

IDAHO



Comprehensive Cancer
Strategic Plan 2006-2010



Idaho **Comprehensive Cancer** **Strategic Plan 2006-2010**

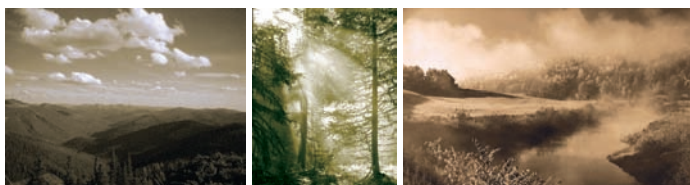


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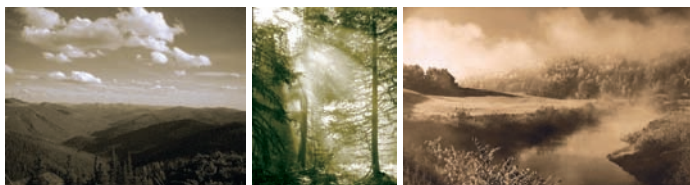
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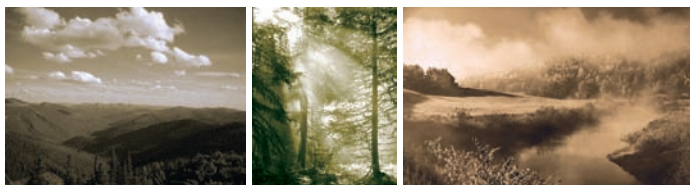


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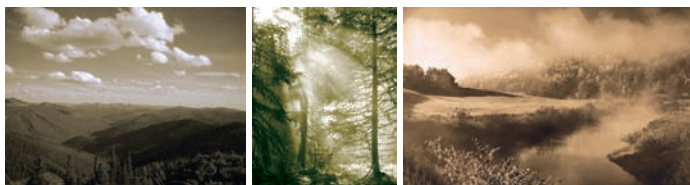
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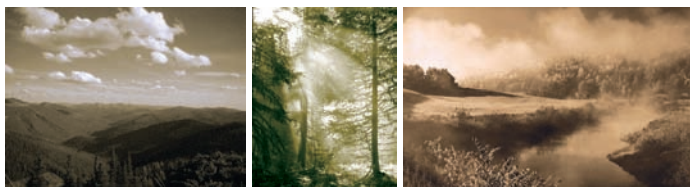
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Hope is the thing with feathers—That perches in the soul—And sings the tunes without the words—And never stops—at all.
 Emily Dickinson



Cancer Prevalence and Cause

Cancer is a term that includes more than 100 different diseases, each characterized by the uncontrolled growth and spread of abnormal cells.¹ Cancer is the second leading cause of death in both Idaho and the United States. In Idaho, about one in two men and one in three women will be diagnosed with cancer sometime in their lives. About 22% of all deaths in Idaho each year are from cancer.²

Although cancer may occur at any age, it is a disease of aging. Nearly 80% of cancers are diagnosed in persons aged 55 or older. Cancer is caused both by external factors such as tobacco use and exposure, chemicals, radiation and infectious organisms, and by internal factors such as genetics, hormonal factors and immune conditions. These causal factors may act together or in sequence to initiate or promote carcinogenesis. Ten or more years often pass between exposure to external factors and detectable cancer. The long period of time between the first cellular abnormality and the clinical recognition that cancer is present often makes it difficult to pinpoint the cause of the cancer.³

Cancer is the **2nd** leading cause of death in both Idaho and the United States.

About **22%** of all deaths in Idaho each year are from cancer.

“I believe that I am about to start on my third go round for treatment. I was diagnosed in August 2003, went through about 10 months of treatment, had 2 months of remission, went through about 10 more months of treatment including a stem cell transplant. After 2 months of remission, I believe that I will soon be in treatment again. I’d like to see the end of my treatment and live the rest of my life cancer free. I will turn 30 in August.”

Jill Johnson, Boise

Idaho Demographics



Idaho is a large geographical state of 82,413 square miles with high desert areas, forests, rugged mountains, open plains and large valleys.⁴ In 2004, the state population was 1,393,262. From 1994 to 2004 the population grew by almost 23%. The mountain states (Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, and Wyoming) experienced more growth than any other region in the U.S. during that time.⁵ Between 2000 and 2004 there was an increase in the Hispanic population of 22,210 people, a 21.8% increase. The population distribution in 2004 in Idaho by race/ethnicity, percent and number was:

White:	96.4% (1,343,609)
Black:	0.7% (10,178)
Native American:	1.6% (21,951)
Asian/Pacific Islander:	1.3% (17,524)
<hr/>	
Hispanic:	8.9% (123,900)
Non Hispanic:	91.1% (1,269,362)

(Race and Hispanic origin are reported separately. Persons of Hispanic origin are included in appropriate race totals.⁶)

Idaho has 44 counties. Of those, nine are classified as urban with a population center of at least 20,000; 19 counties are classified as rural with 6.0 persons per square mile; and 16 counties are classified as frontier with less than 6.0 people per square mile.

Urban counties: Ada, Bannock, Bonneville, Canyon, Kootenai, Latah, Madison, Nez Perce, and Twin Falls.

Rural counties: Bear Lake, Benewah, Bingham, Blaine, Bonner, Boundary, Cassia, Elmore, Franklin, Fremont, Gem, Gooding, Jefferson, Jerome, Lewis, Minidoka, Payette, Teton, and Washington.

Frontier counties: Adams, Boise, Butte, Camas, Caribou, Clark, Clearwater, Custer, Idaho, Lemhi, Lincoln, Oneida, Owyhee, Power, Shoshone, and Valley.





Burden of Cancer in the U.S. and in Idaho

Cost

The cost of cancer care is substantial. The National Institutes of Health (NIH) estimated that in 2005, \$74 billion would be spent in direct medical costs of cancer in the U.S. (e.g., hospital and outpatient costs, physician and other provider services and medications)—approximately \$53,900 in treatment costs per case.⁷ Based on the estimated average cost per cancer case in the U.S., direct medical costs for cancer treatment in Idaho exceeded \$300 million in each of the last several years.⁸ The economic burden, both to society and the individual, is increased by indirect “costs” including lost earnings and reduced work productivity. The total for both direct and indirect cancer related costs in the U.S. was estimated to have been \$190 billion in 2004.⁷

Cancer is among the most expensive conditions to treat. Cost of cancer care varies by the type of cancer, stage at diagnosis, patient age and the presence or absence of other diseases.⁹ Individuals face financial challenges because of lack of insurance, or underinsurance resulting in out-of-pocket expenses including high deductibles, copayments, coverage caps and limits on prescription drug coverage. It is estimated that 7% of cancer patients have no insurance.¹⁰ Costs for cancer treatment have risen substantially since the 1960’s as demonstrated by Table 1.

Table 1. National cancer treatment expenditures in billions of dollars (1963-2004)¹¹

Year	Cancer treatment spending (billions)	Total personal healthcare spending (billions)	Percent of cancer treatment spending to total
1963	\$1.3	\$29.4	4.4%
1972	\$3.9	\$78.0	5.0%
1980	\$13.1	\$217.0	6.0%
1985	\$18.1	\$376.4	4.8%
1990	\$27.5	\$609.4	4.5%
1995	\$41.2	\$879.3	4.7%
2004	\$72.1	\$1,540.7	4.7%

Direct medical costs for cancer treatment in Idaho exceeded **\$300 million** in each of the last several years.

“They say that youth is our future. Cancer can destroy that. The cost of treatment can last longer than parents can handle. Insurance costs are becoming so high, it is hard to keep paying and still have so many uncovered costs. Parents would give up everything to keep our kids healthy. Sometimes that is more a reality than just a saying.”
 Angela Hukill, Nampa

Burden of Cancer



In Idaho in 2003, malignant neoplasms (cancer) was the:

- **Third** leading cause of death for individuals ages 25-34.
- **Second** leading cause of death among those ages 34-44.
- **Leading** cause of death for those ages 45-64.

Although the majority of cancer cases are among adults over age 65, in terms of potential years of life lost, lost productivity and lost earnings, cancer that strikes at younger ages has more far reaching consequences than cancers that affect the elderly.¹² Cancer cases among the working age population has an impact on employers because of employees' high medical costs, lost productivity, short and long term disability and life insurance.¹³ One cost study of a major employer demonstrated that medical conditions not directly related to cancer account for approximately half of the total excess insurance expenditures for patients with cancer and annual healthcare and disability costs for persons with cancer were approximately five times higher than for their counterparts without cancer.¹⁴ In Idaho in 2003, malignant neoplasms (cancer) was the third leading cause of death for individuals ages 25-34, the second leading cause of death among those ages 34-44, and the leading cause of death for those ages 45-64.¹⁵





Disparities

Health disparities exist among groups of people who have historically been disadvantaged in some way, including by race, ethnicity, socioeconomic status, educational level, disability, gender, age, occupation, sexual orientation and/or geographical location. Numerous studies provide evidence that these U.S. populations experience significant disparities for cancer in terms of risk, incidence, stage of disease at diagnosis, care received and disease outcomes. Reports have identified society-wide quality, continuity and access problems experienced by the medically underserved, low income and minority populations. There are concerns that many do not receive adequate prevention and early detection services nor the most appropriate care for their cancer. These populations are more likely to¹⁶:

- Be diagnosed with and die from preventable cancers.
- Be diagnosed with late-stage disease for cancers detectable through screening at an early stage.
- Receive no treatment, or treatment that does not meet accepted standards.
- Die of cancers that are generally curable.
- Suffer from cancer without the benefit of pain control and other palliative care.

In Idaho during 2004:

- Approximately 15.4% lacked health insurance, compared to 9.6% nationally.¹⁷
- There were 212,000 people who were not covered by insurance at anytime during the year.¹⁷
- For individuals under age 65, 16.8% lacked health insurance.¹⁷
- Among women under age 65, uninsured women and women with Medicaid were significantly more likely to have late stage (regional or distant) breast cancer diagnoses (48% and 43%, respectively) compared with women with private insurance or Medicare (33% and 25%).¹⁸

More than **50%** of new cancer cases are among four sites: prostate, breast, lung and colorectal.

Among males, blacks have the highest rates of incidence.

Among women, hispanics have the highest rates of incidence.

Idaho has **higher** mortality rates for melanoma than that of the U.S. as a whole.

Burden of Cancer



In Idaho, **89%** of the geographic area of the state has an HPSA designation in the category of Primary Care, **100%** of the State's area has an HPSA designation in the category of Mental Health, and **92.9%** of the state has an HPSA designation in the category of Dental Health.

Health Professional Shortage Areas

The Federal Government has developed criteria to designate areas of the country as “medically underserved (MUA).” These areas, known as Health Professional Shortage Areas (HPSA), have less than a generally accepted minimum number of clinicians (physicians, dentists, mental health workers, etc.) per thousand population. The Federal Government has designated some 3,960 HPSAs across the U.S. and its territories. Primary medical, dental, and mental health HPSAs are defined by the following criteria¹⁹:

- The geographic area involved is a rational area for the delivery of health services.
- A specified population-to-clinician ratio that represents a shortage is exceeded within the area.
- Resources in contiguous areas are over utilized, excessively distant or otherwise inaccessible.

If a geographic area does not meet these shortage criteria, but a population group within the area has access to care barriers, a population group designation may be appropriate. In some cases, an individual facility may be designated as an HPSA. In Idaho, 89% of the geographic area of the state has an HPSA designation in the category of Primary Care, 100% of the State's area has an HPSA designation in the category of Mental Health, and 92.9% of the state has an HPSA designation in the category of Dental Health.²⁰ There are currently ten Federally Qualified Health Centers, some of which have multiple sites in communities around Idaho, which serve the uninsured and underinsured.

Burden of Cancer



Idaho Data and Surveillance

The Cancer Data Registry of Idaho (CDRI) collects incidence and survival data on all cancer patients who reside in Idaho or who are diagnosed or treated in Idaho. CDRI has been designated a GOLD standard registry by the North American Association of Central Cancer Registries (NAACCR) since 1996.

The Surveillance, Epidemiology, and End Results (SEER) program, part of the National Cancer Institutes (NCI), consists of several population-based cancer registries throughout the U.S. SEER cancer statistics are designed to be representative of the U.S. population and are useful for comparing state to national cancer rates.

The Bureau of Health Policy and Vital Statistics (BHPVS) within the Idaho Department of Health and Welfare (IDHW), under a cooperative agreement with the Centers for Disease Control and Prevention, has conducted the Behavioral Risk Factor Surveillance System (BRFSS) since 1984. The BRFSS is a telephone survey of random samples of adult Idahoans that measures population prevalence of risk factors for the major causes of death, including cancer.

The Youth Risk Behavior Surveillance System (YRBS) focuses on the behaviors related to the leading causes of mortality and morbidity among youth grades 9 through 12. The questionnaire is administered in the classrooms of Idaho's public schools, usually in odd numbered years (2001, 2003). The School Health Education Profile Survey (SHEPS) monitors the current status of school health education, including important health problems, at the middle/junior high school and senior high school levels. There are two questionnaires: one for school principals examining health education from an administrative perspective, and one for lead health education teachers examining health education from an instructional perspective.

The Adult Tobacco Survey (ATS) is a statewide random sample telephone survey of Idaho adults. The survey, conducted in 2004 and 2005, assessed tobacco use and attitudes, including Smoking Prevalence and Tobacco Use History, Purchase Patterns, Quitting Behavior, Interactions with Medical or Dental Providers, Exposure to Environmental Tobacco Smoke, Attitudes toward Smoking and Tobacco Restrictions, Perception of Health Risks, Exposure to Media Sources, and Attitudes toward Tobacco Industry Practices.



Burden of Cancer



Cancer Incidence and Mortality

Overall, Idaho's cancer incidence rate is about 2% lower than the SEER rate for all races and 4% lower than the SEER rate for whites. Idaho's cancer burden differs from that of SEER in notable ways (Table 2):

- Lower rates of colorectal and female breast cancers.
- Higher rates of melanoma, thyroid, and pediatric cancers.

