South Dakota Comprehensive Cancer Control Plan

2011-2015

Revised and Approved by the SD CCCP Steering Committee
December 18, 2012 & March 27, 2014

Comprehensive CANCER CONTROL SOUTH DAKOTA

SOUTH DAKOTA
COMPREHENSIVE CANCER CONTROL PLAN
2011-2015

September 2011

Revised and Approved December 2012 and March 2014

SD Comprehensive Cancer Control Program
SD Department of Health
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An electronic version of this Plan is available on the SD CCCP website at www.cancersd.com.

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Dear South Dakotans:

In 2005 the newly formed South Dakota Comprehensive Cancer Control Program presented its first cancer plan to the people of South Dakota. This ambitious plan contained strategies and actions to collaborate to fight cancer over a five-year time span. Workgroups were formed and much was accomplished. A good start was made towards decreasing the burden of cancer for all South Dakotans.

The South Dakota Comprehensive Control Program is pleased to present its second, updated cancer plan, 2011-2015. This plan moves forward the mission of the original plan. Cancer incidence can be decreased through the promotion of healthy lifestyles. Cancer outcomes can be improved through early detection. High-quality cancer treatment can be made available to all South Dakotans regardless of insurance status. Working together cancer can be conquered!

As work begins on the new plan, all South Dakotans are invited to join in the comprehensive cancer control effort. Please read the plan and visit the website to learn how you can volunteer in the activities of the South Dakota Cancer Control Program.

Sincerely,

Mary J. Milroy, MD
SD Comprehensive Cancer Control Chair

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Acknowledgements

The *South Dakota Comprehensive Cancer Control Plan: 2011-2015* could not have been developed without the dedication of the South Dakota Comprehensive Cancer Coalition's members and partners. Their hard work and motivation provided the foundation for this document, and the work it inspires.

Dedication

The South Dakota Comprehensive Cancer Control Plan 2011-2015 is dedicated to those in South Dakota who have been touched by cancer.

Executive Summary

Comprehensive cancer control is an integrated and coordinated approach to reducing cancer incidence, morbidity, and mortality through prevention, early detection, treatment, rehabilitation and palliation.

-- Centers for Disease Control and Prevention

The *South Dakota Comprehensive Cancer Plan: 2011-2015* is focused on prevention, early detection, treatment, and quality of life. The plan includes the top priorities that cancer control professionals believe should be the focal point for immediate action in order to reduce the burden of cancer.

The goal of the South Dakota Comprehensive Cancer Control Program (SD CCCP) is to ensure that all South Dakotans have access to quality cancer prevention and control information and services in order to reduce the number of new cancer cases as well as the illness, disability, and death caused by cancer and for survivors to live the best quality of life possible. The SD CCCP is dedicated to bringing together individuals, organizations, health care providers, and agencies in order to reduce the burden that cancer places on the people of our state. In order to focus our cancer control efforts on sustainable, population-based initiative, workgroup strategies include integration of evidence-based environmental, system and policy changes related to workgroup goals.

The *South Dakota Comprehensive Cancer Plan: 2011-2015* contains the following components:

- A look at how cancer affects South Dakotans
- The mission and goals of the SD CCCP
- Success stories and projects from the SD CCCP workgroups
- The objectives and strategies of each workgroup, which cover the following aspects of the cancer continuum:
  - Prevention
  - Early Detection
  - Treatment
  - Quality of Life
- Cancer resources at the state and national level

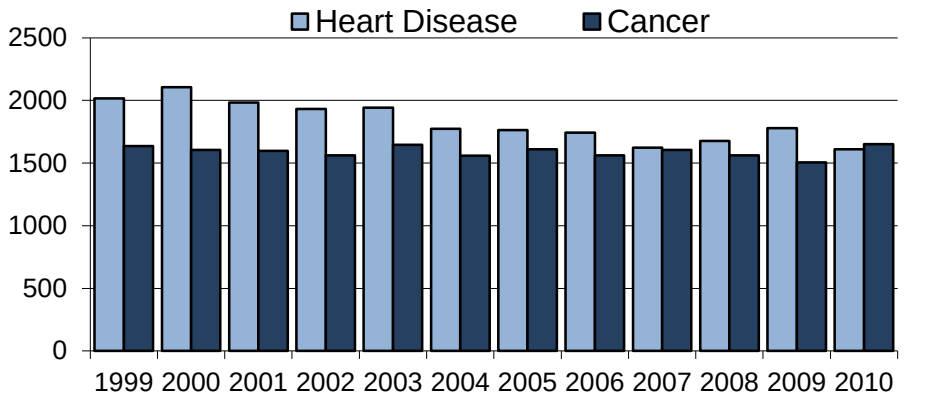
Finally, the plan offers an opportunity for all South Dakotans to become involved in the work of controlling cancer. Please complete and send in the reply form at the end of the plan. Take the opportunity to get involved and make a difference!

Cancer Burden

How Cancer Affects South Dakota

Every year, cancer claims the lives of more than half a million Americans. Cancer is the second leading cause of death in the United States but it is the leading cause of death in South Dakota for 2010. This is the first time that cancer deaths have surpassed heart disease deaths in South Dakota. With the aging population and a continued decrease in deaths from heart disease and stroke, cancer is well on its way to being the number one killer national wide not just in South Dakota.

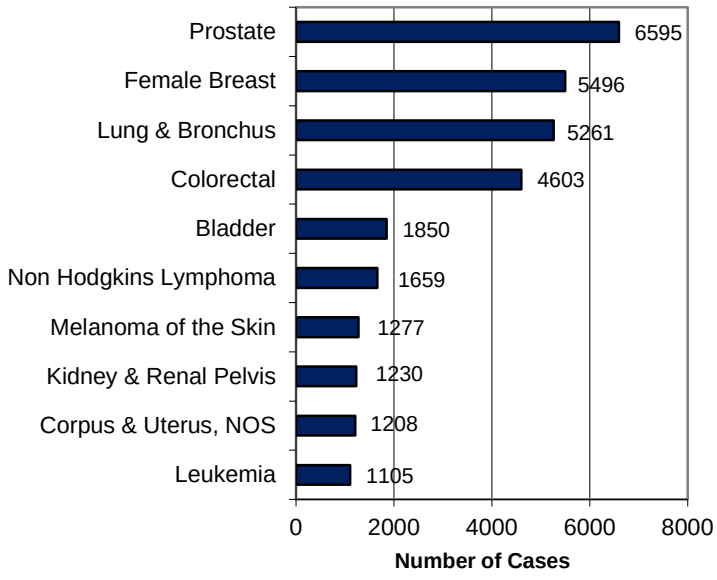
Figure 1. Deaths Due to Heart Disease and Cancer, South Dakota, 1999-2010



Source: South Dakota Department of Health

According to United States Cancer Statistics: 2009 Incidence and Mortality, which tracks cancer incidence for about 98% of the U.S. population and mortality for the entire country, more than 599,000 Americans died of cancer, and more than 1.48 million had a diagnosis of cancer in 2009.The financial costs of cancer also are overwhelming. According to the National Institutes of Health, cancer cost the United States an estimated $263.8 billion in medical expenses in 20101.

Figure 2. Ten Most Common Cancers, South Dakota, 2001-2010



Source: South Dakota Department of Health

In South Dakota during 2001 to 2010, an average of 1,600 people died each year from cancer. That translates into one in four of all deaths in the state occurring from cancer. Also during 2001 to 2010, approximately 4,000people were diagnosed with cancer in South Dakota each year. There are over 200 different types or kinds of cancer.

More than half of the cancers diagnosed in South Dakota are lung, female breast, prostate, or colorectal cancer (Figure 2.) These four primary sites accounted for 55 percent of all cancers diagnosed and 50 percent of all cancer deaths in South Dakota during 2001 to 2010.

Racial and Ethnic Differences

The risk of being diagnosed or dying from cancer is not similar for everyone. Risk may be higher depending on person's racial or ethnic group. National statistics clearly show a higher impact on certain racial and ethnic groups. This difference is similarly reflected in South Dakota's data (Figure 3.). A disparity is also found between genders (Figure 4.), with the greatest cancer impact on males. The reasons for these disparities are not clear; possibilities include genetics, environmental factors, geographic isolation, or socioeconomic differences.

Figure 3. Age-Adjusted Cancer Mortality Rates, United States and South Dakota, by Race, 2001-2010

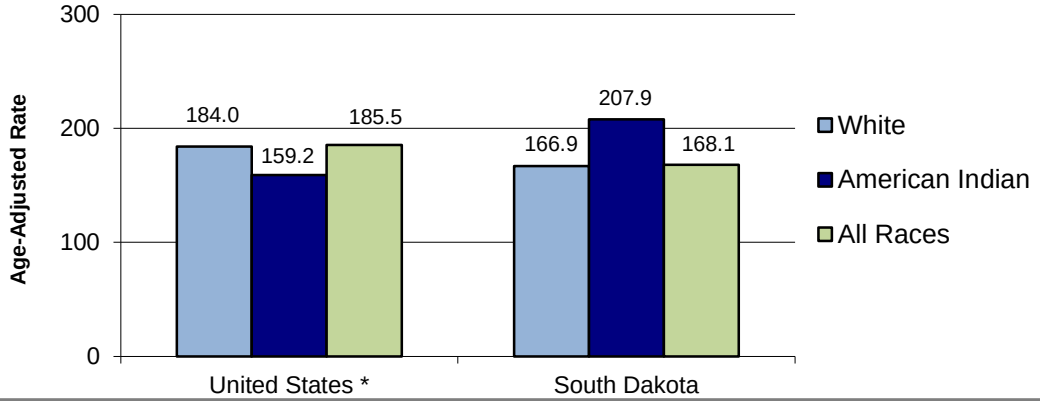
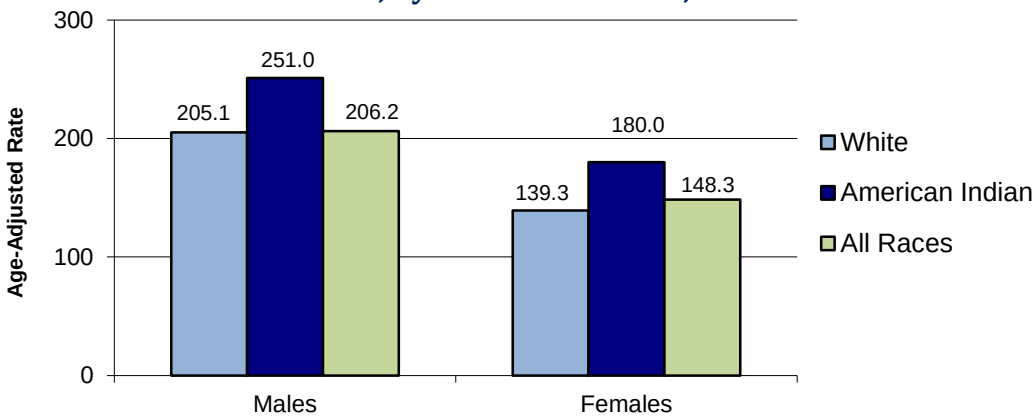


Figure 4. Age-Adjusted Cancer Mortality Rates, South Dakota, by Race and Gender, 2001-2010



Rates per 100,000 U.S. 2000 Standard Population and S.D. estimated population Source: South Dakota Department of Health

Financial Cost of Cancer

In 2007, 127,783 persons in South Dakota were on Medicaid, with 2.1% (or 2,667) having some form of cancer. The average cost per beneficiary was $1,560 (Table 1). South Dakota Medicaid spent over $4 million in Medicaid claims related to cancer. Persons age 65 and over had a majority of the Medicaid cancer expenditures with $2,237,000. The total Medicaid cancer cost among women was over twice the amount spent for men ($3 million to $1 million).

