



REDUCING CANCER DISPARITIES IN KANSAS: THE ROLE OF POLICY, PREVENTION, AND COMMUNITY HEALTH WORKERS

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Kansas Department of Health and Environment

12/1/2024 - 3/31/2025

About Me

- Lenexa, KS
- BS in Medical Biochemistry 2021-2024
- Accelerated BS/MPH 2024-2025
- Ready to Serve: Building a Day-1-Ready Public Health Workforce for Kansas and Beyond Scholarship
- Work Experience:
 - Overland Park Regional Medical Center 2021-2022
 - Pawnee Mental Health Youth Client Support Provider 2022-2023
 - Ascension Via Christi Pharmacy Technician 2022-2024
 - University of Kansas Medical Center MA 2023-present
 - SOF Writer for Parmele Disability Advocates 2024-present
 - KDHE CHW/HIV Coordinator 2024-present
- Future Plans: Medical School @ KU Med in KC starting July 2025





Outline

- How did I get here?
- Public Health Agency Site: KDHE
- APE Products
- MPH Competencies
- Emphasis Area Competencies
- Motivation Behind the Project
- Key Takeaways and Future Directions
- Conclusion
- Acknowledgements

How Did I Get Here?

- Desire to **apply** the information I have learned and the experiences I have been a part of
- Locational Influence



Ratio of Primary Care Physicians
to Population: 840:1
Rate of Uninsured Adults: 7%

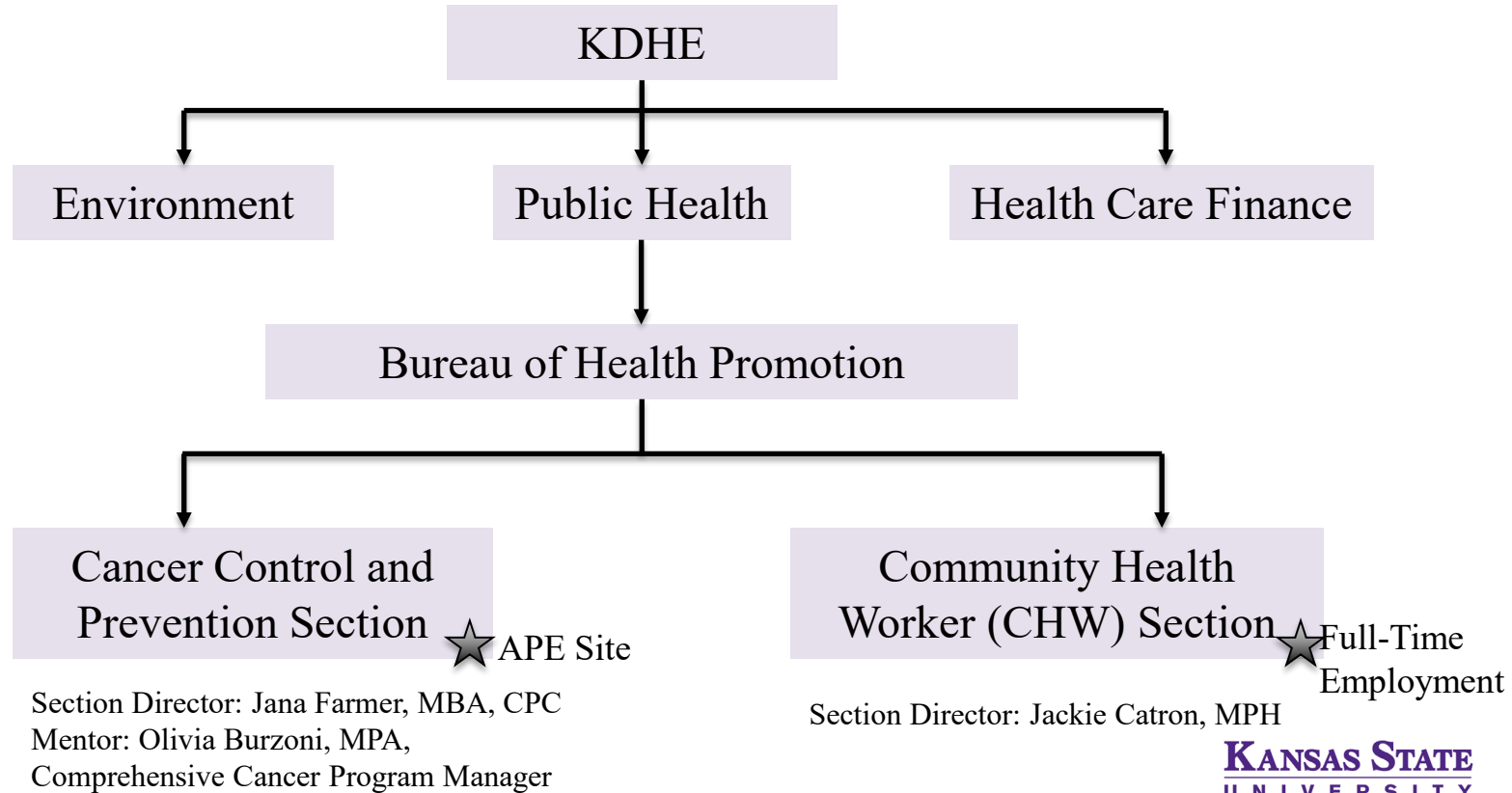


Ratio of Primary Care Physicians
to Population: 1440:1
Rate of Uninsured Adults: 12%

This issue is even more severe in frontier counties in Southwest Kansas

- Uninsured adult rate: Hamilton and Haskell Counties – 25%
- Primary care physician-to-population ratio: Gray County 5,640:1
 - Lane and Wallace Counties 1,500:0

Public Health Agency Site: Kansas Department of Health and Environment (KDHE)





Cancer Control and Prevention Initiatives

- Early Detection Works (EDW)
 - Established January 1995
 - Offers free or low-cost breast and cervical cancer screenings to uninsured and underinsured women in Kansas
- Kansas Cancer Partnership (KCP)
 - A collaborative network of organizations and individuals committed to reducing the cancer burden in Kansas
 - 5 Workgroups
 1. Prevention
 2. Early Detection and Diagnosis
 3. Financial Burden and Health Equity
 4. Survivorship
 5. Policy

