared Decision Making (SDM)

- Ensuring that patients are informed about and included in the healthcare decisions which are made together with their clinicians
  - Clinicians bring expertise as well as their values.
  - Patients bring their values and experiences.
    - How does their sociocultural background affect the SDM process?

What Do We Know About SDM and Diverse Populations?

- Racial difference
- Ethnic difference
- Cultural difference
  - Attitudes
  - Customs
  - Beliefs
  - Language

Focusing on Colorectal Cancer: What We Found in Our Study

- **DATES**: Decision Aid to Technologically Enhance Shared Decision Making (R01CA152413)
  - Goal: Provide detailed understanding of how an interactive decision aid impacts the patient's decision-making process, including SDM, and ultimately, colorectal cancer (CRC) screening adherence
  - 2011-2016

Design

- 2-armed randomized controlled trial
  - 585 patients total (original goal: 600)
  - Intervention Arm (n=284): ColoDATES Web, an interactive web-based decision aid
  - Control Arm (n=286): Non-interactive web-based decision aid
- Setting: 12 community and 3 academic family medicine or internal medicine practices in southeast Michigan (56 physicians)
- Patients: Adults aged 50 to 75 years
  - Not current on CRCS
  - Scheduled for a check-up or chronic care visit with their clinician

Trials 2013; 14:381 (doi:10.1186/1745-6215-14-381)

