



Canoeing on Crooked Lake near Petoskey (Photo courtesy of www.michigan.org)

Comprehensive Cancer Control Plan for Michigan

2009 - 2015

Mapping a Course for Excellence in Michigan



Revised March 2012

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Foreword

March 21, 2012

Cancer is a disease that affects the lives of many, and this is especially true in Michigan, with cancer being the second leading cause of death in our state.

In an effort to make greater strides in the fight against cancer, we are pleased to share the newly revised *Comprehensive Cancer Control Plan for Michigan, 2009 - 2015*. This plan serves as a guide to reducing the human and economic suffering cancer exacts in Michigan. With its release goes a call to action urging all Michigan Cancer Consortium (MCC) members and partners to work together to help promote the plan, implement its strategies, and document their implementation activities.

We commend the 110-plus member organizations of the MCC for their dedication and collaboration in the fight against cancer, and we also extend our thanks to each and every stakeholder that contributed to the development of this plan.

Sincerely,



Aaron P. Scholnik, MD



Chuck Sherwin, MS, RN, BSN

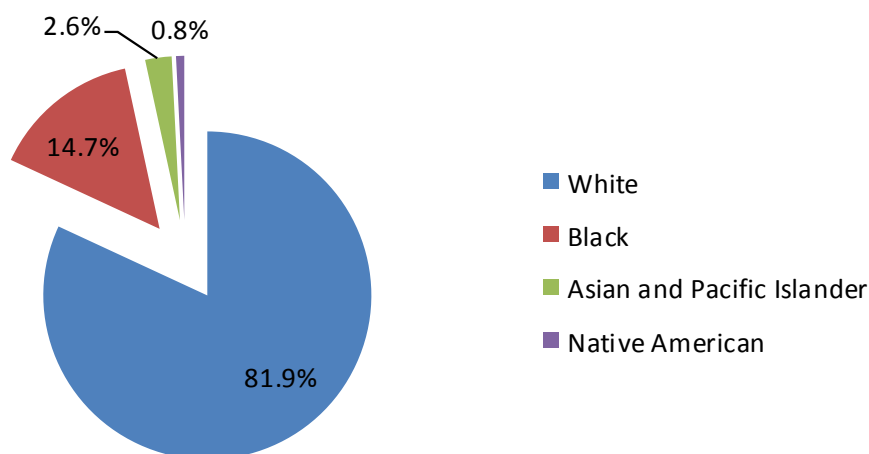
**Co-Chairs
Michigan Cancer Consortium**

Michigan Facts and Figures

Based on 2009 American Community Survey data, Michigan is the eighth most populous state (9.97million people),¹ with nearly equal proportions of males and females. Michigan is a racially diverse state: African Americans make up 14.7% of the total population, while Asian and Pacific Islanders and Native Americans make up 2.6% and 0.8% respectively.²

Michigan is the 8th most populous state in the nation, with more than 10 million residents.

Michigan Population by Race, 2009



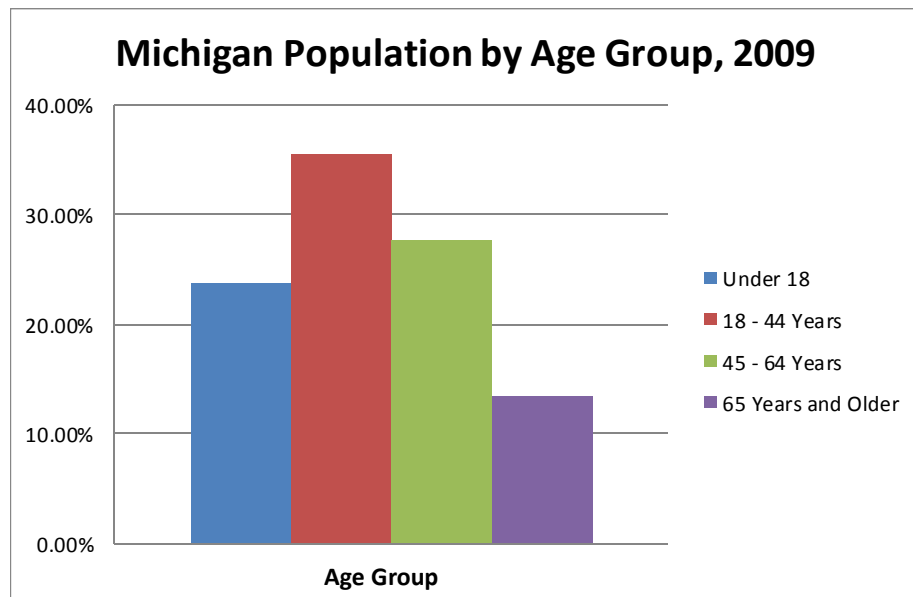
¹ U.S. Census Bureau. American Community Survey Office. Available online at www.census.gov/acs/www/index.html.

² Michigan Department of Community Health. Michigan Population, 1990-2007. Available online at www.mdch.state.mi.us/pha/osr/Index.asp?ld=17.

Michigan Facts and Figures

In recent years, the proportion of Michigan residents who are uninsured has increased, and Medicaid enrollment has doubled. These numbers are only expected to worsen.

The proportion of Michigan's population aged 65 or older has grown steadily over the years and is projected to be 16.8% by 2020.²



In addition, 14.4% of the state's population lived below the poverty level in 2008.¹ In recent years, the proportion of the population that is uninsured has increased, and Medicaid enrollment has doubled.^{3,4} With the current economy, these numbers are only expected to worsen.

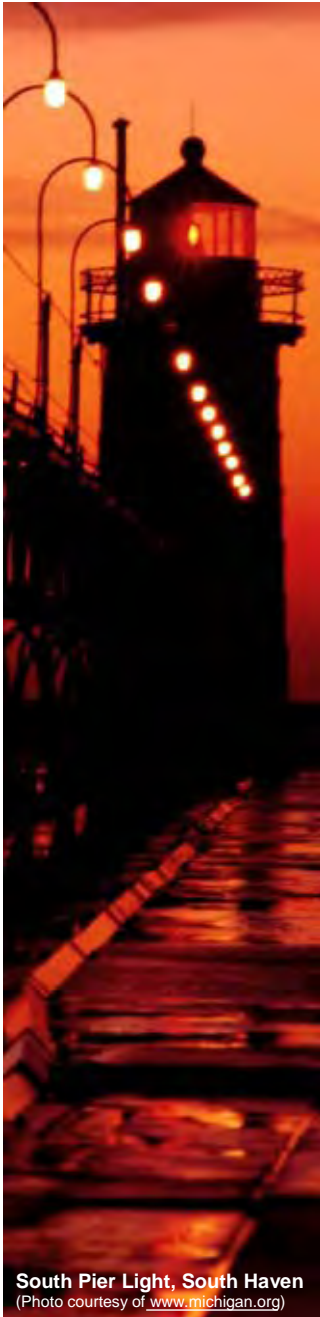
¹ U.S. Census Bureau. American Community Survey Office. Available online at www.census.gov/acs/www/index.html.

² Michigan Department of Community Health. Michigan Population, 1990-2007. Available online at www.mdch.state.mi.us/pha/osr/Index.asp?Id=17.

³ Michigan Department of Community Health, Bureau of Epidemiology. Behavioral Risk Factor Survey, 2010. Available online at www.michigan.gov/brfs.

⁴ Kaiser Family Foundation, Individual State Profiles. Available online at www.statehealthfacts.org.

Cancer Health Disparities



South Pier Light, South Haven
(Photo courtesy of www.michigan.org)

Cancer affects people of all racial and ethnic groups. The American Cancer Society estimates that 571,950 Americans were expected to die of the disease in 2011. However, a close look at cancer rates for specific populations reveals some significant differences, and these differences have been described as health disparities.

The National Cancer Institute defines “cancer health disparities” as “differences in the incidence, prevalence, mortality, and burden of cancer and related adverse health conditions that exist among specific populations groups in the United States.”

These population groups may be characterized by gender, age, ethnicity, education, income, social class, disability, geographic location or sexual orientation. Research has shown that individuals in underserved populations are more likely than individuals in the overall U.S. population to:

- be diagnosed with, and die from, preventable cancers;
- be diagnosed with late-stage disease for cancers that are detectable at an early stage through screening;
- receive either no treatment or treatment that does not meet currently accepted standards of care;
- die of cancers that are generally curable; and/or
- suffer from terminal cancers in the absence of adequate pain control and other palliative care.¹

¹ National Cancer Institute. Available online at www.cancer.gov/cancertopics/types/disparities.

Cancer Health Disparities

Many of the differences in cancer incidence and mortality rates among racial and ethnic groups may be due to factors associated with socioeconomic status (SES) rather than ethnicity.

SES in particular appears to play a major role in the differences in cancer incidence and mortality rates, risk factors, and screening prevalence among racial and ethnic minorities. Moreover, studies have found that SES, more than race, predicts the likelihood of a group's access to education, certain occupations, and health insurance, as well as income level and living conditions — all of which are associated with someone's chance of developing and surviving cancer.¹

Detailed data on cancer health disparities is addressed in each goal area in Michigan's Comprehensive Cancer Control Plan.



Access to Cancer Care in Michigan

Key Facts and Figures

Adults in Michigan who do not have health care coverage are less likely to access health care services and more likely to delay getting needed medical attention.

(Source: C.Fussman. 2011. Health Risk Behaviors in the State of Michigan: 2010 Behavioral Risk Factor Survey. [Lansing, MI: Michigan Department of Community Health, Bureau of Epidemiology, Chronic Disease Epidemiology Section])

In 2010, an estimated 16.6% of Michigan adults aged 18 to 64 years had no health care coverage.

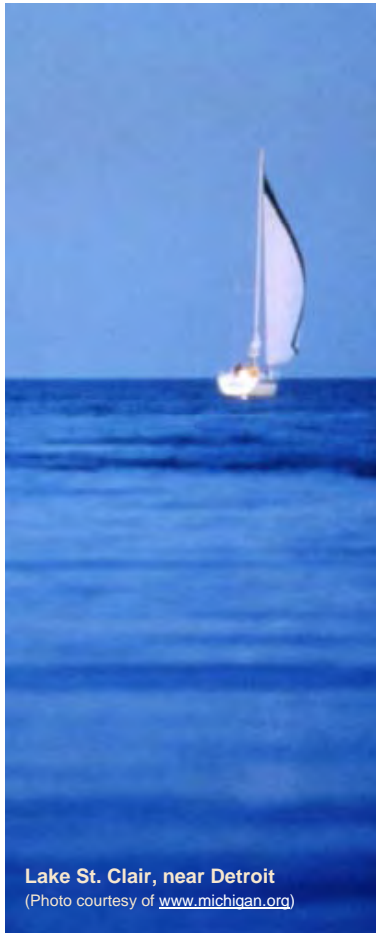
(Source: C.Fussman. 2011. Health Risk Behaviors in the State of Michigan: 2010 Behavioral Risk Factor Survey. [Lansing, MI: Michigan Department of Community Health, Bureau of Epidemiology, Chronic Disease Epidemiology Section])

The highest “no health insurance coverage” rates in Michigan were found among younger persons, those with less education, and those living in low-income households.

Source: C.Fussman. 2011. Health Risk Behaviors in the State of Michigan: 2009 Behavioral Risk Factor Survey. [Lansing, MI: Michigan Department of Community Health, Bureau of Epidemiology, Chronic Disease Epidemiology Section])

Over the past 10 years, the proportion of Michigan adults who reported having no health care coverage has been relatively constant and slightly lower than that of the U.S. median.

(Source: C.Fussman. 2011. Health Risk Behaviors in the State of Michigan: 2009 Behavioral Risk Factor Survey. [Lansing, MI: Michigan Department of Community Health, Bureau of Epidemiology, Chronic Disease Epidemiology Section])



Lake St. Clair, near Detroit
(Photo courtesy of www.michigan.org)

Access to Cancer Care in Michigan

An estimated 12.5% of adults did not have a personal doctor or health care provider in 2010.

(Source: C.Fussman. 2011. Health Risk Behaviors in the State of Michigan: 2010 Behavioral Risk Factor Survey. [Lansing, MI: Michigan Department of Community Health, Bureau of Epidemiology, Chronic Disease Epidemiology Section])

In 2010, the proportion of adults who had needed to see a doctor in the past year but had not been able to do so due to the cost was estimated to be 14.1%, up from 8.9% in 2000.

(Source: C.Fussman. 2011. Health Risk Behaviors in the State of Michigan: 2010 Behavioral Risk Factor Survey. [Lansing, MI: Michigan Department of Community Health, Bureau of Epidemiology, Chronic Disease Epidemiology Section])

An estimated 22.6% of adults were living with a disability in 2010, compared with an estimated 19.9% of adults in 2005.

(Source: C.Fussman. 2011. Health Risk Behaviors in the State of Michigan: 2010 Behavioral Risk Factor Survey. [Lansing, MI: Michigan Department of Community Health, Bureau of Epidemiology, Chronic Disease Epidemiology Section])

In 2009, adults with one or more disabilities were nearly nine times as likely to have reported 14 or more days of physical health that was not good as were their peers who did not have a disability. They also were more than three times as likely to have reported that their mental health was not good, and more than 12 times as likely to have reported that they had activity limitations.

(Source: C.Fussman. 2011. Health Risk Behaviors in the State of Michigan: 2009 Behavioral Risk Factor Survey. [Lansing, MI: Michigan Department of Community Health, Bureau of Epidemiology, Chronic Disease Epidemiology Section])

Access to Cancer Care in Michigan

In 2009, 25.4% of adults reported providing regular care or assistance within the past month to a family member or a friend who has a health problem, long-term illness, or disability

In 2006, 47 million people were without health insurance coverage, up from 44.8 million people in 2005.

(Source: C.Fussman. 2011. Health Risk Behaviors in the State of Michigan: 2009 Behavioral Risk Factor Survey. [Lansing, MI: Michigan Department of Community Health, Bureau of Epidemiology, Chronic Disease Epidemiology Section])

In 2010, an estimated 10.8% of Michigan adults reported they were ever told by a doctor, nurse, or other health care professional, they have cancer.

(Source: C.Fussman. 2011. Health Risk Behaviors in the State of Michigan: 2010 Behavioral Risk Factor Survey. [Lansing, MI: Michigan Department of Community Health, Bureau of Epidemiology, Chronic Disease Epidemiology Section])

In 2010, 30.9% of cancer survivors reported that a doctor, nurse, or other health care professional provided them with a written summary of all cancer treatments that they received.

(Source: C.Fussman. 2011. Health Risk Behaviors in the State of Michigan: 2010 Behavioral Risk Factor Survey. [Lansing, MI: Michigan Department of Community Health, Bureau of Epidemiology, Chronic Disease Epidemiology Section])

In 2010, 7.6% of adults in Michigan reported being denied health and/or life insurance due to a cancer diagnosis.

(Source: C.Fussman. 2011. Health Risk Behaviors in the State of Michigan: 2010 Behavioral Risk Factor Survey. [Lansing, MI: Michigan Department of Community Health, Bureau of Epidemiology, Chronic Disease Epidemiology Section])

Access to Cancer Care in Michigan



Covered Bridge, Frankenmuth
(Photo courtesy of www.michigan.org)

Among cancer survivors in 2010, 6.1% of adults reported they currently have physical pain caused by their cancer and/or cancer treatment

(Source: C.Fussman. 2011. *Health Risk Behaviors in the State of Michigan: 2010 Behavioral Risk Factor Survey*. [Lansing, MI: Michigan Department of Community Health, Bureau of Epidemiology, Chronic Disease Epidemiology Section])

62.1% of cancer survivors in 2010 received the majority of their health care from a Family Practitioner. Internists and other doctors had the next highest percentages of health care at 18.4% and 6.5% respectively.

(Source: C.Fussman. 2011. *Health Risk Behaviors in the State of Michigan: 2010 Behavioral Risk Factor Survey*. [Lansing, MI: Michigan Department of Community Health, Bureau of Epidemiology, Chronic Disease Epidemiology Section])

In Michigan, 88.5% of uninsured are non-elderly adults, while 11.5% are children.

(Source: Michigan Department of Community Health. 2011. *The Uninsured in Michigan: A Profile*. (Released August 2010). [Lansing, MI: Michigan Department of Community Health, Health Policy and Regulation Administration])

Access to Cancer Care in Michigan

Single adults with no children are the most likely to be uninsured with a 25.5% uninsured rate. Married adults with children are the least likely to be uninsured with a 6.7% uninsured rate.

(Source: Michigan Department of Community Health. 2011. The Uninsured in Michigan: A Profile. (Released August 2010). [Lansing, MI: Michigan Department of Community Health, Health Policy and Regulation Administration]

Michigan adults are less likely to be uninsured (15.6%) than adults nationally (20.1%). Specifically, adults aged 18-24 are more likely to be uninsured nationally (28.9%) compared to Michigan young adults aged 18-24 (21.3%).

(Source: Michigan Department of Community Health. 2011. The Uninsured in Michigan: A Profile. (Released August 2010). [Lansing, MI: Michigan Department of Community Health, Health Policy and Regulation Administration])

Nationally, the percent of residents covered by employer-based health insurance was estimated at 62.6% for years 2006-2008. Michigan ranked 13th highest nationally, and ranked higher than the US average rate of employer-based health coverage at 68.7%.

(Source: Michigan Department of Community Health. 2011. The Uninsured in Michigan: A Profile. (Released August 2010). [Lansing, MI: Michigan Department of Community Health, Health Policy and Regulation Administration])

Access to Cancer Care in Michigan

Michigan Cancer Programs and Services

Michigan is committed to providing quality cancer screening and diagnostic services to its uninsured and underinsured populations through several programs, including the Michigan Breast and Cervical Cancer Control Program (BCCCP), the Michigan Colorectal Cancer Early Detection Program, and the Michigan Well-Integrated Screening and Evaluation for Women Across the Nation (WISEWOMAN) Program.



Michigan Breast and Cervical Cancer Control Program

Since 1991, the Michigan Department of Community Health (MDCH) has implemented a statewide BCCCP through a multi-year grant from the U.S. Centers for Disease Control and Prevention. With these funds, low-income women have access to life-saving breast and cervical cancer screening services and following-up care, including cancer treatment, if needed. To date, the BCCCP has screened more than 131,000 women and diagnosed more than 2,400 breast cancers and 1,100 cervical cancers.

BCCCP services are coordinated through 21 local coordinating agencies. These agencies have enlisted the cooperation and participation of physicians, hospitals, and other health care organization in their communities to ensure that all necessary follow-up services are provided. For more information about the BCCCP, please visit www.michigancancer.org/bcccp.



Michigan Colorectal Cancer Early Detection Program

The Michigan Department of Community Health has provided colorectal cancer screening to Michigan's underserved men and women since 2006. In 2010, Michigan received a multi-year grant from the U.S. Centers for Disease Control and Prevention to increase colorectal cancer awareness and screening in Michigan. This is

Access to Cancer Care in Michigan

being accomplished through a statewide collaboration with partners addressing system and policy change and a small screening component, the Michigan Colorectal Cancer Early Detection Program (MCRCEDP).

Implemented in 38 Michigan counties, the MCRCEDP provides colorectal cancer screening to low-income, uninsured or underinsured men and women, aged 50-64, who are at average to increased risk for colorectal cancer. Eligible clients receive risk-appropriate screening (colonoscopy or a fecal occult blood test).

Services for the MCRCEDP are provided through the collaborative efforts of local coordinating agencies, hospitals, participating physicians, and staff. Each individual enrolled in the MCRCEDP receives patient navigation from the initial referral to the completion of the colorectal cancer screening, and if necessary, treatment. Treatment for colorectal cancer detected through the MCRCEDP is provided through the collaborative efforts and generosity of community partners. For more information about the MCRCEDP, please visit www.michigancancer.org/colorectal.



Michigan WISEWOMAN Program

The Well-Integrated Screening and Evaluation for Women Across the Nation (WISEWOMAN) Program is an extension of the Breast and Cervical Cancer Control Program (BCCCP). Women are only eligible for the WISEWOMAN Program if they are first enrolled in the BCCCP.

The main focus of WISEWOMAN is to help participants understand and make healthy lifestyle choices with a focus on nutrition, physical activity and smoking cessation. Leading a healthy lifestyle will help with current chronic disease risk factors and symptoms. It also may prevent or delay the development of new chronic disease risk factors.

Access to Cancer Care in Michigan

The WISEWOMAN Program is administered by 11 agencies and its services are available in 29 Michigan counties. Since October 2003, the WISEWOMAN Program has conducted nearly 19,000 screening cycles on more than 10,000 women.

To learn more about the WISEWOMAN Program, please visit www.michigancancer.org/bcccp/wiseWomanProgram/index.cfm.

Access to Free or Low-Cost Services

MDCH recently launched a Web page containing information and phone numbers for sites with low-cost health care or help with insurance. This Web page is a centralized location of community support services and resources for Michigan's most vulnerable population. It is available at www.michigan.gov/healthcarehelp.

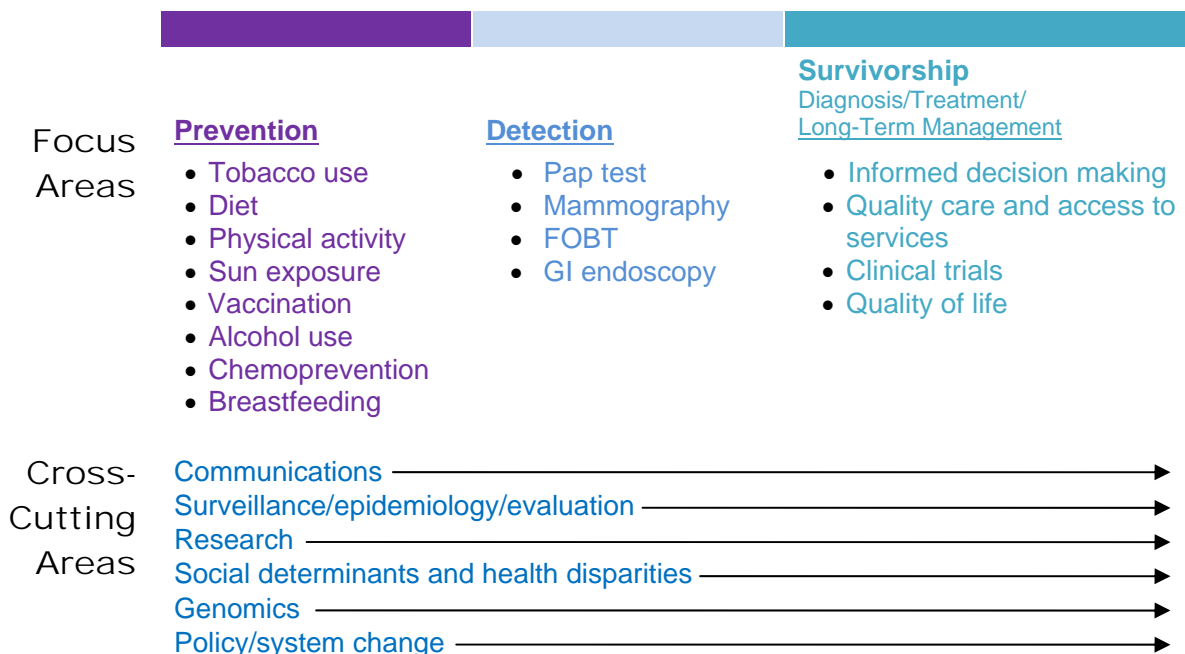
What You Can Do

NOTE: The MCC membership has been a vital player in leading collaborative work necessary to achieve the goals and objectives outlined in the Michigan Comprehensive Cancer Control Plan. If MCC member organizations and key partner organizations commit to implementing various cancer control strategies across the cancer care continuum, then collective efforts will undoubtedly make a significant impact on cancer morbidity and mortality at a much faster rate.

