



Michigan Cancer Consortium Initiative

2006 Strategic Plan

Last Updated 6/1/06

Public and private partners working together to achieve
cancer control priorities in Michigan



Introduction

The Michigan Cancer Consortium (MCC) was established in 1987 as a statewide network of cancer experts to advise and assist the Michigan Department of Community Health in its cancer prevention and control efforts. Over the years, the MCC broadened its mission as well as its membership base. In 1997, the MCC changed from a consortium of individual cancer control experts to a consortium of organizations dedicated to reducing the impact of cancer on Michigan citizens. The consortium's mission is as follows:

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

Since its inception in 1987, the consortium consistently has been at the forefront of cancer prevention and control efforts. In fact, officials of the Centers for Disease Control and Prevention have hailed the consortium and its accomplishments as a model for the nation.

The MCC consists of approximately 80 member and key partner organizations. These member and key partner organizations represent eight different types of organizations. The organizational types include:

- 1) Health Care Delivery Systems with Cancer Programs
- 2) Health Care/Primary Care Delivery Systems and Practices
- 3) Health Care Insurance Plans
- 4) Health Care Purchasers (e.g., employers, unions)
- 5) Public Health
- 6) Trade/Professional Organizations
- 7) Health Education/Health Research and Evaluation
- 8) Organizations Representing or Serving Hard To Reach and/or Special Populations

The cornerstone of the MCC's current efforts is the MCC Initiative. The MCC Initiative is an innovative approach to comprehensively fighting cancer through prevention, early detection, treatment, rehabilitation, palliation, and end-of-life care.

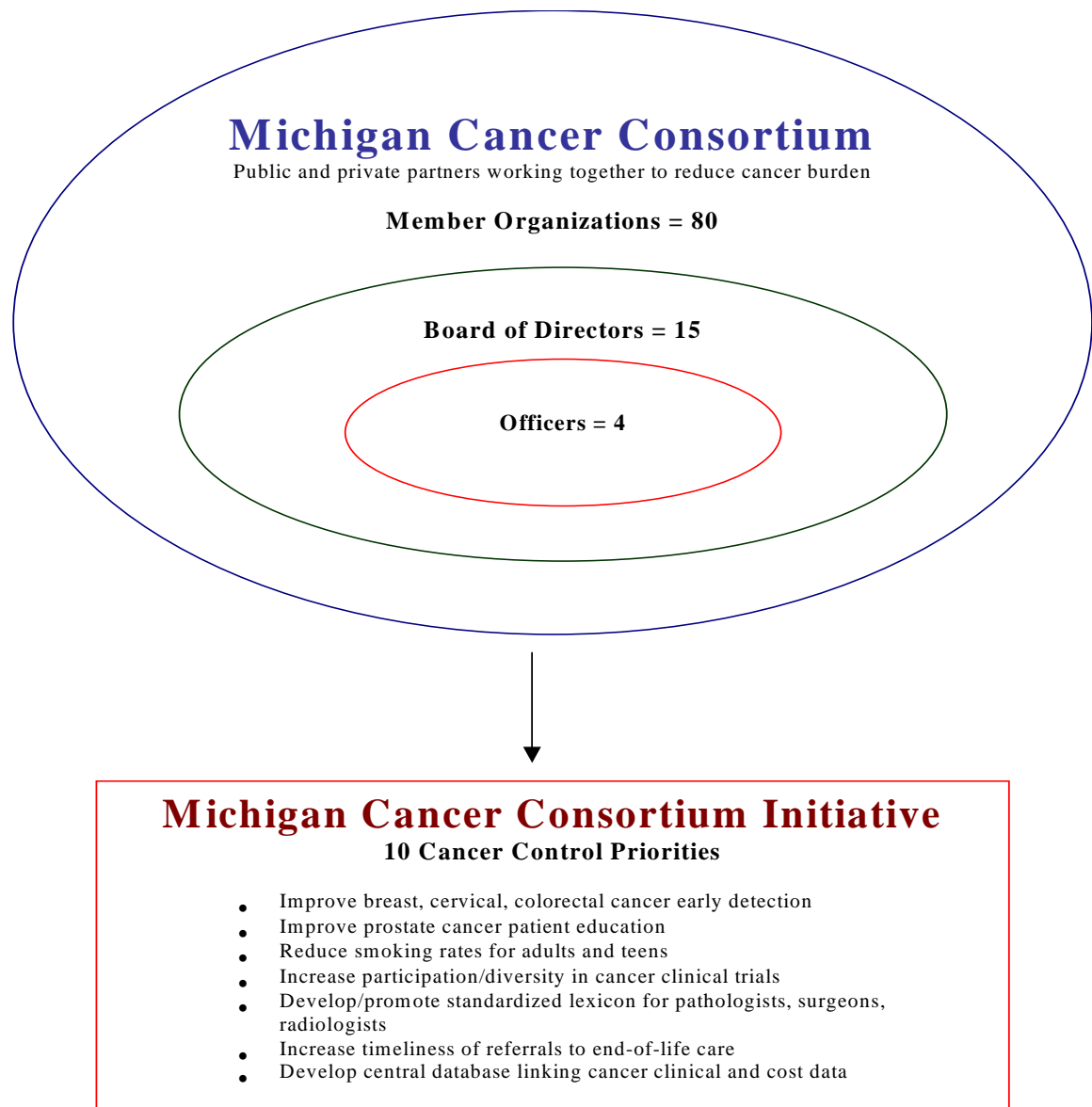
The three main goals of the Initiative are:

- 1) To significantly reduce cancer morbidity and mortality in Michigan
- 2) To establish and maintain a collaborative process to identify and achieve cancer-control priorities
- 3) To achieve cost-effective resource utilization for cancer control

The MCC Initiative has developed a strategic plan for directing cancer control efforts to achieve its three main goals. The MCC Initiative Strategic Plan represents the collective wisdom of a wide range of individuals and organizations in our state, from nationally recognized cancer

experts to state health care leaders to health care providers to insurers to representatives of community-based organizations, all working together to achieve a common priority. Please see *Figure 1* for more information on the relationship between the MCC and the MCC Initiative.

Figure 1 – Relationship Between the MCC and the MCC Initiative



The MCC Initiative Strategic Plan is comprised of specific planned objectives and strategies to address each of the ten MCC priorities. Priority-specific plans provide a concise overview of the priority, including progress markers, why the priority is important, and what needs to be done to achieve the priority with key references that support this data/evidence-driven process. These priority strategic plans encompass what Michigan cancer control experts believe to be the most

important activities that can be addressed during the next few years that will reduce the toll of cancers that currently pose the greatest burden to public health in Michigan. To help facilitate achievement of each priority, specific strategies are recommended for MCC member organizations to implement. Nine strategic plans have been developed and are summarized in this document.

With the assistance of its expert advisory committees, the MCC Board of Directors has been evaluating progress made by MCC member and partner organizations toward achievement of the MCC's 10 priorities. As part of the MCC priority review process, the strategic plans for each revised priority are also being updated. The footer at the bottom of page for each priority strategic plan indicates when the priority-specific strategic plan was last updated or will next be reviewed. The MCC priorities and strategic plans are reviewed biennially unless a change in the science necessitates otherwise.

The MCC Initiative truly is a groundbreaking effort with far-reaching impact. Its goals will be accomplished through the cooperative, collaborative efforts of dozens of public and private partners throughout our state. It is expected to produce a synergy statewide and at the community level and to have an overall impact far greater than that which might have been accomplished by these agencies, organizations, and individuals working independently of one another.

By working together, we truly will make a difference in the health and quality of the life in our state. We will be taking great strides toward eliminating the social, personal, and economic costs that cancer imposes on our families, friends, and neighbors and together we will realize a healthier tomorrow for all our citizens.

We invite you to join with us in this important effort. If you would like more information about the initiative and how you can become involved, please contact MCC Initiative Coordinator, Patty Brookover at 517-335-9620 or brookoverp@michigan.gov.



10 Priorities of the Michigan Cancer Consortium Initiative

Breast Cancer:

By 2010, 80 percent of Michigan women will receive:

- Age and risk-appropriate breast cancer screening with clinical breast examination and mammography
- Information/education on age and risk-appropriate screening and preventive services for breast cancer.

