



Lung Cancer Screening

2023

Milestone #1

Create action items designed to address root causes of low lung cancer screening rates.

Section one introduces the milestone and its relationship with the broader incentive arrangement and program. Section two discusses the parameters and methodology utilized to identify action items. Section three identifies action items to address root causes of low lung cancer screening rates. Section four describes the plan of action for implementation. Section five lists the action items best suited for addressing the root causes low lung cancer screening rates, and section six concludes the report.

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I. INTRODUCTION

The Louisiana Department of Health (“LDH”), as part of its contracts with each Louisiana managed care organization, authorizes additional payments to any Medicaid managed care organization that implements an LDH initiative to increase lung cancer screening (the “Lung Cancer Screening Project”).

The Louisiana Medicaid managed care organizations that chose to work with LDH in this lung cancer screening incentive arrangement hired an extensive network of physicians, mid-level providers, clinics, and hospitals that are capable of reaching Healthy Louisiana enrollees across the State (“ACO”) to assist the Medicaid managed care organizations related to their participation in the incentive arrangement (the Medicaid managed care organizations and ACO are collectively referred to as the “MCO”). As part of this incentive arrangement, the MCO must implement action items to address the root causes of lung cancer screening rates. This goal has been accomplished, in part, due to the feedback from the hospitals participating in the ACO (“Network Providers”).

The following report provides action items for Network Providers to implement to address low lung cancer screening rates among Healthy Louisiana enrollees (“Members”).

II. PARAMETERS AND METHODOLOGY FOR IDENTIFYING ACTION ITEMS

Louisiana has one of the highest rates of lung cancer in the nation—65 per 100,000 compared to 58 per 100,000 across the United States.¹ Louisiana’s five-year survival rate for lung cancer is near the bottom as well.² Low-dose computed tomography (“LDCT” or “low-dose CT”) is an effective way to screen for lung cancer with relatively low risk.³ Lung cancer detected early by LDCT screening dramatically increases a patient’s 5-year survival rate.⁴ The process of screening gives providers a valuable opportunity to help patients stop smoking, drastically lowering the risk of lung cancer.⁵ Louisiana ranks 48th in the nation for rates of smoking; 22% of Louisianans smoke compared to 15% of the population nationally.⁶ And yet, Louisiana’s lung cancer screening rate is barely half of the national average.⁷

In a prior milestone, the MCO identified root causes associated with low lung cancer screening rates.⁸ Root causes were grouped into Member-related and provider-related categories as shown in the chart below:

Member-Related Root Causes	Provider-Related Root Causes
Lack of Member Awareness	Lack of Equipment, Facilities, or Qualified Personnel
Cost/Lack of Insurance Coverage	Clinician Knowledge Gaps
Fear of Cancer Diagnosis, Stigma, or Radiation	Difficulty Identifying Eligible Patients
Lack of Access	Difficulty conducting shared decision-making visits

Some of these root causes are experienced with much greater frequency by Network Providers. Eighty percent of Network Providers identified lack of Member awareness of lung cancer screening as a root cause. Other major root causes were Member cost concerns and insurance coverage (77%); provider unfamiliarity with screening recommendations through lack of protocols, guidelines, or education (66%); and difficulty identifying eligible Members (54%). Difficulty conducting shared decision-making discussions with Members, Members opting out due to stigma, provider unfamiliarity with follow-up recommendations, and provider skepticism regarding effectiveness were additional root causes experienced by more than a third of Network Providers. On the other hand, lack of equipment or personnel and Members opting out due to radiation concerns were root causes identified by fewer than 1 in 10 Network Providers.

In designing the action items, the MCO researched available academic, governmental, and industry sources and surveyed the Network Providers regarding the effectiveness and feasibility of each action item. Further, the MCO prioritized addressing the more frequently encountered root causes, but most of the action items address more than one root cause.

III. ACTION ITEMS DESIGNED TO ADDRESS ROOT CAUSES OF LOW LUNG CANCER SCREENING RATES

A. ACTION ITEMS ADDRESSING PATIENT BARRIERS

1. Addressing Lack of Patient Awareness Through Targeted Education Materials

Across the country, patients are simply unaware of lung cancer screening as a potential procedure to help lower the risk of lung cancer mortality.⁹ Studies conducted in Indiana, Massachusetts, Florida, Kentucky, New Mexico, and Washington showed that between 38% and 59% of screening-eligible patients did not know about lung cancer screening.¹⁰ Effective education of Members addresses the obstacles associated with attempting to increase Members' knowledge base, namely: meeting Members at their level and utilizing a variety of mediums to communicate to different Member groups.

