



# Comprehensive Cancer Control Plan for Michigan

**2007**

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# Introduction

## Background

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 (MDCH) in its cancer prevention and control efforts. Between 1987 and 1996, this advisory group and MDCH combined skills and expertise to develop a more systematic, comprehensive, statewide cancer control effort. In 1996, the MCC began to broaden its membership base to become a more inclusive statewide, public/private partnership, comprised of member organizations rather than individuals. Each member organization that joined the MCC committed to participate in collaborative planning and implementation of a statewide comprehensive control plan.

In 1996-1997, six MCC advisory committees (one each for breast, cervical, colorectal, lung, and prostate cancer, and one for the primary prevention of cancer) were established and provided input into the development of Michigan's first comprehensive control plan. They reviewed relevant cancer burden data and current scientific literature related to cancer prevention, early detection, diagnosis, treatment, and post-treatment with attention to economic and quality of life issues. Based on this work, each committee compiled evidence-based and results-oriented objectives and strategies, and forwarded to the Consortium what they believed to be the most important interventions that would reduce cancer incidence, morbidity, and mortality in Michigan.

Recognizing that the MCC could not possibly implement all of the proposed interventions immediately, representatives from each MCC member agency were invited to participate in a final prioritization process. They used new criteria that focused on the importance of starting implementation during the next few years and the need for inter-agency collaboration to achieve the objectives. In June 1998, the MCC identified ten cancer control priorities. Many more public and private partners joined together to form action-planning groups that developed strategic action plans which are the foundation of this *Comprehensive Cancer Control Plan for Michigan*.

It is important to note that Michigan's initial comprehensive cancer control planning efforts resulted in a composite of the many recommended objectives and strategies developed by each of the advisory groups. And even though all of those recommended objectives and strategies were not included in the final *MCC Initiative Strategic Plan for Implementation*, some of the remaining recommendations have prompted considerable activity and collaboration within the state health agency. For example, objectives related to nutrition, physical activity, sun safety, environmental health, as well as cancer risk and the reduction of cancer health disparities has been referenced in numerous Centers for Disease Control and Prevention-funded projects and programs.

## Mission Statement

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

## Vision Statement

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

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

## MCC Members and Member Responsibilities

Today, the MCC consists of nearly 100 member and key partner organizations. These organizations represent the following eight different types of types:

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

MCC member and key partner organizations are:

- Looking for new ways to make a difference and significantly reduce the cancer burden in our state.
- Taking steps to improve the quality of cancer care that Michigan residents receive.
- Focusing on their current cancer control activities and exploring ways to enhance these efforts.
- Learning what other organizations are doing and looking for new ways to work together to address the ten MCC Priorities:
  - Increase rates of screening and follow-up care for Michigan residents in relation to breast, cervical, and colorectal cancers.
  - Reduce smoking rates among Michigan adults and teens.
  - Increase prostate cancer patients' understanding of treatment options.
  - Increase cancer patients' awareness and participation in clinical trials.

- Develop/promote standardized reporting lexicons for pathologists (and subsequently, for surgeons and radiologists).
- Increase timeliness of referrals to end-of-life care.
- Develop a centralized database that links clinical and cost data to enable research and to support data-driven decision-making for cancer control.

### **MCC Initiative**

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 philosophy behind the MCC Initiative is:

- We believe that a focused, coordinated initiative will produce synergy and an impact far greater than the sum of its parts.
- We believe that the burden of cancer will be reduced substantially by partners working together toward common goals.
- We believe that when organizations work together, they can maximize the potential of limited health care resources and minimize duplication of efforts.
- We believe that all residents are entitled to quality cancer prevention, screening, diagnosis, treatment, and end-of-life information, as well as culturally acceptable services.

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 for Implementation* 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.

### **Comprehensive Cancer Control Plan for Michigan**

The *Comprehensive Cancer Control Plan for Michigan* consists of cancer burden data for Michigan, the ten priorities of the MCC, MCC strategic plans, highlights from the Implementation Progress Report to the Membership, and recognition that the MCC has received at the national level. This plan serves to guide the MCC in its cancer control efforts to reduce the human and economic burden of cancer in Michigan.

## The Burden of Cancer in Michigan

Cancer is the 2<sup>nd</sup> leading cause of death in Michigan as well as the United States. In 2007, the American Cancer Society estimates that 54,410 Michigan residents will be diagnosed with cancer and 19,180 will die from the disease. Michigan has the 9<sup>th</sup> highest overall cancer incidence rate among the 50 states and the District of Columbia.

The following are select findings from *The Cancer Burden of Michigan: Selected Statistics*, which represent an epidemiological analyses of cancer mortality and incidence for the five selected cancer sites: breast, cervical, colorectal, lung, and prostate. The numbers of estimated deaths due to cancer and estimated new cancer cases for 2006 were available from the American Cancer Society.<sup>1</sup>

To view *The Cancer Burden in Michigan: Selected Statistics* in its entirety, please visit: <http://www.michigancancer.org/WhatWeDo/TheCancerBurdenMichiganSelectedStatistics.cfm>

### Michigan Mortality and Incidence

Age-adjusted mortality rates in 2004 and age-adjusted incidence rates in 2003 are presented for the selected cancers. These were calculated by the direct age-adjustment method, using the 2000 U.S. population age distribution as the standard population, to allow comparisons across population subgroups.<sup>2</sup>

Comparisons of age-adjusted mortality and incidence rates between gender and racial groups are presented, as are age-specific rates. The proportions of cases diagnosed at different stages are compared between gender and racial groups to highlight disparities where they exist.

Michigan-specific data on rates of survival from the selected cancers are not available at this time. National data from the National Cancer Institute's SEER program on relative survival rates are presented. The relative survival rate represents the likelihood that a patient will survive their cancer for some specified time (usually five years) after their initial cancer diagnosis.<sup>3</sup>

### County Mortality and Incidence

Ten-year age-adjusted incidence and mortality rates are presented for the selected cancers for each county. Rates were calculated by the direct age-adjustment method using the 2000 US population age distribution, and annual state population estimates based on actual size of the county populations for years 1994 to 2003 and 1995 to 2004 were used in calculating ten-year incidence and mortality rates, respectively. Z tests were used to compare rates among counties, identifying counties with significantly higher or lower rates than the all-county rate. In conducting the Z tests, the age-adjusted rate for all counties combined was calculated including only deaths in the state for which the county was known. Differences in age-adjusted incidence and mortality rates were tested at 95% confidence levels.

<sup>1</sup> Cancer Facts and Figures 2006, American Cancer Society. Available at: <http://www.cancer.org/downloads/STT/CAFF2006PWSecured.pdf>.

<sup>2</sup> Michigan Department of Community Health (MDCH), Vital Records and Health Data Development Section.

<sup>3</sup> Relative survival rates for cases diagnosed 1996-2002.

### **Stage at Diagnosis, by Site and by County**

The percentages of cancer cases diagnosed at the localized stage (Breast, Colorectal, and Prostate Cancer) and at the in-situ stage (Cervical Cancer) are presented for each county for the time periods from 1991 to 1993 and 2001 to 2003 to highlight where changes in the percentages of cases diagnosed at a localized or in-situ stage have occurred. The percentage of cases localized at diagnosis is calculated out of all invasive cancers of the specific sites; the percentage of cases in-situ at diagnosis is calculated out of all invasive and in-situ cancers of the specific sites. To illustrate changes in stage at diagnosis, counties were ranked according to the percentage of resident cases that were diagnosed while the cancer was still localized and/or in-situ in the first three-year period. Counties were divided into quartiles for these ranked percentages. The same percentage ranges were used to classify counties during the second three-year period to allow comparison over time.

Conclusions from this analysis by county must take into consideration the various factors contributing to changes in stage at diagnosis at the county level. One factor to consider is the limitation of the low number of cases in some counties. Several counties had fewer than 20 reported cancer cases for at least one of the time periods and cancer sites. Therefore, a decrease in the percentage of cases localized at diagnosis could reflect a relatively small change in the number of cases at each stage. Also, it is important to note that changes in reporting and staging practices could have changed over time within a county. Usually increases in the percentage of cases localized or in-situ at diagnosis can be associated with an increase in screening but an equivalent decline in the percentage localized or in-situ does not necessarily reflect changes in prevention practices or quality of care. Yet, as an illustration of changing trends in stage at diagnosis, comparing the maps across time periods reveals where broad changes have occurred in the state as a whole.

### **Average Mammography Workload, by County**

Mammography workload data were obtained from the Michigan Department of Community Health's Radiation Safety Section.<sup>4</sup> Monthly patient workloads are provided by mammography facility staff that assist during annual inspections of mammography machines. In some cases, the data received can accurately reflect the mammography facility's true patient workload, but other times will only represent the facility respondent's best estimate of the total mammography patient workload. This analysis was based on the inspections of 4,129 machines with only 57 of these machines having no workload data recorded. For different reasons, one mammography machine may get inspected more than once in a calendar year, but the data used in this analysis only considers one inspection per machine when determining total mammography workload.

The average number of mammograms per 1000 women over the age of 40 was calculated by county for two time periods, 1996-1999 and 2000-2003, using the 1998 and 2002 Michigan female aged 40 and older populations, respectively. The percent change in mammography workload for each county was then calculated by using the average number of mammograms for the two time periods. It is important to note that the number of mammography machines per county may vary from year to year, and the percent change calculated for each county is not

<sup>4</sup> Michigan Department of Community Health, Radiation Safety Section obtained November 2004.

adjusted for any fluctuation in the number of mammography machines operating within each county. A follow-up survey was conducted to gather more detailed information on mammography facilities throughout the state of Michigan. Results of the survey will be published in a separate report.



## Summary

Analyses of deaths due to cancer and new cancer cases at all sites combined are shown in Tables 1 and 2. Most cancer cases and deaths occur in the population aged 55 years and older.

Tables showing statistics for five sites follow: breast cancer (Tables 3 through 10), cervical cancer (Tables 11 through 18), colorectal cancer (Tables 19 through 26), lung cancer (Tables 27 through 34), and prostate cancer (Tables 35 through 42).

Cancer mortality and incidence rates are higher in the older age groups for breast, colorectal, lung and prostate cancer. Cervical cancer mortality rates also increase with age, however cervical cancer incidence rates peak among women age 40-49 years and old stabilize and then decrease amongst women ages 65 and over.

Mortality rates for each of the cancer sites are higher among blacks than among whites. Although breast cancer incidence rates are higher in white women, breast cancer mortality rates are higher in black women (black to white rate ratio of 0.9 for incidence and 1.5 for mortality). For the other four cancer sites, incidence rates, like mortality rates, are higher among blacks than whites. The largest ratios of mortality rates were the ratios of black to white for cervical cancer and prostate cancer mortality rates which were both equal to 2.1. The ratio of black to white cervical cancer incidence rates was 1.8, and the ratio of black to white prostate cancer incidence rates was 1.7. Colorectal cancer black to white ratios for mortality and incidence rates were both 1.4 and lung cancer ratios for mortality and incidence rates were 1.2 and 1.3, respectively.

Five-year survival rates in the U.S. for each of the five cancer sites reveal a disparity in survival between blacks and whites. For breast and cervical cancer, blacks have a lower survival rate than whites even when cancers are detected at the same stage. The five-year survival rates for colorectal cancer are also lower for blacks than whites. When prostate cancer is detected at a localized or regional stage, the five-year survival rates are 100% for both blacks and whites, but as cancers are detected at a later stage, the five-year survival rates among blacks become lower than the rates among whites.

Significant differences in incidence and mortality rates among counties for each of the five sites over a ten-year period are shown in Figures 1, 2, 4, 5, 7, 8, 10, 11, 13 and 14.

Figures 3, 6, 9, 12, and 15, present maps of the percentage of cases diagnosed when the cancer was at the localized and/or in-situ stage between the time periods of 1991 through 1993 and 2001 through 2003. Diagnosis of cancers at an early stage improved most dramatically for prostate, although improvements in early diagnosis are also seen for breast, cervical and colorectal cancers (changes in the state as a whole are listed in Tables 3, 4, and 5 in the Appendix to this report). Detection of breast cancer while localized, cervical cancer while in-situ and colorectal cancer while localized showed modest improvement in Michigan. In the timeframe of 1991-1993, 57.7% of breast cancers were diagnosed at the localized stage in Michigan; 60.7% of breast cancer were diagnosed at the localized stage in the time period from 2001 through 2003. Cervical cancer detection while in-situ improved from 82.3% in 1991-1993 to 87.6% in 2001-2003. Colorectal cancer detection at the localized stage improved from 33.7% in 1991-1993 to 39.1% in 2001-2003. Observed differences in the percentage of cancers diagnosed while

localized or in-situ may possibly be due to changes in early detection, changes in coding or pathology review and reporting, changes in record keeping, or due to the introduction of and increased access to new medical treatments.

Table 1.

