Community-engaged approaches to increase cancer screening in high-risk populations

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ARKANSAS CANCER SUMMIT
MARCH 28, 2017
Presentation Overview

- Overview of disparities in breast, colorectal, and lung cancer
- Cancer screening in underserved populations
- Why a community-engaged approach to increase screening?
- Examples from communities
- Potential impact of healthcare reform on cancer screening
Progress toward 2020 cancer goals

- Cancer mortality rates in the United States (US) began to decline in the 1990s, following declines in smoking and improved screening and cancer treatment (Byers, 2010)

- Unfortunately, significant disparities by race/ethnicity, socioeconomic position persist
Age-Adjusted Breast Cancer Incidence

Rate per 100,000

Year of Diagnosis

White  Black

SEER, 2016
Age-Adjusted Breast Cancer Mortality

SEER, 2016
Age-Adjusted Colorectal Cancer Incidence

SEER, 2016
Age-Adjusted Colorectal Cancer Mortality

SEER, 2016
Age-Adjusted Lung Cancer Incidence

SEER, 2016
Age-Adjusted Lung Cancer Mortality

SEER, 2016
Female Breast Cancer
Breast Cancer Disparities

- Although incidence rates are higher in whites, blacks with breast cancer have a higher breast cancer mortality.

- Compared with their white peers, black women are more likely to be diagnosed at a later stage, are less likely to receive stage-appropriate treatment, and are more likely to have lower stage-for-stage survival rates (Dunn, Agurs-Collins, Browne, et al., 2010; Brawley, 2013).

- Also, compared with white women, black women (especially premenopausal black women) are more likely to be diagnosed with estrogen receptor (ER) negative tumors and ER-negative subtypes, including triple-negative subtype (Dunn, Agurs-Collins, Browne, et al., 2010).
Screening Mammography

- US Preventive Services Task Force recommends that women receive screening every two years from age 50 through 74 (USPSTF, 2009)
- Screening mammography has been nearly equivalent among racial/ethnic groups for a decade (Bickell, 2002; Breen, Wagener, Brown, et al., 2001)
Breast Cancer Mortality Gap

- Even when controlling for stage at diagnosis and insurance status, differences in mortality persist.
- Multiple factors may explain why patients receive different treatments and experience:
  - Health literacy (Polacek, Ramos, Ferrer, 2007)
  - Cognitive and social network factors (Magai, Conedine, Adjei, et al., 2008)
  - Trust in the health care system (Blackman & Masi, 2006)
  - Health-care seeking behavior (Talcott, Spain, Clark, et al., 2007)
- Black women are more reluctant to enroll in clinical trials and thus may have poorer access to innovations in care (Movsas, Moughan, Owen, et al., 2007).
Colorectal Cancer
Colorectal cancer is the second most commonly diagnosed cancer in the US and the second leading cause of death from cancer for both sexes combined (Byers, 2010).

Incidence has been declining since 1985, likely related to declines in smoking and increases in nonsteroidal anti-inflammatory use (Byers, 2010).

Despite screening and improved treatment for CRC, disparities in incidence and mortality between blacks and whites persist (American Cancer Society, 2017).

Blacks have the highest CRC incidence and mortality among racial and ethnic groups (ACS, 2017).

Blacks have an earlier median age at CRC diagnosis than whites (Robbins, Siegel, Jemal, 2012), resulting in some groups recommending screening before the age of 50 for this population.
Colorectal Screening Disparities

- Up to 60% of CRC deaths are estimated to be avoidable through regular CRC screening (Whitlock et al., 2008)

- Screening for CRC (including endoscopy or fecal occult blood testing) in blacks and low socioeconomic populations is lower than whites (American Cancer Society, 2017)
  - Decreased trust in healthcare professionals
  - Fewer preventive healthcare encounters
  - Less access to health insurance
  - Lack of knowledge regarding CRC
  - Fear of screening discomfort

(Halpert, Armstrong, Gandy, et al., 2006; von Wagner, Good, Whitaker, et al., 2011)
Colorectal Cancer Screening

- USPSTF recommends colorectal cancer screening for adults aged 50 to 75 using colonoscopy, sigmoidoscopy, or fecal occult blood testing (USPSTF, 2008)

