



Founding Partners

- American Cancer Society
- Connecticut Department of Public Health
- Connecticut State Medical Society
- University of Connecticut Health Center
- Yale Cancer Center

Board of Directors (elected June, 2005)

Chair

Andrew L. Salner, MD, FACR
Connecticut State Medical Society and Hartford Hospital

Vice Chair

Nancy E. Berger, MPH
Connecticut Department of Public Health

Secretary

Judith Grasso, RN, MSN
Yale Cancer Center

Treasurer

Sarah Shafir, MPH
American Cancer Society, New England Division

Members

Vincent F. Barbetta, CHFC, CLU
Axa Advisors, LLC

Carol E. Bower
Connecticut Department of Public Health

Brenda Cartmel, PhD
Yale University School of Medicine

Marian A. Evans
Bridgeport Health Department

David I. Gregorio, PhD, MS
University of Connecticut Health Center

Jerold Mande, MPH
Yale Cancer Center

Ruth McCorkle, PhD, RN
Yale University School of Nursing

Marion E. Morra, MA, ScD
Morra Communications

Linda Mowad, RN
Yale Cancer Center
Cancer Information Service of New England

Russell J. Munson, MD, FAAFP
Anthem Blue Cross and Blue Shield

Robert J. Piorkowski, MD, FACS
American College of Surgeons, Commission on Cancer
and Hartford Hospital

Susan Richter, RN
American Cancer Society, New England Division

Markos Samos, MA, LPC
Mashantucket Pequot Tribal Nation

Helen Swede, PhD
University of Connecticut Health Center

Patricia Trotta, RN, MSN
American Cancer Society, New England Division

Anna-leila Williams, PA-C, MPH
Yale University School of Nursing



2	Comprehensive Cancer Control, the Partnership, and the Plan
3	Cancer in Connecticut
6	Preventing Cancer Before It Starts
7	Increasing Early Detection
8	Assuring Quality Treatment for All Patients
9	Empowering Survivors and Their Families
10	Palliative and Hospice Care
11	Reducing Health Disparities
12	Stimulating and Translating Research
14	How Can I Help?
16	Comprehensive Cancer Planning Committees
21	Cross-Cutting Committees

COMPREHENSIVE CANCER CONTROL, THE PARTNERSHIP, AND THE PLAN

Comprehensive Cancer Control

Despite progress in the fight against cancer, more than 20,000 Connecticut residents are expected to be diagnosed with cancer this year and more than 7,000 will die of the disease. No Connecticut agency or organization can address every need for cancer prevention and control. But an approach that brings together programs and resources under a common plan offers a better way to fight the disease. This approach, called Comprehensive Cancer Control, is a program supported by the U.S. Centers for Disease Control and Prevention (CDC). Underway in all 50 states, this model program links the state's entire cancer-fighting community in work to develop and implement a plan that crosses the entire continuum of care for all forms of cancer.

The Connecticut Cancer Partnership

The Connecticut Cancer Partnership was created in response to the CDC's comprehensive cancer control initiative. Its five founding partners – the American Cancer Society, the Connecticut State Medical Society, the Connecticut Department of Public Health, the University of Connecticut Health Center, and the Yale Cancer Center – have been working together on this effort since March 2003. With support from CDC and other grants and contributions, the statewide partnership has taken a fresh look at cancer prevention, control, and care, to find a better way to prevent cancer and save lives. Today the Partnership is more than 200 strong and represents all reaches of Connecticut's cancer community, including the public, private, and not-for-profit sectors, academic and clinical institutions, community and advocacy groups, businesses, and insurers, along with cancer survivors and other individuals.

The Plan

Using sound scientific evidence and clinical best practices, the Partnership's subcommittees developed top priorities in five areas along the continuum of cancer care – Prevention, Early Detection, Treatment, Survivorship, and Palliative and Hospice Care. Special attention was paid to the importance of reducing disparities in cancer among different populations. The result of the Partnership's planning effort is the *Connecticut Comprehensive Cancer Control Plan, 2005-2008*, a road map to guide decision-making and action in our state. Participants in the planning process are acknowledged on pages 16-20.

The Plan details goals, objectives, and strategies for achieving them in each of the five priority areas plus the cross-cutting areas of Advocacy, Health Disparities, Communications, Research, and Data, Surveillance, and Evaluation. The complete Plan can be viewed online at the Partnership's web site, www.ctcancerpartnership.org. *Planning for Comprehensive Cancer Control in Connecticut* contains summary information from the Plan about cancer in Connecticut and the priorities for reducing its burden.

In the 2006 legislative session, the Connecticut General Assembly awarded \$7.15 million in new funding to begin implementing selected priorities from the *Connecticut Comprehensive Cancer Control Plan* in the areas of tobacco cessation, nutrition, breast and cervical cancer early detection, colorectal screening, clinical trials, survivorship, and palliative and hospice care.

Individuals and organizations are invited to join in these and other Partnership efforts to lessen the burden of cancer in Connecticut and to improve the quality of life of cancer survivors. Please see "How Can I Help?" on page 14 to learn what you can do.

Despite progress in the fight against cancer, more than 20,000 Connecticut residents are expected to be diagnosed with cancer this year and more than 7,000 will die of the disease.



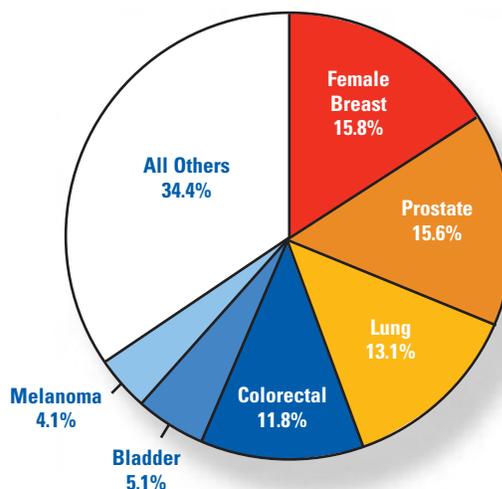
CANCER IN CONNECTICUT

The face of cancer in Connecticut is changing. More people are adopting healthy practices that reduce their risk of developing cancer or ensure that new cancers are detected early, when they are the most treatable. The number of new cancer cases in Connecticut is growing each year, reflecting the aging of the population. The overall rate of new cancer cases has stabilized, however, and the death rate has been decreasing, due largely to better methods of finding cancer early and treating it more effectively. Still, cancer exacts a staggering toll on our state's residents each year.