Table 2. Cancer incidence, Idaho (2003) and SEER (2002)

Primary Site	TOTAL			MALE			FEMALE		
	IDAHO		SEER Rate	IDAHO		SEER Rate	IDAHO		SEER Rate
	Cases	Rate		Cases	Rate		Cases	Rate	
All Sites	5,790	446.5	466.9	3,081	520.5	539.4	2,709	392.7	418.2
Bladder	248	19.3	21.8	200	34.9	37.9	48	7.0	10.0
Brain & Other CNS	87	6.5	6.6	48	7.3	8.0	39	5.6	5.5
Breast	811	61.9	73.1	10	1.8	1.1	801	117.6	135.8
Breast in situ	160	12.0	16.8	1	0.1	0.1	159	23.3	31.9
Cervix	42	3.2	4.1	-	-	0	42	6.4	8.1
Colorectal	584	45.2	49.5	304	52.5	57.4	280	39.4	43.2
Corpus Uteri	119	9.0	13.1	-	-	0	119	17.2	24.4
Esophagus	60	4.6	4.3	49	8.1	7.4	11	1.6	1.8
Hodgkins Lymphoma	46	3.3	2.9	23	3.4	3.2	23	3.3	2.6
Kidney & Renal Pelvis	166	12.7	12.2	103	16.6	17.0	63	9.1	8.2
Larynx	42	3.2	3.3	35	5.9	5.9	7	1.0	1.2
Leukemia	191	14.6	12.2	106	18.0	15.9	85	11.8	9.3
Liver & Intrahepatic Bile Duct	37	2.9	4.9	25	4.1	7.2	12	1.8	2.9
Lung & Bronchus	734	57.7	59.3	402	69.6	72.6	332	48.4	49.9
Melanoma of the Skin	307	23.6	20.5	174	28.6	25.5	133	19.8	17.1
Myeloma	47	3.6	5.0	27	4.6	6.6	20	2.9	3.8
Non-Hodgkins Lymphoma	233	18.1	19.9	112	18.9	23.9	121	17.5	16.7
Oral Cavity & Pharynx	139	10.6	10.5	103	16.6	15.4	36	5.2	6.4
Ovary	75	5.8	7.6	-	-	0	75	11.2	14.0
Pancreas	145	11.1	10.9	70	11.4	12.5	75	10.6	9.6
Prostate	948	73.7	74.2	948	161.3	166.3	-	-	0
Stomach	73	5.7	7.2	50	8.7	10.3	23	3.3	4.9
Testis	38	3.0	3.2	38	5.9	6.2	-	-	0
Thyroid	131	9.7	9.1	31	4.7	4.8	100	14.9	13.4
Pediatric Age 0 to 19	87	20.7	18.1	48	22.3	19.4	39	19.0	16.7

Rates are per 100,000 and age-adjusted to the 2000 U.S. (18 age groups) standard. SEER data shown are for White race only.



Burden of Cancer

Cancer Incidence

Idaho's leading cancer incidence rates parallel those found in many states. More than 50% of new cancer cases are among four primary sites: prostate, breast, lung and colorectal (Table 3).

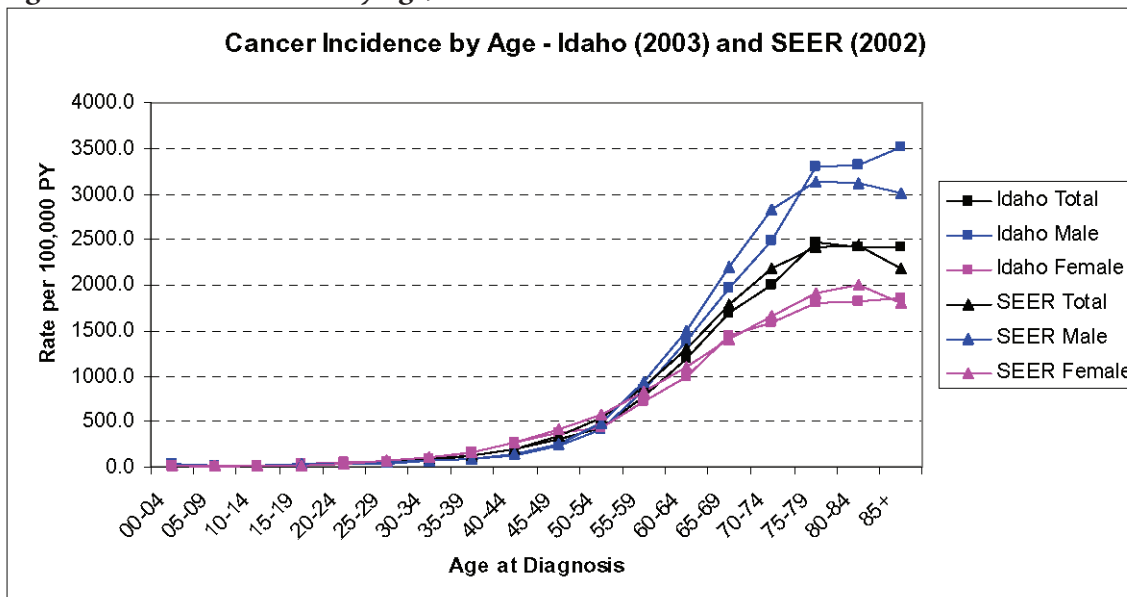
Table 3. Top 10 cancer incidence rates by site and sex, Idaho, 1999-2003

Rank	Cancer Site	Total Rate	Male Rate	Male Cases	Female Rate	Female Cases
-	All Sites	457.3	532.8	14,942	400.8	13,167
1	Prostate	78.2	170.8	4,758	-	-
2	Breast	68.0	1.9	54	128.0	4,158
3	Lung and Bronchus	56.1	70.6	1,937	44.8	1,463
4	Colorectal	45.3	52.2	1,433	39.4	1,331
5	Bladder	21.1	38.0	1,028	7.6	257
6	Melanoma of the Skin	20.8	25.7	755	16.6	536
7	Non Hodgkins Lymphoma	18.9	20.6	588	17.6	579
8	Leukemia	13.5	16.9	474	10.8	366
9	Kidney & Renal Pelvis	12.4	15.5	448	9.7	318
10	Oral Cavity and Pharynx	11.1	16.3	472.0	6.5	216

Rates are per 100,000 and age-adjusted to the 2000 U.S. (18 age groups) standard.

By age group, the Idaho and SEER rates are very similar except for slightly higher rates among Idaho males in the oldest age groups (Figure 1).

Figure 1. Cancer incidence by age, Idaho and SEER rates



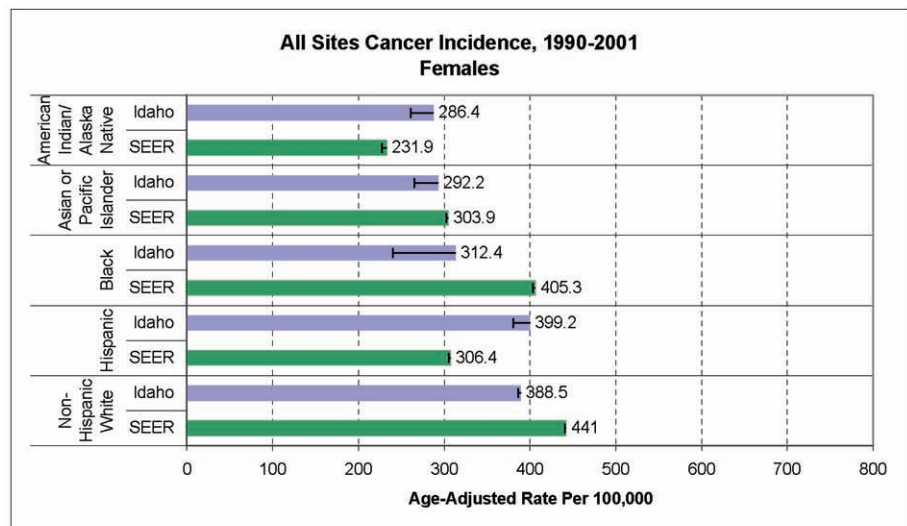
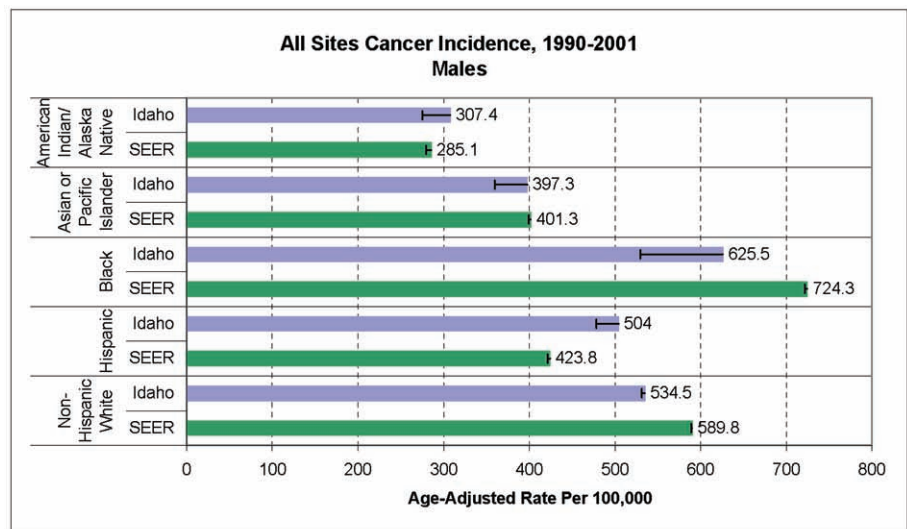
Burden of Cancer



Idaho's cancer incidence rates differ by race and ethnicity. Figure 2 shows overall invasive, age-adjusted cancer incidence rates by race and ethnicity with comparisons to SEER.

- Among males, blacks had the highest rates of cancer incidence in Idaho and SEER regions.
- Among females, non-Hispanic whites had the highest rates of cancer incidence in SEER regions, but Hispanic women had the highest rates in Idaho.
- For both males and females, the rates among Hispanics and non-Hispanic whites were more similar in Idaho than in SEER regions.

Figure 2. Cancer incidence rates by race and ethnicity, Idaho and SEER



Notes: SEER rates are for 1992-2000. Error bars (—) show standard error of rates. Confidence intervals are approximately twice as wide in both directions.



Burden of Cancer

Cancer Mortality

Overall, Idaho's cancer mortality rate is about 13% lower than the U.S. rate for all races and 12% lower than the U.S. rate for whites. Idaho's cancer mortality burden differs from that of the U.S. in notable ways (Tables 4 and 5):

- Lower mortality rates of colorectal, and lung and bronchus cancers.
- Higher mortality rates of melanoma, myeloma and prostate cancers.

Table 4. Cancer mortality rates by site and sex, Idaho (2004) and U.S. (2002)

Primary Site	TOTAL			MALE			FEMALE		
	IDAHO		U.S. Rate	IDAHO		U.S. Rate	IDAHO		U.S. Rate
	Deaths	Rate		Deaths	Rate		Deaths	Rate	
All Causes of Death	10,013	751.5	827.4	5,065	879.8	996.8	4,948	641.1	697.0
All Malignant Cancers	2,225	169.3	191.6	1,173	201.7	236.0	1,052	144.6	161.9
Bladder	48	3.7	4.5	37	6.7	7.8	11	1.5	2.3
Brain & Other CNS	72	5.4	4.8	38	5.8	5.8	34	4.9	3.9
Breast	161	12.1	14.1	0	0.0	0.3	161	22.1	24.9
Cervix	10	0.8	1.2	-	-	-	10	1.5	2.3
Colorectal	194	14.7	19.1	98	17	23.2	96	12.6	16.0
Corpus Uteri	10	0.7	1.0	-	-	-	10	1.3	1.8
Esophagus	51	3.8	4.3	45	7	7.8	6	0.8	1.6
Hodgkins Lymphoma	6	0.5	0.5	2	0.3	0.6	4	0.6	0.4
Kidney	56	4.1	4.3	33	5.3	6.3	23	3.1	2.8
Larynx	8	0.6	1.2	5	0.9	2.1	3	0.4	0.5
Leukemia	116	8.8	7.7	60	10.4	10.4	56	7.5	5.8
Liver & Intrahepatic Bile Duct	47	3.6	4.5	34	5.4	6.5	13	1.9	2.8
Lung	537	41.5	55.2	303	51.7	72.7	234	33.3	42.6
Melanoma of the Skin	46	3.5	2.9	29	4.9	4.2	17	2.2	2.0
Myeloma	67	5.2	3.6	43	7.9	4.5	24	3.3	2.9
Non-Hodgkins Lymphoma	105	8.0	7.9	53	9.0	10.0	52	6.9	6.4
Oral Cavity & Pharynx	31	2.3	2.6	19	3.2	3.9	12	1.6	1.5
Ovary	65	5.0	5.2	-	-	-	65	9.2	9.4
Pancreas	150	11.2	10.3	70	11.7	12	80	10.5	8.9
Prostate	154	11.9	9.7	154	29.3	25.8	-	-	-
Stomach	46	3.5	3.7	29	4.6	5.2	17	2.4	2.5
Testis	3	0.2	0.2	3	0.4	0.3	-	-	-
Thyroid	3	0.2	0.5	1	0.1	0.5	2	0.3	0.5

Rates are per 100,000 and age-adjusted to the 2000 U.S. (18 age groups) standard. U.S. data shown are for White race only.

Burden of Cancer



- The leading cause of cancer death among both males and females is lung cancer.
- Among males, prostate cancer is the second leading cause of cancer death—colorectal cancer ranks third.
- Among females, breast cancer is the second leading cause of cancer death—colorectal cancer ranks third.
- Among males and females combined, colorectal cancer is the second leading cause of cancer death, behind lung cancer.

Table 5. Top 10 cancer mortality rates by site and sex, Idaho, 2000-2004

Rank	Cancer Site	Total Rate	Male Rate	Male Deaths	Female Rate	Female Deaths
-	All Sites	174.6	210.6	5,784	148.9	5,128
1	Lung	44.3	56.4	1,563	35.0	1,179
2	Colorectal	15.7	18.8	511	13.1	467
3	Breast	12.9	0.1	2	23.7	816
4	Prostate	12.1	30.2	749	-	-
5	Pancreas	10.1	10.8	305	9.3	328
6	Leukemia	8.2	10.3	282	6.6	232
7	Non Hodgkins Lymphoma	8.0	9.2	256	6.8	241
8	Brain	5.4	6.7	206	4.2	139
9	Ovary	5.2	-	-	9.5	322
10	Bladder	4.4	7.5	198	2.2	78

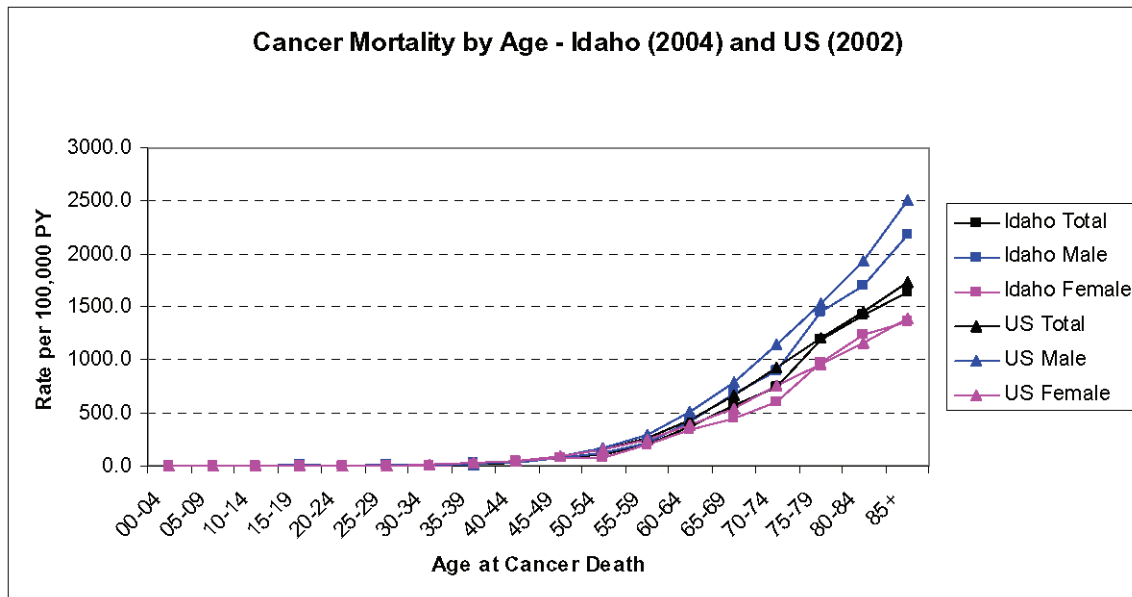
Rates are per 100,000 and age-adjusted to the 2000 U.S. (18 age groups) standard.



