

PHILANTHROPIC COLLABORATIVE FOR A HEALTHY GEORGIA

FRAMEWORK FOR COMMUNITY-BASED CANCER PREVENTION AND CONTROL

This document outlines a framework for designing a community-based cancer prevention program, offers tips for how to best use it, and suggests additional information and resources for communities that wish to tailor it to their own unique needs and priorities.

Cancer continues to take a major toll on the health and well-being of Georgians. In 2001 alone, an estimated 14,000 Georgians died of cancer and another 33,000 new cases were diagnosed.¹ High rates of cancer cases and deaths translate into significant—and often immeasurable—social, psychological, and economic costs. The latest estimate of the annual cost of cancer is \$171.6 billion for the nation as a whole, which includes more than \$110 billion for lost productivity and over \$60 billion for direct medical costs.²

Effective community cancer prevention and control programs are well documented in the scientific literature. These interventions fall into three major categories.

Lifestyle interventions focus on the risk factors that underlie cancer—tobacco use, lack of physical activity, poor eating habits, and sun exposure—in an attempt to prevent cancer cases from occurring. They typically employ strategies to change individual behaviors and/or social policies.

Screening interventions strive to detect cancer in its earliest stages when treatment interventions can be more effective. They vary by cancer site but share a common goal of informing groups at highest risk of disease about screening opportunities, assuring that they receive quality screening, and following up with appropriate referrals.

Treatment facilitation interventions are geared toward individuals who have been diagnosed with cancer and are in need of quality diagnostic, medical care, and social support services. They aim to improve access to needed information,

connect individuals with appropriate services and providers, and sustain support networks for patients and their families.

Given this vast array of interventions, communities can become overwhelmed by the desire to “do it all” while facing the stark realities of limited financial and human resources. They feel pressure to “start somewhere,” yet struggle to know which avenue is best. To assist communities with this challenge, the Georgia Health Policy Center (GHPC) has created a unique and user-friendly tool called the **Framework for Community-Based Cancer Prevention and Control**.

This Framework displays, in one simple table:

- The relative impact that various cancer risk factors have on Georgians (*incidence and mortality in Georgia*).
- The degree to which persons of a particular race, gender, socioeconomic status, or geographic area are disproportionately affected (*disparities in Georgia*).
- The relative value of one intervention to another (*potential returns*).
- Examples of interventions that have proven to be effective (*community interventions*).

The table converts a complex set of information, typically presented in fragmented “silos,” into a simple format that communities can use to select specific prevention and control initiatives tailored to their own circumstances. It depicts the synergy amongst the three types of cancer prevention and control interventions, and facilitates the design of a systematic community-based plan.

¹ DHR Cancer Control Section. Available at www.ph.dhr.state.ga.us/programs/cancer
² Estimates from the National Heart, Lung, and Blood Institute

Framework for Community-Based Cancer Prevention and Control

CANCER FACTORS	INCIDENCE IN GEORGIA	MORTALITY IN GEORGIA	DISPARITIES IN GEORGIA	POTENTIAL RETURNS	EXAMPLES OF COMMUNITY INTERVENTIONS
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LIFESTYLE CHANGES

Tobacco use	HIGH	HIGH	MEDIUM Ethnic/racial Gender Socioeconomic	HIGH	<ul style="list-style-type: none"> Promote smoking cessation Influence laws and culture surrounding teenage access to tobacco products Change environmental smoke policies
Lack of physical activity and poor eating habits	HIGH	HIGH	HIGH Ethnic/racial Gender	HIGH	<ul style="list-style-type: none"> Affect cultural norms surrounding diet and exercise Inform community members of related health risks and promote healthy lifestyle changes Facilitate and emphasize exercise through public wellness centers
Sun exposure	HIGH	LOW	MEDIUM Ethnic/racial	MEDIUM	<ul style="list-style-type: none"> Educate population about risk of skin cancer and prevention measures
Lack of knowledge of healthy behaviors and cancer risk factors	HIGH	Insufficient evidence	HIGH Socioeconomic Ethnic/racial	Insufficient evidence	<ul style="list-style-type: none"> Identify specific disparities Create targeted communication Change norms

