State of Illinois
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Illinois Comprehensive Cancer Control 2005-2010

EXECUTIVE SUMMARY

Illinois Comprehensive Cancer Control Program

Illinois Department of Public Health

Executive Summary

Comprehensive Cancer Control State Plan: According to the U.S. Centers for Disease Control and Prevention (CDC), Comprehensive Cancer Control (CCC) is an integrated and coordinated approach to reducing cancer incidence, morbidity and mortality through prevention, early detection, treatment, rehabilitation and palliation. It is a model that integrates and coordinates a range of activities to maximize the impact of limited resources and achieve desired cancer prevention and control outcomes.

Cancer is the leading cause of death for Illinois citizens 45 to 64 years of age. The Illinois Comprehensive Cancer Control State Plan 2005 – 2010 is organized around the public health model of primary, secondary and tertiary prevention. Within this framework, broad goals are defined for primary prevention, early detection and treatment, along with objectives and strategies that address both general and cancer-specific issues. Likewise, goals, objectives and strategies are identified for the cross-cutting issues of quality of life, data and advocacy.

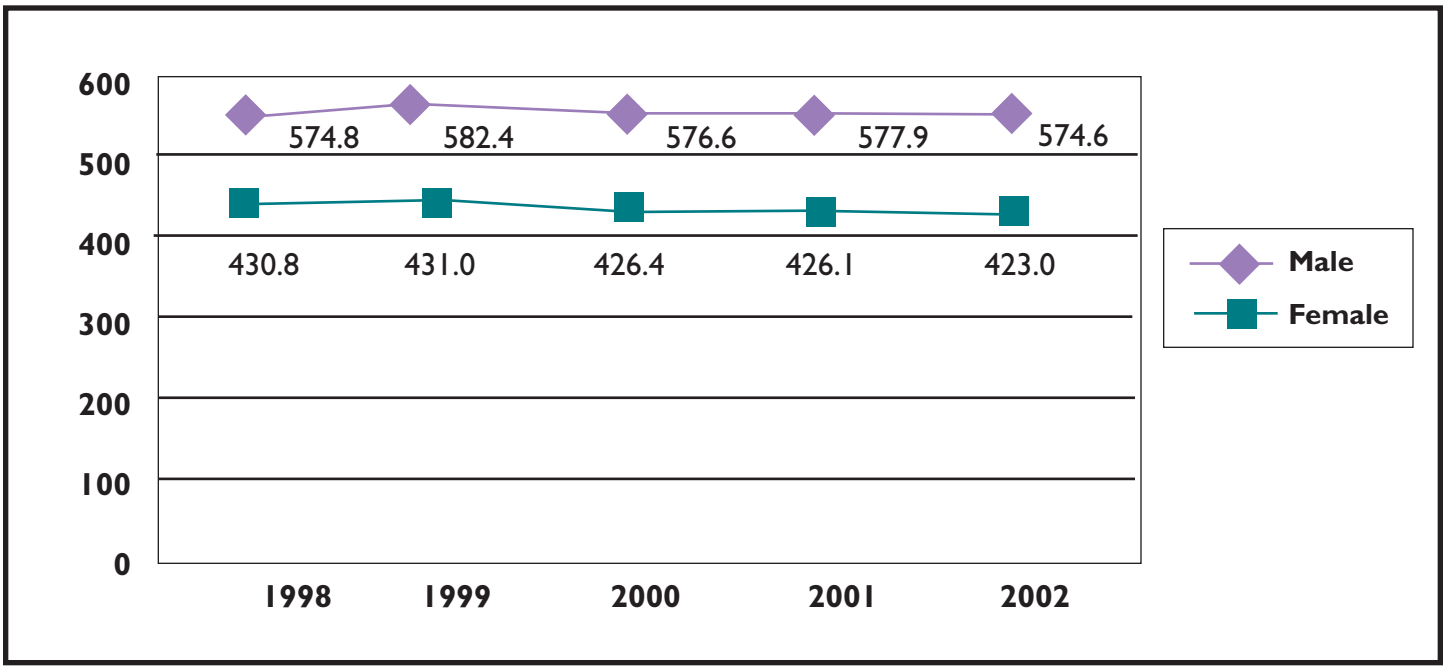
The Structure: Illinois' comprehensive cancer control state plan, hereafter referred to as the state plan, was developed by a broad partnership of public and private stake holders whose common mission is to reduce the burden of cancer in Illinois. More than 100 individuals from more than 60 organizations participated in developing the state plan goals. Priorities for action were identified by state plan participants, based on existing cancer incidence and mortality data, data-driven disparities, scientific research findings, and recognition of the significant role data and advocacy play in making a difference in cancer.

A steering committee guided the work involved in preparing this plan. The result of this process, to establish a plan to enhance the infrastructure for CCC activities, is summarized in this booklet.

The State Plan: The state plan is designed to promote the statewide coordination of public and private cancer control efforts, provide a framework for action to reduce the burden of cancer, and increase communication and collaboration among all those involved in working with cancer. It is not possible to address all the issues associated with cancer control in one document. This plan is designed to be a living document that guides collaborative action throughout the state. CCC is based on the following principles:

- Scientific data and research are systematically used to identify priorities and direct decision making.
- The full scope of cancer care is addressed, including primary preventions, early detection, treatment, rehabilitation, pain relief, symptom management, patient and family care, survivorship and end of life.
- Many stakeholders are engaged in cancer prevention and control, including the medical and public health communities, voluntary agencies, insurers, businesses, survivors, government, academia and advocates.
- All cancer-related programs and activities are coordinated, thereby creating and fostering leadership.

Figure 1: Illinois Cancer Incidence Rates, (per 100,000), All Races, All Sites, 1998 – 2002



- The activities of many disciplines are integrated when considering comprehensive cancer control activities. Contributing disciplines include administration, basic and applied research, evaluation, health education, program development, public policy, surveillance, clinical services and health communications.

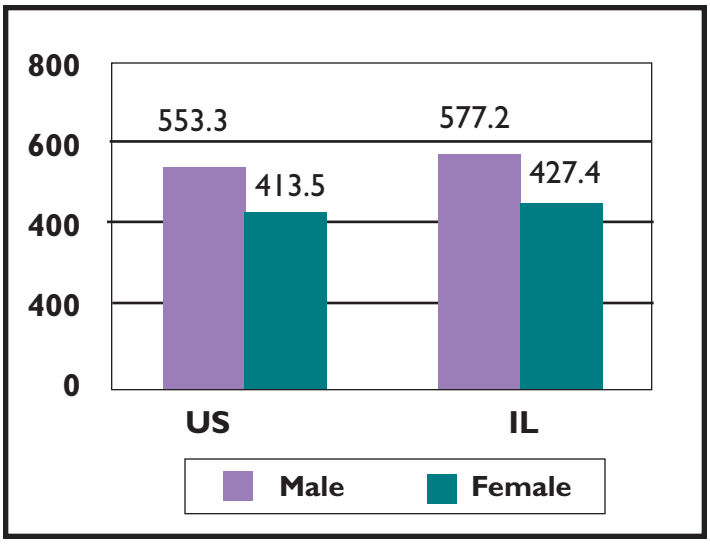
Illinois Cancer Profile

Incidence

Incidence refers to the number of newly diagnosed cases during a specific time period. The extent of occurrence or incidence rate of cancer varies by age, sex, ethnicity and location. The Illinois State Cancer Registry (ISCR) indicates the all sites, age-adjusted cancer incidence rate for males to be 577.2 and females 427.4 per 100,000 people, of all races combined for 1998 - 2002.[i] Men tend to have a higher incidence of cancers than women. Figure 2 shows the incidence rate for men and women from 1998 to 2002.[ii]

