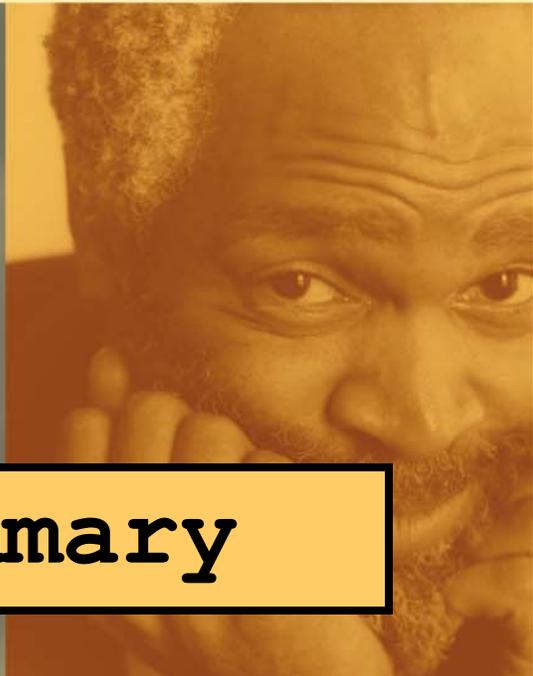


**THE MARYLAND  
COMPREHENSIVE CANCER  
CONTROL PLAN**

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OUR CALL TO ACTION

2004-2008



**Executive Summary**

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# Executive Summary

The Maryland Comprehensive Cancer Control Plan 2004 – 2008: Our Call to Action is a resource and guide for health professionals who are involved in planning, directing, implementing, evaluating, or performing research in cancer control in Maryland. This plan represents the coordinated effort of over 200 individuals across the state that came together through 14 committees and a Core Planning Team to develop a document that reflects the needs of Marylanders. This plan was not developed by, or for, any one organization. It was developed by a broad partnership of public and private stakeholders whose common mission is to reduce the burden of cancer in Maryland. This plan was developed **by** Marylanders **for** Marylanders.

The State of Maryland Department of Health and Mental Hygiene, on behalf of many partnering organizations, received a cooperative agreement from the Centers for Disease Control and Prevention in 2001 to develop a comprehensive cancer control plan for the state. Although there have been two previous Maryland Cancer Control Plans, this plan is more comprehensive in nature and has involved the participation of broader and more diverse organizations in its development than did the previous two plans.

Comprehensive cancer control is defined by the Centers for Disease Control and Prevention as “an integrated and coordinated approach to reducing cancer incidence, morbidity, and mortality through prevention, early detection, treatment, rehabilitation, and palliation.” Comprehensive cancer control is an emerging model that integrates a range of cancer control activities to maximize the use of limited resources to achieve desired cancer prevention and control outcomes. The structure of this plan follows CDC’s definition of comprehensive cancer control. This plan includes chapters that cover cancer control from primary prevention through survivorship and palliative care. Although there are over 100 different cancer sites, it was not feasible to cover every cancer site in this plan. Rather, this plan covers those cancer sites, interventions, or issues that we know from research will have an impact on cancer incidence, morbidity, mortality, and quality of life.

The plan starts with a chapter describing an overview of the burden of cancer in Maryland and a cancer control model for the state. The Plan is then divided into sections. The first section deals with primary prevention of cancer. Chapters in this section focus on tobacco-use prevention and cessation and lung cancer, diet and physical activity, ultraviolet radiation and skin cancer, and environmental issues. The second section addresses secondary prevention or the early detection and treatment of cancer. Chapters included in this section are cancer site-specific. There are individual chapters on breast, cervical, colorectal, prostate, and oral cancer. The next section deals with tertiary prevention. Chapters included in this section cover pain management and end-of-life care. The remaining chapters of the plan highlight crosscutting issues that are of importance to cancer control including cancer disparities, cancer surveillance, and patient issues and cancer survivorship. The Introduction describes the background, past Maryland Cancer Plans, and the processes used to develop the Comprehensive Cancer Control Plan. The Appendix contains information on data sources and methods.

Each chapter was written and/or edited by 10-20 Maryland experts in that area . A committee was formed for each chapter, and in general consisted of epidemiologists, health care providers,

researchers, cancer survivors, and other representatives from local and state health departments, governmental agencies, community-based organizations, academic health centers, hospitals and other health care facilities, and cancer support groups. Committee members, as well as guest speakers and chapter contributors, are listed at the beginning of each chapter.

Each committee reviewed epidemiologic data, scientific research, and existing programs and resources, especially those available in Maryland. They identified gaps and barriers to cancer control in Maryland for the issues addressed in their respective chapter, and from these developed goals, objectives, and strategies. In general, the outline of each chapter is as follows: a review of data in Maryland relevant to the chapter's topic, a discussion of disparities, existing programs and resources, gaps and barriers, and then a section listing goals, objectives, and strategies. In addition, each chapter has a measurable target for change.

The goals, objectives, and strategies that are provided for each chapter serve as a guide to all organizations in the state and show areas where additional attention is needed. The objectives are far-reaching and complex. No one organization can carry out all of these activities. Rather, these goals, objectives, and strategies are listed as our call to action to encourage any organization involved in any aspect of cancer control to address one or more of these goals and objectives, and apply the appropriate strategies as resources and opportunities arise.

Following is a list of the goals, objectives, and strategies for each chapter in the plan.

# Goals, Objectives, and Strategies

## Chapter 2: Cancer Surveillance

**Goal: Fully implement cancer surveillance – the development, collection, analysis, and dissemination of cancer information – in Maryland.**

***Target for Change:***

**By 2008, increase the capacity to conduct cancer surveillance in Maryland.**

**Objective 1: Develop, maintain, and enhance data systems to ensure accurate, timely, and complete information needed for the prevention and control of cancer.**

**Strategies:**

1. Continue to support the Maryland Cancer Registry Advisory Committee in its role as advisor to the Maryland Cancer Registry on issues related to data quality, data use, and data dissemination.
2. Encourage the development of quality assurance and quality control methods in all databases used for cancer surveillance in Maryland.
3. Re-establish a statewide Cancer Surveillance Advisory Group to meet regularly to further cancer surveillance in Maryland.
4. Develop a set of leading cancer indicators (e.g., incidence, stage, survival, mortality, treatment, risk behaviors), avoidable cancer events, and events that are sentinels of problems in the delivery of cancer prevention and control services that can be used to monitor or track changes in cancer control in Maryland.
5. Facilitate standardized measurement of race, ethnicity, and geographic area in databases that can be used for cancer surveillance in Maryland.
6. Provide training opportunities for cancer registrars and other collectors of cancer-related data.
7. Increase the number of Certified Tumor Registrars in Maryland who actively work in cancer registration.
8. Explore barriers as to why hospitals do not have an in-house tumor registry.

**Objective 2: Expand access to, and analysis of, the databases used for cancer surveillance in Maryland in order to better meet the information needs of program planners, policy makers, researchers, and the public.**

**Strategies:**

1. Continue to pursue the creation of a public use (non-confidential) data file for databases that are used for cancer surveillance in Maryland.
2. Expand the interactive access (e.g., Web-based, user-defined utility reports) to databases used for cancer surveillance in Maryland.
3. Develop a list of priority research questions about specific Maryland cancer problems; share these research questions with potential funding sources, the statewide academic health centers, researchers, health leaders, and others.
4. Develop a guide/report that reviews, aggregates, and summarizes methodologies that local and state health agencies and others could use to address small numbers issues and assessment of disparities, while maximizing information and maintaining privacy.
5. Increase the capacity of state agencies to perform small area analysis of cancer-related events in Maryland.
6. Investigate the feasibility of a prospective method for cancer monitoring.
7. Create a surveillance resource that would list existing population-based cancer data for assessment of local or state cancer concerns (e.g., watershed information, demographics available from the census, and others).

**Objective 3: Broadly disseminate cancer surveillance findings to promote cancer awareness, policy development, and implementation of cancer control programs**

**Strategies:**

1. Develop and maintain a master distribution list of cancer reports.
2. Create a list of Internet websites for cancer-related surveillance reports and articles pertaining to Maryland cancer statistics and information.
3. Share major surveillance reports and findings with the media.
4. Establish feedback mechanisms by which users of cancer surveillance system information can provide suggestions, including their unmet needs for information, and other comments.

5. Maintain, periodically revise, and continue to create informational materials about cancer surveillance.
6. Continue to distribute cancer surveillance documents, including reports and articles, to the appropriate audiences.

## **Chapter 3: Cancer Disparities**

**Goal: Reduce cancer health disparities in Maryland.**

***Target for Change:***

**By 2008, develop a system to monitor and document cancer disparities in Maryland.**

**Objective 1: Increase public and community awareness about cancer health disparities and cancer prevention, screening, and treatment in Maryland.**

**Strategies:**

1. Collaborate with government agencies, academic health centers, community and faith-based organizations, and private foundations to educate the public about topics relating to health disparities and cancer, including:
  - the importance of social, economic, cultural, and environmental factors in influencing personal and community health.
  - the role of behavioral and biological factors in determining cancer risk.
  - types of current interventions that can reduce/modify risks for developing cancer or the progression of cancer.
2. Disseminate current and accurate information about cancer prevention, screening, early detection, and treatment, including complementary and alternative therapies to minority and underserved populations in Maryland.
  - Identify “Best Practices” for health communication and interventions for specific minority and underserved populations, in order to improve approaches and effectiveness of resources.
  - Utilize existing educational resources, such as the Cancer Survival Toolbox, and modify as appropriate to educate community members in a variety of settings including health care, schools, social, and faith-based institutions.

**Objective 2: Develop and implement health care programs designed to reduce cancer disparities among targeted populations in Maryland.**

**Strategies:**

1. Adapt the Community Health Worker (CHW) model for use in a variety of settings in Maryland to address barriers to access, culturally therapeutic compliance, services utilization, cancer risk management, and health education.
2. Work in partnership with local Community Health Centers and Area Health Education Centers to develop cancer prevention, screening, and treatment programs aimed at disparate populations.
3. Link U.S. military veterans with cancer prevention, screening, and treatment services within the Veterans Affairs health care system.
4. Implement in Maryland the Department of Health and Human Services standards for Culturally and Linguistically Appropriate Services (CLAS), including availability of interpretation services.
5. Foster development and implementation of “National and Maryland Models that Work” to reduce and eliminate cancer disparities in targeted populations.
6. Collaborate with the Maryland Special Populations Cancer Research Network, National Cancer Institute and NMA, to increase the number of minority and underserved health care professionals including researchers involved in cancer research.

