Data Brief
July 2017

CPCRN Cancer Prevention and Control Research Network

Tobacco & Lung Cancer Screening in Federally Qualified Health Centers

Results from a national survey

While prevalence of tobacco use has declined over the past decade, rates have remained steady and have even increased among some socially and economically disadvantaged populations. Studies have also shown that lower-income cigarette smokers suffer from more diseases, such as lung cancer, than smokers with higher incomes. In August 2016, the Cancer Prevention Research & Control Research Network (CPCRN)—a network of academic, public health, and community partners—conducted a national survey of Federally Qualified Health Centers (FQHCs) to better understand their tobacco cessation and lung cancer screening practices. Of 258 invited, a total of 112 FQHCs completed the survey, representing 48 states.

Why This Study Matters?

FQHCs provide comprehensive health services to economically disadvantaged populations in rural and urban communities across the United States. They are the health care home for more than 24 million people, most of whom are uninsured or Medicaid recipients and have incomes below the Federal Poverty Level.

A recent study reported that the overall prevalence of tobacco use is 25.8% in FQHCs vs. 20.6% in the general population.[1] Better understanding the tobacco and lung cancer screening capabilities of FQHCs can guide efforts to target resources where they are needed most, and help FQHCS meet tobacco-relevant recommendations made by the U.S. Preventive Services Task Force (USPSTF) (see Fig. 1).

Fig. 1 USPSTF Tobacco & Lung Cancer Screening Recommendations

GRADE A (Service recommended):
Clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and U.S. Food and Drug Administration (FDA)–approved pharmacotherapy for cessation to adults who use tobacco.

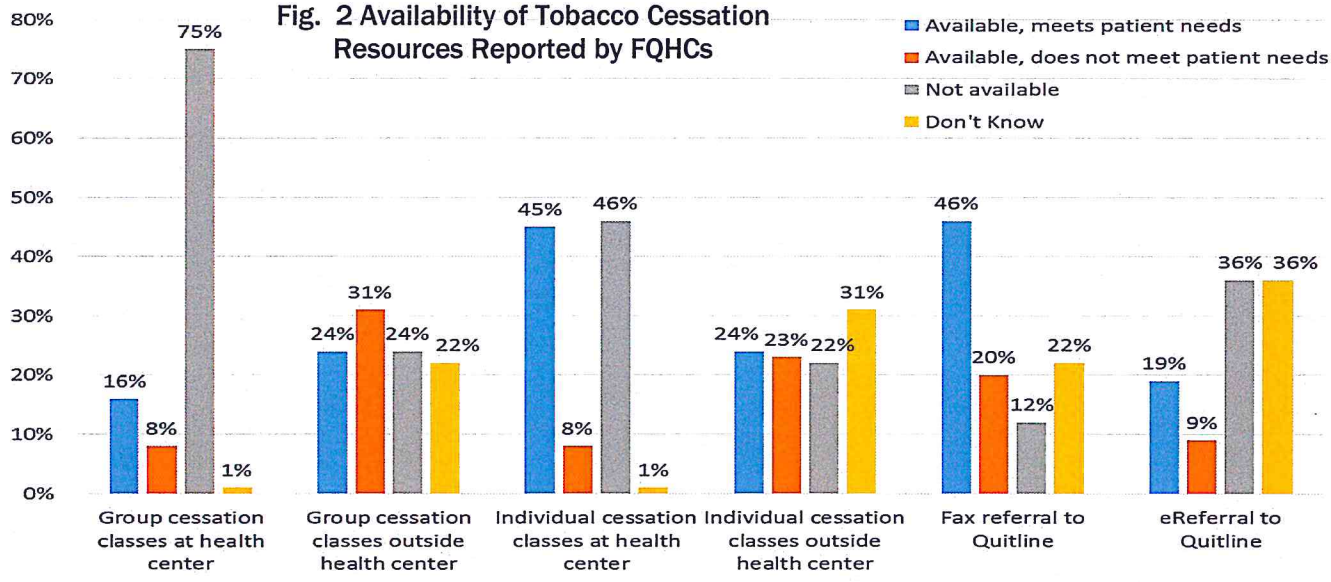
GRADE B (Service recommended) :
Recommends annual screening for lung cancer with low-dose computed tomography (LDCT) in adults aged 55 to 80 years with a 30 pack-year smoking history, and currently smoke or have quit within the past 15 years.