A summary of the cancer control continuum, adapted in the graphic below, was provided several years ago by the National Cancer Institute (NCI) as a simplified framework on which to view plans, progress, and priorities. More recently, [NCI outlined in more detail](#) opportunities to optimize cancer control on multiple levels of the cancer care continuum, taking into account the interactions between types and processes of care, population and patient outcomes.

In an effort to assist member organizations with identifying opportunities for implementation most appropriate for them, broad and cross-cutting areas of intervention are presented in this chapter and indexed according to MCC member organizational category. For more detailed recommendations and specific evidence-based strategies, please refer to the full Strategic Plan at [Comprehensive Cancer Control Plan for Michigan, 2009–2015](#). General areas of implementation were chosen to be aligned with the **2011 National Comprehensive Cancer Control Program Priorities**.

The Cancer Control Continuum



What You Can Do

If you are a...

Community-Based Health Care Delivery System or Practice with a Cancer Program

Goal: Reduce cancer incidence rates in Michigan

Goal: Reduce cancer mortality rates in Michigan

Goal: Improve the quality of life for cancer survivors in Michigan

Goal: Sustain the positive impact of comprehensive cancer control implementation

Goal: Reduce disparities in cancer outcomes among Michigan populations

Help Prevent Cancer!

- ▶ Disseminate information to the public on the importance of adopting a healthy lifestyle
- ▶ Promote provider education in tobacco use assessment and treatment
- ▶ Promote the HPV vaccine

Help Promote Early Detection of Cancer!

- ▶ Educate the public on importance of timely screening for breast, cervical and colorectal cancer
- ▶ Address barriers to screening in underserved populations
- ▶ Educate the general public on the role of genetics in cancer risk and management
- ▶ Educate providers about USPSTF guidelines for family history, genetic counseling, and testing
- ▶ Support use of evidence-based screening guidelines
- ▶ Encourage use of reminder systems to ensure compliance to screening

Support Cancer Survivorship Care!

- ▶ Disseminate information about survivorship resources and standard clinical management guidelines for survivors
- ▶ Promote and/or offer comprehensive survivorship services which address the full spectrum of cancer care
- ▶ Promote participation in clinical trials
- ▶ Support and/use informed decision making tools and survivorship care plans

Support Cancer-Related Policy/System Change!

- ▶ Support partnerships for local policy which endorse adoption of healthy lifestyle
- ▶ Implement changes within your own organization to support employees' healthy behaviors
- ▶ Monitor the effectiveness of your policy/system change interventions

Contribute to Equity in Health Care!

- ▶ Promote equitable distribution of resources and services that address disparities to achieve health equity
- ▶ Sustain partnerships with organizations serving underserved populations
- ▶ Ensure diversity within partnerships/cancer coalitions
- ▶ Support and/or implement interventions with focus on minority/special populations
- ▶ Enhance methods to identify and describe health disparities

What You Can Do

If you are an...

Organization Representing or Serving Hard-to-Reach and/or Special Populations

Goal: Reduce cancer incidence rates in Michigan

Help Prevent Cancer!

- ▶ Disseminate information to the public on the importance of adopting a healthy lifestyle
- ▶ Develop and/or promote prevention messages that are consistent with chronic disease partner messages
- ▶ Implement tobacco use prevention initiatives
- ▶ Promote HPV vaccine uptake

Goal: Reduce cancer mortality rates in Michigan

Help Promote Early Detection of Cancer!

- ▶ Educate the public on importance of timely screening for breast, cervical and colorectal cancer
- ▶ Address barriers to screening in underserved populations
- ▶ Educate the general public on the role of genetics in cancer risk and management
- ▶ Educate providers about USPSTF guidelines for family history, genetic counseling, and testing

Goal: Improve the quality of life for cancer survivors in Michigan

Support Cancer Survivorship Care!

- ▶ Support expansion of/use successful patient navigation programs
- ▶ Promote participation in clinical trials

Goal: Sustain the positive impact of comprehensive cancer control implementation

Support Cancer-Related Policy/System Change!

- ▶ Support partnerships for local policy which endorse adoption of healthy lifestyle
- ▶ Implement changes within your own organization to support employees' healthy behaviors

Goal: Reduce disparities in cancer outcomes among Michigan populations

Contribute to Equity in Health Care!

- ▶ Promote equitable distribution of resources and services that address disparities to achieve health equity
- ▶ Sustain partnerships with organizations serving underserved populations
- ▶ Support and/or implement interventions with focus on minority/special populations
- ▶ Enhance methods to identify and describe health disparities

What You Can Do

If you are a...

Health Education/Health Research and Evaluation Organization

Goal: Reduce cancer incidence rates in Michigan

Goal: Reduce cancer mortality rates in Michigan

Goal: Improve the quality of life for cancer survivors in Michigan

Goal: Sustain the positive impact of comprehensive cancer control implementation

Goal: Reduce disparities in cancer outcomes among Michigan populations

Help Prevent Cancer!

- ▶ Disseminate information to the public on the importance of adopting a healthy lifestyle
- ▶ Develop and/or promote prevention messages that are consistent with chronic disease partner messages

Help Promote Early Detection of Cancer!

- ▶ Educate the public on importance of timely screening for breast, cervical and colorectal cancer
- ▶ Identify barriers to screening in underserved populations
- ▶ Educate the general public on the role of genetics in cancer risk and management
- ▶ Educate providers about USPSTF guidelines for family history, genetic counseling, and testing

Support Cancer Survivorship Care!

- ▶ Support development of informed decision making tools
- ▶ Promote participation in clinical trials and/or assess barriers to participation

Support Cancer-Related Policy/System Change!

- ▶ Implement changes within your own organization to support employees' healthy behaviors
- ▶ Evaluate the effectiveness of policy/system change interventions

Contribute to Equity in Health Care!

- ▶ Sustain partnerships with organizations serving underserved populations
- ▶ Support/implement interventions with focus on minority/special populations
- ▶ Enhance methods to identify and describe health disparities
- ▶ Contribute to evidence base/enhance capacity to evaluate impact of interventions with focus on disparities

What You Can Do

If you are a...

University-Based Health Care Delivery System with a Cancer Program

Goal: Reduce cancer incidence rates in Michigan

Goal: Reduce cancer mortality rates in Michigan

Goal: Improve the quality of life for cancer survivors in Michigan

Goal: Sustain the positive impact of comprehensive cancer control implementation

Goal: Reduce disparities in cancer outcomes among Michigan populations

Help Prevent Cancer!

- ▶ Promote provider education in tobacco use assessment and treatment

Help Promote Early Detection of Cancer!

- ▶ Educate the public on importance of timely screening for breast, cervical and colorectal cancer
- ▶ Educate the public on the role of genetics in cancer risk and management
- ▶ Educate providers about USPSTF guidelines for family history, genetic counseling, and testing

Support Cancer Survivorship Care!

- ▶ Disseminate information about survivorship resources and standard clinical management guidelines for survivors
- ▶ Support expansion of/use successful patient navigation programs
- ▶ Promote/offer comprehensive survivorship services which address the full spectrum of cancer care
- ▶ Promote participation in clinical trials
- ▶ Support/use informed decision making tools and survivorship care plans

Support Cancer-Related Policy/System Change!

- ▶ Implement changes within your own organization to support employees' healthy behaviors
- ▶ Monitor the effectiveness of your policy/system change interventions

Contribute to Equity in Health Care!

- ▶ Promote equitable distribution of resources and services that address disparities to achieve health equity
- ▶ Sustain partnerships with organizations serving underserved populations
- ▶ Support/implement interventions with focus on minority/special populations
- ▶ Enhance methods to identify and describe health disparities

What You Can Do

If you are a...

Health Care Insurance Plan

Goal: Reduce cancer incidence rates in Michigan

Help Prevent Cancer!

- ▶ Disseminate information to the public on the importance of adopting a healthy lifestyle
- ▶ Develop/promote prevention messages that are consistent with chronic disease partner messages
- ▶ Promote and provide the HPV vaccine

Goal: Reduce cancer mortality rates in Michigan

Help Promote Early Detection of Cancer!

- ▶ Educate the public on importance of timely screening for breast, cervical and colorectal cancer
- ▶ Address barriers to screening in underserved populations
- ▶ Support use of evidence-based screening guidelines
- ▶ Encourage use of reminder systems to ensure compliance to screening
- ▶ Reimburse for cancer-screening services

Goal: Improve the quality of life for cancer survivors in Michigan

Support Cancer Survivorship Care!

- ▶ Disseminate information about survivorship resources and standard clinical management guidelines for survivors
- ▶ Promote participation in clinical trials

Goal: Sustain the positive impact of comprehensive cancer control implementation

Support Cancer-Related Policy/System Change!

- ▶ Support partnerships for local policy which endorse adoption of healthy lifestyle
- ▶ Implement changes within your own organization to support employees' healthy behaviors
- ▶ Monitor the effectiveness of your policy/system change interventions

Goal: Reduce disparities in cancer outcomes among Michigan populations

Contribute to Equity in Health Care!

- ▶ Promote equitable distribution of resources and services that address disparities to achieve health equity
- ▶ Sustain partnerships with organizations serving underserved populations
- ▶ Support/implement interventions with focus on minority/special populations
- ▶ Support access to medical homes for all Michigan residents and all cancer survivors

What You Can Do

If you are a...

Trade/Professional/Advocacy Organization

Goal: Reduce cancer incidence Rates in Michigan

Help Prevent Cancer!

- ▶ Disseminate information to the public on the importance of adopting a healthy lifestyle
- ▶ Develop/promote prevention messages that are consistent with chronic disease partner messages
- ▶ Promote provider education in tobacco use assessment and treatment

Goal: Reduce cancer mortality rates in Michigan

Help Promote Early Detection of Cancer!

- ▶ Educate the public on importance of timely screening for breast, cervical and colorectal cancer
- ▶ Educate the public on the role of genetics in cancer risk and management
- ▶ Educate providers about USPSTF guidelines for family history, genetic counseling, and testing
- ▶ Support use of evidence-based screening guidelines

Goal: Improve the quality of life for cancer survivors in Michigan

Support Cancer Survivorship Care!

- ▶ Disseminate information about survivorship resources and standard clinical management guidelines for survivors
- ▶ Promote participation in clinical trials

Goal: Sustain the positive impact of comprehensive cancer control implementation

Support Cancer-Related Policy/System Change!

- ▶ Support partnerships for local policy which endorse adoption of healthy lifestyle
- ▶ Implement changes within your own organization to support employees' healthy behaviors
- ▶ Advocate for third party payment of genetic services and cancer preventive services for Medicaid recipients and the uninsured
- ▶ Engage the community to identify policy, systems, and environmental interventions at the state and local levels

Goal: Reduce disparities in cancer outcomes among Michigan populations

Contribute to Equity in Health Care!

- ▶ Sustain partnerships with organizations serving underserved populations
- ▶ Ensure diversity within partnerships/cancer coalitions
- ▶ Support interventions with focus on minority/special populations

What You Can Do

If you are a...

Public Health Organization

Goal: Reduce cancer incidence Rates in Michigan

Help Prevent Cancer!

- ▶ Disseminate information to the public on the importance of adopting a healthy lifestyle
- ▶ Develop/promote prevention messages that are consistent with chronic disease partner messages
- ▶ Promote and provide the HPV vaccine

Goal: Reduce cancer mortality rates in Michigan

Help Promote Early Detection of Cancer!

- ▶ Educate the public on importance of timely screening for breast, cervical and colorectal cancer
- ▶ Address barriers to screening in underserved populations
- ▶ Support use of evidence-based screening guidelines
- ▶ Encourage use of reminder systems to ensure compliance to screening

Goal: Improve the quality of life for cancer survivors in Michigan

Support Cancer Survivorship Care!

- ▶ Disseminate information about survivorship resources and standard clinical management guidelines for survivors
- ▶ Support expansion/use of successful patient navigation programs

Goal: Sustain the positive impact of comprehensive cancer control implementation

Support Cancer-Related Policy/System Change!

- ▶ Support partnerships for local policy changes which endorse adoption of healthy lifestyle
- ▶ Implement changes within your own organization to support employees' healthy behaviors
- ▶ Engage the community to identify policy, systems, and environmental interventions at the state and local levels

Goal: Reduce disparities in cancer outcomes among Michigan populations

Contribute to Equity in Health Care!

- ▶ Promote equitable distribution of resources and services that address disparities to achieve health equity
- ▶ Sustain partnerships with organizations serving underserved populations
- ▶ Ensure diversity within partnerships/cancer coalitions
- ▶ Support interventions with focus on minority/special populations

About the MCC

Today, the MCC is comprised of more than 100 member and key partner organizations from throughout the state of Michigan.

History

The Michigan Cancer Consortium (MCC) was established in 1987 as a statewide network of cancer experts to advise and assist the Michigan Department of Community Health with its cancer prevention and control efforts.

Over the years, the MCC broadened its mission as well as its membership base, and, in 1997, it changed from a consortium of individual cancer control experts to a consortium of organizations dedicated to reducing the impact of cancer on Michigan citizens.

Consortium membership continues to grow as more and more organizations learn about the MCC's successes and seek to join its coordinated approach to cancer control in Michigan. Today the MCC is comprised of more than 100 member and key partner organizations located throughout the state of Michigan and representing seven different membership categories:

- Community-Based Health Care Delivery Systems and Practices with Cancer Programs;
- Health Care Insurance Plans;
- Health Education/Health Research and Evaluation;
- Organizations Representing or Serving Hard-to-Reach and/or Special Populations;
- Public Health Organizations;
- Trade/Professional/Advocacy Organizations; and
- University-Based Health Care Delivery Systems with Cancer Programs.

About the MCC

Mission Statement

The MCC is a statewide, broad-based partnership that strives to include all interested public and private organizations and provides a forum for collaboration (communication, coordination, and the sharing of resources) to reduce the burden of cancer among the citizens of Michigan by achieving the Consortium's research-based and results-oriented cancer prevention and control priorities.



About the MCC

Vision Statement

The MCC is a statewide cancer control leader, recognized for:

- A dynamic, timely, conscientious response to evolving scientific knowledge, and
- Achievement of or exceeding its established goals in cancer reduction and palliation through member synergy.

Vision Milestones

1. The MCC is effective in achieving the MCC priorities as evidenced by quantitative and qualitative measures.
2. The MCC has developed and implemented a dynamic process that is responsive to opportunities to improve cancer control.
3. The MCC reassesses our priorities as needed.
4. The MCC people/organizations are fully engaged, committed, collaborative, and responsive to MCC issues and priorities.
5. The MCC continues to grow in membership and maintain our commitment to diversity.
6. The MCC has developed the infrastructure, funding and methods to sustain the MCC and the implementation of the MCC priorities.
7. The MCC member organizations will adopt the MCC established goals by incorporating them into standard practice.



Shiawassee River near Corunna
(Photo courtesy of www.michigan.org)

About the MCC



Thunder Bay Island Lighthouse
near Alpena
(Photo courtesy of www.michigan.org)

Guiding Principles

The aim of the MCC is to reduce cancer incidence, mortality and morbidity, and essential to such an initiative are fundamental principles that guide both the Consortium's decisions and the process it uses to periodically establish goals. The following guiding principles are believed to be essential for an effective approach to cancer control:

Principle 1

The MCC's collective focus should be on cancers with a significant disease burden.

Principle 2

Cancer control priorities should be established based upon:

- opportunities and potential to significantly reduce cancer incidence, mortality and morbidity through prevention, detection, treatment, rehabilitation, and/or palliation;
- feasibility; and
- capacity for collaborative partnerships among public health agencies, private organizations, cancer centers, and all other interested agencies and organizations to carry out recommended cancer control activities.

Principle 3

Decisions should be data driven when feasible.

Principle 4

The MCC will seek financial and other resources to support initiatives. Resources should be efficiently used.

About the MCC

Principle 5

Efforts to increase awareness and share strategies to reduce the burden of cancer disparities faced by ethnically diverse and underserved populations will be supported.

Principle 6

All Michigan residents should have knowledge of, and access to, quality comprehensive cancer control services across the continuum of care.

Principle 7

The process to identify, implement and evaluate cancer control priorities should be timely.

Principle 8

Effective strategies undertaken by MCC partners to address cancer control priorities should be maintained and sustained, when appropriate.

Principle 9

The MCC serves as a resource for policy makers regarding cancer control issues, but does not engage in lobbying.

Principle 10

The MCC promotes comprehensive cancer control planning and implementation at the local (community) level and supports community driven projects and programs to improve cancer control.



Lake Michigan beach near Saugatuck
(Photo courtesy of www.michigan.org)

About the MCC

Implementation Evaluation

Over the lifespan of Michigan's Comprehensive Cancer Control Plan development and revisions, the evaluation component has been a central part of strategic planning, implementation monitoring, and outcome measurement. The Evaluation Project provides support in:

- review of science and evidence;
- partnership and process evaluation;
- monitoring plan implementation;
- needs assessment and special studies;
- cancer screening surveillance/disparities review;
- cancer burden assessment; and
- data integration/updates to stakeholders.

Review of Science and Evidence

Evidence-based planning was at the core of this revision of Michigan's cancer plan. Because Michigan's cancer plan is dynamic and responsive to changes in science, program staff conducted literature reviews, data analysis, and reviews of evidence-based interventions and shared the results with the MCC to support its strategic planning efforts. References and citations are found throughout this document and provide a guide to resources that partners can use in the course of implementing this plan.

Partnership and Process Evaluation

Evaluation includes an interface with the activities of the MCC standing committees and leadership and support to method development in conducting assessments and collecting partner feedback, such as regular member satisfaction surveys, MCC Board assessments, advocacy committee surveys, and organization planning evaluations. The current plan revision process included two evaluation activities in this area. The first looked at the capacity within the MCC membership to address additional topics in cancer control

About the MCC

and prevention that were not the focus of previous MCC strategic plans (e.g., childhood cancers, environmental risk factors for cancer). The second activity involved a Member Feedback Survey, which generated an initial list of priorities from the multiple objectives and strategies that partners were asked to rank in order of importance; the MCC leadership then used the priority list to guide its decision making in developing this plan.

Monitoring Plan Implementation

The MCC has been committed to participating in a regular progress reporting evaluation system since its inception in the late 1990s. The design and format of the MCC Implementation Progress Report (IPR) has changed and evolved with each revision of Michigan's cancer plan.

Since markers of progress that are tracked in the IPR are tailored to partner organizations and are derived from the plan's goals and strategies, the MCC recognized the importance of devising SMART (specific, measurable, attainable, relevant, time-bound) objectives to ensure a quality evaluation. The IPR design is customized to the plan, and information is collected from members on an annual basis to track the progress of implementation by all partners involved.

Data from the IPR are compiled and disseminated to all MCC members and partners each year in an Annual Progress Report to the Membership. These Annual Progress Reports to the Membership are available online at www.michigancancer.org/WhatWeDo/MCCAnnualReports.cfm.

Needs Assessment and Special Studies

Evaluation has continually supported any need for background assessment relevant to plan development or targeting interventions. Recently, a special survey of genetic counselors was conducted to examine the profile of genetic counselors and capacity for providing cancer-specific genetic counseling services in the state of Michigan. This survey provides information relevant to the newly established cancer genomics component of Michigan's cancer plan which aims to improve access to genetic services by all Michigan residents.

About the MCC

Another recent special survey was initiated to assess the needs of prostate cancer survivors in managing and coping with the side effects of prostate cancer treatment. Data from this assessment are used in implementing interventions within the prostate cancer plan. Results of these and other special studies are available online at www.michigancancer.org.

Cancer Screening Surveillance/Disparities Review

The Special Cancer Behavioral Risk Factor Survey (SCBRFS) is a key project of Michigan's evaluation component and serves as a major source of outcome data for cancer program planners and partners. The SCBRFS was initiated in 2001 and has been continued as a bi-annual, population-based survey of men and women 40 years or older.

The SCBRFS includes representation from all minorities and special populations within Michigan, thereby providing information on disparities and gaps in cancer-related knowledge and preventive practices among population groups. Data from the SCBRFS play a key role in planning interventions and subsequently gauging progress toward improving cancer outcomes via early detection and prevention. More information about the SCBRFS is available online at www.michigancancer.org/Resources/CancerData.cfm.

Michigan Behavioral Risk Factor Surveillance Survey

The Michigan Behavioral Risk Factor Surveillance Survey (MiBRFSS) is regularly used as a source of information on cancer screening practices and risk factors in the general adult population.

Cancer Burden Assessment

A major element of the evaluation is to regularly conduct reviews of cancer mortality and morbidity statistics, using the data resources of the Michigan Cancer Surveillance Program (state cancer registry and vital statistics) to examine trends in long-term cancer outcomes that the cancer plan aspires to achieve (i.e., reducing mortality, incidence and disparities for the cancers that the plan addresses). A complete report is published annually and is available

About the MCC

online at www.michigancancer.org/WhatWeDo/TheCancerBurdenMichiganSelectedStatistics.cfm.

Data Integration/Updates to Planners

Michigan's evaluation is characterized by its integrative approach to examining attributes of success and by the ongoing engagement of program leaders and partners in both the development and the use of evaluation data. Evaluation results are provided to the MCC Board and MCC advisory committees and workgroups on an ongoing and timely basis to support their planning and assessment of progress toward their plan goals.

Data on implementation of strategies within specific plans using the IPR data also are shared, and recommendations are made accordingly for focused program activities.

In support of the current plan development process, data summaries and fact sheets were prepared using a variety of data sources pertaining to each cancer site or topic area under consideration, including: the burden of the cancer-related topic; disparities; partner implementation (IPR) data; and results of pre-assessments of membership capacity and feedback surveys. The combined summaries were shared with stakeholders to support their deliberations and decisions around cancer plan goals and recommendations for interventions.

Learn More

For more information on these and other Michigan comprehensive cancer control evaluation activities, please contact the coordinator of the Michigan Cancer Plan Evaluation: May Darwish-Yassine, PhD, Program Director, Cancer Control Services, Michigan Public Health Institute, at 517-324-7308 (e-mail: myassine@mphi.org).

