Shared Decision Making Tools for Lung Cancer Screening

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Disclosures

The presenters have no conflicts of interest to disclose.

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Program Purpose

The overarching aim of this program is to develop and implement a comprehensive primary care and community health program for efficient and equitable delivery of lung cancer screening and smoking cessation treatment to the high-risk patients reducing the burden of lung cancer in Harris County.
Learning Objectives

At the conclusion of this activity, participants will be able to:

1. Explain how shared decision making can be helpful to patients and providers in deciding on lung cancer screening.

2. Describe the key components of an effective lung cancer screening toolkit for use in primary care settings.

3. Use effective decision aid in shared decision making and patient counseling visit requirements of the Centers for Medicare & Medicaid Services (CMS) and for Medicare coverage of lung cancer screening with low-dose CT.
New clinical recommendations place primary care clinicians at the forefront of implementing lung cancer screening on a national scale.

For some adults, annual lung cancer screening could lead to an early diagnosis and life-saving treatment.

The decision can be difficult, however; lung cancer screening carries potential harms as well as benefits.

We will discuss the recently developed AHRQ tools and to assist clinicians and patients make informed decisions about lung cancer screening.

AHRQ's new tools help simplify conversations and decision making among patients and primary care clinicians about low-dose computed tomography (LDCT), the only endorsed screening strategy for lung cancer.
Let’s begin with a case

Clinical Context

• A 60-year-old female presents for a periodic health examination.
• She mentions seeing a large billboard along the highway, showing $99 lung cancer screenings at a local medical facility.
• She asks, “Doc, should I get that lung screening test? I’ve been smoking for 40 years.”

What do you recommend?
The National Lung Screening Trial
Evidence-Based

Reduced Lung Cancer deaths by 16-20%

Randomized >53,000 heavy smokers to:

• Low-dose computed tomography (LDCT) or chest x-ray
• 3 annual screens
• Followed 6.5 years

But ...

Lung Cancer screening with LDCT carries potential harms:

- Radiation exposure (?)
- High positive rate:
  - 20-25% per scan
  - ~40% if screened annually for 3 years
- Invasive procedures
- Incidental findings (may be a benefit)
- Overdiagnosis rate estimated at 10-20%

Breasts Cancer Screening

• Main findings published in 2011.
• Between 20% and 50% of screen-detected cancers represent overdiagnosis based on patient age, life expectancy, and tumor type (ductal carcinoma in situ and/or invasive).
Response from the health care community

Evidence-Based

All emphasize the importance of an informed/shared decision making process!

- Update of 2004 recommendation
- Triggered largely by publication of NLST
- Used comparative modeling to determine optimal screening

USPSTF Recommendation: Lung Cancer Screening

Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.

Medicare: 55-77 y/o

http://www.uspreventiveservicestaskforce.org
Medicare will now cover lung cancer screening with LDCT once per year for Medicare beneficiaries who meet all of the following criteria:

- they are age 55-77, and are either current smokers or have quit smoking within the last 15 years;
- they have a tobacco smoking history of at least 30 “pack years” (an average of one pack a day for 30 years); and
- they receive a written order from a physician or qualified non-physician practitioner that meets certain requirements.

Medicare coverage includes a visit for counseling and shared decision-making on the benefits and risks of lung cancer screening. The NCD also includes required data collection and specific coverage eligibility criteria for radiologists and radiology imaging centers, consistent with the National Lung Screening Trial protocol, U.S. Preventive Services Task Force recommendation, and multi-society multi-disciplinary stakeholder evidence-based guidelines.

- It’s the first covered service that explicitly requires **shared decision making**.
- The visit for counseling and shared decision making is reimbursed by CMS.

Other considerations: Smoking cessation counseling

1. Persons referred by a PCP should receive counseling before referral.

2. For persons who present for screening without a referral (e.g., “self-refer” to a screening center), incorporating smoking cessation counseling is encouraged.
Lung cancer screening counseling and shared decision making visit

1. Determination of beneficiary eligibility
   • Age
   • Absence of symptoms
   • “Specific calculation of cigarette smoking pack-years”
   • Number years since quit

2. Shared decision making, including:
   • Use of 1 or more decision aids, to include...
     • Benefits, harms, follow-up diagnostic testing, over-diagnosis, false positive rate, total radiation exposure
Lung cancer screening counseling and shared decision making visit

3. Counseling on importance of adherence to annual LDCT, impact of comorbidities, and ability or willingness to undergo diagnosis and treatment.

