Lung Cancer Screening in Maine:

Annual Survey Summary

August 2025

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Acknowledgements

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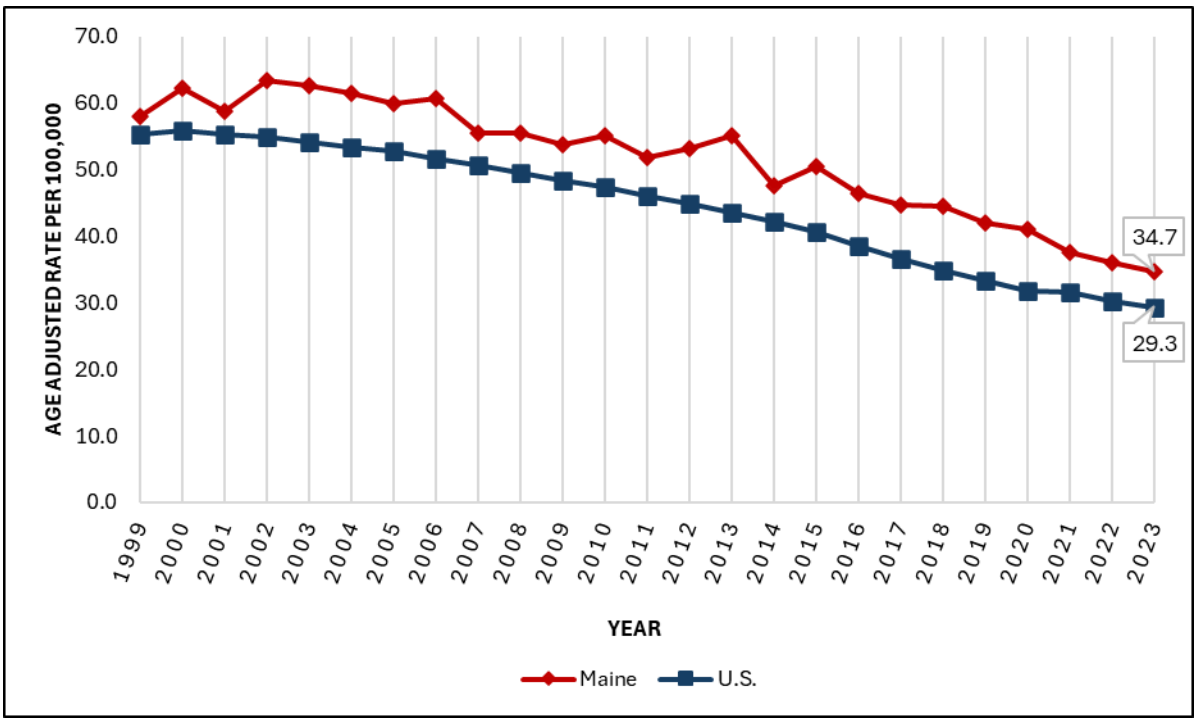
Participating Facilities by County
Androscoggin
Central Maine Medical Center
St. Mary's Health System
Aroostook
Northern Maine Medical Center
Cumberland
Bridgton Hospital
MaineHealth Maine Medical Center
MaineHealth Mid Coast Hospital
Northern Light Mercy Hospital
Franklin
MaineHealth Franklin Hospital
Hancock
Mount Desert Island Hospital
Northern Light Blue Hill Hospital
Northern Light Maine Coast Hospital
Kennebec
Maine General Medical Center
Northern Light Inland Hospital
Knox
MaineHealth Pen Bay Hospital
Lincoln
MaineHealth Lincoln Hospital
Oxford
Rumford Hospital
Penobscot
Millinocket Regional Hospital
Northern Light Eastern Maine Medical Center
Penobscot Valley Hospital
St. Joseph Hospital
Piscataquis
Northern Light Mayo Hospital
Somerset
Northern Light Sebasticook Valley Hospital
Redington-Fairview General Hospital
Waldo
MaineHealth Waldo Hospital
Washington
Calais Community Hospital
Down East Community Hospital
York
MaineHealth Pulmonary and Sleep Medicine
York Hospital

INTRODUCTION

This summary analyzes the findings from the ninth annual Maine Lung Cancer Screening Survey, highlighting the impact of lung cancer throughout the state. With Maine's population of around 1.4 million residents and 3,438 reported cancer deaths in 2023[1], cancer remains one of the leading causes of death in the state. Annual rates of lung cancer deaths in Maine from 1999-2023 show a steady decline, dropping from a high of 63.5 per 100,000 people in 2002 to 34.7 per 100,000 people in 2023 (Figure 1). Yet, Maine's lung cancer death rates remain significantly higher than the U.S. rate of 29.3 per 100,000 (Figure 1). With advances in early detection and treatment of lung cancer, we may continue to see a decline in lung cancer deaths.

