WISCONSIN'S COMPREHENSIVE CANCER CONTROL PLAN

2005 – 2010

Prevention • Screening & Detection • Treatment
Quality of Life • Palliative Care • Data Collection & Reporting

Acknowledgements

A Special Thank You

To all the cancer survivors, family members and caregivers who shared your experiences with us. This Plan is dedicated to your strong spirits and determination.

The Wisconsin Comprehensive Cancer Control Plan acknowledges the following organizations and individuals for their expertise, time, and energy. Without them this plan could not have been developed. The consensus process was used to develop this plan. Each individual or organization may not agree with every point within this document, but they all support comprehensive cancer control for Wisconsin. We look forward to each partner's continued involvement and support. Together we will reduce the burden of cancer in Wisconsin.

Organizations involved in the Wisconsin Comprehensive Cancer Control Plan

ABC for Health
ABCD: After Breast Cancer Diagnosis
Affinity Health System
African American Health Network of Dane County
American Alliance of Cancer Pain Initiatives
American Cancer Society
American College of Surgeons, Wisconsin
AMSURG – The Milwaukee Endoscopy Center
Aurora Health Care System
BioInnovation, LLC
Breast Cancer Recovery Foundation
Brown County Women's Cancer Coalition
Cancer Information Services
Center for Child and Family Services
Covenant Health Care System
Dane County Department of Human Services
Dean Medical Center
Dodge Jefferson Healthier Community Partnership
End-of-Life Coalition for Southeast Wisconsin
Gerald L. Ignace Indian Health Center
Gilda's Club of Madison, Wisconsin
Green Bay Area Chamber of Commerce
Group Health Cooperative of South Central Wisconsin
Gundersen Lutheran Clinic
HospiceCare, Inc.
Kenosha County Division of Health
La Crosse Area Hmong Mutual Assistance Assoc.
Marshfield Clinic
Medical College of Wisconsin
Memorial Hospital – Prairie du Chien
MetaStar, Inc.
Mile Bluff Medical Center – Mauston
Milwaukee Area Health Education Center
Milwaukee Breast & Cervical Cancer Awareness Program
Milwaukee County Department on Aging
Ministry Health Care – St Joseph's Hospital
National Breast Cancer Coalition
Oncology Alliance S.C.
Oneida Nation Health Facility
Pfizer
Planned Parenthood of Wisconsin
ProHealth Care System
Quintessence
Racine/Kenosha City Health Department
Racine-Kenosha WI Chapter – NBNA, Inc.
Riverview Hospital Association
Sacred Heart Hospital – Eau Claire
SELECT Prostate Cancer Prevention Trial
SmokeFree Wisconsin
St. Croix Tribal Center
St. Francis Hospital – Franklin
St. Michael's Hospital – Milwaukee
Stockbridge – Munsee Health & Wellness Center
TEAMSurvivor Madison
The Alliance
The HOPE of Wisconsin
The Monroe Clinic
The Witness Project of Madison
Tomah Memorial Hospital
Trempealeau County Health Department
United Migrant Opportunity Services
Unity Health Insurance
Unity Hospice & Palliative Care
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University of Wisconsin – Madison
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- Center for Tobacco Research & Intervention
- Center for Women's Health
- Comprehensive Cancer Center
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- Department of Population Health Sciences
- Hospital & Clinics
- LaFollette Institute of Public Affairs
- Public Health and Health Policy Institute
- School of Business
- School of Nursing

University of Wisconsin – Milwaukee
- College of Nursing

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Viterbo University
Waukesha Memorial Hospital
Waupaca Co. Dept. of Health and Human Services
WEA Trust
WI Assoc. of Osteopathic Physicians and Surgeons
Wisconsin Breast Cancer Coalition
Wisconsin Cancer Council
Wisconsin Dept. of Health and Family Services
- Division of Health Care Financing
- Division of Public Health
  - Cardiovascular Health Program
  - Environmental Health Bureau
  - Minority Health Program
  - Regional Offices
  - Tobacco Control Program
  - Wisconsin Well Woman Program

Wisconsin Dietetic Association
Wisconsin Hospital Association
Wisconsin Manufacturers and Commerce
Wisconsin Medical Society
Wisconsin Nurses Association
Wisconsin Ovarian Cancer Alliance
Wisconsin Primary Health Care Association
Wisconsin Public Health Association
Wisconsin Women's Health Foundation
WPS Health Insurance

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Executive Summary

Cancer is the second leading cause of death in Wisconsin. In 2003, almost 26,000 new cases of cancer were diagnosed and 10,800 people lost their lives to this disease. Even though residents of Wisconsin are still getting and dying from cancer, it is not the death sentence it once was. More than half of those who have cancer will survive and each year the number of cancer survivors grows.

Comprehensive cancer control is defined by the Centers for Disease Control and Prevention (CDC) as "an integrated and coordinated approach to reducing cancer incidence, morbidity, and mortality through prevention, early detection, treatment, rehabilitation, and palliation." CDC's National Comprehensive Cancer Control Program (NCCCP) provides funding and technical assistance to states for developing and implementing comprehensive cancer control (CCC).

State cancer plans are the stepping stones for advancing state CCC programs. Each state or tribal health agency develops an individual cancer plan to address its unique cancer burden. In September 2002, Wisconsin's Department of Health and Family Services was awarded a comprehensive cancer control planning grant from the Centers for Disease Control and Prevention. With this grant, diverse partners from all over the state came together in 2003–2004 to develop the Wisconsin Comprehensive Cancer Control Plan (WI CCC Plan).

Wisconsin has an opportunity to look at the gaps between where we have succeeded and where we need to improve in cancer prevention and control. The vision of comprehensive cancer control in Wisconsin is healthier people in Wisconsin by reducing the impact of cancer. Its mission is to create a consortium of public and private partners empowered to develop, implement, and promote a statewide coordinated approach to cancer control. Goals of the Wisconsin Comprehensive Cancer Control Plan are to:

- Reduce the risk of developing cancer.
- Detect cancer at the earliest stage possible.
- Promote access to quality comprehensive cancer care that meets or exceeds national guidelines and standards.
- Optimize the health-related quality of life along the continuum of care for those affected by cancer and their support networks.
- Improve consistency, coordination, and compliance of cancer data reporting and surveillance.

The plan has priorities that were developed from collaborative meetings of stakeholders using cancer-related data specific to Wisconsin. Each priority is followed by the rationale and data on disparate burden used in its development. The priorities have strategies with action plans and recommended implementation steps. Each strategy table in this plan contains the steps that need to be implemented to reach the Wisconsin Comprehensive Cancer Control Plan goals. The Wisconsin Comprehensive Cancer Control Plan Priorities are:

Chapter 1: Prevention
- Decrease tobacco use and exposure to tobacco smoke.
- Promote healthy lifestyles through nutrition and physical activity.
- Promote and encourage protective behaviors from sun and UV exposure.

Chapter 2: Screening and Detection
- Increase colorectal screening rates for those 50 years and older, especially in high-risk populations.
- Increase breast cancer screening rates, especially in high-risk populations.
- Increase cervical cancer screening rates, especially in high-risk populations.
- Increase prostate cancer screening rates for men 50 years and older, especially in high-risk populations.

Chapter 3: Treatment

- Increase access to cancer treatment by reducing economic, geographic, cultural, and systems barriers.
- Encourage adherence by physicians to cancer treatment guidelines.
- Increase awareness of and participation in cancer clinical trials.

Chapter 4: Quality of Life

- Increase reimbursement for services related to quality of life at time of diagnosis and throughout the cancer continuum.
- Provide education that will enhance the understanding of the importance of quality of life in the treatment continuum.
- Assemble data on quality of life to establish best practices in measuring optimal treatment outcomes.

Chapter 5: Palliative Care

- Increase access to palliative care.
- Provide education that will enhance the understanding of palliative care in the treatment continuum.
- Identify best practices for delivering palliative care.

Chapter 6: Data Collection and Reporting

- Promote the collection and use of information to increase professional and public understanding and education about cancer and its impact on Wisconsin residents.
- Increase timeliness of reporting cancer cases to the Wisconsin Cancer Reporting System.
- Improve the quality and completeness of treatment data.
- Improve racial and ethnic cancer data collection.

Cross Cutting Issues

The plan also has cross cutting issues that encompass the continuum of cancer care. These cross cutting issues do not have a separate goal but instead are threaded throughout the priorities, strategies and action plans.

Disparities: Ensure that priorities and strategies developed in this plan work to eliminate health disparities. These include differences in the incidence, mortality, and related adverse health conditions that exist among specific population groups.

Public Policy and Advocacy: Ensure that priorities and strategies developed in this plan include population-based and system changes through public policy and advocacy.

Access to Healthcare: Ensure that priorities and strategies developed in this plan support equal access to services throughout the continuum of cancer for all Wisconsin residents.

Evaluation: Ensure that priorities and strategies developed in this plan are measurable and can show improvement over time.

The plan also contains appendices, located at the end of the plan. Appendices include cancer screening recommendations, Wisconsin's comprehensive cancer control history, Wisconsin demographics, acronyms, definitions, and an audience-specific breakdown of the plan.

The Wisconsin Comprehensive Cancer Control Plan (WI CCC Plan) 2005–2010 will serve as a common framework for action in cancer prevention and control over the next several years. It will provide program leaders, policy makers and researchers with a carefully crafted vision of what needs to be done and the resources needed to reduce the burden of cancer on the people of Wisconsin.

To request a complete Wisconsin Comprehensive Cancer Control Plan, contact

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Introduction

Why did Wisconsin develop a comprehensive cancer control plan?

Cancer is the second leading cause of death in Wisconsin. In 2003, almost 26,000 new cases of cancer were diagnosed and 10,800 people lost their lives to this disease. Even though residents of Wisconsin are still getting and dying from cancer, it is not the death sentence it once was. More than half of those who have cancer will survive and each year the number of cancer survivors continues to grow.

Wisconsin has an opportunity to look at the gaps between where we have succeeded and where we need to improve in cancer prevention and control. This plan represents over 200 diverse partners from all over the state coming together to develop a plan with an integrated and coordinated approach to reducing cancer incidence, morbidity, and mortality through prevention, early detection, treatment, rehabilitation, and palliation. The plan itself is not an end product but instead a guide for how to build a sustained effort to reduce the burden of cancer in Wisconsin. The Wisconsin Comprehensive Cancer Control Plan (WI CCC Plan) 2005–2010 will serve as a common framework for action in cancer prevention and control over the next several years. It will provide program leaders, policy makers and researchers with a carefully crafted vision of what needs to be done and the resources needed to reduce the burden of cancer on the people of Wisconsin.

The Wisconsin Comprehensive Cancer Control Plan hopes to:

- Provide a framework of what needs to be done and the resources needed to reduce the burden of cancer on the people of Wisconsin.
- Highlight important cancer issues for future prioritization – The scope of issues that cancer presents is daunting. The plan covers a wide range of important issues. Ideally, all plan strategies would be implemented to achieve all plan goals. In reality, resources are limited and additional prioritization will be necessary to guide the implementation efforts. In addition, partners and other stakeholders can use the plan to select priorities consistent with their missions.
- Set priorities for improvement – The WI CCC Plan priorities provide direction to ongoing and new efforts in cancer prevention and control. Priorities in the plan were developed for important cancer issues in Wisconsin using state specific data.
- Identify evidence-based strategies to achieve priorities – Effective strategies for prevention, screening and detection, treatment, quality of life, palliative care and data collection and reporting have been identified. For strategies where information on effectiveness is limited, the recommendations of workgroup experts and professional organizations were used to select the appropriate strategies. Strategies that are not supported by research evidence should be evaluated to determine their effectiveness in achieving objectives. There is an opportunity to reduce the burden of cancer by doing more of what is already known to be effective.
- Bring interested partners together to work collaboratively toward shared goals – Reducing Wisconsin's cancer burden may only be realized through integrated and coordinated efforts of partners statewide. Collaboration, both in planning and implementation, will lead to more efficient use of limited resources while ensuring that mutually identified priorities are addressed.
- Identify cost-effective means to implement priorities.
- Use resources more efficiently by integrating and coordinating efforts in order to reduce duplication and expand capacity. Target resources to the data-driven highest priorities.

Who should use this plan?

The Wisconsin Comprehensive Cancer Control Plan: 2005–2010 is a resource and a guide for those who are involved in planning, directing, implementing, evaluating programs or performing research in cancer control in Wisconsin.

To accomplish our 2010 Goals, everyone will need to be involved, but not limited to:

- Business Owners & Employers
- Cancer Survivors
- Caregivers
- Community Based Organizations
- Consumers
- Educators
- Faith Based Organizations
- Government Agencies
- Healthcare Systems
- Media
- Minority and Underserved Populations
- Payers & Insurance
- Physicians & Healthcare Providers
- Professional Organizations
- Public Health Departments
- Public Policy Advocates
- Universities & Researchers
- Wisconsin Residents

Appendix F contains a summary of what each group listed above can implement from the Wisconsin Comprehensive Cancer Control Plan.

What is included in this plan?

- **Chapters:** dedicated to a topic on the continuum of cancer control including: Prevention, Screening and Detection, Treatment, Quality of Life, Palliative Care, and Data Collection and Reporting.
- **Priorities:** listed as sub-topics in each chapter. They were developed by looking at a variety of cancer-related data specific to Wisconsin to show where the CCC Plan should focus. The priority represents the change needed in order to reduce the burden of cancer in Wisconsin.
- **Rationale:** cancer-related data used to develop and justify priorities.
- **Disparate Burden:** summary of cancer data specific to disparately affected or underserved populations.
- **What Can Be Done:** Introduces the strategies needed to accomplish the priority.
- **Targets For Change:** represent the long-term outcome expected from the implementation of the strategies.
- **Strategies:** evidence-based approach to address the priority. Each strategy has a table with: **Action Plans** and **Recommended Implementation Steps** needed to be put in place for the strategy to be accomplished.

Background

Comprehensive Cancer Control – A National Effort

Comprehensive cancer control is defined by the Centers for Disease Control and Prevention (CDC) as "an integrated and coordinated approach to reducing cancer incidence, morbidity, and mortality through prevention, early detection, treatment, rehabilitation, and palliation." CDC's National Comprehensive Cancer Control Program (NCCCP) provides funding and technical assistance to states for developing and implementing comprehensive cancer control. This national program is an emerging model that integrates a range of cancer control activities to maximize the use of limited resources to achieve desired cancer prevention and control outcomes. Since 1998, the number of programs participating in CDC's NCCCP has grown from six to 61. With this support, state and tribal health agencies continue to establish broad-based coalitions, assess the burden of cancer, determine priorities for cancer prevention and control, and develop and implement comprehensive cancer control (CCC) plans.

State cancer plans are the stepping stones for advancing state CCC programs. Each state or tribal health agency develops an individual cancer plan to address its unique cancer burden. As states or tribal health agencies implement cancer plans, they integrate expertise and efforts from many disciplines: basic and applied research, evaluation, health education, program development, public policy, surveillance, clinical services, and health communications. More on the National Comprehensive Cancer Control Program can be found in Appendix B and on the CDC's website: www.cdc.gov/cancer.

Development of the Wisconsin Comprehensive Cancer Control Plan

Wisconsin has been actively engaged in cancer control planning and program development over the last 30 years (See Appendix B). In 2002, comprehensive cancer control planning in Wisconsin re-energized with a small group attending the CDC sponsored Leadership Institute and then applying for the CDC planning grant for the WI CCC Plan. In September of that year, Wisconsin's Department of Health and Family Services was awarded a comprehensive cancer control planning grant from the Centers for Disease Control and Prevention. In early 2003, The Core Planning Team, with representatives from the Wisconsin Division of Public Health (DPH), Wisconsin Cancer Council, the UW Comprehensive Cancer Center and the American Cancer Society, convened to discuss the initial planning framework. The UW Comprehensive Cancer Center and DPH then hired a CCC program director and began to develop a planning infrastructure.

The WI CCC Plan needed a decision making body with representatives from many cancer control organizations around the state. The Steering Committee came together in November 2003 to provide leadership and support to the plan's development. The Steering Committee approved the overall planning framework. They also developed the mission, vision, goals and cross cutting issues for the WI CCC Plan.

Vision

Healthier people in Wisconsin by reducing the impact of cancer.

Mission

Create a consortium of public and private partners empowered to develop, implement, and promote a statewide coordinated approach to cancer control.

Goals

- Reduce the risk of developing cancer.
- Detect cancer at the earliest stage possible.
- Promote access to quality comprehensive cancer care that meets or exceeds national guidelines and standards.
- Optimize the health-related quality of life along the continuum of care for those affected by cancer and their support networks.
- Improve consistency, coordination, and compliance of cancer data reporting and surveillance.

Cross Cutting Issues

These cross cutting issues do not have a separate goal but instead are threaded throughout the priorities, strategies and action plans.

- ***Disparities:*** Ensure that priorities and strategies developed in this plan work to eliminate health disparities. These include differences in the incidence, mortality, and related adverse health conditions that exist among specific population groups. In Wisconsin, these population groups may be characterized by gender, age, race, ethnicity, education, income, social class, disability, geographic location, or sexual orientation.
- ***Public Policy and Advocacy:*** Ensure that priorities and strategies developed in this plan include population-based and system changes through public policy and advocacy.
- ***Access to Healthcare:*** Ensure that priorities and strategies developed in this plan support equal access to services throughout the continuum of cancer care for all Wisconsin residents.
- ***Evaluation:*** Ensure that priorities and strategies developed in this plan are measurable and can show improvement over time.

In Fall 2003, the Cancer Data Advisory Group (CDAG) came together to look at the data for Wisconsin to identify priorities and inform decision-making. They wrote the Priority Recommendation Report to reflect these emerging priorities and the rationale behind each one. The priorities are data-based and organized to support a continuum of cancer control and cross cutting issues unique to Wisconsin. The Steering Committee then discussed, revised and approved the priorities.

WI CCC Plan Priorities

Prevention

- Decrease tobacco use and exposure to tobacco smoke.
- Promote healthy lifestyles through nutrition and physical activity.
- Promote and encourage protective behaviors from sun and UV exposure.

Screening and Detection

- Increase colorectal screening rates for those 50 years and older, especially in high-risk populations.
- Increase breast cancer screening rates, especially in high-risk populations.
- Increase cervical cancer screening rates, especially in high-risk populations.
- Increase prostate cancer screening rates for men 50 years and older, especially in high-risk populations.

Treatment

- Increase access to cancer treatment by reducing economic, geographic, cultural, and systems barriers.
- Encourage adherence by physicians to cancer treatment guidelines.
- Increase awareness of and participation in cancer clinical trials.

Quality of Life

- Increase reimbursement for services related to quality of life at time of diagnosis and throughout the cancer continuum.
- Provide education that will enhance the understanding of the importance of quality of life in the treatment continuum.
- Assemble data on quality of life to establish best practices in measuring optimal treatment outcomes.

Palliative Care

- Increase access to palliative care.
- Provide education that will enhance the understanding of palliative care in the treatment continuum.
- Identify best practices for delivering palliative care.

Data Collection and Reporting

- Promote the collection and use of information to increase professional and public understanding and education about cancer and its impact on Wisconsin residents.
- Increase timeliness of reporting cancer cases to the Wisconsin Cancer Reporting System.
- Improve the quality and completeness of treatment data.
- Improve racial and ethnic cancer data collection.

On March 18, 2004, 200 participants from healthcare, public health agencies, community based organizations, businesses, universities and other organizations came together at the CCC Kick Off Summit as a statewide coalition to begin work on Wisconsin's plan for comprehensive cancer control. Workgroups were formed around the areas of prevention, screening and detection, treatment, quality of life, palliative care, and data collection and reporting. These workgroups developed strategies and action plans to address the priorities of the Wisconsin Comprehensive Cancer Control Plan.

Each of the workgroups had participants with knowledge and experience in the specific areas of comprehensive cancer control. The workgroup members recommended appropriate strategies by looking at:

- what has worked well in the past both in Wisconsin and in other states,
- what new strategies should be considered,
- what is the action plan for implementing the strategies, and
- what are the key indicators of success.

The products of each workgroup's efforts are the strategies with action plans and recommended implementation steps for each. These tables contain the steps that need to be implemented to reach the WI CCC Plan goals. Since the scope of the plan is broad and resources are limited, it will be necessary to set priorities among plan priorities, strategies and action plans.

Implementation of the Wisconsin Comprehensive Cancer Control Plan

Strategies and action plans will be prioritized for implementation from the plan by the Steering Committee through a systematic process using specific, measurable criteria (e.g., the magnitude of the burden, the strength of evidence suggesting an effective solution exists, the likelihood that interventions will lead to significant improvements, the presence of major gaps in current efforts, and the existence of disparate burden). The resulting priorities will set the direction for the initial implementation efforts of the statewide coalition.

In April 2005, the statewide coalition that came together to kick off the planning process in March 2004 will once again convene in a daylong "Transition to Implementation" Summit. From this summit, action plans for the next five years of who will be doing what activities from the WI CCC Plan will be identified. These action plans will be posted on the WI CCC Plan website. They will also be the foundation for evaluating the implementation of the WI CCC Plan.

