COVID-19 Impacts in American Indian Communities in the Great Plains Area

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Vice President,
Cancer Control Interventions
American Cancer Society

Tuesday, May 26, 2020

11:00-12:00pm MT / 12:00-1:00pm CT

- Understand cancer screening recommendations during & after COVID-19
- Learn about COVID-19 impact in American Indian communities in the Great Plains Area

North Dakota Cancer Coalition

American Cancer Society

Click HERE to register

NC2 Nebraska Cancer Coalition

NORTH DAKOTA COLORECTAL CANCER ROUNDTABLE

Iowa Cancer Consortium

COVID-19 impacts in American Indian communities in the Great Plains Area

May 26, 2020

Donald Warne, MD, MPH

Oglala Lakota

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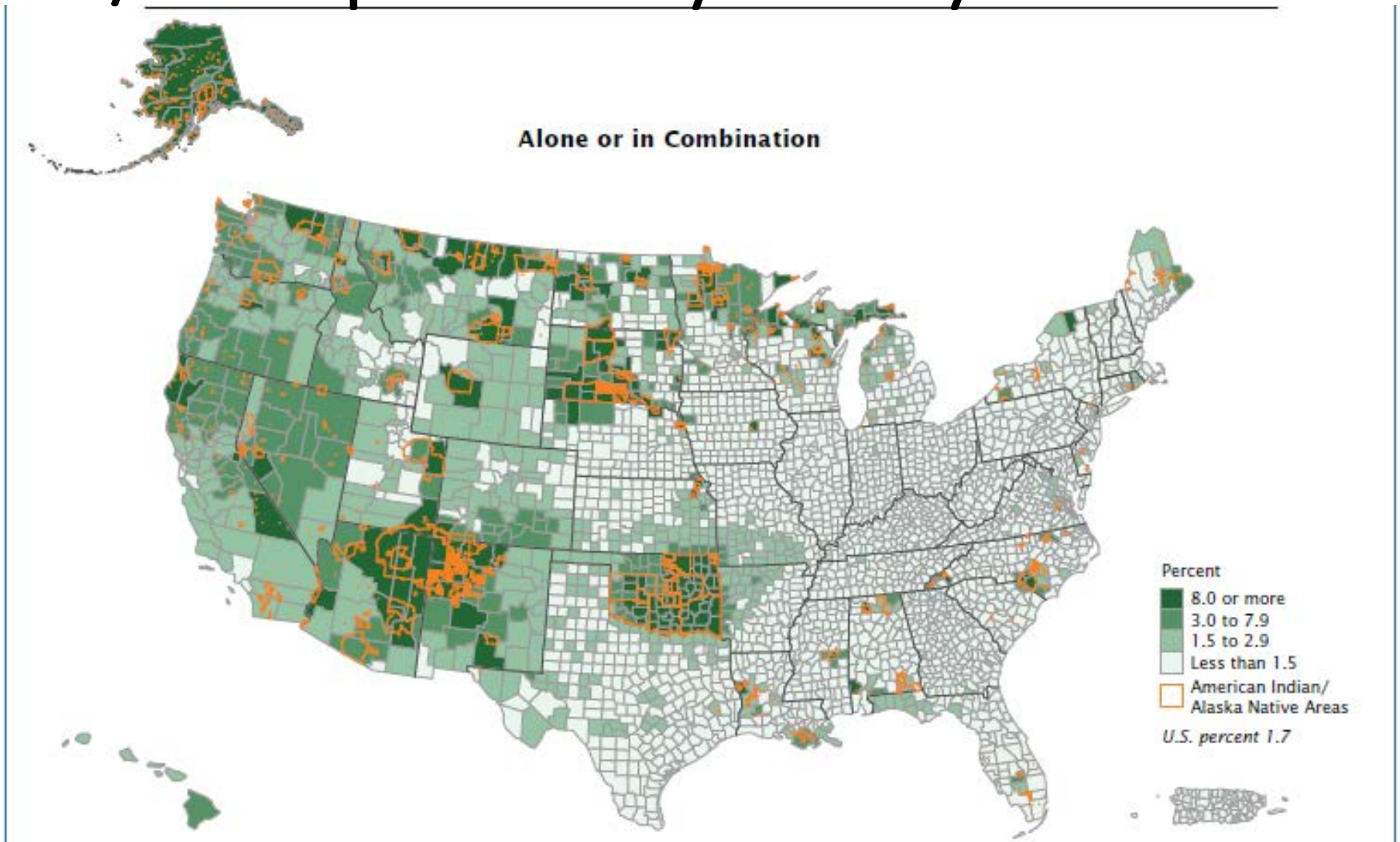
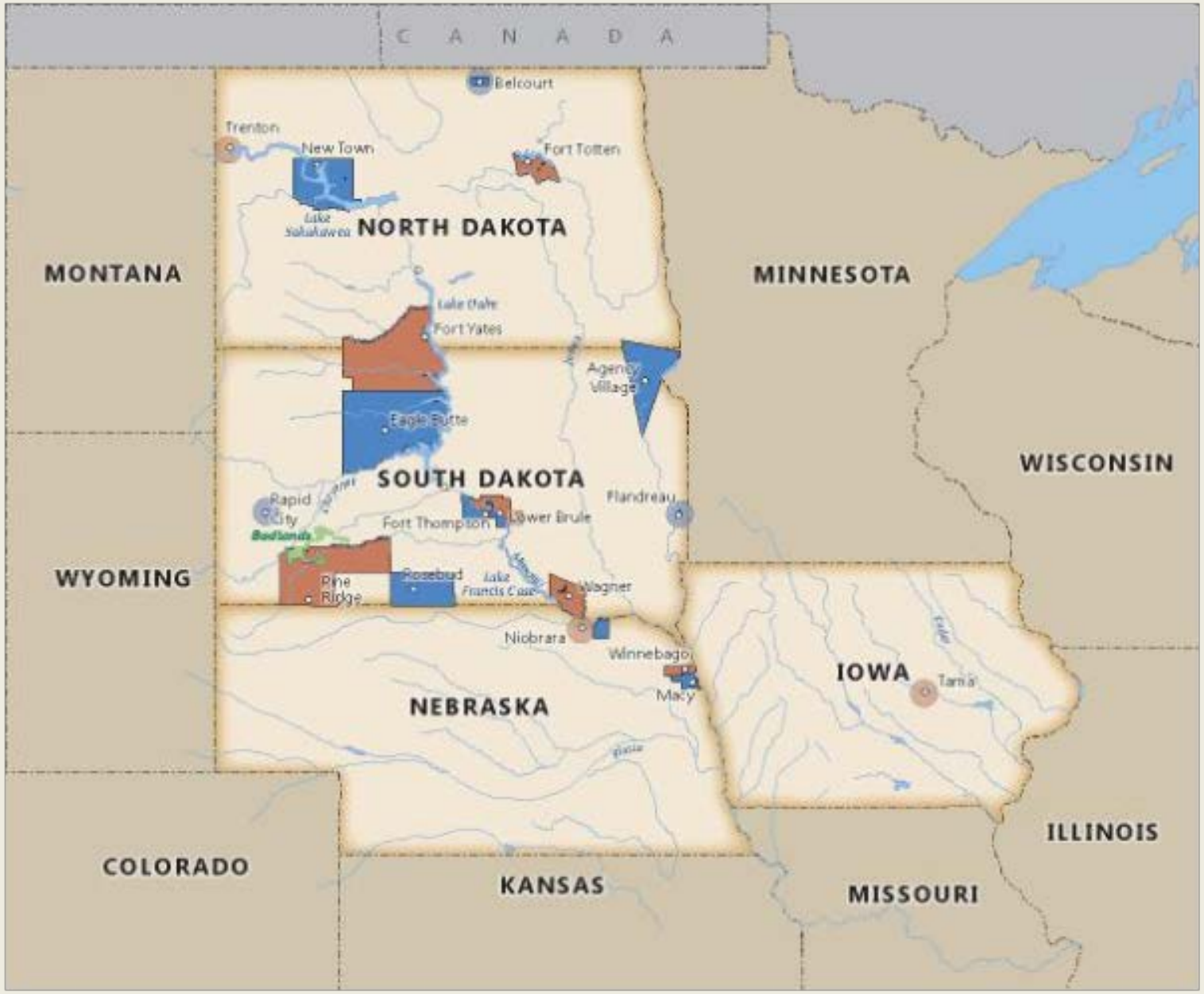
University of North Dakota School of Medicine & Health Sciences

