

ACS - AMERICAN CANCER SOCIETY

CHALLENGE GOALS, PRINCIPLES, & NATIONWIDE OBJECTIVES

EXECUTIVE SUMMARY

Strategic Planning Highlights:

- ◆ In 1996, the Board of Directors set a challenge goal for a 50% reduction in age-adjusted cancer mortality rates by the Year 2015.
- ◆ In 1998, the Board of Directors set parallel challenge goals for a 25% reduction in age-adjusted cancer incidence rates by the Year 2015, and measurable improvement in the quality of life, (physical, psychological, social, and spiritual) from the time of diagnosis and for the balance of life of all cancer survivors by the Year 2015.
- ◆ In 1998, the Incidence & Mortality Ends Committee and the Quality of Life Ends Committee were established by the Board of Directors and charged with bringing information to the Board on the opportunities for significant gains in incidence, mortality, and quality of life.
- ◆ In August 1999, nationwide objectives for specific disease sites, risk factors and quality of life domains as well as the overarching principles of Information, Measurement, Disparities, and Collaboration were adopted by the Board of Directors and integrated into the revised strategic plan by the National Assembly in November, 1999. The overarching principles were adopted as directly related to the achievement of all nationwide objectives.
- ◆ In June 2000, the Board of Directors adopted interim objectives for Incidence & Mortality targeted for years 2002-2005.
- ◆ In August 2000, the Board of Directors adopted interim objectives for Quality of Life and the Overarching Principles targeted for years 2002-2005, and added a new overarching principle for Access to Quality Treatment.
- ◆ In 2001, an interim objective was added to the Overarching Principle for Access to Quality Treatment.
- ◆ In November 2002, the Board of Directors adopted a new Quality of Life nationwide objective related to service delivery systems.
- ◆ In February/March 2003, the National Board of Directors, the Nationwide Leadership Forum, and all Divisions began an 18-month process to identify our optimal role in the fight against cancer, to align with our mission, and to develop strategic priorities with the goal of positioning the American Cancer Society to have an even greater impact on the disease.
- ◆ In June 2004, the National Board of Directors, Division Chairman's of the Board, Division Chief Executive Officers, and the National Home Office Executive Team adopted four leadership roles and eleven focus areas as areas where, on a nationwide basis, we believe we can have the greatest degree of impact. These leadership roles and focus

areas define those areas within the 2015 challenge goals where ACS will explicitly and specifically focus its efforts over the next 3 to 5 years.

The nationwide objectives for specific disease sites and risk factors are credible estimates of future changes in age-adjusted cancer rates that are likely to result both from past improvements in cancer risk factors as well as from plausible future reductions in the prevalence of those same factors. Any shortfall between the total effects of past and future risk factor improvements and the American Cancer Society 2015 challenge goals would then define the proportion of the goals and nationwide objectives that will need to come from new research findings and their rapid application to persons in need.

If the Year 2015 goals are achieved, it is estimated there may be 5.7 million fewer cancer cases and 4.9 million fewer cancer deaths than if 1990 rates remained unchanged throughout the period from 1990 to 2015.

Quality of life is a factor in the cancer experience that is being increasingly acknowledged and addressed. Issues ranging widely from the physical to the spiritual affect the cancer survivor's overall perceptions of well-being. First and foremost, people want to prevent cancer. If cancer is diagnosed, a cure is needed. But whether or not a cure is found, attention to quality of life is essential for survivors and their families. This underscores the need to reevaluate traditional approaches to serving the needs of people with cancer and their families.

The nationwide objectives for quality of life clearly delineate the wide range of effects cancer has on survivors as well as families and caregivers of those affected by cancer. These objectives also illustrate the multidimensional needs of cancer survivors and the need for comprehensive care extending over the long term.

The American Cancer Society challenge goals and objectives for reduction in age-adjusted cancer incidence and mortality rates and improvement in quality of life are not intended to be simply a passive suggestion of what theoretically is achievable. Rather, they are both a declaration and a guide for the American public of what is possible to achieve with redoubled efforts in cancer prevention and control. We hope that these challenge goals inspire and focus the efforts of many individuals, organizations, and institutions that are critical to future success in reducing the burden of cancer in the United States.

