



South Carolina Cancer Alliance

February 19th, 2010 Member Meeting Breakout Summaries



Breast Cancer Breakout Notes

1. What is the science?

- a. Disparities in genetics, eating habits, behaviors, metabolism syndrome

2. What is the need?

- a. Overall increase in rates of screening (AA Females)
- b. F/u care

3. Impediments?

- a. Best chance funding capacity
- b. Societal perceptions of weight

4. Priorities?

- a. Communication Piece
- b. Legislation advocacy
- c. Clinical trials
- d. Increase in partnerships, i.e. Komen Fund, Avon
- e. Continue to study disparities
- f. Success of mobile Program
- g. Latino Female access

Cervical Group Discussion Notes

1. What is the Science?

- a. Reliable early detection
- b. Pap test- best available

2. Opportunities:

- a. Vaccines (HPV)
- b. Politics
- c. Education
- d. Prevention (Pap test)

3. Obstacles:

- a. HPV or abnormal paps not reportable
- b. Patients' lack of HPV knowledge (basic knowledge and clinical recommendations for patients)
- c. Predicting who will get cancer
- d. Politics
- e. Education

f. Concept dissemination / sex at early age

4. What is the Need?

Specific issues/ challenges:

1. Fear of poor distribution, payer issues
2. State health plan- no reimbursement?
3. Follow up care
4. Knowing where to access to care (informing both patients and referring entities: churches, clinics, etc.)
5. Money, community resources, transportation
6. Issues with providers not following guidelines, lack of American College of Obstetricians and Gynecologists (ACOG) and other uniform institutional protocols

Additional helpful data:

- Who are the women not typically screened?
- Why do these women fail to be screened?

5. What are the Impediments?

- a. Lack of providers; inadequate training of providers
- b. Lack of awareness of screening recommendations
- c. Fear/avoidance/uncertainty of where to access and what to do

Intervention strategies:

- Advocacy to create funding and extension of health plan coverage (specifically state health plan)
- Education of women screened and legislators

6. What are our Priorities? (ranked):

1. Educate the community
2. Continue funding BCN, follow up care, and vaccines
3. Emerging populations (Latinas) and overcoming language barriers
4. Promote screening and available vaccines and establish Federally Qualified Health Center (FQHC) guidelines for patient care

CRC Breakout Notes

These notes are from an individual

1. What is the need?

- a. Look at maps provided: incidence, mortality of CRC by race, sex
- b. Last 5yrs- made improvements in Greenville (New Horizons- way to get colonoscopy – improvement)
- c. Practice: Midlevel providers (Dr. Yarborough)- so many colonoscopies done, need more time doing colonoscopy
- d. Uninsured, Underserved: add data
- e. More recent numbers

- f. What is the denominator?
 - g. Goal: Colonoscopy for every applicable person, all you need is screening rates
 - h. Problem recording, no good procedure registry, Can't equal numerator to real denominator. Why don't we have a registry for procedures? We can create the denominator
 - i. Data in a lot of places (hospital billing)
 - j. Find out in Greenville at places that do colonoscopy
 - k. Problems getting this data is in overlap in codes for colonoscopies
 - l. Self-report/ questionnaires
 - m. Something specific in every chart- a good thing (this is possible, done with mammogram registry)
 - n. Are we making a difference? (some populations are not being served or missing)
 - o. Not getting colonoscopies: money, impediments, preparation, misinformation "scare tactics", fear of complication, fear of outcome "knowing", fear that procedure causes cancer, distrust of medical system, don't have system/access or place to be screened, awareness, missed days of work and someone to drive them home (bring procedure to the community), open access, having a provider in your area that can do procedure.
- 2. Priority: what do we want to do?**
- a. 2020 or 2011 plan?
Make the biggest difference, target, crc taskforce (Dr. Gerger and CCR Work)
 - b. What are the priorities? Combine coverage with specific, sensitive, predictable value; quality of tests, focus on this (not every test practice); focus on mortality; preventing cancer and costs associated with it; stool cards vs. colonoscopy
 - c. Unified Message: Here's why we should do this; take in all parameters (stool card, follow-up with colonoscopy and costs); clear plan for states; good, better, best message

These notes are from the flip chart:

1. What is the science?

- a. Public Health- efficiency vs. effectiveness
- b. Most cost effective= hemocult- does not prevent and may catch later, self reported screen rates (better than nothing)
 - 1) Takes part in action
 - 2) Better if in office
 - 3) Need repeat (3 times in office)
 - 4) Not high risk population
- c. Gold Standard = Colonoscopy

2. Impediment Solutions

- a. Primary Care doctors- best group to facilitate/encourage patients, better than awareness camp. And has improved by evidence based medicine (checklists)
- b. If no primary care doctor- Other access points (targeted)

- 1) Media
- 2) Church
- 3) Barber shop

*Massive amounts of insurance money spent avoiding colonoscopies before diagnosis (age 38)- Even state and CMS agree colon. Is “cost effective” therefore state/scca goal

- d. Include GYN
- e. Instill Standards(If not- at least do a deg. 3X Hemocult and records/tracking) Office based reality- need to ensure quality
- f. Making assumption- do smart people go to doctors
 - 1) Target- Medicaid and Medicare (covered but no change in rates)

