Turning *commitment* into *Action*

Year-One Accomplishments

Delaware Cancer Consortium

September 2004

In Memoriam

Sterlin Beckwith ❧ Rebecca Wolhar

Their stories were chronicled in our initial cancer report.
Their advice guided us to make changes.
Their lives were lost after they gave their help so selflessly.
We will never forget them.

This progress report is their legacy.

Thank You

The committee members of the Delaware Cancer Consortium are volunteers who come from all walks of life. They have contributed their insight, their ideas, and hundreds of hours of their time to reduce the burden of cancer in Delaware. We appreciate all they have done on behalf of all of us.

Semaan Abboud, MD • Scott Blaier • The Honorable Patricia Blevins • Willam W. Bowser, Esq. • Paula Breen, MSPH • Deborah Brown, CHES • The Honorable John C. Carney, Jr. • Jeanne Chiquoine • Alicia Clark • David J. Cloney, MD, FACS • Victoria Cooke • Matt Denn, Esq. • Margaretta Dorey, RN, BSN • Jayne Fernsler, DSN, RN, AOCN • Linda Fleisher, MPH • Christopher Frantz, MD • Robert Frelick, MD • Wendy Gainor • Allison Gil • James M. Gill, MD, MPH • Helene Gladney • Constance Green-Johnson • Stephen Grubbs, MD • The Honorable Bethany Hall-Long, PhD, RNC • Richard Heffron • Paula Hess, BSN, RN • Patricia Hoge, PhD, RN • Andrea J. Holecek, RN, MSN, CRNI, AOCN • Cathy Scott Holloway • John Hughes • Nora Katurakes, RN, MSN, OCN • Arlene Littleton • Susan Lloyd, MSN, RN • Susan Lockhart • Lolita Lopez • Kay D. Makar, MPH, RD, CDN • Meg Maley, RN, BSN • Andrew Marioni, Jr. • Gilbert J. Marshall, PG • Steven Martin • The Honorable David McBride • Eileen McGrath • James Monihan, MD • H.C. Moore • Julio Navarro, MD • Nicholas Petrelli, MD • Carolee Polek, RN, MSN, PhD • Anthony Policastro, MD • John Ray • Jaime H. Rivera, MD, FAAP • Catherine Salvato, MSN, RN • Patricia C. Scarborough • Robert Simmons, PhD, MPH, CHES • Edward Sobel, DO • The Honorable Liane Sorenson • James Spellman, MD, FACS, FSSO • The Honorable Donna Stone • Laurel Standley • Janet Teixeira, MSS, LCSW • The Honorable Stephanie Ulbrich • Kathleen Wall • Judy Walrath, PhD • Mary Watkins • A. Judson Wells, PhD • Linda Wolfe

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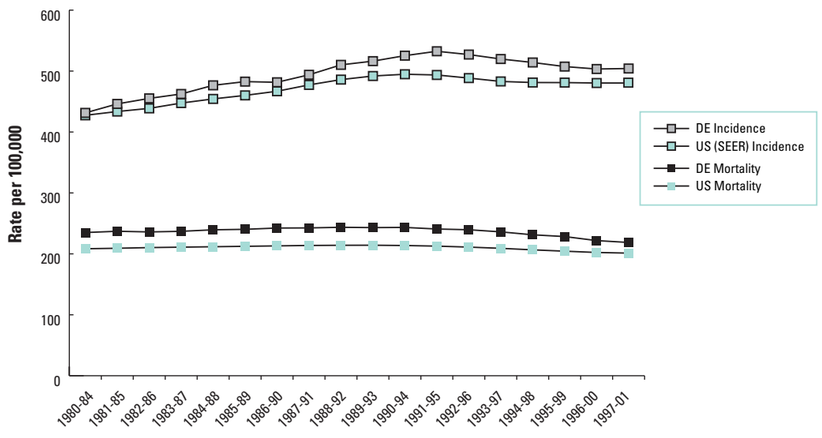
The Big Picture

The four-year plan that was developed by the governor's task force set forth ambitious goals—goals that would help us lower the threat of cancer to all people in our state. This report to you—the people of Delaware—shows the remarkable progress that has been made in just one year. Especially impressive are the implementation of programs to address colorectal cancer and the new program that pays for cancer treatment for the uninsured. You'll also notice that the unequal burden borne by racial and ethnic minorities remains our central focus. The impact is noted in every task. But none of this would have been possible without the funding approved by the legislature and governor's office. It is because of their support—and the allocation of those state funds represented in this report—that we have been able to make such headway. But there is still work to do. We look forward to tackling the remaining objectives—those mandated for completion in years two, three, and four—with equal determination.

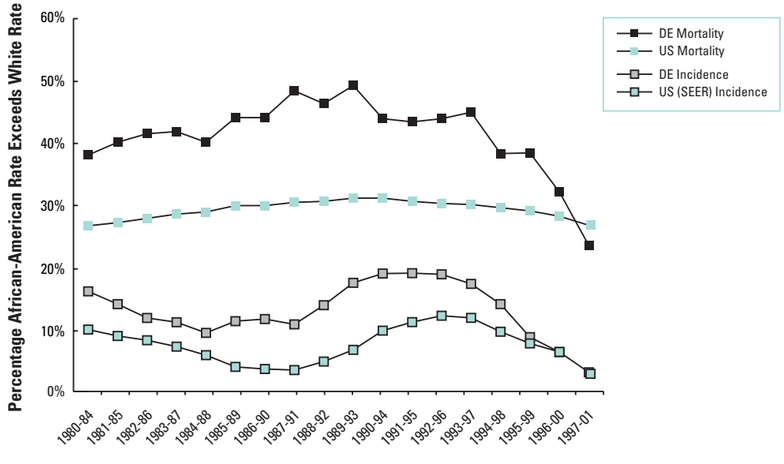
Although they're still higher, cancer rates are falling more rapidly in Delaware than they are in the nation. Just as in the nation, both the death and incidence rates are much higher among Delaware's African Americans. The good news is this gap is smaller in Delaware than in the nation for the first time in more than 20 years.

CANCER IN DELAWARE—THE BIG PICTURE

CANCER INCIDENCE AND MORTALITY AVERAGE ANNUAL AGE-ADJUSTED RATES PER 100,000, DELAWARE AND U.S.

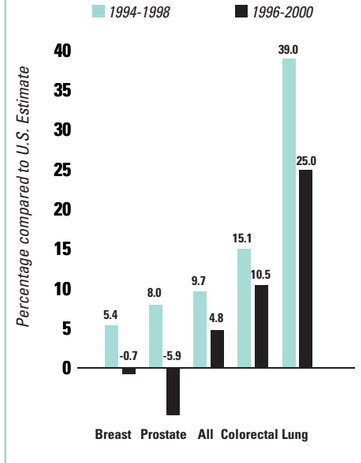


PERCENTAGE THAT AFRICAN-AMERICAN CANCER RATES EXCEED WHITE RATES BASED ON AGE-ADJUSTED RATES PER 100,000, DELAWARE AND U.S.



National Average is represented by SEER (Surveillance, Epidemiology and End Results) Registries, a program of the National Cancer Institute.

DELAWARE AGE-ADJUSTED INCIDENCE RATE PER 100,000 AS PERCENTAGE ABOVE U.S. ESTIMATE FOR 1996–2000



Delaware: Delaware Cancer Registry, Delaware Division of Public Health
U.S.: Surveillance, Epidemiology and End Results (SEER) Registries, National Cancer Institute

WHAT HAS BEEN DONE:

We have introduced services, education, and legislation that limit cancer risks for all people in Delaware.

INCREASE SCREENING FOR AND EARLY DETECTION OF COLORECTAL CANCER

- Obtained the commitment of six major health systems to participate in a screening and advocacy program
- Provided colorectal cancer screening for the uninsured
- Created "Champions of Change"—a comprehensive community program to reach African Americans
- Provided case management to the uninsured after establishing an annual allocation and system for it

PROVIDE THE HIGHEST QUALITY OF CARE FOR EVERY DELAWAREAN DIAGNOSED WITH CANCER

- Established an annual allocation for cancer care coordinators
- Began development of the coordinator program
- Encouraged involvement of the Delaware health systems in Cooperative Oncology Group activities
- Expanded education to health care providers in end-of-life care

REDUCE TOBACCO USE AND EXPOSURE

- Funded comprehensive, statewide tobacco prevention programs above the recommended minimum
- Strengthened and expanded the Delaware Clean Indoor Air Act
- Enforced the Delaware Clean Indoor Air Act
- Strongly endorsed, coordinated, and implemented "A Plan for a Tobacco-Free Delaware"
- Implemented the CDC tobacco model for schools
- Expanded tobacco awareness and cessation campaigns
- Maintained and enhanced integrated cessation programs
- Educated the legislature about an excise tax increase
- Gathered data from state agencies to create a tobacco resource guide

PAY FOR CANCER TREATMENT FOR THE UNINSURED

- Established an annual allocation for cancer treatment for the uninsured
- Established a system for billing and payment for cancer treatment
- Began reimbursement for treatment of the uninsured

INCREASE KNOWLEDGE AND PROVIDE INFORMATION

- Established health councils at the district and school levels
- Began research related to risk factors and preventable cancer cases and deaths
- Amended the Cancer Control Act
- Increased information on Delaware Cancer Registry
- Fully staffed the Delaware Cancer Registry

REDUCE THE THREAT OF CANCER FROM THE ENVIRONMENT

- Monitored ambient air quality
- Monitored shallow aquifers
- Increased testing of fish for carcinogenic substances
- Enhanced on-site advisory information about the safety of Delaware fish
- Provided financial assistance for radon remediation
- Began development of a public education campaign (TEAM)

ELIMINATE THE UNEQUAL CANCER BURDEN

- Began data collection and analysis related to health disparities

IMPLEMENTATION OF RECOMMENDATIONS

- Obtained administrative support for Delaware Cancer Consortium
- Implemented the recommendations with administrative support

YEAR-ONE ACCOMPLISHMENTS

DELAWARE CANCER CONSORTIUM

INSURANCE COMMITTEE

COLORECTAL CANCER COMMITTEE

TOBACCO COMMITTEE

QUALITY COMMITTEE

INCREASE KNOWLEDGE & PROVIDE INFORMATION COMMITTEE

ENVIRONMENT COMMITTEE

DISPARITIES COMMITTEE

"Even though we're beginning to see the trends reverse, we're as focused as ever on our goal—to increase knowledge, add resources, and implement testing to lower the cancer risk for every individual in Delaware." | William W. Bowser, Esquire, of Wilmington, DE, Council Chair whose son, Michael, is a leukemia survivor.