Burden of Cancer

By age group, the Idaho and U.S. rates follow similar patterns, with Idaho cancer mortality rates being generally lower (Figure 3).

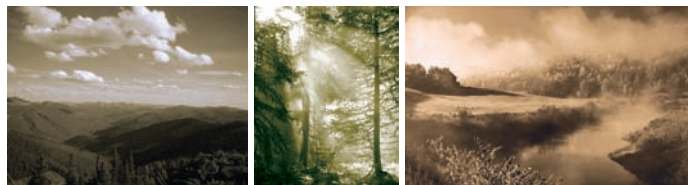
Figure 3. Cancer mortality rates by age, Idaho and U.S.



“Breast cancer, never thought it would find me! But, with the support of my awesome husband and son, along with numerous friends, I’m going down that road...but not alone. Thank goodness for mammograms! One month the results were negative, 5 months later, a large tumor was located through another mammogram...It is a monster, but I know steps are being taken to tame that beast. I will always do mammograms—they saved my life...”

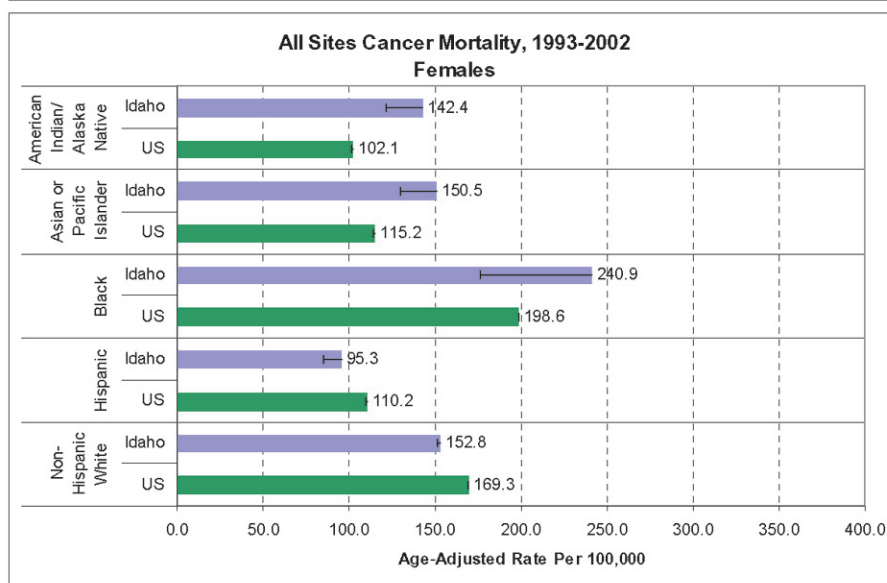
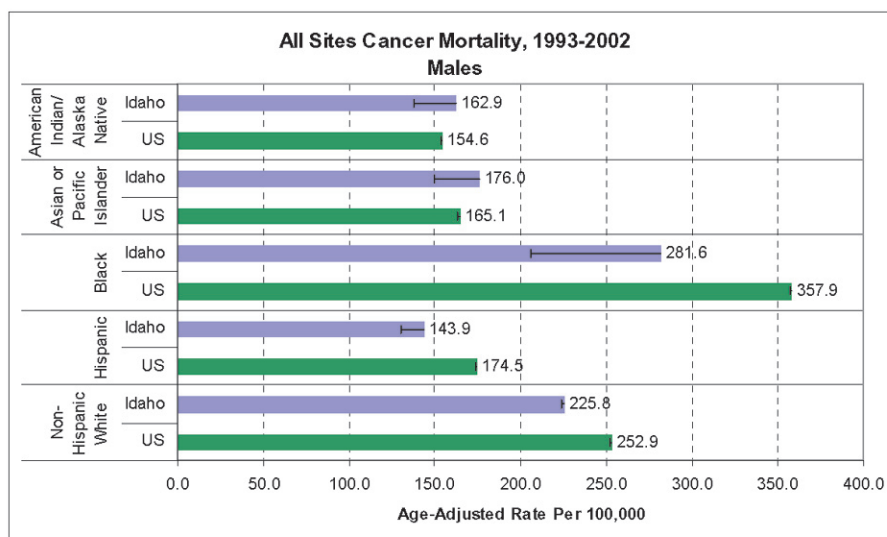
Gina Whitworth, Pocatello

Burden of Cancer



Idaho's cancer mortality rates differ by race and ethnicity. Figure 4 shows overall invasive age-adjusted cancer mortality rates by race and ethnicity with comparisons to the entire country. Blacks had the highest cancer mortality rates for males and females in Idaho and the U.S.

Figure 4. Cancer mortality rates by race and ethnicity, Idaho and U.S.



Notes: SEER rates are for 1992-2000. Error bars (—) show standard error of rates. Confidence intervals are approximately twice as wide in both directions.

Burden of Cancer



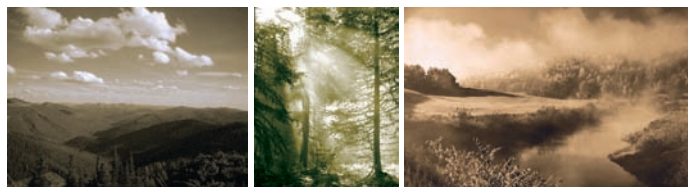
The distribution of cancer is varied geographically within Idaho. The distributions by site have some explained elevations in rates due to cancer risk factors, and others are unexplained. An example of an explained elevation is early stage breast cancer in Blaine County. Blaine County has the highest rates of breast cancer screening in the state, which explained the elevation of early stage breast cancers in this population. Examples of unexplained elevations include three brain cancer clusters investigated in Idaho in the past five years. For two of the cluster investigations, additional data were collected among cases, but no common factor was found. The third brain cancer cluster investigation is ongoing.

The Cancer Data Registry of Idaho and BHPVS link cancer incidence data and cancer risk factor data to produce a set of county cancer profiles annually. BRFSS variables on access to healthcare, tobacco use, cancer screening, diet, weight control and physical activity are reported in the county profiles, and county-level risk factor data have been shown to be correlated with county-level cancer incidence. Findings include:

- Counties with higher proportions of uninsured had significantly higher rates of invasive cancer.
- Counties with higher rates of current smoking had higher rates of lung cancer.
- Trends show lower consumption of fruits and vegetables in recent years and higher rates of obesity.
- Counties with higher rates of obesity had significantly higher rates of colorectal cancers.



Comprehensive Cancer Alliance for Idaho



The Comprehensive Cancer Alliance for Idaho (CCAI) was formed in 2002 and is directed by a Core Steering Committee. This group of healthcare professionals, state agencies and programs, cancer-related non-profit organizations, insurance providers, cancer survivors and others came together to lay the groundwork to apply for funding to establish an Idaho Comprehensive Cancer Control Program (ICCCP). Several CCAI members attended a Comprehensive Cancer Control (CCC) Leadership Institute in September 2004 during which priority areas for Idaho were selected. Priority areas identified include *Prevention, Early Detection and Diagnosis, Treatment and Quality of Life and Survivorship*. A series of meetings of the Core Steering Committee and the CCAI general membership were held during the late summer and fall of 2005 to draft the goals, objectives and strategies found in this document.

Vision

“Every Idahoan deserves the opportunity for proper cancer prevention and detection, state of the art cancer treatment; and the highest possible quality of life which we are committed to provide through a data driven, coordinated, comprehensive cancer plan.”

“*I was diagnosed at age 18 months with a brain tumor, medulloblastoma. I’m now 3 years old and in remission. There is still no known cause of medulloblastoma. We need to know what is causing young children and infants to develop brain tumors and find cures and ways to prevent this.*”

Britt and Crystal Williams for Nita Williams, Boise



Comprehensive Cancer Alliance for Idaho

Values

The human toll and economic impact of cancer in Idaho will be greatly reduced as a result of the efforts of the CCAI. We see a future where:

- Fewer people are diagnosed with cancer in Idaho and more cancer is diagnosed at the earliest and most treatable stages;
- The best available services and support needed for cancer patients, survivors, and their loved ones, exist throughout the state and are accessible and culturally appropriate for all; and
- Health outcomes and the impact of cancer on lives will be improved for survivors.

Mission

To achieve this vision we will strengthen and coordinate efforts to address cancer issues along the continuum of cancer prevention and care. The burden of cancer will be assessed, defined and monitored. Health infrastructure and systems will be enhanced. Partnerships have been forged and will continue to grow across the state and will be key in implementing the plan. Resources will be identified or developed and will be networked through collaborative efforts. Awareness will be raised on many levels, among the general population, healthcare professions, organizations, agencies and policymakers.

Dedication

As we implement this plan with systems approaches, policy enhancement, evidence-based programs and other strategies, we will always remember individual faces and their stories. We will remember those who attended our public forums, our patients and clients, and our friends and loved ones whose lives have been impacted by cancer or who did not survive this disease. It is in their honor that we move forward to fulfill this vision.

Goals

- Decrease the incidence of preventable cancers.
- Decrease preventable cancer deaths.
- Improve the quality of life for people in Idaho affected by cancer.



Comprehensive Cancer Alliance for Idaho



Idaho Needs Assessment Results Summary

The needs assessment was conducted to identify the spectrum of cancer related barriers, issues and problems in Idaho. Seven community forums were held in each region of the state. For anyone unable to attend a forum, and to reach those where forums were not held, a survey was conducted online and was available by hard copy to anyone without Internet access. Interviews were also held with those who represented populations with disproportionate cancer impacts. The following is a summary of only some of the major areas of concern expressed by forum participants and survey respondents:

Cost

Whether underinsured, insured or not insured, the cost of treatment and services was one of the issues most often discussed.

Access to treatment and services

Idaho has many rural areas and many cancer patients need to travel long distances or to other states for treatment (which adds transportation and housing costs to their burden) and often there is a lack of local healthcare options.

Prevention

Confusing messages or lack of education or understanding of links between health behaviors and cancer.

Early detection and diagnosis

Confusion and lack of education about what and when to have screenings, complicated by mixed or confusing messages, fear of having tests and “finding something,” and the cost of some screenings.

Quality of life

Treatment side affects, long-term after-affects of treatment (sometimes years later), lack of information on complementary therapies, no hospice services in some areas of the state, emotional impacts, effects on the families.





Comprehensive Cancer Alliance for Idaho

Environmental concerns

Belief in cancer links to environmental carcinogens related to mining, agriculture and nuclear industries affecting water supplies, soil and air.

Men and cancer

Belief that less attention is focused on men's health, less compliance among men to follow screening guidelines or symptom follow-up.

Patient issues

Difficulty in navigating the medical care system, fear of the unknown and known, networking and support opportunities blocked by Health Insurance Portability and Accounting Act (HIPAA) regulations, stress, missed work by patient and caregiver, sometimes too much information (Internet is overwhelming), but sometimes too little.

Tribes

Lack of trust of external medical systems, need for traditional practice and diet along with Western medicine and the health systems' lack of understanding of culture, beliefs and behaviors of Idaho Indian populations.

Data

A need for better compiled regional or local data, better data on minority populations (knowledge, attitudes, beliefs, behavior and other).

Language and cultural barriers

Growing Hispanic population and increasing refugee populations, cultural mores about physical exams and family issues.





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Note: Idaho resident mortality data were provided by the Bureau of Health Policy and Vital Statistics and compiled for this document by the Cancer Data Registry of Idaho.



Prevention

Certain lifestyle choices can lead to the development of many types of cancers. Smoking and tobacco use and exposure, poor diet choices, lack of physical activity, excessive sun exposure and exposure to environmental carcinogens increase the risk for cancer. Primary prevention through lifestyle and environmental interventions remains the main way to reduce the burden of cancers. In a report from the Harvard School of Public Health, it is estimated that of the seven million deaths from cancer worldwide in 2001, 243 million (35%) were attributable to nine potentially modifiable risk factors. Smoking, alcohol use and low fruit and vegetable intake were the leading risk factors for death from cancer worldwide and in low-and-middle-income countries. In high-income countries, smoking, alcohol use and overweight and obesity were the most important causes of cancer. Sexual transmission of the human papilloma virus is a leading risk factor for cervical cancer in women in low-and-middle-income countries and has been linked to oral and pharyngeal cancer.¹

An average of **1,500** people die each year in Idaho as a direct result of tobacco use.

In Idaho, the average age for starting to smoke regularly for adults who currently smoke is about **18** years.

Tobacco Use and Exposure

Cigarette smoking causes several kinds of cancer including those of the lung, larynx, esophagus, pharynx, mouth and bladder. More than 85% of lung cancers occur because of tobacco smoking.² Smoking also contributes to cancers of the pancreas, kidney, and cervix.² Other tobacco products, such as smokeless tobacco, cigars, pipe tobacco and novelty tobacco products, also pose serious health risks. An average of 1,500 people die each year in Idaho as a direct result of tobacco use.³

In 1992, the U.S. Environmental Protection Agency (EPA) classified environmental (secondhand) tobacco smoke as a Group A carcinogen.⁴ Group A carcinogens are agents known to be carcinogenic (substances that cause cancer) for humans. Although information is not available for Idaho alone, nationally, exposure to secondhand smoke contributes to the deaths of an estimated 3,000 non-smokers from lung cancer each year.⁵

Of the chemicals identified in secondhand smoke, at least 60, such as formaldehyde, benzopyrene and nitrosamines, are carcinogens. Six others, such as nicotine and carbon monoxide, are substances that interfere with normal cell development.⁶ Reducing exposure to secondhand smoke is a proven strategy for reducing cancer incidence. Studies have shown that smoking bans in workplaces can reduce exposure to secondhand smoke by 72%.⁷

Prevention



The single most important strategy for reducing cancer incidence and mortality in Idaho is preventing youth from initiating tobacco use. In Idaho, the average age for starting to smoke regularly for adults who currently smoke was about 18 years.⁸ Reducing smoking in youth not only protects young people from immediate and long-term health consequences, but also will reduce the size of the future adult smoking population.

To ensure a high quality, targeted program, published research on public health interventions should be monitored to identify effective approaches for reducing tobacco use and exposure particularly among high-risk populations.

Although the state is implementing a comprehensive program to reduce initiation of tobacco use and promotion of cessation, the program does not address all aspects and all groups at risk for using tobacco products. Collaboration between the Idaho Tobacco Prevention and Control Program, the Comprehensive Cancer Control Program and other partners provides an opportunity to fill those gaps.

Nutrition and Physical Activity

Diet, physical activity and being overweight are interrelated lifestyle factors that influence individual risk for a variety of chronic diseases and conditions (e.g., cardiovascular diseases, hypertension, diabetes, osteoporosis and some cancers). Although many epidemiologic studies have established an association between diet, physical activity and weight and an altered risk of some cancers, the reasons for these associations are not certain.⁹



There is evidence that cancers of the colon, breast (postmenopausal), endometrium, pancreas, prostate, kidney and esophagus are associated with obesity and that preventing weight gain can reduce the risk of many cancers.⁹⁻¹⁵ Idaho was recently found to have the 37th highest rate of adult obesity in the U.S.¹⁶ Studies have shown that physical activity reduces colon cancer risk by 50%.¹⁰

Eating a healthy diet, participating in regular physical activity and maintaining a healthy body weight are widely accepted as important strategies for maintaining or improving overall health. More information is needed to determine the impact of these strategies on reducing cancer incidence and mortality. The support of existing efforts that encourage eating a healthy diet, getting regular physical activity and maintaining a healthy body weight is a reasonable approach to promoting health that will likely have the added benefit of reducing the burden of some cancers.