Cervical Cancer:

By 2010, the incidence of invasive cervical cancer in Michigan women will be reduced by 50 percent.

- Ninety-seven percent of women over age 21, or 3 years after the onset of sexual activity, will have had a Pap test at least once in their lifetime.
- Ninety percent of women over age 21 will have had a Pap test within the last 2 years.

Colorectal Cancer:

By 2010, increase to 75 percent the proportion of average-risk people in Michigan who report having received appropriate colorectal cancer screening and appropriate follow-up of abnormal screening results.

Lung Cancer:

By 2010, reduce the overall Michigan adult (18 years +) cigarette smoking prevalence from the 2003 level of 25.8% to 15%.

By 2010, reduce the proportion of Michigan youth (grades 9-12) who report smoking cigarettes during the past 30 days from the 2003 level of 22.6% to 16%.

Prostate Cancer:

By 2006, prostate cancer patients will have their knowledge and understanding of localized prostate cancer, treatment options, side effects, and quality-of-life issues measured by patient surveys, with findings used to develop, disseminate and evaluate patient education materials.

Clinical Cancer Trials:

By 2006, double the number and increase the diversity of participants enrolled in clinical cancer research.

Clinical and Cost Data:

By 2008, develop the linked economic and clinical database and infrastructure necessary to support data-driven decisions for control of breast, cervical, colorectal, lung, prostate, and other cancers within the state of Michigan.

End-of-Life:

By 2010, prevent and reduce avoidable suffering up to and during the last phase of life for persons with cancer as measured by specific data markers.

Basic Lexicon:

By 2006, finalize, disseminate, and evaluate basic pathology lexicons for breast, prostate, colorectal, cervix, and lung cancers to include information for making prognostic and treatment decisions. Further expand the number of pathology lexicons to include all common cancer types to enhance their adoption as a reporting system.



Breast Cancer Priority Strategic Plan

Breast Cancer Priority:

By 2010, 80 percent of Michigan women will receive:

- *Age and risk-appropriate breast cancer screening with clinical breast examination and mammography*
- *Information/education on age and risk-appropriate screening and preventive services for breast cancer.*

Progress Markers

How will the MCC know if progress is made toward achieving the Breast Cancer Priority? The following markers will be measured by Behavioral Risk Factor Surveys to evaluate progress toward the priority:

- Number of women age 40 and older who received a mammogram within the preceding year.
- Number of women age 40 and older who received a clinical breast exam within the preceding year.
- Number of women who received information/education on risk-appropriate preventive services for breast cancer.

Why This Priority Is Important

In 2001, there were 7,092 new cases of breast cancer diagnosed in Michigan women. Of those, 60.1 percent were found at the localized stage, a stage at which women statistically have a 97.5 percent chance of surviving five years.

Another 26.7 percent were diagnosed at the regional stage, when women statistically have a 80.4 percent chance of surviving five years.

It is generally agreed that an increase in the use of screening mammography has led to earlier diagnosis and, as a result, fewer deaths from breast cancer. Yet, despite this knowledge, 1,508 Michigan women in 2002 lost their lives to breast cancer. During 2002, Michigan women lost a total of 29,588 person-years of life to breast cancer with white women losing an average of 19.0 years and black women losing an average of 20.7 years.¹

What Needs To Be Done

Although the data from Behavioral Risk Factor Surveys have shown a statistically significant increase in the proportion of Michigan women age 50 and older that receive appropriate breast cancer screening (70.3 percent), this percentage is still below the 80 percent goal.

Much research has been done regarding breast cancer risk factors in women. Assessment is not performed consistently to identify women at high risk for developing breast cancer. During 2002, only 20.9 percent of women reported having discussed breast cancer chemoprevention and risk assessment with their providers.

To lower breast cancer incidence and mortality rates, barriers need to be identified that prevent women from obtaining breast cancer screening and follow-up services. In addition, information/education on age and risk-appropriate screening and preventive services for breast cancer need to be addressed with women and health care providers.

The MCC Breast Cancer Advisory Committee has identified specific objectives and strategies that need to be implemented to achieve this priority.² These objectives and strategies are as follows:

Objective #1

By 2010, 80 percent of women age 40 and older will:

- receive a mammogram within the preceding year.
- receive a clinical breast exam within the preceding year.

Strategies:

- Determine reasons why women are not being screened.
 - Continue to implement surveys that will support evaluation of the objectives.
 - Explore other data sources that are available besides surveys.
 - Review and modify questions in surveys as needed based on data review.
 - Analyze county data to determine trends in mammography patient workloads.

**All MCC member organizations can participate in this strategy.*
- Collaborate to identify processes that:
 - Facilitate promotion of appropriate breast cancer screening by primary care providers.
 - Promote public health education regarding breast cancer screening.
 - Promote professional education/information among providers regarding MCC Breast Cancer Screening Guidelines.
 - Facilitate provider access to trainings for specific clinical skills (i.e., clinical breast exams).
 - Promote universal access to breast cancer screening by all women.
 - Increase accessibility and responsibility of Health Systems.

- Explore opportunities for advocacy and policy considerations that affect the provision of screening and diagnostic services to women.
- Expand the Breast and Cervical Cancer Control Program to reach more eligible women.
- Increase access to convenient, flexible screening services (e.g., weekend, night hours, etc.).

**All MCC member organizations can participate in this strategy.*

Objective #2

By 2010, 80 percent of women will receive information/education on risk-appropriate preventive services for breast cancer.

Strategies:

- Collaborate to:
 - Develop methodology to obtain data needed to evaluate the objective.
 - Develop and implement a plan to test the Breast Cancer Risk Assessment Management Guidelines in primary care provider settings.

**All MCC member organizations can participate in this strategy.*
- Develop a position paper position paper on Magnetic Resonance Imaging (MRI) and other Imaging Technologies for Screening High-risk Women.

**Breast Cancer Advisory Committee Risk Assessment workgroup members and MCC Advisory Committees can participate in this strategy.*
- Develop a comprehensive cancer risk assessment (that includes breast, colorectal, and other identifiable cancers) used in primary care settings.

**Breast Cancer Advisory Committee Risk Assessment workgroup members and MCC Advisory Committees can participate in this strategy.*
- Determine the process for disseminating comprehensive cancer risk assessment to MCC member organizations and other providers throughout Michigan.

**Breast Cancer Advisory Committee Risk Assessment workgroup members can participate in this strategy.*

Endnote

1. Whenever possible, the data quoted in this strategic plan are the most recent available. Frequently there is a 12- to 18-month interval between the time a cancer is diagnosed and the time that information is available from the Michigan Cancer Registry. However, cancer mortality data for any given year generally are available from the Registry within several months after the close of that calendar year. Hence, the cancer-related mortality data that are available often are more recent than the available cancer-related incidence data.
1. For a complete list of the Breast Cancer Advisory Committee members and the references used to determine these strategies, please visit the MCC website at <http://www.michigancancer.org>.



Cervical Cancer Priority Strategic Plan

Cervical Cancer Priority:

By 2010, the incidence of invasive cervical cancer in Michigan women will be reduced by 50%.

- Ninety-seven percent of women over age 21, or 3 years after the onset of sexual activity, will have had a Pap test at least once in their lifetime.
- Ninety percent of women over age 21 will have had a Pap test within the last 2 years.

Progress Markers

How will the MCC know if progress is made toward achieving the Cervical Cancer Priority? The following markers will be measured by Behavioral Risk Factor Surveys, Cancer Registry data, and other assessments to evaluate progress toward the priority:

- Invasive cervical cancer incidence rate.
- Number of women age 21, or 3 years after the onset of sexual activity, who have had a Pap test at least once in their lifetime.
- Number of women over age 21 who have had a Pap test within the last 2 years.
- Number of patient education efforts.
- Number of provider education efforts.
- Number of health care policies initiated by legislature.

Why This Priority Is Important

Death from cervical cancer is considered to be preventable, and no one should die from cervical cancer. Yet, 114 women in Michigan died of the disease in 2002.

