SAFELY RESUMING AND PROMOTING CANCER SCREENING DURING THE COVID-19 PANDEMIC

Cancer prevention and early detection are central to the American Cancer Society's (ACS') mission to save lives, celebrate lives, and lead the fight for a world without cancer. Early detection of cancer through screening reduces mortality from cancers of the colon and rectum, breast, uterine cervix, and lung (see ACS screening guidelines). Cancer mortality has declined in recent decades in part due to progress in cancer screening technologies, awareness, research, and the general population's improved uptake in screening services.

Yet, far too many individuals for whom screening is recommended remain unscreened, and this situation has been aggravated by the substantial decline in cancer screening resulting from the COVID-19 pandemic. At the onset of the pandemic, elective medical procedures, including cancer screening, were largely put on hold to prioritize urgent needs and reduce the risk of the spread of COVID-19 in health care settings. Early projections indicate that these extensive screening delays will lead not only to missed and advanced stage cancer diagnoses, but also to a rise in cancer-related deaths. Adding concern, the pandemic-related disruptions will likely exacerbate existing disparities in cancer screening and survival across groups of people who have systemically experienced social or economic obstacles to screening and care.

In response to these challenges, ACS developed this report to summarize the current state and to provide guidance on how public health agencies, health care providers, and screening advocates across the nation can promote and deliver cancer screening appropriately, safely, and equitably during the COVID-19 pandemic.

A UNITED MESSAGE IN OUR RESPONSE TO THE DISRUPTIONS IN CANCER SCREENING

1. **Despite the challenges we face during the pandemic, cancer screening remains a public health priority**, and we must provide the public with safe opportunities to prevent cancer or detect it early to improve patient outcomes.

2. **Screening disparities are already evident and, without deliberate focus, are likely to increase as a result of the COVID-19 pandemic.** Efforts to promote screening and overcome barriers for populations with low screening prevalence must be at the forefront of our focus.

3. **Engaging patients in the resumption of cancer screening will require effective and trustworthy messaging.**

4. **Implementation of process and policy changes are urgently needed to sustain access to primary care and return screening to pre-pandemic rates.**

Screening refers to testing individuals who have no signs or symptoms of disease. It is critical to ensure that patients with signs or symptoms associated with cancer undergo diagnostic evaluation as soon as possible, yet many people with symptoms – such as breast lumps, abnormal vaginal bleeding, blood in bowel movements, unexplained weight loss, fatigue, or anemia – continue to avoid medical care due to fears of infection with the SARS-CoV-2 virus.

It is important to reassure the public that aggressive infection control measures are being taken in health care facilities throughout the country to ensure that diagnostic procedures can be provided safely for patients with symptoms, and that these evaluations need not and should not be delayed.

UNIVERSAL CANCER SCREENING MESSAGE #1:

Despite the challenges we face during the pandemic, cancer screening remains a public health priority, and we must provide the public with safe opportunities to prevent cancer or detect it early to improve patient outcomes.

BACKGROUND

On March 13, 2020, the U.S. government declared a national emergency in hopes of stopping the spread of COVID-19. Many medical providers and systems across the country immediately halted most "non-essential" care, including cancer screening. The impact was immediate, with drops in screening-related procedures of 83% (Pap tests) to 90% (colonoscopies). Although the pandemic continues, there are signs that routine health care including cancer screening are resuming. However, one study estimated that in mid-June the volume of breast (-29%), colon (-36%), and cervical (-35%) cancer screening remained well below historical pre-pandemic levels. Four months into the pandemic, preventive care gaps persisted with 78% of primary care respondents to a recent survey reporting that patients continue to delay or defer preventive and chronic care visits.

Cancer screening is critical to staying healthy and well and should not be considered "non-essential" health care. Early detection of cancer before symptoms appear transformed the world of cancer care and has continued to have a critical role in the control of cancer types for which screening is available. Additionally, screening can prevent colorectal and cervical cancers through detection and removal of precancerous lesions. Between 1989 and 2017 the overall breast cancer death rate declined by 40%, (resulting in an estimated 375,900 breast cancer deaths averted in that time period), due to a great extent to early detection with the increasing utilization of screening mammograms. Detection and treatment of precancerous lesions and the early detection of cervical cancer have contributed to dramatic decline in both cancer incidence and mortality rates. Colorectal cancer incidence and mortality rates have dropped by over 30% in the U.S. among adults 50 and older in the last 15 years, with a substantial fraction of these declines due to screening. Steady progress has been made in improving cancer screening rates, but the COVID-19 pandemic could potentially reverse these gains.

