Lung Cancer Screening in Maine:

Annual Survey Summary

June 2026

Maine Center for Disease Control and Prevention
Division of Disease Prevention
Chronic Disease Prevention and Control Program
Comprehensive Cancer Control Program
286 Water Street, 4th Floor
11 State House Station
Augusta, ME 04333

Acknowledgements

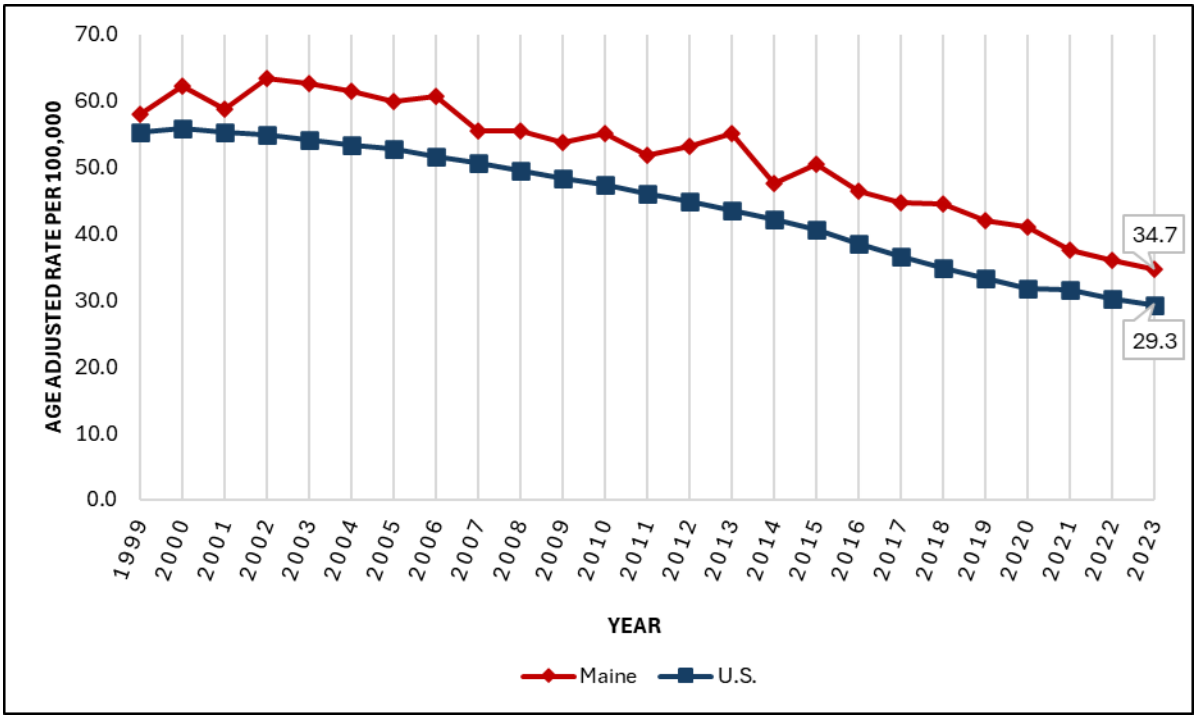
The Maine CDC Comprehensive Cancer Control Program and the Maine Lung Cancer Coalition would like to thank the following facilities for their participation in the survey:

Participating Facilities by County
Androscoggin
Central Maine Medical Center
St. Mary's Health System
Aroostook
Northern Maine Medical Center
Cumberland
MaineHealth Maine Medical Center
Northern Light Mercy Hospital
Hancock
Mount Desert Island Hospital
Northern Light Blue Hill Hospital
Northern Light Maine Coast Hospital
Kennebec
Maine General Medical Center
Knox
MaineHealth Pen Bay Hospital
Penobscot
Northern Light Eastern Maine Medical Center
Piscataquis
Northern Light CA Dean Hospital
Northern Light Mayo Hospital
Somerset
Northern Light Sebasticook Valley Hospital
Redington-Fairview General Hospital
Waldo
MaineHealth Waldo Hospital
Washington
Calais Community Hospital
York
York Hospital

Introduction

This summary analyzes the findings from the tenth 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



Lung Cancer Screening Recommendation

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 this 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 lung cancer screening 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 including on National Lung Cancer Screening Day. (See Appendix A for the 2026 survey tool.) All survey answers were shared with the MLCC with permission from all survey respondents.

