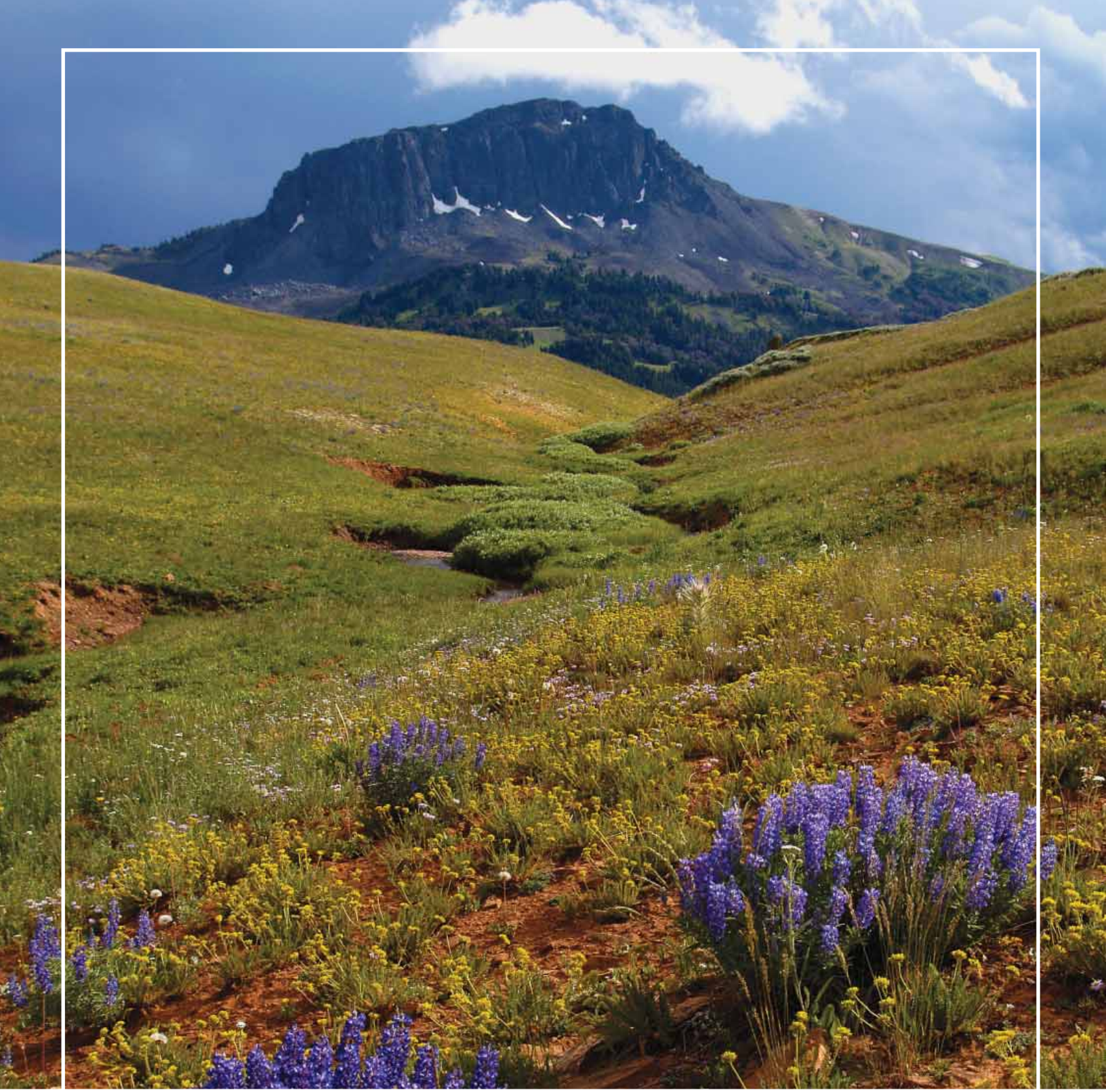

MONTANA COMPREHENSIVE CANCER CONTROL PLAN
2011-2016

MONTANA
CANCER CONTROL
COALITION

Working together...

My fellow Montanans,

Most of us have been affected by cancer personally or through our family members. Cancer is not selective. As Montanans, we have an opportunity to work together to lessen the negative impact of cancer within our great state.

Effective cancer prevention and control requires thorough, collaborative planning and coordination. The Montana Cancer Control Coalition (MTCCC) has taken on that task. Over the past 5 years, and going forward into the next 5, the MTCCC has brought together hundreds of people from around the state to reduce the burden of cancer in Montana. Together they have created a plan that will help prevent and control cancer. These committed people have shared their collective knowledge and expertise for the good of all Montana families.

The result is the 2011–2016 Montana Comprehensive Cancer Control (CCC) Plan. The plan is a living document, a road map of activities that will change and evolve over time while decreasing the overall burden of cancer in Montana. The CCC Plan provides ways to become involved in implementing strategies for comprehensive cancer control. It is a plan that honors our ability to make progress in our efforts to prevent and control a deadly disease. This is a process that can and should give us hope for the future. By working together, we can truly ensure a healthier Montana.

Anna Whiting Sorrell, Director
Department of Public Health and Human Services

Purpose

The Comprehensive Cancer Control (CCC) Plan will serve as a guide for cancer control programs in Montana. This guide will allow involvement of all touched by cancer and will encourage statewide, community-level participation. It has been designed to evolve with changing circumstances and to allow flexible and creative responses to emerging issues. The CCC Plan will promote collaboration to achieve comprehensive cancer control in Montana.

Mission

To reduce cancer incidence, morbidity, and mortality in Montana through a collaborative partnership of private and public individuals and organizations.

To develop, implement, promote, and advocate for a statewide, coordinated, integrated approach to controlling cancer for all Montanans.

To ensure quality of life through cancer prevention, early detection, treatment, research, rehabilitation, and palliation.

Vision

A comprehensive, statewide, evidence-based approach to reducing the burden of cancer in Montana, motivated by compassion…an investment in the future.

Guiding Principles

- Best practices
- Comprehensive
- Cost sensitive
- Culturally sensitive
- Data driven
- Evidence based
- Evolutionary and responsive
- Outcome oriented
- Respectful of the individual's rights, dignity, privacy, and safety

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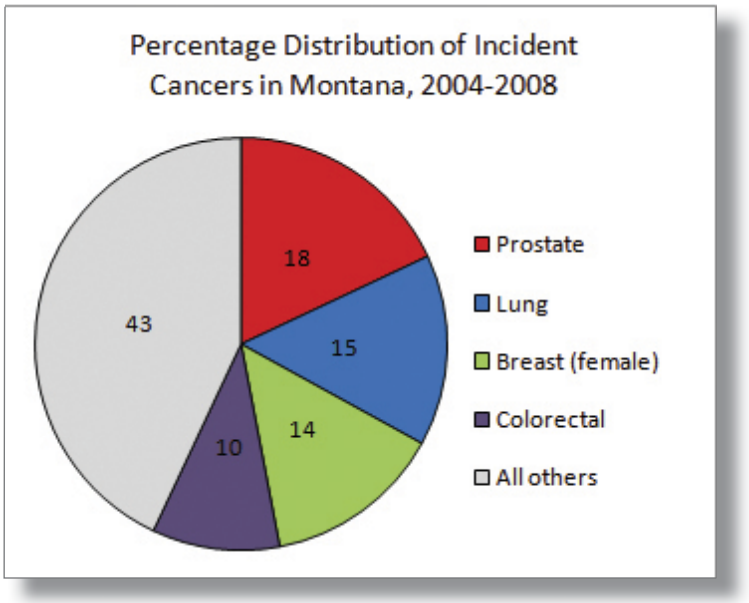
MONTANA
CANCER CONTROL
COALITION

Working together...

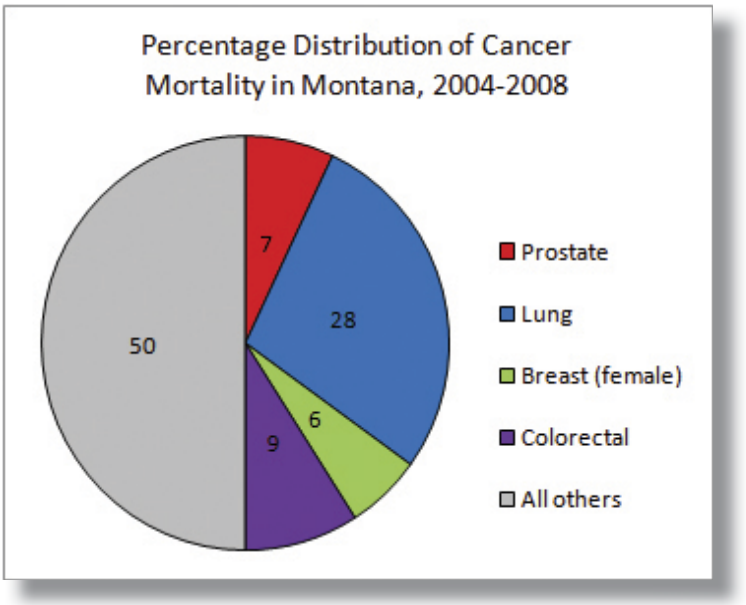
Executive Summary

The Burden of Cancer in Montana

Cancer is the second-leading cause of death among Montana residents, after diseases of the circulatory system such as heart disease and stroke. Each year, an average of 4,690 Montana residents are diagnosed with some form of cancer, and an average of 1,890 die from cancer. It is estimated that 42,000 Montana residents are cancer survivors. Montana's cancer burden is lower than that of the United States as a whole for all cancer sites combined and for many individual sites. However, more can be done to further reduce the cancer burden in Montana.



Four kinds of cancer-prostate, lung, breast, and colorectal-account for 58% of all incident cancers and 50% of all cancer deaths. None of the other kinds of cancer accounts for more than 5% of cases, and the great majority accounts for 1% or less.



The single-greatest cancer prevention measure that can be implemented is tobacco prevention or cessation.