Continuing to improve cancer screening rates is critical as there are still major gaps to fill in decreasing the burden of cancer. For example, breast cancer remains the second leading cause of cancer death among women and colorectal cancer is the third most common cause of cancer death among men and women in the U.S., yet nearly 1 in 3 men and women for whom screening is recommended are not up-to-date on screening.

STRATEGIES FOR GETTING CANCER SCREENING BACK ON TRACK

1. Identifying patients who should receive higher priority for screening is a critical step.

While it is important to address the backlog of patients created by the pandemic, it will be necessary to prioritize the patient population vying for appointments. Delayed or missed screening can result in later stages of cancer diagnosis and poorer outcomes for all patients, but these delays may be especially impactful for those at higher risk for disease who require earlier or more frequent screening. Identification of patients at increased risk of cancer due to genetic, personal, or family history is essential, and these patients should receive priority status when assigning screening appointments. Patients with a history of an abnormal screening test who may need more frequent screening or additional diagnostic evaluation should also be given high priority. In addition, any patient with new or concerning symptoms should be evaluated promptly and assigned a higher priority for appointments than asymptomatic average risk individuals.

UNIVERSAL CANCER SCREENING MESSAGE #1, CONT.

2. Re-igniting cancer screening will require the active engagement of multiple segments of the health care delivery system.

Health care resources and attention will continue to be diverted to the COVID-19 pandemic in many parts of the country for the foreseeable future. Resuming cancer screening and regaining lost momentum will therefore require deliberate and coordinated effort. Health care administrators and policymakers should be educated on the potential long-term ramifications of continued postponement of and inattention to cancer prevention and early detection measures. Collaboration between primary care providers (PCPs) and specialty care services such as Radiology and Gastroenterology will be necessary to facilitate resumption of cancer screening services. Some of the practice and policy changes implemented to assure safety of patients and health care staff (e.g. deep cleaning and social distancing protocols, increased use of telehealth/telemedicine visits) may have lasting effects on how cancer screening occurs and may impact the resources available to support screening. Assertive engagement of stakeholders and patients will be needed to ensure that cancer screening remains a high priority in health care systems and communities across the nation.

UNIVERSAL CANCER SCREENING MESSAGE #2:

Screening disparities are already evident and, without deliberate focus, are likely to increase as a result of the COVID-19 pandemic. Efforts to promote screening and overcome barriers for populations with low screening prevalence must be at the forefront of our focus.

BACKGROUND

Screening is one of the earliest interventions along the cancer continuum, thus closing disparities in screening is an important step towards closing disparities in cancer outcomes. Disparities in cancer screening exist across groups of people who have systemically experienced greater social or economic obstacles to screenings based on their racial or ethnic group, sexual orientation, education, health insurance status, immigration status, or other characteristics historically linked to discrimination or exclusion. The COVID-19 pandemic has exacerbated these social and economic obstacles. For example, one study estimated at least 5 million Black and Hispanic people may lose their health insurance as a result of the pandemic. In April 2020, 42% of U.S. adults in families who lost income reported being unable to pay rent, the mortgage, or utilities; being food insecure; or going without medical care. This has disproportionately affected adults with family incomes below poverty level and Black and Hispanic adults.

We must accelerate the adoption and implementation of the following health equity principles by health care systems and policymakers so everyone has the fair and just opportunity to prevent, find, treat, and survive cancer.

STRATEGIES FOR GETTING CANCER SCREENING BACK ON TRACK

1. Implement focused efforts to screen people who historically have had low screening prevalence and are most affected by COVID-19. Benchmark progress based on increased screenings among this group. This involves reviewing local data to identify these groups in each community. Systems and communities must improve their decision making and ability to track progress by collecting, analyzing, and reporting data disaggregated by race, ethnicity, sexual orientation, gender identity, education, health insurance status, disability status, neighborhood, and other sociodemographic characteristics.

2. Include in decision making people who historically have had low screening prevalence and are most affected by COVID-19. In addition to the general public's reluctance to get screened out of fear of being exposed to the coronavirus, people who have been marginalized are also more likely to distrust clinicians, medical systems, and other institutions due to their experience with historical exploitation, discrimination, and oppression. In order to resume cancer screenings equitably, health systems and policymakers must listen to, act on feedback from, and empower community members to make decisions.