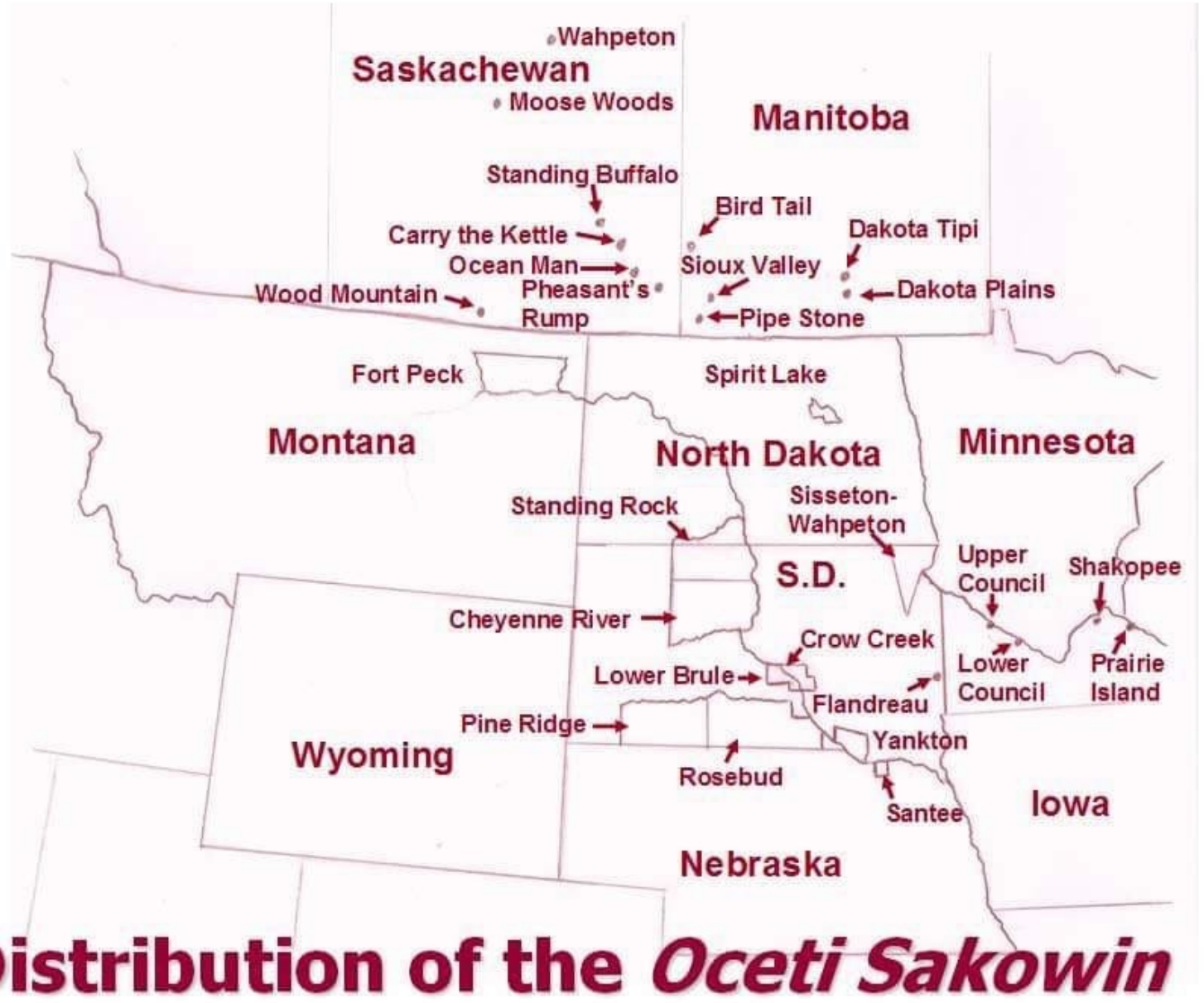
AI/AN Population by County



Source: U.S. Census Bureau, *2010 Census Redistricting Data (Public Law 94-171) Summary File*, Table P1.