Meeting Members at their level is a prerequisite to transferring information, and poorly crafted Member education materials are a limiting factor. Both the National Institutes of Health and the American Medical Association recommend that patient materials be readily understood by those with a third to seventh grade reading level, but only 2.5% of online patient education materials about lung cancer screening qualify.¹¹ One study surveyed the average reading level from different internet sources on lung cancer screening by author group. Community and private hospital sources had the second highest reading level of all publishers, with an average minimum reading ability of ninth grade or higher required to comprehend their lung cancer screening information.¹² Accordingly, education materials should be simplified as much as possible without compromising the core messages.

The Program for the International Assessment of Adult Competencies (“PIAAC”) surveys adult literacy and groups participants’ results into one of three categories.¹³ Level 1 represents low literacy, signifying the ability to read short texts and understand very basic vocabulary.¹⁴ In Louisiana, 27% of adult residents fall into or below this category.¹⁵ Level 2 includes those who may be able to relate multiple pieces of information within a document but still cannot draw complex inferences or evaluations.¹⁶ In Louisiana, 38% of adult residents fall into the Level 2 category.¹⁷ Level 3 represents proficiency and the ability to synthesize information and infer meanings and complex ideas.¹⁸ In Louisiana, 35% of adult residents fall into or above this category.¹⁹ With barely a third of Louisianians reading proficiently, any efforts to raise Member awareness must include materials that are easily comprehended.

Studies regarding effective dissemination about material related to lung cancer screening advocate for distribution of materials in a variety of ways, urging providers to utilize direct mail, social media, and more conventional in-office education.²⁰ Different generations respond more positively to different types of communications. For example, research has shown that people over the age of 50 (the target population for lung cancer screening)²¹ read posters more often.²² Alternatively, utilizing brochures and mailed materials conveying the same information would provide certain benefits that posters do not; the portability of brochures and mailed invitations allows Members to learn about lung cancer screening outside in private. Moreover, mailed materials give Members the opportunity to learn about screening *before* they enter the waiting room. Thus, these materials would give Members more time to digest information on lung cancer screening before seeing their provider.

With these issues in mind, Network Providers created Member education materials in the first year of the Lung Cancer Screening Project. Network Providers will use the materials to educate Members in this and subsequent years.

2. Addressing Cost or Lack of Insurance Coverage through Coverage and Services Education

While little can be done to adjust the cost of services or a Member's insurance coverage, Network Providers can educate Members regarding Medicaid's coverage of lung cancer screening. Often, knowing that care is available and covered is enough to push patients to opt-in for services like screening.²³ Network Providers can also direct Members to services that would help defray the costs attendant to the screening, such as transportation and childcare.

3. Addressing Fear of Cancer Diagnosis, Stigma, or Radiation through Positive Interactions and Additional Information

Many Members are unable to make an informed decision about whether to receive lung cancer screening due to overestimating risks associated with radiation or feelings of being at fault for their diagnosis.

One study discussed comparing the average dose a patient receives through a CT scan (2-20 millisieverts or mSv) to the average annual dose of radiation a patient receives from a background dose of cosmic radiation (approximately 3 mSv), to show the patient that radiation exposure is a "ubiquitous part of everybody's life."²⁴ "For many people, the term radiation is linked to atomic bombs, cancer and death," which causes many patients to overestimate the risk posed by exposure to radiation.²⁵ Educational materials and interactions that emphasize the fact that Members routinely experience radiation exposure in their everyday life may prevent Members from overestimating the risk that exposure to radiation poses to their health.²⁶

Informational posters in Network Providers' waiting rooms could help remove the stigma Members feel about their tobacco use that prevents them from receiving a screening. Emphasizing that most smokers start before they turn 18—a time when people are ill-equipped to make health-related decisions and more susceptible to advertising and peer pressure—may ease feelings for both Members and the broader population that those in need of lung cancer screening are at fault.

Brochures and mailed invitations conveying the same information could be used by Network Providers to give Members more opportunities to gain knowledge about lung cancer screening. Unlike posters, mailed invitations and brochures may be thrown away. Nevertheless, these educational materials provide certain benefits that posters do not; the portability of brochures and mailed invitations allows Members to learn about lung cancer screening outside in private. As noted above, mailed invitations give Members the opportunity to learn about screening *before* entering the waiting room, giving them time to review the information, and preparing them for conversations and questions during the visit.