- A number of interventions have been studied to improve screening in health disparity populations
  - Emphasis on physician recommendation: Increasing availability of PCPs and colonoscopy providers has not closed the screening disparity between blacks and whites
  - Improved health care coverage: ACA Medicaid expansion
  - Patient navigators: Meta-analysis found that interventions comprised of education sessions, reminders and navigation services increased CRC screening by 10-15% (Naylor, Ward, Polite, 2012)

- Higher CRC screening in underserved populations with fecal occult blood tests (Gupta, Halm, Rockey, et al., 2013)
  - In comparing guaiac based fecal occult blood test (gFOBT) and the fecal immunochemical test (FIT), FIT has emerged as the superior option for CRC screening (Park, Ryu, Kim, et al., 2010)
Meta-analysis of 19 studies found FIT sensitivity of 79% (Lee, Liles, Bent, et al., 2014)

As FIT detects protein globin, it is susceptible to false-negative results secondary to protein degradation: factors impacting performance include processing time and temperature.

Offering free FIT kits has been effective in engaging hard-to-reach populations, including US-born and foreign-born blacks in South Florida (Christy, Davis, Williams, et al., 2016) and Appalachian whites (Crosby, Stradtman, Collins, Vanderpool, 2016)

Navigation may still be needed for FIT positive patients to receive colonoscopy.

Many investigators are now tracking multi-year FIT screening and follow up.
Lung Cancer
Lung cancer is the leading cause of cancer-related mortality among both men and women in the US and many other countries (American Cancer Society, 2017).

Reductions in smoking among adults has had the greatest impact on overall cancer rates, but particularly for lung and bronchus.
5-year Survival Rates

- 99% for prostate cancer
- 90% for breast cancer
- 65% for colon cancer
- 18% for lung cancer

American Lung Assoc. Lung Cancer Fact Sheet
Lung Cancer Survival by Stage

Cancer Stage at Diagnosis

<table>
<thead>
<tr>
<th>Cancer Type</th>
<th>Stage 1-2</th>
<th>Stage 3-4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast</td>
<td>0%</td>
<td>100%</td>
</tr>
<tr>
<td>Colon</td>
<td>20%</td>
<td>80%</td>
</tr>
<tr>
<td>Prostate</td>
<td>40%</td>
<td>60%</td>
</tr>
<tr>
<td>Lung</td>
<td>60%</td>
<td>40%</td>
</tr>
</tbody>
</table>

Non-Small Cell Lung Cancer Five-Year Survival Rates, by Stage at Diagnosis


https://progressreport.cancer.gov/diagnosis/stage
Lung Cancer Screening

- Screening high-risk smokers for lung cancer with low-dose computed tomography (LDCT) scans reduced lung cancer mortality by 20% in the National Lung Screening Trial (NLST Research Team, 2011)

- Recommended by the US Preventive Services Task Force, the American Cancer Society and others (Moyer et al, 2014; Wiener, Gould, Arenberg et al, 2015; Wender, Fontham, Barrera, et al., 2013)
  - Annual low-dose CT scans for current or former smokers between ages 55 and 80 who smoked for 30 pack years and currently smoke or quit within the previous 15 years

- A cost-effectiveness analysis by Black and colleagues (2014) found that the NLST protocol (3 annual CT screening rounds) had an estimated incremental cost-effectiveness of $81,000 per QALY gained relative to no screening, which is considered moderate to good value compared with alternative strategies

- However, others have suggested that important factors have not been evaluated... (Roth & Ramsey, 2016)
Quality assurance programs should consider monitoring for overscreening

Educational materials for patients and referring clinicians should be clear regarding
- Risks of false-positive screening results
- How to resolve most abnormal results without invasive procedures
- Management of anxiety with abnormal results

Armstrong, Kim, Halm, et al., 2016
Lung Cancer Screening Considerations

- How CT screening is performed in community practice compared with academic centers, where the NLST was conducted
  - If more false positive results occur in community practices than occurred in the NLST because some clinicians interpreting results may have less experience, there could be more follow-up imaging, more invasive diagnostic procedures and more harms, reducing the value of screening

- Improved nodule management protocols could reduce the proportion of false positive results
  - Already occurring with the introduction of the Lung-RADS protocol, a tool that standardizes CT screening reporting and management recommendations
  - In a retrospective analysis, the Lung RADS protocol was associated with a reduction of false positives from 26.6% (in NLST) to 12.8% (Pinsky, Gierada, Black, et al., 2015)
  - This could reduce overdiagnosis, overtreatment and enhance the value of screening

- Long-term health consequences of repeated low-dose radiation exposure remain uncertain

