

# GEORGIA CANCER CONTROL CONSORTIUM

Georgia Cancer Plan  
2014-2019

May 2014

**Georgia Department of Public Health**

Atlanta, Georgia

**Acknowledgements:** The authors and Steering Team of the Georgia Cancer Control Consortium wishes to acknowledge the volunteer efforts of the many stakeholders throughout the state who worked diligently in revising the Georgia Comprehensive Cancer Control Plan. Over 80 individuals representing various organizations and associations embraced the process and collaboratively engaged in the work of revising the original plan, including incalculable hours of discussions, decision making, and document production over the past year. The Georgia Health Policy Center at Georgia State University played an instrumental role in facilitating the compilation of stakeholder input.

*The Georgia Comprehensive Cancer Control Plan was supported by Cooperative Agreement Number 5U58DP003875-02 from the Centers for Disease Control and Prevention. Its contents do not necessarily represent the official views of the Centers for Disease Control and Prevention.*



Brenda Fitzgerald, MD, Commissioner | Nathan Deal, Governor

2 Peachtree Street NW, 15th Floor  
Atlanta, Georgia 30303-3142  
dph.ga.gov

December 2, 2013

My Fellow Georgians:

.....

Cancer remains the second leading cause of death in our state and disproportionately impacts some of our most vulnerable citizens. We must continue to work together to save more lives and reduce disparities in Georgia. We can do this by building on our strong cancer prevention and control programs that are aimed at reducing the burden of cancer in our state, and by continuing to leverage our partnerships across the government, academic, research, business, and non-profit sectors.

This second edition of Georgia's Comprehensive Cancer Control Plan highlights the importance of these partnerships to reducing the risk of cancer; detecting cancers earlier; improving diagnosis and treatment; enhancing survivorship; and improving quality of life for cancer patients through palliative care. The plan, which was developed through the collaborative work of the Georgia Cancer Control Consortium, builds on the first statewide plan, issued in 2007, and is a roadmap for cancer control in Georgia. It establishes priorities; allocates responsibilities and resources; and, sets targets for prevention and control that will help to continue to move us forward together toward the same goals.

I invite you to bring this plan, Our Collaborative Course of Action, to life and to focus your efforts along with all Georgians to reduce and eliminate cancer statewide.

A handwritten signature in blue ink that reads 'Brenda Fitzgerald'.

**Brenda Fitzgerald, MD**  
*Commissioner and State Health Officer*



***We Protect Lives.***

# GEORGIA CANCER CONTROL CONSORTIUM

Dear Commissioner Fitzgerald,

The Georgia Cancer Control Consortium celebrates our collaboration with the Georgia Department of Public Health (GDPH) that has resulted in this revised comprehensive action plan aimed at reducing the impact and burden of cancer in Georgia.

For nearly 10 years, members of the Consortium have partnered with the state to promote cancer prevention, facilitate early detection and screening, ensure quality care and address the needs of survivors. Through the efforts of these committed individuals representing a broad range of stakeholder organizations, the Consortium assessed progress, reviewed strategies and made recommendations for action across the cancer control continuum. This document is a tribute to the efforts of engaged citizens who responded to a Georgia Department of Public Health challenge to create a battle plan for Georgia in the war against cancer.

Because of our collective passion and ongoing engagement we are enthusiastically supportive of this revised plan and its priorities, and commit ourselves wholeheartedly to assist in its statewide dissemination and successful implementation over the next five years.

In the current changing healthcare environment, we anticipate that external factors are likely to both facilitate and challenge our abilities to achieve the goals and targets set out in this plan. Together with the GDPH, we look forward to overcoming these challenges and taking advantage of future opportunities to save lives, improve survivorship, and minimize the impact of this disease on the people of Georgia.

Sincerely,



**James Hotz**  
Co-Chair  
Steering Team  
Georgia Cancer Control Consortium



**Angie Patterson**  
Co-Chair  
Steering Team  
Georgia Cancer Control Consortium

# Executive Summary

## **CANCER IS THE SECOND LEADING CAUSE**

of death in Georgia. In 2013, an estimated 16,630 Georgians died of cancer. The two leading cancer killers in Georgia are lung and colon cancer. And, each day, more than 120 more Georgians are diagnosed with cancer. That is an average of more than 41,000 new cancer cases each year. Lung, colorectal, breast, and prostate cancer account for 51 percent of all cancer deaths in Georgia. While the burden of cancer is shared by all Georgians, cancer incidence and mortality is disproportionately greater among men and among minority and medically underserved populations.

The Georgia Department of Public Health and other members of the Georgia Cancer Control Consortium, including the Regional Cancer Coalitions of Georgia envision a future for our state that is free from cancer deaths and cancer-related health disparities. However, the causes of cancer and its prevention, diagnosis, treatment, and care are multi-dimensional. A person's health is not only the product of the health care that she or he receives, but also the result of genetic factors, behavior, and the physical, social, and policy environment in which she or he lives. As a result, there is no single approach or intervention that can reduce the impact of cancer in Georgia. Therefore, multi-faceted and layered approaches to the prevention and control of cancer are needed.

This strategic plan is the State of Georgia's roadmap for comprehensive cancer prevention and control. It is a product of extensive input from stakeholders, and describes Georgia's eight priority areas for moving forward —

1. Cancer risk reduction – tobacco and obesity
2. Vaccination for human papilloma virus
3. Breast and cervical cancer screening
4. Colorectal cancer screening
5. Lung cancer screening
6. Quality cancer diagnosis and treatment
7. Access to palliative care and survivorship
8. Patient Case Management and Care Coordination

The plan builds on the strengths of Georgia's cancer prevention, research, and treatment communities. It lays out a path forward to reduce the number of cancer deaths in Georgia, maintain Georgia's place as a national and international leader in cancer research, and improve the quality of life for those being treated for cancer, or who have survived cancer. Efforts over the next five years will focus on linking public and private resources to increase access to evidence-based interventions across the cancer continuum: prevention, early detection and screening, diagnosis and treatment, and survivorship, with palliative care as needed for those living with a cancer diagnosis.

Statewide leadership, including leadership from the government, business, academic, and non-profit sectors is also essential to cancer prevention and control. The Georgia Department of Public Health, through and with the Consortium and its membership, will implement this plan and provide the statewide leadership necessary to bring together communities and resources for cancer prevention and control.



# Contents

Commissioner’s Letter .....	iii
Executive Summary.....	v
Introduction.....	1
Strategic Direction and Priorities.....	4
Statewide Leadership .....	6
Georgia’s Partners in Cancer Prevention .....	6
Georgia’s Programs and Resources for Cancer Prevention and Control .....	9

## Priorities

<b>Priority: Cancer Risk Reduction: Tobacco and Obesity .....</b>	<b>11</b>
<b>Priority: Human Papilloma Virus Vaccination.....</b>	<b>13</b>
<b>Priority: Breast and Cervical Cancer Screening .....</b>	<b>15</b>
<b>Priority: Colorectal Cancer Screening .....</b>	<b>17</b>
<b>Priority: Lung Cancer Screening .....</b>	<b>19</b>
<b>Cross-Cutting Priority: Quality of Care in Cancer Diagnosis and Treatment .....</b>	<b>21</b>
<b>Cross-Cutting Priority: Palliative Care and Survivorship .....</b>	<b>23</b>
<b>Cross-Cutting Priority: Patient Case Management and Care Coordination .....</b>	<b>25</b>
References .....	27
Appendix 1. Georgia Cancer Control Consortium.....	28
Appendix 2. Developing the 2014-2019 Cancer Plan.....	29
Appendix 3. Georgia Cancer Control Consortium Steering Team .....	30
Appendix 4. Georgia Cancer Control Consortium Membership.....	32



# Introduction



**CANCER IS THE SECOND LEADING** cause of death in Georgia. In 2013, an estimated 16,630 Georgians died of cancer. The two leading cancer killers in Georgia are lung and colon cancer. Each day, more than 120 more Georgians are diagnosed with cancer. That is an average of more than 41,000 new cancer cases each year.

However, some cancers can be prevented and its burden reduced by eliminating tobacco use, improving diet, increasing physical activity. Additionally, screening for early cancer detection can dramatically reduce mortality rates. For colorectal cancer, screening can help to detect polyps before cancer begins and for other cancers, like breast cancer, detecting cancer in the early stages has a significant impact on disease prognosis.

The strategies and goals outlined in this plan, when fully implemented, could reduce Georgia's cancer death rate by up to 31 percent, saving nearly 3,000 additional lives each year. According to an analysis conducted by the U.S. Centers for Disease Control and Prevention (CDC), states with lower death rates can be used as benchmarks for setting achievable goals and calculating the number of deaths that might be prevented (Yoon, 2014). When Georgia is compared with the three states that have the lowest cancer death rates, CDC estimates that Georgia has nearly 3,000 cancer death rates per year beyond what is statistically expected given the age and size of the population. While this number may seem high to some, tobacco use alone contributes to more than 11,000 excess deaths from all causes, including cancer and heart disease, each year in Georgia.

According to an analysis conducted by the Georgia Department of Public Health, early screening and detection for breast and cervical cancer alone and colorectal could prevent up to 900 deaths over the five year period of this plan. If current trends continue, approximately 600 lives are expected to be saved from increased screening over the five years. If breast cancer cases could be detected at earlier, more localized stages, the five year survival rate among these survivors could go from 24 percent to 98 percent.

This would prevent an additional 160 breast cancer deaths over the 5 years.

