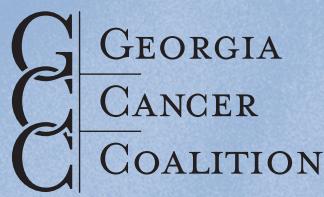


Together we can.

Georgia's Comprehensive Cancer Control Plan

2008 - 2012



October 29, 2007

Coordinated by the Georgia Cancer Coalition and the Georgia Department of Human Resources, Division of Public Health

TABLE OF CONTENTS

ACKNOWLEDGMENTS

Georgia's Comprehensive Cancer Control Plan Steering Committee	ii
Letters to Georgians	iv - vi

EXECUTIVE SUMMARY

1

BACKGROUND

Revising Georgia's Cancer Plan	4
Cancer in Georgia	9
Cancer Control: Accomplishments, Challenges, and Opportunities	17

COMPREHENSIVE CANCER CONTROL PLAN

Introduction	21
Guiding Values	22

CHAPTER ONE: PREVENTION

Acknowledgments	24
Background	26
Goals, Objectives and Strategies	28

CHAPTER TWO: EARLY DETECTION AND SCREENING

Acknowledgments	38
Background	39
Goals, Objectives and Strategies	41

CHAPTER THREE: DIAGNOSIS AND STAGING

Acknowledgments	50
Background	51
Goals, Objectives and Strategies	52

CHAPTER FOUR: TREATMENT AND PALLIATION

Acknowledgments	58
Background	59
Goals, Objectives and Strategies	61

CHAPTER FIVE: DATA AND METRICS

Acknowledgments	70
Background	71
Goals, Objectives and Strategies	73

SUSTAINABILITY

83

IMPLEMENTATION AND EVALUATION OF CANCER CONTROL PLAN

86

APPENDICES

Appendix A: Acronyms and Abbreviations	90
Appendix B: Institute of Medicine Recommended Metrics (2005)	91
Appendix C: References	96

ACKNOWLEDGEMENTS

The Steering Committee for the Revision of Georgia's Comprehensive Cancer Control Plan wishes to acknowledge the volunteer efforts of many stakeholders in health and cancer control who worked diligently in crafting this revised roadmap for cancer control in Georgia.

Nearly 100 individuals, representing many statewide cancer control organizations and associations embraced the process and participated in this collaborative project. We recognize and salute the dedicated commitment of time and energy that went into many hours of formal and informal meetings, discussions, consultations, and document production over the last year.

As we move into the implementation phase of this process we look forward to the continued engagement of talent, wisdom, and experience in service to the people of Georgia.

STEERING COMMITTEE MEMBERS

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American Cancer Society

LETTER OF SUPPORT

As Governor of Georgia, I am pleased to support the development and implementation of this state cancer plan, and I applaud the many Georgians who selflessly invested their time and effort in developing this plan that will reduce the number of cancer related deaths in the state.

Nearly every individual in Georgia has been touched by the effects of this terrible disease in some way, and it is vitally important that we come together to find ways to decrease both the human and economic cost of cancer.

I wholeheartedly support the Georgia Cancer Coalition and the Georgia Department of Human Resources in their collaborative effort to develop unique partnerships between public and private organizations to create a continuum of comprehensive cancer care that maximizes our resources and reduces inefficiencies. The state is committed to this important work.

Please join me in applauding the efforts of all those throughout the state who invest their time and talents in providing quality care for all cancer patients and in striving to unlock the secrets of this disease.

Sincerely,

A handwritten signature in cursive script that reads "Sonny Perdue".

The Honorable Sonny Perdue
Governor of the State of Georgia

LETTER OF SUPPORT

Georgia is fortunate to be blessed with great natural, human and economic resources. Yet, sadly, cancer strikes Georgians with greater ferocity than it does the citizens of many other states – both in the number of cases diagnosed and the number of deaths attributed to this terrible disease. Our mission at the Georgia Cancer Coalition is to bring all of our abundant resources to bear as we strive to reverse these statistics.

In 2007, we, along with our partners at the Department of Human Resources, Division of Public Health, convened a wide spectrum of physicians, community leaders, advocacy groups, researchers, caregivers and survivors, who engaged in a six-month process to inform the revision of the state cancer plan.

Building upon the Institute of Medicine report, “Assessing the Quality of Cancer Care: An Approach to Measurement in Georgia,” this plan embodies the wisdom and insights of a broad range of Georgians and focuses Georgia’s comprehensive cancer control activities for the next five years on specific and measurable objectives.

Georgia has come a long way in cancer research and control over the past five years, and I am excited about how much we will accomplish together in the next five years with this excellent plan as a guide.

Sincerely,



William J. Todd
President and CEO
Georgia Cancer Coalition

LETTER OF SUPPORT

I would like to express my gratitude to the Georgia Cancer Coalition and the 100+ Georgians who came together to develop a comprehensive cancer control plan that all Georgians can enthusiastically embrace and energetically implement.

Cancer is a disease feared by all. Too many Georgia families have suffered the devastating effects of cancer and all Georgians deserve the best cancer control program.

This plan is the product of a collaborative process through which a community and its partners pool resources to promote cancer prevention, improve cancer detection, increase access to health and social services, and reduce the burden of cancer. It is a roadmap that builds on current strengths, establishes priorities, allocates responsibilities, and sets targets using evidence-based metrics designed to focus the efforts of all stakeholders.

These efforts will contribute to reducing cancer risk, detecting cancers earlier, improving treatments, and enhancing survivorship and quality of life for cancer patients.

I invite you to help bring this plan to life and focus your efforts in concert with Georgians statewide to reduce and eliminate cancer statewide. Together We Can!

Sincerely,

Stuart Brown, M.D.
Georgia Division of Public Health

EXECUTIVE SUMMARY

Georgians of all backgrounds have experienced the devastating impact of cancer. It is the second leading cause of death in the state, (nearly 15,000 Georgians were expected to die from the disease in 2006), and each day more than 100 new cases are diagnosed. Four cancer types account for the majority of cancer deaths reported in Georgia. These are: lung, colorectal, breast, and prostate. Presently, among males, mortality rates from lung and prostate cancer are approximately 20% higher than the national average.

It is estimated that the total annual cost associated with cancer care in the state is approximately \$4.6 billion. Much of this represents costs associated with direct medical care, but indirect costs due to lost productivity from illness and premature death are also significant.

Though the burden of cancer is shared by all who live in Georgia, the distribution of its impact is not equally spread across the entire population. Throughout the state, racial/ethnic disparities in cancer incidence and mortality persist, even as the science of cancer prevention, detection, and treatment continues to advance.

As a consequence of these and other advances in medical care, Georgians are living longer and face an ever-increasing risk of developing or living with cancer over their lifetime. Today there are 10 million cancer survivors in the United States, and, though the number residing in Georgia is not known at this time, more will need to be done to address the health issues faced by this population.

In 2001, the Georgia Cancer Coalition, the only such organization of its type in the nation, facilitated the creation of a strategic cancer plan that would serve as the reference point for statewide cancer control efforts for five years. The plan represented the dedicated work of a diverse group of stakeholders who remain committed to comprehensive cancer control throughout Georgia. To date, many of the objectives have been achieved. More, however, remains to be done in the effort to improve Georgia's ability to provide the best cancer care to its residents.

As a part of its mission to improve the quality of cancer care throughout the state, the Georgia Cancer Coalition commissioned the Institute of Medicine (IOM) to conduct a quality of care study in 2004. As a result of this study, the IOM outlined and recommended 52 measures to serve as guideposts for state cancer control activities. Georgia's participation in the Centers for Disease Control and Prevention's (CDC) Comprehensive Cancer Control Leadership Institute has also served as the backdrop for fresh ideas and motivation for even greater efforts at collaborative cancer control.

In April 2006, Coalition partners, led by a 16-member Steering Committee, began the process of revising the state's cancer plan predicated on the recommendations of the IOM, and focusing Georgia's comprehensive cancer control activities for the next five years on specific and measurable objectives. The group defined the values and principles of the planning process, outlined cross-cutting themes, and committed itself to the oversight of plan implementation.

COMPREHENSIVE CANCER CONTROL GUIDING VALUES

VALUE 1: Saving more lives in the future.

VALUE 2: Improving health outcomes and the quality of life for those living with cancer.

VALUE 3: Reducing disparities in cancer prevention, screening, diagnosis, care, and outcomes.

Over 100 stakeholders from across the state participated in a facilitated Work Group process organized according to the continuum of cancer control (Prevention, Early Detection & Screening, Diagnosis & Staging, and Treatment & Palliation). An additional group (Data & Metrics) was charged with the responsibility of developing the analytical capacity for gauging Georgia's progress in improving cancer care and outcomes over time. This culminated in the generation of group-based recommendations with a primary focus on those cancers with the most adverse impact on the residents of Georgia.

Based on the input of some of Georgia's finest minds using the best available scientific evidence, 16 Continuum Goals were identified and developed in order to achieve comprehensive cancer control over the next five years.

COMPREHENSIVE CANCER CONTROL GOALS

Prevention

- To reduce the number of Georgians exposed to the harmful effects of tobacco.
- To reduce overweight and obesity and increase physical activity among children, adolescents, and adults in Georgia.
- To reduce the incidence of cervical cancer in Georgia.

Early Detection and Screening

- To remove barriers to cancer screening services.
- To stimulate participation in recommended screenings for breast, colorectal, cervical, and prostate cancers.
- To improve the quality and effectiveness of cancer screening and follow-up services.
- To become a national leader in translational research related to screening practices for Georgia's cancers with the greatest burden.

Diagnosis and Staging

- To ensure the timeliness and quality of tissue acquisition, pathology, and staging prior to treatment for cancer.
- To ensure the uniformity and accuracy of documentation regarding cancer diagnosis and staging.

Treatment and Palliation

- To ensure compliance with National Comprehensive Cancer Network (NCCN) guidelines for the treatment of colorectal, lung, breast, and prostate cancers in Georgia's hospitals.
- To increase accrual of Georgia residents to cancer clinical trials.
- To increase the proportion of cancer patients in Georgia who receive palliative care and support from the time of diagnosis.

Data and Metrics

- To establish ongoing, collaborative processes for addressing cancer data and metrics issues in Georgia.
- To improve stakeholder knowledge and use of available cancer data.
- To expand and enhance cancer data collection from existing and new sources.
- To implement improved information management tools and technologies.

An Implementation Planning Consortium made up of volunteers from the Work Groups and other key stakeholders will provide the operational details of the revised plan and ensure that the implementation phase considers synchrony with other state level efforts.

The revised Plan is designed as a “living” document that will allow opportunity for continuous input and update as contextual elements change. Driven by the philosophy of Together We Can, implementation of the revised cancer plan will provide the state with the greatest opportunity to collaboratively save more lives and achieve measurable and sustainable improvement in cancer prevention, detection, and care.

BACKGROUND

REVISING GEORGIA'S CANCER PLAN

In 2001, the Georgia Cancer Coalition facilitated the creation of a strategic statewide cancer plan that served as the reference point for cancer control activities for five years. The plan represented the dedicated work of a diverse population of stakeholders who remain committed to comprehensive cancer control throughout Georgia.

As a part of its mission to improve the quality of cancer care throughout the state, the Georgia Cancer Coalition commissioned an Institute of Medicine study in 2004. In its report released in 2005, entitled *Assessing the Quality of Cancer Care: An Approach to Measurement in Georgia*, the IOM outlined a matrix of 52 measures to serve as guideposts for state cancer control activities.

Coalition partners began the task of revising the state's cancer plan in April 2006. This revision, predicated on these "Dashboard" measurements/recommendations of the IOM, will focus Georgia's comprehensive cancer control activities for the next five years on specific and measurable objectives. In so doing, this plan will provide the state with the greatest opportunity to save lives and achieve measurable and sustainable improvement in cancer prevention, detection, and care.

PURPOSE

- To create a roadmap that builds on current strengths, integrates previous planning efforts, and establishes priorities.
- To allocate responsibilities, set targets and timelines using evidence-based metrics in order to focus the efforts of all stakeholders.
- To develop a collaborative framework so that the people of Georgia will benefit as the state becomes a recognized leader in cancer prevention, detection, and care in the nation.

VALUES

- Save more lives in the future.
- Improve health outcomes and quality of life for those living with cancer.
- Reduce disparities in cancer prevention, screening, diagnosis, care and outcomes.

STEERING COMMITTEE

Georgia's participation at the CDC-sponsored Comprehensive Cancer Control Leadership Institute has served as the background for fresh ideas and motivation. Stakeholders who represented the state at the Institute became the core of the Steering Committee with oversight for the revision of the state cancer plan. Executive leadership of the Committee was jointly provided by Stuart Brown, Director, Georgia Division of Public Health and William Todd, President, Georgia Cancer Coalition. The Georgia Cancer Coalition engaged the Georgia Health Policy Center to facilitate the stakeholder conversations necessary for developing the revised plan.

16 - Member Steering Committee

- American Cancer Society (GA)
- Cancer Information Service (GA) – National Center for Primary Care
- Commission on Cancer – American College of Surgeons (GA)
- Dia de La Mujer Latina (GA)
- Georgia Cancer Coalition
- Georgia Cancer Quality Information Exchange
- Georgia Department of Human Resources
- Georgia Department of Community Health
- Lewis Cancer & Research Pavilion – St. Joseph's/Candler Hospital System
- Rollins School of Public Health, Emory University
- Southwest Georgia Cancer Coalition
- West Central Georgia Cancer Coalition

Roles and Functions of the Steering Committee

- Establish framework, with defined actions and objectives; evaluate progress against metrics/objectives; evaluate implementation.
- Ensure the completion of plan revision, serve as a resource when the plan is released, and provide guidance.
- Ensure that all stakeholders are represented in the plan.
- Help make decisions on resource allocation throughout the plan.
- Commit to engagement for revision, implementation, and ongoing evaluation.
- Frame and communicate the state cancer plan to broader audiences.
- Manage participation and monitor process and progress.

The Steering Committee defined the purpose of the plan and established the principles that governed the planning process. The group committed early on to value the input of multiple and diverse voices in the revision of the state cancer plan, and to be responsible for ensuring the plan is disseminated, embraced, and implemented. Great emphasis was placed on ensuring the plan contained the measurable objectives necessary to gauge success over time.

PRINCIPLES OF THE STATE CANCER PLAN REVISION AND IMPLEMENTATION

- Honor diverse and inclusive input to a “living” and time-relevant document.
- Expect and encourage opportunities for genuine collaboration and teamwork among partners and stakeholders.
- Value innovation and creativity while relying on evidence-based strategies and science in decision-making.
- Adopt realistic approaches to ensure sustainability of plan over time.
- Encourage open communication.
- Maintain the engagement of a significant cross-section of community level members in assessment, planning, implementation, and evaluation.

WORK GROUPS

The Steering Committee developed a timeline and invited the participation of more than 120 cancer experts, survivors, caregivers, and other stakeholders to participate in an inclusive process to redesign the state cancer plan. Nearly 100 individuals participated in an August 2006 one-day Work Group Congress, which marked the start of a six-month effort to revise the existing plan. The revision was organized around five topic areas: Prevention, Early Detection & Screening, Diagnosis & Staging, Treatment & Palliation, and Data & Metrics. The Data & Metrics group provided information on the IOM metrics, baseline data values, and was available as a resource to the other groups in developing goals and objectives.

In addition to their respective areas of focus, Work Groups were asked to address the cross-cutting themes of: disparities (access), survivorship, sustainability, workforce, and research in the development of these goals and objectives. The comprehensive approach endorsed by the Steering Committee and facilitated by the Georgia Health Policy Center provided a forum for a variety of stakeholders to contribute and be engaged in the plan development process. Consequently, the planning process consisted of identifying and convening stakeholders, and facilitating meetings that enabled them to have conversations, share information, and reach decisions. A Web portal was used to facilitate the work and communication among Work Group members across the state.

Each of the five Work Groups defined their scope, developed goals, objectives, and strategies to address critical issues affecting the principal areas of the continuum of cancer. Each Work Group was led by two co-chairs, one of whom was a member of the Steering Committee and the other, a subject matter expert. While Work Groups revised portions of the plan independently, the overlap of membership with the Steering Committee helped ensure continuity of purpose, focus, and translation of data across the cancer continuum focus areas.

WORK GROUP SCOPE

Prevention

The scope of this work group is primary prevention, defined as avoiding the development of cancer by eliminating or reducing risk factors. This includes: tobacco use prevention; improved nutrition and physical activity; and, the prevention of HPV associated cervical cancer. Strategies may include clinical interventions.