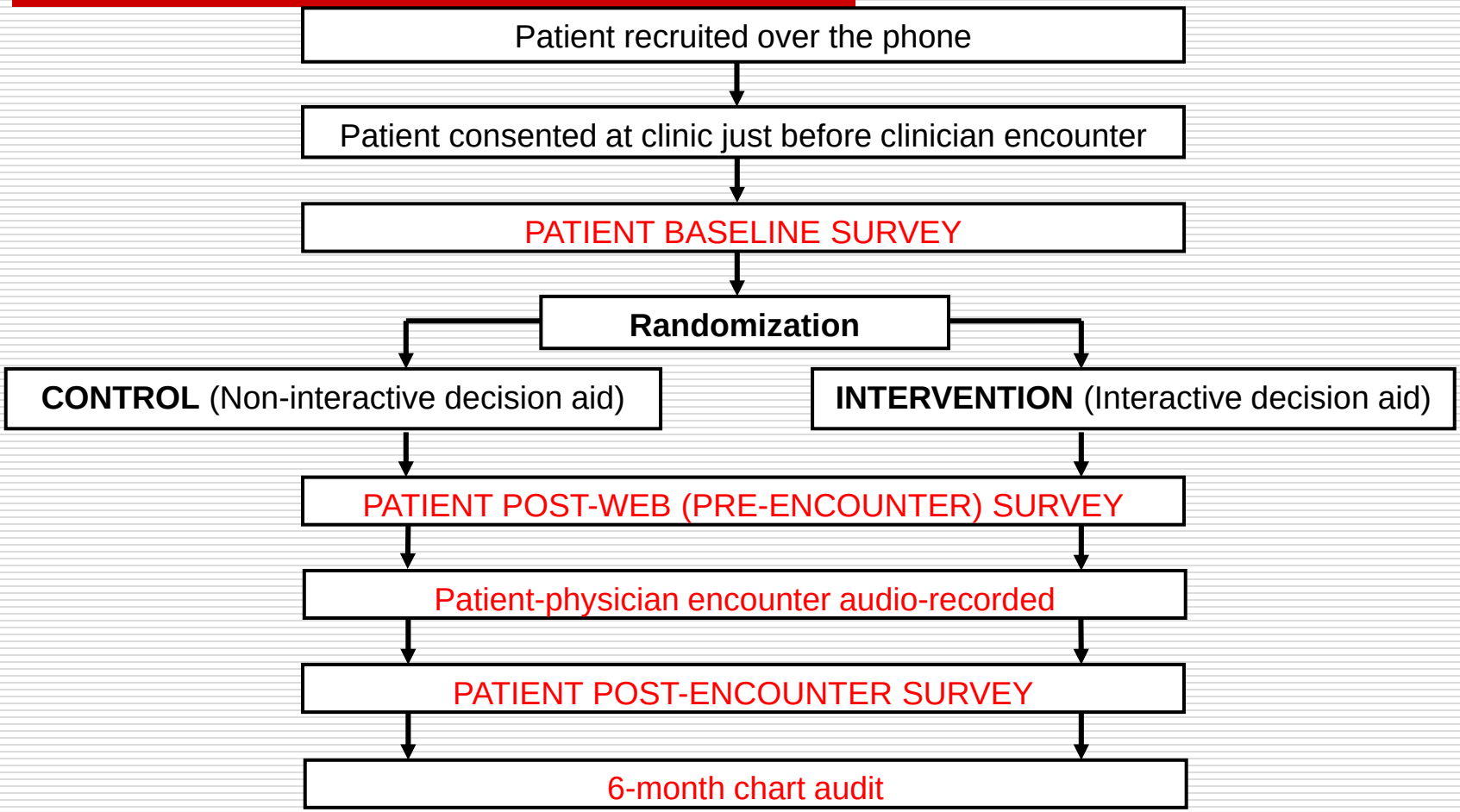
Baseline Demographic Data

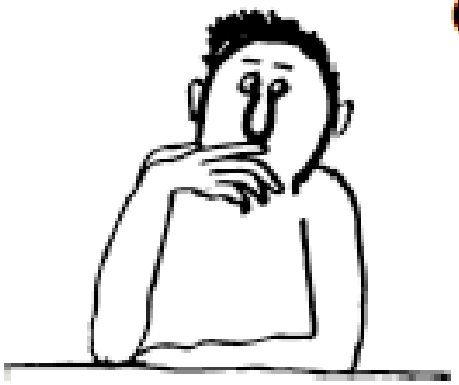
Variable	Overall (n=549)
Age (years) – Mean(SD)	**57.7** (6.9)
Race: number (%)	
Caucasian	298 (54.5)
African American	**204 (37.3)**
Other	45 (8.2)
No Answer (Missing)	2
Gender: number (%)	
Female	**310 (56.5)**
Current Health: number (%)	
Excellent	**45 (8.2)**
Very Good	**166 (30.2)**
Good	**209 (38.1)**
Fair	109 (19.9)
Poor	20 (3.6)
Prior Exposure to CRCS: number (%)	
Yes	**302 (55.0)**

Analysis

- Logistic regression and change score analyses were performed on patient survey, audio-record, and chart audit data.
- SDM was measured by OPTION-12, a validated instrument that measured physician performance of SDM during the patient-physician encounter.
- Main outcomes
  - Change in patient preference and intent as measured by patient survey immediately before and after the encounter
  - CRCS adherence determined by medical record documentation of CRCS 6 months after the visit

Study Flow


Patient recruited over the phone
Patient consented at clinic just before clinician encounter
PATIENT BASELINE SURVEY
Randomization
CONTROL (Non-interactive decision aid)
INTERVENTION (Interactive decision aid)
PATIENT POST-WEB (PRE-ENCOUNTER) SURVEY
Patient-physician encounter audio-recorded
PATIENT POST-ENCOUNTER SURVEY
6-month chart audit



OPTION Observing patient involvement © March 2009

Date of Rating: ..... (dd) (mm) (yy)

Practitioner: ..... Age Sex

Rater Name: .....

Patient: ..... Age Sex

Clinician Code: .....

Consultation Type: ☐ New ☐ Review ☐ Composite

Consultation Number: .....

Consultation Duration: ..... (minutes, seconds)

Another Person In The Room? ☐ Yes ☐ No Who? .....

Description of Index Problem:

1. The clinician draws attention to an identified problem as one that requires a decision making process.

0 = No attempt to draw attention to a need for a decision making process *(there is no clarity about problems, or at least no clarity about the decisions to be taken about the problem or problems identified).*

1 = Very brief or perfunctory attempts to draw attention to the need to embark on a decision making process.

