

**Screening Centers of Excellence Application****Facility Information****Tell us about your program**

- * 1. Month screening program was initiated:

Please select response ▼

- * 2. Year screening program was initiated:

Please select response ▼

- * 3. Please indicate your screening population/criteria: (please check all that apply)

-
- USPSTF (55-80, at least 30 p/y, current smoker or quit within 15 years)
- CMS (55-77, at least 30 p/y, current smoker or quit within 15 years)
- NCCN Category 1a or NLST (55-74, at least 30 p/y, current smoker or quit within 15 years)
- NCCN Category 2a (50 and older, 20 p/y, plus one additional risk factor)
- Other (Please describe in comment box below)

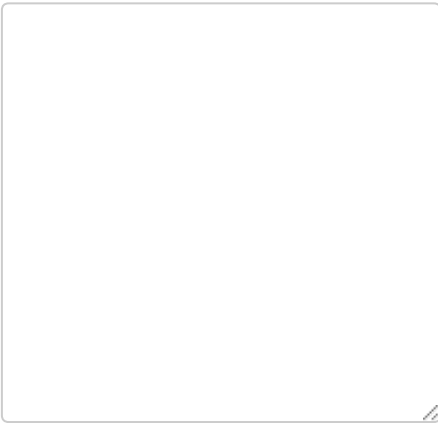
Other:



*
4. Protocol used to guide technical specifications of screening exam and decision-making regarding finding: (please check all that apply)

- ACR LungRADS
- NCCN clinical guidelines
- IELCAP
- Other (Please describe in comment box below)

Other:



Smoking Cessation

*

5. Smoking cessation resources used to refer current smokers: (please check all that apply)

- Group or individual counseling within facility/center
- Group or individual counseling outside of facility/center
- Quitline
- Online resource
- Printed resource
- Other

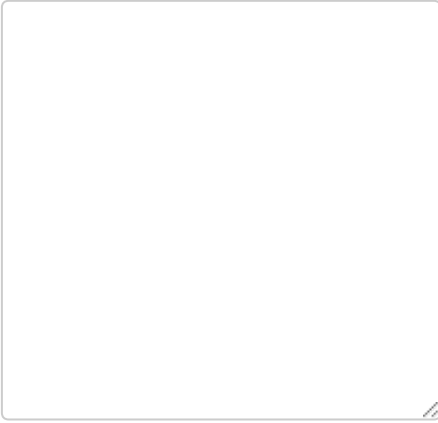
Other:

Online Resources

6A. If you responded that you are providing online resources, please describe: (please leave blank if you do not provide this)

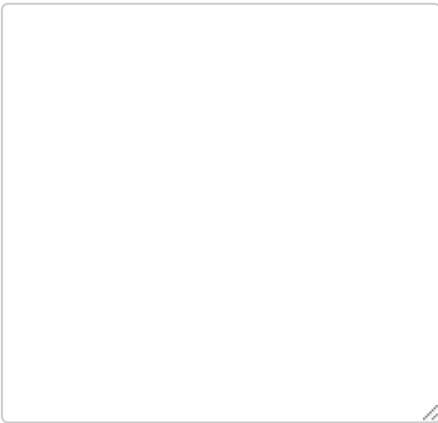
Printed Resources

6B. If you responded that you are providing printed resources, please describe: (please leave blank if you do not provide this)



Other Resources

6C. If you responded that you are providing other resources, please describe: (please leave blank if you do not provide this)

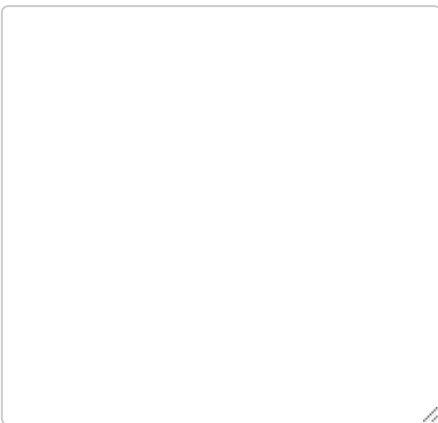


* 7. Does your program conduct any follow-up with smokers referred to cessation services to gauge uptake/success?

Yes

No

8. (Please answer only if you selected "YES" for #7) How does your program conduct follow-up with smokers referred to cessation services to gauge uptake/success?



Multidisciplinary team (MDT)

* 9. Which disciplines are a part of your MDT? (please check all that apply)


- Medical Oncology
- Radiation Oncology
- Thoracic Surgery
- Pulmonary Medicine
- Nursing
- Primary Care
- Other

Other:

* 10. How frequently does your MDT meet?

