December 2013

To:
Honorable Dannel Malloy
Members of the Connecticut General Assembly
All Residents of Connecticut

On behalf of the Connecticut Cancer Partnership, we present the **Connecticut Cancer Plan, 2014-2017**, created under the direction of the Partnership with guidance and funding from the U.S. Centers for Disease Control and Prevention. Although we have made significant progress since the release of the *Connecticut Cancer Plan, 2009-2013*, cancer continues to be the second leading cause of death in the state of Connecticut. In 2010, the state had the fifth highest cancer incidence rate in the nation. We expect that more than 21,000 cancers will be diagnosed in Connecticut residents next year and almost 7,000 Connecticut residents will die of the disease.

The Connecticut Cancer Plan, 2014-2017 builds on a strong foundation, whose underpinnings are based on shared goals and coordinated work among a diverse set of energetic, engaged volunteers from all sectors in the state. While the Connecticut Cancer Partnership is charged with taking the lead in the creation of a state cancer plan, its implementation and success depend on the collaborative work of all individuals and organizations committed to cancer control across the life span for all people. The Plan provides a base for achieving exciting advances in cancer control and prevention. We can each use it to earmark specific goals and objectives to incorporate into our own implementation activities. Working as committed partners with a common cause, we will continue our ongoing fight against cancer.

Now, more than ever, in this exciting period of scientific and policy transformation we look forward to working together with you to reduce the burden of cancer in Connecticut.

Respectfully submitted,
Linda Z. Mowad, RN
Chair, Connecticut Cancer Partnership

Lucinda Hill Hogarty, MPH
Director, Connecticut Cancer Partnership

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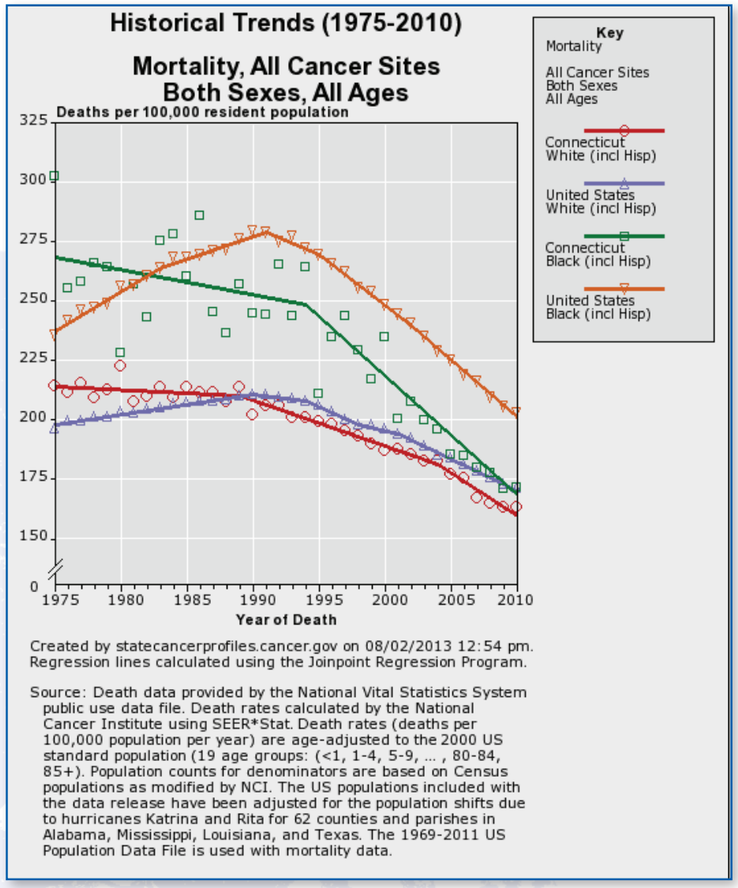
Executive Summary

The Connecticut Cancer Partnership, a coalition comprising volunteers representing 150 organizations and 400 individual members involved in cancer control from around the state, presents the **Connecticut Cancer Plan, 2014-2017**. This Plan, a road map for controlling cancer in our state, addresses prevention, early detection and treatment, as well as quality of life for patients and survivors and for those facing the end of life. We recognize first and foremost that differences in cancer outcomes, based on race, socioeconomic status and other factors exist in our state. Therefore a primary goal is to carefully assess the impact of policies and practices that can help improve health equity and eliminate cancer disparities.



[1]

[1] http://statecancerprofiles.cancer.gov/cgi-bin/quickprofiles/profile.pl?09&001

Although we have made substantial progress since the release of the *Connecticut Cancer Plan 2009-2013*, cancer remains a significant problem in Connecticut. Cancer is the second leading cause of death (after heart disease) in both Connecticut and the United States.[2,3] Connecticut's 2010 cancer incidence rate was the fifth highest in the nation at 478.4 [4], compared with the national incidence rate of 430.5 per 100,000 population. (This may in part be due to higher screening and early detection rates.[5]) Yet, the state's cancer death rate has been decreasing, from 176.3 per 100,000 population in 2006 to 162.4 per 100,000 population in 2010. The Healthy People 2020 goal is 160.6 per 100,000. An additional concern is the fact that between 2000 and 2011, Connecticut saw a sharp increase in hospitalization costs related to cancer care, rising from $369 million in 2000 to $907 million in 2011, an increase of more than 200 percent.[6]

Increased prevention efforts, earlier detection and advances in treatment, as well as healthy behavioral changes, have resulted in decreases in incidence and mortality rates and improvements in survival from the four most commonly diagnosed cancers: breast, colorectal, lung and prostate. Conversely, while great progress has been made to reduce the burden of cancer on the people of Connecticut, not all residents have benefitted equally and alarming disparities in morbidity and mortality persist. Equitable provision of and access to quality services must be a priority. Culturally sensitive approaches to improve the health of all state residents are required, including policy, systems and environmental changes.

[2] American Cancer Society. Cancer Facts & Figures 2013. Atlanta: American Cancer Society; 2013.
[3] CT Department of Public Health. 2008-2010 Behavioral Risk Factor Surveillance Survey data.
[4] http://statecancerprofiles.cancer.gov/cgi-bin/quickprofiles/profile.pl?09&001
[5] Centers for Disease Control and Prevention (CDC). *Behavioral Risk Factor Surveillance System Survey Data*. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2010. http://www.cdc.gov/cancer/colorectal/statistics/screening_rates.htm Accessed Feb. 18, 2014.
[6] Connecticut Department of Public Health (2000). Hospitalization Statistics. http://www.ct.gov/dph/cwp/view.asp?a=3131&q=397512 Accessed July 15, 2013

"The Connecticut Cancer Partnership has been a vehicle for developing and sustaining public health partnerships and for integrating the science and practice of public health relative to cancer prevention and control and staying abreast of developments in cancer prevention and control re. science, funding opportunities, the status of programming and policy in our state and nationally.

Issues of equity and education advocacy all figure into the benefits/activities of the partnerships."

Elaine O'Keefe
Executive Director
Yale School of Public Health
New Haven
Eight-year Partnership member

This Plan is designed to help guide and support the cancer control community, policy makers and all Connecticut residents in:

- **Promoting healthy lifestyles to reduce the risk of cancer incidence and advocating for residents to receive recommended cancer screenings**
- **Increasing access to quality cancer care, including palliative care across the continuum**
- **Enhancing quality of life for cancer survivors and**
- **Ensuring that high-quality hospice care services are available and accessible to all residents**

Our plan is structured around goals, objectives and strategic actions. **Goals**, which are broad and idealistic, reflect our vision statements. **Objectives** represent the activities that can be carried out by the Partnership, primarily through its committee structure and staff. **Strategic Actions** are examples of activities that may be implemented by member/partner organizations of the Partnership over the four years of the Plan.

To identify strategic actions that address our objectives, the Partnership will hold a meeting each year to rank priorities and develop an action plan. Based on these priorities, specific committees, organizations and/or task forces will focus on ways to make progress in each area.

This four-year Plan does not address implementation funding issues directly. Focusing on policy, systems and environmental (PSE) changes provides a sustainable high-impact approach to health improvement efforts. We charge all organizations to take an active role, working collaboratively to leverage support for implementation and to move forward, using this blueprint as a consensus–based guide for resource allocation.

The Partnership will monitor Plan objectives and implementation strategies, as well as data sources, to assess progress toward meeting each goal over time. The goals and objectives are summarized below. Detailed strategic actions, background information and promising practices are located at Tab 3.

Summary of Goals

Goal 1
Primary prevention of cancer through healthy living is addressed at all levels across the state.

Objective 1.1: Promote and support policies, systems and environmental changes that optimize healthy living through good nutrition, increased physical activity and tobacco avoidance

Objective 1.2: Promote and support policies, systems and environmental changes to reduce exposure to environmental carcinogens and cancer-related infectious agents

Goal 2
High-quality cancer screening and early detection services are available to all people living in Connecticut.

Objective 2.1: Support policy, systems and environmental changes that increase the percentage of Connecticut residents receiving recommended and appropriate breast, cervical, colorectal and lung screening

Objective 2.2: Identify and disseminate strategies and best practices to reduce disparities in access to screening services

Goal 3
High-quality comprehensive cancer treatment and the opportunity to participate in clinical trials are available and accessible to all people living in Connecticut.

Objective 3.1: Promote and support the efforts of Connecticut hospitals to meet the standards of the American College of Surgeons' Commission on Cancer (CoC)

Objective 3.2: Promote and support increased participation in cancer-related clinical trials

Objective 3.3: Advocate for policy, systems and environmental changes that lead to equal access to treatment for underserved groups

Goal 4
Ensure that high-quality palliative care is available and accessible to all people living in Connecticut

Objective 4.1: Identify data sources and monitor trends related to the provision of high-quality palliative care including data and trends relevant to disparities

Objective 4.2: Utilize and disseminate data to advocate for high-quality palliative care

Objective 4.3: Convene and educate providers and community members from across the state to strengthen the availability and quality of palliative care

Goal 5
Ensure a high quality of life and care for all Connecticut cancer survivors

Objective 5.1: Promote and support efforts to provide comprehensive and coordinated care to all cancer survivors living in the state of Connecticut

"I use informational emails, the Annual Meeting and the Cancer Control Plan as a guide to funding decisions for our organization, networking, understanding of what other organizations are using as strategies for early detection, education, data surveillance, etc."

Anne Morris
CEO
Susan G. Komen Connecticut, Farmington
Five-year Partnership member

Focusing on policy, systems and environmental (PSE) changes provides a sustainable high-impact approach to health improvement efforts.

Objective 5.2: Promote and support initiatives to educate and empower cancer survivors to engage in a healthy lifestyle (physical activity and nutrition) to improve their health and wellbeing as well as reduce risk of new or recurring cancers

Goal 6
Ensure that high-quality end-of-life care is available and accessible to all people living in Connecticut

Objective 6.1: Identify data sources and monitor trends related to the provision of high-quality end-of-life care, including data and trends relevant to disparities
Objective 6.2: Utilize and disseminate data to advocate for high-quality end-of-life care
Objective 6.3: Convene and educate providers and community members from across the state to strengthen the quality of end-of-life care in Connecticut

Please refer to ***What You Can Do*** on page 61 to see how you and your organization can be a part of this statewide effort to reduce the burden of cancer in Connecticut.

How We Do Our Work

The Connecticut Cancer Partnership is a coalition that supports the work of its members by providing a statewide context for cancer-related programming through its Cancer Plan. Members of the Partnership are drawn from the state's diverse cancer community—academic and clinical institutions, state and local government, health care agencies, industry and insurers, advocacy and community groups. We currently comprise 150 organizations and 400 individual members from across the state. All members work to support the Partnership's vision of reducing the burden of cancer for Connecticut residents, with a special focus on the elimination of cancer-related disparities.

The Partnership, through the volunteer efforts of its committees, the Connecticut Department of Public Health Comprehensive Control Program, staff and community partners work to:

- **convene cancer community partners**
- **educate cancer control partners**
- **mobilize advocates for cancer control including the area of policy, systems and environmental changes**
- **monitor data trends related to the burden of cancer** *and*
- **disseminate best practices to improve care across the continuum of cancer control**

Organizational Structure

A 20-member Board of Directors and an Executive Committee (made up of one representative appointed by each of the Partnership's five founding-member organizations and the officers) govern the Partnership. The Board leadership consists of a Chair, Vice Chair, Secretary, Treasurer and immediate past Chair (see Tab 5). Board members who are not founding-member representatives are elected by the Partnership members to serve two-year terms. Elections take place during a business meeting held every year during the Annual Meeting.

Members of the Partnership's Executive Committee and Board of Directors provide guidance and oversight to two types of committees: committees representing the continuum of cancer control-Prevention, Early Detection, Treatment and Survivorship, Palliative and Hospice; and cross-cutting committees-Advocacy, Communications, Data and Surveillance, Disparities, Education and Evaluation. Because committees are centered on a particular focus area, committee chairs (appointed by the Board Chair) are typically subject-matter experts in that field. Most committees have co-chairs who guide the committee by holding regular meetings and staying in contact with committee members. One of the most important functions of these committees is to promote information exchange. Discussions of current and future projects during committee meetings inform decision-making in individual member organizations and help in reducing duplication of efforts. Meetings of committee chairs are held periodically, fostering cross-cutting integration of activities.

In addition to the voluntary leadership provided by the Board, Executive Committee and Committee chairs, the Partnership has regular staff members. The Director of the Partnership guides all the committees and the Board and works in concert with the Chair of the Board. The Director also works with the Department of Public Health Comprehensive Cancer Control Program to ensure timely reporting and accountability, especially when implementation projects are funded. Management of the Partnership staff, which includes a Project Coordinator, a Disparities Project Coordinator and evaluation sub-contractors, where appropriate, is also the responsibility of the Director. Staff members run the day-to-day business of the Partnership.

Process of Plan Development

The **Connecticut Cancer Plan, 2014–2017** represents the coordinated efforts of Partnership members from across the state who came together through its ten committees to develop a blueprint that represents the needs of the people of Connecticut. It reflects the guidance of the Centers for Disease Control and Prevention's (CDC) National Comprehensive Cancer Control Program (NCCCP) which recommends that state cancer plans:

- **Emphasize primary prevention**
- **Support early detection and treatment activities**

The Partnership's five founding members:

American Cancer Society

Connecticut Department of Public Health

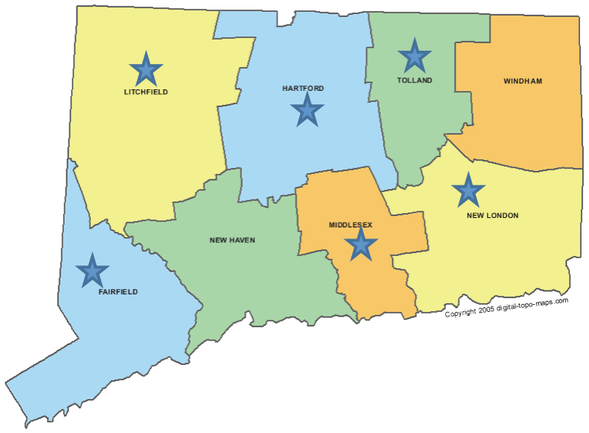
Connecticut State Medical Society

University of Connecticut Health Center

Yale Cancer Center

Among the cross-cutting committees, the Communications Committee's goal is to provide an active, coordinated communications program that will reach diverse audiences who need information essential to the success of the Partnership and its Cancer Plan. It ensures that timely information about the Partnership is conveyed to existing and prospective Partnership members, as well as to target audiences such as policy makers, state leaders, legislators, health professionals, public agencies and private organizations. In addition, working collaboratively with other Partnership committees, the Communications Committee offers expert support to meet committees' individual communications needs, such as transmitting information about present and future activities to particular groups. Among its main channels are the Partnership web site (www.ctcancerpartnership.org), its monthly e-newsletter CA CONNections, fact sheets, press releases, presentations and briefings for specific audiences.

- **Address public health needs of survivors**
- **Implement policy, systems and environmental (PSE) changes to guide sustainable cancer control**
- **Promote health equity as it relates to cancer control**
- **Demonstrate outcomes through evaluation**



The Partnership adhered to these recommendations throughout the process of plan development. In addition, staff surveyed Partnership members for their suggestions. Committee meetings were held to develop content to address the continuum of cancer control in Connecticut.

In the spring of 2013, additional feedback was obtained at six regional meetings across the state. Meetings were held in each geographic region of the state – Central (Hartford and Middletown), Northwest (Torrington), Northeast (Tolland), Southwest (Ridgefield) and Southeast (Norwich).