About the MCC

Progress to Date

Since 1998, the MCC has made considerable progress in the fight against cancer. Through the collaborative efforts of MCC members and key partner organizations, Michigan has developed many cancer control products, including guidelines, position papers, and decision aids.

The strength of the MCC is its members, and the dedication and commitment of MCC members has made a significant difference in Michigan. Notable accomplishments have been made, leading to statewide progress in major cancer control areas:

- **Breast cancer age-adjusted** mortality rate declined by 26% since 1995.
- **Colorectal cancer age-adjusted** mortality rate declined by 26% since 1995.
- **Invasive cervical cancer age-adjusted** incidence declined by 17% since 1995.
- **Adult tobacco use** declined by 27% since 1995.
- **Youth tobacco use** declined by 45% since 1999.

About Michigan's Cancer Plan

The Plan is comprised of specific objectives and strategies to address each of the MCC goal areas, including supporting data and health disparity information.

The MCC has developed its Comprehensive Cancer Control Plan for directing cancer control efforts during 2009 - 2015. The Plan represents the collective wisdom of a wide range of individuals and organizations in our state, from nationally recognized cancer experts to state health care leaders to health care providers to insurers to representatives of community-based organizations, all working together to achieve our common goals.

The Plan is organized into two subsections:

1. Goals for 2009 - 2015
2. Maintenance Projects

MCC goals are comprised of specific objectives and strategies and include supporting data and health disparity information. Every goal area has an associated goal-specific plan that includes what experts believe to be the most important activities that can be addressed during the next few years to reduce the toll of cancer in Michigan. Each cancer topic addresses three key areas — health disparities, access to care, and emerging science and technology — that cut across all goals within the plan where applicable.

The MCC goals will be accomplished through the cooperative, collaborative efforts of dozens of public and private organizations throughout our state. As MCC members and partners implement strategies from within this plan, it is expected to produce a synergy that will have an impact far greater than that which might have been accomplished by these agencies, organizations, and individuals working independently of one another.

Resources for implementation continue to face restrictions in both the public and private sectors. Efforts to seek, secure and track resources to support the implementation of activities outlined within this plan will continue. A resource plan for the MCC has been developed.

Goals for 2009 – 2015: Breast Cancer

Goal

Reduce the breast cancer death rate in Michigan.

Data

Breast cancer is the most commonly diagnosed cancer among Michigan women.¹ During 2007, 6,908 women in Michigan were newly diagnosed with breast cancer. During 2008, 1,471 Michigan women died of the disease.¹

Breast Cancer Health Disparities Data

- Incidence and mortality vary by age and by race.¹
- Incidence is highest among white women.¹
- Mortality is highest among racial minorities, partly due to a later stage at diagnosis.¹
- In 2007, 53.5% of newly diagnosed breast cancer cases among African Americans were found localized compared with % in white women.¹
- Even at the same localized stage of diagnosis, African American women show lower survival rates than white women.^{1,2}

¹ Michigan Cancer Surveillance Program, 2008 Michigan Cancer Death Public Use File & 2007 Michigan Cancer Incidence Public Use File. Michigan Department of Community Health (MDCH) Division for Vital Records & Health Statistics. Available online at www.michigan.gov/mdch/0,1607,7-132-2944_5323---,00.html.

² National Cancer Institute. SEER Cancer Statistics Review, 1975-2007. Available online at http://seer.cancer.gov/csr/1975_2007.

Goals for 2009 - 2015: Breast Cancer

Implementation Objectives

Breast Cancer Implementation Objective 1:³ By 2011, 90 percent of women will report being offered age-appropriate breast cancer risk information, education, and suitable services

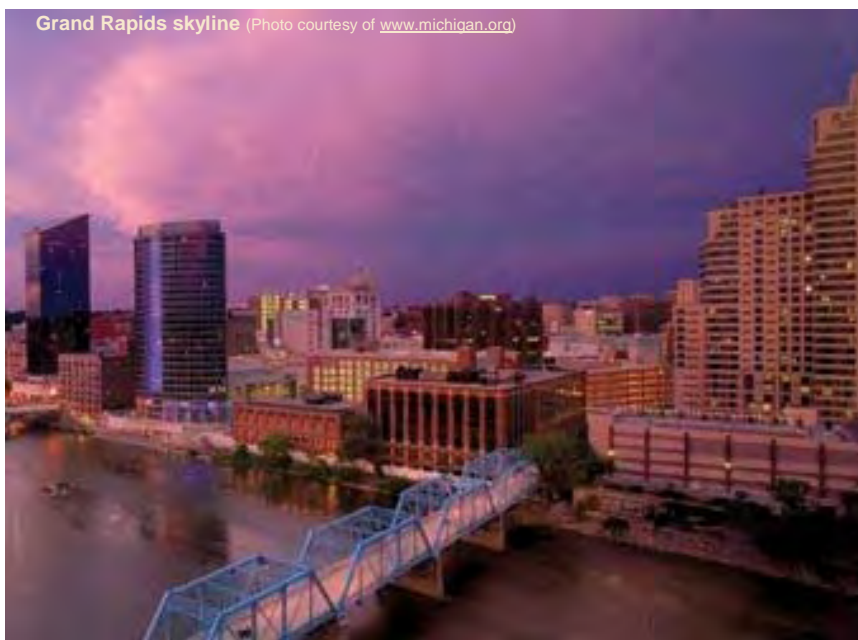
Progress Markers					
Available Data Markers	Data Source	Baseline (2006)	Interim Update (2008)	Interim Update (2009)	Target (2011)
Percent of all adult women who ever discussed family history of breast or ovarian cancer with a health care provider	Michigan Behavioral Risk Factor Surveillance Survey (MiBRFSS)	Not available	Not available	82.7% --83.8% White, non-Hispanic --78.6% Black, non-Hispanic --90.2% Other, non-Hispanic	90%
Percent of all women aged 40 years or older who ever discussed family history of breast cancer with health care provider.	Special Cancer Behavioral Risk Factor Survey (SCBRFS)	87.9%	89.3% --80.6% Hispanics --72.8% Asian Americans --70.1% Arab Americans	Not available	90%
Percent of all women aged 40 years or older who ever discussed family history of ovarian cancer with a provider.	SCBRFS	Not available	75.5% --69.2% Asian Americans --47.4% Arab Americans	Not available	80%
Percent of all women aged 40 years or older reporting family history or hereditary would increase a woman's risk for breast cancer.	SCBRFS	Not available	46.3%	Not available	50%

³ 2009 - 2011MCC Special Project

Goals for 2009 – 2015: Breast Cancer

Strategies

- 1.1. Develop and implement breast cancer risk assessment programs through strategic partnerships.⁴
- 1.2 Collaborate with MCC Genomics workgroup members to educate providers about guidelines for breast cancer risk assessment and genetic counseling referrals.



⁴ Evidence-Based Strategy: Application of Breast Cancer Risk Prediction Models in Clinical Practice. Available online at <http://jco.ascopubs.org/cgi/reprint/21/4/593>.

Goals for 2009 - 2015: Breast Cancer

Breast Cancer Implementation Objective 2: By 2015, 80% of women aged 40 years and older will report having received both a clinical breast exam and a mammogram within the past year.

Progress Markers				
Activity	Data Source	Baseline (2006)	Interim Update (2010)	Target (2011)
Women aged 40 years and older who had both a clinical breast exam and mammogram in the past year	Michigan BRFSS	57.2%	53.0%	80%
Women who had an appropriately timed clinical breast exam	Michigan BRFSS	75.4%	69.9%	80%
Women aged 40 years and older who had a mammogram in the past year	Michigan BRFSS	64.3%	61.4%	80%

Strategies:

2.1. Work in partnership with health providers, health care systems, insurance providers, community organizations, and businesses, to provide appropriate information on the importance of breast health and age appropriate cancer screening.⁵

2.2. Provide appropriate breast cancer screening information utilizing evidenced-based interventions (one-on-one education, Web sites, fact sheets, pamphlets, small media, etc.), focusing the message for never/rarely screened women in counties with high breast cancer incidence/mortality rates.^{5,6,7}

⁵ Evidence-Based Strategy: Empowering Physicians to Improve Breast Cancer Screening. Available online at http://rtips.cancer.gov/rtips/rtips_details.do?programid=14&topicid=4&co=N&cg=.

⁶ Task Force on Community Preventive Services. Recommendations for client- and provider-directed interventions to increase breast, cervical, and colorectal cancer screening. Am J Prev Med 2008;35(1S): S21-5. Available online at www.thecommunityguide.org/cancer/screening/client-oriented/Cancer2008_TaskForceRecs.pdf.

⁷ Evidence-Based Strategy: Breast Cancer Screening Among Non-Adherent Women. Available online at http://rtips.cancer.gov/rtips/rtips_details.do?programid=17&topicid=4&co=N&cg=4.

Goals for 2009 – 2015: Breast Cancer

- 2.3.** Promote and support organizational partnerships that aim to reach minority women and populations experiencing disparities in health care with breast health education, mammography screening, and navigation to services and care.^{7,8}



⁸ Evidence-Based Strategy: Reducing Barriers to the Use of Breast Cancer Screening. Available online at http://rtips.cancer.gov/rtips/rtips_details.do?programid=16&topicid=4&co=N&cg=.

Goals for 2009 - 2015: Cancer Genomics

Goal

Increase availability of cancer-related genetic information to the Michigan public and decrease barriers to risk-appropriate services.

Data

Genetics is the science of heredity; the study of genes and the way they determine traits and characteristics passed from generation to generation. In contrast, genomics is the study of the entire genome, including the complex interactions among multiple genes as well as between genes and the environment. Applied to public health, genomics offers the potential to increase understanding of the role of genes, environment and behavior as risk factors for complex, chronic diseases.¹

Genomics plays a part in nine of the [Ten Leading Causes of Death in the United States](#). All human beings are 99.9 percent identical in genetic makeup, but differences in the remaining 0.1 percent may hold important clues about the causes of disease.¹

According to the Michigan Department of Community Health's Vital Records Data for 2000, genetic factors contribute to the following leading causes of death among Michigan residents: heart disease, cancer, stroke, chronic lower respiratory diseases, diabetes mellitus, Alzheimer's disease, and kidney disease.²

¹ National Institutes of Health, National Human Genome Research Institute. Frequently Asked Questions About Genetics and Genomic Science. Available online at www.genome.gov/19016904. Accessed March 18, 2012.

² A Needs Assessment and State Plan for Michigan – Genetics Through the Life Cycle: Improving Health and Preventing Disease, 2008. Available online at www.michigan.gov/documents/Mlgeneticsplanandassessment_118168_7.pdf.

Goals for 2009 – 2015: Cancer Genomics

More than 950 genetic tests are currently available for clinical testing and most are used for diagnosis of rare single-gene disorders or chromosome abnormalities, with a few being used for newborn screening. However, a growing number of genetic tests may have population-based applications, which includes determining the risk of developing a disease or condition in the future (e.g., predictive testing for breast cancer or cardiovascular disease), and recognizing genetic variations that can influence response to medicines (pharmacogenomics).³

About 5-10% of the common cancers are due to inherited risk:

- 5-10% of breast cancer is inherited.⁴
- About 5% of colorectal cancers are attributed to Hereditary Nonpolyposis Colorectal Cancer.⁴
- 5-10% of women with ovarian cancer have BRCA1 or BRCA2 mutations.⁵



³ Centers for Disease Control and Prevention, Office of Public Health Genomics.

⁴ American Cancer Society. Cancer Facts and Figures, 2011. Available online at www.cancer.org.

Goals for 2009 - 2015: Cancer Genomics

Cancer Genomics Health Disparities Data:

- 8.3% – 10.2% of carriers of BRCA1 genetic mutations are Ashkenazi Jewish;
 - 3.5% are Hispanic;
 - 1.3% – 1.4% are African American;
 - 0.5% are Asian; and
 - 2.2% – 2.9% are non-Ashkenazi Caucasian.⁵
- 2.6% of carriers of BRCA2 genetic mutations are African American, and 2.1% are Caucasian.⁶
- Men who carry mutations in BRCA1 or BRCA 2 are also at an increased risk of developing prostate cancer, facing up to a 20% lifetime risk (most BRCA2 carriers).⁷

⁵ National Cancer Institute, National Institutes of Health: Genetics of Breast and Ovarian Cancer (PDQ) (Last modified February 17, 2012.). Available online at www.cancer.gov/cancertopics/pdq/genetics/breast-and-ovarian/HealthProfessional/page1/AllPages#Section_113. Accessed March 17, 2012.

⁶ National Cancer Institute, National Institutes of Health: Genetics of Breast and Ovarian Cancer (PDQ). (Last modified July 2002.) Available online at www.cancer.gov/cancerinfo/pdq/genetics/breast-and-ovarian. Accessed March 16, 2009.

⁷ Agalliu et al. "Associations of High-Grade Prostate Cancer with *BRCA1* and *BRCA2* Founder Mutations." *Clinical Cancer Research*, 2009. 15:1112-1120.

Goals for 2009 – 2015: Cancer Genomics

Implementation Objectives

Cancer Genomics Implementation Objective 1:¹ By 2011, expand public knowledge about the impact of genetics on cancer risk and management (breast, ovarian, and colorectal cancers).

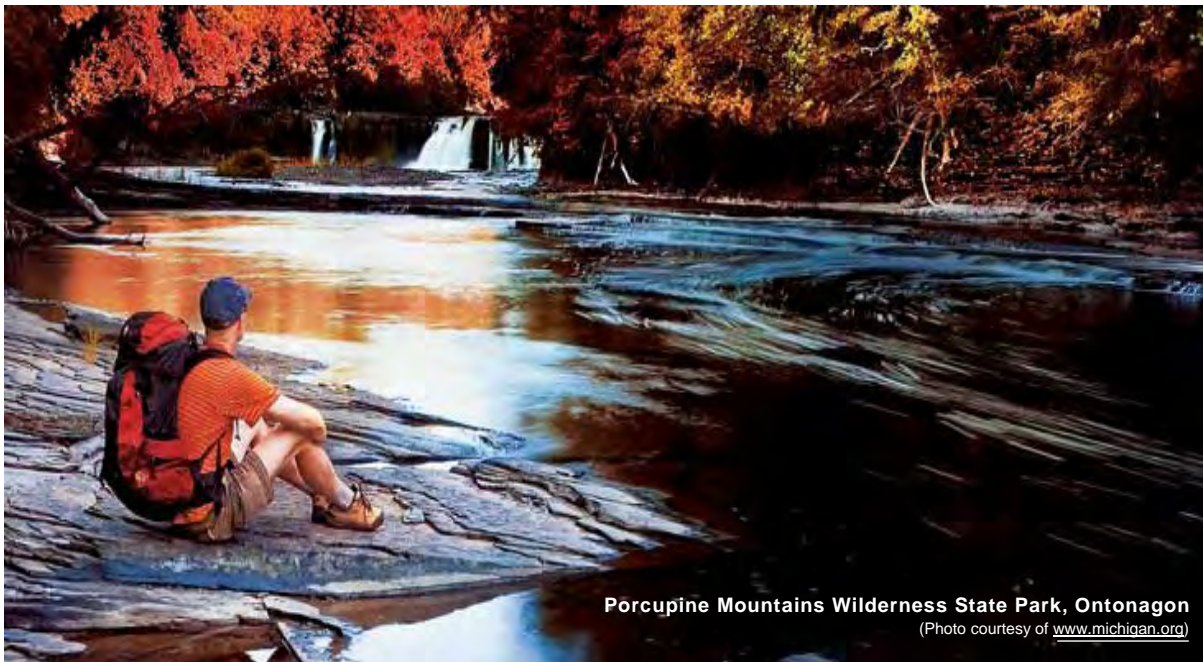
Progress Markers					
Available Data Markers	Data Source	Baseline (2005)	Interim Update (2008)	Interim Update (2010)	Target (2011)
Percent of adults (age 18+) who think family history is 'very important' or 'somewhat important' to their personal health	MiBRFSS	96.6%	Not available	94.8%	95%
Percent of adults (age 18+) who have actively collected health information from their relatives on their family health history	MiBRFSS	37% - Collected	Not available	29.1% - Collected 15.6% - Recorded 26.8% - Shared	50%
Percent of adults (age 18+) who were asked by their health care provider about their family history of cancer in general (including times they filled out a form)	MiBRFSS	Not available	Not available	83.4%	85%
Percent of all adults (age 18+) who received genetic counseling and/or genetic testing for cancer	MiBRFSS	Not available	Not available	7.7% - Counseling 4.7% - Testing	
Percent of all adults (age 40+) who have discussed with their provider family history of specific cancers (Breast or Ovarian)	SCBRFS -2008 MiBRFSS -2009	Not available	Breast 79.2% --10% lower in African, Native, Hispanic-American --20% lower in Arab, Asian-American Ovarian 75.5% ♀ only --69.2% Asian-American --47.4% Arab-American	2009 60.3% --5% lower in Hispanic-American	80%

¹ 2009 - 2011 MCC Special Project.

Goals for 2009 - 2015: Cancer Genomics

Strategies

- 1.1. Assess effect of “direct-to-consumer” ads for BRCA1/2 genetic testing on the public.^{2, 3}
- 1.2. Create and conduct a genetic literacy campaign targeting the general public to dispel myths and misconceptions, as well as increase recognition of the role of genetics in cancer risk and management and promote the benefits of genetic services.²
- 1.3. Make information on underlying genetic causes of common cancers and the importance of genetic counseling and early detection more readily available to the public.²



² Evidence-Based Strategy: Preparing for a Direct-to-Consumer Marketing Campaign for BRCA1 and BRCA2: A Three-State Public Health Collaboration. Available online at www.cdc.gov/genomics/events/file/print/10year/48_DTC_BRCA.pdf.

³ Evidence-Based Strategy: Genetic Testing for Breast and Ovarian Cancer Susceptibility: Evaluating Direct-to-Consumer Marketing, Atlanta, Denver, Raleigh-Durham, and Seattle, 2003. Available online at www.cdc.gov/mmwr/preview/mmwrhtml/mm5327a1.htm.

Goals for 2009 – 2015: Cancer Genomics

Genomics Implementation Objective 2: *By 2015, expand provider knowledge about the impact of genetics (breast, ovarian, and colorectal cancers) on cancer control.*

Progress Markers			
Available Data Markers	Data Source	Baseline (2009)	Target (2011)
NA	NA	NA	TBD

Strategies:

- 2.1. Assess effect of “direct-to-consumer” ads for BRCA1/2 genetic testing on provision of health care.^{2, 3}
- 2.2. Educate clinical providers about HNPCC mismatch repair testing.⁴
- 2.3. Educate clinical providers about USPSTF guidelines for family history, genetic counseling, and BRCA1/2 testing.⁴
- 2.4. Educate clinical providers about gene expression profiling tests (e.g., Oncotype DX, MammaPrint).⁴

⁴ Aligned with “Promoting Cancer Genomics Best Practices through Surveillance, Education, and Policy Change in the State of Michigan (2008-2011)”. A Strategic Plan supported by a cooperative agreement between the Centers for Disease Control and Prevention and the Michigan Department of Community Health Genomics Unit. https://www.michigan.gov/mdch/0,4612,7-132-2942_4911_4916-223425--,00.html

Goals for 2009 - 2015: Cancer Genomics

Cancer Genomics Implementation Objective 3: By 2015, improve genetic health care financing and access to testing and support services.

Progress Markers			
Available Data Markers	Data Source	Baseline (2009)	Target (2011)
MCC Advocacy commitment to improve patient access to genetic testing and support services	MCC Advocacy Committee Platform	TBD	TBD
Number of MCC organizations advocating for improved patient access	MCC Implementation Progress Report	20% (11 of 54) <ul style="list-style-type: none"> Mid-Michigan Medical Center-Midland, Providence Cancer Institute, Spectrum Health Cancer Center, St. Joseph Mercy Oakland, William Beaumont Hospital-Beaumont Cancer Institute, Michigan Cancer Genetics Alliance, Michigan Department of Community Health, Michigan Public Health Institute, Susan G. Komen for the Cure-Grand Rapids Affiliate, Barbara Ann Karmanos Cancer Institute, Henry Ford Health System 	TBD

Goals for 2009 – 2015: Cancer Genomics

Strategies:

- 3.1.** Review Michigan health insurance plan policies for BRCA1/2 genetic testing to determine consistency with USPSTF guidelines.⁴
- 3.2.** Facilitate meetings between health plan personnel and cancer genetic experts.⁴
- 3.3.** Provide technical assistance to promote development of health insurance plan policies consistent with USPSTF guidelines and recognize plans that comply with recommended clinical practices.⁴
- 3.4.** Advocate for third-party payment of genetic counseling (and testing as may be indicated) for Medicaid recipients and those without insurance.⁵
- 3.5.** Determine availability of adult cancer genetic services in Michigan, and make information available to consumers.

⁵ Evidence-Based Strategy: Genomic Tests for Ovarian Cancer Detection and Management. Available online at www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat1b.chapter.94793.

Goals for 2009 - 2015: Cancer Survivorship

Goal

Improve the quality of life for cancer survivors in Michigan.

Definitions

Cancer Survivors are individuals who have been diagnosed with cancer. They also include the people who are affected by an individual's diagnosis, such as family members, friends, and caregivers.¹

Survivorship covers the physical, psychosocial, and economic issues of cancer, from diagnosis until the end of life. It focuses on the health and life of a person with cancer beyond the diagnosis and treatment phases. Survivorship includes issues related to the ability to get health care and follow-up treatment, as well as the late effects of treatment, second cancers, and quality of life issues. Family members, friends, and caregivers are also part of the survivorship experience.²

Survivorship care, as defined in the Institute of Medicine report,³ is a distinct phase of care for cancer survivors that includes four components:

1. prevention and detection of new cancers and recurrent cancer;
2. surveillance for cancer spread, recurrence, or second cancers;
3. intervention for consequences of cancer and its treatment; and
4. coordination between specialists and primary care providers to ensure that all of the survivor's health needs are met.

¹ National Action Plan for Cancer Survivorship: Advancing Public Health Strategies, 2004, Centers for Disease Control and Prevention.

² National Cancer Institute.

³ From Cancer Patient to Cancer Survivor: Lost in Transition, 2006, Institute of Medicine.

Goals for 2009 - 2015: Cancer Survivorship

Quality of Life is the overall enjoyment of life. Many clinical trials assess the effects of cancer and its treatment on the quality of life. These studies measure aspects of an individual's sense of well-being, and ability to carry out various activities.³

Data

The National Cancer Institute estimates there were 11.7 million cancer survivors in the United States in 2007⁴ — a 5% increase from the previous estimate of 11.1 million in 2005. The number of cancer survivors has quadrupled over the last three decades.

According to the Michigan Cancer Registry, the five-year survival rate for all cancers was 60.1% in 1998 (60.4% in men, 59.8% in women). Thirty-eight percent of cancer survivors are of working age (ages 20-64).⁵

Through 2007, the breakdown of cancer survivors in Michigan⁵ includes the following:

- All cancer sites = 650,000 survivors
- Breast cancer = 117,000 survivors
- Cervical cancer (invasive only) = 8,000 survivors
- Childhood cancers (ages 0-14) = 5,600 survivors
- Colorectal cancer = 78,000 survivors
- Lung cancer = 39,000 survivors
- Prostate = 144,000 survivors

⁴ National Cancer Institute. SEER Cancer Statistics Review, 1975-2007. Available online at http://seer.cancer.gov/csr/1975_2007/.

