# Issue Summary

## Strengthening Public Health and Healthcare Systems to Advance Cancer Screening and Care

*A meeting brief from the September 9, 2021, Issue Hub hosted by the American Cancer Society National Consortium for Cancer Screening and Care*

American Cancer Society®

# Introduction

In February 2021, the American Cancer Society (ACS) kicked off a nationwide Return to Screening initiative to encourage patients to resume appropriate cancer screening and follow-up care. This initiative is designed as a comprehensive and multi-sector national movement to dramatically and swiftly increase cancer screening rates to pre-pandemic levels. As one component of this initiative, the ACS created the National Consortium for Cancer Screening and Care (ACS National Consortium) to establish a collective national response to the COVID-19 pandemic's detrimental impact on cancer screening and care.

As an issue-focused, time-bound partnership, the *ACS National Consortium* is guided by action-oriented goal statements that promote the urgency of our collective response and opportunity. Together, *ACS National Consortium* members address each of these goal statements through a consensus-building cycle to create bold but sensible recommendations that will minimize the negative effects emerging from the COVID-19 pandemic and move us forward in cancer screening and care as a nation.

## National Consortium Goals

| Accelerate | Strengthen | Mobilize |
|---|---|---|
| Accelerate our responses to long-standing and emerging barriers to cancer screening and care. | Strengthen our preparedness, infrastructure, and partnerships to minimize disruptions and address inequities. | Mobilize around sustained, coordinated commitments to promote cancer screening and care as a public health priority and improve the long-term effectiveness of screening programs. |

This document summarizes the discussion themes and poll results from the ACS National Consortium's second Issue Hub, *Strengthening Public Health and Healthcare Systems to Advance Cancer Screening and Care*. A recording of the event is available here.

## Issue Hub #2: Strengthening Cancer Screening and Care

*The ACS National Consortium Issue Hubs are public, facilitated panel discussions with renowned subject matter experts who are challenged to identify and discuss the most pressing issues in the recovery and improvement of cancer screening and care nationwide.*

On September 9, 2021, the ACS National Consortium welcomed more than 240 to participate in the Issue Hub *Strengthening Public Health and Healthcare Systems to Advance Cancer Screening and Care*. Invited panelists explored vulnerabilities within our nation's public health and healthcare systems that contributed to the decrease in cancer screening and care during the pandemic as well as the further exacerbation of inequities.

| Panel 1 | Panel 2 |
|---|---|
| • **Crystal Denlinger**, MD, FACP, Chief Scientific Officer, National Comprehensive Cancer Network<br>• **David Meyers**, MD, Acting Director, Agency for Healthcare Research and Quality<br>• **Cheryl Modica**, Ph.D., Director, Quality Center, National Association of Community Health Centers<br>• **Marcus Plescia**, MD, MPH, Chief Medical Officer, Association of State and Territorial Health Officials<br>• **Discussion Lead**: Laura Makaroff, DO, Senior Vice President, Prevention & Early Detection, American Cancer Society | • **Casey Eastman**, MPH, Section Manager, Community Healthcare Improvement and Linkages Section, Washington State Department of Health<br>• **Michael Anderson**, MHA, CPHQ, Division Vice President, Quality and Population Health, Virginia Mason Franciscan Health<br>• **Rhonda Johnson**, Program Manager, Mammovan, Nevada Health Centers<br>• **Discussion Lead**: Marcie Fisher-Borne, PhD, MSW, MPH, Managing Director, Interventions & Implementation, American Cancer Society |

Throughout the 90-minutes, panelists shared their best thinking on:

- Understanding the weaknesses and vulnerabilities in the U.S. healthcare system that worsened outcomes in cancer screening and care during the COVID-19 pandemic.
- Identifying steps for strengthening healthcare systems to be better prepared and equipped to address future disruptions (e.g., pandemics, natural disasters, etc.).
- Learning how healthcare systems successfully navigated cancer screening and care during the pandemic and improved healthcare outcomes.

Non-panel attendees were invited to engage in the discussion through virtual meeting tools that included live polls and interactive chat features.