SCREENING FOR EARLY DETECTION

Breast	HIGH	MEDIUM	MEDIUM Ethnic/racial	MEDIUM	<ul style="list-style-type: none"> Inform women Identify and address barriers to mammography
Cervical/uterine	LOW	LOW	HIGH Ethnic/racial	HIGH	<ul style="list-style-type: none"> Identify groups of women not receiving screening Send targeted messages to encourage Pap test
Colorectal	HIGH	MEDIUM	HIGH Ethnic/racial	HIGH	<ul style="list-style-type: none"> Inform population of risk for colorectal cancer and the effectiveness of screening and early detection and address barriers
Prostate	HIGH	MEDIUM	HIGH Ethnic/racial	Insufficient evidence	<ul style="list-style-type: none"> Educate men about advantages and disadvantages of screening and treatment options
Skin	HIGH	LOW	MEDIUM Ethnic/racial	Insufficient evidence	<ul style="list-style-type: none"> Promote skin cancer monitoring and early detection

TREATMENT FACILITATION

Lack of access to information	HIGH	Insufficient evidence	MEDIUM Socioeconomic	Insufficient evidence	<ul style="list-style-type: none"> Provide access to information about treatment options
Insufficient linkage to “state of the art” cancer treatment	HIGH	Insufficient evidence	HIGH Urban/rural	Insufficient evidence	<ul style="list-style-type: none"> Assure physician referral Provide affordable transportation
Lack of access to local providers who are clinically and interpersonally effective	MEDIUM	Insufficient evidence	HIGH Urban/rural	HIGH	<ul style="list-style-type: none"> Facilitate continuing cancer education for healthcare workers Improve collaboration and coordination among area providers
Inadequate individual and family support networks	MEDIUM	Insufficient evidence	MEDIUM Socioeconomic	MEDIUM	<ul style="list-style-type: none"> Create local or regional support services and outreach for cancer patients and their families

HOW CAN COMMUNITIES BEST USE THE FRAMEWORK?

Who should take part in a community-based initiative?

A first step for communities will be to build a strong coalition of people who are committed to reducing the burden of cancer. Communities best know their strengths, needs, and potential. Representatives from all sectors of the community have unique perspectives to contribute to the process of developing a comprehensive cancer plan. While hospitals, physicians, and public health workers play a critical role in a community's response to cancer, the effects of cancer extend beyond the clinical setting. Thus, a multi-sectoral group of local stakeholders, including the business community, political leaders, cancer survivors, and others, will provide the greatest insight for a cancer plan.

What types of cancer are having the worst impact on residents of your community?

Lung, breast, colorectal, prostate, and skin cancers have the highest incidence in Georgia, and lung, breast, prostate and colorectal have the highest mortality rates. While the framework depicts ratings based on state-level incidence, mortality, and disparity, counties can contact the Georgia Cancer Registry or refer to the 2000 Georgia Cancer Report to derive county-level incidence and mortality rates by cancer site. Thus, counties and regional coalitions can target the types of cancer that pose the greatest burden to their communities.

What disparities exist in cancer risk factors, incidence, treatment, and mortality?

Socioeconomic, racial, and urban/rural factors contribute to cancer disparities in many communities. For example, black Georgians are more likely to die from breast, colorectal, and prostate cancers than are white Georgians. Reasons for these disparities are not fully understood, but some literature has shown that when treatment is equal, racial disparities in mortality decline. Demographic information such as language spoken will help guide the creation of culturally appropriate interventions. Thus, community demographics will inform the development of a comprehensive cancer plan with an angle to target populations that have disproportionate cancer incidence and mortality.

What types of cancer prevention and control activities are available to residents in your community?

Developing a local comprehensive cancer plan begins with examining existing resources. These may range from the national BreastTest and More program to local support groups for families dealing with cancer. Building on existing resources is the best and most cost-effective route for most communities. Existing programs and activities such as health fairs in the schools, healthy worksite programs, or nutrition seminars in healthcare settings can be expanded to include cancer prevention information. Once communities have mapped their resources, they can also analyze the gaps in cancer prevention, treatment, and support. Comprehensive assets mapping and gap analysis will help communities focus on the interventions that are most appropriate for their situation.