Product A/B: Breast Cancer Screening: A Patient and Provider's Guide

BREAST CANCER SCREENING: A PATIENT'S GUIDE

1. UNDERSTAND YOUR RISK

- **Genetic Mutations:** Women with BRCA1 or BRCA2 mutations have a **45-72% lifetime risk** of developing breast cancer compared to about 13% in the general population.
- **Dense Breasts:** Approximately **40% of women** in the US have dense breast tissue, which can obscure tumors during mammograms. Women with dense breasts are **4-6 times more likely** to develop breast cancer compared to women with low breast density.
- **Family History:** If you have a first-degree relative (mother, sister, or daughter) with breast cancer, your risk **doubles**, and it may be even higher with multiple affected relatives or early diagnosis in the family.
- In 2021, there were 2,476 new cases of breast cancer in Kansas, making it one of the most common cancers in the state.

2. FOLLOW SCREENING GUIDELINES

Ages 40-74: Women at average risk should have a mammogram every two years, as per the United States Preventive Services Task Force (USPSTF) guidelines. Regular screening can reduce breast cancer mortality by 30-40% in this age group.

3. LEARN ABOUT SCREENING METHODS

- **Clinical Breast Exam (CBE):** A physical examination by a healthcare provider to detect lumps, pain, or other abnormalities. Typically conducted during annual wellness visits for women starting in their 20s.
- **Mammogram:** A low-dose x-ray of the breast to detect tumors and abnormalities. Detects approximately 87% of breast cancers in women without dense breasts.
- **Ultrasound:** Useful for characterizing abnormalities in dense breasts or in addition to a mammogram, especially in high-risk patients.
- **Breast MRI:** Used for women at high risk. MRI screening, in combination with mammograms, can detect 92.3% of cancers in high-risk women compared to mammograms alone.

4. PRACTICE BREAST SELF-AWARENESS

- **Know What's Normal for You:** Monitor for lumps, changes in size or shape, nipple discharge, or skin changes (e.g. redness, dimpling).
- **Report Changes Promptly:** Early reporting can lead to better health outcomes.
- **Be Your Own Advocate:** You know your body best - if something feels off, trust yourself and seek medical advice.

5. WHAT IF MY SCREENING SHOWS ABNORMAL RESULTS?

If an abnormality is detected during screening, additional diagnostic tools may include:

- **Ultrasound:** often used to evaluate abnormalities detected on mammograms or physical exams.
- **Biopsy:** Removes a small sample of tissue to determine if the abnormality is cancerous. Types include:
 - Fine Needle Aspiration (FNA) Biopsy
 - Core Needle Biopsy
 - Surgical Biopsy (if necessary)

6. TAKE ACTION FOR YOUR HEALTH

- **Free Screenings:** Check if you qualify for no-cost mammograms and cervical screenings through Early Detection Works.
- **Breast cancer screening saves lives.** Understanding your risk, following screening guidelines, and using available resources can help detect cancer early when treatment is most effective. If you have concerns or symptoms, talk to your doctor today!



King, W. A., et al. (2022). Combined screening with ultrasound and mammography or mammography alone in women at elevated risk of breast cancer. *JAMA*, 299(18), 2151-2163.
Boyd, N. F., et al. (2010). Mammographic density and the risk and detection of breast cancer. *New England Journal of Medicine*, 363(3), 227-236.
Centers for Disease Control and Prevention. (2023). Breast Cancer Risk Factors and Screening.
Kansas Cancer Partnership. Breast Cancer Screening Guidelines and Resources.
Mandelblatt, J. S., et al. (2016). Benefits and harms of breast cancer screening: A systematic review. *JAMA*, 315(16), 1714-1725.
National Cancer Institute. (2023). BRCA Mutations and Cancer Risk.
National Comprehensive Cancer Network. (2023). NCCN clinical practice guidelines in oncology: Breast cancer screening and diagnosis (Version 1.2023).
United States Preventive Services Task Force. (2024). Final Recommendation Statement: Breast Cancer Screening.

BREAST CANCER SCREENING: A PROVIDER'S GUIDE

1. ASSESS PATIENT RISK

- Women with dense breasts are 4-6 times more likely to develop breast cancer compared to women with low breast density (Boyd et al., 2010).
- Evaluate for BRCA1 or BRCA2 mutations, which increase lifetime breast cancer risk to 45-72% compared to 13% in the general population (National Cancer Institute, 2023).
- Identify first-degree relatives with breast or ovarian cancer, which doubles the patient's risk. Multiple affected relatives or early diagnoses further increase risk (CDC, 2023).
- Use validated tools (e.g., Gail Model, Tyrer-Cuzick Model) to assess lifetime breast cancer risk.
- Women with $\geq 20\%$ lifetime risk are classified as high-risk and may require enhanced screening with MRI and mammography.

2. PROVIDE COUNSELING ON SCREENING OPTIONS

Average-Risk Patients:

- **Ages 40-49:** Discuss benefits and risks of starting screening early, including false positives and over diagnosis.
- **Ages 50-74:** Recommend biennial mammography, consistent with USPSTF and ACS guidelines. Screening in this group reduces breast cancer mortality by 30-40% (USPSTF, 2016).
- **Ages 75+:** Base screening decisions on health status, comorbidities, and life expectancy.

High-Risk Patients:

- Recommend annual mammography and breast MRI starting at age 30 or earlier, depending on risk factors (NCCN).
- Combine mammography with breast MRI for patients with a $\geq 20\%$ lifetime breast cancer risk (National Cancer Institute, 2023).

3. PERFORM SCREENING

Clinical Breast Exam (CBE):

- Perform a thorough physical exam to detect lumps, skin changes, or other abnormalities.
- Typically conducted during annual wellness visits for women starting in their 20s.