And, if national recommendations for colorectal cancer screening of persons ages 50-74 at average and high risk were followed, an additional 150 colon cancer deaths in Georgia could be prevented over 5 years. Because colon cancer can be prevented if polyps are detected before they become cancerous, other estimates suggest that as many as half of all colon cancer deaths could be prevented in very short period of time. Saving more than 900 lives—and possibly many more—by 2019 from cancer would have significant social and economic benefits for Georgia.

## Cancer Deaths

Lung, colorectal, breast, and prostate cancer account for 51 percent of all cancer deaths in Georgia (Figure 1). And, lung cancer accounts for more deaths than colon, breast, and prostate combined. Lung and prostate cancer mortality rates in Georgia are nearly 16 percent higher than the national average (Georgia Comprehensive Cancer Registry, 2013). Other types of cancer resulting in death are pancreatic cancer, ovarian cancer, leukemia, and lymphoma.

## Differences by Sex

Cancer incidence and mortality rates vary between men and women. Males are 43 percent more likely to be diagnosed with cancer than females. Among men in Georgia, prostate, lung and bronchus, and colorectal cancers accounted for 55 percent of all new cancer cases. The rate of prostate cancer in Georgia is higher than the national average (568 versus 542 per 100,000). Lung cancer and melanoma rates among Georgia males are also higher than the national average.

Breast, lung and bronchus, and colorectal cancers accounted for 54 percent of all new cancer cases among females in Georgia. Unlike prostate cancer, the incidence of breast cancer among women in Georgia is lower than the national average (403 versus 419 per 100,000). However, among some sub-populations, rates are significantly higher in Georgia than the national average (see Disparities).

While lung cancer mortality rates in Georgia have been declining since 1994, rates still remain higher than the mortality rates for all other adult cancers for men and women. Over the last two decades, possibly due to changes in tobacco use patterns as well as advancements in screening for breast cancer, lung cancer has surpassed breast cancer as the leading cause of cancer death in women.

## Disparities in Cancer Incidence and Deaths

While the burden of cancer is shared by all Georgians, cancer incidence and mortality is disproportionately greater among men and among minority and medically underserved populations. Black men in Georgia are 14 percent more likely to be diagnosed with cancer and 31 percent more likely to die from the disease than white men. With the exception of lung cancer, mortality rates for blacks exceeded those of whites from 2003-2009. Black men are almost three times more likely to die from prostate cancer than white men.

While white women have a higher incidence of breast cancer than black women, black women are more likely to die of breast cancer. This may be explained by patterns of screening and access to care. Poverty also delays initiating treatment, failure to complete treatment, etc. Black women were less likely than white women in Georgia to have received recommended screenings for cervical or breast cancer in 2010.

Differences in colorectal cancer mortality may also be explained in part by differences in screening. Black men and black women have a higher incidence of colorectal cancer and higher mortality rates from colorectal cancer than white men and white women. Black adults over age 50 were less likely than whites of the same age group to have been screened for colorectal cancer.

White men and white women have a higher incidence of lung cancer and a higher mortality rate than other races/ethnicities. In Georgia, these patterns of lung cancer death may be explained by differences in tobacco use, which has historically been higher among white men.

There are also clear disparities in the burden of cancer between the urban and rural parts of the state. Statewide maps highlight these disparities, showing the highest mortality rates in rural regions of Georgia. Men living in rural areas are more likely to die from lung cancer than men in more urban parts of the state, which follows patterns of tobacco use and the absence of protections from secondhand smoke. The age-adjusted lung cancer mortality for males are nearly twice that of the Atlanta area.

## Screening and Early Detection

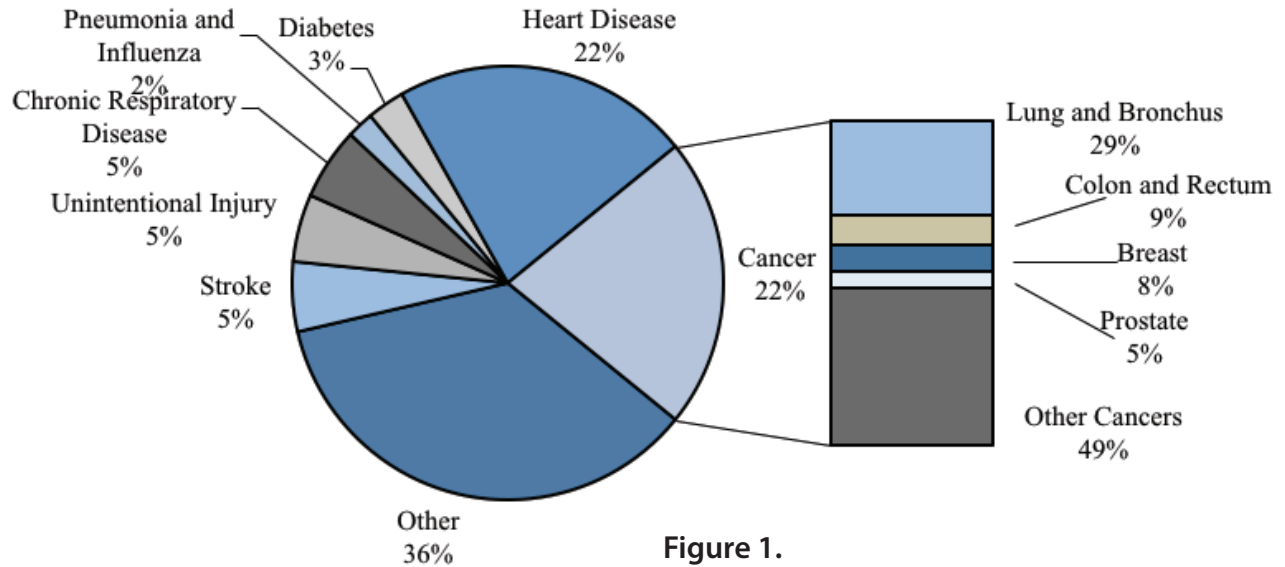
Every Georgian should have access to appropriate cancer screening to detect the disease early and prevent morbidity and premature mortality. Based on current evidence, screening for breast, cervical, lung, and colorectal cancers in appropriate populations by age and/or genetic risk can save lives. However, differences in screening rates continue to be a challenge throughout the state with minority, low income, and rural populations reporting less screening according to recommended guidelines.

Georgia's early detection and screening efforts continue to align with current US Preventive Services Task Force recommendations that are Level B or higher (USPSTF, 2013), as well as guidelines from other credible organizations, such as the American Cancer Society. Most recommended screening tests are covered by health plans operating in the state. Additionally, the Georgia Department of Public Health, through its cancer programs and local partners including the Regional Cancer Coalitions, provides support for a limited number of low-income, uninsured, and underserved individuals with access to timely breast, cervical, and colorectal cancer screening and diagnostic services.

## Care and Survivorship

Because of advances in cancer diagnosis and treatment, Georgians with cancer are living longer than ever before. And, because cancer is disproportionately found among older age groups, as the population of the United States

and Georgia continues to age overall, cancer care and support for cancer survivors has increasing importance. Increased access to treatment in accredited cancer care facilities and support and care for survivors over their lifetimes is needed in Georgia.



**Figure 1.**

Leading Causes of Death in Georgia, 2010  
(Georgia Comprehensive Cancer Registry, 2013)

Vision

# Strategic Direction and Priorities

**THE GEORGIA DEPARTMENT OF PUBLIC HEALTH**, as part of the Georgia Cancer Control Consortium, envision a future in Georgia that is free from cancer deaths and cancer-related health disparities. Cancer impacts all persons in Georgia, and though progress has been made, its toll on the state, remains significant.

## Goal

Georgia's overarching goal is to save every possible life and eliminate disparities in prevention, diagnosis, treatment, and access to care. As deaths from some types of cancer are declining rapidly, there is hope that cancers like colorectal cancer could be nearly eradicated through targeted interventions.

Over the next 5 years through early detection and screening, Georgia will save at least 1,200 lives from cancer, and create the conditions that will save many more in the future. Georgia will also continue to increase access to state of the art cancer treatment and follow up care for all of its citizens.

To promote collaborative work toward its overarching goal, Georgia has been planning and tracking progress around cancer prevention and control in 5-year increments since 2000. Georgia also has been working across the entire cancer continuum from surveillance to prevention to early detection, diagnosis, treatment, and survivorship care.

## Priorities

With statewide governmental and non-governmental leadership and by maintaining a strong infrastructure of cancer prevention and treatment programs, Georgia will move toward this goal from 2014-2019 by focusing on the eight priorities below.

