GEORGIA
CANCER | CONTROL
CONSORTIUM

COMPREHENSIVE CANCER CONTROL PLAN 2019 – 2024

GEORGIA DEPARTMENT OF PUBLIC HEALTH

ACKNOWLEDGEMENTS

The Steering Team (ST) of the Georgia Cancer Control Consortium (GC3) wishes to acknowledge the volunteer efforts of the many stakeholders throughout the state who worked diligently over the past nine months to revise the state's Comprehensive Cancer Control Plan. Close to 100 individuals representing various organizations and associations participated in a collaborative Work Group process that has resulted in this revision. The ST also appreciates the instrumental role played by the Georgia Health Policy Center at Georgia State University in facilitating the compilation of stakeholder input and recommendations into this document.

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GEORGIA DEPARTMENT OF PUBLIC HEALTH

Kathleen E. Toomey, M.D., M.P.H., Commissioner / Brian Kemp, Governor

2 Peachtree Street, NW, 15th Floor
Atlanta, Georgia 30303-3142

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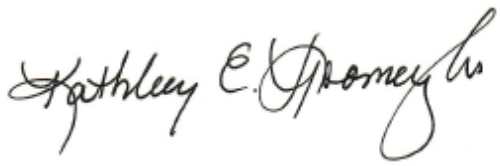
Dear Georgians:

The third edition of Georgia's Comprehensive Cancer Control Plan is an opportunity to review what has been accomplished the last five years, expand our thinking, and explore new strategies to address cancer in our state. This five-year cancer control plan is a strategic guide with ambitious goals and objectives focused on prevention, early detection, and screening; excellence in staging, diagnosis, treatment, and outcomes; statewide access to palliative care; and quality of life for all cancer survivors. The statewide plan aims to reduce cancer incidence and mortality with a focus on breast, cervical, colorectal, lung and prostate cancers and to support Georgians who are surviving cancer.

Cancer continues to be the second leading cause of death Georgia, and disparities in incidence, prevalence, and mortality still exist for some populations. Through the collective impact of communities, government, researchers, health systems, and non-profit sectors, we can promote evidence-based approaches to reduce the burden of cancer for all Georgians

I want to thank the dedicated members of the Georgia Cancer Control Consortium for their contributions to the statewide plan. Together, we can position Georgia as a national leader in cancer control and prevention.

Sincerely,



Kathleen E. Toomey, M.D., M.P.H.
Commissioner and State Health Officer

CO-CHAIR

James A. Hotz, MD

Albany Area Primary Health Care

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Angie Patterson

Georgia Center for Oncology Research and Education (Georgia CORE)

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Albany Area Primary Health Care
American Cancer Society American College of Physicians (Georgia Chapter)
Children's Healthcare of Atlanta
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Georgia Association of Health Plans

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Georgia Research Alliance

Georgia Society of Clinical Oncologists

Georgia State University Health Policy Center

Horizons Community Solutions Mercer University
Morehouse School of Medicine

Northwest Georgia Regional Cancer Coalition

Rollins School of Public Health

St. Joseph's/Candler Health System
West Central Georgia Cancer Coalition
Winship Cancer Institute, Emory University

GEORGIA CANCER CONTROL CONSORTIUM

Kathleen Toomey MD. MPH
Commissioner,
Georgia Department of Public Health
2 Peachtree Street
Atlanta, GA., 30303

Dear Dr. Toomey,

The Georgia Cancer Control Consortium (GC3) is proud to be an integral part of statewide efforts aimed at minimizing the burden of cancer and increasing survivorship. After more than a decade of work as a formal collaborative, this latest revision to our state's cancer control plan signals our continued commitment to partnership with the department and other critical stakeholders to sustain our progress in achieving victory over this disease that affects so many Georgians, directly and indirectly.

A significant level of Georgia-based passion, sacrificial effort, and evidence-informed considerations that have been central to the development of this revised plan. We remain resolutely focused on policy, systems, environmental and program improvements across the cancer control continuum aimed at preventing cancer development wherever possible, finding cancers earlier, promoting appropriate screening practices, ensuring quality standards in diagnosis, treatment, and palliative care; as well as improving quality of life for survivors. All this, while paying attention to screening and outcome disparities across population groups and the health inequities that cause them.

We are excited at the prospect of working with you and your team for another five years, in the service of the people of our state. We recognize that circumstances and externalities are continuously changing even as we embark on the next phase of this journey, but remain confident that as we have demonstrated before, together we are stronger and better equipped to achieve our collective goal of controlling cancer in Georgia.

With our unequivocal support,

James A. Hotz, M.D.

Co-Chair

Angie Patterson

Co-Chair

Brian Rivers, Ph.D., M.P.H.

Co-Chair

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EXECUTIVE SUMMARY

In Georgia, for some time now, cancer has been a leading cause of death, second only to cardiovascular disease. In 2016, around 50,000 Georgians were diagnosed with cancer and during the same year about 17,000 people died of cancer.

Since the last plan revision in 2014, our growing Consortium has made steady progress toward the achievement of collective objectives aimed at controlling cancer throughout the state. Many of the targets that were defined then, including several policy, system, and environmental changes, have been, or are being met. In the face of several challenges related to resources, changing regulations, the consolidation of health systems, and shifting national healthcare policies, Georgia has made steady progress toward achieving comprehensive cancer control.

In addition to meeting many of the targets set out in the previous plan, the Consortium has expanded to address emerging and persistent cancer challenges in innovative ways. This is the second revision of the state's cancer control plan that was originally developed in 2008. The initial plan, based on the strategic road map of the Georgia Cancer Coalition (no longer in existence), was guided by a core set of performance measures identified from a commissioned Institute of Medicine study.[1]

OBJECTIVES, GOALS, AND APPROACH

The plan for the next five years continues to value the overarching aim of Georgia's efforts - saving lives, reducing burden and eliminating disparities in prevention, diagnosis, treatment, and access to care. To that end, this revision was guided and informed by an approach that underscored the importance of:

- Assessing the progress of cancer control efforts over the last five years;
- Forecasting likely facilitators and barriers through environmental scanning.
- Using available evidence, data and guidelines to develop targeted, Georgia-focused actions.

This revision of the state plan, informed by evidence about performance on a number of metrics that build on those recommended by the IOM, is guided by a commitment to enhance cancer control in Georgia by achieving significant progress in the following specific areas over the next five years:

- **Equity –** addressing the root cause of disparities and the factors that prevent some populations from attaining their best health;
- **Translational Research –** a commitment to continuous learning through Georgia-based research studies that are conducted, translated and disseminated across the cancer control continuum;
- **Communications –** appropriate messaging and broader engagement and inclusion of Georgians, including survivors, to increase awareness, knowledge, and understanding about cancer control;
- **Advocacy –** being in action to ensure supportive policy and funding to address cancer control at the level of organizations, institutions, and agencies; and
- **Surveillance –** having excellent, high-quality data and information to inform planning and assess progress over time.

Based on an assessment of progress over the past five years, Georgia will move toward saving lives, reducing burden, and reducing disparities in cancer outcomes by careful attention to five priorities.

[1] *Division of Cancer Prevention and Control, Centers for Disease Control and Prevention. (2014). Basic Information About Health Disparities in Cancer. Retrieved from https://seer.cancer.gov/statfacts/html/disparities.html*

These five priorities were set by working groups after a review of progress and remaining work from the previous plan, and a landscape scan of current priorities included in cancer control plans from states throughout the U.S.

PRIORITIES	KEY OBJECTIVES
 **Supporting cancer prevention efforts with a focus on HPV prevention**	**Objective 1:** Increase the number of females and males who complete the human papillomavirus (HPV) vaccine series in accordance with the Advisory Committee on Immunization Practices (ACIP) and recommendations.
 **Detecting cancers early and screening appropriately for target cancers**	**Objective 1A:** Increase the early detection and use of evidence-based screening approaches for breast, cervical, colorectal, lung and prostate cancers in Georgians. **Objective 1B:** Increase early detection in high-risk persons who fall outside of current criteria and recommendations for screening for breast, cervical, colorectal, lung, and prostate cancers. **Objective 2:** Reduce disparities in screening rates among populations thoughout Georgia. **Objective 3:** Increase early detection rates for non-screenable and potentially aggressive cancers, such as pancreatic, and childhood leukemias and lymphomas.
 **Facilitating statewide access to palliative care and support**	**Objective 1:** Accurately define the baseline landscape of oncological palliative care by 2021 and update annually through 2024. **Objective 2:** Develop and implement a sustainable strategy to connect and inform professionals, providers, patients, organizations, and institutions in Georgia about oncological palliative care best practices, networking, educational opportunities, and quality standards including an underserved and vulnerable population focus. **Objective 3:** Improve access to quality oncological palliative care for adults and children in Georgia.

PRIORITIES	KEY OBJECTIVES
Improving quality of life for cancer survivors	**Objective 1:** Establish and maintain surveillance of the physical and psychosocial quality of life for Georgia cancer survivors of all ages. **Objective 2:** Increase the dissemination of information about cancer survivorship that is inclusive and relevant (e.g., geography, language, cancer type, culture, literacy level, income, education, etc.) among survivors, caregivers, practitioners, and the population of Georgia. **Objective 3:** Increase resources that are available to support quality survivorship care in Georgia
Maintaining excellence in the diagnosis and treatment of cancers	**Objective 1:** Improve the use of quality standards and practice guidelines for the timely diagnosis, staging and treatment of cancers throughout Georgia, with emphasis on, though not limited to, lung, colorectal, breast, prostate, and cervical cancer. **Objective 2:** Reduce diagnoses, staging and treatment disparities (by race, residence, income and insurance status) in Georgians with lung, colorectal, breast, prostate, and cervical cancer: and study the impact on outcomes. **Objective 3:** Study and understand the impact of reductions in diagnosis, and treatment disparities on survivorship outcomes.

In Georgia, we recognize that the government by itself cannot address cancer or any other significant public health challenge. Georgia has a strong fabric of cancer prevention and control programs and success in cancer control through a network of partners, including the Georgia Department of Public Health, the Regional Cancer Coalitions, the Georgia Center for Oncology Research and Education, the Georgia Society of Clinical Oncologists, and national partners including the American Cancer Society. The complex causes and systems of care for cancer make these programs and partners a critical part of saving lives in Georgia. Partners from health care, public health, hospitals, academia, communities, employers, national partners, and faith-based organizations must continue to collaborate meaningfully to address all aspects of cancer prevention, early detection, diagnosis, treatment, and quality of life for survivors.

