EXECUTIVE SUMMARY

District of Columbia Cancer Control Plan

2013–2018

DC Cancer CONSORTIUM

Executive Summary

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 local residents dedicated to addressing the District's cancer burden. The creation of the Coalition formalized the efforts of a group of volunteers who formed in 1990 to advocate for a comprehensive cancer control program in the District.

The response to the clarion call for cancer control in 2001 was energetic.

In an effort funded by the Centers for Disease Control and Prevention (CDC), DC DOH and the Coalition worked for four years. Along the road, the Coalition incorporated to create the District of Columbia Cancer Consortium (DC Cancer Consortium), a nonprofit 501(c)(3) organization comprised of approximately 70 organizations and individuals.

The collaboration 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 due to cancer and improve the quality of life for cancer survivors in the nation's capital.[1]

In 2006, with the passage of the Community Access to Healthcare Act, the Consortium was awarded $20 million 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.[2] That amount was not received until 2007 and in December 2010 was reduced to $16.5 million, with the remaining $3.5 million shifted to balance the District's budget.

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 careand enhancing systems of support for cancer survivors.

The need in 2001 was—and remains in 2013—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.[3] Cancer mortality in the City is highest in Wards 5, 7 and 8—those with the highest concentration of African Americans and low-income residents.[4]

In 2010, roughly nine percent of District residents were Hispanic, and cancer mortality in Ward 1—having the District's highest concentration of Hispanics—is nearly as high as in Wards 5, 7 and 8.[5] Traditionally, Hispanic residents in the District are least likely to have health insurance of any kind.[6]

Moreover, barriers to preventive care and treatment for cancer have existed historically for both Hispanics and African Americans in the District.

These barriers include the lack of medical homes (primary care settings that provide routine health care), inequitable distribution of screening facilities, inadequate or absent insurance coverage and the lack of culturally appropriate care.[7]

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

Working the Plan

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

- The City-wide Patient Navigation 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 income and high cancer risk.
- The breast and cervical cancer screening program, which provides 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 the 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 entity, effectively merging the local and federal public insurance programs administratively within a new cabinet-level agency (the Department of Health Care

Finance) and including a streamlined, unified enrollment process.[8]

- The expansion of Medicaid under the federal Patient Protection and Affordable Care Act (PPAC), 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 36.5 percent improvement in mortality from 2005, the year the initial Cancer Control Plan was crafted.[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 four of this country's poorest states.[13] According to the American Cancer Society, 2,950 District residents were diagnosed with, and 1,010 died from cancer in 2012.[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 Wins: A New Five-Year Plan

To maintain the positive momentum of the first eight years and to properly guide resources and programs for the next five, the Consortium initiated a revision process for the DC 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 16 months, beginning in 2011, 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 and existing data, 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, and including the anecdotal experiences of survivors and providers as appropriate.

The issue that overshadowed all stakeholder discussions was the **disparity** in cancer burden experienced by racial and other specific populations. In the District, African Americans had either the highest incidence or highest mortality rate for each of the identified cancers. African Americans also were most affected by such issues as lack of access, diagnosis at later stage, inadequate palliative care and low participation in clinical trials. According to a recent Rand report, black residents in the District were 90% more likely to die from cancer in 2008 than white District residents.[16]

The stakeholders resolved to tackle this issue directly. Each cancer-specific section of the Plan contains objectives and implementing activities aimed at addressing the disparity experienced by African Americans and other special populations residing in the District. The Plan also contains a special section on Health Equity.

The 2013-2018 Cancer Control Plan chapters present discussions, goals, objectives and action steps for five priority cancers: Breast, Cervical, Colorectal, Oral and Prostate. In addition, the Plan addresses overarching issues affecting all cancers: Clinical Trials, Health Equity, Obesity Prevention, Palliative Care, Cancer Survivorship and Tobacco-related Cancers.