1. Cancer risk reduction – tobacco and obesity
2. Vaccination for human papilloma virus
3. Breast and cervical cancer screening
4. Colorectal cancer screening
5. Evidence based lung cancer screening
6. Quality cancer diagnosis and treatment
7. Access to palliative care and survivorship
8. Patient Case Management and Care Coordination

<b>THE CANCER CONTROL CONTINUUM</b>				
<b>FOCUS</b>				
<b>PREVENTION</b>	<b>DETECTION</b>	<b>DIAGNOSIS</b>	<b>TREATMENT</b>	<b>SURVIVORSHIP</b>
<a href="#">../brp/</a> Tobacco Control Diet Physical Activity Sun Exposure Virus Exposure Alcohol Use Chemoprevention	<a href="http://www.cancer.gov/cancertopics/screening">www.cancer.gov/cancertopics/screening</a> Pap Test Mammography FOBT Sigmoidoscopy PSA	<a href="http://www.cancer.gov/cancertopics/screening">www.cancer/cancertopics/screening</a> informed decision-making	<a href="http://appliedresearch.cancer.gov/">http://appliedresearch.cancer.gov/</a> Health services and outcomes research	<a href="#">../ocs/</a> Coping Health Promotion for survivors
<b>CROSSCUTTING ISSUES</b>				
Communications ( <a href="#">/brp/hcirb/ceccr/ceccr-index.html</a> )				
Surveillance ( <a href="http://seer.cancer.gov/">http://seer.cancer.gov/</a> )				
Social Determinants of Health Disparities ( <a href="#">../research-emphasis/health-disparities.html</a> )				
Genetic Testing ( <a href="http://epi.grants.cancer.gov/">http://epi.grants.cancer.gov/</a> )				
Decision-Making ( <a href="#">../brp/bbpsb/index.html</a> )				
Dissemination of Evidence-Based Interventions ( <a href="#">../cancer_resources.html</a> )				
Quality of Cancer Care ( <a href="http://epi.grants.cancer.gov/">http://epi.grants.cancer.gov/</a> )				
Epidemiology ( <a href="http://epi.grants.cancer.gov/">http://epi.grants.cancer.gov/</a> )				
Measurement ( <a href="http://appliedresearch.cancer.gov/">http://appliedresearch.cancer.gov/</a> )				
<i>Adapted from David B. Abrams, Brown University School of Medicine</i>				

# Statewide Leadership

## Multi-Dimensional Aspects of Cancer

The causes of cancer and its prevention, diagnosis, treatment, and care are multi-dimensional. A person's health is not only the product of the health care that she receives, but also the result of genetic factors, behavior, and the physical, social, and policy environment in which she lives. As a result, there is no single approach or single intervention that can reduce the impact of cancer on the State of Georgia; multi-faceted and layered approaches to prevention and control of cancer are needed. Statewide leadership, including leadership from the government, business, academic, and non-profit sectors is also essential to cancer prevention and control.

## Statewide Leadership

Cancer prevention must occur in Georgia's communities, workplaces, faith communities, and schools through healthier environments, reduced exposure to tobacco and improved nutrition and physical activity. State-of-the-art cancer screening, diagnosis, and care can only take place in strong health care systems that provide access to all persons of all incomes, races, ethnicities, and walks of life. Appropriate cancer screening in target populations throughout the state will likely be more successful when resources from both the public, including the federal and state government, and private (e.g., insurers, business, and philanthropy) sectors are linked to support the achievement of a common set of strategic outcomes.

Supporting cancer survivors and their families requires strong communities where people have access to social supports that are culturally relevant and appropriate. To be effective, Georgia's cancer prevention, screening, and treatment programs that are sponsored by public and private funders must be engaged with communities and systems of care. All of these stakeholders must come together to prevent and control cancer in Georgia.

## The Path Forward

This strategic plan for comprehensive cancer prevention and control, which is a product of extensive input from stakeholders, describes Georgia's priority areas for moving forward around cancer prevention and control. The plan builds on the strengths of Georgia's cancer prevention, research, and treatment communities. It lays out a path forward to reduce the number of cancer deaths in Georgia, maintain Georgia's place as a national and international leader in cancer research, and improve the quality of life for those who have or have survived cancer. Efforts over the next five years will focus on linking public and private resources, increasing access to early detection and screening, and increasing the use of evidence based screening guidelines and practice.

The Georgia Department of Public Health, through the Cancer Control Consortium and its membership, will implement this plan and provide the statewide leadership necessary to bring together communities and resources for cancer prevention and control (See Appendix 1). The Consortium will advise the Department and sustain Georgia's focus on cancer, re-imagine cancer prevention problems, develop new innovative strategies to address Georgia's cancer priorities, and reduce cancer deaths.

## Georgia's Partners in Cancer Prevention

Government can never address cancer or any other significant public health challenge alone. Georgia has a strong fabric of cancer prevention and control programs, and an emerging history of successful cancer control through a network of partners, including the Department of Public Health, the Regional Cancer Coalitions, Georgia Center for Oncology Research and Education, Georgia Society of Clinical Oncologists, and national partners including the American Cancer Society. The complex causes and system of care for cancer make this fabric of programs

and partners a critical part of saving lives in Georgia. Partners from health care, public health, hospitals, academia, communities, employers, national partner organizations, and faith-based organizations must continue to come together to address all aspects of cancer prevention, early detection, diagnosis, treatment, and quality of life for survivors.

### **Academic Partners**

The academic and research communities play an essential role in advancing the understanding of cancer prevention, screening, diagnosis, and treatment by conducting prevention research, identifying the factors that contribute to overall health, conducting cancer-related research, developing new diagnostic and treatment tools, collecting and managing data, and training the next generation of health care providers.

### **Community Leaders**

Community leaders, businesses, faith-based organizations, and others are essential local champions and important contributors that enhance community capacity to reduce cancer risk, detect cancers earlier, improve treatments, and enhance survivorship and quality of life for cancer patients.

### **Health Care Providers and Associations**

Health care providers and their associations are critical partners in cancer screening and treatment. They deliver safe and evidence-based care and services for patients, individuals, families, and communities.

### **Hospitals**

Hospitals play one of the most important roles in treating people with cancer by providing the highest quality inpatient diagnostics and care for cancer patients and their families, as well as access to specialists that are essential to cancer treatment.

### **Employers**

Employers in Georgia can help prevent cancer by implementing workplace wellness approaches and by influencing health care policies, reim-

bursement and industry practices to support the fight against cancer.

### **Georgia Department of Public Health**

The Georgia Department of Public Health (DPH) is the State of Georgia's lead agency in preventing disease, injury and disability; promoting health and well-being; and preparing for and responding to disasters from a health perspective. In 2011, the General Assembly restored DPH to its own state agency after more than 30 years of consolidation with other departments. At the state level, DPH functions through numerous divisions, sections, programs, and offices. Locally, DPH funds and collaborates with Georgia's 159 county health departments and 18 public health districts. Through the changes, the mission has remained constant – to protect the lives of all Georgians. Today, DPH's main functions include: Health Promotion and Disease Prevention, Maternal and Child Health, Infectious Disease and Immunization, Environmental Health, Epidemiology, Emergency Preparedness and Response, Emergency Medical Services, Pharmacy, Nursing, Volunteer Health Care, the Office of Health Equity, Vital Records, and the State Public Health Laboratory.

### **Georgia Center for Oncology Research and Education**

Georgia CORE is a public-private partnership dedicated to generating collaborative resources for cancer prevention, care, research, and education. Georgia CORE marshals several cancer-focused entities into a single force to make higher quality, better organized, more cost-effective cancer care available in Georgia. Specifically, Georgia CORE: 1) Accelerates the exchange of new knowledge and promising practices of cancer care among Georgia health care providers; 2) Expands the number and reach of new clinical trials and treatments across the state; 3) Promotes cancer awareness, prevention and screening in communities throughout Georgia; and 4) Generates broader, deeper support for patients, caregivers and survivors by helping them locate doctors, cancer centers and community resources in Georgia.

## **Georgia Hospice and Palliative Care Organization**

The Georgia Hospice and Palliative Care Organization was established in 2009 to aid and facilitate advocacy, promotion, and education about hospice use and palliative care issues including pain management. This organizational resource represents an opportunity for practice improvement to be supported and disseminated across the state and for the broad participation and engagement of many stakeholders in the field.

## **Local Public Health**

Georgia's local health districts and local public health agencies help to prevent and treat cancer and manage care by providing direct services to Georgia residents. These agencies lead efforts that prevent and reduce the effects of cancer and develop more systematic approaches to cancer screening to better organize and unify the efforts of health care providers. Local public health also helps to ensure community-based preventive services, such as tobacco use cessation.

## **National Partners**

Georgia benefits from a large concentration of national partners. These partners help Georgia to leverage resources to promote cancer prevention, early detection, access to health care and social services, and reduce the state's cancer burden. The partners also assure the availability of a wide range of expertise and skills here in Georgia to address cancer.

## **Regional Cancer Coalitions**

The Regional Cancer Coalitions of Georgia (RCCGs) are local entities organized to reduce deaths and disability from cancer in our state. The RCCGs do the following: 1) Support and build upon existing cancer programs and services; 2) Strengthen programs and services by elevating local cancer efforts to national standards of the American College of Surgeons, National Comprehensive Cancer Network, Association of Community Cancer Centers, and others; 3) Reduce duplication and competition among cancer-related entities; 4) Leverage state dollars and maximize opportunities for private investment; 5) Adapt statewide efforts based on national standards to local communities; and 6) Reduce disparate access to services based on geography, race, insurance status, and other factors.

## **The Public**

The public can help to prevent cancer by practicing a healthy lifestyle that reduces the risk of cancer, including by receiving regular medical care, avoiding tobacco, limiting alcohol use, avoiding excessive exposure to ultraviolet rays from the sun and tanning beds, eating a diet rich in fruits and vegetables, maintaining a healthy weight, and being physically active.



# Georgia's Programs and Resources for Cancer Prevention and Control

**GEORGIA HAS ONE OF THE STRONGEST** networks of cancer programs and resources of any state in the U.S. These programs include community-based programs, federally funded programs, and state prevention, screening and treatment programs.

