EXECUTIVE SUMMARY

District of Columbia Cancer Control Plan

2011–2016

DC Cancer CONSORTIUM

Several years ago, a gathering of expert, committed individuals and organizations collaborated to develop the District's first comprehensive plan to combat cancer.

The plan was ambitious—broad and deep. And, in just a few years, its implementation has produced real progress. But the progress, while significant, is only a beginning: in our area, there are still far too many men, women, and children coping with cancer.

So now it is time to take next steps. Of course, the ultimate goal is to conquer, not just combat, cancer—but for now, it is time for a plan that outlines robust but realistic goals attainable within the next five years.

The full plan is being finalized and will soon be available. In the meantime, this Executive Summary will give you an idea of its considerable scope. We hope you will read and absorb it—and then do whatever you can to help. This effort needs and deserves resources of every kind: expertise, funding, advocacy, and more.

Directly or indirectly, cancer touches every one of us—so every one of us has a significant stake in the collaborative effort to control, and ultimately conquer, this powerful adversary.

Introduction

The First Plan

In 2001, the District of Columbia Department of Health (DC DOH) created the DC Cancer Control Coalition, a partnership of organizations, institutions, advocates, and others addressing the District's cancer burden, in order to engage the community in addressing comprehensive cancer control and prevention.

The need was—and remains—unmistakable.

- In terms of both incidence and mortality, cancer preys particularly heavily on African Americans—and approximately 51 percent of the District's 2010 population was of African descent.[1] Cancer mortality in the city is highest in Wards 5, 7, and 8—those with the highest concentrations of African Americans and low-income residents.[2]
- In 2010, roughly nine percent of District residents were Hispanic, and cancer mortality in Ward 1—with the District's highest concentration of Hispanics—is nearly as high as in Wards 5, 7, and 8.[3] Traditionally, Hispanic residents are the District's least likely to have health insurance of any kind.[4]
- Moreover, barriers to preventive care and treatment for cancer have historically existed for both Hispanics and African Americans in the District. They include the lack of medical homes (primary care settings where routine health care is received), the inequitable distribution of screening facilities, inadequate or absent insurance coverage, and the lack of culturally appropriate care[5].

The result of all these circumstances: cancers that have been diagnosed in late stages, or that could have been prevented entirely, leading to increased mortality for some and a suboptimal quality of life for many survivors.

The response in 2001 was energetic.

In an effort funded by the Centers for Disease Control and Prevention, DC DOH and the Coalition worked for four years. Along the road, the Coalition formalized itself into the DC Cancer Consortium, a non-profit 501(c)(3) organization comprising approximately 70 organizations and individuals.

In 2005, the Coalition produced the District's first Cancer Control Plan—a comprehensive five-year array of strategies designed to reduce the number of new cases of cancer, decrease the number of deaths caused by cancer, and improve the quality of life for cancer survivors in the Nation's Capital.[6]

In 2006, with the passage of the Community Access to Healthcare Act, the Consortium was awarded $20 million (which was reduced to $16.5 million in 2010) from the Master Settlement Agreement (the "tobacco settlement") to implement the Plan. The work was to be done in partnership with DC DOH,

with which the Consortium shares responsibility for a coordinated approach to cancer control.[7]

For the five-year implementation period, the team prioritized the plan's objectives. Among top priorities: increasing access to care, improving the early detection of cancer, reducing tobacco-related mortality, increasing the quality of DC Cancer Registry data, improving awareness of the availability of palliative and end-of-life care, and enhancing systems of support for cancer survivors.

Working the Plan

To move toward achieving the Plan's objectives, myriad initiatives and programs were established through grantmaking and collaboration—particularly with DC DOH and local cancer stakeholders. They include, for example:

- The City-wide Patient Network, a collaborative effort that increases all District residents' access to screening, treatment, and survivorship planning services through personalized patient support
- The DC Screen for Life Program, a partnership providing screening and treatment services for colorectal cancer in communities with low incomes and high cancer risk
- A breast and cervical cancer screening program, providing grants to health institutions to increase services for District women who are uninsured or underinsured and ineligible for public screening or health insurance programs
- A partnership with DC DOH to maintain the District of Columbia *Quitline*, a toll-free telephone service for English- and Spanish-speaking residents who smoke but desire to quit, so they can obtain free nicotine replacement therapy products and smoking cessation counseling

In parallel over the past five years, the District's residents have benefited from strategic and systemic improvements. Those include, for example:

- The transformation of the DC Health Care Alliance into a Medicaid-managed-care lookalike, effectively merging the local and federal public insurance programs administratively within a new cabinet-level agency (the DC Department of Health Care Finance), and including a streamlined, unified enrollment process[8]
- The expansion of Medicaid under the Patient Protection and Affordable Care Act, increasing the availability of insurance to more uninsured District resident adults
- The progress of the public-private Medical Homes DC initiative (managed by the DC Primary Care Association) in expanding primary care capacity and quality, particularly in Wards 7 and 8[9]

Have the efforts produced results? Yes. American Cancer Society projections of cancer mortality in

2011 forecast a 20 percent improvement in mortality from 2005, the year the initial DC Cancer Control Plan was released.[10] The greatest mortality decreases came in colorectal and prostate cancers, two of the cancers targeted in the Plan.[11]

That is excellent news, but there is still much to be done. Unfortunately, the District of Columbia continues to have one of the country's highest cancer mortality rates,[12] lower than only five of this country's poorest states.[13] According to the American Cancer Society, 2,830 District residents will be diagnosed with, and 920 will die from, cancer in 2011.[14] Despite progress, cancer persists as the leading cause of premature (before age 70) death in the District, and as the second most common cause of death overall, regardless of gender or race.[15]

Leveraging the Wins: A New Five-Year Plan

To maintain the positive momentum of the first five years, and to properly guide resources and programs for the next five, the Consortium initiated a revision process for the Cancer Control Plan.

In order to remain inclusive and relevant, the Consortium convened stakeholder groups for specific cancers and life stages along the cancer continuum. The groups were organized to maximize the depth and breadth of viewpoints and included, among others, cancer survivors, advocacy groups, physicians, public health experts, and community-based service providers.

Over nine months, the groups met for a series of conversations in which they assessed the District's cancer epidemiology and overall burden, discussed needs and real-world challenges, and evaluated progress vis-à-vis the first plan.

Utilizing expert opinion, the stakeholders developed five-year goals with measurable objectives designed to ensure movement toward the goals. Action steps and timeframes were devised, incorporating evidence-based interventions as much as practical, but including the anecdotal experiences of survivors and providers as appropriate.

The new Cancer Control Plan's chapters present discussions, goals, objectives, and action steps for these areas: Obesity Prevention, Clinical Trials, Tobacco-related Cancers, Breast Cancer, Cervical Cancer, Colorectal Cancer, Prostate Cancer, Pediatric Cancers, Cancer Survivorship, and Palliative Care.

While the chapters speak to current and projected conditions in the District, circumstances—political, economic, social, and medical—evolve over time, requiring flexibility in planning and openness in modifying strategies. That is why the Consortium intends for the revised DC Cancer Control Plan to be a living document. During its five-year implementation, the Plan will be re-evaluated annually in order to examine data; assess progress and potential impact; and determine any need for refinement in objectives, activities, or timeframes.

Implementation: What Is Needed to Produce Change

The stakeholders set out bold strategies and timeframes for driving down the District's cancer incidence, impact, and mortality over the next five years. But, for goals to be achieved, three elements are absolutely necessary.

1. First is a true sense of ownership of the Plan—not only by the members of the Consortium, but also by the leadership structure of the city. Each member organization, individual stakeholder, executive branch agency, and legislative representative must be—and feel like—a necessary part of a systemic change process, working not only within an individual entity but as an integral and inseparable part of a coalition working to alleviate the local cancer burden.
2. Assets are a "must" for successful implementation. Private and public funding sources will need to be engaged to support the educational, service, and other initiatives outlined in the Plan. However, dollars are only one of the necessary resources. Others include innovations in collaborating and coalition-building among new partners—all with an eye toward breaking out of parochial "silos" and working toward common public health goals. That is not always easy—but it has to happen. And stakeholder organizations must self-inventory internal resources—physical, human, organizational—that can contribute to achieving the Plan's goals.
3. The last element is data for measurement and process improvement. This may seem a simple requirement, but it involves challenges such as the sharing of potentially proprietary information, the improvement of legacy information systems, and the expansion of traditional data elements, all, of course, within the Health Insurance Portability and Accountability Act (HIPAA) framework.

The work of the next five years is formidable—but its importance is immeasurable: this is truly a matter of life and death. DC Cancer Consortium and its member organizations are committed to serving as a unified voice for the District's medically underserved men, women, and children. Through collaboration, community engagement, and—most of all—wholehearted commitment from everyone who believes in the value of the work, we can together make great progress in easing the heavy burden of cancer.

