

**Professional Associations and  
Activities to Promote Breast,  
Cervical, and Colorectal Cancer  
Screening in Massachusetts**

February 1, 2012

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## EXECUTIVE SUMMARY

The Massachusetts Department of Public Health (MDPH) has commissioned a set of studies to investigate the potential to increase state cancer screening rates in Massachusetts through various spheres of influence, including professional associations, employers, and health plans. Mathematica Policy Research conducted the study that focused on professional associations as the sphere of influence and their role in affecting state screening rates for three types of cancer: breast, cervical, and colorectal. The goals of the study were to understand the current and future roles and activities of professional associations related to cancer screening and to determine ways in which MDPH can collaborate with these associations to increase screening rates. From August to October 2011, we interviewed representatives from 15 professional associations in Massachusetts.

**Association Characteristics.** The professional associations included in the study varied in structure, affiliation, and specialty areas. Of the 15 associations, 13 are state or regional affiliates of national professional associations. Ten professional associations served specific provider groups, including physicians, obstetricians, gynecologists, family physicians, gastroenterologists, geriatricians, emergency physicians, public health nurses, oncology nurses, nurse practitioners, and community health centers. Two associations—the Massachusetts Medical Society and the Massachusetts Public Health Association—targeted the broader medical and public health professions. Another two associations—the American Cancer Society and the Commission on Cancer—targeted cancer prevention and treatment. The final association focused on rural health access issues.

**Association Activities.** Professional associations have engaged in policy and advocacy, systems, education/research, communication, and/or partnership activities. In general, the intervention areas, and the types of specific activities within each of the intervention areas, are driven by the professional association’s mission, priorities, and capacity to act within the current policy landscape. Also affecting their level of engagement in such activities is the complex political and organizational environment in which they operate, including significant changes driven by state and federal health care reforms, shifting budgetary priorities, and screening research advances.

Of the 15 associations we interviewed, 13 participate in activities that directly or indirectly promote screening for breast (12 associations), cervical (10 associations), or colorectal (13 associations) cancer as part of larger health care agendas. Although most (10) of the associations interviewed have engaged in activities to prevent all three types of cancers, only 2 work specifically on cancer or cancer care as their primary focus. Most of the other associations promote cancer screening as an extension of their broader goals. Most associations were engaged in communications (13 associations), policy and systems (12 associations), or education and research (10 associations) activities. Finally, although only 4 associations had worked with MDPH in the past on cancer screening, almost all (13 associations) were willing to participate in future cancer screening activities; 12 stated specifically that they would be willing to collaborate with MDPH on such activities.

- **Policy Advocacy Activities.** Associations’ policy and advocacy activities to increase cancer screening rates are related to support of insurance coverage expansions for such services. Eleven associations have participated in efforts to change state and federal legislation, as well as to work with insurance companies to improve payment for cancer screening services in several areas, including the Patient Protection and Affordable Care Act, payment reform, provider reimbursement and practice issues, and MDPH advocacy.

- **Systems Activities.** By working with large systems, associations can reach across constituencies that have the ability to affect cancer screening. Five of the associations in our study have engaged in work to promote cancer screening with these types of systems, often helping the systems to implement cancer screening and outreach programs. These activities include working with hospitals, clinics, and employers, as well as activities to increase the use of technology to identify patients who need cancer screenings, such as cancer registries and electronic health records.
- **Education and Research Activities.** Provider referrals for cancer screenings are one of the most powerful ways to ensure that people get screened. Because associations are seen as sources of expert information and as conveners of clinicians, they are an important avenue for influencing provider behaviors. Specifically, associations can affect provider behaviors through member education and clinical guideline development. Overall, 10 of the interviewed associations engage in these types of activities in relation to cancer screening.
- **Communications Activities.** Professional associations communicate about issues concerning cancer screening with their members, the broader clinical community, targeted patient groups, and the general public. Communications with providers can increase cancer screening referral rates; communications with the public can increase community awareness and support for cancer screening. Overall, 13 of the interviewed associations engage in communications activities to increase the rate of cancer screening. Avenues of communications used by associations include websites; emails, telephone calls, or letters to members; publications (for example newsletters, journal articles, or policy papers); and media outlets (for example, newspapers or television programs).
- **Partnerships.** Synergies can be developed to increase cancer screening rates in the commonwealth through a partnership between MDPH and professional associations. Although 10 of the professional associations we interviewed had experience working with MDPH on many different health issues, relatively few (4) have worked specifically with MDPH to promote cancer screening through either direct service or policy change.

**Recommendations.** To address ongoing barriers to cancer screening in the Commonwealth, the professional associations recommended the following key strategies for collaboration with MDPH and other stakeholders: (1) make screening more convenient for patients; (2) address insurance and cost issues; (3) support the use of innovative technologies; (4) consider promoting alternative screening methods to colonoscopies; (5) develop materials to help physicians adjust to new payment incentives for cancer screening services; (6) conduct outreach to clinicians to promote cancer screening; and (7) support broad-based public education and outreach activities to promote cancer screening.

In conclusion, despite varying levels of interest and engagement in cancer screening among associations, almost all associations indicated a willingness to collaborate with MDPH on cancer screening in the future. MDPH's unique ability to act as a leader in providing guidance could be pivotal in activating and coordinating these professional associations' engagement in cancer screening.



## I. INTRODUCTION

The Massachusetts Department of Public Health (MDPH) has commissioned a set of studies to investigate the potential to increase state cancer screening rates in Massachusetts through various spheres of influence, including professional associations, employers, and health plans. Mathematica Policy Research conducted the study that focused on professional associations as the sphere of influence and their role in affecting state screening rates for three types of cancer: breast, cervical, and colorectal. The goals of the study were to understand the current and future roles and activities of professional associations related to cancer screening and to determine ways in which MDPH can collaborate with these associations to increase screening rates.

The spheres of influence can be seen as aligning to various levels of the socioecological model (Centers for Disease Control and Prevention [CDC] 2011a). Figure II.1 provides a conceptual framework for the study showing where each sphere of influence fits within the levels of the socioecologic model shown as the “Inputs.” Each of these inputs (or spheres of influence), alone or collectively, can contribute to interventions to increase cancer screening rates. The interventions that the inputs support lead to short-term outcomes that, in turn, lead to longer-term outcomes related to cancer screening. Because our study focused on professional associations, included in the “Organization” sphere of influence, this report concentrates on the interventions and results shown in the conceptual framework that relate to professional associations’ activities.

This report begins with background information on cancer and screening rates in Massachusetts. Next, it presents the methods used to collect data and synthesize data collected from interviews with the professional associations about their screening-related activities and interest in working on the issue with MDPH. We then discuss professional associations’ perceptions of the current screening environment in the state and describe their activities in the four intervention areas depicted in Figure II.1: (1) policy and advocacy, (2) systems, (3) education/research and communications, and (4) partnerships. For the report, we have separated education/research and communications into different intervention areas. The report ends with a summary of recommendations and justifications made by the professional associations regarding potential interventions to increase cancer screening rates and a discussion of the roles of professional associations and MDPH in implementing these interventions.

## II. BACKGROUND

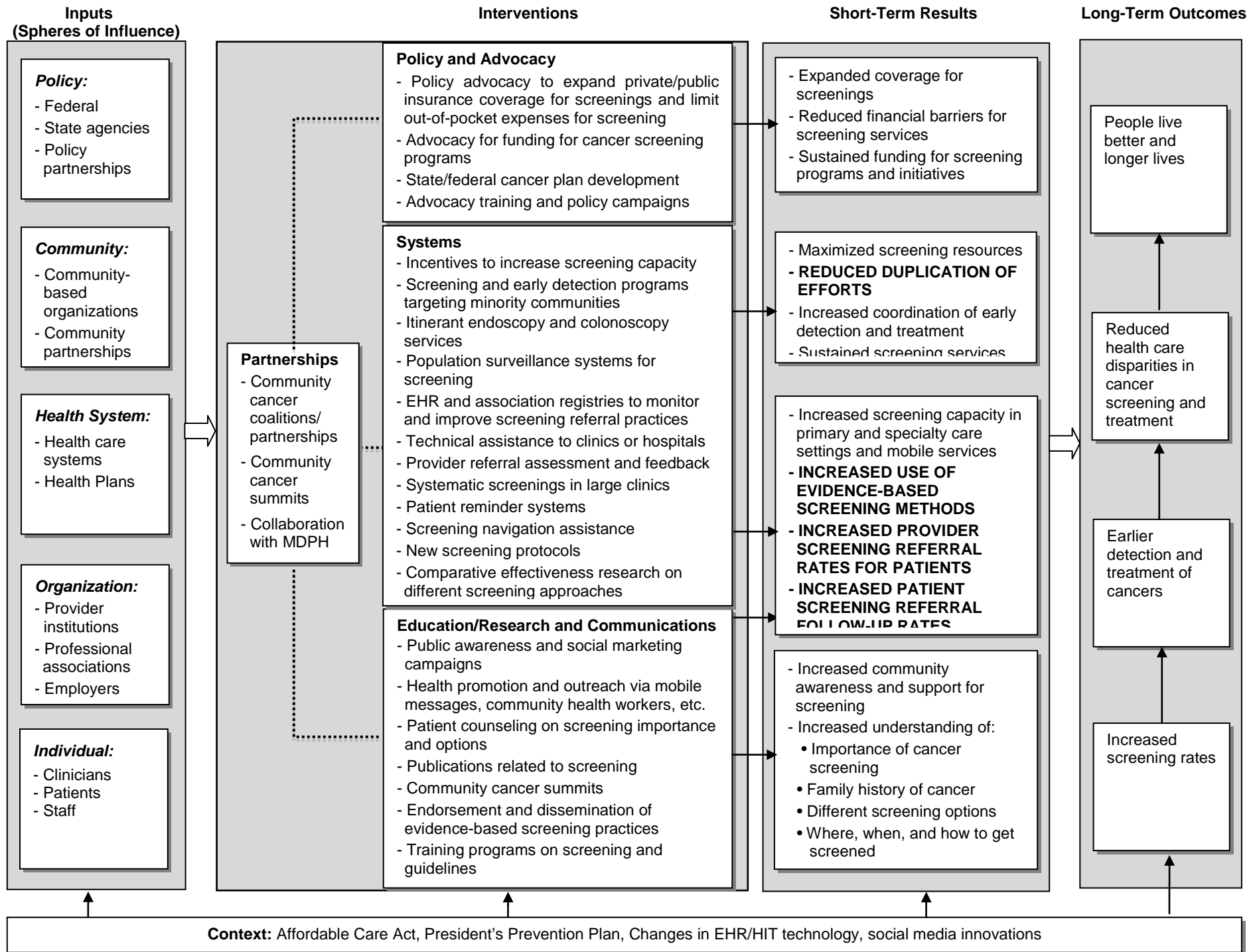
Breast, cervical, and colorectal cancers are among the most common cancers in the state, and screening for these cancers is a standard part of preventive care. Breast cancer is the most common cancer diagnosed among women in the state, accounting for 29 percent of all cancers among women, with an average annual incidence rate of 132.1 per 100,000 (Massachusetts Department of Public Health 2011a). Colorectal cancer is the third most common cancer diagnosed among both men and women in the state, with an average annual incidence rate of 60.7 per 100,000 among men and 44.1 per 100,000 among women (Massachusetts Department of Public Health 2011a). Cervical cancer is less common, with an average annual incidence rate of 5.9 per 100,000 women. However, it is one of the most preventable and treatable cancers if detected early.

Screening rates also vary among the three kinds of cancer. In 2010, 87 percent of women reported having a clinical breast exam in the past two years, and 84 percent reported having a mammogram in the past two years for breast cancer, while 84 percent of women reported having a Pap smear test in the past three years for cervical cancer. For colorectal cancer, in 2010, 63 percent of Massachusetts adults (50 and over) reported having a colonoscopy or sigmoidoscopy in the past five years, and 18 percent reported having a Fecal Occult Blood Test in the past two years (Massachusetts Department of Public Health 2011b).

Although Massachusetts ranks among the states with the highest cancer screening rates in the country (CDC 2011b), screening is not yet universal. To further increase cancer screening rates, MDPH's Comprehensive Cancer Prevention and Control Program has provided free cancer screening services through the Women's Health Network; the Men's Health Partnership has been active in conducting activities to promote digital rectal exams and Prostate-Specific Antigen tests when appropriate. Funding for these programs has been significantly cut in recent years, coinciding with the enactment of Massachusetts' health care reform in 2006. Health care reform in the Commonwealth has resulted in an increase in the percentage of state residents with health insurance coverage for cancer screening, thereby reducing the need for such direct screening programs. A recent survey indicated that only 2.7 percent of state residents did not have health insurance in 2009 (Massachusetts Division of Health Care Finance and Policy 2009). However, cancer screening rates remain well below the percentage of the population with health insurance, indicating that other screening barriers (such as knowledge, awareness, behavior, health care delivery practices, and health system infrastructure) need to be addressed to raise the state's cancer screening rates.

Professional associations can play an important role in improving health care delivery and infrastructure. For example, in a lecture given to the Massachusetts Medical Society, published in the *New England Journal of Medicine*, Claude L'Enfant argued that for professional associations "developing and publishing practice guidelines is an extremely valuable first step" but that professional organizations' efforts to ensure that their recommendations are followed by clinicians are even more important (L'Enfant 2003). Associations can influence rates, because many association members are leaders in their health care organizations and recognized experts in their field, involved in developing and publishing specific cancer screening guidelines. Associations also have direct access to large networks of providers and can provide information to, and organize, members and partners around cancer screening issues. In addition, associations can serve as a communications conduit of screening information to the general public through many channels, including websites, newsletters, press releases, and other media. Finally, many professional associations have collaborated with MDPH before on other public health issues, and these relationships can be readily extended to working with MDPH on cancer screening issues.