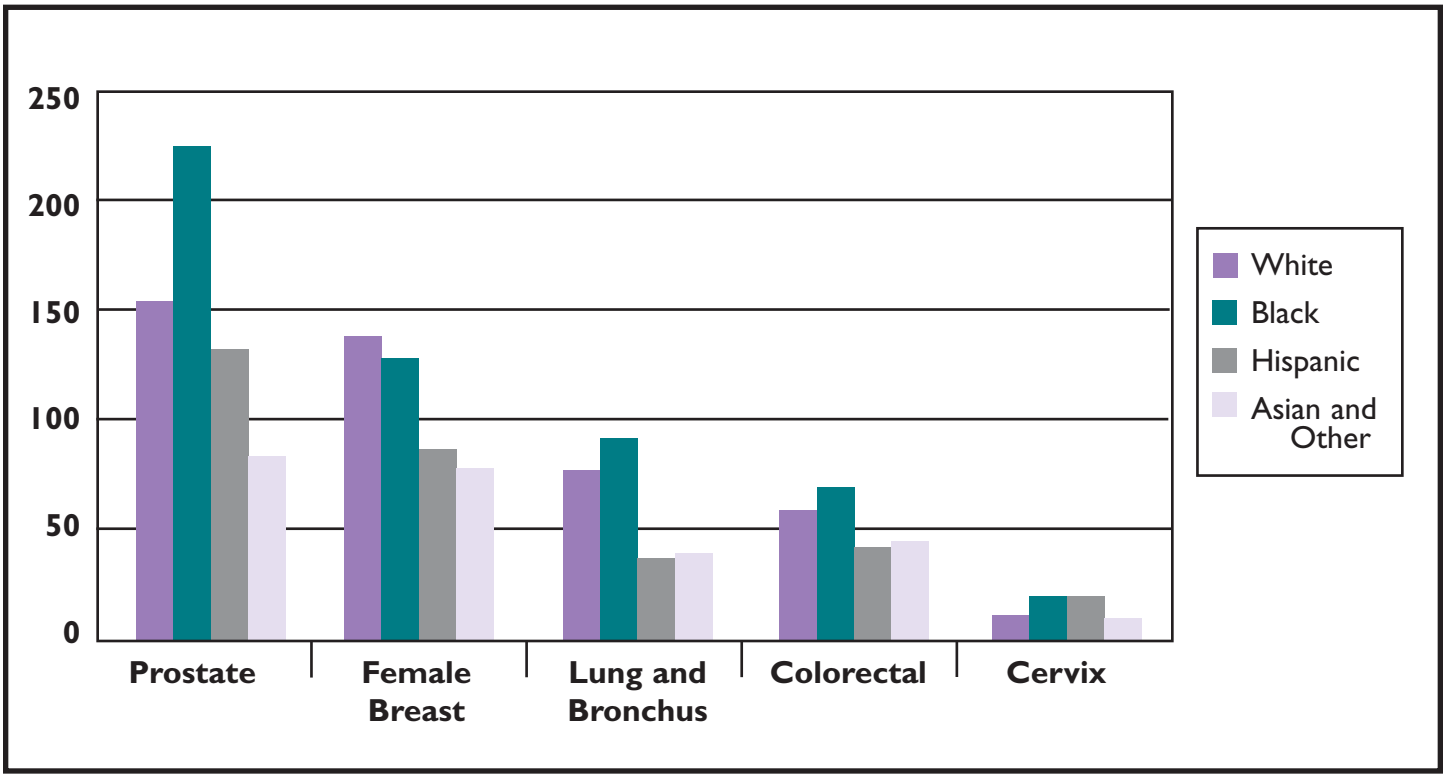
The incidence rate in Illinois is slightly, but consistently higher, than the national incidence rates. Comparisons of actual rates during 1998-2002 are presented in Figure 2.

Figure 2: Comparison National and Illinois Cancer (All Sites) Incidence Rates, (per 100,000) 1998 – 2002



Blacks have a higher incidence rate of prostate, lung and colorectal cancer than any other racial or ethnic group. Whites have the highest incidence rate of female breast cancer and Hispanics have a slightly higher incidence rate of cervical cancer than whites. Figure 3 illustrates the incidence rate by race and ethnicity for selected cancer sites.

Figure 3: Illinois Cancer Incidence Rates (per 100,000) by Race/Ethnicity, 1998 -2002



The top 10 cancer incidence rates for 2002 for race and sex are presented in Table 1a for males and Table 1b for females.

Table 1a: Top 10 Cancer Incidence Rates in Illinois (per 100,000)[iii] Males by Race, 2002

White	Incidence Rate	Black	Incidence Rate	Asian & Other	Incidence Rate	Hispanic	Incidence Rate
Prostate	152.5	Prostate	210.6	Prostate	88.4	Prostate	116.8
Lung and bronchus	91.5	Lung and bronchus	116.1	Lung and bronchus	54.3	Colorectal	52.8
Colorectal	68.9	Colorectal	79.5	Colorectal	49.3	Lung and bronchus	39.2
Bladder	44.6	Kidney	25.3	Liver	18.7	Non-Hodgkin's Lymphoma	24.0
Non-Hodgkin's Lymphoma	23.9	Oral	22.8	Non-Hodgkin's Lymphoma	17.9	Bladder	20.1
Kidney	19.7	Pancreas	19.1	Stomach	17.7	Stomach	14.8
Melanoma	18.3	Bladder	18.5	Bladder	12.1	Liver	14.5
Leukemias	16.8	Stomach	17.1	Leukemias	10.2	Leukemias	13.4
Oral	15.1	Non-Hodgkin's Lymphoma	14.1	Oral	9.1	Kidney	12.3
Pancreas	12.9	Leukemias	12.3	Pancreas	7.2	Oral	9.8

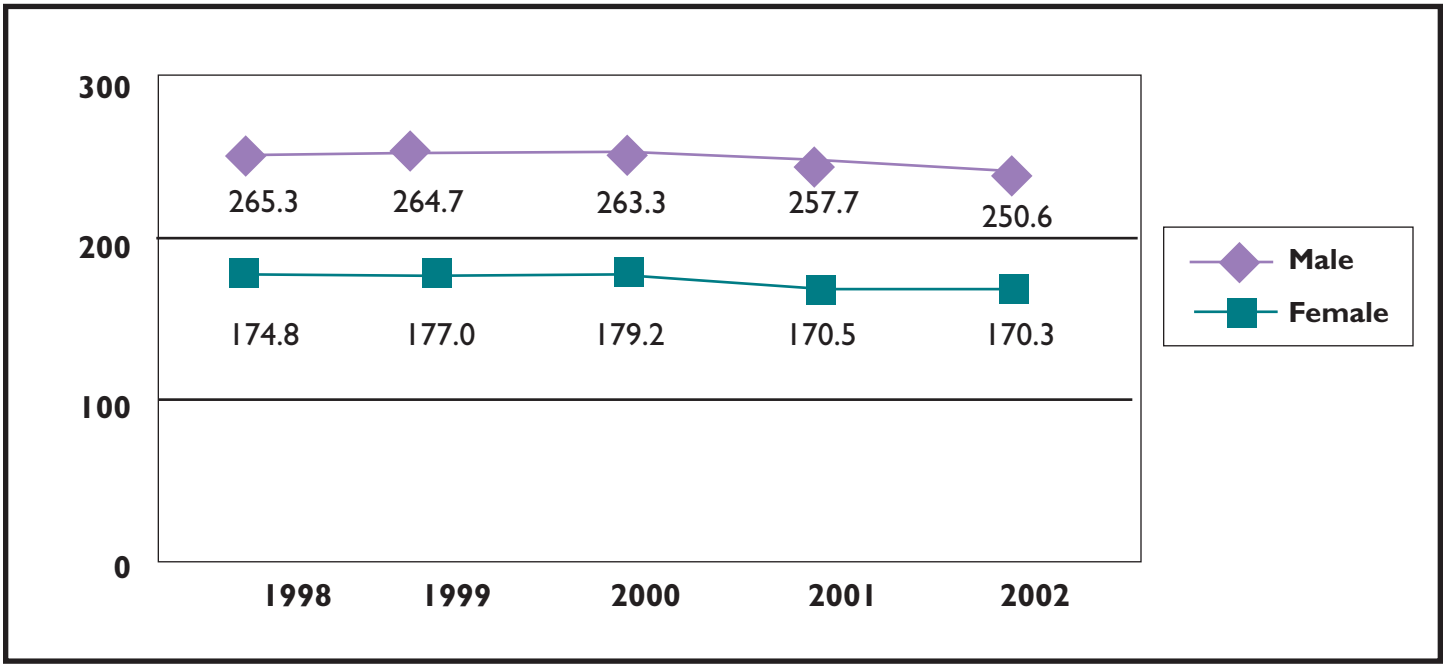
Illinois Department of Public Health, Illinois State Cancer Registry, June 2005