We're Making Strides

Two years ago, the Delaware Advisory Council on Cancer Incidence and Mortality (now the Delaware Cancer Consortium or DCC) researched, reviewed data, talked with people who were affected by cancer, and reported what we learned. It wasn't all good news. There were clear indications of need. There were gaps—especially among racial and ethnic minorities—where cancer was often diagosed later and the chance of dying from the disease was much greater. Statistics supported the larger risk of both getting and dying from cancer in our state. We heard riveting stories. Stories of devastating financial loss. Stories of emotional distress. Stories that led us to the conclusion that we must accept a responsibility to make change happen. It is this commitment to lift the burden borne by those most affected that inspired us.

This report summarizes how much we've accomplished in very little time. How we've broken new ground in becoming the first state in the nation to create a cancer treatment program for uninsured individuals. How we're raising awareness about getting tested for colorectal cancer. How we're taking our message into communities where disparities exist to get to those who most need our help. We have become a permanent force—a viable, effective, active participant in the fight against cancer. You can count on us to stay in it until we win.

- A permanent cancer consortium now reports directly to the governor.
- Resources have been allocated for ongoing administrative support of DCC.
- Stakeholders have been targeted through an initial membership drive, and there are now 61 DCC members.
- A structure and charge was developed for each committee.
- Individual committees were established with specific workplans and performance expectations.
- Bimonthly public meetings update and monitor accomplishments and progress of current recommendations.
- Progress reports update the governor and state of Delaware.

Create and maintain a permanent council, managed by a neutral party, that reports directly to the governor to oversee implementation of the recommendations and comprehensive cancer control planning. The council should have medical, environment, research, policy, and education committees that continually evaluate and work to improve cancer care and cancer-related issues in Delaware.

The following specific tasks and activities should be included:

TASK/ACTIVITY	*RESPONSIBLE PARTY*	*TIMEFRAME*	*COSTS**	*POTENTIAL SOURCES***
1. Reconstitute and make permanent the Delaware Advisory Council on Cancer Incidence and Mortality, which shall report directly to the governor	General assembly	Year 1	None	
DONE *Governor Minner signed SB102 on September 22, 2003, reauthorizing and expanding the role of the Delaware Advisory Council on Cancer Incidence and Mortality and renaming it the Delaware Cancer Consortium (DCC).* ⊕				
2. Disband DHSS's Advisory Council on Cancer Control as authorized in current legislation and replace with DCC listed in Step 1	General assembly	Year 1	None	
DONE *Governor Minner signed SB102 on September 22, 2003, reauthorizing and expanding the role of the Delaware Advisory Council on Cancer Incidence and Mortality and renaming it the Delaware Cancer Consortium (DCC).* ⊕				
3. Allocate resources for on-going administrative support to DCC, including one full-time staff person with the sole responsibility of the coordination of this group and its committees	General assembly	Year 1 and ongoing	Allocated: $100,000 annually	Proposed tobacco excise tax
DONE *The Delaware Division of Public Health provides staff support to DCC, as required in SB102.* ⊕				
4. Solicit participation of all stakeholders for DCC; clear definition of member expectations, roles, and responsibilities should be provided	Staff person, neutral party manager	Year 1	Allocated: $25,000—Steps 4-6	Proposed tobacco excise tax
DONE *Stakeholders involved in the original process were targeted through an initial membership drive. 61 DCC members were approved.* ⊕				

EFFECT ON DISPARITIES

⊕ *POSITIVE* ⊗ *NEGATIVE* ○ *NEUTRAL*

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**Original source recommendation is given. This may differ from actual funding source.

(continued)

Create and maintain a permanent council, managed by a neutral party, that reports directly to the governor to oversee implementation of the recommendations and comprehensive cancer control planning. The council should have medical, environment, research, policy, and education committees that continually evaluate and work to improve cancer care and cancer-related issues in Delaware.

The following specific tasks and activities should be included:

TASK/ACTIVITY	*RESPONSIBLE PARTY*	*TIMEFRAME*	*COSTS**	*POTENTIAL SOURCES***
5. Develop a structure and charge for DCC and each committee	Staff person, DCC	Year 1		
DONE *An organizational structure has been established. Committees have individual workplans and performance expectations based on recommendations of DCC.*				
6. Establish the individual committees—medical, environment, research, policy, and education; experts in the respective fields should lead each committee, and clear definition of member expectations should be provided	Staff person, DCC	Year 1		
DONE *Seven standing committees have been formed, each chaired by a member of DCC.*				
7. Oversee implementation of the current recommendations and any future recommendations in coordination with the planning process	Staff person, DCC and committees	Year 1 and ongoing		
DONE *DCC conducts bimonthly public meetings to review progress on current recommendations, modifying for the future as indicated.*				
8. Coordinate an annual conference on the status of cancer in Delaware	DCC	Year 2 and annually	To be determined	
To be addressed in Year 2.				
9. Develop an annual report to the governor and legislature on the status of current recommendations and the comprehensive cancer control plan, and make additional recommendations as necessary	DCC	Year 2 and annually		
DONE *This updated report summarizes the accomplishments of Year 1.*				

Develop and implement a state cancer control and prevention plan. The plan should be based on CDC guidelines and involve multiple stakeholders with assigned responsibilities.

The following specific tasks and activities should be included:

TASK/ACTIVITY	*RESPONSIBLE PARTY*	*TIMEFRAME*	*COSTS**	*POTENTIAL SOURCES***
1. Develop planning process that incorporates recommendations of DCC	Staff person, DCC	Year 1	Recommended funding: $100,000 Allocated: $0	Proposed tobacco excise tax
DONE *Planning process in place. Council and Consortium meet monthly.*				
2. Fund implementation of the plan	General assembly	Year 1		
DONE *$5M allocated for Year 1 recommendations. $10M allocated for Year 2.*				
3. Monitor progress, give advice of needs and resources in DE, and assist with grants or fund development	DCC	Year 2 and ongoing		
To be addressed in Year 2.				
4. Assign specific roles and accountabilities of private, nonprofit, and government entities involved in implementation	See above	Year 2	N/A	
To be addressed in Year 2.				
5. Publish the plan's development, implementation, and outcomes in the annual cancer report	DCC, DDPH	Year 3 and ongoing		
To be addressed in Year 3.				

EFFECT ON DISPARITIES

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YEAR-ONE ACCOMPLISHMENTS

DELAWARE CANCER CONSORTIUM

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COLORECTAL CANCER COMMITTEE

TOBACCO COMMITTEE

QUALITY COMMITTEE

INCREASE KNOWLEDGE & PROVIDE INFORMATION COMMITTEE

ENVIRONMENT COMMITTEE

DISPARITIES COMMITTEE

"I was diagnosed with cervical cancer through Screening for Life. It had been 17 years since my last Pap test. I simply couldn't afford them. I had two tumors removed. The cancer was very severe. If I hadn't gotten the test, I doubt if I would be here talking to you today." | KATHLEEN MCCLEMENTS

WE'RE PAYING FOR TREATMENT FOR THE UNINSURED.

We know that people who are uninsured often wait to get medical care. We also know that the later a cancer is found, the more difficult it can be to treat. If someone is diagnosed with cancer tomorrow, the last thing they should have to worry about is how to pay for medical care. In a landmark decision, Delaware has allocated $5 million to pay for cancer treatment for any uninsured person with a household income that is 650% of the Federal Poverty Level ($122,525 for a family of four). Not only will this program help to eliminate the financial burden of cancer care, it has the potential to increase the number of people who get tested. With earlier diagnoses of cancer, we can lower mortality rates. We are the first state in the nation to allocate funds to pay for cancer treatment for the uninsured.

ESTIMATES OF NATIONAL EXPENDITURES FOR MEDICAL TREATMENT FOR THE 13 MOST COMMON CANCERS
Based on cancer prevalence in 1996 and cancer-specific costs for 1995-1998, expressed in U.S. dollars.

	Percent of all new cancers (1998)	**Expenditures** (billions in 1996 dollars)	**Percent of all cancer treatment expenditures**	**Average Medicare payments per individual in first year after diagnosis**
Breast	18.2%	$5.4	13.1%	$9,230
Colorectal	11.7%	$5.4	13.1%	$21,608
Lung	12.5%	$4.9	12.1%	$20,340
Prostate	13.6%	$4.6	11.3%	$8,869
Lymphoma	4.2%	$2.6	6.3%	$17,217
Bladder	4.0%	$1.7	4.2%	$10,770
Cervix	2.3%	$1.7	4.1%	$13,083
Head/Neck	3.3%	$1.6	4.0%	$14,788
Ovary	1.7%	$1.5	3.7%	$32,340
Leukemia	2.1%	$1.2	2.8%	$11,882
Melanoma	5.2%	$0.7	1.7%	$3,177
Pancreas	2.1%	$0.6	1.5%	$23,504
Esophagus	0.9%	$0.4	0.9%	$25,886
All Other	18.1%	$8.7	21.2%	$17,201
Total	100%	$41.0	100%	

Source: Brown ML, Riley GF, Schussler N, Etzioni RD. Estimated health care costs relating to cancer treatment from SEER-Medicare data. Med Care 2002 Aug; 40(8 Suppl:IV-104-17.

Reimburse the cost of cancer treatment for every uninsured Delawarean diagnosed with cancer up until one year after diagnosis.
The following specific tasks and activities should be included:

TASK/ACTIVITY	*RESPONSIBLE PARTY*	*TIMEFRAME*	*COSTS**	*POTENTIAL SOURCES***
1. Establish a $5.0 million annual allocation for cancer treatment of the uninsured	General assembly, executive branch	Year 1	None	Proposed tobacco excise tax
DONE *Funds allocated for colorectal cancer treatment.*				
2. Establish a system for billing and payment for cancer treatment whereby funds would be paid directly to health providers for reimbursable services based on Medicare rates; develop a comprehensive monitoring and evaluation program	DHSS	Year 1	See #3	Proposed tobacco excise tax
DONE *System in place as of July 2004.*				
3. Begin reimbursements for treatment for uninsured Delawareans diagnosed with cancer based on established system	DHSS	Year 2	Allocated: $704,700 for #2 & #3	Proposed tobacco excise tax
DONE *Ahead of schedule. Treatment reimbursed for seven patients in Year 1.*				
4. Revise allocation based on actual costs and projections	General assembly	Year 2 and annually	None	
To be addressed in Year 2.				

Points to note:
- Billing and payment system to be determined and should take into consideration existing programs that could be built on or used as a model (e.g., Medical Society of Delaware's MEDNET).