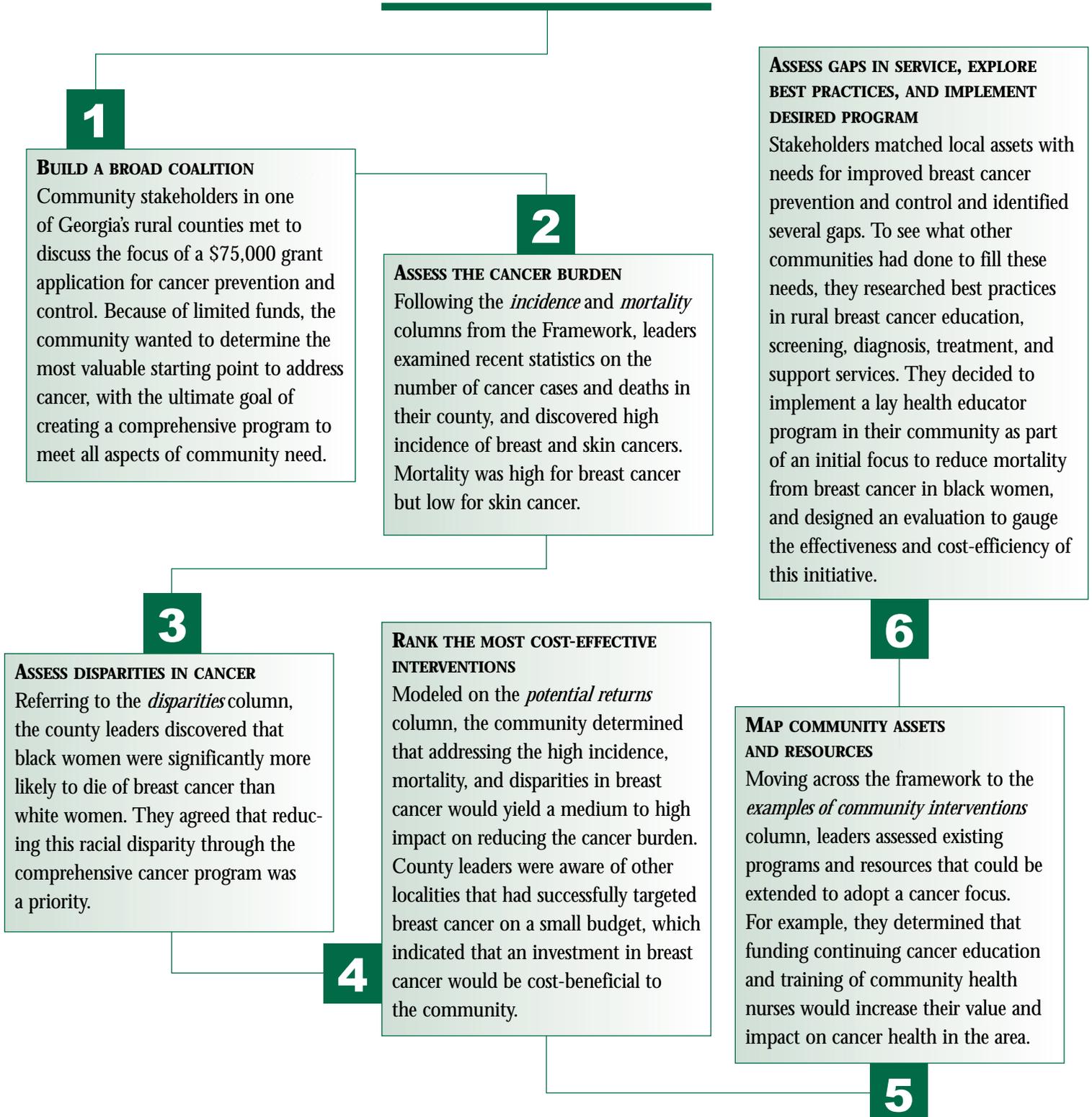
What types of cancer prevention and control activities will yield the greatest return on investment?