Mammography:

- The gold standard for detecting breast cancer, with a sensitivity of 87% in non-dense breasts and 71-75% in dense breasts (CDC, 2023; Mandelblatt et al., 2016).

Ultrasound:

- Useful for characterizing abnormalities in dense breasts or as an adjunct to mammography, especially in high-risk patients.

Breast MRI:

- Particularly effective for detecting cancers in high-risk women, identifying 92.3% of cancers when combined with mammography (National Cancer Institute, 2023).
- Studies show breast ultrasounds can detect 2.3 additional cancers per 1,000 women with dense breasts, while MRI detects 8.2 additional cancers per 1,000 women (Berg et al., 2012).

4. ADDRESS ABNORMAL RESULTS

- Order diagnostic mammography or breast ultrasound for further evaluation.
- Perform or refer for biopsy (e.g., core needle biopsy) if imaging results are suspicious.
- Refer patients with confirmed or suspected breast cancer to oncologists, breast surgeons, or multidisciplinary teams.
- High-risk patients may also benefit from genetic counseling.

5. PROVIDE PATIENT EDUCATION AND RESOURCES

- Provide materials on breast self-awareness and signs of breast cancer.
- Discuss the importance of regular screening and adherence to follow-up.
- For uninsured or underinsured patients, connect them to programs like Early Detection Works (in Kansas) or federal screening programs.
- Be aware of disparities: Women in rural or underserved areas, like parts of Kansas, may have limited access to mammography and face higher rates of late-stage diagnosis (Kansas Cancer Partnership).

King, W. A., et al. (2022). Combined screening with ultrasound and mammography or mammography alone in women at elevated risk of breast cancer. *JAMA*, 299(18), 2151-2163.
Boyd, N. F., et al. (2010). Mammographic density and the risk and detection of breast cancer. *New England Journal of Medicine*, 363(3), 227-236.
Centers for Disease Control and Prevention. (2023). Breast Cancer Risk Factors and Screening.
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United States Preventive Services Task Force. (2024). Final Recommendation Statement: Breast Cancer Screening.

Product C: Healthy Behaviors as Prevention – Evidence Based Interventions (EBIs)

Evidence Based Interventions for Cancer Prevention – KCP Prevention Workgroup

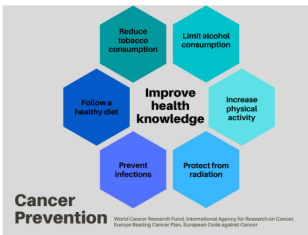
WHY IS THIS IMPORTANT?

"Risk perception influences behavior, so the **lack of awareness** of the importance of behavioral factors among both patients and healthcare professionals is concerning, undermining effective behavior change." [1]

"Patients are often unaware or have **incorrect perceptions** about behavior and cancer risk. In a study that took place in a breast screening service, alcohol was identified as a risk factor by only 19.5% of healthy women attending the screening and by less than half of the healthcare professionals working there." [1]

"Approximately 5%–10% of cancers are inherited, with the **majority** resulting from somatic mutations **acquired during a patient's lifetime.**" [2]

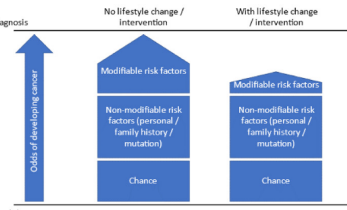
"An estimated 42% of cancer cases and 45% of cancer deaths in the US are attributed to potentially modifiable risk factors. This means that **almost half of all new cancers diagnosed are preventable** or could be detectable at an earlier stage leading to improved survival." [2]



LIFESTYLE BEHAVIOR #2: DIET

"Since cancer cells require more nutrients to support their uncontrollable proliferation, caloric restriction (CR) has been suggested to reduce the risk of cancer. CR would mean chronic reduction of energy intake by about 30% without malnutrition occurring. CR can extend lifespan and reduce age-related diseases including cancer. A systematic review reported that CR displayed a **75.5% reduction in tumor incidence** with a variety of tumor models." [3]

"Increased consumption of non-starchy vegetables and fruits are associated with a **lower risk of mouth, laryngeal, esophageal and stomach cancers**. There is also evidence that higher vegetable intake may lower the risk of breast tumors." [2]



From: Diaz de los Rios de la Serna, C., Fernández-Ortega, P., & Luch-Canut, T. (2022). Lifestyle Behavior Interventions for Preventing Cancer in Adults with Inherited Cancer Syndromes: Systematic Review. *International journal of environmental research and public health*, 19(12), 14098. <https://doi.org/10.3390/ijerph191214098>

LIFESTYLE BEHAVIOR #1: PHYSICAL ACTIVITY

"Obesity is associated with an increased risk of developing several types of cancer: endometrial, esophageal, liver, stomach, kidney, multiple myeloma, pancreas, colorectal, gallbladder, ovary, postmenopausal breast and thyroid." [2]

"It is suggested that physical activity **reduced 25-30% the risk of breast cancer.**" [3]

"Approximately 3% of cancer cases can be attributable to physical inactivity. Physical activity has been associated with a reduced risk of colon cancer, endometrial cancer and postmenopausal breast cancer." [2]

"First, exercise improves the way that the body responds to the hormone insulin and may reduce levels of hormones such as estrogen. Second, physical activity has been shown to support the immune system, which is essential for immune surveillance to potentially destroy cancer cells. Aerobic exercise can decrease oxidative stress, which can damage DNA, and can also **enhance DNA repair mechanisms.**" [2]

"Around 4% of cancer cases can be attributed to poor diet, predominantly colon cancer. It has also been indicated that those individuals with the healthiest diets are **between 11% and 24% less likely to die from cancer** than those with unhealthy eating habits." [2]

"Processed meat has been classified as a carcinogen based on the evidence of association with **increased colorectal cancer risk**. Although the specific mechanisms are not fully understood, substrates such as nitrates or nitrites used to process meats, and heme iron in red meat, can contribute to the formation of nitrosamines, which are implicated in carcinogenesis." [2]

