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THE SHARE 5 STEP COMMUNICATION FRAMEWORK FOR SHARED DECISION-MAKING IN 3RD-LINE TREATMENT OF METASTATIC COLORECTAL CANCER (mCRC)

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INTRODUCTION

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LEARNING OBJECTIVES

After reading this presentation you will know **<u>what</u> you need to explain** to your patients requiring 3rd-line treatment of mCRC and **<u>how</u> to confidently communicate** these messages for an optimal physician-patient interaction.

Ultimately, success is both parties being satisfied with the decision-making process and with the decision that is made.

mCRC, metastatic colorectal cancer.

THE SHARE COMMUNICATION FRAMEWORK FOR SHARED DECISION-MAKING IN 3RD-LINE TREATMENT OF mCRC

mCRC, metastatic colorectal cancer.

WHAT IS THE SHARE COMMUNICATION FRAMEWORK?

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SHARE is a 5 step communication framework to foster shared decision-making in physician–patient interactions regarding 3rd-line treatment of mCRC, that recommends the following communication points:

Step 1 **S** tabilise the disease with 3rd-line treatment

Step 2 **H** ow 3rd-line treatments may differ from previous treatment received

Step 3 **A** dvantages and disadvantages of each treatment option

Step 4 **R** isks and understanding of how to manage side effects

Step 5 **E** xpectation for treatment success

mCRC, metastatic colorectal cancer.

PRINCIPLES AND USE OF THE SHARE COMMUNICATION FRAMEWORK

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Principles of the SHARE framework

- ☑ Reflects the increasing autonomy of patients and their desire to be more involved in their health and medical decision-making
- ☑ Ultimate goal is to improve outcomes through enhanced patient engagement, understanding and outlook
- ☑ The framework may be delivered over a number of interactions and should always be applied as a guide and adapted depending on patient needs
- ☑ The role of the carergiver in the discussion must also be considered so they feel engaged appropriately

How could you use the SHARE framework?

- ☑ Include each step into your consultation with a patient requiring 3rd-line treatment of mCRC
- ☑ Consider the need to incorporate the framework over a series of patient consultations
- ☑ Apply the principles to communication with family or carergivers
- ☑ Encourage your team to complete this training and follow the steps consistently

In this educational programme, we refer to 3rd-line treatment of patients with advanced, progressive mCRC who have been pre-treated with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy, an anti-VEGF therapy, and if the tumour is RAS wild-type, an anti-EGFR antibody.

EGFR, epidermal growth receptor; mCRC, metastatic colorectal cancer; VEGFR, anti vascular endothelial growth factor receptor

CASE STUDY: SANDRA

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Throughout this presentation, Sandra will be used as a patient case study to help articulate **<u>what</u> you need to explain** to your patients requiring 3rd line treatment of mCRC and **<u>how</u> to communicate** these messages for shared decision-making in physician-patient interactions.

This case study explores the treatment of Sandra, a 51-year-old patient with Stage IV rectal cancer. Her disease progressed with liver metastases 16 months after total resection and adjuvant chemotherapy. She has *KRAS*-wild type disease and, at diagnosis, her ECOG performance status was 0 and she had normal renal function. Her daughter is in her final year at university and Sandra would like to attend her graduation in 3 months' time.

Treatment and disease history:

- 1st-line treatment: FOLFOX + cetuximab; progression after 12 months
- Updated patient characteristics: no change in ECOG performance status or renal function
- 2nd-line treatment: FOLFIRI + bevacizumab; progression after 7 months
- Updated patient characteristics: ECOG performance status of 1; no change in renal function; patient reports weight loss, nausea and fatigue

ECOG, Eastern Cooperative Oncology Group; FOLFIRI, irinotecan, fluorouracil and folinic acid; FOLFOX, folinic acid, fluorouracil and oxaliplatin; mCRC, metastatic colorectal cancer.

STEP 1:
STABILISATION OF THE DISEASE AND THE AIM OF 3RD-LINE TREATMENT FOR mCRC

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SHARE – STEP 1

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STABILISE THE DISEASE WITH 3RD-LINE TREATMENT

- mCRC ultimately progresses after standard 1st- and 2nd-line treatments
- By the time patients receive 3rd-line treatment, they still are still generally fit and motivated to receive further treatment
- The decision of what 3rd-line treatment to receive requires consideration of the characteristics of available treatments

mCRC, metastatic colorectal cancer.

SHARE – STEP 1
CASE STUDY: SANDRA

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- Sandra is showing evidence of progressive disease and her CEA levels are rising.
- She is devastated about the news but, after discussion with her physician, expresses motivation to continue with therapy and having no further treatment is "just not an option," from her perspective.
- Her ECOG performance status is now 1 and she reports "doing great" apart from fatigue and some numbness and tingling in her hands and feet.