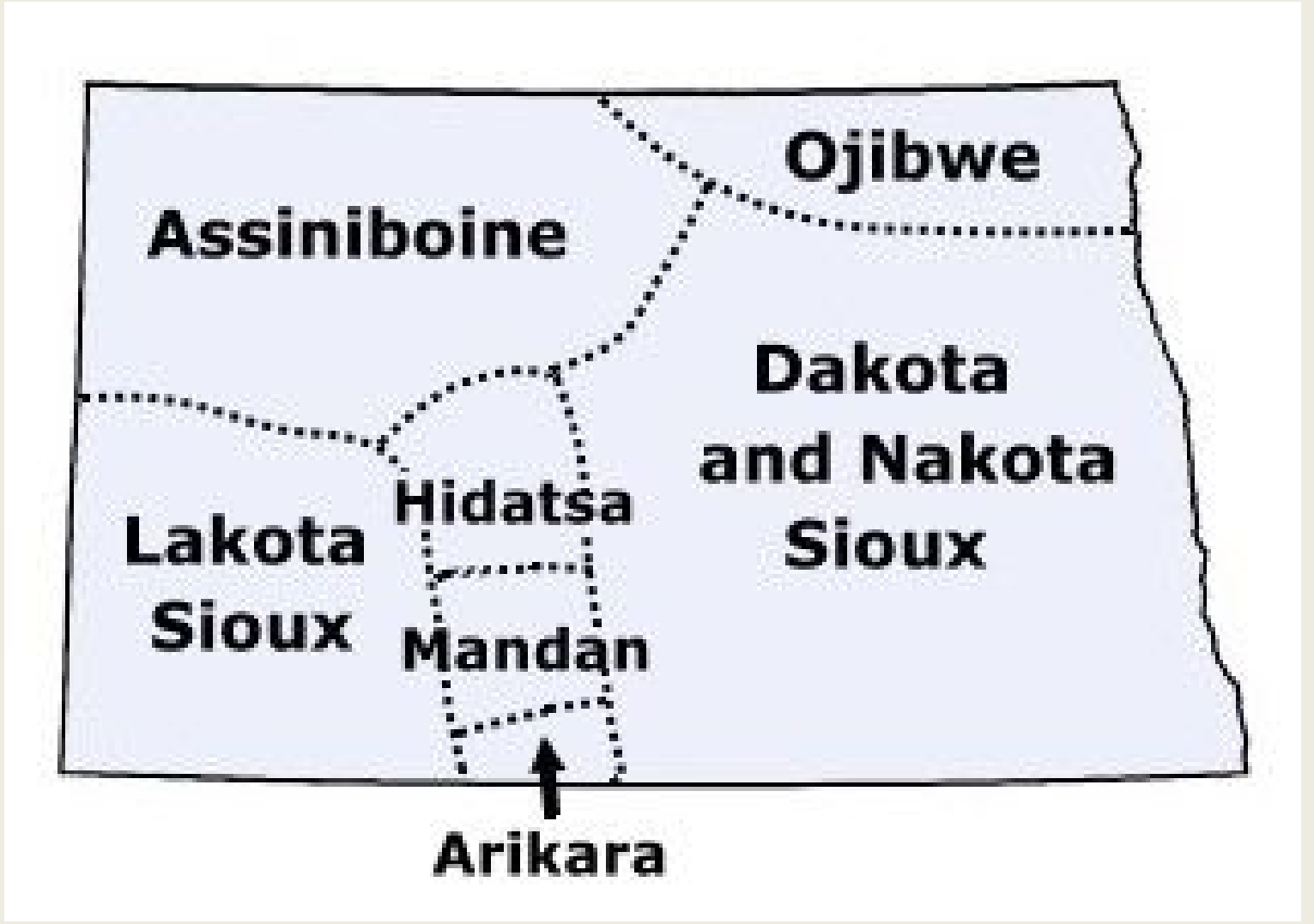

C A N A D A
Belcourt
Trenton
New Town
Fort Totten
Lake Sakakawea
NORTH DAKOTA
MONTANA
MINNESOTA
Lake Oahe
Fort Yates
Agency Village
Eagle Butte
SOUTH DAKOTA
WISCONSIN
Rapid City
Badlands
Fort Thompson
Lower Brule
Flandreau
WYOMING
Pine Ridge
Rosebud
Lake Francis Case
Wagner
Niobrara
Winnebago
Macy
IOWA
Tama
NEBRASKA
ILLINOIS
COLORADO
KANSAS
MISSOURI

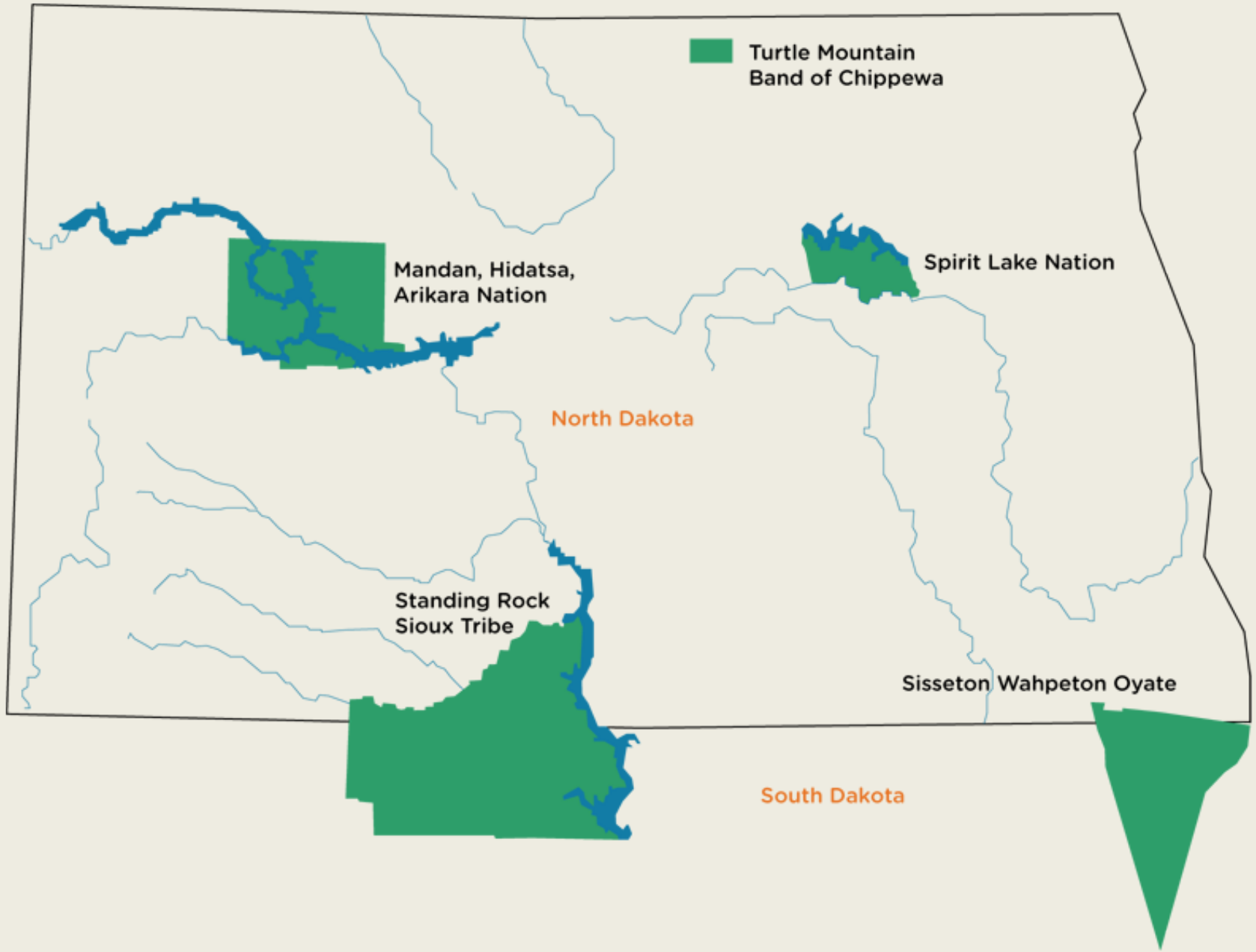

KANADA
Assiniboine
Anishinabe
Absarokee
Hidatsa
Mandan
Hunkpapa
NORTH DAKOTA
Yanktonai
Sisseton
Mdewakanton
MINNESOTA
Sans Arc
Sihasapa
SOUTH DAKOTA
Dakota
Wahpekute
Minneconjou
Lakota
Cheyenne
Yankton
Wahpeton
Two Kettles
Brule
Oglala
Pawnee
NEBRASKA
Omaha
IOWA
Iowa
Arapaho
COLORADO
KANSAS
Ehemaliges Stammesgebiet
Heutige Reservationen
Kilometer
0 50 100 150
0 50 100
Meilen



Distribution of the *Oceti Sakowin*


NAKOTA
LAKOTA
DAKOTA
North Dakota
South Dakota
Minnesota
Wyoming
Nebraska
Colorado
Billings
Bismarck
Fargo
Casper
Omaha
Kansas City
Denver
Rapid City
Sioux Falls
Sioux City
North Platte
Lincoln