Table 1. Economic Burden of Cancer

Group	Beneficiaries	Prevalence	Beneficiaries w/Cancer	Cost Per Beneficiary	Total Medicaid Costs
United States	**55,002,107**	**2.4%**	**1,333,551**	**$1,570**	**$2,088,373,000**
South Dakota	**127,783**	**2.1%**	**2,667**	**$1,560**	**$4,159,000**
Age 18-44	30,557	2.4%	725	$1,560	$1,133,000
Age 45-64	8,191	6.6%	544	$1,450	$789,000
Age 65+	12,677	11.0%	1,398	$1,600	$2,237,000
Males	52,885	1.6%	849	$1,370	$1,159,000
Females	74,898	2.4%	1,818	$1,650	$3,000,000

NOTE: Annual expenditures inflated to 2007dollar value. Prevalence has been rounded to one decimal place; cost per beneficiary is rounded to the nearest $10, while total Medicaid costs are rounded to the nearest $1,000. All results generated are estimates. Actual costs may be larger or smaller than those reported. Source: South Dakota of Department of Health.

South Dakota Data at a Glance

Incidence

2006-2010

- The South Dakota Cancer Registry registered 19,791 newly diagnosed cases of bladder in situ and invasive cancers for South Dakota residents.
- The South Dakota age-adjusted incidence rate was436.8 compared to the national rate from SEER (National Cancer Institute) of *465.2 per 100,000 U.S. 2000 Standard Population. (*National rate for 2005-2009, 2010 rate not available).
- Prostate cancer was the most common cancer reported followed by female breast, lung, and colorectal in that order.
- The four most common cancer sites accounted for approximately 54% of all cases.
- Males comprised 53% of the cancer cases and females 47%.
- Of these cancer cases, 94.3% were white and 4.9% American Indian.
- Of all cancers reported in South Dakota, 88% were among persons age 50 or older with 39% of these cases diagnosed between ages 65-79.

2001-2005

- Incidence trends for all sites of cancer have decreased with an annual percent change (APC) of -1.5% within South Dakota compared to -0.8% for the U.S.[2]
- For American Indians, the APC decreased -5.2% in South Dakota and -1.4% in the U.S.[2]

Mortality

2006-2010

- For South Dakota residents, 7,884 deaths were related to cancer.
- The South Dakota age-adjusted death rate was 165.9 compared to the national rate from SEER (National Cancer Institute) of **178.7 per 100,000 U.S. 2000 Standard Population. (**National rate for 2005-2009, 2010 rate not available).
- The four most common causes of cancer deaths were bronchus and lung; colorectal; female breast; and pancreas cancers, accounting for approximately 50% of all cancer deaths.
- Males comprised 53% of the cancer related deaths and females 47%.
- Of these cancer related deaths, 95% were white and 5% American Indian.
- Of the cancer related deaths in South Dakota, over 95% were among persons age 50 or older.

2005-2009

- Mortality trends for all sites of cancer in South Dakota have decreased with an annual percent change (APC) of -2.0% compared to -1.6% in the U.S.[2]
- For American Indians, the APC decreased -2.3% in South Dakota and decreased -1.5% in the U.S.[2]

[1]Cancer, Addressing The Cancer Burden-At a Glance http://www.cdc.gov/chronicdisease/resources/publications/AAG/dcpc.htm#aag
[2]National Cancer Institute. State Cancer Profiles http://statecancerprofiles.cancer.gov/ Source: South Dakota Department of Health

Cancer Disparities

The South Dakota Comprehensive Cancer Control Plan defines cancer "disparities" as differences in the incidence, prevalence, mortality, and burden of cancer among specific population groups. These population groups may be characterized by age, disability, education, ethnicity, gender, geographic location, income, or race. Persons who are economically disadvantaged, lack health insurance, and are medically underserved, regardless of ethnic and racial background, often bear a greater burden of disease than the general population. Complex and interrelated factors contribute to the observed disparities in cancer incidence and mortality among these groups. Common factors are associated with a lack of health care insurance and low socioeconomic status (SES).

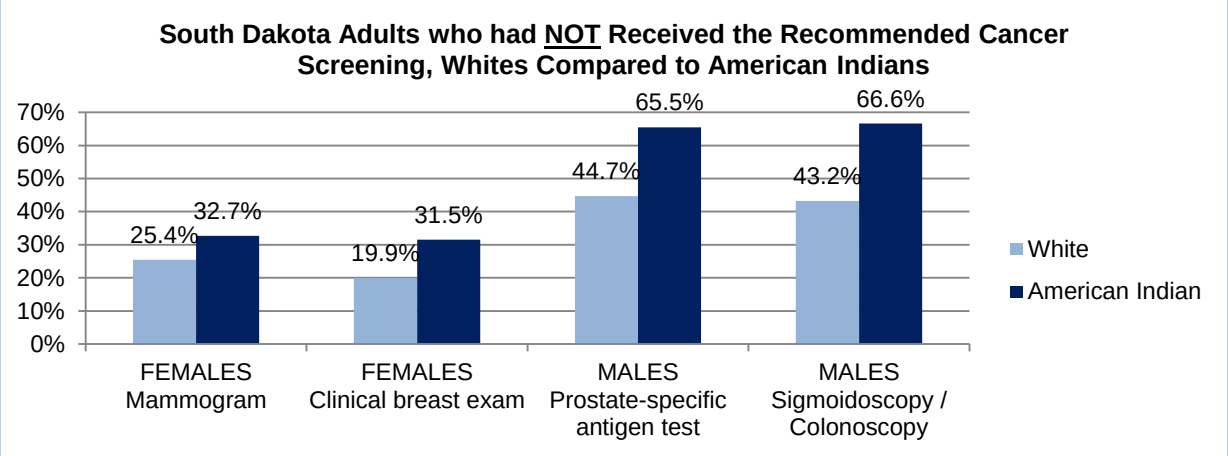
The state of South Dakota is one of the nation's most rural areas. The 2008 US Census population estimate for South Dakota was 804,194 people, which occupy a land mass of 75,885 square miles, or approximately 10.6 people per square mile. Only three cities top 25,000 in population. Nearly 60% of South Dakota's total population lives in small, rural communities of 5,000 or fewer people, with communities of less than 500 people comprising a large portion of this population group. South Dakota is home to nine American Indian tribes comprising 9.0% of the state's population. Adults age 65 and older comprise 14.3% of the population, which is higher than the national average of 12.4%. At 13.2%, the number of South Dakotans living below the poverty level is slightly higher than the national average of 12.4%.

Extensive data are captured through the South Dakota Cancer Registry in order to identify disparate populations. The risk of being diagnosed at a later stage or dying from cancer is greater among the American Indian population. The 2002-2006 age-adjusted cancer mortality rate was 187.3/100,000 for whites and 269.1/100,000 for American Indians.[1] The reason for this disparity could be due to genetics, environmental factors, geographic isolation, and/or socioeconomic differences. There is also a disparity found between the two genders, with the heaviest burden reflected in the male population. Males comprised 53% of the cancer related deaths and females 47%.

[1] South Dakota Cancer Registry. Cancer Burden in South Dakota, 2002-2006. South Dakota Department of Health.

The Behavioral Risk Factor Surveillance System (BRFSS) provides data related to previous cancer diagnosis, cancer risk factors, cancer screening, and access to health insurance and healthcare. In 2007, the American Indian population exhibited higher rates of obesity (38.2%) than whites (26.5%); higher rates of tobacco use (48.8% vs. 17.7%); and higher rates of binge drinking (25% vs. 16.9%).[2]

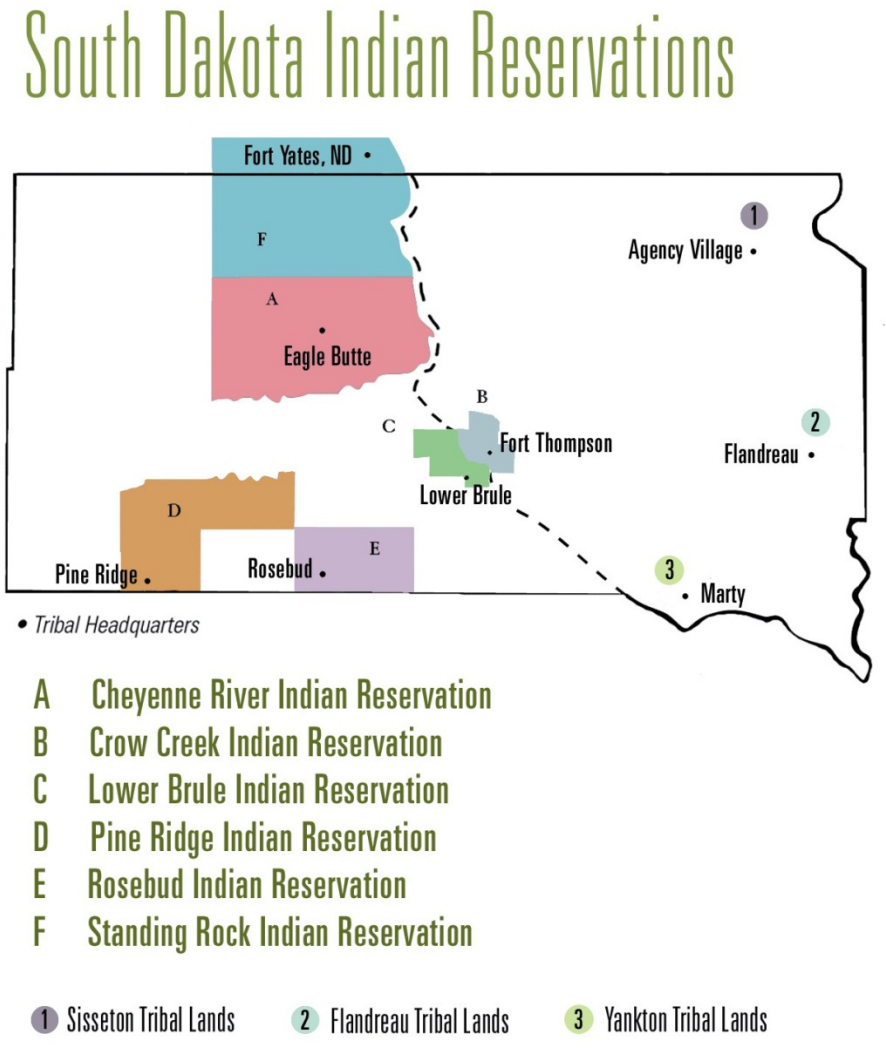
According to the 2006 BRFSS, 32.7% of American Indian female respondents aged 40 and older, indicated that they had not received a mammogram in the past two years, compared to 25.4% of white females; 31.5% of American Indian females had not had a clinical breast exam in the past two years, compared to 19.9% of white women. The disparity in screening is also shown in the male population. Among American Indians, 65.5% of men aged 40 and older had not had a PSA test within the past two years, compared to 44.7% of white men. Among males 50 and older, 66.6% of American Indian males and 43.2% of white males had not received a sigmoidoscopy or colonoscopy.[3]