**Objective 3: Increase cancer disparities documentation and intervention on a systematic basis in Maryland.**

**Strategies:**

1. Support ongoing surveillance efforts and disparities research
2. Produce a status report on cancer disparities in Maryland every two years and disseminate the report to key stakeholders including communities, media, healthcare and social service organizations, and policy makers.
3. Expand and enforce cancer data collection and reporting on racial/ethnic minorities based on Office of Management and Budget (OMB) categories and use sub-population groups where possible. This includes a Maryland uniform method of recording race/ethnicity for all hospitals and other health care facilities that are required to report to the Maryland Cancer Registry.
4. Expand cancer data collection in the Maryland Cancer Registry to include level of education, socioeconomic status, and primary language.
5. Provide technical assistance to community based watch groups that monitor industrial and commercial environment
6. Expand data collection regarding emerging populations of concern for cancer disparities, including the disabled and mentally ill and GLBT populations.

**Objective 4: Increase provider education and reimbursement aimed at reducing cancer disparities.**

**Strategies:**

1. Require educational modules on cancer prevention, education, screening, and treatment for disparate populations and provide training on cultural diversity and barriers to reaching medically underserved populations for health professional students as part of their clinical rotation.
2. Collaborate with the National Cancer Institute, Maryland cancer centers, regionally recognized medical centers and Area Health Education Centers to develop continuing education programs for health care professionals in medically underserved and rural areas on cutting edge cancer prevention, screening, and treatment methods.
3. Provide reimbursement incentives for primary care providers to increase prevention, screening, and treatment services to high-risk groups , including Medicaid incentives for primary care practitioners that refer patients for cancer prevention, screening, and treatment services.

**Objective 5: Improve access to, and utilization of, cancer screening and treatment options for underserved populations.**

**Strategies:**

1. Advocate for lowered of costs of chemotherapy and other cancer treatments for low-income and uninsured or underinsured populations.
2. Increase patient education and access to participation in high quality clinical trials for low-income and uninsured or underinsured populations.
3. Advocate for consistency of benefits and protections for publicly funded HMO enrollees to be the same as private HMO enrollees.
4. Promote the consistency and equity of care through the use of evidence-based guidelines, and structure pay systems to ensure an adequate supply of health care services to minority and underserved populations.

**Objective 6: Improve the quality of cancer care received by racial/ethnic minorities.**

**Strategies:**

1. Foster research on Maryland disparities in quality cancer care.
2. Support health professional continuing education on quality cancer care guidelines, particularly for cancers where disparities are most pronounced.
3. Disseminate cancer care guidelines to the general public via websites, portals or other mechanisms.
4. Foster activities which improve the delivery of quality cancer care.

## Chapter 4: Patient Issues and Cancer Survivorship

**Goal: Enhance the quality of life for all cancer survivors in Maryland.**

***Target for Change:***

**By 2008, establish a Patient Issues and Cancer Survivorship Advisory Board to continuously assess the needs of cancer survivors in Maryland and to make recommendations to address those needs.**

**Objective 1: Enhance access to information and resources for Maryland cancer survivors, their friends, and families.**

**Strategies:**

1. Establish and market a comprehensive cancer information clearinghouse in the form of a website plus a staffed, toll-free telephone number. This website should house all pertinent information relating to national, regional, and local resources for cancer survivors. Consider the Cancer Gateway of Texas and other existing state cancer websites as models for the Maryland website.
2. Encourage oncologists to distribute copies of the National Cancer Institute publications, “Facing Forward” and “Life After Cancer Treatment” to all patients.
3. Identify Patient Navigator tools and systems for use in Maryland to facilitate patient access to cancer information, screening, diagnosis, and treatment.
4. Develop and implement a multimedia public service campaign to empower the public to be informed, proactive consumers of health care and to ask their doctors about appropriate cancer prevention and screening.
5. Educate community leaders throughout Maryland about available cancer resources and involve community leaders in helping to raise public awareness of issues faced by cancer survivors.

**Objective 2: Reduce the financial burden on cancer survivors and their families.**

**Strategies:**

1. Examine the cost of cancer services and develop a statewide financial aid system to help offset the expense of cancer diagnosis and treatment services.

2. Initiate a review of the Maryland Medicaid system with attention to cancer costs.
3. Provide tax credits for chronically ill citizens.
4. Establish a paid medical leave program based on the best practices of existing programs.
5. Modify existing or develop new policies to ensure that patients with managed care insurance may have lab work, scans, and tests performed (and covered by their carrier) at the centers where they are already being treated rather than being forced to travel to other facilities.
6. Develop user-friendly transportation assistance programs to help patients get to and from treatment and medical appointments, support groups, education sessions, and other support services. Coordinate with existing transportation services and consider incentives such as tax credits for companies donating transportation services for cancer patients.
7. Mandate insurance coverage for fertility benefits to cover fertility counseling, sperm banking, or egg harvesting and storage for those affected by cancer treatments or surgeries.
8. Develop methods to increase access to physical and occupational therapy services as well as mental health services for cancer survivors.
9. Develop employer-employee education programs to make the workplace comfortable for survivors as they deal with cancer.
10. Mandate that life insurance be portable when one leaves employment.
11. Expand and develop new educational efforts to make cancer survivors and their families aware of pharmaceutical assistance programs.
12. Expand insurance coverage for screening for cancer survivors, who are often at risk for secondary cancers and other physical problems.
13. Develop programs to make childcare, eldercare, homecare or respite care available while patients are undergoing treatment and follow-up.

**Objective 3: Ensure that all cancer survivors have access to psychosocial support services throughout all phases of their cancer experience.**

**Strategies:**

1. Educate health care practitioners to be aware of and sensitive to the psychosocial needs of their patients. Educate providers about existing mental health services and other psychosocial support services for cancer survivors and the urgent need for increased numbers of timely referrals for mental health services.
2. Establish an annual conference sponsored by the Maryland Department of Health & Mental Hygiene, academic health centers, and Maryland professional organizations to address psychosocial issues of cancer survivors.
3. Expand continuing education offerings to provide training in oncology mental health for those both within and outside the oncology arena. Consider providing certification in this field on the state level to practitioners including nurses, licensed professional counselors, psychologists, psychiatrists, social workers, occupational and physical therapists, physicians, and other health care workers who complete a course and designated hours of practice in oncology mental health.
4. Implement curricula on the psychosocial issues related to cancer in all Maryland universities offering programs in the health and social work professions. Consider the current curriculum written by Margaret Wool, PhD, MSW, being taught at Brown University as a model.
5. Provide incentives for prospective students entering the mental health profession to specialize in oncology.
6. Design and launch a media campaign to educate the public about the psychosocial issues related to cancer and to raise awareness and knowledge of the support services available throughout the state.

**Objective 4: Address the needs of long-term cancer survivors in Maryland.**

**Strategies:**

1. Encourage and provide funding for survivorship research.
2. Establish new and expand existing long-term survivorship clinics in Maryland for both childhood and adult cancer survivors. These clinics should be designed to follow survivors after treatment and to provide them with comprehensive care to address the unique needs of cancer survivors. The Living Well After Cancer Program at the University of Pennsylvania Cancer Center and the Life After Cancer Care program at the M. D.

Anderson Comprehensive Cancer Center in Texas may provide models for such clinics.

3. Educate oncologists and other health care providers about long-term survivorship issues. Providers should be encouraged to explain the long-term effects of the different treatment options available and help their patients make treatment decisions with regard to these long-term effects.
4. Educate oncologists about the need to refer their patients to neurologists, cardiologists, physical therapists, or other specialists as necessary for the management of long-term side effects.
5. Identify or create new programs to address occupational issues of cancer survivors such as job retraining and workplace reintegration.
6. Increase awareness among educators about the specific physical, emotional, and cognitive needs of student cancer survivors, and of the emotional needs of the family members of cancer survivors.

## **Chapter 5: Tobacco-Use Prevention and Cessation & Lung Cancer**

**Goal: Substantially reduce tobacco use by Maryland adults and youth.**

### ***Targets for Change:***

**By 2008, reduce lung cancer mortality to a rate of no more than 57.3 per 100,000 persons in Maryland. Maryland Baseline: 59.5 per 100,000 in 2000 (age-adjusted to the 2000 U.S. standard population).**

*Source: Maryland Division of Health Statistics*

**By 2008, reduce the proportion of Maryland middle school youth that currently smoke cigarettes to no more than 6.2%. Maryland Baseline: 7.3%.**

*Source: Maryland Youth Tobacco Survey (2000)*

**By 2008, reduce the proportion of Maryland high school youth that currently smoke cigarettes to no more than 20.3%. Maryland Baseline: 23.7%.**

*Source: Maryland Youth Tobacco Survey (2000)*

**By 2008, reduce the proportion of Maryland adults that currently smoke cigarettes to no more than 15 %. Maryland Baseline: 17.5%.**

*Source: Maryland Adult Tobacco Survey (2000)*

**By 2008, increase the proportion of Maryland adults that would support a proposal to make all restaurants in their community smokefree to 72.1%. Maryland Baseline: 63.0%.**

*Source: Maryland Adult Tobacco Survey (2000)*

**Objective 1: Fund Maryland's comprehensive Tobacco-Use Prevention and Cessation Program at least at the minimum level recommended by the Centers for Disease Control and Prevention.**

**Strategies**

1. Document the cost of tobacco-related disease in human and economic terms to the Maryland economy and its citizens.
2. Document the benefits of a comprehensive tobacco-use prevention and cessation program in reducing the human and economic toll tobacco use is exacting from Maryland.
3. Document the extent of the resources made available to the state of Maryland as a result of its settlement with the tobacco industry and the reasons for the lawsuit.
4. Document how Maryland is prioritizing its use of proceeds from the tobacco settlement.
5. Communicate these findings to interested citizens and key stakeholders.
6. Advocate for full funding of every component of Maryland's comprehensive Tobacco Use Prevention and Cessation Program, including but not limited to: a comprehensive quit line to assist Marylander's in their attempts to quit; Maryland's mass media campaign to counteract tobacco industry marketing efforts; tobacco-use cessation and prevention programs; surveillance and evaluation activities; and the legal resource center that provides technical support for local tobacco control initiatives.

