

# Tobacco & Lung Cancer Screening Working Group

**Lead: Sue Flocke**

**Co-lead: Steve Zeliadt**

This presentation was supported by Cooperative Agreement Number U48DP001930-SIP011 from the Centers for Disease Control and Prevention. The findings and conclusions in this presentation are those of the author(s) and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

# Participating Centers

Case Western Reserve University- Sue Flocke, Genevieve Birkby, Heidi Gullett, Erika Trapl

University of Iowa – Richard Hoffman

University of Kentucky – Robin Vanderpool

University of North Carolina – Dan Reuland, Allison Brenner-Tytell

University of South Carolina – Jan Eberth

University of Washington – Steve Zeliadt

CDC – Tom Richards

NCI – Stephanie Land, Elizabeth Seaman

# Project Objectives

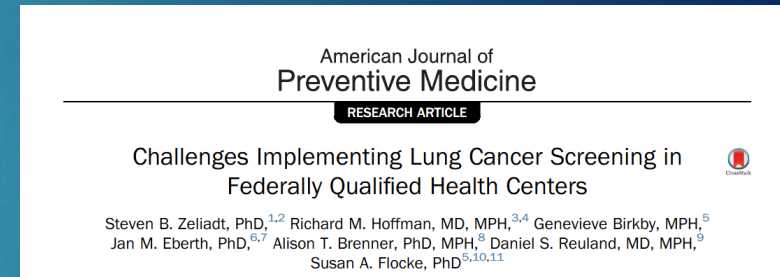
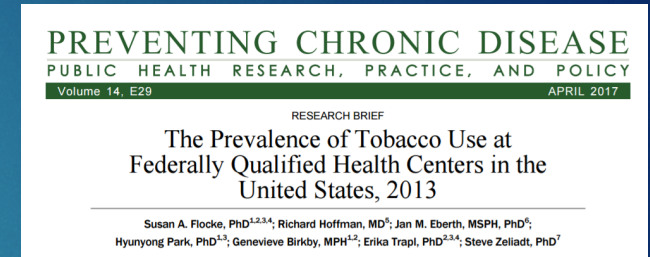
- ▶ To understand the opportunities and challenges faced by Federally Qualified Health Centers related to implementing:
  - ▶ Tobacco assessment and cessation assistance
  - ▶ Low-dose computed tomography (LDCT) for lung cancer screening

# Research Questions

- ▶ What is the burden of tobacco on FQHCs?
- ▶ What resources do FQHCs have for tobacco cessation assistance?
- ▶ What cessation advice and assistance practices are used?
- ▶ Do FQHCs have the ability to identify and approach eligible patients for lung cancer screening with LDCT?
- ▶ What's the current state of lung cancer screening with LDCT in FQHCs?

# Work Completed to Date

- Secondary analysis of Uniform Data Set of all FQHCs. Publication
- August – October 2016 conducted a survey of national sample of FQHCs.
  - 299 sampled; 258 invited, 112 complete (43%)
- 1 manuscript published
- 1 manuscript under review
  - *Addressing Tobacco Cessation at Federally Qualified Health Centers (FQHCs): Current Practices & Resources*
- Papers presented at ASPO March 2017, American Thoracic Society May 2017, CDC Cancer Conference August 2017.



# Work Completed to Date

- Disseminated a data brief to all those invited to participate in the survey and to other CPRN partners.

**Data Brief**  
May 2017

## Tobacco & Lung Cancer Screening In Federally Qualified Health Centers

Results from a National Survey of Federally Qualified Health Centers

While prevalence of tobacco use has declined over the past decade among some demographic groups, rates have remained steady and even increased among some socially and economically disadvantaged populations. Lower income cigarette smokers suffer from more diseases, such as lung cancer, than do smokers with higher incomes. (CDC 2014).

**A recent study reported that the overall prevalence of tobacco use is 25.8% in FQHCs vs. 20.6% in the general population.**

**Federally qualified health centers (FQHCs)** provide comprehensive health services to economically disadvantaged populations in rural and urban communities across the United States. They serve as the health care home for over 24 million people nationally. Most patients are uninsured or Medicaid recipients and have incomes below the Federal Poverty Level.