Figure II.1. Spheres of Influence Conceptual Model



### III. METHODS

For this study, we interviewed representatives from 15 health care–related professional associations operating in the state. In consultation with MDPH, we initially identified 13 organizations in the state; many of these associations were state affiliates of national professional associations. To avoid duplication of effort and reduce burden on associations, three of these organizations were subsequently excluded because they were already being interviewed by other organizations conducting a study for MDPH about cancer screening activities. The remaining 10 professional associations were included in the study. During our interviews, we asked respondents to provide the names of other professional associations. Through that process, we identified an additional five organizations for inclusion in the study.

Before conducting the interviews, we gathered background information on each organization, using information from the association’s website. We developed a profile for each association, including its name, website, key characteristics, and past and current cancer screening activities (Appendix A). We then contacted each association’s executive leader (either the chief executive officer or the president) to schedule and conduct the interviews. In smaller organizations, the president or chief executive officer was knowledgeable about the association’s cancer screening activities. In some larger associations, these functions were assigned to middle-level managers who knew more about the details of their association’s activities related to cancer screening. Where appropriate, we interviewed those middle managers in addition to the executive director, to gain a complete picture of the organization’s activities.

From August to October 2011, we completed 22 interviews. In most cases, the representative of the state affiliate organization was interviewed. However, when there was no state organization that represented a particular medical profession (such as gastroenterologists), a representative of the national association was interviewed. Interviews ranged from half an hour to slightly over one hour and followed a semistructured interview protocol (Appendix B). All interviews were recorded with a digital recorder. Notes from all interviews were loaded into Atlas.ti version 5.0.67 qualitative data analysis software. A coding scheme was developed that included 62 codes (Appendix C). The interview notes were coded by a research assistant, and a research analyst reviewed the coding. Finally, the coded notes were used to develop summary tables and this report.

## IV. RESULTS

### A. Professional Association Characteristics

In this study, we interviewed a wide range of professional associations. Of the 15 associations, 13 are state or regional affiliates of national professional associations. Ten (two-thirds) of the professional associations served specific provider groups, including physicians, obstetricians, gynecologists, family physicians, gastroenterologists, geriatricians, emergency physicians, public health nurses, oncology nurses, nurse practitioners, and community health centers. Two associations—the Massachusetts Medical Society and the Massachusetts Public Health Association—targeted the broader medical and public health professions. Another two associations—the American Cancer Society and the Commission on Cancer—targeted cancer prevention and treatment. The final association focused on rural health access issues.

Of the 15 associations we interviewed, 13 participate in activities that directly or indirectly promote screening for breast (12 associations), cervical (10 associations), or colorectal (13 associations) cancer as part of larger health care agendas (Table IV.1). Although most (10) of the associations interviewed have engaged in activities to prevent all three types of cancers, only 2 work specifically on cancer or cancer care as their primary focus. Most of the other professional associations promote cancer screening as an extension of their broader goals.

Within the intervention areas of the conceptual framework, most associations were engaged in communications (13 associations), policy and systems (12 associations), or education and research (10 associations) activities. Finally, although only 4 associations had worked with MDPH in the past on cancer screening, almost all (13 associations) were willing to participate in future cancer screening activities; 12 stated specifically that they would be willing to collaborate with MDPH on such activities.

The study also explored whether there were differences in the attributes of the professional associations that influenced their level of engagement in cancer screening or that might limit their capacity to work on cancer screening in the future. The analysis of the interview data revealed no major differences among the associations except in their size, both in the number of members served and in the number of paid staff. The national associations, covering all 50 states, typically had much larger memberships than their state affiliates and were staffed by paid professionals; the state and regional associations were largely operated by volunteers, with a very limited number of paid staff. For example, the Massachusetts Coalition of Nurse Practitioners was run completely by volunteers, but the national Oncology Nursing Society had roughly 130 paid staff.

We also examined whether the state affiliate associations could act autonomously from national organizations and could engage independently with MDPH, or functioned as branch offices of national organizations with the national organization controlling state-level activities. The results of this investigation varied, with state affiliates having varying degrees of independence from their national associations. For example, the Massachusetts Medical Society and the Massachusetts Public Health Association act largely independently of the national associations with which they are affiliated. In contrast, the Massachusetts Academy of Family Physicians and the local affiliate of the American Congress of Obstetricians and Gynecologists function as local arms of their national associations, with less state-level activity. However, nearly all state affiliates have their own activities to some degree and rely on national associations for expertise, guidance, or educational materials.

**Table IV.1. Summary of Professional Association Characteristics**

Professional Association Name	Screening Activities by Cancer Type			Screening Activities by Activity Type						
	Breast	Cervical	Colorectal	Policy and Advocacy	Systems	Communications	Education and Research	Previous Work with MDPH on Cancer Screening	Open to Future Cancer Screening Work	
<b>State Associations</b>										
American College of Physicians, MA Chapter	✓	✓	✓	✓	✓	✓	✓		✓	
American Congress of Obstetricians and Gynecologists – District I <sup>a</sup>	✓	✓	✓	✓		✓	✓		✓	
Commission on Cancer of the American College of Surgeons – MA	✓	✓	✓		✓	✓	✓	✓	✓	
Massachusetts Academy of Family Physicians <sup>b</sup>	✓	✓	✓	✓		✓	✓		✓	
Massachusetts Association of Public Health Nurses <sup>c</sup>	✓	✓	✓			✓	✓		✓	
Massachusetts Coalition of Nurse Practitioners <sup>d</sup>	✓		✓	✓		✓	✓		✓	
Massachusetts College of Emergency Physicians <sup>e</sup>										
Massachusetts Geriatrics Society <sup>f</sup>	✓		✓	✓		✓			*	
Massachusetts League of Community Health Centers <sup>g</sup>	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Massachusetts Medical Society <sup>h</sup>	✓	✓	✓	✓		✓			✓	
Massachusetts Public Health Association <sup>i</sup>	✓	✓	✓	✓		✓			✓	
<b>Regional Associations</b>										
American Cancer Society – New England Division <sup>j</sup>	✓	✓	✓	✓	✓	✓	✓	✓	✓	
New England Rural Health RoundTable <sup>k</sup>									✓	
<b>National Associations</b>										
American Gastroenterological Association			✓	✓	✓	✓	✓	✓	✓	
Oncology Nursing Society	✓	✓	✓	✓		✓	✓		✓	

Source: Association interviews and websites.

Note: Check marks for local associations may indicate activities of either local affiliates or their national associations.

<sup>a</sup> local affiliate of the American Congress of Obstetricians and Gynecologists.

<sup>b</sup> local affiliate of the American Academy of Family Physicians.

<sup>c</sup> local affiliate of the American Association of Public Health Nurses.

<sup>d</sup> local affiliate of the American Academy of Nurse Practitioners.

<sup>e</sup> local affiliate of the American College of Emergency Physicians.

<sup>f</sup> local affiliate of the American Geriatrics Society.

<sup>g</sup> local affiliate of the National Association of Community Health Centers.

<sup>h</sup> local affiliate of the American Medical Association.

<sup>i</sup> local affiliate of the American Public Health Association.

<sup>j</sup> local affiliate of the American Cancer Society.

<sup>k</sup> local affiliate of the National Rural Health Association.

\* We interviewed the current president of the Massachusetts Geriatrics Society, but he indicated that he has not been active in the association since he became president of the American College of Physicians – American Society of Internal Medicine. Therefore, we are unsure if the Massachusetts Geriatrics Society would be open to working on cancer screening issues in the future.

## **B. Perceptions of Current Cancer Screening Landscape**

Professional associations in Massachusetts operate in a complex political and organizational environment that is undergoing significant change due to state and federal health care reforms, shifting budgetary priorities, and screening research advances. This section presents perspectives of the interviewed professional association representatives on the unique context in Massachusetts for cancer screening.

State health care reform legislation, enacted in 2006, sets Massachusetts apart from other states. This legislation has increased the number of people insured by requiring that all state residents have insurance. However, further reform is needed to address the increased demand for health care services and ensure adequate quality services for everyone. Over the past year, several professional associations have worked intensively with the governor, legislators, and others to develop and implement payment reforms to change provider reimbursement structures for cancer screening and other preventive care and reduce patients' out-of-pocket expenses for these services.

During the period when health care reform was enacted, federal and state budgets for cancer screening and other prevention services were cut significantly, including program funding for direct screening services to underserved populations. As a result, the safety net of free or reduced-cost services, including screenings, is no longer available. These circumstances place increased burden and responsibility on health plans, hospitals, and providers, to fill the gap through community outreach and self-initiated screening programs. Several professional associations indicated that they have sought guidance from MDPH about such gap-filling activities.

To further complicate the environment under which cancer screening occurs at the practice level, several professional associations indicated that multiple, conflicting cancer screening guidelines exist. Developed by federal authorities and individual professional associations, differing guidelines create confusion for individual clinicians and patients. Specifically, guidelines differ regarding the age group for which screening is a priority, the recommended frequency of screening within various age brackets, and the tests that are considered appropriate for screening. In response to conflicting guidelines, some professional associations avoid endorsing any one set of guidelines and recommend that patients consult with their physicians about family history of cancer and individual health risks.

Professional associations discussed their activities related to cancer screening within this context. The activities are described in the following section.

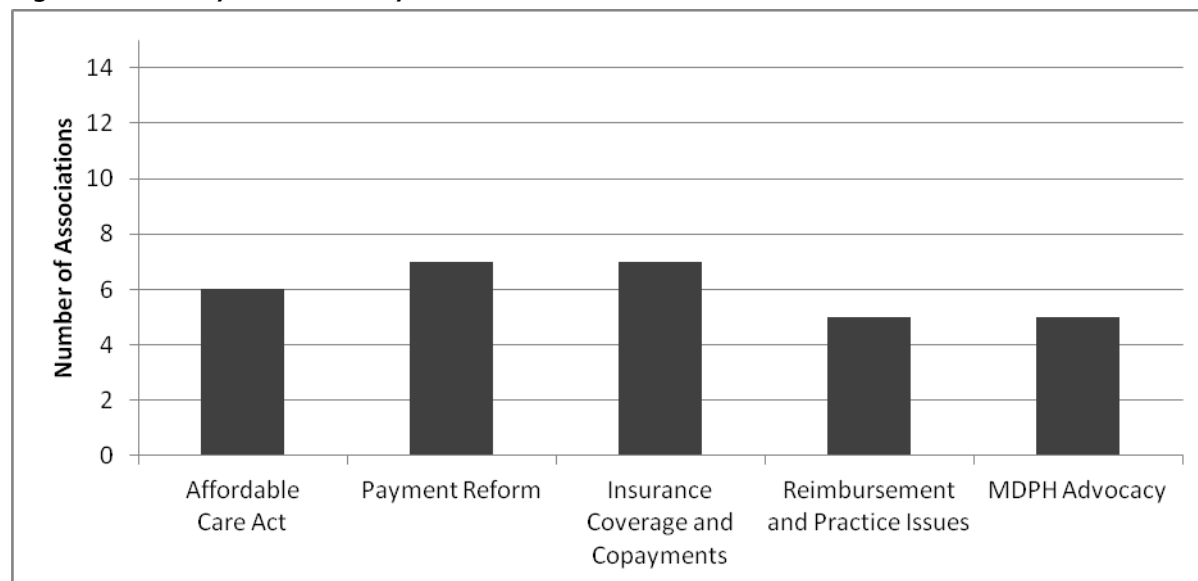
## **C. Engagement in Cancer Screening**

As Figure II.1 shows, the types of interventions professional associations can support and implement to increase cancer screening rates in Massachusetts vary. Working alone or in partnership with MDPH and other organizations, professional associations can engage in policy and advocacy, systems, education/research, communication, and/or partnership activities. In general, the intervention areas, and the types of specific activities within each of the intervention areas, are driven by the professional association's mission, priorities, and capacity. The following subsections describe the current engagement in cancer screening of the professional associations interviewed within each of the five main intervention areas.

## 1. Policy and Advocacy Activities

Associations' policy and advocacy activities to increase cancer screening rates are related to support of insurance coverage expansions for such services. Eleven associations have participated in efforts to change state and federal legislation, as well as to work with insurance companies to improve payment for cancer screening services (Table IV.1). We categorized the policy and advocacy efforts of associations into the following general areas: the Patient Protection and Affordable Care Act (ACA), payment reform, provider reimbursement and practice issues, and the MDPH advocacy (Figure IV.1).

**Figure IV.1. Policy and Advocacy Activities**



**Affordable Care Act.** The Affordable Care Act (ACA) requires new state health benefit exchange insurance plans to cover cancer screenings. In addition, the legislation will alter provider payment incentives in ways that can affect cancer screening rates. For example, one respondent noted that the ACA will likely shift payments from fee-for-service payments to accountable care organizations, a payment and delivery reform model that ties provider reimbursements to quality metrics. Such a shift could force physicians to ensure that their patients are screened appropriately. Six of the associations we interviewed have participated in ACA-related advocacy. Two respondents stated that their national associations were involved in the drafting of the legislation; one of these associations was involved in developing the bill's cancer screening provisions.

**Payment Reform.** Massachusetts policymakers are currently working on health care payment reform legislation to affect provider reimbursement for cancer screening services. Respondents indicated that inadequate reimbursement for these services could result in a reduced willingness by clinicians to provide the services, thereby reducing cancer screening capacity in the state. Seven respondents stated that their associations have worked on state payment reform, but only two respondents discussed payment reform advocacy activities that directly relate to cancer screening. These latter two associations worked with the state legislature's prevention caucus to ensure that any global payments to clinicians made under payment reform would include adequate funding for preventive services, including cancer screening. One of the associations also advocates for a prevention trust that would be funded by a tax on health care payments. The trust would be used to



cover community-based primary prevention services, but it is unclear whether it would include cancer screening services.

**Insurance Coverage and Copayments.** Although most Massachusetts residents have health insurance, some insurance plans do not cover all cancer screening services, or they include high copayments for these services. Seven associations have engaged in advocacy-related efforts to increase coverage for cancer screenings and reduce out-of-pocket costs for these services. Six have worked to ensure that health plans cover preventive services, and five of these have worked to ensure that cancer screening is included as a covered preventive service. Four associations have advocated for health insurance plans to cover cancer screening with no copayments. One association has proposed legislation mandating that insurers cover colorectal cancer screening in Massachusetts. The legislation would mandate more comprehensive coverage for colorectal cancer screening than the ACA by (1) eliminating the ability of health plans to avoid this mandate if they were grandfathered in; (2) including provisions for coverage of earlier screening for people at high risk for colorectal cancer; and (3) including coverage for additional types of colorectal cancer screening, such as virtual colonoscopy.

