

Ravi Salgia<sup>1</sup>; Leigh M. Boehmer<sup>2</sup>; Catherine Celestin<sup>3</sup>; Hong Yu<sup>3</sup>; David R. Spigel<sup>4</sup>

<sup>1</sup>Department of Medical Oncology and Therapeutics Research, City of Hope, Comprehensive Cancer Center and National Medical Center, Duarte, CA, USA;

<sup>2</sup>Editorial Content & Strategy, Association of Community Cancer Centers, Rockville, MD, USA; <sup>3</sup>Oncology Group, AstraZeneca, Gaithersburg, MD, USA;

<sup>4</sup>Lung Cancer Research Program, <sup>4</sup>Sarah Cannon Research Institute and Tennessee Oncology, Nashville, TN, USA

## INTRODUCTION

- Complex requirements and ever-changing guidelines for the management of stage III/IV non-small cell lung cancer (NSCLC) in a fragmented U.S. healthcare system can impede consistent access to optimal care for patients with NSCLC<sup>1</sup>
- Optimization of care coordination, screening, diagnosis, biomarker testing, staging, and treatment planning, along with refinement of the multidisciplinary team (MDT) approach, offers significant potential for improving the quality of NSCLC care and adherence to guideline-recommended protocols
- Multidisciplinary care in lung cancer is perceived as patient centric and efficient, improving timelines and access to high-quality care<sup>2</sup>
- The Association of Community Cancer Centers (ACCC) has designed a quality metric for ideal NSCLC care, which has guided the development of a national survey to improve understanding of diagnosis and management of patients with stage III/IV NSCLC across different U.S.-based practice settings and to design and execute process improvement plans to address the identified barriers

