Show me the money

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Lung cancer screening was approved in the current era in which the concept of cancer screening is increasingly challenged. Barriers to screening have never been higher and include many that are unique to lung cancer, perhaps contributing to its low overall adoption rate. Although obstacles certainly exist at the patient level, undoubtedly provider-level and system-level barriers also exist.¹ For busy thoracic surgeons trying to meet departmental budgets, the main questions regarding establishment of a lung cancer screening program are often, Who is willing to do it? and, Who is willing to support it?

Gilbert and colleagues² from Swedish Cancer Institute provide data to answer those questions. The authors describe the economic influence of a nurse practitioner-directed lung cancer screening program, incidental nodule clinic, and tobacco cessation program. A registered nurse practitioner would seem to be a natural fit to lead such a multipronged program. Although in some institutions, a surgeon, pulmonologist, or radiologist may take the reins, this model makes little sense given the other responsibilities of these physicians, not to mention their salaries (which are often dependent on procedure-based billing). As such, running the screening program is often relegated to a side job. On the other hand, the authors used a single, dedicated nurse practitioner to run all of these clinics. And although the majority of patients (69%) seen in the clinics have negative radiologic studies, many had lung nodules, including 7% of patients who needed further diagnostic procedures. The authors go on to show us the money and to share the information to provide to the administrators who can give us the money. The clinic generated revenue of \$733,336, or roughly \$1057 per patient. Most of this (69%) was from facility fees, whereas the remainder was procedure revenue and outpatient clinic revenue directly to the Division of Thoracic Surgery and Interventional Pulmonology. Although this may not seem spectacular, it at least seems sustainable particularly in light of the remarkable growth

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Central Message

A nurse practitioner-directed lung cancer screening, incidental pulmonary nodule, and tobacco cessation clinic generates significant downstream revenue for hospitals.

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of the programs each quarter. It should also be noted that the authors did not capture revenue for subsequent radiologic tests or referrals because they did not believe they could unequivocally state this revenue was “downstream.” Certainly, that revenue would add to a hospital’s bottom line. Indeed, Jones and colleagues³ have previously shown that downstream revenue from an outpatient thoracic surgery clinic has an excellent return on investment for hospitals and that the clinic’s operating margins exceed that of most Fortune 500 companies. So the development of a lung cancer screening program, although likely not directly profitable for the thoracic division itself, may be a win for the hospital and is certainly a win for patients. Just as we have a duty to educate patients and primary care providers about the benefits and risks of lung cancer screening, we also have a responsibility to educate administrators about the economics of lung cancer screening so that effective programs can be established with institutional support.

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