# Cancer Control Success Stories

July 1, 2012 - December 31, 2013

***Progress Report***

on the Maryland Comprehensive Cancer Control Plan

# The Maryland Comprehensive Cancer Control Plan

phpa.dhmh.maryland.gov/cancer/cancerplan/SitePages/publications.aspx

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## *2012-2013 Progress Report*

# Introduction

The Maryland Comprehensive Cancer Control Plan was revised and released in July, 2011. The Cancer Plan is meant to serve as a guide for health professionals, as well as a resource for all Marylanders. It is a comprehensive publication that represents the work of more than 200 individuals who authored 15 chapters including cross-cutting topics such as cancer disparities, primary prevention, and survivorship, as well as site specific topics that focus on early detection and treatment. Each chapter outlines goals, objectives, and strategies that individuals and organizations can use to guide cancer control activities.

The Cancer Plan focuses on seven site specific cancers: lung, skin, colorectal, breast, prostate, oral, and cervical. These targeted cancers have been selected as priorities because they have high incidence and/or mortality rates in Maryland; effective, evidence-based screening interventions; and/or modifiable risk factors.

The Cancer Plan encourages collaboration and cohesiveness among stakeholders working to control cancer in Maryland. To engage collaboration in conjunction with the release of the new Cancer Plan, a new statewide coalition was established in 2011 to implement the Plan. The goals of the Maryland Cancer Collaborative are to work with individuals and organizations throughout the state to implement the Maryland Comprehensive Cancer Control Plan, and to bring together existing groups and new partners from across the state to collaborate on a common goal: reducing the burden of cancer in Maryland. The six committees of the Maryland Cancer Collaborative are structured around six priority areas of cancer control and include: 1) Primary Prevention; 2) Early Detection and Treatment; 3) Survivorship, Palliative Care, and Pain Management; 4) Cancer Disparities; 5) Evaluation; and 6) Policy. Each committee has identified priorities from the Cancer Plan and began work to implement priorities in 2012. In 2013 the committees continued to implement priorities through a range of activities detailed in the "Maryland Cancer Collaborative" section of the report.

This report highlights cancer control efforts in Maryland and progress made on selected goals, objectives, and strategies in the Cancer Plan. The Progress Report is organized into sections based on the priority areas of cancer control, and on progress of the Maryland Cancer Collaborative. Success Stories included in this report represent successful collaboration that demonstrates the impact that cancer control activities have on Marylanders. Updates on policy action and surveillance data are also throughout the Progress Report.

Data sources are referenced throughout the Progress Report. Abbreviations include:
MCR - Maryland Cancer Registry
BRFSS - Behavioral Risk Factor Surveillance System
CDC WONDER - Centers for Disease Control and Prevention Wide-ranging Online Data for Epidemiologic Research
MATCH - Maryland Assessment Tool for Community Health
HP 2020 - Healthy People 2020

**Acknowledgements**

The Center for Cancer Prevention and Control would like to thank everyone who contributed to this Progress Report, including staff and representatives from the Johns Hopkins University, Hospital, and Health Systems, Peninsula Regional Medical Center, Coastal Hospice and Palliative Care, Westat, Maryland Cancer Registry, and the Primary Care Coalition.

# Incidence and Mortality Updates

## *Seven Targeted Cancers*

| | | Baseline | Update | 2015 Target |
|---|---|---|---|---|
| ***Overall Cancer:*** | Incidence | 426.3 per 100,000<br>2006 Maryland Cancer Registry | 449.8 per 100,000<br>2010 Maryland Cancer Registry | *No target in Cancer Plan |
| | Mortality | 186.7<br>2006 CDC WONDER | 170.9<br>2010 Maryland Vital Statistics MATCH | 160.6 per 100,000<br>(Healthy People 2020 Target) |
| ***Lung Cancer:*** | Incidence | 63.4 per 100,000<br>2006 Maryland Cancer Registry | 57.6 per 100,000<br>2010 Maryland Cancer Registry | *No target in Cancer Plan |
| | Mortality | 52.7 per 100,000<br>2006 CDC WONDER | 46.0 per 100,000<br>2010 Maryland Vital Statistics MATCH | 45.5 per 100,000<br>(Healthy People 2020 Target) |
| ***Melanoma:*** | Incidence | 19.7 per 100,000<br>2006 Maryland Cancer Registry | 21.4 per 100,000<br>2010 Maryland Cancer Registry | *No target in Cancer Plan |
| | Mortality | 3.0 per 100,000<br>2006 CDC WONDER | 2.4 per 100,000<br>2010 Maryland Vital Statistics MATCH | 2.4 per 100,000<br>(Healthy People 2020 Target) |
| ***Colorectal Cancer:*** | Incidence | 41.3 per 100,000<br>2006 Maryland Cancer Registry | 37.4 per 100,000<br>2010 Maryland Cancer Registry | 29.4 per 100,000 |
| | Mortality | 18.4 per 100,000<br>2006 CDC WONDER | 14.9 per 100,000<br>2010 Maryland Vital Statistics Administration | 11.0 per 100,000 |
| ***Breast Cancer:*** | Incidence | 112.8 per 100,000<br>2006 Maryland Cancer Registry | 129.0 per 100,000<br>2010 Maryland Cancer Registry | 96.5 per 100,000 |
| | Mortality | 25.0 per 100,000<br>2006 CDC WONDER | 24.2 per 100,000<br>2010 Maryland Vital Statistics | 22.0 per 100,000 |
| ***Prostate Cancer:*** | Incidence | 153.9 per 100,000<br>2006 Maryland Cancer Registry | 140.6 per 100,000<br>2010 Maryland Cancer Registry | *No target in Cancer Plan |
| | Mortality | 26.3 per 100,000<br>2006 CDC WONDER | 22.3 per 100,000<br>2010 Maryland Vital Statistics | 14.9 per 100,000 |