EFFECT ON DISPARITIES
⊕ *POSITIVE* ⊗ *NEGATIVE* ○ *NEUTRAL*

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"I had two polyps removed through the Screening for Life program that could've become cancer. I've been laid off for a while now. I don't know if I would've had the test if I hadn't been able to get it through Screening for Life." | DAVID GARDNER

WE'RE INCREASING SCREENING AND EARLY DETECTION OF COLORECTAL CANCER.

Colorectal cancer kills 170 Delawareans every year. And it can be cured if it's found early enough. It's even preventable in many cases. Unlike many other cancers, there are reliable and cost-effective tests that can find colorectal cancer early. Yet tragically, too few Delawareans know about or take advantage of these life-saving tests. Starting this year, we're changing that. Screening for Life will now cover the cost of a colonoscopy for individuals who meet income guidelines. A new multimedia campaign will urge every Delawarean age 50 and older to get tested. Since African-American deaths from colorectal cancer are significantly higher, a grassroots effort called "Champions of Change" is taking the "get tested" message to neighborhoods, churches, and community organizations. And we've established a system for case management and implemented it to guide people through the process. The more people tested for colorectal cancer—the sooner we can eliminate it.

MORE PEOPLE ARE GETTING TESTED FOR COLORECTAL CANCER

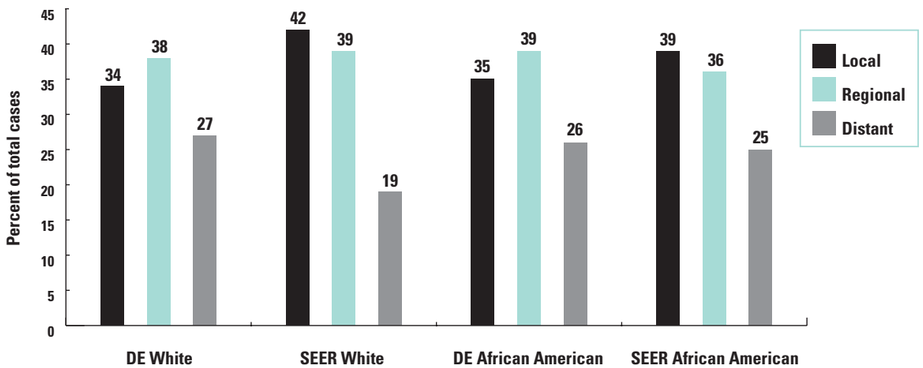
In 1999, percent of Delawareans by race reporting ever having a colorectal cancer screening:

- *African American* 39.6%
- *Hispanic* 19.0%
- *White* 45.3%

In 2003, percent of Delawareans by race age 50 and older who have ever had a sigmoidoscopy or colonoscopy:

- *African American* 48.8%
- *Hispanic* 46.2% *(figure based on smaller sample size)*
- *White* 64.2%

STAGE OF DIAGNOSIS OF COLORECTAL CANCER BY RACE FOR DELAWARE AND U.S. (SEER), 1996–2000



Sources:
Ries LAG, Eisner MP, Kosary CL, Hankey BF, Miller BA, Clegg L, Mariotto A, Feuer EJ, Edwards BK (eds). SEER Cancer Statistics Review, 1975-2001, National Cancer Institute. Bethesda, MD, http://seer.cancer.gov/csr/1975_2001/, 2004. Delaware Cancer Registry

Create a comprehensive statewide colorectal cancer screening and advocacy program.
The following specific tasks and activities should be included:

TASK/ACTIVITY	*RESPONSIBLE PARTY*	*TIMEFRAME*	*COSTS**	*POTENTIAL SOURCES***
1. Reach out to the six major health systems serving adult populations (Nanticoke, Beebe, Bayhealth, Christiana Care, Veterans Hospital, and St. Francis) to participate in a comprehensive, community-focused colorectal cancer screening and advocacy program (may be Request For Proposal)	Delaware Healthcare Association, DHSS	Year 1	None	
DONE *All six systems have agreed to participate by summer 2004.* ⊕				
2. Develop an evaluation plan	DHSS	Year 1 and ongoing	Allocated: $50,000	Delaware Health Fund, proposed tobacco excise tax, existing resources
DONE *An independent research group developed program performance and monitoring measures and processes. Baseline data was compiled before the program startup.* ⊕				
3. Hire project screening advocates	Health systems	Year 2	Recommended: $250,000 Allocated: $0	Same as above
To be addressed in Year 2. ⊕				
4. Market project and services	DHSS, health systems	Year 2 and ongoing	Recommended funding: $100,000 Allocated: $600,000	Same as above
DONE *Activities ahead of schedule.* ⊕				
5. Project startup	All	Year 2	Recommended: $125,000 Allocated: $0	Same as above
To be addressed in Year 2. ⊕				
6. Operational support	DHSS	Year 1 and ongoing	Allocated: $25,000 annually	Same as above
We have begun the process to provide each of the six participating health systems with the resources to hire and house a screening advocate. ⊕				

Points to note:

- Each program will include at least one full-time professional position of "Project Screening Advocate" housed within the hospital system. The advocate works with communities and organizations within the surrounding area to develop and oversee the program according to the specific needs of each.
- The advocate will be responsible for providing culturally sensitive outreach and recruitment, assuring screening access and scheduling, monitoring screening compliance, and assuring prompt clinical evaluation and follow-up to positive testing.

EFFECT ON DISPARITIES

⊕ *POSITIVE* ⊗ *NEGATIVE* ○ *NEUTRAL*

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Reimburse for colorectal cancer screening of uninsured Delawareans age 50 and older.

The following specific tasks and activities should be included:

TASK/ACTIVITY	RESPONSIBLE PARTY	TIMEFRAME	COSTS*	POTENTIAL SOURCES**
1. Establish a $1.5 million annual allocation to colorectal cancer screening for the uninsured	General assembly, executive branch	Year 1	None	Proposed tobacco excise tax
DONE *Funds allocated for colorectal cancer screening.*				
2. Establish a system for billing and payment for colorectal cancer screenings whereby funds would be paid directly to health providers for reimbursable services based on Medicare rates	DHSS	Year 1	Dependent on system developed	Proposed tobacco excise tax
DONE *Existing Screening for Life infrastructure modified.*				
3. Provide colorectal cancer screening for uninsured Delawareans age 50 and older that includes a comprehensive monitoring and evaluation program	Dependent on system developed	Year 2 and ongoing	Recommended funding $1.5 million annually Allocated Year 1: $849,000	Proposed tobacco excise tax
DONE *662 people tested, 53 potential cancers prevented, 10 cancers diagnosed.*				
4. Revise allocation based on actual costs and projections	General assembly	Annually	None	
To be addressed in Year 2.				

Case manage every Delawarean with an abnormal colorectal cancer screening test.

The following specific tasks and activities should be included:

TASK/ACTIVITY	RESPONSIBLE PARTY	TIMEFRAME	COSTS*	POTENTIAL SOURCES**
1. Establish a $900,000 annual allocation for case management of Delawareans with abnormal colorectal cancer screening results	General assembly, executive branch	Year 1	None	Proposed tobacco excise tax
DONE *Annual allocation established.*				
2. Establish a system for case managing every Delawarean with an abnormal colorectal cancer screening using current systems as models that include a comprehensive monitoring and evaluation system	DHSS	Year 1	To be determined	Proposed tobacco excise tax
DONE *An interim system is in place; permanent system to be in place by fall 2004.*				
3. Begin case management system	Dependent on system developed	Year 2 and ongoing	Recommended funding: $900,000 annually Allocated Year 1: $77,600	Proposed tobacco excise tax
DONE *Ahead of schedule.*				
4. Revise allocation based on actual costs and projections	General assembly	Annually	None	
To be addressed in Year 2.				

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YEAR-ONE ACCOMPLISHMENTS

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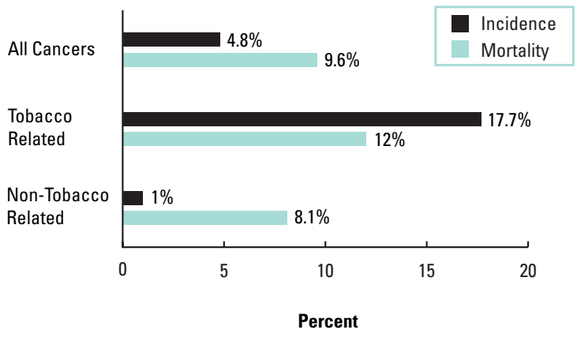
"My wife and I smoked for 20 years. We called the Quitline two years ago. It was very comfortable for us. The people were great. The big thing is the counseling. They helped us prepare to quit. I am now cigarette-free."

CARL HUMPHREY

WE'RE REDUCING TOBACCO USE AND EXPOSURE.

Lung cancer continues to be the leading cause of cancer death in both men and women in Delaware. The use of tobacco is the number one cause of lung cancer. But we're doing something about it. For the past three years, the Delaware Health Fund has provided $5 million for comprehensive tobacco prevention and control programs. Last year an additional $1 million was provided directly for comprehensive tobacco prevention programs from cancer council recommendations. Through our efforts, we've passed the Clean Indoor Air Act to eliminate exposure to secondhand smoke indoors in public places and workplaces. We've created a program that Delawareans can call to quit smoking—called the Delaware Quitline. We've initiated more prevention efforts in schools and in the media. And we're seeing the first significant decrease. Only one in four Delawareans still smokes. Adult smoking has decreased overall from 24.6 to 21.9 percent. And youth smoking—those who are 18 to 24 years of age—has dropped 25 percent. But there's still more we can do. Although we've increased the excise tax on cigarettes to keep our children from picking up the habit, the amount was below the recommended minimum. To continue to make an impact, we have to stay focused on our goal to keep tobacco of any kind from affecting the health of every Delawarean.

PERCENTAGE INCREASE IN DELAWARE CANCER AGE-ADJUSTED INCIDENCE AND MORTALITY VS. U.S., 1996–2000



National Average is represented by SEER (Surveillance, Epidemiology, and End Results) Registries, a program of the National Cancer Institute. Tobacco-related cancers: lung, bladder, larynx, esophageal, kidney, pancreas, and oral.

At a minimum, fund comprehensive statewide tobacco control activities at $8.6 million (CDC recommended minimum).