Attendees included local public health officials, physicians, nurses, community advocates, patient navigators, hospice workers and survivors. The following themes emerged from the meetings:

- **Barriers to care include lack of, or limited transportation options in both rural and urban areas and lack of culturally- and linguistically- appropriate patient education about screening guidelines and early detection services. There is also a need for better access to primary care and for increased coordination between primary care and specialty care.**

- **Shortages in the primary care workforce pose problems for cancer screening and diagnosis in parts of the state. This may worsen over the next four years with an increase in the insured populations due to implementation of the Affordable Care Act.**

- **Participants noted the importance of patient navigators or community health workers (CHWs) to improve access to care and the need for trained and funded CHWs to work in this rapidly changing health care landscape.**

- **Palliative care and end-of-life/hospice care should be considered as separate patient needs, since palliative care should be available throughout the course of illness.**

- **The Partnership should consider increased use of regional-level coalitions to implement more locally targeted strategies. (The Hartford Cancer Task Force was cited as a model.)**

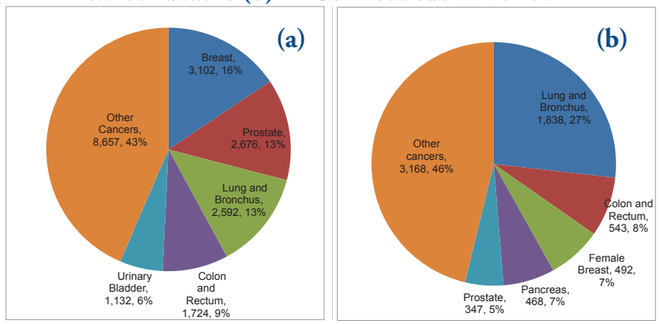
The Burden of Cancer in Connecticut

The Burden of Cancer chapter is reprinted with permission from the Connecticut State Medical Society, publisher of Connecticut Medicine. A more comprehensive version of this chapter was published in the June/July 2012 issue. (76(6):335-351.) The authors of the Connecticut Medicine article are Brenda Cartmel, PhD, Lou Gonsalves, PhD and Lloyd Mueller, PhD. The article has been modified and updated for this publication by Brenda Cartmel, Lou Gonsalves and Lucinda Hogarty.

It has been estimated that one in two men and one in three women in the United States will be diagnosed with cancer during their lifetime[1]. In Connecticut, as in the nation, cancer is the second leading cause of death. Cancer risk increases with age and in a state where the proportion of residents aged 65 years and older is expected to reach more than 20 percent by 2030[2], cancer poses a significant burden on the state's residents and resources. In terms of financial cost, it is projected that by 2020 national costs for cancer care will exceed $158 billion (in 2010 dollars)[3].

Almost 20,000 new cancers were diagnosed in Connecticut residents in 2010; the four most commonly diagnosed cancers – breast, prostate, lung and colorectal – accounted for more than half of these diagnoses and just under half of all cancer deaths.

Newly diagnosed cancers (a) and cancer deaths (b) in Connecticut in 2010.



Sources: Connecticut Tumor Registry; Connecticut Department of Public Health.

Many of these cancers can be prevented through lifestyle changes to minimize risk factors or can be detected early through screening when treatment is more effective. Despite the substantial mortality and morbidity burden still imposed by these four cancer groups, there have been significant and welcome declines in death rates reported for all four. Between 1990 and 2008 these four sites accounted for 78 percent of the decline in U.S. male cancer mortality reported for all cancers, while breast and colorectal death rates among U.S. women accounted for 56 percent of the overall decline. [4]

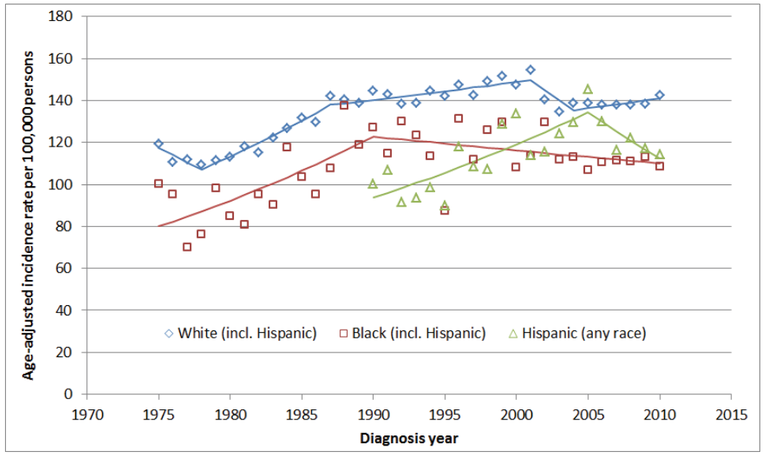
Cancer affects some populations disproportionately; this disparity is one of the fundamental drivers for this Plan. In particular a person's gender, race, ethnicity and other socio-demographic factors have a major impact on their risk of developing or dying from cancer. Below, we explore these cancer disparities in the Connecticut population for the four most common cancers focusing on incidence, mortality and relative survival, as well as trends over the past three decades.

Breast Cancer

Incidence

In Connecticut, the female breast cancer incidence rate for 2010 was 138.5 per 100,000, significantly higher than the rate for the U.S. as a whole. Breast cancer incidence rates and historical trends differ between racial and ethnic groups. Throughout the entire time period the incidence rate in white women has been higher than any other race or ethnicity.

Breast cancer incidence rates in Connecticut women, 1975-2010.



Source: Connecticut Tumor Registry

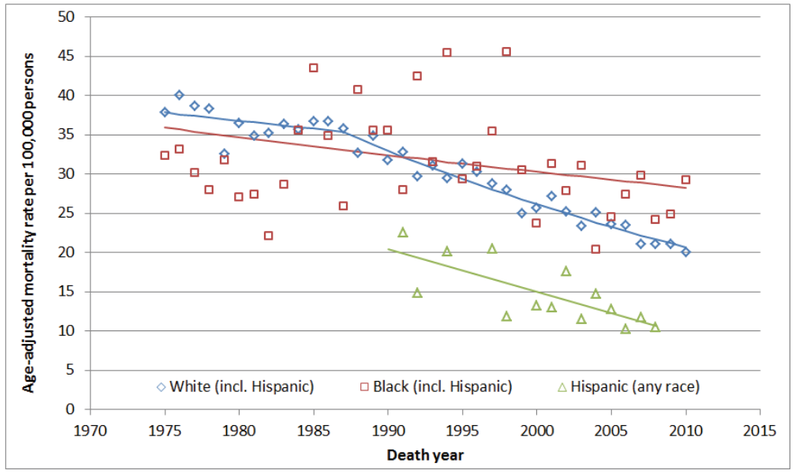
Connecticut has the second highest state incidence rate of breast cancer in the nation. The relatively high socioeconomic status (SES) of women living in Connecticut is one of the factors contributing to the comparatively high incidence rate. Women with higher SES tend to have a higher likelihood of developing breast cancer as they start childbearing later in life and have fewer children, both of which are risk factors for breast cancer.[7] In addition, higher SES is associated with higher compliance with screening mammography, which could increase incidence rates. The difference in childbearing practices and screening mammography rates may also, in part, explain the differences seen in incidence rates between black and white women. The high breast cancer incidence rate in Hispanic women in Connecticut, relative to their counterparts in the nation as a whole, may be explained in part by the high proportion of Puerto Ricans in Connecticut compared to the U.S. (53 percent of Hispanic population in Connecticut versus nine percent in the U.S.).[8] A study of cancer rates in Florida Hispanics has indicated that Puerto Rican Hispanics have cancer rates higher than do other Hispanic subpopulations.[9]

Mortality

In Connecticut, breast cancer is the second leading cause of cancer deaths in women. In 2010, the breast cancer mortality rate in women was 23.2 per 100,000, lower than the national rate with Connecticut ranking 35th in the nation. Overall, mortality rates have been declining since 1975. In 1975, mortality rates in black women were lower than in white women, a pattern that mirrored incidence rates. However, since 1992 mortality rates in black women have been higher than mortality rates in white women, despite blacks continuing to have lower incidence rates; notably the gap between white and black mortality rates has been increasing. The breast cancer mortality rates in Hispanic women are considerably lower than in white and black women and have been decreasing over the period 1990-2008. Breast cancer mortality rates are declining for several reasons, including improvement in treatment for breast cancer and detection of breast cancers at an earlier more treatable stage due to screening mammography.

In Connecticut, as in the U.S.[5], invasive **breast cancer** is the most common cancer in women. It is projected that 3,050 women will be diagnosed with **breast cancer** in Connecticut in 2013 and 460 women will die from this disease.[6]

Breast cancer mortality rates in Connecticut women, 1975-2010.



Source: Connecticut Department of Public Health

Survival

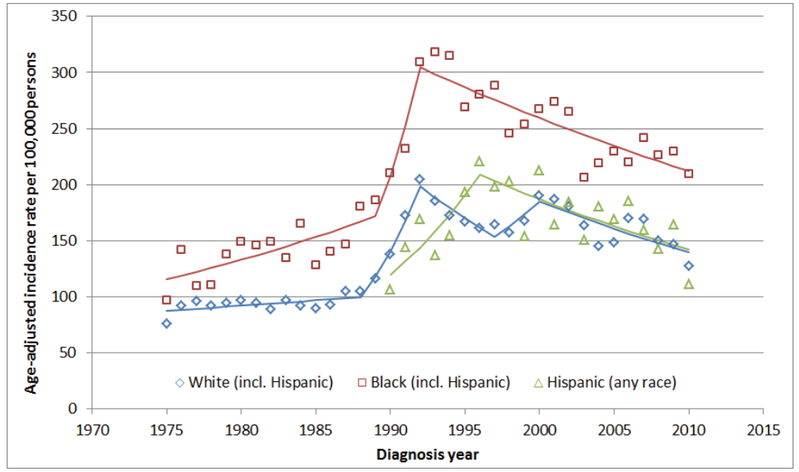
The five-year relative survival rates for women diagnosed with breast cancer in 2001-2007 were significantly lower for black women than for white and Hispanic women (79.5 percent versus 92.3 percent and 88.8 percent, respectively). The higher proportion of late stage diagnoses in black women (6.6 percent of breast cancer diagnoses in 2004-2008, compared with 4.5 percent in white women) undoubtedly contributes to this disparity. However, other factors including tumor subtype, patient socio-demographic characteristics and access to quality treatment also impact patient outcomes. [10]

Prostate Cancer

Incidence

The prostate cancer incidence rate in Connecticut in 2010 was 137.0 per 100,000, which was higher than the national rate. Rates have fluctuated over the years and vary with race and ethnicity.

Prostate cancer incidence rates in Connecticut men, 1975-2010.



Source: Connecticut Tumor Registry

Over the entire period examined, the incidence rates in black men were considerably higher than those in white and Hispanic men. The increased risk of prostate cancer in black men is observed nationally and worldwide. The reasons are as yet unclear, but differences in genetic susceptibility, diet and other environmental factors have been suggested as contributing to this disparity.[12,13]

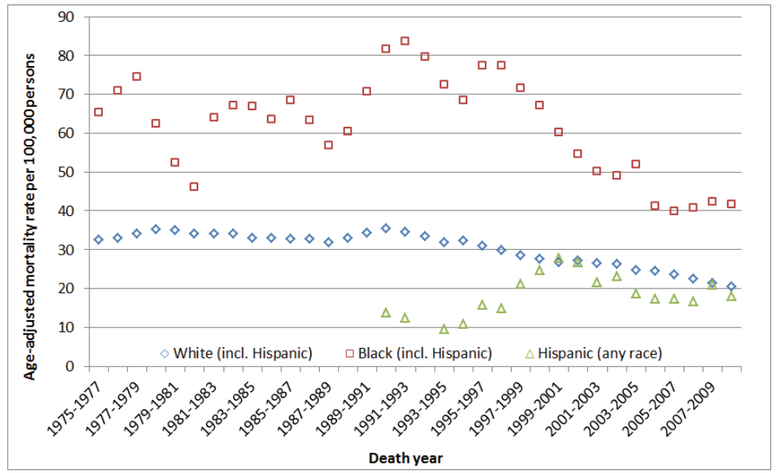
Mortality

The mortality rate for prostate cancer in Connecticut men in 2010 was slightly but not significantly lower than the national rate (20.5 versus 21.8 per 100,000). There has been a steady decrease in mortality from prostate cancer since the early 1990s. Throughout the entire period the mortality rates in black men were considerably higher than those in white and Hispanic men, over double for more than half of the years covered.

While some of the disparity in mortality rates between black men and white men may be explained by differences in incidence rates, socioeconomic status, unequal access to services, higher levels of comorbidities in black men and differences in disease management, these factors do not fully explain the poorer prognosis of black men with prostate cancer, calling for more research in this area.[12,14, 15, 16]

Cancer of the prostate gland is the most commonly diagnosed cancer in males in the developed world.[11] The American Cancer Society estimates that almost 3,000 men in Connecticut will be diagnosed with **prostate cancer** in 2013 and around 400 men will die from the disease.[6]

Prostate cancer mortality rates in Connecticut men, 1975-2010.



Source: Connecticut Department of Public Health

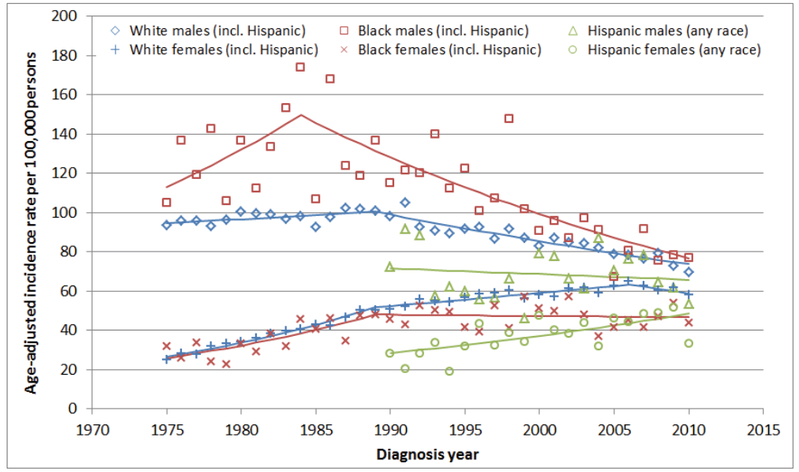
Source: Connecticut Department of Public Health

Survival
While there is little variation in survival by race or ethnicity, stage at diagnosis impacts prostate cancer survival rates hugely. Men diagnosed with localized (early stage) prostate cancer have survival rates comparable to the general population, whereas those diagnosed at a late stage have a relative survival rate of less than 30 percent. In Connecticut, more than 80 percent of prostate cancers are diagnosed at an early stage.

Lung Cancer

Incidence
While the numbers of new lung cancer cases reported for men and women in Connecticut during 2010 were similar (1,285 and 1,307, respectively) the age-adjusted incidence rates for men and women are quite different, due to differences in the age-distributions of the underlying populations – 70.3 per 100,000 in men and 56.2 per 100,000 in women. Incidence rate trends vary somewhat by race and ethnicity.

Lung cancer incidence rates in Connecticut men and women, 1975-2010.



Source: Connecticut Tumor Registry

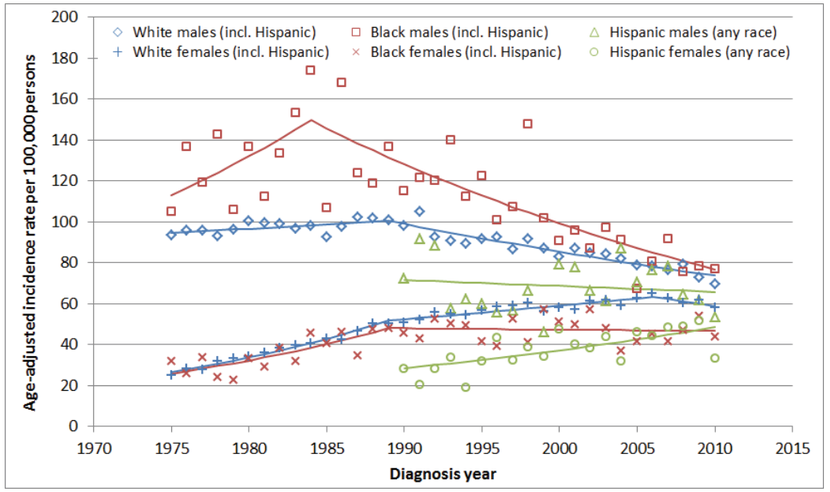
Source: Connecticut Tumor Registry

Mortality
Lung cancer mortality rates track incidence rates due to lung cancer's high fatality rate and short survival times. Connecticut lung cancer mortality rates for black and white males have been declining steadily, reflecting changing patterns in tobacco use. The rate in Hispanic males, which is considerably lower, has remained relatively unchanged. Rates have plateaued in white and black women and while the rate in Hispanic women is lower, it shows a slight increase over time.

Survival
Around half of all lung cancers are diagnosed at a late stage. Consequently, the overall survival rates for this cancer are poor: 17.3 percent in men and 22.8 percent in women diagnosed 2001-2007.

In Connecticut, there are projected to be 2,780 new **lung cancer** cases diagnosed in 2013 and 1,740 deaths. **Lung cancer** accounts for about one in seven invasive cancers and it is the underlying cause for 26 percent of all cancer deaths in Connecticut. **Lung cancer** is the leading cause of cancer deaths in Connecticut, the United States,[4] and worldwide.[11]

Lung cancer mortality rates in Connecticut men and women, 1975-2010.