Ojibwe
Assiniboine
Dakota
and Nakota
Sioux
Hidatsa
Lakota
Sioux
Mandan
Arikara


Turtle Mountain
Band of Chippewa
Mandan, Hidatsa,
Arikara Nation
Spirit Lake Nation
North Dakota
Standing Rock
Sioux Tribe
Sisseton Wahpeton Oyate
South Dakota


Saskatchewan
Lake Winnipeg
Lake Manitoba
Qu'Appelle
Regina
Assiniboine
Winnipeg
Souris
Lake of the Woods
Red
Missouri
Grand Forks
Fargo
ND
MN
SD

AI Demographics

- Over 3 million American Indian Only in 2010 Census
- Over 5 million AI and 'other' in 2010 Census
- ~60% of AI people live in urban areas
- Indian Health Service serves approximately 2 million ("User Population")
- Annual appropriation for IHS is ~ $5 billion
- Over 570 federally recognized AI/AN tribes

Legal Basis for Federal Services to American Indians and Alaska Natives

- ✓ United States Constitution
- ✓ The Snyder Act of 1921
- ✓ The Transfer Act of 1954
- ✓ Indian Sanitation Facilities and Services Act of 1959
- ✓ The Indian Self-Determination and Education Assistance Act (enacted 1975)
- ✓ Indian Health Care Improvement Act of 1976
- ✓ The Indian Alcohol and Substance Abuse prevention and Treatment Act of 1986
- ✓ The Indian Child Protection and Family Violence Prevention Act of 1990

This is not an all-inclusive list.

Wichetas:
To-sa-quas, (White Tail,)
Cho-wash-ta-ha-da, (Runner,)
Kow-wah, (Shirt Tail,)
Wich-qua-sa-is, (Contrary,)
His-si-da-wah, (Stubborn.)
Towa-karroes:
Ke-chi-ko-ra-ko, (Stubborn,)
Nes-ho-chil-lash, (Traveller,)
Na-co-ah, (Dangerfield,)
Ka-ra-ko-ris, (Deceiver,)
Ha-ke-di-ad-ah, (Gallant Man,)
Wha-cha-ash-da, (Looker-on,)
Wash-le-doi-ro-ka, (Don't you do so,)
Te-ah-kur-rah, (Lightman,)
Sar-rah-de-od-a-sa, (Straight Looker.)
Wacoes:
A-qua-gosh, (Short Tail,)
Ho-hed-orah, (Long Ways over the River,)
Chos-toch-ka-a-wah, (Charger,)
Cha-to-wait, (Ghost.)
Secretaries:
Thomas J. Wilson,
Isaac H. Du Val.
Witnesses:
Robt. S. Neighbsor,
Hugh Rose,
Jno. H. Rollins,
Thomas J. Smith,
E. Morehouse.
Interpreters:
Louis Sanches,
John Conner,
Jim Shaw.

(To each of the names of the Indians is affixed his mark.)

TREATY WITH THE POTAWATOMI NATION, 1846.

June 5 and 17, 18

9 Stat., 853.
Ratified, July 1846.
Proclaimed, July 1846.

Whereas the various bands of the Pottowautomie Indians, known as the Chippewas, Ottawas, and Pottowautomies, the Pottowautomies of the Prairie, the Pottowautomies of the Wabash, and the Pottowautomies of Indiana, have, subsequent to the year 1828, entered into separate and distinct treaties with the United States, by which they have been separated and located in different countries, and difficulties have arisen as to the proper distribution of the stipulations under various treaties, and being the same people by kindred, by feeling, and by language, and having, in former periods, lived on and owned their lands in common; and being desirous to unite in one common country, and again become one people, and receive their annuities and other benefits in common, and to abolish all minor distinctions of bands by which they have heretofore been divided, and are anxious to be known only as the Pottowautomie Nation, thereby reinstating the national character; and

Preamble.

Whereas the United States are also anxious to restore and concentrate said tribes to a state so desirable and necessary for the happiness of their people, as well as to enable the Government to arrange and manage its intercourse with them:

Now, therefore, the United States and the said Indians do hereby agree that said people shall hereafter be known as a nation, to be called the Pottowautomie Nation; and to the following

Articles of a treaty made and concluded at the Agency on the Missouri River, near Council Bluffs, on the fifth day of June, and at Pottawatomie Creek, near the Osage River, south and west of the State of Missouri, on the seventeenth day of the same month, in the year of our Lord one thousand eight hundred and forty-six, between T. P. Andrews, Thomas H. Harvey, and Gideon C. Matlock, commissioners on the part of the United States, on the one part, and the various bands of the Pottowautomie, Chippewas, and Ottowas Indians on the other part:

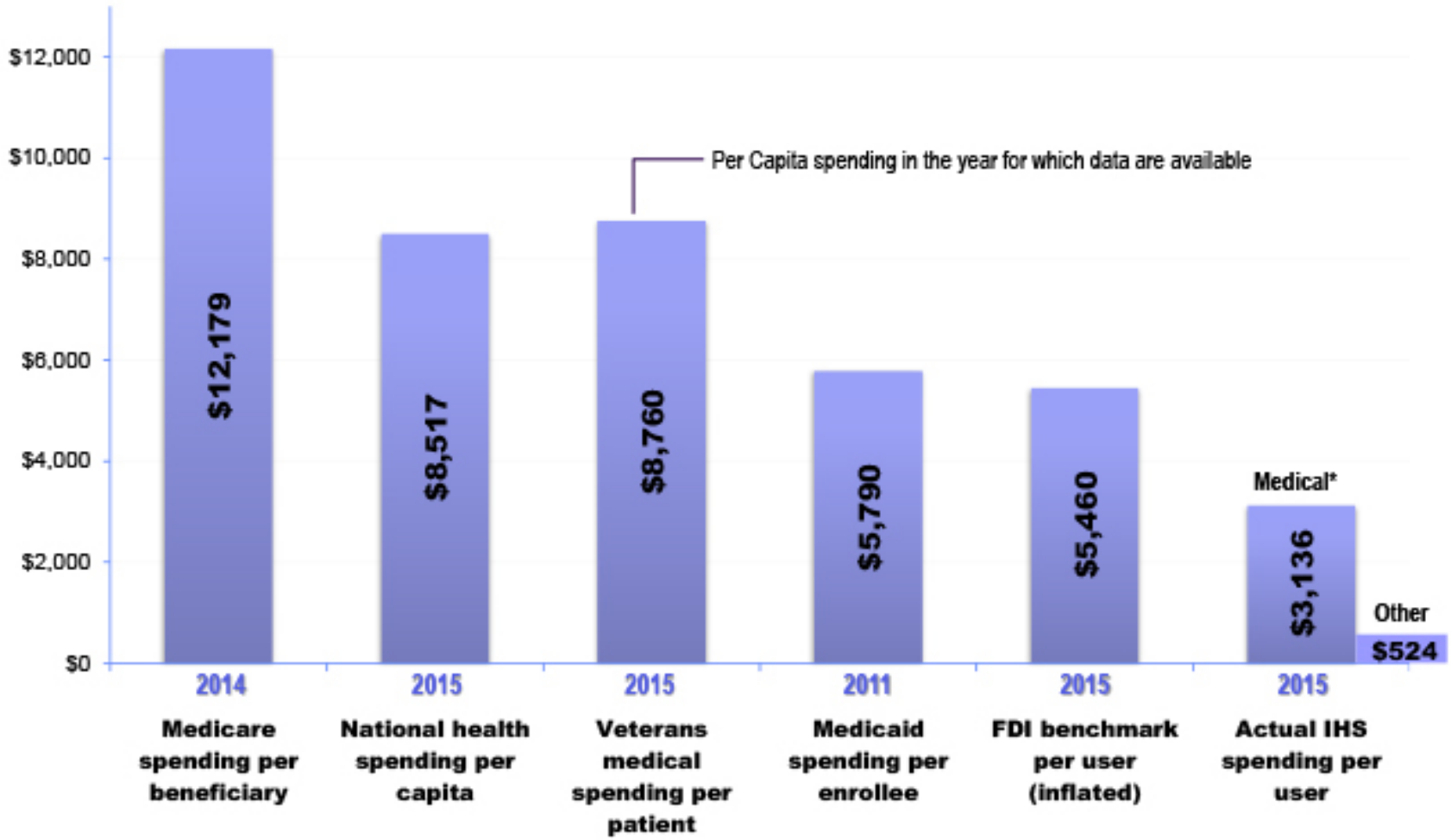
Peace and friendship to continue forever.