The following specific tasks and activities should be included:

TASK/ACTIVITY	*RESPONSIBLE PARTY*	*TIMEFRAME*	*COSTS**	*POTENTIAL SOURCES***
1. Educate members of the Delaware Health Fund Advisory Committee regarding the need for adequate funding in order to achieve the desired results	IMPACT	Year 1 and ongoing	None	
DONE *Education ongoing.*				
2. Create increased public demand for a fully funded, tobacco control program using polling and public awareness activities	IMPACT	Year 1 and ongoing	Recommended: $25,000 Allocated: $0	Robert Wood Johnson Foundation
DONE *Public awareness and polling activities ongoing.*				
3. Advocate for Health Fund allocations at CDC recommended funding levels	IMPACT, DHFAC	Annually	None	
DONE *Delaware funding level exceeds CDC recommendations.*				
4. Report to the public on the use of tobacco funds	All agencies receiving funds	Annually	Existing funds	
DONE *Delaware Health Fund meetings are open to the public. Information on meetings and budgets are available on the DHSS Health Fund website at http://www.state.de.us/dhss/healthfund/.*				
5. Fund tobacco control activities at the CDC minimum recommendations	DHFAC, general assembly	Year 1 and ongoing		Delaware Health Fund
DONE *Delaware funding level exceeds CDC recommendations.*				

EFFECT ON DISPARITIES

⊕ *POSITIVE* ⊗ *NEGATIVE* ○ *NEUTRAL*

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Strengthen, expand, and enforce Delaware's Clean Indoor Air Act to include public places and workspace environments.

The following specific tasks and activities should be included:

TASK/ACTIVITY	RESPONSIBLE PARTY	TIMEFRAME	COSTS*	POTENTIAL SOURCES**
1. Advocate passage of a strong anti-exposure to Environmental Tobacco Smoke (ETS) law, Senate Bill 99 as originally written *(An Act to Amend Title 16, Delaware Code Relating to the Clean Indoor Air Act, 2001)*	General assembly, executive branch	Year 1	None	
DONE *SB99 signed into law May 2001. Clean Indoor Air Act (CIAA) went into effect on November 27, 2001.* ⊕				
2. Mobilize the support of governmental offices and other resources together and disseminate relevant data	Executive branch, DHSS	Year 1	None	
DONE *DPH conducted an annual Adult Tobacco Survey (ATS).* ⊕				
3. Continue ETS media and educational campaigns	DHSS	Year 1 and ongoing	Existing resources	
DONE *Continuing.* ⊕				
4. Continue grassroots support efforts begun in 2001	IMPACT, volunteer groups	Year 1	None	
DONE *IMPACT Coalition and volunteer organizations continue to be active. Membership should continue to grow.* ⊕				
5. Begin public polling to assess support for proposed legislation	IMPACT, Campaign for Tobacco-Free Kids	Year 1	Recommended: $50,000 to $75,000 Allocated: $0	Campaign for Tobacco-Free Kids
DONE *Public polling showed strong support for the CIAA.* ○				
6. Communicate with those opposed to new legislation to ensure correct information and understanding	IMPACT, concerned health organizations	Year 1	None	
DONE *CIAA passed by Delaware Legislature in May 2001.* ⊕				
7. Upon passage, enforce law	DHSS	Ongoing after passage	None	
DONE *Underway. DPH enforces public place violations, and Department of Labor enforces workplace violations.* ○				

Point to Note:
The council wishes to emphasize that advocates of the Clean Indoor Air Act must be vigilant to ensure that law is not weakened.

Strongly endorse, coordinate, and implement the action plan recommendations presented in "A Plan for a Tobacco-Free Delaware."

The following specific tasks and activities should be included:

TASK/ACTIVITY	RESPONSIBLE PARTY	TIMEFRAME	COSTS*	POTENTIAL SOURCES**
1. Increase visibility of support for current plan actions/activities *(IMPACT Delaware Tobacco Prevention Coalition 1999)*	General assembly, executive branch	Year 1 and ongoing	None	
DONE *Continuing. IMPACT and DCC Tobacco Committee are updating and creating FY05 priorities.* ○				
2. Conduct activities outlined in the plan	IMPACT, DHSS	Year 1 and ongoing	*See note below*	Delaware Health Fund
DONE *Continuing. DCC Committee members participated in the update of the Tobacco plan.* ○				
3. Continue process, impact, and outcome evaluation of plan goals and objectives	IMPACT, DHSS	Year 1 and ongoing	Existing resources	
DONE *Continuing.* ⊕				

Point to Note:
Cost: To complete these activities, the CDC-recommended minimum funding of an additional $3.6 million to existing resources would be needed and is outlined in the first tobacco control recommendation *("Best Practices for Comprehensive Tobacco Control Programs" 2001).*

EFFECT ON DISPARITIES		
⊕ *POSITIVE*	⊗ *NEGATIVE*	○ *NEUTRAL*

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Formally adopt, implement, and enforce the CDC model policy for tobacco control in all Delaware schools.

The following specific tasks and activities should be included:

TASK/ACTIVITY	*RESPONSIBLE PARTY*	*TIMEFRAME*	*COSTS**	*POTENTIAL SOURCES***
1. Reeducate school leadership regarding the content and merits of the CDC model school policy *("A Coordinated School Health Program: The CDC Eight Component Model of School Health Programs" 2001)*	IMPACT, DHSS, DOE	Year 1	Existing staff and resources	
DONE *Continuing.*				
2. Obtain administration's support for model policy adoption	IMPACT	Year 1	None	
DONE *Continuing.*				
3. Draft legislation requiring model adoption	IMPACT, general assembly	Year 1	None	
DONE *Delaware Department of Education Regulation 877.*				
4. Implement the model (including education and enforcement components)	IMPACT, DOE, DHSS, local schools	Year 1	Allocated: $100,000	Delaware Health Fund
DONE *Funding on a per-capita basis provided to all public school districts to create and enforce policy that adheres to tobacco regulations. Signs distributed to schools to inform students, faculty, and visitors about school tobacco policies.*				

Point to Note:
An existing federal mandate prohibits the use of tobacco products at any time on properties that serve children and receive federal funds. Yet daily violations by staff, visitors, and students continue to be visible.

Expand and sustain a comprehensive public awareness campaign on the health risks of tobacco use and support resources available to help quit smoking.

The following specific tasks and activities should be included:

TASK/ACTIVITY	*RESPONSIBLE PARTY*	*TIMEFRAME*	*COSTS**	*POTENTIAL SOURCES***
1. Conduct a high-profile media campaign	DHSS	Ongoing	Recommended funding: $1.2M plus $1.3M of existing resources Allocated Year 1: $500,000	Delaware Health Fund, proposed tobacco excise tax
DONE *Continuing.*				
2. Maintain and enhance integrated cessation services	DHSS	Ongoing	Recommended funding: $1.05M plus $450,000 of existing resources Allocated Year 1: $650,000	Delaware Health Fund, proposed tobacco excise tax
DPH has expanded cessation services and is developing a web-based listing of all community-based tobacco control services in Delaware.				
3. Formulate and coordinate consistent messages to be delivered by all stakeholders (materials development)	DCC—Education Committee	Ongoing	Recommended funding: $250,000 Allocated Year 1: $0	Delaware Health Fund, proposed tobacco excise tax
DONE *Coordinated year-round multimedia campaign continues.*				
4. Significantly expand Quitline services	DHSS	Ongoing	See cessation costs above	
DONE *The American Cancer Society is the contractor for Delaware's Quitline cessation services. Budget has been significantly expanded, and Quitline statistics are measured and monitored by the DCC.*				

Points to Note:
- As proven interventions become available, cessation services specifically targeting youth and young adults should be expanded.
- Resources used to formulate the recommendation: *(Hopkins, Husten et al. 2001)* *(Healthy Delaware 2010)*

EFFECT ON DISPARITIES		
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Increase the Delaware excise tax on tobacco products to $0.74 and seek to identify other potential funding sources to support tobacco and cancer control efforts.

The following specific tasks and activities should be included:

TASK/ACTIVITY	*RESPONSIBLE PARTY*	*TIMEFRAME*	*COSTS**	*POTENTIAL SOURCES***
1. Draft legislation to increase existing excise tax by $0.50 per pack	IMPACT, legislative consultants	Year 1	None	
Tax was increased by $0.31 in July 2003 to $0.55 per pack. Revised Tobacco Plan will include increasing excise tax to $1 per pack. Surrounding states' tobacco tax (per pack of cigarettes): NJ= $2.05; PA=$1.35; MD=$1.00. Average of surrounding states is $1.47. Delaware ranks 30th in state excise tax per pack in the nation. ⊕				
2. Seek legislative and administrative support; identify sponsor for bill	IMPACT, health lobbyists	Year 1	None	
Proposed legislative activity will begin in FY05. ○				
3. Ensure that funds are directed to the Delaware Health Fund with major portion going to tobacco control, cancer control, and other chronic diseases	Executive branch, IMPACT, legislative sponsors	Year 1	None	
DONE *Delaware Health Fund has provided $5 million for comprehensive tobacco prevention and control programs (includes various state agencies) for the past three years. Last year an additional $1 million was provided directly for comprehensive tobacco prevention programs from DCC recommendations.* ⊕				
4. Conduct community polling	Campaign for Tobacco-Free Kids (CFTFK)	Year 1	Recommended: $75,000 Allocated: $0	Robert Wood Johnson, CFTFK, AHA, ALA, ACS
DONE *Continuing.* ○				
5. Implement grassroots awareness/support campaign	IMPACT	Year 1	Recommended: $250,000 Allocated: $0	Same
DONE *Continuing.* ⊕				
6. Conduct public awareness campaign	IMPACT, DCC, DHSS	Year 1	Recommended: $200,000 Allocated: $0	Same
DONE *Continuing.* ⊕				
7. Educate general assembly	IMPACT, lobbyists	Year 1	Recommended: $400,000 Allocated: $0	
DONE *Continuing.* ○				
8. Pass legislation increasing tax	General assembly	Year 2		
The General assembly passed HB 270, which increased the state excise tax on a pack of cigarettes by $0.31 (total tax now $0.55). The tax went into effect on July 31, 2003. The tax revenue goes into the general fund. ○				

EFFECT ON DISPARITIES

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YEAR-ONE ACCOMPLISHMENTS

DELAWARE CANCER CONSORTIUM

INSURANCE COMMITTEE

COLORECTAL CANCER COMMITTEE

TOBACCO COMMITTEE

QUALITY COMMITTEE
- Care Coordination Subcommittee
- Credentialing Subcommittee

INCREASE KNOWLEDGE & PROVIDE INFORMATION COMMITTEE

ENVIRONMENT COMMITTEE

DISPARITIES COMMITTEE

"A collaborative effort has begun involving all the major health systems in the state to open the door to better cancer care. We will be better able to solve problems, identify new issues, and begin to coordinate care for every cancer patient." | James E. Spellman, MD, FACS, FSSO

WE'RE IMPROVING THE QUALITY OF CARE FOR EVERY DELAWAREAN DIAGNOSED WITH CANCER.