3. Invest to address the underlying causes of low screening prevalence in communities and foster resilience. Policymakers must identify and invest in efforts addressing the root causes of screening disparities, such as financial security, housing, transportation, and food security. This can be done by reviewing local data, collecting data to fill in gaps, and listening to and collaborating with community members that historically have had low screening prevalence. Health systems must then act in partnership with community-based and multi-sector organizations.

4. Identify existing policy gaps contributing to screening disparities and advocate for high-impact policy changes *(See Universal Message #4)*.

UNIVERSAL CANCER SCREENING MESSAGE #3:

Engaging patients in the resumption of cancer screening will require effective and trustworthy messaging.

BACKGROUND

In order to return cancer screening rates to pre-pandemic levels, it is imperative that providers and health systems recognize that simply re-opening facilities and offering screening will not be enough. Recent surveys indicate that 68% of respondents cancelled or postponed an in-person medical appointment during the pandemic and 35% of Americans have missed routine cancer screening due to COVID-19 related fears and service disruptions. Health care providers and systems are reporting that many patients continue to refuse or delay cancer screening appointments, in many instances based on patient concerns about visiting medical facilities and the associated fears of exposure to COVID-19. Some of the new health and safety procedures put in place to lower the risk of COVID-19 transmission – including pre-visit testing, fever checks, and required use of personal protective equipment (PPE) by both patients and medical staff – might paradoxically exacerbate patient fears and create the impression that these environments are, as one patient remarked, "crawling with COVID-19." In addition to stoking patient concerns, these measures serve as new barriers to screening for some populations. For instance, the requirement for documented negative results on COVID-19 testing prior to screening colonoscopy can lead to last-minute postponements when patients are unable to get the test performed or if results are not returned in a timely manner. For patients who were already procrastinating about getting screened, these added precautions may reinforce their inclination to delay or refuse screening.

To address these concerns and challenges providers and public health professionals will need to tailor messaging for their audiences, helping them to overcome new and old fears related to screening while also conveying the importance of screening and clear guidance on reengaging safely with the health care system for routine screenings.

STRATEGIES FOR GETTING CANCER SCREENING BACK ON TRACK

1. Providers and facilities should be proactive in educating patients about the measures being taken to protect their health.

Messaging should be designed to help patients understand that measures, such as those described above, have been implemented to enhance their safety and are not in place because of any identified risk in the facility. The patient education process addressing these potential fears should be planned at multiple patient touchpoints and utilize various communication channels. For example, through small media (e.g. short videos on websites and social media), adding messaging to online scheduling portals, or by sending emails or letters to all scheduled patients. When disseminating information to patients about COVID-19, reading levels should be taken into consideration, e.g. limiting the use of complex syntax or technical terminology.

2. Reassuring patients about the importance of resuming cancer screening and communicating their options related to screening is critical.

Patients at high risk for disease and those who are overdue because of canceled appointments should be actively followed up. It may be confusing for some patients to know what's best and safe as COVID-19 infection rates are rising, stable, or declining, and local trends are highly subject to change. Conveying the message that cancer screenings are essential to keep you healthy and that, particularly for those at higher risk, the potential harms associated with delayed screening likely outweigh the risk of infection. ACS guidelines for screening average-risk persons for colorectal and cervical cancer offer varying intervals for screening depending on the screening test used, and for breast cancer, postmenopausal women over age 55 may choose to extend screening to a 2-year interval. Average-risk individuals who have received regular cancer screening and are not overdue may choose to wait, but persons at high risk for these cancers require more frequent screening and should be counseled to return to screening as soon as feasible (based on local circumstances) and given priority for screening.

UNIVERSAL CANCER SCREENING MESSAGE #4:

Implementation of process and policy changes are urgently needed to sustain access to primary care and return screening to pre-COVID rates.

BACKGROUND

The consequences of COVID-19 are devastating and far-reaching. Health care systems have reorganized around telemedicine and reprioritized services out of necessity. Community health centers, a critical part of the nation's health care infrastructure, have been hardest hit while stretching facilities and staff to combating COVID-19 within their communities. People across the country are dealing with a loss of employment and thus, employer-sponsored health care coverage. Ultimately, across our entire health care infrastructure, the pandemic has emphasized and widened our nation's largest process and policy vulnerabilities.

