

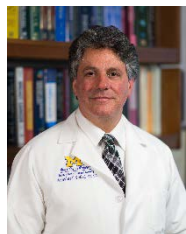
ASCO® Quality Care Symposium

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2018 Symposium Highlights Notable Research Advances in Quality of Care

Expert Perspective



“To improve the quality of care that patients with cancer receive, it’s critical to evaluate which approaches are working and how to make them better,” said Michael S. Sabel, MD, FACS, ASCO expert and member of the Quality Care Symposium News Planning Team. “The studies presented at ASCO’s Quality Care Symposium analyze a range of issues related to the nation’s cancer care delivery system, from value-based payment models, to uptake of breast cancer treatment guidelines, to integrating mental health professionals into cancer care teams.”

PHOENIX – Eight noteworthy studies exploring key research related to improving cancer care quality will be presented at the 2018 Quality Care Symposium, taking place September 28-29, at the JW Marriott Phoenix Desert Ridge in Phoenix, Arizona. These abstracts examine different approaches to improving the quality of treatment and care for patients with a variety of cancers.

Experts in quality of care are available to comment on the studies below.

Abstract 30:

[Practice transformation: Early impact of OCM on hospital admissions](#)

Oral Abstract Session A
Friday, September 28, 2018

Time: 10:00–11:30 a.m.

Location: Grand Saguaro Ballroom, Salon South, Level 1

Presentation Time: 10:35-10:45 a.m.

Molly Mendenhall, BSN, RN
Oncology Hematology Care
Cincinnati, Ohio

Abstract 31:

[The Washington State Community Cancer Care Report: A multi-stakeholder effort to characterize quality of care and costs for Washington State oncology practices](#)

Oral Abstract Session B
Saturday, September 29, 2018

Time: 10:00–11:30 a.m.

Location: Grand Saguaro Ballroom, Salon South, Level 1

Presentation Time: 10:00–10:10 a.m.

Scott David Ramsey, MD, PhD
Fred Hutchinson Cancer Research Center
Seattle, Washington

Abstract 51:

[Patterns in breast cancer staging imaging: Are we choosing wisely?](#)

Poster Session A
Friday, September 28, 2018
Time: 11:30 a.m.–1:00 p.m. & 5:15–6:15 p.m.
Location: Grand Canyon Ballroom, Salon

Brett Barlow
University of Alabama at Birmingham
Birmingham, Alabama

Abstract 52:

[Utility and factors associated with imaging early-stage breast cancer: Are we choosing wisely?](#)

Poster Session A
Friday, September 28, 2018
Time: 11:30 a.m.–1:00 p.m. & 5:15–6:15 p.m.
Location: Grand Canyon Ballroom, Salon 7

Ana I. Velazquez Manana, MD, MS
Mount Sinai Beth Israel Foundation
New York, New York

Abstract 75:

[Comparing quality of care for Medicaid and commercially insured patients with cancer in Washington State](#)

Poster Session A
Friday, September 28, 2018
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Catherine R. Fedorenko
Fred Hutchinson Cancer Research Center
Seattle, Washington

Abstract 83:

[Integrating mental health professionals into the care team to better recognize and manage delirium in hospitalized oncology patients](#)

Poster Session A
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Time: 11:30 a.m.–1:00 p.m. & 5:15–6:15 p.m.
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Joseph Hooley, MBA
Cleveland Clinic
Cleveland, Ohio

Abstract 142:

[Introducing enhanced navigation and supportive care into the curative treatment of cancer \(SCOOP pathway\)](#)

Poster Session A
Friday, September 28, 2018
Time: 11:30 a.m.–1:00 p.m. & 5:15–6:15 p.m.
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Christopher Koprowski, MD, MBA
Helen F. Graham Cancer Center & Research
Institute Christiana Care Health System
Newark, Delaware

Abstract 159:

[Choice of radioactive iodine treatment for thyroid cancer: Results from a population-based survey](#)

Rapid Abstract Session B
Saturday, September 29, 2018
Time: 2:00–3:00 p.m.
Location: Grand Saguaro Ballroom, Salon South, Level 1
Presentation Time: 2:00–2:05 p.m.