## Georgia Comprehensive Cancer Control Program

The Georgia Comprehensive Cancer Control Program (GCCCCP) is part of a national effort launched by the Centers for Disease Control and Prevention (CDC) aimed at reducing cancer-related morbidity and mortality. The GCCCCP supports a collaborative process through which a community and its partners pool resources to promote cancer prevention, improve cancer detection, increase access to health and social services, and reduce the burden of cancer. These efforts will contribute to a reduction of cancer risk, detection of cancers earlier, an improvement in treatments, and the enhancement of survivorship and quality of life for cancer patients.

## Breast and Cervical Cancer Screening Program

With combined federal and state funds, the Georgia Breast and Cervical Cancer Screening Program (BCCP) ensures access to timely breast and cervical cancer screening and diagnostic services. These services are available for low-income, uninsured, and underserved women who are between the ages of 40-64 years for breast cancer and 21-64 years for cervical cancer. Priority is given to women who are never or rarely-screened for breast and cervical cancer, women aged 50-64 years, and whose income does not exceed 200 percent of the federal poverty level. With available funds, the Georgia Breast and Cervical Cancer Program serves approximately 15,000 women for breast cancer screening and 65,000 women for cervical cancer screening each year. There are more than 100,000 women in Georgia who meet the program eligibility criteria. CDC's National Breast and Cervical Cancer Early

Detection Program, which distributes funds to programs including Georgia's, is funded to serve approximately 15-20 percent of the national eligible population.

## Cancer Genomic Health Consortium

The overarching goal of the project entitled, "Georgia Breast Cancer Genomics ESP: Enhancing Breast Cancer Genomics through Education, Surveillance and Policy," is to promote the use of evidence-based guidelines to improve the identification of young women at genetic risk for breast and ovarian cancer with the ultimate goal of reducing the cancer burden in this population and in disparate sub-populations. The main areas of focus include education, surveillance and policy. Existing U.S. Preventive Services Task Force and National Cancer Control Network guidelines provide the foundation to maximize the understanding and utilization of appropriate genetic assessment within four targeted groups—clinicians, public health practitioners, payers/policy makers, and young women at risk.

## Colorectal Cancer Control Program

The Centers for Disease Control and Prevention has awarded the state of Georgia a grant to provide colorectal cancer education and screening services to low-income residents ages 50 years and older who are underinsured or uninsured. The goal is to increase population-level screening among all persons 50 years and older and to reduce the incidence and mortality of colorectal cancer. The program also aims to reduce health disparities associated with receiving colorectal cancer screening.

This effort works with various program and community partners to conduct a combination of health system interventions, clinical and community preventive services, patient support services, and public outreach/education approaches using strategic planning approaches based on current Georgia colorectal cancer burden data and results from evaluation reports

developed by Emory Prevention Research Center. Program annual activities align with the CDC Colorectal Cancer Control Program Logic Model.

### **Georgia Comprehensive Cancer Registry (GCCR)**

The Georgia Comprehensive Cancer Registry (GCCR) is a statewide population-based cancer registry collecting all cancer cases diagnosed among Georgia residents since January 1, 1995. This information furthers our understanding of cancer and is used to develop strategies and policies for prevention, control, and treatment. The availability of this data at the state level allows health researchers to analyze geographic, racial, and other differences that provide clues that point to risk factors.

This data also helps in determining where early detection, educational, or other programs should be directed. GCCR is a participant in the National Program for Cancer Registries (NPCR) that was established by the Centers for Disease Control and Prevention (CDC) in 1992 through the Federal Cancer Registry Amendment Act (Public Law 102-515). GCCR is also a participant in the Surveillance, Epidemiology, and End Results (SEER) Program of the National Cancer Institute.

### **Women's Health Medicaid Program**

Women's Health Medicaid Program (WHMP) provides treatment for breast and cervical cancer, as well as other Medicaid benefits, to women diagnosed with breast or cervical cancer through the Breast and Cervical Cancer program to eligible women in Georgia. WHMP was established in July 2001 by the National Breast and Cervical Cancer Prevention Treatment Act of 2000 and is administered by the Georgia Department of Public Health.

### **Cancer State Aid**

The Cancer State Aid Program funds cancer treatment services for eligible low-income, uninsured cancer patients in Georgia. Established in 1937 by the Georgia legislature at the request of Georgia physicians, the program is available through participating treatment facilities statewide. Participating facilities agree to treat approved patients at no cost. Physicians who agree to participate donate their services.

# PRIORITY: Cancer Risk Reduction Tobacco and Obesity

## Key Facts

Cancer can be reduced by preventing or stopping tobacco use, improving diet, and increasing physical activity. The physical, social, and policy environment in which a person lives influences their opportunities to be healthy. By creating healthier communities and reducing risk factors for disease, Georgia can prevent most types of cancer over time, and improve the quality of life for cancer survivors.

Tobacco use and exposure is the most preventable cause of cancer (CDC, 2013). About 30 percent of all cancer deaths are associated with cigarette smoking and other tobacco use. Tobacco use is responsible for 87 percent of lung cancer deaths. The risk of developing tobacco-related cancers increases with total lifetime exposure to cigarette smoke and it is estimated that secondhand smoke is responsible for more than 3,000 lung cancer deaths among U.S. nonsmokers each year. Smoking cessation has been shown to have major and immediate health benefits, including decreasing the risk of lung and other cancers, heart attack, stroke, and chronic lung disease. The Centers for Disease Control and Prevention (CDC) estimates smoking costs Georgians \$1.8 billion in direct healthcare costs every year and \$3.2 billion in lost productivity (CDC, 2013).

Obesity is also a risk factor for some types of cancer, including breast and colorectal cancer. CDC reports research conducted in 2007 estimated that in the United States, about 34,000 new cases of cancer in men (4 percent) and 50,500 in women (7 percent) were due to obesity. Encouragingly, Georgia has seen declines in childhood obesity among the 2 to 5 year old age group. However, if adult trends continue, obesity will lead to about 500,000 additional cases of cancer in the United States by 2030. Nearly two in every three adult individuals in Georgia are overweight and approximately 30 percent are obese. Poor dietary habits and insufficient physical activity are the leading contributors to obesity (CDC, 2013). Diets low in fruits and vegetables and whole grains also contribute to cancer.

Georgia's Tobacco Use Prevention Program, Georgia's SHAPE Initiative to address obesity and promote breastfeeding, and other chronic disease prevention and management programs have numerous activities designed to address tobacco use, physical activity, nutrition, and other risk factors associated with cancer risk.

## Georgia's Objectives

Reduce Georgians' exposure to tobacco and secondhand smoke, increase opportunities for physical activity and promote a healthy diet in early care settings, schools, worksites, and community settings.

### Strategic Initiatives and Activities

1. **Support** physical activity and healthy eating for youth in early care settings and schools and promote breastfeeding and healthy communities through policy, systems, and environmental changes through Georgia's SHAPE initiative.
2. **Promote** healthy worksites and access to worksite wellness programs aimed at increasing physical activity, improving nutrition among adults, and promoting preventive screenings and self-management of chronic diseases.
3. Support the adoption of tobacco-free environments, particularly government agencies, universities and colleges, hospitals, and schools.
4. Reduce youth access to tobacco and alternative tobacco-products, including e-cigarettes.
5. Increase the number of people served through the Georgia Tobacco Quit Line.

### Targets by 2019

- Achieve all targets set by the SHAPE Initiative to address obesity, nutrition and physical activity.
- Achieve all targets in Georgia's statewide 2014-2019 Tobacco Plan.
- Achieve 18 of 18 Health Districts that have conducted community health assessments, developed health improvement plans, and implemented at least one healthy community initiative.
- Increase the number of adults who consume the recommended daily servings of fruits and vegetables and who achieve the recommended amount of weekly physical activity to the national average.

# PRIORITY: Human Papilloma Virus Vaccination

## Key Facts

HPV is a cause of cervical cancer and cancers of the mouth and pharynx. There is no cure or treatment for HPV infection. There is no general test for HPV infection for men and women, but there are several HPV tests that are used in conjunction with cervical cancer screening. Vaccination prevents infection with certain strains of HPV.

Approximately one in five, or 80 million, Americans are infected with HPV. HPV can be spread with no signs or symptoms, and many people with HPV are unaware that they are infected. About 14 million people become newly infected each year. HPV is spread through oral and genital contact and can be spread, although rare, from pregnant women to their babies during delivery. HPV is so common that nearly all sexually-active adult men and women become infected at some point in their lives (CDC, 2014).

There are more than 100 different strains or types of HPV. Strains 16, 18, 31, 33 and 45 are more likely to lead to the development of cancer. More than half of all cervical cancers are associated with infection by HPV strains 16 and 18. Genital warts are closely associated to HPV strains 6 and 11. Lack of regular pap tests, cigarette use, and a history of multiple sexual partners are also risk factors for the development of cervical cancer (CDC, 2013).

To reduce the incidence of cancer and reduce the incidence of HPV in the population as a whole, CDC and ACIP recommend routine HPV vaccination of all adolescent females and males. The vaccine can be given as early as age 9. A course of HPV vaccine consists of 3 doses. The recommendation for females has been in place since 2007 and for males since 2011. Studies have shown that a strong, clear recommendation from a healthcare provider is associated with HPV vaccination.

According to the 2012 CDC National Immunization Survey, nationally, 53.8 percent of females ages 13-17 have received one or more doses of HPV vaccine and 33.4 percent have completed the entire course. Georgia rates for females are slightly lower than the national rate. 52.3 percent of females ages 13-17 have received one or more doses of HPV vaccine; 29 percent have completed the entire course. Nationally, among males ages 13-17, 20.8 percent have received one or more doses of HPV vaccine and 19.5 percent have completed the entire course. In Georgia 19.8 percent have received one or more doses of HPV vaccine; 8.7 percent have completed the entire course.