Two associations have identified as an issue, and worked to cover, removal of polyps discovered during colonoscopies, or polypectomies. In the past, the removal of polyps detected during screening colonoscopies was not covered by some insurance plans and patients paid out of pocket for these procedures. The two associations worked on this issue through different means; one lobbied legislators to mandate coverage for polypectomies in these instances and the other worked directly with health plans in the state to adjust billing codes. Another association made providers and hospitals aware that patients were being charged approximately \$200 for colonoscopies when they did not already have a positive stool test. This awareness effort encouraged doctors to advocate against this charge.

**Reimbursement and Practice Issues.** Adequate reimbursement and reduced paperwork encourage clinicians to provide cancer screening services to patients. Five associations advocated for better reimbursement rates or simplification of practice issues related to cancer screening, such as reducing the amount of paperwork associated with patient care. One respondent indicated that further cuts to Medicaid reimbursement rates for cancer screening could lead some providers to stop accepting Medicaid patients and reduce access to cancer screening among vulnerable populations.

**MDPH Advocacy.** In 2011, the governor proposed eliminating the Health Promotion Disease Prevention line item in the state budget, which includes funding for breast, cervical, and colorectal cancer screening programs. These programs provide free cancer screenings to people who might not otherwise be able to afford them. Three associations have advocated for funding for such MDPH cancer screening programs. One association developed an ad hoc coalition to support the restoration of the line item. It also worked on this issue through direct lobbying and by putting out press releases with each version of the budget. The coalition held rallies at the State House, and many of the associations involved mobilized their clients or memberships to attend the rallies. Ultimately, approximately half of the funding for this line item was restored. Most of the restored funding is for the Women's Health Network, which includes breast and cervical cancer early detection programs, in part because of the program's federal match. Another association has worked

with MDPH to increase the availability of mammograms by addressing workforce issues. Two associations have worked at the national level to advocate for funding for cancer screening programs. These associations have also advocated for funding for treatment in cases in which cancer is detected.<sup>1</sup>

## 2. Systems Activities

By engaging in systems activities, professional associations can increase cancer screening capacity and provider screening referral rates. These activities can also improve the coordination of the early detection and treatment of cancer. Five of the interviewed associations have engaged in systems activities that could affect cancer screening in Massachusetts (Table II.1). These activities include work with hospitals, clinics, and employers, as well as activities to increase the use of technology to identify patients who need cancer screenings.

**Hospitals, Health Plans, Employers, and Community Health Centers.** By working with large systems, associations can reach across constituencies that have the ability to affect cancer screening. Three of the associations in our study have engaged in work to promote cancer screening with these types of systems, often helping the systems to implement cancer screening and outreach programs. In their work with employers, associations facilitate access to cancer screening services for employees.

- **Hospitals.** One association has an accreditation program for hospital cancer programs. To become accredited, hospitals must maintain cancer screening and outreach programs. Hospitals are also asked to conduct community surveys to assess barriers to cancer screenings. Another association focuses on working with a Commission on Cancer-accredited hospitals to create and implement community outreach and education programs. Association staff also sit on hospital cancer committees and help plan activities.
- **Health Plans.** One association provides assistance to health plans that are conducting cancer screening outreach activities. This includes providing materials for outreach letters and co-signing those letters.

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<sup>1</sup> Associations employ a wide range of methods to achieve their policy goals. The most popular is lobbying or working in other ways with state legislators. One respondent indicated that, in her association's work, association members identify illustrative stories from "hometown" constituents who can testify or advocate with their local representatives. Two of the local associations indicated that they rely on a larger organization to help them track or understand state legislation. One of these relies on the national organization with which it is affiliated, while the other relies on another professional association in the state. Other advocacy methods used for both screening and nonscreening issues include (1) writing letters of support, (2) holding legislative breakfasts or other grassroots events, (3) working in coalitions or partnerships, (4) writing reports or policy statements, (5) media relations, (6) conducting advocacy trainings for partner organizations, (7) alerting members of relevant legislation, (8) developing a grassroots advocacy network, (9) giving testimony, (10) commenting on legislation, (11) sitting on policy committees, (12) working with state agencies and policy groups, (13) activating members or volunteers around policy issues, and (14) advertising campaigns. Four associations have changed their tax status to create political action affiliates, PACS, or have become 501(c)(6) organizations themselves to do more legislative advocacy work. One association commented that this enables the organization to provide a scientific perspective and expertise to all phases of the legislative process, including commenting on the rules and regulations after a bill is passed.

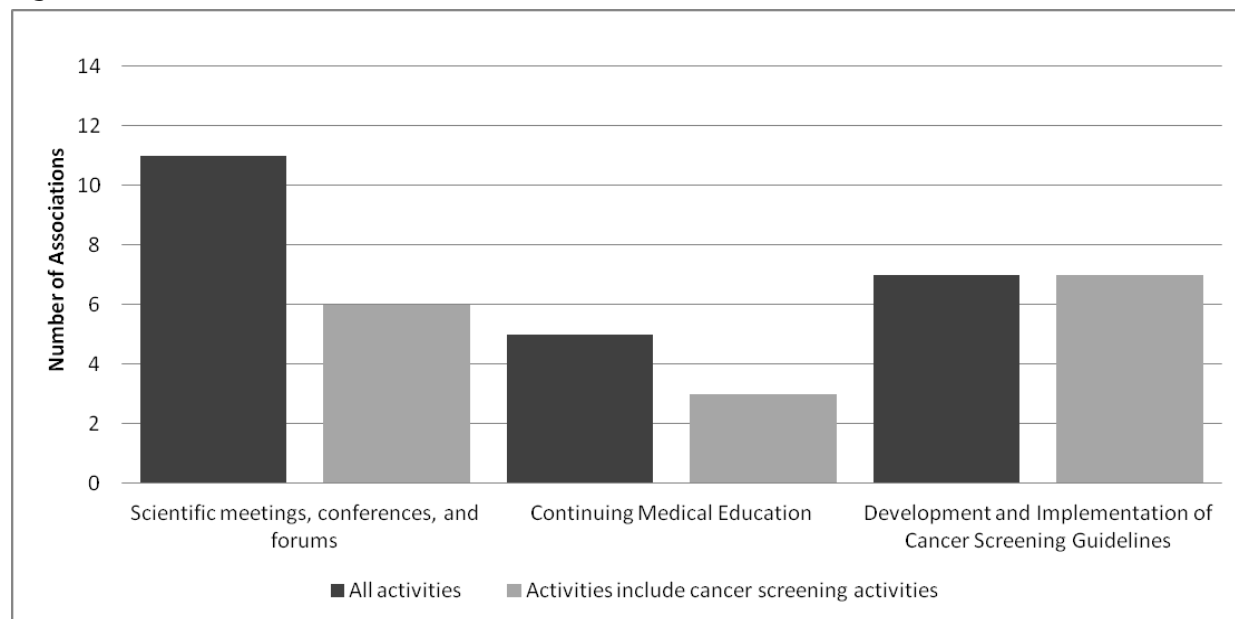
- **Employers.** One association works with large employers to develop workplace policies that include health screening benefits and time off for cancer screening. It also provides worksite cancer screening educational materials to these employers.
- **Community Health Centers.** One association provides materials, expert talks, and volunteer support to educate outreach workers at community health centers about cancer screening. In addition, in collaboration with two foundations and MDPH, this association provided grant writing technical assistance to community organizations to improve breast cancer outreach and screening. Another association provides technical assistance to health centers on reporting cancer screening program results to meet grant requirements and on the use of patient navigators and community health workers for outreach, education, and navigation related to cancer screening. This association also provided health centers with cancer screening educational materials and collaborated with MDPH in planning for cancer screening grants.

**Electronic Medical Records.** Electronic medical records can help clinicians identify and reach out to patients who should have a cancer screening, particularly people who do not visit their clinicians regularly. Three associations are actively promoting the use of this technology for this purpose. One association works with primary care physicians and hospitals to incorporate reminders about cancer screening into electronic medical records. Another association will include a discussion of the definition of “meaningful use” of electronic health records at its annual meeting this year, and a third association is working with health centers to prepare them for meaningful use.

**Cancer Registries.** The aggregation of data from insurance companies and multispecialty groups in cancer registries is another avenue to identify people who should have cancer screenings. These data can also be used to target cancer screening outreach programs and to monitor a variety of cancer screening process and clinical outcomes. One association developed a registry into which physicians can enter data about their patients. Another association developed a registry that will provide feedback to clinicians when patients who have been diagnosed with cancer do not receive the needed treatment within a certain time frame. Some cancer control plans use the data from this registry to identify characteristics of and geographic areas with populations that present with later stages of cancer and use this information to target their cancer screening activities.

### 3. Professional Education and Research Activities

Provider referrals for cancer screenings are one of the most powerful ways to ensure that people get screened. Because associations are seen as sources of expert information and as conveners of clinicians, they are an important avenue for influencing provider behaviors. Specifically, associations can affect provider behaviors through member education and clinical guideline development. Overall, 10 of the interviewed associations engage in these types of activities in relation to cancer screening (Table II.1).

**Figure IV.2. Professional Education and Research Activities**

**Member Education.** Education to providers conducted by associations includes updates on current practices in the field for cancer screening. Professional associations provide educational and training sessions at scientific meetings, conferences, and forums. Six associations provide cancer screening education at association meetings (Figure IV.2). One association provided a conference session presenting new cervical cancer screening guidelines before the new guidelines were released. Three associations provide, or plan to do so, continuing education credits related to cancer screening, through annual meetings or web courses. One association plans to offer a continuing medical education course on colorectal cancer screening for primary care physicians, which will include information on referrals, guidelines, and reminder systems. One association is planning a project for next year that will teach nurses to speak to public groups about topics that include screening and healthy lifestyles.

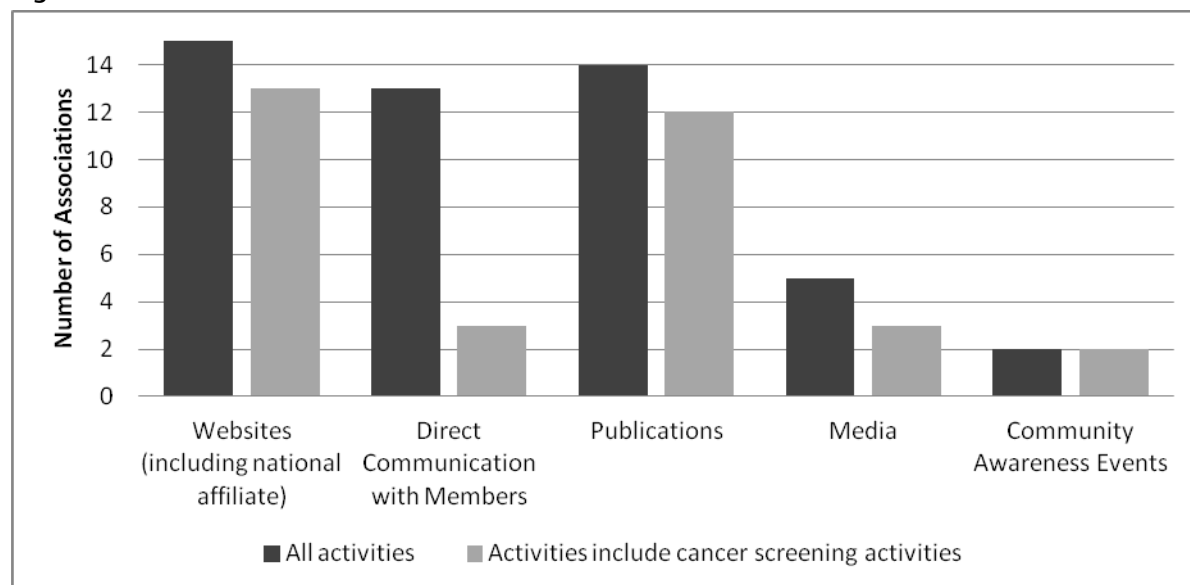
**Cancer Screening Guidelines.** To build the knowledge base in their fields, several of the professional associations are researching, developing, or promoting their own cancer screening guidelines. Five associations have developed their own cancer screening guidelines and two have endorsed guidelines developed by other organizations. Guideline development is generally done by national associations, based on the organization's review of the evidence, its expertise, and its experience with the issue. For example, one association has created a working group to consider writing new risk-based colorectal cancer screening guidelines for African Americans, because this population has a higher colon cancer mortality rate at a younger age than other groups. When finished, cancer screening guidelines are communicated to professional association members through a variety of means, including partner hospitals, emails or webinars, annual meeting activities,

websites, or journals. One association includes its guidelines in educational materials that it distributes to hospitals, community health centers, outreach groups, and others.<sup>2</sup>

#### 4. Communications Activities

Professional associations communicate about issues concerning cancer screening with their members, the broader clinical community, targeted patient groups, and the general public. Communications with providers can increase cancer screening referral rates; communications with the public can increase community awareness and support for cancer screening. Overall, 13 of the interviewed associations engage in communications activities to increase the rate of cancer screening (Table II.1).