Number of Cancer Deaths and New Cancer Cases  
by *Age Group* and *Gender*, All Sites, Michigan 2003-04

		All Ages	Under 35	35-54	55-74	75 and Over
Deaths, 2004	Total	19,654	249	2,326	8,362	8,717
	Males	10,198	127	1,186	4,528	4,357
	Females	9,456	122	1,140	3,834	4,360
New Cases, 2003	<b>Total</b>	49,659	1,730	9,517	23,305	15,107
	<b>Males</b>	25,835	728	4,055	13,385	7,667
	Females	23,796	998	5,454	9,907	7,437

Table 2.

Cancer Mortality and Incidence Rates  
by *Gender* and *Race*, All Sites, Michigan 2003-04

		Rate per 100,000*		Ratio
		Blacks	Whites	Blacks/Whites
2004 Mortality	Total	232.7	184.4	1.3
	Males	301.8	226.0	1.3
	Females	188.7	156.5	1.2
2003 Incidence	Total	547.9	468.4	1.2
	Males	731.6	545.1	1.3
	Females	423.3	417.0	1.0

\*Rates are age-adjusted and computed by race and gender.

Table 3.

Estimated Number of Breast Cancer Deaths and  
New Breast Cancer Cases, Michigan 2006

Deaths	1,360
New Cases	7,070

Table 4.

Number of Breast Cancer Deaths and  
New Breast Cancer Cases by *Age Group*,  
Michigan 2003-04

	All Ages	Under 35	35-54	55-74	75 and Over
Deaths, 2004	1,417	18	297	568	534
New Cases, 2003	6,837	160	2,182	2,912	1,583

Table 5.

**Breast Cancer Mortality Rates,  
Michigan 2004 vs. US 2003**

	Number in Michigan	Age-Adjusted Rate*	
		Michigan (2004)	US-SEER (2003)
Total	1,417	24.3	25.2
Whites	1,165	22.9	24.6
Blacks	227	33.6	34.1

\*Rate per 100,000 race- and gender-specific population.

Table 6.

**Breast Cancer Incidence Rates,  
Michigan 2003 vs. US 2003**

	Number in Michigan	Age-Adjusted Rate*	
		Michigan (2003)	US-SEER (2003)
Total	6,837	122.8	124.2
Whites	5,892	123.3	128.5
Blacks	770	113.2	120.5

\*Rate per 100,000 age- and gender-specific population.

Table 7.

### Age-specific Breast Cancer Mortality Rates, Michigan 2004

	Number	Rate*
25-39 Years	44	4.4
40-49 Years	148	18.4
50-64 Years	389	44.2
65 Years and Over	835	114.2

\*Rate per 100,000 age- and gender-specific population.

Table 8.

### Age-specific Breast Cancer Incidence Rates, Michigan 2003

	Number	Rate*
25-39 Years	360	35.3
40-49 Years	1,194	148.7
50-64 Years	2,364	276.4
65 Years and Over	2,911	401.6

\*Rate per 100,000 age- and gender-specific population.

Table 9.

Breast Cancer Five-Year Relative Survival Rates  
by Stage at Diagnosis and *Race*, US 1996-2002

	Total %	White %	Black %
All stages	88.5	89.7	77.3
Localized	98.1	98.5	93.6
Regional	83.1	84.6	71.8
Distant	26.0	27.7	16.1
Unknown	54.1	56.0	44.9

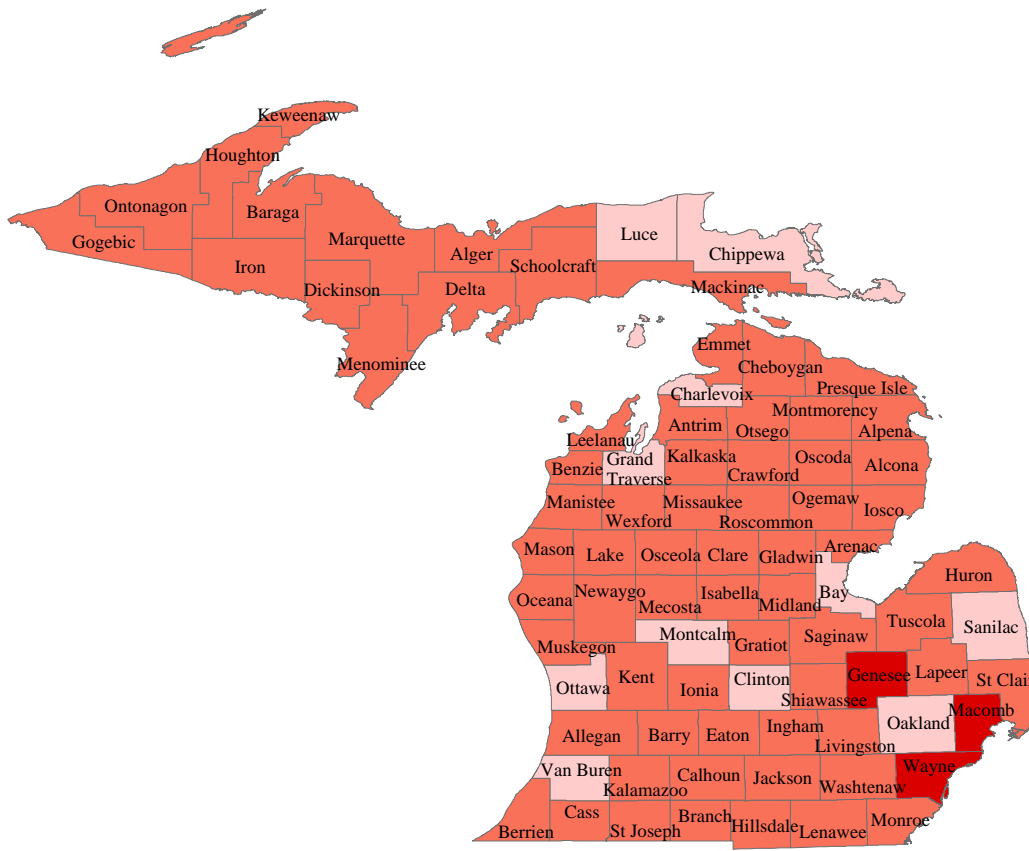
Table 10.

Numbers and Percentages of Invasive Breast Cancer  
by Stage at Diagnosis and *Race*,  
Michigan Residents, 2003

	Total Number	Stage at Diagnosis							
		Localized		Regional		Distant		Unknown	
		Number	%	Number	%	Number	%	Number	%
Total	6,837	4,129	60.4	1,971	28.8	255	3.7	482	7.0
Whites	5,892	3,639	61.8	1,651	28.0	191	3.2	411	7.0
Blacks	770	400	51.9	265	34.4	59	7.7	46	6.0

Figure 1.

### Breast Cancer Mortality Rates by County, 1995-2004



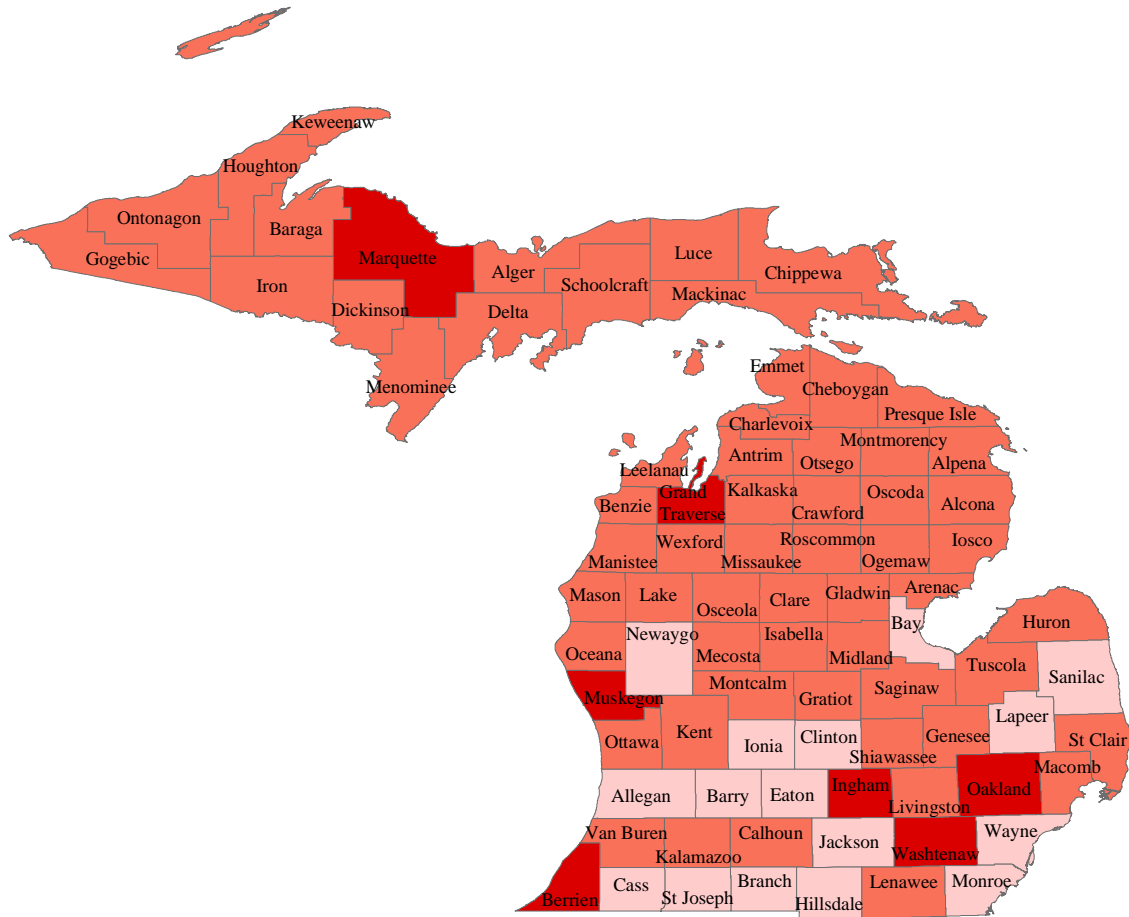
- Counties with significantly lower mortality rates\*
- Counties without significantly different mortality rates\*
- Counties with significantly higher mortality rates\*

\*Differences in age-adjusted mortality rates were statistically tested at 95% confidence levels to compare each county with the all-county rate.



Figure 2.

### Breast Cancer Incidence Rates by County, 1994-2003



- Counties with significantly lower incidence rates\*
- Counties without significantly different incidence rates\*
- Counties with significantly higher incidence rates\*

\*Differences in age-adjusted incidence rates were statistically tested at 95% confidence levels to compare each county with the all-county rate.

Figure 3.

### Percentage of Breast Cancer Cases Localized at Diagnosis by County

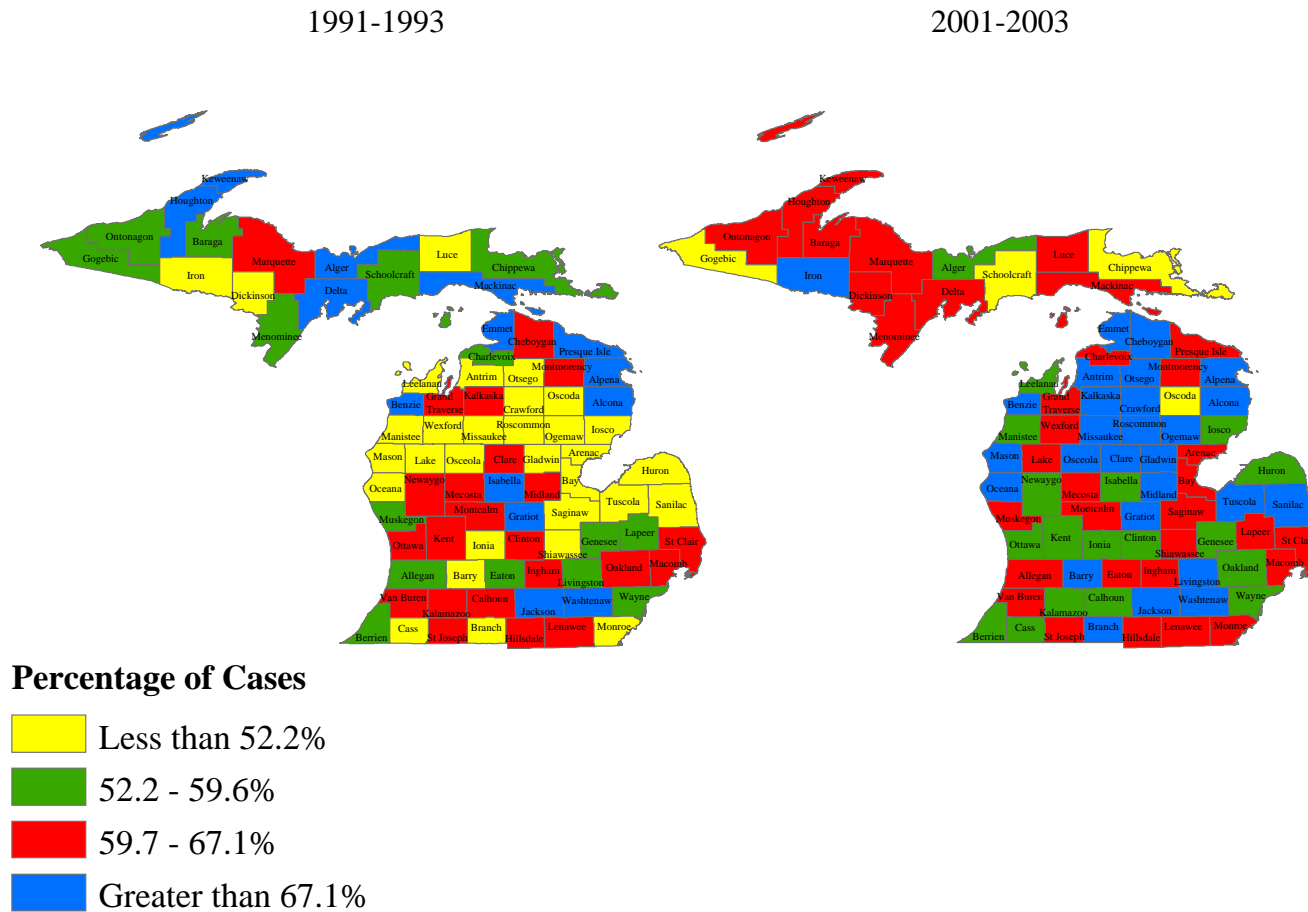


Table 11.