ARTICLE 1. It is solemnly agreed that the peace and friendship which so happily exist between the people of the United States and the Pottowautomie Indians shall continue forever; the said tribes of Indians giving assurance, hereby, of fidelity and friendship to the Government and people of the United States; and the United States giving, at the same time, promise of all proper care and parental protection.

The I/T/U System

- "I"—Indian Health Service (IHS)
  - Snyder Act
- "T"—Tribal "638" Programs
  - ISDEAA, Title I & Title V
- "U"—Urban Indian Health Centers
  - IHCIA, Title V

2015 IHS Expenditures Per Capita and Other Federal Health Care Expenditures Per Capita



*See page 2 notes on reverse for sources. *Payments by other sources for medical services provided to AIANs outside IHS is unknown.*

12/29/2015

Impact of COVID-19

- **Barriers to services (3 Ts):**
  - Testing
  - Contact Tracing
  - Treatment
- Infrastructure
- PPE

https://www.ihs.gov/coronavirus/

https://gptec.gptchb.org/covid-19/great-plains-area-covid-19-surveillance-data/

Impact of COVID-19

UND Programming

- *MPH and other Graduate students*
- *PRC Coordination*
- *Strike Teams*
- *DACCOTA CTR Grant (NIH)*

Indigenous Health MPH

Online, Fall 2019

Indigenous Health PhD

Summer 2020

COVID-19 AND CANCER SCREENING

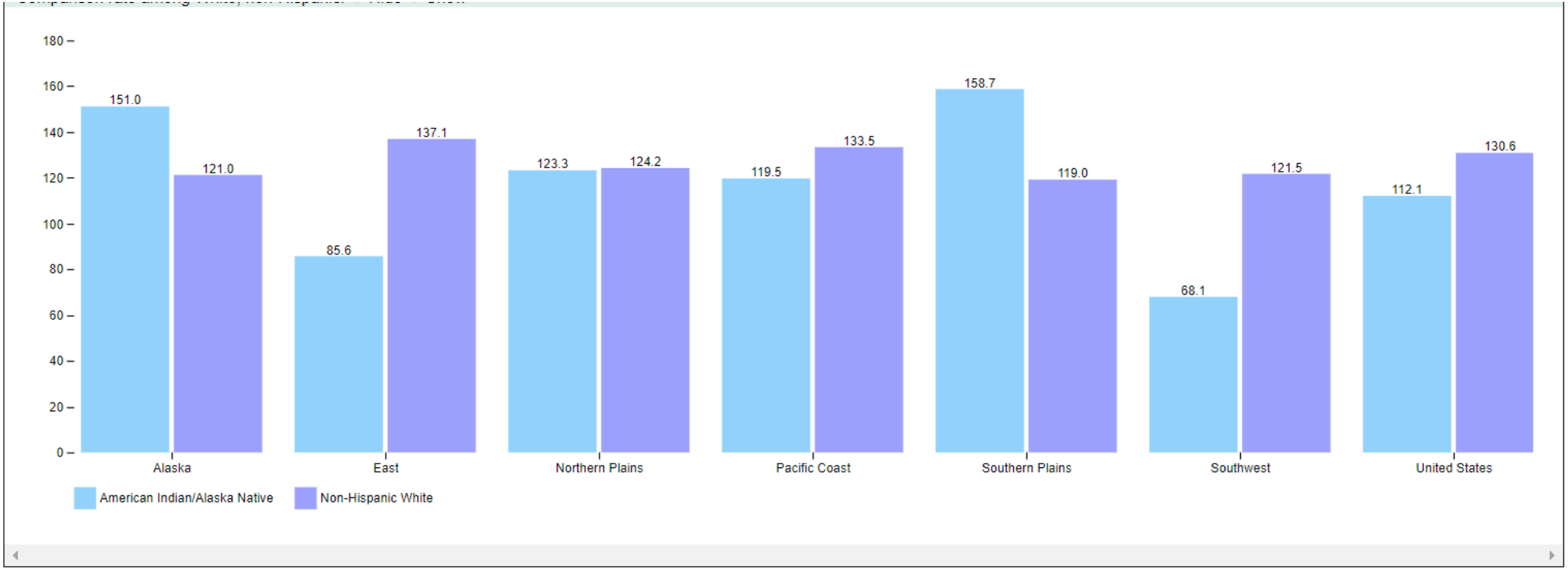
DURADO BROOKS, MD, MPH

CANCER SCREENING TESTS

- Tests Recommended by the American Cancer Society (ACS), United States Preventive Services Task Force (USPSTF) and others:
  - **Mammograms for breast cancer**
  - **Pap smears and human papilloma virus (HPV) testing for cervical cancer**
  - **Stool tests, colonoscopy and other tests for colon cancer**
  - Low-dose CT scans (LDCT) for lung cancer
  - Prostate specific antigen (PSA) for prostate cancer

