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Impact of a Prostate Specific Antigen Screening Decision Aid on Clinic Function

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Abstract

INTRODUCTION—Decision aids (DAs) around prostate cancer screening can increase knowledge and shared decision making (SDM), but remain underutilized due to cost and time constraints that disrupt clinic flow. We examined the impact of a simple prostate specific antigen (PSA) screening DA distribution strategy on clinic flow as well as SDM in a diverse urban primary care clinic.

METHODS—Men ages 50–75 viewed the DA while waiting for physicians. Participants and physicians completed questionnaires evaluating the SDM process. Focus groups were conducted with clinic staff and physicians to evaluate the impact on clinic operations.

RESULTS—Fifty percent of men discussed PSA screening and 85% reported the DA made decision making easier. Participants reported an average of 12.9 min reading the DA. Participants reported high decision satisfaction and low decisional conflict. Physicians reported an average of 5.2 minutes discussing PSA screening. Clinic staff reported increased enthusiasm for the process after adjustments were made in response to concerns including time, and lack of both knowledge about the DA subject matter and involvement in the process. Physician-reported barriers included ambivalence about PSA screening.

CONCLUSIONS—A PSA DA, requiring few resources, can be implemented with broad involvement of clinic staff and minimal disruption to clinic flow in an urban primary care clinic, and may facilitate SDM.

Keywords

clinical decision support; prostate cancer; prostate specific antigen

INTRODUCTION

The controversial United States Preventative Services Task Force (USPSTF) recommendation against routine PSA screening has decreased rates of PSA screening and early diagnosis of prostate cancer since 2012^{1, 2} with unclear future consequences as rates of men presenting with advanced disease may be on the rise³. In addition, the Prostate, Lung, Colorectal and Ovarian Screening Trial⁴, which was weighted heavily in the USPSTF's decision to recommend against PSA screening, has been found to have significant methodological concerns including an approximately 90% contamination rate⁵ (men receiving PSA tests that were not intended to) in the control arm, thus calling into question the validity of the conclusion of the study that there was no advantage to PSA screening⁶. Further, there is little to no evidence to guide recommendations for high risk men such as those with a family history of prostate cancer and African-Americans (AAs), two groups who might stand to benefit more from screening than men of average risk. Therefore, despite the USPSTF recommendation, many men will still likely benefit from shared decision making (SDM) regarding prostate cancer screening as endorsed by the American Urologic Association (AUA) in their Guideline for the Early Detection of Prostate Cancer⁷. In addition, SDM was recently highlighted in an AUA White Paper⁸ as an important component to high quality health care delivery and noting that it may soon be tied to reimbursement models. Therefore, effectively implementing SDM around PSA screening remains extremely important.

Barriers to SDM include resources, patient preferences, and applicability of SDM for particular clinical situations⁹. Decision aids (DAs) may overcome some of these barriers and have been shown to enhance SDM and effect behavior change though many require significant costs and time to implement, preventing their use by most practices¹⁰⁻¹⁶. Physicians may be more willing to engage in SDM if it can be done in a time and cost conscious manner potentially benefitting many patients. Therefore we sought to evaluate the impact of a simple delivery method of a PSA screening DA primarily on physicians, clinic staff and clinic work flow as well as on SDM.

MATERIALS and METHODS

This study was approved by the University of Minnesota Institutional Review Board and registered on ClinicalTrials.gov. Eligible men were 50 to 75 years old, scheduled to see a physician, and English speaking. Patients with prostate cancer, previous prostate biopsy or those who had had a PSA test within the past 12 months, voiding problems as the reason for the visit, or those who had scheduled their appointment the same day they were being seen, presumably for urgent problems for whom discussion of PSA screening would not be appropriate, were excluded. Physician participants were family medicine residents and faculty working in a diverse urban clinic.

Recruitment for the study occurred over approximately 6 months involving parts of 44 clinics. Participants were identified from a list of scheduled patients for the day. Front desk staff gave potential participants information about the study. A research assistant confirmed eligibility, and provided the participant with the DA to read while waiting for the physician.