To assure the continued implementation of this plan, we must maintain our current coalition of public and private partners empowered to develop, implement, and promote the WI CCC Plan. With this group, successful implementation will include:

- Sustaining and growing the current coalition to include key decision-makers in cancer prevention and control.
- Assuring leadership and accountability with implementation of the plan.
- Promoting the WI CCC Plan with key decision-makers and healthcare consumers in Wisconsin.
- Obtaining additional funding for comprehensive cancer control efforts in Wisconsin.
- Continually evaluating our implementation progress and adjusting our action plans as needed.

Evaluation of the Wisconsin Comprehensive Cancer Control Plan

The purpose of developing and implementing the WI CCC Plan is ultimately to reduce cancer incidence, morbidity, and mortality and to improve the quality of life for those affected by the disease. The plan and its implementation must be evaluated to ensure that:

- Strategies are being appropriately implemented,
- Priorities are being addressed and
- 2010 targets for change are being achieved.

Wisconsin's Comprehensive Cancer Control Planning and Implementation Evaluation

CCC Plan	CCC Plan Implementation	Impacts and Outcomes
If we develop an evidence-based plan…	**To integrate and coordinate efforts as we implement the plan…**	**THEN we may produce these impacts and achieve these outcomes…**
Provides a framework and guide for coordinated and integrated action Highlights important cancer issues across the continuum Sets priorities and goals for improvement Proposes evidence or theory-based strategies Catalyzes existing partnership and potential partners to take action	Mobilize current partnership and resources Recruit new partners and resources Implement strategies and action plans targeting mutually identified priorities	IMPACTS Changes in knowledge, attitudes, behaviors, practices, or policies within environments, systems, and individuals SHORT TERM OUTCOMES • Reduce the risk of developing cancer. • Detect cancer at the earliest stage possible. • Promote access to quality comprehensive cancer care that meets or exceeds national guidelines and standards. • Optimize the health-related quality of life along the continuum of care for those affected by cancer and their support networks. • Improve consistency, coordination, and compliance of cancer data reporting and surveillance. LONG TERM OUTCOMES • Decrease morbidity/mortality. • Decrease direct health care costs. • Increase access to care throughout the cancer continuum. • Increase employee productivity (part of indirect health care costs). • Increase years of life and quality of life. • Decrease disparate burden of cancer on minority populations. • Increase our ability to collect and use data.

Chapter 1: PREVENTION

Decrease Tobacco Use and Exposure to Tobacco Smoke

Rationale

In 2000, over 7,000 Wisconsin residents died from smoking-related diseases, making tobacco use the single most preventable cause of disease and premature death.[2] Smoking is responsible for an estimated 1/3 of all cancer deaths.[1] Lung cancer is the leading cause of cancer mortality in Wisconsin.[1] The 2,600+ deaths each year from cancer of the lung and bronchus represent more than a quarter of all cancer deaths. Lung cancer is also among the most preventable cancers, as tobacco use is responsible for an estimated 87% of lung cancers cases.[1] In addition to lung cancer, smoking causes cancers of the larynx, mouth, esophagus, pharynx, and bladder, and contributes to cancers of the pancreas, kidney, and cervix. Secondhand smoke has been shown to cause cancer among non-smokers as well.

Smoking is a problem that often begins in youth. More than 90% of smokers in Wisconsin begin to smoke before age 20.[1] The proportion of Wisconsin high school students who reported being a current smoker (smoking at least once a day for the past 30 days) remained high throughout the 1990s (39% of males and 38% of females smoked in 1999). Since 2000, steady progress has been made in reducing youth smoking. In Wisconsin, there has been a decline in high school smoking rates for both genders.

It is also clear that smoking is an addiction; according to the University of Wisconsin, Center for Tobacco Research and Intervention (CTRI), 70% of Wisconsin smokers have tried to quit; and 50% try to quit each year.[1] There was little change in the prevalence of adult smoking in the last ten years (27% of men and 23% of women in 1993 vs. 24% of men and 20% of women in 2003).

Current Rates of Tobacco Use in WI

Middle School (2004)	12.7%[a]
High School (2004)	27.8%[a]
Adult (2003)	22.0%[b]

Sources:
a. Wisconsin Youth Tobacco Survey, Department of Health and Family Services, Wisconsin Tobacco Prevention and Control Program.

b. Wisconsin Behavioral Risk Factor Surveillance System, Department of Health and Family Services, Bureau of Health Information.

Disparate Burden

There is a disparate burden of tobacco use by race, income and education. American Indians have the highest smoking rate (48%) of all racial/ethnic groups in Wisconsin.[3] 27% of African Americans, 25% of Hispanics, 23% of whites and 23% of Asian/Pacific Islanders smoke.[3] Persons with an average household income of less than $15,000 per year have a smoking prevalence rate (39%) more than double the rate of persons with a household income over $50,000 (16%).[3] Nationally, among those with a master's degree or higher, only 8% smoked, compared to 47% of those with a GED or less education.[3]

Lung cancer mortality disproportionately affects some population subgroups. Age-adjusted death rates are higher in Wisconsin among African Americans (80.9 per 100,000) and American Indians (64.8 per 100,000) than among Whites (48.5 per 100,000).[1] African American lung cancer rates are also higher (93.5 per 100,000 for incidence and 79.2 per 100,000 for mortality) than white rates (60.9 per 100,000 for incidence and 48.7 per 100,000 for mortality).[1]

What Can Be Done?

The Wisconsin Department of Health and Family Services' Tobacco Control Program coordinates a comprehensive, statewide effort, with multiple partnerships at the local, state and national level. The following strategies match those already in place by the Wisconsin Tobacco Control program. It is the intent of the WI CCC Plan to fully support the existing tobacco control program in Wisconsin in their efforts to:

- Decrease youth tobacco use and support tobacco addiction treatment by establishing a tobacco user's fee.
- Protect all employees from the dangers of secondhand smoke by increasing the number of smoke-free workplaces in Wisconsin.
- Help tobacco users quit by increasing access to affordable tobacco addiction treatment.
- Fund a comprehensive tobacco prevention and control program.

Targets for Change

LUNG CANCER

Reduce deaths from lung cancer

WI Mortality Rate (1999–2000)	Healthy People 2010 Target	Percent Decrease Needed to Achieve Healthy People 2010 Goal in WI
49.5%	44.9%	9%

Sources:
American Cancer Society. Wisconsin Cancer Facts and Figures 2003-2004 Pewaukee, WI. 2003.

U.S. Department of Health and Human Services. Healthy People 2010. 2nd ed. With Understanding and Improving Health and Objectives for Improving Health. 2 vols. Washington, DC: U.S. Government Printing Office, November 2000.

1. Rates are averaged per 100,000 population and age-adjusted to the 2000 U.S. standard population.

2. Refer to Understanding Cancer Incidence and Mortality Rates (WI Cancer F&F, pages 6-8) for explanation and cautionary notes.

3. Total gender specific sites are shown for a single sex.

TOBACCO USE

Reduce adult tobacco use by 20%

WI Rate (1999–2000)	Healthiest Wisconsin 2010 Target	Percent Decrease Needed to Achieve Healthiest Wisconsin 2010 Target
24%	19.2%	20%

Reduce high school tobacco use by 25%

WI Rate (1999–2000)	Healthiest Wisconsin 2010 Target	Percent Decrease Needed to Achieve Healthiest Wisconsin 2010 Target
39%	29.25%	25%

Reduce middle school tobacco use by 25%

WI Rate (1999–2000)	Healthiest Wisconsin 2010 Target	Percent Decrease Needed to Achieve Healthiest Wisconsin 2010 Target
16%	12%	25%

Sources:
Report by the Wisconsin Turning Point Transformation Team to the Wisconsin Department of Health and Human Services. Wisconsin State Health Plan, Healthiest Wisconsin 2010: A Partnership Plan to Improve the Health of the Public. 2000–2010

Wisconsin Behavioral Risk Factor Surveillance System, Department of Health and Family Services, Bureau of Health Information.

Wisconsin Youth Tobacco Survey, Department of Health and Family Services, Wisconsin Tobacco Prevention and Control Program.

SMOKE-FREE ORDINANCES

Wisconsin smoke-free restaurant ordinances, 2005

Ashland, Bristol, Eau Claire, Fond du Lac, Holmen, Janesville, Kenosha, La Crosse (City), La Crosse County, Madison, Middleton, Neenah, Onalaska, Oshkosh, Phillips, River Falls, Shorewood Hills, Wauwatosa, and West Salem.

Wisconsin smoke-free workplace ordinances, 2005

2005 Ordinances	2010 Target
2 (Madison and Bristol)	20

Sources:
Smoke-Free Wisconsin website: www.smokefreewi.org

STRATEGY A: Decrease youth tobacco use and support tobacco addiction treatment by establishing a tobacco user's fee.	
Action Plan	**Recommended Implementation Steps**
Support adoption of a $1 per pack increase in the price of cigarettes as a user's fee.	Support the Wisconsin's Children's Initiative, led by SmokeFree Wisconsin.
	Designate revenues from this user's fee increase to tobacco prevention programs and other tobacco-related health costs.

STRATEGY B: Protect all employees from the dangers of secondhand smoke by increasing the number of smoke-free workplaces in Wisconsin.	
Action Plan	**Recommended Implementation Steps**
Support adoption of local smoke-free workplace ordinances in 20 communities.	Support local communities as they work to pass smoke-free workplace ordinances.
Establish a state law making all government buildings smoke-free.	Support statewide tobacco prevention and control efforts to make all government buildings smoke-free.

STRATEGY C: Help tobacco users quit by increasing access to affordable tobacco addiction treatment.

Action Plan	Recommended Implementation Steps
Increase usage of the WI Quit Line and Fax to Quit Programs. WI Tobacco Quit Line: 1-877-270-STOP (7867) 1-877-2NO-FUME (266-3863) American Cancer Society Quit Line: 1-877-YES-QUIT (937-7848)	Support the University of Wisconsin Center for Tobacco Research and Intervention and others in promoting the treatment of tobacco addiction in Wisconsin.
Involve health care providers in promoting tobacco addiction treatment.	
Insurers, including Medicaid, and purchasers will report covering all effective tobacco addiction treatments as identified in the Clinical Practice Guideline.[4]	
Develop a plan for integrating tobacco addiction treatment into private and public mental health and Alcohol and Other Drug Abuse (AODA) treatment systems.	

STRATEGY D: Fund a comprehensive tobacco prevention and control program.

Action Plan	Recommended Implementation Steps
Build grassroots and grass-top support to advocate for $31 million from Wisconsin revenues for a comprehensive tobacco prevention and control program.	Support the development of a comprehensive tobacco prevention and control program consistent with CDC funding recommendations.

Promote Healthy Lifestyles through Nutrition and Physical Activity

Rationale

Similar to tobacco use, unhealthy diets and sedentary lifestyles are estimated to account for 1/3 of all cancer deaths.[5] Poor nutrition and lack of physical activity lead to obesity. Obesity increases the risk of many chronic diseases including many cancers.

These lifestyle factors are important for cancer prevention not only because of their contribution to morbidity and mortality, but also because they are modifiable. Despite this, poor choices in nutrition, limited physical activity, and excess body weight are the norm rather than the exception. Nearly 80% of Wisconsin's adult population does not eat the recommended five or more servings of fruits and vegetables each day, and this proportion is even higher among high school students (82%) and younger adults age 18-34 (85%).[1] More than half (53%) of Wisconsin adults are physically inactive or do not engage in regular physical activity.[1] The percentage of the population carrying excess body weight has increased dramatically in the last decade, such that six out of ten Wisconsin adults are now overweight (39%) or obese (22%).[1]

Disparate Burden

It is also recognized that many of these lifestyle risk factors occur disproportionately among some subpopulations. All races reported a similar percentage of the population not eating five servings of fruits and vegetables a day (about 80%).[1] The prevalence of overweight in ages 2-5 years was highest among American Indian (18.1%), Asian (17.7%), and Hispanic (15.3%) children. The rates were lowest among white (10.4%) and black (8.4%) children.[6] The prevalence of sedentary lifestyle is inversely related to both education and income, and the prevalence of obesity is highest among those who did not attend college. African Americans have substantially higher rates of sedentary lifestyle (67%) and obesity (35%) than other races.[1]

What Can Be Done?

Wisconsin is developing a Nutrition and Physical Activity Plan that coordinates a comprehensive, statewide effort, with multiple partnerships at the local, state and national level. The following strategies match those being developed by the Wisconsin Nutrition and Physical Activity workgroup. It is the intent of the WI CCC Plan to not duplicate but be fully supportive of the upcoming Wisconsin Department of Health and Family Services' Nutrition and Physical Activity Program's efforts to:

- Encourage adequate and appropriate nutrition for healthy weight.
- Create active community environments.

Targets for Change

PHYSICAL ACTIVITY

Increase the proportion of children and adolescents who engage in at least 30 minutes of moderate physical activity, on 5 or more of the previous 7 days		
WI Rate 2000	Healthiest Wisconsin 2010 Target	Percent Increase Needed to Achieve Healthiest Wisconsin 2010 Target
27%	37%	37%

Increase the proportion of adults who engage regularly, preferably daily, in moderate physical activity for 30 minutes or more per day		
23%	38%	65%

Sources:
Report by the Wisconsin Turning Point Transformation Team to the Wisconsin Department of Health and Human Services. Wisconsin State Health Plan, Healthiest Wisconsin 2010: A Partnership Plan to Improve the Health of the Public. 2000–2010.

Wisconsin Behavioral Risk Factor Surveillance System, Department of Health and Family Services, Bureau of Health Information.

NUTRITION

Increase the proportion of adults who eat 5 or more fruits and vegetables per day		
WI Rate 2000	Healthiest Wisconsin 2010 Target	Percent Increase Needed to Achieve Healthiest Wisconsin 2010 Target
22%	28%	18%

Increase the proportion of high schoolers who eat 5 or more fruits and vegetables per day		
28%	34%	18%

Sources:
Report by the Wisconsin Turning Point Transformation Team to the Wisconsin Department of Health and Human Services. Wisconsin State Health Plan, Healthiest Wisconsin 2010: A Partnership Plan to Improve the Health of the Public. 2000–2010.

Wisconsin Behavioral Risk Factor Surveillance System, Department of Health and Family Services, Bureau of Health Information.

OBESITY

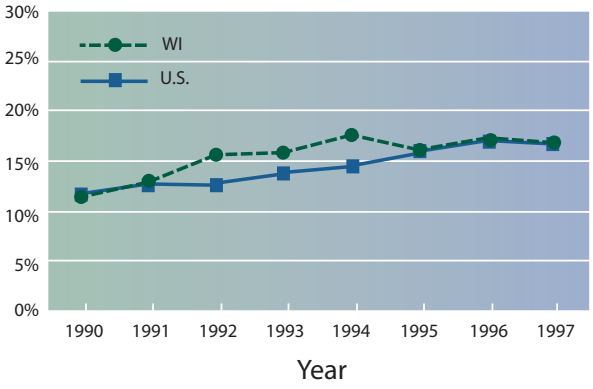
Reduce the proportion of children who are overweight		
WI Rate 2000	Healthiest Wisconsin 2010 Target	Percent Decrease Needed to Achieve Healthiest Wisconsin 2010 Target
11.4%	9.4%	17.5%

Reduce the proportion of adolescents (ages 12-19) who are overweight		
10%	8%	20%

Reduce the proportion of adults who are obese		
20%	15%	25%

TRENDS IN OBESITY

Trends in Obesity in Wisconsin Adults, Wisconsin and U.S., 1990–2001



Sources:
Behavioral Risk Factor Surveillance System, Department of Health and Family Services, Bureau of Health Information.

1. Obesity is defined as a body mass index of 30 kg/m2 or more.

STRATEGY A: Encourage adequate and appropriate nutrition for healthy weight.	
Action Plan	**Recommended Implementation Steps**
Promote school-based interventions that reduce intake of high fat and high sugar foods and increase fruit/vegetable consumption.	Increase availability, attractiveness and variety of fruits and vegetables in school lunch programs.
	Offer incentives and pricing strategies that encourage consumption of fruits and vegetables in schools.
	Support nutritious breakfast, lunch and snack programs to all students in all schools.
	Provide effective, consistent nutrition education for staff, students and parents.
	Adopt policies to decrease access to high fat and high sugar foods.
Promote healthy eating options at worksites.	Educate employers and vending companies about the value of providing low fat/low calorie nutritious snacks in vending machines.
	Offer incentives and pricing strategies that encourage consumption of fruits and vegetables in the workplace.
Promote healthy eating within the community.	Utilize grocery store and restaurant point of purchase prompts, product placement, and nutrition education.
	Increase availability of fruits and vegetables through community gardens, community recoupment programs, free seed programs, free window gardening kits, senior and WIC farmers markets.
	Initiate or support current nutrition coalitions that promote policy change for the treatment of obesity and nutrition.
	Collaborate with the 5 A Day Campaign and implement the 5 A Day action plan.
	Promote dietary guidelines and food guides.
	Develop a campaign on healthy eating with emphasis on healthy weight, portion control, etc.
	Provide ongoing public access to nutrition information through multiple communication channels.

STRATEGY B: Create active community environments.

Action Plan	Recommended Implementation Steps
Increase physical activity in schools.	Enhance physical education classes by promoting increased length, activity level and enforcement of state requirements.
	Increase other opportunities for physical activity in schools including integration of physical activity across the curriculum and in after school programs.
	Promote safe routes to schools that encourage walking or biking to school.
Create worksite opportunities that help employees to incorporate physical activity into their lives.	Promote worksite facility design to provide walking opportunities.
	Provide flexible lunch/breaks to help incorporate physical activity into daily routings.
	Provide wellness education at worksites.
Promote opportunities for safe physical activity within neighborhoods and the community.	Create and improve access to places of physical activity (i.e. creating walking trails, exercise facilities, providing access to existing facilities).
	Provide social support in community settings, such as building social networks or walking groups.
	Initiate or support current physical activity coalitions that work on policy change.
	Promote community-wide physical activity campaigns with consistent, culturally relevant messages delivered through multiple channels.

Promote and Encourage Protective Behaviors from Sun and UV Exposure

Rationale

Skin cancer is the most common form of cancer in the United States. Most of the mortality from skin cancer (9,800 deaths nationally, 140 deaths in Wisconsin) annually, is due to melanoma. Death rates from melanoma in Wisconsin (2.6 per 100,000) are similar to those for the U.S. (2.7 per 100,000).[1] The number of melanomas diagnosed in the U.S., as well as Wisconsin, is increasing. Since 1990, the number of melanomas annually in Wisconsin has almost doubled from 360 to 700. Melanomas develop more often when skin has been damaged by exposure to ultraviolet radiation (sunlight). Nearly all skin cancers are preventable by limiting direct exposure to the sun.

Disparate Burden

Although anyone can get skin cancer, the risk is greatest for people who have fair skin that freckles easily, often those with red or blond hair and blue or light-colored eyes. The risk of melanoma is more than twenty times higher for whites than African Americans. Incidence is higher for men than for women overall, but young women have higher rates than young men. The national incidence rate for men is 22.5 per 100,000 men compared with 14.4 per 100,000 for women. Approximately 60% of melanoma deaths occurred in men and 40% of deaths occurred in women.[1]

What Can Be Done?

- Establish programs focused on protecting youth from sun and UV exposure.
- Explore areas of policy changes regarding sun exposure and UV protection.

Targets for Change

The Youth Risk Behavior Surveillance System (YRBSS) does not currently collect data on youth sun protective behaviors. The goal by 2010 is to establish a measure for youth.

SUNBURNS		
WI adults who have had sunburn in the past 12 months		
1999	2003	2010 Target
48%	40%	35%

Sources:
Wisconsin Behavioral Risk Factor Surveillance System, Department of Health and Family Services, Bureau of Health Information.

SKIN CANCER		
Reduce deaths from skin cancer (melanoma)		
WI Mortality Rate (1996–2000)	Healthy People 2010 Target	Percent Decrease Needed to Achieve Healthy People 2010 Goal in WI
2.6%	2.5%	4%

Sources:
American Cancer Society. Wisconsin Cancer Facts and Figures 2003–2004. Pewaukee, WI. 2003.

U.S. Department of Health and Human Services. Healthy People 2010. 2nd ed. With Understanding and Improving Health and Objectives for Improving Health. 2 vols. Washington, DC: U.S. Government Printing Office, November 2000.

1. Rates are averaged per 100,000 population and age-adjusted to the 2000 U.S. standard population.

STRATEGY A: Establish programs focused on protecting youth from sun and UV exposure.	
Action Plan	**Recommended Implementation Steps**
Collect data on sun exposure behaviors in youth.	Expand surveillance systems (YRBSS, YTS) to establish baseline of sun exposure behaviors.
	Establish a surveillance system for monitoring progress with sun exposure intervention programs.
Develop community-based interventions to increase sun protective behaviors in youth.	Involve key collaborators (Health professionals, parents, daycare providers, dermatologists, meteorologists, educators, recreation departments, school athletic associations and youth clubs) to develop new community-based sun protection programs.
	Identify any current community-based interventions.
	Catalog proven and available programs and resources.