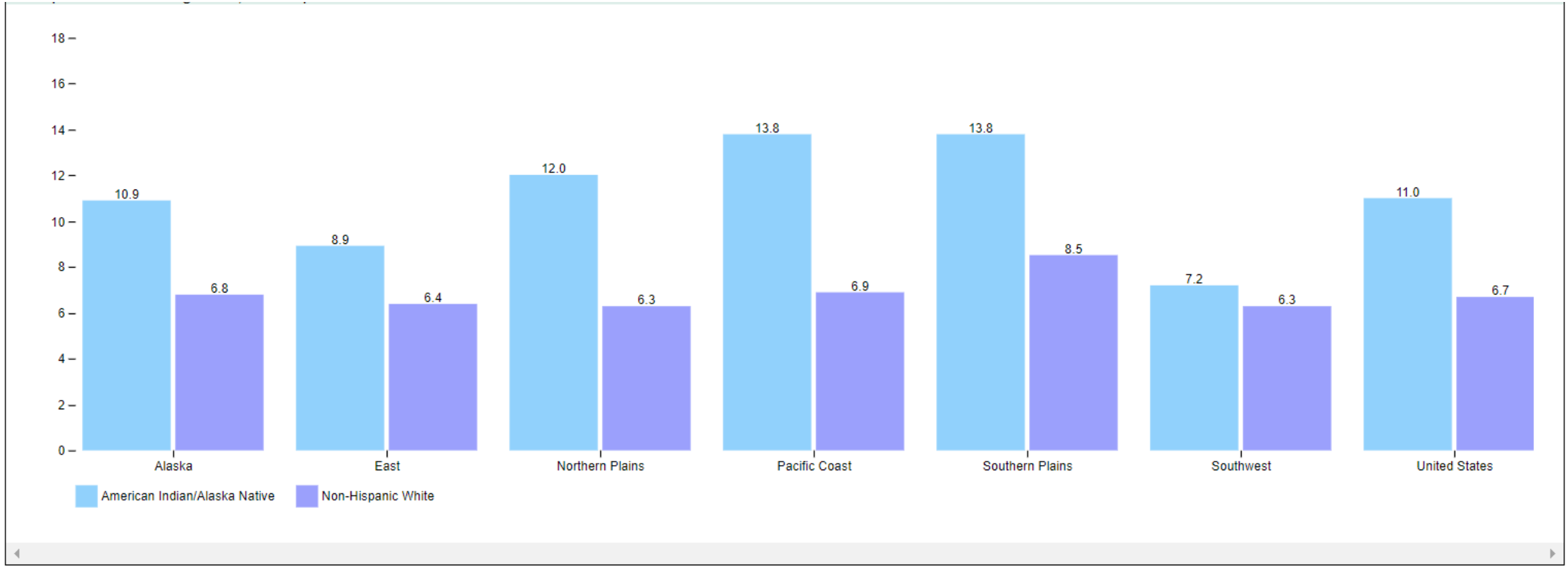
American Indian/Alaska Native Cancer Incidence, 2012 - 2016

Rate of New Female Breast Cancers by IHS Region (per 100,000 women)



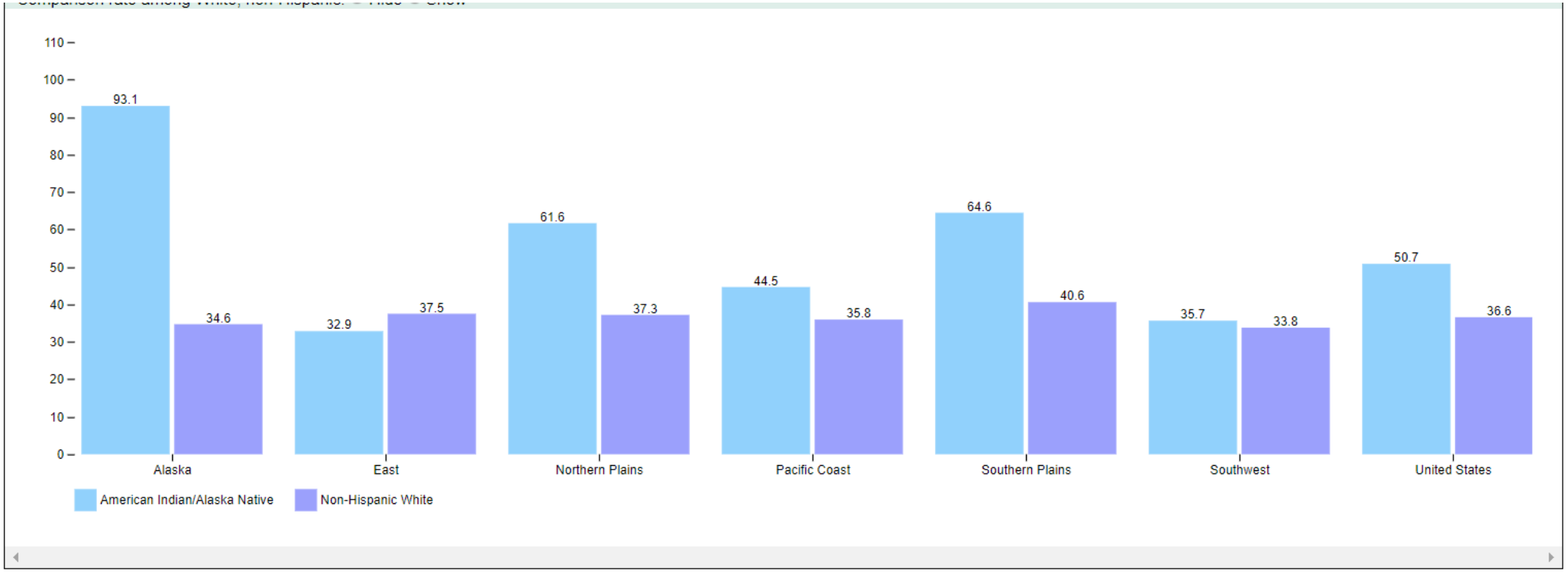
American Indian/Alaska Native Cancer Incidence, 2012 - 2016

Rate of New Cervical Cancers by IHS Region (per 100,000 women)



American Indian/Alaska Native Cancer Incidence, 2012 - 2016

Rate of New Colorectal Cancers by IHS Region (per 100,000 men and women)



American Indian/Alaska Native Screening Targets and Rates

GPRA SUMMARY REPORT 2018

PREVENTION

Prevention measures focus attention on early detection of disease (cancer screenings) and management of risk factors to prevent disease (tobacco cessation and HIV screening).

Prevention can focus on appropriate treatment of chronic conditions (cholesterol and blood pressure treatment) to avoid complications.

Prevention also focuses on healthy behaviors/lifestyles (childhood weight control and infant breastfeeding) that have been shown to prevent diseases.

	FINAL	NATIONAL TARGET
(CERVICAL) PAP SCREENING	36.0%	35.9%
COLORECTAL CANCER SCREENING	31.9%	32.6%
MAMMOGRAPHY SCREENING	42.6%	42.0%
TOBACCO CESSATION	28.9%	27.5%

https://www.ihs.gov/sites/quality/themes/responsive2017/display_objects/documents/GPRASummaryReport-2018.pdf

CANCER SCREENING RATES, U.S., 2018

	Breast	Colorectal	Cervix
Healthy People 2020 Target	81.0%	70.5%	93.0%
2018 Screening Rate (Total U.S. pop.)	68%	70%	85%
2018 GPRA Target	42%	32.6%	35.9%
2018 Screening Rate (GPRA)	42.6%	31.9%	36%

Source: NHIS 2018

CANCER SCREENING RECOMMENDATIONS: MARCH 2020

- On March 13, 2020, a United States national emergency was declared due to COVID-19.
- Subsequently, the American Cancer Society recommended that *no one should go to a healthcare facility for routine cancer screening until further notification*.
- Other societies such as The American Society of Breast Surgeons, the American College of Radiology, and the American Society for Colposcopy and Cervical Pathology also advised patients to postpone elective care – including cancer screening – and plan to reschedule screening tests when healthcare facilities resume screening.

CANCER SCREENING RECOMMENDATIONS: MARCH 2020

- These recommendations apply only to people at average risk of cancer who do not have any signs or symptoms of cancer. Those with symptoms of cancer (e.g. a breast lump; blood in the stool, etc.) or those at a higher risk of cancer (e.g., women who have a mutation on a BRCA gene, etc.) should consult with a health care professional for guidance, since they may need to be evaluated more quickly than those at average risk.