Lauren P. Wallner, PhD, MPH
University of Michigan
Ann Arbor, Michigan

2018 Quality Care Symposium News Planning Team:

- Timothy D. Gilligan, MD, MSc, FASCO (Chair)
- William Dale, MD, PhD
- Michael S. Sabel, MD, FACS

View the [disclosures](#) for the News Planning Team.

ATTRIBUTION TO THE 2018 QUALITY CARE SYMPOSIUM IS REQUESTED IN ALL NEWS COVERAGE.

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About the American Society of Clinical Oncology:

Founded in 1964, the American Society of Clinical Oncology, Inc. (ASCO®) is committed to making a world of difference in cancer care. As the world's leading organization of its kind, ASCO represents nearly 45,000 oncology professionals who care for people living with cancer. Through research, education, and promotion of the highest-quality patient care, ASCO works to conquer cancer and create a world where cancer is prevented or cured, and every survivor is healthy. ASCO is supported by its affiliate organization, the Conquer Cancer Foundation. Learn more at www.ASCO.org, explore patient education resources at www.Cancer.Net, and follow us on [Facebook](#), [Twitter](#), [LinkedIn](#), and [YouTube](#).

Oral Abstract Session A
Friday, September 28, 2018
Time: 10:00–11:30 a.m.
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Presentation Time: 10:35-10:45 a.m.

Molly Mendenhall, BSN, RN
Oncology Hematology Care
Cincinnati, Ohio

Abstract 30: Practice transformation: Early impact of OCM on hospital admissions

Authors: Molly Mendenhall, Brian Bourbeau, Karyn M. Dyehouse, Andrew S Guinigundo, Teresa Meyer-Smith, David Michael Waterhouse; Oncology Hematology Care, Cincinnati, OH; OHC Hem Onc Care, Cincinnati, OH; Oncology Hematology Care, Inc., Cincinnati, OH

Background: The purpose of the Oncology Care Model is to improve quality and reduce cost through practice transformation. A foundational tenant is to reduce avoidable ER visits and hospitalizations. In anticipation of being an OCM participant, we instituted a multidimensional campaign designed to meet these objectives. **Methods:** Prior Actions:

- Established phone triage unit.
- After-hours and weekend call.
- Instituted weekend urgent care.

Year One:

- Improved education provided by nurse navigators and APPs prior to start of treatment (OCM Treatment Planning visit).
- Implemented triage pathways: 38 symptom and 27 follow-up pathways (modified COME HOME, Barbara McAneny, M.D.).
- Proactive symptoms follow-up calls to help circumvent emergent admissions.
- Increased APP staffing to provide blocked time slots for same day patient visits w/o schedule disruptions.
- Initiated “Call Us Early – Call Us First” campaign. Incorporated verbal and/or written instructions at all patient touch points, emphasizing patient’s responsibility to call before going to the emergency room.

Results: Based on data from the Chronic Condition Warehouse, as provided by CMS, we were successful at reducing the acute care admissions rate by 16 percent.

	Baseline Jan '16 – Mar '16	Year One Jul '16 – Jun '17	Year One Benchmark (Risk Cohort)
Patients per Quarter	1,722	1,600	-
Mean Patient Risk Score	2.999	3.000	>2.724
Admissions per 100 Patients, per Quarter	27.0	22.6	25.9
Cost per Admission Event	11,122	11,106	-
Inpatient Cost per Patient, per Quarter	3,003	2,505	-

Conclusions: By implementing a cost efficient, reproducible, and scalable campaign targeting ER avoidance and hospitalizations, we were able to decrease hospital admissions. Reported Medicare savings amounted to nearly \$798,000 in inpatient cost per quarter over 1,600 patients.

