

# 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.

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

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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.

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## 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.

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# 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 MILLION  
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.:

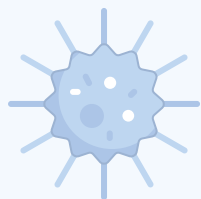
2. **Prepare for more permanent implementation of telehealth services, address policy barriers that prevent patients from engaging with telehealth services, and educate patients about accessing these services.**
  - **Effective utilization of telehealth:** Advising on screening via telehealth requires 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.

# PROMOTING COLORECTAL CANCER SCREENING DURING THE COVID-19 PANDEMIC



The American Cancer Society (ACS) recommends that people at average risk of colorectal cancer start regular screening at age 45. This can be done either with a sensitive test that looks for signs of cancer in a person's stool (a stool-based test), or with an exam that looks at the colon and rectum (a visual exam). [To learn more, access the ACS guidelines for colorectal cancer screening.](#)

## WHY COLORECTAL CANCER SCREENING?



- Colorectal cancer is the second-leading cause of cancer death in the U.S. among men and women combined, and an estimated 147,950 adults are expected to be diagnosed in 2020.
- Colorectal cancer screening can save lives, but only if people get tested.
- Screening can prevent colorectal cancer through the detection and removal of precancerous growths, as well as detect cancer at an early stage, when treatment is usually less extensive and more successful.
- There are several safe and effective tests to screen for colorectal cancer, including stool-based tests (fecal immunochemical test [FIT], high-sensitivity guaiac fecal occult blood test [FOBT], multi-target stool DNA [mt-sDNA]), and tests that provide a structural exam of the colon and rectum, including colonoscopy, sigmoidoscopy, and CT colonography (also called virtual colonoscopy).

## IMPLICATIONS OF COVID-19 ON COLORECTAL CANCER SCREENING



- [An estimated 90% drop in colonoscopies and biopsies in March through mid-April](#) compared to same period in 2019
- [1.7 million missed colonoscopies](#) estimated from March to June 5.
- [18,000 missed or delayed diagnoses of colorectal cancer](#) from mid-March through early June
- [4,500+ excess deaths from CRC over next decade](#)



# PROMOTING COLORECTAL CANCER SCREENING DURING THE COVID-19 PANDEMIC



## SCREENING FOR COLORECTAL CANCER (CRC) DURING COVID-19



- Despite the challenges we face during the pandemic, colorectal cancer remains a public health priority, and we must provide the public with safe opportunities to prevent and detect colorectal polyps and cancer.
- Colonoscopy remains safe, is a good option for screening, and is quickly reopening around the country, but identifying patients who should receive higher priority for colonoscopic screening is a critical step.
- During a time when availability of elective screening colonoscopy may be limited by the COVID-19 pandemic, colorectal cancer screening can be safely offered through at-home stool-based tests. Importantly, a positive (abnormal) stool-based test must be referred promptly for colonoscopy to complete the screening process.
- Screening disparities are already evident and, without deliberate focus, are likely to increase as a result of the COVID-19 pandemic.
- Close collaboration between every partner in the health care system and critical policy changes will help us regain traction.

## PRIORITIZING PATIENT POPULATIONS FOR CRC SCREENING



- For those at the highest risk, access to colonoscopy should be prioritized. Priority should be given to:
  - ✓ Those with abnormal stool-based cancer screens;
  - ✓ Patients with a family history of adenomas or cancer;
  - ✓ Patients with inflammatory bowel disease; and/or
  - ✓ Patients with a genetic syndrome that elevates risk for colorectal cancer.
- Although screening colonoscopy is now available in many communities, in locales experiencing colonoscopy limitations or a high burden of COVID-19 related illness the average risk group should predominately be screened using non-invasive stool test screening options.

## A UNITED RESPONSE TO COVID-19

The colorectal cancer fighting community stands prepared and well-positioned to respond to and overcome the difficult task ahead. Learn more at [NCCRT.org](https://www.nccrt.org).