Source: Connecticut Department of Public Health

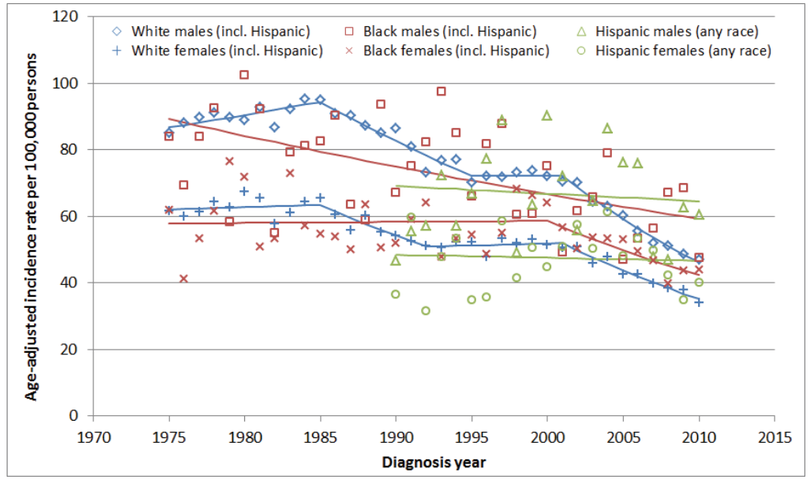
Colorectal Cancer

Incidence

The incidence rates of colorectal cancer in men and women in Connecticut (46.9 and 35.6 per 100,000, respectively) are comparable to the national rates. Colorectal cancer incidence rates in Connecticut have been falling in both males and females; comparable declines have been observed nationally.[5] However, as with other cancer sites, patterns differ by sex and race and ethnicity. Incidence rates in women are lower than those seen in men for each racial or ethnic group.

Differences in incidence rates may be due to difference in screening rates, differences in genetic factors, environmental or lifestyle factors and socioeconomic disparities.[17,18] Some studies have indicated that the specific sub-site location of the colorectal tumor also varies with race and ethnicity, with the proportion of cancers proximal to the sigmoid colon or splenic flexure (sub-sites accessible by colonoscopy but not always reached during sigmoidoscopy) higher in blacks than whites. It has been suggested that screening practices contribute to this disparity. [19,20]

Colorectal cancer incidence rates in Connecticut men and women, 1975-2010.



Source: Connecticut Tumor Registry

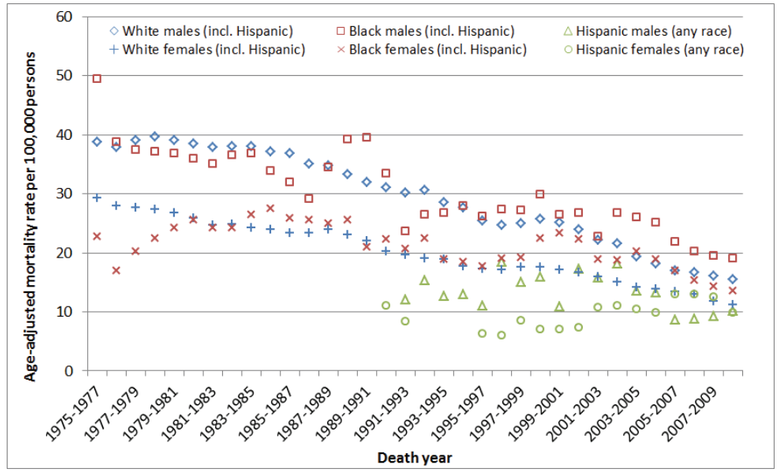
Mortality

The colorectal cancer mortality rates in Connecticut, 15.0 per 100,000 in men and 10.7 per 100,000 in women, are lower than the national rates. Racial disparities in colorectal cancer mortality are observed nationally and in Connecticut.

The reasons for the higher death rate in blacks are complex; variations in access to screening and quality treatment have been implicated.[21,22] When barriers to these differences are removed, the disparities are much reduced.[23, 24] In addition, proximal tumors have been shown to have poorer outcomes[25] and these tumors are diagnosed in a higher proportion in blacks.[19,20] A recent study confirms the effectiveness of colonoscopy, a screening modality of increasing popularity, in reducing colorectal cancer mortality.[26] Continuing efforts to further increase compliance with colorectal cancer screening will likely lead to a further decline in colorectal cancer incidence and mortality.

Colorectal cancer is the third most commonly diagnosed cancer in men and in women in Connecticut. In 2013, a projected 1,670 Connecticut residents will be diagnosed with **colorectal cancer** and 470 people are projected to die of the disease.[6]

Colorectal cancer mortality rates in Connecticut men and women, 1975-2010.



Source: Connecticut Department of Public Health

Survival

As has been observed nationally, disparities in five-year relative survival from colorectal cancer were observed in men and women in Connecticut diagnosed in 2001 to 2007. The survival rates in black men and women were 61.3 percent and 61.2 percent, respectively, compared with 69.1 percent and 66.5 percent in white men and women. This survival disparity has been the subject of considerable research. Findings indicate that multiple factors contribute to this survival disparity, including differences in screening, access to care (screening and treatment), socioeconomic status, physiological factors (BMI, comorbidity) and tumor characteristics. A concerted effort is required to further delineate and address the causes of this inequity.

Other Cancers

The Connecticut Cancer Plan burden chapter addresses the issues surrounding the highest burden cancers in the state. See State Cancer Profiles[27] for resources and data on other cancers. Lower burden cancers that are preventable by vaccination, such as cervical cancer are addressed in the Prevention Section (Tab 3).

Cancers Increasing in Incidence and Mortality Rates

In Connecticut, the majority of age-adjusted incidence and mortality rates for specific types of cancer and the overall cancer incidence and mortality rates are falling. However, both the incidence (Figure 1) and mortality rates (Figure 2)[28] for four cancer sites are increasing, namely pancreas, uterus, liver and bile duct and oral cavity and pharynx. Cancer of the brain and other nervous system (ONS) has had an increase in mortality rate (Figure 2) but not an increase in incidence rate; notably the increase in mortality is not significant.

An increase in obesity rates may account for some of the increase in cancers of the uterus, pancreas and liver.[29] Some portion of the increase in liver cancer is likely due to a relatively high prevalence of hepatitis C infection in specific sectors of the population. The increase in oral cavity and pharynx appears to be due to an increase in human papilloma virus-related cancer, as in contrast to HPV-related oral cavity and pharyngeal cancers, tobacco-related oral cavity and pharyngeal cancers are declining due to declining rates of tobacco use. [30]

Changing trends in cancer incidence and mortality for Connecticut provide useful data to monitor progress against cancer in the state. Increasing trends in cancer incidence and mortality should prompt investigation into the causes of such change and subsequent interventions to mitigate causative factors or behaviors.

Figure 1

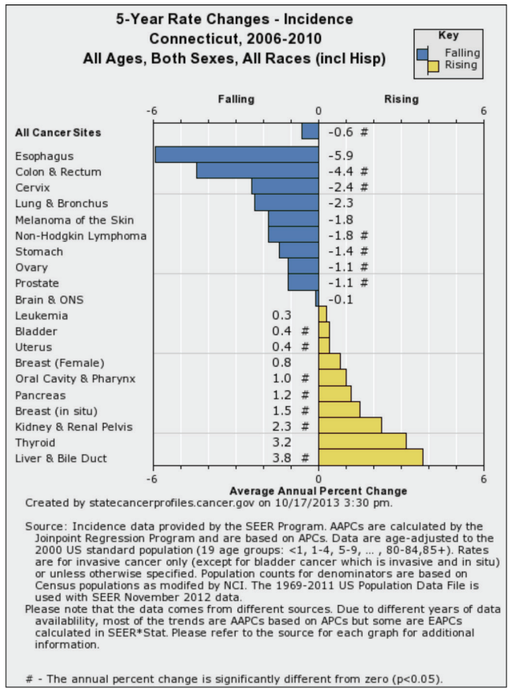
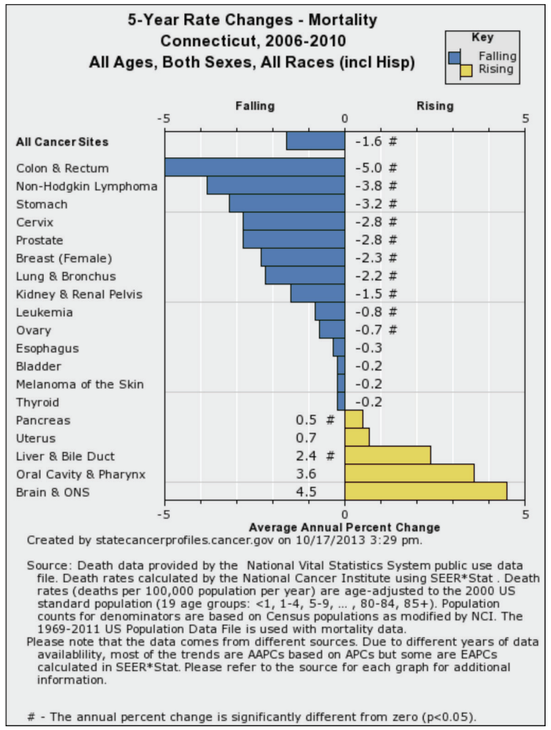


Figure 2



The Aging of the Population

A 2013 draft report from the Institute of Medicine addresses another increasingly important issue in cancer control.[31] In the report entitled "Delivering High-Quality Cancer Care: Charting a New Course for a System in Crisis: Addressing the Challenges of an Aging Population" the authors spell out additional considerations for caring for the burgeoning older cancer patients.

"Cancer care for older adults …is especially complex. Age is one of the strongest risk factors for cancer and there are many important considerations to understanding older adults with cancers' prognoses and formulating their care plans, such as altered physiology, functional and cognitive impairment, multiple coexisting morbidities, increased side effects to treatment, distinct goals of care and the increased importance of social support. The current health care delivery system is poorly prepared to address these concerns comprehensively. Thus, addressing the needs of the aging population will be an integral part of improving the quality of cancer care.

…In addition, there are less data from clinical trials to guide treatment decisions in older patients.
…Stereotypes held by clinicians about older adults may also deter them from treating patients aggressively (Foster et al., 2010).

Older adults with cancer may have different treatment goals or preferences than younger patients with cancer. Clinicians' treatment recommendations are greatly impacted by their patients' age, comorbidity and health status and do not always take into account individual preferences (Hurria et al., 2008). Clinicians' communication styles and their own treatment preferences also have an impact on the type of care older adults with cancer receive."

The report recommends ten strategies to address these issues and improve the quality of cancer care for older adults (See Tab 5).

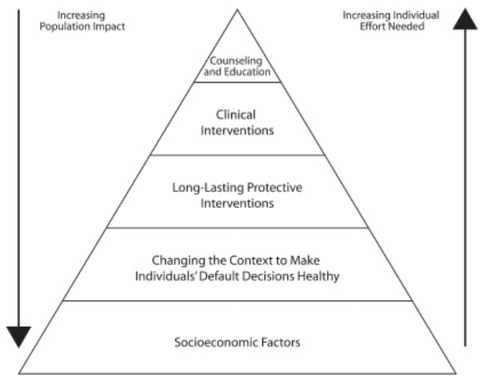
Comprehensive Cancer Control in Connecticut: The Evolving Landscape

The development of the **Connecticut Cancer Plan, 2014-2017** has occured in a rapidly changing health care environment. Topics covered briefly in the following pages are examples of issues to be reviewed at the annual action planning meetings and explored by the Connecticut Cancer Partnership through one of its existing committees or new workgroups.

Some of these topics reflect activity to be undertaken by the Connecticut Cancer Partnership and others represent conditions in the environment that will affect our work.

Policy, Systems and Environmental Changes

Policy, systems and environmental changes (PSE) are self-sustaining interventions that can improve health on a population-wide basis for years, affecting the ways through which health and public health services are delivered. The **Connecticut Cancer Plan, 2014-2017** embraces the use of the PSE approach to achieve results, following the 2012 recommendations of the National Comprehensive Cancer Control Program (NCCCP) that all state cancer control plans "implement PSE changes to guide sustainable cancer control."



The use of policy, systems and environmental changes are increasingly viewed as the most effective way to enable long-term transformation. The "Health Impact Pyramid"

"The Connecticut Cancer Partnership helps build relationships to work towards the same goals, coordinate activities and leveraging of resources.

Having people come together for a common goal allows for greater information sharing and collaboration."

Joe Oros
Regional Director
Boehringer Ingelheim
Ridgefield
One-year Partnership member

The Advocacy Committee of the Connecticut Cancer Partnership plays an active role in supporting implementation of Plan objectives and strategies. It coordinates advocacy efforts on behalf of the Connecticut Cancer Partnership. Working closely with the Partnership's Communications Committee, it informs membership, public officials, other cancer stakeholders and the public of the goals and progress of this PSE approach to comprehensive cancer control.

The Committee supports the Board by providing background information on policy issues related to cancer and assists with seeking funding to help support programs and projects across the continuum of the Plan, as approved and recommended each year by the Connecticut Cancer Partnership Board of Directors.

proposed and described by Dr. Thomas R. Frieden, Director of CDC, in 2010 illustrates how PSE strategies can have a broader and longer lasting impact on public health when compared with more limited counseling, education and treatment interventions. [32]

Decisions and actions made by local, state and national government leaders and legislatures influence the health of residents. Smoke-free public spaces, mandates for insurance coverage for evidence-based early detection techniques and cancer genetic tests are examples of policies that can prevent or reduce the burden of cancer. Policy action can improve access to therapy, support programs and services for cancer patients and survivors. Advocacy at all levels is an important component for implementing the **Connecticut Cancer Plan, 2014-2017**.

Policy Issues

While all the objectives in this Plan are designed to work within the PSE change approach, the Advocacy Committee will monitor the following evolving issues, among others.

Tobacco Taxation
Taxation of tobacco products is a policy supported by health care advocates, who cite both the reduced numbers of young people starting smoking and cessation among current smokers. It is also a valuable revenue stream. Connecticut's current rate is $3.40 per pack compared to neighboring states: New York at $4.35 per pack, Rhode Island at $3.50 per pack and Massachusetts at $2.51 per pack. Snuff is taxed at $1.00 per ounce. Cigars are taxed at 50 percent of the wholesale sales price not to exceed $0.50 per cigar. All other tobacco products are taxed at 50 percent of the wholesale sales price.

Electronic Cigarettes
More research is needed to determine health consequences of the use of electronic cigarettes, a vapor-based nicotine delivery system, unregulated as yet by the Federal Drug Administration. Since electronic cigarettes are used in an attempt to quit smoking, the use of the "e-cig," becomes a public health issue. It has not been proven to be a safe and effective cessation aid, while other evidence-based aids, such as the nicotine patch, are available.

The Affordable Care Act

The **Patient Protection and Affordable Care Act** (ACA) is transforming the health system across the country. The ACA aims to increase insurance coverage, which should improve access to preventive services and cancer treatment. Health insurance exchanges have been established to help individuals and businesses gain access to health insurance plans. Many low-income individuals are now eligible for subsidized insurance, which can help them gain coverage and reduce disparities.

ACA provisions related to cancer control include:

1. High-risk pools have been established in every state to provide coverage for the uninsured, providing immediate access to coverage for people in every state who have been uninsured for six months or more and have cancer or another pre-existing condition.
2. The Affordable Care Act has closed the Medicare gap in prescription drug coverage.
3. Health plans are prohibited from denying coverage to persons with pre-existing conditions, such as cancer.
4. Health plans are banned from setting lifetime dollar limits on coverage, ensuring that people with cancer have access to needed care throughout their lifetimes. Annual dollar limits have been eliminated.
5. Health insurers are barred from dropping people from coverage when they get sick.
6. Coverage is guaranteed and out-of-pocket costs are eliminated in new insurance plans for proven preventive and screening services, giving people access to lifesaving screenings for breast, cervical and colorectal cancer.
7. Insurers are prohibited from dropping or limiting coverage for individuals participating in clinical trials.
8. Medicaid is required to cover, without cost sharing, counseling and pharmacotherapy services for smoking cessation for pregnant women.
9. All federally-funded health care or public health programs, activities, or surveys must collect and report standardized data on race, ethnicity, sex, primary language and disability status.
10. A National Coordinator for Health Information Technology will develop national standards for management of the data collected.

Connecticut's Health Care Costs

The rollout of the Affordable Care Act in Connecticut marks the beginning of a period of change in the financial underpinning of health insurance for individuals and employers. Monitoring its implementation will take center stage as an emerging issue during the period covered by the **Connecticut Cancer Plan, 2014-2017**. Connecticut's health exchange is known as Access Health CT.

The Partnership plans to monitor the prescribed elements of covered cancer control addressed in the Affordable Care Act, including prevention and screening as well as the identification of gaps in the continuum of care.

"I have had the opportunity to build stronger professional relationships with people and agencies with like goals. I have used reports produced by the CT Cancer Partnership in Federal reporting and to guide future work plans.

The CT Cancer Plan has helped me glean facts to educate youth and tobacco merchants about the health effects of tobacco use, the burden of providing health services for tobacco users, and the benefits of prevention to improve the general health of Connecticut residents."

Robin Cox
Primary Prevention Services Coordinator
Department of Mental Health & Addiction Services
Hartford
Four-year Partnership member

"Being on the Advocacy Committee gives me an understanding of the importance of political issues in achieving the objectives of our Cancer Plan."