During 2001, 428 women in Michigan were diagnosed with invasive cervical cancer. Approximately 23 percent of these women were between the ages of 25 and 39; 27 percent were between 40 and 49; 27 percent were between 50 and 64 years old; and 22 percent were 65 years of age or older.

During the Year 2002, Michigan women lost a total of 2,917 person-years of life to cervical cancer, with an average of 25.6 years of life lost per person.

The Pap test is the most efficient cancer screening procedure known to medicine. Although very effective, it is not perfect. Most precancerous abnormalities affecting the uterine cervix are very slow in developing. Pap tests can detect cellular abnormalities before they develop into cancer. Evidence strongly suggests that regular screening with Pap tests decreases mortality from

cervical cancer, as about sixty percent of women who die of cervical cancer have not had a Pap test in the last five years.

Experts believe that virtually all cervical cancer deaths could be prevented by a combination of safe sex practices, routine Pap tests, and appropriate follow-up and treatment of abnormal screening results. Yet, research indicates that certain groups of women do not get regular Pap tests.

What Needs To Be Done

To lower cervical cancer incidence and mortality rates, the barriers to screening must be addressed. These barriers include patient, provider, and/or health care system aspects. There is also a need to understand why cervical cancer is developing in particular individuals and what is unique to those individuals.

More than 96 percent of Michigan women age 18 and older have received at least one Pap test during their lifetime. But only 85 percent of Michigan women age 18 and older have received a Pap test within the past three years. Women less likely to receive cervical cancer screening within the past three years include those with low incomes, those with less than a high school education, and those who are over the age of 60.

The MCC Cervical Cancer Advisory Committee has identified specific objectives and strategies that need to be implemented to achieve this priority.² These objectives and strategies are as follows:

Objective #1

Increase patient education efforts regarding cervical cancer screening.

Strategies:

- From within targeted communities, identify and train male and female peer spokespersons to help develop and disseminate prevention messages to community members.
**Organizations representing or Serving Hard to Reach Special Populations can participate in this strategy.*
- Identify unique community leaders and educate them in order to increase screening rates.
**Organizations representing or Serving Hard to Reach Special Populations can participate in this strategy.*
- To promote screening, develop a narrowly targeted message that is culturally specific and disseminate through small, local, culturally specific media.
**Organizations representing or Serving Hard to Reach Special Populations can participate in this strategy.*

- Provide education through media, targeting January (Cervical Cancer Awareness Month)
 - Education should follow the Breast Cancer model of awareness.
 - Education should be in the medical sections of newspapers and use cancer support groups to educate the public.
 - Increase screening efforts to women in substance abuse treatment centers and homeless/domestic violence centers.

**All MCC organizations can participate in this strategy.*
- Before college admission physical, provide information to university students to ask provider about Pap test.

**MCC Key Partner organizations can participate in this strategy.*

Objective #2

Increase provider education efforts regarding cervical cancer screening.

Strategies:

- Educate all Michigan health care providers on MCC cervical cancer screening guidelines early and often.
 - Mail MCC cervical cancer screening guidelines to all Michigan providers.
 - Review cervical cancer screening guidelines in health care provider curriculum.
 - Provide MCC cervical cancer screening guidelines to all health care provider students.
 - Include one-page MCC cervical cancer screening guidelines summary in professional organizations' newsletter.

**All MCC member organizations can participate in this strategy.*
- Provide information to Emergency Department physicians regarding the suggestion to include information on possible need for Pap testing on Emergency Department Discharge Instructions.

**Health Care / Primary Care Delivery Systems and Practices can participate in this strategy.*
- Encourage providers to offer Pap testing, as appropriate, to women who present for STI screening.

**Health Care / Primary Care Delivery Systems and Practices can participate in this strategy.*
- Provide education through media, targeting January (Cervical Cancer Awareness Month)
 - Education should follow the Breast Cancer model of awareness.
 - Education should be in the medical sections of newspapers.

- Increase screening efforts to women in substance abuse treatment centers and homeless/domestic violence centers.
- *All MCC organizations can participate in this strategy.*

Objective #3

Influence health care policy reform.

Strategies:

- Require that Medicaid Managed Care contracts have a mechanism for incentives for adherence to MCC cervical cancer screening guidelines.
**Health Care Insurance Plans can participate in this strategy.*
- Create voucher-type program for uninsured/underinsured women who do not qualify for federal program to “purchase” Pap tests at lower costs.
**Health Care Insurance Plans and Health Care / Primary Care Delivery Systems and Practices can participate in this strategy.*
- Request funding for ongoing cervical cancer education for both providers and patients.
**All MCC member organizations can participate in this strategy.*
- Strongly recommend that pathologists provide correlation between the index Pap and the biopsy result on the report.
**Health Care / Primary Care Delivery Systems and Practices can participate in this strategy.*
- Explore feasibility of laboratories mailing Pap test reports to patients (similar in procedure to the mailing of mammogram reports).
 - Convene Cervical Cancer Advisory workgroup to evaluate current effectiveness of mammogram mailing data and determine baseline data on follow-up of abnormal Pap tests.
**Cervical Cancer Advisory Committee workgroup members can participate in this strategy.*
- Mandate that hospitals in Michigan offer Pap testing during hospital admissions for all eligible women who have not been screened within previous 18 months.
**Health Care / Primary Care Delivery Systems and Practices can participate in this strategy.*
- Address non-coverage by traditional third-party payment sources of prevention services such as Pap and HPV testing.
**Health Care Insurance Plans can participate in this strategy.*

- Provide uniformity in Cervical Cancer screening recommendations.
 - Medicaid and the Michigan Department of Community of Health should promote MCC screening guidelines to providers.
- *The Michigan Department of Community Health can participate in this strategy.*

Objective #4

Participate in Cervical Cancer Research Projects.

Strategies:

- Measure cervical cancer screening rates at the county level.
 - Analyze counties where screening rates are low.
 - Analyze demographics of non-screened populations and administer targeted surveys in those counties.
 - Target “low-screening” counties for intervention based on county level demographics and associated factors.
 - Use next iteration of Behavioral Risk Factor Surveys to evaluate impact of interventions.
 - Disseminate research results to interested parties.
- *Health Care Insurance Plans can participate in this strategy.*

Endnote

1. Whenever possible, the data quoted in this strategic plan are the most recent available. Frequently there is a 12- to 18-month interval between the time a cancer is diagnosed and the time that information is available from the Michigan Cancer Registry. However, cancer mortality data for any given year generally are available from the Registry within several months after the close of that calendar year. Hence, the cancer-related mortality data that are available often are more recent than the available cancer-related incidence data.
2. For a complete list of the Cervical Cancer Advisory Committee members and the references used to determine these strategies, please visit the MCC website at <http://www.michigancancer.org>

Colorectal Cancer Priority Strategic Plan

Colorectal Cancer Priority:

By 2010, increase to 75 percent the proportion of average-risk people in Michigan who report having received appropriate colorectal cancer screening and follow-up of abnormal screening results.

Progress Markers

How will the MCC know if progress is made toward achieving the Colorectal Cancer Priority? The following markers will be measured by Behavioral Risk Factor Surveys to evaluate progress toward the priority:

- Colorectal cancer screening rates in the Medicare population.
- The proportion of people younger than 60 years of age that have been screened for colorectal cancer for the first time.

Why This Priority Is Important

In Michigan, colorectal cancer is the fourth most commonly diagnosed cancer, with 5,363 new cases of colorectal cancer diagnosed in 2001. It is a cancer of both genders – 2,634 new cases were diagnosed in men in 2001, while 2,729 cases were diagnosed in women.

Colorectal cancer ranks second overall as a cause of cancer death in our state; lung cancer is the only other cancer that takes the lives of more men and women. In 2002, 1,935 Michigan residents died from colorectal cancer – 985 men and 950 women. Men are more likely than women to develop colorectal cancer and die. African Americans have higher colorectal cancer incidence and mortality rates than people of other racial groups.

During 2002, Michigan residents lost a total of 27,709 years of life to the disease, with an average of 14.3 years of life lost per person.

Most colorectal cancers can be traced back to a polyp, a non-cancerous growth in the inner walls of the colon and rectum. The longer a polyp goes undetected, the greater the chance that it will become cancerous.

