

Exploring the Short-Term Impact of Provider Education on Lung Cancer Screening in LVHN Primary Care Practices: A Pilot Quality Improvement Project

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Published In/Presented At

Griffith, K., Greenberg, G., & Johnson, M. (2022). *Exploring the short-term impact of provider education on lung cancer screening in LVHN primary care practices: A pilot quality improvement project*. Poster presented at Lehigh Valley Health Network, Allentown, PA.

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Exploring the Short-Term Impact of Provider Education on Lung Cancer Screening in LVHN Primary Care Practices: A Pilot Quality Improvement Project

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Background

- March 9, 2021, the U.S. Preventative Task Force recommendations for lung cancer screening were updated
- New guidelines recommend adults aged 50-80 who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years should be screened yearly with low-dose-CT.
- This is an expansion in age range and a reduction in the number of pack-years to qualify for low-dose CT screening.
- Lung cancer is the third most common type of cancer and leading cause of cancer deaths in the US.
- Nationally, lung cancer screening is known to be poorly implemented
- In the Lehigh Valley Health Network (LVHN) only 11% of the eligible population are screened.

Problem Statement

If we employ provider education in the context of lung cancer screening will LVHN primary care providers increase lung cancer screening rates in the short-term?

Methods

- Project proposal formulated
- IRB approved through HSRD
- Recruited a cohort of 8-10 LVHN primary care providers
- Completion of an educational training module on lung cancer screening (through the LuCa National Training Network)
- 2-week post-training module survey collected and data analyzed

Results

- Results have yet to be determined as the data collection part of the project is still in process



Discussion

- Nationally lung cancer screening is known to be poorly implemented with studies finding that only a small percentage of eligible patients are screened.
- There are various reasons for low screening rates, but our project choose to focus on the provider knowledge barrier to screening in hopes that education of the new guidelines will improve screening rates and be an option to implement network-wide.
- Improved provider confidence with who qualifies for screening especially in the short term should lead to improved outcomes for patients.
- Limitations met from this study are that the data is not fully collected yet so we cannot come to any conclusions about feasibility of implementation on a large scale. More broadly our small cohort, and self-reported survey data by providers make our results less objective. Another limitation was poor planning of the study timeline.
- Future studies would include expansion of the pilot study to a larger cohort

Conclusions

- More data is needed to determine if education had a positive impact on self-reported lung cancer screening rates and comfort level with new USPTF screening guidelines by providers and therefore the feasibility of expanding this study to a larger cohort.
- Health systems was incorporated in this project through the goal of improving screening rates and therefore quality and access to care for our patients.
- SDL goals of self-assessment, localization/utilization of resources, and appraisal of said resources were partially met. Improvement of self-assessment would have bettered the timeline of this project

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