- More than 90% of cases of cancer in the lung and bronchus are attributed to cigarette smoking and exposure to secondhand smoke. These cancers, accounting for 15% of all newly diagnosed cases in Montana, are almost entirely preventable.
- One third of all cancer deaths in Montana are caused by cigarettes.
- Cigarette smoking also increases the risk of cancers of the sinuses, mouth, throat, liver, pancreas, stomach, kidneys, bladder, colon and rectum, and cervix.

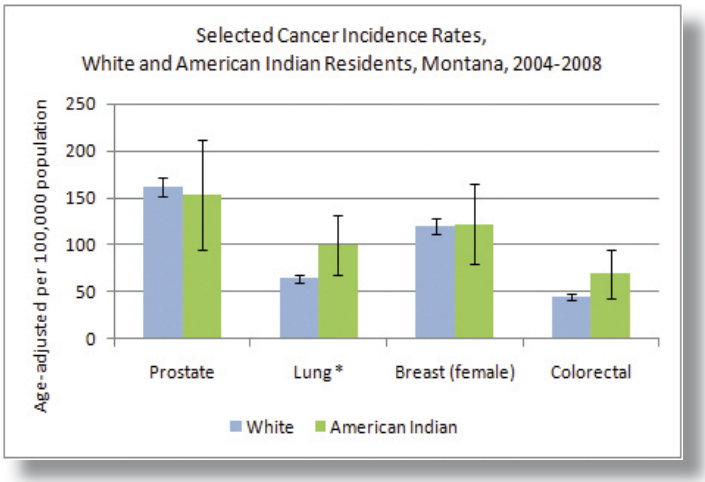
Screening for breast, cervical, and colorectal cancer is effective and saves lives, either by finding cancer at an early stage when it is most treatable or by finding and treating precancerous lesions so they do not progress to cancer.

- Colorectal cancer accounts for 10% of all cases and can be detected by either fecal occult blood testing or endoscopic screening.
- Approximately 80% of colorectal cancer could be prevented by endoscopic screening that can find and remove polyps and other precancerous growths.
- Invasive cervical cancer has been almost eliminated by the widespread use of Papanicolaou (Pap) screening.
- Mammography is a minimally invasive procedure that can discover a large proportion of breast tumors at an early stage when they are most treatable. More than 95% of women whose breast cancer is diagnosed at the local stage survive for 5 or more years after diagnosis, compared to less than 25% of women whose cancer is diagnosed at the distant stage.

Cancer among American Indian Residents

The most common cancers among American Indian residents of Montana are the same as those for the state as a whole: prostate, breast, lung and bronchus, and colon and rectum. Approximately 250 cases of cancer per year are reported and diagnosed in American Indians in Montana. The incidence rates of prostate and breast cancers among American Indian residents are not significantly different statistically from the statewide incident rates. However, American Indians have significantly higher incidence rates statistically of lung, colorectal, kidney, stomach, and liver cancers.

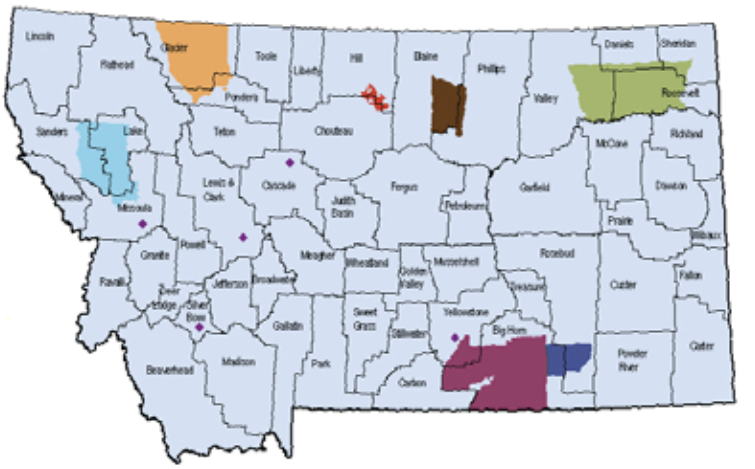
Cancer survival among American Indian residents of Montana is slightly lower than survival for all Montana residents for patients diagnosed between 1998 and 2002 (to allow for at least 5 years of survival). The lower survival rate is attributable in part to later stage at diagnosis among American Indian patients, which did not improve between 1998 and 2002 and between 2003 and 2007.



*American Indian lung cancer rate is statistically significantly higher than White lung cancer rate.

Cancer Disparities

Most health disparities affect groups because of socioeconomic status, race/ethnicity, sexual orientation, gender, disability status, geographic location, or some combination of these. People in these groups not only experience worse health but also tend to have less access to resources that support health.



Tribal Reservations

- Blackfeet
- Crow
- Fort Belknap
- Fort Peck
- Northern Cheyenne
- Rocky Boy's
- Flathead
- Urban Indian Centers

Blackfeet Reservation
Home of the Blackfeet Nation headquartered in Browning, Montana

Crow Reservation
Home of the Crow Nation headquartered in Crow Agency, Montana

Flathead Reservation
Home of the Confederated Salish, Pend d'Oreille, and Kootenai Tribes headquartered in Pablo, Montana

Fort Belknap Reservation
Home of the Gros Ventre and Assiniboine Tribes headquartered in Fort Belknap Agency, Montana

Fort Peck Reservation
Home of the Assiniboine and Sioux Tribes headquartered in Poplar, Montana

Little Shell Tribe of Chippewa Indians of Montana
State recognized

Northern Cheyenne Reservation
Home of the Northern Cheyenne Tribe headquartered in Lame Deer, Montana

Rocky Boy's Reservation
Home of the Chippewa Cree Tribe headquartered in Rocky Boy Agency, Montana

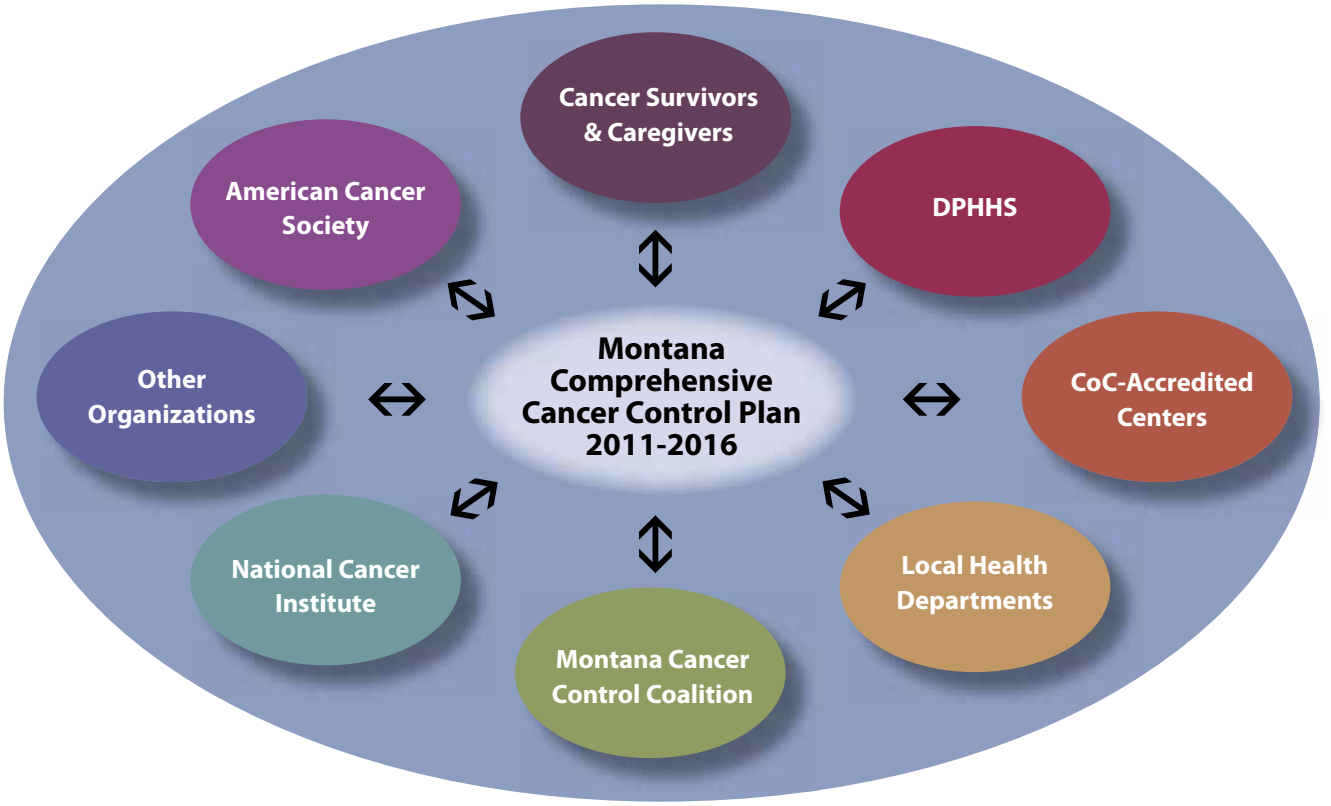
Approximately 85% of cases of lung cancer are attributable to smoking cigarettes; 54% of American Indian adults in Montana smoke, compared to 14% of non-American Indian adults in Montana. Among American Indian adults in Montana age 50 and older, 43% have never had an endoscopy, compared to 57% of non-American Indian adults age 50 and older in Montana.

In Montana, people with disabilities, including physical, sensory, developmental, and intellectual, experience health disparities. Specifically, 68% of women with disabilities received a mammogram in a two-year period compared to 73% of women without disabilities (BRFSS, 2008). For people with disabilities, a lack of accessible medical equipment, such as height-adjustable exam tables and mammography machines, as well as wheelchair-accommodating weight machines also creates problems for receiving preventive services (Mudrick & Schwartz, 2010; Drew & Short, 2010).

It is the intention of the MTCCC, along with its supporting partners, to address the barriers to healthcare for all Montanans and to work to break down these barriers.

Tribes in Montana each have their own unique cultures, traditions, and histories. For many American Indians, symbols and their meanings are an integral part of their culture. In collaboration, the MTCCC and the Montana American Indian Women's Health Coalition (MAIWHC) created a symbol featured in the CCC Plan, designed to represent all tribes in Montana. This symbol is used throughout the plan to showcase American Indian activities around the state. The American Indian symbol was created as a circle to represent cultural beliefs, a lodge (teepee) to represent families, and a buffalo to represent endurance and strength.

