

Back to Basics: Driving Preventive Care Utilization

March 23, 2022





Welcome!

Cheryl Larson

President and CEO

Midwest Business Group on Health

Catalysts for Change in Health Care & Benefits



Since 1980 – One of the nation's leading and largest non-profit coalitions of HR/health benefits professionals



4M+ Lives – Represent more than 145 mid, large & jumbo self-insured public & private companies



15B+ – Annual employer member spend on health care



Community of Your Peers – A sharing and friendly environment to help you collaborate, benchmark and learn



Trusted Source – Helping benefits professionals find solutions to better manage the cost of benefits and the health of employees and families

Upcoming 2022 Educational Events

- **May 4-5:** 42nd Annual Conference: Beyond the Pandemic – Employers Uniting to Accelerate Change in Health Care & Benefits
- **June 22:** Employer Forum On Pharmacy Benefits & Specialty Drugs
- **August TBD** – Interrupting Access to Opioids to Reduce Your Surgical Costs
- **September 14:** Future of Digital Health Technologies: Innovations in Patient Care to Treat and Manage Serious Diseases

Register at www.mbgh.org/events

MBGH 42ND ANNUAL CONFERENCE

BEYOND THE PANDEMIC

Employers Uniting to *Accelerate Change*
in Health Care & Benefits

MAY 4-5, 2022 • CHICAGO

Keynote Speakers



Midwest Business Group on Health



Rebuilding Health Care &
Benefits While Navigating
Disruption, Consolidation &
Cost Pressures

Ford Koles, Jr.
Vice President & National Spokesperson
Advisory Board



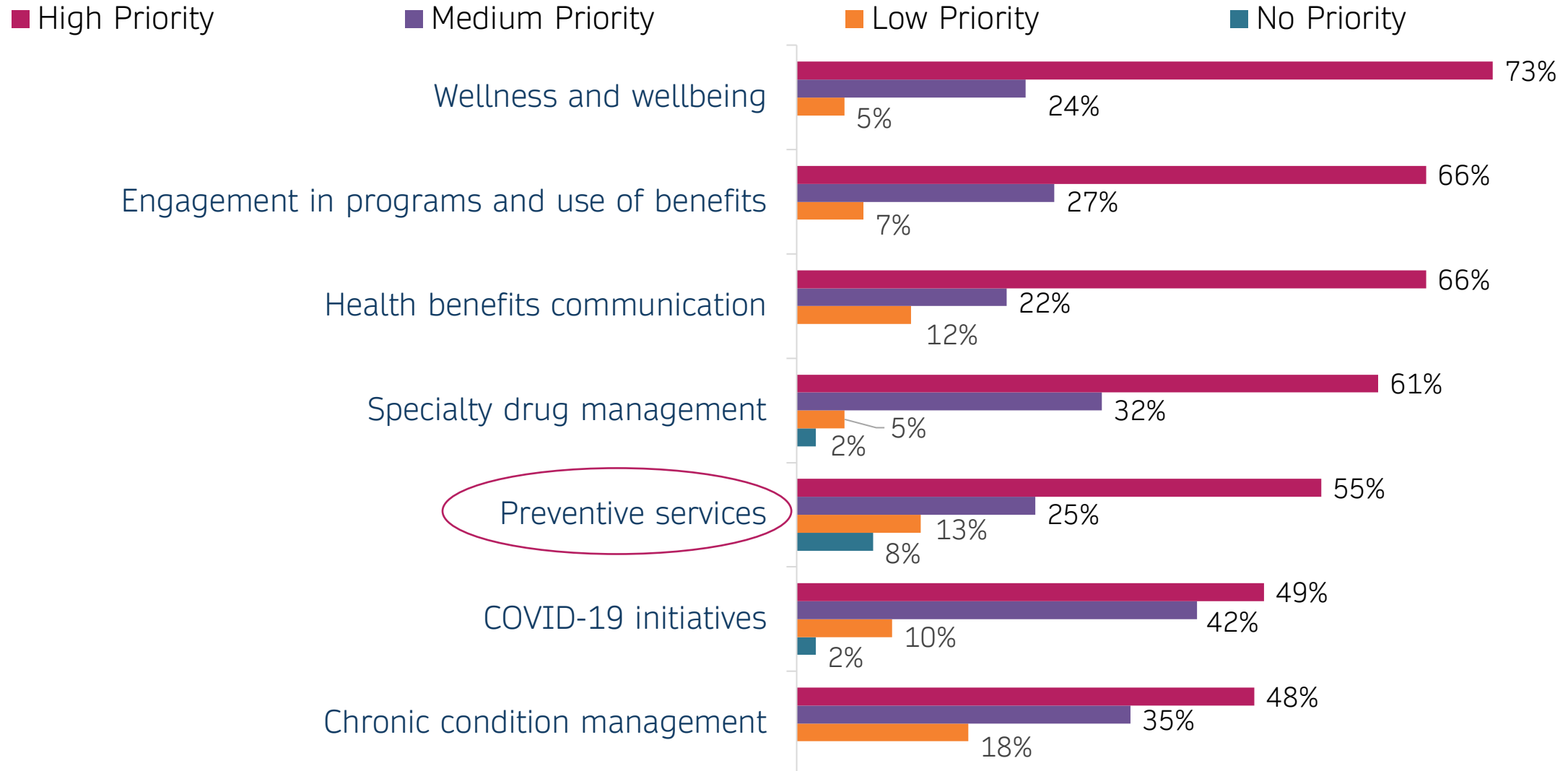
Rebuilding Trust to Drive
Health Care Value & Improve
Employee Engagement

Jan Berger, MD, MJ
MBGH Medical Director & CEO
Health Intelligence Partners

MBGH Annual Employer Health Benefit Directions Survey 2021-2022

November 2021

2022 Health Benefit Priorities



COVID 19 = Less Medical Care

According to a recent study published in JAMA, more than 40% indicated they skipped medical care in the early months of the pandemic:

- 63% medical practice was closed temporarily or permanently
- 57% feared COVID-19 exposure
- 7% blamed financial repercussions of the pandemic

Source: "[Reports of Forgone Medical Care Among US Adults During the Initial Phase of the COVID-19 Pandemic,](#)"

Other Missed Medical Care

Researchers examining the period between March and mid-July 2020 found that, among the 1,337 respondents:

- 29% missed preventive care visit
- 26% missed outpatient general medical appointment
- 8% missed one or more doses of prescription medicine (from retail pharmacy)
- 8% missed outpatient mental health appointment
- 6% missed elective surgery
- 3% did not receive health care for a new severe mental or physical health issue

Source: "[Reports of Forgone Medical Care Among US Adults During the Initial Phase of the COVID-19 Pandemic](#),"

Today's Program

Attending in person...

- Please silence your devices
- Ask questions!



Wifi: Uclub

Password: 3127262840

Participating virtually...

- Use the Q&A function to ask questions of the speakers
- Use the chat function to communicate with other virtual attendees and to notify staff of any technical issues

Reminder!

Please complete the program evaluation following today's program

HR Certification Institute® (HRCI®) has pre-approved this activity

- Activity/Program ID: 586191
- Title: Back to Basics! Driving Preventive Care Utilization
- Credit Hours Awarded: 3.0
- Credit Type: HR (General)



For questions, contact Allison Larsen at alarsen@mbgh.org

Keeping us Safe!



=



=



No hugs or
handshakes



Thank You Sponsors!

FORUM



Thank You Sponsors!

EXHIBITOR

eden
health



SWORD HEALTH



RESOURCE

Genentech
A Member of the Roche Group

Prize Drawing



Hinge Health

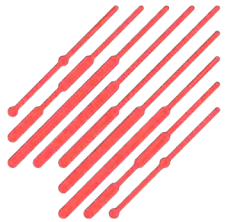
Apple AirPods Pro



inspera health

Healthy employees. Healthy business.

Fitbit Tracker



SWORD HEALTH

\$125 Gift Card to Royal Palms
Shuffleboard Club



Apple Watch SE

Prize Drawing
will be held at
close of program

Must be “present”
to win!


Turn in your
completed card
by 11 AM

PRIZE DRAWING


Just like you check off completing preventive screenings and annual visits, have each sponsor check off your visit to their table for a chance to win some incredible prizes!




Hinge Health




Inspera Health



Vida Health



Eden Health



Novo Nordisk



Sword Health

Once complete, enter your card in the prize drawing at registration.

Good Luck!
Must be present to win

In-Person Participants

Return prize card to the registration table at end of morning break.

Virtual Participants

Use chat and Q&A functions to interact with other participants and ask questions of speakers. Must interact at least twice!

Download our Event Mobile App!

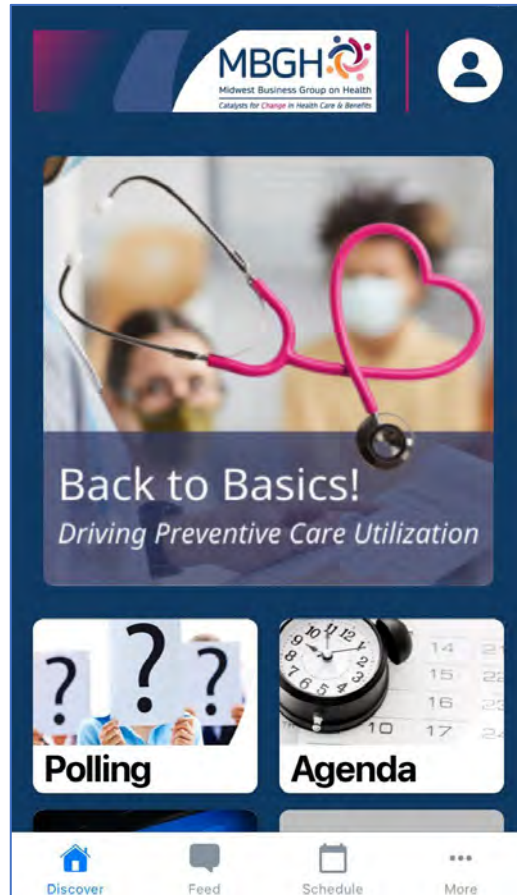
Search “MBGH Events” in your App Store or scan a QR code below.
Login with the email address you used to register for the event.



Android:



Apple:

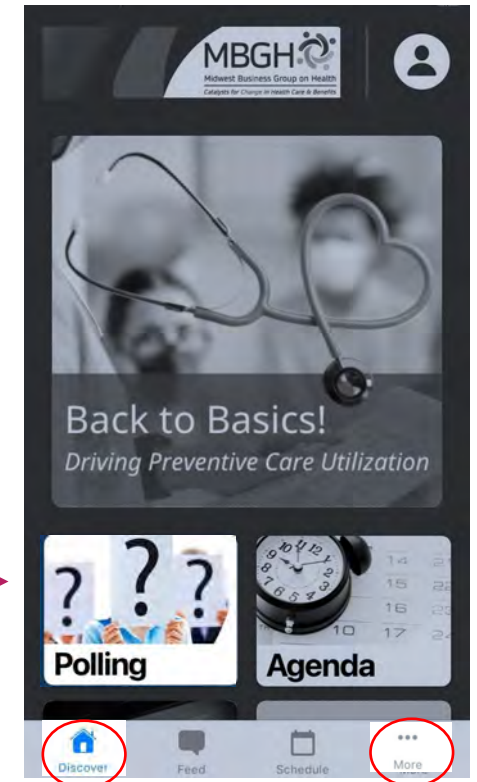


App includes:

- Agenda
- Speaker bios & presentations
- Sponsor information
- Attendee list
- Evaluation form
- Participate in audience polling questions
- Link to MBGH COVID Safety Partner

Polling Questions

- We'll be asking for your input throughout today's event.
- All can participate – those attending in-person as well as virtually by using the MBGH Events Mobile App
- How to participate...
 1. Click on home icon at bottom left of MBGH Events App. If you do not see March Back to Basics on your home screen, click on "...More" at the bottom right and select the March event.
 2. Click on the "Polling Questions" card
 3. Answer the poll, scroll down & click "Send"
- First question!

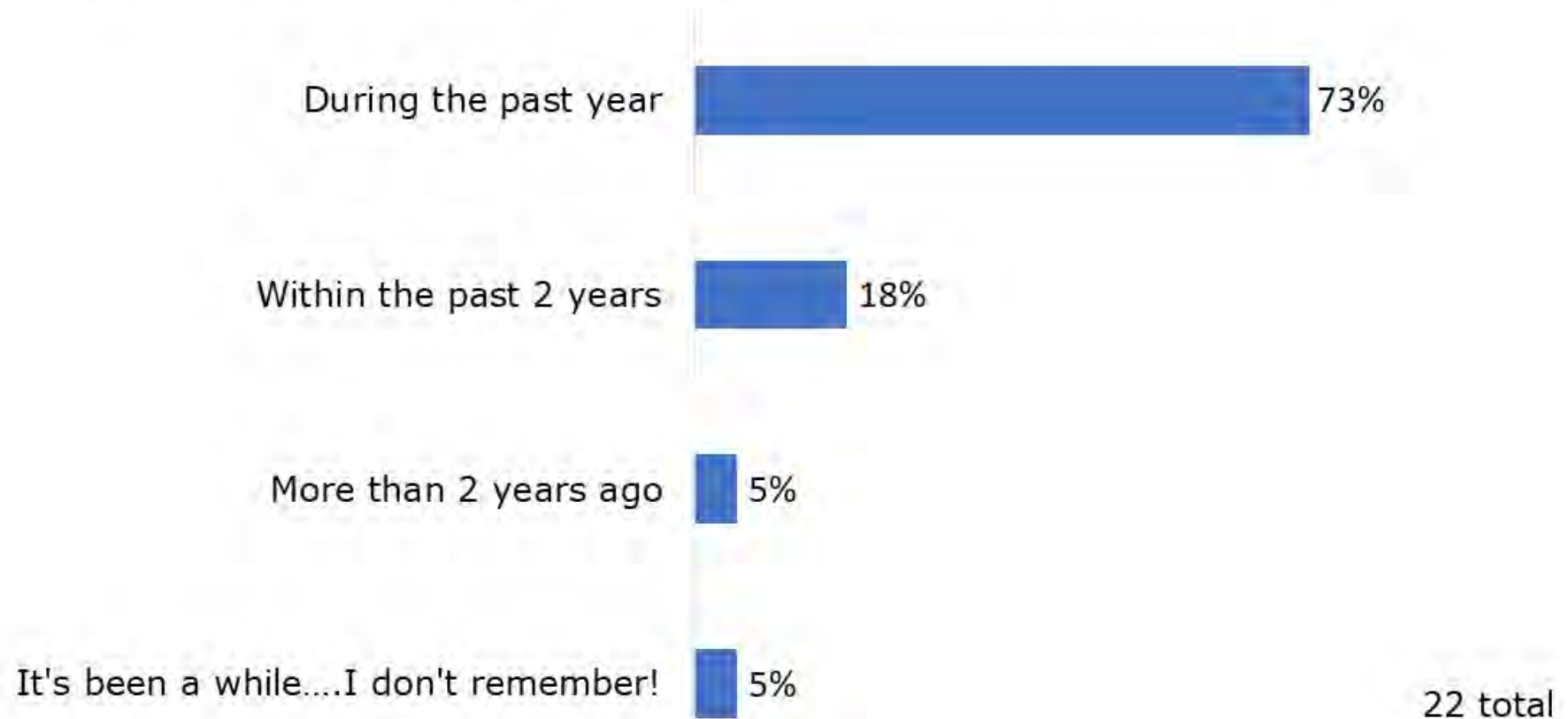


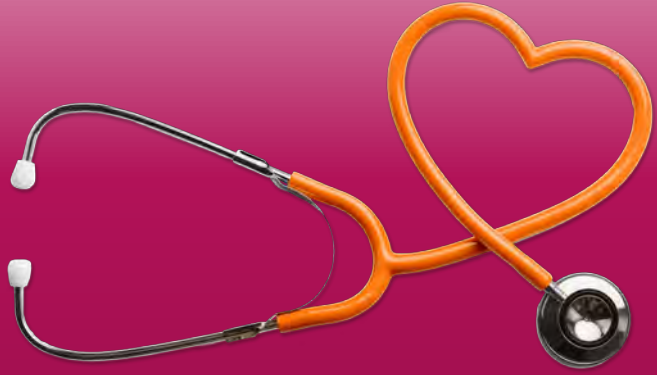
When was YOUR most recent preventive exam?

- ☐ During the past year
- ☐ Within the past 2 years
- ☐ More than 2 years ago
- ☐ It's been a while...I don't remember!



When was YOUR most recent preventive exam?





*a word from
our sponsor*



inspera health

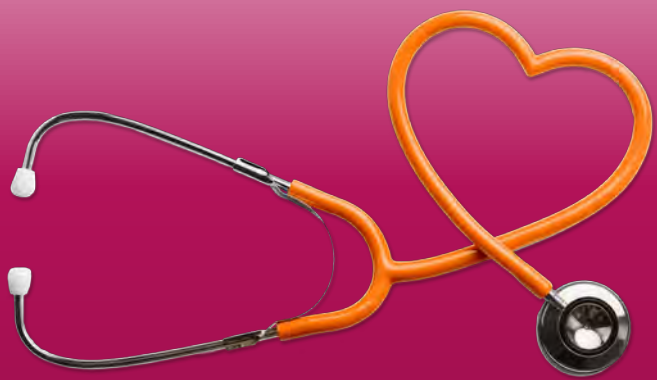
Healthy employees. Healthy business.

What is your self-care reminder strategy?



Virtual Participants

Share your self-care
strategy with other
virtual attendees
using the chat
function!



*a word from
our sponsor*



Hinge Health



Advance Primary Care: Driving Performance through Shared-Risk- Based Payment Models

Ann C. Greiner

President and CEO

Primary Care Collaborative

Advanced Primary Care: Foundation of a High Performing Health System

*Midwest Business Group on Health
March 23, 2022*



Primary Care Collaborative:

A (very) Brief History

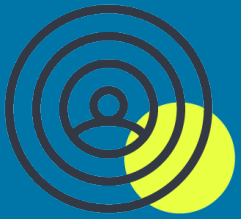
- Initial partnership between employers and physician specialty societies (2006)
- PCPCC (2007) launched — PCMH Joint Principles
- Team-based advocacy spurred widespread adoption of PCMH
 - Nearly 33 % of physicians are in a medical home, up from 24 % in 2014 (AMA, 2021)
- PCPCC releases Shared Principles (2017)
- Re-brand to PCC (2019)

② Mission & Vision

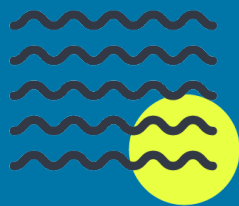
MISSION

The Primary Care Collaborative advances comprehensive primary care to improve health and health care for patients and their families by convening and uniting stakeholders around research, care delivery and payment models, and policies.