Access to care means people are able to get the cancer care services they need, when they need them, and in a way that they can use and benefit from them. The disparities in cancer care include financial barriers, physical barriers, and barriers related to the organization and operation of the health care system. Adequate cancer care means that services are both available and accessible. Availability is an obvious prerequisite for access to care; however, accessibility is especially important because available resources are only beneficial if cancer patients can obtain and use them when needed. Cancer care resources are concentrated in the Eastern portion of South Dakota which creates a distance barrier for those individuals living in rural communities. Such communities often have limited public transportation. In fact, no public transportation services exist in much of South Dakota.

[2] South Dakota Department of Health. Behavioral Risk Factor Surveillance System (2007).
[3] South Dakota Department of Health. Behavioral Risk Factor Surveillance System (2006).

The South Dakota Comprehensive Cancer Control Program (SD CCCP) has had many successful strategies, policies, and new screening programs implemented because of the efforts of the coalition members and their partners. Specifically, the SD CCCP was awarded funding from the Centers for Disease Control and Prevention (CDC) to implement a colorectal screening program for persons aged 50-64 living at or below 200% of the federal poverty guideline who are uninsured or underinsured for colorectal cancer screening and who are asymptomatic and at average risk for developing colorectal cancer. The SD CCCP has also partnered with the Northern Plains Comprehensive Cancer Control group to implement a colorectal screening program in Pine Ridge. In addition, the SD CCCP has conducted numerous train the trainer cancer workshops for American Indian health care professionals throughout South Dakota.



Background

"During the last decade there has been tremendous growth in the scope and number of programs designed to reduce the burden of cancer; these programs generally address a particular cancer site (breast, prostate, etc.) or reducing specific risk factors (e.g. tobacco use).

The experience and knowledge gained from these categorical programs provide a solid basis for a more comprehensive approach to cancer prevention and control. The significant growth of cancer prevention and control programs within health agencies has resulted in recognizing that improved coordination of cancer control activities is essential to maximize resources and achieve desired cancer control outcomes. Comprehensive cancer control (CCC) results in many benefits including increased efficiency for delivering public health messages and services to the public. Individual leaders are willing to join together to focus time, resources, and staff on a comprehensive cancer control approach. They can make decisions and take actions that affect cancer control across the whole community."

-- The Centers for Disease Control and Prevention

The Vision

The vision of the South Dakota Comprehensive Cancer Control Program (SD CCCP) is to reduce the human and economic impact of cancer on South Dakotans through the promotion and support of collaborative, innovative, and effective programs and policies for cancer prevention and control.

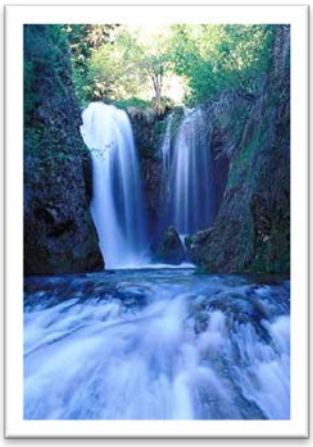
The Goal

The goal of the SD CCCP is to ensure that all South Dakotans have access to quality cancer prevention and control information and services in order to reduce the number of new cancer cases as well as the illness, disability, and death caused by cancer and for survivors to live the best quality of life possible.

- All South Dakotans should receive culturally appropriate information about cancer risks and prompt access to high quality cancer prevention, screening, diagnosis, treatment, and rehabilitation information and services;
- Strong, collaborative partnerships at the state and local levels will help reduce the human and financial impact of cancer on the people of South Dakota;
- A collaborative and unified effort by public, private, and volunteer agencies and individuals increases the effective use of limited resources and minimizes duplication of efforts.

Creating the Plan

In 2002, a group of representatives from agencies focused on cancer control began to make this vision a reality in South Dakota. A team of 14 individuals attended a Cancer Leadership Training Institute sponsored by the American Cancer Society, the American College of Surgeons, the Association of State and Territorial Health Officers, C-Change, the Centers for Disease Control and Prevention, the Chronic Disease Directors, the Intercultural Cancer Council, the National Cancer Institute, and the North American Association of Central Cancer Registries. The purpose of the institute was to provide a strategic opportunity for a group of highly skilled, influential individuals to engage in collective action to support implementation efforts for a comprehensive cancer control approach within the state.



The group of 14 individuals that attended the Cancer Leadership Training Institute became the first members of the CCC Steering Committee. Its purpose was to provide leadership for the fledgling project by establishing protocols for making decisions and moving ahead with funding. During this year-long period, the American Cancer Society (ACS) provided funding for consultation, logistics support and technical assistance. A funding proposal was submitted to the Centers for Disease Control and Prevention (CDC), with the SD Department of Health serving as the funding recipient, and the ACS continuing its support for consultation. Under the leadership of the Steering Committee, the plan for infrastructure was put into place awaiting funding.

In 2004, with financial support in place, a facilitator was employed and the first of several meetings was held with additional cancer stakeholders. Over 75 individuals committed to serving a four month term on a planning committee to develop a draft of the 2005-2010 Plan. The planning framework followed the disease continuum in six sections: Prevention, Early Detection, Data and Research, Treatment, Survivor Issues, and End of life issues. Sub-committees lead by co-chairs met by phone and in person to develop priorities for action for the proceeding five years to reduce the burden of cancer in South Dakota. All committees had technical assistance available from the project consultant, the project facilitator, CDC, and the collective expertise of their members. An additional Leadership Institute, to which all of the committee co-chairs were invited, was held in Chicago in the fall of 2004.

From the beginning, the planning committee recognized that the plan for Comprehensive Cancer Control belongs to all of the people in South Dakota. So, they sought the opinions of a varied group of South Dakota residents to understand what was important to them about cancer and whether it was

included in the plan. South Dakota State University nursing students, American Cancer Society staff, and trained individuals facilitated thirty-two meetings in twenty-two communities. The communities and attendees reflected the diversity of South Dakota. Meetings were held across the state in large and small communities, including the reservations. The voices of the more than 500 individuals who participated are reflected throughout the plan. It is truly a plan for the people.

In 2010, the SD Comprehensive Cancer Control Program came to the end of its first Plan with much accomplished and a promising future. Once again, each workgroup worked diligently to develop goals and objectives for the 2011-2015 Plan. The workgroups now consist of: Prevention, Early Detection (Colorectal and Breast and Cervical), Treatment, and Quality of Life. The SD CCCP also includes an external evaluator that tracks cancer-related data, measures program outcomes and ensures the workgroups' strategies and activities are aligned with their goals.

Policy, System, and Environmental Change In the South Dakota Cancer Control Plan

The South Dakota Comprehensive Cancer Control Plan 2011-2015 includes strategies aimed not only at individual level change but at the broader policy, system and environmental change factors that can reduce the burden of cancer for the people of South Dakota. Efforts to impact change on a policy, system or environmental level are present in all four priority areas of the SD Cancer Plan – Prevention, Early Detection, Treatment, and Quality of Life.

- *Policy changes* include passing of laws, ordinances, rules, resolutions, or regulations that reduce the risk of cancer or improve quality of life for cancer survivors. Government agencies, employers, healthcare institutions, and schools, among others, can impact policy change. An example of policy change that has impacted cancer control in South Dakota is the expansion of the smoke-free law to include South Dakota bars, Deadwood casinos, video lottery establishments and restaurants.
- *System changes* include activities that change the rules, or social norms, within an organization in order to address a cancer-related population health issue. System changes are often derived from policy changes. One example is the Healthy Concessions project aimed at providing healthy food choices at the concession stands of youth sports events.
- *Environmental changes* are interventions that change the physical environment in some way to address cancer-related issues. An example would be installation of shade structures at playgrounds to reduce sun exposure.

Success Stories

In its first Plan, from 2005 to 2010, the South Dakota Comprehensive Cancer Control Program had many successful projects and outcomes to be proud of. A few of these successes are highlighted below.

Scouts Aid in Skin Cancer Prevention

CCCP Goal
Increase number of South Dakotans who practice sun protection behaviors.

Were you ever a Girl Scout or a Boy Scout? It was fundamental to my community… a rite of passage as a youth. I have fond memories of helping out at the County Fair by showing projects at the Scouting booth. At the beginning of each school year, we looked forward to our first meeting and all the events planned for us over the coming months.

So, when the Breast and Cervical Cancer Program Manager of the *All Women Count!* Program contacted the SD Comprehensive Cancer Control Program (SD CCCP) regarding a Girl Scout leader looking for information on projects about skin cancer prevention, my attention was raised. The SD CCCP Prevention Workgroup was in search of events where UV bracelets and sunscreen packets (SPF 30) could be distributed. It was a perfect match!

The workgroup goal of promoting awareness through education to the public had been a huge success over the prior two years -- such a huge success that distribution of the sunscreen packets and UV bracelets took only five weeks in year two! For this summer, we doubled our distribution goal, and have nearly depleted this supply at summer's end.

The gold star at the top of this collaboration was the *Relay for Life* (American Cancer Society) event at which the Girl Scouts of a small community in South Dakota distributed these skin cancer awareness tools. It was a win/win celebration of integration. The scouts also learned about skin cancer through a CCCP educational video link to complete a merit badge requirement through community outreach and education.