CANCER BURDEN IN GEORGIA

Figure 1. Mortality and Incidence by All Cancer Sites[1]

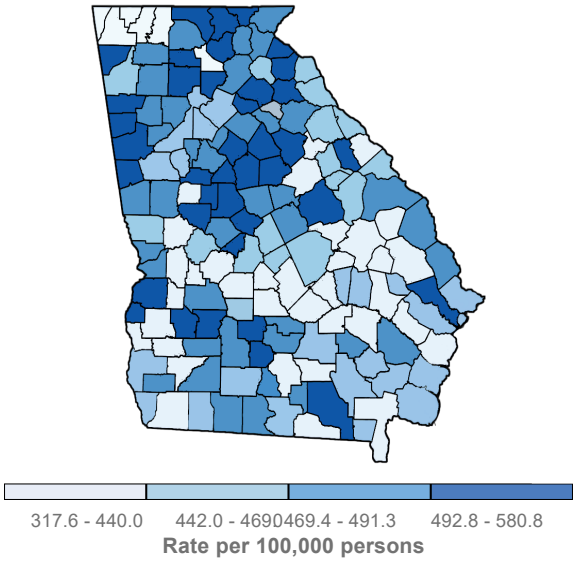
INCIDENCE	MORTALITY
From 2012-2016	From 2012-2016
• **249,235** cancers were diagnosed among Georgia residents – an average of **49,850** new diagnoses each year. • **51.5%** or **128,293** cases were among males. This is approximately **25,660** new diagnoses each year. • **48.5%** or **120,910** cases were among females. This is approximately **24,180** new diagnoses each year.	• **82,230** cancer deaths occurred among Georgia residents. This is approximately **16,450** cancer deaths each year. • **53.6%** or **44,057** deaths were among males. This is approximately **8,810** cancer deaths each year. • **46.4%** or **38,173** deaths were among females. This is approximately **7,630** cancer deaths each year.

CANCER INCIDENCE AND MORTALITY

In Georgia, one out of every five deaths is attributable to cancer (see Figure 2). In 2016, there were an estimated 16,450 cancer deaths each year; in addition, just under 50,000 Georgians were diagnosed with cancer (see Figure 1).[2] More males (25,660) than females (24,180) were diagnosed with new cancers.[1]

Lung and colorectal cancers continue to be the leading causes of cancer deaths in Georgia with lung, colorectal, breast, and prostate cancers contributing almost 50% of cancer deaths in Georgia.[3] The second and third leading causes of new cancer cases in both men and women are lung and colorectal cancer. From a county-level, 42 of the 159 counties have higher cancer mortality rates than the state average, and 17 counties have lower mortality rates than the state average (see Figure 2 for more information).[3,4] The risk of getting cancer increases as a person's age increases since most cancers affect middle-aged adults or older. For Georgia, about 76% of all cancers are diagnosed among adults aged 55 years and older.[3] Additional risk factors include cigarette smoking, obesity, and lack of regular physical activity.

Figure 2. Rate of New Cancers in Georgia
Map All Types of Cancer, All Ages, All Races/ Ethnicities, Male and Female (2012 – 2016)



[2] *Bayakly, A.R. & et al. (2016 - 2019). Georgia Cancer Plan: 2014 – 2019 Presentation, Georgia Department of Public Health, Georgia Comprehensive Cancer Registry, Georgia Vital Records.*

[3] *McNamara, C., Bayakly, A.R., & Ward, K.C. (2016). Georgia Cancer Data Report [PDF file]. Georgia Department of Public Health, Georgia Comprehensive Cancer Registry. Retrieved from https://dph.georgia.gov/sites/dph.georgia.gov/files/Cancer_2016_Final.pdf*

[4] *U.S. Cancer Statistics Working Group. U.S. Cancer Statistics Data Visualizations Tool, based on 2020 submission data (1999-2018): U.S. Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute; www.cdc.gov/cancer/dataviz*

Approximately 17% of adults (those 18 years and older) are currently smoking cigarettes in Georgia in 2017.[3] Sixty-five percent of adults (18 years and older) in Georgia have excess body weight; and the obesity prevalence in Georgia is 32%, which is marginally higher than the national average.[3] Georgians can reduce their risk of getting cancer by improving their diet, increasing physical activity, and eliminating tobacco use.[3]

There is no universal cure for all types of cancer; however, treatment options and outcomes can be significantly improved for most types of cancers with early stage diagnosis, which is accomplished through preventive screening and timely diagnostic protocols.

Additionally, new treatment and preventive options are being discovered and developed that may lead to the prevention of cancer. The human papillomavirus (HPV) vaccination is one such example of a preventive treatment option being used to prevent and reduce cervical cancer rates.

DISPARITIES IN CANCER

Research from the Centers for Disease Control and Prevention (CDC)'s Office of Minority Health and Health Equity shows that life expectancy and overall health has not improved equally among all Americans.[1] Closing these gaps in outcomes involves reducing the differences in incidence and mortality rates of cancer within population groups defined by gender, race and ethnicity, education, income, and geography. Common barriers in reducing health disparities in cancer are barriers to cancer screening and other prevention services, lack of physician referral, perceived cost of care and fear.[5]

In Georgia, 249,235 cancers were diagnosed among residents from 2012 to 2016. The likelihood of being diagnosed among residents from 2021 to 2016. The likelihood of being diagnosed with and dying from cancer varies by gender, with men slightly more likely than women to be diagnosed (51.5% and 48.5% respectively) and die (53.6% and 46.4% respectively) from cancer.[4]

The most diagnosed cancer among women was breast cancer(127.4 per 100,000 pop.), and prostate cancer was the most diagnosed cancer among men (123.3 per 100,000 pop.).[4] The five-year aggregate incidence rate for prostate cancer has increased since 2014, while breast cancer rates are the same. Diagnosis rates are higher for lung and colorectal cancers among men (82.6 and 50.2 per 100,000 pop. respectively) than women (52.3 and 36.3 per 100,000 pop. respectively), with men nearly twice as likely to die of lung cancer than women (59.2 to 33.0 per 100,000 pop. respectively).[4]

In Georgia, Black males are 19% more likely than White males to die from cancer, while Black females are 9% more likely to die of cancer than White females.[6] Black males are about three times as likely to die from prostate and stomach cancer compared to White males.[3] There are more new cases of prostate and colorectal cancer among Black males compared to White males. Black males are 56% more likely to die from colorectal cancer than White males.[3]

There are similar racial disparities among women. Black females are more likely to die of breast (47% higher) and colorectal cancers (33% higher) than White females. Lung cancer mortality rates are 38% higher in White than in Black females.[3]

Geographic disparities in cancer also exist. Cobb, Douglas, Fulton, and DeKalb counties have higher incidence rates of breast cancer compared to the state of Georgia. Based on recent mortality rates, Clayton, East Central, West Central, Southeast, and Northeast health districts have more deaths attributed to colorectal cancer than the state average.[3] Addressing geographic disparities through community programs, media campaigns, and other targeted interventions is necessary to minimize outcome differences across all groups.

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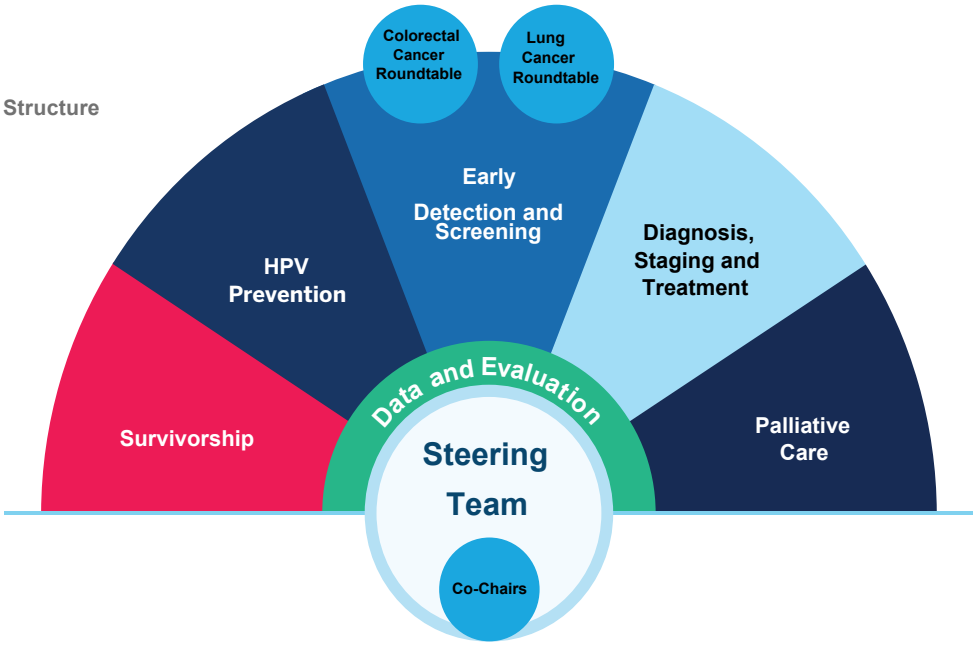
[5] Hendren, S., Chin, N., Fisher, S, et. al. (2011). Patients' barriers to receipt of cancer care, and factors associated with needing more assistance from a patient navigator. Journal of the National Medical Association, 103(8), 701–710. https://doi.org/10.1016/s0027-9684(15)30409-0

[6] Surveillance Research Program, Division of Cancer Control and Population Sciences, National Cancer Institute. (2019). Retrieved from https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/cancer-treatment-and-survivorship-facts-and-figures/cancer-treatment-and-survivorship-facts-and-figures-2019-2021.pdf

CONSORTIUM STRUCTURE

At the center of the Consortium's effort is a diverse multi-organizational, 32-member Steering Team providing oversight to the effort (See figure 3). The Data and Evaluation Committee touches all five work groups and is responsible for facilitating the Consortium's best use of data and information in guiding decision-making and evaluating progress. Five work groups direct and monitor the strategies outlined in the plan (see Appendix).

