HRSA Office Women's Health

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Advancing equity in cancer prevention in primary care and rural health settings

>> All right. Looks like we're at the top of the hour. I'd like to have us go ahead and get started. So if we could have our panel members please turn on your video, we'll go ahead and kick off this meeting. So thank you all for being here. My name is Nancy Mautone-Smith. I'm the Director of women's Health at HRSA and we're so thrill today have all of you here with us for this Cancer Moonshot Community Conversation, Advancing Equity in Cancer Prevention in Primary Care and Rural Health Settings. I'm pleased to be joined by Tom Morris from HRSA's Federal Office of Rural Health Policy. Tom, I'll turn it over to you for a few opening remarks for our group today.

>> Great. Nancy, thank you so much, and thanks to everybody for joining us today for the community conversations as part of the Cancer Moonshot. As Nancy noted, I direct the Office of Federal Rural Health Policy at Health Resources and Services Administration and the U.S. Department of Health and Human Services. Want to thank the Office for Communications and Bureau of Primary Healthcare for all their work and coordinating the event on today's important topic and focusing this on rural and primary care conversation.

My office has made a point of supporting research and issues over the years and we're happy to be joined by two of the research center staff who led the studies. They'll be introducing themselves shortly. This is really an important issue for us. Cancer is one of the leading causes of avoidable or excess death in the country and we see gaps within the data. And the rural challenges in cancer are in some way a bit of a conundrum. We see lower incident rate but higher mortality, and there are particular challenges in certain preventable cancers. This likely speaks to a range of factors, lower screening rates, higher risk factors, distance to care. Other challenges related to health literacy and transportation but what they all result in are outcomes that are unacceptable and so it's great to be able to focus on that and Nancy will talk about it today, and also hear from people at the community level who are doing their best to sort of make a difference.

Our awareness on these issues is informed not only by the research we fund but also by the ongoing partnership we have with the National Cancer Institute or NCI. A few years back, they independent of us, noticed the same data gaps between rural and urban areas we have been focusing on and decided to

make it an area of focus. And their work I think offers up a promising model because the data led not only to action but collaboration. They obviously had the cancer expertise but rural was new to them. So we partnered with them and able to convene experts to inform the efforts and that is funding a series of grants that the cancer (?) to really focus on addressing rural cancer control issues with a focus on community partnerships.

That led us to convince the advisory committee to focus on this issue and they did a policy brief in 2019 that included a number of recommendations to the secretary. I think most of those are really still relevant so if you're interested in all of that policy brief and recommendations were all online and easy to find.

To NCI's credit they have continued to focus on the issues and expanded that into a larger examination of cancer and persistent poverty counties and many are in rural areas and we see a big focus on that. It also brought in, you know, a lot of activities that communities that are where we have community health centers and, you know, the collaboration has been fantastic because we are able to present at their meetings and highlight their work and in fact, later this year, you'll hear from Tim from Texas A&M. They'll do a case study because I think it offers a great example of collaboration to address a persistent public health issue.

I think it also points out the great value of partnerships and so our colleagues at the Bureau of Primary Healthcare are also partnering with NCI on cancer screening efforts and efforts across the country. Today they just released a new notice of funding opportunity to support linking health centers to cancer centers to really increase screening rates and ultimately improve outcomes.

And so we're really excited to see that happen and then NCI has also begun working with our Office of Advancement Of Telehealth in HRSA because they have a focus at NCI on how to leverage telehealth technology to improve care coordination and also screening rates. So as you can see, you know, it's a joint effort among all of us. And one we hope will expand in the coming years. So with that, I think you get a sense of what's going on federally. Let me hand it back to Nancy and we look forward to the conversations.

>> Thank you. Thank you so much, Tom. I'm getting a message about the meeting being recorded. Thank you. I'm the Director of the HRSA Office of Women's Health and it's my pleasure to be here with the esteemed partners and many stakeholders and partners watching around the country. The community conversation is closely aligned with the mission of our agency which focuses on advancing health equity, improving access to care for the underserved population and supporting workforce. My office, the office of women's health works to advance health and wellness for women across the life span. We are committed to working together with our partners inside and (screen frozen) collaborative which was an offshoot of the Cancer Moonshot. An inter agency partner tonight to increase access to high quality cervical care in safety settings of care and will promote innovative approaches through engagement with providers, patients, other stakeholders and through the development of educational resources for both providers and patients.

