



# SCREENING IMPLEMENTATION:

Current Practices and Continued Implementation  
Challenges

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LUNG CANCER ALLIANCE



# DISCLOSURES

- I have nothing to disclose



# LCA HISTORY OF IMPLEMENTATION GUIDANCE

## A Decade to SCREENING

Working For Those At Risk

2005

### VOICE OF AT RISK

Lung Cancer Alliance (LCA) makes screening for high risk a priority.

2006

### RESEARCH

Landmark study in The New England Journal of Medicine finds CT screening detects lung cancer early, when curable.

2010

### VALIDATION

NCI halts pivotal study; Concludes CT screening can reduce number of people who die by 20%.

### MILLIMAN I

Actuarial study comparing early and late stage lung cancer.

2011

### GUIDANCE

NCCN releases first clinical guidelines for lung cancer screening.

2012

### IMPLEMENTATION

LCA develops National Framework for Screening; Begins identifying Screening Centers.

### MILLIMAN II

Actuarial study showing cost benefit of lung cancer screening.

### NO ONE DESERVES TO DIE

National stigma awareness campaign.

2013

### RECOMMENDATION

USPSTF recommends lung cancer screening for high risk; insurance companies must cover before end of 2015.

### MILLIMAN III

Actuarial study showing benefits of smoking cessation incorporation with screening programs.

### LIVE MORE MOMENTS

National screening awareness campaign.

2014

### MILLIMAN IV

Actuarial study showing lung cancer screening is cost effective and saves lives for high risk Medicare beneficiaries.

2015

### COVERAGE

Medicare agrees to coverage for at risk seniors; 10M at risk >55 now covered.

SOURCE:  
Lung Cancer Alliance



# LCA SCREENING CENTERS OF EXCELLENCE NETWORK AT A GLANCE

- 523 programs
- 42 states and DC
- Mostly hospital-based
- Commit to best-practices