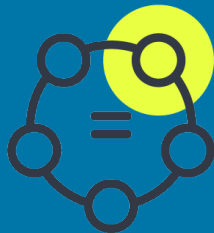
VISION -- *Shared Principles of Primary Care; 350 + signatories*



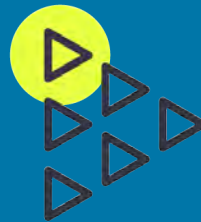
Person and
Family-centered



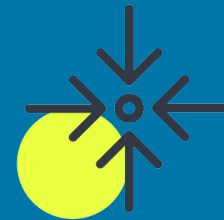
Continuous



Comprehensive
and Equitable



Team-based
and
Collaborative



Coordinated
and
Integrated



Accessible



High-value



PCC's 60 plus Members

From AARP to URAC, and 60 organizations in between

96% PCC membership renewal in 2021



PCC 2022 Board

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American Academy of Pediatrics

Susan Edgman-Levitan, PA-C

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University of Rochester Medical Center

John G. Murtha, MBA

Global Health Plan Segment Leader
IBM Corporation

Nwando Olayiwola, MD, MPH, FAAFP

Chief Health Equity Officer and Senior Vice President
Humana, Inc.

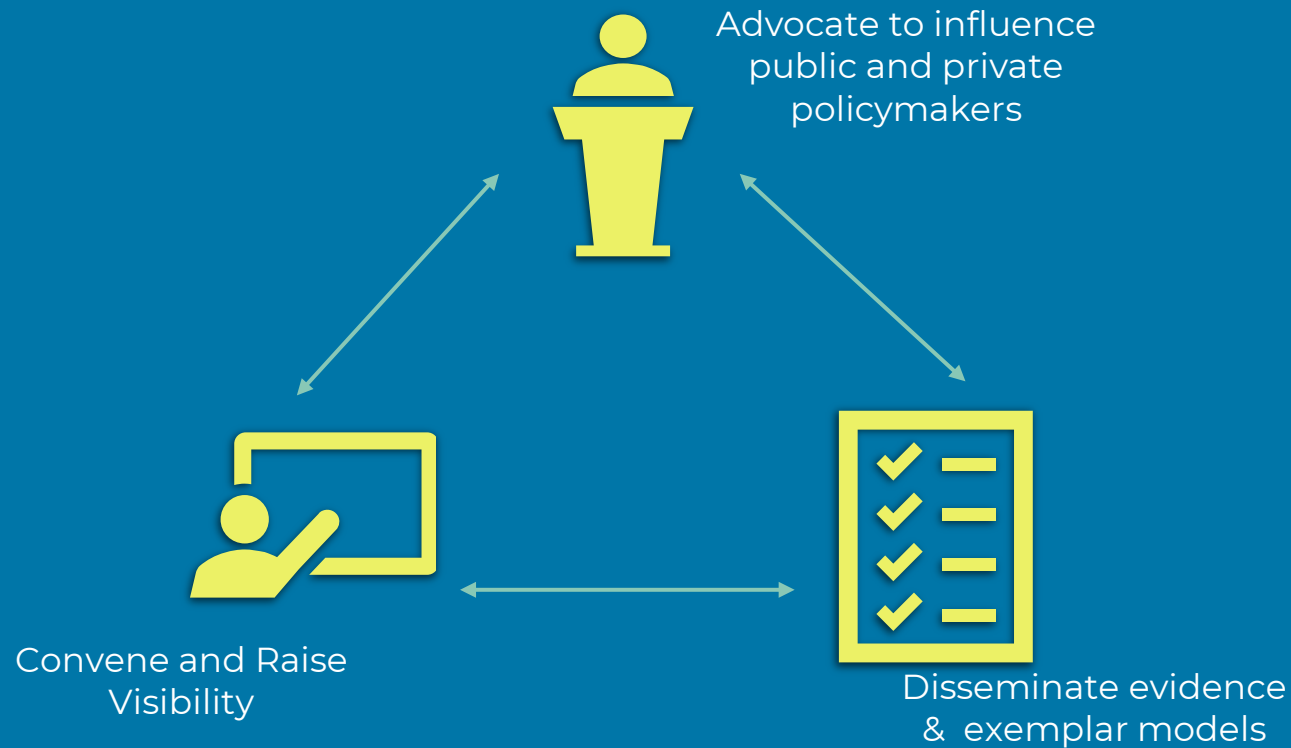
Dorothy Seimon, JD

Senior Vice President
AARP

Baligh Yehia, MD, MPP, FACP

Senior Vice President
Ascension
President
Ascension Medical Group

@ PCC Levers to Achieve Mission and Vision





PCMH Results



2017 PCC Evidence Report
Synthesizes Research Literature



2018 PCC Evidence Report
Examines Contribution of PCMH to ACOs



PCMH Contributed to Outcomes But...



primary care
collaborative

...The Model is Underpowered:

- Most primary care practices are still paid on a fee-for-service basis
- Insufficient investment in primary care/PCMH
- Lack of alignment across the medical neighborhood



PCC's Three Strategic Priorities

1

Broaden recognition that primary care is central to high value care

2

Increase and reform primary care payment to achieve Shared Principles

3

Catalyze and influence primary care delivery system reform to achieve Shared Principles

👤 Recent Thought Leadership

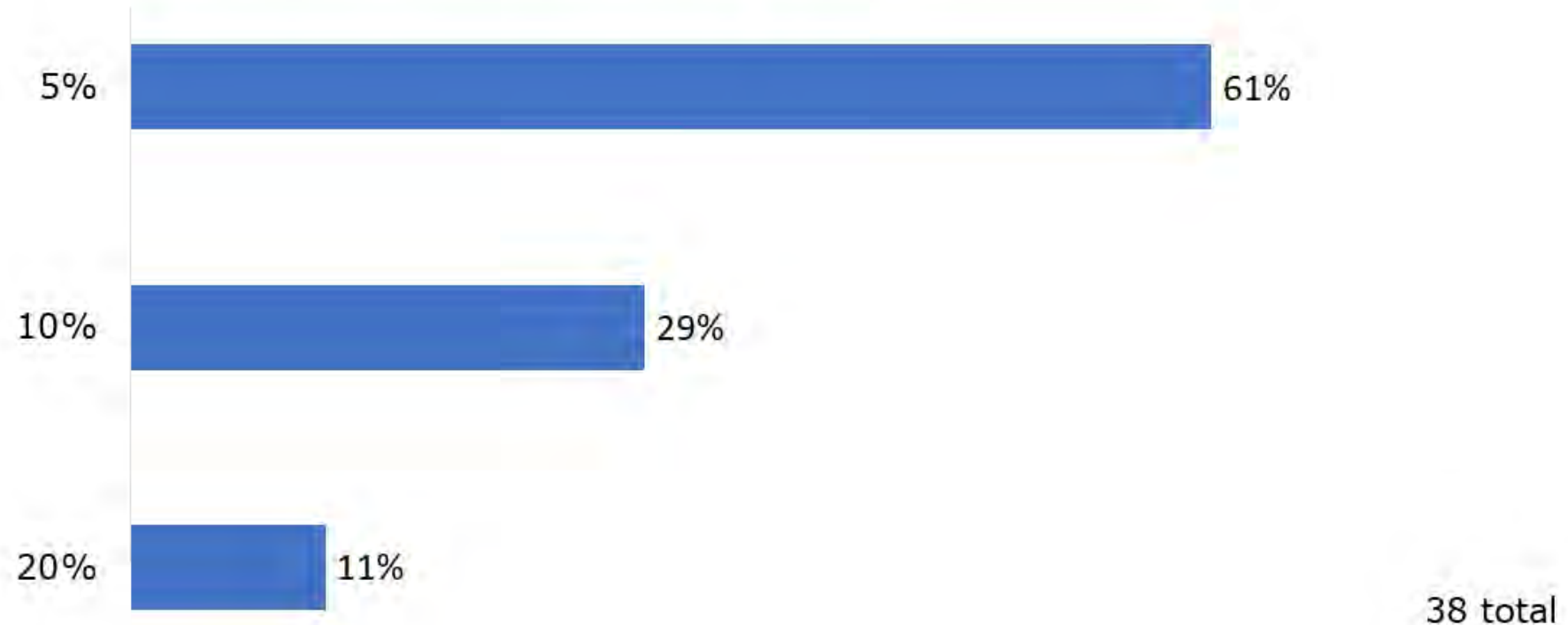
- “Reform of Payment for Primary Care — From Evolution to Revolution” — co-authored by Allan H. Goroll, MD, Stephen C. Schoenbaum, MD, MPH, and Ann Greiner, in *New England Journal of Medicine*
- “Building back better requires strengthening primary care” by Elizabeth Mitchell, president and CEO of the Purchaser Business Group on Health, and Ann Greiner, in First Opinion on *STAT*
- “Hidden In Plain Sight: We Must Leverage Primary Care To Mitigate Covid-19,” co-authored by Ann Greiner, Darilyn Moyer and Anand Parekh, Bipartisan Policy Center, in *Forbes*
- “Primary care practices are relying on bold payment reform to meet CMS goal,” by Ann Greiner and Larry McNeely, in *Healio*

Approximately, how much of total U.S. health care spending is spent on primary care?

- ☐ 5%
- ☐ 10%
- ☐ 20%



Approximately, how much of total U.S. health care spending is spent on primary care?



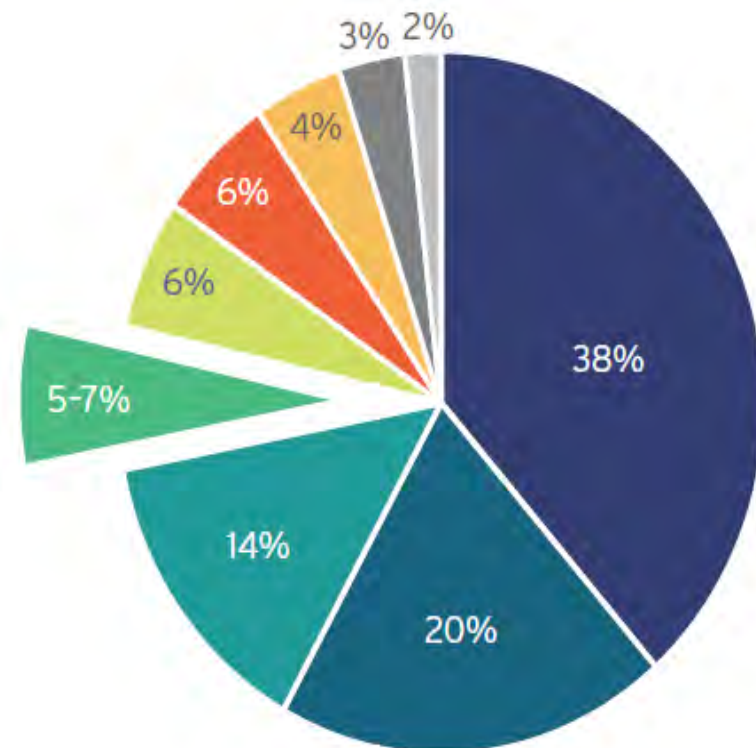


Low US Primary Care Spend

(European
countries avg
= 14%)

Health Care Spending

- Hospital care
- All other physician and professional services
- Prescription drugs and other medical nondurables
- Primary care
- Nursing home care
- Other health, residential, and personal care
- Dental services
- Home health care
- Medical durables





PCC Reports on Primary Care Spend 2019 & 2020



Primary Care Spending: High Stakes, Low Investment

December 2020

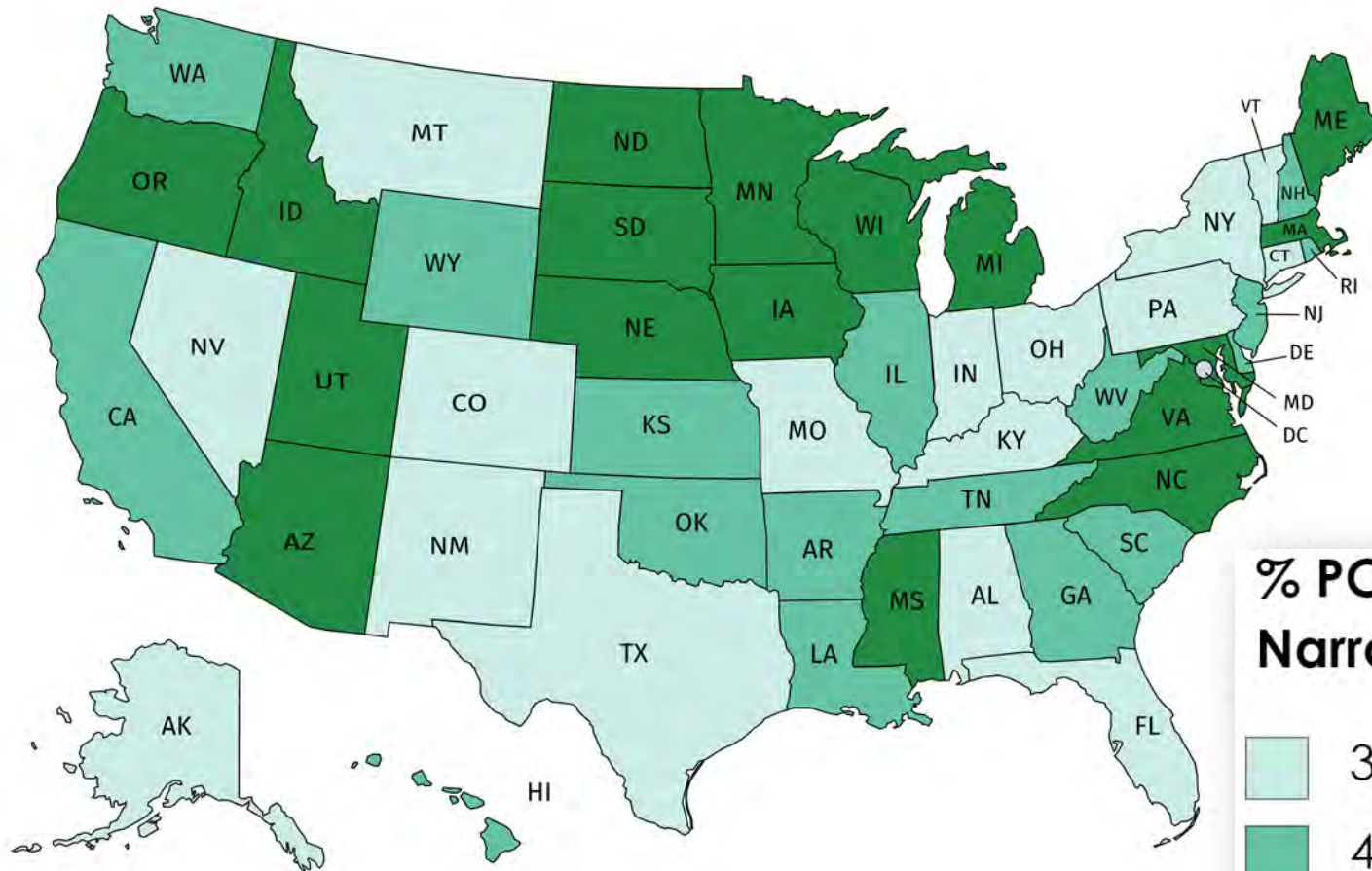




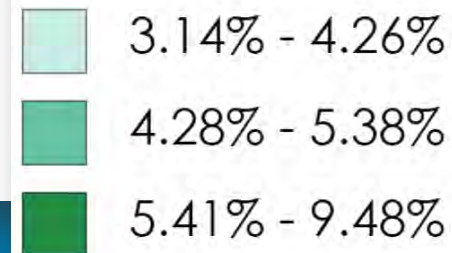
Variation Across States (and Plans)

