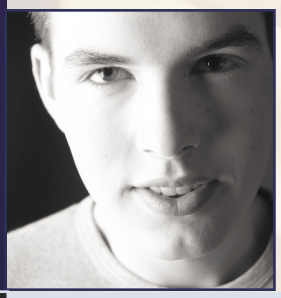
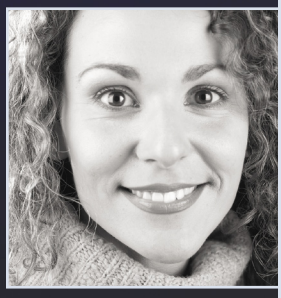
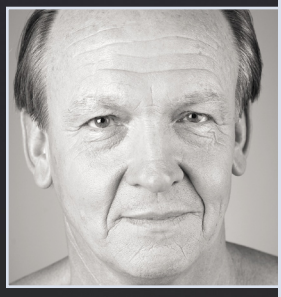
UNITED
IN THE FIGHT
AGAINST
CANCER







State of Nevada Comprehensive Cancer Plan

A GUIDE FOR COMPREHENSIVE CANCER CONTROL EFFORTS IN THE STATE OF NEVADA

Nevada Cancer Council

Funded by the Nevada State Health Division Through
Cooperative Agreement Number U55/CCU922006
From the Centers for Disease Control and Prevention

KENNY C. GUINN
Governor

OFFICE OF THE GOVERNOR

December 2, 2005

My fellow Nevadan:

With more than 11,000 individuals in our state diagnosed with cancer each year, and 4,600 more dying from the disease, it is imperative that health organizations coordinate efforts and resources in their fight against this often tragic condition. The Nevada Comprehensive Cancer Control Plan that I share with you today allows health care providers and health partners statewide to better accomplish this important objective.

As a cancer survivor myself, I understand the toll the disease can take on individuals, their family members and their friends. Those we love share our concerns upon detection, our anxieties during treatment, and our joy upon remission. Additionally, the entire state experiences significant economic and social impacts as a result of this deadly disease. Reduction in cancer rates is not only beneficial to us individually, but to the entire state as it lessens the burden on the health care systems we have in place.

In this plan you will uncover strategies Nevada can implement to reduce the incidence of cancer within our state. I encourage you to join with me, the Nevada Cancer Council, and the Nevada State Health Division's Bureau of Community Health in the fight to gain better control of this disease through enhanced education and prevention efforts, earlier detection and improved treatment options for all those diagnosed with cancer.

Sincerely,

KENNY C. GUINN
Governor

LF:sc

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STATE OF NEVADA

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Dear Colleague:

The Nevada State Health Division, Bureau of Community Health is pleased to share with you a copy of the State of Nevada Comprehensive Cancer Plan. The Nevada Comprehensive Cancer Control Program produced this plan, through funding from the Centers for Disease Control and Prevention. This plan addresses the burden of cancer and the strategies to reduce cancer incidence and mortality in Nevada.

Each year approximately 11,000 Nevadans are diagnosed with cancer and an additional 4,600 deaths are attributed to this disease. Reduction in the rates of cancer in Nevada will be accomplished through lifestyle changes that eliminate tobacco use, improve dietary habits, increase physical activity, maintain a healthy weight, avoid harmful ultraviolet light, increase early detection through cancer screening, and increase the receipt of appropriate and timely cancer treatment.

The Nevada Cancer Council is comprised of a diverse group of statewide organizations, partners, and advocates who are committed to the reduction of the cancer burden in our state. Through the hard work and dedication of each member, the Nevada Comprehensive Cancer Control Plan was developed. It is our hope this plan will become the driving force behind cancer control activities in the state.

The Nevada Department of Health and Human Services and Nevada State Health Division's Bureau of Community Health extends its appreciation to all those individuals who helped prepare the plan. The information presented serves as a starting point in the effort to define and reduce the burden of cancer in Nevada.

Finally, I encourage you to become involved in reducing the cancer burden on Nevada residents. By working together, we can ensure a healthier future for the people of Nevada.

Sincerely,

Bradford Lee, MD
State Health Officer
Nevada State Health Division

TABLE OF CONTENTS

PHOTOGRAPHY AND COPY FOR CANCER PATIENT STORIES GENEROUSLY PROVIDED BY JOE RUBINO.

TABLE OF CONTENTS

Executive Summary

The Nevada State Health Division (NSHD) received a grant from the Centers for Disease Control and Prevention's National Comprehensive Cancer Control Program to develop a comprehensive cancer control plan for Nevada. The Nevada Cancer Institute received a sub-grant from the NSHD's Comprehensive Cancer Control Program to facilitate the process and was joined by the resources of the American Cancer Society, local hospitals, community-based organizations, cancer centers, survivors and advocates.

The Nevada Cancer Council is dedicated to bringing together and coordinating cancer prevention, early detection, treatment, support, and research efforts to improve the quality of life for everyone in Nevada. Its aim is to increase coordination and collaboration among programs, to reduce duplication, and to increase opportunities for cancer prevention and control.

Defining cancer control: In creating this Plan, the Nevada Cancer Council embraced the definition developed by the Centers for Disease Control and Prevention to help states address cancer on a comprehensive scale:

"Comprehensive cancer control is an integrated and coordinated approach to reducing cancer incidence, morbidity and mortality through prevention, early detection, clinical trial enrollment, and quality of life palliative care."

Setting broad goals: Because of Nevada's unique health care environment, the Nevada Cancer Council, with input from diverse community groups, approached its cancer planning efforts by looking at five specific categories: 1) prevention, 2) early detection and diagnosis, 3) treatment, 4) clinical trials; and 5) quality of life and palliative care. Using this base model, the Nevada Cancer Plan has set six broad goals:

- Reduce the risk for developing cancer
- Increase early detection and appropriate screening for cancer
- Increase access to appropriate and effective cancer treatment and care
- Increase access to clinical trial initiatives
- Address quality of life issues for health care consumers affected by cancer
- Improve the coordination and collaboration among cancer control efforts

Addressing special issues: The Plan also addresses survivorship, disparities and special populations in Nevada. It includes information about existing programs and services, describes gaps and barriers that inhibit successful cancer control efforts, and recommends a vision for improving cancer control statewide. Strategies for attaining the broad goals included in this Plan incorporate public and professional education, collaboration and coalition building, policy development, and surveillance.

A road map for action: The Plan identifies areas of common interest and need and offers a road map to guide action. The goals are broad and are directed at improving the lives of all Nevada residents. The objectives and strategies included in this Plan are varied and intended to provide numerous "binding sites" with which interested partners can connect. Implementation will include local activities in communities across the state, collaborative efforts among small groups around specific areas of interest, and statewide efforts. Progress toward meeting the goals in this plan will be evaluated annually, and a report will be distributed to the appropriate stakeholders. This plan will be regularly updated to meet the changing needs and capacities of our state.

What You Can Do To Fight Cancer In Nevada

The Nevada Cancer Plan identifies broad goals to reduce the burden of cancer. To accomplish these goals, everyone needs to be involved. What can you do?

If you are a Hospital…You can:

- Assure that your cancer cases are reported in a timely manner.
- Provide meeting space for cancer support groups.
- Collaborate to sponsor community screening and education programs.
- Maintain American College of Surgeons membership.
- Encourage participation in cancer clinical trials.

If you are a local Public Health Department…You can:

- Provide cancer awareness information and data to citizens and groups.
- Collaborate with community-based coalitions.
- Work with physicians and other health care providers to promote screening programs and case management.
- Provide space for community survivor support groups.
- Assess community needs and implement policy and environmental changes to reduce cancer risks.
- Assure access to care for uninsured and underinsured.
- Encourage participation in cancer clinical trials.

If you are a Community Based Organization…You can:

- Promote cancer awareness information to constituents.
- Promote cancer screening.
- Encourage participation in clinical trials.
- Collaborate to provide community prevention programs.

If you are a Professional Health Organization…You can:

- Provide continuing education credits on cancer topics.
- Include clinical trails information in meeting agendas.
- Form speakers' bureaus to provide cancer education.
- Train facilitators for survivor support groups.

If you are an Employer…You can:

- Establish a smoke-free work place policy.
- Provide healthy foods in vending machines and cafeterias.
- Encourage employees to increase physical activity.
- Collaborate with hospitals to host screening events.
- Provide health insurance coverage.

If you are a School or University…You can:

- Include cancer prevention messages in health classes.
- Provide healthy foods in vending machines and cafeterias.
- Increase physical education requirements.
- Make your entire campus a smoke-free environment.

If you are a Faith Based Organization…You can:

- Provide cancer prevention information to members.
- Collaborate with other community-based groups.
- Learn how to provide healthy potlucks and meeting meals.
- Open your building for walking clubs.
- Encourage members to get cancer-screening tests on time.

If you are a Physician, Nurse, Social Worker, or other Health Professional…

You can:

- Make sure patients get appropriate cancer information on screening tests.

WHAT YOU CAN DO

What You Can Do To Fight Cancer In Nevada

- Refer patients to smoking cessation classes and nutrition programs.
- Be sure your cancer cases are reported in a timely manner.
- Find out how to enroll patients in clinical trials.
- Make earlier referrals to hospice for end of life care.
- Encourage participation in cancer clinical trials.

If you are a Nevada Resident… You can:

- Avoid all tobacco products and secondhand smoke.
- Eat a nutritious and balanced diet and maintain a healthy weight.
- Increase your daily physical activity.
- Know when to be screened and obtain screenings on schedule.
- Support smoke-free environments.
- If diagnosed with cancer, consider enrolling in a clinical trial.
- Show your support and care for those who are diagnosed.
- Volunteer with your hospital, health department, faith community or local groups who support cancer control efforts.

CANCER IN NEVADA

Stacy Marino

knows more than any other 25 year old should know. Cancer has taught her. Two and a half years ago, when her daughter was two months old, Stacy was diagnosed with one of the most aggressive forms of Non-Hodgkin's Lymphoma. She went through immediate, intensive chemotherapy and radiation, then more treatment, more chemotherapy, and more radiation. The cancer spread to her back and her brain. Finally, in the spring of 2002, Stacy went to the City of Hope, a comprehensive cancer center in Los Angeles for a Stem Cell Transplant that could not be performed in Las Vegas. Two hundred miles from home; she spent two months enduring one of the most difficult and debilitating treatments in medicine. She returned to Las Vegas last summer, and still the problems, the hospitalizations, the cancer, were not finished with her. Today, her future is uncertain. When you hear her story, you are forced to wonder about fairness and fate. You wonder when someone will finally cure this horrible disease. But when you are with her, you are pulled into her intensity and power. When she laughs, you feel the open, full joy associated with children. But it has a different quality. This joy has been soaked in pain and harrowing knowledge, and in absorbing those things; it burns brighter within this radiant, unyielding woman.

CANCER IN NEVADA

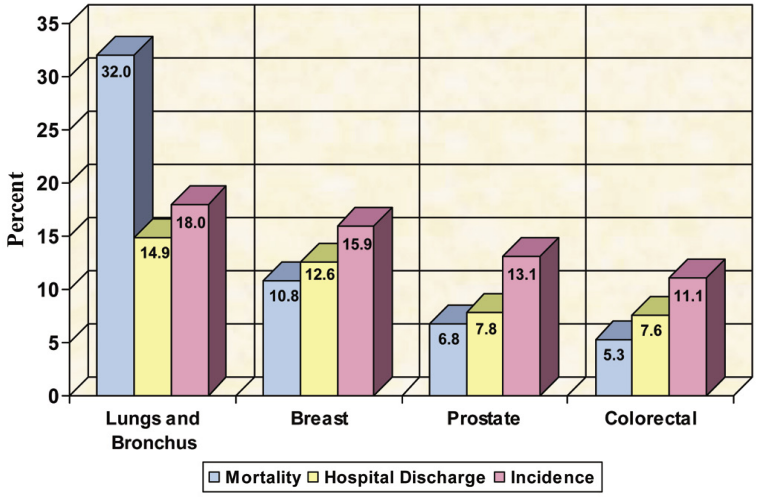
HEALTH CARE AND CANCER RANKINGS

Out of the 50 states, Nevada ranks:

- 14th in the number of adults who smoke
- 9th in cancer mortality rates
- 48th in the number of hospital beds per 1,000 residents
- 44th in the total number of hospitals
- 48th in the number of doctors per 100,000 residents
- 43rd in the number of rural health clinics
- 50th in the number of registered nurses per 10,000 residents
- 38th in total health care employment
- Nevada has 14 federally qualified health centers.

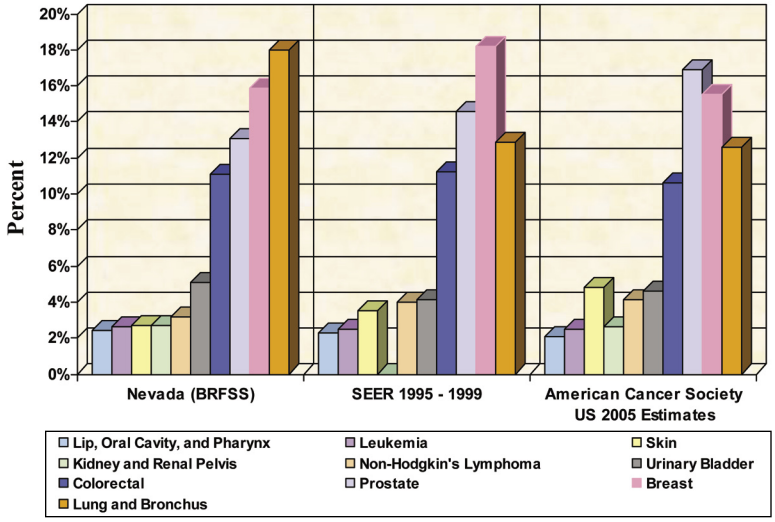
Sources: *The Henry J. Kaiser Family Foundation statehealthfacts.org, United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), National Center for Healthcare Statistics (NCHS), Office of Analysis, Epidemiology and Health Promotion, Compressed Mortality File (CMF) compiled from 1999-2001.*
Source: Report on Cancer In Nevada, 1997-2001,

Figure 1. Leading Cancers – Nevada 1997-2001



Report on Cancer in Nevada, 1997-2001

Figure 2. Comparison Of The Most Common Cancers In Nevada



MOST COMMON CANCERS IN NEVADA

It is estimated that 11,120 new cancer cases will be diagnosed in Nevada this year and about 4,620 residents will die of this disease in 2005. Cancer incidence and mortality rates vary, depending on the site, age, gender, ethnicity, access to health care, and other factors.