COMMUNICATION BEST PRACTICE

WHAT TO DO

- Warm welcome and introduction; provide questions to demonstrate an ongoing relationship, interest and empathy
- Make it clear that the main treatment aim is about controlling vs curing the disease
- Ask if the patient has any questions and continually seek confirmation of their understanding
- Allow the patient time to digest and assimilate information
- Highlight any positives (e.g. patient's current state of well being)
- Reassure that all patients are different and there is a need to find the right treatment for them as an individual

WHAT NOT TO DO

- Failing to make a connection with the patient from the start; short introduction and straight into the consultation
- Emotional response of the patient not sensitively handled
- Moving quickly onto 3rd-line treatment options without establishing with the patient why they should be considered in the first place
- Not giving the patient time to absorb the news that their disease is not under control
- Not allowing the patient the opportunity to articulate or define their own treatment aims

CEA, carcinoembryonic antigen; ECOG, Eastern Cooperative Oncology Group.

STEP 2:
HOW 3RD-LINE TREATMENT OPTIONS FOR mCRC MAY DIFFER FROM 1ST- AND 2ND-LINE TREATMENTS WITH DIFFERENT MECHANISMS OF ACTION

mCRC, metastatic colorectal cancer.

SHARE – STEP 2

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HOW 3RD-LINE TREATMENTS MAY DIFFER FROM PREVIOUS TREATMENT RECEIVED

- Available 3rd-line therapies have different molecular targets and mechanisms of action
- Identifying which patient may benefit most from 3rd-line therapies is possible, and the choice of therapy is dependent on patient- and disease-related factors
- International guidelines recommend the multikinase inhibitor regorafenib, or a therapy combining a nucleoside inhibitor and a thymidine phosphorylase inhibitor (TAS-102)

SHARE – STEP 2
CASE STUDY: SANDRA

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- You explain to Sandra the differences in mechanisms of action, efficacy outcomes, and administration of the available 3rd-line therapies
- Sandra reiterates her desire for additional therapy and receipt of the therapy that will give her the best chance of being able to attend her daughter's graduation while maintaining her current quality of life
- She also expresses concern regarding how the treatments are administered and how often, as she does not want treatment to be burdensome, like the chemotherapy she received previously

COMMUNICATION BEST PRACTICE

WHAT TO DO

- Explain equivalent options
- Explain in layman terms, avoiding language that is too technical
- Include information that is important to the patient such as how often the treatments will need to be taken, how they are administered and where they are taken (e.g. home vs hospital)

WHAT NOT TO DO

- Giving a fast explanation without recognising options
- Using extensive technical language and jargon
- Providing inappropriate reference to data, which lacks relevance to the patient
- Ignoring the need for clear background information upon which to base any form of decision-making

STEP 3:
ADVANTAGES AND DISADVANTAGES OF EACH 3RD-LINE TREATMENT OPTION, FOCUSING ON EFFICACY WHILST WAITING TO EXPLAIN SIDE EFFECTS AND SAFETY

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SHARE – STEP 3

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ADVANTAGES AND DISADVANTAGES OF EACH TREATMENT OPTION

- Recommended 3rd-line treatments for mCRC have the potential to reduce the risk of death versus placebo or best supportive care
- Treatment after 2nd-line have the potential to provide OS benefit
- Beyond treatment goals of prolongation of survival and disease control, physicians consider alleviation of tumour-related toxicities, maintaining QoL, and respecting patient preferences

mCRC, metastatic colorectal cancer; OS, overall survival; QoL, quality of life.

SHARE – STEP 3
CASE STUDY: SANDRA

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- Sandra is very motivated to receive additional treatment that will give her the greatest chance of being at her daughter's graduation
- Given that Sandra's 1st-line treatment was FOLFOX plus an anti-EGFR therapy and her 2nd-line treatment was bevacizumab, and because she has a reasonable performance status, you feel she is a potential candidate for regorafenib or TAS-102

COMMUNICATION BEST PRACTICE

WHAT TO DO

- Provide appropriate information that is fact-based and not misleading
- Clarify why a treatment might be recommended as the most appropriate whilst explaining the different options
- Provide plenty of pauses to allow the patient to consider and ask questions
- Actively seek confirmation of the patient's understanding and provide opportunity to ask questions
- Emphasise that the patient's opinions are valuable
- Focus on the efficacy of the different options; safety and side effects are important in the choice of treatment and will be explained next

WHAT NOT TO DO

- Deliver a monologue that goes into extensive technical detail
- Not involving the patient in the discussion, and not providing the ability or opportunity to ask questions or consider alternatives
- Not reassuring the patient that their opinions are equally valid

EGFR, epidermal growth factor receptor; FOLFOX, folinic acid, fluorouracil and oxaliplatin.

