TRANSCRIPT

[00:00:00] Karen Knudsen: I am on the road and airplanes because we work in 5,000 communities across the country to provide prevention and screening, education, patient housing, patient transportation, and the all-important patient navigation. We measure our success at ACS by our ability to get more people into prevention and screening programs and to impact lives through education and giving access to care. That's actually every single person on my team owns our organizational goals, which are how it is that we adhere to our strategy to improve lives.

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[00:00:36] Speaker: Welcome to A&M Healthcare Industry Group's *What's Your Moonshot?* podcast series where world-class healthcare leaders seek to solve big problems. Listen, as we talk to today's health system CEOs about the journey to achieve their moonshots.

[00:00:54] Larry Kaiser: Welcome to A&M's *What's Your Moonshot?* podcast. I'm Larry Kaiser, managing Director at Alvarez & Marsal Healthcare Industry Group. I'm joined today, as I am usually, by my co-host, the ninth Secretary of the Veterans Administration, the Honorable Dr. David Shulkin. Today, we welcome Dr. Karen Knudsen, Chief Executive Officer of the American Cancer Society and its advocacy affiliate, the American Cancer Society Cancer Action Network.

As a well-respected cancer researcher, leader, and advocate, Dr. Knudsen guides the organization in its vision to end cancer for everyone. Prior to joining ACS, Dr. Knudsen served as Executive Vice President of Oncology Services and enterprise director for the Sidney Kimmel Cancer Center at Jefferson Health in Philadelphia. She also serves on the board of advisors for the National Cancer Institute and on 12 external advisory boards for NCI-designated Cancer Centers. Dr. Knudsen, welcome to the podcast. We're delighted to have you with us today.

[00:01:52] Karen: Oh, thank you so much for having me. It's a pleasure.

[00:01:55] David Shulkin: Karen, it's really special to have you with us today. We're catching you probably in between getting an airplane somewhere because we know that you're spending your time all over the country talking to people, listening, learning, but also sharing your vision for where the American Cancer Society is trying to lead the country in this important area.

You've had a focus on cancer for quite a while. You've seen big initiatives in cancer like the President's Moonshot, and that's clearly an important part of developing this type of moonshot for cancer, but why don't you tell us a little bit about what your hopes are for where we can go as a country and maybe even beyond the country to be able to conquer cancer?

[00:02:46] Karen: Yes, a great question. We have been shaping our place in the universe at the American Cancer Society. We're 110 years old, true and false in the same statement. ACS actually used to be a federated model, so up until not very many years ago, it was separate organizations, 12 at least, with different ideas and different strategies. I'm very honored to be the second CEO to lead as a single organization.

Our goal is to end cancer as we know it, for everyone. Our strategy to support the moonshot is tripartite in nature. To support through research, we're the largest funder of cancer research outside the US government, but to make sure that people have access to those breakthroughs through advocacy, this is where the CAN, the 501(c)(4) comes into play. I'm so proud of what we've been able to achieve already just through CAN these even six months.

It's the case that too many patients actually don't get access to cancer prevention, cancer treatment at the right time, or even access to quality cancer care. That's where our third approach comes in, in patient support. I am on the road and airplanes because we work in 5,000 communities across the country to provide prevention, screening, education, patient housing, patient transportation, and the all-important patient navigation.

[00:04:06] Larry: Karen, healthcare inequities are a big focus for a lot of healthcare leaders today. Access, and you mentioned that, as well, as disparity challenges are no doubt a hindrance to achieving your moonshot of ending cancer. Can you talk a little bit about some of the challenges with treating cancer when access to care and disparities and outcomes vary so significantly? What are some of the steps you're taking toward closing this gap?

[00:04:29] Karen: Yes, no question. Let's just take a recent example. We're seeing a 5% year-over-year increase in advanced prostate cancer diagnoses across the country, all demographics, right? We know that Black men and White men are screened at approximately the same levels. It's low, only one-third of eligible men screened for prostate cancer, yet Black men have 224-fold the mortality rate of any other demographic in the US in this country.

A lot of that is associated with access to care. We can and need to do better. Our patient support pillar is intended to help solve for that. Those things that we do, the transportation, housing, lodging, education, navigation are meant to solve for the social determinants of health that we know are associated with a poor outcome. That said, we still have a lot to do.