Stephen Corman
Executive Advisor
National Alliance of State Prostate Cancer Coalitions
Stamford
Six-year Partnership member

Medical Home Model

The Affordable Care Act supports implementation of the medical home model of care, which aims to reduce costs while improving quality and efficiency through an innovative approach to delivering comprehensive patient-centered preventive and primary care. The medical home relies on a team of providers—such as physicians, nurses, nutritionists, pharmacists and social workers—to meet a patient's health care needs. One project has received federal funding "to implement and test a medical home model of care delivery for newly diagnosed or relapsed Medicare and Medicaid beneficiaries and commercially insured patients with breast, lung, or colorectal cancer." (See Tab 5)

Connecticut Chronic Disease Prevention and Health Promotion Plan

The **Connecticut Cancer Plan, 2014-2017** developed with the guidance of Connecticut's chronic disease policy team, features a collaborative relationship with chronic disease prevention programs within the Connecticut Department of Public Health (DPH). This relationship assumes ongoing support of cross-cutting policy, communications, epidemiology and evaluation activities among chronic disease programs. The Centers for Disease Control have recognized the synergy possible through partnerships between cancer coalitions and state chronic disease programs. Chronic diseases, including heart, stroke, diabetes, asthma and cancer are among the most common and costly of all health problems. They are also among the most preventable, since four health behaviors – lack of physical activity, poor nutrition, tobacco use and excessive alcohol consumption – are responsible for much of the illness, suffering and early death related to these chronic diseases.

Connecticut's Coordinated Chronic Disease Plan places a strong emphasis on addressing root causes and shared risk factors across chronic diseases. It fills a gap in the existing spectrum of Connecticut's chronic disease programs by defining strategies that enable a comprehensive *proactive* approach in the prevention of modifiable risk factors with a focus on health equity and avoidable disparities. The DPH has defined health disparities as:

> . . . differences in disease risk, incidence, prevalence, morbidity and mortality and other adverse conditions, such as unequal access to quality health care, that exist among specific population groups in Connecticut…. Specifically, health disparities refer to those avoidable differences in health that result from cumulative social disadvantages.

Vulnerable population groups may be based on race, ethnicity, age, gender, socioeconomic position, immigrant status, sexual minority status, language, disability, homelessness, mental illness and geographic area of residence. The DPH recognizes these groups as "priority populations" in addressing health disparities and DPH plans to address health issues related to priority populations.

The Coordinated Chronic Disease Plan builds on the successful implementation of several categorical disease-specific and risk factor-based plans, including the previous version of Connecticut's Cancer Plan. The Chronic Disease Plan transcends categorical or disease specific plans and focuses on promoting system changes that produce a higher collective impact across multiple disease conditions.

The Chronic Disease Plan introduces four main strategies that work across chronic diseases.

1. Use ***environmental approaches*** to promote health and support and reinforce healthful behaviors throughout the lifespan. Promoting wellness in childcare settings, schools and workplaces, as well as supporting healthy communities, is key to preventing chronic disease at the most basic level.
2. Promote ***health system interventions*** to improve the effective delivery and use of clinical and other preventive services. This strategy focuses on making evidence-based practices a part of the standard of care for all patients, regardless of their point of entry to the medical system.
3. Improve ***community-clinical linkages*** to ensure that communities support and clinics refer patients to, programs that improve management of chronic diseases. Disease prevention in the community is cost-effective and promotes healthy environments. Coordination between formal healthcare providers and community-based advocates allows individuals to be at the center of their care.
4. Support an ***epidemiology and surveillance*** system that gathers, analyzes and disseminates data and information and conducts evaluation to inform, prioritize, deliver and monitor programs and population health. Enhancing epidemiology and surveillance is central to creating and monitoring the plan across chronic diseases and measuring its impact on health disparities.

The Partnership will continue its collaborative relationship with the state's chronic disease prevention programs.

"The Connecticut Cancer Partnership helps build relationships, provide underserved communities with services and contacts to develop their own relationships.

The Partnership continues to address cultural sensitivity for various minority populations and shows how current systems have a negative impact on health equity, educational opportunities, networking, advocacy, etc."

Mui Mui Hin-McCormick
Executive Director
Asian Pacific American Affairs Commission, Hartford
Five-year Partnership member

Access, Disparities and Health Equity

Changes in healthcare policy have affected how the Partnership addresses disparities in this cancer plan. In 2010, the Affordable Care Act (ACA) legislation established provisions to improve access to cancer prevention, early detection and treatment. In addition, the ACA promotes changes for workforce development such as diversifying staff, integrating culturally and linguistically appropriate services (CLAS standards) and training in cultural competence.

In alignment with the Affordable Care Act, the CDC requires state cancer coalitions to promote health equity relating to cancer control to reduce disparities and improve health outcomes and quality in healthcare for racially, ethnically and culturally diverse populations.

The Partnership endorses the following five strategies, in accordance with this national priority:

1. **Enhanced Data Collection:** Standard collection of race and ethnicity data, including an option for preferred language
2. **Strategic Planning:** Organizational support, adoption and integration of CLAS Standards
3. **Resource Allocation:** Participation in local chronic disease and health access task forces
4. **Workforce Development:** Workforce development in the areas of health equity, disparities reduction and culturally and linguistically appropriate care
5. **Coalition Diversity:** Establish organizational policies and practices to include leadership representative of the population served.

The Partnership forges key alliances, addresses workforce capacity and maintains a public voice in the health disparities community across the state.

Workforce and Education

As a convening organization, the Connecticut Cancer Partnership has a unique opportunity to provide continuing education to members in the evolving healthcare landscape. In recent years, the Partnership launched a disparities internship program that focused on providing college students and recent graduates an opportunity to experience disparities-related cancer control projects and trainings. In addition, the Partnership has worked with state Area Health Education Centers to provide training to health professionals on CLAS Standards, health literacy, patient navigation and motivational interviewing. (See Tab 5)

The ACA reauthorized a patient navigation program to connect patients with health care service coordinators to diagnose, treat and manage chronic disease. Patient navigators play a particularly important and growing role in cancer control. Also called community health workers, promotoras and health educators, many of these workers, based in their communities, are able to reach and connect with people in culturally appropriate ways. There is no uniform training, certification or reimbursement system in place at this time. To help fill this gap, the Partnership has sponsored a certification pilot program at Gateway Community College and hosted a conference to train and educate patient navigators.

Cancer Program Accreditation Requirements

Health care quality is measured by constantly evolving accreditation mechanisms carried out by a number of different national organizations, such as the American College of Surgeons' Commission on Cancer (CoC) and National Accreditation Program for Breast Centers (NAPBC), Joint Commission, American Society of Clinical Oncology's, Quality Oncology Practice Initiative (QOPI), and the Center to Advance Palliative Care (CAPC). Member organizations have found opportunities for quality improvement through their involvement in the Connecticut Cancer Partnership. Many Partnership member organizations incorporate accreditation standards into their programs. Some common elements may include:

- community outreach
- use of community needs assessment data
- cultural competence
- workforce development

According to their website,
"The Commission on Cancer is a nationally recognized multidisciplinary accreditation program. By working with its national partners, the CoC has developed comprehensive, patient-centered standards for cancer programs that went into effect on January 1, 2012. Each cancer program will be evaluated against these standards to demonstrate compliance and commitment to providing high quality cancer care.

The foundation of CoC accreditation includes these five elements: State-of the-art clinical, rehabilitation and support services; quality improvement mechanisms for evaluating and improving patient outcomes; a cancer registry and database that provide the basis for monitoring patient care data; cancer committees that provide leadership and cancer conferences that provide a forum for patient consultation and physician education." [33]

The **Connecticut Cancer Plan, 2014-2017** aligns with CoC requirements by offering information and support to Connecticut hospitals with cancer programs in the accreditation survey process. Many resources required to meet CoC standards are available within the context of the Connecticut Cancer Partnership.

CoC Standard 1.11 requires that all members of the cancer registry staff participate in at least one cancer-related educational activity each year.

Collaboration with member organizations to offer programs for professional development is increasingly important. The Partnership's Education Committee will continue to identify opportunities that satisfy requirements for CEUs, CMEs and other credits, working with partner organizations to offer professional development programs in areas ranging from cultural competence, to clinical guidelines development, to emerging science. In addition to the annual meeting, the Partnership strives to collaborate on workforce development by sharing educational materials and seminar/conference information with members. The Education Committee also helps member organizations acquire needed information and resources, such as sharing the best practices to meet the American College of Surgeons Commission on Cancer (CoC) Standards. Education is frequently referred to as an "implementation mechanism" for ensuring that objectives and strategic actions set forth in this Plan are undertaken to enhance and improve cancer care in Connecticut.

Out of 29 Connecticut acute care hospitals, 25 are accredited by the American College of Surgeons Commission on Cancer.

Emerging Issues

Genomics

Comprehensive cancer control is a rapidly changing field. One of the developments driving this change is the trend toward personalized cancer care based on the use of the genetic profile of a tumor to make improvements in diagnosis and allow for targeted therapies. Traditional classification of cancer cases has been based on the tissue of origin of the cancer. Increasingly, cancers are being classified and sub-classified by their molecular characteristics. On a limited scale, the molecular characteristics are becoming part of information gathered by state cancer registries. For example, registration of breast cancers now includes their estrogen and progesterone receptor status and HER2/neu status.

Genetic Risk Assessment

Genetic risk assessment has only recently been seen as a routine part of cancer control. Information is being distributed to clinicians, patients and the public in many formats. The National Cancer Institute (NCI) has developed information for hereditary cancer syndromes. (See Tab 5) [34]

The Connecticut DPH Genomics Office has also developed guidelines entitled *Cancer Genomics Best Practices for Connecticut Healthcare Providers – Hereditary Breast and Ovarian Cancer Syndrome and Lynch Syndrome.* (See Tab 5)

As many as ten percent of pancreatic cancers may also be due to abnormal genes, for which tests are available.[34a] Pancreatic cancer, a disease with low incidence but high mortality, causes more deaths in Connecticut than breast or prostate cancer. Since there are no proven evidence-based early detection tests and a disparity exists (blacks experience greater incidence and mortality rates), monitoring the potential for the use of genetic testing for these inherited genetic mutations may be a useful approach to the control of this especially difficult type of cancer.

Cancer Research and Clinical Trials

The landscape of clinical trials is also evolving. While trials continue to be the definitive method for defining best practices, the approach to their organization is undergoing changes. The emergence of targeted therapies based on

"This collaborative relationship has allowed for the first "official" Patient Navigator curriculum to be developed and implemented in our state. Many conversations regarding the role of community healthcare workers and patient navigators have occurred over the last two years, all of which have been very useful."

Victoria Bozzuto
Dean
Workforce Development and
Continuing Education Gateway
Community College
New Haven
Two-year Partnership member

"The Connecticut Cancer Partnership has provided me with key resources with respect to patient education, available trials and the latest technologies."

Nancy Teixeira, MSN, RN
Administrator
Wren Laboratories
Branford
Two-year Partnership member

molecular sub-classifications of cancer requires further specialization in cancer research. This is leading to new challenges in clinical trial accruals, because patients will be required to have a particular molecular lesion to qualify.

According to the National Cancer Institute Website,

"For over 50 years, NCI has supported a standing infrastructure — the NCI Clinical Trials Cooperative Group Program — to conduct large scale cancer clinical trials across the nation, with successful completion of many important trials that have led to new treatments for cancer patients. Over time, however, oncology has evolved into a more molecularly-based discipline including genetic sub-classification of tumors and individualized treatments. It is truly an exciting time in oncology research and we are presented with immense scientific opportunities to be systematically explored. NCI must ensure that the Cooperative Groups are optimally situated and well-prepared to design, enroll and complete state-of-the-art trials for cancer patients."

The Partnership will continue to monitor this issue and, as appropriate, educate the cancer control community on new developments.

Electronic Health Records

The emergence of the electronic health record (EHR, the more comprehensive version of the electronic medical record), health information exchanges and patient portals will provide important opportunities for cancer control. The adoption of EHR will be helpful in the promotion and documentation of screening tests and survivorship care plan development. (see Tab 5)

Goals, Objectives and Strategic Actions

Guide to the Reader

The following pages have been designed to help the reader visually identify various elements of cancer control outlined in this plan:

- **Goal:** The vision statement.
- **Objectives:** The role and work of the Partnership through its committees and staff.
- **Strategic Actions:** Example activities that our Partnership member organizations may be engaged in, which align with the Cancer Plan.

  At the annual action planning meetings of the Board and co-chairs, these activities and others will be examined and ranked by priority, based on needs determined by review of the data and emerging science. A link will be provided within the electronic version of this document that will allow readers to connect to current issues, in the form of an Annual Action Plan (Please visit ctcancerpartnership.org to view the electronic version).
- **Why This is Important:** Illustrates why we are focusing on these issues, highlights disparities and reinforces the Centers for Disease Control's requirement to focus on the highest burden cancers.
- **Data graphs and charts:** Show trends over time, disparities and/or comparisons to other states.
- **Promising Practices:** Showcases a model, enabling readers to learn from each other's successes.

GOAL 1

Primary prevention of cancer through healthy living is addressed at all levels across the state

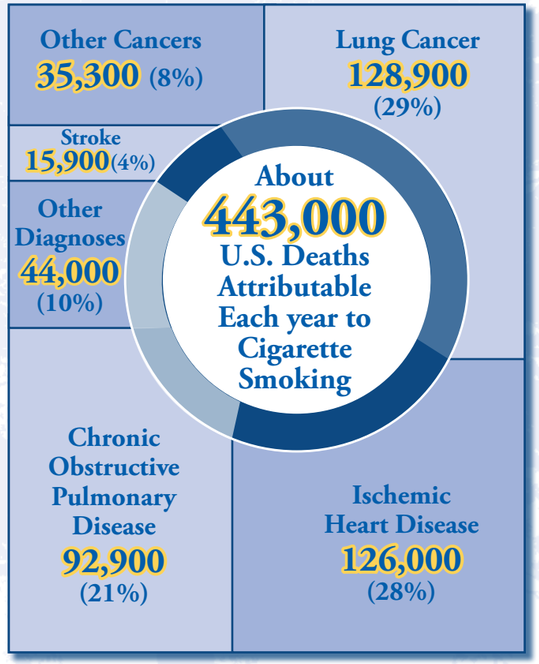
Objectives

1.1 Promote and support policies, systems and environmental changes that optimize healthy living through good nutrition, increased physical activity and tobacco avoidance

1.2 Promote and support policies, systems and environmental changes to reduce exposure to environmental carcinogens and cancer-related infectious agents

Strategic Actions

- Advance awareness of the types of policy and environments that support cancer preventive nutritional choices, such as daily access to a variety of fruits and vegetables and avoidance of heavily processed foods
- Support policy, systems and environmental changes to create opportunities for physical activity where Connecticut residents live, work, play and learn
- Collaborate with state and local agencies to implement policy for tobacco-free living and the support of cessation efforts
- Promote the use of environmental changes, such as shade structures, to reduce the risks of harmful UV exposure
- Advocate for policies that reduce the risks of harmful UV exposure through artificial sources
- Advocate for evidence-based interventions to reduce exposure to and infection with cancer-related infectious agents (such as HPV, hepatitis B and C and HIV)
- Monitor trends in data related to cancer risk, including trends in relative cancer risk among priority populations



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Why This is Important

- The U.S. Centers for Disease Control and Prevention (CDC) recommends that Connecticut spend $43.9 million a year to have an effective, comprehensive **tobacco prevention** program. Connecticut currently allocates $6.0 million a year for tobacco prevention and cessation. This is 13.7 percent of the CDC's recommendation and ranks Connecticut 23rd among the states in the funding of tobacco prevention programs. Connecticut's spending on tobacco prevention amounts to 1.1 percent of the estimated $535 million in tobacco-generated revenue the state collects each year from settlement payments and tobacco taxes. [36] Smoking is known to cause cancers of the lung, esophagus, larynx, mouth, throat, kidney, bladder, pancreas, stomach and cervix, as well as acute myeloid leukemia.
- In Connecticut, rates of **tobacco use** are associated with income and education. Among persons earning less than $15,000 per year tobacco use is substantially higher than those earning $50,000 or more, 26.6 percent versus 10.7 percent.
- Overweight and **obesity** are clearly associated with an increased risk for developing many types of cancer. About one-quarter to one-third of new cancer cases in the U.S. in 2013 will be related to overweight or obesity, physical inactivity and poor nutrition. Fewer opportunities for physical activity and less access to fresh fruits and vegetables generally adversely affect persons with low socioeconomic status. Policy, systems and environmental changes can help to alleviate these health inequities.
- Among students in grades 9-12 in the 2011 Connecticut Youth Risk Behavior Survey 20 percent of females and 33 percent of males were **overweight and/or obese.** Rates were significantly higher among black (43.9 percent) than white (21.1 percent) students.[38]
- Connecticut has one of the highest **skin cancer** incidence rates in the country.[39, 40] The rate of new melanoma diagnoses—responsible for 75 percent of all skin cancer deaths—was 24 percent higher in Connecticut than the national average from 2006-2010 and was the 11th highest in the U.S. An estimated 934 state residents were diagnosed with melanoma in 2010. The recent ban on indoor tanning for minors under the age of 17 is an example of a policy change as an effective and far-reaching course of action.
- Populations that include large numbers of recent immigrants, such as Hispanics and Asians, have higher rates of cancer related to **infectious agents**. Hispanic women have the highest incidence rate for cervical cancer. The U.S. Food and Drug Administration has approved two types of vaccines to prevent cancer: vaccines against the hepatitis B virus, which can cause liver cancer, and vaccines against human papillomavirus (HPV) types 16 and 18, which are responsible for about 70 percent of cervical cancer cases. The HPV vaccine is recommended for females aged nine to 26 and males aged nine to 21. It protects against the HPV types that most often cause cervical, vaginal, vulvar, and anal cancers. Additionally, studies show that about 60 to 70 percent of cancers of the oropharynx may be linked to HPV.
- Connecticut blacks and Hispanics are disproportionately impacted by **HIV** and thus bear increased added burden of **HIV** associated cancer risk.
- Early and sustained antiretroviral therapy for persons with **HIV** is a crucial cancer prevention strategy.