Narrow Definition

2019 U.S.
Average:
4.67%



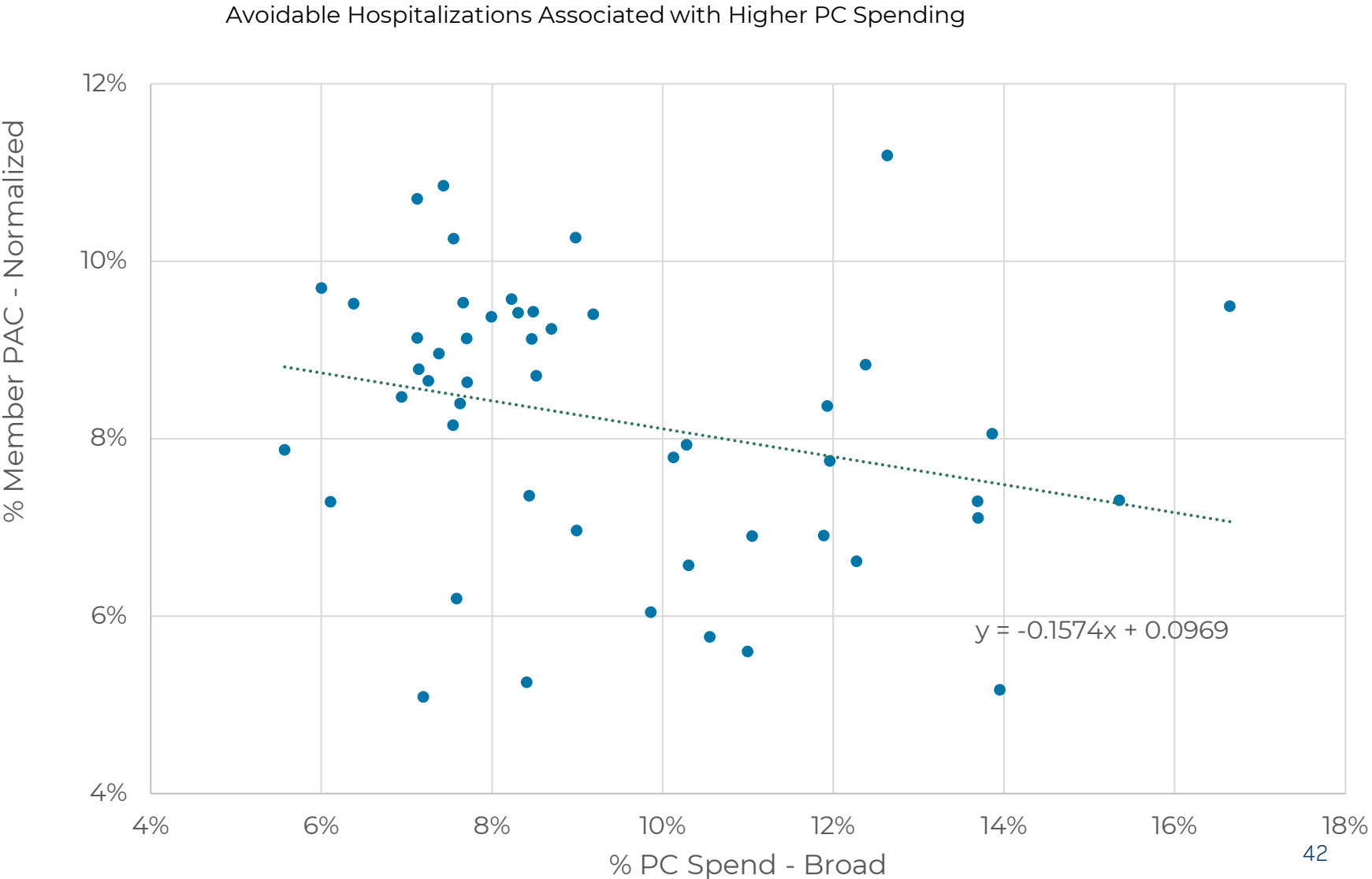
**% PC Spend by State
Narrow Definition**





More investment in primary care leads to better health and equity

Higher PC Spending Associated With Avoidable Hospitalizations



@ Higher PC Spending & Other Outcomes

ED Visits
Negative



Hospitalizations
Negative



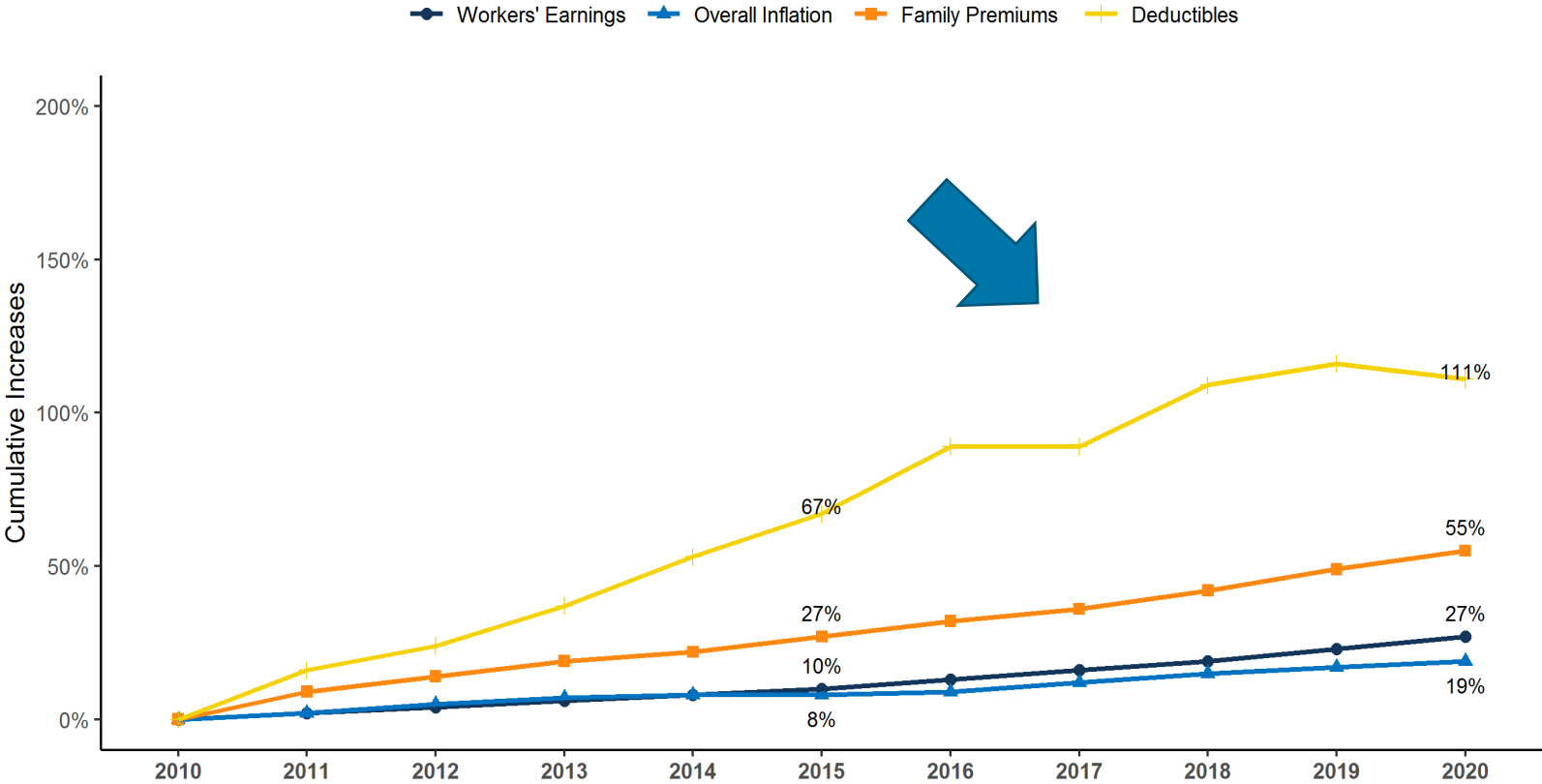
② Potential Causes of PC Spending Decline

- Measurement error
- PC spending outpaced by increases in rest of system
- Demand-driven decline due to rising deductibles and cost-sharing



Declines in PC Spending, Utilization Coincide with Sharp Rise in Deductibles

Cumulative Increases in Family Coverage Premiums, General Annual Deductibles, Inflation, and Workers' Earnings, 2010-2020



NOTE: Average general annual deductibles are for single coverage and are among all covered workers. Workers in plans without a general annual deductible for in-network services are assigned a value of zero.

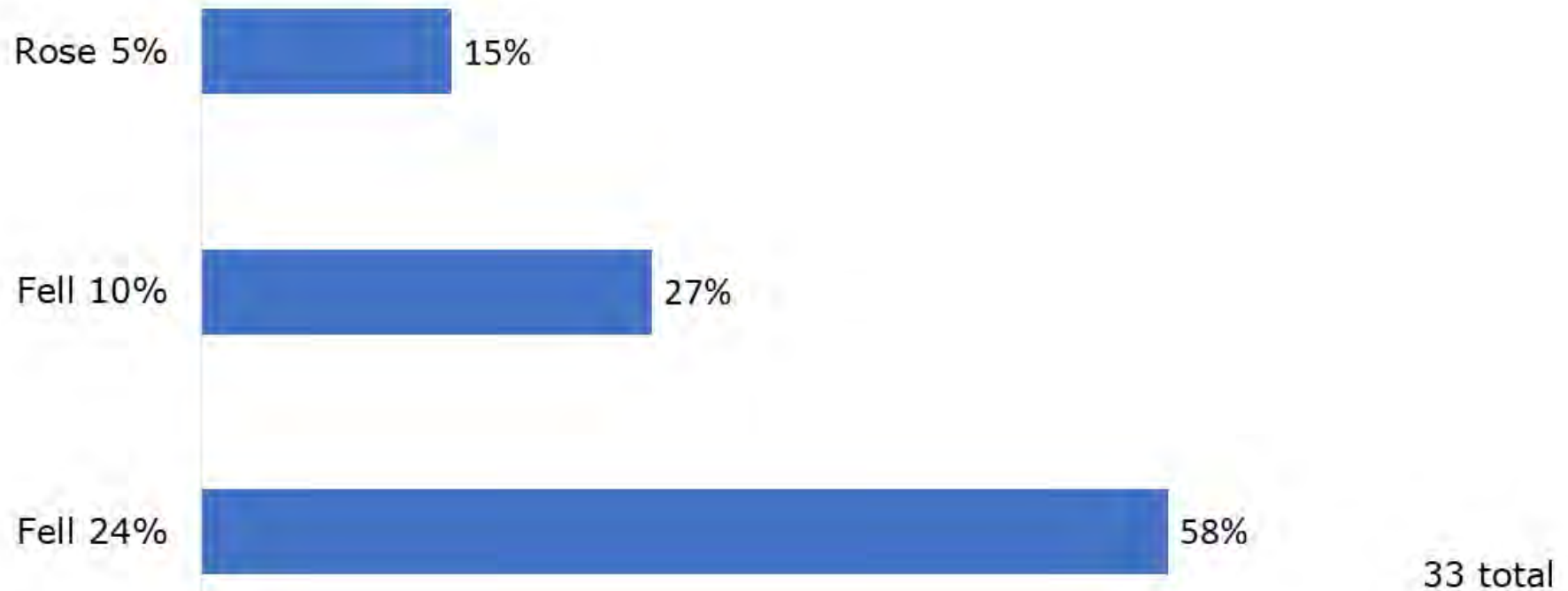
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010-2017. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation, 2010-2020; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 2010-2020.

Between 2008 – 2016, adult primary care visits covered by commercial insurance...

- ☐ Rose 5%
- ☐ Fell 10%
- ☐ Fell 24%



Between 2008 - 2016, adult primary care visits covered by commercial insurance...



① Start presenting to display the poll results on this slide.



Acute Care/Specialty Orientation Increasing

**Primary
Care
Spending
Low &
Declining**

**PCC; JAMA;
JAMA Internal
Medicine**

Adult PC visits fell
24% 2008–2016 for
commercially
insured; visits to
specialists
remained stable

*Annals of Internal Medicine,
2020*

The % of non-elderly
adults reporting
“usual source of
care” has been flat
since 2016

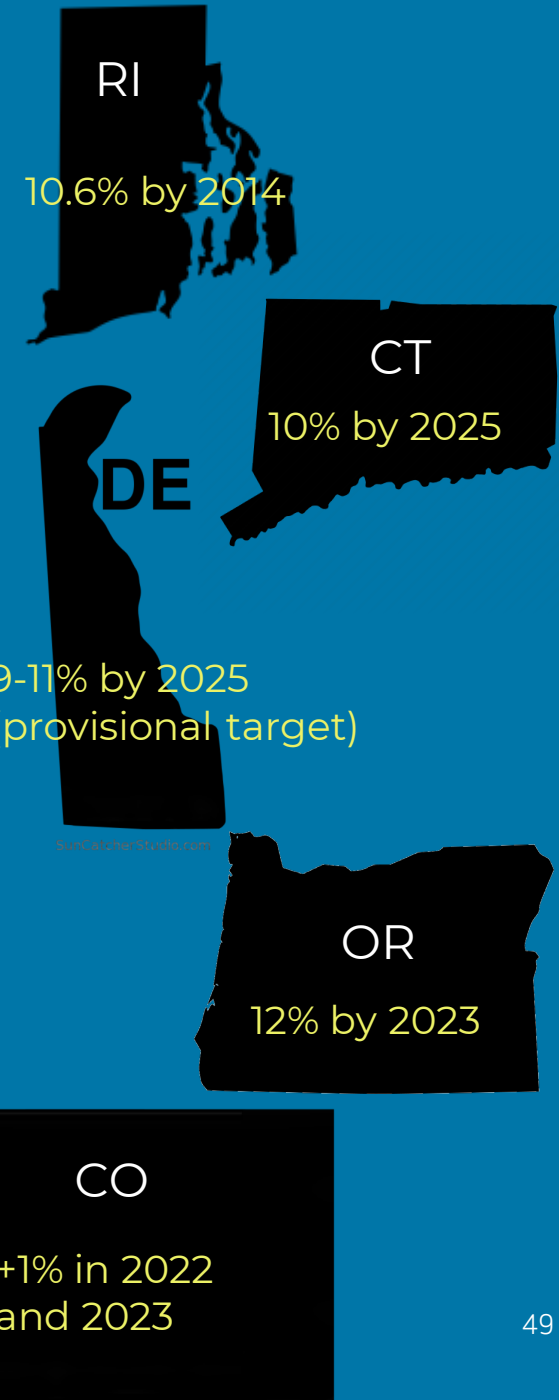
KFF – Peterson Health Tracker

Lower rates reported by
Black, Latinx adults

Commonwealth Fund, 2020

@ State Leaders Reorienting toward Primary Care

- In 2018, 2 states had passed legislation, laws or regulations to measure and/or invest more in primary care; there are 13 today.
- 5 states have set targets for primary care spending in legislation without growing total cost of care
- Ten states (so far) are considering legislation or regulation in 2022



Attributes of Advanced Primary Care

How Employer-Identified Practice Attributes Align with the Shared Principles of Primary Care

This table crosswalks employer-identified attributes of advanced primary care (APC) with the Shared Principles of Primary Care. It is a first step on the path to achieving APC. Measures, including those reported by and about patients, that assess the extent to which a practice has achieved advanced primary care are forthcoming. We will continue to engage with all the stakeholders in primary care and expect that these attributes will evolve over time.

This table crosswalks employer-identified attributes of advanced primary care (APC) with the Shared Principles of Primary Care. It is a first step on the path to achieving APC. Measures, including those reported by and about patients, that assess the extent to which a practice has achieved advanced primary care are forthcoming. We will continue to engage with all the stakeholders in primary care and expect that these attributes will evolve over time.		Shared Principles of Primary Care						
		Person & Family-Centered	Continuous	Comprehensive & Equitable	Team-based & Collaborative	Coordinated & Integrated	Accessible	High Value
		The patient statements below offer examples of what patients want from primary care. They were developed by PBGH through a multi-stakeholder process.						
		"I can get care and information from my primary care team when I need it and in the way that best meets my needs"	"My primary care team knows me and keeps me well."	"My primary care team knows and supports the whole me—not just my body."	"My primary care team can meet most of my healthcare needs."	"When I do need a specialist, [my primary care team] helps me find the right one and communicates with them about me. "	"I can get care and information from my primary care team when I need it and in the way that best meets my needs"	"When I need planned surgery or emergency care, [my primary care team] knows what happened and support me in becoming well again."
Employer-Identified Attributes of Advanced Primary Care*	Enhanced access for patients							
	Patients can access care in a way that meets their needs and preferences without financial barriers to access, including via: same-day and walk-in appointments; virtual care; a secure patient portal to view their medical records, receive labs and communicate with their care team; access to a care team member after hours.							
	Optimize time with patients							
	Patients are active participants in their care through: shared decision-making; input on their care plan and treatment goals; opportunities to share their preferences, including serious illness conversations, advanced directives, and end-of-life care; and addressing barriers due to their social determinants of health.							
	Realigned payment methods							
Practices are paid in a way that that enables and promotes quality, access, efficiency, team-based patient-centric care and population health management. Primary care payments are tied to patient experience and outcomes, and not volume or face-to-face visits.								

Employer-Identified Attributes of Advanced Primary Care*

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Employer-Identified Attributes of Advanced Primary Care*



COVID: A Sucker Punch

FEATURE

Pandemic exacerbates primary care practices' financial struggles

Publish date: October 26, 2021

HEALTH NEWS

✓ Fact Checked

Why Black, Native American, and Latino Communities Experience Higher COVID-19 Death Rates

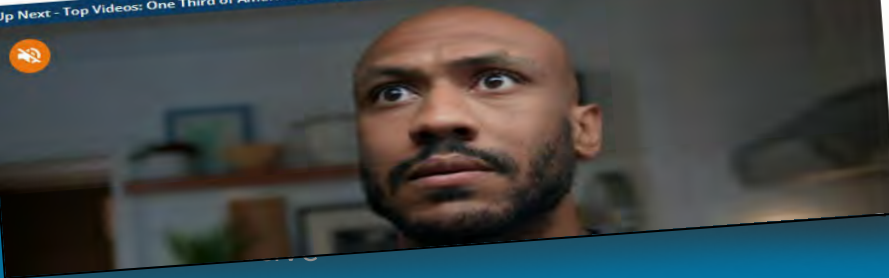
CORONAVIRUS

Doctors are calling it quits under stress of the pandemic

By REED ABELSON
THE NEW YORK TIMES | NOV 16, 2020 AT 12:55 PM

CORONAVIRUS VIDEO UPDATES

Up Next - Top Videos: One Third of Americans Skip Medical Care Because They Can't Afford It



News

Occupation a major factor in Covid's disproportionate impact on ethnic minority groups, govt says

5 Dec 2021 By Francis Churchill

Minister warns against 'one size fits all' approach



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Los Angeles Times

Latino pandemic experience The middle class at risk Family struggles to survive

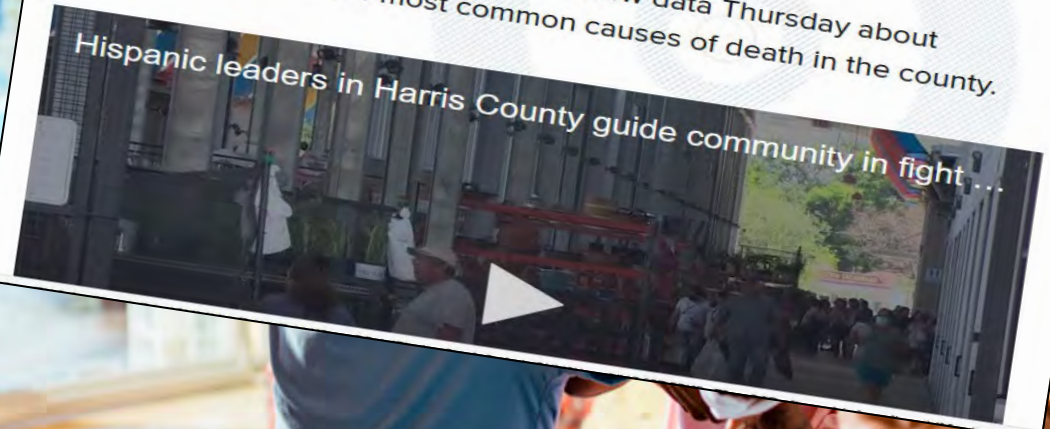
CALIFORNIA

Young Latinos are dying of COVID at an alarming rate — the effects could be felt for generations

COVID-19 leading cause of death for Hispanic residents in Harris County last year, report says

Harris County Public Health released new data Thursday about mortality rates and the most common causes of death in the county.