Limited resources may compel communities to rank elements of their comprehensive cancer plan. The column for Potential Returns may assist communities in identifying and implementing appropriate interventions. The Potential Returns ratings are based on the literature, recommendations from the federal Task Force on Community Preventive Services, and consultation with national cancer scholars. The recommendations reflect statewide data and may change slightly by community. For example, if a community has cervical cancer incidence and mortality rates that are significantly higher than state rates, the potential returns for addressing cervical cancer may be higher for that community than for others with low rates. Communities may also reference economic analyses of cancer interventions through a Medline search on the Internet. Many published studies evaluate the impacts and cost-benefit of specific cancer interventions. Evaluation of the community's program is also an integral component of the planning and implementation of a cancer initiative. Evaluation of the outcomes may inform the design of the program itself and will allow the community to measure the return on its investment.

How can communities implement the comprehensive cancer plan?

After the coalition has decided upon a comprehensive cancer plan, the community may implement all aspects concurrently, or may begin with those interventions that are most feasible and that offer the greatest promise for success. Though resource constraints may influence a community to implement the program incrementally, the ultimate goal is a program that will provide the community with the best services and support for cancer factors related to lifestyle, screening, and treatment.

EXAMPLE OF FRAMEWORK IN ACTION



FOR FURTHER INFORMATION

General Cancer Resources

The following online resources are intended as a reference point for communities to find more cancer information. The Georgia Health Policy Center does not endorse or accept responsibility for their content.

- Georgia Cancer Coalition:
Available at: www.gacancercoalition.com
- National Cancer Institute:
Available at: www.cancer.gov
- American Cancer Society:
Available at: www.cancer.org
- Centers for Disease Control and Prevention:
Available at: <http://www.cdc.gov/cancer/>
- Guide to Community Preventive Services:
Available at: <http://www.thecommunityguide.org>
- Cancer Control Planet:
Available at: <http://cancercontrolplanet.cancer.gov/>
- Georgia Health Policy Center:
Available at: <http://www.gsu.edu/ghpc>

Cancer Rates in Georgia

- Cancer data from the Department of Human Resources, Division of Public Health, Cancer Control Section
Available at: <http://www.ph.dhr.state.ga.us/programs/cancer/stats.shtml>
- Georgia Cancer Data Report, 2000
Available at: <http://www.ph.dhr.state.ga.us/programs/cancer/pdfs/cancerreport2000.pdf>
- Georgia Childhood Cancer Report, 2002
Available at: <http://www.ph.dhr.state.ga.us/pdfs/chronic/cancer/childcancer.02.pdf>
- Age-adjusted mortality rate 1996-2000 by all sites and for colorectal, lung, breast, and prostate cancers
Available by county:
<http://www.ph.dhr.state.ga.us/pdfs/chronic/cancer/mortalitycounty.96-00.pdf>
Available by health district:
<http://www.ph.dhr.state.ga.us/pdfs/chronic/cancer/mortalitydistrict.96-00.pdf>
- State Cancer Profiles, interactive charts and maps by state, county, and economic area
Available at: <http://statecancerprofiles.cancer.gov>
- SEER Cancer Data for selected Georgia counties
Available at: <http://seer.cancer.gov/statistics>

PROMISING PRACTICES IN COMMUNITY INTERVENTIONS

The following bibliographic references are intended as a starting point for communities to research promising practices. The list is a sampling of the literature and does not reflect a ranking of significance. The Georgia Health Policy Center does not assume responsibility for content of materials.

Tobacco Use

The Task Force on Community Preventive Services. 2000. Strategies for reducing exposure to environmental tobacco smoke, increasing tobacco-use cessation, and reducing initiation in communities and health care systems. Available at:
<http://www.thecommunityguide.org/tobacco/default.htm>.