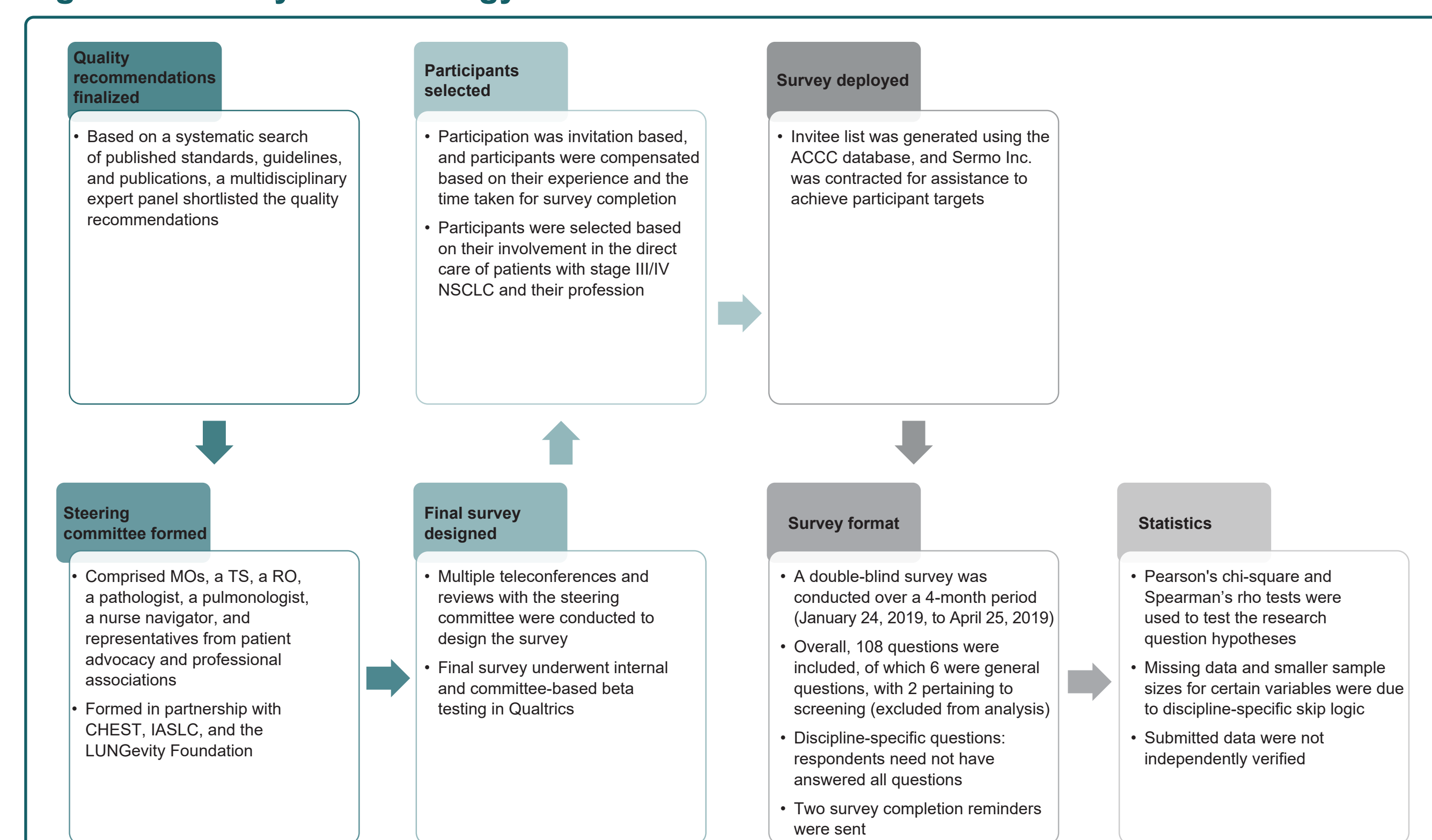
## OBJECTIVES

- Primary objectives of the survey among U.S. healthcare providers:
  - Evaluation of the understanding of evolving standards for diagnosis and management of patients with stage III/IV NSCLC
  - Adoption of guideline-recommended protocols for screening, diagnosis, and treatment
  - Investigation of coordination and communication within the multidisciplinary specialties involved in NSCLC management
  - Identification of barriers to optimal care
- The goal of the survey was to identify practice areas and patterns that would benefit from the delivery of appropriate resources and application of process improvement initiatives, thereby ensuring the highest quality of care for patients with advanced NSCLC

## METHODS

- The expert steering committee guiding the development of the survey included medical oncologists, a thoracic surgeon, a radiation oncologist, a pathologist, a pulmonologist, a nurse navigator, and representatives from patient advocacy and professional associations
- The survey was conducted over 4 months between January 24, 2019, and April 25, 2019. The methodology is detailed in **Figure 1**

**Figure 1: Survey methodology**



ACCC, Association of Community Cancer Centers; CHEST, American College of Chest Physicians; IASLC, International Association for the Study of Lung Cancer; MO, medical oncologist; NSCLC, non-small cell lung cancer; RO, radiation oncologist; TS, thoracic surgeon

## CONCLUSIONS

- This survey provides an overview of the barriers to quality care for patients with stage III/IV NSCLC, including a lack of consistent use of MDTs, optimized diagnosis using biomarker testing, and timely, complete staging of patients, in U.S. cancer programs
- Multiple opportunities exist to improve the quality and delivery of care for patients with stage III/IV NSCLC by enhancing screening, diagnosis, treatment, and care coordination for better outcomes in this patient population

## REFERENCES

1. Association of Community Cancer Centers. <https://www.accc-cancer.org/projects/nsclc-care-delivery/overview>. 2020.
2. Kedia SK, et al. *Transl Lung Cancer Res* 2015;4:456-464.

## FUNDING

This project was funded by AstraZeneca.

## DISCLOSURES

For details on author disclosures, please scan the QR code.

## ACKNOWLEDGMENTS

- The multiphase initiative, "Fostering Excellence in Care and Outcomes in Patients with Stage III and IV NSCLC," involved the following partner organizations: the American College of Chest Physicians (CHEST), the International Association for the Study of Lung Cancer (IASLC), and the LUNGevity Foundation
- The authors are grateful for the contributions of the Steering Committee and patient advocacy partners
- The authors thank all Association of Community Cancer Centers (ACCC) survey respondents at cancer programs nationwide for participating in the survey and providing valuable insights
- Data analysis services were provided by Elite Research, and medical writing support for the development of this poster was provided by Shaleen Multani, PhD, and Juliane Moloney, PhD, of Cactus Life Sciences (part of Cactus Communications), in accordance with Good Publication Practice guidelines (<https://www.ismpp.org/gpp3>)



Copies of this poster obtained through Quick Response (QR) Code are for personal use only and may not be reproduced without permission from ASCO® and the author of this poster

## RESULTS

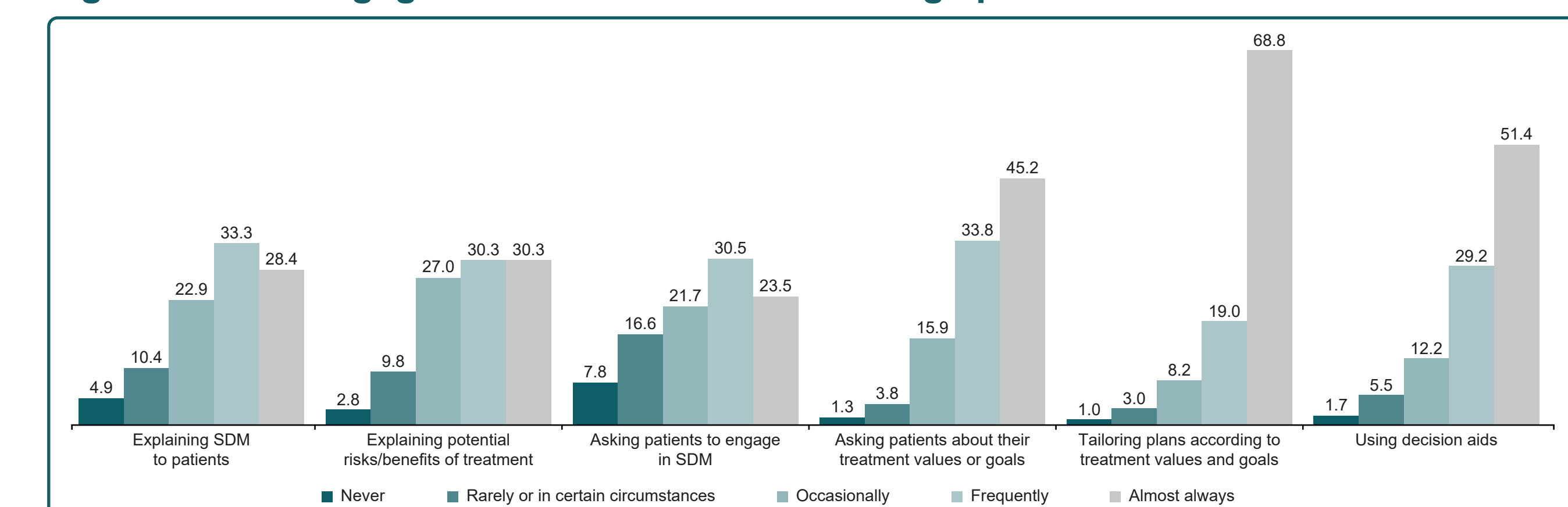
### Respondent disposition and characteristics