Early Detection and Screening

The scope of this work group is improving cancer outcomes by increasing early detection, decreasing late detection, and shortening the time between detection and diagnosis. Areas of focus include: information and education; patient access to early detection and screening services; standardization and use of clinical protocols; and, strategies to stimulate research in Georgia on early detection and screening.

Diagnosis and Staging

The scope of this work group is improving cancer outcomes through advances in timely and effective diagnosis and staging. Areas of focus include: the process and documentation of staging and diagnosing cancer in Georgia; the statewide use of practice guidelines; and, the use of data and metrics to improve compliance with appropriate staging and diagnosis practices.

Treatment and Palliation

The scope of this work group is quality control and improvement of treatment for all types of cancer and the enhancement of quality of life—psychological, social, and spiritual—for patients and their families. Strategies will incorporate collaborative, multi-disciplinary systems of care. Palliation begins at diagnosis.

Data and Metrics

The scope of this work group is the identification, collection, analysis, management, and application of data to measure Georgia's progress in improving the quality of cancer care and achieving better cancer related outcomes. The group will serve as a resource on available data and metrics to the other work groups, and will propose goals and objectives to improve the overall use of data for cancer quality assessment and improvement.

2006 TIMELINE

April	Comprehensive Cancer Control Leadership Institute Planning Process Development Attendees compile lists of persons to serve on Work Groups
May	Steering Committee Meeting <ul style="list-style-type: none">▪ Goal – populate work group lists▪ Discuss and define framework▪ Gain information/structure for the work groups
June	Steering Committee Meeting
August	Work Group Congress
September – December	Work Group/Steering Committee Meetings

2007 TIMELINE

January	Work Group drafts to the Steering Committee for integration into the Plan. “Final” draft of Georgia’s State Cancer Plan
February – April	Revisions
May	Final State Cancer Plan
June – December	Implementation Design and Planning

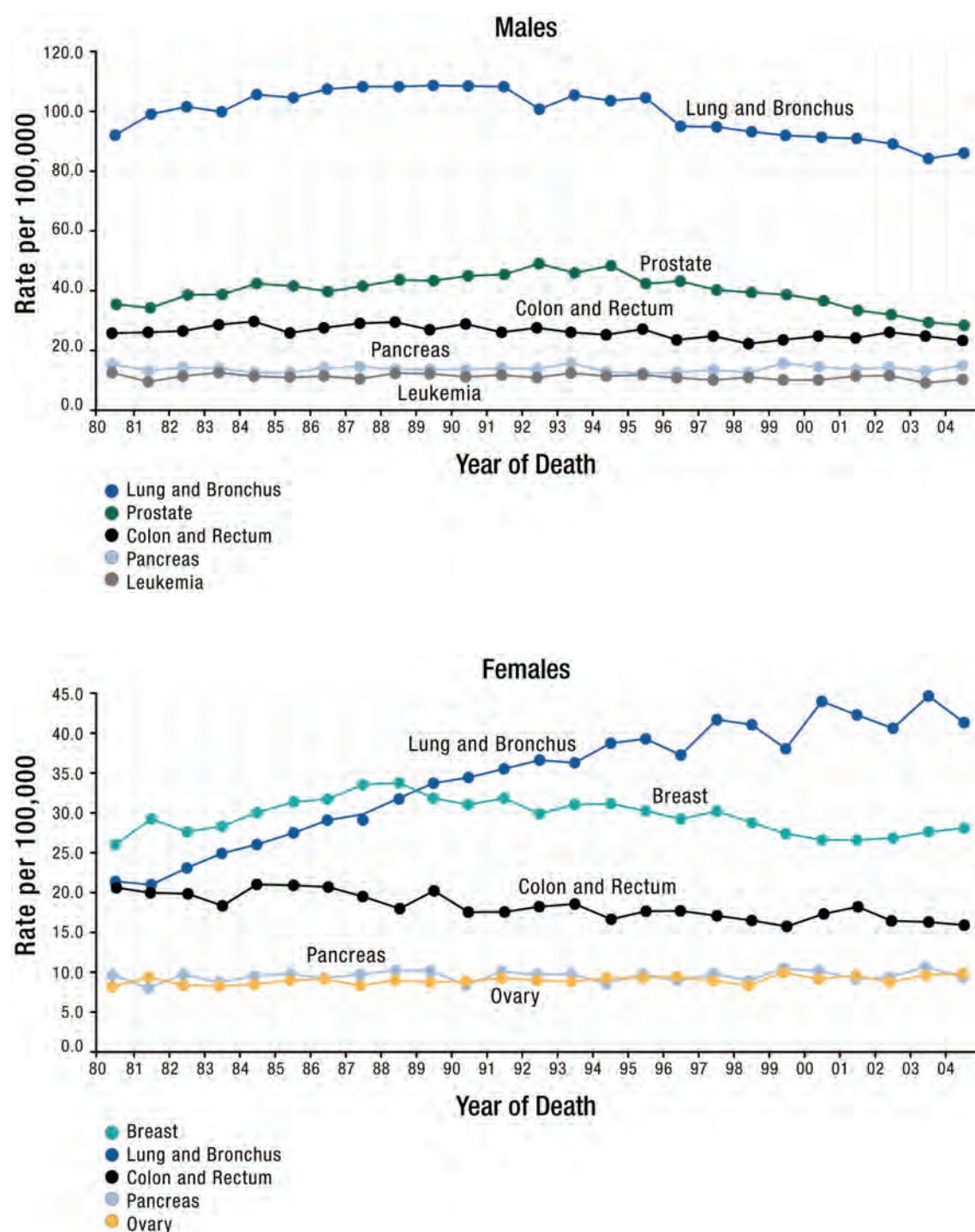
CANCER IN GEORGIA

Every year cancer impacts the lives of many Georgians, in some way – whether by coping with a diagnosis, providing care for a patient, supporting a loved one, or searching for a cure. Like much of the rest of the nation, due to advances in medical care, Georgians are living longer and now face an increasing risk of developing or living with cancer at some point in their lives.

Nationally, cancer kills over 550,000 Americans each year. In Georgia, cancer is the second leading cause of death, accounting for almost a quarter of all deaths. In 2000, at the time of the drafting of the last Strategic Plan, nearly 33,000 Georgians were expected to be newly-diagnosed with the disease and 13,700 were expected to die of cancer. By 2006, the estimated number of new or incident cases rose to 36,600 (about 100 cases per day) and more than 15,000 Georgians were expected to die from the disease. Although there has been a 10% increase in Georgia's population over this period, it does not account for the increase in the number of incident cases.

Lung, colorectal, breast, and prostate cancer account for 53% of all cancer deaths in Georgia. The state's lung and prostate cancer mortality rates, for males, are nearly 20% higher than the national average. In Georgia, lung cancer accounts for more deaths than colon, breast, and prostate combined. While lung cancer mortality rates among men have been declining since 1990, they still remain higher than the mortality rates for all other cancers. Over the last two decades, lung cancer has surpassed breast cancer as the leading cause of cancer death in women.

Figure 2: Georgia Cancer Mortality Trends (1980-2004)



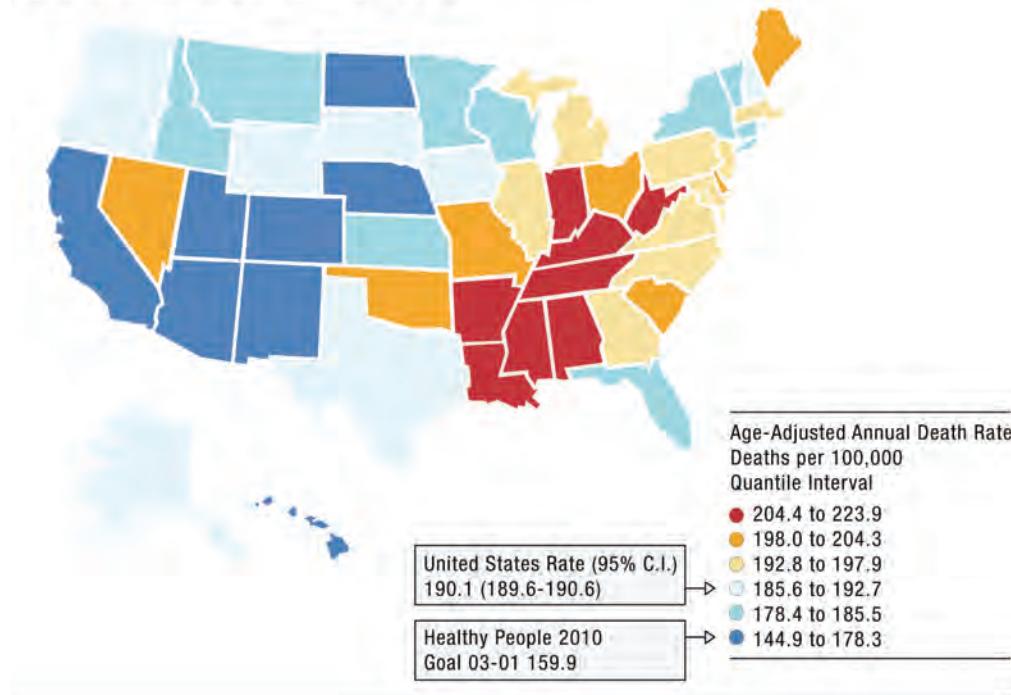
Source: Georgia Comprehensive Cancer Registry

The remaining cancer deaths are primarily due to pancreatic cancer, ovarian cancer, leukemia and lymphoma.

Figure 3: U.S. Age Adjusted death rates by cancer site

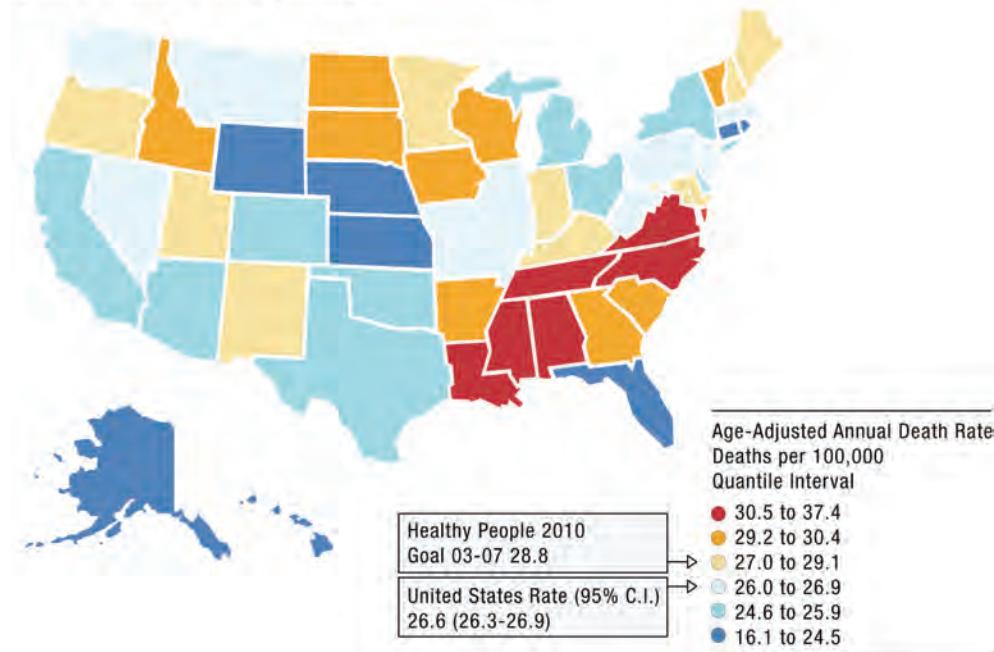
Age-Adjusted Death Rates for United States, 2003 **All Cancer Sites**

All Races (includes Hispanic), Both Sexes, All Ages



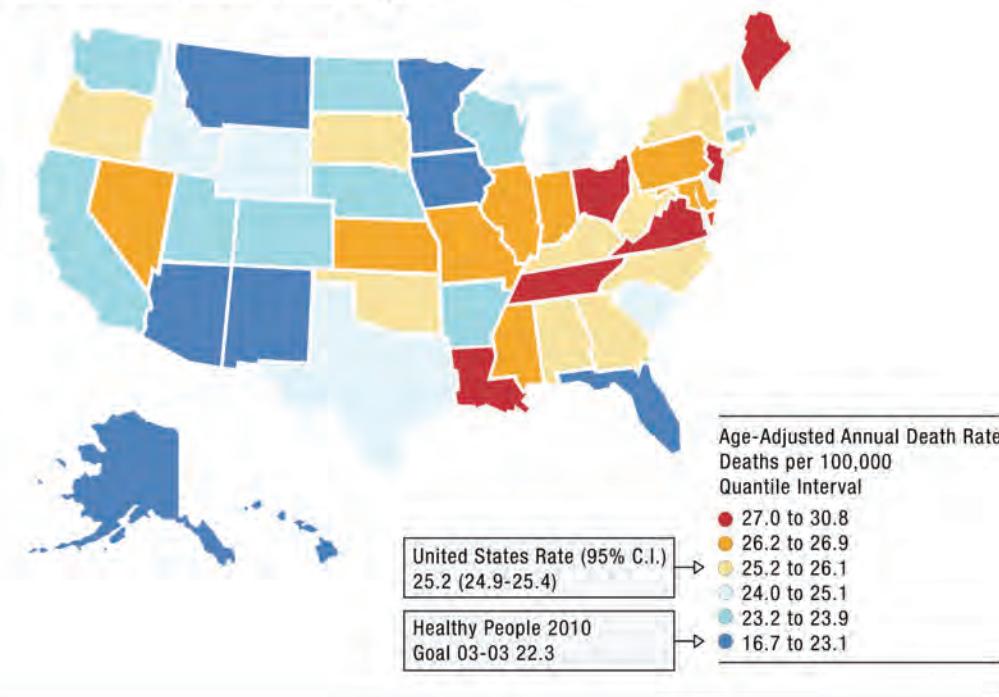
Age-Adjusted Death Rates for United States, 2003 **Prostate**

All Races (includes Hispanic), Male, All Ages



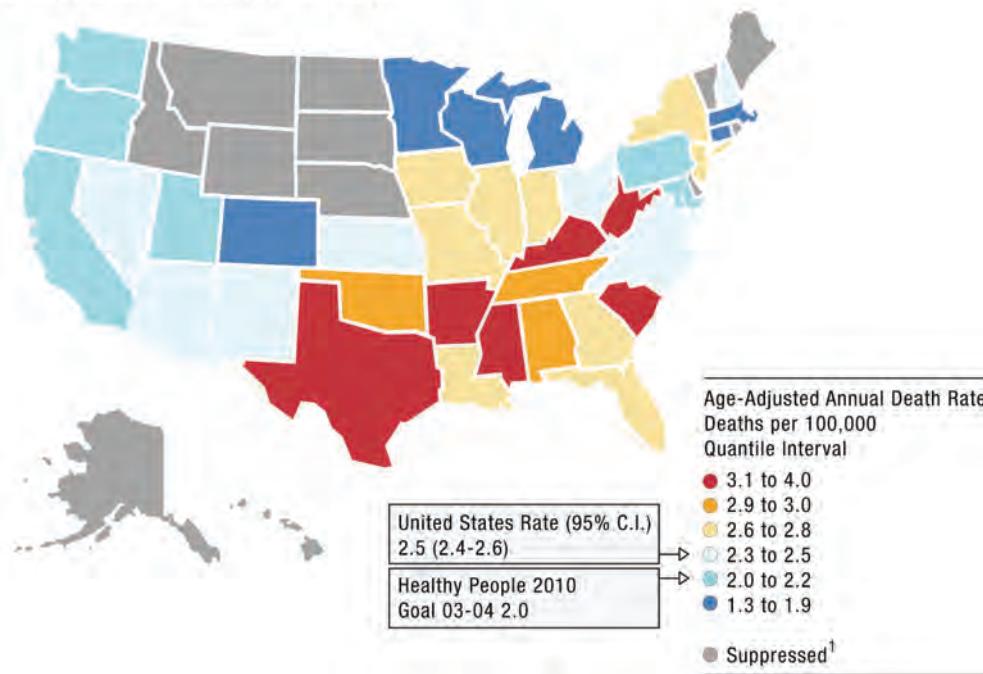
Age-Adjusted Death Rates for United States, 2003 **Breast**