Table 1b: Top 10 Cancer Incidence Rates in Illinois (per 100,000) Females by Race, 2002

White	Incidence Rate	Black	Incidence Rate	Asian & Other	Incidence Rate	Hispanic	Incidence Rate
Breast	128.3	Breast	124.5	Breast	82.1	Breast	86.0
Lung and bronchus	56.8	Lung and bronchus	66.6	Colorectal	32.6	Colorectal	30.3
Colorectal	47.7	Colorectal	61.4	Lung and bronchus	27.7	Lung and bronchus	26.8
Corpus and uterus	26.5	Corpus and uterus	20.6	Corpus and uterus	15.7	Corpus and uterus	20.8
Non-Hodgkin's Lymphoma	16.3	Pancreas	15.5	Ovary	14.4	Cervix	15.3
Thyroid	14.1	Cervix	13.9	Stomach	12.0	Non-Hodgkin's Lymphoma	13.2
Ovary	13.8	Non-Hodgkin's Lymphoma	10.2	Thyroid	10.7	Stomach	10.6
Melanomas	11.3	Kidney and renal pelvis	9.9	Cervix	7.6	Thyroid	10.1
Kidney	10.4	Ovary	9.8	Non-Hodgkin's Lymphoma	7.3	Ovary	9.6
Bladder	10.0	Multiple Myeloma	9.5	Leukemias	6.4	Leukemias	9.1

Illinois Department of Public Health, Illinois State Cancer Registry, June 2005

Figure 4: Illinois Cancer Mortality Rates, (per 100,000) All Races, All Sites 1998 – 2002



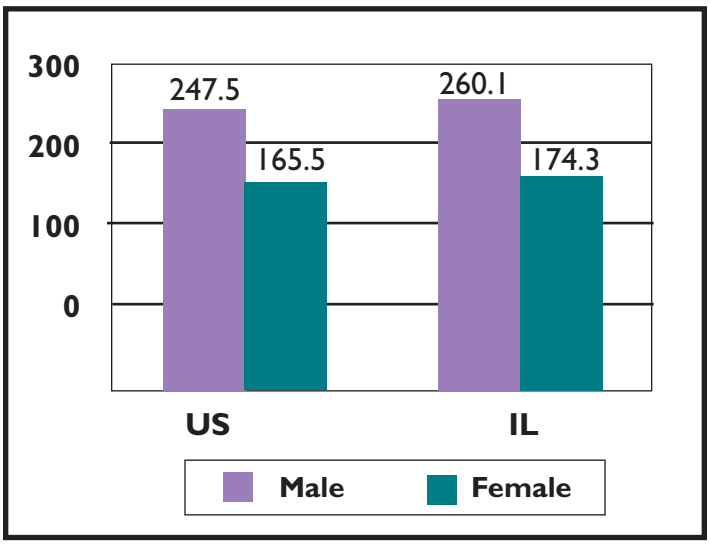
Mortality

Mortality refers to the total number of deaths in a given population. Data comparisons show the mortality rate of cancer for males is somewhat higher than females in Illinois. Figure 4 shows the comparison of age-adjusted mortality rates for males and females of all races in Illinois from 1998 to 2002.[iv]

In 2002, cancer caused 24,671 deaths in Illinois.[v] As with cancer incidence, the mortality rates vary significantly between males and females, and whites and blacks. The mortality rate of blacks is higher than of whites and men have a higher mortality rate than women. Overall, men have a mortality rate of 260.1 whereas women have a mortality rate of 174.3. Figure 5 shows the male and female cancer mortality rates for national rates compared to Illinois.

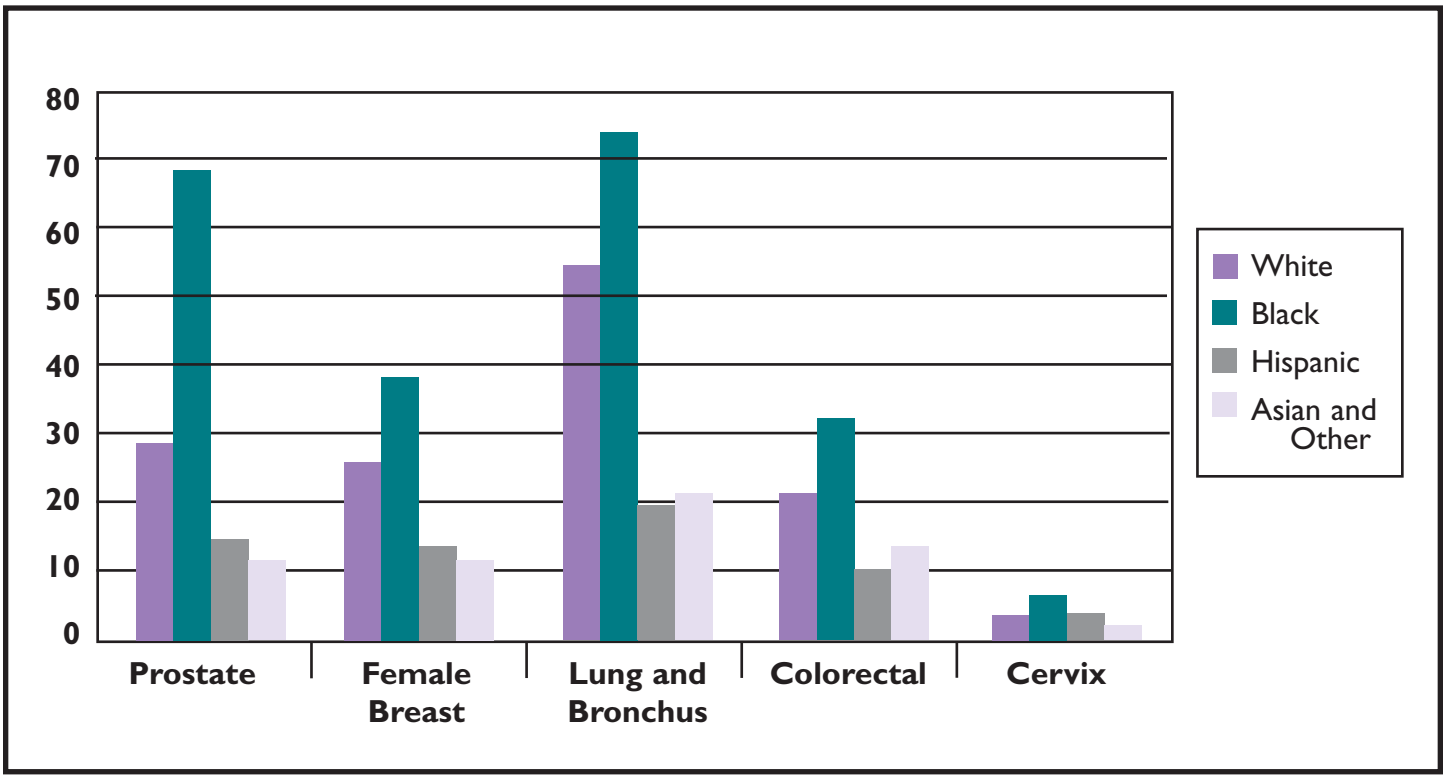
There is a noticeable difference in cancer mortality rates between black men and other races in Illinois and the United States. Black women are also dying more often than white women of cancer. Black men have the highest mortality rate, 359.5, while white women have the lowest

Figure 5: Illinois vs. United States Cancer Mortality Rates, (per 100,000) 1998 – 2002



(169.7). Cook County, with its diverse racial and ethnic population, also has a higher mortality rate (219.0) than the state average.[vi] Blacks also have the highest mortality rate of prostate, female breast, lung, colorectal and cervical cancer than any other racial or ethnic group. Figure 6 illustrates the mortality rate by race and ethnicity for selected cancer sites.