President Biden and First Lady Dr. Jill Biden reignited the Cancer Moonshot with new goals. First, to reduce the death rate from cancer by 50% over the next 25 years. And second, to improve the experience of patients and families living with and surviving cancer and direct us towards ending cancer as we know it today. HRSA has critical programs working to support these goals every day. The president and first lady announced a call to action on cancer screening to jump start progress on the nearly 10 million screenings missed as a direct result of the COVID 19 pandemic. And help ensure that everyone in the United States equitably benefits from the tools we have to prevent, detect and diagnose cancer. As such, today's conversation will focus on strengthening screening in primary care and rural settings with the focus on health equity. Over the next hour, we'll hear directly from HRSA grantees and stakeholders about the very important work they're doing to promote cancer prevention and screening in communities all across the country. And we'll be sharing the information directly with the White House Cancer Cabinet to inform and advance Cancer Moonshot priorities. As Tom said, thank you to our colleagues in the White House Office of Science and Technology, Secretary Basera for supporting this conversation today, and also I'd like to take a moment to thank our Bureau of Primary Healthcare colleagues and our Federal Office of Rural Health colleagues Nigel Stinson, saria, Michael and James from my team for their support with today's important event.

And with that, Tom and I are looking forward to hearing from our panel. Let's go ahead and start by having some brief introductions. I'll go ahead and Dr. Andrilla, why don't you start with you. Introduce yourself and your organization.

>> Hi. I'm the Deputy Director of the WAMI Rural Health Research Center located in Seattle and we have done a number of we focus on the workforce and we have done a number of studies looking at the stage at which patients with various types of cancer are diagnosed to sort of establish if that was contributing to the differential mortality rates we see in rural and urban patients.

>> Thank you so much. Welcome. So happy to have you here. I'll go to the right on my screen. Dr. Caudle?

>> Hi. I'm the Director of Women's Health at Cherokee Health Systems. It has a number of rural sites. The positive screens are funneled down to us and our center in Knoxville and other sites. So we have a number of rural sites and we Tom said a lot. We have been collaborating with partners and so on to try to improve the results.

>> Wonderful. Thank you for joining us today. Dr. Amin, over to you.

>> Hi. Good afternoon. Thanks, Nancy. My name is Robby Amin. I'm the Southwest Georgia Clinical Liaison for the colorectal cancer control program. It's a group of several different organizations in the state of Georgia. First Horizons South Cancer Collaboration and FQHC and another partner in the east which is East Georgia healthcare and Augusta University. The core is cancer oncology educational institute. And so our goal is to increase screening rates by implementing interventionist based in rural sites and clinics across Georgia.

>> Thank you so much. Welcome. Dr. Callaghan?

>> Yes. So I'm Tim Callaghan. I'm the director of evaluation for the southwest rural health center at Texas A&M University. We do quite a bit of work in the area of cancer in two different areas. We do research focused on cancer primarily by HRSA and chronic diseases including cancer and other chronic diseases looking at urban and rural comparisons and why cancer outcomes, especially mortality are different in rural and urban communities. We also have an outreach arm of our rural health research center which does quite a bit of work on cancer screenings and large grants through the state of Texas focusing on screening related to lung cancer and colorectal cancer we're working on right now. So that's us.

>> Wonderful. Thank you. Welcome. Dr. Monroe?

>> Hi. Just Casey. I'm not a doctor. My name is Casey Monroe. I'm the Senior Director of Health Promotion at Adajio Health in Pittsburgh, Pennsylvania. And we're a primarily women's health and wellness organization. My work focusing on our breast and cervical cancer screening programs of which we offer in 62 counties of western, central and northeast Pennsylvania the majority of our territory is fairly rural. And deal with a lot of the issues that I know we'll discuss today. My other hat I wear is the Director of our Tobacco Prevention and Control Services in western Pennsylvania which obviously have a lot of correlation.

>> Fantastic. Thank you for joining us. And Dr. Ghosh?

>> Hello. So my name is Dr. Ghosh. I'm a gynecologist in Boston and the majority of my work with the clinic has been specifically with cervical cancer screening and I recently led a cervical cancer screening project in the middle of the pandemic and we got pretty interesting results and made a lot of assumptions of how we were going to be able to improve screening and some of the results were surprising. Some of our understanding is definitely much better than what it was prior to the pandemic and I'm hoping to share. I'm not rural. I realized I'm the only I'm an urban clinic, but I really am excited to share what we learned.