Forster, J.L. Murray, D.M., Wolfson, M., Blaine, T.M, Wagenaar, A.C., and Hennrikus, D.J. 1998. The effects of community policies to reduce youth access to tobacco. *American Journal of Public Health*, 88, 1193-1198.

Wakefield, M., and Chaloupka, F. 2000. Effectiveness of comprehensive tobacco control programs in reducing teenage smoking in the USA. *Tobacco Control*, 9, 177-186.

Physical Activity and Nutrition

The Task Force on Community Preventive Services. 2001. Increasing physical activity. Morbidity and Mortality Weekly Report, 50, No.RR-18, 1-16. Available at:
<http://www.thecommunityguide.org/pa/default.htm>.

Biener, L., et al. 1999. Impact of the working well trial on the worksite smoking and nutrition environment. *Health Education and Behavior*, 26,4, 478-494.

Campbell, M.K., et al. 2000. The North Carolina black churches united for better health project: Intervention and process evaluation. *Health Education & Behavior*, 27,2, 241-253.

UV Exposure

The Task Force on Community Preventive Services. 2002. Reducing harmful UV light exposures. Available at:
<http://www.thecommunityguide.org/cancer/cancer-int-reduce-uv.pdf>.

Dietrich, A.J., et al. 1998. A community-based randomized trial encouraging sun protection for children. *Pediatrics*, 102,6, E64.

Graffunder, C.M., Wyatt, S.W., Bewerse, B., Hall, I., Reilley, B., and Lee-Pethel, R. 1999. Skin cancer prevention: The problem, responses, and lessons learned. *Health Education & Behavior*, 26,3, 308-316.

Cancer Education

Navarro, A.M., et al. 2000. Community-based education in nutrition and cancer: The Por La Vida Cuidandome curriculum. *Journal of Cancer Education*, 15,3, 168-172.

Swider, S.M. 2002. Outcome effectiveness of community health workers: An integrative literature review. *Public Health Nursing*, 19, 1,11-20.

Breast Cancer Screening

Allen, J.D., et al. 2001. Promoting breast and cervical cancer screening in the workplace: Results from the Woman to Woman study. *American Journal of Public Health*, 91,4, 584-590.

Earp, J.A., et al. 2002. Increasing use of mammography among older, rural African American women: Results from a community trial. *American Journal of Public Health*, 92,4, 646-654.

Cervical/Uterine Screening

Sharp, P.C., et al. 1998. Working with lay health educators in a rural cancer-prevention program. *American Journal of Health Behavior*, 22,1, 18-27.

Rimer, B.K., et al. 1999. The impact of tailored interventions on a community health center population. *Patient Education and Counseling*, 37, 125-140.

Colorectal Screening

Powe, B.D. 2002. Promoting fecal occult blood testing in rural African American women. *Cancer Practice*, 10,3, 139-146.

Thompson, N.J., et al. 2000. A randomized controlled trial of a clinic-based support staff intervention to increase the rate of fecal occult blood test ordering. *Preventive Medicine*, 30,3, 244-251.

Prostate Screening

Frosch, D.L., Kaplan, R.M., Felitti, V. 2001. Evaluation of two methods to facilitate shared decision making for men considering the prostate-specific antigen test. *Journal of General Internal Medicine*, 16, 391-398.

Weinrich, S.P., et al. 1998. Increasing prostate cancer screening in African American men with peer-educator and client-navigator interventions. *Journal of Cancer Education*, 13,4, 213-219.

Wilt, T.J., Paul, J., Murdoch, M., Nelson, D., Nugent, S., and Rubins, H.B. 2001. Educating men about prostate cancer screening: A randomized trial of a mailed pamphlet. *Effective Clinical Practice*, 4,3, 112-120.

Skin Cancer Screening

Aitken, J.F., Elwood, J.M., Lowe, J.B., Firman, D.W., Balanda, K.P., and Ring, I.T. 2002. A randomized trial of population screening for melanoma. *Journal of Medical Screening*, 9,1, 33-37.

Harris, J. 2000. Plan to promote the prevention and early detection of melanoma. *Dermatology Nursing*, 12,5, 329-333.

