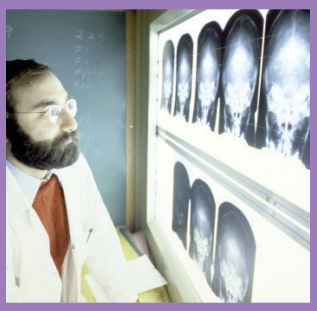
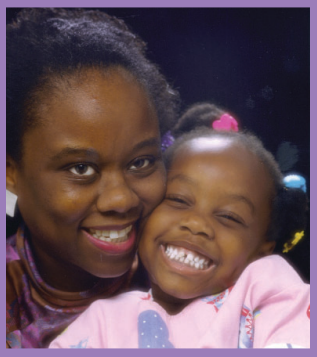
State of Illinois
Rod R. Blagojevich, Governor

Department of Public Health
Eric E. Whitaker, M.D., M.P.H., Director





Illinois Comprehensive Cancer Control 2005-2010

STATE PLAN

Illinois Comprehensive Cancer Control Program

Illinois Department of Public Health

For more information or for additional copies of this plan please contact:

Illinois Department of Public Health
Office of Health Promotion
535 W. Jefferson St., 2nd Floor
Springfield, IL 62761

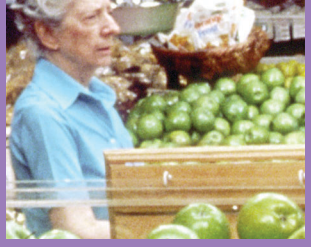
Phone: 217-782-3300
800-547-0466 (hearing impaired use only)
Fax: 217-782-1235
www.idph.state.il.us

This cancer plan was printed with funds from Cooperative Agreement #U55/CCU521913-04 from the U.S. Centers for Disease Control and Prevention (CDC).

Table of Contents

Acronym List

ACS	American Cancer Society
ACoS	American College of Surgeons
AHRQ	Agency for Healthcare Research and Quality
ALA	American Lung Association
BRFSS	Behavioral Risk Factor Surveillance System
CATCH	Coordinated Approach to Child Health
CBE	Clinical Breast Exam
CCC	Comprehensive Cancer Control
CDC	U.S. Centers for Disease Control and Prevention
CIS	Cancer Information Service
CTEP	Cancer Therapy Evaluation Program
CoC	Commission on Cancer
CTR	Certified Tumor Registrar
DRE	Digital rectal exam
ETS	Environmental Tobacco Smoke
FOBT	Fecal occult blood test
HFS	Illinois Department of Healthcare and Family Services
HPV	Human Papillomavirus
IBCCP	Illinois Breast and Cervical Cancer Program
ICCCP	Illinois Comprehensive Cancer Control Program
HFS	Illinois Department of Healthcare and Family Services
IDPH	Illinois Department of Public Health
IPCPC	Illinois Partnership for Cancer Prevention and Control
ISCR	Illinois State Cancer Registry
ITFC	Illinois Tobacco Free Communities
IYTS	Illinois Youth Tobacco Survey
MSA	Master Settlement Agreement
MUA	Medically-underserved areas
MUP	Medically-underserved populations
NAACCR	North American Association of Central Cancer Registries
NCI	National Cancer Institute
PDQ	Physician Data Query
PSA	Prostate-specific antigen
SAC	Stand Against Cancer
SEER	Surveillance, Epidemiology and End Results
SPF	Sun protection factor
USPSTF	United States Preventive Services Task Force
UV	Ultraviolet
YPLL	Years of potential life lost
YRBSS	Youth Risk Behavior Surveillance System







I. Preface

I. Preface

According to the U.S. Centers for Disease Control and Prevention (CDC), Comprehensive Cancer Control 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. Comprehensive Cancer Control is achieved through a broad partnership of public- and private-sector stakeholders whose common mission is to reduce the overall burden of cancer.

Comprehensive Cancer Control is based on the following principles[1]:

- Scientific data and research are systematically used to identify priorities and direct decision making.
- The full scope of cancer care is addressed, including primary prevention, 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.
- 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.

The Illinois Comprehensive Cancer Control State Plan, hereafter referred to as the state plan, provides a framework for action to reduce the burden of cancer in Illinois. Its purpose is to provide an organized approach to cancer prevention and control efforts that are needed in Illinois. The state plan is intended for use by people and organizations, in all areas of cancer prevention and control. The goals are broad and directed at all populations in Illinois. Based on these goals and priorities the state plan presents recommendations and examples of strategies in support of a statewide public health approach for cancer prevention and control.

In order for the goals outlined in the state plan to be achieved, the strategies must be implemented. The state plan will serve to mobilize individuals, organizations, institutions and communities committed to fighting cancer. These groups can use the state plan to select strategies for implementation consistent with their own missions. Effective implementation of these diverse strategies will require an ongoing, coordinated and collaborative effort (See Appendix A for a list of evidence-based interventions). All partners must embrace the state plan to make a true impact on cancer prevention and control in Illinois.

Priorities to Address Comprehensive Cancer Control in Illinois

A. Primary Prevention and Early Detection — Reduce the risks for developing cancer among all populations and increase the knowledge of the general public and health care providers regarding early detection guidelines and the importance of screening.

B. Rehabilitation and Supportive Care — Improve the quality of life for patients with cancer, survivors and their families.

C. Access to Care — Increase the access to cancer services and resources, especially among diverse populations.

D. Policy and Tobacco Control — Reduce tobacco use through evidence-based interventions.

E. Research and Clinical Trials — Improve the awareness of and participation in cancer research, especially among diverse populations

F. Data and Surveillance — Improve and maintain a high quality surveillance system on all aspects of cancer and improve the utilization of cancer data reported to the Illinois State Cancer Registry.

Steering Committee

A steering committee of experts in many areas of cancer prevention and control guided the creation of the State Plan by identifying goals and priorities to address cancer prevention and control in Illinois.

Richard Anderson, MD — American College of Surgeons/OSF St. Francis Medical Center

Funmi Apantaku-Onayemi — National Black Leadership Initiative on Cancer

Steve Derks — American Cancer Society, Illinois Division, Inc.

Evelyn Diaz, MD — Adult Wellness Center

Carol Ferrans, PhD, RN, FAAN — University of Illinois at Chicago - School of Public Health

Quin Golden, MBA — Illinois Department of Public Health

William Hartsell, MD — Advocate Good Samaritan Hospital

Claude-Alix Jacob, MPH — Illinois Department of Public Health

Daniel Kacey, MD — American College of Surgeons

Karen Kim, MD — University of Chicago - Asian Cancer Prevention Organization

Michelle LeBeau, PhD — University of Chicago Hospitals Medical Center

Cheryl Lee, MS — SimmonsCooper Cancer Institute at Southern Illinois University School of Medicine

Marcy List, PhD — University of Chicago - Cancer Research Center

Patricia Merryweather — Illinois Hospital Association

Chandana Nandi, MS, RD, LDN — Illinois Department of Public Health

Javette Orgain, MD — Cook County Physicians Association

Ramona Rodriguez, MD — Logan Square Health Center

Tiefu Shen, MD, PhD — Illinois Department of Public Health

Erica Vassilos, MPH — National Cancer Institute's Cancer Information Service

Tim Volpe — Robert H. Lurie Comprehensive Cancer Center, Northwestern University

Richard Warnecke, PhD — University of Illinois at Chicago - Cancer Center

Gwendolyn West — National Cancer Institute's Cancer Information Service

Eric E. Whitaker, MD, MPH — Illinois Department of Public Health

Adrienne White — American Cancer Society, Illinois Division, Inc.

Illinois Partnership for Cancer Prevention and Control

More than 100 individuals representing more than 60 organizations participated in the creation of the state plan. The Illinois Partnership for Cancer Prevention and Control is made up of a broad representation of organizations working together to reduce the burden of cancer in Illinois.

Jeffrey Altman, MD
Illinois Dermatological Society

Lissa Anderson
Cancer Wellness Center

Yasmeen Z. Ansari, MPH
American Cancer Society, Illinois Division, Inc.

Jamie Appelwick
Cass County Health Department

Steven Ayre, MD
Contemporary Medicine

Pamela W. Balmer, MPA
Illinois Department of Public Health - [Illinois Breast and Cervical Cancer Program]

Ermilo Barrera, Jr., MD
American Cancer Society, Illinois Division, Inc.

Maxine Barth
Bond County Health Department

Al Benson, MD
Illinois Medical Oncology Service

Stephanie Bess, MS, RD, LD, CLC
Illinois Department of Human Services - [Bureau of Family Nutrition]

Kathleen Boss
Gilda's Club Chicago

Steve Bradley
Illinois Department of Public Aid

Lori C. Brannan, MA
Illinois Department of Public Health - [Comprehensive Cancer Control Program]

Gene Brodland, LCSW
Bohlen and Associates

Patricia Canessa
Salud Latinas/Latinos Health

Therese Carpizo, RN, MSN, AOCN
Provena St. Joseph Hospital

Diane Carr-Lynn
Ingalls Memorial Hospital

Christine Carver, RN, MSN
Illinois Department of Public Health - [Illinois Breast and Cervical Cancer Program]

Yvonne Collins, MD
University of Illinois at Chicago

Doug Corbett
Perry County Health Department

Angela Daniello
Robert H. Lurie Comprehensive Cancer Center - [Northwestern University]

Joan Davis, RDH, MS
Southern Illinois University at Carbondale

Yolanda Davis, MPH
University of Chicago - [Cancer Research Center]

Myrtle DeLoach
University of Illinois Extension

Abby Drevs
Y-ME Illinois

Barbara Dunn
Community Health Improvement Center

Dawn Elliott
University of Chicago - [Cancer Risk Clinic]

Margaret Farina
American Cancer Society, Illinois Division, Inc.

Ginnie Flynn
Illinois Academy of Family Physicians

Wanda Foster
McDonough District Hospital

Amy E. Gaier
National Cancer Institute's Cancer Information Service

Sofia Garcia, PhD
Evanston Northwestern Healthcare

David Goldberg, MD
John H. Stroger Jr. Hospital of Cook County

Melanie Goldish
SuperSibs!

Gina Graci, PhD
Robert H. Lurie Comprehensive Cancer Center - [Northwestern University]

John Greager, MD
John H. Stroger Jr. Hospital of Cook County

Logan Grimes
Lesbian Community Cancer Project

Stephanie Gutz, MSW, LCSW, OSW-C
Robert H. Lurie Comprehensive Cancer Center - [Northwestern University]

Ernestine Hambrick, MD, FASCRS, FACS, FACG
STOP Colon/Rectal Cancer Foundation

Margie Harris, RN, MPH, CHES
Logan County Health Department

Arthur Hoffman, MD, MPH
Rush University Medical Center

Alicia Huguelet
Y-ME Illinois

LauraJane Hyde
Gilda's Club Chicago

Stacy Ignoffo, MSW
American Lung Association of Metro Chicago

Holly Jensen
National Ovarian Cancer Coalition, Illinois Division

Diane Johner, RN, MSN
Macon County Health Department

Robin Koehl
Franklin Williamson Bi-County Health Department

Lewis N. Lampiris, DDS, MPH
Illinois Department of Public Health - [Division of Oral Health]

Jonathon Lavin
Illinois Coalition on Aging

Charles LeHew, PhD
University of Illinois at Chicago - [Institute for Health Research and Policy]

Karen Litwack, LCSW, ACSW
Chicago Center for Jewish Genetic Disorders

Hong Liu, PhD
Asian Health Coalition of Illinois

Kelly Long
American Cancer Society, West Central Region

Kathleen Lutz, RDH
Illinois Department of Public Health - [Division of Oral Health]

Lisa Mann
American Cancer Society, Southern Region

Linda Maricle
Susan G. Komen Breast Cancer Foundation - [Peoria Memorial Affiliate]

James L. McGee, MD, SM
OSF Healthcare System

Lil Mejia
Michael Reese Hospital

Gail Mitchell
Gilda's Club Chicago

Claudia Nash
Illinois Department of Public Health - [Newborn Screening Program]

Rick Nelson, MD
University of Illinois at Chicago/American Society of Colon and Rectal Surgeons

Kristen N. Nolen, CHES
Illinois Department of Public Health - [Tobacco-Free Communities]

Luna Okada, MS
Illinois Department of Public Health - [Genomics Program]

Funmi Olopade, MD
University of Chicago - [Center for Clinical Cancer Genetics]

Tracey Printen
Illinois State Medical Society

Garth Rauscher
University of Illinois at Chicago - [School of Public Health]

Arthur Rhodes, MD
Rush Department of Dermatology

Sandi Ring
SuperSibs!

Marjorie Rosenbaum, MD
Marjorie Mintz Rosenbaum, MD, LLC

Jene Ruppert
Macoupin County Public Health Department

Michael F. Scheer, MD
Furman and Scheer Surgical Associates

Mary Ellen Simpson, PhD
University of Illinois College of Medicine at Peoria

Susan Slivka
Provena St. Joseph Hospital

Patricia Smith
American Cancer Society

Jan Snodgrass, CTR
Illinois Department of Public Health - [Illinois State Cancer Registry]

Terry A. Solomon
Illinois African - American Family Commission

Arvind Soni, MD
Elmhurst Memorial Hospital

Mark J. Steinberg, DDS, MD
Illinois Society of Oral and Maxillofacial Surgeons

Bruce Steiner
Illinois Department of Public Health - [Center for Health Statistics]

Steven J. Stryker, MD
Northwestern Colorectal Institute

Lizbeth Swords
Decatur Memorial Hospital

Doris Turner
Illinois Department of Public Health - [Center for Minority Health Services]

Susan Tybon
Leukemia and Lymphoma Society, Illinois Chapter

Nancy Valentinsen
Community Hospital of Ottawa

Garry Veicht
SimmonsCooper Cancer Institute at Southern Illinois University School of Medicine

Anne Walker, MSW, LCSW
Wellness Place

Lynne Welling
Jersey County Health Department

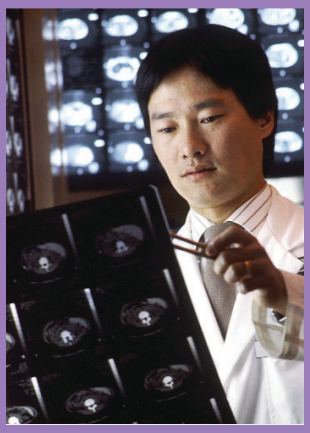
Diana Weyhenmeyer, RN, MA, OCN
St. John's Hospital Cancer Institute

Ron Willard
Pfizer Oncology

Bob Zettler, MBA
Illinois Department of Public Health - [Prostate and Testicular Cancer Program]

Jing Zhang, PhD
Asian Human Services

Katie M. Zinn, MPH
Illinois Department of Public Health - [Comprehensive Cancer Control Program]



II. Introduction

II. Introduction

Cancer is the second leading cause of death in Illinois and the United States. Every year, Illinois lives are lost to cancers that could be prevented. Priorities identified for cancer control in Illinois are: 1) awareness and education of primary prevention and early detection, 2) rehabilitation and supportive care, 3) increased access to care, 4) reducing the use of tobacco products, 5) enhancing participation in research and clinical trials and 6) improving data and surveillance of diverse populations all while paying close attention to the various health disparities that exist in all areas of the state.

Cancer is a common disease. According to the U.S. Centers for Disease Control and Prevention (CDC), one in four deaths in the United States is attributable to cancer. Cancer is the leading cause of death for Illinois citizens aged 45 to 64. Many types of cancer can be prevented, and the prospects for surviving cancer are better than ever before. One-third of the cancer deaths in Illinois can be prevented by increasing physical activity, improving nutrition, reducing tobacco use and reducing overweight and obesity. Early detection and improved treatments are allowing more people who have been diagnosed with cancer to live longer. By adopting a healthier lifestyle and visiting a physician regularly for a cancer-related checkup, many people can reduce their chances of developing or dying from cancer. (See Appendix B for Illinois legislation related to cancer).