While written educational materials can provide Members with enough information to make an informed decision, Members often still have questions. Because front desk staff are typically the first point of contact for Members, they are well positioned to answer these questions or to let them know that providers have additional information.²⁷ Thus, to help supplement the education Members receive through written materials, front desk staff could be trained to answer basic questions about lung cancer screenings and payment options, including during the new-patient intake process. Ensuring that Members have a variety of written materials and personal interactions to convey information on lung cancer screening is more likely to lead to successful Member education.

4. Addressing Lack of Access through Resource Investment

While lack of access and lack of equipment, facilities, or qualified personnel were not commonly identified root causes of low lung cancer screening rates, they pose significant barriers because even Members who would like to be screened for lung cancer are unable to receive screening. To remedy this issue, hospitals that lack the equipment necessary to perform a LDCT scan could utilize Medicaid transportation to help Members travel to other facilities with screening equipment. Non-emergency Medicaid transportation covers travel to out-of-town appointments “when no comparable healthcare service can be provided.”²⁸ Notably, longer transport times may burden those without sick-leave benefits who often must forego income to attend doctor’s appointments.²⁹

An alternative to transporting Members to well-equipped facilities is to transport well-equipped facilities to Members. Network Providers could purchase a mobile lung cancer screening unit to reach populations that otherwise have difficulty accessing screenings and hold events to screen for lung cancer.³⁰

B. ACTION ITEMS ADDRESSING PROVIDER BARRIERS

Providers also share responsibility for low lung cancer screening rates. Several root causes of low screening rates identified in the survey are related to providers’ lack of knowledge. As with Member knowledge gaps, education is the tool to address these root causes.

1. Addressing Clinician Knowledge Gaps and Difficulty Conducting Shared Decision-Making Discussions with Provider Assessments and Internal Meetings

Providers should take an active role in their education to ensure that the material is effectively absorbed. A standard webinar only requires passive observation, but more interactive webinars would increase buy-in and participation. By way of example, the beginning of the webinar could feature common provider misconceptions regarding lung cancer

screening to engage providers in the material as they may share some of the misconceptions. Adding a discussion section to the end of the webinar would allow providers to reflect more fully on the material as well. The combination of targeted education and active discussion gives providers the opportunity to hear information about lung cancer screening multiple times while also allowing providers to address colleagues' skepticism regarding the effectiveness or other questions that may arise. Facilitating providers' further engagement with the material learned during a lecture has been shown to improve knowledge retention.³¹ Finally, after the discussion, providers could take short assessments to reinforce what they learned. Studies have shown that learning techniques that require learners to retrieve information, like taking tests and quizzes, boost long-term retention of knowledge.³²

2. Addressing Clinician Knowledge Gaps and Difficulty Conducting Shared Decision-Making Discussions with Workshops and Interactive Trainings

Interactive training could be used to improve providers' ability to conduct shared decision-making conversations with Members. Specifically, the Agency for Healthcare Research and Quality ("AHRQ") offers a workshop to help providers improve their ability to conduct shared decision-making conversations.³³ In the AHRQ training, providers attend a workshop that teaches them how to conduct a shared decision-making conversation, and providers are subsequently asked to practice leading a shared decision-making conversation with other workshop attendees.³⁴

3. Addressing Difficulties Identifying Eligible Patients through Automated Technology

Providers should receive education on how to better identify Members eligible for lung cancer screening, but this education should be buttressed by utilization of computer automated software.³⁵ Patients could fill out a pre-consultation form that asks them about their smoking history, with their responses entered into their medical records. At appointments, a notification could remind providers that the Member is eligible for lung cancer screening.³⁶ This would not only reduce the difficulty of identifying eligible Members but would also remind providers to have a discussion with each Member about screening.³⁷

IV. PLAN OF ACTION FOR IMPLEMENTATING ACTION ITEMS DESIGNED TO ADDRESS ROOT CAUSES OF LOW LUNG CANCER SCREENING RATES

Consistent with milestones in other incentive arrangements, Network Providers anticipate choosing from among the action items and beginning implementation in early 2024. Implementation will include continued evaluation of the effectiveness and feasibility of the action items to ensure they are tailored to the unique needs of Members served by the

Network Providers. Prior to implementation, the MCO utilized a survey of Network Providers, attached as Appendix A, to determine anticipated effectiveness and feasibility. These evaluations will be revisited in future years as Network Providers gain experience with the action items.