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. This is why the Consortium intends the revised Cancer Control Plan to be a living document. During its five-year implementation, the Plan will be 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. They are:

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—is critical. 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 that is making an enormous difference in the local cancer burden.

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. As yet unknown, the potential assets provided by the PPAC must be factored into the portfolio of assets that may become available to implement the Plan.

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. In addition, more substantial and comprehensive data collection is required to better target resources and efforts.

The work of the next five years is formidable—but its importance is immeasurable: this is truly a matter of life and death. For many cancers, the District of Columbia has among the highest incidence or mortality rates in the nation; in most cases, the rates in the District are higher than the national rates.

The 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 lightening the heavy burden of cancer.

Now, after countless hours of work by scores of dedicated professionals and stakeholders, including those directly affected by cancer, the 2013-2018 DC Cancer Control Plan is complete. It provides the most current information on status, incidence and mortality of specific cancers, along with an array of strategies to reduce the disproportionately high rates of cancer deaths and diagnoses in the District of Columbia.

The challenges, while considerable, are not insurmountable; they are simply factors that must be taken into account. The new Plan builds on the achievements of the original and recognizes new opportunities for collaboration with members and partners united in the urgency of the mission.

Two criteria were used to identify the cancers to be addressed in the 2013-2018 Plan: 1) those cancers that were the most preventable and most easily detected by testing and 2) cancers for which the District had among the highest incidence or mortality rates as compared with national figures. The cancers addressed in the new Plan are:

- Breast
- Cervical

- Colorectal
- Oral
- Prostate

Additional chapters are devoted to overarching issues affecting all cancers:

- Clinical Trials
- Health Equity
- Obesity
- Palliative Care
- Patient Navigation
- Survivorship
- Tobacco Use

Goals and Objectives of the 2013-2018 Cancer Control Plan

OVERARCHING GOAL 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. Priorities for achieving the goal include the following:

Improving access to cancer care

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 gaps and challenges in cancer prevention, surveillance and quality of care

Increasing public awareness of healthy behaviors that may prevent cancer

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

Educating health care providers

Improving the collection and use of DC data about cancer

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

Chapter Goals and Objectives

DC Breast Cancer Goal and Objectives

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

Objective 1: Increase from 81.6% to 90% the number of women aged 40 years and older who have received a mammogram within the past two years.

Objective 2: Increase early detection and prevention by improving the role of health care providers in ensuring access to appropriate women's health care, including risk reduction and clinical breast examination.

Objective 3: Decrease to no more than thirty days the time from abnormal breast cancer screening to definitive cancer diagnosis for all racial and income groups. (The current screening-to-diagnosis time is generally acknowledged to average 45 days.)

Objective 4: Decrease to no more than thirty days the time from diagnosis of breast cancer to treatment for all racial and income groups. (The current diagnosis-to-treatment time is generally acknowledged to average 45 days.)

DC Cervical Cancer Control Goal and Objectives

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

Objective 1: Increase cervical cancer screening rates for African American, Hispanic/Latina and Asian women aged 21 to 70 years 10% above 2010 Behavioral Risk Factor Surveillance System (BRFSS) City-wide baseline of 87.1%.

Objective 2: Decrease incidence of invasive cervical cancer below 2008 baseline of 9.4 per 100,000 for all races.

Objective 3: Increase knowledge about and the availability of HPV vaccination above established baseline.

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

DC Cancer Clinical Trials Goal and Objectives

GOAL: Increase by 15% 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 of Columbia.

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.

DC Colorectal Cancer Goals and Objectives

GOAL 1: 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: Reduce by 50% the gap in the 2008 colorectal cancer incidence rate between Black residents (49.3) and White residents (33.9).

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

GOAL 2: Reduce morbidity and mortality due to colorectal cancer in the District.

Objective 1: Increase by 20% colorectal cancer screening activity (fecal occult blood test and colonoscopy) for average-risk residents 50 years and older. This would increase the percentage of residents who are up-to-date with any screening in the past two years to 28.4% from the 2010 BRFSS baseline of 23.7%.