New Cancer Cases (Incidence)

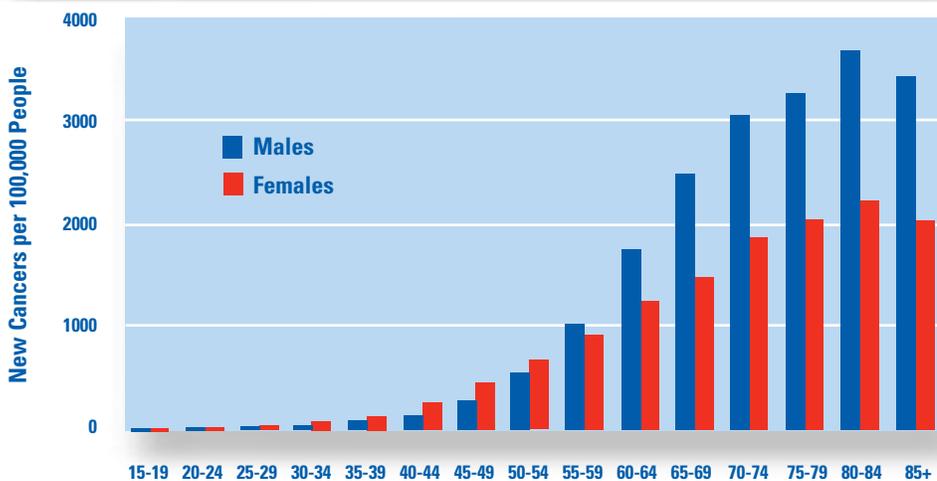
In 2001, Connecticut had the fourth highest rate in the nation of new cancer cases among females and the tenth highest rate among males. Prostate, breast, lung, and colorectal cancers, together with melanoma of the skin, account for six out of ten new cases. Many of these cancers could be prevented if people changed their habits – by quitting smoking, maintaining a healthy weight through diet and exercise, making healthier food choices, and avoiding the sun – or if they were screened regularly.

Most Frequently Diagnosed Invasive Cancers Connecticut 2001



Source: Connecticut Tumor Registry
 Note: Invasive cancers are those that have penetrated into cells beyond the layer of tissue in which they developed, or have spread to distant parts of the body.

New Cancer Case Rates by Age Connecticut 1995-1999



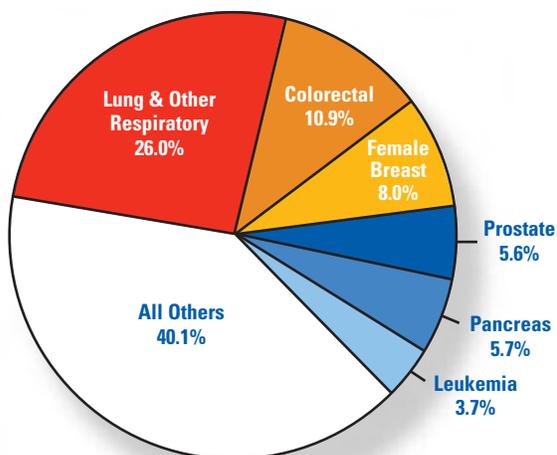
Source: Connecticut Tumor Registry
 Note: Rates are 3-year averages.

The chances of developing cancer increase as a person ages. In Connecticut, nearly 60% of cancers are found in people 65 and older. Cancer rates also tend to be higher among men than among women. Connecticut's population is growing older on average, and in 2000, nearly half a million state residents were over the age of 64. As our population grows older, the number of new cancer cases is expected to increase, as is the number of persons living with cancer.

Deaths

Cancer is the second leading cause of death in Connecticut, following heart disease. More than 7,000 state residents die of cancer each year, and more than half of all cancer deaths in Connecticut are due to cancers of the lung, colon/rectum, female breast, and prostate.

Most Common Types of Cancer Deaths
Connecticut 1999-2001

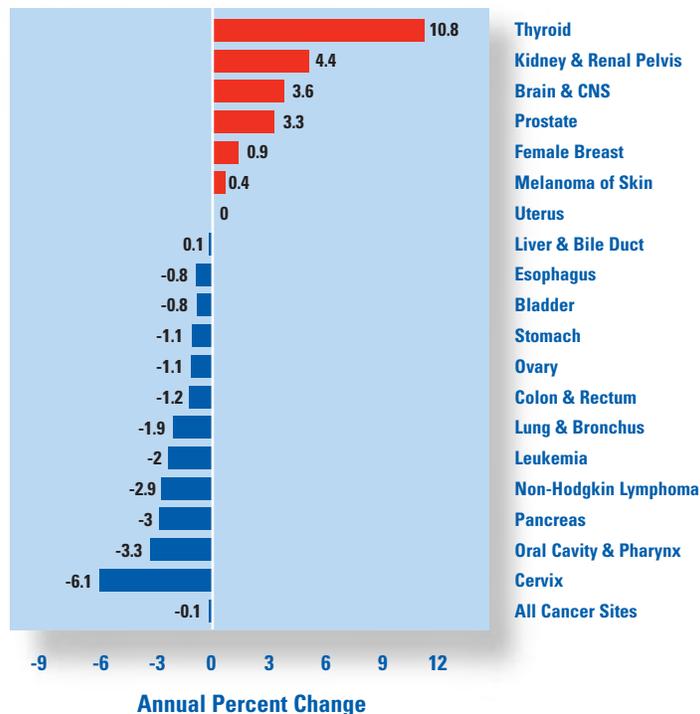


Source: Connecticut Department of Public Health

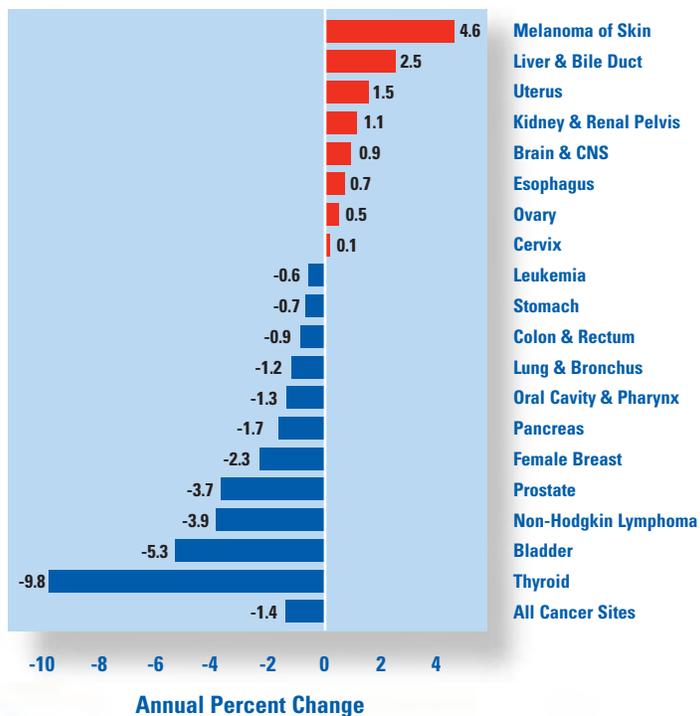
Trends in New Cancer Cases and Deaths

Between 1997 and 2001 in Connecticut, the overall rate of new cancer cases stabilized and the cancer death rate declined slightly; however, there was a wide range of increases and decreases in rates for different types of cancer.