STRATEGY B: Explore areas of policy changes regarding sun exposure and UV protection.	
Action Plan	**Recommended Implementation Steps**
Increase the number and type of public park/recreation sun protection policies.	Convene a workgroup to establish the number of parks and recreation departments with sun and UV protection policies.
	Research and present effective park and recreation sun protection policies.
	Encourage local governments to enact these policies.
Develop occupational safety plans emphasizing sun protection for seasonal outdoor workers.	Convene a workgroup (with employers and other key stakeholders) to research and present effective occupational safety plans that emphasis sun protection.
	Establish a baseline with the number of employers with occupational safety plans emphasizing sun and UV protection for seasonal workers.

References

1. American Cancer Society. *Wisconsin Cancer Facts and Figures* 2003–2004. Pewaukee, WI. 2003. Available from: www.cancer.org

2. Wisconsin Division of Public Health, University of Wisconsin Comprehensive Cancer Center, American Cancer Society and Wisconsin Tobacco Control Board. *The Burden of Tobacco in Wisconsin Fact Sheet*. 2002 Feb. Available from: www.dhfs.state.wi.us/health/TobaccoControl/pdffiles/BurdenofTobaccoinWI2000Summary.pdf

3. Wisconsin Department of Health and Family Services, Wisconsin Tobacco Control Disparities Strategic Planning Workgroup. Bringing Everyone Along: *A Strategic Plan to Identify and Eliminate Tobacco-Related Disparities in Wisconsin*. 2002 Dec. Available from: www.dhfs.state.wi.us/health/TobaccoControl/pdffiles/DisparitiesStrategicPlan.pdf

4. Agency for Healthcare Research and Quality. Clinical Practice Guideline for Tobacco Cessation (no. 18). Available from: www.ahcpr.gov/clinic/cpgarchv.htm

5. Byers T, Mouchawar J, Marks J, et al. The American Cancer Society Challenge Goals: How Far Can Cancer Rates Decline in the U.S. by the Year 2015? *Cancer*. 1999; 86(4):715-727.

6. Polhamus B, Dalenius K, Thompson D, Scanlon K, Borland E, Smith B, Grummer-Strawn L. *Pediatric Nutrition Surveillance 2001 Report*. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. 2003. Available from: www.cdc.gov/nccdphp/dnpa/pdf/2001_ped_nutrition_report.pdf

Chapter 2: SCREENING & DETECTION

Increase Colorectal Screening Rates For Those 50 Years and Older, Especially in High-Risk Populations

Rationale

Colorectal cancers can almost always be cured if detected early. The American Cancer Society recommends that adults age 50 and older (at average risk) get screened for colorectal cancer. Unfortunately, fewer than 44 percent of Americans age 50 and older follow the recommended screening guidelines. The percentage of Wisconsin adults over 50 having had a sigmoidoscopy within the last five years increased 10% from 1999 to 2000 but still less than half (45%) have had the procedure.[5] More than 90 percent of people survive colorectal cancer when it is diagnosed before it spreads beyond the intestinal wall. In 1996–2000, about 35 percent of invasive colorectal cancers diagnosed in Wisconsin were at an early stage, compared to 77 percent for prostate cancer and 64 percent for breast cancer.[1] Mortality rates have dropped from 26.8 per 100,000 in 1990, to 20.8 in 2000.[1] Increased use of sigmoidoscopy and colonoscopy has contributed to the decline in mortality rates. Screening for colorectal cancer can also result in detection and removal of pre-invasive or pre-cancerous lesions, thereby preventing the development of invasive carcinoma and reducing the risk of subsequent cancer mortality.[5] It has been estimated that a 9-14% reduction in the incidence of colorectal cancer could be achieved by 2015 through reasonable improvements in screening utilization.[5]

Disparate Burden

African Americans in Wisconsin had moderately higher colorectal cancer incidence rates than whites (64.5 per 100,000 compared to 58.3 per 100,000), but experienced almost a 50 percent higher mortality rate than whites (29.1 per 100,000 compared to 20.7 per 100,000).[1] American Indian men faced the greatest risk of colorectal cancer with an age-adjusted rate of 112 per 100,000; the comparable rate for white men was 70 per 100,000.[7] Among women, African Americans had the greatest risk for colorectal cancer and Hispanic women were less likely than white women to be diagnosed with colorectal cancer.[7] The reasons behind the incidence and mortality disparities between whites and non-whites are not clearly defined.

Colorectal Cancer Screening Rates by Race 2001–2002

African American = 45% (± 8%)

White = 47% (± 2%)

Total = 46% (± 2%)

Sources:
Wisconsin Behavioral Risk Factor Surveillance System, Department of Health and Family Services, Bureau of Health Information.

Explanations vary from information on incidence reports and death certificates to differences among socio-economic, lifestyle, environmental, genetic, occupational and dietary factors. Access to care and timing of diagnoses (late stage diagnoses reduces treatment options and chances of long-term survival) are also important aspects in determining reasons for the disparities.

What Can Be Done?

- Develop a public awareness campaign for colorectal cancer screening.
- Promote system changes that will increase colorectal cancer screening.
- Increase the availability of colorectal screening to populations facing geographic, economic, or cultural barriers.

Targets for Change

COLORECTAL CANCER		
Reduce deaths from colorectal cancer		
WI Mortality Rate (1996–2000)	Healthy People 2010 Target	Percent Decrease Needed to Achieve Healthy People 2010 Goal in WI
21%	13.9%	34%

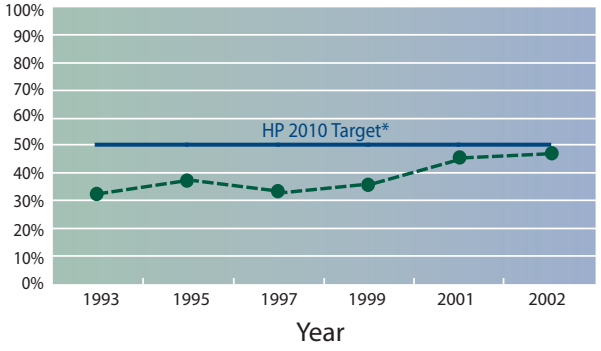
Sources:
American Cancer Society. Wisconsin Cancer Facts and Figures 2003–2004. Pewaukee, WI. 2003.

U.S. Department of Health and Human Services, Healthy People 2010. 2nd ed. With Understanding and Improving Health and Objectives For Improving Health. 2 vols. Washington D.C: U.S. Government Printing Office, November 2000.

1. Rates are averaged per 100,000 population and age-adjusted to the 2000 U.S. standard population.

COLORECTAL CANCER SCREENING

Colorectal Cancer Screening Among Persons in Wisconsin Aged 50+ Years who have had a Sigmoidoscopy or Colonoscopy Within Past 5 Years



Sources:
Wisconsin Behavioral Risk Factor Surveillance System, Department of Health and Family Services, Bureau of Health Information, American Cancer Society, Wisconsin Facts and Figures 2003–2004. Pewaukee, WI. 2003. Fig. 19, p. 23.

U.S. Department of Health and Human Services, Healthy People 2010. 2nd ed. With Understanding and Improving Health and Objectives For Improving Health. 2 vols. Washington D.C: U.S. Government Printing Office, November 2000.

CR Screening questions were asked in 1993, 1995, 1997, 1999, 2002. 1993, 1995, 1997 the question asked if person received a prostoscopy, but not sigmoidoscopy. 1999 the question asked if person received a sigmoidoscopy or prostoscopy. 2001, 2002 the question asked if the person received a sigmoidoscopy or colonoscopy.

* Healthy People 2010 Goal is for adults over 50 yrs old who have received a sigmoidoscopy.

STRATEGY A: Develop a public awareness campaign.	
Action Plan	**Recommended Implementation Steps**
Develop an education and awareness campaign to increase the number of adults receiving colorectal cancer screenings.	Convene key stakeholders, such as advocacy groups, healthcare organizations and other partners to develop this campaign.
	Provide information on: • who is at risk • role of early detection in preventing colorectal cancer • who needs screening • what are the risk factors • what screening tests are available • how you can obtain screening
	Enlist statewide media support with identified community groups to provide consumer-centered awareness messages.

STRATEGY B: Promote system changes that will increase colorectal cancer screening.	
Action Plan	**Recommended Implementation Steps**
Partner with health care organizations to enact health care delivery system changes. Partners should include HMOs, group practices, professional organizations, WI Colorectal Cancer Task Force, primary care physicians, nurse practitioners, other organizations, etc.	
Develop a professional education campaign for healthcare providers.	Training should include: • colorectal cancer screening guidelines • cost-benefits of colorectal screening • the need for more endoscopy service capacity • screening options for average and high-risk individuals • importance of discussing screening with all patients
	Develop training for other health care personnel to provide colorectal screenings.
Work with health systems to encourage regular colorectal screening.	Develop health systems reminder systems to encourage regular colorectal screening.
	Develop incentive programs that encourage participants to get screened.
Develop a plan to address the issue of colorectal screening financial coverage shortcomings.	Network with Wisconsin Division of Health Care Financing, the Wisconsin Association of Health Plans, the Association of Medical Directors, and others to address the screening availability issues.
	Investigate feasibility of Congress providing a federally funded colorectal screening program similar to the Breast and Cervical Cancer Early Detection Program.

STRATEGY C: Increase the availability of colorectal screening to populations facing geographic, economic, or cultural barriers.	
Action Plan	**Recommended Implementation Steps**
Partner with community-based organizations to promote colorectal cancer screening program for at-risk and underserved populations.	Identify underserved areas in Wisconsin.
	Identify possible cultural barriers to getting screened.
	Develop culturally appropriate information and to disseminate at community locations such as grocery stores, churches, hair salons, health clubs, etc.
	Hire community outreach people to work with the identified target population.
	Coordinate a forum or panel of people from the community that can talk about colorectal cancer screening in a culturally appropriate way.

Increase Breast Cancer Screening Rates, Especially in High-Risk Populations

Rationale

The majority of breast cancers can be treated successfully, if detected early. Mammography can detect breast cancer about 1.7 years earlier than by clinical or breast self-examination alone. In 2001, 72 percent of Wisconsin women age 40 and older surveyed in the Behavioral Risk Factor Surveillance System (BRFSS) reported having had a mammogram in the past year. The proportion of women reporting having had a mammogram in the past year increased from 61 percent in 1990 to 70 percent in 2000.[1] Rates of ever having had a mammogram also increased from 66 percent in 1990 to 91 percent in 2000.[1] Improved mammography screening to detect breast cancer early has made breast cancer a more curable disease than it was 30 years ago. Screening for female breast cancer can result in detection and removal of pre-invasive or pre-cancerous lesions, thereby preventing the development of invasive carcinoma and reducing the risk of subsequent cancer mortality.[5] It has been estimated that a 5% reduction in the incidence of female breast cancer could be achieved by 2015 through reasonable improvements in screening utilization.[5]

Disparate Burden

While African American women in Wisconsin are less likely to be diagnosed with breast cancer than white women (114.0 cases per 100,000 compared to 131.3 per 100,000 cases for white women), they are more likely to die from the disease (30.7 deaths per 100,000 African American women compared to 26.5 deaths per 100,000 white women).[1] This may be due to diagnoses at later stages of the disease for African Americans and a higher frequency of more aggressive tumors. Screening rates among underserved populations are lower than the general population due to many barriers. Access is a huge barrier in rural and minority populations. The Spirit of EAGLES Capacity Building Project found that in 2002, 58% of the Wisconsin Tribal Health Clinics offered mammograms solely via a mobile unit that made site visits to the clinic.[8] The frequency of mobile unit visits varied between once per year, twice per year, once per month and twice per month.

What Can Be Done?

- Develop a public awareness campaign for breast cancer screening.
- Promote system changes that will increase breast cancer screening.
- Increase the availability of breast cancer screening to populations facing geographic, economic, or cultural barriers.

Targets for Change

BREAST CANCER		
Reduce deaths from breast cancer		
WI Mortality Rate (1996–2000)	Healthy People 2010 Target	Percent Decrease Needed to Achieve Healthy People 2010 Goal in WI
26.5%	22.3%	16%

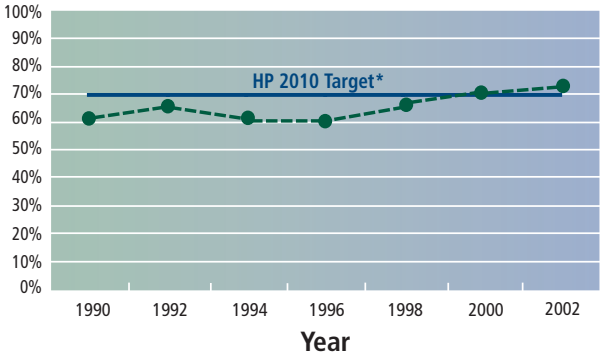
Sources:
American Cancer Society. Wisconsin Cancer Facts and Figures 2003–2004. Pewaukee, WI. 2003.

U.S. Department of Health and Human Services. Healthy People 2010. 2nd ed. With Understanding and Improving Health and Objectives for Improving Health. 2 vols. Washington, DC: U.S. Government Printing Office, November 2000.

1. Rates are averaged per 100,000 population and age-adjusted to the 2000 U.S. standard population.

BREAST CANCER SCREENING

Mammography Screening Among Women in Wisconsin Aged 40+ Years Within the Past Year



Sources:
Wisconsin Behavioral Risk Factor Surveillance System, Department of Health and Family Services, Bureau of Health Information,

U.S. Department of Health and Human Services. Healthy People 2010. 2nd ed. With Understanding and Improving Health and Objectives for Improving Health. 2 vols. Washington, DC: U.S. Government Printing Office, November 2000.

*Healthy People 2010 Goal: Mammography Screening among Women Aged 40+ years within the past two years.

STRATEGY A: Develop a public awareness campaign.	
Action Plan	**Recommended Implementation Steps**
Develop an education and awareness campaign to increase the number of women receiving mammograms.	Convene key stakeholders, such as advocacy groups, healthcare organizations and other partners to develop this campaign.
	Provide information on: • who is at risk • who needs screening • what are the risk factors • debunk the myths about breast cancer and mammograms
	Disseminate information on free clinics/providers/ programs, targeting women with healthcare access problems.

STRATEGY B: Promote system changes that will increase breast cancer screening.	
Action Plan	**Recommended Implementation Steps**
Partner with health care organizations to enact health care delivery system changes. Partners should include HMOs, group practices, professional organizations, Ob/Gyns, primary care physicians, nurse practitioner organizations etc.	
Develop a professional education campaign for healthcare providers.	Training should include: • appropriate screening principles and technique • current screening practices • how to identify high-risk women and the importance of doing so • cost-benefits of breast cancer screening
Work with health systems to encourage regular breast screening.	Create a model form or card to remind of screening dates and time frames.
	Develop incentive programs that encourage participants to get screened.
	Work with pharmacies to distribute reminders and information on the importance of cancer screening with prescriptions.
Encourage statewide consumer-friendly quality measurement and reporting of breast cancer screening.	To be determined.
Create a uniform statewide family/medical history questionnaire to identify high-risk women.	To be determined.
Develop recognition for physicians, organizations, etc., for excellence in breast cancer screening.	To be determined.

STRATEGY C: Increase the availability of breast cancer screening to populations facing geographic, economic, or cultural barriers.	
Action Plan	**Recommended Implementation Steps**
Partner with community-based organizations to promote breast cancer screening program for at-risk and underserved populations.	Identify underserved areas in Wisconsin.
	Identify possible cultural barriers to getting screened.
	Develop culturally appropriate information and to disseminate at community locations such as grocery stores, churches, hair salons, health clubs, etc.
	Hire community outreach people to work with the identified target population.
	Coordinate a forum or panel of people from the community that can talk about breast cancer screening in a culturally appropriate way.
Create a better distribution of mammography services.	Explore the possibility and feasibility of mobile mammography vans.
	Protect and expand the Wisconsin Well Woman Program.
	Support a forum or summit on how to increase mammography use in disparate populations.
	Provide extended clinic hours for screening services.

Increase Rates of Cervical Cancer Screening, Especially in High-Risk Populations

Rationale

Before the development of the Pap smear, cervical cancer was the second leading cause of female cancer deaths in the U.S. Screening tests offer a powerful opportunity for the detection and elimination of pre-cancerous lesions as well as the early detection and successful treatment of cervical cancer. Due to the increase in women having Pap tests, the number of cervical cancer deaths declined by 74 percent from 1955 to 1992.[1] More than 90 percent of Wisconsin women age 40 and older have had a Pap test at some time in their lives. In the last decade, the percentage of Wisconsin women who reported having a Pap test in the past three years did not change significantly. In 2001, 89 percent of Wisconsin women aged 18 and older reported having had a Pap test in the past three years.[1] While these numbers are encouraging, cervical cancer still exists, especially in some minority populations. This suggests our efforts should be focused and targeted to high-risk populations.

Disparate Burden

The highest incidence of cervical cancer in Wisconsin occurred among Asian women and they received the fewest Pap smears nationally compared to other races.[7] The age-adjusted incidence rate was 30 per 100,000 vs. 10 per 100,000 for all Wisconsin women.[7] African American and American Indian women in Wisconsin were also more likely than white women to be diagnosed with cervical cancer. Among Hispanic/Latino women in Wisconsin, relatively few cases of cervical cancer were diagnosed, for a rate of 8 per 100,000 population.[7] This contrasts with national data that has found elevated cervical cancer rates among Hispanics. African American, American Indian, and Asian women in Wisconsin are more likely than white women to die from cervical cancer.[7] Educational level and access to insurance also determine cervical cancer screening usage among women of all races.

What Can Be Done?

- Develop a public awareness campaign for cervical cancer screening.
- Promote system changes that will increase cervical cancer screening.
- Increase the availability of cervical cancer screening to populations facing geographic, economic, or cultural barriers.

Targets for Change

CERVICAL CANCER		
Reduce deaths from cervical cancer		
WI Mortality Rate (1996–2000)	Healthy People 2010 Target	Percent Decrease Needed to Achieve Healthy People 2010 Goal in WI
2.3%	2%	13%

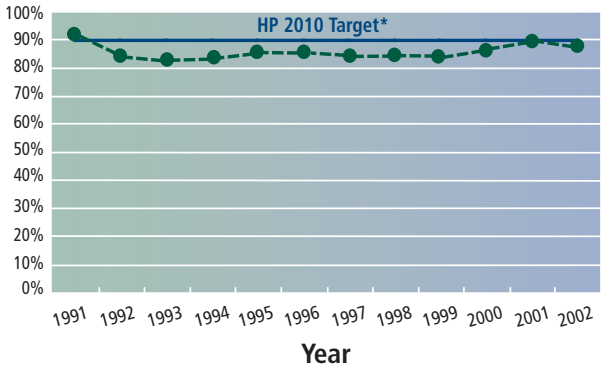
Sources:
American Cancer Society. Wisconsin Cancer Facts and Figures 2003-2004. Pewaukee, WI. 2003.

U.S. Department of Health and Human Services. Healthy People 2010. 2nd ed. With Understanding and Improving Health and Objectives for Improving Health. 2 vols. Washington, DC: U.S. Government Printing Office, November 2000.

1. Rates are averaged per 100,000 population and age-adjusted to the 2000 U.S. standard population.

CERVICAL CANCER SCREENING

Cervical Cancer Screening Among Women in Wisconsin Aged 18+ Years Who Have Had a Pap Smear Within Past 3 Years



Sources:
Wisconsin Behavioral Risk Factor Surveillance System, Department of Health and Family Services, Bureau of Health Information, American Cancer Society, Wisconsin Facts and Figures 2003–2004. Pewaukee, WI. 2003. Fig. 16, p. 34.

U.S. Department of Health and Human Services, Healthy People 2010. 2nd ed. With Understanding and Improving Health and Objectives For Improving Health. 2 vols. Washington D.C: U.S. Government Printing Office, November 2000.

* Excludes women who report a hysterectomy.

STRATEGY A: Develop a public awareness campaign.	
Action Plan	**Recommended Implementation Steps**
Develop an education and awareness campaign to increase the number of woman receiving Pap smears.	Convene key stakeholders, such as advocacy groups, healthcare organizations and other partners to develop this campaign.
	Provide information on: • who is at risk • who needs screening • what are the risk factors
	Disseminate information on free clinics/providers/ programs, targeting women with healthcare access problems.
	Develop partnerships with those that work in/with corrections, domestic abuse, homeless, and the disabled to increase awareness of need for screening among these populations.
	Coordinate with middle schools and high schools to include education on cervical cancer, how it develops and the importance of screening for it.

STRATEGY B: Promote system changes that will increase cervical cancer screening.	
Action Plan	**Recommended Implementation Steps**
Partner with health care organizations to enact health care delivery system changes. Partners should include HMOs, group practices, professional organizations, Ob/Gyns, primary care physicians, nurse practitioner organizations etc.	
Develop a professional education campaign for healthcare providers.	Training should include: • appropriate screening principles and technique • current screening practices • how to identify high-risk women and the importance of doing so • cost-benefits of cervical cancer screenings
Work with health systems to encourage regular cervical cancer screenings.	Create a model form or card to remind of screening dates and time frames.
	Work with pharmacies to distribute reminders and information on the importance of cancer screening with prescriptions (especially with birth control packets).
Create a uniform statewide medical history questionnaire to identify high-risk women.	To be determined.
Develop recognition for physicians, organizations, etc., for excellence in cervical cancer screening.	To be determined.