Disclosures: Brian Bourbeau, MBA: speaker’s bureau for Janssen Oncology; Karyn M. Dyehouse, MD: leadership with Oncology Hematology Care/US Oncology, stock and other ownership interests with Oncology Hematology Care/US Oncology, honoraria from Pfizer, research funding from Genentech; Andrew S Guinigundo, MSN, RN, CNP, ANP-BC: leadership with Oncology Hematology Care/US Oncology, consulting or advisory role with Amgen and Pharmacyclics, speakers bureau from Amgen, Celgene, Genentech, Merck, and Pfizer; David Michael Waterhouse, MD, MPH: consulting

or advisory role with Abbvie, Amgen, AZTherapies, Bristol-Myers Squibb, speakers bureau for Bristol-Myers Squibb, Celgene, Genentech/Roche, Lilly

Research Funding Source: No funding source disclosed

Oral Abstract Session B
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Scott David Ramsey, MD, PhD
 Fred Hutchinson Cancer Research Center
 Seattle, Washington

Abstract 31: The Washington State Community Cancer Care Report: A multi-stakeholder effort to characterize quality of care and costs for Washington State oncology practice

Authors: Scott David Ramsey, Karma L. Kreizenbeck, Laura Elizabeth Panattoni, Catherine R. Fedorenko, Li Li, Qin Sun, Sarah Barger, Gary H. Lyman; Fred Hutchinson Cancer Research Center, Seattle, WA

Background: Although many quality measures exist in oncology, there have been few efforts to prioritize, measure, and report quality and costs for an entire region. Here, we report the results of a multi-year, multi-stakeholder effort aimed at public reporting of nationally recognized quality metrics for oncology practices in Washington State. **Methods:** Quality metrics were selected from nationally-recognized measures through a structured process involving oncology providers, health insurance leaders, patient advocates, and policy experts. Cancer registry records from 2014 to 2016 were linked with claims data from two commercial insurers and Medicare, representing approximately 70% of cancer patients in the state. Patients were assigned to oncology clinics using claims data; 27 clinics were large enough for inclusion in at least one measure in the report. Thirteen metrics were combined to produce one clinic-level quality score per measure. Each quality score was mapped to total episode cost per patient. Results were adjusted to account for clinic size, cancer characteristics (e.g. stage), demographics, and comorbidity where appropriate. **Results:**

Measure	Clinic-Level Ranges		Relationship between Quality and Cost
	Summary Quality Score*	Average Episode Cost	
Recommended Treatment	Breast, Lung, Colorectal	-5.4% to 1.7% \$62,292 to \$83,935	None
	Breast only	-6.4% to 1.8% \$63,132 to \$98,942	None
Hospitalizations during Chemo		-14.6% to 8.0% \$42,758 to \$61,848	Lower cost was related to higher quality
Advanced Imaging after Treatment	Breast, Lung, Colon	-1.0% to 0.7% \$16,130 to \$19,489	None
Advanced Imaging and Tumor Markers after Treatment	Breast only	-21.2% to 20.9% \$11,592 to \$15,811	Lower cost was related to higher quality
End of Life Care		-30.4% to 31.4% \$12,259 to \$17,091	Lower cost was related to higher quality

* Zero represents the regional average **Conclusions:** The Community Cancer Care in Washington State: Quality and Cost Report 2018 is the first publicly accessible report showing clinic-level quality measures linked to cost in oncology. Its ultimate goal is to improve care and lower costs by spurring collaboration, research and innovation.

Disclosures: Scott David Ramsey, MD, PhD: consulting or advisory role with Bayer, Bristol-Myers Squibb, Genentech, Kite Pharma, and Seattle Genetics; travel, accommodation, expenses from Bayer Schering Pharma, Bristol-Myers Squibb, Flatiron Health; institution research funding from Bayer and Bristol-Myers Squibb; Gary H. Lyman, MD, MPH, FASCO, FRCP: consulting or advisory role with Coherus Biosciences, G1 Therapeutics, and Halozyme; leadership with GenereX Biotechnology; research funding from Amgen

Research Funding Source: No funding source disclosed

Poster Session A
Friday, September 28, 2018
Time: 11:30 a.m.–1:00 p.m. & 5:15–6:15 p.m.
Location: Grand Canyon Ballroom, Salon

Brett Barlow
University of Alabama at Birmingham
Birmingham, Alabama

Abstract 51: Patterns in breast cancer staging imaging: Are we choosing wisely?