Goals and Objectives

The full 2011–2016 DC Cancer Control Plan will soon be available. Meanwhile, this Executive Summary includes the Plan's major goals and objectives. Overarching goals and objectives are presented first, followed by chapter goals and objectives.

Overarching Goals and Priorities

Overall Goal: Reduce overall cancer incidence and mortality, reduce racial and other disparities in cancer incidence and outcomes, and improve the quality of care for, and the life of, cancer survivors by…

Improving access to care

- Secure sufficient funding for the combined Alliance and Medicaid programs
- Ensure that every resident has a primary care medical home
- Provide patient navigation for cancer screening and treatment
- Coordinate cancer services by linking clinics and hospitals
- Improve cancer patients' access to clinical trials

Increasing rates of screening, particularly for breast, cervical, and colorectal cancers, and providing all necessary follow-up cancer care.

Encouraging District-based research on its cancer burden, including identification of gaps and challenges in cancer prevention, surveillance, and quality of care

Increasing public awareness of healthy behaviors that prevent cancer.

- Eliminate tobacco use
- Reduce obesity
- Increase regular physical activity
- Eat healthy foods and avoid overeating
- Have routine access to preventive health care services through medical homes
- Increase safe sexual health practices

Advocating with the District government and other funding organizations on issues and funding relating to cancer.

Educating health care providers about…

- State-of-the-art information on cancer risk factors, prevention, and early detection
- Use of best practice tools to increase cancer screening rates
- Rehabilitation
- Palliative and end-of-life care

Improving the collection and use of DC data about cancer

- Improve quantity and quality of data collected about racial and ethnic minority groups, as well as other identified subpopulations at risk of high cancer incidence and mortality.

Educating survivors and caregivers about resources and follow-up care, and assuring the quality of those supporting services

Increasing the awareness, availability, and quality of palliative care and end-of-life care

Obesity Prevention Goals and Objectives

Goal: Reduce the incidence of cancer in the District by improving the nutrition and physical activity, and supporting the healthy weight, of its residents.

Objective 1: Ensure the promotion and enactment of policies that create access to healthy foods and opportunities for physical activities in all District wards.

Objective 2: Advocate for and support an educational program utilizing effective behavior-change messages to make District residents aware of linkages among cancer, unhealthy body weight, and actions to achieve healthy weight.

Clinical Trials Goals and Objectives

Goal: Increase the participation of the District's minority populations in clinical trials.

Objective 1: Implement a process for tracking patients participating in clinical trials in the District.

Objective 2: Monitor, review, and provide annual feedback on the minority recruitment efforts of the District's cancer centers.

Objective 3: Develop a strategic plan to address the economic barriers to clinical trial participation faced by minority patients.

Tobacco-Related Cancers Goals and Ojectives

Goal A: Reduce disparities in tobacco usage and tobacco-related cancer in the District.

Objective 1: Reduce the proportion of African-American and Hispanic residents who are either adult smokers or middle and high school youth users by 10% of 2010 BRFSS and YRBSS baselines.

Objective 2: Increase venues covered by tobacco-use restrictions or bans above the 2010 baseline.

Objective 3: Increase District policies addressing tobacco product promotion and marketing above the 2010 baseline.

Objective 4: Increase District funding to CDC-recommended levels for local public and/or

non-profit tobacco-control programs.

Goal B: Decrease the District's mortality due to oral cancer.

Objective 1: Develop a system of oral cancer data collection, with screening activity and quality elements.

Objective 2: Initiate District-wide professional education program on appropriate oral cancer screening activity.

Objective 3: Increase the proportion of African-American males over the age of 40 who have had an oral cancer examination in the past year by 10% over the established baseline.

Breast Cancer Goals and Objectives

Goal: Reduce the District's mortality due to breast cancer.

Objective 1: Increase to 90% the number of women age 40 years and over who have received a mammogram within the past two years.

Objective 2: Increase early detection and prevention by assuring access to appropriate women's health care, including risk reduction and clinical breast examination.

Objective 3: Decrease to no more than 30 days the time from diagnosis of breast cancer to treatment for all racial and income groups.

Objective 4: Decrease to no more than 30 days the time from abnormal breast cancer screening to diagnosis for all racial and income groups.