A. Illinois Background

1. Demographics

Illinois covers 56,400 square miles in the Midwest and is more than 385 miles long and 218 miles wide. Bordering Illinois are six states and Lake Michigan. Nearly 80 percent of this area is farmland, covering more than 45,000 square miles or 28 million square acres.[2]

Illinois is the fifth most populous state in the United States with a 2004 population estimate of just over 12.7 million residents.[3] Illinois has 102 counties, with Cook County having the largest population of 5,376,741.

Chicago is the most populated city in Cook County, as well as in the state of Illinois. It is located in the northeast part of the state and covers more than 220 square miles.[4] With a population of about 2.9 million residents, Chicago makes up nearly 25 percent of the total population of the state. The state capital of Springfield is located in the central part of the state and is the sixth most populous city.

Table 1: Illinois' largest cities and counties by population 2000

The cities with the largest population in Illinois are:

1. Chicago 2,896,016
2. Rockford 150,115
3. Aurora. 142,990
4. Naperville 128,358
5. Peoria 112,936
6. Springfield 111,454
7. Joliet 106,221
8. Elgin. 94,487
9. Waukegan 87,901
10. Cicero 85,616

The counties with the largest population in Illinois are:

1. Cook 5,376,741
2. DuPage. 904,161
3. Lake. 644,356
4. Will 502,266
5. Kane 404,119
6. Winnebago 278,418
7. McHenry 260,077
8. Madison. 258,941
9. St. Clair 256,082
10. Sangamon 188,951

From 1990 to 2000 Illinois' population grew by almost one million people. According to the 2000 U.S. Census, Illinois' population was made up of 73.5 percent whites, 15.1 percent blacks, and 9.5 percent of Asian and other races. Of these races, 12.3 percent were reported as Hispanic ethnicity. The trends over the last 10 years show an increase in the Hispanic population of nearly 70 percent. This

accounts for more than two-thirds of the overall population increase in Illinois. The Asian and Pacific Islander population grew by nearly 60 percent and the black population grew from 10 percent to 14 percent from 1990 to 2000.[5]

Females make up 51 percent of the population and outnumber males by more than 250,000. The median age is 34.7 years and nearly 74 percent of Illinoisans are aged 18 and over. People over the age of 65 represent 12.1 percent of the population in Illinois.[6] People the age of 85 and above have become the fastest growing population with a 20.6 percent increase since 1990.[7]

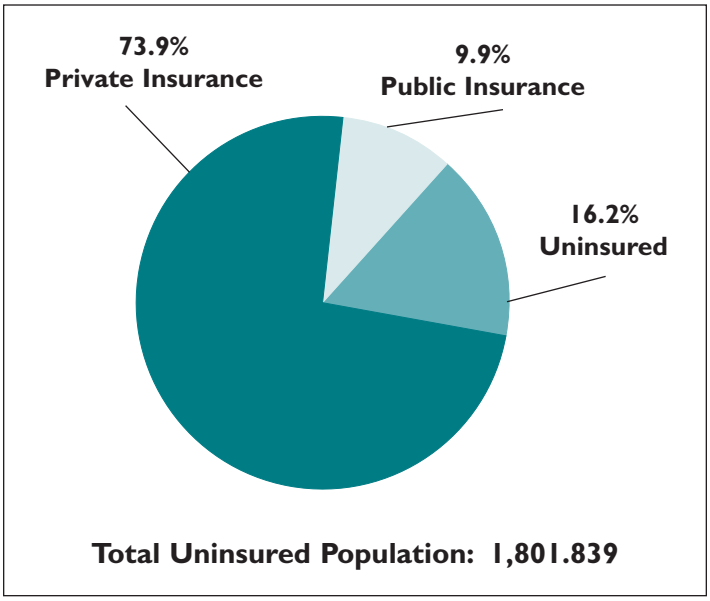
Illinois per-capita personal yearly income was $33,690 in 2003 and the median household income was $45,607 (2001-2003). Illinois' unemployment rate in November 2004 was 6.0 percent, compared to the U.S. unemployment rate of 5.4 percent.[8]

2. Health Care Coverage

The Uninsured

Nearly 1.8 million or 16.2 percent of Illinois residents were uninsured in 2003. Being uninsured is a common disparity that is not limited to poor Illinois residents. Many people have health insurance through their jobs or are covered by a family member's job, but, not all employers offer health insurance. In 2001, 14.1 percent of the population in Illinois did not have health insurance, which represents the largest percentage increase since 1992 and this trend is increasing. With the cost of health insurance premiums continuing to rise, estimates for the average premiums of annual employee sponsored family health coverage in 2006 are expected to be more than double the average premium of 2001.[9] Figure 1 represents Illinois' insurance status for people ages 0 to 64 in 2003.[10]

Figure 1: Illinois Insurance Status Ages 0 – 64, 2003



Racial and ethnic minorities are a disproportionately large group without health insurance. Approximately 11.4 percent of the total white population was uninsured in 2003.

Subsequently, the black population had 25 percent uninsured and the Hispanic population had 30.4 percent, more than twice that of the white population. Other racial/ethnic populations represent 15.3 percent of the uninsured in 2003.

Lack of insurance frequently affects younger adults. The population between the ages of 19 and 29 represent 29.3 percent of the uninsured. Those age 19 and over with less than a high school education represent 41.9 percent of the uninsured.

Medicaid and Medicare

The Illinois Department of Healthcare and Family Services (HFS), formerly known as the Illinois Department of Public Aid, offers Medicaid to those who are eligible. Medical assistance programs pay for medically necessary services for eligible individuals and families.[11] The number of people with Medicaid in 2002 was 975,044, up from the previous year's total of 893,755. Legal immigrants may be covered by Medicaid for emergency medical care only.

In 2002, there were 12 percent of children under the age of 18 in Illinois who were uninsured. Again, this is a slight increase from the 11 percent the previous year. Of the total number of children living in Illinois, 17 percent were on Medicaid in 2002, up from 16 percent in 2001.

For those over the age of 65, Medicare is one source for health care coverage. In 2002, the total number of people with Medicare was 1,739,129.

B. Illinois Cancer Profile

1. 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

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

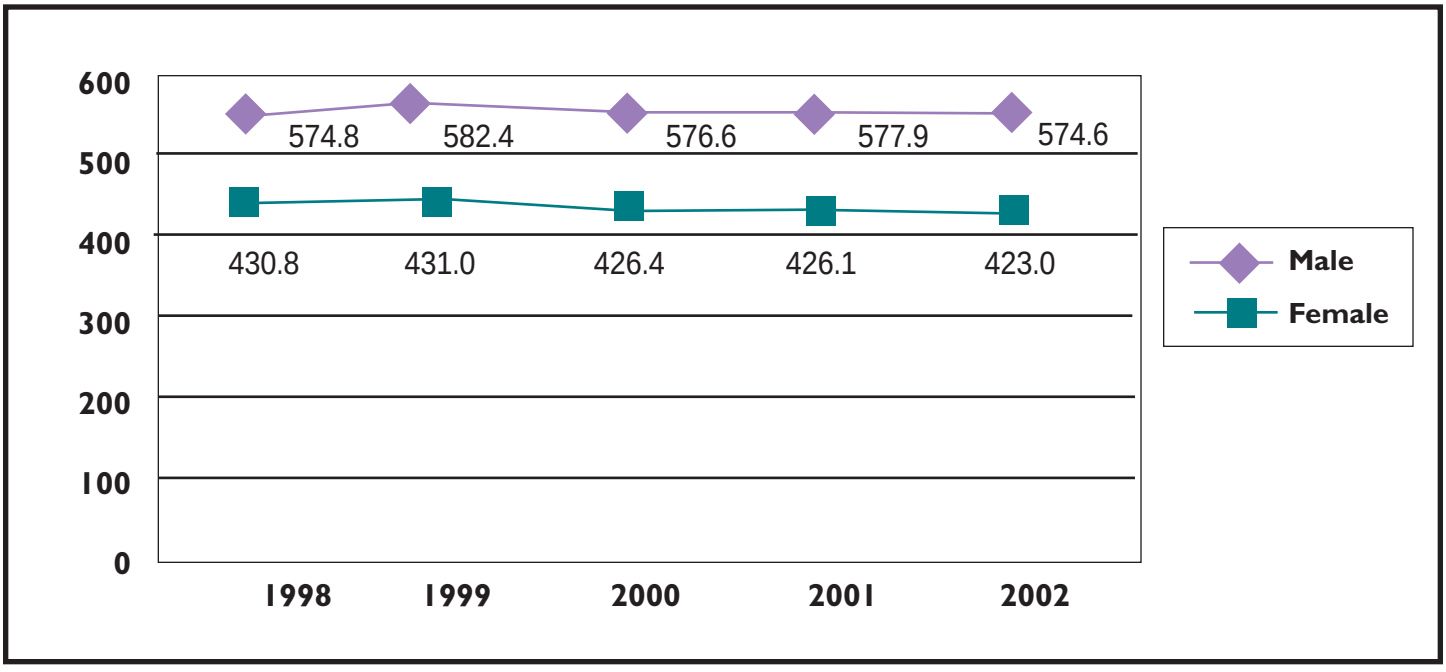
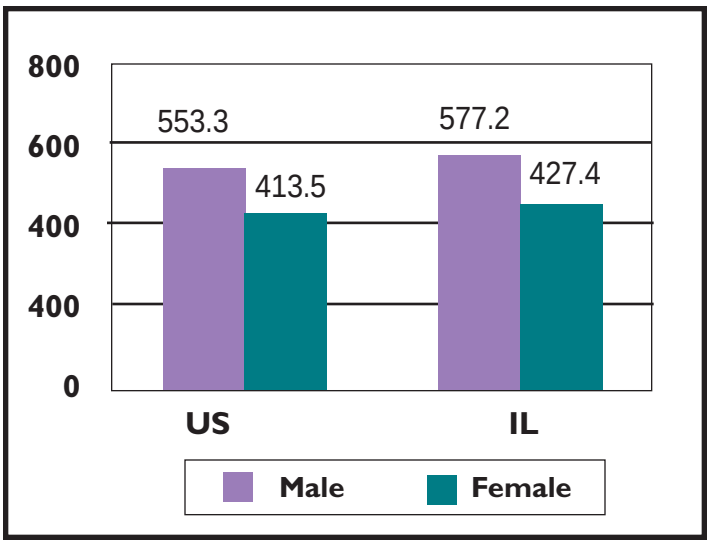


Figure 3: Comparison National and Illinois Cancer (All Sites) Incidence Rates, (per 100,000) 1998 – 2002



be 577.2 and females 427.4 per 100,000 people, of all races combined for 1998 - 2002.[12] 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.[13]

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 3.

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 4 illustrates the incidence rate by race and ethnicity for selected cancer sites. The top 10 cancer incidence rates for 2002 for race and sex are presented in Table 2a for males and Table 2b for females.

Figure 4: Illinois Cancer Incidence Rates (per 100,000) by Race/Ethnicity, 1998 -2002

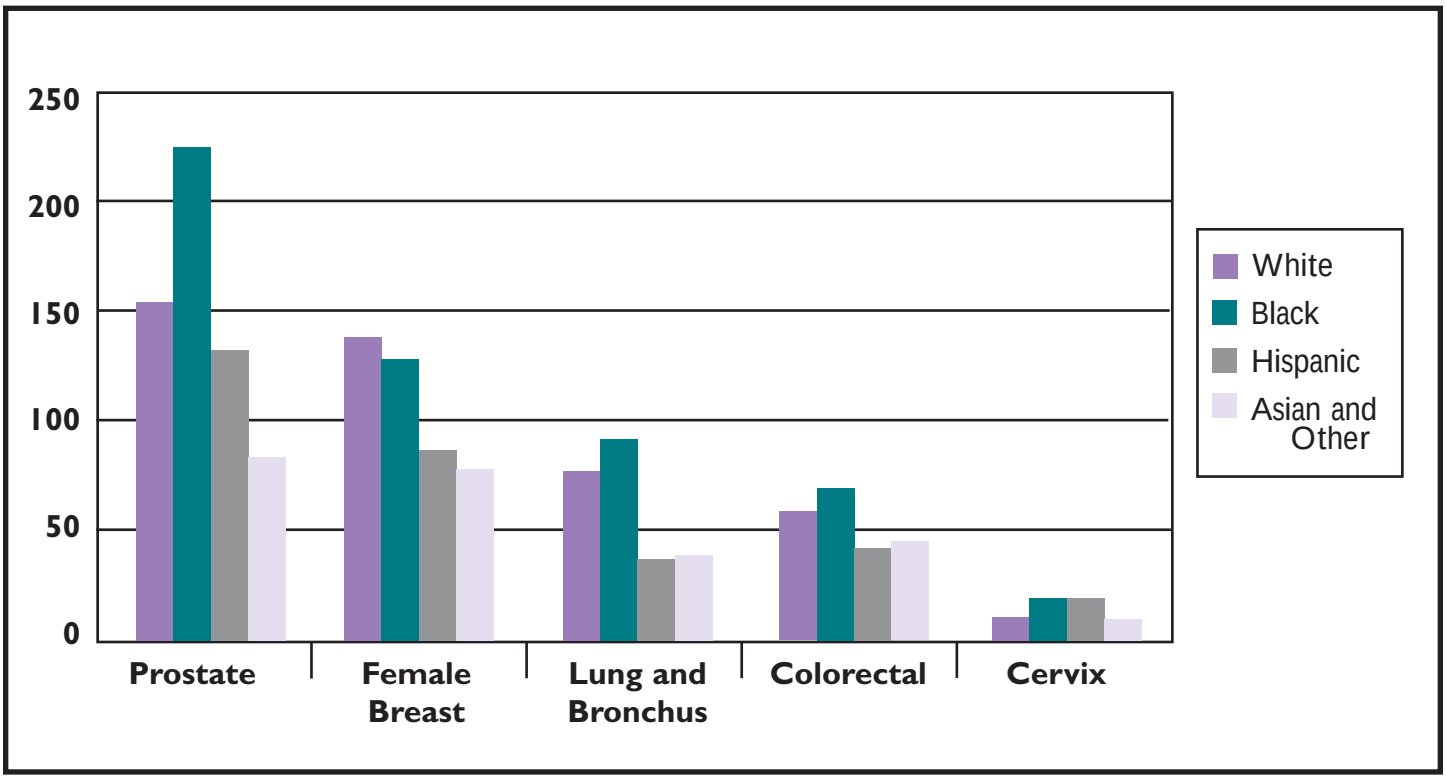


Table 2a: Top 10 Cancer Incidence Rates in Illinois (per 100,000)[14] Males by Race, 2002