Changes in New Cancer Case Rates
Connecticut 1997-2001



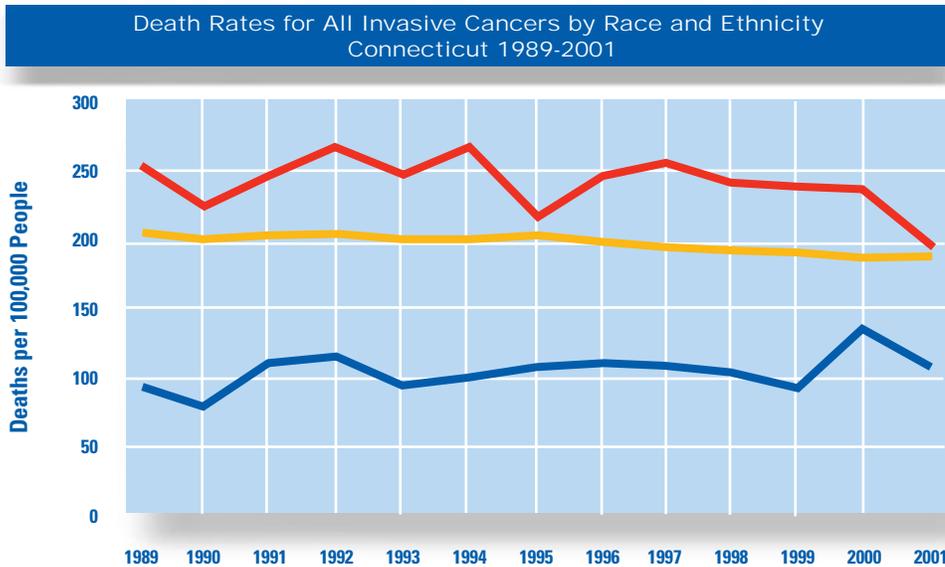
Changes in Cancer Death Rates
Connecticut 1997-2001



Source: CDC State Cancer Profiles

Disparities

Cancer does not discriminate. The burden of cancer often is greatest for those with low income and less education, and for people of color, especially those who have no health insurance or do not speak English well. Although the types of cancer found most often and the leading causes of cancer death are similar for different racial and ethnic groups, overall rates of new cases, deaths, and survival are very different. African Americans, for example, are more likely than any other racial or ethnic group to develop and die from cancer, and American Indians have the lowest cancer survival rate.

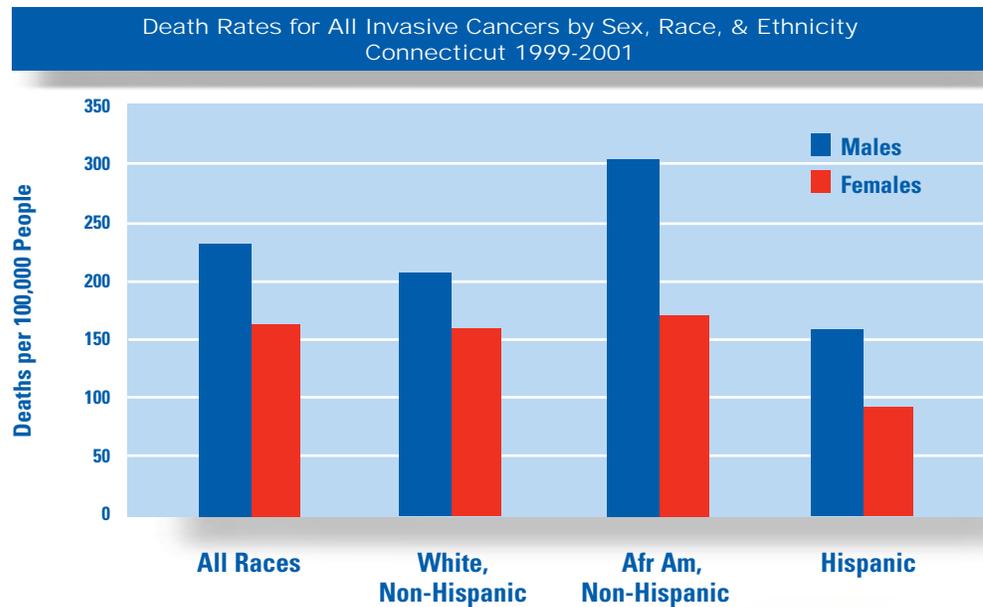


Even greater disparities are seen for specific types of cancers. The prostate cancer death rate, for example, is twice as high for African Americans as for whites; Hispanic women are the most likely to develop cervical cancer; and Asian Americans and American Indians have the highest rates of new stomach and liver cancers.

- African American
- White
- Hispanic

Source: Connecticut Department of Public Health
Note: Rates are age-adjusted

Cancer also affects males and females differently. The overall cancer death rate is higher for males than for females, regardless of race or ethnicity. Since 1989, the overall cancer death rate has declined significantly for males but not for females. The difference between the sexes is especially great for lung cancer. Although the lung cancer death rate is higher for males than females in Connecticut, it has been decreasing for males but increasing for females. In 1988, lung cancer replaced breast cancer as the leading cause of cancer death among Connecticut women, and it still holds that rank.



Source: Connecticut Department of Public Health
Note: Rates are 3-year averages and are age-adjusted

PREVENTING CANCER BEFORE IT STARTS

Background

At least half of all cancer cases might be avoided or delayed by changing behaviors. Smoking causes nearly all lung, mouth, and throat cancers and increases the risk of pancreatic, bladder, kidney, and cervical cancers. A diet high in fat and salt but low in fruits and vegetables could increase the risk of colon, prostate, and stomach cancers. Obesity increases the risk of colon, kidney, esophageal, and endometrial cancers. Long-lasting infection with human papillomavirus, which can be transmitted through sexual contact, causes nearly all cervical cancers. Heavy alcohol use (more than one drink a day for women and more than two for men) increases the risk of liver, mouth, throat, esophageal, and laryngeal cancers. Unprotected exposure to ultraviolet radiation from the sun and artificial tanning devices increases the risk of melanoma and non-melanoma skin cancers. Occupational exposures to cancer-causing substances also contribute to cancer risk.

While some risk factors, such as a family history of cancer, cannot be changed, other risks can be lowered through changes in behavior. The percentages of Connecticut adults and high school students with modifiable risk behaviors for cancer are shown here.

Risk Factor	Percentage of Persons at Risk*	
	Adults	Students
Current cigarette smoking (2003)	18.6%	22.5%
Eating less than 5 servings of fruits/vegetables a day (2003)	70.2%	78.4%
Physical activity:		
No leisure time physical activity (2003)	21.0%	N/A
No vigorous physical activity (2003)	69.4%	40.3%
No moderate physical activity (2003)	48.3%	73.9%
Body weight:		
Overweight (2003)	35.7%	N/A
Obese (2003)	19.1%	N/A
Heavy drinking (Adults, 2002; Students, 2003)	6.7%	27.2%
Did not use a condom during last intercourse (2003)	N/A	38.1%
Never/almost never use condom during intercourse (1998)	29.4%	N/A
Sunburned one or more times in past year (2003)	34.4%	N/A

Sources: Connecticut Behavioral Risk Factor Surveillance System and Youth Risk Behavior Survey

* Adults were 18 years of age and older; students were in grades 9-12.

Priorities for Cancer Prevention in Connecticut

Tobacco

- Reduce the proportion of adults and youths who currently use tobacco, paying special attention to populations experiencing tobacco-related disparities

Nutrition, Physical Activity, and Obesity

- Increase the proportion of adults and youths who make healthy food choices, including increasing consumption of fruits and vegetables
- Decrease the proportion of adults and youths who do not engage in leisure time physical activity or exercise
- Reduce the percentage of overweight and obese adults and children

Environmental Exposures

- Increase the public's awareness of cancer-related environmental exposures and protective measures
- Increase the practice of sun protection behaviors especially among youth; increase awareness of risk of overexposure to ultraviolet light in tanning booths

Alcohol Use

- Reduce the percentage of adults and adolescents who engage in excessive drinking (more than 2 drinks per day for males and 1 drink per day for females)

Multiple Sex Partners and Unprotected Sex

- Increase the proportion of adults who always use condoms if sexually active with more than one sex partner
- Increase the proportion of youths who abstain from sexual intercourse or use condoms if sexually active

INCREASING EARLY DETECTION

Background

Screening tests that detect cancers early can save lives, because cancers found early are easier to treat and often can be cured. For some cancers, early detection can reduce how long and how severe the treatments will be. It also can improve quality of life and survival. Screening can even prevent certain kinds of cancer from occurring, such as when polyps in the colon are found and taken out before they become cancerous.