4. Counseling on importance of maintaining cigarette abstinence, or furnishing information about tobacco cessation services.

5. “If appropriate,” furnishing a written order
   - G0296 –Counseling visit to discuss need for lung cancer screening LDCT (service is for eligibility determination and shared decision making)
   - G0297 –LDCT for lung cancer screening
ACR Designated Lung Cancer Screening Centers

Eligibility criteria – Centers of Excellence

**Radiologist**
- Certified by American Board of Radiology.
- Documented training in diagnostic radiology and radiation safety.
- Supervision/interpretation of 300+ chest CT acquisitions in past 3 years.
- Participation in CME in accordance with ACR standards.

**Imaging Center**
- Performs LDCT with volumetric CT dose index.
- Utilizes standardized nodule identification system.
- Collects/submits data to national registry for each
- LDCT lung cancer screening performed.

*Some LCSR participants in Houston:*
  - CHI/St. Luke’s
  - MD Anderson
  - Memorial Herman
  - Methodist
New clinical recommendations place primary care clinicians at the forefront of implementing lung cancer screening on a national scale.

But are we ready?
1. Shared decisions require good communication between clinicians and patients.

2. Decision aids provide a structured approach to providing information about options and trade-offs, values related to options and outcomes, and can help foster deliberation.

3. But, decision aids are not sufficient to ensure a high-quality shared decision making process.
Implementation needs of primary care clinicians

✓ Clarity about the guidelines/recommendations
  • Eligibility, when to start/stop
✓ Clarity about insurance/Medicare coverage
  • Who pays for what?
✓ Finding screening centers for referral
  • Where to send interested/eligible patients?
✓ Patient educational tools/decision aids
✓ Integrating screening programs with EHRs
✓ Training for clinic staff in implementation
✓ Toolkits to help with implementation

Volk et al., Preventive Medicine Reports, 2015.
Components of lung cancer screening tools

For Primary Care Clinicians

**Lung Cancer Screening: A Summary Guide for Primary Care Clinicians**

- To be used by the health care professional in preparation for a shared decisionmaking visit regarding lung cancer screening with LDCT
- Provides an overview of lung cancer screening according to the recommendations from the U.S. Preventive Services Task Force on screening for lung cancer
- Reviews the new eligibility criteria for lung cancer screening with LDCT for Medicare beneficiaries and people with private health insurance
- Presents evidence about the potential benefits and harms of screening with LDCT

AHRQ Publication No. 16-EHC007-10

**Lung Cancer Screening: A Clinician’s Checklist**

- To be used by the health care team during and after the shared decisionmaking visit
- Provides step-by-step guidance on meeting the beneficiary eligibility requirements for lung cancer screening for people covered by Medicare
- May also be useful for smokers not covered by Medicare

AHRQ Publication No. 16-EHC007-11
Components of lung cancer screening tools

For Patients

Is Lung Cancer Screening Right for Me? A Decision Aid for People Considering Lung Cancer Screening With Low-Dose Computed Tomography

» To be used by the patient before a visit with a health care professional to discuss lung cancer screening
» Presents information about:
  » Lung cancer screening
  » Eligibility for screening
  » Potential harms and benefits of screening
  » What is important in making a decision to be screened
  » Questions to ask a health care professional about screening
  » Insurance coverage

AHRQ Publication No. 16-EHC007-12

Components of lung cancer screening tools

Summary guide for clinicians

Lung Cancer Screening: A Summary Guide for Primary Care Clinicians

Lung Cancer Screening With Low-Dose Computed Tomography (LDCT)

BACKGROUND
Primary care clinicians play a key role in determining the eligibility of patients for lung cancer screening, ensuring patients understand the benefits and harms of lung cancer screening, and working with patients to make decisions about screening that are consistent with the patient's values. Currently, annual screening with low-dose computed tomography (LDCT) is the only recommended screening strategy for lung cancer.

In 2012, lung cancer deaths accounted for about 27 percent of all cancer-related deaths in the United States. The median age at diagnosis was 70 years, and the number of new lung cancer cases was about 200,000 people. Although early detection and treatment is ideal, only 15 percent of lung cancer cases are diagnosed at an early stage, and smoking is the largest risk factor for lung cancer, causing about 85 percent of lung cancer cases in the United States.