All Races (includes Hispanic), Female, All Ages



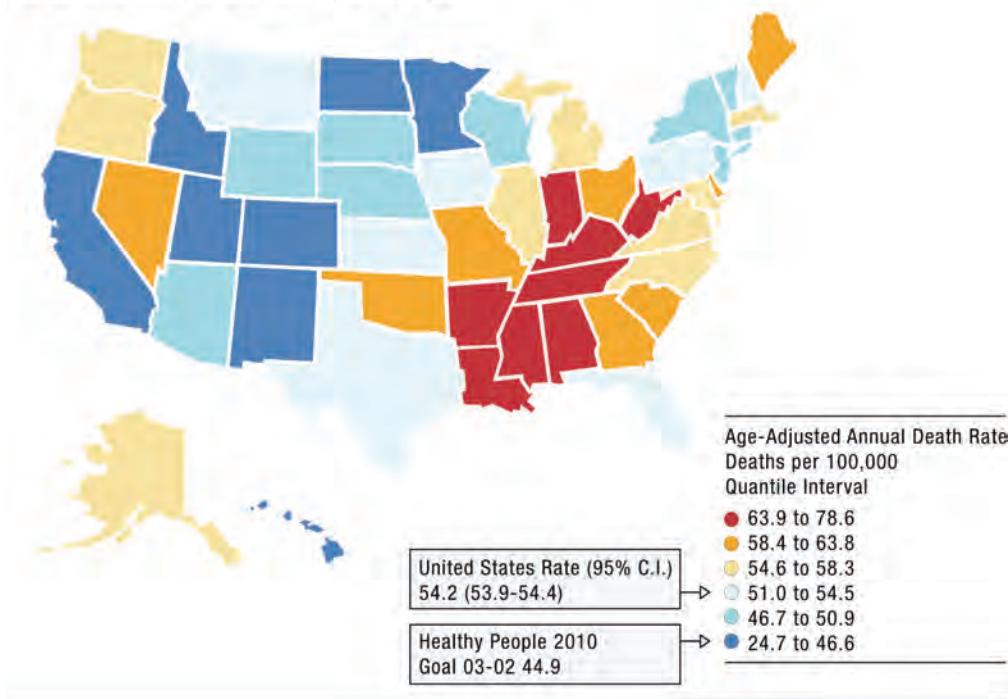
Age-Adjusted Death Rates for United States, 2003 **Cervix**

All Races (includes Hispanic), Female, All Ages



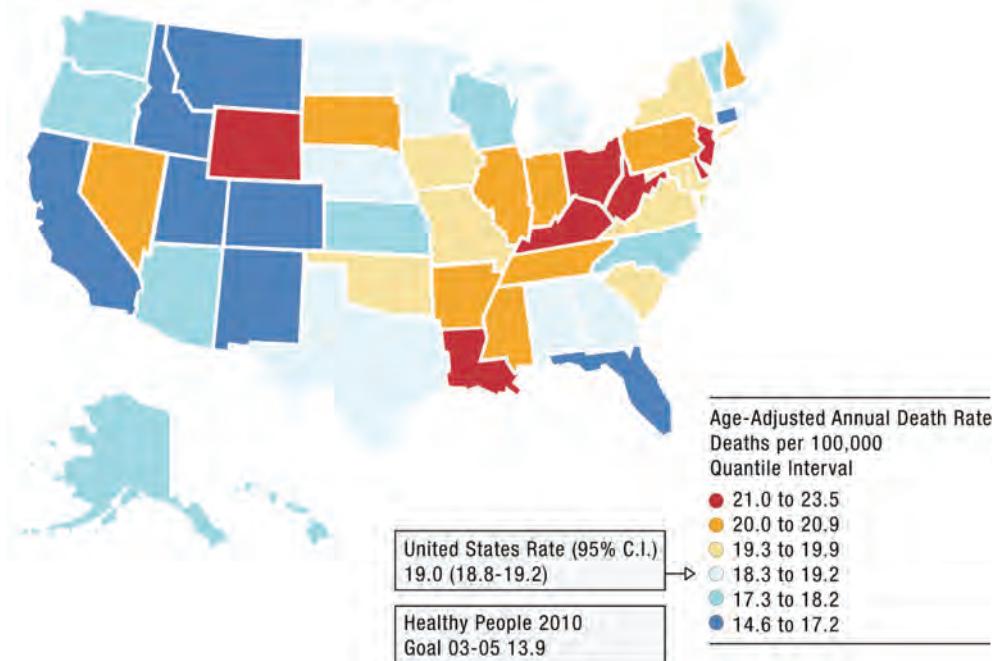
Age-Adjusted Death Rates for United States, 2003 **Lung & Bronchus**

All Races (includes Hispanic), Both Sexes, All Ages



Age-Adjusted Death Rates for United States, 2003 **Colon & Rectum**

All Races (includes Hispanic), Both Sexes, All Ages



Source: statecancerprofiles.cancer.gov

DISPARITIES

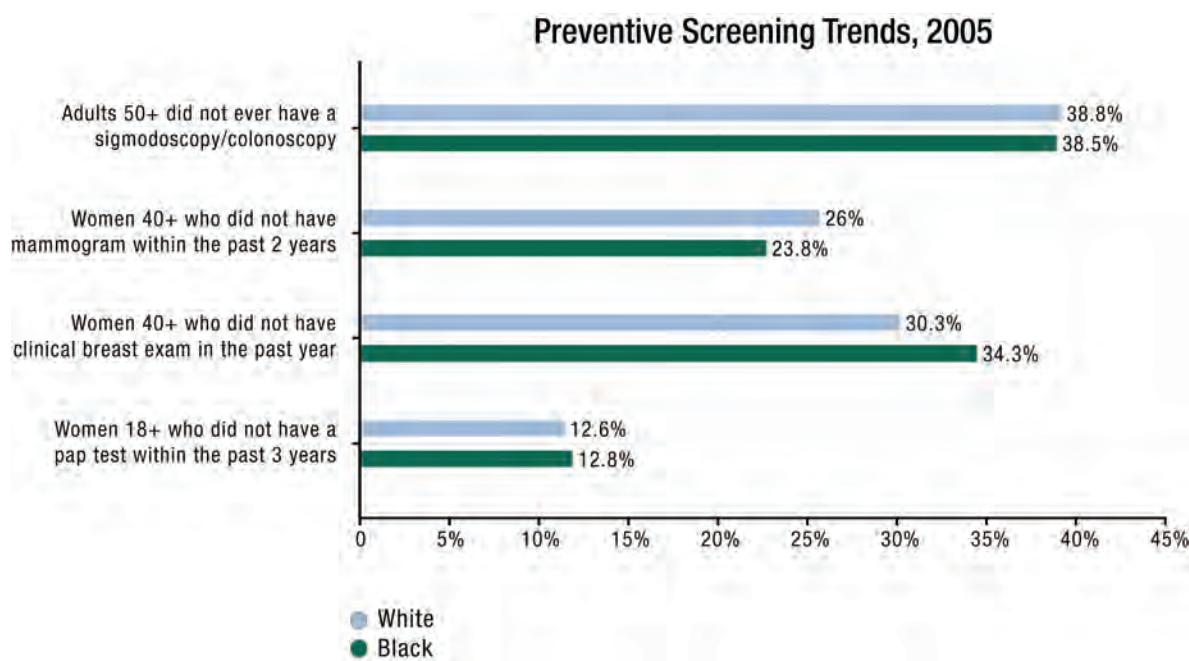
A detailed examination of available data reveals that, while the burden of cancer is shared by all Georgian's, the impact is disproportionately greater among certain populations. Minority and underserved Georgian's have higher cancer incidence and mortality rates.

Specifically, disparities in incidence and mortality occur by gender, race/ethnicity, geography, and insurance status. Males are 44% more likely to be diagnosed with cancer than females. Black men in Georgia are 17% more likely to be diagnosed with cancer than white men and 34% more likely to die from their disease. The disparity is even more pronounced with specific cancers:

- *Prostate cancer* – black men are twice as likely as white men to die from the disease
- *Lung cancer* – white women have a 40% higher incidence than black females; rural males are more likely than urban males to die from this cancer
- *Colorectal cancer* – black men and women have higher mortality rates than their white men and women
- *Breast cancer* – white women have a higher incidence rate than black women, however, black women have a higher mortality rate than white women
- *Cervical cancer* – Latino women have a higher incidence rate when compared to white women

While ongoing global research is attempting to clarify the contribution of biology to some of this disparity, present evidence suggests that differences in access to screening and patterns of care contribute significantly to these unequal outcomes. The burden of cancer in minority groups and non-urban populations in Georgia is exacerbated by insufficient use of screening technology (mammogram, fecal occult blood testing, colonoscopy/sigmoidoscopy, etc.) and other early detection methods.

Figure 4: Screening Trends in Georgia 2005 by Race/Ethnicity



A significant number of Georgians from ethnic minority groups continue to lack health insurance and are therefore unable to access cancer screening and/or treatment. Georgia also has a relatively high percentage of residents who live in poverty and have not completed high school. Research shows that these socioeconomic indicators are highly correlated with incidence of and mortality from cancer.

SURVIVORSHIP

Major advances in prevention, early detection, diagnosis, and treatment of cancer are allowing more people to survive and live longer with the disease. Today there are 10 million cancer survivors in the United States. According to the National Cancer Institute (NCI), 65 percent of adults diagnosed with cancer will survive their cancer for at least 5 years. Little is presently known about the number or status of cancer survivors in Georgia.

In the last decade, understanding the issues and challenges faced by cancer survivors has grown in importance. More research in this area is being done on the national and local levels. Over the next 5 years, Georgia will focus on issues related to understanding and improving cancer survivorship throughout the state. Survivorship issues include: the ability to get health care and follow up services; late effects of treatment; second cancers; and quality of life for those who are post-treatment. As the number of survivors increases, issues that impact their physical, psychosocial, and economic wellbeing will need to be researched.

ECONOMIC BURDEN

The economic burden of cancer on individuals and the state as a whole is very significant. In Georgia, it is estimated that the annual cost associated with cancer care is approximately \$4.6 billion. Of this amount, \$1.7 billion is spent on medical care, \$406 million for indirect morbidity costs, and \$2.5 million for indirect costs associated with premature death. Further, the costs associated with treating breast, lung, and prostate cancers account for more than half of all direct medical costs.

CANCER CONTROL: ACCOMPLISHMENTS, CHALLENGES, AND OPPORTUNITIES

While the human suffering and economic cost of cancer continues to be a burden on the state, there have been continuous efforts, over the past 5 years, to save more lives and reduce the impact of the disease. The Georgia Cancer Coalition (GCC), as the first such coalition of its kind in the nation, remains committed to uniting providers, public health agencies, academic institutions, survivors, and community-based organizations throughout Georgia, in the fight against cancer.

Following the development of the first Strategic Plan in 2001, the GCC engaged a number of public and private stakeholders in cancer control efforts that resulted in the accomplishment of a number of the Plan objectives. These achievements laid the ground-work for the current state cancer plan revision. The following are examples of achievements to date:

CANCER PREVENTION AND SCREENING

- More than 200 community anti-tobacco programs were initiated for teens and middle school students.
- A tobacco use prevention education and awareness campaign focusing on second-hand smoke was developed and implemented.
- Challenge grants were awarded to improve mammography screening in 68 rural counties with high breast cancer mortality rates.
- A partnership with the American Cancer Society, the National Black Leadership Initiative on Cancer (NBLIC), and the Department of Human Resources was established to award community grants to rural, ethnic and minority populations to promote cancer awareness and education activities.
- Expansion of the Georgia Breast & Cervical Cancer Screening program occurred more than doubling the number of women served each year.
- The Georgia Tobacco Quit Line (1-877-270-STOP), established in November 2001, has fielded more than 50,000 calls since its inception.
- An award winning cancer education and awareness campaign was developed and implemented by the Department of Human Resources.

CANCER EDUCATION

- More Georgians learned about state programs for cancer prevention and treatment following a one-year public education campaign; nearly 40% believe the state is helping them fight cancer.
- The Georgia University System's Intellectual Capital Partnership Program (ICAPP) was created to fund the development of a well trained cancer caregiver workforce.
- Regional Cancer Coalitions of Excellence were funded to implement innovative, replicable cancer education initiatives.
- The Georgia Society of Clinical Oncologists (GASCO) in partnership with the GCC developed continuing education programs for oncologists.
- The American Association of Family Practice with support from the GCC provided physicians with continuing education on cancer and cancer care.
- The Georgia Cancer Center for Excellence at Grady was designated as a training center for chemotherapy and biotherapy certification by the Oncology Nursing Society.

CANCER RESEARCH AND ECONOMIC DEVELOPMENT

- Ninety-one Distinguished Cancer Clinicians and Scientists have been recruited to Georgia from nationally renowned research institutions, resulting in \$200 million of Federal and Private research funding flowing into the state of Georgia.
- A Morehouse School of Medicine initiative to increase access to clinical trials for minorities was funded by the GCC.
- The Georgia Cancer Research Laboratory at the Medical College of Georgia was constructed and opened in March 2006.
- Grants were awarded to fund breast, prostate and ovarian cancer research, established with funds donated through an income tax check-off.
- The University of Georgia received a \$6.7M research grant for cancer research.
- Emory University's Winship Cancer Institute received a \$10 million award from the U.S. Department of Defense for prostate cancer research.
- Funds were awarded for the establishment of the Biorepository Alliance of Georgia for Oncology (BRAG-Onc) in Augusta, with regional nodes in the Savannah, Albany, and Rome areas and a single site at Dekalb Medical Center in Atlanta.
- All universities conducting cancer research in Georgia were granted access to the Celera genomics database.
- The first Cancer Research Symposia was convened in Spring 2005, attracting more than 1,350 attendees.
- A statewide cancer clinical trials and research network - Georgia CORE was developed by the Georgia Society of Clinical Oncology (GASCO) in partnership with the GCC.
- The Winship Cancer Institute at Emory University was awarded a P-20 grant to begin the process of securing NCI Cancer Center designation.
- Ten research laboratories are now housed in the Georgia Cancer Center for Excellence at Grady.

CANCER CARE

- The nine largest insurers in the state now cover recommended cancer screening exams and have agreed to cover the routine costs of care for beneficiaries who participate in cancer clinical trials in Georgia.
- Medicaid eligibility was expanded to include coverage of uninsured, low income women diagnosed with breast and cervical cancer; over 3,800 women have been provided services.
- The Georgia Cancer Center for Excellence at Grady Memorial Hospital was established utilizing funding from the State's Tobacco Master Settlement Agreement and the Avon Foundation. An internationally recognized leader in cancer disparities research, from the NCI, was engaged as Medical Director of the Center for Excellence.
- The Georgia Comprehensive Cancer Registry was awarded the Gold Certification by the North American Association and Central Cancer Registries (NAACCR) for the collection of complete, accurate and timely cancer data for five consecutive years (2000-2004); completeness of cancer data has risen from 75% to more than 97%.
- Nine Regional Programs of Excellence were awarded planning grants of \$312,000 to develop regional approaches to address the GCC's goals. Six have continued as Regional Cancer Coalitions of Excellence funded by the GCC and other locally leveraged dollars.
- The Breast Cancer License Tag initiative was established. Funds from breast cancer license tag sales have been used to award grants that support breast cancer services for underserved women.

- NCCN care guidelines were distributed to all oncologists in Georgia.

While the accomplishments of the last five years are noteworthy, many challenges still remain. Some of these challenges include:

- Lack of a comprehensive statewide ongoing multimedia campaign to promote the prevention and early detection of the major cancers.
- Most Georgians do not follow approved guidelines for reducing cancer risk.
- Opportunities for breast and cervical cancer screening for the uninsured and underinsured are limited. Funding for the state program only serves 15 percent of the target population and few hospitals offer free or low cost mammograms.
- There is no statewide inventory of facilities performing diagnostic follow-up tests for breast cancer.
- Limited numbers of health clinics exist in the public domain, where diagnostic colposcopic examinations for cervical cancer can be performed.
- Lack of adequate faculty in academic health centers and private practice who are engaged in the types of clinical research necessary to provide cutting edge treatments.
- Many Georgians lack access to health care because they are uninsured or underinsured, or, live far away from the facilities that provide the care they need.
- Georgia does not have a world-class faculty research base in genomics-oriented cancer research; there is no state health network for genomics-based detection research in product development for FDA approval.
- Lack of a cancer informatics center for biotechnology sector field-testing of new tests around existing screening technologies.
- More needs to be known about barriers preventing patients from participating in clinical trials in Georgia.
- The sample of Georgians used in the Behavioral Risk Factor Surveillance (BRFSS) program is not large enough to give a county-by-county description of the behaviors of Georgians to inform planning and evaluation of statewide cancer prevention, early detection, and educational efforts.
- There is no statewide system of surveillance for participation in cancer screening tests.
- Lack of an ongoing tobacco use prevention awareness and education campaign, or ongoing promotion of the Georgia Tobacco Quit Line.