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

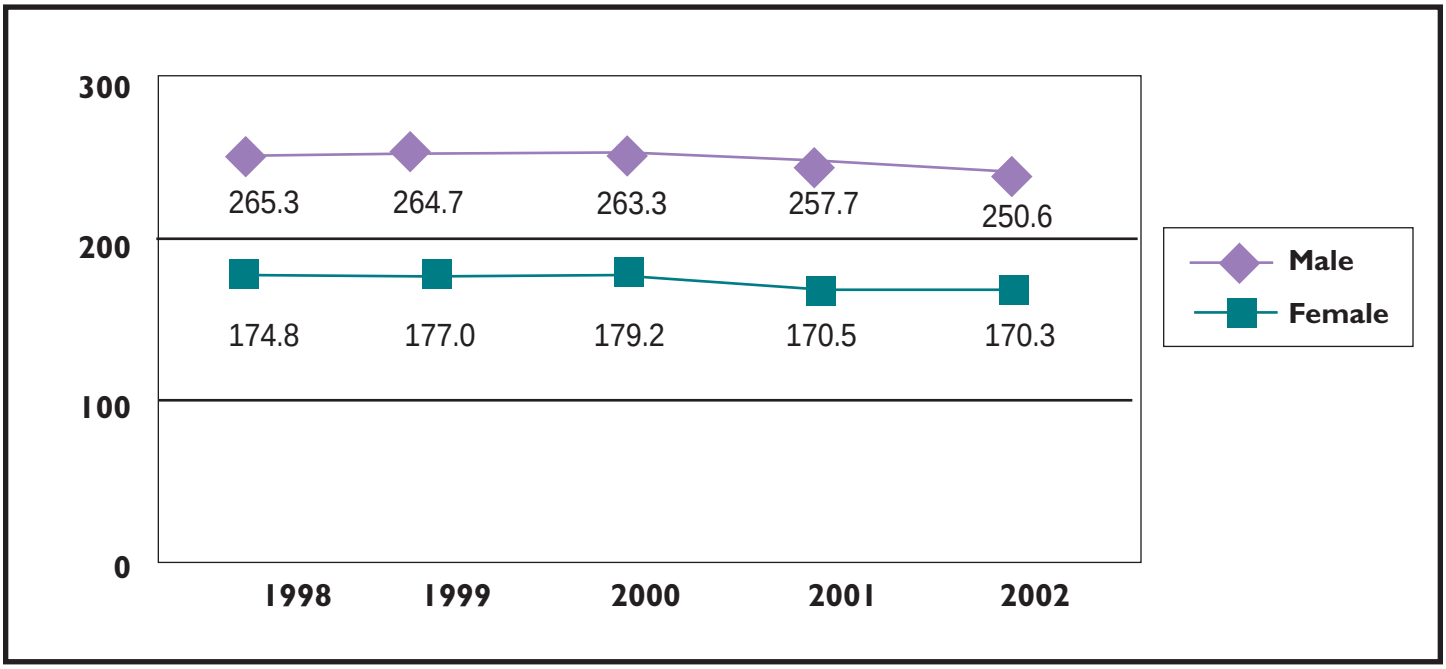
Illinois Department of Public Health, Illinois State Cancer Registry, June 2005

Table 2b: 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 5: Illinois Cancer Mortality Rates, (per 100,000) All Races, All Sites 1998 – 2002



2. 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 5 shows the comparison of age-adjusted mortality rates for males and females of all races in Illinois from 1998 to 2002.[15]

In 2002, cancer caused 24,671 deaths in Illinois.[16] 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 6 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 (169.7). Cook County, with its diverse racial and ethnic population, also has a higher mortality rate (219.0) than the state average.[17] Blacks also have the highest mortality rate of prostate, female breast, lung, colorectal and cervical cancer than any other racial or ethnic group. Figure 7 illustrates the mortality rate by race and ethnicity for selected cancer sites.

The top 10 mortality rates for 2002 are presented in Table 3a for males and Table 3b for females.

Figure 6: Illinois vs. United States Cancer Mortality Rates, (per 100,000) 1998 – 2002

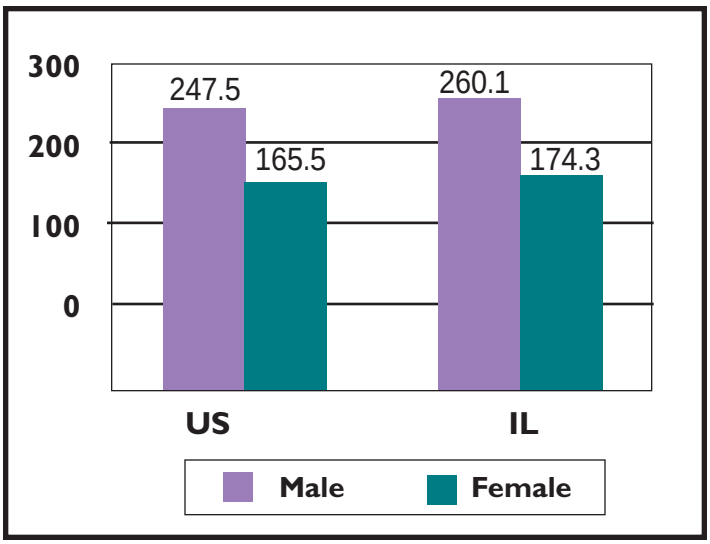


Figure 7: Mortality Rates by Race/Ethnicity, (per 100,000) All Sexes, 1998 – 2002[17]

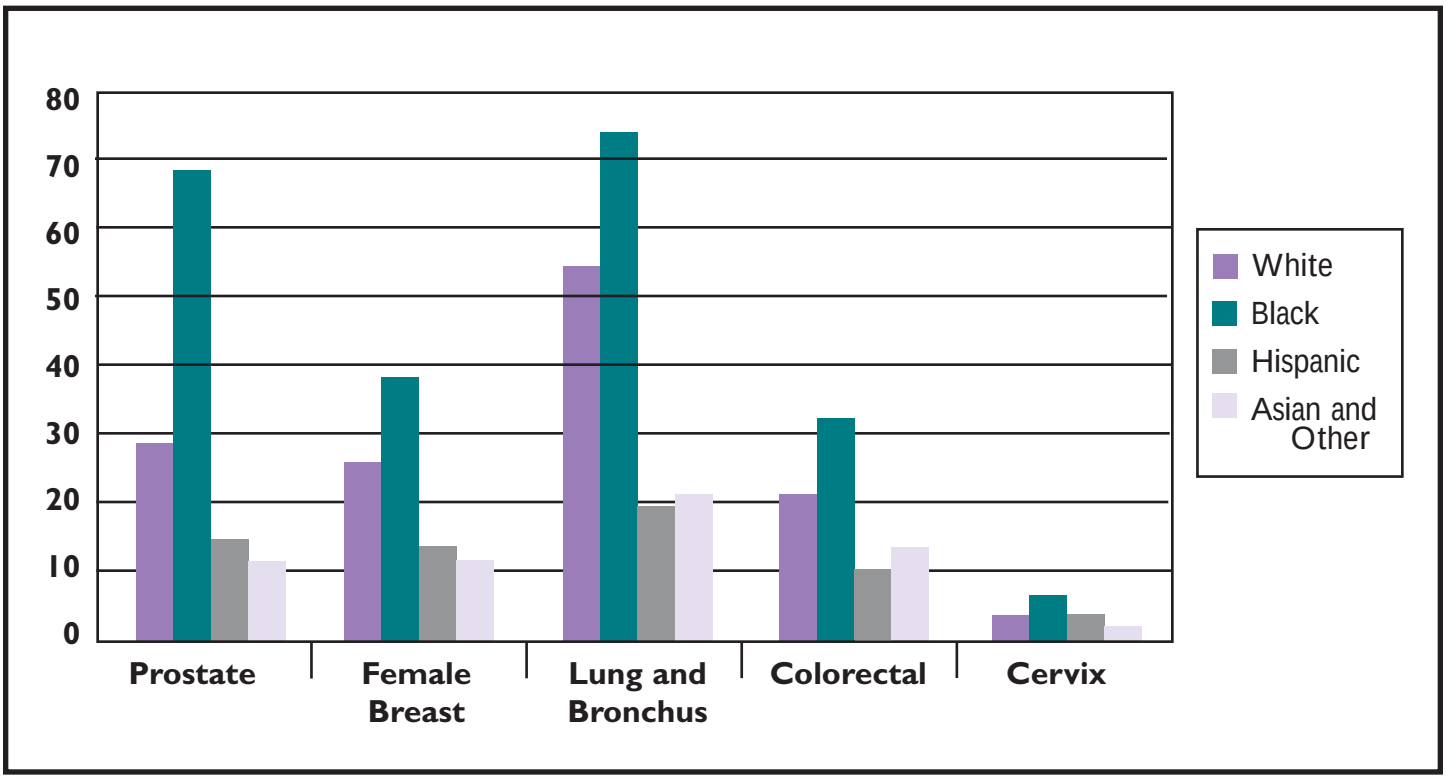


Table 3a: Top Ten Cancer Mortality Rates in Illinois (per 100,000) Males by Race, 2002[17]

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 3b: 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

3. 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 (YPLL) between the time of death and 65 years of age. In the U.S., YPLL 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.[18] 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.

4. 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 five-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.

C. 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 8 through 11 are rounded to the nearest 10 deaths and represent projected new cases and projected deaths for 2006.[19]

Figure 8: Illinois Projected New Cancer Cases All Races, Men, 2006

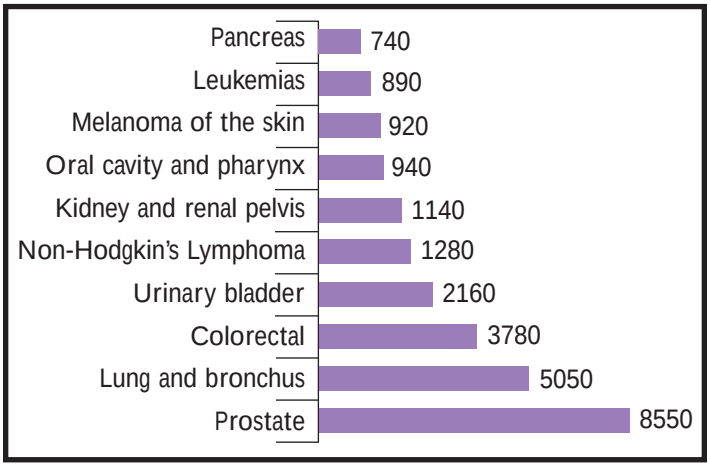


Figure 9: Illinois Projected Cancer Deaths All Races, Men, 2006

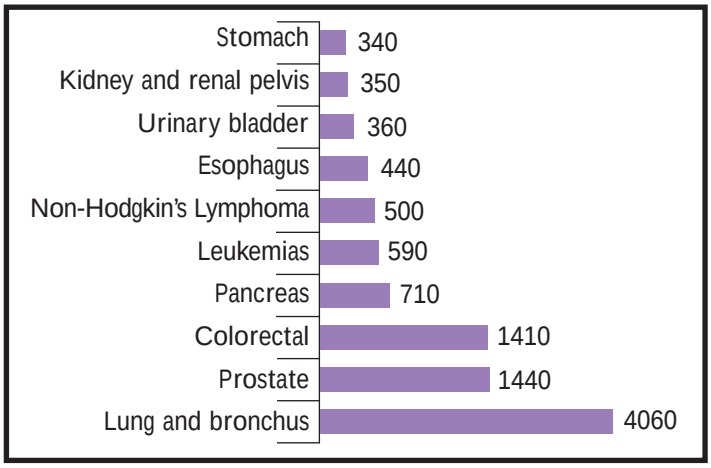


Figure 10: Illinois Projected New Cancer Cases All Races, Women, 2006

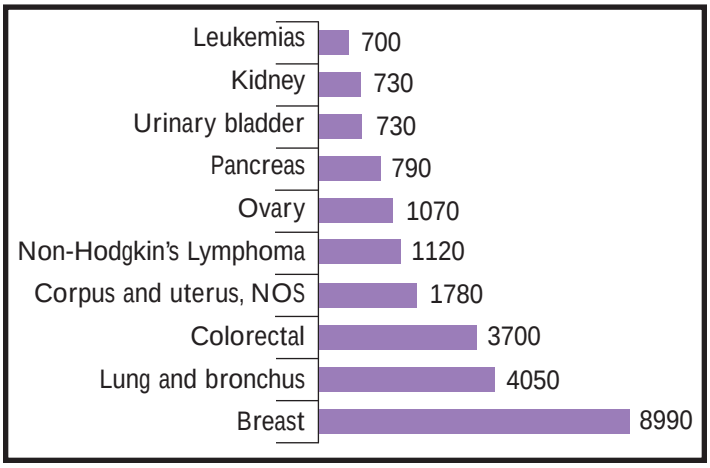
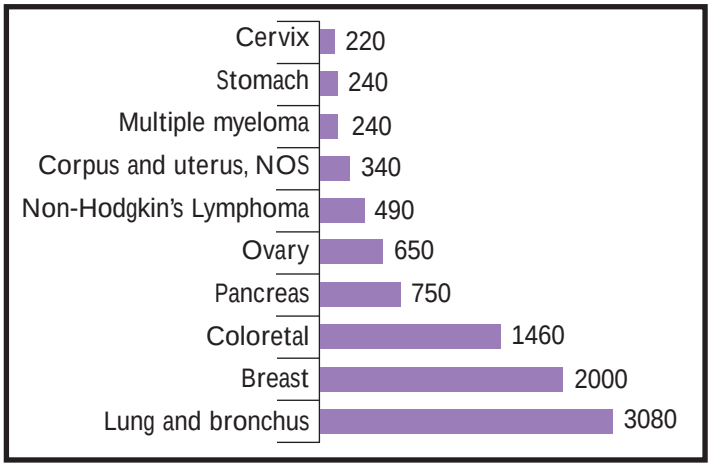
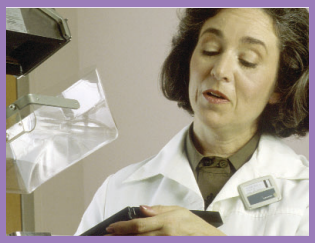


Figure 11: Illinois Projected Cancer Deaths All Races, Women, 2006









III. Priorities to Address Comprehensive Cancer Control in Illinois

III. Priorities to Address Comprehensive Cancer Control in Illinois

A. Primary Prevention and Early Detection

GOAL: Primary Prevention

Reduce the risks for developing cancers among all populations.

Problem statement: Primary prevention is the complete prevention of disease through methods that inhibit exposure to certain risk factors. The most important behavioral risk factors for cancer are poor nutrition, lack of physical activity, tobacco use and exposure to ultraviolet light. Numerous evidence-based measures exist today to prevent much of the cancer burden and to curtail its consequences.

According to the National Cancer Institute and other cancer experts, prevention is the key strategy to reduce the nation's cancer burden. According to the American Cancer Society, 30 percent of cancer deaths can be attributed to tobacco use. One-third of the 26,740 Illinois cancer deaths expected to occur each year will be related to poor nutrition, physical inactivity, obesity and other modifiable lifestyle factors. Additionally, many of the more than 1 million skin cancers that are expected to be diagnosed nationally each year could have been prevented by protection from the sun. If Illinois expects to reduce its cancer burden, further aggressive preventive strategies must be employed.

Lifelong health habits, many established in childhood, are difficult to change. Reaching young people through school health programs, before unhealthy behaviors begin, yields the greatest potential for return on investment. Targeting school-aged children can prevent adoption of unhealthy behaviors. Studies have shown that comprehensive health education in schools provides the knowledge and development of skills that can effectively reduce risky health behaviors.

Targeting the hard-to-reach population is crucial to primary prevention efforts surrounding cancer. This population includes minority groups, those without regular health care and those who are resistant to services. By understanding the beliefs, attitudes and barriers of this population, health professionals can tailor communication and outreach strategies.

Professional education is essential to ensure consistent health communication and education to patients, clients and the general public. Professional education increases health care providers' access to and knowledge of the latest and most accurate cancer prevention and early detection recommendations as well as knowledge of state-of-the-art diagnostic and clinical practices. Professional education is a vital link between the health professional community and the public. These health professionals may sometimes be the only primary source of information for Illinoisans about cancer risks, screening and treatment.

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 second hand smoke.
- 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[1] in adults.
- Reduce the proportion of adults who are overweight or obese.[2]
- Reduce the proportion of children who are overweight or at risk of overweight.[3]
- Increase the proportion of people who participate in moderate physical activity.[4]
- 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 healthy 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 professions 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.

[1] Healthy weight – BMI between 18.5 – 24.9 kg/m^2

[2] For adults: Overweight – BMI between 25 and 29.9 kg/m^2. Obese – BMI of 30 kg/m^2 or higher.

[3] For children ages 2–20: Overweight – BMI for age-sex >95th percentile. At risk of overweight – BMI for age-sex 85th percentile to 95th percentile.

[4] Any physical activity that meets the following criteria: any activity that causes a large increase in breathing or heart rate for at least 20 minutes three or more times per week **OR** activity that causes small increases in breathing or heart rate at least 30 minutes five or more times per week.