Authors: Brett Barlow, Courtney Williams, Aidan Gilbert, Stacey M Watkins, Gabrielle Betty Rocque; University of Alabama at Birmingham, Birmingham, AL; UAB, Birmingham, AL; UAB School of Medicine, Birmingham, AL

Background: The American Society of Clinical Oncology's Choosing Wisely guidelines recommend no staging imaging in early stage breast cancer (ESBC) patients with low risk of metastasis, as it is potentially harmful and provides no survival benefit. This study evaluates local adherence to this recommendation and identifies factors contributing to unnecessary staging imaging. **Methods:** This retrospective cohort study included patients with AJCC stage 0-II BC diagnosed from 2013-2015 at a single-site, academic medical center. Data was abstracted from chart review. Imaging included computed tomography, positron emission tomography, or bone scans. Imaging for documented symptoms was considered appropriate. Abstracted patient data included demographics, medical oncologist, and clinical characteristics. To evaluate factors influencing inappropriate screening imaging, risk ratios (RR) and corresponding 95% confidence intervals (CI) were estimated using generalized linear models with a log link and Poisson distribution with robust variance estimates. **Results:** Of the 872 ESBC patients, 262 (30%) underwent staging imaging. Median diagnosis age of patients receiving imaging was 55 (IQR 48-63) compared to 60 (IQR 52-68) for patients with no or appropriate imaging. Risk of inappropriate screening imaging was increased for patients who were younger (RR 0.98, 95% CI 0.97-0.98), had triple negative disease vs any hormone receptor positive (RR 2.98, 95% CI 2.25-3.95), had higher stage BC (I vs. 0, RR 3.58, 95% CI 2.05-6.25; II vs. 0, RR 10.86, 95% CI 6.43-18.33), and did not have Medicare insurance (RR 1.52, 95% CI 1.22-1.89). Rates of imaging did not vary by race (non-white vs. white: RR 0.98, 95% CI 0.78-1.23). For medical oncologists with at least 15 patients, prevalence of inappropriate imaging varied from 26-68%. **Conclusions:** A substantial proportion of ESBC patients received unnecessary and potentially harmful staging imaging inconsistent with guidelines. Staging imaging was associated with patient demographic and clinical characteristics related to increased recurrence risk, suggesting a need for further physician education about the low-risk nature of this ESBC population to ensure high value oncologic care.

Disclosures: Gabrielle Betty Rocque, MD: consulting or advisory role with Genentech/Roche and Pfizer; travel, accommodation, and expenses from Genentech and Pfizer; research funding from Carevive Systems, Genentech, Medscape, Pack Health, and Pfizer

Research Funding Source: No funding source disclosed

Poster Session A
Friday, September 28, 2018
Time: 11:30 a.m.–1:00 p.m. & 5:15–6:15 p.m.
Location: Grand Canyon Ballroom, Salon 7

Ana I. Velazquez Manana, MD, MS
Mount Sinai Beth Israel Foundation
New York, New York

Abstract 52: Utility and factors associated with imaging early-stage breast cancer: Are we choosing wisely?

Authors: Ana I. Velazquez Manana, Nina Nguyen, Carlos Rodriguez Bonilla, Theresa Shao; Mount Sinai Beth Israel, New York, NY; Mount Sinai Beth Israel Medical Center, New York, NY

Background: Breast cancer (BC) is the most common malignancy in women with estimated care costs of \$20.50 billion/year by 2020. In 2012, ASCO released the Choosing Wisely Initiative which recommended against the use of routine imaging in patients with newly diagnosed early stage BC. We examined the adherence rate and factors associated with non-adherence in patients with early stage BC treated within a large health care system. **Methods:** We identified all women with stage I-II BC diagnosed between January 1, 2014 and December 31, 2015 from the Cancer Registry of Mount Sinai Health System. Demographic, clinical and treatment related factors were collected. Medical records were reviewed to identify patients who had routine staging scan. Data of initial and follow-up imaging over 1-year period were collected. Odds ratios (ORs) and 95% confidence intervals (CIs) were estimated from logistic regression models. **Results:** Among 733 BC patients, the median age at diagnosis was 58 (range 26-98). One hundred thirty nine patients (19%) had routine imaging with a mean number of initial scans of 1.53 and 59 (42%) patients had at least 1 subsequent scan in the 1-year follow up (range 1-4 scans/year). PET/CT was the most frequent modality, followed by CT. Medical oncologist was the ordering provider in 52% of the cases and surgical oncologist in 44.6%. Routine scan identified no cases of metastatic disease. False-positive findings were identified in 43% and incidental findings in 8% of cases. Total cost of imaging in this group was \$4480/patient. Young age (< 50), TN disease, tumor size > 2cm and positive lymph node were associated with increased staging scan on univariate and multivariate analysis. **Conclusions:** Our study highlights the prevalence of unnecessary scan in up to 19% of patients with stage I-II BC. Routine imaging resulted in increased radiation exposure and additional cost of \$4480/patient. The presence of T2 tumor, positive lymph node, TN disease and young age were associated with increased staging scan. Further educational efforts are needed to avoid unnecessary scans in patients with early stage BC.