Figure 1. Annual Rates of Lung and Bronchus Cancer Deaths, Maine and U.S., 1999-2023



In March 2021, the U.S. Preventive Services Task Force (USPSTF) issued a final recommendation statement on clinical guidelines for lung cancer screening.[2] Their current recommendation is summarized in the chart below.

Population	Recommendation	Grade = B
Adults Aged 50-80, with a History of Smoking	The USPSTF recommends annual screening for lung cancer with low-dose computed tomography (LDCT) in adults aged 50 to 80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.	The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.

Cancer screening is considered a preventive service and health insurance plans generally cover lung cancer screening and most at 100 percent. It is noted, however, that some services associated with the screening service may involve out-of-pocket costs.[3]

METHODOLOGY

Since 2016, the Maine CDC Comprehensive Cancer Control Program (MCCCP) has conducted an annual survey to determine which facilities in Maine are providing the recommended LDCT lung cancer screening. MCCCP continues to partner with the Maine Lung Cancer Coalition (MLCC) to develop the survey, benefiting from their guidance and expertise in developing survey questions and establishing connections with facilities.

The survey includes core questions to assess where LDCT lung cancer screenings were taking place in Maine, how many individuals had been screened during the previous year, population data, perceived barriers to lung cancer screening, and how many facilities are screening outside of regular business hours. (See Appendix A for the 2025 survey tool.) All survey answers were shared with the MLCC with permission from all survey respondents.

In January 2025, the ninth annual Lung Cancer Screening Survey was emailed to 36 imaging centers across Maine. Prior to distribution, the availability of imaging services at each facility was confirmed, and any necessary updates to contact information were made. While some facilities provided imaging services, not all offered lung cancer screening during 2024. However, they were encouraged to participate in the survey and provide answers to key questions to identify barriers that could potentially be addressed through staff education, policy, systems, environmental changes, and/or access to relevant supportive resources. All imaging facilities were sent a gentle reminder on March 20, 2025, encouraging their participation in the survey before it closed in April 2025. A total of 28 facilities were able to provide responses to the survey this year.