We have a lot to do in discovery to understand cancer disparities and to address them for those that are associated with increased risk and understanding, for example, risk for prostate cancer of men of African descent. Really important for us to continue to do research but also to push for common sense, legislation, and policies through advocacy that give access to care.

At the same time we think about moonshots, we think very deeply at ACS about ground shots, as we call them, that we are uniquely positioned to solve for, in addition to patient support programs, things like boosting HPV vaccination rates. Six different cancers are caused by HPV, yet it's the case that vaccination uptake rates for all of those who are eligible, men and women, are poor.

Going around the country, using quality improvement programs that health systems implement to, for example, boost HPV vaccination rates is just one example of the kind of thing that we do so that fewer people get cancer and more people survive.

[00:06:21] Larry: Let me just go back to one of the things you said. Only 1% of men screening for prostate cancer or do you mean specifically--

[00:06:27] Karen: One-third.

[00:06:28] Larry: One-third, screening either PSA or digital rectal exam.

[00:06:32] Karen: Yes, optimally [crosstalk]

[00:06:33] Larry: Only one-third. Amazing.

[00:06:35] Karen: Yes, a very highly survivable cancer, right [crosstalk] but second leading cause of cancer death in this country. It's actually the largest cancer disparity that exists in oncology is Black men with prostate cancer. We actually are really doing quite a lot about that right now in terms of prevention and screening, outreach, working with communities, but also conducting the kind of research that will help us understand, "Are screening guidelines still correct?"

We're refreshing the screening guidelines right now by using best evidence, something ACS is uniquely poised to do, but then at the same time, ensuring that we are educating men about the importance of early detection. This is not the year 2000, the time when people just rushed to radical prostatectomy. The science has moved, medicine has moved, and we have much more sophisticated ways to both assess risk and also to stratify men into treatment regimens.

[00:07:29] Larry: Well, as you point out, you are moving some of the screening timelines. You moved colon cancer back to 45 as opposed to 50 because of the increasing incidence of colon and rectal cancer in younger people.

[00:07:41] Karen: So glad you brought that up. We actually moved our screening guideline from 50 to age 45 for those of average risk. We were the first organization to do that, and two years later, the US Prevention Task Force followed. That said, we are still seeing concerning trends in early-onset colorectal cancer. Our latest report just released a few weeks ago showed us that, in fact, the incidence and mortality rate rise is unique to those that are 55 and younger.

Those 65 and above are actually having reduced incidence and mortality of colorectal cancer because they're undergoing colonoscopy. There's an education component of that.

There's also a very significant advocacy component. Our advocacy is at the federal and state level, but this required a federal fix. Up until January of this year, if someone screened positive at home with the colorectal cancer test, a FIT test, or something that's similar, their screen for colonoscopy, which would be the next logical step, was no longer completely reimbursed because now it's diagnostic; it's not a screen.

This is where we went to work, and we're very thankful for the Biden administration to be responsive to our concern about this as well as CMS to reverse that policy. As of January of this year, we're delighted that there is no financial burden for someone who's elected to take an at-home colorectal cancer test and now needs a follow-on colonoscopy, can get it without financial penalty.

[00:09:17] David: You mentioned so many different aspects to the type of work that you're involved in and what we need to do to improve cancer care. I wonder, what are the metrics that you tend to follow to see whether we're making progress as a country? So many different areas that you could track in prevention and diagnosis, treatment, mortality, time to screening, but what are those key things we should be following to see if we're making that progress?

[00:09:46] Karen: I can tell you the way that we track for the nation, and we also track internally for ourselves. One of the most important things I think that we do as an organization is within our research, our discovery pillar, and that's our epidemiology team in Atlanta all year long conducts a national study of cancer incidence, cancer mortality, and trends, demographic and geographic. When we think about the 200 diseases that are

cancer, we look at that every year, and we announce and distill to the nation, "Here's where we're doing really well."

HPV-induced cancers, as much as we still need to get vaccination rates where they need to be, I was delighted to be able to announce in January that we saw a precipitous 65% decline in mortality for women ages 20 to 24 from cervical cancer, the first real-world evidence that HPV vaccination is doing what it should do. What do we expect? We expect that other HPV-induced cancers as the first generation of those who were vaccinated, like my son, who's 23, that as they age, they will also experience a reduced incidence and mortality from HPV-induced cancers, a win.