## Georgia's Objective

To increase the number of females and males who receive the Human Papilloma Virus (HPV) vaccine in accordance with the National Advisory Committee on Immunization Practices (ACIP) recommendations.

### Strategic Initiatives and Activities

1. Make the offer of HPV vaccination by pediatric providers to parents of boys and girls routine by promoting it in conjunction with other required and recommended childhood and adolescent vaccinations (e.g., seasonal influenza, Tdap, and/or the meningococcal vaccine).
2. Engage community-based organizations to implement a comprehensive, innovative, culturally appropriate cervical cancer communications campaign program targeted at all parents of young children to help them to understand the importance of HPV vaccination.

### Targets by 2019

- Set a baseline for the number of pediatric providers in Georgia that stock and routinely offer HPV vaccine to all patients within ACIP recommended age limits.
- Achieve a 50 percent complete vaccination coverage rate in adolescent females and males aged 13-17 years.
- Reduce the incidence of cervical cancer annually from approximately 8.2 to 7.4 per 100,000 population.

# PRIORITY: Breast and Cervical Cancer Screening

## Key Facts

Breast cancer is the most common cancer diagnosed in women in Georgia, accounting for 31 percent of all new cancer cases among females. Over 6,100 cases of breast cancer were diagnosed in Georgia in 2010. Breast cancer is also the second most common cause of cancer deaths in Georgia women. A combination of environmental, genetic, and behavioral factors influence a woman's individual risk of breast cancer.

White women are more likely to be diagnosed with breast cancer overall, however black women have higher incidence rates at younger ages; black women in all age groups are more likely to die from the disease than their white and Hispanic counterparts. Black women in Georgia are more likely to be diagnosed with breast cancer at later stages (regional/distant), and white women are more likely to be diagnosed at early stage (localized). Five-year survival rates are higher for white women diagnosed at all stages.

Women without health insurance are far less likely to report having had a mammogram within the past two years. Only 76 percent of Georgia women aged 40+ reported having had a mammogram within past two years (2012, Behavioral Risk Factor Surveillance Survey). Georgia women age 65 and older have higher rates of mammography screening than younger women, but utilization is still too low and incidence rates are highest for women over age 60.

Cervical cancer in Georgia has dropped out of the top ten cancers and is now the 12th most common cancer diagnosed in Georgia women. According to the 2012 BRFSS, 80.5% of Georgia women reported having had a Pap test within the past three years. Black women in Georgia have a higher cervical cancer incidence rate than non-Hispanic white women; however Hispanic women have the highest incidence rate among these groups. Before age 50, white women in Georgia have higher cervical cancer incidence

rates than black women; however after age 50, incidence rates are higher in black women. Cervical cancer incidence rates are almost identical in black and white women in Georgia, but after age 40, black women have higher mortality rates than white women.

In Georgia, black women are more likely to be diagnosed with cervical cancer at later stages (regional/distant) than white women, and white women are more likely to be diagnosed at an earlier stage (localized). Five-year cervical cancer survival rates are higher for white women than black women diagnosed at all stages. Uninsured women are less likely to report having had a Pap test within the last three years than insured women regardless of race, education level, or age.

Georgia's Breast and Cervical Cancer Program's funding serves approximately 15-18 percent of the eligible population. While changes in the insurance market may increase coverage, Georgia's Breast and Cervical Cancer Early Detection Program will remain an essential program for the thousands of most vulnerable women still projected to be without access to preventive and diagnostic screenings in the future.

According to the USPSTF recommendations, all women seen in primary care settings should be screened for hereditary breast and ovarian cancer. Georgia is fortunate to be one of only three states that receive funding for the Breast Cancer Genomics ESP (Education, Surveillance and Policy) project.

The project's goal is to increase awareness and screening regarding Hereditary Breast and Ovarian Cancer (HBOC) and the BRCA gene mutation for both healthcare providers and the community. The BRCA gene mutations cause approximately five to ten percent of breast and 15 to 21 percent of ovarian cancers. An initial

surveillance of healthcare providers (oncologist, surgeons, and gynecologist) revealed a substantial knowledge gap regarding HBOC.

Education to reduce this gap for healthcare providers and to increase awareness of all Georgians has been initiated by this project.

Surveillance of women in six Georgia health districts has been initiated with more than 3600 women screened, using the B-RST (Breast Referral Screening Tool) and has resulted in 146 positive screenings. Following genetic counseling, 14 women were tested with one being identified with the BRCA1 mutation.

## Georgia's Objective

Ensure all women, regardless of income, race or employment status, have access to high quality breast and cervical cancer screening as well as genetic screening, counseling, and preventive clinical services related to HBOC.

## Strategic Initiatives and Activities

1. Sustain existing community-based breast and cervical cancer screening programs that screen at least 60 percent of women from racial/ethnic minority groups.
2. Promote genetic screening to all low income and rarely screened women 18 years of age and older.
3. Seek Medicaid and State Health Benefit Plan reimbursement for genetic testing and counseling, as well as preventive surgeries such as bilateral mastectomies and/or oophorectomy/salpingectomy for women with BRCA mutation.
4. Carry out educational campaigns targeting physicians and patients regarding screening for breast and cervical cancer and HBOC.
5. Promote breastfeeding, which lowers a woman's risk of breast cancer, in pregnant and post-partum women statewide through Georgia's WIC program.

## Targets by 2019

- Increase from 77 percent to 81.1 percent, the proportion of women who receive breast cancer screenings based on the most recent USPSTF guidelines of females aged 50 to 74 years.
- Increase from 87 percent to 93 percent, the proportion of women who receive cervical cancer screenings based on the most recent USPSTF guidelines.
- Reduce income and insurance coverage disparities in breast and cervical cancer screening rates by 10 percent.
- Increase by 25 percent the proportion of individuals at high risk for breast cancer who receive evidence-based genetic risk assessment and appropriate screening.



# PRIORITY: Colorectal Cancer Screening

## Key Facts

Colorectal cancer accounts for more than 9 percent of all new cancer cases in Georgia. Nearly 4,000 Georgians are diagnosed each year. It is the second-leading cause of cancer deaths in the state. Routine screening can help to prevent colorectal cancer or to detect it early. Colorectal cancer is caused by abnormal growths, called polyps, inside the colon and rectum, which can become cancerous. Screening can detect polyps and enable them to be removed before they become cancer.

Regular screening is recommended for average-risk adults over 50. For adults with an increased risk or high risk of CRC, healthcare providers should determine appropriate screening tests and intervals based upon current symptoms, medical and family history. For average risk adults aged 50-75 years, the recommended CRC screening test options and intervals are:

- Annual screening with high sensitivity fecal occult blood testing;
- Sigmoidoscopy every 5 years with high sensitivity fecal occult blood testing every 3 years;
- Screening colonoscopy every 10 years (USPTF, 2008).

In Georgia, the colorectal cancer mortality rate (17 adults per 100,000 population) is higher than the Healthy People 2020 objective target (14.5 adults per 100,000 population). The most current Georgia Comprehensive Cancer Registry data reveal that although the colorectal cancer incidence rate among Georgia adults 50-64 years of age overall is 43 per 100,000 (5573 cases), colorectal cancer incidence rates are higher among males in this age group at 51 per 100,000 (3138 cases) compared to females at 36 per 100,000 (2,435 cases). Black and Asian men are at particularly high risk of death from colorectal cancer.

Despite the potentially life-saving effectiveness of early screening test, only 25 percent of adults age 50 to 64 years in the United States, and fewer than 40 percent of adults age 65 and older in the United States are up to date on colorectal cancer screening and other recommended clinical preventive services (CDC, 2011). It is noted that one in three Georgians over age 50 has not been screened according to recommendations. Increasing the number of people who have access to and use clinical preventive services continues to be a major public health challenge.

## Georgia's Objective

Increase screening for colorectal cancer in adults over 50 years to 85 percent by 2019, regardless of insurance status, and increase screening among those with a family history of colorectal cancer.

### Strategic Initiatives and Activities

1. Continue to provide funding for colorectal cancer screening for low income and uninsured individuals.
2. Conduct provider education and trainings to promote stool testing screening options.
3. Continue to conduct an annual statewide communications campaign directed at average risk male adults ages 50-64, particularly those residing in Georgia regions with high CRC burden.
4. Develop and test communications messages aimed at Black and Asian males, groups at high risk of death, regarding colorectal cancer screening.

### Targets by 2019

- Increase from 69.4 to 85 percent the proportion of adults over age 50 who receives colorectal cancer screening.
- Increase by 10 percent the proportion of individuals with a family history of Colorectal Cancer who receives evidence-based genetic risk assessment and appropriate screening.
- Reduce income and health insurance status disparities in colorectal cancer screening rates by 10 percent.

# PRIORITY: Lung Cancer Screening

## Key Facts

Lung cancer is the leading most commonly diagnosed cancer in Georgia, and the second leading cause of cancer death. . It accounts for about 15 percent of all newly diagnosed cancers. The overall age-adjusted lung cancer incidence in Georgia is 153 per 100,000 population (54 per 100,000 population in females and 99 per 100,000 in males). Nine health districts have significantly higher incidence rates for lung cancer in men than the state average and the incidence rate for males in rural communities is significantly higher than the rate in urban counties.