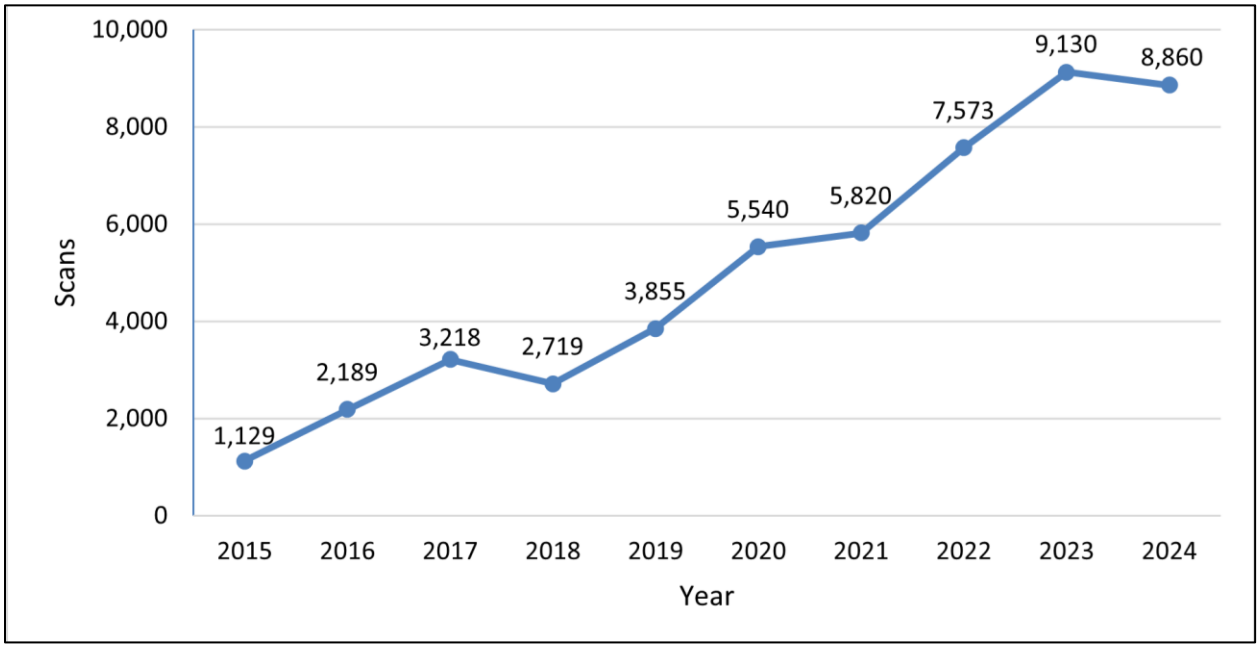
SURVEY FINDINGS

Facilities Providing Lung Cancer Screening

Each year, some facilities are unable to provide data on baseline, follow-up screenings, and/or positive screenings, while others have not been able to break down their data by sex. Therefore, any of the following data are only estimates and may not add properly due to missing data.

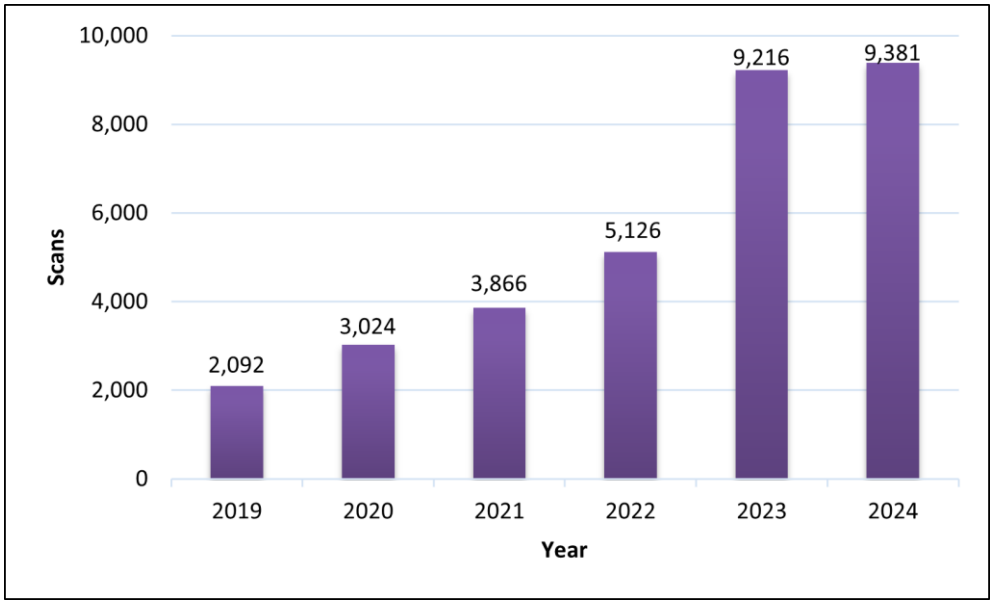
The current 2025 survey had a total of 28 facility responses, all reporting that they were providing LDCT lung cancer screening during 2024. Of those, 25 facilities were able to offer data on those screenings. Based on the data acquired, 8,860 individuals had a baseline LDCT screening for lung cancer during 2024. Penobscot County provided approximately 35 percent of the baseline screenings, having screened 3,120 individuals. Figure 2 represents those facilities that were able to provide baseline LDCT lung cancer screening data.

Figure 2. Reported Baseline LDCT Lung Cancer Screening



Twenty-two of the facilities were able to breakdown their baseline screenings by sex and reported that approximately 3,478 males (53.2%) and 3,060 females (46.8%) were screened for lung cancer. Twenty-one facilities reported performing approximately 9,381 annual follow-up screenings for lung cancer (Figure 3), which is up considerably over the last several years. Of the estimated lung cancer screenings (both baseline and annual follow-up), twenty facilities reported approximately 222 LDCT screenings (1.2%) resulting in a lung cancer diagnosis during 2024.

