

cancer plan minnesota



Workgroup: Detection

Date: 6-30-2016

Issue Statement: In 2013, the US Preventive Services Task Force recommended annual lung cancer screening with low-dose computed tomography (LDCT) in adults ages 55 to 80 who had a 30 pack year smoking history and currently smoke or have quit within the past 15 years. The narrowness of this guideline, the lack of good data collection on a patient's cigarette pack years and the relative newness of these programs poses considerable questions in how to effectively build evidence-based programs that are sustainable. The CDC has provided some resources and guidance at <http://www.cdc.gov/cancer/ncccp/pdf/lungcancerscreeningprograms.pdf> but additional state-level work could help establish community standards supporting improvements in the quality of care, consistency of reimbursement and patient experience.

Describe the issue using public health data, peer reviewed research, or other evidence:

From our most recent available data in 2012, 3,271 Minnesotans were diagnosed with lung and bronchus cancer and 2,332 Minnesotans died from lung cancer. It was the leading cause of cancer death for both men and women. Lung cancer screening could improve mortality for a small but significant subset of this population.

What factors contribute to this issue? What racial, economic, geographic and other barriers contribute to this issue?

Identification of patients who meet the evidence-based guideline is a challenge. Existing programs are likely located a great distance from rural patients who might be eligible. Different racial, ethnic and linguistic populations may be at greater risk based on their different rates of smoking and their access to health insurance which could pay for screening and follow-up care.

What are the gaps in policy, systems and/or environmental services that give rise to this issue?

Guidelines: High risk African Americans are not included in the current guidelines. The Institute of Clinical Systems Improvement (ICSI) currently endorses the U.S. Preventative Services Task Force (USPSTF) recommendations for adults. This targets smoking as the risk qualification and does not account for the Minnesota specific risk of high radon exposure.

Strategy #2: Partner with Minnesota stakeholders (i.e. ICSI) to consider whether the current definition accurately reflects the risk level of African Americans and American Indians.

Data: In Minnesota, tobacco pack-year data is not collected consistently at the provider level. MN does not have population estimates on pack-years and it is a primary indicator of lung cancer risk. Little is known about American Indian/ Alaskan Native (AIAN) rural access to lung cancer screening.

Strategy #1: Support appropriate risk stratification by seeking improvements to data collection to capture the number of pack years that individuals have smoked.

POLICY, SYSTEMS, and/or ENVIRONMENTAL (PSE) CHANGE: What are the policy, systems and/or environmental change opportunities to address this issue? What strategies would you recommend to achieve PSE change?

Policy change:

Strategy #1: Support appropriate risk stratification by seeking improvements to data collection to capture the number of pack years that individuals have smoked.

Systems change:

Strategy #2: Partner with Minnesota stakeholders (i.e. ICSI) to consider whether the current definition accurately reflects the risk level of African Americans and American Indians.

Strategy #3: Partner with Minnesota stakeholders (i.e. ICSI) to seek consensus on appropriate follow-up screening intervals after a positive test.

Strategy #4: Partner with Minnesota lung cancer screening programs to ensure that existing cessation counseling resources are offered to all current smokers in conjunction with screening services.

HEALTH EQUITY: Which strategies promote health equity? Describe how they promote health equity.

There is a much higher incidence, morbidity, and mortality rate of lung cancer among American Indian/ Alaskan Native (AIAN) populations. Current AIAN smoking rate is 4x state smoking rate. Lung screening services and follow-up care is not available at Indian Health Services (IHS)/Tribal facilities.

Smoke is also more common amongst multiracial and African American populations (Facts and Figures 2015). While among cigarette smokers, African Americans and Native Hawaiians are at greater risk of developing lung cancer than whites, Japanese American, and Latinos (Haiman 2006).

Strategy #2: Partner with Minnesota stakeholders (i.e. ICSI) to consider whether the current definition accurately reflects the risk level of African Americans and American Indians.

Strategy #4: Partner with Minnesota lung cancer screening programs to ensure that existing cessation counseling resources are offered to all current smokers in conjunction with screening services.

**Developing the Minnesota Cancer Plan
Step 2: Recommend Objectives and Strategies**

Workgroup: **Detection**

Date: 6/30/2016

Objective: Support the development of evidence-based lung cancer screening programs

Desired Outcome:

At the end of five years, what would you like to accomplish? If you do not expect to achieve the objective by the end of five years, what would success look like?

We need to identify lung cancer screening programs that are in operation or in a state of planning in Minnesota so that we can encourage consistency and adherence to the evidence-based guidelines and establish best practices for primary care data collection and appropriate follow-up care. A Minnesota lung cancer screening network could help peers come together to learn from each other and develop a clear community standard that is supported by a broad group of stakeholders.