	OR	95% CI	<i>p</i>
Age < 50	1.69	1.06-2.67	0.026
T2	2.42	1.55-3.77	0.0001
TN	3.64	2.09-6.29	< 0.0001
Positive lymph nodes	5.24	3.31-8.33	< 0.0001

Disclosures: No relationships to disclose

Research Funding Source: Funding from Medical Student Rotation for Underrepresented Populations (MSR), 2013

Poster Session A
 Friday, September 28, 2018
Time: 11:30 a.m.–1:00 p.m. & 5:15–6:15 p.m.
Location: Grand Canyon Ballroom, Salon 7

Catherine R. Fedorenko
 Fred Hutchinson Cancer Research Center
 Seattle, Washington

Abstract 75: Comparing quality of care for Medicaid and commercially insured patients with cancer in Washington State

Authors: Catherine R. Fedorenko, Laura Elizabeth Panattoni, Julia Rose Walker, Li Li, Karma L. Kreizenbeck, Scott David Ramsey; Fred Hutchinson Cancer Research Center, Seattle, WA

Background: Uniformity in receipt of high quality cancer care is imperative to reduce health care disparities. In order to help prioritize efforts aimed at reducing disparities in care, we compared several quality metrics for Washington State cancer patients enrolled in Medicaid and commercial insurance plans. **Methods:** We linked 2014-2016 Washington state cancer registry records for cancer patients under the age of 65 with enrollment and claims records for the two largest commercial insurers in the state and Medicaid. We then generated thirteen nationally recognized quality measures. Outcome measures were adjusted for age, sex, comorbidity score, stage, cancer site, and treatment factors where appropriate. Process measures were not adjusted. **Results:** 6,868 commercially insured and 2,379 Medicaid patients are represented in the reported quality measures.

Measure	Tumor Site	Commercial	Medicaid	p-value
Recommended treatment	Breast, lung, colorectal	92%	89%	
	Breast	93%	90%	
Anti-nausea meds during chemotherapy	Breast, lung, colorectal	98%	99%	
	Breast	98%	99%	
Emergency department visits during chemotherapy*	All except leukemia	21%	43%	p < 0.001
Inpatient stays during chemotherapy*	All except leukemia	27%	34%	
Advanced imaging after treatment	Breast, lung, colon	14%	17%	
	Breast	15%	25%	p = 0.04
Tumor marking testing after treatment	Breast	30%	24%	
End of Life (EoL): Chemotherapy	Solid	10%	9%	
EoL: 2+ ED visits*	Solid	16%	21%	
EoL: ICU stay*	Solid	26%	22%	p = 0.04
EoL: Hospice	Solid	38%	43%	p = 0.04

* Outcome measure

Conclusions: Care of Washington state cancer patients enrolled in Medicaid is comparable or superior to commercially insured patients, except for significantly higher ED use during chemotherapy. Further research is needed to understand why Medicaid-enrolled cancer patients utilize the ED at more than double the rate of commercially insured patients.