**Objective 2: Establish public policy that supports state and local bans on smoking in all public places and workplaces.**

**Strategies:**

1. Ban smoking in all workplaces, including eating and drinking establishments.
2. Ban smoking at day-care facilities at all times when children may be present (closing the COMAR 07.04.01.33 loophole that prohibits smoking in family day-care facilities *only* while "engaged in care giving activities requiring direct physical contact...").
3. Establish tobacco-free zones that prohibit the use of tobacco products by youth or adults on school and recreational properties at all times.
4. Explicitly permit local restrictions on smoking that are more stringent than statewide restrictions.

**Objective 3: Increase the excise tax on cigarettes to \$1.50.**

**Strategies:**

1. Enact state legislation increasing the excise tax on cigarettes and other tobacco products. This is a proven strategy that will reduce the use of tobacco, particularly among underage youth. Unlike other proposals to

increase taxes, this proposal is directly correlated with improving the health of Maryland citizens.

**Objective 4: Enact civil prohibition on the sale of tobacco to youth less than 18 years of age.**

**Strategies:**

1. Enact state legislation to permit civil agencies to enforce Maryland's existing prohibition on the sale of tobacco products to youth less than eighteen years old, thereby relieving overburdened law enforcement agencies from this responsibility.
2. Civil enforcement must provide for a graduated series of penalties, against both the licensee and the person who makes the illegal sale. These penalties must culminate in a mandatory suspension of a cigarette retailer's license to sell tobacco, and ultimately result in its revocation for chronic violators.
3. Enact state legislation requiring tobacco retailers to take reasonable steps to verify that a prospective purchaser is of legal age by demanding and reviewing photo-identification. ID must be demanded of all persons who appear to be under the age of 27 (the former FDA requirement).
4. Enact state legislation providing an affirmative defense for tobacco retailers who use electronic means to verify identification offered as proof of age in connection with the sale of tobacco products.
5. Enact state and local legislation that requires tobacco retailers to place all tobacco products beyond the reach of their customers absent the intervention of store personnel.
6. Educating tobacco retailers on any changes in the law and their responsibilities as tobacco retailers must be an integral part of any enforcement program.
7. Local communities must be explicitly permitted to adopt local restrictions that are more stringent than statewide restrictions.
8. Local governments should be encouraged to pass ordinances that make it easier to enforce youth access to tobacco laws.

**Objective 5: Ensure access to tobacco-use cessation services.**

**Strategies:**

1. Enact state legislation mandating health insurance plans in Maryland cover tobacco-use cessation programs and products.
2. Implement the CDC recommended statewide quit line to ensure that smokers who want to quit have access to help when they need it from wherever they live in the state.
3. Develop strategies to provide cessation products to the uninsured and underinsured.

## **Objective 6: Enhance existing program activities.**

### **Strategies:**

1. Promote increased collaboration between all Maryland tobacco-use prevention and cessation programs to avoid duplication of resources and efforts.
2. Develop and promote a provider reminder and education program for smoking cessation.
3. Develop and promote tobacco-use cessation programs specifically aimed at college-age individuals and pregnant women.
4. Develop and promote education programs on the benefits of smoke-free homes (i.e. those with small children and/or asthmatics).
5. Continue to work to reduce patients' out-of-pocket costs for effective treatments for tobacco use and dependence, including the uninsured, underinsured, and college-age youth.
6. Improve existing enforcement of smoke-free schools.
7. Improve enforcement of existing local and state prohibitions on sale of tobacco to minors.
8. Develop and promote education programs for members of the judiciary and business community on the importance of enforcing youth access laws.
9. Continue and strengthen tobacco-use prevention education in grades K-12 as part of the comprehensive Tobacco Use Prevention and Cessation Program.

## **Objective 7: Continuously evaluate and improve state and local programs.**

### **Strategies:**

1. Develop and implement a formal evaluation plan to ensure the effective use and allocation of program resources.
2. Contract with an independent evaluator to assess the tobacco-use prevention and cessation programs.
3. Conduct biannual surveys of adult and youth tobacco-use behaviors at the statewide and county levels.
4. Conduct special population studies targeting high risk and targeted populations.
5. Develop a statewide data collection system for all elements of local tobacco grant activity.
6. Develop and disseminate user-friendly reports for a variety of audiences as survey data becomes available.
7. Develop and disseminate user-friendly reports of local tobacco control activities and local resource directories.
8. Encourage the reporting and dissemination of local best practices, information, data, and experiences.
9. Develop a recognition program for efforts of local jurisdictions.
10. Continue to refine and support the counter-marketing/media campaign.

## Chapter 6: Diet and Physical Activity

**Goal: Reduce the burden of cancer in Maryland through the promotion of healthy diet, healthy weight, and physical activity as a means of cancer prevention.**

### *Targets for change:*

These measurable objectives represent modest, population-based targets. It is important to note that continued lowering of BMI within the normal range, increasing physical activity, and increasing consumption of fruits and vegetables will likely reduce cancer risk even further.

**By 2008, increase the percent of Marylanders with a BMI in the normal range (18.5 to 24.9 kg/m<sup>2</sup>) to 50%. Maryland Baseline: 43.3% in 2000.**

*Source: BRFSS*

**By 2008, increase the percent of Marylanders participating in regular and sustained Exercise. Maryland Baseline: 22% in 2000.**

*Source: BRFSS*

**By 2008, increase the percent of Marylanders consuming 5 or more servings of fruits and vegetables per day to 33%. Maryland Baseline: 27.4% in 2000.**

*Source: BRFSS*

**Objective 1: Increase awareness of, and demonstrate healthy eating and physical activity patterns among, Maryland families and communities.**

### **Strategies:**

1. Identify and implement existing effective programs for intervention to improve healthy eating and physical activity targeted to youth, young adults, adults, and healthcare providers. Where gaps exist, design and implement programs based on knowledge, attitudes, and beliefs surveys.
2. Convey simple and culturally appropriate messages, including but not limited to content such as:
  - What does a healthful plate of food look like?
  - What is a healthful portion size?
  - What to choose when eating out?
  - What counts as a serving of fruits and vegetables?
  - What counts as physical activity?
  - How does healthy eating and physical activity reduce cancer risk?

3. Develop and implement programs that result in healthy diet, healthy weight, and healthy physical activity with an emphasis on children, youth, and their families.
4. Develop information for use by local advocates to help persuade local boards of education to provide optimal school meals and physical activity for school and after-school programs.
5. Support communities in grassroots advocacy for activities such as access to healthy food in schools and neighborhoods, development of sidewalks and trails for biking and hiking, monitoring upkeep of playgrounds and parks, addition of safety and lighting features to outdoor recreational areas, and the addition of nutrient labeling for fast foods and restaurant menus.
6. Promote farmers' markets, school and community gardens, and Community Supported Agriculture.
7. Promote healthy eating and physical activity through community groups such as the ACS's "Body and Soul" program within African-American churches.
8. Work with food purveyors to open and maintain grocery stores in urban settings.
9. Enhance links among existing food programs, including WIC and 5 A Day with local farmers' markets.
10. Dedicate funding and resources to enhance and create new sidewalks, trails, playgrounds, and parks and add lighting and safety features to these areas.
11. Allow public access to school tracks, courts, gymnasiums, and other recreational facilities.
12. Build a partnership among planning agencies, parks and recreation departments, and health departments to educate the planning agencies on the health benefits of physical activity and the importance of walking/bicycle trails.

**Objective 2: Increase the prevalence of healthy diet, healthy weight, and physical activity among Maryland youth.**

**Strategies:**

1. Evaluate the effectiveness of existing Maryland laws pertaining to primary and secondary physical education and comprehensive health education.
2. Mandate specific and consistent objectives for nutrition and physical activity education in grades K-12.
3. Compile a comprehensive list of existing nutrition-related curricula and enhance educators' access to these curricula; seek foundation support for curricula implementation.
4. Support the inclusion of questions pertaining to nutrition and physical activity on required Maryland assessment exams.
5. Promote interdisciplinary learning experiences to improve diet and exercise such as field trips to the produce section of supermarkets,

development of school gardens, and stretch or dance breaks during the school day outside of standard physical education.

6. Provide grade-appropriate brief education sessions on topics such as: What is cancer? What are its causes? And how does healthy eating and physical activity reduce risk?
7. Provide healthy snacks and improved physical activity in after-school programs.
8. Provide a greater choice of activities in physical education classes, including noncompetitive and lifelong activities, such as walking, aerobics, and swimming, and tailor activities to students' fitness level.
9. Ensure that school meals and snacks reflect the education students are receiving about nutrition and associated risk factors.
10. Support school health councils in the evaluation of school meals and policy initiatives.
11. Enforce school policies on access to and regulation of vending machines. Advocate for the availability of healthier options in school vending machines, such as 100% fruit juices, water, and fruits and vegetables, and encourage the use of alternative methods for fundraising.

**Objective 3: Increase access to a healthy diet and physical activity at Maryland workplaces.**

**Strategies:**

1. Encourage employers to adopt health promotion programs and policies, including paid release time for physical activity during the workday, provision of on-site exercise facilities and activities, organization of workplace competitions such as stair climbing and running or walking teams, use of stairwell prompts, and gym membership subsidies.
2. Educate workplace events planners to offer healthy food and activity breaks during meetings and other events. Disseminate the American Cancer Society's *Meeting Well Tool*.
3. Provide state tax incentives for employers to incorporate employee wellness programs.

**Objective 4: Increase the number of health care providers offering preventive nutrition and physical activity services.**

**Strategies:**

1. Expand health care provider training regarding the connection among energy imbalance, suboptimal diet, alcohol intake, and cancer.
2. Establish and increase provider reimbursement for nutrition and physical activity counseling targeting high-risk patients within all payor systems in Maryland.
3. Create and establish guidance and assessment tools for use in all health care settings for the promotion of physical activity and healthy eating.

4. Educate providers about their importance as role models for patients, and provide incentives for them to adopt healthy diet and activity habits.

**Objective 5: Engage the public with appropriate health messages related to nutrition, obesity, physical activity, and cancer via the media.**

**Strategies:**

1. Create or enhance local public service campaigns about the importance of healthy eating and physical activity in the prevention of cancer.
2. Create a news article series about nutrition, activity and links to disease.
3. Pitch information about existing programs, campaigns, and specific events to news outlets in the hope of gaining media coverage.
4. Promote existing community, statewide, and national nutrition and/or physical fitness days to both local and statewide news outlets.

