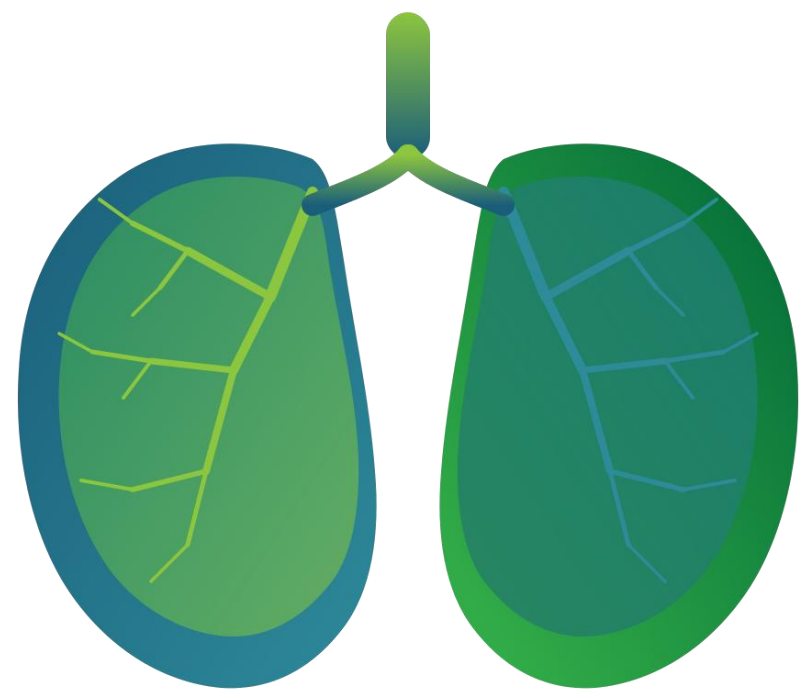


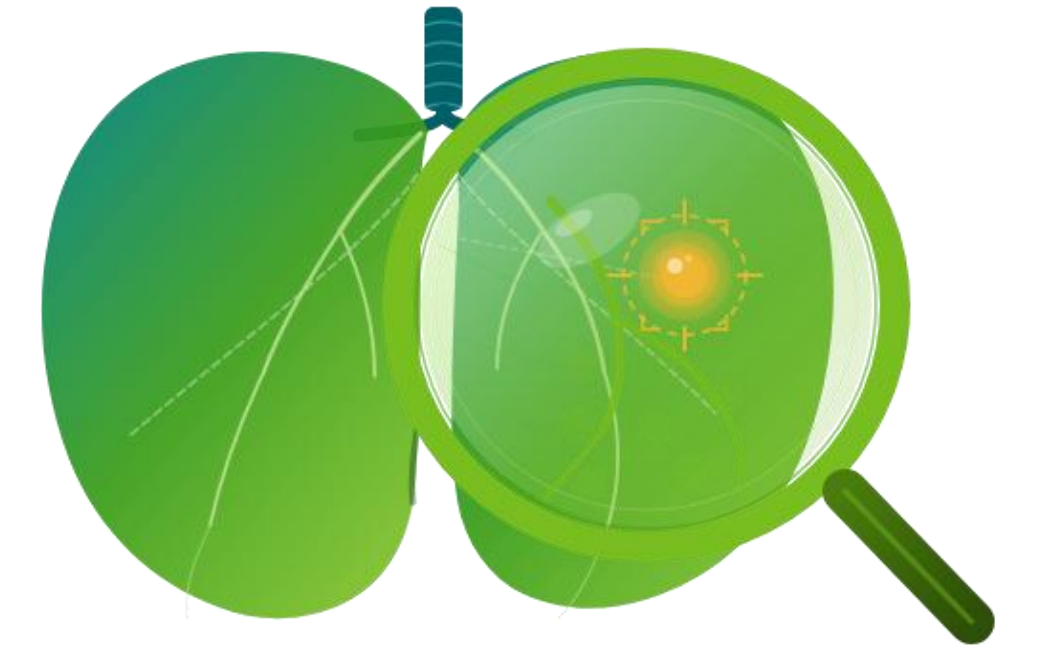
Background



Lung cancer is the leading cause of cancer death with 229,410 new cases and 124,990 deaths expected in 2026.¹

The United States Preventive Services Task Force (USPSTF) recommends annual lung cancer screening (LCS) with low dose CT (LDCT) for adults aged 50-80 with a 20-pack year or greater smoking history.^{2,3,4}

Screening can reduce the death rate by 20% due to early detection, but only about 5% of recommended patients complete screening.⁵



Methods

Five health care organizations (HCOs) partnered with AMGA to improve early detection and diagnosis of lung cancer through multi-level interventions. Electronic health record (EHR) data on screening rates and new lung cancer diagnosis data were collected following a pragmatic measure specification aimed at standardizing submissions across HCOs.