Prevention

The US Department of Health and Human Services (DHHS) lists alcoholic beverages as a known human carcinogen. A causal association has been established between alcohol consumption and cancers of the oral cavity, pharynx, larynx, esophagus, liver, colon, rectum, and breast (women). An association is suspected for cancers of the pancreas and lung.¹⁷⁻²⁰

Combining alcohol consumption and smoking exponentially increases the risk for certain cancers. Compared with the risk for nonsmoking nondrinkers, the approximate relative risks for developing mouth and throat cancer are seven times greater for those who use tobacco, six times greater for those who use alcohol, and 38 times greater for those who use both tobacco and alcohol.²⁰

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.....
In Idaho, melanoma accounted for **335** cases in 2004 and **46** deaths.

Sun and UV Light Exposure

Skin cancer is largely preventable when sun protection measures are used consistently.^{21,22} Exposure to ultraviolet (UV) radiation, either naturally from the sun or from artificial sources such as tanning devices, appears to be the most significant factor in the development of skin cancer.²³ Most deaths due to skin cancer are a result of melanoma. In Idaho, melanoma accounted for 335 cases in 2004 and 46 deaths.²⁴ Use of sunscreen is commonly accepted practice in the prevention of skin cancer, although scientific evidence is equivocal. The International Agency for Research on Cancer (IACR) recommends that sunscreen be used in combination with other sun protection behaviors.²⁵ Less than one-third of youth aged 11-18 practiced any sun protection behavior, and only 31% of adults surveyed in 1998 reported wearing protective clothing, staying in the shade or using sunscreen (National data).²⁶ These results highlight the need for effective interventions that reduce harmful UV light exposures.





The chemicals identified as having the greatest potential impact on public health in Idaho include arsenic, radon, benzene, dioxins/furans and pesticides.

Environmental and Occupational Carcinogens

Several chemicals found in the environment (such as arsenic, benzene and radon) have been classified as carcinogenic by agencies such as the World Health Organization's International Agency for Research on Cancer, the U.S. National Toxicology Program, the National Cancer Institute and the U.S. Environmental Protection Agency. Many others have been identified as being potential human carcinogens. Quantifying the cancer risk posed by these chemicals is challenging due to the difficulty in measuring exposure. Human exposure to any given environmental carcinogen is highly variable and depends on a number of factors, including the concentration of the carcinogen in the environment, individual behaviors (e.g., location of residence, frequency of contact with soil) and how the carcinogen is taken into the body.²⁷ Furthermore, each person's exposure to environmental carcinogens can vary greatly over a lifetime. For these reasons, it may not be possible to provide a reliable estimate of the cancer burden associated with any particular environmental carcinogen in Idaho.

The most common and intense exposure to environmental carcinogens usually occurs in an industrial setting. Workers tend to have more exposure to these chemicals than the general public. The use of proper ventilation, personal protective clothing and equipment and other safeguards helps reduce exposures to carcinogens. Linking individual cancers to a specific occupational exposure, however, is difficult due to the fact that cancer frequently takes years to develop, cancer is a multifactorial disease, and exposures in the workplace are unclear and always changing.

Despite the fact that the contribution of environment carcinogens to the cancer burden is not as well understood as some of the other major causes of cancer, preventive measures can and should be initiated. Such measures include the reduction of exposure to hazardous chemicals in the workplace and the reduction of environmental pollution.²⁸

In order to determine which environmental carcinogens to address in this plan, only chemicals that were determined to be either carcinogenic or probably carcinogenic to humans were considered. Those identified as having the greatest potential impact on public health in Idaho include arsenic, radon, benzene, dioxins/furans and pesticides.



Prevention Goals and Objectives

Prevention Goal

Decrease the risks for developing preventable cancers among Idahoans.

Prevention Overarching Strategies and Activities

Policy/Advocacy

1. Support policies, rules, and/or regulations that enhance environments and that allow people to make healthier choices (communities, workplaces, schools, etc.)

Partnership/Collaboration

2. Identify and capitalize on cross-cutting approaches to health promotion addressing multiple risk factors and disease endpoints.

Education/Communication/Outreach

3. Educate healthcare professionals on their role in promoting cancer prevention.
4. Identify and use various settings (workplaces, schools, etc.) and channels (mass media, targeted marketing, etc.) to educate the general public on health behaviors that lower the risk for cancer.

Data and Surveillance

5. Support efforts to better define the potential cancer disease burden based on risk factors.
6. For all objectives without baseline data, explore methods and means to collect data.

Disparities

7. Support efforts to address populations with disproportionate cancer risk behaviors and exposures.
8. Provide culturally and linguistically appropriate health promotion strategies within Idaho's diverse communities including but not limited to Latinos, Asian/Pacific Islanders, African Americans, American Indian/Alaskan Natives, as well as older Idahoans, people in rural /frontier areas, those with low incomes, the underinsured and the uninsured.



Prevention Goals and Objectives



Tobacco Goal

Reduce the impact of tobacco use and exposure on cancer incidence and mortality in Idaho.

General Strategies and Activities - Tobacco

Policy and Advocacy

1. Reduce exposure to secondhand smoke in private and public places.
2. Promote efforts to increase total funding for the state Tobacco Prevention and Control Program to at least the minimum level recommended by the Centers for Disease Control and Prevention.
3. Support efforts for a larger percentage of tobacco settlement funds to be allocated for tobacco prevention and control.

Partnership and Collaboration

4. Support statewide tobacco prevention and control activities, such as those conducted by the Idaho State Tobacco Prevention and Control Program, Tobacco Free Idaho Alliance, the seven Public Health Districts and others.
5. Work to engage medical and dental providers for prevention, screening and tobacco cessation.

Education, Communication and Outreach

6. Reduce tobacco use among youth using evidence-based media, marketing and outreach campaigns.
7. Monitor emerging science on behavioral approaches to reduce initiation of tobacco use and efficacy of cessation efforts and policy implementation.

Disparities

8. Support multifaceted approaches to address populations with disproportionate tobacco use and risk (e.g., Idaho Tribes).
9. Identify or develop culturally sensitive and linguistically appropriate interventions to reach at risk populations including American Indian, African American, Hispanic and other diverse populations.



Prevention Goals and Objectives

Tobacco Objectives

Objective 1.1

By 2010, decrease to 13.4% the percentage of Idaho students in grades 9-12 who have used any form of tobacco during the previous 30 days.

Baseline: 17.8% (2003)

Data Source: Idaho Youth Risk Behavior Survey (YRBS)

Note: Target based on 25% reduction from baseline measure

Note: Aligned with HP2010 Objective 27-2a. HP2010 objective of 21% was met prior to setting objective.

Strategies

1. Support efforts to decrease illegal tobacco sales to minors by reducing successful attempts to purchase.
2. Raise awareness of the QuitLine/QuitNet and other systems of support for cessation.
3. Support efforts to raise the tobacco tax to fund cancer control activities, public health initiatives, smoking cessation options, access to healthcare, prevention and family support.
4. Support efforts for school-based tobacco prevention curriculum.

Objective 1.2

By 2010, decrease to 18.3% the percentage of Idaho adults exposed to second-hand smoke in their home, workplace or while riding in a car.

Baseline: 24.4% (2005)

Data Source: Idaho Adult Tobacco Survey (ATS)

Note: Target based on 25% reduction from baseline measure

Note: Measure combines three separate questions from Idaho ATS

Strategies

1. Support policy development and enforcement among state and local agencies.
2. Support efforts to promote smoke-free homes, public and private workplaces and facilities and other environments.

Prevention Goals and Objectives



Objective 1.3

By 2010, decrease to 6.8% the percentage of Idaho adult males who currently use smokeless tobacco.

Baseline: 9.0%

Data Source: Idaho BRFSS

Note: Target based on 25% reduction from baseline measure

Strategies

1. Support targeted, evidence-based social marketing campaigns among high risk populations and in venues (e.g., rodeos, auto races, softball games, fairs).

Nutrition Goal

Promote and increase dietary consumption of foods and nutrients known to decrease cancer risk.

General Strategies and Activities - Nutrition

Partnership

1. Support efforts of the Idaho Physical Activity and Nutrition Program to devise and implement a statewide physical activity and nutrition plan.
2. Support and assist schools and school districts in designing and implementing effective school wellness policies.



Nutrition Objectives

Objective 1.4

By 2010, increase to 30% the percentage of Idaho adults who consume at least five daily servings of fruits and vegetables.

Baseline: 20.4%

Data Source: 2003 BRFSS

Strategies

1. Promote “5-A-Day” messages in local public health and community health programs and campaigns.
2. Support increased access to fruits and vegetables at workplaces and in communities.



Prevention Goals and Objectives

Objective 1.5

By 2010, increase to 30% the percentage of Idaho high school students who consume at least five daily servings of fruits and vegetables.

Baseline: 19.0%

Data Source: 2003 YRBS

Strategies

1. Promote “5-A-Day” messages in schools.
2. Support increased access to fruits and vegetables in schools.
3. Promote and support state and local policies that create environments conducive to healthy eating, such as offering fruit and vegetable options in school vending machines.

Objective 1.6

By 2010, increase the promotion of whole grain consumption among Idahoans.

Baseline: To be established

Data Source: To be established

Strategies

1. Support community campaigns and media efforts to promote whole grain consumption.
2. Promote and support state and local policies that create environments conducive to healthy eating, such as offering whole grain options in school and workplace vending machines.
3. Explore a way to measure the consumption of whole grain products among Idahoans.

“My grandmother and mother both died of cancer. I am a survivor. It is proven that cancer is hereditary. I have two children who are at great risk for cancer. I would like there to be a cure if that awful day comes so my children won't have to go through the same awful treatments I did with only the possibility of survival.”

Kristy Jones, Boise

Prevention Goals and Objectives



Objective 1.7

By 2010, decrease to 3.6% the percentage of Idaho adults who are heavy drinkers.

Baseline: 4.8% (2004)

Data Source: Idaho BRFSS

Notes: Target based on 25% reduction from baseline measure. Heavy drinking is defined as consuming 60 or more alcoholic beverages in the last 30 days.

Strategies

1. Partner with tobacco prevention and control efforts to educate the public on the relationship between alcohol and cancer and combined alcohol and tobacco use and increased cancer risk.
2. Increase awareness of treatment and support services available by promoting the 2-1-1 Idaho CareLine information and referral line.
3. Support new and existing public health and public safety programs that address alcohol consumption.



Prevention Goals and Objectives

Physical Activity Goal

Increase Idahoan's participation in regular physical activity, thus decreasing the risk of cancer.

Physical Activity Objectives

Objective 1.8

By 2010, increase to 65% the percentage of Idaho adults who accumulate 30 minutes or more per day of moderate physical activity on five or more days of the week or participate in 20 minutes or more of vigorous physical activity on three or more days of the week.

Baseline: 55.9%

Data Source: 2003 BRFSS

Strategies

1. Support statewide dissemination of active living messages to Idahoans.
2. Improve community and environmental design to enable and promote facilities for recreation, parks, sidewalks, walking and bike paths, and trails in communities by partnering with the planning, development and zoning communities.
3. Promote the provision of physical activity opportunities at workplaces.
4. Promote physical activity opportunities in community parks and recreation programs.
5. Collaborate with faith communities to increase opportunities for physical activity.
6. Partner with other chronic disease programs that are also working to increase physical activity (arthritis, diabetes, etc.)



Prevention Goals and Objectives



Objective 1.9

By 2010, increase to 80% the percentage of Idaho high school students who accumulate 30 minutes or more per day of moderate physical activity on five or more days of the week or participate in 20 minutes or more of vigorous physical activity on three or more days of the week.

Baseline: 70.8%

Data Source: 2003 YRBS

Strategies

1. Promote daily physical activity in schools by increasing participation in physical education classes, sports and other organized activities.
2. Support changes in school policies to require daily physical education.
3. Promote youth physical activity at community parks and in recreation programs.

Objective 1.10

By 2010, increase the number of local communities that provide physical activity opportunities and/or adopt policies that promote physical activity.

Baseline: To be established

Data Source: To be established

Strategies

1. Support community efforts to increase facilities for recreation, parks, open sidewalks and trails.
2. Promote physical activity at community parks and in recreation programs.
3. Explore the use of the Local Health Department Physical Activity Assessment 2003 and the Statewide Comprehensive Outdoor Recreation and Tourism Plan (SCORTP) 2003-2007 to monitor the increase in physical activity opportunities in Idaho.





Prevention Goals and Objectives

Overweight and Obesity Goal

Decrease the prevalence of overweight and obesity as a means of cancer prevention and risk reduction.

Overweight and Obesity Objectives

Objective 1.11

By 2010, increase to 45% the percentage of Idaho adults who are neither overweight nor obese (have a body mass index of less than 25.0).

Baseline: 41.8%

Data Source: 2004 BRFSS

Strategies

1. Encourage and recognize healthy weight policies and programs in public and private-sector workplaces and institutions.
2. Promote and support state and local policy development that create environments conducive to healthy eating, such as limiting access to soft drinks and fast foods in workplaces and public facilities.
3. Support community and media campaigns promoting weight control.

Objective 1.12

By 2010, increase to 85% the percentage of Idaho high school students who are classified as neither overweight nor at risk for being overweight.

Baseline: 81.3%

Data Source: 2003 YRBS

Strategies

1. Promote and support state and local policy development that creates environments conducive to healthy eating, such as limiting access to soft drinks and fast foods in schools.
2. Support efforts to increase physical activity opportunities and programs for youth.

Prevention Goals and Objectives



Sun and UV Light Exposure Goal

Reduce the incidence of skin cancer in Idaho.

General Strategies and Activities - Sun and UV Light Exposure

Policy and Advocacy

1. Promote the establishment or enhancement of policies that increase sun and UV light protection among youth.

Education/Communication/Outreach

2. Utilize existing campaigns to promote skin cancer prevention.

Data and Surveillance

3. Enhance data gathering capacity on risk behavior for skin cancer (all ages).

Sun and UV Light Exposure Objectives

Objective 1.13

By 2010, increase the proportion of Idahoans who use at least one of the following protective measures that may reduce the risk of skin cancer: 1) avoid the sun between 10 a.m. and 5 p.m.; 2) wear sun-protective clothing when exposed to sunlight; 3) use sunscreen with a sun-protective factor (SPF) of 15 or higher; and 4) avoid artificial sources of ultraviolet light.



Baseline: To be established

Data Source: To be established

Note: Idaho spans two time zones; the 5 p.m. guideline is necessary to cover southern Idahoans.

Strategies

1. Support efforts to gather data to measure skin cancer protective measures.
2. Raise awareness through public education campaigns of the “covering up” behavior (wearing protective clothing such as a shirt, long pants and hat).
3. Raise awareness through public education campaigns about the need to work and play in the shade or to stay out of the sun during peak UV hours.
4. Promote the use of sunscreen with SPF 15 as a minimum.
5. Develop educational campaigns, using existing materials, about the need to avoid artificial sources of ultraviolet light.
6. Educate child care providers on sun protection and exposure reduction for children in their care.