- Once per week
- Once every two weeks
- Once per month
- Other

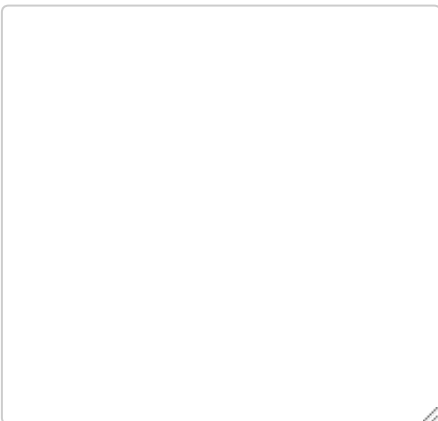
Other:



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11. What (if any) types of screening cases are discussed by the lung cancer multidisciplinary team (MDT)? (please check all that apply)

- None of our screening cases are discussed with the MDT (only diagnoses)
- Lung RADS 4
- Lung RADS 3
- Lung RADS 2
- All screening scans are reviewed by the MDT
- Other

Other:



Patient Education about Risks and Benefits

* 12. For Medicare beneficiaries, how do screening candidates receive the required counseling and shared decision-making visit? (please check all that apply)

- With primary care provider
- With a member of the screening team
- Other

Other:

* 13. Please include a description of what specific risks and benefits are included in patient education resources that your program shares with screening participants.

* 14. For privately insured, do you still require a full counseling and shared decision-making visit?

- Yes
- No

15. If the patient does not have a SDM conversation as part of the referral or if the patient receives SDM outside of your facility, how do you ensure that the screening candidate has received appropriate information on the risk and benefits of screening?

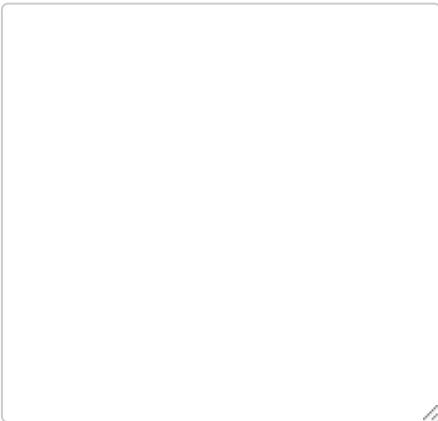


Results Reporting

* 16. How are screening results reported to patients? (please check all that apply)

- By phone
- By mail
- Electronically through EMR
- Through referring provider
- Other

Other:



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17. How are screening results reported to referring providers? (please check all that apply)

- By phone
- By mail
- Electronically through EMR
- By fax
- Other

Other:

*

18. What is the reporting time frame to inform patients/providers about significant positive findings (such as a LungRADS 4 or other urgent incidental finding)?

- Same day
- 24-48 hours
- Within 5 working days/1 week
- Other

Other:

* 19. What is the reporting time frame to inform patients/providers about negative or non-significant findings (such as nodules not needing immediate follow up or less urgent incidental findings)?

- Same day
- 24-48 hours
- Within 5 working days/1 week
- Other

Other:

ACR Lung Cancer Screening Designation

* 20. Has your program applied for or received the ACR Lung Cancer Screening Center designation?

- We have received the designation
- We have applied for but not yet received the designation
- We intend to apply for this designation
- We do not intend to apply for this designation (Please explain below)

We do not intend to apply for this designation (Please explain below):

Attestation

A Screening Center of Excellence will:

- Provide clear information on the risks and benefits of LDCT screening through a shared decision-making process.
- Comply with standards based on best published practices for controlling screening quality, radiation dose and diagnostic procedures.
- Work with or ensure a referral process to a lung cancer multidisciplinary clinical team, including radiologist, pathologists, pulmonologists, thoracic surgeons, oncologists, radiation oncologists and nurses to carry out a coordinated process for screening, follow up and treatment when appropriate.
- Include a comprehensive cessation program for those still smoking or referral to comprehensive cessation programs.
- Report results to those screened and their primary care doctors and transmit requested copies in a timely manner.

* 21. By selecting YES, I indicate that my screening program will continue to screen in the way I have described, that my program will continue to meet the above listed requirements, that I will inform LCA of any changes to my program and that I will be responsive to inquiries from LCA staff about program details and metrics. (If you answer "no" to this question, you will not be eligible to join the Screening Centers of Excellence Network)

Please select response ▼

Title

Please select response ▼

* First Name of Applicant

* Last Name of Applicant

* Position Title of Applicant

* Email Address of Applicant

* Phone Number of Applicant

* Is your facility affiliated with a university or academic medical center?

Contact information for main point of contact at facility: (if different from applicant)

Title

First Name

Last Name

Position Title

Email

Phone Number

Facility Information

* Name of Facility or Center

* Facility address