Patients aged 50-80 with a documented primary care provider and current or former smoker status were included. Pack years data was an optional variable for data submissions given lack of structured field within the EHR for data capture or low confidence in validity of data.

Data were submitted by quarter for the period July 2024- September 2025. Future data submissions will include data by quarter from October 2025-June 2026. Measures were submitted for the overall population and stratified by patient demographics and ordering provider, where available.

Insights & Interventions

Figure 1: Smoking History Documentation

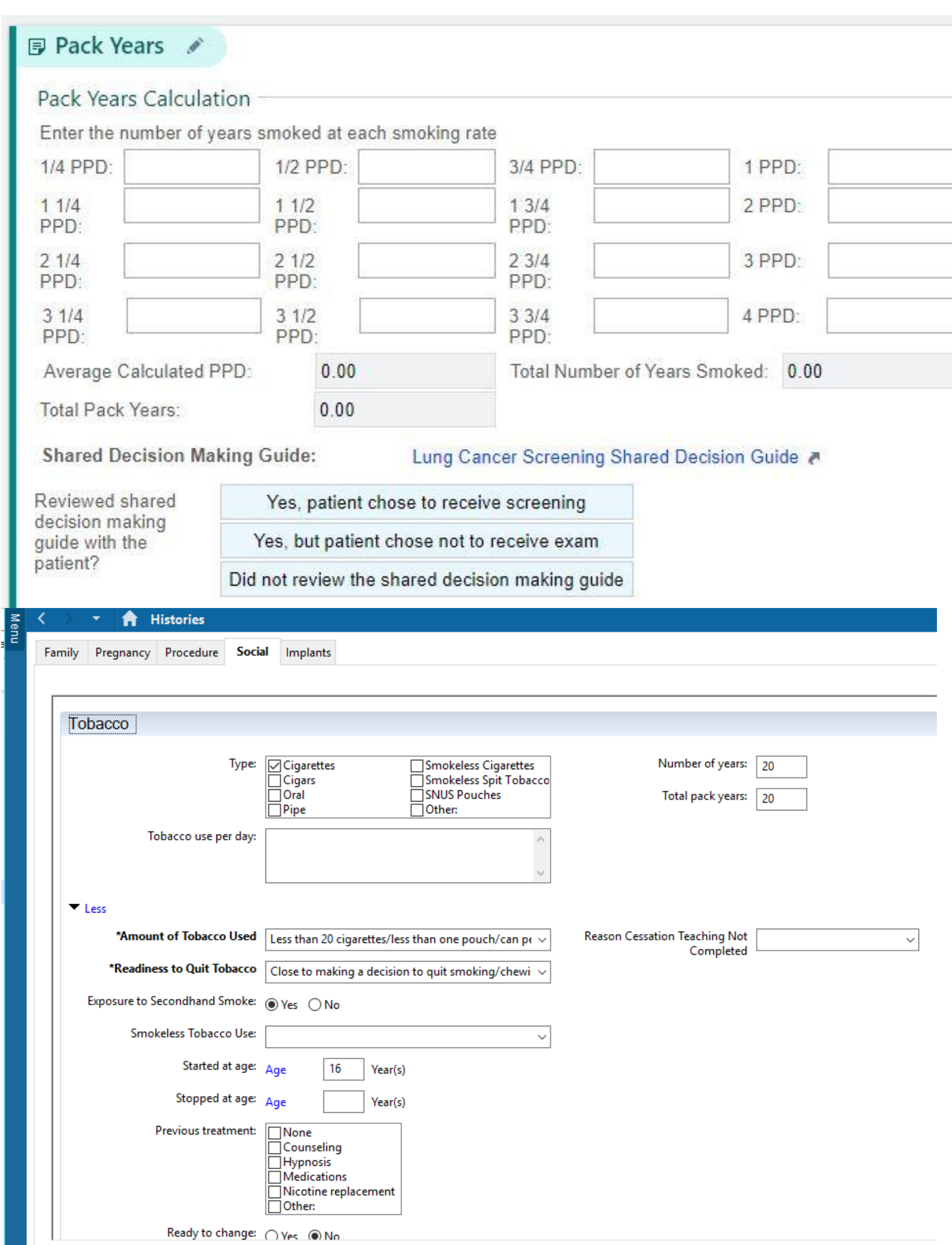
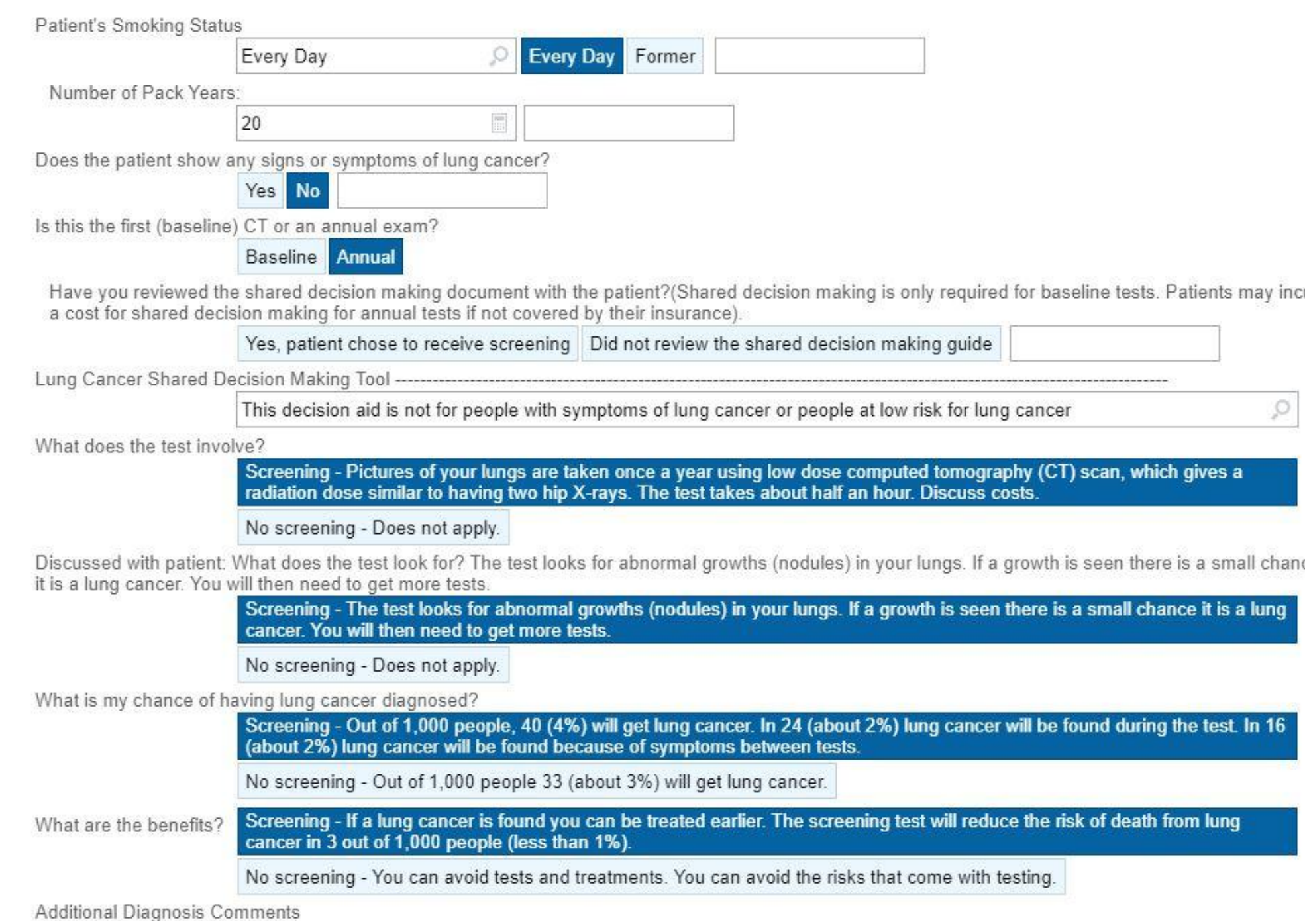
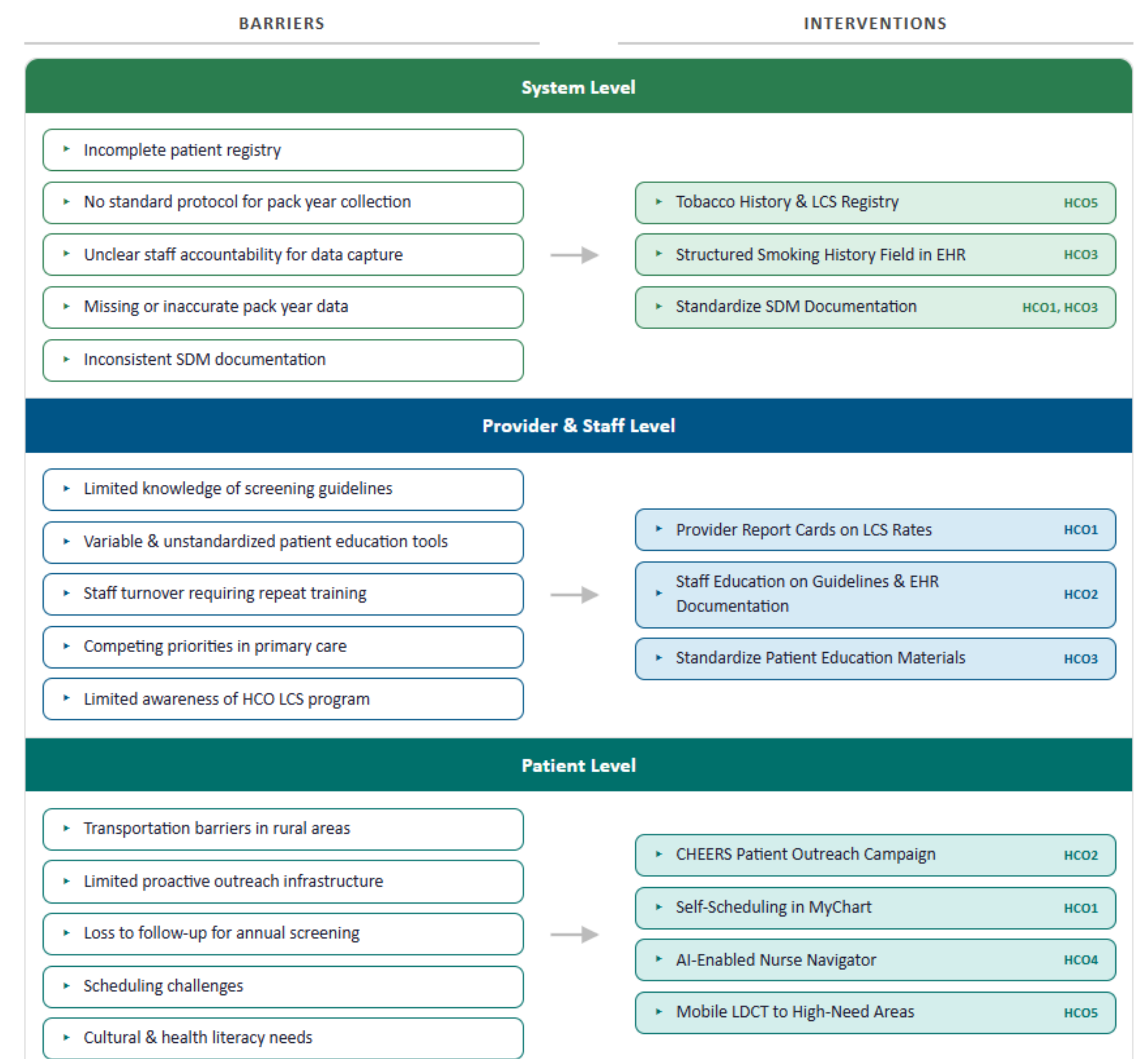