Montana Comprehensive Cancer Control Plan Partners



Who

The Montana Cancer Control Coalition (MTCCC) is a statewide collaborative effort of a diverse group of individuals and organizations working together to reduce cancer incidence, morbidity, and mortality for all Montanans. The MTCCC was formed in 2003 when concerned stakeholders around the state came together to address issues across the cancer continuum, from prevention and early detection to survivorship. Using a coordinated and integrated approach to controlling cancer, the MTCCC strives to ensure better quality of life and to enhance the odds of survivorship through prevention, early detection, and state-of-the-art cancer care.

What

The Comprehensive Cancer Control (CCC) Plan is a guide for achieving the following overarching goals:

1. Prevent the incidence of cancer by reducing risk factors.
2. Detect cancer at the earliest stage possible.
3. Promote access to quality comprehensive cancer care.
4. Optimize the quality of life and survivorship rates for those affected by cancer.
5. Support research to best improve cancer control.
6. Monitor, document, and work to eliminate disparities across the cancer continuum.
7. Develop and support policies and initiatives that enable cancer control.
8. Utilize an evidence-based approach with best practices for cancer control.

How

The CCC Plan is a living document that represents Montana's determination to prevent and control cancer by working together. The CCC Plan describes priorities for cancer control activities that encompass the full cancer continuum, from prevention and early detection to quality of life and survivorship. MTCCC members and statewide partners work to implement the CCC Plan through coordinated and collaborative efforts. Montanans have many different roles, as fathers and mothers, sisters and brothers, teachers, friends, mentors, advocates, and more. The CCC Plan enables all individuals and organizations to get involved in comprehensive cancer control by implementing strategies and working together to reduce the burden of cancer. Following are ways to get involved in cancer control and activities that support the CCC Plan.

If you are a Montana resident:

- Avoid tobacco use.
- Get recommended cancer screenings, and encourage family members and friends to get cancer screenings.
- Participate and volunteer in cancer control activities in your community.
- Complete an advanced directive.
- Become a member of the MTCCC.

If you are a cancer survivor:

- Share your experience to educate the public about the needs of survivors.
- Be a mentor to survivors and co-survivors to empower them to be active participants in their healthcare decisions. Join a support group.
- Encourage employers and schools to support cancer survivors and their needs as they transition through their cancer diagnoses.
- Join an advocacy group or organization working to improve survivor experiences and quality of life.

If you are an educator:

- Promote healthy lifestyle behaviors to students, families, and staff.
- Provide information on the return-to-school transition process for childhood survivors, families, and school staff.
- Encourage staff to get recommended cancer screenings.
- Provide healthy food options to students and staff.
- Organize student advocacy groups to support cancer control activities.
- Learn how to work with kids and families when cancer or death touches their lives.

If you are a healthcare provider:

- Ask all patients whether they use tobacco products, and provide tobacco cessation interventions to patients who do.
- Screen patients for obesity, and support those working to achieve or maintain a healthy weight.
- Recommend cancer screenings to every eligible patient at every opportunity.
- Provide cancer patients with a comprehensive survivorship care plan.
- Pursue continued education to understand survivor needs and available best practices.
- Talk with patients about the benefits of palliative care and hospice.
- Work with the MTCCC to include cancer control messages on display boards and advertising spaces.

If you are an employer:

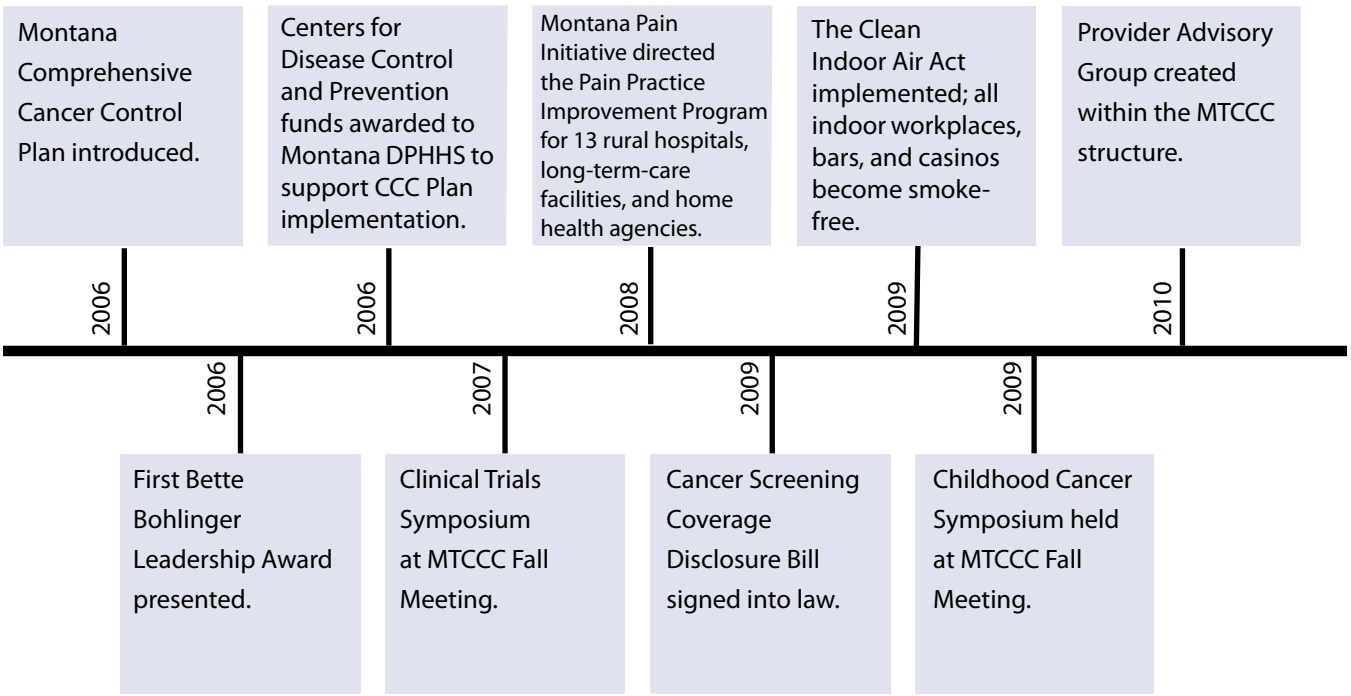
- Provide access to tobacco-use cessation programs for employees.
- Implement a worksite wellness program.
- Encourage employees to be physically active and to select nutritious foods.
- Provide sun-protective gear or products for those working outside.
- Provide full coverage for recommended cancer screenings and time off for employees to get screened.
- Provide information on return-to-work transition issues to survivors and their co-workers, and implement systems to allow employees to continue their work during treatment.

If you are a policy maker:

- Support policies to improve funding for cancer survivorship services, screening, treatment, research, and surveillance.
- Support policies that support and encourage healthy lifestyle choices.

For additional information on how to get involved, please visit the MTCCC website at www.mtcancercoalition.org

This timeline is an overview of progress made on the 2006–2011 Montana CCC Plan. Although we cannot report all successes achieved statewide, this highlights some of the progress made over the past 5 years.



Bette Bohlinger Leadership Award

Bette Bohlinger, Lieutenant Governor John Bohlinger's late spouse, lost her brave battle with cancer in January 2006 after being diagnosed with acute myeloid leukemia in 2004. Bette was an inspiration to many Montanans, exhibiting leadership and encouragement to families affected by cancer.

She was a role model for people with cancer, encouraging them to share their experiences and give hope to others through their stories. Bette was a tireless advocate to get Montanans signed up for the National Marrow Donor Program. Although Bette herself was in need of a donor, she also hoped that her illness could help bring hope to others suffering a similar disease. Bette was also an early supporter and participant with the Montana Cancer Control Coalition.

In honor of Bette, the MTCCC created the Bette Bohlinger Leadership Award in 2006 to honor exceptional individuals or organizations that encourage, inspire, and lead others. These award winners have positively contributed to cancer control activities in Montana and have been actively engaged in moving along the mission and goals of the MTCCC.

Bette Bohlinger Leadership Award: A Commitment to Excellence
The quotes in this section were provided by the people or organizations who recommended the recipients for the award.

2006: Dr. Barbara Lloyd, Helena: "Barb has provided not only me the tools to succeed but others as well. She has trained me in my roles within the MTCCC and has been an inspirational leader. Barb has shown her outstanding commitment to the MTCCC."

2007: Rita McDonald, Lame Deer: "Rita brings a unique perspective to the MTCCC as a survivor and advocate. She embodies why and how we do the work we do. Rita is making a difference in Montana and is contributing to state and local cancer control activities."

2008: Sue Warren, Great Falls: "Sue's contributions to the MTCCC have been tremendous. She has unbelievable energy and passion for cancer awareness, prevention, and control, and she carries these qualities with her in her personal and professional lives."

2009: Betsy Smith, Great Falls: "Betsy has been an integral part of the MTCCC leadership and an active member of the MTCCC. She has risen to the challenges presented to her and encompasses all the qualities of stewardship, professionalism, and leadership that the Bette Bohlinger Award reflects."

2010: Dr. Thomas Purcell, Billings: "Dr. Purcell has contributed in so many ways to the success of the MTCCC. From the first planning meeting when MTCCC was becoming a reality to now, Dr. Purcell has been there to lend his expertise, his vision, and his time to the cause of lowering the incidence of cancer in Montana."

2011: Cheryl Hackett, Great Falls: "Cheryl communicates both the vision and mission of the MTCCC and is effective in empowering the Steering Committee and Teams to strive toward achievement and recognize success."

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Prevention

My mission to educate others about primary and secondary skin cancer prevention and early detection began over 20 years ago with my young husband's death from melanoma. Working in our community and the larger community of dermatology nurses has inspired me.

Karrie and Gary Fairbrother

My children are also involved. One is an ER doctor; another has created a game-Smack a Mole©-that teaches young and old how to recognize skin cancer and describes methods to prevent UV exposure; and the third shares by example as well as word what he does to prevent UV exposure.