Figure 3. Annual Follow-up Lung Cancer Screening

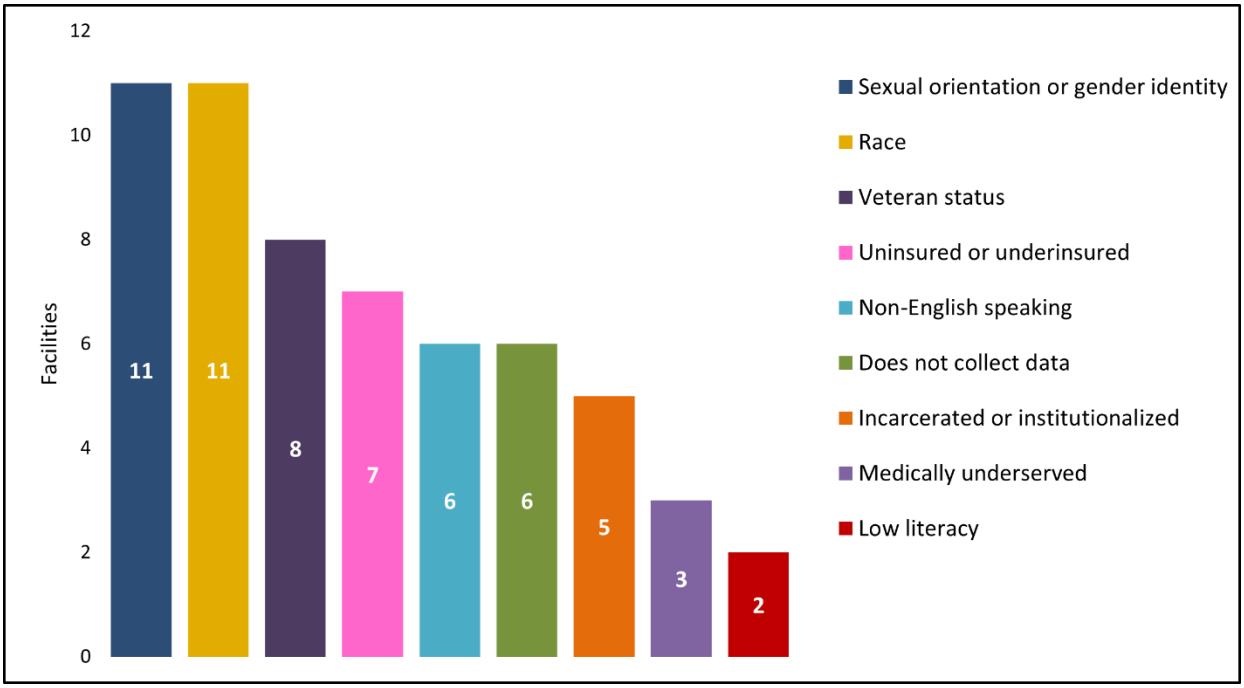


Facilities were asked about the types of population data they collect to assist in addressing disparities. They were given the option of selecting as many answers as were applicable (Figure 4). In response, 11 facilities reported collecting data on race and sexual orientation and/or gender identity, eight on veteran status, and seven on uninsured or underinsured patients. Six facilities gathered data on non-English speakers, while five facilities indicated collecting information on incarcerated or institutionalized individuals. Three facilities reported collecting data on those medically underserved and two captured information on low literacy. Of the 21 facilities providing a response, seven facilities responded as not currently collecting data on any populations with one responding unknown. Identified barriers preventing collection of data on populations included electronic medical record (EMR) limitations or staffing capacity, while others were unsure as to why they couldn't collect these data.

Availability of lung cancer screening appointments outside of normal business hours (e.g., before 8:00am, after 5:00pm, weekends, and/or holidays) was asked in the survey with 16 facilities responding that they do. This metric did not change from last year, the first year in which it was asked. Barriers of access and transportation may be reduced as more facilities consider adding availability outside normal business hours. Of those who reported offering hours outside of normal business hours, ten reported offering early appointments, ten late appointments, and eleven on weekends.

When asked about the most helpful patient education and counseling resources to explain the benefits and risks of lung cancer screening (noting the lack of patient knowledge as a main barrier), facilities cited printed materials as having the most potential to assist, with patient portal communication and Public Service Announcements also referenced at a higher rate.