**Objective 6: Increase scientific knowledge regarding the relationship among nutrition, physical activity, and cancer.**

**Strategies:**

1. Continue to encourage research on nutrition and physical activity in relation to cancer; continuously examine evidence in an effort to determine when evidence is strong enough to merit intervention.
2. Continue to encourage behavioral and economic research on targeted individual and societal interventions for suboptimal diet, obesity, and physical inactivity.
3. Educate the public about the need for etiologic research on nutrition, obesity, and physical activity and cancer.

## **Chapter 7: Ultraviolet Radiation and Skin Cancer**

**Goals:**

- **Prevent increases in mortality from melanoma cancer.**
- **Increase utilization of sun-safe behaviors.**

***Targets for Change:***

**By 2008, maintain the mortality rate from melanoma of the skin at a rate of no more than 2.7 per 100,000 persons in Maryland. Maryland Baseline: 2.7 per 100,000 in 2000 (age-adjusted to the 2000 US standard population).**

*Source: Maryland Division of Health Statistics*

**By 2008, increase the percent of Maryland adults to 71% who use at least one of the following sun protective measures: avoid sun from 10AM-4PM, wear sun protective clothing, or wear sunscreen. Maryland Baseline: 59% in 1998.**

*Source: BRFSS*

## **Objective 1: Increase public awareness about sun safety and skin cancer.**

### **Strategies:**

1. Formulate and disseminate an appropriate educational message for the general public about melanoma and skin cancer prevention. The message should include a recommendation about sun-safe behaviors including:
  - Proper use of a sunscreen that is SPF 15 or higher, including the need for 1 ounce per application, application 20 minutes before exposure, and reapplication every 2 hours or after swimming or excessive sweating
  - Avoidance of the sun during peak hours and wearing protective clothing, hats, and sunglasses
  - Avoidance of artificial UV light sources such as tanning beds
2. Form partnerships with youth service providers and organizations, including preschools, child care providers and facilities, Girl Scouts, Boy Scouts, 4H, and other youth recreation and sports organizations.
3. Form partnerships with occupational organizations to address sun-safety behavior and skin cancer awareness among persons whose occupations require them to work outdoors.
4. Form partnerships with organizations and individuals who routinely see and care for their clients' skin (such as barbers, hairdressers, cosmetologists, manicurists, and massage therapists) to promote non-traditional avenues for sun safety and skin cancer education.
5. Inform the general public about the Maryland State Department of Education Guidelines that:
  - a. Allows use of sunscreen by students.
  - b. States that sunscreen is not considered a medication and therefore students may keep it with them during the day.
  - c. Advocates use of sun-safe clothing, including the use of wide-brimmed hats (for all ages).
  - d. Advocates placement of play equipment in shaded areas when possible.
  - e. Recommends use of safety sunglasses that provide 100% protection from the sun (for all ages).

## **Objective 2: Increase physician awareness about sun safety and skin cancer.**

### **Strategies:**

1. Increase educational opportunities for health care providers, especially pediatricians, regarding the need for skin cancer prevention and early detection.
2. Develop CME programs to teach skin cancer recognition and how to educate patients about skin self-exams and sun protection.

3. Educate health care providers that melanoma may occur in African Americans, particularly on the palms, soles of feet, and under nails.
4. Encourage health care providers to perform skin exams during each routine physical exam.
5. Develop a Medical Advisory Committee and Minimal Clinical Elements guidelines to address melanoma in local public health programs.
6. Explore the possibility of using telemedicine to supplement the low availability of dermatologists within rural and underserved areas.
7. Encourage dermatologists to participate in annual public skin screenings.
8. Develop and fund a pilot program including the development of a medical school curriculum component such as “How to perform a skin cancer screening exam and what to look for.”
9. Encourage health insurers to adequately reimburse health care providers for full skin exams.

**Objective 3: Increase the number of melanoma cancers diagnosed at an early stage.**

**Strategies:**

1. Increase performance of skin exams during routine physical exams.
2. Educate the public about the need for regular skin self-exams.

**Objective 4: Develop improved data to document the prevalence of skin cancer examinations and appropriate diagnosis and follow-up of melanoma and other skin cancers in Maryland.**

**Strategies:**

1. Increase data collection relating to basal and squamous cell skin cancers and melanoma in Maryland.
2. Implement steps to document survival rates for melanoma and skin cancers in Maryland.
3. Improve reporting of diagnostic results to the Maryland Cancer Registry to reduce the number of unstaged cases of melanoma in Maryland.
4. Expand data collection related to skin cancer prevention and screening practices.

**Objective 5: Implement policy changes to increase the use of sun-safe behaviors, particularly among youth in Maryland.**

**Strategies:**

1. Model legislation in Maryland based on Texas law HB663 which requires the posting of warning signs in tanning salons, and regulates their use by those under the age of 18, as follows:
  - a. Children under the age of 13 – not allowed to use unless prescribed by physician
  - b. Children ages 13 to 15 – must be accompanied by parent/guardian
  - c. Children ages 16 and 17 – written consent by parent/guardian

2. Explore the need for policy changes to allow for the use of sun-protective clothing, including hats, by students while at school.
3. Provide funding for provision of shade structures at Maryland schools and other facilities serving youth organizations.

## **Chapter 8: Environmental Issues and Cancer**

**Goal: Improve prevention of environmentally related cancers through:**

- **Better evaluation of existing cancer prevention programs.**
- **Increased knowledge of environmental and occupational carcinogen exposures among scientists, health agencies, and the public.**
- **Increased efforts to reduce exposures to environmental carcinogens.**
- **Increased surveillance of occupational cancers.**
- **Improved links between academic research institutions and state and local health departments.**
- **Increased efforts to control infections known to increase cancer risk.**
- **Increased efforts, including community involvement, toward programs designed to identify and address factors contributing to cancer disparities.**

***Targets for Change:***

**By 2008, improve the quality, utility and use of databases for environmental carcinogens that will enhance exposure assessment.**

**By 2008, improve the capacity to measure bioindicators, measure the levels of compounds in the environment, and use other means to estimate environmental exposures at the population level.**

**By 2008, strengthen the practice of dual appointments or establish other formal cooperative relationships between academic institutions and state and local public health agencies.**

**By 2008, improve the capacity to identify and prevent occupationally-related cancer.**

**Objective 1: Improve cancer prevention program evaluation.**

**Strategies:**

1. Create a primary prevention committee within the State Council on Cancer Control to ensure that environmental as well as lifestyle issues receive appropriate attention.

2. Support efforts to measure the effectiveness of primary prevention programs and policies, including their impact on toxic exposures and cancer.

**Objective 2: Improve data collection and carcinogen exposure assessment.**

**Strategies:**

1. Explore ways to improve regulatory data collection efforts for cancer hazard assessment and tracking.
2. Support the development of an environmental health tracking system in Maryland.
3. Improve the accessibility and utility of environmental-monitoring data by computerizing databases and geo-coding data.
4. Enhance the capacity of state public health and other laboratories to test for the presence of environmental agents and related biomarkers in urine, blood, and other tissue samples.
5. Explore approaches for the expanded monitoring of commercial and noncommercial pesticide use.
6. Expand the capacity of the state to monitor ambient air toxics.
7. Support the development of a strategy for comprehensive, private well water testing and monitoring.

**Objective 3: Improve information regarding occupational risk factors for cancer.**

**Strategies:**

1. Explore opportunities for matching employee databases (from specific industries, trade organizations, etc.) with the state's cancer database in order to better characterize the role of occupation in cancer.
2. Establish an interdisciplinary task force to develop recommendations for occupational cancer investigations in Maryland.

**Objective 4: Enhance collaboration between academic research institutions and state and local public health departments.**

**Strategies:**

1. Develop a formal and adequately funded linkage between academic and government resources to bring their respective teaching, research, and practice agendas in sync with one another. Explore models to make this happen in both the short and long term.
2. Develop a contingency plan for responding to citizen concerns regarding possible cancer clusters that cannot be appropriately handled via routine risk communication and statistical analysis; this plan should include specific contact individuals at local universities.
3. Promote the training of physicians and environmental scientists in occupational and environmental cancer research at Maryland's universities and institutions.

4. Promote the sharing of expertise between the research and practice communities through joint programs such as a “Grand Rounds in Environmental Health” series.

**Objective 5: Improve recognition and screening for cancers associated with infectious agents**

**Strategies:**

1. Encourage screening for human papilloma viruses (HPV) and support efforts to develop a vaccine for HPV.
2. Promote immunization for Hepatitis B virus.
3. Support stronger efforts to control blood-borne infections.
4. Consider a recommendation that encourages physicians to test for and treat *Helicobacter pylori* infection in accordance with the American College of Gastroenterology practice guidelines.
5. Promote implementation of guidelines from the National Institutes of Health (NIH) and CDC for the control of Hepatitis C.

**Objective 6: Reduce the differences in cancer rates attributable to socioeconomic status or racial status.**

**Strategies:**

1. Develop a comprehensive public participation plan as a component of the state’s cancer control initiative.
2. Create community environmental health characterizations or profiles that may be used to support decision-making, priority setting, and the focusing of limited resources in order to best limit exposures and increase accessibility to better preventive health care.
3. Undertake comparative research to better understand and explain different cancer rates between groups.
4. Support community health centers and technical assistance in local communities in order to increase cancer screening and awareness of environmental health issues.
5. Make healthcare services more culturally acceptable and appropriate.
6. Enhance the community planning and zoning processes to reduce health risks by reducing exposures.
7. Continue efforts to document differences in cancer rates among different regions and populations.

## Chapter 9: Colorectal Cancer

### Goals:

- Reduce colorectal cancer mortality.
- Reduce disparities in the incidence and mortality of colorectal cancer.