By sharing our resources, those in attendance at that Relay for Life event were given an opportunity to learn about screenings, prevention and awareness about skin cancer from a troop of trained Girl Scouts. As a team, we just may have saved a life or several lives!

"Just wanted to let you know the bracelets were a HUGE Hit! People wanted them after we totally ran out. I would love to get more or anything new you would have for next year's event so please keep in touch. Thank you again so much for all your help with this project."

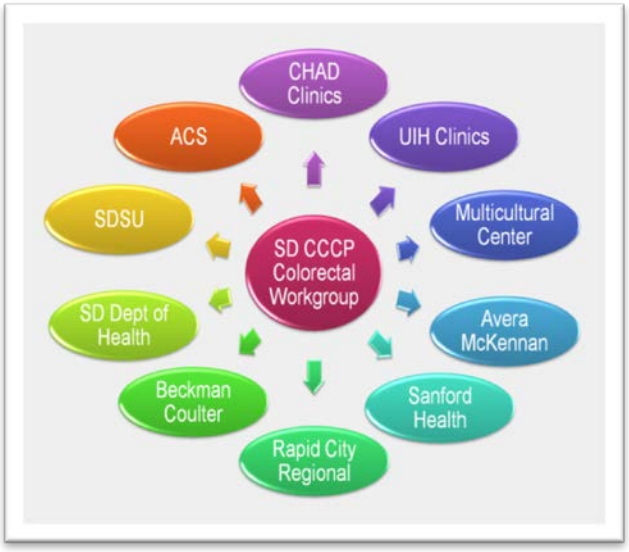
~Troop Leader, July 2011 event, 200 packets provided

Improving Colon Cancer Screening for the Underinsured

CCCP Goal
To increase appropriate screening and early detection for colorectal cancer among underinsured and uninsured population

Cancer in low-income and minority populations is often diagnosed at a later, less treatable stage. About 50% of colon cancer cases in South Dakota are diagnosed at the regional or distal stage, when treatment is less successful. This rate is similar to the US average.

The SD CCCP Colorectal Workgroup designed a pilot project using volunteer and in-kind donations to provide 1,000 colon cancer screenings to men and women ages 50+ who are underinsured or uninsured and who also received health care services at Community Health Centers of the Dakotas (CHAD) or SD Urban Indian Health (SDUIH) clinics. Each participant was given an iFOBT kit to take home with instructions for returning in person or by mail. Clinicians provided education, and follow-up calls were made after two weeks to those participants who did not respond. For positive test results, follow-up colonoscopies were also provided free of charge.



This is Mark's story. Mark is 64 years old, unemployed and uninsured. He was a participant in the pilot project.

This all started when I had so much pain in my foot that I couldn't walk. I knew I had to go to the doctor and my son finally convinced me to go. I went to the local clinic here in town and they didn't find any infection in my foot. The doc suggested that I have a follow-up appointment at a clinic for those like me who can't get insurance.

Mark scheduled a follow-up at a CHAD clinic, where the provider not only examined his foot, but also reviewed routine health screenings. Mark's father and brother had both been diagnosed with colon cancer. Mark agreed to a screening test called an iFOBT test. The nurse provided education on how to take the test, which he did at home, and how to return the cards to the clinic.

The doc told me that it was time I get checked out for colon cancer. The test was pretty easy to do and I just mailed it back in to them. I had some angels looking out for me because I did have blood in my stool that I didn't know about. Then I had a colonoscopy. When I woke up, they told me that they had found polyps… six of them… four were normal and two were precancerous. Now, I have three years before I need to be retested - and probably many more years if I take care of myself and get those screenings.

I would not have completed the test if the doctor wouldn't have been persistent or if it wasn't free. I didn't know this at the time, but the folks at the SD Comprehensive Cancer Control Program care enough about me and others like me to volunteer their time to help stop cancer. I am not sure how you thank people that you might never meet for giving you time to live… to enjoy your grandchildren … to get well … to have improved your attitude about mankind… to go on to get a job … to live a better life because of their sacrifices. These people saved my life.

So, I'm joining them. Never know what I might be able to share if anything, but I will try. My disease is something they are trying to eliminate.

This is my story. I'm Mark and I am grateful to live in South Dakota and to be a part of the South Dakota Comprehensive Cancer Control Program, making a difference in the lives of others like me.

WE SAVED SOME LIVES…and brought about colon cancer awareness.

Partnering for Productivity

National CCCP Goal
To maintain a collaborative process through which a community and its partners pool resources to reduce the burden of cancer

CATALYST -- cat·a·lyst [kàtt'list} (cat·a·lysts) A stimulus to change; somebody or something that makes a change happen or brings about an event

CATALYST is also the name given to a program created by and for the Health Promotions Division of the SD DOH. Ryan Loo, PhD of Spectrum Health Policy Research, LLC and his amazing team of professionals were hired to help create a means of recording the implementation of our action plans, our goals, our strategic plans, our logic models, our evaluation processes, and display the kinds of integration that have been occurring within the Chronic Disease Divisions. In the formulation of this amazing program, future integration and the streamlining of non-repetitive projects and staffing for those projects has been cast and is allowing for a more productive and effective team both creatively and economically. The networking made through the CATALYST connection has been invaluable. Many times those connections have been overlooked but the wheels that have been turned as a result have produced many successes.

The SD Comprehensive Cancer Control Program's Quality of Life Workgroup had as one of its action items to make a connection with parish nurses around the state in an attempt to disseminate information and allow the opportunity for parish nurses to utilize our program as a resource for members of their churches/parishes. Through our CATALYST connection, the SD CCCP Program Manager discovered that the Heart Disease and Stroke Director was going to attend the SD Parish Nurses Annual Conference. The two met and a Fact Sheet on SD CCCP along with brochures on the SD Cancer Treatment Resource Guide and Advance Directives were included in the Heart Disease and Stroke presentation. One leader presented both organizations information at the conference thus saving duplication of time, services and expenses at the same time accomplishing goals for all three organizations. A win/win for all, especially for those they serve!

Another example of collaboration through CATALYST was the insight of the Acting Diabetes Director to connect with the SD CCCP Program Manager in an attempt to bring representatives of both organizations to share in the workshop of a national speaker, Fran Butterfoss, on Coalition Building. By contacting SD CCCP, we had the opportunity to

SOUTH DAKOTA DEPARTMENT OF HEALTH

coordinate the date so our SD CCCP Steering Committee could meet the evening before thus having our leadership represented at the workshop. Seven or eight other coalitions were also in attendance during the workshop and lent opportunity to discuss barriers and successes in coalition building. In turn, Fran Butterfoss presented us with examples and ideas for a means to improve our skills at building more stable and successful coalitions to accomplish our goals. It was a day well spent in honing our methods for the betterment of all.

CATALYST… exactly named… stimulus to change; somebody or something that makes a change happen or brings about an event. May CATALYST continue to catapult us to great success stories!

Cancer Prevention

"There is no greater imperative in American health care than switching from a treatment-oriented society, to a prevention-oriented society."

Vice Admiral Richard Carmona, MD, MPH, FACS
US Surgeon General

The goal of the SD CCCP prevention component is to lower the population's risk of cancer by limiting the number of modifiable risk factors. These risk factors are in three major areas of cancer prevention: tobacco use; nutrition, physical activity, and obesity; and skin cancer related activities. By working to decrease risk factors in these areas the occurrence of cancer will be greatly reduced.

Tobacco

Tobacco use is the most significant preventable cause of cancer. The use of tobacco has been shown to increase the risk of cancer of the lung, liver, pancreas, kidney, bladder, uterine cervix, oral cavity, larynx, stomach and esophagus. The American Cancer Society estimated that in 2004 more than 180,000 cancer deaths were caused by tobacco use in the United States. Tobacco use is responsible for over $1,600 per smoker in excess medical expenditures each year.[4]

South Dakota has made several strides in recent years to reduce tobacco use. The tax on cigarettes has been raised and the South Dakota QuitLine is available to all South Dakotans; however, much remains to be done. Approximately 19% of adult South Dakotans are still smoking. Approximately 29% of 18-24 year olds recently surveyed in the 2007 Behavior Risk Factor Surveillance Survey (BRFSS) reported they were currently smokers.[4] This alarmingly high number shows a great need for tobacco prevention education in our schools.

Nutrition and Physical Activity

Other than not using tobacco, nutrition and physical activity are the next most important approaches to reducing cancer risk.

Studies in the last several years have shown a link between vegetable and fruit consumption and the decreased risk of developing certain types of cancer. Eating a diet rich in fruits and vegetables reduces the chance of developing colorectal, stomach, lung, and esophageal cancer.

[4] Centers for Disease Control and Prevention. United States, 1995-1999. MMWR, 2002; 51:14, 300-303.

The 2005 Dietary Guidelines for Americans recommends four to five servings of fruit and four to five servings of vegetables for the average 2000 calorie a day diet.[5] According to the 2009 State Indicator Report on Fruits and Vegetables, only 25.8% of South Dakota adults even consume two or more fruits per day and only 23.8% consume three or more vegetables. Adolescents are even worse with only 25.1% consuming two or more fruits and 10.9% consuming three or more vegetables. There are several factors that have been identified that relate to low fruit and vegetable consumption. Availability, cost and lack of convenience are all felt to play a part. However, these barriers must be overcome if South Dakotans are to achieve their optimal health status.

Obesity for adults is defined as a body mass index (BMI) of 30 or more and overweight for adults is defined as a body mass index of 25-30. In 2008 28.1% of South Dakota adults were obese and 36.8 percent were overweight. Physical activity decreases the risk of colon, breast and prostate cancer. Including physical activity in a daily routine will help to lower body mass index. In 2007 only 47.8% of South Dakota adults met the recommended amount of physical activity (30+ minutes of moderate physical activity five or more days per week, or vigorous physical activity for 20+ minutes three or more days per week).

According to Centers for Disease Control and Prevention (CDC), there are six science-based strategies to prevent obesity and other chronic diseases. South Dakota developed a State Plan to Prevent Obesity and Other Chronic Diseases in 2006 and is currently updating that plan for 2010. The 2006 state plan can be viewed at www.HealthySD.gov.

The new plan addresses all six CDC strategies:

- Increase physical activity
- Increase fruit and vegetable consumption
- Increase breastfeeding
- Decrease television viewing
- Decrease sweetened beverage intake
- Decrease portion sizes

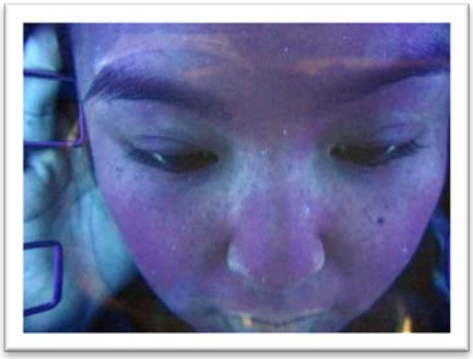
Skin Cancer

[5] US Department of Health and Human Services. Dietary Guidelines for Americans (2005).

