Ovarian Cancer Podcast Series – Collaboration Episode Transcript

[Announcer] This program is presented by the Centers for Disease Control and Prevention.

Announcer: Welcome to our podcast series on CDC’s Ovarian Cancer Demonstration Project. I’m your host, Jake Lynn.

Did you know that ovarian cancer is the fifth leading cause of cancer death among women in the United States and the second most common type of female reproductive cancer?

Today, I spoke with Katie Jones, Mary Charlton, and Jenny Patterson from Iowa and Kelly Smith from Rhode Island about their experiences collaborating on a CDC demonstration project to increase gynecologic oncologist involvement in the treatment for ovarian cancer. While there is no simple and reliable way to screen for ovarian cancer in asymptomatic women, a woman’s chances of survival increases if her treatment is given or directed by a gynecologic oncologist.

So let’s meet our guests.

Katie: Hi I am Katie Jones with the Iowa Department of Public Health. I am the Program Manager of the Comprehensive Cancer Control Program.

Mary: My name is Mary Charlton. I am an Associate Professor in the Department of Epidemiology at the University of Iowa College of Public Health. I’m also the PI and Director of our Statewide Iowa SEER Cancer Registry which is run out of the University of Iowa as opposed to the Iowa Department of Public Health.

Announcer: For our listeners, Mary is a principal investigator or PI who is responsible for directing the project. As Mary mentioned she is the Director of Iowa’s Surveillance, Epidemiology, and End Results Program also known as SEER. SEER provides information on cancer statistics to reduce the cancer burden among the US population. Now, let’s give Jenny an opportunity to introduce herself.

Jenny: This is Jenny Patterson, and I am a research specialist working with Mary at the University of Iowa College of Public Health.

Announcer: And over to Rhode Island.

Kelly: Hi, my name is C. Kelly Smith. I am the Program Manager of the Comprehensive Cancer Control Program.

Announcer: Very good, thank you again. Well, one of the many successes that came out of this project was the great collaboration among the demonstration sites, including the Roundtable, the monthly cross-site calls, and the cross-promotion of events. The Roundtable discussion brought together ovarian cancer experts to discuss ovarian cancer diagnosis as well as the benefits of a rapid referral to a gynecologic oncologist. During the Roundtable, each of the participating sites gave a brief presentation on their demonstration project and selected strategies. Can you all talk a little bit about your experience collaborating on the Roundtable?

Kelly: Ok, great, so when this project first became an opportunity for us, we convened a group of survivors and advocates and other folks here in Rhode Island to advise us as to what they thought was the best method would be to attain the goals of the project. So, we’ve had success in Rhode Island with Roundtable formats finding that often they lead participants to adopt really good PSE improvements. So, our group decided to convene one for this project because there are nuances we found to ovarian cancer diagnoses and primary care that might lead to earlier detection and better outcomes.

So, because we knew that there were other states participating, Rhode Island had suggested that the other states be invited to present summaries of their projects in the Roundtable that we were planning and spent a good deal of project time planning. And that would add value for the people who attended the roundtable, and also would give a platform for a bigger stage for the other states to present their projects. And all of the projects were very different from each other, as we found out, and as you will see later. And that they seemed like they would be a good set of possibilities to offer up for contemplation to the people attending the Roundtable.

Providers throughout the US were eligible to attend the roundtable for CME credit so we thought that the roundtable conversation might also interest their partners in cancer prevention and control. And we used the monthly calls that ICF set up to plan the collaborative parts of the Roundtable.

Announcer: And for our listeners, PSE are policy, systems, and environmental change approaches that are used to support cancer prevention and control in our communities by making healthy choices and behaviors the default choice.

Continuing Medical Education also known as CMEs are educational activities that doctors are required to complete to maintain, develop, and increase their knowledge, skills, and professional performance so that they are able to provide services for patients, the public, or their profession. Now that we’ve covered that let’s turn back to Mary and hear about her experience. How about you, Mary?