Notwithstanding, Georgia possesses the requisite organizational resources to address at least some of these challenges over the next five years. The Georgia Cancer Coalition has convened and linked stakeholders and resources in an effort to achieve Georgia's cancer control goals and objectives. Driven by the philosophy of "Together We Can", opportunities abound for partnerships and collaboration to make a difference. Some of the key partners and resources include:

- A strong public health system that is committed to statewide health improvement and collaboration; also the home of the state cancer registry.
- Nationally recognized institutions of higher learning that continue to be the source of the state's cancer control workforce.
- State-of-the-art medical and treatment facilities.
- An active network of regional coalitions.
- A vibrant and growing technology community.
- Service, civic, and advocacy groups.

- National institutions with expertise in cancer control (the Centers for Disease Control and Prevention, National Cancer Institute, and the American Cancer Society).
- Policymakers and residents with the collective will and energy to effect change.

COMPREHENSIVE CANCER CONTROL PLAN

INTRODUCTION

This revised plan represents the collaborative development of a roadmap for action that, when implemented, will significantly minimize the impact of cancer on all Georgians and be a national model for comprehensive cancer control.

Figure 5: Cancer Control Flow Chart



Driven by the present burden of cancer in the state and a vision for cancer control in the future, 16 goals with accompanying objectives and strategic actions were developed and organized according to the cancer control continuum. Together, these goals and objectives form the basis for strategic action over the next five years.

Though the plan will focus primarily on the four cancers that have the greatest impact on the health of Georgians over this period, strategies within this plan have implications for all cancers. Efforts to prevent and control pediatric and other cancers not specifically targeted in this plan are highly supported and encouraged. Additional focus areas will be incorporated into the plan over time.

GUIDING VALUES

There are 3 important values that together shape the philosophical background of this revised plan; cut across the cancer control continuum; and reflect the long-term commitment to an ongoing process. These are: (1) Saving more lives in the future; (2) Improving health outcomes and quality of life for those living with cancer; and, (3) Reducing disparities in cancer prevention, screening, diagnosis, care, and outcomes. Over the next 5 years these values that have guided the planning process, will also guide implementation and evaluation efforts as the state carves out improvements in cancer care and control.

SAVING MORE LIVES IN THE FUTURE

This key tenet is an overarching measure of a successful comprehensive cancer control plan and the extent to which it results in more lives being saved from the effects of cancer. Presently, Georgia's mortality rates (2000-2004) for the four primary cancers are:

- Lung Cancer – 60 per 100,000 (males 89/100,000; females 41/100,000)
- Colorectal cancer – 19 per 100,000 (males 23/100,000; females 16/100,000)
- Breast cancer – 25 per 100,000
- Prostate cancer – 33 per 100,000

It is anticipated that over the next five years, coordinated statewide activities across the cancer control continuum will result in less people developing, and dying from cancer.

IMPROVING HEALTH OUTCOMES AND QUALITY OF LIFE FOR THOSE LIVING WITH CANCER

There are two important elements to improving survivorship: favorable outcomes as might be measured by metrics such as improved life expectancy post diagnosis and treatment; and ensuring the best quality of life (QOL) for cancer survivors. At present, five-year survival rates in the Metro Atlanta area (1992-1999) vary dramatically depending on the site of the primary tumor (5 year survival rates for Georgia are not available):

- Breast – 87%
- Colorectal – 62%
- Lung – 16.5%
- Prostate – 100%

As is the case in most states, there is no statewide system to measure quality of life for cancer survivors in Georgia. The opportunity exists to engage survivors in strategic planning and the establishment of baseline QOL measurements over the next five years.

REDUCING DISPARITIES IN CANCER PREVENTION, SCREENING, DIAGNOSIS, CARE, AND OUTCOMES

Georgia's long-term goal is the *elimination* of cancer disparities. Over the next five years, this plan will focus efforts on defining, understanding, and reducing disparities related to geographic, ethnic, and socioeconomic differences. The Georgia cancer plan holds as one of its primary goals the reduction in incidence, morbidity, and mortality of the major cancers across *all* racial, ethnic, geographic, and socioeconomic groups.

CHAPTER 1

PREVENTION

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BACKGROUND

Over the next five years, the focus of Georgia's cancer prevention activities will be to reduce tobacco use, obesity, and the prevalence of the human papilloma virus (HPV). Where data is available to inform efforts, attention will be given to reducing disparities in these areas. Further research is needed to illuminate disparities and to identify preventable causes of disparities in the incidence of specific cancers. The Cancer Plan encourages the involvement of cancer survivors in planning and executing prevention efforts.

TOBACCO

Tobacco use is the most preventable cause of cancer. About 30 percent of all cancer deaths are associated with tobacco use and cigarette smoking. Tobacco use is responsible for 87 percent of lung cancer deaths. Tobacco is also a risk factor for cancers of the larynx, oral cavity and pharynx, esophagus, cervix, and bladder. It is estimated that secondhand smoke is responsible for 3,000 lung cancer deaths among U.S. nonsmokers each year. The risk of developing smoking-related cancers increases with total lifetime exposure to cigarette smoke. Smoking cessation has been shown to have major and immediate health benefits, including decreasing the risk of lung and other cancers, heart attack, stroke, and chronic lung disease. Recent advances in tobacco control have proven the effectiveness of the following interventions:

- (1) Raising the tobacco excise tax – An excise tax of one dollar has been projected to:
 - a. prevent 100,000 children from starting the habit of smoking,
 - b. encourage 80,000 current smokers to quit,
 - c. save 50,000 lives; and,
 - d. generate 500 million dollars in tax revenues that can be used to reduce other taxes or to expand cancer control efforts.
- (2) Enhanced enforcement of laws prohibiting sale of tobacco to minors.
- (3) Enforcement of Smoke-Free Air legislation.
- (4) Comprehensive community education efforts coupled with tobacco quit line support.

In Georgia:

- Approximately 10,000 people die each year from tobacco-related diseases.
- Nearly 184,000 children under 18 will die prematurely from smoking.
- Approximately 2,000 adults, children, and infants die each year from second-hand smoke.
- Health care costs directly caused by smoking total \$2.25 billion dollars annually; \$537 million dollars of this is incurred by the state Medicaid program.
- Major productivity losses resulting from smoking-related deaths approximate \$3 billion dollars per year.
- Currently the excise tax on cigarette is 37 cents a pack. This is one of the lowest cigarette excise taxes among the fifty states.

OBESITY AND OVERWEIGHT

Research indicates that obesity increases the risk of coronary heart disease, stroke, high blood pressure, and diabetes. Obesity also increases the risk of cancers of the breast (postmenopausal), endometrium (the lining of the uterus), colon, kidney, and esophagus. Sedentary lifestyle and

television viewing contribute to overweight and obesity. Maintaining a healthy weight and participating in regular physical activity have been shown to lower the risk of these cancers.

In Georgia:

- An estimated 6,700 residents die every year because they are overweight ($25 < \text{BMI} < 30$) or obese ($\text{BMI} > 30$). Overweight and obesity accounts for 10% of all deaths in Georgia.
- In 2002, the percentage of overweight and obese adults was 35% and 24% respectively; by 2005, the number of obese adult Georgians rose to 27% of the population.
- African-Americans, Hispanics/Latinos, and people with household incomes less than \$25,000 per year had the highest prevalence of overweight and obesity in Georgia.
- Obesity and overweight were more prevalent in adults who had not completed high school when compared to those with a high school diploma or GED. Rates were lowest among college graduates.
- Overweight among young children ages 2 to < 5 years has increased 60% over the past decade.
- In 2005, one in four 3rd graders was obese; while one in six middle school students aged 11-14 was obese. Among high school students, 12% were obese.
- Georgians, across all age and ethnic groups do not get adequate levels of physical activity.

HUMAN PAPILLOMA VIRUS

HPV has been implicated causally in nearly 100% of cervical cancers worldwide. There are more than 100 different strains or types of HPV that cause genital and other types of warts. HPV strains 16, 18, 31, 33 and 45 are more likely to lead to the development of cancer. More than half of all cervical cancers are associated with infection by HPV types 16 and 18. Lack of regular Pap tests, cigarette use, and a sexual history of multiple partners are also risk factors for the development of the disease. Recent advances in medical science offer new alternatives to current cervical cancer prevention methods. These advances include: (1) new Pap screening methods, (2) HPV DNA detection, and (3) vaccines to prevent HPV. Because HPV is a major contributor to cervical cancer, the focus should not only be on the prevention and treatment of cervical cancer, but also the prevention and treatment of HPV.

In Georgia:

- An average of 400 new cases of invasive cervical cancer are diagnosed and, on average, 120 Georgia women die each year as a result of cervical cancer.
- Due to wide spread use of the Pap test, the death rate from cervical cancer has continued to decline.
- Only 50% of women diagnosed with cervical cancer in 2000-2004 had early stage (localized) cancers. (The 5-year survival rate for early stage invasive cervical cancer is 92%; the total 5-year survival rate for all stages is 71%).
- Although improving disparities in cervical cancer rates remain. Mortality rates are higher among black and Hispanic/Latina women than among white women.
- Cervical cancer incidence and mortality rates for women living in rural areas are higher than those of women living in urban areas.

PREVENTION GOAL 1

Reduce the number of Georgians exposed to the harmful effects of tobacco.

Goal 1: Reduce the number of Georgians exposed to the harmful effects of tobacco.

Objective 1.1

Reduce the number of smokers by the year 2012:

- A. Reduce high school smoking rate from 17% to 12%.
- B. Reduce middle school smoking rate from 7% to 3%.
- C. Reduce adult smoking rate from 20 % to 12%.
- D. Reduce pregnant women smoking rate from 9.2% to 5.0% for all ages and from 12.3% to 10.0% for women age 15 to 19.
- E. Increase smoker quit rate from 51% to 60%.
- F. Increase the proportion of school districts that enforce a comprehensive, 100% Tobacco Free School environment from <1% to 50%.

Strategies

- 1.1.1 Increase consumer tax on tobacco products.
- 1.1.2 Strengthen enforcement of laws prohibiting sale of tobacco to minors.
- 1.1.3 Implement tobacco education in schools.
- 1.1.4 Enforce 100% Tobacco Free School environments as defined by CDC and within comprehensive school policies (i.e., healthy eating and physical activity).
- 1.1.5 Re-establish community level youth advocacy groups.
- 1.1.6 Educate children on the negative health consequences of their parents' smoking.
- 1.1.7 Provide and promote programs and tools that increase opportunities to quit, such as the Georgia Tobacco Quit Line and local cessation programs.
- 1.1.8 Use community education and media campaigns to promote available services and change knowledge, attitudes, and beliefs about smoking.
- 1.1.9 Introduce health care reminders for tobacco queries and counseling in health care facilities.
- 1.1.10 Educate health care professionals on the success of tobacco cessation programs and available pharmaceuticals to assist smokers in quitting, in accordance with public health guidelines.
- 1.1.11 Reduce out of pocket costs for tobacco cessation programs and pharmaceuticals.
- 1.1.12 Provide tobacco cessation programs in health care facilities and provide reimbursement for tobacco cessation counseling, including referral to the Tobacco Quit Line.
- 1.1.13 Provide tobacco cessation counseling services as part of good prenatal care and make early prenatal care available for smokers, especially low income women.

Objective 1.2

Reduce exposure to second-hand smoke by the year 2012:

- A. Eliminate exposure of non-smokers to second hand smoke in all workplace and public environments.
- B. Reduce exposure of children to second hand smoke in the home from 22% to 15%.

Strategies

- 1.2.1 Establish a statewide Smoke Free Air Act Work Group with the necessary partners to strengthen enforcement of the Georgia Smoke Free Air Act of 2005 and to expand it by eliminating exemptions.
- 1.2.2 Use school programs and mass media campaigns to educate the general public, parents and children on the negative health consequences of parents' smoking.
- 1.2.3 Partner with health care providers such as family physicians and pediatricians, and with community-level programs and schools, to educate parents and assist them in quitting or pledging to smoke only outside the home and car.

Objective 1.3

Enhance infrastructure and resources for reducing tobacco exposure:

- A. Increase fax referrals to the Georgia Tobacco Quit Line by health care providers from 5% to 25% by 2012.
- B. Increase coverage for counseling and pharmacology for nicotine dependency in managed care organizations from 75% to 100% and Medicaid from 24% to 51% by 2012.
- C. Increase to at least 20% by 2009 the proportion of tobacco master settlement funds going to tobacco use prevention and cessation programs integrated with healthy eating, weight loss, physical activity.

Strategies

- 1.3.1 Establish a partnership between health care providers and the Tobacco Quit Line that includes enhancement of services, such as free or low cost nicotine replacement products and other pharmaceuticals for tobacco cessation.
- 1.3.2 Provide toolkits to help providers in office settings assess, counsel, and follow up with patients on tobacco use.
- 1.3.3 Promote the cost-effectiveness of providing counseling and pharmaceuticals for tobacco cessation.
- 1.3.4 Establish relationships with Georgia Department of Community Health (DCH) and US Centers for Medicare and Medicaid Services (CMS) to allow Medicaid to cover pharmaceuticals for tobacco cessation (other health plans to possibly follow that lead).
- 1.3.5 Ensure that Georgia has nationally experienced leadership setting priorities and strategies for comprehensive, statewide tobacco prevention and working with organizations such as the Regional Cancer Coalitions of Excellence (RCCEs) on regional initiatives and research.

PREVENTION GOAL 2

Reduce overweight and obesity and increase physical activity among children, adolescents, and adults in Georgia.

Goal 2: Reduce overweight and obesity and increase physical activity among children, adolescents, and adults in Georgia.

Objective 2.1

Promote healthy weight and lifestyles among adults by the year 2012:

- A. Reduce the average annual increase in overweight and obesity among adults from 3% to 0.
- B. Reduce the proportion of adults who report no leisure time physical activity from 25.8% to 20.0%.
- C. Increase the proportion of adults who are regularly active* from 42% to 45% (*defined as moderate-intensity physical activity for at least 30 minutes per day, 5 or more days per week, or vigorous activity for 20 minutes per day, 3 or more days per week).

Strategies

- 2.1.1 Develop and implement a comprehensive awareness campaign to promote the benefits of moderate physical activity.
- 2.1.2 Promote strategies to encourage physical activity and healthy eating such as those endorsed by the Guide to Community Preventive Services, with emphasis on reaching disproportionately affected populations including African Americans, Hispanics/Latinos, households with incomes less than \$25,000, and the uninsured.
- 2.1.3 Expand worksites' and faith-based physical activity and weight management programs and help them establish nutrition guidelines for meetings and events.
- 2.1.4 Encourage employee participation in worksite wellness interventions by offering exercise time; social support (e.g. walking clubs); competitions; incentives or subsidies for fitness memberships and for walking, bicycling or taking mass transit to work.
- 2.1.5 Educate families about the association between TV/video viewing and increased risk of obesity and encourage them to engage in physical activity such as hiking, cycling, or walking together as opposed to television viewing.
- 2.1.6 Promote existing sidewalks, walking trails, community pools, and public playgrounds in communities as convenient places for physical activity.
- 2.1.7 Organize, coordinate, and promote community watch groups to increase safety for those engaging in physical activities such as walking, bicycling, or jogging.
- 2.1.8 Promote buddy walking programs through existing walking clubs such as Georgia Striders.
- 2.1.9 Offer incentives to real estate developers to build retail centers and housing developments that are pedestrian friendly.

Objective 2.2

Promote healthy weight and lifestyles among children and adolescents by the year 2012:

- A. Reduce the proportion of children aged 2 to <5 years in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) who are overweight or at risk of becoming overweight from 27% to 25%.
- B. Reduce the proportion of third grade students who are obese from 24% to 21%.
- C. Reduce the proportion of middle school students who are overweight or at risk of becoming overweight from 33% to 30%.

- D. Reduce the proportion of high school students who are overweight or at risk of becoming overweight from 27% to 24%.
- E. Increase the proportion of children and adolescents who engage in moderate physical activity for at least 30 minutes daily from 25% to 27%.