The Montana Cancer Control Coalition works with both the Montana medical community and the community at large to support all levels of cancer care from prevention to advocacy to support for our surviving families. I am proud and passionate about the work we are doing to advocate prevention and education for all Montanans! Working with the Prevention Implementation Team allows me to share the SunAWARE message to our communities and hopefully will result in prevention and earlier diagnosis of skin cancer!

-Karrie Fairbrother, BSN, RN, DNC, CDE

Montanans who engage in certain unhealthy behaviors are at increased risk for cancer. Although not all cancers are preventable, many cancers are linked to specific behavioral choices, such as tobacco use, alcohol consumption, physical inactivity, poor diet, and unprotected exposure to ultraviolet (UV) rays.

In Montana, 1,400 people die each year from tobacco use. Two key risk factors for developing lung cancer are tobacco use and exposure to secondhand smoke. Both are preventable risk factors. Tobacco use does not lead only to lung cancer; a wide variety of cancers can be attributed to smoking. Approximately 3,000 distinct chemicals occur naturally in tobacco leaves, and 1,000 more are introduced into tobacco products though agricultural practices and postharvest processing. Fifty-five chemicals in cigarette smoke are established human carcinogens, and cigarettes are the major source of exposure to these chemicals for most people (TSR, July 2008).

Regular alcohol consumption, even as little as a drink or two a day, increases the risk of cancer at several sites throughout the body. Alcohol itself is a carcinogen, as are the chemicals the body produces when it breaks down alcohol. In addition, alcohol interferes with the detoxification of other potential carcinogens (QSR, July 2009).

Being obese or overweight has been linked to cancers of the colon, rectum, esophagus, kidney, endometrium, breast, and thyroid, in addition to being risk factors for other chronic health conditions. Poor nutrition and lack of adequate exercise can lead to obesity, increasing the risk of cancer. An estimated 20 to 30% of the most common cancers may be related to excess weight and physical inactivity.

Most skin cancers are squamous cell and basal cell cancers of the epidermis, which are commonly superficial and have an excellent prognosis when diagnosed and treated promptly. Malignant melanoma is less common but much more serious and has a poorer prognosis. UV radiation is part of the spectrum of energy from the sun and also is emitted by artificial sources, including sun lamps and tanning beds. Exposure and protection from UV rays is a preventable risk factor in developing skin cancer.

Over the next 5 years, the Prevention Implementation Team will work with prevention partners to reduce the burden of cancer in Montana by focusing on reducing the prevalence of tobacco usage and secondhand smoke exposure in Montana residents, reducing obesity levels in children and adults, limiting artificial tanning facility usage, and encouraging sun safety education.

Goal 1: Support the work of prevention partners to reduce the impact of unhealthy lifestyles on cancer risk.

Objective 1.1: By 2016, decrease the prevalence of tobacco use among adults and youth by working with the Montana Tobacco Use Prevention Program (MTUPP) and other tobacco partners.

Baseline: Adults: Smoking (18%); smokeless (12%)
Youth: Smoking (19%); smokeless (9%)
Data Source: ATS, 2004; PNA, 2004

Target: Adults: Smoking (14%); smokeless (10%)
Youth: Smoking (14%); smokeless (7%)

Strategy 1: Promote the Montana Tobacco Quit Line and other existing evidence-based resources to increase cessation attempts.

Strategy 2: Support the MTUPP's React Against Corporate Tobacco (reACT) program to prevent the initiation of tobacco use among youth.

Strategy 3: Support MTUPP's efforts to eliminate disparities in low-income and American Indian populations related to tobacco use and its effects.

Strategy 4: Educate stakeholders and partners on the effectiveness of increasing the unit price of tobacco products to promote cessation.

Objective 1.2: By 2016, reduce exposure to secondhand smoke by working with the MTUPP and other tobacco control and prevention programs.

Baseline: Youth: 60% of youth have had exposure to secondhand smoke.
Adults: 14% of adults are regularly exposed to secondhand smoke at home.
Data Source: PNA, 2004; ATS, 2004

Target: Youth: 40%
Adults: 9%

Strategy 1: Advocate for the continued protection of the Montana Clean Indoor Air Act.

Strategy 2: Support strategic efforts to establish more smoke-free or tobacco-free policies on American Indian reservations, in park and recreational areas, on hospital campuses, and in multiunit housing facilities.

Strategy 3: Support efforts to establish setback policies and/or laws for smoking around public buildings.

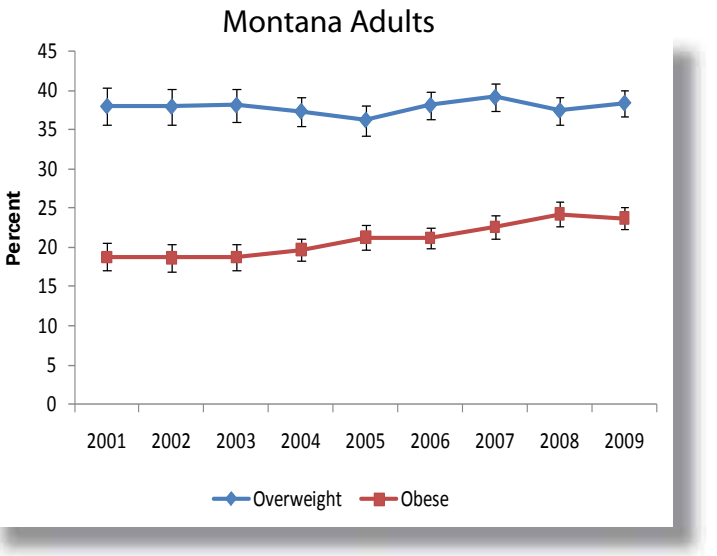
Objective 1.3: By 2016, reverse the trend of increasing self-reported overweight and obesity in Montana by working with the Montana Nutrition and Physical Activity Program (NAPA) and other obesity prevention partners.

Baseline: Adults: 37% are overweight; 19% are obese.
Youth: 8% are overweight/obese; 12% are at risk for becoming overweight.
Data Source: YRBSS, 2003, 2009; BRFSS, 2004, 2009

Interim: Adults: 38% are overweight; 24% are obese.
Youth: 12% are overweight; 10% are obese.

Target: Adults: 37% overweight; 19% obese.
Youth: 12% overweight; 8% obese.

Overweight: respondents with BMI ≥ 25 and < 30.
Obese: respondents with BMI ≥ 30.



Strategy 1: Partner with worksites and support worksite wellness campaigns to encourage biking and walking to work, nutritional support strategies, and worksite lactation programs.

Strategy 2: Work with the Office of Public Instruction and individual school districts to strengthen school wellness policies to:

- include access to nutritious food for all students
- encourage "active transportation" to school with programs such as Safe Routes to School
- provide quality and age-appropriate physical education to all students
- open up recreation facilities to the community after hours
- reduce screen time usage.

Strategy 3: Utilize community media campaigns to encourage nutrition and physical activity among Montana residents.

The Fort Belknap Indian Reservation promotes physical activity and healthy habits by holding events throughout the year. Some of the events include support groups, fun run/walks, nutrition and cooking classes, after-school and holiday break activities for youth, round dances, pow-wows, Native games, Native regalia making classes, stress relief classes, physical fitness classes, and an annual half marathon in May as well as the Ultimate Health Challenge in coordination with the Milk River Pow-Wow and a first-ever triathlon planned for September 2011. These are some of the events that help keep Fort Belknap residents active and on their way to healthier lifestyles!

Goal 2: Promote cancer risk–reducing behaviors through evidence-based education and advocacy.

Objective 2.1: By 2016, reduce the proportion of adolescents who use artificial sources of ultraviolet light for tanning.

Baseline: 16% of adolescents in grades 9–12
Data Source: YRBSS, 2009; CDC, 2010

Target: 15%

Strategy 1: Partner with dermatology groups in Montana to support public policy restricting artificial tanning facility usage by minors.

Strategy 2: Utilize community media campaigns to discourage youth from using artificial tanning facilities.

Objective 2.2: By 2016, increase by 5 the number of new after-school programs, educational settings, recreational settings, or organizations to implement sun safety education (Sun Wise or SunAWARE).

Baseline: 0 programs
Data Source: MCCP data

Target: 5 new programs

Strategy 1: Host workshops on skin cancer prevention in schools and with sports teams in partnership with the MEA-MFT, the Montana Association of School Nurses, and the Montana Coaches Association.

Strategy 2: Work with school paraprofessionals to host workshops on skin cancer prevention in schools and after-school programs.

Strategy 3: Work with organizations such as 4-H, Boy Scouts, Girl Scouts, and Boys and Girls Clubs to include sun safety education within their programs and/or to develop policies or recommendations surrounding sun safety at their events.

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Screening & Early Detection

Priscilla Robinson

Priscilla Robinson is a 75-year-old woman who was born and raised on the Northern Cheyenne Indian Reservation and is an enrolled member of that tribe.

In 2008, Priscilla went to the Indian Health Service in Lame Deer for her annual checkup. She had never had a colonoscopy or any other screening for colorectal cancer. Although she had no symptoms related to colorectal cancer, the doctor suggested she take a fecal occult blood test kit home with her as a screening tool. After the kit was evaluated, she was referred for further testing. Priscilla was then diagnosed with colon cancer.

Priscilla is doing well and since her diagnosis has been an advocate for her family to get their colorectal cancer screenings. Priscilla is the perfect example of how one can use a very inexpensive screening tool to detect colon cancer, catch it in the early stages, and become a survivor.

Early detection of breast, cervical, and colorectal cancers saves lives by finding cancers when they are still localized and when treatment is more likely to succeed. Breast, cervical, and colorectal cancer patients have higher rates of survival if the cancers are found at the early stages. In Montana, promoting early detection methods and access to healthcare and screening opportunities for all citizens is a priority for the MTCCC.

Breast cancer is the most common cancer among Montana women. On average, 800 Montana women are diagnosed with breast cancer each year (QSR, 2006). Mammography is the best available method to detect breast cancer in its earliest, most treatable stage. If detected early, the U.S. 5-year survival rate for localized breast cancer is 97%.