Everyone is at risk of developing colorectal cancer. Men and women of all races are susceptible. The primary risk factor for colorectal cancer is increasing age, with more than 90 percent of cases being found in persons over the age of 50. A family history of colorectal cancer or colorectal polyps also increases the risk of developing colorectal cancer.

At the disease's earliest stages, there are virtually no symptoms. As it progresses, changes in the bowel movement patterns, bleeding, and abdominal discomfort may occur.

It is important to diagnose colorectal cancer early. With early diagnosis, treatment is possible and often successful. As the disease develops, it spreads through the large intestine and invades other organ systems. Survival from colorectal cancer is greatly decreased when the cancer has spread.

Survey data show that half (49.5 percent) of Michigan adults over age 50 report ever having at least one colorectal cancer screening exam.¹

What Needs To Be Done

The men and women in our state must be educated that appropriate screening can detect polyps, that removal of polyps can prevent the development of colorectal cancer, and that colorectal cancer is curable if detected early.

The key to patients, consumers, and health plans being more receptive to colorectal cancer screening methods is for providers to understand and advocate the importance of proper early detection, as well as prevention education, especially for individuals who are age 50 and older.

The MCC Colorectal Cancer Advisory Committee has identified specific objectives and strategies that need to be implemented to achieve this priority.² These objectives and strategies are as follows:

Objective #1

Increase the proportion of health care providers that recommend appropriate colorectal cancer screening.

Strategies:

- By 2006, develop measures to determine health care providers recommendation for appropriate colorectal cancer screening.
**The Colorectal Cancer Advisory Committee members and MCC Key Partner organizations can participate in this strategy.*
- By 2006, develop measures to determine if appropriate care for follow-up of abnormal colorectal cancer screening tests is being given.
 - When developing measures for screening and follow-up, there should be a review of existing literature addressing the full range of colorectal cancer tests.
 - Measures that are developed should be used for future monitoring of progress.**The Colorectal Cancer Advisory Committee members and MCC Key Partner organizations can participate in this strategy.*

- By 2006, disseminate revised MCC Recommendations for Colorectal Cancer Early Detection among health care providers and health plans in Michigan.
 - Coordinate efforts through the American Cancer Society, Great Lakes Division, Inc. and the Michigan Association of Health Plans.

**MCC Key Partner Organizations can participate in this strategy.*
- Repeat Knowledge, Attitudes, and Practice Survey that was completed in 1997 as a baseline measure.
 - Review original survey tool to determine if questions should be revised and/or added.

**MCC Key Partner Organizations and Health Care / Primary Care Delivery Systems and Practices can participate in this strategy.*

Objective #2

Assess status of health care provider training regarding appropriate colorectal cancer screening procedures.

Strategies:

- Survey the top 10 primary care provider training programs in Michigan to determine how many providers are being trained in sigmoidoscopy for cancer screening and the number of procedures required for training.
 - Compare results to national requirements for training and in screening procedures.

**MCC Key Partner Organizations and Health Education / Health Research and Evaluation Organizations can participate in this strategy.*

Objective #3

Continue to increase health plan commitment to colorectal cancer screening.

Strategies:

- Assess insurance coverage in Michigan for colorectal cancer screening through a collaborative project with insurers that develops a report by purchase groups.

**Health Care Insurance Plans can participate in this strategy.*
- Investigate collaborative projects with MPRO and Michigan Association of Health Plans regarding health care provider education conducted in office settings.

**Health Education / Health Research and Evaluation Organizations, Trade / Professional Organizations, Health Insurance Plans, and Health Care / Primary Care Delivery Systems and Practices can participate in this strategy.*

- Explore feasibility of a pilot project to address health care provider incentives, especially financial, that would contribute to the goal of increasing colorectal cancer screening rates.

**Health Care Insurance Plans and Health Care / Primary Care Delivery Systems and Practices can participate in this strategy.*

- Look at ways to educate and collaborate with employers/health care purchasers on colorectal cancer screening issues.

**Health Care Insurance Plans can participate in this strategy.*

Objective #4

Increase awareness of colorectal cancer risks, prevention, and testing for early detection.

Strategies:

- Maintain a focus on addressing health disparities that includes an understanding of barriers to colorectal cancer screening and effective strategies to overcome the barriers.
 - Review effective strategies used in the Breast and Cervical Cancer Control Program.
 - Document the cost of effective strategies.

**Organizations Representing or Serving Hard to Reach Special Populations, Public Health Organizations, and Health Education / Health Research and Evaluation Organizations can participate in this strategy.*

- Explore strategies to educate the public on colorectal cancer in combination with other screenings, e.g., mammograms.
 - Follow the results of the American Cancer Society, Great Lakes Division, Inc. pilot test of the cancer risk “wheel”.

**All MCC member organizations can participate in this strategy.*

- Develop effective strategies with attention to measurement and documentation of outcomes.
 - Consider how to maximize existing efforts that include compilation of resource materials for distribution, the Colorectal Cancer Awareness Network (CRAN), and the Buddy Bracelets.
 - Include new marketing strategies, focusing on links to celebrities such as Katie Couric.
 - Collaborate with new corporate partners, e.g., AARP. Consider a project that links Katie Couric’s existing CD with the Michigan AARP.

- Develop strategies that are ongoing throughout the year instead of focusing only on March as Colorectal Cancer Awareness Month.
- Examine ways to increase public knowledge about colorectal cancer risk factors, such as projects that use storytelling among African Americans.

*All MCC member organizations can participate in this strategy.

Endnote

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1. For a complete list of the Colorectal Cancer Advisory Committee members and the references used to determine these strategies, please visit the MCC website at <http://www.michigancancer.org>

Lung Cancer rity Strategic Plan

Lung Cancer Tobacco Priority:

By 2010, reduce the overall Michigan adult (18 years +) cigarette smoking prevalence from the 2003 level of 25.8% to 15%.

By 2010, reduce the proportion of Michigan youth (grades 9-12) who report smoking cigarettes during the past 30 days from the 2003 level of 22.6% to 16%.

Progress Markers

How will the MCC know if progress is made toward achieving the Lung Cancer Tobacco Priority? The Behavioral Risk Factor Surveillance System (BRFSS), the Adult Tobacco Survey, and the Youth Risk Behavioral Survey will be used to evaluate progress toward the priority:

- Number of Michigan adult (18 years +) cigarette smokers.
- Number of Michigan youth (grades 9-12) who report smoking cigarettes during the past 30 days.

Why This Priority Is Important

Tobacco use is the number one cause of lung cancer as well as the leading cause of all cancer deaths in the State of Michigan and the United States. In 2002, 5,665 Michigan men and women died of lung cancer attributed to smoking, and the financial health care cost burden for lung cancer alone exceeded three billion dollars. In addition, it is estimated that 2,500 non-smokers die each year from the effects of exposure to secondhand smoke, costing Michigan over 200,000 person-years lost to premature death and several billion dollars in lost productivity and health care expenditures.

Ninety percent of all lung cancers occur in people who smoke and ninety percent of all smokers start using tobacco before age 18. While the trend in youth smoking prevalence has decreased from greater than 35% in 1997 to 22.6 % in 2003, the adult smoking prevalence has remained 24% to 28% during the same period of time. The adult Michigan per capita cigarette consumption has increased from 20 cigarettes per day in 1997 to 24 cigarettes per day in 2002. The 2004 United States Surgeon General's Report states that smoking causes diseases in nearly every organ of the body and conclusively links smoking to the development of other types of cancers including acute myeloid leukemia and cancers of the mouth, larynx, pharynx, esophagus, cervix, kidney, pancreas, and stomach. Chronic illnesses and major causes of death also linked to tobacco use include heart disease, stroke, abdominal aortic aneurysms, pneumonia, emphysema, sudden infant death syndrome, and premature delivery in women who smoke.