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, that consume five or more servings of fruits and vegetables a day.

- Illinois Baseline for adults age 18 and older: **23.0 percent** (2003)
  Data Source: Behavioral Risk Factor Surveillance System Public Use Data Tape 2003, National Center for Chronic Disease Prevention and Health Promotion, U.S. Centers for Disease Control and Prevention, 2004.
- Illinois Baseline for high school students: **24.8 percent** (2001)
  Data Source: Youth Risk Behavior Surveillance System, 2001, National Center for Chronic Disease Prevention and Health Promotion, U.S. Centers for Disease Control and Prevention, 2002.

By 2010, increase the proportion of Illinois residents, adults to 48 percent and high school students to 33 percent, that participate in moderate[5] physical activity.

- Illinois Baseline for adults age 18 and older: **43.7 percent** (2003)
  Data Source: Behavioral Risk Factor Surveillance System Public Use Data Tape 2003, National Center for Chronic Disease Prevention and Health Promotion, U.S. Centers for Disease Control and Prevention, 2004.
- Illinois Baseline for high school students: **28.5 percent** (2001)
  Data Source: Youth Risk Behavior Surveillance System, 2001, National Center for Chronic Disease Prevention and Health Promotion, U.S. Centers for Disease Control and Prevention, 2002.

By 2010, decrease the proportion of Illinois residents (adults to 56% and high school students to 4.5%) that are overweight. [6]

- Illinois Baseline for adults age 18 and older: **61.1 percent** (2003)
  Data Source: Behavioral Risk Factor Surveillance System Public Use Data Tape 2003, National Center for Chronic Disease Prevention and Health Promotion, U.S. Centers for Disease Control and Prevention, 2004.
- Illinois Baseline for high school students: **9.5 percent** (2001)
  Data Source: Youth Risk Behavior Surveillance System, 2001, National Center for Chronic Disease Prevention and Health Promotion, U.S. Centers for Disease Control and Prevention, 2002.

GOAL: Early Detection

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

Problem statement: Early detection involves medical exams, tests and self-exams to find signs and symptoms of cancer. For many types of cancer, it is easier to treat and

[5] For adults age 18 and older – any physical activity that meets the following criteria: any activity that causes large increases in breathing or heart rate at least 20 minutes three or more times per week (such as running, aerobics or heavy yard work) **OR** activity that causes small increases in breathing or heart rate at least 30 minutes five or more times a week (such as brisk walking, bicycling, vacuuming or gardening).
For high school students – physical activities that make students sweat and breathe hard for 30 minutes or more on five or more of the seven days preceding the survey.

[6] For adults age 18 and older – Body Mass Index of 25.0 kg/m^2 or higher.
For high school students – 95th or higher percentile for body mass index by age and sex based on reference data.

cure the cancer if it is found early. This provides an opportunity for prompt treatment while the cancer is small and localized. Breast cancer can be detected early through regular breast self-examinations, clinical breast exams (CBE) and mammography. Colon cancer can be detected early through regular fecal occult blood testing (FOBT) and/or colonoscopy. Skin cancer and testicular cancer also can be detected early through regular self examination. Oral and pharyngeal cancers can be detected through an annual professional oral cancer examination. However, the signs and symptoms of cancer may be overlooked by both health care providers and patients. Pre-symptomatic genetic testing is available for some types of cancer, including melanoma, breast, ovarian and colon cancer. Identifying families with genetic predisposition to cancer is primarily conducted through assessing the family history. Medical intervention measures can be offered to reduce the individual's risk for breast, ovarian and colorectal cancers, and early detection can significantly lower the death rate.

For example, in 2002, 60 percent of Illinois Behavioral Risk Factor Surveillance System (BRFSS) respondents over age 50 never had a FOBT. The U.S. States Preventive Services Task Force (USPSTF) recommends men and women aged 50 and older receive a FOBT every year to reduce colon cancer mortality. Cancer screening tests can help detect cancer at an earlier stage. The earlier the stage – the better the prognosis. Promotion of early detection education and screening tests is needed to decrease the cancer death rates in Illinois.

Recommendations:

- Increase the proportion of women age 40 and over that receive an annual CBE.
- 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 (ACS) and USPSTF 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 an annual Pap test.
- Increase the proportion of people receiving a regular skin cancer screening (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 USPSTF and the 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 (IBCCP) 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 FOBT and 41 percent for sigmoidoscopy or colonoscopy who have received these colorectal cancer screening consistent with ACS and USPSTF guidelines.

- Illinois Baseline for FOBT within the past year: **18.4 percent** (2002)
  Data Source: Behavioral Risk Factor Surveillance System Public Use Data Tape 2002, National Center for Chronic Disease Prevention and Health Promotion, U.S. Centers for Disease Control and Prevention, 2003.
- Illinois Baseline for recent sigmoidoscopy or colonoscopy within the preceding five years: **37.0 percent** (2002)
  Data Source: Behavioral Risk Factor Surveillance System Public Use Data Tape 2002, National Center for Chronic Disease Prevention and Health Promotion, U.S. Centers for Disease Control and Prevention, 2003.

By 2010, increase the proportion of colorectal cancer cases diagnosed at an early[7] stage to 37 percent.

- Illinois Baseline: **32.9 percent** (2001)
  Data Source: Illinois Department of Public Health, Illinois State Cancer Registry.

By 2010, increase the proportion of women aged 40 and older who have received a mammogram within the past year to 65 percent.

- Illinois Baseline: **60.2 percent** (2002)
  Data Source: Behavioral Risk Factor Surveillance System Public Use Data Tape 2002, National Center for Chronic Disease Prevention and Health Promotion, U.S. Centers for Disease Control and Prevention, 2003.

By 2010, increase the proportion of breast cancer cases diagnosed at an early[8] stage to 73 percent.

- Illinois Baseline: **66.8 percent** (2001)
  Data Source: Illinois Department of Public Health, Illinois State Cancer Registry.

[7] Early is defined as colorectal cancers diagnosed at the localized state or according to the AJCC staging definition $T_0N_0M_0$
[8] Early is defined as breast cancer cases diagnosed *in-situ* or at the localized stage.
[9] Early is defined as cervical cancer cases diagnosed at the localized stage.

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.

- Illinois Baseline: **84.2 percent (**2001)
  Data Source: Behavioral Risk Factor Surveillance System Public Use Data Tape 2002, National Center for Chronic Disease Prevention and Health Promotion, U.S. Centers for Disease Control and Prevention, 2003.

By 2010, increase the proportion of cervical cancer cases diagnosed at an early[9] stage to 56 percent.

- Baseline: **51.4 percent** (2001)
  Data Source: Illinois Department of Public Health, Illinois Stage Cancer Registry.

B. Rehabilitation and Supportive Care

GOAL: Rehabilitation and Supportive Care

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

Problem statement: The National Cancer Institute (NCI) defines the term cancer survivor as a person with cancer from the time he or she is diagnosed with cancer through the remaining years of his or her life. The impact of cancer on quality of life can be severe including, but not limited to, loss of employment, loss of housing, overwhelming medical bills, intractable pain, strained family relations, depression and the inability to independently complete the activities of daily living, as well as causing a burden on the caregiver. Supportive care and symptom control refers to relieving symptoms and side effects of cancer and cancer treatment in order to improve the quality of life for patients and their families.

The purpose of cancer rehabilitation is to increase the quality of life of those surviving a cancer diagnosis. Rehabilitation attends to a patient's psychological, physical and social needs. For example, nutrition therapy can help patients get the nutrients needed to maintain body weight and strength, prevent body tissue from breaking down, rebuild body tissue and fight infection in order to restore nutrient deficiencies, maintain optimal nutritional health and prevent complications.

According to the National Cancer Institute, there are 9.8 million cancer survivors in the United States in need of rehabilitation or supportive care. This estimate includes people diagnosed with cancer and does not include others affected by the diagnosis, such as family members and friends. Rehabilitation is defined as restoring an individual to as near normal life as possible following the completion of treatment for cancer.

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 health care professionals about rehabilitative and supportive cancer care and promote the use of existing resources from the NCI 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 ACS 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.

- Illinois Baseline: To be determined by 2007
  Data Source: 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.

- Illinois Baseline: To be determined by 2007
  Data Source: National Cancer Institute, Cancer Information Service, Y-ME, Susan G. Komen Breast Cancer Foundation, Us TOO, American Cancer Society and others

C. Access to Care

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

Problem statement: Access to quality medical care is necessary for cancer prevention, early detection and appropriate diagnosis and treatment. Equal access to preventive and early detection services, appropriate treatment and follow-up and quality cancer care are vital to the prevention and control of cancer in Illinois. Once a cancer is diagnosed, timely information on treatment options and access

to appropriate care are critical to improving treatment outcomes and survival rates, thereby resulting in minimized disparities in treatment and survival outcomes. Improving access to quality health care is critical towards eliminating health disparities and increasing the quality and quantity of life. The barriers to accessing health care in Illinois are insurance status, lack of transportation, cultural and language barriers, lack of health care professionals in a designated area and not being able to access treatment services in a different county or state.

According to the U.S. States Census Bureau, there were 1.8 million people in Illinois without health insurance in 2003. The largest number of uninsured are those age 30-49, as well as certain racial and ethnic minorities who more likely to be uninsured than whites.

Lack of transportation affects access to health care in 33 counties in Illinois.[20] According to the Illinois Department of Transportation, when an Illinois county lacks a public transit system, it is very likely that adjacent counties lack one also.

Cultural and language differences present barriers between patients and health care providers. A provider's lack of sensitivity to the culture and the lack of health care materials that are easy – to – read and in other languages can create mistrust in the health care system as a whole. The health care system must provide quality and accessible services that are responsive to the needs of Illinois' growing multicultural population. People from all corners of the world now live in Illinois. These undocumented immigrants lack health insurance coverage and access to interpretation and translation services.

According to the U.S. Health Resources and Services Administration, Illinois has 198 federally-designated medically underserved areas (MUAs) or medically-underserved populations (MUPs). MUAs are whole counties or a group of contiguous counties, a group of county or civil divisions or a group of urban census tracts in which residents have a shortage of personal health services. MUPs are groups of persons who face economic, cultural or linguistic barriers to health care.

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 (ACS) 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 ACS, National Cancer Institute and the 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.

- Illinois Baseline: **16.2 percent** (2003)
  Data Source: *Health Insurance Coverage 2003*, U.S. Bureau of Census, August 2004.

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.

- Illinois Baseline: Currently the only cancers that have programs for early detection and treatment for the underserved are breast and cervical cancers through the Illinois Breast and Cervical Cancer Program (2005).
  Data Source: Illinois General Assembly

By 2010, conduct statewide capacity studies to assess the breast and colorectal cancer screening capacity throughout the state.

- Illinois Baseline: Currently no statewide studies have been completed.
  Data Source: To be determined.

D. Policy and Tobacco Control

GOAL: Reduce tobacco use through evidence-based interventions.

Problem statement: Tobacco use is the leading most preventable cause of disease and death in the United States. Approximately 20,000 deaths directly related to tobacco use occur each year in Illinois. The medical cost is nearly $1.6 billion each year in Illinois.[21]

Half of all Americans who use tobacco products will die from their addiction. The risk of lung cancer is no different in smokers of *light* or *low-tar* cigarettes. Among smokeless tobacco users, oral cancer occurs several times more frequently than with non-tobacco users.[22]

By preventing the onset or continuance of tobacco use, people can reduce their chances of many forms of chronic disease, including many identified forms of cancer. Smoking adversely affects every organ in the human body. In the latest Surgeon General's report on the health effects of smoking, there is evidence sufficient to infer a causal relationship between smoking and bladder, cervical, esophageal, kidney, laryngeal, leukemia, lung, oral, pancreatic and stomach cancers.

Patients will visit their physicians for treatments related to complications from smoking. Many of these patients do not receive recommendations from their physicians about smoking cessation or the risks of developing cancer from prolonged usage of tobacco products. Physicians can and should take a proactive approach with their patients and encourage them to stop smoking. The Community Guide to Preventive Services found that approaches used by health care systems, where providers educate their patients understand the risks and dangers of tobacco use, are effective in increasing the number of patients who quit using tobacco. These health care systems are important venues for smoking cessation.

In addition, the Illinois Tobacco Quitline is funded by the Illinois Department of Public Health and is administered by the American Lung Association of Illinois-Iowa. The Quitline was created to help people quit using tobacco and is staffed by registered nurses, registered respiratory therapists and smoking cessation counselors who interact with clients in any phase of the cessation process. According to The Guide to Community Preventive Services, providing counseling and support to patients by telephone is effective in increasing the number of smokers who quit.

Comprehensive tobacco control involves reduction of disease, disability and death related to tobacco usage, promotion of cessation among users of tobacco products and elimination of nonsmokers' exposure to second- hand smoke. Approximately 80 percent of adults who smoke began smoking before the age of 18. Every day, 5,000 students in Illinois under the age of 18 try their first cigarette. In 2002, 35.7 percent of Illinois high school students reported using tobacco products.[23]

Smoking restrictions are policies, regulations and laws that limit smoking in workplaces and other public areas. Smoking bans prohibit smoking entirely. According to the task force on Community Preventive Services, smoking bans and restrictions are effective measures in reducing exposure to second-hand smoke and reducing the amount smoked.[24] Second-hand smoke has been proven to be a carcinogen. In the U.S., 3,000 nonsmoking adults die of lung cancer every year as a result of breathing second-hand smoke.[25] On August 10, 2005, Gov. Rod R. Blagojevich signed House Bill 672 (HB 672), which revised the Illinois Clean Indoor Act. HB 672 allows local municipalities in Illinois the option of regulating smoking in public places to protect workers and residents from second-hand smoke. Previously, only 21 Illinois communities with existing clean – air ordinances were allowed to set local smoking policies. The new law took effect January 1, 2006. In order to sustain the effectiveness of tobacco control programs, continuous evaluation of the policies and Illinois state laws need to be addressed.

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 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 the 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, middle school students to 6.6 percent and high school students to 28.2 percent, who smoke cigarettes.

- Illinois Baseline for adults age 18 and older: **23.4 percent** (2003)
  Data Source: Behavioral Risk Factor Surveillance System Public Use Data Tape 2003, National Center for Chronic Disease Prevention and Health Promotion, U.S. Centers for Disease Control and Prevention, 2004.
- Illinois Baseline for middle school students: **7.6 percent** (2002)
  Data Source: Illinois Youth Tobacco Survey, Illinois Department of Public Health, 2002.
- Illinois Baseline for high school students: **29.2 percent** (2002)
  Data Source: Illinois Youth Tobacco Survey, Illinois Department of Public Health, 2002.

By 2010, increase the number of calls made to the Illinois Tobacco Quitline by 25 percent.

- Illinois Baseline: 4,276 calls were made to the Illinois Tobacco Quitline from July 1, 2004 through June 30, 2005.
  Data Source: Illinois Department of Public Health, 2005

E. Research and Clinical Trials

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

Problem statement: Clinical trials are an integral part of cancer research. They are utilized to determine what treatments are safe and effective in treating cancers, while others study new ways of diagnosing or preventing the disease. Before gaining approval for use from the U.S. Food and Drug Administration, drugs must go through several phases

of clinical trials. Extensive research, development, and testing occur before a treatment can reach the clinical trial phase. More than 400 cancer drugs were tested in clinical trials in 2001, according to the Pharmaceutical Research and Manufacturers of America. Determining whether or not any of these medications could be effective in the fight against cancer can be delayed because of low clinical trial participation.

According to the American Cancer Society, approximately 4 percent of adults with cancer take part in clinical trials even though cures do not exist for many forms of cancer. There are many barriers that contribute to this low enrollment. Research conducted by the National Cancer Institute indicates that the general public is unaware of clinical trials as a treatment option and misinformed about the process. Other barriers include lack of access, fear and distrust of research, and financial and personal concerns. Overcoming these obstacles and improving awareness are crucial efforts to advancing cancer research and ultimately reducing the burden of this disease.