Promising Practices

- The Community Transformation Grant (being implemented by five Connecticut counties) has identified tobacco-free living as one of three strategic directions. Focused on policy implementation at the local level, these communities are looking to establish tobacco-free parks and other public spaces (including multi-unit housing)
- Healthy Restaurant designation is an initiative in ACHIEVE communities to promote healthy living. It aims to encourage restaurant owners to provide healthy options. The model focuses on always having a fresh non-cooked, non-processed fruit or vegetable available as a side dish or addition and having American Heart Association-recommended portions available.
- The National Prevention Strategy of the National Prevention, Health Promotion and Public Health Council will develop a comprehensive plan to improve the health of the nation with investments in prevention and public health programs.

"Smoking accounts for 30 percent of all cancer deaths and 87 percent of all lung cancer deaths."

-American Cancer Society

GOAL 2

High-quality cancer screening and early detection services are available and accessible to all people living in Connecticut

Objectives

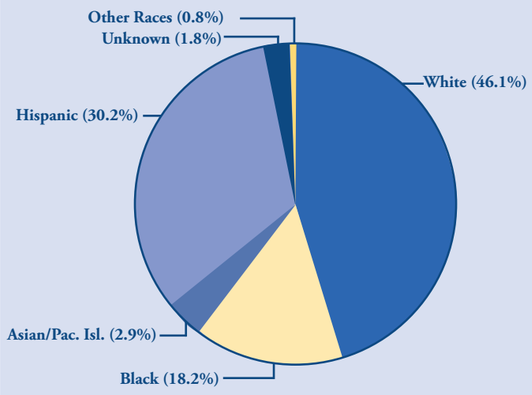
2.1 Support policy, systems and environmental changes that increase the percentage of Connecticut residents receiving recommended and appropriate breast, cervical, colorectal and lung screening

2.2 Identify and disseminate strategies and best practices to reduce disparities in access to screening services

Strategic Actions

- Establish systems to monitor and track the rates of cancer screenings and early detection (colonoscopy, mammography, pap tests, etc.) and to track disparities based on income, geography, race/ethnicity, sexual orientation, age and other factors
- Develop/support regional task forces to share information regarding resources to support chronic disease prevention, screening and management of best practices in collaboration with the Chronic Disease Program
- Implement policies across the health care provider workforce to increase health equity and cultural competency training
- Promote a systems change to increase the capacity for and use of, patient navigators or community health workers for outreach to vulnerable populations for health education and improved utilization of cancer screenings
- Address socio-economic and structural barriers to cancer screening and early detection through improved awareness and use of Medicaid coverage
- Implement evidence-based physician and employer reminder systems and incentives for routine cancer screenings

DISTRIBUTION OF WOMEN RECEIVING MAMMOGRAMS BY RACE/ETHNICITY



CDC's National Breast and Cervical Cancer Early Detection Program (NBCCEDP) funds clinical breast exams, mammograms, Pap tests, pelvic exams and diagnostic testing for women whose screening outcome is abnormal and referrals to treatment to uninsured and underinsured women.[46]

This pie chart illustrates the distribution of 9,951 Connecticut women receiving an NBCCEDP-funded mammogram from July 2007 to June 2012 by race and ethnicity.[45]

Why This is Important

- Receiving **cancer screenings** according to recommended guidelines for breast, colorectal and cervical cancer increases the likelihood of early diagnosis, more successful treatment and reduced mortality. Colorectal cancer is preventable and beatable: Up to 60 percent of colorectal cancer deaths could be prevented if all adults 50 years and older were screened routinely
- Socio-economic and structural **barriers** to cancer screening persist for high risk or **vulnerable populations**, including the location and timing of available services, complex paperwork, inadequate insurance, high out-of-pocket cost, transportation, language and lack of childcare.
- **Patient navigation** (by community health workers or patient navigators) has been found to impact cancer screening in a favorable manner. Participants in several studies who received assistance from patient navigators were significantly more likely to complete cancer screening when compared to those who did not receive navigation.[41]
- **Reminder systems** have been found to increase patient participation in cancer screenings. Though several studies have examined the efficacy of different approaches, most find that there is a positive correlation between reminders and timely screening.
- Racial and ethnic minorities tend to receive lower-quality healthcare than whites, even when insurance status, age, severity of disease and health status are comparable. Social inequalities, including communication barriers and provider assumptions, can affect interactions between patient and physician. **Cultural competency training** for providers can eliminate some of the communication barriers that arise from a lack of understanding.

Promising Practices

- Clinicians' toolkit "How to Increase Preventive Screening Rates in Practice"[42]
- The Guide to Community Preventive Services (The Community Guide) is a resource for evidence-based Task Force recommendations and findings about what works to improve public health[43]

Healthy People 2020 Goal for Prostate Cancer Screening:

Increase the proportion of men who have discussed the advantages and disadvantages of the prostate specific antigen (PSA) test to screen for prostate cancer with their health care provider.

United States Preventive Services Taskforce (USPSTF) A and B Recommendations:

Cervical Cancer:

The USPSTF recommends screening for cervical cancer in women ages 21 to 65 with cytology (Pap smear) every three years or, for women ages 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every five years.

Colorectal Cancer:

The USPSTF recommends screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy or colonoscopy in adults, beginning at age 50 and continuing until age 75. The risks and benefits of these screening methods vary.

Breast Cancer:

The USPSTF recommends screening mammography for women ages 50 – 74. The decision to start regular, biennial screening mammography before the age of 50 should be an individual one. USPSTF recommends that women whose family history is associated with an increased risk for deleterious mutations in BRCA1 or BRCA2 genes be referred for genetic counseling and evaluation for BRCA testing (USPSTF A and B Recommendations).[44]

GOAL 3

High-quality comprehensive cancer treatment and the opportunity to participate in clinical trials are available and accessible to all people living in Connecticut

Objectives

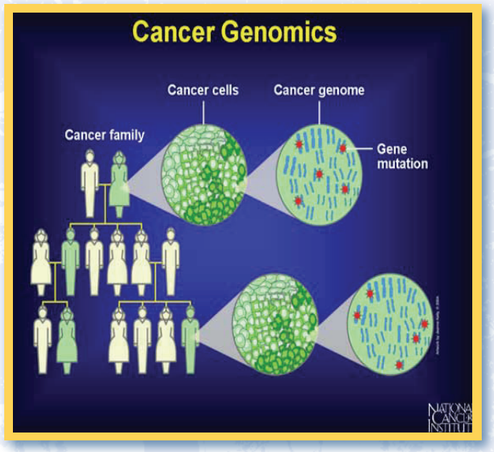
3.1 Promote and support the efforts of Connecticut hospitals to meet the standards of the American College of Surgeons' Commission on Cancer (CoC)

3.2 Promote and support increased participation in cancer-related clinical trials

3.3 Advocate for policy, systems and environmental changes that lead to equal access to treatment for underserved groups

Strategic Actions

- Share implementation strategies and best practices, including development of survivorship care plans (which include treatment summaries) and patient navigation programs
- Support regional cancer task force development
- Address issues at the state and regional levels, such as barriers to participation in clinical trials and strategies to address these challenges, including the establishment of a system to monitor the level of participation in clinical trials by people living in Connecticut diagnosed with cancer
- Monitor efforts at the National Cancer Institute to consolidate Clinical Trials Cooperative Groups regarding molecularly-based therapy clinical trial approaches as appropriate and educate the cancer control community on new developments
- Establish system-wide changes to disseminate information about available clinical trials using culturally and linguistically appropriate methods
- Support efforts to make information on underlying genetic/heritable causes of common cancers and the importance of genetic counseling and early detection more readily available to the public
- Reduce disparities in access to treatment related to geography, income, insurance status, etc. through policy, systems and environmental changes that address barriers and increase access to quality treatment
- Support patient navigation programs
- Disseminate information about medical home approaches to cancer care
- Support efforts to establish policy, systems and environmental changes for an umbilical cord blood collection program, focusing on collection of minority cord blood



"The Connecticut Cancer Partnership has provided me with key resources with respect to patient education, available trials and the latest technologies."

Nancy Teixeira, MSN, RN *Administrator*
Wren Laboratories
Branford
Two-year Partnership member

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Why This is Important

- **Clinical trials** are the critical final step towards determining the efficacy of new cancer treatments. Minority, low income and elderly populations are often underrepresented in clinical trials, making it difficult to extrapolate treatment protocols to all patients. Barriers include fear of increased costs, distance to clinic and lack of information about trials. Only five percent of cancer patients participate in clinical trials (American Cancer Society).
- **Targeted cancer therapies** block the growth and spread of cancer by interfering with specific molecules involved in tumor growth and progression. Targeted molecular cancer therapies may be more effective than other types of treatment and less harmful to normal cells. Many targeted cancer therapies have been approved by the U.S. Food and Drug Administration (FDA) for the treatment of specific types of cancer. Others are being studied in clinical trials and many more are in preclinical testing (research studies with animals)[47] . This is leading to new challenges in clinical trial accruals, because patients will be required to have a particular molecular lesion to qualify.
- Gene expression profiling (**genetic profiling**) is a promising tool to help guide breast cancer treatment. These tests do not show genetic information about a person, but rather information about the genes in a tumor. The gene profiles of some tumors may help predict whether the cancer is more likely to **recur** and metastasize. Tumors with gene profiles showing a high risk of recurrence or metastasis may be more likely to respond to chemotherapy than tumors with gene profiles showing a low risk.[48]
- Blood and marrow transplant are proven therapies for some leukemias and lymphomas. Minority populations are less likely to find an unrelated donor match for transplant than whites. **Umbilical cord blood** can be a bridge for patients needing a transplant and unable to find an adult donor. There is a need for more publicly available cord blood units.
- Patients with **medical homes** are more likely to report better access to care, better coordination of care, improved communication with their primary care provider and fewer medical errors. A survey also showed that medical homes do not just improve, but actually eliminate disparities in getting needed medical care.[49, 50]
- ACOS **CoC Cancer Program Standards** 2012 *Ensuring Patient-Centered Care* establish new requirements around patient-centered needs and expand the focus on improving the quality of care and patient outcomes. Standards ensure that clinical services provide state-of-the-art pretreatment evaluation, staging, treatment and clinical follow-up for cancer patients seen at the facility for primary, secondary, tertiary or end-of-life care. The hospital's cancer committee leads the program through setting goals, monitoring activity, evaluating patient outcomes and improving care. The cancer conferences provide a forum for patient consultation and contribute to physician education. The quality improvement program is the mechanism for evaluating and improving patient outcomes. Finally, the cancer registry and database is the basis for monitoring the quality of care. [51]

Promising Practices

- Commission on Cancer Program Standards 2012: Best Practices Repository related to accreditation standards.

Commission on Cancer Accreditation Standards:

Eligibility Requirement 9 Clinical Trial Information:
A policy or procedure is used to provide cancer-related clinical trial information to patients.

Standard 1.9 Clinical Trial Accrual:
As appropriate to the cancer program category, the required percentage of patients is accrued to cancer-related clinical trials each year.

Standard 2.3 Risk Assessment and Genetic Counseling:
Cancer risk assessment, genetic counseling and testing services are provided to patients either on-site or by referral by a qualified genetics professional.

Standard 3.1 Patient Navigation Process:
A patient navigation process, driven by a community needs assessment, is established to address health care disparities and barriers to care for patients.

GOAL 4

High-quality palliative care is available and accessible to all people living in Connecticut

Objectives

4.1 Promote and support a systematic approach to monitor, disseminate and utilize data trends to advocate for high-quality palliative care, including trends relevant to disparities

4.2 Promote and support system changes that strengthen the quality of palliative care through partnerships with providers and community members from across the state

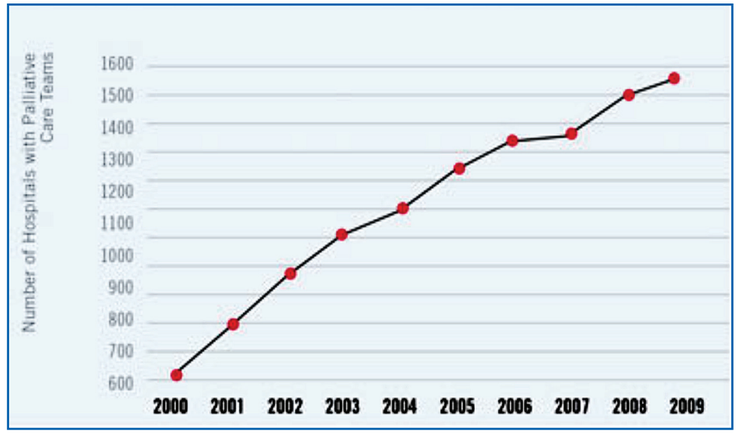
Strategic Actions

- Support submission of data related to:
  - ▶ *The number of Connecticut hospitals accredited by the American College of Surgeons Commission on Cancer (CoC) and/or certified in palliative care by the Joint Commission*
  - ▶ *Existing and developing quality indicators for palliative care programs*
  - ▶ *Utilization of palliative care by underserved populations, including children, the elderly, minorities, the uninsured and veterans*
  - ▶ *The number of healthcare professionals certified in palliative and hospice care, including race, ethnicity and languages spoken*
- Utilize data trends to advocate for policy and system changes that improve the provision of palliative care in all settings
- Advocate for increased national funding, resources and research related to palliative care services
- Support efforts of Connecticut stakeholders to develop collaborative initiatives that provide culturally appropriate palliative care education in all settings, including colleges, hospitals, out-patient settings, long-term care, pediatric care and veteran care
- Align efforts to support activities of the Connecticut Palliative Care Advisory Council

Why This is Important

- According to the American Society of Clinical Oncology (ASCO), palliative care is used to ease symptoms and side effects and manage any challenges patients experience before, during and after cancer treatment.[53] ASCO also notes "substantial evidence demonstrates that palliative care – when combined with standard cancer care as the main focus of care – leads to better patient and caregiver outcomes."[54]
- In addition, ASCO reports "earlier involvement of palliative care also leads to more appropriate referral to and use of hospice care and reduced use of futile intensive care." Patients with invasive cancers who receive palliative care along with cancer treatments tend to enjoy better quality of life and live longer.[55]
- Palliative care complements the national aim of the Affordable Care Act: to improve quality of care at the local, state and national levels, leading to better care and more affordable care.[56]

Prevalence of U.S. Hospital Palliative Care Teams 2000-2009



Source: Center to Advance Palliative Care, March 2011

Promising Practices

- New CoC Standard, required by 2015: Standard 2.4 Palliative Care Services: Palliative care services are available to patients either on-site or by referral…. an essential part of cancer care, beginning at the time of diagnosis and being "continuously available" throughout treatment, surveillance and when applicable during bereavement. ….an interdisciplinary team of medical and mental health professionals, social workers and spiritual counselors provides palliative care services …[58]
- According to the Center to Advance Palliative Care's (CAPC) State-by-State Report Card on Access to Palliative Care in Our Nation's Hospitals, 100 percent of Connecticut hospitals with over 300 beds (9/9) and 72 percent of all of Connecticut hospitals (18/25) had a palliative care team in 2012. Connecticut's grade improved from "C" in 2008 to "B" in 2011.[59]
- Launched in September 2011, The Joint Commission's Advanced Certification Program for Palliative Care recognizes hospital inpatient programs that demonstrate exceptional patient and family-centered care and optimize the quality of life for patients (both adult and pediatric) with serious illness.[60]
- American Society of Clinical Oncology (ASCO), in a 2012 consensus statement, agreed that "combined standard oncology care and palliative care should be considered early in the course of illness for any patient with metastatic cancer and/or high symptom burden."[61]
- The Connecticut Palliative Care Advisory Council was established by the State Legislature in 2013 to analyze the current state of palliative care and advise the Department of Public Health on matters relating to the improvement of palliative care and the quality of life for persons with terminal illnesses.[62]

Definition:

Palliative Care is care that focuses on relieving symptoms caused by serious illnesses like cancer. It can be given throughout the cancer experience whenever the person is having symptoms that need to be controlled. This can be from the time of diagnosis until the end of life. It can be given along with curative treatment or when cancer treatment is no longer working.[63]

GOAL 5

High quality of life and care is available and accessible to all Connecticut cancer survivors