It is estimated that 1,990 men will be diagnosed with Prostate Cancer in 2005 and 260 will die from it. Prostate Cancer, if caught early, is no longer a life ending disease.

Source: 2005, American Cancer Society, Inc. Surveillance Research; US Mortality Public Use Data Tapes, 1969-2002, National Center for Health Statistics, Centers for Disease Control and Prevention, 2004.

INCIDENCE HIGHLIGHTS

- Lung and Bronchus Cancer was the most common cancer in Nevada from 1997-2001. This cancer accounted for 18% of all cancer cases during this period. Breast Cancer was the second common cancer (first among women) and accounted for 15.9% of all cancer cases. (Fig. 1)
- When compared to the national average (1997-2001) the percentage of Lung and Bronchus Cancer in Nevada (18.0%) was significantly higher than the nation (12.9%). On the other hand the percentage of those who developed Breast Cancer in Nevada (15.9%) was considerably lower than the nation (18.2%) during the 1997-2001 period. (Fig. 2)
- Among all racial/ethnic minorities in Nevada, African Americans had the highest age-adjusted

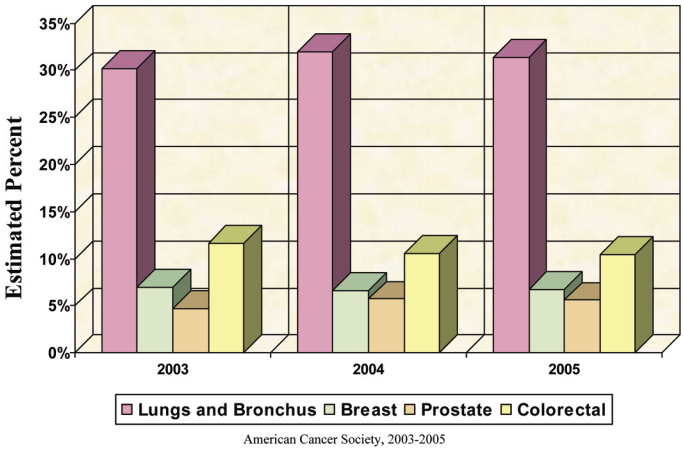
CANCER IN NEVADA

incidence rate of cancer. When compared to rates among Caucasians, the ratio of age-adjusted cancer incidence rate was just 0.94. This means; for every 100 new cancer cases among Caucasians, we may expect to have 94 new cancer cases among African Americans. Asians, Hispanics and Native Americans had comparison ratios of 0.49, 0.46 and 0.40 respectively for Nevada in 1997 to 2001.

Inpatient Hospital Discharge Highlights

- Lung and Bronchus Cancer was the leading cancer for inpatient hospital discharges in Nevada from 1997 to 2001. This cancer accounted for 14.9% of all cancer inpatient hospital discharges. The second leading type of cancer was Colorectal Cancer, which accounted for 7.6% of all cancer inpatient discharges during this period.
- Lung and Bronchus Cancer and Colorectal Cancer accounted for 305.2 million dollars in total billed amounts in Nevada from 1997 to 2001. This accounted for 32.8% of the total 1 billion dollars in billed amounts for cancer inpatient hospital discharges during this period.

Figure 3. Cancer Mortality Rates (Estimated) – Nevada 2003-2005



American Cancer Society, 2003-2005

Mortality Highlights

- Lung and Bronchus Cancer was the leading cause for cancer mortality in Nevada from 1997 to 2001. These cancer types accounted for 32.0% of all cancer deaths during this period. (Fig. 3 - 2003-2005 percentage estimates remained constant.)
- Colorectal Cancer was the second leading cancer cause of death and accounted for 10.8% of all cancer deaths. (Fig. 3 - 2003-2005 percentage estimates remained constant.)

Risk of Developing Cancer

Anyone in Nevada is at risk for developing cancer. Although cancer may strike at any age, it is mostly a disease of middle and older age. About 78% of all cancers in Nevada are diagnosed at age 55 or older. With at least 3,400 individuals dying annually from 1997 through 2001, cancer is second only to heart disease as the leading cause of death among adults in Nevada.

Similar to other chronic diseases, cancer risks are defined into two categories: modifiable and non-modifiable.

Modifiable Risks

Modifiable risks are those that are defined as something we can control. They include but are not limited to:

- Tobacco Use
- Environmental Exposure including sun and chemical as well as infectious exposures
- Nutrition
- Physical Activity
- Overweight or obesity
- Access to preventive heath care services

According to the National Cancer Institute, the most consistent finding, over decades of research, is the strong association between tobacco use and developing cancer. Hundreds of epidemiologic studies have confirmed this association. Further support comes from the fact that lung cancer death rates in the United States have mirrored smoking patterns, with increases in smoking followed by dramatic increases in lung cancer death rates and, more recently, decreases in smoking followed by decreases in lung cancer death rates in men.

Scientific evidence suggests that as many as 50% to 75% of the 570,280 cancer deaths expected to occur in 2005 will be related to nutrition, physical inactivity, overweight or obesity and other lifestyle factors and thus could be prevented. In addition, all cancers caused by cigarette smoking and heavy use of alcohol could be prevented completely. The American Cancer Society estimates that in 2005 more than 180,000 cancer deaths will be caused by tobacco use.

Certain cancers related to infectious exposures, such as hepatitis B virus (HBV), human papillomavirus (HPV), human immunodeficiency virus (HIV), and helicobacter

CANCER IN NEVADA

could be prevented through behavioral changes, vaccines, or antibiotics. In addition, many of the more than one million skin cancers estimated to be diagnosed in 2005 could be prevented by protection from the sun's ultraviolet rays.

Non-Modifiable Risks

Non-modifiable risks are defined as risks that we cannot control. They include but are not limited to:

- Age
- Race
- Gender
- Genetic Predisposition

In depth information on these topics can be found in the Disparities Section of this report. The best way to managed non-modifiable risks is to adhere to recommended screening guidelines and work with your primary care provider to ensure that all risk factors are considered when determining recommended screenings.

The Role of Genetics in Developing Cancer

***(Source:** The National Institutes of Health Cancer Information Services)*

Altered or mutated genes trigger all cancers. Genes that control the orderly replication of cells become damaged, allowing the cell to reproduce without restraint and eventually to spread into neighboring tissues and set up growths throughout the body.

However, just a small portion of cancer is inherited. Family history often identifies people with a moderately increased risk of cancer. Less often, family history indicates the presence of an inherited cancer predisposition conferring a relatively high lifetime risk of cancer. In some cases, DNA-based testing can be used to confirm a specific mutation as the cause of the inherited risk, and to determine whether family members have inherited the mutation.

Identifying a person with an increased risk of cancer can reduce the occurrence of cancer through clinical management strategies (e.g., tamoxifen for breast cancer, colonoscopy for colon cancer) or improve that person's health outcome or quality of life through intrinsic benefits of the information itself (e.g., no genetic predisposition). Intrinsic benefits may include better ability to plan for the future (having children, career, retirement or other decisions) with improved knowledge about cancer risk. Methods of genetic risk assessment include assessment of personal and family history of disease and genetic testing; the latter is generally undertaken only when family history of disease or other clinical characteristics, such as early onset of cancer, indicate a substantial likelihood of an inherited predisposition to cancer.

People affected with cancer may also seek genetic testing; both newly diagnosed individuals and survivors of earlier cancers. Testing may be desired to define personal cancer etiology, to clarify risk to offspring, to define the appropriateness of particular surveillance approaches, or to aid in decision-making about risk-reducing prophylactic surgery.

Gene mutations have been reported for breast cancer, melanoma, leukemia, thyroid, and renal cell cancer, and scientists are closing in on genes for several other cancers. The BRCA1 gene mutation predisposes a person to hereditary breast cancer and ovarian cancer. A mutant BRCA1 is probably responsible for about 5 percent of the 182,000 cases of breast cancer predicted for a single year, and as many as a quarter of the cases occurring in women ages 45 and younger.

Early detection of cancer, through age and gender appropriate screening, accounts for about half of all newly detected cancer cases. Regular screening examinations by a health care professional can result in the detection of cancers of the breast, colon, rectum, cervix, prostate, oral cavity, and skin at earlier stages, when treatment is more likely to be successful.

The Economic Burden of Cancer In Nevada

While the most important cost of cancer is the loss of lives and of quality of life, the huge economic burden of cancer cannot be ignored. The Centers for Disease Control and Prevention (CDC) estimates that the direct and indirect cost of cancer in the United States in 2004 was $189 billion. This estimate includes about $69.4 billion in medical costs and $120 billion for indirect costs and lost productivity. With a population of 1.9 million in Nevada, the economic cost for cancer in Nevada in 2002 was approximately $1.1 billion or $585 per person.

And it does not end here. Due to the emergence of more expensive treatment modalities for each type of cancer, the continuing development of new therapies and the increasing numbers of our elderly population in Nevada, the cost is expected to increase substantially over the next decade.

Lynn Wiesner

holds her granddaughter Tommi Stockham. With them are Lynn's children: Tommi's mother, Kari Stockham and Kurt Wiesner. These are the people Tom Wiesner left behind. Tom Wiesner was a great bright light in Las Vegas, and the state of Nevada. Businessman, county commissioner, community leader, Regent of the University and Community College System of Nevada, he loved many things passionately – his family, his city, his state, the UNLV Rebels. When Tom was diagnosed with leukemia in November 2001, it took all of the persuasion of his friends, his doctors and even the health secretary of the United States to convince him to leave Nevada for the treatment and care he needed. Tom and Lynn went to Fred Hutchinson Cancer Research Center in Seattle. For eight months, they were forced to live away from their family and their friends. They missed baby showers for Kari and even the birth of their first granddaughter. Their children and family made the long trip to Seattle as often as possible, while Tom and Lynn rode the roller coaster of optimism and despair, days of pain and pain-free days. The distance, the separation, was a weight added to the burden they all carried. Tom died in Seattle on June 25, 2002. More than 2500 people attended his memorial service in Las Vegas to acknowledge a large, generous life of meaning, service, and laughter. THESE PEOPLE, these pieces of his huge heart remain – his wife, his son, his daughter, and the effervescent Tommi, carrying his name into the promise of her life.

SETTING THE STAGE FOR CANCER CONTROL

IT TAKES THE THINKING OF MANY MINDS AND THE SIFTING THROUGH MOUNTAINS OF INFORMATION TO CREATE A COMPREHENSIVE CANCER PLAN. The Nevada Cancer Council led the development of the Nevada Cancer Plan and the steering committee made up of 12 experts from the cancer control and medical fields provided oversight and guidance in identifying the areas of focus and setting overall goals. Subcommittees, composed of more than 50 individuals representing over 30 organizations from the public and private sector, met and drafted objectives and strategies for attaining the goals. The Steering Committee reviewed and amended these objectives and strategies and reviewed and approved a draft of the plan.

Steering Committee

Merle Berman, Advocate
Emilia Guenechea, National Cancer Institute's Cancer Information Service
Paula Guzman, Nevada Health Centers, Inc.
Charlene Herst, Manager, Tobacco Prevention and Education Program and Comprehensive Cancer Control Program, Nevada State Health Division
Daniel Kirgan, MD, American College of Surgeons, University of Nevada School of Medicine
Tricia Leland, Director, Outreach and Education, Nevada Cancer Institute
Veronica Perez, Planning Director, American Cancer Society
Christine Peterson, MD, Chief Medical Officer, Sierra Health Services, Inc.
Karen Power, Manager, Nevada Central Cancer Registry, Nevada State Health Division
Ihsan Azzam, MD, MPH, Manager, Environmental Public Health Tracking System, Nevada State Health Division
Deborah McBride, MBA, Chief, Bureau of Community Health, Nevada State Health Division

Subcommittee Members

Bobbette Bond / Hotel Employees and Restaurant Employees International Union (HEREIU)
Buffy Martin / American Cancer Society
Carla Brutico / Carson Tahoe Cancer Resource Center
Carol Vanderharten / Quest Diagnostics
Carolyn Bell
Charlene Herst / Nevada State Health Division
Christine Belle / Sunrise Hospital & Medical Center
Deborah McBride / Nevada State Health Division
Diana Morneault / Sunrise Hospital & Medical Center
Dianne Nangano / Southern Nevada Research Foundation
Dorothy Johnson / National Black Leadership Initiative on Cancer
Dr. Arnold Wax / Comprehensive Cancer Centers of Nevada
Dr. Christine Petersen / Sierra Health Services, Inc.
Dr. Daniel Kirgan / University Medical Center
Dr. Ihsan Azzam / Nevada State Health Division
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Dr. Larry Gamell / University of Nevada Cooperative Extension
Dr. Shamoon Ahmad / Southwest Cancer Clinic
Dr. Patricia Bray-Ward, Nevada Cancer Institute
Dr. David Ward, Nevada Cancer Institute
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Emelda Ekpoudia / Emy's Boutique
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Sue McNutt
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Susen Speth-Briganti / Saint Mary's Regional Medical Center

SETTING THE STAGE FOR CANCER CONTROL

Choosing the Cancers Addressed in this Report

Cancer sites for this Plan were determined by incidence rates and by the availability of evidence-base interventions for prevention, early detection, and effective treatments. In Nevada, the four leading cancers in order of incidence are: **1) lung, 2) breast, 3) colorectal; and 4) prostate**. These four cancers accounted for 57% of all cancers in Nevada. (Fig. 4)

Lung and Bronchus Cancer

Lung and bronchus cancer is the second most commonly diagnosed cancer in the United States and in Nevada. It is the number one killer among both men and women when all racial and ethnic groups are combined. Lung cancer mortality rates for non-Hispanic men and women have increased. Overall, more women die from lung cancer than from breast cancer. Some 1,450 individuals in Nevada are estimated to die from this disease in 2005, contributing heavily to Nevada's ranking of 9th in the country for cancer mortality.

It is estimated that 1,570 new cases of lung cancer were diagnosed in Nevada during 2004. The biggest risk factor for lung and bronchus cancer is smoking. It is also worth noting that Nevada ranks 14th in the nation for adults who use tobacco products.