Screening tests based on strong scientific evidence are recommended for breast, cervical, and colorectal cancers, and populations at high risk for these cancers have been identified. Screening rates in Connecticut differ between males and females and vary by race, ethnicity, and health insurance status.

Although it is possible to screen for lung, prostate, ovarian, uterine, skin, and oral cancers, there is still not enough scientific evidence that widespread screening for these cancers is effective.

The following key facts were used by the Early Detection Committee to create its priorities:

- Breast cancer is the most commonly diagnosed cancer among women in Connecticut. Our state has the second highest rate of new breast cancer cases and the twelfth highest breast cancer death rate in the nation.
- Colorectal cancer is the fourth most commonly diagnosed cancer in Connecticut, and it is the second leading cause of cancer death.
- Survival rates for cervical cancer would be over 90%, if all women who are 18 and over or who are sexually active had a Pap test on a regular basis.
- Rates of new cancer cases and cancer deaths tend to be greatest among certain racial and ethnic groups, people with low incomes and low education levels, and those without health insurance coverage. These differences may be due in part to under-use of screening services. Screening rates for several cancers, but especially colorectal cancer, are particularly low among people of color and low-income populations.
- Recommended screening tests do not yet exist for some of the most common types of new cancers and causes of cancer death. Lung cancer is the leading cause of cancer deaths in Connecticut. The death rate in Connecticut for melanoma of the skin increased almost 5% per year from 1997-2001, while rates for other cancers rose only slightly or fell. Ovarian cancer is the fifth leading cause of cancer deaths among Connecticut women. Prostate cancer is the most frequently diagnosed cancer and the second leading cause of cancer deaths among males in Connecticut.

Priorities for Early Detection of Cancer in Connecticut

Breast, Cervical, and Colorectal Cancer Screenings

- Increase the percentage of women age 40 and over who have had a mammogram in the past two years and who receive timely and appropriate follow-up after receiving abnormal breast cancer screening results
- Increase the percentage of women who have had a Pap test within the past year and who receive timely and appropriate follow-up on receiving abnormal Pap test screening results
- Increase the percentage of adults 50 and over who have had a sigmoidoscopy or colonoscopy within the past five years, a fecal occult blood test within the past year, and who receive timely and appropriate follow-up on receiving abnormal colon screening results

Disparities in Access to and Use of Cancer Screening Services

- Increase the use of screening among underserved minority groups
- Increase enrollment of underserved populations in cancer screening trials

Cancers without Proven Early Detection Tests

- Seek and develop strategies to reduce morbidity and mortality for cancers with high incidence or mortality rates for which effective screening tests are not yet available, including melanoma and lung, ovarian, and prostate cancers
- Increase awareness of lung, ovarian, prostate, skin, and oral cancers through education about risk factors and symptoms
- Increase public awareness of risk factors and early signs of skin cancer, with emphasis on malignant melanoma



Screening tests that detect cancers early can save lives, because cancers found early are easier to treat and often can be cured.

ASSURING QUALITY TREATMENT FOR ALL PATIENTS

Background

As a result of new treatments, many people with cancer are being cured of their disease or are living longer with a good quality of life. Cancer is still a difficult disease to treat, however, often needing complex therapy with one or more types of treatments. It is important for health care providers and their patients to find the latest treatment information, so they can better understand treatment choices. Patients need to be assured that services are geographically and financially available, and that the treatments they receive are of high quality and based on scientific evidence.

Connecticut's cancer treatment services are fairly well distributed throughout the state. Hospitals, cancer centers, oncology centers, physicians' offices, and support services are accessible to most Connecticut residents. Several issues still need to be addressed to ensure that these services are within reach of all Connecticut residents.

The Treatment Committee believes that cancer treatment outcomes will be improved by removing barriers and promoting certain standards and practices:

Standards of Care

Although there are published guidelines for cancer treatment and care, many oncologists, patients, and their families either do not know they exist or do not know where or how to find them. As a result, many cancer patients in Connecticut do not receive state-of-the-art treatments.

Hospital Accreditation

One-third of Connecticut's acute care hospitals do not have an approved cancer program accredited by the American College of Surgeons.

Participation in Clinical Trials When Appropriate

Most adults consider clinical treatment trials a form of high quality care, and though many would take part in a clinical cancer trial, only 5% of cancer patients actually do. Barriers to joining trials include doctors who are not willing to enroll patients, and patients who refuse to participate, because they don't understand the nature of the trials and reasons for them.

Social, cultural, and economic issues also create barriers, especially for patients from racial and ethnic minority groups.

As a result of new treatments, many people with cancer are being cured of their disease or are living longer with a good quality of life.

Equal Access to Treatment Services

Although there are barriers to treatment and gaps in resources, they have not been fully identified or assessed in Connecticut.

Support System for Quality of Life

All cancer patients in Connecticut do not have equal access to pain control and symptom management during treatment. In addition, information on complementary and alternative treatments based on scientific evidence is not readily available.

Education Services for Health Professionals

There is no central source of information for health professionals about educational opportunities regarding cancer management issues.

Priorities for Treatment of Cancer in Connecticut

Access to Information

- Increase the proportion of cancer care providers and cancer patients with access to treatment information and evidence-based quality standards of care
- Increase the proportion of cancer care providers and cancer patients with access to comprehensive information on clinical treatment trials

Access to Clinical Treatment Trials

- Build a statewide clinical trials network supporting investigator-initiated trials and remove barriers to enrollment

Access to Treatment and Support

- Reduce the proportion of cancer patients who experience difficulty or delays in accessing treatment, or who do not receive needed treatment
- Increase the proportion of cancer patients and their families who have access to support systems, including psychosocial support and evidence-based complementary medicine
- Increase the proportion of cancer patients who have access to pain and symptom management during treatment

Hospital Accreditation

- Increase the number of Connecticut acute care hospitals that are accredited by the American College of Surgeons

EMPOWERING SURVIVORS AND THEIR FAMILIES

Background

Completing cancer treatment is a challenge for many cancer patients and their families. Although they are relieved to have ended this phase, they are leaving the health care team with whom they have long been involved. Often, they have many concerns about their next steps.

Cancer patients and their families need to be empowered to make effective choices both during and after treatment. With the passage of time, the needs and problems of people who have had cancer change. Some require few services, while others finding it difficult to continue without support and resources to help them.

Today more people in Connecticut live with cancer than die from it. Because of improvements in early detection, earlier diagnosis, and more effective treatments, survival rates have increased greatly. But even if they are free of the disease, cancer survivors often have more health problems than others.

As Connecticut's population ages, the number of elderly people in Connecticut will grow, and the number of cancer cases and cancer survivors will also increase. This growing number of cancer survivors challenges providers to understand and address survivors' needs and to develop new ways to promote their health and well being.

The members of the Survivorship Committee took many facts into consideration during the process of choosing priorities:

- The number of cancer survivors is growing rapidly; in the U.S. it is expected to increase from 9.6 million (in 2001) to an estimated 11.3 million in 2015.