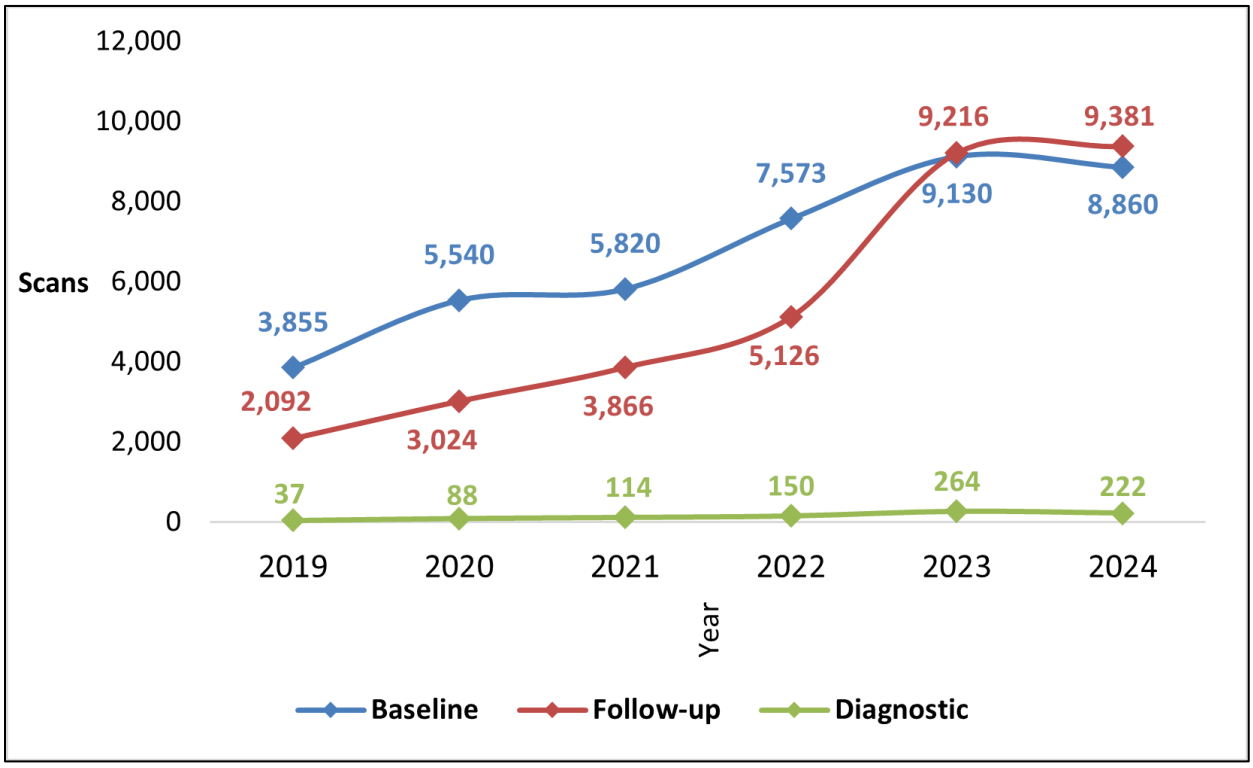
Figure 4. Facilities Collecting Population Data



Lung Cancer Screening

Lung cancer screening has been affected by various factors. With the introduction of expanded guidelines from the USPSTF and the adoption of hybrid care strategies, there has been an increase in lung cancer screening rates (see Figure 4). The updated USPSTF screening guidelines offer potential benefits for improving survival rates by detecting lung cancer earlier when treatments are more likely to be effective. This could lead to ongoing reductions in late-stage lung cancer cases in the future, ultimately decreasing both the number of people affected and the number of lives lost to the disease. Figure 5 provides visual data spanning the past six years of the lung cancer screening survey to illustrate trends in screening.