Cervical cancer screening using the Papanicolaou (Pap) test detects cancer as well as precancerous lesions. Pap tests can find cervical cancer at an early stage, when it is most curable, and can actually prevent the disease if precancerous lesions found during the test are treated.

Colorectal cancer is the fourth most common incident cancer in Montana and the fourth most common cause of cancer death (MCTR, 2010). Nearly 80% of colorectal cancer cases could be prevented by screening methods that find and remove polyps and precancerous lesions (QSR, April 2009). Several screening strategies are used to detect colorectal cancer, with the two main approaches being noninvasive stool tests and direct examination tests.

All adults should discuss cancer prevention, screening, and early detection with their primary care providers. For breast, cervical, and colorectal cancer, tests that improve outcomes are available to screen the general population. Avoiding tobacco use is the best way to decrease risk of lung cancer. A discussion with your provider will help you decide what is best for you. For example, the American Cancer Society recommends that men over the age of 50 talk with their providers about the pros and cons of prostate cancer screening to determine what is right for them. For all other cancers, research continues to search for the best approach to decrease mortality.

Over the next 5 years, the Screening and Early Detection Team will be working to reduce the burden of cancer in Montana by increasing breast, cervical, and colorectal cancer screenings and broadening the use of screening opportunities by all Montanans.

Goal 1: Promote compliance with cancer screening guidelines.

Objective 1.1: By 2016, increase compliance with nationally recognized guidelines for cancer screenings.

Baseline: Breast: 72% of women over age 40 have had a mammogram within the past 2 years.
Cervical: 86% of women over age 18 have had a Pap test within the past 3 years.
Colorectal: 53% of adults over age 50 have ever received a sigmoidoscopy or colonoscopy exam.
Data Source: BRFSS, 2004, 2008

Target: Breast: 75% of women over age 40 will report having had a mammogram within the past 2 years.
Cervical: 88% of women over age 18 will report having had a Pap test within the past 3 years.
Colorectal: 60% of adults over age 50 will have had a sigmoidoscopy or colonoscopy exam.

Strategy 1: Promote nationally recognized guidelines to the healthcare provider community and to the public.

Strategy 2: Work with insurance benefit providers and wellness educators to educate clients on covered services for screening utilizing small media campaigns.

Objective 1.2: By 2016, reduce the number of people over age 50 who report they are unaware they need a breast or colorectal cancer screening service.

Baseline: Breast: 35%
Colorectal: 43%
Data Source: BRFSS, 2007

Target: Breast: 30%
Colorectal: 38%

Strategy 1: Implement small media tools such as videos and printed materials (postcards, letters, brochures, flyers, and newsletters) to inform and motivate people to get screened.

Strategy 2: Implement group and one-on-one education to increase awareness and availability of breast and colorectal cancer screening services and how to access these services.

Strategy 3: Work with specific groups, including but not limited to American Indians and people with disabilities, to educate through culturally competent means on the need for screening.

Objective 1.3: By 2016, reduce the number of people who report their physician did not recommend a breast or colorectal cancer screening.

Baseline: Colorectal: 36%
Breast: 11%
Data Source: BRFSS, 2007

Target: Colorectal: 30%
Breast: 5%

Strategy 1: Engage physician champions to educate physicians on cancer screening rates, nationally recognized screening guidelines, and quality improvement tools, such as the "How to Increase Preventive Screening Rates in Practice Toolbox."

Strategy 2: Ensure healthcare staff receive ongoing education on screening rates, nationally recognized screening guidelines, and quality improvement tools, such as the "How to Increase Preventive Screening Rates in Practice Toolbox."

Goal 2: Broaden the use of low- and no-cost cancer screening services in Montana.

Objective 2.1: Annually, maximize the number of uninsured and underinsured Montanans screened for breast, cervical, and colorectal cancers through the Montana Cancer Screening Program (MCSP).

Baseline: 100% utilization
Data Source: MCSP, 2006

Target: 100% utilization

Strategy 1: Educate healthcare providers and their staff about low- and no-cost cancer screening resources.

Strategy 2: Implement group and one-on-one education in the target population about low- and no-cost resources available to maximize the number of people covered.

Strategy 3: Implement small media tools such as videos and printed materials (postcards, letters, brochures, flyers, and newsletters) to inform people about low- and no-cost resources.

"Pink Ribbon Bingo" and "Boo Bee Bingo" were held in 2010 on the Crow Agency and in Lame Deer to educate women on the importance of breast and cervical cancer screening. In total, over 500 women attended both events, with more than 200 women qualifying for the Montana Breast and Cervical Health screening program. Donations and gifts were collected and presented to women in attendance. Sponsors included but were not limited to Northern Cheyenne Tribal Health, St. Vincent's Healthcare, Ashland Community Health Center, Billings Clinic, Center for Native Health Partnerships, and RiverStone Health. Attendees enjoyed dinner together, heard from cancer survivors, and played bingo. Both events were great successes and have become annual events.

Objective 2.2: Annually, maximize the utilization of grants awarded for uninsured and underinsured Montanans screened for breast cancer through the Montana affiliate of the Komen Foundation.

Baseline: 100% utilization
Data Source: Komen Foundation, 2010

Target: 100% utilization

Strategy 1: Ensure that healthcare providers and organizations receive ongoing education in regard to grants and resources available through the Montana Komen Foundation.

Strategy 2: Annually, in October, encourage eligible MTCCC members and others to apply for funding and resources through the Montana Komen Foundation.

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Treatment & Research

Milton (Swede) Olsen, 20-year cancer survivor

In March 1990, I became ill while on a trip to Thailand. I was examined and tested and given instructions to go to the emergency room when I arrived at home. In Great Falls, I learned of my leukemia diagnosis. My treatment began the next day. I was in the hospital for 76 days, with one weekend at home in Glasgow. The leukemia was cured. I have enjoyed my life and my family since those days of illness.

In 1993, with a new cancer diagnosis, I was back for radiation treatments and decided to participate in clinical trials for prostate cancer. With my doctor's care and research, I have continued to respond to the treatments he advises. I know that I owe my life to Dr. Harrer and the treatment he and his wonderful, caring staff have given me.

Today, I am once again under care for prostate cancer; I have received hormonal therapy, radiation therapy, and chemotherapy and now have access to a new drug–only available on a clinical trial. I am grateful for my care and for all that I continue to do. I ride my tractor, herd cattle, and continue to enjoy my children, grandchildren, and great-grandchildren-all due to the quality of care I receive right here in Great Falls. I encourage everyone to listen to the warning signs and to get regular exams.

-Swede Olsen

A variety of treatment methods for cancer are available depending on the type and stage of cancer as well as various individual factors that include age, health, and cultural and personal preferences. The treatment of cancer for Montanans often depends on state-of-the-art care being available, accessible, affordable, and utilized. Although good cancer treatment can be available at the local level, Commission on Cancer (CoC)-accredited cancer programs ensure the quality of cancer care through adherence to national standards, multidisciplinary consultation, and quality assessments. As of January 2011, six of Montana's medical facilities were CoC accredited.

Clinical trials are research studies with human participants to evaluate new ways to prevent, diagnose, or treat diseases, including cancer. Some new treatments are safer and more effective and will eventually become the new standard of care, but this can happen only with the proof provided by clinical trials. Only 3% of U.S. adults participate in clinical trials, although many more are potentially eligible. Clinical trials may be sponsored by drug companies, foundations, or individual medical centers. Most large cancer clinical trials are sponsored by federal agencies such as the National Cancer Institute (NCI) (QSR, July 2009). Many cancer treatment centers in Montana offer clinical trials to their patients. The Montana Cancer Consortium is an independent, not-for-profit institution that receives support from the Community Clinical Oncology Program of the NCI to offer clinical trials through participating institutions and providers across Montana and northern Wyoming.

Over the next 5 years, the Treatment and Research Team will focus their efforts to reduce the burden of cancer on Montanans by increasing the utilization rates of cancer patients participating in clinical trials and by supporting and increasing the number of CoC-accredited hospitals around the state to ensure the highest level of cancer treatment for all Montanans.

Goal 1: Ensure high-quality cancer research in Montana.

Objective 1.1: By 2016, increase the percentage of patients of Commission on Cancer (CoC)-accredited cancer programs that are annually accrued to clinical trials.

Baseline: 2%
Data Source: Montana Cancer Consortium, 2010; Montana Central Tumor Registry

Target: 4%

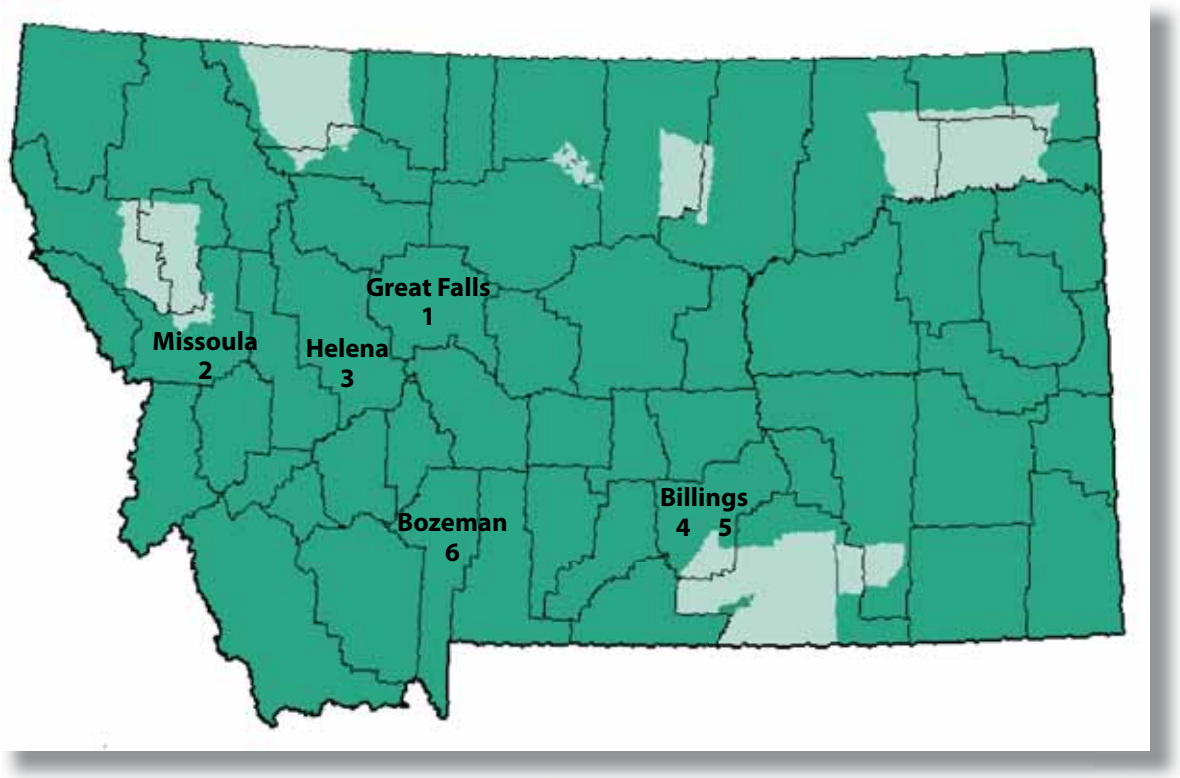
Strategy 1: Work with the Montana Cancer Consortium (MCC) to promote available NCI clinical trials at the CoC-accredited cancer programs.