Strategies

- 2.2.1 Develop and implement a comprehensive awareness campaign targeting WIC families that promotes good nutrition and physical activity for multiple age groups.
- 2.2.2 Provide opportunities for all students to participate in physical activities and competitive sports.
- 2.2.3 Promote the adoption of state standards for healthy eating and physical activity in daycare settings based on the Nutrition and Physical Activity Self-Assessment for Child Care Tool (based on a memorandum of understanding (MOU) between Department of Human Resources (DHR) and Department of Early Care and Learning).
- 2.2.4 Advocate for funded regulations or laws mandating daily physical education in grades K-12.
- 2.2.5 Offer and promote age-appropriate programs, such as those included in the Guide to Community Preventive Services that reduce the amount of time children spend in sedentary activities and promote physical activity during and after school.
- 2.2.6 Provide access to school physical activity spaces outside of normal school hours.
- 2.2.7 Organize, coordinate, and promote community watch groups to increase safety for walkers and runners.
- 2.2.8 Provide walking, jogging, and bicycling paths to schools and encourage schools to promote safe routes for walking or biking to school.
- 2.2.9 Educate parents about the American Academy of Pediatrics' recommendations for TV/video viewing and encourage them to limit children's total entertainment media time (television/video/computers) to no more than 1 to 2 hours per day.
- 2.2.10 Encourage health care providers to routinely track body mass index and offer appropriate counseling and guidance to children and their families.
- 2.2.11 Partner with faith- and other community-based organizations to tailor nutrition interventions to at-risk populations including African Americans, Hispanics/Latinos, and those of lower socioeconomic status.
- 2.2.12 Conduct an assessment of elementary schools' nutrition and physical activity environments using the CDC's School Health Index and implement comprehensive school health programs.
- 2.2.13 Promote implementation of Live Healthy Georgia, and involve high school students in marketing it among youth.
- 2.2.14 Increase the proportion of Georgia schools that implement two or more components of the Coordinated School Health Program.
- 2.2.15 Educate food service staff, teachers, and school administrators on the impact of obesity among children and ways to encourage healthy eating and increased physical activity.
- 2.2.16 Partner with school health advisory councils to educate key decision makers in the school setting on the benefits of a coordinated school health approach and its link to academic achievement.
- 2.2.17 Partner with school decision makers to increase the proportion of schools that eliminate unhealthy food and beverage options in cafeterias, vending machines, and other sources.
- 2.2.18 Provide opportunities for school staff to improve their health status through activities such as health assessments, health education, and health-related fitness activities.

PREVENTION GOAL 3

Reduce incidence of cervical cancer in Georgia.

Goal 3: Reduce the incidence of cervical cancer in Georgia.

Objective 3.1

By the year 2012, reduce the number of women who develop cervical cancer annually from approximately 400 to 200 or fewer, focusing first in health districts and rural areas most impacted by cervical cancer.

Strategies

- 3.1.1 Promote legislation on statewide guidelines and funding for cervical cancer prevention.
- 3.1.2 Implement a comprehensive, innovative cervical cancer education program that helps all women understand the importance of prevention through HPV vaccination with special emphasis on high risk populations.
- 3.1.3 Engage community-based organizations to deliver culturally and linguistically specific education on the importance of HPV and cervical cancer education.
- 3.1.4 Provide access to smoking cessation programs for patients with cervical disease.
- 3.1.5 Include survivors in promoting the importance of this issue.

Objective 3.2

Achieve 75% coverage of 11- and 12-year-old females vaccinated as part of their regular immunization schedule by the year 2012.

Strategies

- 3.2.1 Promote legislation requiring that regular immunization of all females age 11-12 include the HPV vaccine and that school immunization certificates document the vaccination.
- 3.2.2 Target media campaigns to parents and females about HPV vaccination to prevent cancer.
- 3.2.3 Increase funding for Vaccines for Children and programs to reach uninsured and underinsured groups.
- 3.2.4 Provide educational training for providers about HPV vaccination through the Georgia Chapter of American Academy of Pediatrics and/or pharmaceutical companies.
- 3.2.5 Provide educational sessions at middle schools, especially targeting underserved populations such as African Americans, Hispanics/Latinas, and others.
- 3.2.6 Provide incentives to providers with high rates of HPV vaccination in their practices.
- 3.2.7 Encourage providers to record HPV vaccination in GRITS.
- 3.2.8 Provide incentives or funding for HPV vaccination at an earlier age (as with Hepatitis B).
- 3.2.9 Target a media campaign to fathers: “Protect your daughter from cancer: Be sure she’s vaccinated against HPV.”
- 3.2.10 Encourage research on vaccination of adolescent males to decrease the spread of HPV.

CHAPTER 2

EARLY DETECTION AND SCREENING

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BACKGROUND

As acknowledged in Georgia's previous Cancer Plan, early detection is "the best guarantee for successful treatment." It is fundamental to the construct of this Plan that "every Georgian will have access to cancer screenings." Early detection not only saves lives; it reduces the costs and suffering caused by cancer because early stage disease is often amenable to less radical treatment. In some cases, screening actually prevents the development of cancer, as occurs when precancerous polyps are removed during colonoscopy.

In Georgia we know that disparities in screening rates mirror those of cancer mortality. Improving screening efforts thus provides a promising leverage point for reducing disparities in cancer outcomes. The early detection and screening elements of this revised plan will focus on:

- getting more people screened;
- ensuring that the best clinical practices and guidelines are followed for screening; and,
- advancing screening methodology through research.

INCREASING SCREENING RATES

To increase screening rates it is necessary to remove barriers and to stimulate participation. Both will likely impact disparities that are known to exist in mortality rates for breast, colorectal, and cervical cancers.

Research shows that early diagnosis is directly linked to better 5- and 10-year survival rates. Between the years 2000 and 2004, 41% of colorectal cancers, 49% of breast cancers, and 50% of cervical cancers in Georgia were diagnosed at an early stage. These statistics are thought to be due to suboptimal screening in vulnerable populations. Consider that during the same period:

- 50% of women from 40 to 65 years old reported having had a mammogram or clinical breast exam in the previous year.
- 21% of adults over age 59 reported having a fecal occult blood test (FOBT) in the previous three years, while 41% reported having a sigmoidoscopy/colonoscopy.
- 50% of cervical cancer cases were diagnosed late, though screening rates are generally high across all age groups with the exception of women over age 65.

Much of the information on screening behavior is gathered from aggregated, statewide, self-reported data. While this data is useful for state level planning, more data is needed about the nature and extent of screening disparities at the county and community level. More information is also needed regarding the availability of and the providers of screening services throughout the state.

ENSURING BEST SCREENING PRACTICES

Two components of screening practices are of particular importance. These are: a) the use of screening guidelines; and b) follow-up for an abnormal screen. The American Cancer Society (ACS), National Cancer Institute (NCI), and the US Preventive Services Task Force (USPSTF) have recommended guidelines for screening. In general, there is consensus among these groups about the best screening methodologies and when to use them. For colorectal screening the USPSTF notes that “there are insufficient data to determine which strategy is best in terms of the balance of benefits and potential harms or cost-effectiveness.” Studies reviewed by the USPSTF indicate that “colorectal cancer screening is likely to be cost-effective (less than \$30,000 per additional year of life gained) regardless of the strategy chosen.” Georgia’s challenge will be to ensure that both providers and the public are aware of the best practices in screening methodologies and follow them.

An even greater challenge exists in ensuring that screening results are quickly communicated to patients and providers, and that a well defined follow-up system is in place. Though there have been no formal studies, anecdotal evidence suggests that many patients (and their providers) wait for longer than necessary periods of time to obtain screening results. At present there are no standards regarding the timely receipt of screening results and no standardized follow-up protocols to ensure timely, accurate diagnosis following an abnormal cancer screening result.

ADVANCING SCREENING METHODOLOGY

Because of its promise for reducing the overall and disparate burden of cancer, screening is an important area for research. Studies are needed to determine baseline screening rates, to illuminate disparities, and to evaluate strategies for addressing gaps. Through the Georgia Cancer Coalition (GCC) and its partners: the Georgia Center for Oncology Research and Education (Georgia CORE); the Georgia Comprehensive Cancer Registry (GCCR); and, the state tissue and tumor bank, Georgia is positioned to engage in statewide research efforts in cancer screening. This will build from the Institute of Medicine (IOM) recommendations and on the current Point of Care and Georgia Cancer Cohort studies.

Research is also needed to develop and refine screening techniques for other high-impact cancers for which none currently exist. As has been demonstrated with the Distinguished Cancer Clinicians and Scientists (Cancer Scholars) program, there is a potential for positive economic impact as increased cancer research will likely bring more jobs to the state.

Georgia’s Regional Cancer Coalitions of Excellence are well positioned to facilitate the strategic assessment of local efforts, expedite statewide education, and play significant roles in the statewide adoption of best practices, including patient navigators and the mobilization of community groups.

Eliminating disparities between populations receiving cancer screening services will move Georgia toward the goal of reducing cancer mortality in the state.

EARLY DETECTION AND SCREENING GOAL 1

Remove barriers to cancer screening services.

Goal 1: Remove barriers to cancer screening services.

Objective 1.1

Remove financial barriers to receiving recommended cancer screening services by the year 2012:

- A. Achieve 100% insurance coverage for cancer screening for all Georgians for whom it is indicated.
- B. Increase the proportion of tobacco master settlement funds going to cancer screening and treatment for breast, cervix, colon, and prostate cancer to at least 20%.

Strategies

- 1.1.1 Evaluate each health insurance product's coverage to ensure the inclusion of benefits for cancer screening and follow-up, including financial coverage for evaluation (colposcopy, appropriate biopsies, and imaging studies) and treatment of pre-invasive and invasive cervical disease.
- 1.1.2 Implement a cancer screening and treatment insurance product for those uninsured for screening, with premiums on a sliding scale adjusted by federal poverty level.
- 1.1.3 Develop a review of insurance claims to assess reimbursement for screening and monitor for disparities.

Objective 1.2

Develop a comprehensive strategy to pilot programs to address transportation, scheduling, and other barriers to obtaining access to screening by the year 2009.

Strategies

- 1.2.1 Provide transportation to screening sites for populations with transportation barriers.
- 1.2.2 Initiate mobile van screening for cervical, breast, and prostate cancer and explore the potential for mobile colon cancer screening especially in underserved communities.
- 1.2.3 Offer expanded hours for screening services.
- 1.2.4 Expand and enhance Community Health Advocate (CHA) programs throughout the state.
- 1.2.5 Conduct surveys of wait times and financial barriers to colonoscopy and colposcopy, and develop programs to monitor and respond to these barriers.

EARLY DETECTION AND SCREENING GOAL 2

Increase participation in recommended screenings for breast, colorectal, cervical, and prostate cancers.

Goal 2: Increase participation in recommended screenings for breast, colorectal, cervical, and prostate cancers.

Objective 2.1

Improve breast, cervical, and colorectal cancer screening rates by the year 2012:

- A. Increase the proportion of women over 40 who have had a mammogram in the past 2 years from 75% to 90%.
- B. Decrease the proportion of people age 50 and older who have never had a colonoscopy or sigmoidoscopy from 47.3% to 20%.
- C. Increase the proportion of women age 18 and older who have had cervical cancer screening exams in the past 3 years from 87.5% to 95.5%.

Strategies

- 2.1.1 Use community networks represented by the RCCEs to increase public awareness regarding risk factors for these cancers and the availability of effective screening.
- 2.1.2 Develop and implement public service campaigns, both broad and targeted to high-risk, underserved populations, regarding cancer risk, screening efficacy, availability of services, and the applicability of various insurance products. Engage opinion leaders and cancer survivors from diverse population groups throughout the state to deliver the message regarding the need for appropriate cancer screening.
- 2.1.3 Develop culturally and linguistically competent educational materials for distribution through primary care offices and local health departments and for presentations by community groups.
- 2.1.4 Increase public awareness about the effectiveness of the HPV vaccine and the importance of continued screening even after vaccination.
- 2.1.5 Increase funding for Pap Test screening for the BreasTest & More program to be able to screen a larger percentage of the eligible population.
- 2.1.6 Add questions to the Behavioral Risk Factor Surveillance System survey (BRFSS) to establish data on rates of colorectal screening by method.
- 2.1.7 Institute reminder systems that inform patients and providers about screening due dates and recommended screening intervals.

Objective 2.2

Establish baseline prostate screening rates by the year 2009, and continuously inform the public on the latest evidence-based recommendations for prostate cancer screening.

Strategies

- 2.2.1 Collect baseline and ongoing prostate-specific antigen (PSA) and digital-rectal examination (DRE) data to monitor prostate cancer screening rates.
- 2.2.2 Track developments in medical knowledge and recommendations regarding prostate cancer screening.
- 2.2.3 Develop efficient tools to educate men on the latest evidence regarding prostate cancer screening, and promote informed decision making regarding their annual personal prostate cancer screening plan.
- 2.2.4 Develop targeted educational plans for communities of color.

EARLY DETECTION AND SCREENING GOAL 3

Improve the quality and effectiveness of cancer screening and follow-up services.

Goal 3: Improve the quality and effectiveness of cancer screening and follow-up services

Objective 3.1

Achieve a 75% rate of adherence to current cancer screening and follow-up guidelines by 2010.

Strategies

- 3.1.1 Establish baseline data on the use of current cancer screening and follow-up guidelines.
- 3.1.2 Establish a mechanism, using the expertise of Georgia's cancer research community, for regular annual review and upgrading of screening methodologies.
- 3.1.3 Expand and fund new and existing cancer screening initiatives across the state.
- 3.1.4 Provide traditional and web-based continuing medical education (CME) on guidelines and techniques for implementing Prevention-into-Practice, using provider "champions" to market the program.
- 3.1.5 Offer incentives to providers who have high annual screening rates for cervical, colon, breast, and prostate cancer in their practice.
- 3.1.6 Provide information and encourage the use of new and improved technologies for screening for cervical, breast, and colon cancer (liquid-based cytology, digital mammography, and colonoscopy) by all American College of Surgeons Commission on Cancer (CoC) certified hospitals.
- 3.1.7 Foster linkages with the health information technology industry to ensure that electronic medical records systems include recall and reminder systems for cancer screening.

Objective 3.2

By the year 2012, improve follow-up on abnormal screens to increase the proportion of cancers diagnosed at an early stage:

- A. From 69% to 80% for breast cancer.
- B. From 38% to 70% for colorectal cancer.
- C. From 53% to 70% for cervical cancer.

Strategies

- 3.2.1 Establish baselines, tracking methods, targets, and plans for reducing the time intervals between abnormal screens, diagnostic biopsies, and tissue diagnosis.
- 3.2.2 Include survivors in the development of protocols for ensuring patient navigation from initial screening through follow-up, diagnosis, and staging.
- 3.2.3 Inform providers and public health practitioners on issues related to cervical, breast, colon, and prostate cancer screening and follow-up (missed exams, failure to follow up on abnormal tests, failed accuracy of tests, etc).
- 3.2.4 Expand and amplify the patient navigator program (numbers, support, training, and placement) and develop systems to enhance their support for high-risk patients' follow-up after abnormal screens.
- 3.2.5 Assure insurance coverage for all patients screened and found to have abnormalities requiring follow-up.
- 3.2.6 Institute reminder systems that inform providers and patients about screening due dates and recommended screening intervals.

EARLY DETECTION AND SCREENING GOAL 4

Become a leader in translational research related to screening practices for Georgia's cancers with the greatest burden.

Goal 4: Become a national leader in translational research related to screening practices for Georgia's cancers with the greatest burden.

Objective 4.1

By the year 2008, develop the infrastructure to coordinate a statewide primary care, practice-based research network; promote at least nine early detection and screening research projects (one in each region, in addition to the Georgia Cancer Cohort Study, Southwest Georgia Screening Project, and Community Health Workers program).

Strategies

- 4.1.1 Recruit additional clinicians and scientists whose research and activities are focused on early detection and screening.
- 4.1.2 Promote cancer research topics on early detection and screening such as the following:
 - a. Study the role and effectiveness of Community Health Advocates and develop tools to support their work.
 - b. Build on the existing Georgia Cancer Cohort Study to monitor a population with respect to the potential for screening to detect cancers at an early stage.
 - c. Gather baseline data on the delivery of early detection and screening programs throughout Georgia, with an emphasis on identifying gaps and disparities in these programs.
 - d. Study the most effective venues in urban, suburban, small town, rural, and transient populations for the delivery of early detection and screening programs.
 - e. Determine barriers that prevent Georgians from participating in early detection and screening programs for cancer.
 - f. Use the practice-based network to engage in research to enhance cervical, breast, colorectal, and prostate cancer screening and to develop techniques for screening for other cancers, especially lung, ovarian, pancreatic, testicular, and skin cancer.

Objective 4.2

Implement strategic initiatives to address disparities identified through research by the year 2012.