A. EVALUATE ANTICIPATED EFFECTIVENESS AND FEASIBILITY OF ACTION ITEMS

As a threshold issue, the Network Providers were asked whether they have processes currently in place to determine who is screened for lung cancer. Ninety-four percent of the Network Providers already have systems in place, ranging from review of electronic medical records, to utilizing provider discretion, to incorporating screening recommendations into annual wellness visits, to routine evaluations of necessity at intake, to following the formal criteria for lung cancer screening. The remaining Network Providers without processes in place are in active development, and the MCO will work with them and all Network Providers under this and other milestones to ensure that processes adhere to the latest standards.

Network Providers were also asked to rank five action items independently by effectiveness and feasibility (with 1 being best and 5 being worst). The MCO then analyzed the rankings across all Network Providers, which is summarized in the table below.

Action Item	Average Effectiveness Ranking	Average Feasibility Ranking
Patient education regarding risks and benefits of screening	1.97	1.72
Provider education regarding risks and benefits of screening	2.39	2.17
Technology improvements to better identify eligible patients	2.36	3.00
Patient education regarding Medicaid transportation	3.83	3.44
Investment in mobile low-dose CT scan unit	4.44	4.67

“Patient education regarding risks and benefits of screening” was a clear front-runner with the best effectiveness and feasibility rankings. Next was the corollary action item of “provider education regarding risks and benefits of screening,” which scored the second best in feasibility and nearly tied for second in effectiveness as well. As a close third, “technology improvements to better identify eligible patients” scored slightly better in effectiveness but slightly worse in feasibility. “Patient education regarding Medicaid transportation” and

“investment in mobile low-dose CT scan unit” were both disfavored by the Network Providers with the worst effectiveness and feasibility rankings.

B. EVALUATE DEMONSTRATED EFFECTIVENESS AND FEASIBILITY OF ACTION ITEMS

In future years, the MCO will track the effectiveness and feasibility of action items designed to address root causes of low lung cancer screening through both quantitative and qualitative evaluations:

- Quantitative evaluation will measure the MCO’s improvement over baselines for outcome milestones.
- Qualitative evaluation will measure outcome improvements based on Member and Network Provider input.

1. Quantitative Evaluation

At the end of 2023, the MCO will measure the baseline for Members who met criteria for lung cancer screening and received an LDCT scan.

As the action items are designed to address root causes underlying low lung cancer screening rates, the MCO will measure future performance against these baselines to determine how effective the action items are at improving outcomes.

2. Qualitative Evaluation

In addition to the quantitative evaluation, the MCO will solicit and analyze feedback from Members and Network Providers to evaluate the effectiveness of the action items. Doing so will highlight the impactful action items, reveal insights to drive improvement, and identify mismatches between Network Provider and Member perceptions. This comprehensive approach will help the MCO determine whether the action items are effective in addressing root causes of low lung cancer screening rates and whether to modify or supplement the action items in future years.

V. LIST OF ACTION ITEMS BEST SUITED TO ADDRESSING ROOT CAUSES OF LOW LUNG CANCER SCREENING RATES

Based on the MCO’s study and Network Provider input, the action items best suited to address root causes of low lung cancer screening rates, in order, are:

- Patient education regarding risks and benefits of screening
- Provider education regarding risks and benefits of screening

- Technology improvements to better identify eligible patients
- Patient education regarding Medicaid transportation
- Investment in mobile low-dose CT scan unit

VI. CONCLUSION

The action items discussed in this report offer Network Providers crucial first steps to addressing low lung cancer screening rates. Specifically, these action items seek to help Members understand the low costs, small risks, and large benefits associated with lung cancer screening and to make screenings more accessible to Members who are not near a facility that offers the procedure. These action items also address provider knowledge gaps to ensure Members receive optimal care. Ultimately, the MCO expects the action items discussed to help improve lung cancer screening in Louisiana.

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¹ *State of Lung Cancer: Louisiana*, AM. LUNG ASS'N, available at <https://www.lung.org/research/state-of-lung-cancer/states/louisiana> (last visited Mar. 20, 2023).

² *Id.*

³ *Screening for Lung Cancer: US Preventive Services Task Force Recommendation Statement*, 325 J. OF THE AM. MED. ASS'N, 962-970 (2021) [hereafter *Task Force Recommendations*].

⁴ *Id.*

⁵ *See id.*

⁶ *See State of Lung Cancer: Louisiana*, *supra* note 1.