#### *Targets for Change:*

**By 2008, reduce the colorectal cancer mortality to a rate of no more than 20.8 per 100,000 persons in Maryland. Maryland Baseline: 23.9 per 100,000 in 2000 (age-adjusted to the 2000 U.S. standard population).**

*Source: Maryland Division of Health Statistics*

**By 2008, decrease the percentage of Marylanders aged 50 and over who have *never* been screened for CRC to 15% or less. Maryland Baseline: 25.6% in 2002.**

*Source: Maryland Cancer Survey*

**By 2008, increase the percentage of Marylanders aged 50 and over who are up to date with screening (per ACS guidelines) to 73% or more. Maryland Baseline: 63% in 2002.**

*Source: Maryland Cancer Survey*

**By 2008, increase the percentage of Marylanders aged 50 and over who have been screened with either colonoscopy in the past 10 years or FOBT in the past year, plus flexible sigmoidoscopy in the past 5 years, to 57% or more. Maryland Baseline: 47% in 2002.**

*Source: Maryland Cancer Survey*

**Objective 1: Increase the rate of screening for colorectal cancer of those aged 50 and older by increasing the public’s knowledge of colorectal cancer risk factors, symptoms, screening recommendations, and options.**

**Strategies:**

1. Develop “appropriate” messages and use appropriate educational channels for CRC screening recommendations. Messages should be available in various languages and should reach both genders those of different racial, ethnic, and cultural backgrounds, and those with varying literacy levels.
2. Specifically target these messages to people aged 50 and older and to those at increased risk (i.e., those with a family history of CRC or adenomatous polyps in first degree relatives and those with a personal history of inflammatory bowel disease, endometrial cancer, or ovarian cancer).
3. Disseminate information about the availability of insurance coverage for CRC screening.
4. Educate and encourage the public to ask their health care providers about CRC screening and to ask their health insurers about coverage for such screening.
5. Use role models, cancer survivors, community groups, and people who have been screened to reach target audiences.
6. Evaluate the effectiveness of educational messages.
7. Measure the public’s knowledge, attitudes, beliefs, and practices through the Maryland Cancer Survey and BRFSS (e.g., by adding/modifying questions as needed), focus groups, surveys of outreach workers, etc.

**Objective 2: Clarify myths and dispel fears about colorectal cancer related to appropriate screening and prevention methods**

**Strategies:**

1. Develop a committee to focus on education and information that will explore myths, perceptions, and facts surrounding CRC, and methods to dispel myths.
2. Support educational messages that dispel myths identified in focus groups or by outreach workers.
3. Use role models, cancer survivors, community groups, and people who have been screened to reach target audiences.
4. Establish “Patient Navigators” in community-based organizations to help dispel myths, give factual information, and overcome language, literacy, and cultural barriers.

**Objective 3: Increase the knowledge of primary care providers (including family physicians, internists, and gynecologists) of appropriate colorectal cancer screening recommendations, and increase the proportion of providers who recommend or provide screening for colorectal cancer.**

**Strategies:**

1. Examine the current knowledge, attitudes, beliefs, and practices of providers.
2. Support collaboration among community organizations and programs to have one consistent message regarding screening.
3. Develop, promote, and evaluate appropriate messages regarding CRC screening recommendations for providers to share with their patients. For example:
  - a. Discuss CRC screening with every patient aged 50 years and older and those at risk.
  - b. Discuss available screening methods.
  - c. Support colonoscopy as the method of choice for all who have no identified contraindications.
  - d. Discuss informed consent when discussing screening.
  - e. Make information accessible to those with low literacy levels and those with cultural and linguistic barriers.
4. Offer continuing medical education (CME) credits for education on CRC.
5. Discuss CRC at MedChi and other medical and nursing association meetings and conferences.
6. Develop a risk assessment tool to help providers and patients choose the most appropriate screening test.
7. Develop CRC screening reminder systems for provider offices.
8. Develop communication formats to convey the message and the meaning of informed decision-making.
9. Use role models or real-life examples of how practices have increased screening rates among their clients.
10. Encourage providers to volunteer as “test cases” for record review to monitor their implementation of CRC screening.
11. Monitor providers by adding CRC screening as a HEDIS (Health Plan Employer Data and Information Set) measure.

**Objective 4: Increase the trust of the public in the health care system.****Strategies:**

1. Involve community groups to spread the message about the importance of early screening.
2. Use role models, cancer survivors, and outreach workers to target minority or other underserved populations for screening. Utilize people who were successfully screened in this effort.
3. Use members of the community in planning and implementing CRC education and screening programs.
4. Hold a public forum for health care providers, insurers, and the community regarding CRC.
5. Involve the clergy, Ministerial Alliance, community-based organizations, and provider groups, such as the Monumental Medical Society, in developing and delivering educational messages about CRC.

**Objective 5: Promote health insurance coverage for colorectal cancer screening methods that are appropriate for each individual.**

**Strategies:**

1. Amend Maryland's current legislation to make it explicit that insurers should cover the screening procedure that a health care provider orders.
2. Distribute information on the cost-benefit of screening to CEO's of health insurance agencies, legislators, and decision-makers of benefits packages for large groups.
3. Encourage patients to advocate for insurance coverage of CRC screening when negotiating for health benefits, e.g., when union contracts are negotiated.
4. Work to encourage and support top management and businesses that provide screening coverage as part of health insurance packages.

**Objective 6: Overcome barriers to screening, including difficult pre-procedure colonic preparation, transportation issues, scheduling and timing issues including conflict with work schedules, living alone, etc.**

**Strategies:**

1. Have patient advocates and case managers within local health departments, community based organizations, churches, and hospitals assist with overcoming barriers.
2. Provide flexible scheduling for colonoscopies such as after-hours clinics or weekend hours.

**Objective 7: Ensure that patients with insurance coverage for colorectal cancer screening are screened.**

**Strategies:**

1. Encourage companies/employers to educate workers on the importance of screening and the availability of CRC screening coverage under their health care plan.
2. Disseminate messages to the public regarding the importance of understanding their medical insurance coverage for CRC screening.

**Objective 8: Increase available funding to pay for diagnosis and treatment for all who are screened and found to need additional care.**

**Strategies:**

1. Explore the feasibility of initiating and funding a statewide program to pay for diagnosis and treatment of CRC, similar to the Breast and Cervical Cancer Diagnosis and Treatment Program.

**Objective 9: Overcome language, literacy, and cultural barriers in health care provider's offices.**

**Strategies:**

1. Hold cultural competency training and develop educational materials for providers.
2. Educate providers regarding cultural diversity, literacy, and cultural sensitivity as part of the knowledge base for informed consent.
3. Hire advocates and case managers in community-based organizations.
4. Hire multilingual outreach workers in all medical facilities.
5. Have providers reimbursed for time spent overcoming language and cultural barriers (e.g., payment for Language Line).

**Objective 10: Increase funding for colorectal cancer screening among uninsured, low-income Maryland residents, especially in Baltimore City.**

**Strategies:**

1. Maintain funding from the Cigarette Restitution Fund for the jurisdictions currently funded.
2. Initiate a CRC screening program in Baltimore City and secure more funding for screening uninsured residents.

**Objective 11: Ensure that there are sufficient providers to perform colonoscopy and/or sigmoidoscopy for all who require the procedures in Maryland.**

**Strategies:**

1. Assess the degree to which colonoscopy and sigmoidoscopy availability is a problem in Maryland.
2. Have providers perform colonoscopy or flexible sigmoidoscopy in alternative settings such as a mobile unit (Scope-mobile) or freestanding medical centers.
3. Set minimum standards for the number of sigmoidoscopies or colonoscopies that a provider needs to perform each year.
4. Examine the role of nurse practitioners in providing exams, including colonoscopy and flexible sigmoidoscopy.

**Objective 12: Ensure that there are sufficient providers who can perform initial physicals and clearance examinations for the uninsured, accept low-income clients and clients with Medicare and Medical Assistance, and have flexible hours necessary to working patients.**

**Strategies:**

1. Examine providers' attitudes and practices.
2. Determine the current availability of night and weekend hours to patients.
3. Examine the role of nurse practitioners in providing exams, including colonoscopy and flexible sigmoidoscopy.

**Objective 13: Communicate the importance of primary prevention of colorectal cancer through healthy lifestyles. (Please refer to the Goals, Objectives and Strategies in Chapter 6 on diet and physical activity.)**

## Chapter 10: Breast Cancer

### Goals:

- Reduce the incidence of breast cancer in Maryland.
- By 2008, reduce the proportion of the number of late stage breast cancers diagnosed in all women, and especially reduce the rates of late diagnosis in African-American women to that of white women.
- Assure that all women who develop breast cancer are diagnosed with Stage 1 disease with <1 cm tumors;
- Research factors contributing to high incidence and mortality rates in Maryland and develop appropriate interventions (e.g., conduct a case-control study to compare Maryland's Delmarva region to low mortality regions in the United States and examine for possible explanatory factors).
- Ensure access to prevention, screening, treatment, and follow-up care for all Maryland residents.
- Preserve the Cigarette Restitution Fund (CRF) for addressing health issues in Maryland.

### *Targets for Change:*

**By 2008, reduce the female breast cancer mortality to a rate of no more than 23.2 per 100,000 females in Maryland. Maryland Baseline: 27.7 per 100,000 in 2000 (age-adjusted to the 2000 U.S. standard population).**

*Source: Maryland Department of Health Statistics*

**By 2008, increase the number of women age 40 and older that have received a mammogram in the past two years to 85%. Maryland Baseline: 82% in 2000.**

*Source: BRFSS*

**Objective 1: Determine why Maryland has high breast cancer incidence and mortality rates compared to other states in the nation.**

### Strategies:

1. Conduct research to determine what factors are associated with increased incidence, late stage diagnosis, and mortality in Maryland.
2. Intervene on those factors associated with high incidence, high mortality, and late stage breast cancer that can be modified.
3. Maintain and expand the Maryland Cancer Registry in order to identify problems, conduct research, and evaluate the effectiveness of interventions.
4. Explore the possibility of providing open access to the CRF for research and interventions to all health related organizations in the state.

**Objective 2: Continue to monitor breast cancer prevention research and promote activities to prevent breast cancer.**

**Strategies:**

1. Assess existing interventions and conduct multifaceted interventions to reduce obesity and increase physical activity, known factors associated with the risk of breast cancer. Interventions should cover all age groups, including children as well as adults.
2. Create a primary prevention committee within the State Council on Cancer Control to ensure that cancer prevention issues receive appropriate attention.
3. Develop and conduct interventions to promote other factors associated with a lower risk of developing breast cancer, such as breast-feeding.
4. Provide risk-based literature that is culturally and ethnically appropriate.
5. Provide access to breast cancer prevention trials to all Maryland residents.