After the visit, both patients and their physicians completed written surveys; patients were then given a \$20 gift card.

The DA used in this study was a slightly modified version of the previously validated PROCASE DA¹¹ which is written at a 6th grade level (Appendix 1). Modifications reflected information from the Prostate, Lung, Colorectal and Ovarian, and European Randomized Study of Screening for Prostate Cancer screening trials^{4, 17}.

The patient participant survey was a 44 item tool including the Knowledge of Prostate Cancer tool¹⁸- the number of correct answers was summed to create a scale score (0–10); the Decisional Conflict Scale¹⁹- a modified version of this scale was used that utilized only positive statements to allow for consistent scoring. The total score was calculated as described by O'Connor to produce a scale ranging from 5 (no conflict) to 80 (extremely high decisional conflict); the Satisfaction with Decision Scale²⁰- items were summed to produce a scale score ranging from 0 (strongly dissatisfied) to 30 (extremely satisfied); whether a PSA screening discussion occurred; preference for involvement in decision making; and time spent viewing the DA. The provider survey consisted of 7 items assessing whether a discussion of screening occurred, quality of the discussion, whether a decision was made, and time spent in SDM.

Summary descriptive statistics were used for subject characteristics, survey items, scale scores, time viewing the DA, and provider survey results. Generalized linear models examined the influence of covariates on levels of decisional conflict and satisfaction.

Four focus groups (FGs) were conducted at the midway point (Phase I) of the study to identify changes to improve the SDM intervention, and another five focus groups at the end of the study to assess the efficacy of the process (focus group interview guide available in Appendix 2). The clinic staff and physician FGs were held separately. Each FG included 8–15 participants. All focus groups were conducted by the second co-author (J.B.) with a research assistant. Dr. Berge has over 10 years of experience conducting focus groups. The tape-recorded FGs were transcribed verbatim and a grounded hermeneutic approach was used. A grounded hermeneutic approach focuses on people's perceptions of the world in which they live and their meanings. This type of analysis includes describing, organizing, connecting, corroborating, and representing the lived experience of the participant in themes.^{21, 22} The qualitative data was analyzed using NVivo 10 qualitative analysis software (NVivo 10, QSR International Pty. Ltd, Melbourne, Australia, 2000).

RESULTS

Table 1 displays the 68 participants' demographics. Participants reported an average of 12.9 minutes reading the DA. For every additional minute viewing the DA, the odds of having a screening discussion increased by 1.07 (95% CI: (1.01, 1.15)). Ninety-three percent "somewhat or strongly agreed" receiving the DA made them more likely to discuss PSA screening during that visit. Fifty percent actually had a screening discussion and 73.5% of them reported making a screening decision (36.8% of all participants), though whether participants actually did or did not subsequently obtain a PSA test was not tracked.

Participants' evaluations of the DA and SDM are shown in Table 2. Mean time spent discussing PSA screening was 10.2 minutes and 85% felt the DA made decision making easier. Of men having a PSA screening discussion, 82% were started by patients. Overall, participants reported high decision satisfaction with a median score on the Satisfaction with Decision Scale of 26.5/30, and demonstrated a median score of 27/80 on the Decisional Conflict Scale suggesting low levels of conflict (data not shown). Table 3 shows physician reported mean time discussing screening was only 5.2 minutes.

While not the main focus of our study, we evaluated whether there were differences between AA and Caucasian men in the use of the DA and SDM given the disproportionate burden from prostate cancer borne by AA men. We found that AAs were more likely to have a discussion about screening (60% vs. 29%, $P=.04$) than non-AAs (data not shown).

Themes identified by both clinic staff and physicians from the Phase I FGs included: time constraints, training, communication, and lack of knowledge about the DA (Table 4). Physician FGs also identified controversy regarding PSA screening. Changes in response to these themes during Phase II included providing clinic staff with three one-sentence "talking points" about prostate cancer and PSA screening, boosting their confidence interacting with patients. Physicians were also provided an additional training session on SDM emphasizing increasing SDM, not increasing PSA testing per se, and were provided effective ways to integrate SDM skills into their overall practice.