OVERVIEW OF THE EVIDENCE
Published in August 2011, the National Lung Screening Trial (NLST) was the first trial to provide evidence to support screening for lung cancer with LDCT in reducing lung cancer deaths. The NLST randomized 53,484 high-risk individuals aged 55 to 74 years to either three annual screenings with LDCT or standard chest x-rays and followed them for a median of 6.8 years. The study found that people who were invited to screening were less likely to die from lung cancer than those who were not screened, confirming LDCT as a recommended screening strategy.

Eligibility Criteria for Lung Cancer Screening

- Relevant groups: Persons with private health insurance, Medicare beneficiaries
- Age (years): 55–60
- Smoking status: Current or former smoker
- Smoking history: 30 pack-years
- Lung cancer status: Asymptomatic (no signs of lung cancer)
- Screening frequency: Yearly
- When to stop screening: The patient reaches an upper age criterion, but not earlier than 16 years, or if a health problem that substantially limits life expectancy or the ability to undergo screening is diagnosed.

Insurance Coverage
Both private insurers and Medicare offer coverage for annual LDCT screening for lung cancer among eligible high-risk individuals who meet all the eligibility criteria. (See Eligibility Criteria for Lung Cancer Screening table.)

Smoking Cessation Resources
RedTobaccoFree.gov (U.S. Department of Health and Human Services)
- Smoking Quitline: 1-877-444-7944
- Smoking & Tobacco Use (Centers for Disease Control and Prevention)
- SmokingQuilines: 1-800-568-0800

Points to Discuss with Your Patients
- LDCT is the only recommended screening approach for lung cancer.
- Smoking cessation is a crucial step in reducing the risk of lung cancer.
- Encourage patients to quit smoking and make significant lifestyle changes.

Beneficiary Requirements from CMS

- Initial LDCT Lung Cancer Screening Service: The beneficiary must receive a written order for LDCT screening during a lung cancer screening counseling and shared decisionmaking visit with a physician or qualified nonphysician practitioner. The initial screening visit must meet the following criteria and must be appropriately documented in the beneficiary's medical record to be covered by Medicare.
- Must be a shared decisionmaking visit, use one or more decision aids, and include discussion of the potential benefits and harms of screening, such as the possibility of false-negative or false-positive test results.
- Must be conducted by a qualified nonphysician practitioner and must provide information on tobacco cessation interventions.

Subsequent LDCT Lung Cancer Screening Service: Although not required, a physician or qualified nonphysician practitioner may choose to provide counseling and shared decisionmaking visit for subsequent screenings. The components of the visit are the same as those for the initial visit.

- The patient must receive a written order for LDCT screening during any visit.
- Written orders for both initial and subsequent LDCT lung cancer screenings should be kept in the medical record and must be appropriately documented in the beneficiary's medical record.

To locate accredited imaging facilities go to:
LungCancerScreeningRegistry.html

AHRO Publication No. 16-0007-70 March 2016
### Eligibility Criteria for Lung Cancer Screening

<table>
<thead>
<tr>
<th>Criteria according to:</th>
<th>USPSTF</th>
<th>CMS*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relevant group:</td>
<td>Persons with private health insurance</td>
<td>Medicare beneficiaries</td>
</tr>
<tr>
<td>Age (years):</td>
<td>55–80</td>
<td>55–77</td>
</tr>
<tr>
<td>Smoking status:</td>
<td>Current or former smoker</td>
<td></td>
</tr>
<tr>
<td>Smoking history:</td>
<td>30 pack-years</td>
<td></td>
</tr>
<tr>
<td>Lung cancer signs:</td>
<td>Asymptomatic (no signs of lung cancer)</td>
<td></td>
</tr>
<tr>
<td>Screening frequency:</td>
<td>Yearly</td>
<td></td>
</tr>
<tr>
<td>When to stop screening:</td>
<td>The patient exceeds upper age criterion, has not smoked for more than 15 years, and/or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative surgery.</td>
<td></td>
</tr>
</tbody>
</table>

CMS = Centers for Medicare & Medicaid Services; USPSTF = U.S. Preventive Services Task Force

*CMS requires that the beneficiary receive a written order for LDCT by a physician or nonphysician practitioner, as outlined in CMS policies for initial or subsequent LDCT lung cancer screening.

**Former smokers must have quit within the last 15 years.

([Number of pack-years = (Average number of packs smoked per day) X (Years smoked)] Note there are 20 cigarettes in 1 pack.)