Mary: Yeah, I just wanted to echo what a wonderful opportunity that they gave us to join into that Roundtable. Like Kelly said, all the projects were so complimentary and different in that it kind of gave a nice round 360 version I think of what some of the issues are. And then we were able to represent a number of states rather than just our little microcosm. So, it was great. We could contribute information about the interviews that we had done with ovarian cancer survivors who we saw did not get care at a place that had a gynecologic oncologist. I think that was kind of an important contribution we could make to the Roundtable and some of the education materials that came out of our interviews with those patients and with providers across the state.

But Rhode Island definitely had a more robust collection of stakeholders that were having really important conversations with each other and included primary care which was not a part of our project. So, we learned, we probably learned more than we contributed to it, but we were really grateful to have that opportunity.

Announcer: Kelly, can you share how the Rhode Island team evaluated the Roundtable? Please also share any thoughts about how this strategy might be sustained.

Kelly: So, the roundtable had a CME evaluation to assess the success in obtaining the learning objectives that were stated and the results were quite positive. Also, the other thing about the roundtable that I think is important to note is that when we do one of these, either a Roundtable or webinar, as long as the science that guides it remains the same, we have an arrangement with Brown University Continuing Medical Education that they can make it evergreen for two years post broadcast so that other providers who weren’t able to make the live event, can take it and get CME credit.

Announcer: As part of the overall demonstration project, the sites participated in a group call every other month. Sometimes the calls focused on a particular topic, such as discussing their implementation or evaluation plans. Other times, the calls were used as an opportunity for the sites to gather and discuss successes and challenges, or to present drafts of materials they developed, or to share preliminary findings from their evaluation activities. The sites spoke about what they gained from these cross-site calls.

Mary: I thought they were incredibly helpful. You know, you kind of get into your own world and think of course this is just an OB/GYN problem, we have to focus on them. And then to hear the Rhode Island group, and the Michigan group talk about, well primary care actually plays a role in this. And this is how we think that works. And just to hear the different methods and the different stakeholders that were involved, really kind of broadened my view of the issues and kind of really helped us formulate a plan for how to implement what we were trying to do. And it was just helpful to hear what was working for other people, what was not working for other people. It was in the middle of the pandemic so any help trouble-shooting the myriad of issues that one has in running a project like this during a pandemic, it was really helpful to hear from the other sites.

Announcer: Kelly?

Kelly: From our perspective the calls definitely allowed us to understand the approaches that the other states were considering and then taking the lessons that they were learning. In some cases, we may not have pursued something, but we were inspired by something another state was doing. All of this inspired us to want to help promote all of these ideas via the Roundtable. So ultimately, I think it was the calls that led us down the path of inviting our colleagues to participate in the Roundtable which I believe made it much better for everyone.

Also, just to echo what Mary said, the first time we had our first call as a group of funded entities, I was really like, really surprised but also incredibly impressed by the variety of ways in which all of us were choosing to implement our ideas. As these projects evolved and it made me very excited about learning the results of each of the projects because I knew that we could then use what each of the projects found and integrate it better into our own work.

Announcer: Thanks for sharing that. It’s great how each of you were able to learn from the other sites’ demonstration projects and in some cases, incorporate approaches into your own projects. In addition to the Roundtable, each of your teams hosted your own webinar and all of the demonstration sites developed educational materials for patients and providers. Had either of your teams promoted the activities or materials developed by the other sites within your respective state?

Mary: Oh definitely. I think the way Brown set them up made it easy to promote them as a series because there wasn’t just a Roundtable. But you could get CMEs for all of them, so we promoted all of them quite a bit and it was just helpful, like Kelly said just to have the perspectives of what the others were doing.

Kelly: In Rhode Island, we also developed a toolkit to accompany the Roundtable and the toolkit was a product of all three projects in a lot of ways. We took the lead on developing it, but we included materials that were submitted by each of our colleagues. So, there were resources for survivors, resources for providers to use with their patients but also educational resources for the providers. And then, some tools, like how do you determine whether your patient is eligible for genetic counseling. You know other types of tools, not really decision trees but other things that would help providers learn more about the benefits of rapid referral to a GYN oncologist. So, it just was a good experience, I think, all the way around.