LIFESTYLE BEHAVIOR #3: ALCOHOL CONSUMPTION

"The direct link between alcohol consumption and cancer risk is well-established for at least seven types of cancer including cancers of the breast, colorectum, esophagus, liver, mouth (oral cavity), throat (pharynx), and voice box (larynx), regardless of the type of alcohol (e.g., beer, wine, and spirits) that is consumed. For breast cancer specifically, **16.4% of total breast cancer cases** are attributable to alcohol consumption." [4]

"For certain cancers, like breast, mouth, and throat cancers, evidence shows that the risk of developing cancer may start to increase around **one or fewer drinks per day.**" [4]

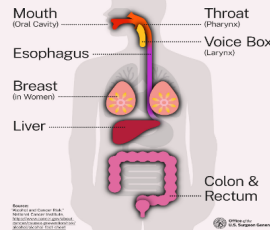
LIFESTYLE BEHAVIOR #4: SMOKING

"It has been well communicated to the general public that cigarette smoking causes lung cancer, following the **US Surgeon General's Report on Smoking and Health in 1964**. This message does seem to be having an impact. In 1965, 42% of adults in the US were cigarette smokers, decreasing to 14% in 2017. However, the burden of smoking-related cancers remains high." [2]

"Smoking prevalence is higher in some parts of the population than others, for example those with low socioeconomic status or with a mental illness. It is estimated that around **30% of all cancer deaths** in the US are still caused by smoking." [2]

"Alcohol is a well-established, preventable cause of cancer responsible for about **100,000 cases of cancer and 20,000 cancer deaths annually in the United States** – greater than the 13,500 alcohol-associated traffic crash fatalities per year in the U.S. – yet the majority of Americans are unaware of this risk," said **U.S. Surgeon General Dr. Vivek Murthy**. [4]

Consuming alcohol increases the risk of developing at least 7 types of cancer



LIFESTYLE BEHAVIOR #5: MEDICAL INTERVENTIONS

HPV Vaccine: "More than 200 types of HPV have been identified, 20 of which have been associated with cancer." [2]

"Hepatitis B virus is the leading cause of **hepatocellular cancer** around the world. The hepatitis B vaccine has been available since 1982, it is on the infant immunization schedule in many countries including the US and the UK." [2]

Chemoprevention: Tamoxifen is approved for preventative use after the results of the Breast Cancer Prevention Trial showed a **49% reduction in invasive breast cancer** in a population of 13,000 high-risk women, for example those carrying mutations in the **BRCA1 gene**. [2]

HOW CAN A CHANGE BE MADE? WHAT ARE THE ACTION STEPS?

The Community Preventive Services Task Force (CPSTF) has identified the following as effective interventions for decreasing cancer risk:

1. Engagement with Community Health Workers
2. Patient navigation services
3. One-on-one education
4. Provider assessment and feedback

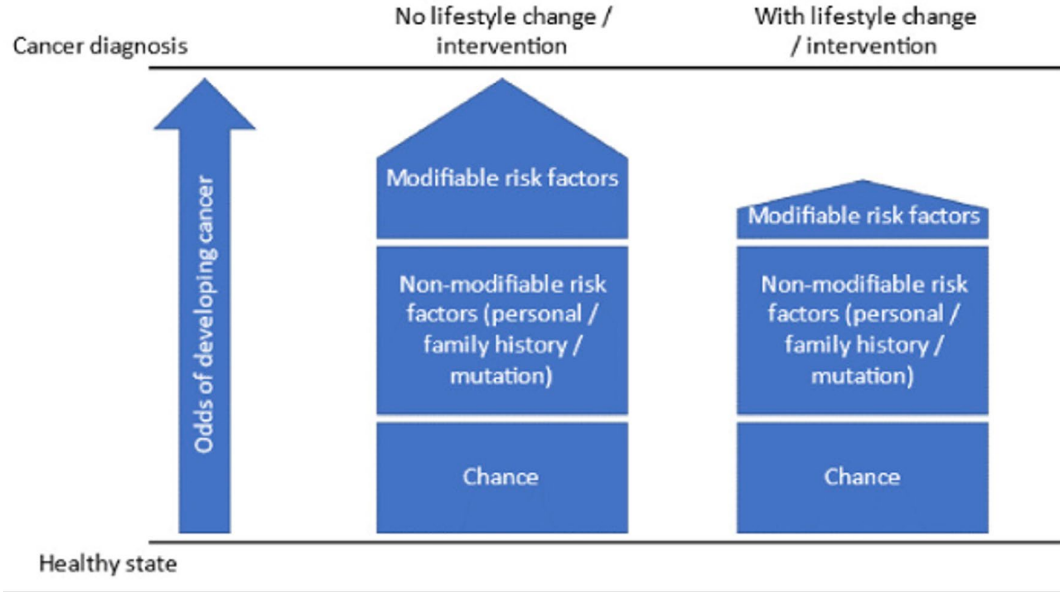
What is obtainable for the KCP Prevention Workgroup? What are the next steps?

1. Looking into funding opportunities?
2. Engaging CHWs into the initiative?
3. Deciding which risk factor to focus on first?

References:

1. Diaz de los Rios de la Serna, C., Fernández-Ortega, P., & Luch-Canut, T. (2022). Lifestyle Behavior Interventions for Preventing Cancer in Adults with Inherited Cancer Syndromes: Systematic Review. *International journal of environmental research and public health*, 19(12), 14098. <https://doi.org/10.3390/ijerph191214098>
2. Rhi-Lanham, A. (2021). Cancer: How to help your patients to reduce their cancer risk. In *Lifestyle Medicine* (2nd ed.) (Chapter 18). Academic Press. <https://doi.org/10.1016/j.lifsci.2021.106504>
3. Chai, J. W., & Hsu, T. S. M. (2020). Impact of Lifestyle Behaviors on Cancer Risk and Prevention. *Journal of Geriatric Medicine*, 11(1), 1–7. <https://doi.org/10.1177/2398264320949444>
4. U.S. Department of Health and Human Services. (2022, January 24). U.S. Surgeon General issues new advisory on link between alcohol and cancer risk. HHS.gov. <https://www.hhs.gov/about/news/2022/01/24/u-s-surgeon-general-issues-new-advisory-link-between-alcohol-cancer-risk>

Product C: Healthy Behaviors as Prevention - Evidence Based Interventions (EBIs)



From: Diez de Los Rios de la Serna, C., Fernández-Ortega, P., & Lluch-Canut, T. (2022). Lifestyle Behavior Interventions for Preventing Cancer in Adults with Inherited Cancer Syndromes: Systematic Review. *International journal of environmental research and public health*, 19(21), 14098. <https://doi.org/10.3390/ijerph192114098>

Product C: Healthy Behaviors as Prevention – Evidence Based Interventions (EBIs)

WHY IS THIS IMPORTANT?