The incidence rate for melanoma of the skin was 14.5 per 100,000 persons for 2003-2007.[6] While this is lower than the national average of 18.3 per 100,000 persons, this form of cancer is extremely preventable. Practicing sun safety behaviors such as wearing sunscreen with a Sun Protection Factor (SPF) of 30 or higher, seeking shade and wearing protective clothing are essential for the prevention of skin cancer.

Educating South Dakotans about, and encouraging them to practice, sun protection behaviors is the primary strategy for prevention of skin cancer. This strategy can be accomplished in part by working with other entities to share information with the public.

One of the ways awareness is raised is through Derma Scan availability at community events. The Derma Scan provides a display of possible skin damage, and an opportunity to encourage screenings by medical personnel during annual medical check-ups or when a mole or patch on the skin changes shape, color or roughness.



[6] National Cancer Institute, 2003-2007.

Prevention Workgroup

Lower the population's risk of cancer by limiting the number of modifiable risk factors.

Tobacco Prevention and Control

GOAL: Eliminate or reduce commercial tobacco use.

Objective: Reduce the percentage of youth, grades 9-12, who smoked cigarettes on one or more of the past 30 days.
- Baseline = 23.2% (YRBS, 2009)
- Target = 20.5%

Objective: Reduce the percentage of adults that smoke every day or some days.
- Baseline = 17.5% (BRFSS, 2009)
- Target = 15%

Objective: Reduce the percentage of American Indian adults that smoke every day or some days.
- Baseline = 43% (BRFSS, 2011)
- Target = 40%

Objective: Increase the percentage of adults who have been advised by a doctor, nurse, or other health professional to quit smoking in the past 12 months.
- Baseline = 71% (BRFSS, 2011)
- Target = 75%

Objective: Reduce the number of youth, grade 9-12, that currently use spit tobacco.
- Baseline = 15% (YRBS, 2011)
- Target = 10%

Objective: Reduce the number of adults that currently use spit tobacco every day or some days.
- Baseline = 7% (BRFSS, 2011)
- Target = 4%

GOAL: Reduce Exposure to Environmental Tobacco Smoke.

Objective: Increase the percentage of adults that report their place of work has an official smoking policy where smoking is not allowed in any work areas.
- Baseline = 93% (BRFSS, 2011)
- Target = 95%

Objective: Increase the percentage of adults who report smoking is not allowed anywhere in their homes.
- Baseline = 82% (BRFSS, 2011)
- Target = 84%

Objective: Reduce the number of youth grades 9-12 that were in the same room or car as someone smoking.

- Baseline = 49% (YRBS, 2011)
- Target = 45%

Strategies

- Support programs of the Department of Health Tobacco Control Program.
- Encourage and assist communities and schools to use effective tobacco-prevention curricula, along with other effective prevention strategies.
- Share effective prevention strategies for post-secondary campuses with staff and student leadership at post-secondary campuses.
- Provide education and resources regarding model tobacco-free buildings and grounds policy to schools, workplaces, and multi-unit housing property managers and residents to foster an environment where these recommended policies can be implemented.
- Promote the statewide QuitLine by providing referral materials to local coalitions, local public health offices, private health care providers, hospitals, health plans and others.
- Provide information about the Public Health Service Guidelines for Treating Tobacco Use and Dependence, along with support material to health care providers and organizations.
- Provide communities and workplaces with information about the economic benefits of smoke-free policies and employee cessation opportunities.
- Provide public education messages about the link between commercial tobacco use and cancer.
- Support tobacco prevention and control advocacy through policy, systems, and environmental change.
- Target SD disparate populations in all partner activities focused on elimination of exposure to environmental tobacco smoke and cancer prevention.
- Disseminate information on FDA regulation of tobacco products, including e-cigarettes, and look for opportunities for tobacco prevention and control created as a results of this regulation.

Nutrition and Physical Activity

GOAL: Increase healthy weight among South Dakotans.

Objective: Decrease the percentage of adults who are obese (BMI 30<).
- Baseline = 28.1% (BRFSS, 2008)
- Target = 25%

Objective: Decrease the percentage of youth, grades 9-12, who are obese.
- Baseline = 10% (SD YRBS, 2011)
- Target = 8%

Strategy
- Promote the adoption of food service guidelines/nutrition standards, which include sodium.

GOAL: Increase healthy dietary behaviors.

Objective: Increase the percentage of adults who consume five servings of fruits and vegetables per day.
- Baseline = 18.6% (BRFSS, 2007)
- Target = 25%

Objective: Increase the percentage youth, grades 9-12, who eat five or more servings of fruits and vegetables per day.
- Baseline = 15% (YRBS, 2011)
- Target = 17%

Strategy
- Expansion of the Harvest of the Month program in community settings.
- Partner with SDSU Extension to promote Harvest of the Month

GOAL: Increase physical activity.

Objective: Increase the percentage of adults who meet the recommended guidelines for physical activity (30+ minutes of moderate physical activity five or more days per week, or vigorous physical activity for 20+ minutes three or more days per week).
- Baseline = 47.8% (BRFSS, 2007)
- Target = 50%

Objective: Increase the percentage of youth, grades 9-12, who are physically active for a total of at least 60 minutes per day, during 5 or more of the past 7 days.
- Baseline = 49% (SD YRBS, 2011)
- Target = 55%

Strategy
- Promote the Strides to a Healthier Worksite Toolkit on Healthy SD website.
- Promote the adoption of physical activity in worksites.
- Promote the adoption of physical education/physical activity (PE/PA) in schools through development and adoption of physical education policies.

Skin Cancer Prevention

<u>GOAL:</u> Educate South Dakotans on, and encourage them to practice, sun protection behaviors.

Objective: Increase the percentage of adults who wear sunscreen with an SPF of 15 or higher when they are outside for more than one hour on a sunny day.

- <u>Baseline</u> = 28% (SD BRFSS, 2011) (Respondents who answered "always" or "nearly always")
- <u>Target</u> = 35%

Objective: Decrease the percentage of youth, grades 9-12, who during the past 12 months used an indoor tanning device such as a sunlamp, sunbed, or tanning booth.

- <u>Baseline</u> = 22% (SD YRBS, 2011)
- <u>Target</u> = 15%

Objective: Increase the percentage of youth, grades 9-12, who wear sunscreen with an SPF of 15 or higher when they are outside for more than one hour on a sunny day.

- <u>Baseline</u> = 11.7% (SD YRBS, 2011) (Respondents who answered "always" or "most of the time")
- <u>Target</u> = 15%

Strategies

- Facilitate community activities to raise awareness of sun safety and skin cancer screening.
- Promote Shade Structure grant applications through the Made for Shade Foundation.
- Disseminate information and tools to provide sun safety education in schools and to child care providers.
- Target the following populations for distribution of sun safety information:
  - State parks and their customers
  - Construction/DOT workers
  - Farmers
  - Day care facilities
  - School age children
  - Young adults/College students
- Provide education to youth and adults on the dangers of tanning bed use.
- Develop materials and methods of distribution for education on dangers of tanning bed use.
- Target high school and college-age youth for education on sun damage from tanning beds.
- Support legislation that regulates the use of tanning beds for minors.

Cancer Detection

Effective screening for cancer will provide detection at earlier stages when treatment is more likely to be successful. Screening has been shown to reduce mortality from cancers of the breast, uterine cervix, and colon and rectum. There are other cancers for which screening may be associated with lower mortality, but evidence is less certain.

Evidence supports the effectiveness of routine screening. To encourage routine screening, guidelines, such as those published by the American Cancer Society, have been established. If a person is not screened regularly, but rather waits until symptoms appear it is much more likely that the cancer will be discovered at a later stage. Additionally, studies show that people who receive a clinician's recommendation for cancer screening are more likely to be screened compared to those who do not receive a recommendation. Studies document that people who lack health care insurance have reduced access to preventative care and are less likely to get timely cancer screening examinations. Multiple interventions directed at patients, physicians, and health care systems may provide the best approach to improving rates of cancer screenings.

Early Detection Workgroups

To increase the appropriate screening and early detection for cancer

Colorectal Cancer Workgroup

Colon and rectal cancers are the fourth leading reported cancer and the second leading cause of cancer death in South Dakota.[7] Colorectal cancer screening reduces death from colorectal cancer. It can also prevent the development of colon cancer by identifying and removing benign polyps, from which colon cancer often develops. Early diagnosis and treatment of colorectal cancer results in a survival rate of greater than 90 percent.[8] As a result of collaboration among partners working toward colorectal cancer control, we will:

GOAL: Provide education to promote the importance and benefits of colorectal cancer screening.

Objective: Increase the number of persons receiving recommended colorectal cancer screenings

- Baseline = 62.4% of adults age 50 and older have ever received sigmoidoscopy or colonoscopy; 20.7% of adults age 50 and older have received a fecal occult blood test (FOBT) within the preceding two years (BRFSS, 2008).
- Target = 80% of adults age 50 and older have received a high-quality colorectal cancer screening within the preceding two years.

Objective: Increase the percentage of persons diagnosed with colorectal cancer at in situ or localized stages

- Baseline = 16% of colorectal cancer cases were diagnosed at distant stage, 32% at regional and 47% were diagnosed at in situ or localized stage (*Colorectal Cancer in South Dakota*, March 2012).
- Target = 60% at in situ or localized stage

Strategies

- Partner with the American Cancer Society and local health plans to remind adults age 50 and older of the importance of screening.
- Continue partnership with GetScreenedSD to promote and support screening among insured, uninsured, under-insured adults age 50 and older.
- Develop an incentive program to increase the return of FIT testing kits.
- Support the development and creation of a colorectal cancer screening website to educate the general public.
- Identify and utilize symbol (similar to breast cancer pink ribbon) to increase colorectal cancer awareness.
- Utilize new technologies/social networking websites to increase public awareness of colorectal cancer risk factors, screening tests and individual responsibility.
- Provide colorectal cancer screening informational "toolkits" to Department of Health screening pilot sites.
- Promote the *Make It Your Own (MIYO)* resources to customize screening information to clinics.

[7] South Dakota Cancer Registry, 2007.
[8] American Cancer Society. Cancer Prevention & Early Detection Facts & Figures (2005).

GOAL: Ensure healthcare providers provide or refer patients to appropriate screening.