⁵ Michigan Cancer Surveillance Program, 2008 Michigan Cancer Death Public Use File & 2007 Michigan Cancer Incidence Public Use File. Michigan Department of Community Health (MDCH) Division for Vital Records & Health Statistics.

Goals for 2009 - 2015: Cancer Survivorship

Cancer Survivorship Health Disparities Data

- African Americans have the highest overall cancer mortality rates nationwide.⁶
- African American women have lower survival rates for most cancers compared to whites due to later stage at detection and poorer-stage specific survival.⁴
- Persons with low socioeconomic status tend to have poorer cancer survival rates.⁷
- In Michigan, African Americans have lower five-year cancer survival rates (men=57%; women=50%) than the general population (60.4%=men, 59.8%=women).⁵
- More than 60% of cancer survivors are aged 65 or older.⁴



⁶ American Cancer Society. *Cancer Facts and Figures for African Americans 2009-2010*.

⁷ Singh GK, Miller BA, Hankey BF, Edwards BK. *Area Socioeconomic Variations in U.S. Cancer Incidence, Mortality, Stage, Treatment, and Survival, 1975-1999*. NCI Cancer Surveillance Monograph Series, Number 4. (Bethesda, MD: National Cancer Institute, 2003. NIH Publication No. 03-5417.)

Goals for 2009 - 2015: Cancer Survivorship

Implementation Objectives

Cancer Survivorship Implementation Objective 1:⁸ By 2011, increase cancer survivors' awareness of and access to survivorship resources and services.

Progress Markers			
<u>Available Data Markers</u>	<u>Data Source</u>	<u>Interim Update 2010</u>	<u>Target 2011</u>
Public awareness of available survivorship resources and services.	2009 survey of MCC member organizations ✓ Member websites	Survivorship Guidebook started and available on the MCC website	Guidebook updated
Guidelines developed by the MCC Prostate Cancer Action Committee for prostate cancer survivors/families/providers	✓ 2008 Needs Assessment {Prostate Cancer Survivor Follow-Back Study} ✓ Literature ✓ Prostate Cancer Action Expert Committee ✓ Prostate Cancer Research Fund projects	Guidelines completed & disseminated	Improved use of guidelines by primary care providers
Prevalence of all cancer among adults	MiBRFS	10.8%	--
Survivors receive cancer care information and/or written care plan from their provider	--MiBRFS --Explore CoC certification program (once implemented)	42.0%	50%
Percent of survivors who had health insurance to pay all/part of their cancer treatment	MiBRFS	94.5%	--
Percent of survivors who report having been denied health insurance because of their cancer diagnosis	MiBRFS	7.6%	--
Percent of survivors who participated in a clinical trial as part of their cancer treatment	MiBRFS	7.4%	--
Percent of survivors who experience current physical pain due to cancer or cancer treatment	MiBRFS	6.1%	--
Types of health care providers currently providing the majority of health care for adult cancer survivors (top three listed)	MiBRFS	62.1% --Family Practitioner 18.4% --Internist 6.5% --Other	

⁸ 2009 - 2011 MCC Special Project

Goals for 2009 - 2015: Cancer Survivorship

Strategies

1.1. Assess and compile existing survivorship resources available to cancer survivors in Michigan.⁹

1.2. Disseminate information about survivorship resources and services using a variety of methods, including new technologies.

1.3. Identify the existence and effectiveness of various models of patient navigation programs in Michigan, including proprietary programs, by polling the MCC membership.

1.4. Promote expansion of successful patient navigation programs within Michigan health care systems as appropriate for specific survivor populations to be served.⁹

1.5. Promote and support comprehensive survivorship services which address needs of cancer survivors throughout the full spectrum of cancer care, from diagnosis throughout remainder of life.⁹

1.6. Promote and support organizational partnerships that decrease barriers to survivorship resources for minorities and underserved populations.

1.7. Collaborate with the Bureau of Health Professions Pain Management and Palliative Care Program to promote and support initiatives pertaining to cancer survivorship.⁹

⁹ Comprehensive Cancer Control Leadership Institute, 2007.

Goals for 2009 - 2015: Cancer Survivorship

Cancer Survivorship Implementation Objective 2: By 2015, expand health care provider education about cancer survivors' needs.

Progress Markers			
Available Data Markers	Data Source	Baseline (2009)	Target (2015)
Existing Care Plans	Survey of MCC members and partners	TBD	TBD

Strategies:

2.1. Assess and compile a list of existing survivorship care plans, including those developed by national organizations such as American Society of Clinical Oncology.

2.2. Support development and use of survivorship care plans.¹⁰

2.3. Explore use of new technology, such as electronic medical records, to develop and increase visibility and use of survivorship care plans.

2.4. Provide training to providers in patient/family-centered approaches that facilitate successful implementation of survivorship care plans. Training will utilize evidence-based health learning principles, such as shared decision making. Training content will include all of the requirements for comprehensive individualized care plans.¹¹

¹⁰ American Society of Clinical Oncology. Available online at www.asco.org/.

¹¹ Evidence-Based Strategy: Interventions for providers to promote a patient-centered approach in clinical consultations. Available online at www.cochrane.org/reviews/en/ab003267.html.

Goals for 2009 - 2015: Cervical Cancer

Goal

Reduce the cervical cancer death rate in Michigan by 30%.

Data

During 2007, 412 women in Michigan were diagnosed with invasive cervical cancer.¹ Death from cervical cancer is considered to be preventable, and no one should die from the disease. Yet, 116 women in Michigan died of the disease in 2008.¹ In fact, cervical cancer mortality rates have been stable for at least a decade.

In 2007, Michigan ranked 34th in the nation in mortality rates from cervical cancer, with 17 states having lower cervical cancer death rates.² The incidence of pre-cancerous lesions of the cervix has notably increased in Michigan over the last decade, especially among younger women between the ages of 20 and 39. Cervical cancer causes the highest number of years of life lost among cancers in Michigan with an average of 26 years of life lost per women who dies of cervical cancer.¹

Nearly 94% of Michigan women age 18 and older have received at least one Pap smear during their lifetime. Almost 78% of Michigan women age 18 and older have received a Pap smear within the past three years.³

¹ Michigan Cancer Surveillance Program, 2008 Michigan Cancer Death Public Use File & 2007 Michigan Cancer Incidence Public Use File. Michigan Department of Community Health (MDCH) Division for Vital Records & Health Statistics. Available at www.michigan.gov/mdch/0,1607,7-132-2944_5323---,00.html.

² National Cancer Institute. SEER Cancer Statistics Review, 1975-2007. Available online at http://seer.cancer.gov/csr/1975_2007/index.html.

³ Michigan Department of Community Health, Bureau of Epidemiology. Behavioral Risk Factor Survey, 2010. Available online at www.michigan.gov/bfrs.

Goals for 2009 - 2015: Cervical Cancer

The American Cancer Society reports that 60% to 80% of American women with newly diagnosed cervical cancer have not had a Pap smear within the past five years. Of the women diagnosed with invasive cervical cancer in Michigan during 2007:

- 31.3% were between the ages of 25 and 39;
- 26.9 % were between the ages of 40 and 49;
- 21.4% were between the ages of 50 and 64; and
- 20.4% were 65 years of age or older.¹

Cervical Cancer Health Disparities Data:

- Women less likely to receive cervical cancer screening within the past three years include those with low income, less than a high school education, and/or between the ages of 18 and 29 and over the age of 70.³
- Women who do not receive cervical cancer screening are also likely not to have a “medical home” and do not receive other screening tests, such as mammograms and colorectal cancer screening.



Goals for 2009 - 2015: Cervical Cancer

Implementation Objectives

Cervical Cancer Implementation Objective 1:⁴ By 2011, reduce rates of cervical *in-situ* cancer among women aged 20 to 39 years by 10%.

Progress Markers for Implementation Objective 1					
Available Data Markers	Data Source	Baseline (2004)	Interim Update (2006)	Interim Update (2007)	Target (2011)
Age-Specific Incidence Rate of CIS per 100,000 women population aged 20-39	Michigan Surveillance System	149.1	135.0	Overall Rate: 128.3 -- White female: 112.3 -- Black female: 110.2 Age 20-29: CIS Rate: 160.6 -- White female: 138.0 -- Black female: 139.5 Age 30-39 CIS Rate: 95.2 -- White female: 85.5 -- Black female: 81.2	134.2

Goals for 2009 - 2015: Cervical Cancer

Strategies

1.1. From within target communities, identify and train peer spokespersons to help develop and disseminate prevention messages to appropriate community members.^{5,6}

1.2. Provide education through media, timed with Cervical Cancer Awareness Month.^{6,7}

1.3. Develop a narrowly targeted message that is culturally specific and disseminate it through small, local, culturally specific media.^{6,8}

1.4. Increase HPV4 vaccine series completion in women age 26 and younger, by 10% per year.⁹

1.5. Increase enrollment in Plan First by 20% per year.¹⁰

⁴ 2009 - 2011 MCC Special Project.

⁵ Evidence-Based Strategy: The Chinese Women's Health Project. Available online at http://rtips.cancer.gov/rtips/rtips_details.do?programid=20&topicid=5&co=N&cg=.

⁶ Strategy from 2007 MCC Cervical Cancer Priority Strategic Plan

⁷ Evidence-Based Strategy: The Forsyth County Cancer Screening Project. Available online at http://rtips.cancer.gov/rtips/rtips_details.do?programid=18&topicid=5&co=Y&cg=8

⁸ Evidence-Based Strategy: Increasing Breast and Cervical Cancer Screening Among Filipino American Women. Available online at <http://rtips.cancer.gov/rtips/programDetails.do?programId=163394>.

⁹ Data available via MICR.

¹⁰ Data available from Michigan Medicaid.

Goals for 2009 - 2015: Cervical Cancer

1.6. Increase number of women served in Family Planning/BCCCP joint project by 10% per year.¹¹

1.7. Promote appropriate Pap testing in minority women.¹²

1.8. Encourage the use of provider/client reminder systems to ensure timely compliance to screening.^{13,14}

¹¹ Data available from MBCIS {in FY07, 1,271 women served}.

¹² Data available from BRFSS.

¹³ Evidence-Based Strategy: Client Reminders are Recommended to Increase Cervical Cancer Screening. Available online at www.thecommunityguide.org/cancer/screening/2_client_rem_cerv_post.pdf.

¹⁴ Evidence-Based Strategy: Provider-Oriented Cancer Screening Interventions: Provider Reminders. Available online at www.thecommunityguide.org/cancer/screening/provider-reminders.htm.

Goals for 2009 - 2015: Cervical Cancer

Cervical Cancer Implementation Objective 2: By 2015, expand public education regarding appropriate cervical cancer screening.

Progress Markers			
Available Data Markers	Data Source	Baseline (2006)	Target (2015)
Documented public education activities	TBD	NA	NA

Strategies:

2.1. From within target communities, identify and train peer spokespersons to help develop and disseminate prevention messages to appropriate community members.⁵

2.2. Provide education through media, timed with Cervical Cancer Awareness Month.^{6,7}

2.3. Develop culturally specific messages and disseminate through small, local, culturally specific media.^{6,7,8}

Goals for 2009 - 2015: Cervical Cancer

Cervical Cancer Implementation Objective 3: By 2015, expand provider knowledge regarding appropriate cervical cancer screening.

Progress Markers			
Available Data Markers	Data Source	Baseline (2006)	Target (2011)
Documented provider education activities	TBD	NA	NA

Strategies:

3.1. Promote educational offerings to all Michigan health care providers and health care students on guidelines for cervical cancer screening and follow-up.¹⁵

3.2. Recommend that providers offer Pap testing to women who present for STI screening.¹⁶

3.3. Evaluate provider performance in frequency of delivery or offerings of cervical cancer screening services to clients and present providers with information about their performance in providing screening services.¹⁷

¹⁵ Evidence-Based Strategy: Adapted from Empowering Physicians to Improve Breast Cancer Screening. Available online at http://rtips.cancer.gov/rtips/rtips_details.do?programid=14&%20topicid=4&co=N&cg=.

¹⁶ Michigan BCCCP/STD Pilot Project (unpublished).

Goals for 2009 - 2015: Cervical Cancer

Cervical Cancer Implementation Objective 4: By 2015, influence cervical cancer health care policy.

Progress Markers			
Available Data Markers	Data Source	Baseline (2006)	Target (2011)
Documented advocacy efforts	TBD	NA	NA

Strategies:

4.1. Advocate traditional third-party payer coverage for Pap and HPV testing.¹⁷

4.2. Advocate for education about the HPV4 vaccine to parents of 6th grade girls.

4.3. Advocate for County Health Plans in Michigan counties not currently served.

¹⁷ Evidence-Based Strategy: Provider-Oriented Cancer Screening Interventions: Provider Assessment and Feedback. Available online at <http://www.thecommunityguide.org/cancer/screening/provider-assessment.htm>.

¹⁸ State Cancer Legislative Database Program.

Goals for 2009 - 2015: Cervical Cancer

Cervical Cancer Implementation Objective 5: By 2015, contribute to increased cervical cancer research.

Progress Markers			
Available Data Markers	Data Source	Baseline (2006)	Target (2011)
Published research	TBD	NA	NA

Strategies

5.1. Measure cervical cancer screening rates at the county level:

- analyze counties where screening rates are low;
- analyze demographics of non-screened populations and administer
- targeted surveys in those counties;
- target “low-screening” counties for intervention based on county level demographics and associated factors;
- use next iteration of Behavioral Risk Factor Surveys to evaluate impact of interventions; and
- disseminate research results to interested parties.

5.2. Endorse and support clinical trials for cervical cancer.

Goals for 2009 - 2015: Childhood Cancers

Goal

Improve the quality of life for childhood cancer survivors in Michigan.

Data

Cancer is a leading cause of death among U.S. children age one to 14, though it is still relatively rare in this age group.¹ Among the 12 major types of childhood cancers, leukemia and cancers of the brain and central nervous system account for more than half of the new cases. About one-third of all childhood cancers are leukemia.²

In Michigan, 331 children (ages 1-14 years) were diagnosed with cancer in 2007, 53 children died of the disease in 2008.³ Childhood cancer is the third leading cause of death in Michigan children ages one to four years and the second leading cause of death in children ages five to 14 years.⁴ Through 2007, there were approximately 5,600 childhood cancer survivors in Michigan.³

Over the past 20 years, there has been an overall increase in the incidence of all forms of invasive cancer diagnosed in children, while death rates have declined and five-year survival rates increased during this time period. Increased risk for some childhood cancers has been linked to high levels of ionizing radiation through accidental exposure or radiotherapy, children with cancer treated with chemotherapy or radiation therapy. Children with AIDS, children with certain genetic syndromes, and children with Down syndrome are also at higher risk for cancer.²

¹ American Cancer Society. Available online at www.cancer.org.

² National Cancer Institute. Available online at www.cancer.gov.

³ Michigan Cancer Surveillance Program, 2008 Michigan Cancer Death Public Use File & 2007 Michigan Cancer Incidence Public Use File. Michigan Department of Community Health (MDCH) Division for Vital Records & Health Statistics.

⁴ Leading Causes of Death and Cause-Specific Rates by Age, Michigan Residents 2006. 2006 Michigan Resident Death File, Vital Records & Health Data Development Section, Michigan Department of Community Health. Available online at www.mdch.state.mi.us/pha/osr/deaths/causageall.asp.

Goals for 2009 - 2015: Childhood Cancers

Seventy-seven percent of children treated for cancer survive five years or more, an increase of almost 45% since the early 1960s.¹ The effects of childhood cancer treatment that may affect the child's health later in life are called late effects. Close, long-term follow-up from health care providers who understand what complications to look for is needed.²

Only a small percentage of childhood cancer survivors are affected by any single, specific chronic health condition. Twenty-six percent of childhood cancer survivors reported no adverse health conditions at all.²

Childhood Cancer Health Disparities Data

- No health disparity data exists.

Implementation Objectives

Childhood Cancer Implementation Objective 1: Improve primary care provider knowledge and practices with respect to childhood cancer survivorship issues.

Progress Markers			
Available Data Markers	Data Source	Baseline (2006)	Target (2011)
TBD	TBD	TBD	TBD

Strategies:

1.1. Improve awareness of late effects and their implications for long-term health care among childhood cancer survivors and their families.⁵

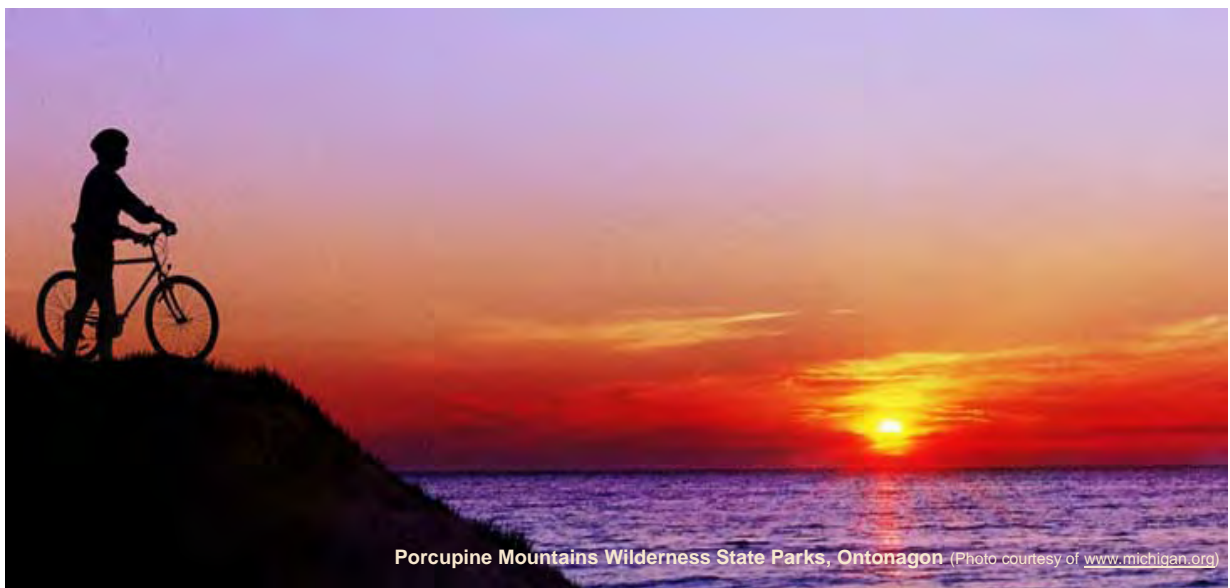
⁵ Evidence-Based Strategy: Childhood Cancer Survivorship: Improving Care and Quality of Life. Available online at www.iom.edu/CMS/28312/4931/14782.aspx.

Goals for 2009 - 2015: Childhood Cancers

1.2. Improve professional education and training regarding late effects and their management for primary care providers.⁵

1.3. Establish collaboration between medical, nursing, and other health profession schools or programs and professional societies to improve the care provided to seriously ill children by creating and testing curricula and trainings that:

- prepare health care professionals who care for children and families to have basic competence in palliative, end-of-life, and bereavement care; and
- prepare a group of pediatric palliative care specialists to take lead responsibility for acting as clinical role models, educating other professionals, and conducting research that extends the knowledge base for palliative, end-of-life, and bereavement care.⁶



⁶ Evidence-Based Strategy: When Children Die: Improving Palliative and End-of-life Care for Children and Their Families. Available online at www.nap.edu/catalog.php?record_id=10390.

Goals for 2009 - 2015: Childhood Cancers

1.4. Establish collaboration between specialty fields of pediatric health care and education and experts in adult and pediatric palliative care to provide instruction and experience appropriate for all health care professionals who care for children and to develop and implement:

- model curricula that provide a basic foundation of knowledge about palliative, end-of-life, and bereavement care that is appropriate for undergraduate health professions education in areas including but not limited to medicine, nursing, social work, psychology, and pastoral care;
- residency program requirements that provide more extensive preparation as appropriate for each category of pediatric specialists and sub specialists who care for children with life-threatening medical conditions;
- pediatric palliative care fellowships and similar training opportunities;
- introductory and advanced continuing education programs and requirements for both generalist and specialist pediatric professionals; and
- practical, fundable strategies to evaluate selected techniques or tools for educating health professionals in palliative, end-of-life, and bereavement care.⁶

Goals for 2009 - 2015: Childhood Cancers

Childhood Cancer Implementation Objective 2: Increase childhood cancer survivors' access to educational and counseling services.

Progress Markers			
Available Data Markers	Data Source	Baseline (2006)	Target (2011)
TBD	TBD	TBD	TBD

Strategy

2.1. Provide peer-delivered telephone counseling to childhood cancer survivors.⁷

Childhood Cancer Implementation Objective 3: Increase the number of health systems that have institutional protocols and procedures for palliation, end-of-life care, and bereavement care for childhood cancer patients and their families.

Progress Markers			
Available Data Markers	Data Source	Baseline (2006)	Target (2011)
TBD	TBD	TBD	TBD

⁷ Evidence-Based Strategy: Partnership for Health. Available online at http://rtips.cancer.gov/rtips/rtips_details.do?programid=5&topicid=12&co=Y&cg=.

Goals for 2009 - 2015: Childhood Cancers

Strategies

3.1. Establish collaboration between pediatric professionals, children's hospitals, hospices, home health agencies, professional societies, family advocacy groups, government agencies, and others to develop and implement clinical practice guidelines and institutional protocols and procedures for palliative, end-of-life, and bereavement care that meet the needs of children and families for:

- complete, timely, understandable information about diagnosis, prognosis, treatments (including their potential benefits and burdens), and palliative care options;
- early and continuing discussion of goals and preferences for care that will be honored wherever care is provided;
- effective and timely prevention, assessment, and treatment of physical and psychological symptoms and other distress, whatever the goals of care and wherever care is provided; and
- competent, fair, and compassionate clinical management of end-of-life decisions about such interventions as resuscitation and mechanical ventilation.⁶

3.2. Establish collaboration and better coordination of responsibilities between children's hospitals, hospices, home health agencies, and other organizations that care for seriously ill children in implementing clinical and administrative protocols and procedures for palliative, end-of-life, and bereavement care. In addition to supporting competent clinical services, such protocols should promote the coordination and continuity of care and the timely flow of information among caregivers and within and among care sites, including hospitals, family homes, and residential care facilities.⁶

Goals for 2009 - 2015: Childhood Cancers

3.3. Establish collaboration between children's hospitals, hospices with established pediatric programs, other institutions that care for children with fatal or potentially fatal medical conditions and professional societies, state agencies, and other organizations to develop regional information programs and other resources to assist clinicians and families in local and outlying communities and rural areas. These resources should include the following:

- consultative services to advise a child's primary physician or local hospice staff on all aspects of care for the child and the family from diagnosis through death and bereavement;
- clinical, organizational, and other guides and information resources to help families to advocate for appropriate care for their children and themselves; and
- professional education and other programs to support palliative, end-of-life, and bereavement care that is competent, continuous, and coordinated across settings, among providers, and over time (regardless of duration of illness).⁶

3.4. Establish collaborative effort that includes children's hospitals, hospices, and other institutions that care for seriously ill children and physicians, parents, child patients, psychologists, and other relevant experts to create policies and procedures for involving children in discussions and decisions about their medical condition and its treatment. These policies and procedures — and their application — should be sensitive to children's intellectual and emotional maturity and preferences and to families' cultural backgrounds and values.⁶

3.5. Establish collaboration between children's hospitals and other hospitals that care for children who die and hospices and other relevant community organizations to develop and implement protocols and procedures for:

- identifying and coordinating culturally sensitive bereavement services for parents, siblings, and other survivors.⁶

Goals for 2009 - 2015: Childhood Cancers

Childhood Cancer Implementation Objective 4: Increase advocacy efforts to improve short- and long-term care for childhood cancer survivors.