Prevention Goals and Objectives

Objective 1.14

By 2010, increase to 95% the percentage of secondary school health educators in Idaho who have included information on sun safety and skin cancer prevention in their classes.

Baseline: 78%

Data Source: 2004 Idaho School Health Education Profile System (SHEPS)

Strategies

1. Encourage schools to address sun exposure prevention and risks when developing wellness policies.
2. Identify partners to support sun protection/sunscreen awareness campaigns.
3. Support the development of a policy regarding the use of artificial sources of ultraviolet light for those under 18 years of age.



Prevention Goals and Objectives



Environmental Exposure Goal

Reduce the cancer incidence and mortality in Idaho by addressing the impact of carcinogens in environmental and occupational settings.

General Strategies and Activities - Environmental Exposure

Education/Communication/Outreach

1. Support efforts to increase public education and awareness of environmental carcinogens.
2. Promote education of healthcare providers on environmental carcinogens.
3. Support efforts to identify and bridge information gaps regarding environmental carcinogens.
4. Promote and support public availability sessions for environmental health investigations on cancer incidence in suspected areas and provide resource materials on cancer prevention and control.
5. Support efforts to respond to individual inquiries related to cancer clusters and known or suspected environmental risk factors.
6. Identify and support policies that address the reduction of environmental health risks in Idaho.

Data and Surveillance

7. Support the development of an environmental health tracking system in Idaho.
8. Support the monitoring of cancer incidence and potential environmental exposures.
9. Support research on the etiology of environmental cancers.
10. Support the identification and education efforts of other environmental carcinogens as additional research and data become available.

Resource Development

11. Support efforts to identify funding sources for sampling of environmental contaminants to determine contamination levels.
12. Support efforts to identify possible funding sources for remediation of environmental carcinogens.



Prevention Goals and Objectives

Partnership and Collaboration

13. Promote better coordination and communication among agencies such as the Idaho Department of Environmental Quality, Idaho Department of Agriculture, Idaho Public Health Districts, U.S. Environmental Protection Agency and other state, federal and local agencies.
14. Support evaluation measures to ensure that the public's needs are being met.
15. Promote and support the reduction of health disparities related to environmental carcinogens.

Environmental Exposure Objectives

Objective 1.15

By 2010, reduce population exposure to arsenic in soil, water, and chromated copper arsenate (CCA)-treated wood.

Baseline: To be established

Data Source: To be established

Strategies

1. Support expanded soil sampling in regions where arsenic contamination is likely.
2. Support research to better characterize exposure to arsenic contaminated soil.
3. Provide support for the development and distribution of educational materials regarding ways to minimize exposure to arsenic-contaminated soil.
4. Support funding for distribution of educational material on the occurrence of arsenic in drinking water, the associated cancer risk and the available options to reduce exposure.
5. Work with the local health departments to distribute educational material to private well owners.
6. Support water testing in areas with known or potential arsenic contamination of groundwater.
7. Support and promote either yearly sealing of CCA-treated wood in playground equipment and decks or replacing playground equipment or decks with alternative materials.
8. Support development and dissemination of educational materials on how to reduce or eliminate exposure to CCA-treated wood.
9. Assist in efforts to identify, generate and develop funding for mitigation.



Prevention Goals and Objectives



Objective 1.16

By 2010, increase to 25% the number of homes that have been tested for radon.

Baseline: 15%

Data Source: 2001 BRFSS

Strategies

1. Provide support for the distribution of educational materials regarding home testing and mitigation strategies for radon.
2. Promote and support indoor radon testing, especially in those areas of the state that have a high radon potential.
3. Support efforts to identify, generate and develop potential funding sources for mitigation.

Objective 1.17

By 2010, reduce population exposure to benzene.

Baseline: To be established

Data Source: To be established

Strategies

1. Support expanded sampling in regions where benzene contamination is likely.
2. Support research to better characterize exposure to benzene.
3. Provide support for the development and distribution of educational materials regarding ways to minimize exposure to benzene.



Objective 1.18

By 2010, reduce population exposure to dioxins and furans.

Baseline: To be established

Data Source: To be established

Strategies

1. Support sampling in regions where dioxin and furan contamination is likely.
2. Support research to better characterize exposure to dioxins and furans.
3. Provide support for the development and distribution of educational materials regarding ways to minimize exposure to dioxins and furans.



Prevention Goals and Objectives

Objective 1.19

By 2010, reduce population exposure to household and agricultural pesticides.

Baseline: To be established

Data Source: To be established

Strategies

1. Support development of educational materials on how to reduce or eliminate exposure to household and agricultural pesticides.
2. Support the local health districts, Idaho Department of Agriculture, and other agencies in distributing culturally and linguistically appropriate educational material to migrant farm workers and their families, farmers, pesticide applicators and healthcare providers.
3. Support efforts to educate farmers on using less pesticides and/or less toxic pesticides.

Objective 1.20

By 2010, reduce exposure to carcinogenic chemicals in the work environment.

Baseline: To be established

Data Source: To be established

Strategies

1. Support and promote workplace-based educational activities on health concerns related to exposure to environmental carcinogens.
2. Support the development of appropriate educational materials designed to identify, assess and reduce opportunities for exposure to environmental carcinogens and to improve understanding of known and suspected risk factors.
3. Support worker health and safety education programs.



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Early Detection and Diagnosis



“Don’t put off taking care of yourself. I knew I had a lump but had issues with my husband, children, home, even dogs, that I put before my own health. Having had a benign lump [when I was] 20 years old, I felt okay putting it off...I felt overwhelmed with no time for me. When I finally went in I was already at a later stage cancer and needed a mastectomy, chemo and radiation. I am just starting the chemo. I stress to everyone, earlier is better than later. You are as important as anyone or anything. Take care of yourself.”

Martee Thomas, Idaho Falls

Early detection of many cancers saves lives by finding cancers when they are still localized and when treatment is more likely to be successful. Generally the prognosis is much better when found early for such prevalent cancers as skin, breast, cervix, colon/rectum, prostate and lung.¹ Techniques to detect cancer range from direct visual observation; palpation to detect lumps, nodules or tumors; procedures and tests such as x-rays and magnetic resonance imaging; and laboratory tests such as blood tests and pap smears.²

Screening is a means of detecting disease early in asymptomatic people. Some of the tests can detect abnormal cell changes that when treated can greatly reduce or eliminate the potential for that cancer entirely. For some cancers, the evidence for screening is not yet conclusive. Population-based screening is not recommended unless the disease is an important health problem, has a detectable preclinical phase and/or offers improved outcomes if detected before clinical symptoms appear rather than if treatment begins after the onset of symptoms. Another consideration includes whether the test has been shown to be accurate, cost effective and acceptable to individuals and healthcare providers.³ The benefits of screening must be weighed against possible harms including potential risks, potential long-term false positive test results or false negative test results which could delay diagnosis.²

It has been shown that people without health insurance are much less likely to have had recommended cancer screenings, more likely to be diagnosed with cancer at later stages and more likely to die from cancer at higher rates than those with insurance.^{4,5} Idaho has a large population of uninsured. Compared to other states, Idaho has some of the lowest cancer screening rates in the United States.

In 2004, Idaho⁶:

- Had the worst mammography screening rate among all states in the U.S. for women ages 40 and over.
- Had the second lowest cervical cancer screening rate in the U.S.
- Was fifth worst for adults having had a blood stool test in the past two years and eighth worst for those ever having had a sigmoidoscopy/colonoscopy for colorectal cancer screening.
- Was twelfth worst in the nation for men age 40 and older who have not had a prostate specific antigen (PSA) test within the past two years.



Early Detection and Diagnosis

Breast Cancer

Breast cancer is the second leading cause of cancer death after lung cancer among Idaho women.⁷ Nationally, breast cancer rates have continued to rise since 1980; however, there is a steady decline in the death rate from breast cancer.⁸ Breast cancer rates increase steadily with age and Caucasians have higher incidence rates as do women in higher income groups.⁹ In 2004, among Idaho women aged 40 and older, 40.7% had not had a mammogram and a clinical breast exam within the past two years.¹⁰

Hispanic women in Idaho are more likely to be diagnosed with late stage breast cancers. In Idaho (1999-2003), 40% of Hispanic women compared to 30% of non-Hispanic women were diagnosed with late stage breast cancers. This is higher than SEER regions, which showed that 34% of Hispanic women and 27% of non-Hispanic women were diagnosed with late stage breast cancers.¹¹

For women under age 65, uninsured women have the highest rates of regional or distant (more advanced) stages of breast cancer (48%) compared to those with private insurance (33%), Medicare (25%), and Medicaid (43%).¹² In Idaho, survival rates differ significantly by stage of diagnosis. The five-year relative survival rate for all Idaho resident females diagnosed with breast cancer was 100% for in situ cases, 97% for localized cases, 79% for regional cases and 16% for distant cases.⁷ It is estimated that Women's Health Check (WHC), the breast and cervical cancer screening program for uninsured and underinsured women, serves only 15 to 21% of eligible Idaho women because of under funding.¹³

Breast cancer is the **second** leading cause of cancer death after lung cancer among Idaho women.

In 2004, among Idaho women aged 40 and older, **40.7%** had not had a mammogram and a clinical breast exam within the past two years.

In Idaho (1999-2003), **40%** of Hispanic women compared to **30%** of non-Hispanic women were diagnosed with late stage breast cancers.



Early Detection and Diagnosis



Among Hispanic women in Idaho, the age adjusted rate of cervical cancer was **16.2** compared to **7.6** per 100,000 population among non-Hispanic whites in 2003.

Women aged 65 and older were significantly more likely to have not had a Pap test in the last three years.

Individuals with incomes below \$15,000 and women without health insurance were less likely to have had a Pap than those with higher incomes or insurance.



Colorectal cancer is the **3rd** leading cause of cancer death for men and women in Idaho.

In 2004, in the 50 and older group:

- **52.6%** never had a sigmoidoscopy or colonoscopy.
- **78.2%** report not having had a blood stool test in the past two years.

Among American Indian/Alaska Natives in Idaho, only **37%** report ever having had a flexible sigmoidoscopy and **38.2%** report having had a fecal occult blood test within the past two years.

Cervical Cancer

Cervical cancer was once the leading cause of cancer death in women. The majority of cervical cancer cases worldwide can be attributed to the human papilloma virus (HPV). The death rate, however, has declined by 70% since the implementation of the Papanicolaou (Pap) test in the 1940's.¹⁴ Cancer of the cervix is rare and can almost always be prevented by finding abnormal cell changes early through regular Pap tests.¹⁵ The five-year survival rate for women diagnosed with localized disease is about 90% and for those with distant metastasis it is about 12%.¹¹

Among Hispanic women in Idaho, the age adjusted rate of cervical cancer was 16.2 compared to 7.6 per 100,000 population among non-Hispanic whites in 2003. Women aged 65 and older were significantly more likely to have not had a Pap test in the last three years and those with income below \$15,000 and women without health insurance were less likely to have had a Pap than those with higher incomes or insurance.¹¹

Colorectal Cancer

In Idaho, colorectal cancer is the second most common cancer-related cause of death among males and females combined. Colorectal cancer is the third leading cause of cancer death for men after lung and prostate cancer and the third leading cause of cancer death for women after lung and breast cancer.¹⁶ The five-year survival rate in early localized stage colorectal cancer is 90%. Only 35% of colorectal cancers are detected at the early localized stage.¹⁷ In 2004, the percentage of Idaho adults aged 50 and older who have never had a sigmoidoscopy or colonoscopy was 52.6%. In the same age group, 78.2% report not having had a blood stool test in the past two years.¹⁸ Among American Indian/Alaska Natives in Idaho, only 37% report ever having had a flexible sigmoidoscopy and only 38.2% report having had a fecal occult blood test within the past two years.¹⁶

Many organizations and agencies are working to raise awareness nationwide about the importance of colorectal cancer screening and the serious nature of the disease. Traditionally, screening rates for this preventable cancer have been low. However, between 1997 and 2004, the BRFSS showed that among adults aged 50 and older, screening rates for colorectal cancer are increasing but still lag significantly behind the current screening rates for breast and cervical cancers.¹⁹



Early Detection and Diagnosis

Prostate Cancer

Prostate cancer is the second overall cause of cancer death for Idaho men and is the most common cancer among males. From 1999 through 2003, there were 4,758 cases of prostate cancer in Idaho with 756 deaths. The age-adjusted incidence rate was 161.3 per 100,000. Of those, 1% were diagnosed in-situ, 75% at the local stage, 10.1% unstaged, 11.8% regional and 3% distant stage.⁷ Prostate cancer survival is related to the stage at time of diagnosis. Five-year relative survival rates for Idaho males diagnosed with prostate cancer were near 100% for localized and regional cases and 30% for distant cases.⁷ Stage-specific survival rates were quite similar between Idaho males and males residing in SEER regions.⁷

Known risk factors for prostate cancer that are not modifiable include age, ethnicity and family history. One modifiable risk factor associated with prostate cancer is a diet high in saturated fat and low in vegetable and fruit consumption. African-American men, men with a first degree relative who have had prostate cancer before age 65 (father, brother), and older men are at higher risk for developing prostate cancer than other groups.²⁰ Farming is the most consistent occupational risk factor for prostate cancer with methyl bromide pesticide application identified as a risk factor by the Agricultural Health Study.²¹ In both SEER regions and Idaho, Blacks have the highest rates of prostate cancer incidence and American Indian/Alaska Natives the lowest.²²

Controversy exists both about the benefits of screening for prostate cancer and about treatment options once diagnosed. The U.S. Preventive Services Task Force (USPSTF) concludes that the evidence is insufficient to recommend for or against routine screening for prostate cancer. While good evidence exists that PSA screening with digital rectal exam (DRE) can detect early-stage prostate cancer, the evidence is inconclusive that early detection improves health outcomes. Potential harms from screening include false-positive results, unnecessary biopsies, and possible complications.²³ Given the uncertainties surrounding prostate cancer screening, the USPSTF concluded that clinicians should not order screening without first discussing with patients the uncertain benefits and possible harms from screening. Patients, guided by their physicians, should consider the gaps in evidence, personal preferences and risk profile before deciding to be tested.²⁴ The American Cancer Society recommends that the PSA test and the DRE be offered annually, beginning at age 50, to men who have a life expectancy of at least 10 years and beginning at age 45, to men considered at high risk.²⁵ Many research studies are being conducted to more conclusively determine the health benefits of prostate cancer screening.

Prostate cancer is the **second** overall cause of cancer death for Idaho men.

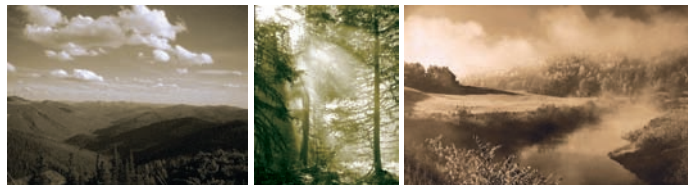
From 1999 through 2003, there were **4,758** cases of prostate cancer in Idaho with 756 deaths.

In both SEER regions and Idaho, Blacks have the highest rates of prostate cancer incidence and American Indian/Alaska Natives the lowest.

“After two bouts of prostate cancer, I continue to support the ACS [American Cancer Society] because a cure is important. As leader of Man-to-Man support group, I see how cancer devastates families.”

Kent Setty, Coeur d'Alene

Early Detection and Diagnosis



Lung cancer is the leading cause of cancer death for both males and females in Idaho.

.....

