



CLOSING GAPS IN CANCER SCREENING:

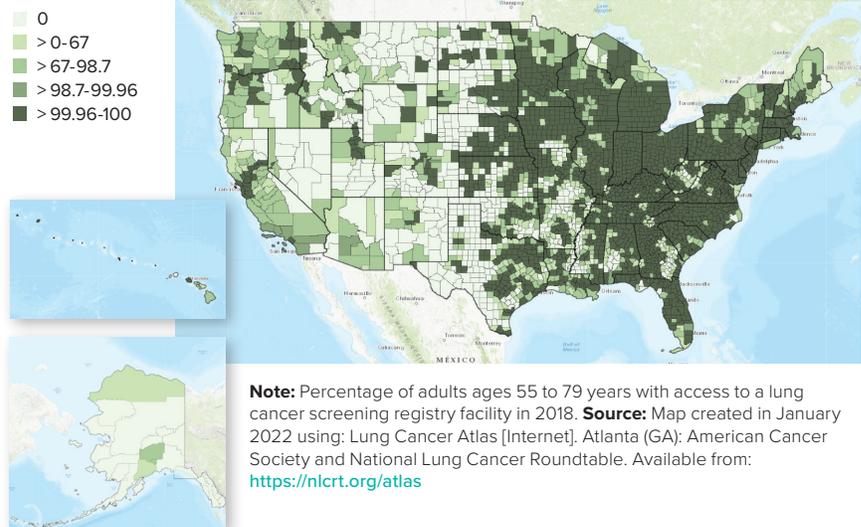
Connecting People, Communities, and Systems to Improve Equity and Access

Lung Cancer Companion Brief

In 2020–2021, the President’s Cancer Panel held a series of meetings on the uptake of cancer screening, with a focus on breast, cervical, colorectal, and lung cancers. Cancer screening saves lives; however, gaps in screening uptake and timely receipt of follow-up care mean too many people are unnecessarily enduring aggressive treatment or dying from cancers that could have been prevented or detected at earlier stages. The Panel’s report, *Closing Gaps in Cancer Screening: Connecting People, Communities, and Systems to Improve Equity and Access*, identifies four critical goals and related recommendations to ensure the benefits of cancer screening reach all populations. Many challenges and opportunities are common across cancer types. This companion brief summarizes issues and recommendations that are highly relevant to lung cancer.

FACTS & FIGURES

Access to a Lung Cancer Screening by County



There were an estimated **235,760 cases** of lung cancer and **131,880 deaths** from the disease in the United States in 2021.

Men are more likely to be diagnosed with or die from lung cancer, with **Black men** at highest risk.

In 2018, **5%** of eligible individuals were screened for lung cancer in the United States. Screening rates vary across the country.

Many eligible patients are not screened for lung cancer due to lack of **awareness, fear** of cancer diagnosis or perceived **stigma**, and difficulty **accessing and/or navigating** healthcare sites. Also, many providers are unfamiliar with lung cancer screening guidelines and report difficulties identifying eligible patients.



ACCESS THE FULL PRESIDENT’S CANCER PANEL REPORT AT:

<https://PresCancerPanel.cancer.gov/report/cancerscreening>

Sources: National Cancer Institute. Cancer stat facts: lung and bronchus cancer [Internet]. Bethesda (MD): NCI; [cited 2021 Dec 7]. Available from: <https://seer.cancer.gov/statfacts/html/lungb.html>; Fedewa SA, et al. J Natl Cancer Inst. 2021;113(8):1044-52. Available from: <https://www.ncbi.nlm.nih.gov/pubmed/33176362>; Wang GX, et al. Radiology. 2019;290(2):278-87. Available from: <https://www.ncbi.nlm.nih.gov/pubmed/30620258>

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GOAL 1: IMPROVE AND ALIGN CANCER SCREENING COMMUNICATION



Communications campaigns for lung cancer screening are needed. These campaigns should raise awareness, increase understanding, and empower people to be screened. Increasing

awareness is particularly important for lung cancer screening since it is relatively new. Key messages should address common knowledge gaps or misperceptions about lung cancer screening. Communications campaigns should use empathic messages to try to overcome the stigma that many current and former smokers feel about their smoking history and lung cancer risk. It also may be helpful to tailor messages based on smoking status.

Support for the National Lung Cancer Roundtable (NLCRT) should be increased so it can continue its work and expand its reach to communities with low rates of screening and follow-up care. NLCRT should prioritize equity and alignment of messaging about cancer screening and cancer screening guidelines. To this end, increased funding for a large-scale campaign, similar to the *80% by 2018* campaign conducted by the National Colorectal Cancer Roundtable, would raise awareness and help implement lung cancer screening nationally.

KEY MESSAGES

- Lung cancer screening is available and can save lives.
- Lung cancer screening can benefit current and former smokers.

GOAL 2: FACILITATE EQUITABLE ACCESS TO CANCER SCREENING



Community-oriented outreach and support services are needed to promote appropriate screening and follow-up care. Community health workers (CHWs), who have a deep understanding

of the culture and life experiences of their communities, can help address various barriers to lung cancer screening, particularly those experienced by populations less likely to be screened. This could include helping to overcome stigma and bias or coordinating tobacco cessation counseling. Sustainable funding, institutional commitment, and training are essential to establish effective CHW programs.

GOAL 3: STRENGTHEN WORKFORCE COLLABORATIONS TO SUPPORT CANCER SCREENING AND RISK ASSESSMENT



Systems and processes that support team-based care should be established. Involving multiple members of the healthcare team—including

physicians, nurses, office staff, and others—can help practices and healthcare systems collect smoking status and history, identify people eligible for lung cancer screening, promote screening, coordinate care throughout healthcare systems, deliver tobacco cessation counseling, and ensure appropriate follow-up for abnormal screening test results. All team members should receive education and training to ensure they have the knowledge and skills to support cancer screening.

Additional members of physician-led healthcare teams should be allowed to conduct shared decision-making for lung cancer screening. Currently, Medicare coverage for lung cancer screening requires that the ordering physician or qualified nonphysician practitioner (e.g., physician assistant, nurse practitioner) conducts a counseling and shared decision-making visit with the patient. If provided with appropriate training and access to patient decision aids, other team members could help with shared decision-making. This would relieve the burden that shared decision-making places on providers, which would allow them to implement lung cancer screening guidelines more broadly.

GOAL 4: CREATE HEALTH INFORMATION TECHNOLOGY THAT PROMOTES APPROPRIATE CANCER RISK ASSESSMENT AND SCREENING



Computable guidelines for lung cancer screening should be created. The availability of guidelines in a format that can be fully interpreted and executed by a computer would facilitate creation of health

information technology that promotes broader, more consistent, and faster guideline implementation.

Effective clinical decision support (CDS) for lung cancer screening and follow-up care should be created and deployed. Computable guidelines can be used to create CDS that helps providers and healthcare systems comprehensively and equitably deliver evidence-based cancer screening. To be optimally effective, CDS should be included in standard electronic health record systems and integrated into clinical workflows. It also should connect team members to ensure seamless delivery of care across providers and sites. For lung cancer screening, CDS will be most effective if it can integrate patient smoking history—including current smoking status and pack-year history—and screening guidelines. Efforts are needed to improve and standardize collection of smoking history data to facilitate identification of patients eligible for lung cancer screening.