- Although the majority of survivors successfully adapt to gradual physical and psychological recovery during the first year after treatment ends, about 20-25% feel symptoms of depression.
- Some survivors struggle with persistent and late physical effects of treatment for many years, if not throughout their lifetimes.
- There are few national guidelines for follow-up, and those that exist are not well known or used by the average doctor. Survivors commonly experience a lack of continuity of care across and within specialty care practices. No one – neither patients and their families nor health care professionals – knows who is responsible for what.
- Resources for supportive interventions are limited in doctors' offices, where most people have received their treatment and care. The scope of existing services or if the services meet the needs is not known.

Priorities for Cancer Survivorship in Connecticut Support Services, Guidelines, and Care

- Increase the proportion of cancer survivors and cancer care providers who access and utilize survivor support services
- Increase the proportion of cancer survivors and health care providers who are knowledgeable about published guidelines for survivorship care
- Increase the proportion of health care providers who are knowledgeable about evidence-based survivorship care



PALLIATIVE AND HOSPICE CARE

Background

Few people are ready to make the hard choices that are needed at the end of life. However, palliative and hospice care offer the best quality of life during the time that remains, by addressing physical, emotional, social, and spiritual needs. They can ease the pain and improve life for those who are dying of cancer, and for their families and friends. Palliative care relieves pain and suffering but does not treat or cure disease. Hospice care is a program of palliative care and support services for both people who are dying and their families.

Connecticut is home to the nation's first inpatient hospice, and several organizations have begun working to improve palliative and hospice care. The availability and use of end-of-life care in Connecticut was surveyed in 2000, and strengths and challenges were identified. This information needs to be updated, and the use of services by underserved populations needs to be measured.

Many patients don't know they have options for end-of-life care and thus don't ask for them. Others do not receive adequate palliative and hospice care services, even when the services are requested. This is the result of several factors. First, the kind, quality, and amount of care received depend on where the patients reside (at home, long-term care or assisted-living facilities, hospitals, or prisons). Second, health care professionals often are not well trained in palliative or hospice care. Third, there are cost issues: Medicare and some insurance plans cover hospice care, but palliative care is often covered indirectly, if at all. In addition, cultural backgrounds, religious beliefs, income, and education can affect both the use and delivery of palliative and hospice care.

Highlights of the information considered by the Palliative and Hospice Care Committee when it formulated priorities are:

- In 2000, only one quarter of one percent of primary care and primary care subspecialty physicians and half of one percent of full-time registered nurses in Connecticut were certified in palliative care.
- Connecticut residents would like better communications with providers about death and dying, more prompt referrals to hospice and palliative care, better coordination of care, more counseling to dying patients, and more access to spiritual care.

Palliative and hospice care offer the best quality of life during the time that remains, by addressing physical, emotional, social, and spiritual needs.

- Racial, ethnic, and religious groups would like providers to have a better understanding of the cultural context (e.g., diet, language, and religion) of their patients. Minorities may be less informed about services due to language or cultural barriers.
- Low-income and medically underserved populations may have less access to palliative and hospice care services.
- Of Connecticut hospitals, only 33% self-report palliative care programs and 58% report hospice programs. Few hospice and palliative care services are available to residents of prisons and long-term care facilities.

Priorities for Palliative & Hospice Care in Connecticut Access and Availability

- Increase the number of health care professionals (physicians, nurses, social workers, and spiritual counselors) who are knowledgeable about palliative and hospice care
- Increase the number of health professionals who are board certified in palliative and hospice care
- Increase the number of health insurance programs that provide coverage for pain and palliative/hospice services
- Increase the proportion of facilities with palliative care programs
- Increase the number of hospitals and long-term care facilities that have contractual agreements with Medicare-certified hospice programs
- Improve end-of-life care in Connecticut State correctional facilities
- Improve end-of-life care services in the State Veterans Home
- Assess patient and family satisfaction with palliative and hospice services

Quality of Life

- Increase legislation and public policy supporting pain, palliative, and hospice care services
- Decrease the prevalence of pain among Connecticut nursing home residents
- Increase patient and family satisfaction with management of pain and symptoms

Awareness of, Preparation for, and Willingness to Seek Care

- Increase utilization of palliative and hospice care
- Increase the number of referrals to hospice and palliative care, especially among persons from minority and medically underserved populations

REDUCING HEALTH DISPARITIES

Background

As discussed in the section on Cancer in Connecticut, cancer rates and patterns vary greatly across racial and ethnic groups. The following disparities exist in the U.S.:

- African Americans are the most likely to develop and die from cancer.
- African American women are less likely than other women to develop breast cancer but they are more likely to die from it.
- American Indian men and African American women have the lowest cancer survival rates.
- American Indians have the highest kidney cancer death rates.
- Hispanic women have the highest rates of cervical cancer.
- Asian Americans and Pacific Islanders have the highest rates of liver and stomach cancers.
- Hispanics and African Americans are less likely than others to be screened for breast cancer, cervical cancer, or colorectal cancer.

The burden of cancer is greatest for the poor, for racial and ethnic minorities, and for those without health insurance. Compared to people with health insurance, those without it have fewer cancer screenings and often do not seek care until their cancers are more advanced and less able to be treated successfully. As a consequence, their death rates are higher. Disparities in health insurance are related to low income and lack of permanent full-time employment. In Connecticut, Hispanics are over-represented among the underinsured; they make up less than 10% of the state's population but 40% of its uninsured.

Although population diversity is one of our state's greatest assets, it presents multiple health challenges and barriers to overcome. Some of the barriers are:

- The complexity and fragmentation of the health care system
- Lack of available providers and services, including support services
- Lack of cultural competency or cultural sensitivity among health care providers
- Problems with geographic isolation, child care, transportation, finances, lack of personal resources, and lack of a personal support system
- Social and cultural barriers such as language, individual perceptions and values, and racial, ethnic, or gender discrimination.

Creative interventions are needed to reach and serve high-risk populations. Each priority area in the statewide Plan contains objectives with implementation strategies aimed at reducing health disparities. An overall strategy is essential to coordinate the approach to addressing disparities across priority areas.

Priorities for Reducing Health Disparities in Connecticut

- Develop internal structure to coordinate cross-cutting efforts to increase access in health care and reduce health disparities
- Support remediation of access and health disparities issues identified in the Plan
- Identify geographic disparities in access for age/gender subgroups, access disparities for populations with special needs, and disparities in financial barriers to cancer care.
- Advocate to ensure access to health insurance coverage for cancer patients and survivors



STIMULATING AND TRANSLATING RESEARCH

Background

Research is the engine that is changing our understanding of cancer and shifting the balance in our fight against it. Connecticut has long been a leader in many fields of cancer research, from basic laboratory work to clinical, prevention, and intervention studies.

Considerable cancer research on various subjects is being conducted in Connecticut. Research in prevention, early detection, behavior modification, communications, and policy development is not as widespread as is research into the biology, causes, and treatment of cancer. Several clinical trials, mostly in the treatment area, are available in the state's medical centers and hospitals.

In 2004, the National Cancer Institute awarded grants totaling more than \$28 million to Connecticut institutions – mainly Yale University, University of Connecticut, and Connecticut Department of Public Health – for new and ongoing research projects. In addition, the American Cancer Society funded more than \$6 million of research in Connecticut – approximately \$1.5 million at the University of Connecticut and \$4.8 million at Yale.

Connecticut is the home of the Yale-Griffin Prevention Center, one of the nation's 28 Prevention Research Centers funded by the National Cancer Institutes. In addition, the Connecticut Department of Public Health, with funding from the U.S. Health Resources and Services Administration, collaboratively drafted a long-range Connecticut Genomics Action Plan to address the implications of genetics for public health, including the role of genetics in cancer.