Progress Markers			
Available Data Markers	Data Source	Baseline (2006)	Target (2011)
TBD	TBD	TBD	TBD

Strategies

4.1. Support the Children with Special Health Care Needs programs.⁵

4.2. Seek support for research in survivorship from institutions like the National Cancer Institute, the National Institute for Nursing Research, and the American Cancer Society.⁵

4.3. Implement a restructuring of hospice benefits by public and private insurers to:

- add hospice care to the services required by Congress in Medicaid and other public insurance programs for children and to the services covered for children under private health plans;
- eliminate eligibility restrictions related to life expectancy, substitute criteria based on a child's diagnosis and severity of illness, and drop rules requiring children to forgo curative or life-prolonging care (possibly in a case management framework); and
- include outlier payments for exceptionally costly hospice patients.⁶

Goals for 2009 - 2015: Childhood Cancers

4.4. In addition to modifying hospice benefits, implement a reform of Medicaid and private insurers' policies restricting benefits for other palliative services related to a child's life-threatening medical condition. Such modifications should:

- reimburse the time necessary for fully informing and counseling parents (whether or not the child is present) about their child's 1) diagnosis and prognosis, 2) options for care, including potential benefits and harms, and 3) plan of care, including end-of-life decisions and care for which the family is responsible;
- increase access to palliative care experts and hospice personnel by covering palliative care consultations;
- reimburse bereavement services for parents and surviving siblings of children who die;
- specify coverage and eligibility criteria for palliative inpatient, home health, and professional services based on diagnosis (and, for certain services, severity of illness) to guide specialized case managers and others involved in administering the benefits; and
- provide for the Centers for Medicare and Medicaid Services to develop estimates of the potential cost of implementing these modifications for Medicaid.⁶

Goals for 2009 - 2015: Childhood Cancers

4.5. Implement a cooperative effort by federal and state Medicaid agencies, pediatric organizations, and private insurers to:

- define diagnosis and, as appropriate, severity criteria for eligibility for expanded benefits for palliative, hospice, and bereavement services;
- examine the appropriateness of reimbursing pediatric palliative and end-of-life care for diagnostic, procedure, and other classification systems that were developed for reimbursement of adult services; and
- develop guidance for practitioners and administrative staff about accurate, consistent coding and documenting of palliative, end-of-life, and bereavement services.⁶



Arch Rock, Mackinac Island (Photo courtesy of www.michigan.org)

Goals for 2009 - 2015: Colorectal Cancer

Goal

By 2015, increase to 75 percent the proportion of average-risk people in Michigan who report having received appropriate colorectal cancer screening and follow-up of abnormal screening results.

Data

Colorectal cancer is the second leading cause of cancer-related death in Michigan, with only lung cancer taking the lives of more men and women. During 2007, 2,524 men and 2,531 women were diagnosed with invasive colorectal cancer. During 2008, 901 men and 919 women died from colorectal cancer.¹ Michigan ranked 26th in the nation in colorectal cancer mortality in 2007, with 25 states having a lower colorectal cancer death rate.²

In Michigan, 40.7% of colorectal cancer cases diagnosed during 2007 were found at a localized stage (40.1% men and 41.2% women). Since the early 1990s, there has been a slight increase in the proportion of colorectal cancer cases diagnosed at a localized stage.¹

There is genetic link to colorectal cancer. The two most common forms of hereditary colorectal cancer (familial adenomatous polyposis and hereditary nonpolyposis colorectal cancer) account for only about 5% of cases of colon cancer.³

Nearly 61% of Michigan men and women age 50+ years have had an appropriately time colorectal cancer screening.⁴

¹ Michigan Cancer Surveillance Program, 2008 Michigan Cancer Death Public Use File & 2007 Michigan Cancer Incidence Public Use File. Michigan Department of Community Health (MDCH) Division for Vital Records & Health Statistics. Available online at www.michigan.gov/mdch/0,1607,7-132-2944_5323---,00.html.

² National Cancer Institute. SEER Cancer Statistics Review, 1975-2007. Available online at http://seer.cancer.gov/csr/1975_2007/.

³ American Cancer Society. Cancer Facts & Figures, 2011.

⁴ Michigan Public Health Institute (Cancer Control Services Program) and Michigan Department of Community Health (Cancer Prevention and Control Section), Special Cancer Behavioral Risk Factor Survey (SCBRFS), 2008.

Goals for 2009 - 2015: Colorectal Cancer

Colorectal Cancer Health Disparities

- In the United States, men are more likely than women to develop colorectal cancer and die.^{1,2}
- African Americans have higher colorectal cancer incidence and mortality rates than people of other racial groups.^{1,2}
- Five-year survival rates of colorectal cancer vary by race and ethnicity.²
- African Americans diagnosed with colorectal cancer at any stage are less likely than other races to survive five years; the five-year survival rate for African Americans is 9.0% lower than for whites.¹
- Michigan adults with lower education levels and lower income levels are less likely to have ever had a sigmoidoscopy or colonoscopy.⁵
- 60.8% of African American men and women age 50+ years have had any appropriately timed colorectal cancer screening.⁴
- 59.2% of African Indian men and women age 50+ years have had any appropriately timed colorectal cancer screening.⁴
- 46.5% of Hispanic men and women age 50+ years have had any appropriately timed colorectal cancer screening.⁴
- 45.6% of Arab American men and women age 50+ years have had any appropriately timed colorectal cancer screening.⁴

⁵ Michigan Department of Community Health, Bureau of Epidemiology. Behavioral Risk Factor Survey, 2010. Available online at www.michigan.gov/brfs.

Goals for 2009 - 2015: Colorectal Cancer

Implementation Objectives

Colorectal Cancer Implementation Objective 1: By 2015, increase the proportion of health care providers that recommend appropriate colorectal cancer screening.

Progress Markers				
Available Data Markers	Data Source	Baseline (2007)	Interim (2010)	Target (2015)
Percent of health care providers recommending FOBT annually for adults aged 50+	Early Detection and Screening for Prostate and Colorectal Cancer: Results from the Knowledge, Attitudes and Practice (KAP)	81.9%	--	TBD
Percent of health care providers recommending flexible sigmoidoscopy every	KAP Survey	35.6%	--	TBD
Percent of health care providers recommending colonoscopy every 10 years	KAP Survey	63.1%	--	TBD
Percent of adults aged 50 years and older that have had an FOBT in the past year, a sigmoidoscopy in the past five years, or a colonoscopy in the past 10 years	MIBRFSS	2008: 66.4%	69.3%	75%
Prevalence of 1 st degree family history of colorectal cancer among Michigan adults	MIBRFSS	--	7.2%	--

Goals for 2009 - 2015: Colorectal Cancer

Strategies

1.1. Disseminate revised MCC Recommendations for Colorectal Cancer Early Detection among health care providers and health plans in Michigan. Coordinate efforts through the American Cancer Society, Great Lakes Division, Inc., and the Michigan Association of Health Plans.^{6,7}

1.2. Utilize provider/client reminder systems to ensure timely compliance to screening.^{8,9,10}

1.3. Implement provider assessment and feedback mechanisms (e.g., assess how often providers offer or deliver screening services to clients [assessment] and then give providers information about their performance [feedback]).¹¹

⁶ Strategy from 2006 MCC Colorectal Cancer Strategic Plan.

⁷ Evidence-Based Strategy: Adapted from Empowering Physicians to Improve Breast Cancer Screening (EPICS). Available online at http://rtips.cancer.gov/rtips/rtips_details.do?programid=14&topicid=4&co=N&cg=.

⁸ Evidence-Based Strategy: Provider-oriented Cancer Screening Interventions: Provider Reminders. Available online at www.thecommunityguide.org/cancer/screening/provider-reminders.htm.

⁹ Evidence-Based Strategy: Physician-Oriented Intervention on Follow-Up in Colorectal Cancer Screening. Available online at http://rtips.cancer.gov/rtips/rtips_details.do?programid=63&topicid=6&co=N&cg=5.

¹⁰ Evidence-Based Strategy: Prevention Care Management. Available online at http://rtips.cancer.gov/rtips/rtips_details.do?programid=94&topicid=6&co=Y&cg=5.

¹¹ Evidence-Based Strategy: Provider-Oriented Cancer Screening Interventions: Provider Assessment and Feedback. Available online at www.thecommunityguide.org/cancer/screening/provider-assessment.htm.

Goals for 2009 - 2015: Colorectal Cancer

Colorectal Cancer Implementation Objective 2: By 2015, increase health plan commitment to colorectal cancer screening.

Progress Markers			
Available Data Markers	Data Source	Baseline (2004)	Target (2015)
Percent of U.S. health plans covering FOBT	National Cancer Institute Survey of Colorectal Cancer Screening Practices ¹²	97%	TBD
Percent of U.S. health plans covering colonoscopy	National Cancer Institute Survey of Colorectal Cancer Screening Practices	57%	TBD
Percent of U.S. health plans issuing guidelines on colorectal cancer screening to providers	National Cancer Institute Survey of Colorectal Cancer Screening Practices	65%	TBD
Percent of U.S. health plans having a mechanism in place to remind patients that they are due for colorectal cancer screening	National Cancer Institute Survey of Colorectal Cancer Screening Practices	25%	TBD

¹² Klabunde CN, Riley GF, Mandelson MT, Frame PS, Brown ML. Health Plan Policies and Programs for Colorectal Cancer Screening: A National Profile. *Am J Manag Care.* 2004 Apr; 10(4):273-279.

Goals for 2009 - 2015: Colorectal Cancer

Strategies:

2.1. Investigate effectiveness of health care provider incentives, especially financial, in increasing colorectal cancer screening rates.⁶

2.2. Educate and collaborate with employers/health care purchasers on coverage for colorectal cancer screening.^{6,13}

2.3. Promote collaboration between special populations and health plans (and vice versa).⁶



Pioneer Park near Muskegon (Photo courtesy of www.michigan.org)

¹³ Evidence-Based Strategy: The Next Step: Worksite Cancer Screening and Nutrition Intervention for High-Risk Auto Workers. Available online at http://rtips.cancer.gov/rtips/rtips_details.do?programid=64&topicid=6&co=Y&cg=2.

Goals for 2009 - 2015: Colorectal Cancer

Colorectal Cancer Implementation Objective 3: By 2015, increase public awareness of colorectal cancer risks, prevention, and testing for early detection.

Progress Markers			
Available Data Markers	Data Source	Baseline (2008)	Target (2015)
Public awareness of the fact that "tests are available to find colorectal cancer early"	SCBRFS	98.9%	TBD
Public awareness of the fact that "regular testing can find changes in the colon before they become cancer"	SCBRFS	97.8%	TBD
Public awareness of the fact that "people older than 50 years are more likely to get colorectal cancer than people younger than 50 years"	SCBRFS	80.8%	TBD
Public awareness of the fact that early detection better cures rate for colorectal cancer	SCBRFS	"There is little anyone can do about getting cancer" 21.3%	TBD
Public awareness of signs and symptoms of colorectal cancer	SCBRFS	Responded: "Blood stool/bleeding from rectum: 63.8% Pain/cramping in abdomen: 27.4% Change in bowel habits: 26.9% Don't know: 21.9% Other: 21.8%	TBD
Public awareness of risk factors for colorectal cancer	SCBRFS	Responded: High fat, low fiber diet: 33.4% Don't know: 30.9% Other: 25.4% Diet related: 19.2% Family history: 17.2% Not getting tested: 14.2%	TBD

Goals for 2009 - 2015: Colorectal Cancer

Strategies:

3.1. Identify barriers to colorectal cancer screening among underserved, hard-to-reach population groups and effective strategies to overcome those barriers.¹⁴

3.2. Promote public education on colorectal cancer in combination with other screenings (e.g., mammograms).⁶

3.3. Develop effective and innovative strategies with attention to measurement and documentation of outcomes.

- Include new marketing strategies, focusing on links to celebrities (as demonstrated in CDC's Screen for Life: National Colorectal Cancer Action Campaign).
- Collaborate with new partners (e.g., AARP, media partners).
- Develop strategies that are ongoing throughout the year instead of focusing only on March as Colorectal Cancer Awareness Month.
- Increase public knowledge about family history as a risk factor for colorectal cancer.⁶

3.4. Implement small media interventions (videos or printed communications, such as letters, brochures, leaflets, pamphlets, flyers, or newsletters).^{14,15,16}

¹⁴ Evidence-Based Strategy: Adapted from Increasing Breast and Cervical Cancer Screening Among Filipino American Women. Available online at http://rtips.cancer.gov/rtips/rtips_details.do?programid=25&topicid=4&co=Y&cg=.

¹⁵ Evidence-Based Strategy: Colorectal Cancer Screening in Chinese Americans Project. Available online at http://rtips.cancer.gov/rtips/rtips_details.do?programid=96&topicid=6&co=N&cg=2.

¹⁶ Evidence-Based Strategy: Effect of a Mailed Brochure on Appointment Keeping for Screening Colonoscopy. Available online at http://rtips.cancer.gov/rtips/rtips_details.do?programid=91&topicid=6&co=N&cg=2.

Goals for 2009 - 2015: Colorectal Cancer

Colorectal Cancer Implementation Objective 4: By 2015, improve access to colorectal cancer screening and treatment services.

Progress Markers			
Available Data Markers	Data Source	Baseline (2008)	Target (2015)
Counties implementing the Michigan Colorectal Cancer Screening Program	Michigan Colorectal Cancer Screening Program Final Report	15 counties	TBD
Enrollees in the Michigan Colorectal Cancer Screening Program	Michigan Colorectal Cancer Screening Program Final Report	541 enrollees	TBD

Strategies:

4.1. Maintain and/or expand the Michigan Colorectal Cancer Screening Program (MCRCS) that serves low-income, uninsured/underinsured men and women.

4.2. Advocate about the need for treatment coverage for clients enrolled in MCRCS.

Goals for 2009 - 2015: End-of-Life Care

Goal

By 2015, prevent and reduce avoidable suffering up to, and during, the last phase of life for persons with cancer by specified data markers.

Data

Over the next three decades, Michigan's population aged 65 and older is expected to increase by approximately 60%. In 2005, it was estimated that about 40% of persons with cancer will not survive five years after the original diagnosis.¹ In 2009, 23.4% of deaths in Michigan were due to cancer.²

Experts maintain that pain and symptoms can be controlled in at least 95% of cases. Yet, in 2008, caregivers report that 40.3% of terminally ill patients have severe pain at the end-of-life, with 56.1% of cancer decedents suffering severe to excruciating pain during their final months.³

In 2010, there were 26 counties in Michigan with palliative care programs, up from 15 in 2006. In 2009, 39.2% of patients who used hospice in Michigan had cancer.⁴ The use of hospice has increased in recent years, but the length of stay has not improved. In 2009, 43.2% of hospice recipients in Michigan died less than seven days after admittance.⁴

¹ Michigan Department of Community Health, Vital Records and Health Data Development Section. Survival data from the Michigan Cancer Surveillance Program are developed through passive surveillance of mortality by matching the registry with state and national mortality files.

² 2008 Michigan Resident Death File, Vital Records & Health Data Development Section, Michigan Department of Community Health; Population Estimate (latest update 9/2010), National Center for Health Statistics, U.S. Census Populations with Bridged Race Categories; National Center for Health Statistics, Deaths: Final Data for 2004. National Vital Statistics Reports; Vol. 55, No. 19.

³ Michigan Public Health Institute (Cancer Control Services Program) and Michigan Department of Community Health (Cancer Prevention and Control Section). Special Cancer Behavioral Risk Factor Survey (SCBRFS), 2008. Available online at www.michigancancer.org/Resources/SpecialMCCRReports.cfm.

⁴ National Hospice and Palliative Care Organization. *2010 National Summary of Hospice Care SUPPLEMENT: State Comparison Report*, December 2010. Available online at www.nhpco.org/nds.

Goals for 2009 - 2015: End-of-Life Care

End-of-Life Health Disparities Data:

- In 2008, caregivers in Michigan minority population groups also reported high levels of pain experienced by their loved one at the end of their life.³
- Special attention is needed for culturally competent palliative care and communication with patient and family. Eliciting culturally based attitudes and beliefs and implementing universal strategies for clear communication is essential in reducing the stress levels that are experienced by patients and caregivers in some minority groups.



Lake Fanny Hooe, Keweenaw County (Photo courtesy of www.michigan.org)

Goals for 2009 - 2015: End-of-Life Care

Implementation Objectives

End-of-Life Care Implementation Objective 1: By 2015, promote system change to increase access to palliative care services throughout Michigan.

Progress Markers				
Available Data Markers	Data Source	Baseline (2006)	Interim Update (2011)	Target (2015)
Number and locations of hospitals with palliative care consultation teams.	Palliative Care Census Project	20 hospitals in 10 counties	57 hospitals in 26 counties	TBD
Proportion of nursing home residents who received hospice services.	Minimum Data Set	4 th Quarter 2008 3.2%	--	TBD
Proportion of cancer decedents who die at home.	SCBRFS	80.1% (own home) 8.0% (home of family member/ friend)	2008: 88.9% own home	TBD
Proportion of cancer decedents who use hospice services.	SCBRFS	68.2%	2008: 75.2%	TBD
Median length of stay in hospice for cancer decedents.	Michigan Hospice and Palliative Care Organization	16 (2006) 17.5 (2003) 25 (1996)		TBD

Goals for 2009 - 2015: End-of-Life Care

Strategies:

1.1. Convene a forum to clarify the perceived and actual competing interests of oncology practices, hospices, palliative care services, and other providers as they serve persons with cancer. Identify and pursue strategies for optimal use of services.⁵

1.2. Encourage oncology practices to participate in the Quality Oncology Practice Initiative (QOPI) of the American Society of Clinical Oncology (ASCO).²¹

1.3. Assess the availability and scope of palliative services in Michigan hospitals at least every five years.²¹

1.4. Increase the number of hospitals offering palliative care services.²¹

1.5. Assess use of hospice services for nursing home residents with cancer and determine reasons why hospice is, or is not, used.²¹

1.6. Seek collaboration and funding for at least one of the following projects:

- improve pain and symptom management of cancer survivors;
- facilitate provider/patient communication about treatment options; and/or
- reduce economic barriers to hospice care and other palliative care services.²¹

⁵ Evidence-Based Strategy: Approaching Death: Improving Care at the End of Life (1997). Available online at www.nap.edu/catalog.php?record_id=5801#toc.

Goals for 2009 - 2015: End-of-Life Care

End-of-Life Care Implementation Objective 2: By 2015, increase the supply of health professionals who are trained in palliative care techniques.

Progress Markers			
Available Data Markers	Data Source	Baseline (2009)	Target (2015)
Proportion of physicians who dedicate the majority of their professional time in a palliative care specialty	Bureau of Health Professions Physician Survey	TBD	TBD

Strategies

2.1. Support the efforts of the Bureau of Health Professional's Pain Management and Palliative Care Programs to ensure that all health professional licensing boards require continuing education in pain and symptom management.

2.2. Seek sessions on end-of-life topics for in-service presentations and annual meetings of MCC member organizations. Essential content includes:

- management of cancer pain and non-pain symptoms, and
- communication about informed treatment choices in advanced illness.

2.3. Increase the number of professionals who have been trained using the EPEC-O curriculum.

Goals for 2009 - 2015: End-of-Life Care

End-of-Life Care Implementation Objective 3: By 2015, increase cancer patients' and caregivers' understanding of options for: 1) care up to, and during, the last phase of life, and 2) pain and symptom relief.

Progress Markers				
Available Data Markers	Data Source	Baseline	Interim Update (2008)	Target (2015)
Prevalence of severe pain as reported by family caregivers	SCBRFS Bureau of Health Professions Public Survey (April 2009)	40% (2006) TBD	56.1%	TBD

Strategies

3.1. Prior to each biennial SCBRFS survey, review and modify as needed the questions on public knowledge and actions related to: 1) options for care up to, and during, the last phase of life, and 2) pain and symptom management.

3.2. Educate the public that they should expect to receive reliable, skillful, and supportive care for pain and symptom management.²¹

3.3. In a variety of health care settings, pilot proven methods to identify candidates and facilitate access to advance care planning, hospice, and other palliative care services for persons with advanced illness.²¹

Goals for 2009 - 2015: Environmental/Occupational Cancer

Goal

Improve education about environmental/occupational exposures and cancer risk in Michigan.

Data

Environmental Factors and Cancer Risk

Environmental factors — which, from a scientist's standpoint, include smoking, diet, and infectious diseases, as well as chemicals and radiation in our homes and workplaces — probably cause three-quarters of all cancer cases in the United States. Among these environmental factors, tobacco use, unhealthy diet, and inadequate physical activity are more likely to affect personal cancer risk than trace levels of pollutants in food, drinking water, and the air.¹

However, the degree of risk from those pollutants depends on the concentration, intensity, and exposure. Substantial increases in cancer risk have been shown in settings where workers have been exposed to high levels of ionizing radiation, certain chemicals, metals, and other substances. Even exposures at low doses, which pose only small risk to individuals, can still cause substantial ill health across the whole population. For example, secondhand tobacco smoke increases cancer risk in the population at large when those who do not smoke are exposed to smoking by others.¹

The following information details risks from some environmental (usually occupational) exposures that are known or suspected causes of cancer.

¹ American Cancer Society. The Environment and Cancer Risk.