Estimated Number of Cervical Cancer Deaths and  
New Cervical Cancer Cases,  
Michigan 2006

Deaths	*
New Cases	260

\* Not Available

Table 12.

Number of Cervical Cancer Deaths and  
New Cervical Cancer Cases by *Age Group*,  
Michigan 2003-04

	All Ages	Under 35	35-54	55-74	75 and Over
Deaths, 2004	118	8	35	50	25
New Cases, 2003	399	74	183	105	36

Table 13.

Cervical Cancer Mortality Rates,  
Michigan 2004 vs. US 2003

	Number in Michigan	Age-Adjusted Rate*	
		Michigan (2004)	US-SEER (2003)
Total	118	2.1	2.5
Whites	90	1.9	2.2
Blacks	27	4.0	4.7

\*Rate per 100,000 age- and gender-specific population.

Table 14.

Cervical Cancer Incidence Rates,  
Michigan 2003 vs. US 2003

	Number in Michigan	Age-Adjusted Rate*	
		Michigan (2003)	US-SEER (2003)
Total	399	7.6	7.1
Whites	288	6.6	6.6
Blacks	84	11.7	10.5

\*Rate per 100,000 age- and gender-specific population.

Table 15.

### Age-specific Cervical Cancer Mortality Rates, Michigan 2004

	Number	Rate*
25-39 Years	14	1.4
40-49 Years	19	2.4
50-64 Years	34	3.9
65 Years and Over	51	7.0

\*Rate per 100,000 age- and gender-specific population.

Table 16.

### Age-specific Cervical Cancer Incidence Rates, Michigan 2003

	Number	Rate*
25-39 Years	111	10.9
40-49 Years	101	12.6
50-64 Years	108	12.6
65 Years and Over	68	9.4

\*Rate per 100,000 age- and gender-specific population.

Table 17.

Cervical Cancer Five-Year Relative Survival Rates  
by Stage at Diagnosis and *Race*, US 1996-2002

	Total %	White %	Black %
All stages	71.6	72.8	62.6
Localized	92.0	92.6	86.4
Regional	55.5	56.0	47.6
Distant	14.6	15.5	6.8
Unknown	59.1	61.2	55.9

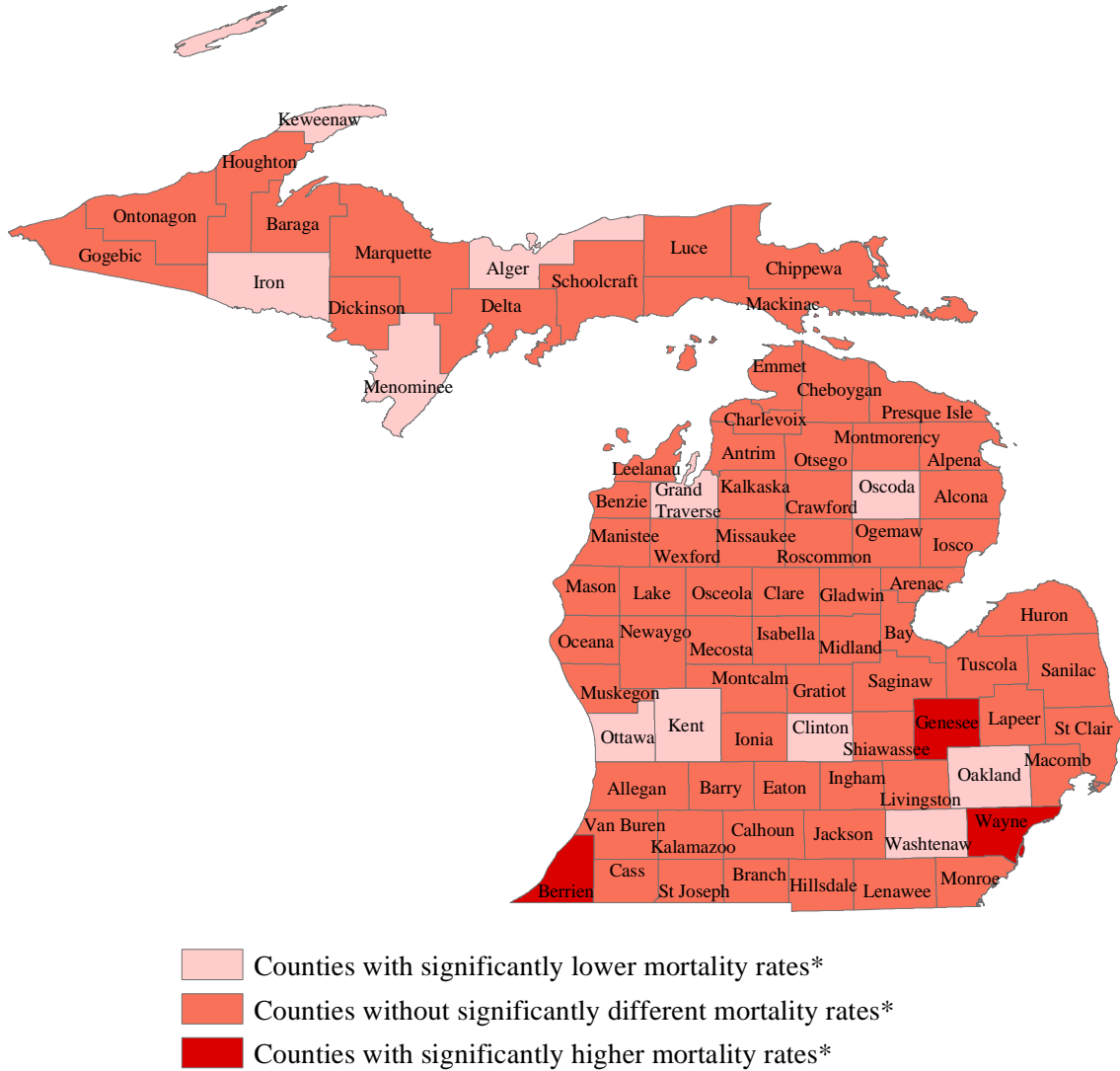
Table 18.

Numbers and Percentages of Invasive Cervical Cancer  
(Primary Site) by Stage at Diagnosis and *Race*,  
Michigan 2003

		Stage at Diagnosis							
		Localized		Regional		Distant		Unknown	
	Total Number	Number	%	Number	%	Number	%	Number	%
Total	399	191	47.9	119	29.8	35	8.8	54	13.5
Whites	288	139	48.3	85	29.5	28	9.7	39	12.5
Blacks	84	40	47.6	29	34.5	7	8.3	8	9.5

Figure 4.

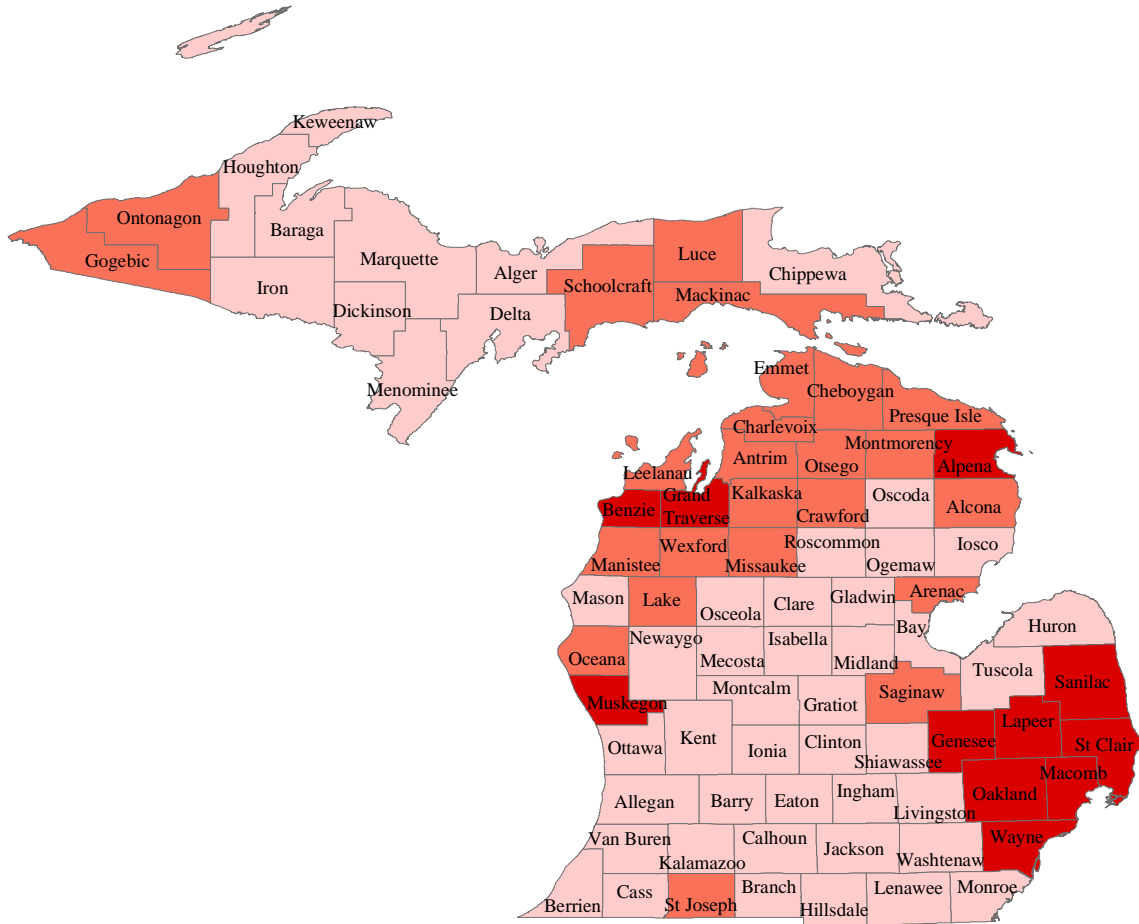
### Cervical Cancer Mortality Rates by County, 1995-2004



\*Differences in age-adjusted mortality rates were statistically tested at 95% confidence levels to compare each county with the all-county rate.

Figure 5.

### In-situ or Invasive Cervical Cancer Incidence Rates by County, 1994-2003



- Counties with significantly lower incidence rates\*
- Counties without significantly different incidence rates\*
- Counties with significantly higher incidence rates\*

\*Differences in age-adjusted incidence rates were statistically tested at 95% confidence levels to compare each county with the all-county rate.





Table 19.

Estimated Number of Colorectal Cancer Deaths and  
New Colorectal Cancer Cases,  
Michigan 2006

Deaths	1,830
New Cases	4,930

Table 20.

Number of Colorectal Cancer Deaths and  
New Colorectal Cancer Cases  
by *Age Group* and *Gender*,  
Michigan 2003-04

		All Ages	Under 35	35-54	55-74	75 and Over
Deaths, 2004	Total	1,872	11	185	690	986
	<b>Males</b>	940	6	109	384	441
	Females	932	5	76	306	545
New Cases, 2003	Total	5,424	63	801	2,389	2,171
	Males	2,709	32	432	1,311	934
	Females	2,710	31	369	1,074	1,236

Table 21.

Colorectal Cancer Mortality Rates by *Gender*,  
Michigan 2004 vs. US 2003

	Number in Michigan	Age-Adjusted Rate*	
		Michigan (2004)	US-SEER (2003)
<b>Total</b>	1,872	18.0	19.0
Males	940	21.8	23.0
White Males	791	20.7	22.4
Black Males	133	31.4	32.1
Females	932	15.2	16.1
White Females	796	14.6	20.4
Black Females	123	19.4	25.4

\*Rate per 100,000 race- and gender-specific population.