In February 2026, the tenth annual Lung Cancer Screening Survey was emailed to 36 imaging centers across Maine. While some facilities provided imaging services, not all offered lung cancer screening during 2025. 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 gentle reminders in March 2026, encouraging their participation in the survey before it closed. A total of 18 facilities provided responses to the survey this year.

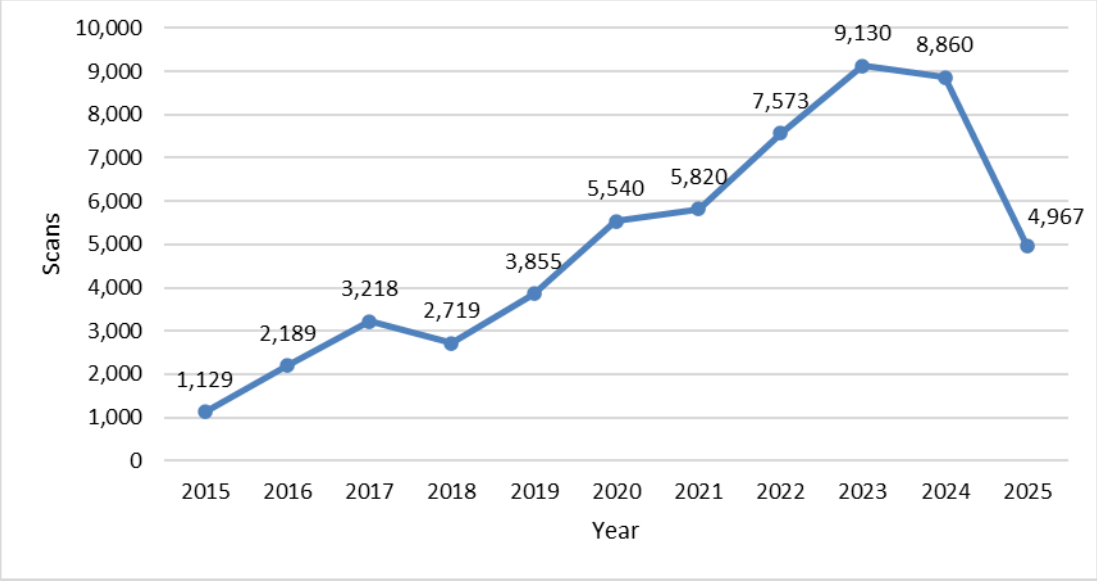
Survey Findings

Facilities Providing Lung Cancer Screenings

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.

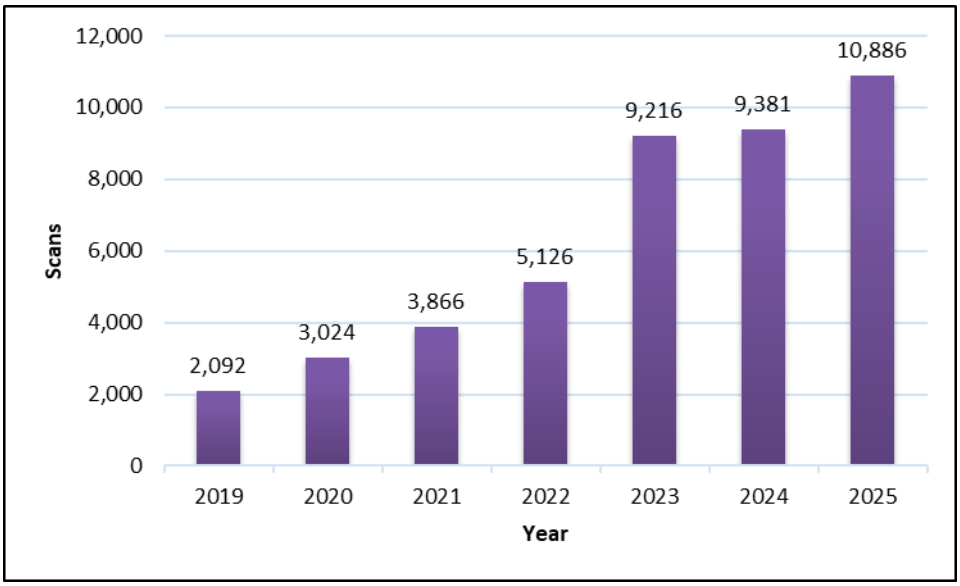
The current 2026 survey had a total of 18 facility responses with all reporting that they were providing LDCT lung cancer screening during 2025. Of those, 17 facilities were able to offer data on those screenings. Based on the data acquired, 4,967 individuals had a baseline LDCT screening for lung cancer during 2025. Twelve of the16 counties are represented in this survey. Kennebec County provided approximately 20 percent of the baseline screenings, having screened 1,022 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