# Incidence and Mortality Updates

## *Seven Targeted Cancers*

| | | **Baseline** | **Update** | **2015 Target** |
|---|---|---|---|---|
| ***Oral Cancer:*** | Incidence | 8.9 per 100,000<br>2006 Maryland Cancer Registry | 10.6 per 100,000<br>2010 Maryland Cancer Registry | 6.5 per 100,000 |
| | Mortality | 2.8 per 100,000<br>2006 CDC WONDER | 2.3 per 100,000<br>2010 Maryland Vital Statistics MATCH | 2.1 per 100,000 |
| ***Cervical Cancer:*** | Incidence | 6.7 per 100,000<br>2006 Maryland Cancer Registry | 7.3 per 100,000<br>2010 Maryland Cancer Registry | *Less than*<br>6.7 per 100,000 |
| | Mortality | 2.2 per 100,000<br>2006 CDC WONDER | 1.9 per 100,000<br>2010 Maryland Vital Statistics MATCH | 1.4 per 100,000 |

# Cancer Disparities

The Maryland Comprehensive Cancer Control Plan's goal is to reduce cancer disparities in Maryland through 1) reduction of disparity between African American versus white all-cancer mortality and 2) through improved data systems and tracking of cancer disparities. Recognizing that disparities exist in many forms (incidence, mortality, stage at diagnosis, access to care, use of screening tests, etc.) for many groups (racial/ethnic groups, language groups, groups with disabilities, and groups of differing sexual orientation), in this report cancer disparities are highlighted in each Cancer Plan Success Story to indicate that disparities are addressed in each of the highlighted cancer control efforts.

## *2013 Maryland General Assembly Session Highlight*

*Cancer Disparities*

⇒ In 2012 the Maryland General Assembly passed the Health Disparities and Reduction Act, which set the framework to establish Health Enterprise Zones and provide funding for two to four zones to address health disparities in those areas. Health Enterprise Zones are designed to reduce health disparities, improve outcomes, and reduce health costs and hospital admissions and readmissions in specific geographic areas of the State.

⇒ Since the passage of the legislation, the Maryland Department of Health and Mental Hygiene and the Community Health Resources Commission received 19 applications from non-profit community-based organizations and local health departments that addressed disparities in defined geographic areas. Ultimately, five Health Enterprise Zones were designated in 2013: Capitol Heights in Prince George's County, Greater Lexington Park in St. Mary's County, Dorchester and Caroline Counties, West Baltimore, and Annapolis. Community coalitions in each area will receive a range of incentives, benefits, and grant funding to address unacceptable and persistent health disparities. Some of the innovative activities that will be conducted to address disparities in the selected Zones include:

- Development of a "health care transportation route" to address barriers to accessing health care in a rural area of the state;
- Creation of a mobile mental health crisis team;
- Creation of new patient-centered medical homes;
- Increasing the number of providers serving the Zones; and
- Increasing access to healthy food retailers and exercise facilities.

More details on each of the projects are available online at http://dhmh.maryland.gov/healthenterprisezones/SitePages/Updates.aspx.

(See Maryland Comprehensive Cancer Control Plan Chapter 3)

# Cancer Disparities

## Measurable Progress

| | Baseline | Current | 2015 Target |
|---|---|---|---|
| ***Chapter 3: Cancer Disparities*** | | | |
| Goal 1. Objective 1. By 2015, reduce the racial/ethnic minority vs. white cancer disparities in all site morality to: | | | |
| Black or African American: 164 per 100,000 | 221 | 203.8 | 164 |
| White: 161 per 100,000 | 189<br>2002-2006 CDC WONDER | 175.4<br>2006-2010 MD Vital Statistics MATCH | 161 |
| By 2015, reduce the Asian/Pacific Islander vs. white liver cancer and stomach cancer mortality disparities by achieving liver cancer and stomach cancer mortality rates: | | | |
| Asian/Pacific Islander Liver Cancer Mortality: Less than 7.9 per 100,000 | 7.9 | 9.0 | <7.9 |
| White Liver Cancer Mortality: Less than 4.2 per 100,000 | 4.2 | 4.8 | <4.2 |
| Asian/Pacific Islander Stomach Cancer Mortality: 6.4 per 100,000 | 7.8 | 8.7 | 6.4 |
| White Stomach Cancer Mortality: 2.4 per 100,000 | 3.1<br>2002-2006 CDC WONDER | 2.9<br>2006-2010 MD Vital Statistics MATCH | 2.4 |
| ***Chapter 5: Tobacco-Use Prevention/Cessation and Lung Cancer*** | | | |
| Goal 1. Objective 2. By 2015, reduce current tobacco use by 10% among Maryland adults who do not have a four-year college degree to 14.5%. | 16.10%<br>2008 MD Adult Tobacco Survey[1] | 21.20%<br>2012 MD BRFSS[2] | 14.50% |

[1]The MD Adult Tobacco Survey and the MD Cancer Survey were not continued after 2008. BRFSS data is used for updates.

[2]Because sampling for the Behavioral Risk Factor Surveillance (BRFSS) changed in 2011, data from the BRFSS in year 2011 and beyond cannot be compared to results from previous years of BRFSS data (2010 and earlier) or to results from the Maryland Cancer Survey.