Figure 6: Mortality Rates by Race/Ethnicity, (per 100,000) All Sexes, 1998 – 2002[17]



The top 10 mortality rates for 2002 are presented in Table 2a for males and Table 2b for females.

Table 2a: Top 10 Cancer Mortality Rates in Illinois (per 100,000) Males by Race, 2002[17]

White	Mortality Rate	Black	Mortality Rate	Asian and Other	Mortality Rate	Hispanic	Mortality Rate
Lung and bronchus	74.2	Lung and bronchus	99.2	Lung and bronchus	26.9	Lung and bronchus	28.9
Colorectal	25.9	Prostate	66.0	Colorectal	15.3	Prostate	17.3
Prostate	25.6	Colorectal	35.0	Stomach	10.1	Colorectal	13.7
Pancreas	13.0	Pancreas	16.8	Liver	8.4	Stomach	9.2
Leukemias	11.6	Esophagus & Liver	10.3	Prostate	7.0	Liver	6.6
Non-Hodgkin's Lymphoma	10.1	Stomach	9.9	Pancreas	6.0	Pancreas	6.3
Esophagus	7.9	Multiple Myeloma	9.0	Leukemias	5.5	Leukemias	5.6
Bladder	7.8	Leukemias	8.7	Kidney	4.7	Non-Hodgkin's Lymphoma	5.5
Kidney and renal pelvis	6.4	Oral	6.3	Non-Hodgkin's Lymphoma	4.4	Multiple Myeloma	4.2
Stomach	5.9	Kidney	6.1	Multiple Myeloma	2.5	Esophagus	3.7

Illinois Department of Public Health, Illinois State Cancer Registry, June 2005

Table 2b: Top 10 Cancer Mortality Rates in Illinois (per 100,000) Females by Race, 2002

White	Mortality Rate	Black	Mortality Rate	Asian and Other	Mortality Rate	Hispanic	Mortality Rate
Lung and bronchus	41.9	Lung and bronchus	55.4	Lung and bronchus	20.0	Breast	16.6
Breast	25.5	Breast	39.3	Breast	10.8	Lung and bronchus	10.2
Colorectal	17.4	Colorectal	27.5	Colorectal	7.4	Colorectal	8.8
Ovary	9.4	Pancreas	15.5	Stomach	4.4	Ovary	6.9
Pancreas	9.3	Corpus and uterus	7.3	Corpus and uterus	4.0	Non-Hodgkin's Lymphoma	6.2
Non-Hodgkin's Lymphoma	6.5	Ovary	6.8	Ovary and Liver	3.8	Stomach	4.6
Leukemias	6.3	Stomach	6.6	Pancreas	3.3	Pancreas	4.4
Corpus and uterus	4.2	Cervix	6.4	Non-Hodgkin's Lymphoma	3.1	Leukemias	4.2
Brain	3.2	Leukemias	6.0	Cervix	2.1	Corpus and uterus	4.1
Kidney	2.9	Non-Hodgkin's Lymphoma	5.3	Leukemias	1.8	Cervix	2.6

Illinois Department of Public Health, Illinois State Cancer Registry, June 2005

Unequal Burden of Cancer

According to the National Institutes of Health (NIH), health disparities are the differences in incidence, prevalence, mortality and burden of disease and other adverse health conditions that exist among specific population groups in the United States. Disparities in cancer prevention and control are usually found among those who encounter barriers to optimal cancer care. These factors include, but are not limited to, race, ethnicity, age, sex, sexual orientation, culture, mental status, social class, economic class, education level, geographic location, religious beliefs, lack of health insurance and employment status.

There is an unbalanced level of health care for racial and ethnic minorities, medically underserved and the rural poor populations in Illinois. Many Illinois residents do not receive adequate screening, follow-up, treatment or accessible cancer care. Rates of cancer are higher in rural and poor counties in Illinois. Blacks bear a disproportionately high burden of cancer. The mortality rate for blacks is higher than any other racial or ethnic group for all cancers combined. In Illinois, the mortality rate for black males and females is higher than the national average for all malignant cancers.

According to the NIH, the overall cost of cancer for the nation in 2004 was $189.8 billion. Of the 60,000 people diagnosed with cancer in Illinois, more than 26,000 will die of the disease. The economic burden of cancer includes direct medical costs, lost productivity due to illness and lost productivity due to premature death. Other expenditures include the time and effort spent by patients, families and caregivers undergoing treatment and rehabilitation.

The societal burden of cancer can be partially measured in years of potential life lost between the time of death and 65 years of age. In the U.S., years of potential life lost due to cancer has been calculated to indicate the severity of the disease and its affect on society. In 2003, more than 75,000

years of potential life are lost to cancer each year in the United States.[viii] This number does not take into consideration life expectancy. Illinois must continue to work toward overcoming the disparities that exist with efforts specifically directed to the state's many diverse and low-income populations.

High Risk Populations

Risk factors for cancer are the internal and external factors that may increase an individual's chances of developing

cancer in his or her life time. Some high risk factors can be avoided, such as prolonged ultraviolet light exposure or smoking. Other risk factors, such as age, race and family history, are unalterable and may increase the risk of a cancer diagnosis.

Populations at high risk for certain types of cancer depend on the various risk factors such as identifiable disparities, obesity, lifestyle, environment, race or genetic makeup. Black men, for example, are more likely than white men to be diagnosed with prostate cancer. Cancer of the oral cavity and pharynx is the fourth most often diagnosed cancer among black men. Black men also have a lower 5-year survival rate from oral cancer than white males. Individuals who smoke tobacco products are in a high-risk category of developing lung cancer. The Asian and Pacific-Islander population is more likely to be diagnosed with liver, stomach and nasopharyngeal cancer than are whites. Hispanic women are twice as likely to be diagnosed with cervical cancer as white women. There are certain populations (Eastern European Jewish, Dutch and Icelandic) that can have mutations in predisposition genes (BRCA 1 and BRCA 2) that give them a higher chance of getting cancer than people from other ancestral backgrounds. Colon cancer occurs mostly in older age groups. Therefore, screening becomes especially important as individuals age.

Projections of Future Cancer Incidence and Deaths in Illinois

Projections for future cancer incidence and deaths are offered as a rough guide and should not be regarded as definitive. The figures estimate new cancer cases and deaths and were derived from the cancer mortality data from the Illinois Department of Public Health. The numbers in Figures 7 through 10 are rounded to the nearest 10 deaths and represent projected new cases and projected deaths for 2006.[viii]