Early detection of lung and bronchus cancer is difficult because the disease is usually far advanced by the time it is diagnosed. Survival rates vary by the stage of the cancer at the time of diagnosis. Those diagnosed at the localized level have the highest one and five year relative survival rates, 76.1% and 38.3% respectively. This was followed by those with regional and with distant levels, with rates of 52.1% and 18.5% for the one-year period and 9.2% and 2.2% for the five-year period.

Breast Cancer

Breast cancer is the most common form of cancer in women in Nevada, as well as in the United States. It is estimated that there will be 1,620 new cases of breast cancer diagnosed in Nevada in 2005. Approximately, three hundred of Nevada women identified with cancer will die in 2005.

Source: 2005, American Cancer Society, Inc. Surveillance Research; US Mortality Public Use Data Tapes, 1969-2002, National Center for Health Statistics, Centers for Disease Control and Prevention, 2004

Breast cancer is most common among women over age 55; however, we continue to see increasing rates of diagnosis among women 45 years of age and under. The 5-year relative survival rate for breast cancer (all stages) is about 84%. If all breast cancers were diagnosed at a localized stage through regular cancer screenings, 5-year survival would increase to about 95%.

Most of the known risk factors for breast cancer such as age, gender, and family history, cannot be changed. The good news is that breast cancer is curable if caught early. There are several screening programs that are active in our communities.

Colorectal

It is estimated that, in 2005, 1,240 colorectal cancers will be diagnosed in Nevada and 480 Nevada residents will die from this disease. Nevada's age adjusted incidence rate of 53.1 for colorectal cancer is slightly lower than the national average of 54.9.

Risk factors include age, diet, polyps (benign growths on the inner wall of the colon and rectum), personal and family medical history, and ulcerative colitis.

Early detection has shown to be effective in reducing both the incidence and mortality of colorectal cancer. Screening with fecal occult blood test cards, colonoscopy, flexible sigmoidoscopy or air-contrast barium enema can detect early stage cancers and pre-cancerous polyps; these growths can be removed during colonoscopy or during more extensive surgery.

Prostate Cancer

Prostate cancer is the most frequently diagnosed cancer among men in Nevada of all racial and ethnic groups. It is estimated that 2,000 new cases of prostate cancer will be diagnosed in 2005 and that 230 men will die from this disease. It is worth noting that African American men in Nevada have higher mortality rates than any other race in the state, a trend that is also observed nationally.

Most significant risk factors for developing prostate cancer, such as gender, age, race/ethnicity and family history, cannot be changed. Because prostate cancer occurs at an age when other medical conditions and major causes of death such as heart disease, stroke and diabetes mellitus are very frequent, it is hard to measure the actual number of prostate cancer patients who die as a direct result of this disease.

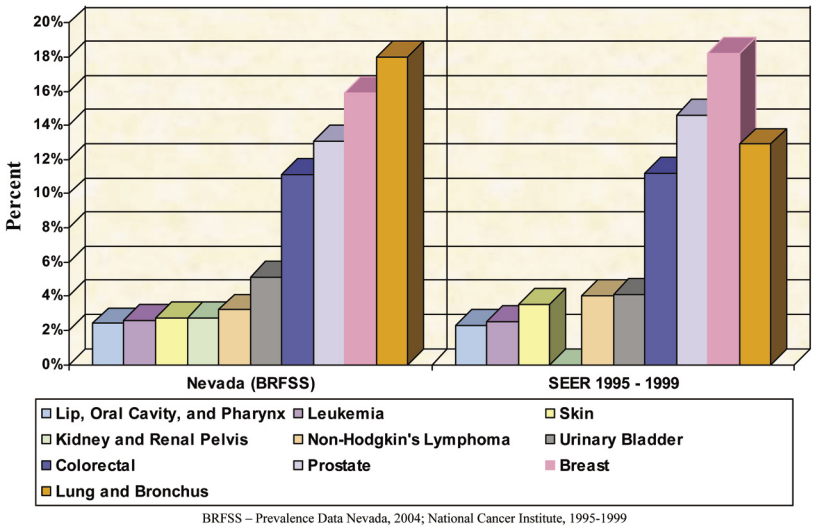
Prostate cancer can be diagnosed at an early stage, but there is controversy about the value of widespread screening. Prostate cancer is often slow growing and, in many cases, the disease will never become a serious health problem. It is a disease of aging. Many men with prostate cancer will likely die from another more life threatening age-related disease. Thus, despite the fact that screening offers the benefit of diagnosing prostate cancer at an early stage, it is unknown if this results in improved outcomes.

In addition, current prostate cancer detection techniques generate a high rate of false positive results, which may lead to unnecessary prostate biopsies and may cause undue worry, physical difficulties and stress for men and their families. Aggressive prostate cancer treatments also can have serious adverse consequences, including incontinence, impotence and bowel problems.

Studies are underway to determine whether widespread prostate cancer screening can save lives. Also needed are methods to determine which types of prostate cancer require aggressive treatment and which would be better treated with "watchful waiting."

In spite of the disagreement as to whether to screen or not to screen, several major organizations in the prostate cancer community have recommended that men begin to establish a baseline PSA at age 45 or age 40 if African-American or those with bloodline relatives who have had prostate cancer. American Urological Association and American Cancer Society had ages 50 and 45 as their recommendations. It is important to watch the PSA number as change in that number is more important than the number itself.

Figure 4. Most Common Cancers In Nevada



BRFSS – Prevalence Data Nevada, 2004; National Cancer Institute, 1995-1999

Coordinating with Other Initiatives

Several ongoing initiatives and programs have contributed to the goals and objectives in the Plan. They range from Healthy People 2010, a health promotion and disease prevention project of the U.S. Department of Health and Human Services, to several projects which are specific to Nevada, such as comprehensive tobacco control efforts, Governor's Task Force on Prostate Cancer, and several community coalitions focusing on minority populations, such as Community Partners for a Better Health and Salud En Accion. Many of the goals and objectives set by the members of the Nevada Cancer Council reflect goals and objectives already set through these national and local programs.

- **Healthy People 2010 has two major goals: 1) to help individuals of all ages increase life expectancy and improve their quality of life, and 2) to eliminate health disparities among different segments of the population.** Cancer is one of 28 focus areas for Healthy People 2010. The goal for cancer is to decrease the number of new cancer cases as well as the illness, disability, and death caused by cancer. The initiative sets targets for improvements in 15 categories, including overall cancer deaths, death rates from specific types of cancer, prevention and screening methods, surveillance, and five-year cancer survival.

- **The Nevada State Health Division** promotes and protects the health of all Nevadans and visitors to the state through its leadership in public health and enforcement of laws and regulations pertaining to public health. Through the Bureau of Community Health, the Division offers numerous programs designed to prevent, control, and ultimately eradicate communicable and chronic disease in Nevada. Growth in population and caseload has affected many of the programs of this Bureau, resulting in an increased need for collaborations and partnerships within the community. Programs within the chronic disease section have been added or enhanced, and include Arthritis Prevention and Control, Diabetes Prevention and Control, Environmental Public Health Tracking, Comprehensive Cancer Control, and Tobacco Prevention and Education.

SETTING THE STAGE FOR CANCER CONTROL

- Designated by the state legislature as the official cancer institute for the State of Nevada, the **Nevada Cancer Institute (NVCI)** is a collaborative, statewide effort involving concerned citizens, the oncology community, academic leaders, legislators, corporations, health care advocates, and cancer patients and their families. NVCI is wholly committed to offering the residents of Nevada a facility that offers the most current and most advanced cancer treatment options. As a non-profit research center, an essential part of the Institute's mission is to ensure that cancer patients and their families, regardless of their geographic location, have access to the latest in cancer prevention, education, detection, and treatment options.

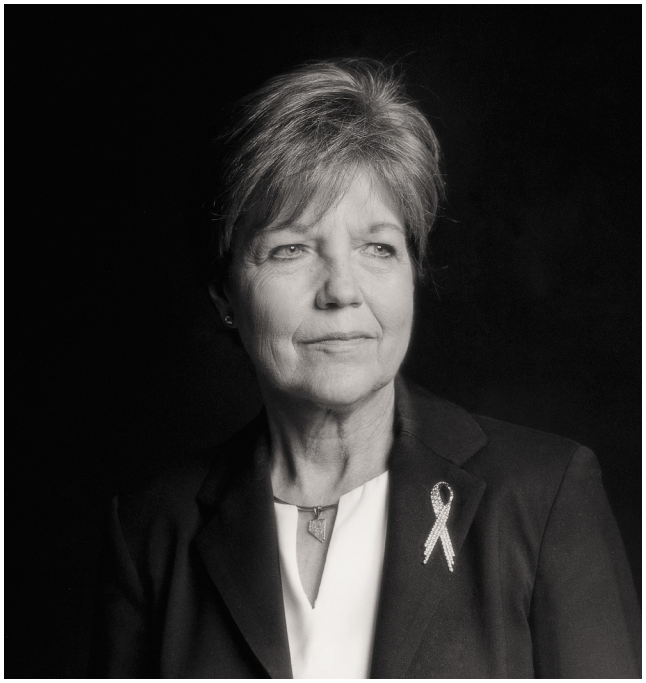
Three cancer-related programs within the Nevada State Health Division exist to prevent chronic medical conditions that adversely affect the health of Nevadans.

- **The Tobacco Prevention and Education Program** provides funding to county health authorities; technical assistance to the tobacco prevention coalitions, including the statewide Nevada Tobacco Prevention Coalition; works with coalition members in the development of tobacco prevention plans and strategies; and provides technical assistance to communities interested in implementation of tobacco control policies and initiatives.
- **The Breast and Cervical Cancer Early Detection Program**, through the Women's Health Connection, assesses public and professional needs related to breast and cervical cancer; provides screening, tracking, follow-up services and treatment referral; provides public education regarding breast and cervical cancer to high risk groups; and provides professional education regarding diagnostic and therapeutic standards for breast and cervical cancer.
- **The Nevada Central Cancer Registry** obtains and summarizes information on trend predictions about cancer cases in Nevada; provides information that allows investigation of the distribution and causes of avoidable cancer; and assists in establishing the effectiveness of cancer prevention programs, and pinpointing problem areas that need further study and evaluation.

Cancer-related coalitions and other formalized cooperative efforts play a significant role in cancer prevention and control in Nevada. Among the more active groups:

- **American Cancer Society –** provides support and information to cancer survivors and their families.
- **Susan G. Komen Foundation –** offers research and community based outreach programs.
- **Candlelighters of Southern Nevada –** makes parent-run support groups available for families of children with cancer.
- **Ovarian Cancer Alliance Network –** provides support and awareness for those affected by ovarian cancer.
- **Nevada Tobacco Prevention Coalition –** involves a community-based coalition, which is helping to reduce tobacco use in Nevada.
- **Nevada Childhood Cancer Foundation –** raises awareness and support for children's cancer initiatives.
- **Leukemia Lymphoma Society –** serves in improving the quality of life for cancer patients and their families.
- **Nevada Cervical Cancer Coalition –** develops policies to promote, protect, maintain, and improve the health of women in Nevada.
- **UsTOO –** is the largest Prostate Cancer support organization in the world with over 330 chapters worldwide.
- **Nevada Prostate Cancer Task Force –** This legislative mandated task force is also a member of the National Alliance of Prostate Cancer Coalitions.

ADDRESSING DISPARITIES, SURVIVORSHIP, GAPS AND BARRIERS



SALLY DELIPKAU

helps people with cancer see over the rough, high walls of fear, despair, and pain. A Cancer Information Representative for Washoe Medical Center in Reno, she spends her days with patients and their families, giving them information, encouragement, and hope. When she speaks to them her words come from years of experience in this work and from another, deeper place within her: the place where her own fondest ideas about her life were rubbed raw by the sudden diagnosis, the long treatment, the trauma of cancer. She knows what chemotherapy is, and radiation. She knows the fear that comes when everything you care about in your life is rushing away from you at once. In 23 years, she has had cancer four times. She has been told to take a trip she always wanted to take, to buy her Christmas presents because Christmas was so many months away and her life might not stretch that far. But Sally has survived it all. If you speak with her, she will tell you she is doing just fine. That's the kind of woman she is. There is lightness to her and a kindness that envelops everyone who enters the warm circle of her presence. This woman must be a wonderful comfort, a gift to a fearful young mother about to have her 22nd radiation treatment in 27 days, to a middle-aged man wondering if he will see his grandchildren grow up.

ADDRESSING DISPARITIES, SURVIVORSHIP, GAPS AND BARRIERS

DISPARITIES

Many different demographic and socioeconomic characteristics are associated with health-related disparities. Income, race/ethnicity, culture, geography, age, gender, sexual orientation, and literacy are just some of the factors. Poverty is the most critical factor. Socioeconomic status influences the prevalence of underlying risk factors for cancer, such as tobacco use and obesity, access to appropriate early detection and cancer treatment, general medical care, and palliative care.
(Source: American Cancer Society Cancer Facts & Figures 2004)

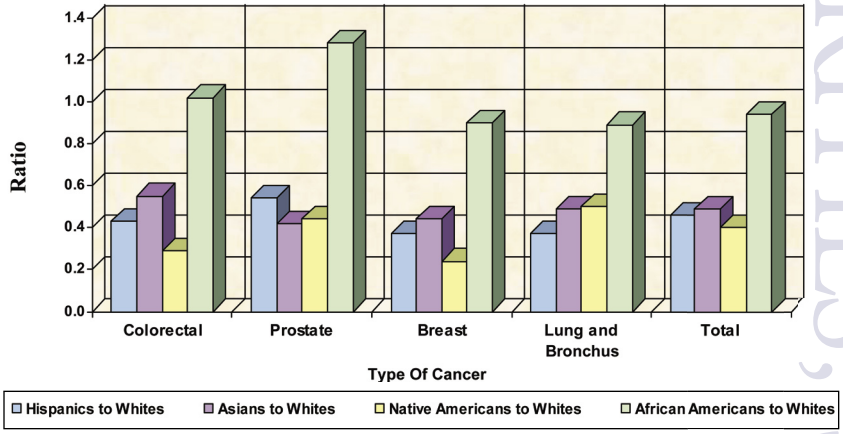
Nevada residents face some of the highest cancer mortality rates in the nation. A significant factor in cancer care outcomes in Nevada is the inadequacy in addressing health care needs of minority populations. A review of population data demonstrates that minority populations are among the fastest growing segments of Nevada's population. This growth has brought an increased diversity of cultures and languages, increased social and public welfare issues, increased stratification in income and increased demand for health and public services. Nevada's public health system and health policy makers have begun to recognize the need for long-range planning to meet the health needs of the state's increasingly diverse populations. In the 2001 report, "The State of Public Health in Nevada," minority health disparities was cited among the top ten planning issues shaping the future design of Nevada's public health system and services.