# Cancer Disparities

## Measurable Progress

| | Baseline | Current | 2015 Target |
|---|---|---|---|
| ***Chapter 6: Nutrition, Physical Activity, and Healthy Weight*** | | | |
| Goal 1. Reduce the proportion of low-income children (ages 2-4) who are obese to 14.1%. | 15.70%<br>2008 Ped. Nutritional Surv. Survey | 15.30%<br>2011 Ped. Nutritional Surv. Survey | 14.10%<br>(2016 Target) |
| ***Chapter 9: Colorectal Cancer*** | | | |
| Goal 2. Reduce the incidence and mortality of CRC to reach targets: | | | |
| *Incidence:* White: 29.5 per 100,000 | 40.2 | 35.9 | 29.5 |
| Black: 32.0 per 100,000 | 42.7 | 43.0 | 32.0 |
| Male: 31.2 per 100,000 | 48.1 | 43.5 | 31.2 |
| Female: 28.2 per 100,000 | 36.2<br>2006 MCR | 32.6<br>2010 MCR | 28.2 |
| *Mortality:* White: 11.1 per 100,000 | 17.6 | 12.9 | 11.1 |
| Black: 13.5 per 100,000 | 22.7 | 21.9 | 13.5 |
| Male: 13.8 per 100,000 | 21.8 | 18.0 | 13.8 |
| Female: 9.0 per 100,000 | 16.1<br>2006 CDC WONDER | 12.5<br>2010 MD Vital Statistics Administration | 9.0 |
| ***Chapter 10: Breast Cancer*** | | | |
| Goal 1. Reduce the incidence of breast cancer in Maryland to reach targets: | | | |
| Black or African American: 97.7 per 100,000 | 109.7 | 129.4 | 97.7 |
| White: 97.7 per 100,000 | 115<br>2006 MCR | 127.6<br>2010 MCR | 97.7 |

# Cancer Disparities

## Measurable Progress

| | Baseline | Current | 2015 Target |
|---|---|---|---|
| ***Chapter 11: Prostate Cancer*** | | | |
| Goal 2. Objective 2. By 2015, reduce the disparity in prostate cancer mortality rates between African American and white men to reach targets: | | | |
| White: 12.4 per 100,000 | 21.7 | 17.6 | 12.4 |
| Black or African American: 23.0 per 100,000 | 51.2<br>2006 MD Vital Statistics | 44.4<br>2010 MD Vital Statistics MATCH | 23.0 |
| ***Chapter 12: Oral Cancer*** | | | |
| Goal 2. Objective 1. By 2015, increase the proportion of black or African American adults with oral cancer detected at a local stage to greater than 25%. | 25%<br>2006 MCR | 23%<br>2010 MCR | >25% |
| Goal 2. Objective 2. By 2015, increase the percentage of black or African American adults, age 40 years and older, who have been screened in the past year for oral cancer to 25.8%. | 23%<br>2008 MD Cancer Survey[1] | 16%<br>2012 MD BRFSS[2] | 26% |

[1]The MD Adult Tobacco Survey and the MD Cancer Survey were not continued after 2008. BRFSS data is used for updates.

[2]Because sampling for the Behavioral Risk Factor Surveillance (BRFSS) changed in 2011, data from the BRFSS in year 2011 and beyond cannot be compared to results from previous years of BRFSS data (2010 and earlier) or to results from the Maryland Cancer Survey.

# Primary Prevention

## Workplace Fitness and Nutrition Program Earns Johns Hopkins a Seal of Approval

The Maryland Comprehensive Cancer Control Plan (MCCCP) states that "a fourth of all cancers are preventable through healthy lifestyles including healthy diet, physical activity, and healthy weight." However in Maryland almost two-thirds of adults were overweight or obese in 2011[1], which could be partially attributed to the energy imbalance created as a result of poor diet (too many calories consumed) and lack of physical activity (too few calories expended). Furthermore, poor diet, such as one that consists of too few fruits and vegetables, and physical inactivity have been associated with an increased risk of cancer. Because such a large percentage of Marylanders are at an increased risk of cancer due to physical inactivity, unhealthy weight, and poor nutrition, it is important to increase opportunities for individuals to make healthy diet choices and engage in physical activity. Since employees spend a significant time at work, employers can play a crucial role in increasing the health of their workforce by providing on-the-job opportunities for their employees to engage in healthy lifestyle choices and activities. Such opportunities benefit both the employee and employer with improved health and productivity of the workforce. Johns Hopkins University, Hospital, and Health Systems have recently been recognized for providing such opportunities for employee health.

Johns Hopkins University, Hospital, and Health Systems recently received national recognition for earning the Alliance for Work-Life Progress seal of distinction. The honor recognizes employers who demonstrate leadership in workplace strategies and practices that help employees achieve success at work and in their personal lives. Johns Hopkins was one of just 54 public and private companies across the United States to be recognized.

"Johns Hopkins has had a long-standing commitment to work-life initiatives with a broad portfolio of support programs and benefits. It is wonderful to have our work recognized with this award," says Michelle Carlstrom, Senior Director of the Office of Work, Life, and Engagement, a Johns Hopkins department focused on helping its faculty and staff members achieve a healthy balance between work, personal life, and academic pursuits.

Johns Hopkins was recognized for a health and wellness program that promotes and aids in healthy nutrition and physical activity for its more than 45,000 employees. Poor diet, obesity, and lack of exercise are significant cancer risk factors, and reducing the risk of cancer by encouraging Maryland businesses to develop policies and supports for promoting healthy eating and physical activity is a goal of the Maryland Comprehensive Cancer Control Plan.