Figure 7: Illinois Projected New Cancer Cases All Races, Men, 2006

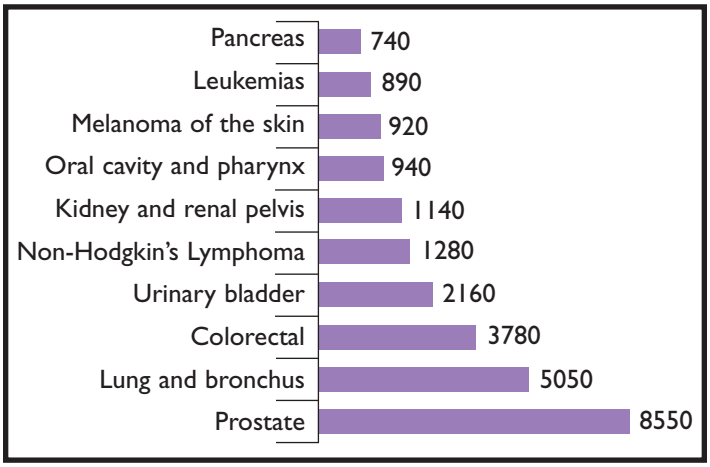


Figure 8: Illinois Projected Cancer Deaths All Races, Men, 2006

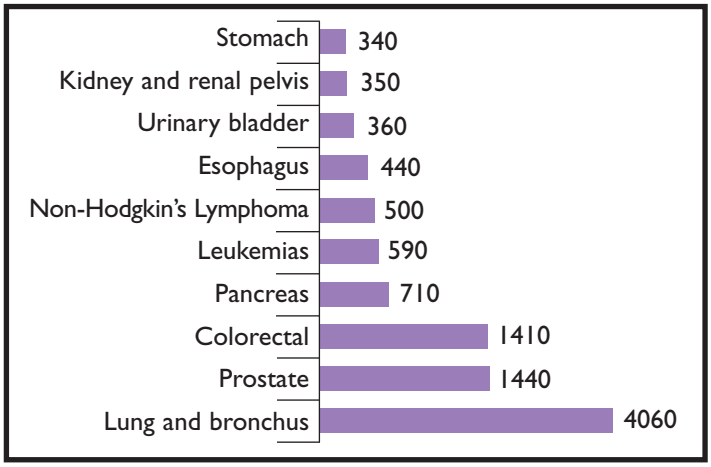


Figure 9: Illinois Projected New Cancer Cases All Races, Women, 2006

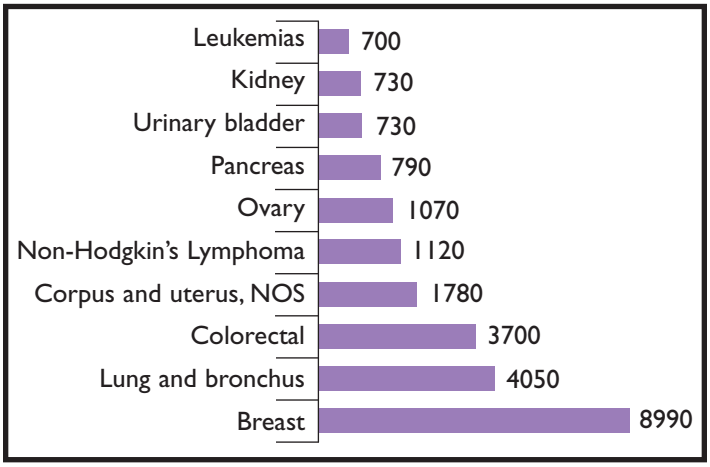
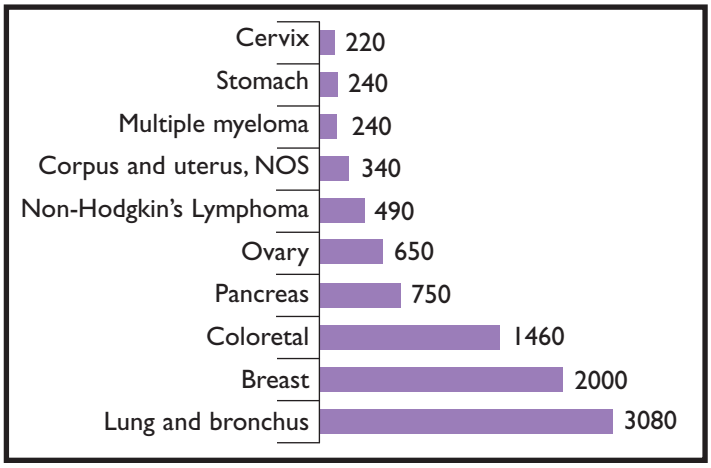


Figure 10: Illinois Projected Cancer Deaths All Races, Women, 2006



Illinois Priorities for Cancer:

A. Primary Prevention and Early Detection

GOAL: Primary Prevention

Reduce the risks for developing cancers among all populations.

Recommendations:

- Increase the proportion of public and private schools that require daily physical education for all students.
- Increase the proportion of people who consume at least five daily servings of fruits and vegetables.
- Reduce tobacco use and exposure to environmental tobacco smoke (ETS).
- Improve sun protective behavior in children through educational and policy approaches in primary schools.
- Increase the proportion of schools of medicine, schools of nursing and other health professional training schools whose basic curriculum for health care providers include the core competencies in public health and are linked to schools of public health.
- Increase the proportion of persons appropriately counseled about health behaviors.
- Increase the proportion of healthy weight in adults.
- Reduce the proportion of adults, adolescents and children who are overweight or obese.
- Increase the proportion of people who participate in moderate physical activity.
- Reduce the proportion of adults who engage in no leisure-time activity.
- Increase the use of social marketing prevention programs aimed at the hard-to-reach populations.
- Increase community resources supporting leisure time activity across the spectrum of age, socioeconomic status, physical ability and ethnicity.
- Incorporate information obtained from genetic risk assessments, environmental and lifestyle risk factors, and family health histories into cancer prevention and control efforts.

Strategies:

a. Advocate for policies that promote and increase physical activity and health food choices in schools.

b. Support evidence-based tobacco prevention and cessation programs targeted at youth as well as adults.

c. Raise school system awareness about their role in primary prevention and engage schools in primary prevention education efforts by making materials and resources available for teachers.

d. Encourage the development and implementation of model curricula for medical schools, nursing programs and other health profession schools.

e. Assess adequacy of cancer-related material in curricula of various professions' continuing education programs, particularly related to communicating and partnering with patients and families, survivorship issues, and supportive care.

f. Increase the opportunities for individuals to engage in daily, moderate physical activity.

g. Increase access to healthy food choices.

h. Educate the public about healthy eating practices.

i. Increase the number of worksite physical education activities.

j. Increase the number of health care systems that are engaged in comprehensive approaches for the treatment and management of overweight and obese populations.

k. Use social marketing techniques when designing primary prevention programs aimed at hard-to-reach populations.

l. Enhance community environments to support physical activity (e.g., sidewalks, bike paths, safety measures).

m. Conduct targeted, planned outreach activities to educate health care professionals, the media, the public and policymakers about genomics, including ethical, legal and social issues.

Objectives for Primary Prevention:

- By 2010, increase the proportion of Illinois residents, adults to 27 percent and high school students to 28 percent, which consume five or more servings of fruits and vegetables a day.

- By 2010, increase the proportion of Illinois residents, adults to 48 percent and high school students to 33 percent, which participate in moderate physical activity.

- By 2010, decrease the proportion of Illinois residents (adults to 56% and high school students to 4.5%) that are overweight.

GOAL: Early Detection

Increase the knowledge of the general public and healthcare providers regarding cancer early detection guidelines and the importance of screening.

Recommendations:

- Increase the proportion of women age 40 and over that receive an annual clinical breast exam.

- Increase the proportion of women age 40 and over that receive an annual mammogram.

- Increase the proportion of adults age 50 and older who have received colorectal cancer screening consistent with the American Cancer Society and U.S. Preventive Service Task Force guidelines.

- Increase the proportion of high-risk men over age 45 that receive rectal exams and prostate – specific antigen (PSA) testing within the past year (high risk defined as black men or men with one or more first degree relatives diagnosed with prostate cancer at an early age).

- Increase the proportion of women that receive a Pap test within the past year.

- Increase the proportion of people receiving a regular skin cancer screenings (every three years for people ages 20-40 and yearly after age 40).
- Increase the number of disparate populations receiving adequate screenings and follow-up.
- Develop new health care initiatives designed to reduce disparities among target populations.
- Monitor the availability of services that are culturally appropriate.
- Monitor the implementation of Public Act 93-0564, which concerns language assistance services in health facilities.
- Increase public awareness of the availability of genetic screening services.
- Monitor documented screening and early detection programs that are available to populations in need.

Strategies:

a. Adopt the U.S. Preventive Services Task Force (USPSTF) and the American Cancer Society (ACS) recommendations for early detection in asymptomatic people.

b. Educate health care providers about strategies to encourage patients about the importance of a yearly physical exam.

c. Develop and disseminate educational material on the importance of screening and early detection targeted toward limited-literacy, culturally diverse and non-English speaking populations.

d. Use the Illinois Breast and Cervical Cancer Program as a model for other cancers for which early detection mechanisms and treatment exists.

e. Increase access to colorectal cancer and prostate cancer screening for the uninsured.

f. Use the Illinois Colorectal Cancer Screening Act as a model for requiring insurance coverage for all cancer screening in asymptomatic people as outlined by the USPSTF and ACS.

g. Collaborate with work sites to promote cancer early detection, screening and treatment among their employees.

h. Implement patient and provider reminders and prompts to increase breast, cervical and colorectal cancer screening rates.

i. Ensure timely diagnostic screening for breast, cervical and colorectal cancer.

j. Educate the public about various health disparities by creating an easy-to-read report on cancer disparities to distribute throughout the state, including to key stakeholders and the public.

k. Engage genetic service providers to educate health care providers and health agencies about genomics.