STRATEGY C: Increase the availability of cervical cancer screening to populations facing geographic, economic, or cultural barriers.	
Action Plan	**Recommended Implementation Steps**
Partner with community-based organizations to promote cervical cancer screening program for at-risk and underserved populations.	Identify underserved women in Wisconsin.
	Identify possible cultural barriers to getting screened.
	Develop culturally appropriate information and disseminate it at community locations such as grocery stores, churches, hair salons, health clubs etc.
	Hire community outreach people to work with the identified target population.
	Coordinate a forum or panel of people from the community that can talk about cervical cancer screening in a culturally appropriate way.
Create a better distribution of cervical cancer screening services.	Explore the possibility and feasibility of mobile vans with the ability to provide Pap smears and pelvic exams.
	Protect and expand the WI Well Woman Program.
	Provide extended clinic hours for screening services.
Encourage the development of new technologies and practices to make screening more comfortable.	To be determined.

Increase Prostate Cancer Screening Rates for Men 50 Years and Older, Especially in High-Risk Populations

Rationale

Early detection of prostate cancer increases survival and treatment options. Most men over 50 in Wisconsin have never received the screening through a digital rectal examination or prostate-specific antigen testing (PSA). In Wisconsin, the number of men age 50 and older who have ever had a PSA test increased from 9 percent in 1993 to 37 percent in 2001.[1] The national five-year survival rate, all races combined, for locally and regionally diagnosed prostate cancers are 100 percent, but survival for distant stage prostate cancer drops to 30 percent.[1]

*Note: Several national organizations and governmental agencies have withheld promotion of screening for prostate cancer until the results of randomized controlled trials of the benefits, or lack of benefits, of screening for and treating prostate cancer are complete. There is insufficient evidence to establish whether a decrease in mortality from prostate cancer occurs with screening by digital rectal examination or serum prostate-specific antigen. Although potential harms of screening for prostate cancer can be established, the presence or magnitude of potential benefits cannot; therefore, the net benefit of screening cannot be determined. See Appendix A: Screening Recommendations, Table A-4: Prostate Cancer Screening Guidelines.

Controlled trials addressing health benefits of screening for prostate cancer are ongoing but results are not yet available. Until then, controversies surround prostate cancer screening. Despite the inconsistency and limitations of prostate screening recommendations, The Wisconsin Screening and Detection workgroup felt we should include prostate screening as part of the Wisconsin Comprehensive Cancer Control Plan 2005–2010.

Disparate Burden

African American males have experienced higher prostate cancer incidence rates than whites (258.7 cases per 100,000 African American males as compared to 157.4 cases per 100,000 white males).[1] Prostate cancer also develops earlier in African American men and their death rate from the disease greatly exceeds that of white men (61.3 deaths per 100,000 African American males and 33.7 deaths per 100,000 for white males).[1] Prostate cancer is mostly detected in older men. 70% of prostate cancers are diagnosed in men over 65.[1]

What Can Be Done?

- Develop a public awareness campaign for prostate cancer screening.
- Promote system changes that will increase prostate cancer screening.
- Develop a screening campaign directed toward African American men over the age of 45 with a strong family history of prostate cancer.

Targets for Change

PROSTATE CANCER		
Reduce deaths from prostate cancer		
WI Mortality Rate (1996–2000)	Healthy People 2010 Target	Percent Decrease Needed to Achieve Healthy People 2010 Goal in Wisconsin
34.3%	28.8%	16%

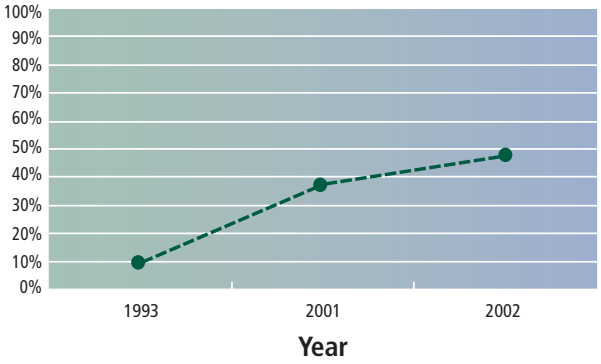
Sources:
American Cancer Society. Wisconsin Cancer Facts and Figures 2003-2004. Pewaukee, WI. 2003.

U.S. Department of Health and Human Services. Healthy People 2010. 2nd ed. With Understanding and Improving Health and Objectives for Improving Health. 2 vols. Washington, DC: U.S. Government Printing Office, November 2000.

1. Rates are averaged per 100,000 population and age-adjusted to the 2000 U.S. standard population.

PROSTATE CANCER SCREENING

Prostate Cancer Screening Among Men in Wisconsin Aged 50+ Years Who Have Eve Had a Prostate-Specific Antigen (PSA) Test



Sources:
Wisconsin Behavioral Risk Factor Surveillance System, Department of Health and Family Services, Bureau of Health Information.

* Healthy People 2010 does not list a Prostate Cancer Screening Goal.

STRATEGY A: Develop a public awareness campaign.	
Action Plan	**Recommended Implementation Steps**
Develop an education and awareness campaign to promote prostate cancer screening.	Convene key stakeholders, such as advocacy groups, healthcare organizations and other partners to develop this campaign.
	Provide information on: • who is at risk • role of early detection • guidelines for early detection • how to talk with your healthcare provider about the benefits and limitations of early detection and treatment of prostate cancer • cost-benefits of prostate cancer screening
	Enlist statewide media support with identified community groups to provide consumer-centered awareness messages.
	Plan Father's Day promotions with media releases, interviews, materials, etc. Continue promotions throughout the month of June.

STRATEGY B: Promote system changes that will increase prostate cancer screening.	
Action Plan	**Recommended Implementation Steps**
Partner with health care organizations to enact health care delivery system changes. Partners should include HMOs, group practices, professional organizations, primary care physicians, nurse practitioner organizations etc.	
Develop a professional education campaign for healthcare providers.	Training should include: • recommended screening practices • informed decision making • risk factors of prostate cancer • benefits and risks of prostate cancer screening
Analyze the cost-benefit and quality of life benefit of prostate cancer screening specific to Wisconsin.	Cost-benefit analysis would include: • outcome and cost of treatment options • cost and quality of life for metastatic disease patients • long-term outcomes

STRATEGY C: Develop a screening campaign directed for African American men over the age of 45 with a strong family history of prostate cancer.	
Action Plan	**Recommended Implementation Steps**
Partner with community-based organizations that work with African American men to promote prostate cancer screening program.	Develop culturally appropriate information and disseminate it at community locations.
	Present the ACS Let's Talk About It community-based prostate cancer awareness and education program to African American audiences.
	Partner with Man to Man and US TOO prostate cancer support group to inform others about treatment options and outcomes.
Partner with urologists and primary care physicians to provide appropriate messages and counseling to their African American patients.	To be determined.
Provide information on Medicare and insurance coverage for screening, diagnosis and treatment of prostate cancer.	To be determined.

Other Screening and Detection Issues

Cancers Not Routinely Screened For

According to the National Cancer Institute, the American Cancer Society, and the U.S. Preventive Services Task Force (USPSTF), some cancers are more difficult to detect at an early stage. Even though certain screening tests are available, in many cases they are either not recommended or lack sufficient evidence for recommendation. (See Appendix A.)

Decisions about screening can often be a difficult choice. Most have risks involved and not all screening tests are beneficial. It is important to know the risk of the test and whether is has been proven to reduce the risk of dying from cancer. One should be aware that some screening methods have a high "false-negative" rate; that is, a test shows no cancer exists when actually cancer is present. Receiving a false-negative may cause delayed medical attention even if there are symptoms. Some screening methods have a high "false-positive" rate; that is, a test shows cancer exists when actually no cancer is present. Receiving a false-positive may cause anxiety and unnecessary follow-up procedures.

Cancer sites not routinely screened include bladder, lung, oral, ovarian, pancreatic, skin, testicular, and thyroid, and are not directly identified in Chapter 2: Screening and Detection. Instead, the Wisconsin Comprehensive Cancer Control Plan focuses on sites that have recommended screening guidelines. See Appendix A for screening guideline information.

Genetics Testing as a Screening Tool

Patients and healthcare providers alike now face many questions regarding genetic screening to determine individual risk and disease-prevention strategies. Not only do these testing opportunities permit risk analysis and intervention possibilities, they may affect family members who may question their own risks. Women may not choose to find out if they carry an altered gene that could increase their risk of developing breast cancer for fear that the information could be used to deny them health insurance coverage or employment. These ethical dilemmas are being addressed by several professional societies and advocacy groups, which support legislation and regulations to prevent any employer or insurance company to require genetic testing or release of records of genetic testing that may adversely affect the status of the individual. Wisconsin does have laws addressing genetic discrimination in health insurance and employee-employer contracts. Necessary genetic testing is covered by most health plans, as they are considered standards of care. To assist patients and providers, the Wisconsin Cancer Risk Programs Network, a consultation service, will provide cancer risk assessment by healthcare professionals with expertise in both genetics and oncology. Participants in the Network are located in seven cities at twelve healthcare centers.

Increased Screening Rates and Follow-up Care

Increased cancer screening rates generate a need for additional resources for diagnostic follow-up and treatment.[9] There are concerns that expanding screening services may overburden existing systems that help uninsured patients obtain treatment. Health care providers may also be concerned about bringing in additional uninsured patients, because of the need to give treatment.

In some cases even if follow-up diagnostics are available, a number of patients never receive follow-up care. A study by the National Cancer Institute reported that approximately 9% of women who ever reported having an abnormal mammogram received no follow-up care.[10] A lack of diagnostic follow-up potentially reduces the effectiveness of mass screening programs. With an increase in screening rates, Wisconsin's healthcare systems must be ready and willing to increase treatment options for all those diagnosed with cancer.

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Chapter 3: TREATMENT

Increase Access to Cancer Treatment by Reducing Economic, Geographic, Cultural, and Systems Barriers

Rationale

Lack of adequate insurance is a large barrier to medical care in the U.S., as well as cancer care in Wisconsin. Twelve percent of Wisconsin's population is without health insurance.[11] Individuals without insurance receive fewer inpatient and outpatient services[12] and are less likely to receive treatment consistent with national guidelines;[13,14] this latter point suggests that the uninsured may receive lower quality care. Those without insurance have been found to have higher mortality than those with private insurance or Medicare.[15] Increasing insurance coverage will improve access to cancer-related care and services in rural areas, since rural residents are more likely than average to be uninsured.[16]

Second, we must ensure an adequate supply of, and access to, cancer specialists and other cancer-related health professionals. In terms of physicians there is evidence of the possibility of a future under-supply of specialists. Such a shortage would be expected to be more acute in rural areas.

Disparate Burden

There is a disparate burden of access to healthcare in Wisconsin. According to The Health of Racial and Ethnic Populations in Wisconsin, 1996–2000, the following groups in Wisconsin were uninsured for an entire year: Hispanic/Latinos (13%), African Americans (10%), Native Americans (7%), Asian-Americans (7%) and whites (4%). Besides having health insurance, lack of transportation, language barriers and education levels can all be culturally linked barriers that contribute to the disparate burden of accessing healthcare. Having a healthcare system that is difficult to navigate only widens the burden.

Geography is another barrier to access. In Wisconsin, 31.7% of the population lives in rural communities. Those in rural areas may have less access to cancer care services.

If a cancer patient does not live near a cancer treatment facility, lack of money and transportation can hamper their ability to get the proper treatment. For a full description of Wisconsin demographics, see Appendix C.

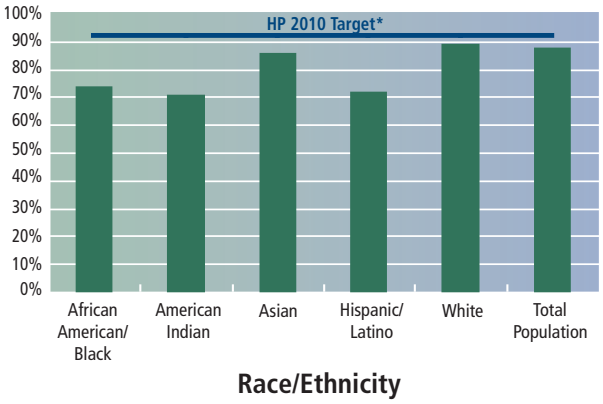
What Can Be Done?

- Develop five "Regional Partnership Networks" (RPNs) dedicated to breaking down barriers to access of cancer care (one for each Division of Public Health region of the state).
- Develop an education program for health care providers on the referral process to specialized oncology care.

Targets for Change

HEALTH INSURANCE COVERAGE

Health Insurance Coverage by Race/Ethnicity, Wisconsin, 1996–2000



Sources:
Wisconsin Department of Health and Family Services, Division of Public Health, Minority Health Program. *The Health of Racial and Ethnic Populations in Wisconsin: 1996–2000.* Madison, Wisconsin: Department of Health and Family Services, 2004 Jun.

SOURCE OF HEALTHCARE
% by Race/Ethnicity, Wisconsin, 1996–2000

All Ages	African/ American Black	American Indian	Asian	Hispanic/ Latino	White	Total Population
Sample size	n=3,941 % (C.I. ±)	n=390 % (C.I. ±)	n=432 % (C.I. ±)	n=889 % (C.I. ±)	n=29,445 % (C.I. ±)	n=35,652 % (C.I. ±)
Has one place where usually goes for routine healthcare	89 (1)	92 (3)	83 (4)	85 (2)	92 (--)	91 (--)
Does not have one place for care	10 (1)	7 (3)	16 (4)	14 (2)	8 (--)	8 (--)
Needed medical care in the past year and did not get it	4 (1)	3 (2)	1 (1)	3 (1)	2 (--)	2 (--)

Sources:
Wisconsin Department of Health and Family Services, Division of Public Health, Minority Health Program. *The Health of Racial and Ethnic Populations in Wisconsin: 1996–2000.* Madison, Wisconsin: Department of Health and Family Services, 2004 Jun.

STRATEGY A: Develop five "Regional Partnership Networks" (RPNs) dedicated to breaking down barriers to access of cancer care.	
Action Plan	**Recommended Implementation Steps**
Conduct a comprehensive evaluation of current cancer care capacity in the state.	Convene a task force to develop an evaluation plan.
	Evaluate workforce supply, types of treatments available/ treatment resources, housing, transportation, translation services and other areas. For rural areas, evaluate rural patient utilization of out-of-area cancer care, type of care sought and type of provider access.
	Conduct an academic literature search on the impact of lack of access to the quality of care received by patients who are under/uninsured. Detail existing studies on the economic impact to communities where there are disparities/lack of insurance: rural and urban.
	Compile list of charity care donations of local/regional health care providers.
	Collect incidence and mortality rates from the Wisconsin Cancer Reporting System.
	Survey impact of new Medicare guidelines on potentially limiting availability of chemotherapy in rural areas.
	Complete comprehensive report outlining evaluation findings.
Develop and implement a strategic plan for each RPN to overcome barriers to cancer care.	Work with local partners to identify leaders and stakeholders who are interested in developing five RPNs in Wisconsin.
	Convene statewide summit of key stakeholders to evaluate data and develop five RPNs in Wisconsin.
	Periodically convene the five RPNs in order to exchange information, plan, and execute statewide initiatives.

Components of the Regional Partnership Network Strategic Plan

- Strategize best use of the evaluation of current cancer care to break down barriers to access to care and increase awareness of actual cancer care capacity across the state, paired with need.
- Facilitate relationship between providers with excess cancer care capacity and underserved areas to facilitate health care delivery liaisons.
- Engage public policy advocates and community leaders to develop networks to advocate for cancer patients and providers regarding treatment issues.
- Plan ways to disseminate information on individual cancer care through five RPNs with written information, talks, presentations, sermons, educational programs, media, internet-based and other.

STRATEGY B: Develop an education program for health care providers on the referral process to specialized oncology care.

Action Plan	Recommended Implementation Steps
Develop CCC coordinated education bureau that would provide educational opportunities for healthcare providers.	Partner with existing organizations and the five RPNs to bring together the educational opportunities on the referral process for healthcare providers.
	Develop a speaker's bureau to provide primary care providers with the benefits of referral to cancer specialists, clinical trials, and adherence of cancer treatment guidelines.
	Provide education to rural health care providers and clients in order to offer specialized cancer care in rural areas.
	Provide information on topics such as cancer care support services and cultural competency.
Establish relationship with new American College of Surgeons (ACoS) required community physician liaison at each approved cancer center.	To be determined.

Encourage Adherence by Physicians to Cancer Treatment Guidelines

Rationale

Credible, evidence-based guidelines can be used to reduce inappropriate variation in the provision of cancer care, with resulting improvements in outcomes and improved cost-effectiveness of care.[17] Many evidence-based cancer related guidelines already exist, but adherence to these guidelines is low. Coordinated, statewide efforts to educate both patients and physicians about these guidelines may lead to improved adherence.

Disparate Burden

There is a difference in how cancer is treated among different populations. A disproportionate number of cancer deaths occur among racial/ethnic minorities.[18] Although differences in incidence and stage of disease at diagnosis may contribute to racial disparities in mortality, evidence of racial disparities in the receipt of treatment of other chronic diseases raises questions about the possible role of inequities in the receipt of cancer treatment.[18] Having a uniform set of cancer treatment guidelines would help ensure that all patients were receive the same type of treatments.

What Can Be Done?

- Select cancer treatment guidelines to publicize.
- Increase awareness of selected cancer treatment guidelines for health systems, practitioners, and consumers.
- Develop methods to assess the clinical impact of increased adherence to the selected cancer treatment guidelines.

Targets for Change

PHYSICIAN GUIDELINES ADHERENCE	
Potential Barriers	
2004 Barriers	Lack of awareness Lack of familiarity Lack of agreement Lack of self-efficacy Lack of outcome expectancy Ability to overcome the inertia of previous practice External barriers to perform recommendations
2010 Target	Uniform set of cancer treatment guidelines for Wisconsin

Sources:
Cabana MD, Rand SC, Powe NR, Wu AW, et al. Why don't physicians follow clinical practice guidelines? A framework for improvement. JAMA. Oct 20, 1999; 282, 15. pg 1458-1465.

STRATEGY A: Select cancer treatment guidelines to publicize.	
Action Plan	**Recommended Implementation Steps**
Partner with local and state oncology physician organizations to select clinical treatment guidelines to publicize.	Identify partners and stakeholders to participate in treatment guidelines selection and updating process.
	Review and select cancer treatment guidelines to publicize.
	Monitor updates of these selected guidelines and re-visit this selection every three years.
	Maintain an ongoing literature review of the guidelines clinical impact.

STRATEGY B: Increase awareness of selected cancer treatment guidelines for health systems, practitioners, and consumers.	
Action Plan	**Recommended Implementation Steps**
Work with community partners and patient advocates to develop multi-tiered approach to publicize selected cancer treatment guidelines.	Use speaker's bureau to educate cancer healthcare providers on the guidelines.
	Provide pamphlets in clinics and community centers.
	Use website as central repository of guidelines.
Investigate means to integrate selected cancer treatment guidelines into electronic medical records.	To be determined.

STRATEGY C: Develop methods to assess the clinical impact of increased adherence to the selected cancer treatment guidelines.	
Action Plan	**Recommended Implementation Steps**
Conduct a pilot analysis of monitoring adherence to selected clinical treatment guidelines.	Partner with a healthcare organization interested in monitoring their adherence to the guidelines.
	Conduct a literature review of the clinical impact of increased adherence to treatment guidelines. This presently exists for non-oncology fields of medicine.
	Communicate with local cancer centers on how best to monitor adherence.
	Publicize pilot analysis results showing the clinical and economic impact of following selected cancer treatment guidelines.
	Recognize clinicians that subscribe and routinely use guidelines.

Increase Awareness of and Participation in Cancer Clinical Trials

Rationale

Only 3% of U.S. adults with cancer participate in clinical trials.[19] More U.S. children with cancer (60%) participate in clinical trials.[19] There are many different clinical trials that exist in the United States. The Physician Data Query (PDQ) is a comprehensive cancer information database that is maintained and updated regularly by the National Cancer Institute. As of February 2004, there were 1,356 active clinical trials posted in the Clinical Trials Protocol section of the PDQ for the United States. Of these clinical trials, 335 are active in Wisconsin. This list includes all cancers, all types of trials (screening, prevention, treatment, genetics and supportive care), all phases, and all sponsors. There are reasons why physicians are not talking to their patients about clinical trials. These barriers must be uncovered. By promoting clinical trials, more Wisconsin physicians will be aware of available clinical trials and can refer their patients to them.

85% of cancer patients are UNAWARE that clinical trials are a treatment option in which they may have an opportunity to participate.

77% of cancer trial participants said they would recommend clinical trial participation to someone with cancer.

Sources:
Coalition of National Cancer Cooperative Groups, Inc. Cancer Clinical Trials: Opportunities for Increasing Enrollment, Poll conducted by Harris Interactive, 2000. Available from: www.cancertrialshelp.org

According to the National Cancer Institute, cancer patients should be aware of potential benefits and risks of clinical trials.