Objectives

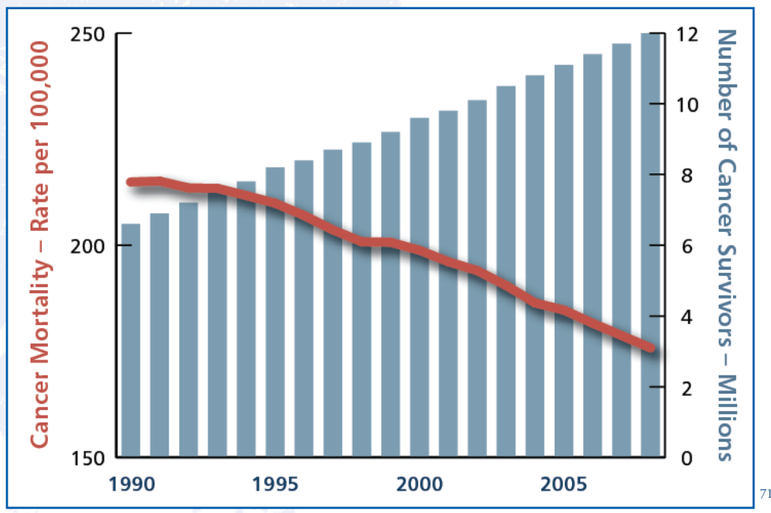
5.1 Promote policy, systems and environmental changes to provide comprehensive and coordinated care, including cancer survivorship plans, to all cancer survivors living in the state of Connecticut

5.2 Promote and support policy, systems and environmental changes that address disparities and empower all cancer survivors to engage in a healthy lifestyle to improve their health and wellbeing, and reduce risk of new or recurring cancers and attenuate late effects of treatment

Strategic Actions

- Support efforts of Connecticut hospitals to meet the American College of Surgeons Commission on Cancer (CoC) standards regarding patient navigation and survivorship care plans, including treatment summaries
- Support and participate in regional cancer task forces to share best practices related to utilization of survivorship care plans and patient navigation
- Advance efforts for policies that support survivorship services (such as cancer rehabilitation) to be reimbursed by public and private insurance
- Advocate for policy, systems and environmental changes that address the need for inclusion of culturally competent survivorship education into graduate medical education for oncology and non-oncology medical training
- Disseminate the current recommended guidelines for cancer survivors on healthy lifestyles to medical providers
- Support and encourage the collection of data related to participation of survivors in survivorship programs
- Promote culturally appropriate best practices for educating cancer survivors about the benefits of healthy living that support prevention of new or recurring cancers

Cancer in the United States, 1990-2008: *Survival Rising, Mortality Decreasing*



[71]

Source: Data from the National Cancer Institute on estimated number of cancer survivors and age-adjusted cancer deaths per 100,000 people

Why This is Important

- **Cancer rehabilitation** is a rapidly emerging and evolving medical field in both Europe and the United States, in large part because of increases in the number of cancer survivors. Although studies evaluating the effectiveness of rehabilitation programs in the cancer setting, particularly exercise, have influenced clinical decision-making in both Europe and the United States for some time, this emerging evidence base is now starting to influence guideline and policy making.[64]
- High quality of life and care requires effective communication and coordination between all providers: specialty, primary care, physical therapy, mental health providers and many others. A **survivorship care plan** helps centralize communication and coordination of patient information, recommendations and future concerns. Vulnerable populations also benefit from **patient navigators** and advocates to ensure access to needed services.
- Livestrong 2012 survivorship survey data indicate that 51 percent of survivors reported receiving a **treatment summary** and 17 percent reported receiving a survivorship care plan (SCP). Survivors were more likely to receive SCPs if they had a navigator.[65]
- **Healthy behaviors** – exercise, diet, not smoking – may be especially important for survivors due to their increased risk for recurrence and for developing a new cancer. Post-treatment physical activity has been associated with increased recurrence-free and overall survival, whereas overweight and obesity have been consistently associated with increased risk of many cancers, as well as recurrence and poorer survival.[66]
- Cancer survivors have a 14 percent increased lifetime risk of developing a **second primary cancer**, though some have a much higher risk. [67]
- *The National Action Plan for Cancer Survivorship* represents the combined effort of almost 100 experts in cancer survivorship and public health. It identifies and prioritizes cancer survivorship needs and proposes strategies for addressing those needs. One of the priority needs is to **educate health care providers** about cancer survivorship from diagnosis through long-term treatment and end-of-life care. [68]

- Commission on Cancer Standard 3.1: Patient Navigation Process: A patient navigation process, driven by a community needs assessment, is established to address health care disparities and barriers to care for patients.
- Commission on Cancer Standard 3.3: Survivorship Care Plan: The cancer committee develops and implements a process to disseminate a comprehensive care summary and follow-up plan to patients with cancer who are completing cancer treatment.
- Commission on Cancer Program Standards 2012: Best Practices Repository related to accreditation standards.[69]

The number of cancer survivors in the United States today is approaching 14 million and is expected to rise by 31 percent to 18 million by 2022.[70] **The American Cancer Society estimates that there are more than 171,800 cancer survivors in Connecticut.**

Healthy People 2020

Objective C13: Increase the proportion of cancer survivors who are living five years or longer after diagnosis

Objective C14: Increase the mental and physical health-related quality of life of cancer survivors

GOAL 6

High-quality hospice care is available and accessible to all people living in Connecticut

Objectives

6.1 Promote and support a systematic approach to monitor, disseminate and utilize data trends to advocate for high quality hospice care, including trends relevant to disparities

6.2 Promote and support system changes that strengthen the quality of hospice care through partnerships with providers and community members from across the state

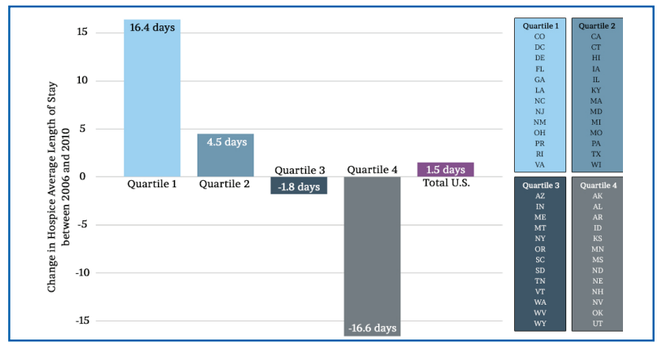
Strategic Actions

- Support submission of data related to:
  - ▶ *Hospice utilization trends of people in Connecticut who receive Medicare and Medicaid*
  - ▶ *Utilization of end-of-life care by children, the elderly, minorities, the uninsured, veterans and prison inmates*
  - ▶ *Existing and developing indicators of quality care used in hospice programs in Connecticut*
  - ▶ *Number of healthcare professionals certified in hospice and palliative care, including race, ethnicity and languages spoken*
  - ▶ *Initiatives to improve symptom management for people near end-of-life in all settings*
- Utilize data trends to advocate for policy and system changes that improve the provision of hospice care in all settings
- Support efforts to convene and educate providers and community members from across the state to strengthen the quality and use of best practices relating to hospice care in Connecticut
- Advocate for policy and systems changes that provide for adequate federal, state and private funding of hospice care, especially for underserved populations
- Support policy and systems changes that improve funding for education about hospice care in colleges, healthcare settings and the community
- Support policy and system changes that increase the use of advanced care planning by residents of Connecticut, including culturally and linguistically appropriate public education programs about end-of-life decision-making (e.g. Medical Orders for Life-Sustaining Treatment or MOLST and other advance directive planning efforts)

Why This is Important

- Even though most patients with advanced cancer prefer care that minimizes symptoms, many still receive intense treatment and are not admitted into hospice care until their last three days of life. Although hospice care for Medicare patients with advanced cancer is increasing, so are the rates of treatment in intensive care units.[72]
- Cancer patients who receive hospice care tend to live longer than those who don't.[73]
- Connecticut's median length of stay on Medicare hospice benefit in 2010 was 14 days compared with 24 days nationally, ranking our state lowest in the country. In other words, 50 percent of patients received hospice support services for less than 15 days, many for only a day or two, before they died.[74]
- Studies have shown that hospice services save money for Medicare and improves quality of care. [75, 76]
- Close to nine in ten adults (88 percent) would prefer to die in their homes, free of pain, surrounded by family and loved ones: hospice works to make this happen.[77]
- Cancer remains the leading cause of disease-related death in childhood. The odds of dying at home are reduced for black and Hispanic children. Geography also matters, as death at home is more likely in the west versus the northeastern United States.[78]
- End-of-life care consumes a disproportionate amount of Medicare spending, accounting for up to 25 percent of all Medicare expenditures. Out-of-pocket expenses for beneficiaries are also high, in one study averaging over $38,000 during the last five years of life.[79]

A Comparison of the Change in Average Length of Stay (ALOS) of Hospice Patients between 2006 and 2010 on a State-by-State Basis



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Source: 2006-2010 Medicare Claims Data

Promising Practices

- The Centers for Medicare and Medicaid Services (CMS) have developed hospice quality measures and, starting July 1, 2014, will require hospices to report annual outcome data.[81]
- The national initiative called "We Honor Veterans" (WHV) is designed to empower hospice professionals to meet the unique needs of dying Veterans. Many Connecticut hospices are utilizing the WHV resources to educate their staff and communities.[82]
- Medicaid reimburses for hospice care but utilization data have not been widely disseminated. Future state data could be used to track utilization by the underserved.[83]
- 2010: A provision in The Patient Protection and Affordable Care Act requires state Medicaid programs to allow children with a life-limiting illness to receive both hospice care and curative treatment. [84]

"Hospice care focuses on quality rather than length of life. It provides humane and compassionate care for people in the last phases of incurable disease so that they may live as fully and comfortably as possible."

-American Cancer Society

What's Next: Implementation

In the implementation of this Cancer Plan, the role of the Partnership is to convene and educate partners, mobilize advocates for cancer control, monitor data trends and disseminate best practices. This will take place from 2014-2017 through a process involving annual action planning meetings, the use of regional cancer task forces, the annual membership meetings and other events. It is anticipated that member organizations will work collaboratively to leverage support for this Plan.

Annual Action Planning Meetings

At the annual action planning meeting of the Board and committee co-chairs, strategic actions listed under each of the goals will be examined and ranked by priority based on review of the data and emerging science. This annual retreat will allow the Partnership to examine and respond to evolving issues, trends and other factors. The Data and Surveillance Committee will support continuum committees throughout this process by providing data and trend analysis as requested. Links will be provided within the electronic version of this document that will allow readers to connect to updates, in the form of Annual Action Plans (please visit ctcancerpartnership.org for the electronic version)

Annual Membership Meetings

In 2013, the Partnership celebrated its tenth annual meeting. The Partnership has the ability and responsibility to convene many diverse organizations and professionals on the subject of comprehensive cancer control. The bylaws that govern the Partnership require the entire membership to convene at least once per year to address business and elect officers. Differing from the annual action planning meetings, the annual meeting is an opportunity for all members to network, learn about promising practices and update other members about their own work.

For each annual meeting, Partnership staff members organize educational sessions which often include speakers who are nationally-known subject-matter experts, as well as programs

Benefits of Membership Include:

"Building key relationships with members of the cancer community involved in all aspects of the continuum of care.

Professional development and learning about many aspects of cancer related projects and initiatives within Connecticut.
This particularly occurs at the annual meetings where a wide variety of speakers present projects.

Addressing disparities and health inequities has been a continuing theme throughout my involvement with the Partnership. I have become much better informed regarding these issues within Connecticut."

Brenda Cartmel
Senior Research Scientist
Yale School of Public Health
New Haven
Ten- year Partnership Member

that reflect the implementation activities based on priorities laid out in the Cancer Plan. Continuing education and medical credits are often offered in collaboration with member organizations.

The Partnership uses the annual meeting to engage and update current members, as well as to recruit new members. The opportunity to network is often rated as one of the most important features of the annual meeting by attendees.

This **Connecticut Cancer Plan, 2014-2017** clearly outlines the responsibilities of the Partnership (through its staff, Board members and committee chairs) as that of convener and educator working to also monitor data trends, mobilize advocates and disseminate best practices. The structure of the annual meeting allows the Partnership to fulfill this role, offering invaluable opportunities to its members.

Regional Task Force Development

Each geographic area in Connecticut faces cancer control challenges specific to its region, in part due to socioeconomic factors, transportation issues, race or ethnicity, language or availability of services. In an effort to create an infrastructure to better support member needs, the Partnership has committed to support a regional task force model to carry out the statewide Cancer and Chronic Disease Plans. The purpose of a regional task force is to create a system that can coordinate allocation of local resources, collection of data, improve access to health care and work across categorical focus areas or "silos." Key partners may include hospitals, community health centers, local health departments, senior centers, visiting nurses associations, school health representatives, mental health agencies, faith-based organizations, employers, pharmaceutical companies or related health care industries and others to be identified.

The Connecticut Cancer Partnership plans to use the Hartford Cancer Task Force and Connecticut's ACHIEVE [86] communities as models in establishing these regional bodies.

Benchmarks and Targets

Throughout the four years covered by the Plan and in particular in preparation for the annual action planning meetings, Data and Surveillance Committee members will monitor baseline data and track trends over time to identify priority areas that will inform the work of the Partnership. Due to the emphasis on policy, systems and environmental changes, the Partnership will become more process-oriented moving forward. Rather than setting its own unique targets, the Partnership will look to both statewide and nationally-set goals as references for baseline and target data. Connecticut's Chronic Disease Plan offers state-specific indicators, baselines and five-year targets. Healthy People 2020 Cancer objectives [87] provide nationwide baseline and target data, as well as evidence-based practices and other resources. (See Tab 5)

The Evaluation Committee, supported by the Data and Surveillance Committee, will work to provide requested resources and relevant data as requested to continuum committees and members.

Monitoring the Plan

In the previous cancer plan, the Connecticut Cancer Partnership committed to implementing evaluation efforts for all supported activities. As part of that commitment, the Data, Surveillance and Evaluation Committee split into two separate committees. In addition to the establishment of the Evaluation Committee, consultants were engaged to evaluate funded Partnership implementation projects.

The work of the Evaluation Committee directly responds to federal requirements for comprehensive cancer control (CCC) programs to demonstrate outcomes through evaluation.

National Comprehensive Cancer Control Program
Priority 6: Demonstrate Outcomes Through Evaluation

- Ensure that all CCC interventions reflect most current data
- Ensure that all CCC interventions are evidence based or contribute to the evidence base
- Develop and enhance capacity to evaluate outcome and impact
- Evaluate impact of CCC partnerships and program interventions

The Evaluation Committee has supported the development of this Plan by reviewing goals, objectives and strategies as developed by each committee. With an emphasis on policy, systems and environmental changes, the Evaluation Committee worked not only to streamline goals and objectives for consistency across the Plan, but also to ensure that objectives were oriented toward sustainable and achievable change. This shift led away from the usual SMART objectives (specific, measureable, attainable, relevant and time-bound) that include a numerical target. For example, a SMART objective might focus on reducing mortality or incidence rates within a certain time frame. While the Partnership does ultimately work toward these types of improvements through its PSE efforts, as a convening body the Partnership cannot directly impact these numbers within the lifetime of this Plan.

Involvement with the Partnership leads to:

"Building partnerships, networking, providing services and resources for Hartford residents, professional development.

Obtaining data and resources from other key partners/providers plays a significant role in addressing health disparities and health inequities in the community. The data and information gathered allows the department to address and receive funds or programs and services to meet the needs of those underserved in Hartford."

Carol Steinke
Public Health Nurse Supervisor
City of Hartford Health & Human Services
Hartford
Four-year Partnership Member

Roles and responsibilities of the Evaluation Committee include:

- Build capacity for evaluation among committees, contractors and grantees through needs assessment, support, education and technical assistance
- Evaluate impact of partnerships, plans, programs and interventions
- Develop baseline evaluation standards for implemented programs
- Share key findings and disseminate evaluation briefs to membership at large
- Monitor ongoing projects and make recommendations to the Board as appropriate

This emphasis on PSE changes requires that evaluation of the Plan, the Partnership and its work be more process-oriented moving forward. The Evaluation Committee will work in collaboration with the Data and Surveillance Committee in supporting continuum committees as they collect relevant process data, including:

- member participation and satisfaction
- meeting minutes
- attendance
- data requests
- presentations
- other Partnership functions

In Conclusion

The Connecticut Cancer Plan, 2014-2017 builds on a strong foundation, with underpinnings based on shared goals and coordinated work among a diverse set of energetic, engaged volunteers from all sectors in the state. This document positions us to achieve exciting advances in cancer prevention and control in our state, for all residents. Individual and organizational Partnership members are urged to examine the plan to identify specific goals, objectives and strategic actions that will advance their own work while fitting into this statewide approach. Committed partners working toward this common cause infuse the effort with synergy and the power of unity to effectively reduce the burden of cancer and improve health equity in Connecticut.

Please refer to **What You Can Do** ***(page 61)*** to see how you and your organization can be a part of this statewide effort to reduce the burden of cancer in Connecticut.

For More Information

Accreditation
American College of Surgeons. National Accreditation for Breast Centers.
Available at: **http://napbc-breast.org/accreditation/accreditation.html** Revised 2/4/2011.

Medical Home Model
Centers for Medicare & Medicaid Services. Health Care Innovation Awards.
Available at: **http://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/Florida.html**
Reviewed 04/11/2013.