To help employees improve their health and fitness and at the same time reduce their risk for cancer and other diseases, Johns Hopkins provides a wide variety of services and programs including: fitness centers and fitness classes; wellness activities such as yoga, mindful meditation, Zumba, and cardio fusion; weight loss programs; healthy food options in on-site cafeterias; health coaching and nutritional counseling; health risk assessments and biometric screenings to help employees understand their potential medical risks and to develop a plan for prevention; lunchtime workshops on topics including simple and easy changes for healthy living, healthy menu planning, and tips to get a better night's sleep; the Faculty and Staff Assistance Program, a life management resource that assists employees to identify and manage challenging issues in healthy ways; an on-site medical clinic and on-site immunizations; and a breastfeeding support program for nursing mothers who have returned to work.

[1] 2011 Maryland BRFSS.

# Primary Prevention

A mother who has benefitted from the breastfeeding program shared, "We have reached the six month mark and she still hasn't had any formula! I've even made a buddy with one of the mothers who pumps around the same time that I do. I'm very excited that I can continue to give my daughter this gift and continue this bond with her. I am so thankful that Johns Hopkins is supportive of breastfeeding mothers." The breastfeeding program as part of the worksite wellness program furthers implementation of the Maryland Comprehensive Cancer Control Plan's efforts to reduce the incidence of breast cancer in Maryland by increasing the proportion of Maryland women breastfeeding because it encourages breastfeeding in the workplace after mothers return to work.

Johns Hopkins health and wellness success has been made possible through the collaboration and cooperation of the Office of Work, Life, and Engagement; the benefits offices; occupational health; talent management; organizational development; and health and wellness program coordinators.

## *2013 Maryland General Assembly Session Highlights*

*Primary Prevention*

⇒ A State Employee and Retiree Health and Welfare Benefits Program was established in 2013, designed to promote health, improve clinical outcomes, prevent or reduce admissions and re-admissions to health care facilities, improve chronic disease treatment compliance, promote healthy behaviors, and prevent and control injury among employees.

(See Maryland Comprehensive Cancer Control Plan Chapter 6)

⇒ In 2013, a Workgroup on Cancer Clusters and Environmental Causes of Cancer was formed in accordance with legislation that was passed by the Maryland General Assembly. The Workgroup is charged with examining issues relating to the investigation of potential cancer clusters and potential environmental causes of cancer. A report on the Workgroup's findings will be released in 2014.

(See Maryland Comprehensive Cancer Control Plan Chapter 8)

# Primary Prevention

## Measurable Progress

| | Baseline | Current | 2015 Target |
|---|---|---|---|
| ***Chapter 5: Tobacco-Use and Lung Cancer*** | | | |
| Goal 1. Objective 2. By 2015, reduce current tobacco use by 10% among Maryland high school youth to 21.8%. | 24.2%<br>2008 MD Youth Tobacco Survey | 16.9%<br>2013 MD Youth Tobacco Survey | 21.8% |
| Goal 1. Objective 3. By 2015, increase the percentage of youth not exposed to secondhand smoke indoors and in motor vehicles to reach the following targets: indoors: 77.6%, motor vehicles: 79.6%. | Indoors:<br>70.6% | Indoors:<br>68.3%<br>2013 MD Youth Tobacco Survey | 77.6% |
| | Vehicles:<br>72.4%<br>2008 MD Youth Tobacco Survey | Vehicles:<br>74.2%<br>2010 MD Youth Tobacco Survey | 79.6% |
| ***Chapter 6: Nutrition, Physical Activity, & Healthy Weight*** | | | |
| Goal 1. Reduce the burden of cancer by improving nutrition and physical activity and promoting the healthy weight of Marylanders.<br>2016 Targets: | | | |
| Increase proportion of MD adults consuming 5 or more fruits and vegetables per day to 32% . | 27%<br>2008 MD BRFSS | 27%<br>2010 MD BRFSS | 32% |
| Maintain proportion of MD adults engaging in moderate physical activity for 30 minutes or more per day, five or more days per week at 36%. | 36%<br>2008 MD BRFSS | 32%<br>2010 MD BRFSS | 36% |
| Increase the proportion of adults who engage in aerobic physical activity of at least moderate intensity for at least 150 minutes/week, or 75 minutes/week of vigorous intensity, or an equivalent combination. | 49%<br>2011 MD BRFSS | 52%<br>2012 MD BRFSS | 47.9%<br>HP 2020 Target |
| Reduce the proportion of Maryland adults engaging in no leisure time physical activity to 19%. | 24%<br>2008 MD BRFSS | 23%<br>2012 MD BRFSS[1] | 19% |
| Increase the proportion of Maryland adults who are at a healthy weight (18.5>= BMI<25.0) to 44%. | 36%<br>2008 MD BRFSS | 36%<br>2012 MD BRFSS[1] | 44% |

[1]Because sampling for the Behavioral Risk Factor Surveillance (BRFSS) changed in 2011, data from the BRFSS in year 2011 and beyond cannot be compared to results from previous years of BRFSS data (2010 and earlier) or to results from the Maryland Cancer Survey.

# Primary Prevention

## Measurable Progress

| | Baseline | Current | 2015 Target |
|---|---|---|---|
| ***Chapter 7: Ultraviolet Radiation and Skin Cancer*** | | | |
| Goal 2. Objective 1. By 2015, increase the percentage of Maryland adults to 44% who always or nearly always do at least two of the following: | | | |
| Limit sun exposure between 10:00 a.m. and 4:00 p.m., use sunscreen with SPF of 15 or higher when outdoors for an hour or more on a sunny day, wear a hat with a broad brim when outdoors for an hour or more on a sunny day, or wear sun-protective clothing when outdoors for an hour or more on a sunny day. | 36%<br>2006 MD BRFSS | 32%<br>2012 MD BRFSS[1] | 44% |
| Goal 2. Objective 1. By 2015, increase the percentage of Maryland children (under age 13) who always or nearly always use sun-protection measures (including sunscreen and protective clothing) to 73%. | 68%<br>2006 MD BRFSS | 68%<br>2010 MD BRFSS | 73% |
| ***Chapter 10: Breast Cancer*** | | | |
| Goal 1. Objective 2. By 2015, increase the proportion of Maryland women who: | | | |
| Ever breastfed to 85%. | 75% | 69% | 85% |
| Were breastfeeding at 6 months to 67%. | 46% | 52% | 67% |
| Were breastfeeding at 12 months to 42%. | 26%<br>CDC National Immun. Survey (2006 births) | 24%<br>CDC National Immun. Survey (2010 births, provisional data) | 42% |