Roth & Ramsey, 2016
Potential Policy Implications of Lung Cancer Screening Programs

- After accounting for cost-savings due to earlier detection of lung cancers, implementation of CT screening among Medicare beneficiaries is projected to increase expenditure by $6.8 billion over 5 years (Roth, Sullivan, Goulart, et al., 2015)

- Health insurers may reduce coverage for other services or increase plan premiums in order to cover the additional cost
Acceptability of Lung Cancer Screening in High-Risk Populations

- Some primary care providers may not be convinced of the efficacy of lung cancer screening or that the benefits outweigh the risks
- We are still understanding acceptance of LDCT among potential patients
- More to come shortly...
Successful Cancer Screening Programs
Keys to successful screening programs

- Develop systems for identifying and recruiting eligible individuals in primary care
  - Linkage of consensus guidelines with EMR, reminder systems
  - Breast, colorectal screening guidelines are based on age and sex
  - Lung eligibility requires information on smoking history and age

- Assure appropriate follow-up of suspicious lesions
  - National Breast and Cervical Cancer Early Detection Program covers treatment for women diagnosed through Medicaid
  - No similar program for colorectal or lung screening
  - Delaware comprehensive colorectal cancer screening program, which included a nurse navigator program, eliminated disparities in screening within 8 years, reducing mortality by 42% for blacks (Grubbs, Polite, Carney, et al., 2013) 

Armstrong, Kim, Halm, et al., 2016
Why Community Engagement?

- Growing recognition that “traditional” cancer prevention research and programming approaches have failed to solve complex health problems
- Demands for cancer prevention programming to address local needs
- Community-based participatory research or community-engaged programming may be more acceptable to communities that are historically distrustful of researchers or academic institutions
Community-Engaged Approach

- Traditional investigator-driven approach is a known barrier to translational cancer screening research and programming.
- Community-based participatory research or community-engaged research is an alternative approach to research that emphasizes partnership in all phases of research activity.
- Increasingly viewed by federal agencies as a promising approach to ensure that research findings are relevant to community needs.
Dallas Cancer Disparities Coalition

Funded by the National Cancer Institute (PI: K. Cardarelli)
1R21CA126732, 3R21CA126732-02S1
South Dallas/ Fair Park

- 75% African American, 22% Hispanic
- Median age is 30 years
- 42% of population is below the poverty level
- 73% of female-headed households are impoverished
- Median income is $17,000
- 57% of adults have not completed high school
- 44% of African American deaths occurred before 66 years of age
- LEAST HEALTHY AREA OF DALLAS COUNTY
South Dallas/Fair Park has the highest rate of age-adjusted cancer deaths in Dallas County.

According to the Texas Department of State Health Services, age-adjusted cancer death rates in South Dallas are 31% higher than the average Dallas county rate and 49% higher than the Dallas County Northern Corridor rate.

Coalition chose a community-based participatory approach to address the problem.
Specific Aims

1. To work collaboratively with the community to identify priority cancer disparities through a baseline community diagnosis that explores behavioral, cultural, dietary, socioeconomic, and political determinants of these disparities and the strengths and assets of the South Dallas/Fair Park area.

2. To develop innovative community-based intervention approaches to reduce and eliminate cancer disparities in the South Dallas/Fair Park area.

This study used a community-based participatory approach.
Focus Groups

Eligibility Criteria:
- 21 years or older
- South Dallas (zip codes 75210, 75215, 75223) resident
- Total of 5 focus groups, 44 participants
Focus Group Questions

- What things increase/decrease your risk of cancer?
- What experiences have you had with cancer (family, friend, self)?
- How do you get your healthcare? How do you feel about the quality of care? Do you trust your healthcare provider?
- Where do you get information about cancer? Do you trust this information?
Focus Group Questions

- What types of cancer screenings have you had?
- What comes to mind when you hear the word “cancer”?
- How do you think cancer rates in your community compare to other communities in Dallas?
- What can be done in this community to reduce cancer rates?
- What do you think about alternative medicines? Why do you/other people use alternative medicines?
Mistrust of institutions

“Also...things we ran into were...doctors talking about...treatment options that they were actually research participants in, and...not revealing that information...Is this really the best treatment for my family member or my friends, or is this just somebody else who you need to be as a research participant?”