The 2003 BRFSS revealed that less than half of all current smokers in Michigan reported that a health professional discussed cessation resources with them. This circumstance especially impacts Michigan communities of color and lower socioeconomic status because they experience an increased and disproportionate burden of tobacco use and tobacco-related morbidity and mortality. The 2003 BRFSS reported that tobacco use among African American adults (18 years +) was more prevalent than among white adults (27.3% vs. 25.6%) and the 2002 U.S. Department of Health and Human Services reported that 44.3% of American Indians (12 years+) used tobacco products. Older adult smoking prevalence (age 50 years +) in Michigan communities of color is highest in the African American (24.1%) and Arab American (23.0%) communities when compared to the general smoking prevalence rate (15.6%). The 2002 Michigan African American male lung cancer mortality rates of 100.9 were significantly disproportionate when compared to the 2002 Michigan white male lung cancer mortality rates of 71.9. The 2002 Michigan African American female lung cancer mortality rates of 47.6 also exceeded those of Michigan white females that were 43.9. In addition, the overall 2001 lung cancer mortality rates in Michigan exceeded the United States mortality rates (58.2 vs. 55.2).

What Needs To Be Done

The multi-faceted nature of tobacco use requires varied strategies to achieve the MCC priorities in the reduction of lung cancer morbidity and mortality. Fortunately, the Centers for Disease Control and Prevention has identified promising practices for sustaining comprehensive tobacco control, reducing tobacco-related disparities, and eliminating the public's exposure to secondhand smoke through implementation of smoke free policies, and increasing cessation rates among current smokers. Smoke-free policies have been proven to protect the public from the health dangers of secondhand smoke, as well as increase cessation and decrease youth initiation.

Upon review of these successful tobacco control initiatives, the MCC Lung Cancer Tobacco Priority Review Workgroup has identified specific objectives and strategies that need to be implemented to achieve this priority in collaboration with Michigan's Tobacco Control Program and the *Five-Year Strategic Plan for Tobacco Use Prevention and Reduction 2003-2008*. These objectives and strategies are as follows¹:

Objective #1

Eliminate the disproportionate burden of tobacco-related morbidity and mortality within the Michigan population, as measured by data from the Behavioral Risk Surveillance System (BRFSS) and the Michigan Cancer Surveillance System, Vital Statistics.

Baseline 2003 cigarette smoking prevalence rates in black adults (18 years+) = 27.3% vs. in white adults (18 years+) = 25.6%

Baseline 2002 Michigan lung cancer mortality rates for black males = 100.9 vs. white males = 71.9

Baseline 2002 Michigan lung cancer mortality rates for black females = 47.6 vs. white females = 43.9

Strategies:

- Engage individuals and organizations of vulnerable populations to help plan, implement, and evaluate tobacco control activities.
- Work with community-based groups that serve African American men to reduce the lung cancer death rate.
- Educate policymakers, community leaders, and health care plans about tobacco-related disparities in Michigan and the need for increased funding.
- Ensure adequate data collection for each vulnerable population in order to provide tobacco, economic, and health-related data to policymakers.
- Encourage MCC organizations to participate in research efforts that address the reduction of tobacco-related health disparities and cancer outcomes. (This strategy is consistent with the MCC Clinical Trials Priority Strategic Plan.)

**All MCC member organizations can address this objective and implement at least one strategy.*

Objective #2

Increase the percentage of Michigan residents who are protected by smoke-free regulations and laws for worksites and public places, including restaurants and bars, as measured by data from the Smoke-free Law Environments Law Project.

Baseline April 2005 percentage of Michigan residents covered by smoke-free worksite and public place regulations = 23.5%

Strategies:

- Actively participate in statewide advocacy for legislation to require smoke-free worksites and public places, including restaurants and bars.
- Enact 100% smoke-free campus policies at all:
 - Colleges, universities, and schools
 - Health care facilities and hospitals

- Volunteer to testify at local and state public hearings supporting statewide smoke-free legislation to require smoke-free worksites and public places, including restaurants and bars.
- Participate in grassroots education and advocacy projects through regional tobacco-free networks.
- Maximize public exposure to evidence-based media messages that promote smoking cessation and smoke-free environments.
- Utilize existing resources to promote smoke-free environments such as:
www.makemiairsmokefree.org
www.michigan.gov/tobacco
www.tcsg.org/sfelp/home.htm

**All member MCC organizations can address this objective and implement at least one strategy.*

Objective #3

Increase the percentage of adult (18 years +) smokers who receive counseling and referral to cessation resources by their health care provider as evidenced by:

- (a) the Behavioral Risk Factor Surveillance System (BRFSS)
- (b) the Health Plan Employer Data and Information Set (HEDIS) measure

Baseline 2003 BRFSS = 59 % of adult smokers report that they have never been advised about available cessation resources to help them quit

Baseline 2004 HEDIS = 8 of 17 Michigan managed care health plans fell below the national average of 66% (smokers and recent quitters who received medical advice to quit during the past year)

Strategies:

- Engage efforts by health care organizations and providers to promote the statewide Quitline (1-800-480-7848).
- Encourage all employers, health insurers, managed health care plans, and health care providers to assure employee and patient access to FDA-approved medications for smoking cessation.
- Integrate evidence-based tobacco cessation guidelines into hospital and health care plan policies.
- Encourage pediatric and family practice providers and other child health care workers to assess child exposure to secondhand smoke and recommend cessation services to parents and caregivers.
- Implement evidence-based clinical practice guidelines for tobacco cessation (including the 5 A's) in both inpatient and outpatient settings.
- Identify and utilize culturally sensitive and language-appropriate cessation services for all populations.
- Encourage MCC organizations to collaborate in research programs to improve smoking cessation rates and address relapse prevention.

- Include opportunities for providers, office managers, and other relevant health care workers to attend training and receive tobacco control resources at annual meetings and conferences.

**All MCC member organizations can address this objective and implement at least one strategy.*

Objective #4

Support a statewide comprehensive tobacco control program that is funded at a level consistent with the U.S. Centers for Disease Control and Prevention (CDC) recommendations.

Baseline CDC recommendation for Michigan annual tobacco control funding = \$55 to \$155 million

Baseline 2004 spending in Michigan for tobacco control = \$4.6 million

Strategies:

- Educate state legislators and other government officials about CDC recommendations for funding best practices in tobacco reduction and prevention.
- Communicate the cost-benefits of a sustained comprehensive tobacco control and prevention program to:
 - Medicaid officials
 - Michigan health care plans
 - Opinion leaders
 - State legislators and policymakers
- Participate in the four statewide Tobacco-Free Michigan implementation and evaluation workgroups (Eliminating Disparities, Smoke-free Air, Cessation, and Youth Tobacco Prevention).
- Advocate for increased and sustained funding for the Quitline and tobacco cessation medications from public and private funding sources including:
 - Tobacco settlement
 - Tax revenues
 - The Healthy Michigan Fund
 - General Fund revenues
- Engage pediatric and family practice providers in efforts to prevent initiation of youth smoking.

**All MCC member organizations can address this objective and implement at least one strategy.*

Endnote

1. For a complete list of the Lung Cancer Tobacco Priority Workgroup members and the references used to determine these strategies, please visit the MCC website at <http://www.michigancancer.org>



Prostate Cancer Priority Strategic Plan

Prostate Cancer Priority:

By 2006, prostate cancer patients will have their knowledge and understanding of localized prostate cancer, treatment options, side effects, and quality-of-life issues measured by patient surveys, with findings used to develop, disseminate, and evaluate new patient education materials.

Progress Markers

How will the MCC know if progress is made toward achieving the Prostate Cancer Priority? The following markers will be measured to evaluate progress toward the remaining priorities:

- Number of *Making the Choice: Deciding What to Do About Early Stage Prostate Cancer* booklets and audio sets that have been distributed or downloaded from the website www.prostatecancerdecision.org.
- Number of visits to the online format of *Making the Choice: Deciding What to Do About Early Stage Prostate Cancer* at www.prostatecancerdecision.org.
- Number of organizations that have created a linkage from their website to www.prostatecancerdecision.org.
- Number of organizations that distributed the patient education materials via their clinics, health education centers, conferences, or any other appropriate venue.
- Completion of collaborative evaluation study with the American Cancer Society, Great Lakes Division, Inc.
- Translation of the patient education materials into Arabic.