The burden of cancer is not borne equally by all population groups in Nevada. Low income and medically underserved populations have higher risks of developing cancer and poorer chances of early diagnosis, optimal treatment, and survival. Moreover, these populations have not benefited equally from recent improvement in cancer prevention, early detection, and treatment.

Eliminating health disparities is a key goal of the Nevada Cancer Plan, as well as national organizations and agencies, including the American Cancer Society and the U.S. Department of Health and Human Services' Healthy People 2010 initiative.

Statistical Cancer Facts for Minority Groups:
The unequal burden is exemplified by differences in cancer incidence and mortality as a function of race, ethnicity, gender, and socioeconomic status.

Figure 5. Race to Race Ratio Comparison Of Age-adjusted Incidence Rates - Nevada 1997 - 2001



Report on Cancer in Nevada, 1997-2001

Cancer General Facts – Hispanics

- Education levels, which are associated with economic levels and health status, are lower among Hispanics than other populations. For example, Hispanics are less likely to have a high school diploma than non-Hispanic Whites. In 1999, approximately 56.1% of Hispanics age 25 and older had finished high school, compared to about 87.7% of non-Hispanic White adults. *(Source: Hispanic Cultures, Latinos, Central Americans, AG Ramirez, L. Suarez, 2000 in press)*
- The most prevalent cancers for Hispanic men and women are the same as for Whites: prostate, breast, lung, and colorectal. *(Source: American Cancer Society Cancer Facts & Figures 2005)*
- Only 38% of Hispanic women, age 40 and older, have regular screening mammograms before symptoms develop. *(Source: US Census Bureau. The Hispanic population in the United States, 1999. Current Population Reports, Series -20-527. Washington, DC, 2000.)*
- Hispanics experience the highest invasive cervical cancer incidence rates (16.2 per 100,000) of any group other than Vietnamese, and twice the incidence rates of non-Hispanic White women (7.9 per 100,000). *(Source: American Cancer Society Cancer Facts & Figures 2004)*
- Low screening participation rates make Hispanic women more likely to be diagnosed at a more advanced stage of the disease

ADDRESSING DISPARITIES, SURVIVORSHIP, GAPS AND BARRIERS

when fewer treatment options are available, resulting in poorer outcomes and higher mortality. *(Source: Cervical cancer screening in regional Hispanic Populations. AG Ramirez, A McAlister, R. Villarreal, E Trapido, GA Talavera, E. Perez-Stable, J. Marti, American Journal of Health Behavior, 2000)*

Cancer General Facts - African American

- Surpassed only by unintentional injuries and homicides, cancer ranks as the third leading cause of death among African American children, ages 1-14 years. *(Source: Cancer Facts & Figures for African Americans 2005-2006)*
- Lung cancer accounts for the largest number of cancer deaths among both African American men (30%) and women (21%), followed by prostate cancer in men (19%) and breast cancer in women (19%). *(Source: Cancer Facts & Figures for African Americans 2005-2006)*
- Cancer of the colon and rectum and cancer of the pancreas rank third and fourth as leading causes of cancer death for African American men and women, *(Source: Cancer Facts & Figures for African Americans 2005-2006)*
- The most commonly diagnosed cancers in 2002 among African American men were prostate cancer (37%), followed by cancers of the lung (15%), and of the colon and rectum (9%). *(Source: Cancer Facts & Figures for African Americans 2005-2006)*
- The most common cancers among African American women in 2002 were breast cancer (31%), followed by lung (12%) and colorectal cancers (12%). *(Source: Cancer Facts & Figures for African Americans 2005-2006)*
- During the period 1989-1994, Whites experienced higher 5-year relative survival rates for all cancers than African Americans, regardless of stage at time of diagnosis. *(Source: Cancer Facts & Figures for African Americans 2005-2006)*
- Cancers among African Americans are more frequently diagnosed after the cancer has metastasized and spread to regional or distant sites. *(Source: Cancer Facts & Figures for African Americans 2005-2006)*

Cancer General Facts - Native American / Alaskan Native

- Cancer rates, which were previously reported to be lower among American Indian/ Alaska Natives has shown increasing rates over the past twenty years. *(Source: US Department of Health and Human Services, Indian Health Services. Trends in Indian health, 1998-99. Rockville, MD: Department of Health and Human Services, Indian Health Services; 2000)*
- Cancer is the second leading cause of death among American Indians and Alaska Natives ages 45 and older. *(Source: US Department of Health and Human Services, Indian Health Services. Trends in Indian health, 1998-99. Rockville, MD: Department of Health and Human Services, Indian Health Services; 2000)*
- The types of cancer experienced within Native American communities vary significantly by the geographic region with some unusual patterns (e.g., colon and lung cancer among Alaska Natives, lung, cervical, breast, and prostate cancer among Northern Plains tribes, and stomach and gallbladder cancer among Southwestern Tribes). *(Source: Patterns of cancer mortality among Native Americans, N. Cobb, RE Paisano, L. Burhansstipanov, Cancer 1998; 83(11):2377-83, Cancer) 2000)*
- Lung cancer is the most common cause of cancer death among eight of the nine Indian Health Service (IHS) Areas (three IHS Areas not included due to significant statistical errors). *(Source: Cancer Mortality Among American Indians and Alaska Natives in the United States: regional differences in Indian health 1989-1993. Rockville, MD: Indian Health Services; 1997. HIS Pub. No. 97-615-23.)*
- While common cancers in the general population are also common among American Indian/Alaska Native communities, there are some rarer cancers that are disproportionately seen among American Indians/Alaska Natives in different geographic regions of the country. Such cancers include:
  - **a.** Elevated incidence rates of stomach and gallbladder observed among Arizona and New Mexico American Indians.
  - **b.** High incidence rates of lung, colorectal, uterine cervix, prostate, kidney and stomach cancers among Alaska Natives.
  - **c.** Elevated lung, prostate and uterine cervix cancer

among Northern Plains American Indians. *(Source: Cancer Mortality Among American Indians and Alaska Natives in the United States: regional differences in Indian health 1989-1993. Rockville, MD: Indian Health Services; 1997. HIS Pub. No. 97-615-23.)*

- In comparison to the general population the prevalence rate of cigarette smoking is higher among American Indian tribes (41.7% for men and 38.1% for women). However, American Indian women in Arizona are the exception with a smoking prevalence rate of 16.7% (prevalence rate among American Indian men in Arizona is 23.6%). *(Source: Centers for Disease Control and Prevention. State specific prevalence of current cigarette smoking among adults – United State 1998. MMWR Morb Mortal Wkly Rep 2000; 49 (39):881-4.)*

Nevada conducted a Native American specific Behavior Risk Factor Surveillance System (BRFSS) over sampling survey in 2004. There were 652 completed interviews among the 18 federally recognized tribes and 1 Urban Indian Center in Nevada. Thirty-one percent of respondents reported current smoking; 34.4% among men and 29.1% among women.

Socioeconomic status (SES)

is an overriding factor closely tied to health status. People with higher income and SES have better health than those with a lower income and SES. SES also appears to be a strong force behind differences in health among racial and ethnic groups. Poverty affects health outcomes in part by limiting access to needed resources. Other factors of SES, such as education, geographic location, and occupation, also affect health. Often poorer neighborhoods are "economically segregated." This means that there may be a limited number of health care facilities available, as well as transportation problems in accessing the facilities.

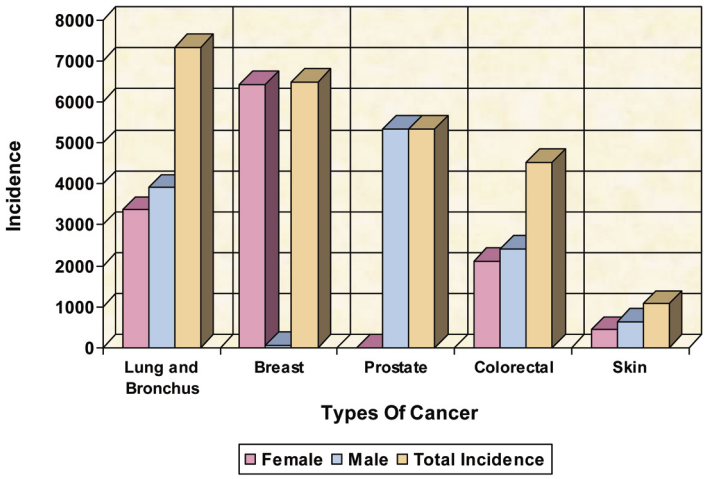
Despite the fact that many cancers can be prevented by taking advantage of current knowledge of primary or secondary prevention, minority and disadvantaged groups are less likely to benefit from knowledge about cancer prevention and early detection. Lower educational attainment and poverty translate into reduced opportunities in many ways beyond just a lack of knowledge. For example, low-income communities are less likely to have access to healthy foods and facilities for recreational physical activity than more affluent communities. Culturally sensitive and culturally appropriate effective cancer education, prevention, screening, early detection, case management, appropriate treatment, and good quality of life following diagnosis requires involvement and actions at various levels, including community groups, health care providers, educators, employers, and the individuals affected.

Although documenting socioeconomic disparities in cancer is clearly important in order to target specific underserved population subgroups and thereby reduce disparities, educational level, occupation, and income are not routinely gathered for cancer patients in Nevada. As an alternative, the county-specific poverty rate (the percentage of population who live at or below the poverty level) will be used as a surrogate measure for the economic deprivation and the uneven distribution of economic resources.

Gender Disparities in Nevada

and in the United States, cancer burden varies by gender. According to the **Report on Cancer in Nevada 1997-2001**, males had a statistically significant higher age-adjusted cancer incidence rate, 496.7 over the female rate of 423.0. Nevada rates are significantly lower than the national rates of 554.3 and 424.4, respectively. For all cancers during the report period (1997-2001) Nevada females had a higher one-year relative survival rate (75.7%) than males (70.2%). The trend was similar for the five-year relative survival rate with females and males at 54.5% and 47.2% respectively.

Figure 6. Most Common Incidence Of Cancer By Gender – Nevada 1997-2001



ADDRESSING DISPARITIES, SURVIVORSHIP, GAPS AND BARRIERS

Age Disparities

According the **Report on Cancer in Nevada 1997-2001**, cancer incidence differed significantly by age groups. Among children age 0-14 years the most common cancer was Leukemia (39.4%), followed by head and neck cancers (18.2%). Thyroid cancer (14.5%) was most common in the age group 15-24, followed by Hodgkin's Lymphoma (11.5%). Thyroid cancer was also most common among young adults ages 25-34, followed by breast cancer (12.3%). Breast cancer was the most common among adults ages 35-54 and it was the second most common among adults ages 55-64. Lung and Bronchus cancers were most common diagnosed cancer among adults ages 55-75+, and the second frequent cancer in the age group 45-54. During the reporting period, Lung and Bronchus cancer was the most commonly diagnosed cancer in Nevada reaching 18.0% of all cancer cases, followed by Breast cancer at 15.9%.

Geographic Disparities

With a total of 110,540 square miles, Nevada is the 7th largest state in the country. It is 485 miles long and 315 miles wide. According to the Nevada State Demographer the population of the state in 2003 was 2,296,566. Approximately 71% of the population resides in southern Nevada (Las Vegas metropolitan area), 18% in northern Nevada (Reno and Carson) with the other 11% living in the other 14 rural and frontier counties. About 87% of state land is federally controlled.

The Nevada State Health Division's Community Health Nursing Clinics, the sole provider of public health nursing in Nevada's 14 frontier and rural counties, endeavors to promote optimal wellness through the delivery of public health nursing, preventive health care, and health education.

Community Health Nursing (CHN) Clinics provide many health care services that include family planning, health education, cancer screening, and the diagnosis and treatment of sexually transmitted diseases. They also provide essential public health services such as immunizations, serve as school nurses in school districts that do not have one, and provide identification and treatment for communicable diseases such as Tuberculosis. With an area of responsibility of over 96,000 square miles, the nurses average 1,000 miles per month of traveling throughout these counties. The staff has earned a reputation of reliability and is a trusted source for health care for the working poor, uninsured, indigent, and rural populations within Nevada. CHN clinics operate on a sliding fee scale depending on income, but do not deny services due to inability to pay. When specialized care is needed residents in these counties have to travel to one of the urban centers in Nevada, or out of state, which can cause additional burdens, including transportation and housing costs and lost days of pay for themselves and their families.

Developing Interventions

Addressing disparities requires a multifaceted approach because the underlying factors producing disparities are complex. Disparate health outcomes are not primarily due only to one pathologic agent or a genetic factor. Instead, a broad range of social, economic and community conditions interplay with individual risk factors to intensify susceptibility and provide less protection and affect unhealthy behaviors. These conditions, such as deteriorated housing, poor education, limited employment opportunities, limited household resources, readily available cheap and inadequate high-fat/low fiber foods, and limited access to parks and recreational facilities are particularly exacerbated in neighborhoods where the racial/ethnic minorities and low-income groups live.

It is the relationship between place, race, and poverty that can lead to the greatest disparities. Research has shown that even after adjusting for individual risk factors neighborhood differences in cancer screening, incidence, treatment, and survival rates persist. Reducing such disparities requires community mobilization and actions at several levels.

The Nevada Cancer Council is committed to working with researchers, health care professionals, community organizations, and others to better determine the needs and priorities of our special populations, including our aging population, and to develop interventions to address these issues across the cancer continuum of care ranging from education, prevention, early detection, diagnosis, treatment, survival, quality of life, and end-of-life care.