Diverse enrollment in clinical trials is an essential step to better understand and reduce cancer disparities. In addition, some cancers are more common in a particular racial or ethnic group than in the general public. Awareness needs to be heightened within racial and ethnic groups disproportionately affected by these cancers in order to better understand the cause, find treatments and cures, and ultimately reduce the burden of disease. Fear and distrust, lack of awareness, access, cultural beliefs, language and literacy barriers are some of the obstacles believed to play a role in low minority enrollment.

Health care providers shape the course of a patient's treatment. Health care providers are a valuable source of information and guidance for patients and their families. Unfortunately, clinical trials may not be discussed with patients as an option for care for a variety of reasons. Some providers are unaware clinical trials are available. Others are hesitant to transfer their patients' care elsewhere.

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 in Illinois.
- 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:

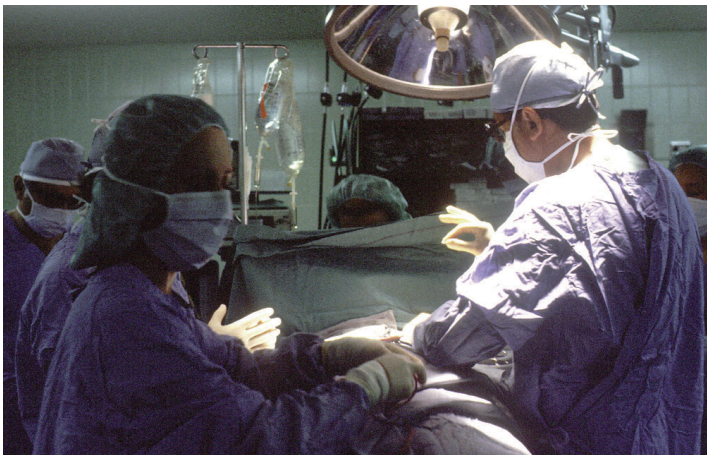
By 2007, determine a baseline for the number of requests for information on clinical trials received by research organizations, such as the National Cancer Institute, Cancer Information Service and the American Cancer Society.

By 2010, increase the baseline of the number of requests for information on clinical trials received by research organizations by 25 percent.

- Illinois Baseline: To be determined by 2007.
  Data Source: National Cancer Institute's Cancer Information Service and the American Cancer Society.

By 2010, increase the number of enrollees in cancer clinical trials in Illinois by 25 percent.

- Illinois Baseline: 1,505 patients were enrolled in NCI-funded Cancer Therapy Evaluation Program clinical trials in Illinois in 2004.
  Data Source: National Cancer Institute's Cancer Information Service, 2004.



By 2010, increase the number of diverse enrollees in cancer clinical trials in Illinois by 25 percent.

- Illinois Baseline: 12 percent of patients enrolled in NCI-funded Cancer Therapy Evaluation Program clinical trials in Illinois in 2004 were from diverse racial and ethnic backgrounds.
  Data Source: National Cancer Institute's Cancer Information Service, 2004.

F. Data and Surveillance

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

Problem statement: Cancer surveillance is the continuous monitoring and routine collection of specific information about cancer cases occurring in Illinois. This data includes demographic information about the patient as well as detailed information about the cancer itself. Surveillance data identify and prioritize at-risk populations for prevention strategies, early detection programs and research. This

data also enables health professionals to identify risk factors for cancer, to determine incidence and mortality, to evaluate the cancer burden at a local and state level and to compare this information to the nation. Generating cancer data that is complete, comprehensive, timely and of high quality is essential to chart the progress of cancer control and prevention in Illinois.

Illinois' greatest resource for cancer data is the Illinois State Cancer Registry (ISCR), within the Illinois Department of Public Health. ISCR is the only population-based source for cancer incidence information in Illinois. Cancer cases are collected through mandated reporting by hospitals, ambulatory surgical treatment centers, non-hospital affiliated radiation therapy treatment centers, independent pathology labs and through the voluntary exchange of cancer patient data with central registries in other states. ISCR collects information about the incidence of cancer, the types of cancers diagnosed, the location of the cancer within the body, the stage of cancer at the time of diagnosis, the kinds of treatment the patient receives and patient demographic information. The ISCR was created in 1984 and data collection began in 1986. The function of ISCR is to serve as the "eye" of Illinois cancer surveillance through which outcomes of cancer prevention and control are seen.

The U.S. Centers for Disease Control and Prevention (CDC) has established national standards to ensure the completeness, timeliness and quality of cancer registry data. CDC also recommends that cancer registries incorporate the standards of the North American Association of Central Cancer Registries (NAACCR). NAACCR reviews member registries annually for their ability to produce complete, accurate and timely data. NAACCR then recognizes those registries meeting the highest standards of data quality with gold or silver recognition certificates for each data year. ISCR has received gold standard recognition for the past six years.

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 determine 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 emphasis an 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.

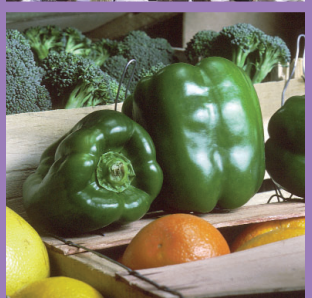
- Illinois Baseline: 99 percent completeness of reporting (2002).
  Data Source: Illinois Department of Public Health, Illinois State Cancer Registry.

By 2010, increase by 25 percent the accuracy of race reporting by cancer registries throughout Illinois.

- Illinois Baseline: 1.3 percent missing/unknown race (2002).
  Data Source: Illinois Department of Public Health, Illinois State Cancer Registry.

By 2010, collect payor source for at least 80 percent of cancer patients in Illinois.

- Illinois Baseline: 0 percent (2005)
  Data Source: Illinois Department of Public Health, Illinois State Cancer Registry.



IV. Evaluation

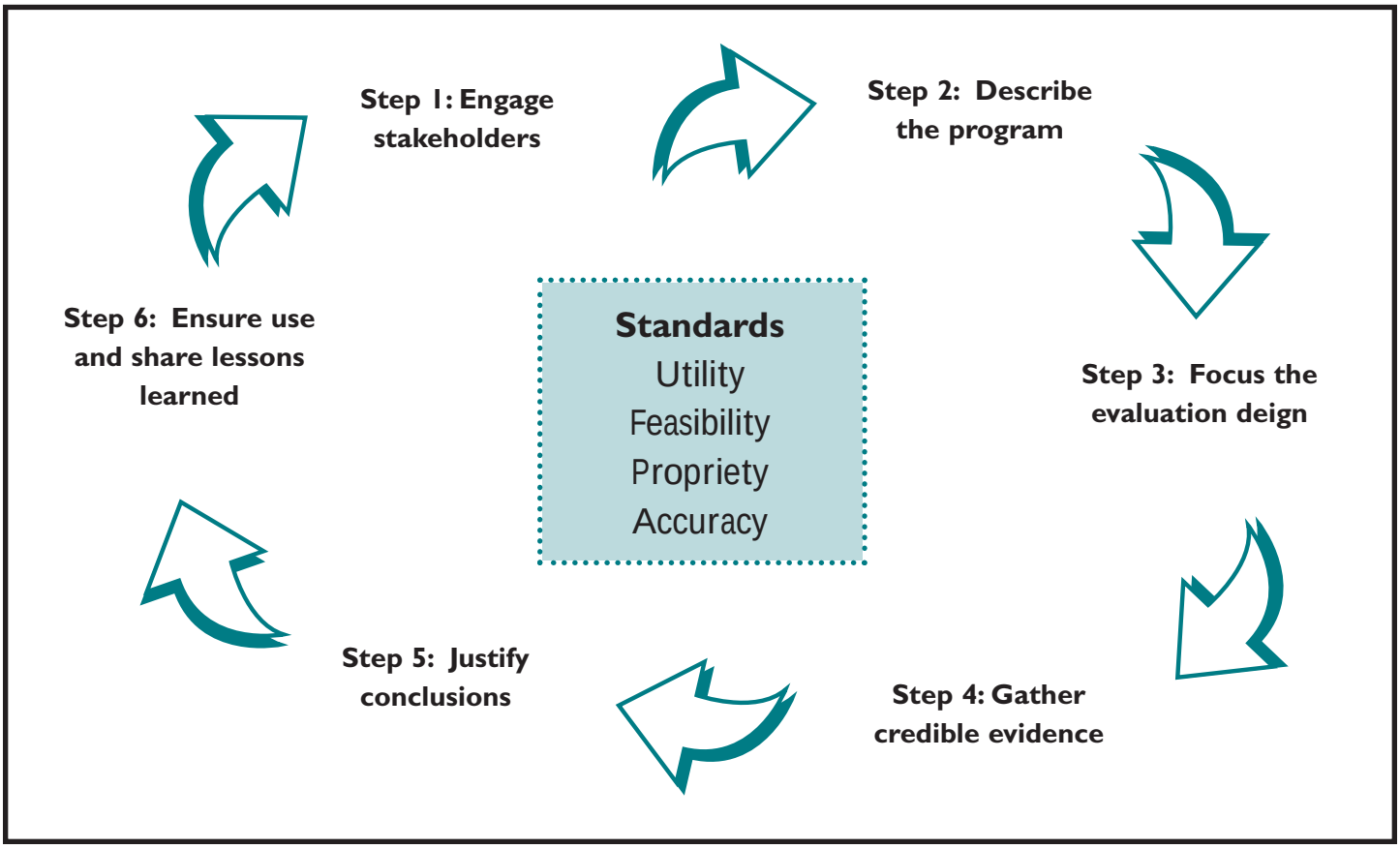
IV. Evaluation

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

Evaluation is a strategy for assessing the planning process, monitoring implementation, and measuring outcomes in place. The goal of program evaluation is to determine the effectiveness of the implementation strategies outlined in the State Plan. The evaluation activities described are directly related to the implementation of the State Plan and will evaluate both process and outcome measures. This technique will give a comprehensive picture of the impact of comprehensive cancer prevention and control activities in Illinois. The Illinois Partnership for Cancer Prevention and Control (IPCPC) and others will be involved with the implementation of state plan activities and will share responsibility of collecting and reporting data to verify the process and outcomes of the intervention strategies.

Figure 1 illustrates the U.S. Centers for Disease Control and Preventions (CDC) recommended framework for evaluating programs. CDC has outlined this framework for program evaluation to ensure that amidst the complex transition in public health, the program will remain accountable and committed to achieving measurable health outcomes[26]

Figure 1: Recommended Framework for Program Evaluation



Step 1: As the framework suggests, it is important to first establish and gain the interest of stakeholders or partners. These organizations or people have a vested interest in comprehensive cancer control and will be instrumental in the implementation of the outlined strategies. Partnerships increase the credibility and competence of the program.

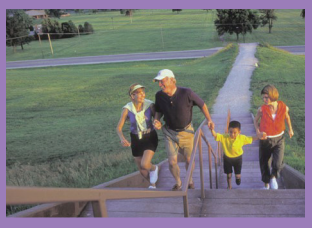
Step 2: Program descriptions convey the goals and objectives of the program being evaluated. Descriptions should be sufficiently detailed to ensure understanding of program goals and strategies. The description should discuss the program's capacity to affect change, its stage of development and how it fits into the larger organization and community. Program descriptions set the frame of reference for all subsequent decisions in an evaluation.

Step 3: The evaluation must be focused to assess the issues of greatest concern to stakeholders while using time and resources as efficiently as possible. Not all design options are equally well-suited to meeting the information needs of stakeholders. After data collection begins, changing procedures might be difficult or impossible, even if better methods become obvious. A thorough plan anticipates intended uses and creates an evaluation strategy with the greatest chance of being useful, feasible, ethical and accurate. Articulating an evaluation's purpose or intent will prevent premature decision-making regarding how the evaluation should be conducted.

Step 4: An evaluation should strive to collect information that will convey a well-rounded picture of the program so that the information is seen as credible by the evaluation's primary users. Information or evidence should be perceived by stakeholders as believable and relevant for answering their questions.

Step 5: The evaluation conclusions are justified when they are linked to the evidence gathered and judged against agreed-upon values or standards set by the stakeholders. Stakeholders must agree that conclusions are justified before they will use the evaluation results with confidence. Justifying conclusions on the basis of evidence includes standards, analysis and synthesis, interpretation, judgment and recommendations.

Step 6: Lessons learned in the course of an evaluation do not automatically translate into informed decision-making and appropriate action. Deliberate effort is needed to ensure that the evaluation processes and findings are used and disseminated appropriately. Preparing for use involves strategic thinking and continued vigilance, both of which begin in the earliest stages of stakeholder engagement and continue throughout the evaluation process.



V. Implementation

V. Implementation

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

This State Plan provides a framework for action and is the product of a statewide effort to identify the cancer-related strengths, weaknesses and needs in Illinois. Through the

dedicated work of the steering committee, goals and priorities have been identified. Based on these goals and priorities, this plan presents recommendations and strategies in support of a statewide public health approach for cancer prevention and control.

In order to achieve the goals outlined in the state plan, the strategies must be implemented. The state plan will serve to mobilize individuals, organizations, institutions and communities committed to fighting cancer. These groups can use this plan to select strategies for implementation consistent with their missions. Effective implementation of these diverse strategies will require an ongoing, coordinated and collaborative effort. All partners must embrace the state plan to make a true impact on cancer prevention and control in Illinois.

Recommendations:

- Begin implementation of selected strategies 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.

Potential Partners

Academic medical centers
American Cancer Society-Illinois Division (ACS)
American College of Surgeons (ACoS)
American Legacy Foundation
American Lung Association (ALA)
Asian and Pacific Islander Cancer Information
Association of Oncology Social Workers (AOSW)
Behavioral Risk Factor Surveillance System (BRFSS)
Business corporations
Cancer Registrars of Illinois
Chicago Area Cancer Registrars' Association
Clinics
Community groups
Community youth groups
Community-based organizations
Comprehensive cancer centers
Coordinated Approach to Child Health (CATCH)
Cultural-diversity programs
Educators/schools
Federally qualified health centers
Health care providers
Heart Smart for Women
Heart Smart for Teens
Hospices
Hospitals
Illinois Breast and Cervical Cancer Program
Illinois business associations
Illinois Chambers of Commerce
Illinois Coalition Against Tobacco
Illinois Department of Human Services
Illinois Department of Public Health
Illinois Hospital Association
Illinois medical schools
Illinois nursing schools
Illinois schools of public health
Illinois Prostate and Testicular Cancer Program
Illinois public and private schools
Illinois Rural Health Association
Illinois School Health Association
Illinois Schools of Social Work
Illinois Smoke-Free Restaurants
Illinois State Board of Education
Illinois State Cancer Registry
Illinois Tobacco Free Communities
Illinois WISEWOMAN Program
Intercultural Cancer Council
Lesbian Community Cancer Project of Chicago
Local chambers of commerce
Local health departments
Local media outlets
Low-literacy programs
Minority health organizations
Minority health professional groups
National Alliance for Hispanic Health
National Asian Women's Health Organization
National Black Leadership Initiative on Cancer
National Cancer Institute's Cancer Information Service (NCI's CIS)
National Cancer Institute designated cancer centers
North American Association of Central Cancer Registries (NAACCR)
IDPH - Office of Minority Health
IDPH - Center for Rural Health
Oncology Nursing Society
Prevention First Inc.
REALITY Illinois Chapters
Religious institutions/organizations
Service organizations
Stand Against Cancer
State chapters of health professional groups
Transit systems
U.S. Preventative Services Task Force
University of Illinois Extension
University/teachers in training
Y-ME Illinois