**Figure IV.3. Communications Activities**



**Websites.** Websites provide associations with a platform to communicate with a broad audience about cancer screening. All the associations in this study have websites to communicate with association members or the general public, promote events, and provide opportunities for

<sup>2</sup> There are important differences among the guidelines developed by associations and national guidelines endorsed by the United States and Canada. Each type of cancer screening presents unique issues. Recommended guidelines seem to vary the most for breast cancer screening. For example, the U.S. Preventive Services Task Force recommends mammography every two years from age 50 to 74 while the American Cancer Society recommends annual mammograms beginning at age 40 for as long as a woman is in good health. Colonoscopies are generally seen as the gold standard for colorectal cancer screening. However, some interviewees think that stool-based methods might be more appropriate for colorectal cancer screening in a public health context due to the many cost- and stigma-related barriers of colonoscopy. Cervical cancer guidelines can also be complicated to follow because guidelines vary for different populations, and different types of tests can be offered. Several respondents spoke about the controversies surrounding different recommended guidelines for cancer screening. Mixed messages due to these variations can prove confusing for patients. One respondent advocated for MDPH to confer with clinicians before promoting any particular screening guideline. Another association did not wish to become embroiled in the debates regarding cancer screening guidelines and was reworking its guidelines to provide a global position on patient-centered care, recommending that people make cancer screening decisions in consultation with their clinicians based on their individual level of risk.

feedback. In some cases, only the national association has a website, whereas in others the local affiliate also has one (Figure IV.3). One association posts on its website health-related communications materials meant for the general public, including articles that have appeared in print and episodes of its monthly cable television show, “Physician Focus.” Four associations designed their websites specifically to communicate with their members. For example, one association is compiling a list of volunteer opportunities and information on opportunities for clinicians to provide free cancer screenings. Several respondents indicated that the cancer screening guidelines their associations developed are available on their websites. One association’s website includes a form that allows members to propose issues for the association’s policy committee. Finally, one association’s website includes discussion boards, monitored by the association, for clinicians to provide one another with information.

**Direct Communication with Members.** By communicating directly with their members through email, telephone calls, or letters, associations can quickly alert them to time-sensitive issues. This can be particularly important for advocacy activities. Some respondents reported that they try to communicate directly with members sparingly to avoid overloading them with information and prevent their emails from being ignored. However, others indicated that they send communications quite often to maintain a sense of contact between the members and the association, and to demonstrate the organization’s value to its members. Thirteen associations communicate directly with their members through email, telephone, or letters. Of these, three mentioned using these methods of communication for issues related to cancer screening.

Several associations discussed their ability to target information to specific groups or customize their electronic communications. One association has a system for sending advocacy action alerts to its volunteers, which enables members to click a button to send a prewritten email to their legislators. This association sometimes targets active volunteers to write letters to the editor or to their local newspapers. Another association can target emails to specific segments of its membership, and a third is currently developing this capability.

**Surveys.** Two associations have surveyed their members on issues related to cancer screening. One of these used the survey to identify the types of volunteer opportunities in which members would be interested. Because the most common response to this question was providing free cancer screenings, this survey led to the creation of a nationwide free cancer screening program being implemented in 15 states this year in collaboration with the CDC. Another association that recently conducted needs assessment of its membership found that many members would like more general information on cancer screening and detection.

**Publications.** The associations produce a wide range of publications, including newsletters, journals, policy papers, and resource manuals that target members, clinicians, patients, legislators, the media, and the general public. Of the 14 associations that have publications, 12 have disseminated information related to cancer screening. At least 7 associations have professional, peer-reviewed journals that have included information on associations’ position statements or practice guidelines regarding cancer screening. Six associations have newsletters or e-newsletters that may sometimes include information about cancer screening or screening events. Two associations regularly publish syllabi for their members that have contained information relevant to cancer screening-related clinical practice. Two associations produce policy reports as part of their advocacy efforts. In addition, 3 associations create printed patient education materials directly related to cancer screening.

**Media.** By communicating through the media, professional associations can efficiently communicate messages to the general public. Three associations have actively developed relationships with members of the media or have public relations departments to promote cancer screening. One association actively collects stories relevant to cancer screening and provides them to local reporters. This association also writes press releases to coincide with specific disease awareness months, including that for cancer screening. Another association produces two kinds of health-related print articles written by physicians for the general public: (1) 600- to 700-word articles and (2) shorter monthly health tips of 150 to 200 words. The articles are published in local newspapers throughout the state (and even in some newspaper chains outside of the state) and have included information on cancer screening in the past.

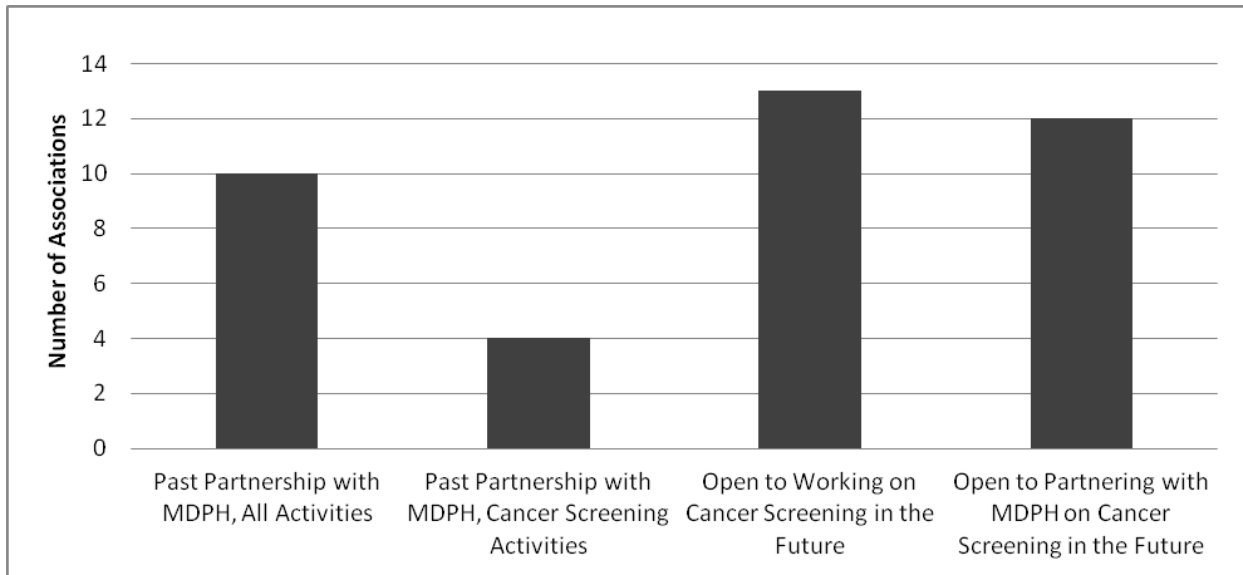
**Community Awareness Events and Other Outreach Activities.** Associations also use creative methods to raise awareness of the importance of cancer screening among the general public. One association regularly holds walk-a-thons, including a particularly large one for breast cancer. One respondent indicated that she previously ran a program that promoted colorectal cancer screening through posters placed in facilities providing mammograms. These facilities were targeted because the population having mammograms is approximately the same age as the population that should have colonoscopies. Another association has a toll-free number for people to call to get answers to any questions they have about cancer. As mentioned previously, one association produces a monthly television show hosted by guest physicians, which airs on cable access stations throughout the state and is available online. In the past, the show has included information on breast cancer screening. Two other associations have members who give expert talks on cancer screening to the public or other physicians. Finally, three associations use social media sites—including Facebook, Twitter, and Linked-In—to communicate with the public.

## 5. Partnering with MDPH

Synergies can be developed to increase cancer screening rates in the Commonwealth through a partnership between MDPH and professional associations. Although most of the professional associations we interviewed had experience working with MDPH on many different health issues, relatively few have worked specifically with MDPH on cancer screening (Table II.1).

Ten respondents indicated that their associations have collaborated with MDPH in the past, and 4 of these respondents stated that the partnerships were to promote cancer screening through either direct service or policy change (Figure IV.4). In some cases, the partnerships took the form of associations providing MDPH with expertise to assist it with the agency's programs. For example, one association leveraged its expertise on community health center operations to advise MDPH on how to develop planning grants to increase breast and cervical cancer screening rates. In other cases, the opposite occurred and associations relied on MDPH for assistance. For example, as one association implemented a program to provide free colonoscopies to patients, it depended on MDPH to identify and refer patients who should have free colonoscopies. In addition, in the past, MDPH has provided funding for association cancer programs. For example, one association used grant money from MDPH to hire an intern whose work included a study of why colorectal cancer patients had not received screening colonoscopies before their diagnoses.

Figure IV.4. Partnering with MDPH





## V. RECOMMENDATIONS AND JUSTIFICATIONS

The professional associations noted that barriers to breast, cervical, and colorectal cancer screening still exist, and that addressing those barriers might help to further increase the rate of cancer screening in Massachusetts. They recommended several strategies that MDPH can implement, either on its own or in collaboration with professional associations and other stakeholders, to surmount these barriers. We report the professional associations' recommendations and justifications in five areas: (1) policy, (2) systems, (3) professional education and research, (4) communications, and (5) partnerships.

### A. Policy Recommendations and Justifications

Many people do not have access to cancer screening because of cost or other access issues. One respondent noted, "Access is always at the top of the list when you talk about affecting populations." Another respondent indicated that it is important to provide access not only for cancer screening but also for follow-up services when a screening test indicates abnormal findings. For these reasons, the associations recommended that MDPH consider the strategies to improve access to cancer screening. When associations provided such information, we highlighted the potential role of MDPH in promoting or implemented these strategies.

#### 1. Make Screening More Convenient for Patients

The inability to access cancer screening is sometimes related to scheduling or transportation. Suggestions to make screening more convenient for patients included the following.

- **Encourage screening centers and programs to expand their hours to evenings and weekends and consider accepting more walk-in patients.** Two respondents indicated that expanded clinic hours would help expand access to care. One indicated that taking walk-ins could increase screening, especially among people without insurance, psychiatric patients, people with substance abuse issues, homeless people, people without telephones, and others.
  - MDPH could partner with professional associations to educate providers about the importance of expanding clinic hours.
- **Explore promoting open access to cancer screening.** Many facilities require that patients see physicians or obtain referrals before they can obtain cancer screenings. However, patients might not want to pay for an office visit they think is unnecessary. One association promotes open access to screening, in which patients can be screened without first seeing a primary care physician.
- **Promote mobile mammography in underserved communities.** Lack of transportation can be a barrier to cancer screening. Two associations suggested increasing the use of mobile mammography (vans) to increase screening rates in different community locations.
- **Work with employers to ensure that employees can be screened.** A barrier to colonoscopy is the amount of time patients must take off from work for the procedure. To address this, employers can give people four hours per year to get screened.

- MDPH could educate employers about the cost benefits of cancer screening and encourage them to provide employees with paid time off for cancer screening.
- **Create initiatives to support patients who need colonoscopies.** A primary barrier to colonoscopies is that patients need someone to take them home after the procedure. This can present a barrier for people who do not have social support or transportation.
  - MDPH could create a program to provide people with transportation to their homes after colonoscopies.

## 2. Address Insurance and Cost Issues

Although almost everyone in Massachusetts has health insurance, six respondents noted that cost issues can still serve as a barrier to cancer screening. Some groups, such as undocumented immigrants, often do not qualify for health insurance coverage. Even for those with health insurance coverage, copayments for primary care appointments at which people would learn about cancer screening or for cancer screening services themselves can be a barrier to receiving cancer screening.

- **Support and promote free and reduced-cost screening programs.** Some hospitals provide screening services to patients who do not have health insurance. Increasing awareness of these programs through public service announcements, primary care doctors, and hospital programs will promote their use. Screening models across the country have shown that these programs might be self-sustaining if the program is open to both insured and uninsured people or if the hospital obtains a screening grant.
  - MDPH could provide resources for cancer screening similar to a flu clinic, such as a site for screening, clinicians, or information.
  - MDPH could continue to participate in partnerships with gastroenterologists to provide free colonoscopies.
  - MDPH could subsidize the direct costs of screening at local health departments, such as providing supplies needed to prepare for and conduct screenings.
- **Support efforts to reduce the out-of-pocket costs of colonoscopies for patients.** Colorectal cancer screening is often not covered by insurance or is covered with a high copayment. MDPH has an awareness program to teach people about colorectal cancer screening, but does not target employers. Educating employers about how colorectal cancer screening could save them money might encourage them to demand that health insurance plans cover colonoscopies, so that insurers who have the resources to provide screening would offer these benefits. One hospital in central Massachusetts has begun to provide free colonoscopy prep kits to patients.
  - MDPH could compile and disseminate strategies used by hospitals to increase colonoscopies, such as free colonoscopy prep kits.

## B. Systems Recommendations

Many providers lack the information technology to identify and monitor the screening services needed and used by their patients. With system-wide implementation of health information systems, some providers have developed innovative solutions to this problem, using patient registries and appointment-reminder tools. There are also system- and policy-level barriers that provide

disincentives to cancer screening. Several associations suggested other systemic initiatives to improve screening rates in Massachusetts by supporting the use of innovative technologies, promoting alternatives to colonoscopies for some patients, advocating for new screening policies, and supporting policy incentives that reward providers for screening their patients.

## 1. Support the Use of Innovative Technologies

During a short office visit, the topic of cancer screening may not be priority in provider-patient interactions. The likelihood of communication about cancer screening during an office visit decreases even further among those that do not see a clinician regularly. These issues prevent some people from learning from their clinicians that they need cancer screening. New technologies surmount these barriers by allowing clinicians to efficiently track patients' cancer screenings over time.

- **Support patient registries to track cancer screening.** Because our fragmented health care system does not allow doctors or institutions to track patient care, one association has set up a national cancer registry to track the treatment of patients. Another has created a registry to help physicians track their patients, including tracking screening results.
  - MDPH could help other associations to develop and implement similar registries and incorporate cancer screening into their designs.
- **Promote cancer screening reminder tools in electronic health records.** Patients sometimes do not see their primary care doctors annually due to cost or other factors, and miss regularly scheduled cancer screenings. When patients come in for acute care but not for a preventive checkup, clinicians sometimes forget to refer them for cancer screening. Electronic health records and screening reminder tools incorporated within them can help to solve these issues. For example, the American Heart Association (AHA) and American Diabetes Association (ADA) developed a reminder tool that integrates with electronic medical records and have asked this association to promote it.
  - MDPH could partner with organizations to build similar tools as those developed by AHA and ADA. This could be particularly helpful for clinicians who work in small practices.