“I mean, these doctors are telling you stuff and it makes no sense to you.”
Mistrust of traditional medicine

“‘The current regiments are very, very...toxic. So, what you have is...you have a relationship between...the medical establishment and the drug company. And, unfortunately, what’s happening is, is that a lot of treatments are being pushed because they’re profitable.”
Fear of cancer

“It’s scary because, like I said, when they told me I have to be rechecked [get another mammogram], I refused to go back…I say I’m not going to let them tell me I have cancer, instead of going to go and get the test redone.”

“They’re fearful to share it with you. They still under that myth that if I tell somebody, they’re not gonna want to be around me anymore, they gonna tell somebody. And it’s like a leprosy, so I’m not gonna tell anybody I got cancer.”
Fatalism regarding cancer

“In the Black community, as a whole, it’s always been taboo.”

“It’s the stigma. They…think they go to the hospital, that they ain’t gonna come back.”

[When you think of cancer] “The first thing that comes to mind is suffering...that the person’s going to suffer...and have a painful death or a long, slow.”
CAB designed a pilot intervention program

- Intervention program: Frazier Court neighborhood
- Control program: West Dallas neighborhood
Intervention Goals

- To increase the number of women above the age of 40 who know the main risk factors for breast cancer and ways to reduce breast cancer risk
- To increase the number of women who understand the importance of mammograms for early detection of breast cancer
- To increase the number of women who have been screened for breast cancer in the last year
Breast Health Education

- Eight week program
- Met once a week for 1 ½ hours
- Speakers were varied
- Grounded in Social Cognitive Theory (Bandura, 1989)
Program Topics

- Breast cancer facts vs. myths
- Methods for early detection
- How to eat healthy on a budget
- God’s will about wellness
- What a lump feels like
- What makes up a healthy community
- How to access health care resources
Lay Health Educators

- Received supplemental award from NCI to fund 2 lay health educators to support intervention activities
- Recruitment and retention
Control Group

- Fish Trap neighborhood with similar demographics to Frazier Courts
- Participants received written educational material from American Cancer Society and the Komen Foundation and were provided links to breast cancer screening
Participants completed survey with questions related to:

- Perceptions and experience with cancer
- Health behavior
- Access to health care/health care information
- Medical history
- Demographic information

Participants from both groups were compensated for their time with gift cards.
PILOT STUDY Results

<table>
<thead>
<tr>
<th></th>
<th>Intervention Group (n= 59)</th>
<th>Control Group (n= 60)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (average)</td>
<td>55</td>
<td>55</td>
</tr>
<tr>
<td>Race (% African American)</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Insurance (% insured)</td>
<td>74.6%</td>
<td>81.7%</td>
</tr>
<tr>
<td>Education (% HS or higher)</td>
<td>67.8%</td>
<td>65.0%</td>
</tr>
<tr>
<td>Income (% $20,000/yr. or less)</td>
<td>74.6%</td>
<td>91.7%</td>
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### Proportions, Odds Ratios, and 95% Confidence Intervals for Selected Intervention Outcomes

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Yes * (%)</th>
<th>OR ** (95%CI)</th>
<th>p Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Self-Examination†</td>
<td></td>
<td></td>
<td>0.047</td>
</tr>
<tr>
<td>Intervention Group</td>
<td>77.8</td>
<td>2.96 (1.01- 8.63)</td>
<td></td>
</tr>
<tr>
<td>Control Group</td>
<td>63.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Breast Examination‡</td>
<td></td>
<td></td>
<td>0.048</td>
</tr>
<tr>
<td>Intervention Group</td>
<td>63.0</td>
<td>1.21 (0.45- 3.22)</td>
<td></td>
</tr>
<tr>
<td>Control Group</td>
<td>61.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mammogram§</td>
<td></td>
<td></td>
<td>&lt; .001</td>
</tr>
<tr>
<td>Intervention Group</td>
<td>80.0</td>
<td>10.43 (2.99- 36.41)</td>
<td></td>
</tr>
<tr>
<td>Control Group</td>
<td>46.8</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Proportion reporting Yes at follow-up.
** Adjusted for baseline screening status in each model.
† Performance of a breast self-examination in the previous month.
‡ Receipt of a clinical breast examination in the previous year.
§ Receipt of a screening mammogram in the previous year.