ADDRESSING DISPARITIES, SURVIVORSHIP, GAPS AND BARRIERS

SURVIVORSHIP

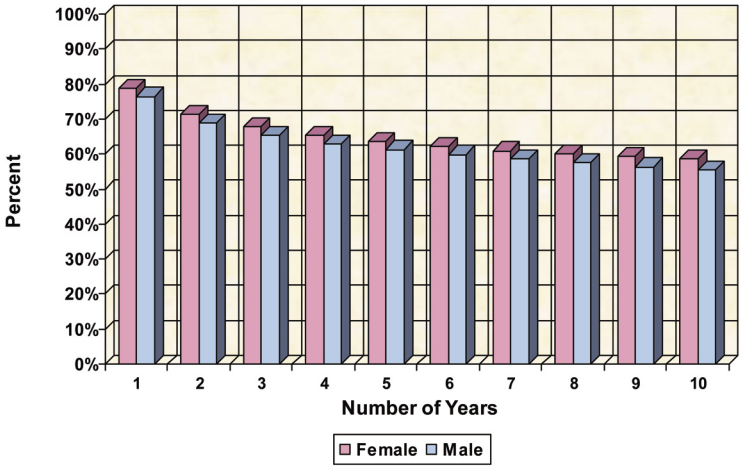
The following information is taken from national databases. Unfortunately, Nevada has limited data in the area of survivorship. This data gap is identified in the Quality of Life goals and objectives section.

A vital component of comprehensive cancer planning identified by the Centers for Disease Control and Prevention, and also recognized by the National Cancer Institute, is the growing cancer survivor population. The number of cancer survivors (cancer prevalence) continues to increase. As of January 2000, there were an estimated 9.4 million cancer survivors nationally (about 3% of the population). Among National Cancer Institute's Surveillance, Epidemiology, and End Results (SEER) programs, the overall 5-year survival rate for all cancers combined among adults is 65% (1995-2001), and the overall 5-year survival rate for children with cancer is 77%. While three out of every four Nevada families will be affected by cancer, the death rate for all cancers combined has been declining since 1990 and the proportion of patients alive five years after diagnosis has been increasing since 1975. Family members, friends, and caregivers are also impacted by the survivorship experience.

National initiatives are underway to address cancer survivorship issues and develop a more comprehensive approach to long-term survivorship. Key to addressing the needs of survivors is gaining understanding of their unique needs and concerns during the time following diagnosis. These needs and concerns span the physical, psychological, social-economical, emotional, and spiritual domains. Examples of survivor issues include concerns regarding quality of life, late-term and long-term effects of cancer treatment, re-employability and insurability, and fear of recurrence.

The Nevada Cancer Council will work to address the needs of the growing survivor population through activities that span the cancer control consortium, including palliation and quality of life. It will take a concerted effort to obtain better and more accurate data to describe the needs of survivors and to develop the means to appropriately and adequately address those needs. The Nevada Cancer Institute is developing a cancer survivorship program made possible by a donation from the Lance Armstrong Foundation. This gift will allow Nevada to have a program that will work towards collecting information and developing meaningful programs that will address issues of cancer survivorship.

Figure 7. Percentage Of Cancer Survivors, By Gender And Years After Diagnosis – US 2004



Surveillance, Epidemiology, and End Results (SEER) Program, November 2004

ADDRESSING DISPARITIES, SURVIVORSHIP, GAPS AND BARRIERS

GAPS AND BARRIERS

There are both gaps and barriers in our present cancer programs and services that need to be addressed in implementing this Plan. Some will require the development of new infrastructure and additional resources. Other will require changes in public policy. Several gaps and barriers can be addressed by improving access to existing programs.

Gaps

Need for additional infrastructure or resources:

- COLORECTAL CANCER Although colorectal cancer is the second leading cause of cancer death in Nevada and regular screening has been shown to be effective in lowering mortality and morbidity from the disease, screening rates are still low in Nevada, as they are nationally. However, before there can be public education campaigns to increase the number of Nevadans seeking screening for colorectal cancer, an assessment of the state's capacity will be needed to determine if additional infrastructure is required such as more trained professionals, facilities, and equipment.

- BREAST AND CERVICAL CANCER Women's Health Connection Program has proven to be effective in reaching low income, underinsured or uninsured older women across the state for breast and cervical cancer early detection and screening; however, additional resources are needed to maintain and expand this program, in order to reach more women of younger age groups that are not currently eligible for this program.

Need for policy changes:

- REIMBURSEMENT RATES The delivery of health care in Nevada is adversely affected by Medicare reimbursement rates that are lower than rates in many other states. Compounding this is the high percentage of Nevadans relying on Medicare and Medicaid (23%) and those who are uninsured (22%). When the cost of providing care exceeds the amount Medicare reimburses, the cost is passed along to health care organizations, providers, and privately insured individuals. In addition, many other health care reimbursement systems match Medicare rates, further limiting the pool of resources to recoup extra costs. Medicare reimbursement rates are calculated by the Centers for Medicare & Medicaid Services (formerly the Health Care Financing Administration) based on a national formula. A change in legislation would be required to increase the rates to better reflect the cost of providing health care in Nevada.

- SERVICE TO RURAL AREAS Some experts in the home health care field believe that metropolitan areas in the state have adequate numbers of service agencies. However, there is a shortage of agencies serving rural areas. Even in rural areas close to metropolitan centers, such as Pahrump and Tonopah (75 miles and 210 miles away from Las Vegas respectively), there is a shortage of services. This problem is exacerbated by the fact that agencies cannot afford to service those areas.

Need for improved education:

- CHANGING PERCEPTIONS There are opportunities to address gaps that do not necessarily require new services, significant increases in resources, or changes in policy. In some cases, education that changes perceptions of the public and/or providers about existing services could narrow gaps. For example, even though hospice reimbursement covered six months of care in 2001, the average length of stay in hospice nationally was two months. This limitation to optimum end-of-life care is believed to be primarily the result of negative attitudes and mistaken beliefs about hospice on the part of patients, family members, and health care providers. Frequently, physicians do not refer to hospice soon enough. Furthermore, patients and families usually do not know enough about the scope and value of hospice services and may not be open to facing the reality of end-of-life situations. Because feelings and beliefs about death and dying are as deeply held as any religious beliefs, health care providers must be sensitive to different ways patients and their families approach end-

of-life issues. Educational efforts to inform the public about the benefits of hospice care may improve utilization of these services.

- CULTURAL SENSITIVITY Another educational approach that could significantly narrow gaps that affect the welfare of Nevada's diverse population groups is enhancing culturally and linguistically appropriate information and programs along the continuum of care, from health education, prevention and risk reduction to screening and diagnostic follow-up, treatment, survivorship programs, and end-of-life care. At the screening and diagnosis stages alone, this could positively impact the unequal burden that Hispanics and American Indians bear as a result of late stage diagnoses.

Barriers

A number of practical barriers sometimes prohibit or delay cancer care for some Nevadans. Practical problems can also affect treatment decisions and make compliance with regular screening, treatment plans, and follow-up care difficult.

FINANCIAL BARRIERS Financial limitations create significant barriers to cancer care for many Nevadans. Research has demonstrated that poverty has a negative impact on cancer survival rates. In 1990, the American Cancer Society estimated low income Americans had a 10% to 20% lower rate of cancer survival than others in the U.S. *Source: Singh GK, Miller BA, Hankey BF, Edwards BK. Area socioeconomic status variations in US incidence, mortality, stage, treatment and survival 1975-1999, National Cancer Institute, 2003, NIH Pub. No. 03-547.*

- Ten percent of all Nevadans live below the federal poverty level, according to the 2000 U.S. Census, and a national ranking of 19th (Maryland is ranked first with 7.3% living below the federal poverty level). It is below the national average of 11.9%. Unfortunately, nearly one half of Native Americans and one quarter of Hispanics living in Nevada are at or below poverty level.
- In 2001, 22% of adults and 17% of children in the state had no health coverage for all or part of the year. Many other Nevadans are underinsured with coverage that does not include the full continuum of cancer care. For the working poor, many of whom are also uninsured or underinsured, leaving work for medical care adds to their financial burden.
- Native Americans are eligible to receive health care provided by the Indian Health Service either within IHS-owned facilities or at the expense of IHS through the Contract Health Services (CHS) Program, depending on the patient's eligibility status for CHS. Most of the 26 tribes in Nevada have a health care clinic and/or hospital, but must travel to Arizona for certain specialized health care services. Services are hard to find for Native Americans not affiliated with a Nevada tribe.

TRANSPORTATION TO AND HOUSING AT TREATMENT CENTERS Transportation in this largely rural state is a significant barrier to cancer care, with many of the state's residents living hundreds of miles from metropolitan areas where most of the cancer care services are offered. The Disabled American Veterans organization operates an extensive, volunteer, statewide transportation system for Veterans Administration patients, and the American Cancer Society (ACS) offers its Road to Recovery program in some areas. Nevertheless, for many Nevadans transportation issues pose major problems to accessing cancer care. When a treatment plan requires regular, sometimes daily, appointments at a cancer treatment facility far from their homes, housing presents major problems to some rural cancer patients and family members.

SOCIAL BARRIERS Psychological and social barriers to cancer care affect all patient groups to some degree, regardless of culture, income level, or age. These barriers have been shown to lower screening rates, delay follow-up of abnormal screening results, influence choices in treatment options, compliance with treatment, and create emotional distress throughout the continuum of care.

- One of the most prevalent psychological barriers is fear. Fear of the medical procedure itself can be a deterrent, but probably more

ADDRESSING DISPARITIES, SURVIVORSHIP, GAPS AND BARRIERS

common is fear of discovering the disease and its potential, real or perceived, for a devastating impact on the lives of the patient and family members. For some patients, mistrust of physicians, western medicine, and the health care establishment contributes significantly to fear.

- Embarrassment and anxiety about loss of privacy are also issues for people of all cultures, although they may be more commonplace in some cultures and some age groups. Depression and shock are common emotional responses to a cancer diagnosis that can be serious deterrents to receiving care, contributing to lack of follow-up and confusion about decisions affecting medical care. For patients and family members who are isolated and without adequate social support, these common psychological barriers can be particularly troublesome.

- Lack of information and knowledge about cancer and the health care system can be a significant impediment to care for all groups of people. This may be more prevalent among patients with low socioeconomic status who tend to have lower education levels. Some public health specialists believe that low socioeconomic status is the most important risk factor for inadequate health care, regardless of culture or race/ethnicity.

- Age also can be a barrier. Generally speaking, elderly patients from all cultures are less comfortable than younger patients with the culture of high technology that is so much a part of modern medical care, and they are also more uncomfortable with the loss of privacy. In addition, older people from minority groups are less likely to be acculturated to the dominant culture.

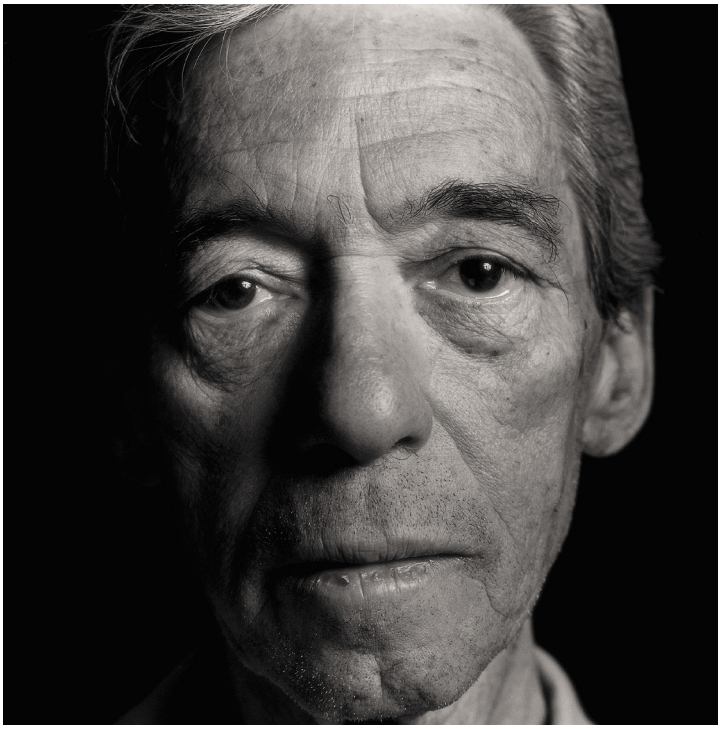
CULTURAL BARRIERS Although none of the ethnic/racial groups in Nevada is homogeneous, and barriers to care vary widely within any group, some barriers to cancer care are more prevalent in certain population groups.

- Language may be the easiest barrier to identify. It is a very real problem in a state that has two major languages (English and Spanish), numerous Native American languages, and many residents who do not speak English, the dominant language in the medical system.

- Differences in communication styles also vary from culture to culture. Simple translation from one language to another is often inadequate for clear communication. Some Native American languages in the state do not even have a word for cancer.

- Beliefs about illness in general, and cancer specifically, also vary significantly. In some groups, cancer may be defined as a death sentence, believed to be contagious, or carry a stigma that makes talking about the disease difficult.

- Decisions about health care are always made within a cultural context. In Nevada, the rich diversity of cultures requires that providers and health care systems be knowledgeable about cultural differences and flexible about the many different approaches that patients bring into health care settings.



Ruben Rivero

shouldn't be alive. The long string of his life should have been broken by now. He thanks four physicians in Las Vegas, and cutting edge technology in Los Angeles for the miracle of these days. Four years ago, working in maintenance at the Forum Shops at Caesar's Palace, Ruben began to experience severe stomach pain. His internist sent him to a gastroenterologist who, suspecting cancer, made an appointment for Ruben with an oncologist. He was diagnosed with pancreatic cancer. The prognosis was not good and surgery was his only chance for survival. The surgeon told Ruben that surgery itself was rife with danger, but that it could not even be attempted without the most precise information about the size and location of the tumor. Because the necessary imaging technology did not exist in Las Vegas, Ruben went to the UCLA Medical Center. The procedure showed that the tumor was in an area where surgery would be possible. It was performed in Las Vegas in October 2001. Ruben continues to beat tremendous odds because his physicians in Las Vegas acted quickly and decisively when his life was in immediate jeopardy.

