cancer plan minnesota

MCA Cancer Plan Revision: Detection Workgroup

May 3, 2016 3:00 – 4:00 p.m.

Participants in person: Matt Flory, Anne Walaszek, Barb Kunz, Michael Parks, Juli Varvel, Maggie Rothstein
Participants by phone: Jana Beckering, Brittany Dahlin, Jerri Hiniker, Anne Snowden
Location: American Cancer Society

Agenda Topic	Key Points Raised	Next Steps
Welcome and introductions		N/A
Review of Cancer Plan Process and Goals	**Planning Elements** **1) Issue statements- objectives-strategies** **2) Cancer Plan MN framework:** Aligning stakeholders, advancing health equity, creating policy, systems and environmental change	Today's meeting will focus on issue statements. Next meeting will focus on objectives/strategies.
Background/ Data on Breast, Cervical, and Colon Cancer Trends/Gaps	**Group Discussion/Brainstorm** **Breast:** Medicaid rates: 62%, other purchasers: 76%, → 14% gap Recommended: every 2 years after the age of 50 Disparities: American Indian, Hispanic, African American **Cervical:** note- there has been a measurement change. Screening rate is at 72% for those 21-64 years old. Disparities: High rate in the American Indian population	Workgroup will brainstorm strategies to address these gaps.

	Colon: 71% screening rate overall and growing by 1% every year, >53% screening rate for other race, ethnicity and language disparate populations and Medicaid Promoting multiple tests Disparities: Somali, Hmong, and American Indian	
Group Discussion/ Brainstorm Strategies	**Breast:** Need to increase identifying patients family history American Indians barriers: more work is needed in late stage services, including repeat/subsequent mammograms. African Americans have high rates of breast cancer compared to other populations as well as high rates of late stage diagnosis. Genetic, SES, or geography, access is a problem. **Cervical:** Confidentiality is an issue. With young adults now allowed to stay on their parents insurance until the age of 26 through the ACA, young women are hesitant about getting a pap smear (often coupled with other STI tests). Trust: there are issues with My Chart and concerns about who has access to these health records. Cultural sensitivity: pap smears are often perceived as a reproductive health issue, rates drop in women after menopause as well. Correctional health: women in a correctional facility are 4 times at risk for having undiagnosed cervical cancer. Jail and prisons have an higher rates in noncommunicable disease compared to the general population. Access to coloposcopy needs to be expanded. **Colon:** Access to specialists is needed. Co-pay and deductibles are a concern- 8-9% of positives from FOBT (fecal occult blood testing) will need diagnostic testing. Lack of awareness of family history assessments and genetic diagnosis. There also is a need for follow-up care for genetic syndromes. Patients are concerned about care needed after colonoscopy, stressing a need for health navigators. Cultural perception: there is no word for screening in some languages and it is perceived as medication. Some new immigrants from countries with a life expectancy of <60, do not see the value in screening after their country of origin's life expectancy. In some cultures they do not believe	**Next meeting:** - Solidify Strategies and Objectives **Next issue areas:** Lung cancer screening: - 1-hour meeting in June - Anne, Matt, and Maggie will compile current data. - Do we need others input/participation in this discussion? Skin cancer screening: - Maggie will provide data and current guidelines for the next meeting. Others?

	in using sedatives and the procedure can be painful. Some cultures find the current billboards with exposed buttocks' offensive. There is a need for targeted outreach for African Americans. Awareness: most people know about colonoscopies but they are never given other options. Some cultures are very private and being given the option to use a test (Fit Kit) they do themselves at home is preferred. Some interpreters do not feel they should give other options. Also cologaurd is becoming highly used amongst high SES populations. **Barriers/gaps:** 1. **Access**- gap between screening and diagnostic procedures 2. **Cultural sensitivity** 3. **Healthcare coverage** 4. **Age-** high rates in screening for those 50-65 years old, however according to the CDC report from the National Health Interview Survey, we're missing a lot of people over the age of 65. 5. **Identifying family history and personal history**- we have a lack of assessment and documentation, there is a need to training healthcare staff on identifying high risk patients. There is also a need for genetic diagnosis. 6. **Connecting resources and services**- the example given with coupling lung cancer screening and smoking cessation.	
Wrap-up	It was noted that in order to drive the rates down we need to include the majority in our strategies, and not solely focus on health disparities.	**Next meeting**: develop strategies for breast, cervical and colon screening **Feedback:** - Brittany is going to share the meeting summary with colleagues to get input from Community Health Centers. - Matt is going to send the meeting summary out to health plans for input.

Next meeting: TBD, late May/ early June.