Why This Priority Is Important

Since 1991, prostate cancer has been the most frequently diagnosed cancer (other than skin cancers) in Michigan. In 2001, Michigan had the third highest incidence rate of prostate cancer in the nation; 8,662 Michigan men were diagnosed with prostate cancer. African American men in Michigan were diagnosed with prostate cancer at almost one and a half times the rate of Caucasian men in Michigan in 2001.

Prostate cancer was the second leading cause of cancer deaths among Michigan men during 2002 when 1,105 men in the state died of the disease. African American men are twice as likely as white men to die of the disease.

Nationally, of the 9.8 million cancer survivors in 2001, the 2nd largest group was prostate cancer survivors, 17% of the total.¹

What Has Already Been Achieved

Objective #1

Completion of patient survey of knowledge and understanding of localized prostate cancer, treatment options, side effects, and quality-of-life issues.

Strategies completed:

- Survey prostate cancer patients' knowledge of their disease and treatment options. Wei, et al. Published abstract.
- Determine strengths and weaknesses of other decision aids. Fagerlin A, Rovner DR, Stableford S, Wei, JT, Jentoft C, Holmes-Rovner M. Patient Education Materials about the Treatment of Early-Stage Prostate Cancer: A Critical Review. Annals of Internal Medicine (May, 2004); 140; 9 (721-728).

Objective #2

Findings from patient survey were used to develop new patient education materials, *Making the Choice: Deciding What to Do About Early Stage Prostate Cancer*.

Strategies completed:

- Develop and pilot test plain language decision aids available in booklet, audio and web formats. Holmes-Rovner M., Stableford S, Fagerlin, A, Wei JT, Kelly-Blake K, & Rovner DR. Combining shared decision making and health literacy: A prostate cancer prototype patient decision support. Under Revision BMC Informatics and Medical Decision Making.
- See completed decision aid at www.prostatecancerdecision.org.

What Needs To Be Done

The MCC Prostate Cancer Action Committee has identified specific objectives and strategies that need to be implemented to achieve this priority.² These objectives and strategies are as follows:

Objective #3

Facilitate the further distribution of *Making the Choice: Deciding What to Do About Early Stage Prostate Cancer* booklet, audio, and online formats by linking with MCC and other organizations and by developing novel institutional mechanisms for the distribution of the patient education materials.

Strategies:

- Create a linkage from your organization's website to the patient education materials' website (www.prostatecancerdecision.org). Please inform Judith Suess, MD, MPH, Prostate Cancer Project Coordinator, at jsuess@mphi.org or 517-324-7391 when this has been done.

**All MCC member organizations can participate in this strategy.*

- Distribute the patient education materials through your organization's conferences, newsletters, or any other appropriate venues. The patient education materials are available to Michigan individuals and organizations free of charge and can be ordered from 1-800-249-0314 or www.prostatecancerdecision.org. Free out of state orders are limited to 20 booklets and one audio set; larger out of state and all out of country orders are filled at cost. Contact Judith Suess, jsuess@mphi.org or 517-324-7391 for a description of the patient education materials, brief article on prostate cancer, or other information.

**All MCC member organizations can participate in this strategy.*

Objective #4

Collaborate with investigators to evaluate the readability, change in behavior, and cost resulting from the use of *Making the Choice: Deciding What to Do About Early Stage Prostate Cancer* by Michigan men.

Strategy:

- Conduct evaluation studies of the patient education materials.

**All MCC member organizations can participate in this strategy.*

Endnote

1. Whenever possible, the data quoted in this strategic plan are the most recent available. Frequently there is a 12- to 18-month interval between the time a cancer is diagnosed and the time that information is available from the Michigan Cancer Registry. However, cancer mortality data for any given year generally are available from the Registry within several months after the close of that calendar year. Hence, the cancer-related mortality data that are available often are more recent than the available cancer-related incidence data.
2. For a list of the Prostate Cancer Action Committee members and references used to determine these strategies, please visit the MCC website at <http://www.michigancancer.org>.



Clinical Cancer Trials Priority Strategic Plan

Clinical Cancer Trials Priority:

By 2006, double the number and increase the diversity of participants enrolled in clinical cancer research.

Progress Markers

How will the MCC know if progress is made toward achieving the Clinical Cancer Trials Priority? The following markers will be measured to evaluate progress toward the priority:

- Number of participants enrolled in clinical cancer research.
- Level of diversity of patients enrolled in clinical cancer research.

Why This Priority Is Important

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

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

What Needs To Be Done

In order to increase the number and diversity of participants enrolled in clinical cancer research, several challenges first must be overcome.

The MCC Clinical Cancer Trials Workgroup has identified specific objectives and strategies that need to be implemented to achieve this priority.¹ These objectives and strategies are as follows:

Objective #1

Measure clinical trial enrollment in Michigan.

Strategies:

- Champion importance of study with research investigators and managers – intervening with those who not respond to survey.
**All MCC member organizations can participate in this strategy.*
- Continue to seek financial support to complete project.
**All MCC member organizations can participate in this strategy.*

Objective #2

Address physician bias.

Strategies:

- Educate our medical colleagues about the benefits of referring their patients to physicians and institutions that participate in cancer clinical trials.
**All MCC member organizations can participate in this strategy.*
- Enhance the recognition, visibility, and credibility of those physicians and institutions that participate in cancer clinical trials.
**All MCC member organizations can participate in this strategy.*
- Highlight participation in clinical trials as a quality indicator for providers and institutions.
**All MCC member organizations can participate in this strategy.*

Objective #3

Influence patient and family attitudes.

Strategies:

- Educate cancer patients and their families about the benefits of participating in clinical trials.
**All MCC member organizations can participate in this strategy.*

- Work with patient advocacy groups to ensure awareness of Michigan clinical trial issues.
**All MCC member organizations can participate in this strategy.*
- Engage media/public press by 1) identifying and developing partnering opportunities with pharmaceutical companies using their marketing, education, and funding resources and 2) using editorial boards, local contacts in print, radio, and TV.
**All MCC member organizations can participate in this strategy.*

Objective #4

Resolve insurance coverage issues.

Strategies:

- Promote awareness of the Guidelines to providers, payers, and purchasers of health care.
**All MCC member organizations can participate in this strategy.*
- Include Phase I trials, Prevention and Screening Trials, in the Guidelines.
**All MCC member organizations can participate in this strategy.*
- Encourage long-term organization and funding of the Michigan Working Group to improve cancer outcomes.
**All MCC member organizations can participate in this strategy.*
- Establish a mechanism to review promising trials that do not fall within the “deemed” status criteria.
**All MCC member organizations can participate in this strategy.*
- Develop a registry of current “deemed” clinical trials in Michigan.
**All MCC member organizations can participate in this strategy.*

Objective #5

Increase clinical trials of under-represented populations.

Strategies:

- Collaborate with minority community thought leaders.
**All MCC member organizations can participate in this strategy.*

Objective #6

Expand access and infrastructure to support to community physicians by contributing to the growth of Community Clinical Oncology Programs and networks.

Strategies:

- Promote awareness and access to resources for community physicians to participate in trials.
**All MCC member organizations can participate in this strategy.*
- Support research managers' networking opportunities.
**All MCC member organizations can participate in this strategy.*

Endnote

2. For a complete list of the Clinical Cancer Trials Advisory Group members and the references used to determine these strategies, please visit the MCC website at <http://www.michigancancer.org>.



Clinical and Cost Database Infrastructure Priority Strategic Plan

Clinical and Cost Database Infrastructure Priority:

By 2008, develop the linked economic and clinical database and infrastructure necessary to support data-driven decisions for control of breast, cervical, colorectal, lung, prostate, and other cancers within the state of Michigan.

Progress Markers

How will the MCC know if progress is made toward achieving the Clinical and Cost Database Infrastructure Priority? The following markers will be measured by various assessments to evaluate progress toward the priority:

- Working group convened.
- Methodological issues outlined; data dictionary developed.
- Access and ownership policies of the databases are developed.
- Appropriate analytical questions, study proposals, and a strategic plan have been developed.
- Translational research has been field-tested.
- Other payers have become active in the Clinical and Cost Database Infrastructure Advisory Group.
- Funding for further studies using the databases has been obtained.
- Cross-institutional collaborations to expand the number of MCC member champions for this priority exist.