Patient Education/Information

Golant, M., Altman, T., and Martin, C. 2003. Managing cancer side effects to improve quality of life: A cancer psychoeducation program. *Cancer Nursing*, 26,1, 37-44.

Kakai, H., Maskarinec, G., Shumay, D.M., Tatsumura, Y. and Tasaki, K. 2003. Ethnic differences in choices of health information by cancer patients using complementary and alternative medicine: An exploratory study with correspondence analysis. *Social Science & Medicine*, 56,4, 851-862.

Wells, N., Hepworth, J.T., Murphy, B.A., Wujcik, D., and Johnson, R. 2003. Improving cancer pain management through patient and family education. *Journal of Pain and Symptom Management*, 25,4, 344-356.

Access to State of the Art Treatment and Care

Desch, C.E., et al. 1999. A rural cancer outreach program lowers patient care costs and benefits both the rural hospitals and sponsoring academic medical center. *Journal of Rural Health*, 15,2, 157-167.

Kaluzny, A., Brawley, O., Garson-Angert, D., Shaw, J., Godley, P., Warnecke, R., and Ford, L. 1993. Assuring access to state of the art care for U.S. minority populations: The first two years of the Minority-Based Community Clinical Oncology Program. *Journal of the National Cancer Institute*, 85,23, 1945-1950.

Paskett, E.D., Cooper, M.R., Stark, N., Ricketts, T.C., Tropman, S., Hatzell, T., Aldrich, T., and Atkins, J. 2002. Clinical trial enrollment of rural patients with cancer. *Cancer Practice*, 10,1, 28-35.

Provider Training in Clinical and Interpersonal Effectiveness

Baile, W.F., et al. 1999. Communications skills training in oncology: Descriptions and preliminary outcomes of workshops on breaking bad news and managing patient reactions to illness. *Cancer*, 86,5, 887-897.

Lane, D.S., Messina, C.R., and Grimson, R. 2001. An educational approach to improving physician breast cancer screening practices and counseling skills. *Patient Education and Counseling*, 43,3, 287-299.

Sheinfeld Gorin, S., et al. 2000. Cancer education among primary care physicians in an underserved community. *American Journal of Preventive Medicine*, 19,1, 53-58.

Support Networks

Shelby, R.A., et al. 2002. The role of community-based and philanthropic organizations in meeting cancer patient and caregiver needs. *Cancer Journal for Clinicians*, 52,4, 229-246.

Tesauro, G.M., Rowland, J.H., and Lustig, C. 2002. Survivorship resources for post-treatment cancer survivors. *Cancer Practice*, 10,6, 277-283.

DOCUMENT BACKGROUND

The Philanthropic Collaborative for a Healthy Georgia serves as a forum for bringing foundations together to better understand and explore the health-related challenges facing Georgia. In 2002, the Collaborative convened an advisory committee of foundation executives and trustees, as well as representatives from the Georgia Cancer Coalition, the American Cancer Society, and the Georgia Division of Public Health. This advisory committee sponsored a series of meetings so that members could learn more about best practices for community-based approaches to cancer prevention and control. The Framework for Community-Based Cancer Prevention and Control was a result of this period of inquiry and discovery. The Philanthropic Collaborative supported the development of the Framework and state and national experts have endorsed it as a tool for communities to use in developing and implementing their own local cancer programs.

The Georgia Health Policy Center (GHPC) at the Andrew Young School of Policy Studies, Georgia State University, defined the Framework ratings through several sources. Cancer factors were identified through a review of the literature and consultation with national cancer experts. Cancer incidence and mortality data, derived from the Georgia Cancer Data Report 2000, were converted into thresholds for user-friendly descriptions of “low,” “medium,” and “high” rates. Cancer disparities were converted into thresholds from National Cancer Institute data and from the literature. Potential returns ratings reflect the literature on intervention efficacy and cost analysis in addition to expert consultation. More detailed information on the Framework is available from the Director of the Georgia Health Policy Center, Dr. Karen Minyard, at 404-651-3104.

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