Webinar: Scaling Up Lung Cancer Screening in the Real World: Navigating Vulnerable Patients
Presenter: Dr Simon Craddock Lee
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Chat questions:

Question 1: I have had some resistance from a few PCP's what would be a good way to address that with them?

Dr Lee: *We focused on the significance of screening as the opportunity to detect cancer early and increase the possibility of curative treatment through timely referral. Secondly, our data from the first year show that the vast majority of real-world patients will not need additional follow-up but simply need the next annual screen. We were fortunate that the health system also worked with us to design the order set and radiology report to make this process as straight-forward as possible for the ordering physician in primary care (see slides).*

Question 2: Are we going to hear about the navigation interventions themselves?

Dr. Lee: *You anticipated the next set of slides which delineated an algorithm-driven, telephone based protocol to address major barriers specific to our system, communicate key logistical information, and repeatedly apply the 5As approach to encourage patients to connect with cessation services in our system and in the community. I'm happy to provide additional detail-* *simoncraddock.lee@utsouthwestern.edu*

Question 3: In your system, are/were navigators located at the Radiology site? or with PCP?

Dr. Lee: *In our trial, we were testing a protocolized telephone-based navigation model with very structured doses. In this case, the navigators did not meet with patients in person and were not located in the clinical setting.*

Question 4: Do you have any projection about the increase of use of LDCT?

Dr. Lee: *I can really only speak to our local setting which, as a county safety-net in a major urban center, opted to initiate **population-level** screening as their standard of care. In this regard, primary care practices already routinely ask and record tobacco use in their EHR so the system was well-positioned to use these data to establish routine screening based on age, tobacco use, and then implement the order set to establish specific pack-history. After presentation of service activation in the primary outpatient clinics, the workgroup monitored order volumes closely. Early scheduling delays were addressed after bringing scheduling service representation into the workgroup. Ultimately, screening volume was absorbed into standard scheduling without need for additional service time-extending contingencies. Within our setting, the data suggest a steady uptake over the course of the first year, culminating in nearly 850 referrals. From June 2017-June 2018, Radiology received an average of 43 LDCT orders per month, or 2.5% of all CT referrals.*

Question 5: You called the Parkland coverage that of an HMO, but the care isn't really captivated; I presume it is county funded on top of FFS collections you do. If it is capitation, where can I find out more how done with this population?

Dr. Lee: *To clarify, you are correct, I was using the idea of a "safety-net HMO" to refer to the concept of a stable population for which Parkland is really the only source of specialty clinical services, like LDCT*

screening, and certainly for lung cancer treatment. Thus, their SOC program is, in effect, a population-based initiative. The analogy was not intended to refer to capitation, as you point out. Parkland accepts Medicare, Medicaid and other public coverage; however, commercial products only comprise a small fraction, less than 6%, of their payor mix. The county medical assistance program is for a majority of patients, the primary source of healthcare coverage.