Why This Priority Is Important

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

Thus, when policy makers want to understand the scope and range of issues surrounding a

cancer intervention, the existing database or an enhanced version will provide better information than would have been obtained through a specialized survey. Real data from existing sources provide them with enough information to evaluate options, perform an economic analysis, and enhance the potential for accurate information. This maximizes the ability of health care policy makers and providers to make decisions that take into account both the cost and outcomes of various treatments, prevention strategies, and screening methods.

Like policy makers, cancer control practitioners and health systems must understand the clinical and economic implications of the decisions they make in order to maximize the benefits to their patients.

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

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

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

What Needs to be Done

A centralized, statewide economic and clinical cancer database for the state of Michigan should be established and maintained to track cost-effectiveness data on cancer treatment, interventions, and risk factors. The database should be accessible to all health care researchers, policy makers, and providers in the state to enable them to evaluate outcomes and compare them with costs, if desired.

To accomplish this, pilot projects must first be developed and run to determine whether it is feasible to select per-patient charge data from one or more payer databases and cross-link them with clinical data from another to create a new database containing both economic and clinical

data related to cancer.

If it can be established that it is feasible, useful, and affordable to do so, a standing, comprehensive statewide economic and clinical database for breast, cervical, colorectal, lung, and prostate cancers should be created in Michigan.

Members of the MCC's Clinical and Cost Database Infrastructure Advisory Committee¹ have developed a strategic action plan, with specific objectives and strategies, to address the questions surrounding the maintenance and expansion of a centralized database for breast, cervical, colorectal, lung, prostate, and other cancers. These objectives and strategies are as follows:

To Determine the Feasibility, Usefulness, and Affordability of a Centralized Database

Objective #1

Develop and implement procedures and policies for determining access to merged cancer-related cost and clinical databases by MCC members.

Strategies:

- Convene a working group to advise the MCC on methodological issues related to the use of these databases. These issues include the development of a useful data dictionary of the databases.
 - A collaborative stakeholder workgroup should be convened to:
 - 1) Agree upon a data dictionary written in a format that is understandable and useful to researchers wishing to use the database for further research;
 - 2) Clarify methodological issues that are related to the matching of these very large and complex databases; and,
 - 3) Decide the ownership issues that accompany the merging of several databases owned by federal, state, and other public or private entities.
 - Consensus should be reached regarding the benefits of maintaining a standing, comprehensive statewide economic and clinical cancer database that can be used by and provide important information that will benefit many partners in the cancer control community.
- * *The Clinical and Cost Database Infrastructure Advisory Committee can participate in this strategy.*
- Policies for access and ownership of databases will be developed.
 - * *The Clinical and Cost Database Infrastructure Advisory Committee can participate in this strategy.*

Objective #2

Design, develop and implement at least two translational applications using the merged clinical cost databases. These studies should be designed to show the utility of using the data to create policy change in systems.

Strategies:

- Convene advisory groups to formulate appropriate analytical questions and develop study proposals and a strategic plan to move forward on these studies.
** The Clinical and Cost Database Infrastructure Advisory Committee can participate in this strategy.*
- Conduct field testing to pilot access methodology; understand translational research into practice issues and to get cost estimates.
** The Clinical and Cost Database Infrastructure Advisory Committee can participate in this strategy.*

Objective #3

Implement and evaluate a statewide field test that adds charge data from Medicare, other managed care plans, self-insured plans, and other major health care payers in Michigan to the statewide cancer database demonstration process.

Strategy:

- Beside Medicaid, Medicare, and Blue Cross Blue Shield, other payers should be brought into the project.
 - Agreements for data have been obtained from Medicare and Medicaid, as well as one underway with Blue Cross Blue Shield. It is very important that as many other major health care payers in the state as possible be added to participate in a statewide cancer database.
 - In this way, Medicaid, Medicare and many managed care plans, self-insured plans, and other major health care payers in Michigan can be cross-linked with corresponding clinical data from the Michigan Cancer Registry to produce a single, comprehensive statewide economic and clinical database for breast, cervical, colorectal, lung, and prostate cancers.
**Health care insurance plans can participate in this strategy.*

To Establish and Maintain a Standing, Centralized Cancer Database

Objective #4

Implement a standing, comprehensive, statewide economic and clinical database for breast, cervical, colorectal, lung, prostate cancers and other cancers in Michigan.

Strategies:

- Encourage institutions to apply for funding for further studies using the databases.
**All MCC members can participate in this strategy.*
- Encourage cross-institutional collaborations to expand the number of MCC member champions for this priority.
**All MCC members can participate in this strategy*

Endnote

1. For a complete list of the Clinical and Cost Database Infrastructure Advisory Committee members and the references used to determine these strategies, please visit the MCC website at <http://www.michigancancer.org>.



End-Of-Life Priority Strategic Plan

End-of Life Priority:

By 2010, prevent and reduce avoidable suffering up to and during the last phase of life for persons with cancer as measured by specified data markers.

Progress Markers

How will the MCC know if progress is made toward achieving the End-of-Life Priority? From the Special Cancer Behavioral Risk Factor Survey (SCBRFS), these indicators will be tracked:

- Prevalence of severe pain as reported by family caregivers. *2004 baseline: 44.7%*
- Proportion of cancer decedents who die at home. *2004 baseline: 44.3%*
- Proportion of cancer decedents who use hospice services. *2004 baseline: 68.2%*

From the Michigan Hospice and Palliative Care Organization, the following indicator will be tracked:

- Median length of stay in hospice for cancer decedents (by diagnosis if possible).
2003 baseline for all hospice recipients including those with cancer: 17.5 days

Why This Priority Is Important

About 40 percent of persons with cancer do not survive five years after the original diagnosis. This fact alone argues for making sure that significant attention is paid toward ensuring that cancer patients receive quality care up to and during the last phase of life.

A number of factors seem to be in place to facilitate the use of end-of-life services. For example:

- We know from opinion polls that Americans prefer to die free from pain, and at home.
- Experts maintain that pain and symptoms can be controlled in at least 90 to 95 percent of cases.
- Michigan statutes have established the patient's right to 1) receive effective pain and symptom control in advanced illness, and 2) be informed about treatment choices.
- Laws protect physicians who appropriately prescribe controlled substances to ease people's suffering.

Nevertheless, input from Michigan citizens and stakeholders, and evidence from state surveys and assessment data, consistently show that too many people with cancer suffer needlessly during the last phase of life. In Michigan in 2004:

- 45 percent of cancer decedents suffered severe pain during their final months, as reported by caregivers.
- 48 percent of sampled hospice directors estimated that half or more new patients are admitted to hospice in severe pain.
- 40 percent of the hospice contacts estimated that half or more enrollees are ill informed about prognosis and treatment options.

And despite the fact that hospice is a proven model for pain and symptom relief, data suggest that it remains greatly underused. That is, while the total number of hospice recipients has grown steadily in Michigan over the past decade, median length of service has dropped from 25 days in 1996 to 17.5 days in 2003.

Also, while access to hospice has been higher at home than in hospitals or nursing homes, services tend to be provided late in the disease process - regardless of the location. In 2003, for example, 35 percent of hospice recipients in the state died in less than seven days. Others were referred so late that they died before they could be admitted for service. Although no one knows when the perfect time is to make a referral to end-of-life care, it is known that the benefits of this care - pain and symptom management, emotional and spiritual support, ease of caregiver burden - accrue over time, time which is too often cut short.

Where is the public outcry! Unfortunately, cancer patients and their caregivers do not know what kind of care is available to them to reduce suffering up to and during this last phase of life. Moreover, people have come to expect and accept misery at the end of life - misery that could be lessened if hospice or other palliative services were provided in a timely manner.

What Needs To Be Done

The MCC 2005 End-of-Life Advisory Committee¹ has established an admirable priority - By 2010, *prevent and reduce avoidable suffering up to and during the last phase of life for persons with cancer as measured by specified data markers*. This priority was established because of the belief that all Michigan residents with advanced, incurable cancer can and should have quality care up to and during the last phase of life.