Goals for 2009 - 2015: Environmental/Occupational Cancer

Chemicals and Radiation

Some chemicals, such as benzene and asbestos, show definite evidence of causing cancer in humans. Others are considered probable human carcinogens (cancer-causing agents) based on animal experiments. These include dichlorodiphenyl-trichloroethane (DDT), formaldehyde, and polychlorinated biphenyls (PCBs).¹

The only types of radiation proven to cause cancer in humans are ionizing radiation and ultraviolet (UV) radiation.¹

Evidence that high dose of ionizing radiation causes cancer comes from studies of atomic bomb survivors, patients receiving radiotherapy, and certain occupational groups, such as uranium miners. Ionizing radiation can affect virtually any part of the body, but especially affects bone marrow and the thyroid gland. Diagnostic medical and dental x-rays are set at the lowest dose levels possible to minimize risk without losing image quality and medical usefulness.¹

Exposure to sunlight (UV radiation) causes almost all cases of basal and squamous cell skin cancer and is a major cause of skin melanoma. Disruption of the earth's ozone layer by pollution may cause rising levels of UV radiation.¹

In addition, radon exposures in the home can increase risk of lung cancer. Cigarette smoking greatly compounds the effect of radon exposure in lung cancer risk. Remedial actions may be needed if radon levels are found to be too high in homes.

Public concern about cancer risks in the environment has typically focused on unproven risks, or on situations in which known carcinogen exposures are at such low levels that risks are negligible.¹

Goals for 2009 - 2015: Environmental/Occupational Cancer

Pesticides

Pesticides are widely used in producing foods in agriculture. High doses of some of these chemicals have been shown to cause cancer in animals, but the very low concentrations found in some foods have not been associated with increased cancer risk. In fact, people who eat more fruits and vegetables, which may be contaminated with trace amounts of pesticides, generally have lower cancer risks than people who eat few fruits and vegetables. Workers exposed to high levels of pesticides, in industry workers or in farming, may be at higher risk of certain cancers.¹

Environmental pollution by pesticides such as DDT, which is now banned but was used in agriculture in the past, degrades slowly and can lead to accumulation in the food chain and persistent residues in body fat. These residues have been suggested as a possible risk factor for breast cancer, although the evidence has not been conclusive.¹

Continued research into pesticide use is essential for maximum food safety. But, pesticides play a valuable role in sustaining the food supply. When controlled properly, the minimal risks they pose are overshadowed by the health benefits of a diverse diet rich in foods from plant sources.¹

Non-Ionizing Radiation

Electromagnetic radiation at frequencies below ionizing radiation and UV levels has not been proven to cause cancer. Some studies suggest it may be associated with cancer, but most of the research in this area does not endorse this finding. Low-frequency radiation includes radio waves, microwaves, and radar, as well as power frequency radiation arising from electric and magnetic fields associated with electric currents (e.g., from cellular phones and household appliances).¹

Goals for 2009 - 2015: Environmental/Occupational Cancer

Toxic Wastes

Toxic wastes in dump sites can threaten human health through pollution of the air, water and soil. Many toxic chemicals found in such sites can be cancer-causing at high doses, but most community exposures appear to involve very low or negligible dose levels. Clean-up of existing dump sites and close control of toxic materials are essential to ensuring healthy living conditions.¹

Nuclear Power Plants

Ionizing radiation emissions from nuclear plants are closely controlled and involve negligible levels of exposure for communities near the plants. Reports about cancer case clusters in such communities have raised public concern, but studies show clusters do not occur more often near nuclear plants than they do elsewhere.¹

Occupational Cancer Risk

The causes of most cancers are not well defined, although epidemiologic studies have identified various environmental and genetic factors associated with some types of cancer. Some of the first observations of the relationship between environmental exposures and cancer were among occupational groups, including scrotal cancer in chimney sweeps (polycyclic aromatic hydrocarbons) and bladder cancer in workers exposed to dyes (aromatic amines). A variety of occupations have been associated with an increased risk of cancer, yet the etiologic agents have not been identified.²

The link between occupation and cancer is not easy to establish, because cancers associated with occupational exposures are indistinguishable clinically and pathologically from cancer of non-occupational origin. The generally long latency period between onset of exposure and disease adds to the difficulty of recognizing the association between work and cancer. In addition, non-occupational risk factors, such as cigarette smoking, may have a synergistic effect with a workplace exposure in the causation of cancer.²

² Profiles of Occupational Injuries and Diseases in Michigan. Available online at www.michigan.gov/documents/mdch_ProfilesReport_94691_7.pdf.

Goals for 2009 - 2015: Environmental/Occupational Cancer

Certain occupations are known to be associated with high cancer risks. Some of these include painters; furniture makers; workers in the iron, steel, coal, and rubber industries; and workers involved in boot and shoe manufacture or repair. Workers exposed to metals (e.g., arsenic, beryllium, cadmium, chromium, lead, and nickel) also have an elevated cancer risk.²

Mesothelioma, a cancer of the lining of the lung and abdomen, and hemangiosarcoma of the liver are the only cancers that are almost uniquely associated with exposure to asbestos and vinyl chloride, respectively.²

Mesothelioma

The Michigan Cancer Registry identified 1,471 incident malignant mesothelioma cases among Michigan residents for the years 1985 through 2000, for an annual average of 92. Incident cases increased from 58 in 1985 to 124 in 2000.²

Malignant mesothelioma incident cases predominately occurred in people 55 years of age and older (87%), in males (75%), and in whites (94%). Mesothelioma cases in the cancer registry indicated a definite upward trend over the 15 years of available data, consistent with trends seen in asbestosis, another disease associated with asbestos exposure.²

Goals for 2009 - 2015: Environmental/Occupational Cancer

Hemangiosarcoma

Between 1985 through 2000, there were 22 incident hemangiosarcomas of the liver, or less than two cases per year. The cases were evenly distributed over the 15 years. Sixty-eight percent of the cases were between the ages of 55 and 84. Cases in males (59%) were more common than cases in females (41%), and whites accounted for 91% of the cases.

During the five years between 1997 and 2001, 51 individuals filed workers' compensation claims for cancer. This included:

- 17 filings in 1997;
- eight filings in 1998;
- 15 filings in 1999;
- eight filings in 2000; and
- three filings in 2001.²

Environment/Occupational Cancers Health Disparities Data

- Malignant mesothelioma incident cases predominately occurred in people 55 years of age and older (87%), males (75%), and whites (94%).²
- More populated counties in Michigan have a greater incidence of mesothelioma cases than less populated ones.²

Goals for 2009 - 2015: Environmental/Occupational Cancer

Implementation Objectives

Environmental/Occupational Cancers Implementation Objective 1:
Improve knowledge about environmental/occupational causes of cancer.

Progress Markers			
Available Data Markers	Data Source	Baseline (2009)	Target (2015)
TBD	Department of Environmental Quality	Pending	TBD

Strategies:

1.1. Provide ongoing education of health care providers and employers about requirements of the occupational disease reporting law and support for enforcement of the law and its provisions.³

1.2. Establish a single data source that is adequate to describe the true burden of occupational disease and injury in Michigan.³

³ Evidence-Based Strategy: Profiles of Occupational Injuries and Diseases in Michigan. Available online at www.michigan.gov/documents/mdch_ProfilesReport_94691_7.pdf.

Goals for 2009 - 2015: Environmental/Occupational Cancer

1.3. Improve some of the source data systems to strengthen the ability to track and prevent occupational illnesses and injuries by:

- expanding the emergency department (“MEDCIIN”) surveillance system to include all hospital emergency departments in Michigan and to include reporting of all conditions, not just injuries;
- expanding mandatory laboratory reporting of blood lead results to include other heavy metals (arsenic, mercury and cadmium) in blood and urine;
- collecting occupational information in communicable disease data systems;
- capturing better information about causes of occupational injuries and illnesses in workers’ compensation data; and
- analyzing and disseminating Michigan occupational disease and injury data based on multiple data sources as an important approach to describe the true burden of occupational disease and injury in Michigan and to target prevention activities.³

1.4. Utilize surveillance data to update exposure standards, such as those for isocyanates, noise, and metalworking fluids.³

1.5. Identify companies in various industry groups with the lowest rates of claims for work-related injuries and illnesses, assessment of the reasons for the low rates, and marketing of these successes to companies in the same industries with higher rates.³

1.6. Ensure that the children of lead-exposed workers are being tested for lead exposure and are being protected from “take-home” lead.³

Goals for 2009 - 2020: Healthy Lifestyles

Goal

Increase the number of Michigan residents who adopt a healthy lifestyle by improving their knowledge, motivation, and opportunity to adopt a healthy nutritional regimen and obtain adequate physical activity levels to maintain good health.

Data

General Health Status

In 2010, an estimated 14.2% of Michigan adults reported their general health to be either fair or poor for their age compared to 14.8% reporting the same rating in 2007. This proportion increased with age from 8.7% (18 to 24 year olds) to 28.3% for those ages 75 or older.¹

The proportion who reported fair or poor health decreased with increasing education (7.0% of college graduates vs. 37.0% of individuals with less than a high school education) and income levels (5.2% of those earning more than \$75,000 per year vs. 33.6% of those earning less than \$20,000 per year). Blacks in Michigan have consistently had a higher prevalence than whites (25.2% vs. 12.2%).¹

Physical Activity

In 2010, an estimated 23.6% of Michigan adults did not participate in any leisure-time physical activity (self-reported physical activities or exercise, such as running, calisthenics, golf, gardening, or walking for exercise in the past month). This proportion was higher among older adults than among younger adults.¹

Women were more likely than men (25.6% vs. 21.6%), and blacks (29.9%) were more likely than other race-ethnic groups to not participate in leisure-time physical activity.¹

¹ Michigan Department of Community Health, Bureau of Epidemiology. Behavioral Risk Factor Survey, 2010. Available online at www.michigan.gov/brfs.

Goals for 2009 - 2020: Healthy Lifestyles

Lack of physical activity during leisure time decreased with higher education (12.8% among college graduates vs. 45.6% among those with less than a high school education) and with higher income levels (13.6% among those with an income of more than \$75,000 vs. 37.7% among those with an income of less than \$20,000).¹

Overweight and Obesity

In 2010, an estimated 35.1% of Michigan adults were overweight, having a Body Mass Index (BMI) between 25.0 and 29.9. This proportion increased with age, from 24.0% of those aged 18 to 24 years to 40.0% of those aged 75 years and older. Men were more likely than women (40.9% vs. 29.4%) to be overweight.¹

An estimated 31.7% of Michigan adults were obese in 2010, compared with 28.4 in 2007. The proportion of adults who were obese in 2010 increased with age from 17.6% of those aged 18-24 years to 38.0% of those aged 55 to 64 years, and then decreased to 22.7% of those aged 75 years and older. Blacks were more likely than whites (45.3% vs. 29.8%) to be obese.¹

The cumulative proportion of overweight and obese Michigan adults was 66.8% in 2010.¹

Michigan has consistently had higher obesity prevalence rates than the U.S. median. In 2010, Michigan was tied for the 8th highest obesity rate among all states.¹

Nutrition

An estimated 77.8% of Michigan adults in 2009 did not consume fruits (including juice) and vegetables five or more times per day. Men were less likely than women to consume fruits and vegetables the recommended number of times per day (81.9% vs. 74.1%). This proportion was lower among college graduates (70.7%), compared with other educational levels, and was lower among those aged 75 years and older (71.8%), compared with younger age groups.¹

Goals for 2009 - 2020: Healthy Lifestyles

Healthy Lifestyles Health Disparities Data

- Gender and racial disparity in reports of adequate physical activity and overweight problems are described previously.

The Healthy Lifestyle goals are adopted from the *Michigan Healthy Eating and Physical Activity Strategic Plan: 2010-2020* www.michigan.gov/documents/mdch/Mi_Healthy_State_Plan_353817_7.pdf.

Physical Activity Goal — Behavior:

By 2020, increase the percentage of Michigan youth and adults that get the recommended amount of moderate physical activity.

Implementation Objectives

Healthy Lifestyles Implementation Objective 1: Increase awareness of the importance of regular physical activity and the need for evidence-based physical activity programs.

Healthy Lifestyles Implementation Objective 2: Implement comprehensive educational programs to promote the importance of regular physical activity.

Healthy Lifestyles Implementation Objective 3: Increase opportunities among disparate populations to increase levels of physical activity.

Goals for 2009 - 2020: Healthy Lifestyles

Progress Markers			
Available Data Markers	Data Source	Baseline (2009)	Target (2020)
Percentage of youth grades 9-12 who were physically active at least 60 minutes/day on at least five of the past seven days	2009 Michigan Youth Risk Behavior Survey (YRBS)	46.8%	65%
Proportion of adults (18+) who report that they usually do moderate physical activities, such as brisk walking, bicycling, vacuuming, and gardening for at least 30 minutes on five or more days per week while not at work	2009 Michigan Behavioral Risk Factor Survey (BRFS)	38.4%	50%

For further evidence-based strategies, refer to page 17 of *Michigan Healthy Eating and Physical Activity Strategic Plan: 2010-2020* (www.michigan.gov/documents/mdch/Mi_Healthy_State_Plan_353817_7.pdf).

Goals for 2009 - 2020: Healthy Lifestyles

Physical Activity Goal — Environmental:

By 2020, increase the number of environmental changes to support physical activity.

Implementation Objectives

Healthy Lifestyles Implementation Objective 4: Create or enhance access to places for physical activity in communities.

Healthy Lifestyles Implementation Objective 5: Support the development and enhancement of environments supportive of physical activity in schools.

Progress Markers			
Available Data Markers	Data Source	Baseline (2009)	Target (2020)
Youth			
Percentage of middle and high schools that allow community sponsored use of physical activity facilities by youth outside of normal school hours	School district administrative offices; U.S. Census; fitness/recreation center data; local jurisdiction park data and where available GIS layers; etc.	86.4% Michigan (89.4% nationally)	92%
Percentage of youth with parks or playgrounds, community centers, and sidewalks or walking paths available in their neighborhood	School district administrative offices; U.S. Census; fitness/recreation center data; local jurisdiction park data and where available GIS layers; etc.	52% Michigan (50% nationally)	60%

Goals for 2009 - 2020: Healthy Lifestyles

Progress Markers <i>(continued)</i>			
Available Data Markers	Data Source	Baseline (2009)	Target (2020)
Percentage of youth with parks or playgrounds, community centers, and sidewalks or walking paths available in their neighborhood	School district administrative offices; U.S. Census; fitness/recreation center data; local jurisdiction park data and where available GIS layers; etc.	52% Michigan (50% nationally)	60%
Percentage of middle and high schools in state that support or promote walking or biking to and from school	School district administrative offices; U.S. Census; fitness/recreation center data; local jurisdiction park data and where available GIS layers; etc.	46.3% Michigan (46.1% nationally)	60%
Adults			
Percentage of census blocks that have at least one park located within the block or 1/2 mile from the block boundary	School district administrative offices; U.S. Census; fitness/recreation center data; local jurisdiction park data and where available GIS layers; etc.	21.3% Michigan (20.3% nationally)	30%
Percentage of census blocks that have at least one fitness or recreation center located within the block or 1/2 mile from the block boundary	School district administrative offices; U.S. Census; fitness/recreation center data; local jurisdiction park data and where available GIS layers; etc.	14.7% Michigan (16.6% nationally)	20%

For further evidence-based strategies, refer to page 19 of *Michigan Healthy Eating and Physical Activity Strategic Plan: 2010-2020* (www.michigan.gov/documents/mdch/Mi_Healthy_State_Plan_353817_7.pdf).

Goals for 2009 - 2020: Healthy Lifestyles

Physical Activity Goal — Policy:

By 2020, increase the number of policy changes to support physical education and physical activity.

Implementation Objectives

Healthy Lifestyles Implementation Objective 6: Support the enhancement and maintenance of a statewide infrastructure and public health workforce to support physical activity.

Healthy Lifestyles Implementation Objective 7: Support the expansion of the number of communities with policies, standards and practices that support physical activity.

Healthy Lifestyles Implementation Objective 8: Support enhancement of physical education and activity in school and physical activity in childcare.

Healthy Lifestyles Implementation Objective 9: Support creation and expansion of policies, standards and practices that support physical activity in worksites.

Healthy Lifestyles Implementation Objective 10: Support expansion of the number of healthcare agencies with practices that support physical activity.

Goals for 2009 - 2020: Healthy Lifestyles

Progress Markers			
Available Data Markers	Data Source	Baseline (2009)	Target (2020)
Local-Level Policies/Ordinances			
Existence of at least one enacted community- scale urban design/ land use policy in the state	<i>Michigan Healthy Eating and Physical Activity Strategic Plan: 2010-2020, page 36</i>	Yes (27 states)	Yes
Existence of at least one enacted street scale urban design/ land use policy in the state	<i>Michigan Healthy Eating and Physical Activity Strategic Plan: 2010-2020, page 36</i>	Yes (23 states)	Yes
Existence of at least one enacted transportation and travel policy in the state	<i>Michigan Healthy Eating and Physical Activity Strategic Plan: 2010-2020, page 36</i>	Yes (36 states)	Yes
State-Level Policies/Ordinances			
State requires or recommends regular elementary school recess	<i>Michigan Healthy Eating and Physical Activity Strategic Plan: 2010-2020 page 36</i>	Yes (20 states)	Yes
State requires elementary, middle and high schools to teach physical education (PE)	<i>Michigan Healthy Eating and Physical Activity Strategic Plan: 2010-2020 page 36</i>	No (37 states)	Yes
State requires moderate or vigorous intensity physical activity in licensed, regulated childcare centers	<i>Michigan Healthy Eating and Physical Activity Strategic Plan: 2010-2020 page 36</i>	No (8 states)	Yes

For further evidence-based strategies, refer to page 20 of *Michigan Healthy Eating and Physical Activity Strategic Plan: 2010-2020* (www.michigan.gov/documents/mdch/Mi_Healthy_State_Plan_353817_7.pdf).

Goals for 2009 - 2020: Healthy Lifestyles

Healthy Eating Goal — Behavior:

By 2020, increase the percentage of Michigan youth and adults that consume the recommended amount of fruits and vegetables.

Implementation Objectives

Healthy Lifestyles Implementation Objective 11: Support culturally appropriate, community-wide campaigns to increase awareness of the value of eating fruits, vegetables and other healthy foods.

Healthy Lifestyles Implementation Objective 12: Support culturally appropriate community-wide campaigns and educational programs to increase awareness of the value of decreasing the consumption of sugar-sweetened beverages.

Progress Markers			
Available Data Markers	Data Source	Baseline (2009)	Target (2020)
Percentage of students grades 9-12 who consumed fruits (including 100% juice) and vegetables five or more times/day in the past seven days	2009 Michigan Youth Risk Behavior Survey (YRBS)	19.6%	50%
Percentage of adults (18+) who consumed fruits (including 100% juice) and vegetables five or more times per day in the past seven days	2009 Michigan Behavioral Risk Factor Survey (BRFS)	22.2%	50%

For further evidence-based strategies, refer to page 23 of *Michigan Healthy Eating and Physical Activity Strategic Plan: 2010-2020* (www.michigan.gov/documents/mdch/Mi_Healthy_State_Plan_353817_7.pdf).

Goals for 2009 - 2020: Healthy Lifestyles

Healthy Eating Goal — Environmental:

By 2020, increase the number of environmental changes to support healthy eating.

Implementation Objectives

Healthy Lifestyles Implementation Objective 13: Support initiatives to increase the availability of healthy food outlets.

Progress Markers			
Available Data Markers	Data Source	Baseline (2009)	Target (2020)
Adults			
Percentage of census tracts that have healthier food retailers located within the tract or within ½ mile of tract boundaries	<i>Michigan Healthy Eating and Physical Activity Strategic Plan: 2010-2020, page 36</i>	66.5% Michigan (72% nationally)	75%
Number of farmers markets per 100,000 residents	<i>Michigan Healthy Eating and Physical Activity Strategic Plan: 2010-2020, page 36</i>	1.6 Michigan (1.7 nationally)	2.4
Percentage of cropland acreage harvested for fruits and vegetables	<i>Michigan Healthy Eating and Physical Activity Strategic Plan: 2010-2020, page 36</i>	4.5% Michigan (2.5% nationally)	5%
Youth			
Percentage of middle and high schools that offer fruits (not juice) and non-fried vegetables as competitive foods	<i>Michigan Healthy Eating and Physical Activity Strategic Plan: 2010-2020, page 36</i>	39% Michigan (20.9% nationally)	50%

Goals for 2009 - 2020: Healthy Lifestyles

Progress Markers (continued)			
Available Data Markers	Data Source	Baseline (2009)	Target (2020)
State Level			
Percentage of farmers markets that accept electronic benefits transfer (EBT)	<i>Michigan Healthy Eating and Physical Activity Strategic Plan: 2010-2020, page 36</i>	3.1% Michigan (7.6% nationally)	6%
Percentage of farmers markets that accept WIC Farmers Market Nutrition Program coupons	<i>Michigan Healthy Eating and Physical Activity Strategic Plan: 2010-2020, page 36</i>	22.8% Michigan (28.2% nationally)	35%

For further evidence-based strategies, refer to page 25 of *Michigan Healthy Eating and Physical Activity Strategic Plan: 2010-2020* (www.michigan.gov/documents/mdch/Mi_Healthy_State_Plan_353817_7.pdf).

Healthy Eating Goal — Policy:

By 2020, increase the number of policy changes to support healthy eating.

Implementation Objectives

Healthy Lifestyles Implementation Objective 14: Support expansion of the number of schools, childcare settings and worksites implementing nutrition standards.

Healthy Lifestyles Implementation Objective 15: Support increasing the number of policies, ordinances and economic incentives supportive of healthy foods.

Goals for 2009 - 2020: Healthy Lifestyles

Healthy Lifestyles Implementation Objective 16: Support expansion of the number of state and local policies that limit the availability of unhealthy foods.

Progress Markers			
Available Data Markers	Data Source	Baseline (2009)	Target (2020)
Local Level			
Increase the number of local food policy councils	Respond to need as identified by Michigan nutritional and related coalitions, by health sector personnel, and disparity reduction advocates	1 (Michigan) (59 across states)	10
State Level			
Establish state-level policy for healthier food retail	Respond to need as identified by Michigan nutritional and related coalitions, by health sector personnel, and disparity reduction advocates	Yes (Michigan) (8 states nationwide)	Yes
Establish state-level food policy councils	Respond to need as identified by Michigan nutritional and related coalitions, by health sector personnel, and disparity reduction advocates	Yes (Michigan) (20 states nationwide)	Yes
Establish state-level policy for farm-to-school programs	Respond to need as identified by Michigan nutritional and related coalitions, by health sector personnel, and disparity reduction advocates	Yes (Michigan) (21 states nationwide)	Yes

For further evidence-based strategies, refer to page 25 of *Michigan Healthy Eating and Physical Activity Strategic Plan: 2010-2020* (www.michigan.gov/documents/mdch/Mi_Healthy_State_Plan_353817_7.pdf).

Goals for 2009 - 2020: Healthy Lifestyles

Breastfeeding

Based on solid evidence, women who breastfeed have a decreased risk of breast cancer.

Magnitude of Effect: The relative risk of breast cancer is decreased 4.3% for every 12 months of breastfeeding, in addition to 7% for each birth.¹ Research also indicates that women who breastfeed may have lower rates of certain ovarian cancers.² A number of studies have provided varying degrees of support that breastfeeding reduces the risk of obesity among children and therefore also reduces the child's chance of developing cancers later in life.