Objective: The percentage of physicians speaking to their patients about colorectal cancer screening will increase.

- Baseline = 34% of adults age 50 and older had physician speak to patient about colorectal cancer screening (SD BRFSS, 2006)
- Target = 68% of adults age 50 and older have physician speak to patient about colorectal cancer

Objective: Increase the percentage of patients who follow through with screening at physician's recommendation.

- Baseline = 78% received colorectal cancer screening (SD BRFSS, 2006)
- Target = 80% receive colorectal cancer screening

Strategies

- Develop a newsletter to educate and update health care professionals throughout South Dakota of the evidence-based colorectal cancer screening practices and resources.
- Work with major health delivery systems to overcome barriers and increase colorectal cancer screening.
- Build a recognition program to honor those individual health professionals who champion colorectal screening efforts at their facilities.
- Explore options to combine colorectal cancer screening with other standard clinic visits (i.e. flu shots).
- Using advances in medical records technology, simplify and implement a screening reminder system for adults age 50 and older.
- Utilize continuing medical education opportunities to educate healthcare providers on tools to increase colorectal cancer screening in practice.

GOAL: Reduce disparities and barriers to colorectal cancer screening, diagnostic services and access to care.

Objective: Monitor colorectal cancer screening rates among American Indians age 50 and older.

- Baseline = 19% of Aberdeen Area active clinical patients aged 50-81 who have received any colorectal cancer screening in the past year. Compared to 29% national average of the 2008 Indian Health Service direct and tribal facilities (Government Performance and Results Act, 2008)
- Target = Annually updated information.

Objective: Monitor trends in colorectal cancer rates among American Indian males.

- Baseline = American Indian males annual colorectal cancer age-adjusted death rate of 22.2% compared to 19.7% of South Dakota male population (*Colorectal Cancer in South Dakota*, March 2012)
- Target = Annually updated information from the SD Cancer Registry.

Strategies

- Collaborate with Northern Plains Colorectal Cancer Control Program to target American Indian males for colorectal cancer education.
- Conduct a statewide assessment of capacity and quality of colorectal cancer screening services.
- Identify strategies to address gaps in colorectal cancer screening and make recommendations for improvement.

Women's Cancer Network (Breast & Cervical) Workgroup

Breast cancer is the most common cancer among women in South Dakota. Breast cancer screening has been shown to reduce breast cancer mortality. The five-year relative survival rate for localized breast cancer is 97 percent (i.e., if the cancer has not spread to other locations and into the lymph nodes).[9]

White women had an incidence rate three times that of American Indian women, however, age-adjusted mortality rate is higher among American Indian women than for white women.[11] An increase in the number of American Indian women receiving recommended screenings will translate into a lower mortality rate.

Cervical cancer is one of the most successfully treatable cancers. The Pap test examines cells that are scraped from the cervix and can detect cancer and pre-invasive conditions or lesions. Pre-invasive lesions are 100 percent curable. At early stages, women with localized lesions have a five-year survival rate of 92 percent.[11]

The age-adjusted incidence rate for American Indian women was twice that of the rate for white women in South Dakota. The mortality data showed American Indians with a six-fold rate of death when compared to whites and to the South Dakota totals for 2001 and for the five-year period 1997-2001.[11]

GOAL: Increase appropriate screening and early detection of breast cancer.

Objective: Increase mammography screening for women aged 40+.

- Baseline = 76.6% of women aged 40+ had a mammogram in the preceding 2 years (SD BRFSS, 2010)
- Target = 80.0% by 2015

Objective: Increase mammography screening for women aged 50+.

- Baseline = 78.7% of women aged 50+ had a mammogram in the preceding 2 years (SD BRFSS, 2010)
- Target = 80.0% by 2015

Strategies

- Promote early detection to statewide organizations, focusing on rarely or never screened women.
- Promote early detection and screening at community colleges.
- Support the *All Women Count!* Ask Me button campaign to encourage discussion about screening.
- Collaborate on a video to be shown in provider in waiting rooms to promote screening for breast, colorectal and cervical cancer. This video will be translated into multiple languages.
- Collaborate on an *All Women Count!* program web-based training for healthcare providers.
- Utilize social marketing to increase early detection messages.
- Provide outreach to women 40 and older through the following tactics:
  - Include *All Women Count!* program materials in "Avera Breast Health Awareness Boxes".
  - Create and distribute an early detection birthday card for women turning 40.

[9] South Dakota Department of Health. Cancer Burden in South Dakota (2007).

GOAL: Eliminate disparities in screening among rural and minority women.

Objective: Increase mammography screening for minority women aged 40+.
- Baseline = 65.2% of American Indian women aged 40+ had a mammogram in the preceding 2 years compared to screening rate of 77.4% of White women in South Dakota (SD BRFSS, 2010)
- Target = 68.0% by 2015

Objective: Increase mammography screening for minority women aged 50+.
- Baseline = 68.2% of American Indian women aged 50+ had a mammogram in the preceding 2 years compared to rate of 79.1% of White women in South Dakota (SD BRFSS, 2010)
- Target = 71.0% by 2015

Objective: Monitor trends in breast cancer diagnoses by stage across populations.
- Baseline = 4% of breast cancer cases were diagnosed at distant stage, 23% at regional stage, 52% at localized stage, and 19% in situ; 5% of American Indian women were diagnosed at distant stage, 20% at regional stage, 60% at localized stage, and 15% in situ (SD Cancer Registry, 2009).
- Target = Annually updated information from the SD Cancer Registry.

Strategies
- "Pink Box" project to promote and provide *All Women Count!* materials at IHS facilities.
- Identify and distribute cultural sensitivity training modules to providers throughout the state.
- Showcase the results of the statewide project on treatment decision-making for early stage breast cancer to determine if differences exist between rural and urban residents.
- Create promotional materials and literature targeted to Native American women.
- Develop and promote client reminder system.

GOAL: Provide information about treatments for breast and cervical cancer.

Objective: Provide information about treatment options, support, transportation and social services to those diagnosed with cancer.
- Baseline: 500-600 *Straight Talk* and *SD Breast and Cervical Resource Guide* distributed annually
- Target: Maintain annual distribution

Objective: Develop a decision making resource for women diagnosed with early stage breast cancer.
- Baseline = Assessment of patient needs and gaps in support underway through community-based participatory research grant; anticipated outcome report Fall 2012.
- Target = If need is identified, provide relevant resources that support women with early stage breast cancer by 2014.

Strategies
- Continue to support distribution of *Straight Talk* and the *SD Breast and Cervical Resource Guide* to support newly diagnosed patients.
- Promote the American Cancer Society's Reach to Recovery program for those patients diagnosed with breast cancer.
- Identify special needs populations (young women) and identify resources.

- Identify certified prosthesis fitters and lymphedema therapists.
- Identify cervical cancer resources.
- Conduct early stage breast cancer decision making research with partners

GOAL: Decrease cervical cancer.

Objective: Increase the percentage of women aged 18+ who have had a pap test within the past three years, as recommended by clinical practice guidelines.

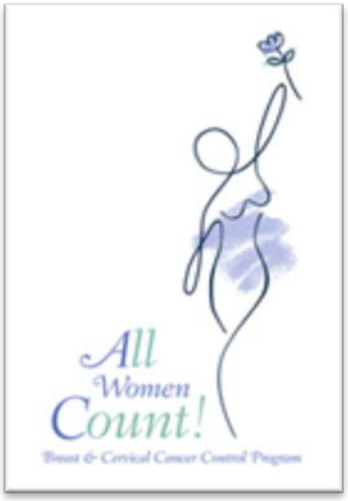
- Baseline = 81% of women aged 18+ had PAP screening in past 3 years (SD BRFSS, 2010)
- Target = 84% of women age 21 to 65 will report having a PAP screening in past 3 years (SD BRFSS, 2015)

Objective: Increase HPV vaccination.

- Baseline = 62.4% of adolescents age 13-17 have received at least 1 dose of the HPV vaccine; 45.0% have received 3 doses (2009 National Immunization Survey, Teens, CDC)
- Target = Increase to 65% of teens ages 13-17 receiving 3 doses of HPV vaccination

Strategies

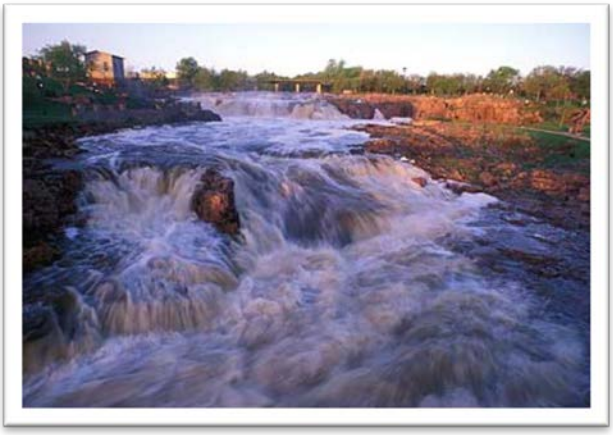
- Explore opportunities to educate parents about HPV vaccination for their children.
- Promote the SD Department of Health HPV monograph.
- Use social media to promote HPV vaccination.
- Promote new Pap screening guidelines to providers throughout South Dakota.
- Investigate insurance coverage for HPV vaccination.
- Explore education options for HPV vaccination within the Breast and Cervical Screening program.
- Partner with Northern Plains CCCP to distribute a video about HPV vaccination that targets teens.



Cancer Treatment

After cancer is diagnosed there are decisions to be made, information to be considered and much to learn. Easily accessible information on treatment options and access to quality care are factors that increase survival rates.

Successful treatment is a partnership that involves health care providers, patients and their families and supporters. While family members and supporters are sometimes reluctant to become involved, having the option is essential. When patients understand their treatment and feel a part of the treatment decisions they are more likely to complete their treatment despite expected side effects.



Typically, treatment options include surgery, chemotherapy, and radiation therapy, and immunotherapy alone or in combination, depending on the site, the type, and the stage of the cancer diagnosis. Palliative treatment is aimed at relieving symptoms.

Access to quality cancer treatment is limited in South Dakota by lack of health insurance, cost of care, geographic location, travel time, transportation, education, cultural and language barriers. These barriers can influence treatment decisions and completion of the treatment plan.

South Dakota was one of the first 4 states to implement the Federal Breast and Cervical Treatment Act of 2000 (BCCPTA). This allows states to provide full Medicaid benefits for income and age eligible women who have a breast or cervical cancer diagnosis for the duration of their treatment. The women must be without insurance coverage and enrolled in the *All Women Count!* program. This federal legislation has helped to address the ethical issue of offering free screening without viable treatment options.

Treatment Workgroup

To assure that all persons diagnosed with cancer receive the best possible care.

