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.

MILLIMAN I
Actuarial study comparing early and late stage lung cancer.

2007
VALIDATION
NCl fatigue pivotal study: Concludes CT screening can reduce number of people who die by 20%.

2009
GUIDANCE
NCCN releases first clinical guidelines for lung cancer screening.

MILLIMAN II
Actuarial study showing cost benefit of lung cancer screening.

2011
IMPLEMENTATION
LCA develops National Framework for Screening: Begins identifying Screening Centers.

NO ONE DESERVES TO DIE
National stigma awareness campaign.

2012
2012
2013
2014
2015

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.

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

SOURCE:
Lung Cancer Alliance

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

Yes
38.3%

No
61.7%
## WHO IS SCREENING?

### WHAT IS THE TITLE OF THE PROGRAM’S COORDINATOR?

<table>
<thead>
<tr>
<th>Title</th>
<th>Percentage</th>
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</thead>
<tbody>
<tr>
<td>Quality Coordinator</td>
<td>2.3%</td>
</tr>
<tr>
<td>Technologist</td>
<td>3.6%</td>
</tr>
<tr>
<td>Nurse Practitioner/PA</td>
<td>2.7%</td>
</tr>
<tr>
<td>Other</td>
<td>8.6%</td>
</tr>
<tr>
<td>Physician</td>
<td>9%</td>
</tr>
<tr>
<td>Radiology Manager/Director</td>
<td>9.9%</td>
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<tr>
<td>Cancer Program Admin</td>
<td>12.6%</td>
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<tr>
<td>Lung Screening Program</td>
<td>13.1%</td>
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<tr>
<td>Coordinator/Manager</td>
<td>38.3%</td>
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<tr>
<td>Nurse Navigator</td>
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</table>
WHO IS SCREENING?

WHEN WAS YOUR PROGRAM ESTABLISHED?

48% est. pre-USPSTF/pre-CMS
24% est. post-USPSTF/pre-CMS
28% est. post-CMS trial

Jan 2014
USPSTF RECOMMENDATION

Feb 2015
CMS COVERAGE DECISION
WHO IS BEING SCREENED?

- NCCN 1: 25.40%
- NCCN 2: 25%
- USPSTF: 48%
- Other: 6.30%
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?

<table>
<thead>
<tr>
<th>Stage</th>
<th>NSCLC</th>
<th>SCLC</th>
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<tbody>
<tr>
<td>Stg. 1</td>
<td>231</td>
<td>74</td>
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<tr>
<td>Stg. 2</td>
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<td>79</td>
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<tr>
<td>Stg. 3</td>
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<td>84</td>
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<tr>
<td>Stg. 4</td>
<td>24</td>
<td>24</td>
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<tr>
<td>Limited</td>
<td>67</td>
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<tr>
<td>Extensive</td>
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</tbody>
</table>

95 Health Systems reported

Cancers diagnosed after initial/baseline screening
Cancers diagnosed after annual screening
INCIDENTAL FINDINGS FROM SCREENING

Frequency of Incidental Findings

- **Breast Cancer**
  - Frequently: 82
  - Occasionally: 60
  - Never: 5
  - Not Sure: 27

- **Esophageal Cancer**
  - Frequently: 100
  - Occasionally: 39
  - Never: 3
  - Not Sure: 29

- **Kidney Cancer**
  - Frequently: 71
  - Occasionally: 64
  - Never: 7
  - Not Sure: 30

- **Cardiac Calcification**
  - Frequently: 115
  - Occasionally: 10
  - Never: 6
  - Not Sure: 44

- **COPD/Emphysema**
  - Frequently: 128
  - Occasionally: 34
  - Never: 9
  - Not Sure: 5
Follow-up for Incidental Findings

- Patient referred back to PCP: 163
- Patient referred to specialist: 82
- Patient informed of finding: 101

Most referred patient to multiple follow up resources
WHICH SCREENING CASES WERE REVIEWED BY MULTIDISCIPLINARY TEAMS?

222 Healthcare Systems Reporting

- All Screening Scans: 5.4%
- Lung RADS 2: 6.8%
- Lung RADS 3: 27.9%
- Lung RADS 4: 64.9%
- None (only dx): 22.5%
CONTINUED BARRIERS

Insurance/billing issues: 63.87%
Lack of support from referring providers: 49.03%
Lack of patient awareness of screening: 58.71%
Lack of patient interest in screening: 29.68%
Internal workflow challenges: 54.84%
Staffing/time limitations: 40.00%
Other (please specify): 23.23%
SPECIFIC INSURANCE/BILLING ISSUES

Claims denials: 68.75%
Coverage co-pays or deductible requirements: 65.63%
Difficulties receiving prior authorization: 55.21%
Coding errors: 60.42%
Other (please specify): 20.83%
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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