[1]Because sampling for the Behavioral Risk Factor Surveillance (BRFSS) changed in 2011, data from the BRFSS in year 2011 and beyond cannot be compared to results from previous years of BRFSS data (2010 and earlier) or to results from the Maryland Cancer Survey.

# Early Detection and Treatment

## Patient Navigation Networking at Primary Care Coalition

Patient Navigation refers to individualized assistance offered to patients, families, and caregivers to help overcome health system barriers and facilitate timely access to quality medical and psychological care.[1] Appropriate cancer patient navigation assists patients along the entire cancer continuum including cancer prevention, screening, treatment and survivorship. This strategy of supporting and utilizing patient navigation to overcome barriers is recommended throughout multiple chapters of the Maryland Comprehensive Cancer Control Plan.

The term patient navigator can refer to a person in an organization whose sole job it is to guide patients and families through the cancer care process, or it can refer to a staff member who navigates patients as one portion of his or her daily tasks. Patient navigation can also refer to a package of services offered by a team of many staff members assigned to a cancer patient. Typically referred to as a "patient navigation care team," such teams may include pain management specialists, social workers, doctors, nurses, psychologists, etc. Because the terms "patient navigation" and "patient navigators" describe a wide range of services and encompass many specialties and types of personnel, the challenges that patient navigators face in their roles are equally as broad. Patient navigators and navigation care teams frequently cite communication challenges, coordination of time and resources, and a lack of knowledge of resources available to them and their patients in an ever-changing healthcare landscape, as barriers to successful navigation.

Recognizing the need for patient navigators to come together to address these difficulties and to network and share ideas, best practices, resources, and support, the Primary Care Coalition (PCC) of Montgomery County, Maryland began hosting bi-monthly patient navigation meetings in December 2012. PCC is dedicated to serving low-income uninsured, ethnically diverse residents of Montgomery County.[2] In this setting, patient navigators share ideas, best practices, resources, and support for one another. The meetings average thirty to forty attendees who gather to discuss a number of topics including patient navigation of Medicaid patients, the perception of patient navigation in healthcare organizations, case studies showcasing particularly difficult or complex navigation situations, and themes from clinical practices like pain management. One recent meeting held in September 2013 focused on substance abuse and palliative care. Experts discussed how a pain management and palliative care team navigate a cancer patient through treatment and survivorship. Throughout the presentations, participants asked questions, spoke about their own navigation experiences, and exchanged information regarding resources at their respective organizations for navigators and for patients. Participants also engaged in unstructured networking time and distributed navigation resources such as flyers about the Maryland Health Benefit Exchange and patient resource guides.

One meeting participant shared that the meetings allow navigators to discuss patient pathways to care with each other, noting that her colleagues are often not aware that they share patients. Another attendee of past meetings described the meetings as a “great way to meet each other, network, and know what resources are available for other patients.” Over the course of the last year, interest in PCC’s patient navigation meetings has continued to grow with attendees from Prince George’s County, Montgomery County, and Washington, DC. The meetings are open to anyone interested in patient navigation. In 2014, PCC hopes to expand to include participants from Frederick and Howard Counties as well as participants from hospitals and clinics, from specialties such as breast, colon health, and behavioral health. By providing this valuable networking opportunity, PCC is helping to address the burden of cancer in Maryland by supporting patient navigation throughout the cancer continuum, including a focus on early detection and treatment.

[1] “Cancer Patient Navigation Overview,”cancerpatientnavigation.org/.

[2] “About PCC,” www.primarycarecoalition.org.

# Early Detection and Treatment

## Measurable Progress

| | Baseline | Current | 2015 Target |
|---|---|---|---|
| ***Chapter 7: Ultraviolet Radiation and Skin Cancer*** | | | |
| Goal 2. Objective 3. By 2015, improve the early detection of skin cancer by increasing the percentage of melanoma cancers in Maryland diagnosed at the local stage to 74.1%. | 59.1%<br>2006 MCR | 52.1%<br>2010 MCR | 74% |
| ***Chapter 9: Colorectal Cancer*** | | | |
| Goal 1. Objective 1. By 2015, increase the percentage of Marylanders ages 50 years and older who are up-to-date[1] with screening per ACS/Multi Society Task Force guidelines to 80%. | 73%<br>2008 MD BRFSS | 69%<br>2012 MD BRFSS[2] | 80% |
| Goal 2. Objective 1. By 2015, increase the rates of up-to-date[1] CRC screening to 80% or higher for the following groups age 50 and older: | | | |
| Black or African American Female: | 75% | 73% | 80% |
| White Female: | 73% | 71% | 80% |
| Black or African American Male: | 68% | 64% | 80% |
| White Male: | 76%<br>2008 MD BRFSS | 70%<br>2012 MD BRFSS[2] | 80% |
| ***Chapter 10: Breast Cancer*** | | | |
| Goal 2. Objective 1. By 2015, increase the percentage of females in Maryland ages 40 and above who have received a mammogram in thepast two years to greater than 77%. | 77%<br>2008 MD BRFSS | 79%<br>2012 MD BRFSS[2] | > 77% |

[1]The definition of "up-to-date" CRC screening from the BRFSS includes the % of adults age 50 years and older who have had at least one of the following: 1) FOBT in the past year; 2) flex sigmoidoscopy in the past 5 years; 3) colonoscopy in the past 10 years.