GOALS, OBJECTIVES AND STRATEGIES

GOALS, OBJECTIVES AND STRATEGIES

From the very early stages community partners showed sustainable involvement and firm commitment to create an inclusive Nevada Comprehensive Cancer Plan that is scientific, realistic, practical. After an extremely rich and diverse community input, the Steering Committee decided to approach cancer planning efforts by looking at five major and specific categories:

- **Prevention**
- **Screening, early detection and diagnosis**
- **Treatment**
- **Clinical trials**
- **Quality of life and palliative care**

Based on the above categories Nevada Cancer Plan has set six broad goals:

GOAL 1. **Reduce the risks for developing cancer.**

GOAL 2. **Increase early detection and appropriate screening for cancer.**

GOAL 3. **Increase access to appropriate and effective cancer treatment and care.**

GOAL 4. **Increase the number and diversity of clinical trial participations in Nevada.**

GOAL 5. **Address quality of life issues for health care consumers affected by cancer.**

GOAL 6. **Improve the coordination and collaboration among cancer control efforts.**

Nevada Cancer Plan offers a road map for use by the community members in all areas of cancer prevention and control. The goals are broad and are directed at improving the lives of all Nevada residents.

Many important issues (needs and priorities) were identified during community meetings. Some became part of the objectives and strategies. Others have been included in the form of general policy or research recommendations under each goal.

The Committees have emphasized objectives and strategies that are realistic given the state's current and expected resources available for cancer prevention and control. The objectives and strategies are varied and provide numerous "binding sites" with which interested partners can connect. Attention has been given to serving all geographic parts of the state and all of the state's diverse populations, and to addressing cancer-related health disparities. Wherever possible, the objectives and strategies are measurable and time-bound, and indicate the source for collecting data. However, some objectives are identified to highlight their importance in cancer control, even though there are no existing sources for data collection or no agencies currently addressing those objectives.

Implementation will include local activities in communities across the state, collaborative efforts among small groups around specific areas of interest, and statewide efforts. Progress toward meeting the goals in this Plan will be evaluated annually and a report will be distributed to the appropriate stakeholders. This Plan will be updated on a regular basis to reflect the progress in cancer control and to ensure that it continues to meet the changing needs and capacities of our state.

GOAL 1: REDUCE THE RISKS FOR DEVELOPING CANCER

Cancer prevention is a proactive approach to keeping the population healthy, therefore reducing the risks for developing cancer involve a long-term commitment and continuous efforts at all levels of society, including community development and mobilization, public policy, public health initiatives, and informed personal choices.

Cancer risks include "unhealthy" behaviors and lifestyles, negative environmental exposures, hereditary, aging, public health policies, and the lack of access to health care. While risk factors such as age and family history cannot be altered, individuals can significantly reduce their own risks by modifying some behaviors. Business policies and government regulations play an important role in cancer prevention for larger segments of the population.

Scientists estimate that as many as 50% to 75% of all cancer deaths in the United States are caused by "risky" human behaviors such as smoking, physical inactivity, and poor diet choices. Eliminating tobacco use, incorporating healthy eating and activity practices, and limiting exposure to ultraviolet radiation would have a significant positive impact on reducing cancer rates over time.

TOBACCO USE

Tobacco use is the most preventable cause of death in Nevada and in the United States. It is responsible for 87% of all lung cancers and is a contributing factor

in other cancers, including head and neck cancer, esophageal, bladder, pancreatic, uterine cervix, and kidney cancers. Each year, more than 2,000 Nevadans die from smoking-related causes.

To address the negative effects of smoking on health, the Centers for Disease Control and Prevention (CDC) formed the National Tobacco Control Program and by 1999 all 50 states were funded. The four goals of this program are: 1) preventing initiation among young people, 2) eliminating exposure to second hand smoke, 3) promoting quitting among adults and young people, and 4) identifying and eliminating disparities among populations.

Because most adult current smokers started smoking before the age of 18, preventing young people from becoming smokers is a critical piece of any tobacco control plan. Of Nevada adults who smoke every day, 72% report having started when they were 18 or younger.

Objective 1.1: Prevent the Initiation of Tobacco Use Among Young People

Baselines:

- **High School Youth Smoking Previous 30 days – Baseline 19.6%**
- **High School Youth Using Chewing Tobacco Previous 30 days – Baseline 3.6%**
- **Adults Currently Smoking – Baseline 23.2%**
- **Adults Attempts to Quit – Baseline to be determined**

Data Source: Centers for Disease Control and Prevention; Healthy People 2010 Report; Youth Risk Behavior Survey (YRBS 2003), Nevada Behavior Risk Factor Surveillance System (BRFSS 2004)

Strategies:

- Increase counter marketing to youth under age 18 and to young adults age 18-24.
- Increase participation in school and community based activities by organizations and individuals serving and/or influencing youth to prevent youth tobacco use.
- Engage the public and political leaders in activities promoting policy change to reduce tobacco use by youth.
- Provide technical assistance to local and statewide partners for the wide use of evidence-based effective interventions promoting non-use of tobacco products by youth.

Objective 1.2: Promote quitting among young people and adults

Strategies:

- Increase awareness, availability, and access to nicotine dependence treatment and tobacco use cessation resources.
- Increase tobacco excise tax.
- Integrate tobacco dependence referral and treatment interventions into routine health care.

Objective 1.3: Eliminate non-smoker's exposure to second hand smoke

Strategies:

- Educate the public, including community leaders, about the harmful effects of secondhand smoke.
- Eliminate state laws that preempt strong tobacco control laws and promote the positive health and economic impacts of laws and policies that restrict smoking.
- Increase enforcement of federal and state secondhand smoke laws and regulations, and corporate voluntary policies.

Objective 1.4: Identify and eliminate the disparities related to tobacco use and its effects among different population groups

Strategies:

- ✤ Increase knowledge and awareness in target populations of tobacco use in their communities and the marketing tactics used by the tobacco industry by involving representatives and organizations in state and local coalitions.
- ✤ Provide technical assistance to local and statewide partners for the wide use of evidence-based effective interventions promoting non-use of tobacco products by target populations with tobacco related disparities.

SUN EXPOSURE

Exposure to the sun's ultraviolet (UV) radiation is a known cancer risk factor. Because more than half of a person's lifetime skin damage from sun exposure occurs by the age of 18, educating parents, caregivers, and children is critical.

Sun safe behaviors can protect against the two categories of skin cancer:

- **Non-melanoma cancers (basal cell and squamous cell carcinomas) are highly curable.**
- **Melanoma is the less common but more serious form of skin cancer.**

The risk for squamous cell carcinoma is strongly associated and increased with long-term overexposure to UV radiation. Episodes of severe, blistering sunburn are a major risk factor for both melanoma and basal cell carcinoma.

To reduce the risk of skin cancer stay out of the sun between 10:00 a.m. and 4:00 p.m. and wear protective clothing, including a wide brimmed hat and sunglasses. Sunscreen with a minimum sun protection factor (SPF) of 15 should be used in addition to other sun protection behaviors.

Objective 1.5: Increase the number of Nevadans using at least one of the following protective measures to reduce the risk of skin cancer:

- Avoid the sun between 10:00 a.m. and 4:00 p.m.
- Wear sun-protective clothing when exposed to sunlight
- Use sunscreen with a sun-protective factor of 15 or higher
- Avoid artificial sources of ultraviolet light

Data Source: CDC Behavioral Risk Factor Surveillance System (2003)

Strategies:

- ✤ Work with public schools to develop policies that reflect sun-safe behaviors, including the provision of shaded play areas and policies allowing/encouraging the use of hats outdoors.
- ✤ Increase the number of day care centers that promote healthy behaviors in regards to sun exposure and protective clothing.
- ✤ Increase the number of employers with outdoor workers that have education programs to encourage protection from sun exposure.
- ✤ Increase the number of communities with public transportation that provide covered bus shelters.
- ✤ Promote social marketing messages about sun safety, reaching the average resident 8-12 times a year.
- ✤ Explore the applicability of a statewide sun safety outreach program modeled after the successful Sun Smart, Australia's sun protection outreach program.
- ✤ Use the Environmental Protection Agency's UV monitoring network already in place to provide the public with practical guidelines for reducing by a factor of two the annual cumulative exposure to UV radiation.
- ✤ Work with meteorologists in the state's mass media outlets to add UV radiation intensity level reporting, including advice on what specific sun safe behaviors should be used to reduce UV exposure, and develop and promote a media-based UV warning system similar to the (green/red drop day) used for water conservation.
- ✤ Develop a surveillance source for determining the number of Nevadans who use at least one protective measure to reduce the risk of skin cancer.

NUTRITION AND DIET

Healthy eating habits and practices, including reduced fat intake and increased consumption of fruits, vegetables, and whole grains, may offer protection from certain types of cancer. In addition, limiting foods that are high in nitrates (used as a preservative in some meats) and foods that are pickled, smoked, or heavily salted can reduce the risk of stomach cancer. Using alcohol in moderation, if at all, can reduce the risk for

oral cancer; and eating a diet low in fat, especially low in saturated fat, may reduce the risk of prostate cancer.

Research suggests that some one-third of all cancer deaths are associated with nutritional factors and obesity. The National Cancer Institute recommends a diet including five or more servings of fruits and vegetables a day, whole grains, and low-fat foods because of indications that these may reduce the risk for developing cancer.

Objective 1:6: By 2006, increase the number of persons aged 13 and older following dietary guidelines that recommend eating five or more servings of fruit and vegetables per day

Target: 25% of adults
45% of all youth, ages 13 - 17

Baseline:
20.4% of adults
44% of male adolescents, ages 13 – 17
27% of female adolescents, ages 13-17 (unweighted data from 2003 Youth Risk Behavior Survey)

Data Source: CDC Behavioral Risk Factor Surveillance System, 2003 Youth Risk Behavior Survey

Strategies:

- Work with the Nevada Alliance for Chronic Disease Prevention, dietetic organizations, school food service workers, and school boards to improve the quality of foods and beverages in schools.
- Explore expanding the use of evidence-based, comprehensive programs such as Pathways* that improve school food.
- Explore implementing evidence-based programs that use youth advisors and peer leaders.
- Increase the number of social marketing messages about the benefits of healthy eating.
- Provide counseling to mothers in the Women, Infants, and Children Supplemental Nutrition (WIC) Program on the importance of reducing dietary fat and increasing consumption of fruits, vegetables, and whole grains.

Physical Activity

Regular, moderate physical activity has been demonstrated to benefit health and decrease overall mortality. Research suggests that regular physical activity may reduce the risk for developing colon cancer. In addition, physical activity may serve to reduce the prevalence of tobacco use.

Objective 1.7: By 2006, increase the number of persons aged 13 and older participating in regular exercise

Target: 55 % of adults
75 % of youth, ages 13 – 17

Baseline: 50.8 % of adults exercise at least 20 minutes per day, three days per week
62.5 % of youth, ages 13 - 17, participate in vigorous physical activity three or more days per week (unweighted data from 1999 Youth Risk Behavior Survey)

Data Source: CDC Behavioral Risk Factor Surveillance System, 2003, 1999 Youth Risk Behavior Survey

Strategies:

- Explore implementing evidence-based programs that use youth advisors and peer leaders.
- Work with the state and local agencies and organizations to increase participation in school and worksite physical activity programs.

GOAL 2:
INCREASE EARLY DETECTION AND APPROPRIATE SCREENING FOR CANCER

Although many cancers could be prevented by lifestyle and behavioral changes, there are no known risk factors for some cancers. For many of these cancers, regular population-based screening or high risk targeted screening, and early detection could provide a good approach to cure or control of cancer. Studies have shown that following age and gender-appropriate cancer screening guidelines was able to significantly lower death rates from breast, cervix, and colon/rectum.

Unfortunately, routine adequate screening methods are not available for many other types of cancer and population-based screening has not yet been shown to increase survival rates of some cancers, such as lung, ovarian and prostate cancer. Research continues to identify new and more efficient methods for early detection and treatment of these and other cancer types.

Breast Cancer

In 2005, an estimated 1,620 new cases of breast cancer will be diagnosed in Nevada, according to the

GOALS, OBJECTIVES AND STRATEGIES

American Cancer Society's 2005 Cancer Facts & Figures. Breast cancer is the most common cancer among women in the U.S. (excluding cancers of the skin). Female gender is the primary risk factor for breast cancer, followed by age. Other risk factors include: family history, early menarche, late menopause, oral contraceptive use, history of estrogen replacement therapy, never had pregnancy and delivery, benign breast disease (fibro cystic changes with biopsy proved atypia), and first pregnancy after age 30.

Objective 2.1: By 2006, increase the proportion of women age 50 and older reporting having had a mammogram in the past two years

Target: 85%

Baseline: 80.0%

Data source: Behavioral Risk Factor Surveillance System, 2002.

Strategies:

- Continue public education and outreach regarding Women's Health Connection Breast and Cervical Cancer Education Program in order to increase mammography in low-income women, and to provide services for uninsured women between 40 and 64 years of age.
- Increase public knowledge of the availability of Medicare coverage for payment of mammography screening for eligible parties.
- Continue outreach efforts to all women in Nevada about the importance of regular mammography screening.
- Promote access to and increased services in women located in rural areas through the promotion of the mobile mammography unit (Mammovan) for Nevada.
- Develop partnerships with correctional, domestic abuse, homelessness and mental health systems, and nursing homes to advocate and promote screening to women.
- Educate primary care providers on strategies for informing women of the need for breast cancer screening and the importance of their role in recommending screening to women.
- Inform the public about available cancer risk assessment services through health care professionals and organizations.
- Encourage churches, civic groups, schools, organizations, and businesses to utilize available resources and screening services during community events.
- Provide periodic continuing provider education programs on mammography and clinical breast exam techniques.
- Work with health professional training programs to teach state-of-the-art techniques for breast cancer screening exams and tests.
- Support the activities of the American Cancer Society and the Susan G. Komen Foundation.

Objective 2.2: By 2008, reduce the disparity gap and increase the rate of minority/ethnic/rural and other certain disparate subgroups of women age 50 and over who have received a mammogram in the past two years by 5%

Baseline: African American Women – 71%

Hispanic Women – 65.3%

Data Source: Behavioral Risk Factor Surveillance System, 2002

Strategies:

- Support existing programs and develop new programs that educate diverse populations of women on breast health and the importance of mammography screening.
- Provide culturally and linguistically appropriate educational/marketing materials.
- Identify marketing channels specific to underserved audiences.
- Promote mechanisms for prompt notification about mammogram results in a form that is comprehensible and culturally appropriate.
- Promote the use of reminder and tracking systems to inform women of their need for follow-up and/or re-screening.
- Increase the use of aggressive notification follow-up for abnormal mammogram results.

