DGIM Project Summary

Name of Project: Lung Cancer Screening: A Multilevel Intervention (Aim 1)

Investigator(s). (Include phone numbers and email address, indicate PI and primary contact):

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Research question(s): What is the overall acceptability and feasibility of the LungCARE intervention?

AIM 1. Develop and evaluate the LungCARE intervention.

- **1.a.** Develop all components of LungCARE, including the short video, patient report, and physician report.
- **1.b.** Evaluate LungCARE with patients and physicians.

Brief Background/Significance:

Currently, most cases of lung cancer are discovered at advanced stages, only after symptoms appear. Treatment options for both small cell and non-small cell lung cancer are based on stage of diagnosis. Although treatments have improved slightly over the last several decades, survival remains low, highlighting the importance of early detection. In December 2013 the USPSTF issued a draft recommendation that high-risk patients be screened for lung cancer annually with LDCT scans. The task force determined that a reasonable balance of benefits and harms could be reached by screening people who are 55 to 80 years old and have a 30-pack year or greater history of smoking, who are either current smokers or who quit within the past fifteen years. In February 2015, the Centers for Medicare and Medicaid Services provided financial support to cover the costs for LDCT. There are several lung cancer risk assessment tools and educational materials currently available, but they are limited and have not been tested or adapted for use with low literacy or racial/ethnic minority populations, particularly in a clinical setting. Our project will develop a clinic-based intervention to promote discussion of lung cancer risk and screening among high-risk patients and their PCPs.

Inclusion/exclusion criteria:

Inclusion:

- Patient Component: 1) age between 55 and 80, 2) smoked at least 30 pack-years in lifetime, 3) if former smoker, have quit smoking within the last 15 years, 4) speak Spanish or English, 5) no prior history of lung cancer, 6) PCP does not object to patient's participation, and 7) will have a scheduled visit at the GIM or Women's Health Primary Care Clinic.

- Physician Component: 1) primary care physician specialty (internal medicine), 2) practices in the Division of General Internal Medicine (DGIM) clinics and Women's Health Primary Care Clinic at UCSF, and 3) dedicates at least 20% of his/her time to direct patient care in a primary care, continuity setting.

Exclusion:

- Patient Component: 1) younger than 55 or older than 80, 2) has not smoked at least 30 pack-years in a lifetime, 3) a former smoker who has quit over 15 years ago, 4) non-English or Spanish speaker, 5) history of lung cancer, and 6) PCP objects to patient's participation.

- Physician Component: 1) non-primary care physician specialty (internal medicine), 2) does not practice in the DGIM or Women's Health Primary Care Clinic at UCSF, and 3) dedicates less than 20% of his/her time to direct patient care in a primary care, continuity setting.

Method of contact/recruitment (be specific):

Aim 1:

- Patient Component: Staff from the Division of General Internal Medicine (DGIM) will create a list of patient participants using the electronic health record (EHR). The identification of these patients will be based on smoking history data. The DGIM staff will then send the list of patients to our research team.

- Once patients are identified, we will contact their Primary Care Physicians (PCP), asking if they object to their patients' participation. If the PCP does not object we will then contact the patients for participation.

- We will randomly identify 20 patients to reach the recruitment goal of 6-8 patients from different demographic groups.

- Potential patients will then be sent an invitation letter and an opt-out postcard. Those who have not opted out will then be called, screened for eligibility, and asked to participate. Those who have not opted out will then be called, screened for eligibility, asked to participate, and notified of the $40 incentive.

- We will then conduct 60-minute, semi-structured interviews with 6 patients.

- The interviews will be conducted by Dr. Kaplan or the study coordinator and will be audio-recorded with participants' permission. We will also obtain written informed consent prior to the interview.

- Physician Component: Physicians will initially be identified using a list of internal medicine physicians providing clinical care in the general internal medicine (GIM) clinics. These physicians include faculty, fellows, and third-year trainees.

- We will then conduct semi-structured interviews with 6 physicians. Potential participants will be approached via email sent by the study team. We will also obtain written informed consent prior to the interview.

Benefits/burden for participants (clearly identify potential for harm):

There are no physical risks to the participants in this study. There is some risk that the participants will feel discomfort or anxiety resulting from discussing lung cancer diagnosis and treatment, but the participants do not have to answer any questions that they are uncomfortable with and can drop out of the study at any time.

Any benefits or burden to DGIM practitioners?

- Benefit: Their patients may be able to better understand their lung cancer risk in the future.

- Burden: None.

Timeline for recruitment (projected start and stop dates):

Starting November 15, 2018 and ending June 30, 2020.

Funding source: Tobacco-Related Disease Research Program

Potential for DGIM collaborators? (We encourage DGIM resident and fellow involvement in particular): All investigators are in DGIM.

Do you agree to notify us when recruitment is completed? Yes

Date form completed: 10/30/2018