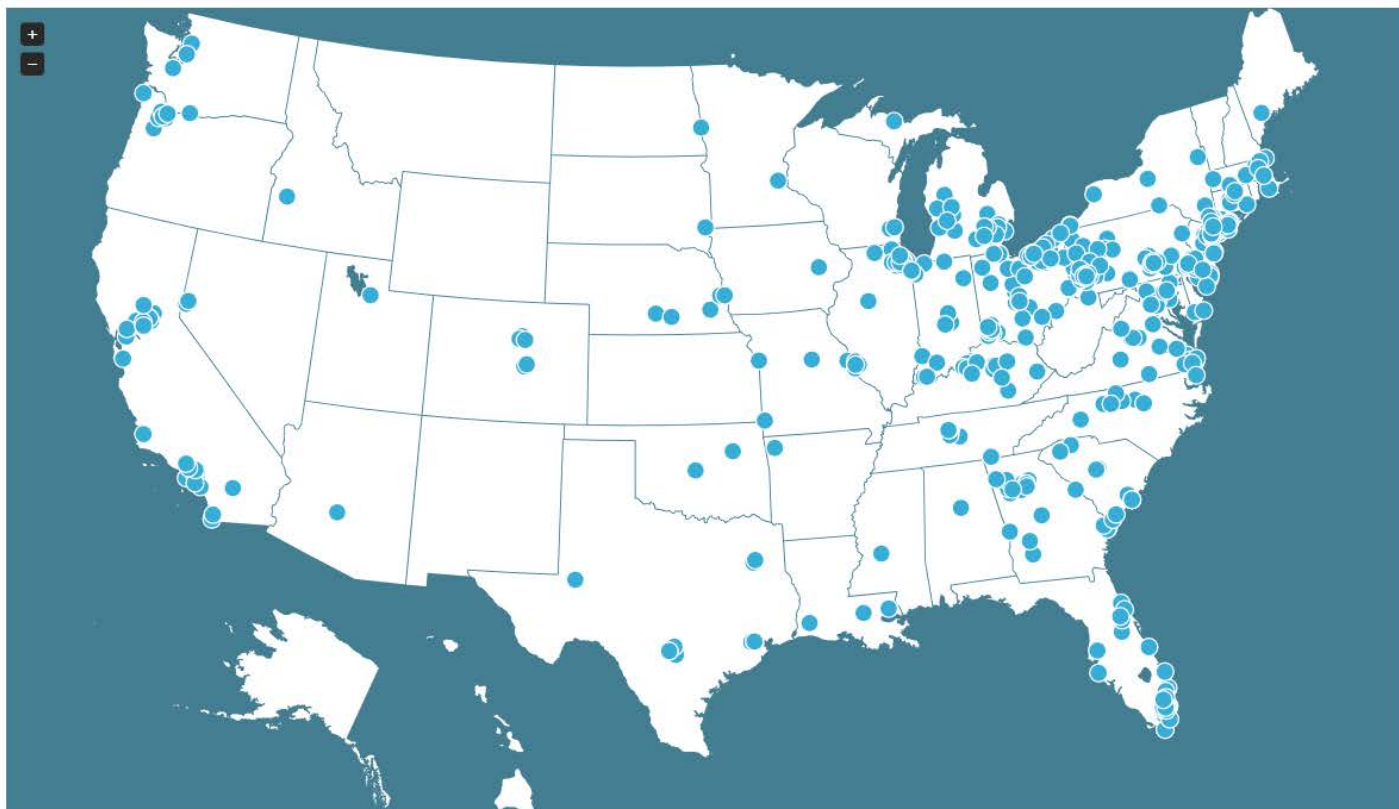
# 2017 DATA COLLECTION INITIATIVE

- Three separate data collection efforts
  - Application Renewal process
  - Spring 2017 Data Survey: Quantitative focus
    - number of scans, LungRADS classifications and lung cancer diagnoses from SCOEs during 2016
  - Late Summer 2017 Data Survey: Qualitative focus