Figure 2: Shared Decision-Making Documentation



- Reliable or available pack-year and shared decision-making documentation are foundational barriers to scaling and measuring impact of interventions.
- Smoking history is complex, particularly in time pressured primary care settings.
- Discordance between USPSTF and Centers for Medicaid and Medicare Services criteria complicates standardization of screening.

Figure 3: HCO Barriers and Targeted Interventions



Results

Screening rates for current smokers ranged from 8%-31% with similar rates by sex and varied by HCOs across insurance types.

Screening was highest for patients aged 65-77 (8-35%) with 3-10% lower rates for patients aged 50-64 at 3 of the 4 HCOs and lowest for patients aged 78-80.

Black and Hispanic patients had lower screening rates compared to White and Non-Hispanic patients.

Rates for former smokers were lower overall (range 4-14% across HCOs). Subgroups trends were similar as in current smoker group but higher screening rates for Medicaid patients.

Figure 4: LCS Rates, Current Smokers

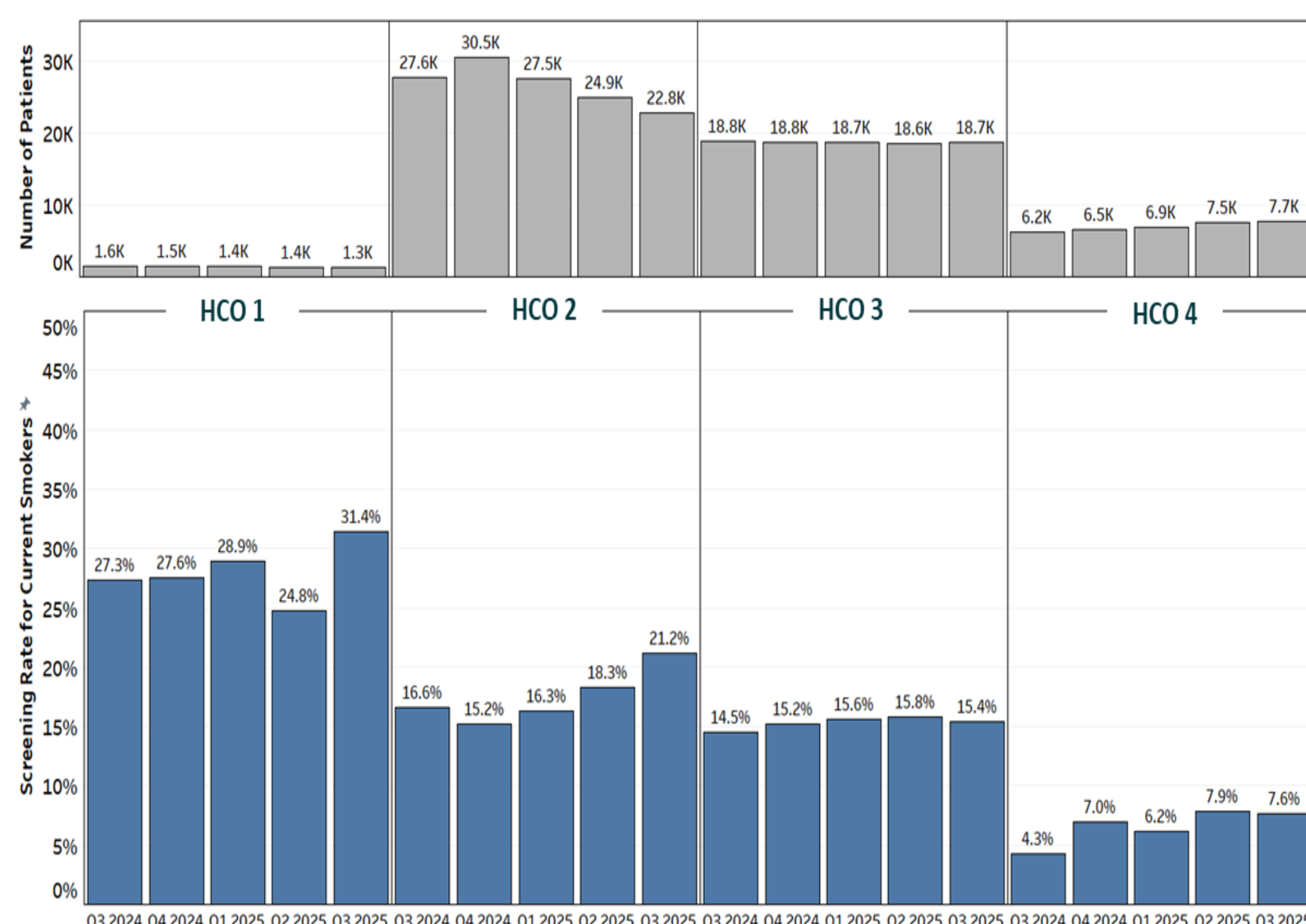


Figure 5: LCS Rates, Current Smokers with and without EHR pack years data (HCO 3)