>> Fantastic. Thank you. We're looking forward to it. All right. I think we have introduced our wonderful panel from what I can see based on my screen here. I'll go ahead and kick this off.

Our first question for our panel is, in your view, what are the highest priority needs when it comes to supporting cancer screening and primary care and how does your organization support this for the patients it serves? So please go ahead and raise your hand. If you would like to speak. Excuse me. Let me change my view. Okay. Dr. Ghosh, please get us started.

>> Yes. So I found out what was a really high priority need was commitment. When I was hired originally as staff at our clinic, there was a cervical cancer screening problem. We knew we had overdue screenings but the pandemic made it worse. Those numbers increased from 3,000 overdue to 7,000 overdue. And it was what what led to us having a project and really starting to focus on change was the commitment from the leadership of our clinic, and that happened because I had the time to evaluate our data and understand the scope of our problem to present the numbers necessary to really understand instead of having anecdoteal discussions of yeah, we need to improve our screening. I

presented to the administrative and clinical leadership to be able to state these are our numbers, and specifically, also saying what inaccuracys were in the numbers so we really had an understanding of actually 20% of the overdue numbers were not overdue, and that really allowed for a commitment and project to be started and funding to be dedicated to the project. So I felt like that was the big first step that led to more than just, you know, paying attention but actually doing.

>> Thank you for that. Quite a few hands. Dr. Monroe or Casey?

>> I'll come out of the discussion with my doctorate. (Laughs)

Thank you. So just to go back to who we are and what we do, so at Adajio Health, we oversee the Pennsylvania funded breast cancer early detection program which we receive funds from the Department of Health and CDC to operate. Part of the work is contracting and working with and working with healthcare providers across the state. So we do not have any restrictions on who we partner with. Though those who connect with us typically fall in the women's health OBGYN. Some FQHCs. So one issue we identified as a team in the space is often times the patients we're seeing are uninsured or under insured and make right about the 250% of federal poverty line or below.

Sometimes their insurance status fluctuates. One year they may have insurance through an employer and one year they may not. That's especially true through the COVID pandemic. One issue we identified is it's difficult as primary care providers may refer a patient to our program either because they're due for their age or abnormality identified or, you know, strong family history.

The tracking of when patients have had their last screening, sometimes kind of falls through the cracks because of the different statuses in their insurance. So a way that we have been able to support this in our work is through patient navigation on our team. We have four patient navigators on our team who are routinely looking at our clientele and folks who used the services in the past to identify when the last screening was based on their age and screen guideline recommendations, follow up with patients to determine their current insurance status, and if we can help connect them to services again to ensure they're connected to screening.

>> Thank you for that. Lots of hands up. Let's go over to Dr. Callahan.

>> Yeah. So when we think about this issue here, in Texas, we think about it in a few different ways. The first thing we're always thinking about is trying to remember that rural health is not a monolith and within rural we need to think about particularly vulnerable groups within rural communities. A bigger point we always have is that we want to make sure the screening we're providing and care we're providing is going to be culturally competent especially in the state of Texas, language specific. So the way our center tries to work on that, is by making community health and working alongside the doctors to make sure the patients get the services they need and service that bridge. So that is something we're always thinking about here in Texas.

>> Great. Thank you. Dr. Amin?

>> Thank you. A lot of things have already been brought up. I'll start with Dr. Ghosh because I agree with her completely. The first think is buy in. Once we get the buy in with the community, even from the clinics, then we're able to move forward. Our project, the GRCCP, the colorectal grant is focusing on the evidence based intervention. And that leads into what Casey was talking about, is our number one thing we found the most effective is patient navigation. So Horizons, the Cancer south Georgia Coalition is they take the patient navigation aspect of our colorectal program and do breast as well. Some mammograms. We found that is the number one way to it increase rates across the board. Because the providers are doing their job nine times out of ten. They're giving the tests or referring to colonoscopy or referring from mammogram. Once they leave the clinic, the patients don't have as much, you know they don't have the buy in themselves so they're not followed so having the navigation aspect is critical.

And also, the other evidence based interventions are the provider reminders. So reminding the providers what they need to do whether it's a daily or weekly basis or what not. Then providers have feedback so giving them the screening rates, as someone mentioned, the data so they know where they stand at a continual basis. That's something we try to do monthly for our providers at Albany Primary healthcare and the metrics we're trying to hit. And finally, patient reminders. That's the hardest thing for us in rural health. Is addressing those barriers. To getting patients to come back to see us in a year and a day or whatever the timeline might be, because, you know, they might lose their phone numbers. They might have out of date addresses. Voicemails are full, XZY XYZ.