Figure 3. Consortium Structure



The use of roundtables, specifically for colorectal cancer screening, ensures that experts in each area are making purposeful contributions individually and collectively to addressing early detection and screening challenges in the state. The principle behind the use of roundtables has been embraced by the GC3 Steering Team and will likely be expanded during the next implementation period.

In 2017, the GC3 established a Prostate Cancer Task Force. Based on the disease burden in Georgia, the Prostate Cancer Task Force recommended that a plan for prostate cancer control be included in this revision. The Task Force also recommended that the plan be evidence-based and specific to the demographics and challenges related to screening, detection, and treatment for prostate cancer in Georgia. To support their recommendations, members of the Task Force joined GC3 work groups.

The Advocacy Task Force, having been set up to engage with legislators and other policymakers, will transition to subcommittee status over the upcoming period and, in so doing, be actively engaged in shaping the policy and advocacy agenda of the GC3 during the next implementation period.

Finally, the Steering Team intends to increase communication with all stakeholders, including the general public, about cancer and cancer control. Consequently, a new committee with responsibility for the development and execution of a communications plan will be established following the ratification of this revised plan.

Plan of Action

The Georgia Cancer Control Consortium (GC3), facilitated by the Georgia Department of Public Health, will focus on 15 strategic objectives through a process that will value and enable statewide collaboration, public-private partnerships, public health leadership, and a commitment to maintaining a strong infrastructure of cancer prevention and treatment programs.

Additionally, given their collective toll on the citizens of Georgia and the state's economic wellbeing, five cancer types will be the focus of attention and efforts over the period – **lung, colorectal, breast, prostate, and cervical**. Particularly in high risk and high burden populations. While this plan was written prior to the global pandemic, GC3 is monitoring on a monthly basis how the global COVID-19 pandemic is impacting cancer control efforts, including the priorities set by this plan, and the burden and outcomes of cancer for Georgians.

As part of the GC3, the Georgia Department of Public Health envisions a future in Georgia that is free from cancer deaths and cancer-related health disparities. Cancer impacts all persons in Georgia, and though progress has been made, its toll on the state remains significant.

This is the second revision of the state's cancer control plan which was originally developed in 2008. The initial plan, based on the strategic road map of the Georgia Cancer Coalition (no longer in existence), was guided by a core set of performance measures identified from a commissioned Institute of Medicine at the time.[1]

I. SUPPORTING CANCER PREVENTION EFFORTS

Prevention is more effective and often much less expensive than treatment. Minimizing the opportunity for cancers to begin is an important and critical element in reducing the burden of cancer in Georgia. There are many risk factors for cancer, including biological make-up, family history, unhealthy behaviors, and exposure to noxious and harmful agents and environments.

The plan seeks to address partnerships, policies, health systems, and environmental strategies that might be leveraged to ensure that Georgians are able to limit their risk of being diagnosed with cancer in their lifetimes. Over the next five years, GC3 will support efforts to eliminate tobacco use, encourage healthy behaviors to reduce obesity, work to decrease exposure to environmental hazards such as radon, and promote HPV vaccination completion.

Key Background Information: Human papillomavirus (HPV) is the most common sexually transmitted infection in the United States and causes approximately 90% of cervical and anal cancers.[7] HPV also causes

[7] *Division of Cancer Prevention and Control, Centers for Disease Control and Prevention. (2018). HPV-Associated Cancer Statistics. Retrieved from https://www.cdc.gov/cancer/hpv/statistics/index.htm*

GC3'S FOCUS ON HUMAN PAPILLOMAVIRUS (HPV) PREVENTION

70% of cancers of the throat (oropharynxy) including the base of the tongue and tonsils, and can cause penile, vaginal and vulvar cancers.[8] HPV is spread through oral and genital contact and and also spread from women to their babies during delivery, although rare. Nearly 80 million Americans are currently infected with some type of HPV. Each year, about 14 million Americans, including adolescents, become newly infected with HPV.[9] On average, 13.14 per 100,000 persons were diagnosed with HPV in Georgia from 2011 to 2015.[10] The HPV vaccine is cancer prevention. Most of the cancers caused by HPV can be prevented by the HPV vaccine.

Objective 1: To increase the number of females and males who complete the human papillomavirus (HPV) vaccine series in accordance with the Advisory Committee on Immunization Practices (ACIP) and recommendations.

STRATEGIES/STRATEGIC ACTIONS

A. Partnership and Advocacy

Actively partner with key public and private agencies and stake-holders who are already engaged in cancer prevention activities across the state to control obesity and tobacco control.

Facilitate advocacy efforts, evidence-based action, and ongoing discussion with critical stakeholders to address exposure to environmental hazards, including radon and excessive ultraviolet radiation. Engage appropriate stakeholder representation on GC3 Steering Team.

B. Health Systems and Policy Action

Use a health systems & policy approach to prioritize HPV vaccinations.

C. Public Awareness and Stakeholder Engagement

Expand public awareness campaigns (i.e., small media and community projects) and stake-holder engagement of females and males, caregivers, and providers aimed at increasing knowledge and changing perceptions to inform decision-making related to HPV vaccination.

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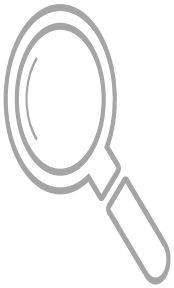
[8] Georgia Tobacco Use Prevention Program, Georgia Department of Public Health. Georgia Tobacco Control Strategic Plan 2015-2020. Retrieved from: https://dph.georgia.gov/sites/dph.georgia.gov/files/DPH%20GTUPP%20Strategic%20Plan_FINAL%208.19.15.pdf

[9] Division of STD revention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, Centers for Disease Control and Prevention. (2017). Genital HPV Infection – Fact Sheet. Retrieved from https://www.cdc.gov/std/hpv/stdfact-hpv.htm

*[10] National Program of Cancer Registries SEER*Stat Database, U.S. Cancer Statistics Incidence [Data file]. (1998– 2015). United States Department of Health and Human Services, Centers for Disease Control and Prevention.*

Retrieved from: https://gis.cdc.gov/Cancer/USCS/#/AtAGlance

SUCCESS MEASURES	TARGETS
Number of health systems that implement evidence-based recommendations and/or policies to prioritize HPV vaccinations.	**At least five** health systems implementing recommendations
Number of vaccines purchased/used.	**TBD**
Percent of adolescents in Georgia who have completed the HPV vaccination series.	**Increase from 45.7% to 70%**
Percent of females and males ages 11 – 26 and 27 and older in Georgia who demonstrate improved knowledge and perception change about the HPV vaccination as cancer prevention.	
Percent of caregivers in Georgia who demonstrate improved knowledge and perception change about the HPV vaccination as cancer prevention.	**25%** increase from **baseline (TBD)**
Percent of caregivers in Georgia who demonstrate improved knowledge and perception change about the HPV vaccination as cancer prevention.	



II. DETECTING CANCERS EARLY AND SCREENING APPROPRIATELY FOR TARGET CANCERS

One of the most important ways to reduce the impact and burden of cancer is to find it early. Many cancers have better outcomes and survival rates if cancer is discovered early. The use of screening tests and procedures help in the process of early detection, especially when guidelines are followed, and high-risk populations have the opportunity and access to be screened.

Key Background Information: Every Georgian should have access to appropriate cancer screening to detect the disease early and prevent morbidity and premature mortality. Based on current evidence, screening for breast, cervical, lung, and colorectal cancers in appropriate populations by age and/or genetic risk can save lives. However, differences in screening rates continue to be a challenge throughout the state with minority, low income, and rural populations reporting fewer screenings according to recommended guidelines.

Georgia's early detection and screening efforts continue to align with current US Preventive Services Task Force recommendations that are Level B or higher (USPSTF, 2019), as well as guidelines from other credible organizations, such as the American Cancer Society. Most recommended screening tests are covered by health plans operating in the state. Additionally, the Georgia Department of Public Health, through its cancer programs and local partners including the Regional Cancer Coalitions, provides support for low-income, uninsured, and underserved individuals to access timely breast, cervical, and colorectal cancer screening, diagnostic services and treatment through the Breast and Cervical Cancer Screening Program and the Georgia Cancer State Aid Program. Table 1 shows the numbers and rates of early stage disease in Georgia by gender and race for selected cancer sites.

Table 1. Early Stage Disease Rates in GA for select cancer types by Gender and Race (2016)

	All Females		Non-Hispanic Black Females		Non-Hispanic White Females	
Cancer Site	**Cases**	**Rate**	**Cases**	**Rate**	**Cases**	**Rate**
Breast	6421	106.2	1838	105.4	4182	109.5
Cervical	183	3.5	59	3.4	91	3.3
Colorectal	910	15.2	281	16.0	580	15.2
Lung	756	12.5	132	8.3	591	14.5

	All Males		Non-Hispanic Black Males		Non-Hispanic White Males	
Cancer Site	**Cases**	**Rate**	**Cases**	**Rate**	**Cases**	**Rate**
Prostate	5217	94.3	2009	145.1	2940	78.0
Colorectal	1003	19.9	283	21.2	640	19.2
Lung	712	15.3	145	13.8	545	16.4

An estimated 17,880 cancer deaths can be prevented through early detection and screening.[1] According to the 2016-2017 Georgia Behavioral Risk Factor Surveillance System, the self-reported Cancer Screening rates are:

- 79% of women ages 50 to 74 years reported having had a mammogram in the last two years;
- 80% of women ages 21 to 65 years reported having a Pap test within the past three years;
- 63.7% of adults ages 50 to 75 years reported having had an fecal occult blood test (FOBT) in the last year, and/or sigmoidoscopy in the last five years, and/or colonoscopy in the last ten years; and
- Nearly two-thirds of Georgia men ages 40 and older discussed the advantages of PSA screening with a physician. Of those men for whom a PSA was recommended by a health professional, about 90% received a PSA, and 70% had done so within the past year.

Objective 1A: Increase the early detection and use of evidence-based screening approaches for breast, cervical, colorectal, lung, and prostate cancers in Georgians.

Objective 1B: Increase early detection in high-risk persons who fall outside of current criteria and recommendations for screening for breast, cervical, colorectal, lung, and prostate cancers.

Objective 2: Reduce disparities in screening rates among people, groups and populations throughout Georgia.

Objective 3: Increase early detection rates for non-screenable and potentially aggressive cancers, such as pancreatic, and childhood leukemias and lymphomas.

STRATEGIES/STRATEGIC ACTIONS

A Broaden Public Awareness to Improve Screening Behaviors

- Use awareness and communication campaigns to improve Georgians' knowledge and understanding of the importance of family history, timing, and screening guidelines in early detection, particularly for those at high risk for these cancers.

Note: self-reported measures are an approximation of actual number due to known reporting bias. Studies have shown that people tend to over or under-report their own behaviors.

STRATEGIES/STRATEGIC ACTIONS

B Improve Clinical Practice

- Work with providers and health systems to conduct educational sessions and trainings that promote evidence-based screening guidelines.
- Promote appropriate use of referrals and referral systems to support early detection.
- Sustain the use of roundtable approaches to engage key stakeholders in collaborating and partnering for action.
- Facilitate targeted health system, initiatives to address low screening rates in Georgia with a focus on disparate populations.
- Promote the use of navigators in targeted populations to increase access to screening.

C Encourage Continuous Learning

- Ensure ongoing and appropriate screening surveillance and assessments to monitor progress and disparities in early detection and screening.
- Promote research and the use of epidemiological data for systems and providers to know, track and monitor screening rates and disparities over

D Advocate for Resources

- Pursue and support direct and in-kind funding for cancer screening in low income and uninsured individuals.

CANCER-SPECIFIC STRATEGIC ACTIONS

Cervical Cancer

- Facilitate access to high-quality cervical cancer screening for all women, regardless of income, race, insurance, or employment status.
- Sustain existing community-based cervical cancer screening programs, including BCCP that screen large populations of women from uninsured and underinsured groups.

Breast Cancer

- Facilitate access to high-quality breast cancer screening for all women, regardless of income, race, insurance, or employment status.
- Sustain existing community-based breast cancer screening programs, including BCCP that screen large populations of women from uninsured and underinsured groups.
- Promote genetic screening to all low-income, high-risk, and rarely screened women 18 years of age and older.
- Seek Medicaid and State Health Benefit Plan reimbursement for genetic testing and counseling, as well as preventive surgeries such as bilateral mastectomies and/or oophorectomy/salpingectomy for high-risk women.

Colorectal Cancer

- Facilitate access to high-quality colorectal cancer screening.
- Increase screening and appropriate genetic testing for colorectal cancer in adults at high risk and/or with a family history of colorectal cancer regardless of insurance status and increase screening among them.
- Conduct provider education sessions and trainings to promote accuracy of stool-based testing, screening methods, and options.
- Develop and test communications messages aimed at groups with low screening rates and other high-risk groups.

Lung Cancer

- Increase the number of eligible Georgia residents who are appropriately screened for lung cancer regardless of income, race, insurance or employment status.
- Encourage high-quality screening that follows existing US Prevention Task Force, and/or NCCN 2 category guidelines.
- Improve access to safe and responsible screening by increasing the utilization of quality lung cancer screening programs throughout Georgia.

Prostate Cancer

- Increase the use of population-specific screening approaches that reduce morbidity and mortality from prostate cancer and its treatment in Georgia.
- Promote the use of informed decision making for the development of appropriate screening approaches.
- Encourage Georgia-based epidemiologic/disparity research on prostate cancer screening, risk factor classification, and effectiveness.

Non-screenable Cancers

- Support the engagement of key stakeholders and clinical providers in improving knowledge and practice that result in earlier detection of non-screenable cancers.

SUCCESS MEASURES	TARGETS
Proportion of women who receive cervical cancer screenings based on current USPSF guidelines	From **79.8%** to **83%**
Race, geography, income and insurance coverage disparities in cervical cancer screening	**10% reduction** in gap (relative)
Proportion of individuals at high risk for breast cancer who receive evidence-based risk assessment and follow up	Increase by **25%**
Proportion of women who receive breast cancer screenings based on current USPSTF guidelines	From **79.3%** to **82%**
Race, geography, income and insurance coverage disparities in breast cancer screening	**10% reduction** in gap (relative)
Proportion of adults over 45 years who have received colorectal cancer screening*	**80%** in every community that intervention and measurement is occurring including FQHCs and **75%** from BRFSS reporting.
Race, geography, income and insurance coverage disparities in colorectal cancer screening	**10% reduction** in gap (relative)

*** At time of creation the guidelines were for adults over the age of 50, as of 2019, the guidelines have changed and it has been updated to reflect such.**

SUCCESS MEASURES	TARGETS
Level of reported informed decision making about prostate screening	At least **70% of men report** having talked with their healthcare provider about advantages and disadvantages of PSA test.
Amount of Georgia based prostate cancer screening research	Complete at **least 2 prostate cancer research projects** by 2024
Early stage rates in target cancers	**5% decrease** over the period
Early detection rates for skin cancer, pediatric cancers, etc.	**10%** increase in rate of non-target cancers that are detected earlier

III. MAINTAINING EXCELLENCE IN THE DIAGNOSIS, STAGING, AND TREATMENT OF CANCERS

Key Background Information: Stage of disease refers to the extent to which cancer has spread when diagnosed. In general, the earlier the stage, the better the chance of survival. In Georgia from 2012 - 2016:

- 58% of colorectal cancers were diagnosed at a late stage while only 38% were diagnosed early
- 80% of lung cancers were diagnosed at a late stage
- Among Georgia women, 59% of breast cancers were diagnosed at an early stage
- Among Georgia women diagnosed with cervical cancer, 39% had early-stage cancers.
- Among Georgia men diagnosed with prostate cancer, 83% had early-stage cancers

Currently, nearly 85% of the treatment of patients with cancer occurs in centers and facilities that have been accredited by the Commission on Cancer(CoC). Those Centers are now being required to participate in the rapid quality reporting system as part of their accreditation.

Objective 1: To improve the use of quality standards and practice guidelines for the timely diagnosis, staging and treatment of cancers throughout Georgia, with emphasis on, though not limited to, five cancers of focus – lung, colorectal, breast, prostate, and cervical.

Objective 2: To reduce diagnoses, staging and treatment disparities (by race, residence, income and insurance status) in Georgians diagnosed with the five cancers of focus - lung, colorectal, breast, prostate, and cervical.

Objective 3: Study and understand the impact of reductions in diagnosis, and treatment disparities on survivorship outcomes.

STRATEGIES/STRATEGIC ACTIONS

A Public Awareness

- Increase public awareness of treatment guidelines, standards of care and access to clinical trials to increase early diagnosis and intervention for cancers with high morbidity and mortality burden including cancers of the lung, breast, prostate, colorectal and cervix.
- Promote and emphasize care delivery at CoC accredited hospitals/centers and demonstrate their value using a scorecard based on or developed from Cancer Program Practice Profile Reports (C3PR).

B Provider Practice Improvement

- Facilitate regional cross-institutional partnerships (with a focus on CoC accredited and non-CoC accredited facilities in underserved areas) and trainings aimed at increasing standards of care, accruals to trials and adoption of best practices across the state.
- Support the efficiency of handoffs between diagnosis and treatment through the engagement of key referral partners along the continuum, including pediatric oncologists, care navigators, and primary care physicians.
- Monitor, track, and promote changes to care guidelines as recommended and/or incorporated by the CoC.
- Partner with Georgia Hospital Association (GHA) to advocate for quality improvement at institutions.

C Continuous Learning

- Promote the conduct and participation in research across the care continuum to address important treatment and outcome disparity questions relevant to the state of Georgia.

SUCCESS MEASURES	TARGETS
Change in healthcare seeking knowledge and practice	**> 75%** of respondents will be aware of guidelines and trials
Patients reporting shared decision making in lung, breast, prostate, and colorectal cancer treatment	**> 60% of patients** will report shared decision making in their cancer treatment
Development and use of Cancer Care Quality Scorecard	Statewide Cancer Care Quality **Scorecard will be developed**
Number and percent of patients who receive oncology services in NCI designated and/or CoC accredited institutions and affiliated centers	**90%** of patients receive care at CoC accredited institutions
Rate of accrual to trials with attention to disparities across groups (race, geography, etc.)	**5%** of NCI patients will report participation in trials
Number and level of partnerships and/or relationships	Establish up to **5 new and functional partnerships/ relationships** between CoC and non-CoC accredited institutions across the state

SUCCESS MEASURES	TARGETS
Median time to treatment	**30-35 days** for target cancers
Late stage diagnosis rate	**3-5% reduction** in rate for target cancers
Number of trainings and convenings (including cancer registry trainings)	At least **one annual convening** of providers and key stakeholder groups.
Number and type of diagnosis, staging and treatment research	**TBD**
Mortality rates with attention to disparities across groups (race, geography, etc.)	Reduced mortality rates **5-10% over the period** in lung, colorectal, breast cervical and prostate cancers

IV. FACILITATING STATEWIDE ACCESS TO PALLIATIVE CARE AND SUPPORT

Key Background Information: Palliative care is an approach to patient/family/caregiver-centered health care that focuses on optimal management of distressing symptoms while incorporating psychosocial and spiritual care according to patient/family/caregiver needs, values, beliefs, and cultures. The goal of palliative care is to anticipate, prevent, and reduce suffering and to support the best possible quality of life for patients/families/caregivers, regardless of the stage of the disease or the need for other therapies.[11]

Studies show that integrating palliative care into routine cancer care can lead to better patient and caregiver outcomes, including improvement in symptoms, quality of life, satisfaction, caregiver burden, and survival.[11] For these reasons, it is important to strive to ensure that people have access to the best possible palliative care in Georgia.

Palliative care in Georgia is available to adults and children in a variety of settings (e.g., inpatient and outpatient clinics, community and home-based programs). The value of palliative care has been increasingly recognized during the last five years. The National Comprehensive Cancer Network (NCCN), American Academy of Hospice and Palliative Medicine (AAHPN), the Commission on Cancer (CoC), and American Society of Clinical Oncology (ASCO) all offer guidance on standards of palliative care, which include some of the following elements:

- Institutions should develop processes for integrating palliative care into cancer care, both as part of usual oncology care and for patients with specialty palliative care needs.
- All cancer patients should be screened for palliative care needs at their initial visit, at appropriate intervals, and as clinically indicated.
- Patients/families/caregivers should be informed that palliative care is an integral part of their comprehensive cancer care.
- Educational programs should be provided to all health

[11] NCCN Guidelines: Palliative Care. Version 2.219 (2019)

care professionals and trainees so that they can develop effective palliative care knowledge, skills, and attitudes.