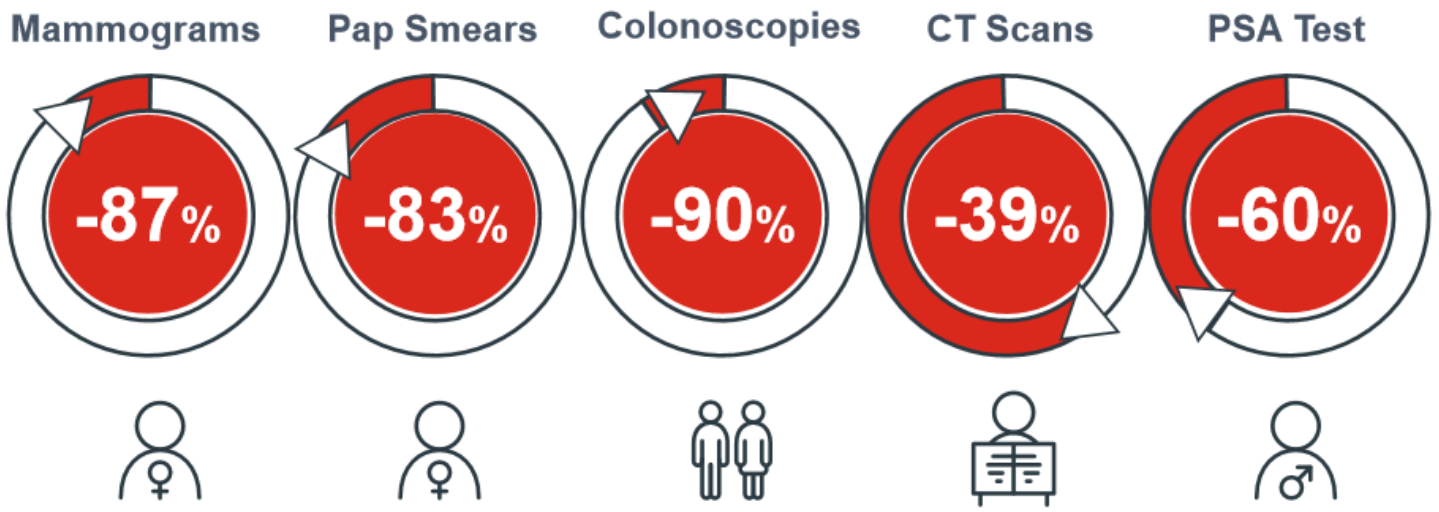
SCREENING RATES DURING COVID-19 PANDEMIC

- The COVID-19 pandemic has led to unprecedented drops in breast, colorectal, and cervical cancer screenings
  - Decreases of **83 - 90%** compared to three-year averages
- The resulting backlog of cancer screenings will pose significant challenges for health systems as they adopt new processes and protocols necessary to safely restart screening.

https://www.iqvia.com/insights/the-iqvia-institute/covid-19/shifts-in-healthcare-demand-delivery-and-care-during-the-covid-19-era

Diagnostics used to screen and monitor cancer have dropped dramatically due to postponement of non-essential visits

Exhibit 14: Reduction in Diagnostic Testing Procedures, Week Ending April 10 Compared to February 2020



Source: IQVIA Real World Claims, April 17, 2020

ESTIMATES OF DELAYED/MISSED CANCER DIAGNOSES

Over 22 million screening tests for five common tumors may be disrupted, risking delayed or missed diagnoses for 80,000 patients

Exhibit 15: Modeled Impact of Reduced Screening Tests Three Months Ending June 5, 2020

	Breast	Cervical	Colorectal	Lung	Prostate
# annually	42 Mn	79 Mn	9.5 Mn	700K	4.3 Mn
% fewer due to COVID	-69%	-67%	-72%	-30%	-48%
# fewer tests over 3 months	7.2 Mn mammograms	13.2 Mn pap tests	1.7 Mn colonoscopies	~52K CT scans	-520K PSA tests
Rate of positive cancer diagnosis per test	1:200	1:5,274	1:91	1:112	1:23
Delayed cancer diagnosis due to COVID	36,000 patients	2,500 patients	18,800 patients	450 patients	22,600 patients

Source: IQVIA Institute, Apr 2020

Over 22 million screening tests and over 80,000 positive cancer diagnosis potentially delayed

https://www.iqvia.com/insights/the-iqvia-institute/covid-19/shifts-in-healthcare-demand-delivery-and-care-during-the-covid-19-era

RESUMING CANCER SCREENING AND ELECTIVE CARE

- As rates of infection and life-threatening illness have either been averted or significantly diminished, various areas around the country are now easing restrictions on elective medical care.
- Recommendations related to re-opening should be flexible, especially if there as a resurgence of COVID 19 cases in any community – in which case elective cancer screenings may be restricted again.

RESUMING CANCER SCREENING

Some Issues Related to Re-Opening

- Institutions are gradually re-introducing cancer screening based local circumstances – but usually not coordinated or taking place at the same time everywhere (different facilities may have different approaches).
- In most places capacity will be lower than usual (25% - 50% less than pre-pandemic in many settings).
- There will be a need to reconcile missed care with care already scheduled at the time of re-opening (complicating efforts to alleviate the backlog).

RESUMING CANCER SCREENING

As sites re-open there will be a need to prioritize based on patient circumstances. These include:

- Symptomatic patients.
- Patients who had an abnormal screening exam before the shutdown, and were scheduled for diagnostic evaluation.
- Patients who had undergone evaluation prior to the shutdown and were scheduled for biopsies or procedures.
- High-risk patients for whom regular screening or further diagnostic evaluation is a higher priority due to the higher probability of disease.
- Patients who are asymptomatic, but behind in adherence.
- New patients just arriving at the age to begin screening.

RESUMING CANCER SCREENING: WHAT TO TELL PATIENTS

Screening facilities should have new precautions in place:

- Patients should be provided with a phone number or online service to answer any questions before or after the screening procedure
- EVERYONE in the facility—including patients—should be wearing a mask. This helps prevent others from infecting those around them
- The facility staff should do everything possible to keep people —including staff — at least six feet apart.
- Waiting rooms should not be crowded. This may mean fewer available appointments or waiting in your car until they call you into the office.

RESUMING CANCER SCREENING: WHAT TO TELL PATIENTS

Screening facilities should have new precautions in place:

- They should check everyone for symptoms of COVID 19 before entering the screening facility. Those symptoms include:
  - Cough
  - Shortness of breath or difficulty breathing
  - Fever
  - Chills
  - Muscle pain
  - Sore throat
  - New loss of taste of smell
- If patients have any of these symptoms, DON'T GO TO THE SCREENING FACILITY. They should call the facility to discuss their symptoms and get their guidance on rescheduling the screening test. You may also want to contact your primary care provider to discuss testing for COVID-19.

RESUMING CANCER SCREENING: WHAT TO TELL PATIENTS

Patient precautions:

- Everything possible should be done to decrease contact with any clipboard or other device such as a credit card machine during your visit. Preferably, information regarding insurance, health and payment should be obtained securely before the visit so that patients don't have to do that in the office.
- Patients should avoid bringing items into the facility or leaving anything—even magazines and newspapers.
- Avoid touching surfaces and items
- Hand sanitizer should be easily available throughout the facility. Patients and staff should use the sanitizer or wash their hands frequently, especially after touching something in the office.