And then addressing the barriers to care which could be transportation, insurance issues. Could be literacy both healthcare and actual literacy issues which we're finding could be the case in some clinics. So I mean, we have already talked about so much stuff but in the next hour, we'll dive into some of the things.

>> Great. Thank you so much. Dr. Caudle, over to you?

>> Yeah. Clearly the strong points are cervical cancer screening, particularly with the new methods. It's disappointing that according to the ACS American Cancer susociety, 30% of women get pap spear only screening when the HPV screening is much more sensitive and accurate. It takes three regular pap smears to equal one HPV test.

It's also disappointing that a lot of the pap smear only smears are done at HQFCs and health departments. So we need it's good that people get something done but we need to encourage people to use the most up to date and reliable methods for cancer screening. There are various reasons such as doctors don't want to change but the financial issue looms in the background too. There is no reason why centers should have to pick an inferior test because of some cost of screening. I'm getting on my soap box.

So the other thing of course is HPV vaccines. Our pediatricians and we are rapidly doing. And of course colon cancer screening like Dr. Amin said. Our problem here is for one thing, Tennessee did not take the Medicaid expansion. We have a real hard problem getting GI to see people with positive screens. And our people do come in and out of various providers as the rest of people have expressed

here. It's hard to track down the data on when the last screens were. And we're kind of dealing with a hodgepodge system.

We had some success and increasing the rate of minority populations. You know, such as, you know, the hospitals in Memphis. The health departments throughout the state. And various other entities.

>> Thank you for that. So many important issues here. Just want to take a moment and offer the floor to our panelists now that you've heard each other kind of share your initial answer to the question a little more about your organizations, do you have any additional thoughts to add for us? Happy to pause for a moment if anyone would like to say anything more before we move to the next question. There so much to say. We don't want to miss a word. Dr. Ghosh, yes, please?

>> We were able to move forward with IT. Initially three years ago, we didn't have IT staff that could really help us we're on an electronic medical record and for us, you know, being able to have those consultants even with Epic which to help us optimize the project that we were doing, our ability to gather data in our clinic was really important for us to be able to move forward and be able to get the data we needed during our project and to be able to move forward with the outreach we need with our patients.

>> Thank you. Dr. Amin?

>> Yes. I actually was thinking along the same lines, Dr. Ghosh. That's one thing we found. In community health centers, the providers are bogged down like crazy given so many metrics to hit and all the KPIs and numbers. It's an uphill battle for sure. A lot of things that are discussed are the physician fatigue aspects. So optimizing we use ECW so just being able to kind of implement the order set so they can quickly and easily get a referral set down and don't have to click 18 different things to get a diagnosis and XYZ. That goes a long way. Streamlining what we have and using the electronics to our advantages.

But to Dr. Caudle's point, the cost is always the biggest issue especially for colorectal and that aspects of colonoscopies and not everyone can handle the cause and that causes a barrier for the uninsured and uninsured patients we deal with.

There is a coalnoscopy needs calculator and you can present that to a hospital system saying this is the patient demographics and this is what we have. If by buying into or partnering with us, offering us some kind of deal or partnership, you'll save X amount dealing with the screening now versus, you know, 7 to 10 years later, dealing with the cancer with cancer prevention or oncology, whatever intervention may be necessary at that time.

So that's a huge thing we're using for our partners to try to show them that this is a reason to buy into the community and help out. Again, it's whether they can do it or not, the GI offices or willing, that's a different story but something we can track.

>> Thank you. Dr. Caudle?

>> I've seen some real tragedies in my time here, 11 years, particularly from rural areas where patients came in with advanced cervical cancer, including deaths and the reasons why they weren't screened was we had no insurance. Well, in Tennessee, everybody can get on what's called the Breast and Cervical program. It's an offshoot of Medicaid. It's very sad. Some of them were quite young but we need some kind of information campaign. I see the things on TV about not smoking. People had radical necks. People need to understand they can get screened, you know, and they don't know that in the rural areas. Or even in in Knoxville sometimes.

>> Go ahead, Dr. Amin. Thank you.