Objective 2.3: By 2008, Develop resources and facilitate access for women age 40-49 who desire to be screened for breast cancer

Target: 75%

Baseline 69.2% women aged 40+ who have had a mammogram within the past two years

Strategies:

- Explore potential funding sources to facilitate

GOALS, OBJECTIVES AND STRATEGIES

access to screening or diagnostic mammography for women age 40-49.

Data Source: Behavioral Risk Factor Surveillance System, 2004

Objective 2.4: Determine current state of mammography access in the state of Nevada, particularly in rural Nevada.

Baseline: To be determined.

Strategies: After determination of current state of access:

- Maintain referral resources at diverse geographic locations to provide comprehensive information on diagnosis and treatment services to women with breast abnormalities.
- Endorse the establishment of networks and linkages among rural providers and urban centers so that screening services and care are available to rural Nevada residents.
- Support American Cancer Society's efforts to make transportation services, such as Road to Recovery, more readily available to cancer patients, particularly in rural areas.

CERVICAL CANCER

The decline in cervical cancer mortality in the 1970's, 1980's, and 1990's is thought to be due primarily to the widespread use of the Papanicolaou (Pap) test for early detection of cervical cancer. Increased use of the Pap test has the potential to further reduce morbidity and mortality due to invasive cervical cancer. A number of studies have found that the Pap test is effective in screening for cervical cancer and can reduce mortality by as much as 75 percent. Cervical cancer is almost always caused by the common human papillomavirus (HPV). Only HPV infection that persists can lead to cancer. A test, approved by the FDA, to detect HPV in women age 30 and older is now available. Nevada Medicaid offers coverage of HPV testing without restriction. A HPV vaccine is currently going through the approval process by the Federal Drug Administration (FDA). Requirements and protocols for administering the vaccine have not been determined yet.

Objective 2.5: By 2006, increase to 90 percent the number of women, age 18 and older, reporting having had a Pap smear in the prior 3 years

Baseline: 84.7% of women in Nevada report having had a pap smear within the past 3 years

Data source: Behavioral Risk Factor Surveillance System, 2004

Strategies:

- Educate primary care providers on strategies for informing women of the need for cervical cancer screening and the importance of their role in recommending screening to women.
- Encourage clinics to extend clinical hours beyond traditional business hours. Compile a directory of those clinics with extended hours.
- Through Nevada's self-insured health plans, encourage the utilization of covered screenings for their membership.
- Continue to support and promote the Women's Health Connection Breast and Cervical Cancer Early Detection Program to provide services for low-income, uninsured women between 40 and 64 years of age.
- Develop partnerships with correctional, domestic abuse, homeless, nursing homes and mental health systems.

COLORECTAL CANCER

Colorectal cancer is the third most common cancer both in men and in women. From 1998 to 2000, incidence rates marginally declined by 3% per year nationally. Research suggests that this decline may be in part due to increased screening and polyp removal, preventing progression of precancerous polyps to invasive cancers. In 2004, over half of Nevadans over age 50 never had a colonoscopy or sigmoidoscopy (BRFSS). **According to the American Cancer Society's "Cancer Facts and Figures 2005,"** more than 1,240 Nevadans will be diagnosed with colon and rectum cancer in 2005.

Objective 2.6: Increase the proportion of people aged 50 and older who have received a flexible sigmoidoscopy every five years or colonoscopy every ten years or double contrast barium enema every five to ten years to 60% by 2007

Target: 60%

Baseline: 46.7% of Nevadans aged 50 and older report having a proctoscopic exam

Data Source: Behavioral Risk Factor Surveillance Survey - 2004

Strategies:

- Promote colorectal screening through public awareness campaigns.

- Develop professional education for primary care providers to support patient education and regular screenings.
- Evaluate the geographic distribution of cancer screening and diagnostic services.
- Evaluate the effectiveness of strategies that encourage people to use screening and diagnostic services with an emphasis on high-risk, underserved populations, and Nevadans residing in rural areas.

Objective 2.7: Increase the awareness and education of prostate cancer among men in Nevada.

Strategy:

- During the 2001 session of the Legislature, a Prostate Cancer Task Force was created, passed and signed by Governor Kenny C. Guinn. In June 2003 the Nevada State Health Division in collaboration with the task force prepared and published a Prostate Cancer Profile for the state of Nevada. The completeness of this Profile allowed it to become a template for the statistics of all cancers; a consistent track to run on which will help the Nevada Statewide Cancer Registry and the SEER registry.

GOAL 3: INCREASE ACCESS TO APPROPRIATE AND EFFECTIVE CANCER TREATMENT AND CARE

Surgery, chemotherapy, and radiation therapy have long been the mainstays of cancer treatment. In more recent years, new approaches such as biologic response modifiers and monoclonal antibodies have been added to standard treatment options. The goals of cancer treatment vary from patient to patient. They may include removing a precancerous lesion or polyp, curing the cancer, managing the disease as a chronic illness, alleviating discomfort or suffering caused by cancer or cancer treatment, or providing comfort during a patient's final months or days of life.

Most of the treatment facilities and oncology practices in the larger communities, Las Vegas, Reno, and Carson City, provide a variety of treatment options, including clinical trials, and have departments or staff dedicated to research. Some facilities and practices offer unique diagnostic or treatment options not available elsewhere in the state. Some also have supportive services for patients and family members provided by professionals such as social workers dedicated to oncology care. These services include individualized counseling, relaxation sessions, support groups, and cancer education tailored to a specific patient. American Cancer Society programs such as I Can Cope, an educational series; Look Good Feel Better, a service to teach women beauty techniques; and Reach to Recovery, a support program for breast cancer patients, are also provided at some treatment facilities.

Objective 3.1: Increase the number of hospitals in Nevada that participate in the American College of Surgeons Commission on Cancer Programs (ACoS)

Baseline: To be determined

Data Source: No current data source exists for this objective

Strategies:

- Determine the number of hospitals currently participating in ACoS surveys.
- Promote the benefits of ACoS approval to hospital administrators.

Objective 3.2: Increase the number of providers that are knowledgeable regarding quality cancer care

Baseline: To be determined

Data Source: No current data source exists for this objective

Strategies:

- Develop data collection methods to set baseline for this objective.
- Pilot a video teleconference tumor board between the Nevada Cancer Institute and the cancer clinicians throughout our state.
- Promote the establishment of a medical oncology residency program in Nevada in partnership with NVCI and the University of Nevada School of Medicine. This will require oncologists, radiologists, pathologists, surgeons, and radiation oncologist in significant numbers.
- Encourage professional oncology organizations such as the Nevada Oncology Society and Oncology Nursing Society to offer educational seminars and collaborate regarding education of non-oncology providers.
- Establish guidelines for home health agencies treating cancer patients to ensure quality of life issues are being addressed.

GOALS, OBJECTIVES AND STRATEGIES

Objective 3.3: Increase the use of guidelines compiled by the National Comprehensive Cancer Network, or other nationally recognized organizations, for cancer care among cancer treatment providers in Nevada

Baseline: To be determined

Data Source: No current data source exists for this objective

Strategies:

- Work with public and private organizations and the University system in Nevada to promote the use of guidelines with providers.
- Develop and implement professional education on the use of guidelines.

Objective 3.4: By 2007, increase the number of providers other than oncologists who are knowledgeable about optimal cancer screening and care

Baseline: To be determined

Data Source: No current data source exists for this objective

Strategies:

- Identify and utilize existing processes to educate providers on the most recent practice guidelines regarding screening and referral for cancer care.
- Increase the number of physicians trained in cancer detection techniques and practices.
- Educate providers on how to interpret and discuss screening results with patients.
- Increase the number of providers who are fully informed about late effects of treatment and who provide appropriate follow-up and information on treatment-related disorders.

Objective 3.5: By 2007, increase access to optimal cancer care for Nevadans living outside of the major metropolitan areas

Baseline: To be determined

Data Source: No current data source exists for this objective

Strategies:

- Implement a comprehensive statewide program to address transportation barriers to care.
- Promote and support existing services that provide housing for patients in cancer treatment and their family members when optimal treatment requires staying away from their homes in communities closer to treatment facilities.
- Increase the number of home health and hospice services that reach Nevadans living in small communities and remote areas.
- Increase screening and support programs being developed for rural residents.

Objective 3.6: Decrease fragmentation of services and improve coordination of existing services for all Nevadans.

Baseline: To be determined

Data Source: No current data source exists for this objective

Strategies:

- Increase the amount of training on end-of-life care for students preparing for cancer-related health care professions.
- Provide educational opportunities for health care providers in cancer related fields on culturally appropriate end-of-life services for all of the state's diverse populations.
- Increase the number of home health care and end-of-life services that reach Nevadans living in small communities and remote areas.
- Educate patients, communities, and clinicians regarding available services.
- Create statewide cancer resource guide for all cancer related services in the state of Nevada.

GOAL 4:
INCREASE THE NUMBER AND DIVERSITY OF CLINICAL TRIAL PARTICIPANTS IN NEVADA

Objective 4.1: Increase the number and diversity of clinical trial participation by 5% per year starting in 2006.

Baseline: Less than 5% adult participation in clinical trials.

Data source: National Cancer Institute, Nevada Report on Cancer, Cancer Information Services, Southern Nevada Cancer Research Foundation

GOALS, OBJECTIVES AND STRATEGIES

Strategies:

- Increase enrollment in clinical trials by enlisting the physicians/providers' support and participation to increase awareness to the critical need of their active role in medical research.
- Review current health insurance legislation and insurance efforts for provisions that promote coverage of the National Cancer Institute-approved clinical trials and state-of-the-art therapies.
- Improve scientific knowledge and offer cutting edge therapies by increasing the number of all participants in approved clinical trials in Nevada as stipulated in the objective.
- Improve information about, access to, and utilization of cancer clinical trails options for racial/ethnic minorities and other underserved populations in Nevada.
- In addition to increasing enrollment in community based oncology practices, increase recruitment of research-focused oncologists to the Nevada Cancer Institute to significantly increase the number of open protocols in our state.

GOAL 5:
ADDRESS QUALITY OF LIFE ISSUES FOR HEALTH CARE CONSUMERS AFFECTED BY CANCER

Quality of Life is a concept that encompasses spiritual, psychological, emotional, financial, and physical well-being. It is influenced by age, gender, sexual orientation, urban/rural location, and socioeconomic status, level of education, immigration status, culture, and access to health care.

The exceptional diversity of Nevada's population presents both a challenge and an asset to addressing quality of life issues. Research into quality of life issues is encouraging; however, it should not preclude offering services to address the needs of people dealing with cancer in their daily lives.

Palliative care addresses relieving pain and other symptoms associated with cancer or its treatment, especially as patients are nearing death. While pain management is a key aspect of hospice care, it is important during any stage of cancer treatment when pain is present. Various methods of relief are available, depending on the source and severity of the pain. Treatment options include medication with non-opioids (such as acetaminophen or ibuprofen), opioids (such as codeine or morphine), steroids, and local anesthetics. Other treatments for pain include surgery, radiation therapy, and chemotherapy.

Objective 5.1: By 2006, increase activities to inform the public about quality of life issues related to cancer and the available resources addressing those needs

Baseline: To be determined

Data Source: No current data source exists for this objective

Strategies:

- Gather resource information from groups including, but not limited to, cancer programs at hospitals, cancer centers, oncology practices, American Cancer Society, rural health providers, support organizations, rehabilitation centers, and hospices.
- Develop and routinely update all inventory resources available to cancer patients in Nevada, and when possible, monitor patterns of utilization and changes in quality of life.
- Develop presentations on quality of life issues for health care consumers, including available resources, information on how to locate additional local and national resources.
- Beginning in 2006, make presentations each year on quality of life issues and resources to at least two I Can Cope classes and to the Nevada Cancer Council.
- Provide information on available quality of life resources to health care providers including the regular updating and distribution of community resource guides.
- Promote educational initiatives on palliative care and end-of-life services for all Nevada residents particularly those in underserved areas.
- Explore how the policies regulating reimbursement for home health care in rural areas can be more culturally appropriate for diverse communities.

Objective 5.2: By 2006, increase activities to inform those affected by cancer of their right to participate fully in their care and encourage them to participate as fully as they are comfortable

Baseline: To be determined

Data Source: No current data source exists for this objective

Strategies:

By 2006, develop presentations on patient

empowerment for health care consumers, including:

- How consumers can make well-informed decisions about medical treatment, complementary and alternative therapies, and integrating different kinds of therapies.
- How to empower patients to consider a wide variety of options to improve quality of life.
- How consumers can advocate for themselves and navigate the health care system.
- The need for appropriate and effective follow-up care.
- The importance of learning about the long-term and late effects of cancer and treatment and how to access this information.
- Home health care, palliative care, and end-of-life information and available services.
- How to locate evidence-based information on healthy lifestyles and reducing risks for cancer.
- Make presentations each year on patient empowerment issues and resources to at least two I Can Cope classes and to the Nevada Cancer Council beginning in 2006.
- Develop and deliver a campaign to educate the general public about palliative care and end-of-life services.
- Explore the possibility of using patient guides/advocates at clinical sites to help patients navigate the medical system.
- Provide easy access to consumer information through agencies, web sites, and cancer care facilities.

Objective 5.3: By 2006, identify and promote successful approaches that make existing quality of life resources more accessible to the state's underserved populations; define and support the creation of new resources where needed

Strategies:

- Convene an annual meeting of lay health workers and public health employees within the context of an existing annual conference to discuss strategies to improve the quality of life of survivors and family members, especially those who are isolated in small communities and rural areas; publish a report; and implement the strategies identified.
- Within the context of an existing conference, develop a workshop on specific strategies for addressing fear and anxiety of those who receive abnormal screening test results but have not yet followed up with definitive diagnostic procedures.
- Gather current research on and develop methods to reduce barriers to services by low income groups, residents living in small communities and remote areas, and undocumented residents.
- Study cancer care issues for undocumented Nevada residents.
- Review literature on the impact of low Medicare reimbursement rates on cancer treatment.
- Create and distribute materials and programs that are sensitive to patient's culture and language and create quality care and referrals to support services.