Appendix A: Examples of Evidence Based Interventions and Programs

Breast Cancer

Client Reminders

Client reminders advise people in the community or health care system that they are due or late for screening. Reminders can be in the form of letters, postcards or tele-

phone calls and the content of reminders varies. Reminders can also be tailored to fit the client's risk profile or other relevant characteristics, such as the individual's barriers to screening. The task force recommends client reminders to increase breast cancer screening on the basis of strong evidence of effectiveness.
(**Source:** Guide to Community Preventive Services)

Reducing Structural Barriers

Reducing structural barriers enables or facilitates client access to a preventive service (e.g., cancer screening) in a clinical or non-clinical setting through changes in such barriers as location, hours of operation, and availability of child care. These interventions are based on the premise that facilitating access to screening will increase demand for and use of these services. The task force recommends reducing structural barriers on the basis of strong evidence of effectiveness in increasing breast cancer screening.
(**Source:** Guide to Community Preventive Services)

Client Incentives With or Without Reminders

Client incentives are non-coercive rewards such as small amounts of money, coupons for retailers, or other gifts that motivate people to seek cancer screening for themselves or significant others. The task force recommends client-directed incentives combined with reminders on the basis of strong-evidence of effectiveness in increasing breast cancer screening.
(**Source:** Guide to Community Preventive Services)

Small Media (Tailored or Non-Tailored)

Small media interventions can include the use of brochures, flyers, newsletters, informational letters or videos and may or may not be tailored to fit the individual's risk profile. These interventions are based on the premise that dissemination or information about the benefits and availability of screening will motivate people to be screened for breast cancer. The task force recommends the use of small media (tailored or non-tailored) on the basis of strong-evidence of effectiveness in increasing screening for breast cancer.
(**Source:** Guide to Community Preventive Services)

One-on-One Education (Tailored or Non-Tailored)

The use of one-on-one education to promote cancer screening is based on the premise that dissemination of information about the benefits and availability of screening will motivate people to be screened. One-on-one education is defined as counseling by health care or allied health professionals (e.g., health educators) or by lay health advisors or volunteers. Clients receive the information by telephone or face-to-face in office or clinic settings, or homes or local gathering places. Counseling can be supplemented by the use of brochures, informational letters or reminders. The interventions can be tailored to address risks, questions or barriers relevant to the individual or not tailored. The task force recommends one-on-one education (tailored or non-tailored) on the basis of strong-evidence of effectiveness in increasing screening for breast cancer.
(**Source:** Guide to Community Preventive Services)

Reduced Client Costs

Reduced client cost interventions are based on the premise that lower costs will increase demand for and use of screening services. Client costs for cancer screening can be reduced by paying for the screening tests, their administration, or both; by providing insurance coverage; by reducing co-payments for services; by reimbursing the client or the screening site for services rendered; or any combination of these approaches. The task force recommends the use of reduced client costs on the basis of sufficient evidence of effectiveness in increasing breast cancer screening.
(**Source:** Guide to Community Preventive Services)

Multi-component Interventions that include Media, Education and Enhanced Access

The use of mass media to increase cancer screening is almost always applied in the context of broader community programs that include small media (e.g., brochures, posters, or newsletters), either a small group or one-on-one educational component and, usually, an access-enhancing measure (removal of financial or structural barrier). Use of multi-component interventions that include media, education and enhanced access is based on the premise that providing information about benefits and availability will increase demand for cancer screening and, along with making services more accessible by removing financial or structural barriers, will promote higher screening rates. The task force recommends multi-component interventions that include media, education and enhanced access on the basis of strong evidence of effectiveness in increasing screening for breast cancer.
(**Source:** Guide to Community Preventive Services)

Breast Cancer Screening Among Non-Adherent Women

Delivery Channel: Individual-directed intervention
Purpose: Designed to address barriers to mammography screening and to identify strategies for motivating women to have regular mammograms.
Behavioral Focus: Motivation
Population Focus: Under-screened women
Program materials can be found at: http://cancercontrol.cancer.gov/rtips/index.asp
(**Source:** Research-Tested Intervention Programs, National Cancer Institute)

Empowering Physicians to Improve Breast Cancer Screening

Delivery Channel: Multi-strategy intervention
Purpose: Physician-based educational curriculum designed to increase physicians' efforts to encourage women to receive regular mammograms.
Behavioral Focus: Awareness building
Population Focus: Primary care physicians
Program materials can be found at: http://cancercontrol.cancer.gov/rtips/index.asp
(**Source:** Research-Tested Intervention Programs, National Cancer Institute)

Friend to Friend

Delivery Channel: Social network intervention
Purpose: Community-based intervention designed to increase mammography utilization among low-income women residing in public housing.
Behavioral Focus: Awareness building
Population Focus: Underserved
Program materials can be found at: http://cancercontrol.cancer.gov/rtips/index.asp
(**Source:** Research-Tested Intervention Programs, National Cancer Institute)

Increasing Breast and Cervical Cancer Screening Among Filipino-American Women

Delivery Channel: Small group education
Purpose: Designed to increase breast and cervical cancer screening among Filipino-American women.
Behavioral Focus: Awareness building
Population Focus: Underserved
Program materials can be found at: http://cancercontrol.cancer.gov/rtips/index.asp
(**Source:** Research-Tested Intervention Programs, National Cancer Institute)

Maximizing Mammography Participation
Delivery Channel: Individual-directed intervention
Purpose: Designed to increase breast cancer screening by encouraging women to schedule and keep mammogram appointments.
Behavioral Focus: Motivation
Population Focus: Women with no history of breast cancer.
Program materials can be found at: http://cancercontrol.cancer.gov/rtips/index.asp
(**Source:** Research-Tested Intervention Programs, National Cancer Institute)

Reducing Barriers to the Use of Breast Cancer Screening
Delivery Channel: Individual-directed intervention
Purpose: The physician intervention aims to increase the breast cancer screening practices of community-based physicians.
Behavioral Focus: Awareness building
Population Focus: Primary care physicians
Program materials can be found at: http://cancercontrol.cancer.gov/rtips/index.asp
(**Source:** Research-Tested Intervention Programs, National Cancer Institute)

Targeted Mailing: Increasing Mammogram Screening Among the Elderly
Delivery Channel: Individual-directed intervention
Purpose: Designed to increase awareness about low-cost mammography screening options, including the Medicare benefit for diverse racial/ethnic groups of elderly women.
Behavioral Focus: Awareness building
Population Focus: Medicare beneficiaries
Program materials can be found at: http://cancercontrol.cancer.gov/rtips/index.asp
(**Source:** Research-Tested Intervention Programs, National Cancer Institute)

The Forsyth County Cancer Screening Project (FoCaS)
Delivery Channel: Multi-strategy intervention
Purpose: Designed to improve the beliefs, attitudes and behaviors regarding breast and cervical cancer screening among low-income, predominately black women age 40 and older.
Behavioral Focus: Awareness building
Population Focus: Underserved
Program materials can be found at: http://cancercontrol.cancer.gov/rtips/index.asp
(**Source:** Research-Tested Intervention Programs, National Cancer Institute)

Cervical Cancer

Client Reminders
Client reminders advise people in the community or health care system that they are due or late for screening. Reminders can be in the form of letters, postcards or telephone calls and the content of reminders varies. Reminders also can be tailored to fit the client's risk profile or other relevant characteristics, such as the individual's barriers to screening. The task force recommends client reminders to increase cervical cancer screening on the basis of strong evidence of effectiveness.
(**Source:** Guide to Community Preventive Services)

Multi-component Interventions that include Media, Education and Enhanced Access
The use of mass media to increase cancer screening is almost always applied in the context of broader community programs that include small media (e.g., brochures, posters or newsletters), either a small group or one-on-one educational component and, usually, an access-enhancing measure (removal of financial or structural barrier). Use of multi-component interventions that include media, education, and enhanced access is based on the premise that providing information about benefits and availability will increase demand for cancer screening and, along with making services more accessible by removing financial or structural barriers, will promote higher screening rates. The task force recommends multi-component interventions that include media, education and enhanced access on the basis of strong evidence of effectiveness in increasing screening for cervical cancer.
(**Source:** Guide to Community Preventive Services)

Increasing Breast and Cervical Cancer Screening Among Filipino-American Women

Delivery Channel: Small group education

Purpose: Designed to increase breast and cervical cancer screening among Filipino-American women.

Behavioral Focus: Awareness building

Population Focus: Underserved

Program materials can be found at: http://cancercontrol.cancer.gov/rtips/index.asp

(**Source:** Research-Tested Intervention Programs, National Cancer Institute)

The Forsyth County Cancer Screening Project (FoCaS)

Delivery Channel: Multi-strategy intervention

Purpose: Designed to improve the beliefs, attitudes, and behaviors regarding breast and cervical cancer screening among low-income, predominately black women age 40 and older.

Behavioral Focus: Awareness building

Population Focus: Underserved

Program materials can be found at: http://cancercontrol.cancer.gov/rtips/index.asp

(**Source:** Research-Tested Intervention Programs, National Cancer Institute)

Cambodian Women's Health Project

Delivery Channel: Small group education

Purpose: Designed to increase cervical cancer screening among Cambodian-American women.

Behavioral Focus: Awareness building

Population Focus: Under-screened women

Program materials can be found at: http://cancercontrol.cancer.gov/rtips/index.asp

(**Source:** Research-Tested Intervention Programs, National Cancer Institute)

The Chinese Women's Health Project

Delivery Channel: Individual-directed intervention

Purpose: Designed to decrease the incidence of invasive cervical cancer among Chinese women by increasing the frequency and regularity of Pap testing.

Behavioral Focus: Motivation

Population Focus: Under-screened women

Program materials can be found at: http://cancercontrol.cancer.gov/rtips/index.asp

(**Source:** Research-Tested Intervention Programs, National Cancer Institute)

Colorectal Cancer

Client Reminders

Client reminders advise people in communities or health care systems that they are due or late for screening. Reminders can be in the form of letters, postcards or telephone calls. Reminders can also be tailored to fit the client's risk profile or other relevant characteristics, such as the individual's barriers to screening. The task force recommends client reminders to increase colorectal cancer screening on the basis of sufficient evidence of effectiveness.

(**Source:** Guide to Community Preventive Services)

Reducing Structural Barriers

Reducing structural barriers enables or facilitates client access to a preventive service (e.g., cancer screening) in a clinical or non-clinical setting through changes in such barriers as location, hours of operation, and availability of child care. These interventions are based on the premise that facilitating access to screening will increase demand for and use of these services. The task force recommends reducing structural barriers on the basis of strong evidence of effectiveness in increasing screening for colorectal cancer.

(**Source:** Guide to Community Preventive Services)

Physician-Oriented Intervention on Follow-Up in Colorectal Cancer Screening

Delivery Channel: Physician-directed intervention

Purpose: Designed to increase physician recommendation and performance of complete diagnostic evaluation screenings for individuals aged 50 years and older and with an abnormal colorectal cancer screening result.

Behavioral Focus: Increase Physician Awareness

Population Focus: Primary Care Physicians

Program materials can be found at: http://cancercontrol.cancer.gov/rtips/index.asp

(**Source:** Research Tested Intervention Programs, National Cancer Institute)

The Next Step: Worksite Cancer Screening and Nutrition Intervention for High-Risk Auto Workers

Delivery Channel: Small group education

Purpose: Worksite program designed to increase colorectal cancer screening and promote health dietary behaviors.

Behavioral Focus: Awareness Building and Behavior Modification

Population Focus: Employees

Program materials can be found at: http://cancercontrol.cancer.gov/rtips/index.asp

(**Source:** Research Tested Intervention Programs, National Cancer Institute)

Nutrition

5-A-Day Peer Education Program

Delivery Channel: Small group education

Purpose: Worksite program designed to increase fruit and vegetable consumption.

Behavioral Focus: Dietary change

Population Focus: Current workers

Program materials can be found at: http://cancercontrol.cancer.gov/rtips/index.asp

(**Source:** Research-Tested Intervention Programs, National Cancer Institute)

5-A-Day Power Plus

Delivery Channel: Family and school-based social support

Purpose: School-based program designed to increase fruit and vegetable consumption.

Behavioral Focus: Dietary change

Population Focus: Elementary school children

Program materials can be found at: http://cancercontrol.cancer.gov/rtips/index.asp

(**Source:** Research-Tested Intervention Programs, National Cancer Institute)

Body & Soul

Delivery Channel: Community-based intervention

Purpose: Community-based program designed to increase fruit and vegetable consumption.

Behavioral Focus: Behavior modification

Population Focus: Black church attendees

Program materials can be found at: http://cancercontrol.cancer.gov/rtips/index.asp

(**Source:** Research-Tested Intervention Programs, National Cancer Institute)

Coordinated Approach to Child Health (CATCH)

Delivery Channel: Family and community-based social support

Purpose: Designed to promote healthy eating habits and increase physical activity among children and adolescents.

Behavioral Focus: Physical activity and dietary change.

Population Focus: Elementary school children

Program materials can be found at: http://cancercontrol.cancer.gov/rtips/index.asp

(**Source:** Research-Tested Intervention Programs, National Cancer Institute)

Eat Well and Keep Moving

Delivery Channel: School-based intervention

Purpose: School-based program designed to increase physical activity and promote healthy dietary habits among fourth and fifth grade students.

Behavioral Focus: Behavior modification

Population Focus: Elementary school children

Program materials can be found at: http://cancercontrol.cancer.gov/rtips/index.asp

(**Source:** Research-Tested Intervention Programs, National Cancer Institute)

Eat for Life
Delivery Channel: Community-based intervention
Purpose: Community-based program designed to promote healthy dietary habits.
Behavioral Focus: Behavior modification
Population Focus: Church attendees
Program materials can be found at: http://cancercontrol.cancer.gov/rtips/index.asp
(**Source:** Research-Tested Intervention Programs, National Cancer Institute)

Gimme 5
Delivery Channel: Family and community-based social support
Purpose: School-based program designed to increase fruit and vegetable consumption.
Behavioral Focus: Dietary change
Population Focus: Elementary school children
Program materials can be found at: http://cancercontrol.cancer.gov/rtips/index.asp
(**Source:** Research-Tested Intervention Programs, National Cancer Institute)

High 5 Fruit and Vegetable Intervention for Fourth Graders
Delivery Channel: Family and school-based social support
Purpose: School-based program designed to increase fruit and vegetable consumption.
Behavioral Focus: Dietary change
Population Focus: Elementary school children
P**rogram materials can be found at:** http://cancercontrol.cancer.gov/rtips/index.asp
(**Source:** Research-Tested Intervention Programs, National Cancer Institute)

Native FACETS
Delivery Channel: Small group education
Purpose: Designed to examine cancer risk among Native Americans through tobacco use prevention and dietary modification.
Behavioral Focus: Tobacco prevention and dietary change
Population Focus: Student non-smokers
Program materials can be found at: http://cancercontrol.cancer.gov/rtips/index.asp
(**Source:** Research-Tested Intervention Programs, National Cancer Institute)

North Carolina Black Churches United for Better Health Project
Delivery Channel: Community-based intervention
Purpose: Designed to increase fruit and vegetable consumption.
Behavioral Focus: Dietary change
Population Focus: Underserved
Program materials can be found at: http://cancercontrol.cancer.gov/rtips/index.asp
(**Source:** Research-Tested Intervention Programs, National Cancer Institute)

Planet Health
Delivery Channel: School-based intervention
Purpose: School-based program designed to increase physical activity and promote healthy dietary habits among sixth, seventh and eighth grade students.
Behavioral Focus: Behavior modification
Population Focus: Middle-school children
Program materials can be found at: http://cancercontrol.cancer.gov/rtips/index.asp
(**Source:** Research-Tested Intervention Programs, National Cancer Institute)

Seattle 5-A-Day Program
Delivery Channel: Family and community-based social support
Purpose: Worksite program designed to increase fruit and vegetable consumption.
Behavioral Focus: Dietary change
Population Focus: Employees
Program materials can be found at: http://cancercontrol.cancer.gov/rtips/index.asp
(**Source:** Research-Tested Intervention Programs, National Cancer Institute)

Teens Eating for Energy and Nutrition at School (TEENS)

Delivery Channel: School-based intervention

Purpose: School-based program designed to increase fruit and vegetable consumption and to promote healthy dietary habits.