## Issue Hub Agenda

**1:00 p.m.** **Welcome and Level Setting**
*Laura Makaroff, DO, Senior Vice President, Prevention and Early Detection, ACS*

**1:12 p.m.** **Audience Poll 1 and Review**

**1:15 p.m.** **Panel 1 – National Perspectives**

- Weaknesses or vulnerabilities in the US healthcare system that worsened outcomes in cancer screening and care during the COVID-19 pandemic.
- Sensible solutions for strengthening our healthcare systems to be better prepared and equipped to address future disruptions (e.g., pandemics, natural disasters, etc.).

**1:55 p.m.** **Audience Poll 2 and Review**

**1:58 p.m.** **Panel 2 – Local Perspectives**

- How systems have successfully navigated cancer screening and care during the pandemic and improved outcomes.

**2:30 p.m.** **Close**

## Follow-Up and Next Steps

ACS National Consortium members will reconvene on October 12, 2021, 2:00 to 4:00 p.m. EST in a virtual summit to further consider the discussion of this Issue Hub, build consensus on sensible next steps, and provide actionable recommendations as the nation reprioritizes cancer screening. These recommendations will be critical to not only accelerate the recovery from the pandemic but also to accelerate the nation's resilience and overall improvement in providing quality cancer screening and care for all.

## Acknowledgments

The American Cancer Society's enterprise-wide screening initiative, of which the ACS National Consortium is a core component, is supported by various generous sponsors, including founding sponsor Genentech (a member of the Roche Group), the National Football League, Merck, Novartis, Pfizer Oncology, Roche Diagnostics, AmerisourceBergen, and BD.

# Opening Poll Results

After an introductory presentation, the Issue Hub kicked off by engaging the audience and panelists in a thought-provoking poll question. The poll provided a predetermined list of vulnerabilities in the U.S. healthcare and public health systems and asked participants to vote for the options that most significantly contributed to worsened outcomes in cancer screening and care during the COVID-19 pandemic. To focus the day's conversations, the list was not meant to be comprehensive. Instead, the poll response options were purposefully narrowed to address the needs of the Strengthen goal statement and to prevent duplication of topics discussed in the previous Issue Hub. The responses helped to frame and guide both facilitated panel discussions.

## Poll Results

*The opening poll question had 108 respondents and 216 votes.*

***Q. From the list below, what are the most significant vulnerabilities in the U.S. healthcare and public health system that likely contributed to worsened outcomes in cancer screening and care during the COVID-19 pandemic? (Pick 2)***

**26%** A culture of healthcare that deprioritizes population health and preventive care, thus eroding public support, understanding, and confidence

**21%** Funding and structural deficits in the U.S. healthcare system leading to diminished resource allocation

**19%** Lack of attention to system barriers that lead to discriminate care

**15%** Under-developed preparedness plans (disaster plans) lacking guidance on addressing cancer and other chronic diseases through times of crisis

**11%** An absence of formal guidance on categorizing patients for the acceptable delay in screening, diagnosis, and treatment

**9%** Dependency on a fee-for-service model versus a value-based model

# Panel 1 Discussion Themes

Throughout the conversation, the panelists considered potential action steps to build resilience in our public health and healthcare systems moving forward. The following key themes were gathered from their discussion.

**Strengthen trust in public health and healthcare systems through a whole-person approach.** Community groups and individuals hold varying perceptions and attitudes toward government agencies and health care organizations, and the pandemic has likely reinforced (or in some instances, caused) lasting challenges of mistrust among some groups. Cancer prevention and screening discussions are better received after trusting relationships are established between the patient and the health care provider. Further, community health workers and patient navigators that represent the communities they support can serve as trusted messengers to help build confidence in the healthcare system and strengthen community partnerships. A whole-person approach can help identify underlying factors that contribute to health inequities, such as access to food, a safe place to live, employment, and other consequential areas. Disparate COVID-19 outcomes have brought increased attention to chronic conditions and co-morbidities, and this improved focus around the implications of co-morbidities can aid in introducing cancer screening as an important preventive measure.

**Strengthen health system and community preparedness plans to address cancer and other chronic diseases.** When COVID-19 hit, primary care and public health staff were often reassigned to help with the surges, thus diverting resources from and likely delaying or disrupting routine care. These professionals are vital in our ability to emerge from the pandemic (or other disruptions) and get back on track with routine care more swiftly, yet these reassigned and expanded roles likely slowed recovery. Improved preparedness planning will help manage resource allocations, establish frameworks for triaging patients in need of cancer screening or treatment, and build resilience within our health care and public health systems.