Although the smoking prevalence among non-Hispanic black males is lower than the prevalence among non-Hispanic white males, the incidence rate of lung cancer is about the same among both groups. Notwithstanding, black males have the highest lung cancer mortality rate of any racial group in Georgia.

Since the last planning period, a significant body of ongoing research has sought to determine the most effective methods of screening for and detecting lung cancer early.

In early 2013, the American Cancer Society published new guidelines that recommended doctors discuss lung cancer screening with people who meet certain criteria that put them at high risk for developing the disease. More recently the United States Preventive Services Task Force (USPSTF) made a level B recommendation for adults aged 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years to have annual lung cancer screening using low-dose computed tomography. Additionally the Task Force recommended that screening should be discontinued once a person has not smoked for 15 years or developed a health problem that substantially limited life expectancy or the ability or willingness to have curative lung surgery.

The recommendations were based on a careful review of several studies that looked at low-dose CT screening including the National Lung Screening Trial (NLST) which found that people who got low-dose CT had a 20 percent lower chance of dying from lung cancer than those who got chest x-rays.

## Georgia's Objectives

Increase the number of qualified Georgia residents who are appropriately screened for lung cancer.

### Strategic Initiatives and Activities

- 1) Promote responsible screening at institutions that comply with NCCN best practice standards for controlling screening quality
- 2) Improve access to safe, responsible screening by increasing the number of lung cancer screening programs in Georgia that comply with best practice standards.
- 3) Educate the public and healthcare providers on risk factors including where to seek safe, responsible screening.

### Targets by 2019

- Support the development of at least 4 lung cancer screening programs in Georgia that comply with best practice standards and are endorsed by the Lung Cancer Alliance (LCA) in Georgia.

# CROSS-CUTTING PRIORITY: Quality Care in Cancer Diagnosis and Treatment

## Key Facts

Three in every four newly diagnosed cancer patients in Georgia receive oncology care and services at a Commission on Cancer (CoC)-accredited hospital facility or center. Maintaining and increasing the number of facilities in Georgia with accreditation is critical to reducing delays in diagnosis of cancer and variability in follow-up care.

Standards for CoC accreditation include quality measures for cancer diagnosis, staging, and treatment. Accredited cancer programs have the following five key features: 1) state of the art staging, treatment, and follow up clinical services; 2) a cancer committee that sets goals and monitors and evaluates outcomes; 3) cancer conferences for patient consultation; 4) quality improvement initiatives; and 5) cancer registries and databases for monitoring quality of care.

The CoC offers a variety of tools to improve care for both accredited and non-accredited facilities. The Rapid Quality Reporting System (RQRS) is a reporting and quality improvement tool that promotes clinical care coordination and provides real time information about hospital adherence to National Quality Forum quality of cancer care measures for breast and colorectal cancers.

Clinical trials are also an important cog in the process of advancing the effectiveness of cancer treatments over time. While recent studies (NCCN, 2010) are reporting improvements to accrual rates over time, it is still recognized that adults and minority groups participate less in trials even at leading treatment facilities and centers. An interactive database of existing clinical trials in Georgia has already been developed – [www.georgiacancerinfo.org](http://www.georgiacancerinfo.org)

## Georgia's Objective

Improve the use of quality standards and practice guidelines for the diagnosis, staging and treatment of cancers throughout Georgia.

### Strategic Initiatives and Activities

- 1) Disseminate information regarding CoC accreditation and use of approved guidelines and RQRS to demonstrate value, especially to hospital administrators.
- 2) Provide targeted technical assistance and resources to allow for increased CoC applications from non-accredited institutions and maintenance of accreditation status at currently approved centers.
- 3) Engage in statewide public awareness efforts to promote cancer care at accredited centers and increase participation in clinical trials.

### Targets by 2019

- Ensure that 85 percent of cancer patients across the state receive oncology care services in NCI designated or CoC accredited institutions.
- Increase the number of hospitals and other hospital systems that are CoC approved from 41 to 44.
- Increase by 10 percent the number of non-CoC accredited hospitals or facilities formally affiliating with nearby CoC-approved programs.
- Increase the number of CoC-approved programs in Georgia participating in Rapid Quality Reporting System (RQRS) initiatives to at least 85 percent.
- Ensure a 6 percent rate of accrual of Georgia residents to cancer treatment clinical trials

# CROSS-CUTTING PRIORITY: Palliative Care and Survivorship

## Key Facts

Georgians, like all Americans, are living longer after a diagnosis of cancer. A cancer survivor is any individual from the time of diagnosis through the balance of his or her life and also includes family members, friends, and caregivers impacted by the survivorship experience.

The National Cancer Institute estimates that there are almost 14 million cancer survivors alive in the US today and that number is expected to reach almost 18 million in the next decade (NCI, 2013). Of the number of current survivors nearly 350,000 live in Georgia. The most common cancers among survivors are breast, prostate, and colorectal. Given this expectation of longer life, it is important that the potential long-term needs of cancer survivors here in Georgia be considered as part of the cancer control agenda for the next five years.

Palliative care and survivorship care are two distinct, but not mutually exclusive types of care. Palliative care is focused on pain relief, comfort, and relieving suffering to improve quality of life for cancer survivors. Survivorship care covers the physical, psychosocial, and economic issues of cancer from diagnosis until the end of life, including the late effects of treatment.

Survivorship care is a distinct phase of care for cancer survivors and includes four components—

1. Prevention and detection of new cancers and recurrent cancer;
2. Surveillance for cancer spread, recurrence, or second cancers;
3. Intervention for consequences of cancer and its treatment; and
4. Coordination between specialists and primary care providers to ensure that all of the survivor's health needs are met.

The Commission on Cancer (CoC) recently developed new patient-centered standards requiring accredited facilities to provide palliative care options, either directly or by referral, as part of the standard care management package for patients diagnosed with cancer. The new CoC patient-centered standards also included new Continuum of Care Services to provide psychosocial distress screening and survivorship care planning to all cancer patients to address survivorship issues. In 2013, the National Comprehensive Cancer Network (NCCN) Survivorship guidelines “focus on the vast and persistent impact that both the diagnosis and treatment of cancer have on the adult survivor. This includes the potential impact on health, physical and mental states, health behaviors, professional and personal identity, sexuality, and financial standing”.

## Georgia's Objective

Increase the proportion of cancer patients in Georgia who receive palliative care and support from the time of diagnosis; and improve the quality of life for all cancer survivors through survivorship care.

### Strategic Initiatives and Activities

### Targets by 2019

#### SURVIVORSHIP

1. Establish a baseline of the physical and psychosocial quality of life for Georgia cancer survivors
2. Create a dissemination plan to provide best practices tools to address the survivors' needs.
3. Develop a toolkit and encourage oncology practitioners to use cancer treatment summaries and survivorship care plans in conjunction with GASCO.
4. Develop and deliver educational campaigns/ events for populations affected by cancer, highlighting the importance of implementing cancer treatment summaries and survivorship care plans.

#### PALLIATIVE CARE

5. Promote integration of national palliative care guidelines into standard oncology services at all CoC cancer centers in Georgia
6. Promote earlier hospice care transitions for all CoC cancer centers in Georgia.
7. Achieve 100 percent registration of each Georgia CoC cancer center with a palliative care program (as defined by the Center to Advance Palliative Care-CAPC) using the GHPCO website.
8. Hold at least one palliative care networking event for the registered CoC cancer centers in Georgia.

#### SURVIVORSHIP

- Improve by 50 percent the number of cancer survivors reporting improvement in their physical and psychosocial quality of life.
- Improve by 50 percent, the number of CoC accredited and non CoC accredited institutions using cancer treatment summaries to address the increased needs for prevention, screening, early detection, diagnosis, and treatment of subsequent cancers.

#### PALLIATIVE CARE

- Establish and maintain a statewide Palliative Care Network.
- Increase the number of Commission on Cancer accredited cancer centers in Georgia with a palliative care program from 0 to 5.
- Extend the Georgia median hospice length of stay for Medicare patients with a cancer diagnosis from 22 days to 27 days tracked by the hospice industry standards.
- Decrease the number of Georgia Medicare patients with a cancer diagnosis who die without hospice care from 6 percent to 5 percent, as tracked by the hospice industry standards.



# CROSS-CUTTING PRIORITY: Patient Case Management and Care Coordination

## Key Facts

In 1990, Dr. Harold Freeman began pioneering the patient navigation program in Harlem. The navigators provided one-on-one support to patients with abnormal findings. Through patient navigation, the five-year breast cancer survival rate was raised from 39 percent to 70 percent in 2000 and demonstrated a reduction in racial, ethnic and poverty-driven disparities in cancer care.

In 2005, President George W. Bush signed the Patient Navigator Outreach and Chronic Disease Prevention Act. Based on the Harlem model, this was a \$25-million demonstration program for patient navigators and outreach, with a requirement to link the program to existing screening programs.

In 2008, the Georgia Society of Clinical Oncology (GASCO) and Georgia CORE partnered to form one of the first statewide multi-disciplinary organizations for cancer patient navigators, focused on reducing barriers to care and increasing access to care. Cancer Patient Navigators of Georgia (CPNG) is open to navigators from a variety of backgrounds, including lay navigators, community health workers, promotoras, nurses, social workers, and other health care professionals. CPNG has more than 300 members representing counties across Georgia.