GOAL: Reduce barriers to cancer treatment initiation and completion.

Objective: Increase awareness of programs that provide transportation assistance for medical appointments.

- Baseline: No measurement
- Target: Identify and promote transportation assistance options available to each cancer treatment center in SD

Objective: Provide information about treatment options, lodging, transportation and social services to those diagnosed with cancer.

- Baseline: 5,000 *South Dakota Cancer Treatment Resource Guide* printed in 2012
- Target: Maintain distribution of 1,500 brochures per year

Objective: Increase the knowledge of cancer patients and providers regarding programs available for pharmaceutical assistance.

- Baseline: No measurement
- Target: The number of brochures distributed and the number of visits to the site providing the online resource.

Strategies

- Assess housing and transportation options for patients receiving cancer treatment in seven regional cities in South Dakota.
- Collaborate with South Dakota transportation programs to assist with development of a statewide transportation database that is accessible to everyone.
- Continue to update and distribute the *SD Cancer Treatment Resource Guide*.
- Gather data from the Veteran's Administration transportation office to determine how many patients travel large distances for treatment.
- Gather information from pharmaceutical companies and develop a list of what services they offer to the oncology community.
- Provide online links to pharmaceutical resources through the South Dakota Comprehensive Cancer Control Program Website (monitor the activity of the site).
- Produce a brochure or information sheet that identifies pharmaceutical programs are currently available to cancer patients.

GOAL: Promote patient-centered care for cancer treatment.

Objective: Support cancer treatment centers in reaching accreditation standards.

- Baseline = 5 of 7 SD Cancer Treatment Centers are accredited by the American College of Surgeon's Commission on Cancer in 2011
- Target = 6 of 7 cancer centers by 2015

Objective: Promote clinical trials through educational processes for medical professionals and cancer patients.

- Baseline = No measurement

- Target = 3 educational opportunities by 2015

Strategies

- Invite the directors from the eight cancer treatment centers to meet regarding development of statewide and/or community-based needs assessment.
- Foster collaboration between cancer treatment centers regarding clinical trials
- Promote clinical trial education among cancer professionals and patients

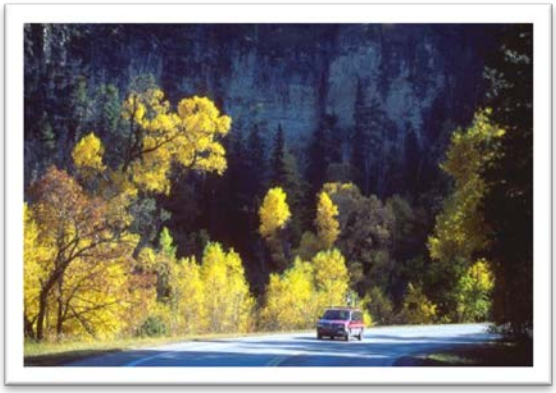
Quality of Life:
Cancer Survivorship, Palliative Care, and End of Life

"People out here [rural South Dakota] look out for one another. Food appears on your doorstep. The men in the church congregation meet to plan for your travel to radiation treatment. People come and clean the house. It just happens."

Survivorship

Everyone is potentially at risk for cancer. If current trends continue, one-third of Americans will be diagnosed with cancer in their lifetime.[10]

The diagnosis of cancer is not the same as it once was. With the improvements in early detection, research and treatments more and more people are becoming cancer survivors. "When cancer was considered incurable, the term 'survivor' was used to describe family members who survived the loss of a loved one to cancer. As knowledge and success in understanding cancer increased, physicians began to use a 5-year time frame to define survivorship. If cancer did not recur in the 5 years following either diagnosis or treatment, patients were considered to have become 'survivors'." Currently, the definition of survivor has expanded to include a wider circle of those affected by the disease. The Lance Armstrong Foundation and the Centers for Disease Control and Prevention now define a survivor as those people who have been diagnosed with cancer and the people in their lives who are affected by their diagnosis, including family members, friends and caregivers. A person becomes a cancer survivor the moment they are diagnosed and continue to be a survivor throughout the remainder of their life.



With over 4,000 new cancer cases expected in South Dakota in 2010, the number of cancer survivors continues to grow.[11] The diagnosis of cancer affects every part of a person's life. Cancer takes a toll physically, financially, and spiritually. It is with this in mind that we set out to address some of the obstacles that cancer survivors face on a daily basis.

Palliative Care/End of Life

[10] National Cancer Institute.
[11] American Cancer Society, Cancer Facts and Figures (2010).

The purpose of palliative care is to relieve symptoms and side effects of cancer and cancer treatment in order to improve quality of life. The World Health Organization defines palliative care as:

> *"The active total care of patients whose diseases are not responsive to curative treatment. Symptom control is paramount and includes the alleviation of symptoms whether they are physical, psychological, social, or spiritual. The goal of palliative care is the achievement of the best possible quality of life for patients and their families."*

Most often palliation is referred to as pain control, but it also includes symptoms such as nausea, vomiting, loss of appetite and fatigue. Some people think of palliative care as end of life care but it can be part of a patient's care at any time during their cancer treatment.

Hospice provides physical, social, emotional and spiritual care to terminally ill patients and their families when the life expectancy is around six months and they are no longer seeking cure-oriented treatments. The goal of hospice care is to improve the quality of a patient's last days by offering comfort and dignity. It addresses all symptoms of a disease, with a special emphasis on controlling a patient's pain and discomfort. Hospice care neither hastens nor postpones death. Palliative care, ideally, will segue into hospice care as the illness advances. To achieve the type of comprehensive care needed, an interdisciplinary team of physicians, nurses, social workers, chaplains, pharmacists, volunteers, and dieticians must work together.

In November of 2002, a report was released by the *Last Acts* coalition rating several areas of South Dakota's end of life care. The findings are outlined below:

- 13% of SD residents used hospice.
- 27% of SD hospitals offered a pain management program.
- 39% of SD hospitals offered hospice programs.
- SD is doing a very poor job of training nurses and a mediocre job of training physicians in palliative care -- only 0.12% of nurses and 0.27% of physicians are certified in palliative care.
- SD received a grade of 2.5 out of a possible 5 on advance planning care.

Dying to Know, a study done in Sioux Falls, South Dakota to create a profile of knowledge and attitudes about dying and end of life care, had the following results:

- 50% have never heard of hospice or have heard 'a little' about hospice.
- 65% would want hospice support if they were dying.
- 67% would prefer hospice at home
- 43% said their doctor should initiate end of life conversation
- 30% had a living will, durable power of attorney or advance directives

Quality of Life Workgroup

To advocate for the needs of the increasing number of persons who have ever had a cancer diagnosis and to maintain for those persons an optimum quality of life until death

GOAL: All cancer patients and/or caregivers are provided with a comprehensive care plan at the end of treatment.

Objective: Increase use of survivor care plans by cancer treatment centers.

- Baseline: Standard survivor care plans were not yet integrated in the electronic system in cancer centers reporting in 2012 (N=5)
- Target: Seven of seven cancer treatment centers will utilize survivor care plans by 2015

Objective: Increase awareness of survivor care plans and survivorship needs through education targeted at primary care providers throughout South Dakota.

- Baseline: No measurement
- Target: 50 health care professionals in South Dakota completed continuing education module on survivor care plans

Strategies

- Investigate and critique available care plans.
- Provide and promote survivorship care plans at statewide cancer treatment centers via letter.
- Provide links to care plan options and resources via the South Dakota Comprehensive Cancer Control Program website.
- Identify resource for continuing education on survivor care plans.
- Distribute information on continuing education and training to primary care providers throughout South Dakota.

GOAL: Improve quality of life for cancer patients, survivors, and caregivers.

Objective: Increase the number of patient navigation resources available.

- Baseline: No measurement
- Target: In collaboration with the GetScreened SD program develop and promote a patient navigation toolkit and training.

Strategies

- Promote ACS survivorship support groups and resources throughout South Dakota.
- Utilize testimonials for promotion of projects.
- Review currently available models of survivorship navigation.
- In collaboration with the GetScreened SD Program, develop patient navigation resources.
-

GOAL: Increase palliative and end of life services throughout South Dakota.

Objective: Assess and increase the number of health care inter-professionals trained in palliative and end of life care.

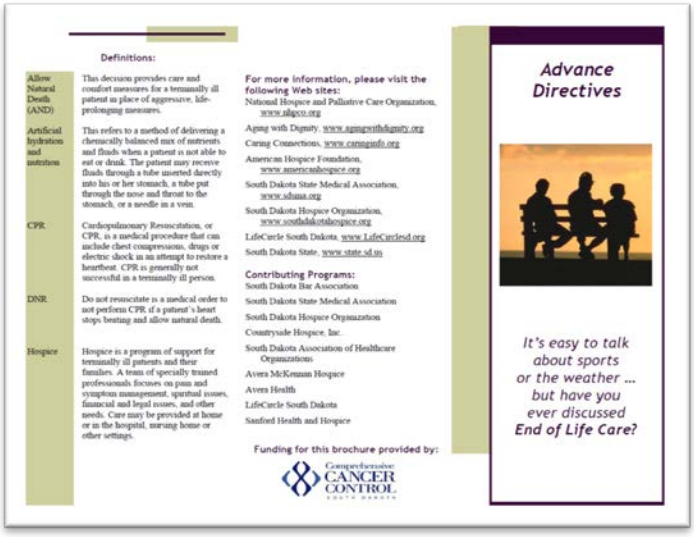
- Baseline: No measurement
- Target: Increase in number of health care professional trained each year.

Objective: Increase education and awareness for healthcare inter-professionals on the importance of completed advance directives.

- Baseline: No measurement
- Target: Increase in number of health care professional educated each year.

Strategies

- Identify palliative care providers in the state.
- Identify end of life care providers in the state.
- Partner with LifeCircleSD to produce a guide to palliative and hospice care in South Dakota.
- Promote Interdisciplinary Palliative Care Seminars offered through LifeCircleSD.
- Distribute Advance Directives brochure to promote end of life planning.



Evaluation

Evaluation monitors the process, impact and outcomes of the South Dakota Comprehensive Cancer Control Program (SD CCCP). Evaluation is a regular and ongoing process of reporting program success and guiding program improvement. Evaluation of the SD CCCP is conducted using both quantitative and qualitative methods focusing on: (a) Partnerships - the quality, contributions, and impact of the CCC coalition; (b) Plan - the quality and implementation of the statewide SD Cancer Plan; and (c) Program - the extent to which interventions outlined in the SD Cancer Plan are executed and yield intended results.[14]

GOAL: To evaluate the implementation and effectiveness of the SD CCCP and its priority strategies, as well as long-term impact on the citizens of SD.