**Strengthen interdisciplinary teamwork.** The pandemic required more coordination among interdisciplinary health care teams that do not normally work together. Significant challenges and barriers were overcome due to working across silos, including triaging patients for screening, diagnostic tests, or treatment; protecting cancer patients undergoing treatment or during their hospital stays from COVID-19 infection; and aiding patients as they transitioned through healthcare systems. Panelists agreed that while there were many feelings of being fatigued and overwhelmed, these interdisciplinary solutions helped health care workers feel more valued during the pandemic as they expanded roles and operated at the top of their licensure.

# Panel 1 Discussion Themes (Cont.)

**Strengthen incentives for health systems to prioritize cancer prevention and screening to reach better patient outcomes.** The message to delay elective procedures and routine care, including cancer screening tests from earlier in the pandemic, is still having a ripple effect. Moving towards value-based payment models that prioritize the *quality* of care provided versus the quantity of services provided can lead to better patient outcomes. Increased coordination and compatibility between public health and primary care can emphasize and incentivize screening as a key mechanism for preventing cancer. Both public health and primary care providers can better communicate health recommendations, screening guidelines and formulate a plan with patients to encourage screening as a preventive, risk-reduction measure.

**Strengthen our understanding of disparate outcomes in cancer screening and care by better collecting demographic data.** There is not enough quality data about the race, ethnicity, sexual orientation, and gender identity of people who use the healthcare system. Being committed to addressing disparities requires the quality collection of information about people who use the system. Comprehensive data systems are a strength that both public health and healthcare systems can use and share to coordinate their worldviews, identify underserved populations and patients in need, and track the delivery of services. With this valuable data collection, however, also comes responsibility in gaining community trust and effectively addressing long-standing screening, treatment, and survivorship inequities.

**Strengthen the flexibility of cancer screening by expanding testing settings and modalities.** The health system should meet people where they are and use multiple screening modalities to meet various patient needs and preferences. Expansion of clinic hours and offering home-based care, telehealth, and community outreach programs like mobile mammography were effective options when people were hesitant to visit inundated hospitals during the pandemic. Similarly, the utilization of at-home stool-based tests proved a convenient method of colorectal cancer screening for people who were sheltering in place. Investing in the development of new modalities will increase the healthcare system's resilience and help us pivot when the system is challenged by future disruptions.

# Panel 1 - Attendee Perspectives and Ideas

Attendees were asked two questions during the first panel. Their top responses are shown below.

***Q. What solutions do you think would address the lack of prioritization of population health and preventive care and help to build resilience in our U.S. healthcare system and processes?***

| | |
|---|---|
| 5 | Agree that "A culture of healthcare that deprioritizes population health and preventive care" is a major contributor, as is "eroding public support, understanding, and confidence." But eroding trust is due to other issues that increased population health prioritization won't necessarily fix. |
| 5 | It needs to be brought into the communities, schools, churches, and workplaces; people need access, information, and resources; we must meet them where they are so that we can all be involved in change! |
| 4 | We need to decouple population health and prevention funding from political timelines and cycles. We need to set more realistic expectations for short and intermediate outcomes for these types of programs and improve our ability to measure and clearly communicate the benefits to various audiences. |
| 3 | Move away from the fee-for-service reimbursement model. Preventive care and population health should be reimbursed just like treatment. |

***Q. What other solutions might you offer to these identified challenges to help build resilience in our U.S. healthcare system and processes?***

| | |
|---|---|
| 2 | Get healthcare out of the specialized and concentrated centers that are densely located together and get healthcare into the communities. |
| 2 | Increase funding to CDC/AHRQ/HRSA -- value practice like we value research (NIH)! |
| 2 | Democratize data across various health systems and health care levels (hospitals vs. FQHCs vs. free & charitable clinics vs. public health). |
| 2 | When people show up for their COVID vaccines and boosters, let's make sure to give them personalized information about other things they can do to protect their health. Think about CVS - let's give young adults info on HPV vaccines! |

## Panel 2 Discussion Themes

The second panel's conversation began with three brief narrative case studies highlighting different health care settings across the country (see pages 10 to 12). Each panelist shared background on their program and how they successfully navigated cancer screening and care during the pandemic and improved outcomes. They were also asked for their comments and top-of-mind reflections on the opening poll question and subsequent conversation in the first panel session.