[2]Because sampling for the Behavioral Risk Factor Surveillance System (BRFSS) changed in 2011, data from the BRFSS in year 2011 and beyond cannot be compared to results from previous years of BRFSS data (2010 and earlier) or to results from the Maryland Cancer Survey.

# Early Detection and Treatment

## Measurable Progress

| | Baseline | Current | 2015 Target |
|---|---|---|---|
| ***Chapter 12: Oral Cancer*** | | | |
| Goal 1. Objective 1. By 2015, increase the proportion of adults 40 years and older who have had an oral cancer exam in the past year to 48%. | 40%<br>2008 MD Cancer Survey[1] | 30%<br>2012 MD BRFSS[2] | 48% |
| Goal 1. Objective 2. By 2015, increase the proportion of oral cancer detected at a local stage to greater than 28%. | 28%<br>2006 MCR | 31%<br>2010 MCR | > 28% |
| ***Chapter 13: Cervical Cancer*** | | | |
| Goal 1. Objective 3. By 2015, utilize state-of-the-art recommendations to increase the proportion of women ages 21 to 70 receiving a Pap test in the last three years to greater than 88%. | 88%<br>2008 MD BRFSS | 88%<br>2012 MD BRFSS[2] | > 88% |

[1]The MD Cancer Survey was not continued after 2008. BRFSS data is used for updates.
[2]Because sampling for the BRFSS changed in 2011, data from the BRFSS in year 2011 and beyond cannot be compared to results from previous years of BRFSS data (2010 and earlier) or to results from the Maryland Cancer Survey.

### *2013 Maryland General Assembly Session Highlights*

*Early Detection & Treatment*

⇒ Beginning in October 2013, centers that perform mammography testing are required to include information about breast density in the screening results letter that is sent to patients. The results letter is now required to: state that dense breast tissue is a common finding and not abnormal; state that dense breast tissue can make it harder to find cancer on a mammogram and that it may be associated with an increased risk of breast cancer; and encourage patients to use density information to talk to their physician about screening options.

(See Maryland Comprehensive Cancer Control Plan Chapter 10)

# Survivorship, Palliative Care, and Pain Management

## End-of-Life (EOL) Care at a Community Cancer Center

In Maryland and nationwide, there is an increased effort to provide palliative and end-of-life (hospice) care services to all patients in all healthcare institutions through a formalized package of staff, facilities, and treatments. Palliative and end-of-life care focuses on the care of patients of all ages with serious illnesses, incorporating patient- and family-centered care and comprehensive care (physical, emotional, social, and spiritual) offered by an interdisciplinary team of health professionals. Palliative and end-of-life care are important because evidence shows that such care can lead to an improved quality of life for the patient, lower health care costs, and for those who receive hospice care, a reduction in aggressive care. Benefits include increased symptom management and counseling against toxic therapies at the end of life, and palliative care may even extend life in some circumstances.

The Maryland Comprehensive Cancer Control Plan states that "the ultimate goal of palliative and hospice care is to improve the overall quality of care for patients with serious illness and their families." While the outcomes associated with accessing and receiving palliative care treatments are positive, the amount of referrals institutions give for palliative care services can be affected by a number of barriers including geographic availability of services, physicians' reluctance to refer to hospice services, financial barriers, insufficient provider training, and patients and families being unaware of or unwilling to discuss palliative and hospice care options. Thus, by working to mitigate these barriers and educate providers and patients, institutions can work to increase access to palliative and end-of-life care and empower patients and families to take an active role in their treatment.

The "Improving End-of-Life Care at a Community Cancer Center" project, a joint project between Peninsula Regional Medical Center (PRMC) and Coastal Hospice and Palliative Care (CHPC), provides inpatient palliative care consultation. The goal of the project is to improve EOL cancer care in the Eastern Shore community and involved a multi-faceted approach to improve palliative care services and increase the number of palliative care referrals from PRMC. The planning for the project began in 2008 when the Medical Director and the Executive Director of the Richard A. Henson Cancer Institute began discussions to improve end-of-life (EOL) care for patients in their facility. They developed a plan to achieve this improvement that consisted of:

1) The development of a multidisciplinary oncology specific palliative care outpatient service in July of 2009;
2) The formation of an End-of-Life Research Committee in 2010 to conduct a retrospective death study to evaluate data within the community to determine the EOL cancer practices, and based on the findings of this research, PRMC and CHPC began to improve the end-of-life care provided in their community;
3) The formation of the Palliative Advisory Committee (PAC) in 2011 to ensure the provision of state of the art palliative care services to enhance the health and wellbeing of patients and families served. PAC achieved this through strategic development, quality oversight, and community engagement;
4) The development of a score card to monitor palliative care referrals, average time from admission to referral to palliative care service, disposition at discharge, and referral source;
5) The formation of an end-of-life medical staff taskforce to identify areas for improvement;
6) The revision of policies and procedures for direct referral to Coastal Hospice or appropriate hospice, and revision of inpatient palliative care policies and procedures;
7) The formation of a Palliative Care/Hospice Educational Sub-Committee to develop a comprehensive educational plan for physicians and clinicians;

# Survivorship, Palliative Care, and Pain Management

8) The development and implementation of a palliative care pathway for patients with a stage IV cancer diagnosis or a distress score greater than four;
9) The improvement of the Oncology Across the Continuum sub-committee to improve communication and continuity of the care provided across the continuum; and
10) The development of a sub-committee to implement advance directive planning in the medical and radiation oncology practices.