2 = Baseline skill level: Clinician draws attention to a problem that requires a decision making process.

3 = Clinician puts emphasis on the decision making process required.

4 = The skill is exhibited to a high standard *(e.g. supplementary explanations and evidence of patient recognizing the need to engage in the process of decision making).*

2. The clinician states that there is more than one way to deal with the identified problem (*'equipoise'*).

0 = The clinician does not state that there is more than one way of managing problems.

1 = Perfunctory attempt to convey the existence of more than one option.

2 = Baseline skill level: Clinician conveys the sense that the options are valid and need to be considered in more depth.

3 = Explains 'equipoise' in more detail and that options have pros and cons that need to be considered.

4 = The clinician also explains 'why' choices are available *(e.g. there is genuine professional uncertainly as to the 'best' way of managing the problem – clinical equipoise);* the skill is exhibited to a high standard.

3. The clinician assesses patient's preferred approach to receiving information to assist decision making *(e.g. discussion in consultations, read printed material, assess graphical data, use videotapes or other media).*

0 = The behaviour is not observed.

1 = A minimal attempt is made to exhibit the behaviour.

2 = Baseline skill level: Clinician asks for patient's preferred method of receiving information.

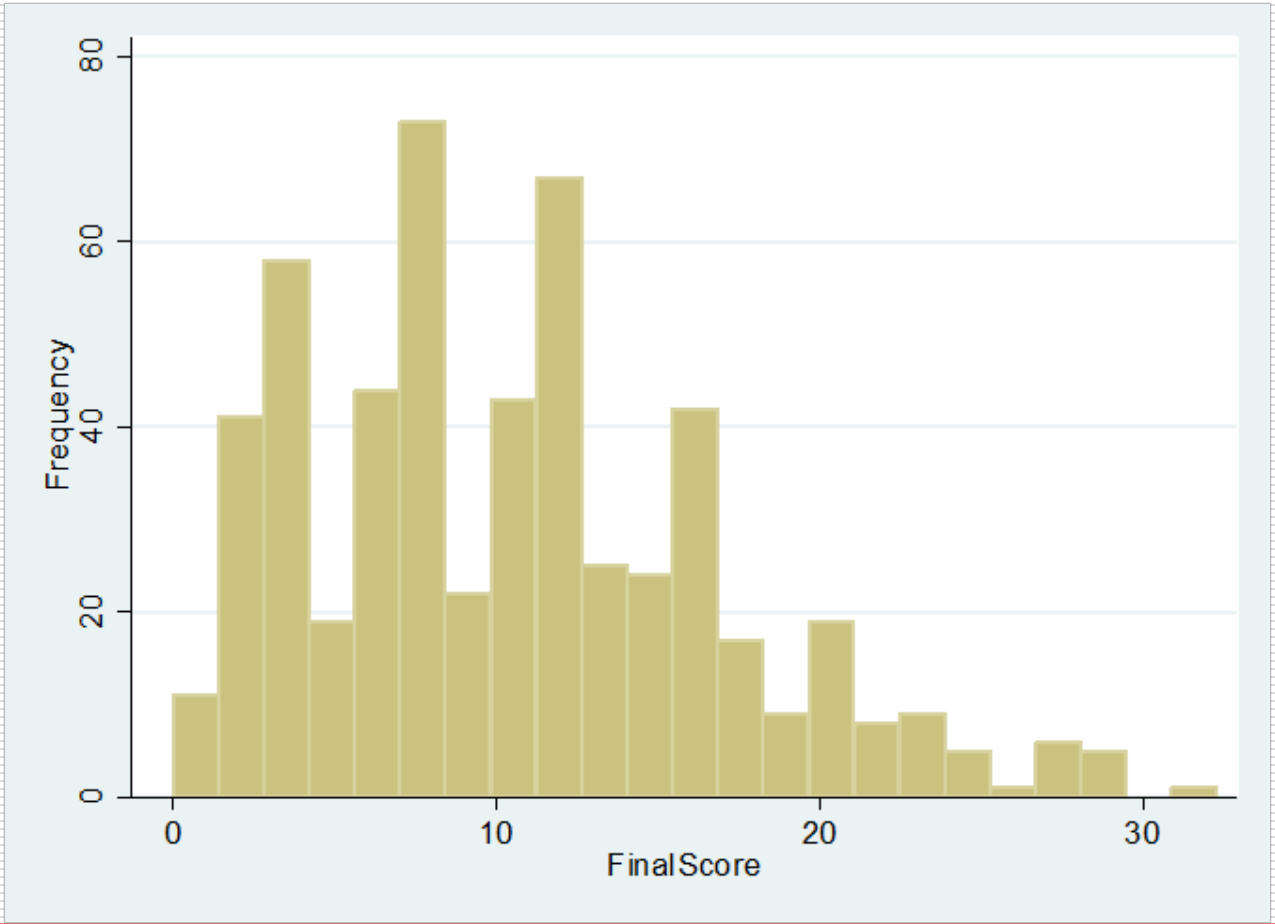
OPTION-12

- 12 items, assessing physician performance, raw score of **0-4** each (total: **0-48**) that is adjusted to **0-100** total score
  - Draws attention
  - Equipoise
  - Assess patient preference
  - Lists options
  - Explains pros and cons
  - Expectations
  - Concerns
  - Understood
  - Opportunities