### Insurance Coverage

Both private insurance and Medicare offer coverage for annual LDCT screening for lung cancer among eligible high-risk individuals who meet all the eligibility criteria. (See Eligibility Criteria For Lung Cancer Screening table.) Private insurance plans and Medicare cover lung cancer screening with no out-of-pocket costs. Follow-up invasive diagnostic procedures and repeat imaging to evaluate an abnormal screening test may require out-of-pocket costs.

### SMOKING CESSATION RESOURCES

- **Best Tobacco Facts** (U.S. Department of Health and Human Services)
  - [tobaccofacts.gov](http://tobaccofacts.gov)
  - Smoking Qualifiers: 1-877-449-7848
  - Smoking & Tobacco Use (Centers for Disease Control and Prevention)
  - [cdc.gov/tobacco](http://www.cdc.gov/tobacco)
  - Smoking: 1-800-784-8660
  - Help for Takers and Other Tobacco Users (Agency for Healthcare Research and Quality)
  - [ahgifc.org/tobacco](http://www.ahgifc.org/tobacco)
  - Smoking.gov (U.S. Department of Health and Human Services)
  - [smoking.gov/getready-to-qit](http://smoking.gov/getready-to-qit)

### Points to Discuss with Your Patients

- **LDCT is the only recommended screening approach for lung cancer.**
- **Smoking is a substitute for quitting smoking.** The most important step is the help of a physician who can help you quit smoking. Quitting should not only benefit the patient. It is better to leave it to the patient. To stop smoking, it is better to have written orders for the patient to stop smoking. Smoking is a process. An abnormal LDCT scan does not necessarily mean cancer. Additional testing may be needed to determine a diagnosis. Review the evidence about the benefits and harms of screening with your patient.
Summary guide for clinicians
A clinician’s checklist

Lung Cancer Screening: A Clinician’s Checklist

This checklist was developed to help clinicians meet the Centers for Medicare & Medicaid Services (CMS) criteria for a lung cancer screening counseling and shared decisionmaking visit. All of the criteria listed below must be met for the screening to be covered as a preventive service benefit under Medicare.

Before...
The Clinical Encounter
Determine patient’s eligibility.
This checklist may be completed with the assistance of a nurse, physician assistant, or other medical assistant.

- Is the patient 55 to 77 years old? [Yes] [No]
- Is the patient asymptomatic for lung cancer with no personal history of lung cancer? [Yes] [No]
- Does the patient have at least a 30 pack-year smoking history? [Yes] [No]
- Is the patient healthy enough to have lung surgery? [Yes] [No]
- Is the patient willing to receive potentially curative treatment? [Yes] [No]

Calculate Pack-Years
(20 cigarettes = 1 pack)

Number of years smoked x Average number of packs smoked per day = Pack-years

During...
The Clinical Encounter
Complete all of the following activities.

- Documented all elements in the patient’s medical chart.
- Used a decision aid
- Discussed potential benefits of lung cancer screening:
  - Reduced mortality from lung cancer
- Discussed potential harms of lung cancer screening, including:
  - False-positive results
  - Followup testing if an abnormality is found (and the possible complications of invasive testing)
  - Overdiagnosis
  - Total radiation exposure (screening and diagnostic testing, cumulative)
- Discussed other issues:
  - The impact of comorbidities on screening (the benefit of screening is reduced in patients with poor health)
  - The patient’s ability or willingness to undergo invasive diagnostic procedures and treatment
- counseled about:
  - The importance of adherence to annual lung cancer screening
  - The importance of maintaining cigarette smoking cessation, as applicable
  - Tobacco cessation interventions (provided information, if appropriate)

After...
The Clinical Encounter
Establish the next steps.
If the patient would like screening, provide a written order for the lung cancer screening visit with the following elements:
- Patient’s date of birth
- Actual pack-year smoking history
- Current smoking status; for former smokers, the number of years since quitting
- Statement that the patient is asymptomatic
- National Provider Identifier (NPI) of the ordering practitioner
- If the patient declines screening, document the discussion and the patient’s decision in his or her medical record.
- If the patient is unsure about screening or wants more time, consider scheduling a followup visit to discuss the patient’s screening decision.
- For all patients, reinforce the importance of smoking cessation and abstinence.

*Screening is not recommended if the patient is a current smoker, encourage smoking cessation and provide resources. If the patient is a former smoker, encourage continued abstinence and provide additional support if needed.