Strategy 2: Create a toolbox of clinical trials information and promote its use to providers eligible to accrue to the included clinical trials.

Strategy 3: Report quarterly NCI trials provider accrual data to the Cancer Committee or Tumor Board of each CoC-accredited cancer program to encourage friendly competition to increase total accrual numbers.

Strategy 4: Monitor policy changes that may affect clinical trial accrual. Educate and advocate for change encouraging increased accrual.

Commission on Cancer-Accredited Centers



1. Benefis Hospitals (Community Hospital Comprehensive Cancer Program)
2. St. Patrick Hospital & Health Sciences (Community Hospital Comprehensive Cancer Program)
3. St. Peter's Hospital (Community Hospital Cancer Program)
4. Billings Clinic (Community Hospital Comprehensive Cancer Program)
5. St. Vincent Healthcare (Community Hospital Comprehensive Cancer Program)
6. Bozeman Deaconess Cancer Center (Community Hospital Cancer Program)

Goal 2: Ensure prevailing standards of care for all cancer patients in Montana.

Objective 2.1: By 2016, increase and maintain the number of CoC-accredited sites.

Baseline: 6
Data Source: American College of Surgeons (ACoS), 2010

Target: 8

Strategy 1: Work with the CoC Cancer Liaison Physicians (CLPs) to maintain and encourage CoC accreditation.

Strategy 2: Support and assist the CoC Cancer Liaison Program state chair's meeting of all CLPs at least annually in conjunction with the MTCCC statewide meeting.

Objective 2.2: By 2016, increase the percentage of adherence to standard-of-care therapies for breast and colorectal cancers by the Montana CoC-accredited cancer programs.

Baseline:

1. Radiation is delivered to candidates under age 70 within 1 year following breast-conserving therapy. Montana: 92.6% (National: 81.6%)
2. Combination chemotherapy is considered or administered within 4 months of diagnosis for women under age 70 with AJCC T1cN0M0, or Stage II or III hormone receptor negative breast cancer. Montana: 91.1% (National: 81.6%)
3. Tamoxifen or third-generation aromatase inhibitor is considered or administered within 1 year of diagnosis for women with AJCC T1cN0M0, or stage II or III hormone receptor positive cancer. Montana: 79.8% (National: 71.3%)
4. Adjuvant chemotherapy is considered or administered within 4 months of diagnosis for patients under age 60 with AJCC Stage III (lymph node positive) colon cancer. Montana: 74% (National: 84.9%)
5. At least 12 lymph nodes are removed and pathologically examined for resected colon cancer. Montana: 78.5% (National: 79.8%)
6. Radiation therapy is considered or administered within 6 months of diagnosis for patients under age 80 with clinical or pathological AJCC T4N0M0 or Stage III receiving surgical resection for rectal cancer. Montana: 100% (National: 87.2%)

Data Source: Commission on Cancer's National Cancer Data Base (NCDB), 2008

Target:

1. 95%
2. 92%
3. 95%
4. 90%
5. 90%
6. 90%

Strategy 1: The Cancer Liaison Physician (CLP) will evaluate and interpret the program's performance using the NCDB data.

Strategy 2: The CLP (or the CLP's designee) will report this information to the program's Cancer Committee quarterly.

Strategy 3: Identify and disseminate best practices for adherence to these standard-of-care therapies.

Over the past 4 years, the Montana Cancer Institute Foundation has worked in partnership with the Confederated Salish and Kootenai Tribes (CSKT) Tribal Health and the University of Montana to study how genetic factors may influence response to cancer treatments in Native Americans. Relationship building and cross-communication with the researchers and CSKT have been an essential part of this project. A Tribal Community Advisory Council has been formed to provide regular input. One primary goal of this project is to develop and evaluate collaborative approaches for improving the diversity of populations participating in this type of research and who might benefit from pharmacogenomic testing.

Goal 3: Provide professionals and the public with access to cancer treatment and research information.

Objective 3.1: Increase state-of-the-art cancer-related treatment and research information provided by the Montana Cancer Control Coalition.

Baseline: Clinical Trials symposium 2007; "Science and Evidence-based Cancer Information," MTCCC website document
Data Source: MCCP data

Target: 3

Strategy 1: Maintain and update the "Science and Evidence-based Cancer Information" website document.

Strategy 2: Market use of the above document to professionals and the public using small media.

Strategy 3: Present at professional meetings to appropriate audiences on state-of-the-art cancer-related treatment and research information, including costs of cancer care and overcoming financial barriers, and cancer chemoprevention measures for breast, prostate, and cervical cancers.

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Quality of Life & Survivorship

Dick Brumley, cancer survivor, member of the Central Montana Cancer Coalition

Dick Brumley is a prostate cancer survivor. Diagnosed in 2002 following a routine physical exam, he has traveled a long distance with cancer: surgery, radiation, hormone therapy, and, finally, remission since December 2006. He believes early detection is crucial to survival. As fast and persistently as his cancer spread, he feels his treatment would not have been successful without early diagnosis.

Dick advises anyone diagnosed with cancer to learn about the disease and to seek out a support group. He is an active advocate who shares his experience with other survivors. He knows there are tremendous benefits in developing relationships with others fighting cancer. Dick says, "We're survivors, and we bond together. We inspire each other; cancer survivorship is a small world."

Improvements in the early detection and treatment of cancer have resulted in more people living longer and surviving after being diagnosed with cancer. Nationally, the number of cancer survivors tripled to 12 million people during the past 30 years (LiveStrong, 2010). Quality of life can be defined as a standard of care throughout the cancer continuum-from diagnosis to remission, cure, or end of life. People who have been diagnosed with cancer and others in their lives are challenged by many short- and long-term issues affecting the quality of their lives, including physical, spiritual, emotional, and pain control issues as well as, for some, decisions about end-of-life care. Improving the quality of life for cancer survivors may also positively influence the lives of caregivers, family, and support members of individual cancer survivors.

Palliative care identifies and addresses the physical, psychological, spiritual, and practical burdens of illness. It begins at diagnosis and should be provided through the entire cancer disease continuum. Palliative care is intended to ease, prevent, or relieve the symptoms of disease and/or the side effects of treatment. In addition, palliative care should include either direct assistance or referrals that can help people with completing legal documents and other documents that describe a patient's wishes, such as advanced directives, powers of attorney, wills, and trusts.

Over the next 5 years, the Quality of Life and Survivorship Team will focus on improving the quality of life for Montanans affected by cancer by promoting palliative and end-of-life care, promoting survivorship care plans for all patients, improving educational information for childhood cancer patients, and educating patients on complementary medicine options.

Goal 1: Promote inpatient and outpatient palliative and end-of-life care.

Objective 1.1: By 2016, develop and share a palliative care program template for implementation in CoC-accredited centers.

Baseline: 0
Data Source: MCCP data

Target: 1

Strategy 1: Conduct a yearly survey to CoC-accredited cancer centers to determine what palliative care outpatient services are available.
Strategy 2: Mentor accredited cancer centers as they develop outpatient palliative care programs.
Strategy 3: Sponsor a palliative care conference at the MTCCC statewide meeting for laypeople and medical professionals.

Objective 1.2: By 2016, identify outpatient hospice care and palliative care services on American Indian reservations.

Baseline: 4
Data Source: Quality of Life and Survivorship Tribal Health phone survey, 2009

Target: 7

Strategy 1: Identify and collaborate with American Indian partners to enhance end-of-life and palliative care services.

Strategy 2: Identify and apply for available grants to develop culturally appropriate training programs for patients, families, and caregivers on reservations.

Objective 1.3: By 2016, increase the number of advanced directives in the state repository.

Baseline: 10,074
Data Source: Montana's Attorney General End-of-Life Registry, December 2010

Target: 16,000

Strategy 1: Identify a peer educator in each of the defined 13 regions in the state to promote and educate healthcare providers and the public about Physician Orders for Life Sustaining Treatment (POLSTs) and advanced directive options.

Strategy 2: Collaborate with the Attorney General's Office to provide information about the state repository to cancer centers.

Goal 2: Promote survivorship care planning for oncology patients.

Objective 2.1: By 2016, increase the number of CoC-accredited cancer centers that offer survivorship care planning.

Baseline: 2
Data Source: Quality of Life and Survivorship phone survey, 2009

Target: 3

Strategy 1: Collaborate with CoC Cancer Liaison Physicians to share with CoC centers survivorship care plan template options that follow Institute of Medicine standards.

On October 2, 2009, the Pink Shawl Ceremony was held at the downtown Montana State University–Billings campus. The event was sponsored by the Intertribal Clan Mothers, MSU-Billings, the Montana Wyoming Tribal Leaders Council, the Billings Clinic Cancer Center, and the National Cancer Institute's Community Cancer Center's Program. The Intertribal Clan Mothers received assistance with fringing of the shawls from American Indian women inmates at the Montana Women's Prison. The evening kicked off with an Honor Guard presentation by young Native veterans representing the flags of each Montana tribe and the Goes Well drum group.