Dealing with cancer is tough enough. Dealing with obstacles built into the system shouldn't add another burden. Making quality cancer care accessible has been our primary goal. We're in the process of creating a cancer care coordination program to help all Delawareans diagnosed with cancer find the help they need on every level—medical, emotional, and financial. Getting high-quality, compassionate care that follows the lastest cancer screening and treatment recommendations can make a difference in finding cancer when it's treatable. Giving individuals an advocate within each health care system in the state will make all the difference.

IMPORTANT STATISTICS:

The cost of care in the first six months of treatment is 33% less when cancers are found in the early stage (in situ) rather than the late stage (distant). (Eddy 1990; Taplin, Barlow, et al. 1995; Penberthy, Retchin, et al. 1999)

Provide a care coordinator who is part of a statewide-integrated system to every person diagnosed with cancer in Delaware. Care coordinators will be culturally competent to overcome the language, ethnicity, and gender barriers.

The following specific tasks and activities should be included:

TASK/ACTIVITY	*RESPONSIBLE PARTY*	*TIMEFRAME*	*COSTS**	*POTENTIAL SOURCES***
1. Establish a $2 million annual allocation for the development of a core group of cancer care coordinators to link patients with medical and support services; 25 coordinators statewide recommended	General assembly, executive branch	Year 1	None	Proposed tobacco excise tax
$1M secured for Year 2. Qualifications and responsibilities of care coordinators finalized. ⊕				
2. Define and oversee the development of the care coordinator program that includes a statewide system to link and maintain systems for multidisciplinary care of all cancer patients	DCC—Quality Committee	Year 1 and ongoing	See implementation recommendations	Delaware Health Fund, proposed tobacco excise tax
In progress. All health systems engaged in committee work to determine the best way to coordinate care. ⊕				
3. Conduct care coordination program for all Delawareans diagnosed with cancer	DCC—Quality Committee	Year 2 and ongoing	Recommended: $2 million annually Allocated: $0	Delaware Health Fund, proposed tobacco excise tax
To be addressed in Year 2. ⊕				

EFFECT ON DISPARITIES		
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Assure insurance coverage for state-of-the-art cancer clinical trials.

The following specific tasks and activities should be included:

TASK/ACTIVITY	RESPONSIBLE PARTY	TIMEFRAME	COSTS*	POTENTIAL SOURCES**
1. Amend Section 3559 G (a)(3)(c) of the Delaware Code and Regulation 69.505 A 3 to include cancer prevention trials	General assembly, executive branch	Year 1	None	
Other state models reviewed, and model legislation identified.				⊕
2. Encourage the involvement of all seven major Delaware health systems (Nanticoke, Beebe, Bayhealth, Christiana Care, Veterans Hospital, A.I. duPont Hospital for Children and St. Francis) in the establishment of a statewide Cooperative Oncology Group in keeping with the American Cancer Society and the Coalition of National Cooperative Groups: A partnership for Cancer Clinical Trials	Delaware Healthcare Association, DHSS, Medical Society of Delaware	Year 1	None	
DONE				⊕

Point to note:
Recently passed legislation assures insurance coverage for treatment through clinical trials. This recommendation adds prevention clinical trials to those covered services.

Institute centralized credentialing reviews of medical practices by third-party payors that include cancer screening, prevention, early detection, and treatment practices as well as ongoing provider education.

The following specific tasks and activities should be included:

TASK/ACTIVITY	RESPONSIBLE PARTY	TIMEFRAME	COSTS*	POTENTIAL SOURCES**
1. Obtain approval for centralized credentialing from National Committee for Quality Assurance (NCQA)	DCC	Year 1	None	
To be carried out in Year 2.				⊕
2. Define and oversee the development and continuing quality of the credentialing program	DCC—Quality Committee	Year 1 and ongoing	*See note below*	
Pilot program to begin late 2004.				⊕
3. Develop and implement a comprehensive program, managed by a vendor selected through Request for Proposal process, that includes: • all data elements required by third-party payors • all appropriate cancer screening, diagnosis, and treatment data elements • education of medical providers and office staff • practice reviews/ data collection • development of practice-specific recommendations • individualized coaching for improvement • evaluation and reporting of progress to DCC	DCC—Quality Committee, contracted vendor, third-party payors	Year 1 and ongoing	Recommended: $210,000 annually Allocated: $0	Third-party payors
Pilot program to begin late 2004.				○

Point to note:
Practices are currently evaluated by individual third-party payors on the content of their records, but effective feedback on how to improve screening methods is lacking. Centralizing the review process would eliminate duplication of efforts and decrease costs. The educational feedback to the individual practices would be comprehensive in nature, tailored to their needs, and focused on improving cancer-screening rates.

EFFECT ON DISPARITIES

⊕ *POSITIVE* ⊗ *NEGATIVE* ○ *NEUTRAL*

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Support training for physicians and other health care providers in symptom management and end-of-life care approaches.
The following specific tasks and activities should be included:

TASK/ACTIVITY	RESPONSIBLE PARTY	TIMEFRAME	COSTS*	POTENTIAL SOURCES**
1. Promote and fund "Education for Physicians on End-of-Life Care" (EPEC) and "End-of-Life Nursing Education Consortium" (ELNEC) (existing programs); two programs per county each year	DHSS, Medical Society of Delaware	Year 2 and ongoing	Recomended funding: $1,800 annually Allocated Year 1: $1,800	Proposed tobacco excise tax, Robert Wood Johnson Foundation
Ahead of schedule. ○				
2. Establish physician and related health care professional accrediting based on EPEC program content	DHSS, Medical Society of Delaware	Year 2	*See note below*	
To be addressed in Year 2. ○				
3. Require that all patient advocates receive credentialing in pain management, palliative care, and end-of-life care issues	DHSS, health systems (see recommendation on care coordinators)	Year 2	*See note below*	Robert Wood Johnson Foundation
To be addressed in Year 2. ○				
4. Fund broad-based community education programs related to end-of-life choices (to include long-term care, palliative care, and hospice care)	DHSS	Year 2	To be determined	
To be addressed in Year 2. ⊕				

DONE

Point to note:
EPEC and ELNEC are nationally recognized programs that educate physicians and nurses in essential clinical competencies around end-of-life care. Existing efforts include Delaware End-of-Life Coalition, Christiana Care Health System, and Delaware Hospice. This recommendation seeks to enhance existing programs. Coordination with existing Continuing Medical Education (CME) sources throughout Delaware could enhance education to the medical community.

EFFECT ON DISPARITIES

⊕ *POSITIVE* ⊗ *NEGATIVE* ○ *NEUTRAL*

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YEAR-ONE ACCOMPLISHMENTS

DELAWARE CANCER CONSORTIUM

INSURANCE COMMITTEE

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ENVIRONMENT COMMITTEE

DISPARITIES COMMITTEE

"It's critical to bring information about cancer prevention—and the symptoms—to the public at large. We need to have every legislator on board. Our job is to develop new ways to reach those who are more at risk."

THE HONORABLE BETHANY HALL-LONG, PHD, RNC

WE'RE PROVIDING RELIABLE AND USEABLE CANCER INFORMATION.

Cancer is a complex disease. New information about causes, early detection, and treatment is available to us every day. We must find ways to provide reliable and useful information in order to make healthy choices. The decisions we make today will affect Delaware's cancer rates in the future. Continuing to inform everyone in Delaware about cancer will help all of us fight it.

Initiate and support statewide and district-level school health coordinating councils. The statewide council will serve as a model, resource, and funding vehicle for the district councils.

The following specific tasks and activities should be included:

TASK/ACTIVITY	*RESPONSIBLE PARTY*	*TIMEFRAME*	*COSTS**	*POTENTIAL SOURCES***
1. Draft and pass enabling legislation	General assembly	Year 1		
No legislation drafted—councils implemented at district and school levels. ⊕				
2. Use current coordinator position at DOE as base for planning and connect to DPH liaison (phase 1)	DOE, DHSS	Year 1	Allocated: $100,000 all phase 1 activities	Proposed tobacco excise tax
DONE *Continuing.* ○				
3. Identify council structure, charge, potential partici-pants, priorities, and job descriptions (phase 1)		Year 1		
DONE *Included in CDC grant application.* ○				
4. Apply for CDC infrastructure grant (phase 1)	DOE with support of DHSS	Year 1		
DONE *Application approved but not funded.* ○				
5. Conduct needs assessment (phase 1)	DOE, DHSS	Year 1	Existing resources	
Ongoing using CDC model. ⊕				
6. Select, fund, implement, and evaluate two pilot councils at the district level (phase 2)	Statewide council	Year 2	Recommended: $100,000 all phase 2 activities Allocated: $0	Proposed tobacco excise tax, CDC grant
To be addressed in Year 2. ○				
7. Work with districts to gain participation in phase 3 (phase 2)	Statewide council	Year 2		
To be addressed in Year 2. ○				
8. Apply model statewide; include 0.5 full-time equivalent (FTE) in each district (phase 3)	Statewide council, all districts	Years 3–4	Recommended: $195,000 all phase 3 activities Allocated: $0	Proposed tobacco excise tax, CDC grant
To be addressed in Year 3. ○				
9. Oversight and evaluation (phase 3)	Statewide council	Year 3 and ongoing		
To be addressed in Year 3. ○				

EFFECT ON DISPARITIES

⊕ *POSITIVE* ⊗ *NEGATIVE* ○ *NEUTRAL*

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Form a statewide, permanent alliance to coordinate and promote public education on cancer.
The following specific tasks and activities should be included:

TASK/ACTIVITY	RESPONSIBLE PARTY	TIMEFRAME	COSTS*	POTENTIAL SOURCES**
1. Solicit participation in the alliance of all stakeholders	DCC—Education Committee	Year 1	None	
To be carried out in Year 2. ⊕				
2. Select an independent facilitator to assist the alliance in needs assessment, planning, organizational structure, and program focus	DCC	Year 1	Recommended: $190,000 all activities Tasks 2 through 6 Allocated: $0	Proposed tobacco excise tax
To be carried out in Year 2. ○				
3. Develop a unified mission to provide consumer information and education on prevention, screening, detection and treatment, best practices for care, and available resources	DCC, facilitator	Year 1		
To be carried out in Year 2. ⊕				
4. Investigate methods to reach populations at higher risk for cancer with screening, early detection, and prevention messages	DCC	Year 2		
To be addressed in Year 2. ⊕				
5. Collect and integrate data on public education in cancer	DCC, facilitator	Year 2		
To be addressed in Year 2. ⊕				
6. Conduct a statewide summit to review findings and opportunities for integration, collaboration, and unique product development	DCC	Year 3		
To be addressed in Year 3. ⊕				

Point to note:
$190,000 estimate includes materials and operational costs to support the needs assessment, planning, data collection and integration, evaluation of media formats and messages, and administrative costs for sustaining this initiative.
(Brownson and Ross 1999)

WE HAVE INCREASED OUR KNOWLEDGE ABOUT CANCER INCLUDING ENVIRONMENTAL CAUSES

Without data and information, we'd never know where there is more need—or risk—than other areas. Data can tell us what we're doing well. And where we must focus our attention.

