OA16.02 SHARED DECISION MAKING (SDM) AND PATIENT DECISION AIDS (PDAS) IN LUNG CANCER: SURVEY OF PATIENTS, SIGNIFICANT OTHERS OR CAREGIVERS

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Background: Shared decision making (SDM) is a desirable goal. However, SDM is not clearly superior to another. PDAs can help present risks and benefits in a simple, visual format. Of the 600 plus validated PDAs, less than 60 deal with lung cancer.

Methods: A survey (via SurveyMonkey) was sent to lung cancer patients or their significant others/caregivers who had signed up for email communication from the Addario Lung Cancer Foundation. The survey collected information regarding demographics, categorization of the difficult decision, and sources of problems encountered during decision making. A PDA regarding prophylactic cranial irradiation (PCI) for limited small cell cancer was made available, and opinions were sought regarding the usefulness of the format. Results: 190 responses were obtained (123 patients, 67 other). This was predominantly a well-educated, white, North American population, with advanced disease, with more women than men (75% vs 25%). 115 (61%) of respondents had faced a difficult decision, women more so than men. Decisions regarding systemic therapy were the most commonly perceived difficult decision (58%) and/or tests that were done/not done (34%). Sources of difficulty were identified as insufficient information (44%), or conflicting information or recommendations from their physicians (34%). The amount of information available was categorized as insufficient, just right, too much or conflicting. 115 (61%) of respondents had faced a difficult decision, women more so than men. Decisions regarding systemic therapy were the most commonly perceived difficult decision (58%) and/or tests that were done/not done (34%). Sources of difficulty were identified as insufficient information (44%), or conflicting information or recommendations from their physicians (34%).

Conclusion: The disparities in lung cancer treatment and outcomes among minorities are well documented.1 Further, 80% of cancer patients are treated in the community hospital setting yet may not receive the same level of care as those treated at leading academic centers. The Addario Lung Cancer Foundation (ALCF) Centers of Excellence (COE) program addresses this unmet need. The COE program is a patient-centric model for lung cancer that establishes a standard of care for community hospitals which often treat minority and underserved patient populations. The COE program, which currently includes 13 hospitals in regions of high unmet need, aims to improve the standard of care, patient experience and patient outcome by offering patients and caregivers the same type of multi-disciplinary and comprehensive care provided at leading academic centers. ALCF also provides lung cancer education and services to patients, caregivers and the community. Methods: The COE program tracks patient process data longitudinally for multiple quality-of-care metrics, including disease stage at diagnosis, molecular testing; tumor board review; time from diagnosis to treatment; treatment type and clinical trial participation. Site data will also be monitored to provide a contextual picture of the program including total patients seen, demographics, insurance mix, rates and outcomes of molecular testing among other metrics. Data is analyzed across the COE community and against comparator groups to demonstrate impact of the COE program. Results: The COE program serves thousands of patients each year with a significant representation of minorities and underserved populations. Baptist Memorial Health Care System is an example of a COE that has demonstrated implementation of the COE model by providing multi-disciplinary care to a diverse population. Among those reporting race at Baptists, minorities represent more than 30% of lung cancer patients. Memorial Health Care System is another COE that is reaching and serving a diverse patient population. The patient mix at Memorial is: 64% whites; 18% Hispanics; and 18% African American. At Memorial, approximately 10% of the patient population is uninsured. Further, Memorial molecularly tests all stage III/IV patients. Compared with community hospitals in the National Cancer Database the patient mix is about 84% white, 2% Hispanic and 11% African American with 3% uninsured. Conclusion: The COE model is demonstrating that underserved lung cancer patient populations can be reached and receive standard of care treatment. The patient-focused COE approach effectively removes barriers to quality care.

Keywords: Community, multi-disciplinary