Table 22.

Colorectal Cancer Incidence Rates by *Gender*,  
Michigan 2003 vs. US 2003

	Number in Michigan	Age-Adjusted Rate*	
		Michigan (2003)	US-SEER (2003)
<b>Total</b>	5,424	53.1	49.5
Males	2,709	61.4	58.0
White Males	2,217	57.0	57.1
Black Males	407	91.4	72.6
Females	2,710	46.7	42.8
White Females	2,286	44.9	42.4
Black Females	360	55.7	52.5

\*Rate per 100,000 race- and gender-specific population.

Table 23.

Age-specific Colorectal Cancer Mortality Rates by *Gender*, Michigan 2004

	Total		Males		Females	
	Number	Rate*	Number	Rate*	Number	Rate*
25-39 Years	28	1.4	17	1.7	11	1.1
40-49 Years	80	5.0	43	5.5	37	4.6
50-64 Years	362	21.0	204	24.2	158	18.0
65 Years and Over	1,402	112.5	676	146.0	726	99.3

\*Rate per 100,000 age- and gender-specific population.

Table 24.

Age-specific Colorectal Cancer Incidence Rates by *Gender*, Michigan 2003

	Total		Males		Females	
	Number	Rate*	Number	Rate*	Number	Rate*
25-39 Years	115	5.6	63	6.1	52	5.1
40-49 Years	361	22.7	194	24.6	167	20.8
50-64 Years	1,381	82.5	775	94.8	603	70.5
65 Years and Over	3,557	287.7	1,673	326.9	1,882	259.7

\*Rate per 100,000 age- and gender-specific population.

Table 25.

Colorectal Cancer Five-Year Relative Survival Rates by Stage at Diagnosis, *Gender* and *Race*, US 1996-2002

	Total %	Males		Females	
		White %	Black %	White %	Black %
All stages	64.1	66.0	55.6	64.2	53.9
Localized	90.4	91.9	85.9	89.9	83.4
Regional	68.1	69.9	62.2	68.2	58.6
Distant	9.8	10.0	7.7	10.3	7.2
Unknown	34.6	40.2	37.5	30.0	32.6

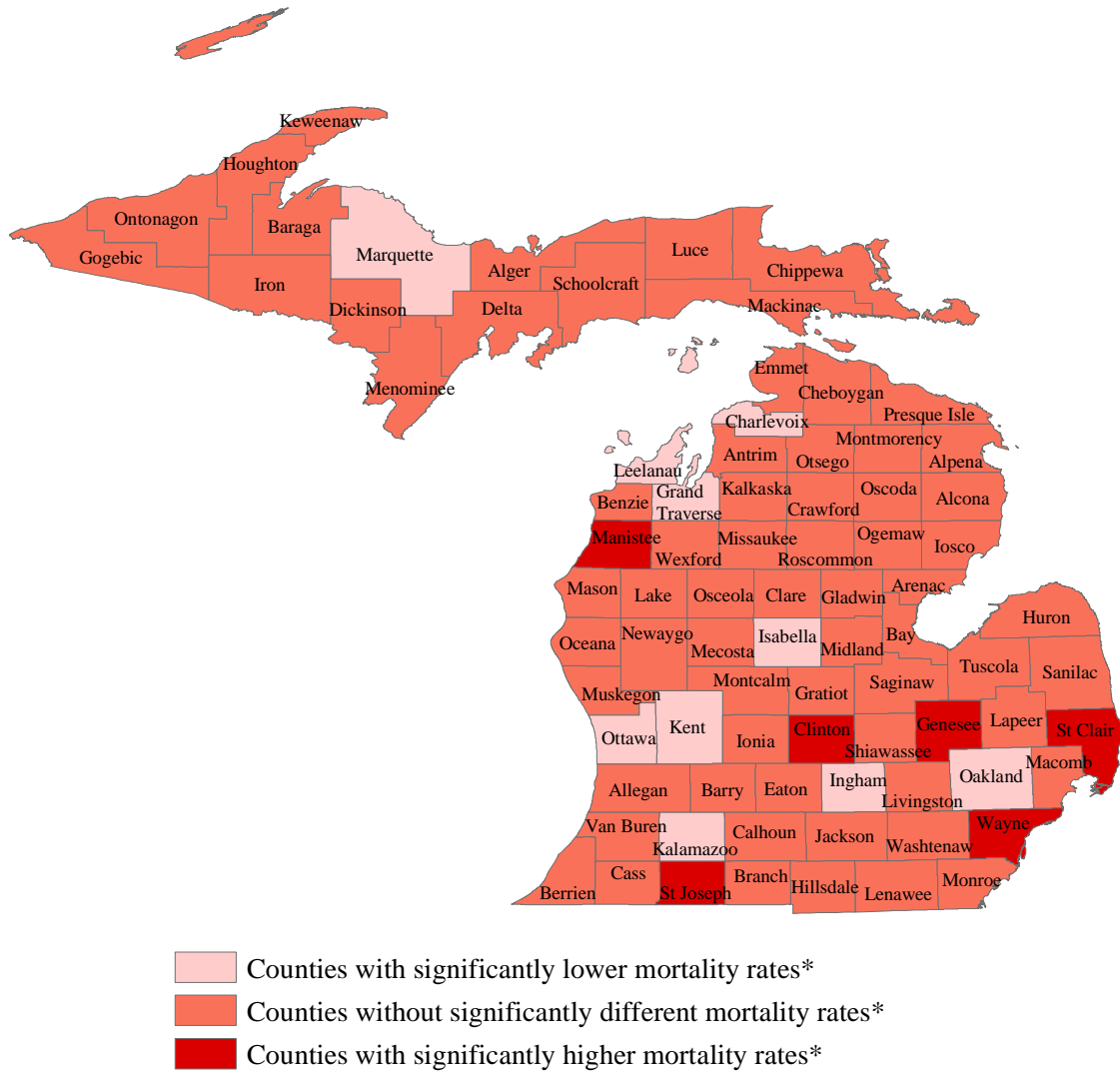
Table 26.

Numbers and Percentages of Invasive Colorectal Cancer (Primary Site) by Stage at Diagnosis and *Race*, Michigan 2003

	Total Number	Stage at Diagnosis							
		Localized		Regional		Distant		Unknown	
		Number	%	Number	%	Number	%	Number	%
Total	5,424	2,096	38.6	1,858	34.3	814	15.0	656	12.1
Whites	4,507	1,763	39.1	1,563	34.7	627	13.9	554	12.3
<b>Blacks</b>	767	275	35.9	248	32.3	164	21.4	80	10.4

Figure 7.

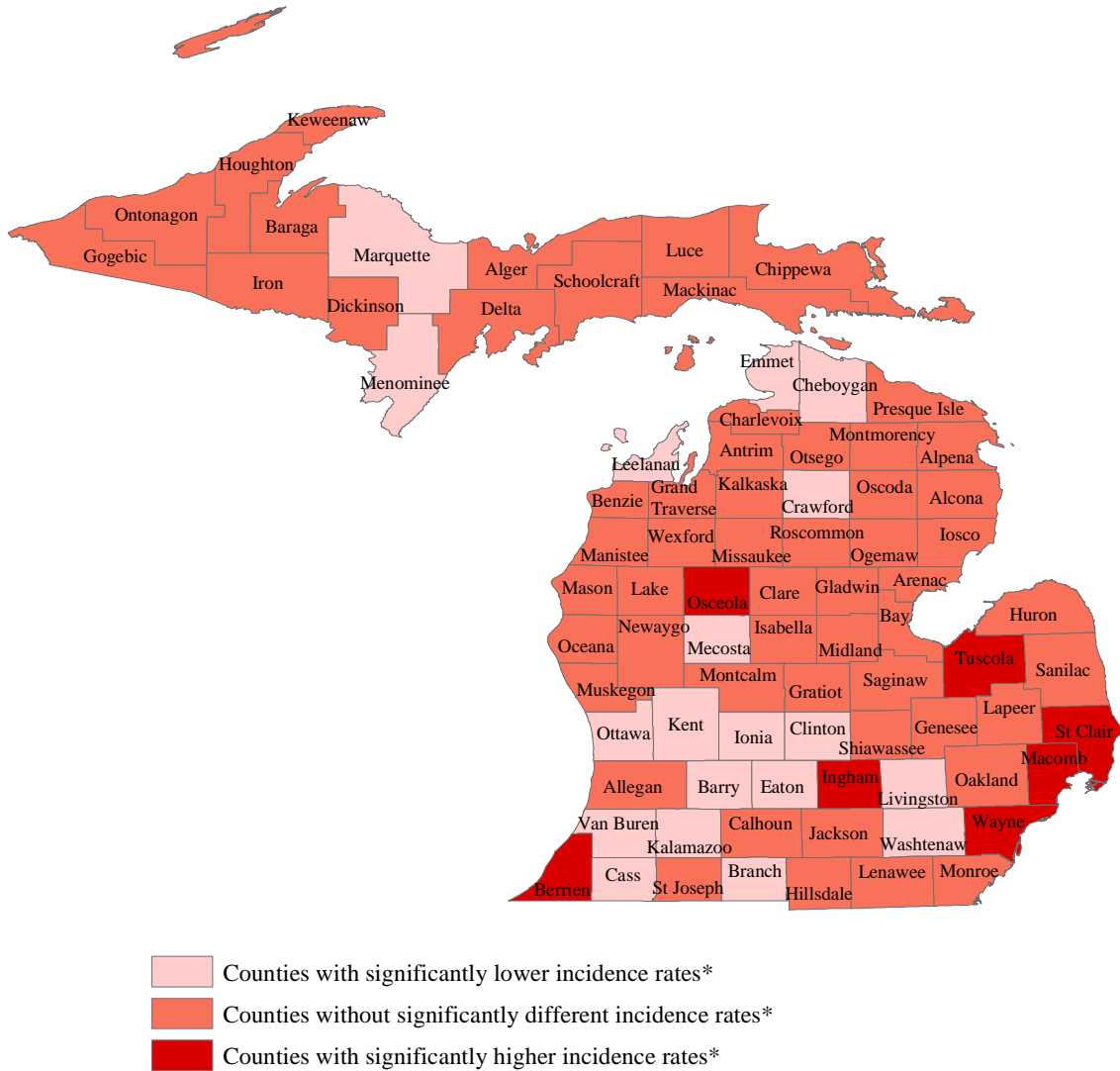
### Colorectal Cancer Mortality Rates by County, 1995-2004



\*Differences in age-adjusted mortality rates were statistically tested at 95% confidence levels to compare each county with the all-county rate.

Figure 8.

### Colorectal Cancer Incidence Rates by County, 1994-2003



\*Differences in age-adjusted incidence rates were statistically tested at 95% confidence levels to compare each county with the all-county rate.

Figure 9.

### Percentage of Colorectal Cancer Cases Localized at Diagnosis by County

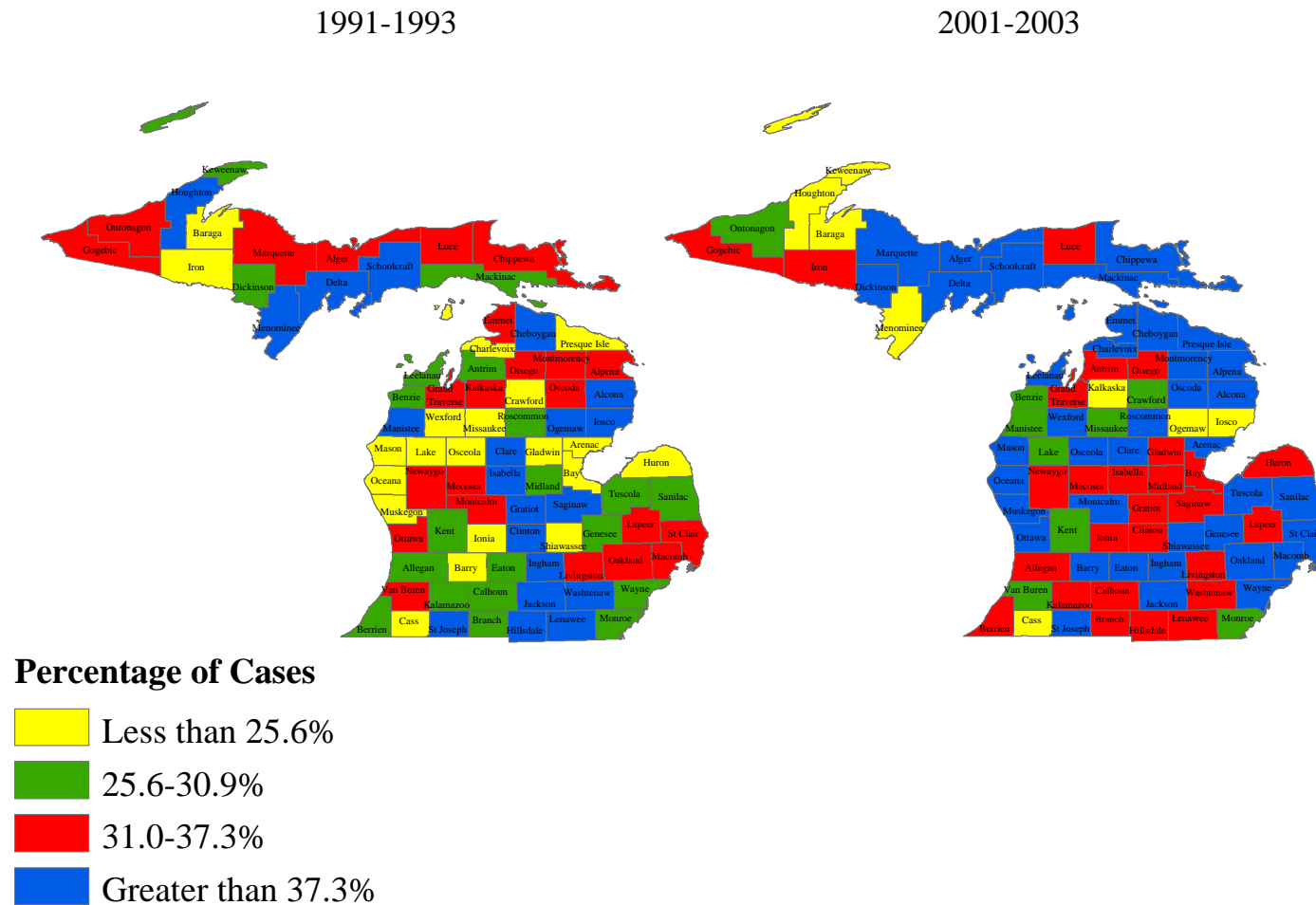




Table 27.

