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ORAL ABSTRACT SESSIONS

SESSION OA16: IMPROVING THE QUALITY OF LUNG CANCER CARE - PATIENTS PERSPECTIVE
TUESDAY, DECEMBER 6, 2016 – 16:00-17:30

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) between the patient and their physicians is recognized as a desirable goal. When one treatment option 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 of these are designed for cancer treatment decisions, and only 10 deal with lung cancer diagnosis or treatment (www.ohri.ca/decisionaid). A survey of lung cancer patients or their significant others/caregivers collected information regarding decision making experiences, and the perceived usefulness of PDAs. **Methods:** A survey (via SurveyMonkey) was sent to lung cancer patients/caregivers/significant others who had signed up for email communication from the Bonnie Addario Lung Cancer Foundation (ALCF), Global Resource for Advancing Cancer Education (GRACE), or the University of Colorado. The survey collected information regarding demographics, categorization of the difficult problem, and the 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 this 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 difficult to know in 14%, 22%, 2%, 50%. Men were more likely to indicate that they had sufficient information, 39% vs 14%, $p < 0.05$. Most patients desired SDM, with only 9% expressing the desire to make the decision alone. However, 26% perceived that they had done so. Fortunately, only 8% of respondents expressed regret regarding their decision. Of 90 respondents who viewed the PCI PDA, 61% felt that this type of decision aid would have been helpful. There were no gender differences regarding opinions towards the PDA, the desire for SDM, or the perception that it had occurred. **Conclusion:** Lung cancer patients desire shared decision making. Improvements in this process are perceived as needed, possibly with PDAs.

Keywords: shared decision making, patient decision aids

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TUESDAY, DECEMBER 6, 2016 – 16:00-17:30

OA16.03 THE ALCF CENTERS OF EXCELLENCE MODEL DELIVERS A STANDARD OF CARE TO THE COMMUNITY SIMILAR TO ACADEMIC AND RESEARCH CENTERS

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Background: 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 Bonnie J. 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 Baptist, 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, 2.5% Hispanic and 11% African American with 3% uninsured. **Conclusion:** The ALCF COE program 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