Cancer

“Risk perception influences behavior, so **the lack of awareness** of the importance of behavioral factors among both patients and healthcare professionals is concerning, undermining effective behavior change.” [1]

“Patients are often unaware or **have incorrect perceptions** about behavior and cancer risk. In a study that took place in a breast screening service, alcohol was identified as a risk factor by only 19.5% of healthy women attending the screening and by less than half of the healthcare professionals working there.” [1]

“Approximately 5%–10% of cancers are inherited, with the **majority** resulting from somatic mutations **acquired during a patient's lifetime**.” [2]

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“An estimated 42% of cancer cases and 45% of cancer deaths in the US are attributed to potentially modifiable risk factors. This means that **almost half of all new cancers diagnosed are preventable** or could be detectable at an earlier stage leading to improved survival.” [2]

Product C: Health Behaviors as Prevention – Evidence Based Interventions (EBIs)

HOW CAN A CHANGE BE MADE? WHAT ARE THE ACTION STEPS?

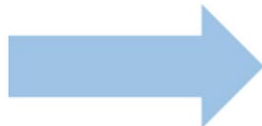
Physical Activity

Diet

Alcohol Intake

Smoking

Medical Interventions



The Community Preventive Services Task Force (CPSTF) has identified the following as effective interventions for decreasing cancer risk:

1. Engagement with Community Health Workers
2. Patient navigation services
3. One-on-one education
4. Provider assessment and feedback

What is obtainable for the KCP Prevention Workgroup? What are the next steps?

1. Looking into funding opportunities?
2. Engaging CHWs into the initiative?
3. Deciding which risk factor to focus on first?

Product D: USPSTF Screenings and KanCare Coverage

Status	Topic Name	USPSTF Recommendation	Source of KanCare Recommendation	KanCare Coverage	Discrepancies?
Published 2021	Colorectal Cancer: Screening	Grade A: Screening for colorectal cancer in all adults aged 50 to 75 Grade B: Screening for colorectal cancer in adults aged 45 to 49 years Grade C: Recommends that clinicians selectively offer screening for colorectal cancer in adults aged 76 to 85 years. Evidence indicates that the net benefit of screening all persons in this age group is small. In determining whether this service is	Bulletin 21233 Professional manual page 8-15	One of the following screening tests based upon clinical presentation: - Fecal occult blood testing (iFOBT) - Fecal immunoassay testing (FIT) - Multi-targeted stool DNA (mt-sDNA) - Sigmoidoscopy or colonoscopy for adults 45 to 75 years of age Intervals for recommended screening strategies:	USPSTF: Grade A 50-75, Grade B 45-49, Grade C 76-85 KanCare: Colonoscopy coverage only 45 to 79 (doesn't cover Grade C recommendation) According to the American Cancer Society, follow up
		appropriate in individual cases, patients and clinicians should consider the patient's overall health, prior screening history, and preferences.		Visual (structural) exams of the colon and rectum: - Colonoscopy every 10 years (G0105, G0120 or G0121) - Flexible sigmoidoscopy (FSIG) every 5 years (G0104 or G0106) Stool-based test: - Highly sensitive fecal immunochemical test (FIT) 82274 - Highly sensitive guaiac-based fecal occult blood test (gFOBT) 82270 - Multi-targeted stool DNA (mt-sDNA) every 3 years 81528	colonoscopies should be done every 1-3 years; however, it is only covered every 10 years.

Product D: USPSTF Screenings and KanCare Coverage

Status	Topic Name	USPSTF Recommendation	Source of KanCare Recommendation	KanCare Coverage	Discrepancies?
Published 2021	Lung Cancer: Screening	Grade B: Annual screening with low-dose computed tomography (LDCT) in adults aged 50-80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.	Professional Manual 8-61, 62	Counseling visit to discuss need for lung cancer screening using low dose CT (LDCT) scan and Low dose CT scan for lung cancer screening is covered by Kansas Medicaid with Prior Authorization (PA) for the Fee-for-Service (FFS) population. Individuals must meet all criteria requirements, to have these services covered every 12 months. Determination of member eligibility • Age (50-77) • Asymptomatic (absence of signs or symptoms of lung cancer) • A specific calculation of cigarette smoking pack-years (tobacco smoking history of at least 20 pack-years (one pack-year = smoking one pack per day for one year; 1 pack = 20 cigarettes) • If a former smoker, the number of years since quitting	USPSTF: annual LDCT for 50-80 w/ 20 pack-year history KanCare: 50-77 years old w/ 20 pack-year history, doesn't include when screening should be discontinued (when patient hasn't smoked for 15 years or develops a health problem that limits life expectancy)

No EDW Contract Workflow

Process for EDW providers who communicated they no longer want to Contract with EDW or have not returned an updated EDW Contract.

Date: 02/05/2025

The process below applies to the following EDW Providers

- Providers who communicated they no longer want to Contract with EDW.
- Providers who have not returned an updated Contract after several attempts to obtain Contact form and W9.
- Providers who have submitted incomplete Provider Contact Form and/or W9 with multiple attempts to obtain corrected forms.