## 2. Consider Promoting Stool-Based Colorectal Screening as an Alternative to Colonoscopies

Perhaps because of the unique barriers to colonoscopy, colorectal cancer screening rates are lower than those for breast and cervical cancer screening. These barriers include a disinclination among patients to get the test, the cost of the test, the required preparation, the amount of time that patients must take off from work for the test, and the need to have someone take a patient home after the test. Newer stool-based tests are less burdensome for patients and might be a viable alternative to colorectal cancer screening in a public health context. Though these tests do not prevent colon cancer, they can provide early detection and might be useful in cases in which patients will otherwise not be able to get any colorectal cancer screening.

### 3. Help Physicians Adjust to a System that Aligns Incentives to Encourage Them to Ensure that Their Patients Receive Needed Cancer Screenings

Under fee-for-service payment structures, primary care providers, which often must spend a lot of time to convince patients to get a colonoscopy, receive no compensation for these activities. The ACA will align incentives so that primary care providers will be rewarded for encouraging their patients to get screened. MDPH can support associations in their efforts to help physicians transition to this system.

## C. Professional Education and Research Recommendations

Several associations emphasized the importance of educating clinicians about cancer screening as they are the ones that provide patients with referrals. Associations made several recommendations for how best to reach clinicians to encourage them to promote screening.

- **Focus on primary care providers.** Patients do not get colonoscopies when they are not strongly encouraged to do so by their physicians. In response, one hospital is implementing a system under which doctors will schedule patients for colonoscopies and remind patients to keep these appointments for colonoscopies.
- **Find ways to incorporate cancer screening into the concept of well-adult care.** Many newer doctors are focused on health maintenance and preventive care. Incorporating cancer screening in hospital protocols might find traction with these types of physicians.
- **Educate clinicians about how the ACA will affect cancer screening.** The ACA will have a provision that preventive services will be covered without out-of-pocket costs. If physicians realized this, they might be more likely to pass this information onto their patients.
  - MDPH could disseminate fact sheets about the ACA to providers, professional associations, and the public.
- **Educate clinicians about underserved groups to target for cancer screening.** Elderly patients are not always instructed to get cancer screening by their clinicians; these patients do not always advocate for themselves. Providing physicians with screening disparity data will help them target their efforts.
- **Use multiple communication channels to reach clinicians.** Associations suggested using a variety of channels to communicate with clinicians about cancer screening to ensure that the messages reach clinicians and that they hear a consistent message.
  - MDPH could collaborate with medical schools and residency programs to educate their students or trainees on the importance of cancer screening
  - MDPH could use professional associations and online education to reach physicians. Associations can pay for trainings related to screening for their members. With funding from MDPH, associations can develop cancer screening-related educational programs for their members.

## D. Communications Recommendations

Several associations stated that broad-based public educational efforts and outreach activities are effective strategies to promote cancer screening rates. Associations suggested integrating both traditional and innovative outreach strategies, including using new messages, leveraging cancer-awareness months, and using local opinion leaders and co-location of screening posters in screening centers.

- **Focus on colonoscopies.** Colonoscopies might be the most challenging screening of the three types of cancers because of the psychological barriers and associated stigma; patients often do not want to undergo the procedure or believe that it will be unpleasant. Continued education to the public about the benefits of colonoscopy is needed as most people do not know about its importance. Messaging targeted to addressing the psychological barriers and stigma could help to increase screening rates.
- **Embrace both traditional and novel approaches to outreach.** Associations stated that people are tired of hearing cancer messages and have “cancer fatigue.” As a result, novel approaches to outreach and education are necessary. Associations suggested that MDPH could model a cancer-awareness initiative on a former MDPH stroke-awareness initiative called the FAST program. This program included new, quick, and catchy public service announcements, such as posters and flyers. Associations also mentioned annual awareness campaigns, endorsements from local public figures, revitalization of the American Gastroenterological Association’s program to promote colorectal cancer screening by placing posters in mammography centers, and other strategic placement of promotional materials.
- **Target populations in which there are disparities in screening rates.** Disadvantaged populations need special focus in outreach efforts. When reaching out to specific communities, associations said that it is important to conduct the outreach in a culturally appropriate manner. For example, one respondent described an outreach program for Latinas that involved meeting in a social setting, because research had shown that women in this group were most interested in that type of outreach.
- **Work through health systems to promote screening.** Health systems, including federally qualified health centers, have a ready-made infrastructure for educating patients about cancer screening. MDPH could encourage hospitals in professional association networks identify populations to target and promotional materials for their cancer screening outreach programs.

## E. Partnership Recommendations

Several respondents indicated that they would be open to partnering with MDPH on specific, future initiatives to increase cancer screening in Massachusetts. Some respondents also spoke about activities in which MDPH could engage to help them with their cancer screening activities.<sup>3</sup>

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<sup>3</sup> The partnership opportunities that were already discussed in the previous sections are not repeated here.

- **Provide data to associations engaged in cancer screening promotion efforts.** The associations value MDPH's ability to provide cancer epidemiological and other research data to support their cancer screening promotion efforts. They were particularly interested in data describing the disparities in cancer screening and suggested aggregated insurance plan, Medicaid, and Medicare data for this purpose. They were also interested in data about the number of gastroenterologists in the state to assess the capacity to perform colonoscopies in the state.
- **Convene a strategic planning group of stakeholders to promote cancer screening.** One association recommended that MDPH convene stakeholders to create a strategic plan to increase cancer screening rates. It recommended that the group include representatives from hospitals, screening sites, large local health departments, foundations, academics, and professional associations. It also suggested that MDPH could bring back state cancer conferences to facilitate increased collaboration across stakeholder groups.
- **Use professional associations as a channel to promote cancer screening initiatives.** Representatives from the Massachusetts Medical Society, the Massachusetts Academy of Family Physicians, and the New England Rural Health RoundTable indicated that their associations would consider promoting screening activities conducted by MDPH or communicating with their memberships about MDPH initiatives. They also indicated that screening could be the focus of a session at one of their annual conferences or that MDPH could prepare evidence-based materials to hand out at one of their conferences.
- **Sponsor cancer program interns.** MDPH has provided funding for cancer program interns at hospitals in the past. Continued funding for this program would help to identify under-screened target populations and their barriers to cancer screening.
- **Leverage willingness of associations to partner from interviews.** Several respondents mentioned specific ways in which they would support MDPH's efforts to increase cancer screening. The Massachusetts Academy of Family Physicians stated it could form a subcommittee to review cancer screening in Massachusetts and indicated a willingness to be involved in a coalition related to screening. The American College of Obstetricians and Gynecologists stated that it would be willing to collaborate on the creation of programs focused on addressing barriers to screening, such as quarterly screening clinics in schools. The Commission on Cancer indicated it could engage its physician liaison members and network of hospital cancer programs on cancer screening if MDPH had specific programs underway.

## VI. CONCLUSION

Professional association representatives had varying interest in cancer screening. Although most believed that cancer screening is an important public health issue, the prioritization of cancer screening within the portfolio of activities for an association competes with that for other issues. In general, increasing reimbursement rates for clinicians was among the most often cited priorities for professional associations. Larger associations were more likely to say that they participated in cancer screening promotion activities, as they had the resources and capacity to work on multiple issues, among which cancer screening might be included. Two of associations interviewed stated that they did not engage in any cancer screening activities. Despite varying levels of interest and engagement in cancer screening among associations, almost all associations indicated a willingness to collaborate with MDPH on cancer screening in the future.

During the interview, many associations stated that they were unsure of where to begin their activities related to cancer screening. However, all of them said that MDPH with its population focus has a distinct role from providers as it does not focus on physician-specific patient panels and geographically-bounded patient catchment areas. And, in this role, MDPH has the unique ability to act as a leader in providing guidance that could be pivotal in activating and coordinating these professional associations' engagement in cancer screening. Many opportunities for collaboration with the professional associations exist. The most promising areas for collaboration cited during the interviews include MDPH and associations compiling evidence to support cancer screening policies; supplying materials for dissemination to providers, employers, health plans, and the public; and educating providers to modify practice behavior and boost screening rates.

Although the relative, immediate influence of professional associations may not be as large as that for other spheres (such as health plans and policymakers), it will be valuable to include representatives of these associations in discussions to further increase cancer screening rates in the Commonwealth. For cancer screening interventions to be sustainable and viable in the long term, providers' buy-in is essential, because they are conducting these screenings. Associations, as representatives of and conduits to providers, will contribute helpful insights on incorporating cancer screening inventions into provider settings and incentivizing providers.

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**APPENDIX A**  
**PROFESSIONAL ASSOCIATION PROFILES**

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## **American Cancer Society – New England Division (ACS-NE)**

30 Speen Street

Framingham, MA 01701

[www.cancer.org/MyACS/NewEngland/index](http://www.cancer.org/MyACS/NewEngland/index)

**Mission:** “The American Cancer Society is the nationwide, community-based, voluntary health organization dedicated to eliminating cancer as a major health problem by preventing cancer, saving lives, and diminishing suffering from cancer, through research, education, advocacy, and service.”

**Background:** The American Cancer Society – New England (ACS-NE) is a division of the umbrella organization that covers the six states in New England. Most of the New England division staff works with hospitals and health systems to improve patient access to programs and services. ACS-NE also coordinates with community health centers, Medicare quality improvement organizations, insurers, and large employers. In addition, some ACS-NE staff is dedicated to government relations and advocacy. ACS-NE is responsible for many community events, including Making Strides Against Breast Cancer fund-raisers. As part of the national organization, ACS-NE supports the cancer screening guidelines produced by the American Cancer Society (ACS) and has participated in advocacy for federal cancer prevention and treatment policy led by ACS.

**Structure:** Chief executive officer, chief operating officer, state vice presidents, and health initiatives staff

**Membership:** Not available

**Cancer Focus:** Breast, cervical, and colorectal cancer

**Involvement in Cancer Screening:** Develops cancer screening guidelines; educates providers about how to ensure that their patients receive appropriate cancer screenings; works with doctors and hospitals to provide colorectal cancer screening for uninsured and underinsured people; is planning a continuing medical education (CME) course about colorectal cancer screening for primary care providers; developed a colorectal cancer screening toolkit for primary care providers; distributes printed materials about cancer screening; works with Commission on Cancer–accredited hospitals on screening and outreach programs; sits on cancer committees at these hospitals; collaborates with the Massachusetts Department of Public Health (MDPH) on educational efforts; works with employers to encourage them to provide benefits that allow their employees to get cancer screenings; in collaboration with MDPH and the Komen and Avon Foundations, provided grants and technical assistance related to cancer screening to organizations and hospitals in communities throughout the state; worked with the American Gastroenterological Association and MDPH on a free colorectal cancer screening program in Massachusetts; provides information on screening and prevention to health centers and health plans that service Medicaid patients; worked to encourage municipal workers and community leaders to promote cancer screening; holds walk-a-thons and other community events to raise funds and awareness about cancer; distributes press releases related to cancer-specific awareness months; maintains a call center that provides information on cancer screening issues; promotes stories relevant to cancer screening to local media; advocates for mandated insurance coverage for cancer screening, funding for MDPH cancer screening programs, cancer screening provisions in the Affordable Care Act (ACA), and funding for cancer screening programs at the federal level; communicates with members about advocacy issues

related to cancer screening; educated doctors about payment issues related to colonoscopies so that they would advocate on this issue with insurance companies.

**Cancer Screening Online Resources:**

- <http://www.cancer.org/Healthy/FindCancerEarly/CancerScreeningGuidelines/american-cancer-society-guidelines-for-the-early-detection-of-cancer>

**Contact Information:**

Randy Schwartz, MSPH  
Senior Vice President, Strategic Health Initiatives, ACS-NE  
508-270-4660  
[randy.schwartz@cancer.org](mailto:randy.schwartz@cancer.org)

Note: This profile was developed using information from telephone interviews and from [www.cancer.org](http://www.cancer.org).

**American College of Physicians (ACP), Massachusetts Chapter**

860 Winter Street

Waltham Woods Corporate Center

Waltham, MA 02451

[www.acponline.org/about\\_acp/chapters/ma](http://www.acponline.org/about_acp/chapters/ma)

**Mission:** “To enhance the quality and effectiveness of health care by fostering excellence and professionalism in the practice of medicine.”

**Background:** The American College of Physicians (ACP) is a national professional association of internists, internal medicine subspecialists, medical students, and trainees. Founded in 1915, ACP merged with the American Society of Internal Medicine in 1998. ACP strives to develop and support high clinical and ethical standards in health care delivery, including preventive screening. It serves as a resource for members, offering courses to help them prepare for board examinations. ACP supports research in internal medicine and publishes a highly respected academic journal titled *The Annals of Internal Medicine*. ACP’s political arm is very active; the association advocates for policies to benefit both the membership and the public. ACP has chapters in each state, as well as in some countries outside of the United States. The Massachusetts Chapter hosts its own annual scientific meeting.

**Structure:** The Massachusetts Chapter has a governor, an executive director, and a governor’s council.

**Membership:** 3,654 physicians, medical students, residents, and retired physicians in the Massachusetts Chapter

**Cancer Focus:** Breast, cervical, and colorectal cancer

**Involvement in Cancer Screening:** Develops cancer screening guidelines and communicates these guidelines directly to association members; produces educational materials related to cancer screening for clinicians; includes cancer screening information in publications; advocates for reimbursement for preventive screening; advocates for better reimbursement for clinicians; plans to include information on meaningful use of electronic health records in future meetings.

**Cancer Screening Online Resources:**

- [www.acponline.org/patients\\_families/womens\\_issues/breast\\_cancer/](http://www.acponline.org/patients_families/womens_issues/breast_cancer/)
- [www.acponline.org/mobile/cyppocketguide/cervical\\_cancer\\_screening.html](http://www.acponline.org/mobile/cyppocketguide/cervical_cancer_screening.html)
- [www.acponline.org/clinical\\_information/journals\\_publications/ecp/janfeb01/selby.pdf](http://www.acponline.org/clinical_information/journals_publications/ecp/janfeb01/selby.pdf)

**Contact Information:**

Lynda Layer

Executive Director, Massachusetts Chapter of ACP

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Note: This profile was developed using information from a telephone interview and from [www.acponline.org](http://www.acponline.org).