**Objective 3: Increase breast cancer risk assessment and risk-appropriate strategies.**

**Strategies:**

1. Conduct research to determine what individuals and providers know about breast cancer risk assessment and management and their current practices related to risk assessment and management.
2. Educate providers and women about assessing breast cancer risk and risk-appropriate management options.
3. Determine mechanisms to promote the practice of breast cancer risk assessment.
4. Conduct research to determine the prevalence of high-risk groups.
5. Evaluate and ensure access to counseling and care for high-risk groups (regardless of race, ethnicity, SES, etc.), including genetic counseling and testing, counseling regarding chemoprevention and access to medications, and other risk management options such as prophylactic surgery.
6. Provide culturally appropriate risk assessment materials to providers for their practices.
7. Create centers throughout the state so that all residents have access to information on breast cancer risk, prevention interventions, and specialized services for high-risk groups (regardless of race, ethnicity, SES, etc.).

**Objective 4: Ensure continued access to early detection and treatment of breast cancer.**

**Strategies:**

1. Continue federal and state funding for the breast cancer early detection and treatment program.

2. Develop culturally appropriate education and outreach activities appropriate to the various and diverse population groups in the state.
3. Provide all residents with access to breast cancer treatment trials.

**Objective 5: Increase the number of providers that perform minimally invasive biopsy techniques.**

**Strategies:**

1. Evaluate patterns of care across regions and racial groups.
2. Educate providers and patients regarding minimally invasive biopsy techniques.
3. Facilitate utilization of minimally invasive techniques.

**Objective 6: Promote optimum state-of-the art breast cancer care for all breast cancer patients without differences based on region, race, age or other disparities.**

**Strategies:**

1. Utilize the Maryland Cancer Registry Data to evaluate patterns of care by region, race, and age and to provide performance evaluation to providers.
2. Educate providers to improve their patients' access to care.
3. Educate the public and providers on standards of care.
4. Develop culturally sensitive materials about breast cancer treatment options.
5. Encourage insurance companies to compensate providers for case management services.

**Objective 7: Increase the number of individuals with Ductal Carcinoma in Situ (DCIS) and early stage breast cancer that receive treatment appropriate for their diagnosis.**

**Strategies:**

1. Implement state-of-the-art treatment for women with DCIS and early stage breast cancer in order to avoid both over-treatment and under-treatment of breast cancer.
2. Promote research to more accurately identify patients with early stage disease that will most likely progress, in order to better tailor therapy.
3. Determine if risks/benefits, including long-term risks, of therapy are adequately discussed with patients.
4. Develop risk/benefit fact sheets for patients with DCIS and early stage breast cancer.

**Objective 8: Provide breast cancer survivors with information regarding the long-term effects of treatment.**

**Strategies:**

1. Conduct research to determine the long-term effects of treatment.

2. Conduct research to determine providers' knowledge of long-term treatment effects and practices regarding discussion of effects with patients.
3. Develop "standards of care" for long-term survivors and educate patients and providers regarding these standards.
4. Educate patients and providers about long-term effects of breast cancer treatment.
5. Develop and evaluate models for long-term care incorporating prevention of new cancers, recurrence of breast cancer, prevention and screening for other cancers, and potential long-term effects of treatment.

## Chapter 11: Prostate Cancer

### Goals:

- **Reduce prostate cancer mortality.**
- **Reduce disparities in the mortality of prostate cancer.**
- **Monitor the proportion of men who have had a PSA test and a digital rectal examination.**

### *Target for Change:*

**By 2008, reduce prostate cancer mortality to a rate of no more than 25.8 per 100,000 persons in Maryland. Maryland Baseline: 31.9 per 100,000 in 2000 (age-adjusted to the 2000 U.S. standard population).**

*Source: Maryland Division of Health Statistics*

### **Objective 1: Increase public education about prostate cancer.**

#### **Strategies**

1. Formulate educational messages about prostate cancer.
2. Educate African-American men and men with a family history of prostate cancer in a first degree relative about prostate cancer and what is known about prostate cancer prevention and early detection.
3. Assure that educational materials take into account cultural differences when developing and implementing educational interventions.

### **Objective 2: Continue to monitor research findings regarding the effectiveness of primary and secondary prevention interventions in reducing prostate cancer mortality.**

#### **Strategies:**

1. Interpret and translate research findings regarding primary and secondary prevention to the public.

2. Promote a healthy diet and active lifestyle as a general guide to good health.

**Objective 3: Promote informed decision-making prior to screening with PSA and digital rectal examination.**

**Strategies:**

1. Disseminate the Minimal Elements for Prostate Cancer Education, Screening, Diagnosis, Treatment and Follow-up developed by the Prostate Cancer Medical Advisory Committee of DHMH to health care providers who screen men for prostate cancer.
2. Convey the benefits and risks of screening to health professionals, community leaders, the general public, and men to be screened.
3. Encourage documentation of informed consent prior to prostate cancer screening.
4. Develop questions regarding informed decision-making for prostate cancer screening to add to the Maryland Cancer Survey in order to measure the extent to which providers are discussing the benefits and risks of prostate cancer screening with men.
5. Promote the use of the “Minimal elements for information, screening, diagnosis, treatment and follow-up” guidelines for all prostate cancer screenings that take place outside of a physician’s office.

**Objective 4: Promote education about prostate cancer treatment and support services for patients diagnosed with prostate cancer.**

**Strategies:**

1. Educate patients about prostate cancer treatment options, including watchful waiting.
2. Educate men that they may seek a second opinion from various specialists after diagnosis regarding different treatment options.
3. Educate patients about their right to ask questions regarding the expertise of the provider in treating prostate cancer (e.g. the number of procedures performed, complication rates, etc.)
4. Disseminate information about support groups and other resources for patients diagnosed with prostate cancer and their loved ones.
5. Encourage support for prostate cancer patients throughout treatment.
6. Advocate for funding for the treatment of uninsured patients diagnosed with prostate cancer.

**Objective 5: Monitor research in primary, secondary, and tertiary prevention.**

**Strategies:**

1. Educate men about what it means to participate in clinical trials and observational research in all areas of prostate cancer.

2. Encourage prostate cancer research in primary, secondary, and tertiary prevention, including but not limited to the following:
  - Benefits of screening.
  - Differences in screening in a clinical versus non-clinical setting
  - Improved sensitivity and specificity of screening tools to detect aggressive tumors early and to distinguish those tumors from changes that are not clinically significant.
  - Psychosocial aspects of prostate cancer.
  - Biochemical failure after apparent cure of prostate cancer.
  - Increased focus on minority men and high-risk groups to determine how culture affects screening and treatment decisions.
  - Promotion of accurate health messages and research findings to the general public.
  - Why African-American men are diagnosed at later stage of disease.
  - Risk factors for primary prevention of prostate cancer.

## Chapter 12: Oral Cancer

### Goals:

- **Reduce oral cancer mortality.**
- **Reduce disparities in the incidence and mortality of oral cancer.**

### *Targets for Change*

**By 2008, reduce the oral cancer mortality to a rate of no more than 2.4 per 100,000 persons in Maryland. Maryland Baseline: 3.0 per 100,000 in 2000 age-adjusted to the 2000 U.S. standard population).**

*Source: Maryland Division of Health Statistics*

**By 2008, increase the proportion of adults 40 and older who have had an oral cancer exam in the past year to 48%. Maryland Baseline: 33.9% in 2002**

*Source: Maryland Cancer Survey*

### **Objective 1: Increase oral cancer literacy among Marylanders.**

#### **Strategies:**

1. Provide education to promote an understanding and awareness of oral cancer risk assessment and reduction, risk factors and behaviors, signs and symptoms, and the rudiments and frequency of adequate and timely oral cancer examinations to the public, health care providers, the media, and policy makers.

2. Provide specific educational messages to individuals who have risk factors and to individuals who may choose to engage in high-risk behaviors in the future.
3. Use the media to provide culturally relevant and age-specific oral cancer literacy messages to the public at large. Consider public service announcements, paid advertisements, as well as various forms of media coverage including television, radio, and print.

**Objective 2: Increase provider education and training related to oral cancer prevention and early detection.**

**Strategies:**

1. Require all currently practicing medical, nursing, and dental professionals to complete continuing education focused on oral cancer prevention and early detection (how to perform an oral cancer examination and tobacco cessation/intervention). This continuing education must be completed before the issuance of medical or dental licensure renewal.
2. Require all medical, nursing, and dental students to complete a cancer comprehension module that includes a test of proficiency in performing oral cancer examinations before receiving licensure.
3. Promote the inclusion of oral cancer prevention and examination training in all health care educational curricula.
4. Ensure that all health care providers adequately identify and assess patients with high-risk oral cancer behaviors.

**Objective 3: Increase public access to oral cancer prevention, early detection, and treatment services.**

**Strategies:**

1. Provide an information clearinghouse for practitioners and patients regarding medical and/or dental coverage for smoking cessation, screening, testing, diagnosis, and treatment of oral cancer and related procedures.
2. Determine costs and payors for oral cancer treatments.
3. Develop a central state information resource for referral and case management of individuals with abnormal oral cancer examination results.
4. Provide uniform, functional dental coverage for adults within the Maryland Medicaid program that ensures an annual oral cancer examination and required follow-up care, if needed.
5. Provide case management and additional resources for uninsured and undocumented patients.
6. Promote coverage for all medically necessary dental procedures under private insurance plans, Medicare, and State Medicaid and managed care organizations.

7. Provide targeted education to individuals diagnosed with oral cancer or a pre-cancerous lesion regarding how to access services and the importance of decreasing risk behaviors.
8. Encourage private dental insurance companies, state Medicaid plans, and managed care organizations to honor coverage and adequate reimbursement of Tobacco Counseling for the Control and Prevention of Oral Diseases.
9. Revise the current forms needed for accessing the health care system into a format that is easily understood by the majority of the general public by taking into account low literacy and language barriers.
10. Develop a model for oral cancer patient navigators to assist patients in navigating the health care system upon diagnosis with oral cancer.

**Objective 4: Increase scientific knowledge regarding oral cancer.**

**Strategies:**

1. Provide funding for research into all aspects of oral cancer prevention, early detection, and treatment.
2. Promote research in the following areas:
  - Practice patterns
  - Screening efficacy
  - HPV and other viral etiology as risk factors for oral cancer
  - Evaluation of existing programs
  - Stage of disease at diagnosis
  - Diagnosis patterns
  - Treatment and cures

**Objective 5: Maintain a centralized, statewide mechanism for support of oral cancer initiatives.**

**Strategies:**

1. Maintain and increase funding for the Maryland State Oral Cancer Prevention Initiative and the DHMH Office of Oral Health.
2. Promote collaboration among Maryland's professional schools to further oral cancer education and research.