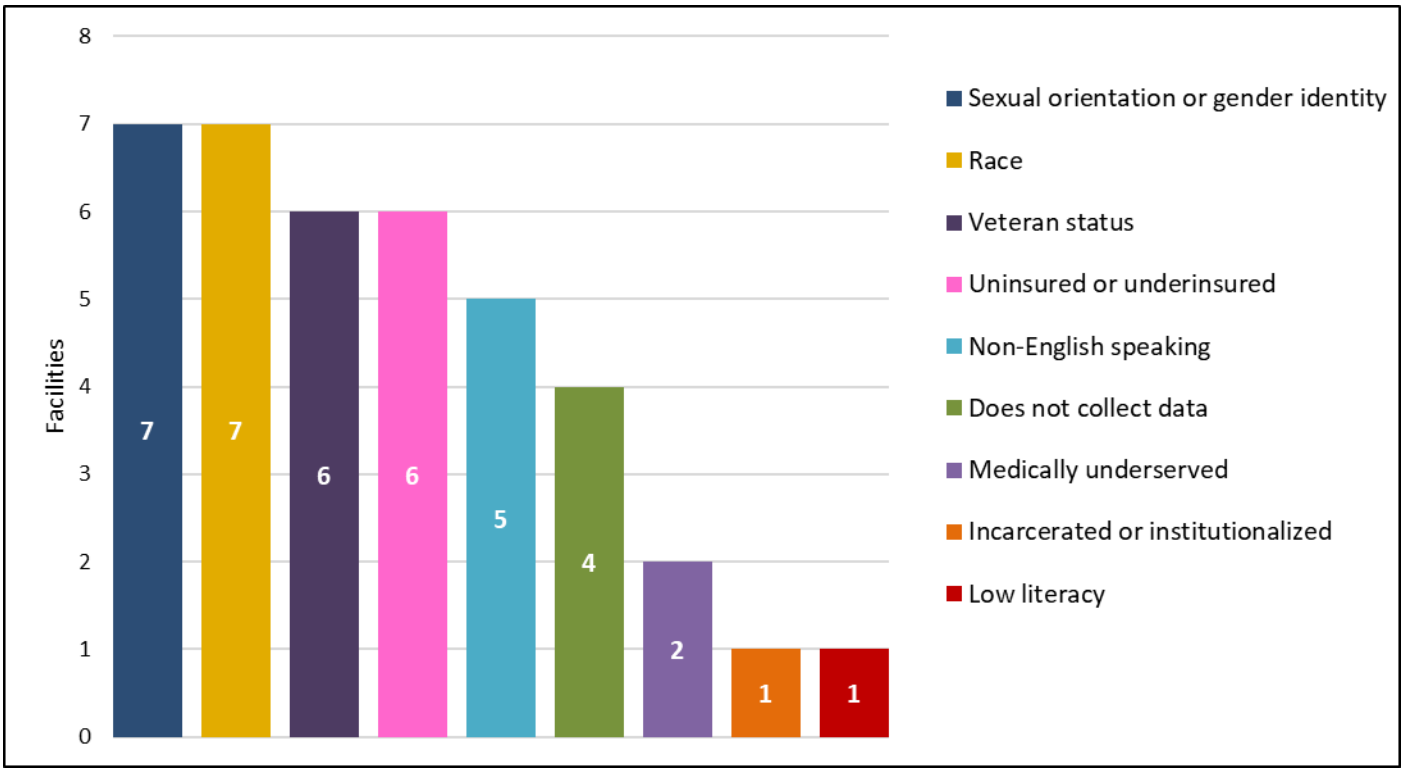
Fourteen of the facilities were able to breakdown their baseline screenings by sex and reported that approximately 1,929 males (55.1%) and 1,570 females (44.9%) were screened for lung cancer. Sixteen facilities reported performing approximately 10,886 annual follow-up screenings for lung cancer (Figure 3), which continues the trend of increasing follow-up lung cancer screenings having been reported; this, despite fewer facilities participating in the survey overall. Of the estimated lung cancer screenings (both baseline and annual follow-up), fourteen facilities reported approximately 185 LDCT screenings (1.2%) resulting in a lung cancer diagnosis during 2025.