    - reaching underserved patient populations, incidental findings, use of educational materials
- Response rate: 69% for Spring survey, 76% for Late Summer survey

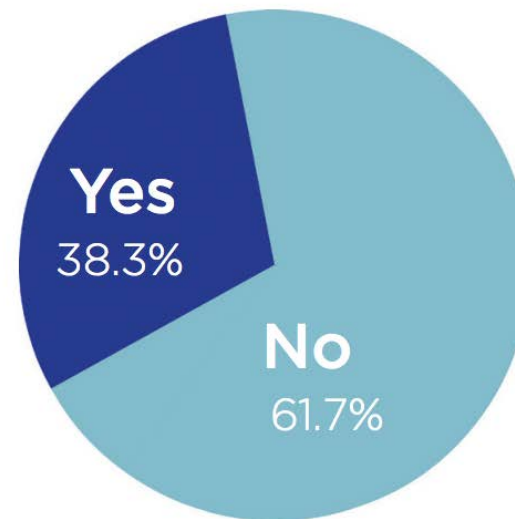




# WHO IS SCREENING?

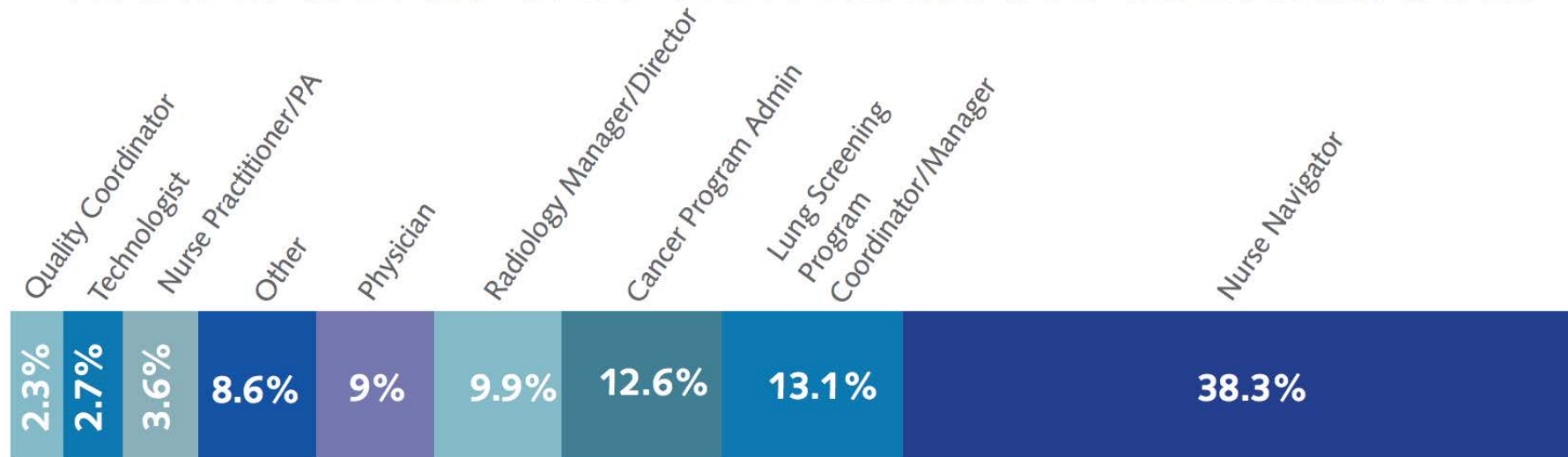


IS YOUR PROGRAM AFFILIATED WITH A UNIVERSITY OR ACADEMIC CENTER?