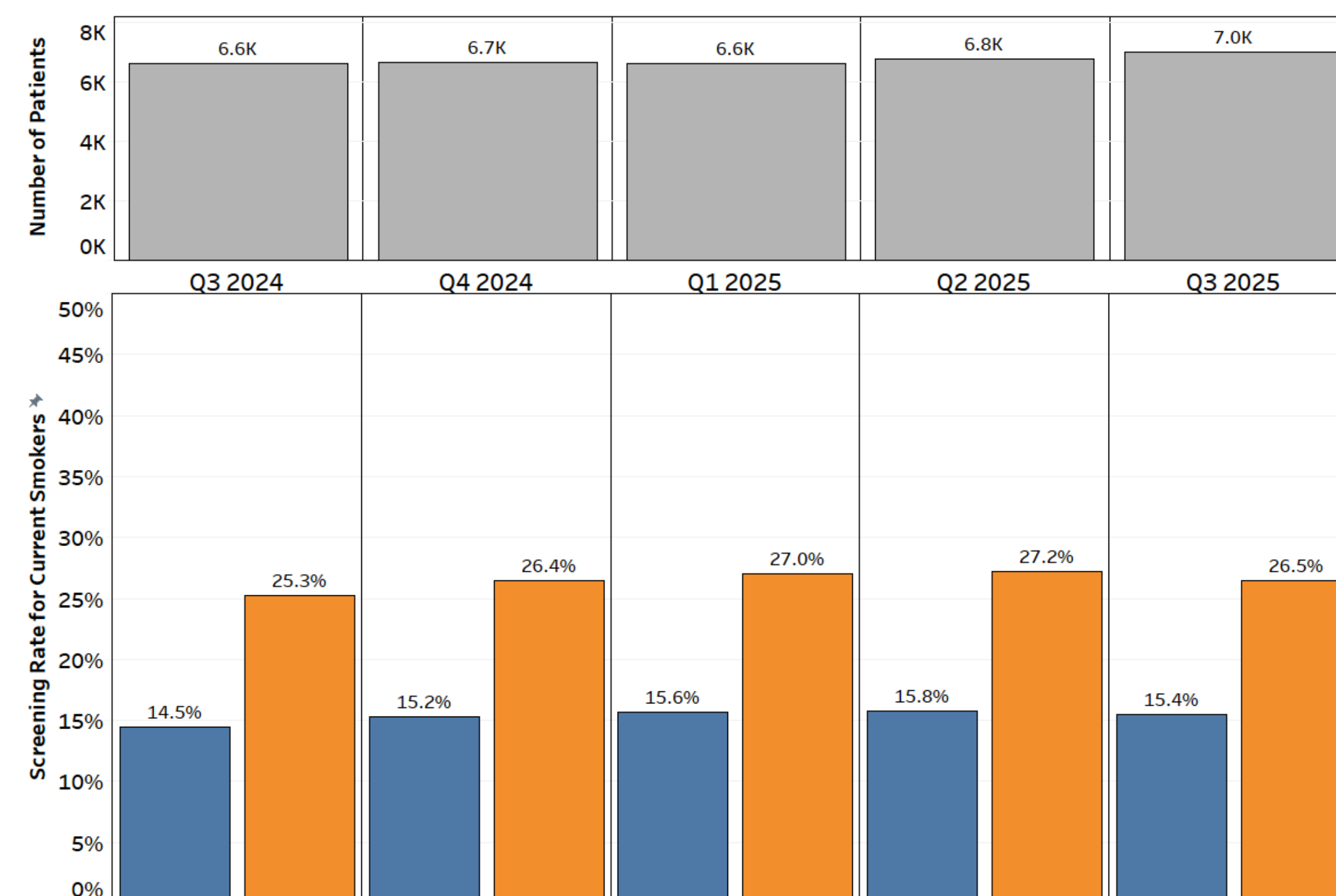
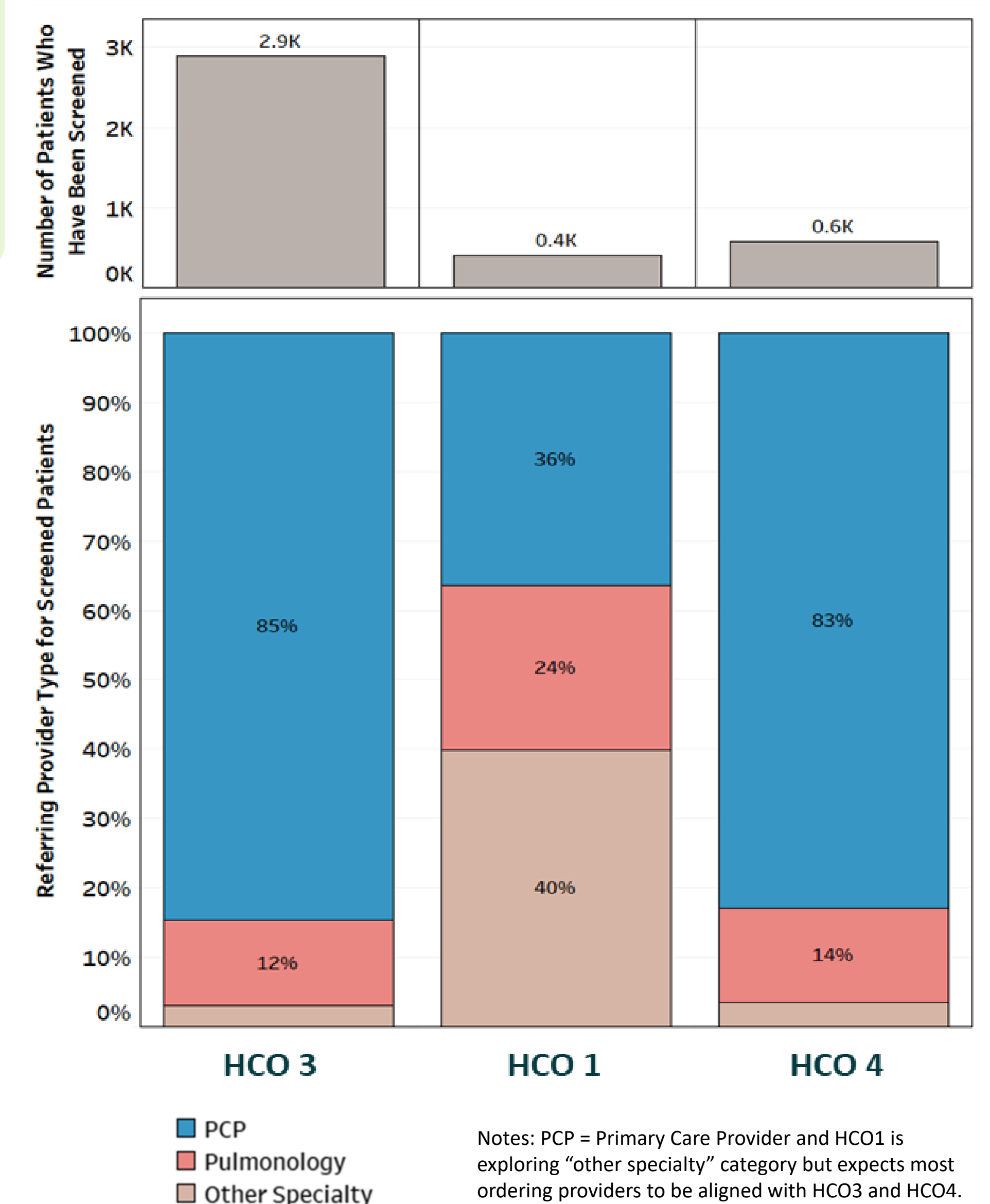


Figure 6: LCS by ordering provider (Q3 2025)



Conclusions & Future Steps

- Accurate LCS eligibility data is essential for identifying appropriate patients, tracking quality improvement efforts, and supporting clinical data integration and monitoring.
- Sustainable LCS improvement requires coordinated, multi-level strategies spanning EHR infrastructure, provider education, and patient outreach.
- Post implementation data, metrics on intervention uptake, and further learnings on intervention adaptations are expected by December 2025.

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Conflicts of Interest. All authors declare no conflicts of interest.

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References:

