Priority Goal: Cancer

Goal 5: Reduce the number of new cancer cases as well as illness, disability, and death caused by cancer.

Process Snapshot:

In the Community Themes and Strengths survey, residents identified cancer as the fourth most troubling health issue in South Heartland communities. Cancers are the second leading cause of death in the health district (five-year period, 2012-2016). Estimates suggest that less than 30% of a person's lifetime risk of getting cancer results from uncontrollable factors (e.g., family history, gender). The remaining 70% risk can be modified by lifestyle change, including diet (Harvard Medical School, Sept, 2016). Strategies, objectives and key performance indicators were developed to address this priority, utilizing strategies focused on health system and community-based settings, access to resources and information, and policy and environmental changes. Cancer prevention strategies include primary and secondary prevention in provider settings, secondary prevention in the community setting, prevention through referral and barrier reduction, research on local cancer risks, and connecting people and organizations to resources and information.

Line of Sight Performance Measures and Targets

Local targets were set to achieve a 6% improvement over the next 6 years, consistent with the target of 10% change over 10 years set by Healthy People 2020. Incidence/Mortality**:** Rates based on 100,000 population. Source - *Nebraska Cancer Registry, 2011-2015*

- Reduce incidence / mortality rates due to Female Breast Cancer
  Baseline: 131.6 (State 124.1) / 22.8 (State 19.9)
  Target: 123.7 / 21.4
- Reduce the incidence / mortality rates due to Colorectal Cancer
  Baseline: 42.6 (State 43.0) / 16.3 (State 15.7)
  Target: 40.0 / 15.33
- Reduce incidence / mortality rates due to Prostate Cancer
  Baseline: 117.1 (State 114.4) / 18.8 (State 20.2)
  Target: 110.1 / 16.9
- Reduce incidence / mortality rates due to Skin Cancer
  Baseline: 29.0 (State 22.1) / 5.6 (State 3.0)
  Targets: 27.3 / 5.3
- Reduce incidence / mortality rates due to Lung Cancer
  Baseline: 63.3 (State 58.7) / 43.9 (State 41.8)
  Target: 59.5 / 41.3

Priority Area 5: Cancer			
Strategy 5a: Primary prevention in the clinic setting			
<u>6 Year objective</u>: Increase the proportion of patients assessed by providers and who are aware and counseled on their cancer risk factors			
What will be measured: • The number of patients who received an annual comprehensive cancer risk assessment and counseling during patient visits • The proportion of patients assessed and counseled annually	**Baseline/Target:** TBD	**Data Source:** • Primary Data Collected from local Provider offices (consider collected by provider, by practice, by district)	**Timeframe:** by 2024
Continuum of Care: • Primary Prevention	**Population:** • All patients	**Setting:** • Provider Offices	**Lead Organizations:** • Brodstone
Evidence Based: USPSTF - screening, Community Guide What Works – Screening/Provider Assessment and Feedback/One-on-one education; State Cancer Plan		**Accountability:** Cancer Steering Committee	
Short Term Key Performance Indicators (KPIs): • Determine the number of providers with knowledge, attitudes and beliefs supporting assessment and counseling on cancer risk factors. • Determine the current assessment practices done in provider offices. • Design or adopt a comprehensive cancer risk assessment tool.	**Intermediate Term KPIs:** • Increase the number of providers with knowledge, attitudes and beliefs supporting assessment and counseling on cancer risk factors. • Providers adopt through policy/protocol a comprehensive cancer risk assessment tool.	**Long Term KPIs:** • Number of patients who have access to providers with policies/protocols for counseling on cancer risk factors. • The number of providers utilizing comprehensive cancer assessment, tool at patient visits.	
Cancer Related Factors, Examples: radon exposure, second hand smoke, smoking, lung cancer screening, sun safe behaviors, farm chemicals, ACEs, nutrition, physical activity or weight, alcohol, HPV vaccination status			

Priority Area 5 : Cancer			
Strategy 5b: Primary prevention in the community setting			
6 Year objective: Implement consistent messaging on cancer risk factors and empower individuals to make healthy choices			
What will be measured: • Knowledge, attitudes and beliefs about cancer risk factors and healthy choices	**Baseline/Target:** • Measured with pre-assessment	**Data Source:** • Pre/post knowledge assessments	**Timeframe:** by 2024
Continuum of Care: • Primary Prevention	**Population:** • All individuals, especially vulnerable and high risk (consider cancer type, age, race, lifestyles, financial/ insurance status, exposure risk)	**Setting:** • Worksites • Schools/School Aged • Pools/Tanning Beds • Multi-unit housing • Rural/Agriculture related	**Lead Organizations:** • Morrison Cancer Center
Evidence Based: USPSTF/Community Guide What Works – small media targeting clients, group education, client reminders, assessment/provider feedback		**Accountability:** Cancer Steering Committee	
Short Term Key Performance Indicators (KPIs): • Implementation of coordinated awareness initiatives to increase knowledge, attitudes and beliefs about cancer risk factors and healthy choices.	**Intermediate Term KPIs:** • Increase the number of partners participating in coordinated awareness initiatives. • Increase the numbers coordinated awareness initiatives to increase knowledge, attitudes and beliefs about cancer risk factors and healthy choices.	**Long Term KPIs:** • Number of awareness initiatives within our communities.	
Examples: Radon awareness (SHDHD), sun safety (MCC and SHDHD), HPV awareness (SHDHD), physical activity and nutrition, smoking, alcohol, emerging risks			

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<tr><td colspan="4">Priority Area 5: Cancer</td></tr>
<tr><td colspan="4">Strategy 5c: Secondary prevention in the community and clinical setting</td></tr>
<tr><td colspan="4"><u>6 Year objective</u>: Increase the number of individuals up to date on recommended cancer screenings</td></tr>
<tr><td>What will be measured:
The percent up to date on cancer screenings:
Cervical- female age 21-65
Colorectal- male/female age 50 through 74
Breast- female age 50-74
Prostate- male age 40+ having doctor/nurse or other health professional discuss PSA test</td><td>Baseline/Target:
Cervical:
80.8% (2016 data) / 92%
Colorectal:
(ages 50 through 74 yrs)
Male: 71.8% / 80%
Female: 65.8% / 80%
Breast:
69% (2016 data) / 73%
Prostate:
no data available</td><td>Data Source:
BRFSS
Target Setting Method:
Cervical: NE DHHS State Cancer Goals
Colorectal: NE DHHS State Cancer Goals
Breast: 1% improvement/year</td><td>Timeframe:
by 2024</td></tr>
<tr><td>Continuum of Care:
Secondary Prevention</td><td>Population:
All age appropriate patients</td><td>Setting:
Provider Offices
Community</td><td>Lead Organizations:
SHDHD Cancer Coalition</td></tr>
<tr><td colspan="2">Evidence Based: USPSTF - screening, Community Guide What Works – Provider reminder & recall systems</td><td colspan="2">Accountability: Cancer Steering Committee</td></tr>
<tr><td>Short Term Key Performance Indicators (KPIs):
Implementation of coordinated District wide awareness initiative to increase knowledge, attitudes and beliefs about cancer risk factors and screenings.
Determine current client reminder/recall practices.</td><td>Intermediate Term KPIs:
Increase the number of partners participating in coordinated awareness initiative.
Increase the number of clinics with reminder/recall protocols/policies.</td><td colspan="2">Long Term KPIs:
Standard practice and communication plan for coordinated District wide awareness initiative.
Increase utilization rates of reminder/recall practices.</td></tr>
<tr><td colspan="4">Community Screening venues: pharmacies, health fairs/screening events, health departments, worksites, mobile screening (mammography - mammovan)</td></tr>
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<tr><td colspan="4">Priority Area 5: Cancer</td></tr>
<tr><td colspan="4">Strategy 5d: Prevention through referral and barrier reduction</td></tr>
<tr><td colspan="4"><u>6 Year objective</u>: Increase the access to cancer screening, diagnosis and treatment</td></tr>
<tr><td>What will be measured:
Screening Rates</td><td>Baseline/Target:
Cervical:
80.8% (2016 data) / 92%
Colorectal:
(ages 50 through 74 yrs)
Male: 71.8% / 80%
Female: 65.8% / 80%
Breast:
69% (2016 data) / 73%</td><td>Data Source:
BRFSS for screening rates
Primary data from Every Woman Matters and organizations or events participating in barrier reduction
NE Cancer Registry Data
Target Setting Method:
Cervical: NE DHHS State Cancer Goals
Colorectal: NE DHHS State Cancer Goals
Breast: 1% improvement/year</td><td>Timeframe:
by 2024</td></tr>
<tr><td>Continuum of Care:
Secondary Prevention
Tertiary Prevention</td><td>Population:
All age appropriate individuals/patients</td><td>Setting:
Provider Offices
Community</td><td>Lead Organizations:
SHDHD Cancer Coalition</td></tr>
<tr><td colspan="2">Evidence Based: CG, What Works – Screening, reducing barriers, USPSTF - screening</td><td colspan="2">Accountability: Cancer Steering Committee</td></tr>
<tr><td colspan="2">Short Term Key Performance Indicators (KPIs):
Identify clinics that incorporate health literacy and Culturally & Linguistically Appropriate Services (CLAS).
Identify clinics that assess patients for barriers to screening, diagnosis and/or treatment and connect them to resources.
Identify resources for barrier reduction (insurance knowledge, transportation, cost, scheduling/extended hours, SHDHD Health Hub program, Health Systems Navigators).</td><td>Intermediate Term KPIs:
Increase the number of health literate organizations, including CLAS (interpretation services).
Increase clinics connecting patients with barriers to appropriate resources.
Implement resources or activities for barrier reduction (insurance knowledge, transportation, cost, scheduling/extended hours, SHDHD Health Hub program, Health Systems Navigators).</td><td>Long Term KPIs:
Increased number of organizations participating in barrier reduction for screening/diagnosis/treatment.
Increase number of clinics identifying barriers and referring patients to appropriate resources.</td></tr>
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Priority Area 5: Cancer			
Strategy 5e: Research on Cancer Risks			
<u>6 Year objective</u>: Conduct an investigation on types and prevalence of other cancers and associated risk factors in our communities			
What will be measured: • Completion of investigation	**Baseline/Target:** N/A	**Data Source:** N/A	**Timeframe:** by 2024
Continuum of Care: N/A	**Population:** • SHDHD general population	**Setting:** • Community/Environment	**Lead Organizations:** • SHDHD • College of Public Health • Morrison Cancer Center/Dr. Copur
Evidence Based: N/A		**Accountability**: Cancer Steering Committee	
Key Performance Indicators (KPI): • Completed report on types and prevalence of other cancers and associated risk factors in our communities. • Report disseminated to appropriate stakeholders.			
Examples: Lymphoma, pediatric cancers; risk factors: pesticides, insecticides, etc.			