It's a win for science. It's a win for medicine, and we should all celebrate. However, we also rang the alarm bell on prostate cancer and said, "Time out. 5% rise year over year since 2014 in men presenting with advanced disease. This is unacceptable." That's the way we measure, is "What does our trend look like?" We also look at geography. In prostate cancer, we saw that while incidence is the lowest in the West of the United States, it's the highest mortality.

What's going on there? Lots to unpack. We are able to distill down and create platforms to say for others in partnership with ACS or even in parallel with ACS to address these issues. Internally, we measure our success at ACS by our ability to get more people into prevention and screening programs and to impact lives through education and giving access to care. That's actually, every single person on my team owns our organizational goals, which are how it is that we adhere to our strategy to improve lives.

[00:12:02] Larry: We talked a little bit about this earlier in this whole issue of access, but the US healthcare system inherently is difficult to navigate for patients, and that can ultimately affect treatment and patient outcomes. You mentioned a little bit about this, and some of that difference in prostate cancer may be an access issue. Your moonshot includes investing in patient navigators. Can you explain, Karen, a little bit how this works and where you see this making the biggest impact?

[00:12:29] Karen: Yes. Without question, this is, again, being led by data. One can only come to the conclusion that patient navigation saves lives, period, end of story. One patient navigator can navigate thousands of individuals, yet they're not reimbursed. Now, what happens when someone's navigated? They understand their care plan. They're much more likely to complete their care plan as planned.

They don't end up in the emergency department, and everybody wins when there's the patient navigator, the patient, the health system, the provider, everyone wins. Because it's not reimbursed, they're in short supply. I can tell you this from my healthcare executive days, how difficult it is to build your business plan to include a patient navigator. This also constrains individuals from being evaluated for clinical trial, which we know is the most advanced form of care for cancer.

We together with our partners who we're very thankful for Janssen and AstraZeneca to help lean in with us, to help us fund patient navigators, we did a call around the country and asked, "What problem would you solve with a patient navigator? What unique patient population would benefit? What cancer inequity would you solve? What creative solution will you entail, and how will this impact your catchment area?" We had more than 200 applicants, 2 different, different health systems, all meritorious, apply. We could only afford to fund 20.

Each of them were having now a navigator for three years with the idea that then they also are in a learning collaborative with each other so that what happens in Philadelphia can

impact something that happens in Nashville. These patient navigators are helping us collect additional data to layer on what's preexisting, to push for patient navigation as something that should be reimbursed in the healthcare continuum. We fully believe that patient navigators can reduce a significant number of the cancer inequities that exist in outcome, in understanding, and in completion of care.

[00:14:37] David: Karen, that's a very important vision that you have, and thank you for advocating for that. Hopefully, we'll see some real progress. One of the things I know you brought to your organization is the creation of a chief experience officer, which is really trying to understand how difficult sometimes it can be to navigate the complexity of our healthcare system.

I wonder what your thoughts are about the role then of artificial intelligence with tools like ChatGPT and only likely to get better. I suspect more and more patients are going to be navigating the system on their computer and asking for ChatGPT to tell them how to get their care, where to get their care. Do you think that's going to help with navigation, or do you think that adds an additional caution that we have to worry about?

[00:15:31] Karen: I think it's a both/and. We do worry, as we say in science, about garbage in, garbage out. What ChatGPT or similar type structures may advise a patient, you have the concern that it may be no better than Dr. Google, which we know is not the place for people to get cancer care. We do have a 24/7 hotline and chatline. The chatline's a real person, not a bot so that we can address, in any given moment of the day, ad we do, people's concerns not just about care but also about prevention and screening and help navigate patients to screening and to care.

At the same time, we want to make sure that we're providing this trusted source, we also recognize that the artificial intelligence strategy may help us, right? It may help us reach more people. We've just got to make sure that there's good rigor in the process. We embrace the new technology and look forward to it but only when and if we're very satisfied that this is not introducing an unneeded confusion when we struggle already to convey information to people about a disease as complex as cancer.

[00:16:44] Larry: Certainly, the use of artificial intelligence can be used by clinicians, in fact, with all of the data out there to actually look at some both risk adjusting, looking at prognosis, perhaps being able to decide which patients are best for clinical trials. I think that there's tremendous possibilities.

[00:17:03] Karen: Totally agree with you. Yes, we absolutely embrace the--In fact, we fund research in the artificial intelligence era. Like with any new technology, it just needs to have rigor in testing, and we're very excited about what we see so far and are absolutely thinking about how it is that for all aspects of the cancer continuum, artificial intelligence can be used to refine strategies.