Behavioral Focus: Behavior modification

Population Focus: Middle school children

Program materials can be found at: http://cancercontrol.cancer.gov/rtips/index.asp

(**Source:** Research-Tested Intervention Programs, National Cancer Institute)

The Next Step: Worksite Cancer Screening and Nutrition Intervention for High Risk Auto Workers

Delivery Channel: Small group education

Purpose: Worksite program designed to increase colorectal cancer screening and promote healthy dietary behaviors.

Behavioral Focus: Awareness building and behavior modification

Population Focus: Employees

Program materials can be found at: http://cancercontrol.cancer.gov/rtips/index.asp

(**Source:** Research-Tested Intervention Programs, National Cancer Institute)

The Treatwell 5-A-Day Program

Delivery Channel: Family and community-based social support

Purpose: Worksite program designed to increase fruit and vegetable consumption.

Behavioral Focus: Dietary change

Population Focus: Employees

Program materials can be found at: http://cancercontrol.cancer.gov/rtips/index.asp

(**Source:** Research-Tested Intervention Programs, National Cancer Institute)

Physical Activity

Community-Wide Campaigns

These interventions are large-scale, intense, highly visible, community-wide campaigns with messages directed to large audiences through different types of media, including television, radio, newspapers, movie theaters, billboards and mailings. The campaigns are typically conducted as part of a multi-component effort that also include strategies, such as support or self-help groups, physical activity counseling, risk factor screening and education, community health fairs and other community events, and environmental or policy changes such as the creation of walking trails. Community-wide campaigns are effective in getting people to be more physically active. The task force recommends this strategy be implemented based on strong evidence of effectiveness. (**Source:** Guide to Community Preventive Services)

Point-of-Decision Prompts to Encourage People to Use Stairs

Point-of-decision prompts are signs placed by elevators and escalators that encourage people to use nearby stairs for health benefits and weight loss. These signs tell people about a health benefit from taking the stairs and/or remind people who already want to be more active that an opportunity to do so is at hand. Point-of-decision prompts that encourage people to use the stairs instead of elevators or escalators are effective in getting people to be more physically active. The task force recommends this strategy be implemented based on sufficient evidence of effectiveness. "How to" materials including downloadable signs can be found at http://www.cdc.gov/nccdphp/dnpa/stairwell/index.htm

(**Source:** Guide to Community Preventive Services)

Enhanced Physical Education Classes in Schools

To increase the amount of time students spend doing moderate or vigorous activity in physical education class, these programs seek to change physical education curricula by making classes longer or having students be more active during class. Intervention include changing the activities taught (e.g., substituting soccer for softball) or modifying the rules of the game so that students are more active (e.g., in softball, have the entire team run the bases together when the batter makes a base hit). Physical education classes taught in schools which enhance the length or activity levels are effective in improving both physical activity levels and physical fitness among school-age children. The task force recommends this strategy be implemented based on strong evidence of effectiveness.

(**Source:** Guide to Community Preventive Services)

Providing Social Support in Community Settings

These interventions focus on changing physical activity behavior through building, strengthening and maintaining social networks that provide supportive relationships for behavior change (e.g., setting up a buddy system, making contracts with others to complete specified levels of physical activity, setting up walking groups or other groups to provide friendship and support). Interventions include either creating new social networks or working with existing networks in a social setting outside the family, such as in the workplace. Efforts made in community settings to provide social support for increasing physical activity are effective. The task force recommends this strategy be implemented based on strong evidence of effectiveness.
(**Source:** Guide to Community Preventive Services)

Health Behavior Change Programs Adapted for Individual Needs

Individually-adapted health behavior change programs teach behavioral skills to help participants incorporate physical activity into their daily routines. The programs are tailored to each individual's specific interests, preferences and readiness for change. These programs teach behavioral skills such as goal-setting and self-monitoring of progress toward those goals, building social support for new behaviors, behavioral reinforcement through self-reward and positive self-talk, structured problem solving to maintain the behavior change and prevention of relapse into sedentary behavior. Interventions are delivered to people in either group settings or by mail, telephone or directed media. Individually adapted health behavior change programs are effective in getting people to be more physically active. The task force recommends implementing this strategy based on strong evidence of effectiveness.
(**Source:** Guide to Community Preventive Services)

Creating or Improving Access to Places for Physical Activity

These interventions involve the efforts of worksites, coalitions, agencies and communities in attempts to change the local environment to create opportunities for physical activity. Such changes include creating walking trails, building exercise facilities or providing access to existing nearby facilities. People will become more physically active in response to the creation of or improved access to places for physical activity, combined with distribution of information. The task force recommends implementing this strategy based on strong evidence of effectiveness.
(**Source:** Guide to Community Preventive Services)

Worksite Programs Combining Nutrition and Physical Activity

These interventions use various combinations of activities and support, such as didactic nutrition education; prescriptions for aerobic/strength training exercise; training in behavioral techniques; and providing self-help materials, specific dietary prescriptions and group or supervised exercise sessions. All interventions are multi-component. Interventions in the worksite that combine nutrition and physical activity are effective in helping employees lose weight and keep it off in the short term. The task force recommends implementing this strategy based on sufficient evidence.
(**Source:** Guide to Community Preventive Services)

Aerobic Exercise Versus Spinal Flexibility + Aerobic Exercise for Sedentary & Functionally Limited Adults

Delivery Channel: Community-based intervention
Purpose: Designed to enhance spinal flexibility and improve physical functioning for older adults.
Behavioral Focus: Disease prevention
Population Focus: Sedentary individuals
Program materials can be found at: http://cancercontrol.cancer.gov/rtips/index.asp
(**Source:** Research-Tested Intervention Programs, National Cancer Institute)

Commit to Quit

Delivery Channel: Small group education
Purpose: Designed to test the efficacy of vigorous-intensity physical activity as an aid for smoking cessation for women.
Behavioral Focus: Behavior modification
Population Focus: Current smokers
Program materials can be found at: http://cancercontrol.cancer.gov/rtips/index.asp
(**Source:** Research-Tested Intervention Programs, National Cancer Institute)

Community Healthy Activities Model Program for Seniors (CHAMPS)

Delivery Channel: Community-based intervention

Purpose: Designed to increase physical activity among sedentary individuals.

Behavioral Focus: Awareness building and behavior modification

Population Focus: Sedentary individuals

Program materials can be found at: http://cancercontrol.cancer.gov/rtips/index.asp

(**Source:** Research-Tested Intervention Programs, National Cancer Institute)

Coordinated Approach to Child Health (CATCH)

Delivery Channel: Family and community-based social support

Purpose: Designed to promote healthy eating habits and increase physical activity among children and adolescents.

Behavioral Focus: Physical activity and dietary change.

Population Focus: Elementary school children

Program materials can be found at: http://cancercontrol.cancer.gov/rtips/index.asp

(**Source:** Research-Tested Intervention Programs, National Cancer Institute)

Eat Well and Keep Moving

Delivery Channel: School-based intervention

Purpose: School-based program designed to increase physical activity and promote healthy dietary habits among fourth and fifth grade students.

Behavioral Focus: Behavior modification

Population Focus: Elementary school children

Program materials can be found at: http://cancercontrol.cancer.gov/rtips/index.asp

(**Source:** Research-Tested Intervention Programs, National Cancer Institute)

Exercise and Physical Functional Performance in Independent Older Adults

Delivery Channel: Community-based intervention

Purpose: Designed to enhance body endurance and body strength among older adults.

Behavioral Focus: Self-efficacy

Population Focus: Sedentary individuals

Program materials can be found at: http://cancercontrol.cancer.gov/rtips/index.asp

(**Source:** Research-Tested Intervention Programs, National Cancer Institute)

Patient-Centered Assessment and Counseling for Exercise and Nutrition (PACE)

Delivery Channel: Physician-directed intervention

Purpose: Designed to increase physical activity among sedentary individuals.

Behavioral Focus: Awareness building and behavior modification

Population Focus: Sedentary individuals

Program materials can be found at: http://cancercontrol.cancer.gov/rtips/index.asp

(**Source:** Research-Tested Intervention Programs, National Cancer Institute)

Physically Active for Life (PAL)

Delivery Channel: Physician-directed intervention

Purpose: Designed to increase physical activity among adults 50 years of age and older.

Behavioral Focus: Awareness building and behavior modification

Population Focus: Sedentary individuals

Program materials can be found at: http://cancercontrol.cancer.gov/rtips/index.asp

(**Source:** Research-Tested Intervention Programs, National Cancer Institute)

Planet Health

Delivery Channel: School-based intervention

Purpose: School-based program designed to increase physical activity and promote healthy dietary habits among sixth, seventh and eighth grade students.

Behavioral Focus: Behavior modification

Population Focus: Middle-school children

Program materials can be found at: http://cancercontrol.cancer.gov/rtips/index.asp

(**Source:** Research-Tested Intervention Programs, National Cancer Institute)

Prostate Cancer

The PSA Test for Prostate Cancer: Is it Right for Me?

Delivery Channel: Individual-directed intervention

Purpose: Designed to enhance knowledge and increase patient participation in the decision making process for prostate cancer screening.

Behavioral Focus: Awareness building and behavior modification

Population Focus: Men considering prostate cancer screening

Program materials can be found at: http://cancercontrol.cancer.gov/rtips/index.asp

(**Source:** Research-Tested Intervention Programs, National Cancer Institute)

Skin Cancer

Reducing Exposure to UV Light Through Educational and Policy Approaches in Recreational or Tourism Settings

Educational and policy approaches in recreational or tourism settings, such as pools or parks, are effective in improving adults "covering up" behavior wearing protective clothing, such as a shirt, long pants and hat. The task force recommends this strategy be implemented on the basis of sufficient evidence of effectiveness.

(**Source:** Guide to Community Preventive Services)

Educational and Policy Approaches in Primary Schools to Decrease UV Exposure

Educational and policy approaches in primary schools are effective in improving children's "covering up" behavior (i.e., wearing protective clothing, such as a shirt, long pants and hat). Interventions in primary school settings were designed to increase sun-protective knowledge, attitudes, intentions and behavior among children from kindergarten through eighth grade. Interventions focused on some combination of increasing application of sunscreen, scheduling activities to avoid peak sun hours, increasing availability of shade and encouraging children to play in shady areas, and encouraging children to wear sun-protective clothing and included in at least one of following activities:

- Provision of information to children (e.g., instruction or small media).
- Additional activities to influence children's behavior (e.g., modeling, demonstration, role-playing).
- Activities intended to change the knowledge, attitudes or behavior or caregivers (i.e., teachers or parents).
- Environmental or policy approaches (e.g., provision of sunscreen or shade, or scheduling outdoor activities to avoid hours of peak sunlight).

The task force recommends these strategies be implemented on the basis of sufficient evidence of effectiveness.

(**Source:** Community Guide to Preventive Services)

Sun Safe
Delivery Channel: Multi-strategy intervention
Purpose: Designed to enhance and promote sun protective behaviors.
Behavioral Focus: Awareness building
Population Focus: Sun-exposed children
Program materials can be found at: http://cancercontrol.cancer.gov/rtips/index.asp
(**Source:** Research-Tested Intervention Programs, National Cancer Institute)

Sunny Days Healthy Ways
Delivery Channel: Policy and advocacy
Purpose: Designed to motivate sun protection behavior and reduce sun exposure.
Behavioral Focus: Awareness building
Population Focus: Sun-exposed children
Program materials can be found at: http://cancercontrol.cancer.gov/rtips/index.asp
(**Source:** Research-Tested Intervention Programs, National Cancer Institute)

Together for Sun Safety
Delivery Channel: Family-based intervention
Purpose: Designed to motivate sun protection behavior and reduce sun exposure.
Behavioral Focus: Awareness building and behavior modification
Population Focus: Sun-exposed children
Program materials can be found at: http://cancercontrol.cancer.gov/rtips/index.asp
(**Source:** Research-Tested Intervention Programs, National Cancer Institute)

Tobacco

Smoking Bans and Restrictions to Reduce Exposure to Environmental Tobacco Smoke (ETS)
Smoking bans and restrictions are policies, regulations and laws that limit smoking in workplaces and other public areas. Smoking bans prohibit smoking entirely; smoking restrictions limit smoking to designated areas. Smoking bans and restrictions are effective in reducing exposure to ETS. The task force recommends this strategy be implemented on the basis of strong evidence of effectiveness.
(**Source:** Guide to Community Preventive Services)

Increasing the Unit Price for Tobacco Products
The unit price for tobacco products can be increased by raising the product excise tax, through legislation at the local, state or national level. In several states, excise tax increases have provided revenue for comprehensive tobacco use prevention and control programs. Interventions to increase the unit price for tobacco products are effective both in reducing the number of people who start using tobacco and in increasing the number who quit. The task force recommends this strategy be implemented on the basis of strong evidence of effectiveness.
(**Source:** Guide to Community Preventive Services)

Mass Media Campaigns
Messages are developed through formative research, and use broadcast messages on television and radio, although other formats, such as billboards, print media and movies, have been used. Campaigns are conducted over long periods of time and employ brief, recurring messages to inform and motivate individuals to quit or remain tobacco-free. The task force recommends this strategy be implemented on the basis of strong evidence of effectiveness.
(**Source:** Guide to Community Preventive Services)

Health Care Providers Who Advise Patients Using Tobacco to Quit
Provider reminders involve efforts to identify patients who use tobacco products and to prompt health care providers to discuss with these patients the importance of quitting. Providers receive these reminders through stickers on patients' charts, vital sign stamps, medical record flow sheets, checklists and by computer. Provider reminders are often combined with other approaches. When health care systems remind providers to counsel their patients about quitting tobacco use, more patients quit. The task force recommends this strategy be implemented on the basis of sufficient evidence of effectiveness.
(**Source:** Guide to Community Preventive Services)

Provider Reminders with Provider Education, With or Without Patient Education

Efforts to increase the number of people who stop using tobacco include prompting health care providers to identify and to discuss with tobacco-using patients the importance of quitting ("provider reminder"), an education program for providers, so that they can help their patients quit tobacco use ("provider education"), and self-help materials for patients interested in quitting ("patient education"). Approaches used by health care systems, where patients who use tobacco are identified for providers and where providers received information to help them help their patients understand the risks and dangers posed by tobacco use, are effective in increasing both delivery by providers of advice to quit and the number of patients who do quit. The task force recommends this strategy be implemented on the basis of strong evidence of effectiveness.

(**Source:** Community Guide to Preventive Services)

Reducing Patient Out-of-Pocket Costs for Effective Therapies to Stop Using Tobacco

Reducing out-of-pocket costs is effective in increasing the use of effective cessation therapies, increasing the number of people who attempt to quit and increasing the number of people who quit successfully. These programs include efforts to reduce the financial barriers that may stop patients from using cessation therapies. Techniques include providing the services within the health care system, or providing coverage for reimbursement of patients for expenditures on cessation groups, or nicotine replacement or other pharmacologic therapies. Programs to reduce out-of-pocket costs, conducted by health care systems, are effective both in increasing use of cessation therapies and in increasing the number of people who stop using tobacco. The task force recommends this strategy be implemented on the basis of sufficient evidence of effectiveness.

(**Source:** Community Guide to Preventive Services)

Multi-component Telephone Counseling and Support

These programs are organized efforts to help tobacco users quit and not start using tobacco again. They provide one or more sessions of counseling or assistance, usually delivered by trained counselors or health care providers. Help is delivered in one of two ways: either the tobacco users' places a call requesting help, or the professional guiding the effort to quit calls the user to offer help or returns a call from a user who requested help. These telephone sessions, which usually follow a standardized approach to providing advice and counseling, are often combined with other efforts, such as distribution of materials about quitting, formal individual or group counseling, or nicotine replacement therapies. Providing counseling and support to patients by telephone, when included as one component of a multi-component strategy to help smokers quit, is effective in increasing the number of smokers who succeed. The task force recommends this strategy be implemented on the basis of strong evidence of effectiveness.