The following common key themes were gathered from the panel discussion.

**Strong relationships are one key to success.** Strong relationships with patients, providers, and care teams are very important. Physician-driven projects can create the engagement that is required for others to buy-in.

**Create data infrastructure to serve everyone.** All the panelists had access to data and utilized it to inform their work and track progress. Data pulled in real-time can help target vulnerable populations and expedite the scheduling of screenings. Ultimately, successes come from good analytics based on good internal data.

**Build a diverse workforce of paraprofessionals**. Case managers and navigators are very important to help patients overcome barriers experienced by those in underserved populations. It is imperative to increase the workforce with more community health workers and navigators that represent the communities they are serving.

**Make a plan.** Many cancer programs didn't have preparedness plans like state health departments. Decisions on how to prioritize and pivot what to work on were made after COVID-19 was already a crisis. Additionally, support staff were reassigned and thus removed support from patients. It's vital moving forward to have a disaster plan and know how to prioritize cancer screening and care for patients.

**Meet patients where they are.** Help reduce barriers for patients by meeting them where they are and including virtual or remote visits, different testing modalities, and various means of communication.

# Case Studies

During the second panel, three programs shared their experiences navigating cancer screening and care during the COVID-19 pandemic. The following sections summarize some of their challenges, strategies, and remarks.

## Case Study 1: Washington Department of Public Health

*The Washington State Department of Health implements breast, cervical, and colorectal cancer screening through six regional contractors (three local health departments, two hospitals, one community non-profit) that understand their communities and partners. They also support a selection of FQHCs with workflow and quality improvement interventions.*

**COVID-19 Impact**. While the Washington Department of Public Health had preparedness plans, the cancer program did not have one. Many staff members were pulled for COVID support leaving only one cancer program employee. Clinic screenings were intermittently shut down throughout the state. Additionally, systems of support for patients in treatment, like volunteer transportation and community health workers, weren't available.

**Health equity.** The department ensures that its workforce represents the disparities in the community to help build trust. Expanding the public health workforce by adding community health workers would help with equity.

**Strategies.** First, they quickly prioritized keeping those patients undergoing treatment in treatment and gave special attention to systems of support like transportation. Then, they focused on tracking and supporting patients with abnormal results through diagnostic biopsies and into the treatment phase. Lastly, they worked with community health centers on quality improvement projects and shared successful pandemic operational lessons with partners.

**Outcomes.** Partnerships, regular communication, and being quick to prioritize goals and strategies helped to keep patients in treatment. Screening numbers dipped in March and April of 2020 early in the pandemic but returned to normal by late summer and early fall 2020.

# Case Study 2: Virginia Mason Franciscan Health

*Virginia Mason Franciscan Health in Washington has partnered with the American Cancer Society for the past two and a half years, working to improve their colorectal cancer screening rates by focusing on population targeting, shared decision making, and improving their system throughput. Prior to COVID, they were seeing consistent improvement in their screening rates month over month.*

**COVID-19.** After years of consistent improvement, their colorectal screening rates plateaued during the early pandemic. They experienced a sharp decline in Medicaid patients for visit rates and care access rates.

**Health Equity.** They serve Black, Hawaiian, and Pacific Islander populations. The healthcare team is working in primary care settings to remove barriers and reactivate patients with preventive healthcare plans.

**Strategies.** Using a new PDSA cycle, they decided to focus on patient outreach through wellness visits to meet patients from vulnerable populations in care settings of their choosing. The team performed daily analyses of screening gaps to prepare for annual wellness visits and scheduled any follow-up testing during visits. Those who didn't want a colonoscopy were mailed a FIT (fecal immunochemical test) kit directly to their home. Using multiple communication channels helped them stay steadily connected with patients and have key conversations about colorectal cancer screening.

**Outcomes.** They saw a 37% improvement in wellness visits and a 10% increase in colorectal cancer screening rates, now up to 71% from 45.7% when they started two-and-a-half years ago.

# Case Study 3: Nevada Health Centers

*Nevada Health Centers operates a Mammovan program to conduct mobile breast cancer screening throughout the state, especially for the uninsured population. The Mammovan serves up to an estimated 100 women per week, reaching them directly in their community. Patients with abnormal results are referred to diagnostic centers for further evaluation.*

**COVID-19.** The Mammovan was shut down at the start of the pandemic for six weeks to conserve PPE and to limit contact with potential COVID cases. This led to an 11% drop in van screenings and created a screening backlog of about 600 women.