Strategies

- 4.2.1 Use population-based Georgia data on early detection and screening to identify disparities, determine causes, and design programs to mitigate them.
- 4.2.2 Consider best practices from outside of Georgia, where comparable.
- 4.2.3 Continue data collection throughout the 5-year cancer plan to monitor and modify strategic initiatives.

CHAPTER 3

DIAGNOSIS AND STAGING

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BACKGROUND

In its report on the quality of cancer care in Georgia, the IOM points out that accurate and timely diagnosis is the basis for combating cancer and is the essential first step in quality care. If diagnostic practice is poor, treatment and outcomes are likely to be less than optimal.

Nationally, a growing body of evidence suggests that the process of cancer diagnosis is often incomplete and insufficiently documented. Though no specific assessment has been carried out in Georgia, it is reasonable to assume that the situation is the same. In order ensure the best possible patient outcomes and system efficiency the following elements must be addressed:

- Adequacy of diagnostic/surgical specimens for timely pathologic assessment or evaluation.
- Quality staging and reporting that informs treatment regimes and protocols.

ADEQUACY OF SAMPLE

Obtaining an adequate sample for pathological investigation is fundamental to accurately diagnosing and staging tumors. The National Comprehensive Cancer Network (NCCN) lays out recommendations and guidelines for tissue collection and biopsies which, if followed, will lead to appropriate material being used in the assessment. Two other components of tissue collection are also important: the assessment of surgical margins and lymph node evaluation.

Research evidence indicates that positive surgical margins are associated with significant morbidity and cost, including higher rates of local tumor recurrence and further surgical or medical treatment. Therefore, every effort should be made to procure tissue samples with negative surgical margins.

Nearly a third of newly diagnosed cancer patients will have metastases detected at the time of their diagnosis. In many instances the metastasis is adjacent to lymph nodes. To ensure that the patient's cancer is not under-staged and thus under-treated, adequate sampling of nodes is recommended. The number of nodes that should be sampled will vary depending on the site of the primary lesion.

QUALITY STAGING AND REPORTING

Before treatment begins, every cancer patient should have a definitive diagnosis and an accurate, determination of tumor stage. Indeed, most treatment guidelines such as those of the American Society of Clinical Oncology (ASCO), American College of Radiology (ACR), NCCN, and others, cannot be followed until the tumor stage has been determined. Throughout the country, evidence indicates that underreporting of pathology information occurs frequently, suggesting that many cancer patients receive treatment before the stage of their disease is properly documented and reported to their care provider. It is essential that the clinician in charge of their care receives a complete and accurate pathology report.

According to the IOM report, while it is difficult to determine from the available research whether shortcomings in pathology data are due to poor documentation practices or poor surgical technique, standardized reporting templates have been shown to yield more comprehensive and complete information than free-text pathology reports. Groups such as the College of American Pathologists (CAP) and the American Joint Committee on Cancer (AJCC) have developed templates to standardize the reporting of pathology findings for cancer specimens.

DIAGNOSIS AND STAGING GOAL 1

Ensure the timeliness and quality of acquisition, pathology, and staging prior to treatment for cancer.

Goal 1: Ensure the timeliness and quality of tissue acquisition, pathology, and staging prior to treatment for cancer.

Objective 1.1

Establish baselines and reduction targets for the time intervals from abnormal prostate, colorectal, cervical, and breast cancer screens to diagnostic biopsy, tissue diagnosis and treatment initiation by the year 2010.

Strategies

- 1.1.1 Collect baseline data and investigate optimal turnaround times. For breast screens, collect data on the number and percentage of women who have had a biopsy within 14 days after first documentation of a category 4 or 5 abnormal mammogram.
- 1.1.2 Establish mechanisms for information exchange between screening providers and patients, and for provider education, to ensure patient access to follow-up diagnostic services.
- 1.1.3 Conduct a survey of the mechanisms used to assure patient follow-up after biopsy.
- 1.1.4 Establish mechanisms by which provider institutions that are below par can improve their performance.

Objective 1.2

Achieve uniform utilization of current practice guidelines (CAP/NCCN) that relate to diagnostic/imaging work-up, staging, and pathology by the year 2012.

Strategies

- 1.2.1 Establish a committee to organize syllabi of current practice guidelines for diagnostic/imaging work-up, staging, and pathology.
- 1.2.2 Distribute syllabi to treatment facility staff with the help of groups such as state trade professional organizations, Georgia Comprehensive Cancer Registry, and Georgia CORE.
- 1.2.3 Implement a system to audit whether guidelines are being followed and to address gaps.
- 1.2.4 Develop a virtual tumor board and web-based tools enabling cancer specialists across the state to collaborate in diagnosing and treating patients.
- 1.2.5 Encourage and assess the use of needle biopsy as the preferred diagnostic follow-up to an abnormal mammogram: collecting data on the number and percentage of women who have a needle biopsy of the breast at least one day prior to breast cancer surgery.
- 1.2.6 Ensure that appropriate histological assessment is being conducted:
 - a. For breast cancer, collect data on the number and percentage of Stage I and Stage II cases with sentinel node biopsy or with histological assessment of 10 or more axillary lymph nodes.
 - b. For colorectal cancer, collect data on the number and percentage of cancer surgery patients with a surgical resection that included at least 12 lymph nodes.
- 1.2.7 Ensure timely and accurate staging prior to treatment (measured as the percentage of new breast, colorectal, prostate, and lung cancer cases with medical chart documentation of pathologic stage prior to initiation of chemotherapy or radiation treatment), using state-of-the-art modalities and being mindful of resources.
- 1.2.8 Monitor and increase the percentage of breast-conserving cancer surgery patients whose surgical margins are free of tumor after their last surgical procedure.

DIAGNOSIS AND STAGING GOAL 2

Ensure the uniformity and accuracy of documentation regarding cancer diagnosis and staging.

Goal 2: Ensure the uniformity and accuracy of documentation regarding cancer diagnosis and staging.

Objective 2.1

Develop and provide a statewide reporting format based on CAP guidelines by the year 2009.

Strategies

- 2.1.1 Advocate for the standard use of the most appropriate staging forms (AJCC recent versions/collaborative stage).
- 2.1.2 Encourage the use of downloadable synoptic reports from the CAP website.
- 2.1.3 Develop and implement a system to audit whether reporting guidelines are being followed.
- 2.1.4 Develop and implement monitoring software that will prevent the transmission of reports unless all fields are completed.

Objective 2.2

Achieve 100% compliance with CAP reporting standards for cancer surgical specimens by pathology laboratories of CoC accredited and non-accredited hospitals by the year 2012.

- 2.1.1 Monitor the proportion of pathology laboratories that report all CoC required CAP data elements for breast, prostate, lung, and colorectal cancer specimens.
- 2.1.2 Ensure adequate pathology reports on surgical specimens at CoC certified hospitals by assessing the proportion of pathology reports on invasive breast cancer, colorectal cancer, lung cancer, and prostate cancer surgical specimens that include CAP data elements.

CHAPTER 4

TREATMENT AND PALLIATION

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BACKGROUND

The State Cancer Plan focuses its treatment and palliation goals on closing gaps between knowledge and practice, both in the general population and more specifically in disproportionately affected populations within the state. These gaps fall into three primary clusters: standardized treatment, clinical trials, and palliative care.

The state seeks to ensure that affordable cutting-edge care is available to individuals affected by all cancers. Given the burden already described, however, the treatment of colorectal, lung, breast, and prostate cancer will be a focus of activity over the next five years.

STANDARDIZED TREATMENT

Extensive medical evidence informs existing treatment and follow-up guidelines for colorectal, lung, breast, and prostate cancer. However, national studies indicate that practice falls short of full adherence to these guidelines. It is vital to assure compliance with the latest treatment guidelines, both to promote the best medical outcomes and to avoid the unnecessary costs and risks of inappropriately used therapies. More Georgia-specific data is needed to evaluate specific gaps and to monitor improvements. In national studies:

- 7.8% of prostate cancer patients diagnosed from 1999 through 2001 inappropriately received hormonal therapy before radical prostatectomy.
- 62% of intermediate-risk prostate cancer patients and 40% of higher-risk patients received external beam radiation therapy in inadequate doses.
- 26% of prostate cancer patients with intermediate recurrence risk, and 10% with high recurrence risk, failed to receive the recommended combination of hormonal and external beam radiation therapy.
- the application of recommended adjuvant therapy for colon cancer varies by hospital, patient age, race, ethnicity, marital, and insurance status.
- 58% of post-surgery colorectal cancer patients who survived 6 years had had a follow-up colonoscopy within that period.
- about 50% of women treated for breast cancer had a first follow-up mammogram 12 months after diagnosis, and 78% by 30 months.

In Georgia, studies have found:

- the accepted practice of breast-conserving surgery for Stage 0 to Stage II breast cancer is followed in only 51% of ACoS certified hospitals.
- not all Georgia women who receive breast-conserving surgery also receive the recommended radiotherapy. Gaps are greatest for African-American women, those who live furthest from radiation facilities, and those who have not consulted with a radiation oncologist.

CLINICAL TRIALS

Clinical trials offer patients a way to try promising treatments, at the same time yielding information that can benefit large numbers of subsequent patients. Those participating in clinical trials may also receive better access to medical professionals and closer attention and monitoring, although evidence has yet to confirm that they experience improved outcomes. At present, enrollment in clinical trials can only be estimated (at less than 2% of all Georgians with cancer in 2000, according to GCC); and, although hard figures are unavailable, it is known that Hispanic and African-American participation is disproportionately low and participation declines with age.

PALLIATIVE CARE

The IOM recommends four metrics related to palliative care: two regarding pain and two regarding hospice. Anywhere from 14% to 100% of cancer patients and survivors experience pain, a significant proportion of which is inadequately treated. In one study, 50% of non-minority patients and 65% of nonwhite and Hispanic patients were not given recommended analgesic prescriptions. The routine and uniform evaluation of patients' pain is essential. Studies show that the gap between physicians' and patients' assessments of pain severity is the primary predictor of inadequate treatment to alleviate it. Similarly, hospice care is under- and disparately prescribed. One national study of Medicare beneficiaries who died of breast, lung, colorectal, or prostate cancer showed that only 30% had received hospice services; another study reported that 17% of patients in this population who did receive hospice care had stays of only 3 days or less. Other disparities in access to hospice care are reported for factors including age, race, ethnicity, and locale.

TREATMENT AND PALLIATION GOAL 1

Ensure compliance with NCCN guidelines for the treatment of colorectal, lung, breast, and prostate cancer in Georgia's hospitals.

Goal 1: Ensure compliance with NCCN guidelines for the treatment of colorectal, lung, breast, and prostate cancer in Georgia's hospitals.

Objective 1.1

Assess the baseline level of NCCN guideline compliance using all IOM measures relevant to these cancers by July 2009.

Strategies

- 1.1.1 Develop a tracking document or revise existing reporting forms to track specific IOM recommended measures.
- 1.1.2 Require all CoC registries to complete the tracking document.

Objective 1.2

Educate and train 75% of Georgia's oncology practitioners on NCCN guidelines and related IOM recommended measures by December 2009.

Strategies

- 1.2.1 Develop a program to train oncology practitioners on the availability and use of NCCN guidelines and related IOM recommended measures, possibly as part of an annual statewide symposium.
- 1.2.2 Offer the training to oncology practitioners statewide.

Objective 1.3

Evaluate ongoing compliance and adherence to NCCN guidelines in order to achieve the following IOM recommended targets by the year 2012:

- A. Ensure that all prostate cancer patients receive therapy or combination of therapies appropriate to their case (prostatectomy, brachytherapy, external beam radiation therapy, hormonal therapy).
- B. Increase the proportion of women who receive radiation treatment within 8 weeks following breast cancer surgery from 27% to 75%.
- C. Increase the percent of women with breast cancer who receive adjuvant hormonal therapy for hormone-receptor-positive cancer >2cm in size from 37% to 67%.
- D. Increase the proportion of women receiving adjuvant combination chemotherapy, when appropriate, for breast cancer from 46% to 75%.
- E. Ensure that all patients have follow-up mammography after treatment for breast cancer.
- F. Increase the proportion of patients receiving adjuvant chemotherapy, when appropriate, after colon cancer surgery from 33% to 90%.
- G. Ensure that all patients have follow-up colonoscopy after treatment for colorectal cancer.

Strategies

- 1.3.1 Develop a multidisciplinary oversight taskforce.
- 1.3.2 Review and publish timely results of compliance as measured by ACS registry.

TREATMENT AND PALLIATION GOAL 2

Increase accrual of Georgia residents to cancer clinical trials.

Goal 2: Increase accrual of Georgia residents to cancer clinical trials.

Objective 2.1

Establish a clinical trials infrastructure outside metropolitan Atlanta supported by Georgia CORE by the year 2012.

Strategies

- 2.1.1 Develop a demonstration project in at least one rural hospital chosen by Georgia CORE through a request for proposals (RFP) to show the ability to increase cancer clinical treatment trials by 20% over 2 years using 2006 baseline.
- 2.1.2 Evaluate the project and extend successful components to at least one other Regional Cancer Coalition of Excellence.
- 2.1.3 Evaluate the potential for further replication.
- 2.1.4 Engage more minority healthcare professionals in clinical trials.

Objective 2.2

Offer provider training for clinical trials program to two RCCEs by the year 2008 and all RCCEs by the year 2010.

Strategies

- 2.2.1 Charge and fund Georgia CORE to develop this program based on existing training programs.
- 2.2.2 Offer training to support staff and principal investigators (PIs).

Objective 2.3

Develop and deliver an educational program for populations affected by healthcare disparities that measures changes in awareness of, and attitudes towards, clinical trials by the year 2008; and extend the program to other disparately affected populations throughout the state by the year 2010.

Strategies

- 2.3.1 Pilot and evaluate an education program at Grady Hospital.
- 2.3.2 Implement the NCI-developed Clinical Trials Education Series to promote awareness of clinical trials among populations affected by healthcare disparities.
- 2.3.2 Include cancer survivors and clinical trial participants in the development and delivery of programs.

Objective 2.4

Add at least two facilities per year to those accruing specimens for the state biorepository through 2012.

Strategies

- 2.4.1 Establish criteria for participation in the state biorepository program.
- 2.4.2 Develop a statewide RFP process for funding facilities statewide.

TREATMENT AND PALLIATION GOAL 3

Increase the proportion of cancer patients in Georgia who receive palliative care and support from the time of diagnosis.

Goal 3: Increase the proportion of cancer patients in Georgia who receive palliative care and support from the time of diagnosis.

Objective 3.1

Increase current levels of service in Georgia by measuring length of hospice stay and pain assessment by the year 2010.

Strategies

- 3.1.1 Facilitate the development of a statewide Pain Coalition to address palliative care and pain issues, charged first with assessing what palliative care services currently exist.
- 3.1.2 Conduct a study to establish a baseline measure for pain assessment in oncology practices and hospices.
- 3.1.3 Encourage CoC certified hospitals to incorporate IOM palliative care and pain measures into ongoing quality improvement processes, and provide potential funding resources to support local level staffing needs.

Objective 3.2

Develop and implement an educational curriculum for providers and community groups utilizing existing best practice in palliative care and pain management by the year 2010.

Strategies

- 3.2.1 Establish a recommended, standardized approach to palliative care.
- 3.2.2 Implement curriculum among care providers throughout the state.
- 3.2.3 Engage survivors in the development and implementation of curriculum.
- 3.2.4 Develop an evaluation process to determine success of curriculum.

Objective 3.3

Pilot and evaluate a demonstration palliative care project to reduce pain and symptom distress from time of diagnosis by the year 2010.

Strategies

- 3.3.1 Select at least two sites for implementation of the pilot project (one rural and one urban) via an RFP process, overseen by the Statewide Pain Coalition, to include populations affected by health disparities.
- 3.3.2 Evaluate the project using applicable IOM recommended metrics.

Objective 3.4

On an ongoing basis, advocate legislative measures related to pain and palliative care as defined by the statewide Pain Coalition.

Strategies

- 3.4.1 Review upcoming legislation using information and support from ACS.
- 3.4.2 Coordinate actions as necessary in response.

Objective 3.5

Establish baselines, targets, and initial improvements in the quality of life for cancer survivors in Georgia by the year 2012.