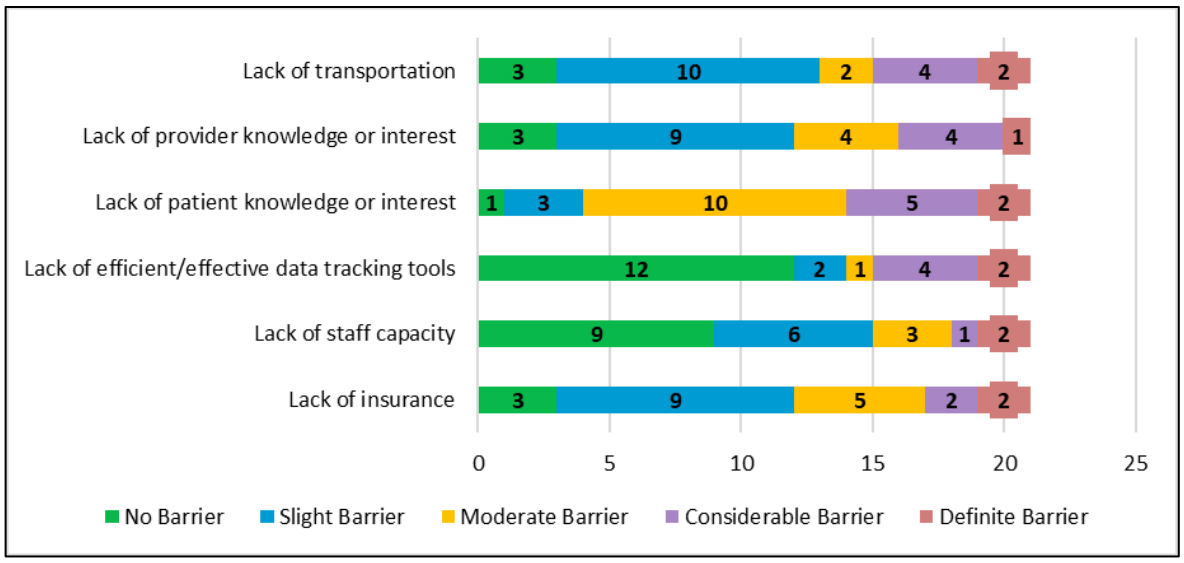
Figure 5. Lung Cancer Screening, Maine, 2019-2024



Reported Barriers to Providing Lung Cancer Screening Services

The survey has employed a Likert Scale to assess the degree to which each barrier to LDCT lung cancer screening was identified as an issue for facilities. Figure 6 includes responses from all 28 facilities regardless of whether they are screening for lung cancer. “Lack of patient knowledge or interest” continues to be identified as at least a “Moderate Barrier” for many facilities. The next set of barriers identified with at least a “Slight Barrier” were “Lack of provider knowledge or interest,” “Lack of transportation,” and “Lack of insurance.” Barriers to “Staff Capacity” and “Lack of Insurance” appear to have lessened over the years but remain for some. Facilities have continued to report fewer “Definite Barriers” over the nine years of the survey.

Figure 6. Reported Barriers to Lung Cancer Screening, 2024



Screening and Tobacco Referral

Smoking cessation is an important aspect of the lung cancer screening process. It is recommended that health care providers engage in a brief intervention at every visit with their patients who use tobacco. Asking all patients about their tobacco use and advising them to stop using tobacco has been cited as an important motivator for making a quit attempt.[4] Nine of the facilities reported that they do refer current smokers to tobacco cessation, five responded that they do not, and seven replied that they were "Unsure". Of the nine facilities that do refer, the health care provider or the screening facility makes the referral to their own in-house cessation services or services such as the Maine QuitLink (1-800-QUIT-NOW).

CONCLUSION

This summary report of the ninth annual survey highlights the responses from 28 facilities providing LDCT lung cancer screening in Maine during 2024. Lung cancer continues to be one of the most common cancers in the U.S. and in Maine. It is estimated there will be 1,460 new lung cancer cases and 830 lung cancer deaths in Maine during 2025.[5] Screening of high-risk individuals using current recommended guidelines could improve survival rates in Maine by finding lung cancer early when treatment may be more successful. Increasing the hours of availability outside of normal business hours may reduce barriers to access for patients. Lack of patient knowledge as a barrier may be reduced with print and other communication resources.

References

1. U.S. Cancer Statistics Working Group. U.S. Cancer Statistics Data Visualizations Tool. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute; https://www.cdc.gov/cancer/dataviz, released in June 2025.
2. *Final Recommendation Statement: Lung Cancer: Screening. U.S. Preventive Services Task Force. March 2021.* Available at: https://www.uspreventiveservicestaskforce.org/uspstf/document/RecommendationStatementFinal/lung-cancer-screening
3. National Center for Chronic Disease Prevention and Health Promotion; Division of Cancer Prevention and Control; https://www.cdc.gov/lung-cancer/screening/index.html
4. National Center for Chronic Disease Prevention and Health Promotion; Office on Smoking and Health; https://www.cdc.gov/tobacco/hcp/patient-care-settings/clinical.html
5. *American Cancer Society. Facts & Figures 2025. American Cancer Society. Atlanta, Ga. 2025; https://www.cancer.org/cancer/types/lung-cancer/about/key-statistics.html*

Appendix A: 2025 MCCCP Lung Cancer Screening: Facility Survey

Lung Cancer Screening Survey – 2025

The Maine CDC Comprehensive Cancer Control Program (MCCCP) in collaboration with the Maine Lung Cancer Coalition (MLCC) has been collecting information from lung cancer screening facilities in Maine since 2016. The information is used to monitor emerging practices, barriers, and the extent of availability of lung cancer screening across the state.