# PROMOTING BREAST CANCER SCREENING DURING THE COVID-19 PANDEMIC



The American Cancer Society (ACS) recommends that women at average risk for breast cancer undergo annual mammography screening starting at age 45 years, and women ages 40-44 years should also have the opportunity to begin annual screening. At age 55, women may transition to screening every 2 years, or if they prefer, may continue receiving annual mammograms. As long as a woman is in good health and is expected to live 10 or more years, she should continue screening mammograms. Annual screening with MRI is recommended for some women at higher than average risk for breast cancer, starting at age 30 years. [To learn more, access the ACS guidelines for breast cancer screening.](#)

## WHY IS BREAST CANCER SCREENING IMPORTANT?



- Breast cancer is the most common cancer and second-leading cause of cancer death among women in the U.S. It is estimated that there will be 276,480 new cases and 42,170 deaths from breast cancer [in 2020](#).
- Deaths from breast cancer have been declining steadily for over 30 years, largely due to the progress made in screening and treatment.
- Screening with regular mammography saves lives, as cancers detected early tend to have better treatment outcomes.

## WHAT TO KNOW ABOUT WOMEN AT HIGHER-THAN-AVERAGE RISK FOR BREAST CANCER



- For those at high risk for breast cancer, access to MRI screening should be prioritized and considered essential medical visits.
- High-risk women who had a canceled mammogram and/or MRI due to COVID-19 or are due for screening should schedule now.

## WHAT ARE THE IMPLICATIONS OF COVID-19 ON BREAST CANCER SCREENING?



- [An estimated 87% drop](#) in mammography screening from the end of February to early April 2020.
- Estimated missed or delayed diagnoses of about [36,000 women](#) for the period of March to early June 2020.

# PROMOTING BREAST CANCER SCREENING DURING THE COVID-19 PANDEMIC



## BREAST CANCER SCREENING DURING COVID-19



- Despite the challenges we face during the pandemic, breast cancer remains a public health priority, and we must provide the public with safe opportunities to resume getting regular mammograms.
- As breast cancer screening centers reopen and follow standard COVID-19 safety measures, getting a mammogram will be safe.
- For average risk women who had canceled mammograms or are delaying appointments, it is important to contact health care providers to reschedule.
- Women who were scheduled for follow-up tests due to an abnormal mammogram should not postpone their appointments and should be given priority in scheduling.
- All women should be aware of changes in the look or feel of their breasts. If they have experienced a change in your breasts during the shutdown, they should call their health care provider to schedule an examination.

## MESSAGING TO PROMOTE BREAST CANCER SCREENING DURING COVID-19



- Women may miss the opportunity to have their breast cancer diagnosed early without deliberate focus to get them back on schedule for regular screening mammograms.
- It should be emphasized that medical facilities are taking appropriate precautions to ensure patient safety, so don't put off getting a mammogram.
- Active reminder systems, including tracking and follow up of women who had canceled appointments in the early months of the pandemic, should be implemented.
- If patients have [signs or symptoms](#) of breast cancer, they should health care provider, even during the COVID-19 pandemic. If they don't have a doctor, they can [call the ACS cancer help-line](#) for assistance finding a provider in your area.
- Screening disparities are already evident and, without deliberate focus, are likely to increase as a result of the COVID-19 pandemic.

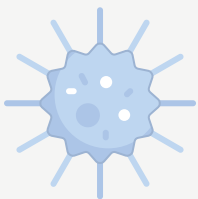
For more information and resources, visit [cancer.org](https://www.cancer.org)

# PROMOTING LUNG CANCER SCREENING DURING THE COVID-19 PANDEMIC



The American Cancer Society (ACS) recommends that people who currently smoke, or once smoked but have quit within the past 15 years, ages 55-74 in good health, and with at least a 30 pack-year history of smoking should undergo annual screening with low-dose computed tomography (LDCT). [To learn more, access the ACS guidelines for lung cancer screening.](#)

## WHY IS LUNG CANCER SCREENING IMPORTANT?



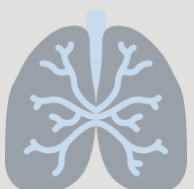
- Lung cancer screening with LDCT is relatively new. It is recommended by leading health organizations, and is covered by private health insurance, Medicare, and in some states, it is covered by Medicaid.
- In adults at high risk for lung cancer due to their smoking history, lung cancer screening with LDCT can save lives, but only if they get tested.
- Lung cancer screening rates still are low in the U.S., and most cases of lung cancer still are diagnosed when patient's present with symptoms.