Hispanic leaders in Harris County guide community in fight...



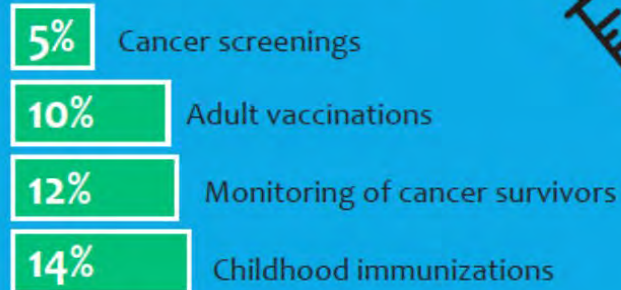


Impact on Patients – DEFERRED CARE

Care is already being deferred.

81% of practices that have limited wellness and chronic care visits

Care least often occurring:



Patients report being **overdue** for:



Results from surveys conducted by the Larry A. Green Center (www.green-center.org), in partnership with the Primary Care Collaborative (www.pcpcc.org) and 3rd Conversation (www.3rdconversation.org).



Source: Rebecca Etz, PhD, co-director, Larry A. Green Center for Primary Care.
<https://www.green-center.org/covid-survey>

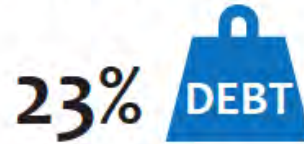


The PC Platform is Weaker

The implications of this failure are bad...



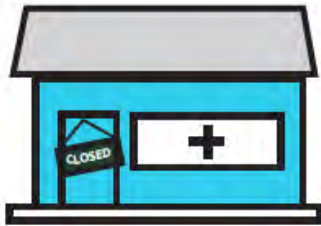
say they
have had to furlough/layoff
practice members.



say they
have gone into debt



have experienced
severe or close to severe
stress for 2 months



...and will get worse:

51%

are uncertain about their financial future one month from now

7%

have already closed

Primary care needs your urgent action because:

72%

If primary care fails,
so too does the health
care system.

55%

We are not ready
for the next wave
of this pandemic.

21%

If my practice closes,
the people in my community
will have no access to care.

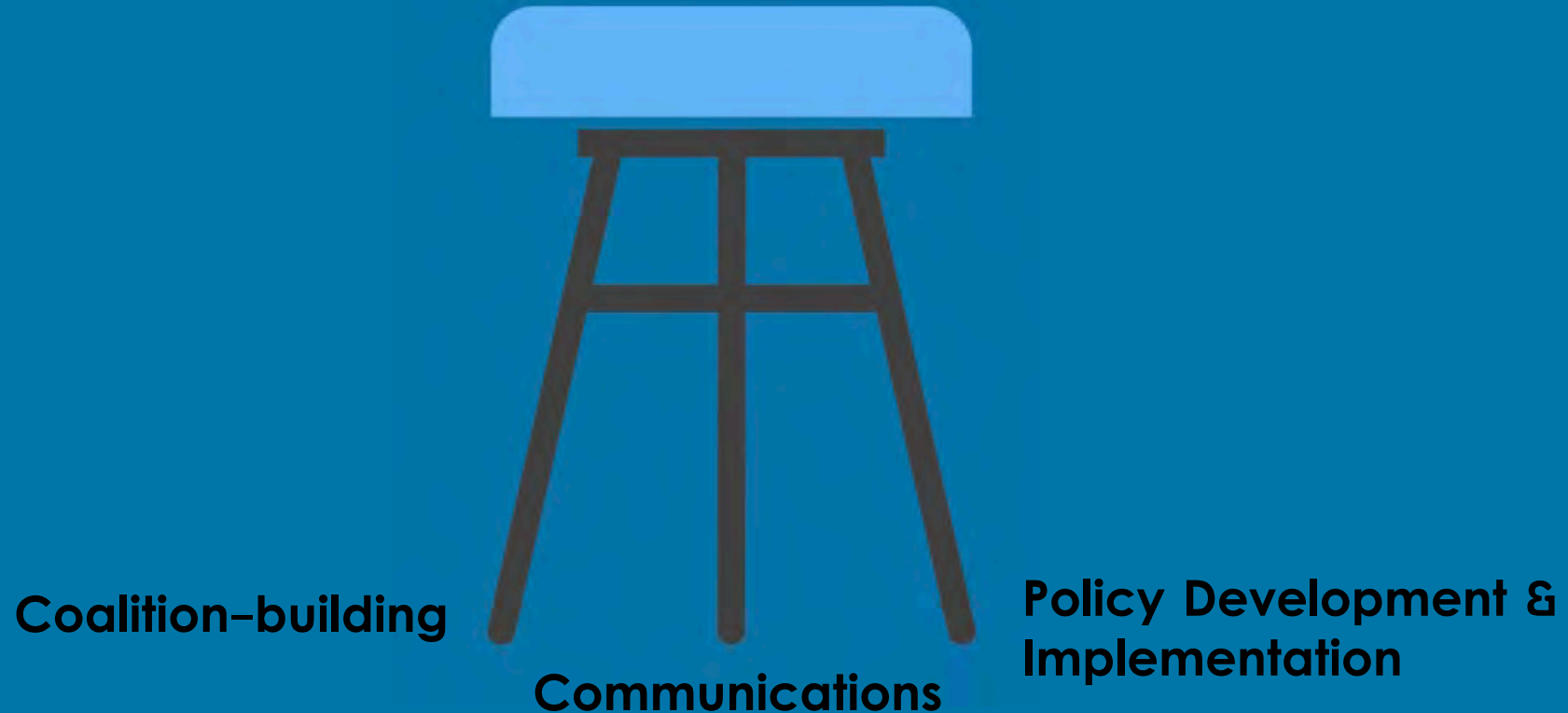
Source: Rebecca Etz, Larry A. Green Center for Primary Care

2021 NASEM Landmark Study

Offers New Opportunity to Advance Our Goals



Ⓒ PCC's Three-legged Strategy: Shaping the Environment





PCC Seized Moment, Convened Leaders in June 2021 & November 2021

primary care
collaborative

PRIMARY CARE COLLABORATIVE CONCORDANCE RECOMMENDATIONS FOR PRIMARY CARE PAYMENT + INVESTMENT

The COVID-19 pandemic, coupled with the heightening national awareness of the persistence of racism and other structural inequities, shone a harsh spotlight on the urgent need for a more resilient, equitable, and higher value health care system for our nation. Primary care must be at the center of the transformed health system we need to ensure that everyone in the country has an equitable opportunity to attain the best possible health and wellness and bend the health care cost curve over time. To succeed in this transformation and improve health care delivery, we need better health care payment systems as well as significant up-front investment in healthcare in the communities that have been systematically under resourced and structurally disadvantaged.

The Primary Care Collaborative (PCC) has committed to advancing a set of recommendations designed to achieve a higher-value health system built on the foundation of high quality, comprehensive primary care, to produce better population health, greater affordability, and the reduction of racial, ethnic, and other structural inequities that sap the health and vibrancy of many communities across the country. In the summer of 2021, the PCC convened a meeting to discuss using the National Academies of Sciences, Engineering, and Medicine (NASEM) primary care report's five payment recommendations as a launching point for health care transformation that improves value while and achieves health equity.

1. Primary care payment should create pathways to rapidly transition from a predominantly fee-for-service model to a predominantly population-based prospective payment (hybrid) model coupled with up-front and ongoing investments and guardrails to ensure that patients and communities most affected by health and health care inequities, and the clinicians that care for them, realize the benefits of a higher-value health system.

These payment pathways should include adjustment for health status, risk, social drivers of health and social risk, historic under-investment, and other elements. Such hybrid models should be implemented widely, while mindful of practice heterogeneity, preserving the viability of primary care clinicians who have earned the trust of structurally disadvantaged communities and provide culturally congruent care, and support greater adoption of telehealth. There should be a pathway for practices to voluntarily pursue higher levels of prospective payment at an even quicker pace with sufficient support.

2. To achieve rapid transition to and sustainability of comprehensive primary care practice models, overall health care spending, both in terms of ongoing payment and needed investment must be rebalanced towards primary care. Currently, primary care spending in the US amounts to only approximately 5-7% of total cost of care and is trending down. There is strong evidence that countries which devote considerably more resources to primary care as a share of total spending than the US achieve more equitable health outcomes, better overall population health and much lower per capita spending. Policymakers committed to slowing spending growth in our inefficient health system should implement needed resource shifts now, understanding that they will ultimately result in a more efficient, higher value, health care system.



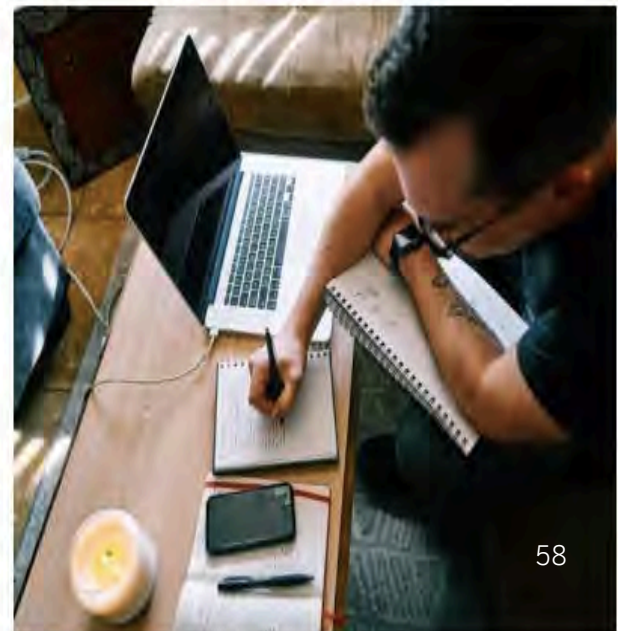
PCC to working summit advanced ideas & brought in new stakeholders

primary care
collaborative

ABOUT THE SUMMIT

What is the summit?

The PCC working summit will convene healthcare stakeholders to discuss the opportunities presented by the National Academies of Sciences, Engineering, and Medicine's (NASEM) report, *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care*. The summit will focus on the report's payment recommendations as a key lever to achieving the report's goals. Achieving the goals is a way of reaching the vision of care presented in the *Shared Principles of Primary Care*. **Our goal with the summit is to catalyze and align broad, diverse leadership in order to formulate an action plan for implementing the high-quality primary care described in the NASEM report.**



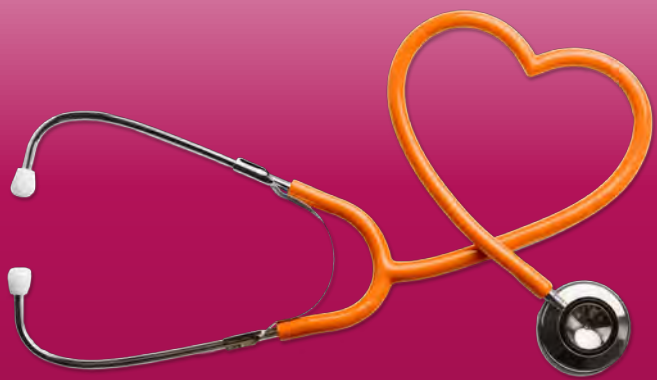


PCC Campaign Launch on 3.29

Better Health *NOW*

A campaign of  pcc primary care
collaborative

Discussion



*a word from
our sponsor*





Employer Stories: Why Preventive Care Matters

Kathy Foulser

Director of Membership Development
Midwest Business Group on Health



Anna Derksen

Director of Wellbeing & Recognition
Bon Secours Mercy Health

Why Preventive Care Matters

Anna Derksen, Director Well-being & Recognition

March 23, 2022

A strong partnership with population health has embedded prevention as a key strategic pillar of Bon Secours Mercy Health's approach to associate health and well-being.

Strategic Pillars

1

Adjudicate

Strong plan
administration

2

Educate

Care gap closures

3

Activate

Condition management

4

Connect

Right care, right place,
right time

Building on fundamentals has improved health and well-being outcomes for our associates.

01 | Adjudicate

Expertise first

Creating a plan design to leverage our quality care

- Custom network design
- Associate Health Plan Oversight Committee (AHPOC)
- Plan review and appeals

02 | Educate

WIIFM approach

Getting upstream of health and well-being needs of associates

- Primary Care 5 measures
- Be Well Health Screenings
- Regular, actionable messaging

The right resources empower individuals to positively impact their health and well-being journey.

03 | Activate

Inspiring engagement

Optimizing prognosis when disease occurs

- Be Well with Diabetes
- Be Well with Baby
- Associate Care Management

04 | Connect

Know where to go

Finding access when it matters

- Nurse Access
- E-visits and virtual care
- Going beyond the walls



Jason Parrott

Senior VP, Strategy, Innovation,
Growth and Partnerships
Vida Health

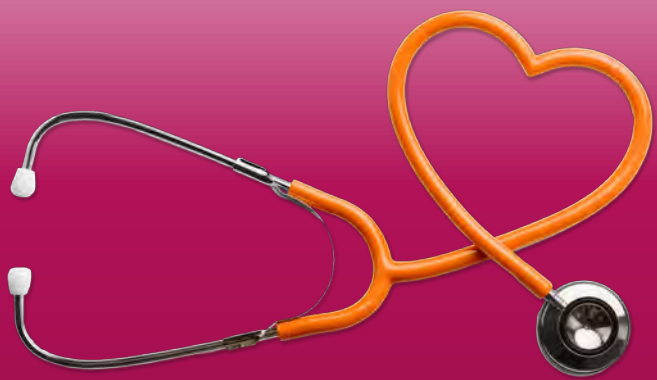


Viktoria Rill

Director of Total Rewards
Illinois Institute of Technology

Questions?





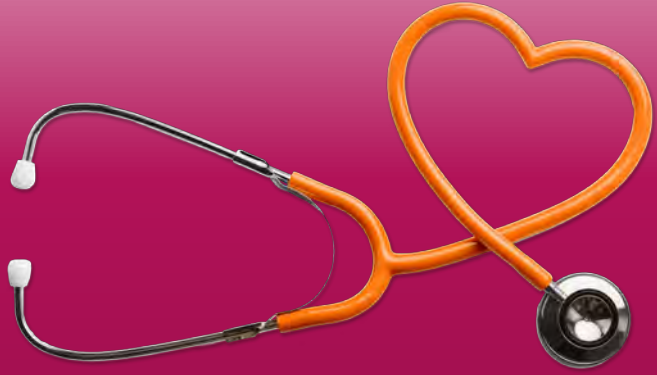
*a word from
our sponsor*



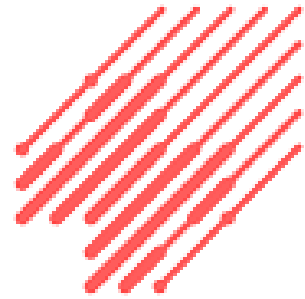


Break and Exhibits

Turn in Your Prize
Drawing Card by 11 AM!



*a word from
our sponsor*



SWORD HEALTH

What % of individuals eligible for lung cancer screening typically get screened?

- ☐ 5%
- ☐ 25%
- ☐ 45%



What % of individuals eligible for lung cancer screening typically get screened?





Oncology: An Employee Focused Approach to Prevention

Denise Wojcik, BSN, R.N.

CT Lung Cancer Screening
Coordinator

Northwestern Memorial Hospital

A photograph of two individuals from the waist up, standing against a solid blue background. The person on the left is wearing a green V-neck sweater over a pink collared shirt and an orange tie. The person on the right is wearing a yellow V-neck cardigan over a green top and a pink skirt. Both individuals have their arms crossed. The text 'ONCOLOGY: AN EMPLOYEE FOCUSED APPROACH TO PREVENTION' is overlaid in white, bold, sans-serif capital letters across the center of the image.