  - Preferred level of involvement
  - Decision making
  - Review

So What Did We See?

- **549** total eligible patient-clinician transcripts
- Most items ranged from **0 to 2**
- Mean of **10.6** (SD=6.2) out of 100, range of 0-32, most transcripts $\leq$20

Distribution of Scores



What's Relevant to This Talk?

- Adjusting for study arms and other variables found to be significant in previous model (race, current health, prior exposure, intent), SDM as measured by OPTION-12 was not significantly associated with CRC screening.
  - **Lower in African Americans**: Odds Ratio 0.48 (0.28, 0.85), p=0.011

So What?

- This, despite African Americans in our study having at baseline:
  - **Greater self-efficacy**
    - Caucasians with odds ratio of 0.37 (95% confidence interval 0.25-0.57; p=0.001) compared to African Americans
  - **Greater intent** to undergo CRC screening
    - Caucasians with odds ratio of 0.53 (95% confidence interval 0.34-0.84; p=0.007) compared to African Americans

Am J Prev Med 2017;52(4):443-450

Did It Affect the Outcome?

- African Americans ended up undergoing CRCS at a **lower rate** than Caucasians.
  - African Americans with odds ratio of 0.45 (95% confidence interval 0.29-0.71; p=0.001) compared to Caucasians

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Am J Prev Med 2019;57(1): 77–86
doi: https://doi.org/10.1016/j.amepre.2019.03.004.

Same Trend Seen in Other Studies

- African Americans with:
  - More advanced CRC at diagnosis
    - Doubeni 2007
  - Less likely to receive recommended CRC treatment
    - Baldwin 2005
  - Increased risk of death from both colon and rectal cancers
    - Siegel 2020

Ubiquitous Issue

- Not confined to African Americans
  - Other racial and ethnic minorities
- Not confined to CRC
  - Other cancers such as breast, prostate, and lung cancers