Phase II FGs results indicated that overall, clinic staff and physicians were satisfied with the changes made from Phase I. Front desk staff reported they felt "more involved" with the distribution of the DA making them more "likely to talk with potential participants" about the study. Physicians reported that the SDM process using the DA "felt comfortable," making them more likely to engage in SDM, and that the SDM process "seemed to work" with their patients.

DISCUSSION

Our results suggest that distribution of DAs to patients waiting for their clinician empowers men to start SDM discussions regarding PSA screening without significant increases in time or cost. Patients and physicians report acceptance of the DA while clinic staff and providers report the intervention was feasible to implement. This approach capitalizes on "down-time" in the physician's office avoiding a separate visit, and increased encounter time by only 5–10 minutes. It overcomes barriers of time and cost seen in other studies using sophisticated strategies including mailing of DAs ahead of time or use of web based tools^{12, 23, 24}. Application of these other approaches may be limited in patient populations that move frequently making mailings unreliable, and web-based interventions may be less effective for those who do not have easy internet access or lack computer literacy. Further, our approach allows for SDM discussions to occur in the same setting in contrast to a study by Tran et al.¹⁶ where a simple printed DA was distributed, but only after the physician visit.

Another aspect to our approach was to provide training on how to conduct SDM. Resident participants had 2 fifty minute training sessions over the course of the study. We chose to

focus on the “ask-tell-ask” approach to SDM²⁵. Training in this simplified approach to SDM may also have contributed to the effectiveness of our approach in two ways; first, the training may have increased physicians’ confidence in engaging patients in SDM, and second, use of this simplified approach helped keep the required time to achieve SDM to a minimum thus increasing the likelihood of acceptance of the approach. Further, the majority of physicians reported that the DA made the PSA screening discussion easier. Therefore, our approach seems to accomplish the goals of facilitating SDM without significantly increasing the encounter time, even when a patient was coming to clinic for a different reason. It should be noted that these results were accomplished in a population consisting of nearly 70% AA men, a group at high risk of prostate cancer for which no evidence based guidance exists and thus are likely to benefit from SDM on this topic. It is interesting to note that AA men chose to discuss screening at much higher rates than Caucasian men. While we do not have the data to determine why this is, there may be bias in counseling of AA men compared to counseling of Caucasian men by physicians. Alternatively, it may simply be that after informing AA men that they are at increased risk of diagnosis of and death from prostate cancer compared to Caucasians, that they chose to discuss screening at higher rates. Further research may help to explain this difference. In addition, while these results were achieved in a resident-run primary care clinic, the approach may be even more successful when implemented by physicians more experienced navigating difficult clinical decisions or in urology clinics where patients may be even more receptive to thinking about urology related topics, even if PSA testing is not the primary reason for their visit.

One particular strength of our study was the use of a mixed methods approach, which few studies to date have done. This led to one of the most interesting and unanticipated findings of our study which was the desire for involvement on the part of the front desk and nursing staff. These important members of the care team have a dramatic impact on the work flow in the clinic but are often overlooked in terms of their role in interacting with patients. However, it was clear from our focus groups that these individuals felt strongly that they wanted to be empowered with a minimum amount of information to be able to answer basic questions about the DA. Further, exposing patients to information about the DA at multiple points during the visit likely reinforced the importance of the DA, and may have facilitated its use. While it is not the role of the front desk or nursing assistants to provide counseling to patients regarding health care decisions per se, including these individuals in the process by providing them with simple talking points explaining the purpose of the DA greatly facilitated their willingness to participate in and satisfaction with the process, minimizing any negative perception of the impact of the DA on the work flow in the clinic, a major barrier to use of DAs. Thus successful implementation of SDM strategies may require a broader clinic wide strategy, beyond just the physician/patient focus.

