

Transcript Details

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Assessing Quality of Care: Implementing a Lung Screening Program

Dr. Sands:

Welcome to *Project Oncology* on ReachMD. I'm Dr. Jacob Sands, and on this program, we welcome back our guest, Dr. Andrea McKee, to continue our conversation about lung cancer screening. Dr. McKee is Chair Emeritus and Radiation Oncology and Director of the Lung Screening Program at Lahey Hospital and Medical Center, along with being President of the Rescue Lung Society.

Are you able to outline some of the important aspects of lung screening and how you've been so successful at Lahey?

Dr. McKee:

Well, so just to kind of give the history of what happened at Lahey, when the NLST was published and, there was a group of us looking at each other saying, oh my goodness, this is huge. We've never seen anything like this. You know, I'm a radiation oncologist. I've been treating brain mets and bone mets from lung cancer for decades. And I believed that lung screening was going to prove there would be a mortality benefit proved by the NLST even before it was published because of my experience in treating patients with stereotactic body radiation therapy. I started using SBRT for medically inoperable patients back in 2006. And I was seeing these stage I lung cancer patients who were really ill, like in a wheelchair and, you know, having significant COPD. Yet they were living longer than my otherwise totally healthy patients who were in their 50s jogging but had stage IV lung cancer. And so I became a believer then. And so we at Lahey were really anxious to translate that mortality benefit into clinical practice. It was really hard to sit and counsel a patient with brain mets who was a screening candidate, knowing that if we had screened them a couple of years prior, then we wouldn't be having this conversation or we'd be unlikely to be having this conversation.

And so we worked together to petition our administration to be able to offer the exam at no cost to patients who were at high risk for lung cancer. So we did community benefit or free CT lung screening for patients who met the NCC and high-risk criteria. And in order to be able to run this program, we knew that there were certain things that we would need to have to be able to safely do lung cancer screening.

One of those things was we needed a database to be able to track the findings so that we could categorize them and evaluate quality within the screening program and make sure that they came back. Our administration said if you're doing this for free, you better make sure that no one, you know, is told of a nodule and then they get lost to follow-up. And so we developed a relational database to track the findings. We developed Lung-RADS, as I mentioned, to categorize the findings to feed the database so that we could keep track of when people needed to come back and when they were due for their annual exam.

We needed primary care to be engaged. So we did an entire CME event or multiple events. We basically would meet with any practice in and around our hospital organization who would agree to meet with us to make sure they understood this is what we're doing. We're using this Lung-RADS system. We're tracking the patients. You don't need to worry about any of this work in the radiology side of things. You just need to counsel the patients about smoking cessation, and you have to go over the risks and benefits of screening with them. And we created materials that they could use in the office to be able to do so.

We have made all of these materials available and resources to help start programs on the Rescue Lung.org website, which is the Rescue Lung Rescue Life website, as well as other pieces of information. So check out the website because it definitely can help centers who are trying to develop their lung cancer screening programs.

So those are sort of the elements that we consider to be critical, as well as the physician champions who run the program, the database, the navigator, and an engaged primary care base.

And now I've come to learn that there really kind of needs to be one other piece that goes with the CME campaign, but it's fighting some of the misinformation that has been out there about lung cancer screening. Fighting that, you know, false positive misconception of being 96 percent. You really need to have people in your program who can correct that. I remember I was at a Grand Round once at Lahey and one of the pulmonologists stood up and quoted that 96 percent false positive rate. And as much as I did not want to call out one of my colleagues at Grand Rounds, I could not allow that misconception to be had amongst the medical community. And so we had to say, no, that's not correct. Because I can tell you this at a conference, and if you go back into the medical literature and see that it's published, you end up feeling conflicted. So we've actually been trying to correct the medical literature by asking that, the 100 incorrect articles that are out there are about the false positive rate issue corrections or errata to get this straight in the medical literature.

Dr. Sands:

That's a great way to wrap our discussion, I want to thank my guest, Dr. Andrea McKee, for joining me today. Dr. McKee, absolute pleasure having you on the program.

Dr. McKee:

Well, thank you, Jacob. It's been a pleasure talking with you.

Dr. Sands:

I'm Dr. Jacob Sands. To access this and other episodes in our series, visit reachmd.com/projectoncology, where you can be part of the knowledge. Thanks for listening.