- Palliative care specialists and interdisciplinary palliative care teams, including board-certified palliative care physicians, advanced practice nurses, physician assistants, social workers, chaplains, and pharmacists, should be readily available to provide consultative or direct care to patients/families/caregivers and/or health care professionals who request or require their expertise.
- Quality of palliative care should be monitored by institutional quality improvement programs.[12]

During the past five years in Georgia, we have successfully advocated for and the legislature passed House Bill 509 (legislation creating an advisory council and a registry for Georgia's palliative care programs) and convened palliative care professionals annually to strengthen connections and inform palliative care practices across the state. During this same period, the CoC added minimum standards of palliative care to their accreditation requirements, ASCO and AAHPM issued a joint guidance statement defining high-quality palliative care, and the NCCN revised their palliative care guidelines.

Objective 1: Accurately define the baseline landscape of oncological palliative care by 2021 with the ability to update annually by 2024.

Objective 2: Develop and implement a sustainable strategy to connect and inform professionals, providers, patients, organizations and institutions in Georgia about oncological palliative care best practices, networking, educational opportunities, and quality standards including an underserved and vulnerable population focus.

Objective 3: Improve access to quality oncological palliative care for adults and children in Georgia.

STRATEGIES/STRATEGIC ACTIONS

A Data Collection and Surveillance

- Identify and access metrics for tracking pediatric and adult oncological palliative care in Georgia by 2024 that measure: operational metrics, clinical metrics, disparities, the provider landscape, advanced care planning, and gaps and barriers in access (geographic mapping, care continuum, cancer type, etc.) especially among diverse, underserved, and uninsured populations.
- Clearly define a continuum of palliative care from ideal to minimal- (that describes palliative in the state of Georgia) by 2024; i.e., Age (adult and pediatric care); Identify gaps in the number of centers that do not have access to palliative care services for adults and children; Location (hospital, clinic, and community-based care); population density (rural and urban); and provider (primary and subspecialty)

[12] *Defining High-Quality Palliative Care in Oncology Practice: An American Society of Clinical Oncology/American Academy of Hospice and Palliative Medicine Guidance Statement Kathleen E. Bickel, Kristen McNiff, Mary K. Buss, Arif Kamal, Dale Lupu, Amy P. Abernethy, Michael S. Broder, Charles L. Shapiro, Anupama Kurup Acheson, Jennifer Malin, Tracey Evans, and Monika K. Krzyzanowska Journal of Oncology Practice 2016 12:9, e828-e838*

B **Public and Provider Awareness** (see table below)**

- Collect and disseminate information about best practices and quality standards in oncological palliative care, including a standard coding and billing practice.
- Support networking and educational opportunities related to oncological palliative care throughout the state, including provider and consumer education that is appropriate to the local context.

C **Enabling Policies and Programs**

- Identify and support payment models and reimbursement that increase access to quality palliative care for adult and pediatric oncology patients, especially among diverse, underserved, and uninsured populations.
- Support an increase in the number of medical and pediatric oncology providers and interdisciplinary staff to ensure adult and pediatric oncology patients have access to early subspecialty palliative care, especially among diverse, underserved, and uninsured populations.
- Add a metric to the SEER-Medicare linked dataset to assess for palliative care consultation in the first months after a cancer diagnosis.

SUCCESS MEASURES	TARGETS
State of palliative care	**Create a dashboard representation** of the state of palliative care for children, adults and the elderly in Georgia
To increase awareness of palliative care providers (name, qualifications, locations, list of service, and what quality standards they meet)	**Post completed list on GC3 stake-holders' website**
Distribution of care models	Documented **care models will have been shared** widely throughout the state
Reach of information sharing mechanisms (hits, shares, # of attendees at events, etc.)**	TBD (based on an assessment)
Number of "documents" shared**	TBD (based on an assessment)
The number of community-based palliative care access points	TBD (based on an assessment)
The number of palliative care trained/boarded providers in the state of Georgia embedded in or locally available and connected to cancer centers for referral purposes.	TBD (based on an assessment)
Centers that take care of children with cancer in Georgia have access to pediatric palliative care services, including a boarded hospice and palliative medicine physician and advanced practice provider.	TBD (based on an assessment)

** There is a dearth of publicly available data to measure palliative care and this plan aims to generate a baseline for measurement which can be reported and measured against in the future.*

*** Section IV.B. in the strategies/strategic actions above*

V. IMPROVING QUALITY OF LIFE FOR CANCER SURVIVORS

Key Background Information: Georgians, like all Americans, are living longer after a diagnosis of cancer. A cancer survivor is any individual from the time of diagnosis through the balance of his or her life and also includes family members, friends, and care-givers impacted by the survivorship experience. Survivorship is defined by the National Cancer Institute as "being focused on the health and life of a person with cancer post treatment until the end of life. It covers the physical, psychosocial, and economic issues of cancer, beyond the diagnosis and treatment phases. Survivorship includes issues related to the ability to get health care and follow-up treatment, late effects of treatment, second cancers, and quality of life."

By 2029, the number of cancer survivors in the United States is projected to grow by 29.1% to 21.7 million from 16.9 million estimated living today.[13,14] Since 2013, the number of adult survivors in Georgia has increased from 355,870 to 446,900 people.[15] The most common cancer sites among adult survivors in Georgia are breast (16%), skin (14%), and prostate (7%).[16] Disparities exist among survivors in Georgia. For example, survivors in Georgia have higher rates of cardiovascular disease, diabetes, and obesity than adults that have never been diagnosed with cancer.[4]

The CDC National Comprehensive Cancer Control Program's priorities for 2018 include addressing the public health needs of survivors through survivorship programs; promoting survivorship care plans; and educating and providing information to survivors, caregivers, and providers. According to the American Society of Clinical Oncology, survivorship care is a specific approach taken to address the long-term needs of cancer survivors and includes monitoring for and managing long term and late effects, as well as health promotion. At the time this plan is being authored, the Commission on Cancer (CoC) is revising the standards that require accredited facilities to provide psychosocial distress screening and survivorship care plans. As the primary accrediting body for cancer centers, revisions will likely have a significant impact on the standard of survivorship care available throughout the state.

Cancer survivorship is dependent on the stage of the disease when the cancer is diagnosed. In 2017, 6% of Georgia's population survived cancer.[16] There are more female survivors (58%) compared to male survivors (42%).[6] Among females, non-Hispanic whites have the highest survival rates compared to other groups. Of the cancer survivors, 75% are 50 years old or older, and approximately 25% of cancer survivors had an income level of $75,000 or more.[6] It is important to improve the quality of life for cancer survivors. This can be improved through continued surveillance, applied research, and evaluation. Increasing and maintaining physical activity among cancer survivors also contribute to improvements in quality of life.

Objective 1: Establish and maintain surveillance of the physical and psychosocial quality of life for Georgia cancer survivors of all age-groups.

Objective 2: Increase the dissemination of information about survivorship that is inclusive and relevant (e.g., geography, language, cancer type, culture, literacy level, income, education, etc.) among survivors, caregivers, practitioners, and the general population of Georgia.

Objective 3: Increase resources that are available for quality survivorship care in Georgia by 2024.

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[13] National Cancer Institute https://cancercontrol.cancer.gov/ocs/statistics/definitions.html

[14] The National Cancer Institute's definition of a survivor includes defines a cancer survivor as: "An individual is considered a cancer survivor from the time of diagnosis, through the balance of his or her life. Family members, friends, and caregivers are also impacted by the survivorship experience and are therefore included in this definition."

[15] American Cancer Society, Cancer Facts & Figures (2018). Retrieved June 18, 2019 from www.cancer.org

[16] 2017 Georgia Behavior Risk Factor Surveillance System

STRATEGIES/STRATEGIC ACTIONS

A Data Collection and Surveillance

- Establish an ongoing assessment process to understand and depict the needs of survivors (pediatric to older adult) with some regularity by cancer type and population.
- Advocate for, and support research that seeks to answer the question "How is meeting the short and long-term needs of survivors good for business," i.e., a business case.
- Use and disseminate assessment findings regularly.

B Disseminate Information

- Collect and disseminate accurate, up-to-date, and relevant information related to survivorship including but not limited to; the short and long-term needs of survivors; best practices; national guidelines; emerging research; studies related to survivorship in GA; available survivorship resources and programs; assessment findings, and the use of survivorship care plans, treatment summaries, and distress screening.
- Establish dissemination mechanisms (e.g., newsletters, social media, blogs, research publications, a website repository, conferences, and events, etc.) to deliver information to a.) professionals, and b.) survivors and caregivers , using a variety of methods to ensure broad reach and access, considering barriers associated with technology.
- Establish a survivorship advocacy council and build capacity among survivors to engage in educational activities and be effective survivorship advocates.
- Improve partnerships between oncology medical specialties, primary oncology, and primary care/referral settings by supporting programs and efforts that aim to bridge these settings.

C Increase supportive resources

- Support organizations and efforts to establish reimbursement models/ policies/strategies for survivorship care, which leads to improved short and long-term outcomes for survivors.
- Encourage effective, efficient business models in the provision of survivorship care to ensure high-quality care
- Increase survivorship programs in GA.

SUCCESS MEASURES	TARGETS
Survivorship Needs Reassessment	Complete **at least one** survivorship needs reassessment among cancer survivors by 2023.
Develop and disseminate a business case	Business case distributed to non-CoC hospitals and all CoC ospitals, **80%** of licensed professionals (including primary care), **five** insurance providers, and the top ten employers in the state.

SUCCESS MEASURES	TARGETS
Assessment Findings Dissemination	Disseminate to **80%** of licensed professionals (including primary care), five insurance providers, and the top ten employers in the state. By 2021, the working group will reach **5% of survivors, all CoC hospitals, five insurance providers, and the top ten employers** in the state with information about survivorship. By 2020, the working group will have established and operated **at least one electronic and one non - electronic dissemination mechanism.**
Quality of life	**50% of survivors** surveyed can verbalize how survivorship care increased the quality of their life in at least one way.
Advocacy capacity of survivors	Establish a survivorship advocacy council by 2021 and insure **all of council members participate in advocacy training.**
Conferences and partnerships	**One conference** to build partnerships and bridge the settings where survivors receive care by 2024.
Use of survivorship care plans (SCP)/participation in survivorship program	**50%** of survivors use an SCP or participate in a survivorship program
Number of survivorship programs	Increase the total number of programs by **five** over the period

PARTNERSHIPS FOR ACTION

The causes of cancer and its prevention, diagnosis, treatment, and care are multi-dimensional. A person's health is not only the product of the health care that she receives, but also the result of genetic factors, behavior, and the physical, social, and policy environment in which she lives. As a result, there is no single approach or single intervention that can reduce the impact of cancer on the State of Georgia; multifaceted and layered approaches to prevention and control of cancer are needed. Statewide leadership, including leadership from the government, business, academic, and non-profit sectors is also essential to cancer prevention and control.

Statewide Leadership - Cancer prevention must occur in Georgia's communities, workplaces, faith communities, and schools through healthier environments, reduced exposure to tobacco, and improved nutrition and physical activity. State-of-the-art cancer screening, diagnosis, and care can only take place in strong health care systems that provide access to persons of all incomes, races, ethnicities, and walks of life. Appropriate cancer screening in target populations throughout the state will likely be more successful when resources from both the public, including the federal and state government, and private sectors (e.g., insurers, businesses, philanthropic) are linked to support the achievement of a common set of strategic outcomes.

Supporting cancer survivors and their families requires strong communities that are culturally relevant and appropriate. To be effective, Georgia's cancer prevention, screening, and treatment programs that are sponsored by public and private funders must be engaged with communities and systems of care. All of these stake-holders must come together to prevent and control cancer in Georgia.

The Path Forward - This strategic plan for comprehensive cancer prevention and control, which is a product of extensive input from stakeholders, describes Georgia's priority areas for moving forward around cancer prevention and control. The plan builds on the strengths of Georgia's cancer prevention, research, and treatment communities. It lays out a path forward to reduce the number of cancer deaths in Georgia, maintain Georgia's place as a national and international leader in cancer research, and improve the quality of life for those who have survived cancer. Efforts over the next five years will focus on linking public and private resources, increasing access to early detection and screening, and increasing the use of evidence- based screening guidelines and practice.

The Georgia Department of Public Health, through the GC3 and its membership, will implement this plan and provide the statewide leadership necessary to bring together communities and resources for cancer prevention and control (See Appendix 1). The Consortium will advise the Department and sustain Georgia's focus on cancer, re-imagine cancer prevention problems, develop new innovative strategies to address Georgia's cancer priorities, and reduce cancer deaths.

Georgia's Partners in Cancer Prevention - Government can never address cancer or any other significant public health challenge alone. Georgia has a strong fabric of cancer prevention and control programs, and an emerging history of successful cancer control through a network of partners, including the Georgia Department of Public Health, the Regional Cancer Coalitions, Georgia Center for Oncology Research and Education, Georgia Society of Clinical Oncologists, and national partners including the American Cancer Society. The complex causes and systems of care for cancer make this fabric of programs and partners a critical part of saving lives in Georgia. Partners from health care, public health, hospitals, academia, communities, employers, national partner organizations, and faith-based organizations must continue to come together to address all aspects of cancer prevention, early detection, diagnosis, treatment, and quality of life for survivors.

Academic Partners - The academic and research communities play an essential role in advancing the understanding of cancer prevention, screening, diagnosis, and treatment by conducting prevention research, identifying the factors that contribute to overall health, conducting cancer-related research, developing new diagnostic and treatment tools, collecting and managing data, and training the next generation of health care providers.

Community Leaders - Community leaders, businesses, faith-based organizations, and others are essential local champions and important contributors that enhance community capacity to reduce cancer risk, detect cancers earlier, improve treatments, and enhance survivorship and quality of life for cancer patients.

Health Care Providers and Associations - Health care providers and their associations are critical partners in cancer screening and treatment. They deliver safe and evidence-based care and services for patients, individuals, families, and communities.

Hospitals - Hospitals play one of the most important roles in treating people with cancer by providing the highest quality inpatient diagnostics and care for cancer patients and their families, as well as access to specialists who are essential to cancer treatment.

Employers - Employers in Georgia can help prevent cancer by implementing workplace wellness approaches and by influencing health care policies, reimbursement and industry practices to support the fight against cancer.

Georgia Department of Public Health - The Georgia Department of Public Health (DPH) is the State of Georgia's lead agency in preventing disease, injury and disability; promoting health and well-being; and preparing for and responding to disasters from a health perspective. In 2011, the General Assembly restored DPH to its own state agency after more than 30 years of consolidation with other departments. At the state level, DPH functions through numerous divisions, sections, programs, and offices. Locally, DPH funds and collaborates with Georgia's 159 county health departments and 18 public health districts. Through the changes, the mission has remained constant – to protect the lives of all Georgians. Today, DPH's main functions include: Health Promotion and Disease Prevention, Maternal and Child Health, Infectious Disease and Immunization, Environmental Health, Epidemiology, Emergency Preparedness and Response, Emergency Medical Services, Pharmacy, Nursing, Volunteer Health Care, the Office of Health Equity, Vital Records, and the State Public Health Laboratory.

Georgia Center for Oncology Research and Education - Georgia CORE is a public-private partnership that connects cancer care providers, leaders, organizations, and advocates throughout the state. Led by a board of directors of cancer experts from academic institutions, hospitals and cancer centers, collaboration orchestrated by Georgia CORE improves access to clinical trials, as well as personalized cancer care and support for patients, survivors, and caregivers. It created GeorgiaCancerInfo.org, the only statewide online information center of its kind, where details can be found on oncologists, clinical trials, treatment centers and survivorship resources throughout the state.

Georgia Hospice and Palliative Care Organization - The Georgia Hospice and Palliative Care Organization was established in 2009 to aid and facilitate advocacy, promotion, and education about hospice use and palliative care issues including pain management. This organizational resource represents an opportunity for practice improvement to be supported and disseminated across the state and for the broad participation and engagement of many stakeholders in the field.

Local Public Health - Georgia's County Boards of Health and local health organizations help to prevent and treat cancer and manage care by providing direct services to Georgia residents. These agencies lead efforts that prevent and reduce the effects of cancer and develop more systematic approaches to cancer screening to better organize and unify the efforts of health care providers. County Boards of Health also help to ensure community-based preventive services, such as tobacco use cessation.

National Partners - Georgia benefits from a large concentration of national non-governmental organizations. These partners help Georgia

leverage resources to promote cancer prevention, early detection, access to health care and social services, and reduce the state's cancer burden. The partners also assure the availability of a wide range of expertise and skills in Georgia to address cancer.

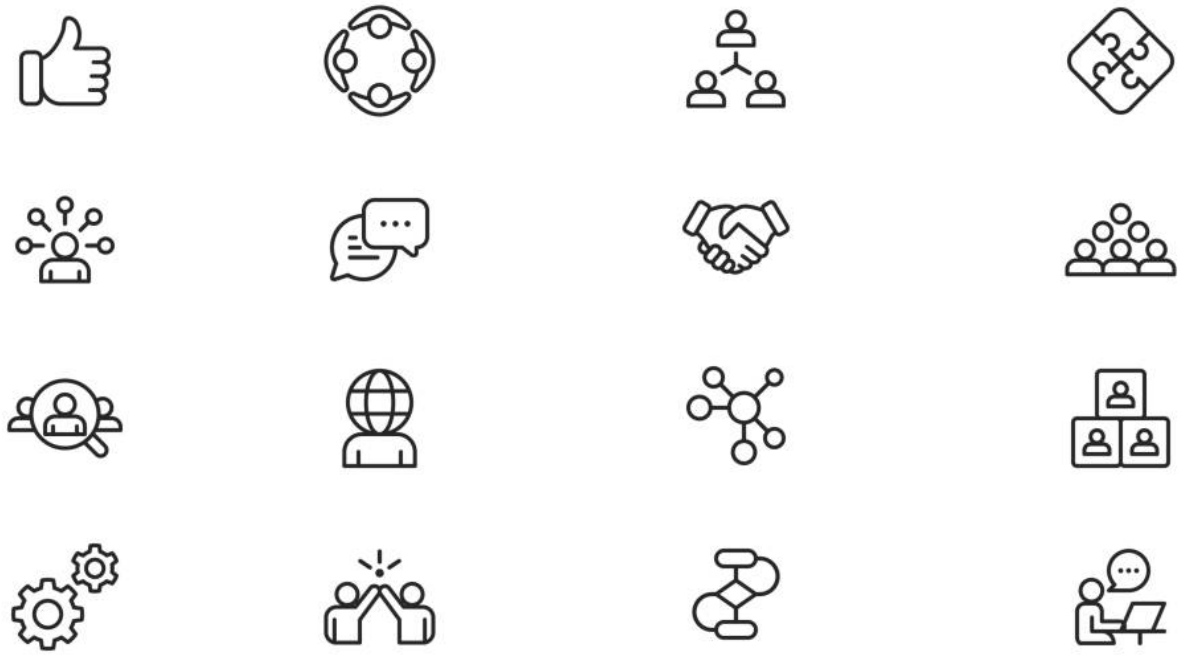
Regional Cancer Coalitions - The Regional Cancer Coalitions of Georgia (RCCGs) are regional entities organized to reduce deaths and disability from cancer in our state. The RCCGs do the following:

1. Develop and deliver cancer programs and services, and support and build upon existing cancer programs and services
2. Strengthen programs and services by elevating local cancer efforts to national standards of the American College of Surgeons, National Comprehensive Cancer Network, Association of Community Cancer Centers, and others
3. Reduce duplication and competition among cancer-related entities
4. Leverage state dollars and maximize opportunities for private investment
5. Adapt statewide efforts based on national standards to local communities
6. Reduce disparate access to services based on geography, race, insurance status, and other factors

Other Non-Profit Organizations - Many non-profit organizations are important advocates for the cancer control effort. Groups such as the Georgia Prostate Cancer Coalition and the Georgia Breast Cancer Coalition assist in engaging survivors to support ongoing cancer control efforts and resources.