Limitations of our study include length of surveys, sample size and lack of control groups in this one-site pilot study. These limitations preclude definitive conclusions about effectiveness of this approach.

CONCLUSION

Our simple approach of presenting a PSA screening DA to patients while they await their physician appears to be feasible without significantly increasing costs or time. Maximization of the approach may be realized with training of physicians in the use of SDM and a broad clinic-wide approach involving all members of the clinic team in the process. This approach may be broadly applicable for encouraging SDM regarding PSA screening and many other difficult medical decisions.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

Key of Abbreviations

USPSTF	United States Preventive Services Task Force
PSA	Prostate Specific Antigen
AA	African-American
SDM	Shared Decision Making
AUA	American Urologic Association
DA	Decision Aid
FG	Focus Group

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Table 1

Participant demographics, knowledge score, time viewing DA and whether a screening decision occurred comparing those who had a discussion to those who did not

	Entire cohort n=68	Discussed screening n=34	Did not discuss screening n=34
Mean age (sd)	60 (6.0)	58 (4.9)	62 (6.5)
Race/ethnicity n, (%)			
African American	47 (69)	28 (82)	19 (56)
White	17 (25)	4(12)	13(38)
Asian	2 (3)	2(6)	0(0)
Native American	8 (12)	4 (12)	4(12)
Multi-racial or Other	1 (1)	0(0)	1(3)
Education n, (%)			
Some high school or less	23 (34)	12(36)	11(32)
High School graduate or GED	23 (34)	7 (21)	16 (47)
Some college or higher	21 (31)	14(42)	7(21)
Unknown	1	1	0
Mean prostate cancer knowledge score (sd)^a	6.8 (1.8)	6.9 (1.9)	6.6 (1.6)
Mean time spent viewing DA in minutes (sd)	12.9 (9.1)	15.4 (9.8)	10.5 (7.7)
Screening decision occurred n, (%)^b	25 (36.8)	25 (73.5)	0 (0)

^a = Number of questions answered correctly out of 10

^b“Screening decision occurred” indicates that a decision regarding screening was made during the visit, but does not indicate that a PSA test was or was not actually obtained

DA= Decision aid, sd= standard deviation. Participants with missing data were excluded from each analysis. Percentages may not add up to 100 due to rounding.

Table 2Patient reported description of the SDM process.^{a*}

Who started the discussion? [#]	
Patient started discussion n, (%)	27 (82)
Doctor started discussion n, (%)	6 (18)
Length of discussion in minutes, mean (sd)	10.2 (6.32)
Was a screening decision made?	
Yes n, (%)	25 (74)
No n, (%)	9 (26)
Did the DA affect your ability to make a decision?	
Made it easier n, (%)	29 (85)
No difference n, (%)	5 (15)
Made it harder n, (%)	0

DA= Decision aid; sd= standard deviation

^aFor men having PSA screening discussions with their physician (n=34)^{*}Columns may not total 100% due to rounding[#]Data missing for one participant (n=33)

Table 3

Physician evaluations of DA use in clinic visits where PSA screening was discussed

Who initiated the discussion? (n=26)	
Patient n, (%)	18 (69)
Doctor n, (%)	8 (30)
Quality of the discussion n, % (n=26)	
Excellent	2 (8)
Above average	8 (31)
Average	15 (58)
Below average	0
Poor	1 (4)
Time spent discussing PSA, minutes (sd)	5.23 (2.82)
Was a screening decision made at visit? (n=25)	
Yes n, (%)	21 (84)
No n, (%)	4 (16)
DA's impact on shared decision making process (n=25)	
Made it easier n, (%)	14 (56)
No effect n, (%)	10 (40)
Made it harder n, (%)	1 (4)
Physicians satisfaction with SDM process (a), mean, (sd)	2.27 (0.78)

(a) Rated on Likert scale. 1= very satisfied, 5= very unsatisfied

DA = Decision aid

Columns may not total 100% due to rounding

Table 4

Themes from focus groups with the clinic staff and providers regarding challenges and ideas for improvement for implementation of the PSA DA