Cervical Cancer Goals and Objectives

Goal: Reduce the District's mortality due to cervical cancer.

Objective 1: Decrease the incidence of invasive cervical cancer below the 2008 baseline.

Objective 2: Increase knowledge about and availability of HPV vaccination above the established baseline.

Objective 3: Increase cervical cancer screening rates for African-American, Hispanic, and Asian women age 21 to 70 years 10% above the 2010 BRFSS baseline.

Objective 4: Increase the proportion of women with abnormal cervical cancer screening results who are diagnosed within 60 days after abnormal screening, and increase the proportion of those who begin treatment within 60 days after diagnosis.

Colorectal Cancer Goals and Objectives

Goal A: Reduce morbidity and mortality due to colorectal cancer in the District.

Objective 1: Increase colorectal screening activity for average-risk residents 50 years and older by 20% over the 2010 BRFSS baseline.

Objective 2: Decrease the difference in mortality between African-American residents and White residents to 50% of the 2008 baseline.

Objective 3: Identify and develop strategies to address colorectal cancer mortality disparities in other high-risk populations.

Goal B: Reduce the incidence of colorectal cancer in the District.

Objective 1: Decrease the prevalence of lifestyle and dietary risk factors for colorectal cancer, including overweight and obesity, low intake of fruits and vegetables, lack of physical activity, and tobacco use.

Objective 2: Decrease the difference in incidence between African-American residents and White residents to 50% of the 2008 baseline.

Objective 3: Identify and develop strategies to address colorectal cancer incidence disparities in other high-risk populations.

Prostate Cancer Goals and Objectives

Goal: Reduce morbidity and mortality due to prostate cancer in the District.

Objective 1: Through the provision of professional and public education, improve the appropriateness of prostate cancer screening for District residents.

Objective 2: Establish a standard for a community prostate screening process, including education and informed decision-making.

Objective 3: Increase the early detection and appropriate management of clinically relevant prostate cancer.

Objective 4: Reduce the proportion of unstaged prostate cancer cases for all races to less than the 2008 baseline percentage.

Cancer Survivorship Goals and Objectives

Goal: Increase access to follow-up care, reduce recurrence, and improve the overall quality of life for the District's cancer survivors.

Objective 1: Analyze and report on the current state of survivorship needs, including medical, psychosocial, financial, nutritional, transportation, and rehabilitation needs for District resident survivors.

Objective 2: Utilizing national standards, establish District-wide comprehensive standards of care for survivorship programs, and subsequently educate providers on those standards.

Objective 3: Educate survivors, families, and caregivers on survivorship issues and appropriate standards for follow-up care.

Objective 4: Utilize the Objective 1 report to develop a strategic plan to address survivorship needs.

Palliative Care Goals and Objectives

Goal A: Improve the quality of palliative care education and services in the District.

Objective 1: Assess and develop recommendations to improve current palliative care practices.

Objective 2: Develop initiatives to assure the appropriate management of pain within the District.

Goal B: Promote the adoption of patient-centered continuity of care (including advance care planning) for patients with serious illness for all District of Columbia healthcare institutions.

Objective 1: Review current programs that highlight a shared decision-making patient-centered continuum of care, including those that focus on advance care planning and advance directives, and make recommendations for improved outcomes.

Objective 2: Develop and implement a strategic plan for assuring patient-centered care and shared decision-making in the District.

Goal C: Improve the policy and regulatory environment impacting access to palliative care services in the District.

Objective 1: Develop an active policy team to advocate for enhanced reimbursement of government support and actively participate in District/national policy initiatives.

Endnotes

(1) US Census Bureau, 2011, “State and County QuickFacts: District of Columbia”

(2) DC Cancer Registry, 2011

(3) DC Cancer Registry, 2011

(4) DC Cancer Coalition, 2005, p. 3

(5) DC Cancer Coalition, 2005, pp. 3–4

(6) DC Cancer Coalition, 2005

(7) Community Health Administration, n.d.

(8) Meyer, Bovbjerg, Ormand, & Lagomarsino, 2010, p. 42

(9) Meyer, Bovbjerg, Ormand, & Lagomarsino, 2010, p. 50

(10) American Cancer Society, 2011 Cancer Facts and Figures

(11) DC Cancer Registry, 2011

(12) National Cancer Institute, 2011

(13) U.S. Census, 2011, “Median Household Income, 2008”

(14) American Cancer Society, 2011, p. 5

(15) DC Department of Health, 2009

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