Objectives for Early Detection:

- By 2010, increase the proportion of adults aged 50 and older to 22 percent for fecal occult blood testing (FOBT) and 41 percent for sigmoidoscopy or colonoscopy who have received these colorectal cancer screening consistent with American Cancer Society and U.S. Preventive Health Taskforce guidelines.
- By 2010, increase the proportion of colorectal cancer cases diagnosed at an early stage to 37 percent.
- By 2010, increase the proportion of women aged 40 and older who have received a mammogram within the past year to 65 percent.

- By 2010, increase the proportion of breast cancer cases diagnosed at an early stage to 73 percent.
- By 2010, increase the proportion of women aged 18 and older who have received a Pap test within the preceding three years to 91 percent.
- By 2010, increase the proportion of cervical cancer cases diagnosed at an early stage to 56 percent.

B. Rehabilitation and Supportive Care

GOAL: Rehabilitation and Supportive Care

Improve the quality of life for patients living with cancer, survivors and their families.

Recommendations:

- Increase the knowledge of patients and their families about rehabilitative and supportive cancer care.
- Increase the knowledge of health care professionals about rehabilitative and supportive cancer care.
- Increase the knowledge of health care professionals about the American Cancer Society patient navigation system as well as other similar programs.
- Increase the proportion of cancer patients who are offered information about advanced directives and options for end of life care.
- Increase the awareness and educational resources of supportive care and the importance of home-based supportive care through emotional, social and spiritual support for cancer patients, caregivers, families and health care professionals.
- Increase the use of nutrition screening and assessment before cancer treatment and throughout the treatment process.

Strategies:

a. Identify existing resources for rehabilitation and supportive care and make the information readily available to cancer patients and their families.

b. Identify support programs for people with cancer, their families, friends and caregivers in Illinois and make the information readily available.

c. Develop educational programs for patients, families and healthcare professionals about rehabilitative and supportive cancer care and promote the use of existing resources from the National Cancer Institute and American Cancer Society.

d. Increase access to psychosocial support services as part of the continuum of care, especially in rural areas.

e. Promote the Agency for Healthcare Research and Quality guidelines on pain management.

f. Provide pain management education for health care providers.

g. Promote the use of the American Cancer Society patient navigation system and other similar programs within hospitals, cancer clinics and other community-based organizations, as well as other similar programs.

h. Promote education for primary care and oncology providers about integration of advanced decision making and end-of-live options for care.

i. Promote and develop comprehensive palliative care resources (literature and Web-based) to cancer patients, caregivers, families and health care professionals at physician offices and cancer clinics.

j. Promote health care professionals use of nutrition screening and assessment before cancer treatment and throughout the treatment process.

Rehabilitation and Supportive Care Objectives:

- By 2007, establish a baseline of the number of calls made to cancer information resources in Illinois, such as the National Cancer Institute, Cancer Information Service, Y-ME, Susan G. Komen Breast Cancer Foundation, Us TOO, American Cancer Society and others.
- By 2010, increase the baseline of the number of calls made to cancer information resources in Illinois by 25 percent.

C. Access to Care

GOAL: Access to Care

Increase access to cancer resources and services, especially among diverse populations.

Recommendations:

- Reduce the number of uninsured.
- Increase access to treatment and completion of treatment and supportive services for low-income, uninsured and undocumented immigrants.
- Increase access to the American Cancer Society Patient Navigation System and similar programs.
- Increase access to transportation services for care.
- Increase access to information on race/cultural diversity and improve sensitivity, knowledge, attitudes and ability of health care providers to treat a culturally diverse clientele.
- Increase the capacity, utilization and infrastructure of the Illinois Breast and Cervical Cancer Program (IBCCP) and Stand Against Cancer (SAC) to ensure effective screening and diagnostic services for the underserved.
- Increase the health care system capacity for breast, cervical and colorectal cancer screening.
- Increase access to and understanding of colorectal cancer screening for underserved populations.
- Increase number of American College of Surgeons – Commission on Cancer approved facilities.
- Increase access to physicians who treat cancer in all counties.
- Increase access to genetic counselors.

Strategies:

a. Increase the publicity of available free or low cost cancer information services, such as those operated by American Cancer Society, National Cancer Institute and Illinois Department of Public Health.

b. Increase access to the ACS Patient Navigator System, as well as similar programs.

c. Implement the use of mobile vans to provide screening services to decrease geographical and financial barriers.

d. Increase the use of telehealth services, especially in rural areas. Telehealth is defined as the use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health and health administration.

e. Enhance non-traditional sources of transportation to provide transportation in rural areas.

f. Implement computerized and manual prompts/chart reminders for providers.

g. Increase ethnic-specific health care settings such as a neighborhood outreach clinic to bring services to cultural groups.

h. Advocate for increased federal (U.S. Centers for Disease Control and Prevention) funding and state funding and appropriation for IBCCP.

i. Advocate for screening programs to cover treatment.

j. Expand the capacity of the health care system by increasing the number of radiologists that read mammograms and increase the number of colorectal cancer screening facilities.

k. Examine barriers, such as malpractice insurance.

l. Educate health care providers and consumers about their rights to adjust health care costs based on need.

m. Educate all health care providers about the services available through IBCCP and SAC, while monitoring and annually evaluating the effectiveness of the programs.

n. Reduce structural barriers to screening, such as the location of a clinic, hours of operation and availability of child care and transportation.

o. Expand targeted messaging that has been proven successful in diverse communities.

p. Encourage hospitals, treatment centers and other cancer facilities to improve their quality of patient care in order to be considered an American College of Surgeons – Commission on Cancer approved facility.

q. Increase the number of bilingual/bicultural health care providers.

Access to Care Objectives:

- By 2010, reduce the proportion of uninsured individuals between the ages of 0-64 in Illinois to 12 percent.
- By 2010, establish a colorectal and prostate cancer act that models the Illinois Breast and Cervical Cancer Program to provide early detection and treatment for the underserved.
- By 2010, conduct statewide capacity studies to assess the breast and colorectal cancer screening capacity throughout the state.

D. Policy and Tobacco Control

GOAL: Policy and Tobacco Control

Reduce tobacco use through evidence-based interventions.

Recommendations:

- Eliminate second-hand smoke from all workplaces statewide, including bars and restaurants.
- Increase state cigarette and tobacco excise taxes.
- Increase the capacity and funding to implement a comprehensive tobacco control program as recommended by the U.S. Centers for Disease Control and Prevention.
- Increase the unit price of tobacco products.
- Increase the awareness and utilization of the Illinois Tobacco Quitline (1-866-QUIT-YES).

Strategies:

a. Expand and promote the use of evidence-based programs that develop youth tobacco resistance skills in schools and community youth programs.

b. Increase the "adult-to-youth" tobacco prevention education programs where adults become leaders/role models.

c. Pass smoke-free local ordinances for bars and restaurants.

d. Educate Illinois legislators on the toll of tobacco in Illinois and smoking prevention strategies and the efficacy of multi-component cessation strategies.

e. Partner with members of the Illinois General Assembly to introduce a cigarette and tobacco excise tax increase.

f. Conduct ongoing, statewide media campaigns promoting tobacco prevention and control that respects the diversity of all populations in the state.

g. Engage health care providers in providing tobacco cessation education, proactive phone counseling and individual counseling consistent with the best practices identified by the U.S. Public Health Service guidelines.

h. Advocate for public and private insurance programs to pay for ambulatory and hospital-based smoking cessation interventions, to include both nicotine-replacement therapy and cessation counseling.

i. Educate providers and the public about the Illinois Tobacco Quitline (1-866-QUIT-YES).

Policy and Tobacco Control Objectives:

- By 2010, decrease the proportion of Illinois residents, adults to 21 percent and young people to 20 percent, who smoke cigarettes.
- By 2010, increase the number of calls made to the Illinois Tobacco Quitline by 25 percent.