Disclosures: Scott David Ramsey, MD, PhD: consulting or advisory role with Bayer, Bristol-Myers Squibb, Genentech, Kite Pharma, and Seattle Genetics; travel, accommodation, expenses from Bayer Schering Pharma, Bristol-Myers Squibb, Flatiron Health; institution research funding from Bayer and Bristol-Myers Squibb; Gary H. Lyman, MD, MPH, FASCO,

FRCP: consulting or advisory role with Coherus Biosciences, G1 Therapeutics, and Halozyme; leadership with GenereX Biotechnology; research funding from Amgen

Research Funding Source: No funding source disclosed

Poster Session A
Friday, September 28, 2018
Time: 11:30 a.m.–1:00 p.m. & 5:15–6:15 p.m.
Location: Grand Canyon Ballroom, Salon 7

Joseph Hooley, MBA
Cleveland Clinic
Cleveland, Ohio

Abstract 83: Integrating mental health professionals into the care team to better recognize and manage delirium in hospitalized oncology patients.

Authors: Joseph Hooley, Laurel Ralston, Joel Daniel Marcus, Carolyn Best, Diana Karius, Heather Koniarczyk, Corrine Shepherd, Cheryl M Carrino, Christa Poole; Cleveland Clinic, Cleveland, OH; Cleveland Clinic Foundation, Cleveland, OH; Cancer Thrpy and Rsrch Ctr UTHSCSA, San Antonio, TX; Taussig Cancer Institute, Cleveland Clinic, Cleveland, OH

Background: Delirium is a common neuropsychiatric condition associated with increased morbidity and mortality, length of hospitalization, and distress. The prevalence of delirium in cancer ranges from 10% to 30% in hospitalized patients and up to 85% in terminally ill cancer patients. Rates of delirium on Cleveland Clinic’s inpatient oncology units were lower than expected. Our goal was to integrate mental health professionals into the care team to assist with better recognition and management of delirium. **Methods:** Education was developed for a range of caregivers, including physicians, nurses, and advanced practice providers. It was facilitated by a psychiatrist, psychologist, and clinical social workers, and included proper identification of both hyper- and hypoactive delirium through use of the Brief Confusion Assessment Method (bCAM) and use of a delirium order set to treat and manage patients identified as positive for delirium. An important component of this education included a proper assessment and comparison of patients’ current mental status compared to their true baseline prior to hospitalization. Additional integration directly into the care team included participation of the psychiatrist, psychologist, and clinical social workers into each team’s multidisciplinary rounds to facilitate discussions around delirium and its appropriate management, and separate targeted rounding which included one-to-one education with front-line caregivers. **Results:** During the first year of integration, substantial improvements were noted. The percentage of patients identified as positive for delirium through bCAM screening increased from 3.4% to 15.8% after 12 months, and utilization of the delirium order set increased from 11.1% to 58.3%. Additionally, the average nursing unit length of stay (LOS) for delirium-positive patients decreased by more than 2 days compared to baseline. **Conclusions:** Integration of mental health providers into the care team to assist with recognizing and managing patients with delirium and to provide direct education to front-line caregivers has helped to rapidly improve delirium identification and management for oncology inpatients.

Disclosures: No relationships to disclose

Research Funding Source: No funding source disclosed

Poster Session A
Friday, September 28, 2018
Time: 11:30 a.m.–1:00 p.m. & 5:15–6:15 p.m.
Location: Grand Canyon Ballroom, Salon 7

Christopher Koprowski, MD, MBA
Helen F. Graham Cancer Center & Research
Institute Christiana Care Health System
Newark, Delaware

Abstract 142: Introducing enhanced navigation and supportive care into the curative treatment of cancer (SCOOP pathway)

Authors: Christopher Koprowski, Ej Johnson, Kenneth Trzepakowski, Karen Sites, Nicholas J. Petrelli; Helen F. Graham Cancer Center & Research Institute Christiana Care Health System, Newark, DE; Christiana Care Health System, Newark, DE; NSABP/NRG Oncology, and Helen F. Graham Cancer Center and Research Institute at Christiana Care, Newark, DE