Objective 2: Decrease by 50% the 2008 gap in mortality rates between African American residents (21.0) and White residents (13.6).

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

DC Health Equity Goal and Objectives

GOAL: Reduce/eliminate cancer burden disparities attributable to race/ethnicity, gender, culture, socio-economic status, language and other social determinants.

Objective 1: Increase awareness among the public and health providers about social determinants and their influence on cancer rates.

Objective 2: Expand existing data base and tracking systems to include health equity factors (e.g., income, geographic area, etc.).

DC Obesity/Prevention Goal and Objectives

GOAL: Reduce the incidence of cancer in the District by improving the nutrition and physical activity of its residents in order to achieve and maintain a healthy weight.

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 of unhealthy body weight to cancer, their weight status and actions to achieve healthy weight.

DC Oral Cancer Goal and Objectives

GOAL: Decrease the age-adjusted mortality due to oral cancer by 15%.

Objective 1: Develop a system of data collection to include measurements for screening and to ensure that best practices are being followed.

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

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

DC Palliative Care Goals and Objectives

GOAL 1: Improve the quality of education about palliative care and related services in the District.

Objective 1: Assess and develop recommendations to ensure that current pediatric and adult palliative care practices are based on national quality standards.

Objective 2: Develop initiatives, including outpatient options, to meet the needs of the palliative care population in the District.

GOAL 2: Promote the adoption of patient-centered continuity of care (including advance care planning) for patients and support family caregivers.

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

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

GOAL 3: Improve the policy and regulatory environment affecting access to pediatric and adult 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.

DC Access to Care and Patient Navigation Objectives

GOAL: Increase access to timely and adequate care for all District residents.

Objective 1: Continue to provide a safety net for individuals across the cancer continuum through the provision of patient navigation that includes community organizations, primary care and screening sites and cancer centers.

Objective 2: Advocate for patient navigation as a reimbursable cost.

Objective 3: Provide cancer educational opportunities to raise awareness and support appropriate cancer screening practices across Metropolitan DC.

Objective 4: Increase proportion of patients diagnosed within 30 days of adverse finding, using local baseline for evaluation.

Objective 5: Increase proportion of patients who begin treatment within 30 days of diagnosis, using local data as a baseline for evaluation.

Objective 6: Increase the numbers of minorities and other underrepresented populations in cancer clinical trials.

Objective 7: Increase number of patients receiving survivorship information and support, using local data as a baseline for evaluation.

DC Prostate Cancer Goal 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 community prostate screening process, including education and informed decision-making.

Objective 3: Increase the early detection and appropriate management of clinically relevant prostate cancer—cases with a high probability of rapid tumor growth—to mitigate adverse impact on chances of survival and quality of life.

Objective 4: Reduce the proportion of unstaged prostate cancer cases for all races from the 2004-2008 Surveillance Epidemiology and End-Year Results (SEER) baseline of 11.7 to less than 3.

DC Survivorship Goal and Objectives

GOAL: Increase access to follow-up care, reduce recurrenceand 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, nutrition, transportation and rehabilitation needs for District resident survivors.

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

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

Objective 4: Develop a strategic plan to address survivorship needs.

DC Tobacco-Related Goal and Objectives

GOAL: Reduce disparities in tobacco use 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 lifetime users by 10% of 2010 Behavioral Risk Factor Surveillance Survey (BRFSS) and Youth Risk Behavior Survey (YRBS) baselines.

Objective 2: Increase venues covered by tobacco-use restrictions or bans above 2010 baseline, which includes restaurants, bars, retail locationsand indoor places of employment.

Objective 3: Increase District policies addressing tobacco product promotion and marketing above 2010 baseline, which includes advertising near schools, couponing, samples and point-of-purchase ads.

Objective 4: Increase District funding to CDC-recommended levels for local public and/or non-profit tobacco-control programs.

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