ONCOLOGY: AN EMPLOYEE FOCUSED APPROACH TO PREVENTION

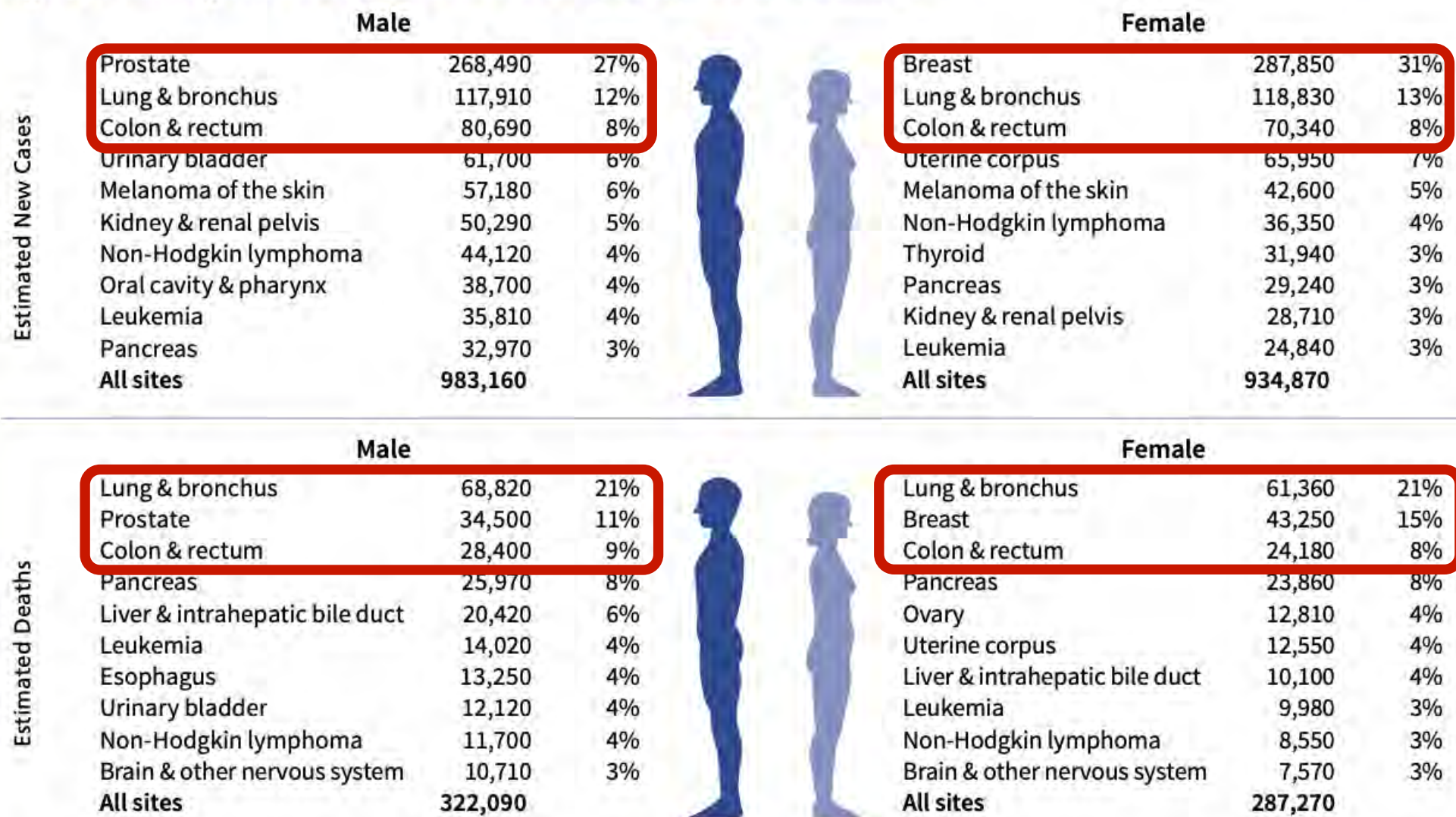
LEARNING OBJECTIVES

- understand COVID-19's impact on cancer screening and diagnosis
- learn about efforts to increase cancer screenings
- discuss recent updates to colorectal screening guidelines
- learn about the newest tool in the detection of lung cancer - lung cancer screening

CANCER'S BURDEN IN THE WORK PLACE

- In 2010, total annual economic cost of cancer through healthcare expenditure and loss of productivity was estimated at US\$ 1.16 trillion
- Cancer-related direct medical costs in the US were \$183 billion in 2015 and are projected to increase to \$246 billion by 2030, a 34% increase based only on population growth and aging; excludes prescription medications

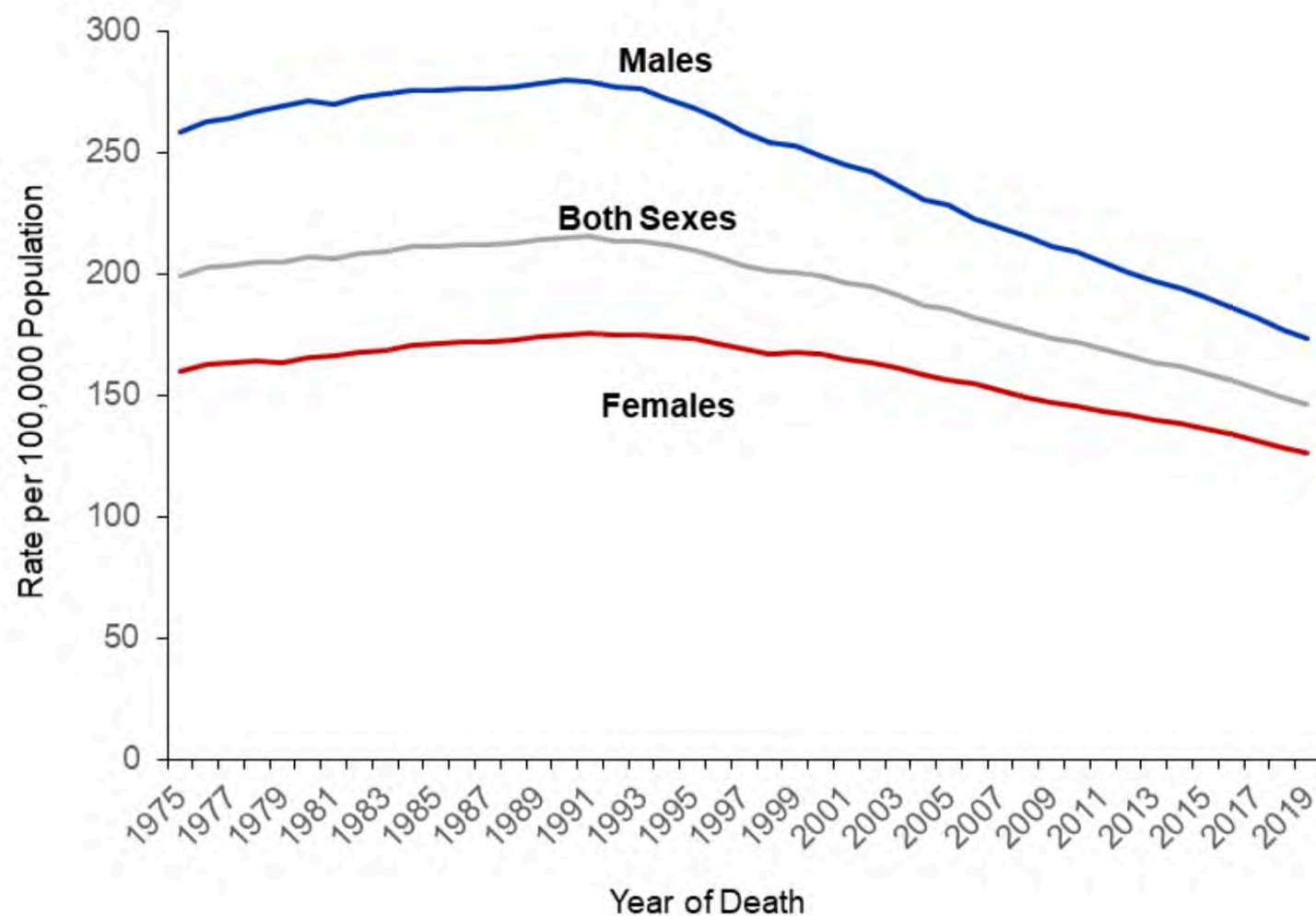
Figure 3. Leading Sites of New Cancer Cases and Deaths – 2022 Estimates



Estimates are rounded to the nearest 10, and cases exclude basal cell and squamous cell skin cancers and in situ carcinoma except urinary bladder. Estimates do not include Puerto Rico or other US territories. Ranking is based on modeled projections and may differ from the most recent observed data.

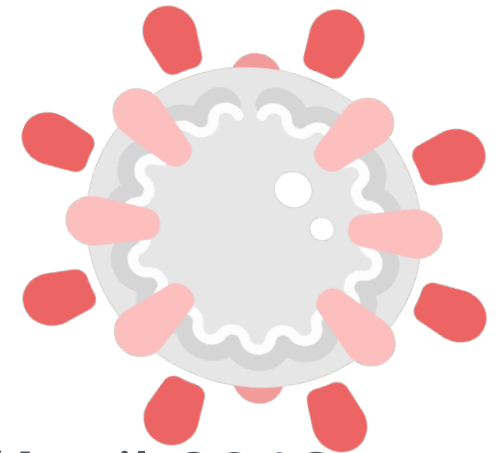
©2022, American Cancer Society, Inc., Surveillance and Health Equity Science

CANCER DEATHS DOWN BY 32% SINCE EARLY '90S



*Age-adjusted to the 2000 US standard population.
Source: National Center for Health Statistics, Centers for Disease Control and Prevention, 2021.

IMPACT OF COVID-19



■ Telehealth (Telemedicine)

- 300-fold increase in telemedicine visits from March/April 2019 to March/April 2020
- Eliminates ancillary costs
- Beneficial with chronic disease management

■ Health Equity

- Raised awareness and discussion of long-standing health disparities

Figure S2. Potential Impact of the COVID-19 Pandemic on Future Cancer Outcomes

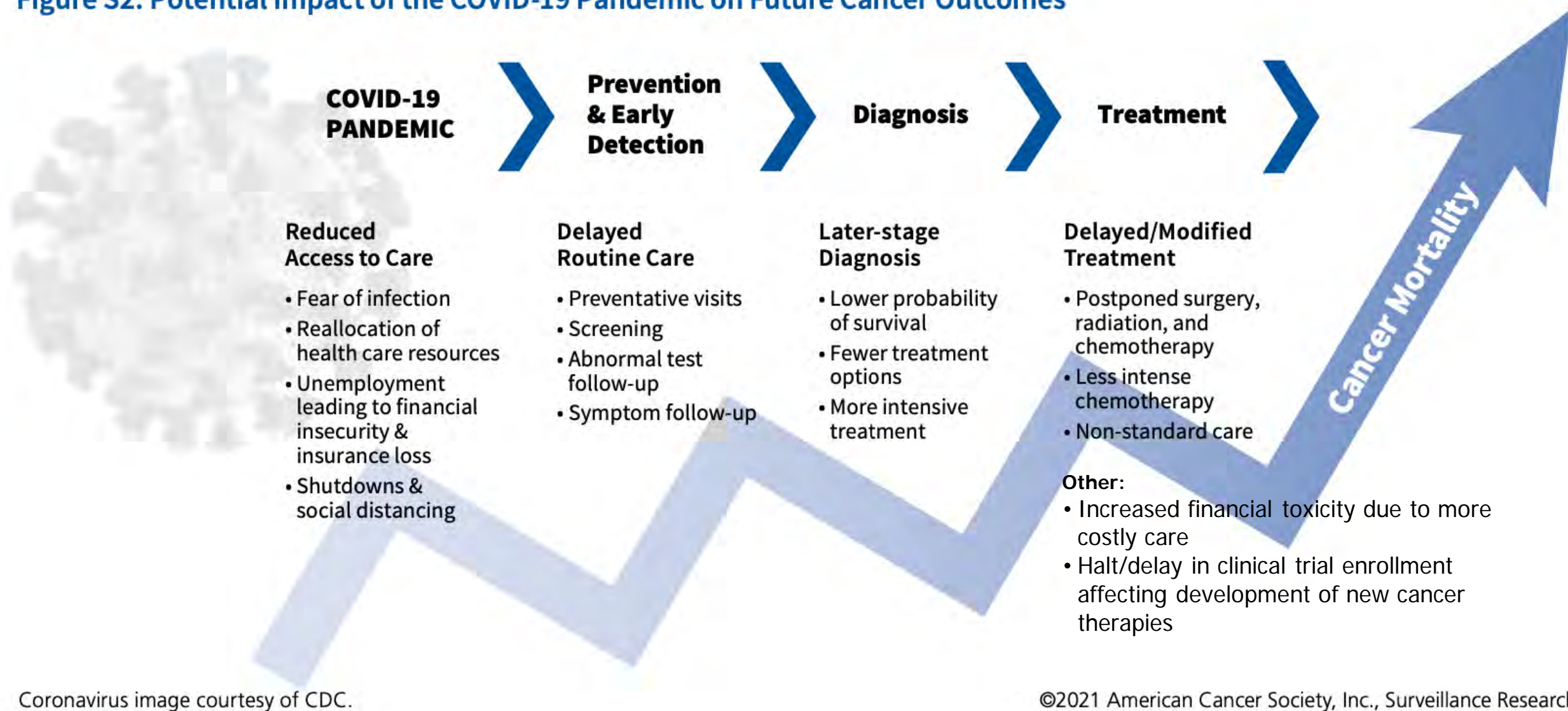
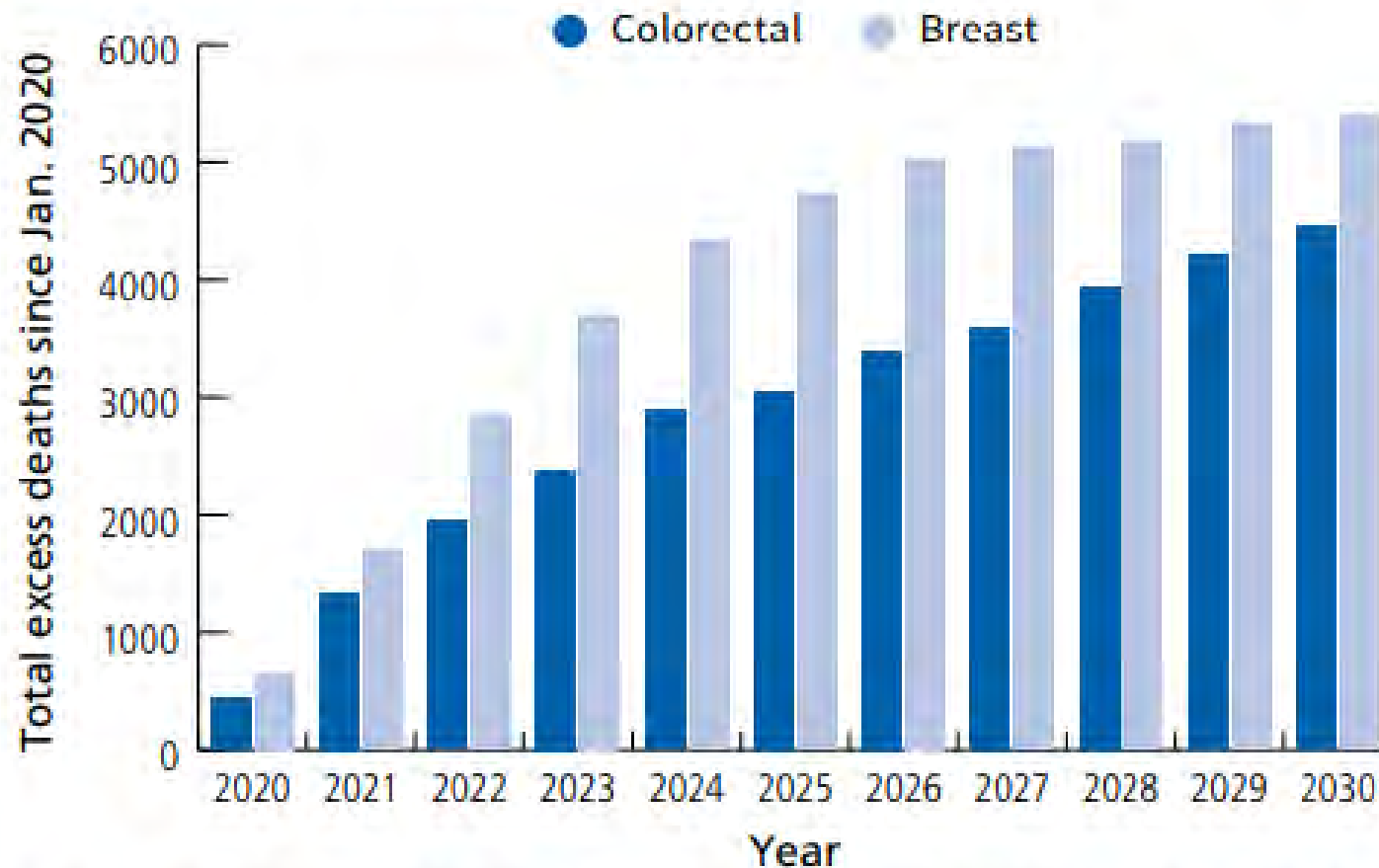


Figure S3. Estimated Cumulative Excess Deaths From Colorectal and Breast Cancers in the US Due to the COVID-19 Pandemic, 2020 to 2030



Source: Sharpless NE. COVID-19 and cancer. *Science*. 2020;368(6497): 1290.
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Closing Gaps in Cancer Screening:

Connecting People, Communities, and Systems to Improve Equity and Access

- Letter To President Biden:
- Misperception that cancer screenings are “elective”
 - Cancer screenings save lives

President's Cancer Panel Goals and Recommendations



Improve and align communication

- Conduct large- and small-scale communications campaigns
- Create and expand National Cancer Roundtables



Facilitate equitable access

- Provide and fund community-oriented outreach and support
- Increase access to self-sampling



Strengthen workforce collaborations

- Empower healthcare team members
- Expand access to genetic testing and counseling



Create effective health IT

- Create computable guidelines
- Create and deploy clinical decision support tools

Companion Briefs

The Panel highlights issues and recommendations relevant to specific cancer types.

% Screened



Breast Cancer

76%



Cervical Cancer

74%



Colorectal Cancer

67%



Lung Cancer

5%

COLORECTAL CANCER SCREENING

■ 2021 Guidelines

Insurers to cover by 2023

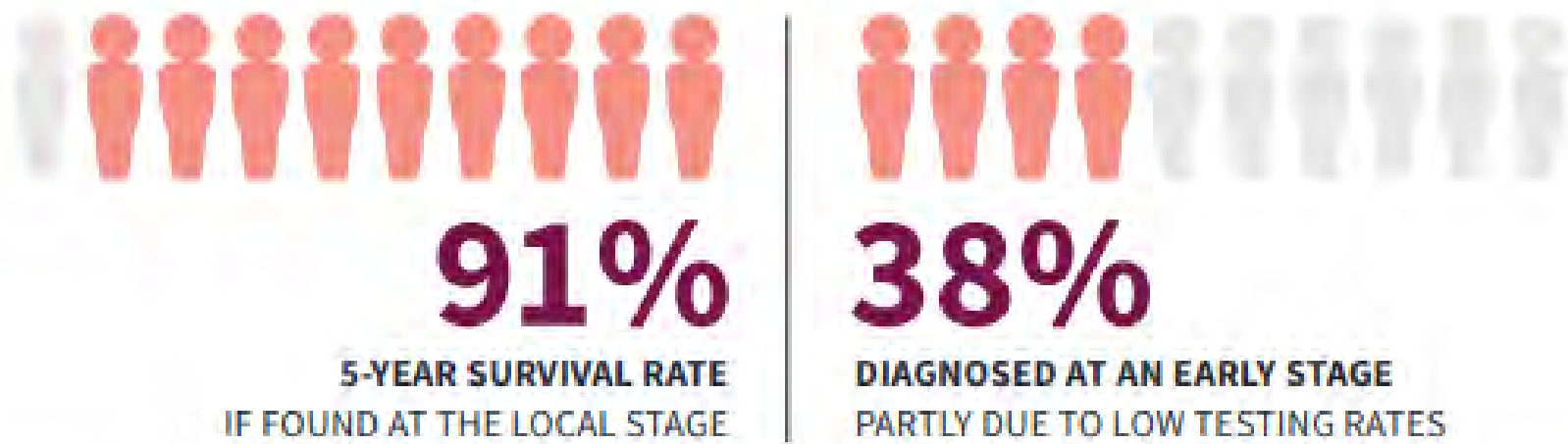
Recommendation Summary

Population	Recommendation	Grade
Adults aged 50 to 75 years	The USPSTF recommends screening for colorectal cancer in all adults aged 50 to 75 years. See the "Practice Considerations" section and Table 1 for details about screening strategies.	A
Adults aged 45 to 49 years	The USPSTF recommends screening for colorectal cancer in adults aged 45 to 49 years. See the "Practice Considerations" section and Table 1 for details about screening strategies.	B
Adults aged 76 to 85 years	The USPSTF 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 appropriate in individual cases, patients and clinicians should consider the patient's overall health, prior screening history, and preferences.	C

COLORECTAL CANCER: CATCH IT EARLY AND REDUCE YOUR RISK

American Cancer Society // Infographics // 2021

Colorectal cancer is the third most common cancer in both men and women in the US. Routine testing can help prevent colorectal cancer or find it at an early stage, when it's smaller and may be easier to treat. If it's found early, the 5-year survival rate is more than 90%. Many more lives could be saved by understanding colorectal cancer risks, increasing screening rates, and making lifestyle changes.