Estimated Number of Lung Cancer Deaths and  
New Lung Cancer Cases,  
Michigan 2006

Deaths	5,810
New Cases	6,240

Table 28.

Number of Lung Cancer Deaths and  
New Lung Cancer Cases  
by *Age Group* and *Gender*,  
Michigan 2003-04

		All Ages	Under 35	35-54	55-74	75 and Over
Deaths, 2004	Total	5,822	8	603	2,931	2,280
	Males	3,288	5	343	1,688	1,252
	Females	2,534	3	260	1,243	1,028
New Cases, 2003	Total	7,636	13	936	4,084	2,603
	Males	4,230	7	521	2,276	1,426
	Females	3,405	6	415	1,807	1,177

Table 29.

Lung Cancer Mortality Rates by *Gender*,  
Michigan 2004 vs. US 2003

	Number in Michigan	Age-Adjusted Rate*	
		Michigan (2004)	US-SEER (2003)
<b>Total</b>	5,822	56.8	54.2
Males	3,288	74.8	71.9
White Males	2,787	72.0	71.2
Black Males	452	99.7	93.1
Females	2,534	44.0	41.2
White Females	2,210	43.9	42.2
Black Females	299	46.6	40.3

\*Rate per 100,000 race- and gender-specific population.

Table 30.

Lung Cancer Incidence Rates by *Gender*,  
Michigan 2003 vs. US 2003

	Number in Michigan	Age-Adjusted Rate*	
		Michigan (2003)	US-SEER (2003)
Total	7,636	75.2	62.7
Males	4,230	96.0	78.5
White Males	3,544	91.4	77.1
Black Males	635	139.0	115.5
Females	3,405	60.2	51.3
White Females	2,934	59.6	53.9
Black Females	413	64.0	53.5

\*Rate per 100,000 race- and gender-specific population.

Table 31.

### Age-specific Lung Cancer Mortality Rates by *Gender*, Michigan 2004

	Total		Males		Females	
	Number	Rate*	Number	Rate*	Number	Rate*
25-39 Years	25	1.2	12	1.2	13	1.3
40-49 Years	270	17.0	144	18.3	126	15.7
50-64 Years	1,445	84.0	837	99.5	608	69.1
65 Years and Over	4,081	327.4	2,294	444.8	1,787	244.5

\*Rate per 100,000 age- and gender-specific population.

Table 32.

### Age-specific Lung Cancer Incidence Rates by *Gender*, Michigan 2003

	Total		Males		Females	
	Number	Rate*	Number	Rate*	Number	Rate*
25-39 Years	42	2.1	24	2.3	18	1.8
40-49 Years	435	27.3	243	30.8	192	23.9
50-64 Years	2,110	126.1	1,181	144.4	928	108.5
65 Years and Over	5,046	408.1	2,779	543.1	2,267	312.8

\*Rate per 100,000 age- and gender-specific population.

Table 33.

Lung Cancer Five-Year Relative Survival Rates by Stage at Diagnosis, *Gender* and *Race*, US 1996-2002

	Total %	Males		Females	
		White %	Black %	White %	Black %
All stages	15.0	13.4	10.5	17.4	14.5
Localized	49.3	46.0	38.7	53.3	45.8
Regional	15.5	14.6	11.6	17.1	15.5
Distant	2.1	1.7	2.0	2.3	1.9
Unknown	7.9	7.3	7.6	8.0	7.6

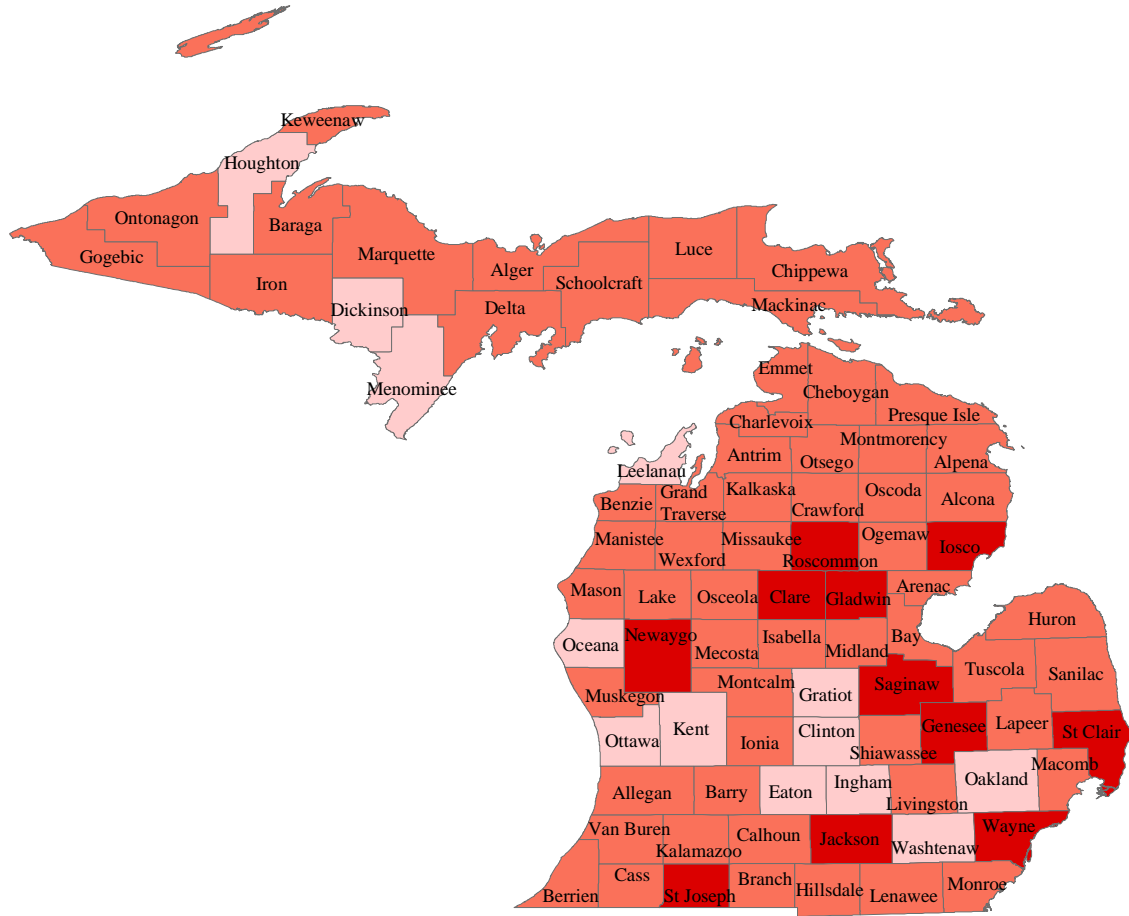
Table 34.

Numbers and Percentages of Invasive Lung Cancer (Primary Site) by Stage at Diagnosis and *Race*, Michigan 2003

	Total Number	Stage at Diagnosis							
		Localized		Regional		Distant		Unknown	
		Number	%	Number	%	Number	%	Number	%
Total	7,636	1,325	17.4	1,819	23.8	3,290	43.1	1,202	15.7
Whites	6,479	1,161	17.9	1,559	24.1	2,693	41.6	1,066	16.5
<b>Blacks</b>	1,048	150	14.3	229	21.9	553	52.8	116	11.1

Figure 10.

### Lung Cancer Mortality Rates by County, 1995-2004

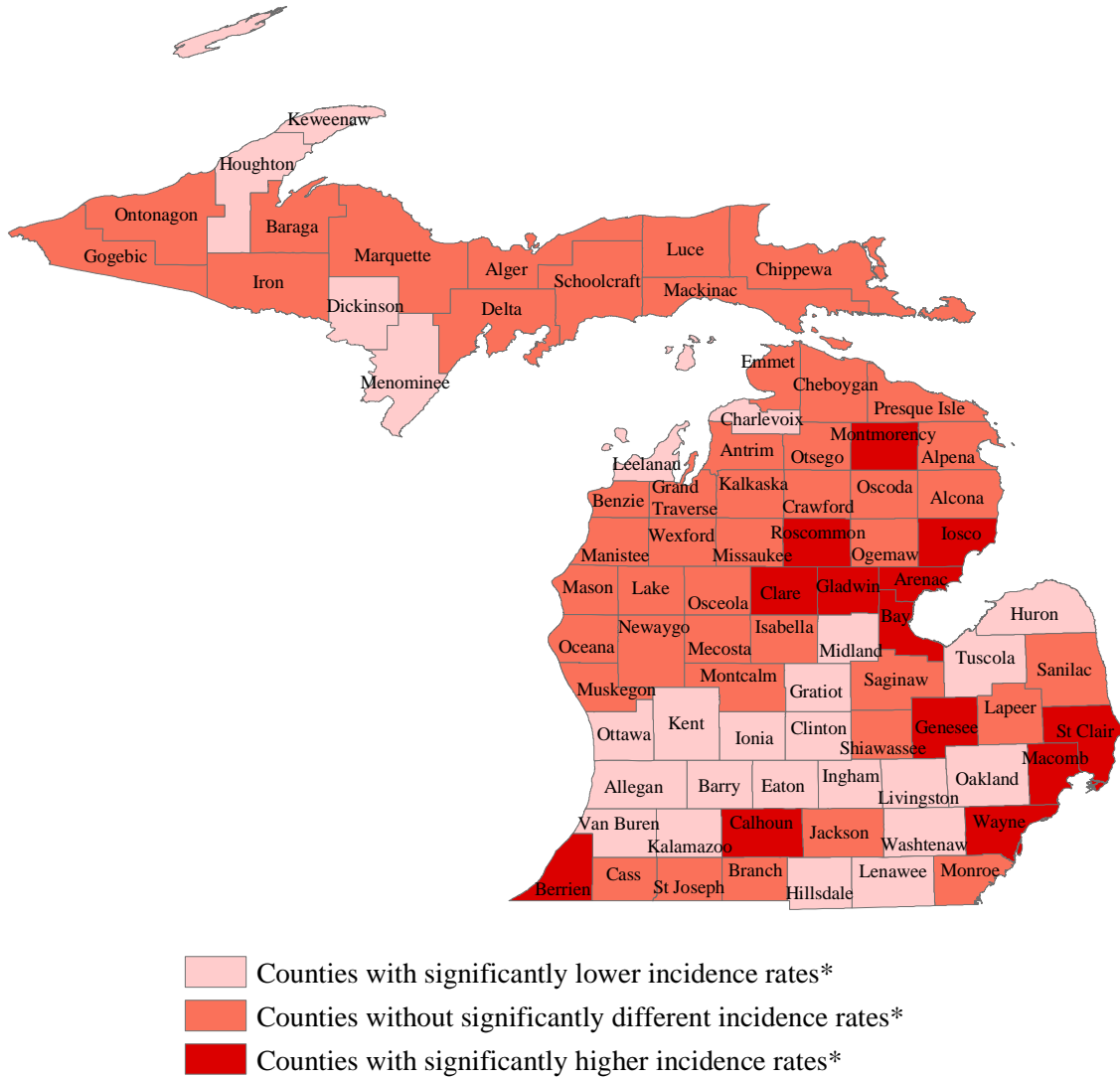


- Counties with significantly lower mortality rates\*
- Counties without significantly different mortality rates\*
- Counties with significantly higher mortality rates\*

\*Differences in age-adjusted mortality rates were statistically tested at 95% confidence levels to compare each county with the all-county rate.