Suzanne Proctor will send a list to the appropriate **Regional Nurse** of providers who fall into one of the above categories including a note with which category they fall into. Please include any previous communication and/or documents with said provider. ****frequency TBD****

Regional Nurse will set up meeting with provider to :

Document reasons for no longer wanting to participate in EDW program and address if possible.

Obtain a signed Contract on sight (include W9) – received permission from **BHP Contract Specialist**.

Complete together the provider contact form and W9 to begin Contracting process.

Obtain any missing information to begin Contracting process.

Was the contract signed during the meeting?

Yes

Regional Nurse will
i. Send signed Contract and W9 to **Laura Ortiz** to obtain Secretary's signature.
ii. Send Provider Contact form and W9 to **Laura Ortiz** to begin the contracting process.

No

Regional Nurse will report detailed outcome of each onsite provider meeting (EDW issues reported, how addressed, etc.) on monthly nurse report.

Product E: EDW Contract Workflows

Case Management Report Instructions

Purpose: Follow up with any patients needing diagnostic breast/cervical services.

The case management report is run by regional nurses at the beginning of each monthly. All EDW patients requiring diagnostic breast and/or cervical services are identified and follow up with using this report. The report must be completed in its entirety every month.

Last updated 11/26/2024

GENERATING THE CASE MANAGEMENT REPORT

1. Set Date Parameters

- Run case management report going back 2 years from today for the start date and subtract 60 days from today's date for the end date.

Example:

- Today's date = 5/1/23
- Case management start date = 5/1/21
- Case management end date = 3/1/23

2. Run the Report

- Click Run Report



The screenshot shows a 'Case Management Report' window with a 'Criteria' dialog box open. The dialog box has a 'Date' field with a calendar icon, showing a date range from 5/1/2021 to 3/1/2023. There are 'Close' and 'Run Report' buttons at the bottom right of the dialog box.

3. Filter for Region

- Choose the region you're working on (NE, SE, NC, SC, W).
 - Always include N/A and Blank

Case Management Report
From: 4/1/2024 To: 4/30/2024

First/Last Name	Case Type	First Name	Last Name	DOB	DOB Date	County or Accession	Region	Lead/Event Provider

Product F: Case Management Report Instructions

Product G: Cancer 101 KansasTRAIN Module



Course Objectives



- Understand cancer prevention, screening, treatment, and disparities.
- Highlight the role of Community Health Workers (CHWs) in cancer education and advocacy.
- Equip participants with tools to address barriers to cancer care.
- Empower CHWs to advocate for patients and navigate healthcare systems.

To protect and improve the health and environment of all Kansans

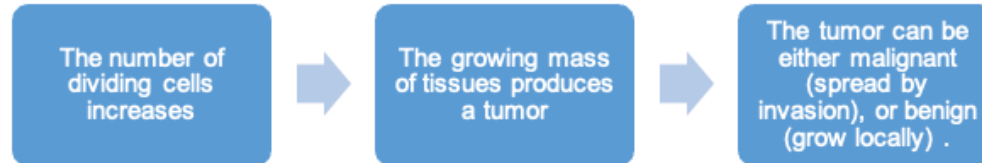
Product G: Cancer 101 KansasTRAIN Module



Overview of Cancer

- Cancer is a disease in which abnormal cells grow uncontrollably and can spread to other parts of the body.
- There are over 100 types of cancer, affecting different body tissues.
- A tumor can be benign (non-cancerous) or malignant (cancerous).

Cancer is essentially uncontrollable growth of cells:



To protect and improve the health and environment of all Kansans

Product G: Cancer 101 KansasTRAIN Module



The Role of CHWs in Cancer Prevention and Care

- Patient navigation, connecting individuals to screening programs (e.g., Early Detection Works).
- Addressing language and cultural barriers.
- Providing emotional support and education.
- Examples of Previous CHW Successes:
 - A Colorado CHW initiative significantly increased breast cancer screening rates among Latina women.¹
 - A Massachusetts CHW program helped 200,000 uninsured individuals enroll in healthcare programs.¹
 - A Washington-based intervention increased mammography follow-up rates by 10-23% for women without health insurance.²



1. National Rural Health Association. (2017). Community health workers: NRHA policy paper. https://www.ruralhealth.us/getmedia/46181600-190e-433c-8d18-9b4f6e8ed3e0/Community-Health-Workers_Feb-2017_NRHA-Policy-Paper.pdf
2. Andersen, M. R., Yasui, Y., Meischke, H., Kuniyuki, A., Etzioni, R., & Urban, N. (2000). The effectiveness of mammography promotion by volunteers in rural communities. *American journal of preventive medicine*, 18(3), 199-207. [https://doi.org/10.1016/s0749-3797\(99\)00161-0](https://doi.org/10.1016/s0749-3797(99)00161-0)

To protect and improve the health and environment of all Kansans

MPH Competencies

Portfolio Product		Number and Competency Addressed	
A	Breast Cancer Screening: A Provider's Guide	19	Communicate audience-appropriate (i.e., non-academic, non-peer audience) public health content, both in writing and through oral presentation
B	Breast Cancer Screening: A Patient's Guide	19	Communicate audience-appropriate (i.e., non-academic, non-peer audience) public health content, both in writing and through oral presentation
C	Healthy Behaviors as Prevention Evidence Based Interventions	7	Assess population needs, assets, and capacities that affect communities' health

MPH Competencies

Portfolio Product		Number and Competency Addressed	
D	USPSTF KanCare Screenings Table	11, 15, 19	Select methods to evaluate public health programs Evaluate policies for their impact on public health and health equity Communicate audience-appropriate (i.e., non-academic, non-peer audience) public health content, both in writing and through oral presentation
E	Early Detection Works Contract Workflows	22	Apply a systems thinking tool to visually represent a public health issue in a format other than a standard narrative

MPH Competencies

Portfolio Product		Number and Competency Addressed	
F	Early Detection Works Case Management Report	22	Apply a systems thinking tool to visually represent a public health issue in a format other than a standard narrative
G	Cancer 101 KansasTRAIN Module	19	Communicate audience-appropriate (i.e., non-academic, non-peer audience) public health content, both in writing and through oral presentation