Tobacco Assessment & Assistance

- All respondents have an electronic health record (EHR)
- 79% use an EHR clinical alert to document tobacco use
- 86% document "packs per day"
- 51% document year/age the patient started smoking and 58% collect year/age the patient quit smoking

Documentation of current tobacco use and the amount smoked is good overall, however, few FQHCs are documenting tobacco information needed to inform lung cancer screening eligibility. FQHCs reported the availability of tobacco cessation resources and the degree to which they meet the needs of patients (see Fig. 2).

Fig. 2 Availability of Tobacco Cessation Resources Reported by FQHCs

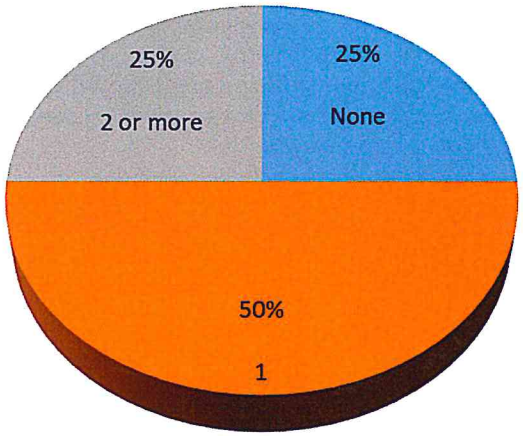


Healthy Neighborhoods
Prevention Research Center for Healthy Neighborhoods at Case Western Reserve University

Tobacco Cessation Resources

As shown in Fig. 3, FQHCs varied in having tobacco cessation resources that met their patients' needs. A full quarter reported not having any tobacco cessation resources available that meet the needs of their patients. We examined if there were differences between three groups of FQHCs: two or more resources, one resource, or no resources that met the needs of patients. There were no differences among those groups in perceived barriers to providing tobacco cessation assistance. There were also no differences in the use of EHR best practice alerts for tobacco use. Those with two or more resources were more likely to rate smoking data as very accurate (67% v. 61% vs. 54%), but this was not statistically significant. Those FQHCs that had two or more resources were significantly more likely to use the smoking data for population-based outreach (39% vs. 24% vs. 8%, p<0.001).

Fig. 3 Number of Tobacco Cessation Resources That Meet Patients' Needs



Barriers to Cessation Assistance

Participants were asked to rate potential barriers to offering cessation assistance to patients. Those that were most frequently noted as a major barrier included:

- Lack of insurance coverage (36%)
- Limited transportation (28%)
- Coverage of services varies by insurance type (26%)
- Language barriers (24%)

Lung Cancer Screening Key Findings

A total of 110 respondents completed the lung cancer screening portion of the survey. A total of 47 FQHCs reported that providers offer at least some LDCT for lung cancer screening. The estimated number of patients screened per month, however, is low (see Table 2).

Table 2 Frequency of Lung Cancer Screening among FQHCs That Offer Any (n=47)

Number of Lung Cancer Screenings per Month	% of Respondents
<5	45%
6-10	6%
11-24	4%
25+	2%
Don't Know	43%

Barriers to Lung Cancer Screening

Major barriers to providing lung cancer screening to patients included:

- Lack of insurance coverage (72%)
- The need for prior authorization (58%)
- Transportation challenges (54%)

Only 12% of sites indicated senior leadership had made lung cancer screening a priority, and 13% reported leadership had committed resources to screening. Notably, just half of responders felt their site has adequate access to specialty providers to adequately manage abnormal findings.

Implications for FQHCs

- Ensuring that all FQHCs have at least one tobacco cessation resource that meets the needs of patients is a high priority.
- Lack of insurance and administrative challenges resolving coverage / authorization are barriers to offering services for both tobacco cessation and lung cancer screening.
- More complete documentation of tobacco history is necessary to determine lung cancer screening eligibility.
- Broad adoption of screening may not be appropriate in this setting unless patient financial burdens are reduced and appropriate management of abnormal findings can be ensured.

Methods:
FQHCs were selected from 2013 Uniform Data Systems (UDS). A random sample of 299 FQHCs were drawn from all health centers with a reported tobacco use prevalence greater than the median. In the survey, medical directors, CEOs, or equivalent personnel were asked to describe current tobacco cessation and lung cancer screening practices at their health center. They were probed on the use of an EHR, availability of cessation resources, and their center's capacity to conduct lung cancer screening with low dose computed tomography (LDCT). Invitations to participate were sent by email, and 112 individuals completed the survey. This study was approved by Case Western Reserve University IRB .

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