The first question to be considered, therefore, has to be on evaluating the effectiveness of our efforts. That is, how is the MCC going to know that it has had a positive impact on reducing the burden of this problem? In recognition of this, the advisory committee identified, for its first objective, the need to establish additional indicators and sources of data.

The second objective - promote system change to increase access to palliative services throughout Michigan, resulted from the recognition that the only way to significantly reduce or eliminate the various end-of-life care problems is to address the systemic roots of the problems. Correspondingly, many of the strategies (activities) were identified based on asking the following question: What will not be addressed unless the MCC, an organization of numerous member organizations, addresses it?

It was further recognized by the advisory committee that educational efforts alone cannot impact these large and systemic public health issues. That is, educational efforts must happen within broader contexts. Given these limitations, the other two strategies include 1) building provider skills in palliative care, and 2) helping patients and caregivers understand their options for care up to and during the last phase of life - options which include relieving cancer pain and symptoms.

Lastly, the end-of-life plan - the priority, objectives, and strategies - was developed with the MCC's Guiding Principles closely in hand: evidence based; important to do now; feasible to address; and empowered by collaborative efforts.

Objective #1

Establish additional indicators and useful sources of data for monitoring end-of-life burden and progress related to cancer.

Strategies:

- Identify needed data elements (system, provider, patient) and explore availability from a variety of sources.
- Recommend methodology for data collection and management.

*Collaborators for Objective #1 may include health care delivery systems, cancer programs and practices, health insurance plans, trade and professional organizations, and health education / health research and evaluation organizations. To facilitate collaboration, it may be useful to convene a workgroup.

Objective #2

Promote system change to increase access to palliative services throughout Michigan.

*Baseline 2004 number and locations of hospitals with palliative care consultation teams: 20 hospitals in 10 counties.
Baseline 2004 proportion of nursing home cancer decedents who received hospice services: Not currently monitored, but available from the Minimum Data Set.*

Strategies:

- In order to best serve the needs of cancer patients up to and during the last phase of life, convene a forum to understand the perceived and actual competing interests of oncology practices, hospices, and palliative care programs. Identify and pursue approaches that would allow for the most appropriate use of the various services.

- Encourage oncology practices to participate in the Quality Oncology Practice Improvement project of the American Society of Clinical Oncology. Initial focus will be on assessing 1) pain measurements on the last clinic visit before death, and 2) the number of patients referred to hospice and their average hospice length of stay.
- Assess the availability and scope of palliative services in hospitals and long-term care facilities. Define scope of palliative care services using the clinical practice guidelines developed in 2004 by the National Consensus Project for Quality Palliative Care.
- Increase the number of hospitals and long-term care facilities that offer palliative care services by enabling consultations with hospices and palliative care programs that are recognized for their excellence. Best practices and lessons learned will be shared.
- Assess use of hospice services for nursing home residents with cancer, and determine reasons why hospice is or is not used.
- Evaluate the use and impact of the MDCH Process Guidelines for Pain Management in Long-Term Care Facilities. If indicated, seek to modify the guidelines to address unmet needs and implementation issues (e.g., problems with use of “as needed” analgesics).
- Seek collaboration and funding for at least one of the following projects:
 - Improve pain and symptom management of cancer patients treated in hospitals, long-term care facilities, and oncology practices.
 - Facilitate provider / patient communication about treatment options in advanced illness.
 - Reduce economic barriers to hospice care and other palliative services.

**Collaborators for Objective #2 may include all types of MCC member organizations. To facilitate collaboration, it may be useful to convene a workgroup.*

Objective #3

Increase the supply of health professionals who are trained in palliative techniques.

Strategies:

- With the MDCH Bureau of Health Professions, clarify reasons why medical and other health care professional boards have not implemented mandated continuing education in pain and symptom management. Based upon findings, pursue next steps.
- Seek sessions on end-of-life topics for in-service presentations and annual meetings of MCC member organizations. Essential content:
 - Management of cancer pain, and non-pain symptoms.

- Communication about informed treatment choice in advanced illness.
- Increase the number of professionals who have been trained using the Education in Palliative and End-of-Life Care for Oncology curriculum.
 - Target oncology fellowship directors and their fellows.
 - Incorporate the EPEC-O curriculum into the oncology fellowship directors' and the fellows' formal training.

**Collaborators for Objective #3 may include all types of MCC member organizations. To facilitate collaboration, it may be useful to convene a workgroup.*

Objective #4

Increase cancer patients' and caregivers' understanding of options for 1) care up to and during the last phase of life, and 2) pain and symptom relief.

Strategies:

- Develop a question(s) for the 2006 Special Cancer Behavioral Risk Factor Survey (SCBRFS) to assess public knowledge of 1) options for care up to and during the last phase of life, and 2) pain and symptom management.
- Convene a workgroup to develop and guide strategies for education and outreach.

Workgroup activities to include:

 - Secure funding for the planning phase.
 - Search for effective educational materials and outreach strategies around cancer care up to and during the last phase of life, considering the diversity of patients and caregivers in Michigan.
 - Based upon this search and the findings of the SCBRFS, develop an evidence-based, culturally sensitive plan for education and outreach about options for care up to and during the last phase of life, and pain and symptom relief.
 - Secure funding for a pilot study to test the intervention.

**Collaborators for Objective #4 may include all types of MCC member organizations.*

Endnote

1. For a complete list of the End-of-Life Advisory Committee members and the references used to determine these strategies, please visit the MCC website at <http://www.michigancancer.org>.



Basic Lexicon Priority Strategic Plan

Basic Lexicon Priority:

By 2006, finalize, disseminate, and evaluate basic pathology lexicons for breast, prostate, colorectal, cervix, and lung cancers to include information for making prognostic and treatment decisions. Further expand the number of pathology lexicons to include all common cancer types to enhance their adoption as a reporting system.

Progress Markers

How will the MCC know if progress is made toward achieving the Basic Lexicon Priority? The following markers will determine progress toward the priority:

- Finalization of a basic pathology lexicon template for breast, prostate, colorectal, cervix, and lung cancers.
- Expansion of the basic pathology lexicon template to include all common cancer types.
- Dissemination of the basic pathology lexicon templates to all pathologists in Michigan.
- Evaluation of the basic pathology lexicons to determine usage and factors that contribute to usage.
- Increase in usage of formatted College of American Pathologists (CAP) compatible pathology reports throughout Michigan.
- An incorporated mechanism for continued scientific updating of the lexicon.

Why This Priority Is Important

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

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

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

Pathologists, radiologists, and surgeons often use a wide variety of narrative descriptions to outline a patient's diagnosis and potential course of cancer treatment.

A lack of consistency in these descriptions can create confusion in the minds of other care providers who review such descriptions to develop an oncology management for the individual patient.

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

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

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

What Needs To Be Done

In order to determine the extent to which the basic pathology lexicons for breast, prostate, colorectal, cervix, and lung cancers are finalized, disseminated, and evaluated, several challenges first must be overcome.

Objective #1

Formally endorse the Basic Lexicon project.

Strategy:

- Support the concept and products developed in this project to improve the reporting format for examination of cancerous tissue specimens.

**All MCC member organizations can participate in this strategy.*

Objective #2

Participate in the development and validation of the Lexicon templates.

Strategy:

- Encourage committee participation to provide expert advice on the project.

**All MCC member organizations can participate in this strategy.*

Objective #3

Participate in the pilot and evaluation of the Lexicon template/instrument.

Strategy:

- Encourage pathologists within health systems and lab facilities throughout the state to participate in the pilot and evaluation phase of the Lexicon template.
**All MCC member organizations can participate in this strategy.*

Objective #4

Partner with public and private organizations to disseminate the Lexicons.

Strategy:

- Promote statewide use of a basic lexicon.
**All MCC member organizations can participate in this strategy.*

Objective #5

Assist with seeking additional avenues of external funding.

Strategy:

- Identify individuals and/or organizations that could provide financial assistance to expand the project to include electronic versions of the template and/or other possible options that would increase/optimize use and access among the variety of institutions/facilities within the state.
**All MCC member organizations can participate in this strategy.*