Through this project, Peninsula Regional Medical Center and Coastal Hospice and Palliative Care have improved awareness within their institutions and gained understanding of the benefit of palliative care referrals. After evaluating the intensity of EOL cancer care and measuring that intensity against performance guidelines in a retrospective study, PRMC and CHPC were able to improve the timeliness of inpatient referral to the palliative care program and were able to improve the care of patients across the continuum. The results of the initial study were published in the American Society of Clinical Oncology's *Journal of Oncology Practice*,[1] and the project continues to implement aspects of the Maryland Comprehensive Cancer Control Plan's palliative and hospice care goals by increasing the participation in and support of palliative and hospice care initiatives by all stakeholders. Furthermore, the project supports the Cancer Plan by increasing access to palliative and hospice care services in Maryland. Because of the initiatives of the project, PRMC and Coastal Hospice and Palliative care have seen a 65% increase in referral to outpatient palliative care services that serve oncology patients only and a 23% increase in palliative care referrals for all patients. Projects such as the "Improving End-of-Life Care at a Community Cancer Center" project demonstrate the commitment of health care institutions and communities to decreasing the burden of cancer in Maryland.

[1]Cowall, DR et al: End-of-Life Care at a Community Cancer Center. Journal of Oncology Practice 8(4):e40-e44, 2012.

# Survivorship, Palliative Care, and Pain Management

## *2013 Maryland General Assembly Session Highlight*

*Survivorship, Palliative Care, and Pain Management*

⇒ Legislation was passed in 2013 to establish palliative care pilot programs across the state. The legislation requires the Maryland Health Care Commission (MHCC) to select at least five hospitals to establish palliative care pilot programs, which will: provide access to information and counseling regarding palliative care to patients with a serious disease or illness; require providers to discuss the benefits and risks of treatment options in a manner that can be easily understood by the patient; facilitate access to palliative care consultations and services; collaborate with the provider community; gather data on costs and savings to hospitals and providers, access to care, and patient choice; and report best practices. By December 1, 2015, the MHCC in consultation with the Office of Health Care Quality and the Maryland Hospital Association will report on the pilot program findings, including recommendations that will be used to develop minimum standards for hospital palliative care programs in Maryland.

(See Maryland Comprehensive Cancer Control Plan Chapter 15)

⇒ The Natalie M. LaPrade Medical Marijuana Commission and Fund were established in 2013, which allow for the investigational use of marijuana for medical purposes. The Commission will establish an application process for academic medical centers to apply to operate medical marijuana compassionate use programs in Maryland.

(See Maryland Comprehensive Cancer Control Plan Chapter 14)

# Evaluation

## Time to Breast Cancer Treatment Assessment

In the state of Maryland, breast cancer accounts for about thirty percent of all cancers diagnosed among women and in 2012 4,236 women were diagnosed. While a significant number of women are diagnosed each year, mortality rates from breast cancer have been decreasing in Maryland due to improved screening and improved treatment. However, it is important to note that African American women continue to show higher breast cancer mortality rates compared to white women. This trend in health disparities is particularly pronounced in Maryland because the state has a larger proportion of African Americans compared to the U.S. Thus, the breast cancer mortality rates in Maryland are likely to remain high.

One important factor in reducing mortality rates is initiating treatment in a timely manner following diagnosis. Dr. Serban Negoita, a researcher from Westat, recently conducted a project to test whether the Maryland Cancer Registry (MCR) database could be used to establish the baseline rates of Maryland women receiving treatment within sixty days. Additionally, the project aimed to identify patterns of treatment delays and aimed to monitor adherence to guidelines for prescribed treatment among women who are vulnerable to the delay of onset of treatment. The project, "Time to Breast Cancer Treatment," focused on Maryland women diagnosed with breast cancer between the years of 2004 and 2009 with no prior history of malignant tumors, and assessed the records of 23,529 Maryland residents diagnosed with localized, locally advanced, or metastatic breast cancer.

The project aimed to develop and test a feasible, robust, and inexpensive method that allows cancer program managers and other public health practitioners to identify and plan interventions in the population groups most vulnerable to delays in breast cancer treatment. The assessment developed its method by using data available through the MCR to recalculate the date of first treatment, and then to calculate the number of days between diagnosis and treatment. All patients were classified according to the length of time between diagnosis and treatment, measured by the number of days. Patients were further classified by the type of treatment and whether their cancer was localized, locally advanced, or metastatic.

The assessment found that while 98% of patients received some breast cancer treatment in the first 365 days after diagnosis, only 88% received breast cancer treatment during the first 60 days. The proportion of women first receiving surgery within 60 days, as recommended by the Maryland Cancer Plan, was even lower at 84%. Similar findings were observed for women with locally advanced cancer (89% receiving treatment in 60 days or less), and metastatic cancer (84%). Statistical modeling of the data in the assessment identified several predictors of untimely treatment including black race, Medicaid insurance, Hispanic ethnicity, more complex surgery like total mastectomy, older age (75 years and older), and not being married.

The "Time to Breast Cancer Treatment Assessment" was made possible due to the completeness of information available within the MCR including accurate diagnosis, stage, and treatment information, as well as demographic, insurance status, and county of residence information. All of these data were necessary for the calculation of time to treatment. The project addresses the Maryland Comprehensive Cancer Control Plan's goal to reduce the morbidity and mortality from breast cancer in Maryland by ensuring that all individuals are promptly treated within sixty days of abnormal screening and receive appropriate surgical options and adjuvant therapy treatment according to national guidelines. Additionally, the project revealed that the high quality of MCR data can support the implementation and future monitoring of time-to-treatment indicators.