Genomics
National Cancer Institute at the Institute of Health. Genetic Testing for Hereditary Cancer Syndrome.
Available at: **http://www.ct.gov/dph/genomics** a
nd at: **http://www.cancer.gov/cancertopics/factsheet/Risk/genetic-testing**

Health Equity & Disparities
U.S. Department of Health & Human Services Office of Minority Health. The National CLAS Standards. Available at: **http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15**
Updated on 05/23/2013.

Cancer Research
The National Cancer Institute. Transforming the NCI Clinical Trials Enterprise.
Available at: **http://transformingtrials.cancer.gov/initiatives/overview**

Electronic Health Record
HealthIT.gov. Benefits of EHR. What is an Electronic Medical Record (EMR)?
Available at: **http://www.healthit.gov/providers-professionals/electronic-medical-records-emr**

The Aging of the Population
Institute of Medicine. Delivering high-quality cancer care:
Charting a new course for a system in crisis. Released 09/10/2013.
Available at: **http://books.nap.edu/openbook.php?record_id=18359**

Prostate Cancer
U.S. Preventive Service Task Force. Screening for Prostate Cancer USPSTF.
Available at: **http://www.uspreventiveservicestaskforce.org/prostatecancerscreening.htm**

Goal 2 - High-quality cancer screening and early detection services are available and accessible to all people living in Connecticut
The Guide to Community Preventive Services. The Community Guide: What Works to Promote Health. Available at: **http://www.thecommunityguide.org/index.html**

Goal 3 - High-quality comprehensive cancer treatment and the opportunity to participate in clinical trials are available and accessible to all people living in Connecticut
Dube N. OLR Research Report: Connecticut's Umbilical Cord Blood Law.
Available at: **http://www.cga.ct.gov/2013/rpt/2013-R-0347.htm**

Benchmarks and Targets
HealthyPeople.gov. Healthy People 2020 Topics & Objectives: Cancer.
Available at: **http://www.healthypeople.gov/2020/default.aspx**

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Connecticut Cancer Partnership Member Organizations

This list reflects organizations represented by individual members. Many organizations have several members. Membership also includes many individual survivors, advocates and volunteers.

American Cancer Society
American Lung Association of New England
Anthem Blue Cross and Blue Shield
AXA Advisors
Boehringer Ingelheim
Boston University School of Public Health
Bridgeport Hospital
Bristol Hospital
Bristol Myers Squibb
Burgdorf/Fleet Health Center
Cancer Support Community of Southern Connecticut
CancerCare
Capital Community College
Celgene
Center for Primary Care
Central Area Health Education Center
Central Connecticut Health District
Charlotte Hungerford Hospital
Charter Oak Health Center
Chatham Health District
Chesprocott Health District
City of Bridgeport
City of Hartford
City of Hartford Department of Health and Human Services
Coalition for a Safe and Healthy Connecticut
Columbus House, Inc.
Comfort Keepers
Community Health and Wellness Center
Community Health Center Association of Connecticut
Community Health Center Inc.
Community Health Services
Connecticut AIDS Resource Coalition
Connecticut Association of Directors of Health
Connecticut Breast Cancer Coalition
Connecticut Carcinoid Initiative
Connecticut Center for Primary Care, Inc.
Connecticut Commission on Health Equity
Connecticut Department of Mental Health and Addiction Services
Connecticut Department of Public Health
Connecticut Department of Social Services
Connecticut Hospice
Connecticut Hospital Association
Connecticut Nurses Association
Connecticut Oncology Association
Connecticut Pathology Laboratories, Inc.
Connecticut Public Health Association
Connecticut Society of Radiological Technologists
Connecticut State Department of Education
Connecticut State- Employment Rights Department
Connecticut Tumor Registry
Connecticut VNA Hospice/Masonicare
Connecticut VNA Partners Hospice
Corma Corporation
Cornell Scott Hill Health Center
Connecticut Challenge
Connecticut Children's Medical Center
Dana-Farber Cancer Institute
Danbury Hospital
Day Kimball Hospital
Derrick L. Davis Forsyth Regional Cancer Center
Diamond Research Consulting
Easter Seals Greater Hartford Rehabilitation Center
Eastern Area Health Education Center, Inc.
Eastern Connecticut Health Network
Eastern Connecticut State University
Eastern Highlands Health District
ECHN Rockville General Hospital
Environment and Human Health, Inc.
ERASE (East of the River Action for Substance Abuse Elimination)
Fair Haven Community Health Center
Fairfield University
Gardner's House Inc.
Gateway Community College
Generations Family Health Center
Gilda's Club Westchester
GlaxoSmithKline
Greater Danbury Community Health Center
Greenwich Hospital
Griffin Hospital
Halloran Sage
Hartford Hospital
Hartford Council of Churches
Hartford Gay and Lesbian Health Collective
Hispanic Health Council
Hospice of Southeast Connecticut
Hospital for Special Care
Hospital of Saint Raphael
IBM
Ingenix
IRDFProject Harvard Univ / Columbia Univ

Connecticut Cancer Partnership Organizations *cont.*

Johnson Memorial Cancer Center
Komen Connecticut
Lawrence+Memorial Hospital
Ledge Light Health District
Leever Cancer Center
Leukemia & Lymphoma Society
Livestrong
Lower Fairfield County Regional Action Council
Mashantucket Pequot Tribal Nation-Foxwoods
Masonicare
MATCH Coalition
MATRIX Public Health Solutions, Inc.
McKesson Specialty Health
MedEthics Consulting
Medical Oncology & Hematology, PC
Merck
Middlebury Department of Health
Middlesex Hospital
MidState Medical Center
Milford Hospital
Mohegan Tribe
Morra Communications
National Alliance of State Prostate Cancer Coalitions
National Lung Cancer Partnership liaison
National Ovarian Cancer Coalition
National Prison Hospice Association
Naugatuck Valley Health District
New England Physical Care
New Haven Health Department
New Haven School District
New Milford Hospital
New Opportunities, Inc./Home Based Family Services
Northwestern Area Health Education Center
Norwalk Community Health Center
Norwalk Hospital
Novartis Oncology
Nubian Sisters Cancer Support Group
OBGYN Group of Manchester
Office of the Healthcare Advocate
Oncology Network of Connecticut
Partnership for Strong Communities
Permanent Commission on the Status of Women
Pfizer
Phoenix Community Cancer Center
Physicians Health Alliance, LLC
Planned Parenthood of Southern New England
Pomperaug Health District
Praxair Cancer Center
Project Access-New Haven
Qualidigm
Quinlan-Wolyniec Consulting, LLC
Quinnipiac University
Regional Hospice and Home Care of Western Connecticut, Inc.
Saint Francis Hospital
Sayhi Translate
Sickle Cell Disease Association of Southern Connecticut, Inc.
Sister's Journey
Smilow Cancer Center
Southern Connecticut State University
Southwest Community Health Center
St. Francis Medical Group
St. Mary's Hospital
St. Vincent's Medical Center
Stamford Dept. of Public Health and Social Services
Stamford Hospital
Staywell Health Center
The Consultation Center
The Hartford
The Hospital of Central Connecticut
The William W. Backus Hospital
The Witness Project
Yale - Heroes Clinic
UConn Health Center
UConn School of Medicine
UConn-Storrs
United Community and Family Services
United Way of Connecticut
University of Hartford
University of Rochester Medical Center
Veterans Administration
VACT Healthcare
Vitas Innovative Hospice Care
VNAHealthcare
Waterbury Health Department - WIC
Waterbury Hospital
West Haven Health Department
Western Connecticut Health Group
Windham Hospital
Windham Regional Community Council
Yale - Rudd Center
Yale New Haven Center for Healthcare Solutions
Yale School of Medicine
Yale School of Nursing
Yale School of Public Health
Yale Stem Cell Center
Yale-Griffin Prevention Research Center

ENDNOTES

1 Lifetime risk of developing or dying from cancer. American Cancer Society Web site. http://www.cancer.org/cancer/cancerbasics/lifetime-probability-of-developing-or-dying-from-cancer. Updated September 5, 2013. Accessed November 4, 2013.

2 Statewide projection data. Connecticut State Data Center. Statewide Projection Data: Statewide Projections. Storrs, CT: Connecticut State Data Center. Web site. http://ctsdc.uconn.edu/projections/state_wide.html. Accessed February 23, 2012.

3 Mariotto AB, Yabroff KR, Shao Y, Feuer EJ, Brown ML. Projections of the cost of cancer care in the United States: 2010-2020. *J Natl Cancer Inst.* 2011; 103(2): 117-28.

4 Siegel R, Naishadham D, Jemal A. Cancer statistics, 2012. *CA Cancer J Clin.* 2012; 62: 10-29.

5 Jemal A, Simard EP, Dorell C, Noone AM, Markowitz LE, Kohler B, et al. Annual report to the nation on the status of cancer, 1975-2009, featuring the burden and trends in human papillomavirus (HPV)-associated cancers and HPV vaccination coverage levels. *J Natl Cancer Inst.* 2013; 105(3): 175-201.

6 American Cancer Society. Cancer Facts and Figures 2013.Atlanta, GA: American Cancer Society; 2013. Web site. http://www.cancer.org/Research/CancerFactsStatistics/CancerFactsFigures2013/2013-cancer-facts-and-figures.pdf. Accessed November 4, 2013.

7 Bernstein L. Epidemiology of endocrine-related risk factors for breast cancer. *J Mammary Gland Biol Neoplasia.* 2002; 7(1): 3-15.

8 U.S. Census Bureau. 2010 Census Summary File 1, Table QT-P3: Race and Hispanic or Latino Origin. Web site. http://www.census.gov/. Accessed: March 5, 2012. Race and Hispanic or Latino origin 2010: 2010 Census summary file 1, Table QT-P3. United States Census Bureau Web site.http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk. Accessed November 4, 2013.

9 Pinheiro PS, Sherman RL, Trapido EJ, Fleming LE, Huang Y, Gomez-Marin O, et al. Cancer incidence in first generation U.S. Hispanics: Cubans, Mexicans, Puerto Ricans, and new Latinos. *Cancer Epidemiol Biomarkers Prev.* 2009; 18: 2162-9.

10 DeSantis C, Siegel R, Bandi P, Jemal A: Breast cancer statistics, 2011. *CA Cancer J Clin.* 2011; 61(6): 409–18.

11 Jemal A, Bray F, Center MM, Ferlay J, Ward E, Forman D. Global cancer statistics. *CA Cancer J Clin.* 2011; 61: 69-90.

12 Brawley OW, Berger MZ. Cancer and disparities in health: perspectives on health statistics and research questions. *Cancer.* 2008; 113: 1744-54.

13 Jemal A, Center MM, DeSantis C, Ward EM. Global patterns of cancer incidence and mortality rates and trends. *Cancer Epidemiol Biomarkers Prev.* 2010; 19: 1893-907.

14 Zeliadt SB, Potosky AL, Etzioni R, Ramsey SD, Penson DF. Racial disparity in primary and adjuvant treatment for nonmetastatic prostate cancer: SEER-Medicare trends 1991 to 1999. *Urology.* 2004; 64: 1171-6.

15 Evans S, Metcalfe C, Ibrahim F, Persad R, Ben-Shlomo Y. Investigating Black-White differences in prostate cancer prognosis: A systematic review and meta-analysis. *Int J Cancer.* 2008; 123: 430-5.

16 Taksler GB, Keating NL, Cutler DM. Explaining racial differences in prostate cancer mortality. *Cancer.* 2012; Sept 1; 118(17): 4280-9. doi: 10.1002/cncr.27379. [Epub ahead of print]. Accessed March 5, 2012.

17 Siegel RL, Jemal A, Thun MJ, Hao Y, Ward EM. Trends in the incidence of colorectal cancer in relation to county-level poverty among blacks and whites. *J Natl Med Assoc.* 2008; 100: 1441-4.

18 Rim SH, Seeff L, Ahmed F, King JB, Coughlin SS. Colorectal cancer incidence in the United States, 1999-2004 : an: An updated analysis of data from the National Program of Cancer Registries and the Surveillance, Epidemiology, and End Results Program. *Cancer.* 2009; 115: 1967-76.

19 Cress RD, Morris C, Ellison GL, Goodman MT. Secular changes in colorectal cancer incidence by subsite, stage at diagnosis, and race/ethnicity, 1992-2001. *Cancer.* 2006; 107: 1142-52.

20 Shavers VL. Racial/ethnic variation in the anatomic subsite location of in situ and invasive cancers of the colon. *J Natl Med Assoc.* 2007; 99: 733-48.

21 Haas JS, Brawarsky P, Iyer A, Fitzmaurice GM, Neville BA, Earle C. Association of area sociodemographic characteristics and capacity for treatment with disparities in colorectal cancer care and mortality. *Cancer.* 2011; 117: 4267-76.

22 Robbins AS, Siegel RL, Jemal A. Racial disparities in stage-specific colorectal cancer mortality rates from 1985 to 2008. *J Clin Oncol.* 2012; 30: 401-5.

23 Robinson CN, Balentine CJ, Marshall CL, Anaya DA, Artinyan A, Awad SA, et al. Ethnic disparities are reduced in VA colon cancer patients. *Am J Surg.* 2010; 200: 636-9.

24 Hofmann LJ, Lee S, Waddell B, Davis KG. Effect of race on colon cancer treatment and outcomes in the Department of Defense healthcare system. *Dis Colon Rectum.* 2010; 53: 9-15.

25 Wong R. Proximal tumors are associated with greater mortality in colon cancer. *J Gen Intern Med.* 2010; 25: 1157-63.

26 Zauber AG, Winawer SJ, O'Brien MJ, Lansdorp-Vogelaar I, van Ballegooijen M, Hankey BF, et al. Colonoscopic polypectomy and long-term prevention of colorectal-cancer deaths. *N Engl J Med.* 2012; 366: 687-96.

27 State cancer profiles. National Cancer Institute (http://www.cancer.gov) Web site. http://statecancerprofiles.cancer.gov/. Accessed November 4, 2013.

28 NCI/CDC. State cancer profiles: Quick profile Connecticut. National Cancer Profiles Web site. http://statecancerprofiles.cancer.gov/cgi-bin/quickprofiles/profile.pl?09&001. Accessed October 17, 2013.

29 Annual Report to the Nation on the Status of Cancer, 1975-2008, featuring cancers associated with excess weight and lack of sufficient physical activity.. Eheman C, Henley SJ, Ballard-Barbash R, Jacobs EJ, Schymura MJ, Noone AM, Pan L, Anderson RN, Fulton JE, Kohler BA, Jemal A, Ward E, Plescia M, Ries LA, Edwards BK.et al. Annual report to the nation on the status of cancer, 1975-2008, featuring cancers associated with excess weight and lack of sufficient physical activity. Cancer. 2012 May 1;118(9):2338-66. doi: 10.1002/cncr.27514. Epub March 28,2012.

30 Annual Report to the Nation on the Status of Cancer, 1975-2009, featuring the burden and trends in human papillomavirus(HPV)-associated cancers and HPV vaccination coverage levels.. Jemal A, Simard EP, Dorell C, Noone AM, Markowitz LE, Kohler B, Eheman C, Saraiya M, Bandi P, Saslow D, Cronin KA, Watson M, Schiffman M, Henley SJ, Schymura MJ, Anderson RN, Yankey D, Edwards BK.et al. Annual report to the nation on the status of cancer, 1975-2009, featuring the burden and trends in human papillomavirus(HPV)-associated cancers and HPV vaccination coverage levels. J Natl Cancer Inst. 2013 Feb 6; 105(3):175-201. doi: 10.1093/jnci/djs491. Epub January 7, 2013.

31 IOM (Institute of Medicine). 2013. Delivering high-quality cancer care:
Charting a new course for a system in crisis. Washington, DC: The National Academies Press.

32 Frieden, TR,. A Framework for Public Health Action. The Health Impact Pyramid, Health Impact Pyramid. Am J Public Health, Vol.. 2010; 100, No. (4,):590-595. April 2010. Web site http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2836340/ Accessed November 5, 2013.

33 Seeking CoC accreditation? Here's how. American College of Surgeons Web site. http://www.facs.org/cancer/coc/seekingaccred.html. Updated September 30, 2013. Accessed November 4, 2013.

34 Genetic Testing for Hereditary Cancer Syndromes. National Cancer Institute.
http://www.cancer.gov/cancertopics/factsheet/Risk/genetic-testing. Accessed November 4, 2013.

34a Pancreatic Cancer Detailed Guide. American Cancer Society. Web site http://www.cancer.org/cancer/pancreaticcancer/detailedguide/index Accessed February 18, 2014.

35 Transforming the NCI Clinical Trials Enterprise. National Cancer Institute Web site. http://transformingtrials.cancer.gov/initiatives/overview. Accessed October 31, 2013.

36 Spending on Tobacco Prevention: Connecticut. Campaign for Tobacco-Free Kids Web site.
http://www.tobaccofreekids.org/what_we_do/state_local/tobacco_settlement/connecticut. Updated December 4, 2012. Accessed November 4, 2013.

37 Smoking-Attributable Mortality, Years of Potential Life Lost, and Productivity Losses—United States, 2000–2004. Published November 14, 2008 / Vol. 57 / No. 45. Web site. http://www.cdc.gov/tobacco/data_statistics/tables/health/attrdeaths/index.htm. Accessed November 4, 2013.