Symptomatic patients may need followup and diagnostic testing, but not screening. Patients with a history of lung cancer need surveillance, but not screening.
A clinician’s checklist

The importance of shared decisionmaking

Lung cancer screening with low-dose computed tomography (LDCT) reduces mortality from lung cancer. There are also potential harms associated with lung cancer screening, including a high-false positive rate and the associated need for diagnostic followup, known and unknown risks of additional testing associated with incidental findings, cumulative radiation exposure, and overdiagnosis. Shared decisionmaking is a collaborative patient-centered process in which patients and clinicians make decisions together, within the context of the best evidence and recommendations and based on the patient’s values and preferences.

Tips To Promote a Shared Decision

Below is a five-step process for shared decisionmaking that includes exploring and comparing the possible benefits and harms of each option through meaningful dialogue about what matters most to the patient.

STEP 1: Seek your patient’s participation in the decisionmaking process.

STEP 2: Help your patient explore and compare the potential benefits and harms of lung cancer screening, and assess your patient’s level of understanding. (See the teach-back examples in the box to the far right.)

STEP 3: Assess your patient’s values and preferences about lung cancer screening.

STEP 4: Reach a decision about lung cancer screening with your patient.

STEP 5: Evaluate your patient’s feelings about the decision by having a followup discussion.

Talking Points

Below are specific points to address during the clinical encounter.

- Lung cancer screening can be effective if patients 1) follow the screening protocol, 2) undergo diagnostic followup procedures after a positive screening result, and 3) receive treatment, which has potential harms.
- Screening does not mean that smoking is OK. Smoking still causes lung cancer, cardiovascular disease, and other lung disease.
- Screening can lead to early treatment that can prevent death, but not all lung cancer deaths.
- False-positive results (“false alarms”) are common, and additional scans or invasive procedures may be needed. Less commonly, major complications of invasive procedures can occur, including bleeding, infection, or a collapsed lung.
- Lung cancer screening may find lung cancer that would not have ever caused symptoms or harmed the patient in his or her lifetime if the cancer had not been found. This could lead to treatment of people who do not really need treatment.
- Screening and followup testing exposes patients to radiation. The harms associated with cumulative radiation exposure are unknown.
- Screening should stop if the patient 1) exceeds the upper age criterion, 2) no longer wants screening, 3) has a worsening health condition that limits their life expectancy or increases the risk of complications from lung surgery, or 4) has not smoked for 15 years.

Teach-Back Examples

- “I know I have given you a lot of information. Tell me in your own words what you have heard.”
- “What are your thoughts about lung cancer screening?”
- “Let’s stop right there for a moment. What questions or comments do you have about the information I have given you?”

Referral Information

To find a radiology imaging facility that meets the CMS eligibility criteria, please visit:

www.cms.gov/Medicare/Medicare-General-Information/MedicareApprovedFacilities/Lung-Cancer-Screening-Registries.html
A decision aid for patients
A decision aid for patients

Possible signs and symptoms of lung cancer

- A new cough that does not go away or gets worse
- Chest pain that is often worse when you breathe deeply, cough, or laugh
- A hoarse voice
- Unexplained weight loss and loss of appetite
- Coughing up blood or rust-colored spit or phlegm
- Shortness of breath
- Infections such as bronchitis and pneumonia that do not go away or keep coming back
- Wheezing

Many patients with lung cancer do not have any symptoms when the cancer first starts. It is best to find lung cancer early before symptoms start, when the cancer is more easily treated. This is why screening is important.

If you have any signs or symptoms of lung cancer, be sure to tell your healthcare professional.
A decision aid for patients

Possible signs:

- A new cough that gets worse
- Chest pain that is constant, deep breathing or coughing
- A hoarse voice
- Unexplained weight loss
- Coughing up blood or phlegm
- Shortness of breath
- Infections that do not go away
- Wheezing

Remember, the best way to lower your chances of dying from lung cancer is to stop smoking.

More than 8 out of every 10 lung cancer cases in the United States are from smoking.

Lung cancer screening should not be done instead of quitting smoking. If you currently smoke, talk to your health care professional or call the nationwide quit line at 1-800-QUIT-NOW (1-800-784-8669).
A decision aid for patients

**COMPARING SOURCES OF RADIATION**

- **Air travel (10 hours):** 0.04 mSv
- **Chest x-ray:** 0.1 mSv
- **Mammogram:** 0.4 mSv
- **LDCT for lung cancer screening:** 1.4 mSv
- **Average background radiation (U.S., 1 year):** 3 to 5 mSv
- **Diagnostic CT:** 7 mSv

millisievert (mSv), a measure of the amount of radiation absorbed by the body.