## Chapter 13: Cervical Cancer

**Goal: Reduce cervical cancer mortality in Maryland.**

### *Targets for Change:*

**By 2008, reduce cervical cancer mortality to a rate of no more than 1.9 per 100,000 persons in Maryland. Maryland Baseline: 2.3 per 100,000 in 2000 (age-adjusted to the 2000 U.S standard population).**

*Source: Maryland Division of Health Statistics*

**By 2008, increase the number of women age 18 and older who have had a Pap test in the past three years to 94%. Maryland Baseline: 90% in 2000.**

*Source: BRFSS*

**Objective 1: Increase awareness in the general public of cervical cancer screening recommendations and availability of programs.**

#### **Strategies:**

1. Increase educational activities among all population groups as to the importance of regular screening.
2. Increase awareness of the availability of screening programs to the general public.
3. Develop culturally sensitive educational messages.
4. Partner with smoking cessation programs.
5. Focus educational and outreach programs on high-risk populations (e.g. recent immigrants, African American women, HIV-positive women).

**Objective 2: Increase cervical cancer screening in women who have not been screened in the last five years, especially older women, and increase compliance with recommended follow-up.**

#### **Strategies:**

1. Identify characteristics of women who may not have been screened in the past five years (e.g. examine changing demographics of the state population).
2. Increase outreach efforts to reach the underserved.
3. Provide low cost/easily accessible mechanisms for the screening of low-income individuals.
4. Encourage providers to have an organized mechanism to track patients, particularly those with high-grade lesions that fail to follow-up.
5. Focus screening and follow-up programs on high-risk populations (e.g. recent immigrants, HIV-positive women).

6. Encourage primary care providers to offer Pap tests or refer patients to providers who offer Pap tests, and then systematically track compliance to assure that their patients receive a Pap test.
7. Continue federal and state funding for the breast and cervical cancer early detection and treatment program.
8. Increase awareness of the availability of screening programs to providers.
9. Provide Pap tests to women seen in hospital inpatient or outpatient settings, including emergency rooms, and assure that a mechanism for follow-up is available.
10. Amend SB 59, Section 19-348 to “provide” Pap tests to all in-patients. Examine hospitals that succeed at providing Pap tests to inpatients. Share lessons learned at these locations with other hospitals.
11. Link Pap test performance or referral to physician re-certification from the Board of Physician Quality Assurance. Monitor providers by adding Pap testing as a HEDIS measure (Health Insurance Employee Data and Information Set).
12. Explore the feasibility of using a colposcopy van to provide colposcopy services to rural and underserved areas of the state.

**Objective 3: Assure that all providers have access to state-of-the-art guidelines for the management of cervical abnormalities.**

**Strategies:**

1. Disseminate management guidelines (ASCCP) to practitioners who care for women with cervical abnormalities.

**Objective 4: Assure access to medical care for all.**

**Strategies:**

1. Increase funding for health care centers that serve indigent women and include funding for staff to provide follow-up services.
2. Provide funding so that all women can obtain a Pap test and follow-up procedures regardless of insurance status.
3. Ensure access to prevention, screening, treatment and follow-up care for all Maryland residents.

**Objective 5: Conduct Maryland-specific surveillance research on barriers to cervical cancer detection and treatment by establishing a statewide follow-back study mechanism to allow for monitoring of failures through follow-back and to evaluate and modify intervention strategies.**

**Objective 6: Determine why there are discrepancies in survival among different segments of the state population, taking into account multiple factors including race and age.**

**Strategies:**

1. Conduct a follow-back study to determine the factors that contribute to women developing and/or dying from invasive cervical cancer. Identify factors that influence or hinder health seeking behaviors (e.g. screening, diagnosis, treatment) for the patient. Also identify factors within the health care system that influence screening, diagnosis, and treatment.
2. Establish and maintain mechanisms to monitor the proportion of cervical cancer cases and deaths attributable to failures of detection, and the proportion attributable to failures of treatment. Identify strategies and implement activities to minimize failures of detection and failures of treatment.
3. Explore whether alternative-screening techniques should be used for special populations.
4. Encourage research to determine why discrepancies in survival exist and what factors can be changed to erase such discrepancies.

## **Chapter 14: Pain Management**

**Goal: Increase awareness of, and access to, comprehensive pain assessment and management services for all cancer patients in Maryland in light of the current public health crisis of inadequate pain control.**

***Target for Change:***

**By 2008, develop a system to monitor the availability and quality of pain assessment and management services for cancer patients in Maryland, with specific attention to the needs of special populations, including pediatrics and minorities.**

**Objective 1: Increase provider awareness and training regarding appropriate cancer pain assessment, management, and relevant regulatory issues.**

**Strategies:**

1. Provide cancer pain management education to all target audiences, which include, but are not limited to, health care systems, licensing boards (including investigators), professional organizations, ethics committees, Ombudsmen, state surveyors, regulators, and reviewers, Inspector General, Insurance Commission, Attorney General, criminal justice officials, medical examiners, and insurers.

2. Require all cancer health care providers (including, but not limited to, physicians, nurses, and pharmacists) to earn continuing education credits in the area of cancer pain assessment and management before license renewal.
3. Health care students in all disciplines should receive both didactic and clinical training in cancer pain assessment and management standards before receiving licensure. This training includes, but is not limited to, disparity issues in cancer pain management and topics related to licensure and cancer pain control as well as drug utilization and surveillance utilization review. The educational curriculum should be assessed by pain management experts, use multiple educational formats, and be accompanied by an assessment of knowledge and competency on an ongoing basis.
4. Each licensing board should develop a statement about their discipline's role in cancer pain assessment and management, including minimum competencies and education requirements. Such documents should be developed with the input of pain specialists and address issues of pain management and licensure. Providers should be required to view the statement prior to licensing or reciprocity. The statement should be broadly available including via electronic media and accompanied by practitioner educational efforts.
5. Professional licensing boards should be encouraged to treat transgressions of untreated or under-treated cancer pain aggressively. Appropriate remedial education should be made mandatory prior to actions against a practitioner's professional license.
  - Evidence-based guidelines (e.g. Federation of State Medical Boards guidelines) and pain experts should be used by licensing boards and the state drug enforcement agency to investigate cancer pain or analgesic-related issues.
6. New policy and legislation relevant to cancer pain assessment and management should be accompanied by educational initiatives targeting appropriate audiences.
7. Increase provider awareness of scientifically validated complementary and alternative cancer pain therapies, and encourage providers to discuss these therapies with their patients.

## **Objective 2: Increase provider reimbursement for cancer pain therapies.**

### **Strategies:**

1. Recommend that insurers in Maryland provide a uniform pain assessment and management benefit for all age and income groups that would include, but would not be limited to:
  - Inpatient and outpatient referral to a pain specialist for pain assessment and treatment planning, short and long-term multimodal treatments, and follow-up, including management of side effects.
  - Follow-up by licensed health care professionals including non-prescribers (e.g., home health nurses, clinical specialists) to provide education, assess adherence, and work with the patient and his/her caregivers and the prescriber to maximize pain management therapy.
  - Uniform minimal reimbursement for pharmacologic and scientifically based non-pharmacologic pain management therapies regardless of therapeutic medication class, choice of drug or therapy, method of medication delivery (i.e., route), site of service, or disease phase. Therapeutic interventions to manage pain including palliative pain interventions (chemotherapy, radiation therapy, and radioisotope therapy), pharmacologics (long- and short-acting analgesics, adjuvants, and side-effect medications), non-pharmacologics (e.g., physical therapy, acupuncture, and behavioral interventions), interventional procedures (e.g., temporary and permanent nerve blocks) and associated durable medical equipment, should be included in uniform minimal reimbursement standards.
  - In the development of this mandated benefit, consideration should also be given to the following items:
  - Minimizing drug premiums and co-pays while keeping the benefit sustainable and attractive
  - Assuring uniformity of coverage across the Medicare and Medicaid programs and coordination of benefits between these programs, including hospice.
  - The components and effect of Medicaid drug utilization review (e.g., the impact of regulations regarding limiting drug quantities, refills, co-payments, the number of allowed prescriptions per month, and pharmacy dispensing fees; provider prescribing practices; referrals to Medicaid Fraud Control Units or Surveillance and Utilization Review programs)
  - Facilitating seamless, timely, and adequate reimbursement of claims
  - Rapid assessment of new therapies by a team of pain experts for inclusion in minimum uniform coverage benefit

2. Extend assistance for payment for pain therapies for patients at or below 250% of the federal poverty level.
3. Encourage insurers to offer a discount on malpractice insurance for providers who have completed continuing education in the area of cancer pain assessment and management and demonstrate competency in this field.
4. Advocate for reimbursement of scientifically validated complementary and alternative pain therapies by insurance companies.
5. Insurance contracts should be required to specifically provide current and prospective plan subscribers with information about the pain management services provided by the plan.

**Objective 3: Increase consistency among different health care systems regarding compliance and adherence to standards for cancer pain assessment and management.**

**Strategies:**

1. Develop and test an external source of norms to which all health care facilities assessing or treating cancer patients in pain would be held accountable. Licensed health care facilities not accredited by the JCAHO (e.g., extended care facilities, nursing homes, freestanding radiation oncology centers, hospices, home health agencies, pain clinics) should be held to pain assessment and management standards similar to JCAHO standards by the applicable state licensing agency. Financial reimbursement should be tied to meeting these quality standards.
2. Reduce limitations to prescribing cancer pain medications (e.g., specific dose required instead of a dose range) and medications for side effects (e.g., use of haloperidol for nausea and vomiting) in extended care facilities.
3. Promote institutional scrutiny for disparity-related cancer pain management issues.
4. Information about a patient's cancer pain management regimen should be transferred with any discharge or transfer of care.
5. Develop standardized definitions of service scope for cancer pain specialists and cancer pain treatment centers.
6. Promote the use of population specific, standardized, reliable, valid, cancer pain assessment tools. Special consideration should be given to the effect of cancer pain on patient function and to patients with limited ability

to communicate or advocate for themselves (e.g., children, people with language barriers, patients with dementia).