Background: We hypothesized that introducing supportive care management and enhanced electronic aids to nurse navigation in selective curative cases could result in cost savings and enhanced patient experience of the sort demonstrated in patients with advanced disease. **Methods:** To test this hypothesis, we introduced a clinical pathway in November 2016 called the Supportive Care of Oncology Patients (SCOOP) program. We limited the scope to patients receiving radiation and chemotherapy concurrently at the Helen F. Graham Cancer Center and diagnosed with potentially curable thoracic, colorectal or head and neck malignancies and seen in our multidisciplinary clinics (MDCs). 1. A nurse navigation checklist was developed for nurse navigators in the Aerial information system to support standardization of care. The navigator has to opt out of ancillary service consults such as nutrition, behavioral health and social work. The check list includes other mandatory tasks that must be completed at various time points before, during and after the patient's concurrent treatment. Examples include: Prescribed communication dates with the patient; capturing of scheduled consults; assessing additional/unmet needs before, during and after treatment phase. 2. A mandatory supportive and palliative care service screening during the MDC visit, and, if indicated, urgent or timely consultation. 3. Flags in the inpatient information system that alert in real time the supportive care service, the navigators and the oncologists whenever a patient is seen in the emergency room, admitted or discharged. **Results:** During the first year, nurse navigation compliance increased from 94% to 99%. ED visits declined from 54% to 32% of SCOOP patients, admissions from 34% to 25% and readmissions from 32% to 20%. Opportunity cost savings were \$1500.00 per patient. **Conclusions:** Much like the results observed in advanced disease, the early introduction of enhanced nurse navigation and palliative/supportive care in high acuity patients treated curatively improves the patient experience and reduces societal costs.

Disclosures: No relationships to disclose

Research Funding Source: No funding source disclosed

Rapid Abstract Session B
Saturday, September 29, 2018
Time: 2:00–3:00 p.m.
Location: Grand Saguaro Ballroom, Salon South, Level 1
Presentation Time: 2–2:05 p.m.

Lauren P. Wallner, PhD, MPH
University of Michigan
Ann Arbor, Michigan

Abstract 159: Choice of radioactive iodine treatment for thyroid cancer: Results from a population-based survey

Authors: Lauren P. Wallner, David Reyes-Gastelum, Ann S Hamilton, Kevin C. Ward, Sarah T. Hawley, Megan Rist Haymart; University of Michigan, Ann Arbor, MI; University of Southern California, Los Angeles, CA; Emory University, Atlanta, GA; Univ of Michigan Health Syst, Ann Arbor, MI

Background: For many patients with differentiated thyroid cancer, use of radioactive iodine (RAI) does not improve survival or reduce recurrence risks. Yet, most patients continue to receive RAI suggesting the need for a better understanding of patient perspectives regarding RAI decision making. **Methods:** All eligible sequentially diagnosed patients with thyroid cancer in 2014-15 from the Georgia and Los Angeles SEER registries were surveyed (N = 2097, current response rate: 63%). Patients with intermediate risk thyroid cancer where selective RAI use is recommended were included in this analysis (N = 1357). Patients were asked whether or not they felt they had a choice to receive RAI (yes/no), how strongly their physician recommended initial RAI treatment (5 point Likert responses: Strongly against RAI-Strongly recommended RAI), whether they received RAI (yes/no), how satisfied they were with their RAI decision (5-pt Likert-type scale), categorized as more (score ≥ 4) vs. less satisfied. Multivariable logistic regression was used to assess 1) association between patient characteristics and perception of no RAI choice, 2) perception of no RAI choice with receipt of RAI and 3) perception of no RAI choice with decision satisfaction. **Results:** In this sample, over half (57%) of the respondents perceived they did not have a RAI choice, and the majority of them (76%) received RAI. The odds of perceiving no RAI choice was greater among Hispanic and Asian patients (Hispanic OR: 1.4, 95%CI: 1.0, 1.9, Asian OR: 1.9, 95%CI: 1.2, 2.9), and those whose physician strongly recommended RAI (OR: 1.9, 95%CI: 1.4, 2.6). Patients who perceived they did not have a RAI choice were more likely to receive RAI (Adjusted OR: 3.2, 95%CI: 2.1, 4.9) and report lower decision satisfaction (Adjusted OR: 2.7, 95%CI: 1.9, 3.7). **Conclusions:** Many patients in whom selective RAI use is recommended, particularly those of more vulnerable groups, did not feel they had a choice about whether or not to receive RAI. Patients who perceived they did not have a RAI choice were more likely to receive RAI and report lower decision satisfaction, suggesting a need for more shared treatment decision making to reduce overtreatment.

Disclosures: No relationships to disclose

Research Funding Source: No funding source disclosed