The Public - The public can help prevent cancer by practicing a healthy lifestyle that reduces the risk of cancer, including receiving regular medical care, avoiding tobacco, limiting alcohol use, avoiding excessive exposure to ultraviolet rays from the sun and tanning beds, eating a diet rich in fruits and vegetables, maintaining a healthy weight, and being physically active.

The Georgia Radon Education Program - is a partnership funded by the Environmental Protection Agency that aims to educate Georgians on how to protect themselves from the risk of developing lung cancer caused by the unwelcome entry of radon gas into their homes.



APPENDIX A

Additional Cancer Control Information

TOBACCO AND OBESITY

Key Background Information: Tobacco use is the leading preventable cause of death in Georgia, costing the state more than 11,500 lives per year and nearly $5B in direct healthcare costs and indirect costs, such as lost wages. Over the last 15 years, adult tobacco use has been declining, with a recent increase in the rate of decline. However, alternative tobacco use rates have increased, particularly among youth. Low income, White, rural males continue to use tobacco at higher rates than the national average, and the Medicaid population continues to be two to three times more likely to use tobacco than the general population. Young adults ages 18-24 continue to smoke at the highest rates of any age group. Smokeless tobacco and smoking among pregnant women remain significant problems in Georgia.[8] There is a Georgia Tobacco Control Strategic Plan in place. The Georgia Tobacco Use Prevention Program (GTUPP) in the Georgia Department of Public Health, along with its partners, strive to eliminate tobacco use and tobacco-related disparities in Georgia.

RADON PREVENTION

Key Background Information: Radon is a naturally occurring gas formed by the breakdown of uranium which is often found in high concentrations in granite and rocky soils that can potentially enter homes through their foundations. Radon is the second leading cause of lung cancer in the United States, after tobacco smoke, accounting indirectly for the deaths of nearly 21,000 people each year, more than 800 of whom are estimated to occur in Georgia. Smokers are at an even higher risk of radon-induced lung cancer than nonsmokers.[9,17]

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[17] *American Lung Association Epidemiology and Statistics Unit Research and Program Services Division, November 2014. Trends in Lung Cancer Morbidity and Mortality.*

APPENDIX B

ACHIEVEMENTS

Many of the defined targets from Cancer Plan 2014-2019, including several policy, system, and environmental changes, have been or are being met. In the face of several challenges related to changing regulations, the consolidation of health systems, and shifting national healthcare policies, Georgia has accomplished moderate progress toward achieving comprehensive cancer control. Some examples include:

- The Cancer Plan 2014-2019 set a target of 50% complete vaccination coverage in adolescents. HPV vaccinations among teens 13-17 years old reached 55% among girls and 36% among boys.[18] The incidence of cervical cancer has decreased from 8.2 in 2014 to 8.0 per 100,000 population.

- The Cancer Plan 2014-2019 set a target for five Commission on Cancer (CoC) Centers to provide a palliative care program. Since then, all CoC approved cancer centers offer palliative care services. Therefore, this target has been met.

- The Cancer Plan 2014-2019 worked to established a baseline of the physical and psychosocial quality of life for Georgia cancer survivors. Results from the statewide assessment of survivors' physical and psychosocial quality of life were published in the Journal of the Georgia Public Health Association (2016) and presented at multiple survivorship related events.

- The Cancer Plan 2014-2019 set a target to establish four lung cancer screening programs.[19] According to the Lung Cancer Alliance (LCA), Georgia had 33 lung cancer screening programs in 2019. This target has also been met.

- The Cancer Plan 2014-2019 set a target for CoC approved increase participation in RQRS to at least 85%. As of June 2017, 95% of Georgia's CoC cancer centers participated in the Rapid Quality Reporting System. In addition to meeting many targets set forth in the previous plan, the GC3 has expanded to address emerging and persistent cancer challenges in innovative ways The consortium has engaged a growing and dynamic membership that leads and informs cancer control throughout the state.

- Georgia's GC3 Colorectal Cancer Screening Roundtable (CCSR) was established in 2015 to define the necessary activities that will increase access to and utilization of high-quality screening and treatment and reduce the incidence and mortality of colorectal cancer in Georgia. Since its inception, the CCSR has held four annual conferences.

- The Prostate Cancer Task Force brought together subject matter experts in 2016 to advise the Steering Team on how to best address prostate cancer in the state.

- The Georgia Lung Cancer Screening Roundtable (LCSR) was established in November 2017 to make Georgia a national leader in detecting lung cancer at its earliest and most treatable stage. Since it was established, the LCSR has held two meetings.

- The Legislative Advocacy Task Force was established in 2018 to maintain and increase the legislative support for cancer control activities in Georgia.

18 Walker, T.Y., Elam-Evans, L.D., Singleton, J.A., et al. (2016). National, Regional, State, and Selected Local Area Vaccination Coverage Among Adolescents Aged 13–17 Years — United States. MMWR Morbidity and Mortality Weekly Report 2017;66:874–882. DOI: http://dx.doi.org/10.15585/mmwr.mm6633a2 Note: Due to changes in survey administration, it is not possible to report HPV vaccination rates of boys and girls separately after 2016. In 2017, the prevalence of HPV vaccination was 45.7% among boys and girls combined.

19 Lung Cancer Alliance (2019), Georgia Screening Centers: Available at www.Lungcanceralliance.org

- The membership of the GC3 Steering Team and work groups increased with the addition of individuals from both the public and private sectors.

Awareness is vital to cancer prevention. While treatment can save and prolong lives, proper screening for early detection and changing behaviors increases treatment efficacy, survival rates, and reduces the prevalence of cancer. Efforts to increase awareness and educate people in Georgia about screening, behaviors that increase the risk of cancer and other topics related to cancer control have included:

- The "Cancer Survivorship: Up Close and Personal" statewide conference in 2016 explored issues faced by survivors of different cultures, best practices, national cancer survivorship guidelines, and evidence-based research.

- The GC3 Summit in 2017 in Macon, GA, aimed at enhancing understanding of the current status of cancer control in the state, celebrating successes, engaging policy makers and researchers for the future, and promoting networking and partnership.

- Palliative Care Networking and Education meetings were held annually from 2015 to 2018 in Macon, Atlanta, and Augusta, GA.

- Providing education on CoC program standards to non-CoC institutions in the state.

- Expanded film screenings of Someone You Love (with discussion) to colleges, universities, and other community organizations. Someone You Love is a video presentation used to increase awareness about HPV, its link to cervical cancer, and the opportunity to be vaccinated.

Several policy changes that will influence cancer control throughout the state occurred after the GC3 led and inspired advocacy action.

- The state passed House Bill 509 which established the Georgia Palliative Care and Quality of Life Advisory Council. The Council is charged with creating a statewide Palliative Care Consumer and Profession-al Information and Education Program.
- The Georgia legislature earmarked $875K in FY 2019 to fund cancer control activities, which increased the resources dedicated to cancer control in the state.
- The US Preventive Services Task Force upgraded the recommendation for prostate-specific antigen (PSA) screening from level "D" to level "C", clearing the way to greater access to prostate cancer screening to men in the state.

There have been several changes since 2014 that have influenced cancer control in the state.

- As of June 2019, there were 35 CoC accredited cancer centers in Georgia. A close comparison of the centers accredited in 2019 with previous years shows a trend of health systems consolidating multiple "cancer centers" into system-level accreditations. For example, the Northside Hospital Cancer Institute (NHCI), WellStar Health System, and Piedmont Health System, three of the largest non-profit health systems in the state, all use a similar model to offer CoC accredited care at more than one location in Georgia by consolidating multiple facilities into one accreditation. In fact, there are 45 individual hospitals with cancer centers in Georgia. The result of such consolidation has been a larger geographic footprint of CoC influence, and yet a lower number of actual accreditations. (Cancer 2014-2019 Target: COC accredited facilities to increase from 41 to 44)

- The CoC Cancer Program Standards were revised in 2016. At that time, palliative care programming and survivorship care plans became a requirement of accreditation. While palliative care programming has increased, cancer centers have continued to struggle meeting the requirement to provide a hand-delivered survivorship care plan to 50% of their patient population. At the moment, further revisions of the national CoC Program Standards pertaining to survivorship care planning are underway; these revised standards will undoubtedly influence survivorship care planning and delivery in Georgia and across the nation in the years ahead.

Measurable progress has been made since the last revision of the state cancer control plan, and existing and newly emerging opportunities will be addressed over the next five years.

APPENDIX C

GEORGIA CANCER CONTROL CONSORTIUM STEERING TEAM

Co-Chairs

James Hotz	President, Council of Regional Cancer Coalitions, Medical Director, Cancer Coalition of South Georgia
Angie Patterson	Director, Georgia Center for Oncology Research and Education (2014-2019)
Brian Rivers	Ph.D., M.P.H., Director, Cancer Health Equity Institute, Morehouse School of Medicine (2019-Present)

Members

Gena Agnew	Executive Director, Northwest Georgia Cancer Coalition
Fred Ammons	Executive Director, Central Georgia Cancer Coalition
Karen Beard	Director, Georgia Society of Clinical Oncology
Mary Daniels	Executive Director, American College of Physicians (Georgia Chapter)
Kelly Drevitch	Account Representative, State Health Systems, American Cancer Society – Georgia Chapter
Kelly Erola	Medical Director, Hospice Savannah
Diane Fletcher	Chief Executive Officer, Cancer Coalition of south Georgia
Marilyn Hill	Program Director, East Georgia Cancer Coalition
Cheryl Johnson	Executive Director, West Georgia Cancer Coalition
Nancy Johnson	Administrator and PSA Director, St. Joseph's/Candler Health System
Duane Kavka	Executive Director, Georgia Association for Primary Health Care
Michelle Kegler	Associate Professor and Director, Emory Prevention Research Center, Emory University
Troy Kimsey	Physician Liaison, Chair, Commission on Cancer (Georgia)
Joseph Lipscomb	Professor, Health Policy & Management, Emory University
Tamira Moon	Manager, Georgia Comprehensive Cancer Control Program, Georgia Department of Public Health
Amy Moore	Director of Research Programs, Georgia Research Alliance
Nancy Paris	President, CEO, Georgia Center for Oncology Research and Education
Joyce Reid	Vice President, Community Health Connections,Georgia Hospital Association