Objective: Monitor the strength of the SD CCCP partnerships, and the satisfaction of partner members.

- Baseline = Results from annual survey of membership participation and satisfaction,
- Target = Improved participation and satisfaction outcomes on an annual basis.

Objective: Monitor the implementation of the SD Cancer Plan 2011-2015.

- Baseline = Annual written report to SD CCCP Program Manager and Program Director measuring progress and quality of SD Cancer Plan implementation.
- Target = All SD Cancer Plan components are fully implemented or revised by 2015.

Objective: Monitor and disseminate surveillance data on cancer-related outcomes to determine if SD CCCP activities are yielding desired results.

- Baseline = Annual presentation and report of cancer data specific to South Dakota at the Fall coalition-wide meeting.
- Target = Continue annual reporting to coalition and analysis of trends to inform plan revisions and updates.

Strategies

- Access all documents relevant to partnership efforts including membership rosters and all SD CCCP project participants.
- Evaluate the representation of diverse organizations within the coalition.
- Conduct an annual review of participation and accomplishments of the steering committee, the workgroups, and other cancer control partners.
- Conduct an annual survey of SD CCCP's steering committee, workgroup members and other partners to provide feedback on the development and effectiveness of cancer control partnerships.
- Contact partners biannually to determine implementation status of each of the plan's evaluation objectives and strategies of the seven priority SD CCCP workgroups.
- Discuss and plan evaluation of the individual roles of consortium staff and leaders.
- After accessing information relevant to implementation efforts, report the extent to which the objectives of each SD CCCP workgroup and consortium staff and leader roles were met.
- Distribute an annual report to the steering committee and other partners.
- Request that all projects funded by the SD CCCP include an evaluation component, with results shared with the workgroup chairpersons and steering committee members.
- Provide technical support to evaluation for all SD CCCP implementation efforts.

- Select one key project from each workgroup for in-depth process evaluation to determine level of success and lessons learned.
- Conduct biannual literature and data search on surveillance and research data related to cancer, specific to South Dakota.
- Share data on cancer-related literature to SD CCCP's steering committee, workgroups and other partners to inform coalition efforts.
- Establish mechanisms for workgroups to quantify improvements in targeted populations by using data from existing programs and surveillance mechanisms.
- Compare surveillance and research data to intended outcomes of the SD Cancer Plan to evaluate progress toward desired outcomes.

GOAL: To disseminate results and recommendations from the overall evaluation process in order to apply the information to planning and improving SD CCCP efforts.

Objective: Make communications recommendations based on annual evaluation results and monitor progress toward recommendations annually.

- Baseline = Recommendations for communication are reported annually.
- Target = Identify how communication recommendations are addressed by SD CCCP leadership.

Strategies

- Discuss recommendations from the annual evaluation and biannually review progress with the SD CCCP Steering Committee.
- Review existing communication mechanisms and reporting mechanisms to identify important potential audiences for evaluation information and develop regular reports designed for target audiences.
- Annually disseminate evaluation information using appropriate communication mechanisms and reporting methods for target audiences.

[14]Centers for Chronic Disease Prevention and Health Promotion, Division of Cancer Prevention and Control. (2010). Comprehensive Cancer Control Branch Program Evaluation Toolkit. Available at www.cdc.gov/cancer/ncccp/pdf/CCC_Program_Evaluation_Toolkit.pdf

Conclusion

Cancer is a burden for all of us. Some of us have been diagnosed, others have had a loved one with a cancer diagnosis, some have had friends as close as family with a diagnosis, and some of us have lived through the death due to cancer of someone close to us. Cancer is a financial burden, it is a psychological burden and it sometimes is a spiritual test. It is a life altering event. Cancer affects us all.

Cancer is not necessarily a death sentence. There is hope and there is life after diagnosis. There is support from health care providers, family, friends, support groups, and organizations. The SD Comprehensive Cancer Control Program is one of those organizations. An invitation to join us in the cause is open to all.

Resources

American Cancer Society
www.cancer.org

Avera Cancer Institute
www.avera.org/cancer-institute

Avera St. Luke's Cancer Center
www.avera.org/st-lukes-hospital/services/cancer

Avera Sacred Heart Cancer Center
www.avera.org/sacred-heart/services/cancer

Avera Queen of Peace Cancer Center
www.avera.org/queen-of-peace-cancer-center

Behavioral Risk Factor Surveillance System
www.cdc.gov/brfss

Cancer Control P.L.A.N.E.T
cancercontrolplanet.cancer.gov

Centers for Disease Control and Prevention
www.cdc.gov

GetScreenedSD
getscreened.sd.gov/screened/index.aspx

Great Plains Tribal Chairmen's Health Board
www.gptchb.org

Healthy SD
www.healthysd.gov

John T. Vucurevich Regional Cancer Care Institute
www.regionalhealth.com/Our-Locations/Institutes/Cancer-Care-Institute

McHale Institute
www.mchaleinstitute.com

National Cancer Institute
www.cancer.gov

National Comprehensive Cancer Control Program
www.cdc.gove/cancer/ncccp

Northern Plains Comprehensive Cancer Control Program
www.javalicense.com/nptec/npcccp

Prairie Lakes Cancer Center
www.prairielakes.com/services

Sanford Cancer Center
www.svconcology.org

South Dakota *All Women Count!* Program
http://getscreened.sd.gov/count

South Dakota Cancer Registry
http://getscreened.sd.gov/registry

South Dakota Chronic Disease Epidemiology
www.doh.sd.gov

South Dakota Comprehensive Cancer Control Program
www.cancersd.com

South Dakota Department of Health
www.doh.sd.gov

South Dakota Diabetes Prevention and Control Program
www.doh.sd.gov/Diabetes

South Dakota Heart Disease and Stroke Prevention Program
www.doh.sd.gov/HDS

South Dakota Oral Health Program
www.doh.sd.gov/OralHealth

South Dakota Tobacco Control Program
www.doh.sd.gov/Tobacco

Susan G. Komen South Dakota
www.komensouthdakota.org

Veterans Administration Medical Center
www.siouxfalls.va.gov

Yankton Medical Center
www.yanktonmedicalclinic.com

Youth Risky Behavior Surveillance System
www.cdc.gov/yrbss

Print materials can be ordered online through the South Dakota Department of Health at the following link:

http://doh.sd.gov/catalog.aspx

Glossary

Age-adjusted.
A method of calculation that shows rates that would have existed if the population under study had the same age distribution as the general population.

Baseline.
An initial or known value to which later measurements can be compared.

Benign.
In this document a growth that contains no cancerous cells.

Body Mass Index.
A way to state the relationship between height and weight (weight in kilograms divided by height in meters squared (kg/m^2).

Cancer.
The umbrella term to describe many different diseases in which cells grow and reproduce out of control.

Cancer Burden.
Overall impact of cancer in a community.

Clinical Trials.
Research studies of new methods or agents to prevent, detect, or treat a disease, or to study quality of life issues. Treatment trials with cancer patients usually involve three phases to compare the current best treatment to a promising new treatment.

Endoscopy.
For this plan refers to examination of the lining of the gastrointestinal tract using a thin, flexible, lighted tube. Flexible sigmoidoscoy allows examination of the rectum and lower part of the colon. Colonoscopy allows examination of the rectum and entire colon; polyps can be removed during this procedure.

HPV.
Human Papillomavirus. Some types of HPV are associated with cancer, most notably cervical cancer. Two vaccines are now available that protect against HPV that can cause cancer in both males and females.

Incidence.
The number of new cases of a condition within a specific population in a given time interval, usually one year.

Informed Decision-Making.
Happens when a person understands the nature and risks of their cancer diagnosis and treatment options. Informed decisions are reflected by the person's preferences and values.

Mammogram.
An X-ray of the breast used for the early detection of breast cancer.

Melanoma.
The least common but most life-threatening form of skin cancer.

Metastasis.
The spread of cancer cells from the original site to other parts of the body.

Morbidity.
Presence of disease.

Mortality Rate.
The rate of deaths in a given population, for a given time.

Pap (Papanicolaou) Test.
A test for cervical cancer that examines cells that are scraped from the cervix; can detect cancer and pre-cancerous conditions.

Prevalence Rate.
Proportion of people with a certain disease at a given time**.**

Prostate Specific Antigen Test (PSA).
A test to detect levels of a blood protein. Elevated PSA levels may indicate prostate cancer, prostate inflammation, or benign prostate conditions.

Risk Factor.
Something that may increase the chance of developing a disease. Some examples include using tobacco, obesity, age, a family history for some cancers.

Staging.

In situ Cancer: Early neoplasm which has not penetrated the membrane surrounding the tissue of origin.

Localized Cancer: Invasive malignant cancer confined entirely to the organ where the cancer began.

Regional Cancer: Cancer that has extended beyond the original (primary) organ to near by organs or tissues, or has spread via the lymphatics to regional lymph nodes or both.

Distant Cancer: Cancer that has spread from the original (primary) organ to distant organs or distant lymph nodes.

Join Us!

The undertaking of creating a truly comprehensive cancer control program lies in the hands of the citizens of South Dakota. If you are interested in becoming a member of this coalition please complete this form and return it to the address below or join online at www.cancersd.com.

Name: _____

Title: _____

Organization: _____

Address: _____

City/State/Zip: _____

Phone: _____

Fax: _____

Email: _____

Areas of interest (please check one or more):

____ Prevention Workgroup (Skin Cancer, Tobacco Prevention, and Nutrition & Physical Activity)

____ Breast & Cervical Cancer Workgroup (Women's Cancer Network)

____ Colorectal Workgroup

____ Treatment Workgroup

____ Quality of Life Workgroup (Survivorship/Palliative Care/End of Life issues)

Please email completed form to:
South Dakota Comprehensive Cancer Control Program
Email: info@cancersd.com
Or join online at www.cancersd.com

Explanation of the Logo

The logo is simple and creates an interesting mark which could stand on its own. The angles are soft and curving to give it a human feel. The shape in the middle can be something human or biological — it could resemble a human form; it could be DNA; it could be 2 cells dividing or multiplying. The 2 curved shapes on either side of the middle form seem to be "controlling" the action in the middle (derived from the logo Cancer "Control"). These 2 curved shapes also represent the "C's" in the logo (Comprehensive Cancer Control). It's not meant to be taken too literal. It's a concept representing the broad field of cancer.

The Vision of Comprehensive Cancer Control

The vision of the South Dakota Comprehensive Cancer Control Program (SD CCCP) is to reduce the human and economic impact of cancer on South Dakotans through the promotion and support of collaborative, innovative, and effective programs and policies for cancer prevention and control.


Comprehensive
CANCER
CONTROL
SOUTH DAKOTA