

**Alliance of Dedicated Cancer Centers (ADCC)
Lung Cancer Care Foundations (LCCF)
Public Comment Request**

The Alliance of Dedicated Cancer Centers (ADCC) represents freestanding, academic cancer hospitals throughout the US: City of Hope Cancer Center (Duarte, CA), Dana-Farber Cancer Institute (Boston, MA), Fox Chase Cancer Center (Philadelphia, PA), Fred Hutch Cancer Center (Seattle, WA), The James Comprehensive Cancer Center (Columbus, OH), Moffitt Cancer Center (Tampa, FL), The University of Texas MD Anderson Cancer Center (Houston, TX), Memorial Sloan Kettering Cancer Center (New York, NY), Roswell Park Cancer Institute (Buffalo, NY), USC Norris Comprehensive Cancer Center (Los Angeles, CA).

In support of our strategic efforts to enhance the quality of cancer care, the ADCC is exploring development of a learning health network (LHN) focused on lung cancer. As a meaningful first step, we convened thoracic oncology experts from across our 10 member centers in a structured consensus process to create the Lung Cancer Care Foundations (LCCF).

The LCCF are services and resources necessary for evaluation and treatment of every patient with a new diagnosis of non-small cell lung cancer, regardless of where they receive care. Our guiding principle is that cancer providers need to have the essential, foundational components in place – or be actively working to address any gaps – to foster and support a learning health network geared at providing high-quality, high-reliability lung cancer care.

The full LCCF methods will be described in a forthcoming manuscript. Briefly, we used a modified Delphi process, including structured ratings conducted by experts; scoring of those ratings using a priori methods and thresholds; virtual expert meetings to discuss areas of uncertainty or disagreement, and create consensus definitions; and iterative edits.

The final step in the LCCF development process is seeking patient and public review and input on the Foundational components, which are documented in Table 1 on the following pages. Patient/public comments will be used to add to or adjust the final LCCF list. A summary of comments received will be included in LCCF publications.

Public comment will be open until August 7, 2023. Please send comments via email to jack.kolosky@adcc.org.

Table 1. ADCC Lung Cancer Care Foundations (LCCF) <i>Public Comment Version; Current as of June 15, 2023</i>		
	Component	Details
1	Timeliness of care	Ability to measure key points in the diagnostic and therapeutic course.
		To enable monitoring of timeliness of care, sites can track time points including: date of diagnosis, date of first visit, date of completion of molecular/biomarker/cell free DNA testing; date of definitive treatment initiation (for applicable modalities).
2	Timely initiation of therapy	Reliable and timely access to testing, imaging/procedures, and initiation of definitive treatment.
		Sites have coordinated medical evaluation and support services that result in initiation of therapy within an appropriate time frame from the date of recognition of cancer.
3	Pulmonary nodule evaluation	Process for coordinated evaluation of suspicious pulmonary nodules (identified incidentally or by screening). ¹
		Sites have access to a program responsible for identifying and tracking persons with undiagnosed solitary pulmonary nodules, and evaluating and providing high-reliability longitudinal follow-up for those patients in a way that is coordinated with the center's primary / referring providers.
4	Multidisciplinary evaluation	Direct evaluation of the patient by specialists in medical oncology, radiation oncology and thoracic surgery ² or dedicated discussion of the complex patient in a prospective multidisciplinary conference. ³
		For patients with clinical stage II and III NSCLC, sites must provide the following: <ul style="list-style-type: none"> 1. Consultation (face-to-face or virtual) before the patient receives the first line of treatment. Consultations do not have to be synchronous, but if provided asynchronously, there must be documentation summarizing an agreed-upon treatment plan including sequencing of therapies. And/or 2. Prospective discussion of the patient in a multidisciplinary case conference with attendance by representatives from – at a minimum – medical oncology, radiation oncology and thoracic surgery.

5	Biopsy (preferred) or FNA	Expertise and ability to obtain sufficient diagnostic material for diagnosis and molecular testing.
		<p>Sites must provide coordinated access to interventional radiology, pulmonary, interventional pulmonary, or thoracic oncology surgery, with expertise in biopsies and fine needle aspiration including percutaneous biopsy, endobronchial biopsy, and endobronchial ultrasound bronchoscopic biopsy, navigational or robot-assisted bronchoscopy and other applicable technologies.</p> <p>Site tracks rates of biopsy sufficiency and need for re-biopsy.</p>
6	Pathologic interpretation	Pathologic diagnosis for biopsies, FNAs and resection specimens follows 2021 World Health Organization Classification of Lung Tumors. ⁴
		Pathologic reporting must adhere to the 2021 World Health Organization Classification of Lung Tumors and results must be reported synoptically using the standards set for by the College of American Pathologists (CAP).
7	Small biopsy management	Immunohistochemistry following parsimonious use of markers per 2021 WHO Classification. ⁴
		Pathology departments affiliated with the sites must follow the 2021 WHO Classification of Lung Tumors use of limited immunohistochemical testing in adherence with parsimonious use criteria.
8	Access to molecular and biomarker analysis	Reliable and timely access to appropriate broad, panel-based testing and for further targeted testing as warranted. ⁵
		Sites must have either a CLIA-certified on-location program or access to a CLIA-certified commercial immunohistochemical and molecular biomarker testing (PDL-1 and tumor genomic testing) required to subclassify NSCLC to enable identification of candidates for targeted treatment approaches. Sites must have a means to assure timely testing and to coordinate specimen submission and results tracking.
9	Cell free DNA testing capability	Reliable and timely access to plasma cell-free tumor DNA genotyping. ⁶
		Sites must have either on-location services or access to commercially available plasma cell-free tumor DNA genotyping required to subclassify NSCLC to enable identification of candidates for targeted treatment approaches.

10	Radiation technique	Minimum technologic standard for RT planning and treatment.
		The minimum standard for RT planning is CT based, accounting for tumor motion during treatment as needed. ⁷ Minimum technologic standard for RT delivery is 3D-conformal radiation therapy (3D-CRT) and intensity modulated radiation therapy (IMRT) (preferred), with image guidance (IGRT). More advanced radiation treatment technologies such as stereotactic body radiotherapy (SBRT) and stereotactic radiosurgery (SRS) may be needed for certain indications.
11	Thoracic surgical expertise	Lung surgery performed by a thoracic or cardiothoracic surgeon.
		Surgery is performed by a board-certified thoracic surgeon or oncology trained surgeon who has focus on lung cancer in an institution where at least 20 lung resections are performed per year.
12	Consultation availability	Access to subspecialist thoracic oncology experts for physician-to-physician consultation prior to initiation of treatment.
		Sites have access to thoracic oncology (medical, surgical and radiation) expertise to provide rapid formal or informal second opinions before patients begin the first line of therapy.
13	Patient monitoring	Routinely monitor patient symptoms throughout treatment. ⁸
		Site has process/workflow to collect patient symptoms, including between office visits; to triage patients based on symptom reporting; and to offer timely response.
14	Palliative care	Referral to palliative/supportive care. ⁹
		For patients with Stage 4 NSCLC or recurrent cancer, the site must have access to either face-to-face or remote consultation with a palliative care provider, social service, spiritual care, and hospice services.
15	Survivorship care	Access to survivorship care. ¹⁰
		Patients should have access to post-treatment care including long-term toxicity management, other screening and health care services, and social and emotional support. This may be through a coordinated survivorship program, or in collaboration with other community resources.

References

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