## WHAT ARE THE IMPLICATIONS OF COVID-19 ON LUNG CANCER SCREENING?



- Although declines in lung cancer screening have not been reported, we expect screenings have declined similar to other cancer screening tests.
- Further, a recent study of the decline in new patient encounters for incident lung cancer had [declined by 47%](#) in April 2020 compared with a similar period in 2019.
- Missed opportunities for early detection or delays in diagnostic evaluations for symptoms means more patients will be diagnosed later, when treatment is likely to be less successful.

## SCREENING FOR LUNG CANCER DURING COVID-19

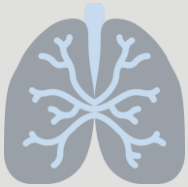


- Despite the challenges we face during the pandemic, lung cancer remains a public health priority, and we must provide high-risk individuals with safe opportunities to detect lung cancer early.
- Individuals who have undergone screening and are in a period of short-term surveillance for nodules, or individuals who have possible signs or symptoms of lung cancer, should be prioritized during the resumption of services.
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# PROMOTING LUNG CANCER SCREENING DURING THE COVID-19 PANDEMIC



## SCREENING FOR LUNG CANCER DURING COVID-19, CONT.



- As imaging facilities reopen for screening, prioritize imaging for adults who are:
  - ✓ undergoing nodule surveillance;
  - ✓ adults who are older;
  - ✓ adults who are approaching 15 years from date they quit smoking;
  - ✓ adults who are near the upper age at which screening will no longer be covered by insurance and
  - ✓ adults who had undergone screening and are the furthest past their 12 month anniversary when their next exam was due.

## MESSAGING TO PROMOTE LUNG CANCER SCREENING DURING COVID-19



- Lung cancer screening with LDCT is an effective and recommended test that has been shown to be the only effective method to detect lung cancer early in high-risk adults, when treatment is much more effective.
- All high-risk adults who smoke should be referred to smoking cessation programs.
- Adults who are experiencing possible signs and symptoms of lung cancer should be prioritized for diagnostic workup.
- Screening disparities are already evident and, without deliberate focus, are likely to increase as a result of the COVID-19 pandemic.

For more information and resources, visit [cancer.org](https://www.cancer.org)

# PROMOTING CERVICAL CANCER SCREENING DURING THE COVID-19 PANDEMIC



The American Cancer Society (ACS) recommends that people at average risk of cervical cancer start regular screening at age 25. Screening should take place every 5 years with an HPV test (called primary HPV testing), which looks for the virus that causes almost all cervical cancer. If this test is not available, screening may be done every 5 years with a cotest (an HPV test with a Pap test) or every 3 years with the Pap test alone, which looks for changes in cells in the cervix. For most people, screening should stop after age 65. [To learn more, access the ACS guidelines for cervical cancer screening.](#)

## WHY IS CERVICAL CANCER SCREENING IMPORTANT?



- Cervical cancer screening can save lives, but only if individuals get tested.
- Screening can find HPV (the virus that causes almost all cervical cancers) and cell changes called pre-cancers years before they become cancer.
- The removal of precancerous tissue that was detected by screening can prevent cancer from developing. Screening can also detect cervical cancer at an early stage, when treatment is usually less extensive and more successful.

## WHAT ARE THE IMPLICATIONS OF COVID-19 ON CERVICAL CANCER SCREENING?



- [An estimated 94% drop](#) in weekly cervical cancer screening appointments in March compared to appointments made from 2017 to 2019.
- [2,500 missed or delayed diagnoses](#) of cervical cancer from early March through early June.