CANCER SCREENING AND PREVENTION RECOMMENDATIONS

- Some individuals may be advised that their test may be safely postponed until a later time.
  - For example, many women still get an annual mammogram, but for women age 55 or older, at average risk, and with no signs or symptoms of breast disease it may be appropriate to delay having a mammogram for up to every two years. Once things are back to normal, these women could return to an annual schedule, or continue screening every 2 years.
  - Cervical cancer guidelines recommend testing at wider intervals (every 3 or 5 years depending on the test used; no annual testing). Women over 65 with a history of normal exams over the past 10 years may be able to safely stop.
- Men and women of advanced age or with life-limiting health issues may be able to cease cancer screening.

CANCER SCREENING RECOMMENDATIONS DURING THE PANDEMIC

- Most cancer screenings are dependent on a single test, requiring a visit to a medical facility
  - Mammography
  - Cervical/vaginal specimen colletion
  - Low-dose CT scans

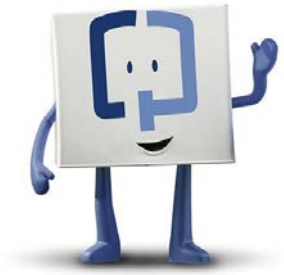
- Due to the availability of options (including tests done at home), screening for colorectal cancer can be viewed as an “outlier” during the pandemic

ACS CRC SCREENING RECOMMENDATIONS FOR AVERAGE RISK

Begin screening at age 45, using any of the following options:

Stool-based tests:

- Fecal immunochemical test (FIT) every year
- High sensitivity guaiac-based fecal occult blood test (HS-gFOBT) every year
- Multi-target stool DNA test (mt-sDNA) every 3 years



Structural (visual) exams:

- Colonoscopy every 10 years
- CT Colonography every 5 years
- Flexible sigmoidoscopy every 5 years

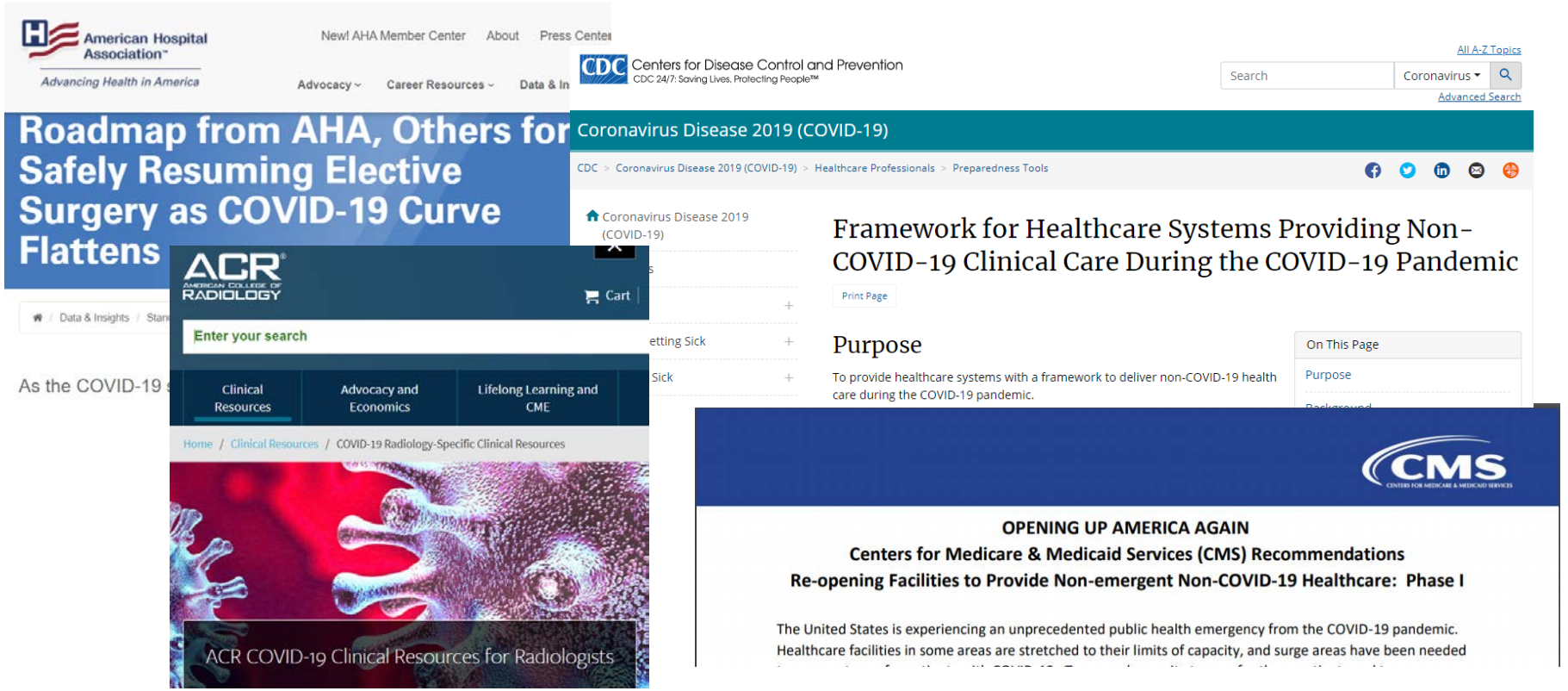
CRC SCREENING RECOMMENDATIONS DURING THE PANDEMIC

- Providers and systems should take advantage of home-based options for CRC screening.
  - FIT, guiaic-based tests and multitarget stool DNA testing (mt-sDNA or Cologuard) are all performed on a stool sample collected at home.
- Kits can be mailed to patients or picked up in a laboratory, and returned the same way.
- FIT or guiaic testing every year, and Cologuard testing every three years are all evidence-based screening methods that:
  - allow for CRC screening to continue during the pandemic, and
  - help avoid a colonoscopy backlog for overwhelmed health systems.

Remember: Every positive result must be followed up with colonoscopy

RE-STARTING NON-ESSENTIAL MEDICAL SERVICES

Guidance on resuming non-essential care has been provided by numerous organizations



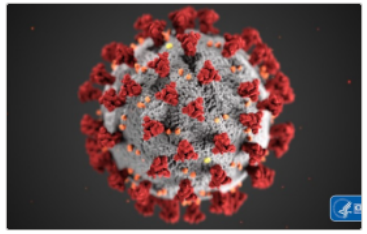
LATEST INFORMATION ON COVID-19 AND CANCER

American Cancer Society's COVID-19 Hub

Coronavirus, COVID-19, and Cancer

If you're having trouble finding the information you need about coronavirus and COVID-19, the illness caused by the current strain of coronavirus, we're here to help with current and reliable information. We are available via live chat or our 24-hour helpline at 800-227-2345.

WHAT YOU NEED TO KNOW

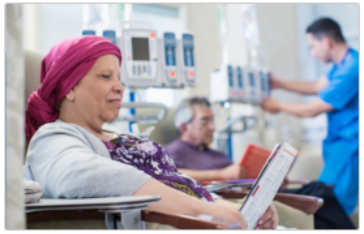


Common questions about coronavirus and cancer

How cancer patients, care, and treatment might be affected.

What to ask your health care team about COVID-19

Questions to ask so you can get the answers you need.



Infections in people with cancer

Why people with cancer can be more at risk and what to watch for.

https://www.cancer.org/about-us/what-we-do/coronavirus-covid-19-and-cancer.html

THANK YOU!

cancer.org | 1.800.227.2345

Questions & Discussion