The following activities related to cancer research are key to the *Connecticut Comprehensive Cancer Control Plan*.

- Translate research discoveries into better methods of prevention, early detection, and treatment
- Deliver these methods to all who could benefit from them
- Increase partnering and resources among Connecticut's researchers

- Support research projects in the Plan
- Develop methods of identifying and funding additional priority projects
- Increase participation in clinical trials

Each priority area of the *Connecticut Comprehensive Cancer Control Plan* contains objectives and implementation strategies involving research. A framework is needed to achieve an integrated and collaborative program of cancer research in Connecticut, especially in the areas of intervention, policy, communications, and behavior change, and for coordinating the efforts needed to translate and disseminate the research findings.

Priorities for Stimulating and Translating Research in Connecticut

- Develop internal structure to coordinate cross-cutting research efforts for the *Connecticut Comprehensive Cancer Control Plan*
- Support research issues identified in the Plan
- Research cross-cutting solutions to allow greater funding for intervention, policy, communications, and behavioral research
- Develop a statewide intervention research alliance
- Develop further relationships with the Yale-Griffin Prevention Research Center and other NCI-funded Prevention Research Centers
- Support the Connecticut Genomics Action Plan

Research is the engine that is changing our understanding of cancer and shifting the balance in our fight against it.





HOW CAN I HELP?

Make a commitment. Join the fight against cancer in Connecticut. You and your organization can become part of the Connecticut Cancer Partnership and help fight cancer in many ways. Visit the Connecticut Cancer Partnership's web site at www.ctcancerpartnership.org for a membership application and to learn more.

Community-Based Organizations

- Provide your members with cancer awareness information
- Encourage those you serve to get screened for cancer
- Appoint a representative from your organization to work on a committee of the Connecticut Cancer Partnership
- Encourage your members who have cancer to participate in clinical trials
- Work with other groups to provide cancer prevention programs in your community

Faith-Based Organizations

- Learn how to provide healthy pot-lucks and meeting meals
- Provide cancer prevention information to members
- Collaborate with other community-based groups
- Open your building for walking clubs in cold or hot weather
- Appoint a representative from your organization to work on a Connecticut Cancer Partnership committee
- Encourage members to get appropriate cancer screening tests on time
- Encourage members to write a living will and to discuss their wishes regarding end-of-life care with family and loved ones

Schools or Universities

- Include cancer prevention messages in health classes
- Provide healthful foods in vending machines and cafeterias
- Increase physical education requirements
- Appoint a spokesperson to become active in the Connecticut Cancer Partnership
- Make your entire campus a smoke-free environment

Local Health Departments

- Assess your community's needs and work for policy and environmental changes to reduce cancer risks
- Ensure access to care for the uninsured and underinsured
- Provide space in your facility for community cancer-related groups
- Provide cancer awareness information and data to citizens and groups
- Participate in community-based coalitions
- Become an active member of the Connecticut Cancer Partnership
- Work with physicians and other health care providers to promote screening programs and case reporting

Hospitals

- Offer meeting space to cancer-related groups
- Sponsor screening and education programs in your community
- Offer access to pain, palliative care, and hospice services for your patients
- Become an active member of the American College of Surgeons
- Report your cancer cases in a timely manner
- Appoint a representative from your hospital to work on a Connecticut Cancer Partnership committee

Visit the Connecticut Cancer Partnership's web site at www.ctcancerpartnership.org for a membership application and to learn more.

Community Health Centers or School-Based Health Centers

- Assess your community's needs and work for policy and environmental changes to reduce cancer risks
- Provide space in your facility for community cancer-related groups
- Provide screening and education programs in your community
- Appoint a representative from your organization to work on a Connecticut Cancer Partnership committee
- Talk with your patients or students about healthy weight, good eating habits and the need to exercise
- Participate in community-based coalitions

Physicians, Nurses, Social Workers, or other Health Care Professionals

- Talk with your patients about cancer in language they can understand
- Help your patients who smoke to quit
- Make sure your patients get appropriate cancer screening tests
- Discuss healthy weight, good eating habits, and the need to exercise with your patients
- Be sure your cancer cases are reported in a timely manner
- Find out how to enroll patients in clinical trials
- Join a Connecticut Cancer Partnership committee
- Make earlier referrals to hospice for end-of-life care

Organizations of Health Care Professionals

- Train persons to facilitate survivor support groups
- Provide continuing education credits on cancer topics
- Include cancer clinical trials information in meeting agendas
- Appoint a representative your organization to work on a Connecticut Cancer Partnership committee
- Form speakers' bureaus to provide cancer education

Businesses or Employers

- Offer in-kind materials or services to the Connecticut Cancer Partnership
- Establish a smoke-free policy in your workplace
- Provide healthful foods in vending machines and cafeterias
- Encourage your employees to increase their physical activity
- Collaborate with hospitals to host cancer screening events in your workplace
- Provide health insurance coverage, including preventive services, for your employees
- Provide resources and support for employees undergoing treatment for cancer and for loved ones facing end of life

Concerned Connecticut Residents

- Avoid all tobacco products and second-hand smoke
- Eat a nutritious and balanced diet and maintain a healthy weight
- Increase your daily physical activity
- Learn what cancer screenings you need and when to get them, and be sure to get them on schedule
- Support anti-tobacco legislation
- Join a Connecticut Cancer Partnership committee
- If diagnosed with cancer, consider enrolling in a clinical trial
- Write a living will, and discuss your end-of-life wishes with your family and loved ones
- Volunteer with your hospital, health department, faith community, or local groups that support cancer control efforts



COMPREHENSIVE CANCER PLANNING COMMITTEES

The *Connecticut Comprehensive Cancer Control Plan, 2005-2008* is the product of the knowledge, commitment, and collaboration of more than 100 members of the Connecticut Cancer Partnership. The Partnership's Core Committee directed the entire planning process, defining and creating subcommittees and work groups, guiding assessment and evaluation, and growing the Partnership. The Partnership's Priority Area Planning Committees dedicated countless hours to researching and assessing needs, developing goals and objectives, setting targets, and creating strategies for achieving objectives and evaluating success. The individuals named below were members of these committees throughout or at any stage of the Plan's development.