Between 1999 and 2003, there were **194** deaths in Idaho from melanoma and **1,311** cases of invasive melanoma.

Lung Cancer

Lung cancer is not included in the *Early Detection and Diagnosis* chapter goals and objectives because current science does not support population-based efforts to screen even among those at higher risk for lung cancer.²⁶ The U.S. Preventive Services Task Force found poor evidence that any screening strategy for lung cancer decreases mortality. Because of the invasive nature of diagnostic testing and the possibility of a high number of false-positive tests in certain populations, there is potential for significant harm from screening.²⁷ However, because lung cancer is the leading cause of cancer death for both males and females in Idaho, the partners will monitor emerging science in the arena of better detection of lung cancer and disseminate new guidelines as they are developed.

Skin Cancer

Skin cancer is the most common form of cancer in the United States.²⁸ This includes the most common types of basal cell and squamous cell carcinomas and less common melanoma. Incidence of malignant melanoma, the deadliest form of skin cancer, has been on the rise in the U.S. in the past two decades.²⁹ Cancer of the basal and squamous cells have a better prognosis, but if left unattended can cause scarring and disfigurement.³⁰ Evidence is lacking that skin examination by clinicians is effective in reducing mortality or morbidity from skin cancer and, therefore, the USPSTF concludes that evidence is insufficient to recommend for or against routine screening for skin cancer using a total-body skin examination for the early detection of cutaneous melanoma, basal cell cancer or squamous cell skin cancer.³¹ The American Cancer Society recommends skin examination by a trained health professional every three years for those aged 20 to 39 and annually after age 40 as part of a periodic check-up. Screening recommendations are justified on the grounds that the visual examination is relatively inexpensive and carries a low risk for harm.³²

Between 1999 and 2003, there were 194 deaths in Idaho from melanoma and 1,311 cases of invasive melanoma. Melanoma rates increase with age. It occurs more frequently among Caucasians, more cases are found among males than females, and there is an increased incidence in higher income groups.⁷



Early Detection and Diagnosis

Oral and Pharyngeal Cancer

Oral health is an essential and integral component of health throughout life. Oral and pharyngeal cancers account for 2 to 4% of cancers diagnosed annually.

These cancers primarily affect adults over age 45 and result in significant illness and disfigurement associated with treatment, substantial cost and more than 8,000 deaths in the U.S. annually.³³ Cancers of the oral cavity and pharynx are usually surface malignancies for which signs and symptoms can be recognized early, but less than half are detected at the earliest stage. Diagnosed in the localized early stage, 5-year survival rate is 81% compared to 22% when diagnosed in the latest stage.³⁴ Early stages can be detected by a visual and tactile examination that takes about 90 seconds and can be performed by a dental or medical professional.³⁵ New oral cancer diagnostic aids, e.g., computer-assisted brush biopsy, toluidine blue dye, and chemiluminescent light, are now available to facilitate early detection and treatment.³⁶

In Idaho, 47% of oral and pharyngeal cancers are diagnosed in situ or at the local stage, 34% at the regional stage and 5% at the distant stage (14% are unstaged). It is estimated that smoking and drinking account for 75% of all oral cancers in the U.S.⁷



Early Detection and Diagnosis Goals and Objectives



Early Detection and Diagnosis Goals

1. Detect and diagnose cancer cases in Idaho at an early stage in order to optimize treatment choices and the probability of cure and/or survival.
2. Increase appropriate screening and early detection for cancer.
3. Promote awareness of and implement early detection initiatives with evidence-based effectiveness.
4. Reduce disparities in cancer screening services for uninsured, underinsured and underserved populations.

Early Detection and Diagnosis Overarching Strategies and Activities

Policy/Advocacy

1. Expand funding resources to develop or further support screening programs for cancers for which there are evidence-based screening modalities.
2. As new evidence-based screening methods are developed, seek funds or other resources to promote and make them available and accessible to Idahoans, including the medically underserved. Disseminate literature for education and screening that is scientifically sound, culturally and linguistically appropriate, in languages necessary for the state's various population groups. These should be a standard part of all early detection activities and initiatives.
3. Develop and support strategies and policies that will help standardize cancer screening services throughout the state.
4. Promote legislative or policy changes to increase insurance coverage for screenings and early detection activities.

Infrastructure Development

5. Increase the utilization of existing healthcare delivery systems to promote and provide screening and early detection.
6. Identify gaps in service delivery and determine methods to bridge those gaps.

Quality Assurance

7. Support the development of consistent screening standards across all populations in order to ensure quality of care.
8. Establish baseline of community-based early detection programs and identify gaps in services and access.



Early Detection and Diagnosis Goals and Objectives

Education/Communication/Outreach

9. Educate the public, healthcare professionals, and patients regarding the benefits of screening, screening guidelines and the available screening resources.
10. Educate the public, healthcare professionals and patients on current Idaho screening rates.
11. Develop funding resources and utilize existing media or create new targeted campaigns to promote appropriate screenings for and early detection of cancer.

Disparities

12. Identify opportunities and resources to address gaps in service and access.
13. Develop culturally sensitive and linguistically appropriate interventions to reach at risk populations including American Indian, African American, Hispanic and other diverse populations.
14. Work with Tribal communities and minority populations to increase participation in screening and early detection clinical trials as they become available.

“I very seldom even had the flu - let alone a major illness. So it was quite a shock to learn I have lymphoma. It has been 3 months since I was given the news I have cancer. I’m fortunate—I have insurance to cover the medical exams. I’m told my form of lymphoma has no cure - so at some point I will relapse - and that scares me. I am asking for help - from you - to help fund research. A cure can be found and needs to be found.”

Tyrone A. Smith, Idaho Falls

Early Detection and Diagnosis Goals and Objectives



Breast Cancer Goal

Increase the appropriate utilization of evidence-based and timely breast cancer screening and diagnosis.

Breast Cancer Objectives

Objective 2.1

By 2010, increase to 70% the percentage of women age 40 and older who report having had a mammogram and clinical breast exam in the past two years. Increase to 74% the percentage of women age 50 and older who report having had a mammogram in the past two years.

Baseline: 59.3% (age 40+)

Data Source: BRFSS 2004

Note: National Target-70%, 50 and older- 67.5 %

Strategies

1. Support efforts to continue and expand free and reduced-cost breast cancer screening programs throughout the state.
2. Support efforts to increase community resources to provide funding for screening/diagnostics for low income, uninsured women.
3. Provide culturally and individually appropriate breast health education to Idaho's diverse communities of women, including but not limited to Latinas, Asian/Pacific Islanders, African Americans, American Indian/Alaskan Natives, older women, women with disabilities, women who partner with women, women in rural/frontier areas, those with low incomes, the uninsured and the underinsured.
4. Increase public knowledge of resources available, including Medicare payment for mammography.
5. Educate primary care providers on importance of regular breast screening, including clinical breast exam (CBE) and mammography.
6. Provide education to all women in Idaho about the importance of regular breast screening.
7. Educate healthcare professionals on the importance of quality clinical breast exams along with mammography for effective screening and on their role in recommending the appropriate breast screening and resources available.

“Every person in the United States is affected by cancer. If it is not directly, it is indirectly. My very good friend died from cancer, along with my grandmother. My aunt has also had two bouts with breast cancer. Please support! It could be you someday, and I don't wish that upon anyone. Let's find a cure with your support!”

Kelsea Ballantyne, Hailey



Early Detection and Diagnosis Goals and Objectives

8. Continue to offer professional education such as the “Partnerships and Patient Focused Care” conference established by the Idaho Breast and Cervical Cancer Alliance.
9. Promote the use of reminder and tracking systems to inform women of their need for regular screening.

Cervical Cancer Goal

Increase the appropriate utilization of evidence-based and timely cervical cancer screening and diagnosis.

Cervical Cancer Objectives

Objective 2.2

By 2010, increase to 90% the percentage of women, age 18 and older, who report having had a Pap smear in the prior three years.

Baseline: 78.2%

Data Source: BRFSS 2004

Note: National Target 90%

Strategies

1. Promote public education about risk factors, such as tobacco use and sexual exposure, and protective behaviors for cervical cancer, including limiting sexual partners.
2. Support community based organizations in promoting cervical cancer screening.
3. Support the use of reminder systems to increase the number of women who receive regular cervical cancer screening.
4. Provide culturally and individually appropriate cervical cancer education to reach Idaho’s diverse communities of women, including but not limited to Latinas, Asian/Pacific Islanders, African Americans, American Indian/Alaskan Natives, older women, women with disabilities, women who partner with women, women in rural/frontier areas, those with low incomes, the uninsured and the underinsured.
5. Support and enhance local and statewide funding for screening for women with limited resources.
6. Promote use of current clinical guidelines for follow-up to all clinicians who collect Pap test results.



Early Detection and Diagnosis Goals and Objectives



7. Monitor emerging science and update education on use of new technology (e.g., HPV vaccine).
8. Educate all women about the importance of regular cervical cancer screening.
9. Promote the use of reminder and tracking systems to inform women of their need for follow-up and/or re-screening at appropriate intervals.
10. Educate primary care providers on data relating to cervical cancer screening and the importance of their role in recommending screening to women.

Colorectal Cancer Goal

Increase the appropriate utilization of evidence-based and timely colorectal cancer screenings and diagnosis.

Colorectal Cancer Objectives

Objective 2.3

By 2010, increase to 50% the percentage of adults age 50 and over who report having received a colonoscopy/sigmoidoscopy within the past five years.

Baseline: 37.9%

Data Source: BRFSS 2004

Note: National Target - no national target for sigmoidoscopy/colonoscopy combined

Strategies

1. Promote legislative and/or policy changes to increase insurance coverage for colorectal screening tests.
2. Promote use of colonoscopy/sigmoidoscopy at recommended screening intervals.
3. Determine provider barriers to recommending, referring to, and/or performing colorectal cancer screening.
4. Promote the development of subsidized screening for colonoscopy/sigmoidoscopy for low income and uninsured or underinsured adults.





Early Detection and Diagnosis Goals and Objectives

Objective 2.4

By 2010, increase to 33% the percentage of adults age 50 and over who report having a fecal occult blood test (FOBT) in the past two years.

Baseline: 21.8%

Data Source: BRFSS 2004

Strategies

1. Educate providers regarding the importance of regularly counseling their eligible patients about the benefits of colorectal screening.
2. Promote evidence-based interventions such as reminder systems for patient education.
3. Reduce barriers to colorectal cancer screening for all adults 50 years or older.
4. Provide culturally and linguistically appropriate colorectal cancer education to reach Idaho's diverse communities.
5. Promote annual use of FOBT for adults over age 50.
6. Provide public education about the importance of these lifesaving tests at appropriate intervals.
7. Support efforts to encourage insurance programs to reimburse for the cost of appropriate colorectal screening (insurance companies).

Early Detection and Diagnosis Goals and Objectives



Prostate Cancer Goals

1. Monitor prostate cancer research in primary, secondary, and tertiary prevention and promote informed and shared decision making about screening and treatment for prostate cancer.
2. Decrease years of potential life lost among Idaho men with prostate cancer.

Prostate Cancer Objectives

Objective 2.5

By 2010, increase the number of men age 45 and older who have talked with their provider about prostate cancer screening.

Baseline: To be established

Data Source: To be established

Strategies

1. Develop supplemental BRFSS questions regarding informed and shared decision making between men and their healthcare providers about prostate cancer screening.
2. Establish a baseline and determine an appropriate target to guide efforts to increase the proportion of men age 50 and older (age 45 for those at high risk) who report being informed about the benefits and risks associated with prostate cancer screening.
3. Monitor emerging science on screening linked with treatment outcomes.
4. Provide educational opportunities for front line healthcare professionals on emerging prostate cancer science related to screening and links to treatment efficacy.
5. Increase awareness about prostate cancer risk factors among men 50 and older (age 45 for those at high risk).
6. Encourage men age 45 and older who are potentially at high risk for prostate cancer to consult with their healthcare provider about the risk and benefits of prostate cancer screening.
7. Promote informed and shared decision making between men and their healthcare provider regarding prostate cancer screening.
8. Address men's health issues collectively for all ages and encourage prostate cancer discussions to be included with other health screenings and examinations (heart health, etc.).
9. Identify existing, or develop, culturally and linguistically appropriate materials to assist men in making informed decisions regarding prostate cancer screening.



Early Detection and Diagnosis Goals and Objectives

Objective 2.6

By 2010, reduce the prostate cancer death rate to 28.8 per 100,000 (age-adjusted).

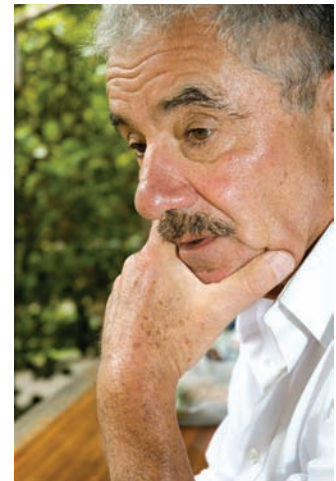
Baseline: 30.2 per 100,000

Data Source: 2000-2004 Idaho mortality data

Note: National Target 28.8 per 100,000

Strategies

1. Monitor emerging science on screening linked with treatment outcomes.
2. Provide educational opportunities for front line healthcare professionals on emerging prostate cancer science related to screening and links to treatment efficacy.
3. Increase awareness about prostate cancer among men.
4. Support community outreach efforts among high risk populations with appropriate materials and information to promote informed decision making regarding screening.



Early Detection and Diagnosis Goals and Objectives



Skin Cancer Goals

1. Increase the utilization of evidence-based skin cancer screening and diagnosis.
2. Reduce the rate of skin cancer/melanoma deaths among Idahoans.

Skin Cancer Objectives

Objective 2.7

By 2010, increase the number of Idahoans who reported having had a visual examination of the skin, including both self-examination and clinical exam.

Baseline: Develop a state added BRFSS question to address this objective.

Strategies

1. Increase awareness among healthcare professionals about Idaho skin cancer rates.
2. Educate healthcare professionals on how to conduct skin cancer screening.
3. Encourage healthcare professionals to include skin and sun exposure questions in yearly physical exams.
4. Conduct campaigns to increase awareness about the serious nature of melanoma and the need to detect it early.
5. Educate public on skin cancer risk, warning signs and screening guidelines.
6. Educate public to request visual examination by their healthcare provider.
7. Educate young adults who have used tanning facilities, or are otherwise at risk for skin cancer, to conduct regular self-exams and request exams by their healthcare provider.

“My cancer was cured because it was detected early and I would like to see more funds for programs that prevent and detect cancer.”

William Bartlett, Rupert



Early Detection and Diagnosis Goals and Objectives

Oral and Pharyngeal Cancer Goals

1. Increase the appropriate utilization of evidence-based oral and pharyngeal cancer screening and diagnosis.
2. Reduce late stage diagnoses of oral and pharyngeal cancer among Idahoans.

Oral and Pharyngeal Cancer Objectives

Objective 2.8

By 2010, increase to 50% the percentage of oral and pharyngeal cancers detected at the earliest stage.