Strategies

- 3.5.1 Conduct a pilot to capture personal health records of Georgia CORE patients during and after treatment that will provide the tools for cancer survivors to partner with their physicians about ongoing care and future health issues.
- 3.5.2 Develop and promote the use of care plans for cancer survivors that address increased needs for prevention, screening, early detection, diagnosis, and treatment of subsequent cancers.
- 3.5.3 Implement a Study of Cancer Survivors needs assessment throughout Georgia.
- 3.5.4 Provide a teaching curriculum to educate oncologists, primary care physicians, nurses, and social workers about cancer survivorship issues.
- 3.5.5 Develop a teaching curriculum for centers that treat pediatric oncology patients in Augusta, Columbus, Macon, and Savannah, to include lecture/grand rounds.
- 3.5.6 Provide grants for cancer survivorship research.

CHAPTER 5

DATA AND METRICS

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BACKGROUND

Appropriate, reliable and timely data are crucial to identifying needs, targets, and progress in the effort to reduce the cancer burden. The focus of Georgia’s cancer data and metrics activities over the next five years is on improving oversight and coordination of data issues; enhancing awareness and use of existing data and metrics; filling data gaps and expanding the available data and metrics; and, putting into place effective tools for collecting, using, sharing, and reporting data.

OVERSIGHT AND COORDINATION

Outside of the Georgia Comprehensive Cancer Registry, sources and uses of data are dispersed and varied. The landscape of disease, research, targets, and resources is complex and shifting. In presenting its quality-of-cancer-care measures, the IOM suggested that Georgia “should regularly revisit the measure set to consider potential new measures, make adjustments to existing measures, and retire measures if they prove to be ineffective or no longer relevant.” Parts of the State Cancer Plan identify areas in which benchmarks and targets are not yet established. These considerations point to the need for ongoing oversight of data and metrics issues by stakeholder representatives and the need for collaboration among data collectors and users.

AWARENESS AND USE

This section emphasizes education across the state on the State Cancer Plan and its metrics in order to promote the Plan’s effective implementation. It also addresses observed gaps in knowledge and use of existing cancer data. Currently, only six researchers are utilizing GCCR data for research purposes within Georgia—five from the Rollins School of Public Health in Atlanta and one at Mercer University Medical School in Macon.

AUGMENTATION OF DATA

Traditional cancer registry data can be augmented with information from a variety of sources to provide effective baselines, benchmarks, and targets for change. Examples include special studies; patient-reported outcomes, satisfaction and genetic factors; electronic medical records; personal health records; insurance claims; and, other sources. To date, most of the information available has existed within the various silos of public health reports, research data bases, and clinician documentation. A focus of the State Cancer Plan is to combine the strengths of point-of-care delivery process improvement and population health management to establish a unique data model for Georgia. At present, 41 cancer programs in Georgia are approved by the CoC; together they treat 75% of the state’s incident cancer cases. In conjunction with community-based initiatives to further enhance the scope and breadth of data collection, these CoC programs are envisioned as forming the nucleus of a long-term data collection and management plan that ensures accurate and timely cancer-care information that is accessible and useful to multiple stakeholders. The Georgia Cancer Quality Information Exchange, now in its demonstration phase, is working toward that end.

INFORMATION MANAGEMENT TOOLS

The IOM noted that its measure set should be “drawn from established clinical guidelines or quality measures already in use,” but that “current availability of the data necessary to develop the measures was not a principal concern because GCC intended to invest simultaneously in creating a state-of-the-art information infrastructure.” This part of the Plan involves implementing the technological infrastructure, tools, automation, and portals necessary for all of the above to be accomplished.

DATA AND METRICS GOAL 1

Establish ongoing, collaborative processes for addressing cancer data and metrics in Georgia.

Goal 1: Establish ongoing, collaborative processes for addressing cancer data and metrics issues in Georgia.

Objective 1.1

Establish a Standing Committee on Data and Metrics in Georgia comprised of stakeholders from public health, clinical practice, and academic sectors by December 2007.

Strategies

- 1.1.1 Develop structure, charter, membership contracts, funding, budget, and reporting processes for a Standing Committee. Recommendations include having 8 to 12 members representing a broad array of disciplines, serving 24-month rotating terms, with self-selected leadership. A primary charge of this stakeholder committee would be to shepherd the Data and Metrics goals and objectives of this and future statewide cancer plans.
- 1.1.2 Establish initial group of Standing Committee members and meeting schedule.
- 1.1.3 Establish a process for ongoing goal-setting and benchmarking; set thresholds for mid-level goals to monitor progress.

Objective 1.2

Develop a model collaboration agreement for use by state government agencies, health care providers, academic institutions, and other for- and not-for-profit enterprises across the state whose activities relate to cancer prevention, treatment, diagnosis, or palliation by December 2008.

Strategies

- 1.2.1 Draft a model agreement for collaboration.
- 1.2.2 Solicit and incorporate feedback from stakeholder institutions across the state.
- 1.2.3 Distribute the template to appropriate stakeholder institutions for pilot testing.
- 1.2.4 Incorporate modifications to template as recommended by stakeholder institutions and prepare for full-scale implementation.

Objective 1.3

Establish linkages for the inclusion of relevant motor vehicle registration data in the GCCR to enhance the accuracy and completeness of data on cancer patient survival outcomes by May 2008.

Strategies

- 1.3.1 Assess the willingness of the Georgia Department of Community Health and the Georgia Department of Motor Vehicles to collaborate on data-sharing.
- 1.3.2 Convene representatives from both agencies to plan for formalizing and implementing this collaboration.
- 1.3.3 Facilitate changes in Georgia law as needed to allow for data-sharing.

DATA AND METRICS GOAL 2

Improve stakeholders' knowledge and use of available cancer data.

Goal 2: Improve stakeholders' knowledge and use of available cancer data.

Objective 2.1

Establish baseline knowledge and train 50% more of Georgia's cancer researchers, clinicians, and registrars about the rationales for and steps in collecting and analyzing data and metrics relevant to the State Cancer Plan by August 2008.

Strategies

- 2.1.1 Assess training needs throughout the state and determine target outcomes.
- 2.1.2 Develop content, materials, and delivery mechanisms for training.
- 2.1.3 Schedule, publicize, and deliver training.
- 2.1.4 Evaluate training and outcomes to improve the next training plan.

Objective 2.2

Implement a multifaceted plan to promote and support the use of existing cancer data by February 2009.

Strategies

- 2.2.1 Develop a plan for highlighting the quality and availability of the GCCR and other data sources through meetings and other channels of communication with potential data users.
- 2.2.2 Offer training on accessing and using GCCR and other cancer related data.
- 2.2.3 Create a supportive environment for the conduct of basic, clinical, and cancer control research in Georgia.

DATA AND METRICS GOAL 3

Expand and enhance cancer data collection from existing and new sources.

Goal 3: Expand and enhance cancer data collection from existing and new sources.

Objective 3.1

Identify and develop plans to address gaps in baseline data, benchmarks and targets by May 2008, particularly diagnosis and treatment data not currently reported within the state's cancer registry; community-level survey data needed to shed light on population disparities in cancer care and outcomes; and quality-of-life data for cancer survivors.

Strategies

- 3.1.1 Use initial inventory and benchmark assessments prepared by the Data and Metrics Work Group, along with input from other State Cancer Plan Work Groups, to develop Phase I state targets for improvement in areas where data sources exist.
- 3.1.2 Develop a process to address identified gaps in data and to link information from various sources (ongoing special studies such as the CDC-supported Breast and Prostate Data Quality and Patterns of Care and Data Quality Study, Georgia Cancer Quality Information Exchange, Healthy People 2010, BRFSS, SEER, NCI data from other states).
- 3.1.3 Develop a process for ongoing assessment and development of baselines, benchmarks, and targets for incorporation into the Georgia Cancer Coalition's Cancer Quality Dashboard.

Objective 3.2

Expand the visibility of the IOM Indicators, the Dashboard, and available data sources to all CoC-certified cancer programs in Georgia by March 2008.

Strategies

- 3.2.1 Initially, present existing aggregated data in an accessible, understandable format.
- 3.2.2 Publicize Exchange Demonstration Project Selection Criteria for CoC cancer programs in Georgia.
- 3.2.3 Using results from a variety of sources, work with CoC cancer programs and other stakeholders to develop long-term reporting and data aggregation model for The Exchange.

Objective 3.3

Develop a framework for incorporating new sources of data by July 2008, and in parallel promote rapid case ascertainment and the accelerated completion and reporting of cases by cancer registries. New data sources may include, among others:

- A. Administrative claims data from Medicare, Medicaid and the major private payers in the state, with an emphasis on how these data could be used to identify cancer care utilization and outcomes for patients and survivors.
- B. Patient-reported outcomes such as health-related quality of life and satisfaction with care.
- C. Biospecimen data.
- D. Additional evidence-based metrics including those from special studies.
- E. Community-level survey data on use of cancer prevention and screening service, and the impact on health outcomes.

Strategies

- 3.3.1 Determine sources and uses of new metrics.
- 3.3.2 Identify complementary initiatives (e.g., NCI-Georgia project linking state registry data to Medicare claims, NCI's Cancer Outcomes Measurement Working Group, etc).
- 3.3.3 Define initial pilot project scopes.
- 3.3.4 Support adoption of electronic data reporting systems, including electronic health records by hospitals and Health Level Seven (HL7) format reporting by pathology laboratories.
- 3.3.5 Develop implementation plans, participant roles, appropriate approvals, data-sharing agreements, privacy protection methods, time-tables, and funding mechanisms.

DATA AND METRICS GOAL 4

*Implement improved information management tools
and technologies.*

Goal 4: Implement improved information management tools and technologies

Objective 4.1

Develop an appropriate technological framework to support statewide collection and reporting of cancer quality-of-care data by the year 2009.

Strategies

- 4.1.1 Assess existing health information technology infrastructure throughout the state, including programs complementary to cancer initiatives such as the Georgia Health Information Technology & Transparency Advisory Board (HITT), the Georgia Regional Healthcare Information Organization (GaRHIO), Georgia CORE, and BRAG-Onc. Examine industry best practices and potential linkages to existing initiatives and resources across the nation such as the CDC's Medical Error Reporting and Prevention (MERP) and the NCI's Cancer Biomedical Informatics Grid (caBIG). Identify and address infrastructure gaps.
- 4.1.2 Design an overarching technology strategy for the state, to include a central data repository that leverages existing data sources and other resources, and means for transmitting, aggregating, and protecting data.
- 4.1.3 Develop the infrastructure, protocols, and methodologies to begin collecting statewide data in the Georgia Cancer Quality Information Exchange, including information on risk factors, incidence rates, screening rates, treatment patterns, survivorship outcomes, quality of life, and mortality.
- 4.1.4 Evaluate and validate existing use of electronic medical records (EMRs) with tools such as Healthcare Information and Management Systems Society (HIMSS) Analytics, and work to develop technological standards that will support the electronic exchange of health information. Coordinate and collaborate with complementary efforts such as HITT and GaRHIO. Provide recommendations to state data reporters regarding best practices with EMR.
- 4.1.5 Work with complementary efforts such as the HITT task force, Georgia CORE, and GaRHIO to promote the expanded use and adoption of EMRs to assist in data capture related to detection, diagnosis, and treatment patterns at the provider level (hospitals, physician practices, and ambulatory facilities).
- 4.1.6 Develop appropriate infrastructure for sharing claims data related to the IOM measures with Medicare, Medicaid, and key third party payors.

Objective 4.2

Develop automation, tool sets, and portals for utilizing, reporting, and sharing data by the year 2011.

Strategies

- 4.2.1 Evaluate existing programs that support the exchange of electronic health information. Identify barriers and propose solutions for the sharing of information.
- 4.2.2 Develop tools to report currently available IOM and other appropriate metrics to various stakeholders through a central web portal, to include: a Dashboard that depicts current performance; trends in performance; and, baselines, benchmarks, and goals.
- 4.2.3 Develop a central repository and clearinghouse for all cancer data related to the existing IOM indicators as well as new measures as they evolve. As part of The Exchange, this

clearinghouse will allow stakeholders to identify areas of best practice as well as areas where disparities and gaps exist, supporting continuous quality improvement in cancer care.

- 4.2.4 Ensure that The Exchange and other sources of cancer care information are accessible to stakeholders at all levels, including consumers, providers, payors, and scientists through the implementation of portals and other tools.
- 4.2.5 Develop and implement a decision support system that utilizes data from The Exchange and allows retrospective analysis of care patterns throughout cancer patients' course of treatment (screening, detection, diagnosis, treatment, survivorship, and end of life). Data should be population-based, to support valid statistical inferences about progress against cancer over time both statewide and in particular groups defined by race, ethnicity, and geographical location.

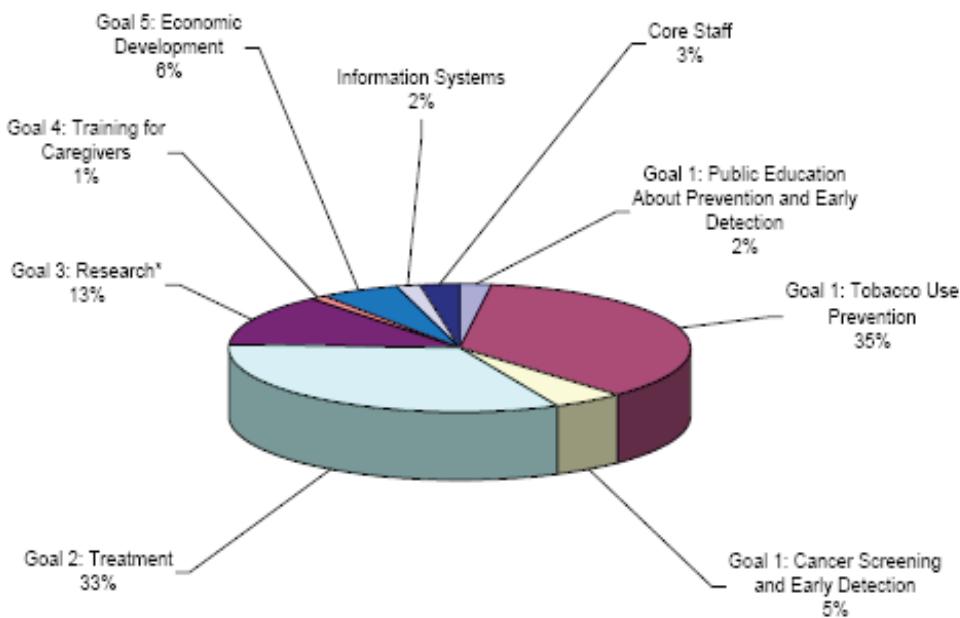
SUSTAINABILITY

Two primary resource inputs are critical to accomplishing the tasks set out under this plan, and sustaining the desired level of comprehensive cancer control over the next five years. These are: adequate funding and the engagement of a culturally appropriate and well-trained workforce.

FUNDING

Nearly two-thirds of Tobacco Master Settlement Agreement Funds (TMSF) in Georgia is spent on healthcare. Presently 18% of this amount (nearly \$29M) is appropriated to the GCC, DHR, and DCH for cancer related programs. In the past 5 years, Georgia, like many other states, faced significant economic challenges and state appropriations of TMSF for cancer control have fallen by nearly 60%.