Objective 5:4 Assist cancer patients in identifying and using cancer care and support services

Strategies:

- Publicize the availability of free cancer information services such as those of the American Cancer Society, the National Cancer Institute, and the Nevada Cancer Institute.
- Maintain an up-to-date, computerized inventory that is easily accessible to the public and contains information about providers, services, and facilities.
- Support information distribution to cancer patients and their families through telephone hotlines, information centers, and medical facilities concerning locally available treatment resources and clinical trial options that may be available for their type and state of cancer.
- Support the American Cancer Society's Patient Services programs and Quality of Life centers in area hospitals.

GOAL 6.
IMPROVE THE COLLABORATION AND COORDINATION AMONG CANCER CONTROL EFFORTS

Over the years, Nevada continues to increase and enhance the number, quality, and services of cancer-related programs. This effort has served to increase community collaborations between the private and public sector and provide a focus on a common goal for preventing cancer and improving the lives of cancer patients and their families. Using this plan as a roadmap, we must move forward with implementing, coordinating, and evaluating our cancer prevention and control work.

Objective 6.1: Continue efforts of the Nevada Cancer Council, a public-private collaboration that focuses on comprehensive cancer prevention and control

Baseline: The Nevada Cancer Council has met quarterly since 2002

Strategies:

- Seek funding sources to support the Nevada Cancer Council and to implement priority strategies of the Nevada Cancer Plan.
- Share programs, resources, and best practices among coalition members.
- Hold an annual cancer conference to share best practices, increase skills, and commence new initiatives where deemed appropriate.

Objective 6.2: Identify and develop an inventory of organizations and programs that engage in or support cancer control and quality of life related activities

Baseline: Five organizations and advocates started the Nevada Cancer Council in 2002

Strategies:

- Identify, on an ongoing basis, cancer control and quality of life organizations and activities in Nevada.
- Continue to recruit emerging and existing cancer control and quality of life organizations in the Nevada Cancer Council.

Objective 6.3: Monitor and coordinate cancer control and quality of life activities in Nevada

Strategies:

- Establish an online information service for cancer control in Nevada.
- Continue to maintain and expand the Nevada Cancer Council.
- Keep apprised of, and disseminate information on activities or organizations engaged in implementing or supporting cancer control in our state.

Objective 6.4: Develop and implement an evaluation plan for the Nevada Cancer Plan

Strategies:

- Recruit and convene a planning and implementation committee experienced and knowledgeable in evaluation techniques.
- Assess and evaluate the efficacy of the Nevada Cancer Plan's strategies by determining its impact on the knowledge and behavior of the citizens of Nevada.
- Perform an annual evaluation and make available to the community the outcomes through a written report and disseminate at an annual Nevada State Cancer Conference.
- Use the annual evaluation to revise the plan as needed.

GLOSSARY

Cancer	The umbrella term to describe many different diseases in which cells grow and reproduce out of control
Clinical Trials	Research studies of new methods or agents to prevent, detect, or treat a disease, or to study quality of life issues. Treatment trials with cancer patients usually involve three phases to compare the current best treatment to a promising new treatment
Digital Rectal Exam (DRE)	Manual examination of the lower rectum
Endoscopy	Examination of the lining of the gastrointestinal tract using a thin, flexible, lighted tube; flexible sigmoidoscopy allows examination of the rectum and lower part of the colon. Colonoscopy allows examination of the rectum and entire colon; polyps can be removed during this procedure
Incidence	The number of newly diagnosed cases of a disease occurring in a specific population in a given period of time
Mammogram	An X-ray of the breast used for the early detection of breast cancer
Melanoma	The least common but most life threatening form of skin cancer
Metastasis	The spread of cancer cells from the original site to other parts of the body
Morbidity	Illness or disability resulting from a disease or its treatment
Mortality	In this publication refers to death resulting from cancer
Pap (Papani-Nicolaou) Test	A test for cervical cancer that examines cells that are scraped from the cervix; can detect cancer and pre-cancerous conditions
Prevention	Primary prevention is preventing or reducing the risks for developing disease. Secondary prevention addresses identifying individuals with a disease, often before they have exhibited symptoms. Tertiary prevention emphasizes delaying advancement of the disease, reducing the risks for complication or recurrence, prolonging life, and promoting quality of life
Prostate-Specific Antigen (PSA) test	A test to detect levels of a blood protein. Elevated PSA levels may indicate prostate cancer, prostate inflammation, or benign prostate conditions
Risk Factor	Something that increases a person's chance of developing a disease, such as age, sex, or tobacco use
Screening	Routine tests that are given if an individual is over a certain age, has a family history or other risk factors for any medical conditions. Early detection can mean that a serious health problem or problems may be avoided. Screening includes a range of procedures used by medical professionals to identify individuals with early cancer

ACRONYMS

ACoS	American College of Surgeons
ACS	American Cancer Society
BRFSS	Behavioral Risk Factor Surveillance System
CIS	Cancer Information Service
CAM	Complementary and Alternative Medicine
CCOP	Community Clinical Oncology Program
CDC	Centers for Disease Control and Prevention
DRE	Digital Rectal Exam
FOBT	Fecal Occult Blood Test
NCC	Nevada Cancer Council
NCDB	National Cancer Data Base
NCI	National Cancer Institute
NSHD	Nevada State Health Division
NTPC	Nevada Tobacco Prevention Coalition
NVCI	Nevada Cancer Institute
PDQ	Physician Data Query
PSA	Prostate-Specific Antigen
SPF	Sun Protection Factor
YRBSS	Youth Risk Behavior Surveillance System

RESOURCES

LOCATING CANCER SERVICES IN NEVADA

The following list of organizations and agencies is intended to be a resource for locating cancer services throughout the state. This listing does not include all cancer control organizations, nor does it constitute an endorsement of these organizations or their programs by the Nevada State Health Division.

AMERICAN CANCER SOCIETY (ACS)

Southern Nevada
1325 E. Harmon Ave.
Las Vegas, NV 89119 702-798-6877

Northern Nevada
6490 S McCarran Blvd. #40
Reno, NV 89509 775-329-0609

The American Cancer Society is a volunteer based health service organization dedicated to eliminating cancer. Support services include: Cancer Information Line (800) ACS-2345; loan closet; gift closet; support groups, "Look Good Feel Better" program, Road to Recovery and Reach to Recovery.

CANDLELIGHTERS FOR CHILDHOOD CANCER

3201 S. Maryland Pkwy, Suite 600
Las Vegas, NV 89109
702-737-1919
www.candlelighters.org

Candlelighters is a parent-run support group for families of children with cancer. Help is available through bi-monthly newsletters, parent-to-parent referrals for the same diagnosis, workshops for siblings of the child with cancer, teen groups for patients and/or their teen siblings, summer and holidays get togethers, annual memorial services in December, parent advocates and a new "parent care bag" upon the child's diagnosis that includes books for the parent and child.

CENTERS FOR DISEASE CONTROL AND PREVENTION

Cancer Prevention and Control Program
Toll free - 1-888-842-6355
www.cdc.gov/cancer

CENTER TO REDUCE CANCER HEALTH DISPARITIES

National Cancer Institute

Created in 2001 to carry out NCI's Strategic Plan for Reducing Cancer Health Disparities. Research will investigate social, cultural, environmental, biological, and behavioral continuum from prevention to end-of- life care.
http://crchd.nci.nih.gov

GOVERNOR'S TASK FORCE ON PROSTATE CANCER

702-227-8028
www.prostatetaskforce.nv.gov

The Governor's Task Force on Prostate Cancer promotes education and screening for early detection and intervention for the improvement of the quality of life of men in Nevada.

HELP OF SOUTHERN NEVADA

953 E Sahara Ave. 35B-208
Las Vegas, NV 89104-3013
702-369-4357
www.helpsonv.org

HELP assists individuals and families to become self sufficient through direct services, training and referrals to support services in the community.

INTERCULTURAL CANCER COUNCIL (ICC)

http://iccnetwork.org

The ICC promotes policies, programs, partnerships, and research to eliminate the unequal cancer burden among racial and ethnic minorities and medically underserved populations in the United States, and its associated territories. It also prepares Cancer Fact Sheets that provide detailed information on cancer occurrence and risk factors.

LANCE ARMSTRONG FOUNDATION LIVE**STRONG** SURVIVOR CARE

Toll free – 1-866-235-7205
http://www.livestrong.org

LIVE**STRONG SURVIVOR***Care* helps survivors face the everyday physical, emotional and practical challenges of cancer through education, qualified referrals and counseling services. Cancer*Care's* oncology social workers provide survivors and their loved ones with emotional support, grief counseling

RESOURCES

LOCATING CANCER SERVICES IN NEVADA

and professional advice, while Patient Advocate Foundation's case managers are available to help with access to care, employment questions and financial concerns. All services are provided free of charge.

LEUKEMIA LYMPHOMA SOCIETY

6280 S. Valley View Blvd. Suite 342
Las Vegas, NV 89118
702-436-4220
www.lls.org/snv

The Society's mission is to cure leukemia, lymphoma, Hodgkin's disease and myeloma, and to improve the quality of life of patients and their families.

NATIONAL CANCER INSTITUTE (NCI)

Cancer Information Services (local representative)
10000 W. Charleston Blvd., Suite 140
Las Vegas, NV 89135
702-821-0003
www.cancer.gov

The NCI was established under the National Cancer Act of 1937 and is the Federal Government's principal agency for cancer research and training. It operates the Cancer Information Service, which includes a toll-free telephone system (1-800-4-CANCER) and a Partnership Program that offers help with local programming and health initiatives for community organizations and agencies. The National Cancer Institute coordinates the National Cancer Program, which conducts and supports research, training, health information dissemination, and other programs with respect to the cause, diagnosis, prevention, and treatment of cancer, rehabilitation from cancer, and the continuing care of cancer patients and the families of cancer patients.

NEVADA CANCER INSTITUTE (NVCI)

10000 W. Charleston Blvd., Suite 140
Las Vegas, NV 89135
702-821-0000
www.nevadacancerinstitute.org

The official cancer institute of the state of Nevada, the Nevada Cancer Institute is developing ground breaking cancer research, clinical trials not currently available in the state, and patient navigation services to help our residents better manage a diagnosis. The dedicated patient services staff serves in the community and helps individuals with insurance questions, community resources, national assistance, and referrals to local and national clinical trials.

NEVADA CANCER RESEARCH FOUNDATION

601 S. Rancho Dr., C-26
Las Vegas, NV 89106
702-384-0013

The Southern Nevada Cancer Research Foundation is a non-profit research organization centrally located just north of University Medical Center on South Rancho Drive and Palomino Lane.

NEVADA TOBACCO USERS' HELPLINE

A division of the University of
Nevada School of Medicine
702-877-0684
Toll Free – 888-866-6642
www.livingtobaccofree.com

The Helpline is a statewide nicotine dependence treatment program that treats all forms of tobacco dependence, both smoked and smokeless. Services include long term, intensive treatment; confidential and individualized treatment plans to meet individual's needs, and education and information to support people moving towards a tobacco-free lifestyle.

OVARIAN CANCER ALLIANCE OF NEVADA (OCAN)

2827 Utica Circle
Las Vegas, NV 89146
702-796-0430
www.ocan.org

Provides support and awareness for those affected with (directly or indirectly) ovarian cancer.

RACIAL AND ETHNIC APPROACHES TO COMMUNITY HEALTH (REACH)

http://www.cdc.gov/reach2010

The REACH program funds community coalitions to develop and implement activities to reduce the level of disparities in one or more of six priority areas, which include breast and cervical cancer screenings.

SUSAN G. KOMEN BREAST CANCER FOUNDATION

Southern Nevada
4850 W. Flamingo, Suite 27
Las Vegas, NV 89103 702-822-2324
komenlv1@earthlink.net

RESOURCES

LOCATING CANCER SERVICES IN NEVADA

Northern Nevada

P.O. Box 19538
Reno, NV 89511 775-355-7311
northernkomen@yahoo.com

The Susan G. Komen Breast Cancer Foundation was founded in 1982 on a promise made between two sisters – Susan Komen and Nancy Goodman Brinker.

More that 20 years later, the Komen Foundation is a global leader in the fight against breast cancer through its support of innovative research and community-based outreach programs. Working through a network of U.S. and international affiliates and events like the Komen Race for the Cure©, the Komen Foundation is fighting to eradicate breast cancer as a life-threatening disease by funding research grants and supporting education, screening and treatment projects in communities around the world.

UsTOO

5003 Fairview Avenue
Downers Grove, IL 60515
Toll Free – 800-808-7866
www.ustoo.org or http://www.ustoo.com

Northern Nevada

P.O. Box 19538
Reno, NV 89511 775-355-7311

UsTOO is a grass roots organization started in 1990 by prostate cancer survivors to serve prostate cancer survivors, their spouses/partners and families. They are a 501(c)(3) not-for-profit charitable organization dedicated to communicating timely and reliable information enabling informed choices regarding detection and treatment of prostate cancer. Ultimately, UsTOO strives to enhance the quality of life for all those affected by prostate cancer.

WOMEN'S HEALTH CONNECTION

Breast and Cervical Cancer Early Detection Program
Nevada State Health Division
505 East King Street, Room 103
Carson City, NV 89701
775-684-5900

The Women's Health Connection is a breast and cervical cancer early detection program available to eligible Nevada women at no cost. This program is made possible by funding from the Centers for Disease Control and Prevention. Women age 40 and above are eligible for annual pelvic exams and pap smears, clinical breast exams, and some diagnostic services. Women age 50 and above are also eligible for an annual screening mammogram. Women age 40 and above who do not have Medicaid or Medicare Part B, are not a member of an HMO, or are underinsured or uninsured, and meet the income guidelines are eligible.

NOTES

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UNITED IN THE FIGHT AGAINST CANCER

Published by the Nevada State Health Division, 2005.

To request a copy of the Nevada Cancer Plan or the American Cancer Society's Nevada Facts and Figures 2005,

Comprehensive Cancer Control Program
Nevada State Health Division

505 E. King Street, Room 103
Carson City, NV 89701-4774
Phone: 775-684-5900
Fax: 775-684-5998

To download a copy of the Nevada Cancer Plan
www.health2k.state.nv.us/cccp