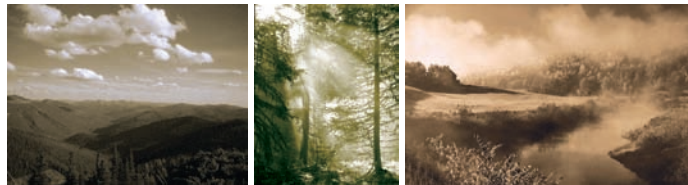
Baseline: 44.6% SEER localized stage

Data Source: CDRI, 1999-2003 Incidence data

Strategies

1. Partner with oral health professionals and programs to include oral and pharyngeal cancer screening in program and project planning.
2. Partner with dental, tobacco and other programs to raise public awareness of oral cancer, risk factors and early signs of oral cancer and pharyngeal cancers for tobacco users.
3. Encourage tobacco users to request cancer screening examinations by their dentists on a regular basis.
4. Integrate education about oral cancer with dental, dental hygiene, medical and nursing education courses.
5. Partner with educational institutions and professional organizations to promote routine oral cancer examinations and provide continuing education to enhance dental and medical clinicians' knowledge of oral cancer risk factors, clinical signs and symptoms, and diagnostic concepts and aids.

Early Detection and Diagnosis Goals and Objectives



Objective 2.9

By 2010, increase the percentage of adults who, in the past 12 months, report having had an examination to detect oral and pharyngeal cancers.

Baseline: To be established

Data Source: Create BRFSS question in the Oral Health module.

Strategies

1. Work with partners to provide educational opportunities for dental professionals (dentists, hygienists) to ensure proficiency and encourage comprehensive oral cancer examinations for all adult patients.
2. Encourage dental professionals to educate patients about the need for the oral cancer examination and make patients aware that the examination has been provided.

“I feel I was blessed with an excellent team of specialists and caregivers. Looking back, we didn't really have the danger signals that warn you to check for cancer. We now realize that there may have been some huskiness of the throat, but with a naturally deep voice and normal aging, we really did not think it was that unusual. We would advise anyone to heed that more carefully. The tumor seemed to come overnight.”

Cloyd Nelson, Meridian



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Cancer treatment has evolved extensively over the past few decades. Treatment includes multiple modalities of cancer therapy such as chemotherapy, biologicals, radiation therapy, surgery and combinations of those treatments. Advances have been made in interdisciplinary approaches to patient treatment and cancer management including the involvement of physicians from several specialties, nurses, social workers, nutritionists and others.¹ Standard treatment approaches, also called standard of care, evidence-based or best practice, are usually based on research findings, a consensus of expert opinions or both.² Definitive treatment guidelines are not always available and physicians may disagree on what approach to take, but for the purposes of this plan, references to cancer treatment and care refer to the best available scientific knowledge.³

Informed and Shared Decision Making

In recent years there has been a growing emphasis on patient involvement in healthcare decisions. The USPSTF defines informed decision making as an individual's overall process of gathering relevant health information from both his or her clinician, and from other clinical and nonclinical sources, with or without independent clarification of values. Shared decision making is a process of decision making by the patient and clinician, in which the patient understands the risk or seriousness of the disease or condition to be treated; understands the treatment including the risks, benefits, alternatives and uncertainties; has weighed his or her values regarding the potential benefits and harms associated with the treatment; and has engaged in decision making at a level at which he or she desires and feels comfortable.⁴ Review committees for the Institute of Medicine suggest that "a patient-provider partnership is needed to ensure that decisions respect patients' wants, needs and preferences and that patients have the education and support they require to make decisions and participate in their own care."⁵

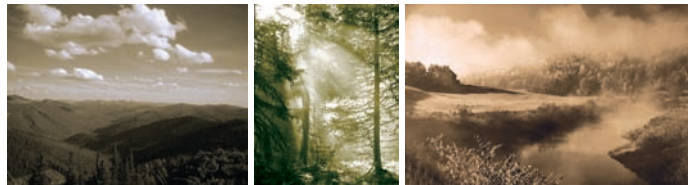
Access to Quality Care

Access, as defined by the Institute of Medicine in 1994, is the timely use of personal health services to achieve the best possible health outcomes.⁶ Multiple factors influence and create access barriers to quality cancer care; many of them are interrelated. System barriers include the medical system's focus on acute care over prevention and early detection, denial of referral or access to specialists because the patient did not meet screening criteria even though cancer was evident,

“I’ve had reoccurring breast cancer for 3 years. Had surgery and chemo and radiation 2x’s. It was the greatest fight for life I’ve ever known. Cancer is about many things but to me it was mostly about love! Cancer is going and growing in numbers so fast, we need money, support and care.”

Diane Harrison, Clark Fork

Treatment



lack of coordination among public payers (Medicaid, Medicare, Veterans administration), delayed enrollment in those programs allowing the disease to progress to advanced stages, and policies that discourage appropriate end-of-life care. Financial barriers include lack of health insurance or inadequate insurance; high out-of-pocket costs for deductibles, co-pays, medications, and other support services that are not covered; providers who demand full payment at the time of service and slow reimbursement by the insurer compromising a patient's financial resources; and inability to find providers who will treat Medicaid patients. This list only scratches the surface of financial barriers faced by cancer patients and their loved ones. Healthcare providers face issues as well, including increasing administrative responsibilities and costs, reduction in reimbursements for drug costs, and growing pressure to see more patients per day. Rural providers often have the same expenses as urban counterparts but face lower reimbursement rates for the same services.

Access issues for patients also include physical barriers such as excessive distance to cancer care, bad weather and road conditions, lack of public or other transportation options (or being too sick to use public transportation), and lack of primary healthcare in rural areas for early detection and diagnosis. Information and education barriers also persist. Information and education opportunities include:

- Better education for primary care providers about cancer
- Keeping providers abreast of rapidly changing treatment options
- Resolving conflicting screening and treatment guidelines
- Improving and using emerging technologies such as distance learning and telehealth
- Providing and promoting medical data systems—including patient monitoring and tracking systems



Education is also needed regarding cultural differences and the way patients need to receive information and how they perceive the disease and treatment.⁷

The issues listed above, which were identified in national research, mirror the concerns and experiences of those affected by cancer in Idaho. Cost of cancer care is a major concern for Idahoans. Lack of health insurance or inadequate coverage, the difficulty in getting to services because of the rural nature of much of the state, fear of “losing everything,” and cultural belief systems influence decisions individuals make regarding cancer treatment and care.⁸



As of June 2006 Idaho had seven hospitals accredited by the American College of Surgeons Commission on Cancer as approved cancer centers. This approval program encourages hospitals, treatment centers and other facilities to improve their quality of patient care through various cancer-related programs. The programs are concerned with prevention, early diagnosis, pretreatment evaluation, staging, optimal treatment, rehabilitation, surveillance for recurrent disease, support services and end-of-life care.⁹ Idaho has several communities that are located near borders with other states and for some of these residents it is more convenient or necessary to seek treatment outside of Idaho.

Few programs exist in Idaho to assist vulnerable populations with cancer treatment. The “Every Woman Matters” law passed by the 2001 Legislature provides cancer treatment coverage through Medicaid for women enrolled, screened and diagnosed with breast or cervical cancer or pre-cancer through “Women’s Health Check.” Women who are not enrolled in WHC and are diagnosed are not eligible for coverage under this program.

Clinical Trials

Clinical trials are research studies to evaluate treatments, drugs or medical devices.¹⁰ Participants are enrolled based on their type of cancer, stage of disease, other medical criteria and their willingness to become a part of the study.

Research protocols are reviewed to make sure the study is conducted fairly and participants are not likely to be harmed. Participants may withdraw at anytime. One of the myths regarding clinical trials is that the treatment is of “last resort.” In fact, clinical trials are just as important for early stage cancers and even prevention as for late stage cancer. Some think that if the patient is not assigned to the group receiving the new therapy, that he or she is receiving a placebo. Those not receiving the new therapy do receive the current standard of care.

Current participation rates in clinical trials for adults is only between 3 and 5% among adult cancer patients in the U.S. Approximately 60% of children with cancer are enrolled in clinical trials. Increasing participation among adults affords people the opportunity for up-to-date care from experts and contributes to the knowledge of, and progress against, cancer.^{10,11}

Treatment Goals and Objectives



“I have some good days and some bad ones. Just the word “Cancer” can put fear in to a person. I’m 82 years old but was working in our business every day. I miss that. Our son, who was also in the business has taken over. That gives me peace of mind - but it will be a happy day when I can walk into my office and work again.”

Dean L. Howell, Idaho Falls

Treatment Goal

All Idahoans diagnosed with cancer will receive quality cancer care.

Treatment Overarching Strategies and Activities

Policy/Advocacy

1. Identify policy changes needed to enhance access to cancer treatment by the uninsured or underinsured.

Infrastructure Development and Enhancement

2. Identify gaps in telecommunication systems and determine strategies to fill those gaps for improved telemedicine and telehealth utilization.

Education/Communication/Outreach

Professional Education

3. Utilize existing educational channels such as the Internet and telehealth communication systems for treatment-related continuing health professional education.

4. Increase the number of health professionals other than oncologists who are knowledgeable about optimal cancer screening and care through existing educational channels (meetings, grand rounds, etc.)

5. Monitor emerging science and determine channels to disseminate new evidence-based and approved therapies.

6. Include information about clinical trials in educational forums.

Patient Education

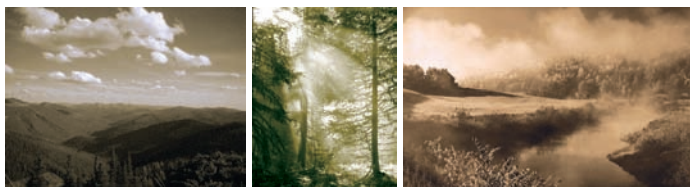
7. Identify and provide existing materials and resources, or create new materials if needed, that help guide patients through the decision making process regarding their cancer treatment.

8. Promote the identification or development of culturally and linguistically appropriate materials for cancer treatment and care.

9. Educate patients and promote enrollment in clinical trials when appropriate.

10. Better utilize existing health systems to address cancer information and referral regarding treatment issues (local health departments, Tribal health systems, community health clinics).

11. Develop systems to assist the uninsured and underinsured find existing resources to assist with the cost of treatment.



Treatment Goals and Objectives

Disparities

12. Measure variations in treatment practices by socioeconomic status, geographic area, race, and ethnicity to identify disparities in best practices.
13. Identify opportunities and resources to address gaps in service and access.
14. Identify existing or develop culturally sensitive and linguistically appropriate materials for diverse populations or other resources to guide and assist patients through the treatment process.
15. Work with Tribal communities and minority populations to increase access and participation in treatment clinical trials as they become available.

Treatment Objectives

Objective 3.1

By 2010, increase provider utilization of evidence-based treatment guidelines.

Baseline: To be established

Data Source: To be established

Strategies

1. Measure trends in best practice/evidence-based cancer care and disseminate to healthcare and public health professionals.
2. Provide educational opportunities for healthcare professionals regarding emerging science and cancer treatment.
3. Measure trends in 5-year relative survival by primary cancer site.
4. Measure trends in cancer incidence and mortality.
5. Monitor the proportion of female breast cancer cases treated with breast-conserving surgery (baseline 50.3%).
6. Monitor research and emerging science regarding prostate cancer treatment and care and disseminate information to clinicians.
7. Monitor the proportion of invasive colorectal cancer cases with regional lymph node sampling with 10 or more lymph nodes sampled (baseline 38.7%).
8. Monitor the proportion of late stage colorectal cancer cases treated with chemotherapy.
9. Monitor the proportion of invasive melanoma cases diagnosed with sentinel lymph node biopsy (baseline 26%).
10. Monitor the use of wide excisional procedure for invasive melanoma of the skin (baseline 52.7%).
11. Monitor first course treatment patterns for patients diagnosed with lung cancer.

Treatment Goals and Objectives



Objective 3.2

By 2010, increase access and referral to specialized cancer care services, including clinical trials.

Baseline: To be established

Data Source: To be established

Strategies

1. Ensure that all pediatric cancer patients are enrolled or offered participation in clinical trials.
2. Monitor adult participation in clinical trials through the CDRI.
3. Educate healthcare professionals in Idaho about the need to refer new cancer patients to cancer specialists early in cancer diagnosis and treatment process.
4. Promote the peer review process, though regional and multidisciplinary decision-making in complex cancer case management by developing electronic communication systems/linkage.



Objective 3.3

By 2010, increase the availability of resources and educational materials to help cancer patients make informed decisions regarding their care.

Baseline: To be established

Data Source: To be established

Strategies

1. Provide access to a clearinghouse for evidence-based treatment guidelines appropriate for the public.
2. Provide Idaho men diagnosed with prostate cancer access to treatment programs and information that will help them make informed choices about treatment options.



Treatment Goals and Objectives

Objective 3.4

By 2010, reduce racial, ethnic, socioeconomic and other disparities in access to cancer treatment and care.

Baseline: To be established

Data Source: To be established

Strategies

1. Utilize the 2-1-1 Idaho CareLine for information and referral to cancer related resources.
2. Reduce financial and geographical barriers to cancer treatment.
3. Reduce cultural and linguistic barriers to cancer treatment.
4. Enhance community-based programs, such as the lay health educators “Promotoras,” to extend reach into minority and rural populations.

“We are self-employed and must pay for our own health insurance. We would like an opportunity to join a group health plan. Due to my daughter’s cancer, our health insurance premiums are extremely high and take most of our income. My husband is a realtor. If realtors were allowed to form a group health plan, it would take a lot of pressure off us financially.”

Anna and Sydney Tapia, Boise



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Quality of Life and Survivorship



The National Cancer Institute estimates that in 2002 there were more than 10 million living Americans who had a history of cancer; some were currently cancer free and some had evidence of cancer or were undergoing treatment. The American Cancer Society estimates that the five-year survival rate for all cancers diagnosed between 1995 and 2001 is 65%—up from 50% in the 1970's.¹ In 2005, there were approximately 18,170 Idahoans with a history of cancer who were one-to-five year cancer survivors. Another 5,900 people will be diagnosed with cancer in 2006.¹

In 2005, there were approximately **18,170** Idahoans with a history of cancer who were one-to-five year cancer survivors. Another **5,900** people will be diagnosed with cancer in 2006.

The definition of “cancer survivor” has evolved over the years. When cancer was considered incurable, “survivor” referred to family members who survived the loss of a loved one to cancer. As the prognosis improved, physicians began referring to patients having no recurrence of cancer five years following diagnosis or treatment as “survivors.” The term includes the individual from the time of diagnosis through the remaining years of life as well as family members, friends and caregivers and will be the definition used for this chapter.² The Lance Armstrong Foundation (LAF) defines the experience of cancer survivorship as living with, through and beyond cancer.²

Quality of life is a multidimensional construct encompassing clinical, financial, functional and psychosocial domains. The concept of health-related quality of life refers to a person or group's perceived physical and mental health over time.³ Health-related quality of life measurements are used to determine the effects of chronic illness in patients to better understand how an illness interferes with a person's day-to-day life.⁴ Health-related quality of life is synonymous with physical, psychological, social, spiritual and economic well-being.⁵

Cancer patients and their families face numerous physical, psychological, social, spiritual and financial issues throughout diagnosis and treatment. These include, but are not limited to, short and long-term physical effects from treatment (pain, fatigue, nausea, hair loss, edema, loss of fertility, diminished sexual function); psychological issues (fear, stress, anger, depression, anxiety); and economic impacts (cost of treatment, job loss, inability to get insurance, caregivers missing work, travel and housing expenses).^{2,6}

Quality of Life and Survivorship



Palliative Care

The term “palliative care” goes beyond what many consider primarily end-of-life issues. The goal of palliative care is to prevent and relieve suffering and to support the best possible quality of life for patients and their families, regardless of the stage of the disease or the need for other therapies.⁷ Palliative care begins at diagnosis and should be provided throughout the entire cancer disease continuum. Palliative care is intended to prevent or relieve the symptoms of disease or the side effects of treatment. It does not alter the course of a disease but can improve the quality of life by alleviating pain, managing symptoms and putting the concerns of patients and their families first.⁸ It attempts to meet the physical, emotional, spiritual and practical needs of patients by helping to relieve pain, depression or other problems.