Better understanding tobacco cessation practices and resources available at FQHCs can guide efforts to target resources where they are most needed and to help anticipate the needs and resources so they can be ready to address lung cancer screening, a recent USPSTF Grade B recommendation [see box]

**U.S. Preventive Services Task Force Tobacco & Lung Cancer Screening Recommendations**

Clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and U.S. Food and Drug Administration (FDA)-approved pharmacotherapy for cessation to adults who use tobacco **GRADE A (Service recommended)**

Recommends annual screening for lung cancer with low-dose computed tomography (LDCT) in adults aged 55 to 80 years with a 30 pack-year

In August 2016, the Cancer Prevention and Control Research Network (CPCRN) - a national network of academic, public health and community partners - launched a national survey of Federally Qualified Health Centers (FQHCs) to better understand the state of tobacco cessation & lung cancer screening practices in these locales.

300 FQHCs with a tobacco prevalence higher than the median were invited to complete a brief, online survey. 110 completed the survey, representing 45 states.

In the 40 question survey, respondents (Medical Director, CEO or equivalent) were asked to describe current tobacco cessation and lung cancer screening practices at their health center. They were probed on the use of an EHR, availability of cessation resources and their center's capacity to conduct lung cancer screening with low dose computed tomography (LDCT).

The main findings are reported on Page 2.

Health Centers are required to report annually on their performance using measures defined by the Uniform Data System (UDS). They include measures for tobacco use screening and cessation advice, but not lung cancer screening.

**Current UDS Reporting Requirements**

**Tobacco Use Screening & Counseling**, Percentage of patients aged 18 and older who were screened for tobacco use one or more times within 24 months and who received cessation counseling intervention if defined as a tobacco user.

**Lung Cancer Screening**, NONE required

**CPCRN**  
Cancer Prevention and Control Research Network

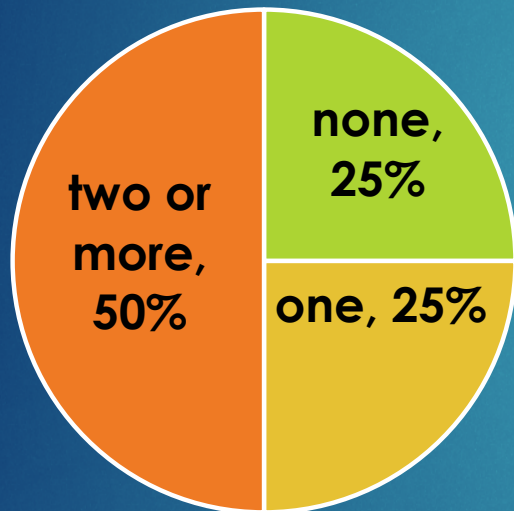
# Key Findings: Tobacco Assessment & Assistance

## Top Barriers to Providing Cessation Assistance

- Patients lack insurance coverage (36%)
- Limited transportation to programs (28%)
- Coverage of services varies by insurance type (26%)
- Non-English speaking patients are more difficult to refer to programs (24%)

# Key Findings: Tobacco Assessment & Assistance

Resources available that meet patient needs



Across the 3 groups, no differences:

- perceived barriers
- EHR best practice alerts

2 or more resources more likely to

- Rate smoking data as very accurate ( 67% vs. 61% vs. 54%)
- Use smoking data for population based outreach (39% vs 24% vs 8%)