Core Committee

Chair:

Andrew Salner, MD, Hartford Hospital, Hartford

Committee Members:

Nancy Berger, MPH, CT Department of Public Health, Hartford

Rosa Biaggi, MPH, MPA, CT Department of Public Health, Hartford

Carol E. Bower, CT Department of Public Health, Hartford

Laurie Bridger, MD, Fair Haven Community Health Center, New Haven

Brenda Cartmel, PhD, Yale University School of Medicine, New Haven

Terri Foster, MS, MPH, CT Department of Public Health, Hartford

Judith Grasso, RN, Lawrence & Memorial Hospital, New London

David Gregorio, PhD, University of CT Health Center, Farmington

M. Tish Knobf, RN, PhD, Yale School of Nursing, New Haven

Jerold Mande, MPH, Yale Cancer Center, New Haven

Cheryl Mayeran, CT Department of Public Health, Hartford

Lisa McCooey, MPH, CT Department of Public Health, Hartford

Ruth McCorkle, PhD, Yale University School of Nursing, New Haven

Beth Mielcarek, RN, MSN, CT Department of Public Health, Hartford

Marion E. Morra, MA, ScD, Morra Communications, Milford

Linda Mowad, RN, Yale Cancer Center, New Haven

Connie Olufade, MPH, CHES, Stratford Health Department, Stratford

Christine Parker, MPH, CT Department of Public Health, Hartford

Lawrence Pritchett, RN, CT Department of Public Health, Hartford

Susan Richter, RN, American Cancer Society, N.E. Div., Meriden

Sarah Shafir, MPH, American Cancer Society, N.E. Div., Meriden

Helen Swede, PhD, University of CT Health Center, Farmington

Patricia Trotta, RN, MSN, American Cancer Society, N.E. Div., Meriden

Anna-leila Williams, PA-C, MPH, Yale-Griffin PRC, Derby

Michelle Wolf, American Cancer Society, N.E. Div., Wilton

David Woodmansee, American Cancer Society, N.E. Div., Meriden

Kristin Zarfos, MD, University of CT Health Center, Farmington

Prevention Committee

Co-Chairs:

Jerold Mande, MPH, Yale Cancer Center, New Haven
Sarah Shafir, MPH, American Cancer Society, N.E. Div., Meriden

Past Co-Chairs:

Connie Olufade, Stratford Health Department, Stratford
Kristin Zarfos, MD, University of CT Health Center, Farmington

Members:

Lynn Abrahamson, MPH, RN, Central Area Health Education Center, Bristol
Nancy Alderman, Environment & Human Health, North Haven
Cathy Bartell, New Britain Anesthesia, Wethersfield
Jane Bradley, CAPS, West Hartford
Janell Dube, American Cancer Society, Meriden
Brenda Cartmel, PhD, Yale University School of Medicine, New Haven
Denis Coble, EdD, University of Connecticut, Storrs
Stacy Costello, Connecticut Quitline, Rocky Hill
Dalyn Delgado, Hartford Hospital, Hartford
Ellen Dornelas, Hartford Hospital, Hartford
Linda Drake, University of Connecticut, Storrs
Mary Lou Fleissner, ScD, Connecticut Tumor Registry, Hartford
Terri Foster, MPH, CT Department of Public Health, Hartford
Bruce Gould, MD, University of CT Health Center, Farmington
Mithlesh Govil, MD, Connecticut Oncology Association, New London
David Gregorio, PhD, University of CT Health Center, Farmington
Wanda Harris, Sacred Heart University AHEC, Fairfield
Karen Hudmon, DrPH, MS RPh, Yale University School of Medicine, New Haven
Charles Huntington, MPH, PA, University of CT Health Center, Farmington
Michael Lauzier, American Lung Association, East Hartford
Cheryl Mayeran, MPH, CT Department of Public Health, Hartford
Susan Mayne, PhD, Yale University School of Medicine, New Haven
Maryanne McDonnell, MD, OBGYN Group of Manchester, Manchester
Rajni Mehta, MPH, Yale Cancer Center, New Haven
Barbara Nawrocki MPH, MBA, Lawrence & Memorial Hospital, New London
Maria Polmares, Eastern Connecticut Health Network, Manchester
Steve Root, Tobacco Research, Bloomfield
David Sankar, American Lung Association, East Hartford
Leah Stroman, Mobilize Against Tobacco for Children's Health, Wethersfield
Helen Swede, PhD, CT Tumor Registry, Hartford
Cynthia Swift, Hartford Hospital, Hartford
Nannette Thomas, RN, Lawrence & Memorial Hospital, New London
Eric Triffin, West Haven Health Department, West Haven
Thomas Wegrzyn, Chesprocott Health District, Cheshire



Early Detection Committee

Co-Chairs:

Laurie Bridger, MD, Fairhaven Community Health Center, New Haven

Linda Mowad, RN, Cancer Information Service of New England, Yale Cancer Center, New Haven

Past Co-Chair:

Christine Parker, MPH, CT Department of Public Health, Hartford

Members:

Judith Barr, ScD, Qualidigm, Middletown

Bobbie Beck, Saint Francis Hospital, Hartford

Sandy Calabro, Lawrence & Memorial Hospital, New London

Christine Coble, CT Pathology Laboratories, Inc., Willimantic

Anne Elwell, Qualidigm, Middletown

Donna Goss, Tumor Registrars Association of CT, Norwich

Diane Kosenko, Connecticut Society of Radiological Technologists, Bristol

Joel Levine, MD, University of Connecticut Health Center, Farmington

Wendy Madore, Community Health Center, Middletown

Peggy Marlowe, Naugatuck Valley Health District, Shelton

Althea Marshall, Connecticut Ovarian Cancer Coalition, Branford

Debbie Martin, Women's Center for Wellness (ECHN), Vernon

Susan McGuire, CT Primary Care Association, Hartford

Marilyn Moore, Witness Project, Bridgeport

Russell Munson, MD, Anthem Blue Cross and Blue Shield, North Haven

Carrie Musil, Community Health Center, Middletown

Cathryn Phillips, Connecticut Tumor Registry, Hartford

Jean Pirkey, Connecticut Tumor Registry, Hartford

Roxanne Rotondo, MPH, Partnership for Breast Care, Hartford

Keith Vom Eigen MD, PhD, MPH, University of CT Health Center, Farmington

Michelle Wolf, American Cancer Society, N.E. Div., Wilton



Treatment Committee

Co-Chairs:

Judith Grasso, RN, Lawrence & Memorial Hospital, New London

Andrew Salner, MD, Hartford Hospital, Hartford

Members:

Joyce Bray, New Britain General Hospital, New Britain

Susan Davis, Connecticut Breast Cancer Coalition, Weston

Judi Kulko, RN, University of Connecticut Health Center, Farmington

Beth Mielcarek, RN, MSN, CT Department. of Public Health, Hartford

Dennis Morgan, MD, Phoenix Community Cancer Center, Enfield

N. Chandra Narayanan, MD, St. Francis Hospital, Hartford

Robert Piorkowski, MD, FACS, American College of Surgeons, Hartford

Jean Power, CSW, Cancer Care, Inc., Norwalk

Camille Servodidio, Hartford Hospital, Hartford

Richard Shumway, MD, St. Francis Hospital, Hartford

Andrea Silber, MD, Hospital of Saint Raphael, New Haven

Survivorship Committee

Co-Chairs:

M. Tish Knobf, RN, PhD, Yale School of Nursing, New Haven

Susan Richter, RN, American Cancer Society, N.E. Div., Meriden

Members:

Barry Boyd, MD, Medical Oncologist, Greenwich

Doreen Donahue, LCSW, Middlesex Hospital Cancer Center, Middletown

Maureen Gianni, American Cancer Society, Wilton

Kim Green, CT Komen Race For The Cure, Hartford

Shirley Harkins, RN, ET, Waterbury Hospital, Waterbury

Kate Thomas Hellmuth, ECHN, Manchester

James Kimball, Leukemia and Lymphoma Society, Meriden

Mark L. Kraus, MD, Westside Medical Group, PC, Waterbury

Marion Morra, MA, ScD, Morra Communications, Milford

Irma Nelson, IBM Corporation, Bloomfield

Arlene Quinlan, American Cancer Society, Meriden

Sheila Judge Santacroce, PhD, APRN, Yale University School of Nursing, New Haven

Melissa Seres, MSW, Leever Cancer Center, Waterbury

Maureen Smith, Ombudsman, State of CT, Hartford

Rosemary Spinelli-Reyes, LCSW, Hospital of St. Raphael, Fr. Michael J. McGivney Center for Cancer Care, New Haven

