Lung Cancer Screening Education

Dr. Diane Kostrey Horner, DNP, APRN
Eskenazi Hospital, Indianapolis, IN
317-997-6952 dianekhorner@comcast.net

Purpose

The purpose of this evidence-based scholarly project was to discern the need for education on eligibility criteria for referral to a new Lung Cancer Screening Program. This education would ensure best practices through appropriate referrals of high risk cigarette smokers.

Background

Lung cancer is the number one cancer killer in the United States.
We can reduce the number of lung cancer deaths by screening those at risk and diagnosing cancer early.
A recent study indicates that less than 2% of more than 7 million current and former smokers were screened for lung cancer in 2016.

Introduction

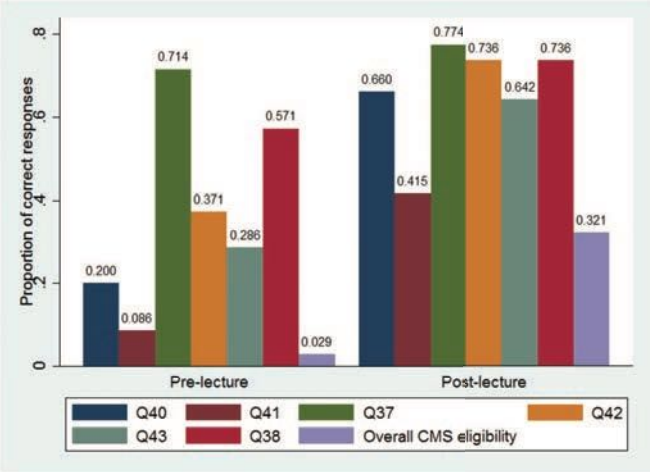
Lung Cancer Screening with Low Dose Computed Tomography (LDCT) is now a preventative standard of care for high risk cigarette smokers.

Opening a new centralized Lung Cancer Screening program requires knowledge of eligibility criteria for appropriate referrals.

Guided Scholarly Research Question

Does face-to-face education increase knowledge of eligibility criteria for appropriate referral to the Lung Cancer Screening Clinic?

Figure 1: Change in Screening Awareness from Pre- to Post-test



LEGEND

Q40: What is the youngest age at which patients should be considered for lung cancer screening?
Answer: 55
Q41: According to CMS, after what age should you not consider lung cancer screening, regardless of smoking history?
Answer: 77
Q37: One can proceed with Lung Cancer Screening if:
Answer: There are no signs or symptoms of lung cancer
Q42: How many pack years dose a patient need to have smoked in order to qualify for lung cancer screening?
Answer: 30
Q43: If a patient meets the requirements for number of pack-years but has successfully quit smoking (now a former smoker), they are still eligible for screening if they quit within the last ___ year (s)?
Answer: 15
Q38: A provider can place the necessary order after:
Answer: Face to face encounter with documented shared decision making

Methods

Non-experimental mixed methods utilizing an online survey, administered through Qualtrics survey platform.
Population: Convenience sample of providers practicing at Eskenazi Health clinical practice sites.
Setting: Large, urban healthcare setting in central Indiana.
Tools: Pre- and post- test of demographic and eligibility variables.

Results

12 different clinical sites were surveyed, consent to participate was obtained and all responses were anonymous.
Final sample consisted of 21 participants (n = 21) which responded to both pre- and post- test.
Questions consisted of demographics, criteria components, understanding elements of screening, placing appropriate orders into the electronic medical record, and the process which follows.
statistical significance set at $p<.05$.

Conclusions

The need for education and awareness is essential in order to recognize those individuals at high risk for lung cancer. A lung cancer screening, counseling and shared decision making on an annual basis with LDCT should be supported.
Ultimately, a greater percentage of the eligible population will receive proper screening which will lead to early diagnosis and better outcomes.

Future Research

Future clinical inquiries and follow up projects can further enhance research and improve patient outcomes.
A succinct education for continued and new providers.
Further studies aimed at understanding why much of the eligible population is not obtaining the screening.

References: Available upon request