Toby Sidman	Founder, Georgia Breast Cancer Coalition
Robert Smith	Senior Director, Cancer Control, American Cancer Society
Graham Thompson	Executive Director, Georgia Association of Health Plans
Kia Toodle	Director, Chronic Disease Prevention, Georgia Department of Public Health
Nannette Turner	Chair, Associate Professor, Department of Public Health, College of Health Professions, Mercer University

APPENDIX D

WORK GROUP MEMBERSHIP

HPV Prevention

Co-Chairs

Dr. Brian Boyce	Assistant Professor, Head and Neck Cancer Surgeon/Faculty, Emory University
Dr. Gabrielle Darville	Assistant Professor, Mercer University
Adrian King	Public Health Program Associate, Winship Cancer Institute

Members

Allison Agnew-Harris	Outreach Coordinator, Northwest Georgia Regional Cancer Coalition
Leanne Bailey	Associate Director, U.S. Vaccine Policy and Government Relations, MERCK
Adam Barefoot	Oral Health, Georgia Department of Public Health
Dr. Bob Bednarczyk	Assistant Professor, Winship Cancer Institute
Garrett Blanton	Associate Director, MERCK
Shirley E. Borghi	Co-Vice Chairman and Executive Director - Federal Certified Navigator, Hispanic Health Coalition of Georgia
Amma Boakye	Research Associate, Georgia Health Policy Center
Anne Bruno-Gaston	Laboratory Manager, Fulton County Board of Health
Noreen Dahill	Immunizatation Coordinator, Georgia Chapter American Academy of Pediatrics
Saron Ephriam	Healthy Systems Manager, State and Primary Care Systems American Cancer Society
Dr. Lisa Flowers	Professor at Department of Gynecology and Obstetrics and Director at Colposcopy Services
Crystal Hand	Associate Director, Three Rivers AHEC
Triana James	
Olga Jimenez	Public Health Program Associate, American Cancer Society
Paige Lightsey	Immunization Program Director - Coastal Health District, Georgia Department of Public Health
Jana Mastrogiovanni	Program Manager, Cancer Pathways
Dr. Roland Matthews	Obstetrician/Gynecologist, Morehouse School of Medicine
Janna McWillson	American Academby of Pediatrics - Georgia Chapter
Tamira Moon	Program Manager, Georgia Comprhensive Cancer Conrol Program, Georgia Department

Tonya Phillips	Senior Manager, State and Primary Care Systems, American Cancer Society
Dr. Debbie Saslow	Director, Breast and Gynecologic Cancers, American Cancer Society - Georgia Chaper
Morphia Scarlet	Oncology Resource Liason, Curtis and Elizabeth Anderson Cancer Institute
Dr. Charan Shikh	Internal Medicine Doctor, Dekalb Medical Center and Primary Care Center
Kenneth Simon	Associate Director of Vaccine Sales, MERCK
Kelsey Schwarz	Health Communications Specialist, Centers for Disease Control and Prevention
Marianne Tarica	Regional Account Manager, VaxCare
Elliot Turner	Vaccines Medical Affairs Lead, MERCK
Andrenita West	HIV Surveillance Epidemiologist, Georgia Department of Public Health
Astrid Wilkie-Mckellar	Community Outreach Coordinator, Northside Hospital

Early Detection and Screening

Co-chairs

Jim Hotz	Co-Chair and President, Albany Area Health Center
Nanette Turner	Chair, Associate Professor, Department of Public Health, Proffessions, Mercer

Members

Madelyn R Adams	Director, Community Benefit, Kaiser Permanente of Georgia
Fred Ammons	Executive Director, Central Georgia Cancer Coalition
Denise Ballard	Chief Mission Officer, Cancer Coalition of South Georgia (now Horizons)
Karen Beard	Director, Georgia Society of Clinical Oncology
Vickie Beckler	I-ELCAP Coordinator, RN, WellStar Health System
Shirley Borghi	Co-Vice Chairman and Executive Director, Hispanic Health Coalition
Cathy Broom	Program Manager, Chronic Disease Prevention Section, Georgia Department of Public Health
Frank Catroneo	ProstAware
Mary Daniels	Executive Director, American College of Physicians (Georgia Chapter)
Kelly Durden	Account Representative, State Health Systems, American Cancer Society-Georgia Chapter
Cam Escoffrey	Associate Professor, Department of Behavioral Sciences and Health Education, Rollins School of Public Health, Emory University
Danny Futrell	Medical Director, CIGNA
Cynthia George	Executive Director, Cancer Coalition of South Georgia (Now Horizons)

Erin Hernandez	Executive Vice President, Northwest Georgia Regional Cancer Coalition
Tenetta Holt	Regional Education Coordinator, West Central Georgia Cancer Coalition
Cheryl Johnson	Executive Director, West Georgia Cancer Coalition
Adam Jones	Radiation Oncology Associate, Phebe Putney
Alice Kerber	Georgia Center for Oncology Research and Education
Dr. Jim Kruse	Chief, Surgical Oncology; Associate Professor of Surgery, Augusta University
Bill Mayfield	Chief Surgical Officer, WellStar Health System
Christina Meyers	Health Program Coordinator, Center for Pan Asian Community Services, Inc.
Scott Miller	Urologist, ProstAware
Brian Rivers	Director, Cancer Health Equity Institute, Morehouse School of Medicine
Morphia Scarlett	Oncology Resource Liaison, Curtis and Elizabeth Anderson Cancer Institute at Memorial Health University Medical Center
Robert Smith	Senior Director, Cancer Control, American Cancer Society – Georgia Chapter Citi Stone CEO, Susan G. Komen Greater Atlanta
Bill Warren	Chief Executive Officer, Founder and Pediatrician, Good Samaritan Health Center
Catherine Willard	Nurse Consultant, Georgia Department of Public Health

Diagnosis Staging and Treatment

Co-Chairs

Nancy Johnson	Administrator and PSA Director, St. Joseph's/Candler Health System Radiation
Dr. Adam Jones	Oncology Associate, Phebe Putney

Members

Debbie Chambers	District 5-2, Georgia Comprehensive Cancer Registry, GDPH Radiation Oncologist,
Arnold Conforti	State Chair, Commission on Cancer
Kelly Durden	Account Representative, State Health Systems, American Cancer Society
Jennifer Forstner	Account Executive, Merck
Joan Kines	Department Manager, Harbin Clinic Radiation Oncology
Scott Miller	Urologist, WellStar Health System
Gabriella Oprea	Assistant Professor, Emory University
Yolanda Palmer	Program Manager, Chronic Disease Prevention Section, Georgia Department of Public Health
Nancy Paris	President, CEO, Georgia Center for Oncology Research and Education

Palliative Care

Tri-Chairs

Dr. Katherine Brock	Assistant Professor of Pediatric Oncology and Palliative Care, Emory University, Children's Healthcare of Atlanta
Dr. Kim Curseen	Director of Supportive and Palliative Care, Outpatient Services, Emory Healthcare
Ashely Derringer	Nurse Practitioner, Northeast Georgia Physician

Members

Tim Adams	Palliative Care Nurse Coordinator, Tanner Health
Carol Babcock	Director, Medical Center Navicent Health
Sarah Collett	WellStar Health System
Melissa Dowd	Family Nurse Practitioner, University Cancer and Blood Center
Dr. Khaliah Johnson	Pediatrician, Children's Healthcare of Atlanta
Dr. Ashima Lal	Emory
Laura Moon	St. Mary's - Athens
Melissa Murray	Director of Hospice Services, Affinis Hospice LLC
Dr. Sherika Newman	St. Joseph's/Emory
Tammy Owenby	Tanner Health
Dr. Tammie Quest	Emory
Paula Sanders	Georgia Hospice and Palliative Care Organization
Dr. John Shaner	Hospice of the Golden Isles
Bob Waggoner	Hospice and Community Palliative Care Program
Dr. Sharon White	Family Nurse Practitioner
Cathy Williard	Nurse Consultant, Georgia Department of Public Health

Survivorship

Chair

Angie Patterson	Chair and Director, GA CORE

Members

Chizelle Archie	Project Coordinator, Grady Health System
Shirley Borghi	Co-Vice Chairman & Executive Director, Hispanic Health Coalition of Georgia
Rachel Cannady	Advisory Board Member, American Cancer Society
Hayes Dawn	QI Specialist, Northside Hospital

Cam Escoffery	Assistant Professor, Rollins School of Public Health
Mary-Ann Heddon	Clinical Trials Coordinator, South Georgia Med (Valdosta)
Marilyn Hill	Program Director, East Georgia Cancer Coalition (Athens)
Ann Hook	Oncology Service Line Director, Redmond Regional Medical Center
Annette Idalski	Survivor
Uzma Khan	Georgia Prostate Cancer Coalition
Kathryn Lewis	Former Genetic Services Coordinator, St. Josephs/Candler (Savannah)
Amy McEachin	Gwinnett Medical
Ann Mertens	Professor, Hematology/Oncology, Children's Healthcare of Atlanta
Pooja Mishra	FACHE Vice-President, Oncology & Sickle Cell Service Line, Grady Health System
Rebecca Shimkets	Survivor
Pam Proman	St. Joseph's/Candler (Savannah)
Toby Sidman	Founder, Survivor; Georgia Breast Cancer Coalition
Judy Stanton	Consultant
Jody Temple	Harbin Clinic
Karen Terry	Memorial University Hospital
Domingo Valpuesta	Gwinnett Medical Center
Qun Zeng	Gwinnett Medical Center

Data and Evaluation

Co-Chairs

Joseph Lipscomb	Professor, Health Policy & Management, Emory University
Rana Bayakly	Chief Epidemiologist, Georgia Department of Public Health

Members

Fred Ammons	Executive Director, Central Georgia Cancer Coalition
Jennifer Hale	Executive Director, Georgia Hospice and Palliative Care Organization
Kia Powell-Threets	Deputy Director, for the Chronic Disease Prevention, Georgia Department of Public Health
Janet Shin (Jeon)	Program Evaluator, Georgia Department of Public Health
Kevin Ward	Georgia Center for Cancer Statistics, Emory University

GEORGIA CANCER CONTROL CONSORTIUM

COMPREHENSIVE CANCER CONTROL PLAN 2019 – 2024