Katie: We really appreciated the opportunity to work so closely, especially with Rhode Island and to work with Brown University. It was really nice that our webinar that we did was Iowa specific with Brown University it could be promoted with the Roundtable, and with Rhode Island's webinar that they did. And Rhode Island really helped us as we pivoted with COVID to switch to do a webinar, whereas before we had planned to do more in person meetings. It was just great that Rhode Island was so helpful in getting us connected with Brown University and helping us to make those changes.

Announcer: I really like how you were able to leverage the efforts of one site to enhance the reach of messaging in your states, particularly for providers. I’m curious, Mary, are there any activities for which you would have liked to have collaborated?

Mary: I think it would have been really interesting if we could have done the same types of interviews we did in Iowa with those survivors, if we could have done them in Rhode Island and Michigan to see if you heard the same things there. That’s something as I reflect and look back, I wish I would have known to do or try to pursue.

Announcer: That would have been interesting. That’s definitely something to consider for future initiatives.

Okay, I want to shift our conversation a little bit. Tell me what made it easier or more difficult to collaborate with the other sites. Let’s start with you, Kelly.

Kelly: I kind of have a list of things that I think were facilitators for us. So, first thing was having a multi-disciplinary planning committee with strong representation by cancer survivors made a huge difference in how we structured our project and what we actually did. Technical support from ICF and CDC was very valuable, particularly as regards to the goals of the project and the evaluation piece. The opportunity to learn what the other states were doing and to kind of brainstorm on occasion with them was very, very helpful.

Mary: I think ICF just setting up the calls and inviting the sites and managing all of that. That would've been pretty difficult for us to manage on our own and if left to our own pandemically hampered schedules and things like that, who knows if they would've e-happened on such a regular basis. So, they really kind of facilitated that.

Kelly: Yeah definitely.

Announcer: Do you have any recommendations for other comprehensive cancer control programs that might be looking to collaborate with other programs?

Kelly: We suggest that you form a well-rounded team of stakeholders and allow them to help shape the required interventions. Generally speaking, you usually get better quality results than if you start with a goal in mind that's very finite. Cancer survivors in my opinion and in our state's opinion in terms of our comprehensive cancer control work should help to inform and shape all of our efforts to improve survivorship. No one has a bigger stake in our success than they do. And their lived experience often leads participants to better understand the importance of an approach. We should all be willing to add value to our projects as good ideas emerge.

Jenny: I would just echo what Kelly said about involving ovarian cancer survivors. I was the project team member who was speaking to the ovarian cancer survivors who were giving us feedback on the patient education materials that we developed. And they were just incredible, as grateful as we were for their time, and their feedback, they were so grateful that we were doing this work. That we had developed these materials and that we were taking the time to speak to them. I got a lot, a lot of thanks from the women I spoke to which was so nice to hear and to hear from them to say, I wish I would've had something like this handed to me shortly after my diagnosis. And I will readily share this with any friend or family member who I know that may also be diagnosed in the future.

Announcer: Wonderful. It sounds like both states have really developed a strong relationship through this experience. Thank you to Kelly from Rhode Island and Katie, Mary, and Jenny from Iowa for joining me today and for discussing your experience collaborating on this demonstration project.

For more information, please take a look at the resources developed by Iowa, Rhode Island, and Michigan, for this demonstration. You can access these resources as well as the Action Plan, which describes the promising strategies identified for this demonstration project, and the accompanying toolkit which is a compilation of tools and resources addressing planning, implementation, and evaluation of the strategies included in the Action Plan. These can be found at www.cdc.gov/cancer/ovarian.

Thanks again for joining us. This episode is part of a five-part podcast series that describes the activities, facilitators and barriers, lessons learned, and recommendations from the demonstration sites. Check out the other episodes in this podcast series on the CDC’s Ovarian Cancer webpage.

[Announcer] For the most accurate health information, visit cdc.gov or call 1-800-CDC-INFO.