⁷ *Id.*; Fedewa et al., *Lung Cancer Screening Rates During the COVID-19 Pandemic*, 161:2 THORACIC ONCOLOGY: RES. LETTERS 586–589 (showing an average lung cancer screening rate of 6.5% nationally and 3.8% in Louisiana).

⁸ *See Lung Cancer Screening Milestone 1.1 report for additional information.*

⁹ Wang et al., *Barriers to Lung Cancer Screening Engagement from the Patient and Provider Perspective*, RADIOLOGY (2019), 290(2):278-287 [hereafter *Barriers to Lung Cancer Screening*].

¹⁰ *Id.* at 279.

¹¹ *Id.*

¹² Haas et al., *Lung cancer screening: Assessment of Health Literacy and Readability of Online Educational Resources*, 18 BMC Pub. Health 5 (2018), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6286598/#!po=32.1429> (last visited Dec. 19, 2023).

¹³ *U.S. PIAAC Skills*, PIAAC, <https://nces.ed.gov/surveys/piaac/doc/PIAAC-SAE-Brochure.pdf> (last visited Dec. 14, 2023) [hereafter *PIAAC Skills*].

¹⁴ *Id.*

¹⁵ *U.S. Skills Map: State & County Indicators of Adult Literacy & Numeracy*, PIAAC, <https://nces.ed.gov/surveys/piaac/skillsmap/> (last visited Dec. 14, 2022) [hereafter *PIAAC Map*].

¹⁶ *PIAAC Skills*, *supra* note 13.

¹⁷ *PIAAC Map*, *supra* note 15.

¹⁸ *PIAAC Skills*, *supra* note 13.

¹⁹ *PIAAC Map*, *supra* note 15.

²⁰ *Barriers to Lung Cancer Screening*, *supra* note 9.

²¹ *Task Force Recommendations*, *supra* note 3; *Who Should Be Screened for Lung Cancer?* AM. CANCER SOC'Y, <https://www.cancer.org/latest-news/who-should-be-screened-for-lung-cancer.html> (last visited Mar. 20, 2023).

²² Ward & Hawthorne, *Do Patients Read Health Promotion Posters in the Waiting Room? A Study in One General Practice*, BRIT. J. OF GEN. PRACTICE (1994), <https://bjgp.org/content/bjgp/44/389/583.full.pdf> (last visited Mar. 20, 2023).

²³ *Health-Care Utilization as a Proxy in Disability Determination: Factors that Affect Health-Care Utilization*, NAT'L ACADS. OF SCIS., ENG'G, AND MED.; HEALTH AND MED. DIV.; BD. ON HEALTH CARE SERVS.; COMM. ON HEALTH CARE UTILIZATION & ADULTS WITH DISABILITIES, <https://www.ncbi.nlm.nih.gov/books/NBK500097/> (last visited Mar. 20, 2023).

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- ²⁹ *Access to Primary Care*, HEALTHY PEOPLE (2020), <https://wayback.archive-it.org/5774/20220414155515/https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/access-to-primary> (last visited Mar. 20, 2023).
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- ³² Karpicke, *Retrieval-Based Learning: A Decade of Progress in Learning and Memory: A Comprehensive Reference*, 2 ACAD. PRESS 487 (2017), <https://files.eric.ed.gov/fulltext/ED599273.pdf> (last visited Mar. 20, 2023).
- ³³ *Module 1: Shared Decision Making and the SHARE Approach*, AGENCY FOR HEALTHCARE RES. & QUALITY, <https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/education/curriculum-tools/shareddecisionmaking/workshop/module1/shareworkshop-mod1guide.pdf> (last visited Mar. 20, 2023).
- ³⁴ *Id.* at 27.
- ³⁵ O'Brien et al., *Piloting Electronic Screening Forms in Primary Care: Findings from a Mixed Methods Study to Identify Patients Eligible for Low Dose CT Lung Cancer Screening – BMC Primary Care*, BIOMED CENT. (2017), <https://bmcpriamcare.biomedcentral.com/articles/10.1186/s12875-017-0666-5> (last visited Mar. 20, 2023).
- ³⁶ *Id.*
- ³⁷ *See id.*

APPENDIX A

Introduction

Network Provider input is needed for three of the milestones to be reported in the first quarter of 2023: one lung cancer screening milestone and two tobacco cessation milestones. Because the milestones are related, this survey covers all of them. Responses to the survey and additional analyses done for project milestones will inform activities and other Network Provider participation requirements in subsequent years, so please answer each question as accurately and completely as possible.

Questions

Lung Cancer Screening Milestone 2.1: Create action items designed to address root causes of low lung cancer screening rates.