Fifty pink shawls were given to women to recognize the impact of cancer on American Indian women. The 50 Pink Shawl Ceremony recipients were honored with a shawl as cancer survivors, in memory of loved ones who lost their lives to cancer, or as a pledge to themselves and/or an advocate to family members to continue with annual screenings. To finish the ceremony, 5 memorial vests were given to men in memorial to a daughter, wife, or mother as a recognition of their loss, and 12 pink bandanas were given to men for their commitment to be cancer awareness advocates in their communities.

The intention with the Pink Shawl Ceremony is to touch American Indians of all generations and to promote cancer awareness, screening, and early detection as well as taking charge of one's own health.

Goal 3: Ensure childhood cancer survivors are provided quality-of-life services.

Objective 3.1: By 2016, develop a toolbox to assist school administrators, teachers, and students with transition-back-to-school challenges for children with cancer and their siblings.

Baseline: 0
Data Source: MCCP data

Target: 1

Strategy 1: Collaborate with the Office of Public Instruction to advocate for best policies and practices for childhood cancer survivors and their siblings.

Strategy 2: Develop Montana-specific in-service and resource kits (possibly web based) to educate school employees and administrators about survivor needs and services.

Strategy 3: Obtain the book *Educating the Child with Cancer: A Guide for Parents and Teachers*, edited by Nancy Keene, for placement in every school's educators library.

Strategy 4: Develop a speakers bureau to assist schools when a child is newly diagnosed.

Objective 3.2: By 2016, develop discharge packets for tertiary care centers that outline Montana-specific services to address the noneducational needs of children with cancer.

Baseline: 0
Data Source: MCCP data

Target: 1

Strategy 1: Research materials for packets.
Strategy 2: Engage CoC centers to incorporate their organizational information in packets.
Strategy 3: Contact tertiary care centers to engage them in distributing packets.
Strategy 4: Track the number of packets distributed to tertiary care centers in Utah, Washington, and Colorado each year, and update the packets as needed.

Goal 4: By 2016, promote opportunities for evidence-based complementary medicine in cancer care.

Objective 4.1: Identify and disseminate materials based on the National Cancer Institute's research on evidence-based complementary medicine modalities in CoC-accredited centers.

Baseline: 0
Data Source: MCCP data

Target: 1

Strategy 1: Educate CoC Cancer Liaison Physicians on evidence-based complementary medicine modalities.
Strategy 2: Monitor the inclusion of complementary medicine modalities used in each CoC-accredited center on a yearly basis and offer education and assistance on how to implement additional options.
Strategy 3: Encourage the Montana Association of Naturopathic Physicians to develop Montana-specific referral networks linking complementary medicine providers and allopathic providers.
Strategy 4: Monitor the National Prevention Interagency Council to be established in 2011 under the Health Care Reform Act 2010 to improve wellness services.
Strategy 5: Include complementary medicine education in the palliative care conference at the MTCCC statewide meeting.

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Get Involved

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Dolly Lingle, breast cancer survivor

When Dolly Lingle was diagnosed with breast cancer, it heightened her bodily awareness and she immediately spread the word to her daughters and granddaughters about early detection. "You can't just wait for a bump," Dolly says, as she advocates for yearly mammogram programs for women from all income levels. Dolly's breast cancer was undetectable by touch, and early detection is what has allowed her to spread the message by becoming a spokeswoman for *Every Woman Matters*, a multimedia project that promotes the Centers for Disease Control and Prevention's Right to Know Campaign to increase breast cancer awareness for women with disabilities in rural Montana. She encourages others to stay in touch with friends and support groups, suggesting they are crucial to assist current and prospective cancer patients with treatment, recovery, and education awareness. Dolly advocates for the increasing network of cancer survivors to come together as support groups. She also highlights that women have a tendency to put themselves last as they become enveloped in life with family and a career. Dolly says, "Women need to pay attention to themselves first when it comes to their personal health; it's not worth it to wait."

How to Get Involved

Promoting Cancer Awareness Activities

When involved in cancer activities around the state, keep in mind that sharing information on all aspects of cancer, including prevention, early detection, and treatment, is critical to keeping Montanans healthy.

It is important to promote health literacy by keeping language simple and easy to understand and by offering linguistically and culturally appropriate materials. Materials should also be age and gender appropriate.

Provide materials with simple and clear messages in places where the targeted populations are most likely to see them, such as doctor's offices, clinics, community centers, worksites, wellness centers, and other similar places in your community.

Online Tools

Promote cancer awareness, prevention, and early detection in your community.

Go to www.mtcancercoalition.org and click on "Promotional Kit" and "Events Calendar."

The **Promotional Kit** includes resources for educational activities, including a postcard, a press release, a brochure, and cancer information.

The **Events Calendar** is updated with activities and events related to cancer topics.

Join the Montana Cancer Control Coalition

As an individual or organization that has a stake in Montana's cancer prevention and control efforts, please consider becoming a member of the MTCCC to assist in reducing the burden of cancer in Montana. The MTCCC consists of implementation teams that work on strategies outlined in this CCC Plan. Active participation with these groups is critical. The MTCCC works to maximize resources, reduce duplication of efforts, make changes in systems and policies, and implement multilevel interventions-all to make a significant impact on cancer in Montana.

For more information about becoming a member, please visit: www.mtcancercoalition.org.

My aunt has been my role model since I was a child. She gave me my first manicure and taught me how to be a lady.

I remember vividly the day I was at my mother's doing the dishes when she told me my aunt had been diagnosed with breast cancer. My whole world stopped for a moment. My mind and body were full of fear and dread. It took me a bit to snap out of it. First, I prayed to God to take the cancer from my aunt's body and make her well. Then I thought about the benefit of early diagnosis.

At the time, I worked at a job where we promoted breast and cervical health by making referrals to the Montana Cancer Screening Program. Our organization decided to promote a mammogram day on which we would all go receive our mammograms together. It started off with a tour of the mammography unit and ended with individual mammograms for the ladies we recruited. My aunt was one of those ladies.

Fortunately, it was an early diagnosis. My aunt underwent treatment. She didn't lose her hair and did not have a mastectomy. Our family learned a valuable lesson about early detection. No one enjoys getting an annual exam or mammogram, but we do it to take care of ourselves and our families. Early detection does save lives. This is a testimonial from my family to yours.

-Kitty Felix

Donate to the MTCCC

Although many activities are accomplished through the generous efforts of volunteers, others require funds. Please consider donating to the MTCCC to assist with implementation activities. Every donation makes a difference in controlling cancer in Montana.

For more information about donating to the MTCCC, please visit: www.mtcancercoalition.org.

Work with Local Cancer Coalitions

Regional cancer coalitions are active around the state. To get involved, see the "Contractor's section" at www.cancer.mt.gov for a map and list of local cancer control contacts.

Use Available Educational Materials

Educational materials are available from several sources, commonly free of charge, to use at events.

Contact your local American Cancer Society office for resources or visit www.cancer.org for ordering information.

The Cancer Support Community offers a network of personalized services and education for all people affected by cancer and is the largest employer of psychosocial oncology mental health professionals in the United States. Visit www.cancersupportcommunity.org for more information.

Native Circle at the Mayo Clinic provides culturally appropriate cancer information: http://cancercenter.mayo.edu/native_circle.cfm.

The Montana American Indian Women's Health Coalition (MAIWHC) is a grassroots coalition made up of American Indian women from all seven reservations and five urban Indian health centers in Montana. The members are healthcare workers, community volunteers, health educators, cancer survivors, and other interested women. MAIWHC members work to:

- *reduce barriers to accessing healthcare services, especially among urban American Indian people;*
- *generate understanding of cultural norms and values of American Indian people;*
- *educate American Indian people about preventive care and healthy lifestyles;*
- *reduce fear and denial related to cancer diagnoses; and*
- *develop effective community outreach and education.*

MAIWHC's overarching goal is to increase the number of American Indian women and men who are screened regularly for breast, cervical, and colorectal cancer.

To get involved with MAIWHC, visit: www.cancer.mt.gov.

"As a member of Montana American Indian Women's Health Coalition (MAIWHC), I urge women of all ages to get regular cancer screenings that detect cancer at its earliest stage, and when it is still localized and curable."

-Theresa Pepion, advocate and member of MAIWHC

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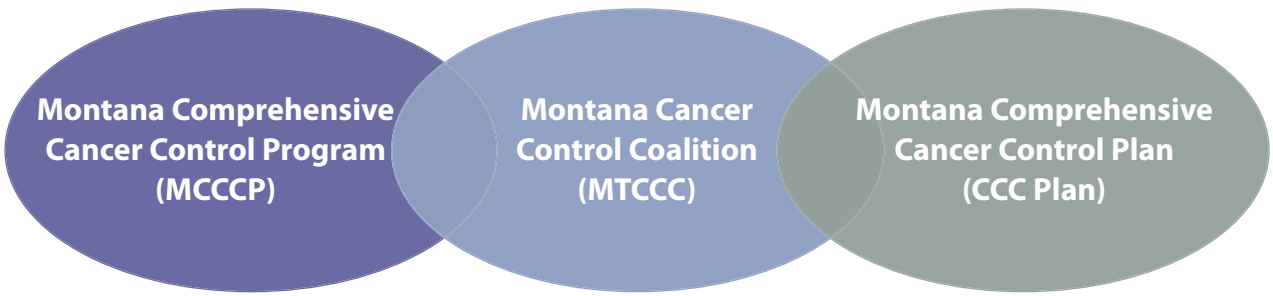
Evaluation

Evaluation Framework

The Evaluation Plan includes three interconnected elements that support one another as illustrated below. The Montana Comprehensive Cancer Control Program (MCCCP) is the foundation for all activities, the MTCCC is the driving force for cancer control in Montana, and the CCC Plan is the guide to keep energies focused.



Several of the CCC Plan's guiding principles focus on ideals that foster evaluation; the CCC Plan is data driven, culturally appropriate, evidence based, and outcome oriented. Data trends related to the outcomes of the CCC Plan objectives are reviewed annually. The CCC Plan will evolve and change through an established Evolution Procedure as circumstances in Montana call for creative responses to emerging issues.