[00:17:29] Larry: The ACS as an organization is obviously very collaborative, and you are in the position of collaborating with other healthcare leaders to push the mission forward, really across the entire country. This is a big question, but what lessons can you share with leaders who are looking to join in your journey to decrease the rates of cancer in their patient populations? Specifically, and you mentioned a little bit about this, how do you see the role of screening for certain malignancies?

[00:17:57] Karen: Yes. To answer your first question, I would absolutely love to have a discussion with other leaders whose organizations are aligned in strategy. We work very well with others. I'm very proud, for example, of our partnerships with ASCO, where even online,

we have cross-connected our information because our stakeholders are slightly different. Ours is the patient and the caregiver; ASCO tends to be the oncology team.

In the middle of us is a primary care physician. Cross-connecting our content and information has allowed people to get different depths of knowledge about cancer. That's just one of the many things that we've done with ASCO. We also put together a global cancer collaboration group. We recognize we can do more even outside the United States to help everyone with cancer.

There's a large number of reasons for us to think beyond the borders of this country to look for cancer solutions and to collaborate. We've just published our first op-ed of multiple cancer organizations leaning in to opine on how it is that this, I think, could accelerate progress against cancer. Of course, we collaborate with pharma and community partners as well to help us get our work done.

Absolutely embrace that concept. Now, what guidance would I give people is the same that I give my own team. Where are we uniquely poised to act alone and where it is that we're better in partnership or better to let another organization take that on is part of the fabric of how we make our strategic choices at ACS. We have so much to do, 200 diseases we call cancer, 19 million survivors at least in the United States right now who would like to ensure that they have a good quality of life or that others actually don't experience cancer.

In order for that to happen, prevention and screening has to be a big part at play. We've placed a lot of focus in discovery as an oncology community on treatment. That is important, but we've got to also start to shift the focus toward early detection and innovation there, for example, in multi-cancer early detection tests. I would expect that much of the innovation that we're going to see outside artificial intelligence and maybe alongside artificial intelligence is going to be in the early detection space and the imaging space.

[00:20:23] David: I think that's a great way to wrap up because lots of good, important advice for both leaders but also everyone who's involved in the healthcare system and then certainly for patients as well. We're grateful for your time today. We're also grateful that you took on this role. I think you're uniquely poised to be able to help lead us over these upcoming new challenges that we face, but also, it's great to see the progress we're making as well.

[00:20:52] Larry: Well, and certainly, it's a big job. Your constituency is huge and multiple, so it's great that you're in that position, and we wish you the best as you continue on this journey. Again, thank you very much for participating with us on the podcast today, Karen.

[00:21:11] Karen: My pleasure. It's a great kind of life when you wake up every day, and you know that every minute of every day, someone in your organization is doing good in the world. It's a good way to live.

[00:21:22] Larry: All good. Thank you.

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[00:21:32] Speaker: Alvarez & Marsal. Leadership. Action. Results.

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[00:21:50] Larry: First of all, I think that the ACS is in great hands with Karen Knudson. She certainly is someone who communicates incredibly well that is an advocacy organization. It's an advocacy organization that has assumed a tremendous amount of importance in this

country for a huge problem. As we pointed out, some of the problems include access and disparities, and she's addressing both of those as best that she can.

Working with the government I think is going to be critically important, having the ACS out front, especially when it comes to screening and improving access. I think she discussed a little bit about the Navigator program. Obviously difficult to pay for but no question is helpful for patients who are seeking treatment. What do you think?

[00:22:37] David: Yes, I think so. I think that a lot of people thought when Karen stepped in since she comes from a research background, that she was going to focus really primarily on ACS's research agenda. She has really come in and widened the aperture for what the American Cancer Society can do and weigh in on. I do think that this approach towards thinking about the patient experience and the problems the patients have in understanding how they can get access to the best care is something that she's embraced and is making a difference because, as she has clearly said, it's not just about treatment and science.

If you don't know how to get access to care, if you don't know about prevention, and if you don't know about screening, you can't really make the type of difference that I think that she's looking to make in this country.

[00:23:33] Larry: Well, even something like the HPV vaccine, it's so readily available and clearly has shown to be efficacious. Even that, most people are not aware of it despite the fact that it's as available as your local CVS, for that matter. I thought, all in all, really well done.

[00:23:51] [END OF AUDIO]