**American Congress of Obstetricians and Gynecologists – District I**

PO Box 70620

Washington, DC 20024

[www.acog.org/About\\_ACOG/ACOG\\_Districts/District\\_I.aspx](http://www.acog.org/About_ACOG/ACOG_Districts/District_I.aspx)

**Strategic Plan:** “The Congress, as the premier organization for obstetricians and gynecologists and providers of women’s health care, will provide the highest-quality education worldwide, continuously improve health care for women through practice and research, lead advocacy for women’s health care issues nationally and internationally, and provide excellent organizational support and services for our members.”

**Background:** The American Congress of Obstetricians and Gynecologists (ACOG) serves as an advocate for quality health care for women. It upholds high standards for clinical practice and continuing education. In addition to conducting rigorous research on women’s health issues and publishing a journal titled *Obstetrics and Gynecology*, ACOG strives to educate patients about, and involve them in, medical care. It works to educate its members and the public about important issues in women’s health care. ACOG also engages in extensive advocacy work.

**Structure:** The national organization is divided into 12 districts, and within each district there are several sections that cover smaller geographic areas such as states or provinces. District I covers New England, Eastern Canada, and Chile. Within District I, the Massachusetts section hosts its own annual meeting.

**Membership:** Not available

**Cancer Focus:** Breast, cervical, and colorectal cancer

**Involvement in Cancer Screening:** Develops cancer screening guidelines and communicates them to its members; includes information on cancer screening in publications; includes cancer screening activities at annual meeting; advocated for coverage for free preventive services in the ACA; advocates for better reimbursement rates for clinicians.

**Cancer Screening Online Resources:**

- [http://www.acog.org/Resources\\_And\\_Publications/Committee\\_Opinions/Committee\\_on\\_Gynecologic\\_Practice/Colonoscopy\\_and\\_Colorectal\\_Cancer\\_Screening\\_Strategies.aspx](http://www.acog.org/Resources_And_Publications/Committee_Opinions/Committee_on_Gynecologic_Practice/Colonoscopy_and_Colorectal_Cancer_Screening_Strategies.aspx)

**Contact Information:**

Ronald Burkman, MD

ACOG Chair, District I

413-794-5256

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Note: This profile was developed using information from a telephone interview and from [www.acog.org](http://www.acog.org).

**American Gastroenterological Association (AGA)**

4930 Del Ray Avenue

Bethesda, MD 20814

[www.gastro.org](http://www.gastro.org)**Mission:** “To advance the science and practice of gastroenterology.”**Background:** Founded in 1897, the American Gastroenterological Association (AGA) is one of the first medical subspecialty organizations. The AGA focuses on policy advocacy, practice guidelines, research, and educational programs. Current legislative issues the association is working on include health care reform, reimbursement, and colorectal cancer screening and treatment for the uninsured. The AGA publishes two academic journals, *Gastroenterology* and *Clinical Gastroenterology and Hepatology*, and it offers opportunities for CME. The organization hosts Digestive Disease Week, a large international meeting of physicians, researchers, and academics in fields related to gastroenterology.**Structure:** Governing board (past president, current president, president-elect, vice president, and secretary/treasurer), between eight and nine counselors, 90 paid staff (including an executive director, two executive vice presidents, and other vice presidents), and a dozen committees of volunteers.**Membership:** 15,000 physicians, residents, fellows, trainees, scientists, and graduate students in the sciences**Cancer Focus:** Colorectal cancer**Involvement in Cancer Screening:** Develops cancer screening guidelines; publishes information on cancer screening guidelines in its journal and on its website; organizes a free colonoscopy screening program during a weekend in March in collaboration with MDPH and CDC; developed a registry to help physicians track colorectal cancer screening for their patients; is developing a website of all AGA-related volunteer programs to help members find opportunities to provide pro bono colonoscopies; advocates for mandates to cover colon cancer screening; advocated for insurance companies to pay for colonoscopies even when polyps are found and removed; had a program to promote colorectal cancer screening in mammography centers; participated in ACA advocacy.**Cancer Screening Online Resources:**

- [www.gastro.org/advocacy-regulation/legislative-issues/colorectal-cancer-screening-treatment-for-the-uninsured](http://www.gastro.org/advocacy-regulation/legislative-issues/colorectal-cancer-screening-treatment-for-the-uninsured)
- [www.gastro.org/patient-center/digestive-conditions/colorectal-cancer](http://www.gastro.org/patient-center/digestive-conditions/colorectal-cancer)
- [www.gastro.org/news/articles/2009/03/20/massachusetts-free-colonoscopy-pilot-program-provides-access-for-uninsured-residents](http://www.gastro.org/news/articles/2009/03/20/massachusetts-free-colonoscopy-pilot-program-provides-access-for-uninsured-residents)

**Contact Information:**

Richard Boland, MD

President, AGA

214-820-2692

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Note: This profile was developed using information from telephone interviews and from [www.gastro.org](http://www.gastro.org).

**Commission on Cancer (CoC) of the American College of Surgeons - Massachusetts**

633 N. St. Clair  
Chicago, IL 60611  
[www.facs.org/cancer](http://www.facs.org/cancer)

**Mission:** “The Commission on Cancer (CoC) is a consortium of professional organizations dedicated to improving survival and quality of life for cancer patients through standard-setting, prevention, research, education, and the monitoring of comprehensive quality care.”

**Background:** Started by the American College of Surgeons in 1922, the Commission on Cancer (CoC) produces accreditation standards and uses these standards to accredit more than 1,500 cancer programs in the United States. The CoC maintains one of the largest cancer registries in the world, which it uses to provide hospitals with quality performance reports. It has also recently developed a care monitoring system to track patients and ensure that they receive adequate and timely care. The CoC’s Cancer Liaison Program is a network of physician volunteers who work to improve their institutions’ cancer-related activities. Massachusetts has 55 hospitals and programs accredited by the CoC.

**Structure:** The national organization has an executive committee (chair, chair-elect, many other chairs and representatives of member organizations), between 20 and 30 paid staff (housed in the American College of Surgeons), and a board of volunteer commissioners. Massachusetts has a state chair.

**Membership:** 47 cancer-related organizations and 53 members representing the Fellowship of the American College of Surgeons

**Cancer Focus:** Breast, cervical, and colorectal cancer

**Involvement in Cancer Screening:** Requires that accredited hospitals engage in community outreach and screening programs; provides technical assistance to hospitals for issues related to cancer screening (often in partnership with the ACS); endorses the ACS’s cancer screening guidelines; encourages association members to include cancer screening in their talks to other clinicians or the public; includes cancer screening activities at annual statewide meetings; conducts studies related to cancer screening in the state with the help of MDPH-funded interns; includes information on cancer screening in publications.

**Cancer Screening Online Resources:**

- [www.facs.org/cancer/coc/cocpracguide.html](http://www.facs.org/cancer/coc/cocpracguide.html)
- [www.facs.org/cancer/coc/cps2012draft.pdf](http://www.facs.org/cancer/coc/cps2012draft.pdf)

**Contact Information:**

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508-540-9771

Note: This profile was developed using information from telephone interviews and from [www.facs.org/cancer](http://www.facs.org/cancer).



**Massachusetts Academy of Family Physicians (MAFP)**

100 Cummings Center Suite 325C

Beverly, MA 01915

[www.massafp.org](http://www.massafp.org)

**Mission:** “The mission of the Massachusetts Academy of Family Physicians is to assist its members in providing compassionate, high quality health care to the people of Massachusetts.”

**Background:** Founded in 1948, the Massachusetts Academy of Family Physicians (MAFP) supports the work of Massachusetts physicians who specialize in family medicine. The association provides clinical review and CME, as well as targeted information to its members. In addition, MAFP’s Committee on Legislation and Regulatory Affairs sets the organization’s legislative agenda. All members of the state organization are members of the national association, the American Academy of Family Physicians (AAFP), which offers clinical recommendations on a variety of health topics, including breast, cervical, and colorectal cancer screening; provides further opportunities for CME; publishes *American Family Physician*, *Annals of Family Medicine*, and *Family Practice Management*; and conducts advocacy work.

**Structure:** MAFP has a 15-person board of directors and two paid staff members.

**Membership:** MAFP has a membership of 1,463 family physicians, residents, and medical students.

**Cancer Focus:** Breast, cervical, and colorectal cancer

**Involvement in Cancer Screening:** Develops cancer screening guidelines; includes cancer screening activities at annual meeting; participated in ACA advocacy activities; advocates for better reimbursement for members; includes cancer screening information in publications.

**Cancer Screening Online Resources:**

- [www.aafp.org/online/en/home/policy/policies/s/diagnosticscreening.html](http://www.aafp.org/online/en/home/policy/policies/s/diagnosticscreening.html)
- [www.aafp.org/online/en/home/clinical/exam/breastcancer.html](http://www.aafp.org/online/en/home/clinical/exam/breastcancer.html)
- [www.aafp.org/online/en/home/clinical/exam/cervicalcancer.html](http://www.aafp.org/online/en/home/clinical/exam/cervicalcancer.html)
- [www.aafp.org/online/en/home/clinical/exam/colorectalcancer.html](http://www.aafp.org/online/en/home/clinical/exam/colorectalcancer.html)

**Contact Information:**

Karen Brenke

Executive Vice President, MAFP

978-232-0022

[karen.brenke@massafp.org](mailto:karen.brenke@massafp.org)

**National Affiliate:**

American Academy of Family Physicians (AAFP)

[www.aafp.org](http://www.aafp.org)

Note: This profile was developed using information from telephone interviews and from [www.massafp.org](http://www.massafp.org) and [www.aafp.org](http://www.aafp.org).

**Massachusetts Association of Public Health Nurses (MAPHN)**

(Address not available)

[www.maphn.org](http://www.maphn.org)

**Mission:** “To strengthen the leadership role of the public health nurses within the Commonwealth of Massachusetts.”

**Background:** The Massachusetts Association of Public Health Nurses (MAPHN) is the only state-recognized association of public health nurses in Massachusetts; it strives to provide a unified voice on issues related to public health nursing. MAPHN works with each of the 351 cities and towns in the state to implement guidelines, regulations, and advances from MDPH. The organization acts as a liaison to the public and providers (including hospitals, prisons, personal care providers, group practices, school nurses, and colleges) on public health issues. MAPHN has five chapters in different geographic regions of Massachusetts and is a member of the Quad Council of Public Health Nursing Organizations.

**Structure:** Executive committee (president, vice-president, treasurer, secretary) and a board that consists of the executive committee and representatives from each chapter

**Membership:** More than 200 public health nurse members; school nurses and representatives from academia are associates.

**Cancer Focus:** Breast, cervical, and colorectal cancer

**Involvement in Cancer Screening:** Provides funding for members to attend an annual colorectal cancer conference; provides information on cancer screening in a resource manual for its members.

**Cancer Screening Online Resources:**

- <http://www.maphn.org/Resources/Documents/MAPHNLeadershipGuide2005.pdf>

**Contact Information:**

Kitty Mahoney RN, MS

President, MAPHN

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[info@maphn.org](mailto:info@maphn.org)

**National Affiliate:**

Quad Council of Public Health Nursing Organizations

[www.achne.org/i4a/pages/index.cfm?pageid=3292](http://www.achne.org/i4a/pages/index.cfm?pageid=3292)

Note: This profile was developed using information from a telephone interview and from [www.maphn.org](http://www.maphn.org).

**Massachusetts Coalition of Nurse Practitioners (MCNP)**

PO Box 1153  
Littleton, MA 01460  
[www.mcnpweb.org](http://www.mcnpweb.org)

**Mission:** “To promote quality health care and support the nurse practitioner profession through education, policy, and political activism.”

**Background:** Organized in 1992, the Massachusetts Coalition of Nurse Practitioners (MCNP) strives to represent nurse practitioners in Massachusetts. It works with consumer groups, business groups, and legislators. MCNP’s umbrella organization, the American Academy of Nurse Practitioners (AANP), provides MCNP support for research and continuing education projects. AANP also maintains a national database of members and produces several publications, including the *Journal of the American Academy of Nurse Practitioners*.

**Structure:** MCNP has a president and volunteers.

**Membership:** 1,600 nurse practitioners, student nurse practitioners, and other advanced practice nurses

**Cancer Focus:** Breast and colorectal cancer

**Involvement in Cancer Screening:** Supports ACS cancer screening guidelines; publishes patient education materials distributed by members; includes cancer screening activities at meetings; produces printed materials related to cancer screening; participated in ACA advocacy efforts; sends emails to members related to cancer screening; supports members in presenting about cancer screening; supported a breast cancer continuing education program.

**Cancer Screening Online Resources:** None

**Contact Information:**

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Past President, MCNP  
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**National Affiliate:**

American Academy of Nurse Practitioners (AANP)  
[www.aanp.org](http://www.aanp.org)

Note: This profile was developed using information from a telephone interview and from [www.mcnpweb.org](http://www.mcnpweb.org) and [www.aanp.org](http://www.aanp.org).

**Massachusetts College of Emergency Physicians (MACEP)**

860 Winter Street  
Waltham Woods Corporate Center  
Waltham, MA 02451  
[www.macep.org](http://www.macep.org)

**Mission:** “The Massachusetts College of Emergency Physicians is dedicated to advancing excellence in emergency care, and advocating for emergency physicians, their patients and the health of the community.”

**Background:** The Massachusetts College of Emergency Physicians (MACEP) serves as a leader in emergency medicine and supports physicians with this specialty. MACEP offers continuing education courses, as well as other educational programs on issues concerning emergency medicine. It is also involved in advocacy work to protect patients and empower emergency physicians. MACEP is a chapter of its national affiliate, the American College of Emergency Physicians (ACEP), but acts independently. MACEP focuses on state issues, while ACEP devotes its energy to national policies. ACEP also publishes *Annals of Emergency Medicine*.