In establishing the 2015 challenge goals and objectives for age-adjusted cancer incidence and mortality rates and improvement in quality of life, the Board of Directors and both Ends Committees recognize our interdependence. The American Cancer Society is not responsible for achieving these outcomes alone and must cooperate with others in productive ways. Even though the recent nationwide prioritization process did not establish specific programs of work for each site, risk factor and quality of life objective, we still have a responsibility to be a catalyst, primarily through collaboration, to ensure that the resources of our cancer control partners address these gaps.

The Board of Directors reviews progress towards the established ends on an annual basis. In response to the review, the Board has the ability to change or modify ends statements related to incidence, mortality, quality of life, and/or principles if necessary. Any

proposed change in ends statements recommended by Divisions, the National Home Office and/or Operating Committees goes to the appropriate Ends Committee for study and then to the Board of Directors for consideration.

Following is an outline of the American Cancer Society challenge goals, principles and objectives as adopted by the National Board of Directors.

AMERICAN CANCER SOCIETY CHALLENGE GOALS, PRINCIPLES & NATIONWIDE OBJECTIVES

2015 GOALS

- ◆ 50% reduction in age-adjusted cancer mortality rates by the Year 2015.
- ◆ 25% reduction in age-adjusted cancer incidence rates by the Year 2015.
- ◆ Measurable improvement in the quality of life (physical, psychological, social, and spiritual) from the time of diagnosis and for the balance of life of all cancer survivors by the Year 2015.

PRINCIPLES

INFORMATION

BY 2015:

By 2015, state of the art information on issues related to incidence, mortality, risk factors, treatment, survivorship and quality of life (physical, social, psychological and spiritual) will be available and accessible through all appropriate channels to all people.

BY 2004:

By 2004, objectively quantify, prioritize, and create plans to fulfill unmet cancer information needs of constituents.

MEASUREMENT

Monitoring systems that track relevant incidence, mortality, risk factor and screening prevalence, and quality of life dimensions should be available nationwide.

BY 2008:

By 2008, all states will have cancer registries that meet NAACR silver or gold certification standards.

BY 2005:

By 2005, tracking systems will be developed or supported to identify and monitor the disparities between population groups in cancer incidence, mortality, risk factor and screening prevalence, and quality of life.

By 2005, systems will be developed or supported that track inputs, activities, and outputs towards achievement of Division-specific outcomes and ultimately nationwide objectives.

DISPARITIES

BY 2015:

By 2015, eliminate the disparities in cancer burdens among population groups by reducing age-adjusted cancer incidence and mortality rates and improving quality of life in the poor and underserved to the population average.

BY 2005:

By 2005, conduct or support comprehensive assessments that identify issues and needs for eliminating disparities to guide decisions on objectives, audiences, and interventions.

BY 2004:

By 2004, ensure that appropriate programs included in the American Cancer Society Nationwide Program of Work address cancer disparities and the needs of the underserved.

COLLABORATION

Efforts should be increased at all levels of the American Cancer Society for working with other organizations and agencies to achieve our common cancer control goals and objectives.

BY 2004:

By 2004, identify, enter into, and measure specific collaborations and partnerships with organizations and systems, especially those related to addressing identified cancer disparity issues.

ACCESS TO QUALITY TREATMENT

BY 2015:

By 2015, assure that all people diagnosed with cancer have access to appropriate, quality treatment and follow-up, achieving 0% disparities in treatment outcomes.

BY 2004:

By 2004, develop long-term action plans by NHO, in collaboration with the National Quality Forum and others, that (a) address access to care and (b) define indicators of quality treatment for each major cancer site.

NATIONWIDE OBJECTIVES

COLORECTAL CANCER

BY 2015:

Incidence: By 2015, reduce the age-adjusted incidence rate of colorectal cancer by 40%.

Mortality: By 2015, reduce the age-adjusted mortality rate of colorectal cancer by 50%.