Potential benefits include:
Health care provided by leading physicians in the field of cancer research
Access to new drugs and interventions before they are widely available
Close monitoring of your health care and any side effects
A more active role in your own health care
If the approach being studied is found to be helpful, you may be among the first to benefit
An opportunity to make a valuable contribution to cancer research
Potential risks include:
New drugs and procedures may have side effects or risks unknown to the doctors
New drugs and procedures may be ineffective, or less effective, than current approaches
Even if a new approach has benefits, it may not work for you

Sources:
National Cancer Institute Website, www.nci.nih.gov

Disparate Burden

Many minority groups have higher mortality rates for cancer than the majority of the U.S. white population. Among patients up to 29 years of age, participation in NCI Cooperative Group trials is comparable across race and ethnicities.[19] As adults, fewer African American men and fewer Asian American and Hispanic men and women participate in trials, compared to whites. According to federal statistics, only 2,400 African Americans and even fewer Hispanic, Asians and other patients enroll annually in clinical trials despite the scope of NCI sponsored trials. The overall number of minority patients in trials has not increased and the proportion of African Americans, Hispanics, Asians and other minority groups involved in trials has, in fact, decreased.

What Can Be Done?

- Create an education campaign for health care professionals and patient advocacy organizations to increase awareness of and participation in cancer clinical trials.
- Provide a statewide website with information regarding cancer clinical trials.
- Facilitate an agreement with third-party payers in Wisconsin to cover standard care costs associated with treatment under a cancer clinical trial.

Targets for Change

CANCER CLINICAL TRIALS	
U.S. adult participation	
2003	2010 Target
3%	5%

Sources:
National Cancer Institute's Clinical Trials Website, 2004. Available from: http://cancer.gov/clinicaltrials/

States that have passed legislation or instituted special agreements requiring health plans to pay the cost of routine medical care for clinical trial participants	
2004	2010 Target
AZ, CA, CT, DE, GA, LA, ME, MD, MA, MI, MS, NV, NH, NJ, NM, NC, OH, RI, VT, VA, WV	Wisconsin

Sources:
National Cancer Institute Website, 2004. Available from: www.nci.nih.gov

STRATEGY A: Create an education campaign for health care professionals and patient advocacy organizations to increase awareness of and participation in cancer clinical trials.	
Action Plan	**Recommended Implementation Steps**
Develop and implement a multi-tiered professional education campaign to publicize the benefits of cancer clinical trial enrollment and the importance of referring patients to clinical trials.	Identify and convene key stakeholders within the five RPNs.
	Identify and increase use of existing educational resources.
	Use a speaker's bureau to address health care professionals and organizations regarding the benefits of cancer clinical trial enrollment.
Engage community leaders, patient advocacy groups, and local media to publicize the benefits of cancer clinical trial enrollment to the lay public, especially for minorities and underserved populations.	To be determined.

STRATEGY B: Provide a statewide webpage with information regarding cancer clinical trials.	
Action Plan	**Recommended Implementation Steps**
Create a webpage on the WI CCC Plan website as a central repository for links to on-line information about cancer clinical trials, for use by health care professionals and consumers.	Comprehensive review of existing on-line cancer clinical trial resources.
	Identify resources for webpage development.
	Monitor usage of the webpage.

STRATEGY C: Advocate for policy change in Wisconsin for third-party payers in Wisconsin to cover standard care costs associated with treatment under a cancer clinical trial.	
Action Plan	**Recommended Implementation Steps**
Assess coverage of standard care costs associated with clinical trials in Wisconsin.	Survey payers, purchasers and employers for coverage of standard care costs associated with clinical trials.
	Survey cancer patients regarding their participation in clinical trials and any financial barriers that they may have faced.
Develop a background paper to justify coverage of standard care costs associated with treatment under a cancer clinical trial.	Identify and convene key stakeholders to review survey results, along with other states' examples of agreements and then develop an advocacy strategy for policy change in Wisconsin payers.
Raise awareness of the need to cover standard care costs associated with treatment under a cancer clinical trial (include clarification of Medicare Coverage).	Work with healthcare consumers to develop a publicity campaign to raise awareness of the need for policy change.
	Create positive publicity for payers that are "change agents" and are "out in front" in the policy change movement.

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Chapter 4:
QUALITY OF LIFE

Increase Reimbursement for Services Related to Quality of Life at Time of Diagnosis and Throughout the Cancer Continuum

Rationale

Quality of life is difficult to define. It is a moving target that changes at different points in a person's life. Many of the strategies in this chapter represent "health-related" quality of life but are not limited to that. Quality of life indicators in individuals diagnosed with cancer can vary, however, for purposes of defining the parameters in this report they might include: pain, fatigue, depression/psycho-social and nutrition. Impediments to effective symptom management to enhance quality of life can arise from different sources and interactions among providers, patients and their families and the health care system.

Cancer survivors are dealing with many different physical and emotional needs, many of which are not covered by insurance. While Medicare, private health insurance, Medicaid, and Health Insurance Risk Sharing Plan (HIRSP) do cover pain management and palliative care for patients who meet eligibility criteria, other necessary non-medical services are not covered. Research has shown that the more holistically patients are treated, the better their treatment outcomes. Wisconsin needs to assess the current state of quality of life services that are reimbursed to begin to increase coverage for all survivors.

Disparate Burden

As mentioned in Chapter 3: Treatment, there is a disparate burden of access to healthcare in Wisconsin. According to The Health of Racial and Ethnic Populations in Wisconsin, 1996–2000, the following groups in Wisconsin were uninsured for an entire year: Hispanic/Latinos (13%), African Americans (10%), Native Americans (7%), Asian-Americans (7%) and whites (4%).[7] Lack of insurance not only makes it difficult to obtain treatment, but also to obtain services related to quality of life. Besides having health insurance, lack of transportation, language barriers and education levels can all be culturally linked barriers that contribute to the disparate burden of accessing quality of life care. Having a healthcare system that is difficult to navigate only widens the burden.

What Can Be Done?

- Educate employers and consumers regarding the importance of including quality of life (QOL) services for cancer patients and their families in benefit packages.
- Enact public policy to ensure comprehensive coverage of quality of life services.
- Establish a gold standard reimbursement model for payers to include QOL services for cancer patients and their caregivers.

Targets for Change

SURVIVORSHIP	
Increase percent of survivors who are living five years or longer after diagnosis	
WI Rate 2003	Healthy People 2010 Target
62% survivor rate	70% survivor rate
16,000 people	18,050 people

Sources:
American Cancer Society. Wisconsin Cancer Facts and Figures 2003-2004. Pewaukee, WI. 2003.

U.S. Department of Health and Human Services. Healthy People 2010. 2nd ed. With Understanding and Improving Health and Objectives for Improving Health. 2 vols. Washington, DC: U.S. Government Printing Office, November 2000.

CANCER MORTALITY		
Reduce overall cancer death rate		
WI Mortality Rate (1996–2000)	Healthy People 2010 Target	Percent Decrease Needed to Achieve Healthy People 2010 Goal in WI
195.7%	159.9%	18%

Sources:
American Cancer Society. Wisconsin Cancer Facts and Figures 2003-2004. Pewaukee, WI. 2003.

U.S. Department of Health and Human Services. Healthy People 2010. 2nd ed. With Understanding and Improving Health and Objectives for Improving Health. 2 vols. Washington, DC: U.S. Government Printing Office, November 2000.

1. Rates are averaged per 100,000 population and age-adjusted to the 2000 U.S. standard population.

STRATEGY A:	Educate employers and consumers regarding the importance of including quality of life (QOL) services for cancer patients and their families in benefit packages.
Action Plan	**Recommended Implementation Steps**
Develop an education plan to help employers and consumers understand the importance of including quality of life services in benefit packages.	Develop and implement a survey to identify gaps in knowledge regarding quality of life – both at the employer and consumer/employee level.
	Use survey results to develop an education plan to help employers and consumers understand the importance of including quality of life services in benefit packages.
	Present this education plan to employers and consumers.

STRATEGY B:	Enact public policy to ensure comprehensive coverage of quality of life services.
Action Plan	**Recommended Implementation Steps**
Assess problem of QOL services reimbursement among cancer patients.	Survey cancer patients, caregivers and providers to identify gaps in reimbursement for QOL services.
	Analyze survey results to identify uninsured and medically underserved and identify their unique barriers to QOL services.
Work to gain support among legislators for reimbursement of QOL services.	Present survey results and personal cancer survivor stories to legislators to gain their interest in QOL reimbursement policy.
	Survey legislators to determine interest in QOL or cancer issues and ask for their support in reimbursement issues.
Build a grassroots campaign to support public policy for reimbursement of QOL services.	Identify a coalition of supporting organizations that can offer grassroots support.
	Research other QOL policy initiatives and legislative mandates that have been enacted in other states.

STRATEGY C: Establish a gold standard reimbursement model for payers to include QOL services for cancer patients and their caregivers.	
Action Plan	**Recommended Implementation Steps**
Determine a gold standard reimbursement model for Wisconsin.	Survey cancer patients and cancer survivors to identify QOL services that are commonly not covered by third party payers, Medicare and Medicaid.
	Interview providers and QOL experts to determine what the gold standard should include.
	Research reimbursement models for QOL services in other states.
	Draft gold standard reimbursement model.
Implement a gold standard reimbursement model among payers in Wisconsin.	Develop a communications plan to alert payers/health insurers about gold standard.
	Develop a system for rewarding and recognizing payers/ insurers who are following the gold standard.

Provide Education that will Enhance the Understanding of the Importance of Quality of Life in the Treatment Continuum

Rationale

Over 60% of those diagnosed with cancer today are expected to be five-year cancer survivors.[20] The number of cancer survivors is expected to increase as the population ages and cancer detection and treatment improve. Cancer survivors are faced with difficult medical and life decisions at each stage of living with the disease. From the time of diagnosis, the quality of life for every cancer patient and survivor is affected in some way. Cancer patients and their families face many issues such as cancer pain management, psychological support, access to quality care, financial and health insurance advice, sexual functioning, nutrition counseling, post-treatment concerns and end of life concerns.[20] Because many contributing variables affect one's enjoyment of life, a personal assessment of well-being is more complex and subjective than other quantitative measurements.

Disparate Burden

The physical and psychosocial needs of medically underserved cancer survivors and their families must be considered within the context of quality of life. Also quality of life is affected by many socio-cultural variables that affect cancer survivorship. The nature and effectiveness of existing post-treatment medical and support services designed for cancer patients from underserved communities need to be researched and strengthened.

What Can Be Done?

- Educate cancer care providers about the importance of symptom management as it impacts quality of life.
- Educate patients and caregivers about the importance of defining and communicating quality of life needs and issues with their healthcare provider.

Targets for Change

QUALITY OF LIFE	
Cancer Patient Bill of Rights	
2004	2010 Target
No cancer patient bill of rights	Wisconsin specific Patient Bill of Rights

STRATEGY A: Educate cancer care providers about the importance of symptom management as it impacts quality of life.	
Action Plan	**Recommended Implementation Steps**
Design professional education outreach to promote symptom management in individuals living with cancer.	Assemble a panel of experts and define "appropriate symptom management in cancer care."
	Develop a Patient Bill of Rights for expectations of cancer care.
	Develop and promote minimum competencies for each cancer care profession regarding their role in cancer pain and symptom assessment and management.
Develop and promote patient advocacy systems for people living with cancer.	Identify American College of Surgeons (ACoS) Commission on Cancer (CoC) facilities in Wisconsin with action plans addressing symptom management.
	Recruit individuals to function as "patient advocates" for appropriate pain and symptom management in all of the ACoS CoC facilities and/or community hospitals.
	Provide training about management of pain and other adverse symptoms of cancer treatment to the patient advocates.

STRATEGY B: Educate patients and caregivers about the importance of defining and communicating quality of life needs and issues with their healthcare providers.	
Action Plan	**Recommended Implementation Steps**
Develop multi-cultural campaign to demonstrate the importance of quality cancer care in meeting successful treatment outcomes.	Identify existing multi-cultural materials that demonstrate how to communicate effectively with health professionals about quality of life needs for individuals experiencing cancer.
Sponsor Annual Cancer Survivors Day.	Assess current statewide activities around the Annual Cancer Survivors Day to focus on the broad spectrum of quality of life issues during and after treatment.

Assemble Data on Quality of Life to Establish Best Practices in Measuring Optimal Treatment Outcomes

Rationale

Quality of life is a very important issue for cancer patients and their loved ones. It is receiving increasing attention around the country by organizations that represent and/or work with cancer patients and by other statewide comprehensive cancer planning groups.[21] There is little hard data in terms of defining where Wisconsin stands in meeting the quality of life needs of its citizens living with cancer.[22] There are many ways to define quality of life and no consistent, agreed-upon way to measure it.[23] There is a nationally developed standard for collecting baseline information about quality of survival, but it is not being used at a population-based collection level. In addition, there currently is no support from state, national or federal organizations, nor are there federal mandates for collecting the data. Also, there has been little funding at the state or federal level to support surveillance programs that monitor these issues. As increasing attention is given to quality of life issues, the data collected to support work in this area needs to increase as well.

Disparate Burden

Data collection for racial and ethnic variables have known limitations, including underreporting, misclassification, and incomplete data items.[24] We don't want these same issues to occur with measuring quality of life and optimal treatment outcomes. As we move forward in collecting quality of life data, we must build in measurements for racial and ethnic variables.

What Can Be Done?

- Establish and implement a statewide repository of quality of life outcomes data.
- Establish evidence-based quality of life interventions.

Targets for Change

QUALITY OF LIFE	
Data and Interventions	
2004	2010 Target
No Statewide repository of QOL outcomes data or evidence-based QOL interventions.	Create statewide repository and evidence-based interventions.

STRATEGY A: Establish and implement a statewide repository of quality of life outcomes data.	
Action Plan	**Recommended Implementation Steps**
Identify potential elements for quality of life data repository.	Develop links and partnerships with state and national registries for collection and reporting of quality of life outcomes data.
	Review capabilities for data capture and use with existing registries and studies.
	Determine whether there are privacy or legal protections that may impede process (e.g., HIPAA).
Establish a uniform assessment tool to collect quality of life outcome data.	Search for evidence-based QOL interventions that include quality of life outcomes assessment.
	Form expert review committee to recommend essential quality of life indicators, variables, and measures.
	Consult with key persons in quality of life assessment on length and format of measures.

STRATEGY B: Establish evidence-based quality of life interventions.	
Action Plan	**Recommended Implementation Steps**
Convene a taskforce to review and recommend evidence-based quality of life interventions to implement in Wisconsin.	Collect and evaluate quality of life education and support materials available.
	Form an expert review subcommittee to recommend targeted evidence-based quality of life protocol.
	Implement evidence-based programs proven to be effective.

References

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21. Iowa Department of Public Health. *The Burden of Cancer in Iowa and the Need for a Comprehensive Approach to Prevention and Control.* 2002 Jan. Available from: www.idph.state.ia.us/hpcdp/
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23. Hultstrom D, editor. Standards for Cancer Registries Volume II: Data Standards and Data Dictionary, Seventh Edition, Version 10. Springfield, IL: North American Association of Central Cancer Registries, 2002 Mar. Available from: www.naaccr.org
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Chapter 5:
PALLIATIVE CARE

Increase Access to Palliative Care

Rationale

Palliative care aims to relieve suffering and improve quality of life for patients with advanced illness and their families. The goal of palliative care is to prevent or treat as early as possible the symptoms of the disease, side effects caused by treatment of the disease, and psychological, social, and spiritual problems related to the disease or its treatment. Despite many recent improvements in palliative care, some Americans have not been able to find good care for themselves or their loved ones when dealing with a life-ending illness.[25] In Wisconsin, too few patients are accessing hospice and palliative care services, there are too few professionals trained in palliative care, and there are too many patients dying in hospitals and nursing homes, rather than at home with their loved ones.

In *Means to a Better End: A Report on Dying in America Today,* a 2002 report by Last Acts, research showed that 70% of Americans would prefer to be at home with loved ones in their final days; however, only 25% died at home.[25]

Disparate Burden

Disparities in the healthcare system between African Americans and whites continue into end of life care. African Americans make up 13% of the total U.S. population, but only 8% of hospice patients (as compared to 83% of whites).[26] Lack of awareness about end of life care contributes to lower levels of pain management and use of hospice care among African Americans and members of other racial and ethnic minority groups compared to whites. Cultural beliefs can be a barrier to end of life care. These barriers need to be considered if we want to increase minority access to palliative care.

Geography can also be a barrier to accessing palliative care. Many patients in Wisconsin have to travel great distances to see a palliative care provider. As shown in the map below, certified palliative care providers are spread throughout the state, with many concentrated in the urban areas.

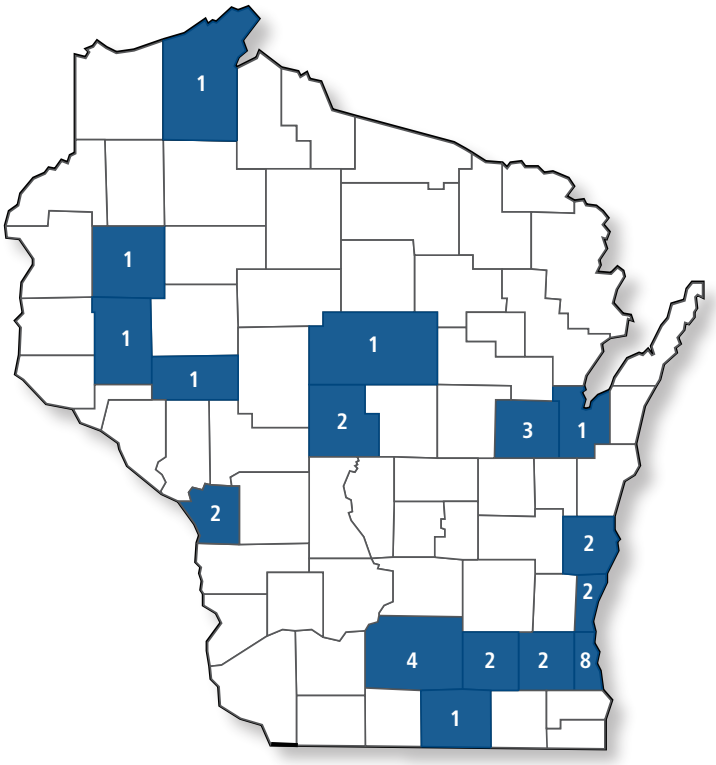
What Can Be Done?

- Increase the number of palliative care health providers in Wisconsin.
- Assess reimbursement for palliative care services.

Targets for Change

Certified* Palliative Care Providers in Wisconsin as of November 2004, by County

*Certification by the American Board of Hospice and Palliative Medicine (ABHPM)



PALLIATIVE CARE PROVIDERS	
Number of certified palliative care providers in Wisconsin, as of November 2004	
Appleton/Seymour	3
Bayfield	1
Beloit	1
Brookfield/New Berlin	2
Cedarburg/Mequon	2
Eau Claire	1
Green Bay	1
Johnson Creek/Lake Mills	2
La Crosse	2
Madison	4
Marshfield	2
Menomonie	1
Milwaukee/Franklin/Whitefish Bay	8
Rice Lake	1
Sheboygan	2
Wausau	1
2004 Total	34
2010 Target	40*

* And assure that all Wisconsin residents have access to a palliative care provider within 75 miles of their home.

Sources:
American Board of Hospice and Palliative Medicine (ABHPM) Website: www.abhpm.org/Locator.aspx

STRATEGY A: Increase the number of palliative care health providers in Wisconsin.	
Action Plan	**Recommended Implementation Steps**
Identify patient access to certified health care providers in palliative care throughout Wisconsin.	Collect, record, and analyze data on numbers, types and geographic distribution of healthcare providers certified in palliative care.
Create a plan to promote certification of palliative care providers throughout Wisconsin, especially in underserved areas.	Disseminate information on certification of palliative care providers to agencies such as hospitals, clinics, healthcare facilities, and Department of Health and Family Services (DHFS).
	Offer more palliative care certification courses and work to increase attendance in underserved areas.

STRATEGY B: Assess reimbursement for palliative care services.	
Action Plan	**Recommended Implementation Steps**
Identify reimbursement models that promote expanded access to palliative care.	Identify top insurance providers in the state to determine palliative care reimbursement mechanisms.
	Identify changes needed in these reimbursement mechanisms.
Advocate for provider reimbursement for longer, more extensive care required in palliative care.	To be determined.
Promote Medicare's reimbursement of hospice care.	To be determined.

Provide Education that will Enhance the Understanding of Palliative Care in the Treatment Continuum

Rationale

Today, more people are living longer and require care for chronic diseases. Cancer is no exception. The concept of "healthy dying" must be promoted to the general public as well as health professionals. Appropriate end of life care to allow healthy dying from cancer requires a team of health professionals trained in palliative care. Training health professionals must be done when they are starting in a college or university program and must continue throughout their careers.

Disparate Burden

Cultural differences in attitudes towards illness or death between healthcare providers and patients and families can be a barrier to proper end of life care. The differences in the perception and expression of pain and other symptoms may compromise the ability of hospice providers to assess the distress of the dying patient (i.e., suffering should be endured as a test of faith). It has also been shown that lack of cultural sensitivity in letters, brochures, fact sheets, and other written materials may be a barrier to hospice access.