>> I wholeheartedly agree. I think the overall question is what's the highest priority, I think it's getting education. Although people may we're in the business and see all the campaigns and everything. But I don't think outside of our bubble sometimes, it spreads far enough. So I think the education is the highest priority. Not even for patients. Patients 100% but also for providers to show them, for instance, the HPV testing rather than just the pap smear because that's all that is really done here at our community health centers. They don't go the extra step. So yeah, 100%. That's kind of what we need to do.

>> Great. Thank you. Go ahead, Casey, then Dr. Ghosh.

>> I would support 100% what my colleagues are saying about education. I would just add to that, for any and all of the funders who are on the call, that often times it's not the most funded work as it's not always, you know, seen as measurable and quantifiable so to keep that in mind, that for those of us who are doing that education work, of which Adajio Health does a ton of, we need to put the dollars behind that to support that work.

>> Thank you for that. Did I miss a hand?

>> I just quickly wanted to just wanted to say something that we learned about education on sort of a real ground level and doing this project, we outreached to approximately 1700 patients. And this was done with a team of a small team of medical assistants and me and just basically calling people. I mean, very sort of basic and also, you know, leaving messages, et cetera. One thing that was interesting is understanding the percentage of patients that not 21 year olds but 54 year olds that didn't understand they needed a pap smear but also once we educated them, not in an in depth level but a phone level that you still need the screening and the whole point was 50% of the project was trying to have patients come in for pap smears by having dedicated pap clinics both within like, regular working hours and extra clinical sessions to have women come in at night or weekends to help them. 40% of the patients still didn't show up. So we know that even our outreach that was so intense, even though 60% of women did show up of those who made appointments, a a lot of women still didn't show up. Even more work for us, our next steps are definitely more work in the community and using our community health workers and to be able to increase awareness for all of this, but I mean, I think I was a bit naive that even with the education we were giving on the phone that still patients making an appointment and coming in for that appointment was still still barriers.

>> Thank you for that. I think I don't see any more hands regarding that topic. Oh so why don't Tom, over to you for our next question?

>> I think this builds on some of the discussion that's already taken place, but I think this will certainly bring Holly back into the discussion. One of the primary barriers that you are seeing in effective cancer care and rural areas and are you aware of any organizations or has your particular organization identified solutions that have been successful and helpful in that regard? Not to set you up, Holly, but I thought I would.

>> Yeah. That's fine. I think that one of the things that is a hard problem to solve, though I think getting easier with telehealth is the workforce. The percentage of rural counties that do not have the right providers to treat patients is huge. And, you know, we we have seen a big differences in the rate of that, you know, the stage of diagnosis, for example, by different socioeconomic status. By different racial groups. And so if the people aren't there where they are, the distance they have to travel is so much farther, that's a big economic impact not just in the cost of traveling but think about being gone from your home, your work and so forth. I think the workforce is a huge issue for all kinds of healthcare, for rural populations and cancer is one of those things.

>> I'm glad you brought up telehealth. Let's go to Tim and then Casey.

>> Yeah. I think Holly is absolutely right. The provider issue is real and needs to be thought about. In addition to that, I think there is other barriers in rural communities. One of the obvious ones is access to care. Especially in more red states with large (?) populations. Texas alone is over 5 million uninsured Texans and that doesn't necessarily take into account the undocumented immigrants in the state with limited access to care. So thinking about a holistic view on screening, and treatment, insurance is going to be a primary barrier to individuals seeking out the service. Rural communities you also have to be worried about transportation and well over 100 rural hospitals closed over the past decade. Providers tend to pack up and leave and people are traveling further and further to the care they need which is increasing the travel burden for people to get the screenings they need.

And two other things, one is we might not even be thinking about this, but for some areas of rural communities, time off work is a real concern. Especially certain agricultural sectors. Getting to a cancer screening during business hours is a huge challenge. And lastly I think we can't ignore in some vulnerable minority communities there are real concerns about trust in healthcare institutions. I think all of those kind of limits the access that some individualess have to the care they might need. Especially preventive care.

>> Great points, Tim. That can also lead us to more discussion in community health workers. Let's go to Casey.