Figure 3. Annual Follow-up Lung Cancer Screening



Facilities were asked about the types of population data they collect to assist in serving all people. They were given the option of selecting as many answers as were applicable (Figure 4). In response, seven facilities reported collecting data on race and sexual orientation and/or gender identity, six on veteran status and on uninsured or underinsured patients. Five facilities gathered data on non-English speakers, while two facilities indicated collecting information on medically underserved individuals. One facility reported collecting data on those incarcerated or institutionalized and one captured information on low literacy. Of the twelve facilities providing a response, four 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.

Figure 4. Facilities Collecting Population Data



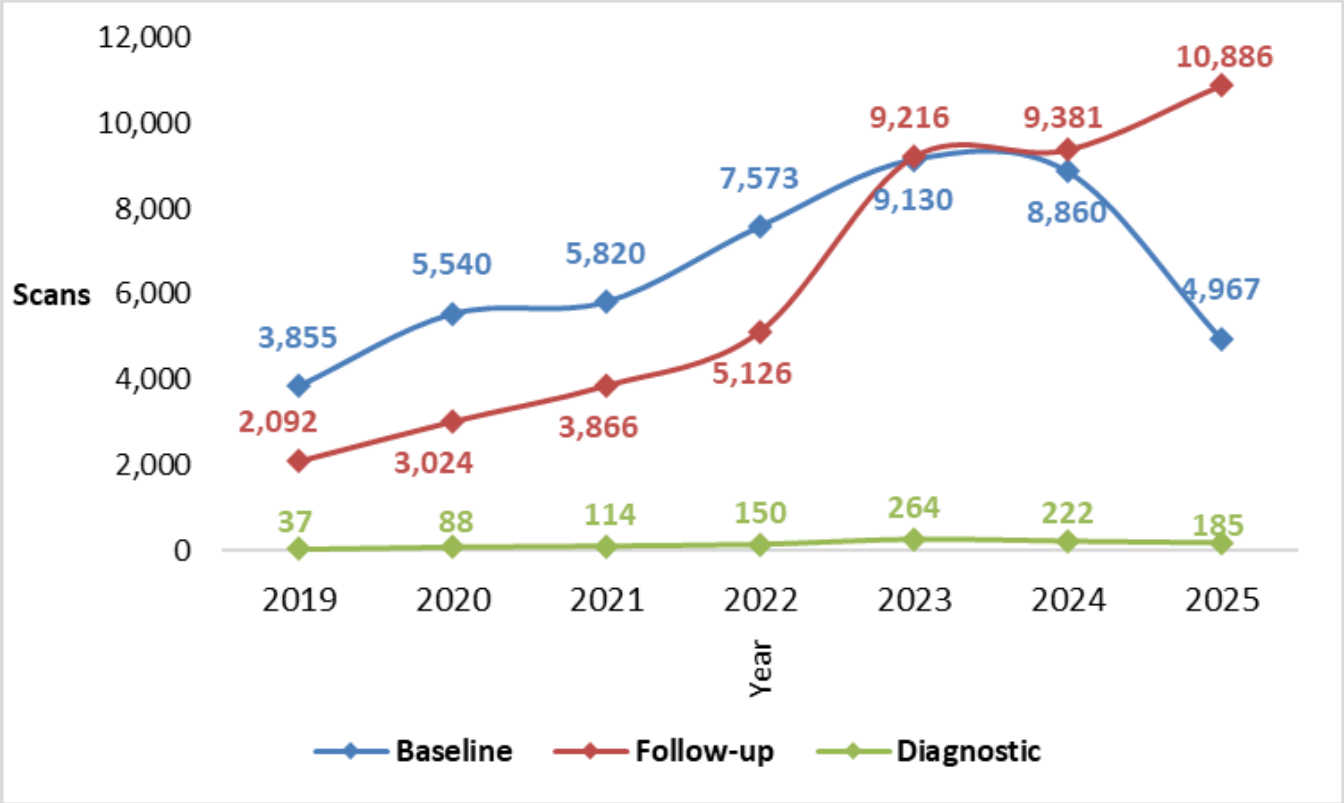
Availability of lung cancer screening appointments outside of normal business hours (e.g., before 8:00am, after 5:00pm, weekends, and/or holidays) was asked in the survey with twelve facilities responding that they do. Barriers of access and transportation may be reduced as more facilities consider adding availability outside normal business hours. Eight facilities reported as having participated in the annual National Lung Cancer Screening Day which occurs on the second Saturday in November.