# The Maryland Cancer Collaborative

The Maryland Cancer Collaborative was established in 2011 as a statewide coalition working to implement the Maryland Comprehensive Cancer Control Plan. The goals of the Collaborative are to work with individuals and organizations throughout the state to implement the Maryland Comprehensive Cancer Control Plan, and to bring together existing groups and new partners from across the state to collaborate on a common goal: reducing the burden of cancer in Maryland.

As of December 2013 there are 170 members on the Maryland Cancer Collaborative, representing state and local health departments, academic institutions, hospitals and healthcare systems, private providers, representatives from nonprofit and community based organizations, survivors, and citizens. Members agree to:

- Support and utilize the Maryland Comprehensive Cancer Control Plan
- Take specific action to implement the Maryland Comprehensive Cancer Control Plan
- Support and participate in evaluation of implementation efforts
- Be identified as a member of the Maryland Cancer Collaborative
- Participate in meetings regularly (except for corresponding members)
- Report implementation efforts and progress to DHMH
- Report in-kind contributions toward Maryland Cancer Collaborative activities
- Abide by and adhere to the ***Approval Procedure for Communicating Beyond the Collaborative***
- Abide by and adhere to ***Policy Ground Rules***
- Bring available resources to the table

The Collaborative structure includes six standing committees (Primary Prevention; Early Detection and Treatment; Survivorship, Palliative Care, and Pain Management; Policy; Cancer Disparities; and Evaluation) and five topic-based workgroups (Tobacco; Worksite Wellness; Survivorship; Palliative Care; Patient Navigation) developed from the committees to implement the committee action plans. Each committee has a Chair or Co-chairs, which comprise the Collaborative Steering Committee. The outgoing Collaborative Chair is a retired Vice President of the American Cancer Society's South Atlantic Division. The incoming Collaborative Chair for 2014 is a professor at the Johns Hopkins School of Public Health and Director of the Cancer Epidemiology, Prevention & Control Training Program. The Chair and Steering Committee have been instrumental in structuring the Collaborative and building its membership base.

From the time that the Collaborative was established in the summer of 2011 through December 2013, committees have met to review relevant chapters, goals, and objectives in the Cancer Plan, select priorities for implementation, and create and implement action plans for selected priorities. Each committee continues to prioritize objectives implemented through the activities of the five workgroups. A summary of each committee's selected priority objectives can be found on page 23.

Anyone who is interested in becoming a member of the Collaborative is welcome to join. For more information, please contact:

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# The Maryland Cancer Collaborative

**Maryland Cancer Collaborative Priority Objectives**

**Primary Prevention Committee**

*By the end of 2015, adopt and implement statewide and local public policies that combat tobacco-industry marketing strategies used to promote and sustain the use of existing and emerging tobacco products. (Chapter 5, Goal 1, Objective 1)*

*By 2015, ensure that at least 25% of Maryland businesses have policies and supports for promoting healthy eating and physical activity. (Chapter 6, Goal 1, Objective 2)*

**Early Detection and Treatment Committee**

*By 2015, increase the percentage of Marylanders ages 50 years and older who are up-to-date with CRC screening per ACS/* Multi Society Task Force guidelines to 80% with special focus on minority groups. (Chapter 9, Goal 1, Objective 1 combined with Chapter 9, Goal 2, Objective 1)

By 2015, increase skin cancer detection education *for Maryland healthcare providers and beauty industry providers and improve the early detection of skin cancer by increasing the percentage of melanoma cancers diagnosed at the local stage to 74.1%. (Chapter 7, Goal 1, Objective 2)*

**Survivorship, Palliative Care, and Pain Management Committee**

*By 2015, develop and disseminate materials and explore the need/feasibility of providing formal training and/or certification to educate policy and decision makers, community leaders, educators, and health care providers about cancer survivorship including psychosocial issues and the role and value of providing long term care and support services to cancer survivors. (Chapter 4, Objective 4 combined with Chapter 4, Objective 7)*

*By 2015, develop an awareness campaign to educate Maryland citizens about palliative and hospice care, including pain management, within 50% of Maryland jurisdictions. (Chapter 14, Goal 1, Objective 1 combined with Chapter 15, Objective 1).*

**Cancer Disparities Committee**

*By 2015, reduce racial/ethnic minority vs. white cancer disparities in Maryland to:*

*Reduce the black or African American vs. white all-cancer mortality disparity by achieving the all-cancer mortality rates listed (see Cancer Plan).*

*Reduce the Asian/Pacific Islander vs. white liver cancer and stomach cancer mortality disparities by achieving the liver cancer and stomach cancer mortality rates listed. (see Cancer Plan). (Chapter 3, Objective 1)*

*By 2015, conduct an assessment and create and implement a plan to improve data systems to better identify and track cancer disparities defined by race, ethnicity, language, disabilities, sexual orientation, and other factors. (Chapter 3, Objective 2)*

**Policy Committee**

*By 2015, reduce current tobacco use by 10% among high risk populations***.** (Chapter 5, Goal 1, Objective 2)

*By 2015, create policies that promote access to healthy food and opportunities for physical activity in 75% of Maryland jurisdictions. (Chapter 6, Goal 1, Objective 5)*

**Evaluation Committee**

*Through 2015, analyze cancer data and develop reports to assist with meeting the needs of the public and researchers. (Chapter 2, Goal 1, Objective 2)*

*Through 2015, increase public availability and awareness of Maryland cancer mortality, incidence, and risk factor information. (Chapter 2, Goal 1, Objective 3)*


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The Maryland Comprehensive Cancer Control Plan

phpa.dhmh.maryland.gov/cancer/cancerplan/SitePages/publications.aspx