**Health Equity.** There is only a 7% screening rate among Black women, and late-stage diagnoses of breast cancer are very prevalent among the Black community. The rates among Hispanics and whites are about even. To help facilitate increased screening among Black women, they are in the process of working with minority groups in the community to have roundtable discussions seeking patient feedback.

**Strategies.** They received a Crucial Catch grant from the American Cancer Society, which helped as a catalyst to increase screening and address the backlog. Once the Mammovan reopened, they messaged they were open by building their public profile: “The Mammovan is on the road and still working.” They used multiple communication channels, including social media, TV, etc.

**Outcomes.** They exceeded their initial goal of an 11% increase. Since January 2021, they have been back to normal. Their biggest challenge now is funding. They help uninsured people and depend on funding from donors.

# Panel 2 - Attendee Perspectives and Ideas

***Q. Was there something discussed in the panelists' case models that resonated with you?***

| | |
|---|---|
| 7 | We need to move away from grant funding to sustainable funding for preventive services. |
| 2 | Analytics = lives saved. |
| 1 | Why don't all health systems send out that many reminders regularly? What motivates some teams to do it, and what are the barriers for other systems? I have never received a reminder card like that. |

***Q. Considering the overall healthcare system vulnerabilities discussed today, how do they compare to what you're experiencing in your local setting?***

| | |
|---|---|
| 3 | We are barely hanging on because of provider burnout; folks are leaving public health and medicine and primary care left and right. |
| 3 | We are finding that the FQHCs and other community partners are still overwhelmed with competing priorities and are not able to focus on cancer control priorities. |

# Appendix – Evaluation Survey Highlights

The summarized highlights from the evaluation survey appear below. About 47-49 participants responded to the closed-end responses that did not require entering comments.

## Participants rated Issue Hub #2 as follows:

- 100.0% of attendees were interested in another issue hub (49 responses: 46 Yes, 3 No Opinion).
- 100.0% would recommend participation to a colleague (49 responses: 46 Yes, 3 No Opinion).
- 100.0% would stay connected to the consortium's efforts. (49 responses: 47 Yes, 2 No Opinion).
- 98% rated the Issue Hub as excellent or good (49 responses: 32 Excellent, 15 Good).
- 94% were satisfied with the Zoom and Slido tools (44 responses, 42 satisfied/very satisfied).

## Participants agreed with the following statements:

Responses 49

- 92% - The information was presented at the right level for audience members like me.
- 90% - The webinar was well organized.
- 89% - I learned something valuable during the issue hub.
- 86% - I learned something new from the session.
- 86% - I can apply what I have learned to my work.

## Participants had a better understanding of the following:

Responses 48

- 89% - Strategies some systems implemented to successfully navigate cancer screening and care and improve outcomes during the pandemic
- 87% - The weaknesses and/or vulnerabilities in the US healthcare and public health systems that likely worsened cancer screening and care outcomes during the COVID-19 pandemic
- 87% - Potential measures that can strengthen our healthcare and public health systems to be better prepared and equipped to address future disruptions (e.g., pandemics, natural disasters, etc.) that my organization could adopt or otherwise support

# Appendix – Complete Poll Results

The opening poll question to 108 respondents was, "*From the list below, what are the three most significant vulnerabilities in the U.S. healthcare and public health system that likely contributed to worsened outcomes in cancer screening and care during the COVID-19 pandemic?*"

| Poll Option | Votes | N Respondents | Pct Votes |
|---|---|---|---|
| A culture of healthcare that deprioritizes population health and preventive care, thus eroding public support, understanding, and confidence | 57 | 108 | 26% |
| Funding and structural deficits in the U.S. healthcare system leading to diminished resource allocation | 45 | 108 | 21% |
| Lack of attention to system barriers that lead to discriminate care | 40 | 108 | 19% |
| Under-developed preparedness plans (disaster plans) lacking guidance on addressing cancer and other chronic diseases through times of crises | 32 | 108 | 15% |
| An absence of formal guidance on categorizing patients for acceptable delays in screening, diagnosis, and treatment | 23 | 108 | 11% |
| Dependency on a fee-for-service model versus a value-based model | 19 | 108 | 9% |
| | **216** | | |