**Structure:** Executive director, board of directors, committees of volunteer members, and a legislative consultant

**Membership:** 850 emergency physicians in Massachusetts

**Cancer Focus:** None

**Involvement in Cancer Screening:** None

**Cancer Screening Online Resources:** None

**Contact Information:**

Tanya Pearson  
Executive Director, MACEP  
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tpearson@macep.org

**National Affiliate:**

American College of Emergency Physicians (ACEP)  
[www.acep.org](http://www.acep.org)

Note: This profile was developed using information from a telephone interview and from [www.macep.org](http://www.macep.org) and [www.acep.org](http://www.acep.org).

**Massachusetts Geriatrics Society**

40 Fulton St., 18th Floor

New York, NY 10038

[www.americangeriatrics.org/ags\\_state\\_affiliates/current\\_state\\_affiliates/massachusetts](http://www.americangeriatrics.org/ags_state_affiliates/current_state_affiliates/massachusetts)

**Mission:** “To improve the health, independence, and quality of life of all older people.”

**Background:** The Massachusetts Geriatrics Society is a chapter of the American Geriatrics Society (AGS). AGS is a national organization of health professionals dedicated to improving the lives of older people. AGS supports research on health services for older adults, and publishes the *Journal of the American Geriatrics Society*. The clinical association recruits physicians and other health care professionals to the field of geriatrics. AGS works to raise awareness about the need for high-quality geriatric health care. During the past few years, AGS’s advocacy work has included that related to preventive screening.

**Structure:** The Massachusetts Geriatrics Society has a president, who also serves as the state’s AGS representative.

**Membership:** AGS has approximately 6,000 geriatric physicians, nurse practitioners, and physician assistants.

**Cancer Focus:** Breast and colorectal cancer

**Involvement in Cancer Screening:** Advocated for preventive examinations to be covered by Medicare; publishes training materials for physicians.

**Cancer Screening Online Resources:**

- [www.americangeriatrics.org/files/documents/annual\\_meeting/2010/handouts/saturday/cancer/S0915A\\_L\\_Walters.pdf](http://www.americangeriatrics.org/files/documents/annual_meeting/2010/handouts/saturday/cancer/S0915A_L_Walters.pdf)
- [www.americangeriatrics.org/files/documents/annual\\_meeting/2010/handouts/saturday/cancer/S0915A\\_W\\_Dale.pdf](http://www.americangeriatrics.org/files/documents/annual_meeting/2010/handouts/saturday/cancer/S0915A_W_Dale.pdf)

**Contact Information:**

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President and AGS Representative, Massachusetts Geriatrics Society

781-235-9089

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**National Affiliate:**

American Geriatrics Society (AGS)

[www.americangeriatrics.org](http://www.americangeriatrics.org)

Note: This profile was developed using information from a telephone interview and from [www.americangeriatrics.org](http://www.americangeriatrics.org).

**Massachusetts League of Community Health Centers (MLCHC)**

40 Court Street, 10th Floor

Boston, MA 02108

[www.massleague.org](http://www.massleague.org)

**Mission:** To represent and serve “the needs of the state’s 50 community health center organizations.”

**Background:** Founded in 1972, the Massachusetts League of Community Health Centers (MLCHC) represents the community health centers in Massachusetts. It provides information on community-based health care issues to policymakers, the media, and other influential individuals. It also provides technical assistance to members and communities through analyses of state and federal health policies; trainings for health center staff, clinicians, and members of the board; workforce development programs; health information technology assistance, such as implementing electronic medical records; and support to local organizations attempting to open new health centers. MLCHC also conducts advocacy work at both the state and federal levels on reimbursement issues and payment reform. MLCHC staff members are actively involved with its national affiliate, the National Association of Community Health Centers (NACHC).

**Structure:** President and chief executive officer, executive vice president and chief operating officer, executive assistant, committees staffed by more than 30 people, and a board made up of representatives from member community organizations

**Membership:** Approximately 60 community organizations and health systems organizations

**Cancer Focus:** Breast, cervical, and colorectal cancer

**Involvement in Cancer Screening:** Creates patient education materials and distributes ACS educational materials; includes cancer screening activities at meetings; worked with MDPH on advocacy to increase the availability of mammograms; collaborated with MDPH to plan grants for initiatives related to breast and cervical cancer screening; conducted a workshop on cancer screening; provided health centers with technical assistance related to reporting for MDPH breast and cervical cancer screening grants.

**Cancer Screening Online Resources:**

- <http://www.massleague.org/Programs/ClinicalQualityInitiatives/AdultGuide.pdf>

**Contact Information:**

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**National Affiliate:**

National Association of Community Health Centers (NACHC)

[www.nachc.com](http://www.nachc.com)

Note: This profile was developed using information from a telephone interview and from [www.massleague.org](http://www.massleague.org).

**Massachusetts Medical Society (MMS)**

860 Winter Street  
Waltham Woods Corporate Center  
Waltham, MA 02451  
[www.massmed.org](http://www.massmed.org)

**Mission:** “To do all things as may be necessary and appropriate to advance medical knowledge, to develop and maintain the highest professional and ethical standards of medical practice and health care, and to promote medical institutions formed on liberal principles for the health, benefit and welfare of the citizens of the Commonwealth.”

**Background:** Founded in 1781, the Massachusetts Medical Society (MMS) is a state professional association that strives to educate and advocate for patients and physicians in the state, regardless of their specialty. MMS publishes the prestigious academic journal, the *New England Journal of Medicine*, in addition to many other publications about relevant topics in health care. MMS also offers CME to members and serves as a resource for physicians and health care providers in Massachusetts. It convenes working groups to discuss changes in clinical practice. MMS is associated with, but independent of, its national affiliate, the American Medical Association.

**Structure:** Executive director, president, president-elect, vice president, secretary/treasurer, assistant secretary/treasurer, House of Delegates, and a Board of Trustees

**Membership:** 23,014 physicians and medical students

**Cancer Focus:** Breast, cervical, and colorectal cancer

**Involvement in Cancer Screening:** Advocates for preventive services to be provided without copayments and included in global payments under payment reform; advocates for funding for cancer screening in the state budget; engages in media activities related to cancer screening (television show and newspaper article); worked to improve payment for colonoscopies during which polyps are removed; promoted cervical cancer awareness month.

**Cancer Screening Online Resources:**

- [www.massmed.org/AM/Template.cfm?Section=Public\\_Health20&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=31890](http://www.massmed.org/AM/Template.cfm?Section=Public_Health20&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=31890)
- [www.massmed.org/AM/Template.cfm?Section=Public\\_Health20&Template=/CM/ContentDisplay.cfm&ContentID=8008](http://www.massmed.org/AM/Template.cfm?Section=Public_Health20&Template=/CM/ContentDisplay.cfm&ContentID=8008)
- [http://www.massmed.org/AM/Template.cfm?Section=Vital\\_Signs5&TEMPLATE=/CM/HTMLDisplay.cfm&ContentID=33668](http://www.massmed.org/AM/Template.cfm?Section=Vital_Signs5&TEMPLATE=/CM/HTMLDisplay.cfm&ContentID=33668)

**Contact Information:**

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**National Affiliate:**

American Medical Association (AMA)  
[www.ama-assn.org](http://www.ama-assn.org)

Note: This profile was developed using information from telephone interviews and from [www.massmed.org](http://www.massmed.org).



**Massachusetts Public Health Association (MPHA)**

101 Tremont St., Suite 1011  
Boston, MA 02108  
[www.mphaweb.org](http://www.mphaweb.org)

**Mission:** “To improve public policy for public health in Massachusetts.”

**Background:** Founded in 1879, the Massachusetts Public Health Association (MPHA) is a statewide membership organization that engages in advocacy work to improve the health of Massachusetts residents. MPHA develops coalitions and partnerships with other organizations in the state; it serves as the body that organizes these coalitions to jointly support legislative initiatives related to public health, including preventive services. MPHA also offers technical assistance and training for organizations that share its goals or that are part of MPHA campaigns. MPHA devotes some of its resources to educating the public about health issues. MPHA is the oldest, and leading, affiliate of the national organization, the American Public Health Association (APHA); however, it acts independently from APHA. APHA publishes the *American Journal of Public Health*.

**Structure:** Executive director, four other paid staff, and a board of directors

**Membership:** Not available

**Cancer Focus:** Breast, cervical, and colorectal cancer

**Involvement in Cancer Screening:** Advocates for funding for MDPH cancer screening programs, and a prevention trust.

**Cancer Screening Online Resources:**

- [www.apha.org/about/Public+Health+Links/linkscancer.htm](http://www.apha.org/about/Public+Health+Links/linkscancer.htm)
- [www.apha.org/membergroups/newsletters/sectionnewsletters/medical/fall08/ACSRFA.htm](http://www.apha.org/membergroups/newsletters/sectionnewsletters/medical/fall08/ACSRFA.htm)
- [www.apha.org/membergroups/newsletters/sectionnewsletters/public\\_edu/winter10](http://www.apha.org/membergroups/newsletters/sectionnewsletters/public_edu/winter10)
- [www.apha.org/APHA/CMS\\_Templates/PressRelease.aspx?NRMODE=Published&NRNODEGUID=%7b352F426F-F028-48A4-B222-28680CC588B8%7d&NRORIGINALURL=%2fabout%2fnews%2fajphreleases%2f2005%2fAugust%2b2005%2bAJPH%2bPress%2bRelease%2ehtm&NRCACHEHINT=NoModifyGuest#language](http://www.apha.org/APHA/CMS_Templates/PressRelease.aspx?NRMODE=Published&NRNODEGUID=%7b352F426F-F028-48A4-B222-28680CC588B8%7d&NRORIGINALURL=%2fabout%2fnews%2fajphreleases%2f2005%2fAugust%2b2005%2bAJPH%2bPress%2bRelease%2ehtm&NRCACHEHINT=NoModifyGuest#language)

**Contact Information:**

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Diane Jette  
Administrative and Financial Manager  
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**National Affiliate:**

American Public Health Association  
[www.apha.org](http://www.apha.org)

Note: This profile was developed using information from a telephone interview and from [www.mpha.org](http://www.mpha.org) and [www.apha.org](http://www.apha.org).

**New England Rural Health RoundTable (NERHRT)**

10 Benning St.

Lebanon, NH 03784

[www.newenglandruralhealth.org](http://www.newenglandruralhealth.org)

**Mission:** “To improve the health and wellbeing of communities throughout rural New England.”

**Background:** The New England Rural Health RoundTable (NERHRT) is a volunteer membership organization that strives to improve the health of rural communities in New England. To fulfill its mission, it offers educational programs and an annual symposium about rural health. In addition, NERHRT conducts advocacy work to promote rural health. NERHRT is linked to the National Rural Health Association (NRHA), which subcontracts federal grant dollars to state organizations, including NERHRT. NERHRT also participates in the national organization’s educational and advocacy activities.

**Structure:** Executive director, VISTA/AmeriCorps volunteers, and VISTA program manager

**Membership:** 700 individual and organizational members who share the RoundTable’s vision, including staff of small critical-access hospitals, federally qualified health centers, private hospitals, and other rural facilities

**Cancer Focus:** None

**Involvement in Cancer Screening:** None

**Cancer Screening Online Resources:** None

**Contact Information:**

Marion Pawlek, MBA

Executive Director, NERHRT

603-643-2800

[mjpawlek@joimail.com](mailto:mjpawlek@joimail.com)

**National Affiliate:**

National Rural Health Association (NRHA)

[www.ruralhealthweb.org](http://www.ruralhealthweb.org)

Note: This profile was developed using information from a telephone interview and from [www.newenglandruralhealth.org](http://www.newenglandruralhealth.org).

### **Oncology Nursing Society (ONS)**

125 Enterprise Drive  
RIDC Park West  
Pittsburgh, PA 15275  
[www.ons.org](http://www.ons.org)

**Mission:** “To promote excellence in oncology nursing and quality cancer care.”

**Background:** The Oncology Nursing Society (ONS) is an association that supports nurses who provide care to cancer patients. ONS provides members with continuing education opportunities related to oncology and supports research in the field. It produces publications about oncology nursing, and it also participates in related advocacy work. ONS publishes the *Clinical Journal of Oncology Nursing* and *Oncology Nursing Forum*. ONS’s foundation is the second-largest funder of cancer nursing research outside of the federal government. ONS has several chapters in Massachusetts; each is associated with the national organization but functions independently, with a focus on local issues.

**Structure:** Chief executive officer, president, and 130 paid staff

**Membership:** More than 35,000 registered nurses, nurse practitioners, and other health care professionals

**Cancer Focus:** Breast, cervical, and colorectal cancer

**Involvement in Cancer Screening:** Produces educational publications related to cancer screening; holds annual meeting sessions related to cancer screening; works on cancer screening issues for cancer survivors; produces position papers on cancer screening that emphasize the role of nurses as educators; is developing an educational program to teach nurses to speak to public groups about cancer screening; provides continuing education related to cancer screening; advocates at the federal level for resources for cancer screening programs.

#### **Cancer Screening Online Resources:**

- <http://www.ons.org/publications/positions/media/ons/docs/positions/summary-breast-cancer-screening.pdf>
- <http://www.ons.org/News.aspx?id=142>
- <http://www.ons.org/News.aspx?id=161>

#### **Contact Information:**

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[prieger@ons.org](mailto:prieger@ons.org)

#### **Local Affiliate:**

Boston Oncology Nursing Society  
[www.bostonons.org](http://www.bostonons.org)

Note: This profile was developed using information from a telephone interview and from [www.ons.org](http://www.ons.org).

**APPENDIX B**  
**INTERVIEW PROTOCOL**

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**Professional Associations and Cancer Screening Interviews  
General Interview Guide: 8-3-11 Version**

**Interview Date:**

**Respondent(s):**

**Interviewer:**

**Introduction:**

Thank you for taking the time to speak with us today about your organization's activities related to breast, cervical, and colorectal cancer screening.

This interview is part of our study of the role that professional associations in Massachusetts are playing in promoting screening for breast, cervical, and colorectal cancers. We are conducting this study to assist the Massachusetts Department of Public Health (or MDPH) with a strategic planning process that is designed to increase screening rates for these cancers in Massachusetts. We plan to interview up to 15 professional associations for this study.

We expect that this conversation will take no more than one hour. We will use the information that you provide to write a summary report for MDPH and in conversations that we will have with MDPH and its other partners in the strategic planning process. Although our report may contain quotes from this conversation, we will not attribute any quotes to specific individuals or organizations.