- Of the 1211 professionals selected, 639 respondents completed the survey, representing 160 unique cancer programs across 44 U.S. states
- The largest proportion of respondents belonged to the Community Cancer Program (CCP; 18.6%) and programs in the urban regions (57.4%) (**Supplementary Table 1**; scan QR code)
- A total of 261 (40.8%) respondents were associated with program types that did not have a thoracic multidisciplinary clinic (MDC) (**Supplementary Table 1**; scan QR code)

### Care coordination and patient education

- A high proportion of respondents indicated that they "frequently" or "almost always" engaged in shared decision-making (SDM) (**Figure 2**)
- Nurse navigators (P = 0.03) and radiation oncologists (P = 0.04) were significantly more likely to engage in SDM

**Figure 2: SDM engagement across NSCLC-treating specialties\***



\*All values are in percentages  
NSCLC, non-small cell lung cancer; SDM, shared decision-making

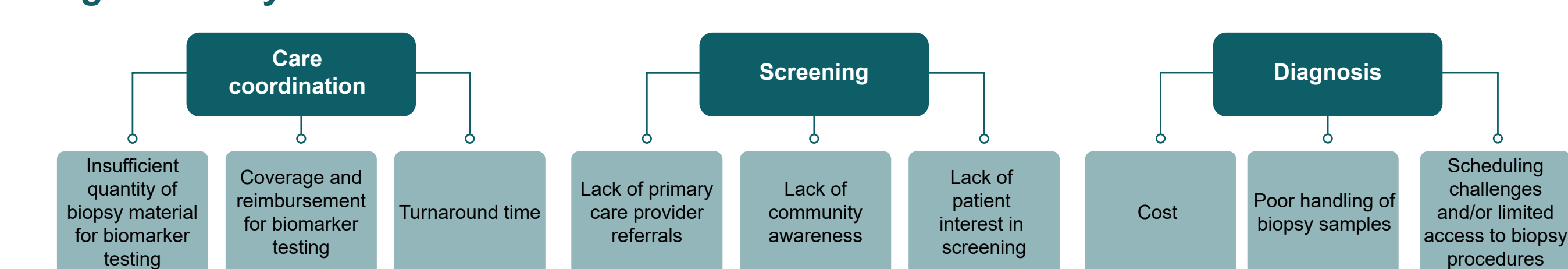
### Screening, diagnosis and biomarker testing, and treatment planning

- Average length of time ± standard deviation required from initial abnormal chest imaging to complete disease staging and to initiation of treatment was 3.13 ± 1.76 weeks and 4.02 ± 1.76 weeks, respectively
  - Approximately 19% of respondents were associated with program types that did not offer lung cancer screening
    - A significantly larger proportion of respondents from Comprehensive CCPs indicated that patients were screened than not screened using low-dose computed tomography (17.6% vs 8.1%; P < 0.001), whereas a significantly larger proportion of respondents from Free-Standing Cancer Center Programs indicated that patients were not screened than screened (13.0% vs 4.5%; P < 0.001) using low-dose computed tomography
    - Overall, 18.4% and 35.2% of respondents were "not" to "somewhat" familiar with the American Joint Committee on Cancer (AJCC) 8th edition Tumor, Node, Metastasis (TNM) staging and the updated molecular testing guidelines for lung cancer, respectively (**Supplementary Figure 1**; scan QR code)
    - Approximately 42% of respondents indicated that their programs did not have an existing standard protocol for biomarker testing
    - Approximately 82% of respondents indicated that tumor board (TB) meetings occurred more than once a month; the frequency of TB meetings negatively correlated with disease staging time (P = 0.03)

### Key barriers to delivering quality NSCLC care

- The survey identified several areas for improvement in enhancing quality of care for patients with NSCLC (**Figure 3**)

**Figure 3: Key barriers in NSCLC care**



NSCLC, non-small cell lung cancer