What Can Be Done?

- Increase public awareness of palliative care.
- Expand provider education related to palliative care.

Targets for Change

MEDICAL SCHOOL CURRICULUM			
(2000–2001) N=125			
Number of U.S. medical schools teaching:	Cultural Diversity	End of Life Care	Palliative Care
Separate Required Course	3	5	5
Part of Required Course	112	116	110
Separate Elective Course	21	46	32
Part of Elective Course	32	40	42
Other Educational Experience	28	16	14

2010 Target: Increase schools that teach required courses in palliative care, focusing on making this change in Wisconsin's Medical Schools.

Sources:
Association of American Medical Colleges, Liaison Committee on Medical Education Part II Annual Medical School Questionnaire for 2000–2001.
Available from: http://services.aamc.org/currdir/section2/LCMEHotTopics.pdf

STRATEGY A: Increase public awareness of palliative care.	
Action Plan	**Recommended Implementation Steps**
Advocate for the inclusion of "healthy dying" in revisions of future Wisconsin State Health Plans.	Palliative care advocates meet with DHFS officials to discuss the importance of including healthy dying in the State Health Plan.
	Language is drawn up on healthy dying.
	The concept of healthy dying is included in the next State Health Plan.
Advocate for the integration of healthy dying and end of life issues into K-12 curriculum.	Assess current curriculum on end of life issues.
	Palliative care advocates meet with Department of Public Instruction (DPI) officials to discuss the importance of including healthy dying in K-12 curriculum.
	Gather examples of possible healthy dying curriculum.
	Curriculum for different grade levels is selected and a plan to implement it is in place.
Work with existing community-based organizations to develop a comprehensive end of life awareness campaign for specific populations.	Identify specific populations where palliative care services are under-utilized.
	Establish partnership with community-based organizations (CBOs) that work with those specific populations.
	Conduct an assessment of those populations on end of life issues and needs.
	Develop and disseminate through CBOs, educational materials tailored to those populations.
Establish a media campaign to increase knowledge of palliative care issues to the public.	Evaluate current media coverage of palliative care issues using a clipping service.
	Assess existing public awareness channels such as websites and hotlines.

STRATEGY B: Expand provider education related to palliative care.	
Action Plan	**Recommended Implementation Steps**
Establish interdisciplinary education on palliative care concepts in university and college curricula.	Assess which schools and universities in Wisconsin have curriculum on palliative care and what is being taught in this area.
	Review and recommend evidence-based curriculum to strengthen the teaching of palliative care concepts to healthcare providers.
Provide and promote palliative care continuing education for providers that care for cancer patients.	Expand palliative care continuing education to include many different healthcare providers including oncologists, primary care providers, administrators, social workers, chaplains, etc.

Identify Best Practices for Delivering Palliative Care

Rationale

Palliative care has grown in recent years in response to an aging population and a clinical interest in effective care for chronic and life-ending illnesses. Integrating palliative care is a major challenge for healthcare in the United States. Palliative care is a critical aspect of patient care and all patients should have access to practitioners who are skilled and knowledgeable about best practices.[28]

Disparate Burden

Disparities in the healthcare system between different racial/ethnic groups are also seen in palliative care programs. Factors such as lack of awareness about palliative care programs and cultural barriers contributes to the disparate burden. These barriers need to be considered as we identify best practices for delivering palliative care.

What Can Be Done?

- Establish guidelines for palliative care practice in Wisconsin.
- Develop a standardized form for Advance Care Planning.
- Educate patients about the importance of Advance Care Planning.

Targets for Change

ADVANCE CARE PLANNING	
In Wisconsin	
2005	2010 Target
No standardized form for ACP.	Establish standardized form.

STRATEGY A: Establish guidelines for palliative care practice in Wisconsin.	
Action Plan	**Recommended Implementation Steps**
Develop a palliative care program registry.	Conduct an inventory of current palliative care programs in Wisconsin.
	Assess these programs in congruence with the definitions from the National Consensus Project for Palliative Care.
Develop guidelines for quality improvement of palliative care programs.	With key stakeholders, use strengths and areas of improvement from current program assessment to develop guidelines.
Disseminate these guidelines to all programs in palliative care.	Develop and deliver training for palliative care programs on established guidelines.
	Evaluate the level of adoption of guidelines by doing another assessment in congruence with the National Consensus Project.

STRATEGY B: Develop a standardized form for Advance Care Planning.	
Action Plan	**Recommended Implementation Steps**
Convene task force to develop a standardized form for ACP.	Review current ACP terminology, other states' examples, and models within Wisconsin.
	Propose a standardized Advance Care Planning document to be used statewide.
Advocate for policy change to promote a standardized ACP form.	Meet with policy advocates to map out strategy for mandating a standardized form.

STRATEGY C: Educate patients about the importance of Advance Care Planning (ACP).	
Action Plan	**Recommended Implementation Steps**
Develop standardized way to track ACP discussions with primary care providers and patients in medical records.	Assess record keeping of completed Advance Care Planning to see if advance directives are readily identifiable.
	Identify primary care providers that complete documentation on ACP.
	Train staff on how to track ACP in medical records.
Provide training to healthcare professionals on the importance of Advance Care Planning.	Develop training on ACP.
	Offer incentives to physicians who consistently discuss ACP with their patients.

References

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27. American Board of Hospice and Palliative Medicine (ABHPM). Physician Directory. Available from: www.abhpm.org/Locator.aspx

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Chapter 6:
DATA COLLECTION & REPORTING

Promote the Collection and Use of Information: to Increase Professional and Public Understanding and Education about Cancer and its Impact on Wisconsin Residents

Rationale

Wisconsin established a state cancer registry in 1976, and the Wisconsin Cancer Reporting System (WCRS) has been part of the CDC funded National Program of Cancer Registries since 1994. WCRS has been consistently recognized by the North American Association of Central Cancer Registries (NAACCR) for high quality data since 1995 when national certification was first awarded. WCRS maintains data to support several local, state and national functions such as:

- Health care planning by state and local health departments,
- Epidemiological, medical and health services research,
- Citizen education,
- Evaluation of prevention and treatment programs, and
- Comprehensive cancer control strategies.

This information needs to be continually collected and, more importantly, disseminated. Analysis of data can influence the entire continuum of cancer and can offer new insights into how cancer is prevented and treated in the future.

Disparate Burden

Data show that there is a disparate burden of cancer in Wisconsin. The collection, classification, and reporting of cancer-related data can be improved. More can be done within research to increase the understanding of disparate burden and cancer. Only then will it be clear what variables are causing the disparities. Data will also point to which interventions should be implemented to try and reduce the disparate burden of cancer.

What Can Be Done?

- Continue funding and support for existing cancer-related data collection.
- Improve and enhance the Wisconsin Cancer Reporting System (WCRS).
- Increase awareness of existing cancer-related publications and educate users to the purpose of such publications, how they should be interpreted, and how they can be used for community programs.
- Increase research and professional access to cancer-related data.

Targets for Change

CANCER-RELATED DATA COLLECTION	
Examples of data sets in Wisconsin in 2003	
• Wisconsin Family Health Survey (WFHS) • Behavioral Risk Factor Surveillance System (BRFSS) • Wisconsin Cancer Reporting System (WCRS) • Tobacco Attitudes and Behavior Survey (TABS) • Youth Risk Behavioral Survey (YRBS) • Youth Tobacco Survey (YTS) • Vital Statistics	
2010 Target:	Expand cancer-related data collection that is Wisconsin specific.

STRATEGY A:	Continue funding and support for existing cancer-related data collection.
Action Plan	**Recommended Implementation Steps**
Actively search and apply for grants to provide sustainable funding for cancer-related data collection.	To be determined.
Incorporate the cancer-related data sets into cancer specific reports through the public use data set, Wisconsin Interactive Statistics on Health - WISH.	To be determined.

STRATEGY B:	Improve and enhance the Wisconsin Cancer Reporting System (WCRS).
Action Plan	**Recommended Implementation Steps**
Obtain additional funding for the Wisconsin Cancer Reporting System.	To be determined.
Partner with the Wisconsin Cancer Registrars Association to promote benefits of Certified Tumor Registrars (CTR) in cancer registry systems in Wisconsin.	Research other states with CTR as models.
	Develop education plan for hospitals on benefits of CTR.
	Develop education plan for employers on use of accredited (ACoS) hospitals.
	Encourage CTR Continuing Education for current CTR staff. Advocate mandating the use of CTR in cancer reporting.

STRATEGY C:	Increase awareness of existing cancer-related publications and educate users to the purpose of such publications, how they should be interpreted, and how they can be used for community programs.
Action Plan	**Recommended Implementation Steps**
Develop an awareness campaign on cancer-related publications.	Identify a lead organization to spearhead an awareness campaign.
	Disseminate information in a meaningful way to appropriate audiences.

STRATEGY D:	Increase research and professional access to cancer-related data.
Action Plan	**Recommended Implementation Steps**
Increase awareness of current systems to access individual use data sets.	Disseminate WCRS policy for accessing individual use data sets, both confidential and non-confidential.
	Assess and disseminate non-WCRS cancer data system individual use data set access policies.

Increase Timeliness of Reporting Cancer Cases to the Wisconsin Cancer Reporting System

Rationale

Timely data are needed for a variety of cancer analyses. The state health plan assessment requires timely data to assess "current/emerging threats to the community's health" (e.g., cancer cluster investigations).[11] Timely data are often needed for case/control studies, especially for cancer types with poor survival rates (brain, pancreas, etc.).

There are state and national standards for timely reporting: WCRS requires all cases be reported within six months of diagnosis, CDC requires a 90% complete database 12 months after the close of the reporting cycle.[22,29] However, most cases are not reported within six months. The majority of cases are reported nine to 12 months after diagnosis. Using the WCRS six-month reporting guideline, 50% of cases diagnosed in 2003 should have been reported by January 1, 2004.

Currently cancer data are published, on average, three years after the diagnosis year.[30] In contrast, other health and vital record publications on births, deaths, hospital discharge data, behavioral risk factor data, etc., are often available 18 to 24 months from the close of the event year. While there are standards in place to assess timeliness, there is a lack of enforcement mechanisms to ensure timely reporting.

Disparate Burden

The timeliness of reporting cancer data transcends all racial/ethnic groups. Therefore, it is important that all data be timely and this will only help us see any data-specific emerging disparities more quickly.

What Can Be Done?

- Increase electronic reporting of cancer cases to WCRS by 20%.
- Implement standard procedures for notification of reporting status for non-compliant facilities.
- Develop a work plan to study long-term timeliness improvements for the WCRS.

Targets for Change

ELECTRONIC REPORTING	
Wisconsin Cancer Reporting System Rates	
WI Electronic Reporting Rate 2003	2010 Target
70%	90%

Sources:
Wisconsin Cancer Reporting System (per Laura Stephenson).

STRATEGY A: Increase electronic reporting of cancer cases to WCRS by 20%.	
Action Plan	**Recommended Implementation Steps**
Promote electronic reporting to those currently using paper reporting.	Identify all reporting facilities in WCRS system that report cases on paper and stratify by annual caseload estimate.
	Send all paper reporting facilities with annual caseloads over 50 a copy of WCRS or CDC data entry software with installation instructions and user's manual.
	Follow up with above selected facilities to make sure WCRS software is installed and operational.
	Send all remaining paper reporting facilities, with more than ten cases per year, data entry software and instructions.
	Assess increase in electronic reporting.

STRATEGY B: Implement standard procedures for notification of reporting status for non-compliant facilities.	
Action Plan	**Recommended Implementation Steps**
Develop a standard procedure for notification for non-compliant facilities.	Determine the different types of non compliant categories.
	Identify a tiered communication structure that establishes who sends the notification at what time, how often, and to whom the notification is sent. Document procedures.
	Draft and send a letter for non-WCRS notification of non compliance.
Implement notification process.	To be determined.

STRATEGY C: Develop a work plan to study long-term timeliness improvements for the WCRS.	
Action Plan	**Recommended Implementation Steps**
Develop a plan for exploring the feasibility of electronic data transfer via the Public Health Information Network (PHIN), electronic data editing, and rapid case ascertainment.	Identify key stakeholders to develop the work plan.
	Complete a feasibility study as part of the work plan.

Improve the Quality and Completeness of Treatment Data

Rationale

Data requests for treatment information have been steadily increasing in recent years. CDC and North American Association of Central Cancer Registries (NAACCR) recently testified before Congress on the status of treatment data collection at the state registry level and the need for treatment supplements for the breast and cervical cancer programs around the country.[31] Based in part on those testimonies, CDC now requires collection of primary site surgeries and a number of state breast and cervical screening programs are providing payment for cancer treatment. However, treatment data are not collected consistently at the state level. WCRS requires reporting of cancer-directed treatment (surgical and nonsurgical), but the quality and completeness of the data are not closely monitored.[22] CDC only requires collection on primary site surgeries. The American College of Surgeons Approved Hospitals require collecting all first course treatment data, but only 29 Wisconsin hospitals have this certification, representing about 60-65% of the annual caseload.[24,32]

Disparate Burden

Data collection for racial and ethnic variables have known limitations, including underreporting, misclassification, and incomplete data items.[33] This also extends into the limited and inconsistent collection of treatment data on different racial and ethnic groups. It is important as more treatment data is collected that racial and ethnic variables within that data are monitored for completeness and proper classification.

What Can Be Done?

- Identify sources that currently collect treatment data.
- Make recommendations on how to collect treatment information for Wisconsin.

Targets for Change

TREATMENT DATA COLLECTION	
In Wisconsin	
2004	2010 Target
Current baseline in WI is not consolidated.	Have a treatment data set that appropriately describes the treatment provided to Wisconsinites regarding their first course cancer treatment plans.

STRATEGY A: Identify sources that currently collect treatment data.	
Action Plan	**Recommended Implementation Steps**
Identify Wisconsin sources for treatment data.	Determine method to identify treatment data collection sources.
	Complete collection and assessment of treatment data sources in Wisconsin.
Assess federal, state, local and other organizational requirements for treatment data collection.	Complete assessment of treatment data collection requirements.

STRATEGY B: Make recommendations on how to collect treatment information for Wisconsin.	
Action Plan	**Recommended Implementation Steps**
Assess federal, state, local and other organizational requirements for treatment data collection.	Complete assessment of treatment data collection requirements.
	Determine the major problems areas for treatment data collection in Wisconsin: Are certain treatments not being collected? Are sufficient treatments being collected but cannot be accessed by researchers? Is treatment data collection complete around the state?
Make recommendations on strategies to collect better treatment information for Wisconsin.	To be determined.

Improve Racial and Ethnic Cancer Data Collection

Rationale

Data collection for racial and ethnic variables have known limitations, including underreporting, misclassification, and incomplete data items.[24] Because data collection limitations are national in scope, the North American Association of Central Cancer Registries (NAACCR) provides reporting guidelines to help standardize collection of race and ethnicity variables. WCRS and the Wisconsin Cancer Council developed a poster campaign and distributed pamphlets with guidelines for reporting race and ethnicity data. Although collection of racial and ethnic data are becoming increasingly standardized through both national and state level initiatives, there are still many problems to address in meeting state and national objectives of reducing racial disparities.

Disparate Burden

See Above Rationale.

What Can Be Done?

- Publish Hispanic/Latino-specific cancer incidence and mortality rates for Wisconsin.
- Compile data from ancillary sources about cancer risk behaviors, health insurance, and cancer treatment related to cancer disparities across race and ethnic groups.

Targets for Change

HISPANIC/LATINO DATA	
Cancer incidence and mortality rates for Wisconsin	
2004 Baseline	2010 Target
N/A	Publish Hispanic/Latino cancer rates for Wisconsin.

CANCER DISPARITIES DATA	
Summary for Wisconsin	
2004 Baseline	2010 Target
N/A	Summarize available WI data applicable to racial/ethnic groups and gaps/weaknesses in data. Report findings as available.

STRATEGY A: Publish Hispanic/Latino-specific cancer incidence and mortality rates for Wisconsin.	
Action Plan	**Recommended Implementation Steps**
Evaluate the quality and completeness of Hispanic/Latino data capture in Wisconsin.	Seek national or other state guidance on possible quality measures for ethnicity capture.
	Examine rates for Hispanic/Latino ethnicity in Wisconsin compared to NAACCR Hispanic Monograph before and after running Hispanic surname algorithm.
	Recruit Wisconsin cancer researcher knowledgeable about Hispanic culture and cancer issues.
	Explore possible differences across Hispanic/Latino subgroups based on national origin.
Participate in future NAACCR call for Hispanic data.	To be determined.
Publish guidelines for reporting Hispanic/Latino cancer data in best way possible with caveats and identified limitations.	To be determined.

STRATEGY B: Compile data from ancillary sources about cancer risk behaviors, health insurance, and cancer treatment related to cancer disparities across race and ethnic groups.	
Action Plan	**Recommended Implementation Steps**
Evaluate existing cancer-related data collection programs for racial and ethnic specific information.	Look specifically at BRFSS, health insurance coverage, and treatment data.
	Summarize available data applicable to racial and ethnic groups and gaps/weaknesses in data. Report findings where race and ethnicity group composites are available.
Make recommendations for improving applicability of databases to tracking and evaluating known disparities in cancer incidence and mortality.	To be determined.

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Appendix A: Screening Recommendations

Site Specific Screening Recommendations

It is clear that recommendations on screening will change over the years as new information is published on the results of screening trials, advances in technology, and changes in morbidity and mortality rates are noted. The Wisconsin Comprehensive Cancer Control Plan will not endorse any one group's guidelines unless national consensus is achieved, but it will continue to promote screenings in an effort to reduce the burden of cancer.

Many entities give cancer screening recommendations; however, three main sources will be cited. The U.S. Preventive Services Task Force (USPSTF) is an independent panel of private-sector experts in primary care and prevention convened by the U.S. Public Health Service, which develops evidence-based recommendations for clinical preventive services.[33] The second body is the National Cancer Institute (NCI), serving as the Federal Government's principle agency for cancer research and training.[34] The NCI conducts and supports cancer research, training, health information dissemination and other programs. The Institute itself does not make screening or prevention recommendations. The exception is mammography, which because of its public health importance, NCI has made specific recommendations. Finally, the American Cancer Society (ACS) is a nationwide community-based voluntary health organization dedicated to eliminating cancer as a major health problem by preventing cancer, saving lives and diminishing suffering from cancer, through research, education, advocacy and service.[35] The recommendations of these three will be used to guide screening standards for the Wisconsin Comprehensive Cancer Control Plan.

TABLE A-1: Colorectal Cancer Screening Guidelines

	USPSTF	NCI	ACS
General	Strongly recommends screening of men and women 50 years of age and older. Insufficient data to determine which strategy has best risk/benefit/cost-effectiveness. Screening is likely to be cost-effective regardless of strategy chosen.	No specific recommendations.	Average risk: Begin age 50 Higher risk (personal history of colorectal cancer or chronic inflammatory bowel disease, strong family history of colorectal cancer or polyps): Discuss appropriate screening tests/schedule with MD.
Fecal Occult Blood Test (FOBT)	Good evidence of mortality reduction.	Annual or biennial testing in people 50-80 decreases mortality.	Annual screening.
Sigmoidoscopy	(alone or with FOBT) Fair evidence of mortality reduction.	Regular use in people over 50 may decrease mortality. Insufficient evidence to determine optimal screening interval.	Every five years (in addition to yearly FOBT is preferred).
Colonoscopy	No direct evidence of effectiveness in reducing mortality.		Every ten years.
Double Contrast Barium Enema (DCBE)	No direct evidence of effectiveness in reducing mortality. Less sensitive than colonoscopy.		Every five years.

TABLE A-2: Breast Cancer Screening Guidelines

	USPSTF	NCI	ACS
	Women at average risk		
Mammography	Every one to two years age 40 and older with or without clinical breast exam.	Every one to two years age 40 and older.	Annually beginning at age 40.
Clinical Breast Exam (CBE)	Insufficient evidence to recommend for or against routine CBE alone to screen for breast cancer.	No recommendation.	Annual for women over 40. Should be part of periodic health exam (about every three years) for women in their 20's and 30's.
Breast Self Exam (BSE)	Insufficient evidence to recommend for or against teaching or performing routine BSE.	Evidence of effectiveness is weak.	Beginning in their 20's women should be told about benefits and limitations of BSE.
	Women at increased risk		
	No specific recommendation	Should seek expert medical advice about whether to begin screening before age 40 and the frequency of screening.	May benefit from earlier initiation of screening and/or addition of breast ultrasound or MRI.

TABLE A-3: Cervical Cancer Screening Guidelines

	USPSTF	NCI	ACS
Younger Women	Strongly recommends screening for women who have been sexually active and have an intact cervix. Indirect evidence suggests most benefit obtained by beginning screening within three years of onset of sexual activity or age 21 (which ever comes first) and screening at least every three years.	No specific recommendation. Evidence strongly suggests a decrease in mortality from regular screening with Pap tests in women who are sexually active or who have reached 18 years of age. The upper age limit at which screening ceases to be effective is unknown.	Annual Pap smear and pelvic exam at onset of sexual activity or age 18. After three consecutive negative tests, screening may be done less often. Appropriate interval for screening should be discussed with the MD.
Older Women	Recommends against routinely screening women > 65 years with adequate recent screening, normal Pap smears, and not otherwise at high risk.	Extra effort is warranted to reach older women who have not been screened. Over 25% of invasive cervical cancers occur in women older than 65.	
Women with hysterectomy	Recommends against routine screening in women with total hysterectomy for benign disease.	A retrospective study suggests little or no benefit of routine vaginal screening for women who have had a hysterectomy for benign disease.	