STEP 4:
RISKS AND UNDERSTANDING OF HOW TO MANAGE SIDE EFFECTS AND SAFETY TO PREPARE THE PATIENT FOR THE MONTHS AHEAD

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RISKS AND UNDERSTANDING OF HOW TO MANAGE SIDE EFFECTS

- Typically, side effects with 3rd-line therapies for mCRC can be effectively managed
- Close communication between the patient and physician is an important component of side effect management

mCRC, metastatic colorectal cancer.

SHARE – STEP 4
CASE STUDY: SANDRA

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- Given her 1st-line treatment was FOLFOX plus an anti-EGFR therapy and her 2nd-line treatment was bevacizumab, and because Sandra has a reasonable performance status, she is a potential candidate for either regorafenib or TAS-102.
- From the efficacy information you have already conveyed to Sandra, she is very interested in receiving the treatment that "will give her the greatest chance of increased survival" so that she has a chance to be at her daughter's graduation. Also, as she is symptomless, 3rd-line treatment may preserve the good quality of life that she has
- Sandra is anxious about side-effects, but is accepting of the fact that every patient is different and she has the support of her physician and oncology nurses to help her manage them

COMMUNICATION BEST PRACTICE

WHAT TO DO

- Openly discuss side effects and providing details regarding what the different side effects are
- Listen to the patient's concerns
- Focus on how the different side effects may be managed
- Remind the patient it is difficult to predict which side effects an individual patient may experience
- Prepare the patient for what they may expect so that they are confident and reassured to move onto 3rd-line treatment

WHAT NOT TO DO

- Brushing discussion of side effects aside
- Generalising side effects rather than mentioning them individually
- Patient has no idea what they may expect and is therefore not reassured about moving onto 3rd-line treatment
- Failing to provide context regarding side effects and how they can be managed

EGFR, epidermal growth factor receptor; FOLFOX, folinic acid, fluorouracil and oxaliplatin.

STEP 5:
EXPECTATION FOR TREATMENT SUCCESS WITH A REMINDER OF THE TREATMENT GOALS IF THE PATIENT IS ABLE TO CONTINUE WITH THE AGREED TREATMENT PLAN

SHARE – STEP 5

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EXPECTATION FOR TREATMENT SUCCESS

- The goal of 3rd-line therapy for mCRC is dependent on individual patient and disease characteristics
- The efficacy benefits of existing therapies include potential for increased survival and control of disease.
- Common side effects are likely to be effectively managed, but require close communication between the patient and physician

mCRC, metastatic colorectal cancer.

SHARE – STEP 5
CASE STUDY: SANDRA

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- From the efficacy, safety, and dosing and administration information that has been provided to Sandra, she is interested in receiving regorafenib treatment, although after the discussion on side effects, she has some continued apprehension
- At this point in your discussion, Sandra needs to be informed of what the treatment goals will be following regorafenib treatment with the aim to help her get to her daughter's graduation

COMMUNICATION BEST PRACTICE

WHAT TO DO

- End the conversation on a positive note and give the patient something to aim for
- Offer written materials for the patient to take away and consider
- Provide reassurance that the decision is being made jointly
- Return to the patient's aim that has been established at the start of the discussion
- Check to confirm patient understanding and allow the opportunity for more questions (at the time or by point of contact for after the discussion)

WHAT NOT TO DO

- Delivering pressurised decision-making
- Not ending the discussion on a positive note around what success can look like
- Not reflecting on the patient's view of what successful treatment means for them
- Not sense checking that the patient fully understands or feels appropriately involved
- Making decisions on a purely clinical basis
- Allowing the conversation to end on side effects rather than potential treatment benefit
- Not giving access to further reading or information

SUMMARY

SUMMARY

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Why is a communication framework needed?

- Shared decision-making is regarded as the best practice model for a physician-patient interaction
- Delivering the right messages to the patient at the right time can make the patient involved in their treatment decisions, facilitate honest and **positive conversations**, and engage the patient in order to provide a better chance of success

The SHARE communication framework

- A 5 step communication framework to foster shared decision-making in physician–patient interactions
- Includes a 'memory aid' – SHARE
- Reflects patient autonomy and involvement in medical decision-making, with the ultimate goal of improving outcomes
- May be delivered over a number of interactions and should always be applied as a guide and adapted depending on patient needs

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THE SHARE COMMUNICATION FRAMEWORK

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S tabilise the disease with 3rd-line treatment

H ow 3rd-line treatments may differ from previous treatment received

A dvantages and disadvantages of each treatment option

R isks and understanding of how to manage side effects

E xpectation for treatment success

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GLOSSARY

- CEA, carcinoembryonic antigen
- ECOG, Eastern Cooperative Oncology Group
- EGFR, epidermal growth factor receptor
- FOLFIRI, irinotecan, fluorouracil and folinic acid
- FOLFOX, folinic acid, fluorouracil and oxaliplatin
- mCRC, metastatic colorectal cancer
- OS, overall survival
- QoL, quality of life
- VEGFR, anti vascular endothelial growth factor receptor

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