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/posters as having the most potential to assist, with online decision aids and Public Service Announcements (PSAs) also referenced at a higher rate. Information around lung cancer screening as well as resources such as PSAs and materials may be found at https://www.screenmaine.org/lung-cancer.

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 5). 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 seven years of the lung cancer screening survey to illustrate trends in screening. Baseline screenings decreased from last year albeit with eight fewer facilities reporting data while follow-ups continued to increase.

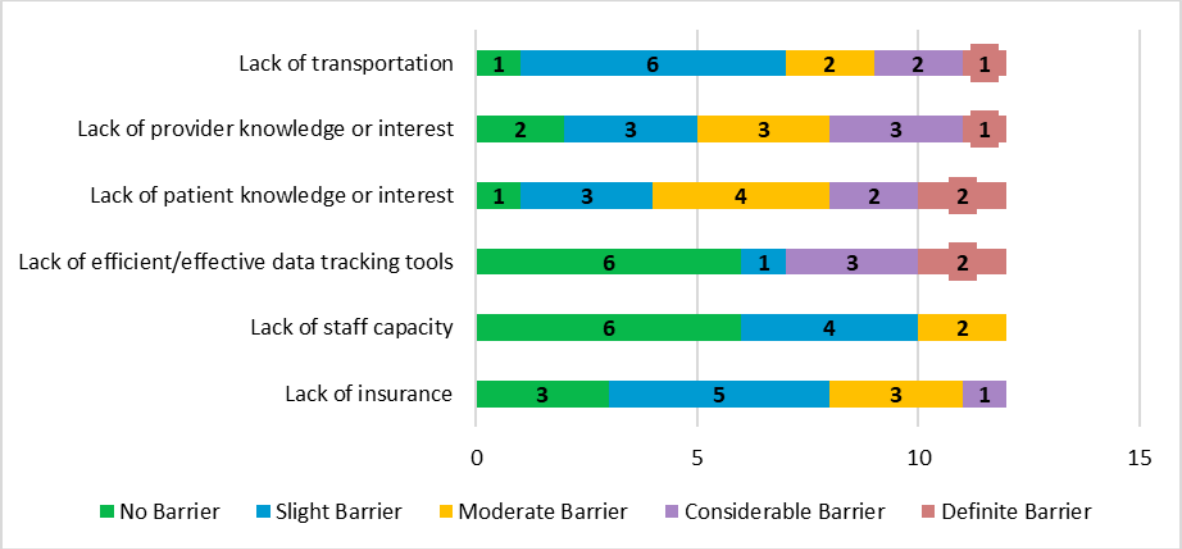
Figure 5. Lung Cancer Screening, Maine, 2019-2025



Reported Barriers

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 12 facilities regarding their perceptions of 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*. *Lack of efficient/effective data tracking tools* was split between the two ends of the scale with no noted *Moderate Barrier*. 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 ten years of the survey.