**A. Organization Background**

Please briefly describe your organization, its mission, size, and staffing in terms of: overall leadership, communication with members, policy advocacy, and changing clinical practice.

- For local affiliates/chapters of national organizations: How are you linked to the national organization, through what structures (committees, steering groups, communications links, other mechanisms)?

**B. Organization's Perceived Role in Influencing Cancer Screening Rates:**

- In your experience, what can or should professional associations do to promote or support breast, cervical, or colorectal cancer screening rates? For example, how appropriate is it for professional associations to:
  - Advocate for policies to cover the insurance costs and out-of-pocket expenses for screening, such as the new free preventive service provisions for women? Participate in cancer coalitions or partnerships? Endorse and publicize cancer screening guidelines? Disseminate materials on evidence-based screening practices to association members or others? Support

screening trainings for association members or others? Other strategies to change provider or public screening behavior?

- What, if any, has been your organization’s role in influencing breast, cervical, or colorectal cancer screening rates in Massachusetts?
  - Has your organization changed its role in influencing these cancer screening rates over time? How?
  - Would your organization like to expand its role in influencing cancer screening? In what ways?
- For local affiliates/chapters of national organizations: How do you, as the local affiliate/chapter work with the (name national organization) on cancer screening activities?
  - What are the advantages of implementing these activities in Massachusetts when compared to other states?
  - What are the barriers to implementing these activities that you confront in Massachusetts that other affiliates do not confront in other states?

### **C. Current Cancer Screening–Related Activities:**

- In what activities, if any, is your organization currently involved to increase breast, cervical, or colorectal cancer screening rates in Massachusetts? Examples may include:
  - Advocating for policies to cover the insurance costs or out-of-pocket expenses for screening; participating in cancer coalitions or partnerships; endorsing or publicizing cancer screening guidelines; disseminating materials on evidence-based screening practices to association members; supporting screening trainings for association members; other roles to change provider or public screening behavior.
- What, specifically, is your organization doing to increase breast cancer screening rates in Massachusetts? How and why did your organization develop and implement these activities?
- What, specifically, is your organization doing to increase cervical cancer screening rates in Massachusetts? How and why did your organization develop and implement these activities?
- What, specifically, is your organization doing to increase colorectal cancer screening rates in Massachusetts? How and why did your organization develop and implement these activities?

### **D. Policy-Specific Strategies:**

*IF RESPONDENT REPORTED ANY POLICY-RELATED ACTIVITIES:*



- Please describe in more detail your organization’s activities to influence provider or patient screening behavior through policy change in Massachusetts.
  - For the Massachusetts Public Health Association: Please describe your organization’s advocacy activities related to maintaining funding for cancer screening in Massachusetts.
  - For the Massachusetts Academy of Family Physicians: Does the Committee on Legislation and Regulatory Affairs include breast, cervical, or colorectal cancer screening activities in its advocacy work? [If yes] Please describe these activities.
  - For the American Cancer Society – NE Division: Do you work with the American Cancer Society Cancer Action Network or its local representatives in Massachusetts on any activities related to breast, cervical, or colorectal cancer screening? [If yes] Please describe these activities.
- How and why did your organization select these strategies? When did they occur?
  - Have you worked with health plans, employers, consumer groups, or other organizations on these activities? [If yes] Please describe these partnerships.
  - Do these activities include advocacy training or policy campaigns? [If yes] Please describe these trainings and/or campaigns.
  - Do these activities include advocacy to expand insurance coverage or to limit out-of-pocket expenses for screening? [If yes] Please describe these activities.
- How has your organization assessed the effectiveness of these activities? What lessons have you learned about how to change screening behavior through policy?
  - What challenges did your organization encounter while implementing these activities? How did you address them?
- What future activities would your organization like to engage in in this area? What are the obstacles impeding the implementation of these activities?

#### **E. Communications Strategies:**

*IF RESPONDENT REPORTED ANY COMMUNICATIONS-RELATED ACTIVITIES:*

- Please describe in more detail your activities to promote screening behavior by communicating with members, other providers, or the public in Massachusetts.
  - For the Massachusetts Medical Society: Please describe your activities related to Cervical Cancer Awareness Month.
- How and why did your organization select these strategies? When did they occur?

- Have you worked with health plans, employers, consumer groups, or other organizations on these activities? [If yes] Please describe these partnerships.
- Do these activities include any public awareness or social marketing campaigns? [If yes] Please describe these trainings and/or campaigns.
- Do these activities include education on the importance of screening for providers or the general public? [If yes] Please describe these activities.
- How has your organization assessed the effectiveness of these activities? What lessons have you learned about how to change screening behavior through policy?
  - What challenges did your organization encounter while implementing these activities? How did you address them?
- What future activities would your organization like to engage in in this area? What are the obstacles impeding the implementation of these activities?

#### **F. Provider Screening Strategies:**

##### *IF RESPONDENT REPORTED PROVIDER SCREENING ACTIVITIES:*

- Please describe in more detail your activities to change the screening behavior of association members, or other providers.
- How and why did your organization select these strategies? When did they occur?
  - Have you worked with health plans, employers, consumer groups, or other organizations on these activities? [If yes] Please describe these partnerships.
  - Do these activities include any screening training programs? [If yes] Please describe these trainings.
    - Has your organization sponsored any continuing medical education programs, webinars, or grand rounds that focus on provider screening? [If yes] Please describe these activities.
  - Do these activities include education on the importance of screening for providers or the general public? [If yes] Please describe these activities.
  - Has your organization worked to alter the clinical or payment context to increase screening capacity in primary care settings? [If yes] Please describe these activities.
  - Has your organization endorsed any specific screening guidelines? [If yes] Please tell us about these guidelines.
  - Has your organization worked to implement systematic screening in large clinics (perhaps with disease management cohorts)? [If yes] Please describe these activities.

- How has your organization assessed the effectiveness of these activities? What lessons have you learned about how to change screening behavior through policy?
  - What challenges did your organization encounter while implementing these activities? How did you address them?
- What future activities would your organization like to engage in in this area? What are the obstacles impeding the implementation of these activities?

**G. Cancer Screening Collaboration with MDPH:**

- What can MDPH do to increase overall screening rates for breast, cervical, and colorectal cancer, both independently and working in partnership with you?
  - How can MDPH support your current cancer screening activities?
  - How can MDPH help with the planning, implementation, or coordination of your future cancer screening activities?
  - What kinds of barriers have you confronted that MDPH could help you surmount?
- Is there anything else that you would like us to know about your activities related to increasing breast, cervical, or colorectal cancer screening?
- Who else should we talk to in your organization who is working on (as paid staff or as a volunteer): changing policy, communicating with members, or changing provider behavior?

Thanks again for taking the time to speak with us. We appreciate your time and will keep you informed about the results of our activities over the next few months.

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**APPENDIX C**  
**CODING STRUCTURE**

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## CODING STRUCTURE

LEVEL 1	LEVEL 2	LEVEL 3	DEFINITION
<b>ORGANIZATION BACKGROUND</b> [A.]			
	Overview [A.1]		Organization's mission, size, membership, governance, and structure; include information about organization type [i.e., 501(c)(3)]
	Staffing [A.2]		Number and types of staff and their roles; include leadership, communications, and policy staff
	Local Affiliate Information [A.3]		Geographic information for local affiliate, local affiliate's relationship with national organization, local affiliate's scope of work
	National Organization Activities [A.4]		For local affiliates only: activities of the national organization that affect Massachusetts
<b>CONTEXT</b> [B.]			
	State-Specific [B.1]		
		History and Context [B.1.1]	Historical information about cancer screening programs in Massachusetts, as well as general information about the context for cancer screening in Massachusetts
		State-Specific Barriers [B.1.2]	Barriers encountered while working on cancer screening in Massachusetts
		Advantages [B.1.3]	Advantages to working on cancer screening in Massachusetts when compared to other states
	Changing Context [B.2]		How health care reform and other anticipated changes to the health care system will change the context of efforts to promote cancer screening
	Role of Data [B.3]		
		Electronic Health Records (EHRs) [B.3.1]	EHRs, meaningful use, and the effect of data from EHRs on cancer screening
		Insurance Company and Large Group Data [B.3.2]	How insurance companies and large group practices use data and the effect of these data on cancer screening

<p>General Barriers [B.4]</p>	<p>Barriers that prevent cancer screening rates from increasing. Include current barriers and barriers anticipated in the future. Include reimbursement issues</p>
<p>Colon Cancer Screening Methods [B.5]</p>	<p>Discussions of the advantages and disadvantages of different types of colon cancer screening</p>
<p><b>PERCEIVED/Actual ROLES</b> [C.]</p>	
<p>Role of Organization [C.1]</p>	
<p>Current Role [C.1.1]</p>	<p>An organization’s perception of its appropriate role in promoting cancer screening, comparison to the organization’s actual role, and which activities the organization chooses to engage in</p>
<p>Changing Role [C.1.2]</p>	<p>How and why the organization’s role in promoting cancer screening has changed over time</p>
<p>Future Role [C.1.3]</p>	<p>How the organization sees its role in cancer screening changing in the future; include information about what would need to happen for the organization to expand its role in cancer screening</p>
<p>Screening Outside Scope of Work [C.1.4]</p>	<p>Reasons why an organization does not consider promoting cancer screening to be part of its role, and what limits it from taking on that role</p>
<p>Role of Insurers, Employers, Hospitals, and Practices [C.2]</p>	
<p>Screening Responsibility [C.3]</p>	<p>Who the organization sees as having the primary responsibility for promoting cancer screening</p>
<p><b>CURRENT ORGANIZATION ACTIVITIES</b> [D.]</p>	
<p>Advocacy [D.1]</p>	
<p>Payment Reform [D.1.1]</p>	<p>Advocacy efforts related to payment reform</p>



	Affordable Care Act (ACA) [D.1.2]	Advocacy efforts related to ACA
	Insurance Coverage and Copayments [D.1.3]	Advocacy for policies to mandate insurance coverage for cancer screening or eliminate copayments for cancer screening
	Reimbursement and Practice Issues [D.1.4]	Advocacy for policies to increase physician reimbursement or to make practicing medicine easier
	MDPH Advocacy [D.1.5]	Advocacy efforts on behalf of MDPH
	Other Past Issues [D.1.6]	Other issues and legislation the organization has worked on in the past
	Other Ongoing or Future Issues [D.1.7]	Other issues and legislation the organization is currently working on or plans to work on in the future
	Successes [D.1.8]	The organization's legislative or other advocacy successes
	Barriers [D.1.9]	Barriers the organization has encountered during its advocacy efforts
	Advocacy Affiliate [D.1.10]	If an organization has created a separate sister organization for advocacy and lobbying, information about that organization
	Communications [D.2]	
	Website [D.2.1]	Information about the organization's website
	Media [D.2.2]	How the organization uses the media to disseminate information and how the organization interacts with members of the media
	Direct Communication with Members [D.2.3]	Methods by which the organization communicates directly with its members and examples of these communications, including emails, news alerts, and broadcast messages
	Busy Members [D.2.4]	Difficulties posed by, and strategies to communicate with, members who are very busy and may not read all communications
	Publications [D.2.5]	Information about the organization's publications. Include information about how they are created, who they are written by, and how they are disseminated

	Community and Awareness Events [D.2.6]	Events run by the organization for the general public, including fund-raising events
	Other Communication Methods [D.2.7]	Other organization efforts related to communications
	Coalitions and Partnerships [D.3]	Instances in which the organization has partnered with another organization or participated in a coalition related to cancer screening
	Guidelines [D.4]	Developing, endorsing, or publicizing cancer screening guidelines, as well as challenges presented by the complexity of these guidelines
	Dissemination [D.5]	Providing information about cancer screening to members
	Training [D.6]	Providing trainings related to cancer screening; include CME and annual meeting activities
	Hospitals and Clinics [D.7]	Collaborations, partnerships, technical assistance, or other work with hospitals or clinics
	Employers [D.8]	Collaboration, partnerships, technical assistance, or other work with employers
	Patients [D.9]	Direct work with patients or resources available for patients
	Breast Cancer–Specific [D.10]	Specific activities related to breast cancer screening
	Cervical Cancer–Specific [D.11]	Specific activities related to cervical cancer screening
	Colorectal Cancer–Specific [D.12]	Specific activities related to colorectal cancer screening
	Evaluation and Effectiveness [D.13]	Activities to evaluate the effectiveness of an organization’s activities, as well as descriptions of the effectiveness of its activities
	Nonscreening [D.14]	Other activities of the association that are not related to cancer screening
	Other Activities [D.15]	Any other activities of the association
	Past Activities [D.16]	Past activities of the association

Community-Based Organizations [D.17]	Collaborations, partnerships, technical assistance, or other work with community-based organizations or consumer groups
Health Plans [D.18]	Collaborations with health plans
Clinicians [D.19]	
<b>FUTURE ACTIVITIES [E.]</b>	
Planned Activities [E.1]	Future activities planned by the organization
Lessons Learned [E.2]	Lessons an organization has learned through its cancer screening activities
Suggestions to Increase Screening [E.3]	Strategies, specific methods, or general comments about ways to increase cancer screening rates
<b>MDPH [F.]</b>	
Collaboration with MDPH [F.1]	Activities in which the organization has partnered with MDPH, in which MDPH has helped the organization, or in which the organization has helped MDPH
Perceived Role of MDPH [F.2]	The organization's understanding of the role that MDPH should play in cancer screening
How MDPH Can Help [F.3]	Ways in which MDPH can support the organization's cancer screening efforts in the future
Supporting MDPH [F.4]	Ways in which the organization can support MDPH's current or future cancer screening efforts
Current and Past MDPH Activities [F.5]	Past and current activities of MDPH that did not involve collaboration with the organization
<b>OTHERS TO CONTACT [G.]</b>	
Organization Staff to Contact [G.1]	Contact information for other people within the organization we may want to contact
Other Organizations to Contact [G.2]	Other organizations we may want to contact, and reasons why we should include them in the project

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