OVERALL
-1%



AGE <50
+2%



AGE 50-64
+1%



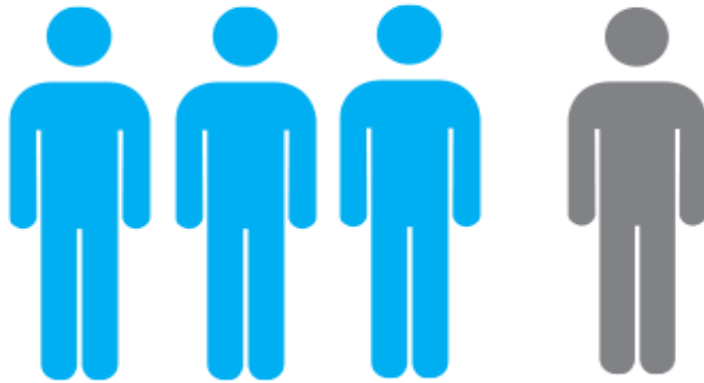
While overall incidence rates of colorectal cancer have been decreasing by about 1% per year, this mostly reflects a decrease in older adults. The incidence rate among people younger than age 50 has been increasing by 2% each year and by 1% for people ages 50-64.

Facts About Lung Cancer

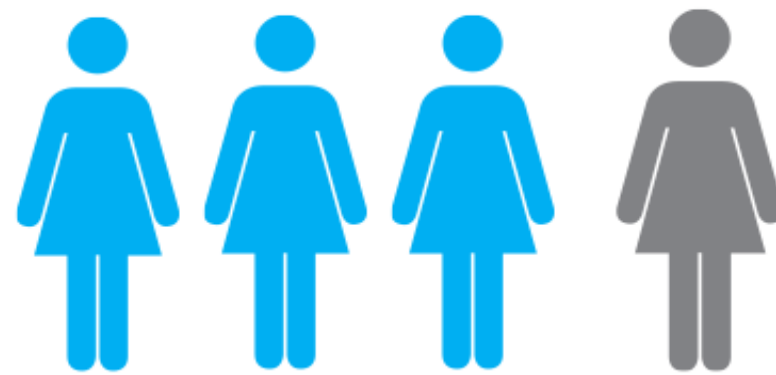
LUNG CANCER is the leading cause of cancer death worldwide.¹

AN ESTIMATED 236,740 PEOPLE will be diagnosed with lung cancer in 2022 in the U.S.²

1 IN 16 PEOPLE will be diagnosed with lung cancer in their lifetime – 1 in 15 men, and 1 in 17 women.²



LUNG CANCER kills almost **3 TIMES** as many men as prostate cancer. ([source](#))



LUNG CANCER kills almost **3 times** as many women as breast cancer. ([source](#))

LUNG CANCER SCREENING

2021 GUIDELINES

1 pack/day for 1
year = 1 pack
year

1 pack year x 20
years = 20 pack
years

Recommendation Summary

Population	Recommendation	Grade
Adults aged 50 to 80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years	The USPSTF recommends annual screening for lung cancer with low-dose computed tomography (LDCT) in adults aged 50 to 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.	B

LUNG CANCER SCREENING TIMELINE

- 2011 National Lung Screening Trial Published in the New England Journal of Medicine:
 - 20% reduction in mortality with low dose CT vs chest X-ray
- 2013 USPSTF gives recommendations with a class B grade
- 2015 CMS reimbursement
- 2018 Nelson Trial/Belgium
- 2019 the MILD Trial from Italy and LUSI Trial from Germany showed decrease in mortality with yearly LCS
- Prompted update of guidelines by USPSTF in 2021 and CMS in 2022

LUNG CANCER SCREENING

- Non-invasive low dose CT of lungs; performed annually if criteria are met
- When lung nodules are found on the scan:
 - 85-90% of scans are benign
 - 8-12% are indeterminate
 - 2-4% are suspicious
 - Follow up: 3-6 months CT
 - PET CT
 - Bx or f/u with a specialist
 - Other “non-lung cancer” clinically significant findings (10%)
- Cancer detection rates around 3% or more
- Surgical intervention
- Recently approved:
 - Immunotherapy + chemo prior to surgery



<https://www.acr.org/-/media/ACR/Files/RADS/Lung-RADS/LungRADSAssessmentCategoriesv1-1.pdf>

<https://go2foundation.org/blog/fda-approves-new-combination-treatment-before-surgery-for-early-stage-nscl/>
<https://www.freepik.com/vectors/medical> > Medical vector created by storyset - www.freepik.com

LUNG CANCER SCREENING - CHALLENGES

- Awareness - uptake of LCS is low - 5% US, 6% in Illinois
- Fear and stigma
- Identifying high risk individuals
- Provider knowledge and education about LCS
- Patients sometimes charged copay or deductible

RECOMMENDATIONS

- Set organizational screening goals
- Develop incentives for screening
- If needed, help employees access care
- Communication: educate on the value of cancer screenings to employees and their families
- Allow time off/privacy (telemedicine) for health screenings and other
- Work with insurers to ensure that cancer screenings are covered without copay or deductibles and coverage adjusted when guidelines change

THANK YOU!

DENISE WOJCIK, RN

DENISE.WOJCIK@NM.ORG



Cody Adams

Benefits Manager
US Roche & Genentech



An Employer Perspective: Call to Action – Cancer Screenings

Cody Adams
Manager, US Benefits



World's largest biotech company



Innovative drugs and diagnostics



Personalized medicine



63M
patients
treated



283M
patients in
clinical trials

 = 10M Patients



94,000 employees in 100+ countries



22,000 U.S. benefit eligible employees



Genentech

A Member of the Roche Group

A Pioneer and Leader in Cancer Innovation

\$12 Billion 

in R&D in 2019. More than any other healthcare company¹²

18



Breakthrough therapy designations for oncology products since 2013³

>21



Different tumor types are treated by our cancer portfolio⁴

~45%



of our late-stage Oncology trials have associated biomarker tests, meaning they include patients whose cancers have specific genomic signatures⁴



Cancer Diagnostics

cobas[®]

VENTANA[®]
A Member of the Roche Group

CINtec[®] **PLUS**



Cancer Genomics



FOUNDATION
MEDICINE



Cancer Medications

Herceptin[®]
trastuzumab

Rituxan[®]
Rituximab

AVASTIN[®]
bevacizumab
Solution for intravenous infusion

TECENTRIQ[®]
atezolizumab

Xeloda[®] tablets
capecitabine

GAVRETO[™]
pralsetinib

Genentech

A Member of the Roche Group

Our Approach: Supports Patients via Personalized Cancer Care

Prevention and Screening



- **Expanded preventive coverage** including breast ultrasound and MRI at 100%
- **\$100 incentive** for cancer screenings
- Actively **promote importance of screenings** leveraging awareness dates (e.g. cancer screen week)

Diagnosis



- **Remove barriers** and **enable personal treatment plans**
- **Robust genetic and genomic testing coverage** to ensure comprehensive diagnosis
- **Dedicated Oncology Nurses** that walk the cancer journey side-by-side with the patient and their caregivers
- **AccessHope Expert Second Opinion** who have expertise in oncology consults and collaborates with treating oncology team to ensure full diagnostic work up and genomic testing

Treatment



- **Personalized Healthcare** with the goal of developing tailor-made solutions for patients and their physicians
- **Support participation in clinical trials**; including PTO and covered travel expenses

Dedicated HealthTeam • Cancer Care Guide • 25 Lyra Mental Health Therapy Sessions
100% Paid Short-Term Disability • 4-week Paid Caregiver Leave • Palliative Care

Compassionate Support throughout the Cancer Journey

Treatment

To support
our people
during their
cancer journey we
provide

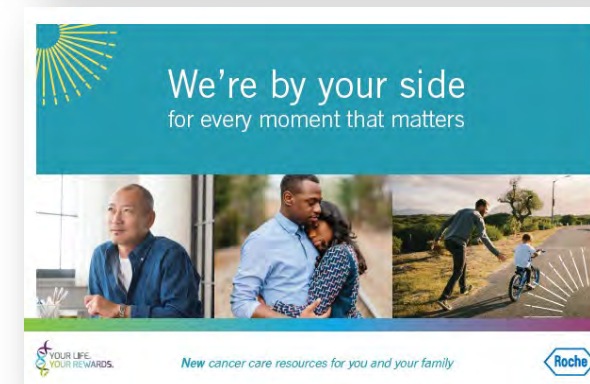
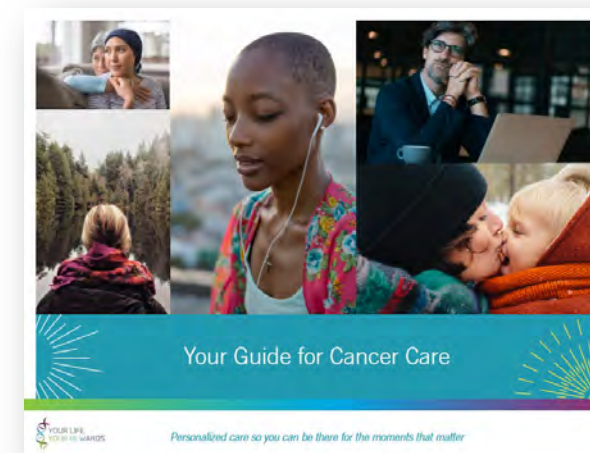
A comprehensive Cancer Care Guide

25 free **mental health therapy sessions** per year through Lyra

100% **paid short-term disability**

4 weeks **paid caregiver leave**
to care for seriously ill family member

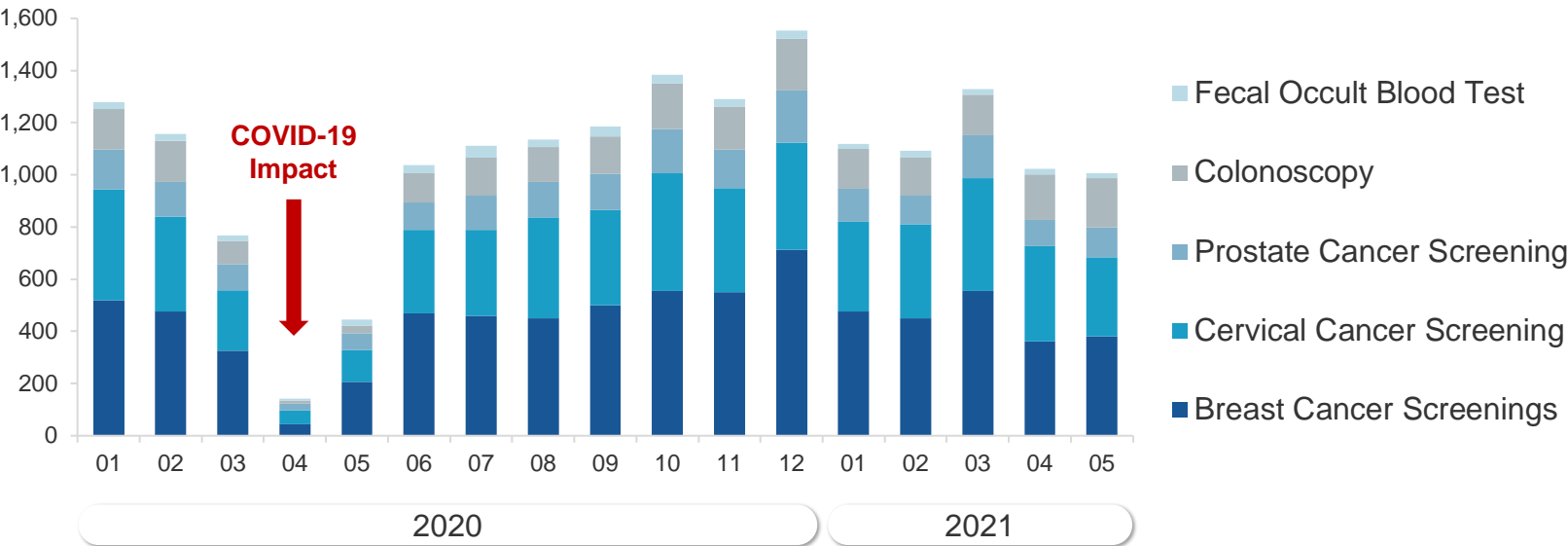
Palliative care




Genentech


A Member of the Roche Group


What we learned through the pandemic



Impact of Annual Wellness Visits on Cancer Screening Compliance

 **+23.8%**
Mammography Screenings

 **+16.4%**
Cervical Cancer Screenings

 **+19.2%**
Colon Cancer Screening



Rates of cancer screenings decreased significantly due to COVID-19



Annual wellness exams drive higher compliance of appropriate cancer screenings



Incentives work!

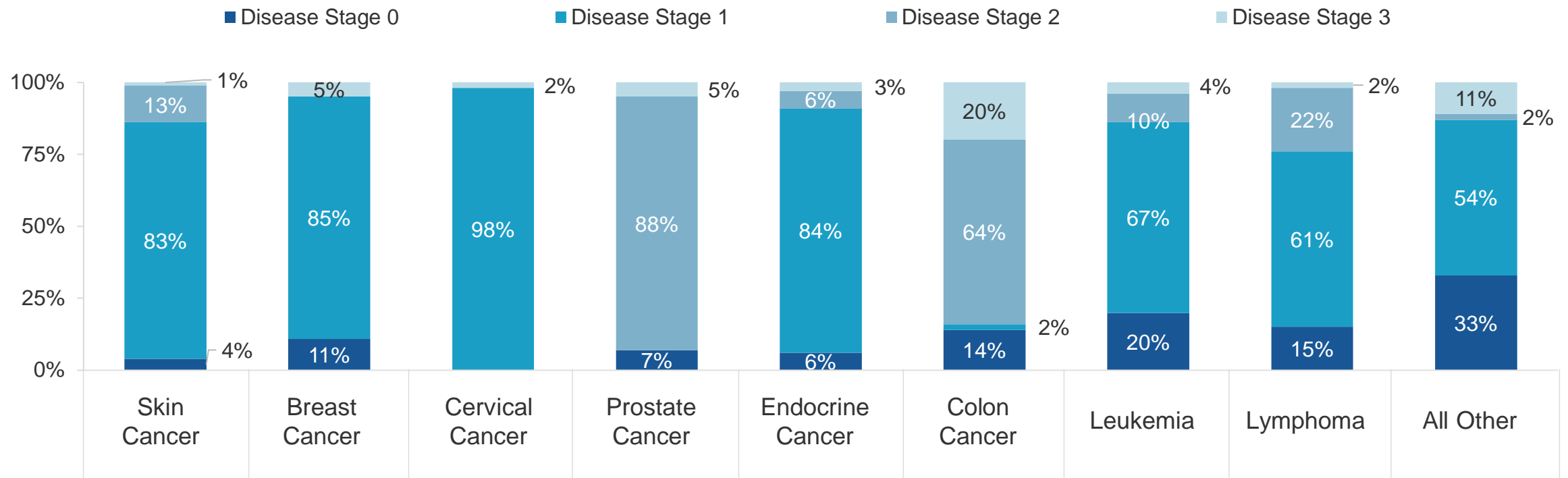


Education and awareness communications are essential

A Focus on Prevention and Cancer Screenings

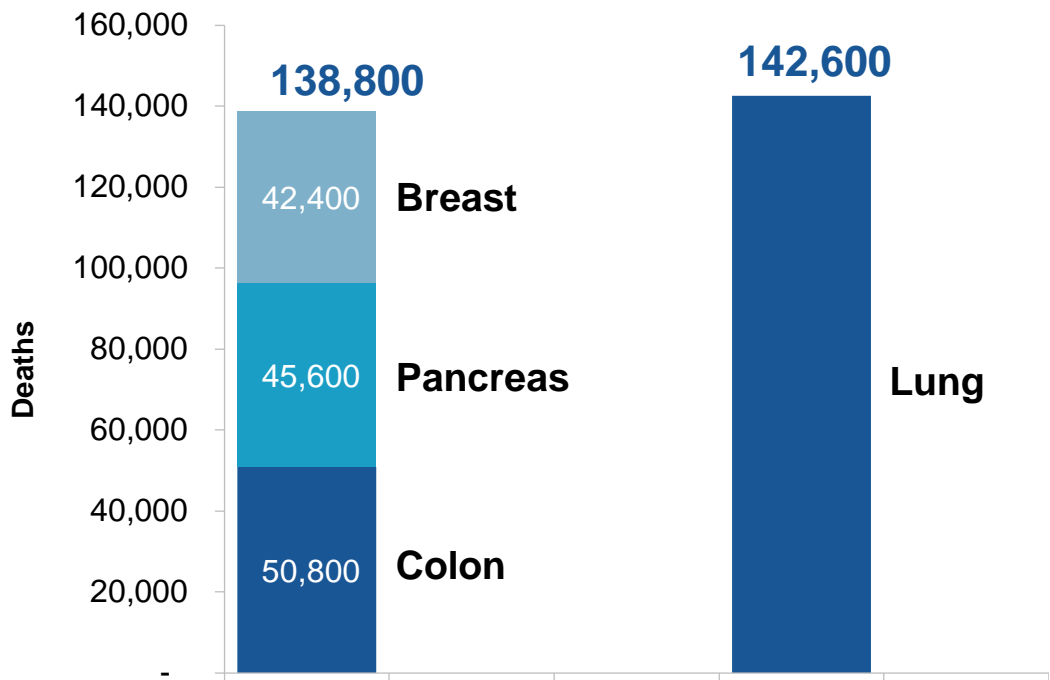
Critical to get caught up on cancer screenings to avoid disease progression











Cancer Disease Stage at Diagnosis (2020 UHC Data)



Lung cancer is the leading cause of cancer deaths more than next 3 cancers combined and has the lowest screening rate

Cancer Deaths



 Breast:	 of women 50 - 74yrs had mammograms within last 2yrs
 Cervical:	 of women 21 - 65yrs up to date with screening
 Colon:	 of 50 - 79yrs had appropriate screening based on most recent guidelines
 Prostate:	 of men 55 - 69yrs has PSA in last year
 Lung:	 of 50 - 80yrs at risk patients screened in last year

Incentivizing Preventive Care and Screening

In 2020, we began rewarding our employees and spouses/domestic partners up to \$500/\$300 per year for completing healthy activities including:

\$150

Annual Physical

\$100

Cancer screening

Delivering real impact: Linda's Story

"In July, I was preparing for a camping trip and realized I needed a water filter and other camping supplies. Of course I could have just bought them, but I realized that if I finally got that mammogram (I had been putting off for a year), I'd get an REI gift card (what can I say, I love free stuff!!).