Breastfeeding Goal — Behavior:

By 2020, increase breastfeeding initiation, duration and exclusivity.

Implementation Objectives

Healthy Lifestyles Implementation Objective 17: Support culturally appropriate community-wide campaigns to increase public awareness and support of breastfeeding.

Healthy Lifestyles Implementation Objective 18: Support the implementation of comprehensive breastfeeding education programs targeting breastfeeding mothers, family members, providers and educators.

¹ Collaborative Group on Hormonal Factors in Breast Cancer. "Breast cancer and breastfeeding: collaborative reanalysis of individual data from 47 epidemiological studies in 30 countries, including 50,302 women with breast cancer and 96,973 women without the disease." *Lancet* 360 (9328):187-95, 2002.

² American Academy of Pediatrics. "Policy Statement: Breastfeeding and the Use of Human Milk." *Pediatrics*. Feb 2005; 115(2).

Goals for 2009 - 2020: Healthy Lifestyles

Healthy Lifestyles Implementation Objective 19: Support the implementation of education and awareness programs for health care professionals that address action steps toward reduction of breastfeeding disparities.

Progress Markers			
Available Data Markers	Data Source	Baseline (2008)	Target (2020)
Breastfeeding Initiation			
Population as a whole	2008 CDC National Immunization Survey (NIS)	64.8% (2008)	TBD
Caucasian	2007 Pediatric Nutrition Surveillance System (PedNSS)	56.4% (2007)	75%
African American	2007 PedNSS	37.8% (2007)	75%
Breastfeeding 6-Month Duration			
Population as a whole	2008 NIS	31.2% (2008)	40%
Caucasian	2007 PedNSS	15.7% (2007)	50%
African American	2007 PedNSS	11.4% (2007)	50%
Breastfeeding 12-Month Duration			
Population as a whole	2008 NIS	14.4% (2008)	TBD
Caucasian	2007 PedNSS	12.5% (2007)	25%
African American	2007 PedNSS	9.6% (2007)	25%

Goals for 2009 - 2020: Healthy Lifestyles

Progress Markers (<i>continued</i>)			
Available Data Markers	Data Source	Baseline (2008)	Target (2020)
Breastfeeding 3-Month Exclusivity			
Population as a whole	2008 NIS	23.5% (2008)	45%
Caucasian	2007 Pregnancy Risk Assessment Monitoring System (PRAMS)	37% (2007)	45%
African American	2007 PRAMS	15% (2007)	45%
Breastfeeding 6-Month Exclusivity			
Population as a whole	2008 NIS	10.7% (2008)	17%
Caucasian	No data available		
African American	No data available		

For further evidence-based strategies, refer to page 27 of *Michigan Healthy Eating and Physical Activity Strategic Plan: 2010-2020* (www.michigan.gov/documents/mdch/Mi_Healthy_State_Plan_353817_7.pdf).

Breastfeeding Goal — Environmental and Policy:

By 2020, increase the number of environmental changes to support breastfeeding.

By 2020, increase the number of policy changes to support breastfeeding.

Goals for 2009 - 2020: Healthy Lifestyles

Implementation Objectives

Healthy Lifestyles Implementation Objective 22: By 2020, support the development of a statewide infrastructure to promote and support breastfeeding activities.

Healthy Lifestyles Implementation Objective 23: By 2020, support increasing policies and practices in businesses supportive of breastfeeding.

Progress Markers			
Available Data Markers	Data Source	Baseline (2009)	Target (2020)
Increase Michigan's Maternity Practices in Infant Nutrition and Care (mPINC) score	State mPINC score (<i>Maternity Practices in Infant Nutrition and Care</i>)	64/100	70
Percent of live births occurring at facilities identified as part of the Baby-Friendly Hospital Initiative (BFHI)	Baby-Friendly Hospitals and Birth Centers	0 (Michigan) (1.93 national avg.)	2
Number of International Board Certified Lactation Consultants (IBCLCs) per 1,000 live births	International Board of Lactation Consultant Examiners (IBLCE)	1.06 (Michigan) (2.2 national avg.)	2
Number of La Leche League Groups per 1,000 live births	La Leche League of Michigan	0.4 (Michigan) (0.34 national avg.)	0.5
State laws protecting breastfeeding in public	Michigan Law	Yes	Yes
State laws supporting breastfeeding mothers who return to work	Michigan Law	No	Yes

For further evidence-based strategies, refer to page 29 of *Michigan Healthy Eating and Physical Activity Strategic Plan: 2010-2020* (www.michigan.gov/documents/mdch/Mi_Healthy_State_Plan_353817_7.pdf).

Goals for 2009 - 2015: Ovarian Cancer

Goal

Improve understanding of, and access to, genetic counseling services for women who may be at high risk for developing ovarian cancer.

Data

Ovarian cancer is the ninth most common cancer in women and ranks fifth as the cause of cancer death in American women. It is also the leading cause of gynecological cancer death in the United States. In 2011, it is estimated that over 21,990 U.S. women will be diagnosed with ovarian cancer with over 15,460 dying of the disease.¹ It is estimated that one of 71 women will develop invasive ovarian cancer in her lifetime.²

The American Cancer Society estimates that 560 Michigan women will die of ovarian cancer in 2011.¹ Data from the Michigan Cancer Registry show that 479 women died from ovarian cancer in 2008,³ and 759 women were newly diagnosed with the disease in 2007.³ Ovarian cancer incidence and mortality rates for Michigan women are similar to U.S. rates, and rates are similar around the state.⁴

The majority (52.8%) of all new cases of ovarian cancer in Michigan diagnosed in 2007 were at the distant stage, with a much smaller percentage (17.9%) of cases diagnosed at the localized stage. Five-year survival rates for women diagnosed at the localized stage are 92.4%; unfortunately, fewer than 30% of ovarian cancers are detected at this early stage. Women diagnosed at a later stage have five-year survival rates of only 27.2%. No racial disparities in the staging of ovarian cancer exist within the Michigan population.³

¹ American Cancer Society. Cancer Facts & Figures 2011.

² American Cancer Society.

³ Michigan Cancer Surveillance Program, 2008 Michigan Cancer Death Public Use File & 2007 Michigan Cancer Incidence Public Use File. Michigan Department of Community Health (MDCH) Division for Vital Records & Health Statistics.

⁴ National Cancer Institute. SEER Cancer Statistics Review, 1975-2007. Available online at http://seer.cancer.gov/csr/1975_2007/.

Goals for 2009 - 2015: Ovarian Cancer

The majority of ovarian cancer cases seem to be sporadic. Currently, there are no effective screening tests to assist with the early detection of ovarian cancer, and the United States Preventive Task Force Guidelines for Primary Care Providers state that family history is the single greatest risk for ovarian cancer. Even though only 10% of women diagnosed with ovarian cancer have one of the genetic mutations associated with ovarian cancer, there is also documented evidence of a familial risk relationship between ovarian and breast (as well as colorectal and prostate) cancer.²

Ovarian Cancer Health Disparities Data

- Incidence and mortality patterns vary among ethnic and racial groups within different age groups, but white women have the highest age-specific mortality rates in all age groups.²
- Ovarian cancer is most common in post-menopausal women; half of all ovarian cancers are found in women over the age of 63.²



Goals for 2009 - 2015: Ovarian Cancer

Implementation Objectives

Ovarian Cancer Implementation Objective 1: By 2015, determine Michigan's available resources for genetic counseling reimbursement.

Progress Markers			
Available Data Markers	Data Source	Baseline (2009)	Target (2015)
Number of health plans reimbursing for genetic counseling services.	MCC Implementation Progress Report	TBD	TBD

Strategies

1.1. Identify sources of funding to pay for genetic counseling (and testing, as may be indicated) for women who may be at high risk of developing "familial" cancer.⁵

⁵ Evidence-Based Strategy: Genomic Tests for Ovarian Cancer Detection and Management. Available online at www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat1b.chapter.94793.

Goals for 2009 - 2015: Ovarian Cancer

Ovarian Cancer Implementation Objective 2: By 2015, improve patient access to genetic testing and support services.

Progress Markers			
Available Data Markers	Data Source	Baseline (2009)	Target (2015)
MCC Advocacy Committee commitment to improve patient access to genetic testing and support services	MCC Advocacy Committee Platform	TBD	TBD
Number of MCC member organizations advocating for improved patient access	MCC Implementation Progress Report	TBD	TBD

Strategies:

2.1. Advocate for third-party payment of genetic counseling (and testing as may be indicated) for Medicaid recipients and those who are uninsured or underinsured.⁵

Goals for 2009 - 2015: Prostate Cancer

Goal

Make available prostate cancer symptom management materials for providers, survivors and families.

Data

Prostate cancer has been the most frequently diagnosed cancer in Michigan since the late 1980s, and it was the second leading cause of cancer deaths in Michigan men in 2007.¹

During 2007, 8,345 Michigan men were newly diagnosed with prostate cancer, and 922 Michigan men died of the disease in 2008.¹

Since the early 1990s, the incidence of prostate cancer in Michigan has declined, but it still exceeds the national incidence rates.^{1,2} Michigan ranks 38th in the nation in prostate cancer deaths, with 13 states having lower rates.²

In Michigan, 82.7% of prostate cancer cases diagnosed during 2007 were found at a local stage.¹ Approximately 99.4% of men with prostate cancer live at least five years.² Survival from prostate cancer is greatest if the cancer is detected before it has spread outside the prostate.³

Currently, there are more than 144,000 prostate cancer survivors in Michigan.¹

¹ Michigan Cancer Surveillance Program, 2008 Michigan Cancer Death Public Use File & 2007 Michigan Cancer Incidence Public Use File. Michigan Department of Community Health (MDCH) Division for Vital Records & Health Statistics.

² National Cancer Institute. SEER Cancer Statistics Review, 1975-2007. Available online at http://seer.cancer.gov/csr/1975_2007/.

³ American Cancer Society.

Goals for 2009 - 2015: Prostate Cancer

Prostate Cancer Health Disparities Data

- The older a man is, the greater his risk for getting prostate cancer.¹
- African American men have the highest incidence of prostate cancer.¹
- African American men are more likely than Caucasian men to die of the disease.²
- Prostate cancer is less common among Hispanic, Asian, Pacific Islander, and Native American men.⁴

Implementation Objectives

Prostate Cancer Implementation Objective 1: By 2015, develop/distribute practice guidelines for prostate cancer symptom management to providers.

Progress Markers			
Available Data Markers	Data Source	Baseline (2009)	Target (2015)
Guidelines developed	TBD	TBD	TBD
Implementation strategies developed	TBD	TBD	TBD
Distribution process developed	TBD	TBD	TBD
Evaluation methods developed	TBD	TBD	TBD

Goals for 2009 - 2015: Prostate Cancer

Strategies

1.1. Develop provider practice guidelines for prostate cancer symptom management that are age-specific and culturally appropriate.⁵

1.2. Develop strategies to facilitate ongoing implementation of the prostate cancer symptom management guidelines during the critical transition from specialty care to follow-up care by primary care providers.⁵

1.3. Develop a process to distribute the practice guidelines to health care providers.⁵

1.4. Develop methods to evaluate the effect of practice guidelines on the health-related quality of life of survivors and families in Michigan.⁵



Goals for 2009 - 2015: Prostate Cancer

Prostate Cancer Implementation Objective 2: By 2015, develop/distribute guidelines for prostate cancer symptom management to survivors/families.

Progress Markers			
Available Data Markers	Data Source	Baseline (2009)	Target (2015)
Gaps identified	TBD	TBD	TBD
Materials adopted, adapted, or developed	TBD	TBD	TBD
Distribution process developed	TBD	TBD	TBD
Evaluation methods developed	TBD	TBD	TBD

Strategies:

2.1. Identify gaps in existing prostate cancer educational materials.⁵

2.2. Adopt, adapt or develop patient educational materials for prostate cancer survivors and their family members.^{5,6,7,8}

2.3. Develop a process to distribute prostate cancer symptom management educational materials to survivors and their families in Michigan.⁵

2.4. Develop methods to evaluate how the utilization of educational materials affects the health-related quality of life of survivors and families in Michigan.⁵

⁶ Mishel, M. H., Belyea, M., Germino, B. B., Stewart, J. L., Bailey, D. E., Robertson, C. and Mohler, J. (2002), Helping patients with localized prostate carcinoma manage uncertainty and treatment side effects. *Cancer*, 94: 1854–1866.

⁷ Northouse, L. L., Mood, D. W., Schafenacker, A., Montie, J. E., Sandler, H. M., Forman, J. D., Hussain, M., Pienta, K. J., Smith, D. C. and Kershaw, T. (2007), Randomized clinical trial of a family intervention for prostate cancer patients and their spouses. *Cancer*, 110: 2809–2818.

⁸ Evidence-Based Strategy: Dyadic Support for Men with Prostate Cancer. Available online at <http://rtips.cancer.gov/rtips/programDetails.do?programId=291668>.

Goals for 2009 - 2015: Skin Cancer

Goal

Reduce melanoma cancer death rates in Michigan.

Data

Skin cancer is the most common form of cancer in the United States.¹ More than one million cases of nonmelanoma skin cancer are diagnosed in the United States each year. Nationwide, it is estimated that between 2,500 and 3,500 people died from non-melanoma skin cancer in 2010. The most serious form of skin cancer is melanoma, which is expected to be diagnosed in approximately 70,230 Americans in 2011 with an expected 8,790 to die from the disease.²

In 2007, 1,925 Michigan men and women were newly diagnosed with melanoma, and 260 died from the disease in 2008. During 2007, 75.1% of all newly diagnosed cases of melanoma skin cancer in Michigan were detected at the localized stage.³ Factors that increase an individual's risk of developing skin cancer include:

- excessive exposure to sunlight and other forms of ultraviolet (UV) radiation (e.g., tanning booths);
- fair complexion;
- occupational exposure to coal, tar, paraffin, or arsenic;
- family history of skin cancer;
- severe sunburns as a child; and
- multiple or atypical nevi (moles).

¹ Centers for Disease Control and Prevention – Skin Cancer Basic Information. Available online at www.cdc.gov/cancer/skin/basic_info/.

² American Cancer Society. Available online at www.cancer.org.

³ Michigan Cancer Surveillance Program, 2008 Michigan Cancer Death Public Use File & 2007 Michigan Cancer Incidence Public Use File. Michigan Department of Community Health (MDCH) Division for Vital Records & Health Statistics.

Goals for 2009 - 2015: Skin Cancer

The best way to lower the risk of skin cancer is to limit exposure to the sun (and other sources of UV light), particularly during the midday hours when the sun is strongest. Long-sleeved clothing and hats are recommended for outdoors activities. For sun-exposed areas, sunscreen with an SPF of 15 or higher and sunglasses with 99 percent to 100 percent UV absorption should be used. Protection is equally important during childhood, since severe sunburns in childhood may be associated with an increased risk of developing melanoma late in life.

The potential for exposure to UV radiation is significant in Michigan due to high participation in outdoor activities. According to the Michigan Department of Natural Resources:

- Michigan has more than 931,000 registered watercraft (third in the nation) and more than 390,000 registered snowmobiles (first in the nation).
- More than two million anglers fish Michigan waters each year.
- Michigan's 98 state parks and recreation areas welcomed more than 23 million visitors in 2008, including more than four million campers.⁴

Indoor tanning is a booming business in the United States, generating estimated revenues in excess of \$2 billion a year.⁵ Most salons use bulbs in their tanning beds that emit a significant amount of UVB and UVA radiation, both of which are associated with the development of skin cancer and premature aging. The Department of Health and Human Services has added UV radiation from the sun or artificial light sources, such as tanning beds and sun lamps, to the government's list of known carcinogens. Currently, there is no regulation or proposed legislation in Michigan limiting the use of tanning booths by minors.⁶

⁴ Michigan Department of Natural Resources. Michigan DNR at a Glance. Available online at www.michigan.gov/dnr/0,1607,7-153-10366-121638--,00.html.

⁵ The Skin Cancer Foundation. Available online at www.skincancer.org/.

⁶ Michigan Legislature. Available online at www.legislature.mi.gov.

Goals for 2009 - 2015: Skin Cancer

Skin Cancer Health Disparities Data

- Caucasians are much more likely than African Americans to develop nonmelanoma skin cancer and melanoma.²
- Men are twice as likely as women to have basal cell cancers and three times as likely to have squamous cell cancers of the skin.²

Implementation Objectives

Skin Cancer Implementation Objective 1: By 2015, 75 percent of Michigan adults report using at least one of the following protective measures that may reduce the risk of skin cancer: 1) avoiding the sun between 10 a.m. and 4 p.m.; 2) wearing sun-protective clothing when exposed to sunlight; 3) using sunscreen with a sun-protective factor (SPF) of 15 or higher; 4) avoiding artificial sources of light.

Progress Markers			
Available Data Markers	Data Source	Baseline (2009)	Target (2015)
When outside during the day for more than one hour, MI adults who use at least one protective measure (sunscreen with an SPF15+, avoid the sun between 10 a.m. and 4 p.m., wear sun protective clothing)	Michigan BRFSS	"Rarely or never used sun protection methods" 38.0%	
MI adults who used a sun lamp or tanning bed within past year	Michigan BRFSS	"Mean # of days per week" 0.1	

Goals for 2009 - 2015: Skin Cancer

Strategies

1.1. Implement sun-protection educational programs in school settings that include:

- providing information to children (e.g., instruction or small media [brochures, flyers, newsletters, informational letters or videos] or both);
- incorporating activities to influence children's behavior (e.g. modeling, demonstration, role playing); and
- engaging in activities intended to change the knowledge, attitudes, or behavior of caregivers (i.e., teachers or parents)^{7,8,9,10,11}

1.2. Implement sun-protection programs in recreational or tourism settings by providing:

- educational brochures, including culturally relevant materials and photographs of skin cancer lesions;
- sun-safety training of and role-modeling by lifeguards, aquatic instructors, and outdoor recreation staff;

⁷ Guide to Community Preventive Services. Preventing skin cancer: education and policy approaches in primary school settings. Available online at www.thecommunityguide.org/cancer/skin/education-policy/primaryschools.html.

⁸ Evidence-Based Strategy: Sun Safe. Available online at http://rtips.cancer.gov/rtips/rtips_details.do?programid=30&topicid=3&co=N&cg=.

⁹ Evidence-Based Strategy: Sunny Days Healthy Ways – Elementary School (Grades K-5). Available online at http://rtips.cancer.gov/rtips/rtips_details.do?programid=87&topicid=3&co=N&cg=.

¹⁰ Evidence-Based Strategy: Sunny Days Healthy Ways – Middle School (Grades 6-8). Available online at http://rtips.cancer.gov/rtips/rtips_details.do?programid=85&topicid=3&co=N&cg=.

¹¹ Evidence-Based Strategy: Together for Sun Safety. Available online at http://rtips.cancer.gov/rtips/rtips_details.do?programid=49&topicid=3&co=N&cg=.

Goals for 2009 - 2015: Skin Cancer

- sun-safety lesson, interactive activities, and incentives for parents and children;
- shaded areas;
- sunscreen; and
- point-of-purchase prompts^{12,13}

1.3. Implement sun-protection educational programs in daycare settings that include:

- sun-safety workshops with daycare staff, and
- parent packets with brochures and learning activities to do with children¹⁴

1.4. Encourage clinicians and other allied health professionals to offer sun protection advice during office visits and other patient encounters.^{8,15}

¹² Guide to Community Preventive Services. Preventing skin cancer: education and policy approaches in outdoor recreation settings. Available online at www.thecommunityguide.org/cancer/skin/education-policy/outdoorrecreation.html.

¹³ Evidence-Based Strategy: Pool Cool. Available online at <http://rtips.cancer.gov/rtips/programDetails.do?programId=288737&topicId=102269&cgId=>.

¹⁴ Evidence-Based Strategy: Block the Sun, Not the Fun. Available online at <http://rtips.cancer.gov/rtips/programDetails.do?programId=281421&topicId=102269&cgId=>.

¹⁵ Evidence-Based Strategy: Project SUNWISE: Skin Cancer Prevention Counseling by Pharmacists. Available online at <http://rtips.cancer.gov/rtips/programDetails.do?programId=282372&topicId=102269&cgId=>.

Goals for 2009 - 2015: Tobacco Control/Lung Cancer

Goal

Promote tobacco addiction treatment (cessation) among adults and youth.

Data

Lung cancer is the leading cause of cancer-related death in both Michigan and the United States.^{1,2} It is the second most frequently diagnosed cancer in Michigan (behind only prostate cancer).¹ Michigan ranks 18th in the nation in lung cancer mortality, with 33 states having lower lung cancer death rates.²

During 2007, a total of 7,712 men and women in Michigan were diagnosed with lung cancer.¹ During 2008, a total of 5,883 men and women in Michigan died of the disease.¹ In Michigan, the incidence of lung cancer has declined slightly over the past 10 years, yet it still exceeds the national incidence rates.^{1,2}

Smoking is the leading risk factor for lung cancer. The risk of lung cancer increases with the quantity and duration of cigarette consumption. Tobacco use accounts for at least 30% of all cancer deaths and 87% of lung cancer deaths.³ Approximately 18.9% of Michigan adults (21.0% of men and 17.0% of women) are current smokers.⁴ In 2009, 18.8% of Michigan high school students reported smoking one or more days in the previous month, an increase from 17% in 2005.⁵

¹ Michigan Cancer Surveillance Program, 2008 Michigan Cancer Death Public Use File & 2007 Michigan Cancer Incidence Public Use File. Michigan Department of Community Health (MDCH) Division for Vital Records & Health Statistics.

² National Cancer Institute. SEER Cancer Statistics Review, 1975-2007. Available online at http://seer.cancer.gov/csr/1975_2007/.

³ American Cancer Society. Cancer Facts and Figures, 2008. Available online at www.cancer.org/Research/CancerFactsFigures/CancerFactsFigures/2008caffinalsecured-pdf.