Estimate the number of cancers that can be prevented and the number of deaths that can be avoided by primary prevention and early detection. Prioritize our common and preventable cancers.
The following specific tasks and activities should be included:

TASK/ACTIVITY	RESPONSIBLE PARTY	TIMEFRAME	COSTS*	POTENTIAL SOURCES**
1. Collect data on known/suspected risk factors, and calculate the number of preventable cancer cases and deaths by gender, race, and age group, for each risk factor	DHSS, permanent council	Year 1	Allocated: $50,000	Proposed tobacco excise tax
Anticipated completion date: October 30, 2004. ⊕				
2. Collect data on cancer diagnosis by stage, and calculate the number of preventable cancer deaths by gender, race, and age group, with earlier detection	DHSS, permanent council	Year 1	Allocated: $50,000	Proposed tobacco excise tax
Anticipated completion date: October 30, 2004. ⊕				
3. Summarize and distribute results to improve program planning and healthy lifestyle choices	DHSS, permanent council	Year 2	Allocated: $25,000	Proposed tobacco excise tax
Anticipated completion date: October 30, 2004. ⊕				

EFFECT ON DISPARITIES
⊕ *POSITIVE* ⊗ *NEGATIVE* ○ *NEUTRAL*

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Improve the collection and reporting of cancer incidence and mortality data.
The following specific tasks and activities should be included:

TASK/ACTIVITY	RESPONSIBLE PARTY	TIMEFRAME	COSTS*	POTENTIAL SOURCES**
1. Amend the Cancer Control Act to extend the time interval within which a newly diagnosed cancer case must be reported to DPH to 180 days, consistent with standards of the American College of Surgeons	General assembly	Year 1	None	
DONE ⊕				
2. Enforce reporting requirements; impose fines for nonreporting	DHSS	Year 1	None	
In progress. ⊕				
3. Increase information collected by the cancer registry including demographics, occupational history, and exposures to certain risks	DHSS	Year 2 and ongoing	Recommended: $300,000 annually Allocated: $0	Proposed tobacco excise tax
DONE *Continuing.* ⊕				
4. On death certificates, improve reporting of the cause of death by educating physicians on proper procedure	DHSS	Year 1 and ongoing	Allocated: $20,000 annually	Proposed tobacco excise tax
DONE *Additional funds provided by DPH Diabetes Program.* ⊕				
5. Introduce and pass legislation requiring hospitals to staff their registries with a certified tumor registrar	General assembly	Year 1	None	
Introduced, but not passed. ○				
6. Provide certification training and annual continuing education for tumor registrars	DHSS	Year 1 and ongoing	Existing resources	
To begin October 1, 2004. ○				
7. Reclassify the director position of Delaware Cancer Registry to a higher pay-grade	DHSS	Year 2	Existing resources	
Position in process of being established. ○				

(continued)

Improve the collection and reporting of cancer incidence and mortality data.
The following specific tasks and activities should be included:

TASK/ACTIVITY	RESPONSIBLE PARTY	TIMEFRAME	COSTS*	POTENTIAL SOURCES**
8. Publish report annually that integrates most recent cancer incidence, mortality, and risk behavior data	DHSS	Year 1 and ongoing	Existing resources	
Infrastructure established. ⊕				
9. Fully staff the Delaware Cancer Registry, and assure appropriate continuing education	DHSS	Year 1 and ongoing	Recommended funding: $40,000 annually Allocated Year 1: $0	CDC grant, Delaware Health Fund
To begin August 1, 2004. ⊕				
10. Expand population-based survey of present and past tobacco use and exposure to environmental tobacco smoke (ETS); report statistically valid results by age, race, income, educational level, occupation, gender, and zip code	DHSS	Year 2	Recommended: $100,000 Allocated: $0	Proposed tobacco excise tax
Current survey collects required data. ⊕				
11. Develop a public education campaign on cancer rates and their age-adjustment to the 2000 U.S. standard population	DHSS, governor's office	Year 1	Existing resources	
Anticipated completion date: September 30, 2004. ⊕				
12. Evaluate the ability to standardize race and ethnicity data collection across cancer-related data sets	DHSS	Year 2	Recommended: $25,000 Allocated: $0	Proposed tobacco excise tax
To be completed in year 2. ⊕				
13. Evaluate the ability to match cancer incidence and mortality records, including special software, and develop matching capabilities	DHSS	Year 2	Recommended: $25,000 Allocated: $0	Proposed tobacco excise tax
To be completed in year 2. ⊕				

EFFECT ON DISPARITIES

⊕ *POSITIVE* ⊗ *NEGATIVE* ○ *NEUTRAL*

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Conduct a survey to examine the importance of past exposure to today's cancer rates.

The following specific tasks and activities should be included:

TASK/ACTIVITY	*RESPONSIBLE PARTY*	*TIMEFRAME*	*COSTS**	*POTENTIAL SOURCES***
1. Conduct a retrospective survey of individuals with cancer or family members of cancer patients to collect information on family history, occupation, lifestyle, diet, exercise, migration, etc. (include only those cancers for which the state is elevated in incidence or mortality); obtain data necessary to determine which environmental factors may contribute to Delaware's heightened cancer rates	DHSS	Years 1-3	Allocated: $250,000	Proposed tobacco excise tax
Anticipated completion date: October 30, 2004. ⊕				
2. Analyze results and develop appropriate control strategies	DHSS	Year 3	Allocated: $50,000	Proposed tobacco excise tax
To be addressed in Years 2 and 3. ⊕				

EFFECT ON DISPARITIES

⊕ *POSITIVE* ⊗ *NEGATIVE* ◯ *NEUTRAL*

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YEAR-ONE ACCOMPLISHMENTS

DELAWARE CANCER CONSORTIUM

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ENVIRONMENT COMMITTEE

DISPARITIES COMMITTEE

"We've begun collecting info about public and well water, fish from the bay, and carcinogens that are harbored in homes and places people least expect. We're working hard to clean up the environment indoors and out. We're getting useful information to the public so they can better understand where they can avoid risks in their everyday lives." | MEG MALEY, RN, BSN

WE'RE REDUCING THE THREAT OF CANCER FROM THE ENVIRONMENT.

Exposure to cancer-causing substances can occur anywhere in our daily environment including in our homes and workplaces, during our commutes, in the buildings we enter, and where we spend time outside. We're working to help learn more about our environmental risks so we can make healthy decisions and good policies.

Reduce exposure to carcinogenic substances in the ambient environment.
The following specific tasks and activities should be included:

TASK/ACTIVITY	*RESPONSIBLE PARTY*	*TIMEFRAME*	*COSTS**	*POTENTIAL SOURCES***
A. Related to Delaware Air				
A1. Conduct specialized ambient air quality monitoring to determine actual concentrations of air toxins in Delaware	DNREC	Year 1	Recommended funding $300,000, plus $300,000 existing resources Allocated: $0	Proposed tobacco excise tax
DONE *DNREC completed air monitoring activities, compiled an inventory of Delaware air toxins (pollutants) that occurred in 2002, and made projections for 2003. (No funds allocated, federal and penalty funds used to cover costs totalling more than $800,000). Monitoring continues through 2005.* ○				
A2. Evaluate the types of cancers associated with those substances found at elevated levels, and compare to those cancers for which Delaware is elevated in incidence and mortality (link databases)	DNREC, DHSS	Year 2	Existing resources	
To be addressed in Year 2. ○				
A3. Notify the public of past and current levels of carcinogenic substances that are monitored in Delaware	DNREC, DCC	Year 2	Existing resources	
To be addressed in Year 2. ○				
A4. Acting on the information from monitoring, develop and implement strategies to reduce air contamination from those sources	DNREC, DCC	Year 2 and ongoing	Existing resources	
To be addressed in Year 2. ○				

EFFECT ON DISPARITIES

⊕ *POSITIVE* ⊗ *NEGATIVE* ○ *NEUTRAL*

*Only state funding for Year 1 costs are shown. The recommended cost is given if it differs from the actual allocation.
**Original source recommendation is given. This may differ from actual funding source.

(continued)

Reduce exposure to carcinogenic substances in the ambient environment.

The following specific tasks and activities should be included:

TASK/ACTIVITY	*RESPONSIBLE PARTY*	*TIMEFRAME*	*COSTS**	*POTENTIAL SOURCES***
B. Related to Delaware Drinking Water				
B1. Expand monitoring of state's shallow aquifers for pesticides by increasing the number of pesticides/ herbicides and their degradants analyzed	DDA, DHSS, DNREC		Recommended: $80,000 annually to support DDA monitoring network Allocated: $0	U.S. EPA
DONE *Department of Agriculture expanded sample size and completed testing.*				
B2. Initiate screening of all public water systems using shallow wells; continue monitoring of public water systems and private shallow wells near known hazardous waste sites for cancer-causing substances not currently regulated by the U.S. EPA or the state	DHSS, DNREC	Year 1 and ongoing	Recommended funding: $400,000 annually Allocated: $0	Hazardous Substance Control Act (HSCA), proposed tobacco excise tax, increase fees for services to public water systems
Recommendation revised (no funds allocated, private well testing to be initiated in Year 2).				
B3. Evaluate the types of cancers associated with those substances found at elevated levels, and compare to those cancers for which Delaware is elevated in incidence and mortality	DHSS	Year 2 and ongoing	Existing resources	
To be addressed in Year 2.				
B4. Notify the public of past and current levels of carcinogenic substances that are monitored in Delaware	DHSS, DCC	Year 2 and ongoing	Existing resources	
To be addressed in Year 2.				
B5. Acting on the information from monitoring, develop and implement strategies to reduce water contamination from those sources	DHSS, DCC	Year 2 and ongoing	Existing resources	
To be addressed in Year 2.				

(continued)

Reduce exposure to carcinogenic substances in the ambient environment.