Figure 6. Reported Barriers to Lung Cancer Screening, 2025



Screening and Tobacco Referral

Tobacco treatment 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] Eight of the facilities reported that they do refer current smokers to tobacco cessation, two responded that they do not, and one replied that it was "Unknown." Of the eight 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 tenth annual survey highlights the responses from 18 facilities providing LDCT lung cancer screening in Maine during 2025. 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 800 lung cancer deaths in Maine during 2026.[5]

Figure 7. Trends in Late-Stage Lung and Bronchus Cancer Age-Adjusted Incidence Rates per 100,000 population, Maine, All Sexes, All Races, 2014-2023

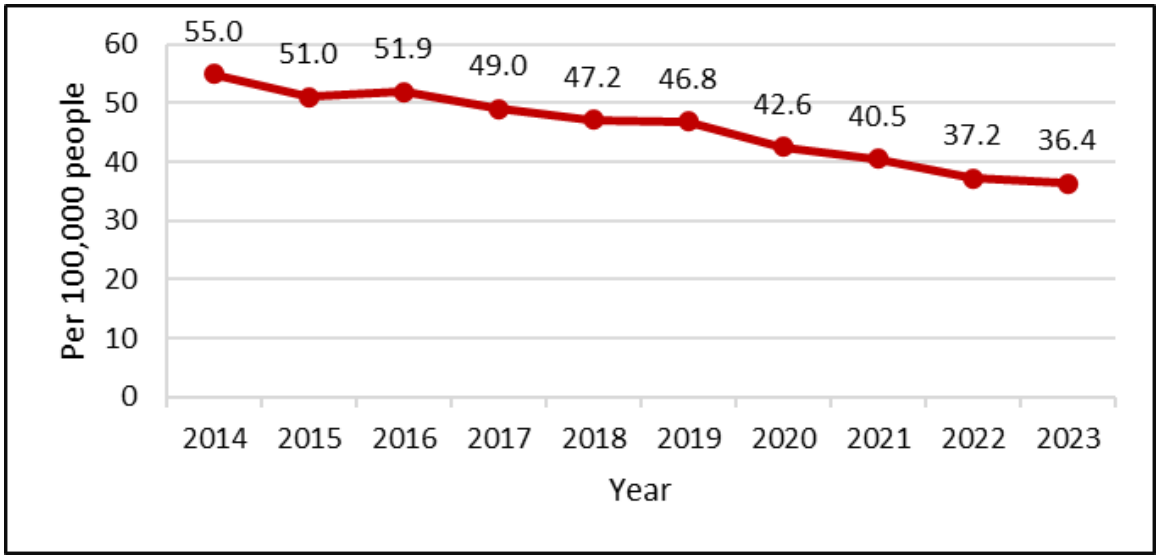


Figure 7 shows how late-stage lung cancer has decreased over ten years.[6] Screening of high-risk individuals using current recommended guidelines could improve survival rates in Maine by finding lung cancer early when treatment may be more successful. Increasing the hours of availability outside of 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. Cancer Facts & Figures 2026*. Atlanta: American Cancer Society; 2026; https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/annual-cancer-facts-and-figures/2026/2026-cancer-facts-and-figures.pdf
6. *Maine Cancer Registry. Data, Research, and Vital Statistics. Maine CDC. SEERStat Analytic file Last updated November 2025*.

Appendix A: 2026 MCCCP Lung Cancer Screening: Facility Survey

Lung Cancer Screening Survey – 2026

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 2025. If your facility did provide lung cancer screening during 2025, 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 2025?