Early Detection: By 2015, increase to 75% the proportion of people aged 50 and older who have colorectal screening consistent with American Cancer Society guidelines.

BY 2005:

Public Awareness: By 2005, 75% of people aged 50+ will be aware of and have knowledge about the need for colorectal screening.

Behavior Change: By 2005, 50% of people aged 50+ will have received colorectal screening following American Cancer Society guidelines as measured by the preferred tests of sigmoidoscopy, colonoscopy, or barium enema.

Access to Screening: By 2005, 100% of states will have comprehensive insurance laws or cooperative agreements that cover the costs of colorectal screening in fully insured and self-insured health plans.

LUNG CANCER/ADULT & YOUTH TOBACCO USE

BY 2015:

Incidence: By 2015, reduce the age-adjusted incidence rate of lung cancer by 45%.

Mortality: By 2015, reduce the age-adjusted mortality rate of lung cancer by 50%.

Adult Tobacco Use: By 2015, reduce to 12% the proportion of adults (18 and older) who use tobacco products.

Youth Tobacco Use: By 2015, reduce to 10% the proportion of young people (under 18) who use tobacco products.

BY 2005:

Adult Tobacco Use: By 2005, reduce to 19% the proportion of adults (18 and older) who use tobacco products.

Adult Tobacco Use: By 2005, reduce by 25% from 2000 baseline prevalence rate the proportion of low SES adults (18 and older) who use tobacco products.

LUNG CANCER/ADULT & YOUTH TOBACCO USE, CONTINUED

Youth Tobacco Use: By 2005, reduce to 15% or less the frequent use of cigarettes by young people (under 18).

Tobacco Settlement: By 2005, 75% of states will direct available tobacco control funds consistent with CDC guidelines.

Clean Indoor Air: By 2005, 50% of U.S. population will reside in communities covered by comprehensive clean indoor air laws/policies.

Tobacco-free Schools: By 2005, 100% of schools will have tobacco-free environments.

Tobacco Excise Taxes: By 2005, all states will achieve a state excise tax level on cigarettes that is equal to the federal level and 50% of states will achieve a state excise tax level on cigarettes that is equal to or greater than \$1.00 per pack.

BREAST CANCER

BY 2015:

Incidence: By 2015, reduce the age-adjusted incidence rate of breast cancer by 15%.

Mortality: By 2015, reduce the age-adjusted mortality rate of breast cancer by 50%.

BY 2008:

Early Detection: By 2008, increase to 90% the proportion of women aged 40 and older who have breast screening consistent with American Cancer Society guidelines.

BY 2005:

Behavior Change: By 2005, the recent screening rates of women aged 40+, women aged 65+, and low SES populations (200% of poverty level and below) will be 70%.

Access to Treatment: By 2005, through advocacy at all organizational levels, 100% of women will have access to appropriate treatment.

PROSTATE CANCER

BY 2015:

Incidence: By 2015, reduce the age-adjusted incidence rate of prostate cancer by 15%.

Mortality: By 2015, reduce the age-adjusted mortality rate of prostate cancer by 50%.

Early Detection: By 2015, increase to 90% the proportion of men who follow age-appropriate American Cancer Society detection guidelines for prostate cancer.

BY 2005:

Behavior Change: By 2005, increase the percentage of men who have been offered age-appropriate PSA screening to 75%.

NUTRITION & PHYSICAL ACTIVITY

BY 2015:

Behavior Change: By 2015, increase to 75% the proportion of persons who follow American Cancer Society guidelines with respect to consumption of fruits and vegetables as published in the American Cancer Society Guidelines on Nutrition and Physical Activity for Cancer Prevention.

Behavior Change: By 2015, increase to 90% the proportion of youth (high school students) and to 60% the proportion of adults who follow American Cancer Society guidelines with respect to the appropriate level of physical activity as published in the American Cancer Society Guidelines on Nutrition and Physical Activity for Cancer Prevention.

BY 2005:

Public Awareness: By 2005, 90% of the public will be aware of and have knowledge about the role of a healthy diet and physical activity in preventing cancer.