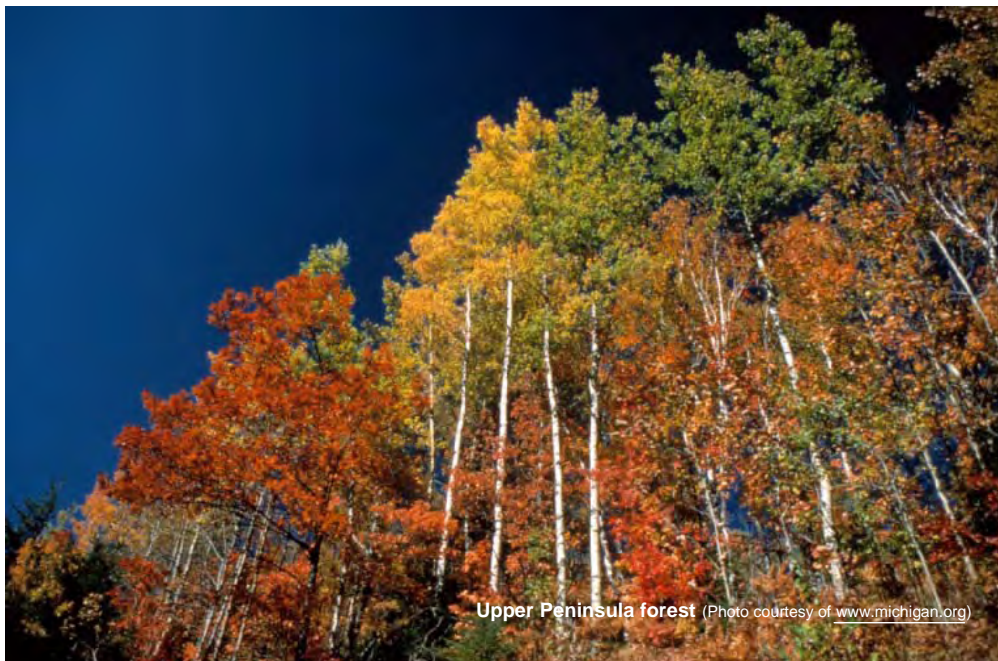
⁴ Michigan Department of Community Health, Bureau of Epidemiology. Behavioral Risk Factor Survey, 2010. Available online at www.michigan.gov/brfs.

⁵ Michigan Department of Education. Michigan Youth Risk Behavior Survey, 2009. Available online at www.michigan.gov/yrbs.

Goals for 2009 - 2015: Tobacco Control/Lung Cancer

Lung Cancer Health Disparities Data

- In Michigan, approximately 88.5% of individuals diagnosed with lung cancer in 2007 were 55 years or older.¹
- Non-smoking spouses of smokers have a 205 to 30% greater risk of developing lung cancer than do spouses of non-smokers.⁶
- Secondhand smoke causes approximately 3,000 lung cancer deaths among U.S. nonsmokers each year.⁶
- Michigan residents with lower household incomes and lower education levels are more likely to smoke.⁴



⁶ U.S. Department of Health and Human Services. The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General. (Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Coordinating Center for Health Promotion, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; 2006.)

Goals for 2009 - 2015: Tobacco Control/Lung Cancer

- African Americans in Michigan have generally higher incidence of lung cancer than Caucasians.⁷
- Smoking is more prevalent among minority groups in Michigan.
 - Hispanic/Latino adults age 18 or older have higher smoking rates compared to both Blacks and Whites.⁴
 - African Americans and American Indians age 40 or older have higher smoking rates than do other racial/ethnic population groups of the same age.⁸
- Michigan residents with lower household incomes and lower education levels have a higher prevalence of smoking.⁴

⁷ Michigan Public Health Institute and Michigan Department of Community Health. The Cancer Burden in Michigan: Selected Statistics 1993-2011. September 2011. Available online at www.michigancancer.org/WhatWeDo/TheCancerBurdenMichiganSelectedStatistics.cfm.

⁸ Michigan Public Health Institute (Cancer Control Services Program) and Michigan Department of Community Health (Cancer Prevention and Control Section). Special Cancer Behavioral Risk Factor Survey (SCBRFS), 2008. Available online at www.michigancancer.org/Resources/SpecialMCCReports.cfm.

Goals for 2009 - 2015: Tobacco Control/Lung Cancer

Lung Cancer/Tobacco Control Implementation Objective 1:⁹ By 2011, increase the number of health care providers¹⁰ and allied health care professionals¹¹ statewide who receive training and apply tobacco use assessment and treatment methods.

Progress Markers				
Available Data Markers	Data Source	Baseline 2006-2007	Interim Update 2009-2010	Target 2011
# Trainings provided to health care professionals	The Michigan Smokefree Hospitals Grant ¹ <ul style="list-style-type: none"> ✓ MDCH Tobacco Section ✓ GlaxoSmithKline ✓ Local coalitions ✓ # hits to Linda Thomas's online Training on "Implementing Evidence-Based Tobacco Assessment and Treatment" 	728	✓ 417 (2009) ✓ 47 completed trainings online (as of June 11, 2010)	874 This target is based on the State Tobacco Plan (20% increase from baseline)
Current youth tobacco use rate statewide (smoked at least 1 day in past 30 days)	Youth Risk Behavior Surveillance System (YRBSS)	18.0% (2007)	18.8% (2009)	TBD
Current adult tobacco use rate statewide	MiBRFS	22.1% (2007)	20.2% (2008)	20%
Former tobacco use rate statewide	MiBRFS	25% (2007)	25.5% (2008)	26%
Percent of youth smokers who did not try to quit smoking	YRBSS	42.4% (2007)	46.4% (2009)	TBD
Percent of adult smokers who received professional advice to quit	MiBRFS	85% (2006)	Not available (Data being collected in the 2011 MiBRFS)	90%

* Holland Community Hospital; United Memorial Health System; Greenville Northern Michigan Hospital; Spectrum Health System; St. Mary's; Grand Rapids Metropolitan; University of Michigan Health System; Michigan Health and Hospital Association

⁹ 2009 - 2011 MCC Special Project.

¹⁰ Health care providers may include, but are not limited to, the following: primary care, family medicine, obstetrics and gynecology, dentists, pediatricians, physician assistants, and nurse practitioners.

¹¹ Allied health care professionals may include, but are not limited to, the following: respiratory therapists, dental hygienists, medical assistants, and other office or hospital staff.

Goals for 2009 - 2015: Tobacco Control/Lung Cancer

Strategies

- 1.1. Increase the numbers of clinical practices in which staff are trained in evidence-based systems approach to treating tobacco dependence.¹²
- 1.2. Increase the number of trainings provided to health professionals.^{12,13}
- 1.3. Promote and seek opportunities to train health professionals at meetings and conferences and arrange for CME/CEUs.¹²
- 1.4. Identify and promote online evidence-based trainings for treating tobacco dependence.¹²
- 1.5. Increase awareness of the statewide Quitline and its services among health care organizations and health professionals.^{14,15}
- 1.6. Increase trainings for health professionals in assessing child exposure to secondhand smoke and providing cessation services to families.^{12,15}
- 1.7. Encourage health professionals to implement systems that support tobacco dependence assessment and treatment as standard of care.¹³

¹² A Five-Year Strategic Plan for Tobacco Use Prevention and Reduction (2008-2013). Available online at www.michigan.gov/documents/DCH_Strategic_Plan-single_113971_7.pdf.

¹³ Evidence-Based Strategy: Ending the Tobacco Problem: A Blueprint for the Nation. Available online at www.nap.edu/catalog.php?record_id=11795#toc.

¹⁴ Guide to Community Preventive Services. Increasing tobacco use cessation: multicomponent interventions that include telephone support. Available online at www.thecommunityguide.org/tobacco/cessation/multicomponentinterventions.html.

¹⁵ Strategy from 2005 MCC Lung Cancer/Tobacco Strategic Plan.

Goals for 2009 - 2015: Tobacco Control/Lung Cancer

1.8. Encourage health professionals to screen and educate youth about tobacco use during all their health care visits with referral to treatment as appropriate.¹²

1.9. Increase the amount of tobacco dependence treatment to individuals receiving in-patient care.

1.10. Promote and support organizational partnerships in interventions that specifically target minority populations with higher rates of tobacco use.

1.11. MCC member organizations should lead the way in encouraging their staff to participate in active training. Each member representative should identify and assign appropriate staff from within their organization to receive training, if appropriate to their role in counseling patients on tobacco cessation.

Goals for 2009 - 2015: Tobacco Control/Lung Cancer

Lung Cancer/Tobacco Control Implementation Objective 2: By 2015, increase the call and enrollment numbers to the Michigan Tobacco Quitline by 10% each year.

Progress Markers		
Data Source	Baseline (2007)	Target (2015)
American Cancer Society (Michigan Tobacco Quitline Provider) Call Rate report	7,813	15,225
American Cancer Society (Michigan Tobacco Quitline Provider) Enrollment Rate report	3,653	7,118

Strategies

- Specific strategies associated with this implementation objective are included in “A Five-Year Strategic Plan for Tobacco Use Prevention and Reduction (2008-2013),” available online at www.michigan.gov/documents/DCH_Strategic_Plan-single_113971_7.pdf.

Goals for 2009 - 2015: Tobacco Control/Lung Cancer

Lung Cancer/Tobacco Control Implementation Objective 3: By 2015, increase the number of billings for tobacco use treatments that are received by Medicaid from health care providers by 10% each year.

Progress Markers		
Data Source	Baseline (2008)	Target (2015)
Michigan Department of Community Health – Medicaid Services	12,928 (Oct 07 – Sept 08)	TBD

Strategies

- Specific strategies associated with this Implementation Objective are included in “A Five-Year Strategic Plan for Tobacco Use Prevention and Reduction (2008-2013),” available online at www.michigan.gov/documents/DCH_Strategic_Plan-single_113971_7.pdf.

Maintenance Projects

Background

Progress made on the original 10 cancer control priorities has been closely tracked and monitored over the years with the assessment of cancer epidemiological data. In addition, evaluation of member implementation activities has been conducted and the results compiled into annual reports to the membership.

This careful examination of cancer data and implementation activities has identified priority objectives that have been achieved in their entirety. The review has also informed MCC leadership that some objectives are best addressed by select member organizations rather than the entire Consortium, due to the specificity of the objectives.

Although some of the original priority objectives are no longer considered goal areas for the Consortium, the MCC Board of Directors maintain a vested interest in their outcomes and have requested annual updates on their activities. These objectives, now known as Maintenance Projects, include:

- Basic Lexicon;
- Clinical Cost Database; and
- Clinical Trials.

Maintenance Projects: Basic Lexicon¹

Goal

Ensure that the basic pathology lexicons for breast, prostate, colorectal, cervix, and lung cancers and progress in adoption of these templates are maintained and sustained.

Background

While evidence exists that screening and early detection can reduce mortality from breast, cervical, and colorectal cancer, it is a fact that mortality from these cancers can be reduced only if early detection is followed by appropriate treatment.

Although treatment alternatives may be available, the decision about which alternative would be most appropriate for an individual depends upon many factors, including the particular characteristics of the cancerous lesion itself.

In fact, cancer treatment services are provided by a team of providers, all of whom must accurately communicate key data to one another so all members of the team have the information they need to evaluate the situation, determine the most effective treatment regimen, and establish a realistic prognosis for the patient.

Pathologists, radiologists and surgeons often use a wide variety of narrative descriptions to outline a patient's diagnosis and potential course of cancer treatment. A lack of consistency in these descriptions can create confusion in the minds of other care providers who review such descriptions to develop an oncology management course for the individual patient.

¹ Continuation of the MCC Basic Lexicon Priority Strategic Plan.

Maintenance Projects: Basic Lexicon

For instance, oncologists use two basic sets of information to make decisions about which treatment to select as the most effective for an individual patient:

- an analysis of the report about the characteristics of the cancer lesion from the pathologist who examined the anatomical specimen to make the diagnosis; and
- information contained in the operative report from the surgeon who performed the initial biopsy or excision.

Inconsistencies in the way these findings are reported may result in an oncologist selecting less-than-optimal treatment options, as well as communicating misleading information to the patients and their families.

Accomplishments

The [Michigan Basic Cancer Pathology Lexicon Project](#) developed a List of Compiled Synoptic Templates for Most Common Cancers in response to the MCC Basic Lexicon Priority. To meet the project's objectives, team members first developed a concordance of key elements currently in use throughout Michigan for gross, microscopic and biochemical reporting of pathology exams on breast, colorectal and prostate cancers. They then used these findings to develop the draft structure of the basic cancer pathology lexicon templates.

Project members used a collaborative approach to obtain information, data and feedback from pathologists, clinicians, tumor registrars, and administrators of cancer treatment facilities throughout Michigan. As one of the key steps in developing the templates, they solicited the input of pathologists who serve as directors of laboratories within Michigan that routinely report more than 250 cancer cases per year, requesting from each a list of elements the laboratory typically includes in its anatomical pathology reports for breast, colorectal and prostate cancers.

Maintenance Projects: Basic Lexicon

After developing a format that they believed to be scientifically valid, clinically usable, and user-friendly, team members created basic pathology lexicon templates for breast, prostate, colorectal, cervix, and lung cancers and then expanded that work to create templates for all common cancer types. These templates were then pilot tested in dozens of facilities across the state.

Pilot test survey results (n=49) showed that the majority of pathologists and health professionals who pilot tested the templates found them to be functional in format and of immediate value in improving surgical pathology reporting practices in laboratory facilities. Specifically:

- more than half (50.1 percent) of respondents said the templates would improve efficiency by being cost effective and lowering the margin of error in reporting;
- a large proportion (72.7 percent) of respondents said the templates covered the American College of Surgeons Commission on Cancer and the College of American Pathologists recommendations and were complete;
- a majority (54.6 percent) of respondents said the checklists would improve the timeliness of the delivery of pathology reports;
- three-quarters (75.1 percent) of respondents said the lexicon would improve the quality of pathology reports; and
- a large majority (70.3 percent) of respondents said the checklists had the potential for widespread use.

To determine the penetrance or prevalence of the synoptic template checklists' use, a telephone survey of Michigan pathology laboratories was conducted in 2006. Sixty-three percent of survey respondents (n=138) indicated that synoptic templates checklists were currently being used, with 26.4 percent utilizing the MCC List of Compiled Synoptic Templates for Most Common Cancers.

Maintenance Projects: Basic Lexicon

Future Directions

The Consortium is working with the Michigan Society of Pathologists and other stakeholders to ensure that the templates are up to date, consistent with the College of American Pathologists Cancer Reporting Protocols, compliant with the American College of Surgeons Commission on Cancer Pathology Reporting Standards, and disseminated to pathology laboratories and cancer treatment facilities throughout the state, as well as that their use and value is understood and widely promoted.

The Michigan Cancer Consortium List of Compiled Synoptic Templates for Most Common Cancers has been endorsed by the Michigan Cancer Registrars Association, the Michigan Society of Hematology and Oncology, and the Michigan Society of Pathologists.

Maintenance Projects: Clinical Cost Database²

Goal

Monitor for changes in the feasibility of developing a linked economic and clinical database and infrastructure necessary to support data-driven decisions for control of breast, cervical, colorectal, lung, prostate, and other cancers within the state of Michigan.

Background

In order to distribute limited cancer control resources in the most efficient manner, we must first understand the relative costs and health outcomes for treatment, prevention and screening. Although many of the resources allocated to cancer control and health outcomes in Michigan are tracked, few are located within one database. The existing clinical cost database created by staff at the Michigan Department of Community Health, Michigan State University, and Blue Cross Blue Shield of Michigan provides an attempt to demonstrate the utility of merging the necessary information about risk factors, preventive measures, and treatments of cancer to allow policy makers to consider both cost and outcomes.

The fact that there currently is no single, centralized statewide database that contains both economic and clinical data for breast, cervical, colorectal, lung, prostate, and other cancers creates a gap that is not easily filled. It means that important information, such as the cost of serving uninsured and insured individuals and the economic impact of failing to provide comprehensive cancer care, is not available to practitioners, health systems, policymakers, and others who may need it.

² Continuation of the MCC Clinical Cost Database Priority Strategic Plan.

Maintenance Projects: Clinical Cost Database

These issues may be addressed by the expansion and establishment of a centralized accessible statewide database that would provide accurate information in a concise manner and give researchers and policymakers the tools they need to display clearly to providers and to the public the trends affecting cancer treatment. Such a database also would provide policymakers with the tools they need to advocate for policy changes that address those new trends by enabling them to more clearly articulate the reasoning behind the recommended policy changes, as well as the benefits of implementing those changes. This could include such vital issues as improved access to treatment and greater awareness of risk factors.

A centralized, statewide economic and clinical cancer database would also enable investigators to explore the cost of cancer patient care by relating cost of care to stage at diagnosis and treatment outcome. Likewise, such a database would allow researchers to study the inter-association between socioeconomic data, health status, and health care cost, including how they relate to incidence and stage at diagnosis.

Accomplishments

Michigan has successfully linked cancer patient data to Medicare, Medicaid, and Blue Cross Blue Shield of Michigan. In addition, merged claims and clinical data for various time periods have been developed.

Future Directions

Plans are moving forward to analyze data and expand into broader time periods and toward other insurers. At this time, a general research database of clinical and cost data has not been completed. Although significant progress is being made on this project, considerable issues relative to accessing these data must be addressed.

Maintenance Projects: Clinical Trials³

Goal

Increase the number and diversity of participants enrolled in clinical cancer research.

Background

Major advancements in cancer prevention and clinical treatment invariably are the result of clinical research. Clinical trials provide the mechanism to transfer knowledge and innovations from the laboratory bench to the bedside, compare current treatment options, and promote excellence in the practice of oncology.

Although the benefits of clinical research have been documented and promoted for years, the participant enrollment statistics for these trials continue to be abysmally low. For instance, it is estimated that 2% to 3% of cancer patients are recruited to participate in treatment clinical trials.

Currently, there is no single source for identifying cancer clinical trial participation in Michigan that is inclusive of government and pharmaceutical sponsored trials.

³ Continuation of the MCC Clinical Trials Priority Strategic Plan.

Maintenance Projects: Clinical Trials

Accomplishments

In an innovative move to open access for Michigan cancer patients to cancer clinical trials, one MCC member, the Michigan Society for Hematology and Oncology (MSHO), convened a unique [coalition](#) of patient advocate groups, employers and insurance companies. This coalition, which was comprised of more than 25 organizations that typically are at odds in the legislative arena, forged an unprecedented agreement to cover routine patient costs associated with oncology clinical trials. The group produced a consensus document that was signed into agreement by insurers and purchasers alike. This accomplishment was announced during a press conference at the Michigan State Capitol building in February 2002.

In December 2002, the MCC released the *Report on a Pilot Study of Cancer Clinical Trial Enrollment in Michigan 2000*. The purpose of the study was originally intended to be a baseline study, but evolved into a pilot test of feasible methods and materials in preparation for a baseline study on the enrollment of patients into cancer clinical trials. The report is available online at www.michigancancer.org/PDFs/MCCReports/MCCReports-PilotStudyCaClinTrialEnroll-Dec2002.pdf.

In 2007, a list of clinical trials resources in Michigan was compiled and posted on the MCC Web site at www.michigancancer.org/WhatWeDo/trials-michiganresources.cfm.

In August 2007, the *Cancer Clinical Trial Accrual in Michigan: 2002 – 2004* report was drafted. Largely building on the earlier pilot study, *Report on a Pilot Study of Cancer Clinical Trial Enrollment in Michigan 2000*, the goal of this study was to build a process to obtain both National Cancer Institute (NCI)-sponsored and non-NCI sponsored clinical trial accrual in Michigan for the period 2002 – 2004. The draft report was subsequently presented at the March 2008 MCC Board of Directors Meeting.

Future Directions

Progress resulting from the consensus agreement to provide coverage for cancer clinical trials will be monitored, maintained and sustained.

Emerging Science and Technology

The MCC is committed to staying abreast of changes to the science and the latest advancements in cancer technologies.

At each Board of Directors meeting, there is a standing agenda item on this topic that allows Board members and guests to share current research or new technologies. Based on the information presented, the Board may recommend that the Consortium take a position on the subject matter and request that a position or white paper be developed by the appropriate MCC advisory committee or workgroup.

Over the years, the MCC has developed the following position papers and statements to help inform both consumer and providers about specific cancer technologies:

Breast Cancer:

- [Use of Chemoprevention Therapy in Women at High Risk for Developing Breast Cancer](#) (MCC Position Paper for Health Care Providers; April 2007)
- [Digital Mammography: Comparison with Screen Film Mammography](#) (MCC Position Paper for Health Care Providers; April 2006)
- [Breast Cancer Screening Recommendations for High-Risk Women](#) (MCC Information for Providers paper; June 2005)
- [Frequently Asked Questions About Digital Mammography](#) (MCC Information for Consumers Sheet; April 2006)
- [Breast Cancer Screening Recommendations for High-Risk Women](#) (MCC Information for Consumers sheet; June 2005)

Lung Cancer:

- [Lung Cancer Screening: Low-Dose Spiral CT Scan](#) (MCC Position Statement for Health Care Providers; November 2011)
- [Lung Cancer Screening for Smokers and Former Smokers](#) (MCC Position Statement for Consumers; November 2011)

What Works in Michigan

Every year since 2001, the Michigan Cancer Consortium has presented its highest honor — the MCC Spirit of Collaboration Award — to member organizations that have done outstanding collaborative work to significantly move comprehensive cancer control activities forward in our state. Nominations for the Spirit of Collaboration Award are reviewed annually by an MCC member committee that scores the submissions based upon their collaborative spirit and ability to impact cancer control in Michigan. While the results of these projects may not have been published in peer-reviewed journals, they do represent strategies MCC members have utilized to improve cancer control in Michigan. As a result, others may wish to replicate these interventions in their own organizations. To learn more, visit www.michigancancer.org/AboutTheMCC/AwardsMCCPriorityObjective.cfm.



Au Train Bay, Lake Superior (Photo courtesy of www.michigan.org)

Acknowledgments

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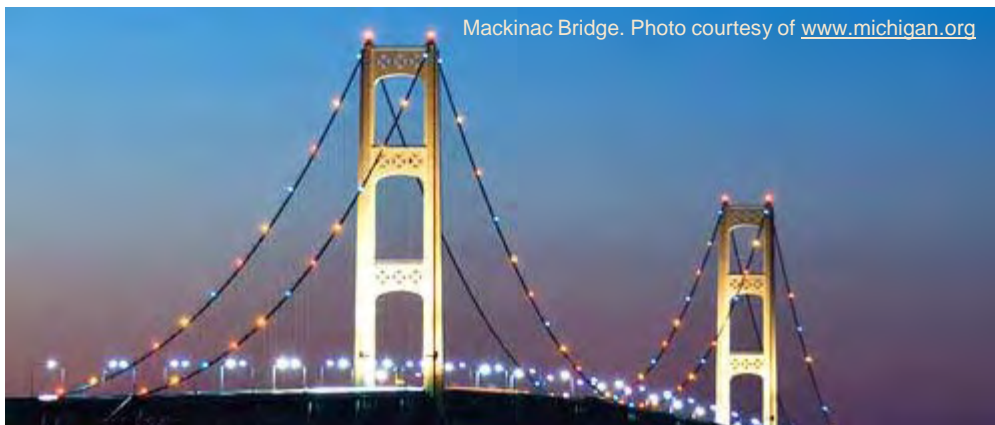
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Mackinac Bridge. Photo courtesy of www.michigan.org

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MCC Member and Key Partner Organizations

(as of March 1, 2012)

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American College of Surgeons
American Lung Association of Michigan
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MPRO

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Sparrow Regional Cancer Center

Spectrum Health Cancer Program

St. John Health System

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University of Michigan School of Public Health

Van Andel Research Institute

Visiting Nurse Services of Michigan

West Michigan Cancer Center

Western Upper Peninsula District Health Department and Superior Home
Nursing and Hospice

William Beaumont Hospital

Z.I.A.D. Healthcare for the Underserved, Inc.



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