- ☐ Yes
- ☐ No (skip to question 27 – 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. Did this facility participate in the annual National Lung Cancer Screening Day in 2025? (2nd Thursday in November)

- ☐ Yes
- ☐ No

8. 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).

9. How many <u>baseline</u> screening LDCTs were performed at your facility in 2025? (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 annual <u>follow-up</u> screening LDCTs were performed in 2025 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 _____

11. How many screening LDCTs <u>resulted in a lung cancer diagnosis</u> at your facility in 2025?

Total _____

Males _____

Females _____

REPORTING LUNG CANCER SCREENING

12. Is your health care 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)

13. Does your health care system submit data to the American College of Radiology Lung Cancer Screening Registry?

- ☐ Yes
- ☐ No
- ☐ Unknown

14. Does your health care 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.

15. 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)

16. Which health care 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)

17. 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)

18. 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)

19. 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.

20. 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:

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

- ☐ Yes
- ☐ No
- ☐ Unknown

22. 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)

23. 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):

24. 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

25. 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

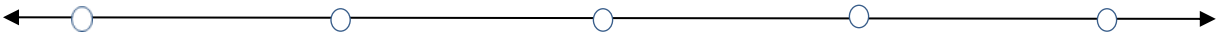
26. What are the barriers to collecting patient population information at your facility?

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?

27. Lack of insurance coverage for patients



No Barrier	Slight Barrier	Moderate Barrier	Considerable Barrier	Definite Barrier

28. Lack of staff capacity

No Barrier	Slight Barrier	Moderate Barrier	Considerable Barrier	Definite Barrier

29. Lack of efficient/effective data tracking tools

No Barrier	Slight Barrier	Moderate Barrier	Considerable Barrier	Definite Barrier

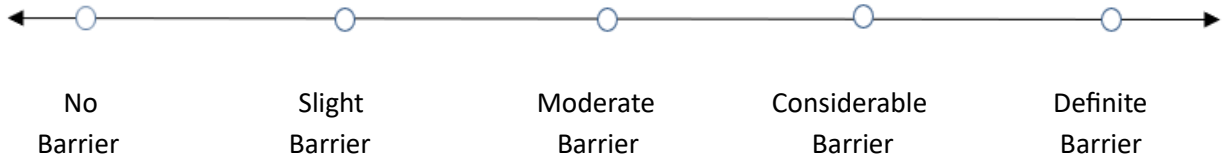
30. Lack of **patient** knowledge or interest in screening

No Barrier	Slight Barrier	Moderate Barrier	Considerable Barrier	Definite Barrier

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

No Barrier	Slight Barrier	Moderate Barrier	Considerable Barrier	Definite Barrier

32. Lack of transportation for patients



No Barrier	Slight Barrier	Moderate Barrier	Considerable Barrier	Definite Barrier

33. Other (please specify)

34. Is there anything you would like to add?

Thank you for participating in the survey!

The Department of Health and Human Services (DHHS) does not discriminate on the basis of disability, race, color, creed, gender, sexual orientation, age, or national origin, in admission to, access to, or operations of its programs, services, or activities, or its hiring or employment practices. This notice is provided as required by Title II of the Americans with Disabilities Act of 1990 and in accordance with the Civil Rights Act of 1964 as amended, Section 504 of the Rehabilitation Act of 1973, as amended, the Age Discrimination Act of 1975, Title IX of the Education Amendments of 1972 and the Maine Human Rights Act and Executive Order Regarding State of Maine Contracts for Services. Questions, concerns, complaints or requests for additional information regarding the ADA may be forwarded to DHHS' ADA Compliance/EEO Coordinators, 11 State House Station – 221 State Street, Augusta, Maine 04333, 207-287-4289 (V), 207-287-3488 (V), TTY users call Maine relay 711. Individuals who need auxiliary aids for effective communication in program and services of DHHS are invited to make their needs and preferences known to the ADA Compliance/EEO Coordinators. This notice is available in alternate formats, upon request.