E. Research and Clinical Trials

GOAL: Research and Clinical Trials

Improve the awareness and participation in cancer research, especially among diverse populations.

Recommendations:

- Increase awareness and knowledge about cancer prevention and treatment clinical trials.
- Increase minority enrollment in clinical trials.

- Increase the number of health care professionals discussing clinical trials with patients.
- Increase communication within hospitals about clinical trials.
- Increase health care provider awareness of the importance of clinical trials enrollment and participation during the early stages of treatment.
- Expand availability of cancer clinical trials.
- Increase referrals of childhood cancer patients to pediatric cancer centers and clinical trials.

Strategies:

a. Incorporate clinical trial information into health care professional training programs.

b. Identify specific barriers for minority participation in clinical trials.

c. Raise patient and provider awareness and promote use of existing clinical trial information resources (e.g., ACS and NCI's CIS).

d. Educate health care providers on techniques for clinical trial recruitment for diverse populations.

e. Raise patient and health care provider awareness of Illinois Cancer Patient Protection Act.

f. Incorporate clinical trial information into community-based education programs.

g. Discuss potential benefits, as well as risks, to participation in clinical trials.

h. Develop information regarding clinical trial enrollment in multiple languages and an easy-to-read format.

i. Develop and/or expand transportation and lodging programs (e.g., American Cancer Society's Road to Recovery and Guest Room Lodging programs) to increase access to clinical trials.

j. Identify specific barriers for minority participation in clinical trials.

k. Identify health care provider's perceived barriers regarding patient participation in clinical trials.

l. Advocate for expanding funding for clinical trials in Illinois.

m. Promote education of health care professionals about pediatric cancer research to advance the search for effective treatment modalities.

Research and Clinical Trials Objectives:

- By 2007, determine a baseline for the number of requests for information on clinical trials received by research organizations, such as the National Cancer Institute's Cancer Information Service and the American Cancer Society.
- By 2010, increase the baseline of the number of requests for information on clinical trials received by research organizations by 25 percent.
- By 2010, increase the number of enrollees in cancer clinical trials in Illinois by 25 percent.
- By 2010, increase the number of diverse enrollees in cancer clinical trials in Illinois by 25 percent.

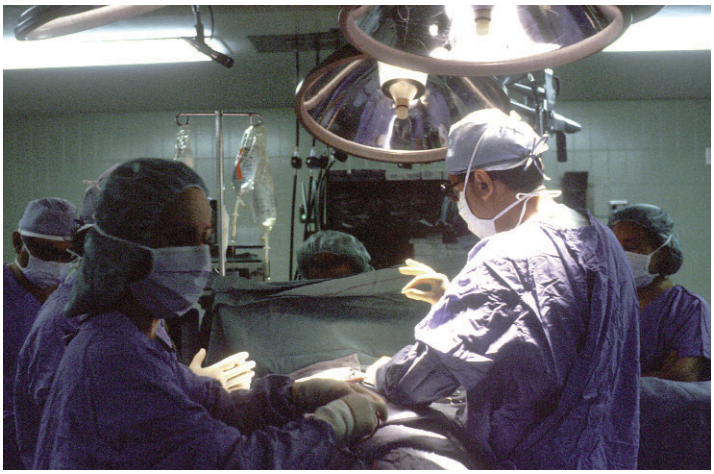
F. Data and Surveillance

GOAL: Data and Surveillance

Improve and maintain a high quality surveillance system for cancer and improve the utilization of cancer data reported to the Illinois State Cancer Registry (ISCR).

Recommendations:

- Maintain at least 95 percent completeness of reporting to ensure continued NAACCR gold standard certification for the Illinois State Cancer Registry.
- Review the quality of treatment data collected by ISCR to provide baseline data for evaluating the impact of cancer prevention and control initiatives and determines patterns of care.
- Establish a rapid case ascertainment program to increase the Illinois Department of Public Health's ability to support epidemiological and quality of life research studies.
- Continue to use case history, data exchange and other activities to maintain at least 95 percent completeness of case ascertainment.
- Utilize updated quality control measures to report < 2 percent missing/unknown of the following: age at diagnosis, sex, race, state and county.
- Maintain an effective death certificate clearance program to obtain < 3 percent death certificate only cases.
- Report < 1 per 1000 duplicate primary cases.
- Report all data within 24 months of the close of the accession year.
- Develop the infrastructure for a comprehensive database on cancer survivorship.
- Increase the proportion of geocoding efforts for cancer data for supporting cancer control and prevention.
- Enhance completeness of race/ethnicity data collection and coding.
- Increase the number of cancer epidemiologists working for ISCR.
- Maintain and enhance educational opportunities for new and established registrars and cancer reporters.
- Continue to inform stakeholders about the cancer burden through the dissemination of a comprehensive Annual Report on the Status of Cancer in Illinois.
- Strengthen data collection within physician offices.



- Enhance cancer surveillance and registries to include genomic information, which can be used in cancer prevention efforts.

Strategies:

a. Continue to emphasize complete reporting of cancer cases by hospital and non-hospital reporting sources.

b. Hire staff to review ISCR treatment data for completeness.

c. Compare treatment data obtained to the recommended treatments defined in the National Cancer Institute Physician Data Query.

d. Increase the number of the proportion of cases reported electronically to reduce reporting time. There are 491 reporting facilities in Illinois. Ninety-six percent of cases are reported electronically and 135 facilities report on paper forms.

e. Identify a standard data set used for the collection and analysis of cancer survivorship data.

f. Increase the number and types of funding opportunities to enable researchers to participate in survivorship surveillance activities.

g. Develop a centralized clearinghouse that includes linkages to all existing data sources, which provides for longitudinal data collection, monitoring and follow-up.

h. Initiate training to hospitals and pathology labs on ensuring correct race/ethnicity and address/ZIP code collection at time of intake and diagnosis.

i. Continue regular linkages with the Illinois Department of Public Health and the Department's Division of Vital Records to enhance the completeness of gender, place of birth, race, maiden name and ethnicity origin variables.

j. Examine national staffing and structure of cancer registries.

k. Increase and sustain funding for ISCR.

l. Target basic training needs for registrars in American College of Surgeons approved hospital cancer registry programs.

m. Offer training assistance for registrars preparing for the Certified Tumor Registrar examination.

n. Enforce reporting by physicians to collect and report cancer diagnosis into the cancer registry, with an emphasis on prostate and melanomas.

o. Evaluate program effectiveness for various categorical cancer control programs.

Data and Surveillance Objectives:

- By 2010, continue to maintain at least 95 percent completeness of reporting to ensure continued NAACCR gold standard certification for the Illinois State Cancer Registry.
- By 2010, increase by 25 percent the accuracy of race reporting by cancer registries.
- By 2010, collect payor source for at least 80 percent of cancer patients.

Implementation:

GOAL: Implementation

Implement the strategies in the Illinois Comprehensive Cancer Control State Plan.

Recommendations:

- Begin implementation of selected activities within three months of state plan ratification.
- Identify work groups to lead priority areas, goals, recommendations and strategies.
- Identify strategies to be implemented first.
- Develop written inter-organizational linkages.