# Key Findings: Lung Cancer Screening

	Total	Yes LDCT (n = 47)	No LDCT (n = 42)	Don't Know (n = 21)	p <sup>1</sup>
<b>Resources to Support LDCT</b> n (% yes)					
LDCT screening center within 30 miles	45 (40.9)	28 (59.6)	12 (28.6)	5 (23.8)	<.001
EHR lung cancer screening best practice alert	6 (5.5)	3 (6.4)	3 (7.1)	0 (0.0)	.47
Routinely document pack-year smoking history	59 (53.6)	25 (53.2)	21 (50.0)	13 (61.9)	.67
Pack-year smoking history accuracy <sup>3</sup>					.67
Very accurate	17 (28.8)	7 (28.0)	5 (23.8)	5 (38.5)	
Somewhat	30 (50.8)	12 (48.0)	13 (61.9)	5 (38.5)	
Not at all accurate	4 (6.8)	3 (12.0)	0 (0.0)	1 (7.7)	
Don't know	8 (13.6)	3 (12.0)	3 (14.3)	2 (15.4)	

# Key Findings: Lung Cancer Screening

	Total	Yes LDCT (n = 47)	No LDCT or Don't Know (n = 63)	p <sup>1</sup>
<b>Barriers to Offering LDCT Screening, n, (% yes)</b>				
Lack of insurance coverage	79 (71.8)	33 (70.2)	46 (73.0)	.75
Prior authorization by health insurance is required	64 (58.2)	27 (57.4)	37 (58.7)	.89
Transportation challenges for patients	60 (54.5)	28 (59.6)	32 (50.8)	.36
Difficult to refer certain patient populations	43 (39.1)	17 (36.2)	26 (41.3)	.59
Coverage denials received	33 (30.0)	18 (38.3)	15 (23.8)	.10
Services for Non-English speaking patients are limited or unavailable	32 (29.1)	11 (23.4)	21 (33.3)	.26
Other	21 (19.1)	6 (12.8)	15 (23.8)	.15
We do not have any barriers to offering LDCT	7 (6.4)	3 (6.4)	4 (6.3)	.99

# Key Findings: Lung Cancer Screening

LDCT Screening Perceptions <sup>2</sup> , n, (% Agree or Strongly Agree)	Total	Yes LDCT (n = 47)	No LDCT or Don't Know (n = 63)	p <sup>1</sup>
Evidence from randomized trials show that lung cancer screening with LDCT scans prevents lung cancer deaths.	73 (67.0)	40 (85.1)	33 (53.2)	<.001
The benefits of lung cancer screening with LDCT outweigh the potential harms.	59 (54.1)	36 (76.6)	23 (37.1)	<.001
We need to provide lung cancer screening to be a leader in cancer prevention.	60 (55.0)	31 (66.0)	29 (46.8)	.05
Our clinical site has adequate access to specialty providers to appropriately manage abnormal findings on lung cancer screening tests.	56 (51.4)	29 (61.7)	27 (43.5)	.06
Under-insured patients are less likely to be referred for lung cancer screening with LDCT.	66 (60.6)	33 (70.2)	33 (53.2)	.07
Available clinical evidence about lung cancer screening will be applicable to our patient population.	89 (81.7)	40 (85.1)	49 (79.0)	.42
Lung cancer is an important clinical concern for our patient population.	92 (84.4)	42 (89.4)	50 (80.6)	.21
Out-of-pocket costs for follow-up procedures of suspicious screening findings will be a significant financial burden for our patients.	79 (72.5)	35 (74.5)	44 (71.0)	.68

# Work in Progress

- ▶ Exploring possible 3<sup>rd</sup> paper
- ▶ Proposal for qualitative data collection

# Exploring possible 3<sup>rd</sup> paper

Half of the 112 survey participants represented a rural FQHC setting.

Compare rural vs. urban setting

1. tobacco assessment & documentation practices
2. tobacco cessation resources
3. barriers / facilitators to provision of tobacco cessation assistance
4. lung cancer screening activities

Looking for others to join this effort –

# Qualitative Study

Conduct a deep dive with FQHCs to better understand those that are more successful in providing cessation assistance vs. those less successful.

- ▶ What are the processes; resources. characteristics of the FQHCs with multiple cessation resources that meet patient needs?
- ▶ Explore opportunities for linkage to resources outside clinic (e.g. quitline and eReferrals)

CWRU has an approved IRB protocol for data collection.

Looking for partners to refine approach, scope of work and timeline.