### Linear Regression Coefficients and $p$ Values of Selected Intervention Outcomes and Intervening Variables

<table>
<thead>
<tr>
<th>Outcome</th>
<th>$\beta$</th>
<th>$p$ Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Cancer Fear and Fatalism*</td>
<td>1.147</td>
<td>0.377</td>
</tr>
<tr>
<td>Sense of Control†</td>
<td>0.319</td>
<td>0.674</td>
</tr>
<tr>
<td>Breast Cancer Knowledge‡</td>
<td>0.713</td>
<td>0.003</td>
</tr>
</tbody>
</table>

* Adjusted for baseline fear and fatalism score.
† Adjusted for baseline sense of control score.
‡ Adjusted for baseline breast cancer knowledge score.

Of women receiving a mammogram:
• 38% noted it was their first mammogram
• 32% had abnormal findings, required follow-up
Program funding

- Shortly after the pilot study, Coalition received two additional years of funding ($300,000) from the Cancer Prevention and Research Institute of Texas (CPRIT).
- First community to receive the program was the Fish Trap neighborhood.
- Then received additional $1.8 million from CPRIT to expand to all of Dallas County.
- Additional funding from NIH allowed the creation of a backbone organization to expand the model into Tarrant County (adjacent county).
Lessons Learned

- Sustainability is always a concern - explored options with Medicaid managed care companies, YMCA to institutionalize.
- Partner organizations (e.g., Komen, YMCA) obtained grant funds to support elements of the program.
- Some of the greatest successes are the removal of system-level barriers.
- Providers tend to not know or understand these barriers.
Lung cancer screening disparities in a high-risk rural Appalachian population

- PI: R. Cardarelli
- Funding: CCTS/ATRN and Markey Cancer Center
Lung Cancer in Kentucky

- Kentucky’s lung cancer mortality rate dramatically exceeds the national lung cancer mortality rate (73.2 KY vs. 49.5 U.S. deaths per 100,000)

- Study Aims:
  1. Develop a lung cancer screening campaign in Eastern Kentucky through a formative assessment involving high-risk target populations
  2. Implement the outreach intervention in Eastern Kentucky to assess the uptake of low-dose chest CTs
Focus Groups

- 2 groups in each region (10 people per group), for a total of 6 focus groups, in fall 2014
- Eligibility criteria:
  - Criteria for lung cancer screening (Age 55-80, Smoking history of ≥ 30 pack years, either former smokers quit <15 years ago or current smokers)
- CHWs conducted the recruitment and were trained to moderate the focus groups: Community capacity building
- $40 to participate (1-1.5 hours)
- 1 person selected in each group for the CAB
Focus Groups

- Began by assessing baseline understanding regarding lung cancer screening (LCS)
- Next, basic information about LCS was reviewed with participants
- Most of the discussion focused on receptivity to LCS
## Results from Focus Groups (n=54)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Smoking status</strong></td>
<td></td>
</tr>
<tr>
<td>Current smokers</td>
<td>34 (63.0%)</td>
</tr>
<tr>
<td>Former smokers</td>
<td>20 (37.0%)</td>
</tr>
<tr>
<td><strong>Pack years, mean</strong></td>
<td></td>
</tr>
<tr>
<td>Current smokers</td>
<td>44.3</td>
</tr>
<tr>
<td>Former smokers</td>
<td>61.7</td>
</tr>
<tr>
<td><strong>Age, mean</strong></td>
<td>61.8</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>21 (36.8%)</td>
</tr>
<tr>
<td>Female</td>
<td>33 (61.1%)</td>
</tr>
<tr>
<td><strong>White race</strong></td>
<td>54 (100%)</td>
</tr>
<tr>
<td><strong>Education level</strong></td>
<td></td>
</tr>
<tr>
<td>&lt; high school</td>
<td>10 (19.2%)</td>
</tr>
<tr>
<td>Did not complete high school</td>
<td>11 (21.2%)</td>
</tr>
<tr>
<td>High school/ GED</td>
<td>23 (44.2%)</td>
</tr>
<tr>
<td>Some college</td>
<td>8 (15.4%)</td>
</tr>
<tr>
<td>&gt; College degree</td>
<td>0 (0%)</td>
</tr>
<tr>
<td><strong>General health status</strong></td>
<td></td>
</tr>
<tr>
<td>Excellent/ very good</td>
<td>4 (7.7%)</td>
</tr>
<tr>
<td>Good</td>
<td>12 (23.1%)</td>
</tr>
<tr>
<td>Fair</td>
<td>20 (38.5%)</td>
</tr>
<tr>
<td>Poor</td>
<td>16 (30.8%)</td>
</tr>
</tbody>
</table>
Baseline Understanding of Lung Cancer Screening

- Overwhelming majority of participants had never heard of LCS
- Little understanding about the difference between diagnostic and screening tests
- Many thought x-rays, ultrasounds, biopsies screened for lung cancer

“*You mean you could be symptom free and still have cancer?*”
A majority of participants stated they would consider having LCS themselves.