Infectious Disease and Zoonoses Competencies

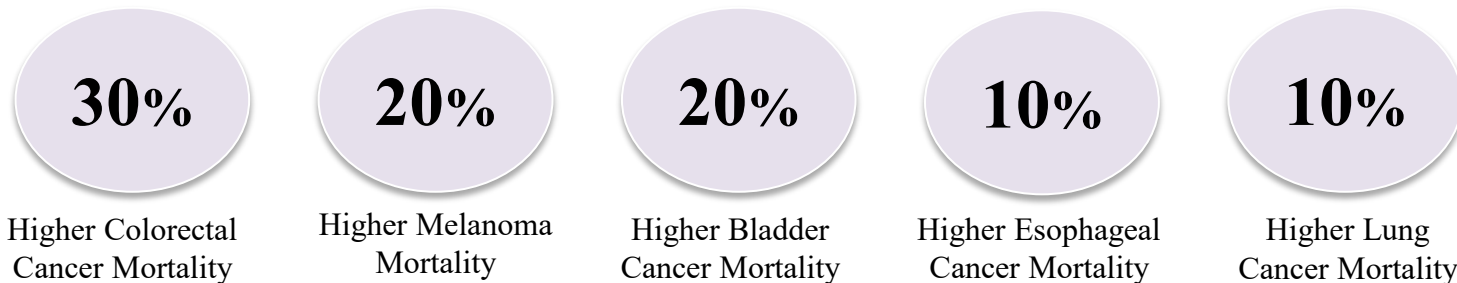
MPH Emphasis Area: Infectious Disease and Zoonoses		
Number and Competency		Description
1	Pathogen/pathogenic mechanisms	Evaluate modes of disease causation of infectious agents.
2	Host response to pathogens/immunology	Investigate the host immune response to infection.
3	Environmental/ecological influences	Examine the influence of environmental and ecological forces on infectious diseases.
4	Disease surveillance	Analyze disease risk factors and select appropriate surveillance.
5	Disease vectors	Investigate the role of vectors, toxic plants and other toxins in infectious diseases.

Motivation Behind the Project

With so many programs in place to support cancer prevention and treatment, why do significant disparities still persevere?

In an ideal world, state-run programs would serve as a universal solution, ensuring equitable cancer care for all—but what factors are limiting their impact?

Rural Patients Have Higher Cancer Mortalities



Key Takeaways and Future Directions

Healthcare Workforce Shortages

+

Low Screening Rates/Preventive Care

+

Rural Kansas Hospitals at Risk of Closure

+

Decrease in Federal Funding

?

A purple vertical bar on the left side of the slide contains a white circular seal of Kansas State University. The seal features a central figure, possibly a Native American, surrounded by the text "KANSAS STATE UNIVERSITY" and "FEBRUARY 1863".

Conclusion

Moving forward, the future of rural cancer care in Kansas will depend on investment in prevention, research, and policy reform.

By addressing the disparities in rural healthcare, Kansas can work toward a future where all residents—regardless of where they live—have access to the cancer care they need.