The following specific tasks and activities should be included:

TASK/ACTIVITY	*RESPONSIBLE PARTY*	*TIMEFRAME*	*COSTS**	*POTENTIAL SOURCES***
C. Related to Delaware Waterways				
C1. Increase location, frequency, and number of fish sampled, from 20 total samples to 40 total samples annually	DNREC, DHSS	Years 1–3	Allocated: $50,000 per year	Proposed tobacco excise tax
DONE *A detailed plan was created and implemented to collect and analyze the increased number of fish in the fall of 2003 by DNREC and DPH.*				
C2. Determine the level of awareness and actual compliance rates with fish advisory information, and develop recommendations for improvement	DNREC, DHSS	Years 1 and 2	Allocated: $10,000 per year	Proposed tobacco excise tax
Project to be completed in February 2005.				
C3. Conduct an education/ awareness campaign related to C2 above	DNREC, DHSS	Years 2 and 3	Recommended: $35,000 per year Allocated: $0	Proposed tobacco excise tax
To be addressed in Year 2.				
C4. Enhance on-site advisory information and warnings to include postings with metal and Tyvek® signs, tamper-resistant hardware, bilingual signs, and related literature	DNREC, DHSS	Years 1–3	Allocated: $30,000 per year	Proposed tobacco excise tax
Planning under way. To be completed in Year 2.				

EFFECT ON DISPARITIES

⊕ *POSITIVE* ⊗ *NEGATIVE* ○ *NEUTRAL*

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**Original source recommendation is given. This may differ from actual funding source.

Coordinate with federal OSHA to reduce workplace carcinogenic risk and exposure.

The following specific tasks and activities should be included:

TASK/ACTIVITY	RESPONSIBLE PARTY	TIMEFRAME	COSTS*	POTENTIAL SOURCES**
1. Establish full cooperative agreement with federal OSHA leading to the creation of an Office of Occupational Health, to monitor, investigate, and enforce workplace OSHA violations and identify populations at risk from occupational exposure to carcinogens intitially, but with intent to extend to other toxic hazards	General assembly, executive branch	Year 1	Recommend funding Year 1: $400,000, $250,000 (Year 2 and on) Allocated: $0	Proposed tobacco excise tax
Legislation under development. ○				
2. Obtain exposure data for exposures to Delaware workplace carcinogens from OSHA	Office of Occupational Health	Year 1		
To be addressed in Year 2. ○				
3. Review federal OSHA requirements limiting exposure from carcinogens, and determine if there are gaps relevant to DE that need to be addressed regarding employee protection	Office of Occupational Health	Year 1		
To be addressed in Year 2. ○				
4. Identify high-risk workers by reviewing the Toxic Release Inventory (TRI) data and targeting occupations not covered by OSHA at high risk for cancer	Office of Occupational Health	Year 2		
To be addressed in Year 2. ○				
5. Implement educational, regulatory, and "right-to-know" programs to reduce exposure	Office of Occupational Health	Years 3–4	Recommended: $50,000 annually Allocated: $0	Proposed tobacco excise tax
To be addressed in Year 3. ○				

Reduce exposure to carcinogens in the indoor environment.

The following specific tasks and activities should be included:

TASK/ACTIVITY	RESPONSIBLE PARTY	TIMEFRAME	COSTS*	POTENTIAL SOURCES**
1. Create and promote new initiative to increase radon testing, and provide financial assistance for remediation to low-income homeowners	DHSS	Year 1 and ongoing	Allocated: $75,000 annually	Delaware Health Fund
DONE *Remediation assistance in place.* ⊕				
2. Require radon testing in all residential real estate transfers (model after lead testing requirements)	General assembly	Year 1		
Legislation under development. ○				
3. Create industry incentives (e.g., interest-free loans) for dry-cleaners to eliminate the use of cancer-causing solvents	DEDO, DNREC	Years 2–5	To be determined	DEDO Strategic Fund
To be addressed in Year 2. ○				
4. Develop and maintain a broad-based public education campaign based on findings from the national Total Exposure Assessment Methodology (TEAM) studies *(Research Triangle Institute 1996)*	DNREC, DHSS	Year 1 and ongoing	Recommended: $80,000 (Year 1) $50,000 (Year 2 and on) Allocated: $80,000	Proposed tobacco excise tax
Campaign under development. ⊕				

EFFECT ON DISPARITIES

⊕ *POSITIVE* ⊗ *NEGATIVE* ○ *NEUTRAL*

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YEAR-ONE ACCOMPLISHMENTS

DELAWARE CANCER CONSORTIUM

INSURANCE COMMITTEE

COLORECTAL CANCER COMMITTEE

TOBACCO COMMITTEE

QUALITY COMMITTEE

INCREASE KNOWLEDGE & PROVIDE INFORMATION COMMITTEE

ENVIRONMENT COMMITTEE

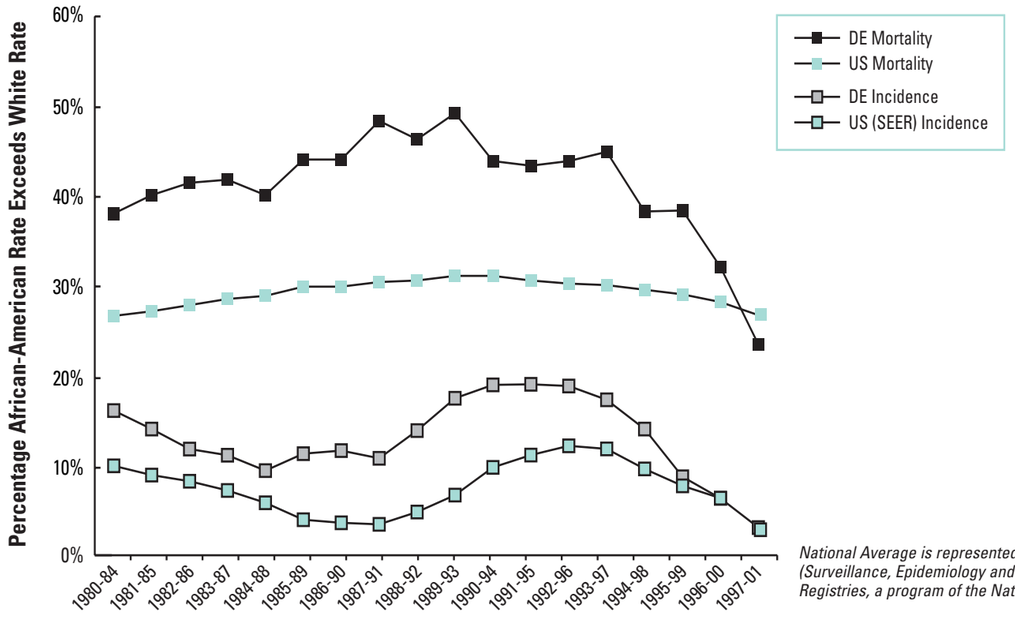
DISPARITIES COMMITTEE

"We are acutely aware of the toll cancer has taken in the African-American community. Death and incidence rates continue to be higher than the national average. But we're seeing those statistics improve. We are making progress." | LIEUTENANT GOVERNOR JOHN CARNEY

WE'RE ADDRESSING THE UNEQUAL CANCER BURDEN.

Every task and every effort we initiated was driven by our goal to reduce the disparity of cancer. We pay for treatment for uninsured individuals who meet income guidelines. Individuals can qualify for free colorectal cancer screenings. We're coordinating care efficiently. We're finding ways to inform people how they can help themselves. And we're making progress. We must continue to find ways to provide culturally competent and linguistically appropriate information and services to those with cancer.

PERCENTAGE THAT AFRICAN-AMERICAN CANCER RATES EXCEED WHITE RATES BASED ON AGE-ADJUSTED RATES PER 100,000, DELAWARE AND U.S.



National Average is represented by SEER (Surveillance, Epidemiology and End Results) Registries, a program of the National Cancer Institute.

Compile and analyze existing data on health disparities and cancer into a report, and inform through a public education campaign.

The following specific tasks and activities should be included:

TASK/ACTIVITY	*RESPONSIBLE PARTY*	*TIMEFRAME*	*COSTS**	*POTENTIAL SOURCES***
1. Analyze data on minorities associated with poor health outcomes for cancer overall and for breast, lung, colorectal, and prostate cancers—specifically	DPH, university-affiliated centers, DCC	Year 1	Allocated: $20,000	Proposed tobacco excise tax
To be completed by end of 2004. ⊕				
2. Analyze trends in disparities related to societal, policy, or system level changes that may affect whether certain groups get cancer or die from cancer at a higher rate	DPH, university-affiliated centers, DCC	Year 1	Allocated: $20,000	Proposed tobacco excise tax
To be completed by end of 2004. ⊕				
3. Develop a fact sheet with action steps and a public education campaign that correlates with the demographic, health, behavior, and social data collected above; campaign would discuss how to decrease cancer incidence and mortality in Delaware among minorities and high-risk groups	DPH, university-affiliated centers, DCC	Year 2	Allocated: $10,000	Proposed tobacco excise tax
To be completed by end of 2004. ⊕				

EFFECT ON DISPARITIES

⊕ *POSITIVE* ⊗ *NEGATIVE* ○ *NEUTRAL*

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Appendix

SPONSOR: Sen. McBride & Rep. Hall-Long & Sen. Sorenson & Rep. Ulbrich & Sen. Simpson;
Sens. Adams, Blevins, Bunting, Cook, DeLuca, Henry, Marshall, McDowell, Peterson, Sokola, Vaughn, Venables, Amick, Bonini, Cloutier, Connor, Copeland & Still;
Reps. Atkins, Booth, Boulden, Buckworth, Carey, Cathcart, Caulk, DiPinto, D. Ennis, Ewing, Fallon, Hocker, Hudson, Lavelle, Lee, Lofink, Maier, Miro, Oberle, Quillen, Reynolds, Roy, Smith, Spence, Stone, Thornburg, Valihura, Wagner, B. Ennis, George, Gilligan, Houghton, Keeley, Mulrooney, Plant, Schwartzkopf, Van Sant, Viola & Williams

DELAWARE STATE SENATE
142nd GENERAL ASSEMBLY
SENATE BILL NO. 102
AN ACT TO AMEND TITLE 16 OF THE DELAWARE CODE TO CREATE A DELAWARE CANCER CONSORTIUM.

WHEREAS, the Delaware Advisory Council on Cancer Incidence and Mortality (the "Advisory Council") was created by Senate Joint Resolution 2 of the 141st General Assembly; and

WHEREAS, the Advisory Council issued a report in April, 2002 containing a series of recommendations to reduce the incidence and mortality of cancer in Delaware; and

WHEREAS, the Advisory Council's recommendations cover a period of five years from the date of its report, and involve the active participation of many members of the public and private sectors; and

WHEREAS, it is important that an entity be established to advocate for and monitor achievement of the Advisory Council's recommendations;

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF DELAWARE:

Section 1. Amend §133, Title 16, Delaware Code, by deleting subsection (b), and replacing it with the following:

"(b) The Delaware Cancer Consortium ("Consortium") shall coordinate cancer prevention and control activities in the State of Delaware. The Consortium will:

Provide advice and support to state agencies, cancer centers, cancer control organizations, and health care practitioners regarding their role in reducing mortality and morbidity from cancer.