Within a week I was diagnosed with invasive breast cancer.

Because it was caught so early, a mastectomy took care of it and I'm now back at work, cancer-free."

”



Encouraging our Employees to Return to Care



Leveraging existing awareness weeks/ months

Utilizing our business campaigns

Creating an incentive program

Reminding employees to schedule and complete their annual physical exam





GET SCREENED. EARN \$100.


Earn \$100 through Rally* when you get a preventive cancer screening: breast, cervical, colon, or prostate (one screening is rewarded in 2020). Your spouse or domestic partner enrolled in a Company medical plan can earn the reward, too.

How to join Rally: Log In or register on Rally and navigate to the Rewards tab on your dashboard. Use the Rally app on your iOS or Android device to make logging in and tracking your progress even easier. [Find more details.](#)

2020 RALLY* REWARDS

Remember! You can earn up to **\$500** (plus your eligible spouse/domestic partner can earn up to **\$300**) in gift cards in 2020. Here's what you can earn:

ACTIVITY**	REWARD
Annual physical or prenatal exam	\$100
Biometric screening	\$100
Cancer screening (One per year: breast, cervical, colon, or prostate)	\$100



GET YOUR ANNUAL EXAM

One of the most important steps men can take for their health is to simply schedule an annual exam. The doctor will help determine appropriate screenings, including colorectal, lung, or prostate screenings, based on personal lifestyle and family history. Early detection of chronic conditions and cancer often leads to much better long-term health — [learn more about minimizing your risks](#). And in-network preventive care is 100% covered in all our medical plans. [Find more details.](#)

Can't get an appointment with your doctor?
Screen your biometrics at home with Rally.

2021 Live Well WEEK SCHEDULE



Take time to schedule something for your personal well-being such as your:

- Annual preventive exam
- Biometric screening
- Cancer screening
- Flu shot
- Or any other **rewardable activities**

Continued Commitment towards Action

New Campaign launched Q3 2021



MOVE YOUR HEALTH
FORWARD.➔



Direct Mailer



Flyer

“After many unsuccessful months of trying to encourage my husband to schedule his annual check-up and colorectal screening, we received the mailer and he finally made his appointment!”

The Importance of Benefit Coverage – Early and Accurate Diagnosis

Diagnosis

Remove barriers to getting screened.

Ensure **full diagnostic work up** to determine personalized treatment plan

What we implemented:

- No age restrictions for cervical, colorectal, prostate screenings & mammograms
- Breast MRI and ultrasound covered as preventive
- No charge for brand or generic colonoscopy prep kits (UHC standard is to only cover generic as preventive)
- BRCA1, BRCA2 covered at 100%
- Genomic testing coverage



Actions You Can Take as an Employer

- ❑ Work with vendor partners to obtain data on cancer screenings and overall wellness visits
- ❑ Promote importance of annual wellness exam - this directly impacts cancer screening rates
- ❑ Leverage existing awareness campaigns to convey the importance of cancer screenings
- ❑ Incent annual wellness and exam cancer screenings
- ❑ Review your coverage policy as it relates to:

Screenings

Diagnostics

Palliative
Care

Centers of
Excellence

- ❑ Ensure you provide the mental health support and time off needed for employees when they or a loved one are diagnosed with cancer



Doing now what patients need next

Blueprint for Employers to Improve Cancer Care

Educate & Engage



- Build senior leadership buy-in and support
- Provide patient advocacy within care delivery
- Engage employees, families and caregivers via ongoing, comprehensive, multi-media communications

Program Design



Provide coverage for:

- Genomic testing
- BRCA1, BRCA2 at 100%
- Cancer screenings at 100%¹
- Prostate and colorectal screenings & mammograms, regardless of age
- Breast MRI and ultrasound covered as preventive
- Palliative care
- Expert medical opinion
- Paid time off for clinical trials even if out of country and doctor appts
- Paid short-term disability
- Cryopreservation of sperm/eggs if undergoing cancer treatment

Infrastructure & Integration



- Implement robust oncology care management program
- Include COE travel and lodging accommodations
- Includes travel and lodging reimbursement for in-network clinical trials
- Connect patient/caregiver/family to emotional support
- Expand caregiver leave

Research & Development



- Participate in population studies, e.g. Athena Wisdom²
- Seek and socialize clinical trials³



Thank You





Paris Thomas

Director of Program Operations
Equal Hope



REDUCING WOMEN'S CANCER RACIAL
MORTALITY DISPARITIES:
THE CHICAGO MODEL
PARIS THOMAS, MS, MCHES

What is Structural Racism?

“The normalization and legitimization of an array of dynamics” including “historical and institutional – that routinely advantage White people while producing chronic adverse outcomes for people of color.”

Lawrence K, Keleher T “Chronic disparity: strong and pervasive evidence of racial inequalities (2004) Paper presented at Race and Public Policy Conference, Berkeley CA, Nov 11, 2004.

Chicago has significant racial outcomes disparities for every major disease

CHICAGO TRIBUNE | FRIDAY, DECEMBER 18, 2009

CHICAGOLAND PAGES 8-29



Dr. Charles Barron meets with breast cancer survivor Mary Howard, 64, in Chicago. He says access to health care contributes to the black-white health gap. "Access is definitely an issue," he says. (Andrew Heppner/Chicago Tribune)

Study: City has vast racial health gap

Chicago's disparity between blacks, whites appears to be worse than nationwide results

By Deborah L. Shults
TRIBUNE REPORTER

A widening gulf in the health status of blacks and whites in Chicago comes even as disparities between the two races nationally have remained relatively constant, a new study has found. The disparity is particularly jarring in five areas: death from all causes, heart disease mortality, breast cancer mortality, rates of tobacco use and rates of low birth weight.

Nationally the racial gap got worse from 2000 to 2005 for six of the 15 health indicators researchers studied. However, in Chicago, disparities worsened for 11 of the 15 indicators, according to research by the Smart Urban Health Institute, published online Thursday in the American Journal of Public Health.

Poverty, segregation and access to health care all appear to play a role, researchers said. In Chicago neighborhoods and medical offices, doctors and patients see the same factors.

Dr. Charles Barron, medical director at Access South-West Family Health Center, said many of his patients struggle to pay for health care.

"Access is definitely an issue, even at federally qualified health centers such as Access Community Health Network, which offers treatment on a sliding-scale basis," he said.

Tonya Jackson, 39, of North Lawndale, takes seven medications to treat heart failure. She is a patient at Mount Sinai Hospital, which is widely known for its initiatives to treat low-income and poor patients.

"Even with health insurance, a lot of medicines are very expensive," she said. "When you're a single parent, you're trying to pay rent, you have your child, and you're trying to pay bills and buy food, so it's difficult. A lot of people don't get the care they need because they have to decide whether they want to keep that dog."

Dr. Niva Lubin Johnson, an African American physician, has witnessed the disparities firsthand in her 28-year solo practice in Chatham.

"Based on what I see," she said, "we have a greater disease burden, and part of that comes from lifestyle, part of it comes from health literacy and people not understanding what they need to do to live a healthy lifestyle."

An author of the study, institute director Steve Whitman, previously has compared breast cancer disparities in Chicago and New York. He said the health of African-Americans in Chicago fares worse than blacks elsewhere.

"The underlying issue here is racism and poverty," Whitman said. "In Chicago, it's exacerbated by segregation. Black people in Chicago are forced to live in neighborhoods where there are no stores to buy fresh fruits and vegetables, where schools are failing, where they don't have parks to exercise in and where they tend to go to segregated health facilities that are poorly funded and, in different ways, failing."

Dr. George Benjamin, executive director of the American Public Health Association, cautioned about making geographic comparisons. "While it is important to

Widening gap in health

According to a new study, the health gap between blacks and whites has widened in Chicago while it has narrowed nationally. DISPARITY IN DEATHS FROM ALL CAUSES: Percentage that blacks are more likely to die than whites

Nationwide	34.9%
2005	20.7%
Chicago	35.0%
1995	41.9%

CHANGE IN GAP BETWEEN BLACKS AND WHITES

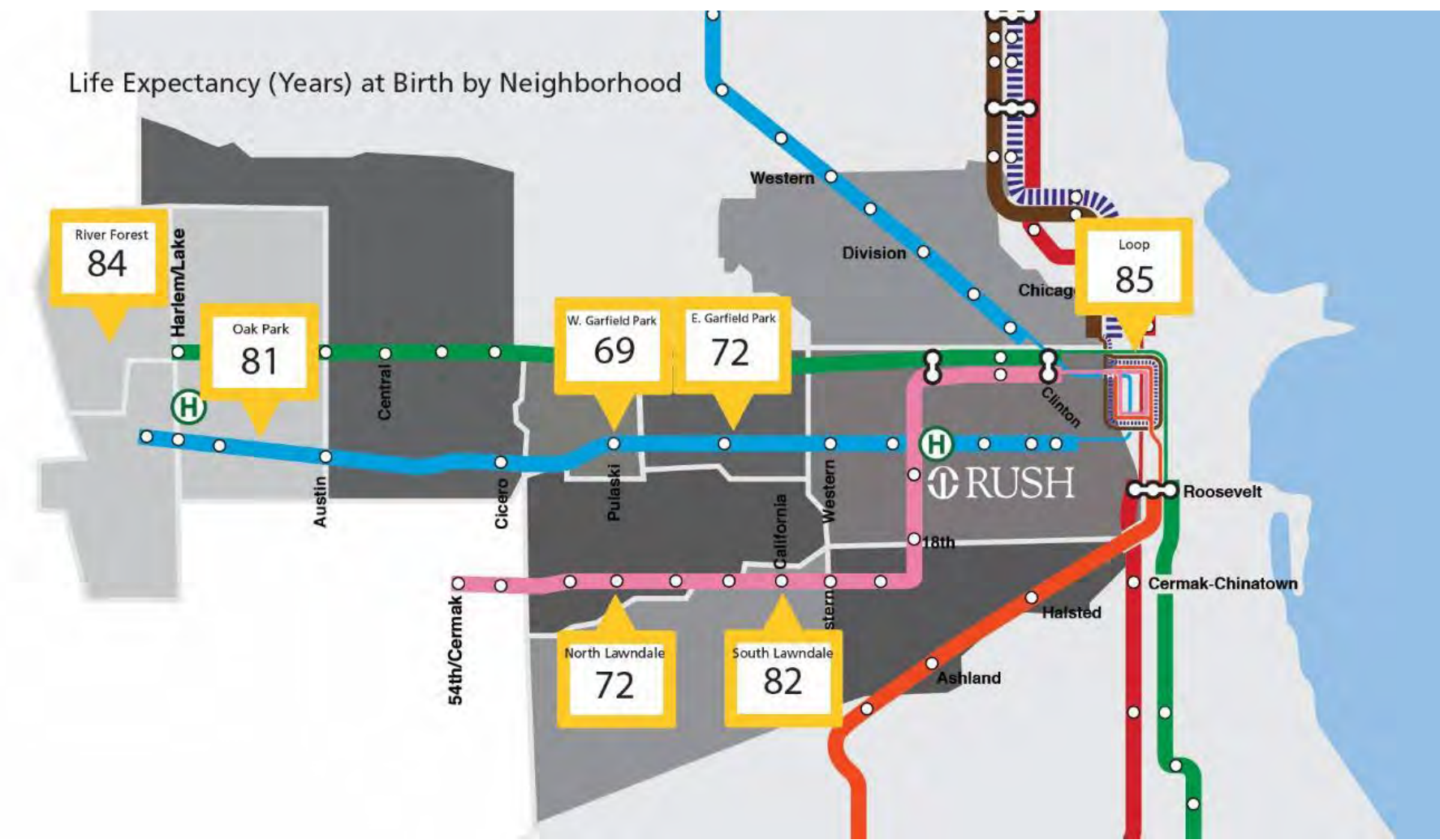
Health measure	Nationwide	Chicago
All causes of death	Narrowed	Widened
Heart disease deaths	Widened	Widened
Stroke deaths	Widened	Widened
Cancer deaths	Narrowed	Widened
Lung cancer deaths	Narrowed	Widened
Female breast cancer deaths	Widened	Widened
Diabetes deaths	Widened	Narrowed
Motor vehicle injury deaths	Narrowed	Widened
Suicide deaths	Widened	Widened
Homicide deaths	Narrowed	Widened
Infant death rate	No change	Narrowed
Low birth weight	Narrowed	Narrowed
Lack of prenatal care in the first trimester	Narrowed	Widened
New cases of tuberculosis	Widened	Widened
New cases of syphilis	Narrowed	Narrowed

SOURCE: Smart Urban Health Institute

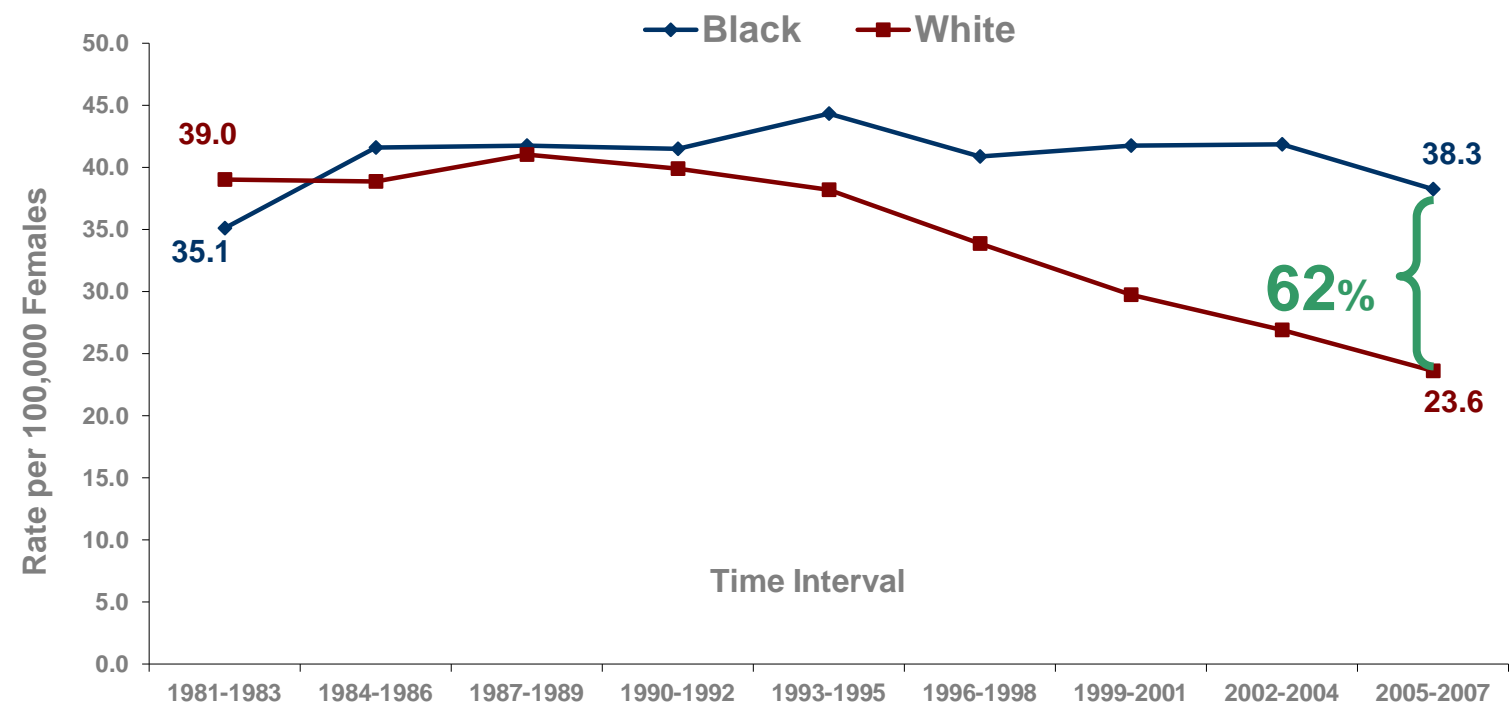
	US	Chicago
All Causes	narrowed	widened
Heart Disease	widened	widened
Stroke	widened	widened
All Cancers	narrowed	widened
Lung Cancer	narrowed	widened
Breast Cancer	widened	widened
Diabetes	widened	narrowed
Motor Vehicle	narrowed	widened
Homicide	narrowed	widened
Infant Death	no change	narrowed
Low Birthweight	narrowed	narrowed
No Prenatal Care	narrowed	widened

Chicago Tribune 2009

Average Life Expectancy on Chicago's Westside



When We Started: Black and White Breast Cancer Mortality Chicago 1981-2007



Age-Adjusted Female Breast Cancer Mortality for Chicago, Per 100,000 Population
Sinai Urban Health Institute, 2010

Equal Hope's Model

THE EQUAL HOPE MODEL

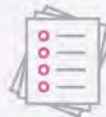
Reducing Disparities in Women's Health Care

Equal Hope, formerly the Metropolitan Chicago Breast Cancer Task Force, has created a successful evidence-based model for understanding and reducing disparities in the diagnosis and treatment of breast cancer. The model described below can be used as Equal Hope expands its focus to more holistically help uninsured, underinsured, and publicly insured women gain access to higher quality care for cervical cancer, other cancers and even other diseases. This model has been cited by major medical journals as an effective way to address inequities in the healthcare system.