>> Thanks. I echo both what holly and Tim shared and rather than talk about barriers, I want to share a little bit of what we're doing to help remove the barriers. About almost two years ago, we received funding as an organization from the Office of Population affairs. We're also a Title 10 provider in Western PA, and we were able to purchase a mobile unit. So Adajio Health has been in business for over

50 years, and we have been in communities in western Pennsylvania for that long. So we have really sunk our roots into the rural communities we serve. We're a trusted and known healthcare provider. So the funds through Title 10 to purchase the mobile unit to kind of reach further into rural Pennsylvania to partner with YMCAs and partner with smaller employers who are not able to offer their employees health insurance to do a pop up mobile event has been really successful for Adajio and our title world and also helped us to compliment our cervical and breast cancer screening programs. While our mobile unit is there offering title services, we're also offering breast and serve cervical cancer screenings as well. A lot of that ties together on how we're trying to remove barriers for patients in the rural communities.

>> Glad you brought up the mobile health option. I think that's incredibly important in this work too. Dr. Amin?

>> Yeah. As Casey said, I was going to mention that we also started the mobile thing. But she mentioned it so I won't do that. But one thing that I can add to some of the similar barriers we're facing, again, access to care, insurance, transportation, cost, everything. One thing we found would help the most is the navigation again. The navigation to screening has helped tremendously. One for ease and education for the patient. They're not as intimidated to speaking with the navigators and help hand hold throughout the whole process and get it done. They also address and help fix the barriers. So for instance, through our program, we're able to offer gas cards for instance to pay for patients to get to clinics or to the GI office if need be. And then prep and things like that. Education and how to do the prep where the providers might be bogged down. The offices can't spend that much time. That helped fill the gap there.

Then just in general, for I guess trust of the whole process. They trust the navigators and like I said, someone bothers you for a whole month to get something done, you're more likely than doing it rather than saying yes and leaving the office.

>> Great points. Nancy, why don't we go back to you for the third question?

>> Thanks, Tom. Okay. The third question is what recommendations might you have to support patient engagement in cancer screening? I know we heard a few of those already. What might you like to share with us about that? Patient engagement in cancer screening. Yes, Dr. Caudle?

>> We need more providers of color. We're not getting anywhere with this idea very fast. But there is a level of distrust among populations when they look at somebody that looks like me. We found even nurses of color and MAs of color help. We have to do something to try to get the providers of color out. I know for example, in the state of Georgia, they formed a network of African American physicians to try to promote this.

I'm getting desperate. I think it's time to go into schools and talk to children at elementary school and encourage them to become doctors, not just nurses. The little girls can be doctors or some other I'm not disparaging the other occupations. But we are a long way from getting anywhere. The number of African Americans and Hispanics and other people of color in medical schools is not going up very much.

>> So important. Thank you for raising that critical workforce issue. Over to Casey.

>> Another thing I want to add, I mention that Adajio Health has been in business for over 50 years now, and one of the things really important to our work is we're serving generations of women. We're currently working with the grandmothers, mothers and grand daughters. Multi generational patients. One thing that I know that we strive to do in our practices and strive to share with our partners across the state is to talk about the importance early on. So for grandmothers to be talking to their daughters and, you know, mothers talking to daughters about, you know, family history. About lifestyle factors and to support that through family has been really important in our work. And I think that you can't underestimate the importance of that familial tie especially between women.

>> Fantastic. Dr. Callaghan?

>> The most important thing to build patient engagement in cancer screening is make sure you're trying to build trust. And getting screening and what they might need. There is lots of approaches you take to do that. The way Our Street is by relying on community health workers to lead the charge. Right? By having leaders from within communities encouraging others within the communities to participate. You're helping to sort of bridge that gap of trust that might exist and make sure people have someone encouraging them that they trust to seek out the care they need. So we tend to rely on that. It's certainly not the only model but we found it to be quite effective ourselves.

>> Excellent points. Thank you so. Dr. Amin? Would you like to add something? Oh, I think you're on mute.

>> Sorry. Everything echoes a bit and it all tied together for sure. Like Dr. Caudle mentioned, having people of color does help. Especially, again, I know I kind of am beating this to death but a navigation process and having someone in the community understanding the barriers you're going through and might reach. Also for providers, 100%, we need more diversity and more someone they can trust. But also just staff in general. I'm noticing a lot of FQHCs. We're having a lot of turnover issues in general and MAs and staffing issues across the board. Not having a cohesive, you know, base for patient to go to, is hard because when you have turnover, there is no standard operating procedure. Then there is chaos within the clinic and then the chaos outside. So that's something there is no easy answer. I don't have a solution. But it's something that needs to be discussed probably, you know, for the the ongoing overall goals.