Facilitate collaborative partnerships among public health agencies, cancer centers, and all other interested agencies and organizations to carry out recommended cancer control strategies.

On at least a biennial basis, analyze the burden of cancer in Delaware and progress toward reducing cancer incidence and mortality.

Section 2. Amend §133, Title 16, Delaware Code, by adding the following new subsections:

"(c) The Consortium's priorities and advocacy agenda shall be dictated by the recommendations contained in 'Turning Commitment Into Action—Recommendations of the Advisory Council on Cancer Incidence and Mortality,' published in April, 2002.

(d) The Consortium's permanent membership shall be as follows:

(i) Two representatives of the Delaware House of Representatives and two representatives of the Delaware State Senate (one selected by each caucus);

(ii) One representative of the Governor's office;

(iii) The Secretary of the Department of Health and Social Services or his or her designee;

(iv) One representative of the Department of Natural Resources and Environmental Control;

(v) One representative of the Medical Society of Delaware to be appointed by the Governor;

(vi) One professor from Delaware State University or the University of Delaware, to be appointed by the Governor;

(vii) Two physicians with relevant medical knowledge, to be appointed by the Governor;

(viii) One representative of a Delaware hospital cancer center to be appointed by the Governor;

(ix) Three public members with relevant professional experience and knowledge, to be appointed by the Governor.

(e) Appointees to the Consortium shall serve at the pleasure of the person or entity that appointed them.

(f) The Consortium's permanent members may enact procedures to appoint additional persons to the Consortium.

(g) The Consortium shall have a chair and a vice-chair, to be appointed from among the permanent members by the Governor and to serve at the pleasure of the Governor. Staff support for the Consortium shall be provided by the Delaware Division of Public Health."

SYNOPSIS

This legislation creates the Delaware Cancer Consortium, a collaborative effort between private and public entities designed to implement the recommendations of the Delaware Advisory Council on Cancer Incidence and Mortality.

Author: Senator McBride

BACKGROUND

Formation of the Delaware Cancer Consortium

The Delaware Cancer Consortium was originally formed as the Delaware Advisory Council on Cancer Incidence and Mortality in March 2001 in response to Senate Joint Resolution 2 signed by Governor Ruth Ann Minner. The advisory council, consisting of 15 members appointed by the governor, was established to advise the governor and legislature on the causes of cancer incidence and mortality and potential methods for reducing both. The advisory council was later expanded and its name changed to the Delaware Cancer Consortium (DCC) in SB102.

Developing a Plan for Action

DCC began meeting in April 2001 with the shared understanding that their work would be focused on developing a clear and useable cancer control plan. Another shared priority was that extensive input would be needed from professionals in cancer control, as well as from Delaware citizens affected by cancer. With these priorities in mind, DCC worked on a system to:

- create a shared awareness and agreement on the range of cancer control issues to be addressed now and in the future;
- create a structure and agenda for addressing these needs;
- enable Delaware to move forward with meaningful action for its citizens.

To accomplish these goals, DCC heard from speakers on Delaware cancer statistics, including Dr. Jon Kerner from the National Cancer Institute, and began monthly presentations from Delaware cancer survivors or family members who had lost a loved one to cancer. The stories, woven throughout this report, provided valuable insight into some of the concerns and barriers faced by people battling cancer, the stress this disease places on all aspects of their lives, and ideas for ways that Delaware can help ease these burdens on its citizens.

A unique project, called Concept Mapping, was also initiated to get input on cancer issues from Delaware citizens and to help DCC establish priorities and its scope of work. DCC invited more than 195 Delaware citizens who are invested in cancer control efforts to participate in the project. Both DCC and those invited completed the brainstorming phase, during which they provided their ideas on completing the statement: "A specific issue that needs to be addressed in comprehensive cancer control in Delaware is…." Over 500 statements were submitted, and editing of these to avoid duplication resulted in 118 ideas about controlling cancer in Delaware. These ideas were then rated, relative to each other, on importance and feasibility.

Development of Subcommittees and Recommendations

From the results of the Concept Mapping activity and the numerous speakers, the DCC developed a clear set of priorities and established six subcommittees to address these issues. Each subcommittee, chaired by a member of DCC, was provided with a list of priorities in its focus area, from which specific recommendations were developed. DCC carefully reviewed the work of the subcommittees, made modifications or additions as needed, and the resulting final recommendations are compiled in this report.

DELAWARE ADVISORY COUNCIL ON CANCER INCIDENCE & MORTALITY MEMBER LISTING

William W. Bowser, Esquire (Chair)
Young Conaway Stargatt & Taylor, LLP

The Honorable John C. Carney, Jr.
Lt. Governor, State of Delaware

Matt Denn, Esquire
Young Conaway Stargatt & Taylor, LLP

Christopher Frantz, MD
A.I. duPont Hospital for Children

Stephen Grubbs, MD
Medical Oncology Hematology Consultants, PA

The Honorable Bethany Hall-Long
University of Delaware

Patricia Hoge, PhD, RN
American Cancer Society

John Hughes
Department of Natural Resources

Meg Maley, RN, BSN
Oncology Care Home Health Specialists, Inc.

The Honorable David McBride
Delaware Senate

Julio Navarro, MD
Glasgow Family Practice

Nicholas Petrelli, MD
Helen F. Graham Cancer Center

Jaime H. Rivera, MD, FAAP
Delaware Division of Public Health

The Honorable Liane Sorenson
Delaware Senate

James Spellman, MD, FACS, FSSO
Beebe Hospital Tunnel Cancer Center

The Honorable Stephanie Ulbrich
Delaware House of Representatives

Colorectal Cancer Committee

Chairperson:
Stephen Grubbs, MD, Medical Oncology Hematology Consultants, PA

Members:
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Victoria Cooke, Delaware Breast Cancer Coalition
Allison Gil, American Cancer Society
James Gill, MD, MPH, Christiana Care Health Services
Paula Hess, BSN, RN, Bayhealth Medical Center
Nora Katurakes, RN, MSN, OCN, Helen F. Graham Cancer Center
Carolee Polek, RN, MSN, PhD, Delaware Diamond Chapter of the Oncology Nursing Society
Anthony Policastro, MD, Nanticoke Memorial Hospital
Catherine Salvata, MSN, RN, Bayhealth Medical Center

Disparities Committee

Chairperson:
The Honorable Lt. Governor John C. Carney, Jr.

Members:
Semaan Abboud, MD, Lewes Medical & Surgical Associates
Matt Denn, Esq., Young Conaway Stargatt & Taylor, LLP
Robert Frelick, MD
Helene Gladney, City of Wilmington
Connie Green-Johnson, Quality Insights of Delaware
Susan Lockhart
Lolita A. Lopez, Westside Health Services
Andrew P. Marioni, State Disability Determination Service
Nicolas Petrelli, MD, Helen F. Graham Cancer Center
Jaime H. Rivera, MD, FAAP, Delaware Division of Public Health
Kathleen C. Wall, American Cancer Society
Mary Watkins, Delaware State University

Environment Committee

Chairperson:
Meg Maley, RN, BSN, Oncology Care Home Health Specialists, Inc.

Members:
Scott Blaier, Delaware Department of Agriculture
Deborah Brown, CHES, American Lung Association of Delaware
John A. Hughes, Department of Natural Resources
Kay Makar, MPH, RD, CDN, American Cancer Society
Gilbert J. Marshall, PG, Marshall GeoScience, Inc.
Patricia C. Scarborough, American Cancer Society
The Honorable Liane Sorenson, Delaware Senate
Laurel Standley, Watershed Solutions, LLC
The Honorable Stephanie Ulbrich, Delaware House of Representatives

Increase Knowledge & Provide Information Committee

Chairperson:
The Honorable Bethany Hall-Long, PhD, RNC, Delaware House of Representatives, University of Delaware

Members:
Jeanne Chiquoine, American Cancer Society
Jayne Fernsler, DSN, RN, AOCN
Linda Fleisher, MPH, NCI's Cancer Information Service, Atlantic Region
Arlene S. Littleton, Sussex County Senior Services
H.C. Moore, Delaware Cancer Registrars Association
John Ray, Delaware Department of Education
The Honorable Liane Sorenson, Delaware Senate
Janet Teixeira, MSS, LCSW, Cancer Care Connection
Judy Walrath, PhD, Christiana Care Health System
Linda Wolfe, Department of Education

Quality Committee

Chairperson:
Julio Navarro, MD, Glasgow Family Practice

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Margaretta Dorey, RN, BSN, Delaware Pain Initiative, Inc.
Christopher Frantz, MD, A.I. duPont Hospital for Children
Wendy Gainor, Physician's Advocacy Program, Medical Society of Delaware
Andrea Holecek, RN, MSN, CRNI, AOCN, Bayhealth Medical Center
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Nicholas Petrelli, MD, Helen F. Graham Cancer Center
Anthony Policastro, MD, Nanticoke Memorial Hospital
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Edward Sobel, DO, Quality Insights of DE
James Spellman, MD, FACS, FSSO, Beebe Hospital Tunnel Cancer Center

Tobacco Committee

Chairperson:
Patricia Hoge, PhD, RN, American Cancer Society

Members:
Deborah Brown, CHES, American Lung Association of Delaware
Jeanne Chiquoine, American Cancer Society
Cathy Scott Holloway, American Cancer Society
Steven Martin, University of Delaware
The Honorable David McBride, Delaware Senate
John Ray, Delaware Department of Education
Robert Simmons, PhD, MPH, CHES, Christiana Care Health Services
A. Judson Wells, PhD

Insurance Committee

Chairperson:
Matt Denn, Esq., Young Conaway Stargatt & Taylor, LLP

Members:
The Honorable Patricia Blevins, Delaware Senate
Alicia Clark, Executive Director, Metropolitan Wilmington Urban League
Richard Heffron, Delaware State Chamber of Commerce
Jaime H. Rivera, MD, FAAP, Delaware Division of Public Health
The Honorable Donna Stone, Delaware House of Representatives

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ABBREVIATIONS

ACS—American Cancer Society

ALA—American Lung Association

AHA—American Heart Association

BRFSS—Behavioral Risk Factor Surveillance Survey

CFTFK—Campaign for Tobacco-Free Kids

DCC—Delaware Cancer Consortium

DDA—Delaware Department of Agriculture

DHFAC—Delaware Health Fund Advisory Committee

DHSS—Department of Health and Social Services

DNREC—Department of Natural Resources and Environmental Control

DOE—Department of Education

IMPACT—IMPACT Delaware Tobacco Prevention Coalition

MCO—Managed Care Organizations

Special thanks

to the Division of Public Health,
Delaware Department of Health and Social Services,
for providing logistic support and its effort
on behalf of this project.