Behavior Change: By 2005, 45% of the population will consume 5 servings of fruits & vegetables daily.

Behavior Change: By 2005, increase to 72% the proportion of youth (high school students) and to 30% the proportion of adults who follow American Cancer Society guidelines with respect to the appropriate level of physical activity as published in the American Cancer Society Guidelines on Nutrition and Physical Activity for Cancer Prevention.

SKIN CANCER

BY 2015:

Behavior Change: By 2015, increase to 75% the proportion of people of all ages who use at least two or more of the following protective measures which may reduce the risk of skin cancer; avoid the sun between 10 a.m. and 4 p.m., wear sun-protective clothing when exposed to sunlight, use sunscreen with an SPF 15 or higher, and avoid artificial sources of ultraviolet light (e.g., sun lamps, tanning booths).

BY 2005:

Public Awareness: By 2005, 50% of parents will be aware of and have knowledge about the importance of sun protection for their children.

Organizational Policy: By 2005, 50% of elementary schools, day-care centers, parks/recreation centers will have policies to foster skin protection.

COMPREHENSIVE SCHOOL HEALTH EDUCATION

BY 2015:

CSHE: By 2015, increase to 50% the proportion of school districts that provide a comprehensive or coordinated school health education program.

BY 2005:

CSHE: By 2005, 20% of school districts will provide CSHE.

School Health Councils: By 2005, 50% of school districts will have active school health councils.

School Health Coordinators: By 2005, 50% of school districts will have trained school health coordinators.

QUALITY OF LIFE

BY 2015:

Physical Effects: By 2015, provide appropriate care for symptom control, emphasizing pain, fatigue, reh

Pain Control: By 2015, provide appropriate care for the control of pain based upon an appropriate care plan using uniform standards of care for 90% of cancer survivors.

Physical Appearance: By 2015, the negative impact of cancer on physical appearance and body image will be substantially reduced in 75% of those affected cancer survivors.

Support Network: By 2015, 90% of cancer survivors and families and caregivers of those affected by cancer will express satisfaction with the available social support network.

Socio-Economic Support: By 2015, 75% of cancer survivors and their families will be appropriately assisted at the community level through program/service delivery, advocacy, referral, and education in addressing identified needs related to financial, employability, insurability issues, and access to treatment and follow-up care.

Psychological, Emotional, Spiritual Effects: By 2015, 90% of cancer survivors and families and caregivers of those affected by cancer will receive appropriate care or appropriate referral to services for identified psychological, emotional, and spiritual distress and/or needs.

Provider Education: By 2015, 90% of health care providers will assess psychological, emotional, and spiritual needs of cancer survivors and families and caregivers of those affected by cancer and provide appropriate care or appropriate referral to services.

QUALITY OF LIFE,

CONTINUED

BY 2008:

Service Delivery Systems:

By 2008, 100% of Divisions will develop or have access to a comprehensive service delivery system that addresses the needs of cancer survivors, their families and caregivers through American Cancer Society programs/services, or referral to other organizations and resource development to fill gaps in services.

BY 2005:

Public Awareness: By 2005, 60% of survivors, their families, and caregivers will be aware of and have knowledge about American Cancer Society quality of life education and support services.

Health Care Provider Awareness: By 2005, 75% of relevant health care providers (e.g. cancer care providers, primary care providers) will be aware of and express satisfaction with and willingness to refer their patients to American Cancer Society quality of life education and support services.

Public Policy/System Change: By 2005, 75% of health care systems will have institutionalized quality standards for the management of pain.

American Cancer Society Patient Support Programs: By 2005, the number of cancer survivors, their families, and caregivers who participate in appropriate American Cancer Society patient support programs or are referred to other community programs will increase by at least 50%.

EVERY 3 YEARS:

Assessment of Need: Every 3 years, the American Cancer Society will document the self-reported needs of cancer survivors, their families, and caregivers to determine American Cancer Society roles, collaborative opportunities, and potential American Cancer Society programs.

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