TABLE A-4: Prostate Cancer Screening Guidelines

	USPSTF	NCI	ACS
Prostate Specific Antigen (PSA) testing and Digital Rectal Examination (DRE)	Evidence is insufficient to recommend for or against routine screening for prostate cancer using prostate specific antigen (PSA) testing or digital rectal examination (DRE). Mixed/inconclusive evidence that early detection improves health outcomes.	Insufficient evidence to establish whether routine screening with PSA or DRE results in decreased mortality.	Annual screening PSA and DRE beginning at age 50 for men with life expectancy >ten years. Higher risk (African American or 1st degree relative diagnosed with prostate cancer at a young age) begin screening at age 45.
Other	Harms of screening include frequent false positives, unnecessary anxiety, complications of treatment of clinically insignificant cancers.		Patient should be informed about benefits/limitations before deciding about screening.

Controlled trials addressing health benefits of screening for prostate cancer are ongoing but results are not yet available. Until then, controversies surround prostate cancer screening. The WI CCC Plan Screening and Detection Workgroup does support the promotion of prostate screening but recognizes its limitations.

TABLE A-5: Melanoma Cancer Screening Guidelines

	USPSTF	NCI	ACS
Skin Examination	Evidence is insufficient to recommend for or against routine screening using a total-body skin examination.	Routine examination of the skin increases the chance of finding skin cancer early.	Adults should practice skin self-examination regularly.

TABLE A-6: Cancers NOT Routinely Screened

	USPSTF	NCI	ACS
Bladder	Recommends against routine screening.	Studies have not shown hematuria testing to be of benefit in detecting bladder cancer. Cytoscopy is not a practical test for screening individuals who do not have a history of bladder cancer; however, it is successful in patients who have previously been treated for bladder cancer.	Bladder is diagnosed by examination of cells in the urine and examination of the bladder wall with a cytoscope. These tests are not recommended for screening people at average risk, but are used for people at increased risk due to occupational exposure or for follow up after bladder cancer treatment.
	USPSTF Rationale: The USPSTF found fair evidence that screening with available tests can detect bladder cancer in asymptomatic individuals. The potential benefit of screening would be small, at best, for the following reasons: there is fair evidence that many of the cancers detected by screening have a low tendency to progress to invasive disease; there is a relatively low overall prevalence of asymptomatic bladder cancer that would eventually lead to important clinical consequences; and there is limited evidence that early treatment of bladder cancer detected through screening improves long-term health outcomes. The potential harms of screening are at least small: screening tests have a low positive predictive value and yield many false positive results, leading to unnecessary invasive procedures. As a result, the USPSTF concluded that the potential harms of screening for bladder cancer outweigh any potential benefits.		
Lung (General)	All patients should be counseled against tobacco use.	Current evidence does not support lung cancer screening.	Early detection not yet proven to improve survival.
Lung (Current Screening)	Routine screening for lung cancer with chest radiography or sputum cytology in asymptomatic persons is not recommended.	Randomized controlled studies have not demonstrated a reduction in lung cancer mortality resulting from screening with chest radiography and/or sputum cytology.	Chest x-ray, analysis of cells of sputum, and fiberoptic examination of the bronchial passages have shown limited effectiveness in early lung cancer detection.

TABLE A-6: (Continued)

	USPSTF	NCI	ACS
Lung (New Screening)		NCI is sponsoring a large national lung cancer screening study (NLST) comparing chest x-ray to spiral CT scan.	Newer tests (helical CT scan, molecular markers in sputum) are being evaluated.
	USPSTF Rationale: The USPSTF found fair evidence that screening with LDCT, CXR, or sputum cytology can detect lung cancer at an earlier stage than lung cancer would be detected in an unscreened population; however, the USPSTF found poor evidence that any screening strategy for lung cancer decreases mortality. Because of the invasive nature of diagnostic testing and the possibility of a high number of false-positive tests in certain populations, there is potential for significant harms from screening. Therefore, the USPSTF could not determine the balance between the benefits and harms of screening for lung cancer.		
Oral	Evidence is insufficient to recommend for or against routinely screening.	Screening may be done during a physical exam by a dentist or doctor; however, it is not known if screening decreases the risk of dying from oral cancer.	Dentists and primary care physicians can identify abnormal changes in oral tissues and detect cancer at an early, curable stage.
	USPSTF Rationale: The USPSTF found no new good-quality evidence that screening for oral cancer leads to improved health outcomes for either high-risk adults (i.e., those over the age of 50 who use tobacco) or for average-risk adults in the general population. It is unlikely that controlled trials of screening for oral cancer will ever be conducted in the general population because of the very low incidence of oral cancer in the United States. There is also no new evidence for the harms of screening. As a result, the USPSTF could not determine the balance between benefits and harms of screening for oral cancer.		
Ovarian	Recommends against routine screening.	There is no standard or routine screening test for ovarian cancer. Tests that may detect ovarian cancer are being studied: pelvic exam, transvaginal ultrasound, and CA 125 assay.	Routine screening for women at average risk is not recommended because no accurate screening tests are available. The combination of a thorough pelvic exam, transvaginal ultrasound, and a blood test for the tumor marker CA 125 should be offered to women who are at high risk and women who have symptoms.
	USPSTF Rationale: The USPSTF found fair evidence that screening with serum CA-125 level or transvaginal ultrasound can detect ovarian cancer at an earlier stage than it can be detected in the absence of screening; however, the USPSTF found fair evidence that earlier detection would likely have a small effect, at best, on mortality from ovarian cancer. Because of the low prevalence of ovarian cancer and the invasive nature of diagnostic testing after a positive screening test, there is fair evidence that screening could likely lead to important harms. The USPSTF concluded that the potential harms outweigh the potential benefits.		

TABLE A-6: (Continued)

	USPSTF	NCI	ACS
Pancreatic	Recommends against routine screening.		At present, only biopsy yields a certain diagnosis. Because of the "silent" early course of the disease, the need for biopsy may become obvious only with advanced disease.
	USPSTF Rationale: The USPSTF found no evidence that screening for pancreatic cancer is effective in reducing mortality. There is a potential for significant harm due to the very low prevalence of pancreatic cancer, limited accuracy of available screening tests, the invasive nature of diagnostic tests, and the poor outcomes of treatment. As a result, the USPSTF concluded that the harms of screening for pancreatic cancer exceed any potential benefits.		
Testicular	Recommends against routine screening.	No studies have been done to determine whether self-examination or examination during routine physicals can help reduce the number of deaths caused by testicular cancer.	
	USPSTF Rationale: The USPSTF found no new evidence that screening with clinical examination or testicular self-examination is effective in reducing mortality from testicular cancer. Even in the absence of screening, the current treatment interventions provide very favorable health outcomes. Given the low prevalence of testicular cancer, limited accuracy of screening tests, and no evidence for the incremental benefits of screening, the USPSTF concluded that the harms of screening exceed any potential benefits.		
Thyroid	Routing screening using neck palpation or ultrasonography is not recommended. There is insufficient evidence to recommend for or against screening persons with a history of external head and neck irradiation in infancy or childhood.		

Appendix B: CCC History

National Comprehensive Cancer Control History

Comprehensive cancer control (CCC) is an integrated and coordinated approach to reducing cancer incidence, morbidity, and mortality through prevention, early detection, treatment, rehabilitation, and palliation. Nationally, sixteen states and one tribal organization have implemented comprehensive cancer control plans (as of 2003). Most of the remaining states, including Wisconsin, are in the process of creating or updating a plan. With approximately $5.3 million in fiscal year 2002 funding, CDC supported CCC programs in 27 states and one tribal organization. With this support, public health agencies worked to establish broad based CCC coalitions, assess the burden of cancer, determine priorities for cancer prevention and control, and develop and implement CCC plans. CDC also provided $3.6 million to support colorectal, prostate, and skin cancer activities within CCC programs during 2002. CDC expects to expand program support and activities for CCC with fiscal year 2003 appropriations.

Wisconsin's Cancer Control History

Wisconsin has been actively engaged in cancer control planning and program development over the past 30 years. The Wisconsin State Legislature established the Wisconsin Cancer Reporting System in 1976 as the state's only population-based data collection and maintenance system for cancer. In 1987 it was one of the first states to receive a NCI Data-Based Intervention Research grant. Similar to the current comprehensive cancer control planning effort, the goal of this grant was to establish a cancer control coalition, assess the cancer burden in the state, establish a set of cancer control priorities, and implement selected programs. Through this grant, the Wisconsin Division of Health hired key staff, revitalized the Wisconsin Cancer Council, developed a state cancer plan (as part of the Public Health Agenda), and selected breast cancer as a key intervention priority.

During this same time, the Wisconsin Cancer Council was working to support cancer control efforts in the state. Dr. Paul Carbone, then Director of the UW Comprehensive Cancer Center, worked with Governor Tommy Thompson to establish the "Governor's Cancer Control Initiative." This Initiative provided approximately $400,000 annually to support statewide cancer control programs and $50,000 to improve the Wisconsin Cancer Reporting System. Through a competitive process, these funds were used to support a variety of cancer control projects, including the ASSIST tobacco control project throughout the state.

In 1993, Wisconsin received funding for The National Breast and Cervical Cancer Early Detection Program, administered by CDC. The Wisconsin Well Woman program helps low-income, uninsured, and underserved women, between the ages of 35 and 64, gain access to lifesaving screening programs for early detection of breast and cervical cancers.

In the new millennium, cancer control was again on the forefront in Wisconsin. The Turning Point Initiative began its planning for Healthiest Wisconsin 2010. In 2002, comprehensive cancer control planning gained momentum after the Leadership Institute and the CDC planning grant for WI CCC Plan. In September of that year, Wisconsin's Department of Health and Family Services was awarded a Comprehensive Cancer Control planning grant from the Centers for Disease Control and Prevention. Over the next three years, the Wisconsin Division of Public Health and its statewide coalition of stakeholders will follow the CDC's building block model for creating a coordinated public health response to cancer. A plan for implementing comprehensive cancer control in Wisconsin should be completed in early 2005.

Table B-1: Recent History of Cancer Control Activities in Wisconsin

Year	Activity
1976	The Wisconsin State Legislature establishes the Wisconsin Cancer Reporting System.
1987	Data-Based Intervention for Cancer Control. National Cancer Institute (NIH RO1 CA46883). $450,000/5 years (9/87 – 10/92), Dr. Henry Anderson, PI.
1988	Governor Tommy Thompson establishes the "Governor's Cancer Initiative," with approximately $400,000 annually for cancer control grants and $50,000 for the Cancer Reporting System.
1990	State publishes its first cancer control plan, as part of the Public Health Agenda for the year 2000.
1991	American Stop Smoking Intervention Study For Cancer Prevention (ASSIST). National Cancer Institute (NCI-CN-95165-38). $7.4 million/8 years (9/91 – 8/99).
1992	State legislature appropriates $540,000 to fund a rural and urban breast cancer screening program.
1992	Core Capacity Program for Breast and Cervical Cancer Control. Centers for Disease Control. $250,000/1 year (10/92 – 9/93).
1992	Public Health Approaches to Breast and Cervical Cancer Control. National Cancer Institute (NCI-CA-57014). $1.3 million/4 years (9/92 – 8/96).
1992	Congress creates National Program of Cancer Registries to provide funding for states and territories to establish or enhance population-based central cancer registries.
1993	Comprehensive Breast and Cervical Cancer Control Program. Centers for Disease Control. $13 million/5 years (10/93 – 9/98).
1994	The Wisconsin Well Woman Program, CDC funding.
1994	CDC funds Wisconsin efforts to enhance the state cancer registry, through the National Program of Cancer Registries. This funding has been approved annually to improve timeliness, completeness and quality of cancer incidence data collected by the Wisconsin Cancer Reporting System.
2000	State legislature establishes Tobacco Control Board using the Tobacco Settlement ($21 million annually).
2000	Turning Point Initiative begins planning for the 2010 public health plan for the state.
2002	CDC/ACS/NCI bring WI cancer control leaders together to begin thinking about comprehensive cancer control at the first Leadership Institute.
2002	Wisconsin receives funding for comprehensive cancer control planning from CDC.
2003	Wisconsin Comprehensive Cancer Control Plan Steering Committee convenes.
2004	Statewide coalition meets at WI CCC Plan Kickoff Summit. Coalition of partners write WI CCC Plan.
2005	Statewide coalition meets at WI CCC Plan Transition to Implementation Summit. Cancer Prevention and Control dollars re-allocated to cancer control.

Appendix C: Wisconsin Demographics

Wisconsin Demographics

Wisconsin covers 56,145 square miles of rolling hills, ridges, fertile plains and valleys and the demographics of people that reside here are just as diverse. Minority groups in Wisconsin include: African American, Hispanic or Latino, Asian/Pacific Islander, and American Indian/Alaska Native (AI/AN). Additional underserved populations include migrant workers, rural poor, and older adults. Demographic and social indicators are important for understanding the health status of communities. These indicators can be used to identify population groups that may be at a higher risk for morbidity and mortality. They can also assist in identifying causal or contributing factors to a health condition. Race and ethnicity, gender and age, education, income, employment, and household characteristics are included in this section.

Race and Ethnicity

Racial and ethnic differences in health status are often attributable to differences in social and economic status. However, knowledge of the racial distributions in the population of a community is essential in interpreting gaps in health status, for identifying structural or cultural barriers for access to care among populations, and in developing strategies to address these problems.

TABLE C-1: Race and Ethnicity Distribution for Wisconsin, 1990 & 2000[36]

		1990		2000	
		Number	Percent	Number	Percent
Race	White	4,514,315	92.3	4,769,857	88.9
	African American	244,305	5.0	304,460	5.7
	AI/AN	39,725	0.8	47,228	0.9
	Asian/Pacific Islander	53,058	1.1	88,763	1.7
	Other	40,366	0.8	86,472	1.6
	2+Races			66,895	1.2
	Total	4,891,769	100.0	5,363,675	100.0
Ethnicity	Hispanic or Latino	93,194	1.9	192,921	3.6
	Not Hispanic or Latino	4,798,575	98.1	5,170,754	96.4
	Total	4,891,769	100.0	5,363,675	100.0

Age and Gender

Both age and gender influence patterns of morbidity, mortality, and utilization of health services. 13.1% of Wisconsin's population is 65 years of age and older. The aging of Wisconsin's population will create an upward pressure on the number of new cancer cases since incidence increases with age.

TABLE C-2: Age and Gender Distribution for Wisconsin, 2000[36]

Age	Males		Females		Total		Change from 1990–2000
	Number	Percent	Number	Percent	Number	Percent	
0-4	175,041	3.3	167,299	3.1	342,340	6.4	-5.4
5-14	401,171	7.5	381,387	7.1	782,558	14.6	+6.7
15-24	391,157	7.3	373,330	7.0	764,487	14.3	+7.0
25-44	797,512	14.9	784,178	14.6	1,581,690	29.5	+2.2
45-64	592,650	11.0	597,397	11.1	1,190,047	22.2	+25.0
65-74	164,381	3.1	190,926	3.6	355,307	6.6	-0.9
75 +	127,129	2.4	220,117	4.1	347,246	6.5	+15.7
Total	2,649,041	49.5	2,714,643	50.6	5,363,675	100.0	+8.8

Urban and Rural

The U.S. Census Bureau classifies urban as one or more block groups each of which has a population density of at least 1,000 people per square mile at the time and surrounding block groups each of which has a population density of at least 500 people per square mile at the time. Rural geography is classified as all territory, population, and housing units located outside of the above urban classification. In Wisconsin, 31.7% of the population lives in rural areas and 68.3% are in urban communities.

TABLE C-3: Urban and Rural population for Wisconsin, 1990 and 2000[36]

	1990	2000	Change (%)
Urban	3,211,956	3,663,643	+12.3
Rural	1,679,813	1,700,032	+1.2
Total	4,891,769	5,363,675	+8.8

For more complete county specific cancer data, see Wisconsin Cancer Facts and Figures 2003–2004, which illustrates the cancer incidence and mortality rates by county for 1996–2000.

Socioeconomic Status

Differences in socioeconomic status can account for many patterns of incidence and mortality. Low socioeconomic status is related to social stressors such as poor access to health care, obstacles in obtaining and using health insurance, unhealthy or unsafe living conditions, and low education levels.

TABLE C-4: Wisconsin SES Indicators, 1990 & 2000[36]

		1990 (%)	2000 (%)	Change (%)
Educational Attainment	High school diploma or higher	75.7	85.1	+12.4
	Bachelor's degree or higher	15.2	22.4	+47.5
Household Income	Less than $10,000	24.0	7.1	-70.2
	$10,000 to $14,999	9.4	5.8	-38.1
	$15,000 to $24,999	18.7	12.7	-32.1
	$25,000 to $34,999	17.4	13.2	-24.0
	$35,000 to $49,999	20.2	18.1	-10.4
	$50,000 to $74,999	14.1	22.7	+61.2
	$75,000 or $99,999	3.6	10.9	+201.4
	$100,000 or more	2.6	9.4	+262.5
Employment	In Labor Force	67.6	69.1	+2.2
	In Armed Forces	0.2	0.1	-50.1
	Employed	94.6	95.2	+0.7
	Unemployed	5.2	4.7	-10.1
	Not in Labor Force*	32.4	30.9	-4.6

* "Not in Labor Force" consists of students, individuals taking care of home or family, retired workers, institutionalized people regardless of work activities, and people doing incidental unpaid family work.

Appendix D: Acronyms

Acronyms	
ACP	Advance Care Planning
ACS	American Cancer Society
ACoS	American College of Surgeons
ACoS CoC	American College of Surgeons Commission on Cancer
ASCO	American Society of Clinical Oncology
BMI	Body Mass Index
BRFSS	Behavioral Risk Factor Surveillance Survey
CBO	Community Based Organization
CCC	Comprehensive Cancer Control
CDC	Centers for Disease Control and Prevention
CTRI	Center for Tobacco Research and Intervention
DHFS	Department of Health and Family Services
DPH	Division of Public Health
DPI	Department of Public Instruction
HIPAA	Health Insurance Portability and Accountability Act
HIRSP	Health Insurance Risk Sharing Plan
NAACCR	North American Association of Central Cancer Registries
NCCN	National Comprehensive Cancer Network
NCI	National Cancer Institute
NIH	National Institutes of Health
PCP	Primary Care Physician
PDQ	Physician Data Query
PSA	Prostate-specific antigen
QOL	Quality of Life
SES	Socioeconomic status
USPSTF	U.S. Preventive Services Task Force
WI CCC Plan	Wisconsin Comprehensive Cancer Control Plan
WCRS	Wisconsin Cancer Reporting System
WIC	Women, Infants, and Children
WISH	Wisconsin Interactive Statistics on Health
YRBS	Youth Risk Behavior Survey
YTS	Youth Tobacco Survey

Appendix E: Definitions

Definitions	
advance care planning (ACP)	The process of discussing end of life care with the patient and developing a valid expression of the patient's wishes regarding future medical care.
Advance directive	A person's oral and written instructions about his or her future medical care, in the event he or she becomes unable to communicate.
Age-adjustment	A statistical technique that allows for the comparison of rates among populations having different age distributions.
Alcohol and Other Drug Abuse (AODA) Treatment Programs	A wide range of programs for persons affected by alcohol or drugs; programs include detox centers, day treatment, inpatient/outpatient facilities, residential programs, and intervention/prevention efforts.
Navigators	Navigators act on behalf of those affected by cancer in every community to identify and obtain beneficial resources. Navigators offer free, confidential assistance to cancer patients and those who care for them.
Breast and Cervical Cancer Early Detection Program	Provides critical breast and cervical cancer screening services to underserved women, aged 35 to 64, in the United States, the District of Columbia, four U.S. territories, and 13 American Indian/Alaska Native organizations.
Cancer continuum	Prevention, screening and detection, treatment, quality of life, and palliative care.
Cancer survivor	People who have been diagnosed with cancer and the people in their lives who are affected by the diagnosis, including family members, friends, and caregivers.
cultural competency	A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency or those professionals to work effectively in cross cultural situations.[37]
Fax to Quit Program	Tobacco cessation counseling service provided by the Wisconsin Tobacco Quit Line, includes intense intervention and follow-up.
High Risk Populations	A population in the community with an elevated risk of disease.[38]
incidence rate	Number of new cases per 100,000 population during a defined period (usually one year).
Let's Talk About It (LTAI)	A free community-based program developed by the American Cancer Society and 100 Black Men of America to increase awareness and knowledge of prostate cancer among African American men.
mortality rate	Number of deaths per 100,000 population during a defined period (usually one year).
National Consensus Project (NCP) for Quality Palliative Care	The purpose of the NCP is to arrive at voluntary consensus Clinical Practice Guidelines describing the scope and characteristics of palliative care services in the United States.

