FOSTERING EXCELLENCE IN CARE AND OUTCOMES IN PATIENTS WITH STAGE III/IV NSCLC

Quality Improvement Key Takeaways

The Association of Community Cancer Centers (ACCC) conducted a national multi-phase effort in 2019 to explore coordination and communication within the multidisciplinary cancer care team to help understand existing barriers and create and execute process improvement plans to support the optimization of care for patients diagnosed with stages III and IV NSCLC.

Six cancer programs—from a variety of settings and locations across the U.S.—were selected by a multidisciplinary Steering Committee to participate in a six-month process improvement initiative. Based on the quality improvement work done across the six participating programs, the following key takeaways may assist other cancer programs as they seek to improve care of this patient population.

Biomarker Testing

- There remain numerous ongoing opportunities to increase testing rates in patients with advanced NSCLC. To identify the root causes that contribute to suboptimal testing, begin by mapping the process and reviewing how tissue and blood testing is ordered, tracked, and reported.
- When tissue samples are insufficient for testing, utilize liquid biopsy (circulating tumor DNA) testing. Some testing labs may have the ability to reflex to blood-based testing if the tissue sample is not sufficient. Discuss the role of liquid biopsy and aim to achieve consensus within the cancer program around which lab(s) will perform the testing.
- There may be opportunities to reduce delays in testing. The optimal approach may be to order biomarker testing at the time of diagnosis. To make this work, the pathologist would need to know that the patient has advanced stage disease. Since some pathology groups may not have easy access to this clinical information, identify ways to proactively provide this to the pathologist at the time of biopsy.

Patient Safety

- As more patients receive immune checkpoint inhibitor therapy, they may be at risk for developing immune-related adverse reactions (iRAEs). Some reactions may be serious and some may occur after treatment ends. Coordinate around the identification and management of iRAEs should occur with emergency departments (ED) and primary care providers. Train and educate these clinicians to identify symptoms and communicate with the cancer team. Incorporate the use of immuno-oncology wallet cards and electronic alerts to ensure that the cancer team is notified when patients visit the ED.
- The collection of patient-reported outcome (PRO) data may help clinicians detect early signs of iRAEs and intervene with clinical interventions. PRO data may be proactively collected via a nurse-administrated survey, mobile app, etc. Assess patients for their level of health literacy and their familiarity with technology to identify the optimal way to collect data.

Care Coordination

- Some patients with advanced NSCLC may be at greater risk for repeat emergency department visits due to multiple comorbidities, limited social support, etc. Some of those visits may be unnecessary or preventable. By working with the hospital IT department, the cancer program may be able to receive a monthly report of all cancer patients who visit the ED. A quality study may reveal insights about patient risk factors and other reasons why some patients may utilize emergency department services unnecessarily.
- Differences in referral patterns to palliative care may be observed across a group of medical oncologists who treat patients with advanced NSCLC. To reduce variation and increase referrals, a streamlined electronic referral process combined with monthly audit/feedback may lead to sustainable improvements.
- To facilitate smoking cessation referrals, explore local partnerships and develop a streamlined referral process. Consider if staff should receiver further training in tobacco treatment through programs like the Memorial Sloan Kettering Tobacco Treatment Specialist Training Program.

Clinical Research

- While most community cancer programs may not conduct phase 1 clinical trials, there may be opportunities to partner with an academic center so that appropriate patients are referred. One effective model is SCOPE (Sacramento Citywide Oncology PhasE I program) led by UC Davis. A research coordinator can review all open studies and present this information to community oncologists at regular intervals.

Watch videos from the program leads and learn more about their work in process improvement for this patient population at accc-cancer.org/NSCLC-QI.

Association of Community Cancer Centers