Priority Area 5: Cancer			
Strategy 5f: Connecting people/organizations through access to resources.			
6 Year objective: Expand and improve the Resource Guide to integrate and promote local resources for accessing health care/services			
What will be measured: • Percent of users satisfied with the Resource Guide	**Baseline/Target:** N/A	**Data Source:** • Survey	**Timeframe:** by 2024
Continuum of Care: N/A **Level of Action:** Systems	**Population:** • General population; referral organizations	**Setting:** N/A	**Lead Organizations:** • Hastings Public Library
Evidence Based: CHRR – promotion of shared decision making in patient centered care & medical homes		**Lead workgroup:** Access to Care Steering Committees	
Short Term Key Performance Indicators (KPIs): • Identify work group to implement strategy (to include at least one member from each Steering Committee). • Resource gaps are identified and filled. • A platform is determined to support interactive/accessible resource and referral guide.	**Intermediate Term KPIs**: • Promotion/education on the improved Resource Guide.	**Long Term KPIs:** • Resource Guide that is more interactive and accessible (i.e., websites, Apps) to people and partners. • Resource Guide Evaluation/Satisfaction Survey Report.	
Potential considerations: 211 system, Network of Care, Library system, SHDHD and Partner websites, App, Task Force (MCC, Social Workers, Catholic Social Services, Salvation Army, WIC, Churches, cities/counties, etc.), include application of Culturally and Linguistically Appropriate Services (CLAS) and health literacy practices, no wrong door! MyLNK app – use as example resource Potential resources to include in the Guide: providers (Medicaid, holistic and alternative medicine), insurance education (expanded Medicaid, Medicaid/Medicare, Commercial Insurance), services in rural areas, provider – led resources, CHW/Navigators, Chambers of Commerce			