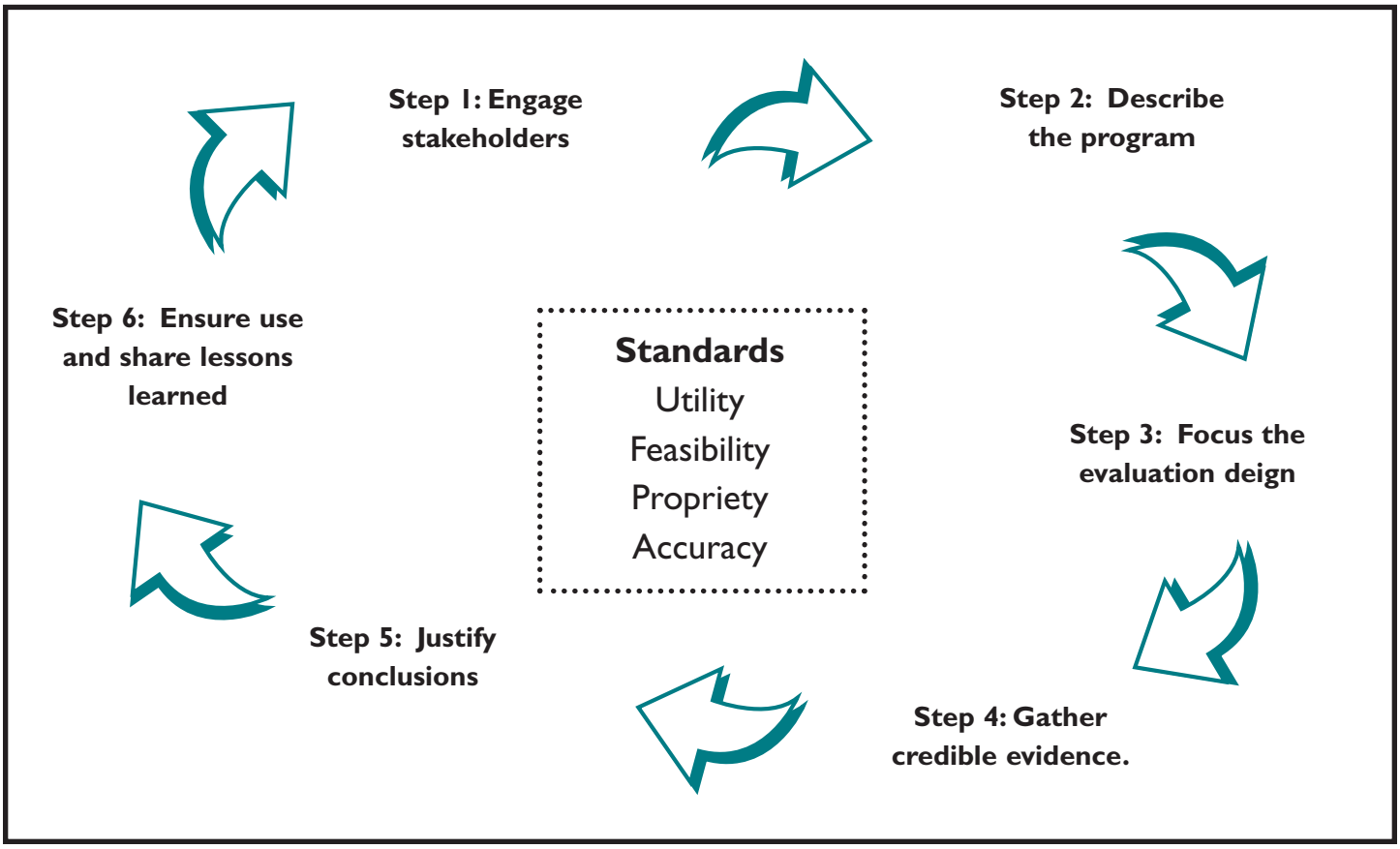
- Develop an evaluation mechanism.
- Identify, coordinate and secure funding opportunities.
- Expand partnerships and collaborations.
- Continuously review progress by tracking activities and measuring results.
- Convene an annual summit to review progress and set new goals.

Evaluation:

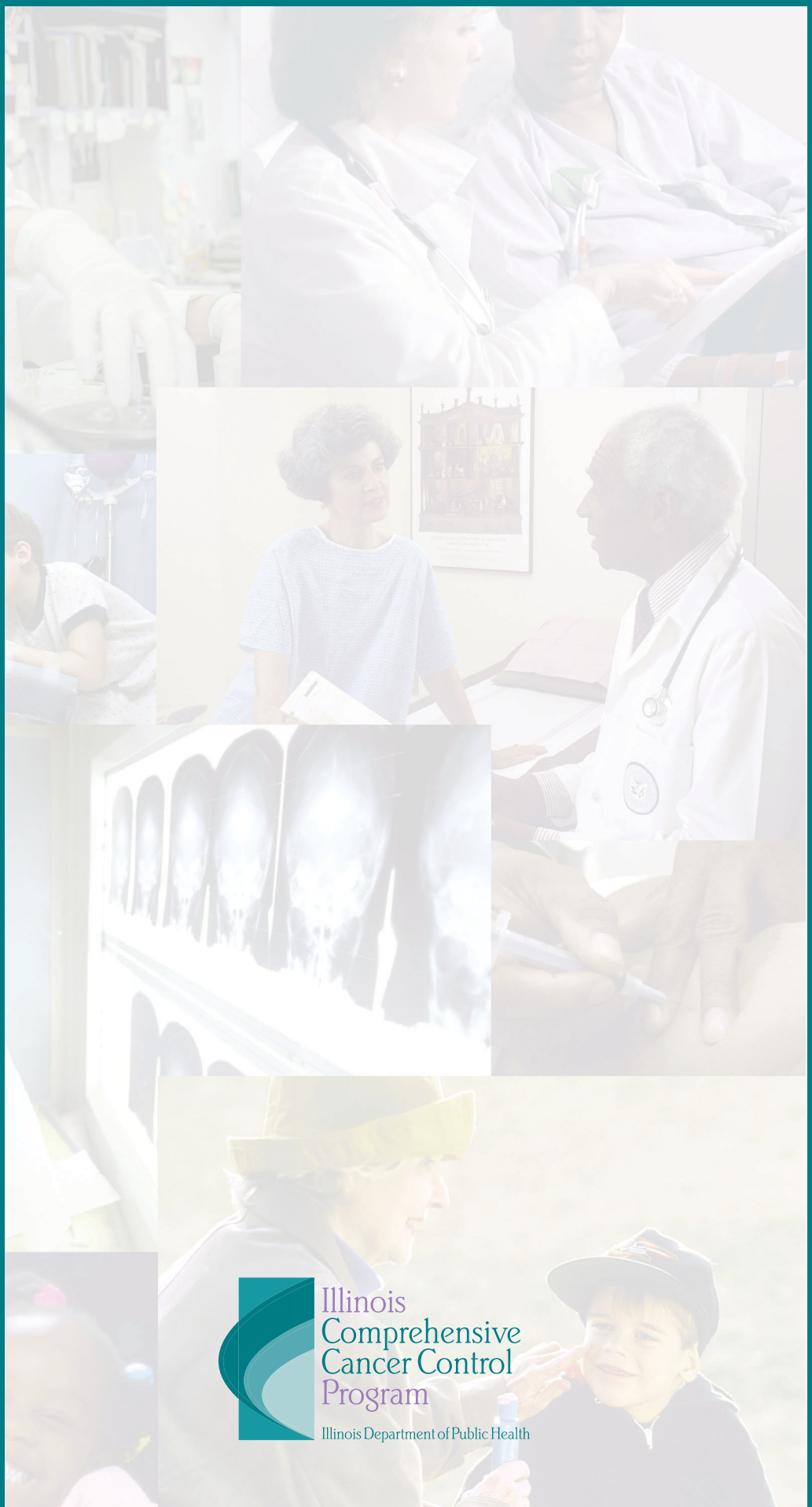
GOAL: Evaluation

Evaluate the success and of the goals and objectives of the Illinois Comprehensive Cancer Control State Plan.

Recommended Framework for Program Evaluation:



[i] Illinois State Cancer Registry, Five-year counts; age-adjusted rates (US 2000 Std) with 95% CI per 100,000.
[ii] Illinois Department of Public Health, Illinois Cancer Registry Public Dataset November 2003.
[iii] Illinois Cancer Statistics Review 1986-2002, June 2005
[iv] Illinois State Cancer Registry, Five-year counts; age-adjusted rates (US 2000 std) with 95% CI per 100,000.
[vi] Leading Causes of Death, Illinois 2002: *www.idph.state.il.us/health/bdmd/leadingdeaths02.htm*
Illinois Cancer Facts and Figures, 2004
[vii] Illinois Project for Local Health Assessment of Needs Data System Report, ICD-10
[viii] Illinois Cancer Statistic Review 1986-2000



Illinois
Comprehensive
Cancer Control
Program

Illinois Department of Public Health