Expanding reach, enhancing capacity: embracing the role of primary care in lung cancer screening and smoking cessation in the United States

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A major update has just been released regarding the proportion and number of cancer cases and deaths attributable to potentially modifiable risk factors in the United States.[1] We are not particularly surprised to note the increasing impact of smoking on the prevalence of lung cancer, given documented minimal changes in smoking rates in middle-aged and older adults in the past decade.[2]

Presently, 85.6% of lung cancer cases are attributed to cigarette smoking, making it the leading cause of lung cancer incidence (estimated over 195,000 cases in 2019) in both men and women.[1] Furthermore, cigarette smoking is responsible for 86% of all lung cancer deaths in adults 30 years and older, translating to over 40% of all cancer deaths attributable to known risk factors.[1] In our assessment, the updated report not only comes at a critical time but also bolsters the impetus to intensify and unify ongoing efforts around achieving the lung cancer screening and smoking cessation objectives of Healthy People 2030 and the Biden Administration's Cancer Moonshot Program.[3,4]

Currently, it is recommended that adults aged 50–80 years with a smoking history of 20 or more pack-years who are current smokers or have quit within the past 15 years undergo annual low dose computed tomography (LDCT) screening.[5] With over 500 million primary care visits in the U.S. annually and more than a third of these individuals likely qualifying for lung cancer screening,[6] it is increasingly important to recognize the essential role of the primary care system as a gateway to lung cancer screening for the majority of the screening-eligible population. We believe that a government and health system priority should include increasing investment in primary care for educating high risk patients about lung cancer screening. An important area of need is building capacity to identify eligible cases and, in areas with centralized lung cancer screening programs, bolstering existing structures for patient referral and/or ordering LDCT screening. In areas lacking a centralized screening program, capacity building is crucial to support primary care providers in conducting shared decision-making visits, including counseling sessions for current smokers, and leveraging external referral networks that patients can access.

Primary care may play a crucial role in accelerating the integration of tobacco use treatment into routine care and reducing the number of adults currently using tobacco. However, an implementation science approach is needed to better understand this role and design effective strategies that support integration into existing primary care work structures, including fully using the care team.[7] Another priority is expanding insurance coverage for nicotine dependency, including smoking cessation counseling and medications.[3] Previously, the Centers for Medicare & Medicaid Services (CMS) recommended providing smoking cessation treatment at radiology imaging facilities for current smokers scheduled to receive LDCT. With the 2022 update no longer requiring this, primary care facilities should be equipped to provide access to interventions and timely referrals.[8] This requires systematically identifying all tobacco users at every visit, strongly urging them to quit, determining their willingness to make a quit attempt, helping them with a quit plan, and scheduling follow-up contact to support their efforts.[9]

With investment, primary care can also bridge existing healthcare access gaps, increasing the proportion of ethnic and racial minority individuals and marginalized/medically underserved communities utilizing cancer prevention and early detection methods. Since 2015, lung cancer screening rates have not exceeded 4.7% for non-White and non-Hispanic or Latino ethnic/racial minorities and 3% for groups experiencing social and economic deprivations.[4] Strategies that expand the existing healthcare safety net and promote community participation and inclusive service delivery, including providing funding for community health workers and/or patient navigators, are promising investment opportunities for reducing health inequalities and increasing patient access and engagement.

Take the Federally Qualified Health Centers (FQHCs), for example. These clinics now number over 1300 and have been providing a healthcare safety net for tens of millions of people in medically underserved areas across America since the Health Centers

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Consolidation Act of 1996.[10] Two unique characteristics make these clinics particularly relevant in government efforts to guarantee access to recommended evidence-based preventive care. First is their strong focus on preventive health and primary care. Second, their unique funding mechanisms—including the sliding fee scale model, federally guaranteed funding under Section 330 of the Public Health Service Act, and enhanced reimbursement rates for Medicare and Medicaid services—ensure access to comprehensive preventive care for a broader low-income population, including Medicare and Medicaid beneficiaries.[10] With expansion and financing of FQHC infrastructure, including workforce development and training, we believe that more medically underserved populations can be reached with tested, evidence-based smoking cessation counseling and treatments, as well as lung cancer screening.

Contributors

EE conceptualized the comment. EE, DTN, and IUA wrote the comment while JME reviewed and edited it.

Declaration of interests

We declare no competing interests. The views and opinions expressed here are those of the authors only and do not necessarily represent those of their affiliated institutions.

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