# WHO IS SCREENING?

WHAT IS THE TITLE OF THE PROGRAM'S COORDINATOR?



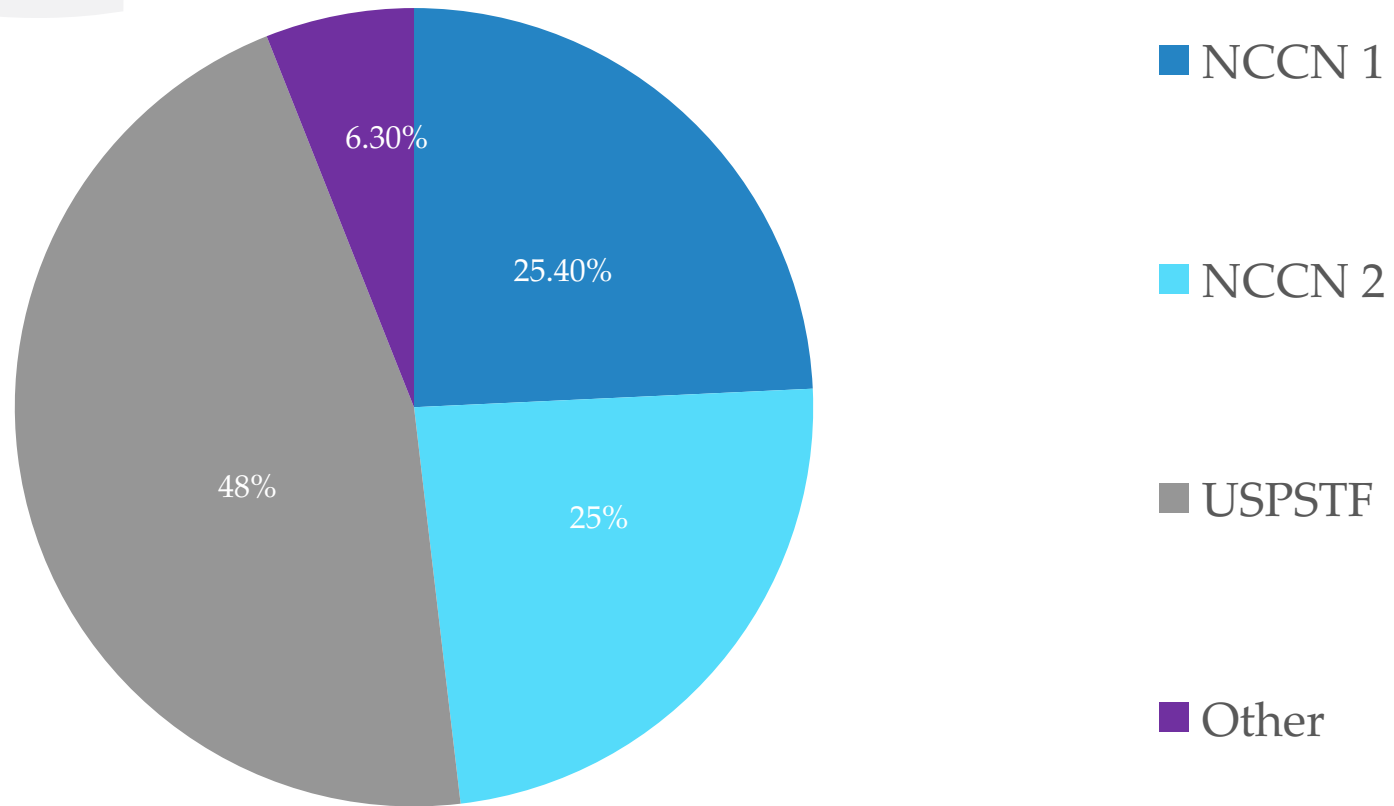
# WHO IS SCREENING?

## WHEN WAS YOUR PROGRAM ESTABLISHED?





# WHO IS BEING SCREENED?



# DATA ON FINDINGS – A FEW CAVEATS

- Our first effort at data collection taught us a few things about how to ask questions
- Data being collected isn't always the same across facilities
- Adequate technology for tracking data efficiently is not yet common
- Our contacts (who implement) don't always have all the information we are looking for
- Effort to minimize data collection burden resulted in fewer objective measurements



# SCREENING VOLUME AND STAGING (2016)

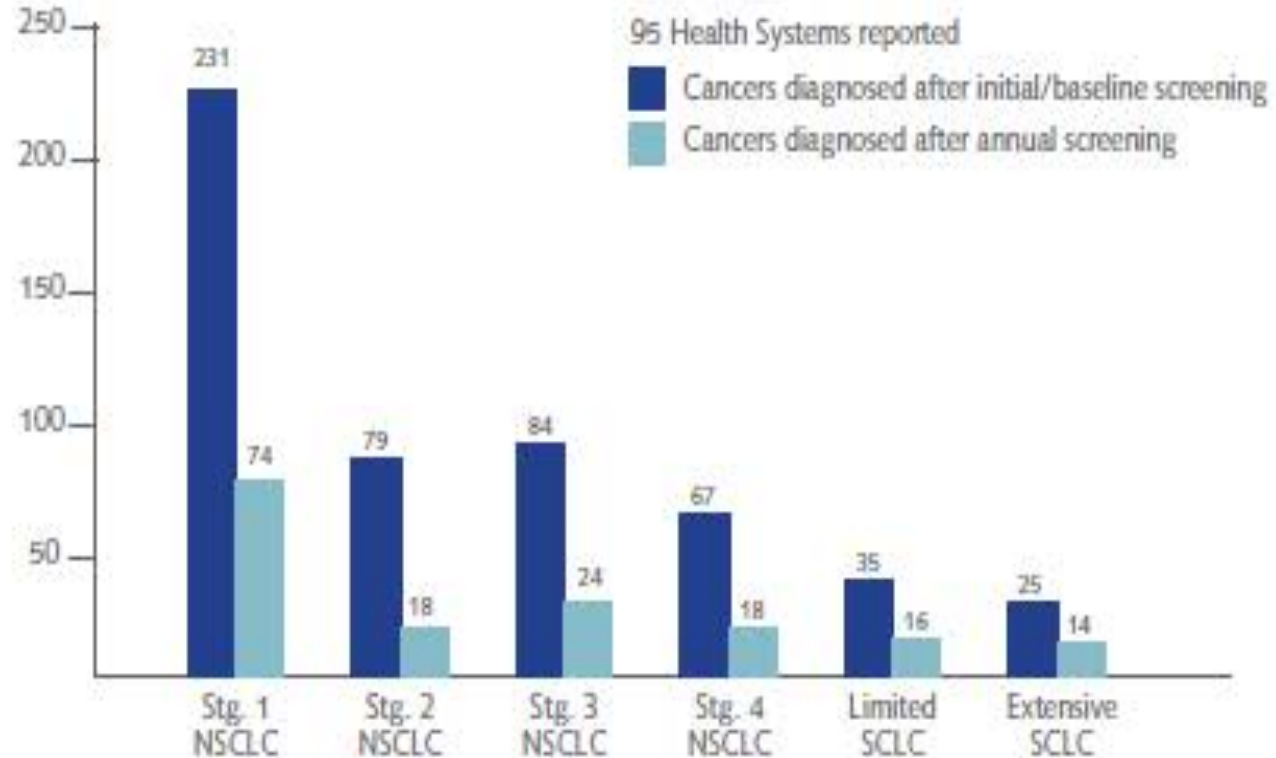
HOW MANY SCREENINGS WERE CONDUCTED?\*

Baseline **30,819**

Annual **11,702**

\*137 Health Systems reported

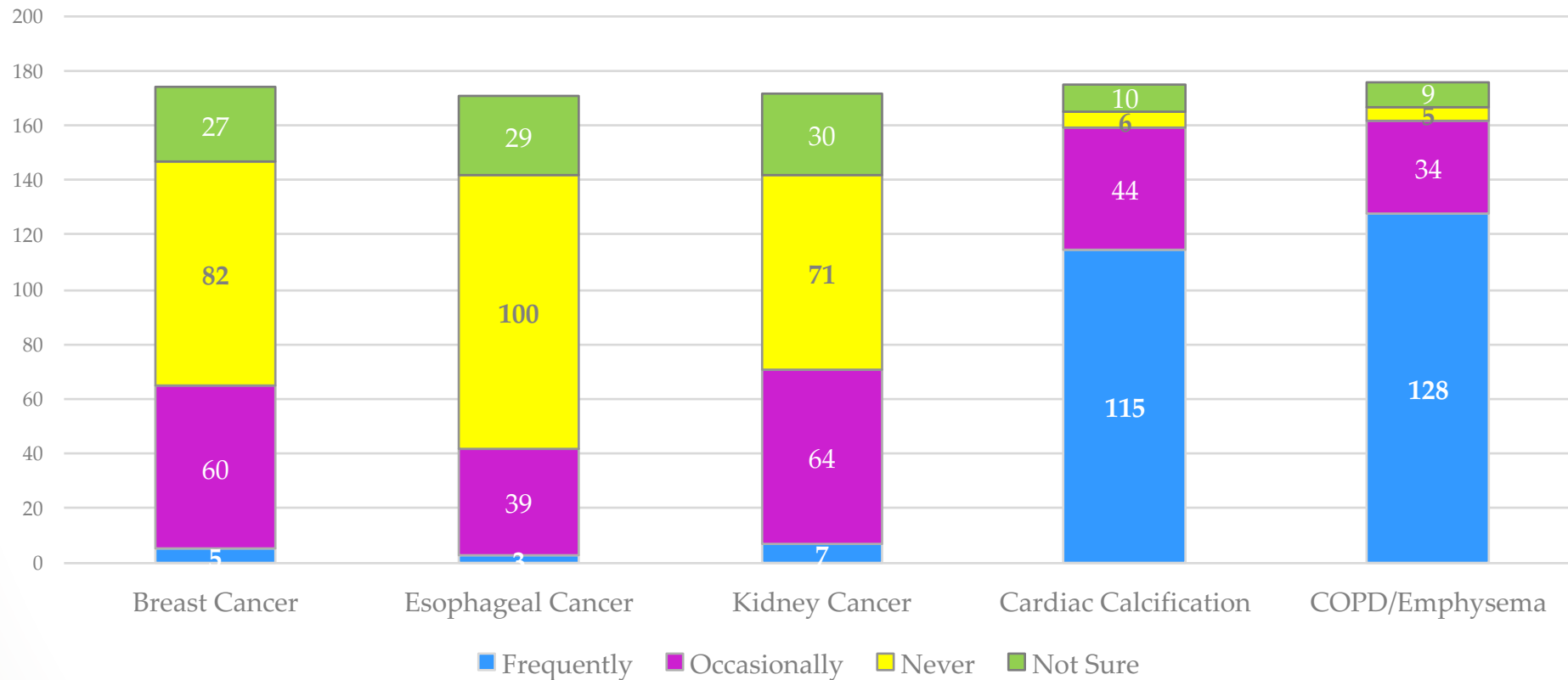
## WHAT TYPE OF CANCERS WERE DIAGNOSED?