Figure 11.

### Lung Cancer Incidence Rates by County, 1994-2003



\*Differences in age-adjusted incidence rates were statistically tested at 95% confidence levels to compare each county with the all-county rate.

Figure 12.

### Percentage of Lung Cancer Cases Localized at Diagnosis by County

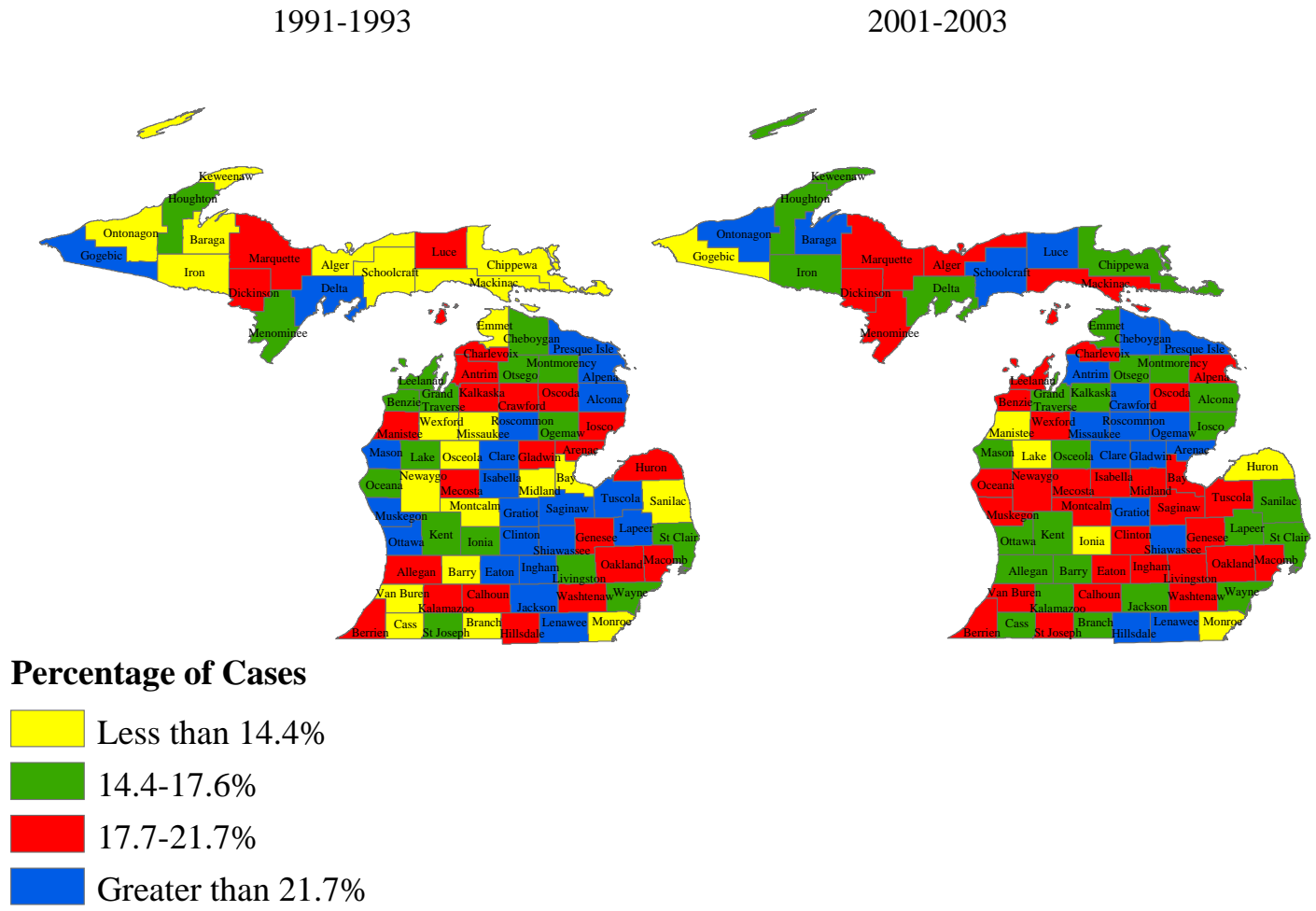


Table 35.

Estimated Number of Prostate Cancer Deaths and  
New Prostate Cancer Cases,  
Michigan 2006

Deaths	860
New Cases	7,370

Table 36.

Number of Prostate Cancer Deaths and  
New Prostate Cancer Cases by *Age Group*,  
Michigan 2003-04

	All Ages	Under 35	35-54	55-74	75 and Over
Deaths, 2004	967	1	26	254	686
New Cases, 2003	8,119	3	826	5,105	2,185



Table 37.

Prostate Cancer Mortality Rates,  
Michigan 2004 vs. US 2003

	Number in Michigan	Age-Adjusted Rate*	
		Michigan (2004)	US-SEER (2003)
Total	967	24.3	26.6
Whites	779	21.9	24.5
Blacks	175	46.4	58.0

\*Rate per 100,000 race- and gender-specific population.

Table 38.

Prostate Cancer Incidence Rates,  
Michigan 2003 vs. US 2003

	Number in Michigan	Age-Adjusted Rate*	
		Michigan (2003)	US-SEER (2003)
Total	8,119	180.5	164.9
Whites	6,324	159.5	160.0
Blacks	1,259	273.8	247.0

\*Rate per 100,000 race- and gender-specific population.

Table 39.

### Age-specific Prostate Cancer Mortality Rates, Michigan 2004

	Number	Rate*
25-39 Years	0	0.0
40-49 Years	9	1.1
50-64 Years	88	10.5
65 Years and Over	869	168.5

\*Rate per 100,000 age- and gender-specific population.

Table 40.

### Age-specific Prostate Cancer Incidence Rates, Michigan 2003

	Number	Rate*
25-39 Years	7	0.7
40-49 Years	238	30.2
50-64 Years	2,875	351.5
65 Years and Over	4,998	976.7

\*Rate per 100,000 age- and gender-specific population.

Table 41.

Prostate Cancer Five-Year Relative Survival Rates  
by Stage at Diagnosis and *Race*, US 1996-2002

	Total %	White %	Black %
All stages	99.9	99.9	97.6
Localized/Regional	100.0	100.0	100.0
Distant	33.3	32.7	31.1
Unknown	79.5	80.5	74.6

Table 42.

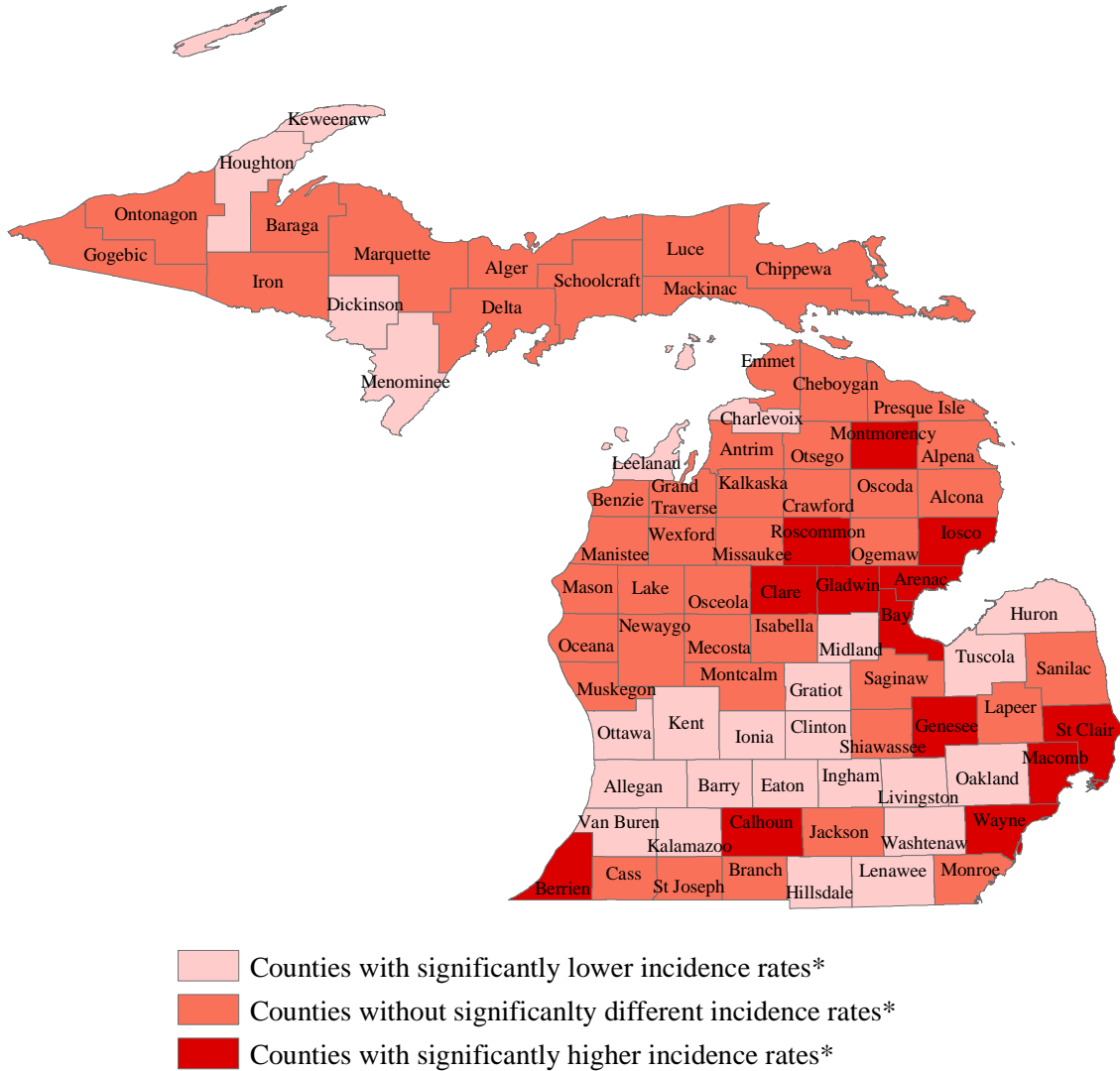
Numbers and Percentages of Invasive Prostate Cancer  
(Primary Site) by Stage at Diagnosis and *Race*,  
Michigan 2003

	Total Number	Stage at Diagnosis							
		Localized		Regional		Distant		Unknown	
		Number	%	Number	%	Number	%	Number	%
Total	8,119	6,331	78.0	723	8.9	192	2.4	873	10.8
Whites	6,324	5,007	79.2	550	8.7	129	2.0	638	10.1
<b>Blacks</b>	1,259	972	77.2	159	12.6	61	4.8	67	5.3



Figure 14.