Only two participants felt differently:

“No, I don’t want any. I don’t wanna know, I just wanna go. When the Lord wants me, I just wanna go.”
What is the most important message?

- Primary response across all focus groups was the importance and benefit of early detection.
- Specifically, that LCS can bring “peace of mind.”
- Also include statements that LCS is covered by most health insurance companies.

“Prolong your life.” “Catch it early.”
What message will resonate?

- Strong consensus among participants of the importance of personal testimony, such as seeing a photo of someone who survived lung cancer after LCS.
- Also, important to link the message to family, such as grandparents watching their grandchildren grow up.

“(Do it) for your loved ones.”
What would make a message trustworthy?

- Participants again stressed the importance of personal testimony and the message of “saved by screening”

- A majority of participants were against scare tactics (i.e., Tips from Former Smokers)

“There are some commercials where the man or the woman or their grandparents is out with their kids and stuff, walking, and stuff like that. Without going through such bad stuff.” “I would much rather hear from someone that’s been through that.”
Campaign Development

- Messages of testimony, hope, survival and a connection to family are thematically important
- Because participants were age 55+, this message was about living to see their children and grandchildren grow up
- Website
- Guidelines, CMS/USPSTF Crosswalk, and SDM disseminated to 450+ providers in interventions regions
- 2nd letter to the same 450+ providers marketing website and roundtable events
- 64,000 post cards printed - being disseminated to 60+ primary care office, Ag extension offices, and health departments in the intervention regions
- Ads running every 2–weeks in 17 community newspapers
- Morehead region NPR- ads twice daily for 6-months
- Hazard region 2 radio stations also had ads
- WalMart, FoodCity, Lowes corporate office said “NO”
An Equal Opportunity University

“I talked with my doctor to see if lung cancer screening was right for me. I’m glad I did.”

Detecting lung cancer early can mean more tomorrows.

A message from the Terminate Lung Cancer (TLC) Study Team.

To learn more, visit our website: ccts.uky.edu/ccts/TLC/home

“For your peace of mind ... and theirs.”

Talk to a doctor about lung cancer screening.

Find out if it’s right for you.

A message from the Terminate Lung Cancer (TLC) Study Team.

To learn more, visit our website: ccts.uky.edu/ccts/TLC

“My friends and I heard about lung cancer screening.

We decided to talk to our doctors to learn more.”

Find out if it’s right for you.

A message from the Terminate Lung Cancer (TLC) Study Team.

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“We talked with my doctor to see if lung cancer screening was right for me. I’m glad we did.”

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To learn more, visit our website: ccts.uky.edu/ccts/TLC/home
Campaign tested in two regions, with a control region
Results

- Analyzed results from 145 surveys
  - ~50 from each region; KY HomePlace members meeting LCS criteria
- Collecting LDCT numbers from our 3 hospital partners
- When all participants asked: “Have you seen or heard any ads, messages, or postcards about lung cancer screening in doctor offices, local newspapers, or on the radio in the last 4-6 months?”
  - 73 (50.3%) said YES
- When asked: “If YES, did it make you”
- Of these 73, it led to 61 individual actions (83.6%), such as
  - “think about quit smoking”
  - “think about quitting smoking”
  - “look for more information about quitting smoking”, “develop a plan to quit smoking”
  - “talk to a doctor about quitting smoking”, “actually quit smoking”
  - “think about getting a low-dose CT scan for lung cancer screening”, etc.

Cardarelli, et al., 2015
Health Care Reform 2017
Patient Protection and Affordable Care Act (also called Obamacare), passed on March 23, 2010, extended health insurance coverage to more than 20 million Americans.

Most Americans do not know much about the law.

At the time ACA was created, un-insurance had reached historic high at the time of the 2008 election.

Fewer employers offered health insurance as an employment benefit.

Insurers were using tools such as preexisting condition exclusions, caps on coverage and other discriminatory practices to eliminate subscribers.

Huberfeld, 2017
KEEP GOVT OUT of MY MEDICARE
Health insurance became a mandate: purchase minimum coverage or pay a tax penalty.