**Objective 4: Eliminate barriers due to cultural, age, gender, and income disparities and ensure equal access to cancer pain management therapies within the health care system.**

**Strategies:**

1. Convene an independent committee to improve and accelerate the process relative to prior authorization of non-formulary medications and invasive techniques used in cancer pain management. The committee should work to reduce excessive co-payments for non-formulary medication if the non-formulary medication provides the best results for a particular patient.
2. Pharmacies should be required to have pain management medications, particularly opioids, readily available for patients.
3. Ensure that excessive restrictions do not exist on the amount of medication prescribed, prescription renewals, and telephone, fax, or other electronic prescription ordering of analgesics for cancer pain.
4. Encourage the establishment of multidisciplinary cancer pain treatment centers employing pain specialists in multiple health care disciplines.
5. Draft legislation that requires cancer patients with unrelieved pain to be referred to cancer pain specialists in a timely fashion and guarantees that information about cancer pain treatment plans is communicated between providers and institutions at the time of discharge or transfer.

**Objective 5: Increase scientific knowledge regarding assessment and treatment of cancer pain.**

**Strategies:**

1. Encourage and promote research in such areas as:
  - Cancer pain assessment tools, particularly for minority populations and populations that are unable to advocate for themselves because of limited communication skills.
  - Low-cost medications for cancer pain management (e.g., methadone).
  - Outcomes analysis (e.g., long term opioid use; opioid rotation, tolerance, and addiction; cancer pain quality tools for use by surveyors and accrediting organizations; and the financial as well as quality impact of recommendations made herein and associated legislative changes).
  - Cognitive, behavioral, complementary, and alternative cancer pain therapies.

- Guidelines for the assessment and management of specific types of cancer pain (e.g., neuropathic pain).
  - When to refer patients to cancer pain specialists and the accompanying credentials for certification of such specialists.
  - Pediatric cancer pain management.
  - Changing clinical practice and clinician's fear of regulatory scrutiny.
  - Improving patient adherence to cancer pain therapy.
  - Occurrence of cancer-related pain by cancer, stage, type of cancer pain, and other factors such as demographics and longitudinal trajectory.
  - Use of medical marijuana for cancer pain.
2. Encourage pharmaceutical companies to continue research and development of new treatments for the management of cancer pain.

**Objective 6: Increase public knowledge and awareness of cancer pain management practices and referral sources.**

**Strategies:**

1. Partner with organizations such as the American Cancer Society, the American Chronic Pain Association, the American Pain Foundation, and the Maryland Pain Initiative to conduct a comprehensive, statewide, and culturally sensitive public health campaign to promote cancer pain assessment and management. This effort should utilize public health strategies and include an educational media campaign. The message should include a focus on the patient's right to adequate cancer pain management and their health care provider's responsibilities in the process as well as their own responsibilities, dispel myths about pain medications, describe options that exist for cancer pain management, and instruct the public to communicate with their health care provider about cancer pain.
2. Provide culturally sensitive and language-appropriate cancer pain control information to all patients and/or their surrogate at the time of diagnosis and throughout their disease process. Consider the use of educational materials already in existence from organizations such as the American Cancer Society and National Cancer Institute. As part of this effort, develop a mechanism to disseminate standard, medically appropriate information on specific cancer pain medications and therapies to patients. Seek to inform patients and/or surrogates of options, alternatives, and potential outcomes and involve them in treatment selection.
3. New policy and legislation relevant to cancer pain assessment and management should be accompanied by educational initiatives targeting the general public.

4. Develop and make available in a variety of media a list of Maryland cancer pain resources including, but not limited to, pain specialists, pain experts, pain clinics, hospices, medical schools, and pain specialty consumer groups.
5. Develop, staff, and publicize a pain management hotline for cancer patients and health care providers.

**Objective 7: Enhance existing legislation and create new regulations designed to increase awareness of, and access to, comprehensive cancer pain assessment and management services for all cancer patients in Maryland.**

**Strategies:**

1. Revise the Advanced Directive and Living Will forms for clarity. Make the Power of Attorney (POA) form the lead form provided to cancer patients and consider eliminating the Living Will in favor of a revised Advanced Directive. Instructions should be written to strongly favor POA, supported with more specific guidance if the declarant wishes.
2. Modify state regulations to facilitate availability and prescribing of cancer pain medications.
3. Modify state regulations to mandate that insurers in Maryland provide a uniform cancer pain assessment and management benefit for all ages, income groups, phases of the disease trajectory and regardless of site of care (see objective 2).
4. Allocate funding to assist in the assessment of relevant new or existing statewide policies regarding their impact on cancer pain control.
5. Develop a Cancer Pain Patient's Bill of Rights based on a similar California bill (1997) CAHLTH & S 124960. This bill should include:
  - a. Some mechanism of enforcement.
  - b. A recommended course of action if an individual is denied cancer pain care.
  - c. A requirement for regular assessment and charting of cancer pain in physician offices, health care clinics, and licensed health care facilities.
  - d. A provision that licensed health care facilities as well as clinics, treatment centers, home health agencies, hospices, and physician offices adhere to an external cancer pain assessment and management standard that defines minimum practice and quality monitoring requirements.
  - e. A requirement for transfer of cancer pain-related information when care is transferred (e.g., at discharge, between providers, or among institutions).

- f. A requirement that patients receive an explanation of cancer pain management options, alternatives, and potential outcomes and are involved in treatment selection.
6. Provide funding for the educational initiatives put forth in this document.
  7. Provide regulatory structure and legislative support for policy initiatives put forth in this document.

(Note: Under-treatment of pain is a public health problem, regardless of the underlying etiology. Hence, the issues related to cancer pain apply to pain in general. Like all pain, cancer pain can be acute or chronic, assessment and management is often inadequate, and the related cultural and psychological issues and barriers are similar in both malignant and non-malignant pain conditions. Therefore, it is suggested that the recommendations in this chapter be extended to the management of acute and chronic pain and associated symptoms of non-malignant conditions so that all the citizens of Maryland, whether or not they have cancer, may benefit from the goals, objectives, and strategies suggested here.)

## **Chapter 15: End-of-Life Care**

**Goal: Increase the number of Maryland cancer patients, as well as their family members and friends, receiving quality end-of-life care and related services.**

***Target for Change:***

**By 2008, develop a system to monitor the availability and quality of end-of-life care services for cancer patients in Maryland, with specific attention to the needs of special populations including pediatrics and minorities.**

**Objective 1: Expand provider education and training related to end-of-life care.**

**Strategies:**

1. Require end-of-life education as part of core curriculum for ALL [JE: caps for emphasis] health care providers in training. Content areas should include, but not be limited to: aggressive symptom management; application and limits of life-prolonging interventions; prognostication, communications and conflict resolution; providing information and guidance on prognosis, options, and decision-making; sensitivity to cultural, religious, and other differences; understanding palliative and hospice services; understanding grief and loss issues; and sensitivity to the psychosocial and spiritual needs of patients and their family members and caregivers.

2. Require specialized end-of-life education for providers that care specifically for cancer patients (e.g., oncologists, primary care providers, social workers, chaplains, etc.) and specialized training for providers caring for pediatric oncology patients, recognizing the unique needs of children and their families at the end of life.
3. Promote membership in and support of organizations that work to improve end-of-life care.
4. Support organizations engaged in proactive outreach including end-of-life training of health care and insurance providers.

**Objective 2: Increase public awareness of end-of-life issues.**

**Strategies:**

1. Support organizations engaged in proactive outreach including community education and political advocacy on end-of-life issues.
2. Increase public awareness of existing end-of-life educational resources such as websites and hotlines.
3. Provide community based end-of-life education for minorities and underserved populations, including multilingual education campaigns and outreach.
4. Provide comprehensive end-of-life care educational resources in all oncology clinics, cancer centers, nursing homes, and assisted-living facilities and make this information readily available on corresponding websites.

**Objective 3: Improve access to end-of-life care for all Marylanders with specific attention to improving physician reimbursement for appropriate end-of-life care.**

**Strategies:**

1. a. Identify existing information about the end-of-life care needs of populations including pediatric, adult, and geriatric patients and special needs groups such as the developmentally disabled and minority populations. Develop additional data as needed to prepare a comprehensive needs assessment for these populations.
1. b. Develop and implement strategies to meet the needs identified in the above assessment.
2. Encourage the Centers for Medicare and Medicaid Services to implement pilot programs, with careful attention to the collection of data on both cost

and patient satisfaction, that would reimburse providers for a full range of palliative care services for patients with any type of cancer that frequently results in death, with no requirement that life expectancy be six months or less. The benefit should be available whether or not a patient continues to pursue therapies aimed at remission or cure.

3. Encourage the Maryland Medicaid Program to contract with managed care organizations to implement pilot programs, with careful attention to the collection of data on both cost and patient satisfaction, that would reimburse providers for a full range of palliative care services for patients with any type of cancer that frequently results in death, with no requirement that life expectancy be six months or less. The benefit should be available whether or not a patient continues to pursue therapies aimed at remission or cure.
4. Encourage the Maryland Insurance Commissioner to study industry compliance with Section 15-809 of the Insurance Article, which requires insurers and nonprofit health service plans to offer benefits for hospice care services, and take appropriate steps to remedy any noncompliance.
5. Support the development of tax credits for informal caregivers, such as family members and spouses, in an effort to alleviate the devastating financial burden of providing end-of-life care.
6. Increase provider reimbursement for the longer evaluations and more extensive management required for terminally ill patients. In addition, adequately reimburse health care professionals for time spent discussing advance care planning with patients.

**Objective 4: Enhance access to the continuum of end-of-life care services throughout the state.**

**Strategies:**

1. Enhance existing partnerships and create new ones among hospices and facilities such as hospitals, home care agencies, nursing homes, and assisted living facilities caring for patients with cancer and other terminal illnesses.
2. Promote the creation of palliative care teams in acute care settings.
3. Support the use of care managers to serve as a constant as patients and their families move among different care settings from diagnosis to bereavement.

4. Support the development of, and reimbursement for, pre-hospice or bridge programs which offer some of the services of hospice with less stringent eligibility requirements.
5. Support and provide funding for the development of new inpatient and residential hospice facilities.

**Objective 5: Enhance scientific research into all aspects of end-of-life care.**

**Strategies:**

1. Support and develop funding mechanisms for end-of-life research. Recognize and promote the importance of research, even with vulnerable populations, to better understand difficulties experienced by cancer patients throughout the trajectory of illness.
2. Develop a statewide mechanism for coordination and dissemination of interdisciplinary end-of-life research among the various professional schools, professional organizations, and government agencies.
3. Support use of Cigarette Restitution Funds for end-of-life research and programs.