According to CoC, “Patient navigation in cancer care refers to individualized assistance offered to patients, families, and caregivers to help overcome health care system barriers and facilitate timely access to quality medical and psychosocial care and can occur from prior to a cancer diagnosis through all phases of the cancer experience.”

The new 2012 Commission on Cancer (CoC) Standard 3.1 requires that “a patient navigation process, driven by a community needs assessment, is established to address health care disparities and barriers to care for patients”. Patient case management, care coordination, and navigation services can enhance patient engagement, remove barriers to care, improve the patient experience, and demonstrate value and quality.

A research study published in 2012 titled “Cancer Patient Navigator Tasks across the Cancer Care Continuum”, reviewed 5 patient navigators programs and the range of tasks the navigators provided across the continuum (education and outreach, screening, diagnosis and staging, treatment, survivorship, and end-of-life). The study concluded that recruiting, training, and retaining individuals to carry out these tasks will help reduce the cancer health disparities experienced by poor and underserved communities.

## Georgia's Objective

To increase access to cancer patient case management, care coordination and navigators, across the continuum of cancer care: from outreach to end-of-life.

### Strategic Initiatives and Activities

1. Promote patient case management and care coordination best-practices to CoC accredited hospitals
2. Provide continuing education. opportunities and events for members.
3. Educate the community and Georgia's health care professionals about the patient navigators' role across the continuum of care.
4. Engage CPNG participation in all working groups of the Comprehensive Cancer Control Plan.

### Targets by 2019

- Provide annual meeting and quarterly webinars for navigators.
- Leverage technology, such as TeleHealth and mobile-enhanced programs to improve patient engagement and access to patient case management and care coordination in underserved areas of Georgia.
- Expand the education opportunities to:
  - a. Provide lay case management and care coordination training to 25% of the CoC hospitals.

# References

**Centers for Disease Control and Prevention.** Healthy Aging Program, Clinical Preventive Services. Atlanta, GA: 2011. Available from <http://www.cdc.gov/aging/services/index.htm>

**Centers for Disease Control and Prevention (CDC).** (2013). Retrieved November 27, 2013 from [www.cdc.gov](http://www.cdc.gov).

**Georgia Department of Public Health.** (2013). 2013 Georgia Cancer Program and Data Summary. Atlanta, GA. Retrieved from: <http://dph.georgia.gov/cancer-reports>.

**Georgia Comprehensive Cancer Registry.** (2013). Retrieved from November 28, 2013 from <http://dph.georgia.gov/georgia-comprehensive-cancer-registry>.

**Online Analytical Statistical Information System (OASIS).** (2013). Georgia Department of Public Health Vital Records. Retrieved November 28, 2013 from <http://oasis.state.ga.us/oasis/>.

**National Research Council.** (2005). From Cancer Patient to Cancer Survivor: Lost in Transition. Washington, DC: The National Academies Press.

**National Comprehensive Cancer Network.** (2013). Retrieved November 27, 2013 from <http://www.nccn.org/index.asp>.

**National Cancer Network.** (2013). Retrieved from November 27, 2013 from <http://education.nccn.org/node/1606>.

**National Cancer Institute.** (2013). Retrieved November 27, 2013 (2013 at the National Institutes of Health. Retrieved from <http://www.cancer.gov>.

**Surveillance Epidemiology and End Results (SEER).** (2013). National Cancer Institute. Retrieved November 28, 2013 from <http://www.statecancerprofiles.cancer.gov>.

**US Preventive Services Tasks Force.** Grade Guidelines. (2013). Retrieved November 27, 2013 from <http://www.uspreventiveservicestaskforce.org/uspstf/grades.htm>.

**U.S. Preventive Services Task Force** Grade Definitions After May 2007. May 2008. Retrieved Nov 27, 2013 from <http://www.uspreventiveservicestaskforce.org/uspstf/gradespost.htm>

**Yoon, PW, Bastian B, Anderson RN, Collins JL, Jaffe HW.** Potentially preventable Deaths from the five leading causes of death—United States, 2008-2010. *MMWR* 2014;63(17); 369-374.

# Appendix 1

## GEORGIA CANCER CONTROL CONSORTIUM

### Current Consortium Structure

The Consortium has been in existence in various forms since the early 2000s. As of March 2014, the Consortium consists of a Steering Team, an Executive Committee, four standing committees, and five continuum-specific Work Groups. The Steering Team is to be broadly comprised of representatives from key public and private stakeholder organizations as determined by the Consortium. The Steering Team's primary responsibilities will include priority setting and oversight for planning, implementation, and evaluation. Leadership of the Steering Team will be provided by two Co-Chairs, who will serve staggered two year terms to enable succession planning.

### Executive Committee

The Executive Committee consists of the two Steering Team chairs, the Immediate Past Chair, and leaders from the Georgia Department of Public Health and the Governor's Office (or the Office of Planning and Budget). This committee will address policy and resource issues that are likely to have an impact on the administration of the cancer control plan.

### Standing Committees

The Consortium will also include four standing committees – Membership, Data and Evaluation, Research, and Communications. These committees will be responsible for providing overarching support and expertise to the Work Groups and the Steering Team during the implementation of the plan.

- The Membership Standing Committee will ensure diversity within the Consortium by reviewing the composition of the membership annually to assure appropriate experience or expertise is represented. The committee will also assist in recruiting members for the general Consortium as well as the Steering Team.
- The Communications Standing Committee will oversee outreach activities, the marketing/distribution of the plan, and communication of the Consortium's activities to stakeholders throughout the state.
- The Research Standing Committee will focus on developing and supporting a cancer research agenda that is relevant across the cancer control continuum, and informs evidence-based practice.
- The Data and Evaluation Standing Committee will support each Work Group by responding to data needs and requests, and developing important metrics and processes to aid the exchange of information and evaluation of cancer control efforts in Georgia.

### Work Groups

Each of the five Work Groups – Prevention and Education, Early Detection and Screening, Diagnosis, Staging and Treatment, Palliative Care, and Survivorship – will monitor statewide activities across the priorities and develop annual work plans to support long term cancer control efforts. Co-Chairs of each Work Group are expected to serve as members of the Steering Team.

# Appendix 2

## DEVELOPING THE 2014-2019 CANCER PLAN

### Planning Approach

Throughout 2012 and into early 2013, the Georgia Cancer Control Consortium steering team and membership participated in providing input into the Georgia Cancer Control Plan and reviewing progress made in Georgia on cancer from 2007 to 2012. A practical approach was taken, focusing on evidence-based interventions that will likely result in improved cancer control and valuing approaches that emphasize policy development and implementation, systems integration and environmental support. The plan was based, in part, on prior versions of Georgia's Cancer Plan.

### Input Gathering

A series of work group meetings and discussions started at a kick off meeting that was held in Macon, Georgia on April 20, 2012, followed by a series of in-person meetings that were held at Georgia State University Policy Center and/or by conference call. The five Work Groups were Prevention (Tobacco and HPV control), Early Detection and Screening, Diagnosis, Staging and Treatment, Palliative Care and Survivorship.

Each Work Group participated in a series of six or more meetings and discussions held between March 2012 and June 2013. The work groups drafted recommendations to retain, modify and/or create goals, objectives and strategies for their respective domains across the cancer control continuum. Each meeting was facilitated by at least one staff member from the Georgia Health Policy Center. The work groups and subcommittees were comprised of Georgia's cancer control experts and stakeholders from the public and private sectors, many of whom have been passionately involved in this work for years and are themselves either providers of care or cancer survivors.

The Steering Team, aided by data and evaluation experts, reviewed and provided periodic feedback to each of the Work Groups during the process. The Steering Team, which met monthly, also developed recommendations to enhance organizational structure and accountability in support of the plan before finally ratifying and submitting it to the Georgia Department of Public Health for review. The result was the creation of a series of strategic objectives in November 2012 (Appendix 5).

### Prioritization

The Georgia Department of Public Health utilized this input to select strategic cancer priorities from among the recommendations by the Consortium and work groups. The priorities reflected in this plan were drawn from the recommendations of the workgroups and were selected using a series of criteria, including funding, feasibility, consistency with other statewide plans, population health need, and opportunities for Georgia to serve as a national leader in these arenas.

### Final Plan Development

Drafts of the plan were produced during 2013 and 2014, and quarterly meetings of the Georgia Cancer Consortium continued. During this time, programmatic changes took place in the Georgia Department of Public Health to enhance its focus and attention on cancer, and to incorporate the shift of the Regional Cancer Coalitions from the Georgia Cancer Coalition to the Georgia Department of Public Health. During this time, the plan was revised and a draft was submitted to federal officials to ensure sustainability of funding for cancer prevention and control. In late winter 2013/2014, the Georgia Department of Public Health assembled and compiled this final plan.