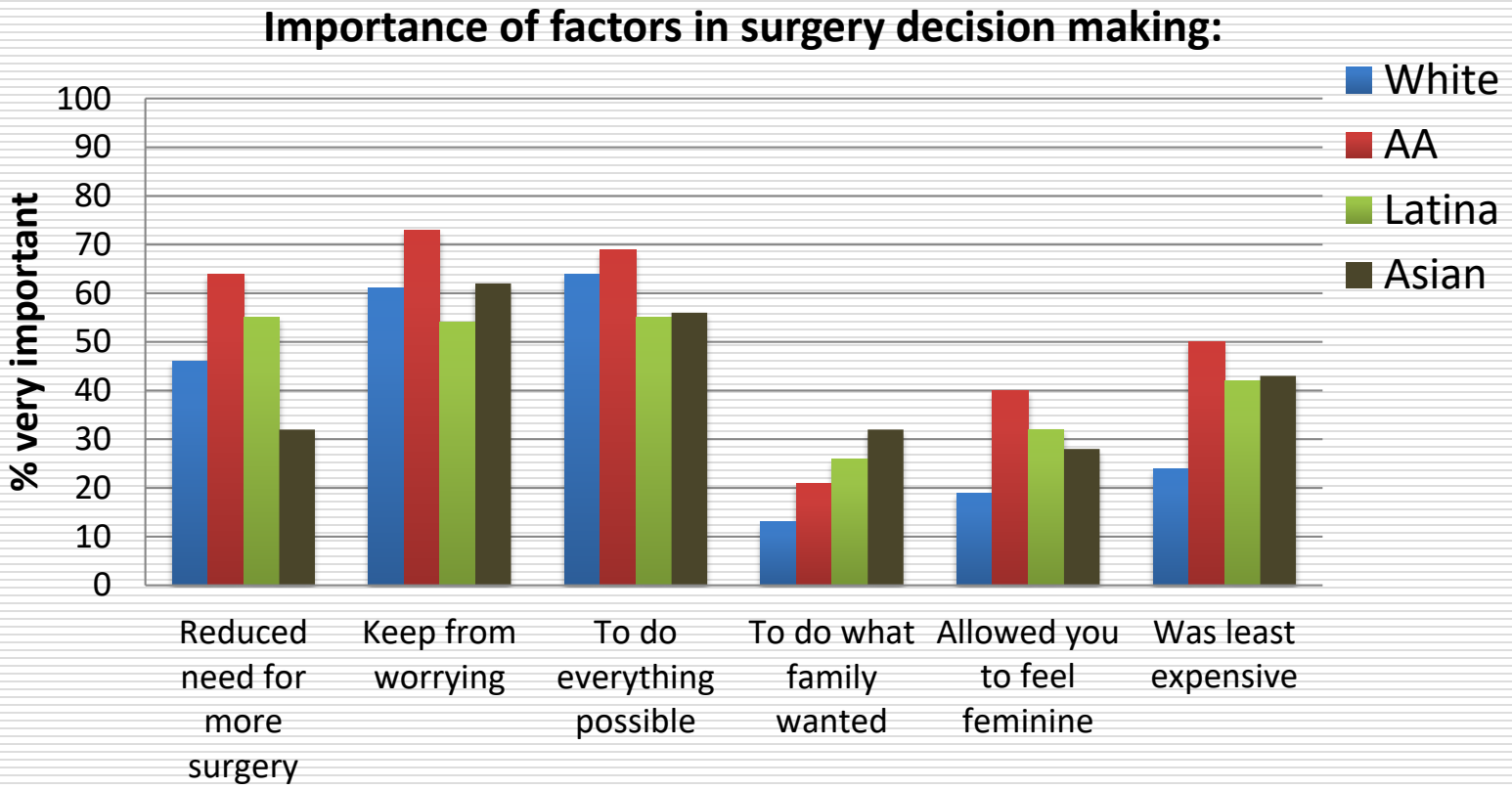
Hawley ST: *Patient Educ Couns.* 2017; 100(1): 18–24
doi:10.1016/j.pec.2016.07.008.

What Does This Have to Do with SDM?

- Racial/ethnic minority and less acculturated patients:
  - Lower decision satisfaction
  - Higher decision regret
  - Greater knowledge gaps
  - Greater role of religion and spirituality
  - Less trust in their providers and the healthcare system
  - Greater role of family

Hawley ST: *Patient Educ Couns.* 2017; 100(1): 18–24
doi:10.1016/j.pec.2016.07.008.