This survey is asking for information about screening for lung cancer at your facility during the calendar year 2024. If your facility did provide lung cancer screening during 2024, having your screening data readily available before you begin may help to expedite the survey. If your facility is **not** currently providing lung cancer screening, we would still appreciate your responses to a few of the questions (the survey will skip over the screening questions if done electronically).

The MCCCP continues to collaborate with the MLCC to reduce the number of surveys and questions being asked of lung cancer screening facilities. All information from the survey will be shared with both organizations, but identifiable information will not be distributed outside of these two groups.

GENERAL INFORMATION

1. Contact Information

Your Name: _____

Job Title: _____

Email: _____

Phone: _____

2. Are you reporting on more than one facility? (The survey will loop back in Survey Monkey if reporting on more than one facility. If filling out on paper, please use the "Additional Facility Reporting" document attached in the email to report on each facility separately.)

- ☐ Yes
- ☐ No

3. Facility Information

Name of facility _____

Address: _____

City/town: _____

County _____

4. How long has your facility been providing lung cancer screening?

- ☐ <1 year
- ☐ 2-4 years
- ☐ 5-9 years
- ☐ 10+ years
- ☐ Unknown
- ☐ None of the above

5. Did this facility provide lung cancer screening during 2024?

- ☐ Yes
- ☐ No (skip to question 25 – page 8)

6. Does this facility offer lung cancer screening appointments outside of standard business hours? *(e.g., before 8:00am, after 5:00pm, weekends, etc.)*

- ☐ No
- ☐ Yes (please specify)

7. Does your facility utilize a Patient Navigator or some other designated staff person to coordinate and manage LDCT screening activities? *(e.g., determination of screening eligibility, shared decision-making counseling, scheduling, and follow up?)*

- ☐ Yes, <12 hours per week
- ☐ Yes, 12-23 hours per week
- ☐ Yes, 24-32 hours per week
- ☐ Yes, 33-39 hours per week
- ☐ Yes, 40+ hours per week
- ☐ No (If your answer is "No," please skip to question __.)
- ☐ Unknown Please skip to question __.)
- ☐ Other: _____

SCREENING DATA

Please provide data from your facility for the questions below to the best of your ability (even if this means making a good faith estimate).

8. How many <u>baseline</u> screening LDCTs were performed at your facility in 2024? (NOTE: do not include 6-month follow-up LDCTs performed in response to an abnormal finding on a screening CT.)

Total _____

Males _____

Females _____

9. How many annual <u>follow-up</u> screening LDCTs were performed in 2024 at your facility? (NOTE: do not include 6-month follow-up LDCTs performed in response to an abnormal finding on a screening CT.)

Total _____

Males _____

Females _____

10. How many screening LDCTs <u>resulted in a lung cancer diagnosis</u> at your facility in 2024?

Total _____

Males _____

Females _____

REPORTING LUNG CANCER SCREENING

10. Is your healthcare system accredited for LDCT screening? (Please select all that apply.)

- ☐ Yes, by the American College of Radiology
- ☐ Yes, by the GO2 Foundation for Lung Cancer (Screening Center of Excellence)
- ☐ No
- ☐ Unknown
- ☐ Other (please specify)

11. Does your healthcare system submit data to the American College of Radiology Lung Cancer Screening Registry?

- ☐ Yes
- ☐ No
- ☐ Unknown

12. Does your healthcare system face any barriers surrounding lung cancer screening data submission? (Please select all that apply.)

- ☐ Staffing Limitations
- ☐ EMR Limitations
- ☐ Time Limitations
- ☐ Unknown
- ☐ None
- ☐ Other (please specify)

SHARED DECISION-MAKING

Please answer the following questions about your facility's protocols for shared decision-making.

13. Where does the shared decision-making (SDM) visit take place?

- ☐ At primary care office prior to scheduling scan
- ☐ At our screening site prior to scheduling scan
- ☐ At our screening site on the same day as the scan
- ☐ Other (please specify)

14. Which healthcare provider has primary responsibility for conducting the shared decision-making visit with the patient?

- ☐ Primary care provider
- ☐ Another clinician (such as a specialty office)
- ☐ Clinician or other staff member affiliated with the LDCT screening program (Nurse Practitioner, Patient Navigator, etc.)
- ☐ Other (please specify)

15. Does your health system provide any type of "decision aid" or decision support tool (e.g., written material, software, or web-based program) to patients to help them decide about LDCT screening? (Please select all that apply.)