>> Really helpful. Thank you. Dr. Ghosh, did I miss your hand?

>> I sort of raised it and put it down. I didn't want to be repetitive. The only thing to add impatient engagement is sort of also obtaining an understanding of lack of engagement so when patients are with you, like surveying patients, again, very basic things to ask patients in their native languages, et cetera, about why don't they want to get the screening done and sort of, you know, to be able to do that with community health workers is great. We do have some community health workers at the FQHC. It's not the main way to reach patients. That's with our MA staff, et cetera. So I did get a greater understanding of patient needs through simple surveys and to be able to understand, you know, why they don't want

to get this done. That's piggybacking on trust and cultural competency and all that. Just sometimes numbers are very interesting for organizations to understand what the going on in the community. We have a feeling that AB and C going on, but it helps to see it on paper and statistics.

>> Absolutely. The data is important. Common theme we're hearing today. Great, any other thoughts to any of the things the panelists have said and an additional opportunity for discussion before we move on?

Okay. Great. I think Tom, back to you for the next question.

>> I think we hit on some of this, but it would be interesting to take a little bit of a deeper dive and talk about how you see this playing out in terms of health equity. We talked about rural/urban gaps. As jarring as those are, I think they're troubling when we look into racial and ethnic gaps and some of the factors and work there. I'm curious what the panel sees as some of the barriers in terms of achieving health equity and cancer prevention. We have Casey.

>> Yeah. This was already mentioned, but I think it warrants being repeated again. Workforce diversity certainly in the clinical staff is challenging from what we hear from patients to open up and trust providers that don't look like them. Also, that don't speak like them or can't speak to them. So I would definitely emphasize that. Access to translation. Especially in the rural areas. We had challenges in Pennsylvania for sure. Where there is not the ability to communicate with providers.

The one thing that I also want to add that we see in our work is breast and cervical screenings and I'm sure you all do as well. But insurance can be tricky. And it's tough to navigate. It's tough to understand. It can land folks in a financial disaster when they don't even know what they're taking action to do. So, you know, it's a pie in the sky hope and dream but if we can perhaps simplify some of these insurance issues, I think it would go a long way for folks to continue to engage in the continuity of care with regard to cancer screening for sure.

>> Yeah. That's a great point. Financial literacy is linked to health literacy and certainly in this condition. Any other thoughts on health equity concerns from the panel? Dr. Callaghan?

>> Yeah. This is more of a research one as opposed to a screening or treatment one. I think it's equally important which is we're increasingly starting to think about not just rural and urban and not just racial disparities but the intersection of the two. I think there is a growing need to have that research looking at the intersectionality. You might see small variations between urban and rural areas but the disparities can grow quite a bit larger. We have a lot less research looking at race and rurality and I think a lot more work needs to look into that. What little work we do have demonstrates that's where the biggest problems are. I think there is more that needs to be done there.

>> We certainly talked about that a lot and the limited sample sizes and sometimes not precluding real analysis. Dr. Andrilla?

>> The other thing, I was going to also mention that some of the interactions of being two different in too different of the disparity groups does have an extra effect. But also the thing that I think we need

to pay attention to is that there is huge regional variation within the country. What will work in one place is not necessarily what's going to work in another place. The problems that they are experiencing are really different. So I think this is going to have to be a tailored approach. There is a lot of data to suggest, you know, the insurance issue and lots of data to look at the racial differences, and there is a ton of data also to look at the geographic variation within our country. It shouldn't matter where you are in the United States whether or not you get the correct definitive cancer treatment, but in fact, it does. That's another thing we'll want to keep in mind.

>> It's a great point. Really is. Dr. Caudle?

>> I agree completely with that, and the Cancer Society is studying the issue of the pap smears and you see a huge variation across the country. The technology will continue to advance. Most of this screening is always going to be done by primary care providers. And we need a better system for educating.

Also, for consultation. I know in Massachusetts they developed a system for child sicitry to get access. We need stuff like this because people are not going to know what to do outside of our system when they get a pause a positive screen. It's one thing to do a test. It's another thing to figure out what to do when you get one.

>> Good point. Dr. Amin?