Definitions (Continued)	
palliative care	Care given to improve the quality of life of patients who have a serious or life-threatening disease. The goal of palliative care is to prevent or treat as early as possible the symptoms of the disease, side effects caused by treatment of the disease, and psychological, social, and spiritual problems related to the disease or its treatment. Also called comfort care, supportive care, and symptom management.
quality of life (QOL)	The overall enjoyment of life. Many clinical trials assess the effects of cancer and its treatment on the quality of life. These studies measure aspects of an individual's sense of well-being and ability to carry out various tasks.
stage at diagnosis	Extent to which a cancer has spread from the organ of origin (e.g., in situ, localized, regional, distant, unstaged/other).
Wisconsin Tobacco Quit-Line	A toll-free telephone service staffed by smoking cessation experts, which provides confidential counseling, information for friends/family, self-help material, and referrals to smoking cessation programs; managed by the Center for Tobacco Research and Intervention. 1-877-270-STOP (English); 1-877-2NO-FUME (Spanish).
Wisconsin Walks Program	Promotes walking for transportation, health and recreation and collaborates with individuals and communities to create walkable places that are delightful, safe and accessible for everyone.
Wisconsin Well Woman Program (WWWP)	Provides preventive health screening services to women with little or no health insurance coverage. Well Woman pays for mammograms, Pap tests and certain other health screenings for women aged 35-64; administered by the Wisconsin Department of Health and Family Services, Division of Public Health.
5 A Day for Better Health Program	National program that encourages Americans to eat 5 or more servings of fruits and vegetables every day for better health; jointly sponsored by the National Cancer Institute (NCI) and the Produce for Better Health Foundation (PBH), a nonprofit consumer education foundation representing the fruit and vegetable industry.

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Appendix F: Specific Audiences

	CROSS REFERENCE OF WI CCC PLAN	Businesses / Employers	Community & Faith Based Orgs	Educators	Gov Agencies & Public Health	Healthcare Systems	Media	Minority & Underserved	Payers & Insurance	Physicians & Providers	Professional Organizations	Public Policy & Advocacy	Survivors, Consumers, Caregivers	Universities & Researchers	Wisconsin Residents
TOBACCO USE	**Decrease youth tobacco use and support tobacco addiction treatment by establishing a tobacco user's fee.**			x	x							x			
	Support the adoption of a minimum of a $1 per pack increase in the price of cigarettes as a user's fee.				x							x			
	Protect all employees from the dangers of secondhand smoke by increasing the number of smoke-free workplaces in Wisconsin.	x	x		x			x				x	x		x
	Support the adoption of local smoke-free workplace ordinances in 20 communities.	x	x		x			x				x	x		x
	Establish a state law making all government buildings smoke-free.				x							x			
	Help tobacco users quit by increasing access to affordable tobacco addiction treatment.	x	x		x	x	x	x	x	x	x		x		x
	Increase usage of the WI Quit Line and Fax to Quit Programs.	x	x			x	x	x	x				x		x
	Involve health care providers in promoting tobacco addiction treatment.					x			x	x	x				
	Insurers, including Medicaid, and purchasers will report covering all effective tobacco addiction treatments as identified in the Clinical Practice Guideline.								x						
	Develop a plan for integrating tobacco addiction treatment into private and public mental health and AODA treatment systems.				x	x			x						
	Fund a comprehensive tobacco prevention and control program.		x		x			x				x	x		x
	Build grassroots and grass-top support to advocate for $31 million from Wisconsin revenues for a comprehensive tobacco prevention and control program.		x		x			x				x	x		x

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HEALTHY LIFESTYLES	**Encourage adequate and appropriate nutrition for healthy weight.**	**x**	**x**	**x**	**x**	**x**		**x**					**x**		**x**
	Promote school-based interventions that increase fruit/vegetable consumption.			x	x			x							
	Promote healthy eating options at worksites.	x						x					x		x
	Promote healthy eating within the community.		x					x					x		x
	Create active community environments.	**x**	**x**	**x**				**x**				**x**	**x**		**x**
	Increase physical activity in schools.			x				x				x	x		x
	Create worksite opportunities that help employees to incorporate physical activity into their lives.	x						x					x		x
	Promote opportunities for safe physical activity within neighborhoods and the community.		x					x				x	x		x
SUN AND UV	**Establish programs focused on protecting youth from sun and UV exposure.**		**x**	**x**	**x**			**x**					**x**		**x**
	Collect data on sun exposure behaviors in youth.				x										
	Develop community-based interventions to increase sun protective behaviors in youth.		x	x				x					x		x
	Explore areas of policy changes regarding sun exposure and UV protection.	**x**			**x**							**x**			
	Increase the number and type of public park/ recreation sun protection policies.				x							x			
	Develop occupational safety plans emphasizing sun protection for seasonal outdoor workers.	x			x										

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COLORECTAL CANCER SCREENING	**Develop a public awareness campaign for colorectal cancer screening.**		**x**		**x**	**x**	**x**	**x**		**x**	**x**		**x**		**x**
	Develop an education and awareness campaign to increase the number of adults receiving colorectal cancer screenings.		x		x	x	x	x		x	x		x		x
	Promote system changes that will increase colorectal cancer screening.				**x**	**x**			**x**	**x**	**x**			**x**	
	Partner with health care organizations to enact health care delivery system changes. Partners should include HMOs, group practices, professional organizations, WI Colorectal Cancer Task Force, primary care physicians, nurse practitioners, other organizations, etc.					x			x	x	x				
	Develop a professional education campaign for healthcare providers.					x				x	x			x	
	Work with health systems to encourage regular colorectal screening.					x			x	x	x				
	Develop a plan to address the issue of colorectal screening financial coverage shortcomings.				x	x									
	Increase the availability of colorectal screening to populations facing geographic, economic, or cultural barriers.		**x**		**x**	**x**		**x**					**x**		**x**
	Partner with community-based organizations to promote colorectal cancer screening program for at-risk and underserved populations.		x		x	x		x					x		x

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BREAST CANCER SCREENING	Businesses / Employers	Community & Faith Based Orgs	Educators	Gov Agencies & Public Health	Healthcare Systems	Media	Minority & Underserved	Payers & Insurance	Physicians & Providers	Professional Organizations	Public Policy & Advocacy	Survivors, Consumers, Caregivers	Universities & Researchers	Wisconsin Residents
Develop a public awareness campaign for breast cancer screening.		**x**		**x**	**x**	**x**	**x**		**x**	**x**		**x**		**x**
Develop an education and awareness campaign to increase the number of woman receiving mammograms.		x		x	x	x	x		x	x		x		x
Promote system changes that will increase breast cancer screening.				**x**	**x**			**x**	**x**	**x**			**x**	
Partner with health care organizations to enact health care delivery system changes. Partners should include HMOs, group practices, professional organizations, Ob/Gyns, primary care physicians, nurse practitioner organizations etc.					x			x	x	x				
Develop a professional education campaign for healthcare providers.					x				x	x			x	
Work with health systems to encourage regular breast screening.					x			x	x	x				
Encourage statewide consumer-friendly quality measurement and reporting of breast cancer screening.				x	x									
Create a uniform statewide family/medical history questionnaire to identify high-risk women.				x									x	
Develop recognition for physicians, organizations, etc., for excellence in breast cancer screening.					x				x	x				
Increase the availability of breast cancer screening to populations facing geographic, economic, or cultural barriers.		**x**		**x**	**x**		**x**					**x**		**x**
Partner with community-based organizations to promote breast cancer screening program for at-risk and underserved populations.		x		x	x		x					x		x
Create a better distribution of mammography services.				x	x									

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CERVICAL CANCER SCREENING	**Develop a public awareness campaign for cervical cancer screening.**		**x**		**x**	**x**	**x**	**x**		**x**	**x**		**x**		**x**
	Develop an education and awareness campaign to increase the number of woman receiving Pap smears.		x		x	x	x	x		x	x		x		x
	Promote system changes that will increase cervical cancer screening.				**x**	**x**			**x**	**x**	**x**			**x**	
	Partner with health care organizations to enact health care delivery system changes. Partners should include HMOs, group practices, professional organizations, Ob/Gyns, primary care physicians, nurse practitioner organizations etc.					x			x	x	x				
	Develop a professional education campaign for healthcare providers.					x				x	x			x	
	Work with health systems to encourage regular cervical cancer screening.					x			x	x	x				
	Create a uniform statewide family/medical history questionnaire to identify high-risk women.				x									x	
	Develop recognition for physicians, organizations, etc., for excellence in cervical cancer screening.					x				x	x				
	Increase the availability of cervical cancer screening to populations facing geographic, economic, or cultural barriers.		**x**		**x**	**x**		**x**		**x**	**x**		**x**		**x**
	Partner with community-based organizations to promote cervical cancer screening program for at-risk and underserved populations.		x		x	x		x					x		x
	Create a better distribution of cervical cancer screening services.				x	x									
	Encourage the development of new technologies and practices to make screening more comfortable.									x	x				

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PROSTATE CANCER SCREENING	Businesses / Employers	Community & Faith Based Orgs	Educators	Gov Agencies & Public Health	Healthcare Systems	Media	Minority & Underserved	Payers & Insurance	Physicians & Providers	Professional Organizations	Public Policy & Advocacy	Survivors, Consumers, Caregivers	Universities & Researchers	Wisconsin Residents
Develop a public awareness campaign for prostate cancer screening.		**x**		**x**	**x**	**x**	**x**		**x**	**x**		**x**		**x**
Develop an education and awareness campaign to promote prostate cancer screening.		x		x	x	x	x		x	x		x		x
Promote system changes that will increase prostate cancer screening.				**x**	**x**			**x**	**x**	**x**			**x**	
Partner with health care organizations to enact health care delivery system changes. Partners should include HMOs, group practices, professional organizations, primary care physicians, nurse practitioner organizations etc.					x			x	x	x				
Develop a professional education campaign for healthcare providers.					x				x	x			x	
Analyze the cost-benefit and quality of life benefit of prostate cancer screening specific to Wisconsin.				x	x								x	
Develop a screening campaign directed for African American men over the age of 45 with a strong family history of prostate cancer.		**x**		**x**	**x**	**x**	**x**	**x**	**x**	**x**		**x**		**x**
Partner with community-based organizations that work with African American men to promote prostate cancer screening program.		x		x	x	x	x		x	x		x		x
Partner with urologists and primary care physicians to provide appropriate messages and counseling to their African American patients.					x		x		x	x				
Provide information on Medicare and insurance coverage for screening, diagnosis and treatment of prostate cancer.		x			x		x	x				x		x

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ACCESS TO CANCER TREATMENT	**Develop five "Regional Partnership Networks" (RPNs) dedicated to breaking down barriers to access of cancer care.**		**x**		**x**	**x**			**x**	**x**	**x**	**x**		**x**	
	Conduct a comprehensive evaluation of current cancer care capacity in the state.				x							x		x	
	Develop and implement a strategic plan for each RPN to overcome barriers to cancer care.		x		x	x			x	x	x				
	Develop an education program for health care providers on the referral process to specialized oncology care.				**x**	**x**				**x**	**x**				
	Develop CCC coordinated education bureau that would provide educational opportunities for healthcare providers.				x	x				x	x				
	Establish relationship with new American College of Surgeons (ACoS) required community physician liaison at each approved cancer center.				x	x				x	x				

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CANCER TREATMENT GUIDELINES	**Select cancer treatment guidelines to publicize.**					**x**				**x**	**x**				
	Partner with local and state oncology physician organizations to select clinical treatment guidelines to publicize.					x				x	x				
	Increase awareness of selected cancer treatment guidelines for health systems, practitioners, and consumers.		**x**			**x**	**x**	**x**	**x**	**x**	**x**		**x**	**x**	**x**
	Work with community partners and patient advocates to develop multi-tiered approach to publicize selected cancer treatment guidelines.		x			x	x	x	x	x	x		x	x	x
	Investigate means to integrate selected cancer treatment guidelines into electronic medical records.					x			x	x				x	
	Develop methods to assess the clinical impact of increased adherence to the selected cancer treatment guidelines.				**x**	**x**								**x**	
	Conduct a pilot analysis of monitoring adherence to selected clinical treatment guidelines.				x	x								x	

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CANCER CLINICAL TRIALS	**Create an education campaign for health care professionals and patient advocacy organizations to increase awareness of and participation in cancer clinical trials.**		**x**			**x**	**x**	**x**		**x**	**x**	**x**	**x**	**x**	**x**
	Develop and implement a multi-tiered professional education campaign to publicize the benefits of cancer clinical trial enrollment and the importance of referring patients to clinical trials.					x				x	x			x	
	Engage community leaders, patient advocacy groups, and local media to publicize the benefits of cancer clinical trial enrollment to the lay public, especially for minorities and underserved populations.		x			x	x	x				x	x		x
	Provide a statewide website with information regarding cancer clinical trials.				**x**			**x**	**x**	**x**	**x**		**x**		**x**
	Create a webpage on the WI CCC website as a central repository for links to on-line information about cancer clinical trials, for use by health care professionals and consumers.				x			x	x	x	x		x		x
	Facilitate a voluntary agreement with third-party payers in Wisconsin to cover standard care costs associated with treatment under a cancer clinical trial.				**x**	**x**	**x**		**x**			**x**		**x**	
	Assess coverage of standard care costs associated with clinical trials in Wisconsin.								x					x	
	Develop a voluntary agreement with third-party payers in Wisconsin to cover standard care costs associated with treatment under a cancer clinical trial.					x			x			x			
	Raise awareness of voluntary agreement to cover standard care costs associated with treatment under a cancer clinical trial.				x	x	x		x						

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INCREASE REIMBURSEMENT OF QOL SERVICES	**Educate employers and consumers regarding the importance of including quality of life (QOL) services for cancer patients and their families in benefit packages.**	**x**	**x**					**x**	**x**				**x**		**x**
	Develop education plan to help employers and consumers understand the importance of including quality of life services in benefit packages.	x						x	x				x		x
	Enact public policy to ensure comprehensive coverage of quality of life services.		**x**		**x**	**x**	**x**	**x**	**x**			**x**	**x**	**x**	**x**
	Assess problem of QOL services reimbursement among cancer patients.				x	x			x				x	x	
	Work to gain support among legislators for reimbursement of QOL services.				x							x	x		
	Build a grassroots campaign to support public policy for reimbursement of QOL services.		x				x	x					x		x
	Establish a gold standard reimbursement model for payers to include QOL services for cancer patients and their caregivers.					**x**			**x**			**x**			
	Determine a gold standard reimbursement model for Wisconsin.					x			x			x			
	Implement a gold standard reimbursement model among payers in Wisconsin.								x			x			
UNDERSTANDING OF QOL	**Educate cancer care providers about the importance of symptom management as it impacts quality of life.**		**x**			**x**				**x**	**x**	**x**	**x**	**x**	
	Design professional education outreach to promote symptom management in individuals living with cancer.					x				x	x	x	x	x	
	Develop and promote patient advocacy systems for people living with cancer.		x			x				x	x	x	x	x	
	Educate patients and caregivers about the importance of defining and communicating quality of life needs and issues with their healthcare provider(s).		**x**		**x**		**x**	**x**					**x**		**x**
	Develop multi-cultural campaign to demonstrate the importance of quality cancer care in meeting successful treatment outcomes.		x		x		x	x					x		x
	Sponsor Annual Cancer Survivors Day.		x		x		x	x					x		x

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QOL DATA	**Establish and implement a statewide repository of Quality of Life outcomes data.**				**x**									**x**	
	Identify potential elements for quality of life repository.				x									x	
	Establish a uniform assessment tool to collect quality of life outcome data.				x									x	
	Establish evidence-based quality of life interventions.				**x**	**x**		**x**		**x**	**x**		**x**	**x**	
	Convene a taskforce to review and recommend evidence-based quality of life interventions to implement in Wisconsin.				x	x		x		x	x		x	x	
ACCESS TO PALLIATIVE CARE	**Increase the number of palliative care health providers in Wisconsin.**				**x**	**x**		**x**			**x**			**x**	
	Identify patient access to certified health care providers in palliative care throughout Wisconsin.				x	x					x			x	
	Create a plan to promote certification of palliative care providers throughout Wisconsin, especially in underserved areas.				x	x		x			x			x	
	Assess reimbursement for palliative care services					**x**			**x**			**x**			
	Identify reimbursement models that promote expanded access to palliative care.					x			x						
	Advocate for provider reimbursement for longer, more extensive care required in palliative care.					x			x			x			
	Promote Medicare's reimbursement of hospice care.					x			x			x			

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AWARENESS OF PALLIATIVE CARE	**Increase public awareness of palliative care.**		**x**	**x**	**x**		**x**	**x**			**x**	**x**	**x**		**x**
	Advocate for the inclusion of "healthy dying" in revisions of future Wisconsin State Health Plans.				x						x	x			
	Advocate for the integration of healthy dying and end of life issues into K-12 curriculum.			x							x	x			
	Work with existing community-based organizations to develop a comprehensive end of life awareness campaign for specific populations.		x					x					x		x
	Establish a media campaign to increase knowledge of palliative care issues to the public.				x		x	x			x				
	Expand provider education related to palliative care.				**x**					**x**	**x**			**x**	
	Establish interdisciplinary education on palliative care concepts in university and college curricula.										x			x	
	Provide and promote palliative care continuing education for providers that care for cancer patients.				x					x	x			x	
	Establish guidelines for palliative care practice in Wisconsin.				**x**	**x**								**x**	
	Develop a palliative care program registry.				x									x	
	Develop guidelines for quality improvement of palliative care programs.				x	x								x	
	Disseminate these guidelines to all programs in the palliative care.				x	x									
ADVANCE CARE PLANNING	**Develop standardized form for Advance Care Planning.**				**x**	**x**				**x**	**x**	**x**		**x**	
	Convene task force to develop standardized form for ACP.				x	x				x	x			x	
	Advocate for policy change to promote a standardized ACP form.				x	x						x			
	Educate patients about the importance of Advance Care Planning.		**x**			**x**		**x**		**x**	**x**		**x**	**x**	**x**
	Develop standardized way to track ACP discussions with primary care providers and patients in medical records.					x				x	x			x	
	Provide training to healthcare professionals on the importance of Advance Care Planning.					x					x			x	

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DATA COLLECTION	**Continue funding and support for existing cancer-related data collection.**				**x**									**x**	
	Actively search and apply for grants to provide sustainable funding for cancer-related data collection sets.				x									x	
	Incorporate the cancer-related data collection sets into cancer specific reports through the public use data set (Wisconsin Interactive Statistics on Health - WISH).				x									x	
	Improve and enhance the Wisconsin Cancer Reporting System (WCRS).				**x**						**x**	**x**			
	Obtain additional funding for the Wisconsin Cancer Reporting System.				x							x			
	Partner with the Wisconsin Cancer Registrars Association to promote benefits of Certified Tumor Registrars (CTR) in cancer registry systems in Wisconsin.				x						x				
	Increase awareness of existing cancer-related publications and educate users to the purpose of such publications.		**x**		**x**		**x**	**x**					**x**	**x**	**x**
	Develop an awareness campaign on cancer related publications.				x		x							x	
	Increase research and professional access to cancer-related data.				**x**									**x**	
	Increase awareness of current systems to access individual use data sets.				x									x	

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WCRS	**Increase electronic reporting of cancer cases to WCRS by 20%.**				**x**	**x**									
	Promote electronic reporting to those currently using paper reporting.				x	x									
	Implement standard procedures for notification of reporting status for non-compliant facilities.				**x**	**x**									
	Develop a standard procedure for notification for non-compliant facilities.				x										
	Implement notification process.				x	x									
	Develop a work plan to study long-term timeliness improvements for the WCRS.				**x**	**x**								**x**	
	Develop a plan for exploring the feasibility of electronic data transfer via the Public Health Information Network (PHIN), electronic data editing, and rapid case ascertainment.				x	x								x	
TREATMENT DATA	**Identify sources that currently collect treatment data.**				**x**									**x**	
	Identify Wisconsin sources for treatment data.				x									x	
	Assess federal, state, local and other organizational requirements for treatment data collection.				x									x	
	Make recommendations on how to collect treatment information for Wisconsin.				**x**									**x**	
	Assess federal, state, local and other organizational requirements for treatment data collection.				x									x	
	Make recommendations on strategies to collect better treatment information for Wisconsin.				x									x	

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RACIAL & ETHNIC DATA	**Publish Hispanic/Latino-specific cancer incidence and mortality rates for Wisconsin.**				**x**			**x**						**x**	
	Evaluate the quality and completeness of Hispanic/ Latino data capture in Wisconsin.				x			x						x	
	Participate in future NAACCR call for Hispanic data.				x			x						x	
	Publish guidelines for reporting Hispanic/Latino cancer data in best way possible with caveats and identified limitations.				x			x						x	
	Compile data from ancillary sources about cancer risk behaviors, health insurance, and cancer treatment related to cancer disparities across race and ethnic groups.				**x**			**x**						**x**	
	Evaluate existing cancer-related data collection programs for racial and ethnic specific information.				x			x						x	
	Make recommendations for improving applicability of databases to tracking and evaluating known disparities in cancer incidence and mortality.				x			x						x	