Palliative and Hospice Care Committee

Co-Chairs:

Ruth McCorkle, RN, PhD, Yale University School of Nursing, New Haven

Patricia Trotta, RN, MSN, American Cancer Society, N.E. Div., Meriden

Members:

Nancy Baccaro, RN, MSN, New Britain General Hospital, New Britain

Barbara Dingfelder, RN, CT Department of Public Health, Hartford

James Duffy, MD, University of Connecticut Health Center, Farmington

Maria Gomes, American Cancer Society, N.E. Div., Meriden

Edward Hargus, MD, Pain Management Center, Norwich

Barbara Helming, RN, Hospice of Central Connecticut, Plainville

Pam Kraiza, RN, MS, Connecticut Council for Hospice & Palliative Care, Hartford

Didi Loseth, RN, MSN, Yale New Haven Hospital, New Haven

Jeffrey Mendenhall, RN, BSN, CHPN, Hebrew Home and Hospital, West Hartford

Janet Perry, RN, Hospice of Northeastern Connecticut, Putnam

Tom Salemme, MSW, Connecticut Council for Hospice & Palliative Care, Berlin

Amy Sumner, MSW, The Connecticut Hospice, Inc., Farmington

Nealy Zimmerman, Connecticut Prison Hospice Initiative, New Haven

Debbie Zlatin, MSW, Lawrence & Memorial Hospital, New London

Data, Surveillance, and Evaluation Committee

Co-Chairs:

Brenda Cartmel, PhD, Yale University School of Medicine, New Haven

David Gregorio, PhD, University of Connecticut Health Center, Farmington

Committee Members:

Carol E. Bower, CT Department of Public Health, Hartford

Helen Swede, PhD, CT Tumor Registry, Hartford

CROSS-CUTTING COMMITTEES

At the June, 2005 Annual Meeting of the Connecticut Cancer Partnership, the membership of the above committees was expanded, and three new committees were established to address issues that cut across the entire spectrum of cancer care.

Advocacy Committee

Chair:

Andrew Salner, MD, FACR, Hartford Hospital, Hartford

Members:

Nancy Cappello, PhD, Woodbury

Patricia Dow, Wallingford

Maria Frassinelli-Sierra, MSW, Johnson Memorial Hospital, Enfield

Dawn Holcombe, MBA, FACMPE, ACHE, Oncology Network of CT, LLC, South Windsor

David Koch, Hamden

Betsy Kunz, MSW, LCSW, The Leukemia and Lymphoma Society, CT Chapter, Meriden

Nancy Matthews, Guilford

Jennifer McGarry, MS, The Leukemia and Lymphoma Society, CT Chapter, Meriden

Beth Mielcarek, MSN, RN, CT Community Care, Inc., Waterbury

Marion Morra, MA, ScD, Morra Communications, Milford

Erin Nielson, Bethel

Phyllis Osterman, MS, The Leukemia and Lymphoma Society, CT Chapter, Meriden

Melissia Petro, American Cancer Society, New England Div., Meriden

Mia Samsel, PE, MSCE, Milford

Marilyn Shirley RN, BA, MA, Tolland

Maureen Smith, RN, MS, CT Office of Managed Care Ombudsman, Hartford

Aimee Monroy Smith, American Cancer Society, New England Div., Meriden

Jane Walsh, Gales Ferry

Kathy Walsh, CTR, Manchester Memorial Hospital, Manchester



Communications Committee

Chair:

Marion Morra, MA, ScD, Morra Communications, Milford

Members:

Carol E. Bower, CT Department of Public Health, Hartford

Kristine Diane, LPN, Cancer Information Service of New England, New Haven

Renee Gaudette, Yale Cancer Center, New Haven

William C. Gerrish, CT Department of Public Health, Hartford

Claribel Gibbs, New Britain General Hospital, New Britain

Dawn Holcombe, MBA, FACMPE, ACHE, Oncology Network of CT, LLC, S. Windsor

Kate Langstone BS, MA, American Cancer Society, New England Div., Meriden

Diana Lopez Villegas, EdM, CT Department of Public Health, Hartford

Erin Nielsen, Bethel

Marcia Olsson, Hartford Hospital, Hartford

Deborah Pierce, New Opportunities, Inc., Waterbury

Eve Potts, Essex Historical Society, Essex

Cheryl Rautio, UConn Cooperative Extension System, Brooklyn

Kathryn Shuttleworth, CT Department of Public Health, Hartford

Simone Upsey, American Cancer Society, New England Div., Wilton

Jim Walter, University of CT Health Center, Farmington

Maureen Q. Wolyniec, Quinlan-Wolyniec Consulting, LLC, New Haven



Health Disparities Committee

Co-Chairs:

Maria Gomes, American Cancer Society, New England Div., Meriden
Beth Jones, PhD., MPH, Yale University School of Medicine, New Haven

Members:

Michele Albert, MPH, CHES, Qualidigm, Middletown
Barbara Benjamini, BA, MA, Caroline House, Bridgeport
Rosa Browne, MBA, Yale New Haven Hospital, Middletown
Shelley Carpenter, BS, American Cancer Society, New England Div., Meriden
Patricia DeWitt, MS, Yale New Haven Hospital, New Haven
Linda Drake, MS, UConn Cooperative Extension System, Storrs
Sandra Fisher, RN, BS, Witness Project of Connecticut, Inc., Stratford
Wayne Frederick, MD, University of CT Health Center, Farmington
Katherine Fowler, Windham Regional Community Council, Windham
Valerie Gallo, American Cancer Society, New England Div., Meriden
Sarah Gauger, MPH, CT Department of Social Services, Hartford
Claribel Gibbs, New Britain General Hospital, New Britain
Ingrid Gillespie, Lower Fairfield County Regional Action Council, Stamford
Bruce Gould, MD, University of CT School of Medicine, Farmington
Silvia Hasselt, Greenwich Health at Greenwich Hospital, Greenwich
Pamela Hodge, BS, CT Department of Public Health, Hartford
Russell Leshne, Cancer Information Service of New England., New Haven
Diana Lopez Villegas, EdM, CT Department of Public Health, Hartford
Debra Martin, MSW, ECHN, Women's Center for Wellness, Vernon
Marilyn Moore, Witness Project of Connecticut, Inc., Bridgeport
Carol Palonen, RN, Windham Hospital, Willimantic
Deborah Pierce, New Opportunities, Inc., Waterbury
Markos Samos, MA, LPC, Mashantucket Pequot Tribal Nation, Mashantucket
Andrea Silber, MD, Hospital of Saint Raphael, New Haven
Maureen Smith, RN, MS, CT Office of Managed Care Ombudsman, Hartford
Anne Somsel, RN, MS, Fair Haven Community Health Center, New Haven
Andrea Spanierman, Aflac, Orange
Merle Stoner, BA, American Cancer Society, New England Div., Norwich
Carolyn Washington, NAACP, Waterbury Chapter, Waterbury
Zelda Williams, CT Department of Public Health, Hartford
Donette Wright, MPH, CT Department of Public Health, Hartford



NOTES:



Production of this publication was supported by Cooperative Agreement No. U55/CCU121932-04 from the Centers for Disease Control and Prevention. Its contents are solely the responsibility of the Connecticut Cancer Partnership and do not necessarily represent the official views of the CDC or any other participating entity.