Alignment:

Partners currently working on this objective and type of activity:

Organization	Activity (such as PSE change, education, programmatic)
(specifics pending survey of CoC network and other investigation)	
Breathe of Hope Foundation	Raises money to fund lung screening research
AICAF	Partnering with HCMC to support outreach to Am Indian Community

Stakeholders for this issue not currently working on it and potential role:

Organization	Potential role (PSE change, education, programmatic)
Stairstep Foundation	Outreach to African American Communities
Rainbow Health	Outreach to LGBT community

Strategies

Strategy #1: Support appropriate risk stratification by seeking improvements to data collection to capture the number of pack years that individuals have smoked.

Rationale:

In Minnesota, tobacco pack-year data is not in the provider work-flow, this data is not collected consistently. MN does not have population estimates on pack-years and it is a primary indicator of lung cancer risk.

Little is known about American Indian/ Alaskan Native (AIAN) rural access to lung cancer screening.

Evidence:

Centers for Disease Control and Prevention. Lung Cancer Screening Programs. Policies and Practices for Cancer Prevention.

Strategy #2: Partner with Minnesota stakeholders (i.e. ICSI) to consider whether the current definition accurately reflects the risk level of African Americans and American Indians.

Rationale:

Health Equity: High risk African Americans are not included in the current guidelines.

AIAN lung cancer incidence and mortality is highest in state. Current AIAN smoking rate is 4x the state's accumulated smoking rate.

PSE change: The Institute of Clinical Systems Improvement (ICSI) currently endorses the U.S. Preventative Services Task Force (USPSTF) recommendations for adults. This targets smoking as the risk qualification and does not account for the Minnesota specific risk of high radon exposure.

Alignment: Allina- Virginia Piper Cancer Institute is currently lobbying for more screening referrals.

Evidence:

Haiman, C.A, Stram, D.O., Wilkens, L.R., Pike, M.C., Kolonel, L.N., Henderson, B.E., Marchand, L.L. (2006). Ethnic and Racial Differences in the Smoking-Related Risk of Lung Cancer. *The New England Journal of Medicine*, 354, 4.

Holford, T., Levy, D., Meza, R. (2016). Comparison of Smoking History Patterns Among African American and White Cohorts in the United States Born 1890 to 1990. *Society for Research on Nicotine and Tobacco*, S16-S29.

Strategy #3: Partner with Minnesota stakeholders (i.e. ICSI) to seek consensus on appropriate follow-up screening intervals after a positive test.

Rationale:

After screening, availability of comprehensive care is limited.

AIAN lung cancer incidence and mortality is highest in state. Current AIAN smoking rate is 4x state smoking rate. Lung screening services and follow-up care is not available at Indian Health Services (IHS)/Tribal facilities

Evidence:

Armstrong, K., Kim, J.J., Halm, E.A., Ballard, R.M., Schnall, M.D. (2016). Using Lessons From Breast, Cervical, and Colorectal Cancer Screening to Inform the Development of Lung cancer Screening Programs. *Cancer*.

Centers for Disease Control and Prevention. Lung Cancer Screening Programs. Policies and Practices for Cancer Prevention.

Qiu, R., Copeland, A., Sercy, E., Porter, N.R., McDonnell, K.K., Eberth, J.M. (2016). Planning and Implementation of Low-Dose Computer Tomography Lung Cancer Screening Programs in the United States. *Clinical Journal of Oncology Nursing*, 20, 1.

Strategy #4:

Partner with Minnesota lung cancer screening programs to ensure that existing cessation counseling resources are offered to all current smokers in conjunction with screening services.

Rationale:

To increase smoking cessation among current smokers who undergo screening.

Evidence:

Centers for Disease Control and Prevention. Lung Cancer Screening Programs. Policies and Practices for Cancer Prevention.

Fucito, L. Czabafy, S., Hendricks, P.S., Kotsen, c., Richardson, D., Toll, B.A. (2016). Pairing Smoking-Cessation Services With Lung Cancer Screening: A Clinical Guideline From the Association for the Treatment of Tobacco Use and Dependence and the Society for Research on Nicotine and Tobacco. *Cancer*.

Haiman, C.A., Stram, D.O., Wilkens, L.R., Pike, M.C., Kolonel, L.N., Henderson, B.E., Marchand, L.L. (2006). Ethnic and Racial Differences in the Smoking-Related Risk of Lung Cancer.

Holford, T., Levy, D., Meza, R. (2016). Comparison of Smoking History Patterns Among African American and White Cohorts in the United States Born 1890 to 1990. *Society for Research on Nicotine and Tobacco*, S16-S29.