Evaluation Design and Methods

The evaluation questions are built on the framework of the three areas of focus as shown in the tables below. Evaluation analysis will be conducted in partnership between the MCCCP and the MTCCC Standing Committees: Assessment and Development, and Membership and Resources. The MCCCP will collect and compile data into spreadsheets. The MTCCC committees will analyze and report findings as detailed under the "Reporting" subsection below.

MTCCC Partnerships

Evaluation Question	Indicators	Data Sources	Timing
Is the partnership representative of the state?	Types and number of partners represented	Program records: membership database	Once per year
Are partners engaged and committed to CCC Plan implementation?	Types and number of partner contributions Number of partners involved in MTCCC meetings	Program records: activity tracking, resource tracking, meeting records	Two times per year
Is the partnership satisfied?	Percentage increase of partners satisfied	Member survey	Every 2 years

Montana CCC Plan

Evaluation Question	Indicators	Data Sources	Timing
How many strategies are being implemented in the CCC Plan?	Number of CCC Plan activities being implemented	Program records: activity tracking, MTCCC group progress reports	Quarterly
Are priority strategies being implemented as intended?	Extent to which CCC Plan priorities are implemented as intended	Program records: activity tracking, MTCCC group progress reports	Quarterly

Montana Comprehensive Cancer Control Program

Evaluation Question	Indicators	Data Sources	Timing
Is the annual work plan being implemented as intended?	Extent to which work plan objectives are being implemented as intended	Program work plan progress report	Two times per year

Reporting

Quarterly newsletters serve as an internal communication tool to inform the membership of MTCCC changes and updates. A dashboard report serves as an internal visual display for the Steering Committee to track key indicator evaluation components quarterly throughout each implementation year. External agencies and partners will receive the annual report as communication of CCC Plan activities and progress. Evaluation reports will be developed and disseminated according to the following table.

Dissemination Strategy Matrix

Audience	Format and Channel for Sharing Findings	Timeline	Responsible Person
CDC	Response to 2 CDC progress report deadlines a year, including evaluation reports	January and September	MCCCP Manager
MTCCC Steering Committee	Dashboard report at meetings Membership and financial report	Quarterly	Assessment and Development Committee; Membership and Resources Committee
MTCCC	Annual progress report based on Dashboard sent to members electronically and presented at fall meeting	Fall statewide meeting	MCCCP will produce annual report with assistance from Assessment and Development Committee.

Glossary

advanced directive: A legal document that allows a person to convey decisions about end-of-life care ahead of time. It provides a way to communicate personal wishes to family, friends, and healthcare professionals.

cancer: An umbrella term used to describe many different diseases in which cells grow and reproduce out of control.

cancer burden: The overall impact of cancer in a community.

Cancer Liaison Physician (CLP): Volunteer physician responsible for providing the leadership and direction to establish, maintain, and support a facility's cancer center. CLPs are a required component of CoC-accredited cancer programs.

carcinogen: Any substance known to cause cancer.

cessation: To cease or end.

clinical trials: Research studies that involve patients. Studies are designed to find better ways to prevent, detect, diagnose, or treat cancer and to answer scientific questions.

complementary medicine: Practices used to enhance or complement standard treatments but that are not recognized as standard or conventional medical approaches.

co-survivor: Co-survivors are family, friends, healthcare providers, or colleagues who are present to lend support from diagnosis through treatment and beyond.

culturally competent: Term used to describe how healthcare providers and organizations understand and respond effectively to the cultural and linguistic needs of a patient. This includes being able to recognize and respond to a patient's beliefs and values, disease incidence, and prevalence and treatment outcomes.

epidemiology: The study of disease incidence and distribution in populations, and the relationship between environment and disease. Cancer epidemiology is the study of cancer incidence and distribution as well as the ways surroundings, occupational hazards, and personal habits may contribute to the development of cancer.

epidermis: The upper or outer layer of the two main layers of cells that make up the skin.

evidence-based: Refers to the use of research and scientific studies to determine best practices.

five-year survival: A term commonly used as the statistical basis for successful treatment. A patient with cancer is generally considered cured after five or more years without recurrence of disease.

follow-up: Monitoring a person's health over time after treatment. This includes keeping track of the health of people who participate in a clinical study or clinical trial for a period of time, both during the study and after the study ends.

healthcare providers: Practitioners in disease prevention, detection, treatment, and rehabilitation. They include physicians, nurses, dentists, dietitians, social workers, therapists, Indian Health Service units, tribal healthcare facilities, complementary medicine providers, and others.

health disparities: Differences in the incidence, prevalence, mortality, and burden of cancer and related adverse health conditions that exist among specific population groups in the United States.

high-risk: Describes an individual or group of people for whom the chance of developing cancer is greater than for the general population. People may be considered to be at high risk from many factors or combinations of factors, including family history, personal habits, and exposure to carcinogens.

hospice: Special care and assistance for people in the final phase of illness as well as for their families and caregivers; usually provided in the patient's home or a homelike facility.

incidence: The number of times a disease occurs in a given population. Cancer incidence is the number of new cases of cancer diagnosed each year. The Montana Central Tumor Registry maintains cancer incidence data in Montana.

incidence rate: A measure of the rate at which new events occur in the population. The number of new cases of a specified disease diagnosed or reported during a defined period of time is the numerator, and the number of persons in the stated population in which the cases occurred is the denominator.

localized stage: Cancer that is limited to the site of origin. There is no evidence of metastasis elsewhere in the body.

malignancy (or malignant): Cancerous; able to invade nearby tissue and to spread to other parts of the body.

metastatic cancer stage: Cancer that has spread from the place in which it started to other parts of the body.

morbidity: Any departure, subjective or objective, from a state of physiological or psychological well-being. In this sense, sickness, illness, and morbid condition are similarly defined and synonymous.

mortality rate: A rate expressing the proportion of a population who dies of a disease, or of all causes.

noninvasive: An early-stage cancer that has remained localized and confined to the layer of tissue from which it first developed and has not spread (metastasized) to surrounding tissue or other parts of the body.

obesity: A condition in which a person has abnormally high amounts of unhealthy body fat; medically defined as a body mass index of 30 or greater.

overweight: Being too heavy for one's height. Excess body weight can come from fat, muscle, bone, and/or water retention. Being overweight (medically defined as 25.0 to 29.9 body mass index) does not always mean being obese.

palliative care: Care that does not alter the course of a disease but does improve quality of life.

Papanicolaou (Pap) screening / Pap test: A test to detect cancer of the cervix or lining of the uterus.

precancerous lesion: A change in some areas of the skin that carries the risk of becoming skin cancer.

prevalence: In medical terminology, the number of cases of a disease that are present in a population at a point in time. In the case of smoking prevalence in a population, the term is used to define the number of people in that population who are regular smokers.

primary prevention: The reduction or control of factors believed to be causative for health problems; prevention strategies might include risk reduction, education, health-service intervention, or preventive therapy.

quality of life: In cancer treatment, the concept of ensuring that cancer patients are able to lead the most comfortable and productive lives possible during and after treatment. New treatment techniques and social and emotional support groups are adding to the quality of life for cancer patients as well as to their survival.

regional cancer: Cancer that extends beyond the limits of the site of origin into surrounding organs or tissues or regional lymph nodes.

risk factor: Anything that has been identified as increasing the chance of getting a disease, for example, tobacco use, obesity, age, or family history of some cancers.

secondhand smoke: Smoke that comes from the burning end of a cigarette and smoke exhaled by smokers.

survivorship care plan: A record of a patient's cancer history and recommendations for follow-up care. It should define responsibilities of cancer-related, non-cancer-related, and psychosocial providers.

tertiary prevention: Involves providing appropriate supportive and rehabilitative services to minimize morbidity and maximize quality of life, such as rehabilitation from injuries. It includes preventing secondary complications.

tribal government: A sovereign, self-governing entity that protects the health, safety, and welfare of its citizens within its geographic boundaries.

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Resources

Agency for Healthcare Research and Quality (AHRQ):
www.ahrq.gov

American Cancer Society (including American Cancer Society Facts and Figures):
www.cancer.org

American College of Surgeons, Commission on Cancer:
www.facs.org/cancer/index.html

American Society of Clinical Oncology (ASCO)–People Living with Cancer:
www.cancer.net/portal/site/patient

Behavioral Risk Factor Surveillance System:
www.cdc.gov/brfss

Cancer Care:
www.cancercare.org

Cancer Control Planet:
http://ccplanet.cancer.gov/index.html

Centers for Disease Control and Prevention (CDC):
www.cdc.gov

Council of State Governments:
www.healthystates.csg.org

Entrez PubMed:
www.ncbi.nlm.nih.gov/entrez

Healthy People 2020:
www.healthypeople.gov/2020/about/

Montana Central Tumor Registry Annual Report:
www.cancer.mt.gov

National Comprehensive Cancer Control Program:
www.cdc.gov/cancer/ncccp/index.htm

National Cancer Institute (NCI):
www.cancer.gov

NCI Cancer Progress Report:
http://progressreport.cancer.gov

National Coalition for Cancer Survivorship:
www.canceradvocacynow.org

National Comprehensive Cancer Network:
www.nccn.org

National Consensus Project on Quality Palliative Care:
www.nationalconsensusproject.org

Partners for Prevention:
www.prevent.org

Youth Risk Behavior Surveillance System:
www.cdc.gov/HealthyYouth/yrbs/index.htm

The Montana Cancer Control Programs of the Public Health and Safety Division of the Montana Department of Public Health and Human Services attempts to provide reasonable accommodations for any known disability that may interfere with a person participating in this service. Alternative accessible formats of this document will be provided upon request. For more information, call the Montana Cancer Control Programs at (406) 444-6888.

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Access the plan online at www.cancer.mt.gov

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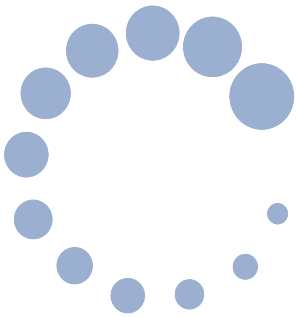

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www.cancer.mt.gov