- 18 of the people who get a "false alarm" will have an invasive procedure like a biopsy.
- Less than 1 of the 18 people who have an invasive procedure will have a major complication, e.g., infection, bleeding in lung, collapsed lung.

*For people screened once a year for 3 years and followed for an average of 6.5 years. This information applies to people who are at high risk of lung cancer because of their smoking history and age.*
**A decision aid for patients**

**WHAT IS IMPORTANT TO YOU WHEN DECIDING ABOUT SCREENING FOR LUNG CANCER?**

There are many things to think about when deciding whether lung cancer screening is right for you. Below is a list of questions that may help you decide.

<table>
<thead>
<tr>
<th>How important is:</th>
<th>Favors Screening</th>
<th>Favors No Screening</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finding lung cancer early when it may be more easily treated?</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How concerned are you about:</th>
<th>Favors Screening</th>
<th>Favors No Screening</th>
</tr>
</thead>
<tbody>
<tr>
<td>Having a false alarm?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Having other tests if you have a positive screening test?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Being exposed to radiation from lung cancer screening?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Being treated for lung cancer that never would have harmed you?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Being harmed by the treatments you receive for lung cancer?</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

**AIR TRAVEL 10 HOURS**

**CHEST X-RAY**

**MAMMOGRAM**

**LDCT FOR LUNG CANCER SCREENING**

**AVERAGE BACKGROUND RADIATION (U.S., 1 YEAR)**

**DIAGNOSTIC CT**

mSV=milliSievert, a measure of the amount of radiation absorbed by the body.

18 of the people who get a “false alarm” will have an invasive procedure like a biopsy.

Less than 1 of the 18 people who have an invasive procedure will have a major complication (e.g., infection, bleeding in lung, collapsed lung).

*For people screened once a year for 3 years and followed for an average of 6.5 years. This information applies to people who are at high risk of lung cancer because of their smoking history and age.
Communication strategies with patients

1. Provide clear information

- Risks and benefits of lung cancer screening
  - (see Checklist Talking Points)
- Use everyday language, pictures, graphs, example, analogies, stories (communicating ‘gist’)
- How do you know your message is clear? Check for patient understanding.
- Examples:
  - “I know you’ve gotten a lot of information. What stands out as particularly important to you?”
  - “So we’ve talked about possible harms of LCS. What do you think about those risks?”
Communication strategies with patients

2. Elicit/validate a patient’s beliefs, concerns, and preferences (or values)
   • Ask what a patient thinks about lung cancer screening by exploring beliefs, concerns, and preferences (or values).
   • But remember:
     ▪ Concerns and preferences are not misinformed; they are grounded in a reality that is coherent, rational, and meaningful to the patient.
     ▪ Try to connect clinical evidence to a patient’s values, preferences, and emotions.
3. Try to reach mutual understanding and Agreement

- Check your understanding of the patient’s perspective.
  - “So what you’re saying is if there is at least some chance to save your life, you want to do it even if the odds of a false alarm are much greater?”
  - “Let me see if I got this right. You think the likelihood this could save your life is quite small, and you really worried about what would happen with a false positive?”

- Check the patient’s understanding of what you have shared with the patient, including any concerns you have.
  - So you know what I’m concerned about?”
Additional considerations for lung cancer screening conversations

• The patient has a knowledge about LCS or has received the decision aid before the consultation
  • *First, ask patient about his or her thoughts about LCS.*
    • This lets the clinician know what the patient understands and what their initial preferences are and why.
    • If a patient has used the aid, but say he/she is not sure what to think about it, then follow with a probe (“Well just tell me some of your thoughts about it.”)
  • *Fill in knowledge gaps and explore preferences/concerns.*

• The patient has no or very limited knowledge of LCS
  • *Use the decision-making tool in the encounter to educate, identify concerns, and discuss preferences.*
In conclusion:
How might the lung cancer screening tools be used?

- Adapt the tools for a variety of primary care settings.
- Integrate the tools with electronic health records (Clinician’s Checklist).
- Adapt the tools for different patient populations.
- Couple the tools with clinician training in shared decision making.
Questions

• Additional recommendations, questions, or concerns?

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Registration is open until 11:00 PM.

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