Patients Value Different Things



Hawley ST: *Patient Educ Couns.* 2017; 100(1): 18–24
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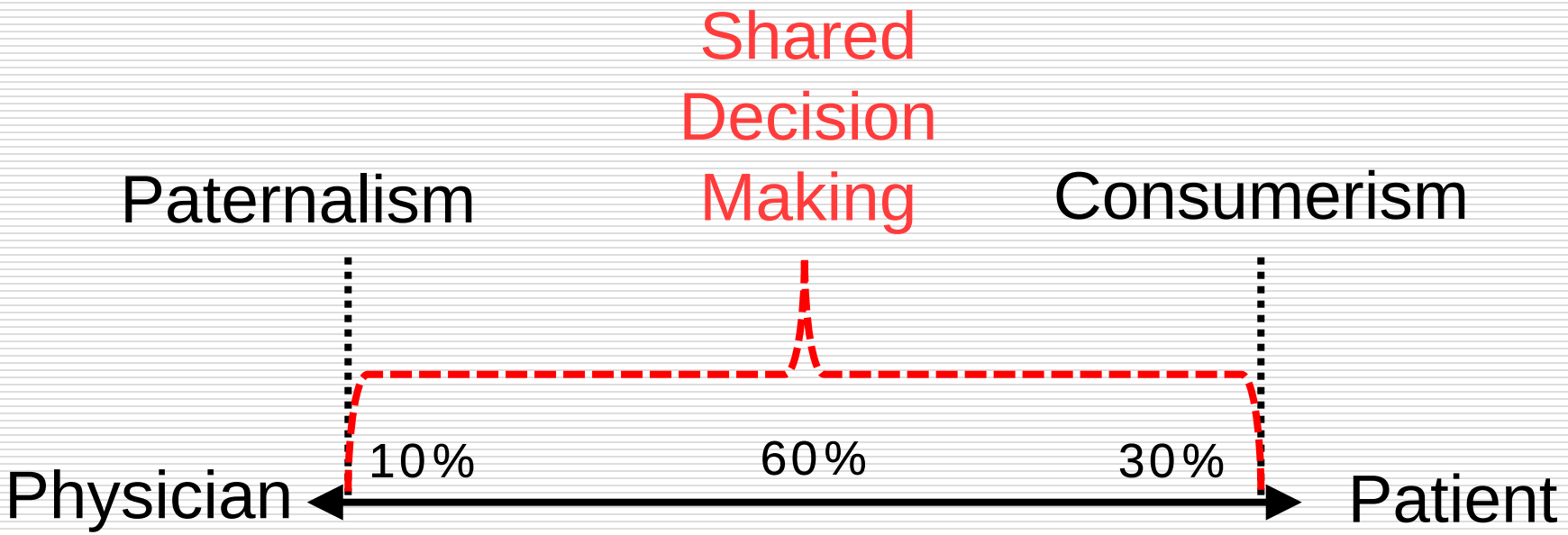
The Spectrum of SDM



- Information Flow
- Decision

Murray E: *Patient Educ Couns*. 2007; 65: 189-196

Can SDM in Current Form Address These Challenges?

- Is it too Eurocentric?
  - Is it focusing too much on the individual?
  - Is it ignoring the role of family/significant other in decision making?
- Is it ignoring the public health implications?
- Is it too focused on transactional issues?
  - Is it ignoring the relational aspect of patient-physician communication?
  - Is it failing to measure the SDM and trust built over time?

Blumenthal-Barby J: *Health Affair* 2019; 38(11):1876-1881
doi: 10.1377/hlthaff.2019.00243.

Can It Be Realistically Incorporated in a Busy Primary Care Practice?

- When there are multiple issues to address in a busy primary care visit, how realistic is it to incorporate SDM on a relevant issue?
  - Decision aid?
  - Physician training?
  - Non-clinician staff prior to the visit?
  - Patient training?
  - How can they be incorporated flexibly?

Conclusion

- There are challenges to incorporate SDM to diverse groups for which the traditional individualistic approach may not be the best fit.
- Solutions to the above would likely entail changes in physician attitude, practice workflow, and technology.

Our Diversity-in-Chief

- “I was just so blown away by New York, so intimidated,” Mr. Ramos recalled.
- “And he said to me, ‘Mike, don’t worry. New Yorkers are just like everybody else — they appreciate a kind gesture and a thoughtful response.’ ”

The New York Times
1/2/2009

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