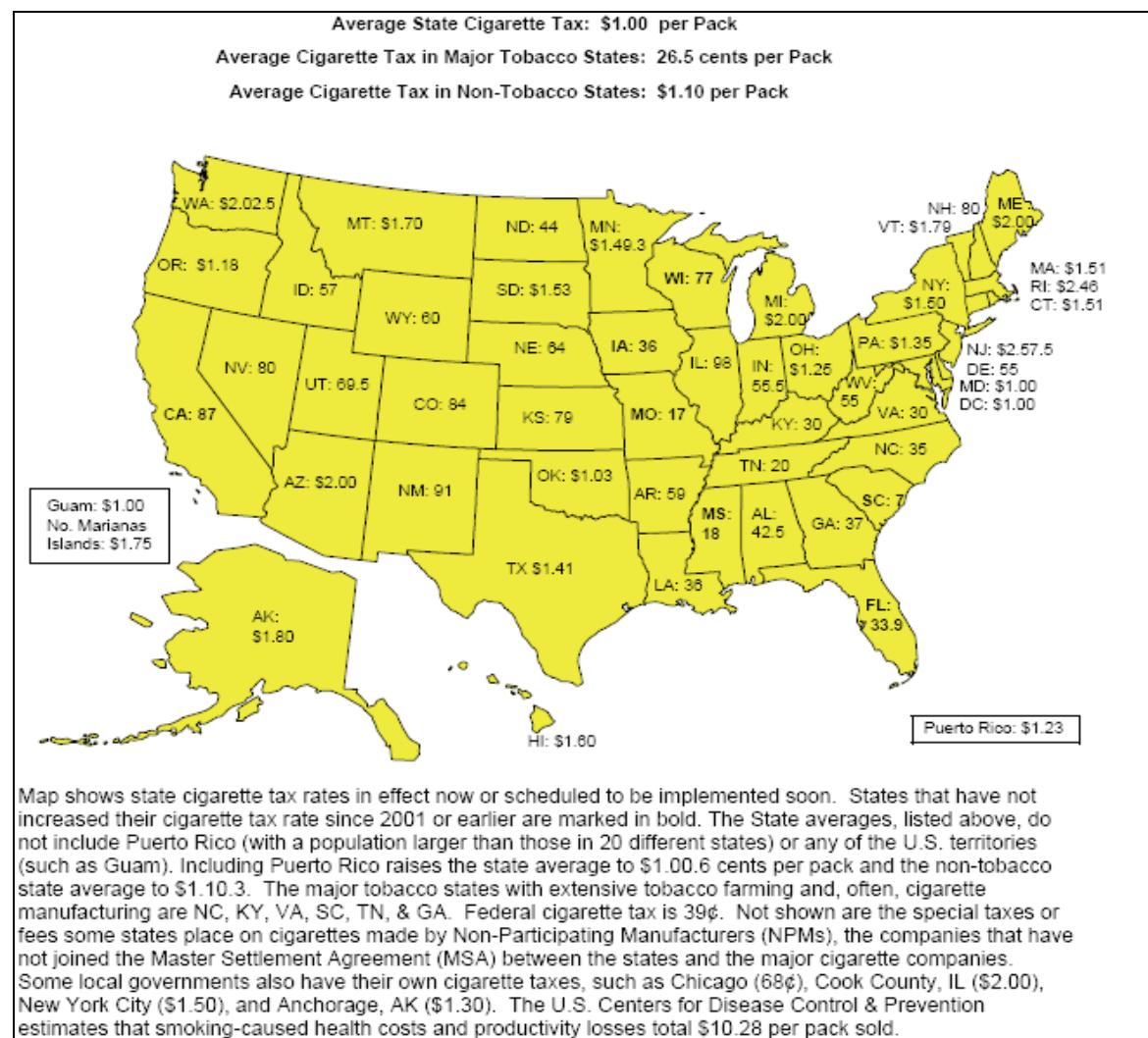
Figure 6 – Tobacco Settlement Fund Appropriations by Strategic Goal



At the same time, Georgia's excise tax on tobacco, 37 cents per pack of cigarettes (up from 25cents in 2002), is one of the lowest (41st) in the nation. Many states utilize all or a portion of this tax and some portion of Tobacco Master Settlement Funds to reduce tobacco use (a contributing cause of many cancers and other chronic diseases) and offset cancer costs.

The Centers for Disease Control and Prevention (CDC) recommends that Georgia spend between \$42.6 million and \$114.3 million annually on comprehensive tobacco use prevention programs. Georgia currently allocates \$2.4 million a year for tobacco prevention. This represents 5.4% of the minimum amount recommended by the CDC. As a result, Georgia is ranked 44th (among all states) in funding for tobacco prevention efforts.

Figure 7: Excise Taxes on Cigarettes in the USA (Jan 2006)



Reprinted from: Campaign for Tobacco-Free Kids, December 7, 2006 / Eric Lindblom

WORKFORCE

Providers and Researchers

Over the past five years the GCC and other organizational partners established programs that have expanded the number of world-class experts engaged in cancer care and research at Georgia's universities and medical centers. These experts include medical and non-medical researchers and providers of care.

Professional trade associations, medical schools, educational institutions, and Georgia's network of Area Health Education Centers continue to encourage and attract individuals to pursue careers in cancer care. In many instances mechanisms to retain qualified professionals in cancer research, treatment and care have also been identified.

One of the most successful of these programs – GCC's Distinguished Cancer Clinicians and Scientists – continues its growing contribution to an increased understanding of the causes and mechanisms of cancer pathophysiology. In so doing, the program has laid the groundwork for the development of more effective cancer diagnostics and therapies. These cancer clinicians/scientists as well as others who are presently engaged in prevention and treatment research are important assets to the traditional and translational research efforts laid out across the cancer control continuum in the revised plan.

Key Strategies for Sustainability

Funding:

- Advocate for more TMSF dollars for cancer control activities in keeping with CDC recommendations; at least 20% to prevention activities and 20% to detection, screening, and management programs.
- Advocate for incremental increase in excise tax on tobacco products to \$1.00 by 2010.
- Aggressively seek opportunities to leverage public sector allocations with matching private sector dollars to fund cancer control activities.

Workforce:

- Identify gaps that currently exist in training and work with relevant groups to ensure that providers and researchers are adequately trained.
- Establish processes that will engage new and existing providers/care-givers in training programs so that they might be regularly updated to incorporate new developments in cancer screening, detection, and treatment.
- Continue to promote educational and training opportunities that attract students and professionals to pursue careers in cancer research, treatment, and care giving.
- Maintain standards of excellence for healthcare training programs relative to cancer prevention, screening, detection, and treatment.
- Assess the ability of existing training programs to meet those standards of excellence and work with the institutions and organizations that deliver the training to adjust those programs as necessary to meet these standards.

IMPLEMENTATION AND EVALUATION OF CANCER CONTROL PLAN

At the end of the revision process the Steering Committee will transition its role to that of an Oversight Committee for plan implementation over the next five years. The Oversight Committee will assess its present membership and invite the participation of other stakeholders, either as members of this group or as members of an Implementation Planning Consortium (IPC). Work Group members who have been engaged in the planning process are invited to participate as volunteer members of the Consortium. Additionally, efforts will be made to recruit legislators and third party payors as a part of this group.

The Consortium is established to provide operational details of the revised plan and to ensure recommended strategies from the Work Groups are synchronized with other state level efforts. The group is also charged with the responsibility of producing a strategic implementation plan that will serve as a complementary document to the State Cancer Plan.

The Consortium in its role will address the following questions:

- What are the gaps and which programs and interventions will close them?
- What needs to be done, by when, and who will be responsible?
- What are the program costs and where might the necessary resources be found?
- What are the priorities?
- How will the plan be rolled out?
- What is the influence of the political context (federal, state, and local)?
- What is the best evaluation structure to support the Plan?

Specifically the deliverables of the Consortium will include:

- Assessment of present cancer care stakeholder activity across the state.
- Action/Process model for implementation of the Cancer Plan over the next five years.
- A definition of the structure, or changes to the structure, that will be necessary for the Plan to be achieved.
- Identification of members for an Accountability Review Team that will ensure that the implementation of the Plan is culturally appropriate.
- Institutionalized adoption and use of the 52 IOM-recommended “dashboard” measures across the state.
- An Evaluation Plan and timeline.

The Consortium will work on the budgetary details of the Plan to assist the Oversight Committee and its leadership group in leveraging both public sector and private sector resources and commitment. The Oversight Committee and Consortium’s work will inform the state budget conversations in November 2007.

During the Winter of 2007/2008, which would mark the end of this planning process, the Georgia Cancer Coalition will convene stakeholders in cancer control from across the state to bring attention to the Plan and gain its ratification.

This revised plan represents the collective efforts of more than 100 Georgians living and working throughout the state. This effort continues to be driven by the passion of stakeholders to ensure the plan is implemented, and it remains a “living” document with its next scheduled revision slated for Spring 2012.

APPENDICES

APPENDIX A – ACRONYMS AND ABBREVIATIONS

ACR	American College of Radiology
ACS	American Cancer Society
ACoS	American College of Surgeons
AHRQ	Agency for Healthcare Research and Quality
AJCC	American Joint Committee on Cancer
ASCO	American Society of Clinical Oncology
BCS	Breast Conserving Surgery
BMI	Body Mass Index
BRFSS	Behavioral Risk Factor Surveillance System
caBIG	Cancer Biomedical Informatics Grid
CAP	College of American Pathologists
Cancer Scholars	Distinguished Cancer Clinicians and Scientists
CDC	US Centers for Disease Control and Prevention
CHA	Community Health Advisors/Advocates
CME	Continuing Medical Education
CoC	American College of Surgeons Commission on Cancer
DHR	Georgia Department of Human Resources
DRE	Digital Rectal Examination
EMR	Electronic Medical Records
Exchange (The)	Georgia Cancer Quality Information Exchange
FOBT	Fecal Occult Blood Test
GaRHIO	Georgia Regional Health Information Organization
GCCR	Georgia Comprehensive Cancer Registry
GED	General Educational Development Test
Georgia CORE	Center for Oncology Research and Education
GRITS	Georgia Registry of Immunization Transactions and Services
HIMSS	Healthcare Information and Management Systems Society
HITT	Health Information Technology and Transparency
HL7	Health Level Seven, Inc.
HPV	Human Papilloma Virus
IOM	Institute of Medicine of the National Academies
MERP	Medication Error Reporting and Prevention
MOU	Memorandum of Understanding
NCCN	National Comprehensive Cancer Network
NCI	National Cancer Institute
NPAP	Nutrition and Physical Activity Plan (Georgia)
PI	Principal Investigator
PSA	Prostate Specific Antigen
PTA	Parent Teacher Association
RCCE	Regional Cancer Coalitions of Excellence
RFP	Request for Proposals
SEER	Surveillance Epidemiology and End Results Registry
USPSTF	US Preventive Services Task Force (AHRQ)
WIC	US Special Supplemental Nutrition Program for Women, Infants, and Children
YRBSS	Youth Risk Behavior Surveillance System

APPENDIX B – INSTITUTE OF MEDICINE RECOMMENDED METRICS (2005)**PREVENTION**

METRIC	GCCR CURRENT MEASURE
Adult smoking rate	Year 2004: 20%
Adolescent smoking rate	Year 2005: High School: 17% Middle School: 7%
Smokers who receive advice to quit	Georgia Year 2004: 67%
Smokers who are recommended pharmacotherapy to assist in quitting smoking	Georgia 2004: 30% Among smokers who saw a health care provider in the past year.
Adult obesity rate	Year 2004: 25% White: 22.6% Black: 32%
Age-Adjusted cancer incidence rate (all sites)	Year 1999-2003: Males: 570/100,000 Females: 394/100,000
Age-Adjusted breast cancer incidence rate	Year 1999-2003: Females: 124/100,000
Age-Adjusted colorectal cancer incidence rate	Year 1999-2003: Males: 62/100,000 Females: 44/100,000
Age-Adjusted lung cancer incidence rate	Year 1999-2003: Males: 109/100,000 Females: 53/100,000
Age-Adjusted prostate cancer incidence rate	Year 1999-2003: Males: 166/100,000

EARLY DETECTION AND SCREENING

METRIC	GCCR CURRENT MEASURE
Breast cancer screening rate	Year 2004: Females 52-69: 80% Females 55-64: 79% Females 65 and older: 73% Females 40 and older, low income <15,000: 57% Females 40 and older, with no access to medical care: 57%.
Colorectal cancer screening rate	Year 2004: FOBT age 52-80: 46% Sigmoidoscopy/Colonoscopy age 52-80: 56%
Early-stage breast cancer diagnosis	Years 1999-2003: Early stage at diagnosis: 69%
Advanced stage breast cancer diagnosis	Years 1999-2003: Incidence advanced-stage for women 40 and older: 95/100,000
Advanced stage colorectal cancer diagnosis	Years 1999-2003: Incidence advanced-stage for adults 50 and older: 94/100,000

DIAGNOSIS AND STAGING

METRIC	GCCR CURRENT MEASURE
Timely breast cancer biopsy	Pending: GA Linked SEER and Medicare dataset/Georgia Pattern of Care Study (POC)
Use of needle biopsy in breast cancer diagnosis	Pending: GA Linked SEER and Medicare dataset/Georgia Pattern of Care Study (POC)
Tumor-free surgical margins in breast-conserving surgery	Pending: Field available from ACOS hospital only/Georgia Pattern of Care Study (POC)
Appropriate histological assessment of breast cancer	Years 1999-2003: Local and Regional Stage Breast Cancer with appropriate histological assessment of breast cancer: 70%
Appropriate histological assessment of colorectal cancer	Years 1999-2003: Appropriate histological assessment of colorectal cancer: 34%
Pathology laboratories' compliance with reporting standards for cancer surgical specimens	Pending: ACOS hospitals required to follow this guidelines/Special Studies compliance with CAP protocol/Georgia Pattern of Care Study (POC)
Adequacy of pathology reports on colorectal cancer surgical specimens	Not Available
Adequacy of pathology reports on lung cancer surgical specimens	Not Available
Adequacy of pathology reports on prostate cancer surgical specimens	Pending: ACOS hospitals required to follow this guidelines/Special Studies compliance with CAP protocol/Georgia Pattern of Care Study (POC)
Breast cancer stage determined before treatment	Pending: Georgia Pattern of Care Study (POC)
Colorectal cancer stage determined before treatment	Not Available
Lung cancer stage determined before treatment	Not Available
Prostate cancer stage determined before treatment	Pending: Georgia Pattern of Care Study (POC)
Adequacy of pathology reports on breast cancer surgical specimens	Pending: ACOS hospitals required to follow this guidelines/Special Studies compliance with CAP protocol/Georgia Pattern of Care Study (POC)

TREATMENT AND PALLIATION

METRIC	GCCR CURRENT MEASURE
Cancer patients' participation in clinical trials	Not Available
Inappropriate hormonal therapy before radical prostatectomy	Pending: Georgia Pattern of Care Study (POC)
Appropriate external beam radiation therapy (EBRT) doses for prostate cancer	Pending: Georgia Pattern of Care Study (POC)
Appropriate hormonal therapy with EBRT for prostate cancer	Pending: Georgia Pattern of Care Study (POC)
Adjuvant radiation after breast-conserving surgery	Years 1999-2003: Percent of women received radiation treatment within 8 weeks of BCS: 27%
Adjuvant hormonal therapy after invasive breast cancer	Years 1999-2003: Percent of women with breast cancer who receive adjuvant hormonal therapy for hormone-receptor-positive cancer >1cm in size: 37%
Adjuvant combination chemotherapy for breast cancer	Years 1999-2003: Percent: 46%
Adjuvant chemotherapy after colon cancer surgery	Years 1999-2003: Percent: 33%
Follow-up mammography after treatment for breast cancer	Pending: Georgia Pattern of Care Study (POC)
Follow-up colonoscopy after treatment for colorectal cancer	Not Available
Prevalence of pain among cancer patients	Not Available
Cancer deaths in hospice	Currently being investigated
Cancer patients' length of stay in hospice	Not Available

OVERARCHING

METRIC	GCCR CURRENT MEASURE
Breast cancer 5- and 10-year survival rates	5 Years Survival rate 1995-2002 Metro-Atlanta (Clayton, Cobb, Dekalb, Fulton, and Gwinnett): 87%
Colorectal cancer 5- and 10-year survival rates	5 Years Survival rate 1995-2002 Metro-Atlanta (Clayton, Cobb, Dekalb, Fulton, and Gwinnett): 62%
Lung cancer 5- and 10-year survival rates	5 Years Survival rate 1995-2002 Metro-Atlanta (Clayton, Cobb, Dekalb, Fulton, and Gwinnett): 16%
Prostate cancer 5- and 10-year survival rates	5 Years Survival rate 1995-2002 Metro-Atlanta (Clayton, Cobb, Dekalb, Fulton, and Gwinnett): 100%
Breast cancer mortality rate	Age-Adjusted Breast Cancer Mortality Rate 2000-2004: 26/100,000 Black Females: 31/100,000 White Females: 24/100,000
Colorectal cancer mortality rate	Age-Adjusted Colorectal Cancer Mortality Rate 2000-2004: 19/100,000 Males: 23/100,000 Black males: 32/100,000 White males: 22/100,000 Females: 16/100,000 Black Females: 24/100,000 White Females: 14/100,000
Lung cancer mortality rate	Age-Adjusted Lung Cancer Mortality Rate 2000-2004: 60/100,000 Males: 89/100,000 Black males: 96/100,000 White males: 88/100,000 Females: 41/100,000 Black Females: 31/100,000 White Females: 44/100,000
Prostate cancer mortality rate	Age-Adjusted Prostate Cancer Mortality Rate 2000-2004: 33/100,000 Black males: 69/100,000 White males: 25/100,000
All cancers mortality rate	Age-Adjusted All Cancer Mortality Rate 2000-2004: 200/100,000 Males: 260/100,000 Black Males: 329/100,000 White males: 246/100,000 Females: 163/100,000 Black females: 160/100,000 White females: 179/100,000

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