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References

1. Kansas Department of Health and Environment. (2025). Kansas Department of Health and Environment (KDHE). <https://www.kdhe.ks.gov/>
2. Kansas Department of Health and Environment. (n.d.). Cancer prevention & control. <https://www.kdhe.ks.gov/816/Cancer-Prevention-Control>
3. Kansas Department of Health and Environment. (n.d.). BRFSF technical notes. Kansas Behavioral Risk Factor Surveillance System.
4. Rocque, G. B., Ramsey, S. D., Wang, T., Pisu, M., Williams, C. P., Martin, M. Y., ... & Banegas, M. P. (2023). Scaling up CHW navigation. *Journal of Clinical Oncology*, 41(28), 5248-5260. <https://doi.org/10.1200/JCO.23.01723>
5. The University of Kansas Cancer Center. (2020). KU Cancer Center catchment area data. <https://www.kucancercenter.org/outreach/community/catchment-area-data>
6. Nazir, A., Banegas, M. P., & Siahpush, M. (2021). The need to study rural cancer outcome disparities at the local level: A retrospective cohort study in Kansas and Missouri. *ResearchGate*. https://www.researchgate.net/publication/356510034_The_need_to_study_rural_cancer_outcome_disparities_at_the_local_level_a_retrospective_cohort_study_in_Kansas_and_Missouri
7. Riley, G. F., & Warren, J. L. (2021). Disparities in access to medical oncology services in the United States. *JCO Oncology Practice*, 17(7), 417-424. <https://doi.org/10.1200/OP.21.00187>
8. National Cancer Institute. (2025). Rural-urban GIS StoryMap. <https://gis.cancer.gov/storymap/rural-urban/>
9. Moscovice, I. S., Parsons, H., Bean, N., Santana, X., Weis, K., Hui, J. Y. C., & Lahr, M. (2023). Availability of cancer care services and the organization of care delivery at critical access hospitals. *Cancer medicine*, 12(16), 17322–17330. <https://doi.org/10.1002/cam4.6337>
10. Meilleur, A., Subramanian, S. V., Plascak, J. J., Fisher, J. L., Paskett, E. D., & Lamont, E. B. (2013). *Rural residence and cancer outcomes in the United States: Issues and challenges*. *Cancer Epidemiology, Biomarkers & Prevention*, 22(10), 1657–1667. <https://doi.org/10.1158/1055-9965.EPI-13-0404>
11. Lee, H., Baeker Bispo, J., Choudhury, P. P., Wiese, D., Jemal, A., & Islami, F. (2024). Factors contributing to differences in cervical cancer screening in rural and urban community health centers. *Cancer*. <https://doi.org/10.1002/encr.35265>
12. University of Kansas Medical Center. (2023). The crisis in rural health care. *Kansas Medicine & Science*. <https://www.kumc.edu/communications/about/publications/kansas-medicine-and-science/fall-winter-2023/the-crisis-in-rural-health-care.html>
13. Rural Health Information Hub. (2021). Healthcare workforce. Retrieved March 28, 2025, from <https://www.ruralhealthinfo.org/topics/health-care-workforce>
14. Davis, M. M., Freeman, M. C., Shannon, J., Coronado, G. D., & Gu, Y. (2019). Barriers to colorectal cancer screening in rural USA. *Rural and Remote Health*, 19(3), 5181. <https://www.rrh.org.au/journal/article/5181>
15. Cancer Research Institute. (2024). Advancing cancer care in rural and underserved communities. <https://www.cancerresearch.org/blog/december-2024/advancing-cancer-care-in-rural-and-underserved-communities>
16. Cervantes, S., Bell, C., Tolbert, J., & Damico, A. (2025, February 25). *How many uninsured are in the coverage gap and how many could be eligible if all states adopted the Medicaid expansion?* KFF. <https://www.kff.org/medicaid/issue-brief/how-many-uninsured-are-in-the-coverage-gap-and-how-many-could-be-eligible-if-all-states-adopted-the-medicaid-expansion/>
17. National Rural Health Association. (2025). *Medicaid cuts one pager*. National Rural Health Association.
18. Centers for Disease Control and Prevention. (2023). National immunization teen data. <https://www.cdc.gov/teenvaxview/interactive/index.html>
19. Polite, B. N., Griggs, J. J., Moy, B., Pal, S. K., & Nabhan, C. (2021). Closing the rural cancer care gap: Three institutional approaches. *JCO Oncology Practice*, 17(6), e926-e932. <https://doi.org/10.1200/OP.20.00174>
20. KC Digital Drive. (2025). *Rural breast cancer health project*. Retrieved March 19, 2025, from <https://www.kcdigitaldrive.org/project/rural-breast-cancer-health-project>
21. National Rural Health Association. (2017). Community health workers: NRHA policy paper. https://www.ruralhealth.us/getmedia/46181600-f90e-433c-8d18-9b4f6e8d3ec/Community-Health-Workers_Feb-2017_NRHA-Policy-Paper.pdf
22. Rocque, G. B., et al. (2023). Scaling up CHW navigation for cancer patients. *Journal of Clinical Oncology*, 41(28), 5248-5260. <https://doi.org/10.1200/JCO.23.01723>
23. Andersen, M. R., Yasui, Y., Meischke, H., Kuniyuki, A., Etzioni, R., & Urban, N. (2000). The effectiveness of mammography promotion by volunteers in rural communities. *American journal of preventive medicine*, 18(3), 199–207. [https://doi.org/10.1016/s0749-3797\(99\)00161-0](https://doi.org/10.1016/s0749-3797(99)00161-0)
24. Community Catalyst. (2019). *Community health workers: An issue brief*. National Health Care for the Homeless Council. <https://nhcc.org/wp-content/uploads/2019/08/Community-Catalyst-CHW-Issue-Brief-1.pdf>
25. University of Kansas Medical Center. (2024). TEAMSPORT: Enhancing rural cancer treatment. <https://www.kumc.edu/about/news/news-archive/teamsport-rural-cancer-treatment.html>
26. American Hospital Association. (2023). Community Cornerstones Podcast: The future of rural hospitals and health systems. <https://www.aha.org/advancing-health-podcast/2023-11-15-future-rural-hospitals-and-health-systems>
27. Kansas Legislative Research Department. (2023, November 27). *Shortage of health care workers in rural Kansas*. Kansas Legislative Research Department. <https://klrd.gov/2023/11/27/shortage-health-care-workers-in-rural-kansas/>
28. American Hospital Association. (2024). AHA letter of support for rural hospital support act. <https://www.aha.org/system/files/media/file/2025/02/aha-voices-support-for-the-rural-hospital-support-act-s-335-letter-2-5-2024.pdf>
29. U.S. Congress. (2024). S.335 - Rural Hospital Support Act. Congress.gov. <https://www.congress.gov/bills/119th/congress/senatebill/335?q=%7B%22search%22%3A%22rural+hospital+support+act%22%7D&s=2&r=3>
30. Liu, B., Wu, Y., & Zhang, X. (2024). The impact of the Affordable Care Act and Medicaid expansion on colorectal cancer screening: Evidence from the 5th year of Medicaid expansion. *Cancer Medicine*. <https://doi.org/10.1002/cam4.7054>
31. Kaiser Family Foundation. (2023). The effects of Medicaid expansion under the ACA: Updated findings from a literature review. <https://www.kff.org/report-section/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-report>
32. American Journal of Public Health. (2019). Health policy and Medicaid expansion. <https://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2019.305168?journalCode=ajph>
33. Georgetown University Center for Children and Families. (2023, January 15). *Medicaid's role in small towns and rural areas*. Georgetown University. https://ccf.georgetown.edu/2025/01/15/medicaids-role-in-small-towns-and-rural-areas/?utm_source=chatgpt.com
34. The American Journal of Managed Care. (2020). Trump endorses budget that would slash Medicaid funding. <https://www.ajmc.com/view/trump-endorses-budget-that-would-slash-medicaid-funding>
35. California Medical Association. (2024). Medicare 2.8% physician payment cut took effect January 1. <https://www.cmadocs.org/newsroom/news/view/ArticleId/50790/Medicare-2-8-physician-payment-cut-took-effect-January-1>
36. American Medical Association. (2024). Fixing Medicare to advance rural health—Congress should act. <https://www.ama-assn.org/delivering-care/population-care/advance-rural-health-congress-should-act-fix-medicare>
37. Kwon, D. H., Tisnado, D. M., Keating, N. L., Klabunde, C. N., Adams, J. L., Rastegar, A., & Kahn, K. L. (2015). Physician-reported barriers to referring cancer patients to specialists: Prevalence, factors, and association with cancer satisfaction. *Cancer*, 124(1), 113–122. <https://doi.org/10.1002/encr.29019>
38. Wilderness Medical Staffing. (2025). The future of rural healthcare: Key trends and predictions for 2025. <https://wildernessmedicalstaffing.com/future-rural-healthcare-2025/>

Questions?