(**Source:** Community Guide to Preventive Services)

Clear Horizons
Delivery Channel: Self-help guide
Purpose: Self-help guide and telephone counseling protocol specifically tailored for the smoking habits, quitting needs and lifestyles of older smokers.
Behavioral Focus: Smoking cessation
Population Focus: Current smokers
Program materials can be found at: http://cancercontrol.cancer.gov/rtips/index.asp
(**Source:** Research-Tested Intervention Programs, National Cancer Institute)

Commit to Quit
Delivery Channel: Small group education
Purpose: Designed to test the efficacy of vigorous-intensity physical activity as an aid for smoking cessation for women.
Behavioral Focus: Behavior modification
Population Focus: Current smokers
Program materials can be found at: http://cancercontrol.cancer.gov/rtips/index.asp
(**Source:** Research-Tested Intervention Programs, National Cancer Institute)

Enhancing Tobacco Control Policies in Northwest Indian Tribes
Delivery Channel: Policy and advocacy
Purpose: Designed to change tobacco-use policies at the community level.
Behavioral Focus: Smoke-free environment
Population Focus: Current smokers
Program materials can be found at: http://cancercontrol.cancer.gov/rtips/index.asp
(**Source:** Research-Tested Intervention Programs, National Cancer Institute)

Enough Snuff
Delivery Channel: Self-help guide
Purpose: Self-help cessation manual specialized for smokeless tobacco users.
Behavioral Focus: Smoking cessation
Population Focus: Current smokers
Program materials can be found at: http://cancercontrol.cancer.gov/rtips/index.asp
(**Source:** Research-Tested Intervention Programs, National Cancer Institute)

Forever Free
Delivery Channel: Self-help guide
Purpose: Designed to test relapse-prevention materials with self-quitters as compared to a more formal treatment program.
Behavioral Focus: Smoking relapse
Population Focus: Former smokers
Program materials can be found at: http://cancercontrol.cancer.gov/rtips/index.asp
(**Source:** Research-Tested Intervention Programs, National Cancer Institute)

Lifeskills Training
Delivery Channel: Small group education
Purpose: Emphasizes personal and social skills development related to general life skills and substance abuse.
Behavioral Focus: Smoking prevention
Population Focus: Non-smokers
Program materials can be found at: http://cancercontrol.cancer.gov/rtips/index.asp
(**Source:** Research-Tested Intervention Programs, National Cancer Institute)

Native FACETS
Delivery Channel: Small group education
Purpose: Designed to examine cancer risk among Native Americans through tobacco use prevention and dietary modification.
Behavioral Focus: Tobacco prevention and dietary change
Population Focus: Student non-smokers
Program materials can be found at: http://cancercontrol.cancer.gov/rtips/index.asp
(**Source:** Research-Tested Intervention Programs, National Cancer Institute)

Appendix B: Cancer-Related Illinois Public Acts

PUBLIC ACTS		
94-0119	**Effective: 01/01/2006**	The Penny Severns Breast, Cervical and Ovarian Cancer Research Fund. Addition of ovarian cancer to the Penny Severns Breast and Cervical Cancer Research Fund.
94-0120	**Effective: 07/06/2005**	Ticket for the Cure. Lottery instant scratch off ticket funds for grants to public or private entities in Illinois for the purpose of funding research concerning breast cancer and for funding services for breast cancer victims.
94-0121	**Effective: 07/06/2005**	Insurance; mammograms. Medical necessity mammograms for women under the age of 40 having a family history of breast cancer or other risk factors to be covered by insurance.
94-0122	**Effective: 01/01/2006**	Insurance; Pap tests. Annual exams and tests to be covered by insurance for women at risk for ovarian cancer.
94-0142	**Effective: 01/01/2006**	Colon Cancer Awareness Campaign. State Sen. Vince Demuzio Memorial Colon Cancer Fund. Creates a colon cancer charitable contribution line on state income tax form to help fund a public awareness campaign to target areas in Illinois with high colon cancer mortality rates.
94-0467	**Effective: 01/01/2006**	Children's Environmental Health Officer Act. The Illinois Department of Public Health shall create and maintain a Children's Environmental Health Officer within the Office of Health Protection.
94-0545	**Effective: 01/01/2006**	The Department of Public Health Powers and Duties Law: Information will be available to the public on the Illinois Department of Public Health Web site about ongoing clinical trials and the results of completed clinical studies, including those sponsored by the National Institutes of Health, academic researchers and the private sector.
94-0649	**Effective: 08/22/2005**	Illinois Brain Tumor Research Fund. Creates a charitable contribution line for grants to public and private entities for the purpose of research dedicated to the elimination of brain tumors.

93-0122	**Effective: 01/01/2004**	Prostate Cancer Screening programs to include public service announcements that publicize the importance of prostate cancer screening to men over age 40.
93-0284	**Effective: 01/01/2004**	The Sale of Tobacco to Minors Act--amended. Prohibits sale of tobacco products within 1,000 feet of any public or private elementary or secondary school grounds by vending machine or "lunch wagon" (mobile vehicle designated to transport food).
93-0324	**Effective: 07/23/2003**	Leukemia Treatment and Education Fund. Leukemia, lymphoma and myeloma grants available to public and private hospitals, medical centers, medical schools and other organizations for education on the treatment of leukemia, lymphoma and myeloma.[1]
93-0564	**Effective: 01/01/2004**	The Language Assistance Services Act. To insure access to health care information and services for limited-English-speaking or non-English-speaking residents and deaf residents. The Illinois Department of Public Health will maintain a complaint system of health facilities in violations of this Act.
93-0568	**Effective: 01/01/2004**	Insurance; colorectal cancer. Amendment to the Illinois Insurance Code to include colorectal cancer examination and screening to be covered by insurance.
93-0886	**Effective: 01/01/2005**	No minor under 16 years of age may sell any cigar, cigarette, smokeless tobacco or tobacco in any of its forms at a retail establishment selling tobacco products. Does not apply to a sales clerk in a family-owned business that can prove that the sales clerk is in fact a son or daughter of the owner.
93-0956	**Effective: 08/19/2004**	Cervical Cancer Elimination Task Force. Requires the task force to examine the prevalence and burden, raise public awareness concerning the causes and nature of cervical cancer, identify prevention and control strategies and technologies, and perform other functions.
93-0973	**Effective: 07/01/04**	The Health Care Justice Act. To insure that all residents have access to quality health care at all costs that is affordable. On or before July 1, 2007, the state is strongly encouraged to implement a health care access plan.

[1] If, on October 1 of any year, the total contributions to any of the IL-1040 charitable contribution funds do not equal $100,000 or more, the fund will be removed from the income tax return for the following and all subsequent years and all subsequent contributions will be refunded to the taxpayer. The Leukemia Treatment and Education Fund appeared on the 2003 income tax return, but failed to reach the $100,000 mark and did not appear on the 2004 income tax return and is no longer available.

93-1000	**Effective: 01/01/2005**	Qualified Cancer Trials. Amends the Illinois Insurance Code and provides that no health insurance issued or renewed in this state on or after the date of this act may be cancelled or non-renewed based on the insured's participation in a qualified cancer trial. Provides that qualified cancer trials must meet specified criteria.
93-1041	**Effective: 09/29/2004**	Genetic Counselor Licensing Act. To protect and benefit the public by setting standards of qualifications, education, training, and experience for those who seek to obtain a license and hold the title of genetic counselor.
92-0047	**Effective: 07/03/2001**	Breast and Cervical Cancer treatment reimbursement. Authorizes Medicaid coverage of breast cancer screening and treatment for persons who are enrolled and participating in Illinois Breast and Cervical Cancer Program and who are eligible for that Medicaid coverage under the federal Breast and Cervical Cancer Prevention and Treatment Act of 2000.
92-0048	**Effective: 07/03/2001**	Mammograms, mastectomies. Coverage for mastectomies shall include reconstruction of the breast, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment for physical complications at all stages of mastectomy, including lymph edemas.
92-0536	**Effective: 06/06/2002**	Cigarette Use Tax Act. A tax is imposed upon any person engaged in business as a retailer of cigarettes at the rate of 20.0 mills per cigarette sold or otherwise disposed of in the course of such business.
92-0711	**Effective: 07/19/2002**	The Stop Neuroblastoma Fund. Neuroblastoma License Plate. Upon issuance, $10 shall be deposited into the Stop Neuroblastoma Fund. For each renewal, $23 shall be deposited into the Stop Neuroblastoma Fund. All money paid as grants to the American Cancer Society for neuroblastoma and cancer research, education, screening and treatment.
91-0104	**Effective: 07/13/1999**	Creation of income tax charitable contribution fund for prostate cancer research requires the Illinois Department of Public Health to use donations to make grants to Illinois entities for patient cancer research.

91-0106	**Effective: 07/13/1999**	Cervical, ovarian and uterine cancer health education and screening information. Requires staff of the Illinois Department of Public Health to provide information to members of the public, patients and health care providers regarding women's gynecological cancer.
91-0107	**Effective: 07/13/1999**	Breast and Cervical Cancer Research Fund changed to the Penny Severns Breast and Cervical Cancer Research Fund and Charitable Contribution; adds a member from the Susan G. Komen Foundation to the advisory committee awarding grants from the fund.
91-0108	**Effective: 07/13/1999**	Ovarian cancer, public education. Requires the Illinois Department of Public Health to promote the services of the Cancer Information Service in relation to ovarian cancer.
91-0109	**Effective: 07/13/1999**	Prostate and testicular cancer screening programs. Establishes the Prostate Cancer Screening Program in the Illinois Department of Public Health to provide screening and other services to men at risk for developing prostate cancer. Provides adoption of rules to implement the program when funding becomes available.[1]
91-0406	**Effective: 08/03/1999**	Coverage for investigational cancer treatments. Provides that health benefit coverage must include patient care provided pursuant to investigational cancer treatments.
91-0666	**Effective: 12/22/1999**	Smoking cessation mandatory coverage for prescription drugs or medical devices approved by the U.S. Food and Drug Administration shall be covered under the medical assistance program for persons who are otherwise eligible for assistance.
91-0699	**Effective: 05/08/2000**	Senior Citizens and Disabled Persons Property Tax Relief and Pharmaceutical Assistance Act increase coverage of prescription drugs for lung disease and smoking related illnesses.
91-0734	**Effective: 06/02/2000**	Tobacco Accessories and Smoking Herbs Control Act amended to increase fines from the sale of bidi cigarettes, which contain tobacco that is wrapped in temburni or tendu leaf or a similar substance and do not contain a smoke filtering device, to minors.

[1] In tax year 2004 – 2005, the total contributions to the Prostate Cancer Research Fund did not equal $100,000 and will not appear on the 2005 income tax return.

90-0007	**Effective: 06/10/1997**	The program of health benefits shall provide the post-mastectomy care benefits required to be covered by a policy of accident and health insurance of the Illinois Insurance Code. Pap and prostate-specific antigen (PSA) tests: Annually PSA to asymptomatic men age 50 and older; black men 40 and older and men age 40 and older with family history of prostate cancer.
90-0009	**Effective: 06/11/1997**	Tobacco sales: U.S. Food and Drug Administration of the U.S. Department of Human Services can conduct unannounced investigations of Illinois tobacco vendors to determine compliance with federal laws relating to the illegal sale of cigarettes and smokeless tobacco products to persons under the age of 18.
90-0171	**Effective: 07/23/1997**	Children's Cancer Fund Grants. A special fund created to make grants through the Illinois Department of Human Services to public or private entities Illinois, including the Mitchell Ross Children's Cancer Fund and the Cancer Wellness Center, for the purposes of funding research into causes, prevention, and treatment of cancer in children; and direct community-based supportive services and programs that address the psychological, emotional, and social needs of children with cancer and their family members.
90-0599	**Effective: 01/01/1999**	Prostate and testicular cancer awareness/screening programs. Requires the Illinois Department of Public Health to conduct a program promoting awareness and early detection of prostate and testicular cancers.
90-0675	**Effective: 01/01/1999**	Mammogram license plates to contain the phrases "Mammograms Save Lives" and "The Susan G. Komen Foundation". In addition, the act creates the mammogram fund and provides funds to the Susan G. Komen Foundation for breast cancer research, education, screening and treatment.
90-0741	**Effective: 01/01/1999**	Colorectal cancers screening reimbursement. An insurer shall provide in each group policy, contract, or certificate of accident and health insurance amended, delivered, issued or renewed covering persons who are residents of this state, coverage for colorectal cancer screening with sigmoidoscopy or fecal occult blood testing once every three years for persons who are at least 50 years old. For persons who may be classified as high risk for colorectal cancer because the person or a first degree family member of the person has a history of colorectal cancer, the coverage shall apply to persons who have attained at least 30 years of age.

BILLS

HB 0352	**Last Action: Rules Committee 03/10/05**	Ovarian Cancer Awareness Fund. Creation of an Ovarian Cancer License Plate.
HB 3721	**Last Action: Rules Committee 04/15/05**	Ovarian Cancer Awareness Month. Designating September annually as ovarian cancer awareness month in Illinois.
SB 1464	**Last Action: Rules Committee 03/18/05**	Amendment to Illinois Insurance Code. MRI for those at high-risk for breast cancer.

Legislation drafted in the form of an act for introduction into the Senate or the House of Representatives and identified with a bill number. If the bill is passed by both houses and signed by the Governor or otherwise becomes law, it becomes an act. [27]

Selected Resources

[1] U.S. Center for Disease Control and Prevention

[2] Illinois Department of Agriculture, Facts About Illinois Agriculture: *www.agr.state.il.us*

[3] U.S. Census 2000 U.S. Census Bureau

[4] *http://www.city-data.com/city/Chicago-Illinois.html*

[5] U.S. Census Bureau State of Illinois Quick Facts Profile of General Demographic Characteristics

[6] Profile of General Demographic Characteristics: 2000 U.S. Census Bureau Fact Finder

[7] Illinois Department of Public Health, Center for Health Statistics, 2000 Census Population for Illinois Counties and Incorporated Places, January 2004

[8] Northeast-Midwest Institute and Bureau of labor Statistics

[9] National Coalition on Health Care

[10] *Numbers and Neighbors: A detailed Description of Illinois' Uninsured, Underlying Tables*, December 2004.

[11] Illinois Department of Healthcare and Family Services (formerly the Illinois Department of Public Aid)

[12] Illinois State Cancer Registry, Five-year counts; age-adjusted rates (US 2000 Std) with 95% CI per 100,000.

[13] Illinois Department of Public Health, Illinois Cancer Registry Public Dataset November 2003.

[14] Illinois Cancer Statistics Review 1986-2002, June 2005

[15] Illinois State Cancer Registry, Five-year counts; age-adjusted rates (US 2000 std) with 95% CI per 100,000.

[16] Leading Causes of Death, Illinois 2002: *www.idph.state.il.us/health/bdmd/leadingdeaths02.htm*

[17] *Illinois Cancer Facts and Figures*, 2004

[18] Illinois Project for Local Health Assessment of Needs Data System Report, ICD-10

[19] Illinois Cancer Statistic Review 1986-2000

[20] Illinois Poverty Summit, 2004

[21] Tobacco Control in Illinois, American Lung Association

[22] *Reducing Tobacco Use: A Report of the Surgeon General*, 2000

[23] Illinois Youth Tobacco Survey, 2002

[24] *Guide to Community Preventive Services*, 2005

[25] *Cancer Facts and Figures*, 2005

[26] *CDC's Framework for Program Evaluation in Public Health, 1999; 48 (No. RR-11)*

[27] Illinois General Assembly, Legislative Information System, 2005, *http://www.ilga.gov/*

Notes

Illinois
Comprehensive
Cancer Control
Program

Illinois Department of Public Health