>> Well, just to add on, education I think is still a key aspect there because if you ask a random patient in the rural community or a person, they automatically have a negative connotation to clinics, to doctors, to cost of healthcare, to what's going to happen. So that I mean, again, as Casey said, pie in the sky. If we're doing a moonshot in front of reach for the stars here, changing the perception of medicine in this country and just what who it's for. Who is able to afford it. Who is able to get it and what it is. It needs to have a shift in some way. Again, it's not an easy answer or small task but if you ask the patients trying to target in the areas, they don't trust the system. They don't trust the providers as we discussed already. And they don't see themselves as the people we're trying to get care for. And so that is the one of the biggest hurdles that we'll have to figure out in this program to work eventually.

>> Thank you. All you raise really important points. If you don't mind me pointing this out, the funding opportunity that HRSA released today for the health centers to create the partnerships between cancer centers and primary care folks that people really trust. I think it will be an important step in addressing a number of the factor you raised today so look forward to seeing how that plays out. With that, Nancy, back to you for the next question.

>> Thank you for that perfect lead in, Tom. In addition to funding, what additional resources do you think are needed to improve cancer screenings and also health equity in cancer screenings? Yes, Dr. Caudle?

>> Not politically but when you think about the fact, that one way or the other, the governments pay for the majority of healthcare whether it's Medicaid, Medicare, the FQHCs, the health departments. But

still, I hear things like oh, these labs are too powerful or money drives everything. Well, somebody needs to get after the MCOs and in our state, the Medicaid is run by various MCOs. They need to insist on quality work, you know, adequately screened for the populations.

This is a hodgepodge medical system that we're trying to deal with, but it's time for somebody to get serious. When ultimately one way or another, it looks to me like the government a paying for a lot of this stuff.

>> Thank you for that. Casey?

>> This may be a Pennsylvania issue, although I'm sure it's not as it's growing across the nation. We are limited to a so our health insurance here is tied to a specific healthcare provider. And it limits the access and quality of care that folks have access to. It has become political and obviously a financial war, so we are seeing in our area that folks are leading quality to care based on their type of insurance. Which has become more and more troublesome.

>> thank you for that. Really important point. Other feedback on what additional resources might be necessary? Yes, Dr. Ghosh?

>> I mean, one thing, what I just mentioned that we don't have a ton of community health workers and actually a lot of our cancer screening work is done through our quality improvement teams to be able to improve that outreach and dedication to understanding what's going on with our patients with cancer screening.

We were one of the grants that I think is going to be a game changer for us is we were able to get 20 Americorps members so young people that are spending their lives and we were able to get the grant to get 20 people to come into the clinics to do what they need to do, and cancer pri it's a priority for us and having someone for cervical screening and to have the appropriate people. We're always talking about the teams around the work and being able to find those teams that is it's difficult and I'll be honest before hearing we were getting the grant, I didn't know much about Americorps, et cetera. But understanding what they were able to do for us, I thought adding to the workforce in the way will be really great and really help with the cause.

>> That's wonderful. Thank you so much for that. I'm seeing unfortunately we're getting to the top of the hour already. We know this conversation was just a start and there is so much so much rich information shared. I want to touch on a couple of themes that I heard coming forth through the discussion.

We heard about the importance of data. Using data. Some of the challenges with data. Some of the successes in using data. And program management with patients and organizations. A number of important workforce issues were raised. In particular, the great need for addressing diversity within the healthcare workforce. The importance of this across all disciplines. And including highlighting the role that patient navigators can play and should play in helping the patients through the healthcare system.

Cultural competency, of course, including linguistic access and competency and all that feeding into the concept of trust. Building trust with the individual patients. With the family and community at large. And how to work how to better work together to help change the perception of that patients may hold of the medical system in their community and across the nation.

Also, education. Importance of education and outreach to patients and also to providers about screening and the need and importance of screening. And of course last but not least, payment issues. Insurance issues. Financial literacy and the way that those issues can impact access to care. So those are just some of the top line highlights I pulled away for this important discussion. We will be summarizing all the feedback as I mentioned in my opening remarks. Feeding your comments back up to the white house cancer cabinet to take action on the goals of the Cancer Moonshot.

Tom, over to you for any closing remarks you might have for our wonderful group of panelists and participants today.

>> Just thank you. I wanted to just hearing you all and watching you react to each other and some interesting models that you have underway and also, you know, just a real understanding of the challenges out there, but you're all solution focused too and that's really rewarding to hear. Thank you for taking the time to be with us today.

>> Thank you so much, everyone. Thank you again and have a great rest of your day.

>> Thank you very much.

>> Thank you for having us.

(Webinar concluded at 2:00PM CT)