AN ESTIMATED 22 MILLLION CANCER SCREENINGS WERE CANCELLED OR MISSED BETWEEN MARCH AND JUNE OF 2020

34% OF PRIMARY CARE PRACTICES HAVE CUT BACK THE NUMBER OF SERVICES OFFERED TO PATIENTS

AN ESTIMATED 12 MILLION INDIVIDUALS HAVE LOST THEIR EMPLOYER-SPONSORED HEALTH INSURANCE COVERAGE, WITH DISPROPORTIONATE IMPACT ON BLACK AND HISPANIC PEOPLE

Yet, in many areas around the U.S., "non-essential" medical services, including cancer screening, have resumed with a variety of new policies and processes in place. Some of these new approaches are aimed at decreasing the risk – to both patients and health care personnel – of contracting infection with the novel coronavirus. Some are required because of cost cuts, resource reallocation, or from internal or external regulations being imposed during the COVID-19 pandemic. Some of the innovations implemented out of necessity will likely find a permanent place in our new health care operational models, and these successes suggest the need for even bolder policy changes and support mechanisms.

STRATEGIES FOR GETTING CANCER SCREENING BACK ON TRACK

1. A key requirement for a return to screening is the development and implementation of new approaches for PCPs and health systems to recommend and complete cancer screening during the pandemic era.

   - Addressing missed screenings: Addressing the backlog created by these lost months will require practices and systems to develop new approaches to tracking and outreach for patients in need of cancer screening. As screening resumes, it will be essential for practices to identify those patients who were due for screening during the shutdown period as well as those patients who are now becoming due.
   - Prioritizing patients: In areas where screening capacity is diminished, it will be necessary to develop prioritization protocols to assure that those patients with the highest need (e.g. patients with a family history of colorectal cancer) are moved to the front of the line for available screening slots (*see Universal Message #1, Strategy #1*).
   - Expanding screening capacity: Systems should consider offering screening appointments outside of standard business hours (e.g. creating evening or weekend slots) to increase screening capacity and to make appointments more accessible to patients who have returned to routine work hours and are not able to take time away from work for a screening visit.

UNIVERSAL CANCER SCREENING MESSAGE #4, CONT.:

2. Prepare for more permanent implementation of telehealth services, address policy barriers that prevent patients from engaging with telehealth services, and educate patients about accessing these services.

   - Effective utilization of telehealth: Advising on screening via telehealth requires new approaches to engaging and educating patients, arranging and tracking screening appointments or consultations, and – in the case of colorectal cancer screening – disseminating and collecting stool-based screening tests.
   - Easing payment policies: Longstanding payment policies were temporarily waived by CMS and commercial insurers early in the pandemic to allow expanded use of telehealth. This led to a rapid expansion in the use of this technology and enabled a greater degree of access to primary and specialty care than would otherwise have been possible in the face of pandemic-related disruptions in the availability of in-person care. As the pandemic gradually wanes it will be necessary to permanently enshrine some of these policy changes.
   - Improving access: Early evidence indicates that the benefits of telemedicine are not being equally distributed, and in the absence of corrective measures, there is concern over exacerbating health disparities. Areas of concern include the availability of technology, digital literacy, and reliable internet coverage for populations that are being disproportionately impacted by COVID-19. Closely monitoring the digital divide and ensuring reliable internet access to all must be a key policy priority to advance telehealth.

3. Advance policy solutions to address the growth of the uninsured population resulting from the pandemic. A recent study estimates that as of July as many as 12 million Americans will lose their employment-related health insurance. This will lead to immediate challenges with access to care, including cancer screening services. Cancer screening rates among the uninsured in the U.S. are typically 40% to 50% lower than screening rates among the insured. It will be imperative for policymakers and the public health community to find ways to provide continued access to care for these millions of individuals. To aid our recovery efforts it will be important to:

   - Develop organized approaches to connect the millions of newly uninsured to safety net programs, including the CDC's National Breast and Cervical Cancer Early Detection Program and the Colorectal Cancer Control Program
   - Enhance funding for these programs and provide resources to support state and local public health system efforts to address the growth of the population needing services

4. Advocating for the nation's primary care infrastructure will be critical in the aftermath of the pandemic.
   The vast majority of cancer screening and other preventive care in the U.S. is initiated by PCPs. For a variety of reasons, including high medical school debt and relatively low compensation for PCPs compared to other specialties, the supply of PCPs in U.S. was already far below the estimated need and the number of PCPs has been falling for decades. In addition, primary care practices have been particularly hard-hit by COVID-related disruptions, with one in three (34%) of PCP respondents to a recent survey indicating they are considering leaving primary care. Shortages may preferentially impact people who are marginalized, such as people of color and those living in rural communities, further exacerbating disparities in access and care. Recovery will require adequate policy and payment support to ensure a robust primary care workforce for the future.