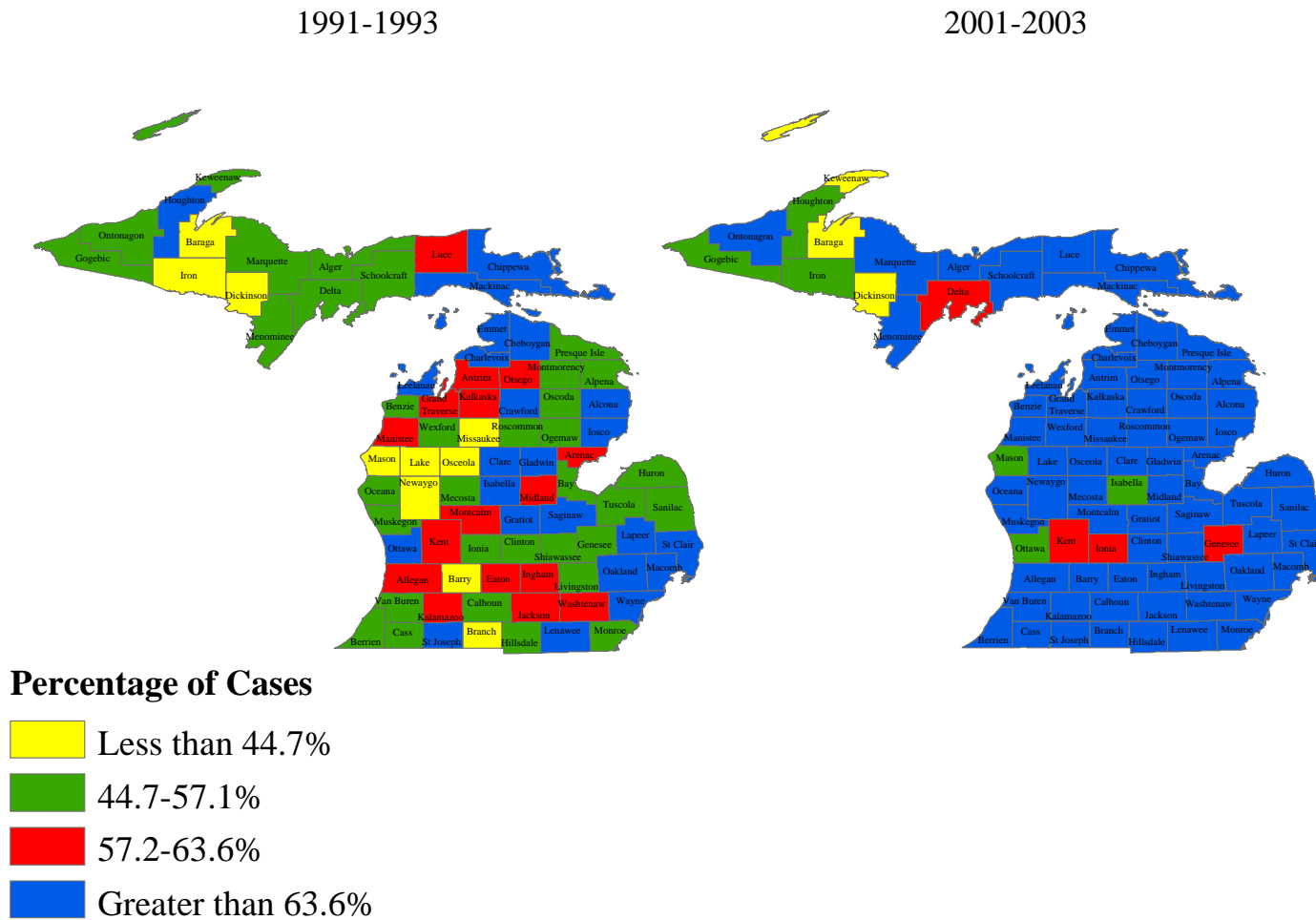
### Prostate Cancer Incidence Rates by County, 1994-2003



\*Differences in age-adjusted incidence rates were statistically tested at 95% confidence levels to compare each county with the all-county rate.

Figure 15.

Percentage of Prostate Cancer Cases Localized at Diagnosis by County



## 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.

## Strategic Plan Overview

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. (Although there are ten MCC priorities, two priorities are included in the Lung Cancer Tobacco Priority Strategic Plan. As a result, only nine strategic plans were developed.)

### Strategic Plan Review and Evaluation Process

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 ten priorities. The priority strategic plans are reviewed by the appropriate advisory committees on a regular basis, unless the science necessitates otherwise. During the review process, the advisory committees assess progress toward achieving the goals as well as determine if the objectives and strategies need to be modified. By working closely with the Evaluation Committee, the advisory committees can ensure that the strategies are achievable, measurable, and appropriate for MCC member organizations.

### New Priority Selection Process

In an attempt to keep up with changing needs, the MCC has developed a New Priority Selection Process. This process outlines when and how a new priority would be brought to the MCC Board of Directors and how the Board would approach such as request. The new priority could address a 1) new cancer; 2) current cancer; or 3) cancer-related cross-cutting issue.

Below is the MCC New Priority Selection Process:



## MCC New Priority Selection Process

### Recommendation:

1. The following process would address **any new priority** to be brought forward for the MCC to consider. The new priority could address a:
  - **New cancer**, for example the Lymphoma Society suggests lymphoma be an MCC priority, or
  - **Current cancer**, for example HPV vaccine for cervical cancer is out of clinical trials and deemed effective in preventing cervical cancer.
  - **Cancer-related crosscutting issue**, for example, end-of-life, standardized lexicon, clinical trials, etc.
2. Any request to the MCC to undertake a new priority would need to be sponsored by at least one MCC member organization, and would be submitted to the MCC Co-Chairs for consideration.
3. The Co-Chairs would determine if an existing advisory group would best address the request or if a new ad hoc advisory group should be appointed. In either case, the champion (organization or individual that initially proposed the new priority) would be invited to serve on the advisory committee and eventually relevant organizations, not already affiliated with the MCC, would be encouraged to join the Consortium.
4. The charge of the advisory group, either new or existing, would be to prepare a presentation of the proposed priority for the Board of Directors which would address the following criteria and considerations\*:

#### Criteria:

- **Incidence reduction:** Cancer incidence could be reduced significantly by addressing this priority;
- **Relative survival** could be increased significantly by addressing this priority;
- **Mortality reduction:** Cancer mortality could be reduced significantly by addressing this priority;
- **Improved quality of life:** Physical, psychological, social and spiritual well-being can be improved by addressing this priority;
- **Feasibility:** The realistic assessment of the barriers to and incentives for addressing this priority e.g. cost, available effective strategies, cultural appropriateness, resources required, political issue, would favor addressing this priority.

#### Considerations:

- **What is feasible?** The job of the group is to recommend that aspect which is most feasible to do;
- **What is important to start now?** The group needs to be very selective and approach selecting a new priority on the basis of a single aspect or group of aspects that are ready to address and are of the highest urgency for the MCC to address at this time and at the exclusion of other aspects that will have to wait.
- **What can we best do together?** The group will need to consider why a particular priority is better to address collaboratively.

**\*Adapted from those developed during the original MCC prioritization process (1996-1998). Definitions are available upon request.**

5. The advisory group for the proposed priority would then request to make a presentation at a scheduled meeting of the Board of Directors, in keeping with the process for the development of the Board agenda established by the MCC Governance Committee.
6. The presentation from the advisory group would include the group's review of the above considerations and criteria, their recommendations regarding the proposed priority and the objectives and strategies needed in the short run to move toward achievement of the priority.
7. The Board would then consider the following:
  - Is this priority feasible, important to start now, and one that can best be done together as a consortium?
  - Would a balance between cancer sites be maintained?
  - Would a balance with crosscutting issues be maintained?
  - Would a balance be maintained between the arenas of: prevention, screening/early detection, treatment and post-treatment (QOL, survivorship, end-of-life)?
8. The Board would decide whether or not to adopt the priority. If adopted by the MCC:
  - Organizations working on the new priority who are not already MCC members would be invited to join the MCC using the recruitment and application process established by the MCC Membership Committee.
  - The review process for the newly established priority would be consistent with the review process for all MCC priorities.

### **Background:**

The process for modifying one of the current ten MCC priorities was presented to the Board of Directors on June 16, 2004, and further developed at the Board Meeting on September 15, 2004.

Unresolved issues included the task of establishing the process for selecting a NEW priority that addresses (a) one of the current 5 cancers, (b) another cancer not currently being addressed or (c) a cancer related crosscutting topic. At the direction of the Board, the Co-Chairs appointed one Board member (A. Scholnik) and one MCC Staff member (K. Shankster) to recommend a process to the Board.

**Definitions:** (Based on the experience of past and current MCC advisory groups):

- **Priority:** Single action or group of actions directed at one “**arena**”/aspect, (prevention, early detection, treatment, and post-treatment- QOL, survivorship, end-of-life care) of a **problem** (cancer or cross-cutting issue), leading to a definable and achievable result. New priorities might address a new aspect/point on the continuum, a new treatment standard or a new crosscutting issue. (Examples of Current Priorities: Early detection of Breast Cancer; Prevention of Lung Cancer)
- **Objective:** Single action or group of actions **within one aspect of a problem** (within a priority) leading to a definable and achievable result. (Example: Increase number of women getting

mammograms; Decrease number of youth who begin smoking) **New objectives** within the current priorities are addressed through the existing advisory groups using the process already approved by the Board.

## Breast Cancer Priority Strategic Plan

### **B**reast 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**

**H**ow 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**

**I**n 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.<sup>1</sup>

### **What Needs To Be Done**

**A**lthough 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.<sup>2</sup> 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, ovarian, 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.
2. 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 annually or semi-annually 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, 118 women in Michigan died of the disease in 2004.

During 2003, 399 women in Michigan were diagnosed with invasive cervical cancer. Approximately 18% were under age 35, 46% were age 35-54, 26% were age 55-74, and 9% were over age 75.

During the year 2004, Michigan women lost a total of 2,899 woman-years of life to cervical cancer, with an average of 24.6 years of life lost per woman.

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.<sup>2</sup> These objectives and strategies are as follows:

### Objective #1

Increase public education regarding cervical cancer screening.

#### Strategies:

- From within targeted communities, identify and train peer spokespersons to help develop and disseminate prevention messages to community members.  
*\*Organizations representing or Serving Hard to Reach Special Populations, Local Public Health, and Insurance Plans, 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, Local Public Health and Insurance Plans can participate in this strategy.*
- Provide education through media, targeting January (Cervical Cancer Awareness Month)
  - Education should be in the medical sections of newspapers and on organization websites  
*\*All MCC organizations can participate in this strategy.*



## Objective #2

Increase provider knowledge regarding cervical cancer screening.

### Strategies:

- Educate all Michigan health care providers and students on MCC cervical cancer screening guidelines
  - Mail MCC cervical cancer screening guidelines to all Michigan providers.
  - Recommend inclusion of cervical cancer screening guidelines in health care provider curriculum.
  - Include information on MCC cervical cancer guidelines in organization newsletter.

*\*All MCC member organizations can participate in this strategy.*
- Encourage written information for women who receive a pelvic exam in Emergency Departments and Urgent Care Facilities that they did not receive Pap or HPV testing, as applicable.
 

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

*\*Health Care / Primary Care Delivery Systems and Practices and Local Public Health can participate in this strategy.*

## Objective #3

Influence health care policy reform.

### Strategies:

- Recommend that Medicaid Managed Care contracts have a mechanism for adherence to MCC cervical cancer guidelines.
 

*\*Health Care Insurance Plans can participate in this strategy.*
- Recommend that women who receive an annual exam also have or are referred for appropriate Pap testing
 

*\*Health Care Insurance Plans and Health Care / Primary Care Delivery Systems and Practices and Local Public Health can participate in this strategy.*
- Strongly recommend that pathologists provide correlation between the index Pap and biopsy result on the biopsy report, when clinically appropriate.
 

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

- Recommend coverage, by traditional third-party payers, for Pap and HPV testing.  
\**Health Care Insurance Plans can participate in this strategy.*

## Objective #4

Future Direction of Cervical Cancer Research

### 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.*
- Endorse and support Clinical Trials for Cervical Cancer  
\**Health Care Insurance Plans and Cancer Centers 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 5,424 new cases of colorectal cancer diagnosed in 2003. It is a cancer of both genders – 2,709 new cases were diagnosed in men in 2003, while 2,710 cases were diagnosed in women.

Colorectal cancer ranks fourth overall as a cause of cancer death in our state; lung, breast, and prostate cancer are the only other cancers that takes the lives of more men and women. In 2004, 1,872 Michigan residents died from colorectal cancer – 940 men and 932 women. Both men and women develop colorectal cancer and die from it. African Americans have higher colorectal cancer incidence and mortality rates than people of other racial groups.

During 2004, Michigan residents lost a total of 26,846 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 just over half (52.7 percent) of Michigan adults over age 50 reports ever having at least one colorectal cancer screening exam.<sup>1</sup>

## 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.<sup>2</sup> 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.
  - Work with health plans on what can be learned from database.
  - Promote incentive programs.

- Develop tools for tracking follow-up by providers.  
\*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.
  - Evaluate dissemination with standardized questions.  
\*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

Continue to increase health plan commitment to colorectal cancer screening.

### Strategies:

- Investigate effectiveness of health care provider incentives, especially financial, in 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.
- Promote collaboration between special populations and health plans (and vice versa).  
\*Health Care Insurance Plans and Organizations Representing or Serving Hard to Reach Special Populations can participate in this strategy.

## Objective #3

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.
  
- Promote public education 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**

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 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 Tobacco Priority Strategic Plan

### **L**ung 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

**H**ow 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

**T**obacco 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 follows<sup>1</sup>:



## 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](http://www.makemiairsmokefree.org)  
[www.michigan.gov/tobacco](http://www.michigan.gov/tobacco)  
[www.tcsg.org/sfelp/home.htm](http://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 2010, practice guidelines and educational materials will be available for professionals and survivors/families that address prostate cancer symptom management across the survivor continuum.*

### 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:

- Development of provider *practice guidelines* for prostate cancer symptom management.
- Number of *practice guidelines* for prostate cancer symptom management distributed to providers and survivors and their families.
- Number of culturally sensitive *educational materials* for prostate cancer symptom management identified for cancer survivors and their families.

### Why This Priority Is Important

Since 1991, prostate cancer has been the most frequently diagnosed cancer (other than skin cancers) in Michigan. In 2003, Michigan had the third highest incidence rate of prostate cancer in the nation; 8,119 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 2004 when 967 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 2<sup>nd</sup> largest group was prostate cancer survivors, 17% of the total. Currently, there are more than 81,000 prostate cancer survivors in Michigan.<sup>1</sup>

## 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.<sup>2</sup> These objectives and strategies are as follows:

### Symptom Management

#### Objective #1

By 2010, develop and distribute *practice guidelines* for prostate cancer symptom management to Michigan primary care providers and pertinent specialists.