## SCREENING FOR CERVICAL CANCER DURING COVID-19



- Despite the challenges we face during the pandemic, cervical cancer remains a public health priority, and we must provide the public with safe opportunities to prevent and detect cervical pre-cancer and cancer.
- Prioritize individuals in surveillance for a previous abnormal screening test result, those who were scheduled for follow-up exams, colposcopy, or excisional treatment.
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# PROMOTING CERVICAL CANCER SCREENING DURING THE COVID-19 PANDEMIC



## SCREENING FOR CERVICAL CANCER DURING COVID-19, CONT.



- Prioritize screening of individuals who are overdue for a HPV test, Pap test, or cotest. Discourage screening too frequently.
- Individuals who are older than 65 who meet criteria for recommended cessation of screening should discontinue screening.
- Individuals without a cervix, including those who had a total hysterectomy, should not be screened.

## MESSAGING TO PROMOTE CERVICAL CANCER SCREENING



- There are several safe and effective tests to screen for cervical cancer, including primary HPV testing, cotesting, and Pap tests.
- Screening disparities are already evident and, without deliberate focus, are likely to increase as a result of the COVID-19 pandemic.
- People who are overdue for screening or who have had a recent positive screening test should be given priority for cervical cancer screening and follow-up visits/procedures.
- Failure to get back on track with cervical cancer screening will delay our ability to reach the goal of eliminating cervical cancer.

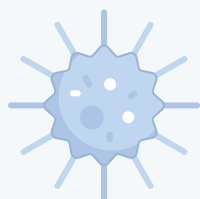
For more information and resources, visit [cancer.org](https://www.cancer.org)

# PROMOTING HPV VACCINATION DURING THE COVID-19 PANDEMIC



The American Cancer Society (ACS) recommends that girls and boys get 2 doses of the HPV vaccine at ages 9 to 12 years. Children and young adults up to age 26 years who have not received the HPV vaccine should get vaccinated. If the first dose is given at or after age 15, 3 doses are recommended. Vaccination of young adults will not prevent as many cancers as vaccination of children and teens. ACS does not recommend HPV vaccination for persons older than 26 years. To learn more, access the ACS guidelines for HPV vaccination.

## WHY IS HPV VACCINATION IMPORTANT?



- HPV vaccination can prevent more than 90% of HPV-related cancers when given at the recommended ages.
- The HPV vaccine prevents HPV infections that can cause 6 types of cancer: cervical, vaginal, vulvar, anal, penile, and oropharyngeal.
- The vaccine also prevents HPV infections that cause most cases of genital warts and, for women, most cervical precancers and abnormal results on cervical cancer screening tests.

## WHAT ARE THE IMPLICATIONS OF COVID-19 ON HPV VACCINATION?



- [>80% drop](#) in weekly HPV vaccine provider orders in March compared to orders in March 2019.
- [73% drop](#) in HPV vaccination in early April compared to mid-February of 2020.
- Although wellness visits and vaccinations for younger children have recovered, visits and vaccinations for preteens and teens have not.

## HPV VACCINATION DURING COVID-19



- Despite the challenges we face during the pandemic, prevention of HPV related-cancers remains a public health priority, and we must provide the public with safe opportunities to vaccinate against HPV-related cancers.
- *Continued on next page*



## HPV VACCINATION DURING COVID-19, CONT.

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- Summer is usually the peak time for HPV vaccination; however, efforts should be made to get patients back on track with vaccinations throughout fall and winter as well.
- Prioritize pre-teens and younger adolescents, for whom vaccination is most effective at preventing cancer.
- Combine telehealth visits with in-person vaccine delivery.
- Find new means to vaccinate through parking lot clinics, community partnerships, mobile units or other creative solutions.

## MESSAGING TO PROMOTE HPV VACCINATION DURING COVID-19

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- Well-child visits and vaccinations are essential services.
- “Call, Don’t Cancel” to encourage patients to ask their providers if they need vaccines and whether it is safe to receive them at this time.
- Now is not the time to skip vaccinations. Vaccinating children on time is the best way to protect them.
- Encourage caregivers and parents to keep children safe by staying up to date on vaccinations during COVID-19. Clinics have changed to make it safe for children to get needed vaccines.
- HPV cancer disparities are already evident and, without deliberate focus, are likely to increase as a result of the COVID-19 pandemic.
- Failure to get back on track with HPV vaccination will delay our ability to reach the goal of eliminating HPV related-cancers, starting with cervical cancer, as a public health problem.