	Staff Focus Groups	Resident/Physician Focus Groups	Actions Taken to Improve the Process in Phase II
Theme/Topic Identified in Focus Groups:			
Time Constraints	<u>Challenges Identified:</u> <ul style="list-style-type: none"> • Patient check-in lines are long making it hard to check patient study eligibility (verifying insurance is priority) • Clinic afternoons are very busy and it's more difficult to check patient eligibility and give out decision aids 	<u>Challenges Identified:</u> <ul style="list-style-type: none"> • Patients brought the decision aid out at the end of the visit precluding time for a shared decision making conversation • Having a shared decision making conversation is difficult due to the 20-minute appointment time blocks 	<ul style="list-style-type: none"> • Eligible patient lists were created daily to reduce front desk staff burden • Providers participated in a training where the ask- tell- ask model, promoting shared decision making, was presented. Residents also role-played scenarios to become comfortable with engaging in shared decision making conversations within a limited time frame
Training	<u>Challenges Identified:</u> <ul style="list-style-type: none"> • Eligible patients ask questions about study participation that the front desk does not know how to answer • Patients need more one-on-one time with someone to explain the study information 	<u>Challenges Identified:</u> <ul style="list-style-type: none"> • Some of the providers missed the original training about PSA screening and shared decision making and did not know about the study in detail • There is confusion about the "gold standard" for PSA screening 	<ul style="list-style-type: none"> • Front desk staff attended a training where they were given a list of three talking points that they could use to describe the study to potential participants • A research team member was hired to sit in the lobby on daily basis. Once front desk had introduced the study to participants they were invited to talk with the team member in more detail about the study and answer questions • Providers participated in a training where shared decision making directly related to PSA screening was taught. Training regarding the USPSTF recommendations was also conducted.
Communication	<u>Challenges Identified:</u> <ul style="list-style-type: none"> • Some of the front desk staff that were new missed the original training and didn't know about the study 	<u>Challenges Identified:</u> <ul style="list-style-type: none"> • Some residents did not check their mailboxes for the follow-up survey, or found it weeks after they saw the patient • There are a lot of projects going on at the clinic, it's hard to keep them all straight 	<ul style="list-style-type: none"> • Utilized the TV monitor in the waiting room to convey study information to potential participants • Gave front desk staff and providers continual reminders about the study through multiple modes (i.e., emails, EMR task messages, mailboxes, announcements at clinic meetings)

	Staff Focus Groups	Resident/Physician Focus Groups	Actions Taken to Improve the Process in Phase II
			<ul style="list-style-type: none"> Reminder cards were put on all front desk staffs' computer monitors to remind them about the study Follow-up surveys were put on providers' desks to fill out the same day as the participant visit instead of in their mailbox
Decision Aid	<u>Challenges Identified:</u> <ul style="list-style-type: none"> Embarrassed to hand out decision aid because of diagrams of the male prostate 	<u>Challenges Identified:</u> <ul style="list-style-type: none"> Some study participants did not show the provider the decision aid during the visit and providers didn't engage in shared decision making regarding PSA screening 	<ul style="list-style-type: none"> Front desk staff participated in a training to talk about the study in more detail in order to help them feel more comfortable with the topic and to help them know how to answer basic questions about the study Decision aids were put in exam rooms and the precepting room where residents and physicians often sit A research team member was hired to sit in the lobby on daily basis. Once front desk had introduced the study to participants they were invited to talk with the team member in more detail about the study and answer questions
Lack of Buy-in Regarding the Study Objective		<u>Challenges Identified:</u> <ul style="list-style-type: none"> Some providers didn't think PSA screening was an important topic PSA screening conversations don't always fit with the patient agenda, or if there is an acute visit it's hard to fit in a conversation about PSA screening 	<ul style="list-style-type: none"> Residents participated in a training that focused on the process of shared decision making and how this skill can be used across visits and health issues