STEP I Landscape Analysis

Rigorously assess the healthcare system for a specific health disparity. Map out where people go for service (i.e. capacity surveys), and for resources such as equipment, specialists, and Centers of Excellence and look at how this matches or often doesn't match where people of color and people with less income live.



STEP II Develop a Quality Scorecard / Consumer Report

Identify what constitutes the highest quality care that gets a person the best chance of survival with the fewest side effects. Collect quality data. Create an easily read and understood scoring report so that healthcare providers and facilities can see how they are doing and where they can improve.



STEP III Create a Big Tent

Sign up all the healthcare providers/facilities to share quality data confidentially – everybody in and nobody out.



STEP IV Assess how the Healthcare System Works in Real Life

Assess how the healthcare system works for or fails people with an illness. What are the touch points for a patient going through the system? What are the barriers? What helps patients get what they need?



STEP V Listen and Learn from Patients

Listen to patients and the stories they tell about their experience with the healthcare system.



STEP VI Design Evidence-based Interventions

Only after looking at all the data and understanding the experience of patients, targeted interventions can be created, tested and evaluated. Interventions might include patient outreach, education and navigation, and education of health care providers. To ensure long-lasting systemic change, policy advocacy may also be needed.

Quality Measurement And Improvement



Through Equal Care, we looked at disparity by:

- Mapping Resources
- Measuring Quality
 - Mammography
 - Treatment
- Looking at care practices

Unequal Distribution of Resources

Chicago Community Areas with the Highest 2000-2005
Average Annual Breast Cancer Mortality Rates

- 
- The map displays Chicago's community areas, with a color gradient from light green to dark green representing increasing breast cancer mortality rates. A horizontal black line is drawn across the map. Black triangles indicate the locations of hospitals with American College of Surgeons approved cancer programs. The legend identifies three categories: Predominately African American Communities (light green), Non-African American Community Areas (blue), and Hospitals with American College of Surgeons Approved Cancer Programs (black triangle).
-  Predominately African American Communities
 -  Non-African American Community Areas.
 -  Hospitals with American College of Surgeons Approved Cancer Programs

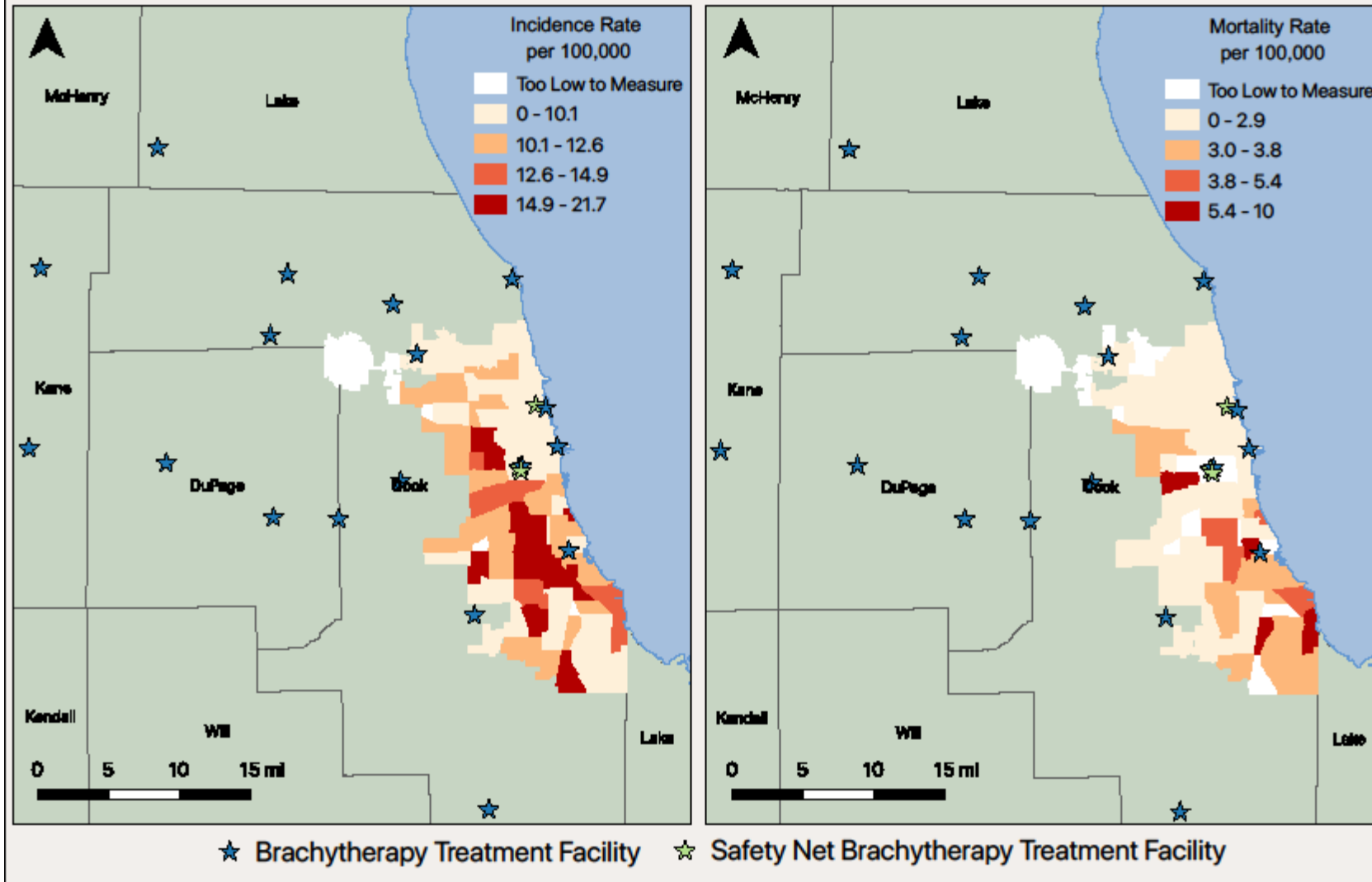
Money and Power: Healthcare and Environmental Equity

In Chicago, your chance of living beside an Imaging Center of Excellence is:

- ▶ almost 40% if you are affluent
- ▶ only 1% if you are poor



Cervical Cancer Rates & Treatment Locations in the Chicago Region



Our Central Hypothesis:

Unequal access to high quality healthcare and structural racism is a significant driver in overall health care disparities including breast and cervical cancer mortality disparities in Chicago.

The healthcare system fails women of color and poor women.

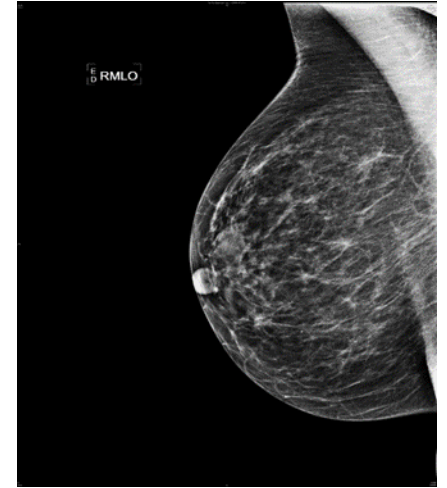
What we did to address this:

- Created a **non-denominational** not for profit
- Established the nation's first federally designated Patient Safety Organization dedicated exclusively to breast cancer disparities
- Persuaded nearly all providers to participate – big tent
- Started with research and quality measurement **not** interventions
- Collected mammography and treatment quality data first across Chicago and later the mammography data was collected across Illinois

Conclusion: There are substantial differences in the quality of mammography and many women of color and publicly insured women receive poor quality mammography and fragmented care for diagnostics and treatment

Not all Mammograms are Created Equal!

- 39% increase in potential miss risk for minority vs white patients
- 58% increase in potential miss risk for those with incomes less than \$30k
- 41% increase in potential miss risk for those with less than high school education
- 63% increase in potential miss risk for those with no insurance or public insurance

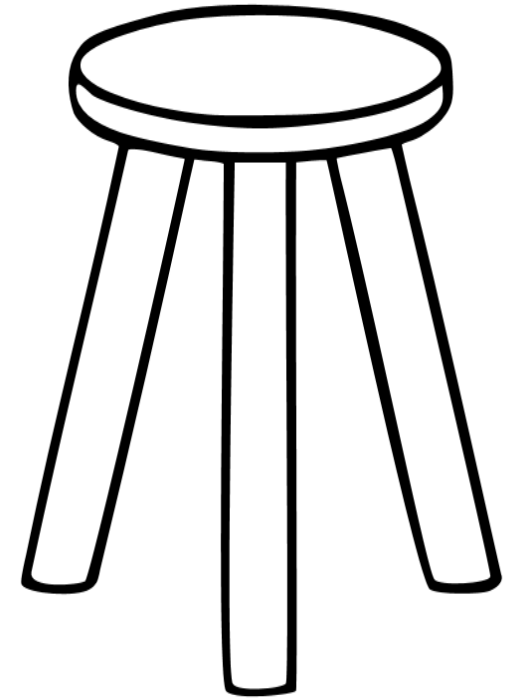


Conclusion: Quality of mammography varies significantly, and some individuals access less effective mammography.

Our Unique Approach

We developed a model that addresses health disparity on multiple levels – personal, community, locally and regionally through:

- Quality Measurement And Improvement
- Advocating for Change
- Education and Patient Navigation



Advocating for Change

We successfully advocated for permanent health system change and resources for women of color and low-income women, including:

- Public Law 95-1045 enacted in 2009 – Breast Cancer Disparities Reduction Act
- Public Law 97-638 enacted in 2012 to improve upon the prior bill
- Public Law 99-433 enacted in 2015 – the Best ACT (Breast Cancer Excellence in Screening And Treatment Act)
- Increased funding for the Illinois Breast and Cervical Cancer Program by over \$15 million over the last 5 years

Specialized Navigation Programs



Education and Patient Navigation

Each year, we work in the community to make sure women know their risk for cancer and how to access the best care.

Reach over 60,000
women a year



Educate over 12,000
in community settings



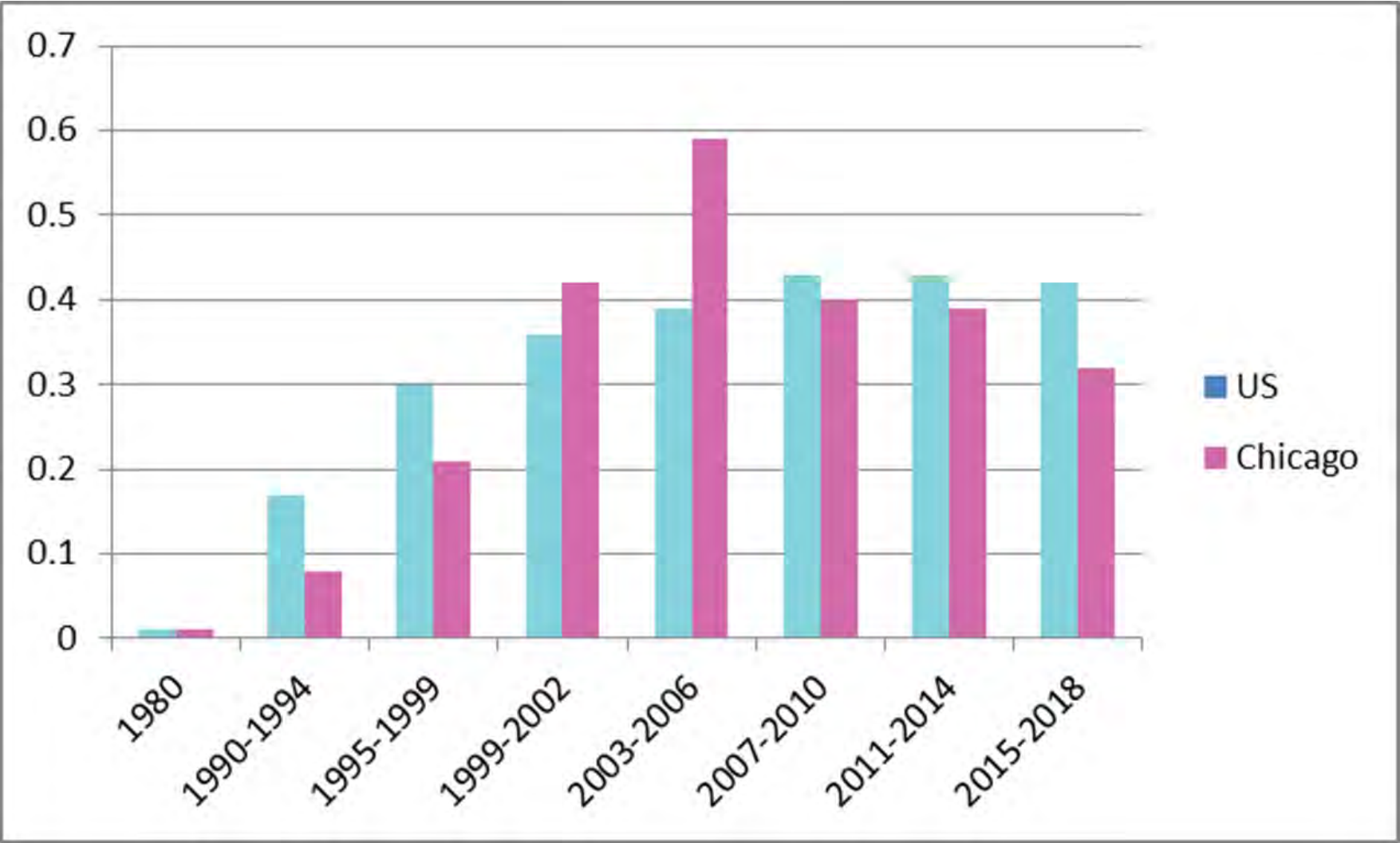
Navigate 1200+ women
to high quality care



Employer Awareness Messages

- Educate employees on risk factors and support healthy decisions.
- Encourage employees to get HPV vaccine and vaccinate their children (if eligible).
- Women should get their cervical screenings every year starting at age 21.
- An annual mammogram is the best screening tool for women 40 years and older.
- The earlier breast cancer can be detected, the better it can be treated.
- When diagnosed early.....95% survival rate!
- Maintain good health and establish care with a primary care provider.
- Don't be afraid. Follow up!

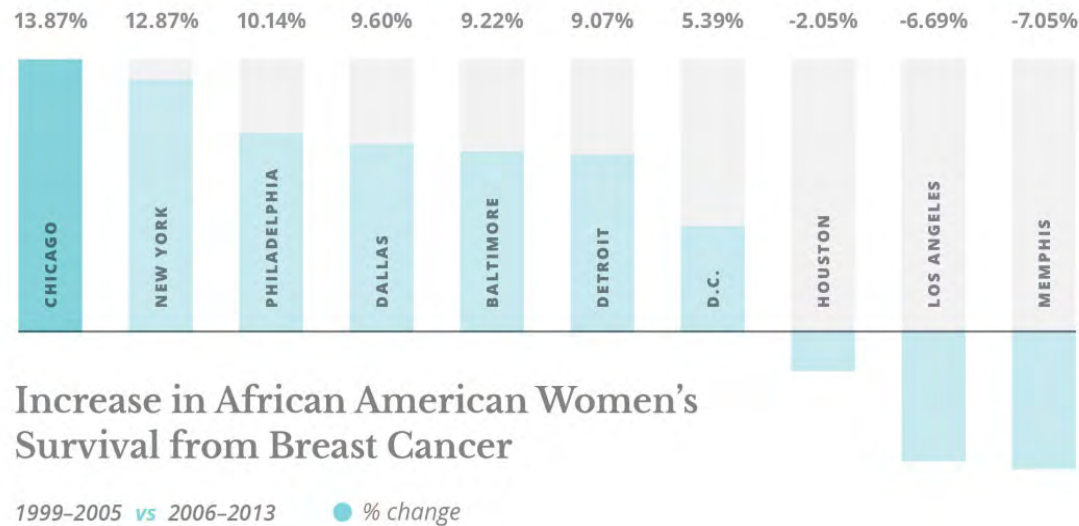
Chicago and US Black/White Breast Cancer Mortality Disparity





Our 2017 research shows that
our approach is working:

Chicago is #1 in the nation
for improving breast cancer
survival for African American
Women



Sighoko et al, 2017 Cancer causes and Control



Because everyone deserves equal hope of access to quality healthcare;

Everyone facing a serious illness should have equal hope of early diagnosis, quality treatment, and recovery; and

Everyone should have equal hope that we can eliminate inequities in health care for every member of our community.

Call us at 312-942-3368



Visit us at www.equalhope.org



See us at 300 S. Ashland Ave., Suite 202 Chicago, IL 60607



Questions?





*a word from
our sponsor*

eden
health

Let's give out some prizes!



Hinge Health

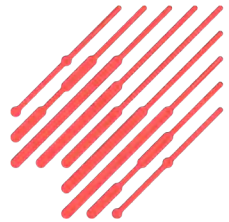
Apple AirPods Pro



inspera health

Healthy employees. Healthy business.

Fitbit Tracker



SWORD HEALTH

\$125 Gift Card to Royal Palms
Shuffleboard Club



Apple Watch SE



Back to Basics!

Driving Preventive Care Utilization

Thanks for attending!

Reminder!

Please complete the
program evaluation
following today's program



Midwest Business Group on Health