# Appendix 3

## GEORGIA CANCER CONTROL CONSORTIUM STEERING TEAM

### Co-Chairs

**James Hotz** President, Council of Regional Cancer Coalitions  
Medical Director, Cancer Coalition of South Georgia

**Angie Patterson** Director, Georgia Center for Oncology Research and Education

### Members

**Gena Agnew** Executive Director, Northwest Georgia Cancer Coalition

**Fred Ammons** Executive Director, Central Georgia Cancer Coalition

**Karen Beard** Director, Georgia Society of Clinical Oncology

**Barbara Crane** Director, Office of Cancer Screening and Treatment,  
Georgia Department of Public Health

**Mary Daniels** Executive Director, American College of Physicians (Georgia Chapter)

**Kelly Drevitch** Account Representative, State Health Systems,  
American Cancer Society – Georgia Chapter

**Kelly Erola** Medical Director, Hospice Savannah

**Diane Fletcher** Chief Executive Officer, Cancer Coalition of South Georgia

**Marilyn Hill** Program Director, East Georgia Cancer Coalition

**Cheryl Johnson** Executive Director, West Georgia Cancer Coalition

**Nancy Johnson** Administrator and PSA Director, St. Joseph's/Candler Health System

**Duane Kavka** Executive Director, Georgia Association for Primary Health Care

**Michelle Kegler** Associate Professor and Director, Emory Prevention Research Center,  
Emory University

**Troy Kimsey** Physician Liaison, Chair, Commission on Cancer (Georgia)

**Joseph Lipscomb** Professor, Health Policy & Management, Emory University

**Tamira Moon** Manager, Georgia Comprehensive Cancer Control Program,  
Georgia Department of Public Health

<b>Amy Moore</b>	Director of Research Programs, Georgia Research Alliance
<b>Jean O'Connor</b>	Director, Health Promotion and Disease Prevention, Georgia Department of Public Health; Faculty, Emory University
<b>Nancy Paris</b>	President, CEO, Georgia Center for Oncology Research and Education
<b>Joyce Reid</b>	Vice President, Community Health Connections, Georgia Hospital Association
<b>Toby Sidman</b>	Founder, Georgia Breast Cancer Coalition
<b>Robert Smith</b>	Senior Director, Cancer Control, American Cancer Society
<b>Graham Thompson</b>	Executive Director, Georgia Association of Health Plans
<b>Nannette Turner</b>	Chair, Associate Professor, Department of Public Health, College of Health Professions, Mercer University

# Appendix 4

## GEORGIA CANCER CONTROL CONSORTIUM MEMBERSHIP

This list includes Work Group members who participated in the plan revision process over the past 2 years and/or will be actively engaged in the implementation process over the next 5 years.

LAST	FIRST	TITLE	ORGANIZATION
Ackerman	Kenneth	Geriatrician	Medical Center of Central Georgia
Agnew	Gena	Executive Director	Northwest Georgia Regional Cancer Coalition
Ammons	Fred	Executive Director	Community Health Works
Ashman	Pam	Former Mission Delivery Director	American Cancer Society South Atlantic Division (2013)
Bailey	Eric	Government Relations Director	American Cancer Society Cancer Action Network
Ballard	Denise	Vice President	Cancer Prevention and Control, Cancer Coalition of South Georgia
Bayakly	Rana	Director/ Epidemiologist	Chronic Disease, Healthy Behaviors and Injury Epidemiology Section, Georgia Department of Public Health
Beard	Karen	Director	Georgia Society of Clinical Oncologists
Beckler	Vickie	Lung Screening Program Coordinator	Wellstar Health System
Bellcross	Cecelia	Assistant Professor/ Director	Genetic Counseling Training Program, Emory University
Black	Steve	Professor/Basic Science Director	Georgia Regents University
Bollag	Ronnie	Associate Professor of Pathology	Georgia Regents University
Bowling	Annette	Executive Director	Albany Advocacy Resource Center
Brantley	Melissa	Health Promotion Coordinator	District 5-1, Georgia Department of Public Health
Brown	Fay	Executive Vice President	Georgia Academy of Family Physicians



Brown	Melody	Georgia Colorectal Cancer Program Manager	Georgia Department of Public Health
Cannady	Rachel	Research Analyst	American Cancer Society
Carvalho	Michelle	Team Lead	Cancer Prevention and Control Research Network (CPCRN) of the Emory Prevention Research Center
Caseman	Matt	Executive Director	Georgia Rural Health Association
Chambers	Debbie	Central Region, Cancer Coordinator	District 5-2, Georgia Comprehensive Cancer Registry, Georgia Department of Public Health
Cherry	Sabrina	Program Coordinator	Northside Hospital
Chung	Marianne	Associate Director	Center for Pan Asian Community Services
Cochran	Maxine	Palliative Care Coordinator	Floyd Medical Center
Crosby	Carol	Southwest Region, Cancer Coordinator	District 8-2, Georgia Comprehensive Cancer Registry, Georgia Department of Public Health
Curran	Dan	Chief Executive Officer	Curran Public Relations
Currin	Jennifer	Social Worker	Memorial Health
Daniels	Mary	Executive Director	Georgia Chapter, American College of Physicians
Davis	Victoria	Epidemiologist	Georgia Cancer Registry, Georgia Department of Public Health
Erola	Kelly	Chief Medical Officer	Hospice Savannah
Escoffery	Cam	Assistant Professor	Rollins School of Public Health, Emory University
Fletcher	Diane	President/Chief Executive Officer	Cancer Coalition of South Georgia
Fournier	Jennifer	Clinical Nurse Specialist	Hospice Savannah
Futrell	Danny	Medical Director	CIGNA
Giblin	Joan	Director, Survivorship Program	Winship Cancer Institute

Glass	Ann	Associate Professor/ Associate Director	Institute of Gerontology, University of Georgia
Hale	Jennifer	Executive Director	Georgia Hospice and Palliative Care Organization
Hassan	Aziz	Professor	Biomedical Sciences, Armstrong Atlantic State University
Haulik	Brenda	Area Executive Director	American Cancer Society
Hill	Marilyn	Director of Opera- tions/Programs	East Georgia Cancer Coalition
Hotz	Jim	President	Council of Regional Cancer Coalitions
Johnson	Cheryl	Executive Director	West Central Georgia Cancer Coalition
Johnson	Nancy	Administrator and PSA Director	St. Joseph's/Candler Health System
Kavka	Duane	Executive Director	Georgia Association for Primary Health Care
Kegler	Michelle	Director	Emory Prevention Research Center
Kemp	Deborah	Nurse Practitioner	Steward Center for Palliative Care
Kennedy	John	Surgical Oncologist	DeKalb Surgical Associates
Kimsey	Troy	Physician Liaison	Commission on Cancer (Georgia Chapter)
Kines	Joan	Department Manager	Harbin Clinic Radiation Oncology
Kinnaird	Adrienne	Director	Avon Comprehensive Breast Center, GradHealth System
Koskela	Linda	Unit Director	Cancer State Aid, Georgia Department of Public Health
Lee	Linda	Cancer Risk Educa- tor	Wellstar Health System
Lewis	Kimberly	Former Genetic Services Coordinator	Georgia Center for Oncology Research and Education (2013)
Lipscomb	Joseph	Professor	Rollins School of Public Health, Emory University

Little	Melinda	Director	Campaign for Tobacco Free Kids (Southern Region)
Lund	Mary Jo	Assistant Professor	Winship Cancer Institute
Marchiolo	Erin	Community Outreach and Grants Manager	Susan G. Komen for the Cure, Greater Atlanta
Martel	Regina	Breast Cancer Nurse Navigator	Phoebe Putney Memorial Hospital
McKenzie	Sandy	Executive Director	Hamilton Cancer Institute
Mertens	Ann	Professor, Hematology/Oncology	Emory University School of Medicine
Moon	Tamira	Program Manager	Comprehensive Cancer Control Program, Georgia Department of Public Health
Moore	Amy	Director of Research Programs	Georgia Research Alliance
Mumber	Matt	Radiation Oncologist	Harbin Clinic Radiation Oncology
Nethery	Patty	Director	Hutcheson Home Health Care
Nguyen	Tran	HAPP Manager	Boat People SOS (BPSOS)
Norman	Sharon	Director/Chief Executive Officer	Blue Ridge Area Health Education Center (AHEC)
Oprea	Gabriela	Assistant Professor, Pathology and Laboratory Medicine	Emory University
Owens	Charles	Executive Director	Georgia State Office of Rural Health
Paris	Nancy	President	Georgia Center for Oncology Research and Education (Georgia CORE)
Patterson	Angie	Director	Georgia Center for Oncology Research and Education (Georgia CORE)
Petruzelli	Guy	Chief Physician	Anderson Cancer Institute
Potter	Jennifer	Program Manager	Young Survival Coalition Inc. (Atlanta Affiliate)
Ray	Kenneth	Program Manager	Georgia Tobacco Use Prevention Program, Georgia Department of Public Health

Redding	Kimberly	Former Director	Health Disease and Promotion, Georgia Department of Public Health (2007-2013)
Reid	Joyce	Vice President	Community Health Connections, Georgia Hospital Association
Rojiani	Amy	Professor/Chairman, Pathology	Georgia Regents University
Savage	Maura	Clinical Social Worker	Children's Health Care of Atlanta
Scott	Kimberly	Health Education Coordinator	Cancer Coalition of Georgia
Sidman	Toby	Founder	Georgia Breast Cancer Coalition
Smith	Robert	Senior Director, Cancer Control	American Cancer Society
Smith	Tenbroeck	Director, Patient Reported Outcomes Research	American Cancer Society
Thompson	Graham	Executive Director	Georgia Association of Health Plans
Turner	Nanette	Associate Professor	Mercer University-College of Health Professions
Turner	Eric	Hematologist/Oncologist	Northwest Georgia Medical Group
Ward	Kevin	Director	Georgia Center for Cancer Statistics
Ziemba	Steve	Director Clinical Research	Phoebe Putney Memorial Hospital
Wilkie-McKellar	Astrid	Community Outreach Coordinator	Northside Hospital Cancer Institute





**FOR MORE INFORMATION CONTACT**

Georgia Department of Public Health

[www.dph.georgia.gov](http://www.dph.georgia.gov)