# INCIDENTAL FINDINGS FROM SCREENING

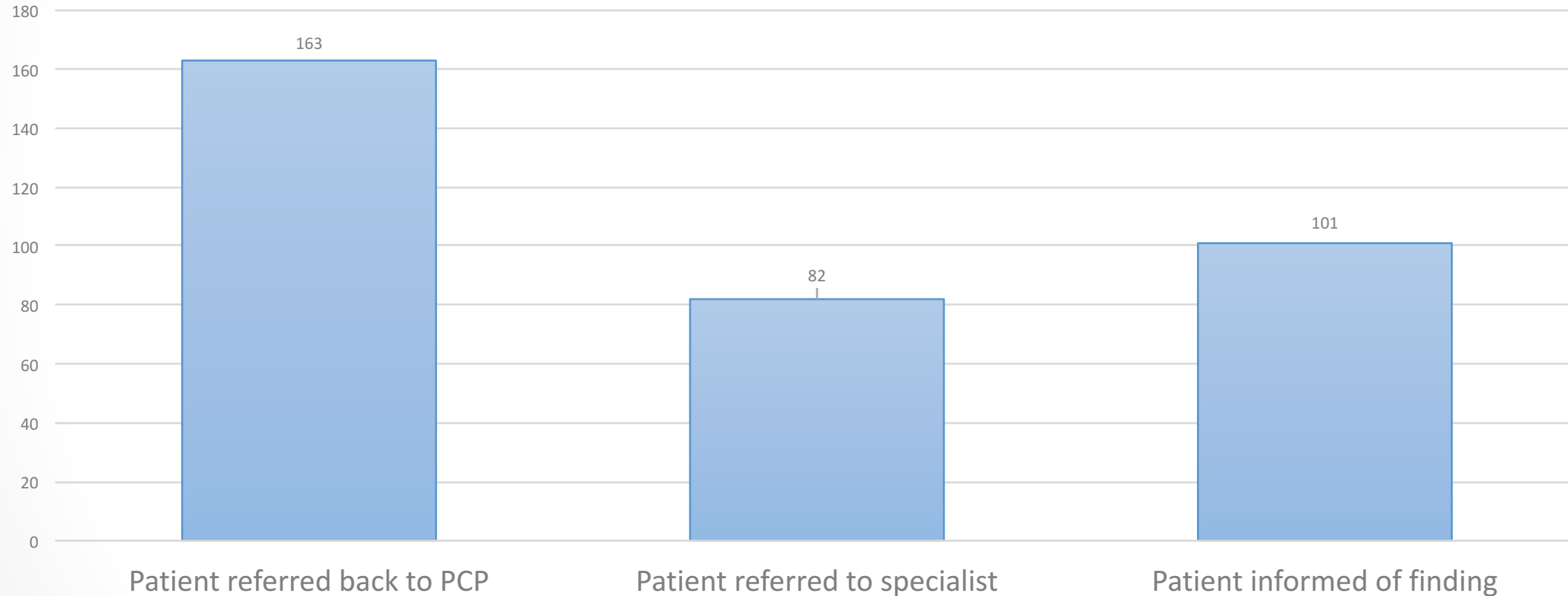
Frequency of Incidental Findings



# REFERRAL FOR INCIDENTAL FINDINGS

181 responses

## Follow-up for Incidental Findings

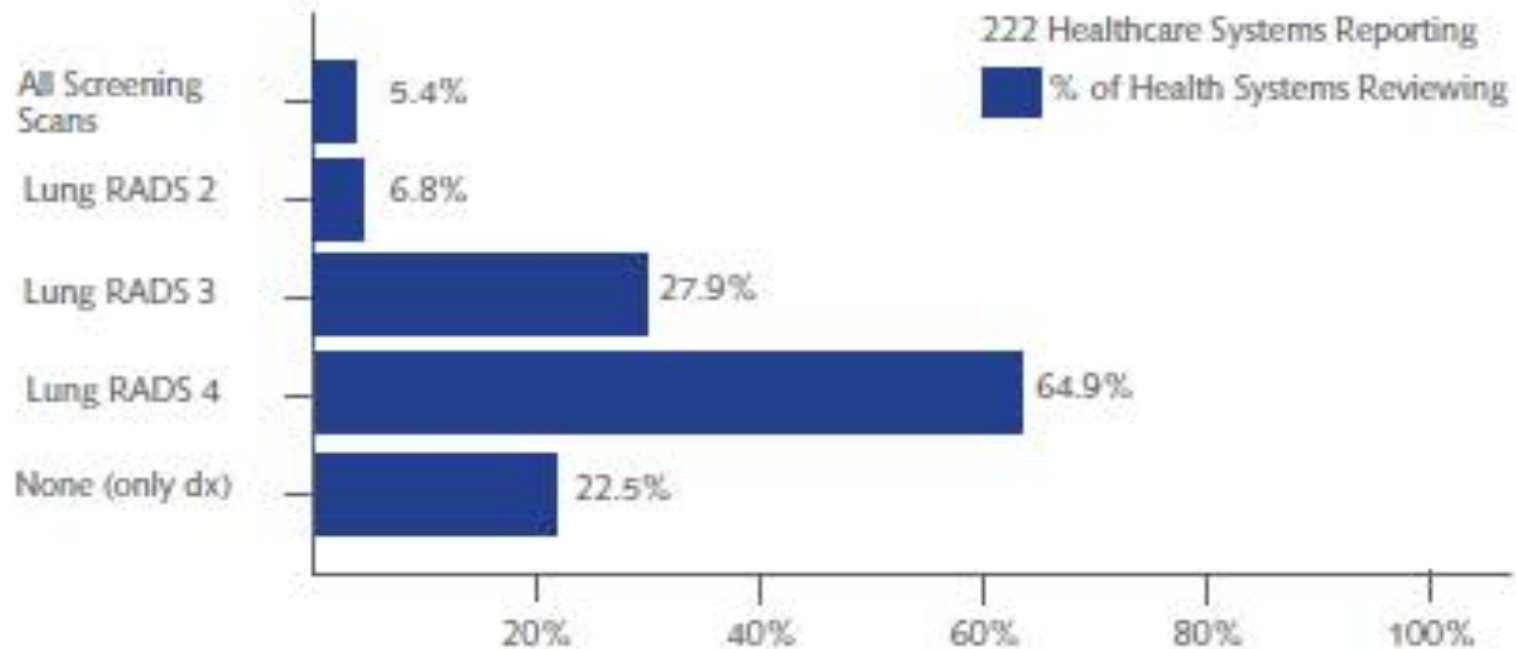


Most referred patient to multiple follow up resources



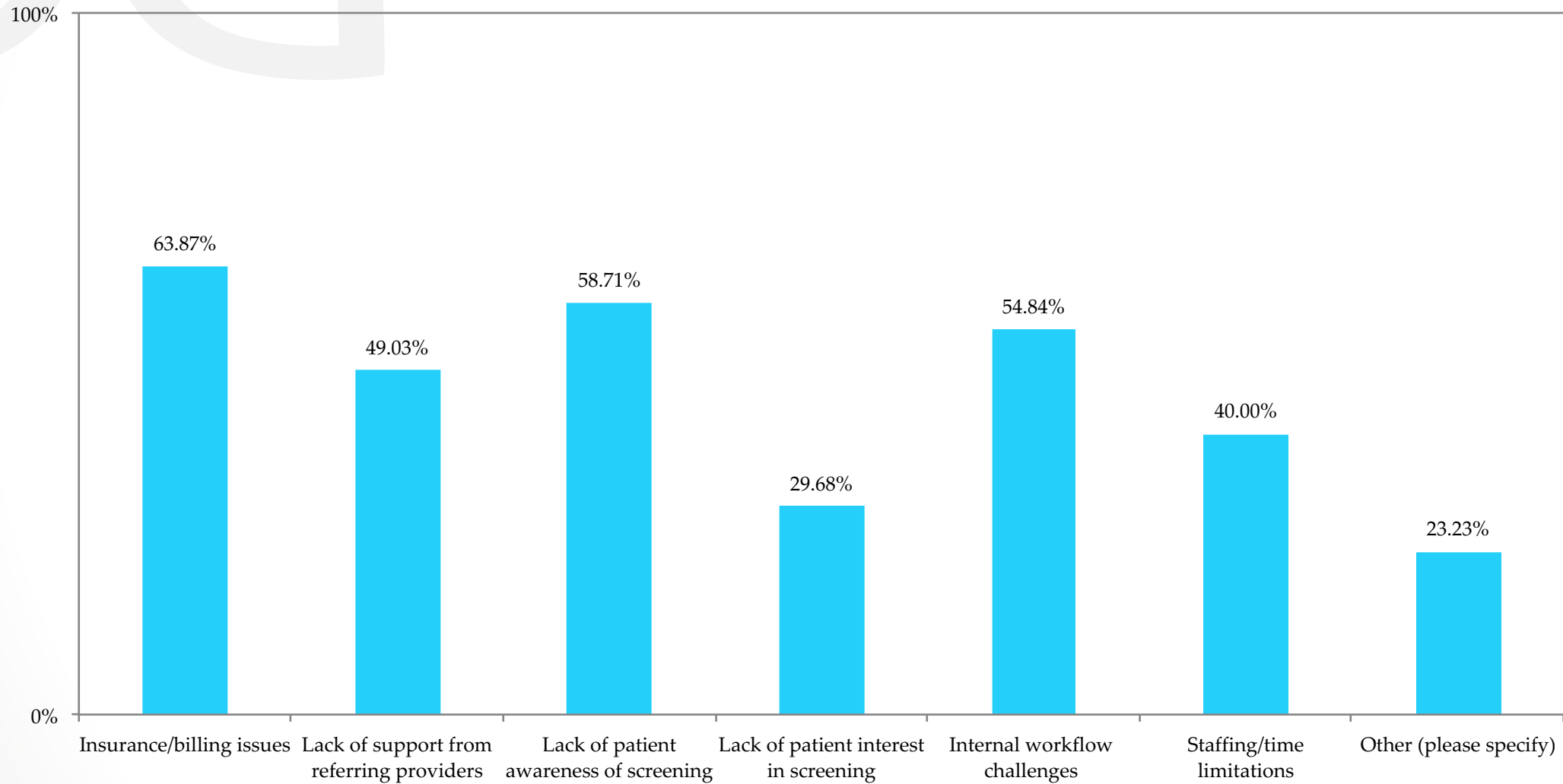