38 Youth Risk Behavior Survey Fact Sheets. Centers for Disease Control and Prevention Web site.
http://www.cdc.gov/healthyyouth/yrbs/factsheets/index.htm#compare. Updated August 16, 2013. Accessed November 4, 2013.

39 http://www.epa.gov/sunwise/doc/ct_facts_web.pd Facts about skin cancer: Connecticut. Environmental Protection Agency Web site.
http://www.epa.gov/sunwise/doc/ct_facts_web.pdf. Published May 2009. Accessed November 4, 2013.

40 Skin Cancer Rates by State. Centers for Disease Control and Prevention Web site. http://www.cdc.gov/cancer/skin/statistics/state.htm. Updated September 6, 2013. Accessed November 4, 2013.

41 Paskett, ED, Harrop, JP, Wells, KJ. Patient navigation: An update on the state of the science.
CA Cancer J Clin. 2011 Jul-Aug; 61(4): 237–249. Published online 2011 June 9. doi: 10.3322/caac.20111 PMCID: PMC3623288
NIHMSID: NIHMS448899 Patient Navigation: An Update on the State of the Science Electra D. Paskett, Ph.D.,* J. Phil Harrop, M.H.A., M.B.A., and Kristen J. Wells, Ph.D., M.P.H.) link used: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3623288/

42 How to Increase Preventive Screening Rates in Practice: An Action Plan for Implementing a Primary Care Clinician's* Evidence-Based Toolbox and Guide Sarfaty, M. How to increase colorectal cancer screening rates in practice: A primary care clinician's* evidence-based toolbox and guide 2008. American Cancer Society Web site. Published by the National Colorectal Cancer Roundtable.
http://www.cancer.org/acs/groups/content/documents/document/acspc-024588.pdf. Accessed November 4, 2013. National Colorectal Cancer Roundtable (NCCRT)http://www5.cancer.org/aspx/pcmanual/default.aspx.

43 The Guide to Community Preventive Services. The Community Guide Web site. http://www.thecommunityguide.org/index.html. Updated October 24, 2013. Accessed November 4, 2013.

44 USPSTF A and B Recommendations. U.S. Preventive Services Task Force Web site.
http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm). Updated August 2013. Accessed November 2013.

45 http://www.cdc.gov/cancer/nbccedp/data/summaries/connecticut.htm National Breast and Cervical Cancer Early Detection Program (NBCCEDP): Connecticut. Centers for Disease Control and Prevention Web site.
http://www.cdc.gov/cancer/nbccedp/data/summaries/connecticut.htm. Updated August 23, 2013. Accessed November 4, 2013.

46 National Breast and Cervical Cancer Early Detection Program CDC Fact Sheet. Centers for Disease Control and Prevention Web site.
http://www.cdc.gov/cancer/nbccedp/pdf/NBCCEDP_FactSheet.pdf. Accessed November 4, 2013.

47 Targeted Cancer Therapies. National Cancer Institute Web site. http://www.cancer.gov/cancertopics/factsheet/Therapy/targeted. Accessed November 4, 2013.

48 Emerging Areas in Chemotherapy, Hormone Therapy and Targeted Therapy. Susan G. Komen Web site.
http://ww5.komen.org/BreastCancer/ChemotherapyandTargetedTherapy.html. Updated August 15, 2013. Accessed November 4, 2013.

49 Abrams MK, Davis K, Haran C. Can patient-centered medical homes transform health care delivery? The Commonwealth Fund Web site.
http://www.commonwealthfund.org/From-the-President/2009/Can-Patient-Centered-Medical-Homes-Transform-Health-Care-Delivery.aspx -. Published March 2009. Accessed November 4, 2013.

50 Beal AC, Doty MM, Hernandez SE, Shea KK, Davis, K. Closing the divide: How medical homes promote equity in health care—Results from the Commonwealth Fund 2006 Health Care Quality Survey. The Commonwealth Fund Web site.
http://www.commonwealthfund.org/Publications/Fund-Reports/2007/Jun/Closing-the-Divide--How-Medical-Homes-Promote-Equity-in-Health-Care--Results-From-The-Commonwealth-F.aspx. Published June 27, 2007. Accessed November 4, 2013.

51 About Accreditation. American College of Surgeons Web site. http://www.facs.org/cancer/coc/whatis.html. Updated February 27, 2013. Accessed November 4, 2013.

52 Understanding Cancer Genomics National Cancer Institute. Web site.
http://www.cancer.gov/cancertopics/understandingcancer/cancergenomics/AllPages. Accessed November 5, 2013.

53 ASCO Recommends Palliative Care as a Part of Cancer Treatment. American Society of Clinical Oncology
Web site. http://www.cancer.net/cancer-news-and-meetings/expert-perspective-cancer-news/asco-recommends-palliative-care-part-cancer-treatment). Accessed November 4, 2013.

54 Smith TJ, Temin S, Alesi ER, et al. American Society of Clinical OncologyASCO provisional clinical opinion: The integration of palliative care into standard oncology care. J Clin Oncol. 2012; 30(8): 880-7. http://www.asco.org/institute-quality/asco-provisional-clinical-opinion-integration-palliative-care-standard-oncology. Accessed November 4, 2013.

55 David C. Goodman, MD, MS, Nancy E. Morden, MD, MPH, Chiang-Hua Chang, PhD, Elliott S. Fisher, MD, MPH, John E. Wennberg, MD, MPH Trends in Cancer Care Near the End of Life.A Dartmouth Atlas of Health Care Brief. Published September 4, 2013. Web site.
http://www.dartmouthatlas.org/downloads/reports/Cancer_brief_090413.pdf. Accessed November 5, 2013.

56 Meier DE. Increased access to palliative care and hospice services: Opportunities to improve value in health care. Milbank Q. 2011; 89(3): 343-80. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3214714/; http://www.hhs.gov/healthcare/rights/law/index.html) doi: 10.1111/j.1468-0009.2011.00632.x

57 http://www.capc.org/capc-growth-analysis-snapshot-2011.pdf. Accessed November 4, 2013.

58 Cancer program standards 2012: Ensuring patient-centered care. American College of Surgeons Web site.
http://www.facs.org/cancer/coc/programstandards2012.pdf. Published 2012. Accessed November 4, 2013.

59 America's care of serious illness: A state-by-state report card on access to palliative care in our nation's Hospitals. Center to Advance Palliative Care Web site. http://www.capc.org/reportcard/. Published 2011. Accessed November 4, 2013.

60 Advanced certification for palliative care programs. The Joint Commission Web site.
http://www.jointcommission.org/certification/palliative_care.aspx. Published 2013. Accessed November 4, 2013.

61 Smith TJ, Temin S, Alesi ER, et al. American Society of Clinical Oncology provisional clinical opinion: the integration of palliative care into standard oncology care. J Clin Oncol. 2012; 30(8): 880-7. (http://jco.ascopubs.org/content/30/8/880). Accessed November 4, 2013.

62 An act concerning an advisory council on palliative care. State of Connecticut General Assembly: Raised Bill No. 991. January Session, 2013.
http://www.cga.ct.gov/2013/TOB/S/2013SB-00991-R00-SB.htm. Accessed November 4, 2013.

63 Palliative or supportive care. American Cancer Society: Web site. http://www.cancer.org/treatment/treatmentsandsideeffects/palliativecare/index. Accessed November 4, 2013.

64 Cancer 2013;119(11 suppl):2170-8. © 2013 American Cancer Society.
Stubblefield MD, Hubbard G, Cheville A, Koch U, Schmitz KH, Dalton SO. Current perspectives and emerging issues on cancer rehabilitation. Cancer. 2013; 119(Suppl 11): 2170-8 doi: 10.1002/cncr.28059.

65 Rechis R, Bann C, Nutt S, Squiers L, Rao N. Who is receiving survivorship care plans? Findings from the 2012 Livestrong survey. J Clin Oncol 31, 2013 (suppl; abstr 9608).

66 American Cancer Society. Cancer Treatment and Survivorship Facts and& Figures 2012-2013. Atlanta: American Cancer Society; 2012, p.: 26.

67 American Cancer Society. Cancer Treatment &and Survivorship Facts & Figures 2012-2013, ACS. Atlanta: American Cancer Society; 2012.

68 The national action plan for cancer survivorship. Centers for Disease Control and Prevention Web site.
http://www.cdc.gov/cancer/survivorship/what_cdc_is_doing/action_plan.htm). Updated April 24, 2013. Accessed November 4, 2013.

69 CoC best practices repository. American College of Surgeons Web site. http://www.facs.org/cancer/coc/bestpractices.html. Updated December 7, 2011. Accessed November 4, 2013.

70 Number of cancer survivors expected to increase to 18 million by 2022. American Association for Cancer Research Web site. http://www.aacr.org/home/public--media/aacr-in-the-news.aspx?d=3038. Published March 27, 2013. Accessed November 4, 2013.

71 Progress Against Cancer: A Snapshot. Web site. http://www.cancerprogress.net/overview.html. A project of American Society of clinical Oncology. Accessed November 5, 2013.

72 http://www.dartmouthatlas.org/downloads/reports/Cancer_brief_090413. Accessed October 18, 2013. (Trends in cancer care near the end of life: A Dartmouth Atlas Project:of Healthcare brief. The Dartmouth Atlas of Health Care Web site. http://www.dartmouthatlas.org/downloads/reports/Cancer_brief_090413.pdf). Accessed October 18, 2013.

73 Connor SR, Pyenson B, Fitch K, Spence C, Iwasaki K. Comparing hospice and non-hospice patient survival among patients who die within a three-year window. J Pain Symptom Manage. Mar 2007; 33(3): 238-46.

74 Connecticut 2013 State Hospice Organization Report: 2011 Medicare Data; Hospice Analytics Market Report. Available from CAHCH.

75 J Pain & Symptom Management 2007, http://www.nhpco.org/research

76 Duke Study Shows Hospice Savings Web site http://www.nhpco.org/duke-study-shows-hospice-savings. Accessed November 5, 2013.

77 Hospice: It's about how you live. National Hospice and Palliative Care Organization Web Site. http://www.nhpco.org/press-room/key-hospice-messages. Accessed October 18, 2013. (NHPCO ref – Gallup Poll: http://www.nhpco.org/press-room/key-hospice-messages)

78 Friebert S. NHPCO Facts and Figures: Pediatric Palliative and Hospice Care in America. Alexandria, VA: National Hospice and Palliative Care Organization, April 2009. http://www.nhpco.org/sites/default/files/public/quality/Pediatric_Facts-Figures.pdf . Accessed November 4, 2013.

79 Wasik J. Tackling end-of-life costs. The Medicare News Group. October 4, 2012. http://www.medicarenewsgroup.com/context/understanding-medicare-blog/understanding-medicare-blog/2012/10/04/tackling-end-of-life-costs October 04, 2012 13:34 Tackling End-of-Life Costsby John F. Wasik/For The Medicare NewsGroup. Accessed November 4, 2013.

80 Trends in Hospice Lengths of Stay. Web site. http://www.healthmr.com/1203-metrics-matter/ Accessed November 5, 2013.

81 Hospice quality reporting. Centers for Medicare and Medicaid Services Web site. http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/ . Updated May 21, 2013. Accessed November 4, 2013.

82 Enroll your hospice. We Honor Veterans Web site. http://www.wehonorveterans.org/i4a/pages/index.cfm?pageid=3283. Accessed November 4, 2013.

83 Hospice benefits. Medicaid.gov Web site. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Hospice-Benefits-.html. Accessed November 4, 2013.

84 Concurrent care for children. National Hospice and Palliative Care Organization Web site. http://www.nhpco.org/resources/concurrent-care-children. Accessed November 4, 2013.

85 Hospice care. American Cancer Society Web site. http://www.cancer.org/treatment/findingandpayingfortreatment/choosingyourtreatmentteam/hospicecare/hospice-care-hospice-care. Updated April 30, 2013. Accessed November 4, 2013.

86 The Connecticut ACHIEVE Initiative. Eastern Highlands Health District Web site. http://ehhd.org/content/103/272/770/default.aspx. Accessed November 4, 2013.

87 Healthy People 2020 Topics and Objectives: Cancer. U.S. Department of Health and Human Services HealthyPeople.gov Web site. http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=5. Updated April 10, 2013. Accessed November 4, 2013.

Connecticut CANCER Partnership
The Power of Unity

What You and Your Organization Can Do to Fight Cancer In Connecticut

The Connecticut Cancer Plan, 2014-2017 includes specific information for each area of cancer control: goals (vision of what is needed), objectives (the role and work of the Partnership through its committees and staff) and strategic actions (activities that Partnership member organizations may be engaged in that align with the Plan). To make a difference in the fight against cancer, the continued commitment of organizations and individual members is required. By harnessing the dedication of members and agencies to implement data-driven strategies as well as policy, systems and environmental changes, progress is possible.

Here are ways you and your organization can contribute to reaching the goals presented in this Plan.

▶ Hospitals/Cancer Programs:

- o Ensure timely, culturally and linguistically appropriate services for cancer patients
- o Ensure that your cancer cases are reported in a timely manner
- o Create and support navigation and survivorship programs
- o Conduct one of the annually required CoC Standard 4.8 Quality Improvement Projects on an item within the Plan
- o Collaborate to sponsor culturally and linguistically appropriate community screening and education programs
- o Seek or maintain accreditation through the Joint Commission, American College of Surgeons, etc.
- o Enforce tobacco-free policies at your facility and support the cessation efforts of employees and patients
- o Provide healthy food and beverage options in vending machines and cafeterias
- o Encourage employees to participate in regular physical activity
- o Provide meeting space for cancer groups

▶ Local Health Departments:

- o Assist in developing regional task forces to share information and implement interventions regarding chronic disease prevention, screening and management
- o Support culturally and linguistically appropriate policy, systems and environmental changes for cancer prevention and control
- o Provide cancer prevention information and screening programs to citizens
- o Collaborate in developing and providing community prevention campaigns
- o Work with providers to promote screening programs and case reporting
- o Provide meeting space for cancer groups

▶ Community or Faith-based Organizations:

- o Support culturally and linguistically appropriate policy, systems and environmental changes for cancer prevention and control (e.g. provide healthy meals for meetings and events)
- o Provide cancer prevention awareness information and screening programs
- o Provide outreach services for clients
- o Encourage participation in clinical trials
- o Collaborate to develop and provide community prevention programs
- o Advocate for development of the built environment that promotes active living
- o Provide space for physical activity programs and nutrition programs

▶ Employers:

- o Seek or maintain CEO Cancer Gold Standard™ accreditation
- o Implement tobacco-free policies at your facility
- o Provide healthy food and beverage options in vending machines and cafeterias
- o Encourage employees to participate in regular physical activity
- o Commit staffing time to assist in implementing one of the Partnership's strategic actions
- o Collaborate with hospitals to host screening events
- o Use reminders and implement programs to reduce barriers and to encourage employees to have regular cancer screenings (e.g., paid time-off for screenings, bringing screenings to the workplace)
- o Provide space for community meetings and for physical activity and nutrition programs

▶ Schools/Universities:

- o Support policy, systems and environmental changes to support healthy lifestyles for cancer prevention
- o Work collaboratively to offer programs for professional development and certifications for community health workers and educators
- o Include cancer prevention messages in health classes
- o Provide healthy food and beverage options in vending machines and cafeterias
- o Encourage students and faculty to participate in regular physical activity
- o Make your entire campus a tobacco-free environment
- o Support development of the built environment that promotes active living

▶ Clinicians:

- o Provide culturally appropriate and relevant information, counseling and referrals for cancer screening tests
- o Conduct a "Meaningful Use" project to improve screening rates (see "For More Information")
- o Provide services in a patient's preferred language in a timely fashion and throughout the patient experience
- o Adhere to guidelines and best practices for prevention, treatment and palliative care
- o Refer patients to smoking cessation, physical activity and nutrition programs
- o Report cancer cases in a timely manner
- o Support and facilitate appropriate clinical trial enrollment
- o Make timely and appropriate referrals to hospice for end-of-life care
- o Adopt regular use of survivorship care plans

▶ Policy Makers:

- o Sponsor or support legislation and funding that promotes cancer research, prevention and control as well as adequate palliative care
- o Raise constituents' awareness about cancer prevention and control programs in your district and help establish new programs where needed
- o Ensure that all Connecticut residents have access to adequate early detection and health care services
- o Ensure that tobacco settlement funds are used for tobacco prevention and cessation and for cancer control
- o Provide and support appropriate funding for comprehensive cancer control
- o Support legislation for Culturally and Linguistically Appropriate Services (CLAS) Standards enforcement
- o Advocate and support the development of the built environment that promotes healthy eating and active living

▶ Funders/Philanthropist and In-Kind Supporters:

- o Fund a strategic action from Connecticut Cancer Plan 2014-2017
- o Commit staffing time to assist in implementation of strategic actions
- o Provide meeting space and meeting materials for Partnership activities
- o Sponsor conferences, covering costs of speakers and travel, hotel, honorariums and materials
- o Provide printing and photocopying services for Partnership business operations

If you are interested in reducing the cancer burden in Connecticut:

Become a member of the Connecticut Cancer Partnership. For More Information, ideas or ways to become involved with the Partnership, please go to **http://ctcancerpartnership.org** and click on 'How to Join."