Pain Management

Despite advances in the field of pain management, studies still show that cancer pain is undertreated in most care settings, and pain is one of the problems patients with cancer fear the most. Undertreatment of cancer pain causes needless suffering, impairs patients’ ability to function, causes mood disturbances, hampers quality of life and increases the burden on family caregivers.⁹

Several barriers to effective pain management have been identified. Among healthcare professionals, problems include inadequate knowledge of pain management, poor assessment of pain, concern about side effects and fear of patient addiction. Problems related to patients include their reluctance to report pain and being perceived as not being a “good” patient, worry about side effects or becoming addicted. Healthcare system challenges include inadequate reimbursement, restrictive regulation of medications and cost. A systematic approach to pain assessment and management is needed throughout the spectrum of cancer from diagnosis, through treatment and after care to end-of life.¹⁰

End-of-Life Care

Generally, end-of-life care refers to the time when a healthcare team determines that a patient’s cancer is irreversible, can no longer be controlled and death is inevitable.^{11,12} Treatment does not end at that point, however. Care transitions from curative therapy to the clinical management of physical symptoms such as

Quality of Life and Survivorship



pain and nausea. In addition, there is a need for assistance with the emotional and psychological issues that arise including decision making, dealing with grief and caregiver support.¹³

There is much diversity in beliefs surrounding death and dying. Although belief systems may be prevalent among groups based on characteristics such as race, ethnicity, religion or country of origin, it cannot be assumed that a patient's origins will determine their approach to dying. Differences in beliefs include whether to inform the patient that they are dying, the use of life sustaining technology and resuscitation, approaches to pain management, and decisions as to where the patient will die. Health professionals need to see patients and their families as unique persons and have a general knowledge about possible differences within groups.¹⁴

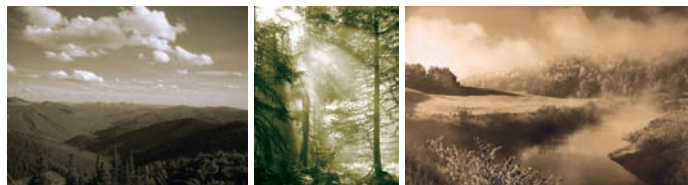
Hospice is a concept of care, not a location. Hospice care is a program that provides comfort, care and support to patients and their families in the last stages of the patient's life. The majority of hospice care is provided in the patient's home, family member's home and in nursing homes. Inpatient hospice facilities are sometimes available to assist with caregiving.¹⁵ In Idaho, as of January 2006, there were 33 hospice programs around the state, but many communities have no such programs and are far from these services.¹⁶

Complementary Therapies

Complementary therapies are practices used alongside conventional medicine. These include, but are not limited to, the area of mind, body and spirit (prayer, Native American healing, Tai Chi, yoga); nutrition (diet, supplements, juicing); and manual healing (healing touch, chiropractic, acupuncture). Complementary or adjunctive therapies are used for symptom management and to enhance quality of life along with mainstream care. Studies have shown that anywhere from 30 to almost 70% of cancer patients have used some type of complementary therapy along with their standard care. It is important to note that some complementary therapies may interfere with standard treatment or may even be harmful. It is critical for healthcare providers and patients to communicate; patients need to let their physicians know which complementary therapies they are using or considering and medical professionals need to be aware of their patients' preferences and use of complementary therapies.¹⁷⁻¹⁹



Quality of Life and Survivorship Goals and Objectives



Quality of Life and Survivorship Goal

Ensure that all cancer survivors, families and caregivers have access to services that enhance quality of life throughout all phases of their cancer experience.

Quality of Life and Survivorship Overarching Strategies and Activities

Policy/Advocacy

1. Encourage policy enhancement that would expand palliative and end-of-life care options.

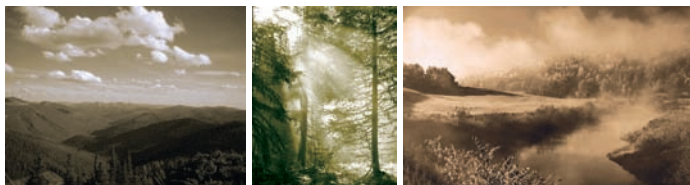
Infrastructure Development or Enhancement

2. Develop or enhance support systems in areas of the state where palliative and end-of-life care options are lacking.
3. Increase the number of palliative care providers.

Education/Communication/Outreach

4. Increase health professionals' awareness of quality of life and survivorship issues.
5. Increase awareness among the general public, policymakers, survivors, providers and others about cancer survivorship issues and impacts.
6. Ensure that all cancer survivors, families and caregivers have resources and knowledge regarding the long-term effects of treatment.
7. Support, disseminate and promote the "National Action Plan for Cancer Survivorship: Advancing Public Health Strategies" (Lance Armstrong Foundation).
8. Disseminate Idaho-specific sources for cancer information, resources and services.





Quality of Life and Survivorship Goals and Objectives

Quality of Life and Survivorship Objectives

Objective 4.1

By 2010, develop an infrastructure for the identification and dissemination of Idaho specific cancer resources.

Baseline: To be established

Data Source: To be established

Strategies

1. Develop an Idaho comprehensive cancer control database using existing Internet or other communication systems (e.g., Idaho Hospital Association web site, 2-1-1 Idaho CareLine).
2. Identify existing regional or community-based programs, projects or resources that could be linked or expanded to other areas to strengthen cancer support resources.

Objective 4.2

Increase the knowledge of health professionals and lay health leaders regarding quality of life and survivorship issues such as support groups, symptom management, pain management, palliative care, emotional and long-term effects and end-of-life-care services.

Baseline: To be established

Data Source: To be established

Strategies

1. Provide educational opportunities for health professionals (physicians, nurses, and others) and lay health leaders (e.g., Promotoras) regarding pain management, symptom control and other quality of life and survivorship issues.
2. Encourage health professionals to provide information on long-term risk reduction for the development of diseases, such as osteoporosis, as a result of cancer treatment; and improve quality of life through other prevention behaviors such as smoking cessation, increased physical activity and fruit and vegetable intake.
3. Gather clinical feedback and standardize the use of tools to assess pain, functional status and other cancer-related symptoms.

Quality of Life and Survivorship Goals and Objectives



Objective 4.3

By 2010, support the dissemination of existing, or the development and delivery of, patient advocacy/navigator training programs for rural/frontier hospitals (local hospital based support system using hospital and/or American Cancer Society volunteers) to increase the knowledge, the availability and the use of psychosocial services for newly diagnosed patients.

Baseline and source: ACS, "Survivorship Research"²⁰

Strategies

1. Identify, or develop if needed, the resources to address psychosocial support.
2. Develop a cadre of trained individuals to assist newly diagnosed cancer patients with resources available to them.

Objective 4.4

By 2010, educate survivors about, and improve access to, quality of life services such as support groups, symptom management, pain management, palliative care, emotional and long-term effects and end-of-life-care services.

Baseline: To be established

Data Source: To be established

Strategies

1. Educate patients on the myths, realities and value of pain management to dispel fears of medication addiction.
2. Utilize a multi-disciplinary "whole person" approach to address survivorship issues.
3. Identify or develop culturally and linguistically appropriate materials for cancer survivors that promote and support positive health behaviors and the reduction of risk for the development of diseases and conditions as a result of treatment (such as osteoporosis).
4. Promote the development of a written survivorship care plan for every survivor discharged from primary cancer care.²¹

Quality of Life and Survivorship Goals and Objectives



Objective 4.5

By 2010, increase patient, healthcare provider and institutional awareness of the use, efficacy, risks and benefits of complementary cancer therapies.

Baseline: To be established

Data Source: To be established

Strategies

1. Increase health professionals' knowledge regarding patients' attitudes toward, and use of, complementary therapies.
2. Increase health professionals' knowledge regarding the efficacy of complementary therapies that support patients' comfort and quality of life during treatment.
3. Identify communication tools that acknowledge the use of complementary therapies and provide patients with guidance on safe use or contraindications for certain therapies during cancer treatment or care.



Objective 4.6

By 2010, identify, develop (if needed) and disseminate physical activity programs that are appropriate for cancer patients and survivors.

Baseline: To be established. Inventory existing programs.

Target: Increase the number of programs and facilities providing programs

Strategies

1. Research physical activity programs adapted specifically for cancer patients and survivors that have been shown to be beneficial and improve quality of life (yoga, tai chi or other).
2. Identify trainers or teachers for cancer physical activity programs in Idaho.
3. Identify methods for expanding programs into areas of the state where there are none or where there is only limited availability.





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Appendix A. Glossary



Appendix A. Glossary

Cancer An umbrella term for over 100 diseases characterized by abnormal and uncontrolled cell division.

Cancer clusters The occurrence of a larger-than-expected number of cases of cancer within a group of people in a geographic area over a period of time.

Cancer health disparities The NCI definition; differences in the incidence, prevalence, mortality, and burden of cancer and related adverse health conditions that exist among specific population groups in the United States.

Cancer staging The process of defining the extent of the disease or the spread of the cancer from the site of origin (how advanced a cancer is).

In situ Cancer cells present only in the layer of cells where they developed.

Localized Cancer cells present within the organ where they developed

Regional Cancer cells found adjacent to organs/tissues or regional lymph nodes.

Distant Cancer cells that spread to other organs or distant lymph nodes.

Clinical trials Research studies that compare groups of people.

Colonoscopy A test of colorectal cancer in which the entire rectum and colon are examined with a fiberoptic instrument.

Cultural competency The ability to work effectively with and/or serve culturally and ethically different population groups which involves an experiential understanding, awareness, and respect for the beliefs, values, and ethics of other cultures; and the cross-cultural skills necessary for delivering services and working with diverse individuals and groups.

Five-year survival The percentage of people with a given cancer who are expected to survive five years or longer with the disease.

Incidence The frequency of new occurrences of a condition within a defined time interval.

Mammogram A low-dose x-ray of the breast used to detect breast cancer.

Palliative care Palliative Care is treatment focused on providing comfort and enhancing the quality of life during the last stages of life.

Promotoras Promotores and Promotoras are community members of minority and underserved populations who integrate information about health and the healthcare system into the community's culture, language and value system, thus reducing many of the barriers to health services. They provide peer education, support and links to services. Farmworkers and Latino health organizations, including Migrant Health Promotion, generally refer to these individuals as Promotores(as) or Promotores(as) de Salud, literally health promoters." In English, most call themselves Community Health Workers.

Risk factor Something that may increase the chance of developing a disease. Some examples of risk factors for cancer include age, a family history of certain cancers, use of tobacco products, certain eating habits, obesity, exposure to radiation or other cancer-causing agents and certain genetic changes.

Radon An odorless radioactive gas released by uranium, which is a substance found in soil and when breathed in can lead to damage of the cell of the lungs and lung cancer.

Target The desired goal and measurement intended to be attained.

Years of potential life lost A statistic that measures the total number of life years lost owing to premature death in a population from a certain cause. Premature death is usually defined as death at the age of less than the average life expectancy.



Appendix B. Abbreviations and Acronyms

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ACS American Cancer Society

BHPVS Bureau of Health Policy and Vital Statistics

BRFSS Behavioral Risk Factor Surveillance System

CBE Clinical Breast Exam

CDC Centers for Disease Control and Prevention

CDRI Cancer Data Registry of Idaho

CERCLA Comprehensive Environmental Response,
Compensation, and Liability Act

CIS Cancer Information Service

DRE Digital Rectal Exam

FOBT Fecal Occult Blood Test

HIPAA Health Insurance Portability and Accountability
Act

HPSA Health Professional Shortage Areas

HPV Human Papilloma Virus

ICCCP Idaho Comprehensive Cancer Control Program

IDHW Idaho Department of Health and Welfare

IPAN Idaho Physical Activity and Nutrition Program

MUA Medically Underserved Area

NAACCR North American Association of Central Cancer
Registries

NCI National Cancer Institutes

NIAAA National Institute on Alcohol Abuse and
Alcoholism

NIH National Institutes of Health

PSA Prostate-Specific Antigen

QOL Quality of Life

SEER Surveillance, Epidemiology, and End Results

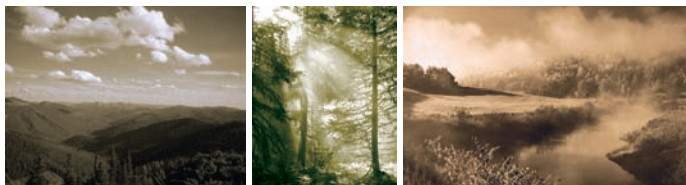
SHEPS School Health Education Profile System

USPSTF United States Preventive Services Task Force

WHC Women's Health Check

YRBS Youth Risk Behavioral Surveillance System

Appendix C. Healthy People 2010 Cancer Objectives



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1. Reduce the overall cancer death rate.
2. Reduce the lung cancer death rate.
3. Reduce the breast cancer death rate.
4. Reduce the death rate from cancer of the uterine cervix.
5. Reduce the colorectal cancer death rate.
6. Reduce the oropharyngeal cancer death rate.
7. Reduce the prostate cancer death rate.
8. Reduce the rate of melanoma cancer deaths.
9. Increase the proportion of persons who use at least one of the following protective measures that may reduce the risk of skin cancer: avoid the sun between 10 a.m. and 4 p.m., wear sunprotective clothing when exposed to sunlight, use sunscreen with a sun-protective factor (SPF) of 15 or higher, and avoid artificial sources of ultraviolet light.
 - 9a. (Developmental) Increase the proportion of adolescents in grades 9 through 12 who follow protective measures that may reduce the risk of skin cancer.
 - 9b. Increase the proportion of adults aged 18 years and older who follow protective measures that may reduce the risk of skin cancer.
10. Increase the proportion of physicians and dentists who counsel their at-risk patients about tobacco use cessation, physical activity, and cancer screening.
11. Increase the proportion of women who receive a Pap test.
12. Increase the proportion of adults who receive a colorectal cancer screening examination.
13. Increase the proportion of women aged 40 years and older who have received a mammogram within the preceding 2 years.
14. Increase the number of States that have a statewide population-based cancer registry that captures case information on at least 95% of the expected number of reportable cancers.
15. Increase the proportion of cancer survivors who are living 5 years or longer after diagnosis.

Source: <http://www.healthypeople.gov/document/Word/Volume1/O3Cancer.doc>



Appendix D. Ten Essential Public Health Services

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1. Monitor health status to identify and solve community health problems.
2. Diagnose and investigate public health problems and health hazards in the community.
3. Inform, educate, and empower people about health issues.
4. Mobilize community partnerships and action to identify and solve health problems.
5. Develop policies and plans that support individual and community health efforts.
6. Enforce laws and regulations that protect health and ensure safety.
7. Link people to needed personal health services and ensure the provision of healthcare when otherwise unavailable.
8. Assure competent public and personal healthcare workforce.
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
10. Research for new insights and innovative solutions to health problems.



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