# SCREENING CASE REVIEW

## WHICH SCREENING CASES WERE REVIEWED BY MULTIDISCIPLINARY TEAMS?

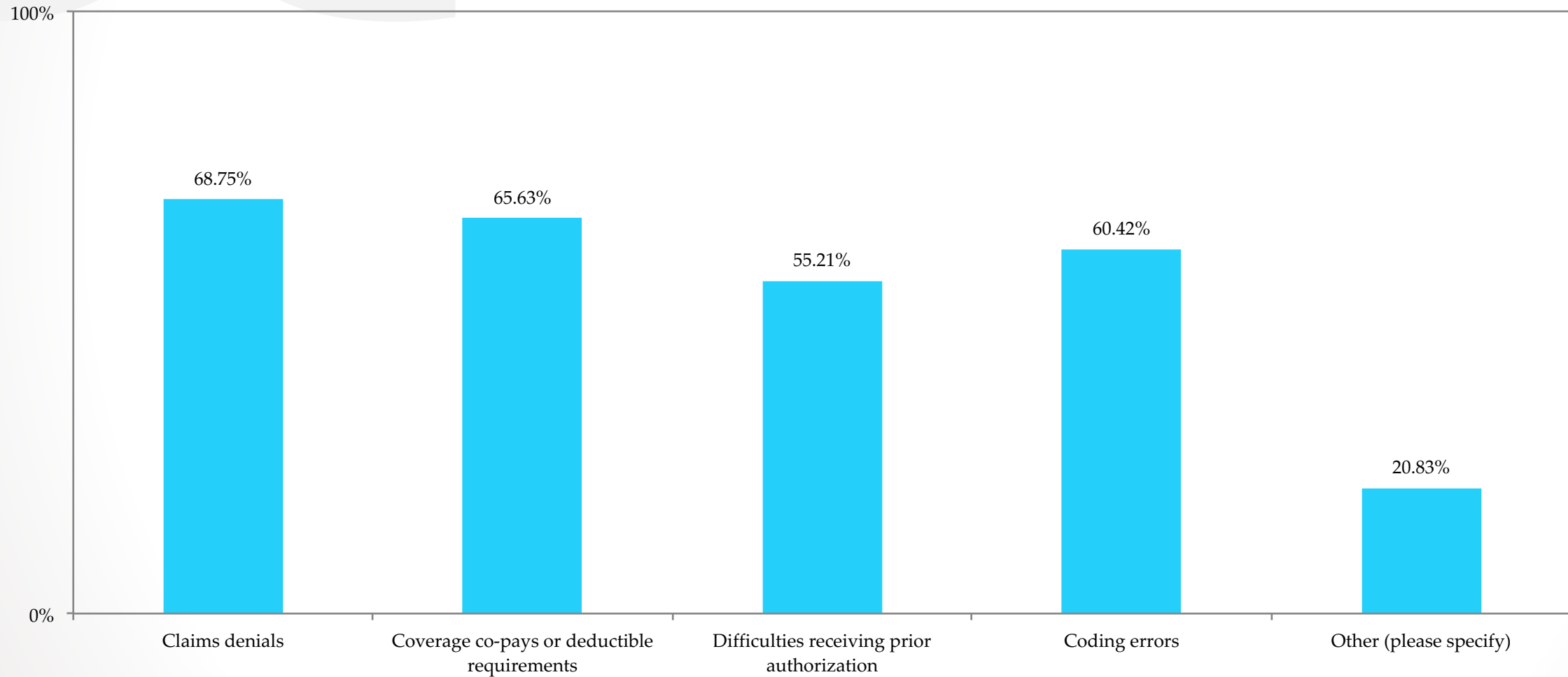




# CONTINUED BARRIERS



# SPECIFIC INSURANCE/BILLING ISSUES



# WHAT ELSE DO WE KNOW?

- Volume is still lower than we'd like to see at this point in time
- Significant variation in screening program design between facilities
  - Where screening “sits” may depend on program champion
  - Differences are not bad nor good, just different
- Movement to IDTFs may mean less multidisciplinary team involvement and more burden to PCPs







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