This expanded the pool of insured subscribers, which in turn sustained private insurance markets to balance the ACA’s reforms that allowed coverage regardless of health history.

This was not enough, with several insurance providers pulling out of some markets in 2016 and 2017.

Medicaid expansion to extend eligibility to non-elderly childless adults.

Creation of health insurance exchanges to facilitate purchase of individuals or small group insurance with tax credits for insurance premiums for those earning 100-400% of the federal poverty level.

Required all health plans to cover preventive services that receive an “A” or “B” rating from the USPSTF with no cost-sharing – includes cancer screening, but not follow up testing if abnormalities are detected.
12 million of 20 million people who gained coverage through the ACA have done so through Medicaid.

Access to primary care and treatment for chronic conditions increased.

Rates of skipping medications to save money decreased.

Uncompensated care dropped by $10 billion for hospitals.

Extrapolated approximately 24,000 lives saved each year.
“Changes in Utilization and Health Among Low-Income Adults After Medicaid Expansion or Expanded Private Insurance”

- Examined access to care, utilization, and self-reported health among low-income adults in three states taking alternative approaches to ACA
  - Arkansas: private option- federal Medicaid funding purchased private insurance
  - Kentucky: Medicaid expansion
  - Texas: no expansion

Sommers, Blendon, Orav, Epstein, JAMA Intern Med 2016
Compared to Texas, both Arkansas and Kentucky saw:

- Increased access to primary care
- Improved affordability of medications
- Reduced out-of-pocket spending
- Reduced likelihood of emergency department visits
- Increased outpatient visits
- Increased screening for diabetes, glucose testing for those with diabetes, and regular care for chronic conditions
- Improved quality of care ratings
- Increase in number of adults reporting excellent health
Changes in Health Insurance Coverage
Pre- and Post-ACA Implementation

Figure. Unadjusted Changes in Health Insurance Coverage in the 3 Study States, 2013 vs 2015

Unadjusted survey-weighted proportions of health insurance coverage by state and year (n = 2864 for 2013, n = 3011 for 2015).
Perceived Impact of the Affordable Care Act on Low-Income Adults in 2016, by State

Sommers & Epstein, NEJM, 2017
American Health Care Act
Did not repeal many of ACA’s insurance reforms, including:

- Cover preexisting conditions
- Cover adult children up to age 26
- Not discriminate on the basis of race, nationality, disability or sex
- Cap out-of-pocket expenditures
- Not impose lifetime or annual limits
No individual or employer mandate - instead, a series of age-based tax credits to induce people to buy insurance on the open market.

Continuous coverage requirement: insurers can increase premiums by 30% for individuals with a gap in coverage of at least 63 continuous days.

Cost-sharing reduction payments end at the end of 2019.

Repeal ACA tax provisions.

End the Prevention and Public Health Fund after 2018.

Prohibits federal funding for Planned Parenthood for one year beginning with the enactment of the law.
Was one of three planned prongs to exact change to Obamacare
- House reconciliation process
- HHS executive regulatory authority
- Additional legislation

March 6: House Republican leadership introduced budget reconciliation bills in the Ways and Means and Energy and Commerce committees
March 23: Was to go to the full House for a vote but was delayed
March 24: Vote again was planned, but the bill was pulled from consideration
The Tail of Three Political Parties

- Freedom Caucus met at the White House on March 23
- Post-meeting, an amendment was discussed to alter the Essential Health Benefits Provision
- The amendment, introduced on March 24, shifted the EHB to the states
ACA Essential Health Benefits

- Ambulatory patient services
- Emergency services
- Hospitalization
- Pregnancy, maternity, and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care
EHB: Preventive Services

- Adult vaccines
- HIV screening
- Cancer screening: colorectal, cervical, breast and lung
- Tobacco use screening
- Obesity screening and counseling
- Contraceptives
Medicaid Changes?

- Block grant or per capita caps?
- State authority to make presumptive eligibility determinations?
- Eliminates the ACA’s disproportionate share hospital cuts?
- Incentives for states to re-determine eligibility for Medicaid more often?
What is Next for Health Care Reform?

- “We are going to be living with Obamacare for the foreseeable future,” Speaker Ryan on Friday
- “It’s enough already,” responded President Trump
Conclusion: Health Care is Complicated

"Trump: Nobody Knew Health Care Could Be So Complicated"
References

- Bandura A. Human agency in social cognitive theory. Amer Psychol 1989;44(9):1175-84.