3. What is the need?

- a. More results in numbers and how in the uninsured, underserved (how to get data- don't know denominator)
- b. See last page- data only shows found
- c. Number of people in each group greater than age 50
 - 1) Hospitals- # of billes proced.
 - 2) Office- different codes
 - i. Col.
 - ii. Col. And polyp removal
- d. Go incidence registry but not procedure rate
 - 1) Money
 - 2) Prep- created problems, miscommunication (mis/scare tactics, stories are about negatives not pluses) * Vocal opponents
 - 3) Fear of complications (actual science->very small)
 - 4) Fear of “knowing”
 - 5) Distrust of medical system (being sold)
 - 6) Don't have system/ access or place to “be convinced”- navigated
 - 7) Awareness (go elsewhere)
 - 8) Missing days of work, transportation/ drive home
 - 9) Make procedure accessible as info/convincing/education

NY success- like SCOPE

 - i. Open access: let primary care do pre-consult and go straight to GT for procedure
 - 10) Inconvenience- 2 appointments
- e. Focus on mortality- focus on all types of testing (stool cards -> still need colon.)
- f. Combine coverage- see James
 - 1) Unified message- good, better, best (stop debating)

Lung Breakout Notes

1. What is Science?

- a. Low cost/ benefits, screening with no decrease in mortality
- b. Lack of supportive science of screening
- c. Low yield mass screenings ? Screen high risk
- d. Lack of funding for clinical trials for screening and treatment
- e. Limited encouragement from primary care providers
- f. Free radon test kits
- g. State tobacco quit line
- h. Increase in tobacco tax will decrease smoking rate
- i. Smoke free workplace

2. What is the need?

- a. Comprehensive statewide smoke free workplace
- b. Increase tobacco tax
- c. More monetary assistance with smoking cessation, meds, etc. and counseling
- d. Increase in money towards youth prevention
- e. Lung cancer research
- f. Educational awareness for healthcare professionals
- g. Develop health lung assessment tool- paper/internet

3. Call to action

- a. Large increase in cigarette tax while making community-Smoke free workplace
- b. Work group for lung cancer awareness and advocacy
- c. Mandatory radon home testing at point of sale

Oral, Head & Neck Cancer

1. 2010 Goals

- a. Increase percentage of reported incidence of oral exam to 30%
- b. Increase in early detection of AA early stage cancers
- c. Increase in early detection of AA and esophageal cancer

2. What is the science?

- a. Dr. Susan Reed: BRFSS had questions added in 2002
- b. Dr. James Hebert: Would like to do some and add HPVquestion To compare results and answer questions
 - 1) Recommendation for SCCA to fund adding these questions to the 2010 BRFSS (\$1000 per question)
- c. Mortality rate nationally better but might not be seeing behaviors, just treating early (Susan Bolick could get information for treatment/stage ---Cancer Registry)

- 1) Need to look at shifting stage of early detection (stage 1 or 11) to over 30%
- d. Should we change language in our cancer plan?
 - 1) add HPV related head and neck cancers
 - 2) 2002-2010- Bar graph separated by year WM,BM,WF,BF to look at incidence/mortality
- e. Intervention only doing talks and screening

3. In the community...

- a. Talking point father:sons to discuss HPV in Columbia
- b. FAQ on HNCA website about HPV and Oral cancer
- c. Get legislation to track nopharynx cancer with HPV testing
- d. Need to educate health care professionals but differently
- e. Goal- what should alliance do next for oral screenings?

4. What is the initiative?

- a. Educate GP's, dentists, NP's, PA's, DNP's, FM(SC academy of family practice)
- b. Get legislative backing to have this included
- c. Contact organizations need to get questions on nursing exams (need LLR approval) Exams equal change in curriculum
- d. Precedence where OBGYN includes component on immunizations
- e. Collaborate with professional organizations to partner with mission statement from SCCA
 - o Ashley Lausen volunteered to work with SCCA and help generate goals for this initiative

Prostate Breakout Notes

1. What is the science?

(PSA only tool we have, do we listen to the science?)

- a. ? new information to urologists
- b. Economically driven
- c. Patient cooperation
- d. Education for everyone, information on PSA costs
- e. Do we over react?, especially high risk?
- f. Not completely there

2. What is the need?

- a. talk to physicians
- b. Do we lose people because of follow-up after screening
- c. Parameters for screening

3. Impediments

- a. Pocketbook- too expensive
- b. Believing the science
- c. Getting the people to get it done

d. Do we stand our ground?

4. Additional data

- a. Screening parameters- primary physicians explain options to patients
- b. Predictive data
- c. Robotic surgery- is it better? Compared to open procedure

5. Opportunities: Prostate Cancer Workgroup

- a. Education-physicians, patients
- b. Screenings (criteria) recommended
- c. Checklist- do you have primary care?
- d. Reactivate workgroup
- e. Develop scripting for screenings?
 - o Are screenings an economical way to find cancer?
 - o Do screenings become a forum for education?

6. Priorities

- a. Educate urologists to the science
- b. Educate primary care physicians to new guidelines
- c. Billboards-cheap way to educate people
- d. Don't screen the wrong people
- e. Practice medicine to do the right thing
- f. More real time report card data