1. Do you currently have a process for determining who is screened for lung cancer?
 - a. If yes, please describe your process.
2. Does your approach vary for different payors (e.g., Medicare vs. Medicaid vs. Commercial vs. Uninsured) or different populations (e.g., socioeconomic, racial, or language differences)?
 - a. If yes, please explain.
3. Please rank the following action items for expected effectiveness for increasing the rates of lung cancer screening (from most effective to least effective):
 - a. Patient education regarding risks and benefits of screening
 - b. Patient education regarding Medicaid transportation
 - c. Provider education regarding risks and benefits of screening
 - d. Investment in mobile low-dose CT scan unit
 - e. Technology improvements to better identify eligible patients
4. Please rank the following action items based on the feasibility of implementation (from most feasible to least feasible):
 - a. Patient education regarding risks and benefits of screening
 - b. Patient education regarding Medicaid transportation
 - c. Provider education regarding risks and benefits of screening
 - d. Investment in mobile low-dose CT scan unit
 - e. Technology improvements to better identify eligible patients

Tobacco Cessation Milestone 2.1: Create action items designed to address root causes of tobacco use and to identify opportunities to prevent use from starting in the Medicaid population.

5. Are you currently engaged in efforts to help prevent tobacco use from starting among patients or the community?
 - a. If yes, please describe your efforts.
6. Does your approach vary for different payors (e.g., Medicare vs. Medicaid vs. Commercial vs. Uninsured) or different populations (e.g., socioeconomic, racial, or language differences)?
 - a. If yes, please explain.
7. Please rank the following action items for expected effectiveness for preventing tobacco use from starting (from most effective to least effective):
 - a. Patient education regarding healthy stress reduction and weight loss
 - b. Patient education regarding risks of tobacco use
 - c. Patient education targeted at specific populations (age, race, etc.)
 - d. Community events emphasizing healthy lifestyles
 - e. Ensuring facilities are tobacco free on the entire campus, including for clinical staff
 - f. Helping practitioners quit tobacco use
 - g. Provider education regarding best practices for conversations regarding tobacco use by demographic
8. Please rank the following action items based on the feasibility of implementation (from most feasible to least feasible):
 - a. Patient education regarding healthy stress reduction and weight loss
 - b. Patient education regarding risks of tobacco use
 - c. Patient education targeted at specific populations (age, race, etc.)
 - d. Community events emphasizing healthy lifestyles
 - e. Ensuring facilities are tobacco free on the entire campus, including for clinical staff
 - f. Helping practitioners quit tobacco use
 - g. Provider education regarding best practices for conversations regarding tobacco use by demographic

Tobacco Cessation Milestone 2.2: Create action items designed to address root causes of lack of tobacco cessation treatment in inpatient and emergency department (ED) settings.

9. Do you currently have a process for initiating tobacco cessation treatment in the inpatient setting?
 - a. If yes, please describe your process.

10. Does your approach vary for different payors (e.g., Medicare vs. Medicaid vs. Commercial vs. Uninsured) or different populations (e.g., socioeconomic, racial, or language differences)?
- a. If yes, please explain.
11. Do you currently have a process for initiating tobacco cessation treatment in the ED setting?
- a. If yes, please describe your process.
12. Does your approach vary for different payors (e.g., Medicare vs. Medicaid vs. Commercial vs. Uninsured) or different populations (e.g., socioeconomic, racial, or language differences)?
- a. If yes, please explain.
13. Please rank the following action items for expected effectiveness for increasing tobacco cessation treatment in inpatient and ED settings (from most effective to least effective):
- a. Patient education regarding risks of tobacco use
 - b. Provider education regarding tobacco cessation options and effectiveness
 - c. Ensuring facilities are tobacco free (including for clinical staff) on the entire campus, including parking lots and outdoor spaces
 - d. Updating protocols regarding when tobacco cessation treatment is to be initiated
 - e. Addressing payor barriers to pharmacological tobacco cessation treatment
14. Please rank the following action items based on the feasibility of implementation in inpatient and ED settings (from most feasible to least feasible):
- a. Patient education regarding risks of tobacco use
 - b. Provider education regarding tobacco cessation options and effectiveness
 - c. Ensuring facilities are tobacco free (including for clinical staff) on the entire campus, including parking lots and outdoor spaces
 - d. Updating protocols regarding when tobacco cessation treatment is to be initiated

Addressing payor barriers to pharmacological tobacco cessation treatment