- ☐ Printed Materials
- ☐ Posters
- ☐ Educational Videos
- ☐ Patient Portal Communications
- ☐ Online Decision Aid
- ☐ Public Service Announcement(s)
- ☐ Unknown
- ☐ None of the above
- ☐ Other (please specify)

16. Which patient education and counseling resources would be most useful to help patients understand the benefits and risks of lung cancer screening? (Please select all that apply.)

- ☐ Printed Materials
- ☐ Posters
- ☐ Educational Videos
- ☐ Patient Portal Communications
- ☐ Online Decision Aid
- ☐ Public Service Announcement(s)
- ☐ Unknown
- ☐ None of the above
- ☐ Other (please specify)

17. Is screening eligibility determined before the patient is screened for lung cancer?

- ☐ Yes
- ☐ No
- ☐ Unknown

SCREENING

Please answer the following questions about lung cancer screening and follow-up at your facility.

18. If people who use tobacco are screened for lung cancer, does the screening protocol include a referral to tobacco treatment services?

- ☐ Yes, through their primary care office
- ☐ Yes, through our screening facility
- ☐ No
- ☐ Unknown
- ☐ Other:

19. Is there a standardized process or care pathway for coordinating appropriate follow-up for patients who have received LDCT screening?

- ☐ Yes
- ☐ No
- ☐ Unknown

20. How is appropriate follow-up care coordinated for patients who have received LDCT screening?
(Please select all that apply)

- ☐ Designated staff person (e.g., nurse, medical assistant, patient navigator)
- ☐ Commercial software program (e.g., LungView) or electronic health record (EHR) tool (e.g., Epic Radiant)
- ☐ Dedicated lung cancer screening data registry
- ☐ Automated (electronic) patient reminder system
- ☐ Unknown
- ☐ None of the above
- ☐ Other (please specify)

21. Who has primary responsibility for coordinating appropriate follow-up for patients with <u>normal</u> LDCT scan results?

- ☐ Referring physician (e.g., primary care physician)
- ☐ Facility staff person (e.g., physician, nurse, medical assistant, patient navigator)
- ☐ Unknown
- ☐ Other (please specify):

22. Who has primary responsibility for coordinating appropriate follow-up for patients with <u>abnormal</u> LDCT scan results?

- ☐ Referring physician (e.g., primary care physician)
- ☐ Facility staff person (e.g., physician, nurse, medical assistant, patient navigator)
- ☐ Unknown
- ☐ Other (please specify)

PATIENT POPULATION INFORMATION

23. Does your electronic medical record capture any of the following population information? (Please select all that apply.)

- ☐ Uninsured or underinsured
- ☐ Incarcerated or institutionalized
- ☐ Medically underserved
- ☐ Race
- ☐ Sexual orientation or gender identity
- ☐ Low literacy
- ☐ Non-English speaking
- ☐ Veteran status
- ☐ Our facility does not currently collect data on any populations

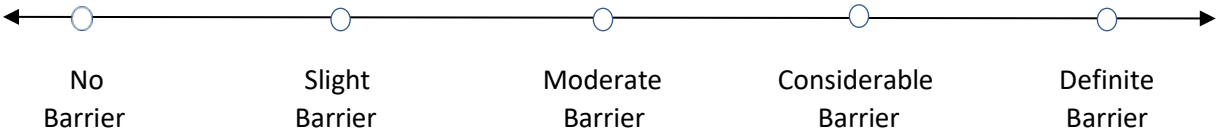
24. What are the barriers to collecting patient population information at your facility?

FINAL QUESTIONS

There are barriers to lung cancer screening that may preclude your facility from being able to provide lung cancer screening. On the other hand, if your facility is providing lung cancer screening, there can still be barriers that make the work challenging. Whichever category your facility falls into, please provide answers to the following topics on barriers to lung cancer screening from your facility's perspective.

What are the greatest barriers to lung cancer screening, and the degree to which each is a barrier?

25. Lack of insurance coverage for patients



26. Lack of staff capacity

27. Lack of efficient/effective data tracking tools

28. Lack of **patient** knowledge or interest in screening

29. Lack of **provider** knowledge or interest in screening

30. Lack of transportation for patients

31. Other (please specify)

32. Is there anything you would like to add?

Thank you for participating in the survey!

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