#### Strategies:

- Identify the content essential to symptom management for the different phases of prostate cancer survivors.
  - \*This strategy will be accomplished through special studies conducted by the Michigan Public Health Institute and the Cancer Registry with input and consultation from members of the Prostate Cancer Action Committee and prostate cancer survivors.*
- Develop provider practice guidelines for prostate cancer symptom management that are age-specific and culturally appropriate.
  - \*This strategy will be based upon the results of the research listed in the first strategy and will be the focus of the Prostate Cancer Action Committee activities over the next few years with input from professional organizations and health care and primary care delivery systems and practices*
- Develop strategies to facilitate ongoing implementation of the prostate cancer symptom management guidelines during the critical transition from specialty care to follow-up care by primary care providers.
  - \*All MCC member organizations can participate in this strategy.*
- Develop a process to distribute the practice guidelines to health care providers as well as to survivors and families in Michigan.
  - \*All MCC member organizations can participate in this strategy.*
- Develop a method to evaluate the effect of the practice guidelines on the health related quality of life of survivors and families in Michigan.
  - \*Public Health, Health Research and Evaluation Member Agencies, and Organizations Representing or Serving Prostate Cancer Survivors can participate in this strategy.*

## Objective #2

By 2010, provide *educational materials* for prostate cancer symptom management to prostate cancer survivors and their families that are culturally sensitive and in clear language.

### Strategies:

- Identify the needs of prostate cancer survivors through a review of the literature and the use of focus groups.  
*\*Public Health Organizations and the Prostate Cancer Action Committee can participate in this strategy.*
- Identify existing educational materials relevant to prostate cancer survivors/families that will address their information needs.  
*\*Health Education/Health Research and Evaluation Organizations, Health Care Delivery Systems with Cancer Programs, and Organizations Representing or Serving Hard-to-Reach and/or Special Populations, including prostate cancer survivors, can participate in this strategy.*
- Identify gaps in existing prostate cancer educational materials.  
*\*Health Education/Health Research and Evaluation Organizations, the Prostate Cancer Action Committee, and Organizations Representing or Serving Hard-to-Reach and/or Special Populations, including prostate cancer survivors, can participate in this strategy.*
- Adopt, adapt, or develop patient educational material for prostate cancer survivors and their family members.  
*\*Health Education/Health Research and Evaluation Organizations, the Prostate Cancer Action Committee, Health Care Delivery Systems with Cancer Programs, and Organizations Representing or Serving Hard-to-Reach and/or Special Populations, including prostate cancer survivors, can participate in this strategy.*
- Develop a process to distribute prostate cancer symptom management educational materials to providers and survivors/families in Michigan.  
*\*All MCC member organizations can participate in this strategy.*
- Develop a method to evaluate how the utilization of educational materials affects the health related quality of life of survivors and families in Michigan.  
*\*Public Health, Health Research and Evaluation Member Agencies, and Organizations Representing or Serving Hard-to-Reach and/or Special Populations, including prostate cancer survivors, can participate in this strategy.*

## Treatment Options Decision-Aid

### Objective #3

Through 2010, maintain the integrity of content and availability of the patient education *treatment decision aid* “Making the Choice: Deciding What To Do About Early Stage Prostate Cancer”.

#### Strategies:

- Periodically review the content of the materials and update to reflect changes in the science.  
*\*The Prostate Cancer Action Committee can participate in this strategy.*
- Monitor dissemination of the materials and utilize tracking reports to make marketing decisions.  
*\*Public health or its partners such as Health Care Insurance Plans or Managed Care Organizations, Health Care Delivery Systems with Cancer Programs, and Health Care/Primary Care Delivery Systems and Practices can participate in this strategy.*
- Disseminate the decision-aid through a variety of channels and in a variety of formats including hard copy, on-line, pdf format.  
*\*All MCC member organizations can participate in this strategy.*
- Develop additional products to disseminate the treatment options information as needed.  
*\*All MCC member organizations can participate in this strategy.*
- Develop additional methods of dissemination to ensure that the materials are provided to men with a new diagnosis of prostate cancer prior to making a decision about treatment.  
*\*All MCC member organizations can participate in this strategy.*
- Maintain availability of the treatment option decision-aid materials in English, Spanish, and Arab languages.  
*\*All MCC member organizations can participate in this strategy.*
- Seek financial and logistical support for publication and dissemination of the materials.  
*\*All MCC member organizations can participate in this strategy.*
- Apply the knowledge learned during development and dissemination of the treatment decision-aid to the development of the symptom management guidelines for prostate cancer survivors and their providers.  
*\*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.<sup>1</sup> 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

1. 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

## **C**linical 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**

**H**ow 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**

**I**n 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 Committee<sup>1</sup> 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*

#### **O**bjective #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*

### **O**bjective #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 Committee<sup>1</sup> 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.*

## **O**bjective #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.*

## **O**bjective #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

### **B**asic 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

**H**ow 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

**W**hile 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.

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

## Implementation Progress Report to the Membership

The MCC recently released its fourth *MCC Implementation Progress Report to the Membership*, which is a reflection of the continued commitment of MCC member and key partner organizations to comprehensive cancer control in Michigan.

Most of the 10 priorities of the MCC Initiative and the overall MCC Strategic Plan for Implementation underwent a thorough revision within the January 1, 2004 and December 31, 2005 reporting period. The *MCC Implementation Progress Report to the Membership (January 1, 2004 - December 31, 2005)* highlights the activities that relate to the newly revised Strategic Plan and presents an in-depth analysis of implementation activities to date, including information specific to each MCC organization reporting, as well as aggregate analysis of data obtained from all organizations that submitted progress reports for the time period.

The MCC continues to generate excitement on the national, state, and local levels. Documenting the collective activities and successes of so many member and partner organizations enhances the MCC's ability to demonstrate the impact of stakeholders working together in a focused effort to change the course of cancer trends at the state level.

The report would not have been possible without the continued cooperation of the organizations that completed the MCC Implementation Progress Reporting Forms. A special note of appreciation is extended to members of the MCC Evaluation who helped redesign the framework for reporting progress markers.

The following are key highlights of the report:

- A total of 63 of 78 (81 percent) MCC member organizations contributed data to this report. The data are reported by organizational type and by MCC priority.
- MCC members are half way to incorporating early detection guidelines in their systems. Fifty percent of most member types have adopted and promoted the MCC guidelines or other national guidelines. This is a step forward in providing uniformity in cancer screening procedures across the state.
- MCC-affiliated health care plans report breast cancer screening rates of 72 to 87 percent, cervical cancer screening rates of 74 to 89 percent, and colorectal cancer screening rates of 49 to 61 percent within their plans.
- Research has shown that using a reminder and tracking system can significantly improve timely compliance of patients to early detection screening. One hundred percent of member health care plans reported that they had established a reminder and tracking mechanism for promoting appropriate cancer screening by their primary care providers. The MCC encourages other member organizations to implement similar systems.

- Improvement is needed in the area of increasing the accessibility of health systems to all Michigan residents by removing barriers of language and transportation and enhancing the cultural competence of cancer control service delivery.
- The majority of MCC members reported that they had successfully implemented public education campaigns related to cancer screening recommendations.
- Health care providers play a critical role in encouraging tobacco use cessation. Although some member health systems have integrated tobacco cessation guidelines into their policies, there is still room for growth in this important cancer control function. Equally important is engaging providers in the prevention of youth smoking.
- There is room for improvement in the area of creating and implementing public awareness programs that are focused on vulnerable populations and that engage community-based organizations.
- Research is lacking on effective methods for impacting smoking cessation rates and relapse prevention. More concerted efforts are needed in this area.
- MCC-affiliated health plans are contributing to efforts to promote smoking cessation by ensuring smokers' access to Food and Drug Administration-approved tobacco cessation medications.
- HEDIS performance measures show that 70 to 77 percent of smokers or recent quitters in member health plans received advice to quit, but only 40 to 49 percent of smokers or recent quitters in the plans were told about smoking cessation medications.
- The patient educational materials that were developed by the MCC are comprehensive and effective tools for guiding men who are diagnosed with early stage prostate cancer in the decision making process regarding their treatment. MCC members are encouraged to help promote these tools.
- An MCC standardized basic lexicon was successfully developed and disseminated. Using standardized lexicons for reporting cancer pathology results is key to facilitating uniformity of interpretation and, thus, decisions by cancer specialists regarding patient prognosis and appropriate treatment. Several member organizations collaborated in implementing this priority. Continued efforts are needed to ensure that all pathology laboratories in Michigan adopt the MCC basic lexicon or national standard lexicon.
- Linkage was accomplished between clinical cancer information that is collected by the Michigan Cancer Surveillance Program and cost data from Blue Cross Blue Shield of Michigan, Medicare, and Medicaid. This is a uniquely challenging project, and it has required overcoming significant and multiple levels of privacy protection and confidentiality provisions. The end result, however, can potentially be a valuable source of data for researchers and public health planners.

- This report includes a synopsis of implementation areas in which MCC member organizations have been individually involved. Members are hard at work addressing different levels of cancer control strategies (public education, professional education, improving access to cancer care, policy and advocacy, system change, research and evaluation), all of which are necessary to further achievement of MCC goals.
- The MCC leadership is committed to maintaining a high level of member motivation and engagement in the Consortium's initiative and programs. Assessment of the current status revealed a fair level of member satisfaction and a number of perceived benefits by members of their affiliation with the MCC. These perceived benefits include: networking opportunities; access to resources; and increased visibility for the organizations that participate.
- Summaries of special accomplishments by MCC members for the reporting period are integrated within each section of this report. These summaries illustrate successful programs and models of collaborative implementation.

The report underlines the depth and complexity and the elaborate resources that are involved in working toward achievement of comprehensive cancer control. It emphasizes the importance of the continued commitment and level of energy required of members for the Consortium to collectively make a positive impact on cancer trends in our state.

To access the report in its entirety, please visit:

[http://www.michigancancer.org/PDFs/AnnualReports/2004-2005/MCCImplementationProgressReport\\_2004-2005.pdf](http://www.michigancancer.org/PDFs/AnnualReports/2004-2005/MCCImplementationProgressReport_2004-2005.pdf)

## National Recognition

On May 20, 2006, the Michigan Cancer Consortium received the first-ever Exemplary Comprehensive Cancer Control Implementation Award from [C-Change](#), a national organization comprised of cancer prevention leaders across the country. President George H.W. Bush, C-Change's chair, presented the MCC with the award during the 2006 Semi-Annual C-Change Meeting in Bethesda, MD.

Dr. Max Wicha, director of the University of Michigan Comprehensive Cancer Center and immediate past co-chair of the MCC, and Patty Brookover, director of MDCH Comprehensive Cancer Control Program, accepted the award on behalf of the Consortium.



“The MCC developed its comprehensive cancer control plan in 1998, and as a result of implementation efforts by our partner organizations, progress has been made in addressing the cancer burden in Michigan,” said MCC Co-Chair Vicki Rakowski, vice president for cancer control at the American Cancer Society, Great Lakes Division, Inc. “Evidence of our progress includes an increase in early stage diagnosis of breast, cervical and colorectal cancers and an associated reduction in mortality.”

### About C-Change

C-Change is comprised of about 130 of the nation's key cancer leaders from government, business, and nonprofit sectors. Members include the heads of federal and state governmental agencies, private businesses, the motion picture industry, and nonprofit groups whose missions relate to cancer research, control, and/or patient advocacy.

Other individuals with a deep concern about cancer and who have achieved prominence in the entertainment, news, and other industries or endeavors also are engaged in C-Change. Former President George H.W. Bush and former First Lady Barbara Bush are co-chairs of C-Change, and U.S. Senator Dianne Feinstein (D-CA) serves as vice chair of the organization.

These cancer leaders share the vision of a future where cancer is prevented, detected early, and either cured or managed successfully as a chronic illness.

One of the underlying principles of C-Change is to leverage the leadership and expertise of all sectors of society to eliminate cancer as a major public health problem at the earliest possible time.

The MCC's nomination for the C-Change award included a copy of the recently completed "Building Bridges" video that provides an overview of the Consortium and highlights activities MCC members are undertaking to control cancer in Michigan.

**Learn More**

[Download a news release](#) from the Michigan Department of Community Health about the award (*available as an Adobe Acrobat PDF file*)\*

[View and/or download photos from the awards ceremony](#)

[Download the nomination application](#) the MCC submitted for the 2006 C-Change Exemplary Comprehensive Cancer Control Implementation Award (*available as an Adobe Acrobat PDF file*)\*

View the "Michigan Cancer Consortium: Building Bridges" video included with the MCC nomination application\*\*

[Download the video as a Quick Time movie](#) (9 minutes, 13 seconds; 18.96 MB file).

[Download the video as a Windows Media video](#) (9 minutes, 13 seconds; 18.69 MB file).